The Role of CDI in Quality Improvement at Georgetown Community Hospital: From Reactive to Proactive

In 2015, Georgetown Community Hospital was able to restore a CDI program for the facility. The CDI role had been vacant for approximately 2 years prior to May of 2015. In the second quarter of 2015, our facility's harms rates were at an all-time high (over a 6 year period). However, despite our increased in "harms", it seemed our rates did not accurately reflect the outcomes we were seeing. Our goal was to bridge the gap - closing the gap between clinical presentations & assuring the correlation with coding to better represent patient outcomes and quality care.

Harms Reduction

We had some initial low hanging fruit that was easily remedied with CDI efforts. Overall, there were several key areas that attributed to our success:

- Initial efforts through CDI to improve accurate representation by provider documentation – Initially, we saw improvement with queries for acuity and severity.
- Collaboration with providers, front-line staff – CDI attends morning rounds with the hospitalist, case management and department directors. Other attendees may include Infection Prevention.
- Education to providers, front-line staff – Physicians, physician assistants and ARNPs were educated on documentation requirements. Tip sheets for conditions were posted at each dictation station and handed out to providers individually.
- Tapped into our resources – There were sister facilities that had remarkable successes in their harms reduction. We reached out to those facilities and their quality teams for advice.
- HAC Team – We began a "Hospital Acquired Condition" team in October 2015 where we discussed any HACs that were impending or already occurred. We meet weekly. This team includes: CEO, CNO, CFO, Quality Director, HIMD, Inpatient Coder (as indicated), Infection Prevention and CDI. We do involve department directors as needed. Our most recent addition is adding Women's Services leadership to the team to drill down on obstetric HAC to mother and/or baby.

By the fourth quarter of 2016, we became more confident that we had a **TRUE** reflection of our harm data. We were able to refine our search for process and problem areas to eliminate further harms. Since 2014, we have seen a **74% reduction** in harms.

Mortality

Our goal was to reduce our mortality index by improving quality care and closing the gap between actual clinical presentations and physician documentation. Naturally, as our harm rate decreased, we saw a corresponding decrease in our mortality index. Key elements in the reduction of our mortality index include:

- Concurrent encounter reviews and queries by CDI; Rounding with hospitalists daily
- Provider engagement in post-mortem reviews; Post-mortem Huddles with front-line staff.
- February 2016 – Began taking all mortality cases to the weekly HAC team meetings to review
- Resources – Continued use of feedback from outside resources such as sister facilities, 3M and Up-To-Date
- 4th quarter 2017 – CDI was included in participation of the LifePoint Health Mortality Collaborative in connection with Duke University
- 1st quarter 2018 – APR-DRG grouper was added to our 3M coding product; CDI can now see data related to severity of illness (SOI) and risk of mortality (ROM) with concurrent coding in the stand alone program

Overall, **36% reduction** in mortality index since 2015.

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