DOES PIC SCORE PICK CORRECTLY? EVALUATION OF A PIC-BASED ADMISSION SYSTEM

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Introduction: Injury to the chest wall is common following blunt trauma and can lead to significant morbidity and mortality if not managed appropriately. A multitude of triage tools have been developed to guide clinical prognostication for this patient population, including the Pain, Inspiratory effort, Cough (PIC) score. First introduced in 2014, the PIC score system has gained momentum as a leading strategy for the triage of patients with chest wall injury. However, to date, the efficacy, accuracy, and safety of the PIC score system have not been validated outside of its original institution. This study evaluates the use of the PIC score system in initial Emergency Department (ED) triage, down-grade, and discharge criteria for trauma patients with chest wall injury at a single institution.

Methods: The original PIC algorithm triages patients by inspiratory capacity. On 12/1/2020, our institution implemented and expanded the criteria to include the PIC-score itself, age, and severity of chest wall injury. This is a retrospective study conducted at a large, academic Level I Trauma Center verified by the American College of Surgeons on patients with chest wall injuries, admitted between 1/1/2018-3/1/2022. The Pre-PIC (1/1/2018-11/20/2020) and Post-PIC (1/1/2021-3/1/2022) group were comprised based on admission date. Patients admitted during guideline implementation (12/1-31/2020) were excluded along with those who were not admitted, intubated or died in the ED, or unable to participate in PIC testing (see Figure 1).

Results: There were 2,461 patients triaged to the Pre-PIC and 1,278 triaged Post-PIC group. The two cohorts did not differ significantly in baseline demographics or mechanisms of injury (see Table 1). Post-intervention, a greater proportion of patients were triaged to step-down units instead of the ICU (p < 0.001). There were no significant differences in ICU length of stay, hospital length of stay, total ventilator days, incidence of respiratory complications, or mortality in the pre versus post PIC groups. A sub-group analysis was performed to assess if patients triaged to units outside of the ICU in the Post-PIC group had less complications, however, found no differences in unplanned ICU admissions, complications, or LOS.

Conclusions: This study demonstrates that implementation of a modified PIC-score triage system did not significantly alter the clinical course of patients with isolated traumatic chest wall injury treated at a high-volume trauma center. While our modified PIC-scoring system did triage less patients to the ICU initially, their hospital LOS, incidence of complications and mortality rates did not differ from the pre-PIC cohort. This suggests that further refinement of the PIC-scoring system is needed in order for this prognostication tool to reach a clinically impactful level.

Figure 1: Rib fracture triage algorithm for admission and down-grading

Intensive Care Unit (ICU), Pain Inspiratory Capacity and Cough (PIC), History (Hx), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Fracture (Fx), Modified Frailty Index (MFI), Intermediate Care Unit (IMU), Incentive Spirometry (IS).
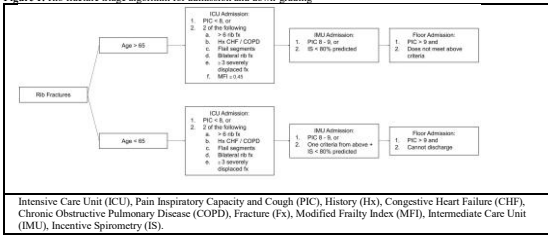
Table 1: Demographics, disposition and clinical outcomes of trauma patients with isolated chest wall injury before and after implementation of modified-PIC score guided admission

Variable	Overall (n = 3,739)	Pre-PIC (n = 2,461)	Post-PIC (n = 1, 278)	P-value
Age (mean years)	48.04	48.09	47.95	1.000
Percent male	69.3% (2,691)	69.6% (1,770)	68.6% (921)	1.000
Percent blunt	87.9% (3,416)	88.1% (2,239)	87.64% (1,177)	1.000
Base Deficit	-3.32	-3.35	-3.19	1.000
ISS (mean)	18.4	18.7	17.7	0.4614
Max AIS Thorax (median)	3	3	3	0.2551
ED Triage Floor Bed Step-Down Unit ICU Observation Unit Operating Room	35.4% (1,374) 4.6% (177) 34.7% (1,346) 2.6% (101) 22.8% (886)	34.6% (879) 2.3% (59) 36.3% (922) 2.8% (71) 24% (610)	36.9% (495) 8.8% (118) 31.6% (424) 2.2% (30) 20.6% (276)	<0.0001
ICU LOS	8.1	8.7	7.44	0.3806
Hospital LOS	11.36	11.75	10.63	1.000
Total Ventilator Days	11.49	11.88	10.47	1.000
Unplanned Return to ICU	3.8% (146)	3.2% (81)	4.8% (65)	0.5990
Unplanned Intubation	4.2% (164)	4.6% (116)	3.6% (48)	1.000
Sepsis	1.2% (45)	1.4% (35)	0.7% (10)	1.000
PE	1.5% (58)	1.5% 938)	1.5% (20)	1.000
Pneumonia	2.0% (78)	2.1% (52)	1.9% (26)	1.000
ARDS	1.5% (58)	1.8% (45)	0.98% (13)	1.000
CA w/ CPR	1.0% (39)	1.1% (28)	0.8% (11)	1.000
Mortality	3.2% (123)	3.4% (87)	2.7% (36)	1.000
Readmission	0.8% (31)	0.8% (21)	0.7% (10)	1.000

Injury Severity Score (ISS), Trauma Score & Injury Severity Score (TRISS), Intensive Care Unit (ICU), Length of Stay (LOS), Pulmonary Embolism (PE), Acute Respiratory Distress Syndrome (ARDS), Cardiac Arrest (CA).

COMMUNITY-LEVEL SOCIAL FACTORS AND FUNCTIONAL OUTCOMES AFTER EXTREMITY INJURY

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Introduction: Extremity injuries represent one of the most common injury patterns seen in the emergency department and are a common cause of long-term functional impairment. Although social determinants as a whole are known to play a key role in long-term trauma outcomes, it is unclear which social factors play a greater role so that interventions can be targeted and resources optimized. This study aimed to identify specific community-level social factors associated with long-term functional limitations after severe extremity injury.

Methods: Adult patients with a severe extremity injury (AIS>2) treated at one of three level-1 trauma centers were prospectively followed six to 12 months post-injury. These data were matched with Social Vulnerability Index (SVI) percentile rankings of 15 social factors at the census tract level (table). We used multivariable-adjusted regression models to assess for independent associations between social factors and functional limitations.

Results: A total of 1,454 patients were included [54% female, mean age 63.7 (SD= 21.5)]. Among them, 1,388 (95%) had an extremity AIS of 3, 1,075 (74%) had surgery, and 314 (22%) were admitted to the ICU. The most common injury type was a hip fracture (45%). Forty-five percent of patients reported a new functional limitation in performing an activity of daily living at 6-12 months post-injury. Several social factors were associated with increased odds of post-injury functional limitations.

Census tract-level variables	OR (95% CI)	P value
Socioeconomic status subindex		
Poverty rate, % under federal poverty level	**1.06 (1.01-1.10)**	**0.01**
Unemployment rate, %	1.02 (0.98-1.07)	0.36
Per capita income, scaled to multiple of $1000	**1.05 (1.01-1.11)**	**0.03**
Education, % age >=25 y with no high school degree	**1.05 (1.00-1.10)**	**0.03**
Household and disability subindex		
Age >=65 y, %	0.98 (0.94-1.03)	0.44
Age <=17 y, %	0.99 (0.95-1.03)	0.51
People with disability (noninstitutionalized), %	1.04 (0.99-1.08)	0.12
Single parent household, %	1.04 (1.00-1.08)	0.06
Minority status and language subindex		
Any racial/ethnic minority, %	1.04 (0.99-1.09)	0.10
Limited English proficiency, %	**1.05 (1.01-1.09)**	**0.02**
Housing and transportation subindex		
Housing in structures with >=10 units, %	1.02 (0.98-1.07)	0.32
Mobile homes, %	1.02 (0.98-1.07)	0.27
Occupied housing units people > rooms, %	1.04 (1.00-1.08)	0.08
Households without vehicles, %	**1.04 (1.00-1.08)**	**0.04**
People in institutionalized group residences, %	1.01 (0.98-1.05)	0.51

Boldface indicates statistical significance [P <0.05 (two-sided)].

Owing to rescaling of the variables, ORs for each index shows the change in odds of each outcome for a 0.1 unit increase of the original index measure (scale from 0 to 1).

Per capita income necessarily reversed as high income equates with low vulnerability and vice versa

Conclusion: Severe extremity injury patients from census tracts with a higher proportion of people living below 150% poverty, no high school diploma, limited English proficiency, no vehicles, and/or lower per capita income are more likely to have injury-related functional limitations in 6-12 months. To reduce these patients' long-term burden, interventions addressing social determinants should prioritize socioeconomic, language, and transportation barriers to care.

OSCILLATORY SHEAR STRESS REDUCES VEIN VALVE MICROTHROMBOSIS IN A CRITICALLY ILL HUMAN POPULATION

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Introduction: Deep Venous Thrombosis (DVT) causes significant morbidity and mortality after Trauma. We have previously shown oscillatory shear stress (OSS) genes maintain an anti-coagulant phenotype at vein valves that is lost in the presence of DVT and in static, critically ill patients. We hypothesized that restoration of OSS-inducing flow in critically ill humans would restore this protective phenotype and decrease spontaneous thrombosis using a Rapid Cycling Compression Device (RCCD).

Methods: Brain dead human organ donors who screened negative for DVT on arrival to our Organ Procurement Center (OPC) had an RCCD applied to a single lower extremity delivering 6 cycles/min of calf compression over < 1 second. The RCCD stayed in place until clinical organ procurement. The bilateral common femoral veins were harvested, and all vein valve segments were serially sectioned and stained with hematoxilyn and eosin (H&E). Microthrombi at vein valves from RCCD treated extremities were compared to those found at vein valves from contralateral nonRCCD treated extremities.

Results: Valves from 7 donors were evaluated (RCCD n= 18, no RCCD n=16). One non RCCD donor had a single valve with gross DVT visible. There was a significant reduction in microthrombosis at vein valves in limbs receiving RCCD therapy. (RCCD 11.1%, no RCCD 43.8%, p=0.038, Fisher exact test)

Conclusions: OSS flow to extremities using RCCD resulted in decreased micro and gross thrombosis in treated extremities in critically ill brain-dead donors. This cutting edge technology has the potential to change how we approach DVT prevention in trauma patients. Future studies will focus on characterization of the immunologic characteristics of microthrombi and their role/progression in DVT pathogenesis, and further reduction of gross DVT/macrothrombi at human vein valves with RCCD therapy.

Table 1 – Chi-squared analysis of thrombosis in RCCD vs no RCCD therapy

	No Thrombosis	Thrombosis	Total
RCCD	16	2	18
nonRCCD	9	7	16
Total	25	9	34
Chi-squared p = 0.016, Fisher Exact test p = 0.038			

DISPARITIES IN THE BURDEN OF TRAUMATIC INJURIES FROM INTERPERSONAL VIOLENCE IN PREGNANT WOMEN

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Introduction: Interpersonal violence (IPV)-related homicide often correlates with a history of non-fatal injuries. Pregnant women have an increased risk and severity of IPV, especially from an intimate partner; however, the nationwide burden and associated social disparities are not well described. The objective of this study is to describe the contemporary burden of IPV on pregnant women and identify patient characteristics associated with an increased risk of IPV.

Methods: The National Inpatient Sample was queried for all pregnant women between Jan 2016-Dec 2019. ICD-10-CM diagnoses were abstracted to generate an approximate Abbreviated Injury Scale (AIS) and Injury Severity Score (ISS). Traumatic injuries from IPV were identified as intentional injuries related to certain injury mechanisms (cut/pierce, firearm, struck by/against). Baseline characteristics were compared between the IPV and no-IPV groups. Multivariable regression was performed to identify clinical factors associated with IPV-related injuries.

Results: 29,735 pregnant patients presented with traumatic injuries with 1,105 (0.04%) identified as IPV. IPV patients had severe injuries (ISS >15) more frequently compared to non-IPV patients (95 [8.6%] vs 750 [2.6%], p<0.001). IPV patients were younger (median 25 years [IQR 21-30] vs 27 [23-32], p<0.001), more likely to be of Black race (550 [50%] vs 7,930 [29%], p<0.001), be in the lowest income quartile (590 [55%] vs 10,800 [38%], p<0.001), and have higher rates of substance use disorder (350 [32%] vs 5,380 [19%], p<0.001). Multivariable regression showed Black race (OR: 2.74, CI: 1.90-3.94, p<0.001) and substance use disorder (OR: 1.95, CI: 1.43-2.66, p<0.001) were associated with increased odds of IPV. Additionally, third trimester pregnancies had increased odds of their intimate partner being identified as the perpetrator of the trauma (OR: 1.71, CI: 1.05-2.80, p=0.031).

Conclusion: There are significant racial and social disparities in the burden of IPV during pregnancy. With the loss of federal protections to access abortion and the expectation these systemic changes may yield increases in IPV, it is imperative that clinicians recognize populations at increased risk for IPV to pursue targeted intervention and prevention services.

GEOCODING: THE IMPACT OF BEING TREATED AT THE NEAREST HOSPITAL

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Introduction: Trauma is a leading cause of death in many large inner cities around the world, in part due to high levels of interpersonal violence, transit accidents, and immature trauma systems.

We evaluated the impact of distance between the site of the injury and the hospital where the patients were first transported and treated. The impact of distance on the most remote poorly served highly violent neighborhoods (HVN) was analyzed.

Methods: We performed a secondary analysis of a prospectively collected cohort of moderate to severe trauma patients treated in four main trauma hospitals in our city between December 2012 and June 2013. We geocoded the injury site and the hospitals to calculate the distance traveled and travel time. Patients treated in the nearest hospital (group A) were compared with those who were taken to more distant sites. (group B). Groups were compared with Chi^2 test or Wilkoxon-Mann-Whitney tests, as needed. Unadjusted and adjusted ORs were calculated with multiple logistic regressions.

Results: We included 606 patients, 85.3% male. Penetrating trauma occurred in 56.3%. Seventy-two percent of the patients were treated in hospitals equivalent to level 1. Patients taken to the nearest hospital were older, less frequently had penetrating trauma, less frequently were uninsured, and less frequently came from (HVN). Trauma severity and survival probability were similar.

Patients injured in HVN sites had a significantly lower probability of

Effect of Being Treated at the Nearest Hospital			
Variable	Group A	Group B	p
n	368	238	--
Male, n(%)	322 (87.5)	195 (81.9)	0.06*
Age, years, median (IQR)	28 (22 – 40)	32 (23 – 44)	0.04**
Penetrating trauma, n (%)	233 (63.3)	108 (45.4)	<0.001*
Uninsured, n (%)	68 (18.5)	19 (8.0)	<0.001*
ISS	16 (11 – 25)	18 (11 – 27)	0.16**
PS	0.99 (0.94 – 0.99)	0.99 (0.90 – 0.99)	0.33**
Agua-Blanca	105 (28.3)	16 (6.7)	<0.001*
Mortality	93 (25.3)	26 (10.9)	<0.001*

ISS. Injury Severity Score. PS Probability of survival.
* Chi2.   **Wilcoxon-Mann-Whitney

being treated in the nearest hospital. After adjusting for the relevant variables, the odds of death were lower when the patients were treated in the nearest hospital (adjusted OR 0.27 95% CI 0.14 - 0.52) and increased when they came from HVN (adjusted OR 1.85 95% CI 1.01 - 3.37).

Conclusions: Our results indicate that regions where disparities in care reflected by higher number of uninsured trauma patients arriving from poorer district were associated with longer distances and traveled time had a higher mortality. These data not only confirm the beneficial impact of trauma regionalization but also points to specific areas were specialized trauma centers need to be located.

# HIGHER SOCIAL DEPRIVATION INDEX IS ASSOCIATED WITH INCREASED MORTALITY IN THE EGS POPULATION

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Introduction: Emergency General Surgery (EGS) disorders represent a wide spectrum of disease with high complication and mortality rates. Race, insurance and socioeconomic status have been associated with mortality in the EGS population. Social deprivation index (SDI) is a geographic area demographic index used to quantify variations in healthcare. We aimed to examine the mortality and complication rates of EGS procedures across a large integrated healthcare system.

Methods: This is a retrospective cohort study of adult EGS patients from 2017 through 2021 with CPT codes for high-risk (small bowel resection, colectomy, or peptic ulcer procedure) or low-risk procedures (appendectomy or cholecystectomy). Primary outcome was 30-day mortality; secondary outcomes were length of stay (LOS) and post-discharge ED visits.

Results: A total of 12,786 patient visits were analyzed, 4,148 high risk and 8,638 low risk procedures. High-risk EGS patients from high SDI areas experienced significantly greater mortality than those from low SDI areas (p=0.023, OR 1.95) when adjusted for age and gender. EGS patients from high SDI areas were more likely to have ≥1 post-discharge ED visit and have longer LOS than those patients from low SDI areas (p=0.008, OR 1.41 and p <.0001, respectively) when adjusted for age and gender.

Conclusion: Living in a high SDI area is associated with higher mortality, greater postoperative ED visits and longer LOS in the EGS population. This study highlights the need for geographically targeted interventions to match resources with EGS patients at highest risk for complications and death.

30-day Mortality Rate by SDI

≥1 postdischarge ED visit by SDI
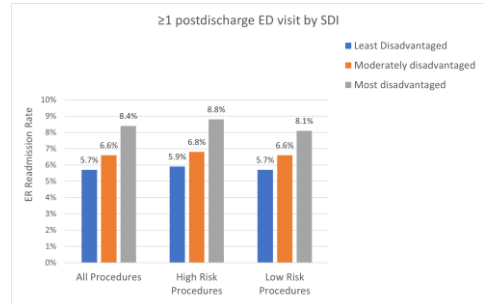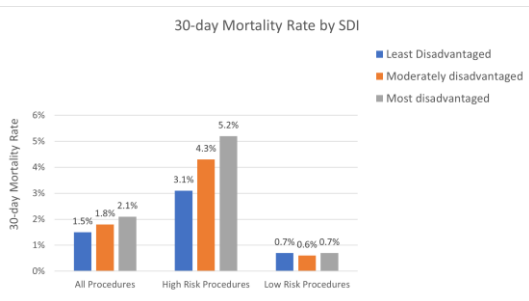
LOST IN TRANSLATION? COMPREHENSION OF CARE IN ENGLISH- VS. SPANISH-SPEAKING TRAUMA PATIENTS

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Introduction: Culturally responsive care is a core recommendation to reduce health disparities. Language barriers contribute to misunderstandings, dissatisfaction, and worse outcomes. This is exacerbated in trauma when communication is constrained by time, complexity, and competing priorities. We hypothesized that Spanish-speaking trauma patients (SSP) would have less accurate comprehension of care (CC) and discharge instructions compared to English-speaking patients (ESP).
Methods: We retrospectively reviewed discharges from a Level 1 trauma center 10/2021-03/2022 who were age ≥18, primarily ESP or SSP, discharge GCS ≥14, and without memory loss. Patients were surveyed <48 hours from discharge to assess CC. Patients self-rated CC on a Likert scale, and answered open-ended questions on CC and discharge instructions. Charts were reviewed to assess and rate concordance of CC with actual care.
Results: We included 46 patients (21 SSP, 25 ESP). Mean age was 48.3 years SSP, 43.3 ESP; 47% SSP were female vs. 32% ESP (p=0.28). 56% SSP had ≥ high school diploma vs. 72% ESP (p=0.34). Self-rated CC was similar, with both groups rating high understanding of their care and follow-up. SSP were less likely to accurately report diagnoses and home medications than ESP, even when corrected for education level, despite having high confidence in their comprehension of care.
Conclusion: Though both SSP and ESP self-rated their comprehension of their care highly, there were significant differences between groups' accuracy. Increased use of certified medical interpreters throughout hospitalization may improve language disparities in patient comprehension.

Component of Comprehension	% Near or Complete Concordance		p-value	Adjusted OR* [95% CI] REF=English	p-value*
	English	Spanish			
Diagnoses	92.0% (23)	57.1% (12)	**0.01**	0.11 [0.02, 0.64]	**0.01**
Inpatient Testing	84.0% (21)	66.7% (14)	0.17	0.33 [0.06, 1.7]	0.18
Inpatient Treatment	76.0% (19)	66.7% (14)	0.48	0.87 [0.21, 3.64]	0.85
Home Medication	84.0% (21)	57.1% (12)	**0.04**	0.20 [0.04, 0.91]	**0.04**
Home Care (non-medication)	76.0% (19)	52.4% (11)	0.09	0.32 [0.08, 1.27]	0.11
Follow-Up Appointments	68.0% (17)	38.1% (8)	**0.04**	0.32 [0.09, 1.13]	0.08
Return Precautions	64.0% (16)	38.1% (8)	0.08	0.34 [0.09, 1.25]	0.10

*Adjusted analysis accounting for patients' self-reported highest level of education

# RACIAL DISPARITIES IN POLICE TRANSPORTATION OF TRAUMA PATIENTS OVER TIME

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Introduction: The study objective was to determine if racial disparities exist among trauma patients brought in by police.

Methods: This retrospective cohort study included adult trauma patients admitted to six level I-II trauma centers in CO, TX, & KS (1/1/15-7/15/22). Transfer patients, and other or unknown races were excluded. Comparisons were made by race: non-Hispanic (NH) White, NH-Black, or Hispanic. The outcome was police transport, $\alpha < 0.01$.

Results: Of 46,581 patients (77% NH-White, 17% Hispanic, 5% NH-Black), there was a disproportionately higher amount of Hispanic (0.9%) and NH-Black (0.4%) patients transported by police (n=128) when compared to NH-White (0.1%) patients, p<0.01. Hispanic patients were 6.4 (4.5, 9.2) times more likely to be transported by police than NH-White patients. NH-Black were 2.7 (1.3, 5.5) times more likely to be transported by police than NH-White patients. The most common cause of injury among Hispanic patients was a fall. For NH-Black and NH-White patients, the most common injury cause was assault, p<0.01. Hispanic patients' injuries were more severe than both NH-White and NH-Black patients, p<0.01. Over time, police transport of NH-White patients remained relatively constant, moderate $r^2 = 0.4$. For NH-Black patients there

Police Transports Over Time by Race

was a negative quadratic association over time with a peak in police transport in 2019 and a continuous decline since, moderate $r^2 = 0.3$. For Hispanic patients, there was a positive quadratic correlation with drop in police transports in 2019 followed by a consistent increase, strong $r^2 = 0.7$.

Conclusions: Hispanic and NH-Black patients were more likely to be police transports than NH-White patients. While police transport of NH-White patients has remained constant overtime, since 2019 police transport of Hispanic patients increased, and for NH-Black patients' police transport decreased. These data could be used to guide action addressing racial inequities in police transport, such as policies providing criteria for police transport of trauma patients.
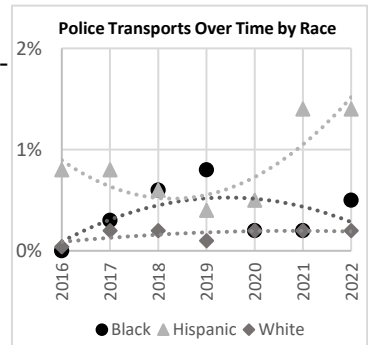
RISK FACTORS FOR LOSS TO FOLLOW-UP AFTER TRAUMATIC INJURY: A SINGLE INSTITUTION STUDY IN AN URBAN, SAFETY NET, LEVEL 1 TRAUMA HOSPITAL

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Introduction: After traumatic injury, loss to follow up (LTFU) occurs at rates up to 47%, though the most recent data is a decade old. This study provides an updated assessment of risk factors for LTFU after trauma.
Methods: A retrospective chart review was conducted of trauma admissions from 12/1/2018 to 12/31/2019. Data from 2020 and 2021 was excluded due COVID-19. Exclusion criteria included age under 18, transferred to another service during hospitalization, and those with no scheduled follow up within 30 days. Categorical variables were compared using Pearson's Chi-square tests. Continuous variables were analyzed using two-tailed t-tests or Mann Whitney Wilcoxon tests for parametric and non-parametric variables, respectively. Logistic regression was used to create an model adjusted for relevant factors identified on univariate analysis. Statistical significance was designated at $\alpha=0.05$. Analysis was completed using SAS Software Version 9.4 (SAS Institute Inc., Cary, NC, USA).
Results: 1,350 patients met inclusion criteria, with a 25.11% LTFU rate. In an unadjusted model, race/ethnicity, language, insurance status, employment, co-morbid psychiatric disorder or substance use disorder (SUD), trauma activation level, injury severity score (ISS), injury location and mechanism, length of hospital and ICU stay, disposition, and follow up scheduled at time of discharge were associated with a significantly lower LTFU. Multivariate logistic regression found insurance and employment status, SUD, and ISS remained significant. The final model was stratified by race due to interactions between race and the significant variables. In this model, white patients with non-private insurance had lower odds of LTFU compared to private insurance (OR 0.377, 95% CI 0.246 – 0.579), non-white patients with SUD had increased odds of LTFU compared to those without SUD (OR 2.77, 95% CI 0.944-0.988) and for each one-point increase in ISS their odds of LTFU decreased by 3.4% (95% CI 0.944-0.988).
Conclusion: Unmodifiable social determinants of health, including insurance status, employment status, and ISS, are associated with LTFU in the trauma population. Close attention should be paid to patients at risk for LTFU to ensure adequate engagement with the healthcare system.

IMPLEMENTATION OF AN OUTPATIENT PTSD SCREENING INITIATIVE AT A LEVEL 1 TRAUMA CENTER

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Introduction: Psychosocial care for trauma patients is fragmented and often limited to inpatient acute crisis counseling. Many trauma patients are at risk for post-traumatic stress disorder (PTSD) but have limited resources after discharge. As part of a trauma-informed care initiative, an algorithm for outpatient PTSD screening was developed. We hypothesized that this would supplement inpatient screening processes and better capture patients at risk.
Methods: Retrospective single-center study conducted at a Level I trauma center between August 2022-January 2023. Trauma patients (≥18 years) seen for outpatient follow-up in Trauma Surgery, Physical Medicine & Rehabilitation (PM&R), Orthopedics, and Neurosurgery clinics were included. Patients were screened for PTSD utilizing the validated PC-PTSD-5 tool or clinical judgement. Rates of screening and follow-up were collected and barriers to care summarized.
Results: 49 trauma psychology referrals were obtained. 19 patients were screened via the PC-PTSD-5 tool, with 11 identified to be at risk for PTSD and provided outpatient referral. 38 referrals were made based on clinical judgment. Referrals were obtained from Trauma (55%), PM&R (29%), Orthopedics (14%) and Neurosurgery (0.06%). 28 new patient encounters were completed (57% virtual visits). There were 8 no-shows (29%). Reported barriers included financial hardship, insurance coverage, traumatic brain injury, and patient disinterest.
Conclusion: In this pilot study, implementation of outpatient PTSD screening at a Level I trauma center generated 49 referrals for psychosocial services. Though challenges persist, this screening process specifically addresses post-discharge needs for the trauma patient. Further research and program development are needed to improve adherence to validated PTSD screening and ensure comprehensive trauma-informed care for patients.