Governor's EMS and Trauma Advisory Council (GETAC)
Department of State Health Services (DSHS)

Friday, March 7, 2025
DoubleTree Hotel by Hilton Austin
Phoenix South Ballroom
6505 N IH 35, Austin, TX 78752

Meeting Minutes

Last Name	First Name	Appointed Position	Attendance 3/7/25	
			In-person	Online
Tyroch, MD, Chair	**Alan**	**Trauma Surgeon - *per HSC §773.012(b)(14)***	**Y**	
Matthews, Vice Chair	**Ryan**	**Private EMS Provider - *per HSC §773.012(b)(5)***		**Y**
Booth	Donald (Donnie)	Rural Trauma Facility - *per HSC §773.012(b)(11)*	Y	
Clements	Mike	EMS Fire Department - *per HSC §773.012(b)(9)*	Y	
DeLoach, Judge	Mike	County EMS Provider - *per HSC §773.012(b)(12)*	Y	
Eastridge, MD	Brian	Urban Trauma Facility - *per HSC §773.012(b)(10)*	Y	
Johnson, RN	Della	RN w/Trauma Expertise - *per HSC §773.012(b)(15)*	Y	
Lail	Billy (Scott)	Fire Chief - *per HSC §773.012(b)(4)*	Y	
Petrilla	Brian	Certified Paramedic - *per HSC §773.012(b)(17)*	Y	
Malone, MD	Sharon Ann	EMS Medical Director - *per HSC §773.012(b)(2)*	Y	
VACANT		Public Member - *per HSC §773.012(b)(18)*		
Martinez	Ruben	Public Member - *per HSC §773.012(b)(18)*	Y	
Tidwell	Rodney	EMS Volunteer - *per HSC §773.012(b)(6)*	Y	
Potvin, RN	Cassie	Registered Nurse - *per HSC §773.012(b)(3)*	Y	
Ramirez	Daniel (Danny)	Stand-Alone EMS Agency - *per HSC §773.012(b)(16)*	Y	
Ratcliff, MD	Taylor	EMS Educator - *per HSC §773.012(b)(7)*	Y	
Remick, MD	Katherine (Kate)	Pediatrician - *per HSC §773.012(b)(13)*	Y	
Salter, RN	Shawn	EMS Air Medical Service - *per HSC §773.012(b)(8)*	Y	
Troutman, MD	Gerad	Emergency Physician - *per HSC §773.012(b)(1)*	Y	

Link to Meeting Presentation

Governor's EMS and Trauma Advisory Council (GETAC)
Department of State Health Services (DSHS)
Friday, March 7, 2025
Meeting Minutes

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1. Call to Order from Recess	Dr. Tyroch called the GETAC Q1 meeting to order at 8:00 AM.			
2. Roll Call	DSHS staff member Sabrina Richardson called the roll for GETAC and noted a quorum of members had been achieved.			
3. Welcome	Dr. Tyroch read the GETAC vision and mission statements.			
4. Review and Approval of Minutes	The November 2024 Q4 minutes were presented for approval, and the Strategic Planning Retreat 2025 minutes were deferred until the June 2025 Q2 meeting. Dr. Brian Eastridge moved to approve the November 2024 Q4 minutes, and Shawn Salter provided a second. The motion carried, and the minutes were approved without further discussion.		Minutes approved.	Place SPR minutes on the Q2 agenda.
5. Chair Announcements	Dr. Tyroch reported that the committees were very busy over the last two days. He added that meeting attendance, both in person and online, has been noteworthy, comparable to the monthly facility calls with the department. He commended the level of engagement. Dr. Tyroch announced that there is now a vacancy on the Council for a public member position and encouraged attendees to get the word out and directed interested individuals to the GETAC website for more information. He formally welcomed the three new members on the council: Mr. Donald Booth, the Rural Trauma Facility representative, will be the council liaison to the GETAC Cardiac Committee; Mr. Brian Petrilla, the Certified Paramedic representative, will be the council liaison to the GETAC EMS Committee; and Mr. Rodney Tidwell, the EMS Volunteer representative, will be the council liaison to the EMS Education Committee. Dr. Tyroch discussed the need for a second consultative visit by the American College of Surgeons (ACS), as a visit is long overdue. It was last done in 2010. Dr. Tyroch provided some background on the changes	DSHS will post the vacancy on the GETAC webpage.	Complete	

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	in the state since 2010: the state has grown by six million people and added 40 trauma centers for a total of 296 currently. Level I trauma facilities have increased from 16 to 22, Level II facilities from 8 to 27, and Level III facilities from 48 to 61. Level IV facilities have remained about the same. He added that a consultative visit allows many stakeholders to provide input. Dr. Tyroch reported that while there are 186 Level IV trauma centers, 53% are in frontier areas of the state, so a focus on the rural trauma system is paramount. Challenges discussed include the time for transfer, implementation of telemedicine, and financial support. He explained that Level IV facilities do not receive the Standard Dollar Amount (SDA), an HHSC add-on, limiting the amount of extra funding received. Pre-hospital whole blood is also a big initiative at the moment. An attendee asked about the next steps regarding the ACS consultative visit. Dr. Tyroch responded that the funding needs to be in place first, with an estimated cost of $150,000. Dr. Tyroch provided the dates for the Q2 meetings: June 3-6 at the Doubletree.			
6. State Reports				
6.a. **DSHS CHEPR**	The Center for Health Emergency Preparedness and Response (CHEPR) did not have a report for Q1.			
6.b. **DSHS EMS/TS**	• Jorie Klein, Director of EMS/Trauma Systems (EMS/TR) Section, provided an update on the activities occurring since the last GETAC meeting. **Legislative Activity** Director Jorie Klein shared the current legislative bills that the EMSTS section is following. SB 1018 regarding an increase in funds to 5111. This	Information only. No Council action required.		Continue quarterly updates to Council.

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	bill aims to redistribute the percentage of traffic fines collected and allocated to the department from 30% to 50%. SB 6721 is a bill regarding diversion. HB 1231 relates to the Medical Advisory Board (MAB); HB 2587 relates to Uncompensated Care Costs (UCC); HB 2058 is regarding perinatal bereavement care (new HB37); and HB 33 relates to active shooters and multihazards. Director Klein encouraged attendees to follow the listed bills. She added that any questions regarding current legislative activity as it relates to trauma and EMS should be directed to Joe Schmider. She commented the TETAF Legislative update is excellent and provides resource information. **Upcoming 157.126 Focus** Director Klein discussed the section's focus and shared a timeline of resource availability. The team produced a 157.125 comparison document in January and a 157.126 gap analysis in March. The gap analysis will be shared during the March conference calls. 157.126 Survey Guidelines will be updated in April. 157.126 establishes a new committee – the Designation Review Committee – for facilities that would like to appeal or have questions. An application for that committee will be rolled out in April. In May, the 157.126 Trauma Designation Assessment Questionnaire will be shared once the ACS provides approval, since their document was used in the foundation process. The designation unit will provide a review of the designation standards and requirements in May. **eDMEP** The department paid for 620 DMEP courses in June 2025. This effort targeted all trauma program managers and trauma medical directors. Participants had one year to complete once logged on. The department receives reports from the ACS reflecting participant status. **ACS Standards**			

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	Director Klein discussed ACS verification standards and how they compare to the Texas trauma designation process. She demonstrated how the Texas contingency process works with facilities to help them meet the requirements and achieve designation. Director Klein pointed out key aspects of the ACS standards but encouraged facilities seeking designation to read the entire ACS document. **GAP Analysis** Director Klein shared a snapshot of the gap analysis demonstrating how the rules are broken down and the facility can assign a priority level based on the facility meeting the requirement. This will help with planning and resource allocation. She also shared a snapshot of the ACS 2022 Standards Quick Reference Guide, explaining that the Level I, II, III, and Level IV trauma facilities managing 101 or more patients meeting the NTDB registry criteria must meet both the ACS and the state criteria. She also shared that if the Texas requirements are higher than the ACS standards, the Texas requirement must be met. **Funding** Director Klein explained the three different funds that support those resources and shared the spider chart demonstrating the various funding streams for EMSTS, indicating that the only way to increase funding in any one particular area is to create a new funding stream. SB 1018 would help increase funding by increasing amount of the fines allocated to trauma funds. Director Klein shared the various categories of items the EMS Trauma funding supports and stated that 96% of the funding the department receives goes through the department to the RACs and designated trauma facilities for trauma uncompensated care. She explained how RAC funding distribution is based on geographic size, population, the number of EMS emergency transports, and the number of trauma facility trauma registry submissions. She stated that the EMS County funds provide 60% to rural EMS and 40% goes to urban EMS.			

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	Extraordinary Emergency Funds (EEF) There was a brief discussion on EEFs, primarily on how the funds are allocated to EMS for equipment and resources in extraordinary situations. For FY25, $1M was made available on 9/1/24. Seven grants have been awarded EMS with $32,620.66 still available. **Uncompensated Care Funding** Director Klein provided details on the application process for uncompensated care funding, including deadlines and validation requirements. She stated that applications sent to the wrong address are an issue. Director Klein encouraged attendees to review TAC 355.8052 for more information on the trauma add-on dollars. Eligibility for trauma add-on dollars requires the facility to be an urban designated facility. Applicants for the 2024 UCC included 290 trauma-designated hospitals and five In Active Pursuit (IAP). Requested charges totaled $2,968,946,363. The 2025 applications went out in January. Part of the process includes looking at the Trauma Facility Readiness Cost FY24. Applications for uncompensated care funding are due by April 20, 2025, with $89 million set aside for this purpose. Director Klein shared graphics showing the significant increase in 2022 UCC requests and the decreased number of designated facilities. She showed data for Level IV facilities and rural Level IV facilities, demonstrating how the rural areas are most impacted by the lack of funding. Dr. Tyroch asked how the percentages in TAC 355.8052 could be changed to increase for rural facilities, and Director Klein stated legislation action are required to change the statute. • Elizabeth Stevenson, Designation Manager, provided an overview of trauma designation processes, common deficiencies, and the importance of meeting standards for funding eligibility.			

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	Trauma Designation and Deficiencies She reported 296 total trauma-designated facilities, with an increase in the number of Level IIIs. There were 29 applications in Q2: 23 renewals and 6 initials. Of the 29 applications, 66% were contingent designations and 34% were non-contingent. Common deficiencies include nursing documentation as number one, followed by trauma performance improvement evidence of loop closure, identification of all variances, and TMD participation in the secondary level of review. Mrs. Stevenson reported on the designation unit's activities. They held Trauma Rule Q&A meetings in December, drafted Section 157.125 Adopted Trauma Rule Comparison Documents for Level III and IV (available on DSHS website), held trauma monthly calls with the top two topics being trauma UCC application and adopted trauma rules, and Initiated a survey following monthly meeting calls to receive stakeholder feedback on benefits and suggestions for future meeting content. **Stroke Designation and Deficiencies** Mrs. Stevenson reported 191 stroke-designated facilities, with only three remaining facilities needing to transition to new levels. There were 14 applications: 10 renewals and 4 initials. Designation unit activities have included Initial Level IV Acute Stroke Ready meetings held September-November 2024 and January-February 2025. Monthly call discussion included diversion versus acceptance of transfers, survey organization requirements for higher-level certification differences, program manager mentoring resources, and suggestions for future meeting content. **Designation Application Performance Measures** Mrs. Stevenson reported on the unit's performance measures regarding the 30-day application turnaround goal for trauma and stroke, non-contingent, and the 60-day goal for contingent. All measures have met the established goals.			

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	• Joseph Schmider, State EMS Director, provided EMS Unit Updates. **Senate Bill 8 Final Update** The final report on Senate Bill 8 was presented, highlighting the distribution of 3,252 scholarships across various categories. The workforce increased by 10,915 people from January 1, 2020, to the present. Director Schmider commented that other states are looking at the model used to increase EMS personnel. The EMS recruitment and retention project was successful due to collective efforts, and a "$20 million gift" was effectively utilized. The Texas 89th legislature is considering a rider to add another $5M to the EMS workforce effort, but it will go through the Texas Workforce Commission if passed. **NEMSIS Update** Texas is approaching around 5 million submitted records and provides 9% of the total data that NEMSIS receives from all states. A patch is coming early April with 90 days to complete; it is a major patch. All major documents from the NHTSA website have been taken down for review, but if in need of one before they are uploaded to NHTSA site, contact Mr. Schmider. **TAC 157.11 Amendment Adopted** Mr. Schmider reviewed the amendments that were adopted and effective February 10, 2025. The language was cleaned up regarding the dialysis transport plan, saying that there must be a plan on how you transport dialysis patients during a disaster. Language was amended to state that EMS must carry 25 triage tags or participate in its RAC's triage plan. The Municipal insurance liability amount was corrected. The letter of credit requirement was set to expire in April but was extended for another ten years. The rule was cleaned up to demonstrate plain language. **89th Legislative Session**			

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	Legislative activities are ongoing with a focus on amendments and bill filings. Mr. Schmider reported that the EMSTS section is following 43 bills. • Brett Hart, EMS Licensing Manager, provided an update on EMS provider licensing and vehicle authorization. **Licensing and Processing Times** The licensing team processed 7,987 applications in the second quarter of 2025, reducing processing times by 50% since 2019. On average, it takes 8 days to receive a license. Mr. Hart provided reminders to EMS personnel: apply after receiving NREMT certification, complete DSHS application before getting the fingerprint background check, keep an eye on email for deficiency notices (check SPAM/junk), and add @DSHS.Texas.gov to the safe sender list. Mr. Hart advised that the licensing unit has no authority to grant certification extensions for renewal applicants. EMS educators, providers, personnel, and FROs will now receive certificates/licenses online. **EMS Provider License and Vehicle Authorization** New procedures for delivering EMS provider licenses and vehicle authorizations online were introduced, aiming to improve efficiency. The license wall certificates and vehicle authorization will be delivered to the DSHS online account secure mailbox beginning in March. He provided a brief tutorial on where to download and print those documents. The vehicle authorization will be a single document that can be printed for each vehicle. To make the authorization valid, the provider will write the vehicle license plate number on the document. Mr. Schmider added that this process makes it easier to take a vehicle out of service and bring one back in service more efficiently and will contribute to the improved processing times and reduced mailouts. He commended the licensing team – processes have improved significantly, with reduced processing times and new online systems for efficiency.			

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	Mr. Salter inquired about the status of the meeting location and hotel for upcoming meetings. Director Klein explained the process and advised that the bidding closes on March 18. She does not anticipate any problems and added that this will be for a five-year contract period.			
6.c. DSHS Injury Prevention Unit	Gavin Sussman, manager of the EMS Trauma and Submersion registries, provided an update for the Injury Prevention Unit. He reminded attendees that the 2024 EMS and Trauma Dataset will close on April 30, with a 5-10% increase in trauma records. Mr. Sussman reiterated the NEMSIS Critical Patch 5 update for version 3.5. **EMSTR Data Quality Webinars** Their team began offering EMS & Trauma registries (EMSTR) data quality webinars in February; over 200 providers attended the first one. The webinar discussed issues such as blood product administration, stroke assessment, documentation, stroke severity, score tools, patient wristbands, and Glasgow coma scale. The next session will be offered in May. **Cardiac Interfacility Transfer Data** Mr. Sussman provided a data analysis of cardiac data from the 2022 EMS registry, focusing on request and response times for cardiac emergencies. EMSTR worked with the GETAC Cardiac Care Committee to provide this presentation. Mr. Sussman shared the cardiac inclusion criteria and definitions. The cardiac data analysis reveals significant outliers (demonstrated through mean times higher than median times) affecting request and response times, with improvements noted in STEMI transfers. **Request Times Exceeding the Mean** When looking at request time over mean, 997 of the 5,618 total patients had a request time over the state average (mean) of 40.4 minutes. The Texas Association of Counties data was used to sort out rural versus			

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	urban to see if there was a difference in the number of patients over the mean, but no great difference was noted. For rural cardiac transfers, 14.01% of request times were greater than 40.4 minutes; 18.66% of urban cardiac transfer request times were greater. This suggests that distance alone is not responsible, but traffic and unit availability may contribute. When looking at request times over the mean by RAC, significant variability is not seen. Mr. Sussman pointed out that RACs C and I had 0% of cardiac transfers over the state average, and RAC S only had 1.85%. **Response Times Exceeding the Mean** There were 2,116 total patients (37.66%) with a response time over 22.3 minutes (mean) of the 5,618 total cardiac patients. These numbers do not include dispatch delays. Of all rural cardiac transfers, 25.56% of response times were greater than 22.3 minutes; of all urban cardiac transfers, 41.17% of response times were greater than 22.3 minutes, again suggesting that traffic in these urban areas is contributing to having responses above the average, more so than in the rural population. There was more variability when looking at response times by RAC, demonstrating distance to be a factor. This analysis does not incorporate dispatch delays; the presented data reflects the time when the unit states they're en route until they arrive at the pickup location. Mr. Sussman concluded his presentation by providing a link to get information on their programs, including the Safe Riders Program and Texas Overdose to Action (TODA) program, and to sign up for Injury Prevention Unit updates. He also provided a QR code to access the EMS and Trauma Registries. (1:14:46 on presentation) He opened it up for discussion, and Dr. Tyroch asked how many STEMIs were included in the dataset. Mr. Sussman stated there were 115 interfacility cardiac transfers from one hospital to another in 2022. Dr. Tyroch commented the number seemed low and asked if it included			

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	freestanding EDs. Mr. Sussman responded that the numbers were from reports where the EMS professional documented an incident pickup location of one hospital ED bed to another hospital ED bed. There was discussion on the challenges of documenting STEMI cases and inter-facility transfers, including issues with coding and delays due to limited ambulance availability in smaller communities (some communities only have one). The consensus was that the delays in EMS transfers are a significant issue, particularly in smaller communities, and require improved communication and resource allocation. Dr. Ratcliff responded to the lack of resources for patient movement and proposed an emergency SOS button to alert the state or region when a facility cannot move a patient, inspired by the success of the Pulsara platform. Dr. Cooley, Cardiac Care Committee vice-chair, indicated this data analysis was a first look at where the system is currently, and the intention is to go back and refine the data collection effort and analysis. There was discussion on the need for collaboration between EMS and the cardiac committee to address system-wide issues and improve service lines. Dr. Tyroch connected the issue to the newly formed terminology and transport task force (Strategic Planning Meeting). Ryan Matthews agreed that too often, there is a misconception that there are boundless transport resources, even in urban areas. He added that there is a need to identify functional definitions to analyze the issue and that there is no one-size-fits-all. Mr. Matthews, chair of the terminology and transport task force, expressed the need to recruit unbiased task force members to address the issue in a way that best allows different regions of the state to implement what best fits their region; this includes educating providers with a standardized definition set. There was also discussion on the need for standardization in data collection and documentation to improve accuracy and understanding of EMS operations. Mr. Matthews stated that this discussion was the best			

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	recruiting tool for the task force, and Dr. Tyroch advised that there needed to be cardiac and stroke representation on the task force. Dr. Troutman has agreed to assist Dr. Malone and Mr. Matthews with the task force. Dr. Ratcliff suggested talking with Pulsara to discuss a mechanical platform for the SOS-type approach; he will work with Dr. Malone and Mr. Matthews on organizing that, per Dr. Tyroch. Mr. Salter discussed the increasing number of unfilled mutual aid requests due to resource saturation and the need for better coordination. Kevin Deramus, EMS Committee chair, asked for available data to come to the EMS Committee as well, so they could look at it. He added they do a reverse Pulsara type of action in their community that alerts when a patient needs to move: *The wristband goes on a patient. If it's a STEMI stroke or trauma acute transfer, they scan it. It goes out through Pulsara to the dispatch center and to the district chief on duty. That lets us know that it's basically a 911 call in a brick building.* Prompted by Dr. Remick, there was discussion on the variability in the NEMSIS database and the need to standardize EMS protocols and streamline data points for better reporting and analysis. Current systems have hundreds of variables, leading to inconsistencies; the NEMSIS database for Texas has many variables related to unit disposition. Mr. Matthews commented that understanding the overall system to align reality with the vernacular is probably number one or two of what the task force is going to have to start with. There was an attendee request to improve the process of data sharing among committees to enhance efficiency and collaboration, such as including sharing data requests among committee chairs to avoid duplication of efforts. Dr. Tyroch suggested the task force could help polish the process to improve efficiency.			

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7. VIPR Project	Jeffrey Temple, PhD, McGovern Medical School, University of Texas Health Science Center at Houston, presented on the Violence and Injury Prevention Research Center (VIPR) project. He shared his appreciation for what GETAC does for the State of Texas. His work is a collaboration between UT Health - Houston and Baylor College of Medicine. Dr. Temple shared a map demonstrating only a handful of states with injury control research centers. He also shared the VIPR organizational chart. A community advisory board guides the organization. VIPR's vision is to be a leader in violence and injury prevention through research, outreach, and training, and he stated he'd be soliciting the support of many in attendance. The center aims to be a leader in violence prevention and research within five to ten years. The focus is on violence prevention, including dating violence, elder abuse, and suicide. The center will take a community-based participatory approach and offer grants and is available to help with training or to assist with getting initiatives rolling.	Information only. No action items were identified for the Council.		
8. GETAC Document Review and Approval	The *GETAC Strategic Plan*, *Standard Operating Procedures*, and Committee Guidelines were presented for approval, with the integration of all approved revisions discussed at the Strategic Planning Retreat, including the integration of EMS Education into the Strategic Plan. Danny Ramirez moved to approve all three documents as presented, and Dr. Eastridge provided a second. The motion passed without further discussion, and all documents were approved.		Approved.	Post approved documents to the GETAC webpage. Complete
9. GETAC Committee Action Items				
9.a. Air Medical and Specialty Care Transport Committee	**Air Medical and Specialty Care Transport Committee (AMSCT), Lynn Lail, RN, Chair** Lynn Lail provided an update on the committee's 2024 priorities that are still in progress. Delays in the DPS Trooper Educational Program due to restructuring within DPS, with plans to finalize and present the content. The final DPS trooper education program presentation is expected to be ready for council review next quarter. The HEMS Specific Mental Health			Continue quarterly report to Council.

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	Awareness resource content is complete, and design options have been created. Hope to have the final product by Q2. Mrs. Lail shared an update on the 2025 Q1 AMSCT Committee activities. The committee is in the data-gathering phase regarding the proper security of pediatric patients, looking at compliance percentage and determining if there is an issue to address. Additional activities will be determined as needed. The Fatigue Risk Management Programs (FRMP) for Air Medical and Specialty Care Transport providers workgroup is in its infancy and will involve gathering support, research, and data over the next quarter. The plan is to develop a white paper supporting the implementation and utilization of an FRMP. The committee has already gathered a great deal of data regarding the No Surprises Act (NSA). The committee plans to develop and disseminate education on how the NSA is protecting patients from exorbitant air medical transport bills. There will be an emphasis on air medical utilization guidelines. Action Items: The committee has three Q2 agenda action item requests: 1. Seek Council approval of the completed Texas DPS State Trooper educational program, as well as approval to hold the first class. 2. Seek Council approval of the completed HEMS Specific Mental Health Resource Document, which will focus on Preparation, Mental Health Emergencies, and Critical Incident Management assets. 3. Seek Council approval of the completed "Trauma Facility Helicopter Safety & LZ Training" presentation, which has been developed to fulfill requirement (h)(6) of the Texas Administrative	The committee requested approval to add three action items to the Q2 GETAC Agenda. No additional action items	Approved.	Add all items to the GETAC Q2 Agenda.

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	Code Chapter 157, Rule 157.126 Trauma Facility Designation Requirements, which will be effective on September 1, 2025. Council approved the request to add these items to the Q2 GETAC agenda.	were identified for the Council.		
9.b. Cardiac Committee	**Cardiac Care Committee, James McCarthy, MD, Chair** Dr. Craig Cooley, committee vice-chair, shared an update on the Cardiac Care Committee activities. The committee reviewed the data presented earlier regarding cardiac transfers and plans to further explore data elements to look for opportunities for improvement in timely transfers. There was discussion about how tracking cardiac patient transfers is challenging due to multiple data sources and competing systems. Dr. Cooley mentioned that a couple of individuals were interested in joining the interfacility terminology and transport task force and expressed his hope that they would reach out, as this is an important issue. To evaluate the penetration of life-saving CPR instruction provision before EMS arrival, the committee plans to distribute a survey statewide to understand challenges and improve CPR education through the RACs. An official ask from the committee to the RACs will occur at the Q2 RAC meeting. Chief Kevin Deramus, EMS Committee chair, requested the opportunity to collaborate on the survey. The committee is working to educate state leaders and the legislature on the importance of data sharing and the need for cardiac designation. Dr. Cooley stated that they continue to analyze AED and bystander CPR data and outcomes, a 2024 priority, to evaluate changes. No specific action item requests at this time.	No action items were identified for the Council.		Continue quarterly report to Council. Add survey request to RAC agenda. Cardiac/EMS collaboration on telephonic CPR instruction and education survey.

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9.c. Disaster Committee	**Disaster Preparedness and Response Committee, Eric Epley, CEM, Chair** Mr. Epley provided an update on the Prehospital Whole Blood Task Force. The Prehospital Whole Blood Task Force meeting had a solid turnout. Discussion included the significant challenges in blood supply management, including the need for domestic production of blood bags. Walking blood banks are cumbersome, and there is a need for pre-screened hospitals. The task force discussed the legislation that the Texas EMS Alliance and STRAC are pursuing for whole blood in Texas for the pre-hospital environment. He reported a cost of $4 million over the biennium and stated language included support for the development of rotation systems. Mr. Epley referenced a NHTSA statement that equated the lifesaving value of pre-hospital whole blood to seatbelts integrated in the 1970s, saving up to 10,000 lives a year. There is a potential issue with the supply of 35-day blood bags, which are mostly manufactured outside the US. Dr. Ratcliff suggested that Texas should consider becoming a domestic producer of blood bags to address supply issues. Mr. Epley agreed and stated the US Department of Defense might be a willing partner and discussed the transition to a 35-day blood bag system by the DoD and its implications for national security, EMS, and civilian trauma systems. He stated that the 35-day blood bag system is essential for readiness and should be recommended to the governor. Mr. Epley also provided an update on the Disaster Preparedness and Response Committee's Q1 activities. The committee reviewed the Emergency Medical Task Force (EMTF) deployment and quarterly performance summary from the EMTF State Coordination Office (SCO). It showed a doubling of deployment tempo, especially with Wildland Fire Medical Support missions.	No action items were identified for the Council.		Continue quarterly report to Council.

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	The committee discussed the value of the Pulsara app's new feature for family reunification in emergencies. Pulsara can upload the Raptor report from schools for accountability and attendance; it helps identify missing individuals during emergencies, addressing the challenge of tracking individuals in crisis situations. Mr. Epley shared how Mr. Schmider took the wristband concept to the National Association of State EMS Officials (NASEMSO), and they adopted it as a national standard for any state that uses the wristbands. The committee also discussed the concerns about the economic drivers affecting the production of 35-day blood bags and their importance for military operations. They reviewed a summary of PHWBTF, walking blood banks, 35- vs 21-day blood bags, and concerns of the 35-day bag going away in 2026. Discussion included the $4M riders TEMSA and STRAC have pursued for whole blood, equipment, and training, especially for rural areas. Mr. Epley commented on the National Disaster Medical System (NDMS) movement to the southern border and the importance of an integrated military-civilian response. Planning for NDMS and large-scale combat operations is underway, focusing on integrated responses. An integrated military-civilian response is crucial for large-scale combat operations. Planning for 1,000 patients a day for 100 days. Air superiority issues may require alternative transport methods. Dr. Ratcliff shared a concern about challenges with EHR vendors like EPIC in making wristband numbers searchable and standardized across facilities. Director Klein suggested it would be best to discuss these issues level with the EHR vendors in the area. Dr. Flaherty suggested discussing with the DoD to bring major HER representatives to the table to integrate the EMS wristband field into patient reports as a default field, like name,			

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	date of birth, etc., and allow it to be searchable. Dr. Tyroch asked if Mr. Epley and Dr. Flaherty could also address the 35-day blood bag issue in their conversations.			
9.d. Emergency Medical Services Committee	**Emergency Medical Services Committee, Kevin Deramus, LP, Chair** Chief Deramus shared an update on the EMS Committee's Q1 activities. Dwayne Howerton is chairing the workgroup on 157.11 rule revision to provide a framework for the DSHS/GETAC Council for revision recommendations. This workgroup meets monthly. Chief Hayes is leading the newly created committee workgroup to discuss the ever-increasing concern and problem of workplace violence against EMS personnel. The workgroup is working with DSHS staff to finalize a data survey for EMS providers to present at the Q2 GETAC meeting. The survey's purpose is to better understand how often workplace violence against EMS personnel occurs in Texas and to reduce it. The committee will have a workgroup to focus on reducing the use of red lights and sirens in emergency responses, linking it to Medicare Committee worker surveys and cost analysis. Donald Janes, chair of the Stroke Workgroup, is working directly with the Stroke Committee to provide updates, and he continues to work with the committee to approve stroke recommendations. Dudley Wait is organizing the collaborative Wall-Times Task Force to analyze the impact of the associated Wall-Times White Paper on the issue. No action items.	No action items were identified for the Council.		Continue quarterly report to the Council. Add survey to Q2 GETAC (previously approved but deferred this quarter) and EMS committee agenda.
9.e. EMS Education Committee	**EMS Education Committee, Macara Trusty, LP, Chair** No report or action items for Council.	No action items were identified for the Council.		Continue quarterly report to Council.

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9.f. EMS Medical Directors Committee	**EMS Medical Directors Committee, Christopher Winckler, MD, Chair** Dr. Winckler provided an update on the committee's activities. The EMS Medical Directors Committee reviewed the prehospital stroke recommendations presented by the Stroke Committee. The EMS Acute Stroke Routing Resource Documents were voted on and approved as recommendations to be acted on by RACs and/or agency EMS Medical Directors as best practice per national guidelines. The Mission Lifeline Algorithm revisions were voted on and approved. The EMS Acute Stroke Routing Resource Documents for Pediatric Stroke were voted on and approved. All documents are considered resource documents only. The committee will review and make recommendations on the Pediatric Consideration for Consultation and Transfer documents, including the Child Physical Abuse Toolkit, the American Burn Association Transfer Guideline, and the Pediatric Interfacility Transfer Quality Improvement Plan. The committee will assist with staffing the task force to develop and recommend interfacility transfer terminology, suggesting there might be a need for a terminology team. Dr. Elizabeth Fagan, EMS Medical Directors Committee vice-chair, presented North Central Texas Trauma Regional Advisory Council wall time performance/times for EMS/hospitals at the committee meeting. This information and process will help advise other RACs on how to implement similar programs in their respective systems. Information shared with other RACs/EMS agencies. The committee had a lengthy discussion on the safe transport of pediatrics in ambulances. Discussed best practices throughout the country on the	No action items were identified for the Council.		Continue quarterly report to Council. Follow up on sharing of NCCTRAC presentation – DL

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	safe transport of pediatrics. There was discussion on what is legally required vs best practice and whether there needs to be an advisory or resource document, or possible integration into 157.11. The first step for this committee is to determine the current law regarding the safe transport of pediatrics in an ambulance. The committee discussed the practice of EMS medical direction under the new Texas Medical Board rule 169, which codifies the delegation of practice for EMS medical directors. The committee discussed options such as developing a list of duties and expectations of Texas EMS Medical Directors, previously found in TMB Chapter 197, possibly placing these duties and expectations in 157.11, or developing an advisory or resource document. The committee is developing resource documents for the State of Texas on prehospital care. Strong consideration will be given to evidence-based prehospital practice. These would be resource documents and would not replace or appropriate any EMS Medical Director's practice of medicine within their EMS agency as prescribed by Texas Administrative Code 169 or 157. There is a need to update the Texas Medical Directors course, which is outdated. The committee is going to research state requirements and go from there. Mr. Salter mentioned that the Air Medical Physicians Association (AMPA) has a medical director's course that may be considered in framework development. Mr. Schmider stated that 157.11 needs to be updated, but it states that medical directors are to meet requirements as stated in TMB 197. Mr. Schmider agreed that the current course is outdated and suggested creating a Texas medical directors' course to present to the department for approval. No action items.			Check the accuracy of the medical directors' course on the DSHS website.

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9.g. Injury Prevention & Public Education Committee	**Injury Prevention & Public Education (IPPE) Committee, Mary Ann Contreras, RN, Chair** Ms. Contreras presented an update on the committee's 2025 Q1 activities. The committee is looking to promote the expansion of the child passenger safety technician work across the state. Current efforts aim to increase the availability of courses. The goal is to increase the ratio of child passenger safety technicians in Texas from 1:1,279 to 1:1,000 by 2025 through increased courses and partnerships. She added that there is significant support within the state, demonstrated by the 200 people at the last workgroup meeting. The committee is looking to improve course attendance options to increase attendance. The committee is also exploring best practices for drowning prevention, aligning with national programs, and implementing bystander intervention education. A position statement on workplace violence is being developed, focusing on reducing violence and promoting worker wellness and stress reduction strategies. No action items.	No action items were identified for the Council.		Continue quarterly report to Council.
9.h. Pediatric Committee	**Pediatric Committee, Christi Thornhill, DNP, Chair** Christi Thornhill shared the committee's Q1 2025 activities. The development of guidelines for transferring facilities is underway: pediatric imaging (following the ALARA principles) and transfusion/massive transfusion timelines. The transfusion guidelines will be for EMS as well. Dr. Tyroch mentioned checking with pediatric facilities to see what's already out there, and Dr. Thornhill acknowledged there was a plethora of information, but the workgroup is looking to pull together a group of			Continue quarterly report to the Council. Dr. Thornhill will send an email to request multi-committee collaboration on

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	resources into one place. She stated she would do an all-call to other committees for members to join the workgroup. T The committee will also develop a pediatric guideline for transferring facilities for pediatric pain assessment and appropriate pain management. They will utilize Regional PECCs and RACs to disseminate best practices regarding a complete set of vital signs and weight in kilograms for pediatric patients. They will review vitals and weight in kg data from EMSC now to get a baseline on the situation and request Registry data once the new rules go into effect to monitor and increase compliance. The committee is working to complete the toolkit on pediatric magnet/button battery ingestion to present to the Council for approval. The development of a toolkit regarding Sudden Cardiac Arrests/Deaths in Pediatrics is underway. Dr. Thornhill stated it's hard to find good data on the number of sudden cardiac arrests and deaths in the pediatric population, but the workgroup is moving forward with the data they can acquire. So far, 530 Sims have been completed in 158 hospitals across the 22 RACs, with almost 4,000 people having participated since 2/2024. The education series will continue, but the time is changing from 7:30 to 10 AM. The regional PECCs will monitor the utilization of 13 pediatric simulations. The committee requests data from the state regarding trauma center compliance after rule 157.126 is in effect. Action items: 1. Request the approval of the GETAC council for the Head Injury/Concussion Toolkit presented last quarter and to allow posting on the committee webpage. Dr. Remick motioned to approve the Head Injury/Concussion toolkit. Donny Booth provided the second. Motion passed. No opposition or additional discussion.	A motion was made to approve the toolkit.	Approved.	the workgroups. Follow up-DL Add Concussion Toolkit to the committee webpage.

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	2. Request the council to 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. Dr. Thornhill addressed another issue regarding facilities receiving SDA money. She reviewed all facilities receiving and only one children's hospital received funding. When she contacted HHSC, they were told that no children's hospitals receive the funding, even if designated. Mrs. Stevenson (DSHS) has already reached out to HHSC to set up a meeting to discuss and get clarification. She advised that she would also address the other questions that have come up regarding SDA when they have the meeting. Dr. Remick provided an update on the TX Pediatric Readiness Improvement Project. TETAF has provided almost 2,500 CE credits for the pediatric readiness education. She shared the National Pediatric Readiness Quality Initiative dashboard as a mechanism to assist with becoming pediatric-ready and adhering to the new rules that go into effect in September. Texas has 29 sites with executed agreements, and 22 sites entering data, with 3,308 records entered thus far. Records can be viewed on national, state, regional, and healthcare network levels. Four RACs have registered: I, J, K, and O. Dr. Remick shared the dashboard data showing some of the performance measurements for Texas compared to the national average – there are 28 shared across 7 bundles of measures. All measures can be viewed in a graph format. Dr. Ratcliff asked if there was a pediatric EMS dashboard. NEMSIS has developed those dashboards, but there are challenges with agencies being able to see their specific performance compared to others.	The council will discuss this topic at the Q2 GETAC meeting.	Approved.	Add HIEs to Q2 Council Agenda. Add TXFR document to Committee agendas for Q2 meetings.

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	Dr. Tyroch commented that the state has made significant improvements with pediatric emergency care in a short amount of time.	No additional action items were identified for the Council.		
9.i. Stroke Committee	**Stroke Committee, Robin Novakovic, MD, Chair** Dr. Novakovic shared the Stroke Committee's 2025 Q1 activities. The Stroke Committee has seven actively engaged workgroups. She stated that Texas is making significant improvements in stroke care performance, with aspirations to further reduce door-to-needle times. She is encouraging stroke facilities to participate in GWTG prehospital and interfacility transfer layers, and with RDC for improving door-to-needle times. Currently, 36% of Texas stroke facilities are participating in RDC. The stroke data the committee receives comes from GWTG, with 196 Texas hospitals participating. There are 191 facilities designated in Texas, with 40 as rural, but not all are participating in GWTG. Dr. Novakovic shared the Texas Stroke Quality Report for door-to-needle time. Median door-to-needle time in Texas for 2024 is 39 minutes, while the national median time is 40 minutes. Urban areas have a door-to-needle time of 38 minutes, rural 46, and suburban 41. The goal is 50% within 30 minutes, 75% within 40 minutes, and 85% within 60 minutes. In 2024, Texas achieved 92% within 60 minutes. Concerns were raised about neuro-IR coverage at multiple facilities, leading to delays in care. The Stroke System of Care Workgroup is seeking objective measures to demonstrate these delays, patients denied, and misuse of resources. Recommendations include internal quality reviews - Encourage hospitals to perform internal multispecialty review of denied thrombectomy and provide feedback on patients deemed inappropriately denied treatment. The workgroup also suggested			Continue quarterly report to the Council.

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	monitoring required and internal performance measures: Neuro IR notification (page) to response, Neuro IR notification to angio team activation, Neuro IR notification to hospital arrival, Neuro IR notification to patient arrival to angio door, Angio door to groin puncture, and Groin puncture to device deployed. Dr. Novakovic sought Council guidance on how best to demonstrate interfacility stroke transfers from CSC to CSC for thrombectomy/higher level of care. Dr. Tyroch suggested going to the RACs to see if they are looking at it regionally. Dr. Novakovic stated she could check with GWTG, but it might not capture all patients. She asked if there was data that could be pulled from EMSTR. Mrs. Stevenson stated that two survey organizations that certify the facilities are the Joint Commission and DNV. Mrs. Stevenson spoke with DNV, and DNV looks at the log of every transfer out of a Comprehensive Stroke Center and why. She was in the process of setting up a meeting with the Joint Commission to look at this as well. Dr. Tyroch recommended the RACs look at this as a PI item. Dr. Novakovic reported that NCCTRAC is working on this. Current or Future Action Items: 1. The EMS Acute Stroke Routing algorithms were approved by GETAC in November 2024, but there was a request to clean up the chart. This has been done, and the final documents were presented to the Council for approval. Dr. Ratcliff moved to approve the documents. Mr. Salter provided a second. Discussion followed regarding the times being nationally approved. Dr. Novakovic stated they were indeed. No opposition. Motion passed. 2. The prehospital adult Stroke Triage and Management Resource document was discussed. The EMS Medical Directors Committee is reviewing, and the plan is to present it to the Council at the Q2 meeting. 3. The EMS Acute Pediatric Stroke Triage Algorithm and resource documents have been reviewed by the Pediatric, Air Medical, EMS	1. The committee presented the EMS Acute Stroke routing documents to GETAC for approval.	1. Approved	2. Add adult resource doc to GETAC agenda 3. Add Peds algorithm and tip sheet to EMS MD and EMS Committee agendas.

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	MD, and EMS committees. The EMS Committee requested some revisions and would like the EMS MD to approve those revisions. 4. Dr. Novakovic requested to participate on the Interfacility Terminology and Transport Task Force. She has also asked for a Stroke Committee liaison with the EMS Committee to help facilitate some of the education opportunities from the Stroke Committee. Dr. Tyroch said it sounded like a good idea and to contact Macara. 5. The committee is working on a TEAM EMS-Ed study to see if standardized stroke education can improve stroke knowledge in EMS. The proposal has been drafted and is seeking funding from LSSC. Will seek collaboration within the EMS and EMS MD Committees. 6. The new Post Acute Stroke Care Workgroup, led by Dr. Sean Savitz, is seeking members. Contact Deidra. 7. The Education Workgroup is discussing a platform and the feasibility of implementing a mentorship program. Will propose a Stroke Managers survey in June. 8. The Rural Stroke Workgroup has held its first meeting and is working on defining the scope and identifying barriers in rural stroke care. They are requesting EMSTR data and to create a map to identify stroke-care deserts in Texas. The group has 27 members. Dr. Novakovic provided a QR code for attendees interested in joining the workgroup. (timestamp 3:17:53). 9. The committee is also requesting approval to conduct a needs assessment survey in rural and resource-challenged regions. Dr. Remick asked if this should go through the RACs since they know their deserts. Director Klein suggested TORCH as well. Mr. Salter asked for clarification that the rural data request would only include patients with a diagnosis of or a suspected stroke. D. Novakovic confirmed. Chief Ramirez requested that Dr. Novakovic work with the Interfacility Terminology and Transport Task Force to ensure standardization of terms. Dr. Tyroch stated this item needs a little more work before approved.	4. Contact Macara - DL 8. Mrs. Stevenson will work committee to get a map created through DSHS. 8. EMSTR rural stroke data request – Committee to work with Registry. 9. Rural stroke needs assessment survey	Complete 8. Both approved. 9. Not approved.	3. Add above to GETAC agenda 5. Add to TEAM EMS-Ed to GETAC Q2 agenda.

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	10. The Texas EMS Stroke Survey is completed. Dr. Novakovic will present the results at the June meeting. 11. Dr. Novakovic requested approval to present the Wake-Up Stroke Survey at the DSHS stroke meetings to encourage participation.	No additional action items were identified for the Council.	11. Approved	
9.j. Trauma Systems Committee	**Trauma Systems Committee, Stephen Flaherty, MD, Chair** Dr. Flaherty shared the committee's 2025 Q1 activities. He started by recognizing Memorial Hermann in the Trauma Spotlight. Memorial Hermann is a Level I trauma center in the Houston area, with excellent facilities and operations. They have streamlined the movement from EMS to the trauma OR for trauma patients needing surgical intervention. He recognized their air medical unit for its role in establishing an effective street-to-OR program. Dr. Flaherty also recognized Parkview Hospital in Mexia, TX. They are a Level IV trauma facility that sees about 9,000 ED patients a year in the 7-bed ED, typically staffed with two RNs and one doctor. They've entered 61 patients into the Trauma Registry. Dr. Flaherty discussed the Integration of Military and Civilian Trauma Systems in Texas, specifically on the Southern Border. Active military operations in Texas are unusual and require special permissions. President Trump declared a national emergency at the southern border of the United States, allowing the deployment of military troops to support operations to maintain territorial integrity to seal the border. Dr. Flaherty discussed the integration of military and civilian trauma systems, focusing on resource allocation, healthcare provision, and the use of civilian infrastructure to support military operations. He also discussed the importance of MIL-CIV integration for emergent care. The DoD wants to know what capabilities are available, so there is communication and coordination between the Joint Trauma System (JTS), the DoD's trauma care authority, and the Regional Advisory Councils (RACs) and Regional Medical Operations Centers (RMOCs) in border			Continue quarterly report to Council.

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	states "to integrate military and civilian trauma systems. Through frameworks like the Trauma System Support branch, JTS shares guidelines, data, and expertise—e.g., collaborating with the Southwest Texas Regional Advisory Council—to enhance rapid patient care within the golden hour. This strengthens DoD-civilian interoperability, aligning with national mandates for improved trauma outcomes." Dr. Flaherty shared the civilian system implications: 1. Optimized Use of Civilian Infrastructure: • Civilian hospitals will serve as the primary destination for time-critical conditions (STEMI, stroke, sepsis, severe trauma), leveraging their established expertise and proximity to reduce time to definitive care 2. Military Air Medical as a Force Multiplier • In austere or remote border regions, military air medical assets (e.g., MEDEVAC helicopters) can bridge gaps where civilian evacuation is limited, enhancing access to care by transporting patients to civilian facilities efficiently. 3. Systemic Resilience Gains • Collaboration enhances regional emergency response capacity, as military evacuation support and civilian hospital expertise combine to create a more responsive network for both populations, especially in border or rural zones. Dr. Flaherty summarized by stating that Executive Order declaring national emergency on the southern border enables the use of DoD resources to support the Lead Agency (homeland Security), anticipate 1,000 personnel involved along the entire course of the border, DoD plans routine healthcare within the DoD system (TriCare), time-critical injury/illness will be managed in the civilian healthcare system, awareness is preparation, military-civilian integration of trauma systems is essential to the defense of the homeland.			

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	He added that they were working to create STRAC as the lead RMOC for the entire border so that the information regarding all resources would be funneled through STRAC to provide the DoD with a single point of contact. Dr. Flaherty advised that HIPAA is a little different for active-duty military. He also stated that he is currently working with Lynn Lail to develop a list of the helipads that can support the heavier helicopters, such as the Blackhawk. The Trauma Systems Committee continues to assess barriers for designation. They also regularly communicate with the RAC chairs to facilitate early awareness of challenges in the trauma system. The committee is active in fostering an inclusive trauma system, as demonstrated by the facilitation of military-civilian integration. They have no update regarding the finances of the trauma system. The committee is reviewing the pediatric documents and will provide feedback at the Q2 meetings. Action items: 1. Dr. Flaherty requested that Dr. Raul Barreda be approved as the committee's vice-chair. 2. Requested to have Dr. Aileen Ebadat added to the Burn Care Task Force.	No additional action items were identified for the Council.	1. Approved 2. Approved	Edit Webpage. - DL Add Dr. Ebadat to roster. – DL Complete
10. Task Force Action Items				
10.a. System Performance Improvement	Dr. Kate Remick, MD, Task Force chair, provided an update on the task force activities for 2025 Q1. The task force requests to be renamed as the System Collaborative for Outcome Review (SCOR) – GETAC approval requested. The mission statement is in development and expected to come to GETAC in June for approval. The task force reviewed representation; it has a member from each of the ten GETAC committees and a member from RAC chairs, Burn Care Task Force, TQIP, and Perinatal Advisory Committee. The task Force voted to write up a			Add SCOR mission statement to GETAC agenda. Add scope of activities and

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	measure prioritization process. The scope of activities and process map are being developed and will be presented to GETAC for approval in June - clinical patient outcomes, data quality and analysis, IT support, and system infrastructure. Della Johnson moved to approve the implementation of the new name, SCOR. Sean Salter provided a second. None opposed. No further discussion. Motion passed. Dr. Remick shared the five measures, SMART aims, and the reporting schedule for the collaborative. Gavin Sussman, DSHS EMSTR, provided a data presentation on Stroke PI data. Data shared included patients suspected of having a stroke according to NEMSIS criteria in 2022, 2023, and the first half of 2024. There were 59,752 suspected stroke patients in CY 2022, 57,082 in CY 2023, and 32,973 in the first half of CY 2024. The data by sex is fairly consistent and evenly distributed among males and females. Mr. Sussman reviewed stroke assessment and screening processes, including the documentation of stroke scales and the use of NEMSIS data for suspected stroke cases. The percentage of patients where a stroke scale was performed increased each of the data years to 65.66% in the first half of 2024 (the goal is 75%). There is no variability between the sexes when looking at the stroke scale performed by the sex of the suspected stroke patient. When looking by RAC at the documented stroke assessments performed on patients who met the inclusion criteria, the numbers are overall trending upward over the data period. Chief Petrilla discussed challenges in data collection and analysis, emphasizing the need for accurate documentation and the importance of defining key terms in the NEMSIS dataset. He mentioned that some will skip some fields and put the information in the narrative, making it difficult to mine data.	Implementation of the new name and group function, SCOR. No additional action items were identified for the Council.	Approved	process map to GETAC agenda. **Does the collaborative need a webpage? -AK**

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10.b. Burn Care	Dr. Ratcliff shared an update, reporting that their current focus is on obtaining data.			
10.c. EMS Wall-Times	Mr. Wait stated that the Wall Time Task Force aims to address issues related to patient wait times after the respiratory season, with plans to involve various stakeholder agencies. The task force expects to meet a couple of times prior to the Q2 meeting.			Follow up regarding TF meeting. DL Complete
11. Executive Committee Activities	The Executive Committee had no activities to report this quarter.			
12. TETAF	Dinah Welsh provided an update regarding the TETAF activities. She discussed the ongoing legislative session, highlighting the day as the 53rd day and the upcoming 60th day, which is the bill filing deadline. TETAF is focused on its Legislative Priorities, along with closely monitoring more than 100 bills. Every other week, TETAF hosts the TETAF Legislative Work Group via Zoom. All stakeholders are welcome to attend. It is usually held at 9:30 AM, but since the next meeting is today, 3/7, it will be at 2:00 PM. Several bills were mentioned, including Senate Bill 1018 and House Bill 3459, which propose changes to state traffic revenue percentages from 30% to 50%. The percentage change is expected to ensure more money flows into the designated account (5111), potentially leading to higher appropriations. Mrs. Welsh discussed Senate Bill 672 regarding hospital diversion plans and cyber-attack preparedness. Concerns were raised about hospitals not having actionable plans for cyberattacks. The filing of hospital diversion plans with HHSC is questioned by Mrs. Welsh, but the need for better preparedness is acknowledged. She mentioned the number of bills on palliative perinatal care and the impact on maternal facilities. They are hopeful to be able to assist with some of the grants to fund resources such as cooling cots. TETAF has been working on a no-cost rider (67) that is being filed to allow rural hospitals to request funds for designation costs. This is related to the			

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	$50 million grant for the Office of Rural Hospital Finance and Coordination. Mrs. Welsh stated the last legislative item related to them working with Dr. Manda Hall, a collaboration with the RACs and the Department of State Health Services, to improve access to the EMS trauma registry for better injury prevention and contractual needs. She stated that the information that the RACs are receiving is not as useful as they need to work within their RACs. TETAF is preparing for the changes to trauma designation requirements effective 9/1/2025, and is working with surveyors, hospital partners, and DSHS to ensure rules are understood and followed. TETAF will recruit additional trauma surgeon surveyors. The volume of surveys in order is currently trauma, maternal, neonatal, and stroke. Perinatal surveys have slowed down due to the low designation cycle year. They've had one stroke survey this fiscal year due to the change from a two-year survey to a three-year survey. TETAF has been approved for another three years as a provider of nursing continuing professional development by the Louisiana State Nurses Association. TETAF would like to thank Courtney Edwards, DNP, MPH, RN, CCRN, CEN, TCRN, NEA-BC, for her hard work and diligence in ensuring TETAF can continue providing important and beneficial educational opportunities for our stakeholders. In 2024, TETAF provided more than 4,000 continuing professional development hours to learners in all 22 Regional Advisory Councils (RACs). The next TETAF Hospital Data Management Course (HDMC) will be held virtually this summer. Visit https://tetaf.org/hdmc/ to be notified of the dates. TETAF continues to provide support to the Texas TQIP Collaborative. The first meeting of the quarter was on Wednesday, March 5. Mrs. Welsh thanked Dr. Carlos Palacio for his leadership. Email texastqip@tetaf.org with questions.			

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	TETAF is proud to once again be a sponsor for the upcoming Texas Organization of Rural and Community Hospitals (TORCH) Spring Conference on April 14-17 in Arlington, TX. Additionally, TETAF/Texas Perinatal Services is a sponsor for the Texas Collaborative for Healthy Mothers and Babies (TCHMB) Summit, June 16-17 in Austin. TETAF welcomes the opportunity to be a resource, support, and/or participant in any meetings to further build the trauma and emergency care network. Lastly, TETAF released its 2024 TETAF Annual Report.			
13. Public Comment	None.			
14. Announcements	None.			
15. Next Meeting Dates	Q2 – June 3-6, 2025 Q3 – August 19-22, 2025 Q4 – November 21-25, 2025, in conjunction with the Texas EMS Conference in Fort Worth.			
16. Adjournment	Dr. Tyroch adjourned the GETAC 2025 Q1 meeting at 12:08 PM.			