Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

57th Annual Meeting

Wednesday, September 2, 2026

Seguin Room

2:45pm-3:45pm

3d. The Augmented Team: How AI Is Transforming Care

Presented by:

Bud Langham, Enzo Health

Thank you to our Partners:

Vesta®

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United Healthcare Community Plan

AXXESS

The Augmented Team

AI in intake, documentation, and quality

Bud Langham

Theme, content, and slide development by Dawn Jelley, RN, CHPN

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“The illiterate of the 21st century will not be those who cannot read and write, but those who cannot learn, unlearn, and relearn.”

Alvin Toffler

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What you'll leave with

01 Where AI fits: intake, documentation, quality

02 How it changes documentation and the care experience

03 What to ask before you buy

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Where we're going

Setting the stage

Readiness and adoption

Intake

Documentation

Quality assurance

Putting it together

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Setting the stage

01

- **Setting the stage**
- Readiness and adoption
- Intake
- Documentation
- Quality assurance
- Putting it together

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Why now

The pressure

- **Complexity**
- **Regulation**
- **Data demands**
- **Productivity**

The opening

- **AI is already here**
- **Care is being reshaped**

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Work is fragmented

- Intake, documentation, and QA sit in silos
- The entry burden lands on the clinician
- Errors surface late, when they cost most

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Clinicians carry the load

- Decisions made without support
- Compliance by memory, not design
- Overload erodes quality and well-being

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Quality is built before the audit.

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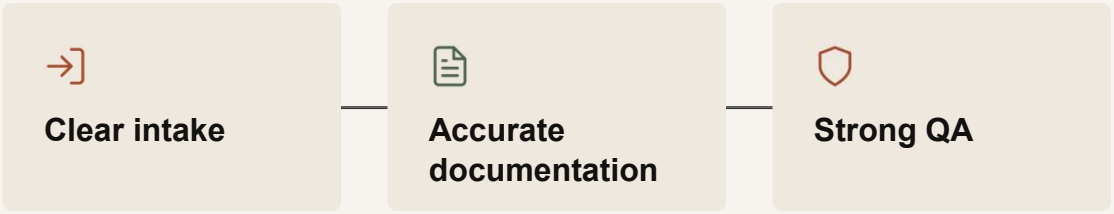
Quality starts upstream



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Readiness and adoption

02

Setting the stage

Readiness and adoption

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Are we actually ready?

A pulse check before any tool decision.

Map the workflow

Know who’s ready

Fix before you automate

Focus the work

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Why AI efforts stall

It is rarely the technology.

Trust

Earned where the work happens, not announced

Leadership

Intent meets frontline reality; training is underestimated

Friction

Tech outpaces people, and workarounds follow

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Support or surveillance?

- Support and surveillance feel different
- Framing and transparency decide trust
- Adoption grows on early wins and visible follow-through

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Tribal knowledge

A strength and a single point of failure.

- **Years of expertise**
- **Gatekeepers of the workflow**
- **Influence from being needed**
- **Fear when systems change**

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Readiness vs. Risk

- Do we trust the tool?
- Is the agency aligned on purpose and impact?
- Have we asked the hard questions?

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What to ask a vendor

1 / 2

Trust and safety

HIPAA compliant? SOC 2 certified?

How is PHI protected?

Is the AI advisory, not directive?

Can outputs be explained and audited?

Support after go-live

Who helps when something breaks?

How fast, and through what channel?

Workflow fit

How does this change our workflow?

What must be redesigned first?

Training

What does training look like?

How much time should we plan?

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What to ask a vendor

2 / 2

Superusers

How are they chosen and trained?

What is their role after launch?

Cost and upgrades

What is included?

What costs extra?

Feedback

How is frontline feedback collected?

How do we see it lead to change?

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Intake

03

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The front door sets the tone

- A weak start creates lasting friction
- Intake decisions ripple across the episode
- Eligibility and experience trace back here

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AI intake in practice

Fills the form

Referrals pre-populate fields

Ambient listening captures the visit

Bottles scanned into the profile

Checks the work

Completeness checked as you go

Eligibility surfaced early

Clinical risk flagged early

Lifts the burden

Fewer follow-ups, less rework

Cleaner handoffs

More time at the bedside

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What the clinician sees

Fields arrive filled in and verified. The clinician confirms rather than transcribes.

PATIENT INTAKE

Name	**Jane Doe**	✓
Date of birth	**02 / 07 / 1960**	✓
Insurance	**HealthPlan**	✓
Eligibility	**Verified**	✓
Medications	**Lisinopril**	✓

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Readiness vs. Risk

- Where do intake errors start, and who pays later?
- What do clinicians re-enter that we already know?
- What should the system carry instead?

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What to ask about intake

Auto-population

Do demographics fill from referral and payer data?

Can clinicians see history during the visit?

Is context surfaced at the point of care?

Medications

Can bottles or lists be captured by photo?

Do they land in the profile, not an image?

Does it suggest the reason for use?

Required fields

Are they clearly defined?

Is each one clinically justified?

Ambient capture

Does it run from arrival to completion?

Is there a clear opt out?

Does it work offline and sync later?

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Documentation

04

Setting the stage

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Documentation touches everything

Patient and family

Clinician experience

Care and outcomes

Retention

Quality

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How it feels to the patient

- Clinicians look at the person, not the screen
- Conversations feel natural, not scripted
- The care plan feels intentional

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How it feels to the family

- Families are informed, not guessing
- One consistent story across clinicians
- They know what's next and who to call

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How it feels to the agency

- Fewer billing delays
- Lower audit exposure
- More predictable reimbursement

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AI documentation in practice

During the visit

Ambient capture replaces note-taking

Assessments completed in the home

Results available immediately

Guidance built in

Prompts follow the OASIS manual

Gaps and conflicts flagged

Required items confirmed before you leave

After the visit

Suggested diagnoses and goals

Clinician override, always

Narrative preserved, not just checkboxes

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Readiness vs. Risk

- Where do clinicians build workarounds?
- What would make them say this gives time back?
- How much turnover is about how the work feels?

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What to ask about documentation

1 / 2

Regulatory alignment

Is guidance aligned to the OASIS manual?

Are required items confirmed before leaving?

Can sensitive detail be added later?

Assessments

Are PHQ-2, PHQ-9, and BIMS captured digitally?

Are results available immediately?

Decision support

Does it augment judgment, not replace it?

Does it flag missing or conflicting answers?

Suggestions

Are diagnoses suggested from findings?

Are goals generated from the assessment?

Can the clinician override everything?

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What to ask about documentation

2 / 2

Real-world visits

Can fields be deferred or declined with reason?

Does it handle interruptions and refusals?

How soon is the note ready for review?

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Quality assurance

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QA becomes continuous

- Risk surfaces while you can still act
- Real-time visibility replaces the audit
- Leaders see patterns, not single charts

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The financial case

- Gaps found early protect reimbursement
- Less rework, lower administrative cost
- Real-time reporting strengthens survey readiness

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Readiness vs. Risk

- How late do leaders hear about quality problems?
- Which risks do we find only after they cost us?
- Where does QA give clarity, and where noise?

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What to ask about quality

1 / 2

Risk visibility

Can QA see completeness without re-reading charts?

Are risks flagged before the audit?

Escalation

Do dashboards show only what is outstanding?

Is escalation role-based?

Can leaders see where work is stuck?

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What to ask about quality

2 / 2

Reporting

Is reporting real time, not static?

Are HIPPS codes shown with dollar amounts?

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Putting it together

06

Setting the stage

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When it works

Patients don’t repeat their story

Clinicians arrive informed

Follow-up happens on time

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What becomes possible

01 Change how you operate, not just how you document

02 Fix what you’ve only talked about

03 Pass TPEs, because gaps are caught early

04 Improve HHVBP by design, not by chance

05 Win referrals, because trust is visible

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Analysis vs. Instincts

Five-year decisions lean too hard on logic — and not enough on instinct.

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Sources

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Thank you

Questions

Bud Langham

With gratitude to Dawn Jelley, RN, CHPN — theme, content, and slide development

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