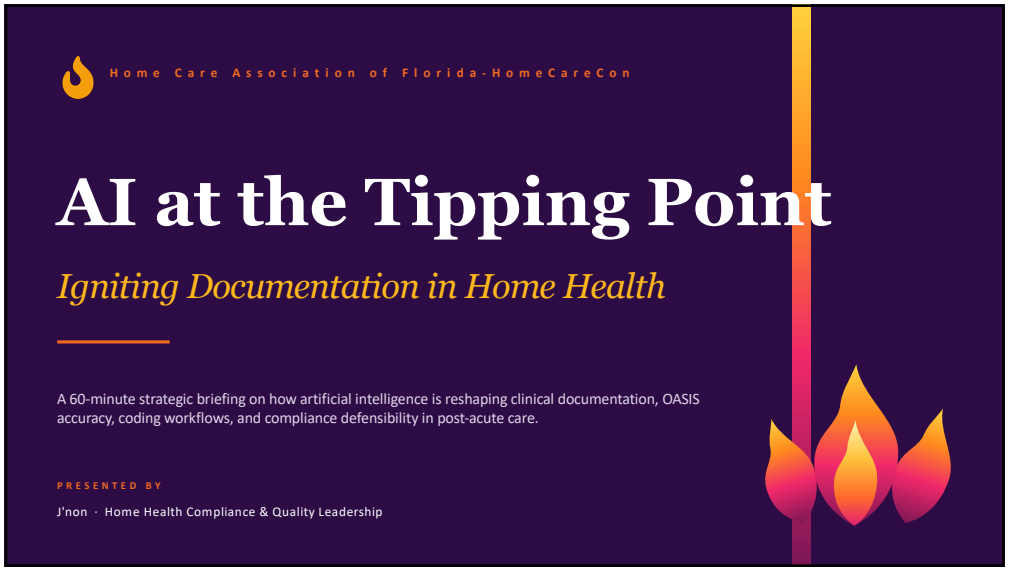
Home Care Association of Florida-HomeCareCon
AI at the Tipping Point
Igniting Documentation in Home Health
A 60-minute strategic briefing on how artificial intelligence is reshaping clinical documentation, OASIS accuracy, coding workflows, and compliance defensibility in post-acute care.
PRESENTED BY
J'non · Home Health Compliance & Quality Leadership


AGENDA
What we'll cover in the next 60 minutes
01
The Documentation Crisis
Burnout, regulatory pressure, audit risk
5 min
02
AI's Transformation of Workflows
Ambient listening, NLP, automation
8 min
03
OASIS Accuracy & Compliance
HHVBP, PDGM, audit defensibility
10 min
04
Real-World Use Cases
Intake, visit docs, OASIS, coding, daily ops
12 min
05
Risks & Compliance Considerations
Integrity, governance, accuracy, oversight
12 min
06
Action Plan for Implementation
Where to start, vendors, pilot + scale, ROI
5 min
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SECTION 01

The Documentation Crisis in Home Health

Setting the stage: the perfect storm of clinician burnout, rising regulatory pressure, and escalating audit risk.

01 · THE CRISIS

Clinicians are drowning in documentation

34–50%

of a home health clinician's workday

is spent on documentation rather than direct patient care

2–3 hrs

of after-hours "pajama time"

is typical per clinician per day completing notes at home

63%

of home health nurses report burnout

with documentation cited as the #1 contributor

28%

average OASIS error rate

on internal audits before QA intervention

Sources: figures reflect published industry surveys and internal QA benchmarks commonly cited across home health operations; actual values vary by agency.

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01 · THE CRISIS

A perfect storm of pressure

The Human Cost

What the numbers don't show

- Turnover costs of $40K–$60K per clinician — documentation fatigue is a leading exit driver
- Reduced census capacity — each clinician sees fewer patients because charting eats visit time
- Erosion of clinical judgment — rote form-filling crowds out the nursing process itself
- Downstream patient impact — late notes, missed communication, care plan drift

The Regulatory Vise

Rising expectations, tighter margins

- HHVBP nationwide — every agency now has reimbursement tied to measured quality
- PDGM case-mix pressure — accurate OASIS and coding directly drive payment
- RCD, TPE, and UPIC activity — documentation integrity scrutinized at the visit level
- 2026 HHVBP refinements — expanded measure set raising the documentation bar again

The clinicians feeling the burden are the same clinicians whose documentation drives your payment and survey defense.

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01 · THE CRISIS

From documentation gap to dollars lost

1 **Incomplete / Inconsistent Documentation**

Missing clinical justification, OASIS inconsistencies, late entries

→

2 **Coding & OASIS Errors**

Wrong HIPPS, missed comorbidities, inaccurate functional scoring

→

3 **Denials, Takebacks, ADR Failures**

Medical review requests, partial payments, appeal costs

→

4 **HHVBP Penalties + Survey Findings**

Lower TPS scores, condition-level deficiencies, CAPs

The Operational Multiplier Effect

Every documentation gap travels downstream. A single missed comorbidity on OASIS can shift a patient's HIPPS assignment, affect case-mix, flag an ADR, and surface again months later during a post-payment audit. The cost isn't the note — it's what the note sets in motion.

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SECTION 02

AI's Transformation of Home Health Workflows

Ambient listening, natural language processing, and workflow automation — what's real tod and why it changes everything.

02 · AI CAPABILITIES

The three engines reshaping clinical documentation

Ambient Listening

Passive capture of the clinician–patient encounter in real time

- Records and transcribes the visit conversation
- Distinguishes speakers (clinician vs. patient vs. caregiver)
- Generates a structured draft note keyed to your EMR template

Natural Language Processing

Extracts clinical meaning from unstructured narrative

- Identifies diagnoses, medications, symptoms, functional status
- Maps free text to OASIS items and ICD-10 codes
- Flags missing elements and internal contradictions

Workflow Automation

Orchestrates the repetitive and the rule-based

- OASIS scrubbing against logical consistency rules
- Pre-visit chart prep and post-visit QA routing
- Auto-generation of supporting narratives and order sets

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02 · AI CAPABILITIES

Ambient listening: hands-free charting

How it works in a home health visit

1. Clinician activates app on phone or tablet at the start of visit
2. Device passively captures the encounter; speaker diarization separates voices
3. NLP structures the conversation into SOAP or OASIS-aligned sections
4. Clinician reviews, edits, and signs — usually before leaving the driveway

DOCUMENTED IMPACT

What clinicians report after adoption

60–75%	reduction in post-visit charting time
2+ hrs	returned per clinician per day
95%+	of draft notes require only minor edits
↑ Eye contact	and presence during the patient encounter

02 · AI CAPABILITIES

NLP + automation: the intelligence behind the workflow

Natural Language Processing

Turns narrative into structured, codeable, auditable data

Condition & symptom extraction
Reads narrative for dyspnea, wounds, pain, confusion — surfaces what the clinician said but may not have coded.

Medication reconciliation
Matches home med list against what was discussed, identifies omissions, duplications, and high-risk drug interactions.

OASIS item mapping
Translates free-text assessment findings into aligned OASIS responses with supporting evidence citations from the note.

Workflow Automation

Applies rules and routes work without human prompting

OASIS consistency scrubbing
Cross-checks responses (e.g., dyspnea vs. oxygen use, ADL scoring vs. narrative) before submission.

QA routing and prioritization
Ranks charts by risk and directs the scarce QA resource to the records most likely to yield findings.

Documentation completion workflows
Auto-drafts face-to-face encounter notes, 485 narratives, and care coordination communications from source data.

02 · AI CAPABILITIES

Traditional vs. AI-enabled documentation

	TRADITIONAL WORKFLOW	AI-ENABLED WORKFLOW
During visit	Clinician splits attention between patient and tablet; keyboarding replaces presence.	Clinician focuses on patient; device captures the encounter passively.
Note creation	Typed or dictated from memory hours later, often with gaps.	Structured draft ready within minutes of visit end, grounded in actual conversation.
OASIS completion	Manual entry, then manual QA review days or weeks later.	Real-time consistency checks catch contradictions before submission.
Coding	Coder works from an incomplete narrative, queries clinician, waits for response.	NLP surfaces all supported diagnoses from the note; coder validates rather than hunts.
After-hours work	2–3 hours of pajama-time charting per clinician per day.	Most charting complete before clinician gets home.

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SECTION 03

AI for OASIS Accuracy & Compliance

How AI sharpens item intent, internal consistency, and defensibility across HHVBP, PDGM, and medical review.

03 · OASIS ACCURACY

The three failure modes AI addresses

Item Intent Drift

Clinicians answer what the item sounds like it asks, not what CMS specifies.

ILLUSTRATIVE EXAMPLE

Example: M1830 (Bathing) scored on ability rather than actual safe performance during the look-back.

Internal Inconsistency

OASIS responses contradict the narrative note, medications, or other OASIS items.

ILLUSTRATIVE EXAMPLE

Example: Dyspnea coded at rest, but narrative documents patient walked the dog without SOB.

Missing Supporting Evidence

OASIS response is defensible in theory but has no clinical rationale in the chart.

ILLUSTRATIVE EXAMPLE

Example: GG item scored without documented direct observation or standardized test.

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03 · OASIS ACCURACY

Why accuracy is directly a financial and survey event

HHVBP

Value-Based Purchasing

- OASIS-based outcome measures drive TPS
- GG functional items now weighted heavily
- Accurate baseline = larger measurable improvement
- 2026 measure refinements raise the bar further

PDGM

Patient-Driven Groupings Model

- Clinical grouping, functional impairment, comorbidity adjustment
- OASIS responses directly determine HIPPS
- Missed comorbidities = underpayment
- Overstated acuity = takeback + integrity risk

Audit Defensibility

RCD / TPE / UPIC / ADR

- Reviewers look for internal consistency first
- Narrative must support every OASIS response
- Timing, signatures, and attribution scrutinized
- AI-generated audit trails document the rationale

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03 · OASIS ACCURACY · EXAMPLE 1

M1400 Dyspnea — the classic item-intent trap

THE ITEM

M1400 — When is the patient dyspneic or Short of Breath?

Item intent (what CMS expects)

- Score the level at which the patient becomes dyspneic under observed or reported usual activity
- Must reflect the patient's usual status during the day of assessment look-back
- Oxygen status matters: score while on continuous oxygen if that is the patient's baseline
- Not the patient's opinion about breathing — the observable or reported exertional level

✗ Without AI: typical error pattern

Clinician scores **"2 – With moderate exertion"** based on patient's self-report during intake, but narrative later documents SOB when walking to the bathroom (minimal exertion).

→ Internal contradiction = audit vulnerability + inaccurate case-mix

✓ With AI: what changes

NLP compares M1400 response to narrative: flags ***"SOB walking to bathroom"*** as inconsistent with "moderate exertion." Prompts clinician to reassess to "3 – With minimal exertion" or justify in narrative before submission.

→ Response aligns with evidence, case-mix reflects true acuity, audit trail preserved.

03 · OASIS ACCURACY · EXAMPLE 2

M2020 Oral Medications — a common undercoding trap

THE ITEM

M2020 — Management of Oral Medications

Where clinicians go wrong

- Scored on ability to take the correct dose at the correct time without assistance
- Frequently scored too favorably when caregivers handle the med setup but patient "takes them"
- Must include reminders, prompts, and preparation — not just the act of swallowing
- Complex regimens with cognitive deficits are routinely underscored

How AI catches the undercode

1. **Reads the medication list**
   12 oral medications, multiple timing windows, 3 high-alert drugs
2. **Scans the narrative**
   "Daughter fills pillbox weekly" · "Patient forgets evening dose unless reminded"
3. **Cross-checks M1710 (cognition)**
   BIMS suggests moderate impairment — prompts escalated M2020
4. **Suggests a more accurate response**
   "2 – Unable to take medications unless prepared in advance by another person"

03 · OASIS ACCURACY · EXAMPLE 3

GG functional items — consistency across the whole chart

The GG family (GG0130, GG0170) requires corroborating evidence across PT, OT, nursing, and narrative — inconsistencies here drive HHVBP score loss.

What OASIS Says	What the Narrative Says	What AI Flags
• GG0170C1 (Lying to Sitting): Setup or clean-up assistance • GG0170H (Walk 10 ft): Partial/moderate assistance • M1860 (Ambulation): Independent with assistive device	• PT note: patient requires max assist × 1 to rise from supine • Nursing note: patient ambulated to kitchen unassisted • HHA note: patient needs hands-on assist for transfers	• GG0170C1 likely understated given PT max assist notation • M1860 contradicts GG0170H — review before lock • HHA and nursing observations conflict — clarify scoring rationale

Takeaway: AI doesn't replace clinical judgment — it prevents the chart from silently contradicting itself.

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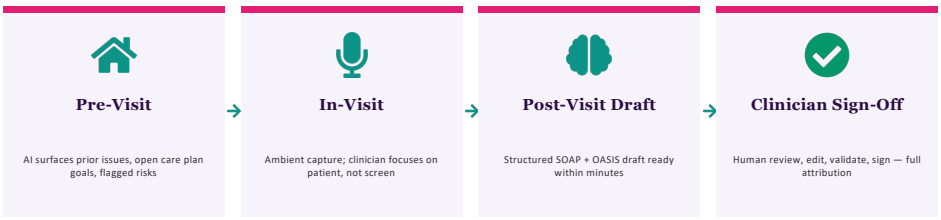
SECTION 04

Real-World Use Cases in the Wild

Four workflows where AI is already delivering measurable value in home health today — wi
before/after scenarios.

04 · USE CASE 1

AI-assisted visit documentation



TYPICAL RESULTS

−45 min	−2 hrs	+20%	99%+
per SOC visit charting time	in after-hours documentation	visit capacity per clinician	clinician adoption when workflow fits

04 · USE CASE 1

Scenario: SOC visit for a CHF patient

BEFORE — TRADITIONAL		AFTER — WITH AI	
9:00 AM	Clinician arrives; spends 15 min reviewing fragmented chart on tablet	8:45 AM	AI pre-brief: prior hospitalizations, meds, risk flags in 60 seconds
9:15 AM	90-minute visit, typing into OASIS fields between questions	9:00 AM	Clinician activates ambient capture; full eye contact with patient
10:45 AM	Departs; partial OASIS, handwritten narrative notes	10:30 AM	Visit ends; structured draft ready in car within 3 minutes
8:30 PM	At home — completes note from memory, inconsistencies creep in	10:35 AM	Consistency checks flag M1400 conflict — resolved before submission
Next day	QA catches M1400 vs. narrative conflict — returned to clinician	10:50 AM	Clinician signs; OASIS passes scrubber; HIPPS assigned same day
+2 days	Correction made; OASIS locked, HIPPS assigned	Same day	Chart complete. Clinician takes the next referral.

04 · USE CASE 2

OASIS scrubbing & validation

What modern OASIS scrubbers check — instantly, every chart, before submission

Logical Consistency

M1830 Bathing vs. M1860 Ambulation vs. GG functional items

Narrative Alignment

Does the clinical note support the OASIS response selected?

Historical Coherence

Does this SOC response align with prior recert or discharge data?

Required Documentation

Face-to-face, homebound rationale, physician orders in place

Coding Support

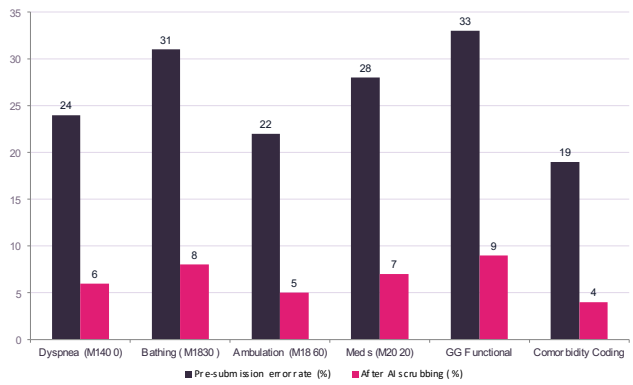
Do the documented conditions justify the ICD-10 codes selected?

Audit Trail

Every flag, edit, and override time-stamped and attributable

04 · USE CASE 2

OASIS error rates before and after AI scrubbing



THE PATTERN

70–80% reduction

in pre-submission OASIS error rates across the items with highest audit exposure.

Downstream effects

- Fewer ADRs
- Higher HIPPS accuracy
- Lower QA rework volume
- Stronger HHVBP scores

04 · USE CASE 3

Coding automation: from hunt-and-peck to validation

TRADITIONAL CODER WORKFLOW

1. Opens chart, reads every note manually
2. Hunts for documented diagnoses and comorbidities
3. Queries clinician for clarification — waits days
4. Assigns codes, assembles HIPPS, submits
5. QA rework when documentation doesn't support

AI-AUGMENTED CODER WORKFLOW

1. AI extracts all supported dx from narrative + OASIS
2. Proposes primary + secondary codes with evidence citations
3. Flags coding gaps: "narrative suggests CKD 3 — not coded"
4. Coder validates, overrides where appropriate
5. HIPPS assembled with full audit trail — time: minutes, not hours

−70%	+12%	−50%	100%
coding turnaround time	average case-mix capture	clinician queries per chart	codes linked to source evidence

04 · USE CASE 4

QA automation: risk-based, not random

The QA capacity problem

- 100% manual review is impossible — most agencies review 10–20% of charts at best
- Random sampling misses systematic issues — the same clinician makes the same error on 15 charts before anyone catches it
- Severity-blind reviews — a low-risk SOC gets the same scrutiny as a high-risk resumption on an unstable patient
- Lag time — issues surface weeks after submission, after the claim has already gone out the door

How AI reshapes QA

Every chart screened. Scarce human review directed at highest-risk charts.

100%

of charts auto-screened for inconsistencies and missing elements

Risk score

assigned to each chart; QA sees the top 10% first

Pattern detection

surfaces clinician-level trends (e.g., systematic M1400 undercoding)

Real-time

flags appear before submission — not after claim is paid

04 · USE CASE 5

AI-assisted intake & referral management

Referral Intake

Faxed and PDF referrals parsed into a structured intake record

Eligibility & Auth

Insurance, benefits, and prior auth verified and tracked

Orders & F2F

Physician orders and F2F documents chased to completion

SOC Scheduling

Cleared referrals routed so the SOC clock is met

TYPICAL RESULTS

−40%	+15%	−50%	100%
referral-to-start-of-care time	referral conversion rate	manual data entry at intake	auths & orders tracked to closure

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04 · USE CASE 5

What AI handles at intake

Six intake tasks AI can take off your coordinators, before the SOC clock starts

Referral Extraction

Pulls demographics, diagnoses, and orders from faxed or PDF referral packets

Insurance & Eligibility

Checks coverage, benefits, and payer rules against the referral

Prior Authorization

Initiates and tracks authorization requests and visit limits to approval

Homebound Pre-Screen

Surfaces homebound and medical-necessity signals for clinician confirmation

Orders & F2F

Flags missing physician orders and face-to-face encounters, then routes them

Referral-to-SOC Clock

Tracks intake timeliness and alerts before the start-of-care deadline

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04 · INTEGRATED SCENARIO

A day in the life: one patient, four workflows

7:45 AM
Pre-visit prep
AI surfaces patient history

9:00 AM
Visit captured
Ambient listening on

10:40 AM
Draft + OASIS
Structured note ready

10:55 AM
Scrubber runs
Inconsistencies resolved

11:15 AM
Coding + HIPPS
Coder validates codes

11:30 AM
QA risk screen
Chart cleared

Elapsed time from visit start to fully submitted, QA-cleared chart: under 3 hours. Without AI, this is typically 2–3 business days.

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04 · DAILY OPERATIONS

Claude Cowork: an AI teammate for daily work

How Cowork works

1. You describe the task in plain language — no coding or setup required
2. Cowork plans the work and uses your files, the web, and connected apps
3. It drafts the document, spreadsheet, or report and shows each step
4. You review, refine it by chatting, and approve before anything is used

WHY IT FITS

An assistant your team can run

Plain English — No formulas, macros, or code to learn

Your files — Works from your spreadsheets, PDFs, and docs

Shows work — Every step is visible and editable by you

You approve — Nothing sends or saves without your sign-off

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04 · DAILY OPERATIONS

What Cowork automates in the back office

Compliance & Regulatory

Survey 2567-to-plan-of-correction drafts, P&P updates, CMS transmittal briefs, and your compliance calendar.

QAPI & Reporting

Monthly OASIS and HHVBP exports turned into QAPI reports, PIP charters, trend logs, and the governing-body deck.

Revenue Cycle (Admin)

ADR responses and appeal letters from your templates, plus denial-trend and reconciliation summaries.

Operations, HR & Education

Job descriptions, onboarding checklists, patient handouts, in-service materials, and messy-spreadsheet cleanup.

PHI guardrail — Cowork drafts the paperwork around the chart; PHI stays in your EMR. Use an approved, BAA-covered setup and have a person review every output before use.

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04 · DAILY OPERATIONS

Spotlight: an executive KPI dashboard

Cowork turns your census, visit, OASIS/HHVBP, and billing exports into one management view — refreshed on the cadence you set.

Active census	Recert rate	LUPA rate
248	82%	7.4%
▲ 12 vs last month	▲ 3 pts MoM	▼ 1.1 pts · good

Visit utilization	OASIS accuracy (post-QA)	Denial / ADR rate
94%	96%	3.1%
of authorized visits	▲ 2 pts MoM	▼ 0.6 pts MoM

Auto-built by Cowork — point it at your monthly exports and it refreshes this view. Figures are illustrative and depend on your data; keep PHI in an approved, BAA-covered setup.

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SECTION 05

Risks, Limitations, & Compliance Considerations

What can go wrong, what CMS will ask, and how to keep AI as augmentation rather than a documentation substitute.

05 · RISKS

Four failure modes every agency must plan for

Hallucinations

AI generates plausible but fabricated content — a symptom not mentioned, a vital sign not measured, a medication not discussed.

Over-Reliance

Clinicians rubber-stamp AI drafts without reading, assuming accuracy. The chart is signed with content no human validated.

Drift From Item Intent

AI maps narrative to OASIS based on keywords, not CMS-defined scoring rules. Plausible answers that miss the item's actual intent.

Survey & Audit Exposure

Charts with identical phrasing patterns across patients, visits, or clinicians signal templated content to a surveyor.

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05 · DOCUMENTATION INTEGRITY

The unchanged principle

"If it's not in the record, it didn't happen."

— The principle that survives every technology shift in healthcare documentation

AI CAN'T FIX WHAT WASN'T ASSESSED

If the clinician didn't assess wound depth, no AI can invent it without creating a falsified record. The clinical work comes first; AI structures what was done.

ATTRIBUTION IS NON-NEGOTIABLE

The signing clinician is responsible for every word in the record — whether typed, dictated, or AI-drafted. Read before you sign.

05 · SURVEY RISK

What a surveyor or reviewer will ask about AI-generated content

Can you demonstrate clinician review before signature?

Audit trail must show the draft was opened, edited or confirmed, then signed — not auto-signed.

How do you detect and correct AI hallucinations?

Documented QA workflow, clinician education, and a feedback loop back to the vendor.

What PHI leaves your environment?

BAA in place, data residency, model training exclusions, and tenant isolation verified.

Are templates or phrases repeating across patients?

Monitoring for suspicious repetition patterns that suggest copy-forward or unexamined AI output.

Who is responsible for errors the AI introduced?

Clinician of record. Period. Full stop. The tool does not shift clinical accountability.

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05 · GOVERNANCE

Human-in-the-loop: the clinician stays in charge

WHY IT MATTERS

AI produces drafts. Clinicians produce records.

Every risk we just discussed — hallucination, over-reliance, drift from item intent, survey exposure — is mitigated by the same thing: a clinician actively reviewing, editing, and taking ownership at each critical checkpoint.

01 DIRECT
The clinician decides when and how AI runs
Consent is obtained, context is provided, and capture is activated deliberately — AI does not operate autonomously in the background.

02 REVIEW
The clinician reads every AI-generated word
Before any draft enters the medical record, the signing clinician reviews it — not skims, reads. Attention is the non-negotiable input.

03 VALIDATE
The clinician edits, overrides, and corrects
AI suggestions are suggestions. Clinician judgment catches item-intent drift, adds missing context, and documents rationale for any override.

04 OWN
The clinician signs and accepts accountability
The signature carries full legal and clinical responsibility for every word — whether it was typed, dictated, or AI-drafted. No exceptions.

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05 · GOVERNANCE

Building an AI governance program

Who's at the table

Cross-functional ownership, not an IT side project

- Clinical leadership and compliance own it jointly
- IT / security, QAPI, and HIM at the table
- A frontline clinician champion keeps it grounded

What the program governs

The rules every AI tool has to follow

- Tool approval, vendor BAAs, and data handling
- Written policies, SOPs, and human-review rules
- Validation standards and accuracy thresholds

How it operates

A cadence that keeps oversight alive

- Charter, roles, and decision rights documented
- Quarterly review of accuracy and incidents
- Incident response and a model/version change log

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05 · ENSURING ACCURACY

How to ensure — and prove — accuracy

Before go-live
VALIDATE

- Test AI output against a clinician gold standard
- Set accuracy thresholds and a baseline error rate
- Dual review until the tool earns trust
- Sign off on intended use and known limits

In production
MONITOR

- Audit a sample of AI-assisted charts each month
- Track error, override, and agreement rates
- Watch for drift, templated phrasing, and bias
- Keep clinician sign-off on every record

Continuously
IMPROVE

- Feed errors back to the vendor and to training
- Refresh clinician education on the weak spots
- Version-control models, prompts, and rule sets
- Keep an audit trail that proves every check

Accuracy isn't a one-time score — it's a documented, repeatable process you can show a surveyor.

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05 · THE RIGHT FRAMING

AI as augmentation, not replacement

WHAT AI DOES BEST

- Structure unstructured narrative
- Cross-check OASIS for internal consistency
- Surface documented but uncoded conditions
- Run every rule on every chart, every time
- Draft tedious narratives from source data
- Flag patterns no human could track at scale

WHAT ONLY THE CLINICIAN DOES

- Perform the clinical assessment
- Apply clinical judgment to ambiguous findings
- Validate every OASIS response against intent
- Correct, override, and document rationale
- Sign the record — and own the content
- Connect with and advocate for the patient

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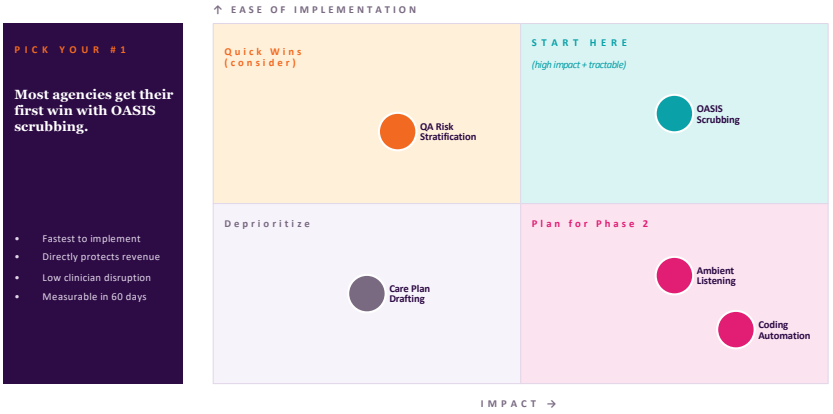
SECTION 06

A Practical Action Plan

Where to start, how to choose vendors, how to scale — and how to build the clinician adoption that makes ROI real.

06 · ACTION PLAN

Where to start — a decision matrix



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06 · ACTION PLAN

Vendor selection checklist

Clinical & Domain

- Purpose-built for home health (not adapted from hospital or primary care)
- OASIS-E and 2026 HHVBP measure set native support
- Demonstrable handling of PDGM case-mix logic

Compliance & Security

- BAA in place; HIPAA audit history available
- Data residency, tenant isolation, training-exclusion clause
- SOC 2 Type II at minimum; HITRUST preferred

Workflow & Integration

- Native integration with your EMR (Homecare Homebase, WellSky, MatrixCare, etc.)
- No duplicate entry for clinicians
- Configurable to your workflow, not the vendor's default

Evidence & Accountability

- Full audit trail: what was drafted, edited, by whom, when
- Clinician override + rationale capture built in
- Client references at similar scale and census type

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06 · ACTION PLAN

Pilot, prove, scale — a 6-month framework

Months 1–2 PILOT

- 1 branch, 1 workflow (recommend: OASIS scrubber)
- Define success metrics upfront (error rate, QA hours, HIPPS accuracy)
- 10–15 clinicians, champion identified per shift
- Baseline measurement before go-live

Months 3–4 PROVE

- Compare before/after on defined metrics
- Capture clinician satisfaction — not just outputs
- Document lessons: configuration, training gaps, vendor responsiveness
- Go/no-go decision with CFO + clinical leadership

Months 5–6 SCALE

- Roll out by region or branch — not all at once
- Train the trainers; build internal champion network
- Layer on workflow #2 (ambient listening or coding automation)
- Establish steady-state governance: clinical + IT + compliance

Scale what works. Kill what doesn't. Don't let sunk cost drive the governance decision.

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06 · ACTION PLAN

Tying it back: ROI and the clinician adoption flywheel

Where ROI shows up

Revenue protection

Reduced takebacks, fewer ADR failures, accurate case-mix capture

Clinician time returned

2+ hours/day at avg loaded cost compounds fast across a 100-clinician workforce

Turnover reduction

Each retained clinician avoids $40K–$60K replacement + training cost

HHVBP upside

Higher TPS translates directly into payment adjustments; the spread matters

THE ADOPTION FLYWHEEL

No adoption, no ROI

1. Clinicians save time on charting
2. Workload feels more sustainable
3. Quality and consistency improve
4. Turnover drops; recruiting pitches change
5. Retained clinicians train the next wave

CLOSING

Six things to take back to your agency

The tipping point is here

AI for home health documentation has moved from experimental to expected. Early movers are already compounding gains.

Clinicians first, always

The best AI strategy returns time to your clinicians before it talks about savings. Win their trust and ROI follows.

Accuracy is a compliance moat

HHVBP, PDGM, and medical review all reward the same thing: internally consistent, evidence-backed records.

Augmentation, not replacement

AI structures what the clinician assessed. If it wasn't assessed, no technology will save the chart.

Start small, prove, then scale

One workflow, one branch, measurable results. Expand only after you've earned the evidence.

Governance is non-negotiable

Clinical + IT + compliance at the table. Audit trails, overrides, and vendor accountability designed in from day one.


HOME HEALTH LEADERSHIP SERIES
Questions?
Let's talk about what this looks like in your agency.
Thank you for your time and attention.
J'non · Home Health Compliance & Quality Leadership