

Guide to Trauma Center Designation for Hospital Executives



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Introduction

Achieving excellence in the delivery of trauma patient care requires dedication and commitment by the entire hospital team, including executive leadership. The development and maintenance of a trauma program in Texas requires a full understanding of the Texas Administrative Code 157.125, the regulatory requirements for achieving and maintaining trauma center designation in Texas. Recognizing the time limitations of executive leaders in hospitals, the Trauma Division of Texas EMS, Trauma & Acute Care Foundation has developed this introduction to trauma center designation requirements. This abbreviated format





is designed to provide the hospital administrator with the basic knowledge and understanding needed to lead a facility and trauma program staff through successful trauma center designation and trauma program maintenance. This publication provides an overview of Texas trauma program requirements. Trauma staff members should maintain full knowledge and understanding of the Texas trauma center designation regulatory requirements, TAC 157.125.

For additional information regarding the Texas trauma system, TETAF invites you to visit its website at www.tetaf.org



Overview of the Texas Trauma System

Epidemiology of Trauma

Almost 30 Texans die every day from injuries – almost 10,000 each year. Since trauma is the leading cause of death in individuals ages 1 – 44, the years of potential life lost are staggering.

Mortality is not the only side of this issue; for every trauma victim who dies, at least six are injured seriously. Many people with severe disabilities resulting from injuries may have some degree of life-long dependence on federal, state and local assistance.

Trauma System

Trauma is a disease that can occur anywhere at any time. Critical trauma victims must reach definitive care within a short period of time, often called the “golden hour,” to help prevent death or disability. To ensure that this occurs, a set of resources must be in place and immediately accessible at all times. These resources include communication systems, pre-hospital care providers and multidisciplinary trauma teams. With the inclusion of public information, prevention activities and rehabilitation, this coordination of resources is called a trauma system.

Rural areas may not have the means to provide this full continuum of resources; therefore, preventable death rates due to trauma may be considerably higher than in urban areas. It has been estimated that rates for preventable trauma deaths in rural areas could be as high as 85 percent. The problem is compounded further because the large urban centers, which usually have the appropriate resources available, are overloaded with patients and may not be able to take rural trauma transfers.

History and Development of the Texas Trauma System

The Texas Legislature wanted trauma care resources to be available to every citizen. The Omnibus Rural Health Care Rescue Act, passed in 1989, directed the Bureau of Emergency Management of the Texas Department of Health to develop and implement statewide emergency medical services and a trauma care system, designate trauma facilities and develop a trauma registry to monitor the system and provide statewide cost and epidemiological statistics.

The Governor’s EMS and Trauma Advisory Council (GETAC, although the name of this council changed multiple times in the early years) was created as a forum to oversee system development, share best practices and make recommendations via the Commissioner of Health to the governor.

Trauma Service Areas with RAC Names

TSA A

- Armstrong
- Briscoe
- Carson
- Childress
- Collingsworth
- Dallam
- Deaf Smith
- Donley
- Gray
- Hall
- Hansford
- Hartley
- Hemphill
- Hutchinson
- Lipscomb
- Moore
- Ochiltree
- Oldham
- Parmer
- Potter
- Randall
- Roberts
- Sherman
- Swisher
- Wheeler

TSA B

- Bailey
- Borden
- Castro
- Cochran
- Cottle
- Crosby
- Dawson
- Dickens
- Floyd
- Gaines
- Garza
- Hale
- Hockley
- Kent
- King
- Lamb
- Lubbock
- Lynn
- Motley
- Scurry
- Terry
- Yoakum

TSA C

- Archer
- Baylor
- Clay
- Foard
- Hardeman
- Jack
- Montague
- Wichita
- Wilbarger
- Young

TSA D

- Brown
- Callahan
- Coleman
- Comanche
- Eastland
- Fisher
- Haskell
- Jones
- Knox
- Mitchell
- Nolan
- Shackelford
- Stephens
- Stonewall
- Taylor
- Throckmorton

TSA E

- Collin
- Cooke
- Dallas
- Denton
- Ellis
- Erath
- Fannin
- Grayson
- Hood
- Hunt
- Johnson
- Kaufman
- Navarro
- Palo Pinto
- Parker
- Rockwall
- Somervell
- Tarrant
- Wise

TSA F

- Bowie
- Cass
- Delta
- Hopkins
- Lamar
- Morris
- Red River
- Titus

TSA G

- Anderson
- Camp
- Cherokee
- Franklin
- Freestone
- Gregg
- Harrison
- Henderson
- Houston
- Marion
- Panola
- Rains
- Rusk
- Shelby
- Smith
- Trinity
- Upshur
- Van Zandt
- Wood

TSA H

- Angelina
- Nacogdoches
- Polk
- Sabine
- San Augustine
- San Jacinto
- Tyler

TSA I

- Culberson
- El Paso
- Hudspeth

TSA J

- Andrews
- Brewster
- Crane
- Ector
- Glasscock
- Howard
- Jeff Davis
- Loving
- Martin
- Midland
- Pecos
- Presidio
- Terrell
- Winkler

TSA K

- Coke
- Concho
- Crockett
- Irion
- Kimble
- Mason
- McCulloch
- Menard
- Reagan
- Runnels
- Schleicher
- Sterling
- Sutton
- Tom Green

TSA L

- Bell
- Coryell
- Hamilton
- Lampasas
- Milam
- Mills

TSA M

- Bosque
- Falls
- Hill
- Limestone
- McLennan

TSA N

- Brazos
- Burleson
- Grimes
- Leon
- Madison
- Robertson
- Washington

TSA O

- Bastrop
- Blanco
- Burnet
- Caldwell
- Fayette
- Hays
- Lee
- Llano
- San Saba
- Travis
- Williamson

TSA P

- Atascosa
- Bandera
- Bexar
- Comal
- Dimmit
- Edwards
- Frio
- Gillespie
- Gonzales
- Guadalupe
- Karnes
- Kendall
- Kerr
- Kinney
- La Salle
- Maverick
- Medina
- Real
- Uvalde
- Val Verde
- Wilson
- Zavala

TSA Q

- Austin
- Colorado
- Fort Bend
- Harris
- Matagorda
- Montgomery
- Walker
- Waller
- Wharton

TSA R

- Brazoria
- Chambers
- Galveston
- Hardin
- Jasper
- Jefferson
- Liberty
- Newton
- Orange

TSA S

- Calhoun
- De Witt
- Goliad
- Jackson
- Lavaca
- Victoria

TSA T

- Jim Hogg
- Webb
- Zapata

TSA U

- Aransas
- Bee
- Brooks
- Duval
- Jim Wells
- Kenedy
- Kleberg
- Live Oak
- McMullen
- Nueces
- Refugio
- San Patricio

TSA V

- Cameron
- Hidalgo
- Starr
- Willacy

TSA W

- El Paso
- Hudspeth
- Culberson
- Reeves
- Ward
- Crane
- Upton
- Winkler

TSA X

- El Paso
- Hudspeth
- Culberson
- Reeves
- Ward
- Crane
- Upton
- Winkler

TSA Y

- El Paso
- Hudspeth
- Culberson
- Reeves
- Ward
- Crane
- Upton
- Winkler

TSA Z

- El Paso
- Hudspeth
- Culberson
- Reeves
- Ward
- Crane
- Upton
- Winkler

A fully implemented statewide trauma system has been developed with many positive results, including decreases in injury severity and the severity of trauma-related disability, and in the number of trauma incidents, preventable deaths and people dependent on state assistance programs due to trauma. As of March 2012, Texas had 264 designated trauma centers.

GETAC continues to oversee the evolving statewide trauma system. This council and all of its committees meet at least quarterly in Austin. The committees include Trauma, EMS, Disaster/Emergency Preparedness, Education, Medical Directors, Air Medical, Injury Prevention, Stroke, Pediatrics and Cardiac. Additionally, the Regional Advisory Council chairs meet within this quarterly venue. Open meetings and discussions allow all stakeholders to share ideas and information, voice concerns, and provide input that improves and further develops the trauma system. These quarterly meetings are critical for the trauma community to stay informed. Rule development and revisions are a key part of this forum.

The state's EMS/trauma system is regulated by the Texas Department of State Health Services' (TDSHS) Office of EMS and Trauma based on the Texas Health & Safety Code, Title 9, Safety, Chapter 773, Emergency Medical Services. This chapter can be viewed at www.statutes.legis.state.tx.us.

The following rules and the attachments included in them regulate the state's trauma centers, the Regional Advisory Councils and the disbursement from the Designated Trauma Facility and Emergency Medical Services Account:

TAC 157.123 – Regional EMS/Trauma System

TAC 157.125 – Requirements for Trauma Center Designation

TAC 157.128 – Denial, Suspension and Revocation of Trauma Facility Designation

TAC 157.130 – EMS and Trauma Care System Account

TAC 157.131 – Designated Trauma Facility and Emergency Medical Services Account

TAC 157.132 – Regional Trauma Account

These rules can be viewed at www.dshs.state.tx.us/emstraumasystems/statutes.shtm.

Administration of a Successful Trauma Center

The Trauma System within Your Facility

The hospital administrator must be committed to the essential criteria of a designated trauma center, regardless of the level of designation, for the program to be successful. The leaders of the trauma program, the Trauma Medical Director and Trauma Program Manager, must have the full support from hospital administration, the medical staff and all hospital departments. The trauma program and team are hospital-wide and include EMS, imaging, laboratory, blood bank, surgical services, nursing, critical care, rehabilitation, quality management, education, public outreach and financial services. In addition, active participation with the Regional Advisory Council (RAC) within the facility's Trauma Service Area (TSA) is required.

Administrative Support for the Trauma Service Line

The role of hospital administration related to the trauma service line is defined specifically through the essential criteria. It is critical that the hospital seeking designation refer to TAC 157.125 for specific designation requirements. However, as a brief overview, all trauma centers must address the following criteria at some level:

- Dedicated personnel and resources to the trauma program;
- Physician contracts and credentialing for trauma response;
- Trauma clinical standards;
- Trauma quality assurance processes;
- Trauma education for nurses, physicians and ancillary support staff;
- Injury prevention and public outreach programs; and
- Community, regional and statewide leadership and participation in the Regional Advisory Council.



Dedicated Personnel and Resources to the Trauma Program

Trauma Medical Director

The Trauma Medical Director (TMD) is a credentialed member of the hospital medical staff with authority to affect all aspects of the trauma program. In facilities designated as Level I, II and III, this position must be filled by a surgeon. In a Level IV facility, this role may be filled by an emergency medicine physician.

Roles and Responsibilities of the Trauma Medical Director

- Monitoring of trauma care provided by the facility;
- Assisting in the development of written protocols;
- Credentialing of staff who provide trauma care;
- Assisting in providing trauma education for staff;
- Maintaining oversight for physician continuing education;
- Participating in the trauma improvement process;
- Maintaining leadership roles in the hospital and community disaster response committees;
- Chairing the hospital trauma committee;
- Participating in the RAC;
- Maintaining current Advanced Trauma Life Support (ATLS) certification;
- Fulfilling responsibilities as defined by the TMD job description and organizational chart; and
- Participating in regional and statewide trauma initiatives.

Trauma Program Manager/Trauma Coordinator

The Trauma Program Manager (TPM) or Trauma Coordinator (TC) is a registered nurse who has direct responsibility and authority to impact the care of trauma patients in all areas of the hospital. Functioning on the same level of authority as hospital departmental leadership, the TPM is to be the expert in the hospital on trauma care and trauma systems. The TPM should be integrated into hospital leadership committees that affect clinical care and quality management.

Roles and Responsibilities of the Trauma Program Manager

- Has responsibility for the oversight of day-to-day trauma patient care throughout the hospital;
- Oversees trauma performance improvement and quality assurance;
- Ensures that the hospital is meeting all of the essential criteria for trauma center designation, as defined by TAC 157.125;
- Communicates and collaborates with hospital departments involved in trauma patient care;
- Assists in the development of written protocols;
- Assists in providing trauma education for staff and maintaining trauma education records for medical and nursing staff;
- Maintains leadership role in hospital and community disaster response committees;
- Coordinates and participates in the hospital trauma committee;

- Participates in the RAC;
- Maintains current Advanced Cardiac Life Support, Trauma Nurse Core Course, Emergency Nursing Pediatric Course/Pediatric Advanced Life Support certification and Trauma Program Manager-specific education courses;
- Maintains responsibilities as defined by the TPM job description and organizational chart;
- Coordinates injury prevention and outreach efforts;
- Supervises trauma registry maintenance;
- Supervises the development and presentation of trauma statistical data; and
- Participates in regional and statewide trauma initiatives including RAC, GETAC, TETAF, the Texas Trauma Coordinators Forum and other injury prevention initiatives.

Trauma Registrar

The Trauma Registrar is separate from but supervised by the TPM, and is trained and skilled at data abstraction, injury coding and database management.

Roles and Responsibilities of the Trauma Registrar

- Maintains the facility's trauma registry database;
- Ensures that data are submitted in a timely manner to the Texas Department of Epidemiology State Trauma Registry;
- Assists the Trauma Program Manager in the development of statistical reports and with performance improvement activities; and
- Assists the Trauma Program Manager in the collection and analysis of facility and regional data to identify and/or establish injury prevention and public education initiatives.

TAC 157.125 currently defines Trauma Registrar education and certification as a "desired" criterion; however, rule revisions currently in process are defining ongoing annual education for the identified trauma registrar. Additionally, Certified Specialist in Trauma Registry designation will be desired. Opportunities to ensure ongoing trauma registrar education are available through several state and national organizations. Current courses targeting trauma registrars to develop and mature their knowledge base and skill sets include:

1. The American Trauma Society offers the combined Basic and Advanced Trauma Registry course. (The Certified Specialist in Trauma Registry (CSTR) credential is available by examination.)
2. The Association for the Advancement of Automotive Medicine (AAAM) offers the Abbreviated Injury Scaling (AIS) course which teaches the coding of traumatic injury. (The Certified Abbreviated Injury Scale Specialist (CAISS) credential is available by examination.)
3. State registry organizations often offer educational opportunities.
4. TETAF is developing a Data Management Course that will be offered in Texas in late 2012.

The Certified Specialist in Trauma Registry (CSTR) credential as well as the Certified Abbreviated Injury Scale Specialist (CAISS) credential are evidence of mastery of the core trauma-related data and critical care processes which are common to every trauma department and system.

Physician Credentialing for Trauma Response

Medical staff support is critical to the success of the designated trauma program. In coordination with the Trauma Medical Director and the Trauma Program Manager, the administrator is responsible for ensuring appropriate physician coverage for trauma care and developing agreements with physicians to ensure compliance with trauma protocols and processes. Additionally, the administrator must ensure that processes are in place to monitor and maintain trauma-specific physician credentials.

Developing an agreement with the Trauma Medical Director defining the authority to oversee the credentialing of all physicians responding to trauma call is a required criterion in the TAC 157.125. Facilities with credentialing specialists should have processes in place to ensure the Trauma Medical Director has credentialing approval for all physicians accepting trauma call. This may occur through the TMD's membership on credentialing committees or final approval through the Medical Staff Committee. Additionally, the Trauma Program Manager must have access to credentialing documents, including ongoing continuing medical education, for all physicians taking trauma call.



Trauma Clinical Standards

In coordination with the Trauma Medical Director and the Trauma Program Manager, the administrator must ensure that the hospital and medical staff are practicing within current, evidenced-based standards of trauma care. Processes must be in place to continuously monitor care provided through the entire continuum of care, including the care provided pre-hospital through rehabilitation. Critical to the success of the program and improved patient outcomes, quality of care must be recognized, monitored and ensured by the facility. In collaboration with the entire hospital and medical staff, the administrator must ensure that all identified deviations from current, clinical, evidenced-based standards of care will be addressed through education, training, equipment procurement and process improvement.

Trauma Quality Assurance Processes

The purpose of the Trauma Performance Improvement (PI) Process is to critically review, evaluate and discuss quality-of-care issues related to all aspects of trauma care delivered at the hospital, including pre-hospital through rehabilitation. The information and action plans developed during the trauma performance improvement process are used to drive improved patient outcomes, improve resource utilization and reduce costs. Most hospitals that have strong trauma performance improvement programs also enjoy marked improvement in their other programs and initiatives. This phenomenon is often referred to as the “halo effect” of trauma.

The trauma performance improvement program should be structured to integrate, facilitate and collaborate with the hospital-wide performance improvement program. These activities are designed to assess key functions of patient care and to identify and study improvement opportunities in the processes of care delivery, and correct problems.

The Trauma Committee should be multidisciplinary and structured within the hospital organizational chart to have the authority to improve and enhance trauma patient care and processes. Chaired by the Trauma Medical Director and coordinated by the Trauma Program Manager, the Trauma Committee is the forum for in-depth, critical discussion of all aspects of trauma patient care and processes. Administrative participation and support at this committee level are critical to the success of the trauma program. This is a dynamic, ongoing process to ensure patients receive the gold standard of care.



Trauma Education for Nurses, Physicians and Ancillary Support Staff

Trauma education begins with a hospital-wide awareness of the high standards and expectations for all members of the trauma care team. Annual trauma-care competencies must be maintained as well as ongoing trauma education specifically addressing issues identified in the trauma quality assurance program. Additionally, specific education and credentials are defined within TAC 157.125 that must be maintained by medical and nursing staff:

Physicians:

- ATLS must be current for the TMD, taken once by physicians board-certified in emergency medicine and current for physicians not board-certified in emergency medicine, and
- A minimum of nine hours of trauma-related CME must be attained annually by the TMD and all physician representatives on the Trauma Committee.

Nursing:

- ACLS training is current;
- All nurses have taken TNCC within 18 months of the assignment to the Emergency Department; and
- All nurses have taken ENPC or PALS training within 18 months of their assignment to the Emergency Department.

Trauma Program Staff:

- The TPM has completed the Trauma Program Management class and the TOPIC course with recertifications every four years;
- The TPM is current in ACLS, TNCC, ENPC or PALS training; and
- The Trauma Registrar has completed both the Trauma Registry Course and Injury Scoring Course with recertifications every four years.



Injury Prevention and Public Outreach Programs

The trauma-designated hospital has the responsibility to provide public education programs that address the major causes of injury within the hospital's service area. These efforts should be driven by data abstracted from the trauma registry. For example, if the trauma registry data identify that "falls" are the number one cause of injury seen at the hospital, then fall prevention education and initiatives should be provided. Additionally, the hospital should participate in any region-wide injury prevention efforts supported through the RAC.

Injury prevention and public outreach strategies are categorized using the concept of three E's: education, enforcement and engineering.

Education – Probably the easiest and most common injury prevention strategy seeks to change behavior through education and information. Examples include but are not limited to:

- Health fairs – providing literature and/or education to the community on prevention;
- Bicycle and helmet safety programs – targeting elementary and middle school-aged children, often sponsored in collaboration with the police department. Examples: bicycle rodeo, helmet fitting and safety fairs, safe city;
- Alcohol and crash awareness programs – targeting high school students to raise awareness on the consequences of distracted driving. Examples: Shattered Dreams, car surfing programs, texting and driving programs;
- Speaker's bureau – providing speakers at civic clubs and miscellaneous organizations to discuss injury prevention strategies; and
- Printed materials – distributing articles to hospital publications or to community newspapers on time-sensitive injury prevention measures (July – firework safety, October – candy inspections/costume safety, December – Christmas tree/light/decoration safety, January – winter concerns including space heater safety, May – swimming pool/drowning prevention measures, etc.).

Enforcement – Although often more time consuming, these strategies identify prevention efforts that can lead to legislation and forced behavior changes. Examples include:

- Seat belt laws,
- Red light cameras,
- Sobriety check points,
- Cell phone use in school zones, and
- Child passenger seat laws.

Engineering – Changes can be made to the environment or product design for the benefit of prevention. Examples include:

- Child safety pill bottle caps,
- Automobile air bags,
- Reflective traffic signs and roadway markings,
- Improvements on newborn and toddler safety seats, and
- Disaster preparedness initiatives – specifically evacuation contraflow routes.

Injury prevention strategies can be individually, facility-wide, community or regionally directed. Public information and education are often the foundation for any injury prevention program with the most effective strategies encompassing a multidisciplinary approach utilizing all three concepts of education, enforcement and engineering.

It is essential that health care providers and trauma centers become involved in injury prevention as injury affects everyone on a daily basis, personally and professionally, while straining financial, operational and strategic capabilities.



Community, Regional and Statewide Leadership and Participation

All designated trauma centers, regardless of level, have a responsibility to participate in the regional and statewide trauma system. Through the participation of the hospital's trauma program staff, the administrator stays connected and aware of regional and statewide trauma issues and initiatives. Participation provides opportunities for staff education, training, mentorship and sharing of best practices. These forums also offer the opportunity to interface with the Texas Department of State Health Services and provide input to rule revision and trauma system development.

Mechanisms for participation:

Periodic Regional Advisory Council meetings (specific to the Trauma Service Area);

Quarterly Texas Trauma Coordinators Forum meetings (www.ttcf.org);

Monthly Texas EMS, Trauma & Acute Care Foundation meetings (www.tetaf.org) via conference calls and quarterly meetings in conjunction with GETAC; and

Quarterly Governor's EMS and Trauma Advisory Council meetings. (www.dshs.state.tx.us/emstraumasystems/default.shtm)



Financial Benefits of Trauma Center Designation

Trauma happens in every community, and trauma patients require care regardless of the trauma designation status of the hospital. The payer status of trauma patients is similar to other patient populations; however, trauma offers opportunities to cover the cost of care.

Link to Disproportionate Share Funding

Trauma designation is a requirement to be eligible for the disproportionate share hospital program. Trauma designation does not itself qualify a hospital for DSH funds; however, the funds will not be distributed without the hospital achieving trauma designation. The Office of EMS/Trauma verifies the trauma designation status to qualify hospitals to receive DSH funding.

Driver Responsibility Program

In 2003, the Texas Legislature passed House Bill 3588 which created the Driver Responsibility Program, which is governed by the Texas Transportation Code, Chapter 708. This program primarily funds the Designated Trauma Facility and Emergency Medical Services Account; hospital allocation is defined in TAC 157.131. All trauma-designated hospitals that apply receive a base amount determined by a funding formula and additionally receive funds based upon the facility's volume of uncompensated trauma care and its cost-to-charge ratio. The application for these funds can be found on the TDSHS website at www.dshs.state.tx.us/emstraumasystems/default.shtm.

Trauma Activation Fees

In November 2002, the National Uniform Billing Committee approved the code for trauma activation billing (068x). Designated trauma facilities may bill for trauma at three levels of team response: full, partial or evaluation. Beginning in 2007, CMS reimbursement became available under HCPCS code G0390 for trauma response on an outpatient basis. This code must be coupled with physician critical care HCPCS code 99291. These fees should be charged in addition to the ER 450 code. Additionally available is the critical care/trauma accommodation code 208 and trauma step-down unit accommodation code 206, and should be used as appropriate.

Standard Dollar Amount

The Texas Health and Human Services Commission revised the Medicaid inpatient hospital reimbursement methodology, effective Sept. 1, 2011. The payment methodology relies on a statewide Standard Dollar Amount base, with add-on adjustments for teaching status, trauma center designation and wage index variations. The trauma add-on recognizes the higher hospital costs associated with becoming and maintaining designation.

Texas EMS, Trauma & Acute Care Foundation (TETAF)

Executive Summary

The Texas EMS, Trauma & Acute Care Foundation is a not-for-profit organization developed to lend operational support for the Texas Department of State Health Services as it continues to develop the statewide trauma and acute-care system. TETAF's activities include areas such as emergency health care, trauma system development, emergency preparedness and response, pediatric care, acute care, continued development of Regional Advisory Councils, professional education, research, injury prevention and injury control system development. TETAF's goal is to support the implementation of state regulations and to assist organizations as they operationalize them on a daily basis.

TETAF has aligned its services to promote a cohesive and multidisciplinary network that enhances the current system. The desired outcome is to optimize support and services in Texas communities in terms of quality of care, crisis management, provider education and effective injury prevention.

Currently, TETAF is the approved surveying agency for Level III and Level IV Texas trauma centers. TETAF maintains a pool of qualified, credentialed surveyors and coordinates trauma surveys in Texas and New Mexico. Additionally, TETAF staff members are available for technical support and are involved with stakeholders at all levels to promote the shared mission of quality trauma patient care in Texas.

In 2009, TETAF became an approved surveying agency for stroke support centers (Level III) in Texas. Modeled after trauma, the stroke surveying process is a polished, refined, consistent service coordinated by TETAF. New to Texas, stroke support center designation is based on the statutory authority of TAC 157.133. TETAF-credentialed stroke surveyors are experienced stroke coordinators from around the state.

Additionally, TETAF seeks to educate the Texas Legislature, and is an advocate for the trauma system. TETAF provides a presence and testimony at hearings during legislative session and non-session years. TETAF also spearheaded legislative advocacy through the coordination of the Coalition to Protect Trauma Funding.

To learn more about TETAF legislative efforts, visit the TETAF Bill Watch at www.tetaf.org. To become involved in trauma funding efforts with the coalition, visit the website www.protecttraumafunding.org and join.

TETAF Goals:

1. Increase public awareness regarding the impact of health emergencies, traumatic injuries and crisis events, and develop effective strategies which reduce the incidence of these events in a statewide collaborative manner.
2. Enhance and integrate the various disciplines and agencies that participate in the trauma system.
3. Foster access to the appropriate level of emergency health care facility, trauma care facility and community crisis management through public and provider education.
4. Enhance and integrate pre-hospital, medical, acute care and rehabilitation resources for research to make advances in emergency/trauma care.
5. Establish mechanisms that promote Texas' growth in health care, trauma care, crisis management and injury control through grant writing and acquisition of public and private support.
6. Ensure advances in care across the age spectrum from pediatric to geriatrics as well as across geographic boundaries from the frontiers of Texas to the very large urban areas of the state and exceed the national standard of trauma care.
7. Foster legislative support through advocacy and education of the Texas Legislature.

Frequently Used Acronyms

GETAC	Governor's EMS and Trauma Advisory Council
TDSHS	Texas Department of State Health Services
RAC	Regional Advisory Council
TETAF	Texas EMS, Trauma & Acute Care Foundation
TTCF	Texas Trauma Coordinators Forum
HPP	Hospital Preparedness Program
TMD	Trauma Medical Director
TPM	Trauma Program Manager
TC	Trauma Coordinator
EMS	Emergency Medical Service
PI	Process Improvement
QA	Quality Assurance
IP	Injury Prevention
M&M	Morbidity & Mortality
ISS	Injury Severity Score
RTS	Revised Trauma Score
TOPIC	Trauma Outcomes Performance Improvement Course

TETAF invites you to visit its website at www.tetaf.org. TETAF welcomes your input and participation in all divisions of the organization.

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