

**Quality Improvement Project: Enhancing Treatment Plan Documentation to Improve Continuity of  
Care in a Secure Residential Treatment Facility**

Celeste Arnold, BSN, RN

Oregon Health & Science University, School of Nursing

PMHNP-DNP

Dr. Andrea Hughes, DNP, PMHNP-BC, FNP-BC

March 13, 2026

### **Abstract**

This quality improvement project (QI project) was implemented at a secure residential treatment facility (SRTF) for adults with severe and persistent mental illness (SPMI) to improve treatment plan documentation supporting third party medical necessity determinations. The intervention consisted of a brief, structured training paired with a practical documentation checklist provided to clinicians responsible for treatment plan creation and maintenance. Training content focused on aligning documentation with the Oregon Administrative Rules (OARs), Oregon Health Authority's (OHA) Level of Service Inventory (LSI) criteria, and third-party reviewer expectations. Outcomes included clinician-reported knowledge, confidence, and perceived utility of the intervention. These outcomes were assessed through pre-training, post-training, and follow-up surveys. Findings suggest that targeted education and structured tools reduce documentation ambiguity and may support clearer communication of medical necessity to external reviewers. This QI project informs future efforts to standardize documentation practices in psychiatric residential settings to improve continuity of patient care.

## **Quality Improvement Project: Enhancing Treatment Plan Documentation to Improve Continuity of Care in a Secure Residential Treatment Facility**

### **Problem Description**

In Oregon's Secure Residential Treatment Facilities (SRTFs), treatment plans function as both clinical roadmaps throughout a patient's stay and primary reference material used for Medicaid authorization determinations. When treatment plan documentation lacks clarity, specificity, or alignment with payer expectations, continued stay requests may be denied despite clinicians' judgment. Such denials can interrupt patient stabilization and increase reliance on crisis services after discharge.

The complexity of OAR requirements, variability in utilization of LSI criteria in treatment plans, and administrative time pressures created structural barriers to consistent articulation of medical necessity at a 16-bed SRTF. Clinicians identified primary problems in the treatment planning process, including canned and superficial documentation practices as well as lack of practical tools to support consistent articulation of medical necessity to third-party reviewers at Comagine Health. Wu et al. (2024) found that copy-forward practices are often used in busy clinics to manage time constraints, which further contributes to documentation poorly reflecting patient acuity, risk, and level of care requirements. This disconnect between clinical need and documentation quality undermines continuity of care and can erode provider morale when unstable patients are prematurely discharged only to be readmitted months, weeks, or days later. This QI project addressed documentation gaps by implementing a structured training and checklist intervention to strengthen clinicians' ability to clearly communicate medical necessity and support continuity of care.

### **Available Knowledge**

High-quality, individualized treatment plans are a core component of evidence-based psychiatric care, especially for individuals with SPMI with complex psychosocial needs. Ideally, treatment planning is a dynamic, collaborative process that integrates comprehensive assessment, interdisciplinary

coordination, and meaningful patient involvement (Treichler et al., 2021; Francis et al., 2024). When done well, these plans guide clinical care, track progress, and ultimately influence critical decisions such as insurance authorization, care transitions, and discharge planning. However, real-world implementation often falls short of these ideals due to systemic barriers, limited stakeholder involvement, and documentation practices that prioritize compliance over patient-centered care. The persistent tension between recovery-oriented, person-centered care and the payer-driven language of medical necessity pose a challenge to many treatment teams (Rudolph, 2021).

This conflict is further exacerbated by documentation fatigue, which contributes to overuse of copy-forward practices and incomplete updates, which ultimately compromises the accuracy, integrity, and therapeutic utility of the treatment plan. Shehadeh et al. (2022) found that mental health professionals working in inpatient psychiatric settings such as SRTFs frequently experience moral distress, defined as the emotional turmoil arising when clinicians cannot act in accordance with their moral values due to systemic and environmental constraints. When documentation demands reduce care to bureaucratic tasks rather than therapeutic connection, clinicians can suffer from diminished morale. This project responds to these problems with evidence supporting the use of structured training paired with usable tools, which may reduce ambiguity and improve alignment between clinical assessment and regulatory, legal, and payer expectations (Frank et al., 2021).

### **Rationale**

This QI project was guided by the Plan-Do-Study-Act (PDSA) framework, a widely used model for testing and refining practice changes in real-world clinical settings (AHRQ, 2024). PDSA was selected because it supports rapid-cycle improvement, emphasizes feasibility within existing workflows, and allows interventions to be adapted in response to contextual constraints and clinician input. These characteristics made the framework particularly well suited to an inpatient environment where clinical demands are high, staffing resources are limited, and changes must support daily patient care.

The intervention targeted treatment plan documentation because documentation quality represents one of the few modifiable factors directly under clinician control that can influence payer authorization decisions. The rationale for the intervention was further informed by provider-identified challenges within the existing documentation process. When informally interviewed, clinicians reported uncertainty regarding how to translate complex clinical presentations into documentation that clearly met Comagine Health authorization standards. Although staff were experienced and highly engaged in patient care, variability in documentation practices and evolving payer expectation contributed to ambiguity. These conditions suggested that targeted education and practical tools were most likely to improve alignment between clinical assessment and documentation.

The intervention combined brief targeted training paired with a checklist tool to address these gaps. Educational components were intended to increase shared understanding of payer expectations, while the checklist provided a concrete structure to support consistent documentation during routine treatment planning. The intervention was expected to work by reducing cognitive load, clarifying rationales for treatment planning expectations, standardizing documentation structure, and supporting consistent articulation of medical necessity during weekly interdisciplinary team (IDT) meetings.

### **Specific Aims**

The purpose of this QI project was to improve the treatment plan documentation at an adult SRTF through implementation of a structured training and checklist aligned with OARs and the OHA's LSI, which Comagine Health refers to during medical necessity determinations. The project evaluated clinician knowledge, confidence, feasibility, and perceived impact on documentation practices.

## **Methods**

### **Context**

The project was implemented at an adult SRTF in Oregon serving individuals with SPMI. Treatment planning involves multidisciplinary collaboration between psychiatric mental health nurse

practitioners (PMHNPs), a family nurse practitioner (FNP), licensed clinical social workers (LSCWs), registered nurses (RNs), and qualified mental health professionals (QMHPs). Treatment plans were initially written at time of patient admission by a QMHP. The plans were often left in patient files after admission without ongoing updates. Ideally, they would be updated monthly to appropriately reflect updates to goals and interventions.

A key contextual factor influencing this project was the role of Comagine Health, the third-party utilization review organization responsible for determining medical necessity for continued stay authorization under Oregon Medicaid. Medical necessity determinations are based on multiple inputs including a single patient interview and review by the third-party reviewers of the treatment plan, provider progress notes, staff progress notes, and daily care records. Documentation functions as the primary mechanism through which clinical acuity, functional impairment, and ongoing risk are communicated to external reviewers. Inconsistencies, canned inputs, omissions, or lack of clarity in documentation sometimes resulted in denied authorizations that diverged from the clinical team's assessment of patient readiness for transition.

The facility had existing infrastructure that supported implementation of the intervention, including regularly scheduled interdisciplinary meetings, internal email communication, and an electronic health record (EHR) with modifiable templates. Leadership support was secured prior to implementation, and organizational endorsement facilitated training attendance and distribution of materials.

Several contextual factors introduced uncertainty during the project period. These included sudden EHR software updates that affected documentation workflows, the OHA's announcement of forthcoming revisions to the LSI, and IDT meeting moved to Tuesdays when project lead was unavailable for ongoing project checkins. Each of these factors posed as barriers to scope, timing, and clinician buy-in to the training at the designated time (i.e. they wanted to postpone the training until these updates

were complete in December 2025 or thereafter). Ultimately, the team agreed to refine the treatment planning process in tandem with EHR updates and LSI changes.

### **Intervention**

The intervention was led by the project lead, a Doctor of Nursing Practice (DNP) student, in collaboration with facility leadership. A one-time, 15-minute structured documentation training paired with dissemination of a treatment plan checklist was delivered to clinicians involved in treatment plan development and maintenance on November 12, 2025, at a regularly scheduled IDT meeting. The training focused on high-value content that was identified via team-based collaboration. This content included an overview of OARs related to treatment planning, LSI criteria, and Comagine medical necessity standards. In addition to educating clinicians on these content pillars, strategies and patient-specific examples for improving documentation were provided.

Training content was delivered using a combination of verbal instruction and written materials. Clinicians received electronic reference materials and printed handouts, including the treatment plan checklist designed to guide documentation during routine treatment planning workflows. The checklist outlined essential components of medical necessity based on rules and regulations set out by OHA, as well as clinical best practice suggestions to describe symptom acuity, functional impairment, treatment readiness, and ongoing risk.

The project lead facilitated the training session, created and distributed materials, and remained available via email or in-person discussion for follow-up questions after the session. All clinicians involved in treatment planning at the facility participated in the training, resulting in 100% attendance among the target group. The IDT team included the QMHP who was primarily responsible for drafting treatment plans, as well as a LCSW, a RN, a PMHNP, and an administrative director who each contributed to treatment plan maintenance at weekly IDT meetings throughout patients' stay at the SRTF.

To support implementation and assess engagement, a pre-training survey was administered prior to the training to capture baseline clinician perception of documentation clarity and familiarity with the LSI and Comagine Health expectations. A post-training survey was administered following the session to assess perceived changes in knowledge, confidence, and usefulness of the materials. A follow-up feedback survey was distributed approximately eight weeks later, on January 7, 2026, to capture clinician perceptions of the checklist's ongoing usability and barriers to implementation. Follow-up survey administration timing was adjusted in response to the update to the EHR, pending changes to the LSI tool, and scheduling changes to IDT meetings, which meant that a second PDSA cycle was not feasible within the project timeframe.

### **Study of the Intervention**

The impact of the intervention was assessed using a mixed methods approach focused on clinician-reported outcomes. Anonymous pre-training and post-training surveys were used to examine changes in clinicians' understanding of documentation expectations. Qualitative open-ended responses were analyzed to contextualize quantitative findings and identify perceived facilitators and barriers to implementation. Due to the limited post-implementation timeframe and lack of available payer authorization data, causal attribution of outcomes to the intervention was assessed via perceived utility rather than through comparison of system-level metrics as originally proposed.

### **Measures**

This QI project used process and outcome measures to assess the feasibility and perceived impact of a structured documentation training and checklist intervention. The primary outcome measures were clinician self-reported understanding of LSI and Comagine Health documentation expectations and confidence aligning treatment plans with medical necessity standards. Outcomes were operationalized using pre-training, post-training, and follow-up surveys with five-point Likert-scale items assessing documentation knowledge, confidence, and perceived utility of the intervention. These

measures were selected because provider clarity and confidence were central to the project's rationale that clinician's treatment plan documentation was a modifiable contributor to challenges with matching Comagine Health reviewer expectations. Process measures were captured through attendance tracking and survey responses. These included training attendance and reported use of the checklist tool into treatment planning workflows. Training attendance was used to assess intervention reach, while checklist use served as a proxy for intervention fidelity.

Methods to support data completeness and accuracy included anonymous survey collection and standardized Likert-scale items aligned with intervention components, which improved validity. Reliability was limited by small sample size and reliance on self-reported data, consistent with the exploratory nature of this initial quality improvement effort.

### **Analysis**

Quantitative and descriptive qualitative methods were used to analyze project data. Pre-training and immediate post-training surveys administered on November 12, 2025, were summarized using mean Likert-scale scores to assess changes in clinicians' self-reported understanding of LSI criteria and Comagine Health reviewer expectations. A final feedback survey collected on January 7, 2026, was analyzed descriptively to capture perceptions of the intervention's ongoing utility. Open-ended survey responses were reviewed using thematic analysis to identify patterns related to documentation clarity, perceived documentation burden, and implementation experience.

### **Ethical Considerations**

The intervention did not involve direct patient contact, alteration of clinical care, or collection of patient-identifying information. Participation in training activities and associated surveys was voluntary, and all survey responses were collected anonymously with no linkage to individual clinicians or performance evaluations. All project data were stored securely, and access was limited to the project

lead. A letter of support from site leadership was obtained prior to project implementation, confirming organizational awareness and approval of the quality improvement activities.

Formal institutional review processes were followed to determine the project's regulatory status. The project was reviewed and determined to meet criteria for quality improvement rather than human subject research. No conflicts of interest were identified.

## **Results**

Pre-training surveys were completed by seven clinicians (n=7). Immediate post-training surveys were completed by six clinicians (n=6), reflecting one instance of nonresponse. A final feedback survey administered six weeks after implementation was completed by three clinicians (n=3), indicating attrition over time and incomplete capture of longitudinal survey responses.

On a five-point Likert scale, clinicians' self-reported understanding of Comagine documentation requirements increased by 1.00 point, from a pre-training mean score of 3.00 to a post-training mean score of 4.00 (see Appendix D). Smaller changes were observed across additional self-reported competencies, including familiarity with the LSI, confidence aligning treatment plans with Comagine Health medical necessity standards, and perceived clarity in documentation practices.

Post-training perceptions of the intervention were generally favorable. Clinicians reported a mean confidence score of 3.83 regarding the usefulness of the training in supporting documentation practices. Most respondents indicated that they believed the training would improve Comagine authorization outcomes and reported they would recommend the intervention to other clinical settings.

All respondents to the final feedback survey (n=3) agreed or strongly agreed that the checklist was useful in integrating best practices into treatment planning workflows. Qualitative responses suggest the checklist improved clarity, with one respondent noting that the training "demystified" the treatment planning process related to Comagine approval expectations. Additional qualitative feedback

identified two ongoing challenges to satisfactory implementation of the treatment planning process: perceived time constraints and competing demands for direct patient care.

## **Discussion**

### **Summary**

Key findings demonstrated a statistically significant increase in clinicians' self-reported understanding of documentation requirements following the intervention ( $p=0.03$ ), along with favorable perceptions of the checklist's relevance and usability. This intervention was low-cost, feasible within existing interdisciplinary workflows (i.e. weekly IDT meetings), and well-received by an interdisciplinary treatment team in a resource-limited SRTF.

### **Interpretation**

The findings from this QI project suggest a positive association between the brief, targeted documentation training and clinicians' perceived confidence in effective treatment planning. The intervention was designed to reduce ambiguity in treatment planning and strengthen clinicians' ability to clearly communicate medical necessity to improve outcomes of external review processes. Post-implementation survey responses indicated improved knowledge and clarity of Comagine Health reviewer expectations. These results are consistent with existing literature demonstrating that targeted clinician education paired with practical tools can improve provider knowledge, documentation practices, and confidence in clinical decision-making (Frank et al., 2021; Gupta et al., 2021).

Beyond documentation knowledge, the project highlights important implications for interdisciplinary team functioning, Treatment plans serve as a primary communication tool not only for external reviewers but also for interdisciplinary care teams coordinating treatment for individuals with SPMI. Ambiguous or fragmented documentation processes can contribute to moral distress, role confusion, and burnout when clinicians perceive documentation as bureaucratic rather than clinically meaningful (Gupta et al., 2021; Craig et al., 2021).

**Limitations**

Several limitations should be considered when interpreting the findings of this QI project. The project was conducted at a single SRTF with a small number of participating clinicians, which limits generalizability to other psychiatric settings with different staffing structures, payer relationships, and patient populations. Additionally, outcome measures relied primarily on self-report, which was subject to recall and may not directly reflect sustained changes in documentation behavior. Finally, delays related to EHR updates and anticipated revisions to the LSI tool further constrained the project timeline, limiting the original scope of the project. Future iterations of this project may incorporate longitudinal comparisons of authorization rates and structured chart audits to better capture trends in untimely discharges and documentation quality.

**Conclusions**

This QI project demonstrates that a brief, structured training paired with a practical documentation checklist can meaningfully improve clinicians' confidence in aligning treatment plans with legal and industry standards. The intervention was low-cost, feasible within a time-limited meeting, and well received by the interdisciplinary treatment team, suggesting strong usefulness for organizations seeking to improve documentation quality without adding significant burden to clinical practice. Improved clarity in articulating medical necessity may support payer approvals, reduce premature discharges, enhance provider confidence in communicating treatment rationale, and improve team morale. Overall, this QI project provided an exercise in identifying the importance of lifelong learning and professional growth in the context of day-to-day clinical operations.

**Other Information****Funding / Conflicts of Interest**

This quality improvement project received no funding. There are no conflicts of interest related to its development, implementation, or outcomes.

## References

- AHRQ. (2024). *Plan-Do-Study-Act worksheet, directions, and examples*. Agency for Healthcare Research and Quality. <https://www.ahrq.gov/health-literacy/improve/precautions/tool2b.html>
- Craig, K. J. T., Willis, V. C., Gruen, D., Rhee, K., & Jackson, G. P. (2021). The burden of the digital environment: A systematic review on organization-directed workplace interventions to mitigate physician burnout. *Journal of the American Medical Informatics Association*, 28(5), 985-997. <https://doi.org/10.1093/jamia/ocaa301>
- Francis, C. J., Johnson, A., & Wilson, R. L. (2024). Supported decision-making interventions in mental healthcare: A systematic review of current evidence and implementation barriers. *Health Expectations*, 27(2). <https://doi-org.liboff.ohsu.edu/10.1111/hex.14001>
- Frank, H. E., Becker-Haimes, E. M., & Kendall, P. C. (2021). Therapist training in evidence-based interventions for mental health: A systematic review of training approaches and outcomes. *Clinical Psychology*, 27(3). <https://doi-org.liboff.ohsu.edu/10.1111/cpsp.12330>
- Gupta, B. Dongze, L., Dong, P., & Aciri, M. C. (2021). From intention to action: A systematic literature review of provider behaviour change-focused interventions in physical health and behavioural health settings. *Journal of Evaluation in Clinical Practice*, 27(6), 1429-1445. <https://doi.org/10.1111/jep.13547>
- Rudolph, K. (2021). Ethical considerations in trauma-informed care. *Psychiatric Clinics of North America*, 44(4), 521–535. <https://doi.org/10.1016/j.psc.2021.07.001>
- Shehadeh, J., Almaraira, O., & Hamdan-Mansour, A. (2022). Determinants of moral distress among mental health professionals. *The Open Nursing Journal*. <https://doi.org/10.2174/18744346-v16-e2203030>

Treichler, E. B. H., Evans, E. A., & Spaulding, W. D. (2021). Ideal and real treatment planning processes for people with serious mental illness in public mental health care. *Psychological Services, 18*(1), 93–103. <https://doi.org/10.1037/ser0000361>

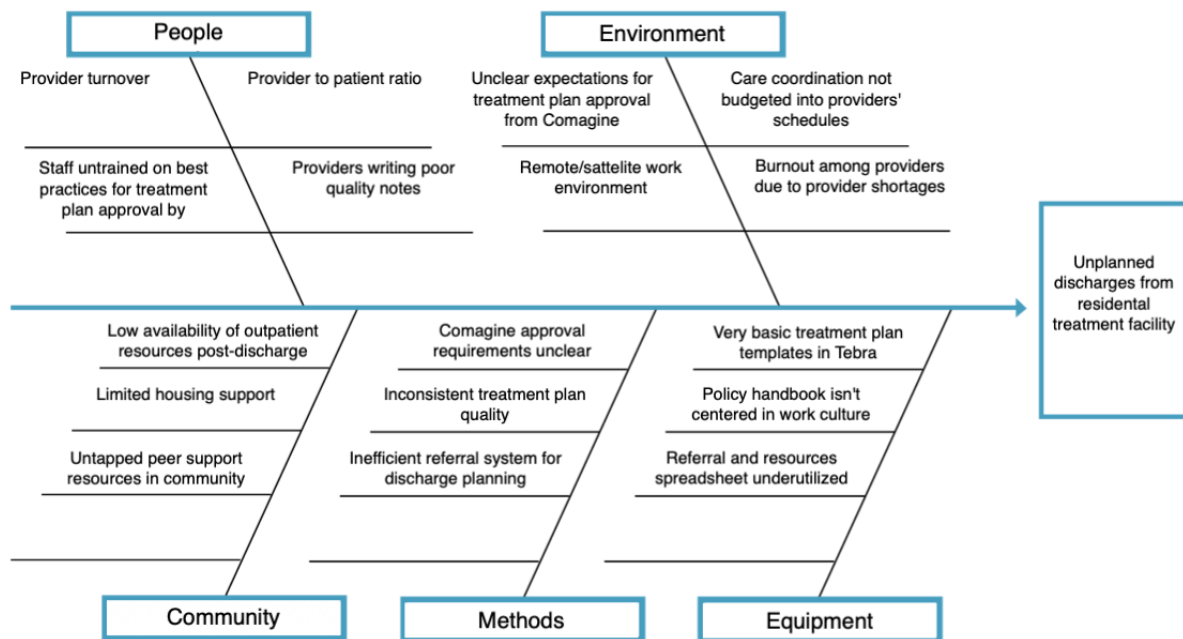
Wu, Y., Wu, M., Wang, C., Lin, J., Liu, J., & Liu, S. (2024). Evaluating the prevalence of burnout among health care professionals related to electronic health record use: Systematic review and meta-analysis. *JMIR Medical Informatics, 12*(1). <https://doi.org/10.2196/54811>

## Appendices

### Appendix A: Project Timeline

	Task	Start Date	End Date	Duration
▼	Project Proposal	8/7/2025	8/17/2025	10
▼	Project Approval	8/17/2025	8/31/2025	14
▼	Data Analysis - Baseline	9/1/2025	9/7/2025	6
▼	Pre-Training Survey Distributio	9/8/2025	9/10/2025	2
▼	Provider Training	9/10/2025	9/11/2025	1
▼	Post-Training Survey Collectio	9/10/2025	9/30/2025	20
▼	Implementation Period - Treat	10/1/2025	12/31/2025	91
▼	Follow-up Feedback Survey	1/1/2026	1/15/2026	14
▼	Post-Implementation Data Ana	1/16/2026	1/31/2026	15
▼	Synthesize Findings into Final I	2/1/2026	2/14/2026	13
▼	Prepare and Deliver Presentat	2/15/2026	2/28/2026	13
▼	Upload to DNP Portfolio	3/1/2026	3/6/2026	5

Appendix B: Cause & Effect Diagram



## Appendix C: Surveys and Feedback Form

### 1. Pre-Training Survey

Please rate your current knowledge and confidence regarding the following areas:

Statement	No Knowledge / Not Confident	Slight	Moderate	High	Expert
1. I understand what Comagine reviewers look for in treatment plan documentation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I am familiar with the Level of Service Inventory (LSI) and its relevance to documentation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I feel confident writing treatment plans that meet medical necessity criteria.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I know how to structure goals and interventions to align with payer expectations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 2. Post-Training Survey

### Section 1: Knowledge & Confidence

Please rate your current knowledge and confidence regarding the following areas:

Statement	No Knowledge / Not Confident	Slight	Moderate	High	Expert
1. I understand what Comagine reviewers look for in treatment plan documentation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I am familiar with the Level of Service Inventory (LSI) and its relevance to documentation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I feel confident writing treatment plans that meet medical necessity criteria.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I know how to structure goals and interventions to align with payer expectations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The training improved my confidence in treatment planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I have used the provided checklist in my documentation since training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 3. Final Feedback Survey

#### Final Feedback Form

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. This training has helped reduce the time I spend second-guessing how to meet documentation criteria.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I believe the training will help reduce Comagine denials.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The checklist is a useful tool that I would continue using.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I would recommend this training to new staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. What other components of care do you think will help reduce Comagine denials?

2. Do you feel the training has impacted your job satisfaction or documentation workload? If yes, how?

Appendix D: Survey Data

