TEXAS
Health and Human Services

Texas Department of State Health Services

Governor's EMS and Trauma Advisory Council

Friday, March 13, 2026
8:00 AM (CDT)

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

1. Call to Order

Governor's EMS and Trauma Advisory Council Meeting

FY26 – 2nd Quarter

TEXAS Health and Human Services

Texas Department of State Health Services

This meeting is being conducted live and virtually through Microsoft Teams.

DoubleTree by Hilton Austin

6505 N Interstate 35

Austin, TX 78752

Virtual Rules of Participation

Rules of Participation

- The Chat section is for producers to provide technical assistance. ***Please do not use this feature for general discussion, questions, or comments, as this could result in a violation of the Texas Open Meetings Act.***
- The use of artificial intelligence (AI) bots is prohibited in this meeting. In accordance with HHS policy, the use of Artificial Intelligence, also known as “AI” Notetakers, is expressly prohibited. Producers will not admit a ‘bot’ or other autonomous agent into the meeting. If a ‘bot’ should inadvertently gain entrance, it will be removed from the meeting by one of our producers.

Rules of Participation

- **Council:** Please have your camera on during today's meeting. When speaking or making a motion, please state your name for the meeting record.
- **Committee members:** Please have your camera on and state your name when speaking.
- **All online participants:** Please sign into the chat with your name and entity you represent and *mute your microphone* unless speaking. Except for GETAC Council members, all participants should have cameras turned off and mics muted unless speaking.

2. Roll Call

Council Members attending virtually: Please have your camera on during today's meeting.

Council Members in the room: Please remember to speak directly into the microphone so that online participants can hear your comments.

Please note that the meetings are live and recorded on TEAMS.

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3. Governor's EMS and Trauma Advisory Council 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.

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David Firenza, RN

GETAC Pediatric Committee Member
2025-2026

David was also an advanced educator for the American Heart Association, teaching Cardiac, Pediatric, and Stroke life support courses and helping to shape the next generation of healthcare professionals.

April 1, 1957 - February 12, 2026

4. Approval of Minutes

Review and Approval of Minutes

- October 28, 2025
- November 24, 2025

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5. Chair Announcements

- **Alan Tyroch, MD, GETAC Chair**

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6. State Reports

- Center for Health Emergency Preparedness and Response (CHEPR)
- EMS/Trauma Systems Section (EMS/TS)
- EMS & Trauma Registries (EMSTR), Injury Prevention Unit

6.a. Center for Health Emergency Preparedness and Response (CHEPR)

DSHS World Cup Activities

March 13, 2026

Michelle Petraitis, Director,
DSHS Response and Recovery Unit

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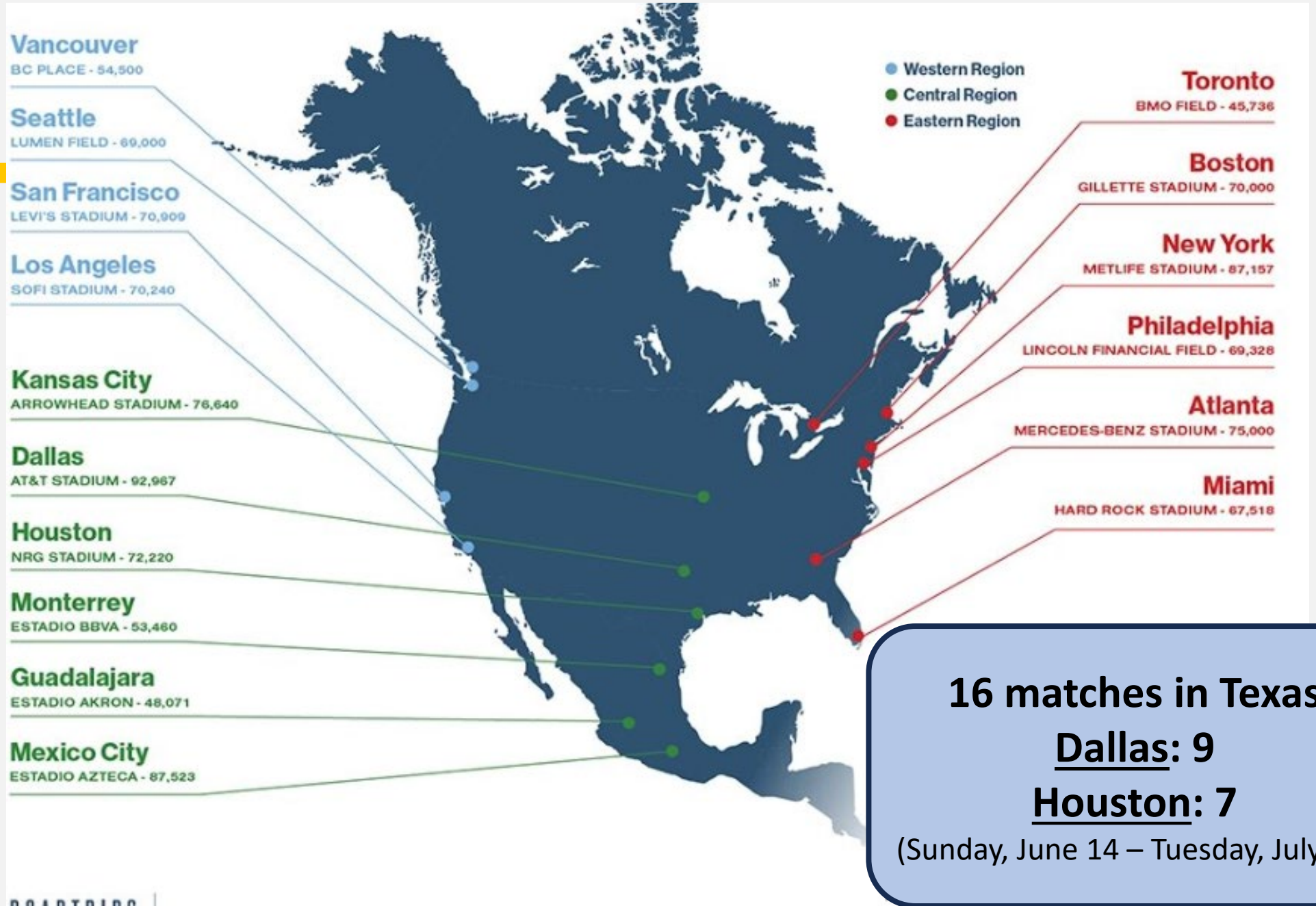
Outline

- FIFA World Cup Timeline
- FIFA World Cup Teams
- Match Schedules
- DSHS Preparedness and Response Activities
- DSHS Current and Future Activities



16 matches in Texas

<u>Dallas</u>: 9

<u>Houston</u>: 7

(Sunday, June 14 – Tuesday, July 14)

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FIFA World Cup 2026 Timeline

- **December 5th**: "Draw Date" Lottery process to assign teams to match play groups.
  - Which teams will be playing Group Play matches
- **January/February**: 48 Team Base camp (TBCs) locations released (some in Texas)
- **April**: Final 6 teams qualify
- **May/June**: Teams begin arriving at Team Base Camps (TBCs)
- **June 11th**: 1st match of tournament (Mexico City)
- **June 12th**: 1st match in US (Los Angeles)
- **June 14th**: 1st matches in Texas (Dallas & Houston)
- **July 4th**: Final match in Houston
- **July 14th**: Final match in Texas (Dallas)
- **July 19th**: Championship (New York City)

39 days from Opening Match to Final Match

30 days in Texas

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FIFA World Cup Teams

- **48 Teams** – First time in World Cup history
- **42 Teams Already Qualified (as of February 2026)**
  - United States, Mexico, Canada, Algeria, Argentina, Australia, Austria, Belgium, Brazil, Cabo Verde, Colombia, Croatia, Curaçao, Côte d'Ivoire, Ecuador, Egypt, England, France, Germany, Ghana, Haiti, Iran, Japan, Jordan, South Korea, Morocco, Netherlands, New Zealand, Norway, Panama, Paraguay, Portugal, Qatar, Saudi Arabia, Scotland, Senegal, South Africa, Spain, Switzerland, Tunisia, Uruguay, Uzbekistan
- **Of the 10 teams expected to draw large crowds, Texas will see 5**: Argentina, England, Portugal, the Netherlands, and Germany
- **Texas Base Camps – only ONE – Austin** – however, other teams could be based in Dallas, Houston or San Antonio in later rounds
  - Team: Saudi Arabia
  - Hotel: Four Seasons Hotel Austin
  - Stadium: Austin FC Stadium (Q2 Stadium)

Houston Schedule (DSHS PHR 6/5S)

7 matches at Houston Stadium (aka NRG Stadium)

Group Play	Playoffs
June 14 (Germany vs. Curacao)	June 29 (Brazil/Morocco/ Scotland/Haiti **vs.** Netherlands/Japan/Tunisia/**Ukraine** /Sweden/Poland/Albania)
June 17 (**Portugal** vs. COD, Jamaica, New Caledonia)	July 4 (**Mexico**/South Korea /South Africa/Denmark/North Macedonia/Czechia/Canada/Switzerland /Qatar/Italy/Northern Ireland/Wales/Bosnia **vs.** Brazil/Morocco/Scotland/Haiti/ Netherlands/Japan/Tunisia/**Ukraine**/ Sweden/ Poland/Albania)
June 20 (Netherlands vs. Albania/Poland/Sweden/**Ukraine**)	
June 23 (**Portugal** vs. Uzbekistan)	
June 26 (Cabo Verde vs. Saudia Arabia)	

Dallas Schedule (DSHS PHR 2/3)

9 matches at Dallas Stadium (aka AT&T Stadium)

Group Play	Playoffs
June 14 (Netherlands vs. Japan)	June 30 – Germany/Ecuador/Ivory Coast/Curacao **vs.** France/Senegal/Norway/Iraq/Suriname/Boliva
June 17 (England vs. Croatia)	July 3 – **USA**/Paraguay/Australia/Slovakia/ Kosovo/Turkey/Romania **vs.** Belgium/**Iran**/Egypt/New Zealand
June 22 (**Argentina** vs. Austria)	July 6 – **Portugal**/Colombia/Uzbekistan/DR Congo/New Caledonia/Jamaica /England/Croatia/Panama/Ghana **vs.** Spain/Uruguay/Saudi/Cape Verde/**Argentina**/Austria/Algeria/Jordan
June 25 (Japan **vs.** Albania/Poland/ Sweden/**Ukraine**)	July 14 – Semi Finals
June 27 (Jordan vs. **Argentina**)	

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DSHS Preparedness & Response Activities

- Identified 9 Lines of Effort in support of World Cup planning
- DSHS planning activities
  - Gain and maintain situational awareness regarding tournament activities and of ESF-8 partner activities
  - Establish a common operating picture
  - Facilitate ESF-8 working groups with partners (Regional, Central Office, Fed/State partners)
  - Identify gaps and anticipated support requirements
  - Identify threats and potential responses
- ESF-8 partners continue to conduct regional training and exercises covering a range of public health threat responses
- DSHS participating in TDEM World Cup planning meetings

DSHS Lines of Effort

- LOE 1: Assess Public Health/Medical Needs
- LOE 2: Conduct Health Surveillance
- LOE 3: Prepare for Medical Surge Due to a Disaster
- LOE 4: Support Patient Care and Movement During a Disaster
- LOE 5 Ensure Food Safety and Defense
- LOE 6: Provide Guidance on Potable Water, Wastewater, and Solid Waste Disposal
- LOE 7: Provide Public Health and Medical Information
- LOE 8: All Hazards Public Health and Medical Consultation, Technical Assistance, and Support
- LOE 9: Fatality Management

DSHS Preparedness & Response Activities

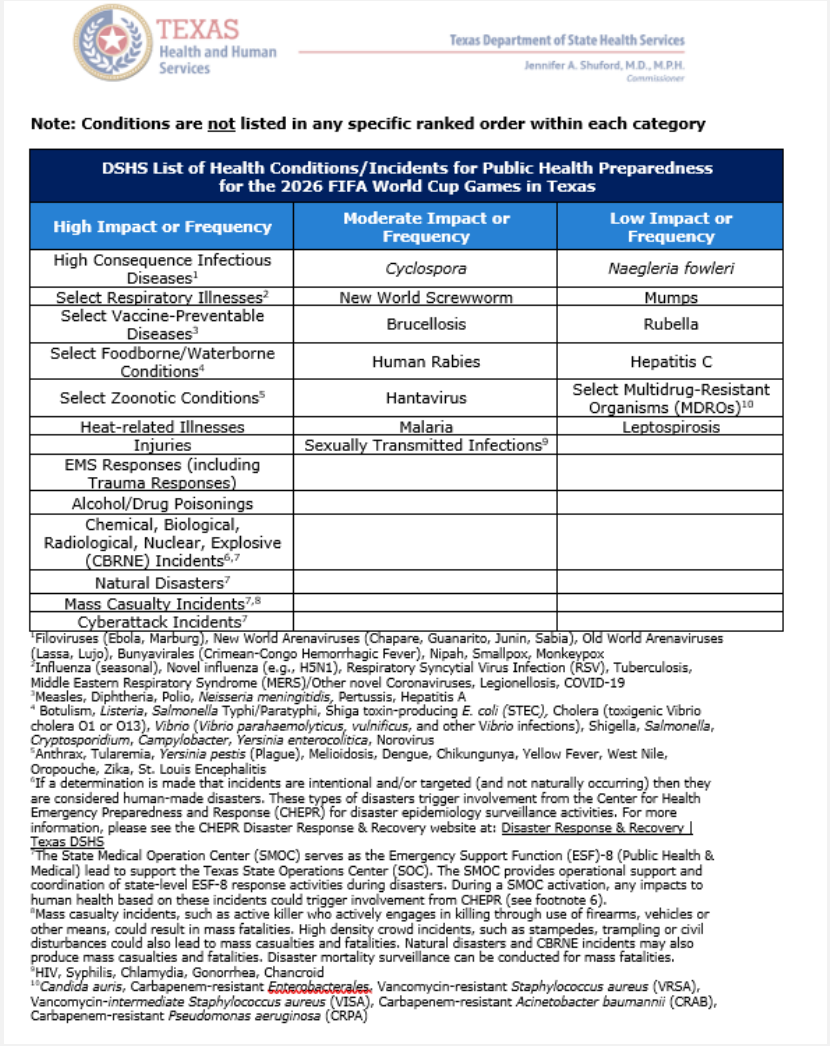
- State Medical Operations Center will mirror State Operations Center and will be activated on match days in Texas and monitor throughout 34 days (June 11 – July 14)
- Regional ESF-8 partners plan to support or activate in various Emergency Operations Centers
- In coordination with TDEM, Emergency Medical Task Force All Hazards packages likely to be staged in Houston and DFW to support disaster response; finalizing packages with regional and state partners
- Coordinating with local, state and federal partners on radiation detection support
- Public Health Regions working with jurisdictions to ensure CHEMPACKs are fully stocked and available
- Receiving, Staging & Storage sites for secure, state-designated warehouses that receive, manage, and distribute Strategic National Stockpile medical countermeasures (vaccines, drugs, PPE) have been identified

2026 FIFA World Cup Games in Texas
Health Conditions and Incidents

- DSHS has been working to develop a list of health conditions and incidents that have an increased potential to affect health around the 2026 FIFA World Cup games in Texas.
  - A multifaceted approach was used to generate a preliminary list of health conditions/incidents of interest.
  - The list, which is now final, was created for public health planning purposes and will guide a unified approach should any public health response activities be needed during the World Cup.
- A companion document that lays out recommended public health preparation, monitoring, and action steps is forthcoming.

2026 FIFA World Cup Games in Texas

Health Conditions and Incidents



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Jennifer A. Shuford, M.D., M.P.H. Commissioner

Note: Conditions are not listed in any specific ranked order within each category

DSHS List of Health Conditions/Incidents for Public Health Preparedness for the 2026 FIFA World Cup Games in Texas		
High Impact or Frequency	**Moderate Impact or Frequency**	**Low Impact or Frequency**
High Consequence Infectious Diseases[1]	*Cyclospora*	*Naegleria fowleri*
Select Respiratory Illnesses[2]	New World Screwworm	Mumps
Select Vaccine-Preventable Diseases[3]	Brucellosis	Rubella
Select Foodborne/Waterborne Conditions[4]	Human Rabies	Hepatitis C
Select Zoonotic Conditions[5]	Hantavirus	Select Multidrug-Resistant Organisms (MDROs)[10]
Heat-related Illnesses	Malaria	Leptospirosis
Injuries	Sexually Transmitted Infections[9]	
EMS Responses (including Trauma Responses)		
Alcohol/Drug Poisonings		
Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE) Incidents[6,7]		
Natural Disasters[7]		
Mass Casualty Incidents[7,8]		
Cyberattack Incidents[7]		

[1]Filoviruses (Ebola, Marburg), New World Arenaviruses (Chapare, Guanarito, Junin, Sabia), Old World Arenaviruses (Lassa, Lujo), Bunyavirales (Crimean-Congo Hemorrhagic Fever), Nipah, Smallpox, Monkeypox
[2]Influenza (seasonal), Novel influenza (e.g., H5N1), Respiratory Syncytial Virus Infection (RSV), Tuberculosis, Middle Eastern Respiratory Syndrome (MERS)/Other novel Coronaviruses, Legionellosis, COVID-19
[3]Measles, Diphtheria, Polio, *Neisseria meningitidis*, Pertussis, Hepatitis A
[4] Botulism, *Listeria*, *Salmonella* Typhi/Paratyphi, Shiga toxin-producing *E. coli* (STEC), Cholera (toxigenic Vibrio cholera O1 or O13), *Vibrio* (*Vibrio parahaemolyticus, vulnificus*, and other *Vibrio* infections), Shigella, *Salmonella*, *Cryptosporidium*, *Campylobacter*, *Yersinia enterocolitica*, Norovirus
[5]Anthrax, Tularemia, *Yersinia pestis* (Plague), Melioidosis, Dengue, Chikungunya, Yellow Fever, West Nile, Oropouche, Zika, St. Louis Encephalitis
[6]If a determination is made that incidents are intentional and/or targeted (and not naturally occurring) then they are considered human-made disasters. These types of disasters trigger involvement from the Center for Health Emergency Preparedness and Response (CHEPR) for disaster epidemiology surveillance activities. For more information, please see the CHEPR Disaster Response & Recovery website at: Disaster Response & Recovery | Texas DSHS
[7]The State Medical Operation Center (SMOC) serves as the Emergency Support Function (ESF)-8 (Public Health & Medical) lead to support the Texas State Operations Center (SOC). The SMOC provides operational support and coordination of state-level ESF-8 response activities during disasters. During a SMOC activation, any impacts to human health based on these incidents could trigger involvement from CHEPR (see footnote 6).
[8]Mass casualty incidents, such as active killer who actively engages in killing through use of firearms, vehicles or other means, could result in mass fatalities. High density crowd incidents, such as stampedes, trampling or civil disturbances could also lead to mass casualties and fatalities. Natural disasters and CBRNE incidents may also produce mass casualties and fatalities. Disaster mortality surveillance can be conducted for mass fatalities.
[9]HIV, Syphilis, Chlamydia, Gonorrhea, Chancroid
[10]*Candida auris*, Carbapenem-resistant *Enterobacterales*, Vancomycin-resistant *Staphylococcus aureus* (VRSA), Vancomycin-*intermediate Staphylococcus aureus* (VISA), Carbapenem-resistant *Acinetobacter baumannii* (CRAB), Carbapenem-resistant *Pseudomonas aeruginosa* (CRPA)

- DSHS Office of Chief State Epi (OCSE) will present on HPP call next week (03/18)
- List has been shared with:
  - LHE/LHAs
  - HPPs
  - TDEM
  - ASPR
  - Various other public health partners

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Note: Conditions are <u>not</u> listed in any specific ranked order within each category

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Heat-related Illnesses	Malaria	Leptospirosis
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EMS Responses (including Trauma Responses)		
Alcohol/Drug Poisonings		
Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE) Incidents[6,7]		
Natural Disasters[7]		
Mass Casualty Incidents[7,8]		
Cyberattack Incidents[7]		

Texas Department of State Health Services (DSHS) list of Health Conditions or Incidents that could impact Human Health for Public Health Preparedness for the 2026 FIFA World Cup Games in Texas

Purpose: This list was created by DSHS for public health planning purposes for the 2026 FIFA World Cup games in Texas.

- Each health condition or incident that could impact human health is designated as either high, moderate, or low impact or frequency based on an evaluation conducted by DSHS. Health conditions were evaluated using several metrics to gauge the likelihood of occurring and its resulting impact.
- **High Impact or Frequency**: represent health conditions or incidents that may present a significant public health concern during the 2026 FIFA World Cup due to their potential for increased probability of occurrence and/or transmission (due to influx of international travelers or mass gathering environments) and/or additional negative health impacts.
- **Moderate and Low Impact or Frequency**: represent health conditions or incidents that are less likely to have a significant increase of occurrence, transmission, and/or negative health impacts during the 2026 FIFA World Cup but may still require additional public health planning.

Questions?

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6.b. EMS Trauma Systems Update

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

PHWB Contracts

- Department activities
  - Contract and Statement of Work
  - Funding allotment
- 20 Contracts are Executed

TSA	Regional Advisory Council	Amounts
RAC A	Panhandle	$ 375,471
RAC B	BRAC	$ 206,779
RAC C	NTRAC - North Texas	$ 183,219
RAC D	BCRAC - Big Country	$ 534,149
RAC E	NCTTRAC - North Central Texas Trauma	$ 1,220,354
RAC F	NETRAC - Northeast Texas	$ 306,861
RAC G	PWRAC - Piney Wood	$ 158,915
RAC H	DETRAC - Deep East Texas	$ 158,994
RAC I	Border RAC	$ 160,077
RAC J	Texas J RAC	$ 604,016
RAC K	CVRAC - Concho Valley	$ 249,047
RAC L	CTRAC - Central Texas	$ 524,175
RAC M	HOTRAC - Heart of Texas	$ 119,935
RAC N	BVRAC - Brazos Valley	$ 586,557
RAC O	CATRAC - Capital Area Trauma	$ 809,365
RAC P	SWTRAC - Southwest Texas	$ 766,947
RAC Q	SETRAC - Southeast Texas	$ 1,047,109
RAC R	ETGRAC - East Texas Gulf Coast	$ 833,573
RAC S	GCRAC - Golden Crescent	$ 95,000
RAC T	SFRAC - Seven Flags	$ -
RAC U	CBRAC - Coastal Bend	$ 377,060
RAC V	LRGRAC - Lower Rio Grande Valley	$ 182,397

§157.126 Trauma Designation Rules

- Rule requirements reviewed – line by line for each level of designation
- Trauma Designation Survey Guidelines
  - Facility planning and preparation – Approximately 600 participants
  - Surveyor training – Approximately 555 participants
- Next steps
  - Designation Assessment Questionnaire
  - Training for completing the questionnaire
  - PI Tool Kit
- PI: Asks the Experts
- Monthly calls 2026
- Level IV PI Tool Kit

Designation Assessment Questionnaire

Transfers

- ACS 5.1, ACS 5.13, ACS 5.14
- 157.126 (d)(2)
- 157.126 (h)(8)(D)
- 157.127 (h)(10)
- 157.126 (c)
- ACS 2014 (CD 2-13, 4-13, 14-D, 4-3)
- 157.126 (h)(32)(F)
- 157.126 (h)(31)(G)
- Transfer Review Process – All levels of trauma facilities
- Transfer in acceptance time
- Transfer request initiated, transport request initiated, timelines
- Transfer feedback

Controversial Discussions

- Transfer Feedback
- Reviewing Transfer Data
- Helipad / Landing Zone Training
- TQIP Participation – Level III
- Operational Plan
- Trauma PIPS Plan

Trauma Uncompensated Care Application

Due March 6, 2026

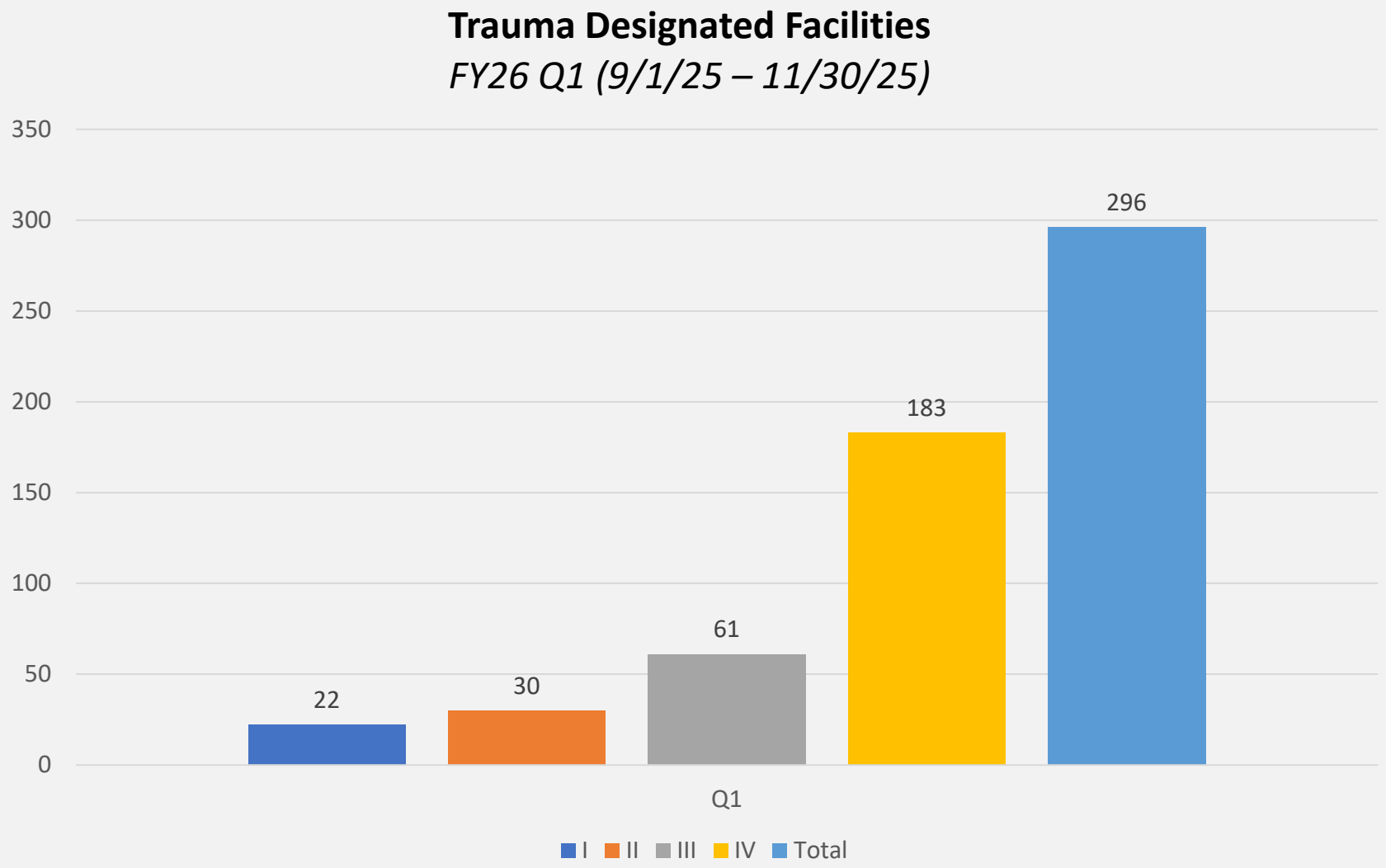
Uncompensated Trauma Care (UCC)

FY2025 Over Payments from DSHS UCC 5111 fund

Designation Update

Elizabeth Stevenson, BSN, RN
Designation Programs Manager

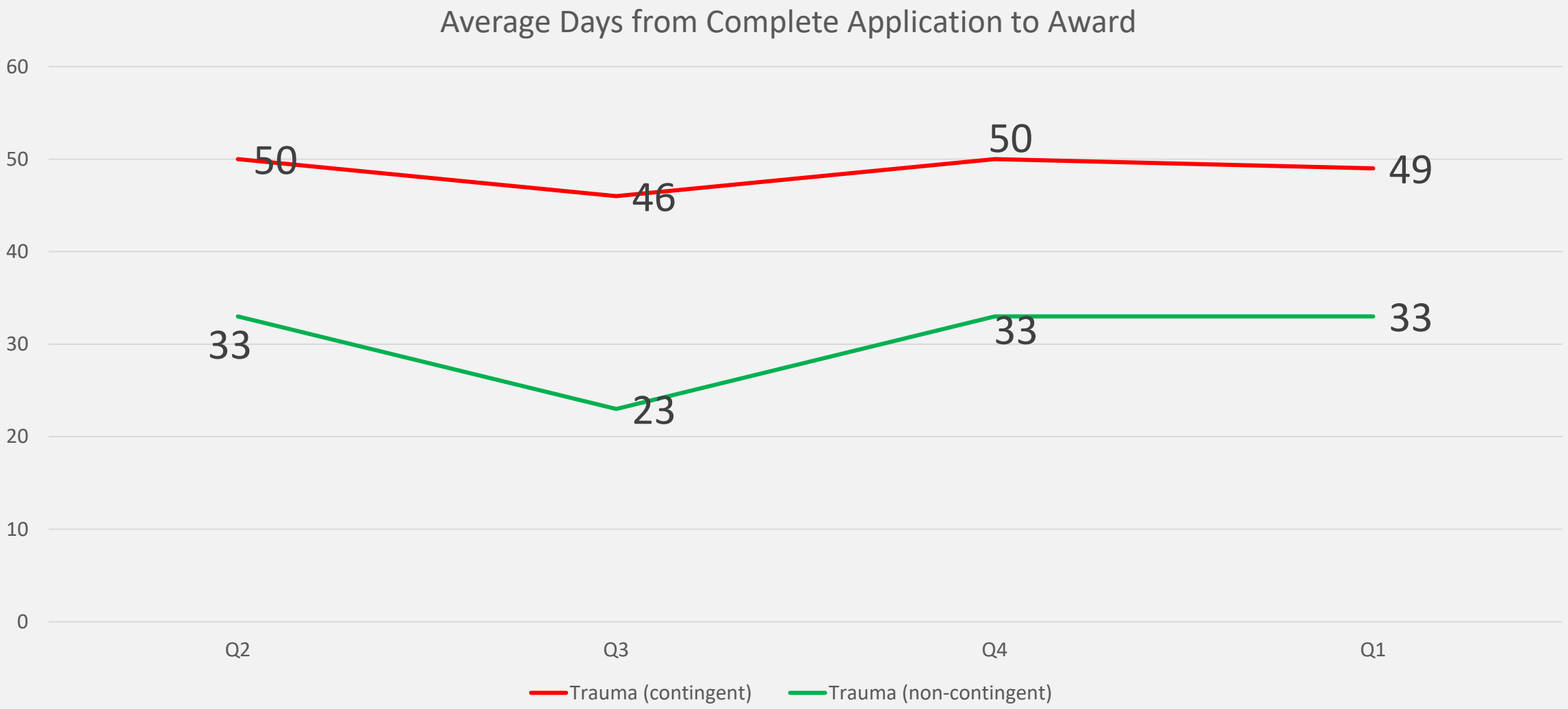
Designated Trauma Facilities



Trauma Application Statistics Q1

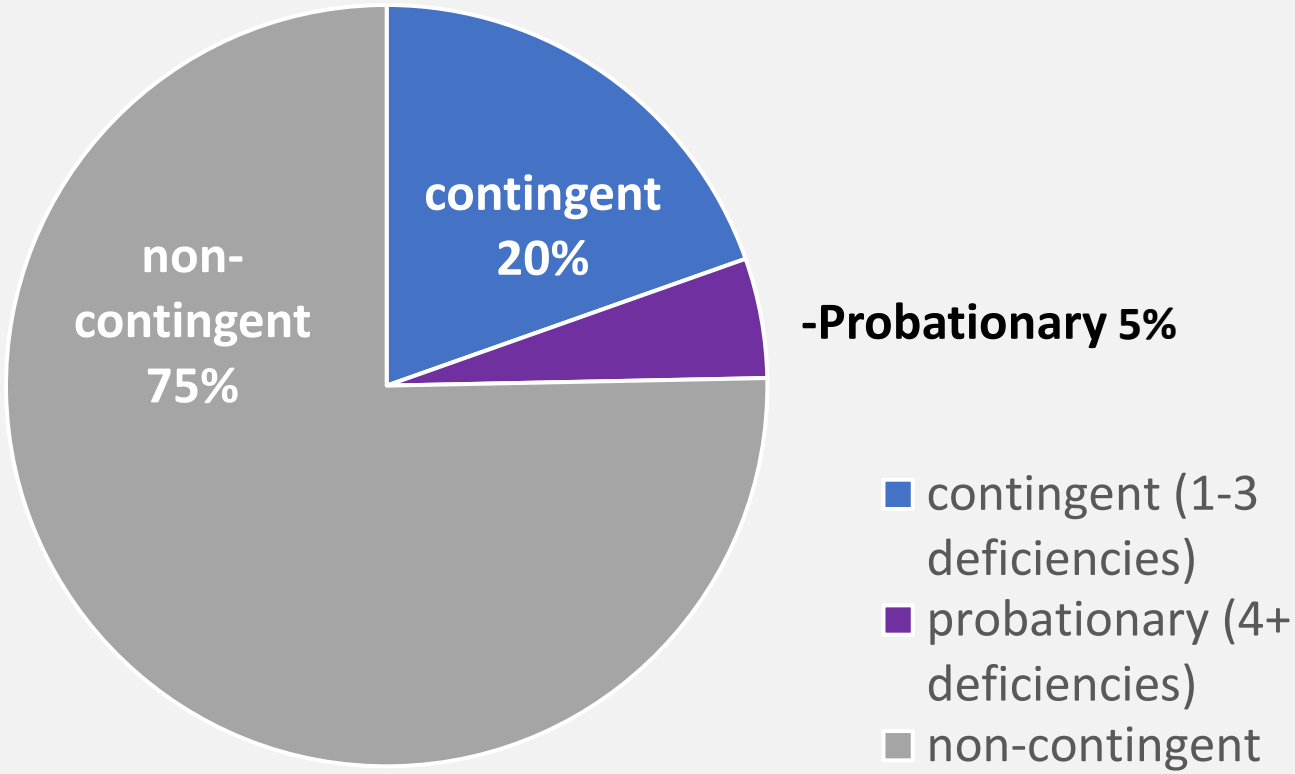
FY'26 Q1 Application Statistics	Trauma Applications
Complete Applications Received	25
New IAP Recognitions	2 (New to designation)
Designations Awarded	30
Initial Designations	5
Designated from IAP (CHOW)	1
Upgrade to Higher Level	4
Re-Designations	25
Contingent Designations	13
Contingent-Probationary Designations	3

Designation Application Performance Measures



Trauma Designation Data

Currently Designated Trauma Facilities



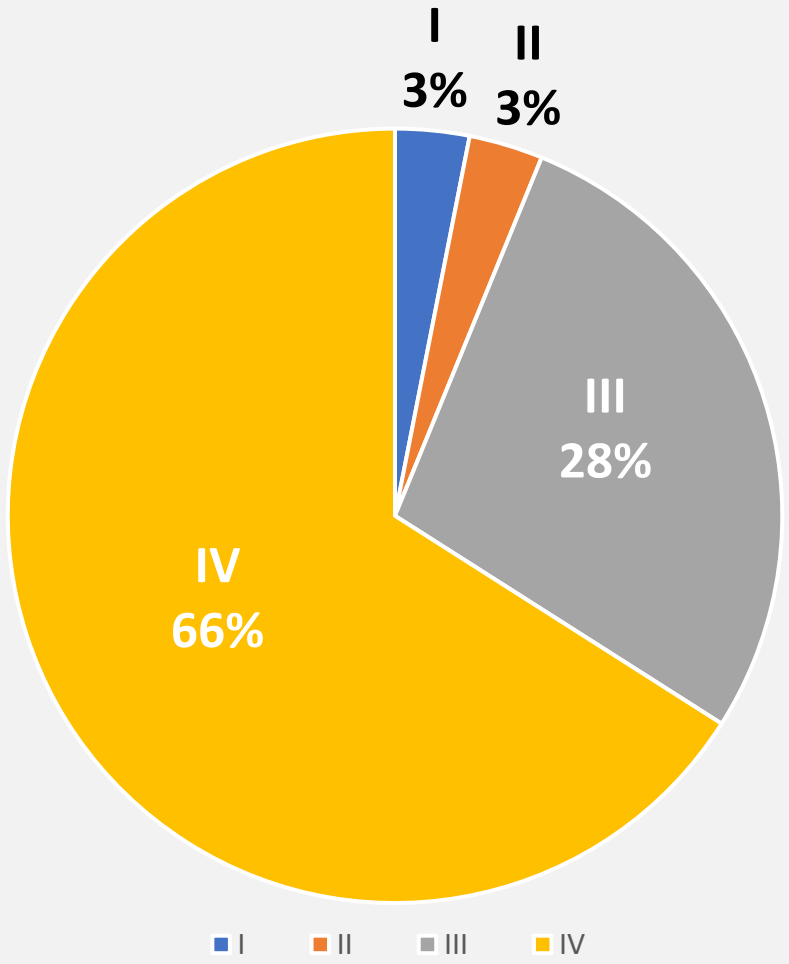
Common Deficiencies

1. Nursing Documentation
2. PI - Identification of all variances
3. PI – Loop closure, effective PI
4. PI – Evidence of corrective actions
5. TMD participation in Disaster Management
6. Transfer process in place
7. Care Management Guidelines

Trauma Designation Data

25% of All Trauma Facilities were contingent at the end of Q1

⬇8% compared to Q4



Trauma Designation Information

Department Activities:

- Monthly calls dedicated to Clarification on Meeting Requirements in the Trauma Rules §157.126
- Trauma Transfers and Example Spreadsheet

Designation Coordinator Activities

Activity	Number
Program Assistance Site Visits	13
Contingent Site Visits	3
Surveys Attended	12
Other Facility Assistance Meetings	28
Corrective Action Reviews	48
Designation Determination Meetings	18

Trauma PI: Ask the Experts

Date	Attendees
September 9	114
October 7	73
November 4	81
February 3	~89
March 3	239

- Dr. Don Jenkins
- Dr. Stephen Flaherty
- Dr. Alan Tyroch

Trauma Facility Helicopter Safety and Landing Zone Training

Texas Trauma DAQ Training

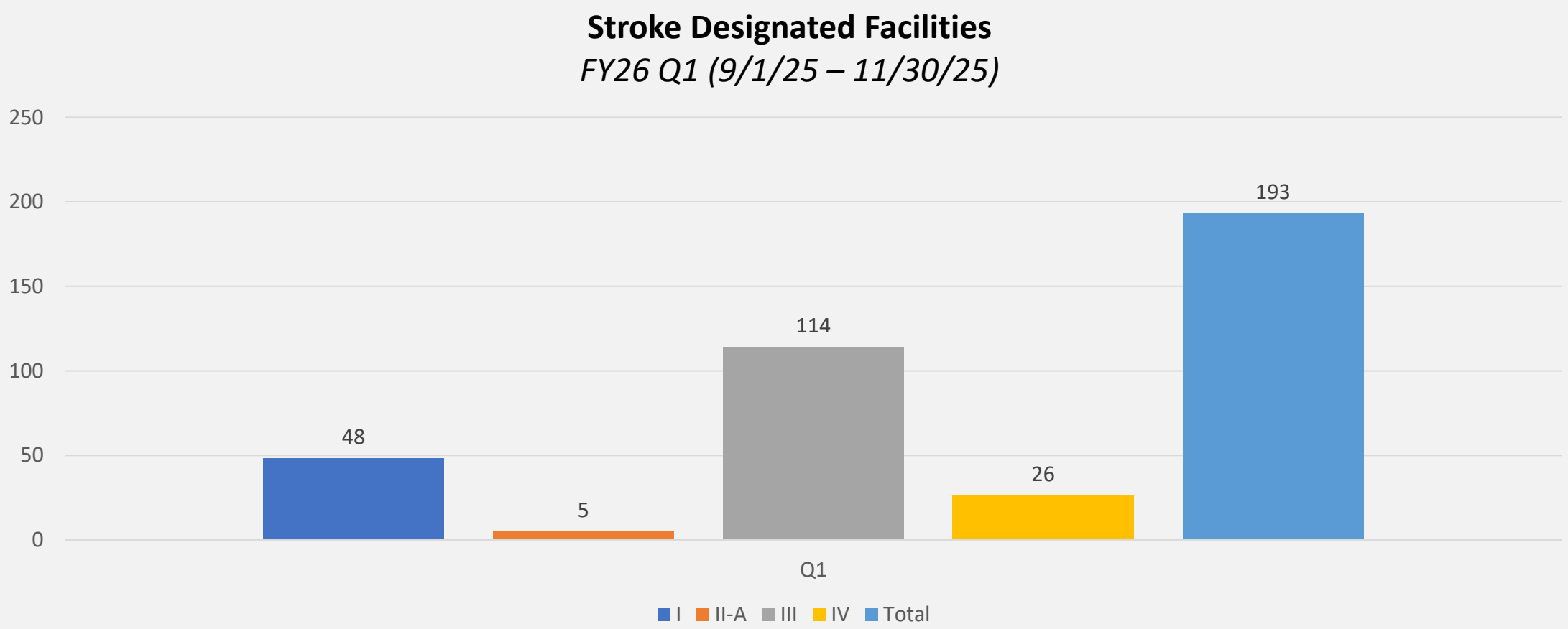
Date	Attendees
February 6 – Level III	53
February 10 – Level III	57
February 10 – Levels I & II	70
February 12 – Level IV 100 or Less	28
February 13 – Level IV 100 or Less	12
February 24 – Level IV 101 or More	48
February 27 – Level IV 101 or More	53

Additional trainings will be offered each month. Schedules will be posted on the trauma designation website and sent in email.

Upcoming Events

Meeting	Date, Time
Level III & Non-Rural Level IV	March 25, 2-3 pm
PI: Ask the Experts	April 7, 3-4 pm
Rural Level IV	April 8, 2-3 pm
Level I & II	April 8, 3:15-4:15 pm
Level III & Non-Rural Level IV	April 22, 2-3 pm
PI: Ask the Experts	May 5, 3-4 pm

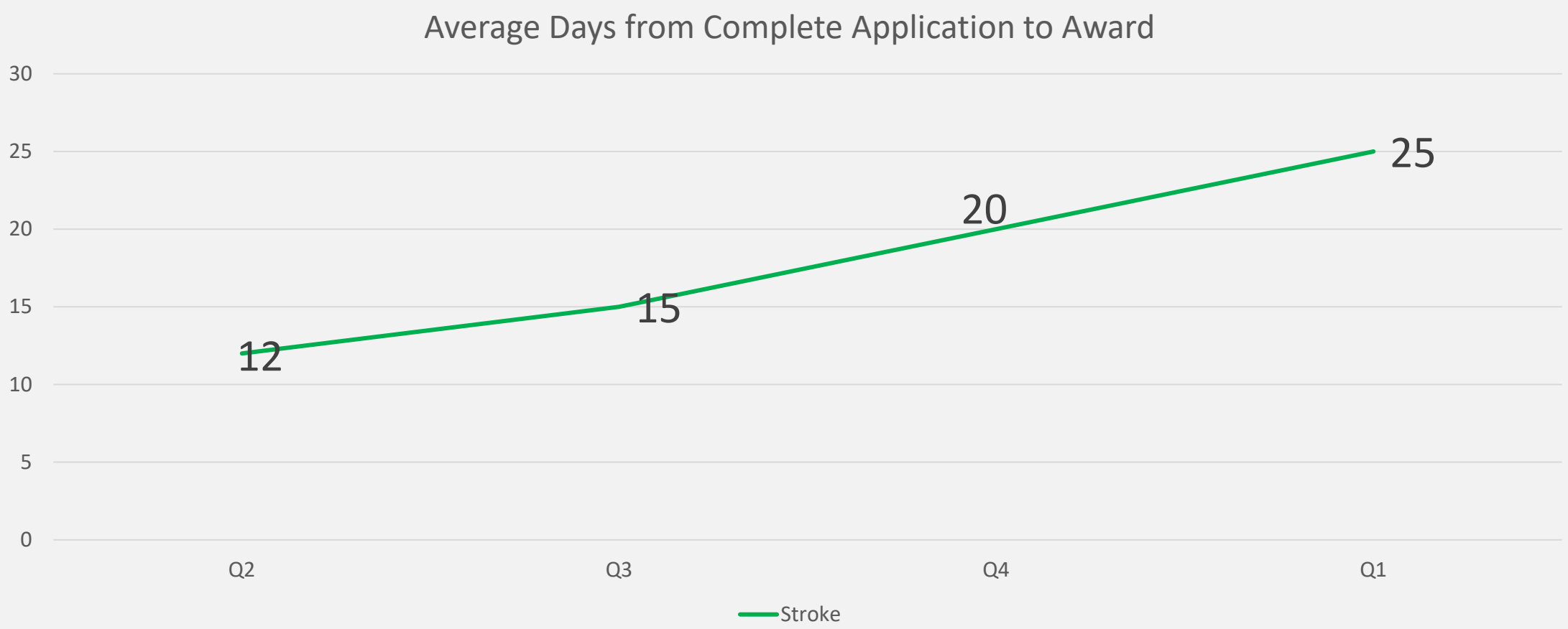
Designated Stroke Facilities



Stroke Application Statistics Q1

FY26 Q1 Application Statistics	Number of Applications
Complete Applications Received	29
Designations Awarded	28
Initial Designations	3
Upgrade	1
New Facility	1
Change of Ownership (CHOW)	1
Re-Designations	25

Designation Application Performance Measures



Stroke Designation Information

Department Activities:

- Monthly call discussions:
  - Survey expectations and tips
  - Reminders on redesignation process
  - Educational opportunities
  - Rural stroke workgroup
  - New thrombolytic guidelines
  - Discussion of an increase in atypical stroke patients


Any
QUESTIONS?

EMS System Update

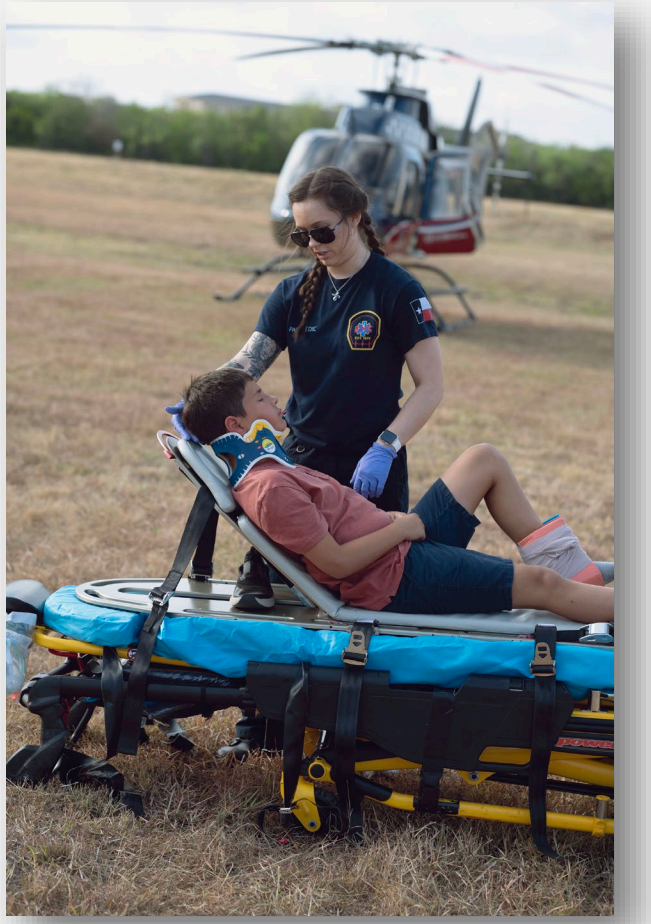
Joe Schmider
State EMS Director

Workforce continues to grow!

Currently **83,891**

…up from

68,474 in 2022



EMS Scholarships

The website for the Texas Workforce Commission (TWC) scholarships is up:

https://www.twc.texas.gov/emergency-medical-response-service-staffing-program.

Friendly Reminder

TEXAS: target date for next major update will be V6 in 2029

For more information on NEMSIS and national dashboards, visit https://NEMSIS.org

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The process has begun to amend the next rule sets due to legislation from the 89R Session.

- **HB 743** Human Trafficking – 157.32/33/34
- **HB 33** Active Shooter Planning – 157.11
- **HB 149** AI Policy – 157.11
- **HB 35** Peer Support for FRs – 157.36
- **SB 1021** Stalking Conviction – 157.37

All rules will be updated to "plain language" standards.

Once these amendments are completed, we will move back to what the committees have been working on. (Expecting to be done by the fall of 2026)

Please do not stop working on updating current rules and building support!!

Plan to move forward on rules:

- Webinar(s) in 2026
- Review with GETAC Committees as needed
- Review with Texas EMS Associations
- Review by GETAC at the March meeting

Target dates

- **Public comments October 2026 for 30 days**
- **Adoption March 2027**

EMS Licensing Manager and PS 4 position

- Completing Interviews
- Great candidates to consider internal and external
- Plan on a start date of 4/2026 for both positions
- Scheduling interviews PS 4

Questions for EMS/Trauma Systems?

Thank You

6.c. Emergency Medical Services and Trauma Registries (EMSTR) Update

Jia Benno, MPH
Injury Prevention Unit Director

Emergency Medical Services and Trauma Registries (EMSTR) Program Updates and Texas Trauma-Related EMS Deaths

March 13, 2026

Jia Benno, MPH
Newborn Screening and Injury Prevention Section Director
Gavin Sussman, EMT-B, OEC-T, B.S.
EMS and Trauma Registries Manager

About EMSTR

- EMSTR collects reportable event data from EMS providers, hospitals, justices of the peace, medical examiners, Long Term Acute Care (LTAC) facilities, and rehabilitation facilities.
- Submitters must electronically report all EMS responses and reportable trauma events to EMSTR under Texas Administration Code, Title 25, Chapter 103.
- Records are due to EMSTR a maximum of **90** calendar days after the date of the EMS dispatch. Real-time submissions are strongly encouraged.
- For any months where no EMS activations occurred, providers are required to submit an electronic *No Reportable Data* attestation.

About Presentation Data

- Trauma-related EMS deaths:
  - When the patient disposition is dead at scene, destination is a morgue, resuscitation was not attempted by EMS, or patient is deceased. This does not account for hospital outcome data.
  - Limited to instances where the complaint reported to dispatch was a trauma including traffic, falls, gunshot wound, etc.
- Urban, rural, and frontier data: Based on criteria from the Texas Demographic Center Texas populations estimate:
  - Urban – Large central metro, large fringe metro, medium metro, and small metro areas.
  - Rural – Micropolitan (10,000-50,000 people) and noncore (<10,000 people) areas.
  - Frontier – Six or less people per square mile.

EMSTR Updates

- 2025 EMS and trauma datasets*:
  - **EMS – 5,205,262 total unique records.**
  - **Trauma – 185,971 total records.****
- Implementation of NEMSIS 3.5.0 (critical patch 6)

  NOTE: Effective 10/21/2025, biological sex is **required.**
- Quarterly data requests and data sharing.
- 2025 dataset closure dates:
  - NEMSIS: 02/14/2026
  - Texas: 05/01/2026 (projected)

*As of 02/19/2026.

**Total unique trauma records are subject to change when final dataset is available.

EMSTR Partner Updates (1 of 2)

Data Manager's Council Guidance from National Association of State Emergency Medical Services Officials (NASEMSO):

- Blood Product Administration Documentation Guidance (v2)
- Artificial Intelligence (AI) Use In EMS (electronic Patient Care Report / ePCR documentation)
- Requesting EMS Data Across States

EMSTR Partner Updates (2 of 2)

- Aggregate Data Use:

  Examples: *The Washington Post* (EMS request times), *Tarrant County Public Health* (ISS scores in trauma activations), *Medical Civil Rights Initiative* (evaluating aggregate carceral transport use), and *Texas Transportation Institute and University of Texas at San Antonio* (evaluating blood administration efficacy for Motor Vehicle Crash (MVC) patients).

- American Heart Association (AHA) Partnership:

  Example: Using National EMS Quality Alliance (NEMSQA) performance measures to assess statewide cardiac and stroke response performance.

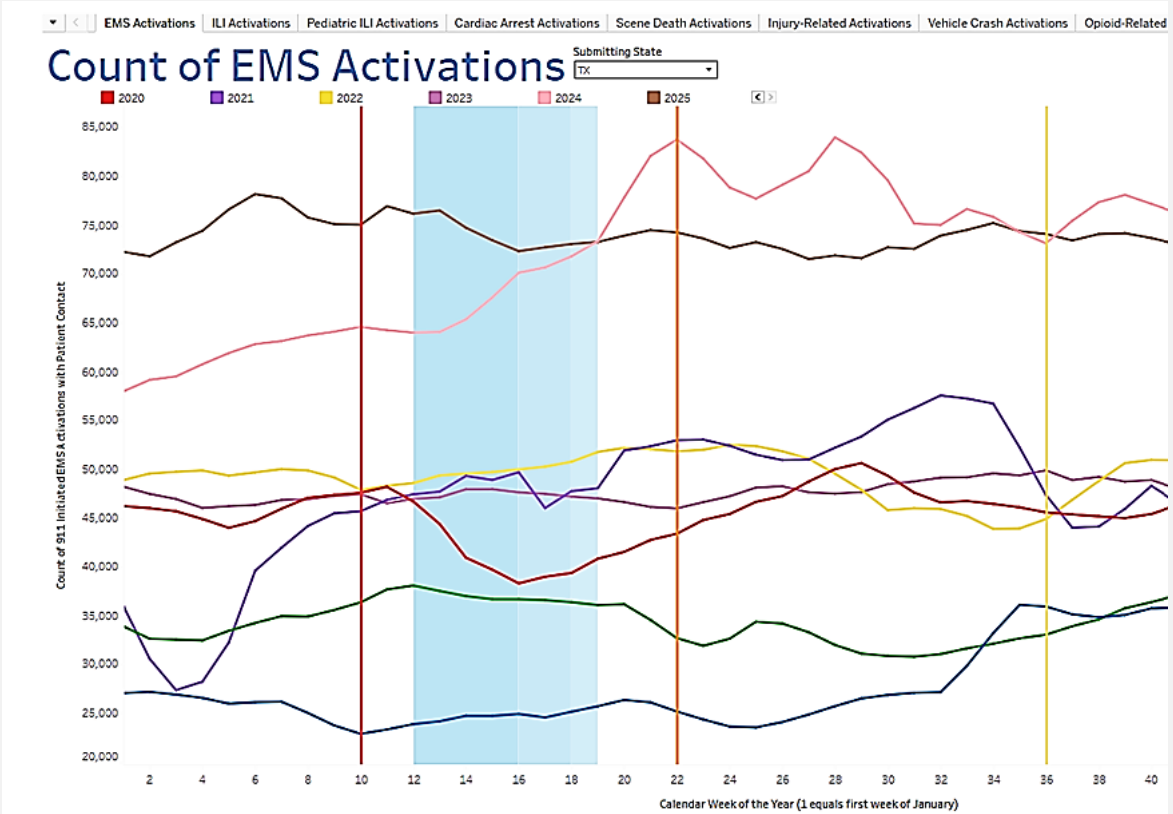
- Sharing results at the State EMS Conference and November Governor's EMS and Trauma Advisory Council (GETAC) meetings.

EMSTR Surveillance Updates

Surveillance Work:

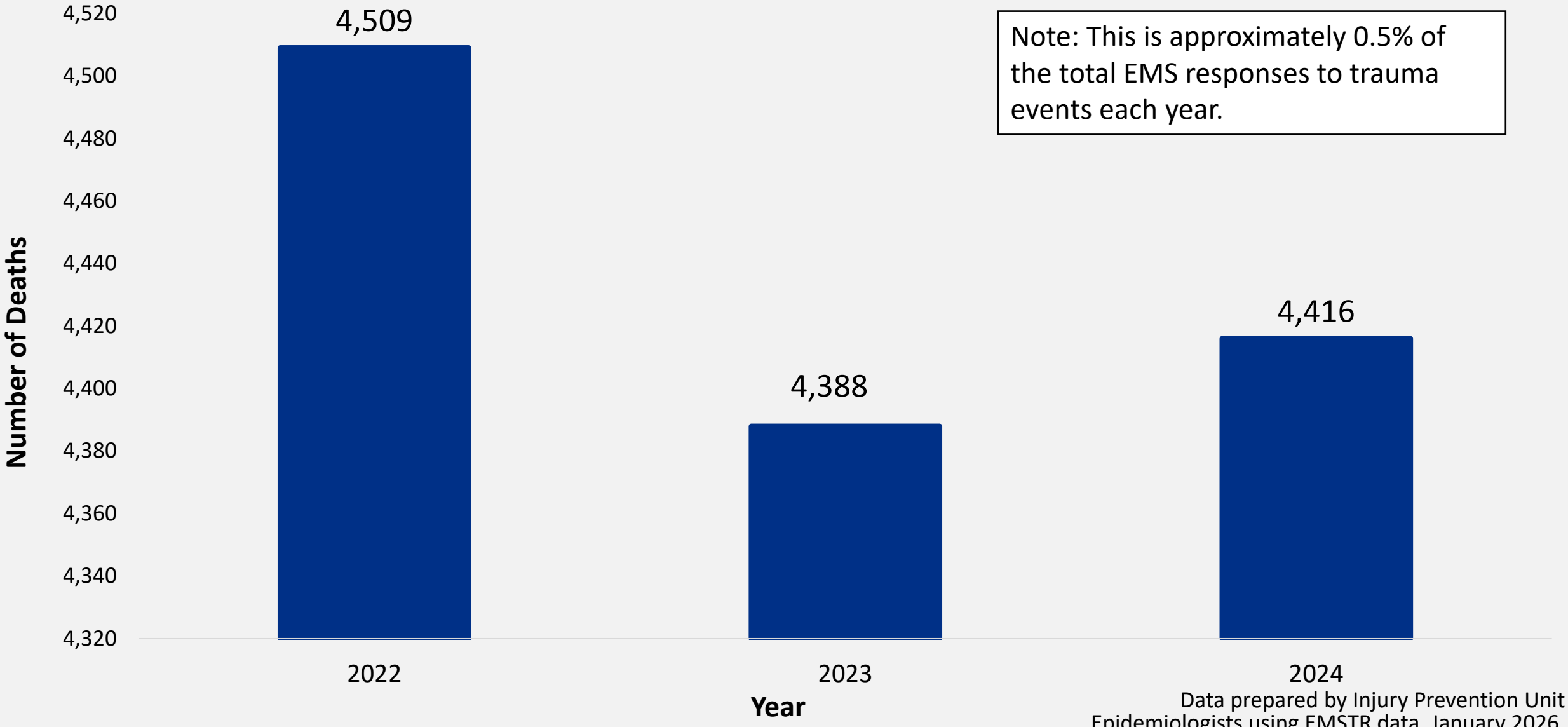
- Staff reviewed all 2025 ePCR submissions for approximately 770 agency accounts.
- Staff incorporated a new delinquency communication process, and proactively included Regional Advisory Councils (RACs) and the Office of the State EMS Director:
  - 219 providers fully regained compliance.
  - 55 agencies actively working with their vendor to submit missing 2025 data.
- With approximately 2 months remaining in state collection, EMSTR received over **357,000** additional records because of this initiative.

Example of National EMS Information System (NEMSIS) Report



Trauma-Related EMS Deaths 2022-2024

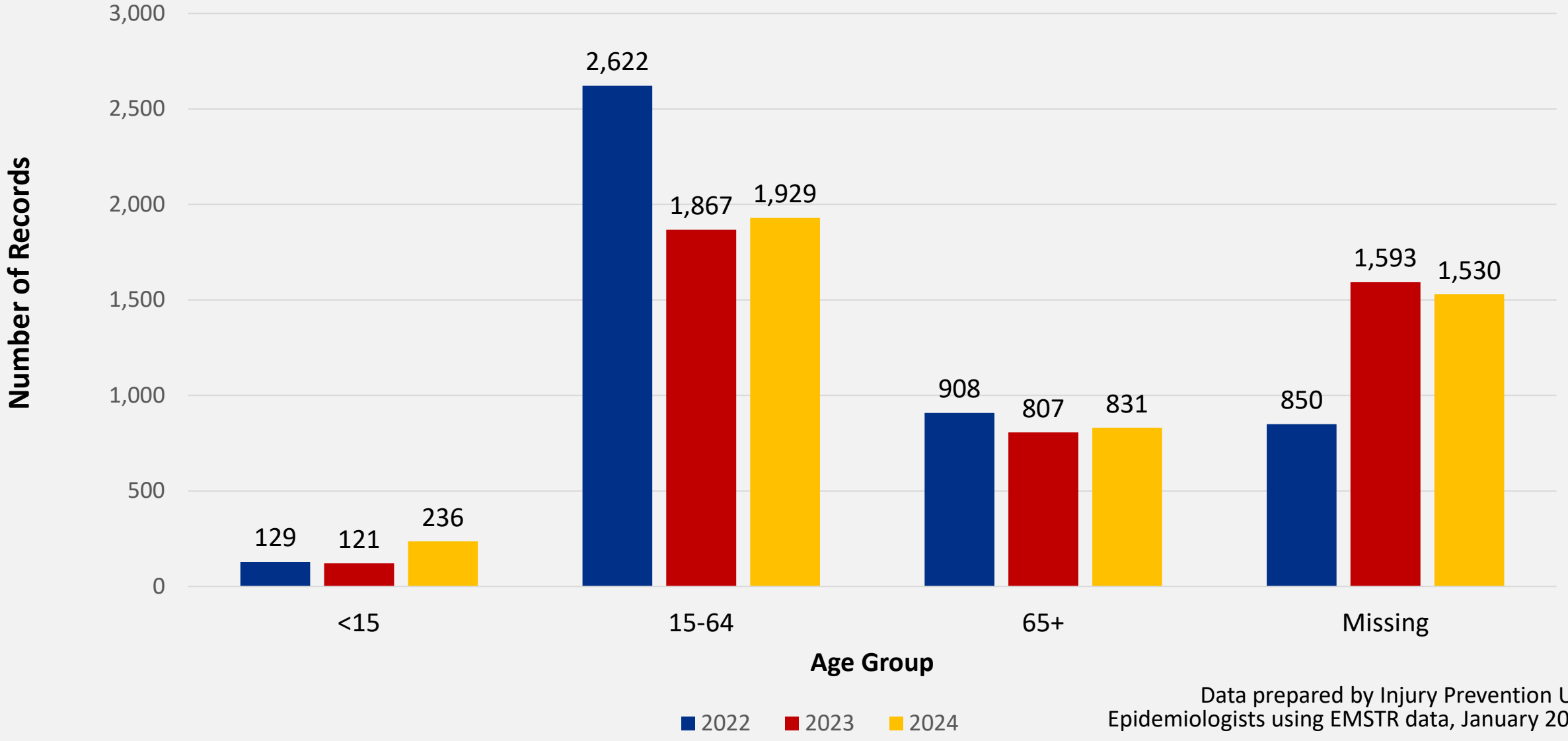
Trauma-Related EMS Deaths, Texas, 2022-2024



Note: This is approximately 0.5% of the total EMS responses to trauma events each year.

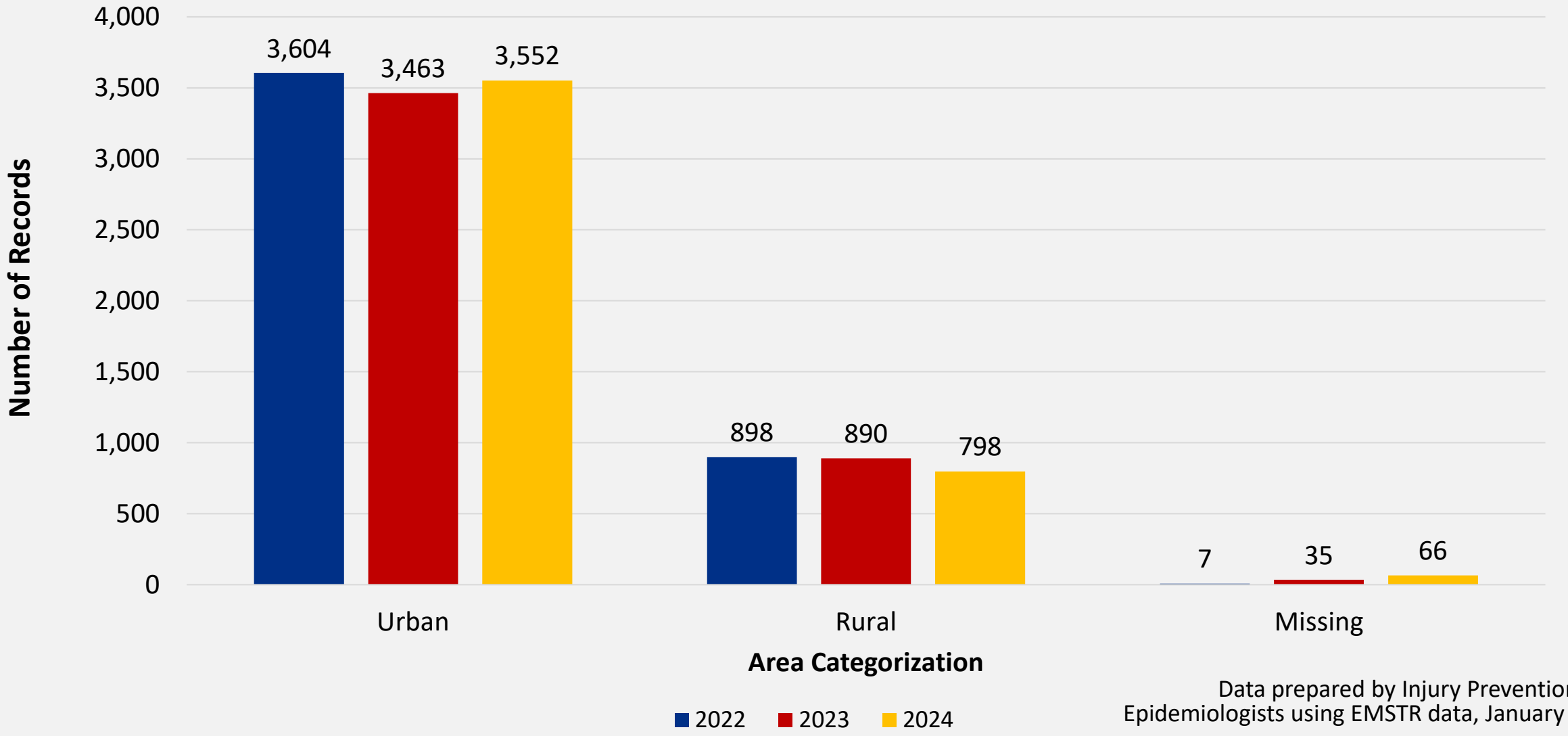
Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, January 2026.

Trauma-Related EMS Deaths By Age Group, Texas, 2022-2024



Data prepared by Injury Prevention Unit
Epidemiologists using EMSTR data, January 2026.

Trauma-Related EMS Deaths By Area Categorization, Texas, 2022-2024



Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, January 2026.

Trauma-Related EMS Deaths by Complaint Reported to Dispatch, Texas, 2022-2024

Call to Dispatch	2022	2023	2024
Traffic/Transportation	2,113	1,911	1,931
Stab/Gunshot Wound	1,156	981	904
Falls	596	753	786
Traumatic Injury	289	325	349
Drowning/Diving/Scuba	138	147	148
Hemorrhage	74	108	101
Assault	49	74	71
Fire	25	27	41

Note: Table only includes the leading eight (8) complaints reported to dispatch.

Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, January 2026.

Trauma-Related EMS Deaths by Complaint Reported to Dispatch – Urban, Texas, 2022-2024

Call to Dispatch	2022	2023	2024
Traffic/Transportation	1,623	1,401	1,465
Stab/Gunshot Wound	988	836	765
Falls	497	630	675
Traumatic Injury	211	240	268
Drowning/Diving/Scuba	113	128	133
Hemorrhage	62	94	85
Assault	44	67	64
Fire	19	22	37

Note: Table only includes the leading eight (8) complaints reported to dispatch.

Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, January 2026.

Trauma-Related EMS Deaths by Complaint Reported to Dispatch – Rural, Texas, 2022-2024

Call to Dispatch	2022	2023	2024
Traffic/Transportation	488	493	437
Stab/Gunshot Wound	165	137	124
Falls	97	119	101
Traumatic Injury	78	82	74
Drowning/Diving/Scuba	25	17	13
Hemorrhage	12	13	15
Fire	6	5	*
Assault	5	6	7

Note: Table only includes the leading eight (8) complaint reported to dispatch.

Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, January 2026.

Trauma-Related EMS Deaths by Complaint Reported to Dispatch – Age <15, Texas, 2022-2024

Call to Dispatch	2022	2023	2024
Traffic/Transportation	52	39	41
Drowning/Diving/Scuba	37	40	38
Stab/ Gunshot Wound	23	18	19
Traumatic Injury	11	6	14
Falls	*	10	6

Note: Table only includes the leading five (5) complaint reported to dispatch.
* = Data suppressed to protect confidentiality.

Data prepared by Injury Prevention Unit
Epidemiologists using EMSTR data, January 2026.

Trauma-Related EMS Deaths by Complaint Reported to Dispatch Ages 15-64, Texas, 2022-2024

Call to Dispatch	2022	2023	2024
Traffic/Transportation	1,293	836	872
Stab/Gunshot Wound	803	554	494
Traumatic Injury	190	134	159
Falls	170	183	211
Drowning/Diving/Scuba	47	44	47
Hemorrhage	42	43	48
Assault	31	40	41
Electrocution/Lightning	16	5	12

Note: Table only includes the leading eight (8) complaints reported to dispatch.

Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, January 2026.

Trauma-Related EMS Deaths by Complaint Reported to Dispatch Ages 65+, Texas, 2022-2024

Call to Dispatch	2022	2023	2024
Falls	395	372	397
Traffic/Transportation	226	183	220
Stab/Gunshot Wound	145	106	78
Traumatic Injury	41	59	57
Drowning/Diving/Scuba	36	26	18
Hemorrhage	25	38	28
Assault	11	5	8
Fire	10	6	7

Note: Table only includes the leading eight (8) complaints reported to dispatch.

Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, January 2026.

Summary

- From 2022-2024, approximately 4,500 patients died in trauma-related EMS deaths.
- Most trauma-related EMS deaths occurred in urban areas (approximately 80%) and to youth and adults between the ages of 15 and 64 (approximately 44%).
- In both rural and urban areas, MVCs were the leading call to dispatch in trauma-related EMS deaths.
- For the <15 and 15-64 age groups, MVCs were the leading complaint reported by dispatch in trauma-related EMS deaths. In ages 65+, falls were the leading complaint reported by dispatch.

Thank you!

EMSTR Program Updates and Texas Trauma-Related EMS Deaths

Injury.epi@dshs.texas.gov

TEXAS
Health and Human Services

Texas Department of State Health Services

7. Council Action Items

a. Approve: Revised GETAC Standard Operating Procedures

b. Approve: Revised GETAC Committee Guidelines

8. Discussion: American College of Surgeons (ACS) consultative visit

a. Texas State Trauma System Plan

9. GETAC Committee Action Items

9.h. GETAC Stroke Committee Update to Council

Chair: Robin Novakovic, MD

Vice-chair: Sean Savitz, MD

9.a. GETAC Air Medical and Specialty Care Transport Committee Update to Council

Chair: Lynn K. Lail, BSN, RN, CFRN, LP

Vice-Chair: Cherish Brodbeck, RN, LP

AMSCT Committee

2025 Committee Assignments

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Assignments	Current Activities	Status
Trauma Facility Helipad Safety & Landing Zone Training Presentation	• Presentation creation - **Complete** • AMSCT Committee approval received 6/4/2025 • **Council approval received 6/6/2025**	To date: 424 Nursing CEs have been awarded
EMS Helicopter Safey & Landing Zone Training Presentation	• CE's being granted every Monday	To date: 730 DSHS CEs have been provided

AMSCT Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
Emergency Preparedness and Response *Develop an integrated, cross-regional information-sharing process to enhance statewide visibility and awareness of NOTAM alerts*	• Statewide visibility permissions • Standardized NOTAM categories/definitions • Consistent formatting language • List serve for notifications • Pilot the program with select RAC regions	Metrics to be reported back to AMSCT Committee
Performance Improvement & Patient Safety: *Fatigue Risk Management Programs for Air Medical & Specialty Care Transport Providers*	• Supporting research & data collection - **Complete** • Development of a White Paper supporting the implementation & utilization of a FRMP continues	U.S. Helicopter Safety Team – New Resource
System Integration *Develop criteria for the minimum requirements of a transport team when accepting and conducting an adult critical care transport by ground, with the goal of ensuring and enhancing the overall safety, quality of service, and level of care provided to patients being treated and transported by critical care ground providers.*	• Develop goals for the requesting facility • Revise verbiage & terms with feedback from SMEs • Cross reference TAC, Chapter157, Rule §157.11 to avoid duplicity • Send to Mr. Schmider for initial review & feedback • Final draft revision to be sent to EMS & Medical Directors' Committee for feedback. • Further revisions PRN	

9.b. GETAC Cardiac Care Committee Update to Council

Chair: Dr. Craig Cooley

Vice-chair:

Cardiac Care Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. *Evaluate challenges to the use of T-CPR instructions prior to EMS arrival for public safety answering points (PSAPS) and work to overcome barriers to increase T-CPR across Texas.*	*Workgroup being formed to determine current state of T-CPR in Texas, partner with other committees to address issues, and determine available data to help determine current state and future QI/reporting goals.*	In progress
2. *Provide recommendations guiding regulatory and legislative decision-making relevant to Texas emergency healthcare system*	*Workgroup being formed to evaluate current state of cardiac center designations and create document outlining potential state level cardiac center designations to provide to GETAC for review.*	In progess
3. *Partner with DSHS using EMS statewide data to evaluate AED and CPR across the state and then identify gaps and opportunities for improvement.*	*In process. Report from DSHS and TxCARES planned for June meeting.*	In progress

9.c. GETAC Pediatric Committee Update to Council March 2026

Chair: Christi Thornhill, DNP, APRN, ENP, ACNP-BC, CPNP-AC, CP-SANE

Vice-chair: Belinda Waters, BSN, RN

Pediatric Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Clinical Element-Coordinated Clinical Care: *Identify opportunities for professional and public education leading to improved clinical outcomes.*	***a.*** ***Strategy:*** *Disseminate current information on best practices and educational opportunities to satisfy knowledge gaps.* **b.** **SPECIFY:** Develop a Pediatric Transfusion/Massive Transfusion Guideline.	
2. Clinical Element-Coordinated Clinical Care: *Identify opportunities for professional and public education leading to improved clinical outcomes.*	***a.*** ***IDENTIFY:*** *Disseminate current information on best practices and educational opportunities to satisfy knowledge gaps.* **b.** **SPECIFY:** Develop a Pediatric pain assessment and intervention guideline	
3. Clinical Elements – Performance Improvement and Patient Safety: *Develop and utilize standardized measures to evaluate patient and system outcomes that include levels of harm*	***a.*** ***IDENTIFY****:* Utilize evidence-based best practices to improve outcomes for patients, as well as healthcare providers, and promote a culture of safety. **b.** **SPECIFY:** Review available data to monitor for complete vital signs and weight recorded in kilograms for pediatric patients.	

Pediatric Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Clinical Element-Coordinated Clinical Care: *Identify opportunities for professional and public education leading to improved clinical outcomes.*	***a.*** ***Strategy:*** *Disseminate current information on best practices and educational opportunities to satisfy knowledge gaps.* **b.** **SPECIFY:** Develop a Pediatric Toolkit addressing Pediatric magnet/button battery ingestion.	
2. Clinical Element-Coordinated Clinical Care: *Identify opportunities for professional and public education leading to improved clinical outcomes.*	***a.*** ***IDENTIFY:*** *Disseminate current information on best practices and educational opportunities to satisfy knowledge gaps.* **b.** **SPECIFY:** Develop a Pediatric Toolkit Addressing Sudden Cardiac Arrests/Deaths in the pediatric population	
3. Clinical Elements – Performance Improvement and Patient Safety: *Develop and utilize standardized measures to evaluate patient and system outcomes that include levels of harm*	***a.*** ***IDENTIFY****:* Utilize evidence-based best practices to improve outcomes for patients, as well as healthcare providers, and promote a culture of safety. **b.** **SPECIFY:** Monitor utilization of 13 pediatric simulations by regional PRISMS; will request data from state regarding compliance with bi-annual simulations in alignment with rule 157.126.	

9.d. GETAC Injury Prevention & Public Education Committee Update to Council

Chair: Mary Ann Contreras, RN

Vice-Chair: Courtney Edwards, DNP

Injury Prevention Public Education Committee

3/2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1.Pillar: Clinical Elements Objective #4 Identify evidence-based prevention strategies that increase capacity for a safe and healthy lifestyle	*Translate Texas Trauma Registry data that focuses on the top 3 mechanisms of injury resulting in fatality:* Falls, *MVC (including CPST expansion) and* ***GSW.*** *-Include: the development of:* ***Discussion of broad methods identifying effective prevention strategies*** *- ACTFAST: adopting Comprehensive Training for Firearm Safety in Trauma Centers. Johns Hopkins University Research in 3 Pediatric trauma Centers and 3 Adult Trauma Centers that will:* *-Demonstrate best practice on firearm injury prevention strategies promoting safe storage practices.* *-Increase firearm safety knowledge, attitudes and safe storage* *-Increase trauma center clinician's firearm safety knowledge and confidence in delivering firearm safety intervention within adult and pediatric trauma centers* *https://publichealth.jhu.edu/center-for-gun-violence-solutions/actfast*	

Injury Prevention Public Education Committee

3/2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1.Pillar: Clinical Elements Objective #4 Identify evidence-based prevention strategies that increase capacity for a safe and healthy lifestyle	*Translate Texas Trauma Registry data that focuses on the top 3 mechanisms of injury resulting in fatality:* Falls, ***MVC (including CPST expansion)*** *and* GSW***.*** *-Include: the development of:* ***Discussion of broad methods identifying effective prevention strategies*** ***-****National strategy sessions for increasing expansion of Child Passenger Safety Professionals with Safe Kids, on April 18 at the annual Life Savers Conference (Pre-conference event)*	

Injury Prevention Public Education Committee

3/2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
2. Pillar: System Support *Objective #2* *Explore innovations for providing interactive, collaborative, and targeted public education.*	*Strategy: 4* *Promote and provide information to local agencies related to bystander education and training so that they can provide timely and appropriate interventions.* *- Drowning Prevention Workgroup: in progress with partnering in the development of the Texas Water Safety Prevention Plan to align with existing state and national plans to promote drowning prevention strategies for public consumption across the State of Texas.* *-Collaborative work with Stroke Committee to raise public awareness and understanding for the urgency of timely care during stroke events*	

9.e. GETAC EMS Committee Update to Council

Chair: Chief Kevin Deramus, LP

Vice-chair: Chief James Campbell, LP

9.f. GETAC Trauma System Committee Update to Council

Chair: Stephen Flaherty, MD, FACS

Vice Chair: Raul Barreda, MD, FACS

Trauma Systems Committee

2025 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
SCOR Project Transfer delays for patients with severe hypotension or GCS < 9	• RAC leaders increased their activity assessing and managing the identified concerns. • Initial presentation to our committee yesterday • Continue efforts at the RAC level	

Delayed Trauma Transfer Ranking Survey Analysis

Survey Methodology & Statewide Participation

- This survey was distributed to RAC Executive Directors, who coordinated directly with regional trauma subject matter experts to rank the primary reasons for severe trauma transfer delays within their hospitals. While ranking reflects expert assessment, these evaluations are informed by operational experience and review of regional trauma data. All delay reasons included in the survey were derived from the State's Severe Trauma Transfer Delay dataset.

- 304 of 337 hospitals completed the survey (**90% statewide response rate**).
  - **14 RACs had a 100% response rate**
  - **6 RACs had above 80% response rate**
  - 1 moderate size RAC had a 60% response rate
  - 1 small RAC had a 50% response rate

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Reason	Facility Geographic Classification Type		State Ranking
	Rural	Urban	
Delayed transfer transport	1	2	1
Delayed transfer decision time	2	1	2
Complex life-saving interventions required	5	3	3
Delayed image reads	3	7	4
Delayed transfer acceptance	4	6	5
EMERGENT time-sensitive transfer needs not identified	8	4	6
URGENT time-sensitive transfer needs not identified	9	5	7
Accepting facility requested additional workup	7	8	8
Weather prohibited transport	6	10	9
Accepted but waiting on bed availability	10		10
Images requested for emergent life-saving transfers		9	

* Not in top 10 ranking

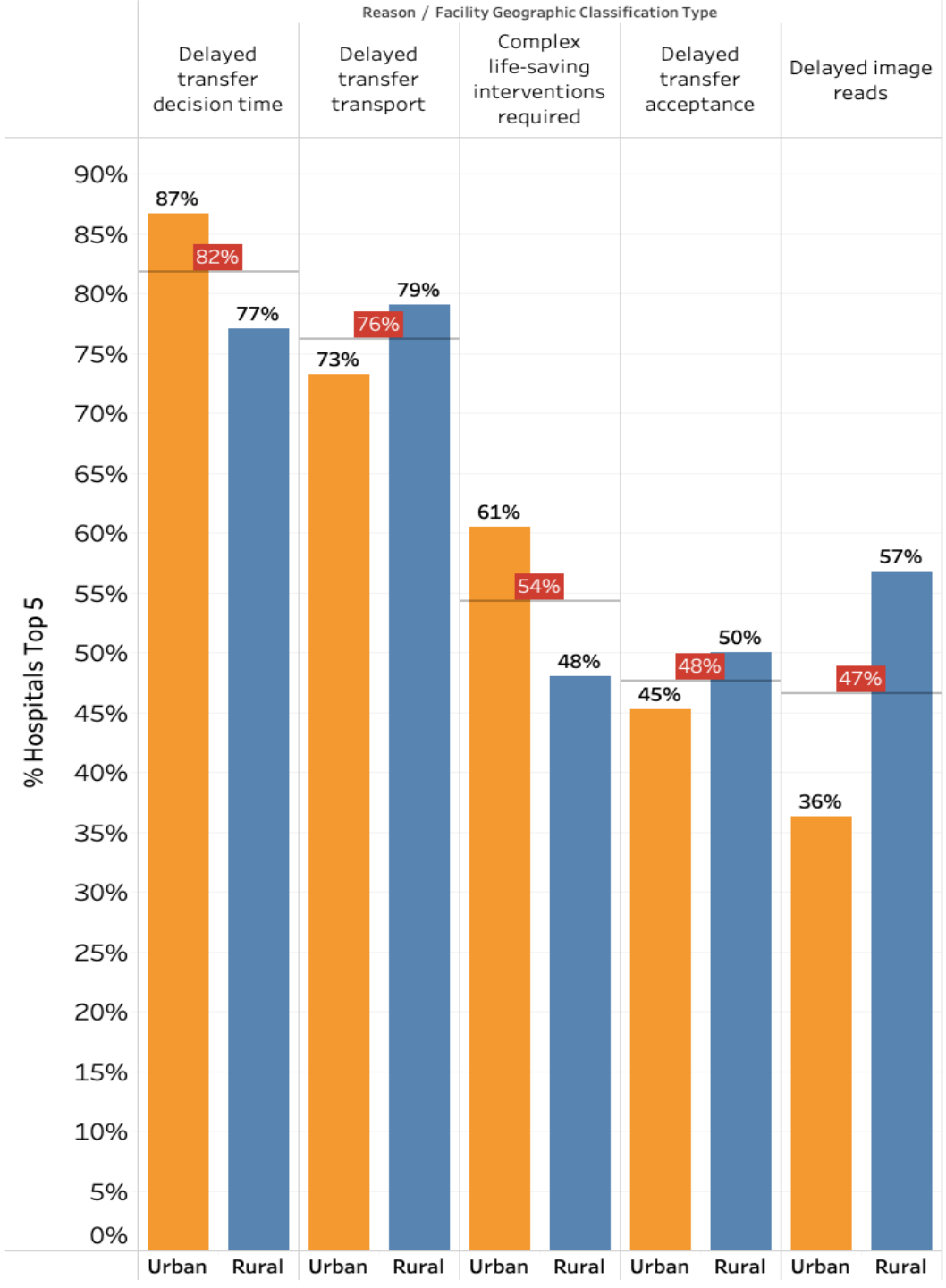
Top 10 Transfer Delay Reasons:

State Geographic Comparison of Delayed Trauma Transfer Drivers

- The top two causes of delayed trauma transfers are consistent statewide: transport delays and delayed transfer decision time.
- Urban facilities rank time-sensitive identification issues higher than Rural facilities.
- Rural facilities rank imaging and weather-related barriers more highly.
- Strong agreement in top-tier barriers suggests system-level process constraints rather than geography-driven issues.

TETAF TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services



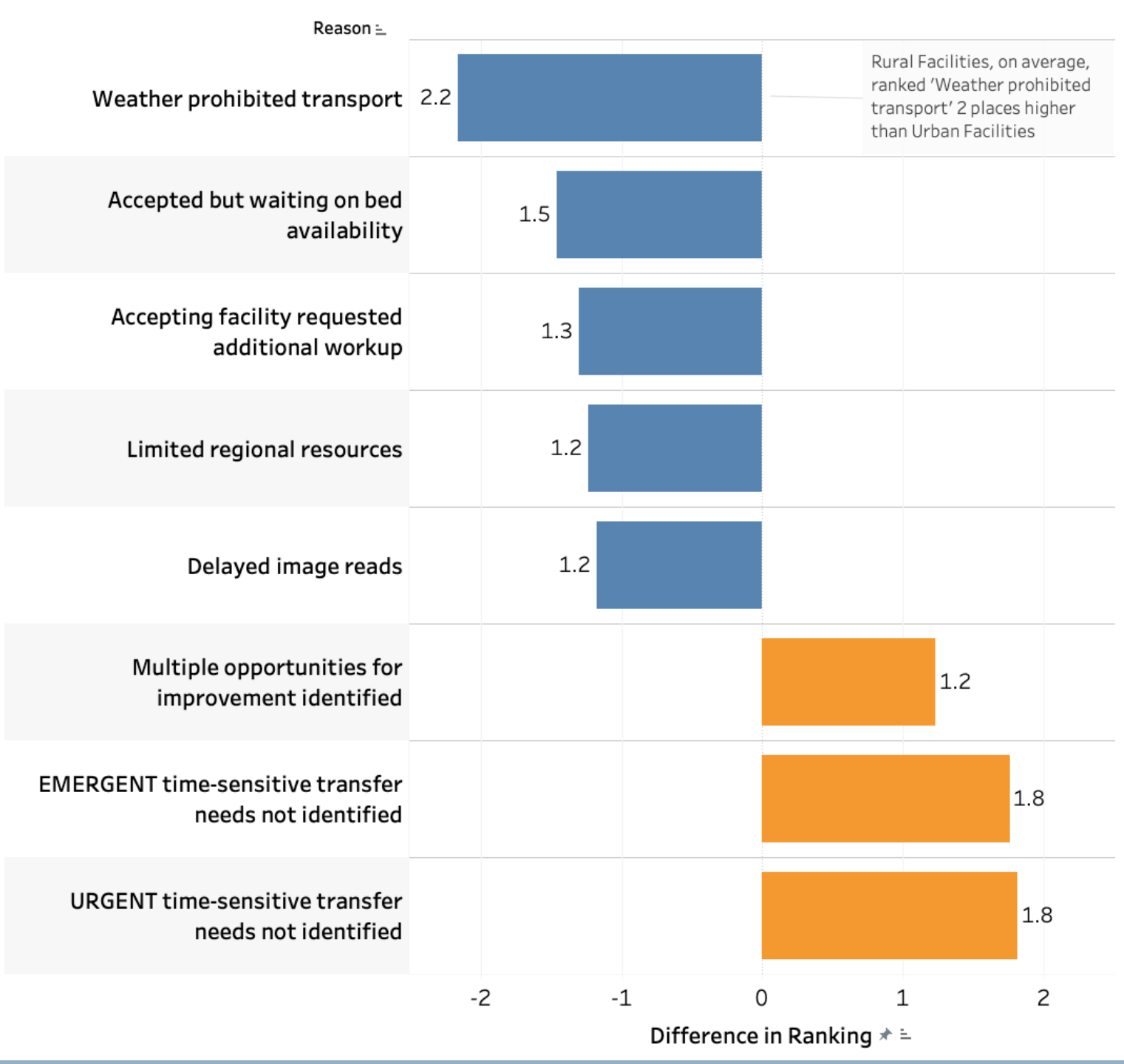
Frequency of Top 5 Delay Reason (Statewide Comparison)

- Delayed transfer decision time appear to be the most universal pressure point in the transfer process.
- Delayed Transfer Decision Time is Ranked in the Top 5 by 82% of Hospitals Statewide
- Delayed Image Reads show a notable Rural burden (57% vs 36% Urban)

Facility Geographic Classification Type
Urban
Rural
State Percentage

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Transfer Barriers with Greatest Rural-Urban Disparity



- Rural disparities are primarily driven by environmental and resource constraints.
- Urban disparities are primarily driven by time-sensitive need identification.
- Geographic variation is most pronounced in mid-tier rankings rather than top-tier drivers.

Ranks Higher In

Rural Facilities

Urban Facilities

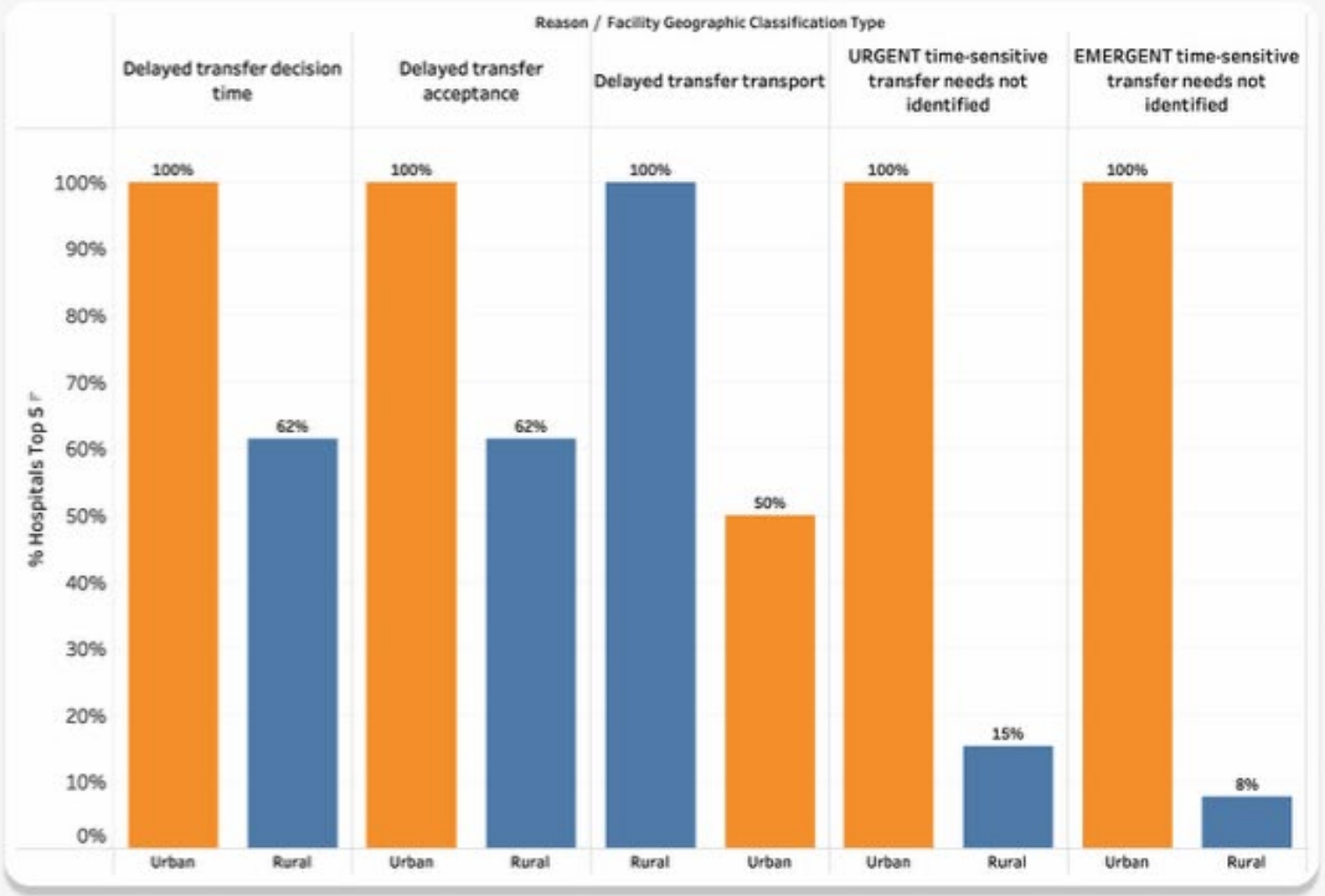
Texas Perinatal Services

RAC

Delayed Trauma Transfer Ranking: RAC Analysis

Top 10 Reasons by Geographic Classification Type

Reason	Facility Geographic Classification Type	
	Rural	Urban
Delayed transfer transport	1	6
Delayed transfer acceptance	2	2
Weather prohibited transport	3	
Delayed transfer decision time	4	1
Delayed image reads	5	9
Complex life-saving interventions..	5	5
Accepting facility requested addit..	7	8
Limited regional resources	8	
Images requested for emergent li..	9	7
Accepted but waiting on bed avail..	10	
Patient cooperation		10
URGENT time-sensitive transfer n..		4
EMERGENT time-sensitive transf..		2



Trauma Systems Committee

2025 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Designation Pillar: Assess for barriers to designation.	No new activity	
2. Improve communication with RAC Chairs to facilitate early awareness of challenges in the trauma system.	No new activity	
3. Inclusive trauma system pillar (to include military-civilian integration)	No new activity	

Trauma Systems Committee

2025 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
4 Financial health pillar	Monitoring news, social media and other platforms to identify financial developments that may impact trauma centers or the trauma system.	
5. Pediatric injury pillar	Duplication of radiographs concern No interval activity	
6. Burn Injury Pillar	Monitoring the Burn Care Task Force	

9.g. GETAC EMS Medical Directors Committee Update to Council

Chair: Christopher Winckler MD, LP

Vice Chair: Elizabeth Fagan MD,

EMS Medical Director Committee

[2026] Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Develop a list of duties and expectations of Texas EMS Medical Directors. Provide supporting documentation on the benefits of direct medical director involvement.		
2. Provide examples of asynchronous EMS programs that have been implemented by EMS Medical Directors in the State of Texas. List these program outcomes and how they benefit the community.		
3. Connect EMS Board Certified physicians with underserved communities. Identify appropriate EMS medical director course.		

EMS Medical Director Committee

[2026] Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
4. Develop a list of prehospital best practices recommendations utilizing evidence-based medicine and best current practices: Prehospital sepsis treatment, including antibiotics; Prehospital hemorrhagic shock treatment to include prehospital blood products; clinical action plan for a heat MCI to include active cooling with a patient in ice inside a thermal emergency management patient bag; guidance on potential need and best practice for a prehospital clinical ultrasound program	*Committee voted to start with best practice recommendations of Heat Mass-Casualty Incident and Texas Wristband project*	
5. Support Texas wristbands for trauma patients and all clinical patients in a way that provides continuity of registry and tracking, making sure this is a discrete searchable field		
6. Develop evidence-based guidelines with the help of appropriate committees to provide appropriate prehospital pediatric transport..		

EMS Medical Director Committee

[2026] Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
7. Provide recommendations guiding regulatory and legislative decision-making relevant to the Texas Emergency Healthcare System.		
8. Participate in the EMS Committee's review of 157.11 and 157.14. Completed 2025 activities include:	*Participation in committee review. Planned upcoming Panel Discussion on 157.11 at TX NAEMSP*	

9.i. GETAC EMS Education Committee

Chair: Macara Trusty, LP

Vice-Chair: Christopher Nations, LP

EMS Education Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Review/Revise EMS Education Rules to meet the needs of the workforce and the patients that are treated and transported daily.	*Drafted. Pending. New date, March 2027. Removed from agenda due to date push back.*	
2. Continue to Improve access to initial EMS Education Programs. a. Review and enhance advanced placement and open enrollment opportunities	*Data shared showing success of open enrollment cohorts. Will continue pilot programs until official rule can be changed.*	
3. Continue to Improve access to initial EMS Education Programs. a. Develop guidance document for High School EMT Programs.	*High School Guidance document drafted and in final revision stages. Once approved by committee, will be forwarded to council for recommendation for adoption by DSHS as a guidance document only.*	

9.j. GETAC Disaster Preparedness Update to Council November 24, 2025

Chair: Eric Epley

Vice-chair: Dr. Emily Kidd

March 2026 Meeting Summary

- CDPA-1 Blood Bags Update
- Emergency Medical Task Force (EMTF) Program Updates
  - Continuing to respond to activations while expanding program components and training opportunities
  - Growing national interest in the TX EMTF structure
- Pulsara Incident Reconciliation Process
  - Reviewed and approved by the committee to be established as initial framework
- Pre-Hospital Whole Blood Task Force Updates
  - Continued discussion on blood provider logistics and operational realities as prehospital whole blood programs expand

Disaster Preparedness Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
1. Emergency Medical Task Force (EMTF) Initiatives *Collaborate with the EMTF to identify and implement at least three new initiatives aimed at improving disaster response capabilities across Texas.*	• Managing rising activation levels while maintaining consistent, high-quality care across the state. • Expanding training opportunities and strengthening leadership capabilities.	

Disaster Preparedness Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
2. Pulsara Rollout for Mass Casualty Incidents (MCI), School Shooting Roster Uploads, and General Population Sheltering Modules *Implement the Pulsara platform throughout Texas for MCIs and school roster upload for family reunification processes, and in general population shelters within Texas. Success will be measured by the number of entities trained and actively using the platform during drills and actual events*	• Reviewed and approved the draft Pulsara Reconciliation Plan to begin standardization and improve collaboration among all stakeholders involved in mass casualty incidents and post-incident family support. • Continuing to coordinate meetings with school leadership to begin outlining the RAPTOR–Pulsara collaboration.	

Disaster Preparedness Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
3. Wristband Rollout/Expansion/Integration with EMS Electronic Medical Records (EMRs), Hospital EMRs, and Regional-State Registries *Achieve full integration of patient wristband systems with EMS and hospital EMRs, as well as regional and state registries, in at least 80% of healthcare facilities statewide. Integration success will be assessed through system interoperability tests and user feedback.*	• Increasing utilization of Pulsara wristbands across participating partners • Continuing to communicate the growing need for wristband use, particularly within initiatives such as the Prehospital Whole Blood Task Force	

Disaster Preparedness Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
4. National Disaster Medical System (NDMS) 2.0 Pilot Project Impacts to Texas *By March 31, 2026, conduct a comprehensive assessment of the NDMS 2.0 Pilot Project's impacts on Texas, including resource allocation, response times, and patient outcomes. Findings will be compiled into a report with actionable recommendations for statewide implementation.*	• Continue pilot site updates and compile findings for reporting. • Continue development of the RMOCC framework and work toward standardization at the national level. • Continue preparation and coordination of NDMS and pilot site capabilities, while collaborating with RMOCCs statewide	

GETAC Committee/Stakeholder Action Item Request for Council March 2026

Mr. Eric Epley

GETAC Disaster Preparedness

Action Item Request and Purpose

Request:

- Approve the *Draft Pulsara Incident Reconciliation Process* as the initial agreed-upon framework to be implemented during large-scale incidents.

Purpose:

- Establish a standardized process for reconciling patient information during large-scale incidents using Pulsara, providing a consistent platform for patient tracking, maintaining records of all individuals involved in an incident, and supporting eventual family reunification efforts.

Benefit and Timeline

Benefit:

- Improves patient tracking and accountability during mass casualty incidents by creating a consistent reconciliation process between field responders, hospitals, and the family reunification efforts. This helps reduce duplicate records, improves situational awareness, and supports more accurate patient identification and reunification during large-scale events.

Timeline:

- Approval is requested today so the document can be shared and utilized as an initial framework, allowing the process to continue evolving and improving as it is implemented and refined through use.

10. Task Force Updates and Action Items

10.a. Prehospital Whole Blood Task Force

Chair: Mr. Eric Epley

Vice-chair: Dr. CJ Winckler & Dr. Don Jenkins

GETAC Pre-hospital Whole Blood Task Force Update to Council March 2026

Chair: Mr. Eric Epley

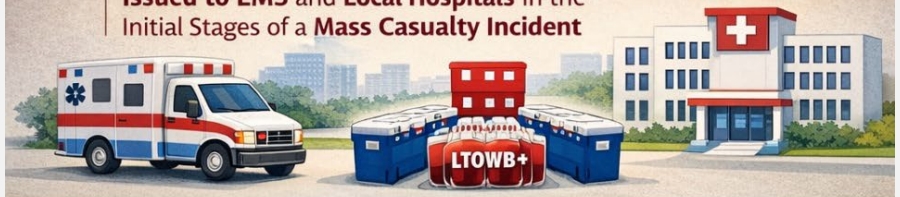
Vice-chair: Dr. CJ Winckler & Dr. Don Jenkins

March 2026 Meeting Summary

- Walking Blood Bank - Pilot Sites drafted
- Spray Dried Plasma – Inclusive Language
- Air Medical Providers - Statewide Map
- Statewide Blood Program - Donor Estimates
- PI Data Field Questions (Document 4)
  - EMS and Hospital fields approved for initial version and rollout

REGIONAL PUSH PACK OF LTOWB+ ISSUED

Issued to EMS and **Local Hospitals** in the Initial Stages of a **Mass Casualty Incident**



- **Low Titer O Whole Blood +**
- **Other Blood Components**

BLOOD EMERGENCY READINESS CORPS (BERC)

Activated During a Mass Casualty to Resupply Blood Center

- **Coordination of Interstate Blood Resupply**
  - **Shipments of Blood Products**
  - **Reinforce Local Blood Supply**

AABB | AABB DISASTER RESPONSE

Association for the Advancement of Blood & Biotherapies (AABB)

- **Organized Blood Resource Management**
- **Multi-Organizational Effort to Serve Affected Stakeholders**

Pre-hospital Whole Blood Task Force

2025 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. PHWBTF – Planning for the PHWB pilot program	*Continuing implementation efforts and collaborating with members across the state to prepare for pilot launch.*	
2. PHWBTF – Tasks	• *Actively working through assigned tasks on a defined timeline and moving forward once contracts are signed* • *All participating members have clearly outlined responsibilities and report weekly to the PHWBTF with progress updates.*	
3. Texas Whole Blood pilot deployment Resources	• *Resource documents are circulated weekly for review and refinement by the PHWBTF.* • *PI processes and documentation have been widely discussed and developed by the committee.*	

GETAC Committee/Stakeholder Action Item Request for Council March 2026

Mr. Eric Epley

Pre-hospital Whole Blood Taskforce

Action Item Request and Purpose

Request:

- Approve the *Pre-Hospital Whole Blood Public Education Awareness Tool* for publication and use in the PHWBTF pilot program.

Purpose:

- Provide a standardized public education resource to increase awareness of prehospital whole blood programs in Texas and educate communities on the importance of early blood transfusion in trauma and medical emergencies

Benefit and Timeline

Benefit:

- Improves public understanding of prehospital whole blood programs and their role in saving lives before patients reach the hospital, while supporting statewide awareness efforts that encourage blood donation and reinforce the importance of rapid hemorrhage control and early transfusion in reducing preventable deaths from severe bleeding.

Timeline:

- Requesting approval today so the document can be published and utilized immediately in the PHWBTF pilot program.

Action Item Request and Purpose

Request:

- Approve the *GETAC PHWBTF Purpose Statement* for publication and use in the PHWBTF pilot program.

Purpose:

- To formally define the task force's mission, vision, goals, and scope of work, and provide clear guidance for stakeholders participating in the PHWBTF pilot program.

Benefit and Timeline

Benefit:

- Establishes a shared framework and direction for the task force, ensuring alignment among EMS agencies, hospitals, blood centers, Regional Advisory Councils, and other partners while supporting consistent communication, collaboration, and implementation of prehospital whole blood initiatives statewide.

Timeline:

- Approval requested today so the document can be published and referenced as the guiding framework for PHWBTF activities and pilot program implementation moving forward.

10.b. Burn Care Task Force

Taylor Ratcliff, MD, and Amber Tucker, RN, Co-chairs

10.c. Time-sensitive Transfer Deconfliction Task Force

Ryan Matthews

11. System Collaborative for Outcome Review (SCOR) Update to Council

Chair: Kate Remick, MD

Vice Chair: Shawn Salter, RN

SCOR Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. [Performance Improvement]: *Tracking top 5 clinical quality measures*	*Reviewing performance on the top 5 performance measures, identify trends (positive and negative)*	
2. [Performance Improvement]: *Data reporting and dissemination strategies*	*Discussing mechanisms to support RACs in driving improvement efforts, Disseminating results from the performance improvement process*	
3. [Performance Improvement]: *Consideration of other system priorities, needs, and measures*	*Considering future measures for adoption once SMART aims achieved or measures abandoned*	

Measure Report

Stroke screening (prehospital)

Door-to-needle time in acute ischemic stroke (ED)

11.a.A. Emergency Medical Services and Trauma Registries (EMSTR) Stroke Performance Improvement Data

March 13, 2026

Jia Benno
Newborn Screening and Injury Prevention Section Director

About EMSTR

- EMSTR collects reportable event data from EMS providers, hospitals, justices of the peace, medical examiners, and rehabilitation facilities.
- All submitters must report all EMS responses and reportable trauma events to EMSTR under Texas Administrative Code, Title 25, Chapter 103.

NOTE: An EMS response is a resulting action from a call for assistance where an EMS provider is dispatched to, responds to, provides care to, or transports a person.

Stroke Performance Improvement (PI) Data

January 1, 2023 - June 30, 2025

Inclusion Criteria – All Suspected Strokes

- Primary symptom, other associated symptom, provider's primary impression or provider's secondary impression variables included a stroke.
- Protocols used were "Medical – Stroke/TIA".[1]
- Stroke Scale Result was "Positive".
- Destination Prearrival Activation is "Yes-Stroke".

[1] TIA = transient ischemic attack

Suspected Stroke Numbers, 2023-2025

	2023	2024	2025*
Total Suspected Stroke Patients	59,898	69,129	37,617

*2025 data is from January 1 – June 30, 2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMS and Trauma Registries (EMSTR), January 2026.

Suspected Stroke by Sex, 2023-2025

Sex	2023	2024	2025*
Male	28,582	33,757	17,977
Female	31,125	35,228	19,040
Missing / Not Recorded	191	144	600
Total	**59,898**	**69,129**	**37,617**

*2025 data is from January 1 – June 30, 2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2026.

Stroke Scale Status for Suspected Stroke Patients, 2023-2025

Status	2023	2024	2025*
Stroke Scale Performed	33,858	44,807	25,415
Percentage	56.53%	64.82%	67.56%
Missing	26,040	24,322	12,202
Percentage	43.47%	35.18%	32.44%
Totals	**59,898**	**69,129**	**37,617**

*2025 data is from January 1 – June 30, 2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2026.

Stroke Scale Performed by Sex for Suspected Stroke Patients, 2023-2025

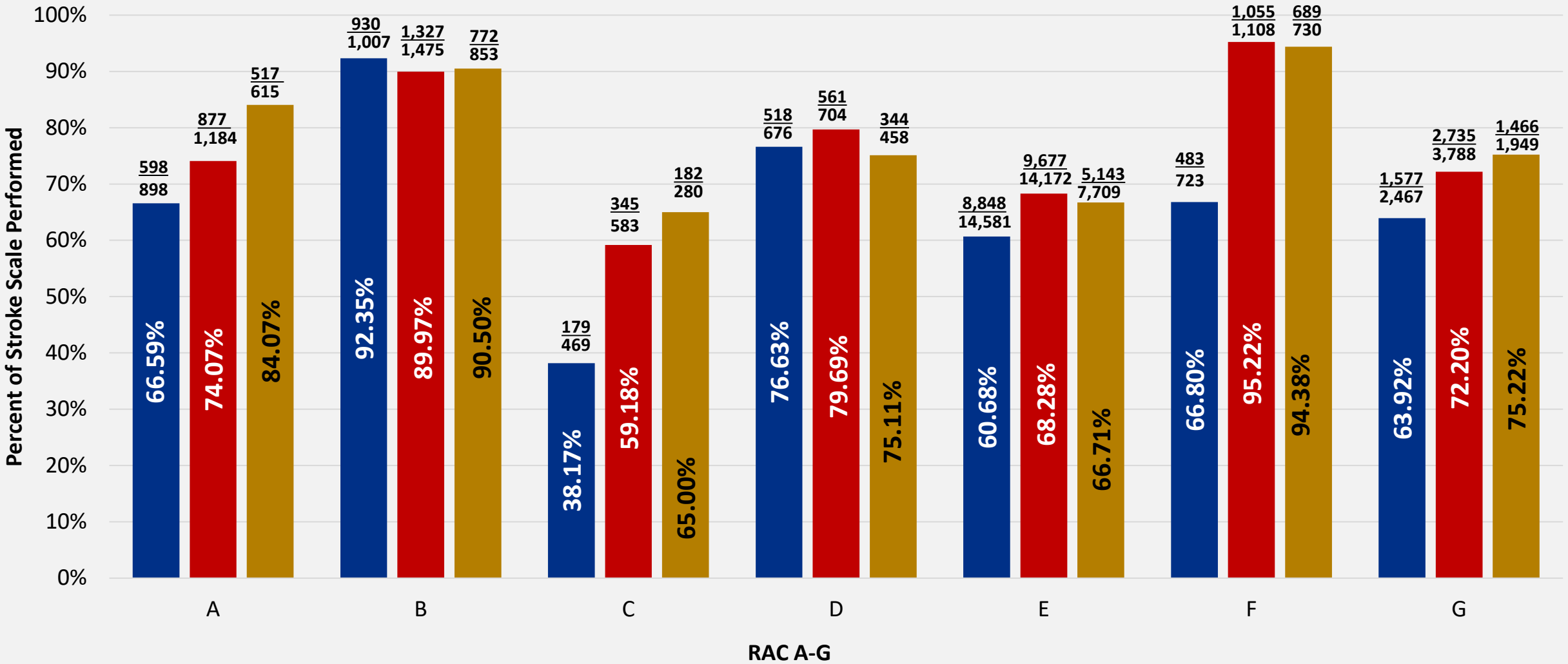
Sex	2023	2024	2025*
Male	16,186	21,709	12,283
Percentage	56.63%	64.31%	68.33%
Female	17,604	23,015	13,034
Percentage	56.56%	65.33%	68.46%

Note: Data does not include stroke scales performed when sex was missing or unknown.

*2025 data is from January 1 – June 30, 2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2026.

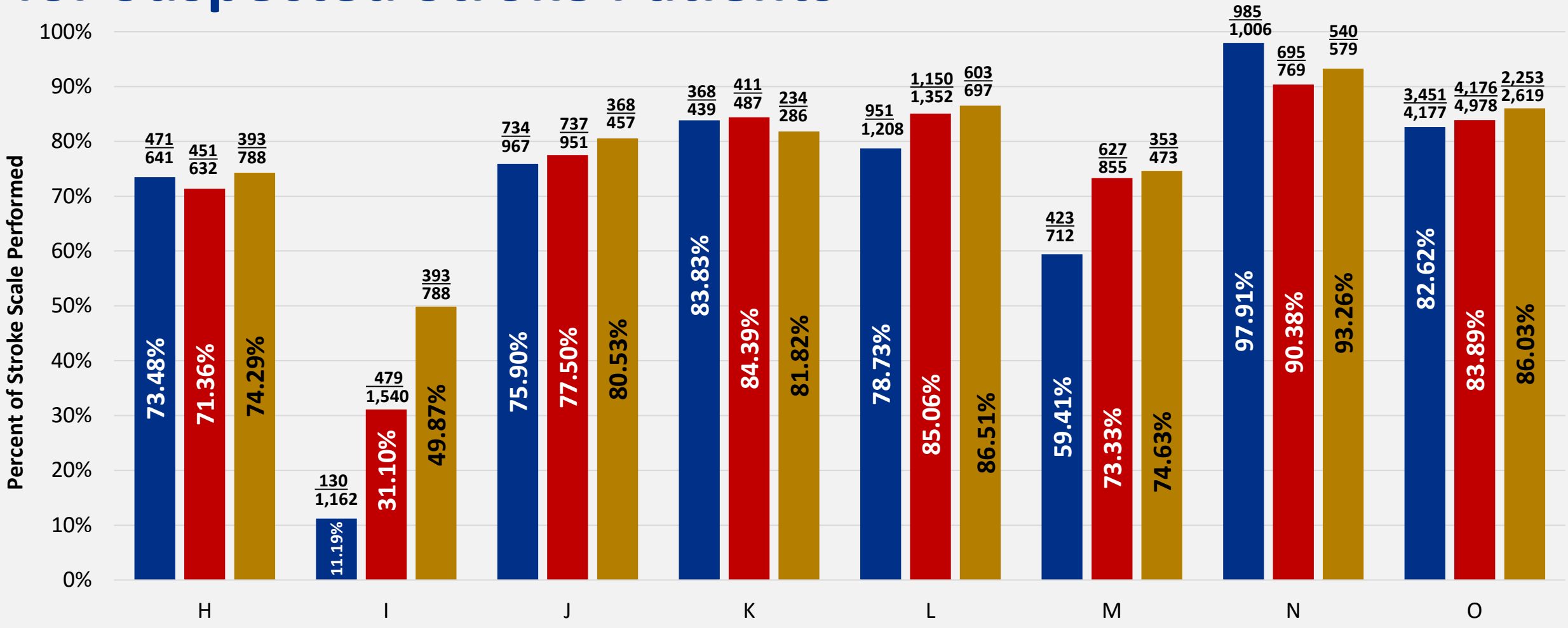
Stroke Scale Performed by Regional Advisory Council (RAC) A-G for Suspected Stroke Patients



*2025 data is from January 1 – June 30, 2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2026.

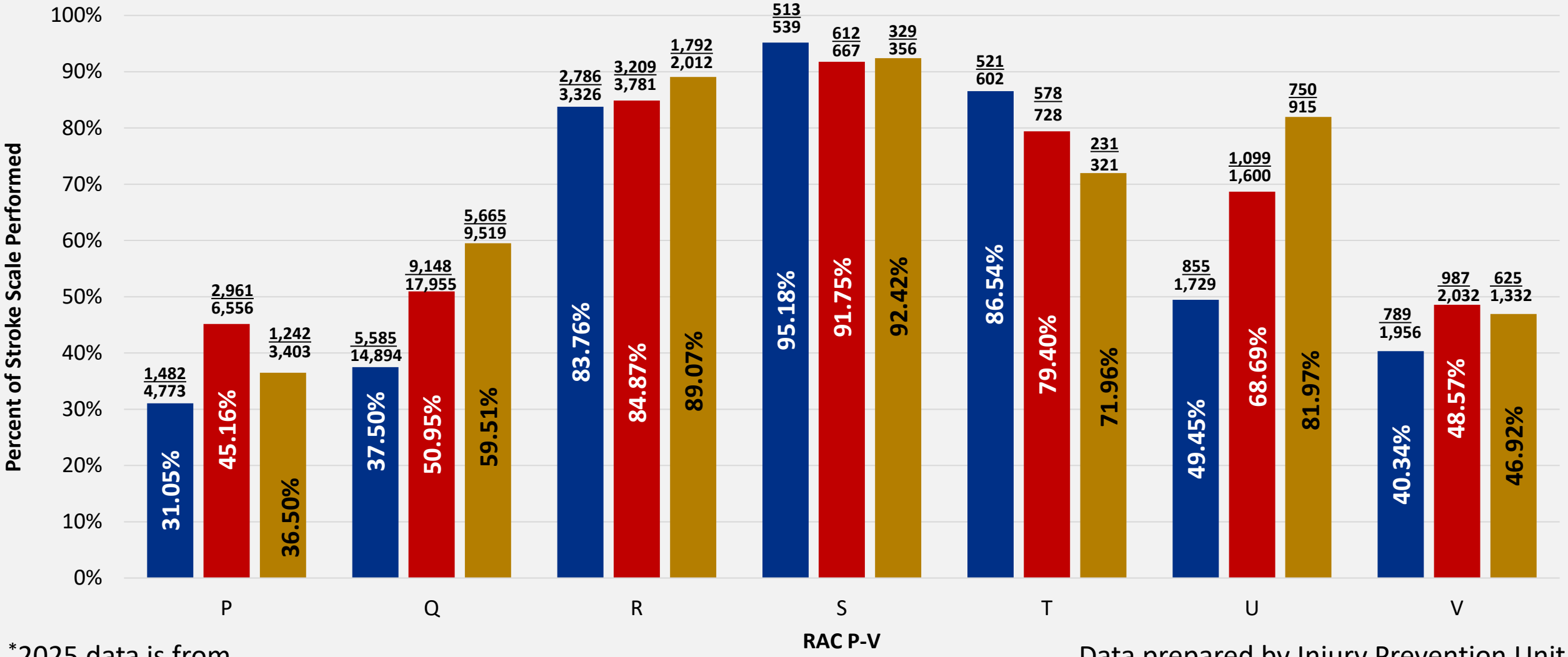
Stroke Scale Performed by RAC H-O for Suspected Stroke Patients



*2025 data is from January 1 – June 30,2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2026.

Stroke Scale Performed by RAC P-V for Suspected Stroke Patients



*2025 data is from January 1 – June 30, 2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2026.

Trauma Transfer Delay – Median Time to Transfer (Follow-up data)

2023-2024

Median Trauma Transfer Delay, 2023, Transfer Time

Age Group	Median Time	Number of People
Less than 15	1.90 hours	107
Age 15-64	2.13 hours	550
Age 65+	3.15 hours	883

Median Trauma Transfer Delay, 2024, Transfer Time

Age Group	Median Time	Number of People
Less than 15	2.45 hours	107
Age 15-64	2.65 hours	515
Age 65+	3.82 hours	985

American Heart Association.

American Heart Association. Get With The Guidelines. Stroke

11.a.B. Semiannual GETAC Stroke Quality Report

Data Sourced from Get With The Guidelines® - Stroke
on February 12th, 2026
Reports reflect CY 2023 – 2025 data

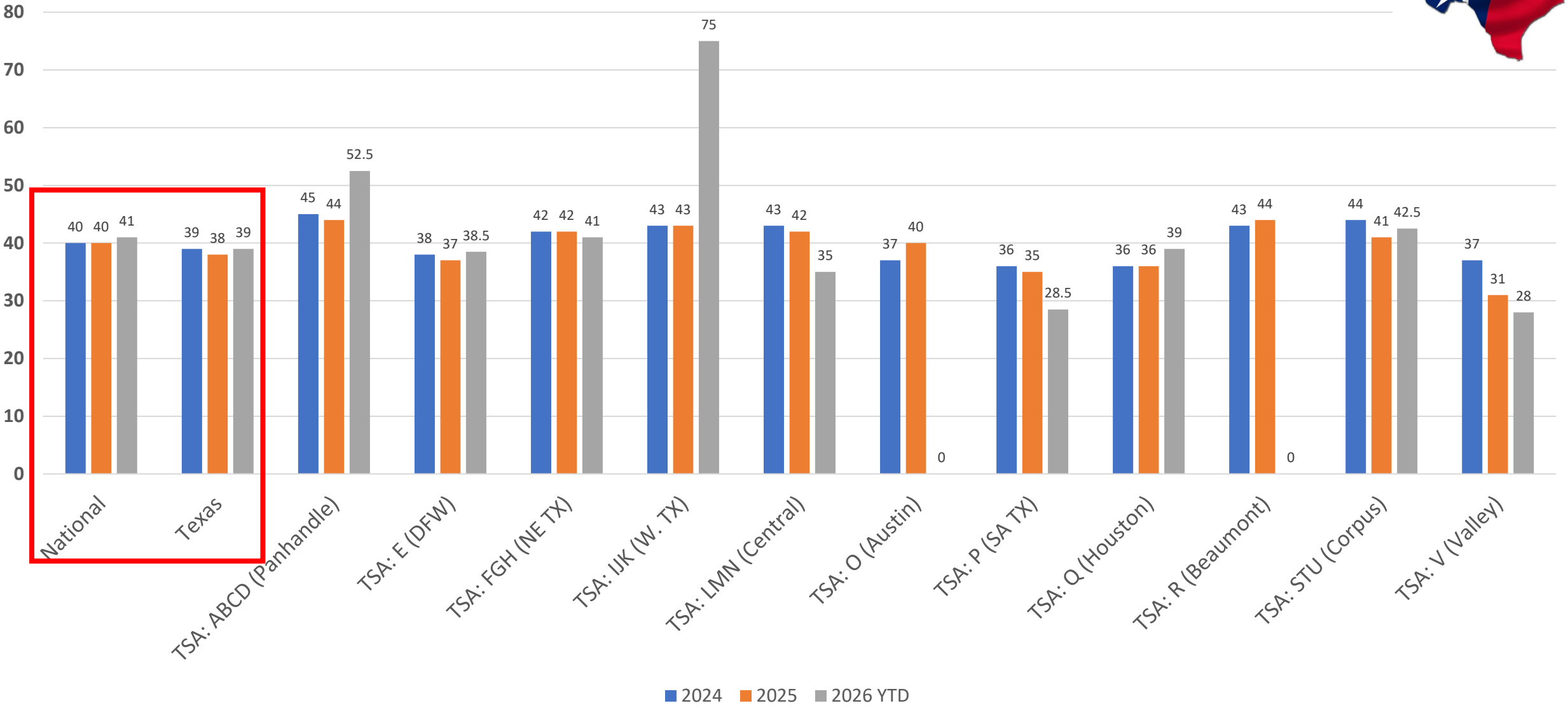
Currently Participating

Texas Stroke GWTG Sample

- **236 (+5)** TX Hospitals participating in GWTG
  - **60 (+1)** participating hospitals classified as **"Rural,"** using the Rural Urban Commuting Area (RUCA) codes 4-10 and 99
    - **43 (+5)** of these joined as part of the **Rural Healthcare Outcomes Accelerator** program
  - **95 (+2)** participating in RDC = **40% (No Change)** of TX GWTG Hospitals
  - As of February 2026, **177 of the 194 (91%) (+1%)** designated facilities in Texas are currently using GWTG Stroke

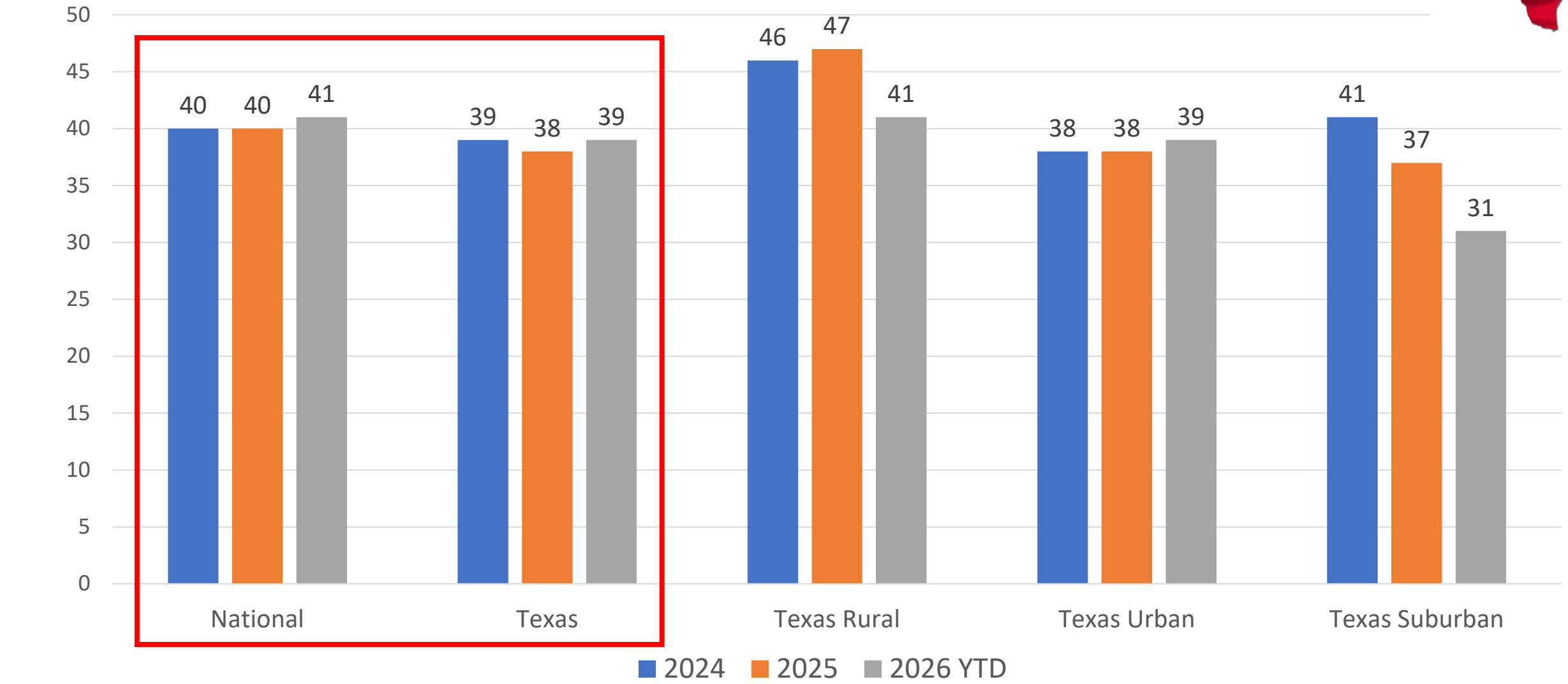
Disclaimer: Report generated on 02/04/2026

Median DTN by RAC (minutes)



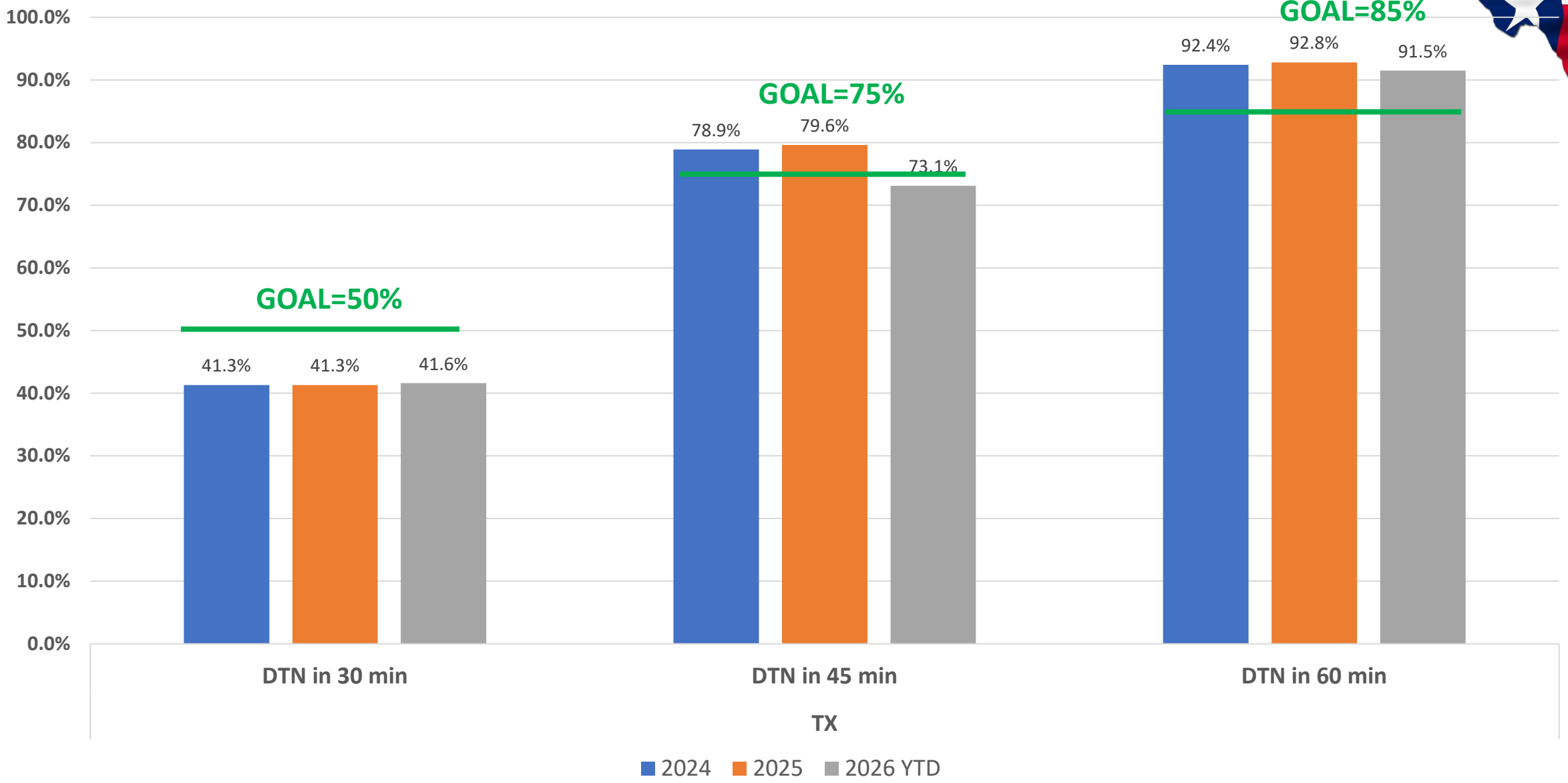
Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 02/12/26.

Median DTN by Geographic Size



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 02/12/26.

Door to Needle (30'/45'/60' window)



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 02/12/26.

GETAC Committee/Stakeholder Action Item Request for Council March 2026

Kate Remick, MD

System Collaborative for Outcomes Review

Action Item Request and Purpose

Request approval to identify a replacement measure for Severe Maternal Morbidity and Mortality Rates.

- Given 2-year delays in data availability/reporting, tracking and oversight by PAC and TCHMB, we request consideration of other high-priority measures.
- PAC representative will continue to provide updates on SMMR (at a cadence TBD) during SCOR meetings to maintain situational awareness.

Benefit and Timeline

Allows SCOR to continue tracking and reporting on 5 priority measures to GETAC. Allows for expansion of system improvement efforts.

- Timeline: March GETAC session – approval to consider alternate measure
- Future GETAC meeting – Approval of alternative measure

11.a.C.
Top 11 Measures: Approve Revised Language

1. For injured adult patients <65yrs with a GCS <9 or SBP<90mmHg, time from arrival to departure from sending facility
2. # of severe maternal morbidity events (21 ICD-10 codes) per 1000 live births
3. For patients with acute ischemic stroke, door-to-needle time
4. Percent of EMS patients with primary impression of "stroke" who have a stroke screening scale documented by EMS
5. Percent of OHCA patients that received bystander CPR prior to EMS arrival
6. Percent of OHCA patients in public locations where AED was applied prior to EMS arrival
7. Mean or Median pediatric readiness score for designated trauma centers
8. Percent of trauma centers that took the pediatric readiness assessment in a given calendar year
9. Percent of patients greater than or equal to 12 years of age who are screened for suicide
10. Percent of admitted injured patients greater than or equal to 12 years of age who are screened for substance use/misuse
11. Percent of newborns (<28 days) transported by EMS who arrive at the hospital with a temperature <36.5 Celsius

Eight Measures for Ranking

1. For injured adult patients <65yrs with a GCS <9 or SBP<90mmHg, time from arrival to departure from sending facility (>65yrs with SBP<110mmHg, <15yrs SBP <70 + 2(age))
2. # of severe maternal morbidity events (21 ICD-10 codes) per 1000 live births
3. For patients with acute ischemic stroke, door-to-needle time
4. Percent of EMS patients with primary impression of "stroke" who have a stroke screening scale documented by EMS
5. Percent of OHCA patients that received bystander CPR prior to EMS arrival
6. Percent of OHCA patients in public locations where AED was applied prior to EMS arrival
7. Mean or Median pediatric readiness score for designated trauma centers
8. Percent of trauma centers that took the pediatric readiness assessment in a given calendar year

Texas EMS and Trauma System Quality Measure Final Rankings (n=15)

Measure	Total Score	Ranking
For injured adult patients < 65yrs with a GCS < 9 or SBP< 90mmHg, time from arrival to departure from sending facility	**39**	**1**
For patients with acute ischemic stroke, door-to-needle time	**52**	**2**
# of severe maternal morbidity events (21 ICD-10 codes) per 1000 live births	**55**	**3**
Percent of EMS patients with primary impression of 'stroke' who have a stroke screening scale documented by EMS	**69**	**4**
Mean and Median pediatric readiness score for designated trauma centers	**75**	**5**
Percent of OHCA patients that received bystander CPR prior to EMS arrival	81	
Percent of trauma centers that took the pediatric readiness assessment in a given calendar year	84	
Percent of OHCA patients in public locations where AED was applied prior to EMS arrival	85	

Record ID	For injured adult patients < 65yrs with a GCS < 9 or SBP< 90mmHg, time from arrival to departure from sending facility	# of severe maternal morbidity events (21 ICD-10 codes) per 1000 live births	For patients with acute ischemic stroke, door-to-needle time	Percent of EMS patients with primary impression of 'stroke' who have a stroke screening scale documented by EMS	Percent of OHCA patients that received bystander CPR prior to EMS arrival	Percent of OHCA patients in public locations where AED was applied prior to EMS arrival	Mean or Median pediatric readiness score for designated trauma centers	Percent of trauma centers that took the pediatric readiness assessment in a given calendar year
1	3	8	2	1	7	6	4	5
2	1	3	5	4	2	6	7	8
3	8	3	5	7	6	4	1	2
4	3	4	5	7	2	6	1	8
5	3	1	2	6	7	4	5	8
6	1	4	2	3	8	7	5	6
7	1	2	4	3	7	5	6	8
8	1	2	3	6	7	8	4	5
9	1	2	3	6	5	4	8	7
10	6	8	7	3	1	2	5	4
11	1	3	4	2	5	8	6	7
12	7	1	2	3	4	6	8	5
13	1	8	2	4	6	7	5	3
14	1	2	3	7	8	4	5	6
15	1	4	3	7	6	8	5	2
	39	55	52	69	81	85	75	84
ale was 1-8 |	Rank 1	Rank 3	Rank 2	Rank 4	Rank 6		Rank 5	

Lowest Value = Highest Priority (scale was 1-8 | calculated sum for each measure)

Measure	Data Source	Frequency of Reporting	Baseline Data	National Average	Source
Percent of OHCA patients that received bystander CPR prior to EMS arrival	Texas EMS and Trauma Registry	Quarterly	44.5% of OHCA patients received bCPR prior to EMS arrival,	2023 national average is 41.2% (CARES 2023)	CARES
Percent of OHCA patients in public locations where AED was applied prior to EMS arrival	Texas EMS and Trauma Registry	Quarterly	17.0% AED applied without defibrillation 4.0% AED applied with defibrillation 21% AED applied with or without defibrillation (combined)	2023 national average is 11.7% (CARES 2023)	CARES

Reporting Schedule

Quarter	Measures
Q1	Prehospital stroke screening + Door-to-Needle time for acute ischemic stroke
Q2	Time from arrival-to-departure for unstable injured patients + Pediatric readiness score at trauma centers
Q3	Prehospital stroke screening + Door-to-Needle time for acute ischemic stroke
Q4	Time from arrival-to-departure for unstable injured patients + Rate of severe maternal morbidity events

12. Executive Committee Activities Summary

Executive Committee:

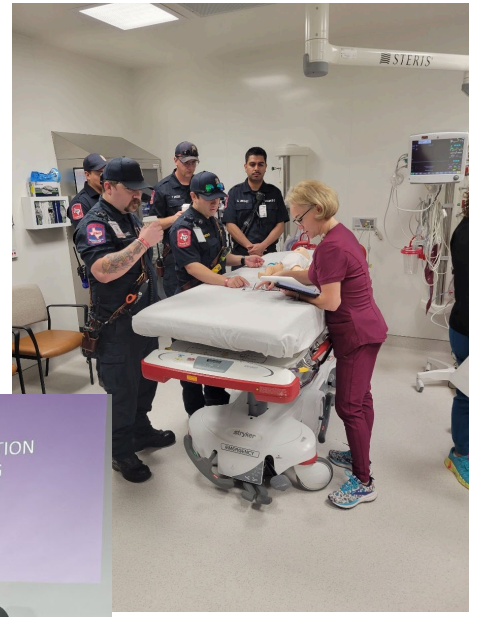
Alan Tyroch, MD, GETAC Chair

Ryan Matthews, GETAC Vice-Chair

Scott Lail, GETAC Council Member

13. Update: TX Pediatric Readiness Improvement Project

Dr. Kate Remick



Texas Pediatric Readiness Improvement Project Update

GETAC March 2026

Project Arms:

- TPRIP Virtual Education Series - Season 2
- 13 Standardized Pediatric trauma simulation scenarios
- 16 Pediatric Readiness Improvement & Simulation Mentors
- Pediatric QI performance and dashboards to drive Pediatric QI efforts

Supported by:

GETAC

Texas EMS for Children

Texas ENA

Texas Trauma Coordinators Forum

TETAF

NPRQI

Everyday Pediatric Readiness

National PRP
Pediatric Readiness Project
Ensuring Emergency Care for All Children

For EDs

- High Pediatric Readiness associated with up to 76% lower mortality risk

Est. 2012

National PRP
Prehospital Pediatric Readiness Project
Ensuring Emergency Care for All Children

For EMS

- Inaugural national assessment results published last month (7K agencies)

Est. 2019

National PRP Pediatric Readiness Project
Ensuring Emergency Care for All Children

Map View:
- (•) Response Rate
- ( ) Number of Responses

Responses to the NPRP assessment vary by state/territory due to factors such as size, resource availability, and regulatory structure. You may view the map and color shading by response rate or number of responses by selecting the "Map View" on the left.

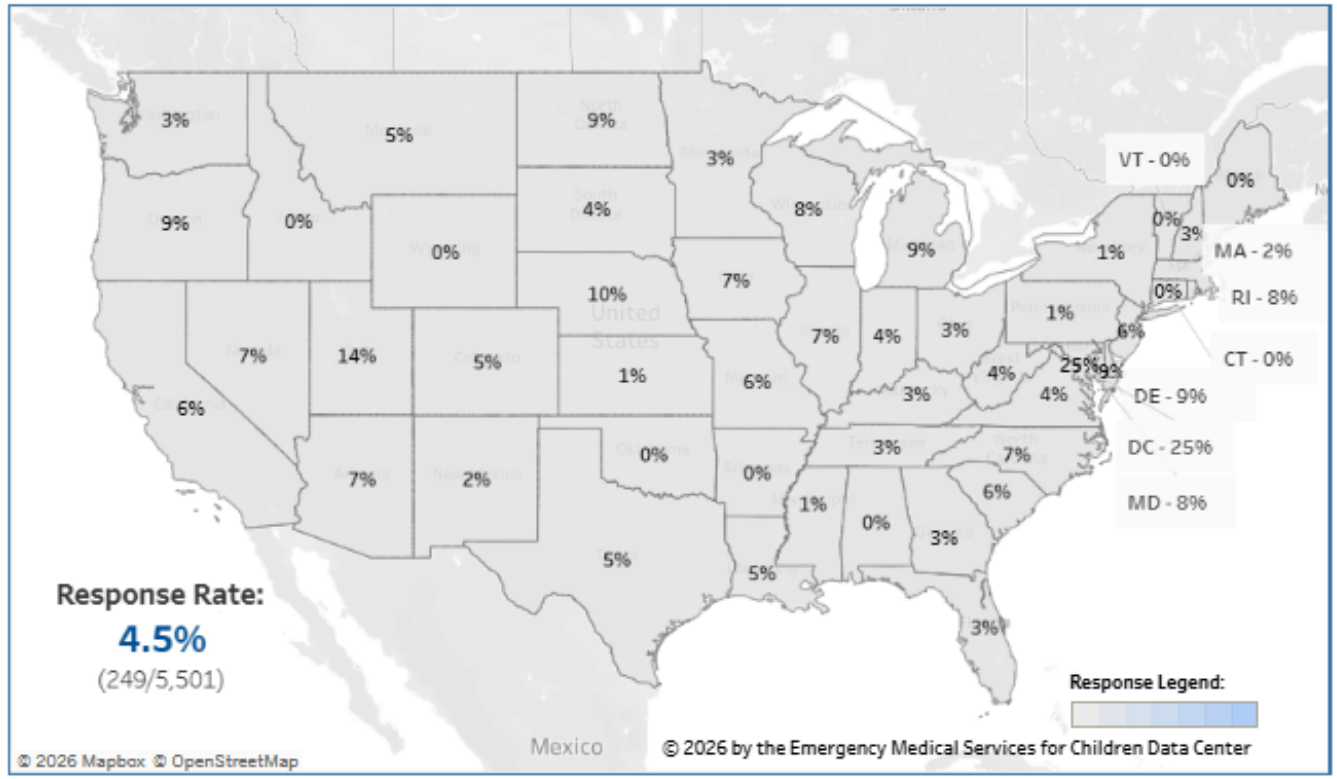
EMSC Emergency Medical Services for Children

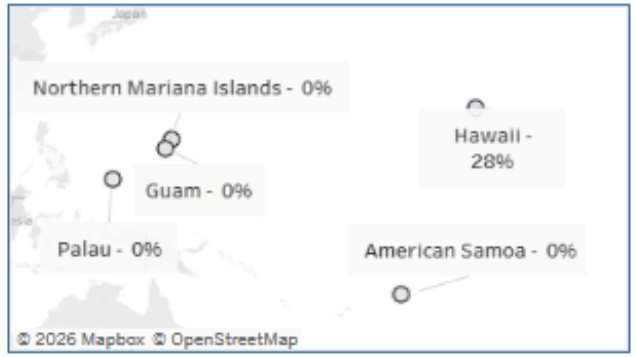
NPRP is funded by the Health Resources and Services Administration EMSC Program

2026 National Pediatric Readiness Project (NPRP) Response Rate by State/Territory

Last Updated: 3/6/2026 2:55:13 PM

State Name	Numerator	Denominator	Response Rate
New York	3	269	1%
North Carolina	10	134	7%
North Dakota	4	44	9%
Northern Mariana I..	0	1	0%
Ohio	7	222	3%
Oklahoma	0	116	0%
Oregon	5	58	9%
Palau	0	1	0%
Pennsylvania	2	170	1%
Puerto Rico	3	50	6%
Rhode Island	1	12	8%
South Carolina	5	80	6%
South Dakota	2	55	4%
Tennessee	3	120	3%
Texas	29	581	5%
Utah	8	58	14%
Vermont	0	14	0%
Virgin Islands	0	3	0%
Virginia	4	112	4%
Washington	3	92	3%
West Virginia	2	47	4%
Wisconsin	11	137	8%
Wyoming	0	29	0%
Grand Total	249	5,501	5%

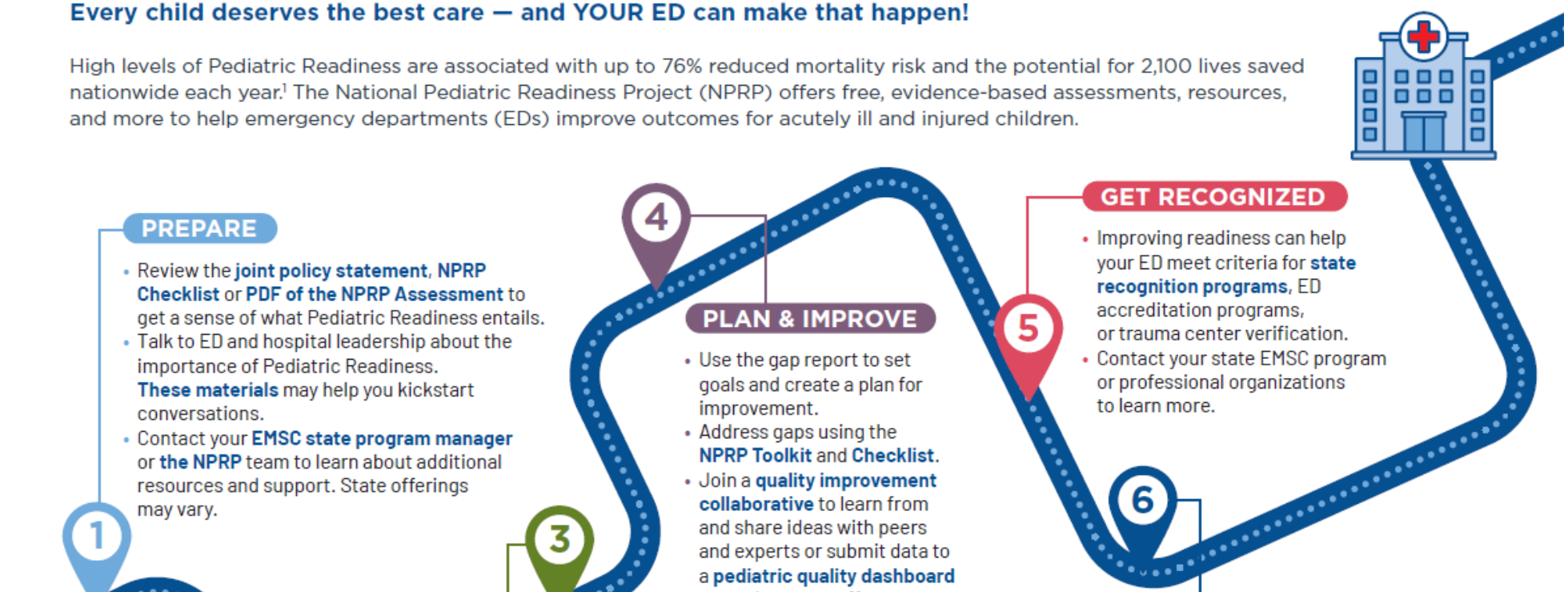




The Route to Pediatric Readiness in Emergency Departments

Every child deserves the best care — and YOUR ED can make that happen!

High levels of Pediatric Readiness are associated with up to 76% reduced mortality risk and the potential for 2,100 lives saved nationwide each year.[1] The National Pediatric Readiness Project (NPRP) offers free, evidence-based assessments, resources, and more to help emergency departments (EDs) improve outcomes for acutely ill and injured children.



1 PREPARE

- Review the **joint policy statement**, **NPRP Checklist** or **PDF of the NPRP Assessment** to get a sense of what Pediatric Readiness entails.
- Talk to ED and hospital leadership about the importance of Pediatric Readiness. **These materials** may help you kickstart conversations.
- Contact your **EMSC state program manager** or **the NPRP** team to learn about additional resources and support. State offerings may vary.

2 APPOINT PECCS

- Talk with ED leadership about appointing both a physician and nurse pediatric emergency care coordinator (PECC) to oversee Pediatric Readiness. PECCs are essential to improving readiness.
- Explore **a PECC learning series** to get started.

3 ASSESS & REVIEW

- Identify the best person (typically the ED nurse manager or a PECC) to coordinate completion of the NPRP Assessment (the next nationwide period is March–May 2026).
- **Complete the assessment**, which typically takes 30-45 minutes, to recieve your score, benchmarking information and a gap report.
- Review the results with your leadership and team.

4 PLAN & IMPROVE

- Use the gap report to set goals and create a plan for improvement.
- Address gaps using the **NPRP Toolkit** and **Checklist**.
- Join a **quality improvement collaborative** to learn from and share ideas with peers and experts or submit data to a **pediatric quality dashboard** to see how your efforts are impacting clinical practice.

5 GET RECOGNIZED

- Improving readiness can help your ED meet criteria for **state recognition programs**, ED accreditation programs, or trauma center verification.
- Contact your state EMSC program or professional organizations to learn more.

6 KEEP IT UP!

- Repeat steps 3 and 4, taking the assessment once every 1-3 years, to stay on the path to our shared destination: high-quality emergency care for ALL children!

National PRP
Pediatric Readiness Project
Ensuring Emergency Care for All Children

1. https://media.emscimprovement.center/documents/Pediatric_Readiness_Impact_Statistics.pdf

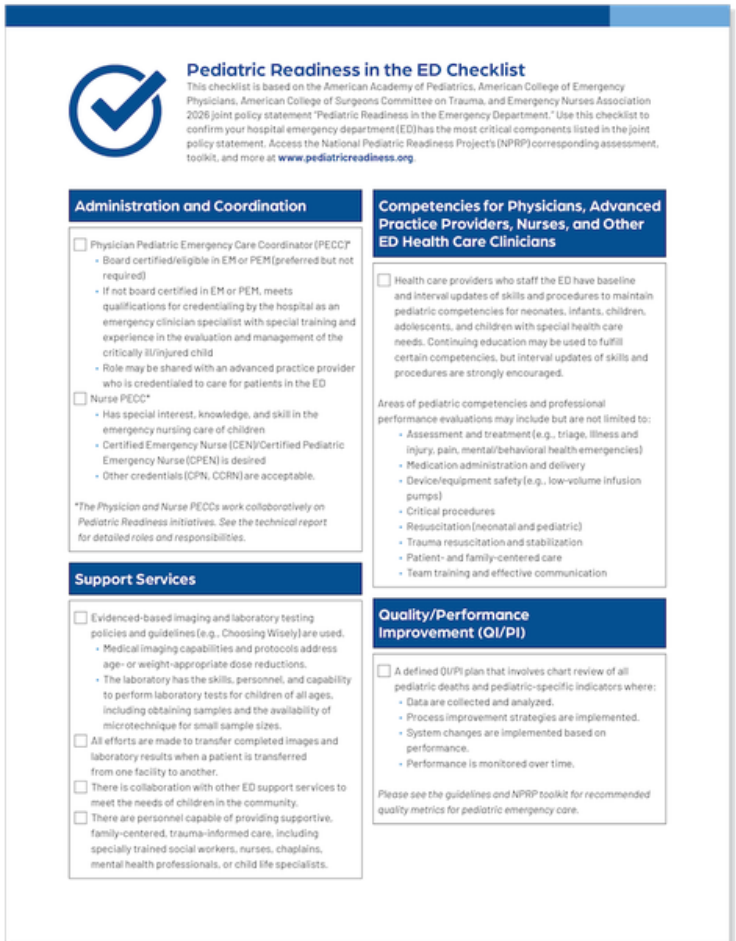
This EMSC Innovation and Improvement Center resource is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award (U07MC37471) totaling $2.5M with 0 percent financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov. 251201 | Updated 1/5/2026

Checklist

Use this informal tool to quickly check if your ED is ready to care for children as outlined in the 2026 joint policy statement.

The checklist can be especially useful to help you prepare for the NPRP Assessment and understand what will be asked. Then, use the corresponding NPRP Toolkit to address gaps identified by the checklist.

Download checklist



Pediatric Readiness in the ED Checklist

This checklist is based on the American Academy of Pediatrics, American College of Emergency Physicians, American College of Surgeons Committee on Trauma, and Emergency Nurses Association 2026 joint policy statement "Pediatric Readiness in the Emergency Department." Use this checklist to confirm your hospital emergency department (ED) has the most critical components listed in the joint policy statement. Access the National Pediatric Readiness Project's (NPRP) corresponding assessment, toolkit, and more at www.pediatricreadiness.org.

Administration and Coordination

- ☐ Physician Pediatric Emergency Care Coordinator (PECC)*
  - Board certified/eligible in EM or PEM (preferred but not required)
  - If not board certified in EM or PEM, meets qualifications for credentialing by the hospital as an emergency clinician specialist with special training and experience in the evaluation and management of the critically ill/injured child
  - Role may be shared with an advanced practice provider who is credentialed to care for patients in the ED
- ☐ Nurse PECC*
  - Has special interest, knowledge, and skill in the emergency nursing care of children
  - Certified Emergency Nurse (CEN)/Certified Pediatric Emergency Nurse (CPEN) is desired
  - Other credentials (CPN, CCRN) are acceptable.

**The Physician and Nurse PECCs work collaboratively on Pediatric Readiness initiatives. See the technical report for detailed roles and responsibilities.*

Support Services

- ☐ Evidenced-based imaging and laboratory testing policies and guidelines (e.g., Choosing Wisely) are used.
  - Medical imaging capabilities and protocols address age- or weight-appropriate dose reductions.
  - The laboratory has the skills, personnel, and capability to perform laboratory tests for children of all ages, including obtaining samples and the availability of microtechnique for small sample sizes.
- ☐ All efforts are made to transfer completed images and laboratory results when a patient is transferred from one facility to another.
- ☐ There is collaboration with other ED support services to meet the needs of children in the community.
- ☐ There are personnel capable of providing supportive, family-centered, trauma-informed care, including specially trained social workers, nurses, chaplains, mental health professionals, or child life specialists.

Competencies for Physicians, Advanced Practice Providers, Nurses, and Other ED Health Care Clinicians

- ☐ Health care providers who staff the ED have baseline and interval updates of skills and procedures to maintain pediatric competencies for neonates, infants, children, adolescents, and children with special health care needs. Continuing education may be used to fulfill certain competencies, but interval updates of skills and procedures are strongly encouraged.

Areas of pediatric competencies and professional performance evaluations may include but are not limited to:

- Assessment and treatment (e.g., triage, illness and injury, pain, mental/behavioral health emergencies)
- Medication administration and delivery
- Device/equipment safety (e.g., low-volume infusion pumps)
- Critical procedures
- Resuscitation (neonatal and pediatric)
- Trauma resuscitation and stabilization
- Patient- and family-centered care
- Team training and effective communication

Quality/Performance Improvement (QI/PI)

- ☐ A defined QI/PI plan that involves chart review of all pediatric deaths and pediatric-specific indicators where:
  - Data are collected and analyzed.
  - Process improvement strategies are implemented.
  - System changes are implemented based on performance.
  - Performance is monitored over time.

Please see the guidelines and NPRP toolkit for recommended quality metrics for pediatric emergency care.

Toolkit

Questions or Feedback on the NPRP Toolkit?

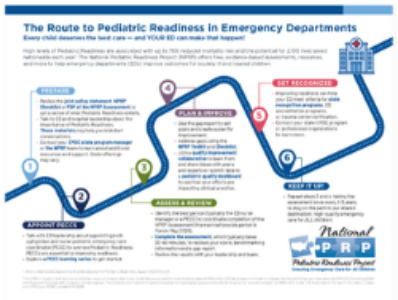
Contact us

Sign Up for Updates

The NPRP Toolkit has been redesigned to align with the NPRP Roadmap, making it easier to navigate resources in a structured, step-by-step way. If you have trouble finding something, please contact us.

The National Pediatric Readiness Project (NPRP) Toolkit is a comprehensive, evidence-based resource designed to help emergency departments (EDs) strengthen and sustain their ability to care for children. Grounded in a joint policy statement by the leading organizations in pediatric emergency care, "Pediatric Readiness in the Emergency Department," the toolkit provides practical guidance and resources to help EDs improve Pediatric Readiness.

Maintained by the EMSC Innovation and Improvement Center, the toolkit serves nurse and physician pediatric emergency care coordinators (PECCs), ED clinicians and staff, as well as hospital leadership and other partners advancing pediatric emergency care. This toolkit is organized into sections that align with the suggested steps in the Pediatric Readiness roadmap, guiding EDs from assessment to planning through implementation and sustainability.



To submit content or feedback for this toolkit, use this form. Questions about the toolkit? Contact us.

To submit content or feedback for this toolkit, use this form. Questions about the toolkit? Contact us.

Section 1: Prepare

Build Awareness and Get Leadership Buy-In

Section 2: Appoint PECCs

Establish and Develop Nurse and Physician Coordinator Roles

Section 3: Assess and Review

Measure Your ED's Readiness and Understand Your Results

Section 4: Plan and Improve

Implement Changes to Advance Pediatric Readiness

Section 5: Get Recognized - COMING SOON!

Validate and Celebrate Your Progress

Section 6: Keep It Up - COMING SOON!

Sustain Your Progress through Continuous Improvement

Section 7: More to Explore - COMING SOON!

Expand Your Impact and Pediatric Readiness Beyond

Texas Pediatric Readiness Education Series

Attendance Information

Years	Months	Topics	Registrants	Webinar Attendees
2024	January	Introduction to Pediatric Readiness	404	227
2024	February	Pediatric Assessment & Triage	993	351
2024	March	Respiratory Distress	1238	312
2024	April	Traumatic Brain Injury	1341	312
2024	May	Child Maltreatment	1404	259
2024	June	Long Bone Fractures & Pain Management	1468	270
2024	July	Overdoses & Poisoning	1488	236
2024	August	Shock Recognition & Management	1528	240
2024	September	Newborn Resuscitation	1567	219
2024	October	Pediatric Resources (Sim & Data Platforms)	1590	141
2024	November	Abdominal Trauma	1619	191
2024	December	Seizures	1644	185
2025	January	Upper Abdominal Obstruction & Anaphylaxis	1661	221
2025	February	Diabetic Ketoacidosis	1709	202
Launched 2nd Iteration of Education Series				
2025	March	Abdominal Surgical Emergencies	596	250
2025	April	Pediatric Acute Care Through Simulation	681	225
2025	May	National Pediatric Readiness Quality Initiative	741	210
2025	June	Safe Sleep & Sudden Unexpected Infant Death	769	184
2025	July	Mental & Behavioral Health Emergencies	795	204
2025	August	Cross-Sectional Imaging in Pediatric Traumas	839	206
2025	September			
2025	October	QI Collaboratives	1035	264
2025	November	Burns	1073	231
2025	December	Pre-Hospital Management of Pediatric Strokes	1123	224

Learner and Organizational Representation

The most common titles included:

- Registered Nurses
- Trauma Program Managers
- Trauma Coordinators
- Paramedics

- Hospital / Health System: 51.9%
- Government / Public Health / RAC: 6.6%
- EMS / Fire: 6.2%
- Academic Institutions: 3.1%
- Associations / Nonprofits: 1.6%
- Other / Unknown: 30.6% (primarily blank or non-standard entries)

Pediatric Readiness Education Series

February 2026 - Pediatric Head Trauma

- Registrants 1460
- Webinar Attendees 598

Pediatric Readiness Education Series

March 19, 10-11 am CT

Recurring on the third Thursday of each month at 10 am CT

EIIC EMSC Innovation and Improvement Center | TEXAS Pediatric Readiness Education Series

The Pediatric Readiness Education Series is a free, national webinar series delivered as a collaboration between the EIIC and the Texas Pediatric Readiness Education Series. Building on the success of the Texas-led series, this co-effort expands the reach of Pediatric Readiness education while aligning content with national Pediatric Readiness priorities.

The monthly sessions will focus on common clinical conditions and experiences in the emergency department (ED) setting and are designed for ED clinicians and staff across disciplines, including nurses, physicians, advanced practice providers, administrators, and Pediatric Emergency Care Coordinators (PECCs). EMS clinicians are also welcome to attend.

All webinars are free. The series is not affiliated with the Texas EMSC State Partnership Program. **Participation is currently limited to the first 1,000 attendees.** If you are unable to attend, the event will be recorded.

Date	Topic	Speaker
February 19	Head Trauma	Aaron Jensen
March 19	Mental Health	Heather Theaux
April 16	Neonatal Fever	Julia Magana
May 21	Drowning	Sarah Walter

Prehospital Pediatric Readiness National Assessment Results

In 2024, the National Prehospital Pediatric Readiness Project – led by the federal Emergency Medical Services for Children (EMSC) Program in collaboration with leading organizations in prehospital, emergency, and pediatric care – assessed how prepared emergency medical services (EMS) agencies are to care for children according to **national recommendations**. The results of this inaugural assessment were published in the ***Annals of Emergency Medicine***.

About Responding EMS and Fire-Rescue Agencies

6,989
out of 15,293 agencies (46%) responded

74%
see eight or fewer children per month

70%
provide advanced life support (ALS) services

60%
are located in urban areas

58%
are fire-based agencies

Key Findings

MEDIAN SCORE: 66 OUT OF 100

38%
of EMS agencies report having a pediatric emergency care coordinator (PECC)

52%
do skills testing with pediatric equipment at least twice per year

60%
collect pediatric elements as part of their patient care data

74%
have a performance improvement plan that includes review of pediatric encounters

83%
have all recommended pediatric equipment

Trends and Takeaways

- **PECC Impact:** Fewer than half of agencies report having a pediatric emergency care coordinator (PECC)—someone responsible for overseeing pediatric training and care processes—yet the presence of a PECC is associated with consistently higher scores across every category measured, even in low-resourced, low-volume settings.
- **Call Volume:** Agencies that care for more children annually tend to have higher readiness scores, yet the majority of agencies see less than 8 children per month, underscoring the need for repeat practice and advanced preparation.
- **Progress Achieved:** Most agencies reported having the nationally recommended pediatric equipment and supplies, reflecting years of efforts driven by EMS and emergency care leaders and the EMSC Program.

National PRP

Prehospital Pediatric Readiness Project

Ensuring Emergency Care for All Children

Improve Your Agency's Readiness Today

To find out more about Pediatric Readiness, the national assessment, or to access resources, visit:

pediatricreadiness.org

Data based on the paper "The National Pediatric Prehospital Readiness Project: First Comprehensive Assessment of United States Emergency Medical Services Agencies," published in February 2026 in the *Annals of Emergency Medicine*.

The Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS) provided financial support for this Prehospital Pediatric Readiness Project. The EMSC Innovation and Improvement Center award provided 12% of total costs and totaled $2.5M; and the EMSC Data Center award provided 20% of the total cost and totaled $3.2M. The contents are those of the author. They may not reflect the policies of HRSA, HHS, or the U.S. Government. 260120 | Updated 2/23/2026.

Pediatric Readiness Improvement & Simuatlion Mentors

14 PRISMs

Regional Training Events

June - October

Methodist Health System, 2/18/26

22 H-PECCs

Sim Scenarios conducted by H-PECCs

1,187 simulations in 2025

*Data represents training done Jan-Mar 2026

PRISMS by RAC

John and Glenda Sappington RAC A
Vicente Martinenz RAC B
Belinda Waters RAC B
Heather Casebeer RACs J&K
Barry Hudson RAC E
Amy Tucker RAC E

Brittany Ray RAC G

Verline Steptoe RAC I

Robin Hazlett RAC Q
Eric Parmley RAC Q
Ronnie Hamilton RAC R
Santana Olvera RAC R

Jules Boatright RAC U
Samantha Martinez RAC V

Complete and Available:

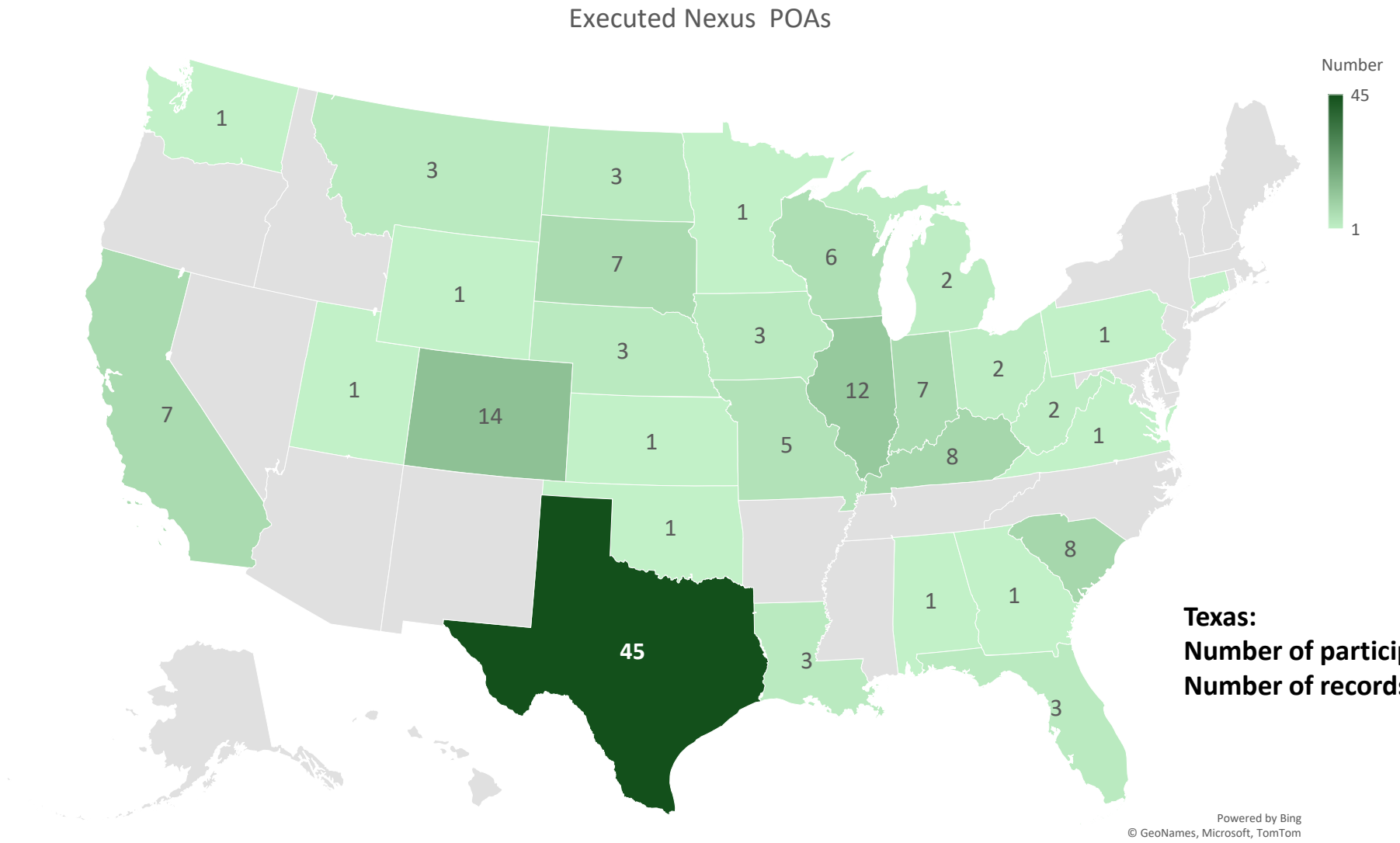
- TBI
- Pediatric Burn
- Non-Accidental Trauma (vomiting baby)
- Abdominal Trauma
- Newborn Resuscitation
- Respiratory Distress-Bronchiolitis
- Pediatric Diabetic Ketoacidosis

Still in Production:

- C-Spine inj.
- Hanging-suicide attempt
- Long-bone fracture
- Penetrating trauma (near completion
- Pediatric (child) sepsis

www.emergencysimbox.com

NPRQI: Participating Sites



Texas:
Number of participating sites: 45
Number of records entered: 7,980

NPRQI: Texas Participating Sites

Texas Registered Sites	80
Texas Sites with Executed POA	45
Texas Sites Entering Data	40
Texas Registered RACs (TSA: E, J, I, K, O, R)	6

Texas **Participating Sites** By Regional Advisory Council (RAC) With Executed Agreement

A-Panhandle
Golden Plains Community Hospital
Hansford County Hospital*
Pampa Regional Medical Center
Parkview Hospital - Wheeler

B-B
Cochran Memorial
Cogdell Memorial Hospital
Covenant Children's Hospital
Lamb Healthcare Center
Memorial Hospital Seminole
University Medical Center

C-NorthTexas
Graham Regional Medical Center

D-BigCountry
Stephens Memorial Hospital

E-NorthCentralTexas
Baylor Scott and White All Saints Medical Center- Fort Worth
Cook Children's Medical Center Prosper
Methodist Charlton Medical Center*
Methodist Southlake Hospital
Palo Pinto General Hospital
Texas Health Harris Methodist Hospital Hurst-Euless-Bedford

F-NortheastTexas
Titus Regional Medical Center*

G-PineyWoods
Christus Mother Frances Hospital - Jacksonville

I-Border
El Paso Children's Hospital
University Medical Center of El Paso

J-TexasJ
Big Bend Regional Medical Center
Medical Center Health System
Midland Memorial Hospital
Odessa Regional Medical Center
Permian Regional Medical Center
Ward Memorial Hospital
Winkler County Memorial Hospital

* Indicates POA has been submitted for review.

Texas **Participating Sites** By Regional Advisory Council (RAC) With Executed Agreement

K-ConchoValley
Lillian M. Hudspeth Memorial Hospital
Schleicher County Medical Center

L-CentralTexas
Coryell Memorial Hospital

N-BrazosValley
St Joseph Health - Grimes Hospital*

O-CapitalArea
Ascension Seton Edgar B Davis

P-SouthwestTexas
Christus Santa Rosa Hospital - Westover Hills
Guadalupe Regional Medical Center

Q-SoutheastTexas
Memorial Hermann Cypress Hospital
Memorial Hermann Katy Hospital

R-EastTexasGulfCoast
Liberty - Dayton Regional Medical Center

S-GoldenCrescent
Citizens Medical Center*
Cuero Regional Hospital
DeTar Hospital Navarro
DeTar Hospital North
Lavaca Medical Center
Yoakum Community Hospital

V-LowerRGV
South Texas Health System Mcallen*

* Indicates POA has been submitted for review.

Texas **Registered Sites** By Regional Advisory Council (RAC) - No POA

E-NorthCentralTexas
Lake Granbury Medical Center
Medical City ER Saginaw
Methodist Richardson Medical Center
Texas Health Hospital Mansfield
TMC Bonham Hospital

G-PineyWoods
Christus Mother Frances Hospital - Tyler
Christus Mother Frances Hospital - Winnsboro
UT Health East Texas Pittsburg Hospital

K-ConchoValley
North Runnels Hospital District
Reagan Hospital District

L-CentralTexas
Adventhealth Rollins Brook

M-HeartofTexas
Hill Regional Hospital

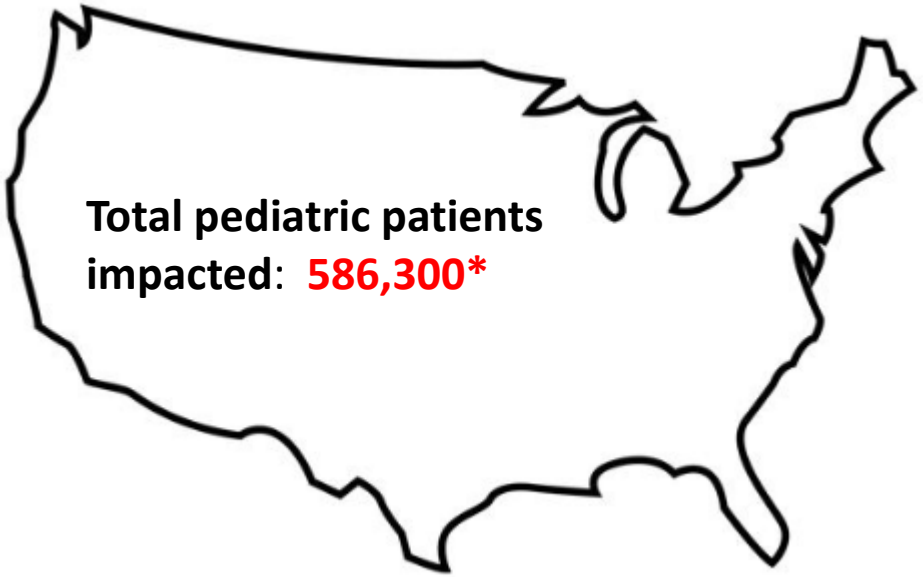
N-BrazosValley
Baylor Scott and White Medical Center - College Station
St Joseph Health - Burleson Hospital
St Joseph Health - College Station Hospital
St Joseph Health - Madison Hospital
St. Joseph Health Regional Hospital

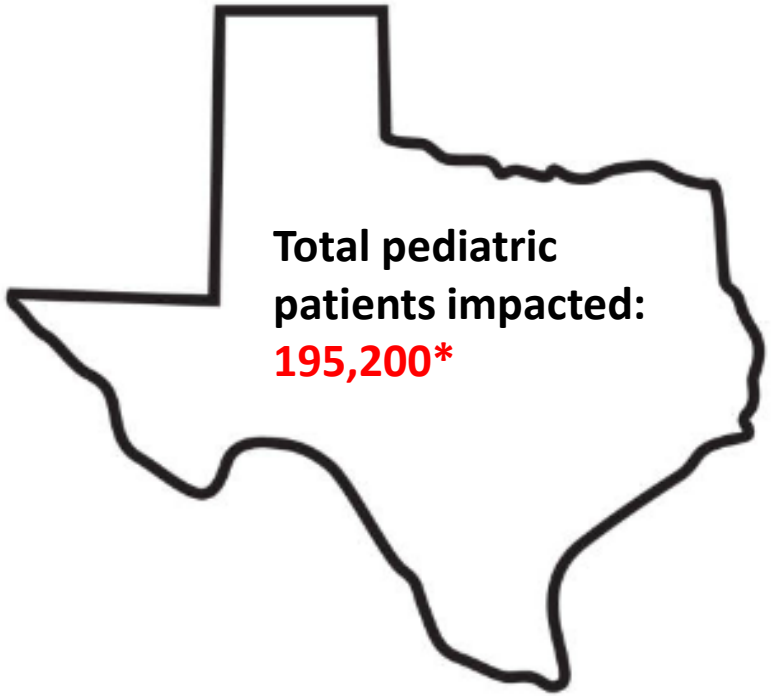
O-CapitalArea
Ascension Seton Southwest
Baylor Scott and White Medical Center - Marble Falls

P-SouthwestTexas
Christus Children's Hospital

R-EastTexasGulfCoast
Baptist Hospitals of Southeast Texas
HCA Houston Healthcare Mainland

NPRQI: Patients Impacted

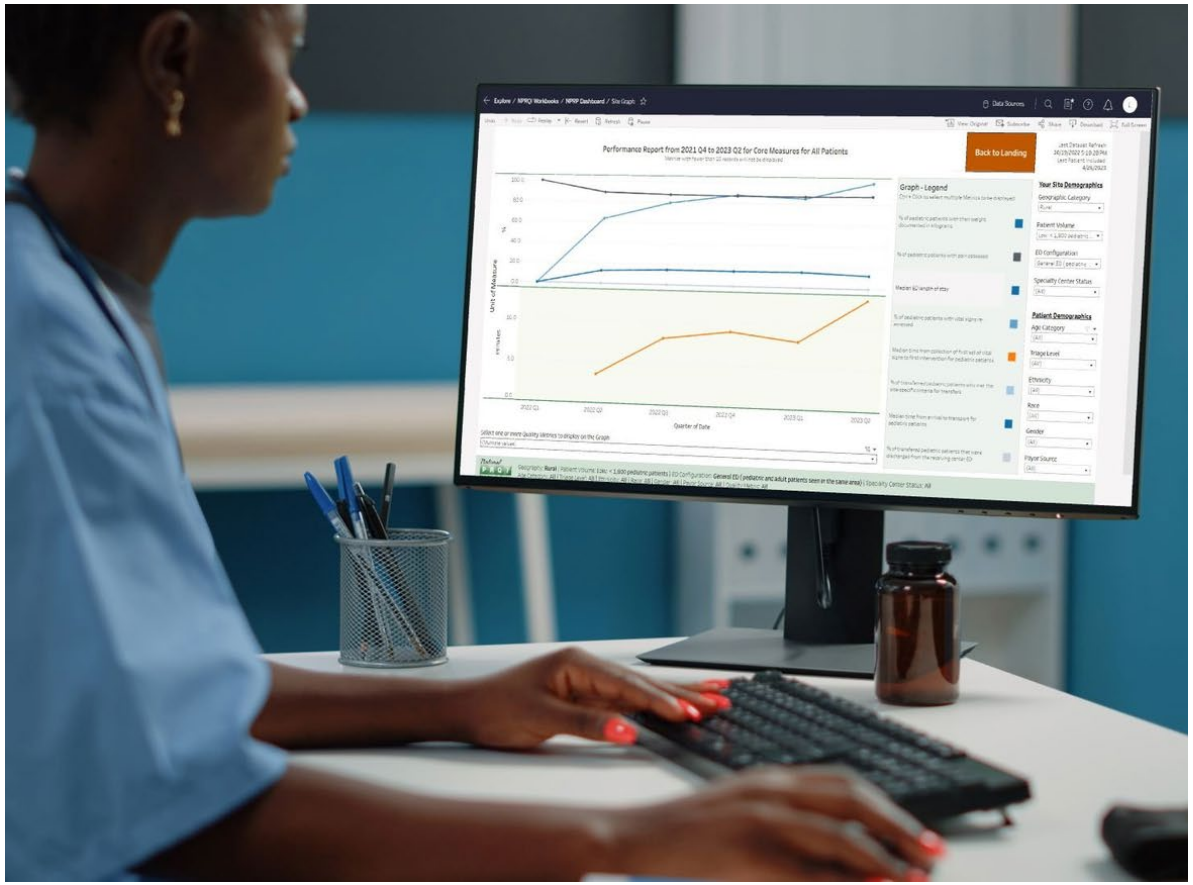




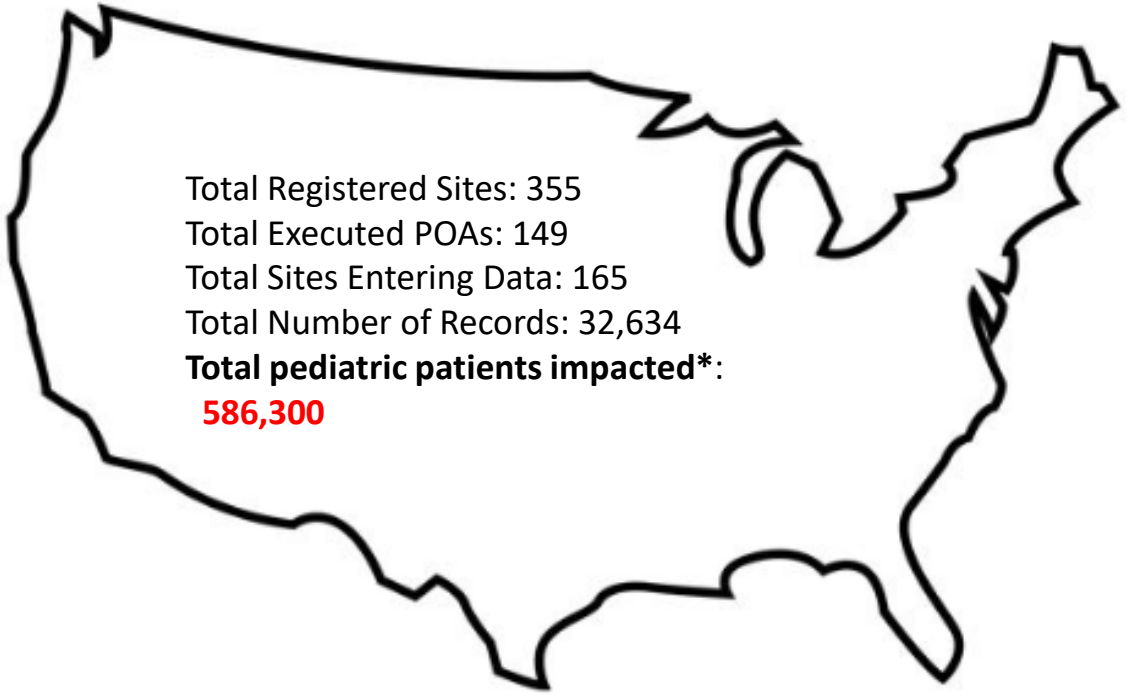
*This impact metric only reports on sites that have executed a new POA with the upgraded platform that launched in 2026. Previous reporting accounted for all participants on the initial NPRQI platform.

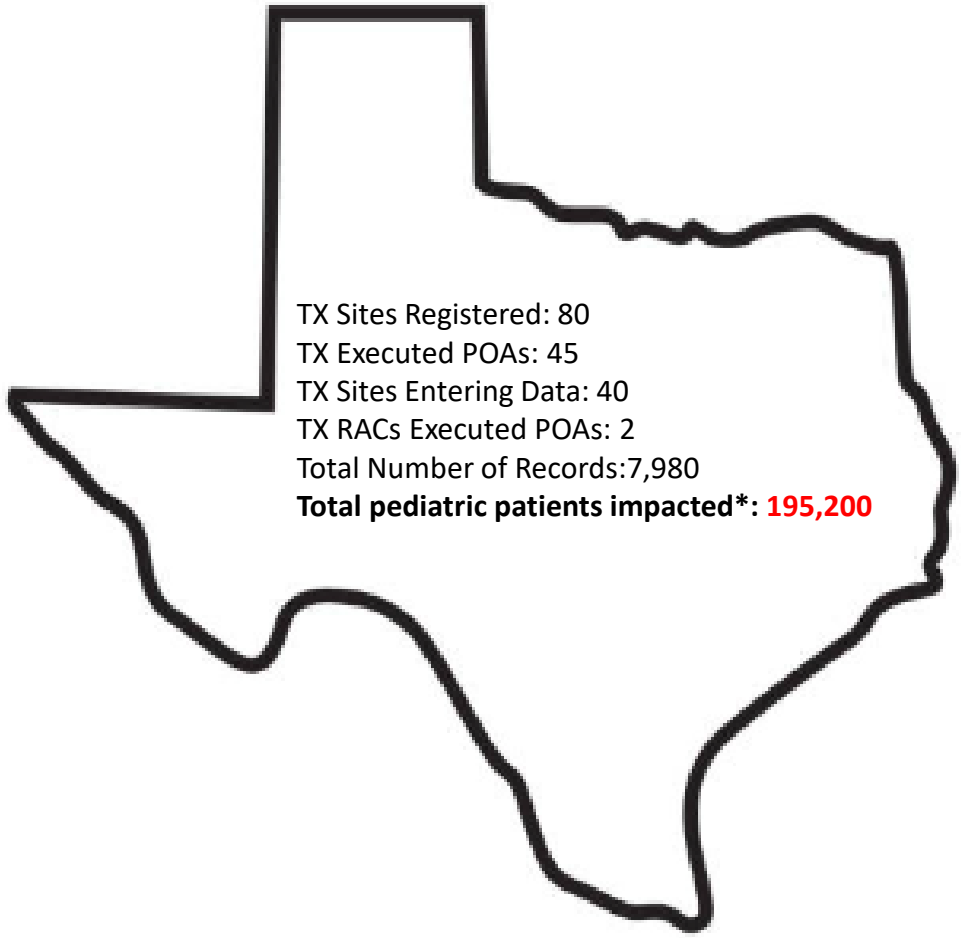
Enhanced Engagement

- Texas-centric Collaborative
  - Launched January 2026
  - 178 EDs participating/38 TX EDs
- Interactive performance dashboards
  - QI tracking capabilities



NPRQI Impact to Date





**This impact metric only reports on sites that have executed a new POA with the upgraded platform that launched in 2026. Previous reporting accounted for all participants on the initial NPRQI platform.*

14. Texas EMS, Trauma & Acute Care Foundation (TETAF)

Dinah Welsh, TETAF President/CEO

TEXAS EMS, TRAUMA AND ACUTE CARE FOUNDATION UPDATE

Dinah Welsh
TETAF President & CEO
March 13, 2026

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services

Elected to the TETAF Board of Directors

- **Kelly Galloway** – ED Director and Trauma Program Manager at Moore County Hospital, RAC A
- **John Baker** – Paramedic at Idalou EMS, RAC B
- **Dr. Christina Chan** – Associate Div. Chief of Perinatal Medicine at UT Southwestern, RAC E
- **Dr. Jessica Ehrig*** – Maternal Medical Director at Baylor Scott & White – Temple, RAC L
- **Dr. Terri Major-Kincade** – Perinatal Palliative Care Director at UT McGovern School of Medicine, RAC Q
- **Jennifer Carr** – Trauma Program Director at CHRISTUS Spohn Shoreline, RAC U

* Denotes incumbent board member

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION
Texas Perinatal Services

TETAF Advocacy

- The 90th Texas Legislative Session begins January 12, 2027.
  - Interim charges expected soon
  - The TETAF Advocacy Committee is meeting monthly to prepare and draft the TETAF Legislative Priorities.
  - TETAF is developing materials for the RACs to use as they meet with their legislators during the interim.

SURVEYS – Trauma, Stroke, Maternal, and Neonatal

- **TETAF and Texas Perinatal Services Surveys** – Volumes are steady and on pace with three-year cycles.
- **Surveyors** – TETAF/Texas Perinatal Services welcomes the opportunity to visit with interested surveyors to determine if they meet requirements.

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION
Texas Perinatal Services

TETAF Education

- TETAF continues to offer continuing education through its virtual Texas Quality Care Forum. The next forum is on Tuesday, March 31 at 11:00 a.m. and the topic is “Wired for Damage: Understanding Electrical Burn Injuries”
- TETAF is launching The Roundtable, an opportunity to come to the table to discuss and ask important questions on important topics affecting trauma, stroke, maternal, and neonatal care, as well as other potential topics, such as advocacy.
- The TETAF Hospital Data Management Course (HDMC) was held virtually in February with a full cohort of learners.

Register for the Texas Quality Care Forum (TQCF)

THE ROUNDTABLE

TETAF TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services

TETAF Collaboration

- TETAF continues to provide support to the Texas TQIP Collaborative.
  - Texas TQIP is establishing a pediatric collaborative.
  - Questions about Texas TQIP? Email texastqip@tetaf.org.
- TETAF welcomes the opportunity to be a resource, support, and/or participate in any meetings to further build the trauma and emergency care network.

TETAF Rural Trauma System Development Fund

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services

15. Next Council Meeting Dates

Quarterly Meetings:

FY26 Q3: June 2-5, 2026 (Austin)

FY26 Q4: August 25-28, 2026 (Austin)

FY27 Strategic Planning Session/Committee Selection: October 14-15, 2026 (Austin)

FY27 Q1: November 22-25, 2026 (Fort Worth)

2027:

FY27 Q2: March 9-12 (Austin)

FY27 Q2: June 15-18 (Austin)

FY27 Q3: August 17-20 (Austin)

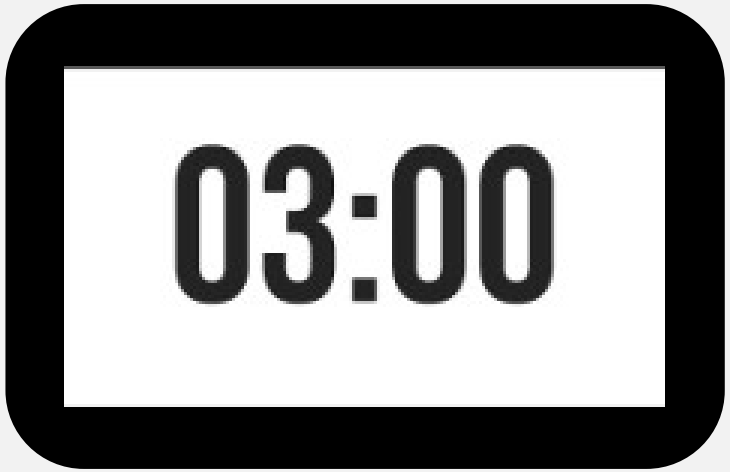
FY28 Strategic Planning Session/Committee Selection: October 13-14 (Austin)

16. Final Public Comment

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

Please state the following when making comments:

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



TEXAS Health and Human Services

Texas Department of State Health Services

17. Adjournment -

Alan Tyroch, MD, GETAC Chair

Thank you for all you do to support the GETAC mission to promote, develop, and advance an accountable, patient-centered Trauma and Emergency Healthcare System!