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A Clinical Documentation Practice Improvement to Increase Insurance Reimbursement

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A Clinical Documentation Practice Improvement to Increase Insurance Reimbursement

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DOCTOR OF NURSING PRACTICE

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Abstract

Background: The National Institute Mental Health (2015) estimated there were about 44.7 million people diagnosed with a serious mental illness and 62.9% of those diagnosed were without mental health services. The loss of services was due to unemployment, reoccurring hospitalization, inabilities to care for themselves, and lack of participation in societal norms (World Health Organization [WHO], 2014). According to Insel (2011/2015), the U.S. cost of mental healthcare was an estimated $57.5 billion in 2006. This cost was not due to actual care but associated with the economic burden of job loss and the excessive use of community resources. The Affordable Care Act (ACA) and the Mental Health Equality and Parity Act (MHEPA) has positively influenced access to mental healthcare, but healthcare coverage continues to be deficient. Insufficient clinical documentation practices decrease insurance reimbursement potential.

Purpose: The purpose of this quality improvement project was to enhance the current clinical documentation practices and policies and increase insurance reimbursement in an adult psychiatric inpatient unit in a private, non-profit mental and behavioral health organization.

Theoretical Framework: The Kurt Lewin's 3 Step Change Management Theory

Methods: A quantitative design guided this project utilized an investigator-developed tool modeled from the CMS Inpatient Unit Worksheet as a data collection tool from the clinical chart documentation reviews.

Results: Fisher's Exact and Chi square tests measured the cross tabulation of pre and post comparison sample frequency of staff's integration of an evidence-based descriptive documentation method into practice. The results presented with statistical significance of the

progress narrative notes. The declined chart claims a $p < 0.001$, and the numbers related to case scenario utilization of the documentation method was $p = 1.00$.

Conclusion: The relationship between descriptive clinical documentation and insurance reimbursement was evident in the usage of the Data, Assessment/Action, Response, and Plan (DARP) method in the clinical documentation progress narratives notes. There was a 24% improvement in insurance reimbursement claims and a 17% decrease in charts declined for the study period.

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Chapter 1: Nature of Project and Problem Identification

According to the National Institute of Mental Health (2015), one in five Americans are estimated to have a diagnosable mental and or behavioral health disorder. A significant number of those diagnosed with mental illness are without insurance, and those with insurance often do not have coverage for behavioral health services. Since the initiation of the Affordable Care Act (2010), primary care providers experienced an increase in patient encounters that included mental health disorders or the need for treatment of a behavioral health problem (Golden & Vail, 2014). According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), previous surveys reported that an estimated 18.7% of adults, which is about 45 million people, may experience any mental health disorder. According to the National Institute of Mental Health (NIMH, 2015), 62.9% of this population may be without mental health services. Medicaid or Medicare is often the primary payer source for many individuals diagnosed with mental and behavioral health disorders (Lee et al., 2013).

Individuals diagnosed with mental and/or behavioral health disorders may experience disparities related to the negative stigma of mental illness (Cummings, Lucas, & Druss, 2013). Individuals with mental health disorders may suffer from limited access to services, as well as problems with insurance coverage, reimbursement, and continuity of care (NIMH, 2015). In 2008, Congress passed the Medicare Improvements for Patients and Providers Act (MIPAA) to prevent discrimination practices for patients who needed mental health services (Golden & Vail, 2014). This act improved access to services, which are now covered 80% by Medicare for outpatient services (CMS, 2018c).

The initiation of the MIPAA's ruling supported access to services without discrimination. Mental Health Parity and Addiction Equity Act (2008) and The Affordable Care

Act of 2010 improved access to governmental insurance coverage for mental and behavioral health services (Beronio, Frank, & Glied, 2014). However, disparities of access to care continue between medical and psychiatric insurance coverage (O'Donnell, Williams, Eisenberg, & Kilbourne, 2013).

Background Problem

Psychiatric inpatient units must adhere to the Centers for Medicare and Medicaid Services (CMS) (2016) reimbursement guidelines for mental health services to ensure reimbursement for services provided. Mental and behavioral health services are considered one of the costliest areas of healthcare in the U.S. The NIMH (2015) estimated the cost of mental and behavioral health care at $57.5 billion dollars a year, though only a fraction of this is attributed to actual provision or reimbursement of direct clinical care. Most of this cost was estimated to be for expenses related to Social Security Disability Insurance (SSDI) and specifically concerning patients' disability and loss of wages. The National Advisory Mental Health Council (Kirchstein, 2000/2015) recommended seeking quality measures to retain cost and maintain clinical quality in mental and behavioral healthcare.

A value-based documentation system support care delivered and the increase in insurance reimbursement for claims in the mental and behavioral health programs. The Department of Health and Human Services Quality of Care programs increased reimbursement based on accurate documentation of clinical care delivered across the healthcare continuum (Fee & Clesi, 2016). The goal of quality improvement programs are to drive reimbursement and efficient healthcare delivery (Buttner, 2018). The Quality of Care Programs impact inpatient safety, integration of quality of care, and the integration of evidence-based practices (Kittinger, Matejicka, & Mahabir, 2016). CMS quality improvement standards enhance healthcare delivery

and improve quality outcomes and the quality of care provided to support reimbursement (Bae, 2016).

The performance of clinical care must be clear, concise, and accurately documented as a quality indicator for payment of insurance reimbursement claims (CMS, 2018a). Patient care delivery is measured by the efficient and medically necessary treatment depicted in the descriptive clinical documentation (CMS, 2018b). Insurance reimbursement claims will be denied if the medical record is lacking quality documentation supporting the need for treatment, as well as clear documentation of the care that was delivered.

The adult inpatient stay in the behavioral health facility impacts economics and insurance reimbursement. According to the American Health and Information Management Association, best practices include utilizing descriptive documentation for every patient encounter (Dolan & Farmer, 2016). Clinical staff and nurses must be prepared, and held responsible for accurate objective documentation that supports the medically necessary admission into the inpatient level of care. Under the Health Insurance Portability and Accountability Act (HIPPA), accurate documentation confirms the standards of the diagnosis and treatment plan for evidence-based care (Dolan & Farmer, 2016). These standards will determine reimbursement guidelines for integration of descriptive clinical documentation and the support needed for clinical practices that quantify inpatient care.

Problem Statement

The lack of efficient descriptive clinical documentation in an adult psychiatric inpatient unit in a private, non-profit mental and behavioral health organization contributed to the increase in chart denials for insurance reimbursement claims.

Purpose

The purpose of this quality improvement project was to enhance the current clinical documentation practices and policies and increase insurance reimbursement in an adult psychiatric inpatient unit in a private, non-profit mental and behavioral health organization.

Project Objectives

The project was guided by the following objectives:

Objective 1. Improve clinical documentation of descriptive data in the adult psychiatric inpatient chart by providing staff with educational sessions.

Objective 2. Integrate national clinical documentation standards into the documentation policy and practices of the mental and behavioral health organization.

Objective 3. Enhance evidence-based practice in the clinical assessment and documentation of the adult psychiatric inpatient units.

Objective 4. Decrease number of declined charts that are related to insufficient clinical documentation.

Theoretical Foundation

Kurt Lewin's three step change management theory was used to guide the DNP project. Lewin's (1951) theory directly relate to the theory of changing practices and implementing evidence-based practices into healthcare organizations. This theory has been classified as the fundamental approach to change (Cummings, Bridgman, & Brown, 2016). The phases of the theory includes unfreezing, change, and refreezing (Lewin, 1951). The PDSA quality improvement strategy was also integrated into Lewin's theory of change management to guide the steps of the DNP project.

Unfreezing

The first step of Lewin's theory involves changing the perception and behaviors of stakeholders within an organization (Lewin, 1951). The driving forces are the proponents that determine the need for change and the restraining forces are the barriers that impact the integration of the change (Payne, 2013). It is imperative that there is open communication with the leadership team during this phase. A needs survey was conducted during this phase, which included feedback for the key stakeholders. Additionally, the education committee assisted the DNP student to develop a standardized documentation practice that was integrated in the organization's documentation system.

Change/Moving

Change/Moving is the process of integrating the change into practice. This process occurs when the stakeholders recognize the current practice does not benefit the organization (Sutherland, 2013). The two mandatory, 30-minute educational sessions were developed with the collaboration of the leadership, the fiscal reporting team, educational team, and the clinical leadership managers. This group met weekly to discuss educational sessions content, documentation guidelines, standards, and practices. The educational sessions included all nurses, therapists, physicians, and social workers on the acute inpatient units.

Refreezing

Refreezing involved evaluating the updated clinical documentation practices using the retrospective chart audit tool and a case scenario example writing sample. The evaluation process also included a review of declined insurance reimbursement charts, staff documentation examples and a retrospective chart review. Sustainability of the updated documentation system was a vital component that addressed the leadership team post implementation. It is hoped that

that the outcomes of this DNP project will increase the insurance reimbursement and improve the descriptive clinical documentation in the adult psychiatric inpatient units.

Significance of the Project

Documentation in the psychiatric inpatient units impact healthcare delivery, healthcare outcomes, protocols, practices, billing, and insurance reimbursement (Dolan & Farmer, 2016). Primary funding in the behavioral health inpatient facility is provided by Medicare and Medicaid. Quality descriptive documentation support insurance reimbursement entity's criteria for inpatient care (Dolan & Farmer, 2016).

The inconsistencies noted in the clinical documentation and charting methods will impact the organization's practice outcomes and delivery of care. Improving descriptive documentation practice, policies, and standards will enhance the delivery of care, patient outcomes, practice, and increased insurance reimbursement claims.

Nursing Practice

This quality improvement project impacted the adult psychiatric inpatient unit's nursing documentation practices and improve reimbursement of declined charts. Adequate descriptive clinical documentation in the adult psychiatric units is an important component in receiving financial reimbursement. A standardized documentation in mental and behavioral health will promote a decrease in patient inpatient length of stay, improve providers' ability to accurately diagnose, evaluate for appropriate treatment plans, and decrease the loss of insurance reimbursement funding.

Healthcare Outcomes

This quality improvement project will have a positive outcome on clinical practices. These outcomes will include an increase in insurance reimbursement and efficient descriptive

clinical documentation in the adult psychiatric inpatient units. It is hoped that the findings from this project will impact the standardization of overall clinical assessment and management of the mental and behavioral health patient's treatment plan.

Healthcare Delivery

Inconsistencies in the documentation in mental and behavioral health impacts reimbursement and the delivery and quality of care of patients with mental health disorders in the acute care setting (Kunic & Jackson, 2013). Developing a standardized documentation system will ensure consistency in practice and the delivery of high-quality patient care (Dolan & Farmer, 2016). Standardized practice guidelines ensures efficient clinical documentation, improved insurance reimbursement, and decreased inpatient length of stay (Dolan & Farmer, 2016). Healthcare delivery in mental and behavioral health is dependent on accurate documentation to support the care given (Dolan & Farmer, 2016).

Healthcare Policy

According to the U.S. Department of Health and Human Services Rules (2015), the expansion of Medicaid reimbursement was a component of care that federal and state funding supported in mental and behavioral health (Scarbrough, 2018). The ACA's standards and the Mental Health Parity and Addiction Equity Act (MHPAEA) are policies that determine the application of treatment and factors in the mental and behavioral health arena (Ostrow, Steinwachs, Leaf, & Naeger, 2015). Psychiatric inpatient units must adhere to the Center for Medicare and Medicaid Services (CMS) (2016) reimbursement guidelines for mental health services to ensure reimbursement for services provided. Clinical staff and nurses must provide accurate, objective documentation that supports the medically necessary admissions into the inpatient level of care.

Summary

The purpose of this DNP project was to enhance the clinical documentation practice to increase insurance reimbursement claims and its' importance to enhance clinical documentation practices for patient quality of care, to improve healthcare delivery and to improve insurance reimbursement. Utilizing a theoretical framework to provide structure is substantial in developing a practice change. Lewin's change management theory was the DNP project's theoretical framework. This theory utilized unfreezing, change, and refreezing concepts on descriptive clinical documentation development and integration into practice. This theory was significant in integrating the changes within the private, non-profit mental and behavioral health organization.

Chapter 2: Review of the Literature

A review of the literature included searching electronic databases using the search terms (a) mental health narrative documentation, (b) insurance reimbursement in the mental and behavioral health setting, (c) mental health documentation guidelines, and (d) clinical documentation. The following electronic databases from the university's library's systems were utilized: CINAHL, PsycINFO, and ProQuest. The search locations included domestic and international journals from publication years 2013- 2018. The data reviewed included statistical, economical, and political data from the United States on mental and behavioral health services. Unfortunately, the proportion of the population without coverage affects the fiscal healthcare budget and the economic stability of national mental and behavioral healthcare services (NIMH, 2015). The Center for Medicare and Medicaid Services (2015), SAMHSA (2014), and American Psychiatric Association guidelines were important to the appraisal of the literature on mental health and behavioral health clinical documentation standards. Primary and secondary research articles and national mental health websites were also substantial resources.

Quality of care in documentation is not always clear and easy to explain. In the private, non-profit mental and behavioral health organization, clinical narrative progress notes were a way of documenting escalating conditions and subjective data (Collins et al., 2013; Finn, 2015; Hall & Powell, 2011). This data gave a clear picture of the adult psychiatric inpatient's clinical status. Documentation in the psychiatric inpatient units were declared deficient, as evidenced by the limited documentation guidelines, processes, and descriptive details of the patient's assessment (Instefjord et al., 2014). Pay-for-performance was the current quality improvement practice of measuring clinical reimbursement standards in the adult psychiatric inpatient units

(Glied et al., 2015). Insufficient documentation contributed to poor patient care billing outcomes and faulty health care practices (Glied et al., 2015). The integration of the electronic medical records quality documentation practices was an important aspect of economic stability, quality clinical practices, and optimal healthcare delivery in the psychiatric inpatient unit. The purpose of this practice improvement project was to enhance the descriptive clinical documentation practices and policies and to increase insurance reimbursement in the adult psychiatric inpatient units.

Mental Health Coverage

According to the National Alliance on Mental Illness (2015), approximately 18.5% of adults experienced a mental illness, which is an equivalent of over 43 billion people. Insurance coverage increased with the development of the Affordable Care Act (ACA), but there were still many who lacked mental and behavioral health coverage. In mental and behavioral health, access to care was impacted by the introduction of the ACA integration and its effects on inpatient care and revenue streams (Rowan, McAlpine, & Blewett, 2013). This shift was attributed to multiple factors including changes in reimbursement, deficiently trained staff, and unclear financial models and practices (Rowan et al., 2013).

Fee for service was the common payment method under the Chronic Care Model (CCM) for mental health services (O'Donnell et al., 2013). The CCM model was primarily used in the hospital location. However, this model provoked questions of healthcare delivery and reimbursement practices in mental and behavioral health (O'Donnell et al., 2013). In the adult psychiatric inpatient units, the plan of care and treatment depended on the Department of Health and Human Services' guidelines for mental health care carve outs and reimbursement (Beronio, Frank, & Glied, 2014).

Documentation

Over the last 7 years, the insurance reimbursement entities supported documentation practices that follow mental and behavioral health quality indicators (SAMHSA, 2014). These indicators determined how an organization was practicing under guidelines that supported medically necessary care (Wolf, 2016). Several international research journals explained that a lack of standardized reimbursement guidelines in the mental and behavioral health setting existed (O'Donnell et al., 2013). The lack of standardization included direct clinical care, documentation, policies, and standardized delivery of care practices (Perlman et al., 2013). The indicators supported the accountability for reimbursement, healthcare delivery, outcomes, and services (Perlman et al., 2013). The Centers for Medicare and Medicaid Services, SAMHSA, and the National Behavioral Health Quality Framework (NBHQF) services rated healthcare organizations' quality of delivery of care practices (Bae, 2016). These ratings utilized indicators of healthcare outcomes and their success in practice to measure the quality and safety of the care delivered (Bae, 2016). The insufficient interdisciplinary documentation practices contributed to the decrease of financial reimbursement in the mental health care setting (O'Donnell et al., 2013).

According to the commercial payors, the need for upfront documentation became critical in establishing medical necessity of mental health care (Wolf, 2016). There was a gap in literature between international and American research on specific quality indicators in the psychiatric inpatient unit. These gaps were the effects of the differences in their healthcare system in comparison to the socialized medicine system.

Reimbursement Methods

A study by O' Donnell et al. (2013) provided research analysis of challenges in a CCM of reimbursement techniques. This model was important in developing sustainable reimbursement practices in the adult psychiatric inpatient units. Governmental subsidiaries such as Medicare and Medicaid covered mental health care, but the Medicaid recipients may have limited coverage for mental and behavioral healthcare services (Beronio et al., 2014).

Mental and behavioral health coverage resulted in a critical oversight of descriptive documentation parameters in the delivery of care in the adult psychiatric inpatient units (ACA, 2010). Beronio et al. (2014) explained how the ACA adopted mental health care into its plan of care. This plan of care limited how care was delivered because of the complexity of the mental and behavioral health diagnosis. The ACA's access to care plan had limited recommendations for clinical documentation methods.

The CMS' (2018) guidelines for payor criteria and descriptive clinical documentation became more critical in the sustainability of mental and behavioral healthcare practices. The recognized descriptive documentation deficits included criteria for medically necessary care, insufficient documentation, or the use of investigational drugs (Wolf, 2016). Medicaid is a managed care program that includes guidelines that integrate clinical treatment plans into practices that ensured an organization's receipt of full reimbursement (Sheehan & Lewicki, 2016). The constant Medicaid oversight of clinical documentation is controlled by business practices and addresses pressure to an already strained healthcare system (Sheehan & Lewicki, 2016). Within an organization that lacked documentation practices, stringent documentation and paperwork requirements increased the workload of the clinical staff (Hess, 2015). The evidence

of the strain was seen in the organization's inability to update current documentation practices, insurance reimbursement policies, and provision of continual educational offerings (Wolf, 2016).

Mental Healthcare Parity

The ACA developed insurance guidelines that provide mental health and substance abuse coverage (Beronio et al., 2014). This act provided funding for mental health coverage and share of cost for the low socioeconomic groups with mental health and substance abuse disorders (Beronio et al., 2014). The MHPEA (2008) and the ACA (2010) are important acts that address areas of growth, focus, and cost in adult psychiatric inpatient units. Care coordination, access to care, quality of care, social determinants of health, and customer support continue to suffer from gaps in clinical practice (Adams, 2015).

Summary

The literature review used primary resources to ascertain the available research on descriptive clinical documentation in the behavioral health setting. These resources explained the need for mental and behavioral health coverage in the acute settings. The research of descriptive clinical documentation in the mental and behavioral health setting included disparities that were addressed by governmental agencies and acts. National standardized organizations such as SAMHSA, APA, and ANA developed substantial guidelines that supported clinical documentation practices. Evidence-based literature was pivotal in analyzing the clinical quality documentation in the mental and behavioral health setting.

Chapter 3: Methods

Accurate clinical documentation is a substantial component in mental and behavioral health. Clear and concise documentation in psychiatric inpatient units impacts healthcare delivery, healthcare outcomes, protocols, practices, billing, and insurance reimbursement (Dolan & Farmer, 2016). Psychiatric inpatient units must adhere to the Centers for Medicare and Medicaid Services (CMS) (2016) reimbursement guidelines for mental health services to ensure reimbursement for services provided. The purpose of this DNP project was to enhance the clinical documentation practices and policies and decrease insurance reimbursement claims in an inpatient mental and behavioral health organization in Florida.

Project Design

A quantitative descriptive design guided the data collection and the data analysis process. The tools utilized to collect the data included a retrospective chart audits, case scenario writing samples, and demographic surveys of the participants and declined chart ratios. The Fisher's exact and chi-square test were used to analyze the data.

Setting

The project was implemented in two of the 30-bed units of the 239-bed adult psychiatric inpatient units in a private, non-profit mental and behavioral health organization. The facility consisted of inpatient adult beds, outpatient services, action teams, children's acute care services, substance abuse, and detox units. For this DNP project, the setting was a 60-bed inpatient area.

Participants

Of the 38 clinical staff on the adult psychiatric inpatient units, the anticipated sample size was 20 participants. The participants included three shifts of nurses, physicians, social workers, and therapists. The final sample size was $N = 19$.

Inclusion Criteria

The inclusion criteria consisted of clinical staff who completed orientation, directed patient contact, and documented in the clinical record. This staff also included staff that work on the adult psychiatric inpatient unit for 30 days. The inpatient staff members were responsible for the clinical care of the adult psychiatric inpatient unit's mental and behavioral health patients diagnosed with schizophrenia, bipolar, depression, psychotic disorders, multiple personality disorders, and sexual dysfunction.

Exclusion Criteria

The exclusion criteria included any staff that had not completed Human Resources-facilitated orientation and was employed less than 30 days. This included the unit secretaries, unit clerks, patient care technicians, travel, float staff, and any staff who had not worked on the unit for the 30 days of the declined clinical chart documentation period.

Data Collection Procedure

Demographic

A demographic survey was given to each potential participant to collect data on his or her age, credentials, degree, clinical role, psychiatric inpatient unit experience, and general work experience. The survey was designed to collect the participant's individual professional characteristics and their impact on the project. The participants were responsible for the

assessment and evaluation of the adult psychiatric patient on admission, direct patient care, and clinical documentation.

Case Scenario

A case scenario writing example was developed to assess the clinical staff's clinical documentation practices. The purpose of the case scenario writing example was to measure the staff's clinical documentation practices before and after an educational session of the new practice. For the purpose of this project, the writing sample was utilized as a pre and post comparison of a hypothetical acute mental and behavioral health patient. Past documentation practices and its comparison to the updated practice was evaluated utilizing this tool (Appendix F). Evaluation of the writing sample utilized a post-educational intervention sample to compare the improvement in descriptive clinical documentation.

Retrospective Chart Audit

A retrospective chart audit evaluated the number of charts declined for insurance reimbursement in the adult psychiatric inpatient units. The psychiatric inpatient audit tool was an investigator modeled tool adopted from a CMS Psychiatric Inpatient Worksheet (Appendix E). The worksheet served as a checklist to determine if each patient chart included the admission criteria of the history and physical, psychosocial note, psychiatric note, medical note, nursing note, and interdisciplinary team note.

Declined Charts

An audit was done to compare the number of insurance reimbursement declined charts from the adult psychiatric inpatient admissions over the fiscal quarter of 2017. These numbers compared the charts declined for reimbursement from the partial first and second fiscal quarter of 2018.

Interdisciplinary Meetings

Throughout the project, the interdisciplinary and leadership team discussed ongoing practice changes within the organization. Weekly to biweekly meetings were held to discuss benchmark data of evidence-based practice changes. These meetings included practice, policies, and standardized practice development for the organization.

Ethical Consideration

Ethical consideration for the DNP project was valuable to its integrity. The participants' integrity was maintained in this project. Conducting a practice improvement project with a vulnerable population require pristine ethical regulations. Within this quality improvement project, The University's Institutional Review Board's (IRB) granted approval. This ensured that all ethical practices were upheld. The IRB guidelines maintained beneficence, justice, and respect of persons (Foote, Conley, Williams, McCarthy, & Countryman, 2015).

Ethical consideration of protecting the staff and medical records were carefully reviewed during the project. The protection of the staff included anonymous data collection by numbers. The anonymous collection technique was utilized during the case scenario and survey portion of the data collection. This portion included collecting the necessary data regarding staff practices, retrospective chart audit data, and case scenario clinical documentation examples. Consents were obtained during the first informational session and completed by the interested participants (Appendix A). An envelope was placed in the common area for potential participants who were not prepared to sign consents in the staff's lounge for 1 week. A request letter was sent to the mental and behavioral health director of medical services with solicited approval to begin the project (Appendix G). The project proceeded with the approval by the organization's legal authorities.

Health Insurance Portability and Accountability Act (HIPAA) is the standard for the protection of medical records during the study (Mishra, Rai, Pandey, & Jaiswal, 2013). With today's technology and changing healthcare system, the maintained ethical standard decreased the risk of misconduct.

Permission, consent, and the protection for all participants was integrated into the practice improvement. This included the overall protection from any negative consequences for sharing their personal beliefs, feelings or needs during this study. The participants acknowledged their understanding of their right to self-determination; this right gave the participants the autonomy to speak honestly and realistically without any coercion or deception (Foote et al., 2015). The participants were informed that they had the right to withdraw at any time from the project. The leadership team determined that the participants were required to participate in the educational sessions but were not obligated to participate in the study demographic surveys, pre/post documentation case scenarios, and questionnaires. Throughout this DNP project, open communication was encouraged by maintaining scheduled availability on the units. The medical records were protected under HIPAA guidelines and remained in the medical records department; thus, the retrospective chart audit records and participants' data collected was protected. The retrospect chart audit data and participants' data were maintained on the unit in a locked file cabinet, behind double locked outer doors. The DNP student possessed the only key to the file cabinet and the project information.

Project Objectives

Planning, implementing, and evaluating the project in the adult psychiatric inpatient units had multiple moving parts. The overarching theory that guided the project was Lewin's change

theory. In addition, the Plan, Do, Study, and Act (PDSA) model was used to guide the planning and implementation process.

The project was guided by the following objectives:

Objective 1. Improve clinical documentation of descriptive data in the adult inpatient chart by providing staff with educational sessions.

Objective 2. Integrate of national clinical documentation standards into the documentation policy and procedure of the mental and behavioral health organization.

Objective 3. Enhance the evidence-based practice in the clinical assessment and documentation in the adult inpatient psychiatric units.

Objective 4. Decrease the number of declined charts that are related to insufficient clinical documentation.

Project Phases

Phase I

Planning Phase/Unfreezing

This phase began with the shadowing and meeting with the leadership team. Current practice concerns were discussed during the meetings. The meetings established the benchmarks for the audit of the organization's quality practices, protocols, and healthcare outcomes. The clinical documentation practices, policies, and insurance reimbursement were the focus of the meetings with the leadership team. During the planning phase, the problem and objectives were defined. This phase also included the unfreezing of old practices and leadership recognizing the need for practice change.

Phase II

Do Phase/Change

Integrating the goals and objectives into planning began the early part of practice development. The structure of the project components such as the quantitative design, Lewin's change management theory, and evidence-based literature were foundational components of the project. The problem was determined by reports of an increase in chart denials of insurance reimbursement claims because of the lack of descriptive clinical documentation. The clinical documentation and insurance reimbursement claims were pillars in the stability of the adult psychiatric inpatient units. These variables were key components in the economic and clinical practices of the organization. A quantitative descriptive design was the ordinal measure for this type of project (Kaur, 2016).

Phase III

Study Phase/Change

The study phase of the project involved continual recognition of the need for change in the documentation practices of the mental and behavioral health care organization. There was 41% loss of insurance reimbursement revenue in the fiscal quarter of 2017, which supported the need for change in the documentation practices.

Phase IV

Act Phase/Refreezing

During this phase, information about the mental and behavioral healthcare organization documentation practices was collected via retrospective chart audits, case scenario, and observation of declined chart reports. Two of the seven (30) minute educational sessions were held during this phase. During the education sessions, staff were educated on why the new

documentation method was needed and warranted. Each session explained the DARP method, components, and documentation qualities.

The final phase was refreezing, which occurred with the review of charts utilizing a retrospective chart audit of the past 90 days. Additionally, a post survey was done to review the assimilation of the new documentation method into practice behaviors. Evaluating the results of refreezing included reviewing the clinical staff's adherence to the new documentation method by evaluating patient charts and a case scenario review.

Timeline

The project's planning occurred over a 14-week period prior to IRB approval (see Table 1). At this point, data were collected from staff or the adult psychiatric inpatient charts. Each week included meetings with the organization's interdisciplinary leadership team and the development of a plan to address the needs of the organization. Upon receiving IRB approval, the Act phase of the DNP project included two 30-minute educational sessions with clinical staff. The clinical staff were required to attend two of the six sessions. Each session included information on DARP narrative documentation. The organization's educational team facilitated each session by reviewing pre-documentation policies and introducing the updated documentation policy and practices.

Table 1

Timeline

Activity	Date	Time	What
IRB submission	December 2017		
Project Planning	August 25, 2017	Monday-Friday 14 weeks	Clinical/shadowing rotation

Staff Pre- Surveys	January 2018	Week 1 & 2	Questionnaire
Retrospective Chart Audits	January 2018	Week 3	Last fiscal quarter declined charts review dates were 09/2017-12/2017
Educational sessions (6)	January 2018	Week 5 Monday, Wednesday and Friday@ 3	1/20/2017
Retrospective Chart Audit evaluation	April 2018	Week 13	Psychiatric Chart Audit Tool 1/18-4/18(chart review extended to 5/24/2018 per IRB approval).
Staff Post-Surveys	April 2018	Week 13	

Resources/Budget

The budget (see Table 2) for the DNP project included all monies and funding from the student. The participants were offered snacks and drinks during the informational sessions and other interactions with the facilitator. The paper copies, gas, and transportation were the resources needed to promote the success of the project. The mental health facility offered staff pay for 2 hours for educational time if it was their day off. Financial support was not provided from the private, non-profit mental and behavioral health organization nor the university. Printed copies of educational material, consents, surveys, audit tools, and documentation examples were utilized as resources. This budget was established based on the DNP student personal funding.

Project Resources and Budget

Table 2

Budget

Category	Item	Description	Quantity	Total
Planning Phase/clerical	Copies of the consents	Black/white copies	150	$25.00
Planning Phase/clerical	Copies of the survey	Black/white	240	$25.00
Planning Phase/clerical	Copies of documentation tool	Black/white	240	$25.00
Planning Phase/clerical	Copies of questionnaire	Black/white	240	$25.00
Planning Phase/clerical	Copies of educational material	Black/white	240	$25.00
Planning Phase/clerical	Copies of the flyer	Color copies	6	$5.00
Do/Act/Phase/meeting sessions	Coffee/juice/doughnuts/bagels Snacks		20	$80.00
Travel/transportation	Private care		108 miles	$200.00
Total				$410.00

Outcome Measures

The American Psychiatric Association, SAMHSA, and the American Nurses Association (ANA) are defined as the foundations of professional core practices in mental and behavioral health standards of practice. SAMHSA, the Agency for Healthcare Quality and Research

(AHQR), the Center for Medicare and Medicaid Services (CMS), and National Quality Forum (NQF) utilize quality measures for quality improvements.

The outcome of this DNP project were evaluated using the following measures:

Outcome 1

Improve clinical documentation of descriptive data in the adult psychiatric inpatient chart by providing staff with educational sessions. This objective was measured by the evaluation of the introduction of seven educational sessions and documentation improvements noted in the clinical progress narrative notes. Having evaluated the pay-for-service criteria, the Centers for Medicare and Medicaid Services (2015) is the gold standard for insurance companies. This was evaluated using the retrospective chart audit worksheet and a case scenario writing sample.

Outcome 2

Integrate national clinical documentation standards into the documentation policy and practices of the mental and behavioral health organization. This objective was measured by the evaluation of the new documentation method integration and development of a new clinical documentation policy. The Agency for Healthcare Quality and Research is an important agency that SAMHSA utilized as a resource when writing standards in healthcare practices (Zivin, O'Malley, Bigby, Brown, & Rich, 2016). The case scenario writing sample and a retrospective chart audit worksheet was used to measure the outcomes.

Outcome 3

Enhance the evidence-based practice in the clinical assessment and documentation of the adult psychiatric inpatient units. The investigator modeled CMS Psychiatric Inpatient Worksheet was important for a clear understanding of Medicaid's reimbursable guidelines (CMS, 2015). Throughout implementation and evaluation of the clinical documentation, the "medically

necessary" standard of care guided the process in the mental and behavioral health facility. This objective was measured using a retrospective chart audit worksheet.

Outcome 4

Decrease the number of declined charts that are related to insufficient clinical documentation. This objective was measured using the comparison of admitted patients to the number of declined insurance reimbursable charts.

Summary

The purpose of the DNP evidence-based quality improvement project was to enhance the descriptive clinical documentation practices in the mental and behavioral health organization. These enhancements included a quantitative design that reviewed the documentation practice before and after and educational intervention. Lewin's three-step change management theory and the PDSA strategy were concepts that provided structure in the implementation of the project. The development and integration of the quality improvement practices and policies increase insurance reimbursement claims. This project's implementation was guided by a specified timeline to ensure the project's assimilation into practice.

Utilizing competent outcome measurement tools for this project supported the practice improvements in the adult psychiatric inpatient units. Furthermore, the use of these tools measured the staff's clinical documentation proficiency, competence, and synthesis of the DARP descriptive techniques into organizational practices and policies.

Chapter 4: Results and Discussion

The DNP project focused on the utilization of the Medicare and Medicaid standard for descriptive clinical documentation in the adult psychiatric inpatient units, in a private non-profit behavioral health organization. After completing an assessment of the organization's economic deficits, clinical documentation practices, and descriptive documentation instability, it was determined that the decline of insurance reimbursement occurred as a result of lack of clear descriptive clinical documentation.

According to the American Health and Information Management Association, best practices includes utilizing descriptive documentation for every patient encounter (Dolan & Farmer, 2016). The purpose of this quality improvement project was to enhance the current clinical documentation practices, policies, and increases in insurance reimbursement in a psychiatric inpatient unit in a private, non-profit mental and behavioral health organization.

Results

The retrospective chart audits and case scenarios were done pre-and post-educational sessions. Each case scenario evaluation was completed by the physicians, therapists, physicians, social workers, and nurses, utilizing the DARP charting method. This project measured how clinical documentation of the adult psychiatric inpatient unit's charting affected insurance reimbursement from February 9, 2018 to May 9, 2018. After the first audit, the project's facilitator realized the (n = 19) charts for the retrospective chart audit sample was small and requested an amendment from the Institutional Review Board (IRB) to extend the size and data collection period. The sample number of chart audits increased from (n = 19) to (n = 35) charts and the data collection time frame was extended until May 24, 2018. Furthermore, the pre-case

scenario documentation samples was $n = 19$ as compared to the post scenario sample size of $n = 15$; this was a decrease due to the participants who left the project.

Demographic Results

Of the 38 employees in the psychiatric inpatient units, 20 of the individuals volunteered to participate in the DNP project survey. In terms of gender the participants were 60% ($n = 12$) female and 40% (n = 8) male. In terms of age groups, 85% ($n = 17$) of participants were from ages of 31 and older, and 15% ($n = 3$) of participants were less than 30 years old (see Table 3). The demographic data results are represented in the tables below. In terms of the participants' profession and credentials, 40% ($n = 8$) were registered nurses (RNs) and 35% ($n = 7$) were licensed practical nurses (LPNs), with 25% of which were ($n = 3$) therapists, ($n = 1$) a social worker, and ($n = 1$) a physician (see Table 4). According to the work experience of participants in the Inpatient Units, the results were 45% ($n = 9$) for less than 5 years, 35% ($n = 7$) between 6 and 10 years, and 15% ($n = 3$) for greater than 10 years. The majority of the participants, 75% ($n = 15$), reported they participated in annual educational updates. The IBM Statistical Package for the Social Sciences (SPSS) analyzed the program and aggregated data throughout the analysis process. Upon completion of the project, an evaluation was completed on question number nine from the demographic survey. The question was, "Which narrative documentation method do you utilize in the organization's acute inpatient unit?" There were 35% ($n = 7$) staff who responded to the question. Out of the 35%, ($n = 7$) reporting 20% ($n = 4$) answered with the DARP method as the current organization's documentation practice method, 10% ($n = 2$) answered SOAP method, and 0.05% ($n = 1$) answered the DAP method.

Table 3

Descriptive Participant Demographics

Age	Frequency	%
26 to 30	3	15
31 and older	17	85
Total	20	100

Note. Descriptive demographics of participants' age from both acute psychiatric inpatient units

Table 4

Descriptive Participant Demographics

Interdisciplinary Team	Participants	% of the total
RN	8	40
LPN	7	35
Other(SW, MD and therapists)	5	25
Total	20	100

Note. Descriptive demographics of participants' credentials from both acute psychiatric inpatient units

Case Scenario

The interdisciplinary team's case scenario example was the measurement tool for the DARP training. The pre-DARP intervention case scenarios sample size was $n = 19$ and post-DARP intervention case scenario size was $n = 15$. During the project, $n = 4$ participants

withdrew from the post-case scenario. Therefore, the post-participation numbers decreased. The pre- and post-intervention training were not statistically significant for the usage of the DARP method (see Table 5). Each participant's response was reviewed for trends that correlated with the declining of the insurance reimbursable charts because of the insufficient clinical documentation. The results were not significant, as the practice improvement percentages were similar, with a pre-result of 40% and a post-result of 50% before and after training usage of the DARP documentation method. Therefore, there was not a statistical significance with the DARP training utilized in the case scenario example $p = 1.00$.

Table 5

Responses and Results of Fisher's Exact Tests and Chi-Square Test Frequencies and Percentages of Pre- and Post-Audit Yes

	Count (Percent)			
	Pre-Audit	Post-Audit	χ^2	*P*
[b] DARP	7 (38.9)	6 (40.0)	.004	1.000
[an] Admission	14 (77.8)	8 (53.3)	2.200	.163
[n] Narrative	13 (72.2)	8 (53.3)	1.262	.300

[a] *Note*. Chi square test for independence.

[b] *Note*. Fisher's Exact, two-sample difference in proportions test for comparing yes observations

Retrospective Chart Audit

The retrospective chart audit reviewed declined from the pre-DARP education training. An amendment was made to the IRB to review and additional 16 declined patient charts were reviewed. A total of 35 charts were reviewed. Fisher's Exact and the Chi-square test explained the usage of the DARP method pre- and post-education training (see Table 6). This table further

explains the comparison of pre- and post-DARP educational training with a 95% confidence interval (CI) for the admission specific criteria. The two-proportion comparison explained the lower interval and the higher level of integration of the method into clinical documentation practices. The 95% CI for the admission criteria of the narrative note's history, psychiatric note, nursing, psychosocial, medical note, progress note and interdisciplinary note, respectfully. The progress note was significant with a $z = 5.84$ and $p < 0.001$. Each admission criteria presented with a non-statistical significance except for the progress note. The progress note validated the statistical significance of the DARP documentation method utilization into practice.

Table 6

Pre-Post Audit Comparisons: Comparing Yes Responses

Chart Notes	Pre-Audit Count (Percent)	Post-Audit Count (Percent)	Difference (95% CI)	P-Value
[b] History	18 (94.7)	33 (94.3)	0.40 (-12.6,13.5)	Z=.005 p = 0.11
[b] Psychiatric	16 (84.2)	28 (80.0)	4.20 (-20.9,29.3)	Z=.145 p = 0.21
[b] Nursing	18 (94.7)	30 (85.7)	9.00 (-10.3,28.4)	Z =1. 015, p = 0.408
[b] Psychosocial	14 (73.7)	29 (82.9)	-9,20 (-36.6,18.2)	Z = 0.639, p = 0.489
[b] IDT	15 (78.9)	30 (85.7)	-6.80 (-32.5,18.9)	Z = 0.406, p = 0.704
[a] Progress	16 (84.2)	1 (2.8)	81.4 (59.9,99.9)	Z = 37.785, p < 0.001
[b] Medical	4 (21.1)	12 (34.3)	-13.2 (-41.4,14.9)	Z = 1.034,p = 0.365

Chart Notes	Pre-Audit Count (Percent)	Post-Audit Count (Percent)	Difference (95% CI)	P-Value

[a] *Note*. Chi square test for independence.

b *Note*. Fisher's Exact, two-sample difference in proportions test for comparing yes observations

Declined Charts

Declined charts over a 3-month period were benchmarks for the project. The pre-DARP educational intervention included declined charts out of 480 admitted patients to the adult psychiatric inpatient units. This number represents the charts for the last fiscal quarter of 2017. This figure equated to a 41% loss of billable revenue. The post 3-month period DARP education declined charts from February 9, 2018 to May 24, 2018, resulting in 95 charts declined for insurance reimbursement out of the 545 patients admitted to the units. This was an estimated 35% of the total declined charts that equated to a 17% loss of billable revenue for the first and partial second fiscal quarter (see Table 6). The overall results of the integration of the updated DARP educational improvement decreased the declined charts by 24%. Of the 545 admitted patients, 450 of the charts were eligible for reimbursement, which equated to an 83% increase in the reimbursement of authorized charts compared to the previous 41%. Utilizing an SPSS statistical analysis of the Chi-square test findings was significant with a $p < 0.001$.

Table 7

Utilization Review and Medical Records Reporting

	Pre-Intervention	Post-Intervention	95% CI	Z score and P value
[a] Reimbursed	284 (59.1)	450 (82.6)	-23.5 (-17.7, -29.0)	Z =68.75 , p < 0.001
[a] Declined	196 (40.8)	95 (17.4)	23.4 (17.7, 29.0)	Z =68.75 , p < 0.001

[a]Note. Chi-square test of independence

Demographic Results

Data collected from employees in the adult psychiatric inpatient units included a total of 38 employees that consisted of therapists, nurses, physicians, and social workers. Each direct patient care professional was invited to voluntarily participate in the project. A total of 18 staff members did not volunteer to participate in the study, which left *n* = 20 participants. The participants' inclusion criteria included full-time clinical staff who had completed orientation, provided direct patient care, and worked independently on the unit for 30 days.

Of the 20 participants, 40% (*n* = 8) were RN', and 35% (*n* = 7) were LPNs with a majority (75%, *n* = 15) female. Twenty-five percent (*n* = 5), which included therapists, social workers, and a physician (see Table 4). The participant group consisted of 80% (*n* = 16) from ages of 31 and older, and 20% (*n* = 4) from the ages less than 30 years old (see Table 3). The results are represented in the tables below. The IBM Statistical Package for the Social Sciences (SPSS) analyzed the program and aggregate data throughout the analysis process. Upon completion of the project, an evaluation was completed on question number nine from the

demographic survey. The question was, “Which narrative documentation method do you utilize in the organization’s acute inpatient unit?” There were *n* = 7 staff who responded to the question. Out of the *n* = 7 reporting, *n* = 4 answered with the DARP method as the current organization’s documentation practice method, *n* = 2 answered SOAP method, and *n* = 1 with the outdated previous charting method, DAP .

Case Scenario

The clinical interdisciplinary team’s hypothetical adult psychiatric inpatient case scenario example will be the measurement tool for the DARP training. The pre-DARP intervention case scenarios sample size was (*n*=19) and post-DARP intervention case scenario size was (*n*= 15). During the project (*n*=4) participants withdrew from the post case scenario. Therefore, the post participation numbers decreased. The pre and post-intervention training were not statistically significant for the usage of the DARP method (see Table 5). Each participant’s response was reviewed for trends that correlate with the declining of the insurance reimbursable charts because of the insufficient clinical documentation. The results were not significant as the practice improvement percentages were similar, with a pre-result of 40% and a post-result of 50% before and after training usage of the DARP documentation method. Therefore, there was not a statistical significance with the DARP training utilized in the case scenario example p=1.00.

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Retrospective Chart Audit

An amended inclusion of 16 more declined patient charts were requested to be analyzed. This IRB amendment brought the post retrospective chart samples to (*n*=35). Fisher's Exact and the Chi-square test explained the usage of the DARP method pre education training and post education (see Table 6). This table further explained the comparison of pre-and post-DARP educational training with a 95% confidence interval (CI) for the admission specific criteria. The two proportion comparison explained the lower interval and the higher level of integration of the method into clinical documentation practices. The 95% CI for the admission criteria of the narrative note's history, psychiatric note, nursing, psychosocial, medical note, progress note and interdisciplinary note, respectfully. The progress note was significant with a z=5.84 and p<0.001. Each admission criteria presented with a non-statistical significance except for the

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Expected/Unexpected Findings

Expected findings included the lack of consistency with the organization's clinical documentation policy, practices, and standards. These inconsistencies were detrimental to the staff's competence in documenting descriptive care and insurance reimbursement. A positive, unexpected outcome was the staff's desire for change and the request for access to updated educational offerings as evidence by the DNP facilitators' observations and conversations with the staff. Their inquiring questions regarding ongoing training, and the request for consistent unit support, validated the positive outcome. The staff's readiness for change, monitoring change, and implementation of updated practices are sustained by practice improvements (Gutierrez & Kaplan, 2016). There was a lack of continuity in clinical documentation practices, policies, and standards among the inpatient professionals. CMS laws and regulations govern documentation practices at the federal, state and local levels (Dolan & Farmer, 2016). The clinical staff's interpretation of their clinical documentation methods differed from the organization's previous practice standards.

Strengths and Limitations

The project encountered strengths and limitations in practice, policies, and standards. The strengths of the project included the staff's willingness to learn updated methods of clinical documentation and their passion to care for the behavioral health patient. The limitations included the staff's reluctance to voluntarily participate in the study and their uncertainty that the changes would improve the delivery of care. These limitations became an ongoing concern throughout the project's progression. The limitations included employee resignations, latent effects of the company's merger, language barriers, terminations, limited retrospective chart audits, and the small sample size. Nurses, therapists, social workers, and the physician's

documentation methods were based on their educational backgrounds. Therefore, neither of the clinical staff participants utilized the organization's standardized previous DAP documentation method.

The common documentation methods utilized ranged from DAP, SOAP, subjective, SOAPIER, and other derivations. The facilitator was forthcoming with being an active employee of the organization and did not allow any implicit bias to affect the significance of the project's findings, strengths, or limitations.

Implications

Nursing Practice

The findings from this project are important to nursing practice because they explain the impact that standardized documentation practice had on clinical care. Clear clinical documentation in mental and behavioral health improved the providers' ability to accurately diagnose and manage patient care (ANA,2010b). The standardization of practices impacted the length of stay of the psychiatric inpatient units. It is imperative that health care providers utilize a standardized documentation system based on CMS guideline to accurately treat, manage, assess, and provide care for the mental and behavioral health patient (Jones, Ku, Smith & Latdiere, 2014). The accurate treatment of this client ensured the receipt of insurance reimbursement.

Healthcare Outcomes

Understanding the deficits in clinical documentation is a substantial part of pay for performance billing (Fallati, 2015). Standardization of clinical documentation practices, monitored measurable progress, and positive outcomes are required for payer source reimbursement and facility admission requirements (Waldon, 2016). Pay-for-performance impacted insurance reimbursement claims. The deficits in clinical documentation practices may

have contributed to the number of declined insurance reimbursement charts. This financial loss was generated from insufficient insurance billing, which occurred because of the lack of descriptive clinical documentation. The standardized tools are critical to the quality of documentation, practices, and policies in the adult psychiatric inpatient charts (Balfour, Tanner, Jurica, Rhoades and Carson, 2015). Standardization in documentation improved the healthcare outcomes such as the continuity of clinical practices, policies, and standardized documentation methods within the organization. The clinical documentation outcomes were dependent on NBHQF factors that guided mental and behavioral health practices (Seibert et al., 2013). Sustainable standardized practices may have improved insurance reimbursement and clinical staff's descriptive documentation. Therefore, the development of standardized guidelines impacted the insurance reimbursement claims, providers' assessment and treatment management, patients' treatment plans, and practice outcomes in the mental and behavioral health organization.

Healthcare Delivery

Inconsistencies in the documentation in mental and behavioral health impacts reimbursement and the delivery and quality of care of patients with mental health disorders in the acute care setting (Kunic & Jackson, 2013). Developing a standardized documentation system ensured consistency in practice and the delivery of high-quality patient care (Dolan & Farmer, 2016). Standardized practice guidelines ensure efficient clinical documentation, improved insurance reimbursement, and decreased inpatient length of stay (Dolan & Farmer, 2016). The healthcare delivery in the mental and behavioral health is dependent on accurate documentation to support the care given (ANA, 2014). The patient's admission documentation and length of stay were impacted by the documentation in practice and efficiency of the descriptive care

documented. Secondary to time constraints, the results presented impacted the staff's awareness of the updated charting method. Sufficient integration of the DARP method into practice was an ongoing educational intervention that required reinforcement. The attentiveness of the staff's assessment method improved the progress narrative notes documentation. These standardized practices impacted the providers delivery of care. Standardized practice guidelines ensured efficient clinical documentation, improved insurance reimbursement, and decreased inpatient length of stay (ANA,2010a).

Healthcare Policy

According to the Department of Health and Human Services Rules (2015), the expansion of Medicaid reimbursement was a component of care that federal and state funding supported in mental and behavioral health. The ACA's standards and the Mental Health Parity and Addiction Equity Act (MHPAEA) are policies that determine the application of treatment and factors in the mental and behavioral health arena (Ostrow et al., 2015). Psychiatric inpatient units must adhere to the Centers for Medicare and Medicaid Services' (CMS) (2016) reimbursement guidelines for mental health services to ensure reimbursement for services provided. Clinical staff and nurses must provide accurate, objective documentation that supports the medically necessary admission into the inpatient level of care. The American Psychological Association (APA) Record Keeping Guidelines (2007) recommended that clinicians document significant factors such as the presence of a psychotic episode, current stressors, or recent crises that impacted psychological status or observed levels of functioning during the assessment (Waldon, 2016). Therefore, it is imperative that a standardized documentation system is utilized in mental and behavioral health to improve insurance reimbursement claims and for the integration of evidence-based policies into practice.

Recommendations for Future Research

Future research should include a qualitative study of standardized clinical documentation practices in mental and behavioral health. It is also important to evaluate the impact of standardized documentation, policies, and practices or the lack of impact on patient care. Further research of mental and behavioral health professionals should include the benefits and hardships that are related to inefficient clinical standardized documentation.

Summary

Accurate descriptive documentation of patients in the mental and behavioral clinical setting is important to the stability of patient care outcomes, healthcare delivery, and financial stability within an organization. The descriptive clinical documentation of a patient's care must meet the standards of CMS guidelines for pay-for-performance. Standardization of clinical documentation practices and policies in mental and behavioral health will help to increase insurance reimbursement claims and improve patient care outcomes (ANA,2014). Enhanced clinical documentation practices for the patient's quality of care, improvements in healthcare delivery, and improvements in insurance reimbursement claims were the goals of the DNP evidence-based project.

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Appendix A

General Informed Consent Form

A Clinical Documentation Practice Improvement to Increase Insurance Reimbursement

Who is doing this research study?

College:
Principal Investigator: Allison R. Hamilton RN, MSN

Faculty Advisor/Dissertation Chair: Marcia Derby-Davis PhD
Co-Investigator(s): none
Site Information
Funding: This study is not f funded by any institution or agency.
If there is no funding, list: Unfunded

What is this study about?

This is a research study, designed to test and create new ideas that other people can use. The purpose of this research study is to assess the clinical documentation practices utilized in a mental and behavioral health facility. The study will be analyzing at the effects of the clinical documentation on insurance reimbursement. The benefit of this study will be to improve clinical documentation practices, delivery of healthcare and optimize healthcare delivery in the organization.

Why are you asking me to be in this research study?

You are being asked to be in this research study because you provide direct patient care as a full-time employee on an acute mental and behavioral health inpatient unit in a community based facility.
This study will include about 37 people from 3 East Inpatient unit primary staff. It is expected that 37 people will be from various disciplines such as therapist, social workers and nurses at this location.

What will I be doing if I agree to be in this research study?

While you are taking part in this research study, you will participate in a survey/questionnaire and interview. The questionnaire will be a selection of questions on the participant's demographics and familiarity with organizational policy. There will be 6 (20) minutes sessions, 1 per week. Each participant will be required to attend 2 sessions. There will be a third session with 1 final 25-minute session, which include an interview. You may have to come back to the location of the staff lounge on 3 East for the final session. All sessions will occur over 90-days.

Research Study Procedures - as a participant, this is what you will be doing:

Participant

The participants will include those who have completed the 3-week organizational orientation and who currently document in the clinical record. The participants will be invited by memo, email and flyer posted in the staff lounge and common areas. The consents will be numbered to protect the anonymity of the participant. This will be a non-randomized group of participants based on a convenient sampling. That will participate in educational sessions/in-services

Survey

You will participate in a survey of selected questions on the organization's current clinical documentation practices. The purpose of the survey is to gather information of your familiarity with organizational documentation practices, policies and procedures. The study will include all clinical employees hired and working on the unit at least 30-days. What clinical documentation method or tool do you utilize? Have been trained on the organizations policy and procedures? This data will get a general understanding of the status of the clinical staff in the mental health inpatient setting.

Interview

The interview process will include questions regarding documentation practices in your clinical discipline. How these clinical practices impact your practice? The participants educational background, first language, years in mental health practice, age and gender. This information will synthesize the experience and familiarity with the clinical documentation in the mental health discipline.

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Could I be removed from the study early by the research team?

There are several reasons why the researchers may need to remove you from the study early. Some reasons are: exclusion from the study will be considered if the participant does not participate in the (2)-15-minute sessions, which include educational sessions, an interview and questionnaire.

Are there possible risks and discomforts to me?

This research study involves minimal risk to you. To the best of our knowledge, the things you will be doing have no more risk of harm than you would have in everyday life.

What happens if I do not want to be in this research study?

You have the right to leave this research study at any time, or not be in it. If you do decide to leave or you decide not to be in the study anymore, you will not get any penalty

or lose any services you have a right to get. If you choose to stop being in the study, any information collected about you **before** the date you leave the study will be kept in the research records for 36 months from the conclusion of the study, but you may request that it not be used

What if there is new information learned during the study that may affect my decision to remain in the study?

If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by the investigators. You may be asked to sign a new Informed Consent Form, if the information is given to you after you have joined the study.

Are there any benefits for taking part in this research study?

There are no direct benefits from being in this research study. We hope the information learned from this study will improve the organization's clinical documentation process and procedures. This improvement will support the clinical team's job duties and responsibilities in providing quality direct patient care.

Will I be paid or be given compensation for being in the study?

You will not be given any payments or compensation for being in this research study.

Will it cost me anything?

There are no costs to you for being in this research study.

Please ask the researchers if you have any questions about what it will cost you to take part in this research study (for example bills, fees, or other costs related to the research).

How will you keep my information private?

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. This data will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any regulatory and granting agencies (if applicable). If we publish the results of the study in a scientific journal or book, we will not identify you. All confidential data will be kept securely. All data collected in this study will be kept in a file cabinet locked behind office doors. The survey, questionnaire and interview data will be evaluated daily and protected by

anonymity by numbered surveys, interviews and questionnaires. The researcher will hold the only key that opens the locked file cabinet. All data will be kept for 36 months and destroyed after that time by shredding data with the organizations leadership team.

Whom can I contact if I have questions, concerns, comments, or complaints?

If you have questions now, feel free to ask us. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact: Allison R. Hamilton RN, MSN

If primary is not available, contact:
Research Participants Rights
For questions/concerns regarding your research rights, please contact:
Institutional Review Board
Nova Southeastern University
(954) 262-5369 / Toll Free: 1-866-499-0790
IRB@nova.edu
You may also visit the NSU IRB website at www.nova.edu/irb/information-for-research-participants for further information regarding your rights as a research participant

Research Consent & Authorization Signature Section

Voluntary Participation - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

If you agree to participate in this research study, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:

You have read the above information.
Your questions have been answered to your satisfaction about the research.

Adult Signature Section

I have voluntarily decided to take part in this research study.

Printed Name of Participant	Signature of Participant	Date

Appendix B

Site Letter Approval

10 / 30/ 2017

Nova Southeastern University
3301 College Avenue
Fort Lauderdale, FL 33314 - 7796

Re: Site Approval Letter

To Whom It May Concern:

This letter acknowledges that I have received and reviewed a request by Allison R. Hamilton to conduct a research project entitled "A Clinical Documentation Practice Improvement to Increase Insurance Reimbursement" at Aspire Health Partners, Inc., Princeton Campus and I approve of this

Appendix C

Institutional Review Board Agreement

NOVA SOUTHEASTERN UNIVERSITY
Institutional Review Board

To: **Allison Hamilton**
From: **Vanessa Johnson,**
Center Representative, Institutional Review Board

Date: **January 4, 2018**

Re: **IRB #: 2018-9; Title, "A Clinical Documentation Practice Improvement to Increase Insurance Reimbursement"**

I have reviewed the above-referenced research protocol at the center level. Based on the information provided, I have determined that this study is exempt from further IRB review under **45 CFR 46.101(b) (Exempt Category 2)**. You may proceed with your study as described to the IRB. As principal investigator, you must adhere to the following requirements:

1) CONSENT: If recruitment procedures include consent forms, they must be obtained in such a manner that they are clearly understood by the subjects and the process affords subjects the opportunity to ask questions, obtain detailed answers from those directly involved in the research, and have sufficient time to consider their participation after they have been provided this information. The subjects must be given a copy of the signed consent document, and a copy must be placed in a secure file separate from de-identified participant information. Record of informed consent must be retained for a minimum of three years from the conclusion of the study.

2) ADVERSE EVENTS/UNANTICIPATED PROBLEMS: The principal investigator is required to notify the IRB chair and me (954-262-5369 and Vanessa Johnson, respectively) of any adverse reactions or unanticipated events that may develop as a result of this study. Reactions or events may include, but are not limited to, injury, depression as a result of participation in the study, life-threatening situation, death, or loss of confidentiality/anonymity of subject. Approval may be withdrawn if the problem is serious.

3) AMENDMENTS: Any changes in the study (e.g., procedures, number or types of subjects, consent forms, investigators, etc.) must be approved by the IRB prior to implementation. Please be advised that changes in a study may require further review depending on the nature of the change. Please contact me with any questions regarding amendments or changes to your study.

The NSU IRB is in compliance with the requirements for the protection of human subjects prescribed in Part 46 of Title 45 of the Code of Federal Regulations (45 CFR 46) revised June 18, 1991.

Cc:

Appendix D

Clinical Documentation Quality Improvement

Demographic Survey

Please complete the following information to provide demographic information. Please indicate your response to the following question by circling your choice. If you do not feel comfortable answering any questions please leave them blank and proceed to the next question.

1. What is your gender?

    - Male
    - Female

2. What is your age range?

    - 19-24
    - 25-30
    - 31-older

3. What is your profession?

    - Nurse
    - Therapist
    - Social worker
    - Physician

4. What is your professional credentials?

    - LPN
    - RN
    - SW
    - LCSW
    - MD
    - LMHC
    - PMHNP
    - PMHCNS
    - ARNP
    - FNP
    - DO

5. How long have you practiced in the psychiatric/mental/behavioral health profession?

- Less than 5 years
- 6-10 years
- More than 10 years

6. How long have you worked on the acute inpatient unit?

- Less than 5 years
- 6-10 years
- More than 10 years

7. How often do you participate in mental and behavioral health educational updates?

- Annual
- Bi-annual
- Every 2 years
- Never

8. What is your highest grade completed ?

- GED
- High School Diploma
- Associate
- Bachelors
- Masters
- Doctorate

9. Which narrative documentation method do you utilize in the organization's acute inpatient unit?

- Data Assessment Plan
- Subjective Objective Assessment Plan
- Subjective Objective Assessment Plan Intervention Evaluation Revision
- other _____(write in))

Appendix E

Retrospective Inpatient Chart Audit Tool

Modeled from the CMS Inpatient Criteria Worksheet

Month	# of insurance declination Or declined claims	# chart audited	1. Physician's History & Physical	2. Psychiatric Evaluation by the Physician	3. Nursing Assessment	4. Psychosocial Assessment	5. Interdisciplinary team Plan	6. General Progress note	7. Medical diagnosis
Oct 2017									
Nov 2017									
Dec 2017									

Feb 2018									
Mar 2018									
Apr 2018									

**Note*. Individual tool will be utilized for each chart reviewed/Y=yes N=no

1. The History and Physical exam was completed within 24 hours of admission which included past psych history and signed by the MD. yes or no

2. Psychiatric Evaluation completed by psychiatrist within 24 hours and reflects admission medically necessity(DSM-V). yes or no

3. Nursing Admission Assessment initiated and signed by RN within 24 hours. yes or no

4. Psychosocial Assessment completed by therapist within 24 hours. yes or no

5. Interdisciplinary treatment plan completed with patient objectives and signed by each discipline within 5 days of admission.

   If one of the below sections are signed, the question will be marked as a no:

   a. Signed/EMR by a RN? yes or no
   b. Signed/EMR by a MD? yes or no

c. Signed/EMR by a Therapist (vocational hx, educational hx, family hx)? yes or no

6. Descriptive progress note completed and reflects client symptoms and the need for acute treatment utilizing DARP/SOAP (participation in ADL's, mood, behavior, cognition and functionality). Yes or no

7. Is there a Medical Diagnosis/comorbidity or problems identified? yes or no

a. if yes, was it addressed in Nursing Assessment?

b. Medications were prescribed/taken as needed. yes or no

Appendix F

Quality Improvement Documentation

Case Scenario Sample

***Please document in a narrative note utilizing your organization's current documentation policy/practice**

Admit: 11/1/2017

Time: 03:00am

Admitting vitals: T- 99.0 P-110 R-22 BP-130/90

History: Multiple Inpatient Admissions, Baker Acts and police arrests

A.M was brought to the unit pacing, disheveled, dirty and without shoes, by the police department. He was found in the middle of a major intersection speaking to himself and waving a knife. According to the police officers he has been combative, aggressive and loud and would not surrender his weapon. A.M has cuts and bruises on his hands and is threatening to kill himself, the police officers and the President. He also claims the President has sent alien men to kill him and his dog. Currently, he is holding open conversations about a strategy to kill the president and the alien men who is assisting the President. A.M doesn't want to be touched and refuses to consent to admission. Physician evaluation concludes client meets criteria for Baker Act.

06:00am Since arriving to the unit, A.M remains secluded and paces the floor blurting explicit language to the other clients, staff and in the air. Unfortunately, he had not shared any information with the staff and refuses to bath. He was identified by staff as being a previous patient in the facility.

Appendix G

Pre and Post Case Scenario Analysis

1. Reflects admission criteria (danger to self/others; DSM criteria, descriptive note)

2. Include a descriptive DARP/DAP narrative documentation method.

3. Descriptive progress note completed and reflects client symptoms and the need for acute treatment utilizing DARP/SOAP (participation in ADL's, mood, behavior, cognition and functionality).

a. Is there an interdisciplinary team note by the (__RN, __LPN, ___MD, ___Therapist) yes or no?
b. General note is completed but does not reflect symptoms or the need treatment by the (___RN, ____LPN, _____MD, ____Therapist) yes or no

Appendix H

Research Timeline Letter

Dear Ms. Robinson,

My name is Allison R. Hamilton, RN, MSN. I am a doctoral student in the College of Nursing at Nova Southeastern University and I'm conducting a quantitative research study under the supervision of... I am researching the increase in the decline of insurance reimbursement claims secondary to inappropriate clinical documentation. Now, I am writing to share a timeline for approval assistance in gaining access to the population of interest for my study.

The Study

The study will begin tentatively upon IRB approval in January 2018, and consist of several parts. A retrospective chart audit will be conducted to review the quantitative data relating to insurance declined charts. The staff portion will consist of (6) 30-minute educational sessions to capture each shift, which include a collaborative educational presentation by the documentation committee leaders (nurse managers, therapist, educator and utilization review nurse) of your organization. These sessions will begin and end with the completion of a pre/post survey/questionnaire. All the meetings will be held on 3 East in the staff lounge. All the data collected will be kept confidential. The data will be housed behind a double locked office and cabinet on the 3rd floor. The study will be conducted over a 90-day period. I have enclosed the questionnaires, interview and discussion questions for your review.

Participation

Participation in this study is voluntary. Participants must be employees of your Company and have been working on the unit for at least 30 days. There will be no monetary compensation for participation, although perishables/snacks and drinks will be available during the survey/questionnaire sessions. The participants may withdraw from this study at any time and for any reason up to the time of data analysis without penalty, prejudice, or loss of benefits. If a participant chooses to withdraw from the study prior to data analysis, the participant's information will be destroyed.

Risk

There is a possibility of minimal risk with participation in this study. Participants may experience some anxiety while completing the survey/questionnaires. If a participant experiences anxiety related to participation in this study, the employee will have access to counseling services currently provided through your company's employee assistance program.

Benefit

The benefit involved in this research study includes providing health care professional with valuable information related to improving descriptive clinical documentation practices and improving revenue from insurance reimbursement claims within your organization. This information will be helpful in determining which clinical documentation provide the greatest assessment of the clinical data of the patients in the inpatient unit setting. Should you have questions regarding this research, you may contact the principal investigator's faculty advisor, …Should you have questions regarding the rights of the employees in the study, you also may contact at the Nova Southeastern University Institutional Review Board at (954) 262-5369 or irb@nova.edu. This research project is involving human subjects and will only be conducted with the prior approval from your Institutional Review.

Allison R. Hamilton RN, MSN
Doctoral Student
Principal Investigator