Washington State Department of Social & Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION
RESIDENTIAL CARE SERVICES
"Transforming Lives"

CHAPTER 10 – QUALITY ASSURANCE (QA)

OVERVIEW

A Quality Assurance (QA) or Quality Management System (QMS) is a commonsense approach of organizing the business and support processes that affect the quality of regulatory 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.

ALTSA Quality Assurance (QA) is located within the Office of the Assistant Secretary (OAS). 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. ALTSA QA collaborates with RCS Field Operations and Headquarters (HQ) to promote continuous improvement.

AUTHORITY

- SOCIAL SECURITY ACT 1819(G)(2)(D)
- SOCIAL SECURITY ACT 1919(G)(2)(D)
- 42 CFR § 488.312 CONSISTENCY OF SURVEY RESULTS
- SOM CHAPTER 7 § 7800.2 CONSISTENCY OF SURVEY RESULTS: MEASURING CONSISTENCY
- SOM CHAPTER 7A PRINCIPLES OF DOCUMENTATION: LEGAL ASPECTS OF THE SOD
- 42 CFR § 441: SERVICES & 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
- CMS QUALITY MEASURES AND REPORTING MEMO:
    - SECTION 3 – 86% PROFICIENCY THRESHOLD AND PIP REQUIREMENT
    - SECTION 2 – INDIVIDUAL FINDING REMEDIATION REQUIREMENT
- HCBS TRANSITION PLAN TO COMPLY WITH HCBS SETTING RULES
- RCW 43.17.385 QUALITY MANAGEMENT, ACCOUNTABILITY, & PERFORMANCE SYSTEM
- RCW 74.39A.051 QUALITY IMPROVEMENT PRINCIPLES
- STRATEGIC PLAN
    - OBJECTIVE 3.1: CONDUCT QA ACTIVITIES AND COMPLY WITH FEDERAL, STATE, & PROGRAM REQUIREMENTS

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This chapter contains information about the Quality Assurance process followed for completing RCS process reviews. The content is relevant to RCS staff, external stakeholders, and anyone seeking to understand how QA process reviews are conducted for RCS.

SUBJECT MATTER EXPERTS

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CHAPTER 10 –QUALITY ASSURANCE INDEX

This section contains the Standard Operating Procedures (SOPs) that must be followed for Quality Assurance. Additional sections include resources and links to forms as listed below.

OVERVIEW

STANDARD OPERATING PROCEDURES

APPENDIX A: RESOURCES AND FORMS

APPENDIX B: RCS CONNECTION TO CMS

APPENDIX C: CHAPTER 10 CHANGE LOG

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10A – QA Standard Operating Procedures

This section contains the Standard Operating Procedures that RCS and ALTSA QA staff are required to follow.

A. **QA Procedures**

1. General Guidelines
2. Process Review Schedule
3. QA Question Development
4. Sample Methodology
5. Process Reviews
6. Exit Conference
7. Remediation
8. Change Requests
9. Thirty-Day Reviews
10. Final Proficiency Report
11. Proficiency Improvement Plan (PIP)
12. Record Retention
13. Annual Statewide Final Reports

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10A1 – General Guidelines

Background

QA was developed for RCS as part of ALTSA's Quality Management System (QMS) to improve processes within RCS and to ensure federal guidelines for participation in federal programs are maintained.

In February of 2014, six positions were funded through the Roads to Community Living grant. The original grant included a Unit Manager, four Social and Health Program Consultants (SHPCs), and one Management Analyst. The unit was added to the official RCS budget as of July 1, 2018 and transitioned to the Office of the Assistant Secretary (OAS) on April 16, 2021.

The purpose of conducting QA Process Reviews is to ensure RCS activities are in compliance, and continue to remain in compliance, with minimum licensing standards, current RCW, 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 A: Resources and Forms.
- For information about the federal connection between RCS and CMS, see Appendix B: RCS Connection to CMS.

Procedure

A. **Process Review Frequency**

1. QA completes process reviews as required for each program.

B. **General Information – QA will:**

1. Conduct required process reviews to determine compliance with minimum standards and federal regulations.
2. Follow all procedures to ensure consistent QA process reviews.
3. Complete process reviews in a timely manner.
4. Monitor the RCSQuality@dshs.wa.gov email box and respond to inquiries within 1 business day.
5. Clearly communicate findings and trends.

6. Track dates and update leadership on Proficiency Improvement Plan (PIP) progress throughout the division.
7. Always maintain professional and respectful conduct.

QA UNIT MEMBER ROLES:

A. ALTSA QA UNIT MANAGER

1. Supervises and provides oversight to the QA Unit to ensures all processes and procedures are followed and QA reviews are completed as required.
2. Performs regular spot checks of QA Consultant work for quality, consistency, and interrater reliability.
3. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.
4. Assures the statistical relevance for all sampling and sample methodology and determines samples sizes required.
5. Maintains the QA Monitor Tool.
    a. Ensures all RCS staff have access to the QA Monitor Tool.
    b. Ensures trainings are available related to use of the QA Monitor Tool.
    c. Coordinates with Management Services Division (MSD) to repair bugs, create reports, or work on issues as they arise.

B. PROCESS REVIEW LEAD

1. The Process Review Lead (Lead) is the QA Consultant assigned to coordinate the process review and all associated tasks to ensure completion.
2. Creates and distributes statistically significant and accurate samples.
3. 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.
4. 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.
5. 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.
6. Creates or runs required reports to ensure historical records are available.
7. Tracks field PIP due dates and report progress as required.

C. **QA CONSULTANT**

1. Is a member of the QA Unit who coordinates and completes Quality Assurance process reviews.
2. Completes process reviews in the manner prescribed in the instruction documents, in this chapter, and in documents produced through the question development process.
3. Works within the unit to ensure all work is completed in a professional and collaborative manner.

D. **ALTSA MANAGEMENT ANALYST**

1. Is a member of the ALTSA Quality Management System who reports directly to the ALTSA Senior QA Administrator.
2. Provides RCS Quality Improvement Coordinators (QICs) data analysis one day prior to the exit conference and two days after initial proficiency reports are finalized.
3. Collaborates and consults with QA and QI when reviewing data.
4. Provides Ad Hoc data analysis and reports as requested by agreed deadlines.
5. Documents potential enhancements to QA reports throughout the year.
6. Work with the QA monitor Development Team to correct issues with QA reports, suggest improvements and test changes to the QA tool or reports.
7. Creates and maintains the system to track data and information which was provided annually to RCS via SharePoint.

QA UNIT MANAGER RESPONSIBILITY

A. The QA Unit Manager:

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

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QUALITY ASSURANCE REVIEW

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A2 – PROCESS REVIEW SCHEDULE

BACKGROUND

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 input into the QA Monitor Tool by QA or as Supervisory reviews input by RCS staff must be closed and completed before the system lock-out in December when updates are processed for the next review year. This includes adding necessary 30-Day reviews or overturning findings as required.

PROCEDURE

A. 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, and the RCS QA SharePoint site will be updated.

B. 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 for the preliminary Statewide Exit Conference with initial proficiencies.
4. Change request due dates.
5. Change Request Committee dates.
6. Question Development meeting dates.
7. PIP due dates.

QA UNIT MANAGER RESPONSIBILITY

A. The QA Unit Manager:

1. Ensures staff are able to demonstrate a working knowledge of this policy.
2. Conducts periodic reviews to ensure staff are following the policy.
3. Ensures that the QA Unit Schedule is created and disseminated.
4. Creates and disseminates annual Management Bulletins with updated process review information.
5. Sends weekly updates as required.

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QUALITY ASSURANCE REVIEW

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A3 – QA QUESTION DEVELOPMENT

BACKGROUND

Quality Assurance (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 developed with input from RCS Policy, Training, and other subject matters experts and are approved by the QA Steering Committee, which consists of RCS Executive Leadership.

QA Questions are developed based on current policies, procedures, the ALTSA Strategic Plan, federal legislation, federal requirements for RCS settings, state legislation, current issues the division is experiencing, or in response to external audits.

How QA reviews each of the questions is developed through input from subject matter experts and feedback from staff.

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 in 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 at RCSQuality@dshs.gov.

PROCEDURE

A. Documents are reviewed, updated, and revised as changes are required.

B. The Lead will facilitate a meeting with policy, training, area specific subject matter experts, and interested staff to review QA questions. In this meeting, all sections of the documents are reviewed are revised.

C. The Lead may submit revised question documents to RCS Document Review to get feedback from RCS staff when required or when the Lead determines it is needed.

D. Once final drafts are completed, questions and expected proficiencies are reviewed with the QA Steering Committee for final approval. The instructional sections are not required to be approved by the Steering Committee.

E. When MBs or new policies are published, QA will conduct reviews to that standard 30 calendar days after the MB or policy is effective.

F. QA question materials to be used for the year are published to the QA SharePoint site, and are provided in the QA Schedule Management Bulletin.

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QA Unit Manager Responsibility

A. The QA Unit Manager:

1. Ensures QA staff are able to demonstrate a working knowledge of this policy.
2. Reviews required changes with the QA Steering Committee, when their approval is required, in order to obtain final approval.
3. Researches and responds to inquiries from the QA Unit.
4. Conducts periodic reviews to ensure QA staff are following the policy.

QA Steering Committee Responsibility

A. The QA Steering Committee:

1. Reviews questions, documents, and processes used by QA, when required.
2. Grants final approval of changes and updates to QA activities and expected proficiencies.

Quality Assurance Review

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A4 – SAMPLE METHODOLOGY

BACKGROUND

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

A. For settings, QA determines the total sample size required for the entire state using the methodology noted above. If the setting being reviewed is not a Headquarters based program, the number of files to be reviewed per region is based on that region's pro-rated share.

   Example of a Nursing Home Sample Calculation (used for field-based programs):

   1. In 2018, there were 226 Nursing Homes (NHs) in the state.
   2. When 226 is entered into Raosoft, a statistically significant sample size was calculated at 143. Therefore, 143 NHs that were Surveyed during 2018 were chosen to be reviewed by QA.
   3. Region 2 had 98 NHs, which equals 43% of the total universe.
   4. Because 43% of 143 is 61, Region 2 had 61 NH Surveys reviewed.
   5. When the survey being reviewed had a revisit that fell within the sample timeframe, that revisit was reviewed by QA. If the revisit was after the sample timeframe ended, the revisit was not reviewed by QA.

B. For other program areas being reviewed such as Statements of Deficiencies (SODs), Complaints, CRU intakes, CCRSS Evaluations, and OBRA Registry inquiries, the sample is derived using methodology appropriate to the work completed.
   1. 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.

2. 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.

C. 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 10A5 of this chapter. 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.

FIELD STAFF RESPONSIBILITY

A. Working paper documents/non-electronic records:

1. When files needed for review must be scanned, the Lead will coordinate with the Regional Administrator (RA) to ensure file scanning is completed at least one week prior to the start of the review.
    a. QA requires a minimum of one week prior to the start of the review to ensure files are scanned and QA is trained on the specific review.
2. In the event QA must travel to an office to complete a review, paper files must be available for QA by the time QA arrives at the office.
3. When QA is not travelling, or there are no paper files, QA will send the sample in the entrance email and will indicate no paper files are required.
4. For further information or questions about dates, please email RCSQuality@dshs.wa.gov.

QA UNIT MANAGER RESPONSIBILITY

A. The QA Unit Manager:

1. Ensures QA staff are able to demonstrate a working knowledge of this policy.
2. Ensures sample and sample methodology meet required standards.
3. Assists Lead with getting approval for and scheduling travel to scan non-electronic records, when needed.
4. Conducts periodic reviews to ensure staff are following the policy.
5. Requests training or clarification from headquarters as needed.

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QUALITY ASSURANCE REVIEW

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A5 – PROCESS REVIEWS

BACKGROUND

The QA Unit is responsible for determining whether specific proficiencies were met based on a prescribed set of questions. See section 10A3 of this chapter for information about question development.

The process reviews discussed in this section are defined as: the entrance, the initial process review work completed by QA, and the preliminary Exit Conference. Process reviews are primarily conducted remotely by the ALTSA QA Unit. Staff are periodically required to travel to regionally located offices throughout the state to scan or retrieve documents.

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 subject matter expert 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 RCSQuality@dshs.wa.gov or refer to the QA Schedule.

PROCEDURE

Entrance:

A. QA will e-mail entrance correspondence to designated staff for the area being reviewed, including Central Files when necessary. This will include the official request for records (also known as the "Sample") and pertinent information related to the process review, such as:
    1. The name of the review Lead.
    2. The Sample and the official request for records.
    3. An information sheet, which contains meeting and due dates for the review.

B. The Lead will contact the 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 files requested and arranging any required document scanning.

C. The Lead is responsible for ensuring communication between the staff and QA occurs during the review, as questions arise.

D. The Lead will communicate with Policy, Training, and other Subject Matter Experts, as needed to ensure the review is as accurate as possible, and new policies and procedures are communicated with QA.

E. 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 development meeting and documents can be updated as appropriate.

Initial process review:

A. 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 for 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 business day.
   4. Acquire keys, entry codes, visitor badges needed, and verify times when QA may enter and exit an office and use equipment to scan, when needed.
   5. Establish how the program would like any files or data returned, as needed.
   6. Coordinate requested preliminary office or unit exit meetings in coordination with the QIC, the RA, or the Field Manager(s).

During the process review:

B. During the process review, the Lead will:

   1. Track issues or missing files and work to resolve them before the end of the review for that area.
   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 daily and identify items still open, or issues which must be resolved. This is typically referred to as “balancing” the team’s work.
      a. Balancing should be done periodically throughout the review, preferably daily, but timing is dependent on the review’s complexity.
      b. If working in field offices, this should be done, at a minimum, prior to the unit leaving each office.

Process review preliminary office/unit exit:

A. Once the process review has been completed for each office, the office may request an individualized preliminary exit meeting. This meeting is intended to be an overview of the QA results for only that location and provides an opportunity for QA to answer questions or address concerns about the review. Policy and Training staff will be invited to attend to listen and respond to inquiries or requests. The Lead will coordinate exit meetings as they are requested.

B. As QA leaves an office or workspace, the Lead will ensure the space is left clean, and anything used is put away or replaced in the manner the office has requested.

QA Unit Manager Responsibility

A. The QA Unit Manager:

1. Ensures QA staff are able to demonstrate a working knowledge of this policy.
2. Conducts reviews of QA staff work to ensure staff are following the policy.
3. Work with QA staff during the process review to complete the review and address any concerns or specific questions related to how to complete any part of the review.
4. Requests training or clarification from leadership as needed.

Quality Assurance Review

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A6 – STATEWIDE PRELIMINARY EXIT CONFERENCE

BACKGROUND

A Statewide Preliminary Exit Conference will be conducted at the completion of each process review to discuss the initial proficiencies and trends found during the statewide review. The initial proficiencies are the preliminary results prior to any changes made during the change request process and at the Change Request Committee meetings. The results are subject to change once all change requests are finalized. Finalization of results occurs after the 30-day process review described in section 10A9 of this chapter.

PROCEDURE

A. Exit Conference dates are determined during the initial QA Unit process review schedule creation and are found on the official posted QA Unit Schedule. Exit Conference dates should not change once the schedule is published, as dates for the Change Request and PIP processes are driven by the date of this meeting.

B. The Lead will coordinate and facilitate the Exit Conference. The following individuals will be sent an invitation and will share the invitation with field staff at their discretion:

- RCS Director
- Office Chiefs overseeing the area being reviewed.
- Office Chief for Policy, Training, and Quality Improvement.
- Regional Administrators (RA) for the area being reviewed and their Administrative Assistants.
- Quality Improvement Coordinator (QICs).
- Policy Unit Manager and Program Manager for the area being reviewed.
- Training Unit Manager.
- ALTSA's QA Senior Administrator.

The exit conference is an open meeting. Please contact your Supervisor, your QIC, or email QA at RCSQuality@dshs.wa.gov if you did not receive an invitation and would like to attend.

C. The Exit Conference will include the following information:

1. QA questions included in the process review.
2. Expected proficiency for each question and the proficiency achieved.
3. Process review trends and positive outcomes since last review.
4. Any new information regarding question development meetings or processes.

5. The change request process, due dates, and meeting dates.
6. The initial proficiency report(s) from the QA Monitor Tool.
7. PIP due date.

D. The QA Lead will send final proficiency reports to program contacts once Change Requests, Remediation, and the 30-day process has been completed for the review.

QA Unit Manager Responsibility

A. The QA Unit Manager:

1. Trains new staff and ensures they are able to demonstrate they understand this procedure.
2. Attends Exit Conferences.
3. Conducts periodic reviews of this procedure to ensure staff are following it correctly.
4. Requests training or clarification from leadership as needed.

Quality Assurance Review

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A7 – REMEDIATION

BACKGROUND

Remediation provides verification that QA findings have been corrected. Remediation is a CMS requirement for our Quality Management System and must be completed within 30 calendar days of the Exit Conference.

For background check reviews required by certain programs; remediation must be completed within three (3) working days from the notification of the finding. MB R19-091 explains the remediation process.

There are times when remediation is not possible. QA question documents identify these questions by using "Historical data, unable to remediate" as a remediation option.

QA will enter the appropriate remediation response for each finding during the 30-day review cycle, or that remediation was not possible. This input is required to allow the QA Monitor Tool to properly close each review cycle.

PROCEDURE

QA UNIT RESPONSIBILITY

A. QA will enter all review results into the QA Monitoring Tool during the initial review.

B. The QA Lead will notify the program designee as soon as possible when a file is missing, or when the file is missing information required for the review.

C. The QA Lead will advise the identified program staff when findings require remediation within three (3) working days, providing the remediation required and the date the remediation is due.

D. The Lead will track and coordinate remediation requests and ensure all remediation activities are completed as required.

E. The Lead will monitor the RCS Quality email box during the 30-day cycle and track that all remediations are completed.

F. QA findings must show they have been remediated by the 30-day due date. For more information about 30-day reviews, please see section 10A9 of this chapter.

G. See section 10A8 of this chapter for information on change requests if you do not agree with the QA finding and the review has ended.

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FIELD STAFF RESPONSIBILITY

A. Review findings which require remediation and complete the required remediation. For 3-day remediations, refer to MB R19-091.

B. Enter a Review Cycle Note (RCN) into the QA Monitor Tool explaining the remediation action, use the code "Action Taken" for the RCN type when adding a remediation.

C. Notify QA when the remediation has been completed via email, send notifications to RCSQuality@dshs.wa.gov. Additional documentation is not always required, if it is required, attach it with this email.

QA UNIT MANAGER RESPONSIBILITY

A. QA Manager will conduct the following activities in relation to this procedure:

1. Train new staff and ensure they are able to demonstrate they understand this procedure.
2. Attend all unit meetings and act as final determination if there is not agreement as to how to proceed with a remediation or a change request.
3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
4. Request training or clarification from leadership as needed.

QUALITY ASSURANCE REVIEW

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A8 – CHANGE REQUESTS

BACKGROUND

The purpose of the change request process is to provide staff the opportunity to request a QA finding be overturned.

All change requests must be submitted not more than 30 calendar days after the date of the exit conference. Due dates for change requests are published on the QA Schedule and submissions received after the close of business on the date requests are due will not be considered.

PROCEDURE

FIELD STAFF RESPONSIBILITY

A. Request Changes to QA findings:

Prior to sending the change request, program staff will:

1. Review QA question documents and instructions.
2. Review the policy in place at the time the work was completed.
3. Review historical Change Request Committee (CRC) decisions located on the QA SharePoint, to determine whether a decision about this issue has been made by the CRC.
    a. If the CRC has historically upheld a QA determination related to the same issue, the change request may not be sent to the CRC to review again.
    b. If there has been a change to policy or there is a compelling reason for leadership to discuss the issue, QA may still forward the request.

After determining the Change Request should be sent to QA:

1. The field will enter a Review Cycle Note (RCN) into the QA Monitor Tool. Instructions are located on the QA SharePoint.
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 needed, it must be sent to rscquality@dshs.wa.gov by the specified due date.
    a. E-mail QA only when supporting documentation is required. Screen shots and information found in our computer systems or in scanned documents should be explained in the RCN. Do not alter or scan and mark on official working paper documents.

b. If an email is required, include the facility name and license number in the subject line.

4. Run the ALTSA Reporting *2309 Change Request Report* to verify everything you entered is on this report and is attached to the correct QA review cycle. This is the report QA will use to process change requests.

QA UNIT RESPONSIBILITY

1. Review and research each change request received.
2. Request additional information from appropriate subject matter experts (e.g., Training, Policy, Regional Staff, etc.) as needed to clarify the issue.
3. Attempt to resolve the issue, which may include overturning the decision or upholding the decision when there is clear policy guidance, or the CRC has ruled on the issue in a previous CRC meeting.
4. Forward requests that require a CRC decision to the committee prior to the CRC meeting.
5. Overturn any findings the CRC has determined should be overturned.
6. Distribute final reports once the process is completed, following the procedure in section 10A10 of this document.

CHANGE REQUEST COMMITTEE (CRC) RESPONSIBILITY

A. Purpose: To make final determinations on change requests related to QA findings. Each topic area or finding will be discussed during the meeting and a determination will be made by the voting members as to the outcome of the QA finding.

1. CRC meetings are scheduled by QA and dates are published on the QA Process Review Calendar. Dates for these meetings are sent annually and may only change by request of CRC members.
2. CRC does not repeat change requests that have been decided in historical committee meetings unless there is a compelling reason to hear the request.
3. CRC does not hear change requests that have clear internal, state, or federal policy guidance. Change requests may be upheld by QA in these circumstances.

B. The CRC includes the following voting members:

1. RCS Director
2. RCS Office Chiefs not in charge of the area subject to review
3. Training Unit Manager
4. Policy Unit Manager

Note: A voting member may assign a designee who will attend and vote in their place.

C. The CRC will:

1. **Review** the change request and all supporting documentation.
2. **Discuss** the issue and ask questions of everyone attending.
3. **Vote** to determine whether to uphold or overturn the QA finding.
    a. When the CRC upholds the QA finding, the field must remediate the finding with 10 working days, when remediation is possible.
    b. When the CRC overturns the QA finding, QA must reverse the finding and update proficiency reports within 10 working days.
    c. If the vote is a tie, the RCS Director or designee will make the final decision.

QA Unit Manager Responsibility

A. QA Manager will conduct the following activities in relation to this procedure:

1. Train new staff and ensure they are able to demonstrate they understand this procedure.
2. Facilitate CRC meetings, maintain professionalism, and ensure the meeting stays on task. This meeting is to determine whether to overturn or uphold the QA finding.
3. Provide clarification of QA findings.
4. Ensure field staff are provided the opportunity to present their request through their program's representative and is afforded the opportunity to respond to questions and information requests from the CRC voting members.
5. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
6. Request training or clarification from headquarters as needed.

Quality Assurance Review

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A9 – Thirty Day Reviews

Background

Thirty-day reviews are completed by QA staff to show all work has been finalized and all remediations are complete. Outstanding QA findings can be reviewed 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 findings are closed before the end of the QA review year.

Anyone entering QA reviews, including those individuals entering supervisory reviews, must enter a 30-Day review when there were findings on any initial review. This must be completed prior to the close of the QA Monitor's annual cycle. For more information, please contact QA at RCSQuality@dshs.wa.gov.

Procedure

A. QA Consultants analyze all QA findings at least 30 calendar days after the date of the exit conference and once the change request process has been completed.
   1. If the QA finding is not able to be remediated, the QA Consultant will open a new 30-day review cycle, choose "N/A" and the appropriate remediation response.
   2. If the QA finding is able to be remediated, it must be remediated within 30 days. Once the remediation is complete and has been accepted, QA will input a 30-day review cycle, chose "Yes" and the appropriate remediation response.

B. The QA Lead will verify all 30-day reviews have been entered and all process reviews have been closed at the end of the review and again at the end of the year.

QA Unit Manager Responsibility

A. QA Manager will conduct the following activities in relation to this procedure:
   1. Train new staff and ensure they are able to demonstrate they understand this procedure.
   2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
   3. Request training or clarification from headquarters as needed.

Quality Assurance Review

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A10 – FINAL PROFICIENCY REPORT

BACKGROUND

Once all change requests and thirty-day reviews are completed, proficiencies are re-calculated, and a new statewide final proficiency report is issued for the program or area by the Lead.

Regions and offices may print new reports that show the final proficiencies for their specific region and/or office if they choose. These reports are available once QA has completed the thirty-day review cycles and may be printed at any time by staff that have access to ALTSA Reporting.

PROCEDURE

A. The Lead will verify the review is completed.
   1. All reviews must be closed in the QA Monitor tool.
   2. Once everyone who entered reviews indicates they have finished the 30-day process, the Lead will verify the review shows as fully complete and all reviews in the QA Monitor Tool are closed.

B. The Lead will send final statewide proficiencies, which include:
   1. The questions, the expected proficiency, and the final proficiency achieved.
   2. The “no responses” and frequency of each “no response”.

QA UNIT MANAGER RESPONSIBILITY

A. QA Manager will conduct the following activities in relation to this procedure:
   1. Train new staff and ensure they are able to demonstrate they understand this procedure.
   2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
   3. Request training or clarification from headquarters as needed.

QUALITY ASSURANCE REVIEW

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A11 – PROFICIENCY IMPROVEMENT PLAN (PIP)

BACKGROUND

EXPECTED PROFICIENCIES:
QA question expected proficiencies take into consideration the minimum expected proficiency levels for the Centers for Medicare and Medicaid Services (CMS) waivers, any areas outlined on the ALTSA strategic plan, and the expected proficiencies required by external auditors. 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 a Statewide proficiency report.

The action required for PIP development is based on the initial 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. Some questions require a higher proficiency level because of expectations by CMS, an external auditor, or executive leadership.

PROCEDURE

A. PIP development and completion is the responsibility of the designated program staff (e.g., the QIC or Field Manager, if there is no QIC).
   1. 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.
   2. The use of Lean and Continuous Improvement tools is encouraged. Information and tools for ALTSA's Lean program can be found here.
   3. Anyone assigned a task on the PIP must be aware they are included on the PIP before it is signed by the RCS Director.

B. The completed PIP must be submitted to the RCS Director for final approval by 45 working days after the Change Request Committee Meeting. This due date is included on the published QA Schedule.

C. A copy of the approved PIP must be sent to QA through the RCSQuality@dshs.wa.gov email box once it is signed by the RCS Director.

D. PIP Monitoring:

1. The QA Lead will send the final signed PIP to anyone who is assigned a task.
2. The QA Lead tracks due dates on the final approved PIP and requests information as to the date tasks were completed or to update when the task will be completed when the due date is not achieved.
3. QA provides RCS leadership with status reports as requested.

QA Unit Manager Responsibility

A. QA Unit Manager to conduct the following activities in relation to this procedure:

1. Train new staff and ensure they are able to demonstrate they understand this procedure.
2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
3. Request training or clarification from headquarters as needed.

Quality Assurance Review

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A12 – Annual Statewide Final Report

Background

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.

Procedure

A. The QA Unit Manager creates and posts the report annually and seeks clarification and information from programs as needed to clarify results or explain circumstances that may be needed to properly analyze the data.

B. The QA Unit Manager publishes the report in an MB once the report is complete.

QA Unit Manager Responsibility

A. The QA Unit Manager to conduct the following activities in relation to this procedure:

1. Creates and distributes any required final reports.
2. Request training or clarification from leadership as needed.

ALTSA QA Senior Administrator Responsibility

A. The ALTSA QA Senior Administrator will review and approve the report prior to presentation to RCS Leadership for review, approval, and distribution.

Quality Assurance Review

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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10A13 – 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

A. 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.

B. 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.

C. QA unit members may retain paper checklists only until the 30-day reviews are completed and the full review process is closed.

D. 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.

E. 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.

QA UNIT MANAGER RESPONSIBILITY

A. QA Manager to conduct the following activities in relation to this procedure:
   1. Creates and distributes any required final reports.
   2. Request training or clarification from leadership as needed.

QUALITY ASSURANCE REVIEW

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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APPENDIX A – RESOURCES AND FORMS

BACKGROUND

In 2016, the RCS QA/QI Intranet Site was developed to provide more information about QA activities within RCS. The QA Unit has transitioned to using a QA SharePoint 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 sent to RCSQuality@dshs.wa.gov 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

A. PROCESS REVIEW AREAS AND PROGRAMS

(For more information on each setting/program, please review the SOP Manual)

1. Certified Community Residential Services and Supports (CCRSS)

a. CCRSS is sometimes referred to as Supported Living, however, Supported Living is only one aspect of the CCRSS program. Typically, there are between 4 and 10 residents residing in their own homes who hire providers to assist with their identified care needs. Group Training Homes and State Operated Living Alternatives 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

2. 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 Center 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

3. 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 2020, there are 5 ICF/IIDs in Washington.

b. RCS Surveyors are also referred to as State Agencies (SA) and are contracted by the Center 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 in the community are certified settings. The ICF/IID policy is found in Chapter 17 of the SOP Manual.

e. QA reviews the following areas:

1. Surveys
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. **Assisted Living Facilities (ALF)**
    a. ALFs, formerly known as Boarding Homes, 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 2020, there are about 540 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
6. **Adult Family Homes (AFH)**
    a. AFHs are residential homes that are licensed to care for between two and eight residents. They provide residents with room & board, meals, laundry, supervision, and personal care. As of January 2020, there are about 3,135 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
7. **Residential Inspection and Quality Assurance (RIQA) Program**
    a. RIQA, 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. RIQA 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.
        2. AFH Quality Assurance visits, if completed by RIQA staff within 120 days of licensure.

8. **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).
    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, which is currently pending publication by the RCS Policy Unit.
    d. QA reviews the following areas:
        1. Inspections
        2. Follow-ups
        3. Statements of Deficiency
        4. Complaints

ADDITIONAL INFORMATION:

A. Complaints are reviewed for AFH, ALF, CCRSS, ESF, ICF/IID, and SNF settings. The policies specific to complaints are located in Chapter 20 of the SOP Manual, not in the chapter for the specific setting. Priority change information for complaints is located in SOP Chapter 4.

B. Additional reviews may be conducted as requested by executive leadership. As of 2021, QA is also reviewing the OBRA Registry (SOP, Chapter 26) and changes to the CRU Intake priority which were made by Field Managers. Reviews are subject to change by leadership and a schedule is posted each year to clarify which reviews will occur that year and when those reviews will occur.

QA UNIT MANAGER RESPONSIBILITY

A. QA Manager will conduct the following activities in relation to this procedure:
    1 Train new staff and ensure they are able to demonstrate they understand this procedure.
    2 Conduct periodic reviews of this procedure to ensure staff are following it correctly.
    3 Request training or clarification from headquarters as needed.

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QUALITY ASSURANCE REVIEW

A. This procedure will be reviewed for accuracy and compliance at least every two years.

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APPENDIX B – RCS CONNECTION TO CMS

The Social Security Act Section 1915 gives states the authority to provide Home and Community Based Services 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).

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

Settings that Residential Care Services (RCS) regulates which must adhere to HCBS rules:

- Adult Family Homes
- Assisted Living Facilities
- Enhanced Services Facilities
- Supported Living Services provided within individuals homes
- Group Training Homes
- Group Homes
- State Operated Living Alternatives

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:

- 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.

- 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.
- 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.

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 COPES waiver who are at risk of losing the ability to pay for home and community-based services if this waiver is revoked.

To read more, open the sections below by clicking the arrow to the left of the heading.

More information about waivers

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

- Community Options Program Entry Service (COPES) Waiver
- New Freedom Waiver
- Residential Support Waiver

DDA offers services under the following Medicaid HCBS waivers:

- Basic Plus Waiver
- Children's In-home Intensive Behavioral Support Waiver
- Core Waiver
- Community Protection Waiver
- Individual and Family Services Waiver

Additional non-waiver community-based programs:

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

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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:

- **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**.

- **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.
   - An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
   - 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.
   - 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.
   - The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
   - 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.
   - Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.
   - Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.
   - Services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan.
   - 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.
   - The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.
   - 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.
   - State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
   - 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

- 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.
- The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

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APPENDIX C – CHANGE LOG

EFFECTIVE DATE	CHAPTER SECT #	WHAT CHANGED? BRIEF DESCRIPTION	REASON FOR CHANGE?	COMMUNICATION &TRAINING PLAN
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 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.	To ensure clear policy and update procedures to be consistent. To clarify unit changes.	MB R22-001
7/3/2018	Chapter 10 All Sections	MB & SOP issued	To ensure all staff are familiar with QA processes and procedures.	Reference MB R18-049 R18-049 - SOP Chapter 10 QA.doc
6/2018	10A9 added, renumbered later sections	Added 30-day review process	Previously missing	Added upon publication
6/2018	Chapter 10 All Sections	All QA Policies and Procedures transitioned to formal RCS SOP format from historical Policy and Procedure format.	To ensure all staff are familiar with QA processes and procedures.	MB

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