MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

OHCA 2006-04

April 11, 2006

Dear Long Term Care Provider:

Effective July 1, 2006, the form used to collect data for the required monthly Quality of Care Report (QOCR) and the e-mail address for electronic reporting will change. Facilities are required to utilize the enclosed new report and new e-mail address for June 2006 information due by 5:00 p.m., July 17, 2006. The new e-mail address is LTCAUDIT@okhca.org.

To reiterate, we have outlined below the significant changes in addition to clarification on Part C of the QOCR:

- Effective July 1, 2006, all "e-filed" reports are submitted to LTCAUDIT@okhca.org.
- Effective July 1, 2006, the QOCR (June 2006) is utilized.
  - Note: This updated report reflects the change in the e-mail address and mailing addressee to Provider Compliance only.
- In Part C of the QOCR, "Compensable" days are considered all days for which any payment is or will be received (even at less than the daily charge) and are reported. Leave days that are not compensable are not counted while days in facilities awaiting certification that may not be compensable in the future are not reported.

Please find enclosed a copy of the new Quality of Care Report. It is important that this new form be distributed with the appropriate personnel within your facility or contractor to ensure timely and accurate submission. This will allow staff to respond to any questions that may arise. Current providers who submit the monthly Quality of Care Report via electronic mail will also receive an e-mail notification and revised form within the next few weeks.

If you wish to obtain a copy of the new Quality of Care Report in the excel format, please e-mail LTCAUDIT@okhca.org and request the new form. Facilities may also visit the OHCA website at www.okhca.org.

Should you have any questions, please contact Teri Dalton, (405) 522-7209 or Tana Parrott, (405) 522-7538. Clarification on compensable days should be directed to David Branson, (405)-522-7294.

Sincerely,

Mike Fogarty
Enclosure

Oklahoma Health Care Authority **Quality of Care Report**

Facility Name: ______________________ **Reporting Month:** __________ **Reporting Year:** __________

Medicaid Number: ____________________ **Facility Address:** ______________________________________

A) Direct Care Staffing*

	Day Shift ______ to ______		**Evening Shift** ______ to ______		**Night Shift** ______ to ______		**Flexible Staff Scheduling 24 Hour Staffing** (Only)	
Day of the Month	Peak In-House Resident Count	Direct Care Staff Hours	Peak In-House Resident Count	Direct Care Staff Hours	Peak In-House Resident Count	Direct Care Staff Hours	Daily Peak In-House Resident Count	Total Daily Direct Care Hours
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
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21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								

B) Minimum Wage reporting revoked on July 2003.

C) Total Gross Receipts and Total Patient Days

Total Gross Receipts ____________________

Total Patient Days ____________________

*****Important - The facility shall complete the applicable signature blocks on page 2 for regulatory submission compliance.***

Facility Name: ________________________ **Reporting Month:** ____________ **Reporting Year:** __________

This report must be signed by the preparer and by the Owner, Authorized Corporate Officer or Administrator of the facility for verification and attestation that this report was compiled in accordance with OAC 317:30-5-131.2 and 310:675-1 et seq.

I hereby certify that I have examined the Quality of Care Report, and to the best of my knowledge, is a true, correct and complete statement prepared from the books and records of the facility in accordance with applicable instructions, state and federal rules and regulations.

1) ______________________________ ( ) ______________ ____________

Preparer's Name and Title | Phone Number | Date

____

Signature

2) ______________________________ ( ) ______________ ____________

Owner, Authorized Corporate Officer or Administrator's Name & Title | Phone Number | Date

____

Signature

This signature box shall be completed for flexible staff reporting (24 hour staffing) by authorized facilities.

I hereby attest that the Oklahoma State Department of Health has authorized this facility to utilize the flexible staff schedule (24 hour staffing) option for the reporting month in accordance with OAC 310:675-1 et seq.

3) ______________________________ ( ) ______________ ____________

Owner, Authorized Corporate Officer or Administrator's Name & Title | Phone Number | Date

____

Signature

DIRECT CARE STAFFING

For purposes of this report, direct care staff is limited to:

Registered Nurses
Licensed Practical Nurses
Nurse Aides
Certified Medication Aides
QMRP (ICFs/MR only)

Physical Therapist (Professional)
Occupational Therapist (Professional)
Respiratory Therapist (Professional)
Speech Therapist (Professional)
Therapy Aide / Assistant

Activity and Social Services staff performing direct hands-on care

*For information on staffing requirements reference OAC 310:675-1 et seq. and 63 O.S. 2001, Section 1-1925.2.

Send the completed form by **certified mail** to: **OR** **by electronic mail to:**

Oklahoma Health Care Authority
Provider Compliance Audits
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

LTCAUDIT@okhca.org