OKLAHOMA

Health Care Authority

SFY 22-23

Quality of Care Report

Training Guide

Table of Contents

PURPOSE OF GUIDE

This guide is intended as a reference document for Licensed Nursing Facility Providers. The primary purpose of this guide is to assist providers in completing the Quality of Care (QOC) Report which documents the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios. It contains instructions for completion of the Quality of Care Form, definitions, requirements and report submission to the Long Term Care (LTC) Financial Management Unit in the Finance Division. This guide also includes a resource listing and other reference information.

In conjunction with the QOC reporting process the Pay for Performance program utilizes collected data to assign point value and reimbursement dollars.

A copy of the applicable administrative rules can be obtained from the OHCA website at http://www.okhca.org/xPolicy.aspx?id=734. Providers are responsible for ensuring compliance with current state/federal Medicaid policies pertaining to the services rendered. **This guide does not supersede state/federal Medicaid rules and is not to be used in lieu of them.**

Please send any comments, suggestions or questions you have regarding this guide to the attention of:

Oklahoma Health Care Authority
LTC Financial Management- Finance Division
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
LTCAUDIT@okhca.org
405-522-7124 Karen Stinson

Your questions, comments and suggestions will help us to increase the usefulness of this guide.

OKLAHOMA HEALTH CARE AUTHORITY QUALITY OF CARE FORM INSTRUCTIONS

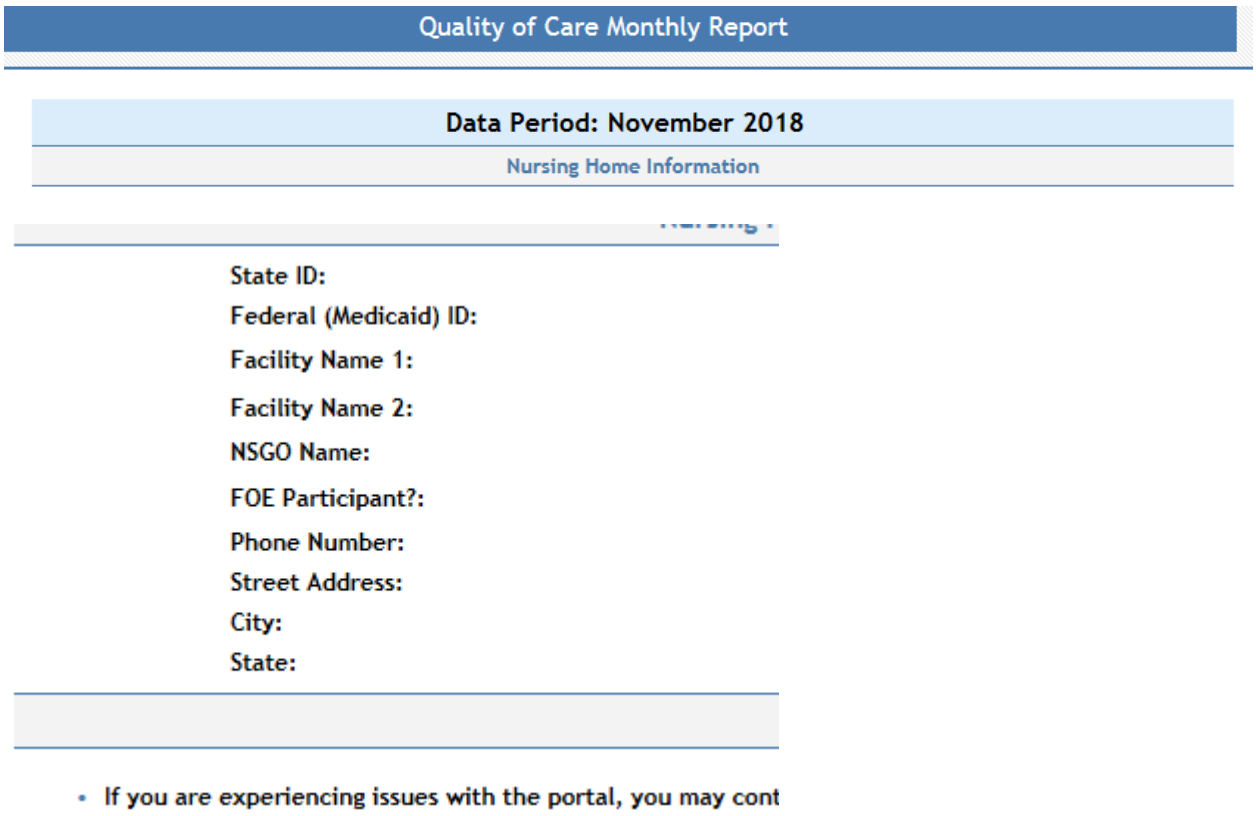
Overview and Purpose of Form

This form is used to report monthly statistical information for direct-care-staff-to-resident ratios, total gross receipts, total patient days, total available bed days, total direct care staff hours, total Medicaid and Medicare days to the Oklahoma Health Care Authority.

Instructions for Preparation of Form (***Please make sure to review the facility page to ensure all areas are up to date)*

The Quality of Care Form is separated into several sections. In this guide we will display the overall Guide for a visual reference. Then display the detail of each section and explain how each section is completed or verified accordingly.

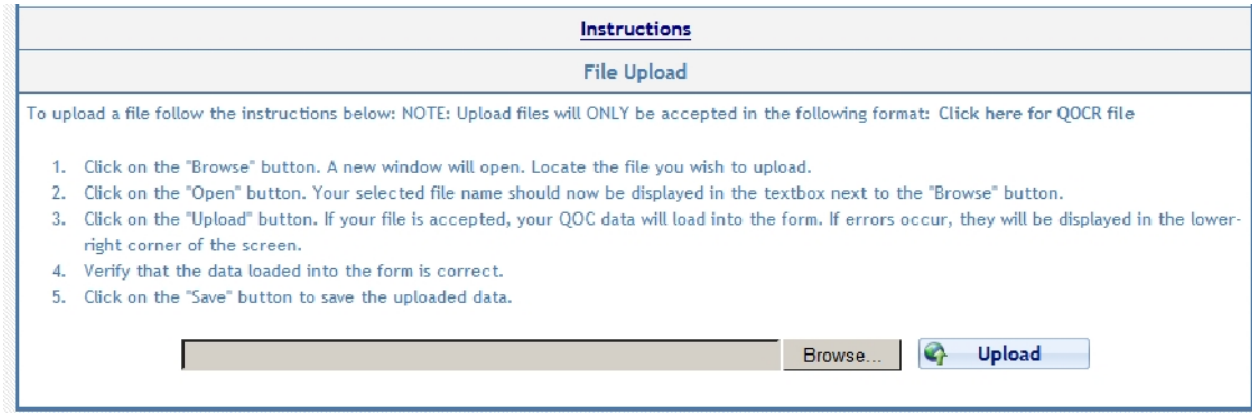
Section 1 Labeled: **Nursing Home Information**



This section of the report will automatically populate with the data stored with the user's log-on information. It is the users/facilities responsibility to verify all of the following information is correct:

- **Facility Name-**The physical name of the facility and/or billing name
- **Facility Medicaid Number-**Active Medicaid number
- **Reporting Month-**Verify that the information is being uploaded to the correct month
- **Reporting Year-** Verify that the correct year
- **Facility Address-** The address your facility will want all paper documents mailed to

Section 2 Labeled: Instructions for File Upload



This section is provided so the user may upload a file or worksheet that contains monthly QOC data. In some instances, facilities may want to use a shell and reformat monthly so that they may enter the QOC data daily. Then at the end of the month the file can be uploaded automatically. This makes it easier for the facility to complete the report at their convenience (daily or weekly). See form for uploading instructions.

Section 3 Labeled: **(A) Direct Care Staffing**

(A) Direct Care Staffing*

	Day Shift 7:00 To 15:00		Evening Shift 15:00 To 23:00		Night Shift 23:00 To 7:00		Flexible Staff Scheduling 24 Hour Staffing (Only)	
Day of the Month	Peak In-House Resident Count	Direct Care Staff Hours	Peak In-House Resident Count	Direct Care Staff Hours	Peak In-House Resident Count	Direct Care Staff Hours	Daily Peak In-House Resident Count	Total Direct Care Staff Hours
1	114	146.22	114	147.58	114	73.15	0	0.00
2	112	218.73	112	141.16	112	89.28	0	0.00
3	114	206.90	114	139.07	114	98.72	0	0.00
4	114	196.59	114	131.76	114	93.13	0	0.00
5	115	199.80	115	139.05	115	68.65	0	0.00
6	115	227.54	115	157.45	115	104.08	0	0.00
7	114	147.67	114	123.00	114	84.11	0	0.00
8	114	128.27	114	129.02	114	84.55	0	0.00
9	115	224.94	115	141.49	115	96.75	0	0.00
10	116	204.29	116	141.34	116	105.27	0	0.00
11	116	221.00	116	142.89	116	100.12	0	0.00
12	113	214.59	113	135.37	113	90.79	0	0.00
13	114	211.17	114	137.56	114	92.97	0	0.00
14	115	146.87	115	130.18	115	82.74	0	0.00
15	114	143.17	114	150.89	114	97.85	0	0.00
16	114	233.02	114	131.79	114	87.56	0	0.00
17	113	206.05	113	140.24	113	106.02	0	0.00
18	114	243.65	114	141.79	114	83.35	0	0.00
19	114	206.25	114	131.22	114	110.95	0	0.00
20	114	213.32	114	129.42	114	93.96	0	0.00
21	115	139.60	115	139.44	115	86.31	0	0.00
22	114	138.26	114	129.21	114	73.57	0	0.00

A) DIRECT CARE STAFFING: The purpose of this section is to determine the direct-care-staff-to-resident ratio levels for the reporting month. For purposes of this report, direct care staff is limited to:

Registered Nurses	Physical Therapist (Professional)
Licensed Practical Nurses	Occupational Therapist (Professional)
Nurse Aides	Respiratory Therapist (Professional)
Certified Medication Aides	Speech Therapist (Professional)
QMRP (ICFs/MR only)	Therapy Aide / Assistant

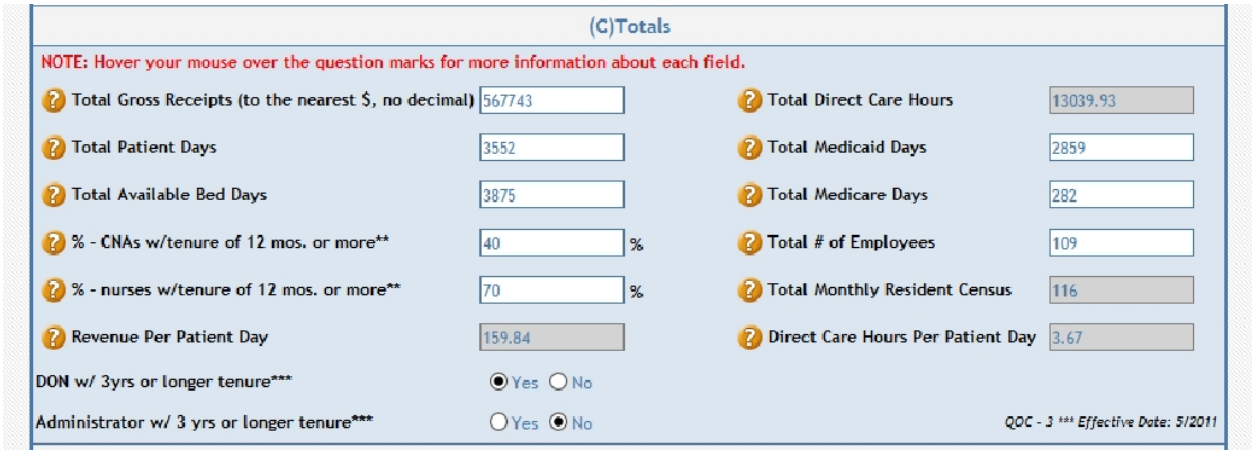
- **Shift Times.** State the shift beginning and ending times for each of the three (3) shifts (day, evening and night)
- **Day of the Month.** These dates coincide with calendar days.
- **Peak In-House Resident Count.** Enter the maximum number of in-house residents at any point in time during the applicable shift for each day of the month and each shift.

Direct Care Staff Hours. Enter the total number of hours worked during the applicable shift by direct care staff for each day of the month and each shift. *****NOTES: The administrator shall not be counted in the direct-care-staff-to-resident ratio regardless of their licensure or certification status. The hours reported in this section should only represent the hours worked. Some facilities use shift scheduled hours to report in this section. This is incorrect.***

- **Totals.** Verify the automated number is correct.
- **Twenty-Four-Hour-Based Scheduling:**

Twenty-Four-Hour-Based Scheduling (Only). Daily Peak In-House Resident Count. Enter the maximum number of in-house residents for each day of the month.
Total Direct Care Staff Hours. Enter the total number of hours worked by direct care staff for each day of the month (not the scheduled hours).
Totals. Enter the total number of Direct Care Staff Hours for the month **worked** not **scheduled**.

Section 4 Labeled: **(C) TOTALS**



C) TOTALS

The purpose of this section is to determine the total of gross receipts, patient days, available bed days, direct care hours, Medicaid & Medicare days, number of employees, the monthly resident census as well as the tenure of CNAs, Nurses, DONs, & Administrators for the reporting month. The user may hover over the question marks to receive additional information regarding the fields. **Note: shaded boxes are auto calculated for PFP and cost reporting purposes, when hovering over the mouse there will be text that explains how the field is calculated.**

- **Total Gross Receipts.** Enter the cash received in the current reporting month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, Private Pay and Insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility shall not be included. (Pending monies should only be counted when received.) **Note: The gross receipts should be the actual receipts for the month not the daily rate times the patient days.**

- **Total Patient Days.** Enter the total days of service (patient census days) for the month. Be sure to include all paid leave days (even if paid at less than the full rate.) **Note: The Total Patient days cannot be greater than the Total Available Bed Days.**

- **Total Available Bed Days.*** Enter the number of beds available for occupancy multiplied by the number of days available in the month. ***(For example, a sixty (60) bed home (with all beds available or being used) and a month with 30 days would have total available days of 1,800 (60 beds x 30 days). If one of those beds were not in use for all or a part of the month then do not count those days as available and do not report them in the total. Another example would be a facility licensed for 60 beds but only have 50 available for use would report this total as 1,500 (50 beds x 30 days).***

- **Total Direct Care Hours.** Enter the **actual** total number of direct care hours from the day shift, evening shift and night shift added together. **For Flexible Staff Scheduling 24 Hour Staffing** enter the **actual** total number of Direct Care Staff Hours for the month.

- **Total Medicaid Days.** Enter the monthly census days for patients that qualify for Medicaid and are billed as such. This should include paid leave days and days billed as Medicaid prior to final approval of eligibility status. (For example, Medicaid resident in facility 15 days - # of days billed x number of days in the month). (15 days x 30 days)

- **Total Medicare Days.** Enter all census days where the primary payor is Medicare; this should include all paid leave days (at any amount) billed as Medicare.

- **% of Nurses with tenure of 12 months or more.** Enter percentage of nurses employed with the facility for 12 months or more with no more than 45 day break in service during prior 12 month period. Example: if you have 60 nurses with tenure of 12 months or more out of 75 total nurses, divide 60 by 75 which comes to 0.8 then multiply by 100 which is 80% (60/75) x 100 = 80%. ***(Does not include temporary contract nurses.)***

- **% of CNAs with tenure of 12 months or more.** Enter percentage of CNAs employed with the facility for 12 months or more with no more than 45 day break in service during prior 12 month period. (Use same calculation as above for nurses.) ***(Does not include temporary contracted CNAs.)***

- **DON with tenure of 3 years or more.** Check Y or N to answer whether current DON has been employed with facility for 3 years or more with no more than 90 day break in service during previous 36 months.

- **Administrator with tenure of 3 years or more.** Check Y or N to answer whether current Administrator has been employed with facility for 3 years or more with no more than 90 day break in service during previous 36 months.

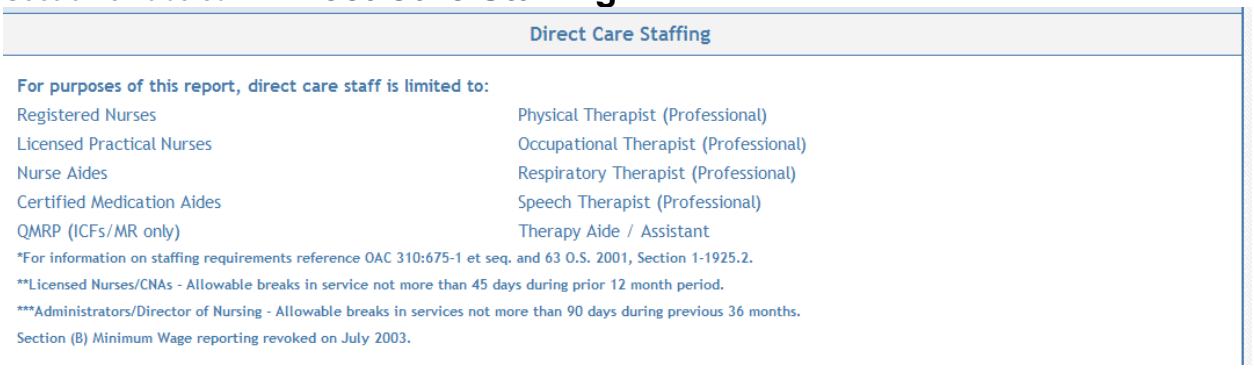
- **Total # of Employees.** Total number of employees in the entire facility.

- **Total Monthly Resident Census.** Enter the total number of residents on the last day of month.

Completion of (C) Totals

If the upload feature is used review all information to ensure accuracy. Make any necessary changes or add information.

Section 5 Labeled: Direct Care Staffing



This section lists all staff that may be considered or classified as "Direct Care Staffing" on the form for ease of reference.

Section 6 Labeled: Additional Comments/Explanation (Optional)

This section may be used to inform Oklahoma Health Care Authority of any special circumstances as well as make notes to the user for historical reference.

Section 7 Labeled: Signature

This section provides a place for the preparer of the form to type their name for accountability, answer questions that may arise and provide a point of contact for The Oklahoma Health Care Authority.

Note the user must first save the form and then sign the form. If there are errors there will be a notification to the User explaining the errors. The form may not be submitted to OKHCA until all errors are fixed and the form is signed. Once the form is saved, signed and no errors are displaying the user may enter "Submit to OHCA". At this point the form has been completed and submitted to OHCA.

The user should always verify the form has been submitted by reviewing the portal which displays the report has been moved from "Upcoming Submissions" to "Completed Submissions" before logging out.
Also, a confirmation email would be sent to the provider's email address listed in the portal.

OKLAHOMA HEALTH CARE AUTHORITY QUALITY OF CARE FORM INSTRUCTIONS (CONTD.)

Submission
Save
Sign
Submit

Note: The Oklahoma State Department of Health does not use this method for the purposes of 63 O.S. § 1-851.2© and § 1-852©(1)(b): calculation of occupancy rates for certificate of need. Certificate of Need relies on licensed beds only and makes no adjustment for available beds.

Frequently Asked Questions Regarding the Monthly Quality of Care Reports:

1. ***How Do I get the information to start entering my report on the web portal?***

   Contact LTC Financial Management at 405-522-7124, 405-522-7294 to receive log on information

2. **Can I change my password once I log on to the web portal?**

   Yes. Your facility can change the password at any time on the facility upload page. Your facility will need to ensure you hit the "update profile button" to save changes.

3. ***Do I include SNF and Hospice patients in the peak-in-house resident count?***

   The Peak-in-House Resident Count -Yes, include SNF and Hospice patients residing in the facility.

4. ***Can contracted staff be counted in a facility's direct care hours and what about hospice?***
   Direct Care Hours- Contracted staff can be counted in direct care hours. Hospice is <u>not</u> considered contracted staff and cannot be counted as such because it is not a nursing home service.

5. ***What are the current Direct Care Staff to Resident Ratios?***

   - **Direct Care Staff to Resident Ratios.***
     a) From 7:00 am to 3:00 pm, one direct-care staff to every six residents, or <u>major fraction thereof</u>,
     b) From 3:00 pm to 11:00 pm, one direct-care staff to every eight residents, or <u>major fraction thereof</u>, and
     c) From 11:00 pm to 7:00 am, one direct-care staff to every fifteen residents, or <u>major fraction thereof</u>.

If this changes or is updated you will be notified. These same ratios apply to both regular Nursing Facilities and Regular ICF/IID Facilities. The Ratios for Acute Care (16 bed or less) ICF/IID facilities are 1:4; 1:4 and 1:8, respectively for the three shifts (a,b,c above).

6. ***Can I fax my Quality of Care Report if the web portal is not working?***

   You will need to contact the QOCR team to make appropriate arrangements.

7. ***When is the Quality of Care Report due and what happens if we're late?***

   Facilities are encouraged to double-check their monthly reports prior to the reporting person's signature and its subsequent submission. Reports not submitted by the monthly submission deadline are subject to the $150 per calendar day penalty until the completed report is formally submitted. Reports that do not contain the <u>required</u> information in each section of the report will be considered incomplete and subject to the $150 per calendar day penalty until a completed report is formally submitted. This is applicable even if an incomplete report is submitted timely.

8. **I noticed that the QOCR is locked. If I have a correction or make a mistake how can I fix it?**

Your facility may contact a member of the QOCR team.

9. **How do I know that my QOCR has been received?**

Once you hit submit to OHCA button you will receive a pop up that verifies it has been accepted. You may also go on to the facility web portal page and look at the completed submission section and check the "date completed" box.11. Also, a confirmation would be sent listed in the portal. Please make sure a correct email is listed in the system.

10. ***Can a Quality of Care (QOC) Assessment be adjusted when a facility discovers an error in the QOC Report more than 5 days after it was submitted?***

No, policy states, "Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the OHCA. "OAC 317:30-5-131.2(d)(7).

11. ***Are facilities allowed to have more than one password to the PFP/QOC portal?***

Only one password is assigned to each facility.

12. ***Should Medicaid days exceed Patient days on the QOC report?***

Medicaid days should never exceed patient days.

317:30-5-131.2. Quality of care fund requirements and report

[Revised 02-12-20]

(a) Definitions. The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise:

(1) "Annualize" means that the calculations, including, for example, total patient days, gross revenue, or contractual allowances and discounts, is divided by the total number of applicable days in the relevant time period.

(2) "Direct-Care Staff" means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(3) "Major Fraction Thereof" means an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

(4) "Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities" means any home, establishment, or institution or any portion thereof, licensed by the Oklahoma State Department of Health (OSDH) as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

(5) "Peak In-House Resident Count" means the maximum number of in-house residents at any point in time during the applicable shift.

(6) "Quality of Care Fee" means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this state.

(7) "Quality of Care Fund" means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(8) "Quality of Care Report" means the monthly report developed by the Oklahoma Health Care Authority (OHCA) to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each

nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the state.

(9)"Service Rate" means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(10) "Staff Hours Worked by Shift" means the number of hours worked during the applicable shift by direct-care staff.

(11) "Staffing Ratios" means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(12) "Total Gross Receipts" means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, private pay, and insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

(13) "Total Patient Days" means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(b) Quality of care fund assessments.

(1) The OHCA was mandated by the Oklahoma Legislature to assess a monthly service fee to each licensed nursing facility in the state. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) Annually, the Nursing Facilities Quality of Care Fee shall be determined by using the daily patient census and patient gross receipts report received by the OHCA for the most recent available twelve months and annualizing those figures. Also, the fee will be monitored to never surpass the federal maximum.

(3) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services regarding waiver of uniformity requirements related to the fee.

(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(5) The method of collection is as follows:

(A) The OHCA assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months

prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The OHCA notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the OHCA by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of 10 percent (10%) of the amount and interest of 1.25 percent (1.25%) per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m., Central Standard Time (CST), of the following business day (Monday-Friday).

(C) The monthly assessment, including applicable penalties and interest, must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for OHCA cost reporting purposes.

(E) The Quality of Care fund, which contains assessments collected including penalties and interest as described in this subsection and any interest attributable to investment of any money in the fund, must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) Quality of care direct-care-staff-to resident-ratios.

(1) All nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

(A) Registered Nurse

(B) Licensed Practical Nurse

(C) Nurse Aide

(D) Certified Medication Aide

(E) Qualified Intellectual Disability Professional (ICFs/IID only)

(F) Physical Therapist

(G) Occupational Therapist

(H) Respiratory Therapist

(I) Speech Therapist

(J) Therapy Aide/Assistant

(3) The hours of direct care rendered by persons filling non-direct care positions may be used when those persons are certified and rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and ICFs/IID must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

(d) Quality of care reports. All nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the OHCA, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the owner, authorized corporate officer, or administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The owner or authorized corporate officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by

or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b.

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report through the OHCA Provider Portal.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the Long-term Care Financial Management Unit written notification with adequate, objective, and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the OHCA.

(8) An initial administrative penalty of $150.00 is imposed upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the OHCA notifying the facility in writing that the report was not complete or not timely submitted as required. The $150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For 100 percent (100%) private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for OHCA cost reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of certified nursing assistants, nurses, directors of nursing, and administrators.

(10) Audits may be performed to determine compliance pursuant to subsections (b), and (c) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the OSDH for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The OSHD informs the OHCA of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for OHCA Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of $6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of $25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for OHCA cost reporting purposes.

(13) Under OAC 317:2-1-2, long-term care facility providers may appeal the administrative penalty described in (b)(5)(B) and (e)(8) and (e)(12) of this section.

.Important Telephone Numbers

OHCA Main Number **(405) 522-7300**

Email: www.LTCAUDIT@okhca.org

Quality of Care Report Team:

Financial Analyst II
Karen Stinson (405) 522-7124
Karen.Stinson@okhca.org

Manager, LTC Financial Management
Peter Onema (405) 522-7098
Peter.Onema@okhca.org

Payments and/or Penalties
Ernest Chiang (405) 522-7089
www.Ernest.Chiang@okhca.org

Requests for copies of QOC Reports
Carolyn Berry-Greer
Legal Services (405) 522-7268
Fax your request to:
(405) 530-3444