



Week 3 Agenda

Monday June 14, 2021: Work from Tyler office then Travel to Tulsa. **Oklahoma staff business as usual**

Veronica's schedule:

- Travel Monday afternoon to Longview
- All day training with Lauren Swetnam Tuesday and Wednesday
- Half day training with Lauren Swetnam Thursday then travel back to Oklahoma

Tuesday June 15, 2021: Tulsa Office

8:30-4:30 pm CM/Admin Training—Presented by Larry Montgomery with Amber Taft as a backup.

Intake Training—Presented by Kandi Patterson

- F2F
- Medical Necessity
- Homecare Order

Virtual ADP training for staff—presented by Jordan Gross

Wednesday June 16, 2021: Tulsa Office (Amber and Kandi will exit this day)

8:30-4:30 pm CM/Admin Training—Presented by Larry Montgomery assist from Amber Taft

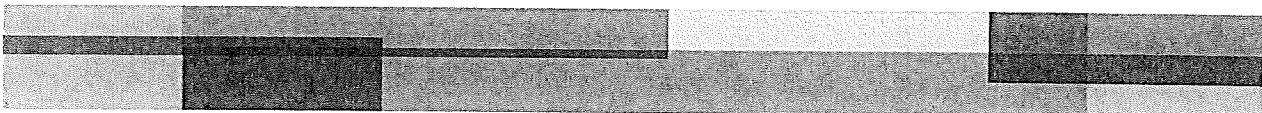
- Coding Process
- Visit Verify

Thursday June 17, 2021: Each office location (Amber and Kandi will be virtual)

8:30-10:30 Presented by Admin/CMS to their clinical staff

- Coding Process
- Visit Verify

Friday June 18, 2021: Business as usual



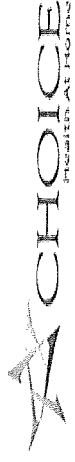


Please provide feedback regarding the communication of information delivered this week. Please list any items you need additional information on regarding the transition and items covered this week.

Employee Name: _____ Date: _____

Employee Signature: _____





Office Training for Administrator/Alternate Administrator

Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Company				
Company Overview (Company Website)				
Services provided by our Company				
Partnerships/Joint Ventures				
Leadership Team				
Growth Strategy				
Home Office Resources				
Contacts				
Operations				
Administrator Job Description				
Professional Appearance and Dress Code				
Attendance				
Acronyms				
Review Job Descriptions of Direct Reports				
Delegation of Authority				
Administrator Hours				
Office Hours				
Governing Body				
Branch/Site Structure/Org Chart				
*Some positions may not be in branches due to ADC Matrix				
Administrator				
Clinical Director				
Clinical Manager				
Team Assist (maintains pt schedules/on-calls logs/Hosp. Report				
HIM (Process (un)signed orders/POC/monitor F2F/Scan doc's/EMR				
Clinical Triage Nurse				
Office Coordinator				
*QAPI (may or not be branch specific)				
*Intake Department				

Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Operations Cont....				
Home Office Structure/Org Chart				
Chief Executive Officer				
Chief Operating Officer				
Chief of Staff				
*VP's Sales/Clinical Operations				
*Accounting Department				
Clinical Educator				
Human Resource Department				
Policy and Procedures (HCL Website)				
*Review HCL for complete list of P&P & discuss pertinent items.				
F2F Process				
Answering Service				
On-Call P&P (TeleONE Communications)				
Staffing Matrix				
Calculating FTE Census				
Field Staff Productivity Expectations				
Documentation Expectations for Field Staff				
Contract Therapists (branch specific)				
Case Conference				
Home Health Aide Competencies				
Aide Supervision				
Outlier Expectations				
Intake Process				
Continuing Education				
Field Clinician Resources				
OASIS Item-by-Item Books				
Preceptors (in progress)				
Emergency Preparedness				
Payroll Process				
Management & Evaluation				
Maintenance Therapy				
Strategic Health Programs (SHP-Manual)				

Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Operations Cont....				
Coding Team- CODES Correct				
Dual Eligibility (Home Health & Hospice)				
Name Badges				
Survey Readiness Checklist				
When a Surveyor Arrives				
Corrective Action Plans				
Pay Grids (Branch Specific)				
Branch Site Supervision				
Weekly Reports *discussed in further detail in another section				
Patient Handbooks				
Patient Planners				
Quality & Outcomes contact				
Home Health-Hospice Partnership				
Use of Care Insights for Palliative/Hospice appropriate patients				
Choice Vendors				
Translation Services in Contract book				
Daily Management and Lead Measures to move metrics				
*Discuss further in Reports Section				
Public Relations				
Culture				
Customer Service Videos				
Culture Meetings with Kevin Clayton, RN-Choice Experience				
A3				
Travel				
Approval and Travel				
Company Credit Card				
Technology				
Email Access				
Laptop				
Technology Contact				

Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Technology Cont....				
Copier				
Phones				
Medical Supply Approval				
Human Resources				
*This section is information of HR's Role				
Employee Handbook (How to access online)				
Employee Status/Clarification Types				
Employee Documentation				
New Hires/Changes for Existing Employees				
Employee Evaluations				
I-9/E-Verify/Employee Verification				
Background Checks				
CPR Requirements				
TB Testing				
Hep B Vaccine				
COVID Vaccine				
New Hire Orientation				
Holidays				
Personnel Files				
Mileage Reimbursement				
Employee Drug Testing (for cause)				
Field Staff Scrubs				
Group Insurance Plans				
401 (k) Plan				
Benefits				
Company Car Program				
Paid Time Off (PTO)				
Quality				
Professional Advisory Committee (PAC)				
Annual Agency Evaluation				

Quality Cont....	Task	Trainer Initials	Trainee Initials	Date Completed	Comments
QAPI	Publicly Reported Outcomes				
Recruiting	Role of Recruiting				
References	Employee Referral Bonus				
Indeed (other hiring platforms)					
Billing	Billing Department Structure				
Payor Overview	Payors by location				
Medicare Secondary Payor (MSP)	Authorization Department				
Re-Auth Responsibilities	Bad Debt Write-Offs				
Eligibility Alerts	PECOS				
Face-to-Face (F2F)	Episode Realignment				
Legal	Legal Department Structure				
Communication regarding legal matters	Existing Non-Compete Agreements for Applicants or New Hires				
	Non Solicitation Agreement/Employment Agreement				
	State, Federal, and Accreditation Correspondence				

Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Compliance				
Compliance Department Structure				
Compliance Training				
Reports of Violations and Investigations				
Employee Reports of Compliance and Privacy (HIPAA) Concerns				
Non-Retaliation				
Medical Director/Medical Consultant				
Medical Records Requests				
Contracting Process				
Accounts Payable				
AP Invoices				
New AP Vendor				
Credit Card Reconciliation-Keri Ishmael				
AP Contact				
* ap@choicetx.com				
Sales				
Sales Department Positions Overview				
Speciality Programs				
Sales Compliance				
Business Development				
Integration				
*As needed				
Finance				
Budget Process				
Financial Statements/Key Financial Drivers and definitions				
Key Financial Reports (how to pull and what they mean)				
Kinnsler				
*Determine previous experience with Kinnsler				
Overview				
Rights				

Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Kinnser Cont...				
Administrative Tasks				
Visit Codes				
Medical Supply Approval				
OASIS Review Process				
QA of notes				
Communication Notes				
*All things Kinnser				
Reports				
Consoles				
Clinical Input				
Forcura				
Overview				
Clinical Input				
"Buckets"				
Referrals				
Referral entry				
Review eligibility alerts				
On-Call				
On-Call Schedules				
Employee Title/Phone List				
Direct Report Tasks				
Call In P&P				
Evaluations (90 Day/Annual/Incidental)				
Disciplinary Actions				
Top Reports				
Pending Admits				
Previous Day SOC Report				
Weekly Reports				

Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Top Reports Cont...				
Daily Administrator Duties				
Unbilled Claims Report				
Auth/Re-Auth Reports				
Non-Start Report (can we contact patient and "save" the admit)				
Additional Reports				
Admissions Report				
Field Staff Productivity Reports				
Claims Held Report				
Census Report				
Discharge Report				
On-Call Report				
QI Event Report				
Resources				
ADP				
HCL				
*Needed websites				
Meetings				
Weekly Operational Meeting with VP of Clinical Operations				
Weekly Case Conference with Field Staff/Office Clinical Managers				
Weekly Sales/Ops Meeting				
Weekly A3 Meetings				
Monthly Administrator Meetings				
Miscellaneous				
Location of books in the office vs. online				
Contract Book				
Emergency Preparedness Book				
Business Profile Book				
Medical Director Timesheets				
Potentially Avoidable Events (PAE's)				



Administrator Home Health

JOB DESCRIPTION			
Full Time	Salary	Exempt	Branch Office
This position is primarily located at the assigned, local branch office(s).			

POSITION OBJECTIVE

The Administrator is the local chief executive agent and contributes to the overall success of Choice Health at Home by leading the local provider in a better way to care for the community in which it serves. This position is responsible for ensuring that the execution of branch operations is completed daily. The Administrator effectively manages branch operations, services, personnel performance, and office management ongoing.

EDUCATION, EXPERIENCE, QUALIFICATIONS

Education and Experience, hired prior to Jan. 13, 2018 (ESSENTIAL):
 Must possess a degree in health care administration or related field. Must have demonstrated knowledge and understanding of the federal, state, and local laws and regulatory guidelines that govern the operation of a home care office.
 Must not have been employed in the last year as an Administrator with another operation at the time any enforcement action was taken against the business (further described in the Choice Health at Home compliance policies).

Education and Experience, hired on or after Jan. 13, 2018 (ESSENTIAL):
 Must be a licensed physician, registered nurse, or possess a bachelor's degree. Must have demonstrated experience in health service administration with at least one year in a supervisory or administrative capacity. Must have demonstrated knowledge and understanding of the federal, state, and local laws and regulatory guidelines that govern the operation of a home care office.
 Must not have been employed in the last year as an Administrator with another operation at the time any enforcement action was taken against the business (further described in the Choice Health at Home compliance policies).

Education and Experience (DESIRED):
 A high school diploma with two years of management and supervisory experience in a health-related field may be considered in lieu of a degree. A licensed physician, registered nurse, licensed social worker, licensed therapist, or a licensed nursing home administrator with at least one year of management and supervisory experience may be considered in lieu of a degree.
 Previous experience in a home health care or hospice program is preferred. Previous experience in management is preferred.

Education and Experience (STATE SPECIFIC):

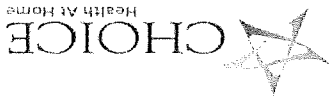
OKLAHOMA

Must possess an Oklahoma administrator license. Must complete 12 continuing education units per year.

TEXAS

Must comply with Texas state regulation 97.259 a-g requiring 24 hours of training in the first 12 months if a first-time administrator. Must have documented completion of a minimum of 12 clock hours per year at a health administration seminar or through an approved provider.

Administrator Home Health



Qualifications:

Must be organized with the ability to communicate effectively, orally and in writing. Must be able to utilize computers and technology to present information. Must be able to manage multiple tasks simultaneously. Must be able to function in a stressful atmosphere.

Must maintain a professional and friendly demeanor. Must possess a passion for helping patients. Must comply with accepted professional standards and practices.

Must be able to prepare and deliver educational material to employees and community referral sources.

Requirements:

- Must possess a valid state driver license
- Must maintain automobile liability insurance as required by law
- Must maintain dependable transportation in good working condition
- Must be able to safely drive an automobile in all types of weather conditions
- Must be licensed in the state which they practice, if clinical.

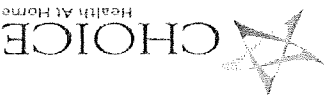
SPECIFIC DUTIES AND RESPONSIBILITIES

The duties and responsibilities of this job are outlined below.

Administrative:

1. Compile and analyze statistical data from performance markers for each branch to evaluate productivity, cost analysis, and quality care delivery.
2. Utilize Choice Health at Home tools to monitor daily financial, operational, and clinical outcomes as they relate to the branch budget.
3. Provide oversight and management of all branch expenses.
4. Ensure all staff are meeting and exceeding set productivity expectations.
5. Ensure billing and corrections are completed timely and outstanding claims are kept to a minimum.
6. Ensure end of episode billing is completed timely and outstanding claims are minimal.
7. Assist branch leadership with initiation and management of contractual relationships.
8. Conduct ongoing meetings with physicians, discharge planners, and other health professionals to monitor quality improvement issues, coordinate contacts and protocols, and to facilitate education regarding Medicare guidelines.
9. Ensure all referral sources clearly understand the benefits of home health and hospice care.
10. Ensure deficiencies related to internal audit findings are addressed and corrected per action plan.
11. Be competent with the state and federal survey process and ensure that the branch as a whole and all the branch staff are prepared for on-site surveys and other external audits.
12. Attend and conduct committee and management meetings, as needed.
13. Participate in continuing education rollouts for clinical licensed professionals as directed by the home office leadership.

14. Work with the billing department to process all denials received by the payor.
15. Track individual branch progress.
16. Ensure policy and procedure, emergency preparedness, and other manuals are always current.
17. Manage and participate in emergency preparedness and disaster planning; review plan annually, oversee tests of call tree, activate, and supervise plan implementation when needed, oversee reports on disaster plan execution, ensure adequate coverage to monitor related information, and communicate any impact on employee and patient safety appropriately.
18. Maintain liaison with the governing body, the group of advisory professional personnel, and the local staff; ensure appropriate documentation of meeting attendance and minutes.
19. Ensure the development and implementation of general and job-specific orientation, safety training, compliance education, and appropriate in-services for the local staff.
20. Ensure the development and execution of local staff and leadership training.



- 21. Ensure culture events are completed at each branch.
- 22. Ensure office operations at each branch are efficient, productive, effective, and organized; each environment should adhere to local ordinances and safety regulations and provide a safe working environment for all employees.
- 23. Participate in administrative on-call as a support to the on-call nurse and provide software management related to processing intake and critical workflow during off hours.
- 24. Manage on-call oversight, including daily log follow-up and schedule creation.
- 25. May be required to perform patient visits, if clinical.
- 26. Manage professional staff in patient homes through written and verbal communication, including timely completion of onsite visits if necessary.
- 27. Ensure monthly completion of required aide in-services.
- 28. Manage the provision of in-services and education based on need and trends.
- 29. Complete all workflow tasks per policy and procedures/processes.
- 30. Complete all daily management assigned to Administrator.
- 31. Provide oversight to duties assigned to Clinical Managers for completion. Address if not done.
- 32. Manage and oversee field clinicians to ensure visits are made timely and documentation is submitted per policy and procedures.
- 33. Review Medical Director Timesheets for accuracy. Complete and submit in timely (monthly)
- 34. Review and approve or deny PTO based on branch needs.
- 35. Complete all other duties as assigned.

Regulatory:

- 1. Ensure branch meets federal, state, and local laws regarding certification and licensure process.
- 2. Ensure branch meets all budget metrics, operational and financial, to ensure success and stability;
- 3. monitor and respond appropriately to applicable dashboards and technology resources.
- 4. Execute daily operations in compliance with conditions of participation in Medicare and Medicaid and ensure compliance with job descriptions through utilization of the operation plan procedures.
- 5. Disseminate regulatory, procedural information as directed by the Choice Health at Home, home office.
- 6. Communicate with the executive leadership for direction, problem solving, and implementation of protocols and programs.
- 7. Review incoming correspondence from regulatory entities and forward to executive leadership. Compile outgoing correspondence as needed.
- 8. Ensure all instances of abuse and neglect are reported accordingly.

Quality Control:

- 1. Review and process complaints regarding the health insurance portability and accountability act, and function as a liaison with the privacy officer, maintaining all required documentation.
- 2. Conduct quality assessment and performance improvement (QAPI) quarterly committee meetings to follow up on internal audit reviews, negative patient satisfaction surveys, and referral source issues; ensure timely follow-up.
- 3. Conduct post-acute care meetings within stated regulations; ensure timely follow-up.
- 4. Manage submission of medical record and billing denial reviews.
- 5. Manage internal chart audits, outcomes reports, and quality improvement reports, as needed.
- 6. Conduct quality improvement visits in the field with clients, families, referral sources, and other entities receiving services to monitor program effectiveness and enhance delivery of client care.
- 7. Collaborate with branch leadership to identify appropriate preceptors for field staff; ensure each ambassador is a representation of the Choice Health at Home culture.
- 8. Complete and review on-site visits with field staffs, as needed; maximize efforts on each visit to ensure no unnecessary visits are performed in any given episode.
- 9. Manage branch ability to meet and exceed annual wildly important goals of Choice Health at Home.

- 1. CULTURE - Participate as a positive contributor to the Choice Health at Home culture.
 - 2. INTEGRITY - Engage in decision-making processes with the goal of ensuring the Choice Health at Home.
 - 3. COMMUNICATION - Ensure that communication style and approach is professional at all times.
- Be an active participant in building Choice Health at Home success.

Key Contributions:

- 1. THINK - Be thoughtful, stay prepared, and maintain a positive mental attitude to pave the way for great customer service.
 - 2. ENGAGE - Consistently interact positively and professionally when representing Choice Health at Home.
 - 3. ACT - Take action to ensure all needs are met for stakeholders.
 - 4. MOTIVATE - Respond to excellence and encourage the culture of service to thrive.
- Maintain a T.E.A.M. focus in every interaction.

Customer Service:

- 1. Be knowledgeable and comply with HIPAA privacy and compliance programs.
- 2. Read and adhere to the Choice Health at Home standard operating procedures, policies, and procedures.
- 3. Read and adhere to the Choice Health at Home employee handbook.
- 4. Read and adhere to the Choice Health at Home standards of business conduct.
- 5. Adhere to safe driving practices, including distracted driver policy, when driving during work hours.

Compliance:

- 1. Provide requested documentation timely to keep personnel file current and in good standing.
- 2. Comply with activities associated with the management of workplace health and safety.
- 3. Identify and report health and safety risks, accidents, incidents, injuries, and property damage at the workplace in a timely manner.
- 4. Maintain a professional relationship with all workers, interns, volunteers at all times.
- 5. Adhere to Choice Health at Home dress code at all times.
- 6. Properly request and utilize appropriate personal protective equipment, as applicable.

Human Resources:

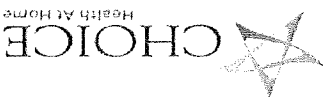
- 1. Supervise the daily operation of the department. Create and implement strategy for growth.
- 2. Oversee direct reports to ensure timely completion of duties and responsibilities.
- 3. Perform all counseling's, evaluations, and supervisor related functions in a timely manner.
- 4. Collaborate with direct reports to identify development goals and support professional growth.
- 5. Ensure documentation is provided by direct reports to keep worker files current and complete.
- 6. Organize and lead team meetings effectively and timely to ensure participation in company and professional goals and growth.
- 7. Evaluate and manage an appropriate staffing matrix within the department to effectively achieve ongoing workload.
- 8. Identify and manage performance improvement processes, as needed.

Management:

- 1. Claims held for billing, less than 15%
- 2. Claims held greater than 60 days, 0%
- 3. Claims held for internal reasons, 100% cleared weekly
- 4. Clinical internal audit, 85%
- 5. Operational internal audit, 90%
- 6. Human resources audit, 100%

Performance Expectations:

Administrator Home Health



- Demonstrate interest in professional growth and development.
 - Promote the Choice Health at Home purpose, guiding principle, and values in every action.
- Initiative:**
- Have a comprehensive understanding of home health and hospice regulations, as applicable.
 - Display an understanding of job duties and responsibilities.
- Job Knowledge:**
- Punctual to work and completing a full workday.
 - Able to strategically and effectively prioritize assignments.
 - Consistently meet performance goals per Choice Health at Home standards.
- Time Management:**
- Refrain from conducting personal business during work hours.
 - Complete duties and responsibilities properly and timely.
- Dependability:**
- Able to gather information needed to participate in a solution-based approach to issues.
 - Able to make effective decisions to facilitate efficient operations.
 - Provide timely and viable solutions to issues.
- Problem Solving:**
- Support team effort by positively contributing to departmental and company goals.
 - Demonstrate kindness, consideration, and courtesy to others; serve as a role model to staff.
 - Be willing to modify work schedule to meet work demands and assist personnel in completion of tasks to support efficiency.
- Teamwork:**

- Support team effort by positively contributing to departmental and company goals.
 - Demonstrate kindness, consideration, and courtesy to others; serve as a role model to staff.
 - Be willing to modify work schedule to meet work demands and assist personnel in completion of tasks to support efficiency.
- Communication:**
- Effectively communicate with stakeholders at all levels while maintaining a high level of professionalism and courtesy.
 - Demonstrate an appropriate level of tolerance and even temperament when dealing with people while using sound judgment.
- The following competencies are required for this position.

COMPETENCIES REQUIRED

1. STEWARDSHIP - Committed to going above and beyond, never settling for anything less than excellence. Be an industry leader and challenge self to continuously improve.
 2. EMPATHY - Take the time to understand the physical, mental, and emotional needs of each other and those we support. Listen, make deep connections, and engage on a personal level to better serve those we support.
 3. DO WHAT'S RIGHT - Do the right thing, no matter how difficult, even when no one is looking. Do not be afraid to have hard conversations. Acknowledge mistakes and proactively seek resolution. Bring your whole self to work. Celebrate successes and inspire others to create meaningful impact.
 4. POSITIVITY - Have a positive spirit and find the light in difficult situations. Bring your whole self to work. Collaborate with others building on individual strengths. Take accountability for actions and connect across teams.
 5. TEAMWORK - Work collaboratively with others building on individual strengths. Take accountability for actions and connect across teams.
- Demonstrate the key values of Choice Health at Home at every interaction.
- Key Values:**
5. COMPETENT - Must be able to consistently meet all competencies listed in this job description.
 4. UNDERSTANDING - Proactively ask for assistance and clarification to complete all assigned job duties.
 4. Appropriately share knowledge of issues and concerns with managers.



Administrator Home Health

Reports to: VP of Clinical Operations

Significant guidance and instruction from: VP of Clinical Operations

Direct Reports: Clinical Director (if in place); Clinical Managers; Site Office Staff; Field Positions

OCCUPATIONAL HEALTH AND SAFETY

Risk Category II - May experience occasional exposure to:

- blood and body fluids during the performance of job duties.
- extremes in temperature and humidity when traveling and at non-office locations.
- dust, gas, fumes and odors when traveling and at non-office locations.

Physical Demands:

- Work is moderate with a combination of sitting, standing, and walking.
- Visual and aural acuity, as well as manual dexterity, is required.
- Operate standard office equipment including, but not limited to, computers, printers, and copiers.
- Must be able to safely drive an automobile in all types of weather conditions.
- Travel to other Choice Health at Home locations and patient homes.
- Additional physical demands for this position are attached.

ACKNOWLEDGEMENT

This job description has been designed to indicate the general nature and level of work performed. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of workers assigned to the role. Choice Health at Home retains the right to change or add tasks, duties, and responsibilities at any time, with or without notice to worker. I have reviewed this job description and understand my expected job performance. I also understand that periodically it may be necessary for me to perform other duties as assigned.

Worker Signature _____

Supervisor Signature _____

Worker Printed Name _____

Date _____

Supervisor Printed Name _____

Date _____

Worker Printed Name _____ Date _____
 Worker Signature _____
 Supervisor Printed Name _____ Date _____
 Supervisor Signature _____

I have reviewed these additional physical demands and understand that periodically it may be necessary for me to perform physical demands not indicated here.

ACKNOWLEDGEMENT

1. Alertness	Yes	2. Precision	Yes	3. Analytic ability	Yes
4. Problem solving	Yes	5. Memory	Yes	6. Communication	Yes
7. Creativity	Yes	8. Concentration	Yes	9. Judgment	Yes
10. Imagination	Yes	11. Initiative	Yes	12. Patience	Yes

MENTAL DEMANDS

1. Mechanical	Yes	2. Electrical	No	3. Explosives	No
4. Burns	No	5. Chemicals	No	6. Fumes/gases/odors	No
7. Toxic waste	No	8. Frequent travel	Yes	9. Long/irregular hours	Yes
10. Stressful atmosphere	Yes	11. Inadequate work area	No	12. Moving machinery	No

Situational hazards that the individual is/may be exposed to definite risk of bodily injury.

HAZARDS

1. Inside work	Yes	2. Outside work	No	3. Noise	Yes
4. Vibration	Yes	5. Wet/Humid	No		

WORK ENVIRONMENT

1. Lift or transfer	0	2. Carry	0	3. Push or pull	0
a. Up to 10 pounds (sedentary)	F	4. Climb (stairs)	0	5. Reach	F
b. 11-20 pounds (light)	0	6. Stoop or bend	F	7. Crouch	F
c. 21-50 pounds (medium)	0	8. Kneel	F	9. Handle or feel	C
d. 51-100 pounds (heavy)	0	10. Talk	C	11. Hear	C
e. >100 pounds (very heavy)	N	12. See	C	13. Sit, walk, stand	C

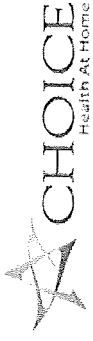
In a regular work day, worker is required to:

N=Not at all (0%) O=Occasionally (1-33%) F=Frequently (34-66%) C=Continuously (67-100%)

WORK POSITION AND ACTIVITIES

Position: Administrator home health

ADDITIONAL PHYSICAL DEMANDS



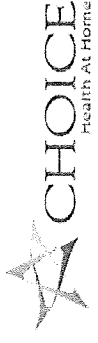
Staff Performance Evaluation

This evaluation should be completed and reviewed between the employee and their supervisor. All scores should include supporting comments. If the category is not relevant to the employee, select "N/A" or leave the score and comments blank.

- 1 Does Not Meet Job Expectations - *Inadequate performance that is frequently below job requirements. Counseling or PIP required.*
- 2 Needs Improvement - *Adequate performance but needs some improvement to consistently meet job expectations. PIP required.*
- 3 Meets Expectations - *Satisfactory performance that consistently meets and occasionally exceeds job requirements.*
- 4 Frequently Exceeds Expectations - *Strong performance that meets and frequently exceeds job requirements.*
- 5 Consistently Exceeds Expectations - *Superior performance that consistently exceeds job requirements. Reserved for truly outstanding performance.*

EVALUATION INFORMATION	
Job Title:	Employee Name: <small>Click or tap here to enter text</small>
Administrator	
Evaluator Name: <small>Click or tap here to enter text</small>	Evaluator Position: <small>Click or tap here to enter text</small>
Type of Evaluation: <input type="checkbox"/> 90 Day <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual <input type="checkbox"/> Special Incident <input type="checkbox"/> Self Evaluation	Date of Review: <small>Click to pick date</small>

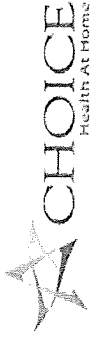
ADMINISTRATIVE TASK REVIEW	
1. Compile and analyze statistical data from performance markers for each branch to evaluate productivity, cost analysis, and quality care delivery.	Choose a score <small>Click or tap here to enter comments</small>
2. Utilize Choice Health tools to monitor daily financial, operational, and clinical outcomes as they relate to the branch budget.	Choose a score <small>Click or tap here to enter comments</small>
3. Provide oversight and management of all branch expenses.	Choose a score <small>Click or tap here to enter comments</small>
4. Ensure all staff are meeting and exceeding set productivity expectations.	Choose a score <small>Click or tap here to enter comments</small>
5. Ensure billing and corrections are completed timely and outstanding claims are kept to a minimum.	Choose a score <small>Click or tap here to enter comments</small>
6. Ensure end of episode (EOE) billing is completed timely and outstanding claims are minimal.	Choose a score <small>Click or tap here to enter comments</small>
7. Assist branch leadership with initiation and management of contractual relationships.	Choose a score <small>Click or tap here to enter comments</small>
8. Conduct ongoing meetings with physicians, discharge planners, and other health professionals to monitor quality improvement issues, coordinate contacts and protocols, and to facilitate education regarding Medicare guidelines.	Choose a score <small>Click or tap here to enter comments</small>



Staff Performance Evaluation

1 Does Not Meet Expectations • 2 Needs Improvement • 3 Meets Expectations • 4 Frequently Exceeds Expectations • 5 Consistently Exceeds Expectations

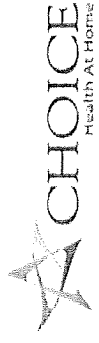
<p>9. Ensure all referral sources clearly understand the benefits of home health and hospice care.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>10. Ensure deficiencies related to internal audit findings are addressed and corrected per action plan.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>11. Be competent with the state and federal survey process and ensure that the branch as a whole and all the branch staff are prepared for on-site surveys and other external audits.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>12. Attend and conduct committee and management meetings, as needed.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>13. Participate in continuing education rollouts for clinical licensed professionals as directed by the regional and home office leadership.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>14. Work with billing department to process all denials received by the payor.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>15. Track individual branch progress.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>16. Ensure policy and procedure, emergency preparedness, and other manuals are always current.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>17. Manage and participate in emergency preparedness and disaster planning; review plan annually, oversee tests of call tree, activate and supervise plan implementation when needed, oversee reports on disaster plan execution, ensure adequate coverage to monitor related information, and communicate any impact on employee and patient safety appropriately.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>18. Maintain liaison with the governing body, the group of advisory professional personnel, and the local staff; ensure appropriate documentation of meeting attendance and minutes.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>19. Ensure the development and implementation of general and job-specific orientation, safety training, compliance education, and appropriate in-services for the local staff.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>20. Ensure the development and execution of local staff and leadership training.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>
<p>21. Ensure culture events are completed at each branch.</p>	<p>Choose a score</p>	<p>Click or tap here to enter comments</p>



Staff Performance Evaluaton

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22. Ensure office operations at each branch are efficient, productive, effective and organized; each environment should adhere to local ordinances and safety regulations, and provide a safe working environment for all employees.	Choose a score	Click or tap here to enter comments
23. May participate in on-call rotation, as needed.	Choose a score	Click or tap here to enter comments
24. Manage on-call oversight, including daily log follow-up and schedule creation.	Choose a score	Click or tap here to enter comments
25. May be required to perform patient visits, if clinical.	Choose a score	Click or tap here to enter comments
26. Mange professional staff in patient homes through written and verbal communication, including timely completion of onsite visits if necessary.	Choose a score	Click or tap here to enter comments
27. Ensure monthly completion of required aide in-services.	Choose a score	Click or tap here to enter comments
28. Manage the provision of in-services and education based on need and trends.	Choose a score	Click or tap here to enter comments
29. Complete all workflow tasks per policy and procedures/processes.	Choose a score	Click or tap here to enter comments
30. Complete all daily management assigned to Administrator.	Choose a score	Click or tap here to enter comments
31. Provide oversight to duties assigned to Clinical Managers for completion. Address if not done.	Choose a score	Click or tap here to enter comments
32. Management and oversight of field clinicians to ensure visits are made timely and documentation is submitted per policy and procedures.	Choose a score	Click or tap here to enter comments
33. Review Medical Director Timesheets for accuracy. Complete and submit timely. (monthly).	Choose a score	Click or tap here to enter comments
34. Review and approve or deny PTO based on branch needs.	Choose a score	Click or tap here to enter comments
35. Complete all other duties as assigned.	Choose a score	Click or tap here to enter comments
36. Administrative	Average Score:	



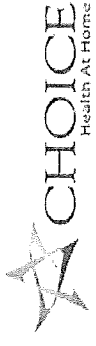
Staff Performance Evaluation

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REGULATORY TASK REVIEW		
1. Ensure branch meets federal, state, and local laws regarding certification and licensure process.	Choose a score	Click or tap here to enter comments
2. Ensure branch meets all budget metrics, operational and financial, to ensure success and stability; monitor and respond appropriately to applicable dashboards and technology resources.	Choose a score	Click or tap here to enter comments
3. Execute daily operations in compliance with conditions of participation in Medicare and Medicaid, and ensure compliance with job descriptions through utilization of the operation plan procedures.	Choose a score	Click or tap here to enter comments
4. Disseminate regulatory, procedural information as directed by the Choice Health home office.	Choose a score	Click or tap here to enter comments
5. Communicate with the executive leadership for direction, problem solving, and implementation of protocols and programs.	Choose a score	Click or tap here to enter comments
6. Review incoming correspondence from regulatory entities and forward to regional leadership. Compile outgoing correspondence as needed.	Choose a score	Click or tap here to enter comments
7. Ensure all instances of abuse and neglect are reported accordingly.	Choose a score	Click or tap here to enter comments
Regulatory Average Score:		0.0 *Click cursor on the average score and type F9 to update calculation.

QUALITY CONTROL TASK REVIEW		
1. Review and process complaints regarding the health insurance portability and accountability act, and function as a liaison with the privacy officer, maintaining all required documentation.	Choose a score	Click or tap here to enter comments
2. Conduct quality assessment and performance improvement (QAPI) quarterly committee meetings to follow up on internal audit reviews, negative patient satisfaction surveys, and referral source issues; ensure timely follow-up.	Choose a score	Click or tap here to enter comments
3. Conduct post-acute care meetings within stated regulations;	Choose a score	Click or tap here to enter comments

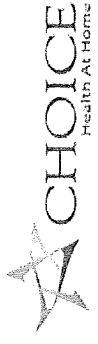


Staff Performance Evaluaton

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 ensure timely follow-up.

4. Manage submission of medical record and billing denial reviews.	Choose a score	Click or tap here to enter comments
5. Manage internal chart audits, outcomes reports, and quality improvement reports, as needed.	Choose a score	Click or tap here to enter comments
6. Conduct quality improvement visits in the field with clients, families, referral sources, and other entities receiving services to monitor program effectiveness and enhance delivery of client care.	Choose a score	Click or tap here to enter comments
7. Collaborate with branch leadership to identify appropriate preceptors for field staff; ensure each ambassador is a representation of the Choice Health culture.	Choose a score	Click or tap here to enter comments
8. Complete and review on-site visits with field staffs, as needed; maximize efforts on each visit to ensure no unnecessary visits are performed in any given episode.	Choose a score	Click or tap here to enter comments
9. Manage branch ability to meet and exceed annual wildly important goals of Choice Health.	Choose a score	Click or tap here to enter comments
Quality Control Average Score:		0.0
*Click cursor on the average score and type F9 to update calculation.		

PERFORMANCE EXPECTATIONS	TASK REVIEW	Requirement	Last 12 months	Last 9-12 months
Claims held for billing <i>home health only</i>		15%	Enter metric	Enter metric
Claims held greater than 60 days <i>home health only</i>		0%	Enter metric	Enter metric
Claims held for internal reasons, cleared weekly <i>home health only</i>		100%	Enter metric	Enter metric
Clinical internal audit		85%	Enter metric	Enter metric
Operational internal audit		90%	Enter metric	Enter metric
Human resources audit		100%	Enter metric	Enter metric



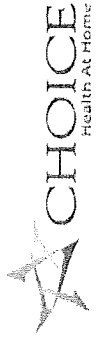
Staff Performance Evaluaton

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Performance Expectations **Average Score: 0.0** *Click cursor on the average score and type F9 to update calculation.

MANAGEMENT TASK REVIEW		
1. Supervise the daily operation of the department. Create and implement strategy for growth.	Choose a score	Click or tap here to enter comments
2. Oversee direct reports to ensure timely completion of duties and responsibilities.	Choose a score	Click or tap here to enter comments
3. Perform all counselings, evaluations and supervisor related functions in a timely manner.	Choose a score	Click or tap here to enter comments
4. Collaborate with direct reports to identify development goals and support professional growth.	Choose a score	Click or tap here to enter comments
5. Ensure documentation is provided by direct reports to keep worker files current and complete.	Choose a score	Click or tap here to enter comments
6. Organize and lead team meetings effectively and timely to ensure participation in company and professional goals and growth.	Choose a score	Click or tap here to enter comments
7. Evaluate and manage an appropriate staffing matrix within the department to effectively achieve ongoing workload.	Choose a score	Click or tap here to enter comments
8. Identify and manage performance improvement processes, as needed.	Choose a score	Click or tap here to enter comments
Management	Average Score: 0.0	*Click cursor on the average score and type F9 to update calculation.

HUMAN RESOURCES TASK REVIEW		
1. Provide requested documentation timely to keep personnel file current and in good standing.	Choose a score	Click or tap here to enter comments
2. Comply with activities associated with the management of workplace health and safety.	Choose a score	Click or tap here to enter comments
3. Identify and report health and safety risks, accidents, incidents, injuries, and property damage at the workplace in a timely manner.	Choose a score	Click or tap here to enter comments
4. Maintain a professional relationship with all workers, interns, volunteers at all times.	Choose a score	Click or tap here to enter comments



Staff Performance Evaluaton

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5. Adhere to Choice Health dress code at all times.			
6. Properly request and utilize appropriate personal protective equipment, as applicable.	Choose a score	Click or tap here to enter comments	
Human Resources Average Score:		0.0	*Click cursor on the average score and type F9 to update calculation.

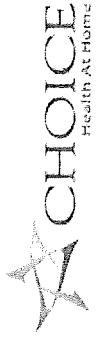
COMPLIANCE TASK REVIEW

1. Be knowledgeable and comply with HIPAA privacy and compliance programs.	Choose a score	Click or tap here to enter comments	
2. Read and adhere to the Choice Health standard operating procedures, policies and procedures.	Choose a score	Click or tap here to enter comments	
3. Read and adhere to the Choice Health employee handbook.	Choose a score	Click or tap here to enter comments	
4. Read and adhere to the Choice Health standards of business conduct.	Choose a score	Click or tap here to enter comments	
5. Adhere to safe driving practices, including distracted driver policy, when driving during work hours.	Choose a score	Click or tap here to enter comments	
Compliance Average Score:		0.0	*Click cursor on the average score and type F9 to update calculation.

CUSTOMER SERVICE TASK REVIEW

1. THINK - Be thoughtful, stay prepared and maintain a positive mental attitude to pave the way for great customer service.	Choose a score	Click or tap here to enter comments	
2. ENGAGE - Consistently interact positively and professionally when representing Choice Health.	Choose a score	Click or tap here to enter comments	
3. ACT - Take action to ensure all needs are met for stakeholders.	Choose a score	Click or tap here to enter comments	
4. MOTIVATE - Respond to excellence and encourage the culture of service to thrive.	Choose a score	Click or tap here to enter comments	
Customer Service Average Score:		0.0	*Click cursor on the average score and type F9 to update calculation.

KEY CONTRIBUTIONS

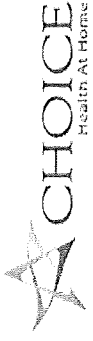


Staff Performance Evaluation

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1. CULTURE - Participate as a positive contributor to the Choice Health culture, including engaging with the branch culture committee.	Choose a score	Click or tap here to enter comments
2. INTEGRITY - Engage in decision-making processes with the goal of ensuring the Choice Health guiding principle of a better way to care is honored at all times for stakeholders.	Choose a score	Click or tap here to enter comments
3. COMMUNICATION - Ensure that communication style and approach is professional at all times. Appropriately share knowledge of issues and concerns with managers.	Choose a score	Click or tap here to enter comments
4. UNDERSTANDING - Proactively ask for assistance and clarification as needed to complete all assigned job duties.	Choose a score	Click or tap here to enter comments
5. COMPETENT - Must be able to consistently meet all competencies listed in job description.	Choose a score	Click or tap here to enter comments
Key Contributions		0.0
Average Score:		*Click cursor on the average score and type F9 to update calculation.

KEY VALUES		
1. STEWARDSHIP- Committed to going above and beyond, never settling for anything less than excellence. Be an industry leader and challenge self to continuously improve.	Choose a score	Click or tap here to enter comments
2. EMPATHY - Take the time to understand the physical, mental, emotional needs of each other and those we support. Listen, make deep connections and engage on personal level to better serve those we support.	Choose a score	Click or tap here to enter comments
3. DO WHAT'S RIGHT - Do the right thing, no matter how difficult, even when no one is looking. Do not be afraid to have hard conversations. Acknowledge mistakes and proactively seek resolution.	Choose a score	Click or tap here to enter comments
4. POSITIVITY - Have a positive spirit and find the light in difficult situations. Bring your whole self to work. Celebrate successes and inspire others to create meaningful impact.	Choose a score	Click or tap here to enter comments
5. TEAMWORK - Work collaboratively with others building on individual strengths. Take accountability for actions and connect across teams.	Choose a score	Click or tap here to enter comments
Key Values		0.0
Average Score:		*Click cursor on the average score and type F9 to update calculation.



Staff Performance Evaluation

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EVALUATION SUMMARY	
Overall Performance Score: 0	Overall Average Score: 0.0
If Counseling or PIP is Required: <input type="checkbox"/> Refer to attached <u>counseling</u> form <input type="checkbox"/> Refer to attached <u>PIP</u>	

Summary of Average Scores by Sub Category			
Administrative:	Regulatory:	Quality Control:	Performance Expectations:
0.0	0.0	0.0	0.0
Human Resources:	Compliance:	Customer Service:	Key Contributions:
0.0	0.0	0.0	0.0
			Management:
			0.0
			Key Values:
			0.0

* To update all calculations and linked fields in the above chart, type CTRL+A then F9

SUPERVISOR ACKNOWLEDGEMENT

Supervisor Comments/Goals:
 Click or tap here to enter text

Professional Development Plan/Career Goals: Professional Development
 Click or tap here to enter text

By signing, I validate the scores listed and acknowledge that I have communicated them to the employee.
 Supervisor Signature: _____ Date: _____

EMPLOYEE ACKNOWLEDGEMENT

Employee Comments/Goals:
 Click or tap here to enter text

Staff are encouraged to sign indicating acknowledgement of review, not necessarily agreement.
 Employee Signature: _____ Date: _____



Office Training for Clinical Manager *May be Alternate Administrator

Company	Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Company Overview (Company Website)					
Services provided by our Company					
Partnerships/Joint Ventures					
Leadership Team					
Growth Strategy					
Home Office Resources					
Contacts					
Operations					
Clinical Manager Job Description					
Professional Appearance and Dress Code					
Attendance					
Acronyms					
Review Job Descriptions of Direct Reports					
Delegation of Authority					
Clinical Manager Hours					
Office Hours					
Governing Body					
Branch/Site Structure/Org Chart					
*Some positions may not be in branches due to ADC Matrix					
Administrator					
Clinical Director					
Clinical Manager					
Team Assist (maintains pt schedules/on-calls logs/Hosp. Report					
HIM (Process (un)signed orders/POC/monitor F2F/Scan doc's/EMR					
Clinical Triage Nurse					
Office Coordinator					
*QAPI (may or not be branch specific)					
*Intake Department					

Operations Cont....	Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Home Office Structure/Org Chart					
Chief Executive Officer					
Chief Operating Officer					
Chief of Staff					
*VP's Sales/Clinical Operations					
* Accounting Department					
Clinical Educator					
Human Resource Department					
Policy and Procedures (HCL Website)					
*Review HCL for complete list of P&P & discuss pertinent items.					
F2F Process					
Answering Service					
On-Call P&P (TeleONE Communications)					
Calculating FTE Census					
Field Staff Productivity Expectations					
Documentation Expectations for Field Staff					
Contract Therapists (branch specific)					
Case Conference					
Home Health Aide Competencies					
Aide Supervision					
Outlier Expectations					
Intake Process					
Continuing Education					
Field Clinician Resources					
OASIS Item-by-Item Books					
Preceptors (in progress)					
Emergency Preparedness					
Payroll Process					
Maintenance Therapy					
Strategic Health Programs (SHP-Manual)					

Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Operations Cont....				
Coding Team- CODES Correct				
Name Badges				
Survey Readiness Checklist				
When a Surveyor Arrives				
Corrective Action Plans				
Pay Grids (Branch Specific)				
Branch Site Supervision				
Weekly Reports *discussed in further detail in another section				
Patient Handbooks				
Patient Planners				
Quality & Outcomes contact				
Home Health-Hospice Partnership				
Use of Care Insights for Palliative/Hospice appropriate patients				
Choice Vendors				
Translation Services in Contract book- Lingalex				
Daily Management and Lead Measures to move metrics				
*Discuss further in Reports Section				
Public Relations				
Culture				
Customer Service Videos				
Culture Meetings with Kevin Clayton, RN-Choice Experience				
A3				
Travel				
Approval and Travel				
Technology				
Email Access				
Laptop				
Technology Contact				

Technology Cont.....	Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Copier					
Phones					
Medical Supply Approval					
Human Resources					
*This section is information of HR's Role					
Employee Handbook (How to access online)					
Employee Status/Clarification Types					
Employee Documentation					
New Hires/Changes for Existing Employees					
Employee Evaluations (Field Evals if assisting Administrator)					
I-9/E-Verify/Employee Verification					
Background Checks					
CPR Requirements					
TB Testing					
Hep B Vaccine					
COVID Vaccine					
New Hire Orientation					
Holidays					
Personnel Files					
Mileage Reimbursement					
Employee Drug Testing (for cause)					
Field Staff Scrubs					
Group Insurance Plans					
401 (k) Plan					
Benefits					
Company Car Program					
Paid Time Off (PTO)					
Quality					
Professional Advisory Committee (PAC)					
Annual Agency Evaluation					

Quality Cont....	Task	Trainer Initials	Trainee Initials	Date Completed	Comments
QAPI					
Publicly Reported Outcomes					
Recruiting					
Role of Recruiting					
References					
Employee Referral Bonus					
Indeed (other hiring platforms)					
Billing					
Billing Department Structure					
Payor Overview					
Payors by location					
Medicare Secondary Payor (MSP)					
Authorization Department					
Re-Auth Responsibilities					
Bad Debt Write-Offs					
Eligibility Alerts					
PECOS					
Face-to-Face (F2F)					
Episode Realignment					
Compliance					
Compliance Department Structure					
Compliance Training					
Reports of Violations and Investigations					
Employee Reports of Compliance and Privacy (HIPAA) Concerns					
Non-Retaliation					
Medical Director/Medical Consultant					
Medical Records Requests					
Contracting Process					

Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Accounts Payable				
AP Invoices				
AP Contact				
* ap@choicetx.com				
Sales				
Sales Department Positions Overview				
Speciality Programs				
Sales Compliance				
Business Development				
Integration				
* As needed				
Finance (If Alternate Administrator)				
Budget Process				
Financial Statements/Key Financial Drivers and definitions				
Key Financial Reports (how to pull and what they mean)				
Kinnsler				
*Determine previous experience with Kinnsler				
Overview				
Rights				
Kinnsler Cont...				
Administrative Tasks				
Visit Codes				
Medical Supply Approval				
OASIS Review Process				
QA of notes				
Communication Notes				
*All things Kinnsler				
Reports				
Consoles				
Clinical Input				

Task	Trainer Initials	Trainee Initials	Date Completed	Comments
Forcra				
Overview				
Clinical Input				
"Buckets"				
Referrals				
Referral entry				
Review eligibility alerts				
On-Call				
On-Call Schedules				
Employee Title/Phone List				
Direct Report Tasks				
Call In P&P				
Evaluations (90 Day/Annual/Incidental)				
Disciplinary Actions				
Top Reports				
Pending Admits				
Previous Day SOC Report				
Weekly Reports				
Top Reports Cont...				
Daily Administrator Duties				
Unbilled Claims Report				
Auth/Re-Auth Reports				
Non-Start Report (can we contact patient and "save" the admit)				
Additional Reports				
Admissions Report				
Field Staff Productivity Reports				
Claims Held Report				
Census Report				
Discharge Report				
On-Call Report				
QI Event Report				

Resources				
ADP				
HCL				
*Needed websites				
Meetings				
Weekly Operational Meeting with VP of Clinical Operations				
Weekly Case Conference with Field Staff/Office Clinical Managers				
Weekly Sales/Ops Meeting				
Weekly A3 Meetings				
Monthly Administrator Meetings				
Miscellaneous				
Location of books in the office vs. online				
Contract Book				
Emergency Preparedness Book				
Business Profile Book				
Medical Director Timesheets				
Potentially Avoidable Events (PAE's)				

JOB DESCRIPTION

Full Time Salary Exempt Branch Office

This position is primarily located at the assigned, local branch office(s).

POSITION OBJECTIVE

The clinical manager (CM) ensures the overall coordination of home health services provided to the patient is delivered according to acceptable standards of practice and all company procedures. This position reviews and approves all patient information submitted by the licensed professional during a startof care, recertification, resumption of care, or evaluation visit. This position assists with patient care review meetings, the review and approval of orders, and provides oversight of patient care. The CM is responsible for assisting the branch director with day-to-day office and staff management related to patient care. This position assists the branch leadership with ongoing education and training of all branch clinicians to ensure understanding of documentation requirements to meet regulatory standards. The CM facilitates the relationship between physicians, referral sources, patients, caregivers, and employees.

EDUCATION, EXPERIENCE, QUALIFICATIONS

Education and Experience (ESSENTIAL):

Must be a graduate of an approved school of professional nursing. Must be licensed in the state in which they currently practice, or in accordance with the board of nursing rules for nurse licensure compact for the state in which they practice. Must have at least two years of nursing experience. Must have one year experience in home health or hospice. Must have demonstrated knowledge and understanding of the federal, state, and local laws and regulatory guidelines that govern a home care operation.

Education and Experience (DESIRED):

Previous experience in management is preferred.

Qualifications:

Must be organized with the ability to communicate effectively, orally and in writing. Must be able to manage multiple tasks simultaneously. Must be able to function in a stressful atmosphere. Must maintain a professional and friendly demeanor. Must possess a passion for helping patients. Must comply with accepted professional standards and practices.

Requirements:

- Must possess a valid state driver license
 - Must maintain automobile liability insurance as required by law
 - Must maintain dependable transportation in good working condition
 - Must be able to safely drive an automobile in all types of weather conditions
- The duties and responsibilities of this job are outlined below.

SPECIFIC DUTIES AND RESPONSIBILITIES

Administrative:

1. Review on call coordination note reports daily.
2. Review and answer all emails withing a timely manner.

Clinical Manager

3. Provide educational material for family and staff on medical diagnoses, provision of care, and psychosocial aspects of chronic illness and disability.
4. Assist with maintaining provider requirements; work with providers, sales, and clinical staff to resolve issues, as appropriate.
5. Process workflow, coordination notes, and administrative tasks timely.
6. Review infection control, complaint, and occurrence reports; document all follow up.
7. Backup the intake coordinator to receive and enter referrals from payors, physicians, facilities, and staff; clearly identify who obtained the referral. **if necessary*
8. Attach referral paperwork to medical record timely, as needed.
9. Communicate acceptance of referrals clearly with referral sources, as needed.
10. Backup the patient scheduler to ensure timely completion.
11. Review patient schedules and approve schedule changes to ensure clinical skills of assigned staff meets patient requirements.
12. Follow up on orders, as needed, when medical records is unable to retrieve the unsigned order.
13. Remain up-to-date on internal information announcements and ensure Choice Health at Home policies and procedures, critical pathways, standards of care, and practice guidelines are met.
14. Provide orientation and in-service training to field and office staff to meet patient needs, particularly with OASIS and documentation standards; track and document education appropriately.
15. Assist the Administrator during any survey, as directed.
16. Attend and participate in staff meetings and in-services.
17. Attend and participate in community education functions.
18. Address lead measures to ensure the branch and Choice Health at Home is able to accomplish the established action goals.
19. Participate in administrative on-call; support the on-call nurse and provide software management related to processing intake and critical workflow during off hours.
20. Conduct continuous quality assessment and performance improvement activities, as assigned.
21. Complete onsite supervisory visits, as assigned.
22. Assist with the day-to-day supervision of branch clinical operations.
23. May assume a position of leadership when the Administrator is out of the office; perform supervisory tasks, such as evaluations and counselings, or make hiring and termination recommendations for branch and field staff, as requested.
24. Complete all other duties as assigned. *See CM Daily/Weekly/Monthly Mgmt duties.

Clinical:

1. Responsible for the QA process to ensure patients receive assessment/visits, scheduled, and performed timely per Choice Health at Home policy.
2. Assist Administrator with patient review meetings; address care decisions based on review.
3. Review and approve patient care assessment notes submitted by case managers. Contact physicians to obtain orders for continued service provision or add-on services, as needed.
4. Review and approve all patient information submitted by the licensed professional.
5. Review orders as written by clinicians; approve or decline as appropriate. Follow up with licensed professional, as necessary, when editing an order.
6. Ensure all orders are complete, including frequency, and that any corrections are made by the licensed professional who wrote the order, prior to approving the order; complete any follow up tasks as deemed necessary, by the order.
7. Enter and approve all orders; route to medical records to be sent for physician signature.
8. Ensure that there are existing orders for requested medical supplies.
9. Enter detailed non-admit information into patient record in coordination notes if no visit was made; ensure the Administrator is informed and approves the non-admission.

Clinical Manager



10. Review and process all wound score deviations, documenting any action and follow up.
11. Review and process vital alert reports; document follow-up action and physician notification.
12. Receive lab reports and assesses for normality; fax lab report to the physician with signature indicating review. Scan both the reviewed labs and the fax confirmation page (showing it was sent to physician) to medical records for uploading into the patient chart.
13. Initiate employee and patient infection reports, as necessary.
14. Complete review of evaluation documentation, OASIS, and plans of care (POC). Review the data submitted to ensure accuracy with the comprehensive assessment, face to face, and the POC; follow up on any documentation that requires correction.
15. Process POC and verify the correct start of care date and episode date range.
16. Review and verify that service utilization correlates with assessment data.
17. Ensure that appropriate care types and pathways are selected based on the patient medical condition and the staff assessment data.
18. Process unlisted supplies, medications, activity, functional limitations, and allergies.
19. Review comprehensive assessments that cannot be processed due to licensed professional documentation deficiencies; follow up appropriately.
20. Perform and maintain ongoing chart audits according to standard operating procedure.
21. Run Case Conference list on Friday prior to Case Conference and send to field staff for review using SHP Einstein tool to determine improved outcomes and Kinners' Care insights for appropriate palliative/Hospice transition.
22. May perform all duties and visit expectations of a licensed professional, as needed.
23. May participate in on-call rotation, as needed.

Human Resources:

1. Provide requested documentation timely to keep personnel file current and in good standing.
 2. Comply with activities associated with the management of workplace health and safety.
 3. Identify and report health and safety risks, accidents, incidents, injuries, and property damage at the workplace in a timely manner.
 4. Maintain a professional relationship with all workers, interns, volunteers at all times.
 5. Adhere to Choice Health at Home dress code at all times.
 6. Properly request and utilize appropriate personal protective equipment, as applicable.
1. Be knowledgeable and comply with HIPAA privacy and compliance programs.
 2. Read and adhere to the Choice Health at Home standard operating procedures, policies and procedures.
 3. Read and adhere to the Choice Health at Home employee handbook.
 4. Read and adhere to the Choice Health at Home standards of business conduct.
 5. Adhere to safe driving practices, including distracted driver policy, when driving during work hours.

Customer Service:

1. THINK - Be thoughtful, stay prepared, and maintain a positive mental attitude to pave the way for great customer service.
2. ENGAGE - Consistently interact positively and professionally when representing Choice Health at Home.
3. ACT - Take action to ensure all needs are met for stakeholders.
4. MOTIVATE - Respond to excellence and encourage the culture of service to thrive.

Key Contributions:

1. CULTURE - Participate as a positive contributor to the culture.
 2. INTEGRITY - Engage in decision-making processes with the goal of good moral and ethical decision-making.
- Be an active participant in building Choice Health at Home success.

Clinical Manager



3. COMMUNICATION - Ensure that communication style and approach is professional at all times. Appropriately share knowledge of issues and concerns with managers.
4. UNDERSTANDING - Proactively ask for assistance and clarification to complete all assigned job duties.
5. COMPETENT - Must be able to consistently meet all competencies listed in this job description.

Key Values:

- Demonstrate the key values of Choice Health at Home at every interaction.
1. STEWARDSHIP - Committed to going above and beyond, never settling for anything less than excellence. Be an industry leader and challenge self to continuously improve.
 2. EMPATHY - Take the time to understand the physical, mental, and emotional needs of each other and those we support. Listen, make deep connections, and engage on a personal level to better serve those we support.
 3. DO WHAT'S RIGHT - Do the right thing, no matter how difficult, even when no one is looking. Do not be afraid to have hard conversations. Acknowledge mistakes and proactively seek resolution.
 4. POSITIVITY - Have a positive spirit and find the light in difficult situations. Bring your whole self to work. Celebrate successes and inspire others to create meaningful impact.
 5. TEAMWORK - Work collaboratively with others building on individual strengths. Take accountability for actions and connect across teams.

COMPETENCIES REQUIRED

The following competencies are required for this position.

Communication:

- Effectively communicate with stakeholders at all levels while maintaining a high level of professionalism and courtesy.
- Demonstrate an appropriate level of tolerance and even temperament when dealing with people while using sound judgment.
- Serve as a reference contact for referral sources.

Teamwork:

- Support team effort by positively contributing to departmental and company goals.
- Demonstrate kindness, consideration, and courtesy to others; serve as a role model to staff.
- Be willing to modify work schedule to meet work demands and assist personnel in completion of tasks to support efficiency.

Problem Solving:

- Able to gather information needed to participate in a solution-based approach to issues.
- Able to make effective decisions to facilitate efficient operations.
- Provide timely and viable solutions to issues.

Dependability:

- Refrain from conducting personal business during work hours.
- Complete duties and responsibilities properly and timely.

Time Management:

- Consistently meet performance goals per Choice Health at Home standards.
- Able to strategically and effectively prioritize assignments.
- Punctual to work and completing a full work day.

Worker Printed Name _____ Date _____
 Worker Signature _____
 Supervisor Printed Name _____ Date _____
 Supervisor Signature _____

This job description has been designed to indicate the general nature and level of work performed. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of workers assigned to the role. Choice Health at Home retains the right to change or add tasks, duties, and responsibilities at any time, with or without notice to worker. I have reviewed this job description and understand my expected job performance. I also understand that periodically it may be necessary for me to perform other duties as assigned.

ACKNOWLEDGEMENT

- Work is moderate with a combination of sitting, standing, and walking.
 - Visual and aural acuity, as well as manual dexterity, is required.
 - Operate standard office equipment including, but not limited to, computers, printers, and copiers.
 - Must be able to safely drive an automobile in all types of weather conditions.
 - Travel to other Choice Health at Home locations and patient homes.
 - Operate and demonstrate use of patient care equipment.
 - Additional physical demands for this position are attached.
- Physical Demands:
- blood and body fluids during the performance of job duties.
 - extremes in temperature and humidity when traveling and at non-office locations.
 - dust, gas, fumes and odors when traveling and at non-office locations.
- Risk Category 1 - May experience regular exposure to:

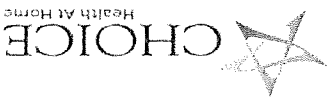
OCCUPATIONAL HEALTH AND SAFETY

Reports to: Administrator-Home Health
 Direct Reports: none
 May indirectly supervise and provide guidance to: home health office staff, home health field staff

COMPANY RELATIONSHIPS

- Job Knowledge:
- Display an understanding of job duties and responsibilities.
 - Have a comprehensive understanding of home health and hospice regulations, as applicable.
- Initiative:
- Promote the Choice Health at Home
 - purpose, guiding principle, and values in every action.
 - Demonstrate interest in professional growth and development.

Clinical Manager



Worker Printed Name _____ Date _____
 Worker Signature _____
 Supervisor Printed Name _____ Date _____
 Supervisor Signature _____

I have reviewed these additional physical demands and understand that periodically it may be necessary for me to perform physical demands not indicated here.

ACKNOWLEDGEMENT

1. Alertness	Yes	2. Precision	Yes	3. Analytic ability	Yes
4. Problem solving	Yes	5. Memory	Yes	6. Communication	Yes
7. Creativity	Yes	8. Concentration	Yes	9. Judgment	Yes
10. Imagination	Yes	11. Initiative	Yes	12. Patience	Yes

MENTAL DEMANDS

1. Mechanical	Yes	2. Electrical	Yes	3. Explosives	Yes
4. Burns	Yes	5. Chemicals	Yes	6. Fumes/gases/odors	Yes
7. Toxic waste	Yes	8. Frequent travel	Yes	9. Long/irregular hours	Yes
10. Stressful atmosphere	Yes	11. Inadequate work area	Yes	12. Moving machinery	Yes

Situational hazards that the individual is/may be exposed to definite risk of bodily injury.

HAZARDS

1. Inside work	Yes	2. Outside work	Yes	3. Noise	Yes
4. Vibration	Yes	5. Wet/Humid	Yes		

WORK ENVIRONMENT

1. Lift or transfer	0	2. Carry	0	3. Push or pull	0
a. Up to 10 pounds (sedentary)	F	4. Climb (stairs)	0	5. Reach	F
b. 11-20 pounds (light)	0	6. Stoop or bend	F	7. Crouch	F
c. 21-50 pounds (medium)	0	8. Kneel	F	9. Handle or feel	C
d. 51-100 pounds (heavy)	0	10. Talk	C	11. Hear	C
e. >100 pounds (very heavy)	N	12. See	C	13. Sit, walk, stand	C

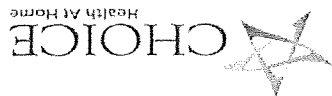
In a regular workday, worker is required to:

N=Not at all (0%) O=Occasionally (1-33%) F=Frequently (34-66%) C=Continuously (67-100%)

WORK POSITION AND ACTIVITIES

Position: Clinical Manager

ADDITIONAL PHYSICAL DEMANDS



STAFF PERFORMANCE EVALUATION

This evaluation should be completed and reviewed between the employee and their supervisor. All scores that indicate the employee is not meeting the job requirements should include supporting comments. If the category is not relevant to the employee, select "N/A" or leave the score blank.

- 5 Consistently exceeds expectations, superior, outstanding performance that consistently exceeds expectations.
- 4 Frequently exceeds expectations, strong performance that meets and frequently exceeds expectations.
- 3 Meets expectations, performance that consistently meets and occasionally exceeds expectations.
- 2 Needs improvement, adequate but supervisor has provided guidance on how to improve.
- 1 Does not meet expectations, inadequate performance that is frequently not meeting expectations.

EVALUATION INFORMATION	
Job Title:	Employee Name:
Clinical Manager	Click or tap here to enter text
Evaluator Name:	Evaluator Position:
Click or tap here to enter text	Click or tap here to enter text
Type of Evaluation:	Date of Review:
<input type="checkbox"/> 90 day <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual <input type="checkbox"/> Special incident	Click to pick date
Self evaluation	

ADMINISTRATIVE TASK REVIEW	
1. Review on call coordination note reports daily.	Choose a score
2. Review and respond to emails in a timely manner.	Choose a score
3. Provide educational material for family and staff on medical diagnoses, provision of care, and psychosocial aspects of chronic illness and disability.	Choose a score
4. Assist with maintaining provider requirements; work with providers, sales, and clinical staff to resolve issues, as appropriate.	Choose a score
5. Process workflow, coordination notes, and administrative tasks timely.	Choose a score
6. Review infection control, complaint, and occurrence reports; document all follow up. <i>Home health only</i>	Choose a score
7. Backup the intake coordinator to receive and enter referrals from payors, physicians, facilities, and staff; clearly identify who obtained the referral. <i>*if necessary</i>	Choose a score
8. Attach referral paperwork to medical record timely, as needed.	Choose a score
9. Communicate acceptance of referrals clearly with referral sources, as needed.	Choose a score
10. Backup the patient scheduler to reschedule missed and declined visits, and process reassigned and reschedule requests to ensure timely completion.	Choose a score
11. Review patient schedules and approve schedule changes to ensure clinical skills of assigned staff meets patient requirements.	Choose a score
12. Follow up on orders, as needed, when medical records is unable to retrieve the unsigned order.	Choose a score
13. Remain up-to-date on internal information announcements and ensure Choice Health policies and procedures, critical pathways, standards of care, and practice guidelines are met.	Choose a score
14. Provide orientation and in-service training to field and office staff to meet patient needs, particularly with OASIS and documentation standards; track and document education appropriately.	Choose a score
15. Assist the Administrator during any survey, as directed.	Choose a score
16. Attend and participate in staff meetings and in-services.	Choose a score
17. Attend and participate in community education functions.	Choose a score
18. Address lead measures to ensure the branch and Choice Health is able to accomplish the established wildly important goals.	Choose a score

Clinical Manager

5 consistently exceeds • 4 frequently exceeds • 3 meets expectations • 2 needs improvement • 1 does not meet

19. Participate in administrative on-call; support the on-call nurse and provide software management related to processing intake and critical workflow during off hours.	Choose a score
20. Conduct continuous quality assessment and performance improvement activities, as assigned.	Choose a score
21. Complete onsite supervisory visits, as assigned.	Choose a score
22. Assist with the day-to-day supervision of branch clinical operations.	Choose a score
23. May assume a position of leadership when the Administrator is out of the office; perform supervisory tasks, such as evaluations and counselings, or make hiring and termination recommendations for branch and field staff, as requested.	Choose a score
24. Complete all other duties as assigned. *See CM Daily/Weekly/Monthly Mgmt. duties.	Choose a score
Administrative tasks average:	0.0
<i>*Click cursor on the average score and hit F9 to update calculation.</i>	
REQUIRED - ratings of (1) (2), document comments and expectations to clarify performance improvement:	Click or tap here to enter comments
REQUIRED - ratings of (3) (4) (5), document comments on how to improve and/or continue to exemplify excellence:	Click or tap here to enter comments

CLINICAL TASK REVIEW

1. Responsible for the QA process to ensure patients receive assessment visits, scheduled and performed timely per Choice Health policy.	Choose a score
2. Assist Administrator with patient review meetings; address care decisions based on review.	Choose a score
3. Review and approve patient care assessment coordination notes submitted by case managers. Contact physicians to obtain orders for continued service provision or add-on services, as needed.	Choose a score
4. Review and approve all patient information submitted by the licensed professional.	Choose a score
5. Review orders as written by clinicians; approve or decline as appropriate. Follow up with licensed professional, as necessary, when editing an order.	Choose a score
6. Ensure all orders are complete, including frequency, and that any corrections are made by the licensed professional who wrote the order, prior to approving the order; complete any follow up tasks as deemed necessary, by the order.	Choose a score
7. Enter and approve all orders; route to medical records to be sent for physician signature.	Choose a score
8. Ensure that there are existing orders for requested medical supplies.	Choose a score
9. Enter detailed non-admit information into patient record in coordination notes if no visit was made; ensure the Administrator is informed and approves the non-admission.	Choose a score
10. Review and process all wound score deviations, documenting any action and follow up.	Choose a score
11. Review and process vital sign alert reports; document follow-up action and physician notification.	Choose a score
12. Receive lab reports and assesses for normality; fax lab report to the physician with signature indicating review. Scan both the reviewed labs and the fax confirmation page (showing it was sent to physician) to medical records for uploading into the patient chart.	Choose a score
13. Initiate employee and patient infection reports, as necessary.	Choose a score
14. Complete review of evaluation documentation, OASIS, and plans of care (POC). Review the data submitted to ensure accuracy with the comprehensive assessment, face to face, and the POC; follow up on any documentation that requires correction.	Choose a score

Clinical Manager

5 consistently exceeds • 4 frequently exceeds • 3 meets expectations • 2 needs improvement • 1 does not meet

15. Process POC and verify the correct start of care date and episode date range.	Choose a score
16. Review and verify that service utilization correlates with assessment data.	Choose a score
17. Ensure that appropriate care types and pathways are selected based on the patient medical condition and the staff assessment data.	Choose a score
18. Process unlisted supplies, medications, activity, functional limitations, and allergies.	Choose a score
19. Review comprehensive assessments that cannot be processed due to licensed professional documentation deficiencies; follow up appropriately.	Choose a score
20. Perform and maintain ongoing chart audits according to standard operating procedure.	Choose a score
21. Run Case Conference list on Friday prior to Case Conference and send to field staff for review; using SHP Einstein tool to determine improved outcomes and Kinners' Care insights for appropriate palliative/Hospice transition.	
22. May perform all duties and visit expectations of a licensed professional, as needed.	Choose a score
23. May participate in on-call rotation, as needed.	Choose a score
Clinical tasks average: 0.0	
<i>*Click cursor on the average score and hit F9 to update calculation.</i>	
REQUIRED - ratings of (1) (2), document comments and expectations to clarify performance improvement:	Click or tap here to enter comments
REQUIRED - ratings of (3) (4) (5), document comments on how to improve and/or continue to exemplify excellence:	Click or tap here to enter comments

HUMAN RESOURCES TASK REVIEW	
1. Provide requested documentation timely to keep personnel file current and in good standing.	
2. Comply with activities associated with the management of workplace health and safety.	
3. Identify and report health and safety risks, accidents, incidents, injuries, and property damage at the workplace in a timely manner.	
4. Maintain a professional relationship with all workers, interns, volunteers at all times.	
5. Adhere to Choice Health dress code at all times.	
6. Properly request and utilize appropriate personal protective equipment, as applicable.	
Human resources tasks score: Choose a score	
REQUIRED - document how to continue to meet expectations, and clarify performance improvement expectations:	
Click or tap here to enter comments	

COMPLIANCE TASK REVIEW	
1. Be knowledgeable and comply with HIPAA privacy and compliance programs.	
2. Read and adhere to the Choice Health standard operating procedures, policies and procedures.	
3. Read and adhere to the Choice Health employee handbook.	
4. Read and adhere to the Choice Health standards of business conduct.	
5. Adhere to safe driving practices, including distracted driver policy, when driving during work hours.	
Compliance tasks score: Choose a score	
REQUIRED - document how to continue to meet expectations, and clarify performance improvement expectations:	
Click or tap here to enter comments	

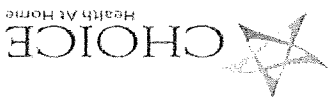
5 consistently exceeds • 4 frequently exceeds • 3 meets expectations • 2 needs improvement • 1 does not meet

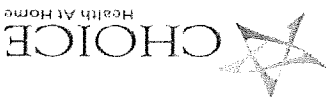
CUSTOMER SERVICE TASK REVIEW	
1. THINK - Be thoughtful, stay prepared and maintain a positive mental attitude to pave the way for great customer service.	
2. ENGAGE - Consistently interact positively and professionally when representing Choice Health.	
3. ACT - Take action to ensure all needs are met for stakeholders.	
4. MOTIVATE - Respond to excellence and encourage the culture of service to thrive.	
Customer service tasks score:	Choose a score
REQUIRED - document how to continue to meet expectations, and clarify performance improvement expectations:	

KEY CONTRIBUTIONS TASK REVIEW	
1. CULTURE - Participate as a positive contributor to the Choice Health culture, including engaging with the branch culture committee.	Choose a score
2. INTEGRITY - Engage in decision-making processes with the goal of ensuring the Choice Health guiding principle of a better way to care is honored at all times for stakeholders.	Choose a score
3. COMMUNICATION - Ensure that communication style and approach is professional at all times. Appropriately share knowledge of issues and concerns with managers.	Choose a score
4. UNDERSTANDING - Proactively ask for assistance and clarification as needed to complete all assigned job duties.	Choose a score
5. COMPETENT - Must be able to consistently meet all competencies listed in job description.	Choose a score
Key contributions tasks average:	0.0
REQUIRED - ratings of (1) (2), document comments and expectations to clarify performance improvement: Click or tap here to enter comments	
REQUIRED - ratings of (3) (4) (5), document comments on how to improve and/or continue to exemplify excellence: Click or tap here to enter comments	

KEY VALUES TASK REVIEW	
1. STEWARDSHIP - Committed to going above and beyond, never settling for anything less than excellence. Be an industry leader and challenge self to continuously improve.	Choose a score
2. EMPATHY - Take the time to understand the physical, mental, emotional needs of each other and those we support. Listen, make deep connections and engage on personal level to better serve those we support.	Choose a score
3. DO WHAT'S RIGHT - Do the right thing, no matter how difficult, even when no one is looking. Do not be afraid to have hard conversations. Acknowledge mistakes and proactively seek resolution.	Choose a score
4. POSITIVITY - Have a positive spirit and find the light in difficult situations. Bring your whole self to work. Celebrate successes and inspire others to create meaningful impact.	Choose a score
5. TEAMWORK - Work collaboratively with others building on individual strengths. Take accountability for actions and connect across teams.	Choose a score
Key values tasks average:	0.0
REQUIRED - ratings of (1) (2), document comments and expectations to clarify performance improvement: Click or tap here to enter comments	
REQUIRED - ratings of (1) (2), document comments and expectations to clarify performance improvement: Click cursor on the average score and hit F9 to update calculation.	

Clinical Manager





Clinical Manager

5 consistently exceeds • 4 frequently exceeds • 3 meets expectations • 2 needs improvement • 1 does not meet

REQUIRED - ratings of (3) (4) (5), document comments on how to improve and/or continue to exemplify excellence:

EVALUATION SUMMARY

Overall Average Score: 0.0
 Refer to attached counseling form to address performance improvement plan related to overall performance evaluation

* To update calculation of overall average score, type CTRL+A then hit F9

SUPERVISOR ACKNOWLEDGEMENT

Supervisor Comments/Goals:
 Click or tap here to enter text

Professional Development Plan/Career Goals: Professional Development
 Click or tap here to enter text

By signing, I validate the scores listed and acknowledge that I have communicated them to the employee.
 Supervisor Signature: _____
 Date: _____

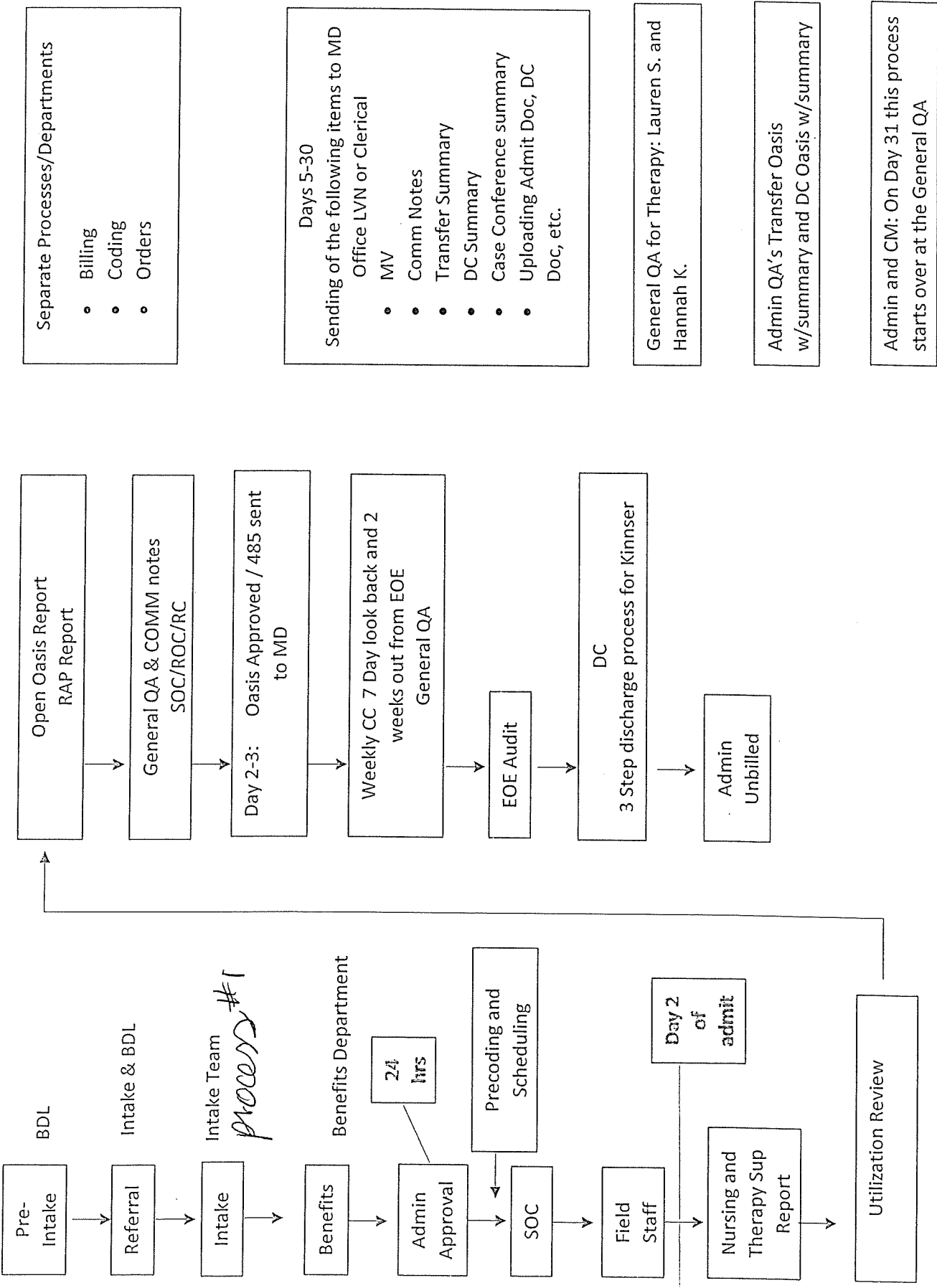
EMPLOYEE ACKNOWLEDGEMENT

Employee Comments/Goals:
 Click or tap here to enter text

Employee is encouraged to sign indicating acknowledgment of review, not necessarily agreement.
 Employee Signature: _____
 Date: _____

Office: Tyler

Tracking of patient from Start to Discharge—30 Day Cycle



Separate Processes/Departments

- Billing
- Coding
- Orders

Days 5-30

Sending of the following items to MD

- Office LVN or Clerical
- MV
- Comm Notes
- Transfer Summary
- DC Summary
- Case Conference summary
- Uploading Admit Doc, DC Doc, etc.

General QA for Therapy: Lauren S. and Hannah K.

Admin QA's Transfer Oasis w/summary and DC Oasis w/summary

Admin and CM: On Day 31 this process starts over at the General QA

PROCESS NAME:	Intake	ORIGINAL DOCUMENT DATE:	6/10/2015g
PROCESS MANAGER:		LAST REVISION:	04/20/2021
APPLIES TO:	All locations Forcura Intake User Guide	ATTACHMENTS:	Insurance Authorization Process;

Introduction

Intake is the department that receives all referrals from accounts regarding patient orders to admit at Choice Homecare. It is important that this process be uniform and accurate to ensure the patients are being admitted timely per regulations and company policy. This process is designed to be a checks and balance through each level of operation, with the result being free of errors.

Document Scope

Describe what is included. Specify also what is not included. For example:

- This document provides an overview of the INTAKE PROCESS.
- It defines the objectives, recommendations, best practices, policies....
- Use it to guide you through the steps of a referral to a patient's start of care.

Process Overview

A. Historical Overviews

Choice Rehab has grown considerably since 2007, including the development and growth of the home health agency --thus increasing the volume of referrals to start of care.

B. Process Objectives

Create an efficient, effective, and error free intake process.

C. Benefits

This process allows for a universal and objective approach to the evaluation of the success of the Intake process.

D. Users

Administrators, Director of Clinical Services, Intake department, Business Development Liaison, Billing Department, and Insurance Department

E. When to use this process

For every referral, this process should be completed.

F. Roles and Responsibilities

- Process Supervisor- COO Assessment of the effectiveness via the objective measurements created for review. Also, to coordinate utilization in the absence of the Intake Department employees.
- Process Manager- CCO & Billing Manager
- Process Driver— CHC Agency Administrators, CHC CMs
- Process Advisory Team- CHC COO, CHC CCO, CEO
- Support Group- CHC COO, CHC CCO

G. Impacts to other processes:

Describe relationships to known processes that significantly impact or are impacted by this process:
Errors with patient referrals creates dissatisfaction towards the company. It is also a loss of trust for the accounts to utilize our agency for their patients' care and financially is impacted with the involved people's efficiency.

Terms and Definitions

BDL: Business Development Liaison

RSM: Regional Sales Manager

SOC: Start of Care

DC: Discharge

ALF: Assisted Living Facility

ILF: Independent Living Facility

MC: Memory Care

Intake Week: 7 days a week. Sunday to Saturday. Regional supported intake.

Process Activities

Office LVN - Intake

The purpose of the Office LVN - Intake(s) is to facilitate referrals to the entities and to maintain the referral log daily.

1. Intake will receive referrals via the following healthcare portals:
 - a. Forcura/ECIN/Allscripts/NaviHealth (previously Curaspan)/Trinlink/Aidin/Doctors Alliance/hand-delivered referrals. Intake will have their own login for each ECIN site.
2. Any referral from an outside source (ECIN/Allscripts/NaviHealth/Trinlink/Aidin/Doctors Alliance/hand-delivered) will be printed/uploaded via DirectConnect into Forcura.
3. For all referrals, create a case in Forcura.
 - a. If Insurance referral, intake LVN needs to review referral first to be sure we want to take referral clinically. If clinically accepted move to "Pending Benefits Check" with ordering MD, Diagnosis, Disciplines expected and assumed SOC date. If referred patient is wound care, intravenous therapy, and/or deemed medically complicated by Intake. If said conditions apply, send to "Pending Admin Approval" with the correct Security Group.
 - b. If Medicare referral, send to "Pending Benefits Check" with the correct Security Group.
4. Intake will follow the remaining steps in the Forcura Intake User Guide to process the referral (attached).
5. Intake will send an email with the referral information to the following employees:
 - a. BDLs/Associated RSMs.
6. Intake LVN will be responsible for the Referral Log.
 - a. Once the referral has been processed in Forcura, the Intake LVN will enter the appropriate information onto the Referral Log.
 - b. The Referral Log should be updated at 9, 11, 1, 3 and 5, and then emailed to the following employees once Intake has completed daily tasks:
 - i. VPCO

- ii. All Administrators
 - iii. All CM's
 - iv. Scheduling Department (Nursing and Therapy)
 - v. All BDLs
 - vi. All RSMs
 - vii. President of Sales
 - viii. COO
 - ix. CCO
 - x. CEO
 - xi. Coding Department
7. Intake LVN will email the BDLs/RSMs, President of Sales, and COO the "Pending List" every morning by 10:00 am. When the BDLs/RSMs respond with corrections/admits, etc., intake will update the Referral Log and in Forcura.

Insurance Department

1. Each referral is received by the insurance department via the Intake Card in Forcura.
 - a. Insurance will check the "Pending Benefits Check" bucket for new referrals.
 - b. Benefits will be verified for each referral.
 - i. If a medicare referral, benefits will include the MCR# and anything noted on the CWF in the comments section. Attachments will include CWF, and transfer form if needed.
 - ii. If an insurance referral, benefits will run benefits, obtain initial authorization and make any necessary calls to the patient regarding financial responsibility. Attachments will include patient portas, authorization forms, financial forms and transfer forms if applicable.
2. Once authorization has been obtained benefits will move the patient back to pending admin approval. They will comment the date span, visits approved with each discipline, and any additional information provided.
 - a. If there is a delay in receiving authorization, benefits will notify intake via the comments section and send to "Pending Admin Approval". Intake will notify BDL of delay and comment they have been notified then place the patient back into pending "Pending benefits check".
 - b. Benefits will make daily calls to patients to update them on the status of their pending authorization.

Administrator/CMs/Office LVN

Workflow In Forcura:

1. Referral is placed in the Pending Benefits check or Pending Admin Approval depending on the insurance.
 - a. If referral is clinically or financially declined move to "Declined Referral"
 - b. If **DECLINED**, the BDL will be notified immediately by the intake LVN or designee through email, the BDL/RSM will call the referral source and/or patient. Intake/designee will notify BDL/RSM of reason declined and give 3 in-network providers off spreadsheet or send out spreadsheet with every declined referral.
2. Intake LVN reviews referral for complete information and/or documentation, then moves the referral to the "Pending Benefits Check" bucket on the Intake Card.
 - a. If information or documentation is missing, the BDL/Office LVN will assist with required information.

- b. PCP/Following MD is identified/Paperwork reviewed to evaluate what is needed/Face to Face determined.
 - c. If no order, fax Standard Order Request form to PCP and/or call MD to obtain verbal order.
 - d. If additional documentation is required, contact the referral source and/or the appropriate BDL/RSM and/or fax documentation request.
 - e. Intake will work referral doc from referral to completion on all admits until all technical components are met within 7 days.
 - i. Order for Home Health
 - ii. Face to Face Encounter with Supporting Documentation
 - iii. Referral Information with demographics
 - iv. Insurance Verification documents
 - v. Patient Financial Responsibility form (if applicable)
 - vi. Transfer Verification form (if applicable)
3. The Insurance Department will check benefits and move the referral to the "Pending Admin Approval" bucket on the Intake Card.
4. Administrator and/or designee will review the referral from the "Pending Admin Approval" bucket. Administrator will either:
- a. Accept the referral and move referral to the "Approved Referrals" for Medicare patients.
 - b. Intake will change Security Location to the office that will give clinical approval and leave in "Pending Admin Approval" bucket.
 - c. Patient is then moved to "Precoding" once financially and clinically approved.
 - d. After precoding, the referral is sent to "Request Initial Authorization" bucket for insurance patients; or Ready to SOC for Medicare patients
5. Notify Intake, BDL, RSM and/or Referral Source of Referral status.
- a. If **ACCEPTING**, please notify the referral source and BDL/RSM through email.
 - b. Intake will accept or decline the referral within the electronic portal if applicable (i.e., Trinlink, NaviHealth, Allscripts, Aidan, etc.)

Workflow in WellSky:

6. Referrals in the "Ready to SOC" bucket on the Intake Card in Forcura will be processed into WellSky as follows:
- a. Open a new medical record in WellSky.
 - b. If indicated, the receiving entity will coordinate with another entity to accept the patient.
 - c. Referral will be entered in WellSky and all documentation will pull from Forcura into "Intake Documents" under the Miscellaneous tab.
 - i. A complete referral should have the following documentation:
 1. Order for Home Health
 2. Face to Face Encounter with Supporting Documentation
 3. Referral Information with demographics
 4. Insurance Verification documents
 5. Patient Financial Responsibility form (if applicable)
 6. Transfer Verification form (if applicable)
 - d. Add in the Yellow Sticky note: SOC Date, Diagnoses, Disciplines Ordered, Physician's Name, Clinicians, Verification of Demographics.
 - e. Add Tasks for Consent, Eligibility Check, Face to Face.

- f. Send KMAIL to ADMINISTRATORS, CMs, CLINICAL SCHEDULER, THERAPY SCHEDULER, INSURANCE DEPARTMENT, FIELD CASE MANAGER
 - i. KMAIL SHOULD INCLUDE: Admit date, Diagnosis, Disciplines Ordered (RE: Nurse, PT, OT, ST, HHA, MSW), Physician name, and any communication indicated to promote a quick, smooth, transition for the clinicians and patients.
 - ii.
7. Administrator/CMs/Office LVN to call the patient and schedule the Start of Care.
 - a. EXAMPLE: Call should consist of: Hello Mrs. Jones, This is Trina with Choice Homecare, your physician, Dr. Ford has ordered home health to evaluate and treat as indicated. There will be a clinician calling you within 24 hours to schedule the admission visit time. Do you have any questions? If you should think of anything before you hear from a clinician, please feel free to call me @ phone number and ask for Trina. Thank you and have a great day!
8. Admin/Clinical Manager/CMs/Office LVN will email Insurance Department, BDLs, and RSMs by 10am the next day the following information for previous day/weekend admissions:
 - a. Patient Name
 - b. Admit Date Confirmed
 - c. If non admit, why? If rescheduled, what date so the referral log can be updated.
 - d. Clinician confirmation of Face-to-Face appointment if indicated.
9. Pending admissions: all pending admissions will go in Wellsky daily.
 - a. Patients will go into Wellsky into the correct location as a pending admission. You will data entry the patient in wellsky as if you are putting a patient in just do not add the SOC date patient will then be moved to pending.
 - b. Pending admission reports can be pulled by going to GO TO, Reports and admin, Pending admissions.
 - c. Patient will be moved to SOC when patient is ready to be SOC'ed
 - d. A non-admit patient needs to be made a non-admit in the pending admission by intake.
 - e. If a SOC patient is a non admit, the patient will need to be inactivated by admin, CM, intake/designee.
 - i. To inactivate patients go to Patient chart, edit, episode, click inactivate patient, update.
 - ii. Then you will need to follow the steps as above to make a non admit.
10. Pending Referrals: All pending referrals will be addressed daily via phone calls to accounts, BDLs/RSMs, Admin/CMs' if indicated. Pending referrals will not stay on the referral log longer than 7 days, except for surgical patients and if BDL/RSM is followed with daily updates.
 - a. Denote pending referral post 7 days as a NON-ADMIT
 - b. Notify BDL/RSM when pending changed to a NON-ADMIT
 - c. BDL/RSM Daily Updates via email/phone call/text to Administrator regarding pending referrals is acceptable.
 - d. Pending referral comment section is to be updated daily during the 7 day follow up process.
11. Playmaker -
 - a. When a BDL adds a new account to their list intake department needs to add that account to Wellsky immediately as an external referral.
 - b. External referrals also need to be added to Wellsky anytime they are not listed as an option.

- c. When you need to add an external referral to WellSky you will need to go to File - New - External Referral and add in all information and tie the BDL to that account.

Best Practices

Remember each patient's admission is important, and the ultimate goal is to ensure the utmost accuracy with Choice Homecare services at all times. If an error is made on referral/intake, it is expected for intake to promptly correct the error; all while maintaining a professional and courteous attitude with the patient and/or referring account.

Tools to Use:

1. Forcura Software
2. WellSky Software
3. Electronic Intake Form
4. Standard Order Fax request form
5. Documentation Fax request form
6. All Fax emails noted and All ECIN/Allscripts accounts noted above
7. Electronic Surgical Calendar
8. BDL/RSM Account List
9. Patient Financial Responsibility form
10. Transfer Verification Form
11. Allscripts
12. Trinlink
13. Doctors Alliance
14. Aidin
15. Navi Health

Communication

Each level should communicate any issues or discrepancies immediately to guarantee the resolution on the Intake Referral log and Patient's admission. Also, when an error is made, it is important to always follow up with the BDL/RSM and patient to ensure they received satisfaction with our services.

Training

Orientation to this process should take place for any persons that are tasked with performing this process at any time. It is recommended that the COO, CCO, Billing Manager, Case Managers, Field Case Managers, Administrators, and all departments be trained on all processes.

Recommendations

A. Critical Success Factors

Ensure that each step is followed precisely to reduce any chance of error with the Intake Process resulting in customer satisfaction.

B. Implications

Completion of the workflow as indicated, meeting the set time frames, along with meeting the goal of an error free intake process are criteria for involved employee's annual review.

Metrics and Process Verification

A. Process Verification Plan

Referral Log will be reviewed daily and emailed to BDLs, RSMs, Administrators, CMs, Billing Department, Insurance Department. Referral log will be reviewed for accuracy regarding Patients being assigned to the referral log with SOC Dates & Communication if indicated. If anyone contests the accuracy of the Referral Log, an email should be generated within 24 hours of receipt of contested referral log. BCC the following people on the referral log daily President of sales, COO, CCO, VP of clinical operations, and COO of Rehab.

B. Measurements

Referral Log will be reconciled continuously throughout the day by Regional Intake office LVN.

All Referrals Admitted within 24-48 hours= Compliance with CMS & Company policy

ALL SOCS scheduled=Happy Customers

Intake notes:

All start of care admissions are required to be admitted within 24-48 hours once the order is received per Company policy. If a patient refuses admit within the policy timeframe of 24-48 hours a new order must be written to initiate the start of care for the patient. Administrators are required to notify the BDL/RSM of any order changes made outside the 24-48-hour window resulting in a new Start of Care Admission date.

In the event a patient is admitted outside the 48-hour window and order received for the new Admission date: Administrator to notify Start of Care Clinician and QA via sticky note attached to SOC OASIS in WellSky of Physician Order Start of Care date to answer OASIS MO102.

BDL/RSM will notify the account/referral source. Administrator is to notify the patient and KMAIL ADMINISTRATORS, CLINICAL MANAGER, SCHEDULING, THERAPY SCHEDULER, BILLING MANAGER, INSURANCE DEPARTMENT, & FIELD CASE MANAGER with new SOC date and that order has been written.

Process Change Control

Any changes to the process should be reviewed by the Choice Homecare COO and CCO and then approved by the CEO. The CEO, COO, and CCO along with the administrator may propose changes. Again, all proposals must be reviewed by the COO and CCO, AND then approved by the CEO. The administrator and other involved employees must sign and be in-serviced on any changes prior to implementation. Any changes should include an implementation process to include the changing of necessary workflow and employee training PRIOR to implementation.

Contacts

COO: Trina Lanier

CCO: Brenda Bryant

CEO: David Jackson

Approvals

Obtain required sign-offs for this document version. Delete or add signature lines as needed.

Name	Role	Signature	Date

Surgery/Bundle Referral Process:

Same referral process as above with the following exceptions:

Bundle Frequency must be noted in KMAIL to ADMINISTRATORS, CMs, SCHEDULING, THERAPY SCHEDULER, BILLING MANAGER, & FIELD CASE MANAGER, with Protocols attached to SOC visit.

Intake notes the Surgery Admit date on the Surgical List on the share drive. Surgical List is emailed out daily by 5pm for BDLs/RSMs to approve.

BDL's call surgery patients BEFORE surgery and VISIT/CALL PATIENT/CAREGIVER POST SURGERY.

Intake LVN and/or designee calls the Surgical Hospital the day of surgery and speaks to the Case Manager/Social Worker/Discharge Planner stating:

Example: Choice Homecare is following "Mrs. Patient", please let us know if you need anything prior to dc and when dc is appropriate please call "entity @ phone number" and fax paperwork to "@ fax number."

.....

Choice Homecare CODER-QA Process

- Start by going into the QA Manager
- Type OASIS in the "Filter by Search" bar - this will bring up all the oasis from oldest to newest. (if just starting into a new office please start with the oasis that is NOT coded this will allow you to start with a full oasis to Code and QA) you can run your cursor over the yellow sticky notes this allows you to see if the oasis has already been coded if it has already been coded then it has already been assigned to a QA reviewer.
- Once you have chosen a starting place please mark in the yellow sticky "Coder/QA reviewer initials" so that the oasis has been flagged as being worked on.
- **With a SOC** – you will want to check for the following: SOC order present; Current H&P/DC Summary etc.; F2F present in chart; Accurate Consents uploaded to chart(if in a CHAP accredited office then a CHAP consent must be present -this being the 4th page of the consent has the CHAP statement in **BOLD** print), The Emergency Prep with disaster and triage codes uploaded to chart.

1. **HINT:**

ORDERS:

- Is there a SOC order (Ensure the order meets regulations)
- If the order is in the referral and meets regulations an additional order does not need to be written/taken

H&P:

- check referral date/paperwork faxed to Choice
- if using the order within this paperwork for SOC check to make sure it is within compliance with disciplines stated, signed and dated by the MD, date with the correct timetable for SOC
- look for wound care, IV, shunts, diabetes, injections, lab draws, new medication started, new pacemaker

FACE TO FACE:

- Diagnosis match the reason for admission

CONSENTS:

- (if in a CHAP accredited office then a CHAP consent must be present -this being the 4th page of the consent has the CHAP statement in **BOLD** print) CHAP offices are Austin, Webster and CP Tyler
- **With a RECERT** – you will want to check for the following: F2F is uploaded to the chart (if not present then administrator needs to be emailed); the accurate consents are uploaded to the chart
- **With a ROC** – you will want to check for the following: F2F is uploaded to the chart, Hospital/Rehab etc. documentation is uploaded to chart
- When beginning to Code –

2. **HINT:**

- First step to take when opening the Oasis: Read the narrative before starting with page 1 of the Oasis Review—you can gain further knowledge and or realize mistakes instantly by reading the narrative **FIRST!!**
- **Complete Coding per Guidelines**
- **Once Coding complete -> into the QA Review**
- **1st Run Oasis Check and PPS PLUS analytics**

PRIORITY ITEMS FOR ALL OASIS

Process Measures –

- M0104 Timely initiation of Care - SOC/ROCs - must be within the 48hr window (M0104)
- M2010 Drug Education
- M2020 Management of Medications
- M1041 Flu Vaccination (RISK PROFILE Seasonal)
- M1730 Depression Screening

Outcome Measures –

- M1242 Pain
- M1400 Dyspnea
- M1830 Bathing
- M1850 Transferring
- M1860 Ambulation

3. HINT:

- If any of the above items have recommendations made to the nurse and reason behind the recommendations and the nurse does not take the suggestions or make the accurate changes the ADMINISTRATOR MUST BE NOTIFIED.

➤ General Oasis Information required for QA (Guidelines)

- Medical Record # present for every patient
- SOC date matches the SOC date of the episode (either the SOC oasis or therapy evaluation whichever comes first)
- M0090 Date is either that same as the Visit date or within 5 days of the visit date
- If No SS# is present, then the check box NA must be checked
- M0102 has a date -Physician requested SOC date or *****M0104 is within 48hrs of SOC**
 - **Date (verify an order is present for either answer) M0110 has the accurate selection - early / late episode timing _____**
- Ht/Wt/V/S all documented -Abnormal reading reported to MD and documentation present to support
- V/S parameters listed per policy unless ordered by MD specific parameters
- Past Medical History checked off and listed appropriately
- Risk Assessment
- Vaccines Documented as appropriate
- Advance Directives Documented
- Functional Limitations
- Safety Measures
- Triage and Disaster Codes present
- Homebound status checked appropriately

*****M1242 Pain Scale***** (reflects ability to show improvement if Pain is present)

- Per Pain Policy – equal to or greater than 7 the MD must be notified
- Integumentary - Follows the Coder's guidelines with accurate answers to Pressure Ulcers/Stasis Ulcers
- Wounds/Incisions Documented Accurately with Wound care / Incision Care Documented as performed (Location/Measurements/Description)

*****M1400 Respiratory***** (reflects ability to show improvement if Dyspnea is present)

- If patient is on dialysis the following must be documented: Shunt/Graft site, Bruit/Thrill present, what facility dialysis is done at, name of nephrologist
- Cardiac Section – if patient has a pacemaker – who checks is and last and next check
- Diet selection per MD orders and diagnosis specific
- **M1700 Depression** (this must always be marked **YES**, we have 3 types of depression scales that the nurse utilizes)

- **ADLS:** This section reflects several **OUTCOME Answers** (if the clinician does not choose to take the recommendations then the Administrator must be notified to query clinician regarding any discrepancies in documentation either selected answer or supporting documentation)

Make sure the selected answers are appropriate according to supporting documentation. These questions are targeted to set the baseline for the patient and to help develop a POC focused on improving the patient's functional status over the course of the admission. If these questions are not answered appropriately at SOC and/or ROC it skews the data and adversely effects the data collected at DC.

******M1830 – Bathing**

- ******M1850 - Transferring**
- ******M1860 - Ambulation**
- *****M2010** Education on High Risk Medications
- *****M2020** Management of Oral medications must be answered appropriately to show improvement
- M2200 needs to have the accurate number of therapy visits selected, if the evaluation is not completed the selection should reflect 007
- Standardize Tools should all be completed (Fall risk, Braden scale, depression scale)

- **FREQUENCIES**

- Nursing Frequencies should reflect appropriateness and follow the frequency overview, if clinician is wanting more the administrator must approve, if frequency is less then ok to approve.
- The HHA is not allowed to be over 3 weeks and only 2 x a week (never 3) and then must show a decline in visits per week unless admin approval.
- MSW freq should always be 1m1 if order
- Therapy Frequencies should be on the Oasis if evaluation has been completed
- If the initial order has listed out multiple disciplines and the disciplines that are not warranted must have an order written or stated that on the MD statement in the oasis that the following disciplines are not warranted at this time and MD notified. EXAMPLE: SN, PT/OT/ST ordered and only SN and PT see the patient the therapist/nurse needs to notify MD and have a statement on their oasis or evaluation and MD notified that the additional disciplines are not warranted at this time or an order needs to be written

- **Interventions and Goals:** Items that must be included at the minimum
 - Emergency preparedness
 - Primary / secondary Diagnosis
 - Pain
 - Braden <18 PUP
 - Wound / Incision care orders
 - Diabetic measures, Blood Sugar Checks, Med administration, Foot Care,
 - O2 SAT
 - Falls
 - Medications including high risk meds
 - Depression I/G along with the Depression I/G each visit s/s present not present
 - Blood thinner - Q visit inspection if s/s of bleeding present
 - Anticoagulation if on coumadin/warfarin with PT/ INR checks as ordered – next due on ??
 - Weights / Measurements on all CHF, COPD, Dialysis, Edema
 - All goals and interventions must be extended as necessary for recerts, all must have target dates, all must NOT generic BUT patient specific.
 - For episodes where SN completes the SOC OASIS, and that are therapy only or only have 1 or 2 nursing visits, ALL the interventions to assess and to teach must all state either "clinician" or "SN/Therapist".
 - Process measures - referring to all the conditions that CMS tracks and/or reports to the public, and affect the agencies Star rating. They include pain assessment and management, pressure ulcer prevention, depression monitoring, fall prevention, Diabetic foot checks/care. Also important is the medication reconciliation and the patient's knowledge of all meds, along with High risk medications

HINT:

- At Recert, you do not have to keep adding all the process measure interventions if they have been instructed, understood by patient/caregiver and DOCUMENTED AS SUCH since the SOC or the most recent ROC. Wellsky makes it easy to mark interventions as completed, so you should be able to look back and see what has been instructed with completion and what has not. If there are process measures that have not been completed, add the interventions for them on the Recert OASIS.

➤ **Narrative**

- Focus of care and skilled need is documented, is patient specific, and matches reason for HH as per F2F documentation
- Plan for all disciplines involved in patient's care
- Homebound Status is clearly documented and supports both required criteria items
- Coordination of Care with physicians, care team and caregivers documented as appropriate - example SN spoke with Dr. Joe at 0830 regarding patient SOC, disciplines, and frequencies. Documentation clearly supports medical necessity Prognosis and Rehab potential documented.
- Recerts- must reflect a different narrative than the previous.
- Narratives should be patient specific

- Recert statement must be present on all Recertification - including the words “continued need”
- Medication Reconciliations must be completed for all oasis - if it is a CHAP office the Nurse must complete the reconciliation NOT the Therapist.
 - Must have O2
- Consents
 - must be present with all sections completed accurately, signed by the patient/POA and the clinician.
 - CHAP Accredited offices must have the CHAP Consent (Austin, Webster, and CP Tyler)

Oasis Submitted with Signature after Return for Reviews with corrections

1. If the Oasis is submitted with signature and **NO** corrections were made from the recommendations on the return for review - 1st time – send back to clinician for corrections
2. If the oasis is submitted with signature without any of the corrections made from the recommendations, then (2nd time) - an email or phone call to the Administrator/ designee needs to be notified immediately. (this however does not mean that it is now in the Administrators hands to QA the Oasis – this just means the administrator/ designee is responsible for talking/meeting with the clinician to go over the return for review)
3. If the Admin/designee is not successful with the clinician, then they will notify VP of clinical Ops who will reach out to the Clinician with a verbal conversation.
4. When the clinician has had the education/communication and all corrections have been made and justified then the Admin/designee will email the Coder/QA reviewer that the oasis is ready for the 2nd round of QA review from the return for review recommendations
5. If the PT therapy frequency is not in the freq. section and the nurse just missed putting it in, please just add it and the number to the 2200 section
6. If small wording needs to be added to the I/Gs for accuracy – go ahead and add it
7. If a process measure I/G needs to be added – go ahead and add it if that is all that is missing

****NEW **** On all SOC and ROCs - once all the QA coder process has been completed and the Coder is ready to approve the oasis and assign 485 or post hospital order - THIS IS WHERE THE ADMINISTRATOR TAKES OVER EFFECTIVE 2/8/2020

CODERS WILL NOT APPROVE A SOC OR ROC OASIS WHEN IT HAS COME TO THAT TIME POINT - ALL ADMINISTRATORS ARE RESPONSIBLE FOR THE APPROVING OF ALL SOC AND ROC OASIS AFTER EACH HAS BEEN LOOKED AT AND THE TRACKING LOG HAS BEEN FILLED OUT. IT IS NOW THE RESPONSIBILITY OF ALL ADMINISTRATORS TO KNOW WHERE AND WHAT YOUR OUTCOMES AND PROCESS MEASURES START AT AND END UP AT.

CODERS WILL STILL ASSIGN THE 485 AND THE POST-HOSPITAL ORDER TO THE CLINICIAN AT TIME OF READY TO APPROVE BUT JUST NOT APPROVE THE OASIS.

Once the SOC/ROC is ready for admin approval in the yellow sticky note under details please add “initials and ready for admin approval”

THE RECERT AND SCIC PROCESS HAS NOT CHANGED - CODERS WILL STILL APPROVE THE OASIS AND STILL ASSIGN THE 485s and SCIC ORDER.

- If the Patient Specific goals are on the oasis, they should be in Patient language – these being ones that may be unrealistic but what the PATIENT specifically wants to achieve. EXAMPLE: I want to be able to walk 2 miles again; I want to be able to go to the Casino again; or I want to be able to feel safe in the shower again.

*****This is a CODER / QA Review only NOT a COMPLETE CHART AUDIT – if you find items that need to be addressed just email the administrator or designee. *****

Kmail the Clinician
Email Administrator / DOCS
All Emails are with first name, last name @choicetx.com

Tyler -Sheri Shelton
Palestine - Michelle Rayburn
Lufkin - Michelle Rayburn
Austin - Lorry Snyder
Dallas - Nora Mettlen
CP Sulphur Springs - Juanita Buchanan
Houston - Deb Tomlin
Baptist -Katie Mathews
Longview - Toledo Montgomery
NTMC - Barbara Rohrbough

You can add Amber Taft to all the emails as necessary

V/S Parameters	Above	Below
Temp	100.5	95.0
Heart Rate	100	55
Respirations	28	12
Blood Pressure	170/90	90/56
Blood Sugar (Fasting)	250	60
Blood Sugar (Non-fasting)	300	60

See Freq. Overview for the recommended Frequencies

OASIS Coding/QA process from Clinician perspective

1. Clinician to complete the SOC/ROC/RECERT/SCIC (within 24 hours doc policy) sign and submit it for Coding/QA to be completed.
2. Coding/QA team member will complete coding and QA review and send a kmail with an attached coding review sheet with all coding listed out and any recommendations or areas not completed listed out for review of the clinician.
3. The clinician is required to address recommendations for review/change noted on the coding/corrections sheet, within 24 hrs of receipt from coder. When issues are addressed, the clinician will sign and submit the oasis again for it to go into the QA manager.
 - If the clinician has questions on the review sheet for the coder then a kmail can be sent for clarification or the coder can be contacted via phone.
4. The Coder then will review the oasis from the review sheet checking for any corrections. If the clinician is in disagreement with the Coder, you can document that response in a different color text prior to returning to the QA Manager. (this process may go on for 2+ times if necessary but the goal is to get the issues addressed on the first "pass through")
5. Once the Coder has approved the oasis the following will occur.
 - The 485/post hospital orders/scic order will be assigned to the clinician that completed the oasis
 - If the oasis is a SOC/ROC – the Coder will place in the yellow sticky that the oasis is ready for admin approval – at this point the admin will go in and review all process measures and outcome questions for tracking
 - If the Oasis is a Recert/SCIC the Coder will approve the oasis
6. The clinician will complete the 485/Post hospital/SCIC making sure the following is accurate
 - Frequency is accurate with "week of" included in the freq.
 - The SOC/ROC date to be included in the frequency
 - The Oasis Narrative with Homebound statement and medical necessity is added into the 485 under the frequency
 - All intervention and goals are present and "clean up" has occurred with any extra wording present
 - Once all has been completed sign and submit for QA review (Do not Approve)
 - The Administrator will approve the 485/Post hospital/SCIC.

FREQUENCY OVERVIEW



These recommendations are guidelines for the MAXIMUM number of visits in these categories without additional documentation regarding need.

1

Cardiac/Pulmonary Post Acute/IRF:

SN 2wk2, 1wk1, 1QOWk6** (<=/8 visits)

PHILLIPS Ordered if Cardiac Dx

CHF Teaching if identified diagnosis

THERAPY 2wk5, 1wk3 (<=/13 visits)

MSW 1m1 – follow program out lines, identify E/M/L(not for IRF unless circumstances present a need)

HHA only on need and DOCS approval

2

Cardiac, Neuro, or Pulmonary Post SNF, Chronic DX Admit, or 2nd+ Cert

SN 2wk1, 1wk2, 1QOWk6** (<=/7visits)

PHILLIPS Ordered—HOWEVER if second cert continue only up to 30 days and phase to self-monitor

CHF Teaching if identified diagnosis. Teach based on test outcomes if second cert (focus on improving low grade areas)

Therapy 2wk3, 1wk1,QOWk4 (<=/9 visits)*HEP!!!

COPD Program 2wk3,2wk1,qowk4 (<=/10 visits)

MSW 1mo1 if new admission /readmission/or significant decline – follow program outline identify E/M/L

2nd cert 1w2,0w1,1QOW6 if only discipline and need additional support then add 1 to 2 HHA visits -or - SN 1w3, 1QOW6

HHA only on need and DOCS approval

3

Ortho Post Acute

(if Bundle follow order exactly!!) If not:

SN 2wk1, 1wk1 at Staple or suture DC*

DC Nursing following staple * suture removal if pain is under control. DO NOT EXCEED 5 Nursing visits on orthos patient without DOCS approval

Therapy per MD guidelines--Teach ice, elevation, and movement MAX 16 if not Rx

Discuss with patient and evaluate need for HHA. If needed HHA for no more than 6 weeks

Ortho Post SNF/IRF or Second Cert

4

(if Bundle follow order!!) If not:

SN: 2 SN if staples have not been removed. *DC Nursing following suture removal if pain is under control and NO SECONDARY COMPLICATIONS. DO NOT EXCEED 5 Nursing visits on ortho patient without DOCS approval

Teach ice, elevation, and movement

Therapy 3wk1,2k3,1wk4 (13 visits) HEP!!!

If Hypertensive Phillips x 2 weeks for BP

Discuss with patient and evaluate need for HHA. If needed HHA for no more than 3 weeks

Ortho Post ACUTE/SNF/IRF or Second Cert with SECONDARY DIAGNOSIS (CHF, COPD)

5

(if Bundle follow order exactly!!) If not:

SN 2wk1, 1wk2, 1QOWk6 *Staples Out day 14

Therapy 3wk1,2k3,1wk4 (13 visits) HEP!!!

MSW 1m1 if secondary Dx present and there has not been a previous MSW eval

2nd cert 1w2,0w1,1QOW6 only discipline and need additional support if then add 1 to 2 HHA visits -or - SN 1w3, 1QOW6

PHILLIPS Ordered—HOWEVER if second cert continue only up to 30 days and phase to self-monitor

CHF Teaching if identified diagnosis. Teach based on test outcomes if second cert (focus on improving low grade areas)

Neuro Post Acute

6

SN 2wk1, 1wk2, 1QOWk6** (<=/7 visits)

NURSE Calls (scheduled opposite of visits in each week): 1wk1, 2wk6, 1wk1

Discuss with patient and evaluate need for HHA.

MSW 1m1 – follow program out lines, identify E/M/L

THERAPY Based on Severity (exceed 16 visits only with coordination of DOCS)

These are protocol outlines. You may go outside these protocols only with thorough documentation of your reasoning and ADMIN/DOCS approval. IF YOU HAVE QUESTIONS ASK ADMIN/DOCS!!

*OBTAIN ORDER FOR SUTURE/STAPLE REMOVAL

** (QOWk4= 0wk1,1wk1,0wk1,1wk1)

Choice Homecare

Authorization Process

Created 8/8/2018

Updated 09/14/2020

1. Intake receives insurance referral and works up according to Intake Process.
2. Once patient is entered into the obtain initial auth box in Focura:
 - a. Authorization is requested-
 - i. SOC does not occur until authorization is obtained.
 - ii. If pending authorization all information is entered into focura including, pending reference #, where to fax clinicals, approximate time for approval.
 - iii. If authorization is denied, intake is notified and referral is moved to "Declined Referral"
 - b. Authorization is approved-
 - i. Authorization information is entered into the notes section of request in Focura. Details will include date span, discipline with count, authorization number and any additional information that is needed.
 - c. Intake will enter the approved authorization information and notes into Wellsky after entering the referral.
3. Reauthorizations
 - a. After Intake completes entering in referral they will then place the patient into "New SOC scheduled" in focura.
 - b. Reauthorization LVNs review charts in "New SOC scheduled" daily to see if SOC and 485 and have been completed.
 - i. Once completed, they request the remaining visits to complete the 485.
 1. Once approved, the patient is moved to "ready to schedule" and our scheduling team then plots visits based on authorization approved.
 - ii. If we have already obtained enough visit to cover what is requested on 485 the case is then archived.
 - c. PRN Visits, SCIC, ROC or any additional visits needed are sent "Additional Authorization Request" by our scheduling team. They provide the order or information to where the request was generated.
 - i. Authorization LVN review orders and send for additional requests.
 1. If request is approved patient is moved to "ready to schedule"
 2. If request is denied exact details as to why the request was denied are provided to scheduling and admins via email.
 - d. Recertification authorization
 - i. Scheduling sends "Additional Authorization Request" for the new cert period.
 1. Authorization LVN awaits the recert Oasis and 485 for the new cert period to be complete.
 - a. If request is approved patient is moved to "ready to schedule"
 - b. If request is denied exact details as to why the request was denied are provided to scheduling and admins via email.

The Scheduling Main Process:

- Intake notifies scheduling dept of new admission.
- Scheduler identifies appropriate RN and informs intake.
 - Scheduler adds the visit to the spreadsheet schedule, as it is updated throughout the day.
 - In the event that an appropriate RN is not available, or RN unknown/unconfirmed, intake assigns to the admin.
- After an RN completes a SOC, ROC, RC, or SCIC visit, they are to send a Hangouts message with the new frequency to the Nursing Scheduler and/or send a k-mail, attached to the chart. They should also save this frequency in the document before leaving the patient's home.
 - It is recommended to send a Hangouts message for anything daily or anything that needs to be scheduled right away.
 - K-mail alone is ok for weekly or less urgent visits.
 - In the message, it is important to identify if specific days are needed, if labs need to be drawn on certain days, if it is RN only, or any other pertinent information.
 - If a SOC, ROC, RC, or SCIC is completed over the weekend and requires a Monday visit, the RN should notify the admin to schedule or schedule it to themselves.
- If additional authorization is needed, scheduling will submit a request in Forcura. From there, it is in the hands of the insurance department until an answer is provided. Admins should review the spreadsheet provided by the insurance department for additional inquiries as to why there may be a delay in obtaining authorization.
- If a same day SOC/ROC or PRN visit is called in or ordered, the scheduling department will assist in identifying the most available/appropriate clinician.
 - The admin will then notify the clinician of a visit being added.
 - The spreadsheet schedule will be updated by Scheduling.
 - No PRN visit is to ever be scheduled without first writing an order. The order should have an effective date and a reason for the PRN visit.
 - If new wound care orders are received from the MD that will change the patient's SN frequency, a separate clarification order should be written to identify if there are specific days that SN will provide care vs caregiver, and the effective date and duration of the new frequency.
 - If lab orders are received without an effective date, it needs to be determined how soon they are needed and Nursing Scheduler should be notified. If they are needed in the same week and a visit is already scheduled, they should be drawn then. If they are needed in the same week, and there is no visit available, an order must be written for a PRN visit. If it can wait until the following week or the next available visit, this needs to be communicated to Nursing Scheduler so there is no question.
- In the event of a call-in, the coverage is the admin's responsibility. The admin will communicate the changes that are made to scheduling or the changes that need to be made.
- Scheduling re-pulls fresh reports between 2-3 each day to catch anything that was added to Kinnser and not captured on the spreadsheet. This is updated around 3 each day. It is the

same spreadsheet all week long. All morning tabs are hidden in the afternoon and the previous day's afternoon tabs are hidden each morning.

- Admins are to review the schedule promptly and identify visits that need to be reassigned by highlighting the row in yellow and writing in the right margin what change needs to be made, i.e. to a different clinician, to a different day.
 - All changes need to be marked by 430 and a reply to Nursing Scheduler should be sent each day by 430 that the schedule is approved.
 - Any changes that need to be made after 430 that affect the following day need to be completed by the admin.

Miscellaneous Notes:

- Nursing Scheduler should be consulted prior to any PTO being approved to ensure there is proper coverage.
- Every effort will be made by the Schedulers and the Admins to assign visits to full-time staff before utilizing PRN staff.
- When there is a possibility of a patient being hospitalized, the designated person for the office that provides the care to the patient should make every effort to locate and learn if the patient is admitted or under observation.
 - If admitted, that designated person should send an email to Nursing Scheduler and Amy Davis with the date of admission, which hospital the patient is in, and any other pertinent information.
 - If the patient discharges from the hospital to a different facility, the designated office person should again email Nursing Scheduler and Amy Davis with this information.
- When a patient is denied additional nursing visits by their insurance provider, the insurance department notifies all involved parties via email.
 - If a patient has a limited number of visits remaining, the admin should review the patient's chart and determine if a frequency clarification order is needed due to an extended delay in obtaining auth or in an attempt to avoid a LUPA.
 - If all remaining visits are denied and there are none left, the admin should identify whom they want to complete the final DC visit or to backdate a DC document and either schedule it themselves or notify Nursing Scheduler of the clinician and date to schedule via replying to the email.
- If a patient receives authorization after an extended period of time and there are missed visits per the current frequency, Nursing Scheduler will email (both if necessary) the admin caring for the patient and the admin over the office that the patient is in.
 - Nursing Scheduler will inform the admin(s) of the number of visits missed and request a clarification order if needed.
 - If missed visits are to be written, the admin will identify the clinician they choose to complete those tasks and notify Nursing Scheduler to assign them as Missed Visits.
 - If an order is needed, it should be written, then the admin will reply back to Nursing Scheduler and Nursing Scheduler will assign per updated frequency. The order should include an effective date and duration.

Additional Observations:

- I don't think nurses notify admins of missed visits. If they do, then I don't think the admins are looking at the chart. I've been coming across more charts that have missed visits and LUPAs on these 1W3 QOW6 frequencies when that 2nd visit is missed. This also has an affect on insurance patients that are needing add'l auth. If a patient has a MV, that visit needs to be rescheduled before Hollie can request. Sometimes, Hollie lets us know this and it may be hours before we see it, then it's hours or maybe days before Hollie can come back around to it. If those visits are rescheduled right away, this would decrease the lag time in getting auth requested.
- Also, I don't think admins are reviewing LUPAs and the chart before approving OASIS. If they were, I'm not sure why we are starting out episodes with LUPAs... I came across a new admission last week that was nursing only with 1W3 QOW6 but LUPA was 5/2. So freq should have been 1W5, QOW4.
 - I have stopped identifying these because nothing ever changed. If there is a different channel you'd like me to take, I'd be happy to do it.

I would like to add to the part about hospitalizations. On a regular basis I see "Patient Hospitalized" as the reason for a missed visit, and nothing is done about it. Whoever is QA'ing missed visits and/or completing them, needs to be the one to start the process of tracking the status of the patient with the first step being to notify nursing and therapy scheduling. (Amy)

RAP PROCESS effective 1.1.2021

- Administrators or designee will complete the following steps/task each morning:
 1. As part of Daily management - when reviewing for the Start of Cares having a frequency either plotted or in the oasis the Time in, Time out, and SOC date is in the oasis and saved along with the primary DX in the patient profile assigned
 2. The Open oasis Report will be pulled Daily exported to Excel and all Start of cares not in at least "Saved" format will be contacted for update
 3. The RAP report will be run for the "Not Ready" tab to review the days to RAP number and action taken for any setting at day 1 without a time in and time out, date saved and Primary DX listed.
- For any SOC that does not have time in, time out, date assigned, and primary dx in the patient profile list the Admin and or Designee will contact the clinician immediately for status update on the oasis.
- Communication between the Admin and or designee with the Billing department on any oasis which will not move over is key and needs to be escalated to the VP of Clinical Operations.
- A RAP report will need to be update daily with the Billing report that is built on Monday's

Additional

- Scheduling will act at the 2nd check on the open oasis when they are reviewing for Frequencies.

Weekends:

- Administrator on call will need to be reviewing all open oasis reports for SOC being completed by the 9am documentation time (oasis at least has to have a time in time out and date of service
- If a SOC is not have time in, time, out and date of service then the admin on call contacts the clinician for completion
- Once the oasis has been saved with time in, time out, and date of service the admin on call will contact the week oncall bill to notify ready for RAP submission

NOTE:

- If PT only admission with a nursing oasis data collection the PT eval will be the identifier for the RAP first billable visit and will need to verify completion by 9am the next morning.
- The admin will need to be aware of all therapy only admissions with nursing oasis data collection

Billing Process - RAPs and EOE

Weekly Billing Cuts off at 4pm on Thursday

Raps -

- All RAPS billed Daily by the Billing Department
- All Administrators and or Designee will follow the 1.1.2021 RAP process (separate form)
- Once a RAP pulls to the Ready Tab the Billing department will bill
- Reports to be pulled Daily and worked by the Administrator and/or Designee:
 - Open Oasis - Sorted by Start of Cares
 - Billing Manager - RAP Report - "Not Ready" tab
- The "Not Ready" Tab will be pulled to your Weekly Billing spreadsheet that is built in Google Sheets on Friday and updated Daily

EOEs -

- Fridays start the first day of a new billing week
- EOE's need to be pulled from the "Not Ready" tab and the "Ready" tab to your billing worksheet.
- The "Ready" tab is called the "GreenLights" - under this tab you will see check marks out to the right and when you hover over the check mark it will have all items needed to bill the EOE lit up GREEN. These are your easy to work EOE billing audits that can be sent into billing daily.
- The "Ready" tab or Greenlights should be pulled daily and updated in your billing worksheet
- The "Ready" tab will also have ones that have pulled to the report that are not ready with Green Lights these also will need to have a billing audit completed on EOE and the audit held till it is ready to be billed.
- The "Not Ready" tab will be worked weekly also with a billing audit completed on each EOE that is listed under the tab.
- For each Billing audit that is completed a comment is to be placed in the billing worksheet that is holding up the claim. This is for "Not Ready" and "Ready" tabs
- The EOE Billing Audit sheet must be utilized when an EOE billing audit is being completed
- The EOE billing audit is Also Called "Triple Check EOE Audit" - this means that the EOE will initially be audited by Admin or Designee starting the EOE audit form. Once the EOE appears to be "Ready to Bill" the Admin or designee will then complete a second audit on the EOE utilizing the same form. The 1st and 2nd check must be completed by 2 different people) The third check will come from the Billing department before they push the button to bill the claim.
- When a billing audit has gone through the 1st and 2nd checks and is "Ready to Bill" a email needs to be sent with the following information
 - Email sent to your assigned billier along with the billing manager
 - The subject line needs to state: "Location" EOE ready to bill (Example: Tyler EOE's Ready to Bill)

- The body of the email needs to have the patient's name and the billing period that is ready to bill
- The biller will complete the 3rd billing audit on the EOE Claim and if the claim is ready to bill the biller will push the button
- The biller will “reply all” on the billing email sent in with comments out beside each patient sent in if the patient was “billed” or if they found something in their 3rd billing audit what was found and needs to be correct or completed

Example:

Super Man 4/30 to 5/30 Billed

Spider Man 7/20 to 8/20 Needs RN co-signature on order 7/30

Bat Man 2/24 to 3/22 Billed

Wonder Woman 10/8 to 11/8 Signed 11/8 PT re eval not uploaded

- The Admin or Designee is responsible for addressing the items that the billing department finds. Once the items have been addressed and ready to bill the admin or designee will resend email that the EOE claim is not ready to bill.
- If the claim is not able to be billed due to the findings of the biller the claim must go back onto the billing report with a comment on what is needed and continued to be worked until able to bill again

Additional Items:

- If the Claim is Ready and only waiting on the PCR tracking # you still send this EOE in on the Ready to Bill email with the comment out beside it “Needs PCR”
- The Biller will add it to their spreadsheet to bill once the PCR tracking number is back and on the chart

Patient: _____ Episode Dates: ____/____/____ to ____/____/____

DR: _____ Lupa Threshold 1st30 days ____/ 2nd 30days ____

SN freq: _____

PT freq: _____ OT/ST freq: _____

HHA freq: _____ MSW? _____

1. F2F Initials _____

Uploaded to chart and signed by MD,

The ordering MD and F2F should be the same MD, If Not is there a F2F attestation order?

2. Consents Initials _____

- uploaded to chart _____
- filled out accurately and completely _____
- signed and dated by client and clinician _____

3. Orders

- Start of care order _____
- Returned order uploaded to accurate task _____
- MD signature present _____
- PRN orders written _____
- RN signature accompanying an LVN written order _____

Recert within 5 day window _____

Recert Statement in 485 _____

DC

Non-MCR coverage form _____

5 Day Notice given and uploaded _____

F2F Statement written/sent/logged (if needed): _____

Notes: _____

Consents checked and uploaded by _____

First check completed by: _____

Second check completed by: _____

Patient: _____ Episode Dates: ____/____/____ to ____/____/____



Patient-Centered Case Conference Agenda - Home Health	
Date:	Quality Star Rating: out of 5 Stars
Start Time:	Month to Date Census:
End Time:	Month to Date Budget:
Time Keeper:	

Reminders:

- Please put away your phones and devices during PCC
- If you must take a call please quietly leave the room
- Please sign the sign-in sheet

I. Announcements and Employee Recognition time

II. Review of Home Health/Company Updates

III. Billing

- SOC's from prior week, check & SOC order frequencies, if incorrect, write order
- Recerts check if orders have been signed and returned, order for every visit including PRNs
- Check for F2F (appropriate F2F)
- Check for consents

IV. Patient-Centered Case Conference

- **Admissions, Recertifications and discharge decisions**
 - Team discussion (brief and focused)
 - Admissions (MOO answers, primary Dx, MSW ordered and plotted, Medical Necessity, Safety issues/concerns)
 - Review Frequencies for new Admissions
 - Review consents (1 person to be assigned in CC to make sure in chart)
 - EOE (MOO answers, primary Dx, MSW ordered and plotted, Medical Necessity, Safety issues/concerns)
 - Recertifications-Check for COMM Notes IN CC (complete if not done)
 - Review Frequencies for recertifications
 - M & E Screening
 - Maintenance Therapy
 - Discharges-Check COMM Notes IN CC (complete if not done)
 - Ensure discharge planning and notification is underway and patient notification has been plotted/signed



- **Medically complex / High risk patients / Potential declines in function**
 - Review patients NOT included on CC list due to COC, etc...
 - Team discussion and problem solving
 - Discuss hospitalizations/new infections/follow up on infections/falls

- **Transitional Care Planning**
 - Palliative Care Screening
 - Hospice Screening using Care Insights

V. **Education Items**

VI. **Other Site Business**

VII. **Closing Remarks and Dismissal**

Step by Step Instructions on How to DC a Patient out of Kinnser

There is 3 Places in a Patient's Chart you have touch in order to DC a patient out of Kinnser

Go into the Patient's Chart

Step 1

- Edit > Patient
- Check the Box in the Left upper corner that reads Discharged / Not Yet Admitted

Step 2

- Edit > Episode
- This section you must place the end date the date of the DC oasis / summary or the last day of the 1st 30 day billing period if the DC falls as the 1 billable visit in the 2nd 30 days

Step 3

- View > Episode List
- Click on the Admission and date
- In this section the Discharge date needs to be entered at the same date must match the "End Date" that was entered in the second step
- The "Patient Discharge Status" needs to have a selection also other than "Still a Patient"

How to Pull daily census NPI and All

1. Census Drive in the found in in the Shared Drive "CENSUS"
2. Once you are in the Census Drive choose your Location Folder then the current year Daily Census Report
3. Once you have the Current Daily census pulled choose the current month from the tabs at the bottom of the workbook

Pulling the Data that goes into the Census report

Pulling NPI

Note:

- Must Make sure all admits are accounted for from previous day (verified if they are a full admit)
- Must Make sure all discharges are DC'd from the EMR from previous day

1. In EMR - GO to Reports / Admins
2. Under the Clinical Task section ->Pull a "Schedule Report" from previous day "All Task"
3. Export to Excel
4. Sort by "Task Name"
 - a. Verify all Start of Cares were admit
 - Once Admissions are verified send email to to Intake with the names of admissions confirmed
 - If an admission was moved to another day or a non-start you will state this information in the body of the email
 - Subject line of email should read location admits from and a date
 - Example: Tyler admits 2/9/2021

Note: If a patient was a non admit and/or will be going back on the pending list inactivate the patient - In the patient's chart -> on the toll bar -> Edit -> Episode -> scroll to the bottom and click the box "Inactivate Episode")

Note: If the Episode can not be inactivated due to the RAP being billed - Notification sent via email to the assigned Biller to void out the RAP related to NON-admit.

- b. Verify All DC Oasis are discharged out of the system (3 steps)
- c. Verify that all DC summaries have been discharged out of the system (3 steps)
- d. Verify any PT/SN with DC summary (if discharged) have been discharged out of the system

NOTE: If there is no visit in the 2nd thirty days then or only a Transfer oasis you plot the DC appropriately but the of the episode will be the last day of the first 30 days.

5. Go to Reports / Admin and scroll down to the Census Reports Section -> Pull Patient roster by the previous date (scroll to the bottom of this report and choose the first selection "Include only active episodes by Date:)
6. Export to Excel ->sort by insurance (Column AJ in the excel spreadsheet)

7. Fill the data pulled by insurance count into the NPI columns of the Census spreadsheet
 - a. Example:

Date	PALESTINE NPI CENSUS:	PALESTINE KINNSER ONLY						
		PALESTINE NPI CENSUS						
		TRAD	ADV	COMM	Wk Comp	PSP	Pvt	Crtsy
1	143	47	6	90	0	0	0	0

Pulling ALL census

Note:

- These steps must be completed in all Kinnsers your location has patients in
1. Go to Reports / Admin and scroll down to the Census Reports Section -> Pull Patient roster by the previous date (scroll to the bottom of this report and choose the first selection "Include only active episodes by Date:)
 2. Export to Excel ->sort by Medical Record number (Column A of the excel spreadsheet)
 3. Verify all patients listed with your location MRN have not been admitted or discharged out of the system
 4. Fill the data pulled by MRN count into the ALL Census columns of the Census spreadsheet

a. Example:

Date	ALL KINNSER CENSUS:	ALL OFFICE										
		TYLER KINNSER	DFW KINNSER	CP Tyler KINNSER	LUF KINNSER	PAL KINNSER	PINES Kinnser	Houston Kinnser	ATX KINNSER	BMT KINNSER	NTMC KINNSER	HTA KINNSER
1	71	0	6	0	0	54	0	1	0	0	2	8

How to Pull Daily Management Data

SAFETY 1

(# Initial visits scheduled)* / (# prior day admissions + # prior day recerts)

*frequency comm note submitted day of visit

Pull all your All Oasis form the prior day from the schedule report (if you have commercial insurance that conduct SN assessment D1 task then those will need to be pulled also) check for all freq to be scheduled/Plotted out accurately

Reports & Administration

Dashboard

Display Dashboard (Integrity Family Homecare,LLC
DBA, Choice Homecare)
Smart QAPI

Clinical Tasks

Schedule Deviation
Print Queue
Patient Vital Signs

Blank Forms
Past Due Visits
CNA Episodes
Orders Manager

Miscellaneous Reports
Schedule Report
OASIS Export
Authorizations

Date Range

From:

11/03/2020

To:

11/03/2020

**The date range cannot exceed 90 total days*

Include tasks of the following type

Nursing

MSW

Misc

Physical Therapy

HHA

Occupa

Claims

Communications

Specific Task

All OASIS

View Authorizations

October 2020							November 2020							December 2020						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
							1	2	3	4	5	6	7			1	2	3	4	5
							8	9	10	11	12	13	14	6	7	8	9	10	11	12
							15	16	17	18	19	20	21	13	14	15	16	17	18	19
							22	23	24	25	26	27	28	20	21					
			28	29	30	31	29	30												

PLOTTED

Example:

If you had 10 oasis from the prior day and only 7 had frequencies plotted out from the prior day so your data you enter into the ffdaily would be 70% and the Gap would be 30% so you take the Target subtracted from the Daily

SAFETY 2

485's for SoCs 2 days prior completed / # SoCs conducted 2 days prior (QAPI)

Pull a scheduled report from reports and admin tab, select all Oasis/SN assessment D1s from 2 days prior. Then pull a scheduled report of 485s from 2 days prior and confirm all POCs(485s) have been assigned and completed

Reports & Administration

Dashboard

Display Dashboard (Integrity Family Homecare, LLC
DBA, Choice Homecare)
Smart QAPI

Clinical Tasks

Schedule Deviation
Print Queue
Patient Vital Signs

Blank Forms
Past Due Visits
CNA Episodes
Order Messages

Miscellaneous Reports
Schedule Report
OASIS Export
Authentification

Date Range

From: 11/03/2020

To: 11/03/2020

**The date range cannot exceed 90 total days*

Include tasks of the following type

Nursing MSW Misc

Physical Therapy HHA Occupa

Claims Communications

Specific Task

All OASIS

(Choosing 485 task for the oasis 48 hrs prior)

Date Range

From:	11/03/2020
To:	11/03/2020

**The date range cannot exceed 90 total days*

Include tasks of the following type

<input type="checkbox"/> Nursing	<input type="checkbox"/> MSW
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> HHA
<input type="checkbox"/> Claims	<input type="checkbox"/> Communications

Specific Task

Orders - CMS 485

Example:

If you are pulling data on 11/3/2020 you would pull report 11/1/2020 - you have 5 SOC's from 11/1/2020 then you would pull a report from 11/3/2020 of 485s and compare to the oasis to see if scheduled and completed
5 socs and only 3 485s completed then your % would be 60% (3 / 5 = 60%)

QUALITY 1 and QUALITY 2

% Prior day discharges positive outcomes (Target 100%)

And

% Prior day positive process measures (Target 100%)

Pull a Schedule report of all previous day Discharges and review for Positive Outcomes at 100% - this would be Qaing them and running Oasis Analysis and or SHP depending what you have in your kinnser as an oasis scrubber.

No snip its here if you all need education and instruction on how to QA a Discharge then please get with me and we will set up a education time

Example:

If you have 7 discharges from the previous day and after QA review has been completed and only 5 have positive outcomes your total would be 5 / 7 = 71%

DELIVERY 1

Daily Transitional Docs Completed (SoC's+Recerts+Discharges) / # Daily Transitional Docs Conducted (Admits+Recerts+Discharges) by 9 AM

Go in to Reports and Admin select schedule report and pull all Oasis / SN assessment D1s scheduled from the previous day and confirm that all visits were conducted /completed

Reports & Administration

Dashboard
 Display Dashboard (Integrity Family Homecare,LLC DBA, Choice Homecare)
 Smart QAPI

Clinical Tasks

Schedule Deviation
 Print Queue
 Patient Vital Signs

Blank Forms
 Past Due Visits
 CNA Episodes
 Order Manager

Miscellaneous Reports
Schedule Report
 OASIS Export
 Authentication

Date Range

From: 11/03/2020
 To: 11/03/2020
 *The date range cannot exceed 90 total days

Include tasks of the following type

Nursing MSW Misc
 Physical Therapy HHA Occupa
 Claims Communications

Specific Task

All OASIS

If you have items NOT started or in Saved you will need to verify that the visit was completed/conducted

Task	Status	
(11/03/2020 - 11/03/2020)		
OASIS-D1 Recertification	Submitted with Signature	
(11/03/2020 - 11/03/2020)		
OASIS-D1 Recertification	Saved	Re-Assign
OASIS-D1 Transfer	Exported	
OASIS-D1 Recertification	Saved	Re-Assign
OASIS-D1 Start of Care	Saved	Re-Assign
(11/03/2020 - 11/03/2020)		
OASIS-D1 Resumption of Care	Saved	Re-Assign

Example:

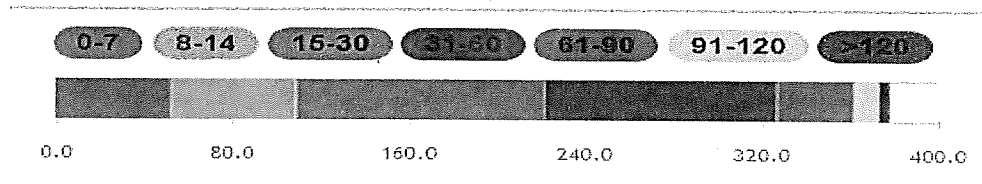
If you have 10 oasis scheduled from the previous day and only 8 were conducted because 1 was a missed visit and request for a different day and the 2nd one the nurse did not see it on their schedule. $8 / 10 = 80\%$

DELIVERY 2 and DELIVERY 3

% Orders Outstanding >15 days (Target <15%)

%Orders Outstanding >30 Days (Target 0%)

Go into Orders Manager under the pending Physician signature tab / under the colored tabs to left of the page



Pending by Days

You click on the tabs 15-30 and scroll down to see the count then you click on the 31-60 to scroll down to get the total number of orders out and then so on for the rest of the tabs 61-90, 91-120, >120

(Hint you can get your Delivery 1 and Delivery 2 data in one pulling)

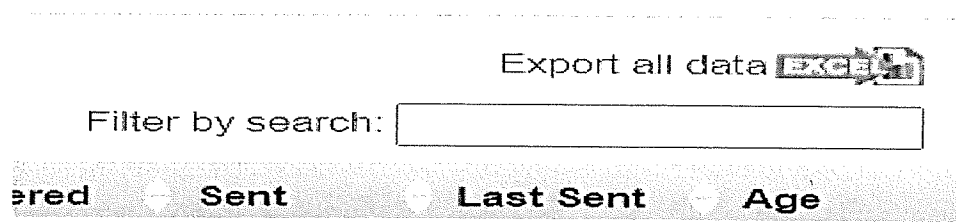
Example: Take your total number of orders greater than 15 days (120) and then divide by the total number of orders (240) = 50%

Then do the same for the >30 Day orders

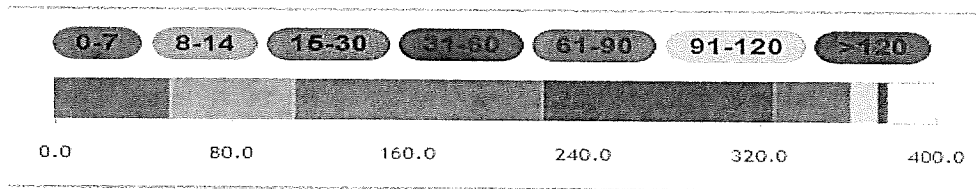
PRODUCTIVITY 1

% Orders Outstanding >10 days without F2F completed (Target 0%)

Go into Orders Manager under the pending Physician signature tab then type in the filter by search: F2F



This will bring up only Face to Faces pending physician signature
Then go to the colored tabs



Pending by Days

And get your data from the number of F2F outside of 10 days

Example:

If you have 25 faces to faces outside of 10 days divide that by the total number of face to faces 100 to get your total % ($25 / 100 = 25\%$)

PRODUCTIVITY 2

% Scheduled PoCs that Matches a Group (Target 95%)

Go to schedule a report, pull all Oasis form the prior day - all SOC, ROC, and RECRTs need to be reviewed for matching a grouping (falling into a frequency overview grouping).

If you need to have a Grouping sheet (frequency overview) sent to you please let me know

Example: You have 3 SOCs from prior day - 2 oasis with primary DX of CHF and have frequencies that are 1w1,2w2,1qow6 which falls into the suggested grouping or CHF, then you have a SOC with primary DX of COPD with frequency of 2w5, 1w4 which does not fall into a specific grouping. So you would take $1 / 3 = 33\%$

Weekly Agency Audit Report

WAAR

Census

ADC:

Stretch Target:

MTD %:

DCs:

Recerts:

Productivity: % of clinicians meeting expectations. Should be 95% or higher

RN:

LVN:

HHA:

MSW:

Billing Pieces here:

TIOC:

A3/Strategy Pieces here

If branch has an active POA: put blurb here what the update is and where you are on POA actions.

•Open Oasis:

•Late Documentation:

*This will be done in an email and the Administrators will send to Amber/Trina/Kandi/Kristen(?). They will need to give high level explanations on where the deficit is and what they are doing to work on it! Every Wednesday (?) by 3pm.

Accountability Weekly Sales & Ops Meeting



Meeting Date:

REQUIRED: Administrator; RSM; BDL

OPTIONAL: President of Sales; VP of Clinical Ops; Back Office Staff as necessary

Focus Areas From Prior Strategy Meeting: OPS	
Focus Priority GROWTH	
Focus Priority GROSS MARGIN	
Focus Priority QUALITY	

Focus Areas From Prior Strategy Meeting: SALES	
Focus Priority GROWTH	
Focus Priority GROSS MARGIN	
Focus Priority QUALITY	

GROWTH			
	MTD / Target	% Goal	Admits/Day to achieve goal
FTE \geq Budget			
Operations Admissions \geq Budget			
Sales Admissions $>$ Budget			
Recerts \geq Budget			Branch Discharges Current Week:
Improvement Strategy			

CONVERSION RATE (GOAL 80%)			
	Current Week	Previous Week	Barriers
Conversion Rate			
Top Non-Admit Reason			
Pending Referrals 5+ Days			
Referral Process			
Improvement Strategy			

Accountability Weekly Sales & Ops Meeting



RECRUITING / STAFFING		
	Current Week	Previous Week
Open Sales Reqs		
Open Back Office Reqs		
Open Field Reqs		
Upcoming Hires		
Resignation/Terms		
Recruiting Events		
Turnover		
Improvement Strategy		

ASSISTED LIVING GROWTH			
	Current Week	Previous Week	Trends / Barriers
Admissions			
Referral Conversion %			
# of Patients >3 COC			

BILLING			
	Current Week	Previous Week	Trends/Barriers
Unbilled > 90 Days			
Unsigned Orders			
F2F Tracking			
Improvement Strategy			

QUALITY			
	Current Week	Previous Week	Focus Area/Barriers
Focus Area Outcomes			
Satisfaction			
TIMELY INITIATION OF CARE			
% Within 24 Hours			
Improvement Strategy			