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How to Set Up Your SUD Center's QA Process

The complete guide to setting up your SUD center's quality assurance team & workflow

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How to Set Up Your SUD Center's QA Process - Brellium & BHA Compliance

Brellium helps dozens of mental health & substance use centers automate their chart review with AI, including Cerebral Mental Health, The Sylvia Brafman Mental Health Center, and Alter Behavioral Health. With Brellium, centers no longer need to audit charts one-by-one. Brellium automatically analyzes each of your patients charts in real-time, and tells you which need to be fixed and how to fix them.

BHA Compliance helps mental health & substance use centers build robust Quality Assurance programs. BHA Compliance's CEO, Matt Michaels, previously was VP of Quality & Compliance at Zinnia Health, one of the nation's leading Behavioral Health providers. He has a Ph.D. in Clinical Psychology from Florida State

University, where he wrote over 20 scientific publications, including a book chapter for the Oxford Handbook of Mood Disorders. He utilizes his clinical and analytic background to implement world-class quality and compliance efforts for behavioral health providers that are both practical and data-driven, and has done so for facilities in CA, CO, FL, GA, IN, NJ, RI, and TX.

So, together, we've seen (almost) every derivation of how mental health & substance use centers handle QA!

In theory, QA should be standardized across clinics by payor. If two SUD centers bill Medicaid in Florida, their requirements and QA process should be identical.

In practice, this couldn't be farther from the truth. This is mostly because payor rules and industry best-practice processes are opaque, so everyone does their best based on what they've seen work in the past. So, every center's QA requirements and processes end up looking completely different.

Which is inefficient, and results in a lot of lost sleep, time, and $$ because nobody is quite sure what they should be doing.

In this guide, we'll outline how to most efficiently set up your quality assurance process for your behavioral health clinic, from our learnings across dozens of provider groups. This guide is most helpful for Quality Assurance Leads at small-to-mid size centers who are looking to build out an efficient QA process. It'll also be helpful if you're a part of the founding team of a startup clinic, or at a large clinic looking to make your operation more efficient.

Why QA is important

(1) - to make sure your patients are being treated correctly and according to your clinical standards. (2) - to make sure that every dollar your payors pay you stays in your pocket, instead of being clawed back months or even years down the line after payment.

In short, good QA = you sleep well at night. It's not the most glamorous part of your business - that's caring for your patients and growing your footprint. But, you know you've got a good QA team when you hear about issues upfront, rather than getting an upset phone call from a client's parent or the dreaded "Payor Audit" email.

And good sleep = priceless.

Setting up your note template

A good note template = way less time spent on auditing.

Humans make mistakes. And your providers have a million things going on. So, you've got to do your best to make your note template bulletproof.

It's essential to strike a balance between creating preset automated options and free text sections.

Automated recommendations:

1. All session info (Provider info, Client Info, Session Info).
    a. These fields should be populated by your EMR rather than your providers. Populating these ahead of time based on the schedule will reduce clawbacks, and time spent by your clinical staff members completing their documentation!
2. Required segments (All headers + subsections)
    a. Getting the basics right here is important - make sure your assessment, progress note, and group session templates have the appropriate elements to meet payor, accreditation and state requirements. E.g., first they will fill out the biopsychosocial required elements, then they'll fill in the free text portions.
    b. A provider shouldn't have to choose to include additional sections that are required by payors, accrediting bodies, or state licensure, they should have a place on the note dedicated to this. This logic holds for all your note's subsections.

    c. Treatment Plan Goals - making your goals easy to import is super important for getting billable session notes!

3. Checkboxes
    a. Things like clinical techniques, interventions, and many other sections can be encoded into a checkbox section. Leaving these as free text will lead to clinical staff writing potentially incorrect or irrelevant info in these sections.
4. Signatures
    a. If possible, use automated e-signatures that are required fields. If not possible, make your signatures super easy to fill out! This is one of the most common mistakes.

Free text:

1. Session narrative
    a. Your clinical staff need to be able to clearly communicate what happened in the session! Good session narratives are more about training and guidelines than the note template itself! One minor point of feedback is to have your narrative after the goals so the staff member can reference what they should be discussing.
2. Additional Notes
    a. Edge cases happen. Its important that your providers have the opportunity to explain in free text any exacerbating or unusual circumstances in the session.
3. More!
    a. Depending on the type of note, there may be a lot more free text sections that make sense to include.

Automated options are valuable for a session note framework and easy for providers to use but it can limit opportunities for individualized medical records. Only having freeform options is very time consuming on the providers and will result in very unhappy staff. Efficiency is for everyone!

Creating note templates with the right type of automated options that the providers can elaborate on is crucial for setting your staff up for success. **Pro tip**: BHA Compliance is amazing at helping you set this up!

Outlining clear rules for your Providers

Your QA process is 50% setting up assessment and note templates and 50% training your staff well.

The key for your organization is to have:

1. A go-to person within your organization who your providers and QA staff can go to with questions. Having a 'champion' creates a sense of responsibility and pride for the leader you tap for this role, and reduces a natural tendency to 'pass the buck' when staff members lack the empowerment to be a decision maker.
2. Clear, objective, and all-inclusive expectations on how your providers should complete session notes.

For #1, your selected QA champion should be extremely responsive, deeply understand both the day-to-day of QA and the underlying services, as well as displaying a positive and helpful attitude with your providers. In this case, knowledge is **not** everything. A helpful person the providers trust combined with the necessary QA knowledge is the key. Remember—we want to solve issues upfront, so we want providers to feel as comfortable as possible asking for help.

Recommendations for #2:

1. Examples
    a. Give your providers training examples for what a good note looks like! When doing performance reviews or meeting with them after they ramp up, giving them some positive feedback regarding good notes they've submitted and constructive feedback regarding any bad notes is also helpful!

2. Concrete Deliverables
    a. Outline exactly what should be noted in each free text section using tool tips, training guidance, or cheat sheets. E.g., “First section MSE, next section SOAP format”, etc. Giving specific examples during training and/or number of expected sentences for each section can help clarify expectations and avoid submission of notes that either lack detail or are *too* detailed (an inefficient use of the clinician or provider’s time). These expectations will help guide your providers and are often better than just saying “minimum of 3 sentences”.

Setting up your audit requirements

Pro tips:

1. Make sure your audit criteria are **actual** insurance, accreditation, or state requirements (given the individual payors that you are dealing with). Many times you are being extra cautious because you hear that others are doing the same, but it was only added due to a unique payor’s requirement and may not apply you. It can be so frustrating on both your direct and internal service staff to concern themselves with documenting something that has literally no bearing on care or reimbursement! Check out the above section for guidance on recommendations for requirements to approve, or pull from Brellium’s free question bank.
2. Differentiate your criteria between clear cut technical audit requirements vs clinical requirements. Oftentimes, clinical requirements can be more subjective. Thus, your organization should leave room for clinical judgement when developing your required criteria. The last thing you want to do is give a provider negative feedback for something they documented, when it was clinically justified!
3. Proper checks and balances involving both clinical leadership, training, and QA helps facilitate a smooth process for all stakeholders and has the added benefit of creating valuable and healthy debate as well as a good set of feedback loops.

4. Adjust your criteria based on payor feedback and published changes. Because the industry keeps changing, it is important to internalize payor feedback and updated handbooks to ensure that your criteria are up to date. Some payors update their standards as often as quarterly! While it may not require your organization to change your audit requirements, it is important to look out for anything that needs to be changed. BHA Compliance is awesome at helping with this too!

Setting up your auditing team (and using Brellium!)

OK, so we've covered how to build a great template, what your providers need to know, and what your team should be auditing for. Now, it's time to put our plan into action.

We usually see the most successful audit teams include providers who've transitioned to the operations side of the business. They have context on therapy, working conditions, and can "speak the language" of the provider sessions they're auditing. Usually a minimum of 2 years experience is enough for an detail oriented and audit-minded individual to excel at auditing. Extensive clinical experience is helpful, but not required to be a great auditor.

So, if you have a few providers on your team who're naturally drawn to QA, they can be GREAT candidates to join (and potentially lead) your QA team. Those coming from operations or other non-clinical departments can usually also be paired with a few clinicians-turned-auditors to help show them the ropes.

Your QA team leader should have a comprehensive understanding of both the clinical and business side of your clinic. Quality is vital, but there's a middle ground between zero oversight and needing perfect notes. An overzealous and/or punitive QA department can discourage clinicians. Be in consistent communication with your QA staff on what their middle ground is and ensure that it is followed.

Of course, Brellium helps all of this move quicker. Instead of needing an army of providers to go through every note one-by-one every day, Brellium handles the manual auditing so your team can focus on the important things—helping your providers improve their documentation & standard of care.

If you're not using Brellium, we recommend auditing from a big Google Sheet with each provider's name in Column A, provider's email in Column B, and date in Row 1 in Tab #1. Tab #2 contains the requirements to screen for that we outlined above, so your auditors can quickly toggle back-and-forth to see what they should be looking for. We recommend asking your auditors to have these 2 screens open, plus your EMR to view the session note, while auditing.

Other manual audit tips:

1. Mark "X" in each cell for each note that's passed audit
2. Mark "Contacting Provider" in each cell for each note that failed audit and specify the reason why
3. Add conditional formatting to highlight cells that contain "Contacting Provider" so it's easy to view yet-to-be-fixed issues
4. Create a third tab that uses a VLOOKUP / INDEXMATCH to give you the # of error instances per provider, so you can easily view providers that have a higher error rate

Setting up how to have providers fix errors

You've found all of your errors. Now, it's time to fix them!

Our recommended manual notification method starts with your auditing Google Sheet. At the end of each auditor's day, they should go through each of the cells they've marked as "Contacting Provider" and send an individual email to the provider specifying the note's day & time, and what needs to be fixed or improved on in the future. Note—if your email server is not encrypted & HIPAA compliant (check with your IT team), make sure there is no PHI in the notification email.

Then, ask your auditor to mark the "Notification Sent" cells as orange, so you know they're in progress.

Once the provider has fixed the note and notifies your auditor, they can mark the cell green, confirming that the note has been fixed.

Another Brellium plug—if you use us, you don't have to do any of the above. You can just configure "Please Fix this Note" notifications once, then notifications will automatically send out every week!

Responding to payor audits

The dreaded "Payor Audit" email...

Every so often, each of your payors ask you to send them a portion of their clients' notes.

They want to double check that documentation is correct, and that they're not overpaying for services.

If you're manually auditing notes, we recommend asking your team to focus on only the clients the payor has requested for the audit period for 1-2 weeks. Ask your team to pause their normal auditing, and re-audit the sample size.

It's essential to make sure the initial audit goes smoothly. If errors are found, your payor may ask for a larger sample, which slows your team down even more. If issues are found with the second sample, the payor may claw back funds and/or hold future payments pending the audit. Not good. So, ensure your team understands the gravity of the situation and double checks your notes for the audit period.

Finally, export each requested document from your EMR/PMS, and compile into 1 large PDF to upload to your payor portal.

Final Brellium plug - if you use us, you don't need to do any of the above. Brellium provides a clawback guarantee, where if we make a mistake that a payor claws back on, we pay the bill. Not you. Brellium also lets you easily export all notes for the audit period for a client range in 3 clicks, so you can easily respond to your payor audits.

Your payor may have questions/tips on individual notes & requirements. Answer them politely, quickly, and thoughtfully. If you're ever unsure of a requirement or how to respond to an audit, we HIGHLY recommend reaching out to an ABA quality specialist, like Matt @ BHA Compliance!

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