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How to Set Up Your Home Health Agency's QA Process

The complete guide to setting up your Home Health quality assurance team & workflow

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Ashlee Oliver is the CEO of JWO Home Health Consultants, a full-service home health consulting and quality assurance organization servicing agencies of all sizes across the country. Ashlee has assisted over 100 home health agencies streamline their quality assurance processes while maximizing reimbursement.

Zach Rosen is the CEO of Brellium, which helps home health agencies across the country, from 100 patient census family run agencies up through 15k census multi-state agencies, automate their chart review with AI.

So, together, we've seen (almost) every derivation of how home health agencies handle QA and audited a mountain of home health charts!

In theory, QA should be standardized across agencies by payer. If two agencies bill Medicare in New Jersey, their requirements and QA process should be identical.

In practice, this couldn't be farther from the truth. This is mostly because payer 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 agency'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 home health agency, from our learnings across dozens of home health clinician groups. This guide is most helpful for Quality Assurance Leads at small-to-mid size agencies 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 home health agency, or at a large agency 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 payers pay you stays in your pocket, instead of being clawed back months 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 patient's family or the dreaded "Payer Audit" email.

And good sleep = priceless.

Setting up your note template

Good note template = **way** less time spent on auditing.

Humans make mistakes. And your clinicians 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 visit info (Clinician info, patient info, visit info).
    1. These fields should be populated by your EMR rather than your clinicians. Populating these ahead of time based on the schedule will reduce clawbacks, and time spent by your clinicians completing their documentation!
    2. Templates can be created to include:
        i. Clinician name and license information
        ii. Patient demographics, health history, care preferences, caregiver/living situation, physician information, and more.
        iii. Visit date, time, location, associated mileage
2. Required segments (All headers + subsections)
    1. Getting the basics right here is important - make sure your note template has a "plan" for how it should be filled out. E.g first they will fill out the "Home Techniques" checkbox, then they'll fill in the "Barriers" section, then they'll write their "Visit Narrative" etc.
3. Checkboxes
    1. Things like wound status, interventions, and many other sections can be encoded into a checkbox or required short form-field section. Leaving these as free text will make you prone to clinicians writing potentially incorrect or irrelevant info in these sections.
        i. Additionally, checkboxes in place of free text spaces can eliminate the time spent auditing for discrepancies that are commonly found in narratives.

Free text:

1. Visit narrative

1. Goes without saying that your clinicians need to be able to talk about what happened in the visit! Getting good visit narratives is more about clinician training and guidelines than it really is about the note template! One minor point of feedback is to have your narrative at the end of the document so the clinician knows what they should be discussing.
    i. An excellent narrative includes:
        1. Summary of the visit
        2. Physical and psychosocial assessment summary
            a. Keep it pertinent and succinct!
            b. "Paint the clinical picture"
                i. Example: "Mr. Smith is an 80 yr old male patient requiring home health services for a recent CHF exacerbation. Mr. Smith was sitting in his recliner when SN arrived. He is alert and oriented with periods of forgetfulness. He has 2+ pitting edema to his BLE with SOB upon exertion. He lives with his wife and daughter who assist him with ADLs, transportation to medical appointments, and meal set-up."
            c. Justify the patient's homebound status and need for services
2. Additional Notes
    1. Extraordinary cases happen. It's important that your clinicians have the opportunity to explain in free text any exacerbating circumstances in the visit.
    2. 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 visit note framework and easy for clinicians to use but it can limit opportunities for individualized medical records. Only having freeform options is very time consuming on the clinicians and will result in really unhappy staff!

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

Outlining clear rules for your clinicians

Your QA process is 50% setting up a great visit note template and 50% training your staff well.

The key for your organization is to have:

1. A go-to person within your organization that your clinicians and QA staff can ask questions to while providing services.

2. Clear, objective, and all-inclusive expectations on how your clinicians should complete visit notes.

#1 should be your QA team lead, or another experienced member of your QA team. They should respond quickly, deeply understand the day-to-day of both QA and providing services, and be cheery with your clinicians. Remember—we want to solve issues upfront, so we want clinicians to feel as comfortable as possible asking for help.

1. Your QA team lead should understand the Conditions of Participation for home health or at least know how to access and navigate them.
    a. It's important that the QA team lead can provide the "why" behind the documentation requirements.

Recommendations for #2:

1. Examples
    1. Give your clinicians good examples to base their note templates off! When doing performance reviews or meeting with them after they ramp up, giving them both good and not-so-good examples of notes they've submitted can be very helpful!
        i. Don't simply return documentation with demands for corrections. Instead, when you identify a major issue in documentation, reach out to the clinician directly to discuss the errors. This makes the clinician feel valued as an integral part of the team and someone worth investing time and education in.
2. Concrete Deliverables
    1. Outline exactly what should be noted in each free text section.
        i. Examples: "1 sentence describing patient's living situation"; "2-3 sentences describing patient's medical necessity"; "1-2 sentences summarizing the patient's homebound status".
    2. These will help guide your clinicians 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** payer and policy requirements (given the individual payers that you are dealing with). Many times in home health, auditing processes become based on "what everyone else is doing". However, your agency's auditing process may need to be adjusted based on your certification, accreditation and/or payer contracts (especially Medicare Advantage and some commercial insurances!). It can be so frustrating on both your field and administrative staff to stress

on something that doesn't affect your gold standard documentation! 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 and organizations should have the correct criteria with a proper protocol to double check to see if it is a concern. The last thing you want to do is return a note to a clinician requesting clarification/revision when their assessment or narrative was clinically justified and the only reason why you noted an error was due to poor audit criteria!
    a. Tip: Strike a balance in your audit process between the "must-haves" and the "patient-specifics."
        i. This means that your audit team has a clear understanding and expectation that there are some assessment items that must be included in every. single. chart., but there also needs to be room for documentation that applies very individually to the patient being cared for.
3. Adjust your criteria based on payer feedback, best practices and agency and certification policies. Since the industry keeps on changing, it's important to look out for Condition of Participation, OASIS and best practice updates to ensure that your criteria are up to date. Some of these organizations can update their standards each quarter! While it may not require an organization to change their audit requirements, its important to look out for anything that needs to be changed. JWO Home Health 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 clinicians 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 clinicians who've transitioned to the operations side of the business. They have context on field visits, working conditions, and can "speak the language" of the clinician visits they're auditing. Note: a clinician doesn't need to be in the field for years to be successful in QA. They need to have been in the field to understand the clinicians (usually at least 2 years). Extensive clinical experience is helpful, but not required to be a great auditor.

So, if you have a few clinicians on your team who're looking to transition towards operations, they can be GREAT candidates to join (and potentially lead) your QA team. They can usually also be paired with a few clinician-turned-auditors to help show them the ropes.

Your QA team lead should have a comprehensive understanding of both the clinical and business side of your agency. Quality is vital, but there's a middle ground between zero oversight and

needing 50 requirements perfectly filled out in each OASIS document. 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 clinicians 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 clinicians improve their documentation & standard of care.

If you're not using Brellium, we recommend auditing out of a big Google Sheet with each clinician's name in Column A, clinician'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 visit note, while auditing.

Other manual audit tips:

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

Setting up how to have clinicians 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 Clinician" and send an individual email to the clinician specifying the note's day & time, and what needs to be fixed or improved on in the future. Note—if your messaging 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 clinician 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 payer audits

The dreaded "Payer Audit" correspondence (a.k.a. ADRs)...

Every so often, each of your payers ask you to send them a portion of their patients' 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 patients the payer has requested for the audit period for 1-2 weeks. Ask your team to pause their normal auditing, and reaudit the sample size.

It's essential to make sure the initial audit goes smoothly. If errors are found, your payer may ask for a larger sample, which slows your team down even more. If issues are found with the second sample, the payer 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 payer portal. Also be sure that all of the notes are in the correct format and order as requested by your payer. Many ADRs are denied on this basis alone!

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 leads to a payer requesting reimbursement, we pay the bill. Not you. Brellium also lets you easily export all notes for the audit period for a patient range in 3 clicks, so you can easily respond to your additional documentation requests.

Your payer 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 a home health quality assurance specialist, like Ashlee @ JWO Home Health!

Learn More

- Go to JWO Home Health Consultants' website
- Go to Brellium's website

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