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# PROCESS MANAGEMENT OVERVIEW

The purpose of this manual is to provide guidance for processing Medicaid in the South Carolina Department of Health and Human Services (DHHS). The procedures are designed to make work processes more consistent and efficient. This procedural manual is an outcome of the South Carolina Process Improvement Team, and describes the processes and procedures based on Process Management Principles. All DHHS local eligibility processing and processing centers will follow the procedures outlined in this manual.

Process managementprovides DHHSwith opportunities for improvement in all functional areas by managing the processes of:

* Intake and interview
* Verification and Eligibility Determinations
* Renewals
* Changes
* Escalations
* Exceptions
* Phones

Understanding these processes allows us to measure, manage, and make improvements that result in the Medicaid-eligible citizens of South Carolina accessing benefits efficiently and accurately. These processes have been created from the view of the customer, with a focus on their needs and making their goals our goals. This manual has been created with the sole purpose of freeing up your ability to better serve customers while resulting in improved quality and timeliness.

# PROCESS MANAGEMENT PRINCIPLES

## Eliminate Unnecessary Customer Interactions

Eligibility determinations will be completed to the best of the agency’s abilities at the first contact with the customer. All sources available will be used to verify customer resources at the time of the interview to avoid pending a case. This includes but is not limited to using online verification, system verification and collateral verification to obtain all required information.

## Eliminate Rework

Consistent use of the eligibility tools and standard business practices allows the agency to eliminate elapsed time, batches, bottlenecks and backlog. The process management tools are designed to foster consistency and eliminate rework to make more efficient and accurate eligibility determinations.

## Recognize Customers Have Different Needs and Respond Appropriately

Triage all pathways. Triaging is the process of sorting and prioritizing work entering the office based on customers’ need for service(s). Triaging allows the agency to link the customer with the team best qualified to process their case based on program type, case complexity and access point (i.e., lobby, non-lobby, phones).

## Use Real-Time Data to Manage Available Resources

Collecting and using real-time data enables the agency to respond to an ever-changing environment more rapidly and effectively, including fluid staff assignments. Real-time data also provides process measures that help the agency evaluate the effectiveness of processes and staff performance. The ability to impact change is severely limited without real-time data.

# CORE VALUES

We will strive to:

1. Be accessible and responsive by providing timely and useful answers to the customer’s questions. This includes information and referral to other agencies outside of DHHS.
2. Address customer inquiries and needs at first contact or inform the customer of the specific time to expect a return call or other follow up action.
3. Resolve customer complaints whenever possible. When unable to resolve a complaint, staff will work with the senior worker or supervisor in reaching a resolution for the customer.
4. Make all decisions regarding program eligibility in a consistent manner according to the South Carolina DHHS Policy Manual.
5. Apply the “One and Done” principle to all areas of our work.

**WHAT DOES “ONE AND DONE” MEAN?**

* Attempt to achieve a determination at first touch, without pending for information, for all customer interactions (applications, reviews, changes) and access points (lobby, non-lobby, phones).
* Conduct collateral calls, three-way calls using the customer, electronic interfaces and cross-matches, and apply other strategies to obtain all required verification.
* When unable to make a determination, take the case as far as possible: complete system of record work in MEDS and/or Curam, thoroughly complete the documentation template, disposition tracking forms accordingly in OnBase , and disposition the task in PathOS.

# BPR CONSISTENCY TOOLS

Several tools have been designed for staff to follow DHHS Medicaid eligibility processes. All staff are required to use these tools. Each tool has a specific customer, purpose and “why” it should be used.

## PathOS

**Customer(s):** Supervisor, to monitor all process pathways (teams), Navigator or anyone reading the case; and customers applying for or receiving services.

**Purpose:** PathOS is a tool that provides real-time data to effectively manage the BPR process. The review and analysis of real-time data allows supervisors and quarterbacks to make quick decisions about adjusting and allocating resources effectively. The collection of real-time data allows the agency to quantify its volume of work, determine how quickly work is being completed and whether it is being completed in a timely manner, identify trends, and develop “blitz” points. PathOS also provides individual worker data which allows management to monitor and evaluate office efficiency.

**How should it be used?** PathOS is used as a management tool, minute-by-minute, hour-by-hour, day-to-day, week-to-week, and monthly. PathOS calculates the volume of work for each individual, process pathway (team), office, and region in order to better inform management of the time and resources needed to complete the work. PathOS is also used to identify trends such as peak times, slow times, impact of the lunch hour, training, and other factors that affect office workflow. Additionally, PathOS is used to identify a “blitz” point for each team and all avenues of service (i.e., lobby, non-lobby, and phones). PathOS provides data used to analyze the offices’ completion rates, transaction times, and unfinished work, as well.

## Resource Verification Matrix and Income Verification Matrix

**Customer:** All process pathways (teams) and customers applying for or receiving services.

**Purpose:** The verification matrices were designed to support standard verification procedures by reducing unnecessary over-verification or under-verification and to shift the burden from customers to provide verifications. Consistent verification procedures will also help increase trust among DHHS staff by improving verification accuracy, thereby reducing rework.

**How should it be used?** To ensure eligibility staff are only requesting required verification to determine eligibility for the program(s) applied for or renewing. The matrices will also reassure staff that everything needed to make an eligibility determination was provided or requested.

## Eligibility Interview Scripts

**Customer:** All process pathways (teams) and customers applying for services.

**Purpose:** The eligibility interview scripts ensure workers only ask the questions necessary to determine eligibility based on the programs for which the customer has applied.

**How it should be used?** Eligibility workers will use the interview scripts to ensure they conduct an efficient, accurate, and focused interview. Use of the eligibility script will promote an environment of trust and allow the process pathways teams to trust that an accurate eligibility determination or interview was completed, thereby eliminating rework. Customers benefit from the interview script by only being asked questions relevant to the programs for which they are applying.

## Documentation Template

**Customer:** All process pathways (teams) and customers applying for services.

**Purpose:** The documentation template provides staff with a consistent format for documenting accurately during case processing so if pending a case becomes necessary, the Assessment and Processing (Purple) Team has the ability to pick up the case where it was left off and complete it. Rework will be unnecessary.

**How it should be used?** The documentation template will be used during the eligibility determination process to ensure the interviewer has asked and documented answers to all relevant customer information. The “Who, What, When, and Where” information will be keyed into the eligibility system. The “Why” of the customers’ circumstances will be keyed into the documentation template. The Assessment and Processing (Purple) Team should be able to use the information in the template to finish pended cases once verification has been received.

Documentation exists to allow a worker, a supervisor and anyone reading the case to follow the action taken on a case and to complete a case without having to extensively research past actions. Consistent use of the documentation template is necessary to reduce rework.

Workers **must** use the documentation template to record the following information:

1. Data entry into MEDS/CURAM completed
2. Verifications provided by applicant assessed
3. Electronic verifications checked
4. Collateral contacts and the results
5. Household composition (number of adults and children)
6. Categorical eligibility components (pregnancy, aged, disability, tax filing status, other)
7. Household income (HH member, income source, verification status)
8. Countable resources (HH member, resource type, source, verification status)
9. Documentation of disability report when VR determination is needed (status and completeness of disability report)
10. Outcome and action summary (case status, worker name, ID, date of action, type of action)

# PATHOS DISPOSITIONS

## No Contact

When to mark No Contact in **Lobby:**

* After two attempts to call the customer from the lobby, it is presumed the Customer left the Lobby. Disposition as **no contact** by the Worker.
* When the customer notifies the Navigator they can no longer wait, the Navigator will disposition as **abandoned**.

When to mark No Contact in **Non-Lobby:**

* After searching Onbase, CURAM and MEDS, and no Documents or HH# could be found, and no Person ID or Document ID is listed in the Remarks section for retrieval from OnBase or CURAM.
* Documents found were categorized incorrectly and worker does not have the required training/permission to complete (TEFRA, LTC, etc.). Correct the Keywords and update the Tracking Form Site Code and/or Claim Type.
* Another worker is currently working or has already worked the case.
* If all submitted documentation has been addressed and eligibility has been determined but the case still has an Active Tracking Form, document your actions and move the tracking form to Worker Archive.
* If all submitted documentation has been addressed but additional information is still pending, including a disability determination from Vocational Rehabilitation, then send back to Follow-up using the date the information is due.

## Approve/Deny

When to **Approve:**

* Eligibility is determined, and benefits are approved.
* Eligibility is continued, and benefits are continued.

What to do when a case is **Approved:**

1. Complete all work in the system of record
2. Complete the documentation template
3. Update all documents in OnBase with the newly created Application ID number in the HH#/App ID Keyword field
4. Process the tracking form in OnBase as “Approved”
5. Update the Case ID field in PathOS with the newly created Application ID number (if needed)
6. Select the “Approve/Deny” disposition in PathOS
7. Claim “Next” from the Case Worker Desktop in PathOS

When to **Deny:**

* Eligibility is determined, and benefits are denied.
* Eligibility is discontinued, and benefits are closed.

What to do whena case is **Denied:**

1. Complete all work in the system of record
2. Complete the documentation template
3. Update all documents in OnBase with the newly created Application ID number in the HH#/App ID Keyword field
4. Process the tracking form in OnBase as “Denied”
5. Update the Case ID field in PathOS with the newly created Application ID number (if needed)
6. Select the “Approve/Deny” disposition in PathOS
7. Claim “Next” from the Case Worker Desktop in PathOS

## Pended

When to **Pend:**

* You have followed the steps for One and Done and attempted all collateral calls, including three-way calls, to obtain required verification and are unable to obtain the verification needed to make an eligibility determination.
* You are unable to obtain the required verification to make an eligibility determination and have sent a 1233 requesting required information.
* You are sending a disability determination referral to Vocational Rehabilitation.
* You have completed the financial determination and are awaiting a 30-day stay in the institution.

What to do when a case is **Pended:**

1. Send 1233
2. Send the tracking form in OnBase to “Follow-Up” and record the appropriate number of days to return to workflow according to policy
3. Update the Case ID field in PathOS with the newly created Application ID number (if needed)
4. Select the “Pend” disposition in PathOS
5. Claim “Next” from the Case Worker Desktop in PathOS

What to do if the case was **previously Pended:**

1. Attempt to contact the client to conduct collateral calls including three-way calls to obtain required verification.
2. If able to obtain required verification, process the case.
3. If unable to obtain required verification and there is still time left in follow-up for the customer to provide the information, No Contact the case action.
4. If every effort has been made and the information is not obtained, and it is **past** the due date for the customer to provide the information.
	1. The worker will close or deny the case following policy requirements.
	2. Update the Documentation Template and complete the required process in OnBase for all active tracking forms. Take all required actions in the eligibility system.
	3. Disposition in PathOS as **approve/deny.**

## Finish Later

When to place a case in **Finish Later**:

* Help Desk Ticket (enter Ticket Number) (send to Follow-up in OnBase)
* Break/Lunch/End of day
* Training/Meeting
* Awaiting policy clarification
* 2-Day process
* Reassigned to other duties
* Other

What to do when placing a case in **Finish Later**:

1. Enter remarks in PathOS giving one of the above reasons
	* If submitting a Help Desk Ticket, please include the ticket number and a brief explanation (e.g., HDT #123456 Server Error)
2. Send to Follow-up in OnBase for:
	* 10 days if HDT
	* 1 day for all other reasons, unless instructed differently by supervisor

## PathOS Disposition Examples

**Example 1: *Dual claim type:*** Worker claims a case that includes MAGI and Non-MAGI claim types. The worker is trained in MAGI only. The worker completes all work required for the MAGI program. For each MAGI task in PathOS the worker will disposition with approve/deny or pend as appropriate. The worker will disposition the Non-MAGI tasks as No Contact. The worker will update the Claim Type of the OnBase tracking form to SSI Non-Institutional, so it will upload into PathOS for a Non-MAGI worker to complete. Do not disposition the OnBase tracking form.

**Example 2*: Multiple Tasks same pathway:*** Worker claims a task that has multiple Purple tasks in PathOS. The worker processes the Purple (Assessment/Processing) tasks. The worker will process all related tracking forms in OnBase (approve, deny, follow-up). The worker will disposition all the Purple tasks in PathOS as approve/deny or pend as appropriate.

**Example 3: *Multiple Tasks and multiple pathways for the same claim type:*** Worker claims a task in PathOS with a Green, Yellow, and Purple task. The worker reviews the case and determines the (Green) application has not been processed and the client reported a change (Yellow). The worker is unable to find any information in the system for the Purple task (no 1233 has been sent because the application has not been processed). The worker processes the Green and Yellow tasks and approves/denies Medicaid. The worker will disposition the tracking form(s) as approved/denied in OnBase and disposition the Purple task in PathOS as No Contact. The Purple tracking form is Worker Archived in OnBase.

**Example 4: *The worker claims a task to return a call to the client. This type of task can be found in any pathway depending on the status of the case*.** The worker is expected to research the case and complete all required case actions if any. When the worker returns the call, speaks to the client and provides resolution, the task is dispositioned as Approve/Deny or Pend if a 1233 is sent. If the worker is unable to reach the client after two attempts, the worker is expected to research the case and complete all required case actions, if any. The task is dispositioned as No Contact if the worker does not speak with the client or make an eligibility determination or send a 1233.

**Example 5: *The worker claims a task for Non-MAGI and all work has been completed on the case and the only action remaining is the disability decision from VR***. The worker will disposition the task as No Contact and send the tracking form to follow-up in OnBase according to policy.

**Example 6:** ***The LTC worker approves a NH application with an HMA in MEDS, OnBase, and Pathos.*** The worker will use the Approve/Deny disposition in PathOS, approve the case in MEDS, however in OnBase, the tracking form is sent to Follow-up for the designated time frame. Complete the documentation template explaining the reason for sending the tracking form to follow-up.  After the follow-up period is up, a worker will claim the case from the purple pathway in PathOS. The worker will read the template and inquire in MEDS to see what has to be done.  Do not create a tracking form in OnBase.

**Example 7:** ***The LTC worker claims a Green task in PathOS***. Upon inquiry in OnBase there is an active Tracking Form.  The Tracking Form was created because the client is currently auto-enrolled into CLTC services however, we have received nothing from the client. The Worker sends an application according to policy. The worker will disposition task in PathOS as a No Contact. The Tracking Form is archived in OnBase by the worker. If the client submits an application, it will initiate a Tracking Form in OnBase and go into normal workflow.

# PROCESS PATHWAYS

Customers access DHHS for a variety of reasons. By using the BPR process, we can quickly ascertain the reason for the visit and route the customer to the appropriate pathway. The goal is to serve customers at the time of request for services by utilizing the proper PathOS pathways.



# NAVIGATOR RESPONSIBILITIES

For customers who visit a DHHS office in person, their process begins at the navigation station (front counter) in the office lobby, where they are greeted by and check in with the Navigator.

The Navigator function is one of the most important for process management. They are responsible for determining what a customer needs and where to route them (triaging). Triaging is the process of sorting and prioritizing customers based on their request for service(s). The Navigator will review and route all lobby and non-lobby workload by the triage criteria defined in the “Determining the Process Pathway” section below. (Customers who call into an office or submit information via mail, fax, or email, are considered non-lobby customers. Customers who drop off information in an office lobby and do not stay to see a worker are also considered non-lobby customers).

The message the Navigator communicates to customers coming in the office has a major impact on office processes. It is vital the Navigator inform customers of their approximate wait time if they stay to see a worker, and the approximate processing time if they drop off information. Accurate messaging allows the customer to make an informed decision determining what avenue of service they wish to pursue based on their individual circumstance.

## Lobby Processes

**Greeting Customers**

1. Greet the customer in a professional and courteous manner.
2. Direct the customer according to their needs (e.g. DHHS, DSS, combination, or other agency)
3. Ask the following questions to determine customer needs:
	* How may I assist you today?
* Long Term Care service requests will be routed to the on-site supervisor.
	+ Are you here to apply, provide information, report a change or inquire on the status of your case?
	+ Do you have time to speak with someone regarding your case?
1. Research the customer in the available system(s) to obtain case specific information such as the household number.
2. Check provided applications and reviews to ensure all required fields are complete and documents signed.
3. Accept the paperwork and scan into OnBase according to the Application Scanning Crosswalk and other scanning tools.
4. Determine if the customer would like to stay and speak with someone regarding their case. Make sure to provide them an approximate wait time to see a worker AND an approximate time with a worker.
	* **Always** encourage clients to stay and see a worker, no matter what they came for – applications, reviews, changes, etc.
	* If the customer would like to stay, add them to the appropriate pathway in PathOS as described in the next section.
	* When entering customers in PathOS, only enter the HH#/App ID or Person ID in the Client ID field.  (Additional information prevents PathOS from bundling other tasks with the same number.) If the client is unable to stay, follow the non-lobby processes.
	* Customers entered into PathOS who report to the Navigator that they are no longer able to stay will be marked as “Abandoned” in PathOS. Do not manually add the customer to the non-lobby in PathOS.

*\** *For appeal requests: Please see the Appeals section in the Policy Manual for more information*.

**Application Registration**

* All applications should be checked for all required items to be considered a valid application.
* All valid applications are to be registered upon receipt to allow for immediate processing.
* If a customer is new to the system, they must be registered in the appropriate system of record prior to scanning the document into OnBase. (Refer to Job Aid “Registering a Person in Healthy Connections CURAM” or Creating a Household in MEDS.)

**Reviews**

* All reviews or applications received as a review should be screened for all required items to be considered valid.
* Reviews should be marked as received in CURAM or MEDS. (Refer to Job Aid “Marking Annual Reviews Received in CURAM or Registering a Review in MEDS.)

**Monitoring Lobby Traffic**

1. If long lines develop for customer check-in, notify supervisor or quarterback of the day.
2. If customers have waited an excessive amount of time, typically over an hour, notify supervisor or quarterback of the day.
3. If clients waiting in the lobby and the information in the PathOS Lobby Waiting do not match, notify supervisor or quarterback of the day.
4. At the end of each work day, navigators should be sure their PathOS lobby is empty.

## Determining Process Pathway

Work will be routed using process pathways (teams). These pathways are based on:

* Customer need (application, review, assessment/processing, change)
* Staff skill set
* Complexity/duration of the work

|  |
| --- |
| **MEDICAID** |
| **Teams** | **Primary Area of Responsibilities** |
| **Green – MAGI** | Initial applications for MAGI |
| **Green – Non-MAGI** | Initial applications Non-MAGI |
| **Blue – MAGI** | Reviews for all MAGI programs |
| **Blue – Non-MAGI** | Reviews for all Non-MAGI programs |
| **Yellow – MAGI** | Changes for all MAGI programs |
| **Yellow – Non-MAGI** | Changes for all Non-MAGI programs |
| **Purple – MAGI** | Assessment/Processing – processing returned verification for all MAGI programs |
| **Purple – Non-MAGI** | Assessment / Processing – processing returned verification for all Non-MAGI programs |
| **White** | Questions and non-eligibility changes (e.g., address changes, name changes, adding Social Security numbers) |

*\** *For appeal requests: Please see the Appeals section in the Policy Manual for more information*.

Work triaged into the White pathway in the lobby will be for general customer questions and non-eligibility changes. Examples may include but are not limited to:

1. Change of address
2. Name changes
3. Adding Social Security numbers to existing customers
4. Requesting a new Medicaid card

To ensure a timely and effective triage, customers with general questions and non-eligibility changes that can be resolved by the Navigator can be placed in the White track and called back up to the navigation station for assistance after all lobby customers have been effectively triaged. The White pathway may also be used for clients with questions for LTC Worker or a Supervisor. The White pathway should be monitored by the Navigator the same as other pathways.

For drop off documents received in the lobby, when a tracking form or active workflow begins in OnBase an automatic upload to PathOS will occur the next day generating a task in the appropriate program process pathway.

## Non-Lobby Processes

Phone calls:

* Phone calls to DHHS offices will be entered manually into the appropriate non-lobby pathway in PathOS using the Non-Lobby Clerical Role.
	+ A search with HH#/AppID is conducted to locate any active tasks in PathOS.
	+ Express Route options are limited to:
		- Medical emergencies
		- PW cases
		- Supervisor requests
	+ Workers will enter notes about the nature of the call in the most recent Documentation Template.

Mail, fax, drop off:

* An application, review, verification or change that is dropped off or received by mail or fax will be scanned into OnBase and if appropriate, noted as Information Received in CURAM. OnBase and/or CURAM will create or route a task to the appropriate process pathway in PathOS according to the corresponding indexing values the following business day. These tasks will be delivered to and processed by the first available eligibility worker.

# ELIGIBILITY WORKER RESPONSIBILITIES

Eligibility workers will be assigned to a specific process pathway team(s) for eligibility determinations to ensure efficient and accurate delivery of benefits. Eligibility workers will be assigned to provide either face-to-face service or to handle non-lobby service requests, including phones. Assignments to a specific team may change as needed based on workload demand.

Eligibility workers are responsible for ensuring all eligibility determinations are made in an efficient manner for all types of application(s), review(s), change(s) and verification(s) received online, by mail, by fax, dropped off, or from walk-in customers.

#### FOLLOW THE STEPS FOR ONE AND DONE

Staff must take the following steps for “One and Done” to exhaust all avenues to obtain required verification and achieve a determination:

1. Assess what the **customer provided** with the application, review, verification or change.
2. Reference the Income and/or Resource Matrix. Only ask for **required verifications** to avoid over or under verifying information.
3. Check OnBase to assess if verification is **already available.**
4. Check the eligibility system to assess if verification is already available.
5. Obtain verification through **electronic interfaces**:
	1. Person Service Composite (PCS)
	2. Work Number
	3. Wage Match (If same employer and below income standard – act on it)
	4. DSS Data
	5. VerifyDirect
	6. CHIP
	7. SVES
	8. DMV
	9. Bendex or SDX for Social Security
	10. SAVE
	11. UCB
	12. SC State Retirement
	13. AVS (Asset Verification System)
6. If unable to obtain verification through electronic interfaces, conduct **collateral calls** and **three-way calls** to obtain verification over the phone (i.e., verify employment, or verify resources by reaching out to financial or insurance institutions).
7. **Determine eligibility** if all required verification is obtained.
8. **Pend case** by sending a 1233 asking the customer to provide required specific verification if all other efforts fail.
9. **Ensure MEDS and** CURAM has been updated with all available information.
10. **Process** all active tracking forms in OnBase with available information.
11. Complete the Documentation Template.
12. **Update PathOS** with the appropriate disposition

## Collateral Calls

* Before sending a request for information, you are required to call the client or employer or financial institution **twice**.
	+ Make **two attempts** to obtain the required verification prior to pending.
	+ Do not leave a voice mail after the second attempt requesting a return call (no name, no instructions to call back).
* Face-to-face collateral calls
	+ Utilize the speakerphone and have the customer attempt to obtain the required verification. Third-party entities are more likely to share information with their employee or customer versus a third-party agency.
* Conference calling
	+ Utilize the three-way calling functionality and have the customer attempt to obtain the required verification. Third party entities are more likely to share information with the customer.
* If unsuccessful **send 1233** (Verification Checklist) asking for specific verification required to make the eligibility determination.

## Lobby Process

1. From the Case Worker Desktop in PathOS:
	1. Click the White Check Mark to view the Lobby pathways and identify the longest wait time.
		1. The Wait Time is the average wait time based on the number of clients waiting.
		2. In the example below, the Green pathway should be selected since the wait time is longer (average 30 minutes for 3 clients waiting).
	2. Make sure you are in the correct team (pathway).
	3. Select the “NEXT” case button to claim the next customer in PathOS.
	4. If the assigned pathway is empty check all other Lobby pathways.
	5. If all Lobby pathways are empty:
		1. From the Case Worker Desktop, select “Switch to This Team” and the appropriate pathway based on your non-lobby assignment. *(See Non-Lobby)*
2. Retrieve the customer from the lobby. If the customer does not answer on the first attempt wait a few minutes (3-5 minutes) and call the customer a second time.
	1. Move the active Tracking Form in Onbase into workflow.
	2. If the customer has left the lobby, update the case in PathOS with the “No Contact” disposition and return to step 1 above.
3. Search for the customer in the appropriate system of record.
4. Locate all required documents in OnBase via “Retrievals.”
5. Work one case at a time and keep the customer with you for the duration of the eligibility determination.
6. Process applications following the steps for “One and Done”:
7. Only ask for **required verifications**. Avoid over-verification or under-verification. (*Use Verification Matrix)*
8. Review **all documents** provided by the customer with the application.
9. Check the system of record (MEDS or CURAM) and OnBase to assess if verification is **already available.**
10. Obtain verification through **electronic interfaces**:
11. Person Service Composite (PCS)
12. Work Number
13. Wage Match (If same employer and below income standard – act on it)
14. DSS Data
15. VerifyDirect
16. CHIP
17. SVES
18. DMV
19. Bendex or SDX for Social Security
20. SAVE
21. UCB
22. SC State Retirement
23. AVS (Asset Verification System)
24. Obtain verification through collateral calls and three-way calls to obtain required verification over the phone (i.e., verify that employment has ended, or verify resources by reaching out to financial or insurance institutions). If you are unable to make contact on the first attempt wait a few minutes and call a second time prior to sending a request for information.
25. Determine eligibility if required verification is obtained.
26. Process the Active Tracking Form(s) in OnBase.
27. If all efforts fail to establish eligibility, inform the customer of the required next steps.
28. Mail the customer a checklist outlining the specific required verification(s) needed to complete the case.
29. Complete the system of record and take the case as far you can, completing all screens with available or known information.
30. Do not hand off programs (if application is for both MAGI and Non-MAGI programs the worker needs to be prepared to take the case as far as possible utilizing all available resources).
31. Send the tracking form to “Follow Up” in OnBase.
32. Update OnBase by processing all active tracking forms.
33. Record all actions on the Documentation Template.
34. Escort customer to the lobby.
35. Complete any remaining work for example addressing an envelope.
36. Update PathOS with the appropriate disposition of the case:
	1. Approve/Deny
	2. Pend
	3. No Contact

## Non-Lobby Process

1. From the Case Worker Desktop in PathOS:
	* Make sure you are in the correct team
	* Select “NEXT” to claim the next case
2. Locate all required documents in OnBase via “Retrievals.”
3. Move the active Tracking Form in Onbase into workflow. This will lock the case.
4. Work one case at a time.
5. Process applications following the steps for “One and Done”:
	1. Only ask for **required verifications**. Avoid over-verification or under-verification. (*Use Verification Matrix)*
	2. Review **all documents** provided by the customer with the application.
	3. Check the system of record (MEDS or CURAM) and OnBase to assess if verification is already available.
	4. Obtain verification through electronic interfaces:
		1. Person Service Composite (PCS)
		2. Work Number
		3. Wage Match (If same employer and below income standard – act on it)
		4. DSS Data
		5. VerifyDirect
		6. CHIP
		7. SVES
		8. DMV
		9. Bendex or SDX for Social Security
		10. SAVE
		11. UCB
		12. SC State Retirement
		13. AVS (Asset Verification System)
6. Obtain verification through collateral calls and three-way calls to obtain required verification over the phone (i.e., verify employment, or verify resources by reaching out to financial or insurance institutions). If you are unable to make contact on the first attempt wait a few minutes and call a second time prior to sending a request for information.
7. Determine eligibility if required verification is obtained.
8. If all efforts fail to establish eligibility, inform the customer of what are required next steps.
9. Mail the customer a checklist outlining the specific required verification(s) needed to complete the case.
10. Complete the system of record and take the case as far you can, completing all screens with available or known information.
11. Do not hand off programs (if application is for both MAGI and Non-MAGI programs the worker needs to be prepared to take the case as far as possible utilizing all available resources).
12. Process all active tracking forms in OnBase.
13. Record all actions on the Documentation Template.
14. Update PathOS with the appropriate disposition of the case:
	1. Approve/Deny
	2. Pend
	3. No Contact

# LONG-TERM CARE

## Long-Term Care Process Pathways

Customers access DHHS for a variety of reasons and by using the BPR process we will have the ability to quickly ascertain the reason for the service request and triage the customer using process pathways (teams). These pathways are based on:

* Customer need (application, review, verification or change)
* Staff skill set
* Complexity/duration of the work



|  |
| --- |
| **LONG-TERM CARE MEDICAID** |
| **Teams** | **Primary Area of Responsibilities** |
| **Green – Long Term Care** | Initial Applications for long term care |
| **Blue – Long Term Care** | Reviews for all long-term care programs |
| **Yellow – Long Term Care** | Changes for all long-term care programs |
| **Purple – Long Term Care** | Assessment/Processing – processing returned verification for all long-term care programs |

*\** *For appeal requests: Please see the Appeals section in the Policy Manual for more information*.

# LONG-TERM CARE ELIGIBILITY WORKER RESPONSIBILITIES

Long-Term Care (LTC) eligibility workers will be assigned to a specific process pathway team(s) for eligibility determinations to ensure efficient and accurate delivery of benefits. Eligibility workers will be assigned to provide either face-to-face service or to handle non-lobby service requests, including phones. Assignments to a specific team may change as needed based on workload demand.

Eligibility workers are responsible for ensuring all eligibility determinations are made in an efficient manner for all types of application(s), review(s), change(s) and verification(s) received online, by mail, by fax, dropped off, or from walk-in customers.

####  FOLLOW THE STEPS FOR ONE AND DONE

1. Contact the customer or authorized representative via phone to review information and gather verification.
2. Only ask for required verification using the Resource Verification Matrix, Income Verification Matrix, and the LTC Matrix.
3. Evaluate all verification provided by the customer.
4. Check MEDS and ONBASE to determine if the agency already has required verification.
5. Conduct electronic interfaces search to obtain required verification.
6. Obtain verification through collateral contacts and three-way calling. Make every attempt to contact financial institutions via three-way calling utilizing the customer or authorized representative to obtain required verifications.

## Collateral Calls

* Before sending a request for information, you are required to call the client or employer or financial institution **twice**.
	+ Make **two attempts** to obtain the required verification prior to pending.
	+ **Do not leave a voice mail requesting a return call** (no name, no instructions to call back).
* Face-to-face collateral calls
	+ Utilize the speakerphone and have the customer attempt to obtain the required verification. Third-party entities are more likely to share information with their employee or customer versus a third-party agency.
* Conference calling
	+ Utilize the three-way calling functionality and have the customer attempt to obtain the required verification. Third party entities are more likely to share information with the customer.
* If unsuccessful **send 1233** (Verification Checklist) asking for specific verification required to make the eligibility determination

##  Lobby Process

The goal is to serve customers at the time of request for services by utilizing the proper PathOS pathways. Eligibility workers are expected to follow the “One and Done” steps to ensure First Contact Resolution and eliminate unnecessary handoffs.

Lobby services for LTC differ across the state depending on whether the local office has an LTC worker on site.

Any lobby interaction for LTC will be at the discretion of the supervisor, based in part on the availability of an LTC worker on site and the needs of the customer. If a lobby customer requests a face-to-face interaction regarding LTC, the supervisor should determine what their need is. The supervisor will then determine whether the LTC worker should finish their current task (preferred) or stop their current task to assist the customer. If at all possible, work should not be disrupted. It is acceptable in most situations for the customer to wait while the worker completes their task.

When the office has determined a customer will be seen in the lobby, the **Navigator** or **Supervisor** will:

1. Sign into PathOS under the “Lobby Greeter” role, in the appropriate Long-Term Care Domain.
2. Add the customer’s case to PathOS.
	1. Select the “Add Case” button and enter available information.
3. Inform the LTC worker that face-to-face services have been requested in the lobby and provide them with the customer ID, name and process pathway.
4. From the Case Worker Desktop in PathOS:
	1. Click the White Check Mark to view the Lobby pathways and identify the longest wait time.
		1. The Wait Time is the average wait time based on the number of clients waiting.
		2. In the example below, the Green pathway should be selected since the wait time is longer (average 30 minutes for 3 clients waiting).
	2. Make sure you are in the correct team (pathway).
	3. Select the “NEXT” case button to claim the next customer in PathOS.
	4. If the assigned pathway is empty check all other Lobby pathways.
	5. If all Lobby pathways are empty:
		1. From the Case Worker Desktop, select “Switch to This Team” and the appropriate pathway based on your non-lobby assignment. *(See Non-Lobby)*
5. Retrieve the customer from the lobby. If the customer does not answer on the first attempt wait a few minutes (3-5 minutes) and call the customer a second time.
	1. Move the active Tracking Form in Onbase into workflow.
	2. If the customer has left the lobby, update the case in PathOS with the “No Contact” disposition and return to step 1 above.
6. Search for the customer in the appropriate system of record.
7. Locate all required documents in OnBase via “Retrievals.”
8. Work one case at a time and keep the customer with you for the duration of the eligibility determination.
9. Process applications following the steps for “One and Done”:
10. Only ask for **required verifications**. Avoid over-verification or under-verification. (*Use Verification Matrix)*
11. Review **all documents** provided by the customer with the application.
12. Check the system of record (MEDS or CURAM) and OnBase to assess if verification is **already available.**
13. Obtain verification through **electronic interfaces**:
14. Person Service Composite (PCS)
15. Work Number
16. Wage Match (If same employer and below income standard – act on it)
17. DSS Data
18. VerifyDirect
19. CHIP
20. SVES
21. DMV
22. Bendex or SDX for Social Security
23. SAVE
24. UCB
25. SC State Retirement
26. AVS (Asset Verification System)
27. Obtain verification through collateral calls and three-way calls to obtain required verification over the phone (i.e., verify that employment has ended, or verify resources by reaching out to financial or insurance institutions). If you are unable to make contact on the first attempt wait a few minutes and call a second time prior to sending a request for information.
28. Determine eligibility if required verification is obtained.
29. Process the Active Tracking Form(s) in OnBase.
30. If all efforts fail to establish eligibility, inform the customer of the required next steps.
31. Mail the customer a checklist outlining the specific required verification(s) needed to complete the case.
32. Complete the system of record and take the case as far you can, completing all screens with available or known information.
33. Do not hand off programs (if application is for both MAGI and Non-MAGI programs the worker needs to be prepared to take the case as far as possible utilizing all available resources).
34. Send the tracking form to “Follow Up” in OnBase.
35. Update OnBase by processing all active tracking forms.
36. Record all actions on the Documentation Template.
37. Escort customer to the lobby.
38. Complete any remaining work for example addressing an envelope.
39. Update PathOS with the appropriate disposition of the case:
	1. Approve/Deny
	2. Pend
	3. No Contact

## Non-Lobby Process

1. From the Case Worker Desktop in PathOS:
	1. Make sure you are in the correct team
	2. Select “NEXT” to claim the next case
2. Locate all required documents in OnBase via “Retrievals.”
3. Work one case at a time.
4. Process applications following the steps for “One and Done”:
	1. Only ask for **required verifications**. Avoid over-verification or under-verification. (*Use Verification Matrix)*
	2. Review **all documents** provided by the customer with the application
	3. Check the system of record (MEDS or CURAM) and OnBase to assess if verification is already available
	4. Obtain verification through electronic interfaces:
5. Work Number
6. Wage Match (If same employer and below income standard – act on it)
7. DSS Data
8. VerifyDirect
9. Bendex
10. SDX
11. SC State Retirement
12. Person Composite
13. Obtain verification through collateral calls and three-way calls to obtain required verification over the phone (i.e., verify that employment has ended, or verify resources by reaching out to financial or insurance institutions). If you are unable to make contact on the first attempt wait a few minutes and call a second time prior to sending a request for information.
14. Determine eligibility if required verification is obtained.
15. Process the Active Tracking Form(s) in OnBase.
16. If all efforts fail to establish eligibility, inform the customer of what are required next steps.
17. Mail the customer a checklist outlining the specific required verification(s) needed to complete the case.
18. Complete the system of record and take the case as far you can, completing all screens with available or known information.
19. Do not hand off programs (if application is for both MAGI and Non-MAGI programs the worker needs to be prepared to take the case as far as possible utilizing all available resources).
20. Send the tracking form to “Follow Up” in OnBase.
21. Process all active tracking forms in OnBase.
22. Record all actions on the Documentation Template.
23. Update PathOS with the appropriate disposition of the case:
24. Approve/Deny
25. Pend
26. No Contact

# OUT STATIONED ELIGIBILITY WORKER RESPONSIBILITIES

Eligibility workers who are out stationed will be responsible for processing applications, reviews, changes and verification (Assessment/Processing). Out stationed workers will process work received face-to-face (lobby). If there is no face-to-face work to process, out stationed workers will process work received in the non-lobby pathways in PathOS based on staffing assignments provided by their Performance Manager. Non-lobby work will be completed following the non-lobby process.

## Lobby Process

1. Sign into PathOS under the “Lobby Greeter” role.
2. Add the customer’s case to PathOS.
	1. Select the “Add Case” button and enter available information.
		1. If no case identifier is available, leave the case ID field blank.
3. From the Case Worker Desktop in PathOS:
	1. Click the White Check Mark to view the Lobby pathways and identify the longest wait time.
		1. The Wait Time is the average wait time based on the number of clients waiting.
		2. In the example below, the Green pathway should be selected since the wait time is longer (average 30 minutes for 3 clients waiting).
	2. Make sure you are in the correct team (pathway).
	3. Select the “NEXT” case button to claim the next customer in PathOS.
	4. If the assigned pathway is empty check all other Lobby pathways.
	5. If all Lobby pathways are empty:
		1. From the Case Worker Desktop, select “Switch to This Team” and the appropriate pathway based on your non-lobby assignment. *(See Non-Lobby)*
	6. Retrieve the customer from the lobby. If the customer does not answer on the first attempt wait a few minutes (3-5 minutes) and call the customer a second time.
	7. Move the active Tracking Form in Onbase into workflow.
	8. If the customer has left the lobby, update the case in PathOS with the “No Contact” disposition and return to step 1 above.
4. Search for the customer in the appropriate system of record.
5. Locate all required documents in OnBase via “Retrievals.”
6. Work one case at a time and keep the customer with you for the duration of the eligibility determination.
7. Process applications following the steps for “One and Done”:
8. Only ask for **required verifications**. Avoid over-verification or under-verification. (*Use Verification Matrix)*
9. Review **all documents** provided by the customer with the application.
10. Check the system of record (MEDS or CURAM) and OnBase to assess if verification is **already available.**
11. Obtain verification through **electronic interfaces**:
12. Person Service Composite (PCS)
13. Work Number
14. Wage Match (If same employer and below income standard – act on it)
15. DSS Data
16. VerifyDirect
17. CHIP
18. SVES
19. DMV
20. Bendex or SDX for Social Security
21. SAVE
22. UCB
23. SC State Retirement
24. AVS (Asset Verification System)
25. Obtain verification through collateral calls and three-way calls to obtain required verification over the phone (i.e., verify that employment has ended, or verify resources by reaching out to financial or insurance institutions). If you are unable to make contact on the first attempt wait a few minutes and call a second time prior to sending a request for information.
26. Determine eligibility if required verification is obtained.
27. Process the Active Tracking Form(s) in OnBase.
28. If all efforts fail to establish eligibility, inform the customer of the required next steps.
29. Mail the customer a checklist outlining the specific required verification(s) needed to complete the case.
30. Complete the system of record and take the case as far you can, completing all screens with available or known information.
31. Do not hand off programs (if application is for both MAGI and Non-MAGI programs the worker needs to be prepared to take the case as far as possible utilizing all available resources).
32. Send the tracking form to “Follow Up” in OnBase.
33. Update OnBase by processing all active tracking forms.
34. Record all actions on the Documentation Template.
35. Escort customer to the lobby.
36. Complete any remaining work for example addressing an envelope.
37. Update PathOS with the appropriate disposition of the case:
38. Approve/Deny
39. Pend
40. No Contact

## Non-Lobby Process

1. From the Case Worker Desktop in PathOS:
2. Make sure you are in the correct team
3. Select “NEXT” to claim the next case
4. Locate all required documents in OnBase via “Retrievals.”
5. Work one case at a time.
6. Process applications following the steps for “One and Done”:
7. Only ask for **required verifications**. Avoid over-verification or under-verification. (*Use Verification Matrix)*
8. Review **all documents** provided by the customer with the application
9. Check the system of record (MEDS or CURAM) and OnBase to assess if verification is already available
10. Obtain verification through electronic interfaces:
	1. Person Service Composite (PCS)
	2. Work Number
	3. Wage Match (If same employer and below income standard – act on it)
	4. DSS Data
	5. VerifyDirect
	6. CHIP
	7. SVES
	8. DMV
	9. Bendex or SDX for Social Security
	10. SAVE
	11. UCB
	12. SC State Retirement
	13. AVS (Asset Verification System)
11. Obtain verification through collateral calls and three-way calls to obtain required verification over the phone (i.e., verify that employment has ended, or verify resources by reaching out to financial or insurance institutions). If you are unable to make contact on the first attempt wait a few minutes and call a second time prior to sending a request for information.
12. Determine eligibility if required verification is obtained.
13. Process the Active Tracking Form(s) in OnBase.
14. If all efforts fail to establish eligibility, inform the customer of what are required next steps.
15. Mail the customer a checklist outlining the specific required verification(s) needed to complete the case.
16. Complete the system of record and take the case as far you can, completing all screens with available or known information.
17. Do not hand off programs (if application is for both MAGI and Non-MAGI programs the worker needs to be prepared to take the case as far as possible utilizing all available resources).
18. Send the tracking form to “Follow Up” in OnBase.
19. Process all active tracking forms in OnBase.
20. Record all actions on the Documentation Template.
21. Update PathOS with the appropriate disposition of the case:
22. Approve/Deny
23. Pend
24. No Contact

# PROCESS MEASURES

Supervisors, managers, HSCIIs and senior workers have access to real-time data from PathOS, OnBase, MEDS, and CURAM to monitor workflow, worker activity, and customer service.

The following key measures are available at the worker, team, office, regional, and statewide levels:

* Workload ready to process by pathway
* Total eligibility decisions made (productivity)
* Completion/pending rates (One and Done rate)
* Transaction times for all case actions
* Wait time (the amount of time applications, reviews, changes, and returned verifications spend in each process pathway)

# SUPERVISOR RESPONSIBILITIES

Supervisors will:

1. Answer questions.
2. Periodically conduct lobby and non-lobby case processing observations to ensure your team is following the process correctly, including following the steps for One and Done and using the consistency tools.
3. Complete supervisor reviews for all team members.
4. Conduct team huddles.
5. Monitor PathOS Office Workload Report every 45 minutes to an hour to ensure all workers are working in the process and have work claimed.
6. Understand PathOS data and share it with the team as appropriate.
7. Monitor Daily, Weekly, Monthly Reports.
8. Have daily conversations with staff concerning measures of families being served.
9. Identify training needs.
10. Monitor incoming work versus families receiving eligibility decisions.
11. Work directly with the Performance Manager on staffing assignments.

## Supervisor Hourly Reconciliation Process

Every 45 to 60 minutes, supervisors will use the Office Workload report in PathOS to:

1. **Reconcile**: Check PathOS for staff productivity:
	1. Healthy Process: 80% of workers have cases claimed
	2. Follow-up Needed: 40% of workers have cases claimed
2. **Review**: Check the transaction times and completion rates:
	1. Healthy Process: Tasks are within timeframes
	2. Follow-up Needed: If tasks are outside of timeframes, check the individual worker detail to see if any coaching is needed
3. **Re-adjust**:
	1. Compare the lobby traffic to the non-lobby pending work to identify any shifting of staff between the pathways

**Communicate** with everyone ALL THE TIME. Process management requires constant communication. The entire office needs to work together to serve customers.

* Supervisors should decide how to communicate depending on the situation.
	+ See guidelines below for huddles.
* Decisions need to be made very quickly in some instances and others can wait until the manager huddle. If the wrong decision was made, the supervisor will take responsibility for that decision and apply the lessons learned to future decisions.

**In Process Management:**

1. All work belongs to the state. The supervisors are responsible for making sure all cases are processed timely and accurately.
2. Supervisors need to have a plan for how the work will get done and the ability to adapt and make adjustments every minute if necessary.
3. Supervisors can make temporary adjustments to assist in the lobby to ensure the work gets completed.
4. Staff are the valuable resources that supervisors utilize to process cases.
5. Performance Managers and supervisors will work together to strategically place staff where they will help the most.
6. Supervisors will plan out the day for the whole team.
7. Supervisors are responsible for checking that all team members are utilizing the consistency tools and job aids as well as ensuring that staff are following the processes defined in this procedural manual.

**Steps to Effectively Manage Your Process:**

*All of the following refer to minute, hour, day, week and monthly timeframes.*

1. Always know the volume of work you have and how much time and staff are needed to complete the work.
2. Know the trends for your process – peaks, slow times, impact of lunchtime, etc. – and respond accordingly with your team or with the help from other teams.
3. Establish the quarterback role for the office, to monitor and manage resources in the lobby. This person will be responsible for utilizing PathOS and conducting a periodic walk through of the office to appropriately manage the lobby.
4. Staff will be assigned to teams, but process management is a fluid process where staff go wherever the work is at that moment. As soon as there is a change in the demand, staff will be shifted accordingly. Communicate adjustments with the regional Performance Manager.
5. Monitor PathOS Office Workload report every 45 minutes to 1 hour to ensure all available workers have work claimed.

**Tools and Resources to Effectively Manage Your Process:**

1. PathOS
	1. Shows how much work has been completed in the lobby and non-lobby, enabling you to “forecast” the amount of time needed to complete the current workload based on staffing.
	2. Wait and transaction times can be used to determine staff efficiency and identify workers who may not be using the consistency tools.
	3. Provides minute-by-minute, day-by-day, and week-to-week comparative data.

**Huddles for Management:**

Supervisors should meet daily to assess office performance, identify issues, and plan resource allocation. Communication between Supervisors is essential to success. The Supervisor huddle ensure supervisors are on the same page with procedures and expectations; allow open discussion and sharing of ideas and solutions; and keep the connection between teams on track.

Talking points:

1. Discuss staffing adjustments, barriers and solutions, productivity, volume of work completed and backlog.
2. Review backlog amounts and oldest case. Revisit plan to eliminate backlog to ensure you are on track.
3. Review staff call-ins and vacation and make adjustments for coverage of lobby, non-lobby and phones. Don’t forget lunch coverage, too.
4. Go over the prior day’s lobby and non-lobby data (e.g., total customers, wait times, % completed) and analyze this information. Do the numbers look good? If so, what are we doing right? If not, what do we need to change?
5. Discuss any anticipated issues, trainings, vacations, high volume of reviews due the following month, back to school volume increase, etc. What needs to be done to plan ahead?
6. Discuss obstacles and barriers to getting work done. Always include solutions and leave with a plan.
7. Discuss successes and new ideas. All data, decisions, and solutions should be shared office wide.

**Huddles for Teams:**

The management team must conduct regular huddle meetings with their teams. These meetings ensure staff is informed about updates and changes from management meetings; allow open discussion and sharing of ideas and solutions; and keep the connection between teams on track.

Talking points:

1. Discuss staffing adjustments, productivity, volume of work completed and backlog.
2. Review backlog amounts and oldest case. Revisit plan to eliminate backlog.
3. Review staff call-ins and vacation and make adjustments for coverage of lobby, non-lobby and phones. Don’t forget lunch coverage, too.
4. Go over the prior day’s lobby and non-lobby data (e.g., total customers, wait times, % completed). This should open up a discussion or reminders about using the consistency tools correctly if completion rates are low, interview times are too low or high, and/or rework is occurring.
5. Discuss obstacles and barriers to getting work done. Always include solutions and leave with a plan.
6. Discuss successes and new ideas.

# QUARTERBACK RESPONSIBILITIES

Quarterbacking is managing and oversight of the workflow and process pathways specific to the lobby. The office quarterback will make decisions based on a “moment in time” using PathOS data for the entire office. The quarterback is typically an office supervisor but could also be a senior worker.

The quarterback will:

* Continually monitor PathOS and make staffing adjustments IF needed. The PathOS Office Workload report should be reviewed at least every 45 - 60 minutes.
* Always make the smallest adjustment possible to resolve the issue, whether it is long wait times or more capacity is needed at any access point.
* Communicate all adjustments to supervisors and staff as quickly as possible.
* Ensure all eligibility workers are actively working in PathOS when assigned.
* Keep track of start times and lunch times for all workers.

## Quarterbacking for an Office

1. Monitor lobby process pathways (teams) and make adjustments if needed. Every 45-60 minutes review the Office Workload report in PathOS. Specifically look at:
	1. How many customers are waiting in each process pathway?
	2. How long is the wait time in each process pathway?
	3. Is the wait time equal to or less than the average transaction time for the process pathway? If not, then adjustment may be needed.
2. Using the above information (how many are waiting and average transaction time per process pathway), calculate how long it will take to clear the customers waiting in each process pathway based on the number of eligibility workers available.

**FORMULA**

* 60 (minutes) divided by the average transaction time = the average number of transactions per hour. Example: If changes take 20 minutes, 60÷20=3 changes per hour.
* The number of transactions per hour multiplied by the number of eligibility workers available = the average number of transactions per hour. Example: If an office has 4 workers, 3x4=12 transactions per hour.
* The number of customers waiting divided by the number of transactions per hour = the number of hours needed to clear the process pathway. Example: If 15 customers are waiting for changes, 15÷12=1 hr. 15 min. to clear the lobby.

**EXAMPLE**

There are three eligibility workers assigned to the lobby Green MAGI process pathway and there are 18 customers waiting in that pathway. Because each Green MAGI transaction should take approximately 20 minutes to finish, each worker process about three Green MAGI applications per hour (3 eligibility workers x 3 interviews/hr. = 9 interviews per hour). Dividing the 18 customers waiting by the number of interviews per hour (9) tells us it will take approximately two hours to clear the lobby Green MAGI process pathway with the three eligibility workers currently assigned.

1. Always make the smallest adjustment possible to resolve the issue. For example:
	1. Ask a worker assigned to the non-lobby to claim their next case from a specific lobby pathway (team) and then go back to their primary assignment.
	2. If all tracks are behind be very careful about using the “bus” strategy (all hands-on deck). It can create a “roller coaster” effect and the office ends up doing a “bus” from one pathway to the next. This can also lead to staff claiming the oldest customer waiting regardless of pathway, which is not effective.
	3. Use your capacity calculation to determine when to move to basic service for the lobby pathways at the end of the day.
		1. If all pathways will take until the end of the day, it is time to go to basic service the pathways.
		2. If only some pathways will take until the end of the day to finish, then the other pathways should be able to help and can stay open longer.
2. Communicate all adjustments to supervisors and staff
	1. To avoid confusion, communicate to staff and all other supervisors as quickly as possible.
	2. Don’t forget to communicate when you want staff to stop helping other pathways and go back to their primary pathway
3. Ensure all workers are actively working their case assignments from PathOS.
	1. Know your workers’ lunchtime schedules and ensure they take lunch on time.
	2. Check the total number of workers you have working (Office Workload report). Does it match the number of workers assigned?
	3. Remember, the work takes as long as it takes; however, if an action is taking an exceedingly long period of time, check with the worker to see if they need assistance.
4. Continually communicate with staff about procedures, even if it feels repetitive. They need to hear from you whenever you make a change to a procedure that day if necessary, otherwise communicate it during the morning huddle.