TEXAS
Health and Human Services

Texas Department of State Health Services

Governor's EMS and Trauma Advisory Council

Monday, November 21, 2022

4:00 PM CDT

Alan Tyroch, MD, FACS, FCCM, Chair
Ryan Matthews, LP, Vice Chair

This meeting will be conducted live and virtually through Microsoft Teams.

Public participation will also be available at:

Hilton Austin Hotel, Salon H

500 East 4th Street

Austin, Texas 78701

Virtual Rules of Participation

Rules of Participation

- Please be respectful during the meeting to ensure all members can be heard.
- Please do not monopolize the time with your comments.
- Please limit comments to 3 minutes or less.
- Please allow others to voice their opinion without criticism.
- Everyone’s voice and opinion matters.

Rules of Participation

- If you would like to make a statement or ask a question, please put your question in the chat with your name and entity you represent.

  Please note: Anonymous entries in the chat are unable to be shared.

- Please do not put your phone on hold at any time if you are using your phone for audio.
- How to mute/unmute if not using the computer for audio:
  - **Android phones: Press *6**
  - **iPhones: Press *6#**

Rules of Participation

- All participants will sign into the chat with their name and entity they represent.
- All participants will mute their microphone unless speaking, except the Chair.
- Committee members: Please have your camera on and state your name when speaking.
- Council: Please have your camera on during today's meeting. When speaking or making a motion, please state your name for the meeting record.

Call to Order

&

Roll Call

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Health and Human Services

Texas Department of State Health Services

Vision and Mission

Vision:

A unified, comprehensive, and effective Emergency Healthcare System.

Mission:

To promote, develop, and advance an accountable, patient-centered Trauma and Emergency Healthcare System.

Moment of Silence

Let's take a moment of silence for those who have died or suffered since we last met.

TEXAS Health and Human Services

Texas Department of State Health Services

Approval of Minutes

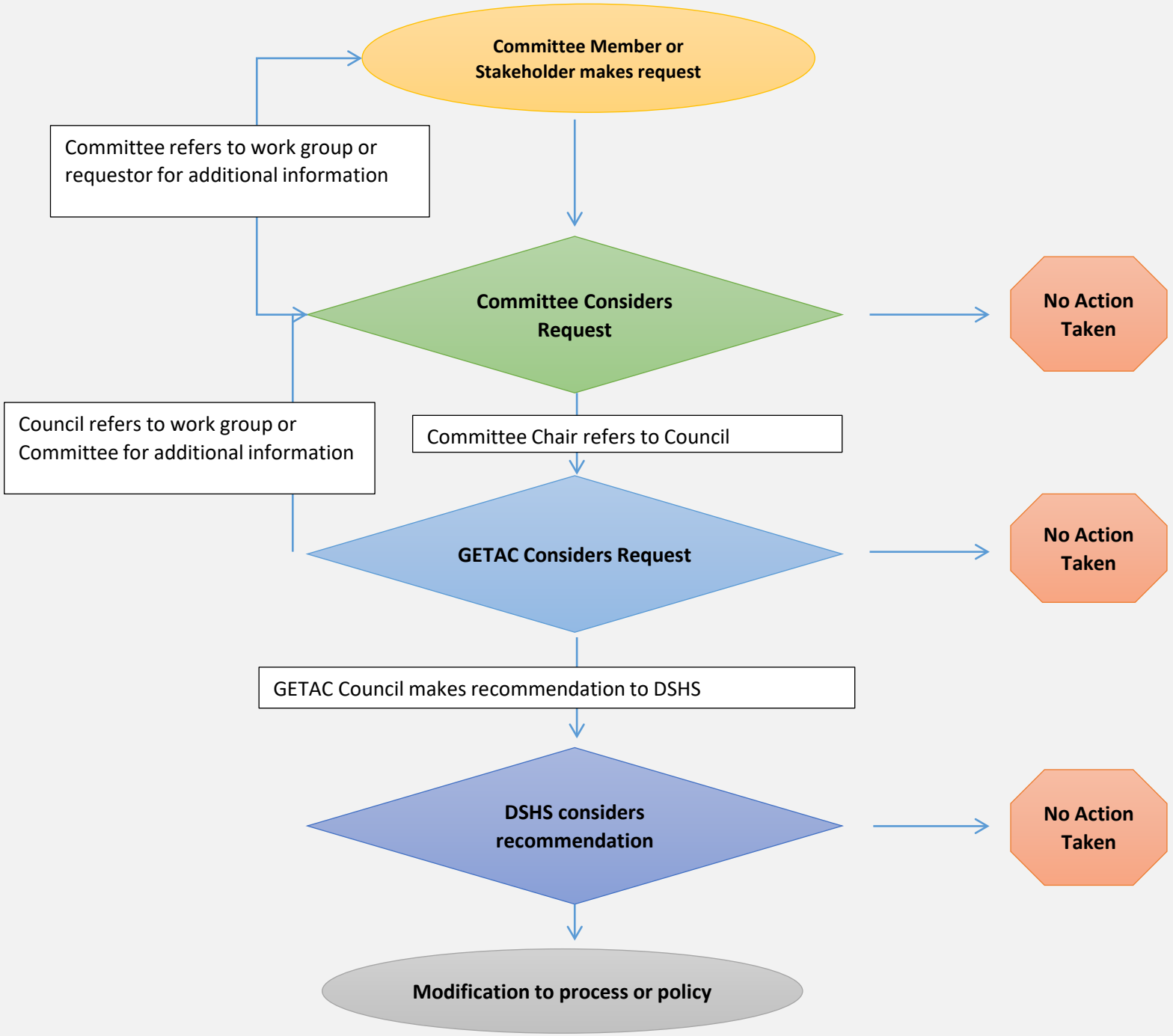
Review and Approval Minutes

- August 19, 2022, Minutes

TEXAS
Health and Human Services

Texas Department of State Health Services

Committee Focus



New Conflict of Interest

- Each Council and Committee Member
- Completed Conflict of Interest on File Annually
- Goal is Transparency
- Recognized as Subject Matter Experts
- Financial Interest Declared
- Does not Mean You Can Not Participate in Discussion
- If Associated Financial Interested – Recommendation and Voting- Should Abstain

Council and committee members cannot participate in March 2023 meeting without an annual Conflict of Interest form on file with DSHS.

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Texas Department of State Health Services

Center for Health Emergency Preparedness and Response

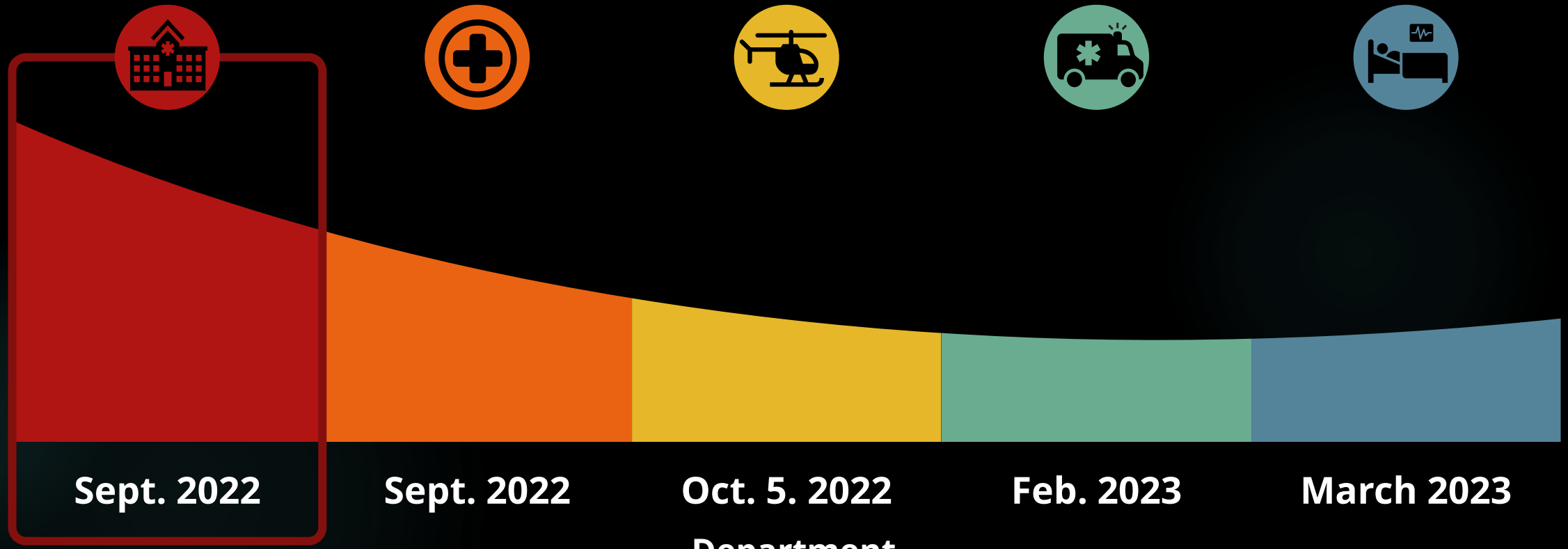
EMS Trauma Systems Update

Jorie Klein, MSN, MHA, BSN, RN, Director

Trauma Rules Update

- 157.2 Definitions
- 157.123 Regional Emergency Medical Services /Trauma System
- 157.125 Requirements for Trauma Facility Designation
- 157.128 Denial, Suspension, and Revocation
- 157.130 Emergency Medical Services and Trauma Care Account and Emergency Medical Services, Trauma Facilities and Trauma Care System Fund
- 157.131 Designated Trauma Facility and Emergency Medical Services Account

Trauma Rule Timeline



Sept. 2022

Enter Rule Coordination Office (RCO)

Sept. 2022

Informal Public Comment for 2 Weeks, ending Sept. 23.

Oct. 5. 2022

Department addresses comments and sends Rule back to the RCO.

Feb. 2023

Presented at HHSC Executive Council Meeting

March 2023

Formal Public Comment (Ends April 2023.

Trauma Rule Timeline

April 2023

Program addresses public comments and integrates changes into the rule.

April 2023

Program develops adoption packet.

June 2023

Rule packet with Office of Executive Commissioner

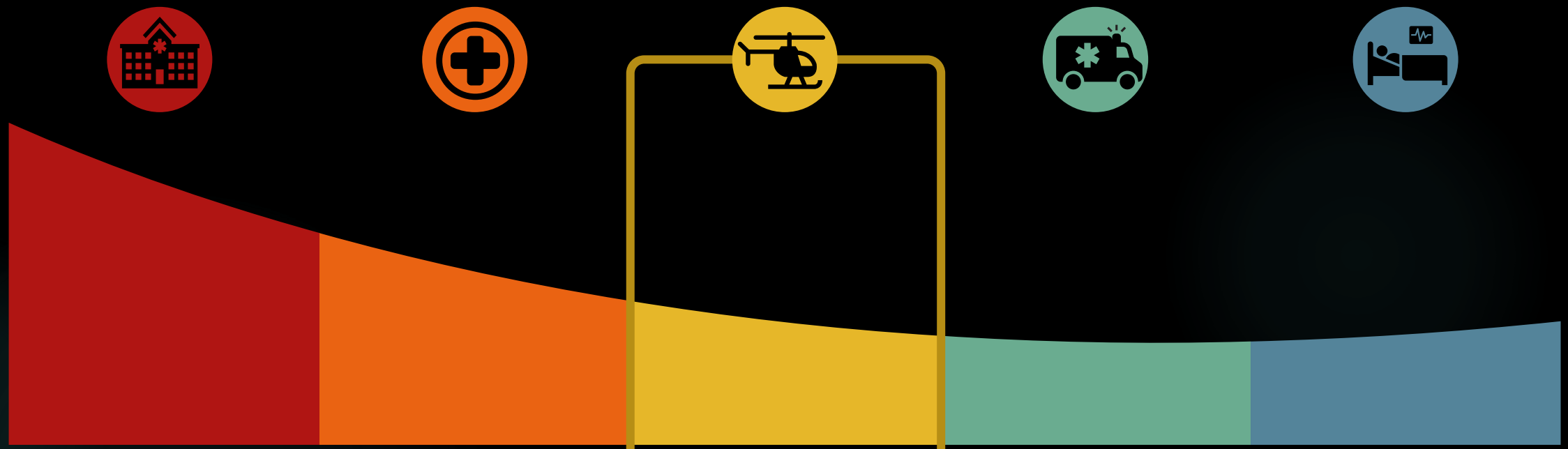
July 2023

RCO submits rule to Texas Register.

July 27, 2023

Adoption and rule effective date is defined.

Trauma Rule Timeline



July 2023

Department implements educational program for the Rule.

January 2024

Designation process is integrates the Rules.

Sept. 1, 2024

Rule is integrated into the RAC Contracts utilizing the “Initial Self-Assessment Tool”.

Sept. 2025

RAC contract integrates the “Inclusive Self-Assessment Tool”.

Sept. 1, 2023

REMEMBER Level I and Level II facilities are accountable to 2022 ACS Standards.

Activities

- Rural Level IV / Non-Rural Level IV/III Monthly Calls
  - Technical Assistance
  - Funding – Explain Uncompensated Care Grant
  - Focus on Rule Discussion
- RAC Monthly Meetings
- Initiate Calls with Survey Organizations / Surveyors
- Rural Trauma Center Project

ISS Coding; Implementing TQIP Workgroup

- Targeting Level IV and Level III Facilities
- Selected Subject Matter Experts Across Texas
- Goal – Two Calls Per Month
- AIM: Reduce the 2019 missing ISS scoring rate of 4.57& to less than 2% by December 31, 2023.
- AIM: 70% of the Texas designated Level III trauma facilities will successfully submit data to TQIP by July of 2024.

Issues of Concern

- Designation Process
  - Gaps in Programs
  - Performance Improvement
  - Registry
  - TPM or TMD
  - Lack of Fulfilling the TMD job functions
  - Excessive Diversion
  - Lack of RAC Participation
  - Lack of Outreach Education / Injury Prevention

FUNDING

Uncompensated Trauma Care Grant

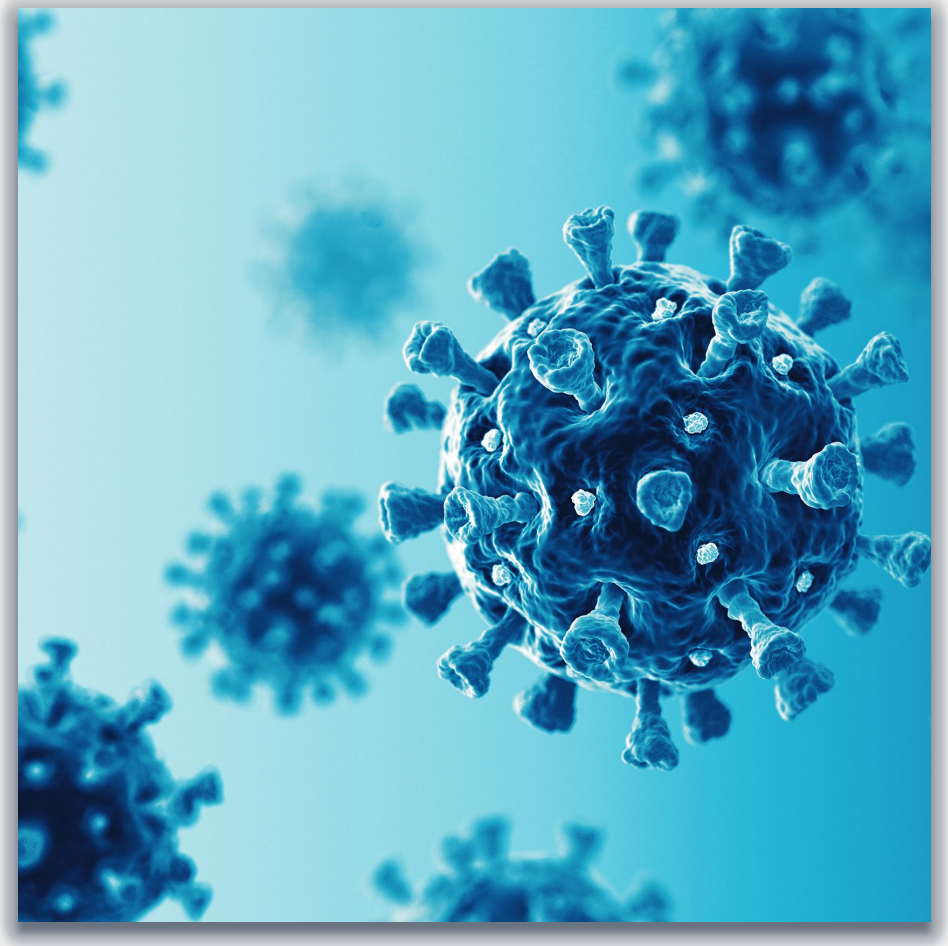
Due February 19, 2023 at Midnight

State Reports

EMS System Update

Joe Schmider
Texas State EMS Director

Staffing Waiver



ENDS

November 25, 2022

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Texas Department of State Health Services

Website: Live since 9-1-2022

- Education Scholarships
- EMS Programs by Counties
- Includes online courses
- RAC information
- Certification process
- NREMT Information
- Videos from EMS Providers
- Spreadsheet of current EMS Providers with contact information

Website and Email Addresses

EMAIL:
TEAM-TEXAS-EMS@dshs.Texas.gov

WEBSITE Location:
https://www.dshs.texas.gov/Team-Texas-EMS/

Education Scholarships Refresher

Scholarships

- EMT $2,000 = 1 year of service
- AEMT $3,200 = 2 years of service
- Paramedic $8,000 = 2 years of service

COMMITMENT WITH CURRENT EMS PROVIDER:
96 hours per month

STUDENTS THAT PASS THE NREMT EXAM ON THE FIRST TRY!

Incentive Program:

EMS Education Program or Provider

- $100 for EMT
- $150 for AEMT
- $200 for Paramedic

RAC Support

Two-year statement of work

½ the funding in September 2022

½ funding in January 2023

Funds to support the administrative needs for this project to include **annual audit**

All applications will go through the RACs

Fund to support the equipment needs for additional EMS education courses.

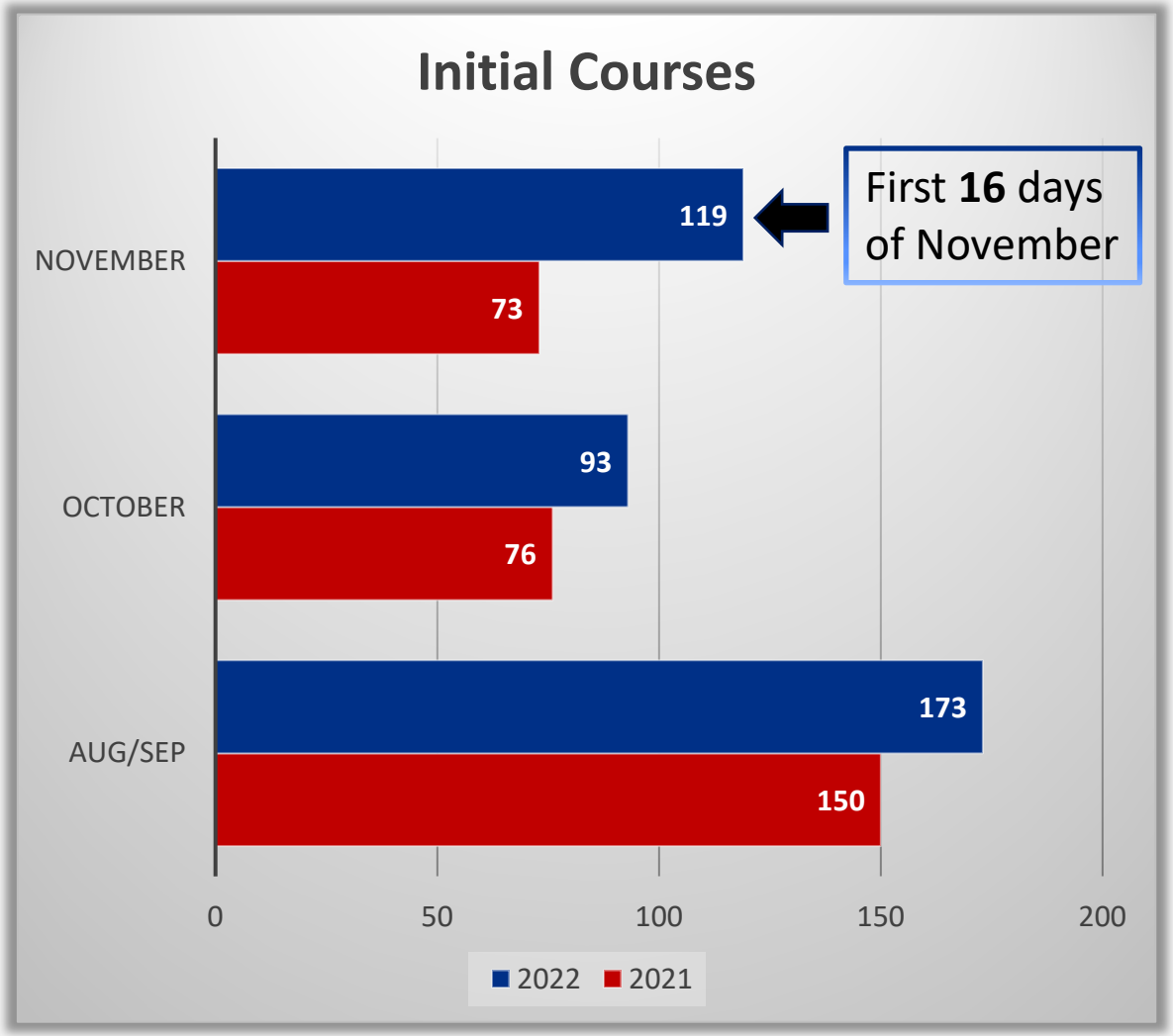
Funding returned can be used for other EMS Education scholarships

Play book for RACs

EMS Conference focusing on Retention

EMS Personnel and Initial Course Data

EMS Personnel			
Certification Level	**March 2022**	**October 2022**	**November 2022**
ECA		1,966	1,972
EMT		37,663	37,783
AEMT		3,313	3,332
Paramedic		29,701	29,730
TOTAL	**75,733**	**72,643**	**72,817**



Designation Update

Elizabeth Stevenson, BSN, RN
Designation Programs Manager

Designated Perinatal Facilities

Designated Maternal Facilities	1st Quarter 2022	2nd Quarter 2022	3rd Quarter 2022	4th Quarter 2022
Total	222	222	222	222
Level IV	32	32	32	32
Level III	44	44	44	44
Level II	93	93	93	93
Level I	53	53	53	53

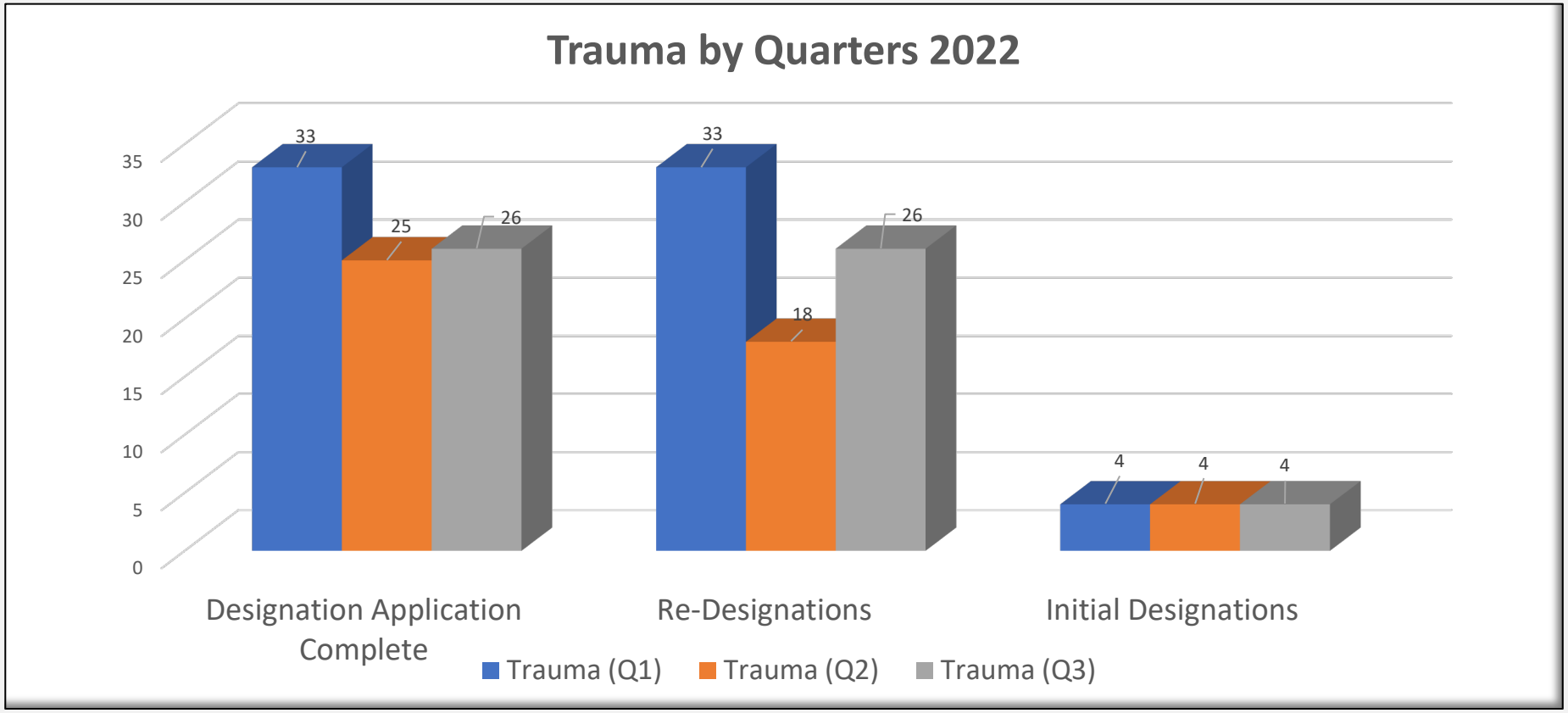
Designated Neonatal Facilities	1st Quarter 2022	2nd Quarter 2022	3rd Quarter 2022	4th Quarter 2022
Total	227	227	227	227
Level IV	22	22	22	22
Level III	66	69	73	73
Level II	57	54	50	52
Level I	82	82	82	80

Designated Trauma/Stroke Facilities

Designated Trauma Facilities	1st Quarter 2022	2nd Quarter 2022	3rd Quarter 2022
Total	301	303	305
Level I	20	20	20
Level II	26	26	26
Level III	61	59	61
Level IV	194	198	198

Designated Stroke Facilities	1st Quarter 2022	2nd Quarter 2022	3rd Quarter 2022
Total	175	178	180
Level I	39	39	41
Level II	117	119	119
Level III	19	20	20
Level IV	0	0	0

Trauma Designation Data



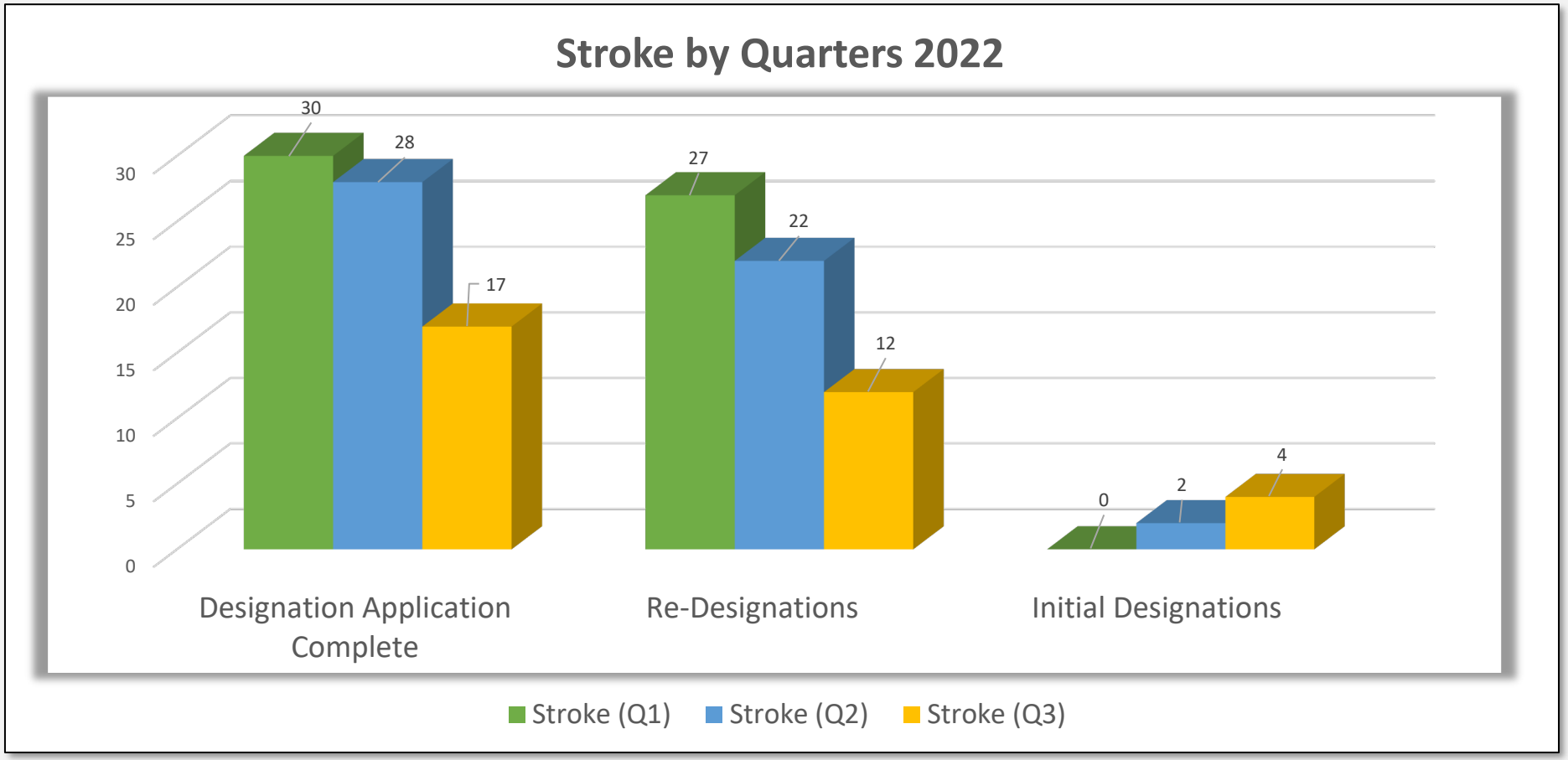
Trauma Designation Data

Trauma 2022	Trauma (Q1)	Trauma (Q2)	Trauma (Q3)
Designated at a Higher Level	**2**	**0**	**0**
Designated at a Lower Level	**0**	**1**	**1**
Facilities In Active Pursuit	**14**	**12**	**8**
Level I	0	0	0
Level II	0	0	0
Level III	2	4	3
Level IV	9	6	5
New IAP Recognitions	**3**	**2**	**0**
Contingent Designations	**1**	**4**	**11**
Level of Contingent Designation	**Level III**	**Level IV**	**Level III - 2, Level IV - 9**

Common Deficiencies

Common Theme for Contingencies and Focused Review:
Trauma Performance Improvement Plan and Follow Through
Trauma Medical Director Role/Leadership
Monthly Reporting of ISS, GCS, Outcomes
Physician Response/Attendance
Nursing Documentation
Continuous PI for 3 Year Cycle
Physician Credentialing
Mortality & Morbidity Reviews
Multidisciplinary PI Committee

Stroke Designation Data



Designation Application Process Performance Measures

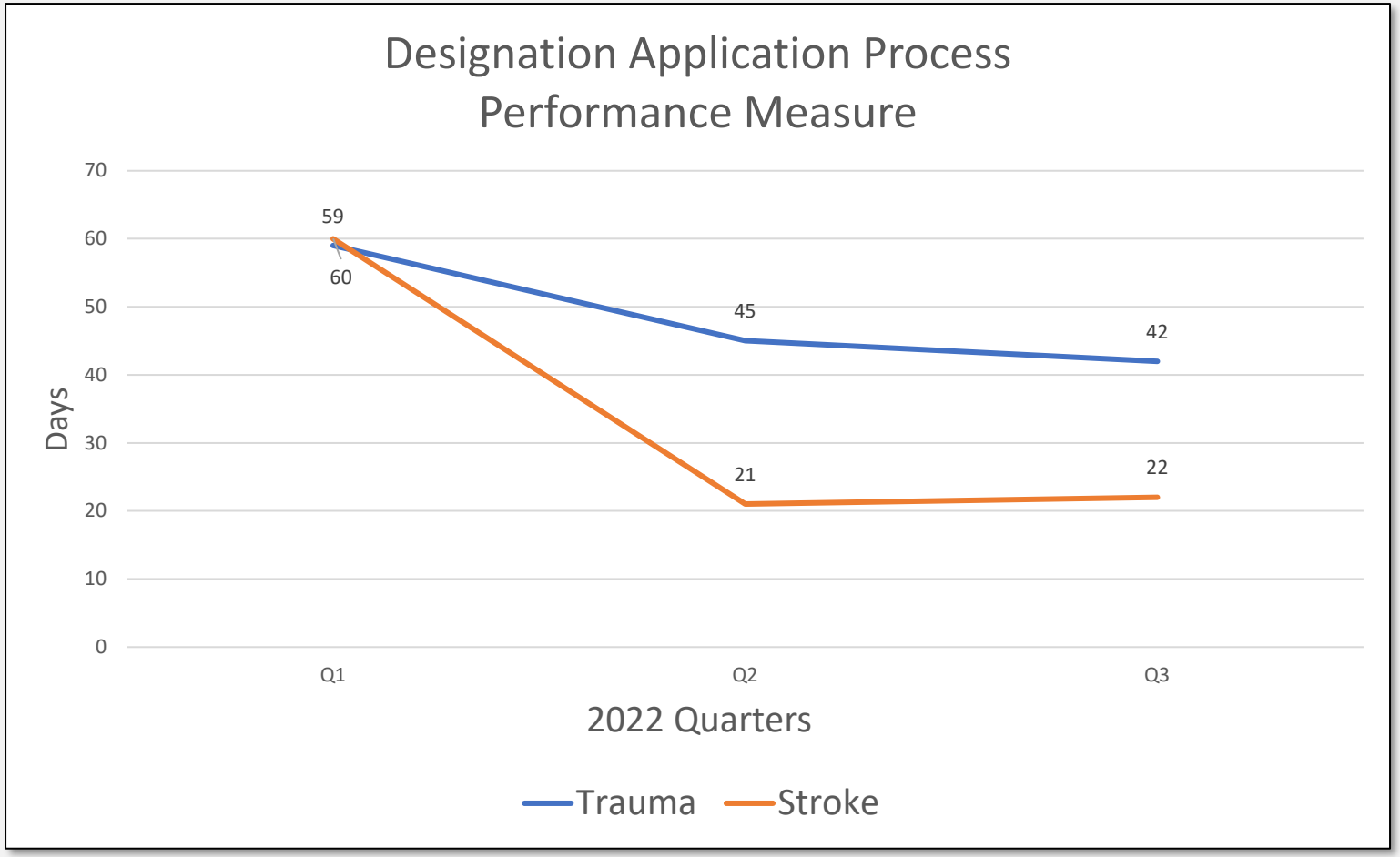
Goal – 30 days

Trauma – 42 days

Stroke – 22 days

Department receipt of a complete application, including fee, through facility receipt of approved documents.

Approved Documents to Facilities – 2 days.



Designation Support Trauma/Stroke

Support Provided 3rd Quarter 2022	July	August	September
Facility visit	1	0	1
Virtual meetings for designations	6	8	5
Virtual meetings for reporting, follow-up, or assistance	9	6	6
Telephone assistance	10	13	10

Stroke Designations Website List

Stroke Levels Designated After September 1, 2022	Stroke Levels Designated Before September 1, 2022
• **Comprehensive (Level I)** • **Advanced (Level II)** • **Primary (Level III)** • **Acute Stroke Ready (Level IV)** • Primary (Level II) • Support (Level III)	• **Comprehensive (Level I)** • **Primary (Level II)** • **Support (Level III)**

Survey Organization Approval

- Survey organizations apply for department approval to conduct surveys for designations in Texas.
- All survey organizations for Trauma, Stroke, Maternal, and Neonatal designations are required to apply.
- Application will be released after January 1, 2023.
- The survey organization must meet the Survey Guidelines set forth by the department.
- Approved survey organizations will be listed on the designation websites.

Questions for EMS/Trauma Systems?

Thank You

DSHS Texas EMS and Trauma Registry Update

Jia Benno, MPH
Office of Injury Prevention Manager

Trauma Systems Data Request GETAC Presentation Part 2 (Texas 2021)

Prepared by the Office of Injury Prevention

November 21, 2022

Jia Benno, MPH

Injury Prevention Unit Director

Introduction

EMS & Trauma Registries
Texas Department of State Health Services

- DSHS used hospital-reported traumatic injuries data. Hospitals must report spinal cord injuries, traumatic brain injuries, and other traumatic injuries specified in Texas Administrative Code, Title 25, Chapter 103.

- This data report includes only records submitted into the Emergency Medical Services/Trauma Registries (EMS/TR) through a passive surveillance system.

- Patients transferred between hospitals will result in more than one registries record since each hospital must independently submit a patient's record to the registries.

Methodology Notes

EMS & Trauma Registries
Texas Department of State Health Services

- In June 2022, EMS/TR pulled and standardized 2021 trauma variables.
- In calendar year 2021, EMS/TR received a total of **153,135** unique patient records.
- Per epidemiology best practice, EMS/TR suppressed data when there were less than 5 records to protect identifiable data, noted with a "*".
- Not all table data will add up to 100%.
- Trauma Systems data request included patients between ages 16 and 64.

Definitions

EMS & Trauma Registries
Texas Department of State Health Services

- Shock – a patient with a blood pressure (BP) of 90 systolic or less on arrival or admission to the trauma center. For this request, EMS/TR used patients ages 16-65.
- Glasgow Coma Scales (GCS) – used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients.
- Double Transfer – a patient who arrives at a facility by a transfer from another facility and is then transferred out.
- Missing – Providers did not fill in the section.

Governor's EMS and Trauma Advisory Committee (GETAC) Data Request – Trauma Systems Subcommittee Part 2 (Follow-up from August Meeting)

Trauma Center Levels by Injury Severity Scores (ISS)

Injury Severity Scores 11-14

	Total	Transferred In	Transferred Out	Double Transfer	LOS**	Mortality
Level I	3,418	34.46%	0.23%	*	6.59	1.87%
Level II	2,085	24.03%	1.77%	*	5.49	2.11%
Level III	1,279	12.51%	21.50%	0.63%	5.90	2.42%
Level IV	775	3.10%	66.06%	*	4.67	1.94%

**Length of Stay (LOS) – the average length of stay in days for each trauma center level

Injury Severity Score 15-24

	Total	Transferred In	Transferred Out	Double Transfer	LOS**	Mortality
Level I	4,476	33.60%	0.56%	0.25%	8.95	5.45%
Level II	2,507	25.69%	2.07%	*	8.08	5.46%
Level III	1,568	12.56%	22.00%	*	8.33	6.44%
Level IV	802	7.11%	69.45%	0.62%	6.03	3.12%

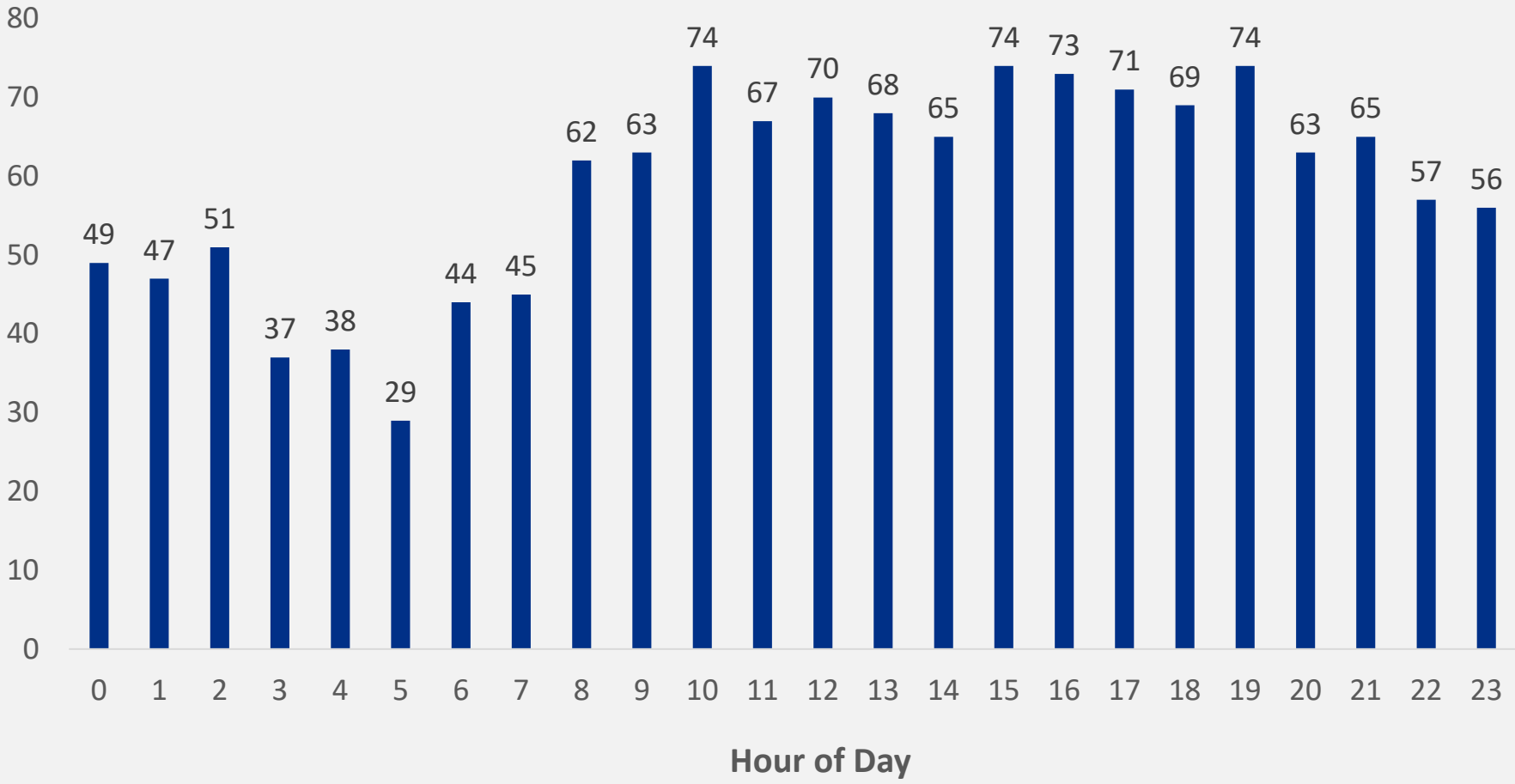
**LOS – the average length of stay in days for each trauma center level

Injury Severity Score ≥ 25

	Total	Transferred In	Transferred Out	Double Transfer	LOS**	Mortality
Level I	3,286	25.65%	0.70%	0.21%	14.20	24.44%
Level II	1,748	19.85%	1.37%	0.00%	11.83	27.12%
Level III	871	10.79%	15.38%	*	11.75	25.26%
Level IV	410	8.54%	57.80%	*	7.08	12.20%

**LOS – the average length of stay in days for each trauma center level

Level IV Entities with Fewer Than 100 Records by Hour of Day



Traumatic Brain Injury (TBI) compared with:

TBI + Glasgow Coma Score (GCS) of 9-12 in Emergency Department (ED);

TBI + GCS ≤ 8 in ED; and

TBI + ≤ 12 GCS and at least 1 BP ≤ 90 Systolic Incident

Breakdown of Number of TBI and GCS criteria

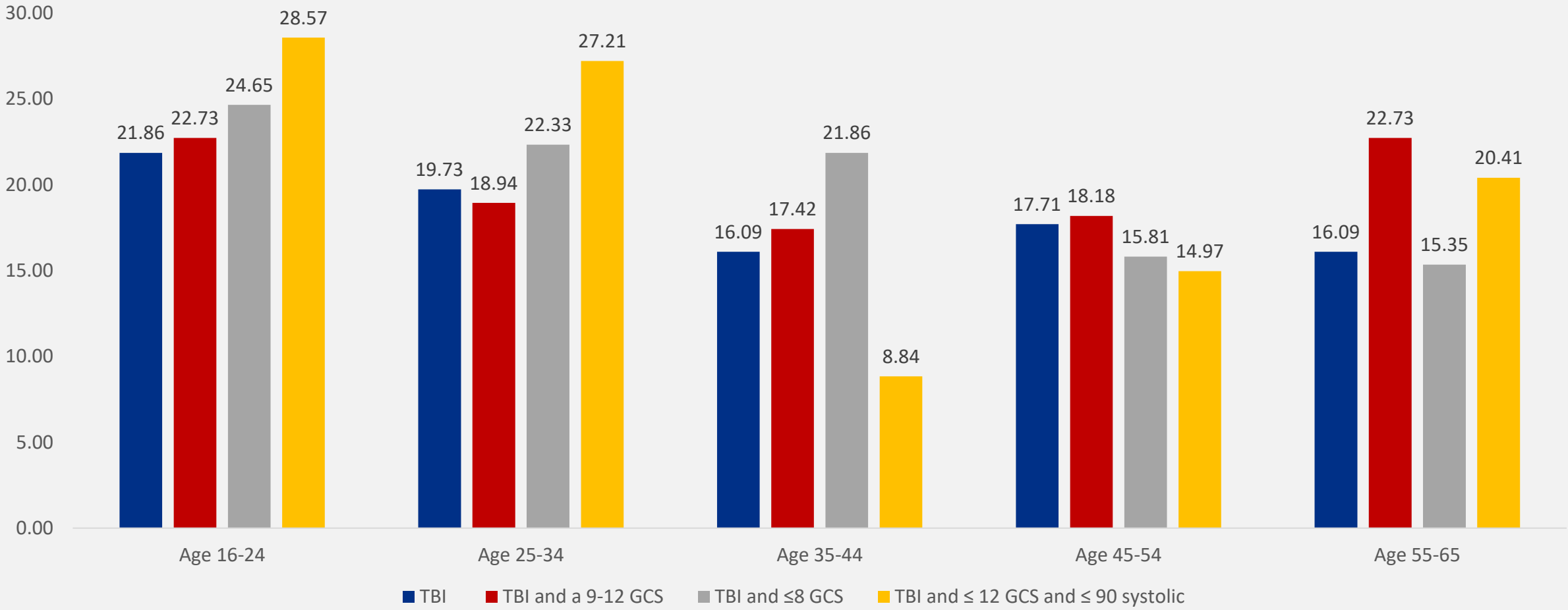
GCS Levels	Count
TBI	2,722
TBI + GCS of 9-12 arriving at ED	132
TBI + GCS ≤ 8 arriving at ED	645
TBI + ≤ 12 GCS and at least 1 BP ≤ 90 Systolic Incident	147

Mechanism of Injury by GCS criteria

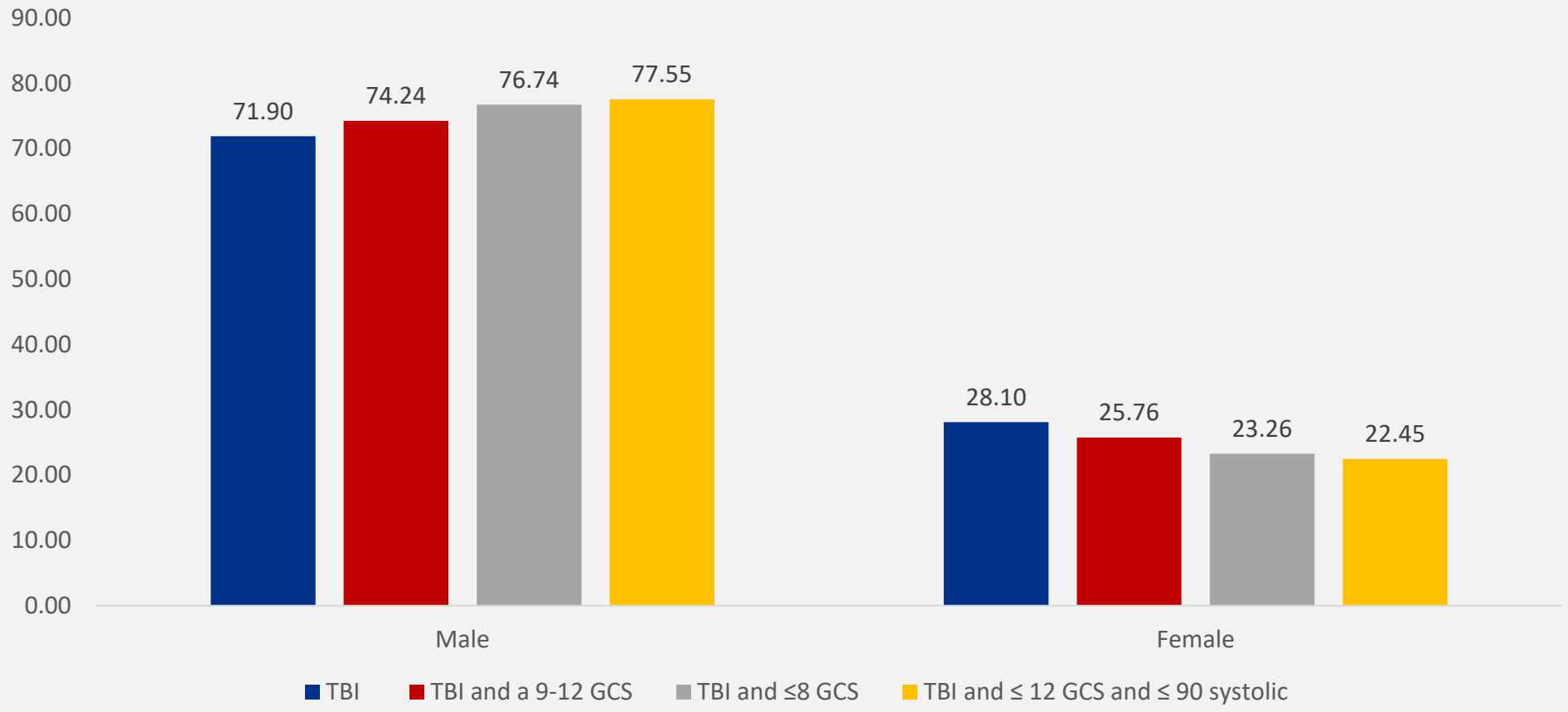
MOI	TBI	TBI and 9-12 GCS	TBI and ≤ 8 GCS	TBI and ≤ 12 GCS and ≤ 90 systolic
Fall	39.09%	43.18%	26.36%	12.24%
MVT - Occupant	21.20%	18.94%	17.98%	21.77%
Struck By / Against	12.78%	12.88%	6.98%	*
Firearm	8.96%	6.06%	29.15%	45.58%
Other**	8.56%	14.39%	8.06%	9.53%
MVT - Motorcyclist	3.75%	*	4.03%	4.76%
MV - Non-Traffic	3.20%	*	2.79%	*
MVT - Pedestrian	2.46%	4.55%	4.65%	6.12%

**Other includes pedal cyclist, natural/ environmental, machinery, other transport, etc.

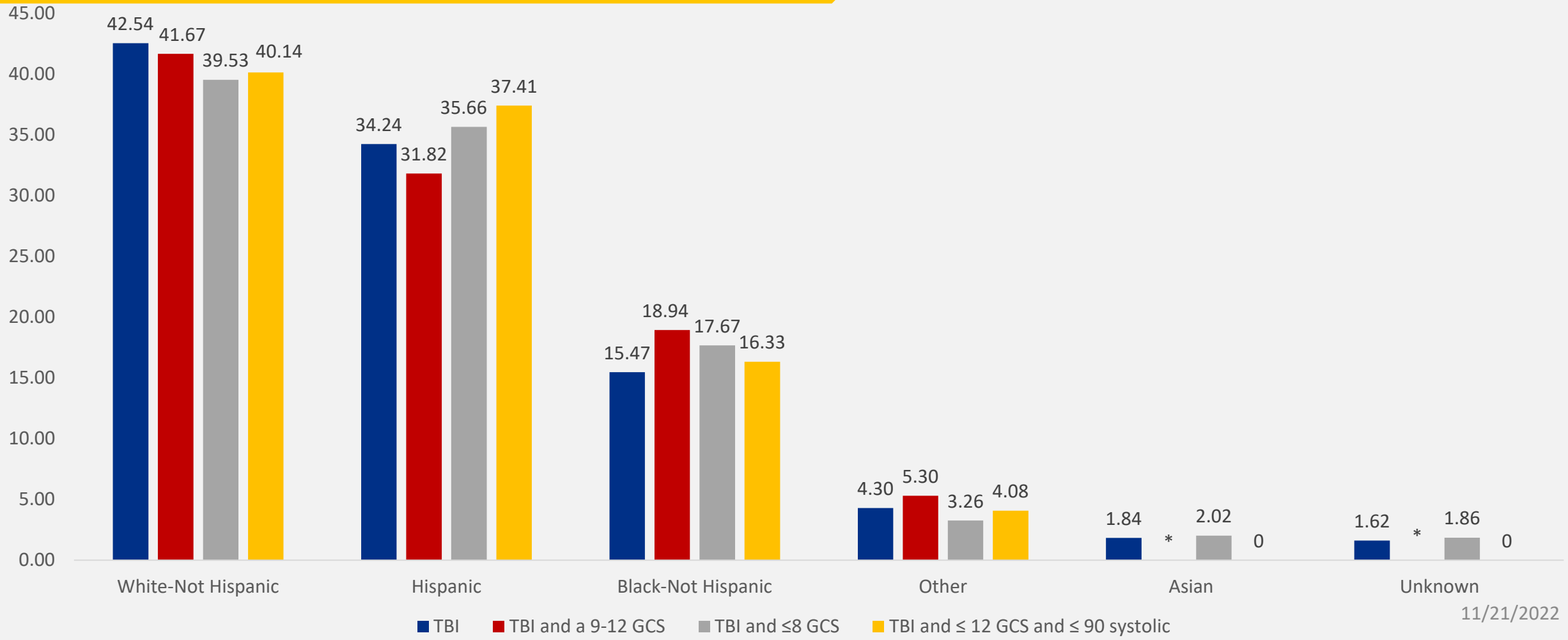
Patient's Age by GCS criteria



Patient’s Gender by GCS criteria



Patient's Race and Ethnicity by GCS criteria



Transport Mode by GCS criteria

Transport Mode	TBI	TBI and a GCS of 9-12	TBI and GCS of ≤ 8	TBI and ≤ 12 GCS and ≤ 90 systolic
Ground Ambulance	72.30%	89.39%	75.04%	81.63%
Private / Public Vehicle / Walk-in	18.88%	6.06%	7.29%	4.76%
Helicopter Ambulance	7.86%	3.79%	16.59%	11.56%
Police	0.37%	0.0%	*	*
Fixed-wing Ambulance	0.29%	0.0%	*	*
Not Known / Not Recorded	0.30%	*	*	*
Other	*	*	*	*

ED Disposition – TBI versus TBI and a 9-12 GCS versus ≤ 8 GCS

ED Disposition	TBI	TBI and a 9-12 GCS	TBI and GCS of ≤ 8
Intensive Care Unit (ICU)	29.90%	53.03%	44.81%
Transferred to Another Hospital	20.35%	23.48%	11.32%
Floor bed (general admission, non specialty unit bed)	19.58%	7.58%	4.65%
Telemetry / step-down unit (less acuity than ICU)	6.83%	5.30%	1.71%
Operating Room	6.47%	4.55%	12.71%
Home without services	6.17%	*	1.24%
Deceased / Expired	4.41%	0.0%	18.60%
Observation unit (unit that provides < 24 hour stays)	3.20%	*	1.86%
Not Applicable	2.20%	*	2.64%
Left against medical advice	0.48%	*	*

ED – TBI, ≤ 12 GCS, and at least 1 BP ≤ 90 Systolic Incident

ED Disposition	TBI	TBI + Criteria
Intensive Care Unit (ICU)	29.90%	17.01%
Transferred to Another Hospital	20.35%	4.76%
Floor bed (general admission, non specialty unit bed)	19.58%	3.40%
Telemetry / step-down unit (less acuity than ICU)	6.83%	*
Operating Room	6.47%	9.52%
Home without services	6.17%	*
Deceased / Expired	4.41%	56.46%
Observation unit (unit that provides < 24 hour stays)	3.20%	*
Not Applicable	2.20%	5.44%
Left against medical advice	0.48%	0

Hospital Disposition – TBI versus TBI and 9-12 GCS

Hospital Disposition	TBI	TBI and a 9-12 GCS
Discharged to home or self-care (routine discharge)	46.29%	45.45%
Not Applicable (N/A)**	32.07%	25.76%
Deceased / Expired	6.25%	*
Discharged / Transferred to inpatient rehab or designated unit	5.51%	9.85%
Discharged / Transferred home to home health	2.53%	0.0%
Left against medical advice or discontinued care	2.46%	6.06%
Discharged / Transferred to Skilled Nursing Facility	1.58%	3.79%
Discharged / Transferred to court / LE	0.81%	*
Discharged / Transferred to Long Term Care Hospital	0.70%	*
Discharged / Transferred to a short-term general hospital	0.62%	*
Discharged / Transferred to hospice care	0.55%	*
Discharged / Transferred to a psychiatric hospital or psychiatric	0.51%	*

**N/A is reported if ED disposition is left against medical advice, deceased, discharged home or self-care, hospice, court/ law enforcement, or inpatient rehab.

Hospital Disposition – TBI versus TBI and ≤ 8 GCS

Hospital Disposition	TBI	TBI and GCS of ≤ 8
Discharged home or self-care (routine discharge)	46.29%	25.74%
Not Applicable (N/A)**	32.07%	31.47%
Deceased / Expired	6.25%	22.95%
Discharged / Transferred to inpatient rehab or designated unit	5.51%	9.15%
Discharged / Transferred home to home health	2.53%	2.33%
Left against medical advice or discontinued care	2.46%	1.55%
Discharged / Transferred to Skilled Nursing Facility	1.58%	1.71%
Discharged / Transferred to court / LE	0.81%	*
Discharged / Transferred to Long Term Care Hospital	0.70%	2.17%
Discharged / Transferred to a short-term general hospital	0.62%	0.78%
Discharged / Transferred to hospice care	0.55%	1.24%
Discharged / Transferred to a psychiatric hospital or psychiatric	0.51%	*

**N/A is reported if ED disposition is left against medical advice, deceased, discharged home or self-care, hospice, court/ law enforcement, or inpatient rehab.

Hospital Disposition – TBI, ≤ 12 GCS, and at least 1 BP ≤ 90 Systolic Incident

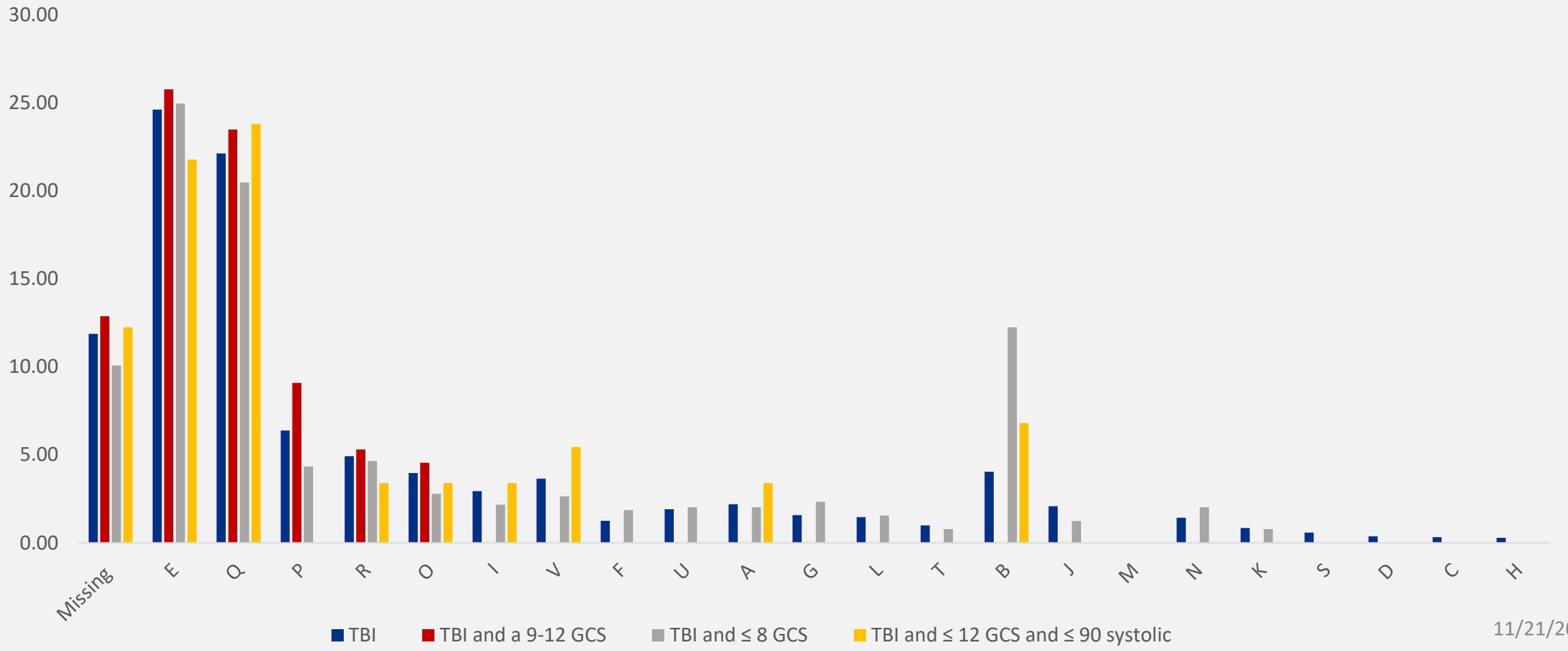
Hospital Disposition	TBI	TBI + Criteria
Discharged home or self-care (routine discharge)	46.29%	11.56%
Not Applicable (N/A)**	32.07%	61.90%
Deceased / Expired	6.25%	20.41%
Discharged / Transferred to inpatient rehab or designated unit	5.51%	*
Discharged / Transferred home to home health	2.53%	*
Left against medical advice or discontinued care	2.46%	*
Discharged / Transferred to Skilled Nursing Facility	1.58%	*
Discharged / Transferred to court / LE	0.81%	*
Discharged / Transferred to Long Term Care Hospital	0.70%	*
Discharged / Transferred to a short-term general hospital	0.62%	*
Discharged / Transferred to hospice care	0.55%	*
Discharged / Transferred to a psychiatric hospital or psychiatric	0.51%	*

**N/A is reported if ED disposition is left against medical advice, deceased, discharged home or self-care, hospice, court/ law enforcement, or inpatient rehab.

Hospital Designation by GCS criteria

Hospital Designation	TBI	TBI and 9-12 GCS	TBI and GCS of ≤ 8	TBI and ≤ 12 GCS and ≤ 90 systolic
Trauma Center Level 1	30.42%	33.33%	37.83%	30.61%
Trauma Center Level 2	7.38%	7.58%	9.92%	8.84%
Trauma Center Level 3	24.72%	26.52%	22.79%	29.25%
Trauma Center Level 4	15.42%	12.2%	10.23%	10.20%
Hospital	4.85%	*	4.19%	6.12%
Missing	16.97%	17.42%	15.04%	14.97%

Regional Advisory Council (RAC) by GCS criteria



Trauma Patients with Spinal Cord Injury (SCI)

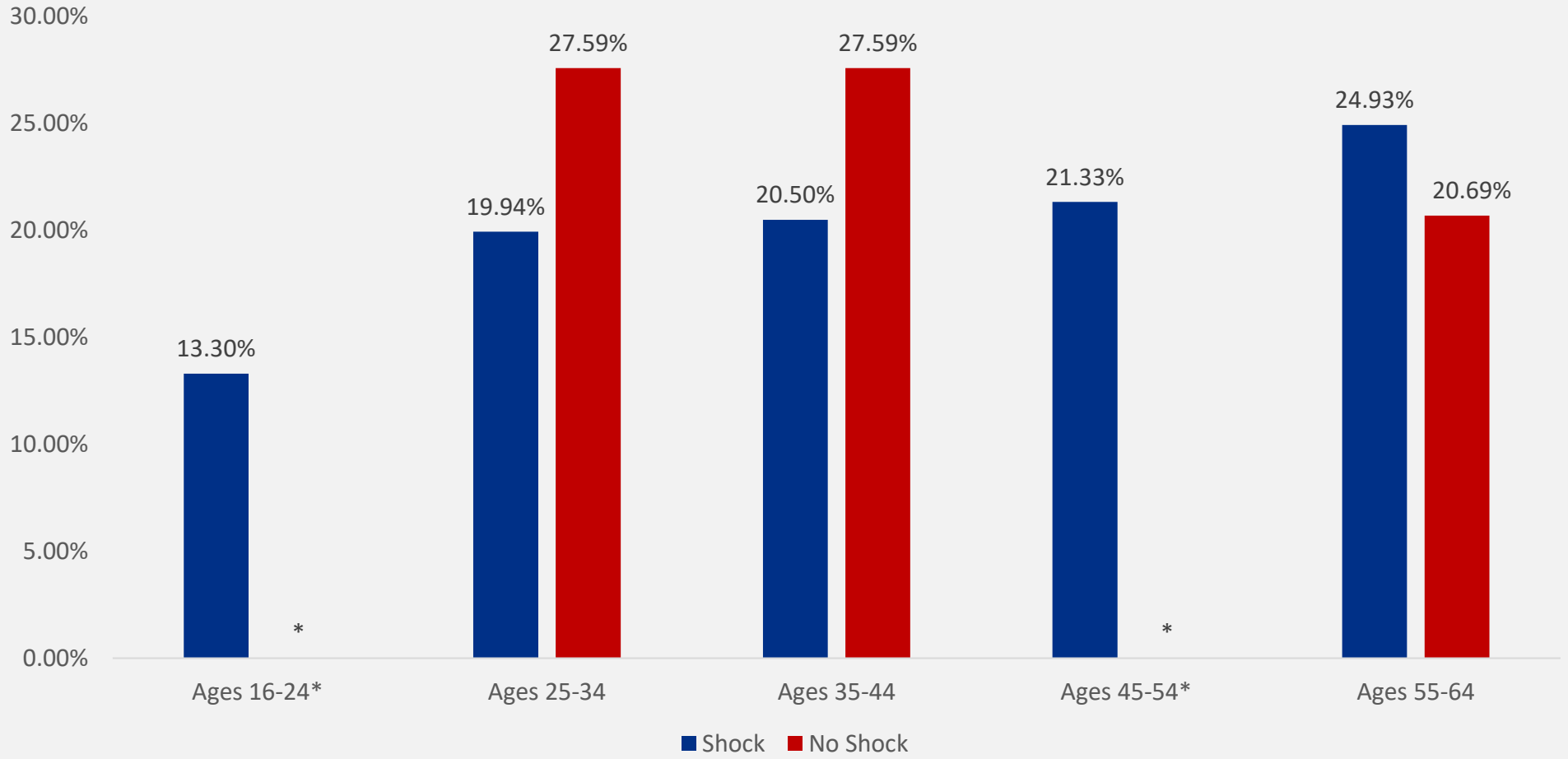
Mechanism Of Injury (MOI) – Trauma Patients with SCI or SCI and Shock

MOI	SCI	SCI + Shock
Fall	41.83%	17.24%
MVT - Occupant	29.09%	24.14%
Firearm	6.93%	31.03%
Struck by / against	4.71%	*
MVT - Motorcyclist	4.16%	*
MV - Non-traffic	3.32%	*
Other Land Transport	2.49%	*
MVT - Pedestrian	1.66%	*
Other**	5.81%	*

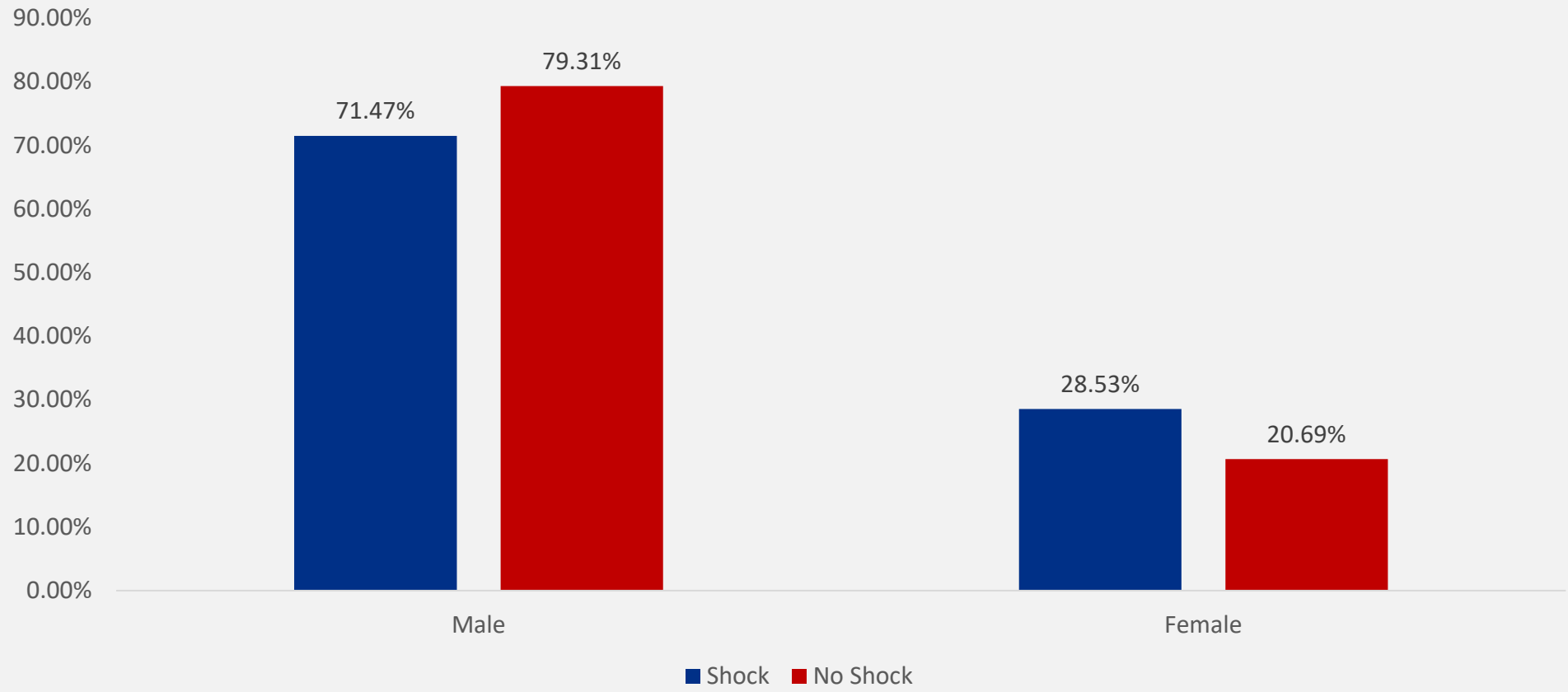
Spinal Cord = 361
Spinal Cord + Shock = 29

**Other includes pedal cyclist, natural/environmental, other transport, cut/pierce, etc.

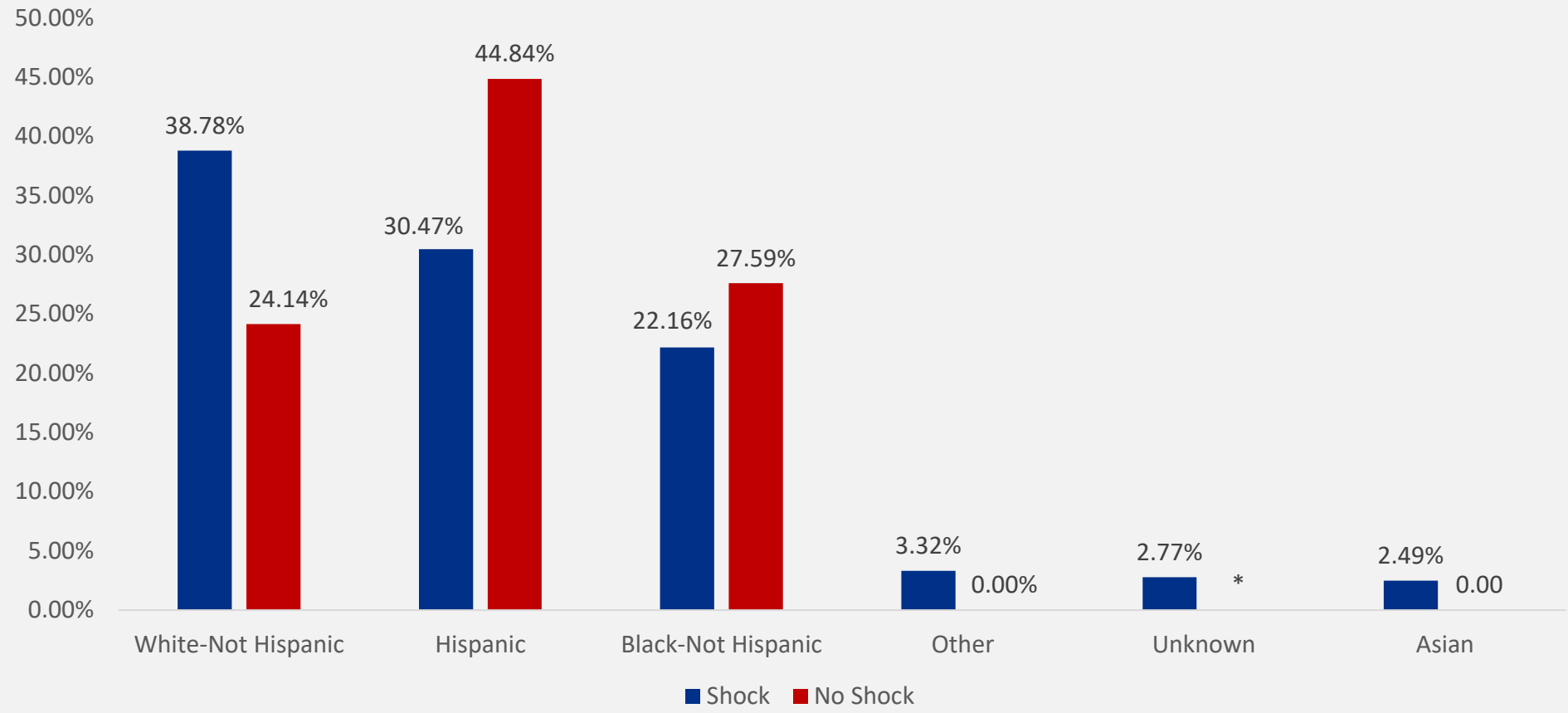
Patient's Age – Trauma Patients with SCI or SCI and Shock



Patient's Gender – Trauma Patients with SCI or SCI and Shock



Patient's Race and Ethnicity – Trauma Patients with SCI or SCI and Shock



Transport Mode – Trauma Patients with SCI or SCI and Shock

Transport Mode	SCI	SCI + Shock
Ground Ambulance	76.73%	75.86%
Private / Public Vehicle / Walk-in	11.63%	0.0%
Helicopter Ambulance	11.08%	20.69%
Fixed-wing Ambulance	*	0.0%
Police	*	*

ED – Trauma Patients with SCI or SCI and Shock

ED	SCI	SCI + Shock
Intensive Care Unit (ICU)	37.40%	41.38%
Floor bed (general admission, non specialty unit bed)	23.27%	*
Operating Room	13.85%	27.59%
Transferred to Another Hospital	10.80%	*
Telemetry / step-down unit (less acuity than ICU)	8.03%	*
Home without services	2.22%	*
Observation unit (unit that provides < 24 hour stays)	2.22%	*
Deceased / Expired	1.66%	17.24%

Hospital Disposition – Trauma Patients with SCI or SCI and Shock

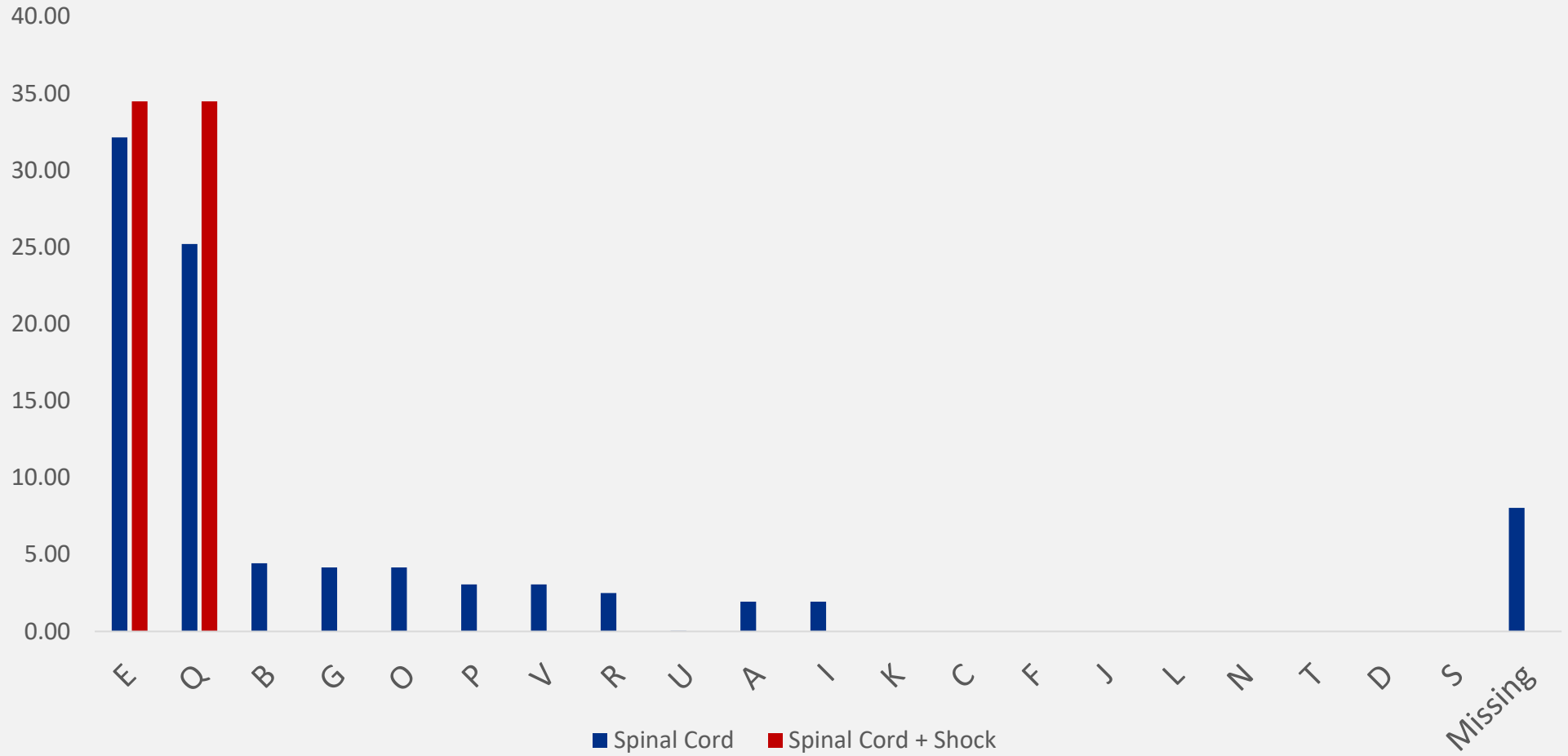
Hospital Disposition	SCI	SCI + Shock
Discharged home or self-care (routine discharge)	49.03%	34.48%
Discharged / Transferred to inpatient rehab or designated unit	21.33%	20.69%
Not Applicable (N/A)**	14.68%	20.69%
Discharged / Transferred home under care of organized home health	4.71%	*
Discharged / Transferred to Skilled Nursing Facility	2.49%	*
Deceased / Expired	1.94%	*
Discharged / Transferred to Long Term Care Hospital	1.94%	*
Discharged / Transferred to court / LE	1.66%	*

**N/A is reported if ED disposition is left against medical advice, deceased, discharged home or self-care, hospice, court/ law enforcement, or inpatient rehab.

Hospital Designation – Trauma Patients with SCI or SCI and Shock

Hospital Designation	SCI	SCI + Shock
Trauma Center Level 1	32.96%	48.28%
Trauma Center Level 2	13.57%	24.14%
Trauma Center Level 3	22.44%	20.69%
Trauma Center Level 4	9.97%	*
Hospital	4.99%	0.0%
Pediatric Center	*	0.0%
Missing	15.79%	0.0%

RAC –
Trauma Patients with SCI or SCI and Shock



Trauma Patients with Pelvic Fractures and Pelvic Fractures with Shock

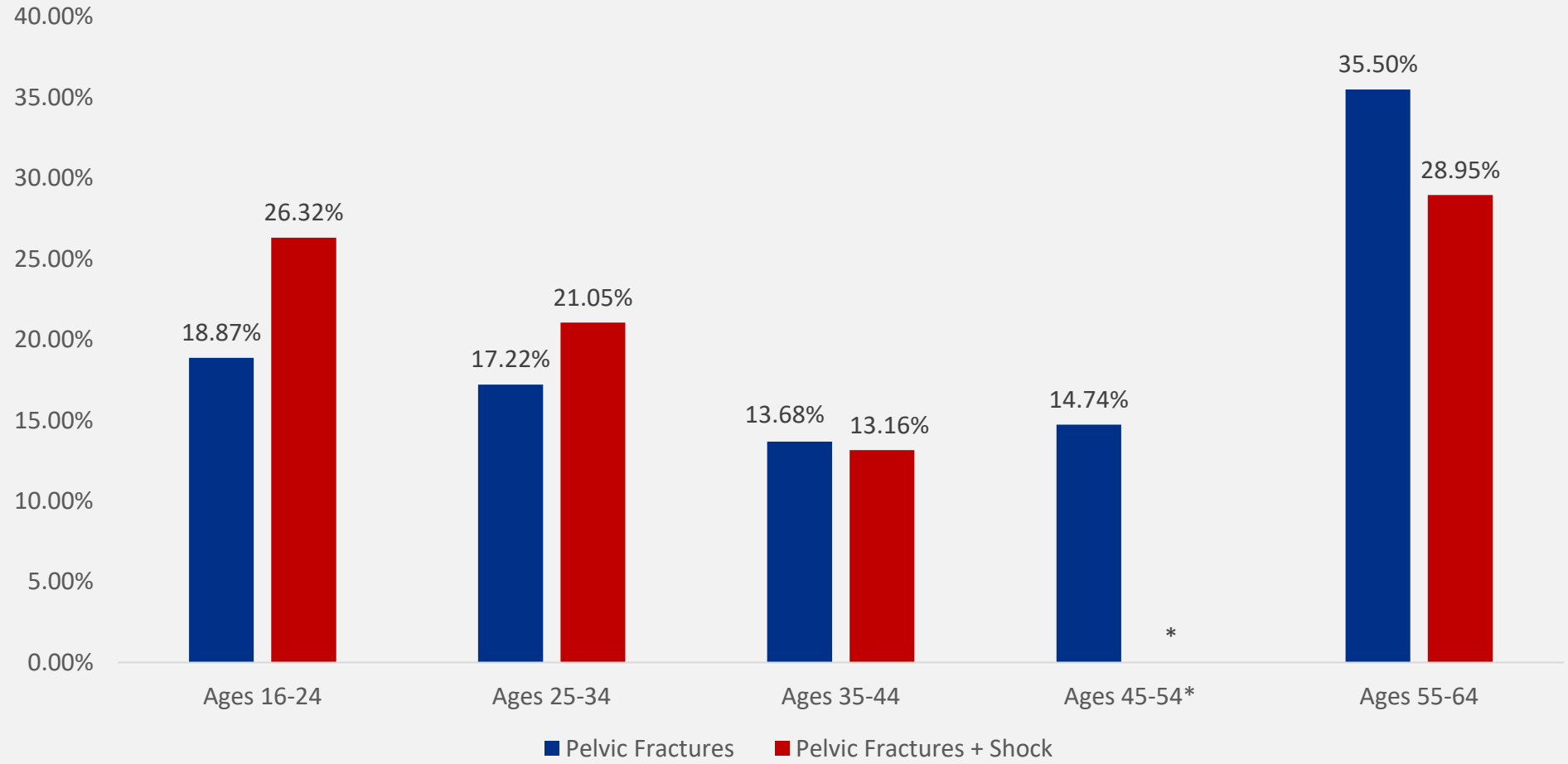
MOI – Trauma Patients with Pelvic Fractures and Pelvic Fractures with Shock

Pelvic Fractures = 848

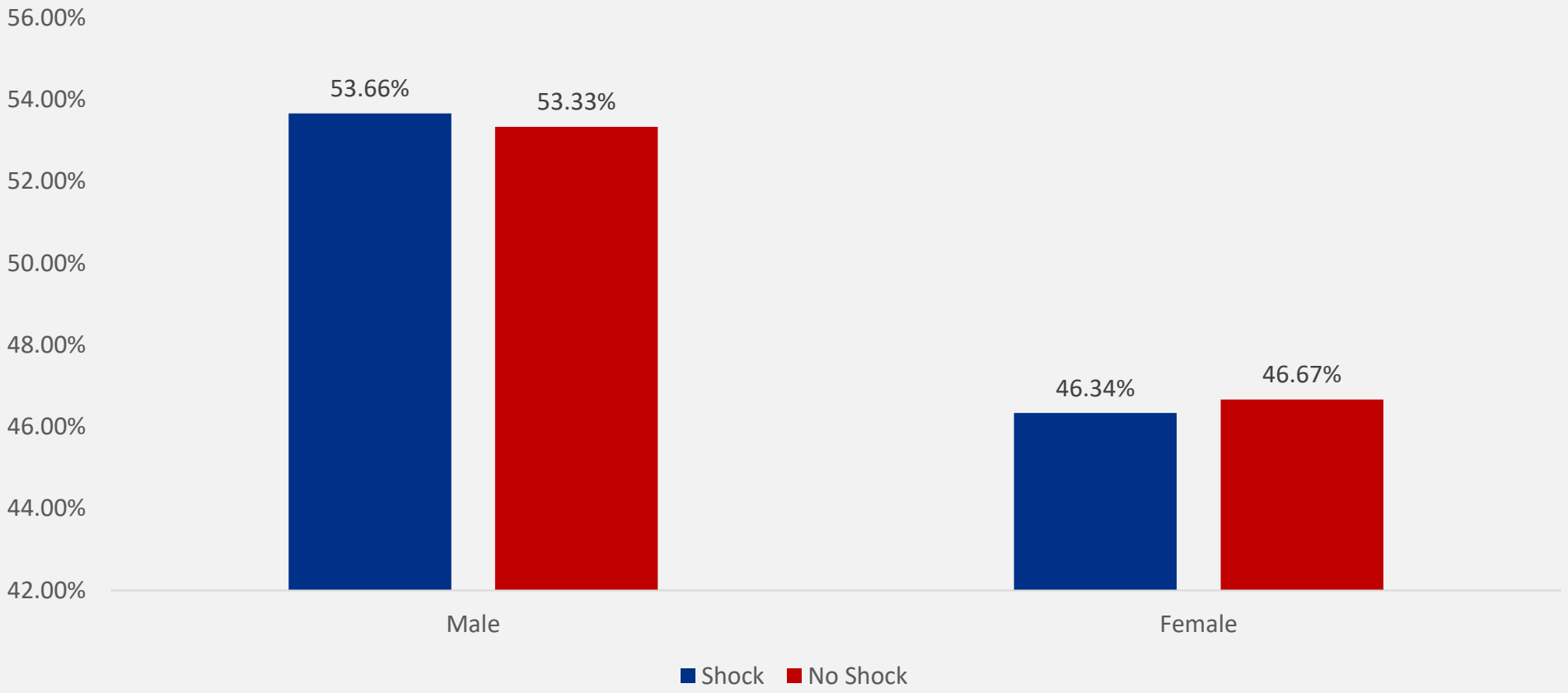
Pelvic Fractures + Shock = 38

MOI	Pelvic Fractures	Pelvic Fractures + Shock
Fall	43.28%	21.05%
MVT - Occupant	22.64%	31.58%
Firearm	10.73%	21.05%
MVT - Pedestrian	4.60%	*
Other Land Transport	3.30%	*
MVT - Motorcyclist	2.83%	*
MV – Non-Traffic	2.83%	*
Struck By / Against	2.59%	*
Pedestrian, Other	1.65%	*

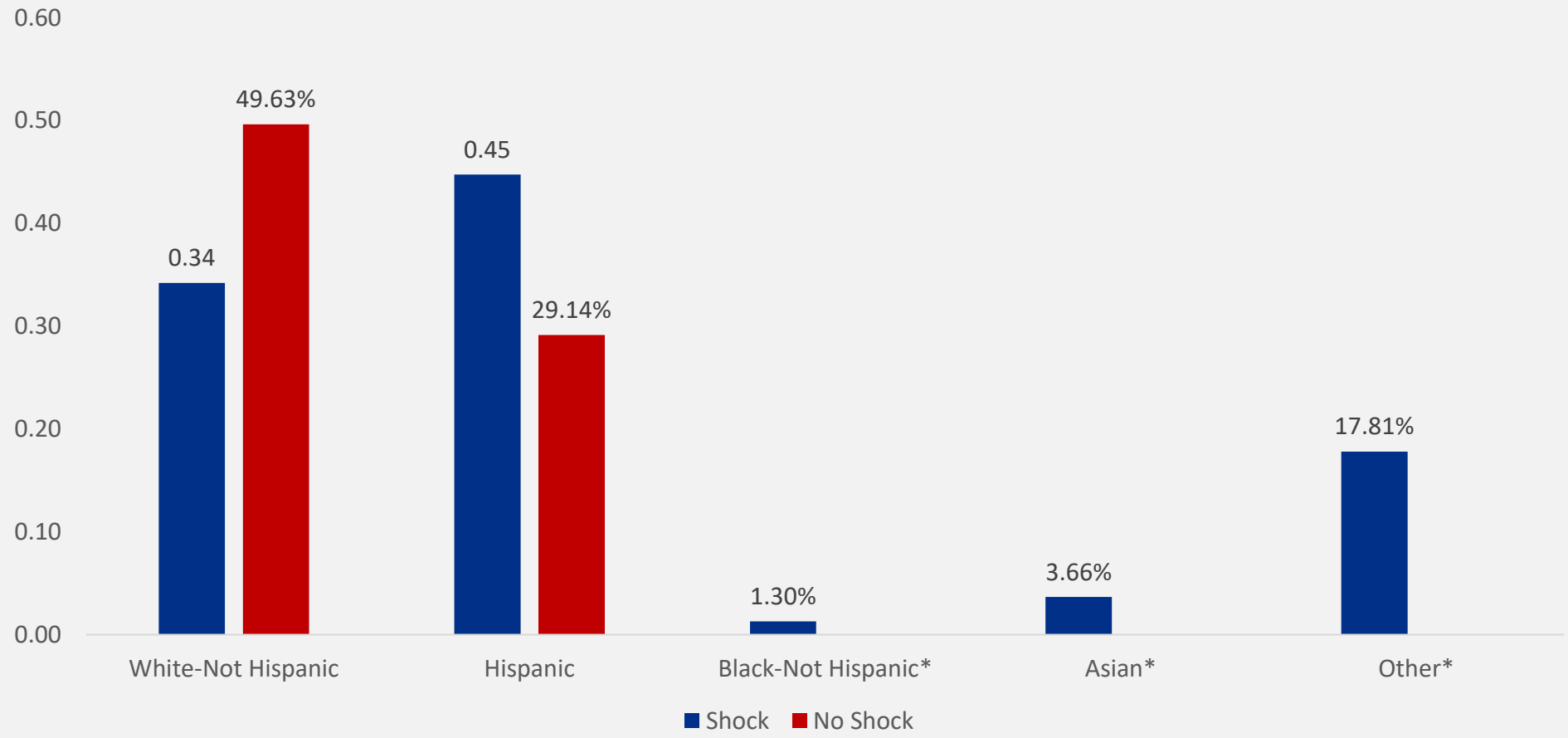
Patient's Age – Trauma Patients with Pelvic Fractures and Pelvic Fractures with Shock



Patient's Gender – Trauma Patients with Pelvic Fractures and Pelvic Fractures with Shock



Patient's Race and Ethnicity – Trauma Patients with Pelvic Fractures and Pelvic Fractures with Shock



Transport – Trauma Patients with Pelvic Fractures and Pelvic Fractures with Shock

Transport	Pelvic Fractures	Pelvic Fractures + Shock
Ground Ambulance	77.48%	77.28%
Private / Public Vehicle / Walk-in	14.74%	14.69%
Helicopter Ambulance	7.08%	7.41%
Other**	0.70%	*

**Other includes police, fixed-wing aircraft, etc.

ED – Trauma Patients with Pelvic Fractures and Pelvic Fractures with Shock

ED	Pelvic Fractures	Pelvic Fractures + Shock
Floor bed (general admission, non specialty unit bed)	46.82%	45.75%
Transferred to Another Hospital	14.03%	*
Intensive Care Unit (ICU)	12.03%	*
Operating Room	10.50%	9.43%
Telemetry / step-down unit (less acuity than ICU)	9.08%	*
Observation unit (unit that provides < 24-hour stays)	3.07%	*
Home without services	1.65%	*
Deceased / Expired	1.30%	*
Not Applicable	1.30%	*
Other	*	40.33%

Hospital Disposition – Trauma Patients with Pelvic Fractures and Pelvic Fractures with Shock

Hospital Disposition	Pelvic Fractures	Pelvic Fractures + Shock
Discharged to home or self-care (routine discharge)	49.65%	48.00%
Not Applicable (N/A)**	17.22%	15.92%
Discharged / Transferred to inpatient rehab or designated unit	12.62%	*
Discharged / Transferred home under care of organized home he	8.14%	*
Discharged / Transferred to Skilled Nursing Facility	6.72%	*
Deceased / Expired	1.42%	*
Discharged / Transferred to court/law enforcement	1.42%	*
Discharged / Transferred to a short-term general hospital for in	1.06%	*
Discharged / Transferred to hospice care	0.71%	*
Other***	1.04%	31.60%

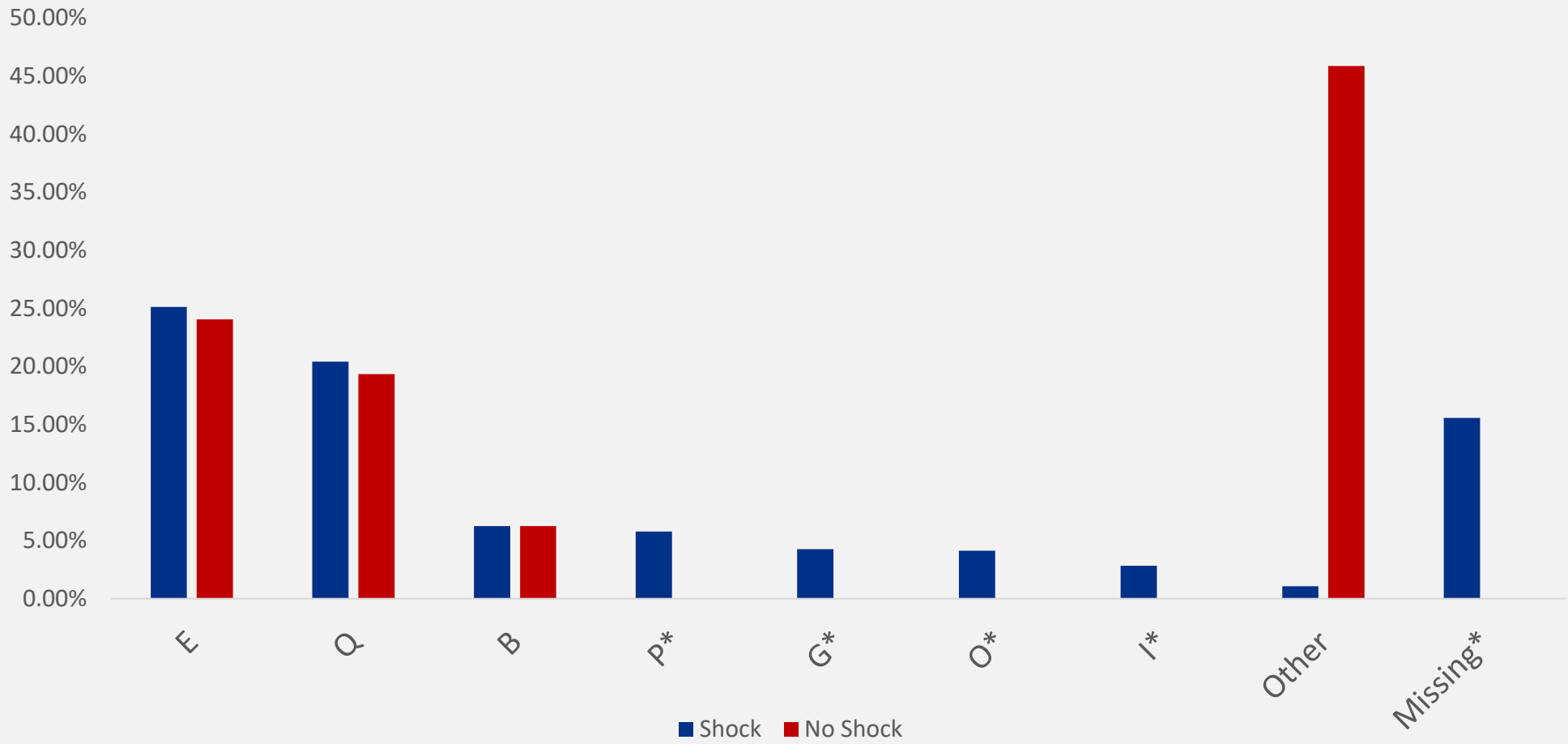
**N/A is reported if ED disposition is left against medical advice, deceased, discharged home or self-care, hospice, court/ law enforcement, or inpatient rehab.

***Other includes when hospital disposition is transfer to hospice, transfer to psychiatric hospital, left against medical advice, etc

Hospital Designation – Trauma Patients with Pelvic Fractures and Pelvic Fractures with Shock

Hospital Designation	Pelvic Fractures	Pelvic Fractures + Shock
Hospital	5.54%	*
Trauma Center Level 1	30.90%	18.42%
Trauma Center Level 2	11.67%	21.05%
Trauma Center Level 3	22.17%	31.58%
Trauma Center Level 4	12.62%	15.79%
Missing	17.10%	*

RAC – Trauma Patients with Pelvic Fractures and Pelvic Fractures with Shock



Resources

EMS & Trauma Registries
Texas Department of State Health Services

- National Trauma Data Bank (NTDB) data dictionary - facs.org/quality-programs/trauma/tqp/center-programs/ntdb/ntds.
- NSW Institute of Trauma and Injury Management - aci.health.nsw.gov.au/get-involved/institute-of-trauma-and-injury-management.
- Coding is based on the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).

Thank you!

Trauma Systems Data Request GETAC Presentation Part 2 (Texas 2021)

November 21, 2022

injury.epi@dshs.texas.gov

GETAC Committee Reports November 2022

Air Medical and Specialty Care Transport Committee

Lynn Lail, RN, Chair

GETAC Committee Reports November 2022

Cardiac Care Committee

James McCarthy, MD, Chair

GETAC Committee Reports November 2022

Disaster Preparedness and Response Committee

Eric Epley, NREMT, Chair

GETAC Committee Reports November 2022

Emergency Medical Services Committee

Eddie Martin, EMT-P, Chair

GETAC Committee Reports November 2022

EMS Education Committee

Macara Trusty, LP, Chair

GETAC Committee Reports November 2022

EMS Medical Directors Committee

Heidi Abraham, MD, FAEMS, Chair

GETAC Committee Reports November 2022

Injury Prevention & Public Education Committee

Mary Ann Contreras, RN, Chair

GETAC Committee Reports November 2022

Pediatric Committee

Belinda Waters, RN, Chair

GETAC Committee Reports November 2022

Stroke Committee

J Neal Rutledge, MD

GETAC Committee Reports November 2022

Trauma Systems Committee

Stephen Flaherty, MD, Chair

Agenda Items

Agenda Item 4

Discussion and possible action on the Trauma Registry Flowchart

Agenda Item 5

Discussion, review, and recommendations for initiatives that instill a culture of safety for responders and the public with a focus on operations and safe driving practices

Agenda Item 6

Trauma Rule Amendments Recommendations – Update

Agenda Item 7

Discussion of Rural Priorities

Agenda Item 8

Discussion and possible actions on initiatives, programs, and potential research that might improve the Trauma and Emergency Healthcare System in Texas

GETAC Stakeholder Reports

GETAC Stakeholder Reports November 2022

Texas EMS, Trauma & Acute Care Foundation (TETAF)

Dinah Welsh, TETAF President/CEO

Texas EMS, Trauma & Acute Care Foundation Update

Dinah Welsh, TETAF President/CEO

Monday, November 21, 2022

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services
A Program of the Texas EMS Trauma & Acute Care Foundation

TETAF Committees

- TETAF Advocacy Committee is among the busiest of TETAF's five committees. This committee is preparing for the upcoming 88th Legislative Session and refining TETAF's legislative priorities.
- TETAF's Governance Committee is preparing for the December 8 TETAF General Assembly meeting and election for the TETAF Board of Directors.

Surveys – Trauma, Stroke, Maternal, and Neonatal

- TETAF submitted comments to the proposed draft changes to Texas Administrative Code (TAC) Rule 157.125, Requirements for Trauma Facility Designation.
- TETAF hired Terri Rowden, BSN, RN, TCRN, as its new survey services senior director. Terri will manage the trauma and stroke service line operations for TETAF and provide expertise and collaboration to ensure quality is maintained in all TETAF and Texas Perinatal Services service lines.

Education

- The TETAF Hospital Data Management Course (HDMC) was held virtually in November. More opportunities for the TETAF HDMC in 2023 will be announced soon.
- *(First official announcement!)* The Texas Perinatal Forum will transition to the Texas Quality Care Forum starting in January 2023. The Texas Quality Care Forum will be monthly and will offer a wider variety of topics that include trauma, stroke, maternal, neonatal, and acute care.
- TETAF continues to offer exclusive, free educational opportunities to our hospital partners via Mighty Networks.

Scan with the camera on your phone to join Mighty Networks or visit www.tetaf-tps.mn.co

Advocacy

- The TETAF Advocacy team is conducting regular planning meetings during the interim to prepare for the 88th Legislative Session.
- TETAF met with leaders at the Texas Department of State Health Services (DSHS) to discuss concerns of potential funding cuts to the trauma system.
- TETAF testified during the Legislative Budget Board's Joint Budget Hearing to review DSHS' Legislative Appropriations Request (LAR).
- TETAF's Legislative Work Group will meet via Zoom every other week throughout the session beginning on January 20, 2023.

Collaboration

- Texas TQIP met virtually on August 22 and will meet in Phoenix during the national TQIP conference on December 11-13.
- TETAF is once again sponsoring the Texas Collaborative for Healthy Mothers and Babies Summit.

GETAC Stakeholder Reports November 2022

EMS for Children (EMSC) State Partnership

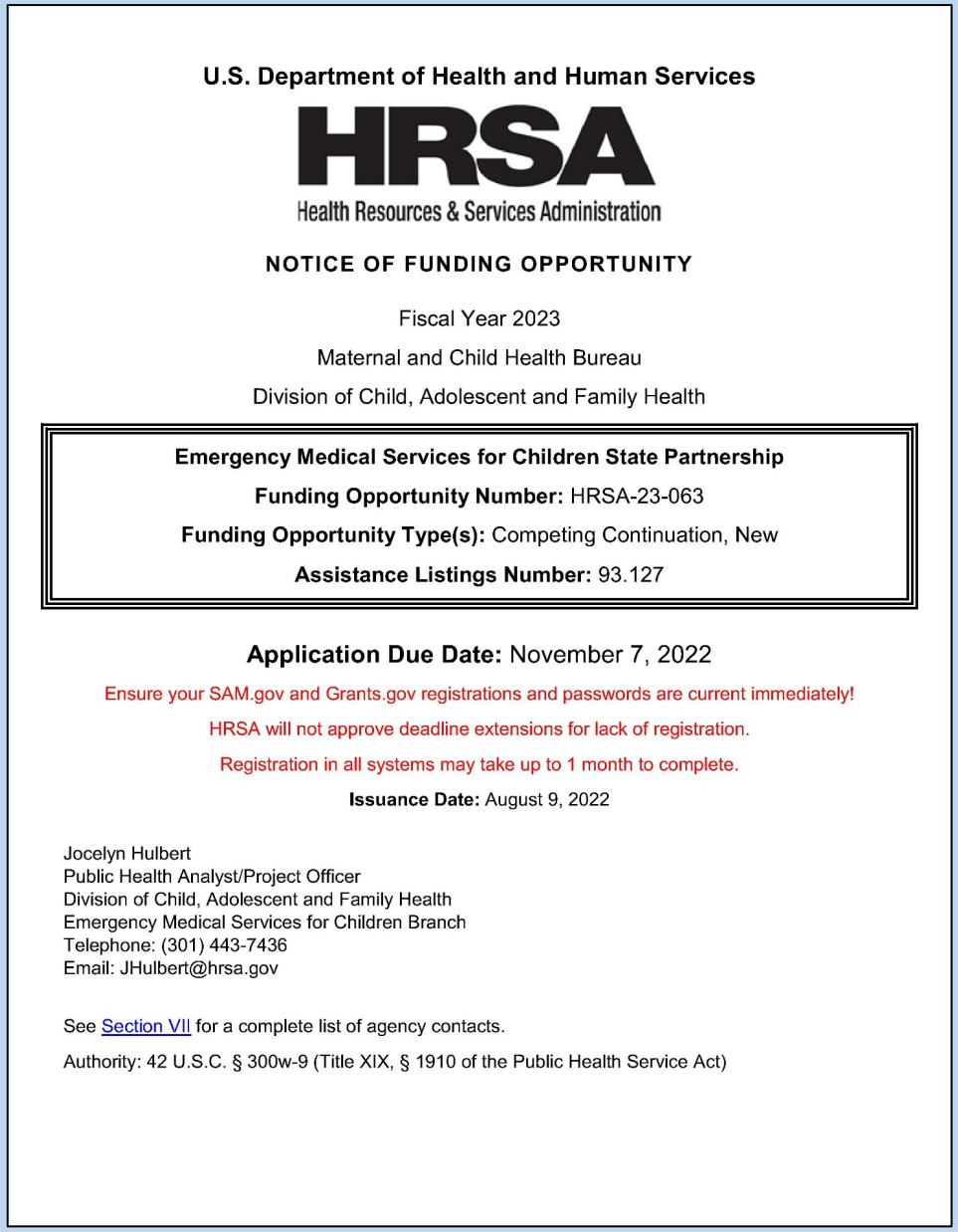
Sam Vance, MHA, LP, Program Manager

EMS for Children State Partnership Update

Governor's EMS and Trauma Advisory Council
November 21, 2022

EMSC Notice of Funding Opportunity

- NOFO Published August 9, 2022
- April 1, 2023 – March 31, 2027
- Emphasis on:
  - Facility Recognition Program
  - EMS Recognition Program
  - Peds Disaster readiness in ED and EMS
  - Family partnership and leadership
- Application Due Date: Nov. 7, 2022



U.S. Department of Health and Human Services

HRSA
Health Resources & Services Administration

NOTICE OF FUNDING OPPORTUNITY

Fiscal Year 2023

Maternal and Child Health Bureau

Division of Child, Adolescent and Family Health

Emergency Medical Services for Children State Partnership

Funding Opportunity Number: HRSA-23-063

Funding Opportunity Type(s): Competing Continuation, New

Assistance Listings Number: 93.127

Application Due Date: November 7, 2022

Ensure your SAM.gov and Grants.gov registrations and passwords are current immediately!

HRSA will not approve deadline extensions for lack of registration.

Registration in all systems may take up to 1 month to complete.

Issuance Date: August 9, 2022

Jocelyn Hulbert
Public Health Analyst/Project Officer
Division of Child, Adolescent and Family Health
Emergency Medical Services for Children Branch
Telephone: (301) 443-7436
Email: JHulbert@hrsa.gov

See Section VII for a complete list of agency contacts.

Authority: 42 U.S.C. § 300w-9 (Title XIX, § 1910 of the Public Health Service Act)

Baylor College of Medicine

EMSC
EMS FOR CHILDREN STATE PARTNERSHIP

ASPR Pediatric Disaster Care Centers of Excellence

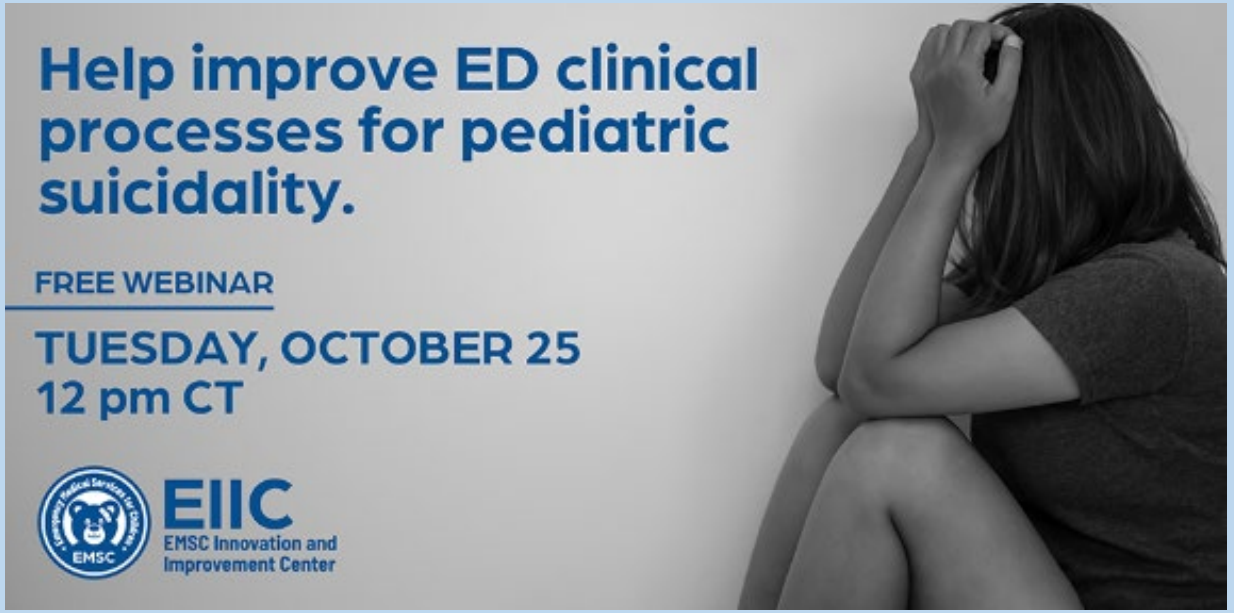
- Developing a coordinated pediatric disaster care capability for pediatric patient care in disasters;
- Texas Children's Hospital

Baylor College of Medicine

EMSC
EMS FOR CHILDREN STATE PARTNERSHIP

ED STOP (Screening and Treating Options for Pediatric) Suicide Collaborative

- February 2023 – November 2023
- Eight, one-hour monthly sessions
- Work with national experts
- Earn CEUs, CEs, or MOC Part 4 credits



Baylor College of Medicine

EMSC EMS FOR CHILDREN STATE PARTNERSHIP

2023 EMSC Survey

- HRSA conducting EMS Surveys yearly
- Will launch January 4, 2023
- PPRP Survey - 2024

GETAC Stakeholder Reports November 2022

Texas Cardiovascular Disease and Stroke Council

J Neal Rutledge, MD

GETAC Stakeholder Reports November 2022

Texas Cardiac Arrest Registry to Enhance Survival (TX CARES)

Micah Panczyk

Texas-CARES

Presentation to GETAC Council

November 21, 2022

TX CARES

CARES Summary Report

Demographic and Survival Characteristics of OHCA

Non-Traumatic Etiology | Arrest Witness Status: All | Date of Arrest: From 01/01/2022 Through 06/30/2022

Data	State (All Agencies) N=5410	National N=73232
Age	**N=5410**	**N=73222**
Mean	61.9	62.4
Median	65.0	65.0
Gender (%)	**N=5408**	**N=73228**
Female	2112 (39.1)	27569 (37.6)
Male	3295 (60.9)	45638 (62.3)
Race (%)	**N=5410**	**N=73228**
American-Indian/Alaskan	8 (0.1)	261 (0.4)
Asian	142 (2.6)	1831 (2.5)
Black/African-American	1251 (23.1)	15934 (21.8)
Hispanic/Latino	1207 (22.3)	6070 (8.3)
Native Hawaiian/Pacific Islander	11 (0.2)	303 (0.4)
White	2575 (47.6)	37017 (50.6)
Multi-racial	23 (0.4)	308 (0.4)
Unknown	193 (3.6)	11504 (15.7)
Location of Arrest (%)	**N=5410**	**N=73231**
Home/Residence	3776 (69.8)	53307 (72.8)
Nursing Home	702 (13.0)	7517(10.3)
Public Setting	932 (17.2)	12407 (16.9)
Arrest witnessed (%)	**N=5410**	**N=73225**
Bystander Witnessed	2006 (37.1)	27418 (37.4)
Witnessed by 911 Responder	635 (11.7)	8504 (11.6)
Unwitnessed	2769 (51.2)	37303 (50.9)
Who Initiated CPR? (%)	**N=5410**	**N=73157**
Not Applicable	7 (0.1)	43 (0.1)
Bystander	2450 (45.3)	29574 (40.4)
First Responder	1505 (27.8)	23663 (32.3)
Emergency Medical Services (EMS)	1448 (26.8)	19877 (27.2)
Was an AED applied prior to EMS arrival? (%)	**N=5410**	**N=73225**
Yes	1728 (31.9)	21529 (29.4)
No	3682 (68.1)	51696 (70.6)

TX★CARES

CARES Summary Report

Demographic and Survival Characteristics of OHCA

Non-Traumatic Etiology | Arrest Witness Status: All | Date of Arrest: From 01/01/2022 Through 06/30/2022

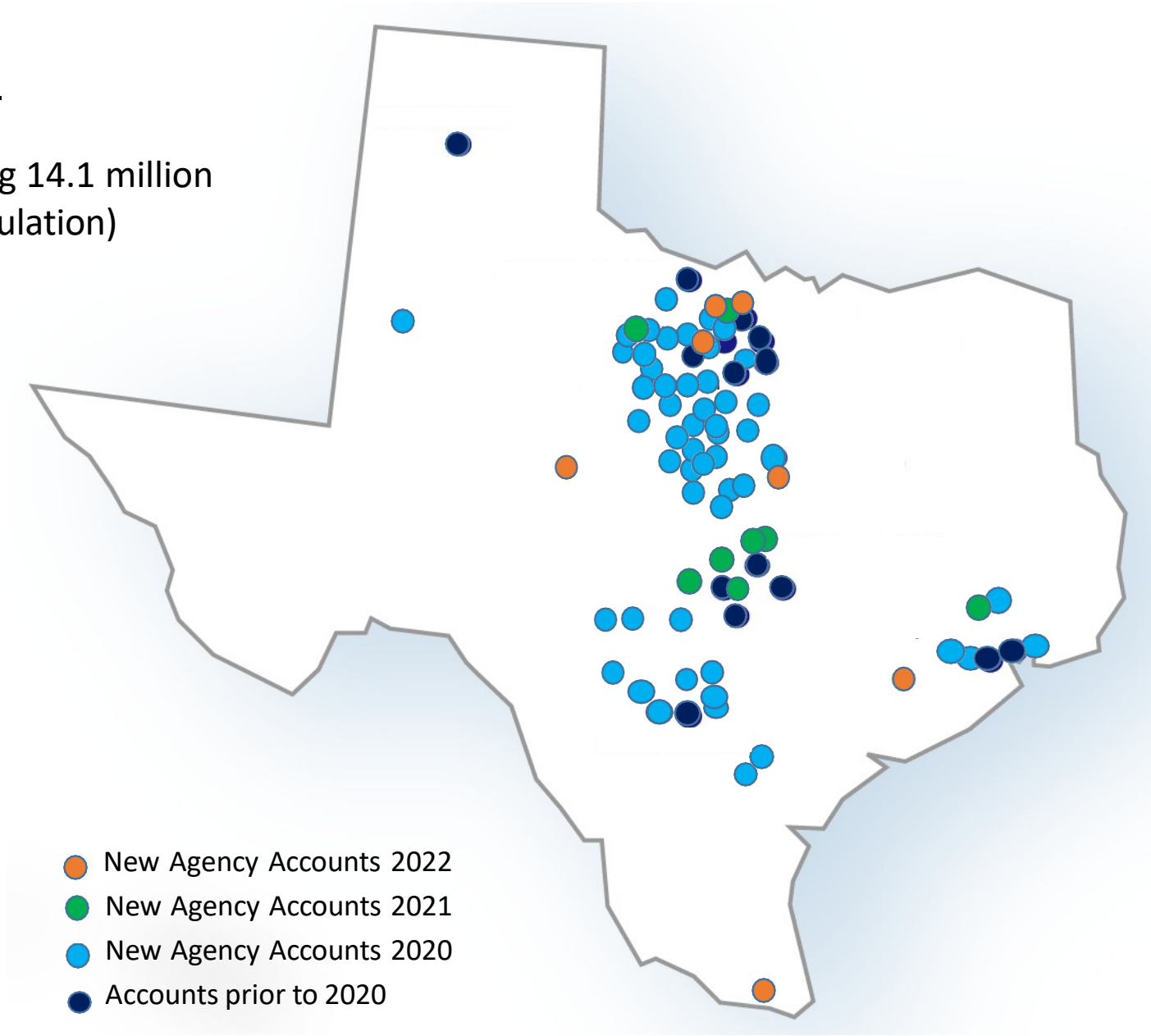
Who first applied automated external defibrillator? (%)	**N=1722**	**N=21501**
Bystander	479 (27.8)	4446 (20.7)
First Responder	1243 (72.2)	17055 (79.3)
Who first defibrillated the patient?* (%)	**N=5410**	**N=73131**
Not Applicable	3960 (73.2)	51972 (71.1)
Bystander	108 (2.0)	1111 (1.5)
First Responder	284 (5.2)	4539 (6.2)
Responding EMS Personnel	1058 (19.6)	15509 (21.2)
First Arrest Rhythm (%)	**N=5404**	**N=73193**
Vfib/Vtach/Unknown Shockable Rhythm	827 (15.3)	12299 (16.8)
Asystole	2818 (52.1)	38784 (53.0)
Idioventricular/PEA	1517 (28.1)	16148 (22.1)
Unknown Unshockable Rhythm	242 (4.5)	5962 (8.1)
Sustained ROSC (%)	**N=5409**	**N=73004**
Yes	1363 (25.2)	19452 (26.6)
No	4046 (74.8)	53552 (73.4)
Was hypothermia care provided in the field? (%)	**N=5410**	**N=73217**
Yes	54 (1.0)	1918 (2.6)
No	5356 (99.0)	71299 (97.4)
Pre-hospital Outcome (%)	**N=5410**	**N=73232**
Pronounced in the Field	2312 (42.7)	31800 (43.4)
Pronounced in ED	768 (14.2)	6943 (9.5)
Ongoing Resuscitation in ED	2330 (43.1)	34489 (47.1)
Overall Survival (%)	**N=5410**	**N=73232**
Overall Survival to Hospital Admission	1180 (21.8)	15818 (21.6)
Overall Survival to Hospital Discharge	472 (8.7)	5782 (7.9)
With Good or Moderate Cerebral Performance	355 (6.6)	4598 (6.3)
Missing hospital outcome	282	4263
Utstein[1] Survival (%)	**N=489**	**N=7315**
	28.6%	26.0%
Utstein Bystander[2] Survival (%)	**N=292**	**N=4186**
	31.2%	29.5%

TX★CARES

Agency Accounts

Coverage

81 agency accounts covering 14.1 million people (48% statewide population)



TX CARES

QI Research: Rural vs. Urban Populations 2014-2020

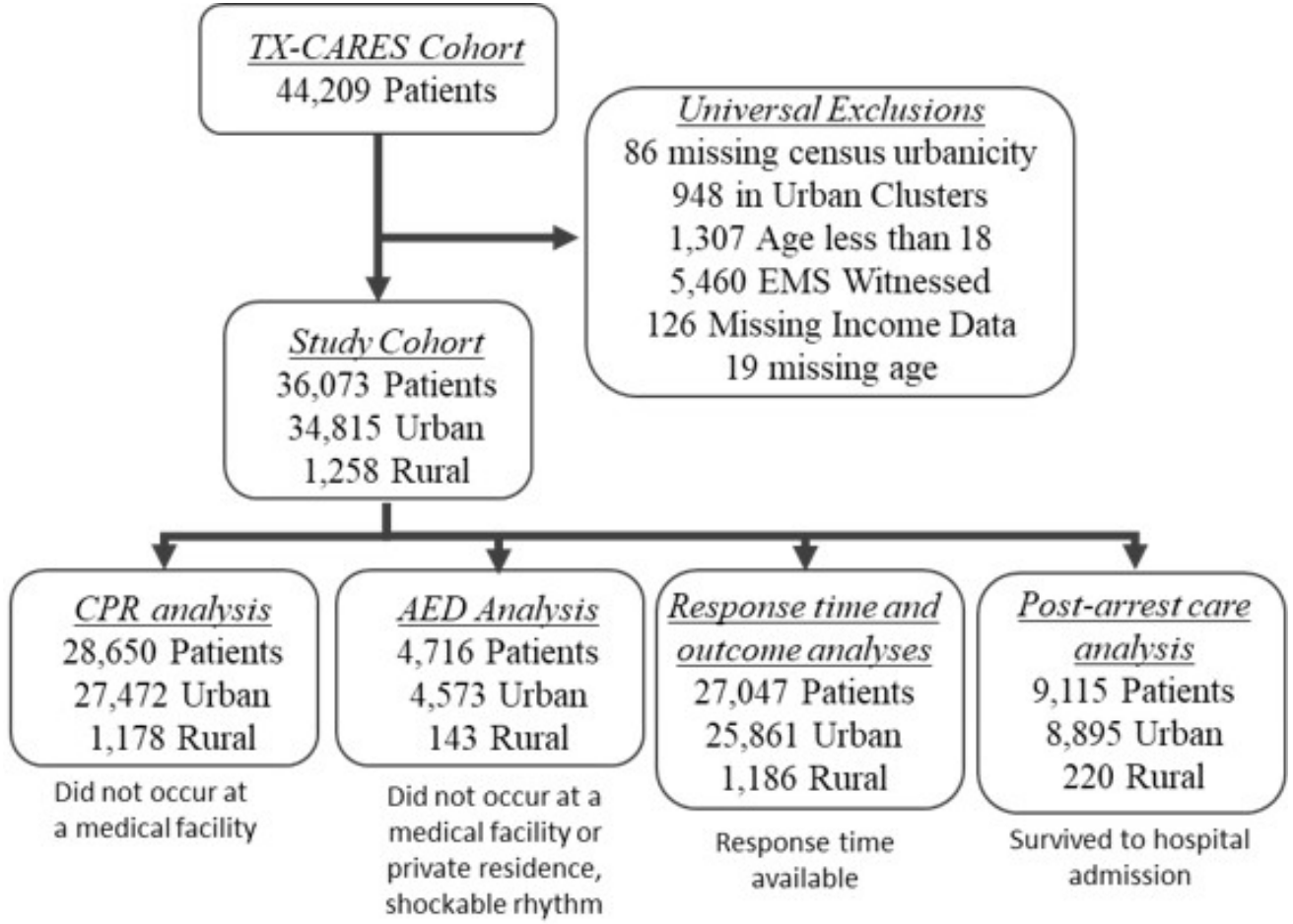


Figure 1. Flowchart of inclusion in different analyses

TX★CARES

Patient & Event Characteristics

Table 1. Texas CARES Patient Characteristics Stratified by Urbanicity from 2014-2020

	Rural N= 1,258	**Urban N= 34,815**
Age[1]	66 (55-76)	65 (54-77)
Male[2]	810 (64.5%)	21,238 (61.0%)
Race[2]		
White	1,010 (80.3%)	14,481 (41.6%)
Black	63 (5.0%)	8,945 (25.7%)
Hispanic	110 (8.7%)	8,223 (23.6%)
Low Income[2]	1,151 (91.5%)	17,164 (49.3%)
Location of Arrest[2]		
Home/Residence	1,035 (82.3%)	22,899 (65.8%)
Public	143 (11.4%)	4,573 (13.1%)
Other	80 (6.4%)	7,343 (21.1%)
Bystander Witnessed[2]	663 (52.7%)	15,016 (43.3%)
Initial Shockable Rhythm[2]	233 (18.5%)	5,883 (16.9%)
Survived to Hospital Admission[2]	220 (17.5%_	8,895 (25.5%)
Response time-[1]	11.1 (7.3-15.1) min	7.2 (5.5-9.6) min

1.Reported as median (IQR)
2.Reported as N (%)

TX★CARES

Care & Outcomes

Table 2. Provision of care and outcomes, stratified by urbanicity

	Rural N=1,202 N (%)	Urban N=28,288 N(%)	OR (95% CI)	aOR (95% CI)	P value
Prehospital Care					
Bystander CPR	582/1,178 (49.4%)	11,198/27,472 (40.6%)	1.4 (1.3-1.6)	1.3 (1.1-1.5)	<0.01
Bystander AED	10/143 (7.0%)	446/4,573 (9.8%)	0.7 (0.4-1.3)	0.6 (0.3-1.3)	0.185
Response time < 10 min	501/1,186 (38.9%)	19,975/25,861 (77.2%)	0.2 (0.2-0.2)	0.1 (0.1-0.2)	<0.01
Post-Arrest Care					
PCI	25/220 (11.4%)	492/8,895 (6.1%)	2.2 (1.4-3.4)	1.6 (0.9-2.7)	0.097
TTM	84/220 (38.2%)	2,885/8,895 (32.4%)	1.3 (0.98-1.7)	0.95 (0.7-1.4)	0.8
Outcomes					
Survival to Hospital Discharge	64/1,186 (5.4%)	2,282/25,861 (8.8%)	0.6 (0.5-0.8)	0.5 (0.4-0.7)	<0.01
Survival with CPC score of 1 or 2	54/1,186 (4.6%)	1,463/25,861 (5.7%)	0.8 (0.6-1.05)	0.7 (0.5-0.97)	0.03

TX★CARES

Event factors impacting cardiac arrest survival

	Survival to hospital admission			Survival to hospital discharge			1 year survival		
	OR	95% CI	*p*	OR	95% CI	*p*	OR	95% CI	*p*
Urban vs. rural	1.84	1.43– 2.36	< 0.001	1.51	1.08– 2.11	0.017	1.58	1.11– 2.26	0.012
EMS response time ≥ 10 min vs < 10 min	0.69	0.55– 0.87	0.002	0.61	0.45– 0.83	0.002	0.57	0.41– 0.79	< 0.001
Age (one additional year)	0.97	0.97 –0.98	< 0.001	0.96	0.95– 0.97	< 0.001	0.96	0.95– 0.97	< 0.001
Gender, male vs. female	1.94	1.51 –2.51	< 0.001	3.15	2.10– 4.72	< 0.001	3.02	1.98– 4.61	< 0.001
EMS physician attendance vs. no EMS-physician attendance	2.63	1.86 –3.74	< 0.001	1.37	0.87– 2.16	0.17	1.39	0.86– 2.24	0.18
Witnessed arrest vs. non-witnessed arrest	4.12	3.12– 5.44	< 0.001	7.23	4.20–12.43	< 0.001	6.63	3.78–11.61	< 0.001
OHCA location in public vs. home	1.20	1.10– 1.30	< 0.001	1.31	1.20– 1.43	< 0.001	1.27	1.16– 1.39	< 0.001
Bystander CPR vs. no bystander CPR	1.98	1.52– 2.58	< 0.001	3.05	2.00– 4.65	< 0.001	2.84	1.83– 4.39	< 0.001
Shockable vs. non-shockable rhythm	8.25	6.21– 10.95	< 0.001	25.74	15.71–42.18	< 0.001	39.52	21.14–73.87	< 0.001
Cardiac vs. medical cause for cardiac arrest	1.31	0.92– 1.88	0.14	0.34	0.18–0.63	< 0.001	0.16	0.07– 0.40	< 0.001

Odds ratios (OR) in univariable analysis of key factors associated with survival to hospital admission, survival to hospital discharge and 1 year survival in out-of-hospital cardiac arrest (OHCA) (n = 1138). *CI* confidence interval, *CPR* cardiopulmonary resuscitation, *EMS* emergency medical services, *OR* odds ratio

Mathiesen, W.T., Bjørshol, C.A., Kvaløy, J.T. *et al.* Effects of modifiable prehospital factors on survival after out-of-hospital cardiac arrest in rural versus urban areas. *Crit Care* **22**, 99 (2018). https://doi.org/10.1186/s13054-018-2017-x

Texas-CARES Symposium

State-of-the-Art Cardiac Resuscitation: From BLS to ECMO To Post-Arrest Care

- November 11 at McGovern Medical School, UTHealth-Houston
- 110 attendees
- Topics included:
  - Video in Telecommunicator CPR
  - High-Performance CPR
  - Esmolol and Shock Refractory VF
  - Double-sequential defibrillation
  - Prehospital ECMO
  - Point-of-Care Ultrasound
  - TTM
  - Post-Arrest Catheterization

TX★CARES

For more information, please contact

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GETAC Stakeholder Reports November 2022

Texas Suicide Prevention Coalition

Christine Reeves

Texas Suicide Prevention Council

- Since the local coalition leaders have been meeting, information sharing is higher than it has ever been across the State. The meetings are pulling our State closer together for suicide prevention.
- Focus areas remain as youth (in general), LGTBQ+ community, and the Armed Forces (active & retired). New areas such as workplace and healthcare workers is rising.
- The 2023 Texas Suicide Prevention Symposium is planned for mid-June in New Braunfels. More information to come.

GETAC Stakeholder Reports November 2022

Stop the Bleed Texas Coalition

Christine Reeves

Stop the Bleed Texas Coalition

- Ms. Reeves was one of 31 people chosen from across the Nation to serve on the ACS STB Version 3 Workgroup. Dr. Lillian Liao was also chosen to serve. Feel free to forward any suggestions their way.
- Our STB TX Coalition will take time off for the holidays and not meet again until after the first of year, so be on the lookout for the invite.
- Contact creeves@centraltexasrac.org to get added to the list & invite or to be removed.

GETAC Stakeholder Reports November 2022

Texas Wristband Project

Christine Reeves

Texas EMS Wristband Project

- Texas EMS Wristband Project Steering Workgroup was formed at the August GETAC Council meeting as a joint effort between the Disaster and EMS Committees.
- The Steering Workgroup has met 3 times. The meetings are open to anyone in our emergency healthcare community. If you are interested in participating let Eric Epley, Eddie Martin, or Christine Reeves know.
- The Steering Workgroup is the place where succusses, concerns, suggestions, changes, etc. can be brought for discussion, action, and consensus.

Goal: To have all patients that ride in an ambulance get a Texas EMS Wristband. The number is recorded by the EMS agencies and hospitals involved with the treatment of the patient for that event into their electronic medical records systems. Preferably in a field that can be queried.

Texas EMS Wristband Project – cont'd

The Steering Workgroup agreed on some basic principles:

- ✓ The number will be formatted as TX – first letter of vendor name – 6-digit alpha numeric characters.
- ✓ It must have a barcode and be human readable.
- ✓ Changing name back to **Texas EMS Wristband**, since the patients are related/involved with EMS.
- ✓ It is anticipated that Texas may have two levels of wristbands that may be chosen by the RAC and its EMS partners.

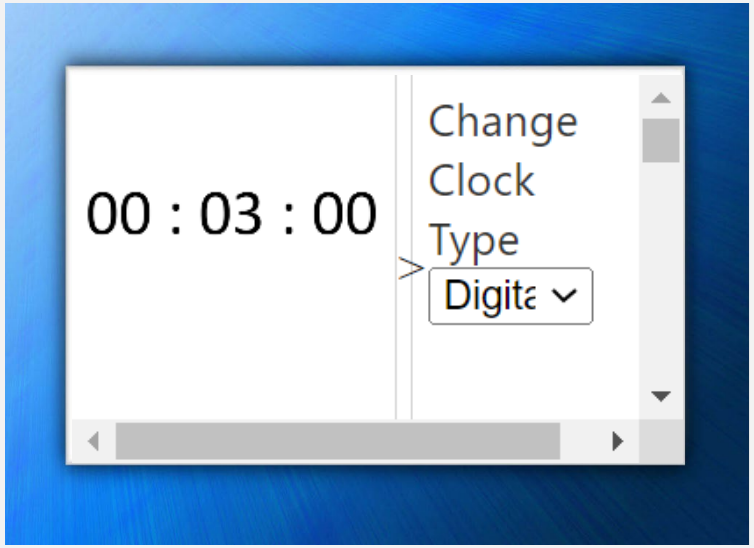
Next Steps: The Steering Workgroup will be developing a one-pager about the project, as well as standardized training materials.

General Public Comment

Three minutes is the allocated allotment of time for public comment.

Please state the following when asking questions or making comments:

- Your name
- Organization you represent
- Agenda item you would like to address.



Announcements

Next Council Meeting Dates

- March 6-9, 2023
- June 6-9, 2023
- August 14-18, 2023
- November 19-22, 2023

Adjournment

Thank you!