

CLINICAL DOCUMENTATION PROGRAM

*Balancing
quality
and cost
of care*



**SULLIVAN
LAKIER
GROUP**

Producing Results

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Clinical documentation and record keeping are often viewed by healthcare professionals as a time consuming burden. However, clinical documentation provides the foundation for effective communication among clinical team members, the validation of care provided for payors and regulators, assurance of quality patient care, and maximization of financial reimbursement. Sullivan Lakier Group is available to work with your organization to evaluate the quality, completeness, and efficiency of documentation. Based on the evaluation findings, we will work with your multidisciplinary healthcare team and HIM to develop clinical documentation improvement strategies as it relates to quality, regulatory, licensure, legal and financial mandates.

Sullivan Lakier Group also recognizes the important difference between inpatient and outpatient rules, processes, and payment systems. We have experienced consultants who can help you make your documentation as effective and efficient as it can be.

Additional Services >>

BENEFITS OF OUR CLINICAL DOCUMENTATION SERVICES

We will work with you to develop and implement strategies that result in:

- Enhanced communication for continuity and coordination of care
- Improved compliance with regulatory, legal, and licensure requirements
- Confidentiality of the medical record
- Minimize time and complexities of charting
- Accuracy of documentation to support DRG assignment and utilization of resources
- Accurate data for quality assurance and utilization review
- Enhanced documentation to support accurate and appropriate coding
- Enhanced accuracy of data to support Medicare Case Mix Index
- Accurate data to contribute to research
- Optimize Same Day Surgery Patient status and LOS
- Improved standardization where appropriate

OUR APPROACH

We utilize a four step process in our consulting which is tailored to the level of support you need. These four steps typically are as follows:

1. Evaluate your overall clinical documentation function or specific areas identified and make recommendations for improvement
2. Develop an action plan to guide the improvement work for either your team or a combined hospital-consultant team
3. Provide project leadership or hands-on support for implementation as needed
4. Provide an operations dashboard and training that allows the organization to monitor progress and ensure the gains are maintained.



KEY AREAS

The areas of focus for a clinical documentation assessment typically fall into the following categories:

- Exposure to OIG, Medicare, and JCAHO compliance issues
- Quality and completeness of documentation
- Communication effectiveness amongst the care team
- Exposure to legal or malpractice issues
- Institutional charting policies
- Data to support accurate severity of illness and resource consumption
- Charting efficiency and complexity
- Use of automation
- Shifting task records to critical thinking records
- Improving paper and information flow