Fact:
“Recent changes to reimbursement and quality measures make internal transformation fundamental to a hospital’s survival.”

CHC Coding & Documentation

Major Changes To The Healthcare System Are Underway

Changes due to healthcare reform require a transformation of how hospitals and providers review EMRs and encounters.

Hospital Executives must implement and sustain improvements to clinical documentation in response to:

- Medicare Severity Diagnosis Related Groups
- RAC
- Present-on-Admission and Hospital Acquired Conditions
- ICD-10

Result of Changes Can Be Devastating To A Hospital

- **Cause** ➔ **Effect**
  - Poor Documentation ➔ Case Mix Reduction
  - Inaccurate Coding ➔ Excessive Denials
  - Failure of MCC/CC Capture ➔ Revenue Reductions
  - Lack of Efficient CDE Program ➔ Increased Audits & Reimbursement
  - Lack of Expert CUI Team ➔ Take-backs
  - State and Federal Reforms ➔ Poor Quality & Compliance Results

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Improper Data Collection & Error in Documentation Process

- Inefficient admissions data collection
- Documentation error by clinician
- Patient data are too clinical
- Lack of coordination between physician & HIM
- (P4P) Negatively affects pay for performance
- Public health reporting
- Research & parameters

The Creative Health Concepts Solution

Qualified Staff
- On-site Certified Coding Team
- Physician Leadership
- Virtual CDI Experts Upon Demand

Evaluation & Tracking
- Concurrent Review of Physician Documentation
- Analyze and Trend Performance
- Create Physician Report Cards

Education & Training
- Approach and Advise Physicians
- Present at Organized Physician Meetings (e.g. Grand Rounds)
- Develop Standard Documentation Templates

Integration
- Align Case Management, UM, HIM and Quality Management
- Establish Internal Regulatory Documentation Task Force
- Coordinate Steering Committee Ensuring Appropriate Communication and Continual Improvement