WISCONSIN DEPARTMENT of HEALTH SERVICES

Division of Public Health

Wisconsin Admin. Code ch. DHS 118 Frequently Asked Questions

Wisconsin Admin. Code ch. DHS 118 Appendix A outlines the classification criteria for level III and IV trauma care facilities. These classification criteria underwent an administrative rule rewrite and went into effect October 1, 2021. The intent of this document is to provide clarification to frequently asked questions relating to the criteria.

If your question is not answered below, please email the Department of Health Services (DHS) Trauma Team at dhstrauma@dhs.wisconsin.gov.

General

What are the differences between type 1 and type 2 criteria?

If any type 1 criteria or more than three type 2 criteria are not demonstrated at the time of the initial classification site visit or at the initial site visit for any subsequent renewal of classification, the hospital's application may not be approved. If all type 1 criteria are demonstrated but one to three type 2 criteria are not demonstrated at the time of a site visit, then a one-year provisional certificate of classification may be issued, and another review will be required before the hospital's application may be approved. This second review must occur within one year from the date of notification and may include an on-site re-visit or a review of documents submitted by the hospital to the Wisconsin Department of Health Services. If the trauma care facility successfully corrects the deficiencies, the period of classification will be extended to three years from the date of the initial site visit.

The table below provides an overview of this information.

Type of criteria, status, and hospital responsibility

Criteria	Status	Hospital responsibility
All criteria met	Classified	Continue to do great work
All type 1 criteria met, but one to three type 2 criteria not met	One-year provisional certificate	Request re-review within one year
Any type 1 criteria not met	Not classified	Reapply
More than three type 2 criteria not met	Not classified	Reapply

What are the requirements for Advanced Trauma Life Support (ATLS)?

- Trauma medical director must be current in ATLS.
- Emergency physicians and providers:
  - If board certified in emergency medicine, must have successfully completed the ATLS course at least once.
  - If not emergency medicine board certified, must be current in ATLS.
  - If the physician is in the alternate pathway, must be current as an ATLS instructor or provider. Note: The Rural Trauma Team Development Course does not fulfill this requirement.
- General surgeons:
  - If board certified in general surgery, must have successfully completed the ATLS course at least once.
  - If not board certified in general surgery, must be current in ATLS.
  - If in the alternate pathway, must be current as an ATLS instructor or provider.
- Emergency advanced practice providers:
  - Advanced practice providers and midlevel providers practicing in the emergency department must be current in ATLS, unless their only function is entering orders or a scribe.
  - In a level IV facility, this requirement may be fulfilled by the Comprehensive Advanced Life Support program if the program includes the mobile trauma module skills station and the provider is re-verified every four years.
- Neurosurgery and orthopedic surgery: If in the alternate pathway, must be current as an ATLS instructor or provider.

Description of trauma care facilities and their role in a trauma care system

What is an acceptable surgeon response time upon trauma team activation?

The maximum acceptable surgeon response time, with notification from the field and tracked from patient arrival, is 30 minutes for the highest level of trauma activation. This response time must be met for at least 80% of trauma activations. The surgeon must be activated for all highest-level activations regardless of impending transfer or other scenario.

The clock start time depends on the patient's method of arrival:

- If a patient is transported in via emergency medical services (EMS) and EMS activates them, the clock starts once the patient hits the facility doors. Ideally, the surgeon should be at the bedside prior to patient arrival.
- If a patient arrives at the facility on their own, the clock starts once the patient is examined and activated.

In the instance that the surgeon is on site performing a surgery during a trauma activation, and is therefore unavailable to respond to the bedside, the backup plan needs to be activated (for example, call in another surgeon or rapid transfer out). Anytime the backup plan is activated, it should be clearly documented why it was activated, why the surgeon couldn't respond, and the reason for rapid transfer. The activation backup plan should be thoroughly reviewed in the Performance Improvement and Patient Safety (PIPS) program with evidence of clear loop closure. An activation of the backup plan counts as a non-response. The response time must be met for at least 80% of trauma activations.

During the site review, the surgeon and trauma team response time will be evaluated. If the response time is not documented in the patient medical record, please pull any data or documentation to support the response time.

Can the liaison to the multidisciplinary meeting be a non-physician as long as there is a physician liaison to trauma and a plan for communication?

The liaison should be a physician ideally, or a person within a leadership position who has at least a 50% meeting attendance rate.

For a level IV facility, is a rapid transfuser needed, or does a pressure bag suffice?

Best practice indicates that a pressure bag will suffice as long as the facility has a heating system to use with it.

Prehospital trauma care

What is the difference between a bypass and diversion?

- Bypass: Facility is no longer accepting patients.
- Diversion: Patient acceptance is on an individual case-by-case basis.

Regardless of the terminology used, facilities need to have contingency plans and review within the PIPS program. The facility does not need to monitor a bypass implemented by EMS decision.

How does a facility fulfill the prehospital performance improvement criteria if the facility does not serve as medical direction for the prehospital service and hasn't been invited to any prehospital performance improvement activities, despite efforts?

Strengthening relationships with EMS agencies is an opportunity for improvement for most facilities. The reviewers understand that most communities have multiple EMS agencies bringing patients to the hospital, and relationship development takes time. Involvement in the PIPS program can be done in a variety of ways, with multiple communication forms. It can be documented that feedback was provided about improvement events and through monitoring, repeat events improved, or if events continued to occur, some form of escalation of feedback was involved. There should be evidence that communication occurred with station supervisor or medical director.

What method is acceptable for over and under triage?

Any method that works best for the facility and maintains integrity among the data is acceptable.

Is it acceptable to notify the trauma medical director after a diversion, as opposed to before a diversion (for example, a level IV facility diverts a patient, but the trauma medical director is not working)?

The trauma medical director needs be a part of the diversion policy development. The trauma surgeon on call needs to be notified during the event. The trauma medical director can be notified after the PIPS process review of the event.

Interhospital transfer

What is the required contingency plan and credentialing for general surgeons?

All general surgeons and emergency providers must be credentialed to provide initial evaluation and stabilization of the trauma patient.

Hospital organization and the trauma program

How often is an Ongoing Professional Practice or Focused Professional Practice Evaluation required?

The trauma medical director must perform an Ongoing Professional Practice or Focused Professional Practice Evaluation on an annual basis and recommend changes based on this evaluation. For example, if a provider is not following ATLS guidelines, the trauma medical director has the authority to request corrective action up to removing the provider from care of any trauma patient.

Note: It is recommended to work with your medical staff and credentialing office.

Does the trauma surgeon or general surgeon have to be consulted on all admitted trauma cases? For example, if the orthopedic surgeon is consulted due to an orthopedic injury, does the trauma surgeon or general surgeon still need to be consulted?

No, just the most appropriate surgeon needs to be consulted. If it is a low mechanism of injury and an isolated orthopedics injury, only the orthopedic surgeon should be notified. If it is a poly-system injury, then the general and orthopedic surgeons should be notified. Have a written policy regarding this and utilize your PIPS program to monitor it.

Clinical functions: emergency medicine

Who ideally should serve as the prehospital PIPS program representative?

The PIPS representative may be from the hospital, not just the emergency department. However, information about trauma must be communicated with the trauma medical director. For example, a nurse from the inpatient unit may be an emergency medical technician and may serve as the representative.

Clinical functions: neurosurgery

Is a facility able to transfer a patient from a level III facility without neurosurgery to a level III or IV facility with neurosurgery?

Ideally, multisystem injured patients should be transferred to level I and level II American College of Surgeons-verified centers with neurosurgery. Patients with isolated neurological trauma can be admitted or transferred to classified facilities with 24/7 neurosurgery coverage. The facility must develop a transfer out guideline for neurologically injured patients. This guideline should be developed in collaboration with the classified receiving facilities. In addition, neurosurgery must be actively involved in the trauma PIPS process, and the PIPS process should review the appropriateness of admission and transfers.

Does neurosurgery need to see a patient admitted for comfort measures due to a subdural hemorrhage (SHD)?

At the facility's discretion, if the advanced directive is very specific, follow the facility's policies or guidelines and use best judgment. The neurosurgeon should review scans and assessments, and document findings in the patient's chart. The neurosurgeon should consider seeing the patient, but it might not be necessary. Utilize PIPS review when necessary.

Clinical functions: orthopedics

What is the requirement for orthopedic surgeon coverage?

Per criteria 9(d), a level III facility must have an orthopedic surgeon on call and promptly available 24 hours a day, 7 days a week. If the on-call surgeon is not able to respond due to being encumbered at another facility, responding to a case at the same facility, or other extenuating circumstances, the level III facility must have a contingency plan. Per criteria 9(f), this contingency plan must include a published backup call schedule or guidelines to transfer.

Does the orthopedic surgeon need to see a patient with an isolated hip injury?

If the patient is being admitted for operative care, then yes, the orthopedic surgeon should see the patient. If the patient is being transferred out, then it might not be necessary.

Collaborative clinical services

When is consent of trauma service for admitted trauma patients needed?

Clinical consent includes written guidelines for specific clinical situations or documentation in the medical chart about the conversation had with the trauma team.

Trauma service includes any surgeon currently involved in the care and management of the patient.

Is a step down unit or progressive care unit in place of an intensive care unit acceptable for level III criteria?

This is acceptable if the facility is providing care at the level of an intensive care unit, as defined by Resources for Optimal Care of the Injured Patient 2014 (6th edition).

Can patients go from the operating room back to the emergency department while awaiting transport to a higher level of care?

This is acceptable if the facility determines that this is the most appropriate place for the patient to await transfer. Review through your facilities PIPS process as necessary in these situations.

At some facilities, it can take 20 minutes to thaw fresh frozen plasma, though the requirement says that facilities must have an adequate supply of packed red blood cells and fresh frozen plasma available within 15 minutes. How should these facilities proceed to meet this requirement?

The site reviewers are less concerned about the actual time to thaw. Rather, facilities need to ensure that they have a thorough transfusion protocol, that patients are able to receive plasma in a timely manner, and that the 1:1:1 ratio (one each of red blood cells, frozen plasma, and platelets) is being met.

Trauma Registry

What type of trauma registry training is required?

At least one staff trauma registrar at each trauma care facility must have previously attended the following two courses or must attend the following two courses within 12 months of being hired:

- The American Trauma Society's two-day, in person or virtual, trauma registry course or equivalent provided by a state trauma program
- The Association of the Advancement of Automotive Medicine's Abbreviated Injury Scale and Injury Scoring: Uses and Techniques course

Can DHS provide sample data protection language?

All information documented on this form is privileged to the fullest extent under Wis. Stat. §§ 146.37 and 146.38, any amendments thereto, and all applicable federal law.

Performance Improvement and Patient Safety (PIPS)

How do you identify events for PIPS review?

Events can be identified across all settings that care for injured patients, such as the emergency department, intensive care unit, general inpatient unit, outpatient, laboratory, imaging, operating room, EMS (both scene and transferring agency), or the accepting facility. The sources of event identification can be written documentation or verbal report from any area or individual that cared for the patient, the hospital quality department, registry data, daily rounds, patient and family feedback, risk management reports, or autopsies. *For more information, visit Trauma Outcome and Performance Improvement Course (TOPIC).*

Prevention

What are the alcohol screening requirements?

In relation to criteria 17(c), the Wisconsin Department of Health Services (DHS) aligns with the American College of Surgeons' clarification that "all" refers to at least 80% of trauma patients who are admitted or discharged from the emergency department. This is only for patients who meet inclusion criteria. These patients must receive a screening only. DHS does not define the type of screening performed, as this is up to the facility. In the registry, the National Trauma Data Bank (NTDB)-required alcohol screen question is in relation to Blood Alcohol Content (BAC) and the respective value. Should you wish to track other validated screening options in the trauma registry, these can be added as facility-specific questions. If you need assistance to add facility-specific questions, please email the DHS Trauma Team at dhstrauma@dhs.wisconsin.gov.