Overview

A Quality Management System (QMS) is a commonsense approach of organizing the business and support processes that affect the quality of regulatory oversight and service delivery. While an individual is critical to the success of the system, they are only one component. The success of any QMS relies upon clearly documented policy and procedures, adequate training, review of the processes being used, and, when necessary, a plan for improvement.

The Aging and Long-Term Services Administration (ALTSA) QA unit is located within the Office of the Assistant Secretary (OAS) and collaborates with the Residential Care Services (RCS) Quality Improvement (QI) Unit.

The QA Unit's purpose is to complete process reviews which provide data to show required standards are met, to work collaboratively with the divisions, to act as an internal control, and to help identify areas for improvement.

The QI Unit's purpose is to develop Proficiency Improvement Plans (PIPs) in response to the QA process reviews, as well as maintain the RCS Standard Operating Procedures and associated forms. Additionally, the QI unit leads the RCS division in the development and implementation of all statewide QI policies, processes, and procedures to assist in assuring division compliance with all state and federal requirements, as well as agency and administration policies.

RCS must comply with the following federal regulations and Revised Code of Washington (RCW) chapters:

- Social Security Act 1819(g)(2)(D)
- Social Security Act 1919(g)(2)(D)
- 42 CFR § 488.312 Consistency of Survey Results
- 42 CFR § 441: Services: Requirements and Limits Applicable to Specific Services
  - Subpart G – Home and Community Based Waivers § 441.301 and 302
  - Subpart K – CFC § 441.500 through 590, § 441.530 HCBS Rules
- RCW 43.17.385 Quality Management, Accountability, and Performance System
- RCW 74.39A.051 Quality Improvement Principles
- SOM Chapter 7 Section 7800 – 7800.2 Consistency of Survey results: Measuring Consistency
- SOM Chapter 7A Principles of Documentation: Legal Aspects of the SOD
- CMS Quality Measures and Reporting Memo:
  - Section 3 – 86% Proficiency threshold and PIP requirement
  - Section 2 – Individual finding remediation requirement
- ALTSA Strategic Plan

This chapter contains information about the QMS within RCS related to QA process reviews and QI activities. The content is relevant to RCS staff, community engagement partners, and anyone seeking to understand the RCS QMS.

These procedures are in addition to DSHS Administrative Policies, as they are specific to RCS. These procedures will be reviewed for compliance and accuracy at least every five years

Contacts

- OAS/RCS Quality Assurance Unit General Contact
- RCS Quality Improvement Unit General Contact
- RCS Policy Unit General Contact (**internal** RCS use)
- RCSPolicy@dshs.wa.gov (**external** RCS use)

Table of Contents

Part IV: Appendices

A. Glossary of Terms
B. Acronym List
C. Sample QA Process Review Result Email Template (for QI Use)
D. Resources and Forms
E. RCS Connection to CMS
F. Change Log

Part I: Quality Assurance Process Reviews

A. General Guidelines

Purpose

The Quality Assurance Unit under the Office of the Assistant Secretary (OAS) is tasked with conducting QA Process Reviews for RCS. The purpose of conducting QA Process Reviews is to ensure RCS activities comply, and continue to comply, with minimum licensing standards, current RCWs, Washington Administrative Codes (WACs), and relevant federal regulations. The primary focus is on resident rights and their safety and well-being, including assuring continued inclusion in Medicare and Medicaid programs.

- For information about each setting or program area reviewed by QA, see Appendix D: Resources and Forms.
- For information about the federal connection between RCS and CMS, see Appendix E: RCS Connection to CMS.

Procedure

1. The QA Unit will:
   a. Conduct required process reviews to determine compliance with standards and federal regulations.
   b. Follow all procedures to ensure consistent QA process reviews.
   c. Complete process reviews in a timely manner.
   d. Monitor the email box and respond to inquiries within one working (business) day (WD).
   e. Clearly communicate findings and trends.

      Note: The purpose of findings is to demonstrate an identified gap between policy guidance and what was found during the process review. It should not be considered positive or negative, only what was found (identified).

   f. Always maintain professional and respectful conduct.
2. QI Unit will:
   a. Participate in any collaborative training sessions with the QA unit.
   b. Assist with facilitating discussions with RCS staff when process questions arise.
   c. Monitor the email box and respond to all inquiries within two WD.

Definition of roles within the QA Unit

1. ALTSA QA Unit Manager
   a. Supervises and provides oversight to the QA Unit to ensure all processes and procedures are followed and QA reviews are completed as required.
   b. Performs regular spot checks of QA Consultant work for quality, consistency, and interrater reliability.
   c. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.
   d. Assures the statistical relevance for all sampling and sample methodology and determines samples sizes required.
   e. Maintains the QA Monitor Tool.
      1) Ensures all RCS staff have access to the QA Monitor Tool.
      2) Ensures trainings are available related to use of the QA Monitor Tool.
      3) Coordinates with Management Services Division (MSD) to repair bugs, create reports, or work on issues as they arise.
2. Process Review Lead
   a. The Process Review Lead (Lead) is the QA Consultant assigned to coordinate the process review and all associated tasks to ensure completion.
   b. Creates and distributes statistically significant and accurate samples.
   c. Ensures all information and files are available for the process review, including updated reports, updated question documents, information sheets, required files, and any other information needed for the review.
   d. Coordinates information requests to or from the program to be sure all questions and data requests for the review are addressed. Tracks responses to ensure any required updates to documents and processes are complete.
   e. Ensures all QA reviews are entered and closed correctly during reviews, at the end of the review, and at the end of the calendar year to validate reviews are completed in the QA Monitor Tool.
   f. Creates or runs required reports to ensure historical records are available.
3. QA Consultant
   a. Is a member of the QA Unit who coordinates and completes QA process reviews.
   b. Completes process reviews in the manner prescribed in the instruction documents, in this chapter, and in documents produced through the question document review process.
   c. Works within the unit to ensure all work is completed in a professional and collaborative manner.
4. ALTSA Management Analyst (MA)
   a. Is a member of the ALTSA QMS who reports directly to the ALTSA Senior QA Administrator.
   b. Provides RCS QI Coordinators (QICs) data analysis one WD prior to the exit conference and two WD after initial proficiency reports are finalized.
   c. Collaborates and consults with QA and QI when reviewing data.
   d. Provides Ad Hoc data analysis and reports as requested by agreed deadlines.

e. Documents potential enhancements to QA reports throughout the year.
f. Works with the QA Monitor Development Team to correct issues with QA reports, suggest improvements, and test changes to the QA tool or reports.

QA Unit Manager Responsibility

1. Recruits, hires, and ensures that new QA staff are trained.
2. Ensures QA staff demonstrate a working knowledge of this policy.
3. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.
4. Requests clarification from RCS and ALTSA leadership as needed.

Definition of roles within the QI Unit

1. RCS QI Unit Manager
   a. Supervises and provides oversight to the QI Unit to ensure all processes and procedures are followed and QI activities are completed as required.
   b. Performs regular spot checks of QIC work for quality, consistency, and accuracy.
   c. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.
   d. Distributes QA Process Review result reports to the Regional Administrators (RAs), Field Service Administrators (FSAs), and Field Managers (FMs), following both the preliminary proficiency reports, as well as the final statewide exit conference.
   e. Present overview of QA/QI in collaboration with the QA Unit Manager, coordinated with the training unit.
   f. Maintains the QI SharePoint site (also known as QIC Central)
      1) Ensures all RCS staff have access to QIC Central Resources.
      2) Establishes protected folders for individual unit process review results.
2. QI Program Lead
   a. The Program Lead is the QIC assigned to coordinate all QI activities for the assigned program. This includes but is not limited to QA process reviews response, including data analysis, change requests, root cause analysis, and PIP development, as well as associated tasks to ensure completion and ongoing monitoring. The lead is responsible for the success of all QI activities.
   b. Coordinates creation and delivery of any QI driven trainings related to PIP activities and form updates.
   c. Presents QI Overview at program specific trainings, coordinated with the training unit.
   d. Coordinates trainings for QI team members (i.e., needed QI checks, etc.).
   e. Responds to all communications related to the assigned program received via the unit email inbox.
   f. Ensures all relevant program information is available to the team via QIC Central or in the Teams Channel.

g. Coordinates quarterly program lead meetings with the following units:
    1) Policy – Send the invite to the assigned Policy Program Manager (PPM) with a cc (carbon copy) to the Policy Unit Manager.
    2) Training – Send the invite to the general training contact with a cc to the appropriate Training Unit Manager.
    3) Compliance and Enforcement – Send the invite to the Compliance and Enforcement Unit Manager.
    4) Informal Dispute Resolution (IDR) – Send the invite to the IDR Unit Manager.
    5) Quality Assurance – Send the invite to the general QA contact with a cc to the QA Unit Manager.
    6) Project Specialist
    7) Other persons identified as relevant to topics on the upcoming agenda
h. Ensures all QI monitoring checks are entered and closed per the process defined in the section labelled 'Thirty Day Reviews.'
i. Lead will coordinate QI activities with their Co-Lead.

3. QI Program Co-Lead
    a. Supports the Lead in completing program related QI activities.
    b. If the Lead is unavailable, the Co-Lead will take additional Lead responsibilities as needed.
        1) If what is needed is unclear, consult with the Unit Manager.
    c. Provide technical support during any QI provided trainings and presentations (e.g., note taking, PowerPoint navigation, etc.).
    d. Co-Lead will coordinate QI activities with the Program Lead.
4. QI Coordinator
    a. Is a member of the QI Unit who coordinates and completes QI activities.
    b. Works within the unit to ensure all work is completed in a professional and collaborative manner.

QI Unit Manager Responsibility

1. Recruits, hires, and ensures that new QI staff are trained.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Conducts supervisory reviews of QI staff work to ensure policies and procedures are followed.
4. Requests clarification from RCS leadership as needed.

B. Process Review Schedule

Overview

ALTSA QA maintains a 12-month QA Process Review Schedule, which runs January through December. The schedule is available on the RCS QA SharePoint site.

All QA reviews entered into the QA Monitor Tool by QA or as a Supervisory review (also called 'checks' by QI when completed by them) must be closed and completed before the system lock-out in December when updates are processed for the next review cycle. This includes adding necessary 30-Day reviews and overturning findings when required. When reviews are not fully closed by the end of the calendar year, they are locked in place and remain in the QA Monitor as open reviews with no way to close them. This creates a layer of complexity that interferes with the functionality and ease of use of the system.

Procedure

The QA Unit Manager will publish a Management Bulletin (MB) at the beginning of each year to update the process review schedule. If the dates or the number of reviews change after the original release, staff will be notified by Management Bulletin (MB), and the RCS QA SharePoint site will be updated.

The Process Review Schedule includes key information, such as:

1. Each process review area being completed for the year and whether a full or a focused review will be completed.
2. Review dates: QA team trainings, entrance dates, and file review dates.
3. Dates the initial statewide proficiencies will be provided to QI.
4. Change request and remediation due dates.
5. Change Request Committee (CRC) dates.
6. Final statewide exit conference dates.
7. QA Question Document Review Meeting dates.

QA Unit Manager Responsibility

1. Creates and submits the annual MB to the QI unit for publication to provide RCS with the updated schedule and process review information.
2. Conducts end of year review verifications to ensure staff are following the policy.
3. Assures that weekly updates are sent for posting when changes to the schedule are required.

C. QA Question Document Review Meetings

Overview

QA is responsible to complete process reviews using specific questions developed to ensure we are meeting federal, state, and ALTSA leadership guidelines. The questions are reviewed and updated with input from RCS Policy, Training, QI, and other subject matters experts (SMEs) and are approved by the RCS Director.

Questions are updated based on current policies, procedures, the DSHS and ALTSA Strategic Plans, federal legislation, federal requirements for State Plans, Waivers, and Home and Community-Based setting rules, state legislation, current issues the division is experiencing, or in response to external audits or litigation.

How QA reviews each of the questions is developed by the QA Unit with input from SMEs and feedback from staff. These meetings are key to providing the opportunity for all staff to provide input and ensure QA has as much information as possible to complete the review accurately and efficiently.

QA data is tracked and may be reported to federal partners to provide evidence of compliance with, and for continued inclusion in, Medicare and Medicaid programs. The information gathered from QA process reviews is also intended to assist the division with process improvement activities, act as an internal control, as well as maintain compliance.

All current QA question documents are located on the QA SharePoint site and are available by contacting QA.

Procedure

1. QA Question documents are reviewed, updated, and revised as changes are required.
2. The Lead will facilitate a meeting with QI, policy, training, area specific SMEs, and interested staff to review QA questions. In this meeting, all sections of the documents may be reviewed and revised.
3.
4. Once final drafts are completed, significant changes to questions or proficiency expectations are reviewed and approved by the RCS Director. Questions and expected proficiencies may be reviewed with the QA Steering Committee for final approval only when the RCS Director determines it is necessary.

5. When MBs or new policies are published, QA will conduct reviews to that standard 30 calendar days after the MB or policy is effective unless it is more beneficial to RCS to implement the standard immediately.
6. QA question materials to be used for the year are published to the QA SharePoint site Schedules Page, and links are also provided in the QA Schedule MB.

QA Unit Manager Responsibility

1. Reviews required changes with the RCS Director to obtain final approval.
2. Researches and responds to inquiries from the QA Unit.

QI Program Lead Responsibility

1. Participate in all QA Question Document Review meetings for their assigned program.
2. If unable to attend, coordinate with the co-lead or Unit Manager.
3. Notify QA of process changes that may affect how QA Process Reviews are completed (i.e., form updates, Standard Operating Procedure [SOP] updates, etc.).
   a. It is encouraged to notify QA as topics arise.
   b. Maintain a log of potential updates between process reviews for tracking purposes.

D. Sample Methodology

Overview

The QA Unit uses the statistically valid sampling methodology recommended by the Centers for Medicare and Medicaid Services (CMS). Raosoft's Sample Size Calculator is used to determine statewide sample sizes using the recommended 5% margin of error and 95% confidence level. There are reviews in which the universe (the entire population subject to review) is too small to use only a sample of the population. In these cases, the entire universe is reviewed.

The RCS Sample Methodology statement is available from QA by request and is also published on the QA SharePoint site.

Procedure

1. For Adult Family Homes (AFH), Assisted Living Facilities (ALF), Enhanced Services Facilities (ESF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and Nursing Home (NH) settings, QA determines the statistically significant sample size required for the entire state using the methodology noted above with the number of facilities in the state being the universe. Because these settings are regionally based, the number of files to be reviewed per unit is based on that unit's pro-rated share and may be adjusted to ensure the sample size requirement is met.

   Example of a sample calculation

   - In 2023, there were 550 Assisted Living Facilities (ALFs) in the state.
   - When 550 was entered into Raosoft, a statistically significant sample size was calculated at 227. Therefore, 227 ALFs which had a licensing visit during the sample timeframe were chosen.
   - Region 2 had 238 ALFs, which equals 43% of the total universe.
   - Because 43% of 227 is 98, Region 2 will have 98 ALF licensing visits reviewed.
   - When the licensing visit being reviewed had a follow-up visit that fell within the sample timeframe, that follow-up was reviewed by QA. If the follow-up was after the sample timeframe ended, it was not reviewed by QA.

2. For other program areas being reviewed such as Statements of Deficiencies (SODs), Complaints, CRU intakes, CCRSS Evaluations, Residential Inspection and Quality Assurance Program (RIQAP), and Business Analysis and Applications Unit (BAAU), the sample is derived using methodology appropriate to the work completed.
   a. For SODs, the statewide sample is based on the number of settings within the state. The sample is pro-rated by the number of, and the type of facility found in each region.
   b. For the other reviews, the work completed is used to derive the sample. Using CRU as an example, if there are 40,000 intakes that year, the universe would be 40,000 and 382 intakes would be the sample size to be reviewed by QA. Those 382 intakes are pro-rated by the priority assigned to the intakes.

3. The sample and entrance documents will be sent to the program's designees prior to the start of the process review as described in section labeled 'Process Reviews'. The timeframe for the entrance communication may be adjusted based on program need, or to allow time for files to be gathered and provided to QA.

RCS Staff Responsibility

Working paper documents/non-electronic records:

1. When paper files or documents are required for a review, the Lead will coordinate with Regional Leadership to ensure files are provided to QA according to direction provided in the following section. Files must be received by QA at least one week prior to the start of the review.
2. For further information or questions about dates, please email the QA unit.

QA Unit Manager Responsibility

1. Ensures sample methodology meets required standards.

E. Sending files or documents to ALTSA QA

Overview

ALTSA QA serves as the primary technical quality control to ensure timely and consistent processes for meeting federal and state regulatory requirements. Documents reviewed contain confidential information and potentially contain protected health information. This process was created to ensure all information is transmitted as securely as possible.
The purpose of this section is to provide all RCS staff with a standardized and secure process for sending information and documents to ALTSA Quality Assurance (QA) until the paperless system is fully implemented.

Option 1: Use the copy machine in any RCS office to scan documents directly to QA.

1. Using the scan feature, choose the option that says either "RCS Upload" or "QA PDD". Change the scan setting to double sided and use the auto feeder to scan the documents. E-mail RCSQuality@dshs.wa.gov to tell us a file was sent.

Option 2: Send documents using the QA shared folder.

1. Add your folder to the shared file at this link: Q:\RCS QA PDD\Deliver to QA.
2. Include an identifier such as the facility name in the document title, and email QA at RCSQuality@dshs.wa.gov to tell us a file was added to the folder.

Procedure

1. RCS Staff will:
   a. Review and use the methods for securely providing files to QA.
   b. Contact their Field Manager or QA at RCSQuality@dshs.wa.gov for additional information, if needed.
   c. NOT use e-mail, create cloud files, or send files to QA in any other format.
2. ALTSA QA will:
   a. Understand this policy and ensure staff questions are responded to promptly.

F. Process Reviews

Overview

The QA Unit is responsible for determining whether specific proficiencies were met based on a prescribed set of questions. See section labeled 'QA Question Document Review Meetings' for information on the process question development for the process reviews.

The process reviews discussed in this section are defined as: the entrance, the initial process review work completed by QA, and the preliminary reporting. Process reviews are conducted remotely by the ALTSA QA Unit and staff are not required to travel.

Each process review is assigned a Process Review Lead (Lead), who is responsible for ensuring process review activities are completed. The Lead is considered the liaison and the SME for QA activities for the areas to which they are assigned. For information about which QA Unit Member is assigned as Lead for a specific area, please email the QA unit or refer to the QA Schedule.

Procedure

Entrance:

1. QA will e-mail entrance correspondence to designated staff for the area being reviewed. This will include pertinent information related to the process review, such as the name of the Lead and an information sheet with pertinent dates and information for the review.
2. The Lead will contact designated representatives to communicate any questions, concerns, or needs of the unit prior to the start of the review. This will include verifying receipt of non-electronic records or files requested.
3. The Lead is responsible for ensuring communication between the staff and QA occurs during the review, as questions arise.
4. The Lead will communicate with Policy, Training, QI, and other SMEs, as needed to ensure the review is as accurate as possible, and new policies and procedures are communicated to QA.
5. The Lead will track any issues with the review, with questions, or with question documents. This information is gathered so that any issues are addressed at the next question document review meeting to inform potential updates.

Initial process review work:

At the beginning of the review, the Lead will ensure the program subject to review is aware the review has begun.

The Lead will:

1. Ensure all files and data are available to QA.
2. Establish an open line of communication for the process review, and act as the primary point of contact.
3. Monitor the QA mailbox and respond to inquiries within 1 WD.
4. Verify that any required non-electronic records are received in compliance with the section labeled 'Sending files or documents to ALTSA QA' at least one week prior to the start of the review.

   Note: if records are not received prior to the completion of the review, this will result in a finding as QA will not be able to consider records submitted after the start of the review. See Remediations for more information

5. Update the community SharePoint to ensure that all information is current and accurate.

During the process review, the Lead will:

1. Track all issues and missing non-electronic records and work toward a resolution before QA begins to review records.
2. Notify the program contact of remediation requests and the date they are due and follow up until all remediation requests are addressed.
3. Pull reports on a regular basis and identify issues which must be resolved. This is typically referred to as 'balancing' the team's work. The Lead will manage this process and ensure issues are found and corrected as soon as possible during the process review.

F. Statewide Initial Reports

Overview

At the completion of the review of records, initial proficiencies are sent to the QI unit or the Unit Leadership when QI does not work with the program area. These are the preliminary results prior to any changes made during the change request process or at the Change Request Committee (CRC) meetings (refer to section labelled 'Change Requests' for more information). These preliminary results are subject to change once change requests are finalized.

Finalization of results in the QA Monitor tool occurs after the 30-day process described in the section labeled 'Thirty-Day Reviews' is completed.

Procedure

1. The ALTSA QA MA will send preliminary reports by the date posted on the official QA Unit Schedule. Reports are sent to QI or the Unit Leadership (see overview section above).
2. The QI Unit Manager will compile the results by Program and then provide a breakdown of the data by State, Region, and Unit. Results will include overview graphs, the proficiency reports, and the QA Analysis Comments. Reports will be distributed to the RAs, FSAs, and FMs.
   a. Emails to the RAs, FSAs, and FMs should include details of next steps, including when change requests are due. Sample email template can be found in Appendix C.
   b. Change Requests must be entered into the QA Monitor Tool by the due date identified on the official QA Unit Schedule. To ensure timely receipt and review of all submitted change requests, they must be submitted to QI five WD prior to the due date on the schedule.

G. Remediations

Purpose

Remediation is the process of correcting an issue found during QA's review. Some findings relate to health and safety, some issues could result in litigation, and other issues may result in monetary penalties or federal payback of funds. These types of findings require the issue to be corrected. There are times when remediation is not possible. QA question documents identify these questions by using '*Historical data, unable to remediate*' as the remediation option.

Background check reviews are required during many of our licensing and survey activities. When there is a finding, remediation is required and must be completed within three WD from the notification of the finding.

Other remediation types include missing non-electronic records, required referrals were not sent, updates to internal systems, or the continuing education training requirement was not met by a provider. Timeframes for when the remediation is due is provided by QA when the region is notified of the finding.

QA will enter the appropriate remediation response for each finding during the 30-day review cycle or indicate that remediation was not possible. This input is required to allow the QA Monitor Tool to function properly at the end of each review year.

Procedure

The following findings require remediation:

1. **Background Check Reviews Not Documented**
   a. During licensing visits, surveys, and evaluations, RCS staff review employee files to verify a system is in place for completing required background checks and required training.
   b. When these systems are not in place, the residents or clients are at risk for potential harm.
   c. The state must prove that providers have met qualifications to receive federal funding. When we are not able to, we may be required to pay back federal money received for that resident or client during the time the provider was not proven to be qualified to provide care.

RCS RAs, FSAs, FMs, or Designated Staff will:

1. When the background check was in the working papers and the administrative record form was incorrect:
   a. Provide the explanation on the Remediation List. (Do not send background checks or other documents with sensitive information).
   b. When QA has confirmed receipt, the remediation is complete. No further action is required.

2. When there was a background check review completed at a subsequent visit such as a complaint investigation or a follow-up:
   a. Provide the explanation on the Remediation List; include the Compliance Determination (CD) Identifier for the visit (Do not send background checks or other documents with sensitive information).
   b. When QA has confirmed receipt, the remediation is complete. No further action is required.
3. When there is no evidence to show that the background check has been completed:
   a. Email the Complaint Resolution Unit (CRU) to initiate a 10-day complaint investigation.
   b. Provide the intake number and explanation on the Remediation List.
   c. When QA has confirmed receipt, the remediation is complete. No further action is required.

2. **Continuing Education (CE) for AFH providers licensed by the Washington Department of Health (DOH) as a Home Care Aide (HCA)**

   a. During licensing visits, surveys, and evaluations, RCS staff review employee files to verify that all required trainings were completed.
      1) When staff are not properly trained, the residents or clients are at risk for potential harm.
   b. The state must prove that providers have met qualifications to receive federal funding. When we are not able to, we may be required to pay back federal money received for that resident or client during the time the provider was not proven to be qualified to provide care.
   c. The state reports information on these specific providers CEs to our federal partners to show we are meeting waiver and state plan requirements.

RCS RAs, FSAs, FMs, or Designated Staff will:

1. When there is evidence of CE completion in the working papers and the administrative record form is incorrect:
   a. Provide this information on the Remediation List. (Do not send training completion certificates or documents with sensitive information).
   b. When QA has confirmed receipt, the remediation is complete. No further action is required.
2. When there was evidence of CE completion at a subsequent visit such as a complaint investigation or a follow-up visit:
   a. Provide this information on the Remediation List.
   b. When QA has confirmed receipt, the remediation is complete. No further action is required.
3. When there is no evidence to support that CEs have been completed:
   a. Email CRU to initiate a 10-day complaint investigation.
   b. Provide this information on the Remediation List.
   c. When QA has confirmed receipt, the remediation is complete. No further action is required.

3. **Required Referrals Were Not Sent**
    a. When additional information gathered during a complaint investigation supports the need for a referral to another entity, QA verifies that referral has been sent.
    b. When these referrals are not made, the residents or clients are at risk for potential harm.

RCS RAs, FSAs, FMs, or Designated Staff will:
1. Email CRU to notify them that additional referrals are required.
2. Provide this information on the Remediation List.
3. When QA has confirmed receipt, the remediation is complete. No further action is required.

4. **Missing File or Documents**
    a. When a working paper file or a document requested by QA was not provided during the initial records request.
    b. Missing records pose a risk to RCS because we would not be able to produce evidence for requirements without our documentation.
    c. Documentation in our records may also include protected health information, background check results, or other sensitive information which are subject to our record retention and protection policies.

RCS RAs, FSAs, FMs, QI Staff, or Designated Staff will:
1. Send QA the documentation requested as soon as possible.

> Note: When the information is provided to QA **prior** to the end of the review period, there will not be a finding. When the information is provided to QA **after** the end of the review period, there will be a finding, and the documentation will be considered remediation for the finding.

5. Applications do not match Internal Systems (BAAU)
    a. When internal systems do not match information listed on an application.
    b. Internal systems should reflect accurate information as submitted by applicants.

RCS RAs, FSAs, FMs, or Designated Staff will:
1. Update the system with the information that did not match the application.

Remediations that require complaint investigations

1. CRU Staff will:
   a. Process field requests per SOP Chapter 4, Complaint Resolution Unit:
      1) Assign 10-Day priority to investigation requests for background check and training reviews.
      2) Process referral requests as required.
2. Complaint Investigation Staff will:
   a. Review or investigate only what was stated as missing in the intake following SOP Chapter 20, Complaint Investigations. It is not necessary to provide information about your investigation to QA.

For all remediation types

1. ALTSA QA Staff will:
   a. Email appropriate RCS staff as soon as possible upon discovery of a required remediation, including:
      1) Regional Administrators (RA)
      2) Field Service Administrators (FSA)
      3) Field Managers (FM)
      4) Quality Improvement (QI)
      5) Other assigned designees
   a. Include a link to the Remediation List.
   b. Follow up as appropriate to verify the remediation is completed.
   c. Maintain and update the remediation list.
   d. Provide documentation that illustrate the findings.
      1) Enter initial review results into the QA Monitor Tool during the initial review.
      2) Enter all remediations into QA Monitor during the 30-day review process.

H. Change Requests

Purpose

The purpose of the change request process is to allow staff the opportunity to provide additional explanation or information so that QA findings can be reconsidered. When QA receives a change request, the actions QA may take regarding the finding include:

- ***Overturn*:** When QA agrees with the information provided, they will overturn the finding.
- ***Uphold*:** When both QA and QI agree that the information provided does not support overturning the finding, they will uphold, and QI will follow up to determine any necessary next steps.
- ***Change Request Committee*:** When QA and QI do not have enough information to overturn or to uphold the finding or determines that leadership needs to make the final determination, the QA Unit Manager will forward the finding to the Change Request Committee (CRC) to be considered.

Change requests must be submitted by the due date provided on the QA schedule. All requests must be submitted as an RCN in the QA Monitor Tool using Contact Code '*Change Request*.' E-mail submissions and RCNs which do not include a correct contact code will not be considered.

Procedure

Requesting Changes to QA findings:
Prior to sending the change request, RCS staff and QI will:

1. Review applicable QA question documents and instructions.
2. Review the policy in place (this includes both SOPs as well as form instructions) at the time the work was completed.
3. Review historical Change Request Committee (CRC) decisions located on the QA SharePoint site.
   a. If CRC has upheld a QA determination on the same issue, the request will not be forwarded to CRC and the QA finding will be upheld.
   b. If there has been a change to policy or a compelling reason exists for leadership to discuss the issue again, QA will forward the request to CRC.

After determining the Change Request should be sent to QA:

1. RCS Staff or QI will enter the RCN into the QA Monitor Tool. Instructions are located on the QA SharePoint site. For individual training, e-mail your request to the QA unit and a unit member will schedule you or your team for training.
2. Use the contact code '*Change Request*.' This code must be selected, or the request will not be visible to QA and will not be considered.
3. If supporting documentation is required, it must be e-mailed no later than the change request due date found on the QA schedule.
   a. Do not mark on original or scanned documents.
   b. All change requests must appear on the *2309 Change Request Report* in ALTSA Reporting to be considered. (Using the contact code '*Change Request*' accomplishes this).

The QI Unit will:

1. Ensure staff are aware of change request due dates and, if QI will be submitting requests on behalf of staff, dates for when requests must be received by the QI Unit for processing.
2. Review all change requests and determine what will be forwarded to QA.
3. Collaborate with QA Unit Manager to determine what will be upheld or overturned and which requests will be sent to the CRC for consideration.
4. Report back to requestors to advise them of the outcome of their requests.

The QA Unit will:

1. Review and research each change request received considering the additional information.
2. Request additional information from appropriate SMEs (e.g., Training, Policy, Regional Staff, etc.) as needed to clarify the issue.
3. Collaborate with the QI Unit Manager to determine what will be sent to CRC.
4. Forward requests that require a CRC decision to the committee prior to the CRC meeting.
5. QA Consultants will update findings in the QA Monitor Tool as directed by the CRC within 10 WD after the CRC Meeting and will complete the 30-day reviews before the Final Exit Conference.
6. The ALTSA QA MA will e-mail updated reports to QI within two WD when the proficiencies have changed from the initial proficiencies or when required.

Change Request Committee (CRC) Responsibility

Purpose

To make the final determination as to whether to overturn or uphold QA findings. Each topic area or finding will be discussed during the meeting and a determination will be made only by the voting members as to the outcome of the QA finding(s).

Due to time constraints, countermeasures are not determined or discussed in detail at these meetings.

Change Request Committee Meetings:

1. CRC meetings are scheduled by QA and dates are published on the QA Schedule.
   a. A scheduled CRC Meeting may only be changed with the approval of the RCS Director.
   b. When a voting member is unable to attend, they have the option to send a designee who will stand in for them and act as a voting member.
   c. It is not required that all voting members attend. It is preferred, but if one or two members are unable to attend, the meeting may proceed without them.
2. CRC does not repeat change requests which have been decided in historical committee meetings unless there is a compelling reason for them to hear the request again.
3. CRC may not hear change requests that have clear internal, state, or federal policy guidance. In these cases, QA and QI will discuss these requests to determine the outcome.

The CRC includes the following voting members:
1. RCS Director and Deputy Director
2. RCS Office Chiefs who are not in charge of the area subject to review
3. One of the Training Unit Managers
4. Policy Unit Manager

All non-voting CRC attendees will support the CRC's purpose by:
1. Allowing the process to flow without interruption.
2. Responding to questions from CRC voting members and others who require their expertise.
3. Responding to requests to provide evidence, policy guidance, best practice, or experience.
4. Refraining from voting or expressing a desired outcome.
5. Holding comments and questions about next steps, countermeasures, or follow-up.
6. Not forward invitations to CRC meetings.
    a. For those whose attendance is required to provide expert opinion or information the CRC voting members need, they will e-mail the meeting organizer to add the individual.

The CRC will:
1. **Review** all change requests submitted and all supporting documentation.
2. **Discuss** each issue and ask questions that enable them to make an appropriate determination based on the policies and procedures in place at the time the work was completed.
3. **Vote** to determine whether to uphold or overturn the QA finding.
    a. If the vote is a tie, the RCS Director or their designee will make the final decision.
    b. When the CRC upholds the finding, RCS must remediate the finding within 10 WD if remediation is possible.
    c. When the CRC overturns the finding, QA must overturn the finding within 10 WD.

QA Unit Manager Responsibility

1. Provide clarification for QA findings and collaborate with QI to determine which requests are overturned, which are upheld, and which are forwarded to CRC.
2. Only forward invitations to those whose attendance is required to provide expert opinion or information the CRC voting members need.
3. Facilitate CRC meetings, maintain professionalism, and ensure the meeting stays on task.

QI Unit Manager Responsibility

1. Collaborate with QA to determine which change requests will be overturned and which are forwarded to CRC.
2. Ensure staff are provided the opportunity to present their request through their program's representative, their FM, or appropriate SMEs.
3. Only forward invitations to those whose attendance is required to provide expert opinion or information the CRC voting members need.

I. Thirty-Day Reviews

Purpose

Within the RCS System, 30-day reviews are completed after the initial review when the initial review included at least one finding (at least one question was answered with no). The purpose of the 30-day reviews is to show all work has been finalized, all required remediation is complete, and the review requires no further action.

Outstanding QA findings are listed on the '*Cases Requiring Action*' report found in ALTSA Reporting. The '*Analysis Comment Report*' provides additional information about findings. Both reports must be run and compared to be sure all process review cycles are closed as required.

Anyone entering QA reviews, including those individuals entering supervisory reviews or QI checks, must also enter all 30-day reviews within 45 calendar days after the initial review is entered or before the QA Monitor blackout period begins in December, whichever occurs first.

The QA Monitor blackout period occurs in December during which no reviews can be entered into the system. During the QA Monitor blackout, the prior year is closed out and frozen, so any open reviews create complications and unnecessary work for those using the system. For more information, please contact QA.

Procedure

The QA Unit will:

1. Complete 30-day reviews within 10 WD after the CRC meeting date.
    a. When remediation is not possible, QA will answer with N/A and choose the appropriate remediation option.
    b. When remediation has been completed, QA will answer Yes and choose the appropriate remediation option.
2. The QA Lead will verify all reviews entered by QA are closed at the end of each review and again at the end of the calendar year, prior to the blackout period.
3. The QA Lead will verify all reviews entered by anyone other than QA are closed by the end of the year prior to the blackout period.

The QI Unit will:

1. Enter checks into the QA Monitor Tool periodically throughout the year to gauge impact and effectiveness of PIP countermeasures or systemic changes.
2. Verify that all reviews entered are closed within 45 calendar days of the date the review was entered, or before the QA Monitor Tool blackout dates, whichever comes first.

J. Statewide Exit Conference and Final Reports

Overview

Once all change requests and 30-day reviews are completed, proficiencies are re-calculated, and a Final Statewide Exit Conference is held by QA to disseminate final QA results.

Procedure

1. The QA Lead will:
   a. Verify the review is completed and all reviews are closed in the QA Monitor Tool.
   b. Coordinate and facilitate a Statewide Exit Conference which will include the following information:
      1) Information related to how the sample was chosen.
      2) QA questions asked during the process review.
      3) Review of findings and proficiencies achieved.
      4) Highlights from the review, including how the change request process impacted proficiencies.
      5) Any new information regarding question document review meetings or processes.
2. The ALTSA QA MA will
   a. Send final statewide proficiencies to QI within one WD prior to the meeting date. ALTSA QA will send an all-RCS staff meeting invitation to allow anyone with an interest in attending the opportunity to accept and attend. Meetings are held remotely using a digital platform.
3. The QI Unit will:
   a. Attend all Statewide Exit Conferences and will present information about upcoming Root Cause Analysis meetings and next steps, including PIP due dates if a PIP is required.
   b. Once completed, the QI Unit Manager or designee will distribute any updated proficiency reports to RAs, FSAs, and FMs, if applicable.

K. Root Cause Analysis

Purpose

The QI Unit will determine the root cause of why expected statewide proficiencies were not met following a QA process review (see 'Proficiency Improvement Plan' for more information). The purpose of determining the root cause is to ensure any proposed interventions will be effective in improving proficiency levels. These meetings will also be utilized to explore potential interventions.

Procedure

The QI Unit will:

1. Schedule meetings with the individual program related units when the process review was specific to a particular program (i.e., AFH, ALF, CCRSS, ESF, ICF/IID, NH, and RIQAP). Invites will be sent by the program lead and will include an agenda of topics to be discussed.
   a. When the process review spans multiple programs (i.e., Complaints and SODs), the meetings will be scheduled with unit staff based on program. Invites will be sent by the QI Unit Manager and will include an agenda of topics to be discussed.
2. Invite a representative from Policy and Training Units to sit in as observers. This provides an opportunity for Policy and Training Unit staff to hear the information provided to QI. The collaboration between the HQ units and the field is needed to determine effective interventions.
3. Information gathered during these meetings is used to inform improvements to RCS processes and develop the Proficiency Improvement Plan. (See 'Proficiency Improvement Plan' for more information).

L. Proficiency Improvement Plan (PIP)

Overview

Expected Proficiencies:

QA question expected proficiencies take into consideration the minimum expected proficiency levels for the CMS waivers, any areas outlined on the ALTSA strategic plan, and the expected proficiencies required by external auditors. Some questions require a higher proficiency level because of expectations by CMS, an external auditor, or executive leadership. The RCS Director makes the final determination as to RCS expected proficiencies.

Proficiency Improvement Plans:

A Proficiency Improvement Plan (PIP) outlines a plan for addressing QA questions that did not meet the expected proficiency on Proficiency Reports across the state and program.

The action required for PIP development is based on the findings of the process review once all change requests are considered and the final proficiency results are distributed. A PIP is not required when the expected statewide proficiency level is reached for QA questions included in the review.

Procedure

1. The PIP will be developed by the QI Program Lead (or Unit Leadership, if the review is not covered by the QI unit [e.g., CRU]).
   a. The QA Unit is not involved in PIP development activities and does not direct the work that needs to be accomplished to complete the PIP.
   b. The use of Lean and Continuous Improvement tools is encouraged. Information and tools for ALTSA's Lean program can be found here.
   c. Any units assigned a task on the PIP must be notified of the assignment before the PIP is signed by the RCS Director.
2. The QI Program Lead must submit the completed PIP to the RCS Director for final approval within 45 WD after the CRC Meeting. This due date is included on the published QA Schedule.
3. A copy of the approved PIP must be saved to QIC Central in both PDF and Word formats once it is signed by the RCS Director.
   a. The Word format version is used as a working document and will be updated throughout the process until all steps are finalized or the next PIP is needed, whichever comes first.
4. PIP Monitoring:
   a. The QI Lead will send the final signed PIP to any units assigned a task.
      1) The QI Lead tracks due dates on the final approved PIP to monitor for completion.
      2) The QI Lead will notify the QI Unit Manager if there are any potential barriers to completing interventions within the defined timelines.

b. QI Unit Manager provides RCS leadership with status reports as requested.
c. If PIP interventions or due dates change, the QI Lead will update the working version.
d. There should only be one working PIP at any given time for a process review. If the previous PIP is not yet completed by the next process review, the PIP should be closed with notation that future updates can be found on the current PIP.
e. QI will make every attempt to utilize the same Sample Methodology process when completing monitoring checks to determine if PIP interventions are working.

> Note: FMs may request additional support from QI in monitoring working papers. Samples will be determined based on the FM support request.

M. Quarterly Program Lead Meetings

Purpose

To enhance communication and collaboration among headquarters (HQ) staff.

Responsibilities

The QI Program Lead will:

1. Issue the meeting invitation to all attendees.
2. Facilitate the Quarterly Meetings and take notes to capture the discussion.
   a. The QI Lead and co-lead may coordinate duties as needed.
   b. If both lead and co-lead are unable to assist or facilitate this process, contact the QI Unit Manager for further direction.
3. Upon conclusion of the meeting:
   a. Distribute the meeting notes to all attendees.
   b. Send the meeting invite for the next quarterly meeting.

Quarterly meetings will occur for the following programs:

• **AFH**	• **ALF**
• **CCRSS**	• **ESF**
• **NH**	

Note: At this time, meetings are being held on an as needed basis for the following programs:

• ICF/IID	• RIQAP
• Complaints	• SODs

N. Record Retention

Background

Records are retained for historical information, data, and public disclosure purposes. For RCS records retention information, please visit the record retention intranet site.

This section will provide an overview of how the QA Unit retains records of process reviews completed.

Procedure

1. QA unit members may use paper checklists or OneNote checklists while completing the process review to ensure all process review questions are answered and input into the QA Monitor Tool correctly.
2. Once the review is completed, the review must be entered into the QA Monitoring Tool as soon as possible. All information pertinent to the findings must be included in the analysis comments in the QA Monitoring Tool.
3. QA unit members may retain paper checklists only until the 30-day reviews are completed and the full review process is closed.
4. All paper documents related to the QA process review must be shredded in confidential shredding to avoid the release of any resident names or other protected information.
5. All electronic documents created on OneNote, on the computer's desktop, or using any other programs created by the QA Consultant will be deleted once the 30-day reviews are completed. The QA Monitor Tool is the final and complete record for all QA reviews.
6. Records will be retained in the QA Monitor tool for six years, after which, the records will be purged, unless there is a reason for which the record must be retained.
    a. The QA Unit Manager will send a notification annually to Central Files prior to the scheduled record purge to determine which records may not be purged from the system and the reason the record may not be purged.

QA Unit Manager Responsibility

1. Creates and distributes any required final reports.

O. Annual Statewide Reports

Purpose

The ALTSA QA Unit Manager develops an Annual Statewide Final Report to publish results of the annual QA process review cycle for RCS. This report outlines the results for each area being reviewed on a statewide basis and compares any historical data for the reader's analysis.

The RCS QI Unit Manager develops an Annual Report to publish information about the status and effectiveness of all Quality Improvement interventions implemented in response to QA Process Reviews.

Procedure

1. The QA Unit Manager will:
   a. Create and post the report annually and seek clarification and information from programs as needed to clarify results or explain circumstances that may be needed to properly analyze the data.
   b. Publish the report in an MB once the report is complete.
   c. Create and distribute any required final reports.
2. The QI Unit Manager will:
   a. Creates and post the report annually to demonstrate the effectiveness of PIP interventions on overall proficiencies.
   b. Post the report on QIC Central and announce its release in a management bulletin once available.
3. The ALTSA QA Senior Administrator will:
   a. Review and approve the report prior to distribution.

Part II: Management of Standard Operating Procedures

Overview

1. Sunset Reviews:

   All SOPs will be reviewed in their entirety at least once every five years. These **full** reviews are called 'Sunset Reviews' within RCS. The QI unit will track the last date of the full sunset review, as well as any updates that took place between full reviews. SOP reviews may occur more frequently than every five years depending on the individual SOP content.

2. Formatting:

   SOP formatting will be as consistent as the SOP content allows, to maintain standardization. Definitions of terms, abbreviations and acronyms will be consistent throughout SOPs.

3. Training:

   If changes to the SOP are significant (i.e., process requirements have been updated), the QI Unit or the Subject Matter Expert (SME) will provide training to staff during the monthly Support Call.

A. General Procedures

Overview

This section contains the process that RCS Quality Improvement (QI) Unit staff are required to follow for the development and amendment of RCS Standard Operating Procedures (SOPs) and related forms and attachments.

SOPs detail regularly recurring work processes that are to be conducted or followed within RCS. SOPs contain both "policy" aspects (decisions made by RCS leadership about who is responsible to take what actions within the organization) as well as "procedure" aspects (task outlines detailing the steps to take in order to complete a business process).

The QI unit is the gatekeeper to the processes that drive RCS and should collaborate with the SME to ensure all new or revised SOPs meet the formatting, style, and understandability needs of the division. SOP formatting, such as sections, ordering, and style are expected to be as uniform as possible across all chapters but may vary based on the needs of the content. SOPs should state clearly who the subject of the required action is in most cases and should follow plain talk principles as outlined in DSHS Administrative Policy 2.11.

Procedure

1. A project to amend or create an SOP can arise in many different ways. Regardless of the source of the project, when a new SOP requires development, or an issue is identified in a current SOP that needs to be addressed, the QI Unit Manager must be notified. The Unit Manager may assist in scoping the project; most SOP projects should be defined by chapter (e.g., "8"), section (e.g., Part I), or subsection (e.g., "Part I, A"), depending on the content.
2. Version control of drafts is important in order to be able to backtrack to previous language while drafting is in progress. When a draft version is released during the targeted, document review, Office Chief 5-Day (OC5D), or Director review steps, a current file version should be saved to the Policy Unit Project (PUP) Tracker to reflect the version review stage, with the appropriate version number appended to the date:

Targeted Review (Initial Draft)	**v1.0**
Document Review	**v2.0**
Office Chief 5-Day Review (OC5D)	**v3.0**
Director Review	**v4.0**

For example, when the drafting of the initial language is complete, "v1.0" needs to be added to the document footer beside the date at the time the document is saved and ready for release to the targeted review audience. Then the feedback from the targeted review will be incorporated, editing may take place, and when the draft is complete the document needs to be saved as "v2.0" for release to document review. Dates may be used to supplement the filename. Proper labeling ensures that the correct files are used.

3. At the time of amending a published SOP, the QIC should retrieve the current SOP from the official SharePoint archive folder found here. The QIC should enable track changes to capture all alterations to current text; this enables reviewers to see what is being changed and allows them to compare the current live published version of the SOP to the language being reviewed.

During the development of a new SOP, track changes are only necessary if changes from one draft to the next need to be shown.

4. The final track changes version has to be saved separately prior to accepting all changes for the final publishable draft and must to be kept as a separate file. All track changes must be removed from the final published document.
5. Targeted review must include all staff who are directly required to act under the SOP and may include others who could be affected by the new processes. Review must include, at a minimum, the QI Unit, and the Policy Unit.

6. Upon completion of the Targeted Review, the QI Unit Manager will create a new item in the PUP Tracker and fill out all appropriate sections, including:
   a. Document Review: this is generally standard but may be skipped or abbreviated due to time constraints, the limited scope/impact of the SOP updates, or the coverage of Targeted Reviews.
   b. OC5D: always select "Needed" on all SOP projects other than general maintenance or error correction updates.
   c. Driver - Notes - Deadlines: describe the need or issue that is driving the project, any relevant deadlines, or other notes relevant to the project. This section should be kept up to date as the project evolves.
   d. Status: "Document Review" should generally be initially selected if the Targeted Review is complete.
7. To ensure handoffs are not missed, the QI Unit Manager and Communications Program Manager (CPM) must ensure alerts have been created in SharePoint to automatically send notifications when the PUP Tracker status has been changed to a status requiring their role to take action.

B. Initial Draft and SOP Workgroups

Overview

Workgroups are an effective way to develop new SOPs, complete Sunset Reviews, or implement other major updates to an SOP.

Procedure

1. Composition of Workgroups:
   a. Quality Improvement: Lead / Co-Lead will attend all workgroup meetings. The QI lead will:
      1) Facilitate the workgroups, including scheduling meetings, setting the agenda, and sending the information to be reviewed in the workgroup meeting to the participants at least one week prior to the meeting.
      2) Seek clarification from leadership on topics if the workgroup is unclear about requirements.
      3) Complete final review and formatting prior to sending to the Unit Manager for next steps. (See General Procedures for more information).
   b. Field Staff:
      1) If the SOP is related to a specific field program (e.g., AFH), QI will request one field staff from each unit for that program, plus one Field Manager (FM) for the State, unless it is determined more input is needed.
         a) Request for FM participation should be sent to the Regional Administrators (RAs) and Field Service Administrators (FSAs).
         b) Request for field staff participation should be sent to the FMs.
      2) If the SOP is related to multiple field programs (e.g., Complaint Investigations or Across All Settings), QI will request one field staff from each program (i.e., AFH, ALF, NH, etc.) plus one FM per program, with the goal of statewide representation.
   c. Request one representative from the following units:
      1) Training
      2) Policy
      3) Informal Dispute Resolution (IDR)
      4) Compliance and Enforcement
   d. Any other SME required based on topic.
2. Attempt to limit workgroups to 10 participants, with no more than 15 participants.
3. Workgroups should not exceed six months. If workgroup goals cannot be achieved within six months, consult with QI Unit Manager to discuss barriers to completion.

> Note: This time frame does not include the subsequent formatting of the SOP or the SOP vetting process.

4. Workgroups will meet for one to three hours monthly.
   If unable to attend a workgroup meeting, participants will send their comments on agenda topics to QI prior to the meeting.
5. Material to cover in the workgroup meeting will be posted to the Teams Channel at least two weeks prior to the meeting. Participants are expected to come to the meeting prepared with their recommendations.
   a. Participants are encouraged to consult with their peers to request input.
6. Once the draft is completed, the entire document will be posted for all participants to review one more time to complete the Targeted Review (See General Procedures for more information and next steps).

> Note: Efforts should be made to avoid scheduling workgroups during legislative session due to increased workloads during this time.

C. Targeted Review (V1.0)

Overview

Once a draft has been developed, the QI staff leading the update will send the draft to the SME identified in the SOP (if applicable), the Policy Unit, and the Training Unit. Include others as needed depending on SOP topic. Reviewers will be provided response deadline, including the process to request additional time, if needed. If no response is received from the reviewers by response deadline, the QI Unit Manager will be notified. The QI Unit Manager will email the respective parties, their Unit Managers, and will cc the Office Chief, requesting a response within two WD. If still no response is received after the two WD, the QI Unit Manager will confer with the Office Chief to determine if the process should proceed to the next step.

Note: Allow extra time for reviews during legislative session due to increased workloads during this time.

Procedure

1. In the event that the SOP project is a new SOP chapter or section, the initial drafting will usually be done by the unit(s) or program manager(s) that are responsible for performing the work and who are the subject matter experts (SMEs) in their own processes. If the SOP project is an update or amendment to a currently existing section, it may be drafted by the QI unit as appropriate. In either case, the assigned QIC will work closely in developing the content with those who are responsible for performing the work, also known as a 'targeted review.'
   a. An initial SOP draft should focus primarily on the content, including clarity, readability, and accuracy of the process.
   b. If the SOP project is an update or amendment, the QIC will be responsible for reviewing and clarifying the language of the entire chapter, including incorporating any outstanding issues by reviewing for clarifications or typos in existing language, old terminology, or other changes.
   c. All draft documents must be clearly marked as a 'draft' by adding a watermark.
2. The QIC is responsible for coordination and assistance with the creation of the initial draft. It is recommended that the QIC consult with other authors involved and provide advice as to a suitable policy structure, the active voice style, and what level of detail may be desirable. It is the role of the QIC to ask questions, look for opportunities for improvement, and help ensure that the SOP is clear, not just to current staff but new staff unfamiliar with RCS processes, as well as community engagement partners.
3. The QIC is also responsible, in coordination with the Policy Unit, to help ensure that the SOP follows all relevant RCWs and WACs, which includes preventing unpromulgated rulemaking in violation of the WA Administrative Procedure Act (Chapter 34.05 RCW). Unpromulgated rulemaking is a policy that requires a nongovernmental person or entity to take action for which a violation is subject to penalty. It is best for the QIC to consult with the QI Unit Manager and Policy Unit if there are any questions about unpromulgated rulemaking.

4. The QIC must review and address any documents related to the project, which may include forms, template letters, or other related documents.
   a. The QIC must also search currently published MBs and if any are found relevant to the SOP in development, confirm their content is incorporated into the draft.
5. Any issues identified at the initial drafting stage which require a decision from RCS leadership must be resolved according to the process under section labelled 'Leadership Decisions.' However, drafting should continue during the leadership decision-making process as appropriate.
6. When the initial draft is completed to the satisfaction of the QIC, the QI Unit Manager will:
   a. Enter the SOP update into the PUP Tracker, including the implementation plan needed, by filling out the appropriate column in the PUP Tracker.
   b. Ensure the PUP Tracker status is set to the status appropriate to the next step.
   c. Ensure the CPM is notified of any MBs incorporated by noting in the PUP Tracker which MBs will need to be rescinded.

D. Leadership Decisions

Procedure

1. Issues identified at any point during review are appropriate for RCS leadership review if they are of significant consequence or special note. This may include budget impact, impact to relationships with non-DSHS entities, or issues with a significant and unresolved difference of opinion among reviewers.
2. The QIC should vet issues identified as meeting the criteria above with the appropriate chain of command through the QI unit and consultation with the Policy Unit, as well as any units affected by the issue. Leadership decisions should be resolved at the lowest level reasonably empowered to decide the issue.
3. If unable to resolve issues at the SME level, the QIC will consult with the QI Unit Manager to determine next steps.

E. Document Review (V2.0)

Overview

Document Review is a process that allows RCS staff to internally comment on proposed language and provide input on the draft. This step may not be necessary if affected staff have had the opportunity to review during the targeted review step. However, the purpose of document review is to allow other units not otherwise involved to have the opportunity to view the changes, assess whether they would be impacted, and to provide further input. Document Review is available on the RCS intranet site.

The document review period is 20 WD in most instances. An abbreviated review may be appropriate in some circumstances (e.g., if the update is minor, or driven by an audit with an associated deadline).

Upon completion of the document review period, the CPM will forward any comments received to the QI Unit Manager. The QI Unit Manager will forward any comments needing clarification on regulatory requirements to the Policy unit and/or the Subject Matter Expert. There is no need to forward comments related to spelling and grammar.

> Note: The QI Unit Manager will determine, in collaboration with the QIC when needed, when to respond to individual comments provided on doc review.

Procedure

1. At the time a draft SOP is ready for document review, the QI Unit Manager will enter the SOP into the PUP Tracker, with the status set to 'Doc Review.'
2. The CPM will post the draft to document review and update the PUP Tracker with the end date for that review period. Related forms or documents may also be put on document review to be reviewed, as appropriate.
3. The CPM will include an item in RCS weekly bulletins while the draft is on document review.
4. When the document review period is over, the CPM will remove the draft, change the PUP Tracker status to 'PPM in-progress', and email the received comments to the QI unit.
5. The QI Unit Manager will review the comments, seeking clarification as necessary from the commenter, the unit, or others as appropriate and incorporate any needed edits. Comments may not always be able to be incorporated into the draft; this is at the discretion of the QI Unit Manager.
    a. Issues newly identified as requiring a leadership decision will go through the same process as identified in the section labelled 'Leadership Decisions'.
    b. If significant changes have been made to a draft and further staff input is warranted, it may be appropriate to put a draft onto document review a second time for an abbreviated review period.
6. Once all comments are reviewed and addressed as needed, the QI Unit Manager will update the PUP Tracker status to the status appropriate for the next step.

F. Office Chief 5-Day (OC5D) Review (V3.0)

Overview

The Office Chief Review period is typically five working days. The QI Unit Manager will notify the Office Chiefs of the need for review via the electronic tracking system in Smartsheet using the 'Proof' function. The Unit Manager will notify the Office Chiefs the document is ready for review using the Smartsheet notification process. Notification will include the review deadline, as well as the process to follow if needing to request more time to review.

> Note: Allow extra time during legislative session due to increased workloads during this time. Additional time may also be needed for long documents.

Procedure

1. The QI Unit Manager will review the most recent draft to determine whether the draft is ready for OC5D review. If the QI Unit Manager approves, the draft proof will be added to the Smartsheet tracking system and the Office Chiefs will be notified of the needed review and any associated deadlines.
2. The QI Unit Manager will update the PUP Tracker status to "OC 5 Day Review" and indicate the review deadline in the notes section.
3. After the deadline, the QI Unit Manager will review and incorporate any comments received from the OC5D Review, seeking clarification as necessary from the commenter, the unit, or others as appropriate.
4. Any items that need a leadership decision will follow the same process identified in the section labelled 'Leadership Decisions.'

G. Final Draft and Publishing

Overview

The final step in the process is review by the RCS Director. If the Director has no comments or questions, the final version will be posted to the intranet in the RCS SOP manual.

Procedure

1. Once comments are incorporated, all outstanding leadership decisions are addressed, and the content of the draft is finalized, the assigned QIC will review the following to create the final publishable version:
   a. Formatting;
   b. Typos and grammatical errors;
   c. Hyperlinks;
   d. Change log updates;
   e. MB updates (ensuring the content matches the final content of the SOP, and if appropriate, a track changes version of the SOP should be included as an attachment in the MB for staff convenience);
   f. Finalization of any forms (including forms that need to be approved through the DSHS Forms Manager);
   g. Removal of track changes; and
   h. Incorporation of the draft sections into the full chapter file.

   > Note: the Director should only review the "v4.0" draft version rather than the full incorporated chapter. However, the final incorporated and publishable version should be ready in the PUP Tracker for upload prior to Director Review.

2. The QI Unit Manager will select "Director Review" status in the PUP Tracker once the SOP is in a final publishable state. Attached to the tracker should be the final version of the SOP with the watermark removed and track changes removed.
3. A Management Bulletin (MB) should be developed for release along with the final SOP to explain the reason for the update. The responsibility to draft any accompanying MB should be the same as the SOP.
   a. Minor "housekeeping" edits or error fixes do not need an MB, but any significant change in procedure to which staff will need to be alerted must include one.
   b. A Dear Provider Letter (DPL) will generally not be needed for an SOP update.
4. The CPM will deliver the final draft version to the RCS Director for review and approval. If approval is not granted, the CPM will notify the QI Unit Manager and return the PUP Tracker status to 'PPM In-progress.'

5. Once the RCS Director has approved the SOP, the CPM will:
   a. Update the SOP change log to include the official published date, which will match the date of the MB release. These updates will include:
      1) The date on the MB and assigned MB number;
      2) The change log with the publishing date in MM/DD/YYYY format; and
      3) The footer with the new version number in MM.DD.YYYY format;
   a. Save a copy of the current live published version to the archive folder on SharePoint;
   b. Send the final full chapter document to IT for publishing to the DSHS internet and RCS intranet sites;
   c. Issue the MB and rescind any old MBs as appropriate; and
   d. Notify the QI Unit Manager by email that the SOP has been published.
6. The CPM will update the PUP Tracker to reflect the completed project by changing the status to 'Completed', entering the completion date, and adding the control number (the same as the MB number). If no MB was issued, "no MB issued" may be put into the PUP Tracker to complete the item.
7. The QI Unit will continue working with the policy and training units, as well as others as appropriate, on any needed implementation plans.
8. The assigned QIC will provide training, in coordination with the training unit, via the Support Call.
   a. If a Support Call cannot be scheduled within the time frame required to provide timely training to staff, the QIC will coordinate with individual FMs to ensure staff are appropriately trained.

> Note: All QI presented trainings, whether via the Support Call or through other forums, must be vetted by the training unit.

Part III: Management of Program Forms

Overview

If a program form needs a major update, or a new form is needed, a workgroup may be organized. The workgroup composition should follow the same process as the SOP Workgroup composition noted in the section labelled 'Initial Draft and SOP Workgroups.'

Procedure

1. If a workgroup is organized, meetings should not exceed three hours and should be focused exclusively on the form(s) needing updates. Rarely would more than one meeting per form be needed. However, multiple meetings may be needed if revising multiple forms.
2. Changes to the form will be made in real time during the meeting so the workgroup can view the proposed product. Track changes must be used.
3. Once the updated form draft is completed, send any significant proposed edits to all FMs for the applicable program to request they review with their staff to obtain feedback.
4. Concurrent to step 4, send a copy of the proposed draft to the Policy and Training units for targeted review. A response deadline must be included, as well as the process to be followed if more time is needed to review.
   a. Additional units may be included in the review, as deemed appropriate by the QIC.
5. Once feedback is received, proceed with document review if needed following the guidance in the section labelled 'Document Review (V2.0).'

   Note: For forms, an abbreviated review of 10 WD is the standard, when required.

6. Once the document review period has ended, the CPM will send any received comments to the QI Unit Manager.
7. The QI Unit Manager will address any comments from document review, consulting with the Policy or Training units if questions arise related to regulatory requirements.
8. The QI Unit Manager will send the final proposed edits to the Forms Manager, with a cc to the CPM, to have updates completed. The Forms Manager will post the revised version once edits are approved.

   Note: Office Chief and Director Reviews are not needed for form updates, unless there is a question that requires a leadership decision (see section labelled 'Leadership Decisions' for more information).

9. For any changes other than spelling or grammar corrections, an MB should be issued notifying RCS staff of the changes made, as well as the reasons for the updates. The MB must also include the date the new form is required to be used by staff. The QI Unit Manager will send the MB to the CPM through the PUP Tracker.

10. The assigned QIC will provide training, in coordination with the training unit, via the Support Call.
    a. If a Support Call cannot be scheduled within the time frame required to provide timely training to staff, the QIC will coordinate with individual FMs to ensure staff are appropriately trained.

> Note: All QI presented trainings, whether via the Support Call or through other forums, must be vetted by the training unit.

Part IV: Appendices

A. Glossary of Terms

Adult Family Home (AFH) – State licensed residential homes to care for two to eight vulnerable adults who may have mental health, dementia, and/or developmental disability/special needs. The homes are private businesses providing each person with a room, meals, laundry, supervision, assistance with activities of daily living, and personal care. Some provide nursing or other special care and services.

Agency – State agency.

Aspen (Automated Survey Process Environment) – a suite of software applications designed to help State Agencies collect and manage healthcare provider data.

Aspen Central Office (ACO) – refers to Centers for Medicaid and Medicare Services (CMS).

Assisted Living Facility (ALF) – State licensed facilities providing basic services assuming general responsibility for the safety and well-being of vulnerable adults. ALFs allow the vulnerable adults to live an independent lifestyle in a community setting while receiving necessary services from a qualified workforce. ALFs can vary in size and ownership from a family-operated 7-bed facility to a corporation-based facility with 150+ beds. ALFs may provide intermittent nursing services or serve vulnerable adults with mental health needs, developmental disabilities, or dementia.

Background check – means a name and date of birth check or a fingerprint-based background check, or both. WAC 388-113-0010.

Certification evaluation – A CCRSS regulatory process whereby contracted evaluators assess provider compliance with statutes and regulations. In addition to certification evaluations at least once every 24 months, contracted evaluators may also conduct follow-up visits.

Certified Community Residential Services and Supports (CCRSS) – Includes Supported Living (SL), Group Homes (GH), and Group Training Homes (GTH). These are residential services provided to individuals who are eligible clients of the Developmental Disabilities Administration (DDA). Supported living clients are vulnerable adults living in their own homes in the community. The client or legal representative owns, rents, or leases the home.

Change request committee – outcome following a submitted change request. This means QA and QI do not have sufficient information to determine if a change request should be upheld or overturned and determines RCS leadership needs to make the final determination.

Character, competence, and suitability (CCS) – the screening and assessment of the potential personal and professional capability of an employee or applicant to work with or serve minor or vulnerable adults based on a review of crimes and negative actions. CCS requirements must meet those in WAC 388-113-0060.

CMS State Operations Manual, Appendix J – Federal Guidance to Surveyors for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

CMS State Operations Manual, Appendix PP – Federal Guidance to Surveyors for Long Term Care Facilities.

CMS State Operations Manual, Appendix Q – Federal Core Guidelines for Determining Immediate Jeopardy.

Code of Federal Regulation (CFR) – The Departments and Agencies of the Federal Government providing codification of the general and permanent rules published in the Federal Register.
Community programs – includes Adult Family Homes (AFH), Assisted Living Facilities (ALF), Certified Community Residential Services and Supports (CCRSS), and Enhanced Services Facilities (ESF).
Complaint – A report communicated to Residential Care Services' (RCS) Complaint Resolution Unit (CRU) by anyone NOT acting as an administrator or designee for a provider licensed or certified by RCS. The report alleges abuse, neglect, exploitation, or misappropriation of property for one or more vulnerable adult. The complainant could be a vulnerable adult, a family member, a health care provider, a concerned citizen, other public agencies, or a mandated or permissive reporter. Report sources may be verbal or written.
Complaint investigation – means an onsite investigation as a result of receiving a complaint related to provider practice.
Complaint investigator (CI) – means an RCS regulatory staff assigned to investigate a complaint received by the department.
Compliance – The state of an organization that meets prescribed specifications, contract terms, regulations, or standards.
Department – This term refers to the Washington state Department of Social and Health Services (DSHS).
Electronically stored information – DSHS records stored in an electronic format. Requires hardware and software to be accessed and read (e.g., spreadsheets, databases, images, video recordings). Also known as electronic records.
Enhanced Services Facilities (ESF) – means a facility that provides support and services to persons for whom acute inpatient treatment is not medically necessary. RCW 70.97.010.
Entity – A standard term used throughout this document to depict the long-term care program homes, facilities, and licensees participating in transforming lives of the vulnerable adults living in residential settings.
Federal programs – This includes Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and Nursing Homes (NH).
Finding [QA] – A term used to describe an identified gap between policy guidance and what was found during a QA process review. It should not be considered positive or negative, only what was found (identified).
Fingerprint check – means a fingerprint check is considered a positive identification check. The fingerprints of an applicant are reviewed to match fingerprints taken at the time of an arrest or conviction of a crime.
Initial inspection – A generic term use to describe a process conducted by RCS staff in evaluating a prospective licensee for compliance with the statutes and regulations required for an Adult Family Home license, an Assisted Living Facility license, or an Enhanced Services Facility license.
Inspection – A generic term used to describe the process by which RCS staff evaluates a licensee's compliance with statutes and regulations. Complaint/incident investigations are only one type of on-site inspection/survey done to determine the health and safety of vulnerable adults in licensed or certified long-term care residential settings.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – The Social Security Act created this optional Medicaid benefit to fund "institutions" (four or more beds) for individuals with intellectual disabilities. The Secretary defines this as providing "active treatment."

Nursing facility (NF) – a nursing home, or any portion of a hospital, veterans' home, or residential habilitation center, that is certified to provide nursing services to Medicaid recipients under section 1919(a) of the federal Social Security Act. All beds in a nursing facility are certified to provide Medicaid services, even though one or more of the beds are also certified to provide Medicare skilled nursing facility services.

Nursing home (NH) – A term that can include both 24-hour Skilled Nursing Facilities (SNF) and Nursing Facilities (NF). SNFs are those that participate in both Medicare and Medicaid. NFs are those that participate in Medicaid only.

Overturn – means QA agrees with the information provided within a change request and overturns the process review finding.

Provider – a) any individual or entity that provides services to DSHS clients, OR b) a person, group, or facility that provides services to DSHS clients. RCS providers include Adult Family Homes, Assisted Living Facilities, Certified Community Residential Services and Supports, Enhanced Services Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities and Nursing Homes.

Records retention – The required minimum amount of time a records series must be retained to meet legal, fiscal, administrative, or historical value as listed on an approved records retention schedule or general records retention schedule.

Records retention schedule – a legal document approved by the state or local records committee that specifies minimum retention periods for a records series and gives agencies ongoing disposition authority for the records series after the records' approved retention period has been satisfied.

Regulatory process – Regulatory staff evaluate current entity compliance with statutes and regulations. Types of regulatory processes include pre-occupancy, abbreviated complaint investigations; full inspection/recertification surveys; initial certification surveys; follow-up or post surveys; initial licensing and relicensing, and monitoring visits.

Regulatory staff/Regulator – RCS staff responsible for enforcing the rights, safety, and health regulations of individuals living in Washington's licensed or certified residential settings.

Revised Code of Washington (RCW) – The compilation of all permanent laws now in force. It is a collection of Session Laws (enacted by the Legislature, and signed by the Governor, or enacted via the initiative process), arranged by topic, with amendments added and repealed laws removed. It does not include temporary laws such as appropriation acts.

Skilled nursing facility (SNF) – a nursing home, a portion of a nursing home, or a long-term care wing or unit of a hospital that has been certified to provide nursing services to Medicare recipients under section 1819(a) of the federal Social Security Act.

Smartsheet – is a web-based data and work management tool that includes functional elements of a traditional spreadsheet as well as the ability to notify parties when work is due and track information and communication in the tool.

State agency (SA) – A permanent or semi-permanent organization in government that is responsible for the oversight and administration of specific functions.

Statement of deficiencies (SOD) – The official, publicly-disclosable, written report document from RCS staff that identifies violations of statute(s) and/or regulation(s), failed facility practice(s) and

relevant findings found during a complaint/incident investigation conducted at an any setting regulated by RCS. Included in SODs for AFHs, ALFs, and ESFs is an attestation statement the entity signs and dates indicating the projected correction date for the cited deficient practice. The SOD is a legal document available to the public on request.
Unit leadership – means the individuals responsible for the activities of a designated unit. This can include Unit Managers, Program Managers, Field Managers, Field Services Administrators, and Regional Administrators.
Universe [QA] – The entire population subject to review.
Uphold – means QA and QI agree that the information provided in the submitted change request does not support overturning the finding, and the finding will remain in place.
Washington Administrative Code (WAC) – Regulations of executive branch agencies issued by authority of statutes. Similar to legislation and the Constitution, regulations are a source of primary law in Washington State. The WAC codifies the regulations arranging them by subject or agency.
Working days (business days) – defined as Monday through Friday, excluding federal and state holidays.

B. Acronym List

AA	Administrative Assistant
AAA	Area Agencies on Aging
AFH	Adult Family Home
ALF	Assisted Living Facility
ALTSA	Aging and Long-Term Support Administration
BAAU	Business Applications and Analysis Unit
CC	Carbon Copy (in emails)
CCRSS	Certified Community Residential Services and Supports
CFC	Community First Choice
CFR	Code of Federal Regulations
CI	Complaint Investigator/Investigations
CMS	Centers for Medicare and Medicaid Services
CoP	Conditions of Participation
COPES	Community Options Program Entry Service
CP	Community Protection
CPM	Communications Program Manager
CQI	Continuous Quality Improvement
CRC	Change Request Committee
CRU	Complaint Resolution Unit
CS	Compliance Specialist
DDA	Developmental Disabilities Administration/Administrator
DPL	Dear Provider Letter
DSHS	Department of Social and Health Services
eCFR	Electronic Code of Federal Regulation
ESF	Enhanced Services Facilities
FFP	Federal Financial Participation
FM	Field Manager
FSA	Field Services Administrator
GH	Group Home
GTH	Group Training Home
HCBS	Home and Community-Based Services
HCS	Home and Community Services
HQ	Headquarters
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
IDR	Informal Dispute Resolution
LOC	Level of Care
LTSS	Long-Term Services and Supports
MA	Management Analyst
MAC	Medicaid Alternative Care
MB	Management Bulletin

MPC	Medicaid Personal Care
MSD	Management Service Division
N/A	Not Applicable
NF	Nursing Facility
NH	Nursing Homes
OAS	Office of the Assistant Secretary
OC5D	Office Chief 5 Day Review
PACE	Program of All-Inclusive Care for the Elderly
PIP	Proficiency Improvement Plan
PPM	Policy Program Manager
PUP Tracker	Policy Unit Project Tracker
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Coordinator
QMS	Quality Management System
RA	Regional Administrator
RCN	Review Cycle Note
RCS	Residential Care Services
RCW	Revised Code of Washington
RIQAP	Residential Inspection and Quality Assurance Program
SHPC	Social and Health Program Consultants
SL	Supported Living
SME	Subject Matter Expert
SNF	Skilled Nursing Facility
SOD	Statement of Deficiency
SOLA	State Operated Living Alternative
SOM	State Operations Manual
SOP	Standard Operating Procedures
SPA	State Plan Amendments
STARS	Secure Tracking and Reporting System
TSOA	Tailored Supports for Older Adults
WAC	Washington Administrative Code
WD	Working Day

C. Sample QA Process Review Result Email Template for QI Use

I have attached the QA results for the <insert name of review> review. I have included graphs to display the results. If you have any questions at all about what the data is showing, please do not hesitate to reach out. QI is currently going through every finding to determine what should be sent for a change request. We are also taking this opportunity to clarify questions with policy, training, etc. as needed.

Next Steps: Please send all change requests to ImproveRCS@dshs.wa.gov by **COB <insert date>.** In your request, include the following information:

- Your Name
- Event ID#
- Facility ID#
- Q# being disputed
- Specific details of why you believe this finding should be overturned. Include information about where we can find the evidence to support your position (STARS, page # of working papers, etc.)

- If the information provided is sufficient to provide a clear and compelling argument for overturning the findings, we will notify you that we are moving ahead with the change request.
- If more information is needed, we will contact you to determine next steps.
- For change requests received that do not meet criteria (meaning the SOP was clearly not followed), QI will contact the Regional Administrator to confirm the request should be submitted.
- If you have multiple findings you would like us to review, combining them in one request will support this process in moving forward smoothly.

Thank you,

D. Resources and Forms

Background

The QA Unit has transitioned to using a QA SharePoint site as the primary means of communication with RCS staff, Policy, Training, and anyone at RCS interested in QA activities. Anyone in RCS may access this SharePoint. Questions may be emailed to the unit at any time.

Members of the QA Unit have access to the QA Unit's internal SharePoint site. This site is only accessible to the QA Unit and other leadership staff as required. The site provides the tools, templates, and information needed to complete process reviews.

Procedure

Process Review Areas and Programs
(For more information on each setting/program, please review the SOP Manual)

1. Adult Family Homes (AFH)
    a. AFHs are residential homes that are licensed to care for up to eight residents. They provide residents with room & board, meals, laundry, supervision, and personal care. As of January 2024, there are about 5,500 AFHs in Washington.
    b. RCS regulates AFHs and conducts licensing visits every 9-18 months and investigates complaints made against the facilities.
    c. AFH policy is found in Chapter 12 of the SOP Manual.
    d. QA reviews the following areas:
        1) Inspections
        2) Follow-ups
        3) Statements of Deficiency
        4) Complaints
2. Assisted Living Facilities (ALF)
    a. ALFs provide housing, basic services, and assume general responsibility for the safety and well-being of residents. ALFs may house seven or more residents. As of January 2024, there are about 550 ALFs in Washington.
    b. RCS regulates ALFs and conducts licensing visits every 9-18 months and investigates complaints made against the facilities.
    c. ALF policy is found in Chapter 13 of the SOP Manual.
    d. QA reviews the following areas:
        1) Inspections
        2) Follow-ups
        3) Statements of Deficiency
        4) Complaints

3. Certified Community Residential Services and Supports (CCRSS)
    a. CCRSS is sometimes referred to as Supported Living (SL), however, Supported Living is only one aspect of the CCRSS program. Typically, there are between one and 10 residents residing in their own homes who hire providers to assist with their identified care needs. Group Homes (GH), Group Training Homes (GTH), Supported Living (SL), and State Operated Living Alternatives (SOLA) are included in the CCRSS program.
    b. RCS regulates the companies who provide direct care for clients and completes complaint investigations for these facilities.
    c. The Developmental Disabilities Administration (DDA) is responsible for assessing resident care needs and authorizing services.
    d. CCRSS policy is found in Chapter 14 of the SOP Manual.
    e. QA reviews the following areas:
        1) Certification Evaluations
        2) Statements of Deficiency
        3) Complaints
4. Complaint Resolution Unit (CRU)
    a. The CRU receives and prioritizes complaints of alleged incidents of abuse, neglect, or exploitation of vulnerable adults. Complaints may be received from anyone in the community and must be disseminated properly.
    b. The CRU policy is found in Chapter 4 of the SOP Manual.
    c. QA reviews the following areas:
        1) Intakes
5. Enhanced Services Facilities (ESF)
    a. ESFs provide community placement options for individuals for whom complicated personal care and behavioral challenges do not rise to a level that requires institutionalization. Rather than extended stays in State Hospitals, individuals who are stable and ready for discharge can be referred for placement in an ESF through Home & Community Services (HCS). As of January 2024, there are nine ESFs in Washington.
    b. RCS regulates ESFs and conducts licensing visits every 9-18 months and investigates complaints made against the facilities.
    c. ESF policy is found in Chapter 15 of the SOP Manual.
    d. QA reviews the following areas:
        1) Inspections
        2) Follow-ups
        3) Statements of Deficiency
        4) Complaints

6. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
    a. ICF/IIDs are facilities that meet the needs of four or more individuals with Developmental Disabilities. A range of clients are served, and facility sizes vary. As of January 2024, there are three ICF/IIDs in Washington.
    b. RCS Surveyors are also referred to as State Agencies (SA) and are contracted by the Centers for Medicare and Medicaid Services (CMS) to conduct annual Recertification Surveys and Complaint Investigations.
    c. RCS re-certifies facilities each year based on Federal Regulations and State Operations Manual (SOM) guidelines.
    d. ICF/IIDs are certified settings. The ICF/IID policy is found in Chapter 16 of the SOP Manual.
    e. QA reviews the following areas:
        1) Surveys
        2) Statements of Deficiency
        3) Complaints
7. Residential Inspection and Quality Assurance Program (RIQAP)
    a. RIQAP, also known as "Initial Licensing," performs pre-occupancy on-site inspections of ALF, AFH, and ESF settings and recommends licensure once all requirements for licensure are met.
    b. RIQAP policy is found in Chapter 11 of the SOP Manual.
    c. QA reviews the following areas:
        1) Initial licensing pre-occupancy inspections for ALF, AFH, and ESFs.
8. Skilled Nursing Facilities
    a. A Skilled Nursing Facility (SNF), also known as a Nursing Facility (NF), or Nursing Home (NH) provides 24-hour supervised nursing care, personal care, therapies, nutrition, activities, social services, room & board, and laundry services to residents who meet the Nursing Facility Level of Care.
    b. RCS Surveyors are also referred to as State Agencies (SA) and are contracted by the Centers for Medicare and Medicaid Services (CMS) to conduct annual Recertification and Complaint Investigation Surveys.
    c. RCS re-certifies facilities each year based on both State regulations in WAC Chapter 388-97 and Federal Regulations found in the State Operations Manual (SOM) guidelines.
    d. Nursing Home policy is found in Chapter 17 of the SOP Manual.
    e. QA reviews the following areas:
        1) Surveys
        2) Re-visits
        3) Statements of Deficiency
        4) Complaints

9. Business Analysis and Application Unit (BAAU)
    a. The BAAU is responsible for the initial processing of licensing applications from entities who wish to open AFH, ALF, NH, and ESF settings.
    b. Regulatory authority for BAAU includes licensing requirements for each setting found at:
        1) WAC 388-76 for AFH settings
        2) WAC 388-78A for ALF settings
        3) WAC 388-97 for nursing facilities
        4) WAC 388-107 for ESF settings
    c. BAAU policy is found in Chapter 3 of the SOP Manual.
    d. QA reviews the following areas:
        1) AFH applications
10. Additional Information
    a. Complaint investigations are reviewed for AFH, ALF, CCRSS, ESF, ICF/IID, and NH settings. The policies specific to how complaints are investigated is located in Chapter 20 of the SOP Manual, not in the chapter for the specific setting. Priority change information for complaint intakes is located in SOP Chapter 4.
    b. Additional reviews may be conducted as requested by executive leadership. Reviews are subject to change by leadership and a schedule is posted each year to clarify which reviews will occur that year and when during that year those reviews will occur.

E. RCS Connection to CMS

The Social Security Act Section 1915 gives states the authority to provide Home and Community Based Services (HCBS) to individuals who would otherwise be served in an institutional setting. Services are paid for partially by the federal government, partially by the State, and partially by the person receiving the services (based on how they are eligible and their income).

(HCBS) rules apply to all settings where the federal government is providing funding for the provision of services.

Settings that RCS regulates which must adhere to HCBS rules:

- Adult Family Homes (AFH)
- Assisted Living Facilities (ALF)
- Enhanced Services Facilities (ESF)
- Certified Community Residential Services and Supports (CCRSS)

There are other settings for which HCBS rules apply, including Adult Day Health, Adult Day Care, State Operated Living Alternatives for children, Individual Provider services provided by HCS, and others. However, these settings are not regulated by RCS.

How individuals access federal funds to get help paying for services provided by these settings:
In Washington, Apple Health is what we call our Medicaid program. Apple Health provides medical services such as preventative care and regular medical care. We have two State Plan Amendments (SPA) which add Long-Term Services and Supports (LTSS) to Apple Health. These programs are Community First Choice (CFC) and Medicaid Personal Care (MPC).

CFC is authorized under the authority of Section 1915 (k) of the Social Security Act established under the Affordable Care Act of 2010. To be eligible for Apple Health's CFC or MPC services, one must meet both the financial and functional eligibility requirements. MPC is a small program that serves individuals with lighter care needs and only a small portion of the population uses these services. CFC is the primary program, serving over 70,000 residents statewide.

HCBS Waivers are designed to allow the provision of institution level services to clients in community settings. In other words, people who would have been served in a hospital, nursing facility, or ICF/IID can waive their entitlement to institutional level care and receive services in their home or a residential community-based setting instead.

Both State Plans and Waivers must adhere to the HCBS rules found in CFR §441.301 (4) released in 2014:

1. Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan.
2. CMS will require transition plans for existing section 1915(c) waivers and approved state plans providing home and community-based services under section 1915(i) to achieve compliance with this section.
3. Upon approval by CMS, the State will begin implementation of the transition plans. The State's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation (FFP).

ALTSA's HCBS Transition Plan outlines how we will come into compliance and continue to comply with these setting rules.

RCS is the regulatory arm of ALTSA. In order to assure CMS that we are in compliance, we have provided language in the SPA, the Waivers, and the HCBS transition plan which says we will QA the work completed by ALTSA staff, including RCS. Some of the QA results the ALTSA QA Unit completes are provided to CMS on evidence reports required by CMS in order to continue to be eligible to provide waivers in the state. If our results do not meet CMS standards, CMS may revoke our waiver. In HCS, there are over 40,000 Washingtonian's served by the Community Options Program Entry Service (COPES) waiver who are at risk of losing the ability to pay for home and community-based services if this waiver is revoked.

More information about waivers

HCS offers services under the following Medicaid HCBS waivers and programs:

1. Community Options Program Entry Service (COPES) Waiver
2. New Freedom Waiver
3. Residential Support Waiver

DDA offers services under the following Medicaid HCBS waivers:

1. Basic Plus Waiver
2. Children's In-home Intensive Behavioral Support Waiver
3. Core Waiver
4. Community Protection (CP) Waiver
5. Individual and Family Services Waiver

Additional non-waiver community-based programs:

1. Program of all-inclusive Care for the Elderly (PACE)
2. Roads to Community Living Demonstration
3. Medicaid Transformation Demonstration (accessed through Area Agencies on Aging)
   a. Medicaid Alternative Care (MAC)
   b. Tailored Supports for Older Adults (TSOA)

CMS Waiver Assurances and Requirements

CFR §441.302 State Assurances

1. Adequate standards for all types of providers that provide services under the waiver;
2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and
3. Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR part 1397 for board and care facilities.
4. Assurance that the State is able to meet the unique service needs of the individuals when the State elects to serve more than one target group under a single waiver, as specified in §441.301(b)(6).
5. Assurance that services are provided in home and community-based settings, as specified in §441.301(c)(4).

Waiver Application and Technical Guide Language:

1. Quality Improvement: The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified throughout the application and in Appendix H.
2. Continuous Quality Improvement: CMS expects states to follow a continuous quality improvement (CQI) process in the operation of each waiver program. The process involves a continuous monitoring of the implementation of each waiver sub-assurance, methods for remediation or addressing identified individual problems and areas of noncompliance, and processes for a) aggregating collected information on discovery and remediation activities, and b) prioritizing and addressing needed systems changes on a regular basis.

Waiver Assurances and Other Federal Requirements

The waiver assurances (and their component elements) that must be included in the QIS follow. Also included in parentheses are references to the specific parts of the application that pertain to the respective assurance.

1. Administrative Authority (*Quality Improvement: Appendix A)*
   - Assurance: The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
2. Level of Care (LOC) *(Quality Improvement: Appendix B)*
   Assurance: The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/re-evaluating and applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/IID.
   a. An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
   b. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant LOC.
3. Qualified Providers (Quality Improvement: *Appendix C)*
   Assurance: The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.
   a. The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
   b. The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
   c. The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.
4. Service Plan (*Quality Improvement: Appendix D)*
   Assurance: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for the waiver participants.
   a. Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.
   b. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
   c. Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.
   d. Participants are afforded choice between/among waiver services and providers.

5. Health and Welfare *(Quality Improvement: Appendix G)*
   Assurance: The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
   a. The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.
   b. The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.
   c. State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
   d. The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.
6. Financial Accountability *(Quality Improvement: Appendix I)*
   Assurance: The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program
   a. The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
   b. The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

G. Change log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
01/17/2025	Entire Chapter	• Formatting updates	• Comply with new DSHS branding	N/A
01/17/2025	I.E Sending files or documents to ALTSA QA	• Section added	• Incorporates guidance contained in MB R22-060	N/A
01/17/2025	Entire Chapter	• Housekeeping updates	• Updated with current processes, including incorporation of guidance contained in MB R23-027	N/A
09/08/2023	Chapter 10 All Sections	• Chapter updated and converted to new format. • Added final exit and removed preliminary exit conference.	• To ensure all staff are familiar with QA processes and procedures. • To add the change from a preliminary exit format to a final exit format.	MB R23-075
09/08/2023	New sections added	QI procedures added to chapter	QI is a new unit within RCS	MB R23-075
1/6/2022	Chapter 10 All Sections	• Updated language to reflect the change from RCS QA to ALTSA/OAS. • Updated members of committees and meetings as appropriate for the restructuring of RCS leadership and change of QA from RCS to OAS. • Updated due date requirement for PIP timelines to 45 working days from	To ensure clear policy and update procedures to be consistent. To clarify unit changes.	MB R22-001

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
		the CRC Meeting date. • Updated period for MB and Policy change implementation to allow 30 calendar days before the new standard is subject to QA. • Updated information in Appendix A. • Added Appendix B.		