TEXAS
Health and Human Services

Texas Department of State Health Services

Governor's EMS and Trauma Advisory Council

Monday, November 24, 2025
4:00 PM (CST)

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

1. Call to Order

Governor's EMS and Trauma Advisory Council Meeting

FY26 – 1st Quarter

TEXAS Health and Human Services

Texas Department of State Health Services

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

Omni Fort Worth

Fort Worth Ballroom 4/5

1300 Houston Street

Fort Worth, Texas 76102

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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4. Approval of Minutes

Review and Approval of Minutes

- August 22, 2025

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5. Chair Announcements

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

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6. State Reports

- EMS/Trauma Systems Section (EMS/TS)
- EMS & Trauma Registries (EMSTR), Injury Prevention Unit

6.a. EMS Trauma Systems Update

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

PHWB Funding Allotment

- Department activities
  - Contract and Statement of Work
  - Funding allotment

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

Welcome to the Training

Thank to everyone who contributed to this process. All public comments and feedback helped align the survey guidelines with the Texas Administrative Code (TAC) 157.126 and follow the American College of Surgeons (ACS) standards and processes when possible.

We express our gratitude to everyone:

- Stakeholders
- Designation Team
- Rebecca Wright, Adrienne Kitchen, Deidra Lee
- Jia Benno and the State Registry Team
- DSHS Leadership
- Dr. Alan Tyroch, Dr. Stephen Flaherty, and Dr. Robert Greenberg
- Dr. Kate Remick, Sam Vance, and the Pediatric Committee
- Courtney Edwards, DNP, and TETAF
- Lynn Lail AMST – LZ/Helipad Safety Training

Your participation made a difference!

§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

Telemedicine – County with Less than 30,000 Population

- Level IV facilities in a county with less than 30,000 population
- Telemedicine resources with an APP
- Telemedicine physician and APP assess patient collaboratively through video
- Telemedicine physician immediately available
- APP must be at bedside within 30 minutes (APP must maintain current ATLS)
- Follow documentation trauma resuscitation guidelines
- Documentation that trauma management guidelines followed
- Documentation reflecting telemedicine physician credentialing
- All assessments, physician orders, interventions and patient response is documented in the medical record

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

Trauma PIPS Process

If the case is a mortality

- documented evidence of a mortality review through the trauma PIPS process

Autopsies for mortalities are available

- injuries are listed and congruent with the trauma registry data.

Events/Morbidity/Mortality is categorized utilizing the terminology outlined in §157.126.

Evidence that events identified as “regional opportunities for improvement”

- referred to the identified provider
- regional performance improvement process for tracking.

Documentation of trauma PIPS review is objective, through, and consistent

Designation Review Committee

- §157.126(s)(1)(A)(iv) two individuals who each have a minimum of 10 years of trauma facility oversight as an administrator, medical director, program manager, or program liaison
- Designation appeals
- Designation waivers
- Application closes June 20th

Trauma Designation Review Committee

- Alan Tyroch, MD – GETAC Chair
- Stephen Flaherty, MD – Trauma System Committee Chair
- Dawn Koepp- TTCF

- Two Additional Members
- Robert Greenberg, MD – Emergency Medicine Physician
- Barbara Gaines, MD – Pediatric Trauma Surgeon

Trauma Uncompensated Care Funding Application

APPLICATION DUE FEBRUARY 25, 2026

READINESS COST NOT INCLUDED IN THIS APPLICATION

Level III Trauma Facilities - TQIP

- September 1, 2025, Level III Facilities
- Exception – Level III Pediatric Trauma Facilities

Georgia Trauma Center Cost of Readiness

TABLE 1. *Calendar year 2008 Trauma Center Readiness Cost Survey Results*

Cost Category	LI Total	LI Average	LII Total	Lll Average	Georgia Totals
Administrative	2,431,530	607,883	3,339,644	371,072	$5,771,174
Medical staff	18,003,208	4,500,802	12,836,008	1,426,223	30,839,216
In-house OR	1,744,231	436,058	2,284,553	253,839	4,028,784
Education/Outreach	222,518	55,630	1,437,046	159,672	1,659,564
Georgia totals	$22,401,487	$5,600,372	$19,897,251	$1,992,890	$42,298,738

TABLE 6. *Calendar year 2011 Trauma Center Readiness Cost Survey Results*

Cost Category	LI Total	LI Average	LII Total	LII Average	Georgia Totals
Administrative	4,727,837	945,567	4,709,313	523,257	9,437,150
Clinical medical staff	24,901,553	4,980,311	13,315,830	1,479,537	38,217,383
In-house OR	3,937,448	787,490	2,155,000	239,444	6,092,448
Education/Outreach	538,480	107,696	817,876	90,875	1,356,356
Georgia totals	34,105,318	6,821,064	20,998,019	2,333,113	55,103,337

Tennessee Cost of Trauma Center Readiness

2022 Data	Average Readiness Costs
Level I and II	**20,585,135**
Level III	**3,758,885**

> Am Surg. 2025 Nov;91(11):1930-1934. doi: 10.1177/00031348251341957. Epub 2025 May 13.

Readiness Costs for a Statewide Trauma System

Amy A Howk [1], Robert Seesholtz [2], Jessica Story [3], J Bracken Burns [4], Bradley M Dennis [5], Peter E Fischer [6], Darrell L Hunt [7], Robert A Maxwell [8], Regan F Williams [9], Brian J Daley [1]

Affiliations + expand

PMID: 40359572 DOI: 10.1177/00031348251341957

Trauma Center Readiness Cost

Update on Funding for Trauma Readiness - Trauma Center Association of America (TCAA)

Atkins EV, Vaughn KA, Medeiros RS, Patterson GK, Register AR, Ashley DW. Assessing trauma readiness costs in level III and level IV trauma centers. J Trauma Acute Care Surg. 2023 Feb 1;94(2):258-263. doi: 10.1097/TA.0000000000003842. Epub 2022 Nov 14. PMID: 36372925.

Ashley DW, Mullins RF, Dente CJ, Johns TJ, Garlow LE, Medeiros RS, Atkins EV, Solomon G, Abston D, Ferdinand CH; Georgia Research Institute for Trauma Study Group. How much green does it take to be orange? Determining the cost associated with trauma center readiness. J Trauma Acute Care Surg. 2019 May;86(5):765-773. doi: 10.1097/TA.0000000000002213. PMID: 30768564.

Texas Cost of Trauma Center Readiness 2024

FY25

Trauma Designation Level	Number of Hospitals that applied	Readiness Cost
Level I	22	$ 810,541,279.60
Level II	27	$ 229,266,490.03
Level III	59	$ 260,378,137.30
Level IV	176	$ 440,403,202.70
In Active Pursuit (IAP)	4	$ 1,037,388.00

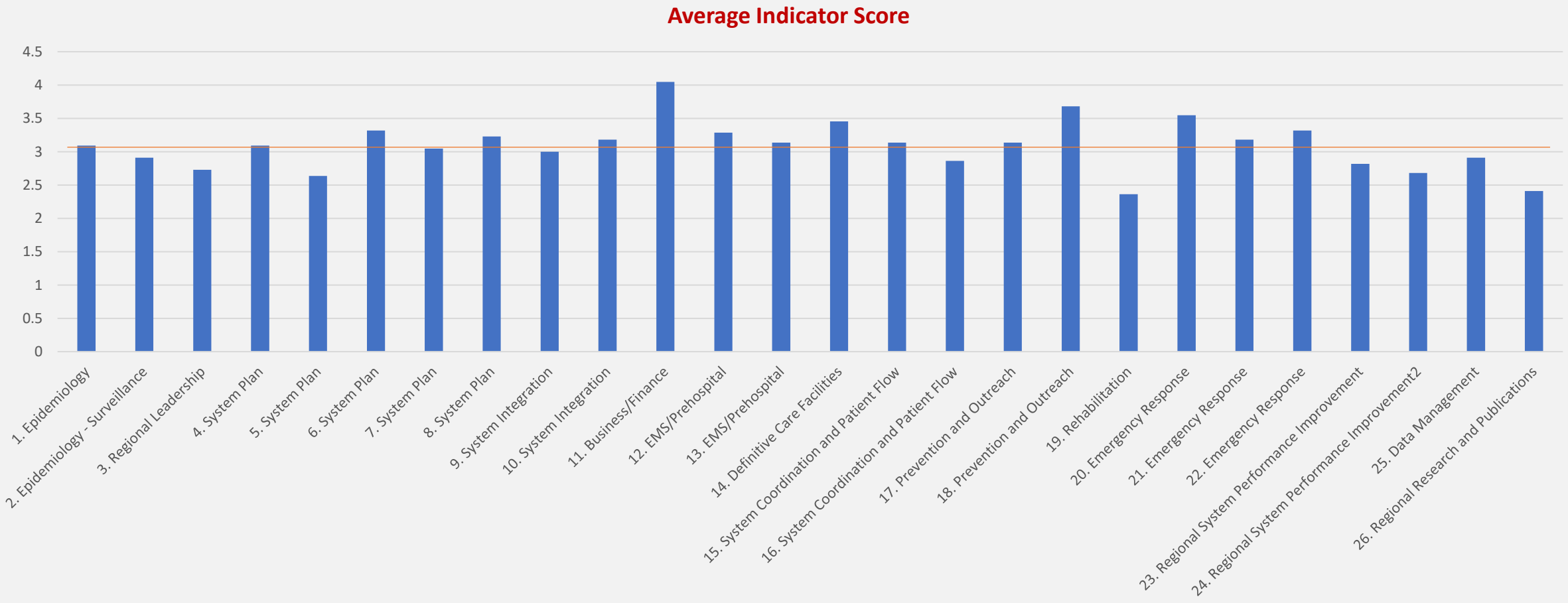
RAC Self-Assessment 2025 Review

Regional Self-Assessment Scoring

Please use the following criteria to assess your region's progress in system development.

Score	Progress Scoring
0	Not Known
1	Elements Not Documented
2	Elements Documented with Ongoing Needs (Minimal requirements not met and need improvement.)
3	Basic Regional System in Place (Meets minimal requirements with opportunities for improvement and system advancement.)
4	Advanced Regional System (Meets and exceeds requirements with some opportunities for improvement and system advancement.)
5	Best Practice Regional System (Meets and exceeds requirements and serves as a model or best practice for others.)

RAC Self-Assessment Average Indicator Score



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Designation Update

Elizabeth Stevenson, BSN, RN
Designation Programs Manager

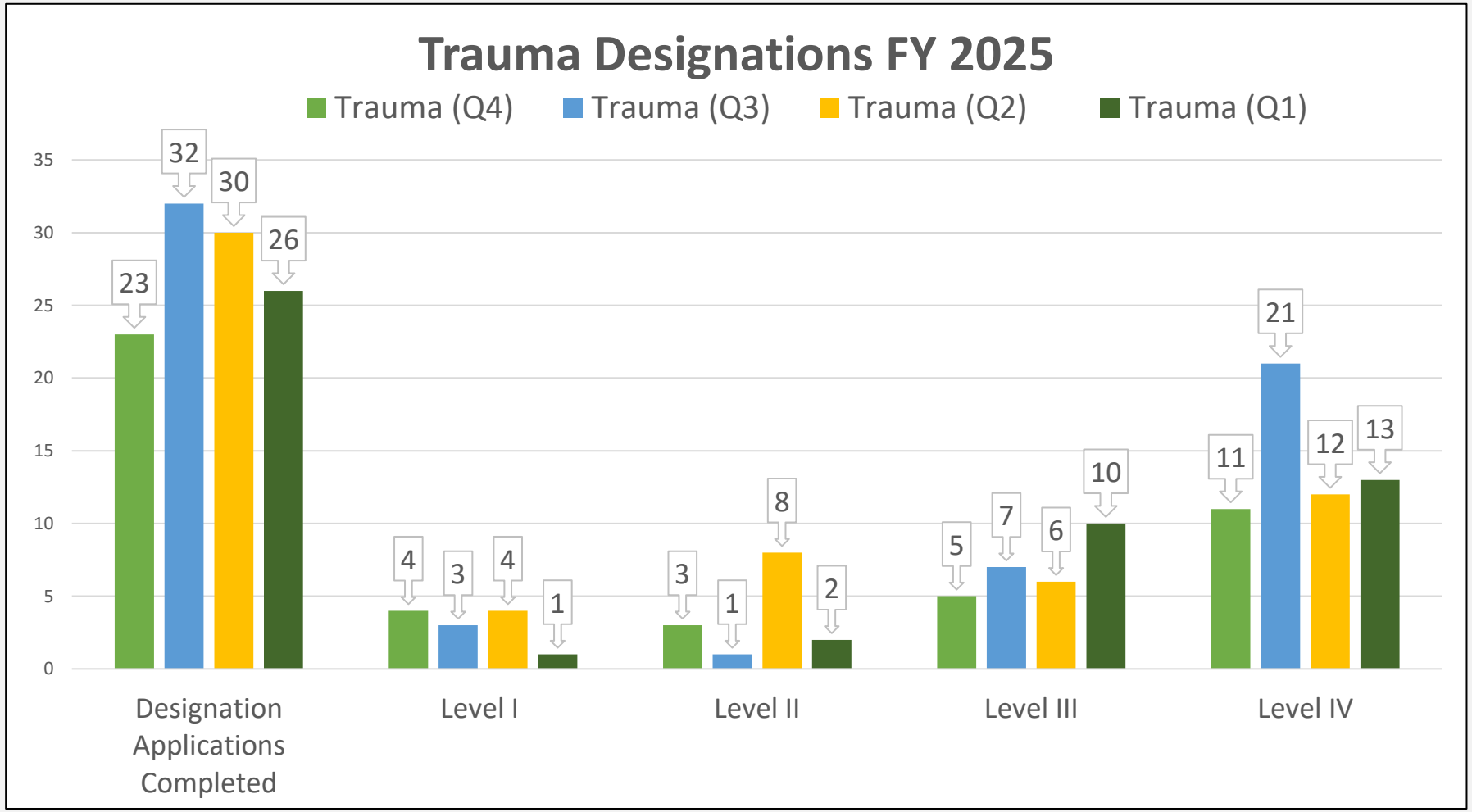
Designated Trauma Facilities

Trauma Facilities FY2025	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter
Total	295	296	296	296
Level I	22	22	22	22
Level II	27	27	28	28
Level III	63	62	60	56
Level IV	183	185	186	190

Trauma Designation Data

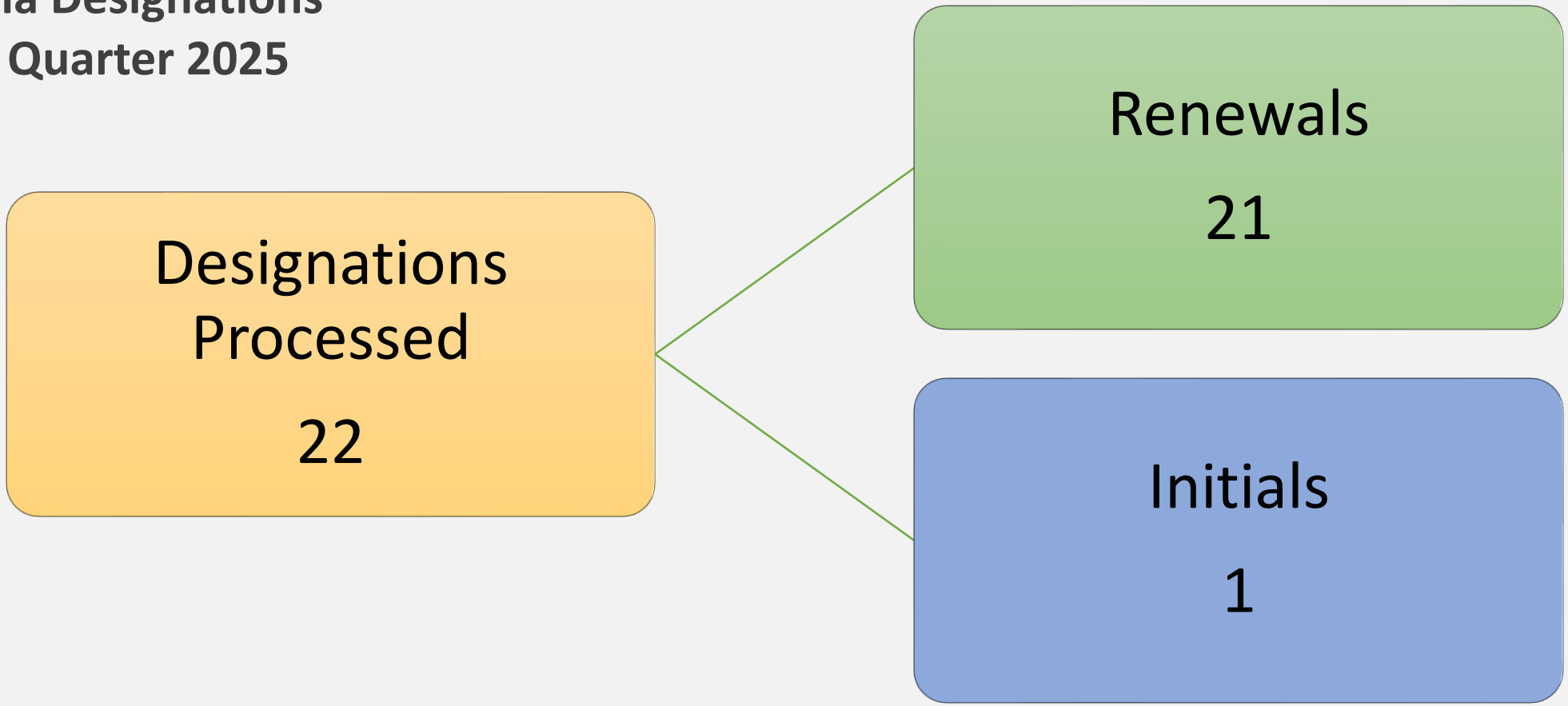
Trauma 2024	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter
New IAP Recognitions	**2**	**2**	**4**	**1**
Facilities In Active Pursuit	**10**	**10**	**9**	**7**
Level I	0	0	0	0
Level II	1	1	1	1
Level III	3	3	3	3
Level IV	6	6	5	3

Trauma Designation Data

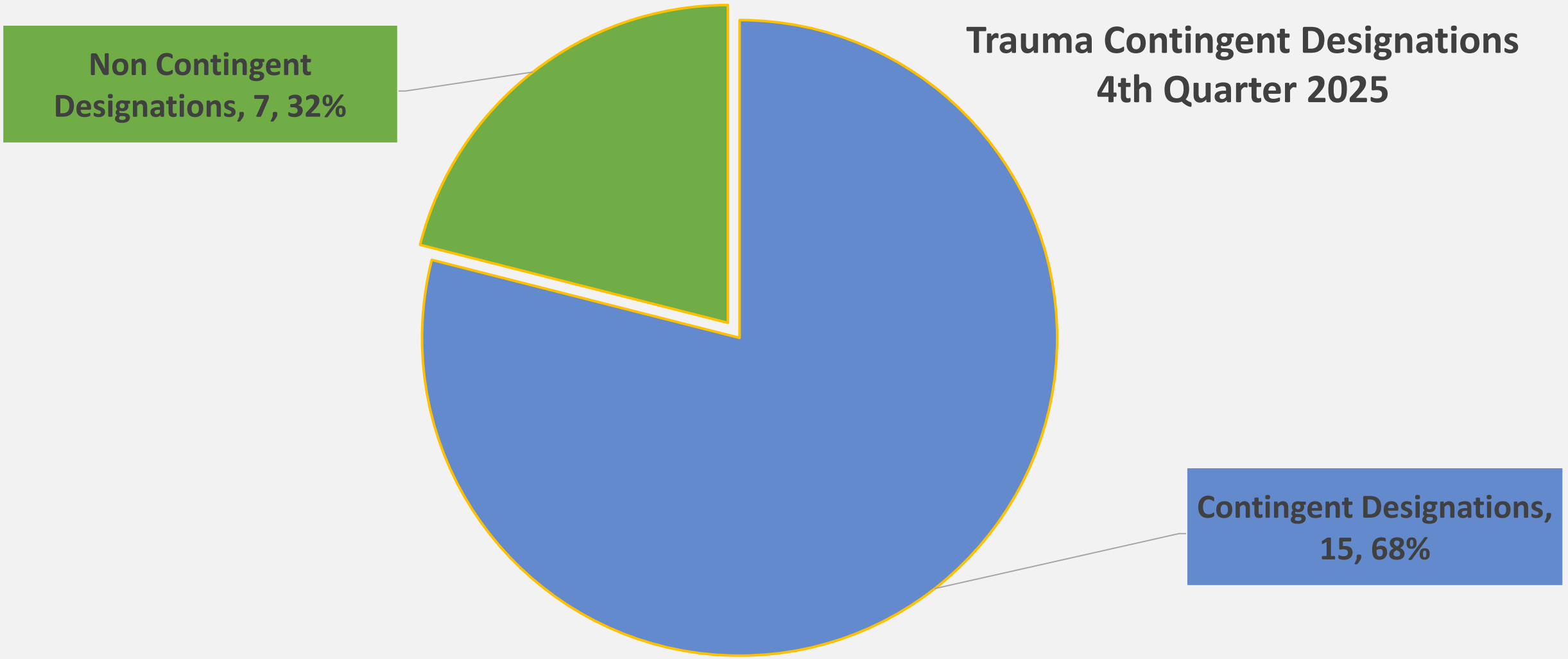


Trauma Designation Data

Trauma Designations
4th Quarter 2025

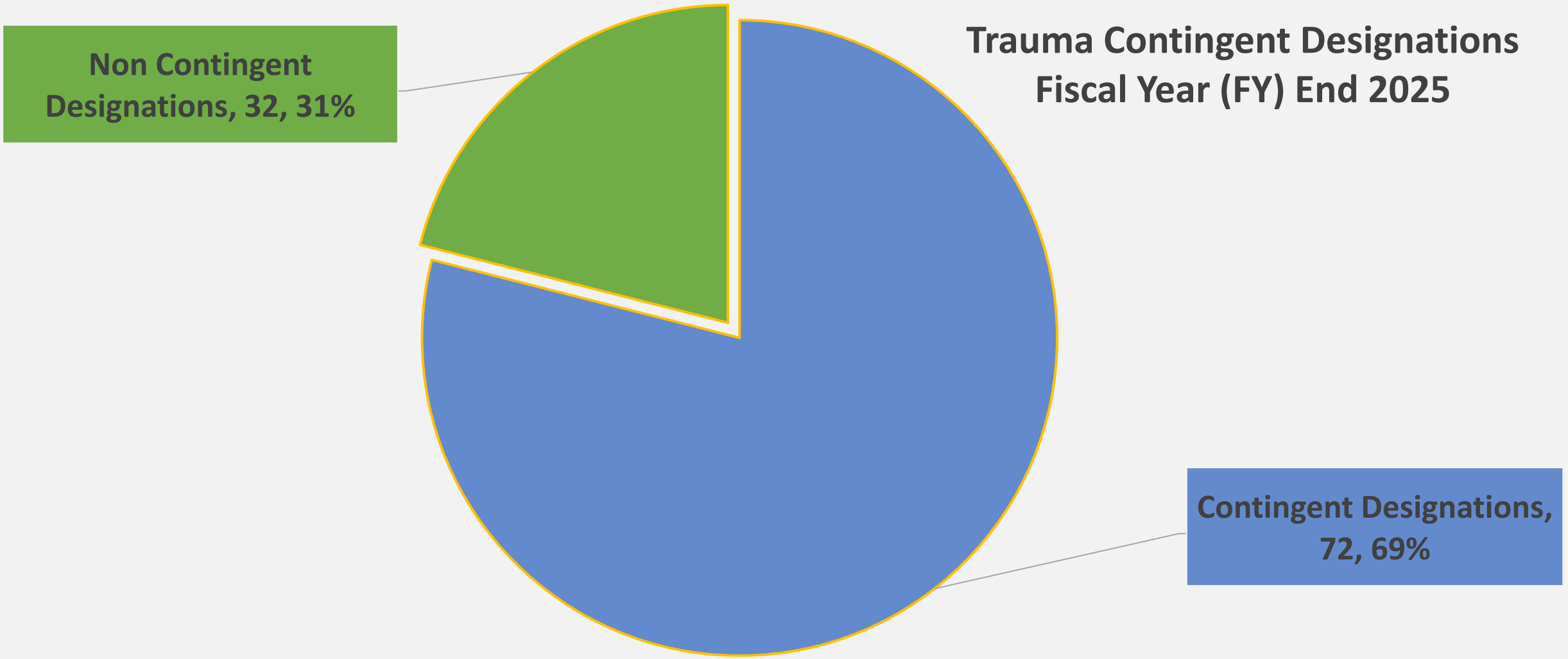


Trauma Designation Data



Common Deficiencies

Trauma Designation Data



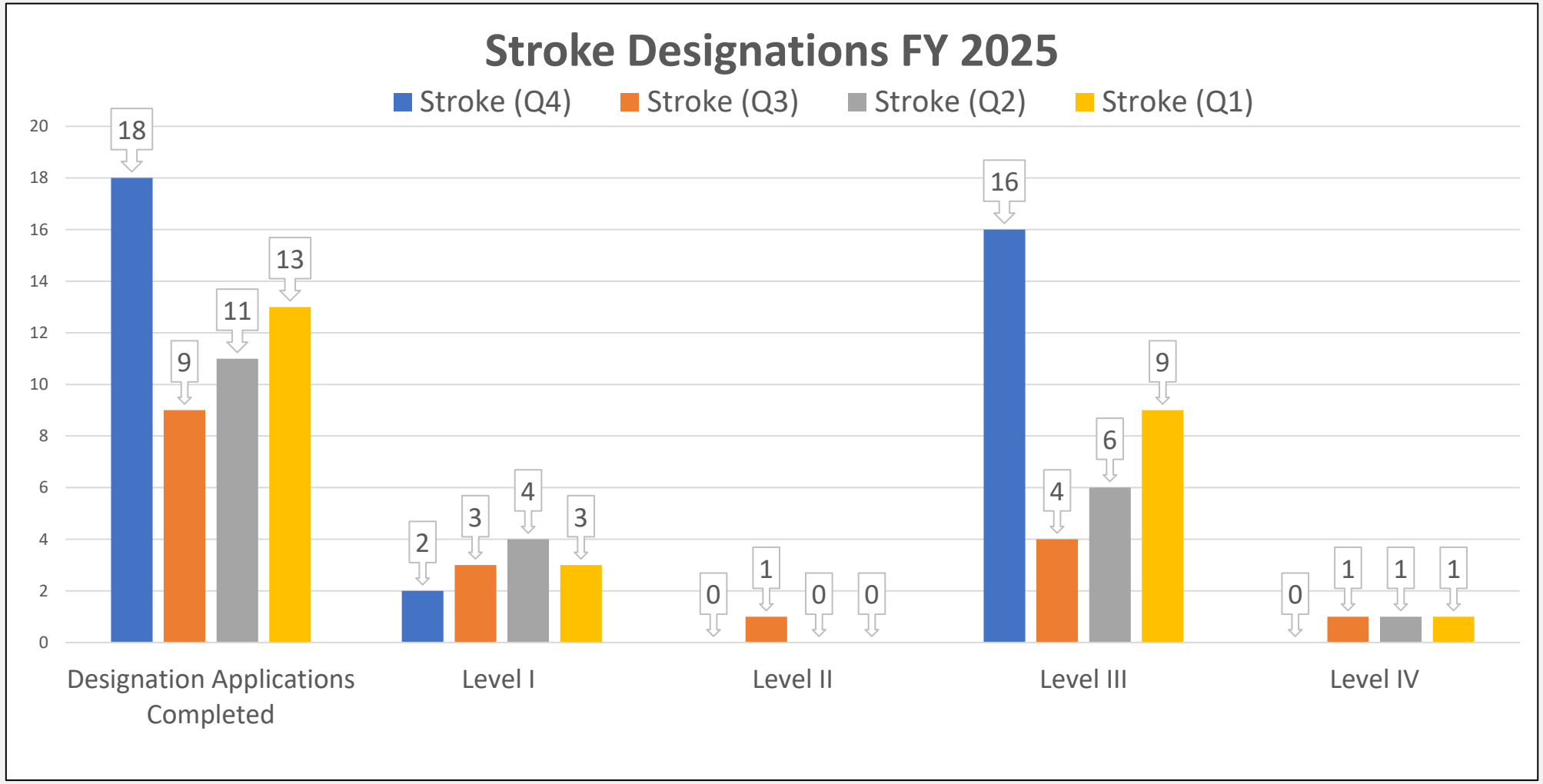
Trauma Designation Information

- Adopted Trauma Rule Q&A meetings in December
- Section 157.125 Adopted Trauma Rule Comparison Documents for Level III and IV available on DSHS website
- Trauma monthly calls top two topics:
  Trauma UCC application and Adopted Trauma Rules
- Implemented a survey following monthly meeting calls to receive stakeholder feedback on benefits and suggestions for future meeting content
- Register for the 2026 trauma monthly meetings.

Designated Stroke Facilities

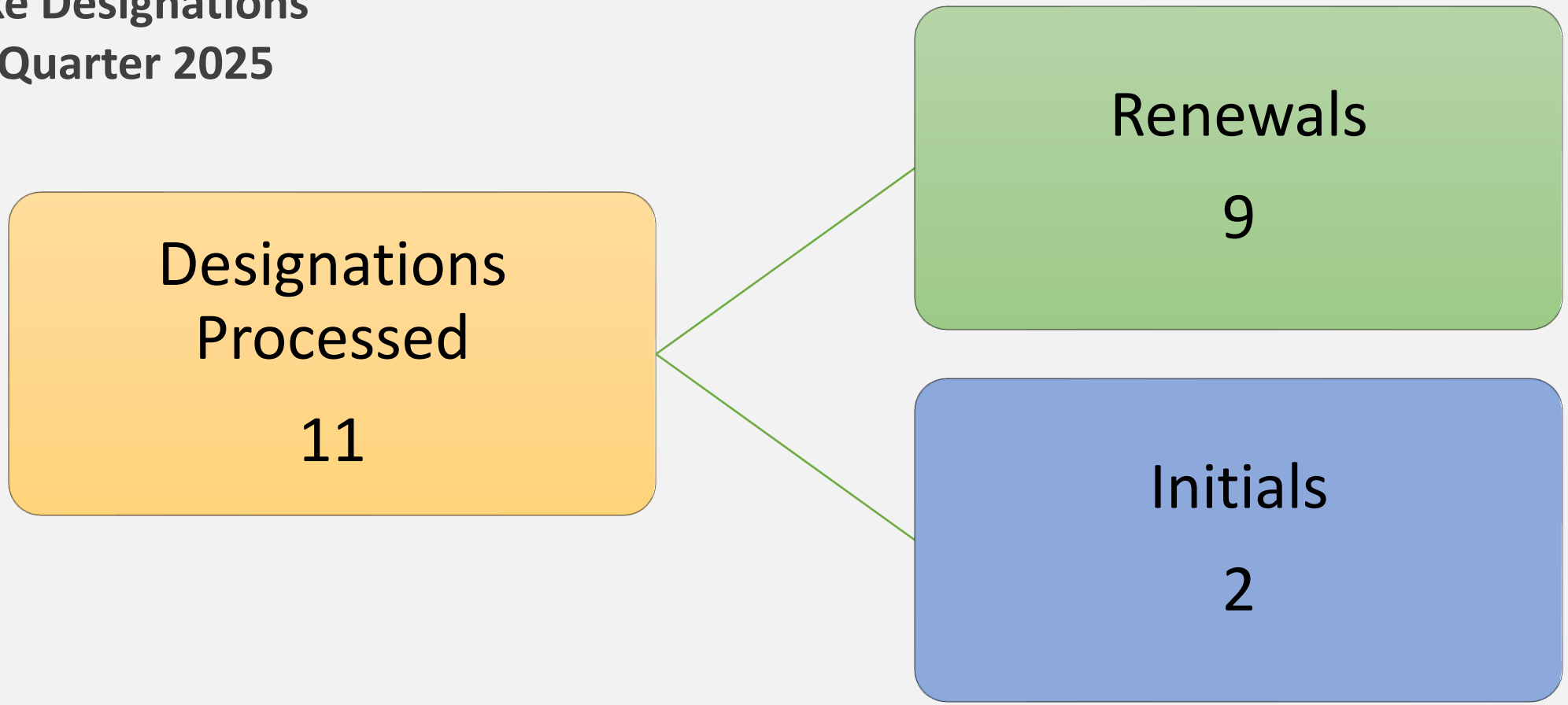
Designated Stroke Facilities FY 2025	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter
Total	192	191	191	189
Comprehensive Level I	48	47	47	45
Advanced Level II	4	5	5	6
Primary Level III *Primary Level II*	112 *2*	*110* *3*	*111* *3*	*101* *12*
Acute Stroke Ready Level IV	*26*	*26*	*25*	*25*

Stroke Designation Data



Stroke Designation Data

Stroke Designations
4th Quarter 2025



Designation Application Process Performance Measures

Goals – 30/60 days

(Non-Contingent Designation 30 Days)

(Contingent Designation 60 Days)

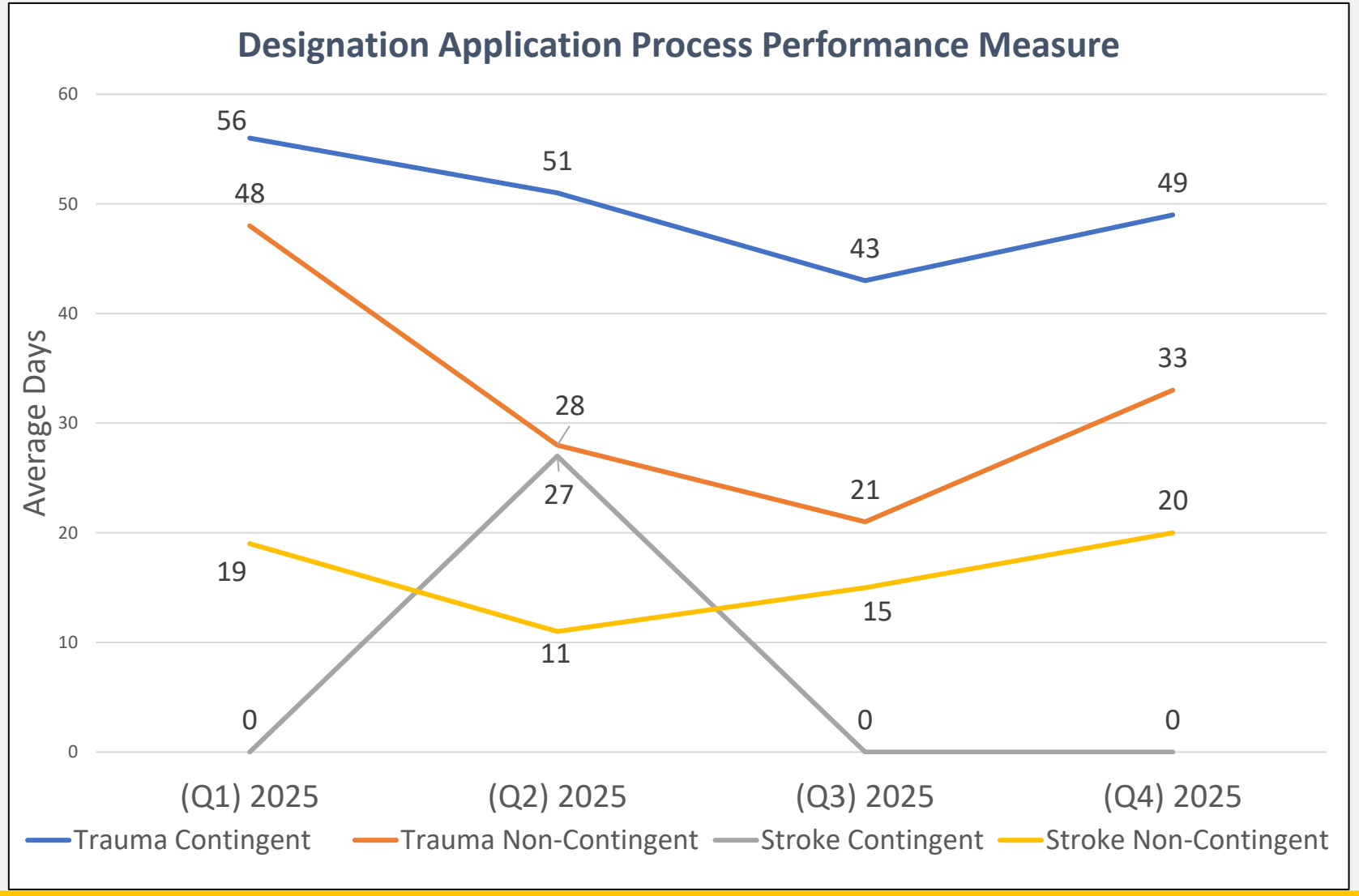
(4th Quarter)

Trauma – 49 days Contingent

Trauma – 33 days Non–Contingent

Stroke – No Contingent Facilities

Stroke – 20 days Non–Contingent




Any
QUESTIONS?

EMS System Update

Joe Schmider
State EMS Director

Number of Workforce by Certification Level

	2019	2020	2021	2022	2023	11-1-2025	Since 2022
ECA	2,245	2,233	2,431	2,023	1,936	1,974	(-49)
EMT	34,686	34,664	39,683	35,645	39,331	43,599	7,954
A-EMT	3,370	3,409	3,539	3,209	3,403	3,481	272
Paramedic	27,309	27,601	30,080	27,597	30,555	33,297	5,700
Total	67,610	67,907	75,733	68,474	75,225	82,351	12,811

All working together!

NEMSIS: Target date for next update will be V6 in 2029.

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

Statute 773: Rules 157 and 103 require EMS Providers to submit PCRs.

TEXAS Health and Human Services

Texas Department of State Health Services

Rules 1.81 and 1.91 Military EMS License

Adoption date: 12-1-2025

TEXAS Health and Human Services

Texas Department of State Health Services

What is being updated?

- Update to: Occupations Code §55.004 §55.0041
- Military members, spouses, and veterans can receive a provisional license as the application is being processed.

REQUIREMENTS:

- Similar licensed in another jurisdiction
- In good standing with the other out-of-state license
- Licensed in Texas within the past 5 years
- Complete the EMS requirement for fingerprinting in Texas and the Jurisprudence Exam

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 early 2026
- Review with GETAC Committees as needed
- Review with Texas EMS Associations
- Review by GETAC at the March meeting

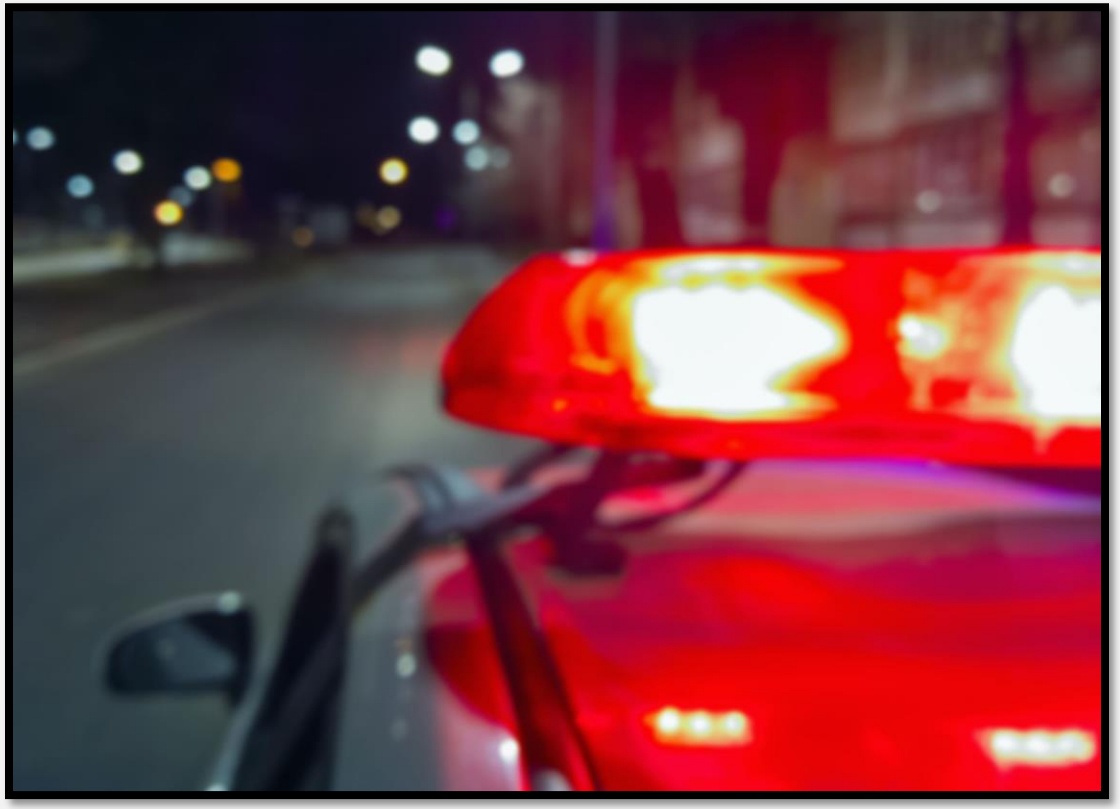
Target dates

- **Public comments April 2026 for 30 days**
- **Adoption August 2026**

HB 3000 Rural Ambulance Grants

- Rules are drafted
- Published in Texas Registry on 11-21-2025
- 30 days to make comments on proposed rules
- Notices concerning the proposed rules have been sent out

Red Lights and Siren Usage



- **Dispatch to scene using L&S in 2024:**
  Emer: 88%
  Non-emer 12%

- **Scene to facility using L&S in 2024:**
  Emer: 58%
  Non-emer: 42%

- **Dispatch to scene using L&S in 2025:**
  Emer: 86%
  Non-emer 14%

- **Scene to facility using L&S in 2025:**
  Emer: 60%
  Non-emer: 40%

Questions for EMS/Trauma Systems?

Thank You

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

Jia Benno, MPH
Injury Prevention Unit Director

Emergency Medical Services and Trauma Registries (EMSTR) National, Program, and Texas Wristband Number Updates

Governor's EMS and Trauma Advisory Committee (GETAC)
November 24, 2025

Gavin Sussman
EMSTR Program Manager

National Updates

NEMSIS Updates (1 of 2)

The National EMS Information System (NEMSIS) is funded by the National Highway Transportation Safety Administration (NHTSA) Office of EMS.

- NEMSIS aims to improve understanding of, confidence in, and support for EMS data collection and analysis across all target audiences within the EMS community.
- NEMSIS goal is to provide a better understanding of EMS documentation that will lead to EMS data being used more effectively to improve patient care.
    - An Annual National EMS Research Dataset (approximately 65 million records)
    - Public Dashboards and Data Cube*
    - Dashboards for State Officials
    - National Data Dictionaries that are developed and maintained by NEMSIS i.e., Version 3.5.0 – Critical Patch 6 Dictionary

Submit a Help Desk Ticket to the NEMSIS Technical Assistance Center with any questions.

*Data Cubes allow the user to run manipulations on the NEMSIS website using the Public Use Data Files (PUDFs).

NEMSIS Updates (2 of 2)

Critical Patch 5 and 6:

- In **April 2025**, NEMSIS released critical patch 5 creating a new optional element for collecting the patient's biological sex. Patch 6 changed the field value from ***Optional* to *Required.*** NEMSIS required all submitters to follow this new standard by 11/04/2025.
- On **07/06/2025**, Texas made critical patch 5 available and sent weekly communications to agencies and vendors. EMSTR also put an article in the State EMS Newsletter encouraging implementation of the new fields.
- On **10/23/2025**, Texas implemented critical patch 6, completing the transition ahead of the federal schedule. All providers must use the new patient sex element for state submissions as of that date.

Note: EMSTR has no plans to implement NEMSIS Version 3.5.1. This is a minor dictionary revision. DSHS will include updates when NEMSIS deploys the next major revision, version 3.6.0. Texas is considering an implementation date closer to 2030, in accordance with the national transition.

NASEMSO Updates

The National Association of State Emergency Medical Services Officials (NASEMSO) Data Manager's Council provides guidance to NEMSIS, states, and agencies on implementing data dictionary and industry changes:

- Produced a Blood Product Administration Guidance.
- Released an Executive Order 14168 position statement on gender and sex and recommendations to maintain compliance while minimizing interruption.
- Developed a multi-state data request framework to minimize duplication between states and requestors.
- Developed an algorithm to uniformly calculate EMS times (response, time spent on scene, transport time, etc.) using NEMSIS elements.
- Working with DSHS and the Texas Water Safety Coalition on a case definition for identifying submersion incidences in the EMS dataset.

EMSTR – 2024 to Present

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.
- In November 2023, EMSTR launched a new data reporting system capable of collecting the Texas Wristband number in EMS and trauma patient records.

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.

EMSTR Updates

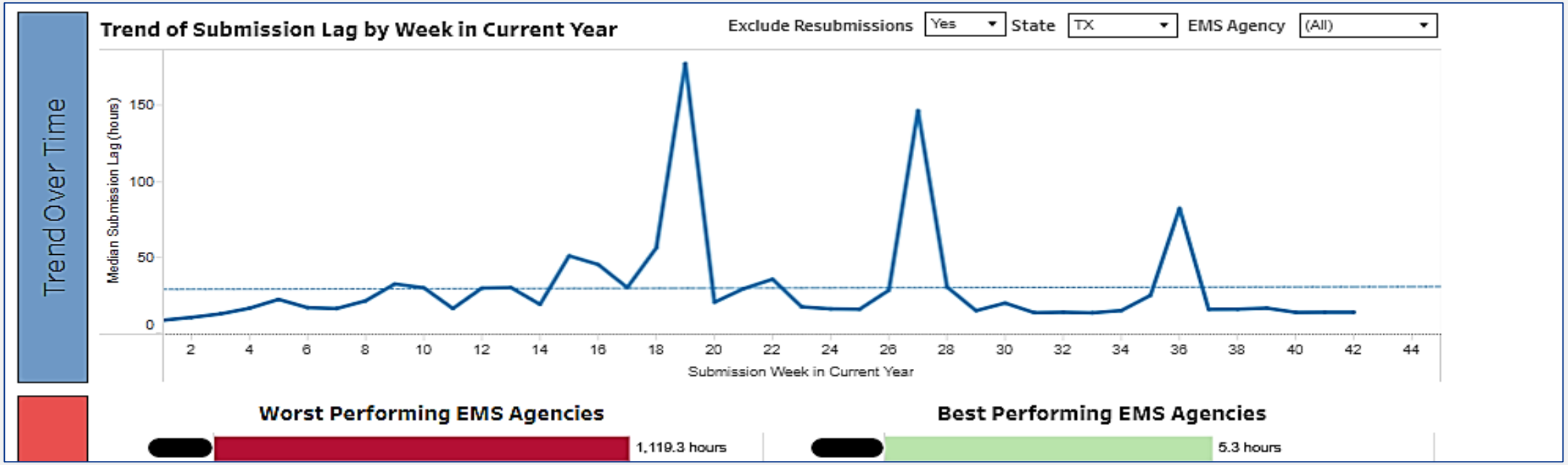
- 2024 EMS and trauma data closeout:
  - EMS – 4,801,876 records
  - Trauma – 183,759 records
- 2025* EMS and trauma progress:
  - EMS – 4,405,316 records
  - Trauma – 129,497 records

*As of 11/13/2025

NOTES:

- Most trauma facilities submit records on a quarterly basis.
- EMSTR anticipates closing the 2025 datasets on 05/01/2026.

Active Surveillance (1 of 2)



NEMSIS Submission Lag data pulled October 2025.

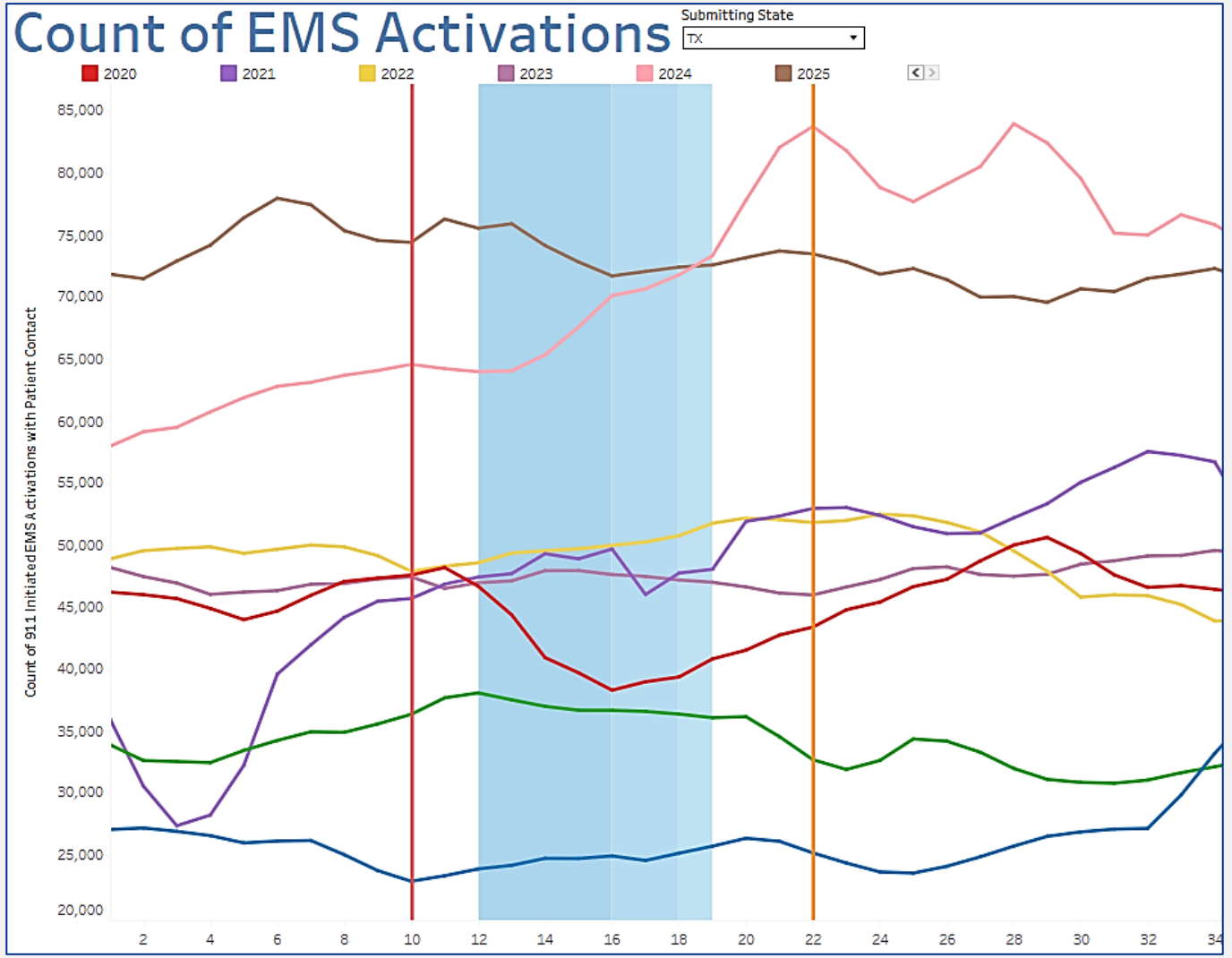
Major improvements in submission timeliness and record completeness:

- Approximately 85 Texas EMS providers send data in real-time.
- EMSTR recognized the top performers in the July EMS Newsletter and sent plaques to the Administrators of Record (AORs).
- Between Calendar Year (CY)2022 and CY2025 year-to-date The state **submission lag** reduced from a 10-day turn-around time to approximately 31 hours.

Active Surveillance (2 of 2)

- Regular Communications: From January through October, EMSTR contacted over 250 EMS providers, 120 trauma facilities and 250 general hospitals with missing data.
- Partnerships with the Regional Advisory Councils (RACs) and DSHS EMS/Trauma Systems to improve compliance.

NEMSIS EMS Activation Tracking Example



NEMSIS Activation data pulled October 2025.

Data Quality Webinar Series (1 of 2)

EMSTR hosts webinars every 6-8 weeks:

- Trainings focus on areas of performance improvement which are streamed live and recorded.
- DSHS Office of EMS Systems provides Continuing Education (CEs) for EMS personnel (CEs started with the September webinar).
- Attendance varies between 100-250 facilities.

Upcoming Events:

- EMS-AOR Training Video (To Be Released November 2025)

Posted:

- Documentation When it Matters Most for EMS (September 11, 2025)
- Hospital Data Management Training (October 30, 2025)

Data Quality Webinar Series (2 of 2)

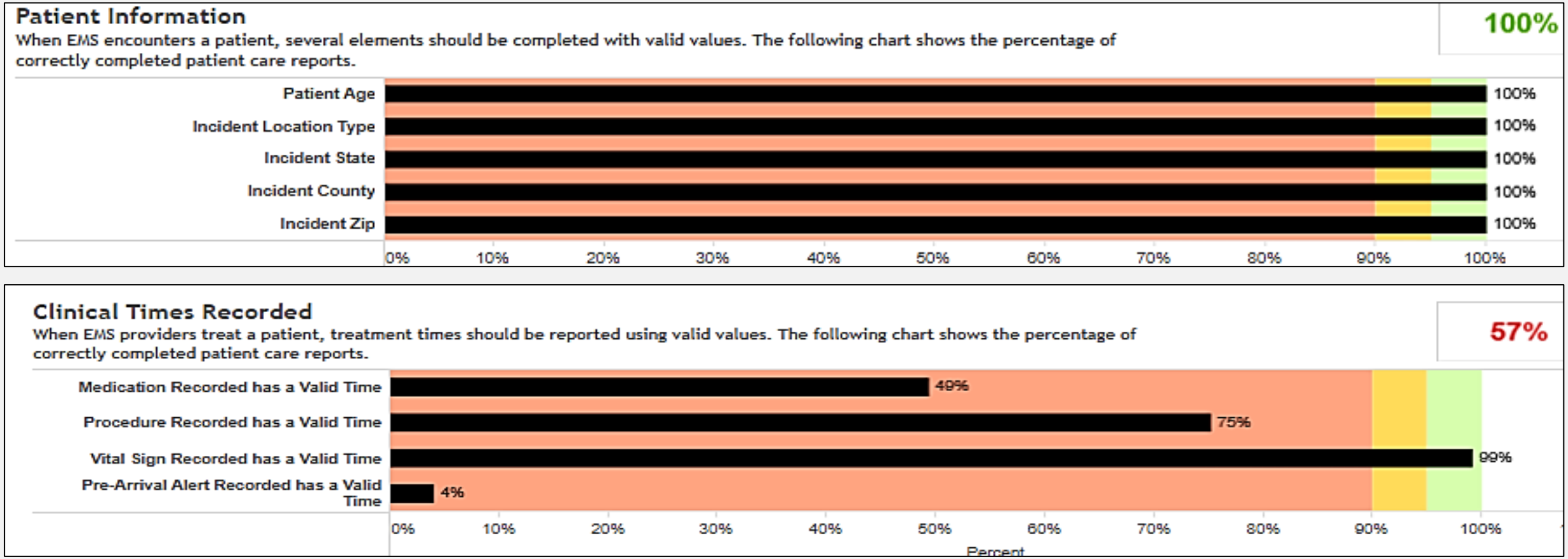
Hospital Topics

- Universal Unique Identifier (UUID), Texas Wristband, transfer facility, and prehospital provider information.
- Abbreviated Injury Score (AIS) and procedure coding improvements.

EMS Topics

- Stroke Assessment, Stroke Severity Scoring, Patient Identifiers, and Pre-Arrival Alert documentation.
- Blood product documentation, Texas Wristbands and improving Clinical Times documentation.

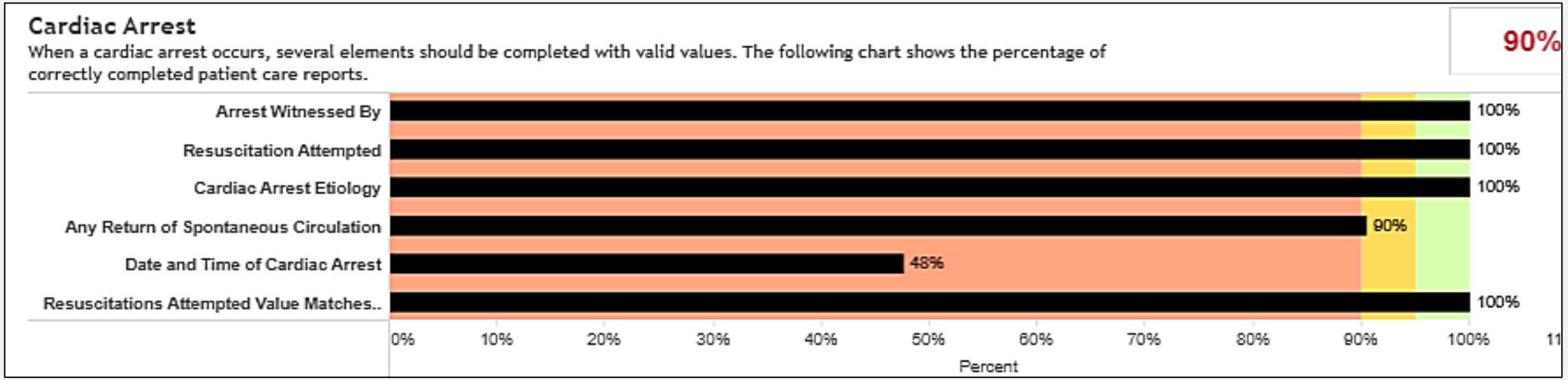
NEMSIS Can Identify Detailed Quality Issues (1 of 2)

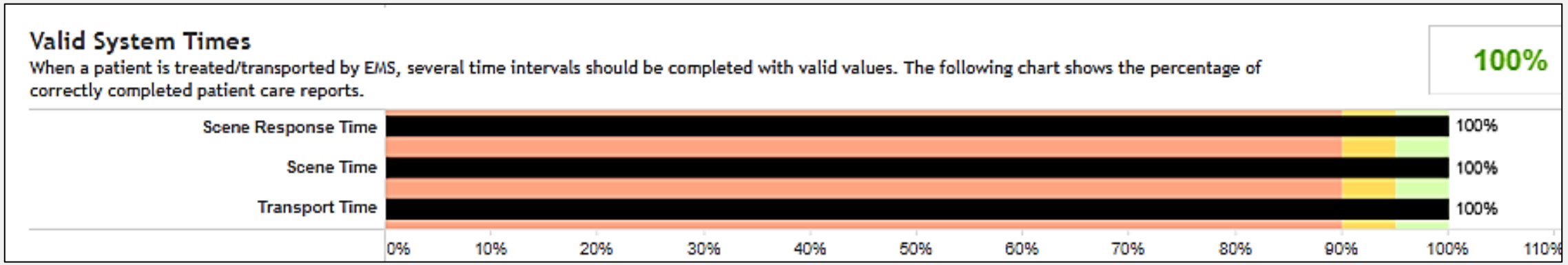


NEMSIS Patient Information and Clinical Times data pulled October 2025.

- EMSTR can provide individual agency consultation(s).
- EMSTR is collaborating with third-party vendors.
- EMSTR identified and counseled approximately 120 providers with data quality issues in the areas shown above.

NEMSIS Can Identify Detailed Quality Issues (2 of 2)

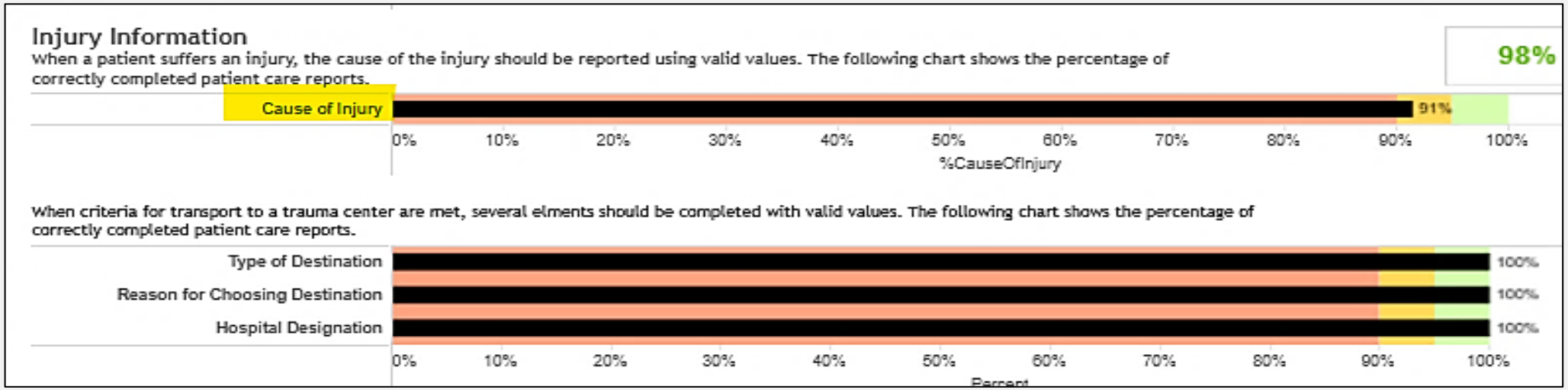




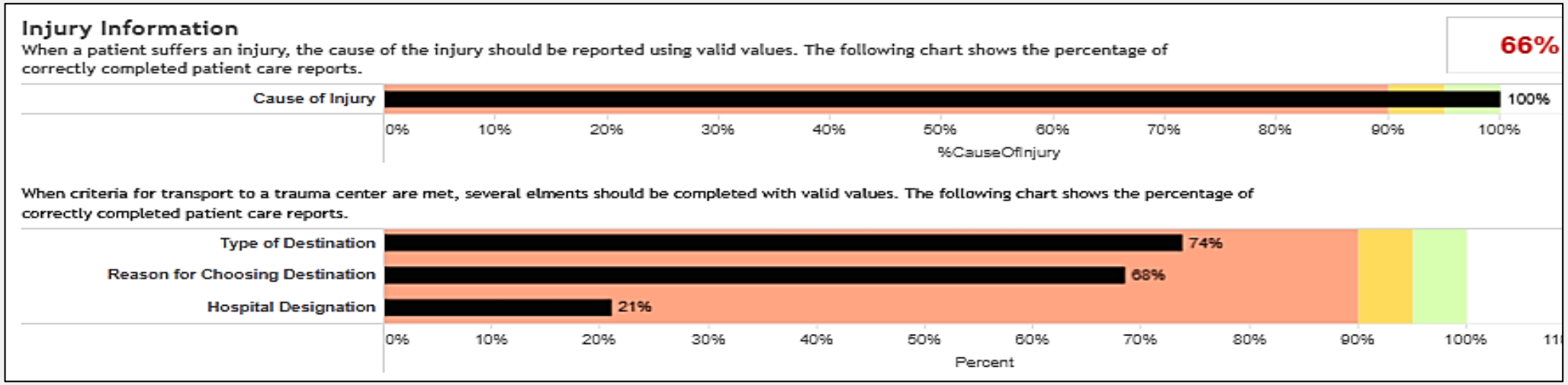
NEMSIS Cardiac Arrest and Valid System Times data pulled October 2025.

Example of Provider-Level Quality Issue Identification

Provider A

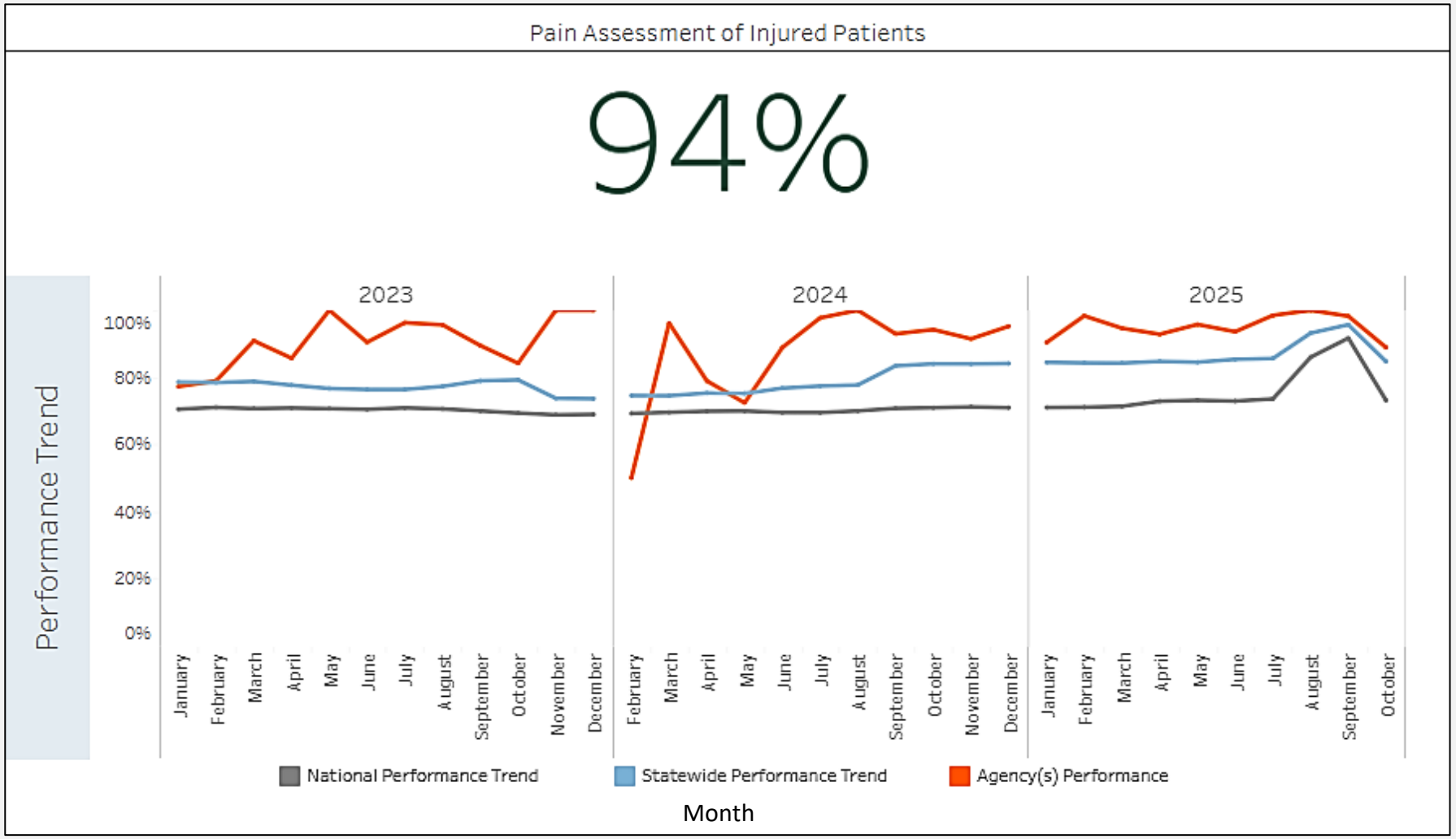


Provider B



NEMSIS Individual Provider data pulled October 2025.

Drilling Down on Performance Issues (1 of 2)



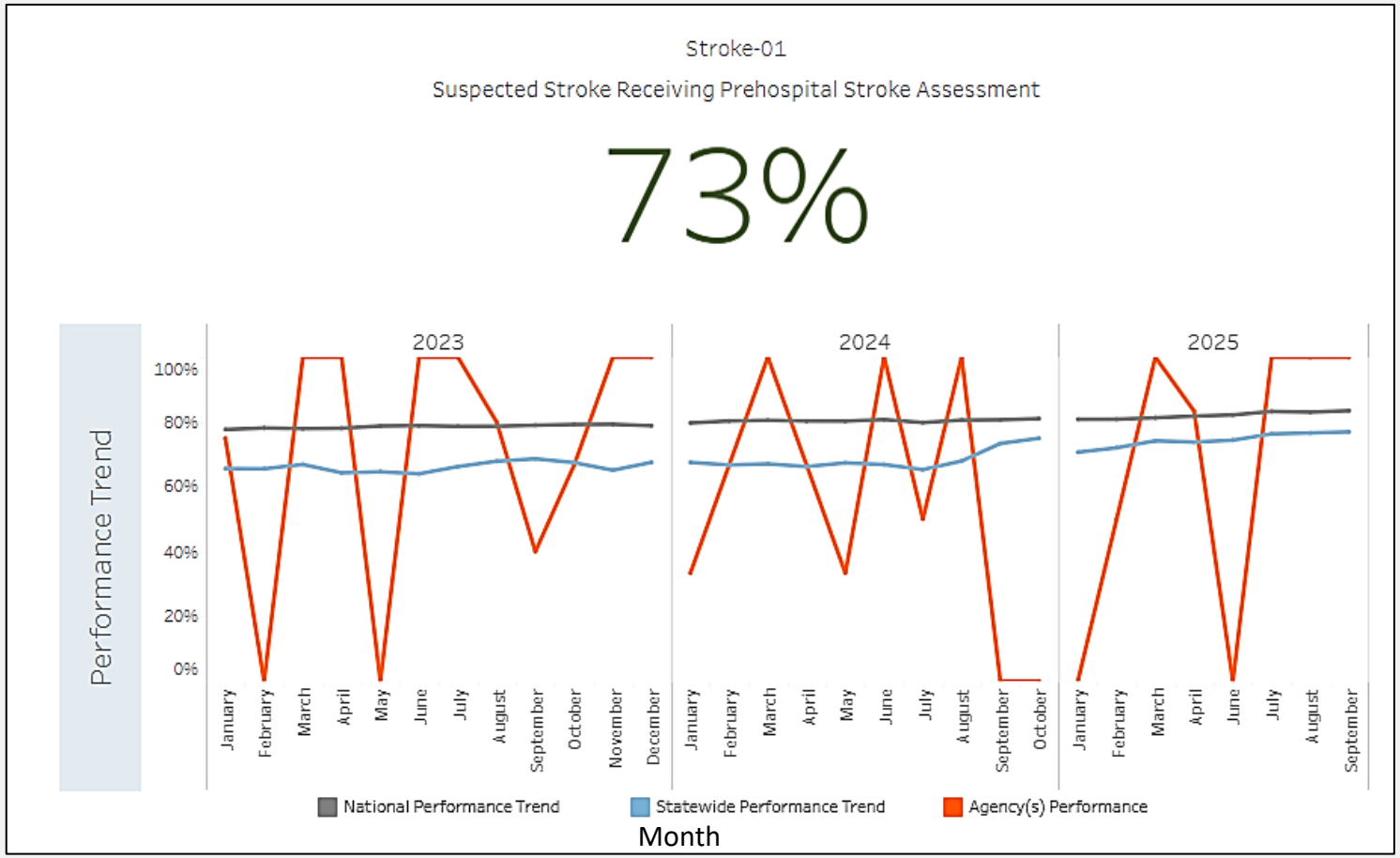
Example of how NEMSIS can help identify performance issues.

I.e., documenting/ performing a pain assessment for a patient with a documented injury.

NEMSIS Pain Assessment data pulled October 2025.

For additional information on how these numbers are calculated, please see the Companion Guide posted on the NEMSIS webpage.

Drilling Down on Performance Issues (2 of 2)



NEMSIS Suspected Stroke data pulled October 2025.

For additional information on how these numbers are calculated please see the Companion Guide, posted on the NEMSIS webpage.

EMSTR is working to improve statewide stroke assessment performance to align with GETAC recommendations

The example on the left is for an individual provider agency. Since the counts for strokes are low, there is some volatility to be expected.

Texas Wristband Number Update

About The Wristband Process

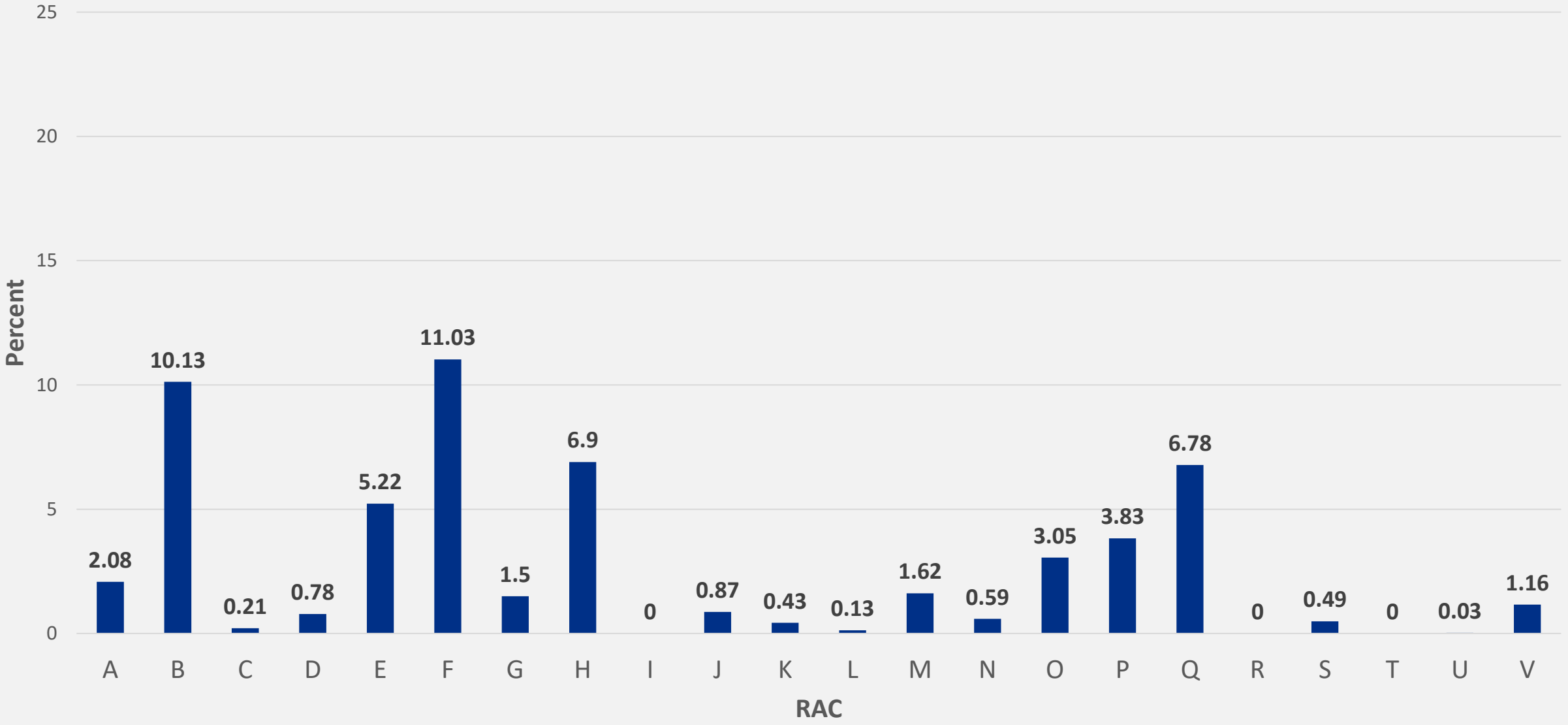
- The Wristband number field allows the injured patient's files to be "*linked*" between the EMS and hospital continuum of care.
- The Wristband can contrast hospital patient disposition and diagnoses with EMS treatments, acuity, dispatch information, and initial impressions.

Wristband Completion – EMS

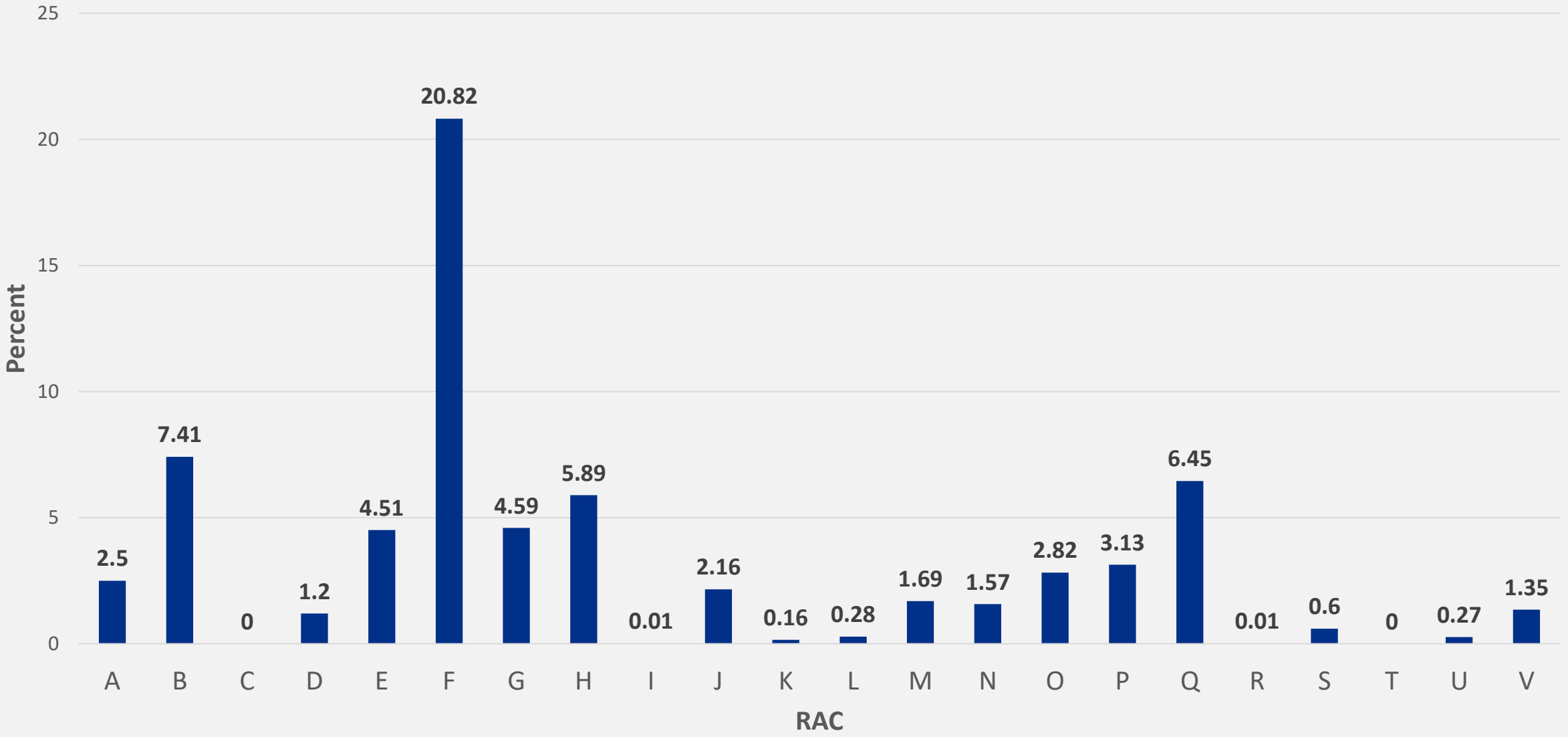
	2024	2025*
Total EMS Records with a Wristband Number Entered	178,172	154,498
Total EMS Records with Patient Contact Made	4,319,826	3,772,492
Percent	4.12%	4.10%

*2025 data pulled 10/31/2025.

EMS Wristband Completion by RAC, Texas, 2024



EMS Wristband Completion by RAC, Texas, 2025*



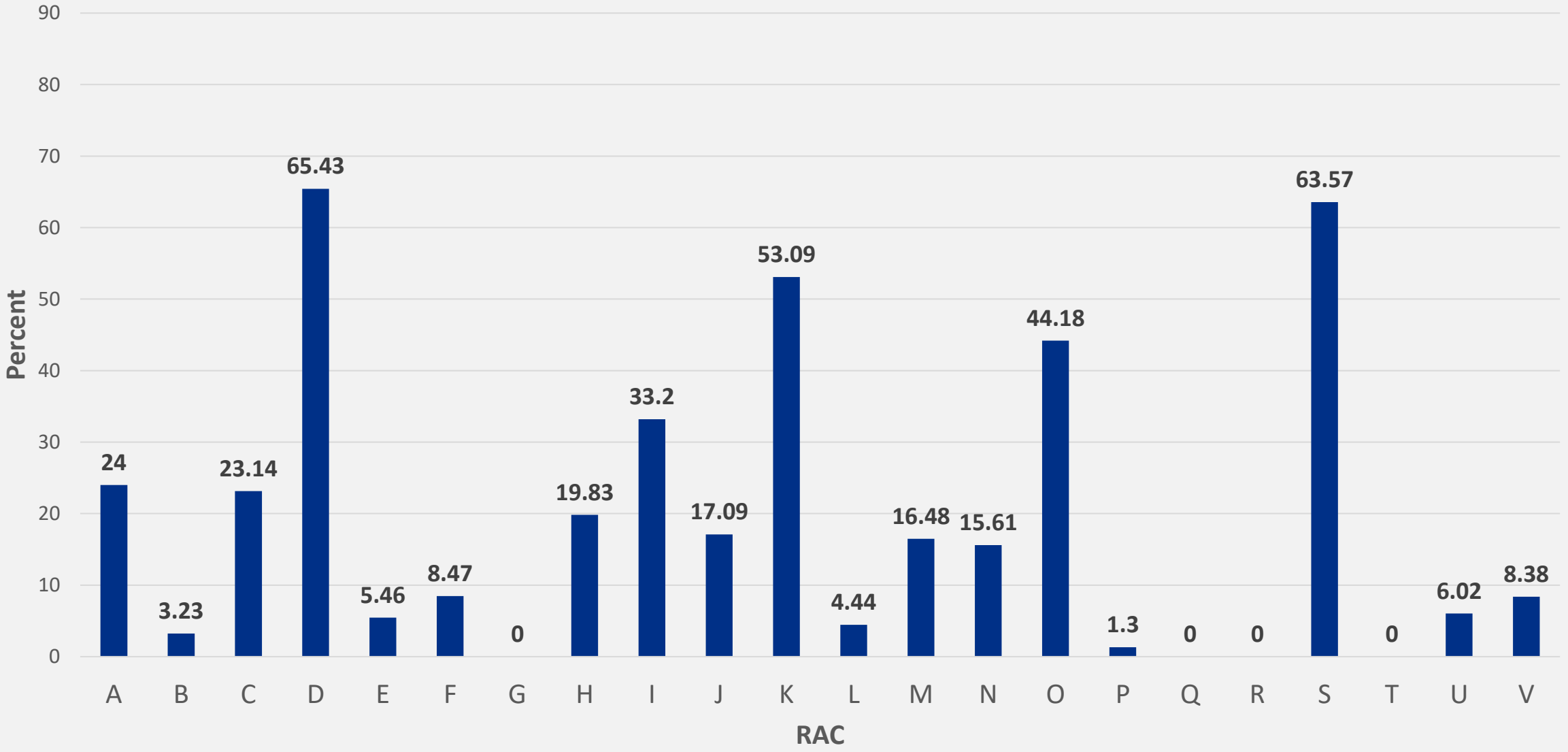
*2025 data pulled 10/31/2025.

Wristband Completion, Trauma, Texas

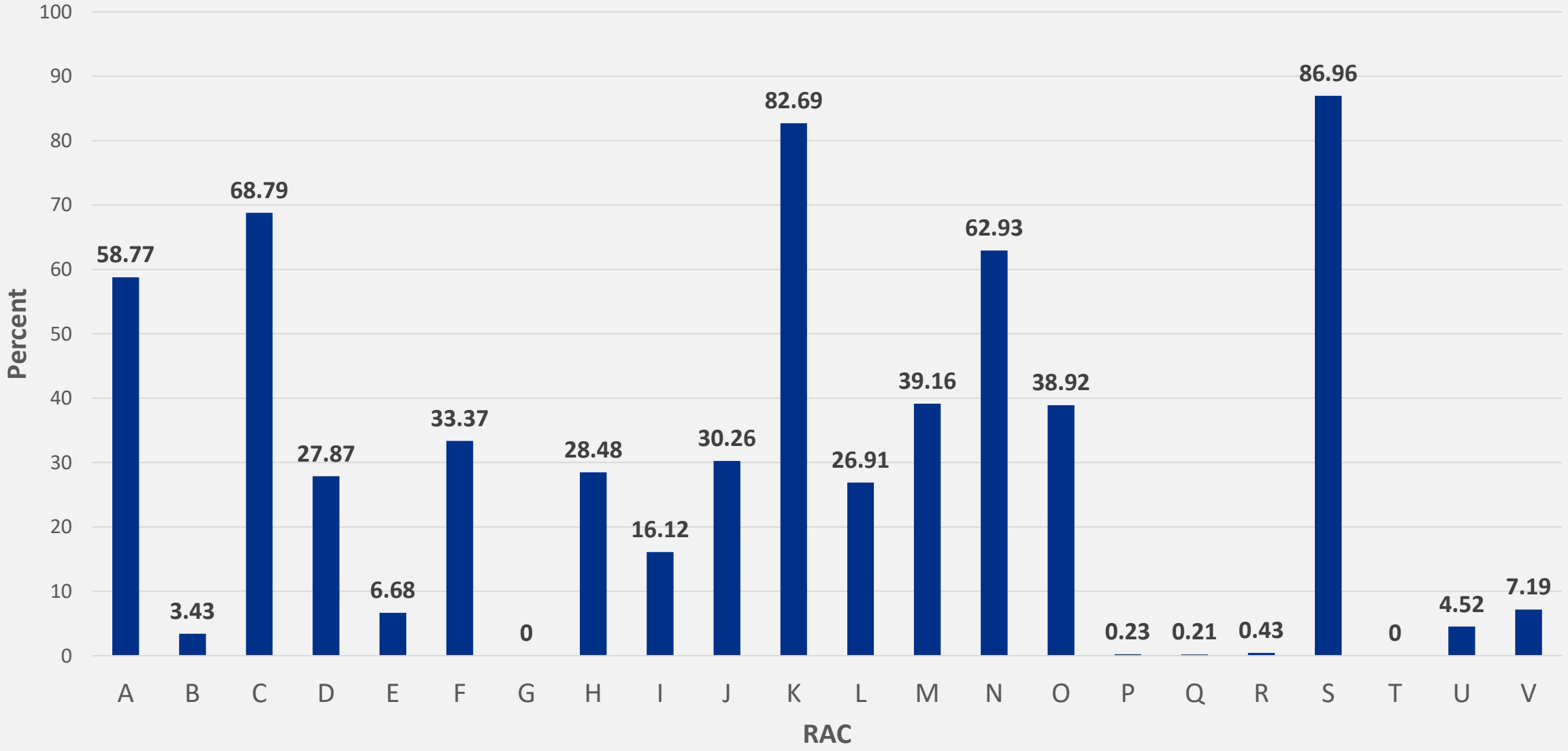
	2024	2025*
Total Trauma Records with a Wristband Number Entered	13,791	10,911
Total Trauma Patients Who Arrived by EMS	142,859	88,512
Percent	9.65%	12.33%

*2025 data pulled on 10/28/2025.

Trauma Wristband Completion by RAC, Texas, 2024



Trauma Wristband Completion by RAC, Texas, 2025*



*2025 data pulled on 10/28/2025.

Helpful Resources for Registry Users

- EMSTR Reports SHARP Reporting Guide - “How to” run each report available in EMSTR Online.
- EMSTR FAQs - Common questions and answers.
- EMS Reporting Requirements – Highlight Requirements for ePCR Reporting in Texas.
- Data Quality Webinar Series – EMSTR hosts these educational webinars every 6-8 weeks.
- NEMSIS 3.5 Data Dictionary – National EMS element listing and collection rules
- NEMSIS Public Research Dataset – National EMS Dataset (published through CY 2024)
- NEMSIS Public Dashboards – Analysis Tools

Thank you!

EMSTR Program Updates and Wristband Number Initiation

Injury.web@dshs.texas.gov

TEXAS
Health and Human Services

Texas Department of State Health Services

7. GETAC Committee Action Items

7.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 Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
Prevention & Injury: *Proper security of pediatric patients during air & ground transport*	• Survey - **Complete** • Workgroup with representatives from AMSCT, Pediatric, EMS, & EMS Medical Directors Committee - 157.11 language **submitted** - Weight/age-based device - Policy regarding use of device	Will continue to collaborate with 157.11 workgroup & working on 157.12 & 157.13 language
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 • **Request to be placed on Council agenda for Q4 meeting** • **Request to be removed from Council agenda – 10/28/2025**	Rolling to 2026 Priorities
Coordinated Clinical Care: *Develop and disseminate education on how the No Surprises Act (NSA) is protecting patients from exorbitant air medical transport bills. To include Air Medical Utilization Guidelines.*	• Air Medical resource utilization guidelines emphasis has been included • Resource document - **Complete** • AMSCT Committee approval received on 6/4/2025 • Medical Directors' Committee approval received on 6/5/2025 • **GETAC Council approval received on 8/22/2025**	Posted on GETAC AMSCT Committee page

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**	Dissemination in progress: TETAF TTCF ENA AMSCT GETAC RAC Chairs
Pulsara Implementation Guidelines for the Air Medical Provider **this was a directive given to the AMSCT Committee by the Disaster Committee*	• Guideline creation – **Complete** • Disaster Committee approval received 6/4/2025 • AMSCT Committee approval received 6/4/2025 • **GETAC Council approval received on 8/22/2025**	Posted on GETAC AMSCT Committee page
Create education for State staff on the OLOS dispatching system	• Workgroup formed - members from AMSCT & EMS Committees - 3 workgroup meetings were held • Transport.Net presentation provided at Q4 AMSCT Committee Mtg	No further action needed

7.b. GETAC Cardiac Care Committee Update to Council

Chair: Dr. Jamie McCarthy

Vice-chair: Dr. Craig Cooley

Cardiac Committee

2025Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. *Promote timely transfer of cardiac emergencies to higher level of care when required.*	*Further data reviewed from DSHS.* *Plan to further explore data elements to look for opportunities for improvement in timely transfers.* *Plan to parter with Trauma, Medical Directors, Stroke and Pediatric Committee for broader exploration.*	In progress
2. *Evaluate penetration of CPR instructions prior to EMS arrival* *Evaluate PSAP centers to determine if pre-arrival, life-saving instructions are being provided*	*Coordinating data eval from CARES and DSHS – reviewing gaps specifically for regions with long 911 response times for OHCA* *Currently, 54% of witnessed prehospital cardiac arrest patients do not receive pre-EMS arrival CPR.* *Partner with the RAC chairs committee on statewide adaptation of TCPR.*	In progress
3. *Educate policymakers on the Texas Emergency Healthcare System.*	*Support the use of the RAC Data Collaborative across the state.* *Collaborate with other relevant cardiac organizations.* *Educate state leaders and the legislature on the importance of data sharing and state designation.*	Ongoing discussion

Cardiac Committee

2025 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
4. Out of Hospital Cardiac Arrest – AED access/bystander CPR - assessment. (continued from 2024)	*Folded into data request for agenda item #2*	Ongoing discussion

7.c. GETAC Disaster Preparedness Update to Council November 24, 2025

Chair: Eric Epley

Vice-chair: Dr. Emily Kidd

Disaster Preparedness Committee

2025 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.*	• Received updates on current activities • MIST course last week • Peer Support efforts underway	

Disaster Preparedness Committee

2025 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*	• Establish framework for family reunification within Pulsara • Meeting with RAPTOR representative to establish Pulsara integration	

Disaster Preparedness Committee

2025 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
Other Items	• TX EMS Wristbands, September 2026 Rules • NDMS RMOCC rollout	

7.d. GETAC EMS Committee Update to Council

Chair: Chief Kevin Deramus, LP

Vice-chair: Chief James Campbell, LP

EMS Committee

2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
Rule Revision 157.11 and 157.14	*Dwayne Howerton is chairing our workgroup on rule revision to provide a framework for recommendations to DSHS / GETAC Council for revision recommendations.*	
Workplace Violence on EMS Personnel Reduction of Red, Lights and Sirens usage.	Chief Hayes is leading the newly created committee workgroup to discuss the ever-increasing concern and problem of workplace violence. Finalizing data survey to EMS providers for the next GETAC Quarterly Meetings. Previously, the Committee's White Paper on the use of RLS. With the committee returning to full 17-member participation in 2025, we will include a workgroup that focuses on the appropriate use of RLS (red lights & sirens). The workgroup's work is underway.	
Stroke Workgroup	Donald Janes – Chair our workgroup that is corresponding and working directly with the Stroke Committee provided updates and continues to work to approve stroke recommendations	

GETAC Committee/Stakeholder Action Item Request for Council 11/2025

Chief Deramus

EMS Committee

Action Item Request and Purpose

- The GETAC EMS Committee is requesting Council approval to send the revised "Workplace Violence Survey" to the agency AORs.

- The purpose is to gather actual Texas data on current EMS practices and assess for gaps in education, processes, and risk mitigation strategies that could benefit EMS personnel faced with an ever-increasing workplace violence atmosphere.

Benefit and Timeline

- We partnered with our Education Committee colleagues to create a survey that could identify actual reporting gaps and to define “violence” in hopes of better identifying the potential concerns facing our responders.

- Our goal is to distribute the survey with a 60-day turnaround deadline. This should allow the workgroup to analyze the data and prepare a presentation at our next quarterly GETAC meetings in March 2026.

7.e. GETAC Pediatric Committee Update to Council

Chair: Christi Thornhill, DNP

Vice-chair: Belinda Waters, 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.	

GETAC Committee/Stakeholder Action Item Request for Council November 2025

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

Pediatric Committee

Action Item Request and Purpose

Request:

- Approval of the Citizen and EMS education regarding Button Battery Ingestions
- Approval of the Sudden Cardiac Arrest in Pediatrics toolkit
- Approval of the Pediatric Consideration for Consultation and Transfer document

Purpose for this request:

- Each of these documents will be part of the Pediatric Resource Toolkit published on the DSHS Pediatric Committee website

Benefit and Timeline

Intended impact or benefit:

- These documents will serve as a public resource for pediatric-specific issues in one place.

Timeline or relevant deadlines for this request:

- As soon as approved by the GETAC council.

7.f. GETAC Injury Prevention & Public Education Committee Update to Council

Chair: Mary Ann Contreras, RN

Vice-Chair: Courtney Edwards, DNP

Injury Prevention Public Education Committee

11/2025 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* *- Blake Milnes to share elements of the current strategies used in a reduction of 911 fall calls in Harris Co. at next GETAC meeting*	
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.* *-Developed community education PP to be shared with all RACS for individual branding to support PHWB initiative including education on the importance of community donation for WB*	

Injury Prevention Public Education Committee

11/2025 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 collaborating to align with existing state and national plans to promote drowning prevention strategies for public consumption across the State of Texas.* - *Syndromic surveillance presentation by Dr. Rohit Shenoi* - *Dr. Cary Cain overview of APHA/VIPR strategies to reduce firearm injury and death with consideration of SDOH elements.* - *Begin collaborative work with Stroke Committee to raise public awareness and understanding for the urgency of timely care during stroke events*	

7.g. GETAC Stroke Committee Update to Council

Chair: Robin Novakovic, MD

Vice-chair: Sean Savitz, MD

GETAC Stroke 2026 Priorities

Chair: Robin Novakovic, MD

Vice-chair: Sean Savitz, MD

Stroke Committee

GETAC 2024 Strategic Plan

2026 Committee Priorities

Strategic Plan Pillar & Objective	Strategy and Implementation Activity
1. **Coordinated Clinical Care:** Promote timely access to care for urgent conditions regardless of geographic location across the state. (Objective 6 of Coordinated Clinical Care) • Develop standardized processes to minimize the time from stroke onset to definitive acute stroke care at an appropriate designated stroke facility. Focusing on public education and early recognition through acute management.	**a. Strategy:** Develop standards to minimize the time from onset of illness or injury to definitive care. (Strategy 2 of Coordinated Clinical Care) **b. Activity:** ▪ Recommendation for prehospital Stroke Triage algorithms for adults and pediatric patients ▪ Rural stroke work group to identify barriers and opportunities to improve access to stroke care, Rural Stroke Survey ▪ Post acute stroke care work group implemented ▪ TX stroke awareness campaigns.
2. **Coordinated Clinical Care:** Utilize evidence-based and/or best practice metrics to evaluate the emergency healthcare system, deliver evidence-based care, and provide public transparency of such data. (Objective 8 of Coordinated Clinical) • Enhance stroke care performance by utilizing evidence-based and best practice metrics to evaluate the emergency healthcare system, ensure delivery of high-quality, evidence-based care, and promote public transparency of outcomes.	**a. Strategy:** Develop standards to minimize the time from onset of illness or injury to definitive care; and define data elements necessary to evaluate emergency healthcare system effectiveness. (Strategy 2+3 of Coordinated Clinical Care) **b. Activity:** ▪ DIDO performance measure recommendation ▪ Neuro IR coverage recommendation ▪ Establishing and maintain standards to minimize the time from last known well to definitive stroke care. ▪ Define, track, and regularly review performance measures necessary to assess and improve the effectiveness of both EMS systems and designated stroke facilities. Examples: ○ Rural stroke performance report from GWTG and EMSTR ○ GWTG performance reports ○ GETAC Stroke semiannual performance report (GWTG and EMSTR)

Stroke Committee

GETAC 2024 Strategic Plan

2026 Stroke Committee Priorities

Strategic Plan Pillar & Objective	Strategy and Implementation Activity
3. <u>Coordinated Clinical Care:</u> Deliver the highest quality care across the continuum of the emergency healthcare system-from prevention to rehabilitation. (Objective 7 of Coordinated Clinical Care) • Develop and maintain a coordinated stroke system of care spanning the entire continuum of the emergency healthcare system—from public recognition and prevention through acute management, post-acute recovery, and secondary prevention. Focusing on disseminating best practices and educational resources to address knowledge gaps and optimize outcomes across all phases of stroke care.	**a. Strategy:** Adopt the national goal of achieving zero preventable deaths related to injury and time-sensitive illness and minimizing trauma and disease-related disability. (Strategy 1 of Coordinated Clinical Care) **b. Activity:** ▪ Best practice recommendation for optimizing and reducing DIDO ▪ Pediatric Stroke Task Force working on tip sheet for thrombolysis in pediatric patients and minimum requirements for pediatric facilities specializing in stroke care. ▪ Endorsing and promoting statewide stroke educational opportunities ▪ Looking to start mentorship program for stroke managers and continue to identify resource documents ▪ TEAM Stroke ED study evaluating standardized stroke education ▪ Resource documents posted to GETAC Stroke Committee website ▪ Establish AHA, DNV and JC liaisons to the committee
4. <u>Public Education</u>: Explore innovations for providing interactive, collaborative, and targeted public education. (Objective 2 of System Support/Public Education) • Develop innovative and applicable knowledge content in stroke recognition and prevention strategies for public consumption across the State of Texas.	**a. Strategy:** Promote and provide information to local agencies related to layperson education and training to improve stroke recognition and utilization of 911 to provide timely and appropriate interventions (Strategy 4 of System Support/Public Education) **b. Activity:** ▪ Texas Stroke Awareness Campaign ▪ Texas Rural Stroke Awareness Campaign ▪ BEFAST education material in Spanish and English ▪ Education to target school age children and adult lay persons

GETAC Stroke Committee 2025 Outcomes

Chair: Robin Novakovic-White, MD

Vice-chair: Sean Savitz, MD

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: GETAC Prehospital Adult and Pediatric Routing and Resource recommendation	• Passed by GETAC committees and GETAC Council. • Working on education and dissemination. • Available on the GETAC Stroke Committee webpage.	
Coordinated Clinical Care: Pediatric Task Force working to outline tip sheet for pediatric stroke workup and management, and minimum capability recommendations for pediatric hospital to be recognized as capable of caring for pediatric stroke	• Task Force Lead – Stuart Fraser, MD • Members consist of EMS providers, pediatric stroke neurologists, RNs and Stroke Committee members • Activities ongoing • Working with International Pediatric Stroke Organization Readiness Work Group – submitted a brief report of examples how pediatric SSOC and recommendations are made, including GETAC efforts.	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: Rural Stroke Work Group – working to improve access and quality of stroke care in rural areas across TX.	• Work Group Lead – Robin Novakovic-White, MD • Members consist of EMS providers and leadership, RAC leadership, stroke neurologists, RNs, AHA representative, and Stroke Committee members • Defined the rural scope of the WG, rural regions, resource challenged and rural hospitals. • Heat Maps for TX • Activities ongoing • Rural Stroke Needs Assessment Survey • Working to define rural stroke recommendations • Rural targeted layperson stroke education • Working on best practice recommendation for DIDO • Exploring ABT in rural areas.	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: Quality and patient safety issue	• Letter presented from providers citing patient safety issue regarding Neuro IR call coverage. • Multiple providers in state of Texas gave first-hand experience supporting statements in the letter. • Stroke Committee and Council approved the concerns are a quality and patient safety issue that need to be reviewed. • DSHS met with accrediting agencies to discuss • Stroke Committee recommended performance measures hospitals could use to monitor • SSOC to present proposal for recommendation on Neuro IR coverage best practice	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: Post Acute Care Work Group	• Work Group Lead – Sean Savitz, MD • Members consist of stroke neurologists, PMR providers, RNs and Stroke Committee members • Activities ongoing, will meet monthly	
Coordinated Clinical Care: Work with DSHS to outline stroke facility level rules	• Task not completed • Stroke Committee endorsed AHA/ASA as resource guideline for DSHS (previously BAC).	
Coordinated Clinical Care: Interfacility Stroke Terminology	Approved by committees but not the GETAC Council. Next steps: EMS Time Sensitive Deconfliction Task Force	
Coordinated Clinical Care: Establish recommendation for stroke facility infrastructure based on ASA recommendations Optimal Care of the Injured Patient 2022 Standards	• The System of Care Work Group reviewed the ASA recommendation. • Reviewed the optimal care of the injured patient 2022 • Paused while waiting for the July 2025 revision.	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: Provide list of recommended stroke education and certification courses	• Education Work Group - compiling a list of courses and certifications pertaining to stroke education endorsed by GETAC Stroke Committee.	
Coordinated Clinical Care: Stroke education resources for stroke facilities	• Next steps: work with DSHS to create webpage resource for stroke education. • Provide lectures at the DSHS level meetings	
Coordinated Clinical Care: Stroke Coordinator Mentorship program and needs assessment survey.	• Education Work Group – working on follow up survey for stroke managers/coordinators • Resource documents for coordinators endorsed and available from GETAC Stroke Committee webpage.	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Performance Improvement: Report and disseminate quarterly TX stroke quality performance report and semi-annual GETAC Stroke performance report	• Share report with committee, council and TCCVDS • Quality reports help guide recommendations • Quality reports assess performance of the Texas stroke system of care. • Stroke Committee PI WG and Rural Stroke WG use the quality report with benchmarks to identify barriers to stroke care and opportunities for improvement.	
Performance Improvement: GETAC Stroke Committee recommended performance measures	• GETAC Stroke Committee has made recommendations on performance measures to follow and registry participation. • Recommendation for participation in GWTG EMS and DIDO layers.	
Performance Improvement: DIDO performance recommendations goals	• Committees and GETAC Council approved. • Disseminated information and educate • Monitor performance	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
EMS Education: Disseminate current information on stroke best practices and educational opportunities to satisfy knowledge gaps.	• Working on TEAM Stroke Ed study - providing standardized stroke education to EMS providers, first responders, and dispatchers. • Endorsed by Committees and Council • Seeking funding for study	
EMS Education: Texas EMS Stroke Survey	• Survey completed • Data analyzed • 3 scientific abstracts accepted at two international meetings from the Texas EMS Stroke Survey Results • Next steps, write finding up for publication.	

Stroke Committee
2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Public Education: Explore innovations for providing interactive, collaborative, and targeted public education.	• Texas Stroke Awareness Campaign, seek approval at the 11/2025 meeting.	
Public Education: Explore innovations for providing interactive, collaborative, and targeted public education.	• Texas Rural Stroke Awareness Campaign, seek approval at the 11/2025 meeting.	

GETAC Stroke Committee Report November 2025

Chair: Robin Novakovic-White, MD

Vice-chair: Sean Savitz, MD

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Texas Stroke Quality Performance Report	• Review and disseminate Texas Stroke Quality report. • Share with TCCVDS. • Use the quality report to identify barriers to stroke care and opportunities for improvement. • Stroke Committee endorses data elements that are highly recommended for completion in GWTG • **Presented quality report from GWTG, and rural stroke data from GWTG and EMSTR** • **Discussion – rural stroke survey may help identify barriers to stroke care and opportunities for improving DIDO**	
RDC report	• Update from RDC at Stroke Committee meeting. • Previously discussed more rural hospitals participating than higher levels I and II. • RDC will not be the ultimate source for the performance report. Need to continue with GWTG	
Stroke Committee 2026 Priorities	• **Stroke Committee 2026 Priorities approved by the stroke committee 11/2025** • **Stroke Committee identified liaisons to the GETAC Committees** • **Stroke Committee identified liaisons from AHA, DNV and JC**	

2026 Stroke Committee Returning & New Members

Stroke Committee Member	RAC/TSA	Affiliation
Sean Savitz, MD	**Q**	McGovern Medical School
Saud Khan, MD	**F (rural)**	Titas Regional Medical Center
Sarah Elizabeth Andrews, RN	**L**	Ascension
Farzan Ghodsianzade, DO	**O**	BSW
Joseph Dominguea, RN	**V (rural)**	KNAPP Medical Center
Avni Kapadia, MD	**Q**	Baylor College of Medicine and Texas Children's

Committee Liaisons

- **Committee Liaison Updates:**
  - Air-Medical – Chantel Molina, RN
  - EMS Education – Amanda Jagolino-Cole, MD
  - EMS – Chief Kevin Cunningham
  - Pediatric – Melanie Aluotto, RN
  - EMS Medical Director – Robin Novakovic, MD

New Liaison Roles

- Allison Capetillo – AHA Liaison
- Janine Mazebob – DNV Liaison
- Andrea Yates – Joint Commission

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Patient safety and quality concern – Neuro IR coverage	• Letter citing patient safety concern regarding Neuro IR call coverage discussed. • Multiple TX providers gave first-hand experience supporting statements in the letter 11/2024. • Stroke Committee and GETAC Council approved as a quality and patient safety concern. • Barriers to finding objective measures to demonstrate delays, patients inappropriately denied MT and misuse of resources. • DSHS is working with DNV and TJC to review transfers out from hospitals • Stroke Committee and SSOC WG recommendation for internal performance measures to follow. • **SSOC work group and Stroke Committee endorsed using the NCTTRAC Neuro IR coverage best practice recommendation as the GETAC recommendation.** • **NCTTRAC approved that it can be branded as the GETAC resource.**	

Neuro IR Proposed Recommendation

NCTTRAC
NORTH CENTRAL TEXAS TRAUMA REGIONAL ADVISORY COUNCIL

Regional Stroke System Plan
Stroke Recommendation for Neuro IR Coverage
Stroke Committee

I. Recommendation

This recommendation serves to provide acceptable neurointerventional coverage (primary and backup call coverage) at Level I-Comprehensive and Level II-Thrombectomy Capable Stroke Centers in the NCTTRAC region and has been endorsed by the NCTTRAC Stroke Committee, the Board of Directors, the Stroke Medical Directors, and the majority of the C-Suites of the Level I and II Stroke-designated facilities in TSA-E.

A. Comprehensive and Thrombectomy Capable Stroke Centers that perform mechanical thrombectomy should have adequate coverage to meet the emergent needs of multiple strokes.
B. Each facility should have a written call schedule readily available within the hospital system, identifying the on-call and backup on-call interventional provider privileged to perform mechanical thrombectomy (neurointerventionalist) 24 hours a day, seven days a week, 365 days a year.
C. The neurointerventionalist taking calls should be available by phone within 20 minutes and available on-site within 30 minutes from notification.

i. When concurrent facilities are covered by either the primary or backup on-call provider, the following should be in place:
   1. If one neurointerventionalist is primary on-call concurrently at two (2) facilities there should be one dedicated backup on-call provider for each facility (e.g., two hospitals with shared coverage, one primary and three tier backup on-call coverage).
   2. The dedicated primary neurointerventionalist on-call at one facility may serve as backup call for no more than one hospital at any given time (e.g. primary call at one facility and backup at one additional facility).
   3. The facilities with cross coverage should be in close proximity, allowing the neurointerventionalist either serving as primary or backup on-call to be available on site within 30 minutes.

ii. Comprehensive and Thrombectomy Capable Stroke Centers that utilize a system of care to deliver stroke care, treatment, and services may utilize the same interventionists provided the following requirements are met:
   1. Written call schedules are readily available within the hospital system to demonstrate how stroke care, treatment, and services are provided at all hospitals in the system 24 hours a day, 7 days a week, 365 days a year.
   2. If one physician is covering more than one facility or another service in the organization, there is a written plan for backup coverage.
   3. Protocols and processes are developed and implemented to detail the system and organizations' plans to meet the emergent needs of multiple complex stroke patients.
   4. Protocols and processes are developed in response to situations when organizations would not be able to provide mechanical thrombectomy services and subsequently transfer patients or notify Advisory-Capability with a comment in EMResource.

iii. Comprehensive and Thrombectomy Capable Stroke Centers that perform mechanical thrombectomy and utilize an independent contracted provider or group for neurointerventional coverage to deliver stroke care, treatment, and services should have the following requirements met by the contracted provider or group:
   1. Written call schedules are readily available outlining all of the hospitals that the primary and backup on-call providers are covering for the shift.
   2. A written plan to meet the emergent needs of multiple stroke patients for each of the facilities if one contracted physician is covering more than one facility.
   3. Protocols and processes are developed in response to situations when the primary and backup on-call providers would not be able to provide mechanical thrombectomy services and subsequently transfer patients or notify of Advisory-Capability with a comment in EMResource.

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Adult Prehospital Stroke Resource	• Final routing algorithm approved through GETAC Council 03/2025 • Resource document for adult algorithm revisions approved by required committees and Council 06/2025. • **Resources available from the GETAC Stroke Committee webpage.**	
Pediatric Stroke Task Force	• **Pediatric Stroke Tip Sheet is still under review by the Pediatric Stroke Task Force. Goal something to review by 11/2025** • Next steps, minimum capability recommendations for pediatric hospitals to be destinations for pediatric stroke. • Algorithm approved by required committees, pediatric stroke task force and Council 06/2025. • Revisions approved by Pediatric, Stroke Committee and Council 08/2025 • **Resources available from the GETAC Stroke Committee webpage.**	

Stroke Committee GETAC Approved Recommendations

Committee Resources

GETAC EMS Acute Pediatric Stroke Routing Resource Document
GETAC Prehospital Pediatric Stroke Triage and Management Resource Document
GETAC Door-in/Door-out (DIDO) Performance Goals
GETAC Prehospital Adult Stroke Triage and Management Resource Document
GETAC EMS Acute Stroke Routing Resource Document - Urban
GETAC EMS Acute Stroke Routing Resource Document - Suburban
GETAC EMS Acute Stroke Routing Resource Document - Rural
Southwest Texas Regional Advisory Council (STRAC) Stroke Program Manager Manual

GETAC Stroke Committee Page:

(Scroll to bottom of the page)

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

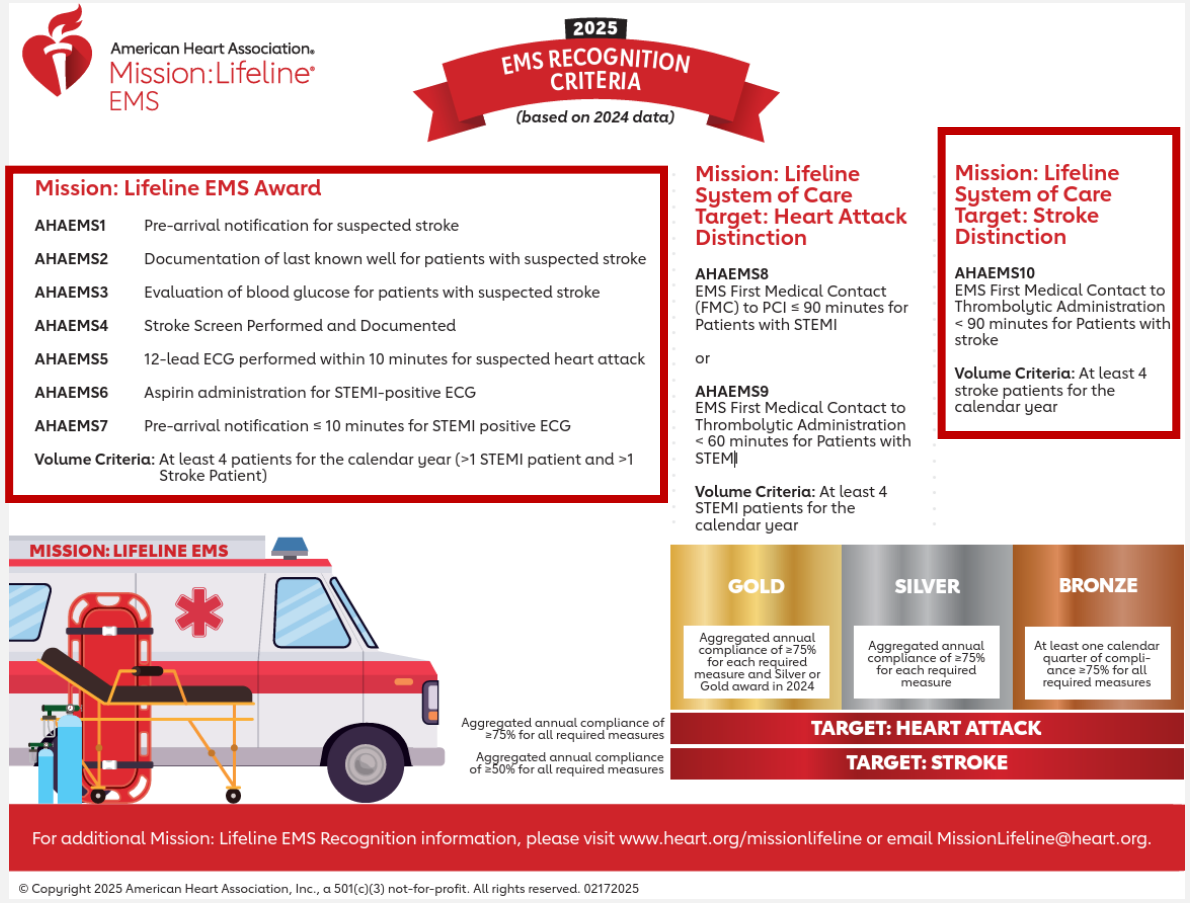
Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• Drs. Fagan and Winckler provided input on terminology, approved by the Stroke, EMS, Air Medical, and EMS Medical Director Committees in 11/2024. • Presented to the GETAC Council but not approved 11/2024. • **Participating with the EMS Time Sensitive Deconfliction Task Force.**	
DIDO performance recommendations	• Approved by Committees and the GETAC Council 11/2024. • Email recommendations to participate in GWTG DIDO layer and performance goals to RAC chairs and continue to share with stroke programs. • Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO • **Recommendation for best practice to improve DIDO – present 03/2026**	
TEAM EMS-Ed Study	• Study endorsed by Stroke, EMS and EMS Medical Directors Committees and council 06/2025. • Informed EMS Education Committee and seeking members for writing group 08/2025. • **Seeking funding.** • **Working on the standardized education**	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Post Acute Stroke Care Work Group	• Approved by Stroke Committee 11/2024 • Dr. Sean Savitz leads the work group • Had their first meeting 11/2025 • **Request made at 11/2025 that the work group look into financial barriers to post acute care.**	
Stroke Managers Mentorship Program and Texas Stroke Coordinators Collaborative Survey	• Education Work Group discussing the platform and feasibility of the mentorship program. • Working on the stroke managers' survey. • Will incorporate some questions from the prior survey.	
STRAC Stroke Program Manager Manual	• Collect and share resources related to stroke program management, stroke coordinator & manager roles, and process improvement. • Presented 11/2024, approved by stroke committee as a good resource. • Available resource from the GETAC Stroke Committee Webpage.	
Mission: Lifeline EMS Recognitions	• **To bridge the gap between data EMS collects to what the hospitals collect for GWTG metrics an EMS recognition was created.** • **Stroke Committee approved endorsement to promote 08/2025** • **APPROVAL ITEM: Approval to distribute the Mission: Lifeline EMS Recognition to committees, RACs and at DSHS stroke meetings**	

Education Workgroup - Mission: Lifeline EMS Recognition



https://www.heart.org/en/professional/quality-improvement/mission-lifeline

Measure Narratives: https://www.heart.org/en/-/media/Files/Professional/Quality-Improvement/Mission-Lifeline/2025-EMS-ML-Measure-Narratives-Final.pdf?sc_lang=en

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Rural Stroke Work Group	• Met twice after the 08/2025 session, plan to meet monthly. • Approved rural and resource-challenged regions and hospitals to be included in the scope of work group. • Reviewed heat maps 08/2025. • Needs assessment survey approved by work group, Stroke Committee and Council 08/2025 • EMSTR data request approved 08/2025 • Working on DIDO recommendation. • **11/2025 review performance from EMSTR and GWTG.** • **Rural Stroke Needs Assessment Survey live.**	

Rural Stroke
Resource and Needs Assessment Survey

Survey QR Code:

Public Survey URL:
https://ais.swmed.edu/redcap/surveys/?s=NT4X9HJYRNPP8ACM

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Texas EMS Stroke Survey	• Results shared • **Two abstracts accepted to ISC 2026 (one accepted as oral presentation), one abstract presented at SVIN 2025** • **Plan for paper**	
The Stroke Committee endorsed stroke education and certification courses.	• Ongoing effort identifying stroke educational opportunities for providers	
Stroke Education Resources for stroke facilities	• Council approved stroke resources to be posted to GETAC Stroke Committee webpage 08/2025. • GETAC Approved Stroke Resources available on Committee webpage. • EMS Education Liaison – Dr. Jagolino-Cole • Met with RAC chairs 08/2025 to seek guidance, recommended email RAC chairs via Deidra with updates.	
Work with DSHS to outline recommendations for stroke rules for ASRH	• Pending further direction	

Confidence Drives Utilization: EMS Provider Perspectives on Stroke and LVO Screening Tools in Texas

UT Southwestern Peter O'Donnell Jr. Brain Institute

S. Hegde[1], S. Novakovic[1], J. Schmider[2], C. Winckler[3], E. Fagan[4], J. Benno[5], E. Stevenson[5], J. Klein[5], H. Pervez[1], S. Savitz[6], K.Cunningham[7], L. Hutchinson[8], C. McAlpine[4], C. Escobar[9], A. Capetillo[10], J. Mazabob[11], A. L. Jagolino-Cole[6], V. Cairns[12], M. Aluotto13, S. Khan[14], M.Steiner[15], J. Burwell[16], A. Webb[17], C. Molina[18], A. Kapadia[19], R. Novakovic[1];[1]UT Southwestern Medical Center, Dallas, TX, [2]Texas Department of State Health Services, Dallas, TX, [3]UT Health, San Antonio, TX, [4]Baylor Scott &White, Dallas, TX, [5]Texas Department of State Health Services, Austin, TX, [6]UT Health, Houston, TX, [7]Midlothian Fire Department, Midlothian, TX, [8]UTHealth Tyler, Tyler, TX, [9]University Medical Center of El Paso, El Paso, TX, [10]American Heart Association, Dallas, TX, [11]DNV GL Healthcare, Sugar Land, TX, [12]Ascension Texas, Austin, TX, [13]SouthEast Texas Regional Advisory Council, Houston, TX, [14]Titus Regional Medical Center Mount Pleasant, Mount Pleasant, TX, [15]Parkland Health, Dallas, TX, [16]CHRISTUS Trinity Mother Frances Tyler, Tyler, TX, [17]DNV, Corpus Christi, TX, [18]Laredo Medical Center, Laredo, TX, [19]Baylor College of Medicine, Houston, TX.

Background

Stroke screening and large vessel occlusion (LVO) tools are critical for prehospital triage, guiding recognition and transport destination. Provider confidence in applying these instruments may directly affect their frequency of use and reliability. Few studies have compared EMS provider confidence across different stroke screening tools or examined whether similar patterns exist for LVO-specific assessments.

Methods

We analyzed 189 responses from a Texas statewide EMS survey conducted in 2024. Providers reported their confidence in performing stroke screening tools (very confident, confident, somewhat confident, not confident) and LVO tools, along with which instrument they used most often. Associations between tool selection, confidence, training frequency, and utilization were assessed using chi-square tests and Cramér's V effect sizes.

Results

- Confidence significantly influenced stroke screening tool use but varied significantly by stroke screening tool used.
- Cincinnati was most frequently associated with higher confidence and greater utilization (χ^2=15.7, p=0.0035, Cramér's V = 0.32), whereas FAST and LAMS demonstrated lower independent associations with confidence.
- LAPSS and Boston were rarely used.
- Importantly, providers who reported higher confidence in any stroke screening tool were also significantly more likely to report using the tool >75% of the time ($\chi^2 = 44.0$, $p < 0.001$, Cramér's V=0.31).
- For LVO tools, overall confidence was lower compared with general stroke screening. Only 54% of VAN users reported being "very confident," while fewer than half of FAST-ED, C-STAT, RACE, and LAMS users expressed high confidence.
- Utilization followed a similar pattern: >50% of users for RACE, C-STAT, VAN, and FAST-ED reported they used their tool >75% of the time, whereas rates were lower for LAMS (43%). Training frequency varied, but providers receiving annual or more frequent training were more likely to express higher confidence across all LVO tools (trend consistent but not statistically significant).
- Importantly, confidence gaps in LVO tools were consistent across provider levels (EMT vs paramedic), though paramedics tended to report slightly higher confidence.

Results

Table 1. Confidence, Utilization, and Training by LVO Tool

Tool	N	Very Confident %	>75% Utilization %	Annual/More Training %
VAN	52	53.8	50.0	76.9
C-STAT	20	40.0	55.0	70.0
FAST-ED	8	37.5	50.0	50.0
LAMS	7	42.9	42.9	42.9
RACE	7	28.6	57.1	57.1

Table 2. Confidence, Utilization, and Training by Stroke Screening Tool

Tool	N	Very Confident %	>75% Utilization %	Annual/More Training %
Cincinnati	130	59.2	70.8	68.5
FAST	65	52.3	69.2	69.2
LAMS	10	70.0	80.0	60.0
NIHSS	10	50.0	70.0	60.0
LAPSS	5	60.0	60.0	60.0

Figure 1. LVO Tool Comparison

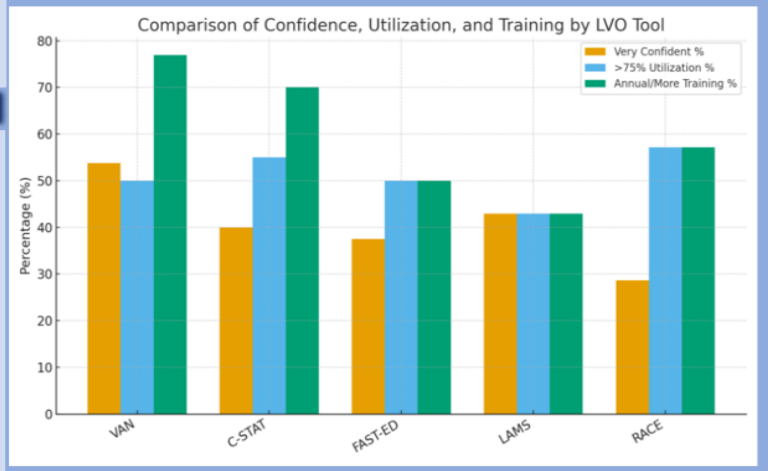


Figure 1. Comparison of EMS provide confidence, utilization frequency (>75%), and annual/more frequent training across five major LVO tools (VAN, C-STAT, FAST-ED, LAMS, RACE).

Figure 2. Stroke Screening Tool Comparison

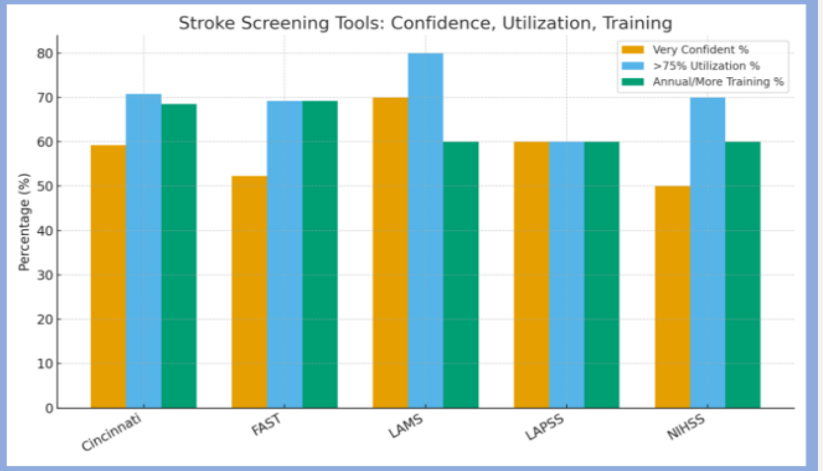


Figure 2. Comparison of EMS provider confidence, utilization frequency (>75%), and annual/more frequent training across general stroke screening tools (Cincinnati, FAST, LAMS, LAPSS, Boston).

Conclusions

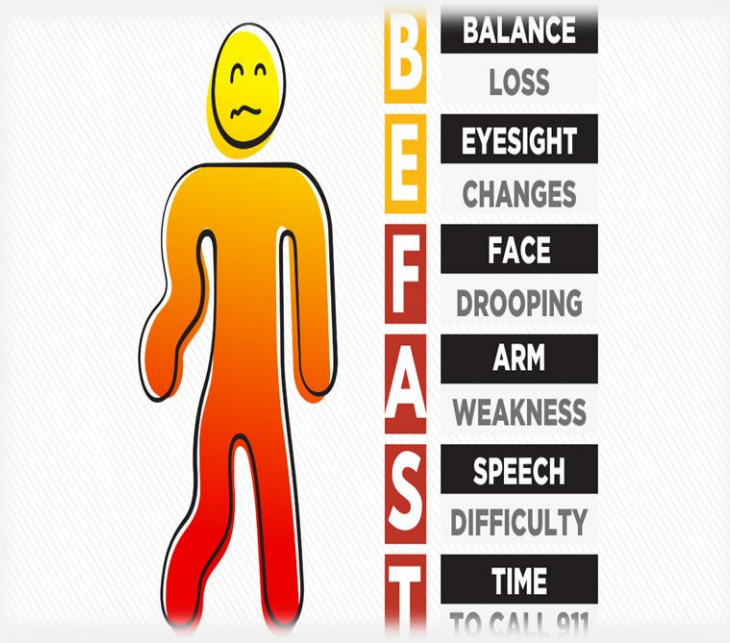
Confidence remains the strongest determinant of utilization for both stroke and LVO tools. Cincinnati was associated with the highest confidence and use among stroke screening tools, while VAN and C-STAT were most common among LVO instruments, albeit with lower confidence overall. These findings highlight an urgent need for standardized, recurring education on LVO tools to strengthen provider confidence and consistency. Improving training may enhance the reliability of prehospital stroke triage and ultimately improve patient outcomes.

GETAC Stroke Committee

- **Committee items presented for Council approval 08/2025:**
  1. Data request EMSTR for rural stroke approved by the stroke committee - APPROVED
  2. Pediatric resource document with recommendation to add edit for end tidal CO2- APPROVED
  3. Rural stroke survey- APPROVED
  4. Council approval for endorsed stroke resources to be on GETAC Stroke Committee website - APPROVED
  5. Approval to distribute the Mission: Lifeline EMS Recognition to committees, RACs and at DSHS stroke meetings. - Differed
- **Committee items needing council approal:**
  1. Neuro IR coverage recommendation best practice
  2. Approval to promote - Mission: Lifeline EMS Recognition. Mission Lifeline EMS Stroke Recognition
  3. Texas Stroke Awareness Campaign and Rural Stroke Awareness Campaign
  4. 2026 GETAC Stroke Committee Priorities

Stroke Care Starts Before the Door

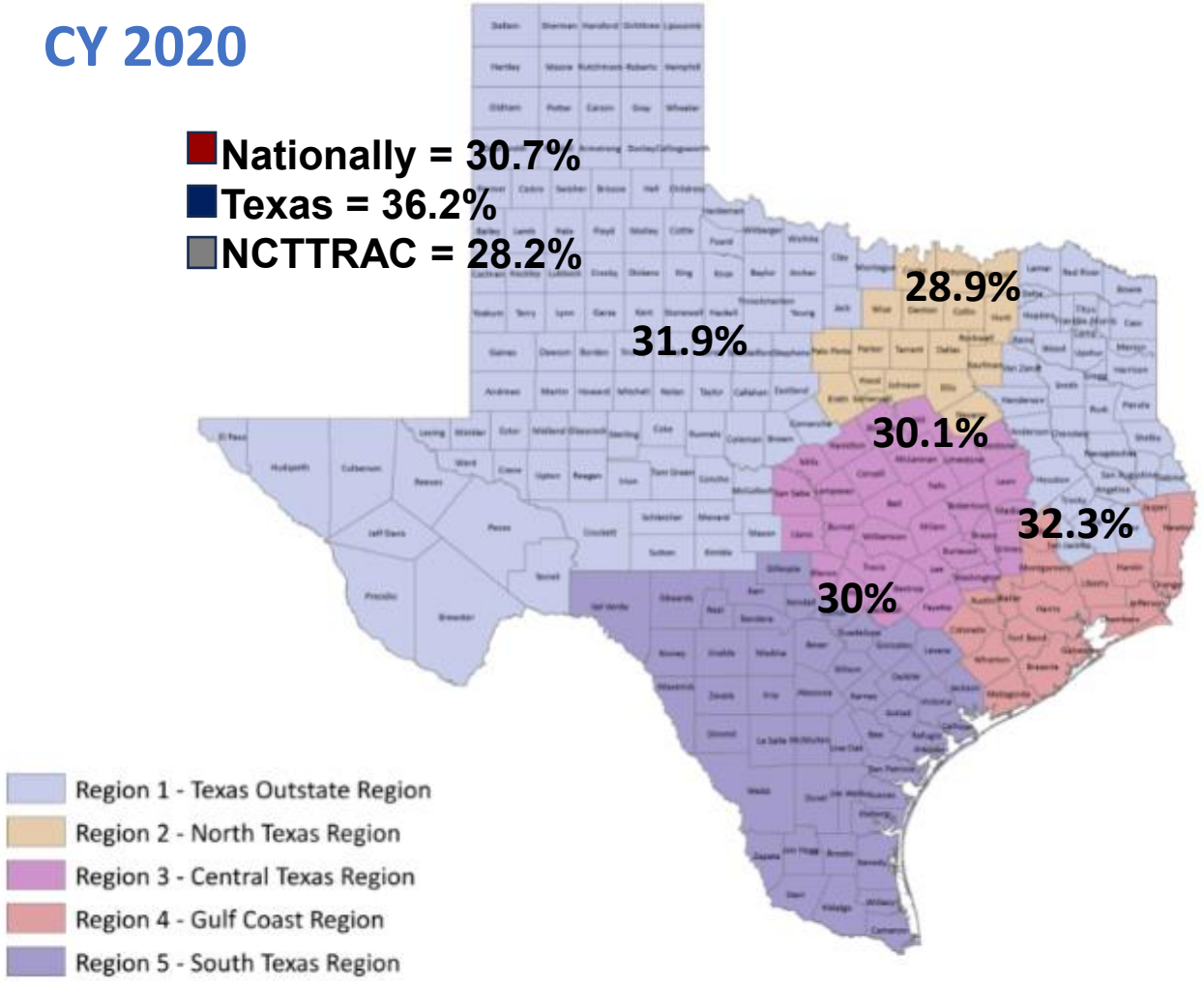
- **Recognition** of stroke symptoms is a critical first step in the access to treatment pathway.
- Early symptom recognition along with EMS **activation** contribute to reduced prehospital delays and faster higher-quality care.



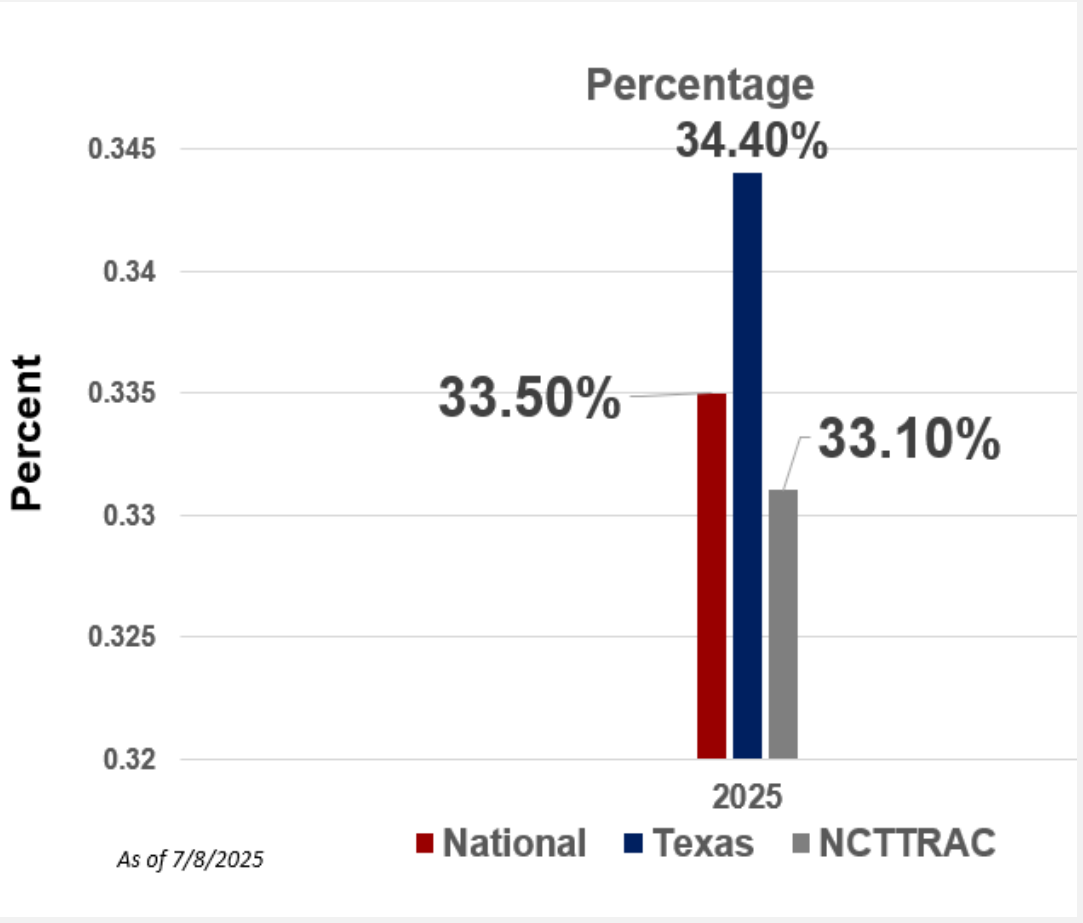
- Patel MD, et al. Prehospital notification by emergency medical services reduces delays in stroke evaluation: findings from the North Carolina stroke care collaborative (Stroke 2011).
- Ekundayo OJ, et al. Patterns of emergency medical services use and its association with timely stroke treatment findings from Get with the Guidelines-Stroke (Circ Cardiovasc Qual Outcomes 2013).
- Nielsen VM, et al. The Association between presentation by EMS and EMS prenotification with receipt of intravenous tissue-type plasminogen activator in a state implementing stroke systems of care (Prehosp Emerg Care 2020).

LKW to Arrival - % arrive within Thrombolysis window

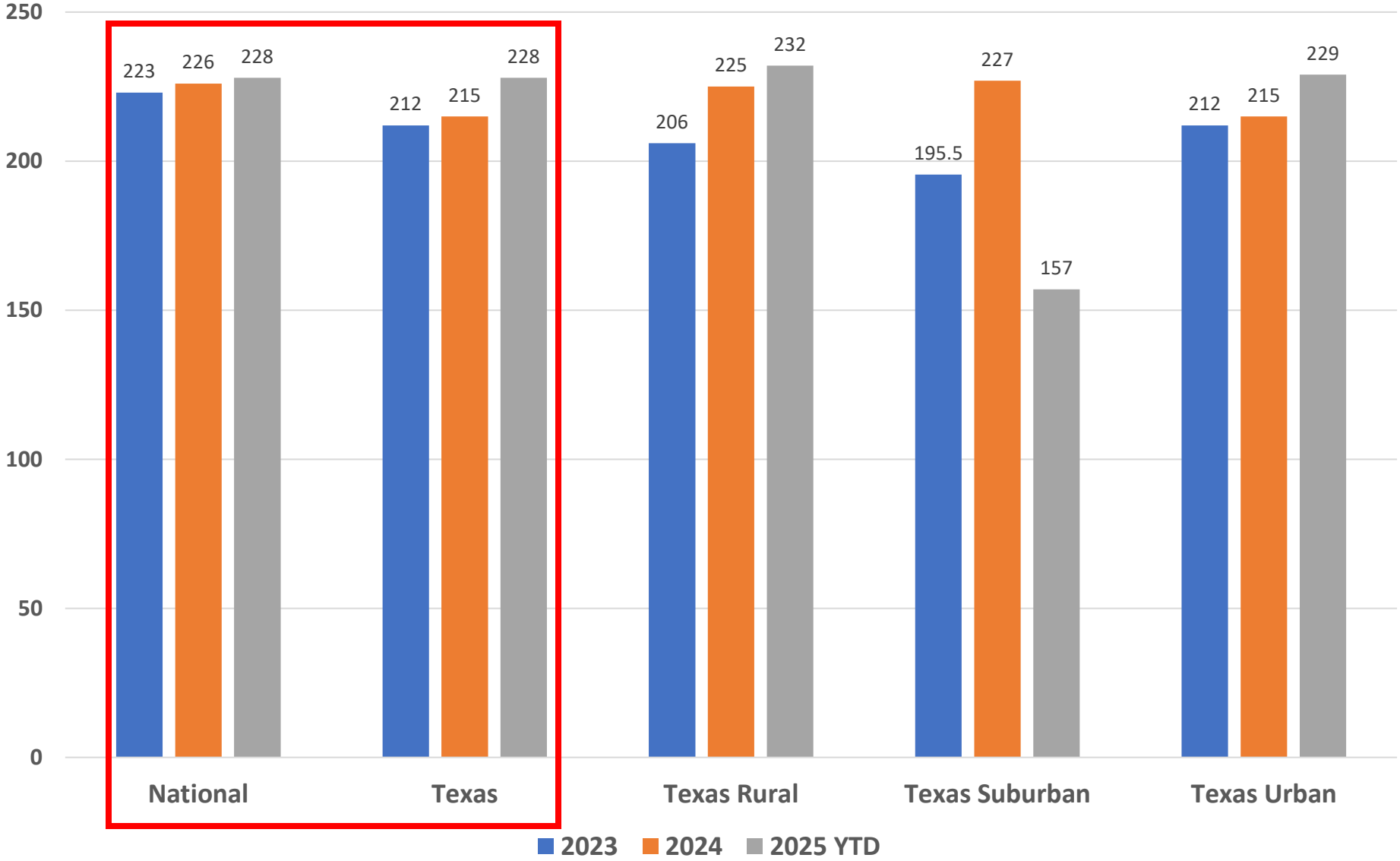
CY 2020



YTD 2025

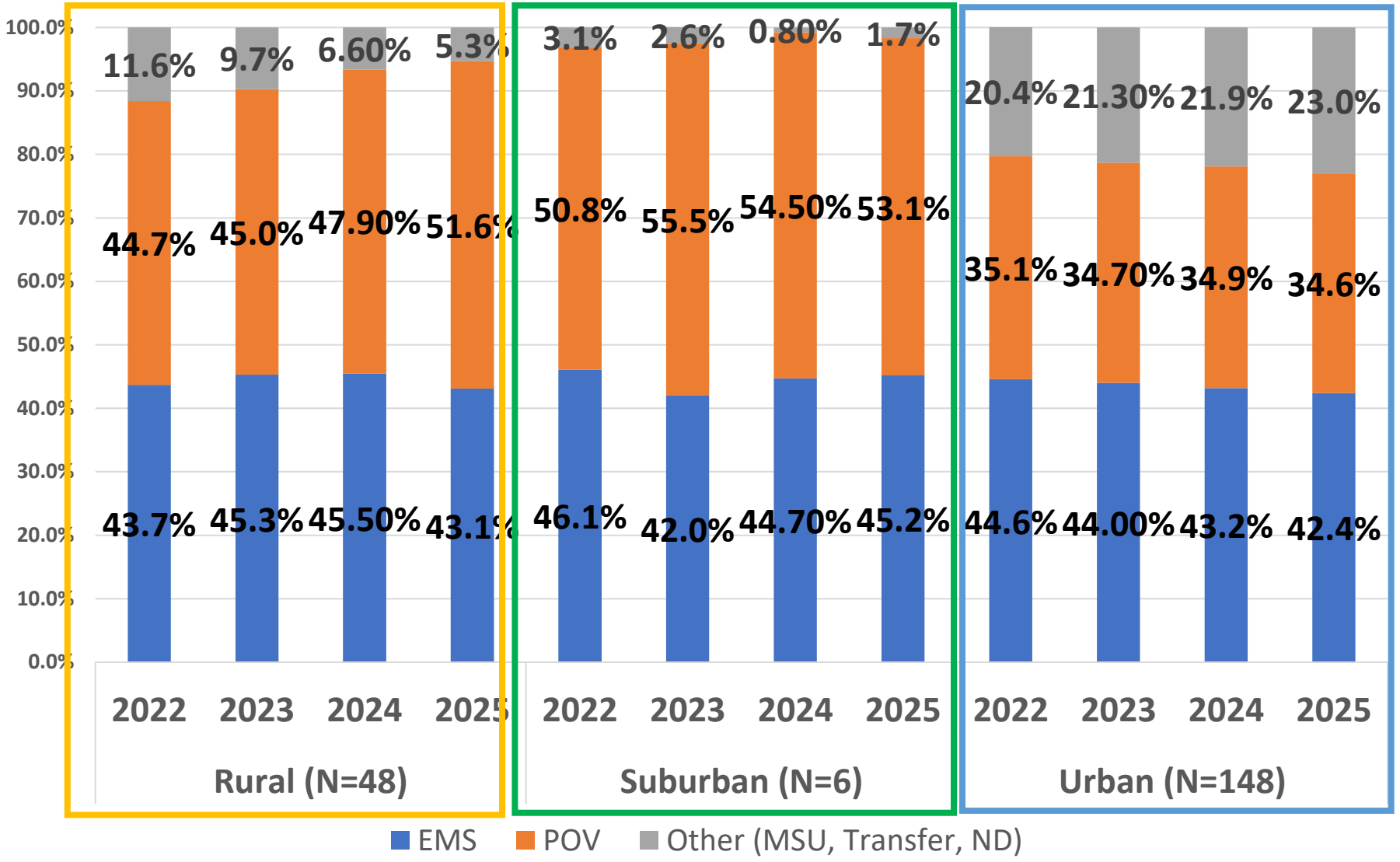


Median Time LKW to Arrival by Geographic Size



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 11/4/25.

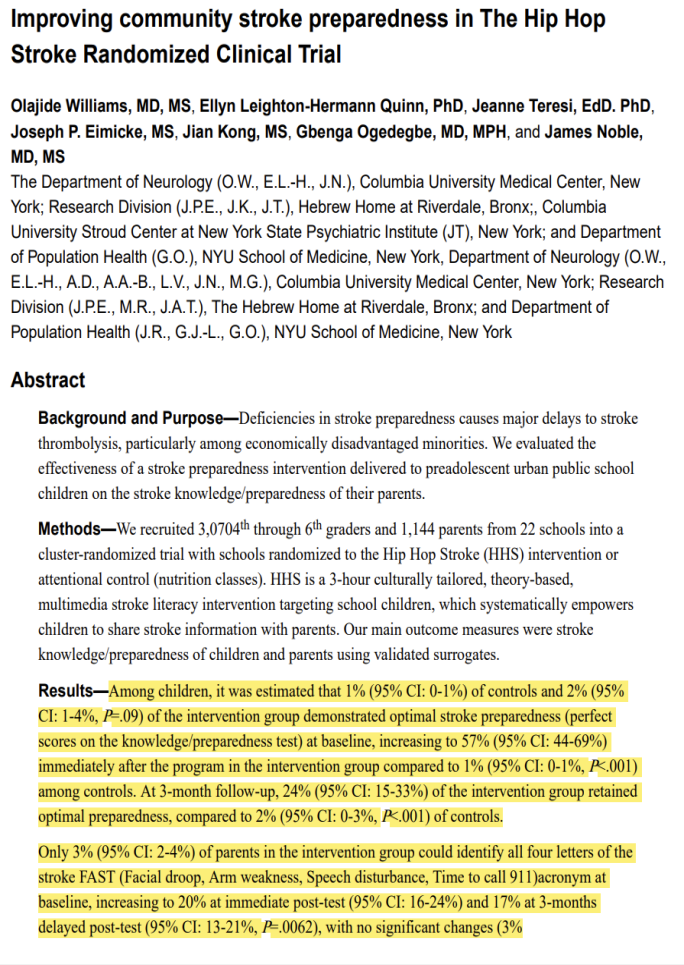
Texas Modes of Arrival to ED by Geographic Classification



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 11/4/25

Innovative Approaches

- **Stroke awareness campaigns** need to improve symptom recognition while emphasizing **rapid EMS response** targeting **multilingual** equity-oriented approach.
  - Massachusetts Department of Public Health
- Other innovative strategies include school-based programs such as Hip-Hop Stroke.



Improving community stroke preparedness in The Hip Hop Stroke Randomized Clinical Trial

Olajide Williams, MD, MS, **Ellyn Leighton-Hermann Quinn, PhD**, **Jeanne Teresi, EdD. PhD**, **Joseph P. Eimicke, MS**, **Jian Kong, MS**, **Gbenga Ogedegbe, MD, MPH**, and **James Noble, MD, MS**

The Department of Neurology (O.W., E.L.-H., J.N.), Columbia University Medical Center, New York; Research Division (J.P.E., J.K., J.T.), Hebrew Home at Riverdale, Bronx;, Columbia University Stroud Center at New York State Psychiatric Institute (JT), New York; and Department of Population Health (G.O.), NYU School of Medicine, New York, Department of Neurology (O.W., E.L.-H., A.D., A.A.-B., L.V., J.N., M.G.), Columbia University Medical Center, New York; Research Division (J.P.E., M.R., J.A.T.), The Hebrew Home at Riverdale, Bronx; and Department of Population Health (J.R., G.J.-L., G.O.), NYU School of Medicine, New York

Abstract

Background and Purpose—Deficiencies in stroke preparedness causes major delays to stroke thrombolysis, particularly among economically disadvantaged minorities. We evaluated the effectiveness of a stroke preparedness intervention delivered to preadolescent urban public school children on the stroke knowledge/preparedness of their parents.

Methods—We recruited 3,0704th through 6th graders and 1,144 parents from 22 schools into a cluster-randomized trial with schools randomized to the Hip Hop Stroke (HHS) intervention or attentional control (nutrition classes). HHS is a 3-hour culturally tailored, theory-based, multimedia stroke literacy intervention targeting school children, which systematically empowers children to share stroke information with parents. Our main outcome measures were stroke knowledge/preparedness of children and parents using validated surrogates.

Results—Among children, it was estimated that 1% (95% CI: 0-1%) of controls and 2% (95% CI: 1-4%, *P*=.09) of the intervention group demonstrated optimal stroke preparedness (perfect scores on the knowledge/preparedness test) at baseline, increasing to 57% (95% CI: 44-69%) immediately after the program in the intervention group compared to 1% (95% CI: 0-1%, *P*<.001) among controls. At 3-month follow-up, 24% (95% CI: 15-33%) of the intervention group retained optimal preparedness, compared to 2% (95% CI: 0-3%, *P*<.001) of controls.

Only 3% (95% CI: 2-4%) of parents in the intervention group could identify all four letters of the stroke FAST (Facial droop, Arm weakness, Speech disturbance, Time to call 911)acronym at baseline, increasing to 20% at immediate post-test (95% CI: 16-24%) and 17% at 3-months delayed post-test (95% CI: 13-21%, *P*=.0062), with no significant changes (3%

- Williams O, et al. Improving community stroke preparedness in the hhs (hip-hop stroke) randomized clinical trial (Stroke 2018)

Emergency Medical Dispatcher Recognition

- **Dispatcher** recognition is a chokepoint.
- Sensitivity to accurate recognition is **~50%** without structured protocols.
- Caller language and the compressed call time hinder recognition, delaying downstream care.
- **Train call-takers with structured stroke prompts**; **target <60-sec dispatch.**

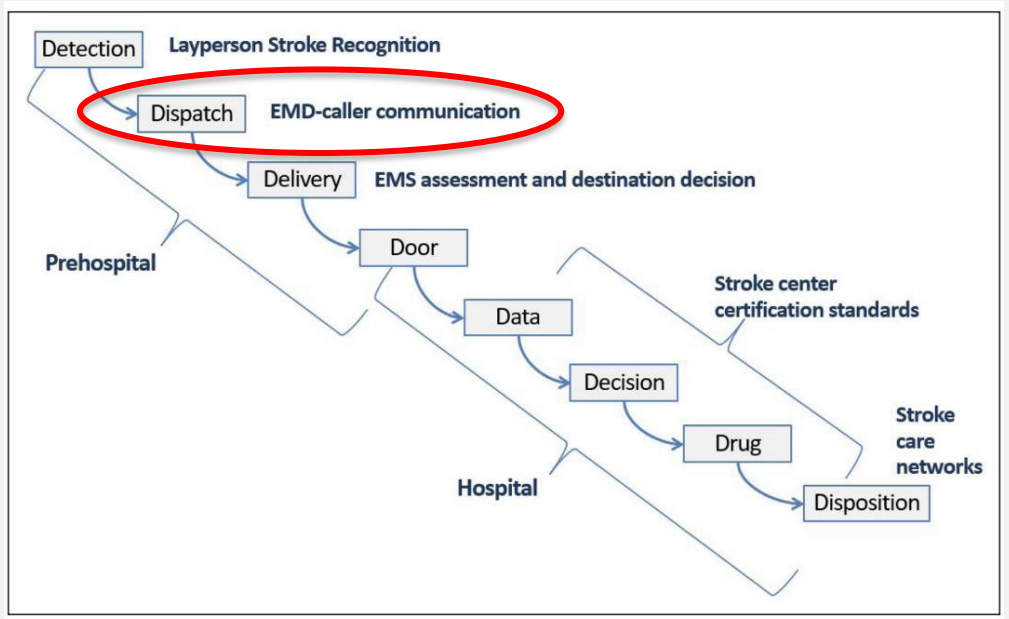


Figure. Stroke chain of survival within a systems of care framework.
EMD indicates emergency medical dispatcher; and EMS, emergency medical services.

- Zachrison KS et al. Prehospital stroke care part 1: emergency medical services and the stroke systems of care (*Stroke* 2023).

Emergency Medical Dispatcher Recognition

- Accurate dispatcher recognition has been associated with:
  - **Faster On-scene times** by responding paramedics
  - Higher rate transport to **stroke center**
  - **Faster Door-to-physician/CT**
  - Higher rate and **faster DTN**
- MSU may be particularly positively impacted accurate stroke dispatch.

TABLE 2. Prehospital and In-hospital Times by Dispatcher and EMS Provider Diagnosis

	Dispatcher Diagnosis			EMS Provider Diagnosis		
	Stroke/TIA $n = 232$	Other $n = 167$	P-value	Stroke/TIA $n = 230$	Other $n = 169$	P-value
Prehospital Time Intervals						
Call to scene arrival	7(5 – 10)	7(5 – 10)	0.553	7(5 – 10)	7(6 – 11)	0.195
On-scene time	17(12 – 22)	16(13 – 23)	0.890	17(14 – 22)	15(10 – 22)	0.011
Transport time	13(8 – 19)	13(8 – 19)	0.653	12(7 – 18)	15(10 – 21)	0.001
In-hospital Time Intervals						
Door-to-physician time, min	6(2 – 19)	6(2 – 20)	0.784	4(1 – 12)	11(3 – 27)	< 0.001
Door-to-CT time, min	27.5(17 – 51)	35(20 – 62)	0.010	23(16 – 37)	48(26 – 73)	< 0.001

Note: Data presented are medians with interquartile range in parenthesis. Wilcoxon Rank Sum used to test for differences between groups.

Abboud ME, et al. (Prehosp Emerg Care 2016)

TABLE 2 Dispatch practices according to suspicion of stroke by emergency dispatchers

	Suspected stroke/TIA N (%)	No suspected stroke/TIA N (%)	Unadjusted OR (95% CI)
Overall	2383 (56%)	1872 (44%)	
Ambulance dispatch priority[a]			
Lights and sirens (within 15 minutes)	2305 (97)	1111 (61)	Reference
Urgent (within 30 minutes)	46 (2)	507 (28)	**0.04 (0.03–0.06)**
Non-urgent (within 60 minutes)	32 (1)	205 (11)	**0.08 (0.05–0.11)**
Transport priority[b]			
Highest priority (time sensitive)	1289 (55)	800 (45)	Reference
Medium priority (non-time sensitive)	1057 (45)	980 (55)	**0.67 (0.59–0.76)**

Eliakundu AL, et al. (J Am Coll Emerg Physicians Open 2022)

Approval Item

- Texas Stroke Awareness Campaign
- Rural stroke Awareness Campaign
- Target dispatcher, first responders, layperson in Spanish and English

GETAC Stroke Committee

- **Committee items needing council approval:**
  1. Neuro IR coverage recommendation best practice
  2. Approval to promote - Mission: Lifeline EMS Recognition. Mission Lifeline EMS Stroke Recognition
  3. Texas Stroke Awareness Campaign and Rural Stroke Awareness Campaign
  4. 2026 GETAC Stroke Committee Priorities
- **Action items for the next session:**
  1. Pediatric stroke tip sheet and supplement – 03/2026
  2. DIDO Best Practice Recommendation – 03/2026
  3. Rural Stroke Work Group recommendation on best practice 2026

Stroke Committee

- **Committee items needing council guidance**
  1. None at this time

- **Stakeholder items needing council guidance**
  1. None at this time

- **Items referred to GETAC for future action**
  1. None at this time

7.h. GETAC EMS Education Committee

Chair: Macara Trusty, LP

Vice-Chair: Christopher Nations, LP

EMS Education Committee

2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
Review/Revise EMS Education Rules to meet the needs of the workforce and the patients that are treated and transported daily.	*Drafted, pending more discussion.*	
Continue to Improve access to initial EMS Education Programs. a. Review and enhance advanced placement and open enrollment opportunities	8 cohorts have proven success in open enrollment programs. Pilot programs are still ongoing, and the education committee is working to increase the number of programs that would like to pilot similar programs so that we may continue to gather data and establish best practices.	
Continue to Improve access to initial EMS Education Programs. a. Develop guidance document for High School EMT Programs.	Guidance program document is currently being drafted.	

7.i. GETAC EMS Medical Directors Committee Update to Council

Christopher Winckler MD, LP Chair

Elizabeth Fagan MD, Vice Chair

GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Prehospital Whole Blood work with the GETAC Prehospital Whole Blood Task Force on the Texas Prehospital Whole Blood Pilot Program	Prehospital Whole Blood Task Force Tool Kit -Includes Transfusion Recommendation Document. -Includes Transfusion for females of child-bearing potential (future child-bearing potential still in process) Members participating: Dr. Winckler, Dr. Palacio, Dr. Abraham	
Prehospital Whole Blood EMS Medical Directors Responsibilities	Discussion on how to inform EMS Medical Directors of Responsibilities of Prehospital Blood --How to Inform State EMS Medical Directors that AABB Document is published and recommends best practice for prehospital blood transfusions	

GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Red Lights and Sirens	Worked with GETAC EMS Committee to write and edit lights and sirens document and provide references. Use of red lights and siren is considered a **medical intervention** per this document, and each agency and agency medical director should evaluate the use of when red lights and sirens are appropriate. Said another way, it is considered best practice to not always respond or transport with light and sirens.	
Red Lights and Sirens	Difficulties with agencies not responding lights and sirens was discussed --difficult when response times are contractual --for example ISO ratings --it was mentioned that CAAS and CFAI both recommend not running lights and sirens --potentially reach out to mayors/city managers/ISO? --more research needed	

GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Practice of EMS Medical Direction	Goal is to make new TMB rule line up with GETAC Strategic Plan. Dr. Winckler working on this.	
Texas Stroke Awareness Campaign	Rural Stoke Awareness Campaign Voted on and approved by committee	
Texas Stroke Dispatcher Education / Improvement Plan	Target Dispatchers to recognize stroke --Difficulties in reaching dispatchers --Discussion on how to implement education --mention for global emd	

GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Prehospital Sepsis Recommendations Prehospital Ultrasound	Need to determine if recommendations are necessary	
Acceptable Texas EMS Medical Director Course	NAEMSP has FOMOC (Foundation of Medical Direction Oversight Course) --Can be done as individual state --Goal is to create a one hour course on what Texas EMS Medical Director Duties/Responsibilities are: ---For example: Texas Statute, DSHS, TMB, Delegated Medical practice concept	
Pediatric Restraint Program Discussion on Safe Transport of Pediatrics in Ambulance	Goal is to increase compliance of pediatric restraint use. Dr. Mark Sparkman has volunteered to work on this with GETAC Air Medical Committee. Safe Transport pediatric devices—Air Medical Committee to lead, working with EMS Committee	

GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Discussion of EMS Board Certification	Discussion of recommendation versus requirement and difficulties of EMS board certified physicians' availability --Requirement would take a legislative change --The statement that it is preferred to have a physician Board Certified in the Subspecialty of EMS is in the GETAC Strategic Plan During the next rules update, evaluate the number of board-certified EMS medical directors licensed in Texas versus the number ideally needed in the state to staff all provider agencies.	
State Emergency Response System	Will have State contracted vendor, Pulsara, present for EMS MD in March	
NEMSQA best practice criteria	Further discussion need on response and transport times	

Use of Red Lights and Sirens (RLS)

The use of red lights and sirens (RLS) occurs in over 85% of emergency responses and approximately 40% of patient transports from the scene. However, studies show that potentially lifesaving interventions are performed in only about 7% of these cases. The use of RLS is associated with an increased frequency and severity of ambulance crashes. Therefore, the decision to operate with red lights and sirens should be regarded as a **medical intervention**, employed only when the anticipated clinical benefits outweigh the known risks. This determination should be made in collaboration with the medical director and guided by established clinical criteria.

7.j. 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	• Project is not on track to meet our specific aim of improvement by 2026 • Workgroup meetings with selected RAC Directors show directed activity is occurring • SCOR meeting requests • recommend focus on gather data specific to patients with penetrating trauma • Request to develop an advisory letter to trauma center leadership teams • Committee members to educate trauma center leaders on this SCOR project • Committee members will collaborate with pediatric committee regarding severely injured children and pediatric readiness score	

HOSPITALS CHARGED CMS FOR TRAUMA TEAM ACTIVATIONS THAT DID NOT COMPLY WITH FEDERAL REQUIREMENTS

- FINDINGS:
  - CMS made Medicare payments to hospitals for trauma team activations that did not comply with federal requirements
  - 18 of 125 sampled claims met Medicare requirements
  - 107 sampled claims did not meet Medicare requirements
  - 100 of the 107 sampled claims, $728,468 was found in unallowable activation charges submitted by hospitals
  - The remaining 7 did not meet requirements due to coding errors
  - It is estimated that 234, 248 claims were submitted to Medicare that did not comply with federal requirements or 77% of all claims submitted
  - Estimate of approximately $2.4 Billion in unallowable charges for activations did not meet requirements

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

Chair: Kate Remick, MD

Vice-chair: Shawn Salter, RN

System Collaborative for Outcome Review

2025 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*	*Regularly track and discuss performance measures, identify trends (both positive and negative).*	
2. [Performance Improvement]: *Data reporting and dissemination strategies*	*Discussing best mechanisms for dissemination that support improvement efforts.*	
3. [Performance Improvement]: *Consideration of other system priorities, needs, and measures*	*Early discussions from collaborative members and committee representatives regarding system challenges and needs.*	

Measure Report

Unstable Trauma Transfers

Emergency Medical Services and Trauma Registries (EMSTR) Severe Trauma Transfer Delay Performance Improvement Data, Texas

November 22, 2025

Jia Benno. MPH
Injury Prevention Unit Director

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.
- All submitters must report all EMS responses and reportable trauma events to EMSTR under Texas Administration Code, Title 25, Chapter 103.

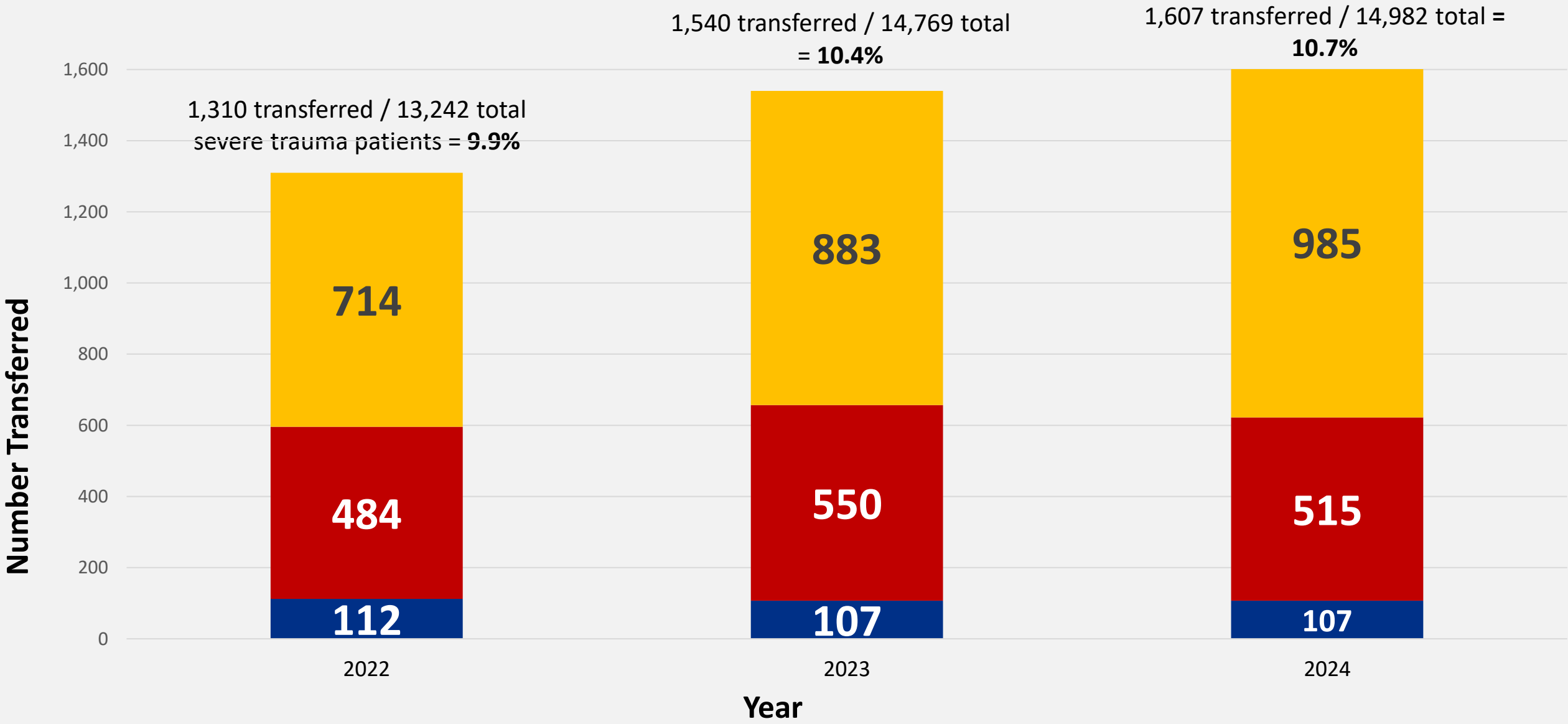
Severe Trauma Transfer Delay Performance Improvement (PI) Data, Texas

January 1, 2022-December 31, 2024

Transfer Delay Definitions

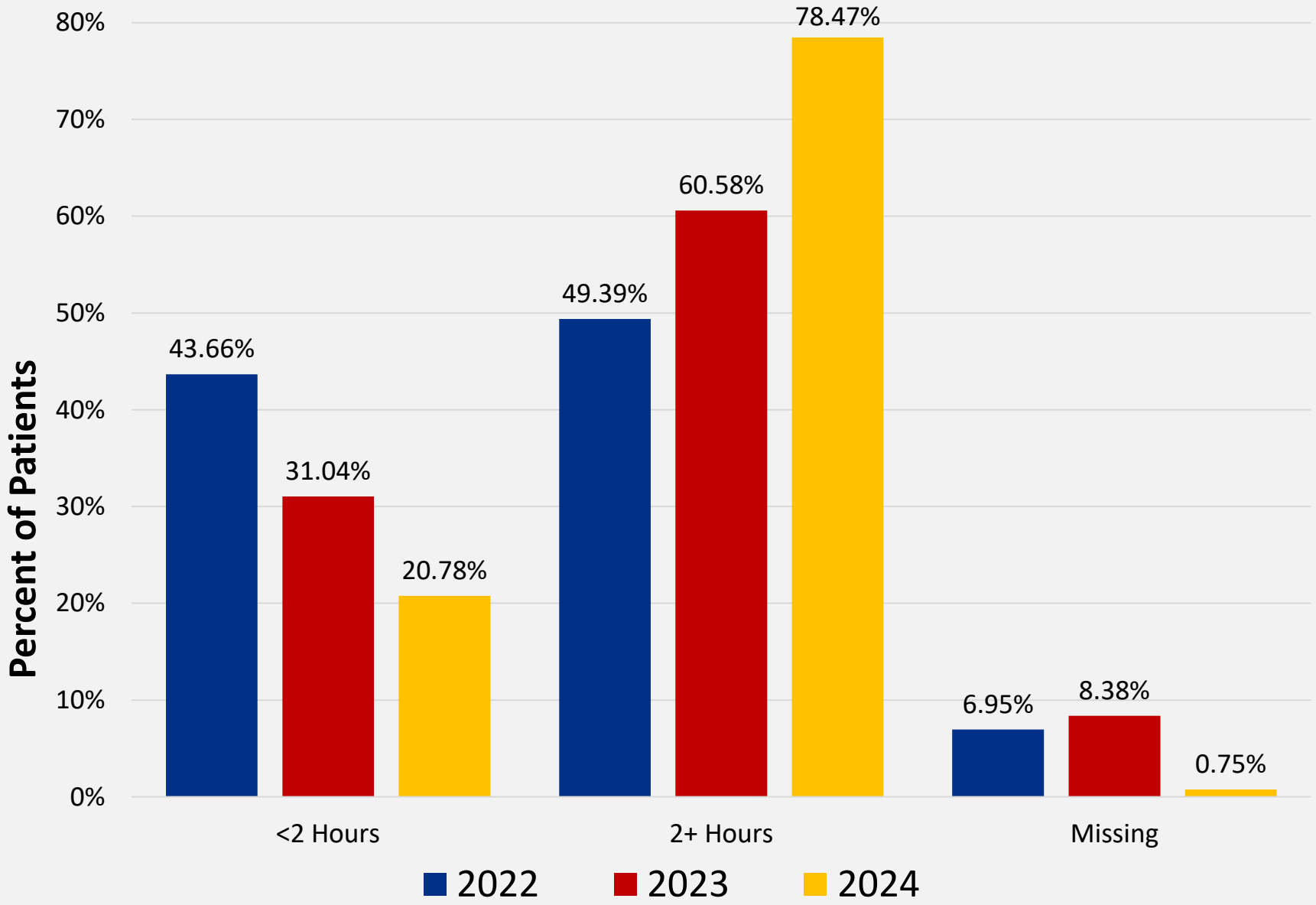
- Severe trauma patients are injured patients with:
  - Glasgow Coma Scale (GCS) <9 or Systolic Blood Pressure (SBP) <110 for geriatric (65+) patients.
  - GCS <9 or SBP <90 for adults aged 15-64.
  - GCS <9 or SBP <70 + 2 x (the child's age in years) for pediatric / children less than 15.
  - Note: SBP is the arrival SBP at the hospital.
- Transfer time = the time from arrival to departure from sending facility for transferred patients.
- Transfer delay = defined as two (2) or more hours from arrival to departure.

Severe Trauma Patients – Total Number Transferred



Data prepared by Injury Prevention Unit Epidemiologists using EMS and Trauma Registries (EMSTR) data, August 2025.

Severe Trauma Transfer Times – All Ages

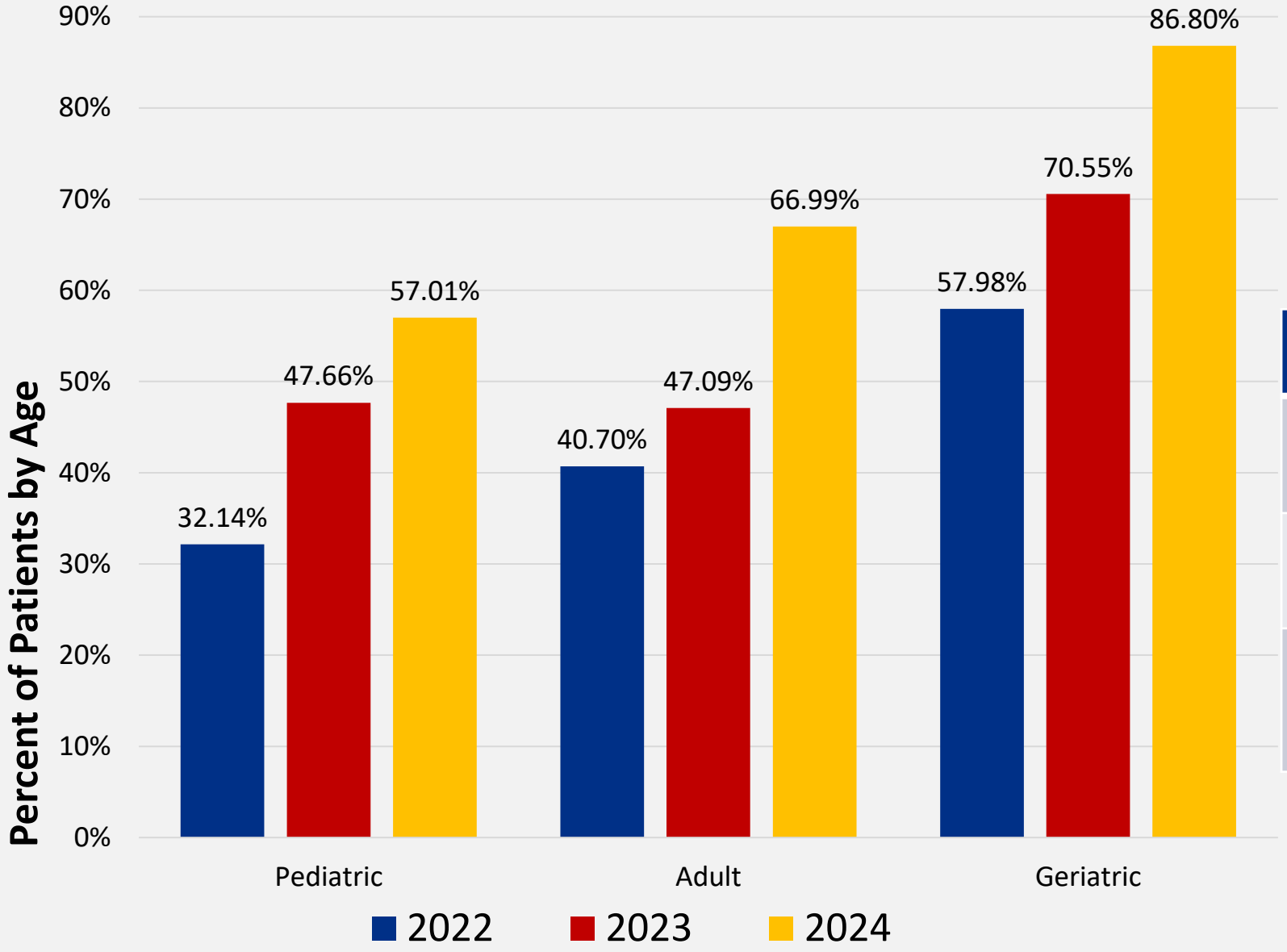


Number of Severe Trauma Transfers

	2022	2023	2024
<2 Hours	572	478	334
2+ Hours	647	933	1,261
Missing	91	129	12

Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

Severe Trauma Transfer 2+ Hours by Age Category



Number Transferred in 2+ Hours / Number Severe Trauma Transfers

	2022	2023	2024
Pediatric	36/112	51/107	61/107
Adult	197/484	259/550	345/515
Geriatric	414/714	623/883	855/985

Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

Severe Trauma Transfer Time by Sex

Sex	Transfer Time	2022	2023	2024
Male	Less than 2 hours	379 (46.56%)	313 (33.95%)	226/968 (23.35%)
	2+ hours	388 (47.67%)	532 (57.70%)	737/968 (76.14%)
Female	Less than 2 hours	193 (38.91%)	159 (26.11%)	108/636 (16.98%)
	2+ hours	259 (52.22%)	398 (65.35%)	521/636 (81.92%)

NOTE: Data excludes missing times, so totals will not equal 100%.

Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

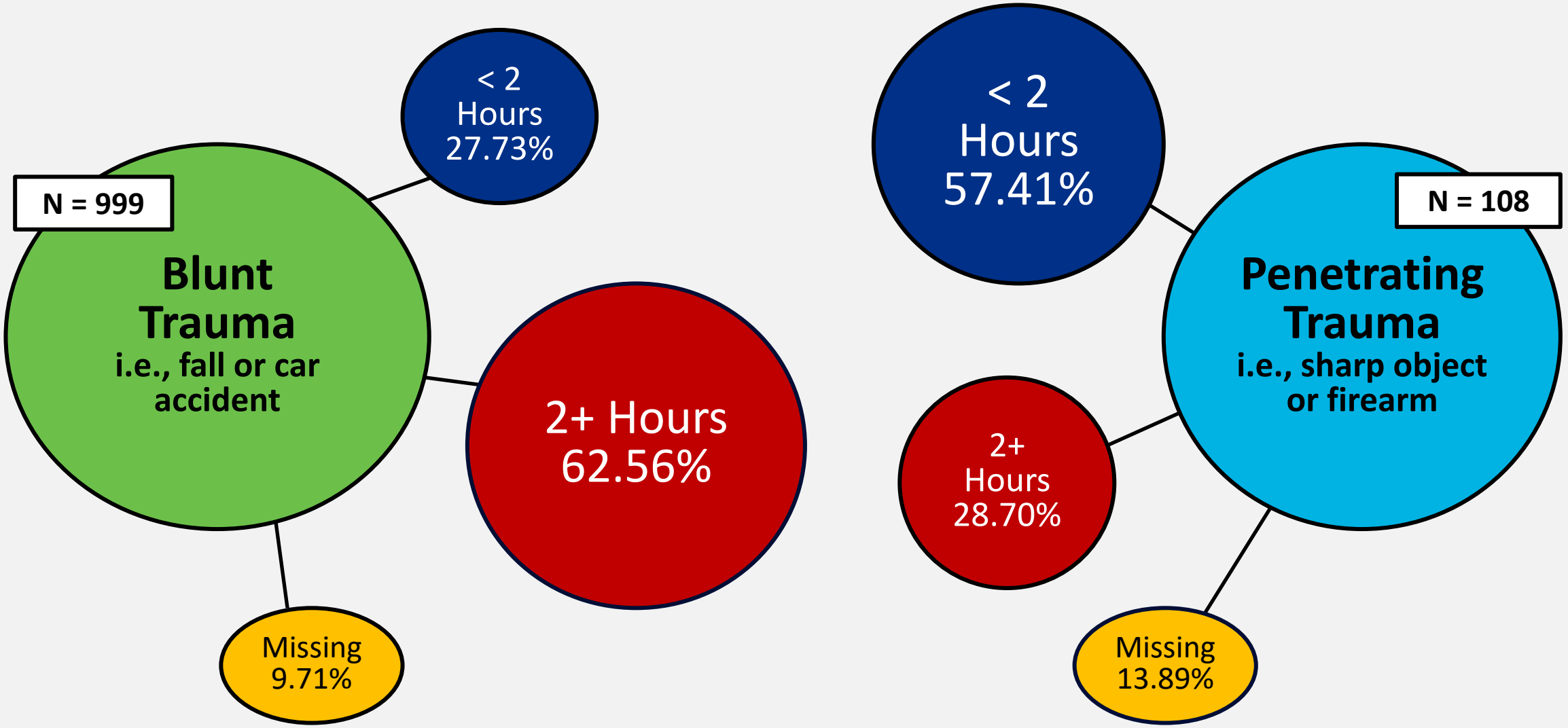
Severe Trauma Transfer Time by Race

Race	Transfer Time	2022	2023	2024
White	Less than 2 hours	421 (41.64%)	342 (28.26%)	174/965 (18.03%)
	2+ hours	513 (50.74%)	765 (63.22%)	782/965 (81.04%)
Black	Less than 2 hours	57 (44.53%)	63 (46.32%)	38/161 (23.60%)
	2+ hours	63 (49.22%)	63 (46.32%)	123/161 (76.40%)

NOTE: Data excludes missing times, so totals will not equal 100%.

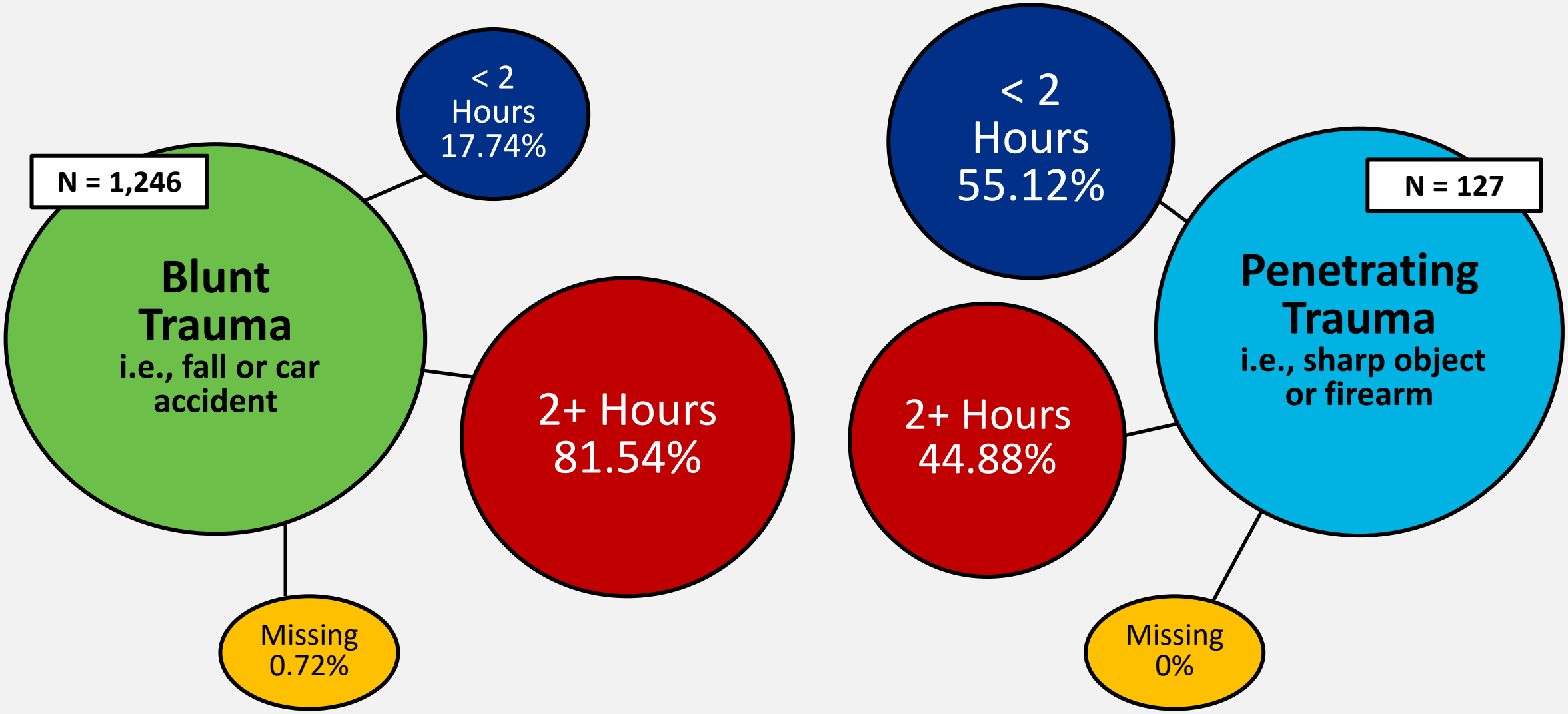
Data prepared by Injury Prevention Unit
Epidemiologists using EMSTR data, August 2025.

Severe Trauma Transfer Time by Trauma Type – 2023



Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, April 2025.

Severe Trauma Transfer Time by Trauma Type – 2024



Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

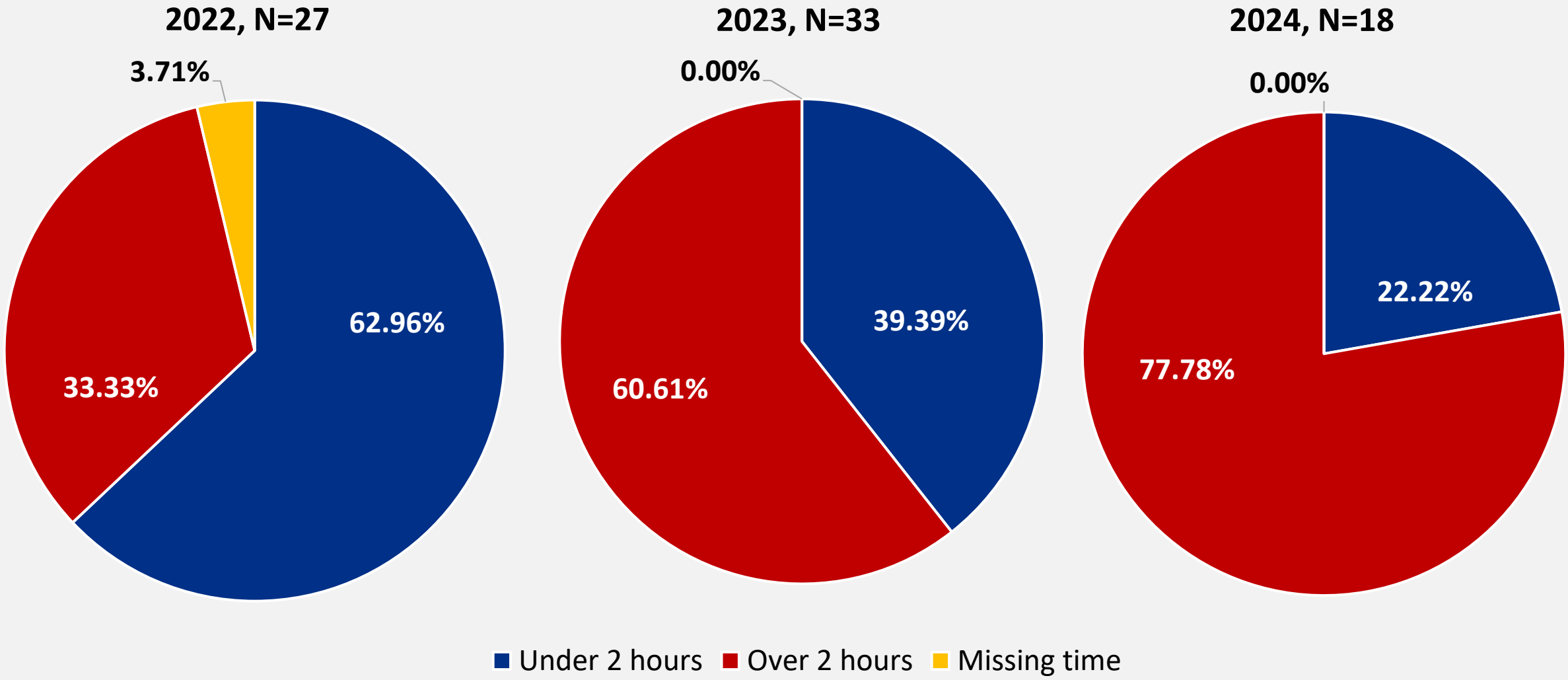
Severe Trauma Transfer Numbers by Designation Level

Trauma Designation*	2022	2023	2024
Level I	27	33	18
Level II	61	61	84
Level III	330	354	406
Level IV	714	840	820

*This data includes designated facilities only and does not include not designated or missing.

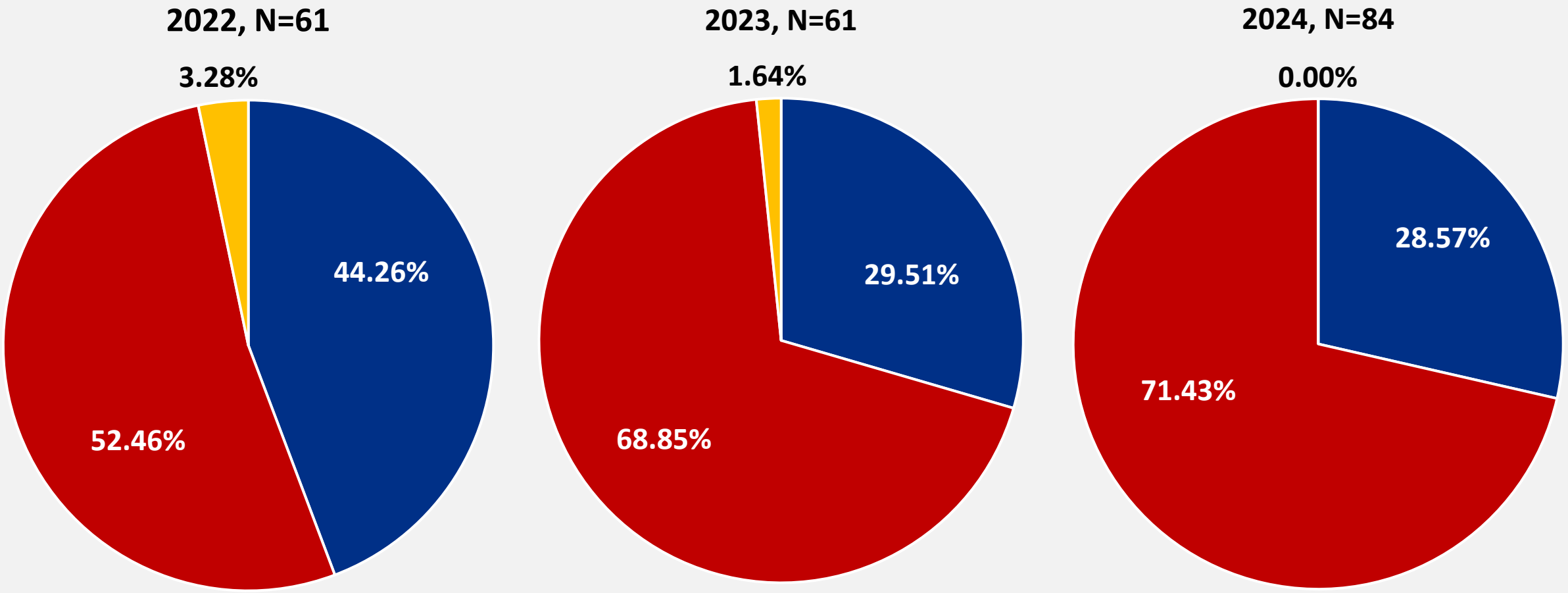
Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

Severe Trauma Transfer Time by Trauma Designation Level I



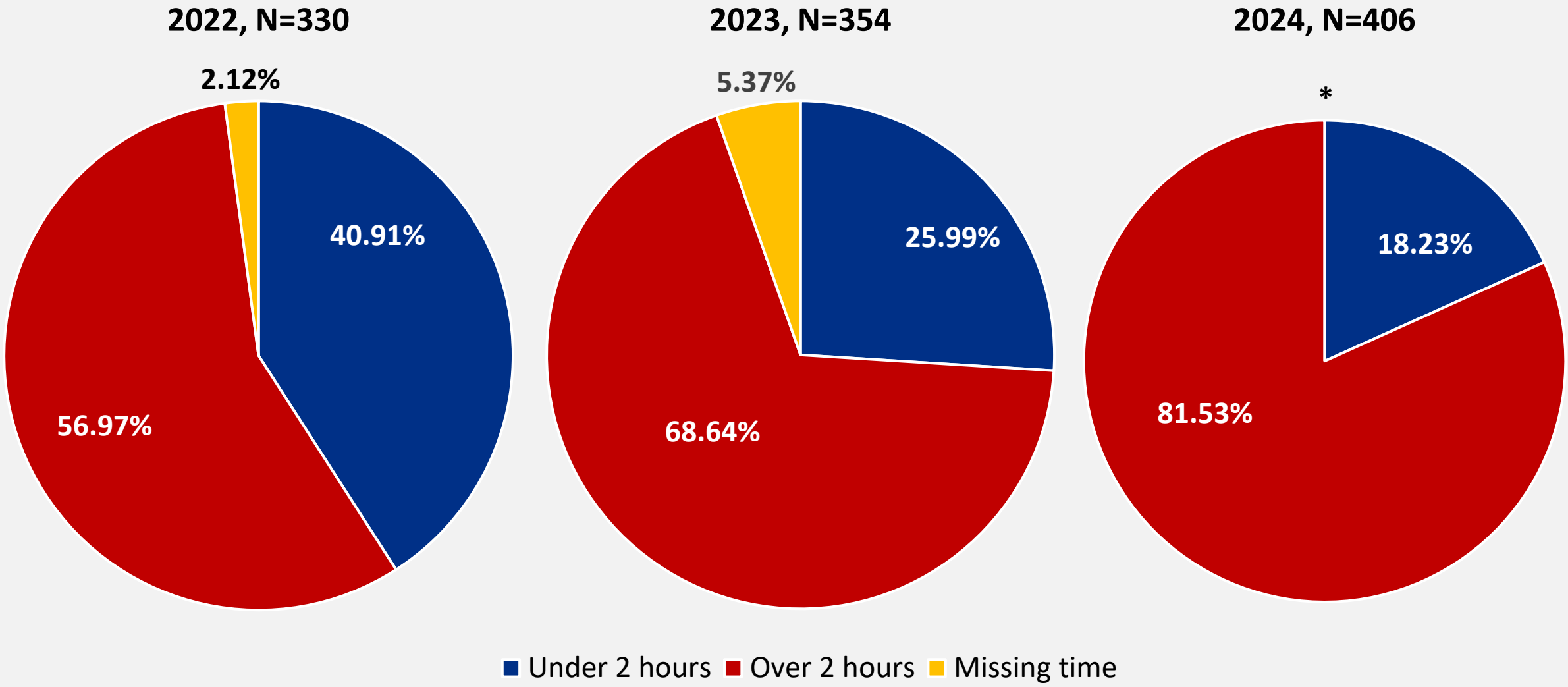
Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

Severe Trauma Transfer Time by Trauma Designation Level II



Data prepared by Injury Prevention Unit
Epidemiologists using EMSTR data, August 2025.

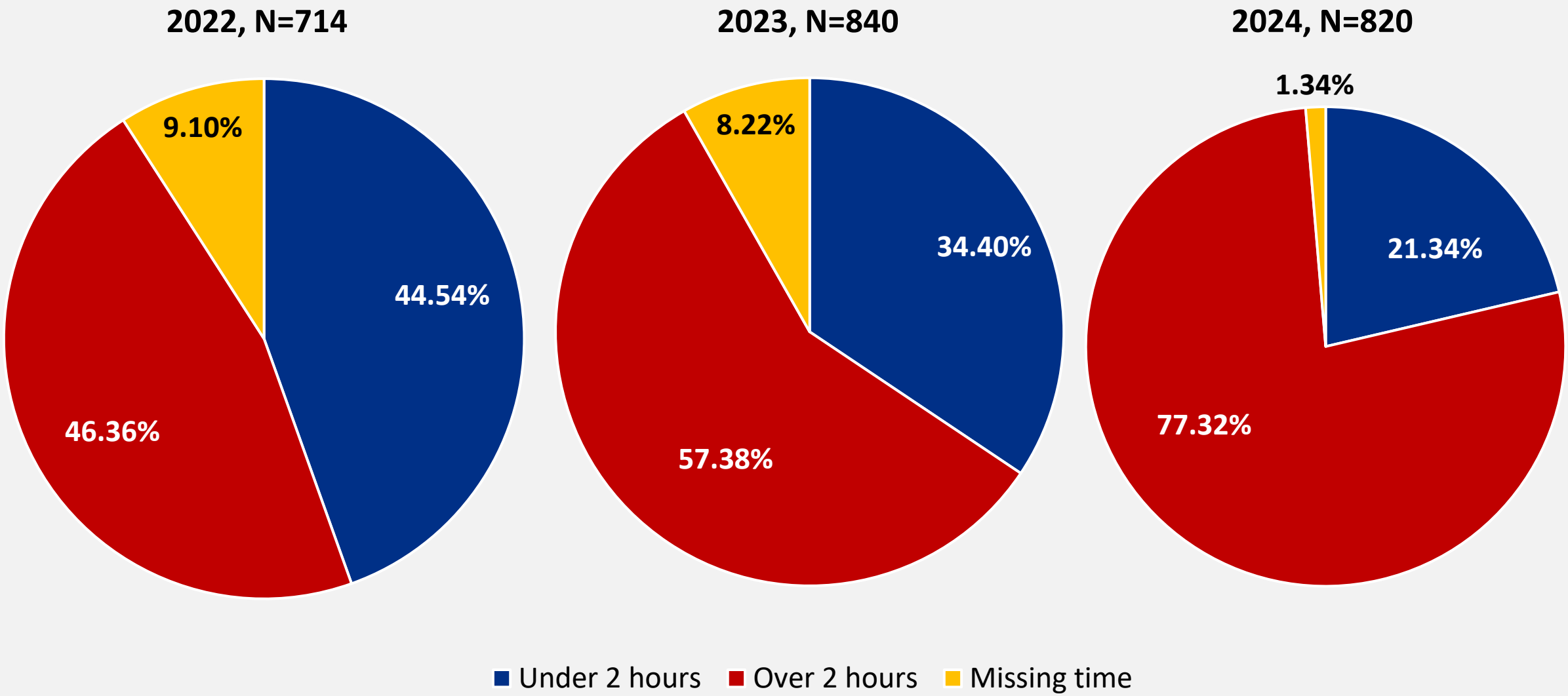
Severe Trauma Transfer Time by Trauma Designation Level III



*Number suppressed due to low count.

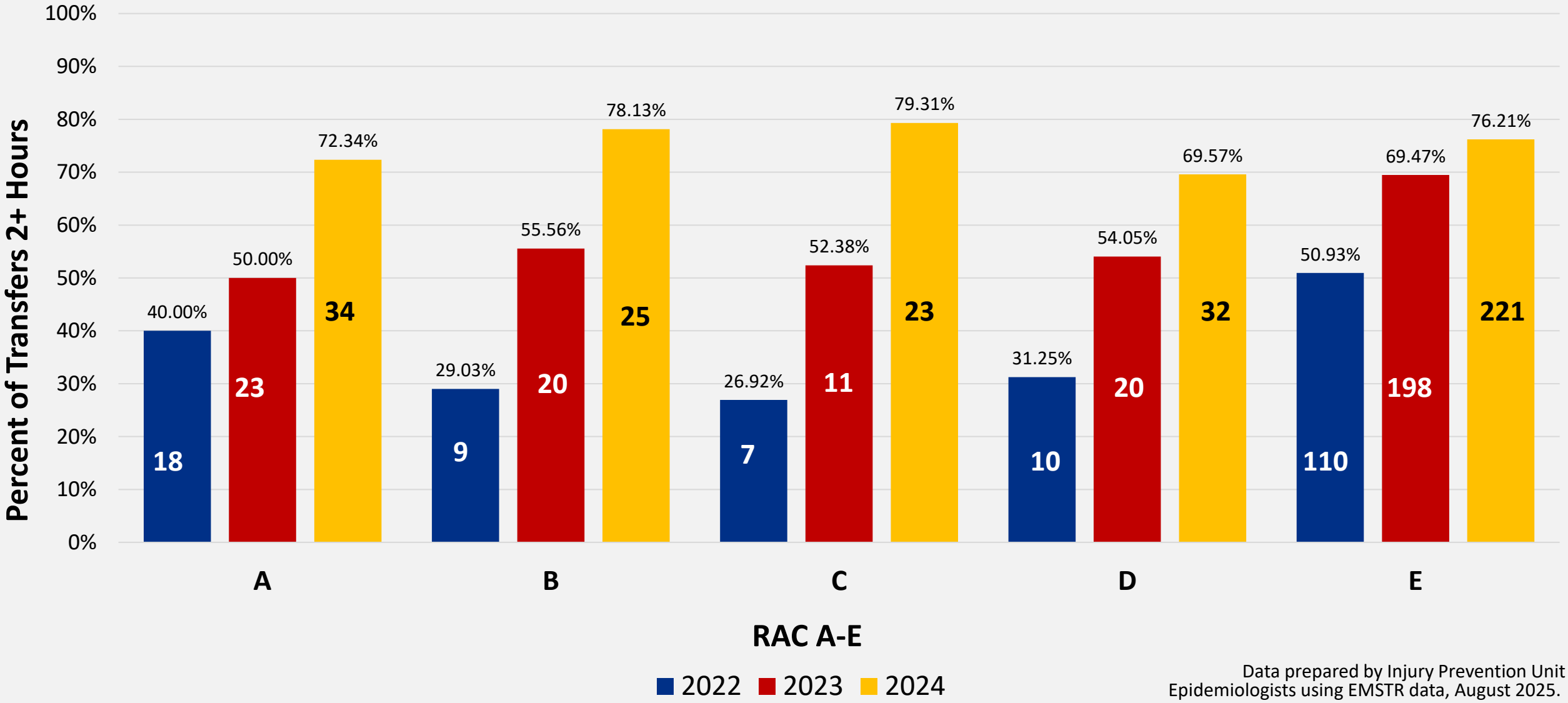
Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

Severe Trauma Transfer Time by Trauma Designation Level IV



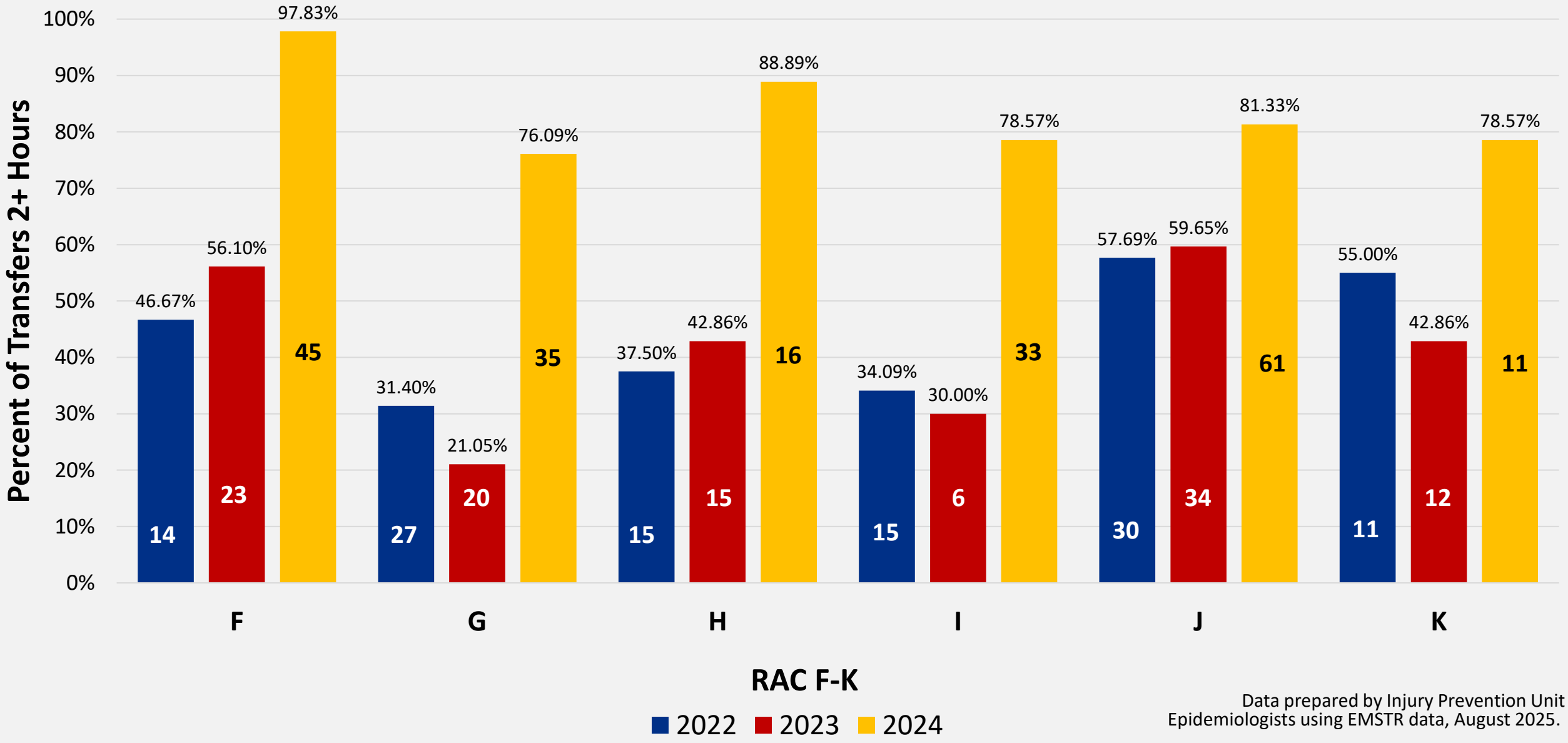
Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

Severe Trauma Transfer Delay 2+ Hours by Regional Advisory Council (RAC) A-E



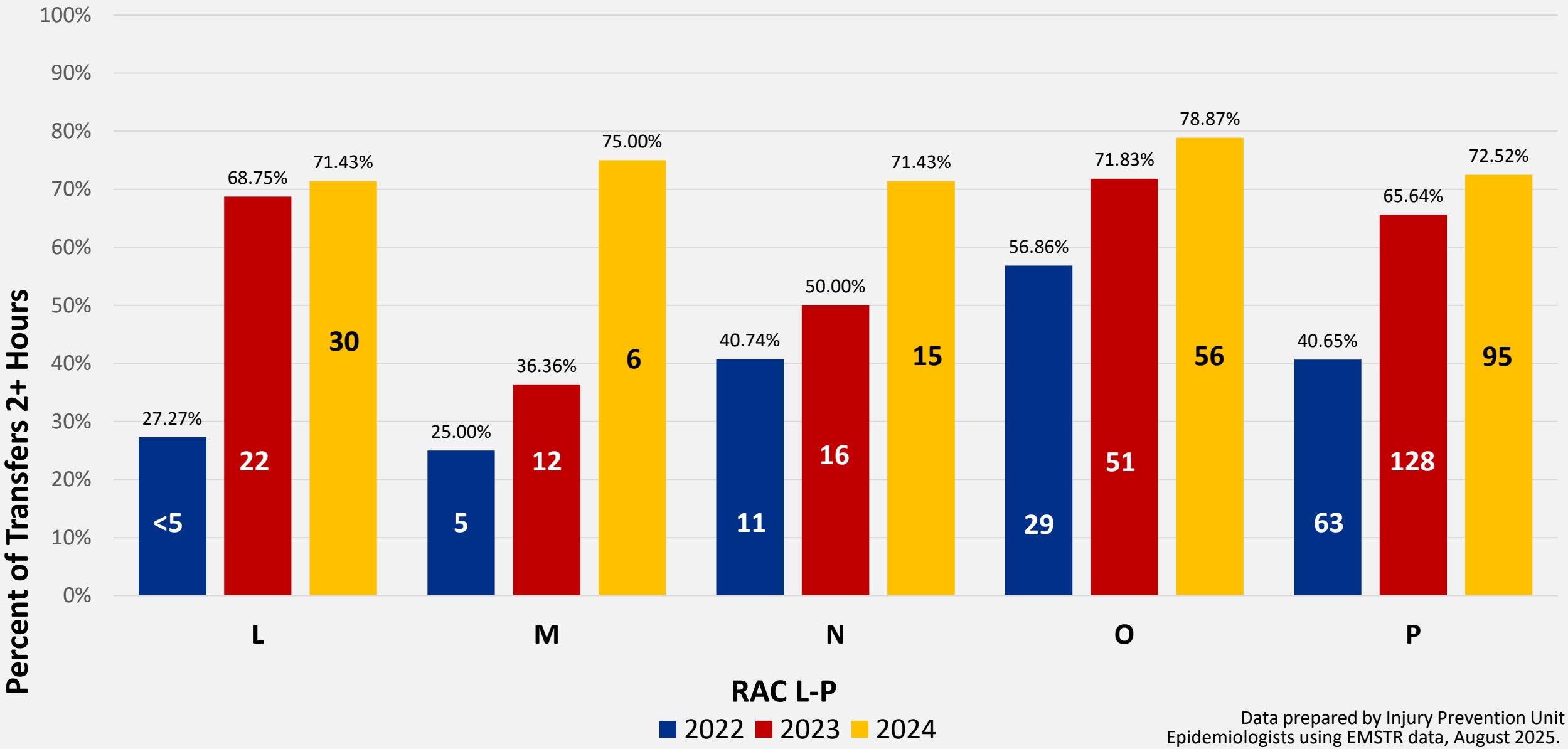
Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

Severe Trauma Transfer Delay 2+ Hours by RAC F-K



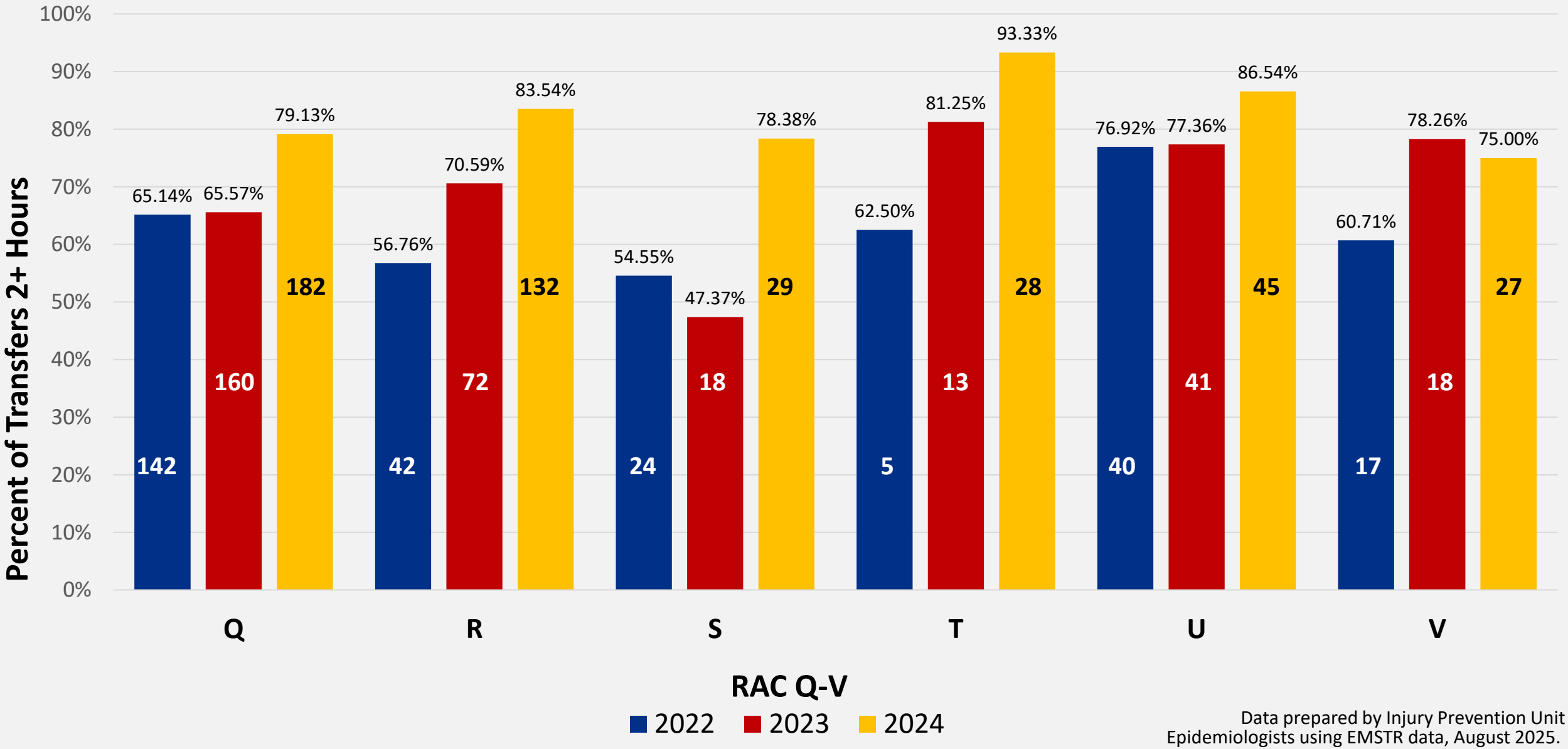
Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

Severe Trauma Transfer Delay 2+ Hours by RAC L-P



Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, August 2025.

Severe Trauma Transfer Delay 2+ Hours by RAC Q-V



Data prepared by Injury Prevention Unit
Epidemiologists using EMSTR data, August 2025.

Thank you!

EMSTR Severe Trauma Transfer Delay PI Data, Texas

Injury.epi@dshs.texas.gov

GETAC Committee/Stakeholder Action Item Request for Council June 2025

Kate Remick, MD

System Collaborative for Outcomes Review

Action Item Request and Purpose

Action item request:

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

Purpose for this request:

Given inability to report on this measure in a timely way and at the RAC level, consider other high-priority measures.

Benefit and Timeline

Intended impact or benefit resulting from this request:

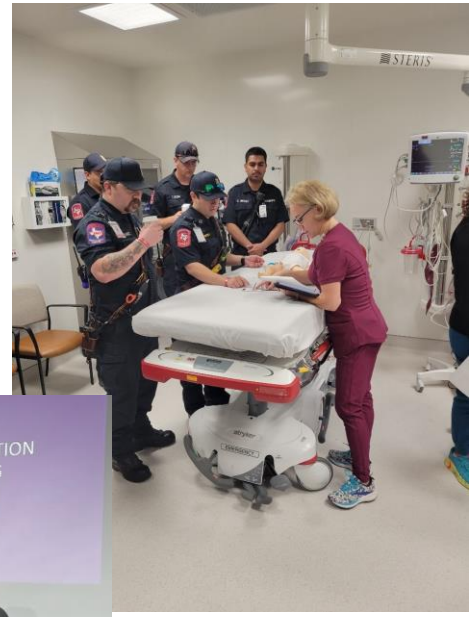
Allows SCOR to continue tracking and reporting 5 priority measures to GETAC. Allows for expansion of system improvement efforts.

Timeline or relevant deadlines for this request.

November GETAC session

9. Update: TX Pediatric Readiness Improvement Project

Dr. Kate Remick



Texas Pediatric Readiness Improvement Project Update

GETAC November 2025

Texas Pediatric Readiness Improvement Project (TPRIP)

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

TX Pediatric Readiness Improvement Virtual Education Series - Season 2
Coming Soon

- 1-hour virtual sessions held 3rd Thursday every month @10am
- Pediatric-specific topics
- Highlight evidence-based practices and resources for adoption
- Emphasis on evaluating ED performance using NPRQI platform

2025 save the date

March 20, 2025	**10am**
April 17, 2025	**10am**
May 15, 2025	**10am**
June 19, 2025	**10am**
July 17, 2025	**10am**
Aug. 21, 2025	**10am**
Sept. 18, 2025	**10am**
Oct. 16, 2025	**10am**
Nov. 20, 2025	**10am**
Dec. 18, 2025	**10am**

https://dellmed-utexas.zoom.us/webinar/register/WN_agwVXDgYT0aD49FENhCgOw#/registration

Texas Pediatric Readiness Virtual Education Webinar Series

- Presented Live: 3rd Thursday of each month at 10am
- CE available for nurses and EMS
- Recorded and available to watch for CE at https://utexas.app.box.com/v/txpripeducationseries

TX PRIP Education Series Attendance

August 21: Glow in the Dark or Miss an Injury: Indications for Cross-Sectional Imaging in Pediatric Trauma (Dr. Aaron Jensen)

Registered - 839

Unique Viewers - 255

September: cancelled

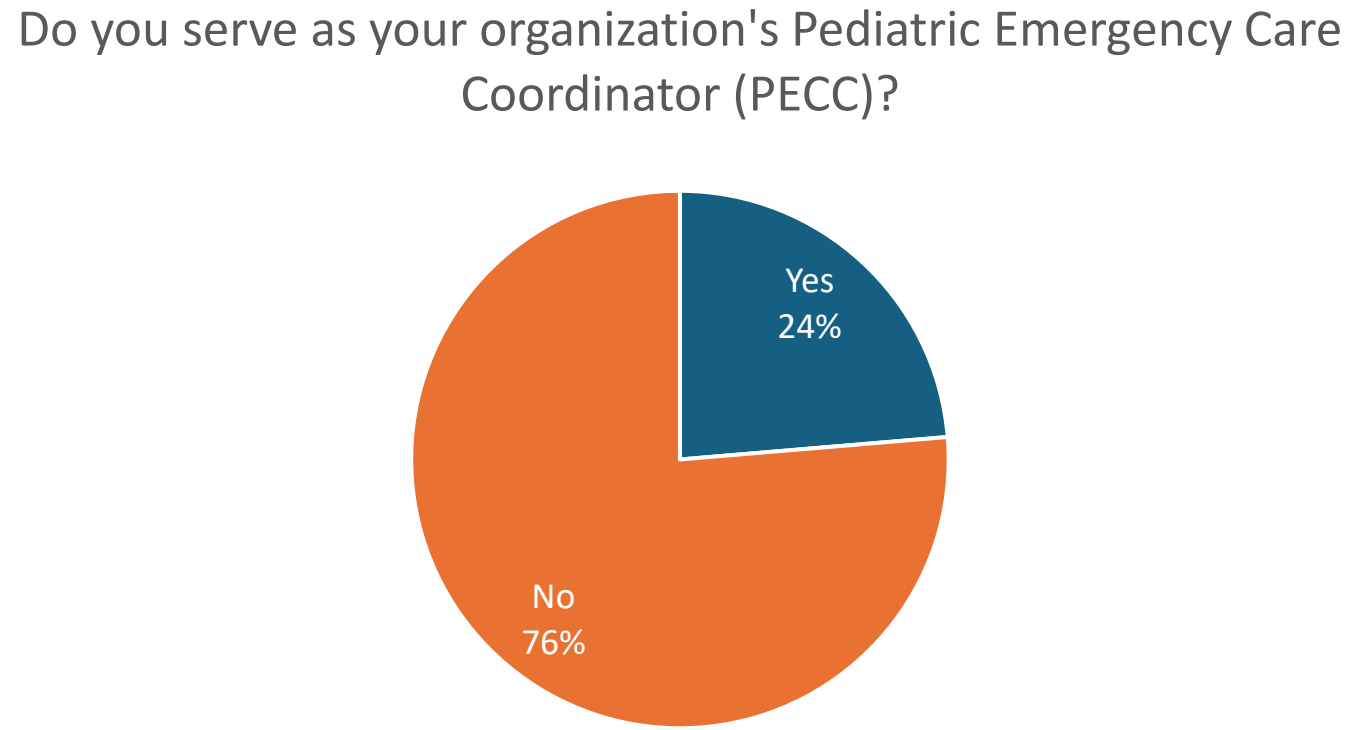
October 16: Advancing Pediatric Readiness Through Quality Improvement Collaboratives

- Registered: 1035
- Attendees: 325

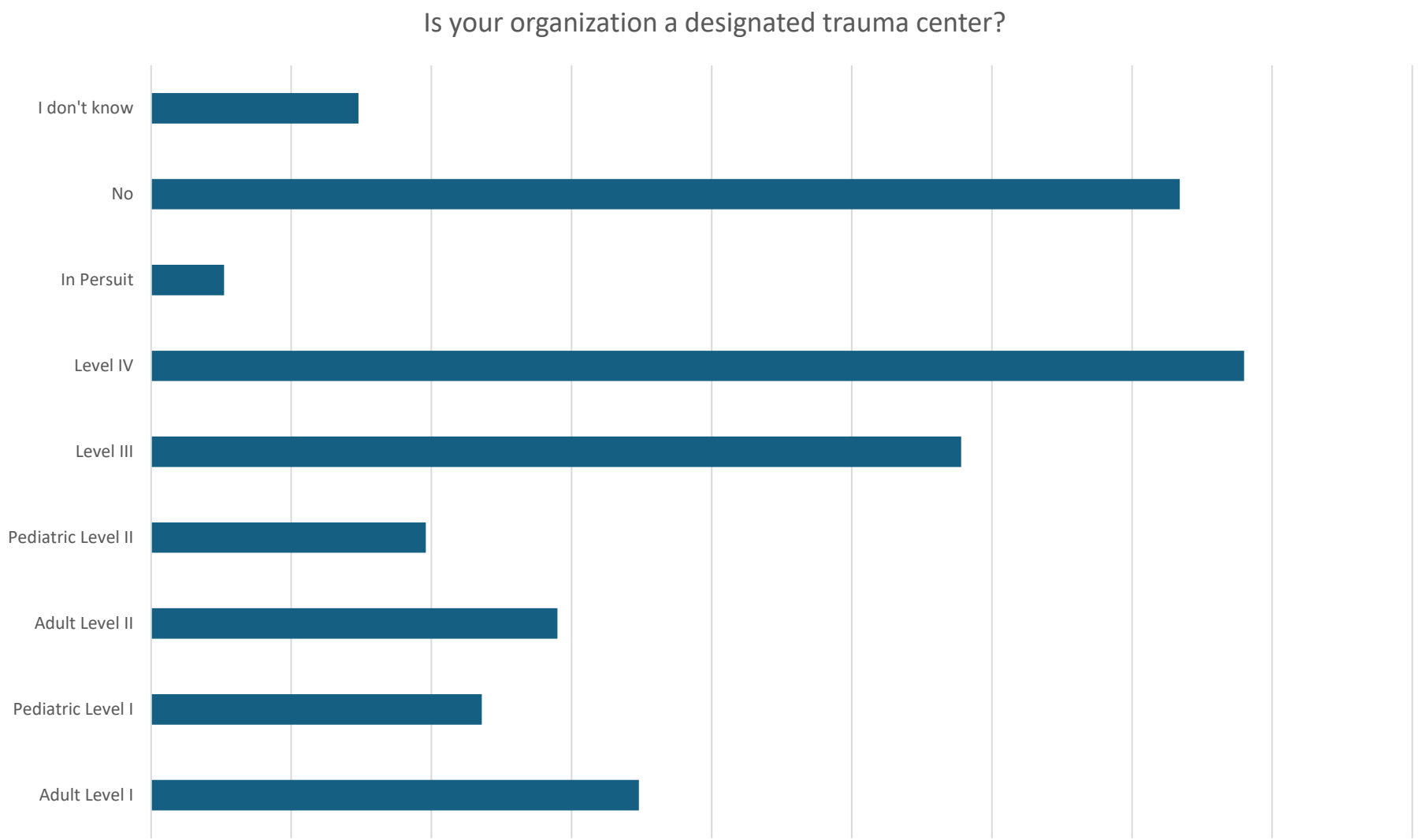
Continuing Professional Development: Summary

	Topic	Unique Viewers	NCPD Attendance	Average Evaluation Score
Session 1	Upper Airway Obstruction; Anaphylaxis		139	4.69
Session 2	Pediatric DKA		160	4.90
Session 3	Abdominal Surgical Emergencies	250	200	4.83
Session 4	Improving Pediatric Acute Care Through Simulation	225	172	4.77
Session 5	Improving Emergency Pediatric Care Nationwide (NPRQI)	210	169	4.74
Session 6	Safe Sleep and Sudden Unexpected Infant Death	184	159	4.86
Session 7	Mental and Behavioral Health Emergencies	204	178	4.88
Session 8	Glow in the Dark or Miss an Injury: Indications for Cross-Sectional Imagining in Pediatric Trauma	255	201	4.92
Session 9	*Cancelled*	--	--	--
Session 10	Advancing Pediatric Readiness Through Quality Improvement Collaboratives	325	139	4.76
Session 11	Pediatric Burn Injuries			
Total Continuing Professional Development Hours Awarded			**1517**	**4.82**

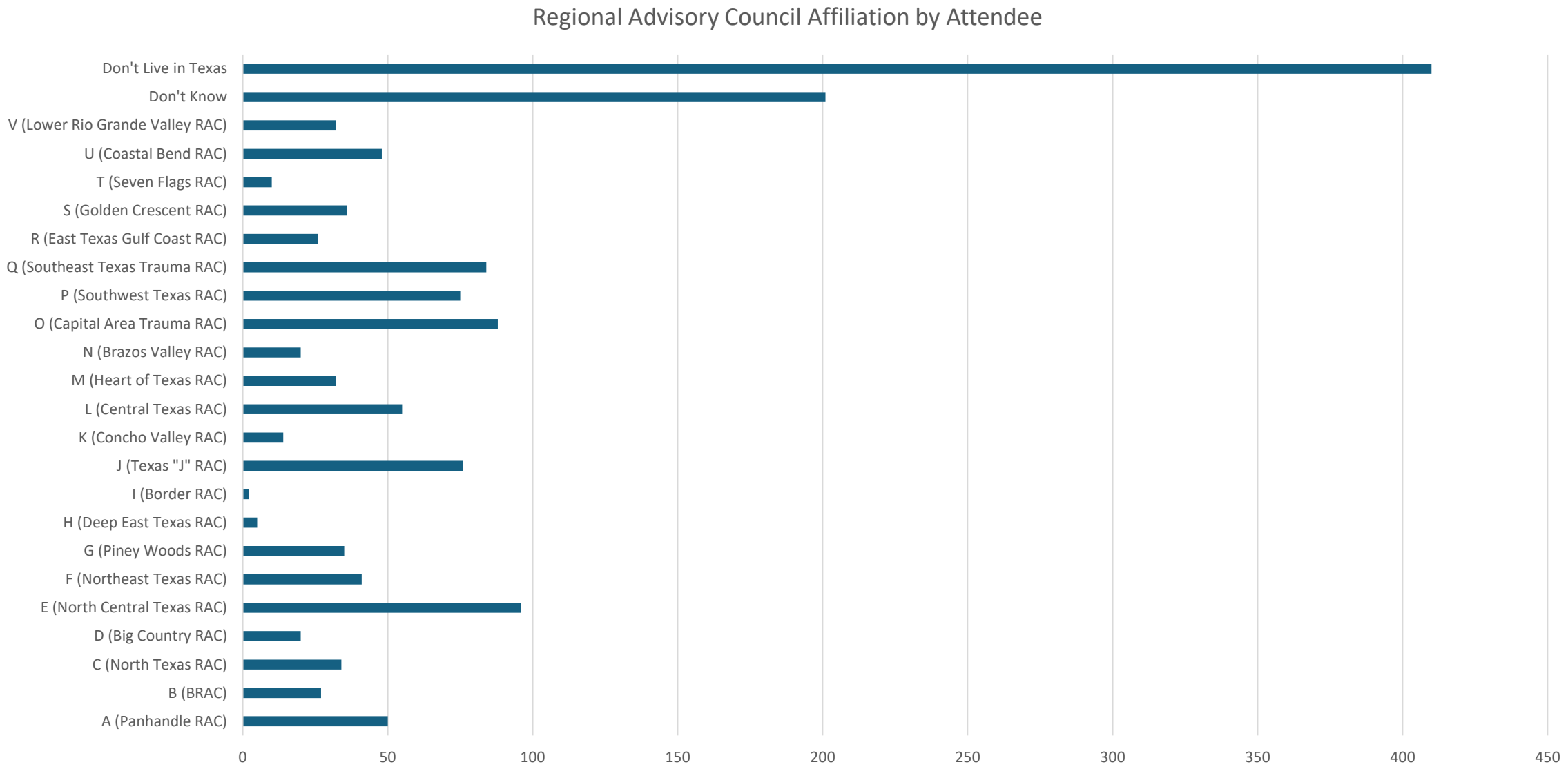
Continuing Professional Development: Summary



Continuing Professional Development: Summary



Continuing Professional Development: Summary



Phase 2 work by PRISMs with Hospital PECCs

Pediatric Readiness Improvement & Simuatlion Mentors

- 16 PRISMs

Regional Training Events

June - October

- Waco 6/9
  - 13 H-PECCs
- Midland 7/22
  - 31 H-PECCs
- HCA Gulf Coast Division 10/1
  - 85 H-PECCs
- Wichita Falls 10/27
  - 13 H-PECCs

H-PECCs Trained

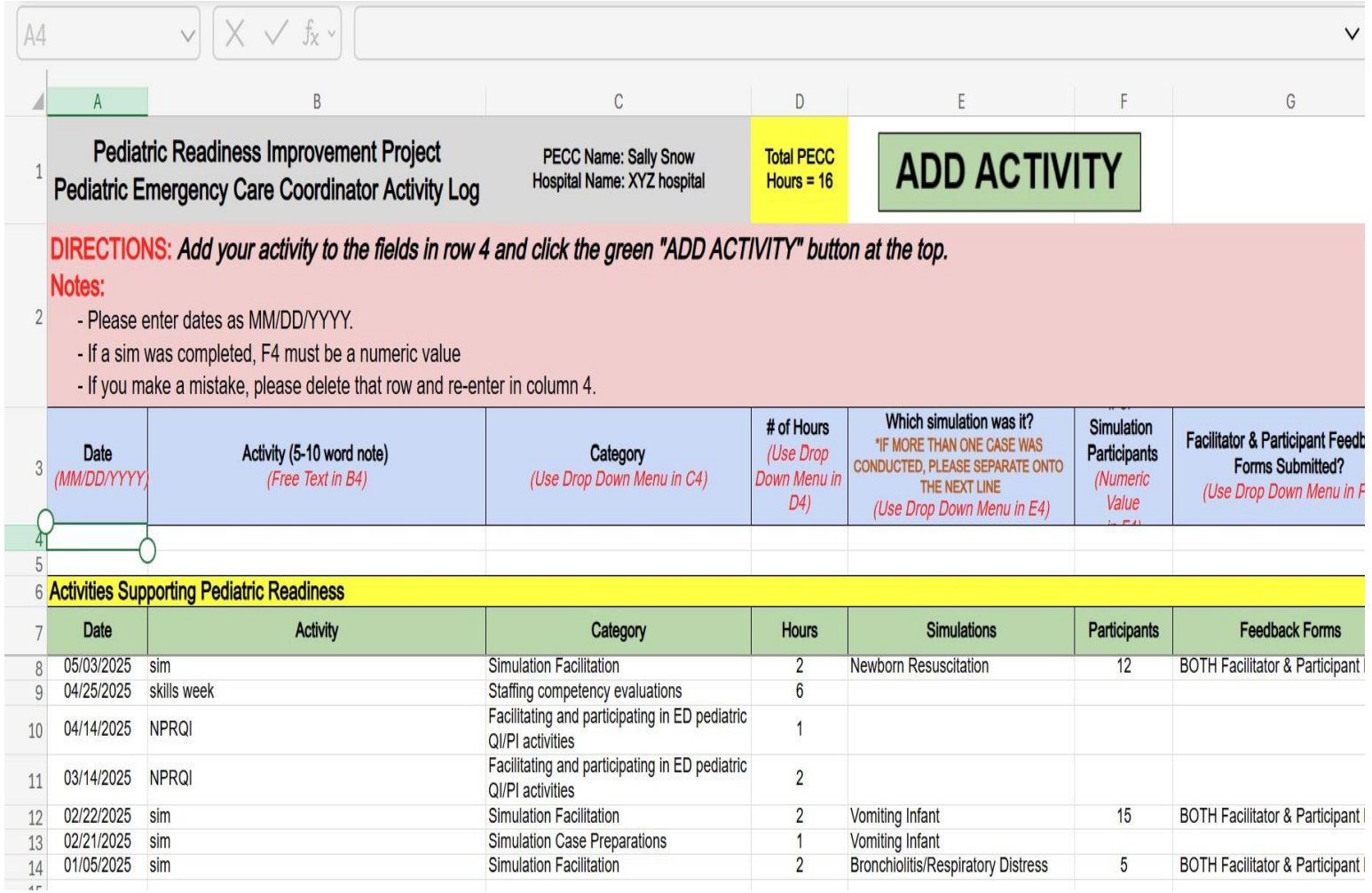
- 252 nurses*

Sim Scenarios conducted by H-PECCs

- 187 sims*
- 1,813 ED/EMS staff participated in sims

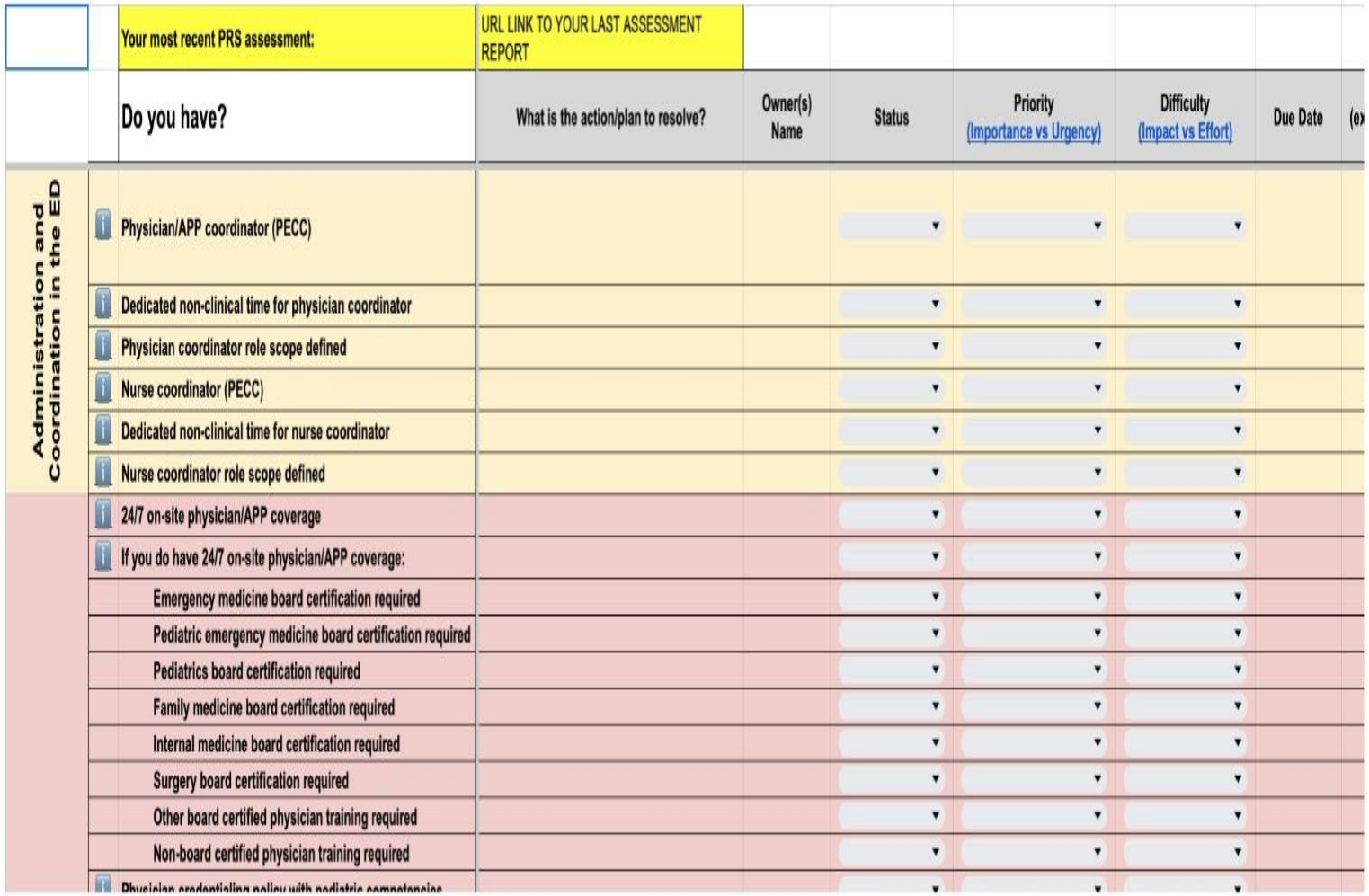
*Data represents training done July to Oct. 2025

Hospital PECC Dashboard



	A	B	C	D	E	F	G
1	Pediatric Readiness Improvement Project Pediatric Emergency Care Coordinator Activity Log		PECC Name: Sally Snow Hospital Name: XYZ hospital	Total PECC Hours = 16	ADD ACTIVITY		
2	DIRECTIONS: *Add your activity to the fields in row 4 and click the green "ADD ACTIVITY" button at the top.* Notes: - Please enter dates as MM/DD/YYYY. - If a sim was completed, F4 must be a numeric value - If you make a mistake, please delete that row and re-enter in column 4.						
3	Date *(MM/DD/YYYY)*	Activity (5-10 word note) *(Free Text in B4)*	Category *(Use Drop Down Menu in C4)*	# of Hours *(Use Drop Down Menu in D4)*	Which simulation was it? *IF MORE THAN ONE CASE WAS CONDUCTED, PLEASE SEPARATE ONTO THE NEXT LINE (Use Drop Down Menu in E4)*	Simulation Participants *(Numeric Value*	Facilitator & Participant Feedb Forms Submitted? *(Use Drop Down Menu in F*
4							
5							
6	Activities Supporting Pediatric Readiness						
7	Date	Activity	Category	Hours	Simulations	Participants	Feedback Forms
8	05/03/2025	sim	Simulation Facilitation	2	Newborn Resuscitation	12	BOTH Facilitator & Participant
9	04/25/2025	skills week	Staffing competency evaluations	6			
10	04/14/2025	NPRQI	Facilitating and participating in ED pediatric QI/PI activities	1			
11	03/14/2025	NPRQI	Facilitating and participating in ED pediatric QI/PI activities	2			
12	02/22/2025	sim	Simulation Facilitation	2	Vomiting Infant	15	BOTH Facilitator & Participant
13	02/21/2025	sim	Simulation Case Preparations	1	Vomiting Infant		
14	01/05/2025	sim	Simulation Facilitation	2	Bronchiolitis/Respiratory Distress	5	BOTH Facilitator & Participant

Hospital PECC Dashboard

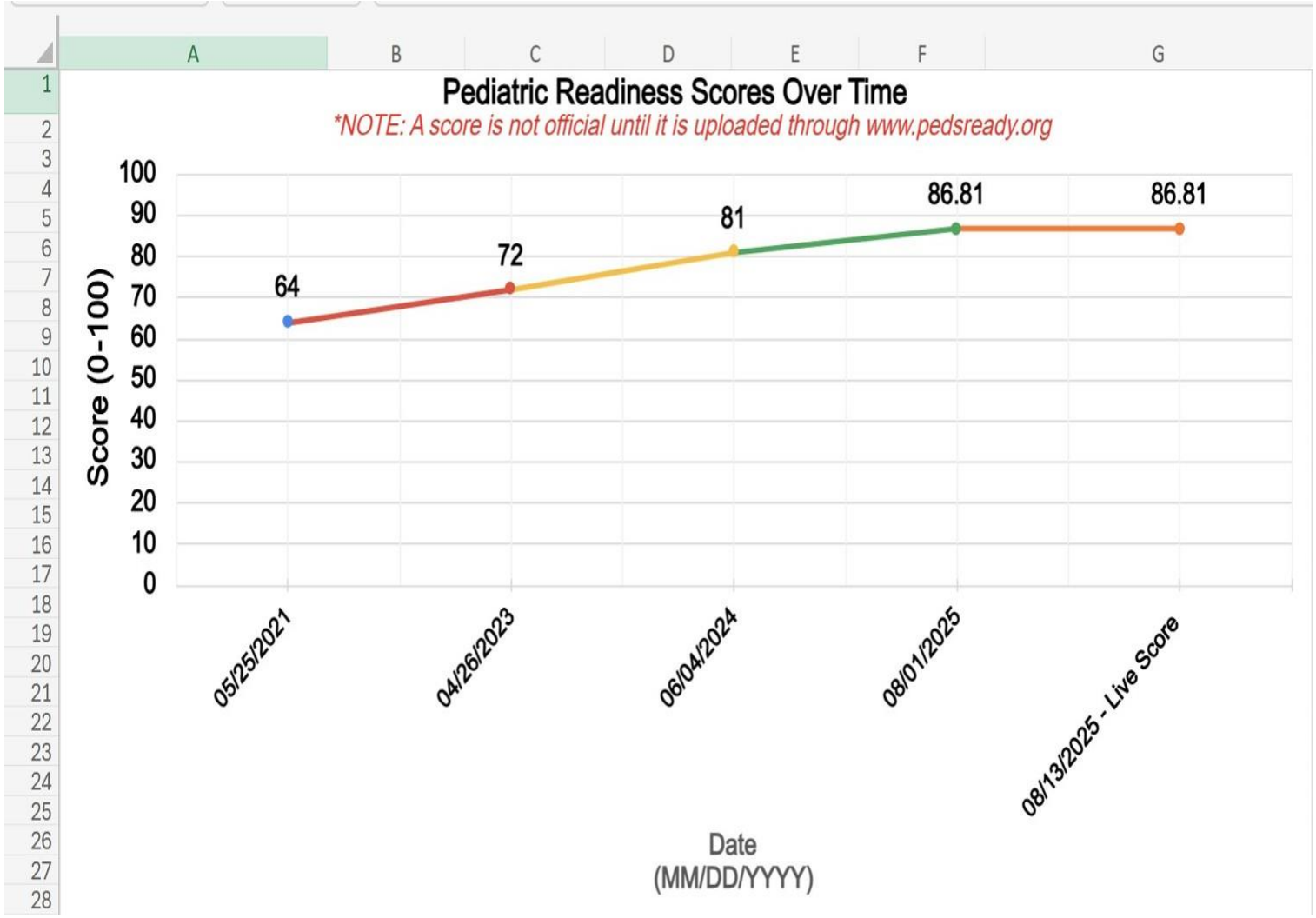


	Your most recent PRS assessment:	URL LINK TO YOUR LAST ASSESSMENT REPORT						
	Do you have?	What is the action/plan to resolve?	Owner(s) Name	Status	Priority (Importance vs Urgency)	Difficulty (Impact vs Effort)	Due Date	(ex
Administration and Coordination in the ED	Physician/APP coordinator (PECC)							
	Dedicated non-clinical time for physician coordinator							
	Physician coordinator role scope defined							
	Nurse coordinator (PECC)							
	Dedicated non-clinical time for nurse coordinator							
	Nurse coordinator role scope defined							
	24/7 on-site physician/APP coverage							
	If you do have 24/7 on-site physician/APP coverage:							
	Emergency medicine board certification required							
	Pediatric emergency medicine board certification required							
	Pediatrics board certification required							
	Family medicine board certification required							
	Internal medicine board certification required							
	Surgery board certification required							
	Other board certified physician training required							
	Non-board certified physician training required							
	Physician credentialing policy with pediatric competencies							

Hospital PECC Dashboard

	Pediatric Readiness Scores	
	Date (MM/DD/YYYY)	**Score** (0-100)
Official PRS 1	01/01/2025	0.00
Official PRS 2		
Official PRS 3		
Official PRS 4		
Official PRS 5		
Official PRS 6		
Official PRS 7		
Official PRS 8		
Official PRS 9		
Official PRS 10		

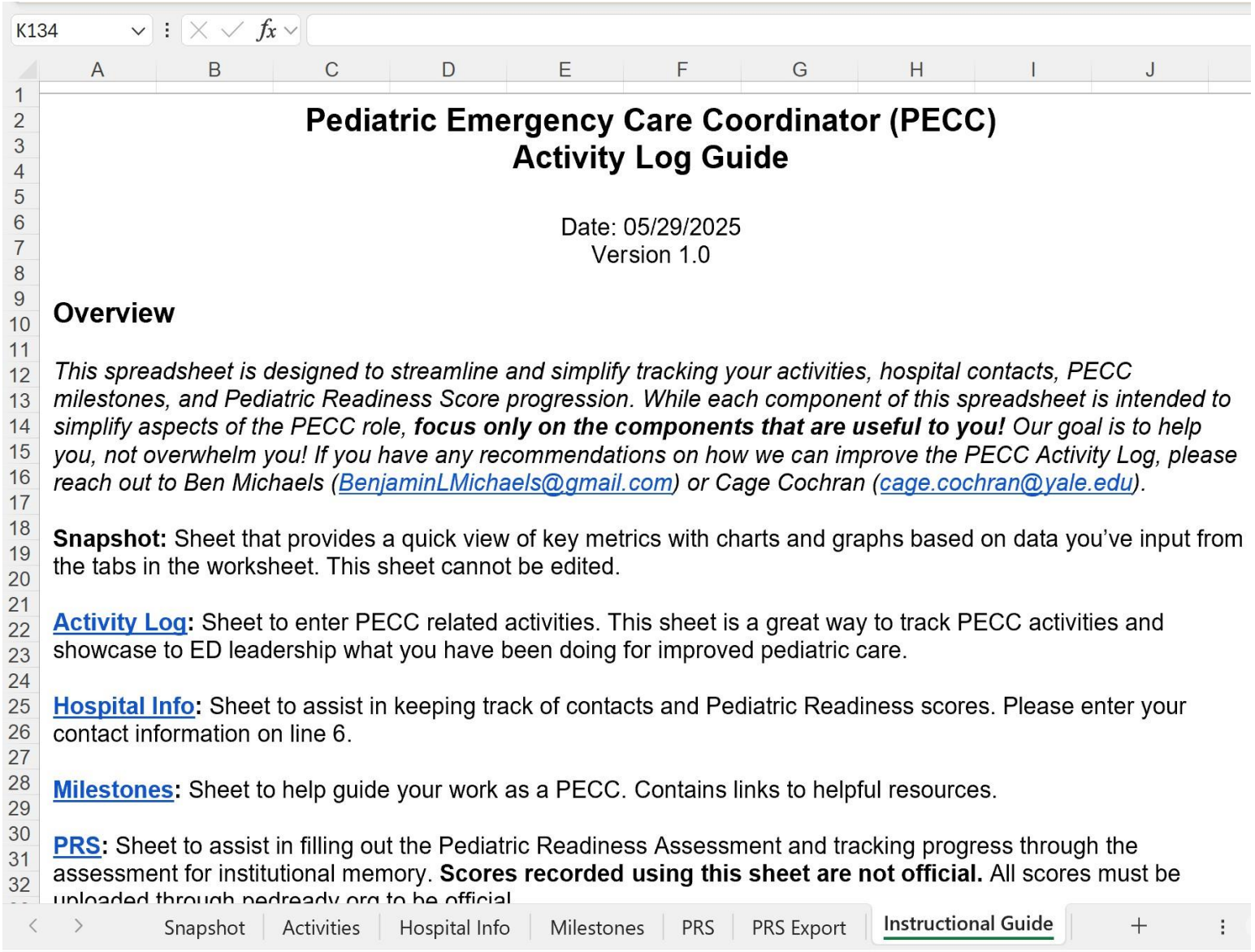
Hospital PECC Dashboard



Hospital PECC Dashboard

	A	B	C
1		**PECC Milestones**	St. Elsewhere MC-Utopia, USA
48	☐	Repeat Sim!	
49			
50		**Physician and Nurse Staffing and Training Milestones**	
51	☐	Review Simulation/Education Guide	X
52	☐	Choose date(s) and time for in situ simulation in ED with PECC	X
53	☐	Complete in situ SimBox in the ED with PECC co facilitating	X
54	☐	Complete associated Facilitator checklist with that scenario	X
55	☐	Schedule quarterly sims (PRISM can co-facilitate virtually if needed)	X
56	☐	Review Sim Report with PRISM and choose at least 1 action item identified in simulation to work on over the next quarter **Domains:** • Administration & Coordination • Equipment & Supplies • Provider Competency • Safety • Policy & Procedure • Quality Improvement (QI)	X
57	☐	Once an action item is completed return to Milestone 2 and repeat!	X
58			
59		**Policies, Procedures, and Protocols**	
60	☐	ED policy templates can be found here: Templates	X
61	☐	Follow your institutions process for implementing new policy, some things include: • Medical direction support • ED leadership support • Policy Committee • IT support through charting system or electronic policy system	X
62	☐	Repeat sim!	X

Hospital PECC Dashboard



K134

Pediatric Emergency Care Coordinator (PECC)
Activity Log Guide

Date: 05/29/2025
Version 1.0

Overview

This spreadsheet is designed to streamline and simplify tracking your activities, hospital contacts, PECC milestones, and Pediatric Readiness Score progression. While each component of this spreadsheet is intended to simplify aspects of the PECC role, ***focus only on the components that are useful to you!*** *Our goal is to help you, not overwhelm you! If you have any recommendations on how we can improve the PECC Activity Log, please reach out to Ben Michaels (BenjaminLMichaels@gmail.com) or Cage Cochran (cage.cochran@yale.edu).*

Snapshot: Sheet that provides a quick view of key metrics with charts and graphs based on data you've input from the tabs in the worksheet. This sheet cannot be edited.

Activity Log: Sheet to enter PECC related activities. This sheet is a great way to track PECC activities and showcase to ED leadership what you have been doing for improved pediatric care.

Hospital Info: Sheet to assist in keeping track of contacts and Pediatric Readiness scores. Please enter your contact information on line 6.

Milestones: Sheet to help guide your work as a PECC. Contains links to helpful resources.

PRS: Sheet to assist in filling out the Pediatric Readiness Assessment and tracking progress through the assessment for institutional memory. **Scores recorded using this sheet are not official.** All scores must be uploaded through pedready.org to be official.

Snapshot | Activities | Hospital Info | Milestones | PRS | PRS Export | Instructional Guide

Simulation Videos Status

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

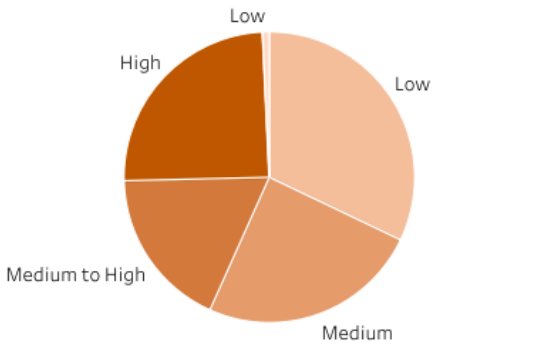
NPRQI Reporting Dashboard
134 Sites / 29,906 Records

Make your selections from the green filter bar, and Click "GO" to return your report

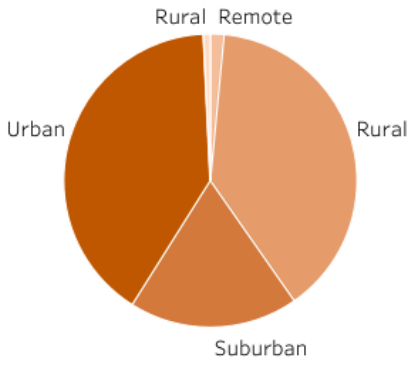
Year	Quarter	Site	Results View	Patient Clinical Group
Select all that apply	Limit the # of Quarters by selecting Year(s) first			
All	All	Multiple values	Table	All Patients (Core Measures)

GO

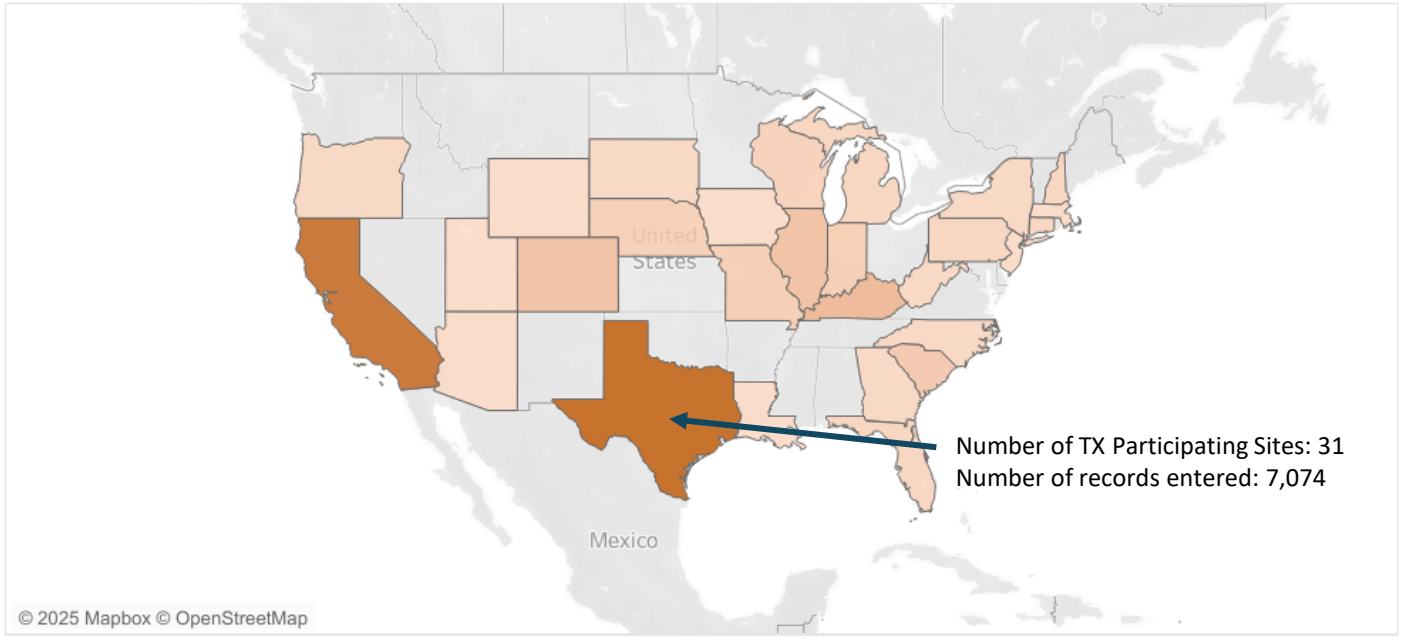
Number of Sites by Patient Volume Category

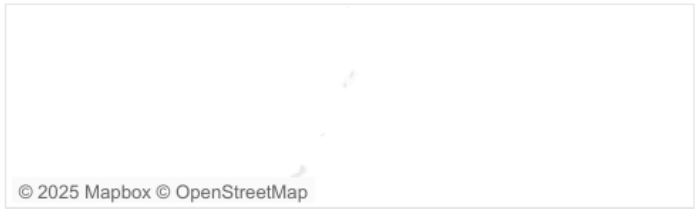


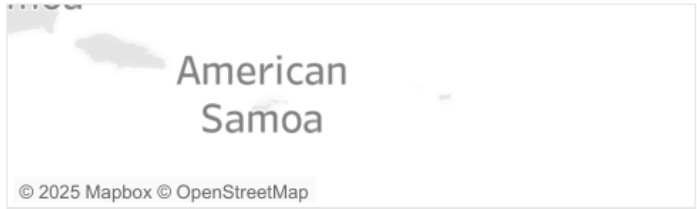
Number of Sites by Geographic Category



Participation in the National Pediatric Readiness Quality Initative







The NPRQI is supported in part by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). Additional funding is provided by the Toyota Way Forward Fund.

Last Dataset Refresh:
11/13/2025 6:13:16 PM
Last Patient Included:
11/9/2025

NPRQI: Texas Participating Sites

Texas Registered Sites	80
Texas Sites with Executed POA	45
Texas Sites Entering Data	31
Texas Registered RACs	5 (E,I, J,K,O)

Data source: NPRQI Texas Registration Data – 11/12/2025

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

A - Panhandle	B - BRAC	C – North Texas	D – Big Countty	E – North Central Texas	F – NorthEast Texas
• **Golden Plains Community Hospital** • Pampa Regional Medical Center	• **Cochran Memorial Hospital** • Covenant Children's Hospital • Memorial Hospital Seminole • **University Medical Center**	• **Graham Hospital District**	• Stephens Memorial Hospital	• **Baylor All Saints Medical Center at Fort Worth** • Medical City ER Saginaw • **Methodist Richardson Medical Center** • **Methodist Southlake Hospital** • **Palo Pinto General Hospital** • **Texas Health Hospital Mansfield**	• **Titus Regional Medical Center**

Bolded Hospitals denotes entering data

Minimum of 5 sites needed to see RAC dashboard

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

G – Piney Woods	I - Border	J - Texas J	K – Concho Valley	L –Central Texas	M – Heart of Texas
• **Christus Mother Frances Hospital - Jacksonville** • **Christus Mother Frances Hospital - Tyler** • **Christus Mother Frances Hospital - Winnsboro**	• **El Paso Children's Hospital** • **University Medical Center of El Paso**	• **Big Bend Regional Medical Center** • **Medical Center Health System** • **Permian Regional Medical Center** • **Ward Memorial Hospital** • **Winkler County Memorial Hospital**	• **Lillian M. Hudspeth Memorial Hospital** • Reagan Hospital District • **Schleicher County Medical Center**	• **Adventhealth Rollins Brook** • **Coryell Memorial Hospital**	• Hill Regional Hospital

Bolded Hospitals denotes entering data

Minimum of 5 sites needed to see RAC dashboard

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

N – Brazos Valley	O – Capital Area	P-Southwest Texas	R – East Texas/Gulf Coast	S- Golden Cresent
• **Baylor Scott and White Medical Center - College Station** • **CHI St Joseph Health - College Station Hospital** • **CHI St Joseph Health Burleson Hospital** • **CHI St Joseph Health Grimes Hospital** • **CHI St Joseph Health Madison Hospital** • **St Joseph Regional Health Center**	• Baylor Scott and White Medical Center - Marble Falls	• **Christus Children's**	• HCA Houston Healthcare Mainland • **Liberty - Dayton Regional Medical Center**	• **Cuero Regional Hospital** • **Detar Hospital Navarro** • **Detar Hospital North** • **Lavaca Medical Center**

Bolded Hospitals denotes entering data

Minimum of 5 sites needed to see RAC dashboard

Texas **Participating Sites** By Regional Advisory Council (RAC) **Registration Started**

A - Panhandle	B-BRAC	C- North Texas	E- North Central Texas	F- North East Texas	G –Piney Woods
• Parkview Hospital - Wheeler	• Lamb Healthcare Center • W.J. Mangold Memorial Hospital	• Faith Community Hospital	• Texas Health Arlington Memorial Hospital • Methodist Mansfield Medical Center • Ennis Regional Medical Center • Lake Granbury Medical Center • Hunt Regional Medical Center • TMC Bonham Hospital	• Christus Mother Frances Hospital - Sulphur Springs	• Longview Regional Medical Center • UT Health East Texas Pittsburg Hospital

Registration Started – No POA

Texas **Participating Sites** By Regional Advisory Council (RAC) **Registration Started**

H-Deep East Texas	I-Border	J-TexasJ	K-Concho Valley	O-Capital Area
• Sabine County Hospital	• William Beaumont Army Medical Center	• Iraan General Hospital • Odessa Regional Medical Center • Reeves County Hospital	• Ballinger Memorial Hospital District	• Ascension Seton Bastrop Hospital • Ascension Seton Edgar B Davis • Ascension Seton Medical Center Austin • St. David's South Austin Medical Center

Registration Started – No POA

Texas **Participating Sites** By Regional Advisory Council (RAC) **Registration Started**

P-SouthWest Texas	Q-South East Texas	R-East Texas/Gulf Coast	S-Golden Cresent	T-Seven Flags
• Guadalupe Regional Medical Center	• HCA Houston Northwest ED • Houston Methodist West Hospital • Memorial Hermann Memorial City Medical Center	• Baptist Hospitals of Southeast Texas • Christus Southeast Texas - St Elizabeth and St Mary • Memorial Hermann Pearland Hospital • UT Medical Branch	• Memorial Medical Center • Yoakum Community Hospital	• Laredo Medical Center

Registration Started – No POA

NPRQI: **Texas Core Measures**

Bundle	#Records	Quality Measure	Statewide Performance	National Performance
Assessment	7,043	% of pediatric patients with weight documented in kilograms only	59.0%	63.4%
		% of pediatric patients with pain assessed	84.2%	80.8%
	6,874	Median length of ED stay	126.3 minutes	167.9 minutes
Abnormal Vital Signs	3,727	% of high acuity pediatric patients with vital signs re-assessed	92.0%	84.5%
	2,460	Median time from triage to first intervention	37.1 minutes	51.3 minutes
Transfer of Patients	532	% of transferred pediatric patients who met site-specific transfer criteria	99.2%	97.9%
		Median time from triage to transport	194.3 minutes	339.1 minutes
	11	% of transferred pediatric patients who were discharged from the receiving ED	--	24.2%

Data source: NPRQI Texas Performance Data – 11/12/2025

NPRQI: **Texas Head Trauma Measures**

Bundle	#Records	Quality Measure	Statewide Performance	National Performance
Head Trauma	779	% of pediatric patients with a full set of vital signs obtained (i.e., temperature, heart rate, respiratory rate, oxygen saturation, blood pressure, mental status	72.3%	63.2%
		% of pediatric patients with a GSC reassessment	57.9%	32.5%
	195	% of pediatric patients with a head CT that met one or more PECARN criteria	73.2%	65.8%

Data source: NPRQI Texas Performance Data – 11/12/2025

NPRQI: **Texas Respiratory Complaints**

Bundle	#Records	Quality Measure	Statewide Performance	National Performance
Respiratory	2,350	% of pediatric patients who received an antibiotic	16.6%	16.6%
		% of pediatric patients who underwent a chest x-ray	40.1%	42.5%
	416	% of pediatric patients with asthma or croup who received a steroid	78.3%	76.5%
	335	Median time to steroids in pediatric patients with asthma or croup	46.3 minutes	47.1 minutes
	263	% of pediatric patients with asthma who received a beta agonist	76.9%	72.1%
	194	Median time to beta agonists in pediatric patients with asthma	--	43.3 minutes

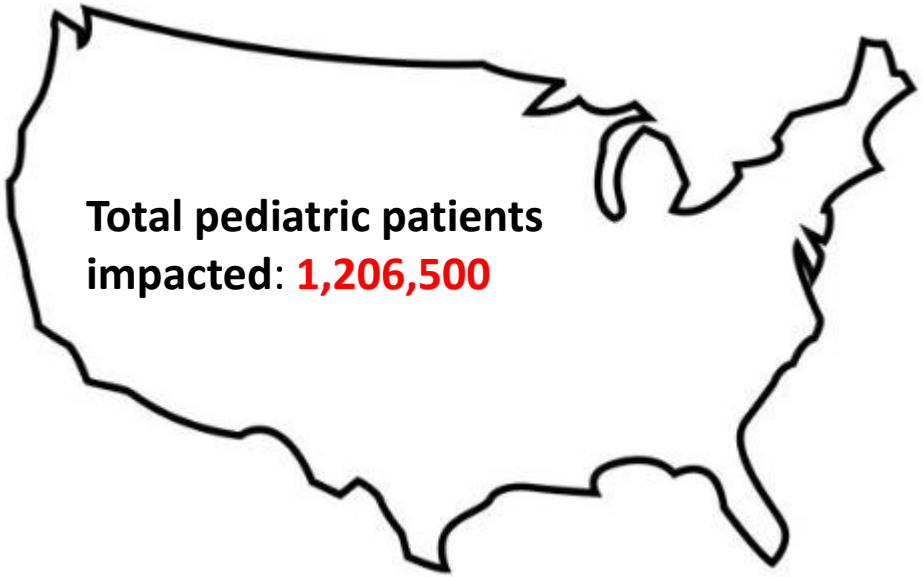
Data source: NPRQI Texas Performance Data – 11/12/2025

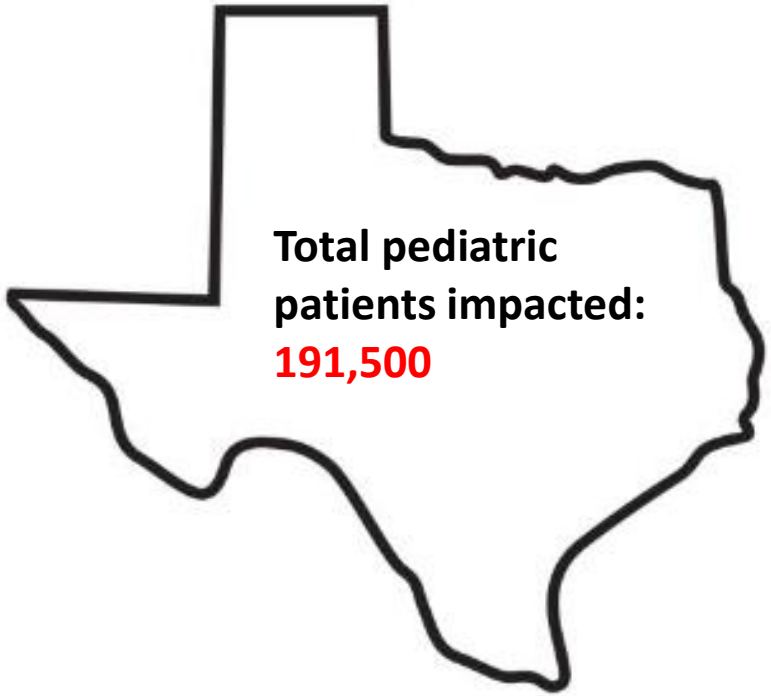
NPRQI: **Texas Suicidality Measures**

Bundle	#Records	Quality Measure	Statewide Performance	National Performance
Suicidality	1.867	% of adolescents who are assessed with a suicide screening tool	50.6%	64.8%
	26	% of pediatric patients with a positive suicide screen who had a structured suicide assessment	--	95.3%
		% of pediatric patients with a positive suicide screen who received consultation with a licensed mental health professional	--	90.9%

Data source: NPRQI Texas Performance Data – 11/12/2025

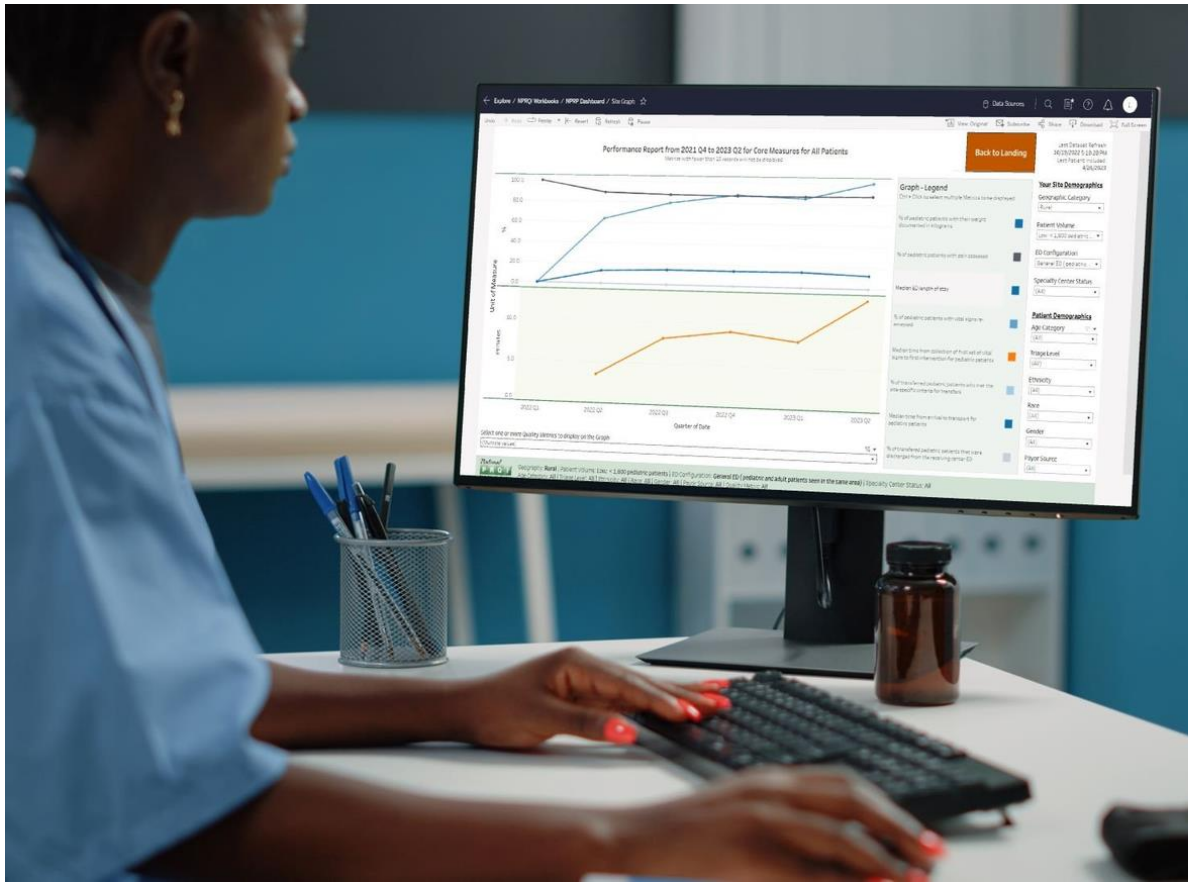
NPRQI: Patients Impacted





Future Plans

- System upgrades completed (beta testing)
- Electronic data entry exploration
- Upcoming EMSC NPRQI Collaborative – launching January 2026
  https://emscimprovement.center/collaboratives/nprqi/2026/



Future QI Engagement Opportunities

Dec. 3rd @ 2:00 PM Central: NPRQI Forum – topic: NPRQI Data Sampling **REGISTER HERE**

Dec. 4th @ 2:00 PM Central
Hosted by the **National Rural Health Association** (NRHA) – topic: Advancing Pediatric Readiness Through Quality Improvement Collaboratives **JOIN HERE**

Feb. 12 @ 1:00PM Central
NEW Pediatric Readiness Guidelines for a NEW National Assessment
https://emscimprovement.center/education-and-resources/webinars/

10. Task Force Updates and Action Items

10.a. Burn Care Task Force

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

10.b. Time-sensitive Transfer Deconfliction Task Force

Ryan Matthews

10.c. Prehospital Whole Blood Task Force

Chair: Mr. Eric Epley

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

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 to ensure readiness once RAC contracts are finalized.* • *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 being consolidated into a toolkit folder and circulated weekly for review and refinement by the PHWBTF.* • *Newly updated documents have been reviewed and are ready for Council consideration and approval.*	

GETAC Committee/Stakeholder Action Item Request for Council November 24, 2025

Mr. Eric Epley

Pre-hospital Whole Blood Taskforce

Action Item Request and Purpose

Request:

- Approve the *Recommendations for PHWB Transfusion Criteria* for publication and use in the PHWBTF pilot program.

Purpose:

- To establish clear, evidence-informed guidance for administering whole blood in the prehospital environment for the pilot program.

Benefit and Timeline

Benefit:

- To ensure consistent, standardized transfusion practices across participating regions and support safe implementation of whole blood.

Timeline:

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

11. Executive Committee Activities Summary

Executive Committee:

Alan Tyroch, MD, GETAC Chair

Ryan Matthews, GETAC Vice-Chair

Scott Lail, GETAC Council Member

No activities identified for this quarter.

12. 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
November 24, 2025

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services

TETAF Advocacy

- TETAF submitted recommendations for allocation of funds from the One Big Beautiful Bill Act as it relates to rural health care.
- SB 672 – Hospitals must submit summary of patient diversion plan for cyber attacks or power outages to HHSC by December 1.
- The 90th Texas Legislative Session begins January 12, 2027.
  - The TETAF Advocacy Committee is meeting monthly to prepare and draft the TETAF Legislative Priorities.

SURVEYS – Trauma, Stroke, Maternal, and Neonatal

- **TETAF and Texas Perinatal Services Surveys** – The current volume of surveys in order are trauma, maternal, neonatal, and stroke.
- **Trauma Rules** – TETAF has surveyed under the new trauma rules and guidelines. While surveyors and hospitals have had a few challenges, they are working through the new processes.
- **Surveyors** – TETAF/Texas Perinatal Services are recruiting physician reviewers for maternal, neonatal, and trauma. Anyone interested may email Terri Rowden (trowden@tetaf.org) for trauma and Jessica Phillips (jphillips@tetaf.org) maternal and neonatal.

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 Monday, December 1 at 10:00 a.m. CST.
- The TETAF Hospital Data Management Course (HDMC) will once again be offered virtually in Spring 2026. Dates will be announced soon! Visit www.tetaf.org/hdmc for updates.

Register for the Texas Quality Care Forum (TQCF)

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services

TETAF Board of Directors - Election

- Kelly Galloway – RAC A (ED Director and Trauma Program Manager at Moore County Hospital)
- John Baker – RAC B (Paramedic at Idalou EMS)
- Dr. Christina Chan – RAC E (Associate Div. Chief of Perinatal Medicine at UT Southwestern)
- Dr. Jessica Ehrig* – RAC L (Maternal Medical Director at Baylor Scott & White – Temple)
- Dr. Ernest Gonzalez* – RAC O (Chair of Trauma Dept. at St. David's South Austin Medical Center)
- Suzanne Curran – RAC Q (Dir. of Emergency Healthcare Systems at SETRAC)
- Dr. Terri Major-Kincade – RAC Q (Perinatal Palliative Care Director at UT McGovern School of Medicine)
- Jennifer Carr – RAC U (Trauma Program Director at CHRISTUS Spohn Shoreline)

* Denotes incumbent board member

TETAF Collaboration

- TETAF continues to provide support to the Texas TQIP Collaborative.
  - Texas TQIP held its final quarterly meeting earlier this month during the ACS TQIP Conference in Chicago.
  - Texas TQIP has met with interested trauma facilities to establish 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 Rural Trauma System Development Fund

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Established in 2024 in recognition of 35 years of the Texas Trauma System, the TETAF Rural Trauma System Development Fund focuses specifically on supporting rural trauma care in Texas.

In 2026, TETAF will provide a limited number of scholarships to reimburse rural trauma facilities for necessary education to meet trauma designation requirements.

Learn more and apply at https://tetaf.org/ruraltraumaapplication/ or scan the QR code.

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services

TETAF Rural Trauma System Development Fund

TETAF TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services

13. Next Council Meeting Dates

Quarterly Meetings:

- FY26 Q1: November 21-24, 2025 (Fort Worth)
- FY26 Q2: March 10-13, 2026 (Austin)
- 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)

14. 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

15. 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!

Safe travels home and Happy Thanksgiving!