



Full Alert! A Guide to Improving Trauma Service Documentation

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Presented By



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Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
 - State why your trauma docs are not documentation rock stars at baseline
 - State how a trauma service program impacts any given organization and its performance metrics
 - List what diagnoses are frequently overlooked by trauma providers
 - Develop processes to encourage and maintain better trauma service documentation practices

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Why Are Trauma Providers **NOT** Great Documenters?

Why Trauma Providers May Be Poor Documenters

- Less note-writing is always a perceived benefit to choosing a career in surgery
 - “I can tell you everything you need to know about that patient in one sentence.”
 - Requesting documentation increases/improvements from any surgeon **represents a potential cataclysmic change in their world’s axis rotation**
- Limited understanding of “The System”:
 - How hospital and individual provider performance data is generated
 - How medical record documentation influences hospital and individual provider performance data
 - “**Obviously, it’s coded wrong!**”
 - How performance data influences patient choice of individual provider and/or hospital
 - How performance data impacts their new patient stream
 - Provider inclusion in payer/employer networks

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Why Trauma Providers May Be Poor Documenters

- Trauma Registry is their Holy Temple! **As long as that looks good . . .**
 - But these are not shared with public or payers
- Assumption that many diagnoses other providers may find significant are **integral** to the trauma patient
 - “You mean there’s a separate code for that?”
 - They think about it. They worry about it. They don’t “think in ink”
- Ego?
 - “Charting is for the fleas!”
 - “There are two types of doctors: Surgeons and those who wish they were surgeons.”
- Time
 - **The most precious commodity to any practicing clinician**
 - Ask a practicing clinician to do something that increase their time on the job, and you better have some strong motivational reasons they will believe and accept

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Why the Trauma Service Matters to CDI

Trauma Service and Performance Improvement

1. How many in-hospital mortalities occur on the trauma service?
 - ~20% at UTM (but your results may vary)
 - All inpatient mortalities count against the host facility
 - Need to make those deaths look as expected as possible
2. How much PMH do you really have for the average trauma patient?
 - The vast majority of trauma service mortalities have encounter numbers that end in '-0001'
 - **They have never been to your facility previously**
 - Is the patient ever able to tell you anything about themselves?
 - Does the family (if there are any) know anything about the patient?
 - Do trauma providers spend time gathering additional information from family/friends for a patient who has just passed?
 - Do you have a robust HIE (if at all) to fill in the gaps?
 - **Does this sound promising for your expected mortality rate?**

Trauma Service and Performance Improvement

3. The shorter the hospitalization, the lower the documentation volume and/or quality
 - Trauma providers want to quickly move on to the next patient they think they can help
 - They learn to quickly compartmentalize to keep going forward (i.e., just human nature)
4. How do you know if/when trauma mortality converts from ER/OBS to IP status?
 - **YOU TELL ME AND WE WILL BOTH KNOW!**
 - Doesn't seem to relate to how long they were physically in the ED
 - Doesn't seem to relate to the number/severity of injuries
 - Virtually no consistency between payers
 - Usually convert to IP status if they make it to the O.R. or the ICU?
 - Can you get additional documentation after a status conversion?
 - *If it's not done right the first time . . .*

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Trauma Service and Performance Improvement

5. Many trauma programs are not money makers
 - How many trauma patients have health insurance?
 - **Hint:** A lower percentage than rest of the house
 - Some may ultimately obtain after hospital works with them (>50% at UTMCI)
 - Positively impacting the bottom line may improve hospital finances
 - Positively impacting the bottom may improve trauma service resources
 - *Keeping the doors open is of paramount importance, right?*
6. If have surgery residents, **they will rotate on other service lines**
 - **THE “HALO EFFECT” CAN ONLY BENEFIT YOUR CDI PROGRAM!**
 - At UTMCI, several other service line documentation patterns also improved after continuous CDI involvement with trauma service
7. Trauma attendings may also do elective surgeries
 - **THE “HALO EFFECT” CAN ONLY BENEFIT YOUR CDI PROGRAM!**
 - UTMCI trauma surgeons make ~50% of their income from elective/non-trauma work

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What Trauma Providers Should Be Documenting

What Trauma Should Document

- **Document every single injury** *no matter how seemingly small or insignificant*
 - Different injuries from different body sites/systems may combine to place case in the **Multiple Significant Trauma (MST)** MS-DRGs (955-965)
 - MST MS-DRGs weighted higher than single-organ injury MS-DRGs
 - There is no way trauma providers can know which diagnoses do and do not count for MST assignment
 - Hospital coders can take many injury specifics directly from radiology reports *as long as bedside provider corroborates their presence in the chart*
 - **If it's not documented, it didn't exist!**
- **Document the 3 individual GCS components**, *not just the total*
 - May impact the MS-DRG
 - Required fields on every electronic UTM trauma H&P

What Trauma Should Document

- Be sure to appropriately **grade** all solid organ injuries **I through V** (contusions, lacerations, hematomas) as each one carries a different code
 - Liver
 - Spleen
 - Kidney
 - Pancreas
- **Problem:** ICD-10 uses **Minor-Moderate-Major** classifications as opposed to **I through V**, which are not equivalent from organ to organ
 - 😊 Therefore, need **internal crosswalk** between provider language and coding language
 - **Ex:** For Liver lacs – Grade I = Minor, Grade II = Moderate, Grades III, IV, & V = Major
 - **Ex:** For Kidney lacs – Grades I & II = Minor, Grade III = Moderate, Grade IV & V = Major
 - *May need help from trauma colleagues to develop*

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What Trauma Should Document

- “If the BP drops in a trauma shop, it’s more than just Hypotension”
 - That’s **SHOCK** and what kind is it, doc?
 - **Cardiogenic** - low cardiac output due to AMI, CHF, cardiac contusion
 - **Hypovolemic**
 - **Hemorrhagic**
 - **Anaphylactic** - “bugs, drugs, toxins”
 - **Septic** - sepsis refractory to fluid resuscitation requiring pressors
 - **Traumatic**
 - **Endocrine** - adrenal insufficiency
 - **Neurogenic** - CNS system/spinal cord damage
 - Causes of shock mnemonic = **C.H.A.S.T.E.N.**
 - If you start a pressor, the next thought should be, “**What kind of shock is it?**”
 - ‘Shock, unspecified’ better than nothing but . . .

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What Trauma Should Document

- Specific CNS radiological findings must be corroborated in the record and/or translated into terminology for which there is a corresponding ICD-10 code
 1. **Cerebral Edema** if seen on CT/MRI
 - If treated with Mannitol or an ICP monitor, *they have this diagnosis*
 2. **Brain Compression** if “mid-line shift” or “mass effect” seen on CT/MRI
 3. **Herniation** if documented *or* if ‘cistern effacement’ seen on CT/MRI
- ☹️ Cannot code diagnoses from radiology reports unless corroborated by bedside clinicians
- *And*, remember to list each individual type of CNS bleed
 - There are separate codes for SAH, SDH, IPH, etc.
 - **No credit for “Multiple Head Bleeds”**

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What Trauma Should Document

- Anybody know what a “**Mesenteric Rent**” is?
 - There is **no alphabetic index entry** in the paper ICD-10-CM for the main term “**Rent**”
 - Using “rent” as a main term in electronic encoder leads to **Z59.81X** (Housing Instability) via “Past due on rent or mortgage”
 - *Probably no impact on trauma outcomes, right?*
- A **Rent** = Tear or **Laceration**
 - *Therefore*, must say **Mesenteric Laceration** if provider wants credit (**S36.893X**)
- Everyone in Trauma PI room knows what a mesenteric rent is
 - **NO ONE** outside of trauma circles has ever heard of a “rent”

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What Trauma Should Document

- How can you not capture **Acute Blood Loss Anemia** in a trauma patient?
 - **Ex:** Chart includes the diagnoses of “hemorrhagic shock, active extravasation, hematoma, grade IV spleen lac” *and* is transfused 4 units PRBCs in first 48 hours.
 - Where’s any mention of an anemia?!?!?!?
 - None of these terms or descriptors are equivalent to **Acute Post-Hemorrhagic Anemia**
- How can you not capture **Rhabdomyolysis** with significant CPK levels?
 - Yes, CPK levels may be somewhat elevated in all traumas
 - *However*, what do they do when the level reaches 5K, 10K, or $\geq 20K$?
 - Trauma surgeons may not separately treat CPK levels until much higher (16K at UTMC) **but closely monitored once hits 5K with serial CPK monitoring**

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What Trauma Should Document

- Trauma providers repeatedly watch ABGs, VBGs, base excess levels, lactic acid levels, and serum bicarb levels due to significant prognostic implications
 - Why can they not document the **Acidosis**?
- Can I please get a label on the that kidney function?
 - **Chronic Kidney Disease, Stage I-V**
 - Trauma patient population increasingly becoming a geriatric service (≥ 55 yo)
 - Age is major determinant of eGFR calculation (Cockcroft-Gault equation)
 - **Ex:** if 80yo F has wt. = 60 Kg & Cr = 1.1, then **eGFR = 45.5**
 - **Acute Kidney Failure/AKI** per KDIGO criteria
 - May need to provide nudge to recognize criteria are met as LOS increases
 - May need to prod &/or help them out finding baseline values for comparison

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What Trauma Should Document

- Why are the liver enzymes up?
 - **Shock Liver/Ischemic Hepatitis** = ~20 to 25-fold rise in AST &/or ALT levels above the 99th URL of normal (~1,000 @ UTMC)
- Why are you giving that patient FFP, cryoprecipitate, FEIBA, etc.?
 - Make sure to recognize and capture the **Coagulopathy**
 - “Acquired” due to trauma (consumption, shock, tissue injury) = **D68.8 (specified NEC)**
 - “Acquired” due to Shock Liver (or cirrhosis) = **D68.4 (due to liver disease)**
- Are you monitoring and/or replacing those **electrolytes**?
 - They all have separate ICD-10 codes
 - How many TBI patients get hypertonic saline (3%)?
 - Do they ever develop **Hypernatremia**?
 - Some reluctant to document this since “iatrogenic” but is monitored, evaluated, treated, etc.

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What Trauma Should Document

- Why is that patient going ape on your service?
 - Please document the right **Category of Substance Usage**:
 1. **USE** = having only 1 or 2 drinks; using PO oxycodone *as prescribed*
 2. **ABUSE** = being drunk; taking something *other than as prescribed* (injecting PO oxy)
 3. **DEPENDENCE** = being *physically or psychologically addicted* to a substance

***Note:** Anyone showing physical or psychological withdrawal signs is dependent

 - “**Alcoholism**” = Alcohol **dependence**
 - “**Addiction**” = **Dependence**
 - Please document any **additional substance manifestations**
 - **Exs:** Intoxication (*be careful in MVC cases due to auto/medical insurance refusals*), hallucinations, withdrawal, delirium tremors

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What Trauma Should Document

- *In my opinion*, every case touched by a trauma specialist should have a D/C summary with a complete problem list, regardless of LOS
 - *Why would you not for liability protection?*
 - **Problem:** Some hospitals do not require D/C summaries for cases in-house less than 48 hours **even if patient goes to the O.R. or ICU** (*though that is changing*)
 - ⊗ Many providers mistakenly take advantage thinking they are getting out of work
 - If D/C summary done for “short stay” cases, **HUGE** opportunity to capture additional diagnoses glossed over in heat of the moment *and/or* previously thought to be integral
- Strongly encourage review of available notes, labs, radiology studies, procedures performed, etc. before D/C summary completion
 - **Remember!** How do you know how or when a trauma mortality converts from ER/OBS to IP status?

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What Trauma Should **NOT** Document

- **DO NOT** document “intubated for airway protection” or “patient could not protect their airway” or “needed to secure the airway”
 - **HUGE** recovery audit target due to *Coding Clinic*, 3Q, 2012
 - Try “intubated for impending respiratory” failure instead (*if feel the need to discuss at all*)
- If the patient is intubated &/or on the vent in the trauma bay, that is **Acute Respiratory Failure** which should be captured!
 - Acute Respiratory Failure diagnosis has **HUGE** impact on SOI/ROM scores
- **Problem:** Some trauma docs initially reluctant to accept this as they don’t see a direct pulmonary injury *or* consider it part of ATLS protocol
- **How to get them to recognize/accept this?**
 - Ask them what would the pO₂ &/or pCO₂ be if the patient’s lungs were not actively, externally ventilated?
 - “Protecting an airway” does no good without air flow/gas exchange
 - Blood gas may be normal if intubated and ventilated during transport from scene

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What Trauma Should **NOT** Document

- **Remove** the term “**Post-Op**” from medical record vocabulary
 - To a **surgeon**, “Post-Op” means **timing**: Something occurred *after* a surgery was completed
 - To a **coder**, “Post-Op” means a **cause-and-effect** relationship exists
 - Something that occurred after a surgery was completed is **due to the surgery**
 - Coders are trained linearly: If see a diagnosis modified by the phrase “post-op,” they WANT to assign a complication code
 - **Ex:** Is an “ileus” after an intra-abdominal surgery an expected occurrence?
 - Will not be coded if no impact on hospital course, right?
 - Is a “**post-op** ileus” after an intra-abdominal surgery a complication?
 - Sounds like one, right?
- How many additional/subsequent surgeries do trauma surgeons do in the course of a single trauma-related hospitalization?
 - Make the coders ask the providers about it if they suspect there is a complication

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How to Achieve Trauma Provider Change

Regardless of Intervention Modality Chosen . . .

- You will need **routine, regular, and consistent personal follow-up**
 - Surgeons are creatures of habit: they do the same thing, the same way, every time
 - Repetition creates habits
 - “*Repetition Breeds Reputation!*”
 - Trauma provider ranks rarely stagnant:
 - Docs move and trauma programs expand/contract
 - Surgical residents may rotate monthly and/or annually
 - NPs and PAs will take over most documentation responsibilities in the foreseeable future
 - And they are much more cooperative and compliant
- ☹ Showing up quarterly for a CDI presentation probably not going to cut it
 - *If you crave immediate results/satisfaction, this may not be the job for you*

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Things That Might Work

- Flyers & posters in ED trauma bays, trauma ICUs, provider dictation areas, resident lounge, trauma/surgery department offices, etc.
 - Not effective at UTM
- Regularly scheduled CDI presentations at lunch & learns, administrative or business meetings, resident education lectures, etc.
 - Does everyone show up?
 - Does everyone pay attention?
 - Receptiveness service-line dependent; CDI does not do these for trauma at UTM
 - ***Note:** Keep them short and sweet! Surgeons like high-yield small doses
- Regularly email/text message Documentation Tip of the Week (DTOWs)
 - Well received at UTM: go to all residents, NPs, & PAs, as well as certain service lines
 - ☹ However, not all actually open/check their work email
- What about periodically rounding with them? Nothing says you can't!
 - UTM trauma service not enthusiastic given high volumes

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Biggest Bang: Participate in Trauma PI/Mortality Reviews

- Why attend these meetings?
 1. Physicians tend NOT to remember patients that live to discharge
 - **They do remember all deaths!** *Therefore*, memories and impressions easily retrievable for discussion purposes
 2. Excellent opportunity to show how performance data/metrics could have been positively impacted by documentation
 - SOI/ROM scores
 - Mortality O:E ratios
 - LOS
 - Final MS-DRG and subsequent data-bucket assignment
 3. Excellent opportunity to provide positive feedback and encouragement
 - **UTMC “Trauma Chick-Fil-A Challenge”** = If nothing missed in all mortality charts from previous week, CDI program (*yours truly*) buys Chicken Minis and coffee for all
 - *Has happened twice in 3 years since started*

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How CDI Works with Trauma PI @ UTMC

- CDI receives trauma mortality list several days prior to weekly meeting (~5 cases/wk)
 - CDI PA or CDI Manager reviews for documentation improvement opportunities including
 - Diagnoses clinically present but not captured
 - Appropriate and accurate terminology use
 - Diagnoses clinically present and documented but not coded
- At the meetings, providers review case history and sequence of events
 - Opportunity to discuss areas where medical care/trauma system could improve
 - Opportunity for resident education
- **CDI then presents documentation improvement opportunities discovered**
 - Opportunity to review/discuss/educate regarding correct terminology and applying recognized diagnostic criteria
 - Most frequent = Diagnosis was present and treated but not captured in the record
 - Very rarely = Diagnosis documented but not clinically present

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What if CDI Finds Something?

- If **coding error** discovered, amended claim sent for rebill if impacts SOI/ROM scores &/or MS-DRG
 - ***Note:** There is no trauma bill hold - UTMC experience is rate of subsequent payer/RA denial not worth AR delay
- If **documentation improvement opportunity** discovered:
 1. If no impact on current case's SOI/ROM scores or MS-DRG assignment, used for educational purposes only
 - Same situation may impact future cases
 2. If will impact SOI/ROM scores only **and not the assigned MS-DRG**
 - Request D/C summary addendum or post-D/C query sent to attending of record
 - Claim sent for rebill for PI data improvement once documentation complete
 - Payers/RAs **DO NOT** care about SOI/ROM scores
 - No fraud allegation risk if reimbursement **NOT** affected

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What if CDI Finds Something?

3. If does impact MS-DRG assignment, case goes through subjective CDI medical director "gut check" **before** action taken
 - ***Note:** ALL MS-DRG rebills resulting in increased reimbursement **will be flagged & reviewed by payer/RA**
 - If **credible and defensible**, request D/C summary addendum or post-D/C query sent to attending of record
 - Claim then sent for rebill once documentation complete
 - If **fails** the "gut check," used for educational purposes only
 - ☒ **DO NOT** unnecessarily feed the RA Beast *or* bait the OIG!!
 - What impacts the "gut check?"
 - LOS
 - Has the D/C Summary been created yet and/or signed by the attending?
 - Is this something that would seem to appear only after coaching or is it just a clarification?

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UTMC Trauma Service Documentation Experience

UTMC's CDI Journey with Trauma Program

- UTMC CDI program started 1/1/2008
 - Initial 3 CDS nurse reviewers now 9; CDI touches ~92% of all IP charts (not OB, ED, NICU)
 - Mandatory 2-hour New Intern CDI Education Session starts 6/31/2009
 - All five years of surgery residency program finally have complete CDI training by 2013
- **Started attending weekly Trauma PI meetings 10/2016 (@ 0630!)**
 - No coverage for when CDI PA on clinical service (~10 weeks/year) or when on vacation
 - 🟢 Now cover almost all 52 weeks/year after arrival of CDI Manager 6/2019 since have two bodies to review and attend the meetings
 - ***Note: CDI Manager (RN, CCS, CCDS) gets no additional/undue push back when CDI PA not present at meetings**
- UTMC residents start receiving weekly emailed CDI DTOWs 1/2020
- Occasionally give Surgery Department Grand Rounds and attend O.R. Committee Meeting (~10 times total for both in 15 years)

Want to see some results?

Ex: 17yo multiple GSWs; 19 day stay

Discharge Diagnoses

Ballistic IVC injury
Ballistic aortic injury
Retroperitoneal hematoma
Ballistic left Renal Artery & Vein Injury
RUQ Mesenteric Vein injury
Ballistic Transverse Colon Injury
Ballistic liver injury Grade 3 liver
Hemorrhagic shock
Coagulopathy
Hyperglycemia
Lactic acidosis
Metabolic acidosis
Acute blood loss anemia
Thrombocytopenia
Morbid obesity
Pneumothorax
Acute hypoxic respiratory failure
Acute pain secondary to trauma
Oropharyngeal dysphagia
Sacral wound
hypernatremia
Ileus
GI bleed
Cardiac arrest
Death
Small bowel ischemia
Liver ischemia
SMA intimal disruption s/p endarterectomy

Code	ROM	SOI	Description
P			Other injury of abdominal aorta, initial encounter
S35.09XA			
T79.4XXA	MCC		Traumatic shock, initial encounter
S27.0XXA	CC	3	Traumatic pneumothorax, initial encounter
S35.19XA	MCC		Other injury of inferior vena cava, initial encounter
S35.492A	MCC	4	Other specified injury of left renal artery, init encntr
S35.495A	MCC	2	Other specified injury of left renal vein, initial encounter
S35.338A	MCC	2	Oth injury of superior mesenteric vein, init encntr
S35.228A	MCC	4	Other injury of superior mesenteric artery, init encntr
K55.029	MCC	3	Acute infarction of small intestine, extent unspecified
J96.01	MCC	3	Acute respiratory failure with hypoxia
K72.00	MCC	4	Acute and subacute hepatic failure without coma
S31.031A	MCC		Phctr w/o fb of low back and pelv w penet retroperiton, init
E87.2	CC		Acidosis
D62	CC		Acute posthemorrhagic anemia
S36.591A	CC		Other injury of transverse colon, initial encounter
S36.118A	CC		Other injury of liver, initial encounter
S36.892A	CC		Contusion of other intra-abdominal organs, initial encounter
I50.20	CC		Unspecified systolic (congestive) heart failure
I96	CC		Gangrene, not elsewhere classified
K56.7	CC		Ileus, unspecified
K91.89	CC		Oth postprocedural complications and disorders of dgstv sys
N17.9	CC		Acute kidney failure, unspecified
E87.0	CC		Hyperosmolality and hypernatremia



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Ex: 76yo MVC mortality; 36 hour stay

Discharge Diagnoses

Grade 2 splenic laceration
Moderate hemoperitoneum
Large right pleural effusion
Hemorrhagic shock requiring transfusion
Left glenoid fracture
Left 4-10 rib fractures
Left hemothorax
LUE abrasions and skin tears
Acute hypoxic respiratory failure
Chronic respiratory failure on home O2
Metabolic acidosis
Lactic acidosis
Septic shock secondary to pneumonia
Diabetes mellitus type 2
CAD
Atrial fibrillation on Plavix
Chronic CHF, diastolic
Acute renal failure on chronic kidney disease, stage IIIB
Stage I pressure ulcer over R greater trochanter
Erythema to scrotum, sacrum
Cardiopulmonary arrest

Code	ROM	SOI	Description
P			Moderate laceration of spleen, initial encounter
S36.031A			
S27.2XXA	MCC	2	Traumatic hemopneumothorax, initial encounter
T79.4XXA	MCC	4	Traumatic shock, initial encounter
J96.21	MCC	4	Acute and chronic respiratory failure with hypoxia
A41.52	MCC	4	Sepsis due to Pseudomonas
J15.1	MCC	2	Pneumonia due to Pseudomonas
R65.21	MCC	4	Severe sepsis with septic shock
S22.42XA	CC		Multiple fractures of ribs, left side, init for clos fx
D62	CC		Acute posthemorrhagic anemia
E87.2	CC		Acidosis
I50.32	CC		Chronic diastolic (congestive) heart failure
N17.9	CC		Acute kidney failure, unspecified
J44.1	CC		Chronic obstructive pulmonary disease w (acute) exacerbation
J44.0	CC	1	Chr obstructive pulmon disease with (acute) lower resp infct
J90	CC	2	Pleural effusion, not elsewhere classified
S42.142A			Disp fx of glenoid cavity of scapula, left shoulder, init
S42.132A			Disp fx of coracoid process, left shoulder, init for clos fx
S42.122A			Disp fx of acromial process, left shoulder, init for clos fx



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Results of UTMC Approach

	2016	2021
UTMC Overall IP Admissions	31,023	33,581
Trauma Service IP Admissions	1,155	1,167
UTMC Overall CMI	1.93	2.15
UTMC Trauma CMI	2.45	2.92
UTMC Overall non-CC/MCC Capture Rate	32.9%	25.1%
UTMC Trauma non-CC/MCC Capture Rate	63.9%	32.6%
UTMC Overall CC Capture Rate	25.5%	25.4%
UTMC Trauma CC Capture Rate	23.5%	37.3%
UTMC Overall MCC Capture Rate	41.6%	49.5%
UTMC Trauma MCC Capture Rate	12.6%	30.1%

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Results of UTMC Approach

	2016	2021
Trauma Number of Secondary Dx's/claim	17	23
Trauma Claims in MST MS-DRGs	14%	22%
Trauma Mortality O:E	1.30	1.32
Trauma Complication Rate O:E	0.87	0.92
Trauma GMLOS O:E	1.02	1.04
Trauma Readmissions O:E	1.53	0.86

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CDI Conversation Pearls for Trauma Services

- **Remember!** You need the trauma docs more than they need you
 - They have been doing things the same way for years and all seems well to them
 - Why should they listen, much less do what you say?
- Trauma docs are very intelligent, well-educated, and they keep up
 - They always know more than us, so give them their props
 - **They can smell blood:** Be concrete and confident (but respectful)
- Trauma docs are way over-worked: **Be Succinct!**
- **DO NOT** start the conversation by telling them how better documentation improves things *for the hospital*
 - If you do get dragged into the money discussion, **turn the tables!**
 - Gee Doc, do you like Da Vinci robots, more nurses, more O.R.s, more NPs/PAs, etc.?
- **DO** start by telling them how better documentation improves things for them
 - Every doc believes they treat sicker patients than the other hospital
 - **PROVE IT!** (*Which can only be done through better documentation*)

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Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.