

Adult Protective Services

The purpose of Chapter 23c is to outline Quality Assurance and Quality Improvement activities for the Adult Protective Services (APS) Division.

Table of Contents

Quality Assurance Overview	2
Statewide Quality Assurance Objectives	3
HQ Quality Assurance Unit Process Overview	4
Part I: Quality Assurance Process Reviews	5
A. General Guidelines.....	5
B. Process Review Schedule	8
C. QA Question Document Review	9
D. Sample Methodology.....	11
E. Process Reviews.....	13
F. Initial Proficiency Reports	15
G. Remediation	16
H. Change Requests	17
Change Request Committee (CRC) Responsibility	19
I. Thirty-Day Reviews	20
J. Final Exit Conference and Proficiency Reports.....	22
K. Proficiency Improvement Plan (PIP)	23
L. Record Retention	24
M. Final Reports.....	25
Part II: Quality Checks.....	27
Part III: Interrater Reliability	27
Part IV: Appendices	28
A. Glossary of Terms	28
B. Acronym List.....	28
C. Sample QA Process Review Result Email Template.....	29
D. Resources and Forms	30

Ask an Expert

For Quality Assurance related questions, please email the Office of the Assistant Secretary (OAS) Quality Assurance (QA) Team for Adult Protective Services (APS) at APSQAUnit@dshs.wa.gov.

QUALITY ASSURANCE OVERVIEW

A 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.

The Home and Community Living Administration (HCLA) QA unit is located within the Office of the Assistant Secretary (OAS) and collaborates with the Quality Improvement (QI) Unit and Adult Protective Services (APS).

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 APS QI Unit's purpose is to examine processes within APS and identify areas to address system gaps. The QI unit develops Proficiency Improvement Plans (PIPs) in response to the QA process reviews in partnership with APS staff. Additionally, the QI unit leads the APS 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.

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

- A. [RCW 74.34](#)
- B. [WAC 388-103](#)
- C. [42 U.S. CODE § 1396r \(g\)\(1\)\(D\)](#)
- D. [42 U.S. Code § 1395i-3 \(g\)\(1\)\(D\)](#)
- E. [SOCIAL SECURITY ACT 1819\(G\)\(2\)\(D\)](#)
- F. [SOCIAL SECURITY ACT 1919\(G\)\(2\)\(D\)](#)
- G. [RCW 43.17.385 QUALITY MANAGEMENT, ACCOUNTABILITY, AND PERFORMANCE SYSTEM](#)
- H. [RCW 74.39A.051 QUALITY IMPROVEMENT PRINCIPLES](#)
- I. [CMS QUALITY MEASURES AND REPORTING MEMO:](#)
 - 1. SECTION 3 – 86% PROFICIENCY THRESHOLD AND PIP REQUIREMENT
 - 2. SECTION 2 – INDIVIDUAL FINDING REMEDIATION REQUIREMENT
- J. [STRATEGIC PLAN](#)
 - 1. STRATEGIC GOAL #2: UPHOLD AND PROTECT CLIENT INDEPENDENCE, HEALTH, SAFETY AND RIGHTS.
 - 2. STRATEGIC GOAL #5: FOSTER A CULTURE OF BELONGING, WELL-BEING AND ENGAGEMENT IN OUR SHARED MISSION, VISION, VALUES AND STRATEGIC GOALS.

This document contains information about the QMS within APS related to QA process reviews and QI activities. The content is relevant to APS staff, external stakeholders, and anyone seeking to understand the APS QMS.

Starting January 2016, Adult Protective Services (APS) Headquarters (HQ) Program Managers (HQ PMs) began completing Quality Assurance (QA) process reviews and entering data into the QA Monitor Tool. Additionally, in 2017 Field Supervisors and Subject Matter Experts (SME) began completing QA reviews in the QA Monitor Tool. In 2024 Quality Improvement Coordinators (QICs) began the work of supporting the continuous improvement process in central intake and the regions.

Timely completion of quality assurance activities helps protect the health and safety of clients and provides oversight of operations. Activities include completing QA reviews to ensure compliance with quality measures; data analysis to identify gaps in the processes being used based on QA review results; developing proficiency improvement plans and creating solutions using feedback from staff at all levels. Identified findings are addressed and improvement plans are developed and monitored to ensure continuous quality improvement. Through these functions, APS will obtain more predictable outcomes that ensure protection of adults who are vulnerable with consistent and timely investigations while offering protective services, supports and referrals.

STATEWIDE QUALITY ASSURANCE OBJECTIVES

1. Analysis of external and internal issues that affect the quality-of-service delivery that is relevant to the division's purpose and its strategic plan;
2. Evaluating and ensuring ongoing compliance with State and Federal law;
3. Ensuring that policies and procedures are clearly documented, and information is available, useable, and updated when needed;
4. Identifying areas in the process that need improvement and developing appropriate counter measures to address areas of concern at all levels – individual, local unit, regional, and statewide;
5. Completing QA process reviews that will assess compliance with existing regulations, policies, and standards;
6. Gathering a consistent and broad range of information to identify trends, strengths, and areas for improvement across the division;
7. Identifying best practices within APS with the purpose of sharing strategies across the state;
8. Developing Proficiency Improvement Plans (PIP) with the objective of continuously improving current processes that affect the quality-of-service delivery and ensure the health and safety of vulnerable adults;
9. Ensuring a continuous flow of communication between all levels of APS.

HQ QUALITY ASSURANCE UNIT PROCESS OVERVIEW

- QA process review occurs at the Office of the Assistant Secretary QA Unit staff level.
- The 12-month QA Activities and Schedule is available on the [OAS QA for APS SharePoint site](#).
- Statistically significant samples are pulled for each regional area based on the number of completed Investigations and Investigations Closed No APS that were processed for each region in an annual time period.
- Statistically significant samples are pulled for screened-in intakes and screened-out intakes that were processed by APS Central Intake within an annual time period.
- Statistically significant samples are pulled for all investigations closed statewide within an annual time period.
- QA Review Entrance letters are sent at the start of each process review cycle.
- APS Central Intake and the Regions have 30 business days from receiving the initial QA proficiency reports to complete the necessary remediations and to also submit change requests.
- APS Central Intake and the Regions then have 5 business days to complete remediation if necessary for findings that were upheld by the change committee.
- An Exit Conference may be conducted via Microsoft Teams at the completion of the review, following any decisions from the change committee.
- OAS QA Consultants(s) conduct a 30-day HQ QA review to document remediation.
- Issues identified in the 30-day HQ QA Review as not fully remediated must be completed immediately by APS Designated Staff.
- OAS QA Consultants(s) complete the Final Report which is a summary of all QA findings.
- A Proficiency Improvement Plan (PIP) will need to be developed for QA questions designated by APS Director and/or the Home and Community Living Administration (HCLA) Assistant Secretary.

PART I: QUALITY ASSURANCE PROCESS REVIEWS

A. GENERAL GUIDELINES

Background

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

Starting January 2016, Adult Protective Services (APS) Headquarters (HQ) Program Managers (HQ PMs) began completing Quality Assurance (QA) process reviews and entering data into the QA Monitor Tool. Additionally, in 2017 Field Supervisors and Subject Matter Experts (SME) began completing QA reviews in the QA Monitor Tool. In 2020 the QA unit was transitioned to the Office of the Assistant Secretary (OAS) and continues to work with APS leadership and staff to complete QA activities. In 2024 Quality Improvement (QI) consultants began supporting APS in implementation of the QMS.

Timely completion of QA activities helps protect the health and safety of clients and provides oversight of operations. Through the QMS system APS will obtain more predictable outcomes that ensure protection of adults who are vulnerable with consistent and timely investigations while offering protective services, supports, and referrals.

For information about each setting or program area reviewed by QA, see [Appendix D: Resources and Forms](#).

Procedure

1. QA Unit will:
 - a. Conduct required process reviews to determine compliance with standards, state law, APS policy, and federal regulations.
 - b. Follow all procedures to ensure consistent QA process reviews.
 - c. Complete process reviews in a timely manner.
 - d. Monitor the APSQAUnit@dshs.wa.gov email box and respond to inquiries within 2 working (business) days (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.
 - 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 APS staff when process questions arise.
 - c. Monitor the ImproveAPS@dshs.wa.gov email box and respond to all inquiries within 2 WD.
 - d. Clearly communicate information.
 - e. Always maintain professional and respectful communication.
3. Region/central intake will:
 - a. Maintain one point of contact within the region or central intake for QA information and work directly with the QI team. This is known as the Designated Staff (DS).
 - b. Enter all new staff with appropriate area and permissions into the QA Monitor application (QAM).

- c. Inactivate any staff within their respective area in QAM.
- d. Notify Program Integrity (PI) Unit Manager of new hires and start dates.
- e. Notify QA Unit Manager of any position changes requiring permission changes to QAM.

Definition of roles within the QA Unit

1. HCLA QA Unit Manager

- a. Recruits, hires, and ensures that new QA staff are trained.
- b. Supervises and provides oversight to the QA Unit to ensure all processes and procedures are followed and QA reviews are completed as required.
- c. Performs regular spot checks of QA Consultant work for quality, consistency, and interrater reliability.
- d. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.
- e. Assures statistical relevance for all sampling and sample methodology and determines samples sizes required.
- f. Ensures QA staff maintain a working knowledge of all relevant policy.
- g. Requests clarification from APS and HCLA leadership as needed.
- h. Maintains the QA SharePoint site.
- i. Maintains the QA Monitor Tool.
 - i. Provides updates on QA Questions, No Responses, and review types based on changes to the review process.
 - ii. Ensure trainings are available related to use of the QA Monitor Tool.
 - iii. 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 (QA 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. Ensure 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 require

- g. ed 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. HCLA Management Analyst (MA)
 - a. Is a member of the HCLA QMS who reports directly to the HCLA Senior QA Administrator.
 - b. Provides QA and APS QI Coordinators (QICs) data analysis one WD prior to the exit conference and two WD after initial proficiency reviews 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. Work with the QA Monitor Development Team to correct issues with QA reports, suggest improvements, and test changes to the QA tool or reports.

Definition of roles within the QI Unit

- 1. APS Program Integrity 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. Recruits, hires, and ensures that new QI staff are trained.
 - c. Ensures QI staff demonstrate a working knowledge of this policy.
 - d. Conducts supervisory reviews of QI staff work to ensure policies and procedures are followed.
 - e. Requests clarification from APS leadership as needed.
 - f. Performs regular spot checks of QIC work for quality, consistency, and accuracy.
 - g. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.
 - h. Distributes QA Process Review result reports to the Regional Administrators (RAs) and Field Administrators (FAs), following both the initial proficiency reports, as well as the final statewide exit conference.
 - i. Present overview of QA/QI in collaboration with the QA Unit Manager, coordinated with the training unit.
 - j. Maintains the QI SharePoint site.
 - k. Ensures all APS staff have access to QIC Central Resources.
 - l. Collaborates with APS leadership, policy, and statewide and regional trainers on QI activities.
 - m. Coordinates quarterly program meetings with the following units:
 - i. Policy – Send the invite to the Senior Policy Advisor.
 - ii. Training – Send the invite to the Training Unit Manager.
- 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. Supports, coordinates creation, and delivery of any QI driven trainings related to PIP activities and form updates in cooperation with appropriate APS staff.
 - 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 ImproveAPS@dshs.wa.gov email inbox.
 - f. Ensures all QI monitoring checks are entered and closed per the process defined in the section labelled '[Thirty Day Reviews](#).'
 - g. Lead will coordinate QI activities with their Co-Lead.
3. QI Program Co-Lead
 - a. Supports the QI Lead in completing program related QI activities.
 - b. If the QI Lead is unavailable, the Co-Lead will take on additional Lead responsibilities as needed.
 - i. If what is needed is unclear, consult with the Unit Manager.
 - c. Provide technical support, including note taking, during any QI provided in-services and presentations.
 - d. Co-Lead will coordinate QI activities with the QI 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.

B. PROCESS REVIEW SCHEDULE

Background

HCLA QA maintains a 12-month QA Process Review Schedule, which runs January through December. The schedule is available on the [OAS QA for APS SharePoint site](#).

QA reviews are entered into the QA Monitor Tool or SharePoint Forms by QA or as a check by QI. Reviews in QA Monitor 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 submit a Management Bulletin (MB) for publication to the APS Senior Policy Advisor 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 [OAS QA for APS SharePoint site](#) will be updated.

The [Process Review Schedule](#) includes key information, such as:

1. Each process review area being completed for the year.
2. Review dates: QA team trainings, entrance dates, and initial review dates.
3. Dates the initial proficiencies will be provided to QI.
4. Change request and remediation due dates.
5. Change Request Committee (CRC) dates.
6. Exit conference dates.
7. PIP due dates.

QA Unit Manager Responsibility

1. Creates QA schedule.
2. Creates and submits the annual MB to the APS Policy unit for publication to provide APS with the updated schedule and process review information.
3. Ensure training for new QA staff occurs.
4. Ensure QA staff demonstrate a working knowledge of this policy.
5. Conducts review verifications to ensure staff are following the policy.
6. Assures that updates are sent for posting when changes to the schedule are required.

Program Integrity Unit Manager Responsibility

1. Review of QA schedule.
2. Ensure appropriate staff are made aware of required dates and scheduled meetings.
3. Refer questions to QA Unit Manager as they arise.

Adult Protective Services Responsibility

4. Review of QA schedule.
5. Ensure appropriate staff are made aware of required dates and scheduled meetings.
6. Refer questions to QA Unit Manager as they arise.

C. [QA QUESTION DOCUMENT REVIEW](#)

[Background](#)

QA is responsible for completing process reviews using specific questions developed to ensure we are meeting federal, state, and HCLA leadership guidelines. The questions are reviewed and updated with input from APS Policy, Training, QI, and other subject matters experts. The questions are approved by the APS Director.

Questions are updated based on current policies, procedures, the [DSHS and HCLA 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 subject matter experts (SMEs) and feedback from staff. This process is 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 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 with applicable laws and policies.

All current QA question documents are located on the [QA SharePoint site](#) and are available by contacting QA at APSQAUnit@dshs.wa.gov.

Procedure

1. Documents are reviewed, updated, and revised as changes are required.
2. The QA Unit Manager will facilitate communication with policy, training, area specific SMEs, and other designated staff to review and discuss QA questions. All sections of the documents may be reviewed and revised.
3. Once final drafts are completed, significant changes to questions or proficiency expectations are reviewed and approved by the APS Director.
4. When MBs or new policies are published, QA will conduct reviews to that standard on the date the MB or policy is effective.
5. QA question materials to be used for the year are published to the [How to Review SharePoint Page](#). Documents and links are also provided in the QA Schedule MB.

QA Unit Manager Responsibility

1. Reviews, updates, revise question documents in preparation for review period in partnership with QA consultants.
2. Communicate draft changes and obtain feedback from policy, training, area specific SMEs, and other designated staff.
3. Outlines required changes with the APS Director to obtain final approval.
4. Ensure training for new QA staff occurs.
5. Ensure QA staff demonstrate a working knowledge of this policy.
6. Researches and respond to inquiries from the QA Unit.
7. Conduct supervisory reviews of QA staff work to ensure policies and procedures are followed.

Program Integrity Unit Manager Responsibility

1. Participate in all QA question document review conversations.
2. Maintain a log of potential policy updates between process reviews for tracking purposes.

Adult Protective Services Responsibility

1. Notify QA and QI by email of process changes that may affect how QA Process Reviews are completed.
 - a. It is encouraged to notify QA as topics arise.

D. 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 entire population subject to review is too small to use only a sample of the population. In these cases, the entire population is reviewed.

Procedure

Investigations

- Samples from each region will be investigations closed inconclusive, substantiated, and unsubstantiated, and closed No APS.
- The sample will be pulled from the one or two months after the PIP interventions are completed if possible.
- When pulling the population, duplicates are removed based on AV Current Full Name. If there are not enough cases to review, duplicates are instead removed by investigation or intake ID.
- Regional sample is divided based on the percentage of cases closed finding, then by unit during the time frame.
- The random sample of cases to be reviewed are then generated by usage of the RAND function in Microsoft Excel.
- This sampling process repeats for each Region and APS Central Intake.

Example of a sample calculation:

9,638 Investigations of all finding types **for Region X, during prior calendar year.**

9,638 entered into RaoSoft = 370 (statistically significant sample)

Total investigations in prior one month before the review begins = 1,198

Region X closed 1,198 cases during the review period with the finding types as follows:

- Inconclusive: 420 or 21.9% of the population
- No APS: 580 or 30.2% of the population
- Substantiated: 250 or 13.0% of the population
- Unsubstantiated: 668 or 34.8% of the population

The overall sample of 370 investigations for Region X will be distributed as follows:

- Inconclusive: 81
- No APS: 112
- Substantiated: 48
- Unsubstantiated: 129

➤ Unit A closed:

- 7.1% of all cases closed Inconclusive.
- 3.6% of call cases closed No APS.
- 7.1% of all cases closed Substantiated.

- 6.3% of all cases closed Unsubstantiated.

Sample size calculation size for Unit A:

- $81 \times .071 = 6$ Investigations Inconclusive
- $112 \times .036 = 4$ Investigations Closed No APS
- $48 \times .071 = 4$ Investigations Substantiated
- $129 \times .063 = 8$ Investigations Unsubstantiated
- ✓ A total of 22 investigations will be reviewed for Unit A.

➤ Unit B closed:

- 1.4% of all cases closed Inconclusive.
- 3.6% of call cases closed No APS.
- 2.8% of all cases closed Substantiated.
- 0.1% of all cases closed Unsubstantiated.

Sample size calculation size for Unit B:

- $81 \times .014 = 1$ Investigation Inconclusive
- $112 \times .036 = 4$ Investigations Closed No APS
- $48 \times .028 = 1$ Investigation Substantiated
- $129 \times .001 = 0$ Investigations Unsubstantiated
- ✓ A total of 6 investigations will be reviewed for Unit B.

Intake

- APS Central Intake data sample Intake Screen-Out and Intake Screen-In.

Example of a sample calculation:

9,525 total screen in intakes processed during prior calendar year.

4,752 total screen out intakes processed during prior calendar year.

9,525 entered into RaoSoft = 370 (statistically significant sample).

4,752 entered into RaoSoft = 356 (statistically significant sample).

During the three months prior to the QA review start date, Central Intake created 2,578 screen in intakes and 1,980 screen out intakes.

Intake Worker A created 3% of 2,578 screen in intakes and 2% of 1,980 screen out intakes created during the three months prior to the QA review start date.

- Sample size calculation size for Intake Worker A:
 - $370 \times .03 = 11$ screen in intakes,
 - $356 \times .02 = 7$ screen out intakes

Intake Worker B created 6% of 2,578 screen in intakes and 5% of 1,980 screen out intakes created during the three months prior to the QA review start date.

- Sample size calculation size for Intake Worker B:
 - $370 \times .06 = 22$ screen in intakes,
 - $356 \times .05 = 18$ screen out intakes

Statewide

- 90-day reason code review
- Safety and Risk review
- Documentation Timeliness
- Statewide sample is stratified by cases closed by region within the population

Example of a sample calculation:

Total statewide investigations closed during prior calendar year with a 90-day reason code other than No Good Cause = 9,959

9,959 entered into RaoSoft for a statistically significant sample of 370

During the 2-month period prior to the QA review start date 1,850 investigations were closed with a 90-day reason code other than No Good Cause.

- Region A closed 480 or 25.9%
- Region B closed 732 or 39.6%
- Region C closed 638 or 34.5%

Sample size calculation for Region A: $370 \times .259 = 95.83$

Sample size calculation for Region B: $370 \times .396 = 146.52$

Sample size calculation for Region C: $370 \times .345 = 127.65$

Region A would round to 96, Region B would round to 146, and Region C would round to 128.

The 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.

QA Unit Manager Responsibility

1. Ensures sample methodology meets required standards.
2. Ensure training for new QA staff occurs.
3. Ensure QA staff demonstrate a working knowledge of this policy.
4. Conduct supervisory reviews of QA staff work to ensure policies and procedures are followed.
5. Requests training or clarification from leadership as needed.

E. [PROCESS REVIEWS](#)

Background

The QA Unit is responsible for determining whether specific proficiencies were met based on a prescribed set of questions.

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 HCLA QA Unit and staff are not required to travel.

Each process review is assigned a QA Process Review Lead (QA Lead), who is responsible for ensuring process review activities are completed. The QA Lead is considered the liaison for QA activities for the areas to which they are assigned. For information about which QA Unit Member is assigned as QA Lead for a specific area, please email APSQAUnit@dshs.wa.gov.

When reviews are created in QA Monitor, the field “Sub Rptg Unit Name” corresponds to the Unit Name assigned to the intake or investigation in TIVA2 as shown in TIVA2 DataMart. The field “Worker Name” will use the generic “APSworke” and the field “Worker Supervisor Name” will use the generic “APSup”.

Procedure

ENTRANCE:

1. QA will e-mail entrance correspondence to the Designated Staff (DS) for the area being reviewed. This will include pertinent information related to the process review, such as the name of the QA Lead and an information sheet with pertinent dates and information for the review.
2. QA receives all correspondence via APSQAUnit@dshs.wa.gov.
3. The QA Lead will contact the Designated Staff to communicate any questions, concerns, or needs of the unit prior to the start of the review.
4. The QA Lead is responsible for ensuring communication between the staff and QA occurs during the review, as questions arise.
5. The QA Unit Manager or their designee 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.
6. The QA 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 QA Lead will ensure the area subject to review is aware the review has begun.

THE QA LEAD WILL:

1. Establish an open line of communication for the process review and act as the primary point of contact.
2. Notify the Central Intake or Regional Designated Staff (DS) of any immediate remediation work necessary. Examples of immediate remediation work include sending a law enforcement referral or updating person management with safety concerns. This will also be noted in the reports provided to the region and QI team at the end of the review period.
3. Monitor the QA mailbox and respond to inquiries within 2 WD.

DURING THE PROCESS REVIEW, THE QA LEAD WILL:

1. Track all issues and work toward a resolution before QA begins the review.
2. Notify DS of any immediate remediation requests and the date they are due and follow up until all remediation requests are addressed.

3. Add an RCN when immediate remediation action is required including the date the field was notified.
4. Verify the action when the field notifies QA the immediate remediation action was taken and add corresponding RCN.
5. Pull reports on a regular basis and identify issues which must be resolved. The QA Lead will manage this process and ensure issues are found and corrected as soon as possible during the process review.

QA Unit Manager Responsibility

1. 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.
2. Ensure training for new QA staff occurs.
3. Ensure QA staff demonstrate a working knowledge of this policy.
4. Requests training or clarification from leadership as needed.

Adult Protective Services Responsibility

1. Designate one specific contact person for information and actions related to the process review, known as Designated Staff (DS).
2. When notified of immediate remediation action, ensure action is taken the same or next business day.
3. Inform QA Lead when immediate remediation action is completed.

F. INITIAL PROFICIENCY REPORTS

Background

At the completion of the review of records, initial proficiencies are sent to the QI unit and the Designated Staff. 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 HCLA QA MA will send preliminary reports by the date posted on the official QA Unit Schedule. Reports are sent to the QA Unit Manager and the Program Integrity Unit Manager.
 - a. Reports will be matched with the data from TIVA2 DataMart to provide the intake worker and supervisor at the time the intake was marked completed.
 - b. Reports will be matched with the data from TIVA2 DataMart to provide the investigator and supervisor at the time the investigation was closed.
2. The QA Unit Manager or designee will forward the preliminary reports to the APS Director, APS Deputy Director, APS Office Chiefs, and the HCLA Senior QA Administrator.

3. The Program Integrity Unit Manager or designee will compile the results and provide a breakdown of the data by Region and Unit. Results will include overview graphs, proficiency reports, and the QA Analysis Comments. Reports will be distributed to the RAs, DRAs, and FAs for the region or to the Unit Manager for CI.
 - a. Email to RAs and FAs should include details of next steps, including when change requests are due. Sample email template can be found in [Appendix C](#).
 - b. The QIC enters Change Requests 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, any requests must be submitted by APS staff to QI 5 WD prior to the due date on the schedule.

G. REMEDATION

Background

Remediation is the process of correcting an issue found during the QA 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 a remediation option.

Law enforcement referrals are required during intake and investigation activities. When there is a finding related to a missing law enforcement referral, remediation is required to be completed the same or next business day from the notification of the finding.

For any QA finding where an action was possible, QI staff will enter the appropriate remediation response for each finding during the 30-day remediation cycle or indicate that remediation was not possible. This will be documented utilizing a Review Cycle Note (RCN) in the QA Monitor Tool.

Procedure

1. Upon receipt of the initial proficiencies, QI and the DS for the region or central intake will review the findings and determine remediation actions in cooperation with APS workers, supervisors, and field administrators as necessary.
2. The DS in partnership with the QI lead for the region or central intake will track and coordinate remediation requests and ensure all remediation activities are completed as required.
3. QA will monitor APSQAUnit@dshs.wa.gov during the 30-day remediation cycle.
4. QI will enter all remediations into QA Monitor during the 30-day remediation process.

QI Staff Responsibility

1. Review all QA findings and work with regional and central intake staff on potential remediation actions.
2. In the QA Monitor Tool, QI will add a Review Cycle Note (RCN) to the process review to explain what was done to remediate the finding, using the code “Action Taken” for the RCN type.

3. If a review requires multiple remediation actions, those actions may be documented within the same RCN. It is not necessary to enter multiple RCNs within the same review. This does not apply for RCNs with the code "Change Request".
4. Notify QA via email when all remediation actions have been completed.
5. Ensure all remediation actions are completed on or before the required due date.
6. Notify APS leadership if deadlines are not met.

APS Staff Responsibility

1. When notification of a finding is received, review the finding documentation to determine what needs to be done. If you do not know what to do, contact QI for assistance.
2. Complete the appropriate remediation by the required due date.
3. E-mail QI that you have completed the remediation and what action you took to complete the remediation. Do not send personal or confidential information via email. If you are not sure what to say or what to send, contact QI.
4. If notified by QI staff that deadlines are not being met, APS leadership will work with regional or intake staff to ensure priority is taken to address all remediation actions and communicate with the QI staff.

QA Unit Manager Responsibility

1. Respond to inquiries and train staff in remediation processes and procedures.
2. Ensure training for new QA staff occurs.
3. Ensure QA staff demonstrate a working knowledge of this policy.
4. Request training or clarification from leadership as needed.

H. CHANGE REQUESTS

Background

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. A change request should only be submitted when requesting a change to the question from a No to a Yes or N/A. Changes to No Responses will not be considered. 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 5:00 PM on 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. For

reviews completed in SharePoint forms, all requests will be entered into the specific form by the designated due date and time.

Procedure

Requesting Changes to QA findings:

Prior to sending the change request, APS Designated Staff and QI will:

1. Review applicable QA question documents and instructions.
2. Review the policy in place at the time the investigation or intake 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.
4. For investigation reviews, discuss the request with the Regional Administrator for the area who will have the final say if the change request will be entered into the QA Monitor Tool.
5. For intake reviews, discuss the request with the Central Intake Unit Manager who will have the final say if the change request will be entered into the QA Monitor Tool.
6. Only requests to change the question response from No to Yes or N/A will be considered. Any request to change the no response to a different no response will not be considered.

After determining the Change Request should be sent to QA:

1. QI will enter the RCN into the QA Monitor Tool.
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. All change requests must appear on the *2309 Change Request Report* in HCLA Reporting to be considered. (Using the contact code “Change Request” accomplishes this).
4. The change request language should include:
 - a. The question and no response requested to be changed,
 - b. The reason why the change is requested, and
 - c. The policy language that supports the requested change.
5. The change request should not hold confidential information including AV or AP names, dates of birth, or other identifying information.
6. If multiple questions and/or no responses within a review require a change request, enter a separate change request RCN for each item.

THE QI UNIT WILL:

1. Ensure APS staff are aware of change request due dates and dates for when requests must be received by the QI Unit for processing.
2. Review all change requests in collaboration with region or intake leadership in determining 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 Program Integrity 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 5 WD after the CRC Meeting.
6. The HCLA QA MA will e-mail updated reports to QA and QI within 2 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 APS Deputy 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 preferred but not required that all voting members attend. 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. APS Deputy Director
2. APS Office Chiefs who are not in charge of the area subject to review
3. Senior Policy Advisor

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 VOTING MEMBERS WILL:

1. **Review** all change requests submitted and all supporting documentation prior to the scheduled meeting.
2. **Ask** clarifying 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 APS Director or their designee will make the final decision.
 - b. When the CRC upholds the finding, APS must remediate the finding within 5 WD if remediation is possible.
 - c. When the CRC overturns the finding, QA will correct the review within 5 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.
4. Ensure training for new QA staff occurs.
5. Ensure QA staff demonstrate a working knowledge of this policy.
6. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Ensure staff are provided the opportunity to present their request through their program's representative, such as their Regional Administrator or HQ Office Chief, their FA, or appropriate SMEs.
4. Collaborate with QA to determine which change requests will be overturned and which are forwarded to CRC.
5. Only forward invitations to those whose attendance is required to provide expert opinion or information the CRC voting members need.
6. Request training or clarification from leadership as needed.

I. THIRTY-DAY REVIEWS

Background

Within the APS 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 that all work has been finalized, all required remediation is complete, and the review requires no further action.

Anyone entering QA reviews in the QA Monitor Tool, 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.

Procedure

THE QA UNIT WILL:

1. Verify any remediation requiring action within TIVA2 has been completed.
 - a. Any questions regarding remediation action will be addressed with the QI unit within 2 WD of discovery.
2. Complete 30-day reviews by the due date listed on the schedule.
 - a. When remediation is not possible and considered to be historical, QA will answer with N/A and choose the remediation “Historical data-unable to remediate”.
 - b. When remediation has been completed, QA will answer Yes and choose the appropriate remediation option.
3. The QA Lead will verify all reviews entered by QA are closed at the end of each review.
4. The QA Unit Manager or their designee 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.

QA Unit Manager Responsibility

1. Ensure training for new QA staff occurs.
2. Ensure QA staff demonstrate a working knowledge of this policy.
3. Conduct supervisory reviews of QA staff work to ensure policies and procedures are followed.
4. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
4. Request training or clarification from leadership as needed.

J. FINAL EXIT CONFERENCE AND PROFICIENCY REPORTS**Background**

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

This process was initiated at the beginning of the 2024 QA cycle in response to feedback from staff that initial results are not as helpful as final results.

Procedure**THE QA UNIT WILL:**

1. The QA Lead will verify the review is completed and all reviews are closed in the QA Monitor Tool.
2. The HCLA QA MA will send final proficiencies to the QA Unit Manager and Program Integrity Unit Manager at least one (1) WD prior to the exit conference.
3. The QA Lead will coordinate and facilitate a Final Exit Conference which will include the following information:
 - a. Information related to how the sample is chosen.
 - b. QA questions asked during the process review.
 - c. Review of findings and proficiencies achieved.
 - d. Highlights from the review, including how the change request process impacted proficiencies.
4. HCLA QA will send an invitation to the Designated Staff and regional leadership. This meeting may be forwarded to allow anyone with an interest in attending. Meetings are held remotely and typically use Teams.

THE QI UNIT WILL:

1. Attend all Final Exit Conferences and will present information about upcoming Root Cause Analysis meetings and next steps, including PIP due dates if a PIP is required.
2. Once completed, the PI Unit Manager or designee will distribute any updated proficiency reports to RAs and FAs, if applicable.

QA Unit Manager Responsibility

1. Ensure training for new QA staff occurs.
2. Ensure QA staff demonstrate a working knowledge of this policy.
3. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Request training or clarification from leadership as needed.

Adult Protective Services Responsibility

1. Forward the exit conference meeting information to staff within the region or unit and encourage attendance.
2. Review provided reports to understand information presented.

K. PROFICIENCY IMPROVEMENT PLAN (PIP)**Background****Expected Proficiencies:**

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

Proficiency Improvement Plans:

A Proficiency Improvement Plan (PIP) outlines a plan for addressing QA questions that did not meet the required proficiency.

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.

Action is required for PIP development. A PIP is **not** required for the current QA Unit review cycle:

- a. When required proficiency of 86% is reached on all QA questions.
- b. When the APS Director has requested APS staff and the PIPA unit to develop a PIP on a QA question that does not meet required or expected proficiency at a statewide level.

Procedure

1. PIP development and completion is the responsibility of the QIC in partnership with APS staff.
 - 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 HCLA's Lean program can be found [here](#).
 - c. Any units or staff assigned a task on the PIP must be notified of the assignment before the PIP is signed by the APS Deputy Director.
2. The completed PIP must be submitted to the APS Deputy Director for final approval within 30 WD after the regional final report. 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 (Word is used as a working document) once it is signed by the APS Deputy Director.
4. PIP Monitoring:
 - a. The QI Lead will send the final signed PIP to any staff assigned a task.
 - i. The QI Lead tracks due dates on the final approved PIP to monitor for completion.
 - ii. The QI Lead will notify the Program Integrity Unit Manager if there are any potential barriers to completing interventions within the defined timelines.
 - iii. The QI Lead provides written monitoring updates to leadership staff on a quarterly basis.
 - b. QI Unit Manager provides APS 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 interventions can be found on 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.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.
2. Ensures QI staff demonstrate a working knowledge of this policy.
3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
4. Request training or clarification from leadership as needed.

Adult Protective Services Responsibility

1. Ensure robust participation in the data gathering and root cause analysis process by regional leadership, supervisors, and workers.
2. Encourage curiosity in examining systems.
3. Actively demonstrate shifting attitudes from blame to accountability and encouraging examination of process within and outside of the individual's control.
4. Allow space within monthly regional leadership meetings to discuss root cause analysis process, interventions, and data from monitoring of the interventions.
5. Regional leadership/Central Intake Unit Manager approves and signs the written PIP before forwarding to APS Deputy Director.
6. Implement identified interventions.
7. Ensure information on the process, interventions, and monitoring are made available to APS staff by way of newsletters, staff meetings, and other appropriate communications.

QA Unit Manager Responsibility

1. Train new QA staff and ensure they can demonstrate they understand this procedure.
2. Request training or clarification from leadership as needed.

L. [RECORD RETENTION](#)

Background

Records are retained for historical information, data, and public disclosure purposes. For APS records retention information, please visit [Policy Tech](#).

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

Procedure

1. QA Reviews are performed in the QA Monitor application or in Microsoft Forms.

2. If desired, QA unit members may use paper checklists or electronic checklists while completing the process review to ensure all process review questions are answered and input into the QA Monitor Tool correctly.
3. Once the review is completed, the review must be entered into the QA Monitoring Tool or Microsoft Forms Review as soon as possible. All information pertinent to the findings must be included in the analysis comments in the QA Monitoring Tool or Microsoft Forms Review.
4. QA unit members may retain paper or electronic checklists only until the 30-day reviews are completed and the full review process is closed.
5. All paper documents related to the QA process review must be shredded in confidential shredding to avoid the release of any alleged victim names or other protected information.
6. 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.
7. Records will be retained in the QA Monitor tool for six (6) 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.
8. Reviews created utilizing Microsoft Forms will be downloaded to Excel and saved in the shared Q drive for six (6) years, after which, the records will be purged, unless there is a reason for which the record must be retained.

QA Unit Manager Responsibility

1. Request training or clarification from leadership as needed.

M. FINAL REPORTS

Background

The QA Lead creates a report for each region or central intake following the completion of their review cycle.

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

The Program Integrity 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

THE QA LEAD WILL:

1. Create the report based on the final proficiencies for Central Intake or the region.
2. Provide the report to the QA Unit Manager two (2) WD prior to the due date for approval and signature.

3. Send the signed report to Central Intake Unit Manager or regional leadership, and APS leadership on the due date.

THE QA UNIT MANAGER WILL:

1. Review the Central Intake and Regional Final Reports for accuracy.
2. Once the Central Intake and Regional Final Report is completed and verified to be accurate, signs the report.
3. Create and post the statewide final 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.
4. Publish the statewide final report in an MB and on the [QA SharePoint site](#) once the report is complete.

THE PROGRAM INTEGRITY UNIT MANAGER WILL:

1. Create and post the report annually to demonstrate the effectiveness of PIP interventions on overall proficiencies.
2. Post the report on the QI SharePoint site.

QA Unit Manager Responsibility

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

HCLA QA Senior Administrator Responsibility

1. Review and approve the statewide final report prior to presentation to APS Leadership for review, approval, and distribution.

The Program Integrity Unit Manager will:

1. Create and post the report annually to demonstrate the effectiveness of PIP interventions on overall proficiencies.
 - a. Program Integrity Unit Manager will send draft information to the process review QI Lead to verify information, including data and status of interventions.
2. Post the report on the SharePoint site.

Adult Protective Services Leadership will:

1. Read the QA and QI final reports.
2. Ensure information from the QA and QI reports regarding process, interventions, and monitoring are made available to APS staff by way of newsletters, staff meetings, and other appropriate communications.

PART II: QUALITY CHECKS

The QA checks completed by Quality Improvement Coordinators (QIC) are very important because they ensure staff are protecting our vulnerable adults by following policy, procedure, and conducting thorough investigations. QIC QA reviews help identify training and policy concerns. The QIC reviews QA questions ensuring the health and welfare of the alleged victim. As a result, the QIC role is a critical part of the foundation for overall APS quality compliance and consistency.

- a. Reviews are completed by QICs or their designee.
- b. QA reviews and PIP checks are performed for new and experienced staff according to the direction of APS leadership.
- c. All reviews are completed within the QA Monitor Tool, in Microsoft Forms, or tracked in Excel.
- d. All remediation activities must be completed, and the review cycle closed within 30 working days of initial review.
- e. Review data will be saved and reviewed from year to year for quality improvement purposes.

Review activities are performed throughout the entire calendar year.

PART III: INTERRATER RELIABILITY

Purpose: To ensure consistency within the APS QA review process.

Prior to beginning the review cycle,

- The QA team will complete three reviews together in training QA Monitor, discussing each question and identifying what to look for. The QI team is invited to participate as time allows.
- After that process, three intakes/investigations of each type (screen in, screen out, investigation, closed No APS) will be selected for independent practice review. Each reviewer will independently complete 3 reviews in training QA monitor. The other reviewer(s) and the QA Unit Manager will review those answers (Yes, No, or N/A) and no responses given and compare for accuracy using the check spreadsheet. Any comments will also be reviewed to ensure accuracy and helpfulness. The group will return back together to discuss each review and the individual findings.
- Any discrepancies will be reviewed and verified within the How to Review guide.

During the compliance review cycle

- The QA unit manager will review 10% of each reviewer's cases for accuracy. Reviews will be completed on the check spreadsheet and shared with each reviewer.
- Each reviewer will select 2-3 reviews per week for peer review. Reviews will be completed on the check spreadsheet and shared with each reviewer.
- Any peer review will be completed with feedback provided at least 3 days before the end of the review cycle to ensure any necessary changes are made before providing QA data to central intake or the region.

Throughout the cycle, the reviewers are in communication with each other when questions arise on how to review situations which are not outlined in the How to Review guide or the training videos. If not in agreement, a discussion is held with the QA Unit Manager who will review the situation and applicable policy in addition to prior guidance. For questions if policy was followed that cannot be identified

through review of Policy Tech guidance or previous decisions from executive leadership, the Senior Policy Advisor will be consulted for the final decision.

Check spreadsheets will be maintained in the APS QA Q: drive.

During the reviewer's probationary period,

- Complete the QA review training videos.
- Shadow a minimum of two other reviewers for 5 reviews each.
- The trainee reviewer will look at 10 historical reviews, comparing the historical reviewer's answers and comments to information found in TIVA2 and the How to Review guide. The trainee reviewer will outline thoughts and questions to review with the QA Unit Manager.
- The trainee reviewer will complete 10 reviews in training QA monitor with review by the QA Unit Manager.
- This process will be completed before beginning QA reviews in production QA Monitor.

PART IV: APPENDICES

A. GLOSSARY OF TERMS

Agency – State agency

Change Request Committee – means QA and QI do not have sufficient information to determine if a change request should be upheld or overturned and determines APS leadership needs to make the final determination.

Department – This term refers to the Washington state Department of Social and Health Services (DSHS).

Designated Staff – Refers to the regional or Central Intake point of contact for QA/QA process.

Finding – A term used to describe an identified gap between policy guidance and what was found during a QA process review.

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

Population – The entire population subject to review.

Unit Leadership – means the individuals responsible for the activities of a designated unit. This can include Unit Managers, Program Managers, and Regional Administrators.

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.

Working days (business days) – defined as Monday through Friday, excluding federal and state holidays.

B. ACRONYM LIST

APS	Adult Protective Services
CMS	Center for Medicare and Medicaid Services
CRC	Change Request Committee
DRA	Deputy Regional Administrator
DS	Designated Staff

DSHS	Department of Social and Health Services
HCLA	Home and Community Living Administration
MA	Management Analyst
MB	Management Bulletin
MSD	Management Service Division
OAS	Office of the Assistant Secretary
PIP	Proficiency Improvement Plan
PM	Program Manager
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Coordinator
QMS	Quality Management System
RA	Regional Administrator
RCN	Review Cycle Note
RCW	Revised Code of Washington
SHPC	Social and Health Program Consultants
SME	Subject Matter Expert
SPA	State Plan Amendments
TIVA	Tracking Incidents for Vulnerable Adults
WAC	Washington Administrative Code
WD	Working Day

C. SAMPLE QA PROCESS REVIEW RESULT EMAIL TEMPLATE

Region X APS HQ QA Process Review has been completed, and the following reports are attached to this email:

- The **QA Review Data workbook** includes the 2307 Proficiency with Details report, the data broken down by supervisor, case manager, a heatmap by offices and the 2303 Questions Requiring Action Report broken down by supervisor.
- The **Findings and Analysis workbook** provides a Data Analysis report with the questions, findings and analysis comments for each review that received a finding, the 2310 Analysis Comment Report, the 2303 Questions Requiring Action Report.

Also attached is the **Remediation and Change Request Process** guide, **2023 Remediations for APS Investigation** guide and the **Region X tracker**.

What's Next?:

- Region X's 30-day remediation timeline is XXXX-XXXX. **Change Requests will need to be submitted by close of business on XXXXX (via QA Monitor).**
- Most remediation items will be considered "Historical Data," which require no physical action; please encourage supervisors to facilitate learning opportunities with their staff regarding these items. Remediation completed by region must be documented in a Review Cycle Note (RCN) when an action is completed to remediate findings. **Using the "Action Taken" drop down, the Review Cycle Note (RCN) must include information about how the finding(s) was remediated.**

Thank you,

D. RESOURCES AND FORMS

Background

The QA Unit has transitioned to using a [QA SharePoint](#) as the primary means of communication with APS staff, Policy, Training, and anyone at APS interested in QA activities.

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 tools, templates, and information needed to complete process reviews.

Procedure

Process Review Areas and Programs

1. Investigation
 - a. QA reviews the following areas:
 - i. Timeliness
 - ii. Documentation
 - iii. AV Interview
 - iv. AP Interview
 - v. Collaterals
 - vi. Decision Making Ability Screening
 - vii. Law Enforcement Referrals
 - viii. Outcome Reports
 - ix. Vulnerable Adult Status
 - x. Allegations
 - xi. Finding
 - xii. Protective Services
 - xiii. Supervisor Actions
2. Closed No APS
 - a. QA reviews the following areas:
 - i. Finding
 - ii. Law Enforcement Referrals
 - iii. Outcome Reports
3. Intake Screen In
 - a. QA reviews the following areas:
 - i. Timeliness
 - ii. VA Status
 - iii. Safety
 - iv. Referrals
 - v. Screen In accuracy
 - vi. Allegations
 - vii. Intake Priority

-
4. Intake Screen Out
 - a. QA reviews the following areas:
 - i. Timeliness
 - ii. VA Status
 - iii. Referrals
 - iv. Screen out reason
 5. 90-Day Reason Code
 - a. QA reviews the following areas:
 - i. Reason code documentation
 6. Safety and Risk Screening (Biennial)
 - a. QA reviews the following areas:
 - i. Screening evidence
 - ii. Staffing
 - iii. Timeliness
 7. Documentation Timeliness (Biennial)
 - a. QA reviews the following areas:
 - i. Case notes
 - ii. File Uploads

Additional Information

- a. Only closed investigations or completed intakes will be reviewed.
- 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.