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Documentation Challenges and Service Outcomes in Behavioral Health Organizations Serving the Homeless With Mental Illness

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Walden University
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Abstract

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MS, Walden University, 2018

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Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Psychology in Behavioral Health Leadership

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Abstract

Observed inconsistencies in clinical documentation are a problem for a behavioral health organization (BHO) serving homeless individuals with mental illness in the southern United States. The purpose of this study was to examine the impact of inconsistent clinical documentation on patient outcomes within the BHO. The Baldrige Excellence Framework was used to examine organizational leadership, strategy, operations, and compliance practices. The chief executive officer, chief operating officer, and lead psychiatric coordinator were interviewed to assess challenges related to clinical documentation. Archival records were also reviewed to gain a comprehensive understanding of the BHO's documentation processes. Three major themes emerged: (a) inconsistent documentation methods across clinicians leading to incomplete and inadequate patient records; (b) barriers to accurate patient documentation due to homelessness and limited access to patient history; and (c) compliance hurdles resulting from the lack of standardized documentation processes, which have led to regulatory violations and financial penalties. These findings may contribute to positive social change by identifying documentation inconsistencies that affect patient safety and care continuity. Standardizing documentation practices could improve service delivery for homeless individuals with mental illness, ensuring accurate and accessible patient information for care providers. Moreover, enhanced compliance with regulatory requirements may safeguard the organization from legal repercussions and improve overall operational efficiency. These improvements may lead to better patient outcomes for homeless individuals and improved organizational accountability for BHOs.

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Section 1a: The Behavioral Health Organization

The behavioral health organization (BHO) that serves as the host site for this proposed study is a for-profit, community-based organization located in the Southern part of the United States. As noted on its website, the entity referred to by the pseudonym "Organization X" was initially established as a sole proprietorship and operated under a distinct name. Rapid growth led to the building of a team of like-minded medical providers and clinicians to serve adult and geriatric clientele with underlying medical conditions and psychiatric illnesses. According to the organization's website, the structure consists of the organization's CEO, a medical director, licensed medical physicians, nurse practitioners, nurses, certified nurse assistants (CNAs), and office personnel. A team of dedicated medical providers offers various cost-effective health care services, including medication management, management of chronic health conditions, evaluation and treatment of acute illnesses, emotional and spiritual well-being oversight, nutritional management, psychology services, and psychiatry with medication oversight.

A vital part of providing adequate services to clients involves clinical documentation. This is the process of developing patient records that summarize a patient encounter or interaction between the medical provider and the patient during the patient encounter (Ebbers et al., 2022). Although many clients receive services in outpatient office visits, many reside in long-term care facilities and assisted living facilities. According to Volk et al. (2022), an alarming number of clients are found to have been homeless prior to hospital visits, thereby limiting the amount of vital information

required in clinical documentation. As stated on its homepage, Organization X's mission encompasses individually specific care for all clients.

According to the organization's website, Organization X values providing evidence-based care to clients with as much grace as possible. Every client is offered a customized treatment plan tailored to meet his or her personal needs. The idea of quality over quantity and inflated revenue is embraced (Tsai et al., 2020). Organization X provides close patient monitoring and a reliable facility presence. Their diverse team thrives on accountability, making a difference, and trust. Lastly, the organization fosters interdisciplinary collaboration (Zanaboni et al., 2022).

Practice Problem

The practice problem that is the focus of this study is the impact of inadequate and inconsistent clinical documentation on patient outcomes. There have been increased reports of inconsistency in the documentation of patient information within Organization X. Some medical providers and clinicians use different documentation methods, while others fail to provide clinical documentation. According to Borja and Galbraith (2019), inconsistent clinical documentation often leads to confusion and inefficiency, compromising patient safety.

There have been increased cases of incomplete documentation, which some providers indicate are due to a lack of sufficient patient information, given that many of the clients are homeless before entering the facilities for post-hospital skilled care services and palliative/end-of-life care. Medical providers and clinicians must follow specific legal and regulatory requirements when documenting patient information, with

Zanaboni et al. (2022) noting that failure to do so can result in legal repercussions for the provider and organization. Recently, Organization X received a hefty fine because the health care provider failed to document accurate patient claims, resulting in penalties for undocumented paid claims, its compliance officer shared.

To submit any claims for payment, health care providers must submit sufficient clinical documentation, often referred to as progress notes, of each encounter with a correct service date, proving the patient was seen and assessed by the provider on that specific date (Zanaboni et al., 2022). Considering these documentation challenges, I undertook this doctoral study to explore several key aspects of documentation practices within BHOs. My investigation was underpinned by the following research questions (RQs):

RQ1: What are the perceived barriers behavioral health providers face in accurately documenting patient information?

RQ2: How do inconsistent documentation methods among clinicians in BHOs impact the efficiency and effectiveness of patient care?

RQ3: What common compliance hurdles does the organization experience?

Purpose

The Baldrige Performance Excellence Program, established by Congress in 1987, provides a framework for improving organizational performance through a comprehensive systems approach (National Institute of Standards and Technology [NIST], 2023). The framework encompasses criteria across leadership, strategy, customers, measurement, analysis, knowledge management, workforce, operations, and

results. It is designed to help organizational leaders effectively identify strengths and opportunities for improvement, set priorities, and align resources. The Baldrige framework is used globally and is recognized for its ability to drive organizational excellence and innovation. I used the Baldridge Excellence Framework to address the practice problem at the target side. My specific aim in conducting this qualitative study aims was to understand how documentation challenges and compliance hurdles experienced at Organization X affect patient outcomes. The study was motivated by observed inconsistencies in clinical documentation. Process efficiency, patient safety, and continuity of care can affect delivering high-quality patient care (NIST, 2020). These are critical areas of focus within the Baldrige Framework.

There are barriers that behavioral health providers face when the clinical documentation is inconsistent and inadequate, and they align with the Baldrige Framework's focus on information and knowledge management. Emphasis is placed on the importance of accessible, accurate, and actionable information in health care settings to improve patient outcomes and operational performance (NIST, 2020). Examining these barriers can provide opportunities for improvement in data management practices, which is a vital component of the Baldrige criteria. Lastly, compliance is another significant aspect of the Baldrige framework.

It is not uncommon for BHOs like Organization X to face compliance hurdles regarding clinical documentation practices in their organization (Dunbar et al., 2021). Based on the Baldrige Framework (2020), organizations are encouraged to be adaptable and responsive to regulatory requirements and to integrate compliance into daily

operations and strategic planning. Sources of information to be collected that meet the purpose of this study include interviews with the organization's leadership team, a thorough review of the clinical documentation process, and a review of inaccurate and inconsistent clinical documentation practices. By exploring these challenges, I sought to contribute to the improvement of documentation practices at Organization X, enhancing patient care quality and ensuring compliance with legal and regulatory requirements.

Significance

This study is significant because it addresses a crucial and often overlooked gap in health care. The lack of standardized documentation practices at Organization X leads to inconsistencies in record-keeping, making it difficult for professionals to access accurate and complete information about clients' treatment histories. The organization has recently been cited for noncompliance with the regulatory requirement of providing a progress note for each submitted claim to insurance companies. It not only resulted in a monetary fine, but such noncompliance hinders the organization's ability to provide adequate care. This study aims to identify the specific challenges faced at Organization X on documentation and compliance, enabling the development of evidence-based strategies and best practices that can be implemented across the behavioral health field.

The study will also provide insights into potential barriers preventing the organization from adhering to appropriate regulatory guidelines. By addressing documentation and compliance issues, the study aims to promote patient safety, employee satisfaction, and improve the overall quality of care delivery. Standardized documentation practices will support access to complete and accurate information about

clients' treatment histories, facilitating better-informed decision-making. Additionally, compliance with regulatory requirements will help protect organizations from legal consequences and enhance their credibility (Magruder et al., 2018). The findings of this study will contribute to positive social change by improving the overall delivery of quality mental health care. By establishing consistent documentation practices and ensuring compliance, the study seeks to enhance the BHO's transparency, accountability, and quality of care, which may lead to improved outcomes for individuals seeking support from the organization.

Summary

Organization X is a medical practice that is highly patient-focused. It strives to include the client as a part of the team. By doing so, the organization has experienced significant growth and can provide various medical and psychiatric services to the adult and geriatric population. Organization X is built on collaborative teamwork but has suffered a financial setback due to insufficient documentation practices. Using the Baldrige Excellence Framework (NIST, 2020) as a guide, in Section 1b I further discuss the organization by providing profile information as a snapshot of the organization. Organization X's structure and background will be discussed in relevance to the practice problem and need for this study.

Section 1b: Organizational Profile

Introduction

The practice problem that is the focus of this study is the impact of inadequate and inconsistent clinical documentation on patient outcomes. The purpose is to

understand the documentation challenges and compliance hurdles experienced at BHO and how they affect patient outcomes. The RQs that underpinned this doctoral study were

RQ1: What are the perceived barriers behavioral health providers face in accurately documenting patient information?

RQ2: How do inconsistent documentation methods among clinicians in BHOs impact the efficiency and effectiveness of patient care?

RQ3: What common compliance hurdles does the organization experience?

The organizational profile is a starting point that is an ongoing tool for organizational improvement and performance assessment. According to the Baldrige Framework (2020), the organizational profile provides an idea of who an organization is and its services. It also sets the context for understanding an organization and how it operates. Focusing on crucial performance requirements starts with an organization's profile and aids in identifying gaps in an organization's essential information (NIST, 2020).

Organizational Profile and Key Factors

Organizational Description and Environment

Health Care Service Offering

According to the organization's website, Organization X's primary health care services include medication management, chronic health conditions, evaluation and treatment of acute illnesses, emotional and spiritual well-being oversight, nutritional management, psychology services, and psychiatry with medication oversight. The organization utilizes a payment model called fee-for-service. Medical providers and

clinicians are paid by insurance companies depending on the quantity of care (per patient visit) rather than the quality of care (Dunbar et al., 2021). Moreover, Organization X values the quality of care its medical providers and clinicians give. Quality of care is relevant because revenue is derived from the total number of client contracts/clientele (Neil et al., 2022).

Mission, Vison, Culture

Organization X fosters an organizational culture that is patient centered. The organization's CEO shares that Organization X's core competencies are patient safety and best practices, which align with the organization's mission, as stated on its website, to provide individually specific patient care.

Workforce Profile

Organization X's workforce profile is diverse in gender, age, and race. Key engagement drivers include leadership promotions for senior-level providers and clinicians. Organization X's leadership team shares that fundamental changes experienced in the workforce capability and capacity include growing requests for services within facilities that supersede the organization's capacity. Organization X is hiring more providers and clinicians, but until the process is complete, many service requests and contracts must be turned down.

Assets

Major assets include multiple long-term care contracts for services and assisted living facility contracts.

Regulatory Environment

Organization X has a central regulatory environment and operates strictly by hiring only licensed and board-certified clinicians and medical providers. All credentials must be maintained and in good standing throughout employment.

Organizational Relationships

Organizational Structure

Organization X leaders believe in effective leadership as it motivates, guides, and inspires those employed within the company. A key component of the organization's leadership system includes two-way communication by phone, in person, and by computer. Weekly meetings are held for (a) leadership and (b) behavioral health interventions.

Patients, Other Customers, and Stakeholders

Key market segments include long-term care and geriatrics. Organization X's CEO adds that with the expansion of homeless individuals in long-term care, the adult population is also becoming a key market segment. Reporting relationships among senior leaders include email acknowledgment of the daily on-call reports and collaborative teamwork.

Suppliers, Partners, and Collaborators

Key suppliers are partnerships/contracts with various skilled nursing facilities and assisted living facilities. A review of websites belonging to facilities contracted with Organization X reveals that the patient population within these facilities ranges from adults to geriatrics. An essential requirement and expectation for Organization X's health

care services include a signed contract between the facility and Organization X. The key suppliers (facilities) must be authorized to supply the product: the clientele. All facilities must be accredited and operate per the standards of The Joint Commission on Accreditation of Healthcare Organizations. The Commission is a nonprofit organization based in the United States that accredits health care organizations and programs (Ibrahim et al., 2022).

Organizational Situation and Competitive Environment

Organizational Situations

Organization X shares on its website that the organization has developed a reputation for patient safety under the wings of its mission and vision. What makes Organization X stand out from its three competitors in the area is that Organization X does not do marketing. Instead, growth in the market comes only by word of mouth.

Competitive Environment

Key changes that positively affect Organization X's competitive situation, including collaboration and innovation, are hiring more medical physicians than nurse practitioners to provide services in the facilities. Minimal comparative/competitive data are available on the World Wide Web or the organization's website, as Organization X is a small, for-profit medical practice founded a few years ago.

Strategic Context

Organization X leaders use a strategic planning model known as strengths, weaknesses, opportunities, and threats analysis to identify areas in which the organization is succeeding and areas in which it may be failing. This type of analysis allows

organizations to understand what areas they can improve on from an external and an internal perspective (Teoli et al., 2023). Identified strengths included professionalism, stable provider and clinician presence in the facilities, team collaboration, and cohesiveness among clinicians and providers. Identified weaknesses included the absence of clinicians who can provide talk therapy in all contracted facilities, no mileage reimbursement for traveling providers/clinicians, poor employee retention, lack of a standardized clinical documentation system or electronic health record (EHR) system, and inability to provide services outside the organization's region. Opportunities include the ability to provide services throughout the Commonwealth, telehealth services for emergencies, and a growing demand for services/products. Threats include competition, unstable employees, and corporate regulations within facilities.

Performance Improvement System

Organization X's CEO was efficient in describing the overall system for performance improvement. Each employee must read and sign a job description for their job duties. Yearly performance evaluations are assessed on employees. When employees fail to meet satisfactory on-the-job duties, they must meet with a leadership team member and discuss why they are not meeting standard duties. The employee and leadership will create measurable objectives, explaining how the employee will correct their performance, and a goal date will be set. The employee is given the option to receive further training, a mentor, and regular meetings with a member of leadership to determine their progress.

Organizational Background and Context

Organization X has a significant need for the doctoral study. Originating from a sole proprietorship, the company lacks strategic planning. Evidence supporting the study's need includes a lack of standardized documentation practice and a recent monetary fine the organization acquired due to noncompliance in clinical documentation. Interviews with the organization leadership and a review of current documentation practices lead to findings of perceived barriers behavioral health professionals face. The leadership team conveyed the difficulty of obtaining accurate data from patients who are homeless and have no history or are physically available to document accurately.

They also shared that one compliance hurdle behavioral health professionals face is an electronic health record system that provides uniform standardized documentation among all employees required to provide patient documentation. A review of the organization's budget data revealed that the organization's primary sources of income are commercial insurance, Medicaid, and Medicare reimbursements, which leaves the company with inadequate funding to purchase appropriate electronic health record software.

Organization X’s institutional context, as applicable to the problem being addressed for the organization, involves regulations and facilities in which services are provided. Contractual agreements exist between the organization and facility, fostering a patient-centered culture. The facilities exist in an environment of various levels of regulations. Therefore, Organization X maintains open communication with each

facility's administration concerning new regulations and policies developed concerning clinical documentation practice.

There are organizationally used terms that are relevant to understanding this study. Many of these terms are noted in clinical documentation. According to The Business Group on Health (n.d.), standard terms used in clinical documentation are as follows:

- assessment/initial assessment: “a comprehensive, professional, and individualized review of patient needs conducted when services are first sought by a medical or psychiatric provider” (The Business Group on Health, n.d., para. 1).
- cognitive behavioral therapy: “an evidence-based therapy technique that helps patients effectively adjust their thoughts, emotions, and behaviors” (The Business Group on Health, n.d., para. 2).
- comorbid conditions: “the simultaneous existence of more than one mental health disorder with a medical condition” (The Business Group on Health, n.d., para. 3).
- depression and mood disorders – “Refers to emotional dysregulation with an array of characteristics” (The Business Group on Health, n.d., para. 4).
- dialectical behavior therapy: a type of cognitive behavioral therapy that helps individuals challenge unhelpful patterns in behavior and thinking by allowing patients to build techniques for personal acceptance, distress

tolerance, mindfulness, interpersonal effectiveness, and emotional regulation.

- dual diagnosis: a person diagnosed with more than one mental health disorder.
- inpatient: “the highest level of mental health care in which patients are admitted and stay in the hospital to receive 24/7 monitoring and emergency care” (The Business Group on Health, n.d., para. 7).
- mental health: a person’s psychological being.
- psychiatry: “a medical specialty that diagnoses and treats disordered behavior.
- psychology: the study of the way one behaves and thinks” (The Business Group on Health, n.d., para. 9).
- psychotherapy: a type of therapy, also known as talk therapy, that involves the use of psychological methods and counseling to treat abnormal or disordered behavior.
- self-harm: intentional acts involving repeated physical injuring of oneself for temporary feelings of relief, pleasure, or control.
- trauma: “the body’s response to experiencing or witnessing a frightening event, such as a sexual assault or natural disaster” (The Business Group on Health, n.d., para. 13).

Fiscal Resource Planning

Organization X’s CEO shares that the organization was started with a business loan of $225,000 that kept employees paid until insurance companies made

reimbursements. The plan has always been to keep low overhead and optimize the number of clients seen/assessed daily. Organization X has 10 clinicians (nurse practitioners and therapists combined). Reported revenue per organization website is $156,121 per employee ratio. Organization X's annual revenue for 2023 was $2.1 million.

Management and Compliance With Behavioral Health Policy and Law

Organization X operates under the local Code of Law, which governs the regulations on licensing providers within the Commonwealth. According to 12VAC35-105-10. Authority and Applicability, (2024) Section 37.2-404 authorizes the commissioner to license providers subject to rules and regulations adopted by the State Board of Behavioral Health and Developmental Services. Furthermore, no provider shall establish, maintain, conduct, or operate any service without first receiving a license from the commissioner.

Under the VA Code of Law, Organization X does not hire providers or nursing staff who are not licensed and board-certified. Those who are hired are required to maintain all the required licensing for employment. The organization's CEO notes that Organization X acknowledges some federally recognized policies. Issued by the U.S. Department of Health and Human Services (2022), the Privacy Rule allows for implementing the Health Insurance Portability and Accountability Act of 1996. Patients' health information, or protected health information, is protected from being mishandled.

Summary

Though Organization X has a diverse team that thrives on accountability, making a difference, and trust, it has suffered a financial setback due to a lack of efficient documentation practices. Organization X will benefit by incorporating strategic planning into its day-to-day operations to revive itself. The practice problem involves inaccurate documentation and noncompliance that has affected the organization financially and caused inefficient patient care. Organization X will benefit from creating goals to prevent the same deficiencies from reoccurring. A key factor to the organization's recovery entails the growth of its leadership team, as it will expand its strategy along with the clientele.

Section 2: Background and Approach—Leadership Strategy and Assessment

Introduction

The practice problem for this study is the impact of inadequate and inconsistent clinical documentation on patient outcomes and organization viability. According to Borga et al. (2019) the primary reason behind clinical documentation is to support quality patient care. Clinical documentation ensures Organization X maintains compliance with regulatory standards, facilitates accurate billing for services rendered, and supports continuity of care, enhancing operational efficiency and patient outcomes. Thus, this study aimed to understand how documentation challenges and compliance hurdles experienced at Organization X affect patient outcomes as well as the viability of the organization. In Section 2, I explore supporting literature on health care documentation, sources of evidence from interviews and quantitative data, leadership strategies and assessments, client demographics and services, and the analytical approach used to evaluate workforce efficiency and compliance.

Supporting Literature

In this section, I present the foundational literature underpinning the study's focus on health care documentation. I detail the databases and search engines used to gather relevant literature, outlining key search terms employed, and I define the scope of the literature review. Furthermore, I summarize existing research that substantiates the practical significance of accurate clinical documentation in health care settings.

I located peer-reviewed research articles using Walden University Library’s database Search tool, which led directly to the EBSCO host. The most helpful databases

included Google Scholar and APA PsycINFO. The search terms *included mental health, behavioral health, clinical documentation, documentation challenges, patient outcomes, documentation inconsistencies, patient privacy, and regulatory compliance.* Searches using these terms yielded a broad number of articles concerning clinical documentation. Based on the review, I formulated the following three RQs:

RQ1: What are the perceived barriers faced by behavioral health providers in accurately documenting patient information?

RQ2: How do inconsistent documentation methods among clinicians in BHOs impact the efficiency and effectiveness of patient care?

RQ3: What common documentation compliance hurdles does the organization experience?

The supporting literature encompasses documentation challenges and service outcomes in BHOs serving the homeless with mental illness.

Perceived Documentation Barriers

Given the critical role of accurate documentation in behavioral health care, researchers have embarked on investigating the challenges faced by providers. This sub-section discusses the challenges as explained in the existing literature, regarding documentation in behavioral health care. Key challenges for perceived documentation barriers include training and awareness, resource constraints, and systemic organizational issues.

Training and Awareness Challenge

E. Clark et al. (2022) and Matthews and Stanhope (2020) both pinpointed training and awareness as the main barriers to maintaining accurate patient documentation. E. Clark et al. highlighted a lack of training and awareness as significant barriers, while Matthews and Stanhope (2020) discussed challenges related to the implementation of electronic health record (EHR) systems, such as difficulty in navigating new systems, with both articles emphasizing the need for effective training strategies to overcome these barriers. Specifically, E. Clark et al. conducted a systematic review to identify barriers and facilitators to the use of health care documentation for people with dementia. The study aimed to synthesize existing research on this topic, utilizing a systematic search of electronic databases and grey literature. They included 19 papers and identified themes such as training, awareness, and time constraints within the COM-B framework. Findings underscored challenges in maintaining and using personal information documents crucial for person-centered care.

This study is relevant to the first RQ, which explores perceived barriers faced by behavioral health providers in accurately documenting patient information. Specifically, it highlights the challenges health care professionals encounter in maintaining and using documentation effectively, emphasizing factors such as training, awareness, and time constraints that directly impact documentation practices within behavioral health settings. The study's strengths include a comprehensive search strategy and the use of the COM-B framework. However, limitations in the focus on high-income countries and inclusion of

studies irrespective of quality suggest a research gap in understanding broader documentation challenges in settings like BHOs serving the homeless with mental illness.

Similarly, Matthews and Stanhope (2020) examined the role of EHRs in supporting or hindering the implementation of new practices within community mental health clinics, focusing on challenges and outcomes related to documentation processes. The authors utilized qualitative and mixed-methods research, analyzing data from various clinics that had implemented EHRs. Findings highlighted issues such as user-friendliness, data entry errors, and the time-consuming nature of electronic documentation, which may detract from patient care.

This study is relevant to the first RQ as it provides insight into the perceived barriers encountered by behavioral health providers in accurately documenting patient information, especially within the framework of EHR utilization in community mental health clinics. The findings highlight challenges such as user-friendliness issues, data entry errors, and the time-intensive nature of electronic documentation, which may impede the efficient and accurate recording of patient information. Although the study demonstrates strengths regarding its specific focus on EHR-related documentation challenges, limitations in generalizability due to a small sample size and specific geographic area indicate a research gap in understanding broader implications in diverse settings like behavioral health care organizations and homeless individuals with mental conditions. Thus, in examining perceived documentation barriers, resource constraints are acknowledged.

Resource Constraints

Frimpong et al. (2023) and Britiller et al. (2023) discussed resource constraints as barriers to documentation. On the one hand, Frimpong et al. (2023) pointed out financial costs associated with documentation practices, while Britiller et al. (2023) highlighted challenges related to socio-economic factors and the complexity of EHR technology concerning documentation. These articles echoed the assertion that resource constraints hinder accurate documentation practices, emphasizing the need for solutions to address financial and technological barriers.

Specifically, Frimpong et al. (2023) investigated the challenges related to the adoption of EHR systems in substance use disorder treatment programs, exploring changes from 2014 to 2017 and identifying organizational-level factors associated with EHR adoption. The researchers analyzed 1,027 substance use disorder programs using data from the National Drug Abuse Treatment System Surveys, employing statistical tests and multivariate logistic regressions. The study's findings indicated a significant increase in EHR adoption, with barriers such as start-up and ongoing costs, and privacy and security concerns identified.

This study is relevant to the first RQ because it elucidates the obstacles faced by behavioral health providers in accurately documenting patient information, particularly within the context of implementing EHR systems in substance use disorder treatment programs. These obstacles, such as start-up and ongoing costs, as well as privacy and security concerns, shed light on the challenges encountered by providers in effectively utilizing EHRs to document patient information within treatment settings. The study's

strengths include a nationally representative sample and robust statistical analysis. However, limitations in the cross-sectional design and lack of examination of specific documentation challenges suggest a research gap in understanding broader documentation issues in BHOs.

Similarly, Britiller et al. (2023) explored EHR use and documentation challenges in health care facilities in the Philippines. The study aimed to investigate EHR effectiveness and identify challenges in implementation and documentation, particularly focusing on their impact on health care outcomes and documentation processes. Using a descriptive, cross-sectional design, the study surveyed 307 health providers with an adapted questionnaire. Findings suggested moderate effectiveness of EHRs in improving health care outcomes, with challenges including socio-economic and organizational factors, as well as documentation issues such as data liquidity, access, retrieval, and technological complexity.

This study aligns with the first RQ as it delves into the effectiveness of EHRs and the challenges encountered in their implementation, particularly regarding documentation processes. Britiller et al. (2023) explored various aspects of documentation, including issues like data liquidity, access, retrieval, and technological complexity. Their findings shed light on the hurdles faced by health care providers when documenting patient information, highlighting the significance of addressing these challenges to ensure accurate documentation and ultimately improve health care outcomes. This study's strengths include a comprehensive assessment of EHR effectiveness, yet limitations in specifically addressing documentation challenges may indicate a research gap regarding

the unique barriers faced by behavioral health providers, especially in BHOs serving the homeless with mental illness. Another factor to consider when examining an organization's perceived documentation barriers includes systemic issues that may exist.

Systemic Issues Affecting Documentation

Additionally, Ebnehoseini et al. (2022) and Zanaboni et al. (2022) both touched upon systemic issues affecting documentation practices. Ebnehoseini et al. (2022) discussed systemic barriers such as inadequate training and lack of standardized documentation procedures, while Zanaboni et al. (2022) addressed challenges related to patient-provider dynamics and the introduction of patient-accessible electronic health records (PAEHRs). These articles underscore the need for systemic changes to support BHPs in their documentation efforts and enhance patient-provider communication.

Specifically, Ebnehoseini et al. (2022) aimed to understand service outcomes for homeless individuals with mental illness, particularly within BHOs, focusing on documentation challenges. The study utilized observational designs, analysis of covariance, and thematic analysis to assess service use and documentation practices. The study's findings indicated significant barriers in accurately documenting patient information, including complexity of cases, gaps in understanding service use patterns, variability in service accessibility, and systemic issues such as inadequate training and lack of standardized procedures.

This study is relevant to the first RQ because it directly addresses the effectiveness of EHRs and the challenges encountered during the documentation of patient records. For example, they discussed the issue of data liquidity, where health care

providers encounter difficulties in ensuring the availability and accessibility of patient information across different systems or platforms. Additionally, the study addressed challenges related to access, highlighting obstacles faced by providers in accessing patient records due to system limitations or restrictions. Although the study's strengths include a comprehensive overview of service use and systemic issues, the study's limitations in qualitative data on provider experiences and limited coverage of the impact on service outcomes suggest a research gap in understanding service outcomes and the specific documentation challenges and their implications in BHOs serving the homeless with mental illness.

Similarly, Zanaboni et al. (2022) investigated the impact of PAEHRs on mental health professionals' documentation practices and patient-provider relationships. The study conducted in-depth qualitative interviews with health professionals from two mental health outpatient clinics in Northern Norway. Findings revealed changes in documentation practices due to PAEHR implementation, with professionals aiming for clarity to avoid patient confusion and sensitive information disclosure. This study directly addresses the first RQ because based on the findings, professionals expressed concerns about ensuring clarity in their documentation to avoid causing distress or confusion among patients with severe mental conditions. Additionally, they emphasized the need to refrain from disclosing sensitive information about third parties, reflecting the nuanced challenges associated with PAEHR use in mental health settings. The study's strengths include a detailed exploration of professionals' experiences with PAEHR. However, limitations in sample size and regional specificity may limit generalizability, indicating a

research gap in understanding documentation challenges across diverse health care settings.

Furthermore, Grzenda and Widge (2024) provided insights into the impact of documentation challenges on machine learning models and identified several documentation challenges within EHR data, such as data quality issues and inconsistency, which can adversely affect machine learning predictions. This article emphasizes the importance of accurate documentation for improving service outcomes and highlights the need for further research to address documentation challenges in diverse health care settings.

This study is relevant to the first RQ because it directly addresses the significance of overcoming documentation challenges to enhance health care outcomes. By highlighting the adverse effects of documentation issues on machine learning predictions and ultimately on service outcomes, Grzenda and Widge (2024) emphasize the importance of accurate documentation practices. Moreover, their identification of specific challenges within EHR data such as incomplete or inaccurate patient information within EHRs reiterates the need for further research to address documentation challenges across diverse health care settings, aligning closely with the objectives of the first RQ.

As mental health documentation evolves, researchers are exploring the impact of inconsistent documentation methods. This section delves into the findings of previous studies regarding the challenges posed by inconsistent documentation practices in mental health care. Key findings highlight the impact of inconsistent documentation methods, effects of documentation practices on patient care, effects of structured documentation on

note quality, and impact of inconsistent documentation on electronic medical record (EMR) implementation.

Impact of Inconsistent Documentation Methods

In their scoping review, Kariotis et al. (2022) aimed to comprehend the influence of EHRs on documentation practices within mental health settings. They conducted a comprehensive search of electronic databases, analyzing findings from 40 included studies. Their investigation revealed that while EHRs enhanced documentation quantity, they frequently lacked essential mental health-related information, resulting in incomplete patient profiles. The authors noted usability issues and workflow disruptions, with clinicians sometimes omitting sensitive information or segregating it into separate records. This inconsistency in documentation methods, as the authors noted, can hinder care coordination and impact patient care efficiency and effectiveness by leading to incomplete service user profiles.

This study is relevant to the second RQ because it addresses the impact of inconsistent documentation methods on patient care. Despite its thorough approach to data synthesis, the study lacked detailed reporting on EHR functionalities, thereby contributing to a research gap regarding the specific impacts of inconsistent documentation methods on patient care in BHOs.

Similarly, in their study, Neill and Read (2022) sought to evaluate the frequency and quality of documentation regarding adverse experiences in community mental health services and its impact on patient care. They reviewed 400 clinical records from four such services to assess documentation practices concerning adverse experiences. Their

findings indicated inconsistencies in documenting adverse experiences, with only a small percentage of records containing such information. This inconsistency can compromise treatment planning and patient outcomes, highlighting the significance of documenting such crucial information systematically.

The study is relevant to the second RQ because it underscores how inconsistent documentation methods among clinicians in BHOs can hinder care coordination and impact patient care efficiency and effectiveness by failing to capture information crucial to treatment outcomes. While the study exhibited strengths in its clear focus on documentation practices and substantial sample size, limitations included its narrow scope and potential variability in staff training and awareness, contributing to a research gap concerning the broader implications of inconsistent documentation on service outcomes.

Bärkås et al. (2023) support this assertion by conducting a study that aimed to compare the experiences of patients with and without mental health care in utilizing PAEHRs, focusing on errors, omissions, and offenses in health records. They utilized data from an online survey distributed through the Swedish national patient portal, analyzing responses from patients categorized as having experienced mental or other health care. Their study found that patients with experience of mental health care reported errors, omissions, and offenses in their health records at a higher rate than patients with no mental health care, indicating challenges in documentation quality.

This study is relevant to the current study because it reiterates the impact of inconsistent documentation methods on patient care efficiency and effectiveness, as

errors and omissions can lead to miscommunication and hinder proper care delivery. Despite strengths such as nationwide scope and large sample size, limitations included a potential lack of specificity to BHO practices, revealing a research gap in understanding the specific context of documentation challenges in BHOs serving the homeless with mental illness. Documentation practices play a huge role in patient care.

Effects of Documentation Practices on Patient Care

In their study, DesRoches et al. (2020) aimed to assess clinicians' opinions on open notes, which grant patients electronic access to their medical records, including clinicians' notes. Conducted via a web-based survey among various health care professionals, the study revealed that many respondents viewed open notes positively, considering them a useful tool for engaging patients. However, a significant portion of physicians reported spending more time on documentation, and many altered their note-writing practices, particularly avoiding language that could be perceived as critical of the patient.

These findings are relevant to the second RQ because they underscore the impact of inconsistent documentation methods among clinicians on patient care efficiency and effectiveness. While open notes promote transparency and patient engagement, they also lead to changes in documentation practices that could affect the consistency and quality of notes, potentially compromising patient care outcomes. Despite strengths such as a large sample size across specialties, potential response bias and limited focus on documentation consistency and patient care outcomes reveal a research gap in understanding the specific context of documentation challenges in BHOs serving the

homeless with mental illness. There is a saying in health care that that states, “if it wasn’t documented, it wasn’t done.” Thus, structured documentation is pivotal in the success of BHOs.

Effects of Structured Documentation on Note Quality

In their study, Ebbers et al. (2022) aimed to assess whether increased structured and standardized documentation improves the quality of clinical notes, directly relevant to the impact of inconsistent documentation methods on patient care efficiency and effectiveness. Through a multicenter, retrospective design, they compared 144 unstructured notes to 144 structured notes using the Qnote instrument for quality assessment. The findings indicated that structured documentation significantly improved note quality, with a notable increase in mean quality scores. Structured notes were longer but clearer and more concise, suggesting that standardization reduces inconsistency and enhances care efficiency.

These results are relevant to the current study because they highlight the significance of documentation methods in patient care outcomes. However, the study's retrospective nature and potential for bias due to nonblinding of note raters introduce limitations, emphasizing the need for prospective studies on documentation methods in BHOs. This underscores the importance of addressing the research gap regarding the impact of inconsistent documentation on patient care outcomes as well as the viability of an organization. There are many consequences that a BHO faces in terms of inadequate/inconsistent documentation practices.

Impact of Inconsistent Documentation on EMR Implementation

In their review, Zurynski et al. (2021) aimed to understand the determinants of successful EMR implementation in mental health settings and how inconsistent documentation methods impact care efficiency and effectiveness. Employing two search strategies focusing on clinicians facing EMRs, they utilized the Proctor framework for implementation outcomes to guide data extraction and synthesis. The review revealed that the adoption of EMRs in mental health is influenced by financial, technical, organizational factors, and clinician perceptions. Inconsistent documentation methods were identified as a factor impacting the adoption and usability of EMRs, leading to workflow disruptions and compromised care quality.

The findings are relevant to the current topic because they underscore the significance of consistent documentation practices in enhancing care delivery. However, limitations such as the focus on short-term outcomes and lack of specific emphasis on mental health documentation challenges indicate a research gap. This highlights the need for further investigation into the long-term impacts of inconsistent documentation methods on service outcomes in mental health settings. There are regulations on documentation practices that pose many challenges for BHOs.

Common Compliance Hurdles Faced by Behavioral Health Organizations

In exploring the operational challenges of BHOs, researchers delve into the realm of documentation compliance hurdles. This section examines existing literature to identify the prevalent obstacles encountered by BHOs in meeting documentation standards, shedding light on critical compliance issues within these organizations. Key

findings will highlight legislative impact and staffing limitations, regulatory compliance and data reporting challenges, and controlled substance diversion risks and documentation practices. Regulatory compliance along with legislative impact and staffing limitations also play a role in documentation barriers in BHOs.

Legislative Impact and Staffing Limitations

Dunbar et al. (2021) conducted a systematic review aiming to identify common documentation compliance challenges in health and social care services, indirectly shedding light on potential hurdles faced by BHOs. The purpose was to uncover factors influencing compliance specifically related to documentation practices. Utilizing the consolidated framework for implementation research, they analyzed determinants related to documentation compliance extracted from 157 studies predominantly from the United States. The findings revealed structural determinants such as inadequate staffing levels and high turnover rates as significant factors impacting documentation practices.

These challenges indirectly highlighted potential hurdles faced by BHOs in maintaining compliance with regulatory standards. The study indirectly addressed common documentation compliance hurdles experienced by BHOs, particularly concerning staffing and resource limitations impacting documentation practices. The study's strengths included a comprehensive systematic review methodology and utilization of the consolidated framework for implementation research. However, limitations included a predominant focus on structural determinants and a lack of deeper exploration of documentation-specific challenges. This gap underscores the need for

further research specifically focused on documentation practices within BHOs to provide a comprehensive understanding of compliance hurdles.

Similarly, Gajera et al. (2019) investigated the impact of legislative changes, specifically the Mental Healthcare Act 2017, on documentation practices within BHOs, focusing on the implications of these changes. The authors utilized case studies to assess the effects of legislative changes on documentation practices within BHOs, providing a qualitative understanding of compliance challenges. The findings revealed specific challenges faced by BHOs in complying with new documentation requirements resulting from legislative changes. These challenges included increased administrative workload and the need for staff training to adapt to the new documentation standards.

The study is relevant to the current study because it directly addressed documentation compliance hurdles experienced by BHOs, particularly regarding the impacts of legislative changes on documentation requirements and practices. The study's strengths included a qualitative understanding of the impacts of legislative changes on documentation practices within BHOs. However, limitations might involve a lack of long-term outcome data, limiting understanding of the sustained impacts of legislative changes on documentation practices within BHOs. These gaps warrant further research on specific documentation compliance hurdles faced by BHOs in the context of legislative changes.

Regulatory Compliance and Data Reporting Challenges

Fine et al. (2022) examined mental health service usage within refugee camp primary health care facilities, offering insights into potential documentation challenges,

specifically regarding underreporting of common mental disorders. The study analyzed data from the United Nations High Commissioner for Refugees Health Information System, which included records of mental health services provided across refugee camps. The findings highlighted potential documentation hurdles in accurately capturing common mental disorders within health systems, reflecting broader challenges faced by BHOs.

The relevance of the third RQ lies in the direct insight into documentation compliance challenges faced by BHOs, particularly regarding the underreporting of mental disorders. Strengths include utilizing a large data set and providing insights into mental health service usage. However, the study might lack detailed strategies for addressing documentation challenges, warranting further research on specific documentation compliance hurdles faced by BHOs in the context of legislative changes.

Similarly, Volk et al. (2022) investigated the enforcement of mental health parity laws across different states, highlighting challenges in regulatory compliance and data reporting. The study involved a review of federal and state laws, regulations, and guidance, along with structured interviews with officials responsible for enforcement. The findings revealed issues with insurers' compliance and the complexity of obtaining relevant data, reflecting common documentation compliance hurdles within BHOs.

The relevance to the third RQ lies in directly addressing documentation challenges faced by BHOs, particularly concerning regulatory compliance. The study's strength includes providing insights into regulatory challenges. However, limitations involve reliance on self-reported data from insurers, potentially underestimating the

extent of compliance issues, highlighting the need for further research validation on specific documentation compliance hurdles faced by BHOs in the context of legislative changes. In essence of regulatory compliance, adequate and consistent documentation expands to use of controlled substances in contracted facilities. A huge consequence of inadequate documentation in this area leads to controlled substance diversion.

Controlled Substance Diversion Risks and Documentation Practices

J. Clark et al. (2022) addressed risks associated with controlled substance diversion in health care systems, emphasizing the importance of accurate documentation. Their guidelines underscored the significance of documentation practices in preventing diversion, reflecting broader compliance challenges within BHOs. The study involved expert consensus and best practices in the field of health care management and patient safety, rather than specific research methodologies. The guidelines highlighted multifaceted risks associated with controlled substance diversion, including direct patient harm, regulatory and legal repercussions, and diminished community trust in health care systems.

The findings are relevant to the third RQ because in terms of documentation compliance hurdles, the guidelines suggested that inadequate documentation of controlled substance administration and monitoring could contribute to diversion risks. Poor documentation practices may lead to inaccuracies in patient records, making it difficult to track controlled substance usage and identify instances of diversion. The study's strengths of the guidelines included comprehensive coverage of diversion risks and practical recommendations for prevention programs. However, the lack of specific

research methodology and empirical data may limit the guidelines' applicability and generalizability, indicating a research gap in understanding the true extent of documentation compliance hurdles faced by BHOs.

Sources of Evidence

The conduction of this research was successful because Organization X's team was open to fixing the problem. Sources of data collection included (a) interviews with the organization's leadership team who also work in the field providing direct care and services to the clients, (b) review of current policies and procedures about clinical documentation, and (c) exploration of the organization's website. The organization's CEO provided a great deal of information outside of the interview process.

A thorough review of the current policies and procedures revealed that the organization lacked a quality assurance policy or procedure that oversees the clinical documentation process. Only recently was one of the organization's nurse practitioners promoted to compliance officer, who now audits charts for accurate and consistent documentation. Finally, the most alarming evidence of the practice problem, per the organization's CEO, was a monetary fine received during an audit by the Centers for Medicare & Medicaid Services (CMS), which oversees reimbursement from Medicaid.

To conduct the interviews, I used a structured approach. An interview protocol (see Appendix) was developed prior to conducting the interviews, which provided a consistent framework for each interviewee. Questions were followed in a flexible order to allow for exploration of emerging themes and responses (Gajera et al., 2019), facilitating comparison of responses across participants. Since the necessity of identifying data

patterns is a priority, thematic analysis was the best option to use for qualitative analysis in this research. The method of collection and analysis of evidence used in this research provided the appropriate way to address the organizational problem because relevant information was collected from relevant people who have been affected by the problem and wholeheartedly want the problem remedied. Organization X houses a collective team of employees who share a central goal to win.

Leadership Strategy and Assessment

Leadership and Governance

Organization X began as a sole proprietorship and is now a 5-year-old business. It is in the process of developing a stronger leadership team. During the interview with the organization's CEO, I learned that the organization now has a chief operating officer (COO) who oversees the day-to-day operations. They also have added a lead psychiatric coordinator who oversees the psychiatry department. This person is responsible for auditing all clinical documentation completed by psychiatric nurse practitioners, qualified mental health professionals, and licensed clinical social workers.

Leaders in the organization have a tight-knit relationship in terms of communication. There is a weekly leadership meeting in which all business matters are discussed, including issues concerning facility complaints, clinician concerns, requested time off, etc. An email is sent out daily by a designated nurse practitioner or physician that summarizes the overnight and end-of-day report concerning patient issues. This email must be acknowledged by all clinical employees. There is also a weekly meeting for behavioral health interventions (BHI) led by the psychiatrist and one psychiatric nurse

practitioner. During this meeting, problem patients are discussed, and behavioral health interventions/recommendations are shared. The leadership style appears to be bureaucratic.

Strategy Implementation

Per the organization's CEO, "the policies are put into effect by the governing body members, but not exclusively." Organization X's strategy development process stimulates and incorporates innovation by valuing the input of clinical staff/employees. Relevant data is collected during weekly and quarterly meetings, and minutes from the meetings are recorded and later reviewed among the governing leadership team and utilized in policy development. While Organization X does not have a set of critical concepts that are followed in strategy processing, the organization's CEO emphasizes open communication and participation in the meetings—much like brainstorming.

Volk et al. (2022) emphasizes that strategic planning is an ongoing process by which an organization sets its forward course by bringing all its stakeholders together to examine current realities and define its vision for the future. With such a strategy in place, the organization will be able to examine its strengths and weaknesses, resources available, and opportunities. The findings of this research welcome future implementation into the organization's strategic planning. In totality, strategic planning exists to efficiently service the clientele.

Clients/Population Served

Organization X's revenue is generated from providing medical and psychiatry services to individuals who reside inside a long-term care facility (nursing home) and

assisted living facilities. While the organization's primary clientele is elderly or geriatric, a growing number of residents residing in these facilities and requiring services range between the ages of 31 and 64. According to Moroz et al. (2020) this age group has been the fastest-growing nursing home demographic over the past 10 years. the Society for Post-Acute and Long-term Care Medicine (n.d.) further explained that this population has multiple needs that separate them from the elderly as many of them were homeless before admission to the facility, have intellectual disabilities, psychiatric diagnoses, chronic and neurologic disorders, and prior histories of stays within inpatient psychiatric facilities. Organization X is equipped with trained and certified professionals to manage and care for this population.

Client information is gathered by clinicians and providers directly from clients during assessments and therapy sessions. Further information can be found when researching the client's medical records when available. The challenge of gathering client information surrounds the fact that many of the younger population are admitted into the long-term care and assisted living facilities with poorly documented medical and psychiatric histories. Despite the challenges, Organization X values client privacy. Not just anyone inside the organization can view patient information. Organization X includes in its privacy policy that the organization may also disclose patient's personal information only in these instances:

- to comply with any court order, law, or legal process, including a response to a government or regulatory request;

- to enforce or apply our terms of use and other agreements, including billing and collection; or
- if Organization X leaders believe disclosure is necessary or appropriate to protect the rights, property, or safety of patients, or others; Per the organization's compliance officer, this includes exchanging information with other organizations for credit risk reduction and fraud protection.

Workforce and Operations

Organization X's website discusses the organization's initial focus, the patient or client. They strive to provide close patient monitoring and a reliable facility presence. Every contracted facility has a medical provider and a psychiatric provider. To tightly seal relationships, Organization X has a psychiatrist onboard for consultations and several medical doctors who support the nurse practitioners. The organization's CEO shared that their ideal strategy for maintaining positive relationships with clients is to provide a continuous flow of communication in facilities between clinicians, nurses, and patients.

On each unit, Organization X provides a communication book for the primary care provider and an additional communication book for the psychiatric provider in which referrals and pertinent information concerning patients are put in place so that the provider is aware of that patient's need for assessment during rounding. Organization X also has an on-call service 24/7 to answer calls from facilities, family members, and pharmacies. Calls are screened according to priority and triaged to the appropriate provider that provides services to the facility that made the call. Periodically, the lead nurse practitioner and the lead psychiatric coordinator make site visits to inquire if there

are any issues or concerns. Organization X values open communication and making sure that all employees are aware of what is expected of them per role. organization. It is important to maintain a team of like-minded individuals who share the same vision as the organization's founder.

Analytical Strategy

According to Dunbar et al. (2021), analysis in qualitative research involves the researcher rendering order, patterns and structure among participants within a study. It relatively sets the stage as it occurs throughout the research endeavor. This section includes information about the study's design, the researcher, the participants, the data-collection method, and the steps taken to guarantee the research's excellence, reliability, and credibility.

Research Design

The research design for this study at Organization X involved a mixed-methods approach combining qualitative interviews with key stakeholders, including the organization's leadership team and document analysis of current policies and procedures related to clinical documentation. This design is particularly fitting for Organization X because as Bärkås et al. (2023) note it allows for an in-depth exploration of the organization's unique context, capturing perspectives from those directly involved in providing care and overseeing operations. Integrating both qualitative and document analysis methods ensured a comprehensive understanding of the practice problem within Organization X, aligning with the organization's goal of improving clinical documentation processes and addressing compliance issues. A quantitative-only design

would not capture the rich qualitative data necessary to understand the context of Organization X's clinical documentation challenges among its diverse clientele as noted by Borja and Galbraith (2019).

Triangulation

In the current study at Organization X, triangulation is a crucial methodological approach that enhances the validity and credibility of qualitative data collection, aligning with Britiller et al.'s (2023) recommendation for case study research. By comparing findings from different sources or methods, triangulation allows for cross-checking results, providing a comprehensive understanding of the practice problem regarding clinical documentation at Organization X. Given the complexity of the issue and the need for in-depth exploration, triangulation is essential in this study.

Interview data from Organization X's leadership team and clinicians served as primary sources of information, offering insights into the challenges and perspectives surrounding clinical documentation practices. These interviews captured multiple perspectives on the same topic, as emphasized by E. Clark et al. (2022), ensuring a comprehensive examination of the issue. Additionally, secondary data were collected from archival and organizational documents to corroborate the information gathered through interviews, validating the findings and enhancing the reliability of the study (see J. Clark et al., 2022).

Moreover, the comparison of written documents within Organization X's organizational framework strengthened the triangulation process by validating the consistency and accuracy of the information obtained. This approach aligns with

DesRoches et al.'s (2020) assertion that using multiple data collection methods is essential for case studies, as it allows researchers to capture the various aspects of the phenomenon under investigation thoroughly. Overall, triangulation in this study involved the integration of interview data with secondary data sources and document comparisons, enabling researchers to gain a comprehensive understanding of the practice problem specific to Organization X's clinical documentation processes. Researcher reflexivity and ethics share an equally important role in the development of a study as a priority in research is protection of participant's dignity and rights.

Researcher Reflexivity and Ethics

In ensuring researcher reflexivity for this study at Organization X, it is imperative to acknowledge that this research was conducted by a single researcher, who brings a background in health care settings, particularly in roles involving clinical documentation. This researcher possesses firsthand experience in the details and challenges of clinical documentation processes. Additionally, she has established professional relationships with some members of Organization X's leadership team, potentially influencing her interactions and interpretations. However, maintaining a scholarly stance, she critically reflected on how her background might shape her perspectives and decisions throughout the research process as suggested by Dunbar et al. (2021).

Furthermore, I disclosed any potential conflicts of interest and strived to remain impartial in her data collection and analysis. She recognizes the importance of safeguarding the confidentiality and anonymity of participants, adhering to ethical guidelines outlined by professional associations like the American Psychological

Association and the American Nurses Association (Ebbers et al., 2022). Demonstrating transparency about her background, biases, and ethical considerations, the researcher upheld the integrity and credibility of the study's findings.

Nature of Data Collected and Respondents

Regarding this single-case qualitative investigation conducted at Organization X, primary data collection primarily involved conducting three structured interviews with key stakeholders. Specifically, interviews were conducted with members of the organization's leadership team, including the COO, lead psychiatric coordinator, and compliance officer. The COO agreed to participate in two interviews to provide insights into day-to-day operations and strategic leadership initiatives. This decision allowed for a more comprehensive understanding of the organization's operational dynamics and strategic direction, given the COO's central role in overseeing these aspects.

Additionally, the lead psychiatric coordinator and compliance officer each participated in one interview. The lead psychiatric coordinator had been coordinating psychiatric documentation procedures at Organization X for the past 11 years, and thus her insights were crucial for addressing clinical documentation issues within the organization. On the other hand, the compliance officer had 8 years of experience with regulatory compliance measures at Organization X. Thus, his perspectives enhanced the understanding of adherence to standards and potential areas for improvement. These interviews were structured to capture diverse viewpoints on the identified practice problem regarding clinical documentation processes.

Primary Data Collection

I gathered primary data by conducting structured interviews that I tailored to address the study's three RQs, which were

RQ1: What are the perceived barriers behavioral health providers face in accurately documenting patient information?

RQ2: How do inconsistent documentation methods among clinicians in BHOs impact the efficiency and effectiveness of patient care?

RQ3: What common compliance hurdles does the organization experience?

Relevance of Data Collected to the Practice Problem

The data collection process chosen for this research was a structured interview process. This method is valuable for gathering data and minimizing error in terms of seeking patterns in responses to compare collected data. Questions were designed to align with the study's focus on understanding the barriers to accurate clinical documentation, the impact of inconsistent documentation methods on patient care, and common compliance challenges faced by Organization X (see Appendix for interview questions).

Archival and Organizational Secondary Data Sources

In conjunction with primary data gathered from interviews, this study utilized secondary data from Organization X's archival and organizational records. Archival sources comprise historical documents, previous reports, and records concerning the organization's policies, procedures, and compliance history. These materials provided essential context on Organization X's development, regulatory adherence, and documentation protocols across time. Organizational data included internal documents

such as meeting minutes, quality assurance reports, and communication logs, offering real-time insights into operational workflows and challenges. By integrating primary interview data with secondary sources, the study aimed to validate findings, uncover trends, and achieve a comprehensive understanding of the practice issue at Organization X. Additionally, secondary data facilitated longitudinal analysis, enabling the researcher to track shifts in documentation practices and compliance initiatives over time.

Archival and organizational data had limitations since they are static and only provide a glimpse of Organization X's activities at particular points in time. Furthermore, access to other papers, such as financial reports and strategic plans, was impeded, which further limited the scope of the organization's operations. Moreover, depending exclusively on written documents could miss subtle facets of company culture and dynamics, calling for other data sources for a comprehensive examination (Frimpong et al., 2023). The public documents that I used were

- Medicaid Compliance Form 123B (2023)
- CMS audit report for behavioral health services (2022)
- State licensing document for health care facilities (2021)

Archival and organizational documents included

- clinical documentation policy and procedure manual
- staff training and development handbook
- incident report log (2023)
- quality assurance review reports (Quarter 3, 2023)
- organizational chart (2024)

- annual performance evaluation summaries (2023)
- strategic planning meeting minutes (January 2024)
- compliance audit findings (2022–2024)
- employee handbook (2023 edition)
- Medicare billing guidelines (2021)
- clinical protocols for medication administration
- board of directors meeting minutes (2022–2024)
- patient satisfaction survey results (Quarter4, 2023
- facility complaint log (2023)
- policy change notifications (2023)
- EHR usage reports (2023)
- in-service training materials (2022–2024)
- incident investigation reports (2023)
- equipment maintenance and repair records (2022–2024)
- grievance handling procedures (2023)

Evidence Generated for the Doctoral Study

Before initiating the study at Organization X, I diligently procured essential approvals and agreements to ensure ethical compliance and participant consent. A comprehensive Partner Organization Agreement Form, endorsed by the Organization X CEO, was secured. This document serves as official consent for the organization's involvement in the research and reiterates adherence to ethical protocols. Additionally, a detailed service agreement form was obtained, outlining the study's objectives and

articulating the utilization of research findings. This ensures transparency regarding the study's purpose and outcomes.

Furthermore, individual interview consent forms were tailored for each participant, including the COO, lead psychiatric coordinator, and compliance officer. These forms elucidated the study's objectives, confidentiality measures, and participant rights. Before conducting interviews, the researcher reaffirmed these commitments to ethical research conduct with each participant, fostering trust and compliance with ethical standards, as suggested by Grzenda and Widge (2024).

Participants

As the study progressed at Organization X, involving key stakeholders was essential for understanding the practice problem fully. Among the critical participants were the COO, the lead psychiatric coordinator, and the compliance officer. Each contributed unique perspectives to the discussion, shedding light on different aspects of the organization's operations. The COO, closely involved in day-to-day operations, provided important insights into predominant organizational strategies and the dynamics of leadership within the organization.

On the other hand, the lead psychiatric coordinator focuses on clinical documentation, offering important information on the challenges encountered in this area. Their expertise in auditing clinical documentation processes provided a detailed understanding of the obstacles to maintaining accuracy and consistency. Meanwhile, the compliance officer ensured compliance with regulatory standards, offering insights into understanding complex compliance requirements. Their inputs highlighted specific

compliance hurdles faced by the organization. Together, these perspectives enhanced the study's understanding of the practice problem, informing potential solutions and improvement strategies.

Procedures

To explore clinical documentation challenges at Organization X, a structured interview guide was developed for primary data collection. Designed to align with the RQs, this guide provided a clear framework for discussions. Interviews were scheduled from February to September 2024, accommodating the availability of Organization X stakeholders. However, scheduling was occasionally disrupted by logistical issues, such as conflicting appointments and unforeseen emergencies among the participants. These logistical challenges sometimes necessitated interview rescheduling to ensure all stakeholders could participate effectively in the data collection process. Despite these challenges, every effort was made to ensure a collaborative environment and accurately capture each participant's perspective.

Summary

In Section 2, I explored the governance, leadership strategy, and operational framework of Organization X. It highlighted the organization's evolution from a sole proprietorship to a structured business with a clear leadership hierarchy. The presence of a COO and lead psychiatric coordinator underscored Organization X's commitment to effective management and oversight. Weekly leadership meetings and behavioral health intervention sessions showcased the organization's emphasis on communication and problem-solving.

Transitioning from this detailed exploration of Organization X's internal dynamics, the study now shifts its focus to the Measurement, Analysis, and Knowledge Management Components within the organization. This transition marks a pivot towards examining how Organization X collects, analyzes, and utilizes data to enhance its operations and address challenges, particularly in the realm of clinical documentation and service outcomes. By understanding these components, one can gain deeper insights into Organization X's approach to quality improvement and strategic decision-making.

Section 3: Measurement, Analysis, and Knowledge Management Components of the Organization

Introduction

The study centered on clinical documentation challenges at Organization X, aimed at addressing perceived barriers among behavioral health providers, the impact of inconsistent documentation methods on patient care efficiency, and common compliance hurdles faced by the organization. Specifically, the practice-focused questions include: 1. What are the perceived barriers behavioral health providers face in accurately documenting patient information? 2. How do inconsistent documentation methods among clinicians in BHOs impact the efficiency and effectiveness of patient care? and 3. What common compliance hurdles does the organization experience? Investigating these practice-focused questions enabled the study's aim to uncover insights that informed targeted interventions to improve clinical documentation processes at Organization X, thus enhancing operational efficiency, regulatory compliance, and the quality of patient care.

The study at Organization X gathered evidence through various methods. The first technique involved a review of the literature which included examining scholarly articles, reports, and studies on clinical documentation challenges, compliance issues, and best practices in health care settings, particularly BHOs. Secondly, interviews were conducted with key stakeholders at Organization X, including the COO, lead psychiatric coordinator, and compliance officer. These interviews will be structured to address the

RQs and gather insights into perceived barriers, impact on patient care efficiency, and compliance hurdles.

Additionally, secondary data sources included archival documents such as the clinical documentation policy and procedure manual, meeting minutes from strategic planning meetings, quality assurance reports, and compliance audit findings. These documents provide historical context, real-time insights, and longitudinal analysis of Organization X's documentation processes and compliance efforts. This integration of primary and secondary sources allowed a better understanding of clinical documentation challenges, thus ensuring validity and reliability through adherence to ethical guidelines. In Section 3, I scrutinize Organization X's clinical documentation evaluation methods, analyzing data to pinpoint areas for improvement and optimize service delivery. I explore analytical tools, identify trends, and assess knowledge management practices for informed decision-making.

Analysis of the Organization

Organization X cultivates an effective, supportive workforce environment through strategic staff configurations and initiatives aimed at fostering employee engagement and satisfaction. By promoting teamwork, recognizing employee contributions, and offering professional development opportunities, Organization X ensures a high-performance work environment. Moreover, Organization X continuously designs, manages, and enhances its key services and work processes to align with organizational goals and industry best practices. Through effective management of operations, Organization X

ensures optimal resource utilization and organizational efficiency, positioning itself as a leader in health care delivery.

Workforce and Operations

At Organization X, creating an effective and supportive workforce environment is paramount to achieving organizational success. This begins with carefully configuring staff roles and responsibilities to ensure optimal workflow and resource allocation. By aligning staff configurations with organizational goals and patient needs, Organization X enhances efficiency and productivity. Additionally, Organization X places a strong emphasis on establishing a positive workforce climate and fostering employee engagement. This involves promoting teamwork, recognizing employee contributions, and providing opportunities for growth and development. Through initiatives such as regular feedback mechanisms and professional development programs, Organization X cultivates a culture of continuous improvement and employee satisfaction. The way workforce and operations are enhanced at Organization X is explained in the sub-sections below:

Development of the Workforce Environment

Organization X leaders recognize that their workforce is important in addressing clinical documentation challenges and achieving organizational goals. With a mission to improve clinical documentation processes and ensure compliance, Organization X places significant emphasis on nurturing an effective and supportive workforce environment. Organization X's leadership, including the COO, compliance officer, and lead psychiatric coordinator, acknowledges the critical role of the workforce in resolving clinical

documentation challenges. According to a study by Bärkås et al. (2023), health care organizations like Organization X rely heavily on a skilled workforce to ensure accurate and timely documentation. With an anticipated increase of 20% inpatient admissions over the next 5 years, per the organization's 2023 annual report, Organization X leaders recognize the need for a well-prepared workforce to manage the growing demand.

The workforce at Organization X comprises various stakeholders, including clinicians responsible for patient documentation, support staff involved in training and compliance monitoring, and leadership team members overseeing operations. The lead psychiatric coordinator, with 11 years of experience in coordinating documentation procedures, plays an important role in ensuring consistency and accuracy. Additionally, as shown in the 2024 organizational chart, the compliance officer, with 8 years of expertise in regulatory compliance, ensures adherence to standards.

Organization X adopts several strategies to cultivate an effective and supportive workforce environment. Recruitment efforts focus on hiring individuals with demonstrated experience in clinical documentation, with a target of increasing the workforce by 15% annually, according to the 2023 recruitment plan. Training programs, such as the clinical documentation excellence initiative, provide ongoing education to staff, resulting in a 25% improvement in documentation accuracy within the 1st year of implementation, according to the 2022 training report. Results from the 2023 employee satisfaction survey show that supportive leadership practices, including regular communication and feedback mechanisms, led to a 30% increase in employee satisfaction scores over the past 2 years.

Creation of Workforce Capability and Capacity

At Organization X, the mission is to deliver high-quality health care services while prioritizing patient safety and satisfaction. This ethos aligns with the organization's values of compassion, integrity, and excellence in care delivery noted in the organization's 2023 annual report. Unlike for-profit entities driven solely by financial gains, Organization X's focus extends beyond profitability to community impact and patient well-being. The organization's commitment to affordable and accessible health care resonates deeply with its stakeholders, fostering a sense of purpose and dedication among staff (Britiller et al., 2023).

Maintaining affordability presents challenges in compensating health care providers adequately, yet Organization X remains steadfast in its pursuit of fair compensation while staying true to its mission. By cultivating a culture of trust and transparency, Organization X cultivates strong relationships with its workforce, emphasizing shared values and organizational objectives, according to the COO. Through effective communication and alignment with organizational goals, Organization X ensures that its workforce is motivated and engaged, driving performance excellence in delivering patient-centered care.

Fostering of Relationships

When a prospective employee responds to job postings or outreach efforts, Organization X's recruitment coordinator promptly initiates contact, aiming to schedule an initial phone call within 24 hr. During this call, candidates are guided through the organization's website and provided access to videos detailing Organization X's mission,

values, and service offerings, the COO noted. These resources are curated to offer a comprehensive understanding of Organization X's commitment to patient-centered care and professional excellence. Following the initial screening, candidates are invited to a face-to-face interview with the department manager or a senior team member. This interview, the lead psychiatric coordinator noted, serves as an opportunity for candidates to delve deeper into Organization X's organizational culture and expectations, ensuring alignment between individual aspirations and the organization's ethos. Moreover, candidates are encouraged to inquire about Organization X's professional development opportunities and employee support programs, reinforcing Organization X's commitment to staff growth and well-being.

Once onboarded, new hires are assigned a dedicated mentor or preceptor who guides them through their initial days at Organization X. This mentorship program, overseen by the chief nursing officer, pairs new employees with experienced staff members who provide guidance, support, and feedback as they navigate their roles within the organization, the executive shared. This personalized approach, as Zurynski et al. (2021) noted, not only accelerates the onboarding process but also boosts a sense of solidarity and belonging among new hires.

Throughout their tenure at Organization X, employees receive regular check-ins from their supervisors, ensuring open lines of communication and opportunities for feedback. As the COO noted, supervisors actively solicit employee input on workflow processes, patient care practices, and organizational initiatives, underscoring Organization X's commitment to continuous improvement and employee engagement.

This collaborative approach as Zurynski et al. (2021) note, not only strengthens the bond between employees and management but also cultivates a culture of trust, transparency, and mutual respect within the organization.

Hiring and Onboarding

The hiring and onboarding process at Organization X involves several steps. First is the initial application screening. Candidates apply online through Organization X's career portal, where human resources (HR) staff has set up an initial screening. This assessment includes reviewing resumes, educational qualifications, and relevant experience to identify suitable candidates, according to the COO. A panel interview is the first step. Qualified candidates are invited for a panel interview consisting of the COO, department heads, and HR representatives. This comprehensive interview helps leaders to assess candidates' professional competencies, alignment with Organization X's values, and cultural fit within the organization, the lead psychiatric coordinator noted.

Upon successful selection, candidates undergo a structured onboarding process managed by HR. As noted by the compliance officer, a detailed checklist ensures all necessary steps are completed:

- submission of the job application form with accurate information; and
- verification of resumes and professional references to validate candidates' work history and credentials; and
- confirmation of academic qualifications and relevant certifications required for the position; and

- validation of professional licensure, if applicable, ensuring compliance with regulatory requirements; and
- provision of personal documents, including a valid driver's license, social security card, and vehicle registration; and
- consent for background checks, encompassing criminal history and driving records, to ensure compliance with Organization X's standards and regulations.

Throughout the onboarding process, HR and assigned mentors provide personalized guidance and support to new hires. This includes clarifying organizational policies, introducing new employees to key stakeholders, and addressing any queries or concerns they may have, according to HR department internal records.

Staff Training

Following the rigorous hiring and onboarding process, newly recruited staff at Organization X undergo specialized training tailored to their respective roles within the organization. This training is structured and conducted by seasoned trainers from the HR department and relevant departmental heads, ensuring that it aligns with Organization X's organizational objectives and standards, according to the COO. Clinical staff members participate in intensive training programs covering a wide range of topics, including

- advanced life support techniques
- emergency response protocols
- disease-specific management strategies
- patient safety protocols
- communication and interpersonal skills

- ethical decision-making
- cultural competence and diversity

These programs are designed to equip clinical staff with the necessary skills and knowledge to deliver exceptional patient care in various health care settings (DesRoches et al., 2020). On the administrative front, staff receive comprehensive training in

- health care administration
- medical billing and coding
- use of EHR systems
- financial management and budgeting
- regulatory compliance and accreditation standards
- HR policies and procedures
- quality improvement methodologies

These training sessions are instrumental in enhancing the efficiency and effectiveness of administrative operations at Organization X, ensuring continuous workflow processes and compliance with regulatory requirements (Dunbar et al., 2021). To gauge the effectiveness of these training programs, Organization X conducts pre-and post-training assessments, along with feedback surveys from participants. As noted in the 2023 annual report, these evaluations provide important insights into the strengths and areas for improvement of the training initiatives, enabling Organization X to continuously refine and enhance its training curriculum.

Staff Configurations

Staffing configurations at Organization X are well structured to address the organization's documentation challenges with precision and efficacy. The COO noted that, under their guidance, staffing decisions are carefully composed to meet the demanding documentation requirements inherent in health care delivery. To ensure continuous documentation processes, Organization X adopts a diverse team of health care professionals, each contributing specialized expertise to the documentation workflow.

Upon admission, patients undergo a thorough assessment conducted by the lead psychiatric coordinator or designated clinical personnel. This assessment, the coordinator noted, includes detailed medical histories, diagnostic findings, and treatment plans, providing a comprehensive foundation for subsequent care interventions. These initial assessments are meticulously documented, capturing critical patient data essential for care coordination and treatment planning.

Organization X's staffing model incorporates a multidisciplinary approach to documentation, leveraging the expertise of RNs, LPNs, and CNAs. RNs are responsible for conducting comprehensive nursing assessments, administering medications, and documenting patient progress in the electronic health record (EHR) system. LPNs provide important support by accurately recording vital signs, patient observations, and treatment interventions, ensuring meticulous documentation of clinical care activities, according to the COO.

Moreover, Organization X recognizes the indispensable role of ancillary staff members in maintaining documentation accuracy and integrity. Medical coders, health

information technicians, and transcriptionists play vital roles in ensuring that clinical documentation complies with coding guidelines, regulatory standards, and reimbursement requirements. Their expertise contributes to fewer documentation errors and mitigation of audit discrepancies, safeguarding the integrity of patient records, the COO noted. In addition to staffing considerations, Organization X prioritizes ongoing education and training initiatives to address documentation challenges effectively, the COO added. Staff members receive specialized instruction on EHR utilization, documentation best practices, and regulatory compliance standards, equipping them with the knowledge and skills necessary to navigate complex documentation requirements with proficiency and confidence.

Workforce Climate and Engagement

Promotion of Work Safety

Promoting work safety at Organization X involves comprehensive safety training programs, continuous education, provision of personal protective equipment, regular safety audits and risk assessments, emergency preparedness drills, incident reporting, and follow-up procedures, as well as staff wellness programs, ensuring a secure and healthy work environment for all employees.

Safety Training Programs

Organization X conducts specialized safety training programs tailored to different job roles and care settings. For example, home health care workers receive training on safe patient handling techniques through the Safe Caregiving Practices program, which includes modules on proper lifting and transferring methods, the COO shared.

Additionally, staff members undergo regular refresher courses such as the Safety-First Refresher workshop to reinforce safety practices and stay updated on industry standards.

Continuous Safety Education

The organization provides ongoing safety education through online modules such as the Safety@Organization X platform, where employees can access interactive training modules covering topics such as workplace violence prevention and infection control, according to the lead psychiatric coordinator. Furthermore, the Safety Spotlight newsletter is distributed monthly to all employees, highlighting safety tips, case studies, and best practices.

Personal Protective Equipment Provision

Organization X ensures that staff members have access to high-quality personal protective equipment through the protective gear program, the compliance officer shared. This program includes the distribution of personal protective equipment kits containing gloves, masks, face shields, and gowns to nursing staff, along with fit testing for respirators to ensure proper respiratory protection.

Safety Audits and Risk Assessments

As noted by the COO, the organization conducts regular safety audits and risk assessments through the Safety-First audit initiative. This program involves comprehensive inspections conducted by trained safety officers, equipment checks using the Equipment Safety Check checklist, and interviews with staff members to assess safety practices and identify areas for improvement.

Emergency Preparedness Drills. Organization X organizes frequent emergency preparedness drills under the emergency response training program, the lead psychiatric coordinator noted. These drills simulate various emergency scenarios, including fire outbreaks, medical emergencies, and natural disasters, allowing staff members to practice their roles and responsibilities in a controlled environment.

Incident Reporting and Follow-Up. The organization maintains a transparent safety incident reporting system, the compliance officer noted. Each reported incident undergoes a thorough investigation, and corrective actions are tracked through the Safety Improvement Tracker tool to prevent recurrence and promote a culture of continuous improvement.

Staff Wellness Programs. Organization X leaders, the COO noted, prioritize staff well-being through initiatives such as the Healthy Minds, Healthy Bodies program. This program includes stress management workshops, yoga classes, access to employee assistance programs like Organization X Cares, and designated relaxation areas within the workplace known as wellness zones.

Enhancement of the Workplace

Employee Recognition and Involvement. Organization X prioritizes a culture of recognition and involvement to enhance job satisfaction and engagement among its staff. Inspired by Ebbers et al. (2022) and Ebnehoseini et al. (2022), the organization emphasizes teamwork and values the contributions of its health care workers. Regular appreciation events, such as the employee of the month awards and team achievement celebrations, acknowledge hard work and foster a sense of belonging, according to the

COO. Additionally, Organization X encourages CNAs to participate in decision-making processes related to patient care through initiatives like the CNA advisory board, providing them with a platform to voice their opinions and contribute to organizational decisions.

Psychological Empowerment and Support. Following the insights of Fine et al. (2022), Organization X prioritizes the psychological empowerment of its staff members by providing access to resources and support systems. The employee assistance program, the lead psychiatric coordinator shared, offers confidential counseling services and mental health support to employees facing personal or professional challenges. Moreover, Organization X conducts regular check-ins and feedback sessions with CNAs to address their needs and concerns, ensuring they feel valued and supported in their roles.

Employee Advocacy and Well-Being. Ebbers et al. (2022) highlighted the importance of advocating for direct care workers at governmental levels to attract and retain staff. According to its compliance officer, Organization X actively engages in advocacy efforts to promote fair wages, adequate staffing ratios, and improved working conditions for its health care workers. Additionally, the organization offers comprehensive employee orientation programs and ongoing training opportunities to support professional growth and development, according to the COO. Through initiatives like the career advancement program, CNAs can access educational resources and pursue further certifications to advance their careers within the organization.

Addressing of Psychosocial Challenges. Recognizing the psychosocial toll of caregiving, as discussed by Frimpong et al. (2023), Organization X implements strategies

to mitigate burnout and promote well-being among its staff. The organization offers resilience training workshops and stress management seminars to equip CNAs with coping mechanisms for dealing with emotional challenges, the lead psychiatric coordinator shared. Moreover, Organization X boosts a supportive work environment where CNAs feel valued and respected, minimizing feelings of alienation and enhancing overall job satisfaction.

Challenges in Staff Recruitment and Retention

At Organization X the endeavor to recruit and retain top-tier health care professionals is tied to the organization's commitment to excellence and its dynamic operational environment. Within Organization X's complex workforce, the challenge lies in discerning between different types of health care professionals, each motivated by unique aspirations and values. For instance, Organization X encounters individuals who perceive health care as a calling, driven by an unwavering commitment to serve vulnerable populations selflessly (Gajera et al., 2019). Conversely, some view health care as a lucrative career path, seeking opportunities for financial stability and professional advancement within the organization (Grzenda & Widge, 2024). Additionally, Organization X attracts individuals who are drawn to the institution's reputation for fostering personal growth and professional development in a supportive environment (Kariotis et al., 2022).

To address these challenges, Organization X leaders have implemented a comprehensive recruitment strategy overseen by the COO and the HR department. As Matthews and Stanhope (2020) note, this strategy involves scrupulous interviews,

thorough background checks, and scenario-based assessments to gauge candidates' alignment with Organization X's mission, values, and organizational culture. For example, candidates undergo rigorous evaluations to assess their compatibility with Organization X's core principles of integrity, compassion, and excellence in patient care, according to the COO. Generally, Organization X recognizes that cultivating a resilient and diverse health care workforce is paramount to its mission of delivering unparalleled care amidst the complexities of the modern health care landscape.

In evaluating potential hires, Organization X emphasizes integrity, honesty, and sound judgment, supplementing traditional vetting methods with scenario-based inquiries to gauge candidates' suitability (Smith, 2022). These inquiries are tailored to ascertain the candidates' approach to documentation challenges, ensuring they possess the necessary skills and mindset to navigate such complexities effectively. Sample interview questions tailored to Organization X's documentation challenges might include

1. “Can you describe a situation where you encountered complex documentation requirements in a previous role? How did you address them?”
2. “How do you prioritize and organize documentation tasks in a fast-paced environment with competing demands?”
3. “Have you ever faced discrepancies or inconsistencies in documentation? How did you identify and rectify them?”
4. “Could you provide an example of a time when you had to collaborate with multiple stakeholders to ensure accurate and comprehensive documentation?”

These questions aim to assess candidates' familiarity with documentation processes, their ability to handle challenges, and their approach to maintaining accuracy and compliance (Smith, 2022). Organization X seeks individuals who demonstrate not only proficiency in documentation but also an understanding of its importance in ensuring quality care delivery and regulatory compliance.

Career Progression and Advancement

Navigating career progression and advancement at Organization X involves addressing documentation challenges inherent in the health care industry. The organization has implemented targeted initiatives to enhance documentation proficiency among its staff, thereby facilitating career growth and advancement opportunities. One such initiative, the COO shared, is the documentation excellence program, spearheaded by the compliance officer. This program provides comprehensive training sessions and workshops aimed at improving staff members' documentation skills. Through interactive modules and hands-on exercises, employees learn best practices for maintaining accurate and detailed medical records, ensuring compliance with regulatory standards (Moroz et al., 2020). In a study by Neill and Read (2022), it was found that structured documentation training programs significantly improved documentation accuracy and completeness among health care professionals.

In addition to formal training programs, Organization X offers mentorship opportunities for staff interested in advancing their careers in health care documentation. As noted by the COO, the documentation mentorship program, led by senior compliance specialists, pairs experienced staff with newer employees to provide guidance and

support in effectively navigating documentation challenges. Research by Vis (2022) highlights the effectiveness of mentorship programs in enhancing professional development and skill acquisition among health care workers.

Moreover, Organization X recognizes and rewards employees who demonstrate exceptional proficiency in documentation through its documentation excellence awards. These awards, presented annually during the organization's staff appreciation event, celebrate individuals who consistently exhibit outstanding documentation practices, serving as role models for their peers and aspiring professionals, according to the COO. A study by Volk et al. (2022) reiterates the importance of recognition and rewards in motivating employees to excel in their roles and contribute positively to organizational objectives.

Rewards and Recognition

Organization X takes a personalized approach to recognize and reward its employees, despite financial constraints. As noted by the COO, the organization acknowledges outstanding contributions through various channels, including the employee of the month program, where exceptional staff members are honored with a plaque and public acknowledgment during monthly staff meetings. Additionally, the compliance officer shared that Organization X hosts an annual Celebration of Service event, where employees with significant years of service receive personalized tokens of appreciation, such as engraved watches or commemorative plaques.

In line with its commitment to employee well-being, Organization X offers nonmonetary benefits, such as flexible work arrangements and professional development

opportunities. For example, according to the lead psychiatric coordinator, the organization sponsors employees to attend industry conferences and workshops to enhance their skills and knowledge. This investment in professional growth not only demonstrates Organization X's appreciation for its employees but also fosters a culture of continuous learning and development within the organization. Furthermore, Organization X recognizes the importance of celebrating individual achievements and milestones. Through a program called "Spotlight on Success," employees are encouraged to nominate their peers for exceptional performance or acts of kindness. Recipients of this recognition receive a certificate of appreciation and a gift card to a local restaurant or retail store, according to the COO.

Retention Through Governmental Changes

Organization X confronts documentation challenges exacerbated by federal and state regulatory frameworks that historically pose obstacles to efficient documentation practices (American Hospital Association, 2019). Legislative measures such as the Health Insurance Portability and Accountability Act and the Medicare Access and CHIP Reauthorization Act have introduced complex documentation requirements, contributing to the burden faced by health care organizations like Organization X (American Hospital Association, 2019). In response to these challenges, Organization X advocates for governmental changes that could alleviate documentation burdens and streamline processes.

Firstl the organization proposes reforms aimed at simplifying documentation standards and requirements, ensuring that regulations are clear, concise, and conducive to

efficient record-keeping practices (U.S. Department of Health & Human Services, 2020). By reducing administrative complexities, governments can enable health care providers at Organization X to devote more time and resources to delivering quality patient care (U.S. Department of Health & Human Services, 2020). Second, Organization X emphasizes the importance of interoperability standards and data exchange protocols to facilitate continuous information sharing among health care stakeholders (CMS, 2021). By promoting interoperability, governments can enhance the accessibility and usability of health information, thereby improving care coordination and patient outcomes (CMS, 2021). Furthermore, Organization X calls for investments in health information technology (IT) infrastructure and systems to support efficient documentation practices (U.S. Department of Health & Human Services, 2020).

By providing funding and resources for electronic health record (EHR) systems and other digital tools, governments can empower health care providers at Organization X to streamline documentation workflows and enhance data accuracy and integrity (U.S. Department of Health & Human Services, 2020). Last, Organization X recommends implementing policies that prioritize data security and privacy safeguards to protect sensitive patient information (Office for Civil Rights, 2021). By enforcing stringent data protection measures, governments can mitigate the risk of breaches and unauthorized access, ensuring the confidentiality and integrity of health care documentation at Organization X (Office for Civil Rights, 2021).

Improvement of Organizational Services, Processes, and Operations Management

According to the 2023 annual report, Organization X leaders have implemented a robust performance improvement system overseen by the COO and compliance officer to enhance organizational effectiveness and optimize patient care outcomes. Initially, upon admission, patients undergo a comprehensive assessment conducted by the lead psychiatric coordinator to determine their health care needs and preferences. This assessment serves as the foundation for developing individualized care plans tailored to each patient's unique circumstances and treatment goals.

Furthermore, Organization X adopts a multifaceted approach to gather feedback and measure patient satisfaction with the services provided. As document in patient experience program materials, patients receive a satisfaction survey alongside their discharge paperwork, allowing them to provide feedback on various aspects of their care experience, including service quality, staff professionalism, and overall satisfaction with the care received. Additionally, as noted in patient advocacy program materials, patients are encouraged to utilize a dedicated hotline managed by the compliance officer to voice any concerns or complaints regarding their care, ensuring that their feedback is promptly addressed and resolved.

Internal records substantiate Organization X’s commitments to quality improvement and patient engagement. Organization X leaders cultivate a culture of continuous improvement by regularly conducting patient follow-up calls facilitated by the COO and compliance officer to assess the effectiveness of interventions and identify opportunities for refinement. These proactive check-ins not only demonstrate

Organization X's commitment to patient-centered care but also enable the organization to cultivate long-term relationships with patients and their families, fostering trust and loyalty.

Knowledge Management

In response to the evolving landscape of health care delivery, Organization X has prioritized knowledge management strategies to improve organizational performance, particularly in addressing documentation challenges prevalent in-home health care settings. Organization X has tailored its approach to meet the unique needs of its patient population and operational environment.

Measurement

Organization X adopts a diversified approach to measure organizational performance, including both quantitative and qualitative indicators relevant to documentation quality and efficiency. Clinical documentation metrics, such as completeness, accuracy, and timeliness, are systematically tracked using electronic health record (EHR) systems and supplemented by manual audits conducted by the compliance officer and designated quality improvement teams. Additionally, patient satisfaction surveys, administered through multiple channels including online portals and telephone interviews, provide important feedback on the clarity, comprehensiveness, and accessibility of medical records and communication materials.

Analysis

Data analysis serves as a basis of Organization X's knowledge management efforts, facilitating the identification of documentation-related issues and opportunities

for improvement. Utilizing advanced analytics tools and techniques, such as natural language processing and sentiment analysis, Organization X's data analytics department analyzes large volumes of clinical documentation to detect patterns, trends, and areas of noncompliance. For instance, text mining algorithms are applied to identify common documentation errors or inconsistencies, enabling targeted interventions and corrective actions by the documentation improvement committee, according to the unit's annual report.

Improvement

Based on the findings from data analysis, Organization X will implement evidence-based interventions aimed at enhancing documentation practices and streamlining workflow processes. Continuous quality improvement methodologies, adapted from industry standards and regulatory guidelines, inform the development and implementation of improvement initiatives at Organization X, according to internal records, 2024). The types of data that could be collected in a rigorous continuous quality improvement program at Organization X include

- patient clinical records, including medical histories, treatment plans, and progress notes;
- patient satisfaction surveys, capturing feedback on the quality of care, communication, and overall experience;
- infection control records, documenting rates of health care-associated infections and adherence to protocols;
- incident reports, detailing adverse events, near misses, and safety concerns;

- staff competency assessments, evaluating proficiency in clinical skills, documentation practices, and compliance with policies;
- management meeting reports, summarizing discussions on quality metrics, performance indicators, and improvement opportunities; and
- reviews of prior continuous quality improvement activities, analyzing the effectiveness of interventions and identifying areas for further enhancement.

The organization's documentation improvement task force encompasses interdisciplinary teams, comprising clinical documentation specialists, compliance officers, and IT experts, that collaborate to address identified gaps in documentation accuracy, completeness, and compliance with regulatory standards. Moreover, as noted in the organization's documentation training curriculum, staff training and education programs are tailored to reinforce best documentation practices and promote a culture of accountability and continuous learning.

Despite the recognized need for advancements in quality management within health care environments like Organization X, there remains a scarcity of research and evidence-based practices specific to implementing total quality management concepts. Zanaboni et al. (2022) highlight this gap, emphasizing the necessity for a structured approach to improving organizational performance. One such framework that offers a systematic method for addressing challenges and driving improvement is the plan-do-study-act cycle. The cycle, which originated from the field of quality improvement, presents a structured and iterative approach to problem-solving and continuous

improvement. It comprises four key stages: plan, do, study, and act (Zurynski et al., 2021).

In the Plan stage, Organization X would identify and define the specific documentation challenges it faces, establish clear improvement goals, and develop a detailed plan outlining the actions to be taken to address these challenges. This planning phase would involve thorough analysis and stakeholder input to ensure that the proposed interventions are well-informed and aligned with organizational objectives. Next, in the Do stage, Organization X would implement the planned changes in its documentation processes according to the established plan. This may involve introducing new documentation protocols, providing staff training on updated procedures, or implementing technology solutions to streamline documentation workflows.

Following implementation, the Study stage involves collecting and analyzing data to evaluate the effectiveness of the implemented changes. Organization X would monitor key performance indicators related to documentation accuracy, efficiency, compliance, and staff satisfaction to assess the impact of the interventions. Based on the findings from the data analysis, Organization X would proceed to the Act stage, where adjustments and refinements to the documentation processes are made as necessary. This may involve scaling up successful interventions, modifying strategies that did not yield the desired results, or addressing any unforeseen challenges that arise during implementation.

In the pursuit of operational excellence, Organization X demonstrates a commitment to pragmatic performance enhancement, led by the COO. The COO champions a philosophy summarized by the quote, "Continuous improvement is better

than delayed perfection." This mantra emphasizes Organization X's dedication to ongoing refinement rather than waiting for an ideal state. For instance, Organization X regularly solicits feedback from both staff and patients to inform improvement initiatives, aligning with the COO's philosophy.

By using innovative methodologies such as Lean Six Sigma and incorporating data-driven insights, Organization X ensures that its performance improvement efforts remain dynamic and responsive to evolving needs. As supported in the literature (J. Clark et al., 2022), it is essential for the COO at Organization X to regularly receive feedback from various stakeholders to inform operational decisions and enhance service delivery. They actively seek insights regarding the effectiveness of existing processes and identify areas for improvement with Bärkås et al. (2023) noting that this reciprocal exchange of information allows Organization X to comprehensively assess the efficacy of its health care delivery model.

Provision of a Safe Operating Environment

At Organization X ensuring a secure operational environment hinge on a culture of trust and transparent communication among all stakeholders. Spearheaded by the COO, Organization X emphasizes the importance of building strong relationships with its workforce to uphold safety standards. By cultivating an atmosphere of honesty and support, the COO instills confidence in employees that their concerns are heard and addressed promptly. Before any task assignment, the COO noted that they and the compliance officer verified the safety of the work environment.

This proactive approach includes thorough assessments to ensure both staff and patients are in secure conditions. Organization X's commitment to safety is epitomized by its proactive measures and dedication to mitigating risks, echoing the sentiment expressed by the COO: "In our caregiving ethos, safety is paramount, ensuring a mutually beneficial environment for all involved." At Organization X performance improvement activities related to safety practices are carefully implemented to uphold a secure operating environment. The COO noted the following initiatives:

- implementing stricter enforcement measures for employees who breach safety protocols, such as failing to follow proper procedures or neglecting safety equipment. Consequences may include retraining, written warnings, or even suspension, depending on the severity of the infraction and its potential impact on patient and staff safety.
- introducing periodic safety audits conducted by trained safety officers to identify potential hazards or areas for improvement within the facility. These audits are comprehensive and cover all aspects of the hospital environment, from patient rooms to administrative offices.
- providing ongoing safety training and education programs for staff members to ensure they remain updated on the latest safety protocols and best practices. This includes regular workshops, seminars, and online courses tailored to different departments and roles within the hospital.
- encouraging a culture of safety where all staff members are empowered to report safety concerns or incidents without fear of reprisal. Organization X

utilizes a confidential reporting system that allows employees to submit safety-related feedback or incident reports anonymously, fostering a transparent and proactive approach to safety management.

These performance improvement activities are integral to Organization X's commitment to maintaining a safe and secure environment for both patients and staff members.

Management of Organizational Knowledge

As a leading health care institution, Organization X faces the challenge of efficiently managing vast amounts of organizational knowledge while ensuring continuous delivery of care. Despite its size and complexity, Organization X adopts a robust IT infrastructure to tackle documentation challenges and enhance operational efficiency. With the recent acquisition of a substantial patient caseload from a former health care provider, Organization X inherited a sophisticated electronic health record (EHR) system tailored to streamline patient data management.

Under the guidance of the COO, the implementation and utilization of this advanced technology are overseen by the IT department. The COO emphasizes the important role of technology in optimizing organizational performance and improving patient outcomes. Through comprehensive training programs led by the IT department, frontline health care professionals, including nurses and physicians, are equipped with the necessary skills to navigate the EHR system. By leveraging cutting-edge technology, such as the Epic Systems EHR software, Organization X aims to centralize patient information, streamline administrative processes, and enhance collaboration among health care teams. This integrated approach facilitates personalized, client-centered care

delivery while boosting a culture of continuous improvement and innovation within the organization (Britiller et al., 2023).

Summary

In Section 3, I presented an analysis of Organization X's strategies for managing organizational knowledge and ensuring a safe operating environment. This included an exploration of how Organization X leverages technology to streamline documentation processes and enhance operational efficiency. Additionally, I examined the importance of trust and communication between organizational leaders and frontline staff in maintaining a safe and supportive work environment. In Section 4, I scrutinize the implications of these findings for Organization X, considering how they can further optimize their workforce management practices and address any identified challenges. Moreover, we will evaluate the strengths and limitations of the study's outcomes, providing insights into potential areas for improvement within Organization X's staff recruitment and retention initiatives. Through this comprehensive analysis, we aim to offer actionable recommendations that align with Organization X's overarching goals and objectives.

Section 4: Results–Analysis, Implications, and Preparation of Findings

Introduction

The organization faces challenges in maintaining accurate and consistent documentation practices, impacting patient care and organizational efficiency. The practice-focused questions underpinning this investigation were

RQ1: What are the perceived barriers behavioral health providers face in accurately documenting patient information?

RQ2: How do inconsistent documentation methods among clinicians in BHOs impact the efficiency and effectiveness of patient care?

RQ3: What common compliance hurdles does the organization experience?

The sources of evidence for this study were gathered through structured interviews with key stakeholders within the organization, including the COO, the lead psychiatric coordinator, and the compliance officer. These interviews were conducted between March and May 2024 and provided firsthand insights into the organization's documentation practices, challenges faced by clinicians, strategies for improvement, and compliance protocols.

Additionally, scholarly literature sourced from peer-reviewed journals and authoritative reports supplemented the interview findings. These sources offered comprehensive insights into industry standards, best practices in documentation, technological impacts, compliance measures, and strategies for enhancing documentation accuracy. The integration of both primary interview data and secondary literature ensured

a robust analysis, providing a comprehensive understanding of the current state of documentation within the organization and broader contextual frameworks.

Analysis, Results, and Implications

Using NVivo 12 software, I analyzed interview transcripts from three structured interviews with key stakeholders, including the COO, lead psychiatric coordinator, and compliance officer. Each interview was transcribed verbatim to ensure accuracy and depth in the subsequent analysis. Initially, there were 11 primary themes identified from the interviews, which were subsequently refined and recoded into the following three distinct themes (subthemes in parentheses):

- Theme 1: Barriers to Effective Clinical Documentation Practices (time constraints and workload pressures, complexity of EHR systems, lack of standardization in documentation practices, insufficient staffing and resources, inadequate training programs, poor interdepartmental communication and coordination, and technological barriers to documentation)
- Theme 2: Impact of Inconsistent Documentation on Patient Care (impact on care quality and patient safety, impact on workflow and care coordination, communication breakdowns among clinicians, monitoring and evaluating of patient outcomes, and increased administrative burden and resource utilization)
- Theme 3: Compliance Hurdles at Organization X (regulatory compliance gaps, inadequate training programs, complex documentation requirements, and resource constraints)

The final set of thematic codes was aligned to each of the three RQs to ensure comprehensive coverage of the study objectives. Following analyses of the findings by RQ, the results are examined with a focus on Organization X client programs and services, client workforce, leadership and governance, financial and marketplace performance, and social implications and impact. These analyses are crucial as they provide a holistic understanding of how documentation practices impact various facets of the organization. They inform targeted improvements and strategic initiatives that can enhance operational efficiency, compliance, and overall patient care outcomes at Organization X.

Thematic Results by Research Question

RQ1: Perceived Barriers to Accurate Documentation

Time Constraints and Workload Pressures. In interviews, clinicians at Organization X identified time constraints and workload pressures as significant barriers to accurate documentation. The lead psychiatric coordinator (P2) emphasized the challenge, stating, "Balancing documentation with patient care is challenging due to time limitations," reflecting the struggle to manage comprehensive documentation amidst high patient volumes and demanding schedules. This issue was underscored by the 2023 incident report log, where several incidents cited time pressure as a contributing factor to documentation inaccuracies.

The organization's 2023 annual performance evaluation summaries further illustrate this barrier, noting frequent feedback about time management difficulties and its impact on documentation quality. The overwhelming workload not only affects the

quantity of documentation but also its quality, as clinicians often have to prioritize direct patient care over thorough record-keeping. This prioritization often leads to rushed or incomplete entries, which can affect patient safety and care continuity. Moreover, the strategic planning meeting minutes from January 2024 reveal discussions about potential solutions, such as increasing staffing levels or adjusting shift patterns to alleviate these pressures. Despite acknowledging the problem, the minutes reflect the challenge of implementing these solutions due to budgetary constraints and the competitive nature of recruiting qualified personnel.

Complexity of EHR Systems. Clinicians at Organization X reported the complexity of electronic health record (EHR) systems as a significant barrier to effective documentation. The COO (P1) remarked, "Our EHR system's interface requires extensive navigation, impacting efficiency." This complexity often leads to documentation errors and omissions, as clinicians struggle to efficiently input data while managing patient care demands. The quality assurance review reports for Quarter 3 of 2023 noted a high incidence of errors related to improper data entry and incomplete records, frequently attributed to difficulties navigating the EHR system.

The compliance audit findings for (2022 through 2024 also revealed that the EHR's lack of user-friendly features contributes to inconsistencies in documentation. For example, clinicians often bypass certain sections of the EHR to save time, resulting in incomplete patient records. This issue is compounded by a lack of adequate training, as highlighted in the staff training and development handbook, which documents the need for ongoing EHR training sessions to address these challenges.

Additionally, the patient satisfaction survey results for Quarter 4 of 2023 indicated patient dissatisfaction related to delays in care due to clinicians spending excessive time on EHR tasks. To address these issues, the organization has considered revising its clinical documentation policy and procedure manual to streamline EHR processes and improve efficiency. However, despite recognizing these challenges, the organization faces difficulties in implementing system upgrades due to financial constraints and the complexity of integrating new technology with existing systems.

Lack of Standardization in Documentation Practices. The lack of standardization in documentation practices across departments was identified as a significant barrier by clinicians at Organization X. The compliance officer (P3) highlighted this issue, stating, "Inconsistencies in documentation practices across departments lead to variations in data quality." This lack of standardization often results in fragmented patient records, making it difficult to track patient progress and coordinate care effectively.

The clinical documentation policy and procedure manual revealed inconsistencies in how different departments approach documentation. For instance, while some departments adhere to strict protocols for data entry and record-keeping, others allow for more flexibility, leading to significant discrepancies in how information is recorded. This inconsistency is further supported by the quality assurance review reports (Q3 2023), which noted frequent errors and omissions in patient records, particularly in departments with less rigorous documentation standards. Additionally, the incident report log for 2023 documented several cases where inconsistent documentation practices contributed to

adverse patient outcomes, highlighting the need for standardized procedures across the organization. The strategic planning meeting minutes from January 2024 also addressed this issue, recommending the implementation of uniform documentation standards to enhance data accuracy and improve patient care coordination.

Insufficient Staffing and Resources. Insufficient staffing and resources emerged as a critical organizational barrier impacting documentation practices at Organization X. The COO (P1) described the situation, stating, "We are often short-staffed, which means clinicians are overwhelmed with their workload, leaving less time for thorough documentation." This shortage not only pressures clinicians but also increases the likelihood of documentation errors as staff rush through the process to meet their clinical responsibilities. The annual performance evaluation summaries for 2023 highlighted the strain on staff, noting high levels of stress and burnout due to excessive workloads. These evaluations revealed that many clinicians are required to work extended hours to complete both patient care and documentation tasks, which compromises the quality of both.

The compliance audit findings further underscored this issue, indicating that inadequate staffing levels contributed to lapses in compliance with documentation standards. Auditors frequently identified incomplete or inaccurate records, attributing these issues to insufficient time and resources allocated for documentation tasks. Moreover, the staff training and development handbook pointed out a lack of ongoing training opportunities for clinicians, exacerbating the problem by leaving staff without the necessary skills to efficiently manage documentation tasks amidst their other duties.

This lack of training results in inconsistent documentation practices and reduced data accuracy.

Inadequate Training Programs. Inadequate training programs have been identified as a significant organizational barrier to effective documentation practices at Organization X. According to the compliance officer (P3), the current training programs lack depth and fail to equip staff with essential skills, stating, "Our training programs are not comprehensive enough to equip staff with the necessary skills for accurate documentation." This deficiency results in frequent documentation errors and inconsistent methods, as staff members are not adequately prepared to handle complex electronic health record (EHR) systems.

The staff training and development handbook highlights that training sessions are irregular and often theoretical, neglecting practical skills essential for documentation. This lack of practical training leads to a significant portion of staff feeling unprepared to use the EHR system effectively, leading to inefficiencies and inaccuracies in documentation. Additionally, the quality assurance review reports pointed out frequent documentation errors attributed to inadequate training. These errors include incorrect data entries and a misunderstanding of standardized documentation protocols, underscoring the need for more structured training programs. The 2023 incident report log reveals multiple cases where documentation errors negatively impacted patient care, highlighting the critical need for enhanced training. These incidents emphasize the connection between comprehensive training and the ability to maintain accurate and consistent documentation practices.

Poor Interdepartmental Communication and Coordination. Poor interdepartmental communication and coordination have been identified as significant organizational barriers to effective documentation practices at Organization X. During interviews, the lead psychiatric coordinator (P2) highlighted that communication gaps often lead to inconsistent documentation, stating, "We often face challenges in aligning our documentation practices across departments, which results in variations in how information is recorded." These discrepancies can lead to incomplete or inaccurate patient records, affecting the quality of care provided.

The strategic planning meeting minutes for January 2024 indicate that several initiatives to improve communication across departments have been discussed, but implementation has been inconsistent. This lack of follow-through on proposed solutions contributes to ongoing challenges in achieving uniform documentation standards. The incident report log further underscores the impact of poor interdepartmental communication on documentation quality. Several incidents were reported where miscommunication between departments led to delays in patient care and discrepancies in medical records. These incidents highlight the need for more structured communication channels to facilitate information sharing and ensure consistency in documentation practices. The board of directors meeting minutes for 2022 through 2024 reflect ongoing concerns about the lack of coordination between departments. The board has identified the need for a centralized communication strategy to streamline documentation processes and improve overall organizational efficiency.

Technological Barriers to Documentation. Findings revealed several

technological barriers to documentation at Organization X. While electronic health records (EHRs) are recognized for improving access to patient information, interviewees noted significant issues with their usability. The lead psychiatric coordinator (P2) expressed frustration, stating, "EHRs have made patient information more accessible, but the interface is complex and not intuitive, which makes documentation more time-consuming than it should be."

The 2023 incident report log reflects numerous instances of technology-related issues, such as system downtimes that delay documentation processes. These downtimes not only cause a backlog in documentation but also increase the likelihood of errors as staff rush to catch up once the systems are back online. The COO (P1) highlighted this concern: "We have faced several system downtimes that have disrupted our workflow, leading to delays and increased error rates."

Additionally, the EHR usage reports indicate frequent technical errors that staff encounter, further complicating documentation efforts. These errors include difficulties in navigating the system and retrieving accurate patient information, which compromises the quality of documentation. The strategic planning meeting minutes from January 2024 also note discussions on the necessity of upgrading to a more user-friendly EHR interface to reduce these challenges. The compliance officer (P3) emphasized this need, saying, "Clinicians often struggle with navigating the current EHR system, which directly affects the accuracy of their documentation."

RQ2: Impacts of Inconsistent Documentation Methods on Patient Care

Impact of Care Quality and Patient Safety. The analysis of inconsistent documentation's impact on care quality and patient safety at Organization X uncovered several critical issues, supported by both interview insights and document reviews. The COO (P1) described the documentation practices as "fragmented," with some departments utilizing outdated systems and others employing more robust protocols. For instance, P1 reported a delay in initiating emergency treatments due to outdated documentation procedures in the psychiatric unit. This observation is corroborated by the clinical documentation policy and procedure manual, which outlines gaps in procedural adherence, particularly in the Emergency Care Documentation section where some departments still follow outdated practices. The quality assurance review reports further support this finding, showing that discrepancies in documentation were a recurring issue impacting care quality, with 15% of reviewed cases revealing delays linked to documentation issues.

Additionally, the lead psychiatric coordinator (P2) noted that incomplete documentation often leads to "incorrect patient assessments," which can endanger patient safety. For example, P2 cited a case where missing vital signs in patient records delayed a necessary intervention for a severe allergic reaction. This finding is reflected in the incident report log, which recorded two instances in the past quarter where incomplete documentation led to significant delays in patient care, one of which involved a delayed allergic reaction treatment. The compliance officer (P3) highlighted that inadequate documentation increases the risk of "medication errors." P3 provided an example where

incomplete medication records led to a patient receiving incorrect dosages, resulting in a medication error. This issue is confirmed by the 2022 CMS audit report for behavioral health services, which identified that 18% of the audits reviewed in the past year showed documentation deficiencies contributing to medication errors and subsequent regulatory noncompliance.

Impact on Workflow and Care Coordination. The investigation into how inconsistent documentation contributes to inefficiencies in workflow and care coordination at Organization X revealed significant insights, supported by both interview insights and document reviews. The COO (P1) highlighted that one area of inconsistent documentation practice marks limitations within the current electronic health record system in which patient visits can be consistently documented. He further notates that the date of service is particularly important in terms of billing as well as next due visit date. Clinicians have been creating separate spreadsheets to document patient visits and maintain consistency in documenting those visits with appropriate dates of service.

The lead psychiatric coordinator (P2) observed that documentation inconsistencies hinder "effective care coordination." P2 cited an example where discrepancies in patient records caused confusion among care teams concerning absence of patient’s plan of care documentation, leading to inability to track pharmacological and nonpharmacological changes made during patient visits. This finding is reflected in the patient satisfaction survey results for Quarter 4 of 2023, which revealed a 20% decrease in patient satisfaction scores related to care coordination and timeliness of treatment. The compliance officer (P3) added that inconsistencies in documentation lead to "duplicative

efforts," where staff must spend additional time reconciling records. The 2023 incident investigation reports support this, noting several incidents where staff had to redo documentation due to previous errors, resulting in a 15% increase in administrative workload.

Communication Breakdowns Among Clinicians. The investigation into how inconsistent documentation leads to communication breakdowns among clinicians at Organization X revealed critical issues. Generally, clinical progress notes serve as a direct means of communication among clinicians. A medical clinician must read the progress notes of the psychiatric provider and vice versa to allow for proper collaboration of patient care. The COO (P1) noted that "inconsistent documentation creates significant communication barriers" among clinicians. P1 specifically described instances where lack of uniformity in patient records led to misunderstandings about treatment plans, affecting the overall coordination of care. This issue is corroborated by the clinical documentation policy and procedure manual, which outlines the expected standards for documentation but also highlights gaps in adherence. Additionally, the incident report log includes several cases where communication errors due to documentation inconsistencies resulted in delays in patient care.

The lead psychiatric coordinator (P2) reported that documentation errors often led to "conflicting information," making it challenging for clinicians to stay aligned on patient treatment plans. This observation is supported by the quality assurance review reports for Quarter 3 of 2023, which indicate that 18% of clinical errors were directly linked to discrepancies in documentation. Furthermore, the compliance officer (P3)

highlighted that inconsistent documentation often necessitates "clarification meetings," which are held during the weekday while most clinicians are seeing patients. The meetings disrupt workflow and delay patient care. This is reflected in the board of directors meeting minutes for 2022 to 2024, where meetings to resolve documentation issues are mentioned as a recurring topic, impacting operational efficiency.

Monitoring and Evaluation of Patient Outcomes. The examination of how inconsistent/erroneous documentation impacts monitoring and evaluating patient outcomes at Organization X has unveiled significant challenges. The COO (P1) reported that inconsistent documentation hampers the ability to effectively track patient progress and outcomes. P1 emphasized that discrepancies in patient records make it difficult to assess the efficacy of treatments and interventions, leading to incomplete evaluations of patient outcomes. This issue is reflected in the quality assurance review reports for Quarter 3 of 2023, which indicate that 22% of audits identified gaps in tracking patient progress due to inconsistent documentation.

The lead psychiatric coordinator (P2) added that "inconsistent data entries disrupt our ability to evaluate the success of treatment plans," pointing out that variations in documentation formats and details lead to challenges in aggregating and analyzing patient data effectively. This finding is supported by the 2023 EHR usage reports, which show numerous instances where data inconsistencies hindered the generation of accurate patient outcome reports. Additionally, the compliance officer (P3) noted that monitoring tools and performance metrics are compromised when documentation practices are inconsistent, resulting in an incomplete understanding of patient outcomes. The incident

investigation reports support this by documenting several cases where outcome monitoring was impeded by documentation issues, affecting the overall quality of care.

Increased Administrative Burden and Resource Utilization. The analysis of the impact of inconsistent documentation on administrative burden and resource utilization at Organization X reveals significant challenges. The COO (P1) observed that inconsistent documentation practices significantly increase administrative workload, noting that staff spend excessive time correcting errors and reconciling discrepancies. For example, billing codes are manually documented by the clinician completing the patient visit and subsequent progress note. Current Procedural Terminology codes are entered to identify the type of visit (initial evaluation, follow up, psychotherapy, crisis). Then, the International Classification of Diseases codes must be entered to identify diagnoses for the patient visit. If there is an error with any of these codes, an insurance company can deny claims.

The COO noted that most of the time the billing team will catch the error and notify the clinical provider, and it must be corrected. P1 described this as a "resource drain," impacting overall efficiency. This observation is supported by the Annual Performance Evaluation Summaries (2023), which highlight that 30% of administrative staff reported a substantial increase in time spent on documentation-related tasks due to inconsistencies (Annual Performance Evaluation Summaries, 2023). The lead psychiatric coordinator (P2) corroborated this, stating, "The inefficiency of correcting documentation errors diverts critical resources from direct patient care."

This perspective aligns with data from the clinical documentation policy and procedure manual, which indicates that 15% of administrative hours are devoted to managing documentation inconsistencies rather than patient care activities. Furthermore, the compliance officer (P3) mentioned that inconsistent documentation requires additional resources for auditing and compliance checks, which increases operational costs. This is reflected in the CMS audit report for behavioral health services, which outlines additional expenditures for compliance-related activities attributed to documentation issues.

RQ3: Common Compliance Hurdles for Behavioral Health Organizations

Regulatory Compliance Gaps. The analysis of regulatory compliance gaps at Organization X reveals several insights. For instance, the COO (P1) identified regulatory compliance gaps as a significant hurdle, noting, “Our organization struggles with keeping up with the evolving regulatory requirements, leading to frequent compliance issues.” This challenge is particularly evident in the 2022 CMS audit report for behavioral health services, which documented multiple instances of noncompliance related to documentation practices, specifically citing deficiencies in adhering to updated billing guidelines. International Classification of Diseases codes and guidelines are updated twice a year by the Centers for Disease Control and Prevention.

The lead psychiatric coordinator (P2) added, “Changes in regulations often lead to gaps in staff understanding and inconsistent application of policies.” This finding is echoed in the compliance audit findings, which highlight recurring issues with staff adherence to new compliance requirements, contributing to frequent regulatory breaches.

An example is when a clinician bills for an International Classification of Diseases code that has been deemed no longer usable. Furthermore, the compliance officer (P3) noted that inadequate training on recent regulatory updates exacerbates compliance issues. The staff training and development handbook confirms this, indicating that 40% of staff reported insufficient training on new compliance regulations.

Inadequate Training Programs. The analysis of common compliance hurdles at Organization X revealed inadequate training programs as a significant compliance hurdle, as evidenced by both interview findings and document reviews. The compliance officer (P3) highlighted that insufficient training programs are a major compliance hurdle, stating, “There’s a noticeable gap in staff training, which leads to frequent errors and noncompliance with documentation standards.” This assertion is corroborated by data from the staff training and development handbook, which shows that training sessions are infrequent and often lack updated content on compliance requirements. The handbook's review revealed that only 50% of staff have completed recent training modules on documentation practices, with many noting outdated materials as a barrier.

Additionally, the lead psychiatric coordinator (P2) noted that inconsistent training exacerbates compliance issues, stating, “newly hired staff along with those promoted to leadership positions are not adequately oriented on the latest compliance protocols, leading to frequent mistakes.” This aligns with findings in the 2023 quality assurance review reports for Quarter 3, which identified that 20% of compliance errors were linked to inadequate training of new staff. The incident report log further supports these findings

by documenting several incidents where inadequate training was directly linked to compliance failures.

Complex Documentation Requirements. The investigation into common compliance hurdles at Organization X reveals that complex documentation requirements are a significant challenge. Insights from interviews and document reviews underscore how these complexities impede compliance efforts. The compliance officer (P3) highlighted that Organization X's documentation requirements are often convoluted and exceed standard practices. P3 noted, "Navigating the complex documentation requirements creates frequent compliance issues, as staff struggle to meet all regulatory demands simultaneously." This is corroborated by the Medicaid Compliance Form 123B (2023), which details intricate documentation protocols that are challenging to adhere to consistently.

The lead psychiatric coordinator (P2) further emphasized the burden of these requirements, stating, "The extensive and sometimes redundant documentation processes make it difficult to ensure accuracy and completeness, leading to frequent compliance discrepancies." This viewpoint aligns with the 2021 state licensing document for health care facilities, which outlines multiple layers of required documentation that can overwhelm staff and lead to errors. Additionally, compliance audit findings for 2022 to 2024 show that frequent noncompliance issues are often traced back to the complexity of the documentation requirements, reflecting how these hurdles contribute to compliance challenges.

Resource Constraints. The exploration of common compliance hurdles at Organization X revealed resource constraints at the facility, supported by both interview data and document reviews. The COO (P1) emphasized that limited resources, particularly staffing and financial constraints, significantly impact the organization's ability to maintain compliance. P1 noted, "Our resource limitations often lead to shortcuts in compliance processes, risking regulatory breaches." This finding is substantiated by the strategic planning meeting minutes for January 2024, which document budgetary constraints and staffing shortages as major concerns impacting compliance efforts.

The lead psychiatric coordinator (P2) echoed these concerns, stating, "We frequently face challenges in adhering to compliance standards due to insufficient staffing levels." For example, each contracted facility should be provided one psychiatric provider (nurse practitioner or psychiatrist) to provide psychotropic medication management and one psychologist or social worker to provide psychotherapy and capacity screenings. Most often, the psychiatric nurse practitioner or psychiatrist has to assume both roles as the organization have a shortage of staff to provide the duties of a social worker or psychologist. The quality assurance review reports for Quarter 3 of 2023 corroborate this, reporting that 25% of noncompliance issues were linked to insufficient personnel and resources. Additionally, the compliance officer (P3) highlighted that resource constraints lead to inadequate training and support for compliance-related tasks. This perspective is supported by the staff training and development handbook, which reveals gaps in training programs due to budget limitations.

Other Organizational Results

Client Programs and Services

Based on the evidence collected, the evaluation of Organization X's client programs, services, and new initiatives reveals a mixed effectiveness. Firstly, the organization's client programs, such as the implementation of standardized documentation practices and regular training sessions, demonstrate positive outcomes. Interviews with the lead psychiatric coordinator (P2) highlighted that quarterly workshops effectively update clinicians on documentation guidelines, enhancing accuracy and compliance. This aligns with findings from Matthews and Stanhope (2020), emphasizing the role of ongoing training in improving documentation practices.

However, challenges persist, particularly in the consistency of documentation across departments and the impact of technology on accuracy. Clinicians cited time constraints and the complexity of electronic health record systems as barriers, impacting workflow efficiency and potentially compromising documentation quality (P1; Ebnehoseini et al., 2022). These findings echo literature emphasizing the need for user-friendly EHR interfaces to mitigate errors (Fine et al., 2022). New initiatives, such as enhanced compliance monitoring and quality assurance processes, have shown promise in addressing documentation discrepancies promptly. The compliance officer discussed newly hired staff that formulate a compliance team to implement of quarterly audits and compliance dashboards, which have improved error detection and corrective actions (P3; Zurynski et al., 2021).

Client-Focused Results

Based on the evidence collected, the organization's client-focused results demonstrate both strengths and areas for improvement. Positive outcomes include improved patient care through enhanced documentation accuracy and streamlined administrative processes. For instance, interviews with the lead psychiatric coordinator (P2) highlighted that standardized documentation templates have contributed to clearer patient records, facilitating better continuity of care. This finding is supported by Grzenda and Widge (2024), who emphasize the role of structured documentation in enhancing patient-provider communication and treatment outcomes.

However, challenges remain, particularly in addressing documentation errors that impact patient care. Clinicians noted instances where inaccuracies in medication administration records and discharge summaries led to delays in treatment and discharge planning (P1; Ebners et al., 2022). This underscores the need for robust quality assurance processes and ongoing training to mitigate risks associated with documentation errors.

Workforce-Focused Results

Based on the evidence collected, the organization's workforce-focused results reveal a nuanced picture of strengths and areas needing improvement. Positive findings highlight effective workforce training initiatives aimed at enhancing documentation skills and compliance with regulatory standards. The compliance officer emphasized the importance of regular compliance checks and audits, which have been instrumental in maintaining adherence to documentation protocols (P3). This approach is supported by

Dunbar et al. (2021), who stress the significance of structured training programs in fostering regulatory compliance within health care settings.

Conversely, challenges persist, such as workforce strain due to inadequate staffing levels and workload pressures. Interviews with frontline clinicians identified time constraints and the complexity of electronic health record (EHR) systems as barriers to accurate documentation (P2; Matthews & Stanhope, 2020). These issues underscore the need for targeted interventions to alleviate workload pressures and improve system usability.

Organizational Leadership and Governance

Based on the evidence collected, the organization's leadership and governance demonstrate a mixed evaluation with notable strengths and areas for enhancement. Positive findings highlight strong governance frameworks that support compliance and quality assurance initiatives. The COO (P1) emphasized the implementation of quarterly audits and random spot checks to ensure adherence to documentation standards and regulatory requirements. This proactive approach aligns with industry best practices recommended by E. Clark et al. (2022), emphasizing the importance of governance in maintaining documentation accuracy.

However, challenges were noted, particularly in the alignment of documentation practices with evolving industry standards. The COO acknowledged gaps in the implementation of best practices and ongoing efforts to benchmark against top-performing institutions (P1). These insights underscore the need for continuous improvement in governance strategies to address emerging regulatory complexities.

Financial and Marketplace Performance

Based on the evidence collected, the organization shows a strong financial performance underscored by strategic market positioning and effective resource management practices. The chief financial officer highlighted a consistent revenue growth of 8% annually over the past 3 fiscal years, attributed to successful service expansions and partnerships. This growth aligns with industry benchmarks for health care organizations, emphasizing sustainable financial health (Business Group on Health, 2024).

Marketplace performance reflects competitive strength with a 12% increase in patient referrals from neighboring communities, indicating growing regional trust and patient satisfaction, the chief financial officer shared. This achievement correlates with Borja and Galbraith (2019), who emphasize the importance of patient satisfaction in maintaining market share and reputation. However, challenges in cost management were noted, particularly in operational overheads impacting net margins. The chief financial officer highlighted ongoing initiatives to optimize operational efficiencies through technology integration and procurement strategies. These efforts align with NIST's (2020) recommendations for cost-effective health care management.

Implications for Individuals, Organizations, Communities, and/or Systems

The findings have significant implications across multiple dimensions—individuals, organizations, communities, and systems—based on the evidence gathered. For individuals, improved documentation practices can enhance patient safety and care coordination, reducing errors/inadequacies in collaborative treatment of the patient

(Ebbers et al., 2022). Clinicians' training and support in documentation can lead to better job satisfaction and reduced burnout, fostering a supportive work environment (DesRoches et al., 2020).

At the organizational level, standardizing documentation practices and implementing robust quality assurance processes can mitigate compliance risks and improve operational efficiencies (E. Clark et al., 2022). Enhanced leadership in governance, as evidenced by clear policies and effective oversight, supports strategic decision-making and organizational resilience (Fine et al., 2022). In communities, accurate documentation supports public health initiatives and enables data-driven policymaking, benefiting population health outcomes (Matthews & Stanhope, 2020).

Moreover, transparent communication of compliance issues and resolutions builds trust with stakeholders and enhances organizational credibility (Volk et al., 2022). Systemically integrating user-friendly technology and maintaining updated documentation standards can drive systemic improvements in health care delivery and regulatory compliance (Zurynski et al., 2021). These implications underscore the interconnectedness of effective documentation practices with broader health care quality and sustainability goals, emphasizing the need for continuous improvement and adaptation in response to evolving health care landscapes.

Social Impact

Effective implementation of improved documentation practices can lead to positive social changes across various dimensions. Firstly, at the individual level, enhanced patient care through accurate and comprehensive documentation contributes to

improved health outcomes, reduced medical errors, and enhanced patient satisfaction (Ebbers et al., 2022). This translates into better quality of life for patients and their families, fostering trust in health care systems.

Organizationally, streamlined documentation processes and adherence to industry standards promote efficiency and cost-effectiveness, optimizing resource allocation and operational workflows (E. Clark et al., 2022). This can result in reduced health care costs and improved resource utilization, benefiting both health care providers and payers. At the community level, standardized documentation supports evidence-based health care practices and facilitates public health initiatives (Matthews & Stanhope, 2020).

Accurate data collection and reporting enable proactive disease prevention strategies and epidemiological research, contributing to healthier communities and reduced health care disparities. Systemically, advancements in documentation technology and practices enhance data security and interoperability, promoting seamless information exchange across health care settings (Zurynski et al., 2021). This supports collaborative care models and enables continuity of care, particularly for vulnerable population.

Strengths and Limitations of the Study

One of the notable strengths was the flexible qualitative design, which allowed for adjustments based on emerging data. This adaptability, as DesRoches et al. (2020) asserted, is crucial for capturing the complexity of compliance issues, ensuring that the study could evolve in response to participant feedback and new insights. This flexibility enhanced the depth of the findings by enabling the research to address unexpected themes effectively.

Moreover, establishing a strong working relationship with interviewees significantly contributed to the study's success. By building trust through pre-interview meetings and follow-up communications, the research facilitated open discussions about sensitive topics such as compliance gaps and staff training. This rapport not only improved the quality of the data collected but also ensured that the perspectives of key stakeholders, including the COO and compliance officer, were fully represented aligning with DesRoches et al.'s (2020) assertions. The depth and honesty of the interviews provided valuable insights into the practical challenges faced by the organization.

Another strength was the adaptive use of the Baldridge Framework (NIST, 2021). This framework offered a structured approach to assess organizational performance and identify areas for improvement. By focusing on leadership and operational processes, the framework provided a comprehensive lens for analyzing compliance challenges. For instance, applying the framework helped pinpoint deficiencies in documentation practices and staff training, which were crucial for understanding the root causes of compliance issues. This structured approach ensured that the analysis was grounded in established best practices.

The utility of data analysis tools also played a significant role in the study's success. The use of NVivo for qualitative data analysis was particularly effective in managing and interpreting large volumes of interview data. NVivo's capabilities for coding and theme identification allowed for a detailed and systematic analysis of complex data, revealing patterns and trends essential for developing actionable

recommendations (Human Metrics Jung Typology Test™, 2024). The efficiency and precision of NVivo greatly contributed to the robustness of the analysis.

Recorded interviews, including tape recordings and transcriptions, ensured accurate and detailed documentation of participants' responses. This method provided a reliable record of the discussions, allowing for thorough review and verification of the data. For example, verbatim transcriptions of interviews with the compliance officer highlighted specific concerns about training gaps, which were critical for understanding compliance challenges (see NIST, 2021). The accuracy and reliability of this data documentation enhanced the overall credibility of the study's findings.

Despite these strengths, several limitations were encountered. One significant challenge was data reliability, particularly due to the reliance on self-reported data from interviews and secondary documents. Variations in responses from different participants could affect the consistency of the findings, potentially introducing bias into the conclusions as also noted by DesRoches et al. (2020). Additionally, the use of secondary and archival documents presented limitations, as these sources might not always reflect the most current practices or regulations. Outdated information in documents like the Medicaid Compliance Form 123B (2023) could affect the accuracy and comprehensiveness of the analysis (NIST, 2021).

Furthermore, the time required for data analysis extended beyond initial expectations, impacting the overall study schedule. The process, which took a month instead of the anticipated week, affected the integration of findings and the development of recommendations. This experience underscores the importance of allocating sufficient

time for thorough data analysis and planning for potential delays (Human Metrics Jung Typology Test™, 2024).

Also, the complexity of documentation requirements posed challenges for both staff and researchers. The intricate documentation protocols, as outlined in secondary sources, complicated the analysis process and affected the efficiency of the research. Extensive and often redundant documentation requirements made it difficult to ensure accuracy and completeness in compliance practices and research findings (see NIST, 2021). These limitations highlight areas for improvement and offer valuable lessons for future research endeavors.

During the course of the study, several unanticipated limitations and outcomes emerged that influenced the research findings significantly. One notable limitation was the extended duration required for data analysis. Initially projected to be completed within a week, the analysis process stretched to a full month. This delay, primarily due to the large volume of qualitative data and the complexity of coding themes using NVivo, impacted the overall timeline of the study. The extended analysis period affected the integration of findings and the formulation of recommendations, as additional time was needed to ensure thorough and accurate interpretation of the data (Regehr et al., 2013). This delay also meant that the study's schedule had to be adjusted, potentially affecting the timely delivery of insights and recommendations to the organization.

Another unexpected limitation involved the reliability of self-reported data from interviews. Despite establishing a strong rapport with participants, discrepancies in responses were noted. For example, while the COO and compliance officer provided

detailed accounts of regulatory compliance gaps, the subjective nature of their responses introduced variability in the data. This variability raised concerns about the consistency and accuracy of the findings, as different perspectives on compliance issues could lead to conflicting interpretations (Human Metrics Jung Typology Test™, 2024). These inconsistencies necessitated additional verification steps and triangulation with secondary data sources to strengthen the reliability of the conclusions.

Additionally, the complexity of documentation requirements posed a challenge that was not fully anticipated. The intricate and sometimes redundant documentation protocols, as highlighted by the compliance officer, created difficulties in both data collection and analysis. For instance, the detailed nature of the Medicaid Compliance Form 123B (2023) and the 2021 state licensing document for healthcare facilities made it challenging to align these requirements with the actual compliance issues observed. This complexity led to potential gaps in understanding how well current practices matched the regulatory expectations, affecting the depth of analysis and the clarity of recommendations (see NIST, 2021).

Moreover, the reliance on secondary and archival documents revealed limitations in reflecting the most current practices and regulations. Some documents, such as the clinical documentation policy and procedure manual, contained outdated information that did not fully align with recent regulatory updates, according to the 2022 CMS audit report for behavioral health services. This discrepancy between documented practices and current standards impacted the ability to provide accurate assessments and recommendations based on the most up-to-date information.

Section 5: Recommendations and Conclusions

Introduction

In Section 4, I evaluated Organization X's documentation practices, analyzing the effectiveness of existing programs and initiatives. It assessed client-focused, workforce-focused, leadership and governance, and financial performance results. The implications for individuals, organizations, and communities were explored, with attention to potential positive social change. The strengths and limitations of the study were discussed, including any unexpected outcomes and their impact on the findings. In this section, I will cover the recommendations and conclusions derived from the analysis of each practice question for the current study. It will detail the proposed solutions, implementation and evaluation procedures, and plans for disseminating the results to the organization.

Recommendations

Recommendations for Practice

Recommendations for Addressing Barriers in Accurate Documentation at Organization X

Implement Administrative Days and Optimize Documentation Processes. Given that the findings revealed significant time constraints and workload pressures, with clinicians reporting challenges in balancing patient care and documentation (P2) and supporting data from the incident report log, it is recommended that Organization X implement a dedicated administrative day each week for clinicians to focus solely on documentation. Additionally, optimizing documentation processes through tools like pre-

populated EHR templates and voice recognition software can further streamline data entry (Abdul et al., 2024; Nguyen et al., 2024).

McNamara (2006) noted the importance of realistic and flexible planning in integrating new processes into daily operations. For example, Organization X may introduce administrative days to manage documentation without affecting patient care, aligning with McNamara's (2006) recommendations for actionable, realistic solutions. Research supports the effectiveness of dedicated time for administrative tasks in reducing clinician burnout and improving documentation accuracy (Adeniyi et al., 2024; Saxena et al., 2024). Moreover, evidence suggests that EHR customization and technological support can significantly enhance data entry efficiency and accuracy (Myklebust et al., 2024; Meier-Diedrich et al., 2024). Thus, the implementation of these strategies could address the identified gaps in documentation practices and improve overall patient care quality.

Upgrade EHR System and Enhance Technical Support. Given that the findings revealed clinicians struggling with complex EHR interfaces (P1) and frequent technical issues noted in the 2023 EHR usage reports, it is recommended that Organization X upgrade to a more user-friendly EHR system with an intuitive interface. Establishing a dedicated IT support team to provide real-time assistance and conducting regular system audits will address technical issues promptly. Comprehensive, scenario-based EHR training programs should also be implemented to improve staff proficiency. McNamara (2006) emphasizes the need for clear action plans and realistic integration of technology. For instance, upgrading the EHR system to enhance usability and reduce

documentation errors aligns with McNamara's (2006) principles of effective and adaptable technological integration. This recommendation is also supported by literature which asserts that user-friendly EHR systems and robust technical support significantly improve clinical documentation and reduce errors (Diya & Ghezzi, 2024; Kalsy et al., 2024).

Develop and Enforce Uniform Documentation Guidelines. Because the findings revealed inconsistencies in documentation practices across departments (P3) and gaps highlighted in the clinical documentation policy and procedure manual, it is recommended that Organization X develop and enforce standardized documentation protocols. This includes creating a comprehensive manual outlining specific procedures and data entry standards for all departments. Implementing these guidelines should be phased, starting with departments experiencing the most significant discrepancies. Training sessions should be conducted to ensure compliance, and a monitoring system with regular audits should be established. McNamara (2006) asserts the importance of collaborative planning and alignment for effective implementation. For example, Organization X may create and enforce uniform guidelines to enhance data accuracy and patient care coordination, in line with McNamara's (2006) recommendations. This approach is further supported by literature emphasizing the need for standardized protocols to improve documentation quality and consistency across health care settings (Abdul et al., 2024; Nguyen et al., 2024).

Expand Staffing and Enhance Resource Allocation. Given that the findings revealed insufficient staffing levels contributing to clinician overload and documentation

errors (P1) and high levels of stress documented in the Annual Performance Evaluation Summaries (2023), it is recommended that Organization X increase recruitment efforts to hire additional clinical staff and allocate administrative tasks to nonclinical personnel or documentation specialists. Implementing a triage system to manage clinical and documentation tasks effectively and providing mental health support programs to address staff burnout are also recommended. McNamara (2006) emphasizes aligning resources with operational goals. For instance, Organization X may expand staffing and allocate resources to reduce clinician stress and improve documentation quality, in line with McNamara's (2006) principles of effective resource alignment. This recommendation is further supported by literature highlighting the positive impact of adequate staffing and support systems on reducing clinician stress and improving documentation accuracy (Adeniyi et al., 2024; Saxena et al., 2024).

Revamp and Expand Training Programs. Given that the findings revealed inadequate training programs contributing to frequent documentation errors (P3) and gaps noted in the staff training and development handbook, it is recommended that Organization X redesign training programs to include comprehensive, hands-on training with the EHR system. This should involve practical, scenario-based exercises and provide ongoing learning resources. Regular refresher courses should be implemented to keep skills updated. McNamara (2006) suggests that detailed action plans for training ensure staff are well-prepared. For example, Organization X may revamp training programs to include practical scenarios, thereby enhancing documentation accuracy as supported by McNamara's (2006) recommendations. This approach is further substantiated by

literature advocating for continuous, interactive training to improve EHR proficiency and reduce documentation errors (Myklebust et al., 2024; Saxena et al., 2024).

Implement a Centralized Communication Strategy. Given that the findings revealed poor interdepartmental communication leading to inconsistent documentation (P2) and the need for better communication noted in the board of directors meeting minutes, it is recommended that Organization X develop a centralized communication platform, such as a secure messaging system or internal intranet. This platform should streamline information sharing and facilitate regular interdepartmental meetings to align documentation practices. Gathering stakeholder input to design this system and ensuring effective communication are critical. McNamara (2006) emphasizes the need for collaborative planning and alignment for successful implementation. For example, Organization X may introduce a centralized communication strategy to address these gaps, as McNamara (2006) suggests, to enhance overall efficiency. This recommendation is supported by research advocating for improved communication tools to reduce documentation inconsistencies and enhance coordination across departments (Meier-Diedrich et al., 2024; Diya & Ghezzi, 2024).

Upgrade Technological Infrastructure and Provide Support. Given that the findings revealed technological barriers, including complex EHR interfaces and frequent system downtimes (P2), with issues reflected in the incident report log, it is recommended that Organization X invest in advanced EHR technologies featuring enhanced usability and robust data entry capabilities. Providing continuous technical support and conducting regular system audits will help address technical issues promptly.

Ensuring the seamless integration of new technologies and implementing comprehensive training programs for staff will also mitigate these technological barriers. McNamara (2006) highlights the importance of realistically integrating technology and aligning it with operational needs. For instance, Organization X may upgrade its technological infrastructure to reduce documentation disruptions, aligning with McNamara's (2006) principles of effective technology integration. This recommendation is further supported by literature emphasizing the need for advanced EHR systems to overcome usability challenges and improve documentation accuracy (Abdul et al., 2024; Nguyen et al., 2024).

Recommendations for Addressing the Impact of Inconsistent Documentation on Patient Care at Organization X

Implement a Comprehensive EHR System Upgrade. Given that the findings revealed delays in emergency treatments and medication errors due to outdated documentation practices (see P1's responses and the clinical documentation policy and procedure manual), Organization X should invest in upgrading to GHERIMED, an EHR system specifically tailored for the geriatric clientele that Organization X serves. This system should include features such as real-time data entry, automated alerts for missing or incomplete documentation, and standardized templates that comply with the regulations of the Commonwealth and CMS. For instance, automated flags for critical data fields and integration with existing emergency care protocols can significantly reduce delays in patient care. McNamara (2006) asserts that such upgrades enhance accuracy and efficiency, addressing the 15% of cases with documented delays. This

recommendation is further supported by literature emphasizing the need for advanced EHR systems to improve documentation and patient care (Kalsy et al., 2024; Adeniyi et al., 2024).

Centralize Patient Documentation Within a Single EHR Platform. Given that the findings revealed inefficiencies in workflow and care coordination due to fragmented documentation practices (see P1's responses and the patient satisfaction survey results), Organization X should consolidate all patient records into a single EHR platform, such as Allscripts. This centralization should integrate features for billing, scheduling, and clinical documentation, with the new system automatically syncing visit dates and Current Procedural Terminology codes to reduce manual spreadsheet use. McNamara (2006) supports that such consolidation enhances workflow efficiency and reduces duplicative efforts, addressing the 20% drop in patient satisfaction noted. This recommendation aligns with research emphasizing the benefits of integrated EHR systems for improving care coordination and operational efficiency (Myklebust et al., 2024; Saxena et al., 2024).

Establish and Enforce Uniform Documentation Standards. Given that the findings revealed significant communication barriers due to inconsistent documentation (see P1's responses and the incident report log), Organization X should develop and enforce a set of uniform documentation standards across all departments. This includes creating standardized forms and templates in the EHR system and mandating quarterly training sessions for staff. For example, clinicians should utilize uniform templates for progress notes and patient care plans to ensure consistency. McNamara (2006) highlights

that standardization reduces communication errors and enhances care coordination, directly addressing issues noted in the clinical documentation policy and procedure manual and quality assurance review reports. This recommendation is further supported by literature which emphasizes the importance of standardized documentation practices in improving clinical communication and patient outcomes (Meier-Diedrich et al., 2024; Saxena et al., 2024).

Adopt Standardized Documentation Framework Within the EHR System. Given that the findings revealed challenges in tracking patient outcomes due to inconsistent data entries (see P1's responses and the EHR -usage reports), Organization X should implement a standardized documentation framework within the EHR system. This framework should incorporate pre-defined data entry fields, validation checks, and automated reporting tools to enhance data accuracy and consistency. For example, the EHR system should feature predefined templates specifically designed for outcome tracking and include automated alerts to notify staff of missing or incomplete data. McNamara (2006) asserts that such standardized frameworks are crucial for accurate patient outcome evaluation, directly addressing the 22% of audits with tracking issues noted in the quality assurance review reports. This recommendation aligns with literature that emphasizes the necessity of structured documentation systems to improve data reliability and patient care outcomes (Abdul et al., 2024; Nguyen et al., 2024).

Implement an Automated Billing and Coding System. Given that the findings revealed increased administrative burden and resource drain due to documentation errors (P1; Annual Performance Evaluation Summaries), Organization X should deploy an

automated billing and coding system integrated with the EHR, such as Optum360. This system should include real-time coding suggestions, automated error detection, and integration with insurance claim processing. For instance, Optum360 should automatically flag coding discrepancies and offer correction suggestions before submission, reducing manual errors and rework. McNamara (2006) supports that such automation streamlines administrative tasks, enhances accuracy, and reduces the manual corrections required, addressing the 30% increase in administrative workload reported. Literature reinforces that automation in documentation and coding can significantly decrease administrative burdens and improve efficiency (Diya & Ghezzi, 2024; Adeniyi et al., 2024).

Recommendations for Addressing Compliance Hurdles at Organization X

Establish a Regulatory Compliance Monitoring System. Given that the findings revealed frequent noncompliance due to evolving regulatory requirements (see P1's responses and the 2022 CMS audit report for behavioral health services), it is recommended that Organization X implement a regulatory compliance monitoring system. This system should include automated updates on regulatory changes, real-time compliance tracking, and alerts for upcoming deadlines. For instance, Organization X could adopt a platform like ComplyTrack, which integrates with existing EHR systems to provide real-time updates on International Classification of Diseases code changes and billing guidelines. McNamara (2006) emphasizes the importance of proactive compliance management and aligning systems with regulatory needs. This recommendation is backed by literature which emphasizes the necessity of timely regulatory updates and efficient

compliance mechanisms to mitigate risks and ensure adherence (Kalsy et al., 2024; Saxena et al., 2024). This approach will address the documented gaps in adherence by ensuring timely updates and reducing the risk of noncompliance.

Enhance and Standardize Training Programs. Given that the findings revealed inadequate training programs leading to compliance issues (see P3's responses and the staff training and development handbook), it is recommended that Organization X overhaul its training programs. This overhaul should include developing a standardized training curriculum for all staff, incorporating regular updates on compliance regulations. For instance, Organization X could implement a quarterly training program using an online learning management system like Cornerstone, which ensures all staff receive timely updates on new compliance requirements. McNamara (2006) supports that consistent training reduces errors and improves adherence to regulatory standards. This recommendation is backed by literature which emphasizes the need for continuous education and regular updates to maintain compliance and improve overall adherence to regulatory standards (Myklebust et al., 2024; Saxena et al., 2024). This approach will address the 40% of staff reporting insufficient training and enhance regulatory compliance across the organization.

Simplify and Standardize Documentation Requirements. Given that the findings revealed complex documentation requirements as a hurdle (P3; Medicaid Compliance Form 123B, 2023), Organization X should streamline and standardize its documentation processes. This could involve consolidating redundant documentation forms and creating a unified documentation protocol. For example, Organization X could

introduce a single, user-friendly template for all documentation needs, reducing complexity and improving accuracy. McNamara (2006) emphasizes that simplifying documentation processes enhances compliance and reduces errors. This recommendation is supported by literature which highlights that streamlined documentation procedures are essential for reducing administrative burden and improving overall accuracy (Abdul et al., 2024; Nguyen et al., 2024). By addressing the compliance challenges noted in the state licensing document for health care facilities and Medicaid Compliance Form 123B, this approach will help ensure consistency and improve adherence to regulatory standards.

Allocate Resources for Compliance and Training. Given that the findings revealed resource constraints impacting compliance efforts (see P1's responses and the strategic planning meeting minutes for 2024), Organization X should increase its budget allocation for compliance and training programs. This should include hiring additional compliance staff and investing in training resources. For example, Organization X could allocate funds to hire dedicated compliance officers and enhance training programs, such as providing additional workshops and support materials. McNamara (2006) underscores that adequate resources are crucial for maintaining high compliance standards. This recommendation is supported by literature which emphasizes that increased investment in compliance infrastructure and training is essential for improving adherence and reducing noncompliance issues (Adeniyi et al., 2024; Meier-Diedrich et al., 2024). Addressing the 25% of noncompliance issues linked to insufficient staffing reported in the quality

assurance review reports will help ensure effective implementation and monitoring of compliance protocols.

Recommendations for Enhancing Client Programs and Services

Upgrade EHR Systems. Given that the findings revealed inefficiencies and gaps in the current EHR system (see P1's responses and the EHR usage reports for 2023), Organization X should initiate a phased upgrade of its EHR system. This process should start with a comprehensive needs assessment involving department heads to identify critical functionalities missing from the current system. For example, the assessment could focus on areas like real-time data entry, automated reminders for medication administration, and integration with lab systems and mobile health applications. The upgrade should prioritize the selection of an advanced EHR platform that supports these functionalities and integrates seamlessly with existing technologies. McNamara (2006) asserts that action planning must align technology improvements with strategic objectives, ensuring smoother transitions and improved care outcomes. This recommendation is supported by literature which emphasizes that aligning EHR upgrades with operational needs enhances system effectiveness and supports better patient outcomes (Diya & Ghezzi, 2024; Saxena et al., 2024).

Standardize Documentation Procedures. Given that the findings revealed inconsistencies in documentation practices across departments (see P3's responses and the clinical documentation policy and procedure manual), Organization X should develop a comprehensive hospital-wide documentation policy. This should start with forming a task force of nursing, administrative, and IT staff to draft and pilot standardized

procedures. Each department should designate "documentation champions" to oversee adherence, provide training, and conduct quarterly audits. McNamara (2006) highlights the need for collaborative planning to ensure that documentation procedures are relevant and adaptable to evolving regulatory requirements. This recommendation aligns with literature supporting standardized documentation to enhance consistency and compliance (Kalsy et al., 2024; Saxena et al., 2024). By implementing this policy, Organization X will address documentation inconsistencies and improve overall quality and regulatory adherence.

Expand Training for Clinical Staff. Given that the findings revealed insufficient training programs impacting EHR proficiency and regulatory compliance (see P3's responses and the staff training and development handbook), Organization X should implement a continuous education program for clinical staff. This program should offer diverse learning formats, including live workshops, online modules, and mobile app-based learning, to accommodate varied schedules. Participation should be mandatory and linked to annual performance reviews, with certificates awarded upon course completion. McNamara (2006) underscores the importance of developing action plans that prioritize long-term learning to achieve sustained improvements in documentation and patient care. This recommendation is supported by literature advocating for ongoing education to enhance staff competency and compliance (Abdul et al., 2024; Nguyen et al., 2024).

Recommendations for Enhancing Client-Centered Workforce

Strategies for Addressing Workforce Burnout. Given that the findings revealed significant staff burnout due to high workloads and inadequate support (P1; Annual

Performance Evaluation Summaries, 2023), Organization X should establish a comprehensive wellness program. This program should include flexible scheduling, on-site mental health counselors, and biweekly debriefing sessions to support staff well-being. Additionally, an internal feedback system should be implemented to allow staff to anonymously report concerns about their workloads. Management should also monitor overtime hours and staff satisfaction rates to make necessary adjustments. McNamara (2006) emphasizes the importance of creating relevant, realistic, and flexible plans to address workforce challenges effectively. This approach aligns with recommendations for tailored wellness initiatives that respond to staff feedback and evolving needs (Adeniyi et al., 2024; Myklebust et al., 2024).

Incentivize Training Completion. Given that the findings revealed challenges in maintaining high documentation standards due to insufficient professional development (see P3's responses and the staff training and development handbook), Organization X should implement a system of financial incentives for staff who complete relevant professional development courses. This system should include bonuses, tuition reimbursement, and continuing education credits specifically for courses related to documentation and patient safety protocols. Performance metrics, such as reduced error rates, should be monitored to evaluate the effectiveness of these training initiatives. Staff who demonstrate significant improvement should be eligible for additional incentives. McNamara (2006) supports integrating financial incentives into action plans as a means to align organizational goals with enhanced staff performance and retention. Research supports this recommendation by highlighting the positive impact of financial incentives

on employee motivation and performance improvement (Meier-Diedrich et al., 2024; Saxena et al., 2024).

Implement a Superuser Support Program. Organization X should create a "superuser" program where experienced staff are trained to assist peers with complex EHR functions. Superusers, selected for their expertise and mentorship capabilities, will be available in each department during shifts to provide real-time support, troubleshoot problems, and conduct informal training sessions. This initiative aims to reduce downtime caused by technical issues and enhance staff confidence in using EHR systems. McNamara (2006) emphasizes the importance of integrating practical roles and performing reality checks in action planning to ensure that superuser positions are effectively defined and implemented. Research supports this approach by demonstrating that peer-led support programs improve system usability and staff proficiency (Baker et al., 2021; Rubin et al., 2020).

Recommendations for Enhancing Organizational Leadership and Governance

Form a Dedicated Compliance Team. Organization X should create a compliance oversight committee comprising senior leaders, legal experts, and representatives from key clinical departments. This committee should meet monthly to review regulatory updates, ensure their swift integration into hospital practices, and prepare for potential audits. Additionally, the committee should develop a comprehensive policy manual detailing each department’s responsibilities in adhering to state and federal regulations. McNamara (2006) emphasizes that action planning must incorporate compliance goals throughout the organization to align with overall governance strategies.

Research supports this recommendation by highlighting that structured oversight and regular policy updates improve compliance and audit readiness (Diya & Ghezzi, 2024; Kalsy et al., 2024).

Enhance Government Accountability. Organization X should implement an internal accountability system by developing a digital dashboard that tracks key performance indicators related to documentation errors, patient outcomes, and regulatory compliance. Department heads should be responsible for monitoring their teams' performance, and those who consistently meet or exceed standards should be publicly recognized and rewarded. Governance meetings should incorporate regular reviews of the dashboard, ensuring leaders are held accountable for improvements. McNamara (2006) recommends that Collaborative Planning focus on flexible governance models, ensuring accountability measures adapt as organizational goals evolve. Research supports this recommendation by demonstrating that digital performance tracking and accountability systems enhance organizational effectiveness and improve compliance (Abdul et al., 2024; Nguyen et al., 2024).

Introduce Cross-Department Learning. Organization X should establish a quarterly learning workshop where department leaders share documentation best practices and innovative patient care solutions. These workshops should be co-led by staff from different departments to encourage the cross-pollination of ideas. The outcomes of these sessions should be documented, with action items integrated into departmental plans to ensure alignment in reducing documentation errors and enhancing care delivery. McNamara (2006) suggests that Developing Vision for Change requires

fostering interdepartmental collaboration to support sustained improvements. Research supports this recommendation by showing that interdepartmental learning and collaboration lead to more effective problem-solving and innovation in health care settings (Adeniyi et al., 2024; Saxena et al., 2024).

Recommendations for Enhancing Financial and Marketplace Performance

Automate Administrative Processes. Organization X should adopt automation software for routine tasks such as appointment scheduling, prescription refills, and billing. Prior to implementation, a thorough cost-benefit analysis should be conducted to ensure that the new technology integrates seamlessly with existing systems. Automation will help reduce labor costs and minimize errors in scheduling and billing, thereby enhancing financial performance. McNamara (2006) underscores that Purpose and Goals must align when introducing automation to ensure that cost reductions do not compromise service quality. The adoption should be phased, with regular feedback loops established to adjust the system as needed. Research supports this approach by demonstrating that phased implementation and ongoing evaluation of automation systems improve overall efficiency and service quality (Myklebust et al., 2024; Saxena et al., 2024).

Expand Strategic Partnerships. Organization X should forge partnerships with regional health care providers to establish referral agreements, particularly for specialty services. These partnerships will enhance patient inflow and bolster the hospital's marketplace presence. Agreements should include cobranding initiatives and joint marketing campaigns to maximize visibility. Such collaborations will create additional

revenue streams and reinforce Organization X's reputation in the community. McNamara (2006) emphasizes Alignment and Integration in expanding partnerships, ensuring that these collaborations align with Organization X's long-term financial and service delivery goals. Research supports this approach by highlighting that strategic partnerships improve market positioning and financial performance (Meier-Diedrich et al., 2024; Diya & Ghezzi, 2024).

Invest in Workforce Retention. Organization X should develop a multi-tiered workforce retention strategy, incorporating mentorship programs, tuition reimbursement for continued education, and career advancement opportunities. Monthly tracking of staff turnover metrics should be implemented to address factors affecting retention, such as workload and professional growth. Additionally, leadership training programs should be offered to mid-level staff to cultivate future leaders, thereby enhancing organizational stability. McNamara (2006) stresses that Developing Vision for Change necessitates investments in workforce retention to maintain consistent organizational performance over the long term. Research supports this approach by demonstrating that comprehensive retention strategies enhance employee satisfaction and reduce turnover (Abdul et al., 2024; Nguyen et al., 2024).

Recommendations for Boosting Social Impact

Expand Mobile and Telehealth Services. Organization X should expand its mobile health clinics to reach rural and underserved communities, offering primary care, screenings, and follow-ups to those with limited health care access. These mobile services should include mental health support and chronic disease management,

particularly for diabetes and hypertension. A target of increasing mobile clinic visits by 25% over the next 2 years should be set. McNamara (2006) supports Developing Vision for Change through strategic initiatives that promote long-term community engagement and adaptability in services. Research indicates that expanding mobile health services enhances access to care and improves health outcomes in underserved populations (Kalsy et al., 2024; Adeniyi et al., 2024).

Launch Health Literacy Campaigns. Organization X should launch a health literacy campaign aimed at educating patients about medication adherence, preventive care, and chronic disease management. The campaign should feature easy-to-understand pamphlets, online resources, and multilingual workshops. Partnering with local community organizations will help distribute educational materials and conduct informational sessions in underserved areas. McNamara (2006) suggests that Action Plans should have measurable impact goals. For Organization X, this could involve increasing patient understanding of care instructions by 20% over the next year. Research supports that targeted health literacy initiatives improve patient outcomes and adherence to treatment plans (Saxena et al., 2024).

Promote Leadership Diversity. Organization X should implement a leadership development program designed to enhance diversity in senior roles by providing mentorship, training, and scholarships to underrepresented staff members. The program should set specific, measurable goals, such as increasing minority representation in leadership positions by 15% within 5 years. McNamara (2006) emphasizes Collaborative Planning for diversity initiatives, ensuring they align with broader organizational goals

for inclusivity and social impact. Additionally, Organization X's action plan should include tracking participation and success rates to monitor progress and ensure continuous improvement. Research supports that leadership development programs focused on diversity contribute to more equitable and effective organizational leadership (Myklebust et al., 2024; Meier-Diedrich et al., 2024).

Recommendations for Future Studies

Future researchers should focus on several key areas to address barriers in accurate documentation. Firstly, studies could examine the impact of implementing administrative days and optimizing documentation processes on clinician workload and accuracy. Research might involve assessing the effectiveness of administrative days and tools like EHR templates and voice recognition in reducing errors and clinician stress. Secondly, evaluating the benefits of upgrading EHR systems and enhancing technical support is crucial, focusing on user interface improvements and real-time assistance. Thirdly, research should explore the effects of standardized documentation guidelines and training programs on consistency and quality across departments.

Additionally, researchers could investigate the impact of increased staffing and resource allocation on documentation practices and clinician burnout. Finally, examining the implementation of centralized communication platforms and advanced technological infrastructure may provide insights into improving interdepartmental coordination and reducing documentation errors. These studies would align with McNamara's (2006) recommendations for practical, flexible solutions.

Implementation and Evaluation Strategies

I outline a detailed plan to implement and evaluate the recommendations. This plan provides sufficient detail to enable the Organization X board of directors, COO, lead psychiatric coordinator, compliance officer, and other stakeholders; both internal and external; to execute and oversee the plan effectively. The strategy is presented in a structured, step-by-step manner, as detailed in Table 1. This approach is designed to improve Organization X's documentation practices within a condensed timeframe, considering the organization's resource constraints.

Table 1

Implementation and Evaluation Strategies

Phase	Phase description	Timeline
Phase 1: Assemble Project Team and Define Roles	Establish the project team, assign roles, and set up communication channels. Secure necessary resources and create detailed project timelines.	Month 1
Phase 2: Develop and Conduct Training Sessions	Design training materials and conduct sessions to familiarize staff with new documentation practices and tools. Evaluate staff readiness through assessments and feedback.	Month 2
Phase 3: Implement New Documentation Practices	Roll out new documentation procedures across the organization. Integrate tools into daily workflows and provide ongoing support to address any challenges.	Month 3–11
Phase 4: Monitor and Collect Feedback	Assess the implementation effectiveness by gathering staff feedback, reviewing documentation quality, and measuring compliance improvements. Conduct regular review meetings to discuss progress.	Month 12–14
Phase 5: Final Evaluation and Reporting	Compile a final report summarizing the implementation outcomes, challenges faced, and lessons learned. Present the report to the board of directors and other key stakeholders. Provide recommendations for further improvements if necessary.	Month 15

In Phase 1, Organization X should establish a project team comprising key personnel from clinical, IT, and compliance departments. The COO may appoint a project manager to coordinate efforts. Specific roles include the clinical irector leading the development of new documentation guidelines and the IT manager handling the integration of the new EHR system. For instance, the clinical director may design new patient intake forms and standardize documentation procedures, while the IT manager may configure the EHR system to support these new guidelines. Regular weekly status meetings and a shared project dashboard should be set up to facilitate communication.

In Phase 2, training materials should be developed by the training coordinator, with input from the clinical director and IT manager. Clinical staff may participate in hands-on workshops, using simulated patient scenarios to practice new documentation techniques. For example, clinicians may complete practice documentation on mock patient cases using the updated EHR system. The IT team should provide technical support, including troubleshooting guides and in-person assistance during training. Assessments, such as quizzes and practical tests, should be used to gauge understanding and identify areas where additional support may be needed.

In Phase 3, the project manager should oversee the rollout of new documentation practices, ensuring that all staff adhere to updated protocols. The IT team may assist in integrating new EHR tools and resolving technical issues. For instance, if clinicians encounter difficulties with the new patient intake forms, IT support should be available to provide immediate assistance. Supervisors, including the lead psychiatric coordinator, may conduct regular audits of documentation practices to ensure compliance. A detailed

checklist should be used to track implementation progress, addressing any operational challenges, such as the phased removal of outdated documentation systems.

In Phase 4, a feedback mechanism should be implemented, including surveys and focus groups, to gather input from clinical and administrative staff. The compliance officer may oversee the collection and analysis of feedback. For instance, clinicians may complete surveys about their experiences with the new system, while focus groups may provide detailed insights into specific challenges faced. The project team should review sample patient records to ensure they meet new standards. Data analytics tools may be used to identify trends, such as frequent documentation errors. Biweekly review meetings should be held to discuss feedback and make necessary adjustments.

In Phase 5, a comprehensive final evaluation should be conducted by the project manager, focusing on metrics such as documentation accuracy and staff compliance rates. The evaluation report should include detailed analyses and examples, such as a reduction in documentation errors or improved compliance rates. The board of directors and other stakeholders may receive the final report, which should include visual aids like graphs and charts to illustrate progress. Recommendations for future improvements, such as additional training sessions or system upgrades, should be included to ensure continued effectiveness and refinement of the documentation practices.

Dissemination Plan

This research study aims to address Organization X's documentation challenges and support both the researcher's academic objectives and the organization's operational goals. Following the study's completion, the researcher will meet with the COO to

present a comprehensive overview of findings and actionable recommendations. This presentation will be delivered using a PowerPoint deck, which will include detailed slides on research methods, key findings, and step-by-step recommendations. For example, the presentation will feature charts illustrating current documentation issues and proposed solutions, such as implementing administrative days and optimizing EHR processes. I will emphasize the necessity for a strategic planning session involving the board of directors and relevant staff. This session will focus on aligning the proposed changes with organizational goals, setting timelines for implementation, and identifying resources needed. The aim is to equip Organization X leadership with a clear, actionable plan to improve documentation practices and enhance overall efficiency.

Conclusion

Based on the comprehensive analysis and findings presented, it is evident that addressing documentation challenges at Organization X is critical for enhancing organizational performance and patient care. I identified key issues such as time constraints, outdated EHR systems, inconsistent documentation practices, and insufficient training (see P1's responses and the incident report log; see also McNamara, 2006). These challenges significantly impact both the quality of patient care and staff satisfaction. The proposed solutions, including the implementation of dedicated administrative days for documentation (McNamara, 2006), upgrading to a user-friendly EHR system (see P2's responses and the EHR usage reports), and standardizing documentation protocols (see P3's responses and the clinical documentation policy and procedure manual), are grounded in best practices and aimed at addressing specific needs at Organization X.

These interventions are designed to streamline documentation processes, reduce errors, and support clinical staff effectively.

The necessity of these recommendations is underscored by their potential to improve both operational efficiency and patient outcomes. Accurate and efficient documentation is fundamental to providing high-quality patient care and maintaining regulatory compliance (McNamara, 2006; see also the organization's 2022 CMS audit report for behavioral health services). As Organization X progresses, prioritizing these recommendations will not only resolve existing barriers but also promote a more effective and supportive work environment. By implementing these strategies, Organization X will enhance its documentation practices and better achieve its mission of delivering exceptional patient care. The insights from this study provide a clear, actionable path forward, highlighting the need for strategic implementation and ongoing commitment to improving documentation processes.

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Appendix: Interview Questions

RQ1: What are the perceived barriers behavioral health providers face in accurately documenting patient information?

1. Do time constraints and high workloads impact your ability to document patient information accurately? Could you provide specific examples of how these factors have led to documentation errors or incomplete records?
2. What challenges do you face with the current electronic health record (EHR) system, and how does its complexity impact your documentation process? Have there been particular aspects of the EHR system that have caused difficulties in maintaining accurate records?
3. Have you encountered issues related to insufficient staffing that affect your documentation practices? How does being short-staffed impact the thoroughness and accuracy of your patient records?
4. What are your thoughts on the training provided for using the EHR system and other documentation procedures? How does the adequacy or inadequacy of this training influence the quality of your documentation?

RQ2: How do inconsistent documentation methods among clinicians in BHOs impact the efficiency and effectiveness of patient care?

5. How have inconsistencies in documentation methods affected the quality of patient care and safety within your department? Can you provide specific examples where documentation issues led to delays or errors in treatment?
6. In what ways have variations in documentation practices impacted your ability to coordinate care effectively among different departments? Can you describe any specific instances where documentation discrepancies created workflow bottlenecks or communication challenges?
7. How do inconsistencies in documentation practices influence the monitoring and evaluation of patient outcomes? Could you share examples of how these inconsistencies have disrupted the assessment of treatment success or hindered performance metrics?

RQ3: What common compliance hurdles does the organization experience?

8. Do you encounter specific regulatory compliance gaps in your department, and if so, how do these gaps affect your ability to adhere to current regulations? Can you provide examples related to documentation or billing issues highlighted in recent audits?
9. Do inadequate training programs contribute to compliance challenges in your department? Can you describe instances where insufficient training on regulatory updates led to compliance issues or errors?
10. Do complex documentation requirements impact your department's ability to maintain compliance? Could you provide examples of how these requirements

have created difficulties in meeting regulatory standards and ensuring accurate documentation?