



TEXAS
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Services

**Texas Department of State
Health Services**

Governor's EMS and Trauma Advisory Council

Friday, June 6, 2025
8:00 AM (CDT)

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

1. Call to Order

2025 Governor's EMS and Trauma Advisory Council Meeting 2nd Quarter



Texas Department of State
Health Services

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

Public participation is available at:

DoubleTree by Hilton Austin, Phoenix Central Ballroom
6505 N Interstate 35
Austin, TX 78752

Virtual Rules of Participation



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Rules of Participation

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

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

Rules of Participation

- If you would like to make a statement or ask a question, please put your question in the chat with your name and entity you represent.
Please note: Anonymous entries in the chat are unable to be shared.
- Please do not put your phone on hold at any time if you are using your phone for audio.

To mute/unmute if not using the computer for audio, press

***6** on Android phones

***6#** on iPhones

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.



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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.



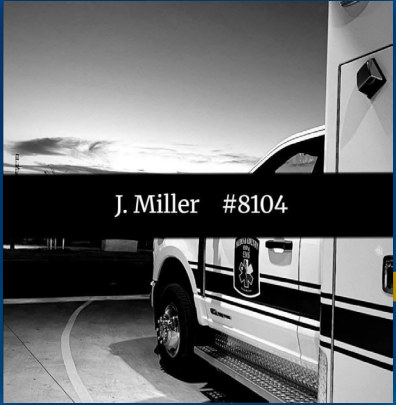
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Moment of Silence

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



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Jason Miller

April 20, 1989 - May 19, 2025

Medina County ESD #4 EMS Chief

GETAC Disaster Preparedness and
Response Committee Member (2025)



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4. Approval of Minutes

Review and Approval of Minutes

- January 30-31, 2025
- March 7, 2025



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5. Chair Announcements

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



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State Reports

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



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

Jeff Hoogheem, Director



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6.b. EMS Trauma Systems Update

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



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EMS/Trauma

- Designation Unit's Focus
 - §157.126 Gap Analysis
 - §157.126 Survey Guidelines
 - §157.126 Designation Review Committee Application
 - §157.126 Trauma Designation Assessment Questionnaire
 - §157.126 Review of Designation Standards / Requirements – May

ACS Standards

ACS Visit Results	Verification Outcomes
Compliant with all standards	Verified, 3- year certificate
Noncompliant with up to 3 Type IIs	Verified, 1 – year certificate
Noncompliant with any Type I or Noncompliant with more than 3 Type II Standards	Not verified

Texas Trauma Designation Process

- All standards and requirements met – 3-year designation
- One to three requirements not met – Contingent Designation with CAP; Focus review or work with state
- Four or more requirements not met – Contingent Probationary Designation with CAP; Re-review or work with state
- Goal – all requirements are met a minimum of 80%

	allotments, and equipment needed for a trauma center to function.					
(h)(19)	Level I, II, and III facilities must have an organized, effective trauma service recognized in the medical staff bylaws or rules and regulations and approved by the governing body. Medical staff credentialing must include a process for requesting and granting delineation of privileges for the trauma medical director (TMD) to oversee the providers participating in trauma call		x	x	x	

Level I Trauma Verification / Designation

- BSW Temple
- Baylor University Medical Center
- Children's Medical Center
- Dell Children's
- Dell Seton Medical Center
- Harris Health Ben Taub
- John Peter Smith
- Medical City Plano
- Memorial Herman
- Texas Children's Hospital
- THR Methodist Fort Worth
- THR Presbyterian Dallas
- University Medical Center
- University of Texas Medical Branch
- UT Health East Texas Tyler

Level II Trauma Facility Verification/Designation

- Ascension Seton Williamson
- BSW McLane Children's
- BSW Medical Center Grapevine
- BSW Medical Center McKinney
- Christus Mother Francis Hospital
- Corpus Christi Medical Center – Bay Area
- HCA Clear Lake
- HCA Conroe
- HCA Kingwood
- HCA Northwest
- Medical City Denton
- Memorial Herman Woodlands
- Round Rock Medical Center
- St. David South Austin
- THR Plano
- HOP East Campus

ACS Standards

- 4.22 Ophthalmology Services – Type II
- 4.26 Medical Specialist – Type II
- 4.30 Advanced Practice Providers – Type II
- 4.31 Trauma Registry Staffing Requirements – Type II
- 4.32 CAISS Specialist – Type II
- 4.35 Performance Improvement Staffing requirements – Type II
- 5.3 Trauma Activation Guidelines – Type II
- 5.9 Anticoagulation Reversal Protocol – Type II
- 5.11 Emergency Airway Management – Type I
- 5.15 Trauma Diversion Protocol – Type II
- 5.16 Trauma Diversion Hours – Type II

ACS Standards

- 5.17 – 5.19 Neurosurgeon Response – Type II
- 5.20 – 5.21 Orthopedics – Type II
- 5.23 Surgical Evaluation of ICU Patients – Type II
- 5.27/28 Rehab – Type II
- 5.30/31 Alcohol Misuse – Type II
- 6.1 Data Quality Plan – Type II
- 7.2 PIPS Plan – Type II
- 7.4 Participation in Risk –Adjusted Benchmarking Program – Type II
- 7.5 Physician Participation in Prehospital PI – Type II
- 7.8 Nonsurgical Trauma Admission Reviews – Type II
- 7.9 Trauma Diversion Review – Type II
- 7.10 Prehospital Care Feedback – Type II

ACS Standards

- 8.2 Nursing Trauma Orientation and Education – Type II
- 8.3 Prehospital Provider Training – Type II
- Important to read and review the “Additional Information” and “Compliance” data

New Initiative



PI: Ask The Experts



Don Jenkins, MD, FACS – Leader



Texas TOPIC Instructors



Open Dialogue

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

Level III Trauma Facilities - TQIP



Coordinated call with ACS



ACS TQIP Team



Discussed navigating the website and portal



Discussed Level III TQIP reports



Provided an example Level III TQIP report

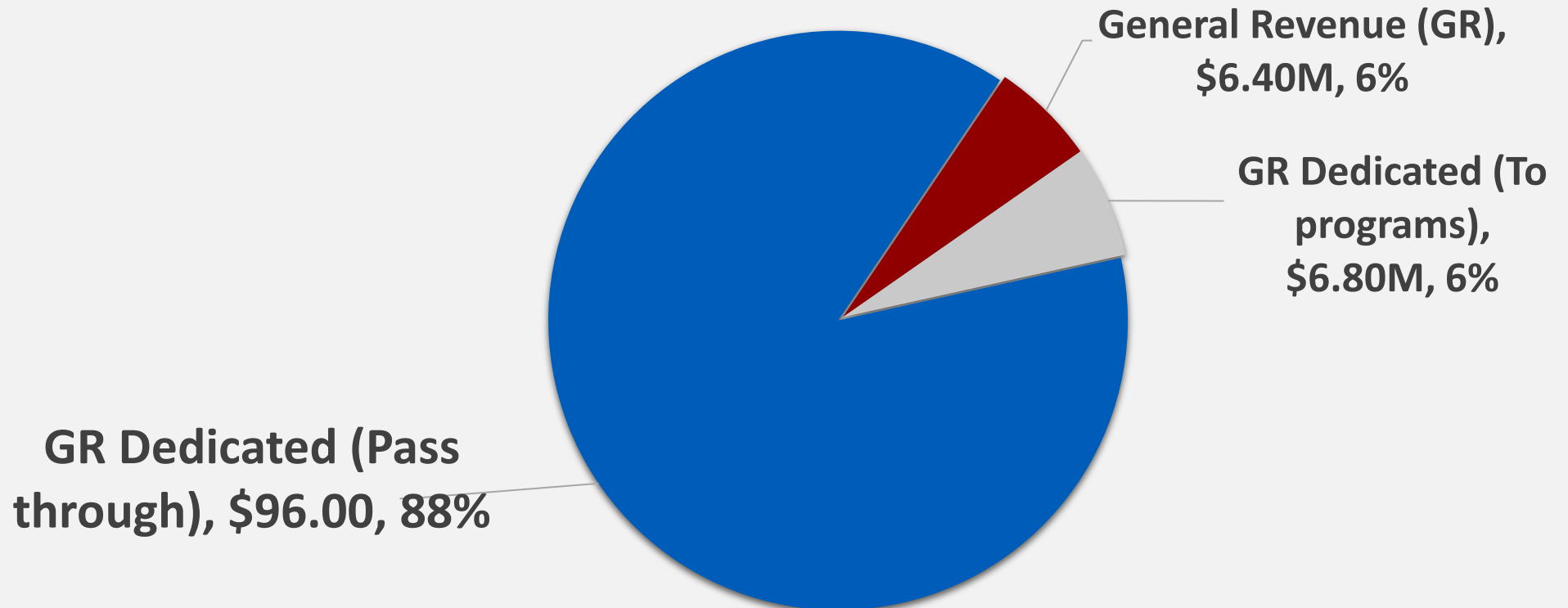


Reviewed the TQIP Level III Cohorts

EMS Funding Overview

EMS and Trauma Care Systems, Strategy B.2.1

FY 25 Budgeted (\$112.3M - \$96M is for grants/pass through)
amount in millions



Types of Trauma Funding: Dedicated Funding Streams



Fund 5007

9-1-1 Equalization
Surcharge Funds

Fund 5108

\$100 DUI/DWI
Conviction
Surcharge

Fund 5111

**30% State
Traffic Fines**

20% of Misc. Traffic
Fines (DWI Traffic
Funds)

60% of Automobile
Burglary & Theft
Prevention
Authority (ABTPA)

EMS Trauma Funds Support



DSHS Administrative Costs (\$1M)

Oversight/integration of TX EMS Trauma Health Care Systems:

- Designation (4 programs)
- Funding/Allocation Distribution
- Emergency Medical Services (EMS)
- Regional Advisory Councils (RACs)
- Medical Advisory Board (MAB)
- 77 FTEs



Regional Advisory Councils (RACs) Allocation (\$7.6M) FY26

Support EMS/Trauma Care System – Advancements

Reduce morbidity and mortality from injuries

Additional directives:

- Stroke
- Maternal
- Neonatal
- Centers of Excellence for Fetal Diagnosis
- Data collection



EMS Allotment Fund (\$4.9M) FY26

Funds for EMS Providers of 9-1-1 services and/or emergency transports

Distributed to RACs on behalf of eligible recipients per county (pass-thru funds)

60% to Rural

40% to Urban



Extraordinary Emergency Funding Requests (EEFs) (\$1.0M)

Support emergent, unexpected needs of:

- Licensed EMS Providers
- First Responder Orgs
- Licensed Hospitals



Hospital Uncompensated Care Allocation FY24 (\$82.1M) and FY25 (84.2M)

IAC to HHSC for Standard Dollar Amount (SDA Add-On) Programs

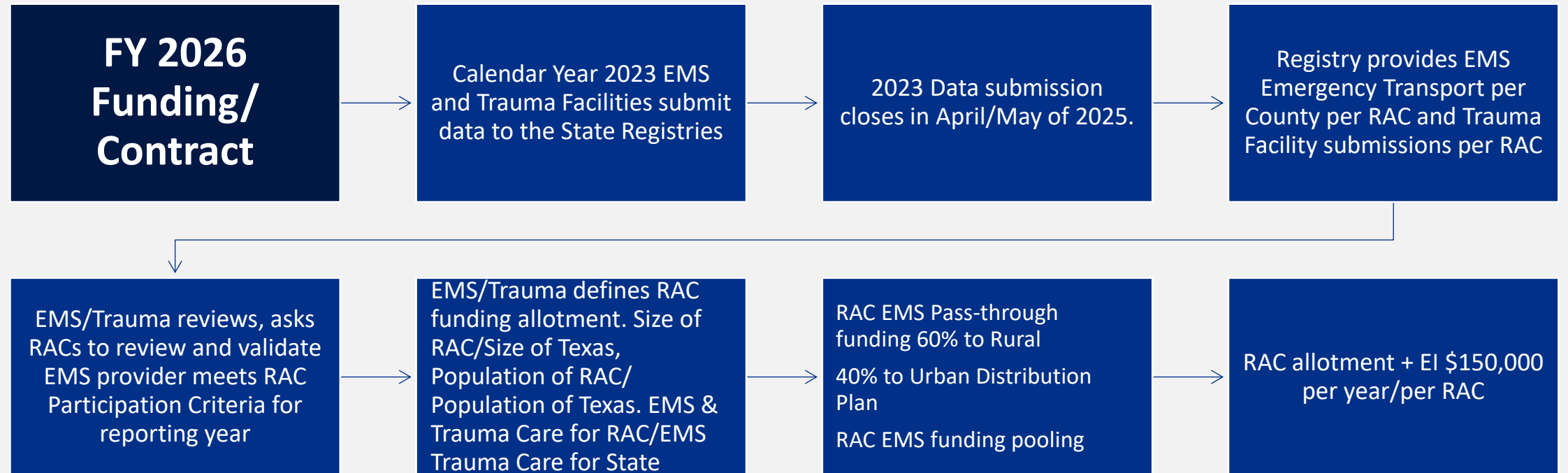


Emergency Care Attendant Training (ECAT) (\$25K)

Facilitate initial training in rural/underserved areas

Communities lacking local EMS training resources

RAC Funding Allotment



Regional Advisory Council (RAC)

Regional Advisory Council (RAC)	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027 Projection
EMS Pass-Through	\$4,795,847	\$4,876,435	\$4,941,600	\$4,964,594	\$4,967,295
RAC	\$2,597,147	\$2,650,510	\$2,661,449	\$2,676,779	\$2,678,580
System Development	\$2,278,187	\$2,278,187	\$2,278,187	\$2,278,187	\$2,278,187
Exceptional Item		\$3,300,000	\$3,300,000	\$3,300,000	\$3,300,000
TOTAL	\$9,671,181	\$13,105,132	\$13,181,236	\$13,219,560	\$13,224,062

Extraordinary Emergency Funds (EEFs):

FY25: \$1M was made available on 9/1/2024

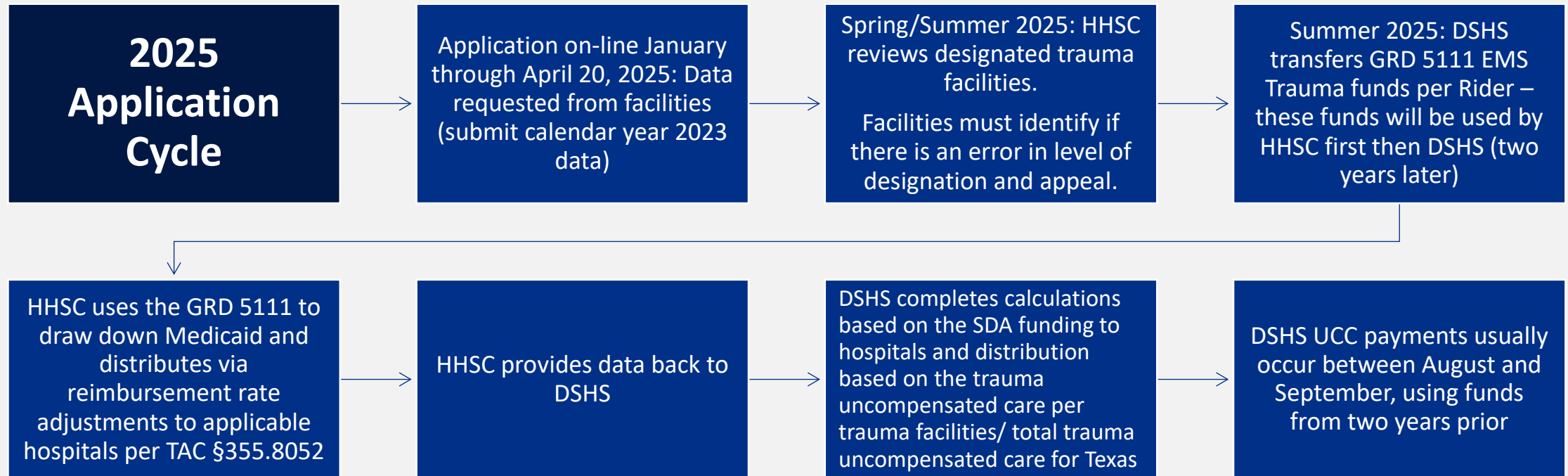
- 11 Applications received
- 7 Awarded, 4 Denied
- Total Expended: \$967,379.34
- Funds remaining: \$32,620.66

7 Grants were awarded to the RURAL counties.

Approved items:

- 1 remount
- 1 ambulance repair
- 1 new transmission
- 1 CPR device
- 1 set of cots
- 1 ambulance
- 1 ambulance chassis

Trauma Funding Two-Step: UCC



2025 Uncompensated Charges

Applicants:

- 287 Trauma-Designated Hospitals
- 3 of them are In Active Pursuit (IAP) Hospitals

Requested/Costs Documented:

- Charges Requested: \$3,667,147,531.85
- Charges validated and met criteria
 - Uncompensated Costs: \$859,217,623.54

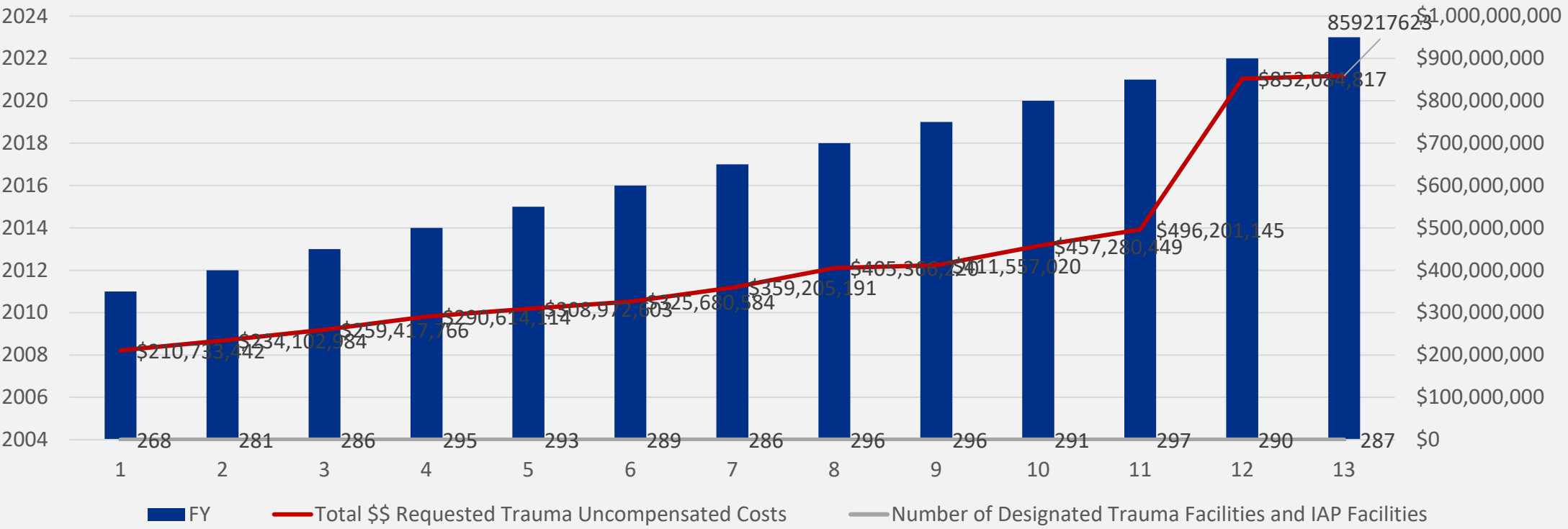
2025 Uncompensated Charges

Applications:

- Opened on January 20, 2025.
- Trauma UCC data Calendar Year 2023
- Trauma Facility Readiness Cost FY24
- Submission closed on April 20, 2025.
- \$89,810,873 allocated for 94% Statute Hospitals.
- \$84.2M moved to HHSC for Trauma SDA Add-On
- Remaining Funds Distribution to
 - All Trauma Facilities
 - Percentage of UCC reimbursement requested compared to the total Trauma UCC funds availability.

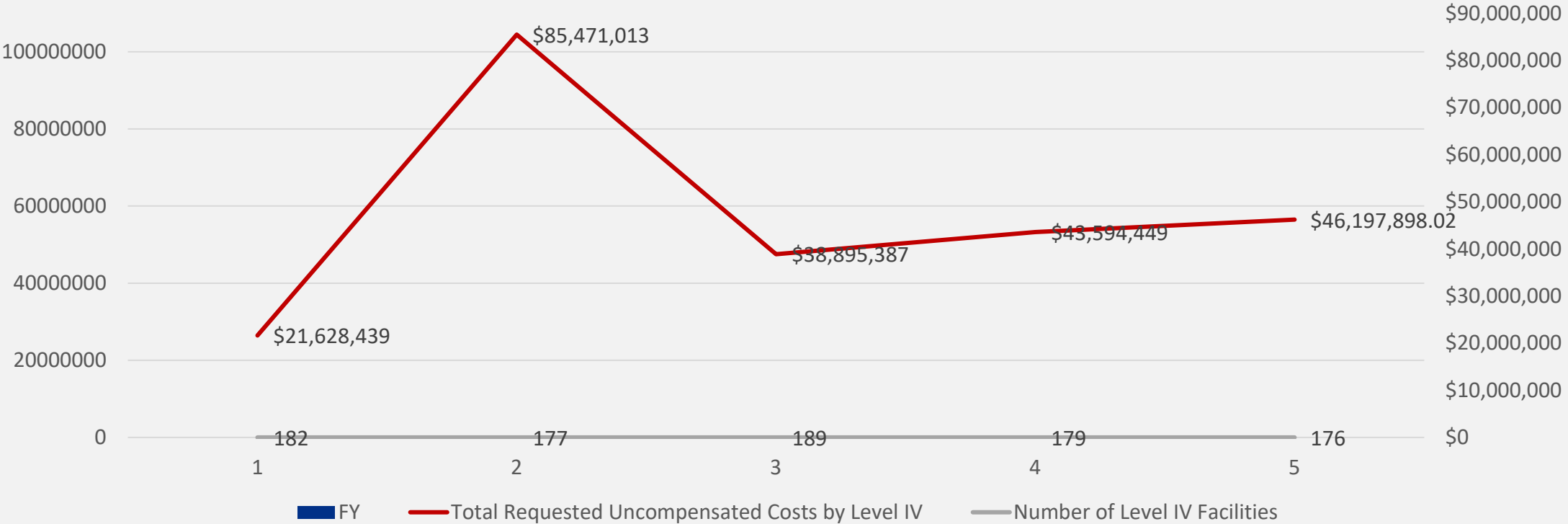
Trauma UCC

Uncompensated Care Charges Cost Over Time, Calendar Year 2011-2023,
Compared to the Number of Qualified Facilities



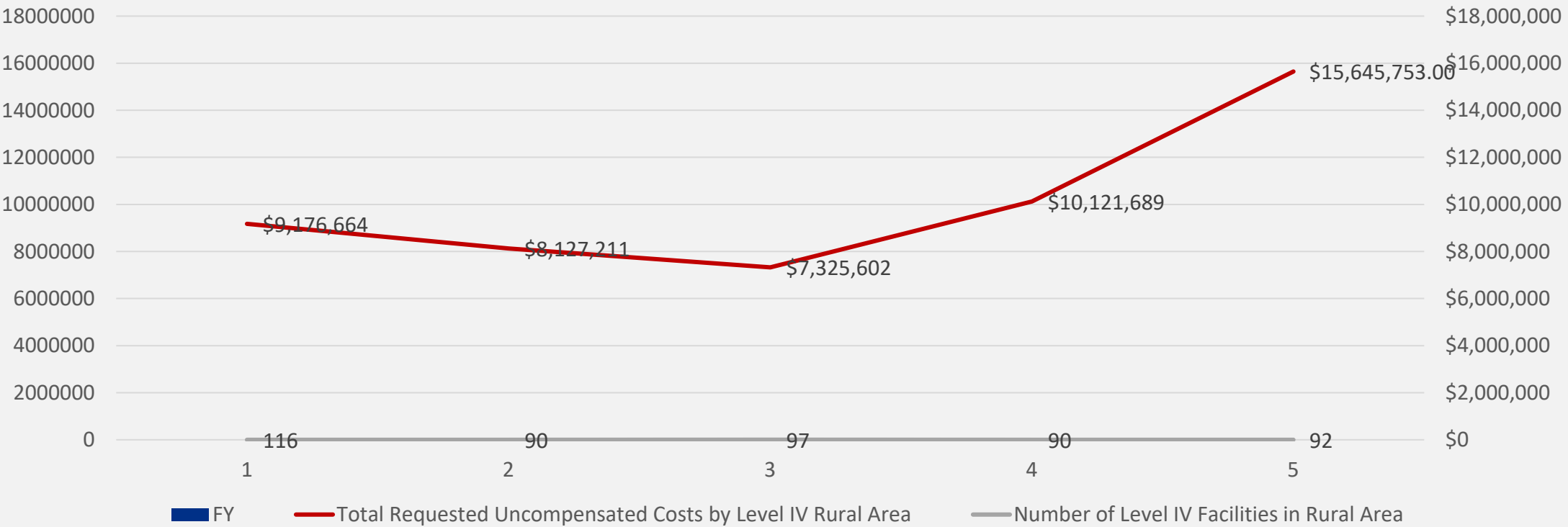
Trauma UCC Level IV Facilities

Uncompensated Care Charges Cost Over Time, Calendar Year 2019-2023,
Compared to Level IV Number of Qualified Facilities



Trauma UCC Rural Level IV Facilities

Uncompensated Care Charges Cost Over Time, Calendar Year 2019-2023,
Compared to Level IV Facilities in Rural Area only





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Designation Update

Elizabeth Stevenson, BSN, RN
Designation Programs Manager



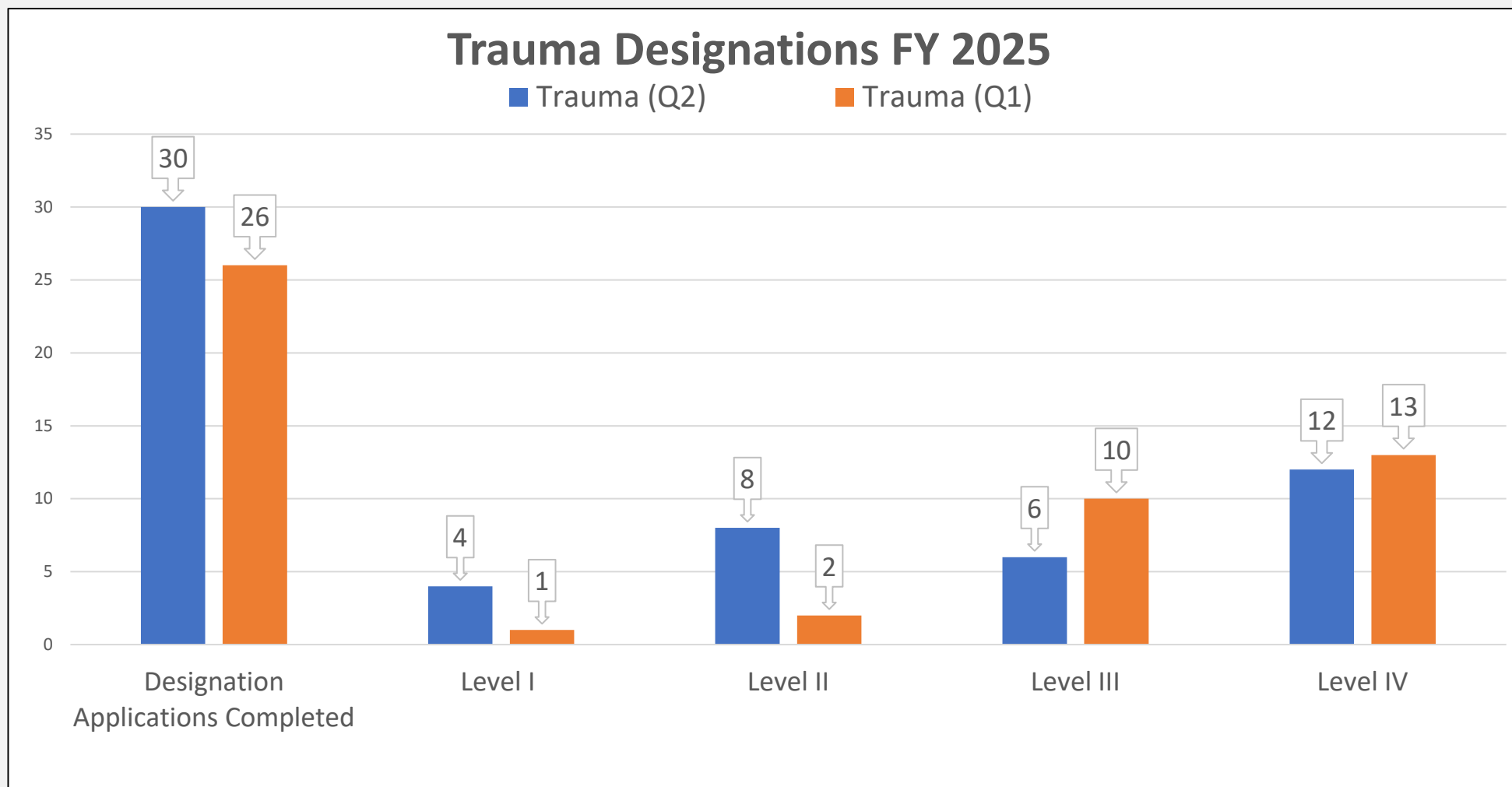
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Designated Trauma Facilities

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

Trauma Designation Data



Trauma Designation Data

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

Trauma Designation Data

Trauma Designations
2nd Quarter 2025

29

Designations
Processed

23

Renewals

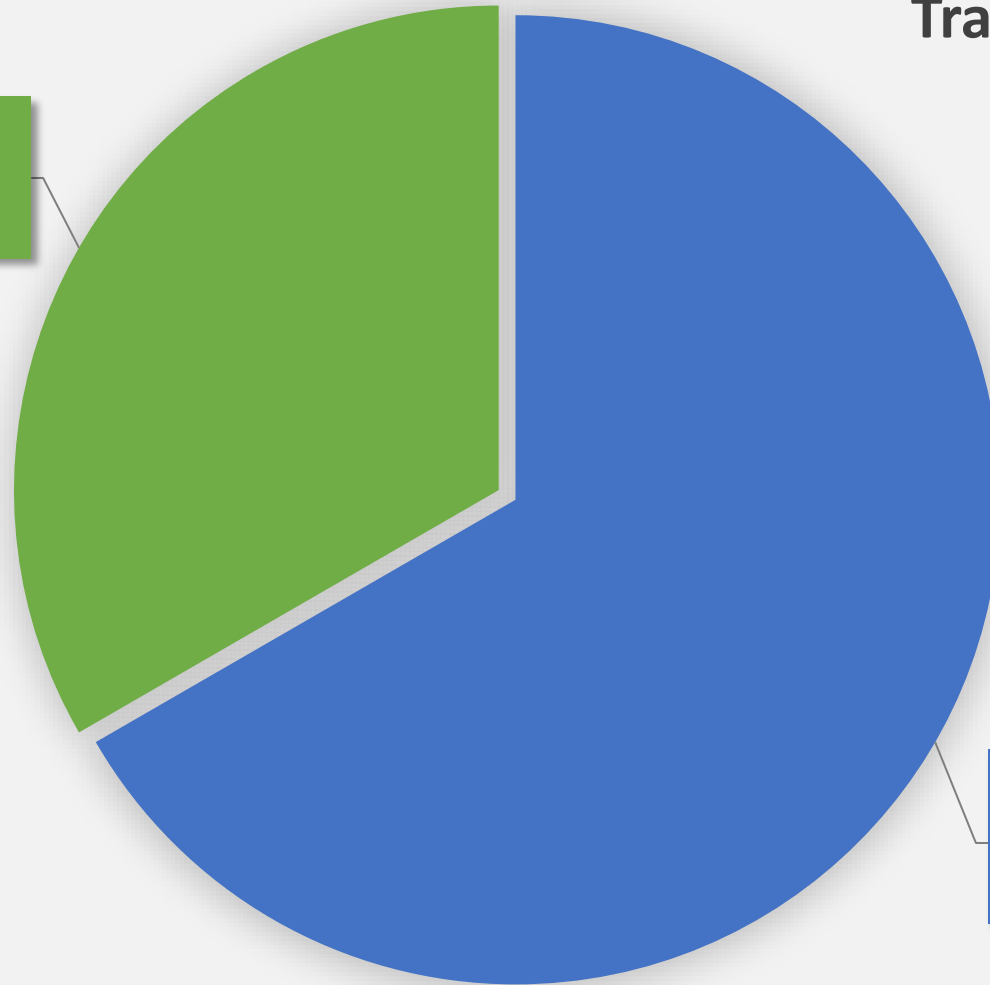
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Initials

Trauma Designation Data

Trauma Contingent Designations
2nd Quarter 2025

Non Contingent
Designations, 10, 34%



Contingent Designations, 19,
66%

Common Deficiencies



Nursing documentation



Evidence of loop closure



Identification of all
variances



TMD participation in PI



Monitoring of Trauma Surgeon
60 min response



TPM 0.8 FTE



Trauma Registry

Trauma Designation Information

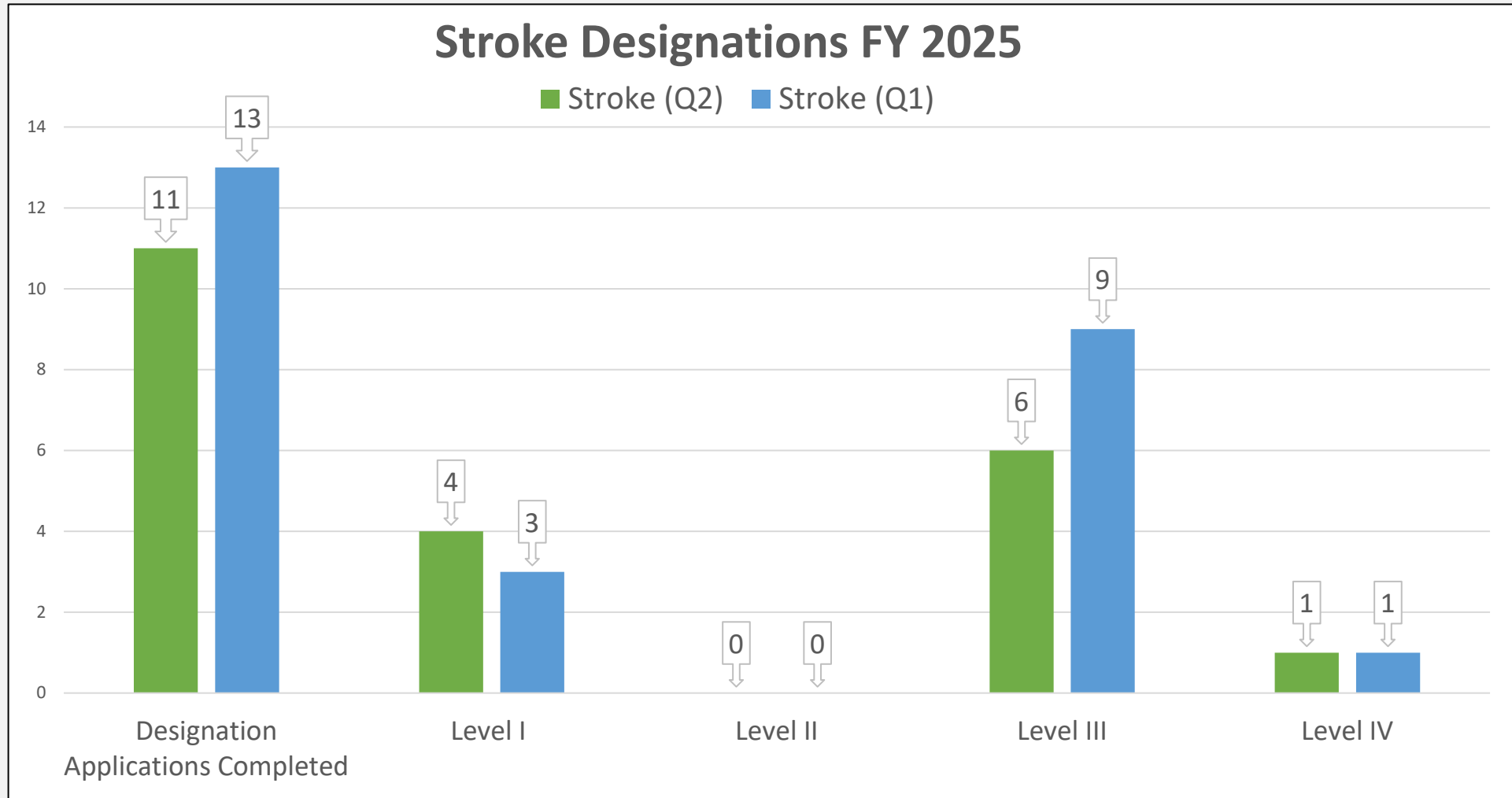
Department Activities:

- 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
- Survey following monthly meeting calls to receive stakeholder feedback on benefits and suggestions for future meeting content

Designated Stroke Facilities

Designated Stroke Facilities FY 2025	2 nd Quarter	1 st Quarter
Total	191	189
Comprehensive Level I	47	45
Advanced Level II	5	6
Primary Level III	111	101
<i>Primary Level II</i>	3	12
Acute Stroke Ready Level IV	25	25
<i>Support Level III</i>	0	0

Stroke Designation Data



Stroke Designation Data

Stroke Designations
2nd Quarter 2025

14

Designations
Processed

10

Renewals

4

Initials

Stroke Designation Information

Department Activities:

- Initial Level IV Acute Stroke Ready meetings held on September 12th, October 10th, November 14th, 2024. January 9th, and February 13th, 2025.
- Monthly call discussion:
 - Diversion versus acceptance of transfers
 - Survey organization requirements for higher level certifications differences
 - Program manager mentoring resources
 - Suggestions for future meeting content

Designation Application Process Performance Measures

Goals – 30/60 days

(Non-Contingent Designation 30 Days)

(Contingent Designation 60 Days)

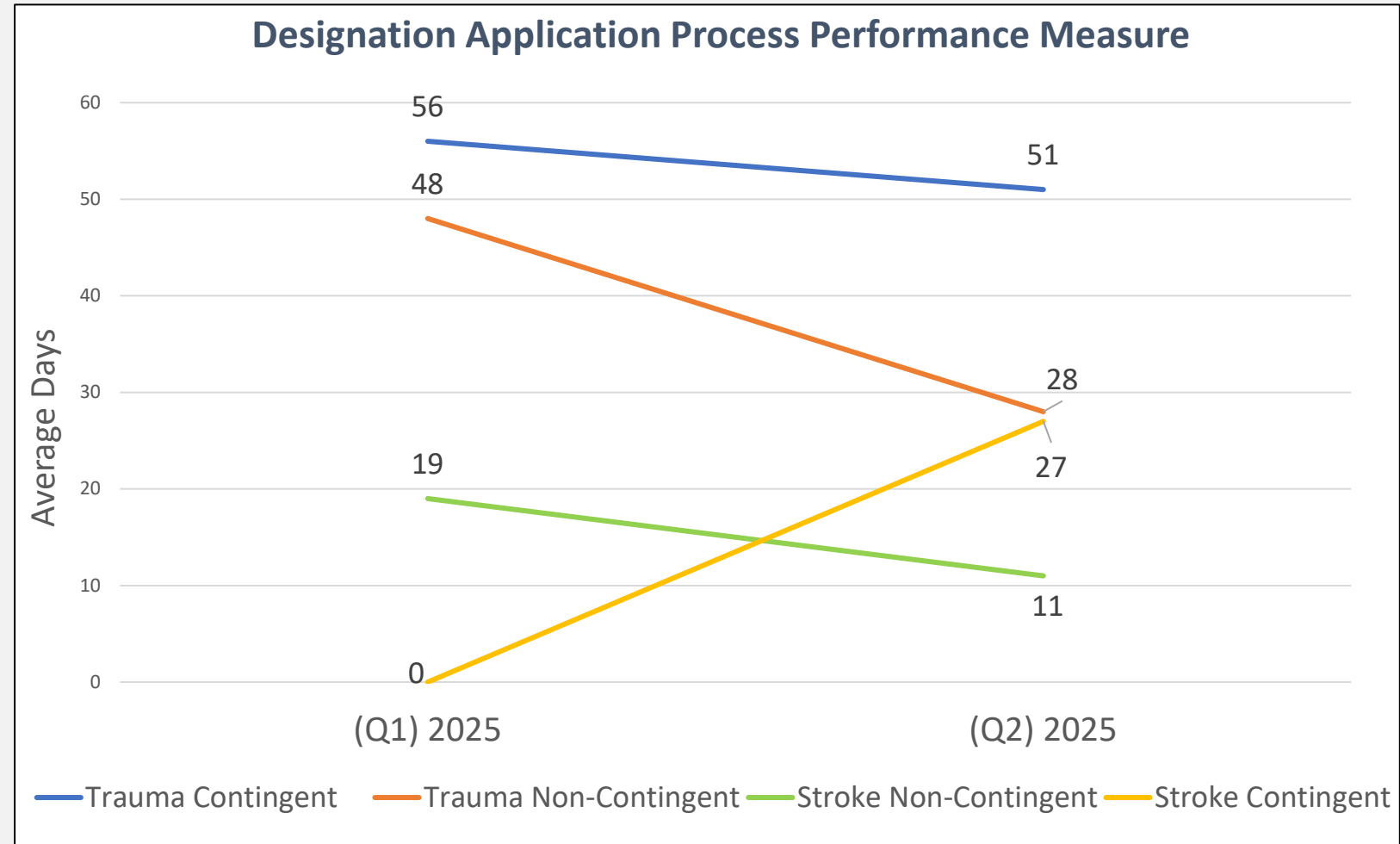
(2nd Quarter)

Stroke – 27 days
Contingent

Stroke – 11
Non-Contingent

Trauma – 51 days
Contingent

Trauma – 28 days
Non-Contingent





EMS System Update

Joe Schmider

Texas State EMS Director



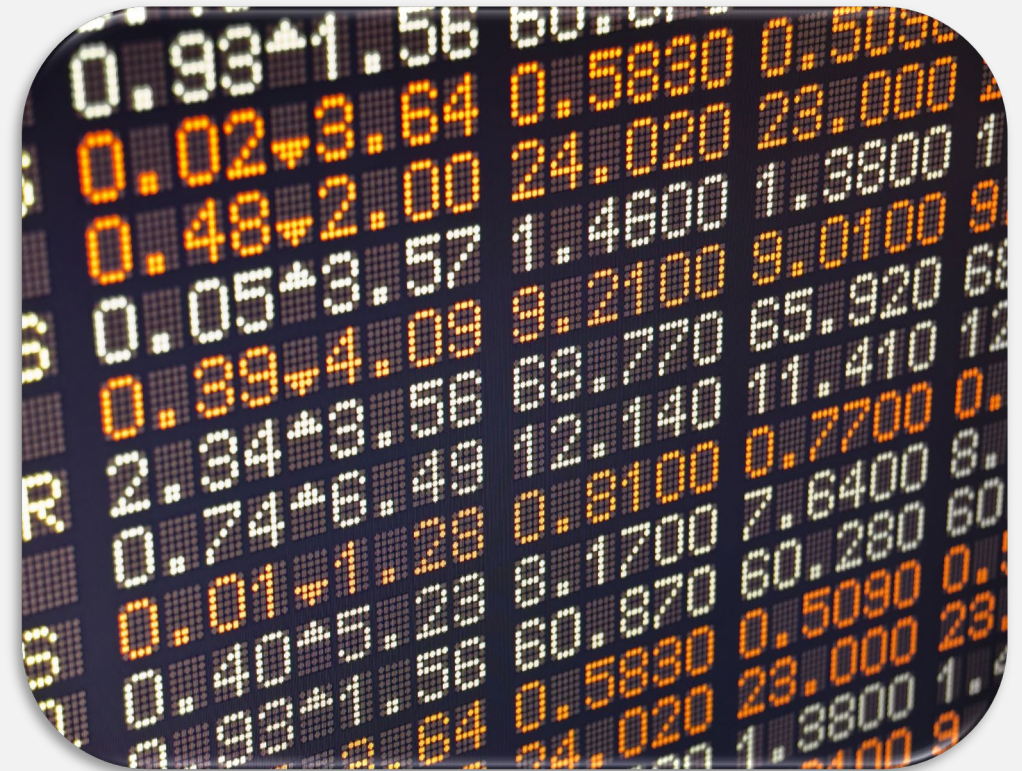
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NEMESIS: V5 Patch Continues to move Forward!

For more information on
NEMESIS and national
dashboards, visit
<https://NEMESIS.org>.

*Please get the
patch installed by
July 5th, 2025.*



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89R Session Legislation (EMS Impact)

- HB 33 Active Shooting
- HB 35 Peer Support System
- HB 742 Human Trafficking Education
- HB 3000 Funding (Rural)
- SB 1021 Stalking Conviction
- SB 1818 Military EMS License



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Rule Process

The priority for rule development will be the recently passed legislation.



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2025 EMS Conference



- Dr. Ed Racht, keynote speaker
- Updated Advanced AOR class with 6 presentations from EMS leaders
- <https://texasemsconference.com>
- November 23 to 26
- Fort Worth, Texas



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EMS Licensing Processing Time

Third Quarter FY 25 (Mar, Apr, May)

Overall – All Applications

- EMS Personnel: DSHS processed 8,418 applications; median processing time of 10 days.
- EMS Educators: DSHS processed 543 applications; median processing time of 106 days.
- EMS Providers: DSHS processed 105 applications; median processing time of 66 days.
- First responder organizations: DSHS processed 85 applications; median processing time of 66 days.



EMS Fingerprint Background Checks

- Application must be on file to receive DSHS background check code.
- The code is sent within the initial application summary email.
- Questions contact EMS Licensing by email at: emscert@dshs.texas.gov
- Please ensure you add the following to your safe sender list: @partner.hhs.texas.gov and @dshs.texas.gov



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Questions for
EMS/Trauma Systems?

Thank You

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

Jia Benno, MPH
Injury Prevention Unit Director



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Emergency Medical Services and Trauma Registries (EMSTR) Program Updates and Texas Trauma Deaths Over Time

June 6, 2025

Jia Benno. MPH
Injury Prevention Unit Director

EMSTR Updates

- 2024 EMS and trauma datasets:
 - EMS – 4,990,859 total unique records.
 - Trauma – 193,056 total records.*
- Sex variable updates.
- Quarterly data requests and data sharing.

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



About EMSTR and Presentation Data

- 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 runs and reportable trauma events to EMSTR under Texas Administration Code, Title 25, Chapter 103.
- Urban, rural, and frontier data was based on rural/urban criteria from the Texas Demographic Center Texas populations estimate:
 - Urban included large central metro, large fringe metro, medium metro, and small metro areas.
 - Rural included micropolitan (10,000-50,000 people) and noncore (<10,000 people) areas.
 - Frontier was defined as six or less people per square mile.
- For some data, 2013, 2014, and 2017 data were unavailable due to data standard changes and variable availability.

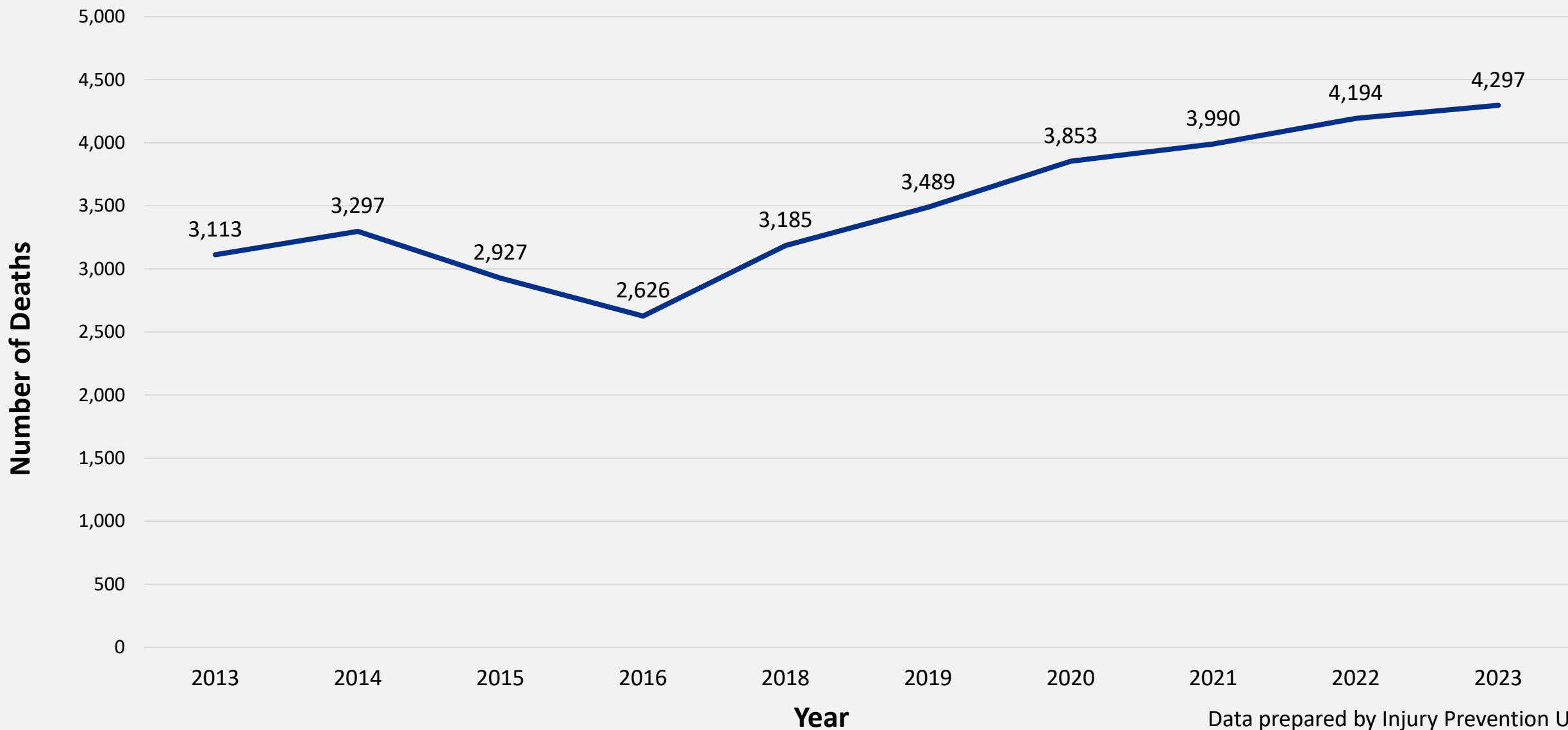
Texas Transfer Deaths Over Time 2013-2023



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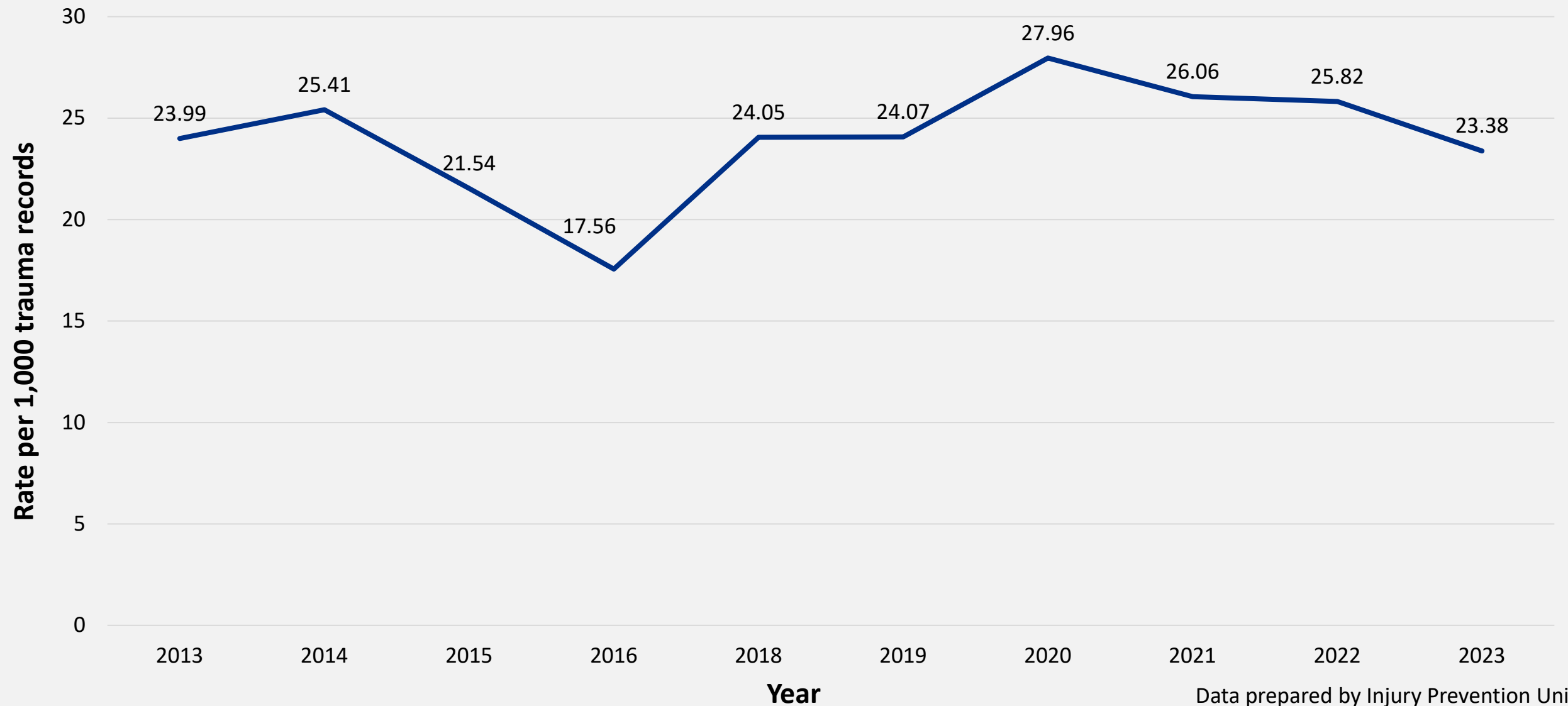
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Total Trauma Deaths, Texas, 2013-2023



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

Trauma Death Rate, Texas, 2013-2023



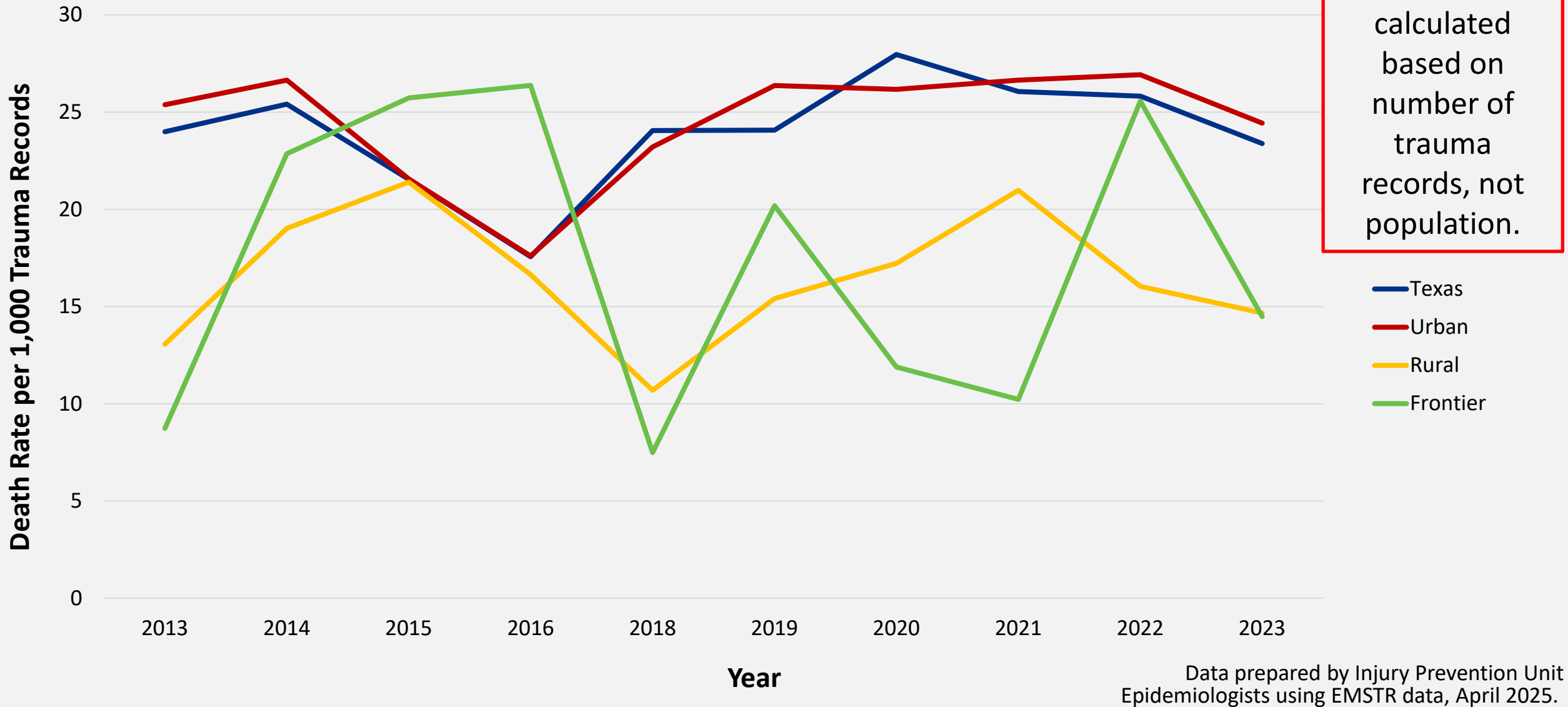
Data prepared by Injury Prevention Unit
Epidemiologists using EMSTR data, April 2025.

Trauma Deaths By Area Characterization, Texas, 2013-2023

Year	Total	Urban	Rural	Frontier
2013	3,113	2,793	154	8
2014	3,297	2,926	205	20
2015	2,927	2,531	248	22
2016	2,626	2,293	189	25
2018	3,185	2,870	117	8
2019	3,489	3,111	177	20
2020	3,853	3,474	193	10
2021	3,990	3,536	222	7
2022	4,194	3,802	172	17
2023	4,297	3,954	186	13

Note: The remaining deaths were missing area characterization.

Trauma Death Rates By Area Characterization, Texas, 2013-2023



Urban Trauma Deaths, Transferred Into Trauma Facility, Texas, 2015-2023

Year	Number	Percent of Deaths
2015	395	15.61%
2016	323	14.09%
2018	432	15.05%
2019	554	17.81%
2020	590	16.98%
2021	609	17.22%
2022	699	18.39%
2023	737	18.64%

Compared to approximately 5% in rural trauma centers.

Injury Severity Score (ISS)

The ISS is an anatomical scoring system providing an overall score for patients with multiple injuries. The ISS scoring categories are:

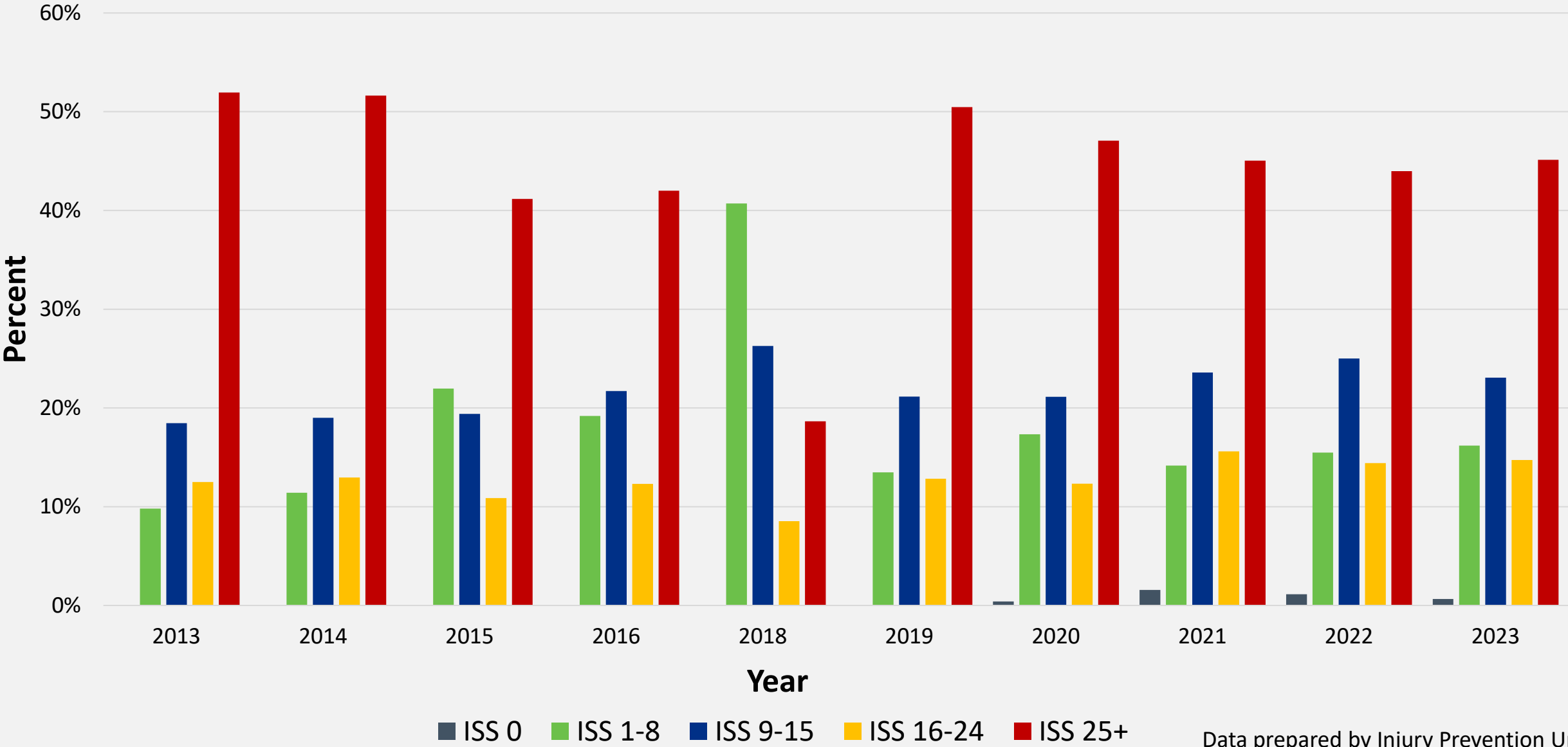
ISS 1-8 = mild trauma.

ISS 9-15 = moderate trauma.

ISS 16-24 = severe trauma.

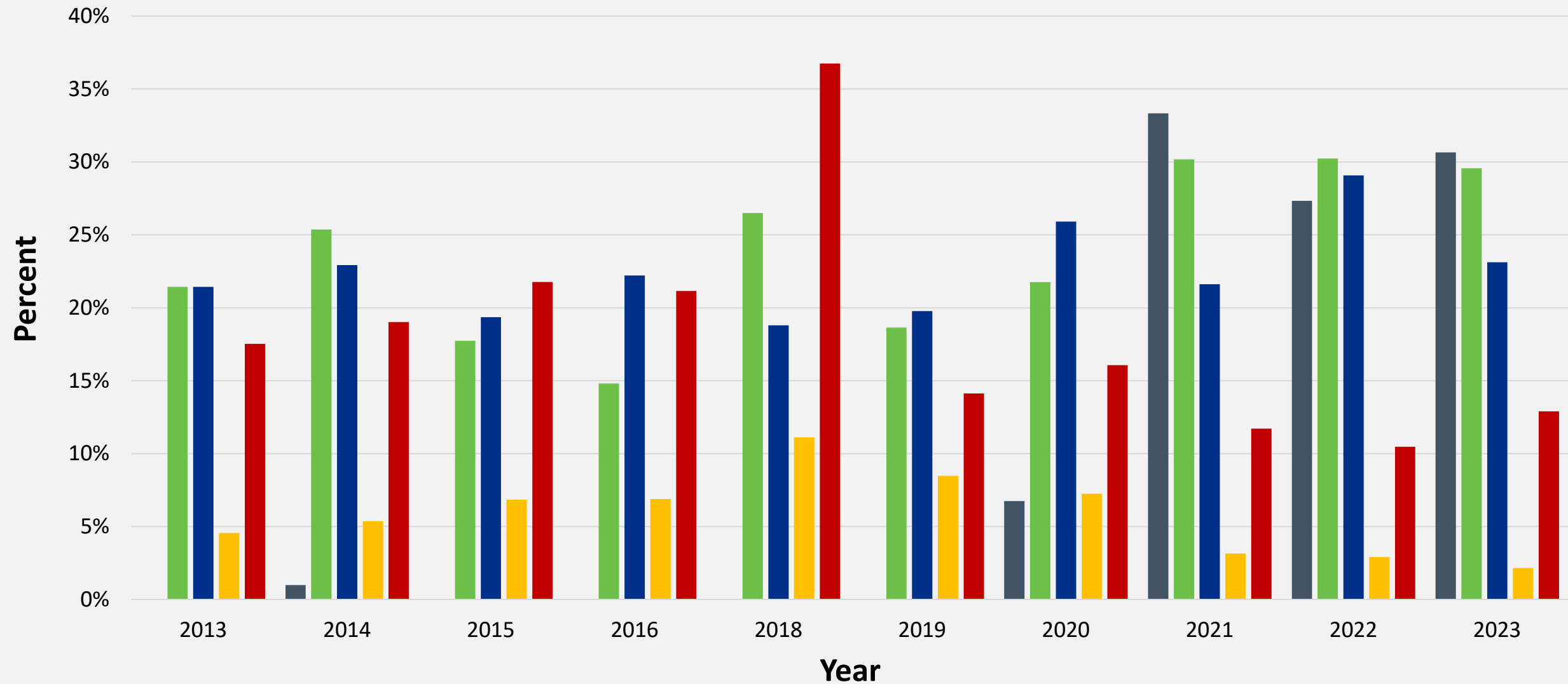
ISS ≥ 25 = profound trauma.

ISS - Urban Trauma Deaths, Texas, 2013-2023



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

ISS – Rural Trauma Deaths, Texas, 2013-2023



Frontier ISS data was suppressed due to low numbers.

ISS 0 ISS 1-8 ISS 9-15 ISS 16-24 ISS 25+

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

Summary

- The trauma death rate stayed relatively consistent between 2013-2023.
- Most trauma deaths occurred in urban areas, which is also where most trauma patients were seen.
- In urban areas, trauma deaths occurred most often in patients with higher ISS scores (25+), while in rural areas, trauma deaths occurred in patients with lower ISS scores (1-15).
- Future areas of focus?

Thank you!

EMSTR Program Updates and Trauma Deaths Over Time

Injury.Prevention@dshs.texas.gov



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7. Discuss and evaluate: Recommendations regarding the use of health information exchanges (HIEs) for radiological image sharing for patient transfers to enhance patient care by enabling secure, efficient, and real-time access to diagnostic imaging, reducing duplication of studies, and facilitating advanced care planning at receiving facilities.



8. GETAC Committee Action Items



8.c. GETAC Disaster Preparedness & Response Committee Update to Council

Chair: Eric Epley, CEM, NREMT-P

Vice-chair: Wanda Helgesen, RN



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June 2025 Meeting Summary

- EMTF Program Updates
 - EMTF Medical Directors came to consensus on Pain Management
 - 10% Increase in Activations (FY24 to FY25 to date)
- Pulsara and wristband update
 - Emphasis on value-add proposition for EMS
 - CAMTS Guidelines on Mobile Devices in Air Medical Environment
- National Disaster Medical System (NDMS) 2.0 Pilot Project
- Recommendation to Add Burn Care & World Cup as Standing Agenda for DP&R

8.c.A. GETAC Pre-Hospital Whole Blood Task Force Update to Council

Chair: Eric Epley, NREMT-P, CEM

Vice-chair(s): Donald Jenkins, MD, FACS; C.J. Winckler, MD



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June 2025 Meeting Summary

- Legislative Updates
- Pre-Hospital Blood Transfusion Coalition (PHBTC)
 - Billing Presentation
- Financial Barriers for Blood Centers
- Alternative Collection Processes
 - Hospital-Based Blood Donor Services and/or Walking Blood Banks
- Whole Blood Positioning Project (UT Health EMS Fellows)

June 2025 Announcements

Join the Discussion with National and International Whole Blood Leaders and Stakeholders from:

- Academia
- Trauma Centers
- Blood Centers
- Pathologists
- EMS Agencies
- Department of Defense

**For more
information or
to register visit:**



8.a. GETAC Air Medical & Specialty Care Transport Committee Update to Council

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

Vice-Chair: Cherish Brodbeck, RN, LP



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AMSCT Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
Coordinated Clinical Care: <i>Texas Department of Public Safety – State Troopers</i>	- Local classes to begin in the Houston & Fort Worth areas with 2 DPS Sergeants that are Academy Instructors - Feedback to be received from those classes - Revisions as needed - Final presentation anticipated to be ready for Q3 committee & Council approval	
Prevention: <i>HEMS Specific Mental Health Awareness</i>	- Resource document complete - Committee approval received 6/4/2025 - Seeking Council approval today, 6/6/2025	

8.a.A.

Approve: Helicopter Emergency Medical Services (HEMS)-Specific Mental Health Awareness Resource Document

Provided by the GETAC Air Medical & SCT Committee



Your Mind Matters

HEMS Resources for Crisis & Mental Health Management

MENTAL HEALTH RESOURCES:

UT Health Houston - CBEAR First Responder Program

- No cost to all first responders in Texas.
- UT Health provides a confidential helpline to assist in locating suitable treatment and recovery options.
- "The First Responders Educational Campaign" is a free, research-driven initiative.
- The campaign is designed to equip first responders across Texas with valuable information about substance use & mental health disorders.

Heroes Helpline:
1-833-367-4689
1-833-EMS-INTX
First Responder Behavioral Health Training:
uthealth.catalog.instructure.com/browse/heroes/

ECHO-FAST

- Dedicated peer support for flight crew members.
- Services include both individual and team support options.
- Flight crew members have access to a peer support hotline available 24/7.
- FAST can mobilize trained peer support teams to various locations throughout Texas and the U.S.
- Post critical incident support for immediate family members.

24/7 Peer Support Hotline (Call or Text)
1-833-247-3278
FAST Team Request:
1-803-526-7620
info@echoflightcrew.org
www.echoflightcrew.org/fast

3FTL

- They provide mental health treatment, case management, medical oversight, trauma-informed counseling, & peer support.
- Services include outpatient care, suicide stabilization, & detoxification.
- They collaborate with facilities across the state to offer long-term treatment options.
- Their mission is to save the lives of those who save us.

Text Jennifer Halley
469-400-8357
Website:
3FTL.com

Survivor's Network

- They build resilience in individuals and organizations through a strong support network.
- Offering educational resources & assistance to medical transport organizations, personnel, & families.
- Focusing on risk mitigation, improving preparedness, & enhancing recovery efforts.
- Raising awareness of industry challenges through targeted education & research.
- Promoting safety and resilience within the community.

Website:
www.survivorsnetwork-airmedical.org
Email:
AirMedSurvivors@gmail.com

LIFT

- The Leadership Incident Fortification Training (LIFT) Program is created by AAMS.
- It equips leaders in emergency medical transport with essential tools for managing high-stress & catastrophic situations.
- Resources that facilitate healing and recovery
- The ultimate goal is to foster post-traumatic growth for both individuals and organizations.

Website:
aams.org/page/lift

Need to talk now?
Call or Text 988.
Free 24/7 Support
Suicide and Crisis Lifeline

AMSCT Committee

2025 Committee Priorities Update

Priority Not Implemented

Priority Activities Recorded

Priority Completed and Monitored

Committee Priorities	Current Activities	Status
Prevention & Injury: <i>Proper security of pediatric patients during air & ground transport</i>	- Survey complete - Workgroup being formed with representatives from AMSCT, Pediatric, EMS, & EMS Medical Directors Committee - Create 157.11 language - Strategies to increase usage compliance	
Performance Improvement & Patient Safety: <i>Fatigue Risk Management Programs for Air Medical & Specialty Care Transport Providers</i>	- Supporting research & data collection - Complete - Development of a White Paper supporting the implementation & utilization of a FRMP continues	
Coordinated Clinical Care: <i>Develop and disseminate education on how the No Surprises Act (NSA) is protecting patients from exorbitant air medical transport bills.</i>	- Air Medical resource utilization guidelines emphasis has been included - Resource document complete - AMSCT Committee approval received on 6/4/2025 - Seeking Council approval today, 6/6/2025	

8.a.B. Approve: Trauma Facility Helicopter Safety & LZ Training presentation



**Trauma Facility
Helicopter
Safety and
Landing Zone
Training**

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 - Seeking Council approval today, 6/6/2025	
Pulsara Implementation Guidelines for the Air Medical Provider	- Guideline creation – Complete - AMSCT Committee approval received 6/4/2025 - Seeking Council approval today, 6/6/2025	
Create education for state staff on the OLOS dispatching system	- Workgroup to be formed - Research and compile information about the OLOS system - Create & present education to the state staff at the Q3 meeting	

GETAC Committee/Stakeholder Action Item Request for Council August 2025

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

Air Medical & Specialty Care Transport Committee



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Texas Department of State
Health Services

Action Item Request and Purpose

- The AMSCT Committee requests to be placed on the Council agenda for the Quarter 3 meeting.
- 1 action items/request
- The purpose of the request is to seek Council approval of the completed, final version, of Texas DPS State Trooper educational program and approval to distribute/release the educational presentation to DPS Academy Leadership for use at their discretion.

Benefit and Timeline

- **Benefit**

- DPS Troopers will be educated on “when” and “how” to request air medical assets when EMS, Fire, and FROs have not yet arrived on scene, which will facilitate earlier pt access to definitive care.

- **Timeline**

- AMSCT Committee approval of presentation – Received 6/4/2025
- Pending Council approval, the first classes will be scheduled – TBD
- If necessary, revisions will be made & approval again sought from AMSCTC & Council – Q3 2025
- Pending Council approval, the completed presentation will be released to DPS Academy Leadership for use at their discretion

8.b. GETAC Cardiac Care Committee Update to Council

Chair: Dr. Jamie McCarthy

Vice-chair: Dr. Craig Cooley



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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.	Data reviewed from DSHS. Plan to further explore data elements to look for opportunities for improvement in timely transfers	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	In progress
3. Educate policymakers on the Texas Emergency Healthcare System.	Support use of RAC Data Collaborative across the state Collaborate with other relevant cardiac organizations Educate state leaders and legislature on importance of data sharing and state designation	Initial 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)	<i>Refining Data request for review with DSHS</i>	Initial discussion

8.d. GETAC EMS Committee Update to Council

Chair: Chief Kevin Deramus, LP

Vice-chair: Chief James Campbell, LP

Stand in: Chief Dudley Wait, LP



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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. Work <u>continues on this</u> with monthly public meetings where the rule is being gone through step by step.	Ongoing
Workplace Violence on EMS Personnel	Chief Hayes is leading the newly created committee workgroup to discuss the <u>ever increasing</u> concern and problem of workplace violence involving EMS personnel. Workgroup continues to meet and evaluate concerns. Discussion ensued in meeting on mechanisms to track all issues and not just those that rise to the level of “reporting”. Workgroup to continue this discussion.	Ongoing
Reduction of Red Lights and Sirens usage	This workgroup has begun to evaluate the earlier position statement on L&S usage. Other committees are reviewing that position statement as well and will deliver feedback to the workgroup.	Ongoing

EMS Committee

2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
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 <i>Stroke Committee recommendations approved by committee vote.</i> <i>EMS Committee is in support of the Stroke TEAM EMS-ED Study. Will name a couple of committee members to assist</i>	Complete
Pediatric Committee Support	Committee voted to approve the Pediatric Consideration for Consultation and Transfer documents as presented by the Pediatric Committee Committee is also naming participants to assist Pediatric Committee with two initiatives: Pediatric Pain Management and Pediatric Criteria for Blood Transfusions	Ongoing Ongoing

8.e. GETAC EMS Education Committee

Chair: Macara Trusty, LP

Vice-Chair: Christopher Nations, LP

*No action items for
Council this quarter.*



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8.f. GETAC EMS Medical Directors Committee Update to Council

Christopher Winckler MD, LP Chair

Elizabeth Fagan MD, Vice Chair



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Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

GETAC EMS Medical Directors

Committee Priorities	Current Activities	Status
Prehospital Stroke Recommendations	EMS Acute Stroke Routing Resource Documents for Pediatric Stroke. Routing Documents are recommendations to be acted on by RACs and/or Agency EMS Medical Directors as best practice per national guidelines. Mission Lifeline Algorithm Revisions. Voted on and Approved. EMS Acute Stroke Routing Resource Documents for Pediatric Stroke. Voted on and Approved. Adult Stroke Resource document. Voted on and Approved.	
Pediatric Consideration for Consultation and Transfer Documents to Review	Will review and make recommendations on the following resource documents: a) Child Physical Abuse Toolkit b) Pediatric Interfacility Transfer Quality Improvement Plan	

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being
Monitored

GETAC EMS Medical Directors

Committee Priorities	Current Activities	Status
Emergency Transport Task Force Discussion	Will assist with staffing of task force to develop and recommend interfacility transfer terminology.	
American Burn Association Transfer Guideline	Voted on and Approved.	
Heat Stroke Resource Documents	These Documents discuss the treatment of a patient in heat stroke. It also covers the approach to address an MCI- Heat. Voted on and Approved.	
Red Lights and Sirens	Council Action Item. Will work with Dr. Jarvis on this.	

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

GETAC EMS Medical Directors

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.	
TEAM EMS-ED Study	Endorsed Study. This Stroke committee project will be supported by Dr. Elizabeth Fagan.	
Aircraft Utilization Resource Document.	Discussed best practices for Air Medical Transport. Document Voted on and Approved with minor edits agreed upon in EMS MD Committee.	

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being
Monitored

GETAC EMS Medical Directors

Committee Priorities	Current Activities	Status
Pediatric Pain Assessment	Pediatric Pain Assessment and Management. Dr. Taylor Ratcliff will assist GETAC Pediatric Committee.	
Pediatric Blood Transfusion Guidelines	Pediatric best practice resource document. Dr. Winckler Will assist GETAC Pediatric Committee.	
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	

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

GETAC EMS Medical Directors

Committee Priorities	Current Activities	Status
Prehospital Blood Transfusions	Need to support education, training, compliance, operations and performance improvement with resource documents. Will work with GETAC WB Task Force. Dr. Winckler et al. will work on this.	

8.g. GETAC Injury Prevention & Public Education Committee Update to Council

Chair: Mary Ann Contreras, RN

Vice-Chair: Courtney Edwards, DNP



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IPPE Committee 2025 Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
Clinical Elements : Identify evidence-based prevention strategies that to increase capacity for a safe and healthy lifestyle. (Objective 4 of Clinical Elements/Injury) ➤ Promote coordinated capacity expansion of Child Passenger Seat Technicians in the State of Texas	Workgroup identification of strategic plan to increase CPST availability from the technician population ratio from 1:1,279 to 1:1,000 by December 2028. Initial steps include: • increasing technician courses, • partnering with community organizations, • establishing technician incentives, • developing mentorship programs, and • developing regional hubs for instructor-led training.	
System Support: Explore innovations for providing interactive, collaborative, and targeted public education. (Objective 2 of System Support/Public Education) ➤ 1. Develop innovative and applicable knowledge content in drowning prevention strategies for public consumption across the State of Texas	Workgroup identification of means to collaborate with existing agencies, including the Texas Drowning Prevention Coalition, to develop a tailored statewide plan aligning with the national plan that promotes drowning prevention strategies for public consumption across the State of Texas. • Assess current rates of drowning in specific types of bodies of water in the State of Texas • Explore best practice strategies • Create a plan of implementation of public education and bystander intervention for drowning prevention	

IPPE Committee 2025 Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
<u>Clinical Elements :</u> • Involve stakeholders in strategic discussions. (Objective 2 under Clinical Elements/System Integration) • Identify and incorporate all patient populations, including children, into system design. (Objective 3 under Clinical Elements/System Integration) ➤ Create a workplace violence position statement paper in which various stakeholders cooperate and build upon shared ideologies and values to enhance clinical performance and reduce injury to healthcare professionals.	• Review literature on the current state of workplace violence in the healthcare system, including successful measures to mitigate harm • Develop recommendations for uniform standards of practice to reduce workplace violence that can be integrated into healthcare systems • Focus areas include worker wellness, fostering the reduction of occupational stress • Draft recommendations have been completed and workgroup of committee members and public members to review. The goal is to have a document to send to other committees in preparation for the August meeting.	

8.h. GETAC Pediatric Committee Update to Council

Chair: Christi Thornhill, DNP

Vice-chair: Belinda Waters, RN



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Pediatric Committee

2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
Develop a pediatric imaging guideline for transferring facilities following the ALARA principles	1. Research and develop a best practice guideline for imaging in pediatric patients following the ALARA principles for pediatric patients. 2. Provide education for transferring and receiving facilities regarding over-imaging of children and delay of transfer due to unnecessary imaging at the referring facility. 3. Utilize Regional PRISMs, Hospital PECCs, and RACs to disseminate guidelines and education.	
Develop a pediatric transfusion/massive transfusion guideline for transferring facilities	1. Research and develop a best practice guideline for pediatric transfusion/massive transfusion guideline. 2. Provide education for transferring facilities regarding the pediatric transfusion/massive transfusion guideline. 3. Utilize Regional PRISMs, Hospital PECCs, and RACs to disseminate guidelines and education.	

Pediatric Committee

2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
Develop a pediatric guideline for transferring facilities for pediatric pain assessment and appropriate pain management	1. Research and develop a best practice guideline for pediatric-specific pain assessment and pain management. 2. Provide education for transferring facilities regarding pediatric pain assessment and pain management. 3. Utilize Regional PRISMs, Hospital PECCs, and RACs to disseminate guidelines and education.	
Request and review data from the state registry and National Pediatric Readiness Improvement Project regarding vital signs and weight in kilograms obtained on pediatric patients.	1. Utilize Regional PRISMs, Hospital PECCs, and RACs to disseminate best practices regarding a complete set of vital signs and weight in kilograms for pediatric patients. 2. Increase compliance.	
Complete 2024 priority of developing a toolkit regarding pediatric magnet/button battery ingestion.	1. Complete toolkit 2. Present to GETAC for approval 3. Utilize Regional PRISMs, Hospital PECCs, and RACs to disseminate information.	

Pediatric Committee

2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
Complete the 2024 priority of developing a toolkit regarding Sudden Cardiac Arrests/Deaths in Pediatrics	1. Complete toolkit 2. Present to GETAC for approval 3. Utilize Regional PRISMs, Hospital PECCs, and RACs to disseminate information.	
Pediatric Simulations	1. Monitor utilization of 13 pediatric simulations by regional PRISM's. 2. Request data from state regarding trauma center compliance with bi-annual simulations after rule 157.126 is in effect.	

8.h.A. Approval: Pediatric Consideration for Consultation and Transfer document

Deferred to Q3 for additional revisions based on cross-committee feedback.



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Action Item Request and Purpose

- Request approval of the GETAC council for the revised Consideration for Pediatric Consultation and Transfer Guideline
 - To be able to post the approved toolkit to the Pediatric Committee website
- Request approval of the GETAC council for the Pediatric Imaging Guideline
 - To be able to post the approved toolkit to the Pediatric Committee website
- Request approval of the GETAC council for the Magnet/Battery Ingestion Toolkit
 - To be able to post the approved toolkit to the Pediatric Committee website
- Request approval of the GETAC council for the Sudden Cardiac Arrest/Death Toolkit
 - To be able to post the approved toolkit to the Pediatric Committee website

Action Items and Requests

- Public resource for the Consideration for Pediatric Consultation and Transfer Guideline
 - Requesting approval at the August 2025 GETAC Council meeting
 - To be able to post the approved toolkit to the Pediatric Committee website
- Public resource for the Pediatric Imaging Guideline
 - Requesting approval at the August 2025 GETAC Council meeting
 - To be able to post the approved toolkit to the Pediatric Committee website
- Public resource for the Magnet/Battery Ingestion Toolkit
 - To be able to post the approved toolkit to the Pediatric Committee website
- Public resource for the Sudden Cardiac Arrest/Death Toolkit
 - Requesting approval at the August 2025 GETAC Council meeting
 - To be able to post the approved toolkit to the Pediatric Committee website

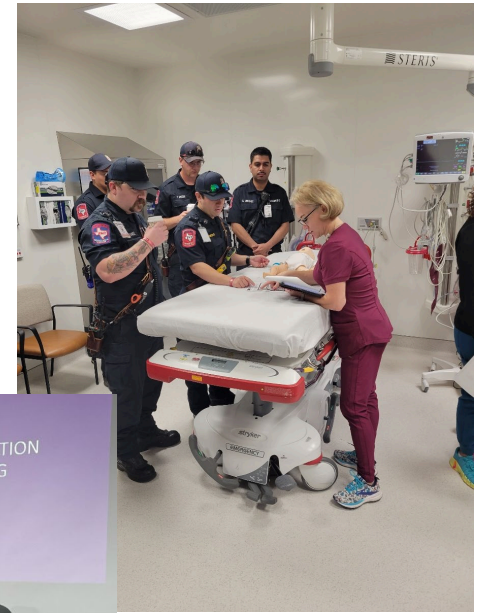
8.h.B. Update: TX Pediatric Readiness Improvement Project

Dr. Kate Remick



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Texas Pediatric Readiness Improvement Project Update, Phase 1 Summary
GETAC June 2025

Texas Pediatric Readiness Improvement Project (TPRIP)

Project Arms:

- TPRIP Virtual Education Series - Season 2
- 13 Standardized Pediatric trauma simulation scenarios
- 14 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

TX PRIP Education Series Attendance

March 2025 - Abdominal Surgical Emergencies

Registered - 596

Unique Users - 250

April 2025 - Improving Pediatric Acute Through Simulation

Registered - 681

Unique Viewers - 225

May 2025 - Improving Pediatric Emergency Care Nationwide: The National Pediatric Readiness Quality Initiative

Registered - 741

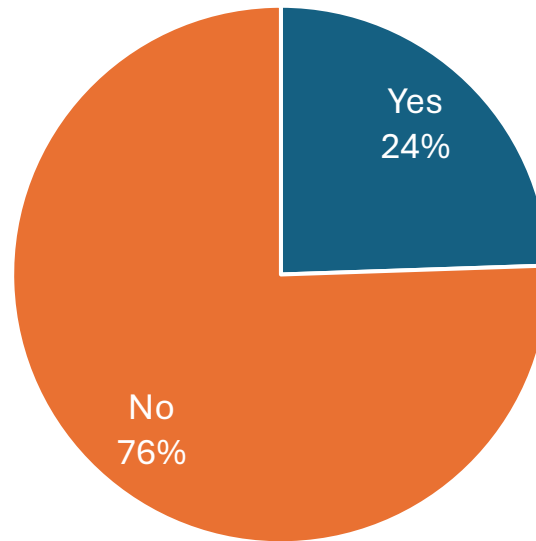
Unique Viewers - 210

Continuing Professional Development: Summary

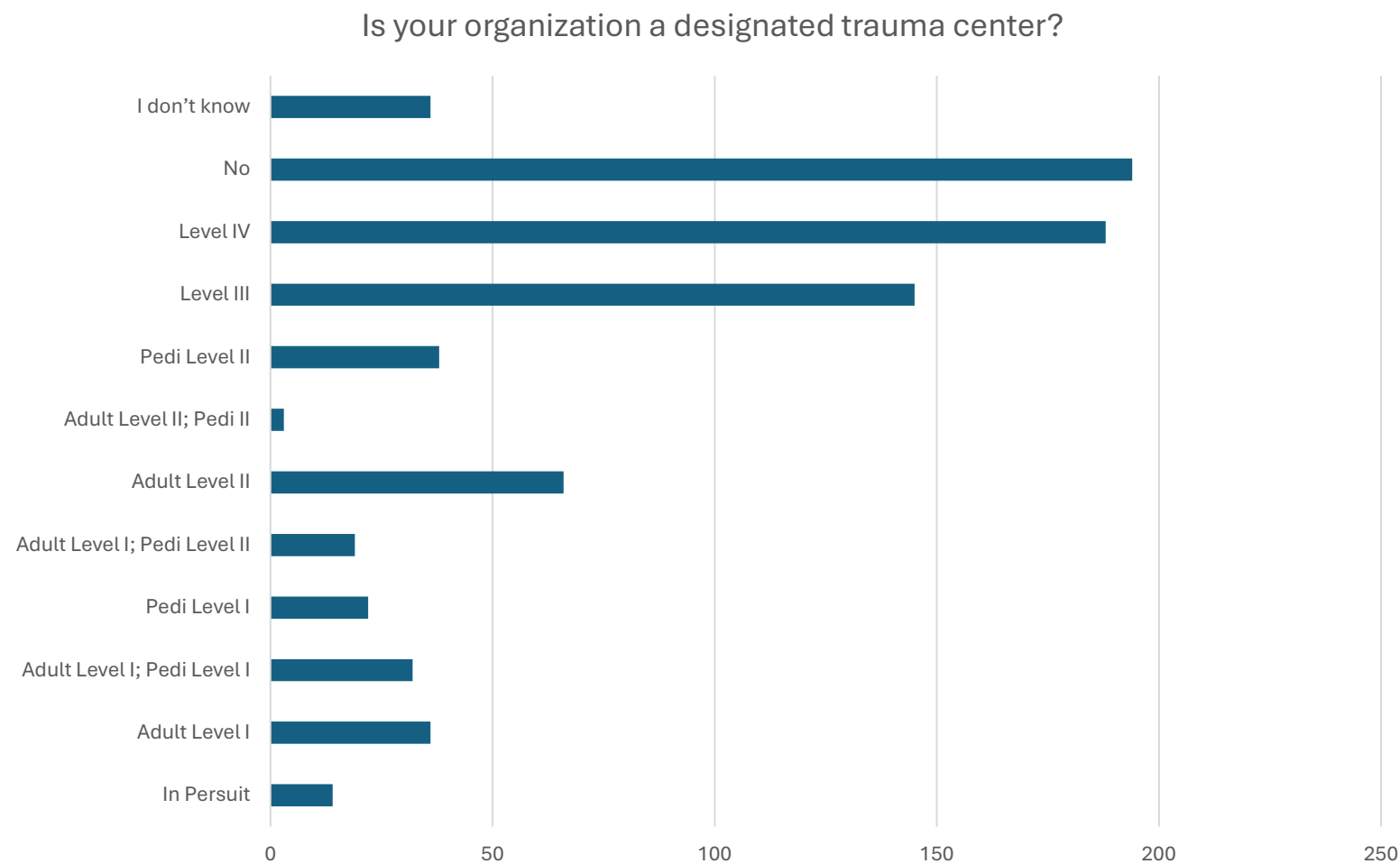
	Topic	Unique Viewers	NCPD Attendance	Average Evaluation Score
Session 1	Upper Airway Obstruction; Anaphylaxis		139	4.69
Session 2	Pediatric DKA		159	4.90
Session 3	Abdominal Surgical Emergencies	250	191	4.83
Session 4	Improving Pediatric Acute Care Through Simulation	225	161	4.78
Session 5	Improving Emergency Pediatric Care Nationwide (NPRQI)	210	144	4.77
Total Continuing Professional Development Hours Awarded			794	4.79

Continuing Professional Development: Summary

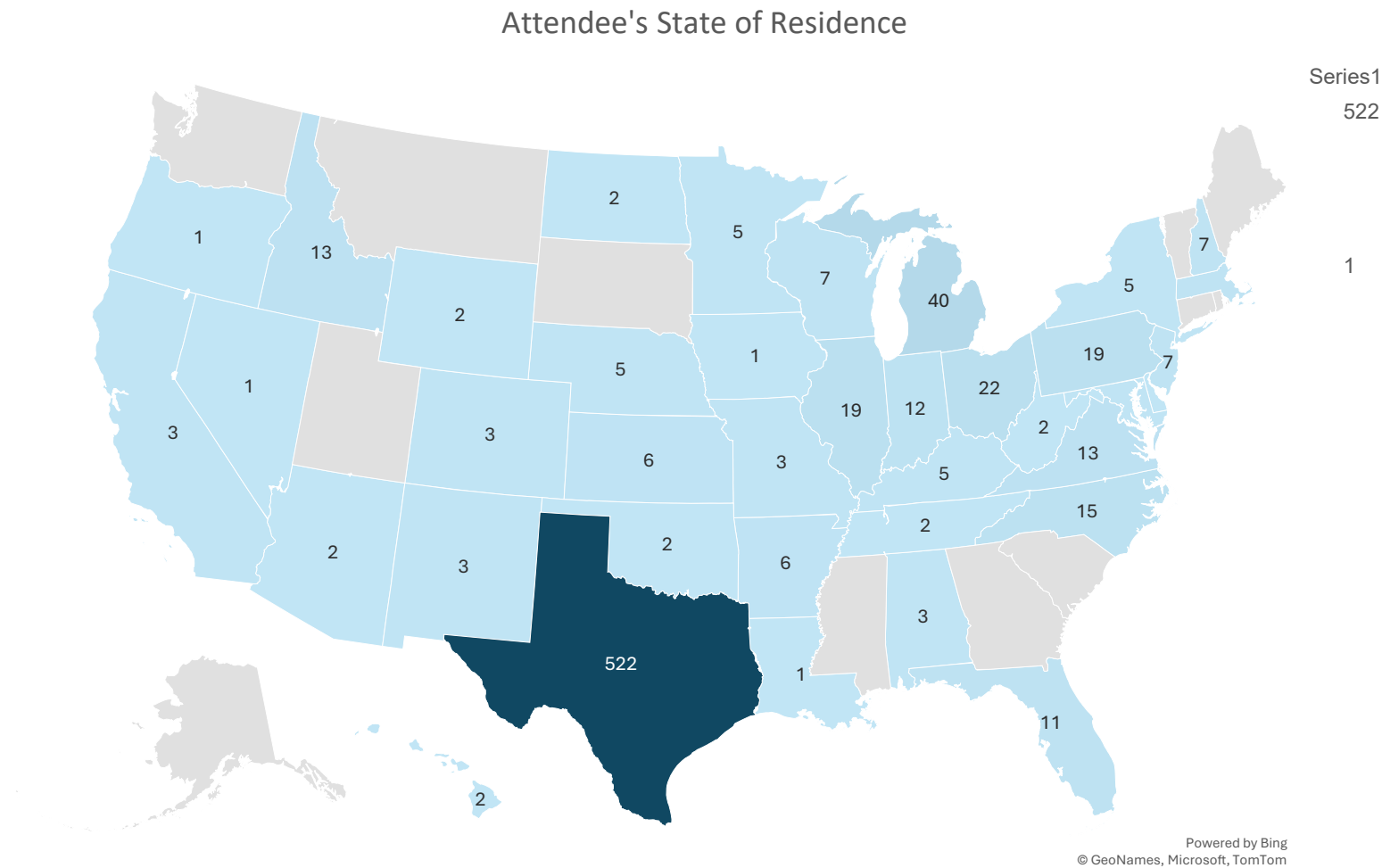
Do you serve as your organization's Pediatric Emergency Care Coordinator (PECC)?



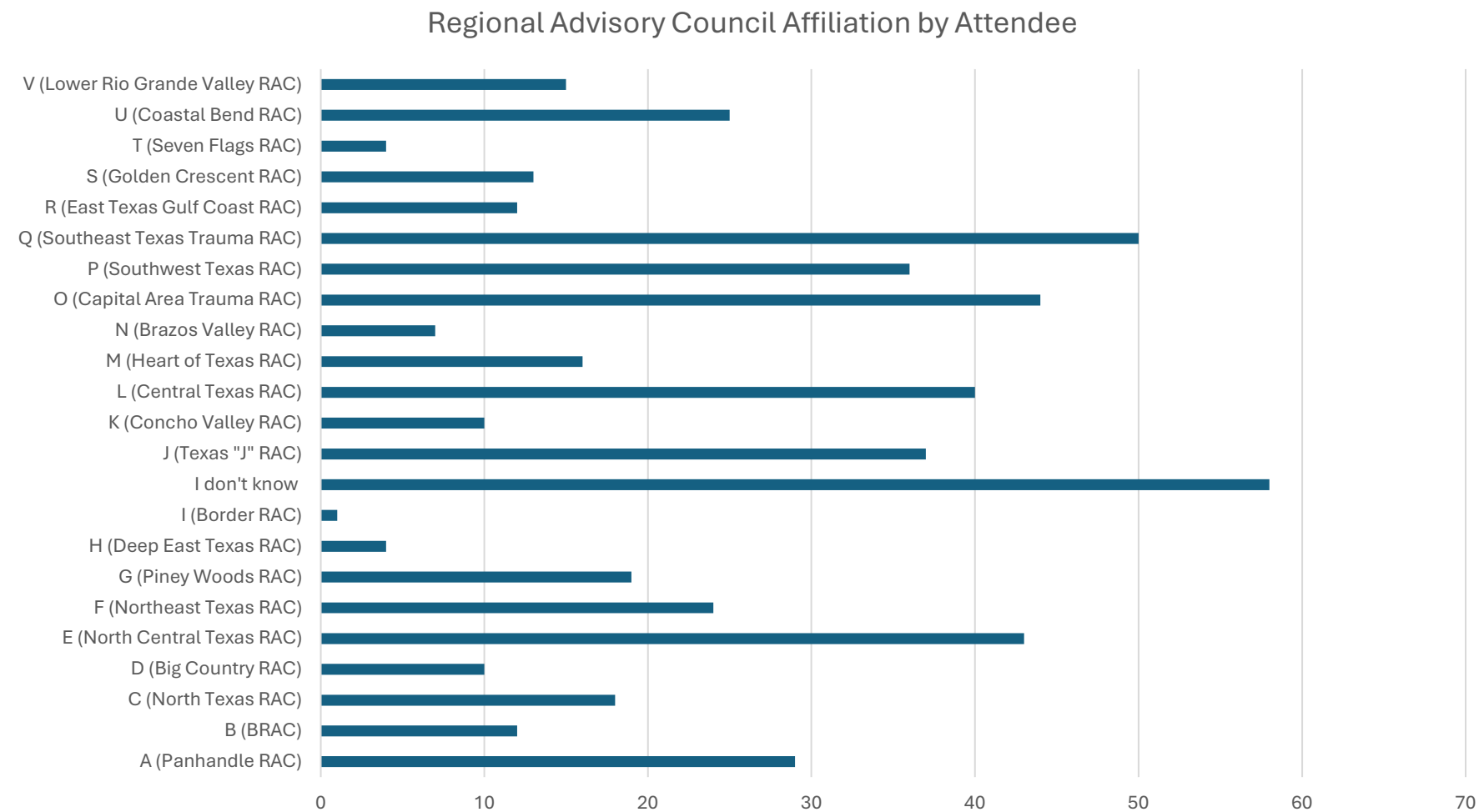
Continuing Professional Development: Summary



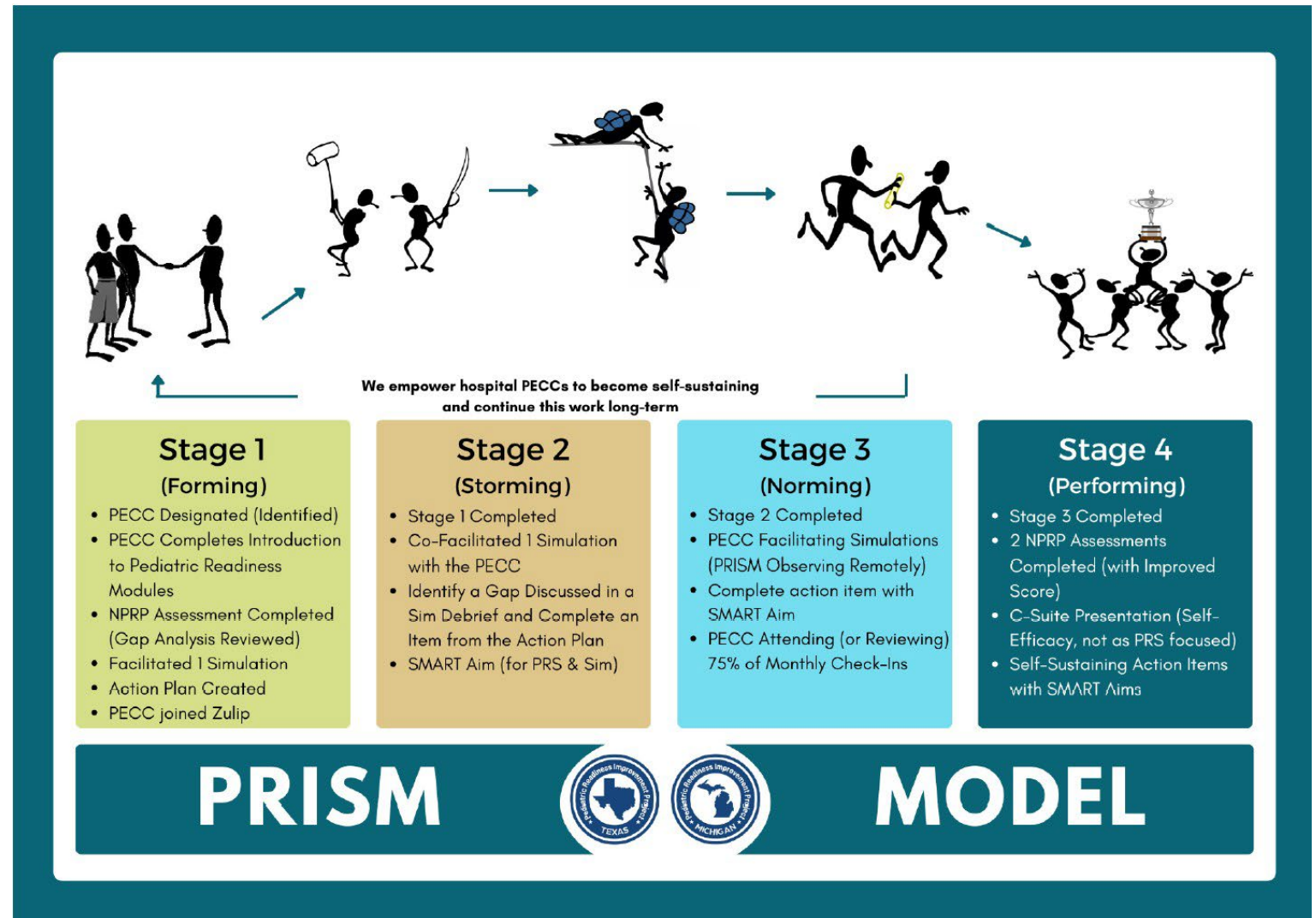
Continuing Professional Development: Summary



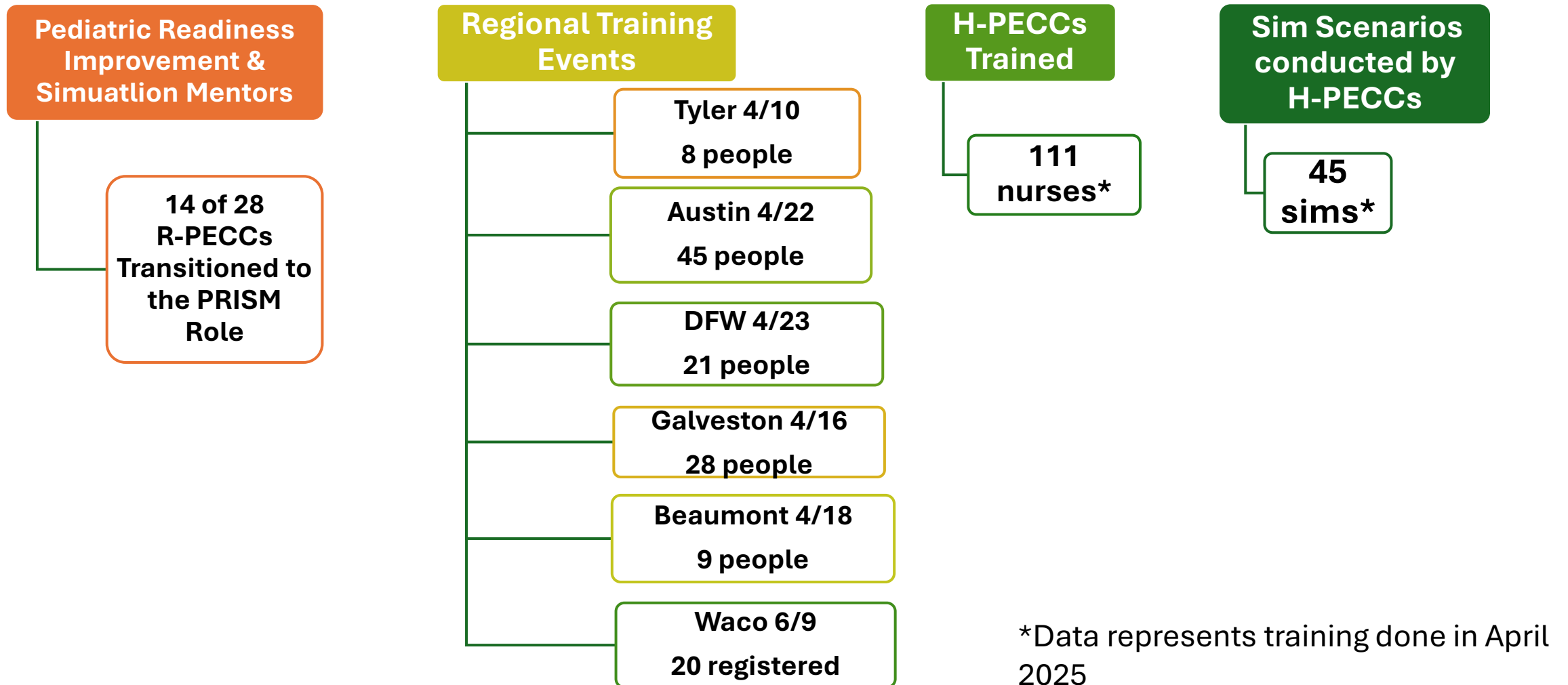
Continuing Professional Development: Summary

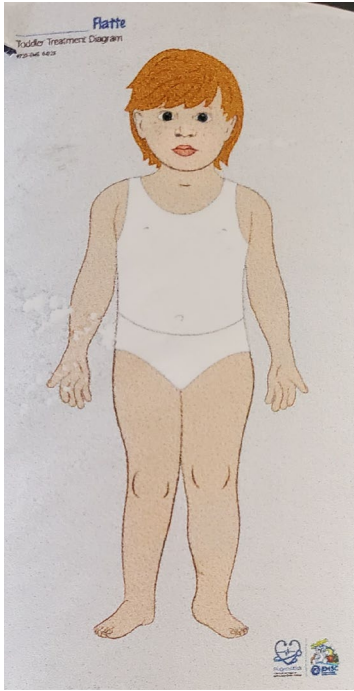


Pediatric Readiness Improvement and Simulation Mentor - PRISM

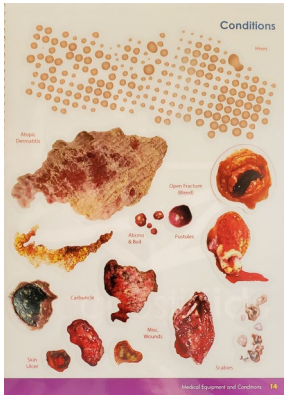
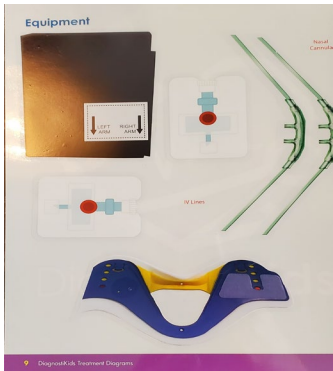
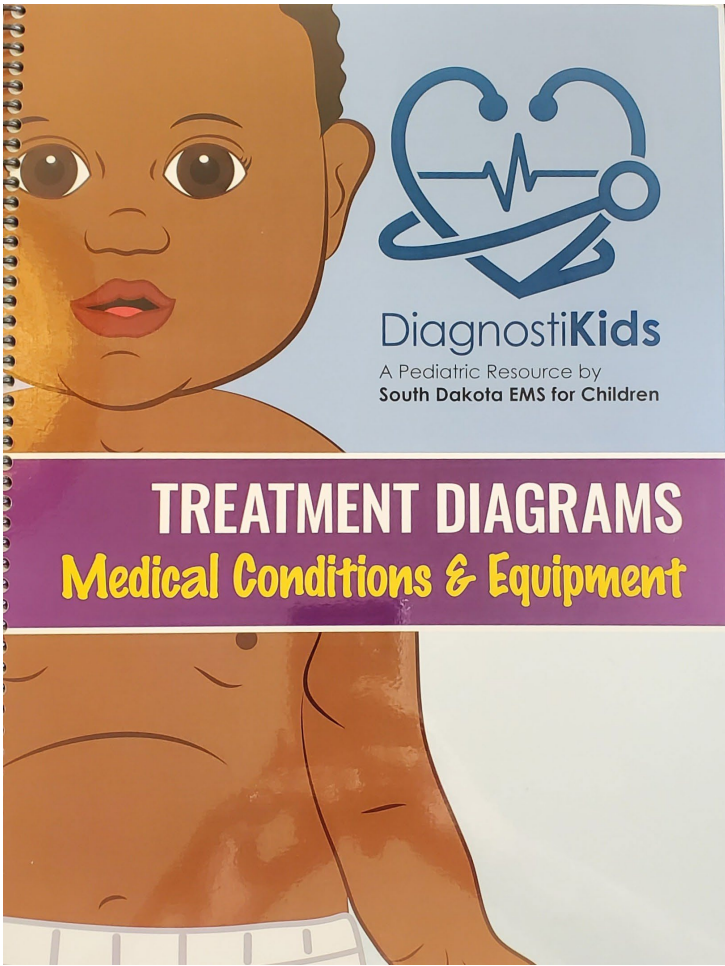


Phase 2 work by PRISMs with Hospital PECCs





The Flatte Family



<https://docs.google.com/forms/d/e/1FAIpQLSevTgbzGa9s-eM1kO7kGnDoM1WJQntoYeLxU69FEjGaRdN-ug/viewform?usp=header>

Simulation Videos Status

Complete and Available:

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

Still in Production:

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

NPRQI Reporting Dashboard
124 Sites / 24,480 Records

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

Year
Select all that apply
All

Quarter
Limit the # of Quarters by selecting Year(s) first
All

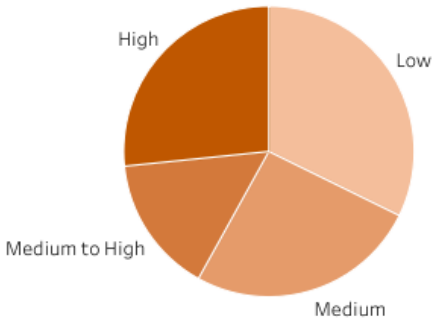
Site
Multiple values

Results View
Table

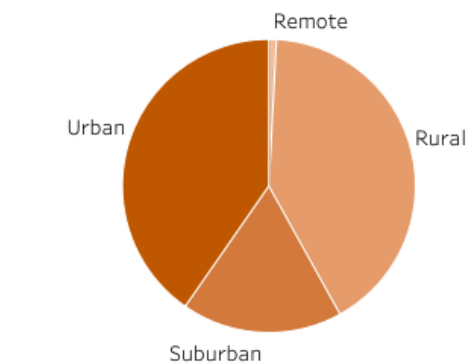
Patient Clinical Group
All Patients (Core Measures)



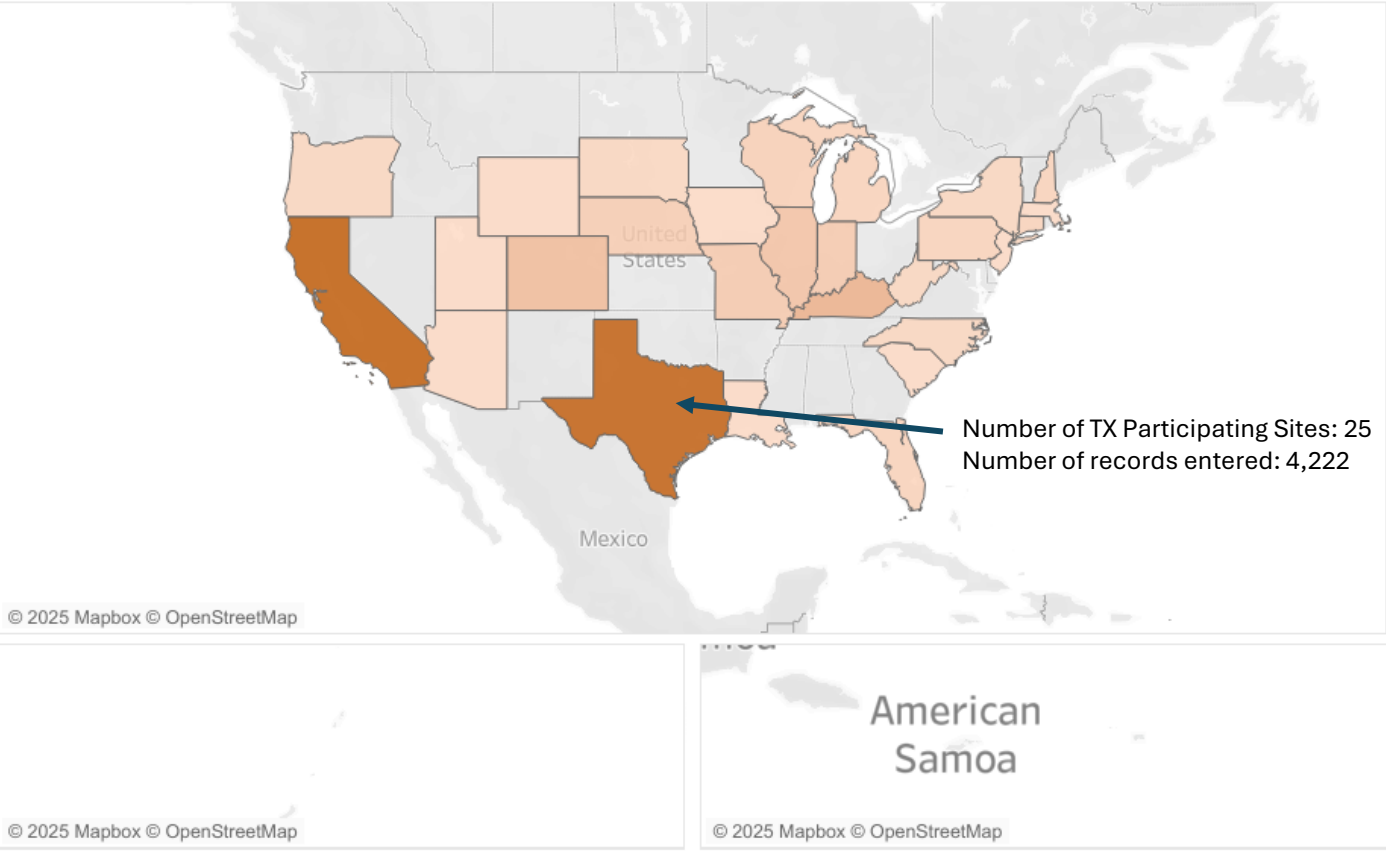
Number of Sites by Patient Volume Category



Number of Sites by Geographic Category



Participation in the National Pediatric Readiness Quality Initiative



NPRQI: Texas Participating Sites

Texas Registered Sites	64
Texas Sites with Executed POA	37
Texas Sites Entering Data	25
Texas Registered RACs	4 (I, J,K,0)

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

A- Panhandle

Golden Plains Com. Hospital *

B-B

University Medical Center *

C-North Texas

Graham Hospital District *

E-North Central Texas

Baylor All Saints Medical Center
at Fort Worth *

Methodist Southlake Hospital *

Texas Health Hospital Mansfield *

Methodist Richardson Medical
Center *

Palo Pinto General Hospital *

Medical City ER Saginaw

F-Northeast Texas

Titus Regional Medical Center *

G-Piney Woods

Christus Mother Frances Hospital –
Jacksonville *

Christus Mother Frances Hospital -
Winnsboro *

Christus Mother Frances Hospital – Tyler *

I-Border

El Paso Children's Hospital *

University Medical Center of El Paso *

J- Texas

Medical Center Health System *

Permian Regional Medical Center *

Ward Memorial Hospital *

Winkler County Memorial Hospital *

Big Bend Regional Medical Center



Denotes sites entering data

Minimum of 5 sites needed to see RAC dashboard

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

K-ConchoValley

Schleicher County Medical Center *

Lillian M. Hudspeth Memorial Hospital *

Reagan Hospital District

L-Central Texas

Adventhealth Rollins Brook *

Coryell Memorial Hospital *

M- Heart of Texas

Hill Regional Hospital

N- Brazos Valley

Baylor Scott and White Medical Center -
College Station

CHI St Joseph Health Burleson
Hospital

CHI St Joseph Health - College Station
Hospital

CHI St Joseph Health Grimes Hospital

CHI St Joseph Health Madison Hospital

St Joseph Regional Health Center

O-Capital Area

Baylor Scott and White Medical
Center - Marble Falls

P- Southwest Texas

Christus Children's *

R- East Texas Gulf Coast

HCA Houston Healthcare
Mainland

S- Golden Crescent

Lavaca Medical Center *

Cuero Regional Hospital *



Denotes sites entering data

Minimum of 5 sites needed to see RAC dashboard

Texas Sites By Regional Advisory Council (RAC) – Registration Started

A-Panhandle

Parkview Hospital - Wheeler

B-B

W.J. Mangold Memorial Hospital

C- North Texas

Faith Community Hospital

E- NorthCentral Texas

Texas Health Arlington Memorial Hospital

Methodist Mansfield Medical Center

Ennis Regional Medical Center

Lake Granbury Medical Center

F- NorthEast Texas

Christus Mother Frances Hospital -
Sulphur Springs

Titus Regional Medical Center

G- Pineywoods

Longview Regional Medical
Center

UT Health East Texas Pittsburg
Hospital

I-Border

William Beaumont Army Medical Center

J- Texas

Iraan General Hospital

Reeves County Hospital

O- Capital Area

Ascension Seton Bastrop Hospital

Ascension Seton Edgar B Davis

Ascension Seton Medical Center Austin

St. David's South Austin Medical Center

P- Southwest Texas

Guadalupe Regional Medical
Center

Q-SoutheastTexas

Houston Methodist West Hospital

Memorial Hermann Memorial City
Medical Center

Woman's Hospital of Texas

S- Golden Cresent

Memorial Medical Center

Yoakum Community Hospital

T- Seven Flags

Laredo Medical Center

R- East Texas Gulf Coast

Baptist Hospitals of Southeast
Texas

Christus Southeast Texas - St
Elizabeth and St Mary

Liberty - Dayton Regional
Medical Center

Memorial Hermann Pearland
Hospital

State Dashboard: Core Measures Table View

Performance Report: Texas

Year(s): All, Quarter(s): All | Clinical Measures Group: Patients with Head Trauma (Bundle only)

Measures with fewer than 10 records will not be displayed

State Performance (As Filtered) represents the average of site performances in Texas and responds to site and patient level filters (displayed with minimum of 5 sites)

*State-Wide Performance represents the average of site performances for ALL hospitals in Texas (displayed with minimum of 5 sites)

**National performance represents the average of site performances across all participating sites (displayed with a minimum of 5 sites)

Back to Landing

Last Dataset Refresh:
6/1/2025 7:22:31 PM

Last Patient Included:
5/31/2025

Site Demographics

Site Demographics filters are not applied to the State-Wide or National Metrics.

Specialty Center Status

All

Patient Volume

All

Geographic Category

All

Patient Demographics

Patient level filters are not applied to the State-Wide or National Metrics.

Age Category

All

Triage Level

All

Bundle	# of Records	Quality Measure	State-Wide Performance*	National Performance **	
HEAD TRAUMA	451	% of pediatric patients with a full set of vital signs obtained (i.e. temperature, heart rate, respiratory rate, oxygen saturation, blood pressure, mental status)	72.5 %	62.6 %	i
		% of pediatric patients with GCS re-assessment	63.9 %	32.4 %	i
		% of pediatric patients who received hypotonic saline	0.0 %	0.2 %	i
	109	% of pediatric patients with a head CT that met one or more PECARN criteria	71.6 %	60.8 %	i

NPRQI: Texas Suicide Measures

Performance Report: Texas

Year(s): All, Quarter(s): All | Clinical Measures Group: Patients with Suicidality (Bundle only)

Measures with fewer than 10 records will not be displayed

State Performance (As Filtered) represents the average of site performances in Texas and responds to site and patient level filters (displayed with minimum of 5 sites)

*State-Wide Performance represents the average of site performances for ALL hospitals in Texas (displayed with minimum of 5 sites)

**National performance represents the average of site performances across all participating sites (displayed with a minimum of 5 sites)

[Back to Landing](#)

Last Dataset Refresh:
6/1/2025 7:22:31 PM
Last Patient Included:
5/31/2025

Site Demographics

Site Demographics filters are not applied to the State-Wide or National Metrics.

Specialty Center Status

All

Patient Volume

All

Geographic Category

All

Patient Demographics

Patient level filters are not applied to the State-Wide or National Metrics.

Age Category

All

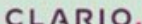
Triage Level

All

Bundle	# of Records	Quality Measure	State-Wide Performance*	National Performance **	
SUICIDALITY	1,015	% of adolescents who were assessed with a suicide screening tool	50.2 %	66.2 %	
	16	% of pediatric patients with a positive suicide screen who had a structured suicide assessment	--	97.4 %	
		% of pediatric patients with a positive suicide screen who received consultation with a licensed mental health professional	--	91.8 %	



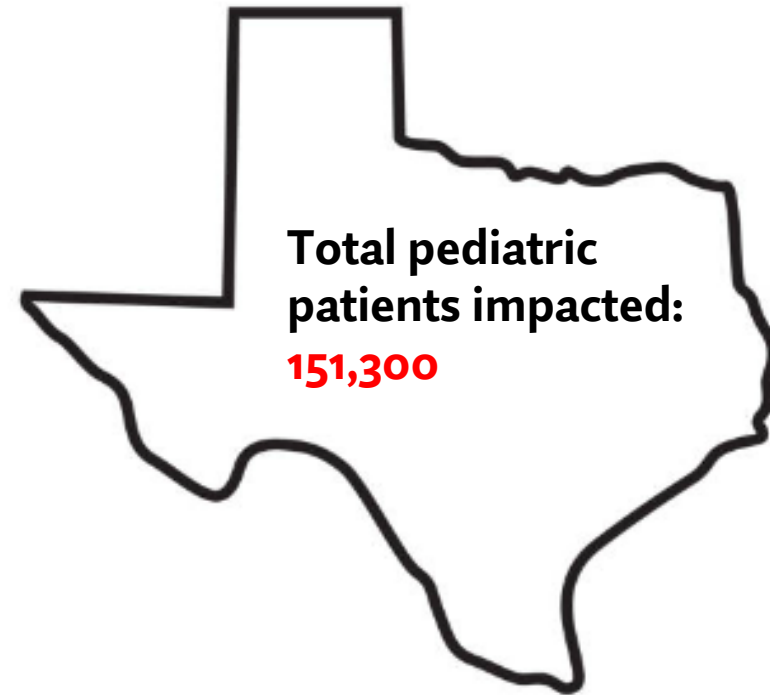
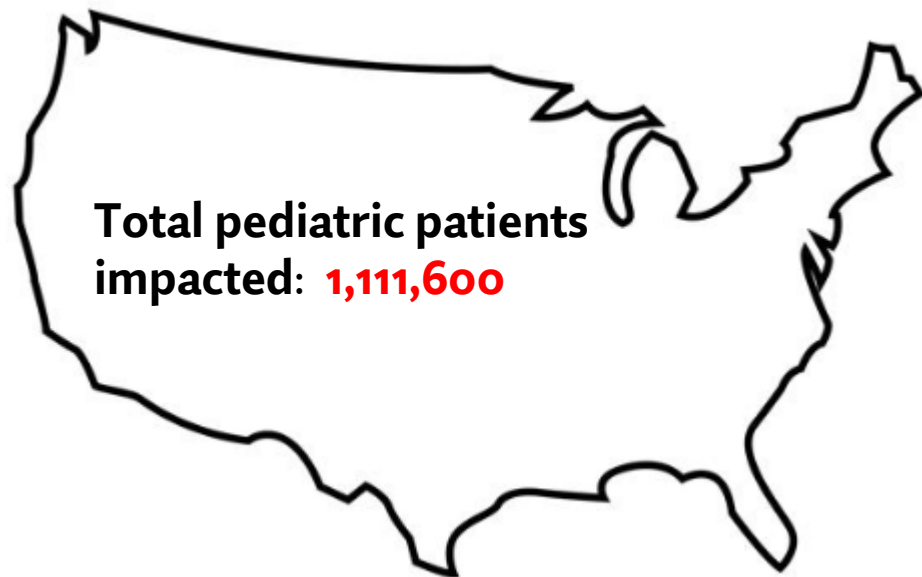
Age Category: All | Triage Level: All



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.

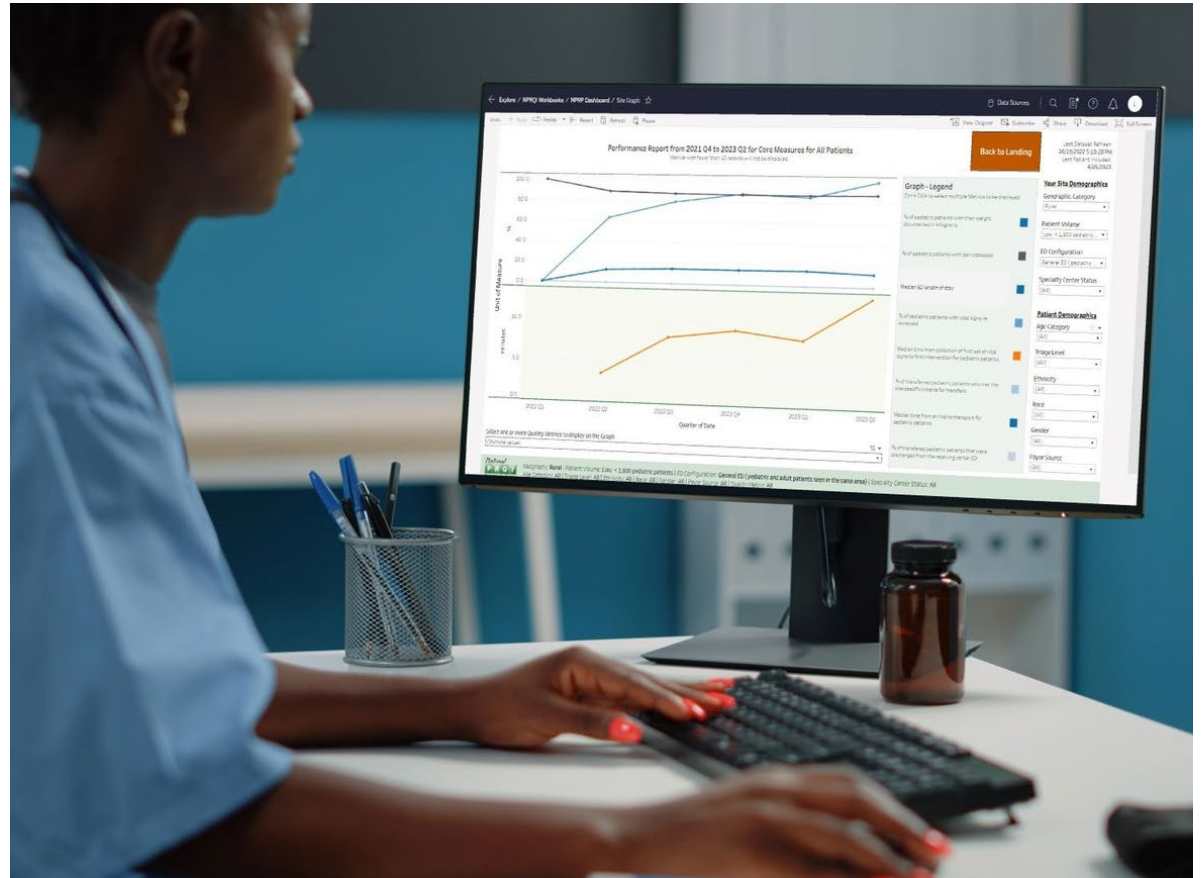


NPRQI: Patients Impacted



Future Plans

- Sustained funding through 2027
- System Upgrades underway
- Electronic Data Entry Exploration
- Upcoming Texas-centric Collaborative
 - Launch January 2026
- Obstetrical Emergency Care Measures



8.i. GETAC Stroke Committee Update to Council



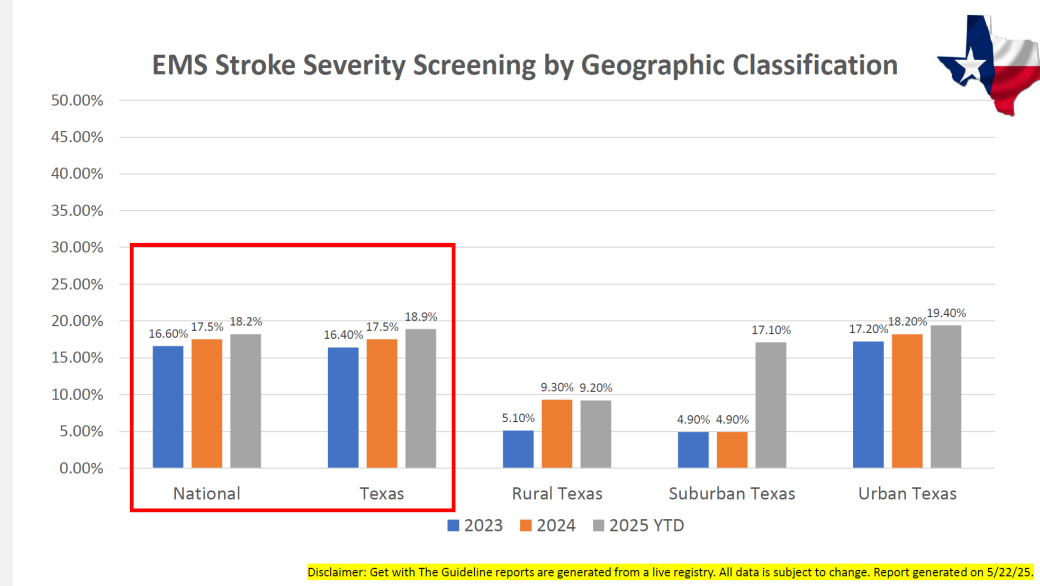
Stroke Committee

Priority Not Implemented
 Priority Activities Recommended
 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 approved endorsing participation with GWTG prehospital and interfacility layers.	
RDC report	- Update from RDC at Stroke Committee meeting. Discussion of 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 Discussion on GWTG super user account	
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 - Disseminate Stroke Committee and SSOC WG recommendation for internal review for hospitals.	

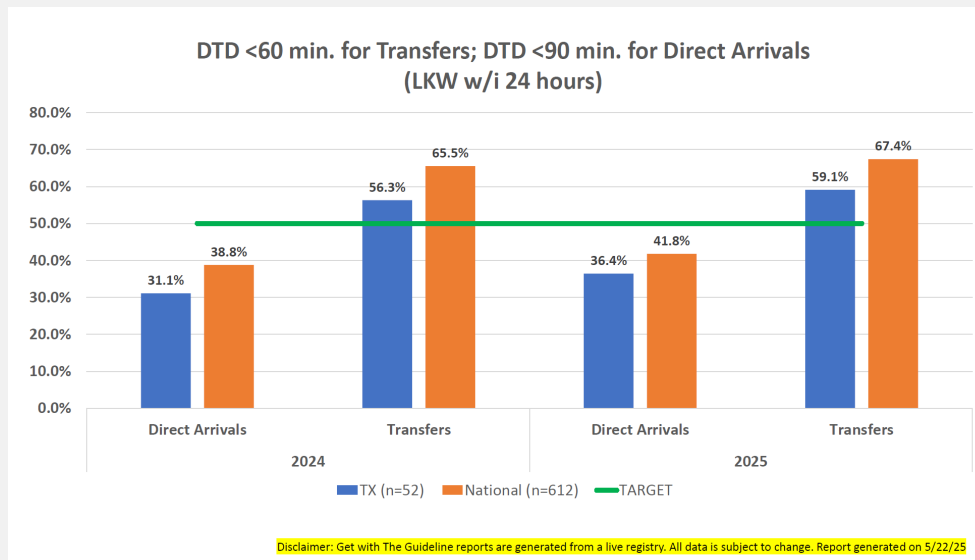
Highlights Texas Stroke Quality Report

- **Median DTN by RAC:** Texas continues to hold below the national median at 39 minutes.
- **Suburban hospital group** is relatively small in comparison to rural and urban and can be easily skewed based on just a few sites' data. Please keep this in mind while reviewing, as their metrics in some areas are significantly better than the other 2 groups.
- **Median DIDO for Acute Therapy Eligible Patients:** Texas continues to lag in the national average, but is seeing a better start to 2025, with a median of 142 minutes.
- **EMS Stroke Severity Screening:** Texas is experiencing continued improvement in compliance with documentation of this element and is slightly ahead of the national compliance rate at 18.9%.



Highlights Texas Stroke Quality Report

- **TPA vs TNK Usage slide:** There appears to be full transition to TNK in 13 additional RACS.
- **EMS on Scene Time:** Percentages of cases where EMS is spending more than 15 minutes on scene before transfer is increasing.
- **Stretch goal to 75% DTD in 90 minutes for transfer cases, since we are over the 50% goal set by GWTG in Texas.**
- **New GWTG Benchmark Groups:**
 - Allison has updated and created manually benchmark groups that can now be applied to the GWTG data for comparison.
 - 212 hospitals in Texas utilize GWTG. Of the 191 Texas-designated stroke hospitals, 168 utilize GWTG (87.9%).



Rural Stroke Facility Opportunity



Currently Participating



Texas Stroke GWTG Sample

- **212** TX Hospitals participating in GWTG
- **49** participating hospitals classified as **“Rural,”** using the Rural Urban Commuting Area (RUCA) codes 4-10 and 99
- **29** Rural sites joined as part of the **Rural Healthcare Outcomes Accelerator** program
- **84** participating in RDC = **40%** of TX GWTG Hospitals
 - PI Workgroup recommended goal = 60% (44 more hospitals)



American
Heart
Association.

RURAL HEALTH CARE OUTCOMES ACCELERATOR

Enrollment open until June 30, 2025

Project Mission

The **Rural Health Care Outcomes Accelerator** will work to ensure Americans living in rural areas have the best possible chance of survival and the highest quality of life attainable by promoting consistent, timely, and appropriate evidence-based care.

Rural Hospital Eligibility & Impact

Enrollment grants are available! Over 550 new participants have joined over the first 2.5 years of this program aiming to enroll 700 rural participants. While the Rural Accelerator is in its 3rd and final enrollment year, most of the program benefits will be sustained except the no cost access to Get With The Guidelines®. The time to join this dynamic program is now! 150 new rural program participant grants remain available within Get With The Guidelines® quality programs for coronary artery disease, heart failure, and stroke. Participants will be invited to learning collaboratives, clinical education courses, and benefit from specialized quality improvement consultation. Target participants include Critical Access Hospitals, Rural Emergency Hospitals and/or hospitals in geographic areas outside of an urban setting located within census tracts associated with Rural Urban Commuting Area of small, large, or isolated Rural.

Benefits for Rural Hospitals



Rural Quality Program Support

New participants will receive Get With The Guidelines®- Stroke, CAD or HF at no cost for 3 years beginning with the year of their enrollment (2025, 2026, 2027) and support by a dedicated AHA Rural Quality Program Consultant.



Rural Education

AHA professional membership scholarships, continuing education courses, and clinical expert guided toolkits that can easily be consumed and assimilated by rural hospital teams will increase the translation of rural acute care opportunities into routine practice. These multimodal stroke, cardiac, and heart failure resources will align with AHA's Quality Improvement & Certification Programs, Scientific Community recommendations, and Outpatient Programs such as Target: PB, Check. Change. Cholesterol, target: Type 2 Diabetes.



Rural Community Network

An AHA virtual network that encourages peer to peer connection of health care professions within the inpatient and outpatient communities through an innovative, accessible, and interactive platform.



Model Sharing & Research

AHA convened quarterly cardiac and stroke rural learning collaboratives provide a forum for sharing model practice strategies and promote opportunities to present at regional and national rural conferences. AHA's Rural Quality Team will convene rural clinical experts and leaders and ultimately establish a writing committee to develop and publish rural quality and outcomes research.



Rural Recognition

Equitable Get With The Guidelines®- Stroke, CAD and HF Rural Recognition Awards are available for rural hospitals who provide excellent care to these unique evidence-based performance measures.



For more information, please email RuralGWTGSupport@heart.org
or apply at heart.org/ruralaccelerator

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Stroke Committee

Priority Not Implemented
 Priority Activities Recommended
 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 approved endorsing participation with GWTG prehospital and interfacility layers.	
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NCTTRAC Proposed Recommendation

Comprehensive and Thrombectomy Capable Stroke Centers that perform mechanical thrombectomy should have adequate coverage to meet the emergent needs of multiple strokes. 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, 7 days a week, 365 days a year. The neurointerventionalist taking calls should be available by phone within 20 minutes and available on-site within 30 minutes from notification. When concurrent facilities are covered by either the primary or backup on-call provider, the following should be in place:

- * If one neurointerventionalist is primary on-call concurrently at 2 facilities there should be one dedicated backup on-call provider for each facility (e.g., two hospitals with shared coverage, one primary and 3 tier backup on-call coverage).
- * The dedicated primary neurointerventionalist on-call at one facility may serve as backup call for no more than 1 hospital at any given time (e.g. primary call at one facility and backup at one additional facility).
- * 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.

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:

- * 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.
- * If one physician is covering more than one facility or another service in the organization, there is a written plan for backup coverage.
- * Protocols and processes are developed and implemented to detail the system and organizations' plans to meet the emergent needs of multiple complex stroke patients.
- * Protocols and processes are developed in response to times organizations would not be able to provide mechanical thrombectomy services and subsequently transfer patients or notify Advisory -Capability with comment.

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:

- *Written call schedules are readily available outlining all of the hospitals that the primary and backup on-call providers are covering for the shift.
- *If one contracted physician is covering more than one facility, there is a written plan to meet the emergent needs of multiple stroke patients for each of the facilities.
- *Protocols and processes are developed in response to times 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 comment. *

Stroke Committee

Priority Not Implemented
Priority Activities Recommended
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 06/2025. • Approval items: Adult Resource Document	
Pediatric Stroke Task Force	• Algorithm put into final form and approved by required committees and pediatric stroke task force 06/2025. • Approval items: Pediatric Routing algorithm • The resource document needs final approval from the Pediatric Committee. Approved by the task force and required committees. • Pediatric Stroke Tip Sheet is still under review by the Pediatric Stroke Task Force. • Next steps, minimum capability recommendations for pediatric hospitals to be destinations for pediatric stroke.	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being
Monitored

Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• Worked with Drs. Fagan and Winckler from the last session presented revisions, which were 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. • Working on disseminating to Stroke programs and RAC chairs. • Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO • Stroke Committee liaison with EMS Education Committee	
TEAM EMS-Ed Study	• Study endorsed by Stroke, EMS and EMS Medical Directors Committees 06/2025. • Will reach out the EMS Education Committee • Study submitted to LSSC for funding. • Update about LSSC, desire to partner with TX projects/studies. • Call for members for the educational content writing group • Request Council endorsement of study	

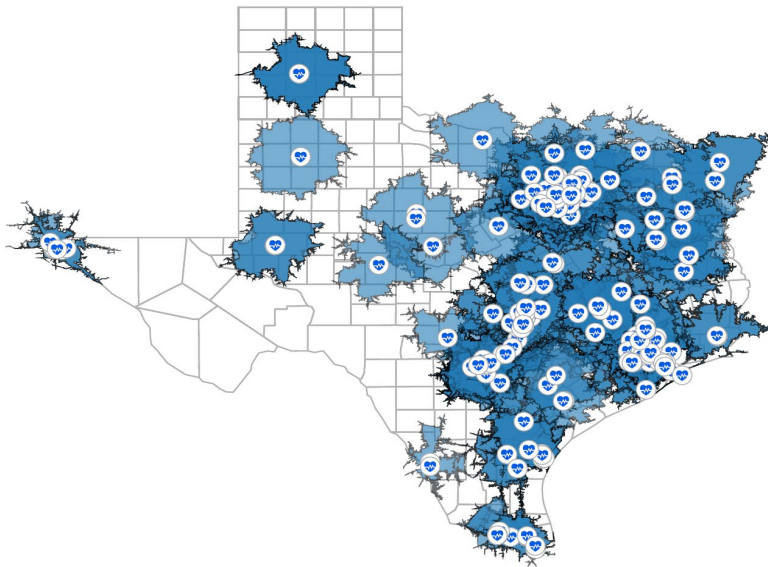
Stroke Committee

Priority Not Implemented
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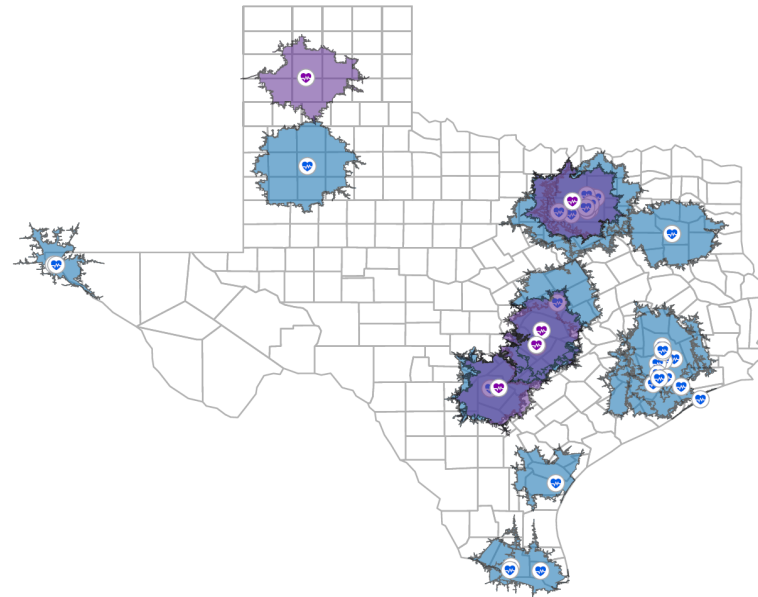
Committee Priorities	Current Activities	Status
Post Acute Stroke Care Work Group	- Approved by Stroke Committee 11/2024 - Dr. Sean Savitz will lead the work group Call for members, planned first meeting 07/2025	
Stroke Managers Mentorship Program and Texas Stroke Coordinators Collaborative Survey	- Education 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, continue to look at opportunities for disseminating the resource.	
Rural Stroke Work Group	Met twice after the prior session, plan to meet monthly. Working on defining rural and resource-challenged regions and hospitals to be included in the scope of work group. Working on questions for the needs assessment survey. Reviewed heat maps.	

Texas Stroke Heat Maps

**Texas Stroke Designated Hospitals
60 Minute Drive Time**



**Texas Stroke Designated Hospitals
60 Minute Drive Time
Level I and Level II**



Rural Stroke Work Group Action Items:

- Martee Tebow, Sarah Hancock, Jennine Fox, Dr. Mandy Jagolino-Cole, and Janine Mazabob will work on a recommendation for public awareness and education on stroke to target rural areas (English and Spanish) – target early September for presentation.
- Looking at performance measures that can be followed for rural areas.
- Guideline statements, AHA/ASA and BAC recommendations specific to rural stroke are being reviewed.

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and
being Monitored

Committee Priorities	Current Activities	Status
Texas EMS Stroke Survey	Results will be shared.	
The Stroke Committee endorsed stroke education and certification courses.	Ongoing effort identifying stroke educational opportunities for providers	
Stroke Education Resources for stroke facilities	Working with DSHS for website access to stroke education	
Work with DSHS to outline recommendations for stroke rules for ASRH	Pending further direction	

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

GETAC Stroke Committee

- **Committee items needing council approval:**

1. Adult EMS stroke resource document
2. Pediatric Stroke Routing Algorithm
3. Endorsement TEAM EMS-Ed study

- **Action items for the next session:**

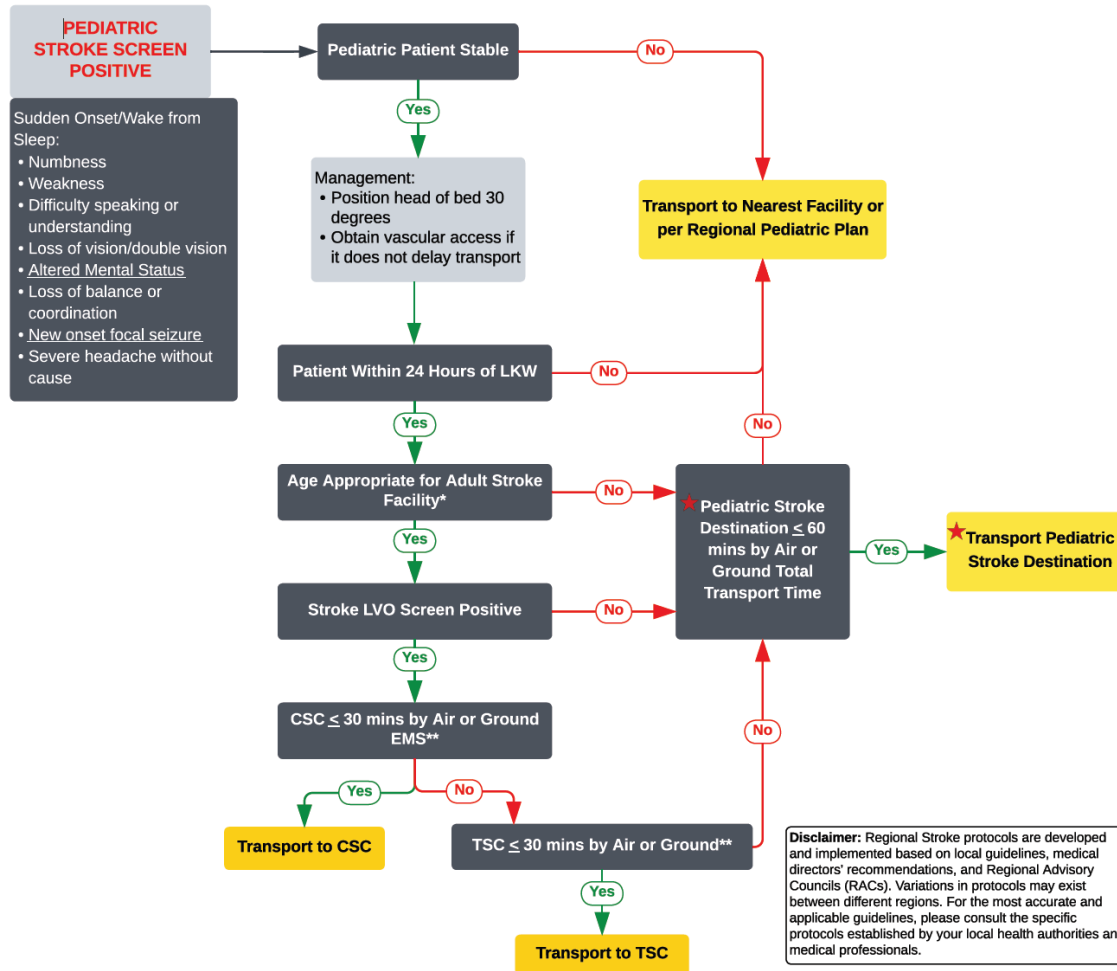
1. Pediatric Stroke resource document.
2. Pediatric stroke tip sheet and supplement
3. Rural Stroke Needs Assessment Survey

8.i.A. Approve: Pediatric Stroke Triage Algorithm with Resource Documents



EMS Acute Pediatric Stroke Routing Resource Document

INSERT WATERMARK - Resource Document



*Different adult stroke facilities will have different capabilities and willingness to evaluate and treat stroke patients under 18. RACs should outline the patients age appropriate for adult stroke facility admission based on regional facility resources and hospital policies; ** Within ≤ 30 minutes past the nearest Pediatric Stroke Destination and no more than 60 minutes total transport time by air or ground.

★ There are **no** formal national or statewide guidelines, certifications, or recognition systems for 'Pediatric Stroke Destination'. EMS Medical Directors should determine which nearby facilities they will direct pediatric patients with suspected or confirmed stroke. **MOST** of these facilities will be tertiary care children's hospitals. CSC: Comprehensive Stroke Center; TSC: Thrombectomy Capable Stroke Center; LVO: large vessel occlusion; RAC: Regional Advisory Council

APPROVAL ITEM 08/2025: Resource Document for Pediatric Stroke

PREHOSPITAL PEDIATRIC STROKE TRIAGE AND MANAGEMENT

1. Goals:

To increase EMS awareness and identification of strokes in the pediatric population (infants and children less than 18 years of age) and to facilitate rapid triage and transport to the nearest appropriate facility.

2. Purpose:

Pediatric Stroke is a rare disease that is, nevertheless, included among the top ten causes of death in pediatrics.¹ However, rapid recognition and appropriate treatment of pediatric stroke can profoundly improve outcomes for these children, sparing them from decades of disability.^{2,3} Thrombectomy has been shown to improve outcomes in pediatric large artery occlusion stroke.⁴ This guidance document is designed to help EMS providers recognize and triage pediatric stroke patients quickly, facilitating improved outcomes throughout the state.

The **GETAC Prehospital Pediatric Stroke Triage Algorithm** was developed in consultation with EMS, EMS leaders, and local, regional, and state medical authorities. The GETAC pediatric stroke algorithm was developed in consultation with the GETAC Stroke, EMS, Pediatric, EMS Medical Directors Committees, and the Council. Available guideline statements and guidance from the GETAC Pediatric Stroke Task Force (a consensus of expert opinion based on clinical experience in the fields of Vascular Neurologists, Neuroendovascular Surgeons, and pediatricians) were integral in the algorithm development.⁵⁻¹³ The recommendations were developed to ensure that all pediatric patients with a known or suspected stroke are rapidly identified, assessed, and triaged as outlined below. Standardizing care to rapidly diagnose and provide appropriate treatment will improve outcomes.⁹⁻¹² The prehospital pediatric stroke triage and transport recommendations serve to direct the regional triage of pediatric patients with acute stroke to the most appropriate facility. See **Annex A: GETAC Pediatric Prehospital Stroke Triage Algorithm**.

Last Update – 06.03.2025

There are no formal national or statewide guidelines, certifications, or recognition systems for Pediatric Stroke Destinations. EMS Medical Directors should determine which nearby facilities they will direct pediatric patients with suspected or confirmed stroke. A pediatric stroke destination should have personnel available to care for pediatric stroke patients and a pediatric intensive care unit. Pediatric stroke destinations should have a multidisciplinary team to care for pediatric stroke patients, the capability to administer antiplatelet drugs, anticoagulants, thrombectomy, and thrombolytic therapies, and the ability to treat complications. Pediatric stroke destinations should have the technical capabilities (including imaging capability, MRI if possible), policies, and procedures to facilitate optimal care of a pediatric stroke patient.⁹⁻¹² Pediatric hospitals that do not meet the above capabilities should be able to identify, stabilize, consult, and transfer patients to a center that can provide the appropriate care and rehabilitative resources.⁹⁻¹²

3. Prehospital Triage of Stroke in Pediatric Patients

Pediatric stroke can present with focal neurologic signs, as well as nonspecific signs like seizure or altered mental status.^{9,14-16}

Sudden onset of any of the following suggests the possibility of acute stroke:

- Numbness or weakness of the face, arm, and/or leg (especially on one side of the body)
- Confusion
- Trouble speaking or understanding language.
- Double vision, trouble seeing in one or both eyes.
- Altered Mental Status
- Trouble walking
- Dizziness
- Loss of balance or coordination
- Severe headache with no known cause (suggests hemorrhagic stroke), especially with altered mental status.
- ❖ For patients with any of the above neurological signs, especially with the listed conditions below, consider triaging as an acute stroke.

Patients with any of the following are at higher risk for acute stroke:

- Heart disease
- History of blood vessel problems in the brain
- History of stroke
- Sickle cell disease
- Cancer
- History of blood clots

Common pediatric stroke mimics:

- Alcoholic intoxication
- Cerebral infections

Last Update – 06.03.2025

APPROVAL ITEM 08/2025: Resource Document for Pediatric Stroke

- Drug overdose
- Hypoglycemia
- Hyperglycemia
- Genetic/metabolic disorders
- Atypical migraines
- Neuropathies (e.g., Bell's palsy)
- Seizure
- Post-ictal state
- Tumors

Basic Level

In suspected pediatric stroke cases, assess and treat ABCDEs per universal pediatric recommendations:

- **A (Airway):** Airway support and ventilation assistance are recommended for patients with acute stroke who have decreased consciousness or who have a compromised airway. Suctioning and oropharyngeal or nasopharyngeal airway as needed to ensure airway patency.
- **B (Breathing):** Supplemental oxygen should be provided to maintain oxygen saturation > 94% (continuous monitoring).
- **NOTE:** Some patients with congenital heart disease have a different goal saturation level (80-90% in some cases). If unsure, confirm the normal level with parents or caretakers.
- **C (Circulation):** Evaluate and treat signs/symptoms of shock according to the Shock Clinical Practice Guidelines
- **D (Disability):** Assess and document GCS, pupillary size, and reactivity.
- **E (Exposure/Environmental):** Assess for evidence of traumatic injury, especially head injury.

Stabilization and Initial Management:

- If there is evidence of shock, treat according to the Shock clinical practice guidelines.
- If there is hypoglycemia (POC glucose < 70 mg/dL),¹⁷ treat according to the diabetic emergencies clinical practice guidelines.
- If seizures occur, treat according to the seizure clinical practice guidelines.
- Place the patient in a supine position, head of the bed elevated 30 degrees.
- Cardiac monitoring during transport is recommended.

Cardiovascular Examination:

- Record blood pressure, rate, rhythm, respiratory rate, and oxygen saturation.
- Obtain an EKG if it will not delay transport.

Neurological Assessment for Pediatric Stroke:

- Weakness of the face, arm, and/or leg (especially on one side of the body)
- Numbness on one side of the face or body
- Confusion
- Trouble speaking or understanding language.

Last Update – 06.03.2025

- Double vision, trouble seeing in one or both eyes.
- Altered Mental Status
- Trouble walking
- Dizziness
- Loss of balance or coordination
- Severe headache with no known cause (suggests hemorrhagic stroke), especially with altered mental status.
- Seizure with post-ictal focal deficit (like weakness) that does not resolve quickly (~15 minutes).

History:

Interview the patient, family members, and other witnesses to determine symptoms, the time of symptom discovery, and the last known well (LKW) or the last time the patient was without symptoms. Ask about seizure at onset, head trauma, history of recent surgeries, history of bleeding problems/diagnosed bleeding disorders, and signs of possible brain hemorrhage (severe headache of sudden onset, nausea/vomiting with headache or loss of consciousness). Obtain a mobile number for the next of kin and witnesses.

- ❖ **NOTE:** For "wake-up strokes," the last known well time is the last time the patient was witnessed to be at baseline, which may have been the night before. The time they are found is not the time of the last known well.

Additional History:

- Obtain past medical history and history of past and recent surgeries.
- Allergies (e.g., iodinated contrast)
- Pre-existing substantial disability (e.g., unable to walk independently)
- Device and implant history (e.g., left ventricular assist device, pacemaker, valve replacement, VP shunt)

Medications:

- Obtain a list of all medications including antiplatelet agents (e.g., aspirin, clopidogrel [Plavix]) and blood thinners (direct thrombin inhibitors [dabigatran/Pradaxa], factor Xa inhibitors [fondaparinux/Arixtra, rivaroxaban/Xarelto, apixaban/Eliquis, edoxaban/Savaysa]), low molecular weight heparin [enoxaparin/ Lovenox], unfractionated heparin, bivalirudin, argatroban, warfarin [Coumadin].
- If possible, record when the last dose was taken.

Management:

EMS personnel should address ABCDEs per universal pediatric guidelines. Additional initial management steps include:

- Prevent aspiration, HOB > 30. Ensure airway patency with suctioning and OPA or NPA as needed.
- Provide supplemental oxygen if needed to keep oxygen saturation > 94%.
 - (Adjust if the patient has known congenital heart disease with a different goal oxygen saturation)
- Treat hypotension per regional pediatric protocols.

Last Update – 06.03.2025

APPROVAL ITEM 08/2025: Resource Document for Pediatric Stroke

- Maintain blood pressure below 20% above the 95th percentile for age.¹² Call online medical control if the systolic blood pressure is consistently above this percentile. The table below is an example of the upper limit of systolic blood pressure by age.

Age	Goal Systolic Blood Pressure
1-4 years	<130mmHg
5-10 years	<145mmHg
11-17 years	<160mmHg

- Hypoglycemia (blood glucose < 70 mg/dL) should be treated in patients suspected of acute ischemic stroke.¹⁷ Evidence indicates that persistent in-hospital hyperglycemia during the first 24 hours after stroke is associated with worse outcomes and increased risk of hemorrhagic conversion in adults than normoglycemia. You should treat hyperglycemia with a blood glucose range of 140-180 being preferred.
- To facilitate expedited stroke workup in the ED, place two peripheral IVs, so long as it does not delay transport time.

System Triage:

- The goal on-scene time is 10-15 minutes or less. If the family is not transported with the patient, encourage them to go directly to the ED.
- See **Annex A: GETAC Pediatric Prehospital Stroke Triage Algorithm** for the pediatric prehospital stroke triage algorithm.

Destination Decision-Making for Suspected Pediatric Stroke in Rural, Urban, and Suburban Areas

Age Criteria and Appropriateness for ADULT Stroke Facility: Please note that different adult stroke facilities will have different capabilities and willingness to evaluate and treat stroke patients under 18. EMS Medical Directors and stroke facility leadership should outline the age appropriateness for adult stroke facility admission based on regional facility resources and hospital policies.

Triage Recommendation:

1. Pediatric patient suspected of having a stroke who is medically stable and last known well **≤ 24 hours**; triage patient based on the following criteria:

Age appropriateness for adult stroke facility:

- Pediatric patient with suspected stroke, **age < appropriate**:
 - Transport suspected stroke patient to the nearest **Pediatric Stroke Destination***
 - **Pediatric Stroke Destination** – EMS Medical Director will recommend local pediatric stroke destinations. Typically, these are pediatric hospitals with the capability to care for pediatric patients

Last Update – 06.03.2025

- with stroke. Please note, there are **NO** formal national or statewide guidelines, certifications, accreditations, or recognition systems for 'Pediatric Stroke Destinations'.
- If no Pediatric Stroke Destination is within 60 minutes by air or ground total transport time, or the patient is unstable, transport to the nearest Pediatric Facility.
 - Suspected pediatric stroke, **age ≥ appropriate**:
 - Perform Validated Stroke Severity Screening Tool to assess for potential large vessel occlusion (LVO), such as RACE score.¹⁸
 - **If LVO Screening Tool Positive:**
 - Transport suspected stroke patients to the nearest adult Comprehensive Stroke Center (CSC/ Level 1) if within ≤ 30 minutes from the nearest Pediatric Stroke Destination and no more than 60 minutes total transport time by air or ground.
 - If no CSC is available within 30 minutes, transport to the nearest thrombectomy capable stroke center (TSC/ Level 2) if within < 30 minutes from the nearest Pediatric Stroke Destination and no more than 60 minutes total transport time by air or ground.
 - If neither a CSC nor TSC is available within ≤ 30 minutes, transport to the nearest Pediatric Stroke Destination.
 - If no Pediatric Stroke Destination is available within ≤ 60 minutes or the patient is unstable, transport to the nearest Pediatric Facility.
 - **If LVO Screening Tool Negative:**
 - Transport suspected stroke patients to the nearest Pediatric Stroke Destination.
 - If no Pediatric Stroke Destination is within 60 minutes by air or ground total transport time, or the patient is unstable, transport to the nearest Pediatric Facility **or most appropriate facility**.
2. Pediatric patient suspected of having a stroke and last known well **> 24 hours**, triage based on the following criteria:
 - Suspected pediatric stroke, **for all ages**:
 - Transport suspected stroke patients to the nearest Pediatric Stroke Destination.
 - If no Pediatric Stroke Destination is within a 60-minute total transport time or the patient is unstable, transport to the nearest Pediatric Facility.

❖ **For all ages:** consider air medical if transport time is prolonged > 60 minutes.

❖ **Stroke Prenotification:** alert the receiving facility that a suspected pediatric stroke patient is en route prior to arrival. A stroke alert prior to arrival will mobilize appropriate resources before patient arrival.

- Prenotification should include: Age, last known well, time of symptom discovery, current vital signs, stroke screening tool score (if performed), and symptoms (weakness on one side, altered mental status, etc.).

❖ **Hand-off Goal:** 120 seconds for EMS to ED triage nurse hand-off.

(Note – Plan is adapted from the 2022 North Central Texas Trauma Regional Advisory Council Regional Stroke Plan)

Last Update – 06.03.2025

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8.i.B. Approve: Adult prehospital stroke triage algorithm resource document



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PREHOSPITAL ADULT STROKE TRIAGE AND MANAGEMENT

1. Goal

- The GETAC endorsed a triage recommendation to assist pre-hospital providers with the rapid identification, assessment, and triage of all suspected stroke patients in Texas. This recommendation aims to lower barriers to seeking emergency care for stroke and ensure that stroke patients receive care at appropriate facilities promptly.

2. Purpose

- In consultation with emergency medical services (EMS) leaders, local, regional, and state agencies, as well as medical authorities, current national guideline statements, and local experts; the following recommendations seek to ensure that all patients with a known or suspected stroke are rapidly identified, assessed and triaged as outlined below.¹⁻¹⁵ 9-1-1 call centers and EMS dispatchers are encouraged to use standardized approaches to prehospital stroke assessment, triage, management, and interfacility documentation.
- The prehospital acute stroke triage and transport recommendations serve to direct the triage of adult patients (greater than ≥ 18 years of age) to the most appropriate facility based on the duration and severity of symptoms. The **GETAC Adult Prehospital Stroke Triage Algorithm** is based on multi-society endorsed guideline statements and recommendations,¹⁻¹⁵ consensus of expert opinion (Vascular Neurologists, Neuroendovascular Surgeons, and Neurosurgeons) based on clinical experience and in consultation with the GETAC council, EMS, EMS Medical Directors, Air Medical, and Stroke Committees. See **Annex A, B, and C: GETAC Adult Prehospital Stroke Triage Algorithm**
- Regional stakeholders should collaborate to consider local prehospital and health care resources, individual stroke center performance, and geographic considerations to create an optimal stroke system of care (SSOC) and destination protocol to ensure effective and efficient stroke care.^{1,4,10,13-15} Ideal destination plans should factor in all available data sources, including traffic patterns, site-specific performance data, and associated clinical outcomes.^{1,4,14} EMS agencies should implement destination plans based on time and severity for patients with suspected large vessel occlusion (LVO) within 24 hours of the last known well. These plans should prioritize a nearby comprehensive stroke center (CSC) over other centers of lower capability when available within acceptable transport times.^{4,14-16}
- In response to the perceived need for greater access to thrombectomy, several of the accrediting agencies for stroke centers introduced a fourth level of certification for facilities that can effectively perform endovascular treatment (EVT) but do not meet all the criteria of a CSC, the Thrombectomy Capable Stroke Center (TSC). The American Stroke Association 2019 SSOC Recommendations and the American Heart Association (AHA) Mission: Lifeline Stroke outline that the TSC certification is intended for regions of the country that are not readily accessible to CSCs; a CSC is the preferred destination for patients with suspected LVO when they are within acceptable transport times.^{1,4,15} If no CSC is available, a TSC should be the preferred destination for these patients from among all nearby primary stroke centers (PSCs).^{1,2,4,15}

- The AHA Lifeline Stroke Committee felt it was best to err on the side of caution and initially set the total transport time from the scene to CSC at 30 minutes for an urban area, 45 minutes in a suburban area, and 60 minutes in a rural area. However, patients eligible for IV thrombolysis (0-4.5 hours from last known well) should be routed to the nearest stroke facility if transport to the nearest CSC or TSC would make them ineligible for thrombolysis due to the additional transport time. In suburban and rural settings, prehospital destination plans and interfacility transport policies should prioritize transporting suspected LVO patients to a facility with well-defined evaluation and stabilization protocols to minimize Door-In-Door-Out (DIDO) times for patients requiring transfer to a higher level of care.^{4,10,15} Additional transport time, including air medical transport, may be reasonable in rural communities or where large distances separate stroke centers.^{1,4,13,15}

3. SSOC Modification for Metropolitan, Non-Metropolitan, and Frontier Regions

- The following is adapted from the AHA Mission: Lifeline Stroke recommendation for Emergency Medical Services for acute stroke triage and routing.^{1,2,4,13,15} These modifications to transport time thresholds are suggested to help EMS agencies adjust their regional stroke triage protocols in collaboration with local resources and key stakeholders.^{4,13,15}
- A Metropolitan SSOC modification is appropriate for a metro region (Urban/RUCA code 1)^{4,17} These areas have a high population density (50,000+ inhabitants) and abundant healthcare resources, with EMS access to one or more TSC/CSC within 30 minutes of ground transport time.^{4,15}
- A Non-Metropolitan SSOC modification is appropriate for large residential communities adjacent to an urban core (Suburban/RUCA codes 2-3).^{4,17} These areas generally have a population density closer to the urban threshold. They may have access to nearby community hospitals and suburban or urban advanced stroke centers within a 30-60-minute transport by EMS air or ground.^{4,15} Patients with suspected LVO should be routed directly to a CSC if the maximum transport time from the scene to the CSC does not exceed 45 minutes. If no CSC is within 45 minutes, then EMS should go directly to a TSC if the maximum total transport time from the scene to the TSC does not exceed 45 minutes. If no TSC or CSC exists within 45 minutes of total travel time, EMS should go to the nearest acute stroke-ready hospital (ASRH) or PSC.^{4,15}
- A Frontier SSOC modification is appropriate for a small or non-metropolitan region (Rural/RUCA codes 4-10).^{4,17} These areas generally have low population density (<50,000 inhabitants), limited local general healthcare resources, few nearby ASRH or PSC, and often no TSC/CSC within 60 minutes of transport time by EMS ground, although there may be one within 60 minutes by air.^{4,15} Patients with suspected LVO should be routed directly to a CSC if the maximum total transport time from the scene to the CSC does not exceed 60 minutes.^{4,15} If no CSC is within 60 minutes, then EMS should go directly to a TSC if the maximum total transport time from the scene to the TSC does not exceed 60 minutes.^{4,15} Consider air medical transport if no certified stroke center is within 60 minutes by ground. If air transfer is unavailable,

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transfer the patient to the nearest hospital per the regional stroke plan.^{4,15}

- The COVID-19 pandemic further emphasized the need for flexible prehospital triage and interfacility transport adaptation in response to local and regional factors. Preferential routing of suspected LVO patients to centers with thrombectomy capability may be of even greater importance when in-hospital and interfacility delays are amplified in conditions such as the COVID-19 pandemic.¹⁸

4. Prehospital Triage of Stroke in Adult Patients

• Basic Level:

- Assess and support ABCs according to UNIVERSAL CARE—ADULT:
 - **A (Airway):** Airway support and ventilator assistance are recommended for patients with acute stroke who have decreased consciousness or a compromised airway. Suctioning and oropharyngeal or nasopharyngeal airway as needed to ensure airway patency.
 - **B (Breathing):** Supplemental oxygen should be provided to maintain oxygen saturation >94% (continuous monitoring).²
 - **C (Circulation):** Evaluate, document, and treat signs/symptoms of shock according to the Shock Clinical Practice Guidelines (CPG).
 - **D (Disability):** Assess and document GCS, pupillary size, and reactivity.
 - **E (Exposure/Environmental):** Assess for evidence of traumatic injury, especially head injury.

• Positioning and Stabilization:

- Place the patient in a supine position, with the head of the bed elevated at 30 degrees, if the patient can tolerate.^{2,10} Keeping the patient at 30 degrees can improve blood flow to the brain^{19,20} and is recommended if the patient can tolerate.^{2,10} Avoid lying the patient flat unless an LVO is documented,²¹ and the patient is not at risk for elevated intracranial pressure or herniation.²⁰
- Ensure airway patency with suctioning and oropharyngeal airway or nasopharyngeal airway as needed.
- Cardiac monitoring during transport is recommended. Obtaining an EKG during workup is acceptable as long as it does not delay transport to the appropriate stroke facility.²
- Treat hypotension. Evaluate, document, and treat signs/symptoms of shock according to the **Shock CPG**.
- If hypoglycemia is present (POC glucose <60 mg/dL),² treat according to **Diabetic Emergencies CPG**. Hyperglycemia in acute ischemic stroke is associated with worse clinical outcomes,^{22,23} including greater infarct growth^{24,25} and hemorrhagic infarct conversion.^{26,27}
- If there is Seizure activity, treat according to the **Seizure CPG**.

• Management:

- EMS personnel should begin the initial management of stroke in the field as outlined in this document.
- Provide supplemental oxygen if needed to keep oxygen saturation >94%.²
- Treatment of hypertension is **NOT** recommended unless blood pressure

is >220/120 mmHg.²

- Avoid dextrose-containing fluids in non-hypoglycemic patients.²
- Perform and document a POC Glucose analysis and treat according to the ASA 2019 Guidelines for Management of Acute Ischemic Stroke.²
 - Hypoglycemia (blood glucose <60 mg/dL) should be treated in patients suspected of acute ischemic stroke.²
- To facilitate expedited stroke workup in the ED, place at least one 18 or 20-gauge IV in the antecubital fossa or forearm (right preferred).
- To facilitate the fastest Door-to-Needle and stroke care, collect blood samples to provide the receiving facility, as long as it does not delay the transfer.

• Assessment:

- **History** - Interview patient, family members, and other witnesses to **determine symptoms, time of symptom discovery, and last known well** or last time patient without symptoms:
 - Obtain a mobile number for the next of kin and witnesses.
 - **NOTE:** For “wake-up strokes,” the time documented is the time the patient was last known well, not the time the patient was found.
 - **NOTE:** Sudden onset of any of the following suggests the possibility of acute stroke:
 - Numbness or weakness of the face, arm, and/or leg (especially on one side of the body)
 - Confusion
 - Trouble speaking or understanding language
 - Double vision, trouble seeing in one or both eyes
 - Trouble walking
 - Dizziness
 - Loss of balance or coordination
 - Sudden onset of severe headache with no known cause (suggests hemorrhagic stroke)
 - Any asymmetry of the neurological exam
- **Additional History:**
 - Obtain the patient's history, including co-morbid conditions, past medical history, recent surgeries, prior strokes, and allergies (iodinated contrast).
 - Items to report: seizure at onset of stroke symptoms, head trauma, history of recent surgeries, history of bleeding problems, history of recent stroke, signs of possible brain hemorrhage [severe headache of sudden onset, nausea/vomiting with headache or loss of consciousness (LOC)].
 - Obtain dates for **recent events:** surgery, stroke, bleed, or trauma.
 - Additional history: ask if symptoms are associated with a severe headache of sudden onset, loss of consciousness, nausea/vomiting, or the worst headache of their life.
 - Be alert to common stroke mimics*.
 - Determine if the patient has a substantial pre-existing disability (e.g., need for nursing home care or unable to walk independently).

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- Obtain a list of all medications including: antiplatelet agents (e.g., aspirin, clopidogrel [Plavix]) and blood thinners (direct thrombin inhibitors [dabigatran/Pradaxa], factor Xa inhibitors [fondaparinux/Arixtra, rivaroxaban/Xarelto, apixaban/Eliquis, edoxaban/Savaysa], low molecular weight heparin [enoxaparin/Lovenox], unfractionated heparin, bivalirudin, argatroban, or warfarin [Coumadin]).
 - If possible, record when the patient took the last dose.
- Device/implant history (e.g., left ventricular assist device, pacemaker, valve replacement).
- **Examination:**
 - Assess and record blood pressure, rate, rhythm, respiratory rate, and oxygen saturation.
 - Apply a validated and standardized instrument for stroke screening, such as: FAST (Face, Arm, Speech, Test), Balance Eyes Face Arm Speech Time Tool (BEFAST), Los Angeles Prehospital Stroke Screen, Melbourne Ambulance Stroke Screen, or Cincinnati Prehospital Stroke Scale.^{1,2,4,10,28-35}
 - In prehospital patients who screen positive for suspected stroke, apply a standard prehospital stroke severity assessment tool such as: Cincinnati Stroke Triage Assessment Tool (CSTAT), Field Assessment Stroke Triage for Emergency Destination (FAST-ED), Rapid Arterial Occlusion Evaluation Scale (RACE), Prehospital Acute Stroke Severity (PASS), Gaze-Face-Arm-Speech-Time (G-FAST), Conveniently-Grasped Field Assessment Stroke Triage (CG-FAST), Vision, Aphasia, Neglect (VAN) Assessment, Austrian Prehospital Stroke Scale, and Ventura Emergent LVO Score.^{1,2,4,10,28,32,33,35-40}
- **System Triage:**
 - The goal for on-scene time is 10-15 minutes or less. If the family is not transported with the patient, encourage them to go directly to the ED.
 - See **Annex A, B, and C: Adult Prehospital Stroke Triage Algorithm** for the adult prehospital stroke triage algorithm.
 - **Call stroke alert** and pre-notify the receiving facility that a suspected stroke patient is en route so that the appropriate resources may be mobilized before the patient's arrival.^{10,41}
 - **Pre-notification** should include the patient's name, age, LKW, time of symptom discovery, vitals, blood glucose, stroke screen and severity score, blood thinner history and last dose, sudden severe headache or loss of consciousness with symptom onset, and the phone number for the next of kin.¹⁰
 - Goal: 30 seconds for EMS to ED triage nurse hand-off.
 - **Bypass Exclusions:**
 - If severe or life-threatening trauma is suspected in addition to stroke, transfer to the appropriate level trauma center.
 - Patients under hospice care or with Medical Orders for Scope of Treatment (MOST) that outline no emergency measures should go to the nearest appropriate hospital.
 - Common ischemic **stroke mimics**: alcoholic intoxication, cerebral infections, drug overdose, hemorrhagic stroke, hypoglycemia, hyperglycemia, metabolic disorders, atypical migraines, neuropathies (e.g., Bell's palsy), seizure, post-ictal state, and tumors.

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APPROVAL ITEM: Resource Document

- scales to detect intracranial large-vessel occlusion in suspected stroke (PRESTO): a prospective observational study. *Lancet Neurol.* 2021;20:213-221. doi: 10.1016/S1474-4422(20)30439-7
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8.i.C. Approve: Pediatric Stroke Task Force Tip Sheet

Deferred to Q3



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8.i.D. Approve: TEAM Stroke-Ed Study



TE_xAs Emergency Medical Services Standardized STROKE Education (TEAM STROKE-ED) Study

Hypothesis: EMS stroke knowledge would improve if standardized stroke education was provided.

- Perform an **+intervention with** standardized stroke education and another that uses current practices (**-intervention**).

Outcomes:

- **Primary Outcome:**
 - Stroke Knowledge:
 - Pre- and post-intervention skill and knowledge assessment
 - Retention assessment testing at 3- and 6-months post-intervention.
 - Assess EMS providers' understanding of stroke symptoms, appropriate interventions, and time-critical actions.
- **Secondary Outcomes:**
 - Regional Performance in Key Stroke Performance Measures:
 - Evaluate EMS providers' ability to recognize stroke symptoms accurately and initiate appropriate care by reviewing GWTG or NEMSIS performance regionally for:
 - Stroke screening tool utilization and documentation
 - Stroke severity tool utilization and documentation
 - Prenotification of suspect stroke patient arrival
 - Percentage of on-scene time ≤ 15 minutes.
 - Regional Time to Treatment:
 - Track regional performance measures for:
 - Door to Needle (thrombolysis intervention)
 - Door to Provider
 - Regional Patient Outcomes:
 - Track regional patient outcomes from GWTG, such as mortality, disability, and functional recovery, to assess the downstream impact of improved EMS performance.

TEAM Stroke-Ed Study

Title: TExAs Emergency Medical Services Standardized STROKE Education (TEAM STROKE-ED) Study

Research Question/Background:

Within a system of stroke care, access to prehospital stroke care requires early recognition of stroke and its severity, with the integration of clinical findings into a complex triage paradigm that factors in regional geography, last known well (LKW), stroke facility capability, and availability. Emergency medical responders are often the first medical professionals with direct patient contact and yet receive less training on stroke recognition and management than other clinicians involved in acute stroke care. Their initial assessment, treatment, and decisions regarding diversion and routing will significantly impact a patient's subsequent care and affect patient outcomes. The current state of emergency medical services (EMS) knowledge regarding stroke varies widely depending on the region, available resources, and training protocols in place. In one US survey, EMS providers reported inadequate stroke severity training and demonstrated gaps in knowledge of stroke types, stroke severity scales, and stroke center levels (Asif et al.). These findings highlight the need for systematic efforts to enhance and standardize the educational content and delivery of stroke education. We aim to investigate the impact of standardized stroke education on stroke knowledge and performance among EMS personnel in suburban, urban, and rural areas. The Texas EMS Standardized Stroke Education (TEAM STROKE-ED) study is a two-phase study. In the phase 1 feasibility portion of the study, a multi-modality acute stroke care curriculum for EMS providers will be implemented at a regional level. The curriculum will focus on core topics in the hyperacute, acute management, and triage of suspected stroke in adult and pediatric patients in the prehospital setting, providing case-based learning vignettes. Based on the feedback from the feasibility phase of the study and the needs assessment survey, a standardized, multi-modality learning module will be implemented for the statewide Phase 2 of the study, with a focus on urban, suburban, and under-resourced areas.

The TEAM STROKE-ED study has three aims:

1. Assess the suitability of implementing the standardized curriculum for EMS providers, as demonstrated by the uptake of stroke screening tools in the prehospital setting, educator and learner perspective surveys, and performance on assessment tools. Specifically, we will assess the impact of a standardized curriculum on the knowledge of EMS providers regarding stroke care and the triage of pediatric and adult patients in the prehospital setting and during interfacility transfers.
2. Assess the impact of the standardized curriculum on acute stroke clinical outcomes in the prehospital, emergency room, hospital setting, and during interfacility transfers for thrombectomy-eligible patients.

3. Assess for similar versus differential uptake of the curriculum in areas with a paucity of resources (including rural areas).

Trial Design:

1. Study Type: Prospective, Randomized Cluster, Open-label, Blinded-Analysis Design

- This design helps establish causality by comparing outcomes between an intervention group (receiving standardized stroke education) and a control group (receiving usual training or no intervention) within defined regions in Texas.
- **Hypothesis:** A state-wide standardized multi-modality acute stroke curriculum for EMS providers will improve the learner experience, stroke knowledge, management, and triage of adult and pediatric patients suspected of having a stroke in the prehospital setting and during interfacility transfers of thrombectomy-eligible patients.

2. Study Population and Research Settings:

- EMS providers: EMTs, AEMTs, paramedics, and other relevant personnel at any level of training or experience practicing in urban, suburban, and rural areas across Texas.
- Both experienced and novice EMS providers across rural, urban, and suburban regions will be enrolled to assess the impact across different skill levels and geographic stroke resources.

3. Intervention and comparators:

- Standardized Stroke Education Curriculum:
 - Develop a comprehensive education program for adult and pediatric patients covering:
 - Anatomy and pathophysiology of stroke
 - Recognition of stroke symptoms and types
 - Recognition of stroke severity
 - Recognition of stroke mimics
 - Importance of time-sensitive intervention
 - Proper assessment and initial management of stroke patients
 - Acute stroke system triage for rapid transfer to stroke centers
 - Stroke facility levels and distinctions
 - Importance of prenotification and hand-off best practices
 - Proper documentation and management of stroke patients during interfacility transfers
 - Introduction to extra ventricular drain basics
 - Ensure the education program is evidence-based, up-to-date, and aligned with established guidelines.
 - Offer training sessions, educational materials, and interactive exercises with case vignettes.

TEAM Stroke-Ed Study

4. Control:

- Usual Training:
 - EMS providers in the control group receive their regular training, which may vary across different EMS agencies but typically includes basic stroke education.

5. Outcomes:

- **Primary Outcome:**
 - Stroke Knowledge:
 - Pre- and post-intervention skill and knowledge assessment
 - Retention assessment testing at 3- and 6-months post-intervention.
 - Assess EMS providers' understanding of stroke symptoms, appropriate interventions, and time-critical actions.
- **Secondary Outcomes:**
 - Regional Performance in Key Stroke Performance Measures:
 - Evaluate EMS providers' ability to recognize stroke symptoms accurately and initiate appropriate care by reviewing GWTG or NEMSIS performance regionally for:
 - Stroke screening tool utilization and documentation
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 - Regional Time to Treatment:
 - Track regional performance measures for:
 - Door to Needle (thrombolysis intervention)
 - Door to Provider
 - Regional Patient Outcomes:
 - Track regional patient outcomes from GWTG, such as mortality, disability, and functional recovery, to assess the downstream impact of improved EMS performance.

6. Sample Size Calculation:

- Determine the required sample size based on the expected effect size, desired power, and significance level.

7. Randomization:

- Randomly assign EMS providers in a region to either the intervention or control group to minimize selection bias.

8. Blinding:

- Given the nature of the intervention, participants will be unblinded. However, outcome assessors will be blinded to group assignments to reduce bias.

9. Data Collection:

Track regional patient outcomes from GWTG, such as mortality, disability, and functional recovery, to assess the downstream impact of improved EMS performance.

10. Statistical Analysis:

- Compare outcomes between the intervention and control groups using appropriate statistical tests (e.g., t-tests, chi-square tests).
- Adjust for potential confounders such as EMS providers' baseline knowledge or experience level.

11. Ethical Considerations:

- Obtain approval from relevant ethics committees or Institutional Review Boards (IRBs).
- Ensure informed consent from participants.

12. Timeline:

- The duration of the trial, including recruitment, intervention delivery, and follow-up assessments will be 2 years.

13. Budget:

- resources for education program development, training sessions, data collection, analysis, and dissemination of findings.

14. Dissemination of Results:

Publish findings in peer-reviewed journals and present them at relevant Regional Advisory Council and State levels to inform EMS practice and policy.

Conclusion:

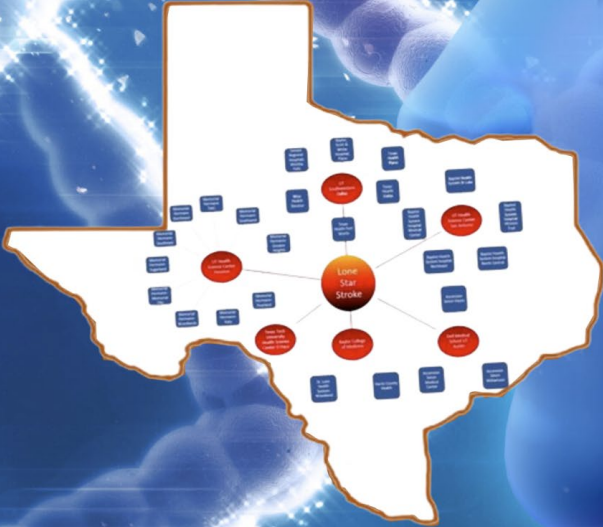
By rigorously evaluating the effectiveness of such education programs, we can improve stroke care and outcomes in the prehospital settings and during interfacility transfers in adult and pediatric patients across Texas.

LSSC



Lone Star Stroke Consortium

Improving the health of Texans affected by cerebrovascular disease



Lone Star Stroke (LSS) Research Consortium

The LSS is a novel collaboration among leading medical research institutions in Texas to improve the health of Texans affected by stroke and cerebrovascular disease. The mission of LSS is to establish a state-wide network for patient-centered stroke research and therapeutic trials within Texas that links academic health institutions with proven expertise in stroke research to community stroke centers. Our objectives are to find better therapies and prevention strategies to improve cerebrovascular health for Texans throughout our state. The LSS Research Consortium has established a robust, geographically diverse, network of sites that has the capability and infrastructure to implement studies quickly throughout Texas. This is crucial for providing the game-changing breakthroughs that are needed now by people who have or may soon develop a stroke





8.j. GETAC Trauma System Committee Update to Council

Chair: Stephen Flaherty, MD, FACS
Vice-chair: Raul Barreda, MD, FACS

*No action items for
Council this quarter.*



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

Chair: Kate Remick, MD

Vice-chair: Shawn Salter, RN



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SCOR

2025 Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. [Performance Improvement]: <i>Tracking top 5 clinical quality measures</i>	<i>Regularly track and discuss performance measures, identify trends (both positive and negative).</i>	
2. [Performance Improvement]: <i>Data reporting and dissemination strategies</i>	<i>Discussing best mechanisms for dissemination that support improvement efforts.</i>	
3. [Performance Improvement]: <i>Consideration of other system priorities, needs, and measures</i>	<i>Early discussions from collaborative members and committee representatives regarding system challenges and needs.</i>	

Action Item Request for Council June 2025

Kate Remick, MD

System Collaborative for Outcomes Review



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Action Item Request and Purpose

- Please provide a **single**, clear and concise statement defining your action item request:

Approval of SCOR Statement of Purpose, Scope of Activities and Request Process

- In **one** clear and concise statement, please explain the purpose for this request:

Provides guidance to the members of SCOR regarding scope of activities and request process.

Benefit and Timeline

- What is the intended impact or benefit resulting from this request?
Please provide a clear and concise response in a single statement.

Allows SCOR members to carry on with current efforts with clear understanding of scope of work.

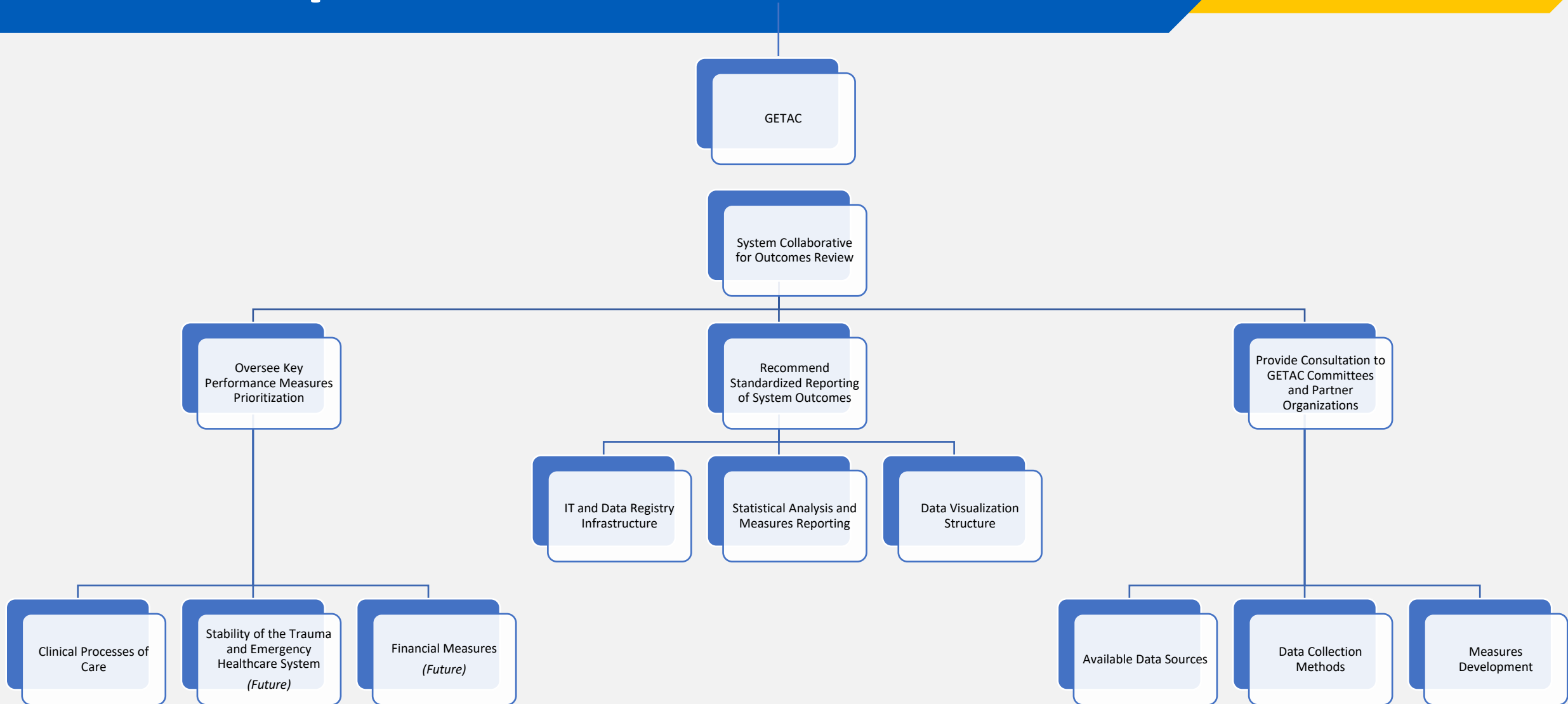
- Please provide the timeline or relevant deadlines for this request.

June GETAC session

SCOR Statement of Purpose

Dedicated to using data to improve and optimize patient outcomes across all phases of care and timely access to appropriate care with the overarching objective of minimizing preventable morbidity and mortality.

SCOR Scope of Activities



SCOR Request Process

**GETAC
(Council)**



GETAC Reviews and Approves, Denies, or Recommends Revision

SCOR Recommends to GETAC Approach, Resource Needs, and Timing

GETAC (Council) Requests Data/Measure reporting/IT or Analytics Support from SCOR

SCOR



Reviews and Discusses Request – Determines Resource Needs, Timing, Plan, Logistics

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

June 6, 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 runs and reportable trauma events to EMSTR under Texas Administration Code, Title 25, Chapter 103.
- 2024 data is from January 1, 2024-June 30, 2024, and is preliminary as of April 9, 2025.

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

January 1, 2022-June 30, 2024



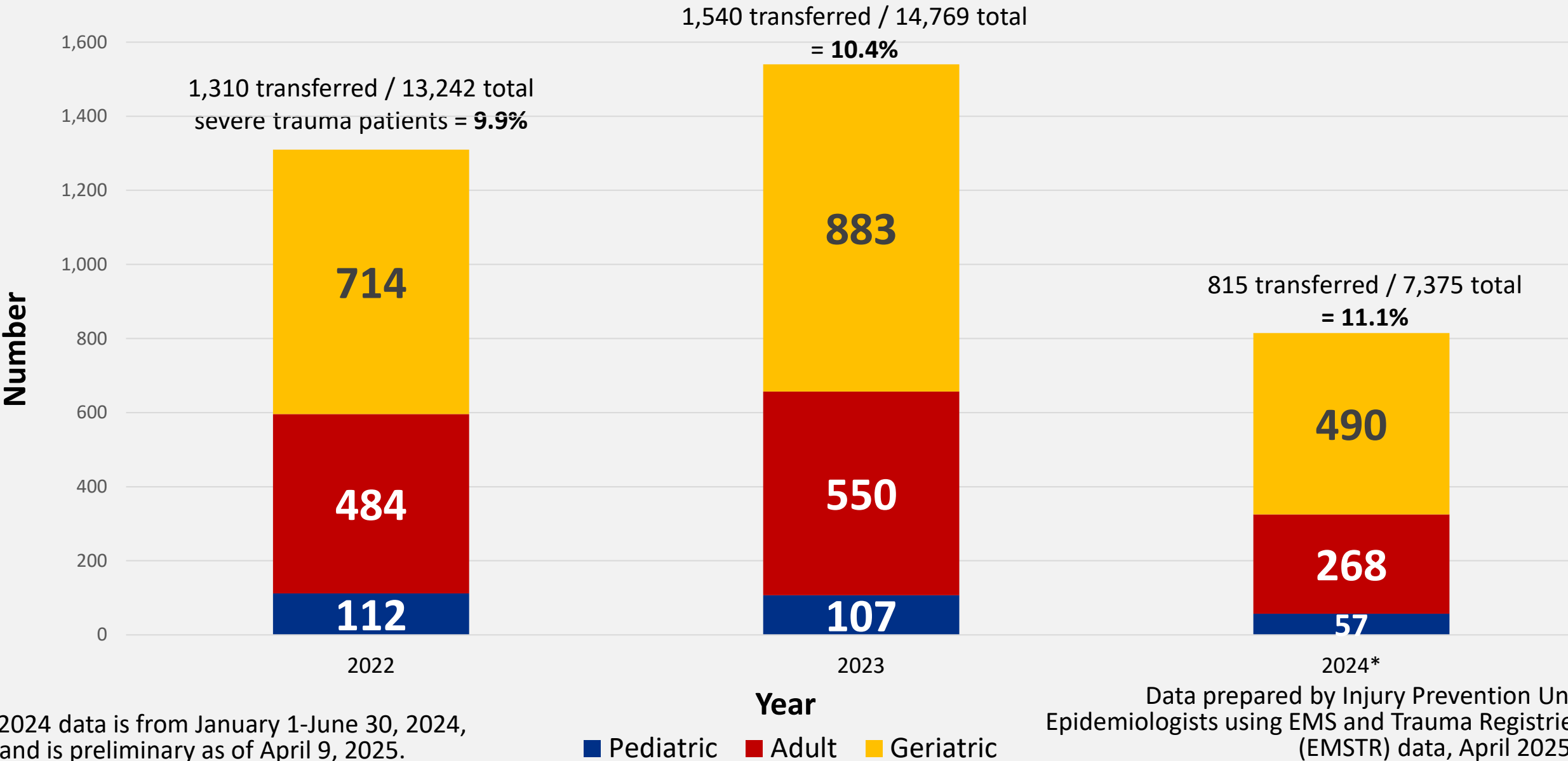
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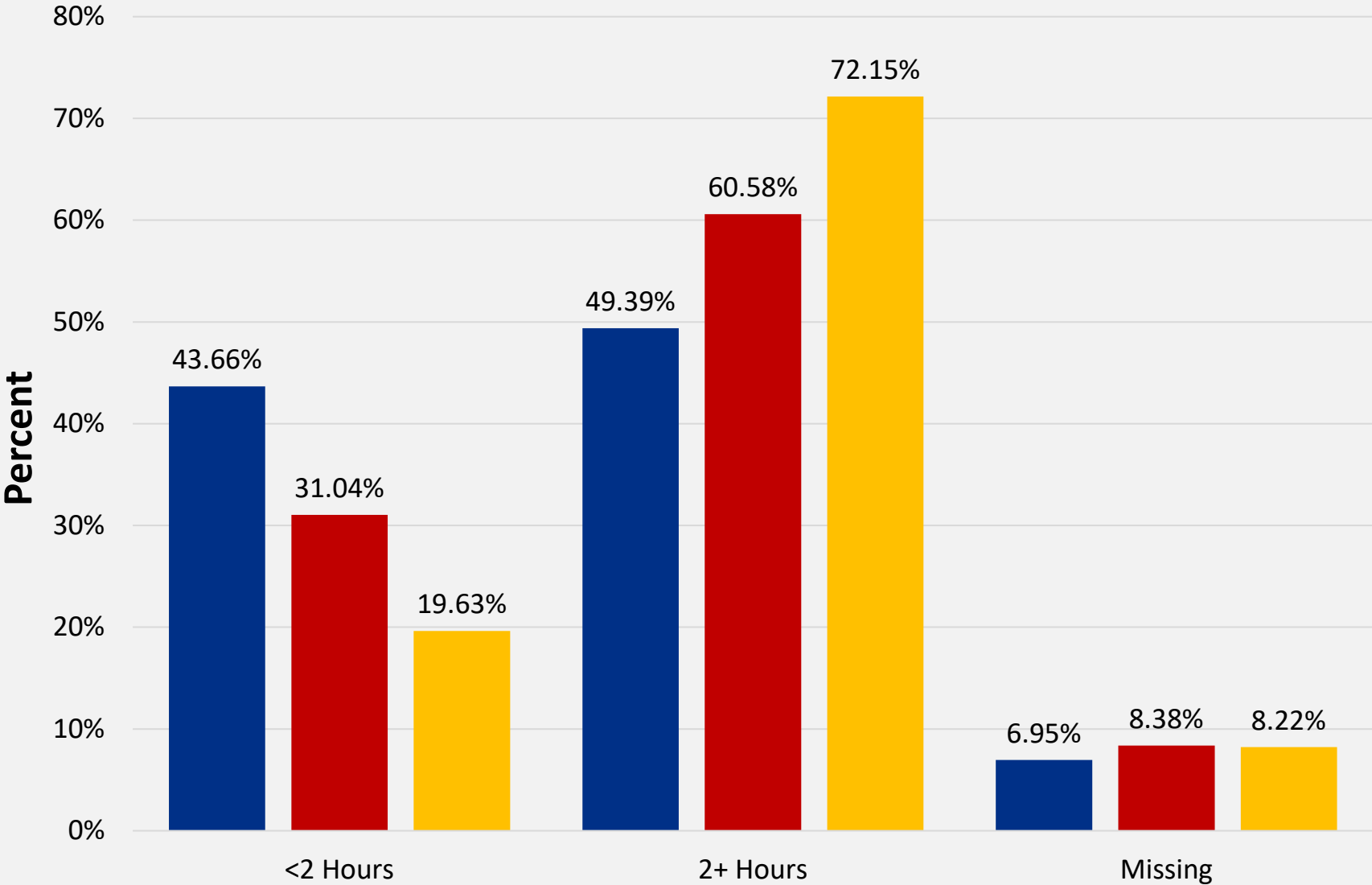
Transfer Delay Definitions

- Severe trauma patients are injured patients with:
 - Geriatric (65+) = Glasgow Coma Scale (GCS) <9 or Systolic Blood Pressure (SBP) <110.
 - Adults (15-64) = GCS <9 or SBP <90.
 - Pediatric (children less than 15) = GCS <9 or SBP <70 + 2 x (the child's age in years).
 - 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



Severe Trauma Transfer Times – All Ages



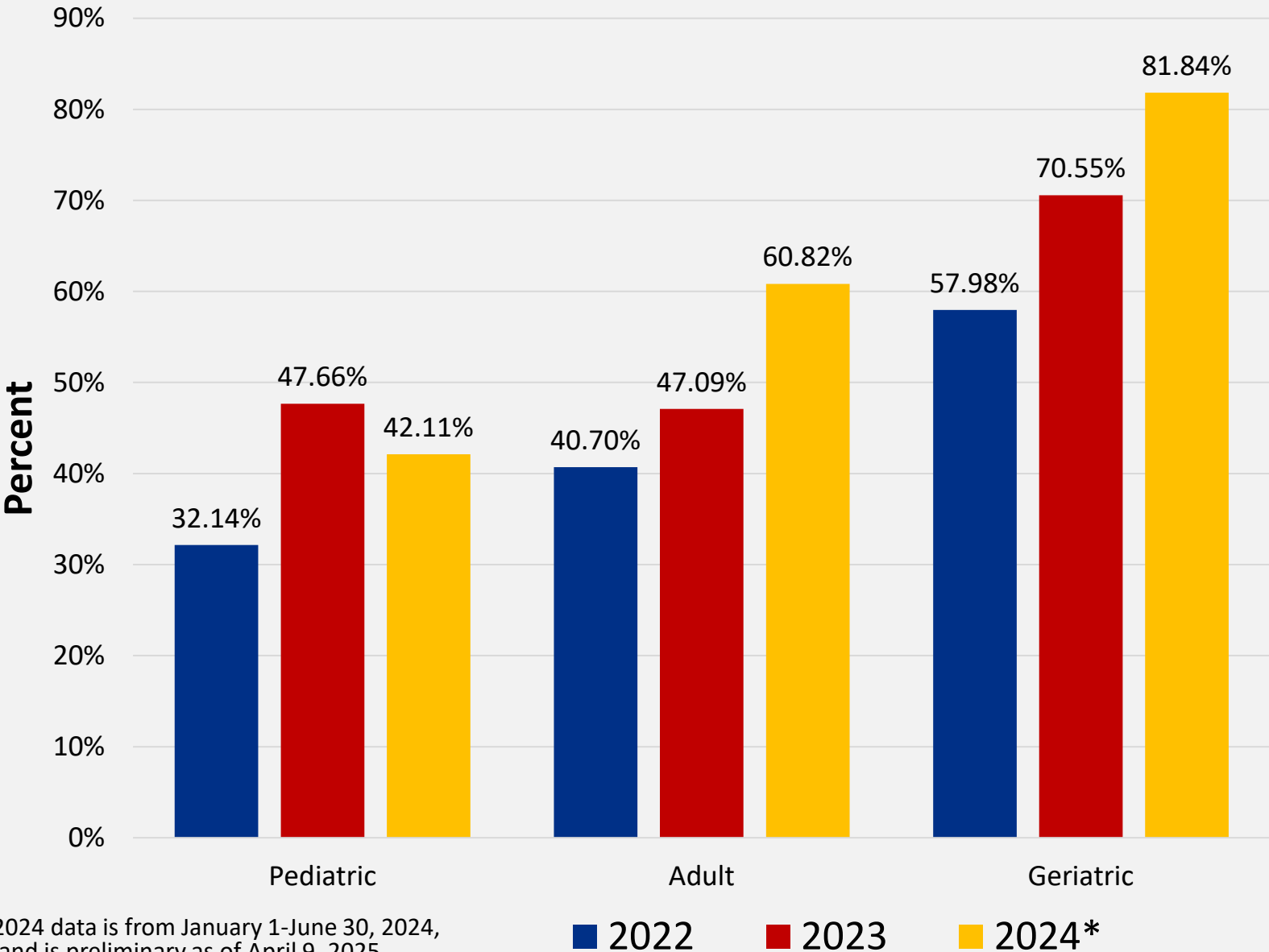
Number of Severe Trauma Transfers			
	2022	2023	2024*
<2 Hours	572	478	160
2+ Hours	647	933	588
Missing	91	129	67

*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

■ 2022 ■ 2023 ■ 2024*

Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, April 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	24/57
Adult	197/484	259/550	163/268
Geriatric	414/714	623/883	401/490

*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

Severe Trauma Transfer Time by Sex

Sex	Transfer Time	2022	2023	1 st half 2024*
Male	Less than 2 hours	379 (46.56%)	313 (33.95%)	111 (22.38%)
	2+ hours	388 (47.67%)	532 (57.70%)	344 (69.35%)
Female	Less than 2 hours	193 (38.91%)	159 (26.11%)	49 (15.36%)
	2+ hours	259 (52.22%)	398 (65.35%)	244 (76.49%)

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

*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

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

Severe Trauma Transfer Time by Race

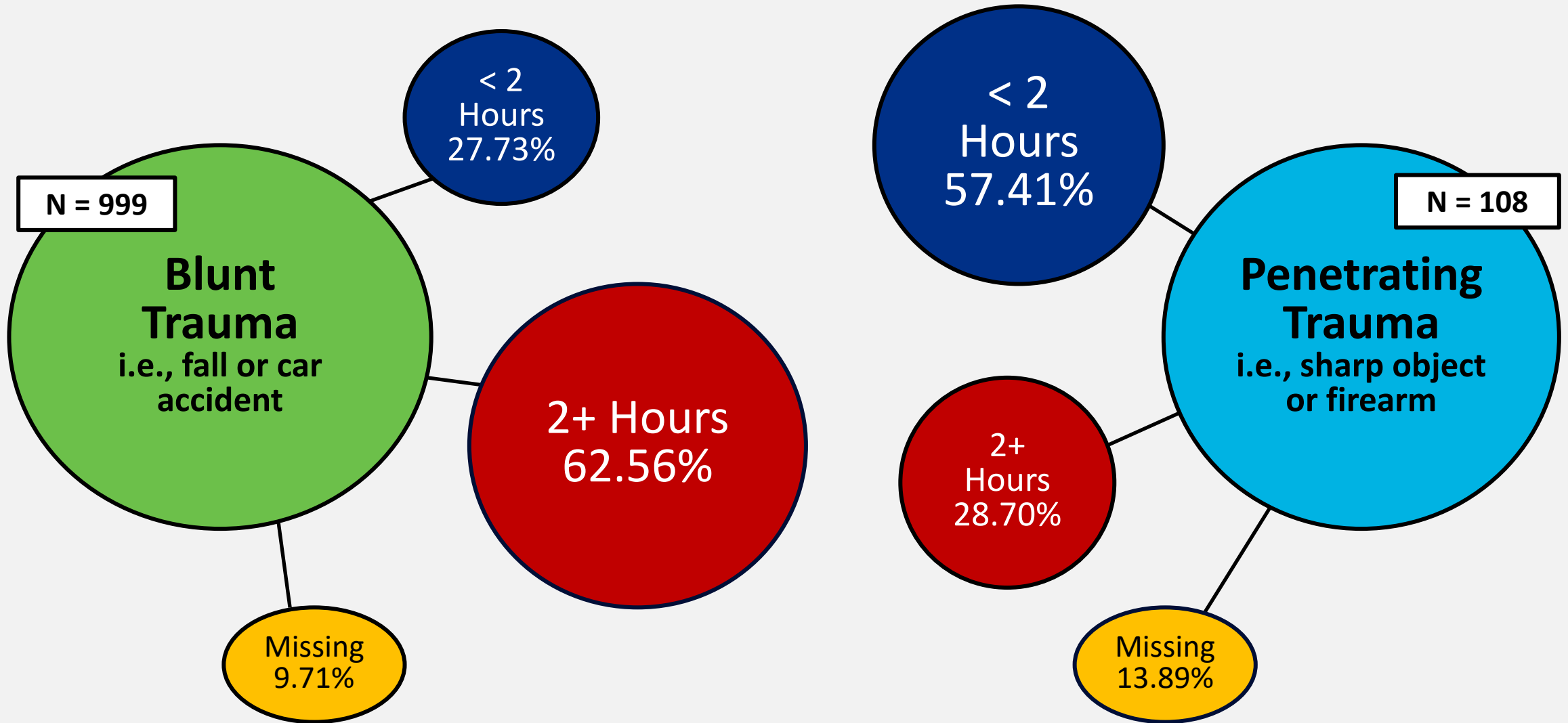
Race	Transfer Time	2022	2023	1 st half 2024*
White	Less than 2 hours	421 (41.64%)	342 (28.26%)	118 (18.27%)
	2+ hours	513 (50.74%)	765 (63.22%)	475 (73.53%)
Black	Less than 2 hours	57 (44.53%)	63 (46.32%)	18 (23.68%)
	2+ hours	63 (49.22%)	63 (46.32%)	47 (61.84%)

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

*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

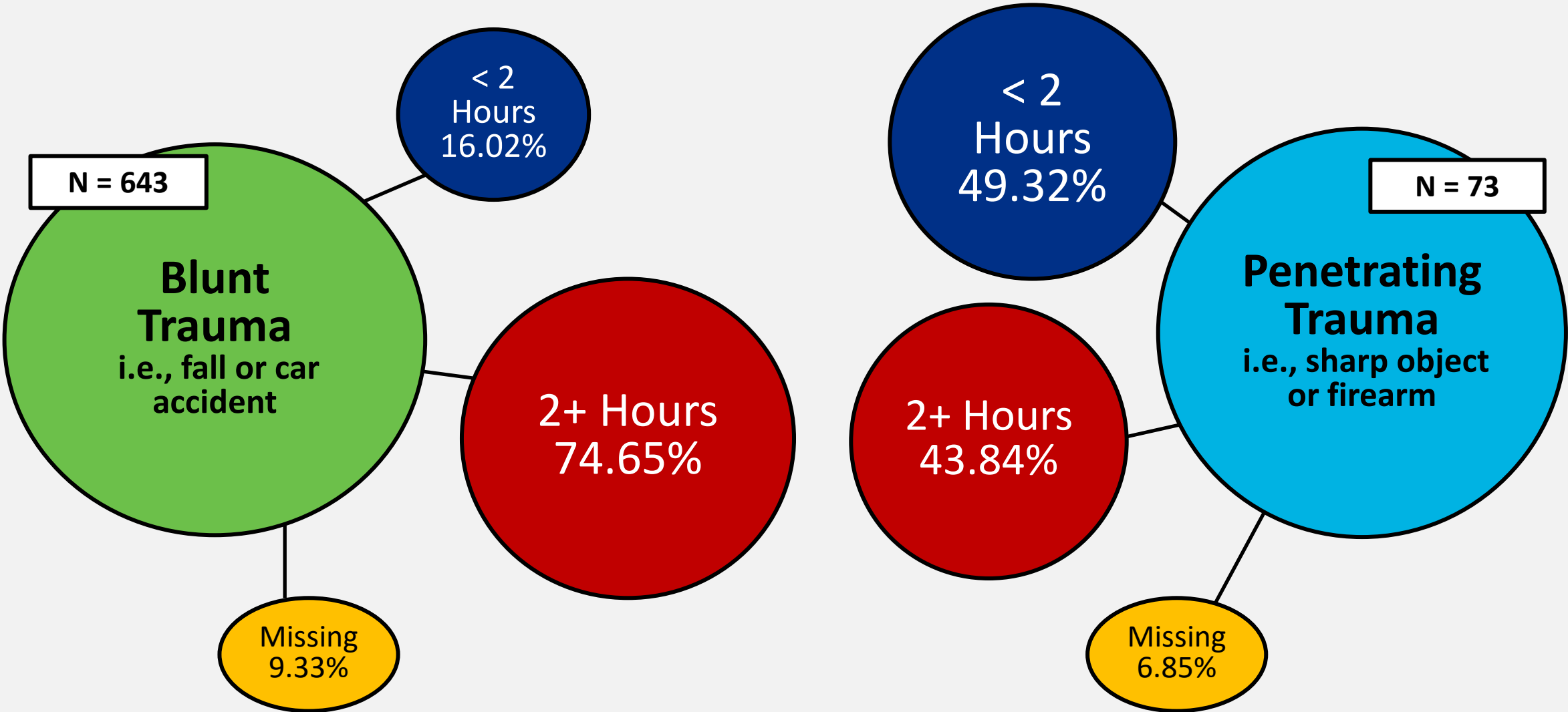
Data prepared by Injury Prevention Unit
Epidemiologists using EMSTR data, April 2025.

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*



*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

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

Severe Trauma Transfer Numbers by Designation Level, 2022-June 30, 2024

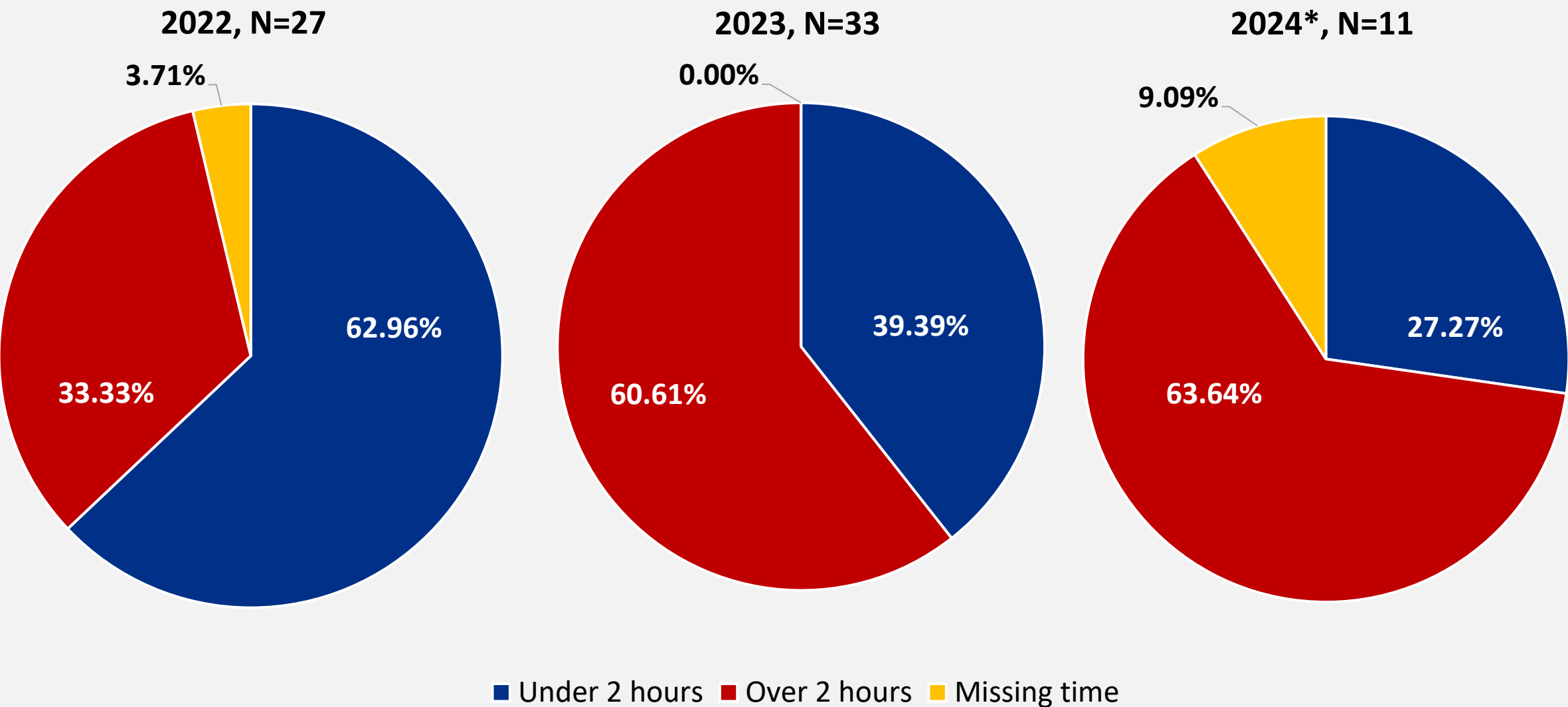
Trauma Designation*	2022	2023	2024**
Level I	27	33	11
Level II	61	61	49
Level III	330	354	226
Level IV	714	840	466

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

**2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

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

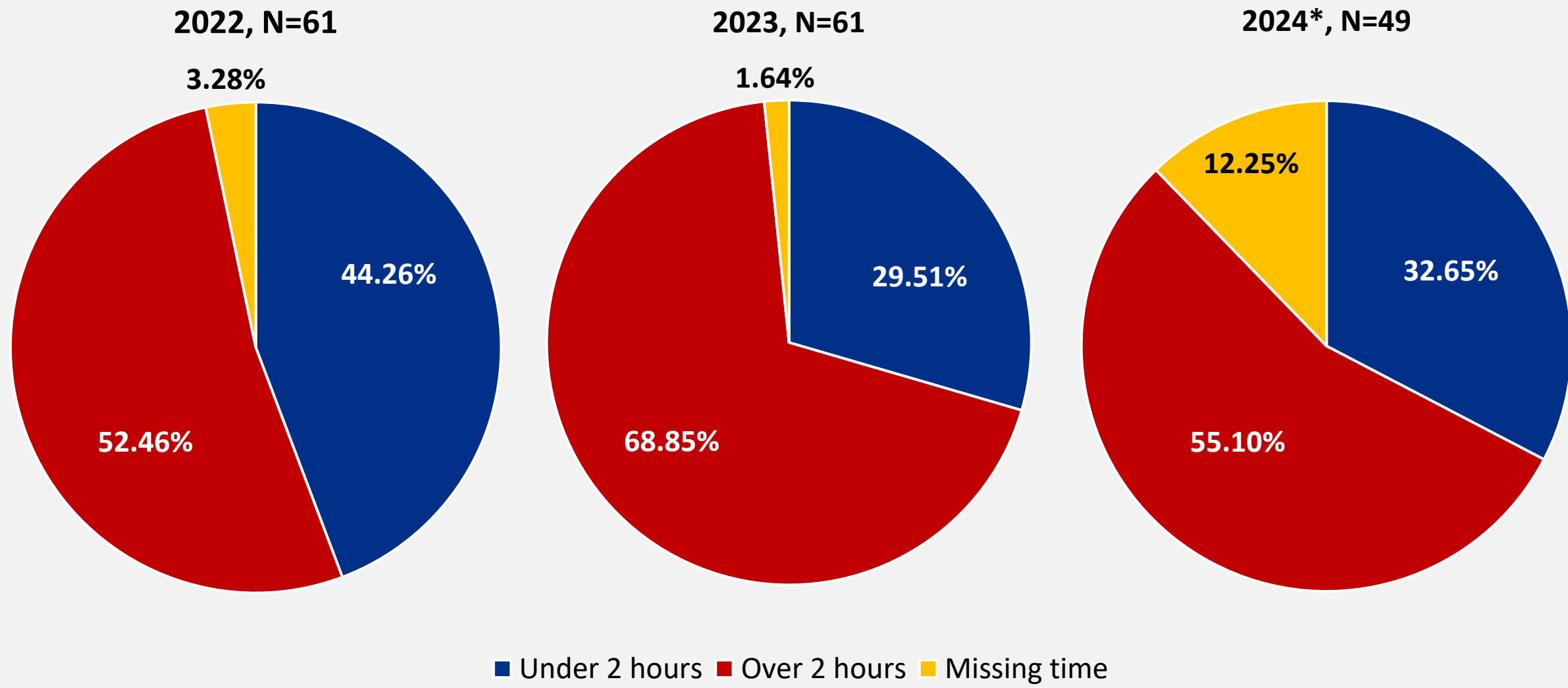
Severe Trauma Transfer Time by Trauma Designation Level I



*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

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

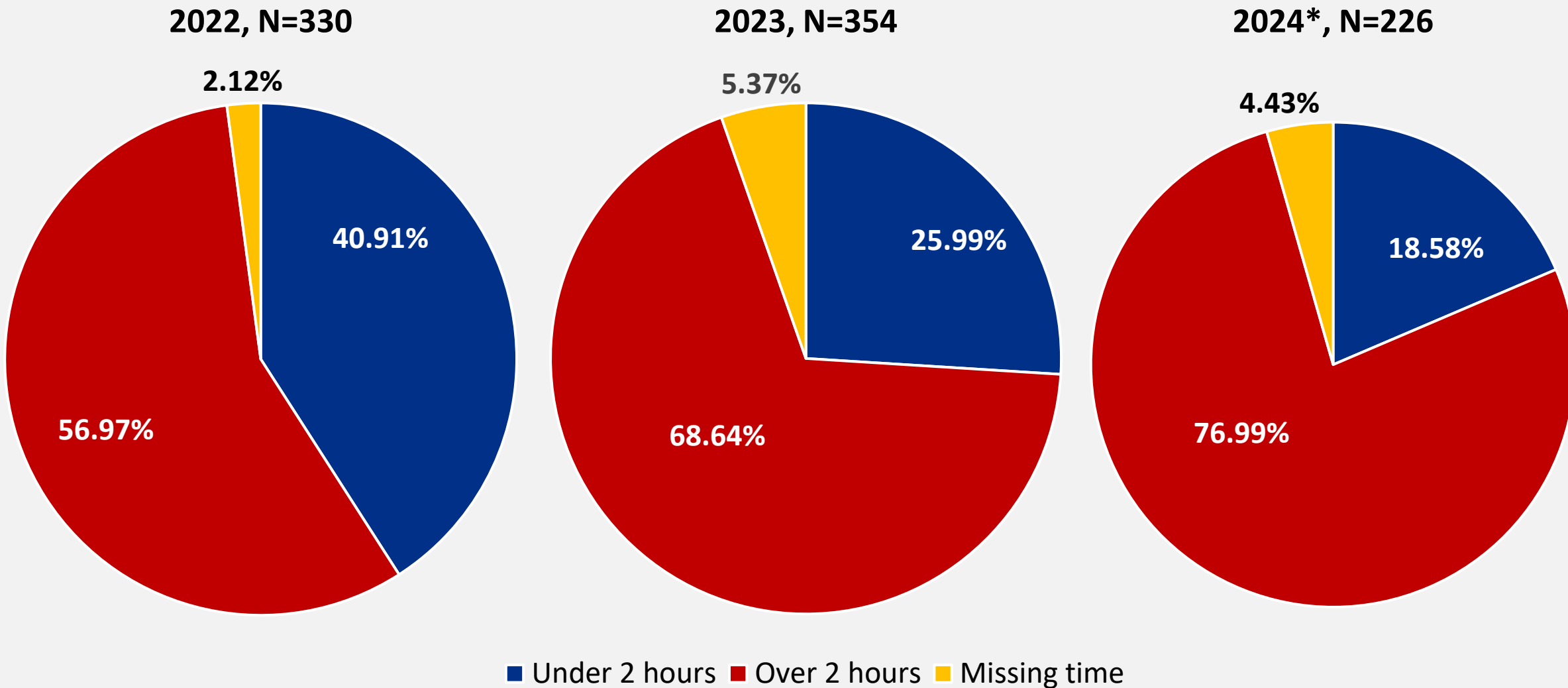
Severe Trauma Transfer Time by Trauma Designation Level II



*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

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

Severe Trauma Transfer Time by Trauma Designation Level III

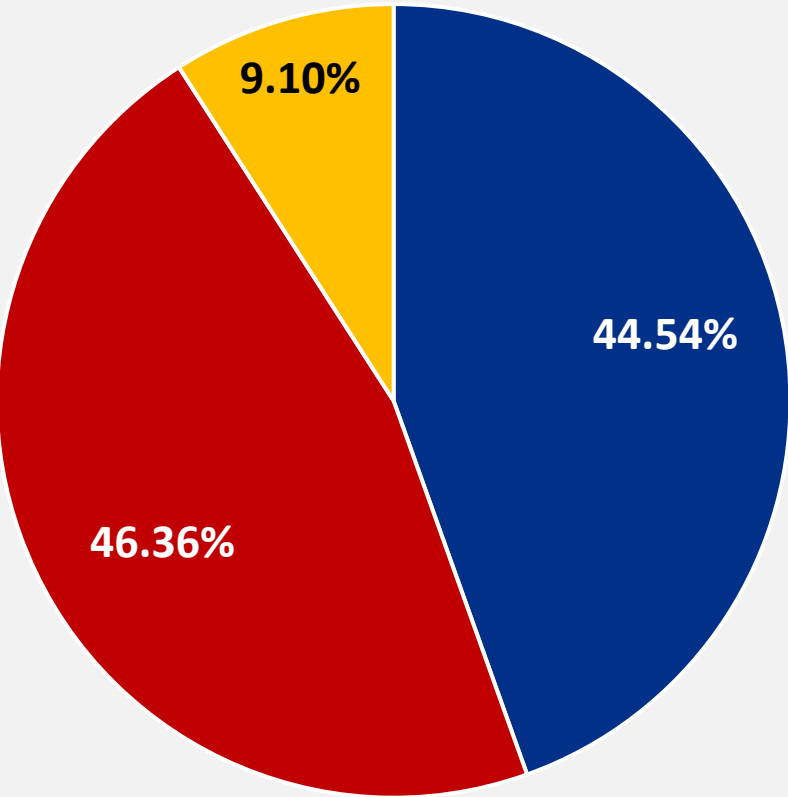


*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

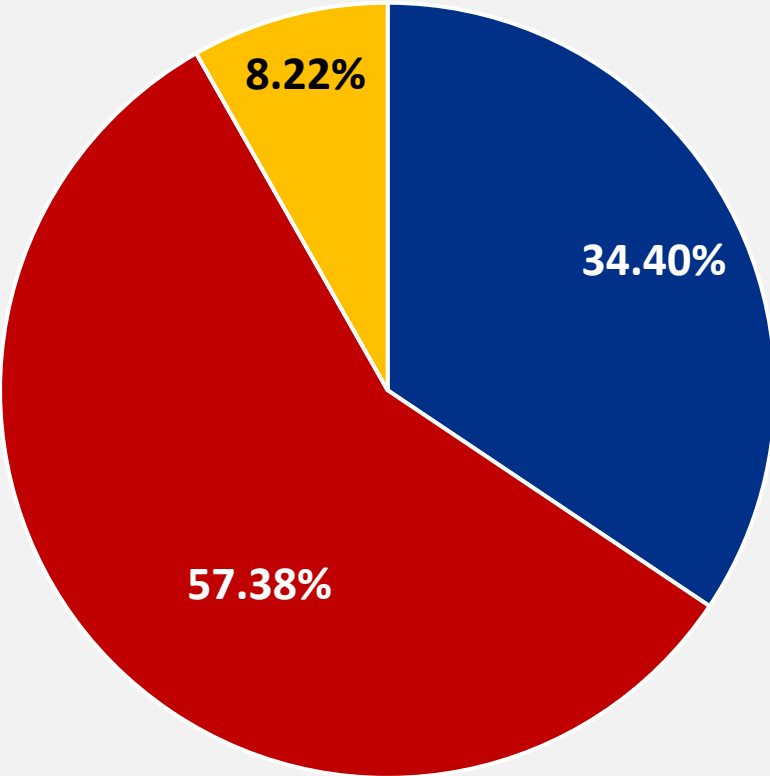
Data prepared by Injury Prevention Unit Epidemiologists using EMSTR data, April 2025.

Severe Trauma Transfer Time by Trauma Designation Level IV

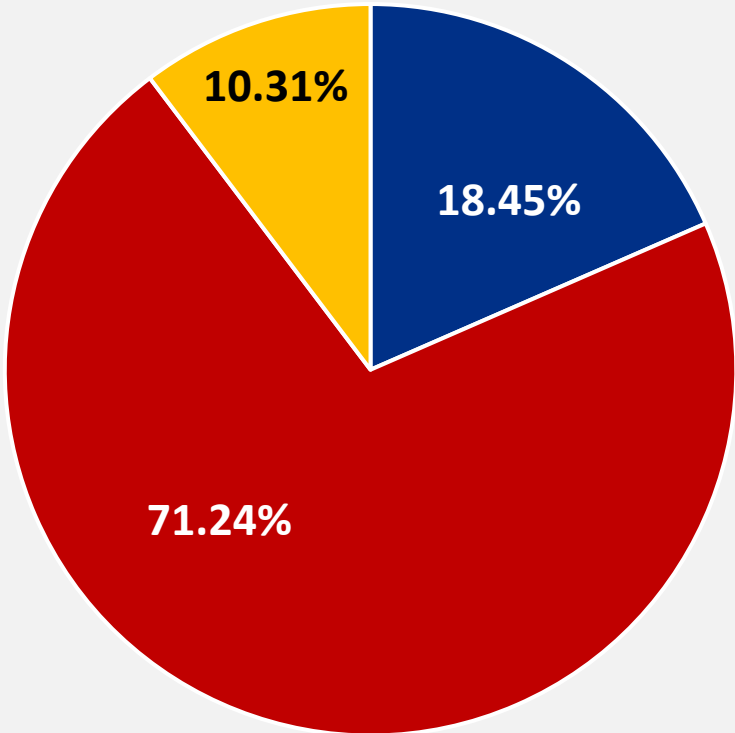
2022, N=714



2023, N=840



2024*, N=466

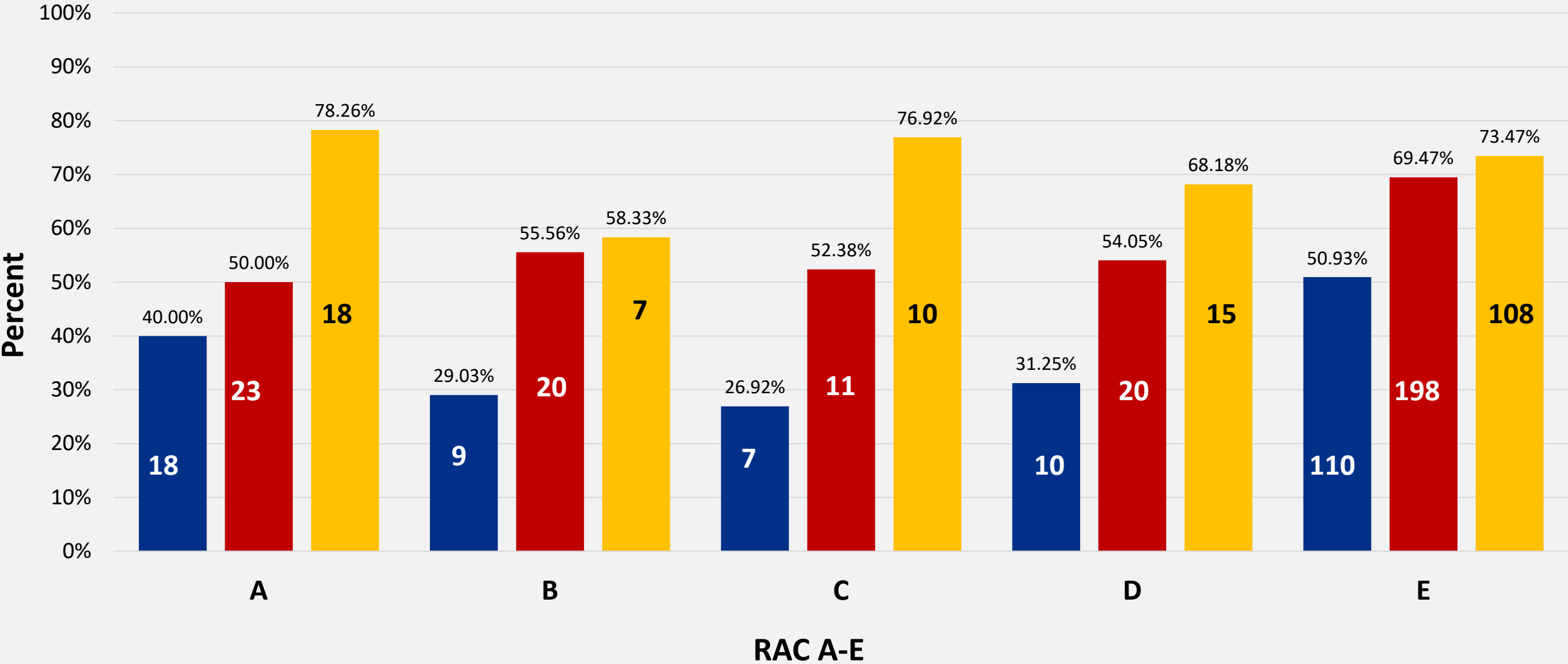


■ Under 2 hours ■ Over 2 hours ■ Missing time

*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

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

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

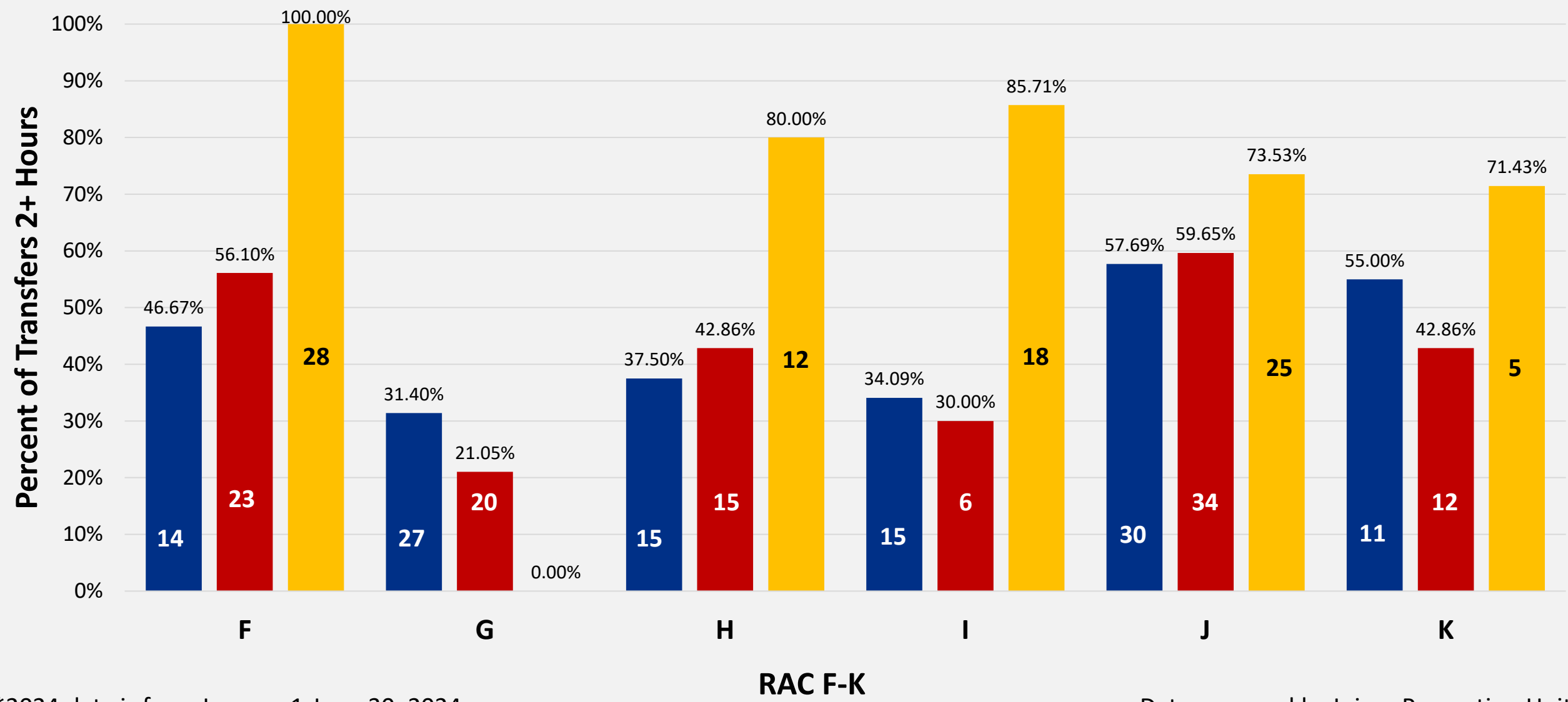


*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

■ 2022 ■ 2023 ■ 2024*

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

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

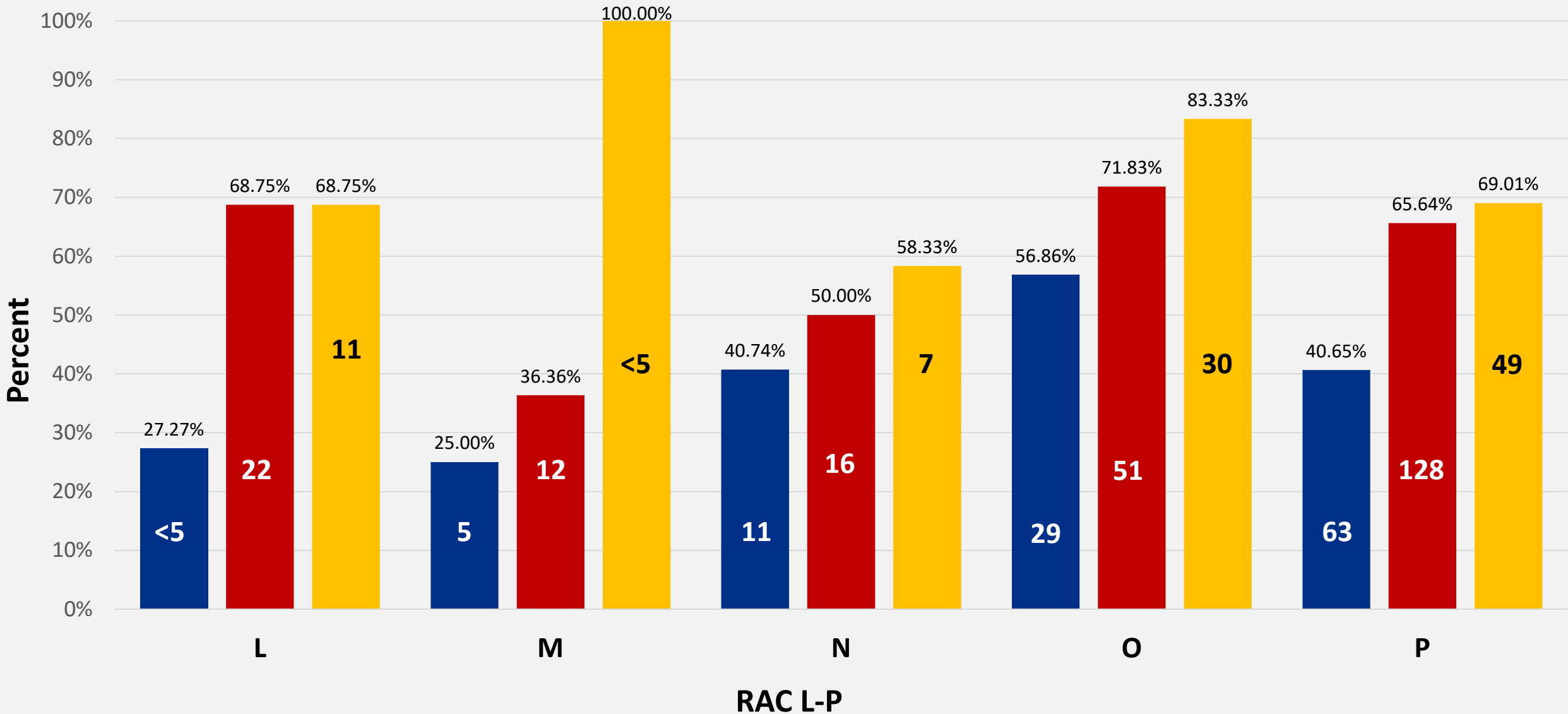


*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

■ 2022 ■ 2023 ■ 2024*

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

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

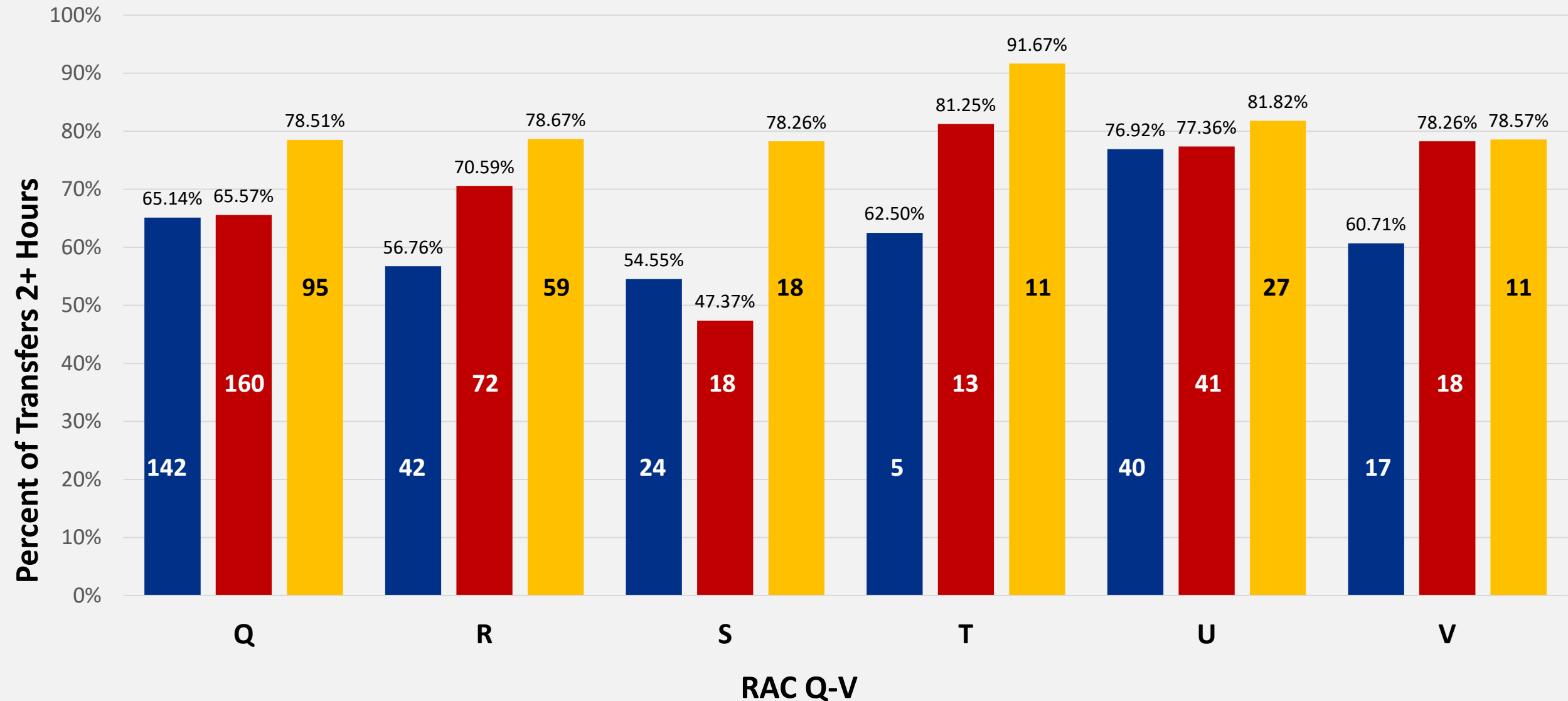


*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

■ 2022 ■ 2023 ■ 2024*

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

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



*2024 data is from January 1-June 30, 2024, and is preliminary as of April 9, 2025.

■ 2022 ■ 2023 ■ 2024*

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

Pediatric Readiness Scores of Texas Trauma Centers

May 5, 2025

NPRP Assessment Summaries

2013-14 Pediatric Readiness Response Rate

Numerator: 305
Denominator: 504
Response Rate: 61%

2021 Pediatric Readiness Response Rate

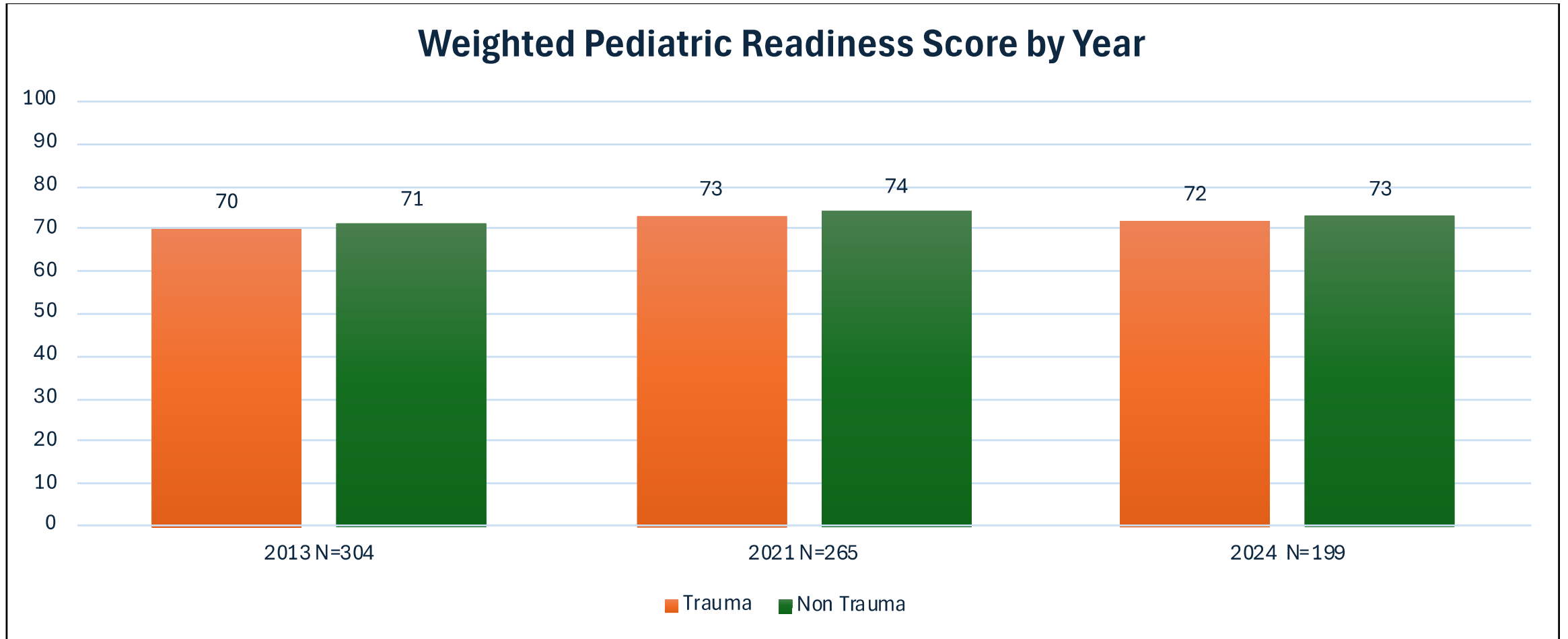
Numerator: 267
Denominator: 525
Response Rate: 51%

2024 Pediatric Readiness Response Rate QI Period

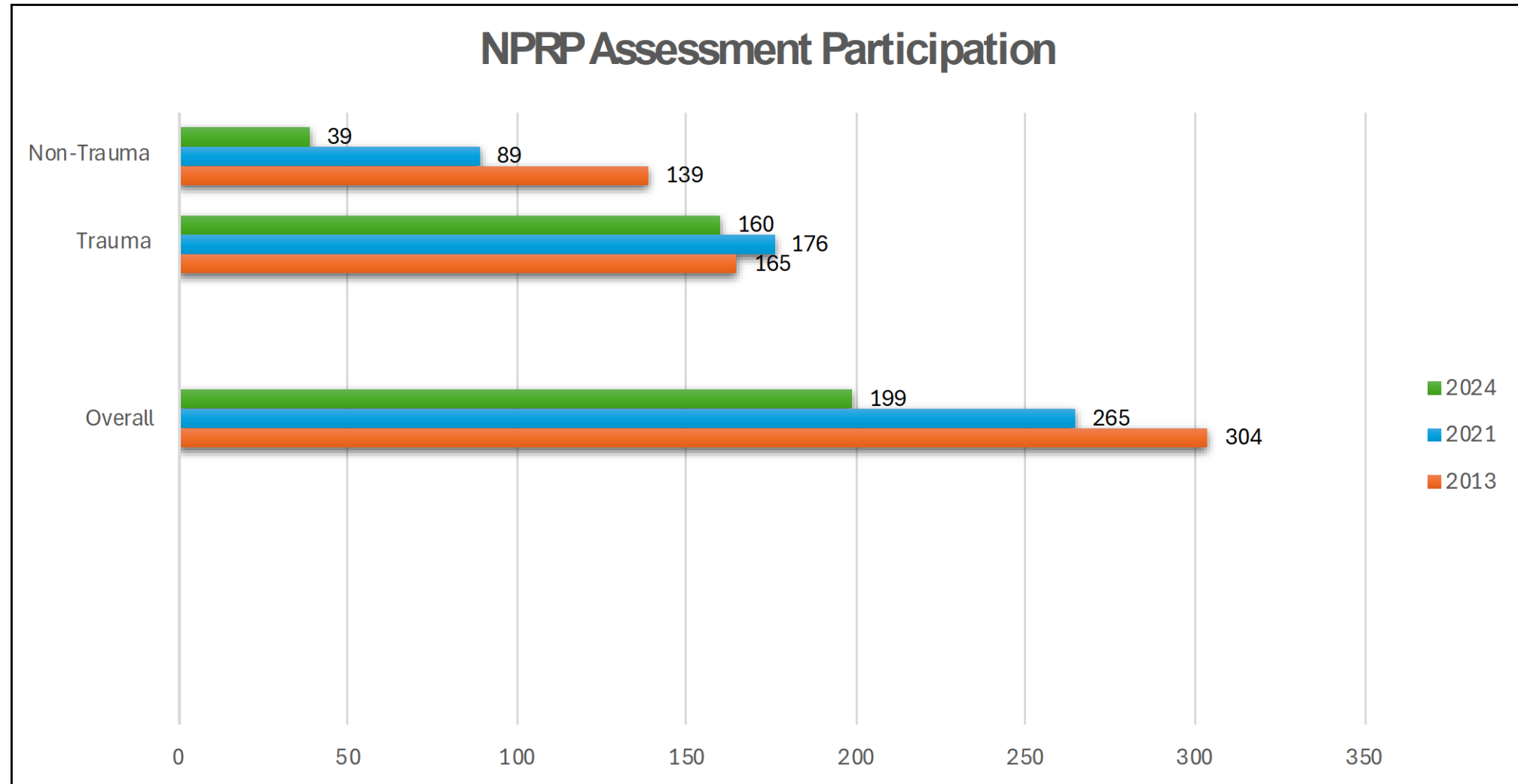
Numerator: 199
Denominator: 567
Response Rate: 35%



Pediatric Readiness Score by Year

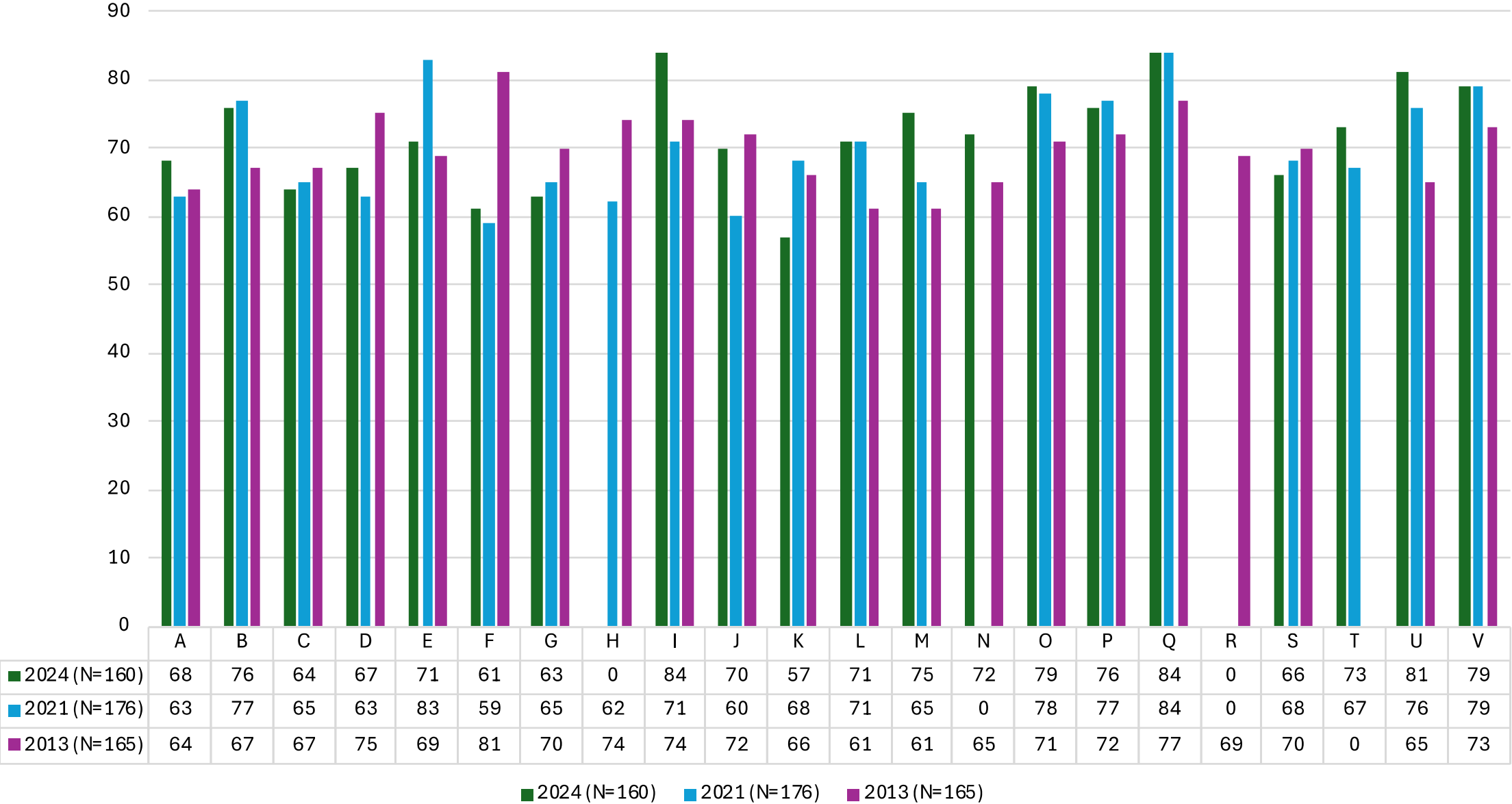


NPRP Assessment Participation



Weighted Peds Ready Score by TSA (Trauma Centers)

* No data = Less than 5 trauma centers responded



Peds Ready Score by Trauma Level Designation

2021	Numbers by Trauma Level Designation							
	Adult Level I (N=7)	Adult Level II (N=12)	Adult Level III (N=33)	Adult Level IV (N=110)	Peds Level I (N=5)	Peds Level II (N=4)	Peds Level III (N=2)	Peds Level IV (N=3)
Weighted Pediatric Readiness Score								
MEAN	78	76	77	69	99	95	99	96
MEDIAN	81	73	77	68	100	96	99	96

2024	Numbers by Trauma Level Designation							
	Adult Level I (N=14)	Adult Level II (N=21)	Adult Level III (N=30)	Adult Level IV (N=90)	Peds Level I (N=5)	Peds Level II (N=3)	Peds Level III (N=0)	Peds Level IV (N=0)
Weighted Pediatric Readiness Score								
MEAN	88	84	75	66	98	87	-	-
MEDIAN	86	86	75	67	99	82	-	-

Presence of a Pediatric Emergency Care Coordinator (PECC)

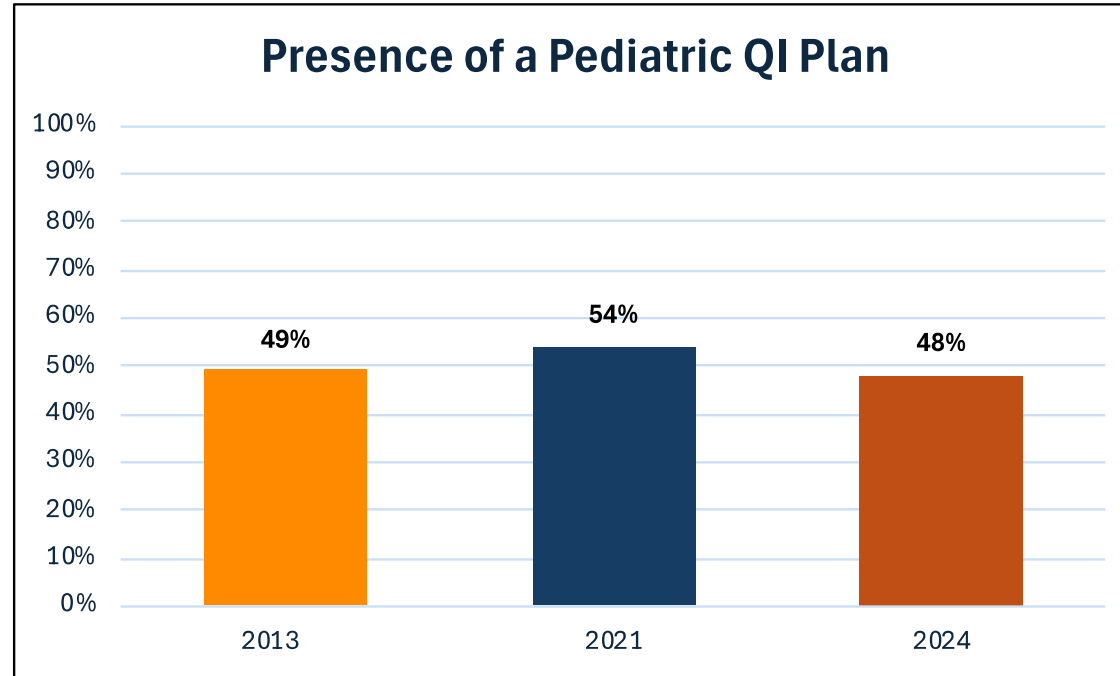
Presence of a Pediatric Emergency Care Coordinator (PECC) in Designated Trauma Centers Level I - IV Adult and Pediatric <u>2013</u>	Number of trauma centers that have item	Percent that have item	Percent that do not have item	Average Score of trauma centers that have item	Average Score of trauma centers that do not have item
Physician Coordinator	78/165	47%	-	-	-
Nurse Coordinator	105/165	64%	-	-	-
Both Physician and Nurse Coordinator	-	-	-	-	-
Neither a Physician or Nurse Coordinator	-	-	-	-	-

Presence of a Pediatric Emergency Care Coordinator (PECC)

Presence of a Pediatric Emergency Care Coordinator (PECC) in Designated Trauma Centers Level I - IV Adult and Pediatric <u>2021</u>	Number of trauma centers that have item	Percent that have item	Percent that do not have item	Average Score of trauma centers that have item	Average Score of trauma centers that do not have item
Physician Coordinator ONLY	15/176	9%	-	72	-
Nurse Coordinator ONLY	15/176	9%	-	75	-
Both Physician and Nurse Coordinator	63/176	36%	-	90	61
Neither a Physician or Nurse Coordinator	83/176	-	47%	-	61

Presence of a Pediatric Emergency Care Coordinator (PECC) in Designated Trauma Centers Level I - IV Adult and Pediatric <u>2024</u>	Number of trauma centers that have item	Percent that have item	Percent that do not have item	Average Score of trauma centers that have item	Average Score of trauma centers that do not have item
Physician/APP Coordinator ONLY	7/160	4%	-	69	-
Nurse Coordinator ONLY	43/160	27%	-	69	-
Both Physician and Nurse Coordinator	61/160	38%	-	86	59
Neither a Physician or Nurse Coordinator	49/160	-	31%	-	59

Presence of a Pediatric Quality Improvement Plan



Presence of a Pediatric QI Plan in Designated Trauma Centers			Yes	No
2013			81/165 (49%)	84/165 (51%)
2021			94/176 (54%)	82/176 (46%)
2024			77/160 (48%)	83/160 (52%)



10. Task Force Updates and Action Items



10.a. Burn Care Task Force

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

Project Deliverables Update

1. Define task force members by February 1, 2025
2. Define and review data available regarding burn care in Texas by March 31, 2025
3. List burn educational resources available in Texas by May 30, 2025
4. Establish process for identifying burn transfer trends and barriers by March 31, 2025
5. List all burn care resources available in Texas and adjacent states by June 30, 2025
6. Establish burn care guidelines from injury to being received at a verified burn center by August 30, 2025
7. Identify telemedicine options for burn care by November 2025
8. Outline strategies and resources to manage a burn disaster by November 2025
Outline strategies to integrate burn care into the Texas Trauma System

10.b. EMS Wall-times Task Force

Chair: Chief Dudley Wait, LP

Reduction of EMS Wall Times in Texas and analyze the impact of the associated white papers on the issue.

This group will form and hold its initial meeting in the coming weeks. The call for all participants is open.

11. Executive Committee Activities Summary

Executive Committee:

Alan Tyroch, MD, GETAC Chair

Ryan Matthews, LP, GETAC Vice-Chair

Sharon Malone, MD, GETAC Council Member

*No activities identified for
this quarter.*



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

Dinah Welsh, TETAF President/CEO



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Health Services

TEXAS EMS, TRAUMA AND ACUTE CARE FOUNDATION UPDATE

Terri Rowden, BSN, RN, TCRN
TETAF Survey Services Senior Director
June 6, 2025



TETAF ADVOCACY

- The 89th Legislative Session concluded on Monday, June 2.
- During the 140 days of the legislative session, TETAF:
 - Monitored the budget and more than 100 bills
 - Budget focus – Trauma, RAC, rural health, perinatal, EMTF, and whole blood
 - Hosted 8 virtual meetings for stakeholders to provide legislative updates
 - Provided oral and written testimony before the Texas Senate and Texas House
 - Developed and submitted formal letters sharing concerns regarding legislation
 - Developed and distributed a one-pager stating concerns regarding perinatal palliative care
- TETAF also advocated at the federal level regarding concerns of potential HPP funding cuts
- The TETAF Advocacy Report will be released later this month via email and the TETAF website with a complete overview of legislative activity.

SURVEYS – TRAUMA, STROKE, MATERNAL, & NEONATAL

- **TETAF and Texas Perinatal Services Surveys** – The current volume of surveys in order are trauma, maternal, neonatal, and stroke.
 - Perinatal surveys have slowed due to the significant dip in the three-year designation cycle
- **Trauma Rules** – TETAF continues to prepare for the changes to trauma designation requirements effective 9/1/2025. TETAF is working with surveyors, hospital partners, and DSHS to ensure rules are understood and followed. TETAF is recruiting additional trauma surgeon surveyors to meet increased survey participation requirement.

TETAF EDUCATION

- TETAF has offered continuing education in March and May through its virtual Texas Quality Care Forum. The next forum is on Thursday, June 26 at 10:00 a.m. CDT. The topic is, “Leveraging Technology to Streamline a QAPI Program”
- The next TETAF Hospital Data Management Course (HDMC) will be offered virtually on July 14-15. Early bird registration is now open.



Register for the
Texas Quality Care
Forum (TQCF)



Register for the
TETAF HDMC

TETAF COLLABORATION

- Last year, TETAF hosted the 35th Anniversary of the Texas Trauma System Celebration.
- The event raised funds for the TETAF Rural Trauma System Development Fund.
- TETAF has formed a committee comprised of board members and stakeholders with representation from rural trauma facilities.
- The committee is working to determine how to distribute the funds and the needs for funding. A brief questionnaire was shared in the TETAF June newsletter for rural trauma facilities.



Scan to complete the questionnaire if you are part of a rural trauma facility.

TETAF COLLABORATION

- TETAF continues to provide support to the Texas TQIP Collaborative.
 - Texas TQIP held its second quarterly meeting this week and is working on trauma data.
 - Questions about Texas TQIP? Email texastqip@tetaf.org.
- TETAF/Texas Perinatal Services was recently a sponsor of the spring Texas Organization of Rural and Community Hospitals (TORCH) Spring Conference and is a sponsor of the upcoming Texas Collaborative for Healthy Mothers and Babies (TCHMB) Summit on June 16-17 in Austin.
- TETAF welcomes the opportunity to be a resource, support, and/or participate in any meetings to further build the trauma and emergency care network.

13. 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.



03:00



Texas Department of State
Health Services

14. Announcements



15. Next Council Meeting Dates



Quarterly Meetings:

- **Q3** – August 19-22, 2025, Doubletree Hotel
- **Q4** – November 21-25, 2025, in conjunction with the Texas EMS Conference in Fort Worth.

16. 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.