1. Executive Summary of Committee Responsibilities

1.1. The Trauma Committee is responsible for the oversight of the trauma system in Trauma Service Area (TSA) - E, including the Regional Trauma System Plan. This Plan includes strategies to focus diverse resources in a collective strategy to reduce morbidity and mortality due to trauma. The committee will provide guidance in the development and review of hospital and pre-hospital assessment tools, regional plans, treatment guidelines, and the committee SOP. Additionally, the committee will interface with other RAC committees, professional associations appropriate to the service line, and the Governor's EMS and Trauma Advisory Council (GETAC).
1.2. Establish standards and procedures for the Trauma Committee.
1.3. Create broad stakeholder representation while working to provide an opportunity to share resources leading to the development, operation, and evaluation of trauma education and advocacy within the 19 counties served.
1.4. Provide guidance in the development of pre-hospital assessment tools and treatment guidelines related to trauma care to the EMS and Air Medical Committees.
1.5. Organize, support, and/or coordinate health care evidenced-based education identified through the NCTTRAC needs assessments.
1.6. Provide oversight to the Trauma Committee Workgroups and Subcommittees.
1.7. Serve as a source to identify trauma expert resources available in TSA-E to members and community partners.

2. Subcommittees and Work Groups

2.1. Subcommittees must be approved in conjunction with a change to the NCTTRAC Bylaws. Work Groups may be established at the discretion of the Chair of the Board of Directors and will operate in due consideration of NCTTRAC's Bylaws and this SOP. Current subcommittees and workgroups include:
- 2.1.1. Public Education/ Injury Prevention Subcommittee
  - 2.1.1.1. Responsible for promoting injury prevention and public awareness through advocacy and education.
- 2.1.2. SPI Subcommittee
  - 2.1.2.1. Responsible for oversight of trauma performance improvement activities of NCTTRAC.
  - 2.1.2.2. Assist committee with evaluating regional data, identifying data needs and/or requirements.
  - 2.1.2.3. Review, evaluate, and recommend to the Trauma Committee referrals and tools.
    - 2.1.2.3.1. SPI Referrals.
    - 2.1.2.3.2. Designation Review Tool
- 2.1.3. Trauma Registry Work Group
  - 2.1.3.1. Assist committee with evaluating regional data, identifying data needs and/or requirements.
  - 2.1.3.2. Share education and information related to National Trauma Data Standard (NTDS), state registry, and Trauma Quality Improvement Program (TQIP).
  - 2.1.3.3. Share registry best practices
- 2.1.4. Regional Prehospital Transfusion Workgroup

2.1.4.1. Identify and research the community and agency need for a Regional Prehospital Transfusion Program
2.1.4.2. Develop framework for the prehospital transfusion program
2.1.4.3. Review data collected for system performance improvement efforts
2.1.4.4. Review and approve agency participation applications
2.1.4.5. Refer to Appendix A: *NCTTRAC Prehospital Transfusion Program Standard Operating Guidelines* for workgroup governance and structure

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 Trauma 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.
3.1.4. The Chair may only vote in the event of a tie; however, the Chair's organization may assign an appropriately documented voting delegate to fill their committee core group position during the Chair's term.
3.1.5. 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. 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 Trauma 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 or if the Chair position is otherwise vacated.
3.2.4. The Chair Elect position will be voted on by the Trauma Committee annually or when the incumbent has vacated this position.
3.2.5. In the event the Chair is unable to fulfill the term, the Chair Elect shall ascend to Chair in accordance with the NCTTRAC Bylaws.

4. Committee Medical Director

4.1. The Trauma Committee will establish a Co-Medical Director position, who meets the same criteria below, to assist as desired.
4.2. The elected Trauma Committee Medical Director is responsible for
  4.2.1. Participating directly with their service line committee
  4.2.2. Attend at minimum 50% of committee meetings
  4.2.3. Establishing and maintaining a standing coordination method with their service line peers
  4.2.4. Maintaining availability for coordinating with other committees' Medical Directors to recommend a minimum standard of care for providers participating in the trauma, acute, emergency healthcare and disaster response systems of TSA-E.
4.3. The Trauma Committee Medical Director provides current physician insight and involvement in support of the Trauma committee and its responsibilities, including:
  4.3.1. Identifying and assessing regional performance improvement standards, formulating strategies, and making recommendations to the committee to ensure that the best possible standards of healthcare can be met within TSA-E.
  4.3.2. Active partnership in the coordination and support of the following service line committee products (see appendix A for the Coordination Flow Chart):
    4.3.2.1. Service Line Regional Plans
    4.3.2.2. Guidelines
    4.3.2.3. Texas Department of State Health Services (DSHS) Rules Reviews
4.4. The Trauma Committee Medical Director must be a documented representative of a NCTTRAC member in good standing as defined in the NCTTRAC Membership and Participation SOP.
4.5. The Trauma Committee Medical Director position will be voted on by the Trauma Committee annually, with each Fiscal Year, or if otherwise vacated.
4.6. The Trauma Committee Medical Director should be prepared, with NCTTRAC staff assistance, to facilitate a peer group of trauma medical directors (by email or meeting) in support of Trauma Committee efforts, as appropriate.
4.7. The Trauma Committee Medical Director will be a liaison to the NCTTRAC EMS Medical Directors Committee.
4.8. The Trauma Committee Medical Director may facilitate a trauma medical directors meeting as a focus group of the Trauma Committee.

5. Committee Representation

5.1. In accordance with NCTTRAC Bylaws Article IX, there is a voting core group identified within the Trauma Committee.
5.2. The Trauma Committee core group shall be comprised of Trauma Program Managers/Coordinators, unless delegated otherwise, from Trauma Designated and In Active Pursuit (IAP) Hospitals that are NCTTRAC member organizations in good standing.

6. Committee Attendance

6.1. While attendance is highly encouraged in support of meaningful participation, there are no specific attendance requirements at committee level.

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

7. Committee Active Participation

7.1. In addition to attendance Trauma Committee identifies the following to be creditable for active participation at the committee level:
- 7.1.1. Attend at minimum 50% of Trauma Committee meetings, preferably in person
- 7.1.2. Meet Texas DSHS Data submission requirements, as applicable
- 7.1.3. For members with a capable registry, evidence of data submission to NCTTRAC's outsourced data reporting service on a quarterly basis

8. Quorum & Voting

8.1. A quorum is a simple majority (50% or more) of the documented and eligible Trauma Committee representatives that are physically or virtually present and participating in a meeting.

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

8.3. The Trauma Committee Leadership Group (Chair, Chair Elect, and Co-Medical Directors) may convene on an ad hoc basis to represent the committee in matters necessary to maintain contractual compliance, execute deliverables, and/or endorse emergency, off-cycle purchases for regional benefit. Actions taken will be reported at the next scheduled committee meeting.

8.4. Standing Committees/Subcommittees voting may be conducted by the following methods, unless otherwise addressed in the committee/subcommittee SOP:
- 8.4.1. In person or virtually during the meeting.
- 8.4.2. Electronically (e.g., email, fax, website) for unscheduled votes between meetings.
- 8.4.3. Votes may be cast by proxy in accordance with NCTTRAC Bylaws Article XIV.
- 8.4.4. The outcome of each action item will be recorded in the meeting minutes or notes.

8.5. As an alternative to a consensus vote at a Trauma Committee Meeting, electronic votes may be employed. A record of responses and results must be maintained in the Meeting Notes or Minutes.
- 8.5.1. Electronic Votes may be called via:
  - 8.5.1.1. Polls
  - 8.5.1.2. Surveys
  - 8.5.1.3. Ballots
  - 8.5.1.4. Other technologies

9. Committee Liaisons

9.1. Governor's EMS and Trauma Advisory Council (GETAC) Trauma Committee
9.2. Texas Trauma Coordinators Forum (TTCF)
9.3. Dallas Fort Worth Hospital Council Foundation

9.4. Texas EMS Trauma & Acute Care Foundation (TETAF)

10. Standing Committee Obligations

10.1. Annual Review of the Trauma Committee SOP
10.2. Annual Review of Regional Trauma System Plan & Guidelines (listed)
  10.2.1. Trauma Triage and Transport Guideline
  10.2.2. Trauma Transfer Guideline
10.3. DSHS "Essential Criteria", Rules and/or contractual deliverables, as applicable
10.4. GETAC Strategic Plan objectives and strategies, as applicable
10.5. Annual Review of Program Guidance and Regional Initiatives (STB, Falls, Etc.)

11. Projected Committee Goals, Objectives, Strategies, Projects

11.1. Annual Committee Goals
  11.1.1. Traumatically injured patients requiring transfer will be transferred within 2 hours of arrival to emergency department (single system injuries with ISS less than 10 excluded) Goal: 75% by end of NCTTRAC FY24
  11.1.2. Designated and in active pursuit (IAP) Trauma centers with a capable trauma registry will submit data to NCTTRAC's outsourced data reporting service. Goal: 80% by end of NCTTRAC FY24
  11.1.3. Implement a minimum of five regional prehospital transfusion provider sites as funding allows.
  11.1.4. Establish a reportable prehospital transfusion data set.
  11.1.5. Achieve Texas EMS Wristband Compliance of 70% or greater for all EMS transports/transfers in TSA-E
11.2. NCTTRAC's "Accountability Scorecard" spreadsheet will be used to document commitments and progress with associated efforts.

12. System Performance Improvement (SPI)

12.1. The Trauma Committee will support the SPI Subcommittee responsibilities by establishing a standing meeting agenda item and corresponding accountability.
12.2. At minimum, the Committee will review, evaluate, and report trauma facility EMResource utilization and make recommendations to the Executive Committee of the Board of Directors for appropriate designation/accreditation of hospitals related to initial or changes to designation/accreditation as requested/required by the Department of State Health Services (DSHS).
12.3. At minimum, the SPI Subcommittee will review, evaluate, and report SPI indicators and referred events as afforded by the Texas Statute and Rule.
12.4. Prior to submitting an SPI event, the referring/requesting agency is expected to first contact the involved agencies/facilities in an attempt to satisfactorily resolve the issue or concern. Only after appropriate attempts have been made to satisfactorily resolve an SPI event should the referring/requesting agency formally submit an SPI event notification/request via the NCTTRAC secured ticket system.

12.5. Closed SPI Subcommittee meetings will support detailed reviews of Performance Improvement (PI) Indicators and referred PI events as afforded by Texas Statute and Rule.
  12.5.1. Representation:
    12.5.1.1. Trauma Committee Chair
    12.5.1.2. Trauma Committee Chair Elect
    12.5.1.3. Trauma Committee Medical Director
    12.5.1.4. Two (2) elected Trauma Committee representatives (As needed)
  12.5.2. Closed SPI Subcommittee meeting participants will sign a confidentiality statement prior to the start of a closed meeting.
  12.5.3. Meeting notes, attendance rosters, and supporting documents of Closed SPI subcommittee meetings must be provided to NCTTRAC staff within 48 hours following each meeting to be secured as a confidential record of committee activities.

12.6. SPI Products
  12.6.1. Trauma SPI Indicators
  12.6.2. Trauma SPI Referral Form
  12.6.3. Trauma Designation Letter of Support Review Forms

12.7. SPI Indicators
  12.7.1. Hospitals will meet and maintain the appropriate trauma facility designation at all times. NCTTRAC will be immediately notified if designation is lost or in jeopardy.
  12.7.2. Hospitals will communicate their open/closed/advisory status through EMResource.
  12.7.3. Hospitals with a capable registry will submit data to NCTTRAC's outsourced data reporting service.
  12.7.4. Trauma patients will only be transferred one time to the appropriate higher level of designated facility. Receiving facility shall inform the SPI Subcommittee of a double transfer.
  12.7.5. All trauma patient transfers will be managed within Trauma Service Area-E as the capacity of the tertiary care facilities allow and the patient's condition dictates. All patient transfers outside RAC-E shall be presented to the SPI Subcommittee.
  12.7.6. Trauma patients will be transferred within two hours of arrival (single system injuries with ISS less than ten excluded) to their emergency department.

13. Injury Prevention / Public Education

13.1. The Trauma Committee will support the Trauma Injury Prevention and Public Education subcommittee responsibilities by establishing a standing meeting agenda item and corresponding accountability (e.g., appoint individual facilitator, workgroup, or subcommittee).
13.2. Focus on injury prevention and education of the public health needs within TSA - E.
13.3. Create a broad stakeholder representation working to provide an opportunity to share resources leading to the development, operation, and evaluation of public education and injury prevention efforts within TSA - E.

13.4. Base decisions on current Trauma trends and data, facts and assessment of programs and presented educational opportunities.
13.5. Organize; support and/or coordinate community evidenced based education and injury prevention programs.
13.6. Recommend/support prevention priorities for TSA-E according to the injury geographic location, cost, and outcome.
13.7. Serve as a resource to identify prevention programs, events, and other prevention resources available in TSA-E to members and community members.
13.8. Establish Ad Hoc Task Forces, as necessary, to address specific issues.
13.9. Review the Public Education and Injury Prevention Resource Document on a bi-annual basis.

14. Professional Development

14.1. The Trauma Committee will support Trauma Professional Development responsibility for all levels of providers by establishing a standing meeting agenda item and corresponding accountability (e.g. appoint individual facilitator, workgroup or sub-committee).
14.2. At minimum, the Trauma Committee will:
14.2.1. Participate in the development of the Annual NCTTRAC Needs Assessment.
14.2.2. Sponsor educational events based on needs assessment results and potential committee request.

15. Data Initiatives

15.1. The Trauma Committee will identify data submission requirements/goals/projects and include the following:
15.1.1. The committee currently identifies the following projects as the main trauma data initiatives:
15.1.1.1. Double Transfers of Trauma Patients
15.1.1.2. Severely Injured Trauma Patients Transferred within Two Hours
15.1.2. Performance Indicators – *To be included* (measurable verification of success)
15.1.3. Registry information and enrollment process is outlined in Appendix B: *Regional Trauma Registry Program Overview*

16. Unobligated Budget Requests

16.1. Recommendations from the Trauma 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.