



# Defense Health Agency

## PROCEDURAL INSTRUCTION

NUMBER 6040.06  
September 8, 2020

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AD-CS

SUBJECT: Combatant Command (CCMD) Trauma System (CTS)

References: See Enclosure 1.

1. **PURPOSE.** This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (q), establishes the Defense Health Agency's (DHA) procedures to support the geographic combatant commanders and select functional combatant commanders (CCDRs) (with validated CCDR requirement) to establish a CTS and provide optimal care for all casualties pursuant to Reference (d) and (e).
  
2. **APPLICABILITY.** This DHA-PI applies to DHA, CCMDs, Office of the Chairman of the Joint Staff and the Joint Staff, Military Departments, and all personnel to include: assigned or attached or detailed Active Duty and Reserve members, federal civilians, members of the Commissioned Corps of the Public Health Service, contractors (when required by the terms of the applicable contract), and other personnel assigned temporary or permanent duties at DHA, to include DHA regional and field activities (remote locations), and subordinate organizations administered and managed by DHA, to include Military Medical Treatment Facilities (MTFs) under the authority, direction, and control of the DHA.
  
3. **POLICY IMPLEMENTATION.** It is DHA's instruction, pursuant to References (a) through (q), that the DHA will establish procedures for:
  - a. Supporting the CCDRs in the establishment of a baseline CTS that can be rapidly scaled to accommodate combat operations, post-conflict operations, or other contingency operational requirements (including disease non-battle injuries and rapid response to infectious disease outbreaks) identified by the CCDR. The CTS should maintain a framework of core functions throughout all phases of operations to facilitate the ability for rapid expansion and adaptation based on the CCDR's requirements.

b. Developing a deployable Service and DHA Trauma Management Team (TMT) and a DHA CTS Assessment Team that assists the CCDRs across the conflict/contingency continuum for the initial management of CCMD medical resources, to include performance improvement (PI), and data management in response to contingency operations, crisis management, and emergency situations.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. The CTS consists of a group of trauma system and emergency services experts that will maintain a framework of core functions and capabilities for Phase 0 operations at all times and will be scaled to contingency (Phases 0-V, pursuant to Reference (f)) requirements identified by the CCDR. The CTS operates with the developmental guidance, operational support, and clinical oversight of the Joint Trauma System (JTS) pursuant to Reference (d). See Enclosure 3.

6. PROPONENT AND WAIVERS. The proponent of this publication is the Assistant Director, Combat Support (AD-CS). When Activities are unable to comply with this publication the activity may request a waiver by providing justification that includes a full analysis of the expected benefits and must include a formal review by the activities senior legal officer. The activity director or senior leader will endorse the waiver request and forward them through their chain of command to the Director, DHA to determine if the waiver may be granted.

7. RELEASABILITY. Cleared for public release. This DHA-PI is available on the Internet from the Health.mil site at: [www.health.mil/DHAPublications](http://www.health.mil/DHAPublications) and is also available to authorized users at: <https://info.health.mil/cos/admin/pubs/SitePages/Home.aspx>.

8. EFFECTIVE DATE. This DHA-PI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with Reference (c).

9. FORMS

a. DD Form 1380, Tactical Combat Casualty Care (TCCC) Card, can be ordered from the Defense Logistics Agency at: <https://forms.documentservices.dla.mil/order/>.

b. DD Form 3019, Trauma Resuscitation Record, is available for download at:  
<https://www.esd.whs.mil/Directives/forms/>.

/S/  
RONALD J. PLACE  
LTG, MC, USA  
Director

Enclosures

1. References
2. Responsibilities
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Glossary

ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
- (b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
- (c) DHA-Procedural Instruction 5025.01, "Publication System," August 24, 2018
- (d) DoD Instruction 6040.47, "Joint Trauma System (JTS)," September 28, 2016 as amended
- (e) Joint Publication 4-02, "Joint Health Services," December 11, 2017, as amended
- (f) Joint Publication 3-0, "Joint Operations," January 17, 2017, as amended
- (g) DHA-Procedural Instruction 6040.01, "Implementation Guidance for the Utilization of DD Form 1380, Tactical Combat Casualty Care (TCCC) Card, June 2014," January 20, 2017
- (h) DoD Instruction 6040.45, "DoD Health Record Life Cycle Management," November 16, 2015, as amended
- (i) DHA-Administrative Instruction 107, "Comprehensive Review of All Trauma-Related Deaths in the Deployed Setting," July 29, 2019
- (j) DoD Instruction 8260.04, "Military Health System (MHS) Support for DoD Strategic Analysis," May 14, 2015
- (k) Public Law 115-232, Section 712, "John S. McCain National Defense Authorization Act for Fiscal Year 2019," August 13, 2018
- (l) DoD Directive 3000.06, "Combat Support Agencies (CSAs)," June 27, 2013 as amended
- (m) Joint Requirements Oversight Council Memorandum, 126-17, "Department of Defense Trauma Enterprise DOTmLPP-P Change Recommendation," December 11, 2017
- (n) DoD Instruction 1322.24, "Medical Readiness Training (MRT)," March 16, 2018
- (o) DoD Instruction 6430.02, "Defense Medical Logistics Program," August 23, 2017
- (p) Chairman of the Joint Chiefs of Staff Instruction 3150.25G, "Joint Lessons Learned Program," January 31, 2018
- (q) Office of the Chairman of the Joint Chiefs of Staff, "DOD Dictionary of Military and Associated Terms," as amended

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness through the Assistant Secretary of Defense for Health Affairs, the Director, DHA, will:

- a. Monitor compliance with this DHA-PI.
- b. Support CCDRs in the establishment of a CTS pursuant to Reference (d).
- c. Facilitate communication among the Joint Staff, operational forces, and medical communities on matters related to DoD trauma care and casualty care systems pursuant to Reference (d).
- d. Establish and fund a CTS Assessment Team capability that is able to deploy to conduct trauma system assessments, providing CCDRs feedback on current capabilities, gaps, and mitigation strategies.
- e. Establish deployable unit identification codes that outline a TMT package to augment CCMD Surgeons' staff when initial surge capability is requested.
- f. Direct that medical records are handled in accordance with References (g) and (h) and provide guidance on capturing all trauma-related information in the Department of Defense Trauma Registry (DoDTR).
- g. Oversee the review of all trauma and critical care cases in deployed settings and communicate preventable death reports related to casualty care and personal protective equipment to the Office of the Joint Staff Surgeon, CCDRs, and the Services, in accordance with Reference (i).
- h. Prioritize CTS support to enable the expedited execution of critical or time sensitive CCDCR requirements.
- i. Develop technical guidance, regulations, and procedural instructions for the DoD Components in the administration of casualty care delivery in accordance with Reference (b).
- j. In collaboration with the Joint Staff and the Military Departments, develop common analytically rigorous methodologies to be used in the development of current and future joint operational medical force requirements (e.g., estimation and application of population at risk, rules of allocation, casualty rates, patient condition occurrence frequencies, and assumptions) pursuant to Reference (j).

k. Conduct PI and support activities to provide feedback to the field on the appropriate evaluation, treatment, and transportation of trauma casualties in support of a full range of military operations.

l. Coordinate with the Secretaries of the Military Departments to ensure that staffing at military MTFs in each region supports readiness requirements of the Services medical personnel to deploy in support of CCDR's requirements in accordance with Reference (k).

2. CHAIRMAN OF THE JOINT CHIEFS OF STAFF. The Chairman of the Joint Chiefs of Staff, in accordance with References (d) and (f), will:

a. Update relevant Joint Publications and Chairman of the Joint Chiefs of Staff Instructions to include key considerations related to the delivery and management of casualty care in the operational environments.

b. Direct that all CCDRs establish a process that identifies priority casualty-related information to be incorporated in the Joint Capabilities Integration Development System Process.

c. Identify where casualty-related information will be stored within the Joint Lessons Learned Information System and provide Joint Staff collection support when required in accordance with Reference (f).

d. Direct that all casualty and after-action reports be transmitted to the JTS, Component S-3s, CCMD J-3s, and CCMD Surgeons.

3. CCDRs. Pursuant to Reference (d), with support of the DHA pursuant to Reference (l), Geographical and Select Functional CCDRs will:

a. Develop a CTS within each of the CCMDs (with validated CCDR requirement), under the supervision of the CCMD Surgeon with support of the DHA, that consistently maintains a framework of core functions and capabilities for Phase 0 operations and is scalable to contingency operations.

b. Submit a request for forces (or CCMD equivalent process) for CTS staff:

(1) Phase 0 operations. Request the minimum CTS staffing positions outlined in Enclosure 3 of this DHA-PI as an enduring requirement (regionally aligned fixed facility). CTS Staff can either be organic to the CCMD or assigned to an MTF with at least 0.2 full time equivalent (FTE) (additional duty) to provide CTS support to a specified CCMD.

(2) Initial contingency operations. Request a CTS capability; either the CTS Assessment Team and or deployed TMT for initial contingency operations.

(3) Enduring contingency operations. Request backfill CTS TMT support through Joint Staff validated requests to the Services.

(4) When operational activity is not high enough to require a separate deployed TMT that is solely dedicated to PI, designate individuals (Trauma Medical Director (TMD), Trauma Program Manager (TPM), and Trauma Registrar) from the deployed force to serve as an additional duty. These individuals are in addition to the Phase 0 operations personnel assigned to the regionally aligned fixed facilities.

c. Mandate that all CTS staff receive DHA-funded CTS training prior to assuming official CTS duties outlined in Enclosure 3.

d. Direct updates to CCMD polices to include CTS requirements.

e. Provide timely casualty reporting through Joint Operational Medical Information System (JOMIS)-approved casualty reporting information systems throughout the continuum of care.

f. Integrate trauma care systems and CTS PI into operational planning, exercises, training, demonstrations, and combat operations.

g. Establish CCMD theater policy to outline baseline procedures after the death of DoD personnel while deployed/stationed/visiting in CCMD area of operations to include notifying the Armed Forces Medical Examiner System.

4. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments, in accordance to Reference (d), will:

a. Establish individual Service CTS unit identification codes that outline a TMT package to augment CCMD Surgeons' staff when a surge capability is needed (outlined by the CCDR), as described in Enclosure 3.

b. Assign CTS Phase 0 support personnel (TMD, TPM, and Trauma Registrar) directly to the CCMD Surgeons Office for those CCMDs that have authorized positions or to CCMD regionally aligned designated DHA-managed MTFs or embedded in designated civilian trauma skill sustainment partnerships. Each position will serve at least 0.2 FTE duty to support the CTS for those CCMDs not conducting ongoing combat/contingency operations.

c. Update Service-level medical planners' doctrine, regulations, publications, and training with CTS planning capabilities and considerations.

d. Provide TMT all required equipment and pre-deployment training (outside of the DHA sponsored and funded CTS Training) in support of CTS functions.

e. Direct that all personnel supporting CTS operations (deployed and MTF assigned) receive DHA-sponsored and funded pre-deployment training.

f. Update Service-level patient administration curricula with DoDTR-related information.

g. Direct that all future Service specific software/hardware designed to capture and translate patient information has bidirectional access into the DoDTR and the Military Health System (MHS) electronic health record (EHR).

5. AD-CS. The AD-CS must:

a. Coordinate with the Joint Staff Surgeon on matters related to CTS development and support.

b. Participate in the development and review of CCMD operational plans to ensure CTS capabilities are incorporated into the planning process.

c. Oversee CTS training curriculum development and delivery.

d. Establish a joint program of instruction to support JTS clinical practice guidelines education and training.

e. Provide updates as required for the Joint Medical Planners Tool Kit and the Joint Medical Planners Course to integrate the CTS capabilities and processes.

f. Coordinate with JOMIS Program Manager to support electronic documentation across a full range of military operations utilizing JOMIS-supported prehospital systems.

g. Coordinate with the JOMIS Program Manager to provide CCMD users training on JOMIS-supported prehospital systems.

6. DEPUTY ASSISTANT DIRECTOR (DAD)-HEALTHCARE OPERATIONS (HCO). The DAD-HCO, must:

a. Oversee MTF operations and make recommendations to the Director, DHA, on manpower adjustments that directly support CCMDs to accurately adjust for CCMD's requirements pursuant to Reference (k).

b. Direct that assigned CTS support personnel receive JTS sponsored and funded trauma system training (all course material to include temporary duty expenses as required) within 3 months of assignment (if not trained prior to assignment).

c. Coordinate through the Director DHA, with the Secretaries of the Military Departments as required, to oversee that CCMD designated CTS support personnel have time and resources required to accomplish the CTS duties outlined in Enclosure 3.



7. DAD-INFORMATION OPERATIONS (IO). The DAD-IO, must:

a. Oversee the DoDTR expansion, consolidate DoD-wide disparate trauma registries pursuant to Reference (m), and update the DoDTR as required to meet the CCMD, CTS, and JTS operational requirements.

b. Process CTS requests for support that increase CCMD compliance with automated documentation collection from point of injury and at all roles of care to include during en route care.

c. Assign CTS support functions to a branch with a single point of contact that coordinates critical information technology support across all CCMDs on all platforms (air, land, sea, and space).

8. CHIEF, CLINICAL BUSINESS OPERATIONS. The Chief, Clinical Business Operations, must:

a. Monitor compliance with the standards and processes in this DHA-PI.

b. Monitor MTF capacity and average empanelment and make adjustments as required in support of CCDR requirements as outlined in Enclosure 3.

c. Make recommendations to the DAD, HCO, on manpower adjustments to active duty, civilian, and contractor medical providers to maximize direct support to the CCMDs.

9. CHIEF, JTS. The Chief, JTS, must:

a. Execute all responsibilities outlined in Reference (d) and (n) that support the CCMDs in the development, training, and sustainment of CTS capabilities.

b. Establish standards of casualty care applicable to the CCMDs through the development, review, and maintenance of clinical practice guidelines, as well as monitoring clinical practice guideline compliance.

c. Communicate with the CCMD Surgeons, CTS staff, and the Joint Staff Surgeon's office in support of all casualty-related activities and requirements specified in the references within this DHA-PI.

d. Develop CTS training curriculum for all specified positions and provide training and funding for all CTS training to include any pre-deployment relevant activities related to CTS operations.

e. Identify all reporting requirements related to the CTS and casualty care provided along the continuum to include the appropriate hardware/software for transfer of protected health information and classified information.

f. Coordinate with the appropriate agencies (e.g., Services, Washington Headquarters Services, etc.) to revise all non-DoD medical documentation forms used by operational forces into DoD or DHA forms (as applicable) in support of Department-wide acceptance and the ability to synchronize with the EHR, JOMIS applications, and the DoDTR.

g. Provide DoDTR clinical functional subject matter expertise to DHA DAD-IO and inform the appropriate office within the DHA DAD-IO when system updates are required.

h. Abstract and analyze trauma and casualty care data in support of PI and clinical analysis in support of the Defense Trauma Enterprise (DTE).

i. Host weekly trauma care PI conference calls with the capability to shift focus areas based on global response requirements in support of the CCDRs.

10. DIVISION CHIEF, ARMED SERVICES BLOOD PROGRAM. The Division Chief, Armed Services Blood Program, must:

a. Coordinate communication between the CCMD Joint Blood Program Officer and the CTS TMD on all issues related to blood and blood products.

b. Prioritize CCMD blood and blood products requirements based on validated joint urgent operational needs statement endorsed by the CTS TMD.

c. Participate in the AD-CS casualty care working groups and prioritize CCMD requirements based on the operational need.

11. DAD-MEDICAL LOGISTICS. The DAD-Medical Logistics, must:

a. Coordinate support for health information technology required to meet medical logistics requirements for the support of CTS operations in accordance with Reference (d).

b. Identify in coordination with the Military Departments medical items to be standardized among the Services and processes to improve efficiency, coordinate procurement, reduce costs, and promote commonality, interoperability, and sustainability.

c. Support the Military Departments by coordinating with the Defense Logistics Agency to ensure the availability of logistical requirements needed to deliver casualty care as outlined in the JTS clinical practice guidelines.

12. MARKET DIRECTORS. The Market Directors must ensure MTFs under their direction and control comply with this DHA-PI.

13. MTF DIRECTORS. MTF Directors must:

- a. Comply with the standards and processes in this DHA-PI.
- b. Manage overall MTF schedules to ensure CCDR requirements are prioritized in accordance with Reference (e).
- c. Make recommendations on additional manpower required if additional beneficiary empanelment demand exists to meet operational clinical knowledge, skills, and abilities.

## ENCLOSURE 3

### PROCEDURES

1. CTS. The CTS is a trauma system informed by the CCMD Surgeon which operates under the authority, direction, and control of the CCDR. The CTS maintains a constant framework of core functions and capabilities during Phase 0 operations in order to be prepared to provide optimal care for trauma patients as well as casualties of disease and all-hazards, with ability to scale to meet CCMD requirements during contingency operations. Phase 0 operations are maintained between contingency operations to care for baseline non-battle trauma injuries and to sustain the capability for rapid expansion and adaptation based on the CCDR's requirements. The CTS operates with the developmental guidance, operational support, and clinical oversight of the JTS in the JTS's capacity as the reference body for all trauma care across the DTE.

### 2. CTS PHASE 0 OPERATIONS

a. Staffing [Reference Enclosure 2, paragraph 3c(1-4)]. Each CCDR is responsible for staffing the CTS during all phases of operations across the conflict/contingency continuum.

(1) During Phase 0 operations, the minimum leadership staffing includes TMD, TPM, and Trauma Registrar who provide part time support to the CTS as an authorized additional duty (at least 0.2 FTE) under the supervision of the CCMD Surgeon.

(2) Additional key leadership roles assigned to the TMT during Phases 1-V may include Prehospital Medical Director and Senior Enlisted Advisor, with trauma system and PI training.

b. Training. All assigned CTS personnel will attend CTS-specific training hosted and funded by the JTS. The CCMD Surgeon will plan to have all designated CTS personnel trained prior to assignment, when possible. For those individuals who are currently assigned and in the need of training, additional coordination with the DHA and Military Departments will be required in order to identify the best avenue to meet CTS training requirements.

c. Equipment. The CTS lead, in consultation with the JTS will identify CTS-specific equipment requirements for data management. The CCMD Surgeon will revise theater entry CTS equipment requirements, as required to support transmission of trauma data.

### 3. CTS CORE FUNCTIONS

a. The 12 core functions of the CTS are established during Phase 0 operations and scaled to the contingency requirements of the CCDR.

(1) Address the full spectrum of casualty care. The CTS addresses the full spectrum of injury and severe health threats, including education and awareness, prevention, prehospital care,

inter-facility transfer, acute facility care, and rehabilitation for all casualties (to include warfighters, non-combatants, detainees, host-nation populations including pediatric and geriatric, and those with mental illness and other vulnerable populations). Host national support will be in line with established CCMD medical rules of eligibility.

(2) Establish authority to enforce standards. The CTS under the authority of the CCMD Surgeon implements casualty care policy and maintains evidence-based standards of care in accordance with DoD policy, JTS standards, prehospital, and clinical practice guidelines.

(3) Establish multidisciplinary advisory group guidance. Receive multidisciplinary advisory support from the Defense Committee on Trauma, to include Tactical, En Route, and Surgical Combat Casualty Care Committees within the JTS regarding trauma system development and operations. Formally establish additional subject matter expert advisory group when needed.

(4) Conduct trauma system planning. Create and implement an integrated, evidence-based trauma system plan, then review annually and update every 3 years, at a minimum, under the direction of the CCDR.

(5) Verify readiness. Review and verify Service provided training records for medical personnel's theater entry training and certification requirements and confirm definitive in-theater organization to ensure they are prepared for their assigned mission. Submit theater entry training and certification shortfalls in a standardized format to the CCMD Surgeons.

(6) Provide infrastructure support. The CCMD establishes theater entry requirements for the Services and the DHA to establish mechanisms and sustained funding to provide trauma system infrastructure (to include equipment and staffing resources for program administration and oversight, data collection, storage, analysis, and PI activities, as well as support for disaster response and civilian integration).

(7) Collect and analyze data. Collect, validate, and analyze injury surveillance data for the purpose of PI. Collect patient records for any and all trauma casualties (regardless of origin) across the full continuum of trauma care starting from the point of injury. Identify major health threats requiring data collection and incorporate when needed. Oversee that records are transferred to the JTS to support PI, research efforts, and inform policy and legislation pertaining to casualty care. All roles of care are required to submit documentation of care and provide after-action reviews for trauma patients, and additional health threats when designated, to the JTS for abstraction into the DoDTR. Information pertaining to submission to JTS can be found at: [https://jts.amedd.army.mil/index.cfm/documents/forms\\_after\\_action](https://jts.amedd.army.mil/index.cfm/documents/forms_after_action).

(8) Ensure patient identification and confidentiality. Establish a process to ensure patient identification and confidentiality and to provide protection from discoverability while at the same time facilitating trauma system PI and research efforts. The CTS in coordination with the JTS will designate casualty pseudo names for patients with unknown identity, oversee the continuity of names within the system, and oversee patient confidentiality and protection from discoverability.

(9) Monitor performance. Support a system-wide trauma registry that meets national and DoD data collection standards and has the capacity to assess trauma system quality. Incorporate major health threats when needed. Provide regular PI reports to support system operations, evaluate performance metrics such as outcomes and preventability of mortality, benchmark internal system components, and inform prevention activities.

(10) Establish a research capability. Establish a process for in-theater casualty care research and investigator-driven PI project approval.

(11) Ensure preparedness. Establish comprehensive operational and disaster preparedness plans. Plans will integrate all components of the trauma system and coordinate with all existing response entities, including civilian local and national, and international military partners. The plans will be exercised at routine intervals, at a minimum, semiannually. At least one of these exercises will be operationally based, testing all components of the system.

(12) Facilitate interoperability and cooperation. Actively support interoperability and cooperation with military, civilian, contract and international partners, MTF, and transport capabilities. This plan should include patient care, education, research, training, disaster response, and deployment readiness preparation.

b. As an integrated Combat Support Agency, in accordance with Reference (l), the DHA provides the framework and support for CTS core functions through assessment, publications, and assurance.

4. CTS CAPABILITIES. The capabilities of the CTS are established during Phase 0 operations and scaled to the contingency requirements of the CDR, under the authority direction and control of the CCMD Surgeon, augmented with trauma subject matter experts.

a. Prevention of injury. The CTS provides oversight and evaluation of the medical care provided through actively reviewing programs and procedures for injury prevention, personnel protective equipment, and tactics, techniques, and procedures. PI data is extracted from records outlining mechanisms of injury, such as air, ground, and water vehicle mishaps; firearms (e.g., unintentional discharge), falls, and sports related injuries. Data is gathered and analyzed, reports are provided to CCMD surgeon to share with partnering DoD and federal investigative agencies involved. Extend to public health threats when needed.

b. Prehospital casualty care. Provide point of injury and Role 1 casualty care in accordance with the standards established by the JTS Committee on Tactical Combat Casualty Care and Prolonged Field Care guidelines.

(1) Pursuant to Reference (n), all Service members and select expeditionary civilians entering each CCMD will be trained in Tactical Combat Casualty Care (TCCC) in accordance with their occupational role or specialty.

(2) During Phase I-V, a Prehospital Medical Director will be assigned to assist in coordinating and overseeing the quality of care delivered by enlisted medical providers in accordance with the TCCC guidelines. The Prehospital Medical Director will facilitate documentation and collection of all Role 1 care (point of injury to next role of care) information.

c. Medical and Casualty Evacuation. The CTS includes point of injury evacuation with en route care capabilities for all operations and facilitates communication between providers and components of the patient movement system. Centralized patient movement regulation, en route care, en route visibility, medical oversight, and PI are necessary functions of the patient movement system.

d. Advanced resuscitative care. The CTS establishes advanced resuscitative teams and capabilities to optimize surgical outcomes and extend time to surgical capability when unavailable within 1 hour. Capabilities include advanced life support, blood product transfusion, management of metabolic derangement, hypothermia prevention, and minor surgical interventions. In addition to interventions in support of airway and breathing, these teams should aim to maintain circulating volume, control hemorrhage, and correct the “lethal triad” of coagulopathy, acidosis, and hypothermia.

e. Damage control surgery (DCS). (Role 2, with surgical capability). The CTS establishes the capability to surgically control hemorrhage, treat life-threatening conditions, implement advanced life support, and resuscitate with blood products early after injury. When supporting contingency operations, medical planners will make every attempt to ensure that DCS capabilities are located 1 hour from planned combat operations. When conditions do not permit treatment by a DCS team within 1 hour, mitigating capabilities will be implemented to augment prehospital capabilities such as whole blood transfusion and non-surgical resuscitation teams; however, this may not achieve the same survival rate.

f. Inter-facility transfer. Transfer between roles of care in theater occurs after initial stabilization by a DCS team. The CTS oversees that the level of care is not degraded during transfer with a goal of at least two critical care providers (e.g., critical care flight paramedic, en route critical care nurse, or critical care physician/physician assistant) with role-specific en route care training conduct critical care transfers to include all patients requiring ventilator or other life support and all patients post DCS.

g. Definitive surgery. (Role 3 or 4). The CTS establishes the capability to perform definitive surgery with a robust patient holding capability to include intensive care and intermediate care inpatient units, either within theater or out of theater.

h. In-Theater Rehabilitation/Return to Duty. The CTS evaluates inpatient and outpatient rehabilitation needs and establishes sufficient resources within the CCMD to sustain mission requirements for those Service members, determined by their medical provider and commander, as having the ability to return to duty with in-theater rehab.

i. Long Range Evacuation. The CTS, in coordination with U.S. Transportation Command, will optimize the preparation of patients for inter-theater long range evacuation to include critical

care evacuation, and facilitate communication between providers and evacuation teams. Patients are stabilized to the greatest extent possible within operational constraints prior to long range evacuation, and adequate documentation on the U.S. Transportation Command approved form is provided to ensure timely and safe validation of casualty movement.

j. Continental United States Hospitalization and follow-up care. The CTS advocates for hospital bed capability and capacity required for the United States to receive and care for ill and injured Service members. This includes hospital intensive and ward care beds, inpatient and outpatient rehabilitation, and long-term support. Outcomes of the care, whether in DoD, Veteran's Affairs, National Disaster Medical System, or other civilian facilities should be documented in the MHS EHR and made available to the DoDTR. The CTS, with support from JTS, tracks outcomes following traumatic injury, and follow-up data is included in PI reports.

## 5. CTS PI PROCESSES

a. PI is included within the CTS core functions, CCMD planning process, and supports all phases of operations throughout the DTE. Planning for CTS PI includes:

- (1) Pre-established metrics to assess trauma system performance.
- (2) Implementation of Phase 0 CTS functions and capabilities.
- (3) Incorporation of a deployable surge capability for TMT into operational plans to augment the CCMD Surgeon's staff when operational activity exceeds a threshold that cannot be managed by the baseline CTS staff.

b. The capability to assess performance relies on timely and accurate data collection relating to patient care and transfer of data to EHR and the DoDTR. The CTS, under the authority, direction, and control of the geographic combatant commander, will:

- (1) Identify the individual or team responsible for PI and ensure the team is trained and appropriately positioned to gather data and report trends.
- (2) Establish standard operating procedures to standardize casualty names for unidentified patients and transmit records to the JTS.
- (3) Capture all initial casualty information on the standardized forms and ensure those forms are available in a format that best supports the operational environment.
- (4) Direct that all point of injury providers are supplied with the DD Form 1380, Tactical Combat Casualty Care (TCCC) Card.
- (5) Direct that all en route care providers are supplied with en route patient care records.



(6) Direct that all trauma resuscitation teams are supplied with DD Form 3019, Trauma Resuscitation Record and/or the Austere Surgical Team/Mass Casualty Resuscitation Record.

(7) Oversee transmission of medical records to the JTS for rapid analysis and feedback and abstraction into the DoDTR.

(8) Use appropriate technology in support of transmitting hand-written records and use secure electronic documentation tools when available.

c. The CTS oversees detailed case review of index cases in order to identify opportunities for improvement in trauma care and facilitate communication between all roles of care and trauma providers.

d. Patient administration capability is available remotely or on-site, as appropriate to the level of care. Transmit all patient information to the patient administration department. In absence of patient administration department capability on-site, maintain records locally until transmission of records is completed.

GLOSSARYPART I. ABBREVIATIONS AND ACRONYMS

AD-CS	Assistant Director, Combat Support
CCDR	Combatant Commander
CCMD	Combatant Command
CTS	Combatant Command Trauma System
DAD	Deputy Assistant Director
DCS	damage control surgery
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
DoDTR	Department of Defense Trauma Registry
DTE	Defense Trauma Enterprise
EHR	electronic health record
FTE	full time equivalent
HCO	Healthcare Operations
IO	Information Operations
JTS	Joint Trauma System
JOMIS	Joint Operational Medical Information System
MHS	Military Health System
MTF	Military Medical Treatment Facility
PI	performance improvement
TCCC	Tactical Combat Casualty Care
TMD	Trauma Medical Director
TMT	Trauma Management Team
TPM	Trauma Program Manager

## PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purpose of this DHA-PI.

CCMD. Defined in the DoD Dictionary of Military and Associated Terms.

CTS. Defined in the DoD Instruction 6040.47.

Contingency Operations. Defined in the DoD Dictionary of Military and Associated Terms.

Disease and non-battle injury. Defined in the DoD Dictionary of Military and Associated Terms.

DTE. All DoD resources, assets, and processes required for the optimal delivery and management of trauma care in support of DoD operations, in both the garrison setting and across the full range of military operations. The DTE includes trauma-centric supporting activities (e.g., training, education, and research) designated to improve trauma care delivery from point of injury through rehabilitation.

DoDTR. Defined in the DoD Instruction 6040.47.

CTS Assessment Team. A deployable DHA assessment team, when requested by the CCDR, will identify areas of improvement (to include partner nation capabilities) to mitigate risk and improve trauma care delivery.

JTS. Defined in the DoD Instruction 6040.47.

MHS. Defined in Joint Publication 4-02, "Health Service Support," July 26, 2012.

MTF. Defined in National Defense Authorization Act for Fiscal Year 2020 as any fixed facility of the DoD that is outside of a deployed environment and used primarily for health care; and any other location used for purposes of providing healthcare services as designated by the Secretary of Defense.

Prehospital Medical Director. A licensed physician (optimally emergency medicine physician fellowship-trained in Emergency Medical Services) who has operational medicine experience, has received trauma system training by the JTS, and is assigned or liaison to augment the CCMD Surgeon's staff to provide prehospital medical direction (Physician Assistant or Trauma Nurse with similar qualification may serve as substitute).

Senior Enlisted Advisor. An Enlisted-7 or above (optimally a paramedic or Special Operations Combat Medic/Corpsman/Pararescuemen) enlisted medical provider who has operational medicine experience, has received trauma system training by the JTS, and is assigned or liaison to augment the CCMD Surgeon's staff for oversight of trauma care.

TCCC. Defined in Joint Publication 4-02.

TMD. A licensed general surgeon (optimally fellowship-trained trauma surgeon) who participates in trauma call, has received trauma system training by the JTS, and is assigned or liaison to augment the CCMD Surgeon's staff for oversight of trauma care.

TMT. A deployable DHA or Service JTS-trained team, capable of deploying forward during initial Phase I to Phase V operations in order to establish the CTS capability in support of CCDR requirements.

Trauma System. Defined in DoD Instruction 6040.47.

TPM. A licensed registered nurse who has received trauma system training by the JTS that serves as the primary patient safety, PI process, and data entry subject matter expert.

Trauma Registrar. A patient administration subject matter expert that has the primary duty to ensure all trauma records are abstracted into the DoD Trauma Registry.