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Nursing Staff Participation in Chart Audits Increases Documentation Compliance

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Abstract

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Susan E. Nelson

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Clinical documentation is an essential quality element that is often not adequately completed. Current data demonstrate that 32% of home health claims do not meet the requirements for federal reimbursement. Rogers's diffusion of innovation was used as a conceptual framework to guide this quality improvement project which determined whether home health nurses with education and chart audit experience demonstrate increased documentation compliance relative to nurses with education only. After completing a 1-hour education program on documentation, a convenience sample of home health nurses ($n = 8$) was divided between a chart-audit group ($n = 4$) and a no-chart-audit group ($n = 4$). Each nurse in the chart-audit group reviewed 4 charts for adequacy of documentation related to pain assessment, homebound status, and skilled nursing notes. Charts of all nurses who attended the education program were independently assessed for documentation compliance 3 weeks after they completed the chart audit session. Based on Fisher's exact test analysis, no significant difference in adequacy of documentation was noted between nurses who conducted chart audits and those who did not; however, all nurses in the audit group had adequate documentation compliance for pain, homebound status, and skilled nursing notes. Nurses with > 4 years in nursing charted more adequately than nurses with ≤ 4 years in nursing, and nurses with ≤ 4 years in homecare were found to chart more adequately than nurses with > 4 years in homecare. Staff participation in chart audits, as a quality improvement strategy, may improve compliance with documentation requirements.

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Dedication

Completion of this project would not have been possible without grace and guidance from God, and encouragement, dedication, and prayers from my family and friends. I would like to thank my husband, Joe, and my children and grandson, Sarah, Shawn, Laura, Jon, Karissa, and Connor, for their support, patience, and understanding of the time required to complete this process. I would also like to thank the staff where I completed my practicum for their commitment to quality improvement to better the lives of the community. I would also like to acknowledge my very special friend, Sharon, and preceptor, Maureen, for without their support and constant encouragement, I would not have made it through from the beginning to this point. I love you all very much, thank you. And lastly, I would like to say to my father, Jim, thank you. Had he lived to see this accomplishment, he would have been very proud of me, as I am sure he is in heaven.

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Section 1: Overview of the Evidence-Based Project

Introduction

Due to healthcare policy changes, an aging population, and shortened hospital stays, the home health industry has emerged as an essential component of the contemporary health system. Annually, home health institutions provide care to more than 2.4 million elderly and disabled clients. By 2020, home health services payments for the aging population will exceed $543.6 million. To meet this demand, home health institutions need to improve patient care and customer service through the formation, implementation, and evaluation of quality improvement measures (Okrent, 2012).

Historically, nursing research focused on acute care services, but it has expanded to other settings such as home health. Evidence-based practice in home health is purposed to improve patient care, to ensure appropriate reimbursement, and to provide transparency in the public reporting of information through Home Health Compare (Medicare.gov, n.d.). Evidence-based home health practice includes work to bring change in patient safety standards, quality improvement measures, and training strategies for clinicians. Examples include fall risk assessment tools, catheter-related infection prevention programs, strategies to increase patient medication compliance, effective patient and staff education, wound care treatment measures, orientation and mentoring programs, infection control interventions, and many more areas (Whittier, 2008).

Adding to the traditional nursing services perspective, contemporary evidence-based practices are being adopted from other industries, including manufacturing, aviation, and financial industries. Primarily, the transfer of knowledge from these

industries into the home health care industry is informing health information technology and quality improvement initiatives. Some quality improvement initiatives, such as implementing clinical pathways, apply evidence-based knowledge to develop a specific care model and measure differences in health outcomes.

Clinical pathways (CPWs) provide a link between evidence and clinical practice used to translate clinical guidelines into local protocols. CPWs are tailored to local structures and systems to guide the management of care and streamline the cost (Rotter et al., 2013). CPWs have been found to be a mechanism to provide cost saving for outcome measures, a decrease in the length of hospital stay, lower readmission rates, reduction in the fragmentation of care, and a positive impact on quality of health care (Panella, Marchisio, & Di Stanislao, 2003; Rotter et al., 2013)

There are many examples of research (Becker et al., 1997; Gregory, Horn, & Kaprielian, 2008; Hanna et al., 1999; Johnson, Blaisdell, Walker, & Eggleston, 2000; Rotter et al., 2008; Wong, 2009) that involves measuring patient outcomes through the chart audit as a research method. Chart auditing is a cost-effective and relatively easy measurement strategy to identify whether a clinical pathway is used, whether the pathway is correctly used for an accurate diagnosis, and whether the clinical pathway results in a good patient outcome. Furthermore, chart audits lead to issue identification specific to compliance with quality and safety standards, the appropriateness of care, areas requiring additional staff education, compliance with each clinical process, and the combination of all areas of concern (Kinsman, 2004).

Background and Context

Those in the health sector face challenges to meet demands associated with growing consumerism, expanding regulations, pressing financial constraints, increasing quality and safety expectations, and an evolving patient-centered care paradigm. Chart audits, as an evidence-based method, support quality improvement in evaluating outcomes with organizational directives, such as mission, goals, vision, and values. Healthcare leaders must be vigilant and proactive in developing the structures and processes needed to improve safety, increase the quality of care, reduce the cost of care, and save valuable resources for the future (Harris, 2010).

In home health, a complete assessment and ongoing evaluation of patient status, health needs, and function begins with the clinician-patient encounter. Assessment documentation and follow-up evaluations need to be clearly stated with sufficient evidence to satisfy the elements required for homebound status. The federal regulation for clinical documentation to support home health reimbursement stipulates specific elements for skilled nursing, including an individualized nursing note for each 60-day episode. Clinical documentation is an essential quality element that is often not appropriately completed. Current data demonstrate that 32% of home health claims did not meet the requirements for federal reimbursement (U.S. Department of Health and Human Services [HHS], 2014).

In addition to communicating patient care information, clinical documentation is essential for reimbursement in patients requiring homebound status and skilled services (Skrine, 2002). Limitations in clinician knowledge, skill level, and understanding of the

requirements for reimbursement are reasons noted to explain incomplete and deficient documentation for a skilled nursing visit. Importantly, each visit note must demonstrate medical necessity for skilled nursing services. Nurses are the solution to address this problem, but they require training and development in clinical documentation to comply with the regulations for reimbursement (Skrine & Brown, 2011).

Problem Statement

The number of home health agencies (HHA) in the United States grew by 39% between 2002 and 2008, increasing from 7,052 to 9,801. Furthermore, Medicare expenditures for HHA services increased by 84% from 2000 to 2007, or from $8.5 billion to $15.7 billion. Increased Medicare expenditures prompted concerns about improper certification of home care patients by physicians for new admission, continued coverage through recertification for homebound status, and skilled nursing care patients (HHS, 2012).

For the HHA to receive reimbursement for services, the clinical documentation must justify the patient's homebound status, support the need for intermittent skilled nursing care or therapies, indicate care by a physician, and contain a nursing care plan that includes diagnoses, functional limitations, frequency of visits, and types of needed services (HHS, 2012). Established by the Centers for Medicare and Medicaid Services (CMS), reimbursement justification includes documentation through the Outcome and Assessment Information Set (OASIS) and weekly nursing notes for the evaluation of elements in three categories: (a) clinical severity, (b) functional severity, and (c) service utilization. The level and the need for continued skilled care are assessed through the

documentation called the Home Health Resource Group (HHRG). This grouping is an assessment of the type and the amount of care that the patient is expected to receive, or that the HHA expects to receive for reimbursement (HHS, 2012).

Purpose Statement and Project Objectives

The purpose of this project was to compare the increase in nursing clinical documentation compliance in a home health organization between staff receiving only education and staff receiving education with participation in chart audits. In the contribution to knowledge acquisition, translation of knowledge, application of knowledge into practice, and additional interaction, this project provided a learning opportunity to increase the awareness of change and the importance of compliance with documentation as related to financial outcomes.

Significance and/or Relevance to Practice

In a large study to determine physician compliance with documentation for the initial certification of patients for skilled in-home care, 32% of home health claims did not meet the documentation requirement, translating into more than $2 billion of inappropriate payments to providers (HHS, 2014). Physicians are inconsistent in completing the required documentation narrative, and CMS oversight for documentation is minimal or insufficient to uncover inappropriate reimbursements (HHS, 2014). Accurate, concise, and complete documentation, which is essential to meet the requirements of reimbursement, is the responsibility of all participating clinicians. Quality improvement methods, as a component of quality management, focus on

identifying causes of poor outcome measures and seek system-wide changes aimed at improving outcomes (Kelly, 2011)

Chart auditing, as a quality improvement method, provides feedback about documentation performance, compliance with state and federal requirements, and management of organizational legal requirements (Wisconsin Department of Health Services, 2009). Inadequate clinical documentation fails to support medical necessity for approval and reimbursement for home healthcare patients. As such, home healthcare agencies whose personnel do not meet documentation requirements place patients and the organization at risk for loss of skilled nursing services (Rowan, 2010).

Chart audits can link process data collection as an aggregated outcome measurement. Chart audits make it possible to document compliance by identifying processes and procedures within a system that do not meet established standards and regulations. Furthermore, audits identify areas with limited or missing information that is necessary to support regulatory compliance. In auditing patient charts, written and electronic documentation is reviewed with attention to patient needs, health provider documentation, patient teaching, medication administration, treatment measures, laboratory results, and physician notification (HHS, 2011).

Project Question

With a quality improvement intervention, do home health nurses with education and chart audit experience have increased documentation compliance relative to nurses with education without chart audit experience?

Evidence-Based Significance of the Project

Evidence-based practice (EBP) has been slow to develop in nursing, resulting in inadequate progress in translational science (i.e., moving discovery into practice). Causes for delay in implementing evidence-based care at the bedside by nurses include misperceptions about the evidence basis for practice, knowledge and skill deficits in translating research into practice, and barriers to evidence implementation (Melnyk et al., 2004). Common barriers to implementing evidence-based practice include the following: (a) nurses are not familiar with the term *EBP*, (b) nurses do not believe their colleagues use EBP findings in practice, (c) nurses have limited knowledge of the use of electronic databases, and (d) nurses lack experience with searching for information in databases (Fineout-Overholt, Melnyk, & Schultz, 2005). Additional barriers include lack of skills to critique or synthesize literature, difficulty understanding research articles, lack of library access, and lack of value placed on research in practice (Pravikoff, Tanner, & Pierce, 2005).

As research findings are slow to be translated into practice in a timely fashion in conjunction with the emphasis on evidence-based practice, cost effectiveness, and accountable health care, nurses need to be educated on the steps to transform research findings into practice. According to the Institute of Medicine (IOM, 2001) and others (e.g., Shattuck, 2003), the translation of knowledge from discovery into practice takes 17 or more years. This results from the more than 2 million research publications available to clinicians to review each year (Mulrow, 1994; Nieva et al., 2005). Living systematic reviews have been suggested as an approach that provides high-quality, up-to-date online

summaries of health research and enhances efficiency and opportunities for knowledge translation (Elliott et al., 2014).

The knowledge-to-action (KTA) process focuses on a broad audience of stakeholders including patients, policymakers, and health care professionals. KTA is a conceptual framework divided into two concepts: knowledge creation and action. The process of KTA is complex and dynamic, with phases that are fluid and permeable. The process moves from acquisition of knowledge into an action cycle of activities for the application of knowledge (Graham et al., 2006). In the case of this DNP project, the project question was directed at an intervention that would assist home care center nursing staff in improving documentation compliance with CMS requirements. The intervention was linked to nursing practice for quality improvement through accurate and compliant documentation. A literature review focused the project on staff education, which had been beneficial but had not provided the motivation, education, and ownership necessary to make a sustainable change while continuing to question the process. The implementation and evaluation of the DNP project permitted staff to participate in the chart audit, to participate in the change process, and to sustain the process with plans to expand throughout the organization.

Rogers's diffusion of innovation theory (DOI) has been used to guide nurse researchers in using innovations that are close to current practice. Other changes required of nurses at the site of this study had been very slow in implementation, such as the addition of a tool to assess the risk of deep vein thrombosis, which increased the time required for documentation. In the case of the deep vein thrombosis tool, after the initial

change period, early-adopter nurses did see the benefit of the tool and soon convinced the slow adopters that the change was beneficial; thus, the change practice was implemented throughout the hospital. DOI theory will provide the guidance and direction needed for the home health care nurses to enhance their knowledge, gain experience, and increase documentation compliance and quality improvement. DOI theory consists of two major concepts that describe categories of individuals and how they react to change. The use of this model will ultimately provide for the development and use of new ideas, innovation, change, and the process and channels of communicating the innovation (Glanz, Rimer, & Viswanath, 2008). The adoption of innovative practices within a healthcare setting must reflect consideration of social influence and networking within the system, the complex nature of the adoption process, the characteristics of the organization that encourage or inhibit innovation, and the sustainability of the innovation (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004).

Implications for Social Change in Practice

Healthcare in the United States is nonsystematic, with a focus on acute illness and little emphasis on prevention or management of chronic illnesses. Healthcare professionals, healthcare organizations, the general public, and other stakeholders are concerned about quality of care, access to care, and the increasing cost of healthcare. The Institute of Medicine recommended improvements to healthcare in order to ensure that it is safe, effective, patient centered, timely, efficient, and equitable. Care should be delivered by a sufficient number of qualified healthcare professionals with attention to prevention and early intervention to ensure that all persons have equitable, accessible,

and quality care. Health care reform is a public policy concern at both the state and federal levels and involves many stakeholders, including patients and families, healthcare organizations, third-party payers, and professional healthcare providers (Ridenour & Trautman, 2009).

Nursing professionals constitute more than 50% of the healthcare workforce (Delucia, Ott, & Palmieri, 2009) and have a role that involves protecting society from harm, using prevention measures to limit or minimize the potential for illness, and providing care for chronically ill patients (IOM, 2013). The role of home healthcare is expected to expand in the coming years with an aging population, increased prevalence of chronic conditions, and increased emphasis on caregiving for patients by family members. The requirements of the Centers for Medicare and Medicaid have placed the home healthcare industry in a situation that demands improvement in quality directed at patient care initiatives. Emphasis has been placed on the accuracy, comprehensiveness, and timeliness of clinical documentation provided by home healthcare agencies for full reimbursement (Mukamel et al., 2014).

More nurses working in home healthcare will lead to improved patient care outcomes (Feldman, Clark, & Bruno, 2006). Improvement in clinical documentation will also lead to greater available funding toward new technology to raise the quality of care for home care patients, such as new technology to monitor patients with chronic illness remotely. Currently, home healthcare agencies are not reimbursed for telehealth monitoring (Suter, Suter, & Johnston, 2011).

Definitions of Terms

Chart audit: "A chart audit is an examination of medical records, electronic and/or hard copy, to measure some component of performance" (Kaprielian, Gregroy, & Sangvia, 2003).

Clinical documentation: As outlined by Russell (2013),

> Clinical documentation needs to be seen through the lens of the patient or care recipient. Any transaction or event that contributes to the determination of the health status of a person, their prognosis, or actual or potential treatments should be available as part of a person's health record to the patient and every authorized participant in their care and service delivery team member. These include but are not limited to encounters, clinical summaries, care plans, applicable clinical practice guidelines and protocols, conversations among care team members, and any and all services provide on the person's behalf intended to promote optimal health status. (para. 2)

Health care quality: Health care quality is defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (IOM, 2013, para. 3).

Outcome Assessment Information Set (OASIS-C): OASIS-C is defined as "the instrument/data collection tool used to collect and report performance data by the home healthcare agencies … required by Medicare-certified home health agencies ... to promote the use of best practices across the home health industry" (CMS, 2014, para. 5).

Quality: Quality is defined as "meeting or exceeding customer expectations" (Sam Houston State University, n.d., para. 2).

Quality improvement: Quality improvement (QI) is defined as "systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups" (HHS, 2011, para. 1).

Assumptions

This project required active participation by the nursing staff at the home healthcare agency. It was assumed that participation in clinical chart audits would increase nurses' knowledge, skill, motivation, self-confidence, and expertise in clinical documentation. Further, it was assumed that the information provided on the survey would be accurate and reflect motivational factors identified by the staff nurses at the home healthcare agency and would therefore assist the agency in future programming, policies, and activities directed at improvement in clinical documentation.

Limitations

The project was limited by the small convenience sample of staff nurses employed by the home healthcare agency. The true effects of the educational program were also limited because of the inability to have a control group that did not receive the education. The project included a two-arm intervention with no control group (education and education with clinical audit experience). Further, due to the limitations in time for this project, there was the potential for nursing staff turnover, which could have limited the number of chart audits per nursing staff for comparison to the original group of participants.

Summary

Quality improvement is a process that is used to determine areas of improvement as well as areas that can be used as strengths within a system. The process for change that will ultimately result in improvement requires a well-developed process that includes all levels of the organization, from microsystem to macrosystem, for effective planning, implementation, and evaluation of interventions to improve quality and provide safe patient care. Chart audits provide essential feedback for quality of care performance; compliance with state, federal, and organizational regulations; and legal requirements (Wisconsin Department of Health Services, 2009). Inadequate clinical documentation leads to a lack of documented medical necessity for initial or continuing approval and reimbursement for home care patients and home care agencies, thereby placing patients, staff, and the agency at risk. Comprehensive staff training programs in the home care setting have been found to be lacking and far below the level seen in other areas of health care regarding documentation compliance (Rowan, 2010). Active participation in in-service training provides an avenue for employees to expand their knowledge, skill, and expertise to enhance the quality of care and improve outcomes for the organization (Nepal Family Health Program, n.d.). Staff development through in-service training establishes roles and responsibilities for the staff, in addition to creating a pathway for motivation toward improvement, practice efficiency, and greater patient satisfaction (Gesme, Towle, & Wiseman, 2010). The results of the project did identify improvement in several areas of documentation but indicated several other areas that need to improve to meet the regulatory requirements for reimbursement by CMS.

Opportunities for active participation in the process of increasing and applying knowledge (as opposed to a lecture-style modality of education) have been demonstrated to enhance motivation for change, self-confidence in the application of new knowledge and skills, and use of evidence-based practice. A systematic approach to quality improvement is essential for organizations to maintain compliance with documentation requirements for reimbursement, to increase awareness of practices based on evidence that will ultimately have a positive impact on patient outcomes, to empower nurses through engagement in problem solving, and to continue to seek strategies using evidence-based practice and innovation (Djukic, Kovner, Brewer, Fatehi, & Seltzer, 2013). An in-depth review of scholarly evidence is discussed in Section 2.

Section 2: Review of Scholarly Evidence

Introduction

The purpose of this project was to compare increases in nursing clinical documentation compliance in a home health organization between nursing staff receiving only education and nursing staff receiving education with participation in chart audits. Relevant scholarly information was derived from a review of general literature on quality improvement interventions used in the home healthcare industry, a review of specific literature on the use of active participation as an intervention for improvement, and a review of literature on diffusion of innovation (DOI) theory as a framework for the enhance knowledge and gain experience. Additionally, I conducted an extensive search of literature related to quality improvement through active participation by nurses and other healthcare providers, through improvement in the clinical documentation required for reimbursement by CMS, and through improvement in the quality of health care provided to patients.

Literature Search Strategy

The Walden Library database was used for a literature search utilizing CINAHL, Medline, Business Source Complete, Academic Search Complete, and Cochrane Database of Systematic Review. I searched for literature that met the following criteria: in the English language, full text, and peer reviewed. There was no limitation related to year of publication or national/international location of research. The key terms used for the literature search were staff development, participation, quality, quality improvement, home health care, healthcare, charts, chart audit, audit, documentation, clinical

documentation, employee, motivation, and empowerment. A total of 3,662 articles, studies, and position papers were identified by the search. The search was narrowed to a total of 84 articles and studies directly related to home healthcare, documentation, staff, motivation, and chart audits. The results were further delineated into groups for systematic review of literature and specific review of literature. The final number of studies was 11; these studies had various designs, including meta-analysis, randomized controlled, quasi-experimental, inductive, prospective, and retrospective.

The final evaluation for the literature review was conducted using the American Association of Critical Care Nurses (AACN) evidence-leveling system. The AACN evidence system has six levels to identify the strength of evidence to support the integration of evidence into practice. The levels are as follows: Level A—meta-analysis of controlled studies; Level B—randomized and nonrandomized studies; Level C—qualitative, descriptive, and correlational studies; Level D—peer-reviewed studies; Level E—based on theory evidence; and Level M—the lowest level of evidence, from sources such as manufacturers' recommendations (Armola et al., 2009). The levels of evidence associated with the literature used for this project ranged from Level A through Level D.

General Literature

The research that is available specific to home health care is limited but growing, due to the demand for knowledge that will improve (and has improved) patient safety, quality of care, and interventions toward overall quality for the home healthcare industry. At the present time, funding for such research is available through Sigma Theta Tau. Research is being conducted through several entities such as the National Association for

Home Care and the Centers for Medicare and Medicaid Services (CMS). Due to decreasing budgets, an increase in the level of care for home care clinicians, and the need to meet governmental requirements for documentation and justification of home healthcare, administrators and home healthcare nurses must consider working with other stakeholders to address the lack of research specific to home care.

One example of the paucity of home-health-related research involves the treatment of pressure ulcers. In 2005, the Centers for Disease Control and Prevention (CDC) identified 9,814 home health agencies (HHA) and 3.1 million patients being treated. The National Home Care and Hospice Survey sampled 1,904 HHA in 2004 and found that 1.3 million of their patients had a current diagnosis of pressure ulcers. A wet-to-dry dressing was the most consistently ordered dressing for the treatment of pressure ulcers. Although repeated research over the last 50 years has indicated that a moist wound environment heals wounds more quickly with a moist wound bed, there were no widely accepted standards or wound care guidelines. The CMS held an advisory meeting to discuss the lack of guidelines to address wound healing. In 2008, the National Institute for Health and Clinical Excellence released guidelines that specifically stated that gauze or moist gauze should not be used as a standard treatment for wound healing. In the last several years, randomized controlled trials have repeatedly demonstrated that the use of wet-to-dry dressing is detrimental to wound healing, often leading to infection; is extremely painful; and impedes wound healing (Dale & Wright, 2011).

Specific Literature

Jefferies, Johnson, Nicholls, and Langdon (2012) surveyed 16 nurses from two different wards within a hospital, all of whom attended a 2-hour workshop to improve their writing skills. Eight of the 16 nurses also participated in one-on-one sessions with a writing coach for the purpose of improvement in documentation. The findings did not indicate a significant change in nursing documentation, but the nurses who participated in the one-on-one coaching session found it valuable as a learning experience. The authors acknowledged that the lack of evidence of significant improvement may have been attributable to high performance in documentation already existing in both groups. These findings were in contrast to a study conducted by Sung, Chang, and Abbey (2008) to evaluate a program to improve nursing home staff's knowledge and adherence to an individualized music protocol. The findings of Sung et al. indicated a positive effect when using multifaceted implementation programs and research in practice to change practices among nursing staff.

Singer et al. (2009) conducted a study "to evaluate if regular feedback on glucose values to staff as well as educational sessions for nurses on the importance of glucose control could improve the quality of tight glucose control " (p. 33) in patients. The results identified that "improved glucose control was obtained through ongoing monthly feedback of glucose values to the staff and structured education of nurses " (p. 35) in an intervention group compared to nurses using only a nurse-driven intensive insulin infusion protocol.

Further studies have involved multifaceted training programs that include staff participation. For instance, Pan, Meng, Gibbons, and Strayhorn (2009) conducted a study to determine the effectiveness of an intervention to improve documentation required for diagnosis of metabolic syndrome. The results demonstrated that a targeted educational intervention and participation through a feedback process, although a simple intervention, is effective in promoting improvement in electronic health record clinical data entry.

In 2009, a retrospective study was conducted in the HHA setting (Dale & Wright, 2011) in which researchers reviewed 202 wound-specific charts and found that 42% of all home care wound care orders were for wet-to-dry dressing, which were not clinically indicated because this type of dressing should only be used for mechanical debridement for a limited time and should not be used for wound healing. Establishing best-practice measures is essential due to changes in state, federal, and third-party payers' requirements for clinical justification of the need for home healthcare skilled nursing services. Some suggestions to increase participation in evidence-based practice are to a) work with administrative staff to provide the resources necessary to conduct literature reviews, b) develop protocols and policy based on best practice measures, c) consider developing a team with a wound-care-certified clinical specialist as the program coordinator, and d) provide staff education to maintain currency of knowledge (Dale & Wright, 2011).

Laamanen, Broms, Happola, and Brommels (1999) conducted a study to identify how staff in home care services have experienced change and how motivated they are in their jobs. The sample consisted of staff in home nursing and home help services and

administrators in social and primary health care (p.61). A total of 490 subjects participated in the study; 392 participants were home helpers and homemakers, and the remaining 76 participants were community nurses and community nurse auxiliaries. Data were collected using a structured questionnaire. The results indicated a significant association between workload, work responsibility, autonomy, work variability, and variety of tasks associated with the job. Also noted in the results was that the motivational strategies used by the administrators to introduce change included staff training, information on goals associated with the job, and increasing the level of skill required to meet the goals of the organization. The final motivational factor related to change and job performance was awareness of the objectives of the organization in relation to health reform.

Theoretical Frameworks

Rogers's Theory of Diffusion of Innovation

The evidence-based practice model selected to support the research and project outcomes was Rogers's theory of diffusion of innovation. DOI theory indicates that there are categories of individuals based on how they react to new ideas, innovation, and eventually change. Individuals fall into five categories in terms of their response to innovation: innovators, early adopters, early majority adopters, late majority adopters, and laggards (Boston University, 2013; Rogers, 2013)). A second concept within DOI theory is diffusion of innovation through channels of communication. The model of innovation-process decision contains five steps: knowledge, persuasion, decision, implementation, and confirmation (Rogers, 2003). Rogers's model of diffusion

innovation can provide the guidance and direction needed for home health care nurses to enhance their knowledge, gain experience, and increase documentation compliance to further the process of quality improvement through the identification of individual characteristics in relation to the adoption of change.

The theory used for this project was based on Rogers's DOI theory. The concept of diffusion was addressed in this project. Rogers (2003) defined *diffusion* as "the process by which (1) an *innovation* (2) is *communicated* through certain channels (3) over *time* (4) among the members of a *social system"*(p. 12). The diffusion process was demonstrated through the application of a new, innovative process based on a participative approach for the nursing staff in conducting chart audits, which was communicated through staff training, direct staff participation, and peer communication. Over time, the nursing staff gained knowledge, confidence, and motivation to continue the process of quality improvement and engagement within the social system for joint problem solving to advance the goal of increased compliance with clinical documentation requirements (Rogers, 2003; White & Dudley-Brown, 2012).

Promoting Change

Hyrkas and Harvey (2010) identified three clusters/perspectives that influence change through the diffusion of innovative practices in industries including health care. The first is the rate of diffusion within the organization, which is often escalated toward completion before the process has the opportunity to be understood within the organization. The innovation may be viewed as negative by the workforce and leadership if sufficient time and commitment to educating the team on the need for change are not

provided in the planning phase. Contextual and managerial factors that can be barriers to change are lack of support, lack of encouragement, lack of time, lack of respect for diversity and workplace culture, and lack of communication by the leadership or champions of the change process. Strategies that can be used to promote a positive reaction to and interaction with change involve the length of time and resources required for researching, planning, and identifying a framework or change theory that works with the change, organization, staff, patients, and other stakeholders (Hyrkas & Harvey, 2010).

Promoting the culture of change is the initial phase of change for an organization. Values, beliefs, and attitudes shape the environment for change to occur. Open communication provides trust, shared knowledge, and a feedback system for all members. The vision, objectives, and goals need to be clearly articulated, along with benchmarks for outcome measurements. One of the key aspects of an effective change process is the involvement of everyone affected by the change through a decision-making process that promotes equity and participation. Goals needs to clear, measurable, and consensual, with a teamwork approach used to build employee morale, passion, and desire for change (White & Dudley-Brown, 2012).

Summary

Quality management incorporates quality improvement processes to identify system-wide areas of strength as well as those areas needing improvement. The process for change must be well developed and must include all levels of the organization, from microsystem to macrosystem, for effective planning, implementation, and evaluation of interventions to improve quality and provide safe patient care. Chart audits provide

essential feedback concerning quality of care performance, as well as compliance with state, federal, and organizational as well as legal requirements (Wisconsin Department of Health Services, 2009). Inadequate clinical documentation leads to a lack of documented medical necessity for initial or continuing approval and reimbursement for home care patients and home care agencies, which places patients, staff, and agencies at risk. Comprehensive staff training programs in the home care setting have been found to be lacking and far below the level other areas of health care for documentation compliance (Rowan, 2010). In-service training provides an avenue for employees to expand their knowledge, skill, and expertise to enhance the quality of care and improve outcomes for the organization (Nepal Family Health Program, n.d.). Staff development through in-service training establishes roles and responsibilities for the staff and creates a pathway for motivation toward improvement, practice efficiency, and greater patient satisfaction (Gesme, Towle, & Wiseman, 2010). The results of the project did identify improvement in several areas of documentation, in addition to several other areas that need to improve to meet CMS regulatory requirements for reimbursement.

Section 3: Approach

Introduction

The purpose of this project was to compare increases in nursing clinical documentation compliance in a home health organization between nursing staff receiving only education and nursing staff receiving education with participation in chart audits. The project design and method, population, sample, setting, data collection, and data analysis are addressed in this section. The strategy for this project involved developing a program to educate a home health agency's nursing staff on the purpose, process, and specific requirements for documentation through chart audits. Through education and active participation as well as the connection and application of learned knowledge, the goal of this project was to promote improvement in quality and thus contribute to good nursing practice and high-quality, safe patient care (Standing, 2007).

Project Design/Methods

A quantitative design was used for this project. Quantitative research is based on positivism, which involves strict rules of logic, truth, laws, axioms, and predictions that identify patterns unique to a specific population. Advantages of the quantitative method include the ability to present logical outcomes that have been scientifically validated; the ability to select an instrument to gather data using an observational approach, which limits the possibility of an emotional connection to the subjects; and the ability to identify potential risks to study participants early in a study. Limitations include lack of subjective data that could enhance the ability to answer questions related to social interactions, human emotions, perceptions, and experiences. Due to the lack of connection between

the subjects and the researcher in a quantitative study, participants of the study may form a negative impression of the research (Terry, 2012).

Context, Samplings, and Setting

Context

According to CMS, the majority of denied payments to home healthcare providers result from improper and insufficient documentation. Review of records submitted to CMS indicated that the two most common documentation lapses relate to homebound status and the need for skilled services. The narrative identifying specifically why the patient is homebound must meet the following criteria:

> "because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchair, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence OR have a condition such that leaving his or her home is medically contraindicated AND a normal inability to leave home; AND leaving home must require a considerable and taxing effort". (CMS, 2012)

The need for skilled services is the second area that has been identified as lacking sufficient documentation for justification of reimbursement. The specific narrative for documentation must address the following:

> "To qualify for home health services, the beneficiary must need intermittent skilled nursing services, physical therapy (PT), or speech language pathology (SLP) services. Nursing services must be reasonable and necessary for the treatment of the patient's illness or injury. Skilled nursing services can be but not

limited to: Teaching/training, observe/assess, complex care plan management, administration of certain medications, tube feedings, wound care, catheters and ostomy care, NG and Tracheostomy aspiration/care, psychiatric evaluation and therapy, and rehabilitation nursing". (CMS, 2012)

The top 11 survey deficiencies and related documentation issues identified by the Bureau of Home Care and Rehabilitative Standards were similar to the results of the chart audits for the last two quarters, including October, November, and December 2013 and January, February, and March 2014, for the specific areas of noncompliance conducted by the home healthcare agency where the project would take place (Bureau of Home Care and Rehabilitative Standards, 2010). Currently, the HHA uses handwritten documentation for all patients' charting, but it will be transferring this information to electronic medical records (EMR) in the near future.

Sample

This project incorporated a convenience sample of all full-time nursing staff. In terms of educational level, the nursing staff was composed of licensed practical nurses or registered nurses holding either an associate of science degree in nursing or a baccalaureate degree in nursing. Excluded from the sample were the administrators of the agency, who were also nurses.

Setting

The home healthcare agency provides skilled nursing services, therapy services (physical, occupational, and speech), and home health aide services. The HHA provides for the needs of patients, families, and caregivers, serving 11 counties in central and

eastern Indiana. Currently the HHA employs four full-time registered nurses, five part-time registered nurses, three full-time licensed practical nurses, eight full-time home healthcare aides, four full-time physical therapists, two part-time physical therapists, two full-time occupational therapists, one part-time occupational therapist, and one full-time speech therapist. The administrative staff consists of the director of health services, assistant director of health services, director of quality assurance, agency administrator, and nursing service coordinator. The HHA maintains an average of 165 patients, with nursing visits accounting for approximately 800 visits per month.

Data Collection

General demographic information was collected to identify level of education, number of years working as a nurse, and number of years working in the home care setting. The educational training presented to the home healthcare nurses consisted of information on the requirements for clinical documentation compliance for reimbursement. The nurses were divided into education-only and education-and-chart-audit groups according to number of years working in the home healthcare setting, level of education, and gender. All participants attended a staff training session on requirements for clinical documentation prior to being placed in either the education-only or education-plus-chart-audit group. The members of the education-plus-chart-audit group participated in chart audits, and the members of the education-only group did not participate in chart audits. The nursing staff involved in the project—that is, the group participating in the chart audits and the group not participating in the chart audits—were presented with verbal and written information regarding the purpose of the project, the

purpose of the data collection activities, any potential risks and benefits, a report of findings after the analysis of the data, and the ability to withdraw from the project at any time.

After a period of 3 weeks, a chart audit was conducted on four charts for each of the subjects who participated in the chart audits as well as for each person in the nonaudit group to assess whether there was improvement in adequate charting using the standard organizational chart audit form. Adequacy of charting was determined for pain assessment, homebound status, and skilled nursing notes if documentation was compliant 3 out of 4 times with each chart reviewed.

To limit the possibility of identification of the nurses completing clinical documentation, the name of the nurse and the name of the client were removed from the charts that were audited. Due to the secondary nature of the data collection process, a code sheet was not necessary to keep track of audited charts. Chart audits are completed by the director of quality assurance of the HHA on a regular basis as a continuous quality improvement process. Participation in the project was on a voluntary basis, with a written guarantee from the administration that refusal to participate would not be reflected in future employment, future performance evaluations, or any form of retribution. Even though participation in chart audits was voluntary, the nursing staff were informed of the results of the chart audits, which were used as a learning tool to identify areas of clinical documentation that were lacking sufficient information. A general group training session was conducted following the results of the charts to improve the knowledge, skill, and expertise of staff toward complete, accurate clinical documentation.

A training session was provided to all eight participants prior to the participants being divided into the education-only and education-plus-chart-audit groups. The training session consisted of verbal information and written examples of the requirements to justify the need for skilled nursing services in the areas of pain assessment, homebound status, and skilled nursing notes. Following the training session, the groups were divided according to level of education, length of time working as a nurse, and length of time working as a homecare nurse. Each group had two RNs and two LPNs. The average length of time working as a nurse was between 11 and 14.5 years, and the average length of time working as a homecare nurse was between 2 and 5.5 years. Each nurse in the audit group completed chart audits on four patient charts. All patient charts were selected randomly, with patient identifiers removed from the charts before the auditing process began.

Data Analysis

The Statistical Package for the Social Sciences (SPSS) version 21 was utilized for statistical analysis. Coded data were entered into SPSS, and a Fisher's exact test was conducted instead of a Chi-square analysis of the data as initially proposed. The Fisher's exact text is useful to analyze dichotomous data in a 2 X 2 contingency table when the total sample size is less than 20 (Pett, 1997).

Summary

Clinical documentation is the core of quality patient care, quality improvement, and federal and state requirements for reimbursement. Accurate, thorough, timely representation of clinical documentation is essential for public reporting of quality

indicators; communication among healthcare providers; tracking and trending of preventable occurrences such as falls, wounds, and medication errors;, and justification of services provided by the home healthcare industry (American Health Information Management Association, 2014). Inadequate clinical documentation is a direct cause of payment denial and withholding of payment from CMS. The two main areas of clinical documentation that have been identified by the CMS and Bureau of Home Care and Rehabilitative Standards as lacking are justification for homebound status and need for skilled care services (Bureau of Home Care and Rehabilitative Standards, 2010; CMS, 2014).

The primary goal of accurate, comprehensive clinical documentation is to ensure the quality and continuity of care, the dissemination of information through written communication, the detection of patient-related problems and changes in health status, and care planning for individualized assessment, treatment, and evaluation of patient needs, goals, and outcomes (Arizona Association for Home Care, 2011). Factors that lead to incomplete or insufficiently specific documentation on a skilled nursing visit include limited knowledge, skill, and understanding of the requirements for reimbursement. Each visit note is scrutinized for medically necessary skilled services. Nursing staff need to be trained specifically on the clinical documentation requirements to meet regulations for reimbursement (Skrine & Brown, 2011). Chart audits are conducted on a routine basis according to regulations set by the state and federal government to assess the accuracy, completeness, and timeliness of specific areas related to quality care and reimbursement (CMS, 2014; Indiana Department of Health, 2014). Active participation in a chart audit

conducted by the nursing staff will improve knowledge of the requirements for clinical documentation for reimbursement purposes, improve patient care through comprehensive assessment, and motivate the nursing staff to become active contributors to efforts toward quality improvement and quality patient care.

Section 4: Findings, Discussion, and Implications

Introduction

The purpose of this project was to compare increases in nursing clinical documentation compliance in a home health organization between staff receiving only education and staff receiving education with participation in chart audits. The project question was the following: With a quality improvement intervention, do home health nurses with education and chart audit experience have increased documentation compliance relative to nurses with education without chart audit experience? The project was conducted to determine the adequacy of clinical documentation requirements determined by CMS for reimbursement in the areas of (a) pain, (b) homebound status, and (c) skilled nursing notes (HHS, 2011).

An identified problem in the home health setting is lack of adequate charting to meet CMS requirements to receive reimbursement for skilled services provided to the patient population. Inadequate clinical documentation that fails to support medical necessity places the home health agency at risk for a lower reimbursement rate from the federal government (Rowan, 2010). Current data demonstrate that 32% of home health claims did not meet the requirements in the specific areas of homebound status and skilled nursing note (HHS, 2014). Chart auditing has been found to be an effective method of documenting and measuring regulatory compliance (HHS, 2012). Comprehensive staff training to increase compliance for reimbursement has not been found to be sufficient (Rowan, 2010).

To address the problem of inadequate documentation, this project was implemented to identify whether nurses who conducted chart audits had an increase in adequacy in clinical documentation compliance. As a quality improvement method, the HHA conducts chart audits on a quarterly basis to identify specific areas of concern related to lack of documentation. The process of chart audits has been limited to the administrative staff at the HHA and has not included participation by professional nursing staff. The method of staff training has been limited to verbal presentation of in-service training without participation in activities.

Chart audits have been found to be a cost-effective and an easy method that leads to the identification of specific areas of documentation compliance (Kinsman, 2004). Active participation in chart audits has been found to increase knowledge, motivation, and application of knowledge to maintain compliance with documentation requirements (Djukie, Kovner, Brewer, Fatchi, & Seltzer, 2013). Using a quantitative approach, the use of the organization's standardized chart audit tool to measure an increase in adequate clinical documentation revealed an improvement in compliance with requirements for clinical documentation in the group that participated in chart audits. The chi-square test was used for data analysis. Nonparametric testing was appropriate because the variables were measured on a nominal scale (Polit, 2010).

Findings and Discussion

Findings With Evidence Support

Current literature supports participation in chart audits as an intervention to improve compliance with documentation requirements for reimbursement and quality

improvement (Dale & Wright, 2011; Pan, Meng, Gibbons, & Strayhorn, 2009; Singer et al., 2009). The use of active participation in chart audits has been found to be a successful intervention as a training tool to improve clinical documentation in the healthcare setting (Becker et al., 1997; Gregory, Horn, & Kaprielian, 2008; Johnson, Blaisdell, Walker, & Eggleston, 2000; Hanna et al., 1999; Rotter et al., 2008; Wong, 2009). Understanding the association between the process of change, innovative strategies, and quality improvement can have an impact on the level of skill and experience required to meet criteria for reimbursement and to provide overall high-quality care to patients (Laamanen, Broms, Happola, & Brommels, 1999). Recommendations to increase participation by staff in evidence-based best practices are essential due to recent changes in state, federal, and third-party payer requirements for clinical justification of skilled services (Dale & Wright, 2011).

Table 1

Demographic Information: Level of Education, Years Nursing, and Years in Homecare

Educational level	Level of education *N* (%)	Years working in nursing *N* (%)	Years in homecare *N* (%)
RN	4(50)		
LPN	4(50)		
Years			
1-4		3(37.5)	6 (75.0)
5-10		1(12.5)	2 (25.0)
11-15		1(12.5)	
16-20		2(25.0)	
> 20		1(12.5)	

There were eight participants in the study—four licensed practical nurses (LPNs) and four registered nurses (RNs). All were full-time nursing staff, and all were female.

Each nurse completed a general demographic survey (see Appendix A). The overall general demographic results for educational level, years working as a nurse, and years working as a nurse in homecare are identified in Table 1.

The research question addressed the need for nurses in home healthcare to be actively involved in quality improvement initiatives to increase documentation compliance through participating in chart audits compared to nurses who were not involved in chart audits. Due to the very small sample size, a Fisher's exact test was conducted instead of conducting a Chi-square analysis of the data as initially proposed. The Fisher's exact text is useful to analyze dichotomous data in a 2 X 2 contingency table when the total sample size is less than 20 (Pett, 1997).

For this analysis, data for pain assessment, homebound status and skilled nursing notes were recoded into two categories. For each of these areas, overall improvement in charting was considered unsatisfactory (coded as 1) if only 4 or fewer instances of adequate charting was noted and an improvement in charting was considered satisfactory (coded 2) if 5 or more instances of adequate charting was noted. There was no significant difference between nurses who participated in chart audits and those who did not in the adequacy of charting related to pain, homebound status, and skilled nursing notes. However, a trend toward more complete charting related to pain, homebound status, and skilled nursing notes was observed in nurses participating in chart audits. Overall, RNs in both groups were found to have more complete charting compared to LPNs for pain and homebound status, and the LPNs were found to have more complete charting in the skilled nurses notes (see Table 2).

A trend was also found when comparing documentation compliance in years of nursing and years as a homecare nurse. In relation to pain and homebound status, those with > 4 years in nursing charted more adequately than those with ≤ 4 years of nursing. Nurses with ≤ 4 years of nursing charted more adequately compared to nurses with > 4 years of nursing in the skilled nursing note section of the chart audit. Another interesting finding was that all nurses with ≤ 4 years as a homecare nurse charted adequately compared to nurses with > 4 years as a homecare nurse (see Table 3).

Table 2

Clinical Documentation by Audit Group and Level of Education

	Audit group	Nonaudit group	Registered nurse	Licensed practical nurse
Pain				
Adequate	4	2	4	2
Inadequate	0	2	0	2
Homebound status				
Adequate	4	1	3	2
Inadequate	0	3	1	2
Skilled nursing note				
Adequate	3	0	1	2
Inadequate	1	4	3	2

Findings With Framework Support

The framework used for this project to demonstrate ease of use for the HHA was the DIT's innovation-decision process. *Diffusion* is defined as "the process by which (1) an *innovation* (2) is *communicated* through certain channels (3) over *time* (4) among the members of a *social system"* (Rogers, 2003, p. 12). The characteristics that hold the most

influence over the adoption of innovation are relative advantage, compatibility, complexity, trialability, and observability (Rogers, 2003).

Table 3

Clinical Documentation per Years in Nursing and Years as a Homecare Nurse

	Years in nursing		Years as homecare nurse	
	≤ 4 years	≥ 4 years	≤ 4 years	≥ 4 years
Pain				
Adequate	3	5	6	2
Inadequate	0	0	0	0
Homebound status				
Adequate	2	3	4	1
Inadequate	1	2	2	1
Skilled nursing note				
Adequate	2	1	2	1
Inadequate	1	4	4	1

Relative advantage was associated with a new innovation to improve quality and completeness of clinical documentation by the home healthcare nurses through participation in chart audits. *Relative advantage* is described as "the degree to which an innovation is perceived as better than the idea it supersedes" (Rogers, 2003, p. 229). Relative advantage was demonstrated by the administrative and nursing staff through the use of staff participation in chart audit for quality improvement. The rate of diffusion within the organization, the perception of innovation to make change in the system, and the commitment to educating the team on the need for change have been identified as clusters that influence change (Hyrkas & Harvey, 2010). Introducing innovative ideas into the healthcare system is imperative to meet requirements for clinical documentation for reimbursement (HHS, 2012).

Compatibility is associated with cultural beliefs, values, and attitudes of the organization. Compatibility is defined as "the degree to which an innovation is perceived as being consistent with existing values, past experiences, and needs of potential adopters" (Rogers, 2003, p. 241). Compatibility with the HHA mission involves providing quality care to optimize comfort and dignity in the home setting, which was congruent with the values of the HHA staff as an essential part of the health delivery system (ViaQuest, Inc, 2014). Motivation for cultural change based on values and beliefs is essential when initiating change from an individual and organizational perspective.

Complexity is defined as "the degree to which an innovation is perceived as difficult to understand and to use" (Rogers, 2003, p. 257). The project intervention, participation by nursing staff in chart audits, was found to take very limited time and to be easy to complete, resulting in improvement in clinical documentation. Research findings have demonstrated the use of a target educational intervention, staff participation, and a feedback process as a simple, noncomplex intervention that is effective toward quality improvement (Pan, Meng, Gibbons & Strayhorn, 2009).

Trialability is the fourth characteristic identified in the DOI framework. Trialability is defined as "the degree to which an innovation may be experimented with on a limited basis" (Rogers, 2003, p. 258). Trialability was demonstrated by selecting a small sample in one department of the HHA for a trial of a new, innovative idea before expanding to the therapy department. Research conducted using small samples has identified trends and has been found to be valuable as a learning experience (Jefferies, Johnson, Nicholls, & Langdon, 2012).

Observability was the final category of the DOI framework used for the project. Observability is defined as "the degree to which the results of an innovation are visible to other" (Roger, 2003, p. 258). The increase in clinical documentation compliance was observable with all of the nurses participating in the chart audits. The ability to observe results in a limited period of time provides motivation to gain knowledge, confidence, and expertise to continue the process of quality improvement and engagement in the goal of increased compliance with documentation (Rogers, 2003, White & Dudley-Brown, 2012).). The diffusion process was demonstrated through the application of a new, innovative process based on a participative approach for the nursing staff in conducting chart audits, which was communicated through staff training, direct staff participation, and peer communication.

Recommendation for Practice

Improvement in nurses who participated in chart audits compared to nurses who did not participate demonstrates the transition of knowledge to practice. All nurses in the audit group were found to be adequate with the chart requirements for pain, homebound status, and skilled nursing notes. To meet the demand for the growing number of elderly and disabled patients being served by the home healthcare industry, it is imperative that quality improvement measures such as participation in chart audits be implemented by home healthcare organizations (Okrent, 2002). In addition to communicating patient care information, clinical documentation is essential for reimbursement for patients requiring homebound status and skilled services (Skrine, 2002). Through active participation and experience, nurses are a major component of the solution to this problem, but they require

training and development in clinical documentation to comply with the regulations for reimbursement (Skrine & Brown, 2011). Home healthcare leaders must bridge gaps related to coverage, patient safety, quality care, access to care, and compliance with clinical documentation (Duckett, 2012).

Applicability of Findings

The findings are applicable to all areas of home healthcare including nursing, therapy, and office personnel to improve compliance with clinical charting requirements for full reimbursement for skilled services. Home healthcare holds increasing importance in the healthcare system for providing services to persons with chronic illness. The number of home healthcare agencies has increased over the last several years from 7,061 in 2001 to 11,815 in 2010, with approximately 3.5 billion Medicare beneficiaries receiving home healthcare services in 2013 (CMS, 2015; Mukamel et al., 2014). Total expenditures for home healthcare were more than $70 billion in 2010. Home healthcare is expected to remain important over the coming years, given an aging population, emphasis on community-based support services, and the number of individuals with chronic illness (Mukamel et al., 2014). CMS recently announced a payment rule change for the home healthcare industry with a greater emphasis on efficiency, flexibility, payment accuracy, and improved quality. The CMS projects payments to home healthcare agencies to decrease by 0.30% or $60 million in 2015 (CMS, 2015). The home healthcare industry must be vigilant in employing strategies to promote compliance with the requirements for complete clinical documentation for financial sustainability and efforts to improve quality of care.

Implications

Policy and Practice

CMS requirements have placed the home healthcare industry in a situation that demands improvement in quality directed at patient care initiatives. Emphasis has been placed on the accuracy, comprehensiveness, and timeliness of clinical documentation for full reimbursement provided by home healthcare agencies (Mukamel et al., 2014). Healthcare reform is an integral part of the healthcare system to create higher value for healthcare dollars and to improve the population's health. Accountability for healthcare spending is the responsibility of sectors of healthcare from organizational leaders, healthcare providers, and internal and external stakeholders. The success of healthcare reform depends on several factors. Flexibility in healthcare delivery enables providers to achieve the highest level of quality in the most efficient manner. The change in the payment system should assure payers and purchasers that spending will decrease while the quality of care improves and hold providers accountable for use of resources. The revised payment system should cover the cost of care according to the mix of patient needs and levels of care (Miller, 2015).

Organizational policy can be written to reflect guidelines for clinical documentation according to the regulatory requirements of CMS. The financial resources required to provide quality care at a lower cost depend on the completeness of clinical documentation for reimbursement. More nurses working in home healthcare will lead to improved patient care outcomes (Feldman, Clark, & Bruno, 2006). Improvement in clinical documentation will also lead available funding toward new technology to raise

the quality of care for home care patients, such as new technology to remotely monitor patients with chronic illness (Suter, Suter, & Johnston, 2011). Emphasis has been placed on the accuracy, comprehensiveness, and timeliness of clinical documentation for full reimbursement provided by home healthcare agencies (Mukamel et al., 2014).

Research and Social Change

The results of this project identified similar results in literature and current research that illustrates the need for a cultural and social change in the home healthcare system. Social change within organizations must include active participation by professional nursing staff and other professional and non-professional healthcare providers. The importance of chart auditing as a strategy for quality improvement should be implemented as an intervention in the home healthcare setting. The homecare environment is a challenging area with more than 7 million patients served each year with an anticipated growth of 66% in the next 10 years. Almost 70% of the home care population is over the age of 65 with approximately 70% of the persons being served in home healthcare at or over 85 years of age (Gershon et al., n.d.). The homecare population is beginning to show a shift in age with as many as 20 million individuals currently at the age of 64 years or younger. Another current trend in home healthcare is related to patients health conditions with a large portion diagnosed with heart disease (47%), injuries (16%), osteoarthritis (14%), respiratory ailments (12%), and an increasing number of patients with highly complex medical conditions and multiple diagnosis (Gershon et al., n.d.).

Financial responsibility to care for the frail and elderly in the homecare setting is more than the amount of reimbursement received for the episode of care being provided. Accountability and responsibility also incorporates the process for quality improvement and the fiscal and resource use including staff participation in chart auditing. Adequate reimbursement equates to an increase in resources for needed equipment, supplies, staff training, orientation, and opportunities for staff participation in quality improvement measures (Gershon et al., n.d.). Active participation in in-service training and chart auditing provides an opportunity for employees to expand their knowledge, skill, and expertise to enhance the quality of care and improve outcomes for the organization (Nepal Family Health Program, n.d.). Staff development through in-service training establishes roles and responsibilities for the staff, creates a pathway for motivation towards improvement, practice efficiency, and improvement in patient satisfaction (Gesme, Towle, & Wiseman, 2010). This project demonstrates the need for future research on participation in quality improvement and reimbursement for the home healthcare setting.

Project Strength and Limitations

An identified strength of the project was the overwhelming willingness of the entire HHA to participate in the process for change. This was apparent by the motivation and excitement demonstrated by the nurses to become a part of change as active participants in the project team. Another identified strength was the short-term commitment for the project completion. The training was limited to one hour and the chart auditing by the nurses were limited to approximately two hours. Although

simplistic, the intervention provided an opportunity to further the knowledge of the staff through the review of the clinical documentation in the three areas assessed for completeness ((pain, homebound status, and skilled nursing notes). The limited number of staff that work in the HHA and the weekly meetings also enhanced the ability to communicate the process and weekly updates on the project which also added a level of commitment, motivation, and ownership for the staff and administration. Limitations of the project included: (a) a convenience sample of 8 nursing staff, (b) a limitation of 1-hour for training, (c) limited timeframe to review charts, (d) limitation of a third group that would have not received training but participated in chart audits and limitation to generalization of results secondary to the small population of participants and limited data.

Recommendations for future projects would be to extend the number of participants to the other HHA in the state owned by the same corporation and an increase in the timeframe to conduct chart audits to maximize the data. Another recommendation would be to enhance the new hire orientation program to address specific areas of home healthcare-required documentation to address the CMS regulations more adequately. Each area of nursing and healthcare setting has specific documentation requirements as far as content, completeness, and timeframes. This would benefit the newly hired nurses to become acclimated to the new environment with a greater understanding of the differences between settings. The final recommendation would be to establish partnerships between the HHA, local colleges, and universities to promote clinical opportunities for all nursing students regardless of nursing degree program. This would

provide the opportunity for nursing students to be introduced to and experience the specific charting needs of the home healthcare setting. The HHA may also consider inclusion of the nursing staff on online opportunities for updates by the CMS through web conferencing and online updates.

Analysis of Self

The journey of lifetime learning will never end but this specific experience has been a plan for many years. My educational journey began with earning a technical certificate as a licensed practical nurse and has continued to this point of achievement. The DNP program provided me with the skills and confidence to build on my career for future roles as a nurse leader. I have gained knowledge and the ability to apply new skills towards the transformation into practice as a scholar, practitioner, and project organizer/manager.

My role as a scholar has been greatly expanded upon due to the combination of coursework, faculty guidance, and opportunity to learn through experience within the DNP program. The level of understanding scholarship as an essential component of the doctoral education began with the introduction and progression of understand the need for evidence-based practice as a nurse leader. The practicum component of several courses provided the opportunities to experience real-life situations with problem identification, defining a target population, planning and designing programs, organizing teams, developing interventions, and the evaluation of outcome measure. Throughout this process, I have improved my skills in the proper process for completing a literature review, deciding on relevant information, assessing the level of available research,

interpretation of findings, and the identification of research based on proper research technique. I also have a better understanding of statistics such as type of test, data analysis, and the emphasis on statistics as a tool for evidence-based practice. The experience I have gained as a scholar has increased my ability to present information based on science through research to the various healthcare setting, focus groups, and projects.

One of the most important areas I have learned throughout this educational journey is the role of practitioner. Initially, I thought this role encompassed the practice of nursing but in effect, a practitioner is responsible for much more, such as the introduction of knowledge to healthcare, the transition of knowledge into practice, and the skill needed to advance nursing practice on a local, state, and national level. The need for nurses to be active in policy and health reform is a massive undertaking but with collaboration and effective communication the role of practitioner will expand health promotion nationally and internationally.

The opportunity to work with healthcare professionals in a community setting has been one of the best learning experiences throughout this program. This gave me the organizational skills needed to assist with making change for the community and the organization. I have learned that change is a process with specific steps to be completed that is undertaken as a group effort with many stakeholders. Although I have been involved with program planning, I never realized the complexity of the process, the research and evidence that has been researched for systems change, the tools and resources available to begin the steps in change and the internal and external key

stakeholders key role in project management and sustainability. I also learned just how important communication is to project development and the importance of this information to be disseminated to the healthcare professional, business organizations, governmental bodies, and the public.

To summarize, the DNP project has expanded my professional growth as a nurse leader, scholar, practitioner, and project organizer, manager, coach, and mentor. The variety of topics that were specific to each course broadened my understating of the complexity of nursing, inter and intra-professional and disciplinary coordination, and partnerships that are required to produce a program. Process change is necessary to meet the needs of the community toward health promotion, disease prevention, and implementation of best practice through evidence-based research. I found the DNP project very humbling and rewarding at the same time. The group of healthcare professionals that assisted me through this journey communicated the improvement in understanding the need to continue working towards quality, safety, and process improvement. I will also be a lifelong learner but with the help of the DNP project and experience learned and earned, I will be more equipped to make a change and assist others with program improvement.

Summary

Due to healthcare policy changes, aging population, and shortened hospital stays, the home health industry has emerged as an essential component of the contemporary health system. To meet this demand, home health institutions need to improve patient care and customer service through the formation, implementation, and evaluation of

quality improvement measures (Orkent, 2012). Chart audits are a cost-effective and relatively easy measurement strategy to identify whether a clinical pathway is used, whether the pathway is correctly used for an accurate diagnosis, and whether clinical pathways results in a good patient outcome. Furthermore, chart audits lead to the issue identification specific to compliance with quality and safety standards, the appropriateness of care, areas requiring additional staff education, compliance with each clinical process, and the combination of all areas of concern (Kinsman, 2004).

Chart audits, as an evidence-based method, support quality improvement in evaluating outcomes with organizational directives, such as mission, goals, and vision, and values. Healthcare leaders must be vigilant and proactive in developing the structures and processes needed to improve safety, increase the quality of care, reduce the cost of care, and save valuable resources for the future (Harris, 2010). The federal reimbursement regulation for clinical documentation to support home health reimbursement stipulated specific elements for skilled nursing, including an individualized nursing note each 60-day episode. Clinical documentation is an essential quality element that is often not adequately completed. Current data demonstrate 32% of home health claims did not meet the requirements for federal reimbursement (HHS, 2014).

This project provided the opportunity to demonstrate the effectiveness of nursing staff active participation in chart audits to increase the understanding and application of clinical documentation as a quality improvement process. The governing organization would benefit with the expansion of future projects to include nursing staff from other

organizational owned agencies to participate in chart audits as a quality improvement initiative. A change in the orientation process to address specific areas of home healthcare required documentation by the CMS to increase compliance for reimbursement. The HHA, colleges, and universities would benefit from partnerships to introduce specific charting needs in the home healthcare setting. Nurses are the solution to address this problem but they require training and development in clinical documentation to comply with the regulations for reimbursement (Skrine & Brown, 2011).

Section 5: Scholarly Product

Abstract

Purpose – To compare the increase in nursing clinical documentation compliance in a home health organization between staff receiving only education to staff receiving education with participation in chart audits.

Background - Clinical documentation is an essential quality element that is often not adequately completed. Current data demonstrates 32% of home health claims did not meet the requirements for federal reimbursement.

Methods – Roger's diffusion of innovation was used as a conceptual framework to demonstrate the process of diffusion on a new innovative process. A quantitative design with volunteer nursing staff participating in chart audits for the following sections: pain assessment, homebound status, and skilled nursing notes.

Findings – The results revealed all the nurses that participated in the chart audit increased clinical documentation compliance. Nurses with > 4 years in nursing charted more adequately than nurses with ≤ 4 in nursing and nurses with ≤ 4 years in homecare were found to chart more adequately than nurses with > 4 years in homecare.

Conclusion - All nurses in the audit group were found to be adequate with the chart requirements for pain, homebound status, and skilled nursing notes. The use of participation by nursing staff in chart audits as a quality improvement method to address the need for compliance with clinical documentation for reimbursement.

Nursing Staff Participation in Chart Audits Increase Documentation Compliance

Introduction

Due to healthcare policy changes, aging population, and shortened hospital stays, the home health industry has emerged as an essential component of the contemporary health system. Annually, home health institutions provide care to more than 2.4 million elderly and disabled clients. By 2020, home health services payments for the aging population will exceed $543.6 million. To meet this demand, home health institutions need to improved patient care and customer service through the formation, implementation, and evaluation of quality improvement measures (Okrent, 2012).

Historically, nursing research focused on acute care services but has expanded to other settings such as home health. Evidence-based practice in home health is purposed to improve patient care, to ensure appropriate reimbursement, and to provide transparency in the public reporting of information through Home Health Compare (Medicare.gov., n.d.). Evidence-based home health practice includes work to bring change in patient safety standards, quality improvement measures, and training strategies for clinicians. Examples include, fall risk assessment tools, catheter-related infection prevention programs, strategies to increase patient medication compliance, effective patient and staff education, wound care treatment measures, orientation and mentoring programs, infection control interventions, and many more areas (Whittier, 2008).

Adding to the traditional nursing services perspective, contemporary evidence-based practices are being adopted from other industries, including manufacturing, aviation, and financial industries. Primarily, the transfer of knowledge from these

industries into the home health care industry is informing health information technology and quality improvement initiatives. Some quality improvement initiatives, such, implementing clinical pathways, apply evidence-based knowledge to develop a specific care model, and measures differences in health outcomes.

There are many examples of research (Becker et al., 1997; Gregory, Horn, & Kaprielian, 2008; Hanna et al., 1999; Johnson, Blaisdell, Walker, & Eggleston, 2000; Rotter et al., 2008; Wong, 2009) that involves measuring patient outcomes through the chart audit as a research method. Chart auditing is a cost-effective and relatively easy measurement strategy to identify whether a clinical pathway is used, whether the pathway is correctly used for an accurate diagnosis, and whether the clinical pathway results in a good patient outcome. Furthermore, chart audits lead to issue identification specific to compliance with quality and safety standards, the appropriateness of care, areas requiring additional staff education, compliance with each clinical process, and the combination of all areas of concern (Kinsman, 2004).

Background

Those in the health sector face challenges to meet demands associated with growing consumerism, expanding regulations, pressing financial constraints, increasing quality and safety expectations, and an evolving patient-centered care paradigm. Chart audits, as an evidence-based method, support quality improvement in evaluating outcomes with organizational directives, such as mission, goals, vision, and values. Healthcare leaders must be vigilant and proactive in developing the structures and

processes needed to improve safety, increase the quality of care, reduce the cost of care, and save valuable resources for the future (Harris, 2010).

In home health, a complete assessment and ongoing evaluation of patient status, health needs, and function begins with the clinician-patient encounter. Assessment documentation and follow-up evaluations need to be clearly stated with sufficient evidence to satisfy the elements required for homebound status. The federal regulation for clinical documentation to support home health reimbursement stipulates specific elements for skilled nursing, including an individualized nursing note for each 60-day episode. Clinical documentation is an essential quality element that is often not appropriately completed. Current data demonstrate that 32% of home health claims did not meet the requirements for federal reimbursement (U.S. Department of Health and Human Services [HHS], 2014).

In addition to communicating patient care information, clinical documentation is essential for reimbursement in patients requiring homebound status and skilled services (Skrine, 2002). Limitations in clinician knowledge, skill level, and understanding of the requirements for reimbursement are reasons noted to explain incomplete and deficient documentation for a skilled nursing visit. Importantly, each visit note must demonstrate medical necessity for skilled nursing services. Nurses are the solution to address this problem, but they require training and development in clinical documentation to comply with the regulations for reimbursement (Skrine & Brown, 2011).

Problem Statement

The purpose of this project is to compare the increase in nursing clinical documentation compliance in a home health organization between staff receiving only education and staff receiving education with participation in chart audits. In the contribution to knowledge acquisition, translation of knowledge, application of knowledge into practice, and the additional interaction, the project provided a learning opportunity to increase the awareness of change and the importance of compliance with documentation as related to financial outcomes. Chart auditing, as a quality improvement, method provides feedback about documentation performance, compliance with state and federal requirements, and management of organizational legal requirements (Wisconsin Department of Health Services, 2009). Inadequate clinical documentation fails to support medical necessity for the approval and reimbursement for home healthcare patients. As such, home healthcare agencies whose personnel do not meet documentation requirements place patients and the organization at risk for loss of skilled nursing services (Rowan, 2010).

Health care reform is a public policy concern at both the state and federal levels and involves many stakeholders, including, patients and families, healthcare organizations, third-party payers, and professional healthcare providers (Ridenour & Trautman, 2009). Nursing professionals constitute more than 50% of healthcare force (Delucia, Ott, & Palmieri, 2009) and have a role that involves protecting society from harm, using prevention measures to limit or minimize the potential for illness, and provide care for the chronically ill patient (Institute of Medicine, 2013). The role of home

healthcare is expected to expand in the coming years with an aging population, increased prevalence of chronic conditions, and increased emphasis on caregiving for patient by family members. The requirements by the Centers for Medicare and Medicaid have placed the home healthcare industry in a situation that demands the improvement in quality directed at patient care initiatives. Emphasis has been placed on the accuracy, comprehensiveness, and timeliness of clinical documentation provided by home healthcare agencies for full reimbursement (Mukamel, et al., 2014).

Project Question, Purpose and Objectives

With a quality improvement intervention, do home health nurses with education and chart audit experience have increased documentation compliance than nurses with education without chart audit experience? The purpose of this project is to compare the increase in nursing clinical documentation compliance in a home health organization between staff receiving only education and staff receiving education with participation in chart audits. In the contribution to knowledge acquisition, translation of knowledge, application of knowledge into practice, and the additional interaction, the project provided a learning opportunity to increase the awareness of change and the importance of compliance with documentation as related to financial outcomes.

Conceptual Framework

Rogers' diffusion of innovation theory (DOI) has been used to guide this project and activities. The theory used for this project will be based on Rogers' diffusion of Innovation (DOI) Theory. The concept of diffusion will be addressed in this project. Rogers (2003) defines diffusion as, "the process by which (1) an *innovation* (2) is

communicated through certain channels (3) over *time* (4) among the members of a *social system"*(p. 12). The diffusion process was demonstrated through the application of a new, innovative process based on a participative approach for the nursing staff in conducting chart audits, which was communicated through staff training, direct staff participation, and peer communication. Over time, the nursing staff gained knowledge, confidence, and motivation to continue the process of quality improvement and engagement within the social system for joint problem solving to advance the goal of increased compliance with clinical documentation requirements (Rogers, 2003; White & Dudley-Brown, 2012).

Methods

A quantitative design was used for this project. This project incorporated a convenience sample of all full-time nursing staff excluded the administrators of the agency who are also nurses. General demographic was collected to identity level of education, number of years working as a nurse, and number of years working in the home care setting. The nurses where divided into the education-only group (n = 4) and education-and-chart audit group (n = 4) according to experience in the number of years working in the home healthcare setting, level of education and gender. Both groups attended a staff training session on requirements for clinical documentation prior to being placed in either the education-only or education-plus-chart-audit group. The education plus chart audit group participated in chart audits and the education only group did not participate in chart audits. The instrument used for the data collection was the chart audit developed by the HHA. Chart audits are completed by the HHA on a regular basis as a continuous quality improvement process.

A training session was provided to all eight participants prior to the groups being divided into the education-only group and education-plus-chart-audit groups. The training session consisted of verbal information and written examples of the requirements to justify the need for skilled nursing services in the areas of pain assessment, homebound status, and skilled nursing notes. Following the training session, the groups were divided according to level of education, length of time working as a nurse, and length of time working as a homecare nurse.

Findings and Discussion

Findings With Evidence Support

The Statistical Package for the Social Sciences (SPSS) version 21 was used for statistical analysis. Coded data was entered into the SPSS and a Fisher's exact test was performed (Pett, 1997). The educational training presented to the home healthcare nurse consisted of information on the requirements for clinical documentation compliance for reimbursement. After a period of three weeks, a chart audit was conducted on four charts for each of the subjects that participated in the chart audits as well as four charts for each person in the nonaudit group to assess whether there was improvement in adequate charting utilizing the standard organizational chart audit form. Adequacy of charting was determined the following sections were compliant with documentation 3 out of 4 times with each chart reviewed.

There were eight participants in the study—four licensed practical nurses (LPNs) and four registered nurses (RN). All were full-time nursing staff, and all female. Each nurse completed a general demographic survey. Each group had two RNs and two LPNs.

The average length of time working as a nurse was between 11 and 14.5 years, and average length of time working as a homecare nurse was between 2 and 5.5 years. Each nurse in the audit group completed chart audits on four patient charts. All patient charts were selected randomly, with patient identifiers removed from the charts before the auditing process began. The overall general demographic results for educational level, years working as a nurse, and years working as a nurse in homecare are identified in

Table 1

Demographic Information: Level of Education, Years Nursing, and Years as a Homecare

Educational level	Level of education *N (%)*	Years working in nursing *N (%)*	Years in homecare *N (%)*
RN	50		
LPN	50		
Years			
1-4		37.5	75.0
5-10		12.5	25.0
11-15		12.5	
16-20		25.0	
>20		12.5	

Table 2

Clinical Documentation by Audit Group and Level of Education

	Audit Group	Non-Audit Group	Registered Nurse	Licensed Practical Nurse
Pain				
Adequate	4	2	4	2
Inadequate	0	2	0	2
Homebound status				
Adequate	4	1	3	2
Inadequate	0	3	1	2

Skilled nursing note				
Adequate	3	0	1	2
Inadequate	1	4	3	2

Due to the very small sample size, a Fisher's exact test was conducted instead of conducting a Chi-square analysis of the data as initially proposed. The Fisher's exact text is useful to analyze dichotomous data in a 2 X 2 contingency table when the total sample size is less than 20 (Pett, 1997).

For this analysis, data for pain assessment, homebound status and skilled nursing notes were recoded into two categories. For each of these areas, overall improvement in charting was considered unsatisfactory (coded as 1) if only 4 or fewer instances of adequate charting was noted and an improvement in charting was considered satisfactory (coded 2) if 5 or more instances of adequate charting was noted.

Based on Fisher's exact test analysis, there was no significant difference between nurses who participated in chart audits and those who did not in the adequacy of charting related to pain, homebound status and skilled nursing notes. However, a trend toward more complete charting related to pain, homebound status, and skilled nursing notes was noted in nurses that participated in chart audits. Overall, including both groups, RNs were found to have more complete charting compared to the LPNs for pain and homebound status and the LPNs were found to have more complete charting in the skilled nurses notes (see Table 2).

A trend was also found when comparing documentation compliance in the years of nursing and years as a homecare nurse. The nurses with >4 years in nursing charted

more adequately than nurses with ≤ 4 years of nursing related to pain and homebound status. Nurses with ≤ 4 years of nursing charted more adequately compared to nurses with > 4 years of nursing in the skilled nursing note section of the chart audit. Another interesting finding identified all nurses with ≤ 4 years as a homecare nurse charted adequately compared to nurses with > 4 years as a homecare nurse (see Table 3).

Table 3

Clinical Documentation per Years in Nursing and Years as a Homecare Nurse

	Years in Nursing		Years as Homecare Nurse	
	≤ 4 years	≥ 4 years	≤ 4 years	≥ 4 years
Pain				
Adequate	3	5	6	2
Inadequate	0	0	0	0
Homebound status				
Adequate	2	3	4	1
Inadequate	1	2	2	1
Skilled nursing note				
Adequate	2	1	2	1
Inadequate	1	4	4	1

Findings With Framework Support

The framework used for this project to demonstrate ease of use for the HHA was the DIT's innovation-decision process. *Diffusion* is defined as "the process by which (1) an *innovation* (2) is *communicated* through certain channels (3) over *time* (4) among the members of a *social system"* (Rogers, 2003, p. 12). The characteristics that hold the most influence over the adoption of innovation are relative advantage, compatibility, complexity, trialability, and observability (Rogers, 2003).

Relative advantage was associated with a new innovation to improve quality and completeness of clinical documentation by the home healthcare nurses through participation in chart audits. *Relative advantage* is described as "the degree to which an innovation is perceived as better than the idea it supersedes" (Rogers, 2003, p. 229). Relative advantage was demonstrated by the administrative and nursing staff through the use of staff participation in chart audit for quality improvement. The rate of diffusion within the organization, the perception of innovation to make change in the system, and the commitment to educating the team on the need for change have been identified as clusters that influence change (Hyrkas & Harvey, 2010). Introducing innovative ideas into the healthcare system is imperative to meet requirements for clinical documentation for reimbursement (HHS, 2012).

Compatibility is associated with cultural beliefs, values, and attitudes of the organization. Compatibility is defined as "the degree to which an innovation is perceived as being consistent with existing values, past experiences, and needs of potential adopters" (Rogers, 2003, p. 241). Compatibility with the HHA mission involves providing quality care to optimize comfort and dignity in the home setting, which was congruent with the values of the HHA staff as an essential part of the health delivery system (ViaQuest, Inc, 2014). Motivation for cultural change based on values and beliefs is essential when initiating change from an individual and organizational perspective.

Complexity is defined as "the degree to which an innovation is perceived as difficult to understand and to use" (Rogers, 2003, p. 257). The project intervention, participation by nursing staff in chart audits, was found to take very limited time and to

be easy to complete, resulting in improvement in clinical documentation. Research findings have demonstrated the use of a target educational intervention, staff participation, and a feedback process as a simple, noncomplex intervention that is effective toward quality improvement (Pan, Meng, Gibbons & Strayhorn, 2009).

Trialability is the fourth characteristic identified in the DOI framework. Trialability is defined as "the degree to which an innovation may be experimented with on a limited basis" (Rogers, 2003, p. 258). Trialability was demonstrated by selecting a small sample in one department of the HHA for a trial of a new, innovative idea before expanding to the therapy department. Research conducted using small samples has identified trends and has been found to be valuable as a learning experience (Jefferies, Johnson, Nicholls, & Langdon, 2012).

Observability was the final category of the DOI framework used for the project. Observability is defined as "the degree to which the results of an innovation are visible to other" (Roger, 2003, p. 258). The increase in clinical documentation compliance was observable with all of the nurses participating in the chart audits. The ability to observe results in a limited period of time provides motivation to gain knowledge, confidence, and expertise to continue the process of quality improvement and engagement in the goal of increased compliance with documentation (Rogers, 2003, White & Dudley-Brown, 2012).). The diffusion process was demonstrated through the application of a new, innovative process based on a participative approach for the nursing staff in conducting chart audits, which was communicated through staff training, direct staff participation, and peer communication.

Recommendation for Practice

Improvement in nurses who participated in chart audits compared to nurses who did not participate demonstrates the transition of knowledge to practice. All nurses in the audit group were found to be adequate with the chart requirements for pain, homebound status, and skilled nursing notes. To meet the demand for the growing number of elderly and disabled patients being served by the home healthcare industry, it is imperative that quality improvement measures such as participation in chart audits be implemented by home healthcare organizations (Okrent, 2002). In addition to communicating patient care information, clinical documentation is essential for reimbursement for patients requiring homebound status and skilled services (Skrine, 2002). Through active participation and experience, nurses are a major component of the solution to this problem, but they require training and development in clinical documentation to comply with the regulations for reimbursement (Skrine & Brown, 2011). Home healthcare leaders must bridge gaps related to coverage, patient safety, quality care, access to care, and compliance with clinical documentation (Duckett, 2012).

Recommendations for future projects would be to extend the number of participants to the other HHA in the state owned by the same corporation and an increase in the timeframe to conduct chart audits to maximize the data. Another recommendation would enhance the new hire orientation programs to address specific areas of home healthcare-required documentation that would address the CMS regulations more adequately. Each area of nursing and healthcare setting has specific documentation requirements as far as content, completeness, and timeframes. This would benefit the

newly hired nurses become acclimated to the new environment with a great understanding of the differences between settings. The final recommendation would be to establish partnerships between the HHA and local colleges and universities to promote clinical opportunities for all nursing students regardless of nursing degree program. This would provide the opportunity for the nursing students to be introduced and experience the specific charting needs of the home healthcare setting. The HHA may also consider inclusion of the nursing staff on online opportunities for updates by the CMS through web conferencing and online updates.

Project Strength and Limitations

An identified strength of the project was the overwhelming willingness of the entire HHA to participate in the process for change. This was apparent by the motivation and excitement demonstrated by the nurses to become a part of change as active participants in the project team. Another identified strength was the short-term commitment for the project completion. The training was limited to one hour and the chart auditing by the nurses were limited to approximately two hours. Although simplistic, the intervention provided an opportunity to further the knowledge of the staff through the review of the clinical documentation in the three areas assessed for completeness (pain, homebound status, and skilled nursing notes). The limited number of staff that work in the HHA and the weekly meetings also enhanced the ability to communicate the process and weekly updates on the project which also added a level of commitment, motivation, and ownership for the staff and administration. A cost benefit for the HHA was also viewed as a strength with the timeliness for submission of

documentation to the CMS. Prior to the project, the HHA experienced a 6-month turnaround time for submission of documentation for reimbursement. Following the implementation of the project, the documentation submission from 6-months post episode to 4-month post episode of care. The improvement in clinical documentation limited the number and time required for correction of documentation.

Limitations of the project included: (a) a convenience sample of 8 nursing staff, (b) a limitation of 1- hour for training, (c) limited timeframe to review charts, (d) limitation of a third group that would have not received training but participated in chart audits and limitation to generalization of results secondary to the small population of participants and limited data.

Summary

Clinical documentation is the core of quality patient care, quality improvement, and federal and state requirements for reimbursement. Accurate, thorough, timely representation of clinical documentation is essential for public reporting of quality indicators; communication among healthcare providers; tracking and trending of preventable occurrences such as falls, wounds, and medication errors;, and justification of services provided by the home healthcare industry (American Health Information Management Association, 2014). Inadequate clinical documentation is a direct cause of payment denial and withholding of payment from CMS. The two main areas of clinical documentation that have been identified by the CMS and Bureau of Home Care and Rehabilitative Standards as lacking are justification for homebound status and need for skilled care services (Bureau of Home Care and Rehabilitative Standards, 2010; CMS,

2014).

The primary goal of accurate, comprehensive clinical documentation is to ensure the quality and continuity of care, the dissemination of information through written communication, the detection of patient-related problems and changes in health status, and care planning for individualized assessment, treatment, and evaluation of patient needs, goals, and outcomes (Arizona Association for Home Care, 2011). Factors that lead to incomplete or insufficiently specific documentation on a skilled nursing visit include limited knowledge, skill, and understanding of the requirements for reimbursement. Each visit note is scrutinized for medically necessary skilled services. Nursing staff need to be trained specifically on the clinical documentation requirements to meet regulations for reimbursement (Skrine & Brown, 2011). Chart audits are conducted on a routine basis according to regulations set by the state and federal government to assess the accuracy, completeness, and timeliness of specific areas related to quality care and reimbursement (CMS, 2014). Each visit note is scrutinized for the need of medical necessary skilled services. Nursing staff need to be trained specifically on the clinical documentation requirements to meet the regulations for reimbursement (Skrine & Brown, 2011). Active participation in chart audit conducted by the nursing staff will improve knowledge of the requirements for clinical documentation for reimbursement purposes, improve patient care through comprehensive assessment, and motivate the nursing staff to become an active component of quality improvement and quality patient care.

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Appendix A: Demographic Survey

ID #_____

1. Level of Education
   ☐ LPN ☐ RN

2. Number of Years Working as a Nurse
   ☐ 1-4 ☐ 5-10 ☐ 11-15 ☐ 16-20 ☐ 21-25 ☐ 26-30 ☐ 30+

3. Years working in the homecare setting

   ☐ 1-4 ☐ 5-10 ☐ 11-15 ☐ 16-20 ☐ 21-25 ☐ 26-30 ☐ 30+