1. Executive Summary of Committee Responsibilities

1.1. The EMS Medical Directors Committee is responsible for recommending a minimum standard of practice for providers participating in the trauma, acute, emergency healthcare and disaster response system of Trauma Service Area (TSA)-E. The EMS Medical Directors committee will provide qualified, expert medical oversight, and physician involvement in the development, maintenance and advancement of the regional trauma, emergency, and acute, healthcare and preparedness systems in North Central Texas.

1.2. The committee will be comprised of EMS physicians providing medical direction and oversight to prehospital providers within TSA-E.

1.3. Provide guidance in the development and review of prehospital assessment tools, regional plans and treatment guidelines, and Committee SOP based on evidence, quality, and safety.

1.4. Provide interface with other RAC committees, professional associations appropriate to the provision, direction, and oversight of prehospital emergency medical services, and the Governor's EMS and Trauma Advisory Council (GETAC).

2. Sub-Committees and Work Groups

2.1. Not Applicable

3. Committee Chair/Chair Elect Responsibilities

3.1. Chair

3.1.1. The Committee Chair serves as the principal liaison between the committee and the Board of Directors with responsibilities that include, but are not limited, to:

3.1.1.1. Knowledge of the Bylaws.

3.1.1.2. Scheduling meetings.

3.1.1.3. Meeting agenda and notes.

3.1.1.4. Providing committee report to the Board of Directors.

3.1.1.5. Annual review of Medical Directors Plans, Guidelines, committee SOP, and SPI indicators.

3.1.1.6. Provide or arrange for knowledge and dissemination of appropriate liaison group activities to committee members and the Board of Directors.

3.1.2. The Chair must be a documented representative of a NCTTRAC member in good standing as defined in the NCTTRAC Membership and Participation SOP.

3.1.3. The Chair will serve a one-year term of office, beginning at the start of the Fiscal year, and be succeeded by the Chair Elect at the end of the Fiscal Year.

3.2. Chair Elect

3.2.1. The Committee Chair Elect assists the Chair with committee functions and assumes the Chair responsibilities for committee activity and meeting management in the temporary absence of the Chair. The Chair Elect may serve in lieu of the Medical Director Committee Chair for Board of Directors responsibilities.

3.2.2. The Chair Elect must be a documented representative of a NCTTRAC member in good standing as defined in the NCTTRAC Membership and Participation SOP.
3.2.3. The Chair Elect automatically ascends to the Chair position at the end of the current Chair's term. In the event the Chair is unable to fulfill the term, the Chair Elect shall ascend to Chair in accordance with the NCTTRAC Bylaws.
3.2.4. The Chair Elect position will be voted on by the EMS Medical Directors Committee annually or when the incumbent has vacated this position.
3.2.5. The Chair Elect will retain his/her position as an appointed/elected representative to their core group position until ascending to the Committee Chair position, at which time he/she may be replaced on the roster of position primary or alternate representatives.
3.2.6. Nominees for the Chair Elect position will originate from the eligible EMS Medical Directors Committee primary and alternate representatives and will be voted on by the EMS Medical Directors Committee annually or when the incumbent has vacated this position.

4. Committee Representation

4.1 In accordance with NCTTRAC Bylaws Article IX, there is a core group identified to be the EMS Medical Directors Committee. The core group shall be comprised of primary or alternate representatives from NCTTRAC Member EMS Agencies or organizations in good standing providing oversight to prehospital providers as follows:

Position	Appointed/Elected by	Notes (all must be from a member organization in good standing)	Representation Category
Committee Chair	Committee Representatives	Ascends from Chair Elect	Committee
Committee Chair-Elect	Committee Representatives	Sourced from active EMS Medical Directors Committee primary/alternate representatives and retains core position until ascension to Committee Chair	Committee
Office of the Medical Director	MedStar Medical Control Appointee	System EMS Medical Director Level	Medical Control
BEST EMS	BEST EMS Medical Control Appointee	System EMS Medical Director Level	Multi-provider medical control
BioTel	BioTel Medical Control Appointee	System EMS Medical Director Level	Multi-provider medical control
Envision	Envision Medical Control Appointee	System EMS Medical Director Level	Multi-provider medical control
Air Provider	Selected by NCTTRAC Air Medical Committee	Agency/System EMS Medical Director Level	Air Medical & Specialty Transport
At Large Inter-facility Transfer EMS	Selected from a peer group of private EMS or IFT agencies	Agency/System EMS Medical Director Level	Private provider
Three At Large Metro Providers – (Collin, Dallas, Denton, or Tarrant or any provider from Ellis, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Parker, Rockwall, or Wise)	Selected from a peer group of EMS physicians in urban counties	Agency/System EMS Medical Director Level	Non-aligned metro provider that is not represented in any of the above organizations

Position	Appointed/Elected by	Notes (all must be from a member organization in good standing)	Representation Category
One At Large Non-metro Provider (from Cooke, Erath, Fannin, Palo Pinto, or Somervell Counties)	Selected from a peer group of EMS physicians in rural counties	Agency/System EMS Medical Director Level	Non-aligned non-metro provider that is not represented in any of the above organizations

5. Committee Attendance

5.1. While attendance is highly encouraged in support of meaningful participation, there is a 75% meeting attendance requirement for the committee.

5.2. Virtual attendees are highly encouraged to utilize video capabilities where available to facilitate meaningful discussion and participation in NCTTRAC meetings and events.

6. Committee Active Participation

6.1. Committee representatives' participation level will be reviewed annually for renewal or replacement opportunity.

7. Quorum & Voting

7.1. Quorum: A quorum is defined as at least 50% of the identified committee members who are present at the call for a vote.

7.2. Voting: The Chair shall manage voting issues in accordance with existing NCTTRAC bylaws and procedures. Appropriately eligible and documented EMS Medical Directors Committee representatives shall exercise the right to vote on EMS Medical Directors Committee matters, as necessary. While the Chair will generally facilitate routine activity by consensus, nonroutine, or electronic voting activity will normally be facilitated and documented by supporting staff.

7.3. As an alternative to a consensus vote at an EMS Medical Directors Committee Meeting, electronic votes may be employed. A record of responses and results must be maintained in the Meeting Notes or Minutes.

- 7.3.1. Electronic Votes may be called via:
  - 7.3.1.1. Polls
  - 7.3.1.2. Surveys
  - 7.3.1.3. Ballots
  - 7.3.1.4. Other technologies
- 7.3.2. Votes may be cast by proxy in accordance with NCTTRAC Bylaws Article XIV.
- 7.3.3. A simple majority vote of the quorum is required to act and will be recorded in the meeting minutes or notes.

8. Committee Liaisons

8.1. Governor's EMS and Trauma Advisory Council (GETAC) EMS Medical Directors Committee

8.2. Collin-Fannin, Dallas, Denton, Ellis, Parker, and Tarrant County Medical Societies

8.3 EMS Committee

9. Standing Committee Obligations

9.1. Annual Update of Committee SOP

9.2. GETAC Strategic Plan objectives and strategies, as applicable

9.3. Performance Standards

9.4. Identify and assess regional performance improvement standards, formulate strategies and make recommendations to committees to ensure that the best possible standards of healthcare can be met within TSA-E. The EMS Medical Director Committee is responsible for the coordination and support of the following service line committee products (see Appendix A for the Coordination Flowchart).
- 9.4.1. Service Line Regional Plan
  - 9.4.1.1. Trauma
  - 9.4.1.2. Stroke
  - 9.4.1.3. Cardiac
  - 9.4.1.4. Perinatal
  - 9.4.1.5. Disaster (Regional Emergency Preparedness)
- 9.4.2. Guidelines
  - 9.4.2.1. Acute Coronary Syndrome (ACS) Triage & Transport Guidelines
  - 9.4.2.2. Stroke Triage & Transport Guidelines
  - 9.4.2.3. Trauma Triage & Transport Guidelines
  - 9.4.2.4. Aircraft Utilization and Systems Performance Review
- 9.4.3. Texas Department of State Health Services (DSHS) Rules Reviews
  - 9.4.3.1. Maternal
  - 9.4.3.2. Neonatal
  - 9.4.3.3. EMS
  - 9.4.3.4. Trauma
  - 9.4.3.5. Stroke

10. Projected Committee Goals, Objectives, Strategies, Projects

10.1. Document commitment to goals, objectives, strategies, or projects in consideration of GETAC/statewide and/or regional priorities established through committee or NCTTRAC strategic planning efforts.

10.2. Support the EMS and ED Operations committees to establish a bariatric resource document in the region to get the right patient, to the right place, at the right time.

10.3. Achieve Texas EMS Wristband compliance of 70% or greater for all EMS transports/transfers in TSA-E.

10.4. Establish a reportable prehospital transfusion data set.

10.5. Establish a minimum of 5 prehospital transfusion provider sites as funding allows.

10.6. Achieve a regional Utstein cardiac arrest survival rate that exceeds state and national rates utilizing CARES data for 3 out of 4 fiscal year quarters.

10.7. NCTTRAC's "Accountability Scorecard" spreadsheet will be used to document commitments and progress with associated efforts.

11. System Performance Improvement (SPI)

11.1. Serve as consultants to NCTTRAC service line committees to assist in any SPI issues that are referred.

12. Injury/Illness Prevention / Public Education

12.1. Support EMS and Air Medical Committee Injury/Illness Prevention / Public Education initiatives

13. Professional Development

13.1. The EMS Medical Directors Committee has indicated there is no current need for NCTTRAC sponsored continued education or training.

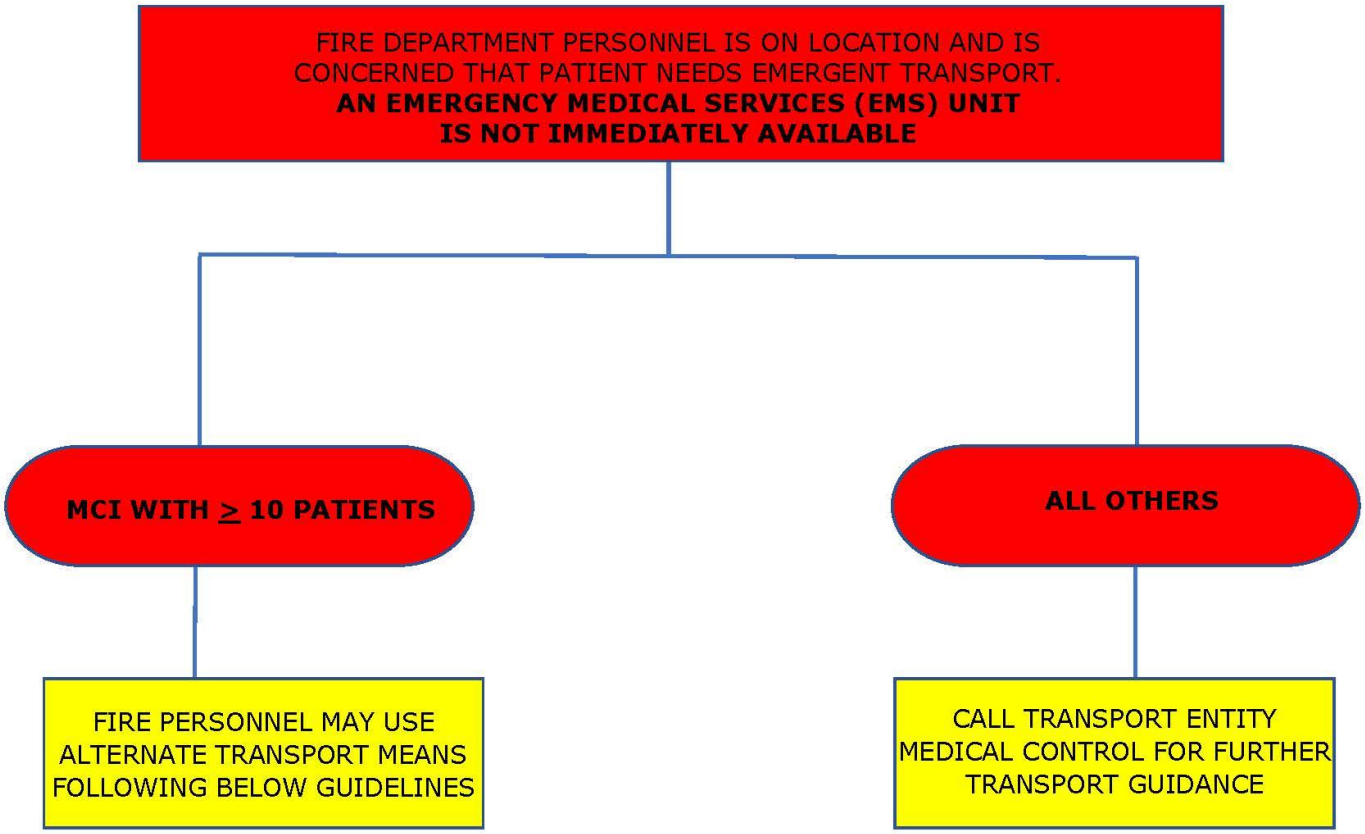
14. Unobligated Budget Requests

14.1. Recommendations from the EMS Medical Directors Committee, coordinated through the Finance Committee, seeking approval from the Board of Directors for financial backing and execution authority in support of related initiatives, projects, and/or education efforts within TSA-E.

Appendix A – House Bill 624 Coordination Flowchart

House Bill 624

NCTTRAC EMS Medical Director Committee Recommendations



Alternate Transport Considerations:

- When possible, the responding EMS agency (including air medical providers) should intercept the patient being transported by the fire service vehicle to render appropriate medical care and safe transport of the patient to the hospital.

- Recommended vehicles used for transportation other than an EMS vehicle (ambulance):
  - Hybrid pumper transport units that combine Type 1 pumper unit with an EMS ambulance type compartment
  - Command and support units
  - Fire apparatus, e.g., pumper units, ladder trucks, heavy rescue trucks
- Except for cases of major catastrophe, the transport vehicle should be an enclosed environment vehicle.

- Refrain from transporting a patient in an open cab fire apparatus, pickup truck bed, fire apparatus hose bed, or back step of fire apparatus.

- Fire department personnel shall follow all applicable state and local laws governing vehicles other than EMS vehicles.

- Fire departments shall follow all vehicle operating safety guidelines as outlined in national standard guidelines, e.g., Texas Transportation Code Section 547.702, National Fire Protection Agency (NFPA) 1500, International Association of Fire Chiefs (IAFC) Policies and Procedures for Emergency Vehicle Safety, and the United States Fire Administration (USFA) and International Association of Fire Fighters (IAFF) emergency vehicle safety program.

- When possible, an attendant should be present with the patient during transport. If any of the firefighters on scene have EMS or other medical licensure or certification, the individual with the highest level of licensure or certification should accompany the patient during transport.

- When possible, and if it will not compromise patient well-being, adult patients shall be seated in approved riding positions with seatbelts or safety restraints always fastened when the vehicle is in motion.

- When possible, and if it will not compromise patient well-being, pediatric patients (≤ 15 y/o for the purpose of this guideline) shall be transported in appropriately sized child restraint system(s) and/or appropriately sized car safety seat following national standard guidelines, e.g., National Association of State EMS Officials (NASEMSO), National Highway Traffic Safety Administration (NHTSA), and the American Academy of Pediatrics (AAP).

- When possible, and if it will not compromise patient well-being, pediatric patients should not be transported unrestrained on the lap of a provider or parent or held in the arms of a provider or parent.

- When possible, and if it will not compromise patient well-being, the driver shall not begin to move the vehicle until all passengers are seated and properly secured. All patients shall remain seated and secured as long as the vehicle is in motion. Seatbelts shall not be loosened or released while enroute.

- Patients transported by alternative means should be transported to the closest hospital.