Quality Assurance and Improvement – Social Services Monitoring

Chapter 23A describes the Quality Assurance process reviews mandated by the Centers for Medicare and Medicaid (CMS). This chapter includes the sampling methodology, timeframes, and requirements from field staff.

Ask the Expert

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TABLE OF CONTENTS

Quality Assurance and Improvement – Social Services Monitoring 1
Table of Contents 1
Quality Assurance Unit Monitoring Process Overview 2
Sampling 3
Determining the number of files to review per HCS/AAA office 4
Monitoring Schedule 4
QA Process Review Notices 4
Exit Conferences 4
Notification of 3-Day Response Time Issues 5
30-Day and 60-Day QA Process Reviews 5
Change Request Committee 6
Final Local Report Summary and Cover Letter 7
Proficiency Improvement Plan (PIP) for Social Services Monitoring 8
Home and Community Living Administration (HCLA) HCS Statewide PIP Process 9
Statewide Final Report 10
Supervisor Monitoring 10
QA Tool and worker administator rights 12
HCS Quality Assurance and Improvement Intranet Site 12
Authority for Policies and Procedures 13

QUALITY ASSURANCE UNIT MONITORING PROCESS OVERVIEW

- All HCS and AAA case managers who have completed a CARE assessment are eligible to have a QA process review completed.
- A statistically valid sample of clients is pulled statewide.
  - Samples are pulled for waiver programs, CFC, and other state plan programs, and per focused review type.
- Each area's sample is pulled based on the percent of population for each program in each geographical area (see sampling below).
- The updated 12-month QA Monitoring Schedule is available on the QA intranet site. If dates or number of reviews change from the original release at the beginning of the monitoring year, which is distributed in a Management Bulletin (MB), the updated information can be found on the QA intranet site.
- Initial QA Process Review Notice will go out to each area prior to the start of each area's process review cycle.
- Monitoring occurs at headquarters; therefore, all required documents must be in the Document Management System (DMS) prior to QA process review.
- Areas have 3 working days to address high priority issues (mandatory reporting).
- An Exit Conference is optional and conducted via video conferencing using MS Teams at the completion of the review.
- Areas have 30 calendar days to make required corrections.
- QA conducts a 30-day review to document remediation.
- Issues identified in the 30-day QA Process Review as not fully remediated must be corrected within 30 calendar days for the 60-day QA Process Review.
- QA conducts a 60-day Process Review and documents remediation.
- QA completes the Regional/AAA Final Report which is a summary of all QA Unit findings for that Region/AAA.
- Questions below the expected proficiency level will need to be addressed in the area's Proficiency Improvement Plan (PIP).
- QA completes the statewide Final Report which is a summary of all QA Unit findings for the annual review for all Regions and AAAs.

Sampling

CMS requires compliance monitoring utilizing a statistically valid sample. For determining population size for sampling, the state is allowed to combine waiver programs: CFC+COPES, Residential Service Waivers (RSW), and New Freedom into one population. This population must be stratified by waiver program when the distribution of the sample is determined.

The QA unit uses Raosoft to help determine the statistically valid sample size. The parameters used in Raosoft are to following: 5% Margin of Error, 95% Confidence Level, and 50% Response Distribution.

- **Margin of Error**: The margin of error is the amount of error that you can tolerate. If 90% of the respondents answer *yes*, while 10% answer *no*, you may be able to tolerate a larger amount of error than if the respondents are split 50-50 or 45-55.
- **Confidence Level**: The confidence level is the amount of uncertainty you can tolerate. Suppose that you have 20 yes-no questions in your survey. With a confidence level of 95%, you would expect that for one of the questions (1 in 20), the percentage of people who answer *yes* would be more than the margin of error away from the true answer. The true answer is the percentage you would get if you exhaustively interviewed everyone. Higher confidence level requires a larger sample.
- **Response Distribution:** For each question, what do you expect the results will be? If the sample is skewed highly one way or the other, the population probably is, too. If you don't know, use 50%, which give the largest sample.

Sampling example to determine statistical sample size:

- There are the following authorizations in the state:
  - COPES = 38,468
  - RSW = 2,046
  - New Freedom = 426
  - TOTAL POPULATION = 40,940
- Using Raosoft to determine a statistically valid sample size of the total population of 40,490 using a 5% margin of error, 95% confidence level, and 50% response distribution will yield a statewide sample size of 382 cases to be reviewed.

Increasing sample size while stratifying waiver programs:

Beginning in 2018, CMS required the statewide sample size to be stratified between the three waiver programs: COPES, RSW, and New Freedom. Further, the state has the discretion to increase the sample size over the minimum statistically valid amount. Using Raosoft and adjusting either the Margin of Error, Response Distribution or both, a sample size for each waiver program is generated so that the total files to be reviewed are equal to or greater than the statewide sample size of 382.

Adjusting the formula to a 7% Margin of Error, 95% Confidence Level, and 70% Response Distribution and uniformly applying this formula to each individual program yields the following results:

- COPES (38,468 cases) = 164
- RSW (2,046 cases) = 153
- New Freedom (426) = 119
- TOTAL REVIEWS TO BE COMPLETED: 436.

Note: *Since the total files to be reviewed is greater than 382, this is an acceptable stratification of the waiver programs. The new statewide sample size is now 436*

DETERMINING THE NUMBER OF FILES TO REVIEW PER HCS/AAA OFFICE

QA determines the number of cases to be reviewed per HCS and AAA based on how much that area contributes proportionally to the total statewide population (see sampling example below).

- Region X has 1,565 COPES cases which = 3% of the statewide total.
- 3% of 164 is 4.92 or 5.
- Region X will have 5 COPES cases reviewed.

This sampling process is repeated for each Regional and Area Agency on Aging (AAA) office.

Monitoring Schedule

A QA monitoring schedule will be distributed by MB prior to the annual monitoring cycle. The schedule will include the following activities:

1. Each Region's process review cycle and timelines (initial, 30-day and 60-day Reviews)
2. Exit Conference dates
3. Final Report due dates
4. Statewide activities such as New Freedom Financial Management Service Reviews, QA Statewide Focus Reviews, and various client survey and service verification activities.

QA Process Review Notices

An Initial QA Process Review Notice will be emailed to each area prior to the start of each area's process review cycle. The QA Review Notice will identify the begin dates and end dates of the process review cycle; the number of regular file reviews; and the number of focus reviews to be completed.

Exit Conferences

1. Exit Conferences are optional. The QA lead will ask the Regional Administrators and/or the Area Directors if they wish to have a QA Exit Conference at the time the office is notified of their upcoming initial review. If a QA Exit Conference is requested, the conference will be conducted through MS Teams by the QA Lead and the QA Unit Manager with the following staff who may be attending via MS Teams or phone.

a. HQ staff, including QA Policy Program Manager, AAA Liaison, SUA Office Chief, HCS Chief of Field Operations, and
b. Regional/AAA Management and line staff at the discretion of the management team.

2. The QA Unit presents the following in power point format:
   a. What QA reviewed
   b. QA questions that met or exceeded proficiency.
   c. QA questions that did not meet expected proficiency.
   d. Why proficiency was not met.
   e. Remediation, Change Request, PIP process; and
   f. 30-day due dates.

Notification of 3-Day Response Time Issues

1. QA Lead will notify the Region/AAA contact of a 3-day response issue at the end of each monitoring day (mandatory reporting question).
2. Action must be initiated and documented within 3 working days after notification.
3. QA staff will verify at the 30-day review if each 3-day remediation was initiated within the appropriate time frame.

30-Day and 60-Day QA Process Reviews

CMS requires full remediation on **all** QA findings at the individual level that do not meet 100% proficiency.

1. All QA findings that require remediation must be completed within 30 calendar days. All documents needed for remediation verification will need to be scanned and emailed to the QA Lead and a copy of the scanned document(s) should be made available in DMS by the 30-day due date. If the documentation is required in the client Service Episode Record (SER), add it directly into the SER. If the remediation requires an interim CARE assessment, it must be moved to current and synchronized for QA viewing online prior to the 30-day due date.

2. Remediation documentation completed by the field is analyzed by Quality Assurance Staff (QAS) at the 30-day review.

3. Any outstanding QA findings after the 30-day process review are identified on the "Cases Requiring Action" report and that remediation are expected to be completed by the 60-day due date. The QA Lead is available to the Region/AAA to help on any outstanding issues.

4. Remediation documentation completed by the field will be analyzed by QAS at the 60-day review.

5. All QA findings that are still outstanding after the 60-day review will be reviewed with the Region/AAA contact who will be expected to have the QA finding fully remediated. The Region/AAA contact will need to inform the QA Lead when the finding is fully remediated so that final analysis can be completed.

6. Remediation completed after the 60-day due date will be documented as to why the remediation was not made within the time frame allotted and how much time past the due date remediation occurred. Remediation time frames will be included in the Final Region/AAA Report.

7. All issues that cannot be resolved will be forwarded to the Executive Management team for action.

CHANGE REQUEST COMMITTEE

The intent of the Change Committee is to interpret policy, make decisions on change requests, and make recommendations if policy is not clear.

1. The Change Committee consists of the following members:
    a. QA Policy Program Manager (facilitator and active member).
    b. Standing Members: Case management unit manager or representative; Waiver Program Manager or representative; CFC Program Manager or representative.
    c. QA Lead for the area.
    d. SUA lead or representative.
    e. The field monitoring contact (either in person or by telephone); and
    f. Other managers, depending on the policy under discussion (e.g., ProviderOne Program Manager, Nursing Program Manager, Representative from APS, etc.).

2. Change Committee Process:
    a. Prior to submitting a change request the field's representative must determine if the finding in question has been previously heard by the Change Committee and thus a precedent-setting decision was made.
    b. For change requests that may be taken to the Change Committee, the local office documents the requested change in the Review Cycle Notes (RCN), using "QA Change Request" drop down. The QA Lead will review the requests.
    c. QA reviews the issue and makes corrections if a QA process review error has been made. Consultation with a policy program manager may occur if needed for clarification.
    d. The QA team reviews prior decisions by the Change Committee. If the issue is the same, the QA Unit will make the change based on the Change Committee's prior decision. These issues are not forwarded to the committee.

e. Issues not corrected by the QA Unit, or which have not had a previous decision are forwarded to the Change Committee and documented in the SharePoint database.
f. The QA Lead sets up the Change Committee meetings with at least a three-day advanced notice of the meeting date according to the QA calendar. If possible, the QA lead will provide more notice. The meeting notice will include a write-up of the Change Request. The QA Lead invites the appropriate HQ program managers to the meeting.
g. The Change Committee:
    i. Reviews the change request documentation
    ii. Hears the field's analysis
    iii. Hears the QA Lead's analysis; and
    iv. Consults with other managers if the issues relate to their program.
h. If a decision cannot be made within the Change Committee, the QA Policy Program Manager will have it addressed at the Executive Management level whose decision is final.
i. If the Change Request is approved, QAS will change the "no" to a "yes" or "NA". If the change is not approved, the Region/AAA contact will ensure the corrections are made. QAS documents the decision in the RCN.
j. The QA Policy Program Manager documents the decision in the SharePoint database.
k. If changes to policy are recommended, the QA Policy Program Manager identifies who will be responsible for follow-up and response to, or completion of, the recommended policy change.
l. At the end of the process review cycle, the QA Policy and Unit Managers review the Change Requests for possible impact on the next review cycle.

FINAL LOCAL REPORT SUMMARY AND COVER LETTER

1. After the 60-day process review, the QA Lead prepares the "Final Report Summary" which includes:
    a. Attachments of the local reports; and
    b. The Proficiency Improvement Plan template.

2. PIPs from the AAA offices will be reviewed and signed by the State Unit on Aging Office Chief or representative. PIPs from HCS Regional Offices will be reviewed and signed by the Deputy Director of Field Operations or representative.

3. The Final Report is due to the AAA Directors/Regional Administrators within 30 calendar days after completion of the 60-day QA process review.

PROFICIENCY IMPROVEMENT PLAN (PIP) FOR SOCIAL SERVICES MONITORING

A PIP outlines a plan for increasing future proficiency. The threshold for when a PIP is required will be specified in the QA Exit Conference. Both HCS HQ and the Regions/AAAs are responsible for developing and implementing a PIP.

1. Regional/AAA action is required for PIP development (based on initial findings). A Regional/AAA PIP is not required for the current QA Unit review cycle:
   a. When the required proficiency is reached on all QA questions.
   b. When HCS HQ is conducting the PIP on a QA question that does not meet statewide proficiency.

2. Regions/AAA will use the PIP template provided for all questions below the expected proficiency level.

3. HQ will identify items that need to be addressed at a statewide level and develop an HQ PIP. Information/training in response to the HQ PIP will be maintained on the QA intranet site and should be utilized by the field offices.

4. Regions/AAAs are required to address all other items that did not meet proficiency, except those items being addressed in the HQ PIP. Items being addressed by HCS HQ may also be addressed on a local PIP if the Region/AAA wants to focus on improving local proficiency. The Region/AAAs will support and reinforce strategies to increase proficiency, and supervisors will continue to work with individual staff to increase proficiency in identified areas.

5. AAA Specialist, designated delegate, and other HQ program managers are available to assist in development and revision of the PIP.

6. The Region/AAA must submit the PIP to the QA Lead within 30 calendar days from the date the Final Report summary was emailed. The QA Lead tracks the time frame, if the PIP has not been received within 30 calendar days, the QA Lead will notify the HCS Deputy Director of Field Operations or the Quality Assurance Policy Program Manager for additional follow-up.

7. HQ Review and Approval

   AAA – When the PIP is received, the Quality Assurance Policy Program Manager and AAA specialist jointly review the plan. The field representative is contacted by email if there are recommended changes. If changes are needed,

the revised document is reviewed with the Quality Assurance Policy Program Manager and AAA Specialist and approved.

The Quality Assurance Policy Program Manager will be responsible for signing the PIP.

HCS – When the PIP is received, the HCS Deputy Director of Field Operations reviews the plan. The field representative is contacted by email if there are recommended changes. If changes are needed, the revised document is reviewed with the HCS Deputy Director of Field Operations and approved.

The HCS Deputy Director of Field Operations, or delegate by the HCS Chief of Field Operations, will be responsible for signing the PIP.

8. Reporting Progress
    a. Regions/AAAs
        i. Progress reporting is unique to each item within the PIP and unique to each Region/AAA.
        ii. The Region/AAA completes the "Progress Reporting Section" and sends it to the HCS Deputy Director of Field Operations for regional offices and the Quality Assurance Policy Program Manager for AAA offices, when due. If the progress report is not received on time, the HCS Deputy Director of Field Operations or the Quality Assurance Policy Program Manager will follow up with the field.
    b. HQ
        i. Upon review of the progress report the Quality Assurance Policy Program Manager, AAA specialist or other management staff may share other ideas or strategies for quality improvement.
        ii. The Quality Assurance Policy Program Manager reports the HQ PIP status on an "as needed" basis and at least quarterly in the QA Update with Executive Management.

Home and Community Living Administration (HCLA) HCS Statewide PIP Process

1. The QA Policy Program Manager will develop a statewide PIP in collaboration with the QA Unit Manager, Strategic Improvement Program Manager, and other program managers based on data in the review cycle Final Report and analysis/experiences/feedback/data, etc., provided by the QA Unit. Any QA question which has a statewide proficiency (from the previous process review cycle) of less than the approved threshold (86%) will require a HQ PIP. Prioritization of PIP timelines may be based on existing PIPs in process and workload impacts. Prioritization is given to

those QA questions reported to CMS as part of the federal assurances and sub-assurances and where the client could be negatively impacted.

2. Implementation time frames are individually determined by items identified.

3. The HQ PIP will be reviewed and approved for implementation by Executive Management.

STATEWIDE FINAL REPORT

1. After the QA statewide process review is completed, the QA team prepares the "Home and Community Services Quality Assurance Final Report" which includes:
   a. Questions monitored
   b. Changes to the QA review process, if applicable
   c. Compliance results

2. The HCLA Quality Assurance Administrator has final approval of the Home and Community Services Quality Assurance Final Report. This report is distributed and presented to the Executive Management team, the Medicaid Agency Waiver Oversight Committee, the HCS Regional Administrators, the AAA Directors, and the regional HCS/AAA offices. The report is also distributed to the State Auditor's Office (SAO) and other stakeholders as requested. Once finalized the report is also posted on the QA intranet site.

SUPERVISOR MONITORING

The QA reviews completed by supervisors in the HCS and AAA offices are very important because they ensure that we are following CMS requirements, and that quality work is being completed by field staff. Supervisor QA reviews help identify training, staff performance, and policy issues. Supervisors review QA questions above and beyond the QA Unit process reviews, ensuring the health and welfare of the client. As a result, the supervisor's role is a critical part of the foundation for overall HCS quality compliance.

HCS/AAA supervisors have the following quality assurance and improvement responsibilities:

1. Training
   a. Annual Training Plan – Each Region/AAA will develop an annual training plan that outlines how mandatory and optional training will occur for new and experienced staff (employed one year or longer). This document is revised

annually at the regional/AAA level. A separate plan does not need to be developed if these elements are included in the PIP.

b. Training Documentation Form – Supervisors will use a method of their choice to document training completed for new and experienced staff.
c. Monthly Manual Chapter – Supervisors must train all case management staff on at least one chapter of the LTC manual each month.
d. Trends Identified through Required Monitoring – Supervisors must identify individual training needs for their staff and arrange for the provision of that training.

2. Monitoring Results – Supervisors will use the "Reviewed Cases with Questions Requiring Action" report to ensure that corrections identified by the QA Unit have been completed.

3. Supervisor QA Monitoring – Supervisors must inform their staff of the QA monitoring process and expectations. Supervisors monitor that their staff are:
    a. Creating an adequate need assessment.
    b. Authorizing, providing, and terminating services in a timely manner.
    c. Following department policies and procedures.
    d. Correctly determining eligibility and funding sources; and
    e. Completing required forms.

4. Supervisory Monitoring of New and Experienced staff:
    a. New staff without CARE experience
        i. Review of first five assessments –
            1. The goal is to provide training on correct assessment techniques and corrections can be made without having to create another assessment.
            2. Review must occur in a timely manner to meet the 30-day response time.
        ii. After the first five, review 50% of assessments for the next 3 months.
        iii. After 3 months, additional reviews are done at the supervisor's discretion based on performance.
        iv. Reviews must be completed using the QA Monitoring tool.

    b. New Staff transferring within the HCLA system with CARE experience
        i. Evaluate skills by reviewing the first three assessments using local QA monitoring tools.

ii. Additional reviews are done at the supervisor's discretion based on performance.

c. Experienced staff (1 year or more of CARE experience)
   i. Random monitoring of three records per worker, over the course of a year.
   ii. Use of the QA Monitor Tool is required, and reviews completed in the QA Monitor Tool will count toward the annual Supervisory reviews of three per year, per worker.

QA TOOL AND WORKER ADMINISTATOR RIGHTS

The QA tool is used by multiple division within HCLA. Because of information that is now placed into the QA monitoring tool, the QA monitoring tool must follow category 4 security requirements. The new requirements are:

1. All users of the QA monitoring tool must log into the tool every six months or lose access to the tool.
2. There will be a limited number of field staff who will have the security group "worker administrator" in the QA monitoring tool. Those with "worker administrator" rights will have the ability to:
   a. Add new staff.
   b. Inactivate staff.
   c. Reactivate staff.
   d. Reset user password.

The field will submit a list of staff members that will need "worker administrator" rights. The QA Unit Manager or QA IT team will grant "worker administrator" rights to those individuals. The field is responsible for sending the QA unit an updated list if changes to security rights are needed.

The QA IT unit will periodically run a report indicating those who have "worker administrator" rights. If anyone has these rights and the individual is not on the list provided by the field, the QA Unit Manager will remove "worker administrator" rights from those individuals.

HCS QUALITY ASSURANCE AND IMPROVEMENT INTRANET SITE

The HCS QA/QI Intranet Site (http://adsaweb.dshs.wa.gov/hcs/QA/) was developed for headquarters and field staff to learn more about quality assurance and quality improvement activities for HCS and the AAAs, and to share best practices.

The site contains information about and links to the:

- HCS QA monitoring schedules.
- List of the QA questions for the current process review cycle.
- Log of the QA Change Requests and Non-Concur requests submitted by field offices in response to QA Unit process review findings. (This has a searchable feature so offices can determine whether a same/similar finding was disputed in the past and the outcome of the disputed finding as determined by the Change and Non-Concur Committee.);
- Innovation center where social and financial workers, case managers, and supervisors can submit their ideas to the HCS QA Unit and program managers for improving and/or maintaining the quality of their work.
- Copies of the annual HCS Statewide QA final process review reports.
- Updates about the statewide proficiency improvement projects in process by HCS Headquarters.
- State and Federal Audits of HCS; and
- Copies of Evidence Reports submitted to the Centers for Medicare and Medicaid Services for continued waiver renewal and approval.

Staff are encouraged to refer to this site at least quarterly for information and updates about HCS quality assurance and improvement.

AUTHORITY FOR POLICIES AND PROCEDURES

Section 1915 (10)(H)(i): Quality assurance. The State ensures that the provision of Home and Community-Based Services meets Federal and State guidelines for quality assurance.

RCW 74.39A.051 (2): DSHS requires an LTC care QI system that focuses on consumer satisfaction and positive outcomes for consumers.

RCW 74.39A.090(5)(a) The department shall assess the degree and quality of the case management performed by the contracted area agency on aging staff or federally recognized Indian tribe for elderly and persons with disabilities in the community