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

Friday, June 6, 2025
DoubleTree Hotel by Hilton Austin
Phoenix Central Ballroom
6505 N IH 35, Austin, TX 78752

Meeting Minutes

Last Name	First Name	Appointed Position	Attendance 6/6/25	
			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)*	N	
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)*	N	
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

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
1. Call to Order from Recess	Dr. Tyroch called the GETAC Q2 meeting to order at 8:00 AM. The meeting was conducted in compliance with the Texas Open Meetings Act and was webcast for public record.			
2. Roll Call	The meeting opened with instructions regarding public recording, use of chat for attendance, guidelines on language and confidentiality, and the process for public comments from both virtual and in-person attendees. Sabrina Richardson (DSHS) 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 2025 Strategic Planning Retreat (SPR) and Q1 March 7, 2025, minutes were presented for approval. Mr. Shawn Salter moved to approve the SPR and Q1 minutes, and Dr. Kate Remick provided a second. The motion carried, and the minutes were approved without further discussion.		Minutes approved.	
5. Chair Announcements	Dr. Tyroch reported that the task forces, collaborative, and committees were remarkably busy over the last three days and expressed his appreciation for all the great work being done. He announced Aundrea Young from Houston was appointed by the Governor's Office last week to fill the public member vacancy on GETAC.			Provide documents and orientation info to Ms. Young. - DL
6. State Reports				
6.a. DSHS CHEPR	Mr. Jeff Hoogheem, Director, provided an update on the Center for Health Emergency Preparedness and Response (CHEPR) activities to date. **Program Health** Director Hoogheem acknowledged that staffing challenges exist but are being managed. They currently have sixty people on staff, twelve vacancies (a 20% vacancy rate), but they can get positions filled, if necessary, despite the state agency hiring freeze. He stated that much of their funding is from federal dollars. **Program Responses**	Information only. No action items identified.		

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	Response activities included a busy, but improving, wildfire season: sixteen fires with seventy-one assets deployed, at $3.5 million. The measles response has kept them busy, but it is much better now. Since January, there have been 742 confirmed cases and ninety-four hospitalizations. The cases peaked in mid-March, with only one case reported in the last week. The State Medical Operations Center (SMOC) activated on February 14. They had 169 staff working on this response. Over 1,500 samples were collected, and 18,000 vaccines were administered; estimated cost for response is $8.8 million. **Preparedness** Director Hoogheem reported that preparedness activities are ongoing for hurricane season and major events. Thirty-two different trainings across six or seven categories have been conducted, including SMOC operations. Training has included 616 personnel. The most recent exercise conducted focused on the World Cup to start planning for the event coming to Texas next year. There will be a lot more planning and training in preparation for that event. The program has updated some of its plans, including the Infectious Disease Annex, which will include lessons learned from the measles response. **Funding** Director Hoogheem stated they were closely watching what is happening at the federal level, as their program is with the public health emergency preparedness and hospital preparedness program (HPP) grants. The Emergency Medical Task Force (EMTF) has some general revenue (GR) funding each year and received a $1.5 million increase to bring it to $5 million, but the rest of the money that they get for the program and hospital preparedness, which is almost entirely pushed out to the HPP providers is "up in the air." He added that he believes the funding will be stable through next June because it was allocated in FY 25, but beyond that is where the uncertainty lies.			

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6.b. **DSHS EMS/TS**	➢ **Jorie Klein, Director of EMS/Trauma Systems (EMS/TS) Section,** provided an update on the activities occurring since the last GETAC meeting. **Trauma Rules** Director Klein reported that the Designation Unit has been focusing on the implementation of 157.126 in September. The unit has developed a gap analysis and revised the survey guidelines. Those documents are currently in the draft phase and will not be released until mid-June. The trauma Designation Questionnaire has been developed, but it has not been released. The questionnaire and survey guidelines are based on the American College of Surgeons' (ACS) documents, and since those items are copyrighted, the unit is waiting for ACS approval. The Designation Unit has completed the 157.126 Review of Designation Standards and Requirements with all facility levels. The entire review has been completed with Level IIIs, Level IVs that manage 101 or more, and Level IVs that manage one hundred or fewer trauma patients. The Chapters 8 and 9 review for Level I and Level II facilities is still pending. **ACS Standards** Director Klein provided a brief review of ACS verification standards and how they relate to state designation. If a facility is compliant with all the ACS verification standards, they are verified. If noncompliant with more than three Type II standards or if noncompliant with one Type I standard, the facility will not be verified. If a facility is not verified, it will not be designated at that level in the state. **Trauma Designation Process** Director Klein stated that the state's designation process is based on the ACS process. If all standards are met, the facility is designated for three years. When one to three requirements are not met, a facility will receive a contingent designation but must work with the department and develop an action plan to correct those issues. If four or more requirements are not met, the facility may receive a contingent-probationary designation with a corrective action plan and work with the state to address the issues. The requirements must be met with documented evidence to be designated.	Information only. No action items identified.		Continue quarterly updates to Council.

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	Director Klein added that there must also be a performance improvement process to demonstrate that the facility is working on identified issues. The goal is to meet the requirements at least 80% of the time. She provided an example of the ACS integration into the state standards (h)(19). Director Klein explained how the department walked through the document line by line and shared examples of how facilities are compliant with the requirements during their review with the facilities. **Level I and II Survey Success** Director Klein acknowledged the excellent work done by several hospitals during their trauma verification/designation survey process and shared the names of those Level I and Level II facilities. Director Klein encouraged struggling facilities to reach out to the programs mentioned to learn more about how they reached that goal. **Level I and II Unmet Standards** Director Klein shared the ACS standards that were not met during Level I and II surveys (Level III and IV will be shared at the August meeting). She emphasized that the trauma medical director and the trauma program manager are responsible for the oversight of the trauma program, and part of that responsibility includes some sort of annual check to ensure compliance with all the standards. Director Klein shared her appreciation that Drs. Tyroch, Flaherty, and Greenberg participate in the monthly facility calls to provide the medical director's perspective and comments. She added that medical directors, program managers, PI coordinators, registry staff, and administration can all be on those calls to hear their comments. *Council Comment: Dr. Tyroch asked how many diversion hours were allowed. Director Klein stated it is more than the hours. This standard reads that facilities must track when they go on and off divert, if there were patients who were diverted away from the facility, what happened to them, and that there is evidence of bringing that to the operations committee for discussion on how to fix being on diversion. Director Klein reiterated that the robust discussion on issues found when monitoring for things like*			

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	ophthalmology coverage could go a long way with reviews and is part of the responsibility of having oversight of the trauma program. Director Klein continued a review of the unmet standards, providing examples for the most questioned standards, and stated that it all goes back to PI and having evidence that issues are being discussed. She provided a solution for addressing ACS Standard 8.3 Provider training: work with EMS agencies and give them an opportunity to rotate in your emergency department or operating rooms. She added that any HIPAA concerns can be worked through. Director Klein reiterated the importance of reading the details of the standards as well as the "Additional Information" and "Compliance" data and encouraged attendees going through the survey process to "find a buddy" from the slides she shared regarding the facilities that had excellent surveys. **New Initiative – PI: Ask the Experts** Director Klein discussed a new initiative where attendees on the PI: Ask the Experts call can ask questions about PI in an open dialogue forum. Dr. Don Jenkins, former chair of the ACS Performance Improvement Committee, leads the meeting with Dr. Tyroch, Dr. Greenberg, and Texas TOPIC instructors on the call. The department has held one call to date with the rural facilities and with one scheduled in July for all facilities. **Designation Review Committee** The application review period is open. Per §157.126(s)(1)(A)(iv), the department is looking for two individuals who each have a minimum of 10 years of trauma facility oversight as an administrator, medical director, program manager, or program liaison. Additional members of this committee include the chair of GETAC, Dr. Alan Tyroch, the chair of the GETAC Trauma Systems Committee, Dr. Stephen Flaherty, the president of the Texas Trauma Coordinators Forum (TTCF), and whoever is selected to fill the two open positions. This group will look at all the designation appeals and waivers that are submitted through a designation review via this process. Applications close June 2, 2025.			

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	Level III Trauma Facilities Engagement with TQIP The department coordinated a call with the ACS TQIP team so the ACS could walk through the process of how to navigate their system, including the portal. The ACS discussed and shared an example of Level III TQIP reports and reviewed TQIP Level III cohorts. The Level IIIs on the call felt this was beneficial and provided a better understanding of the process. Additionally, the Level III's asked if they could participate in the Level I/II collaborative in Texas; Director Klein directed those requests to Dr. Carlos Palacio (TQIP) and Dinah Welsh (TETAF) to allow them to make that decision. **EMS Funding Overview** Director Klein shared that $112.3M was budgeted for FY 25, with $96M for grants/passthrough provision. She demonstrated how Funds 5007, 5108, and 5111 receive dedicated funding and from where. Director Klein stated 5111 is the largest account, and it is where money is allocated for uncompensated care, RACs, and RAC EMS Pass-through money comes from. Currently, the fund receives 30% of what is collected from traffic fines, with 70% going to the state General Revenue (GR) fund. Senate Bill (SB) 1018 allows for the redistribution of the percentage of traffic fines collected and allocated to the department to increase from 30% to 50%. Currently, it is not well-understood how this will affect program funding – will this replace the amount that was taken from GR to cover the funding lost when the tobacco endowment went away, or will this be in addition to what is received? Any potential increase in funding will not be seen until FY26. Director Klein explained where the money goes once it hits EMS/Trauma Systems accounts: administrative costs, RAC allocation, EMS allotment, Extraordinary Emergency Funding (EEF) requests, Trauma Uncompensated Care (UCC) allocations, and Emergency Care Attendant (ECA) training. She reminded attendees of the factors used in calculating the RAC funding allotment: size of the RAC, population of the RAC, and percentage of trauma care provided in the RAC (the number of EMS			

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	responses and the trauma submissions to the registry). Director Klein addressed questions received regarding the exceptional item (EI) funding that the RACs received ($150K each year of the biennium). Any funds not spent in the first year of the biennium may roll over to the second year, but any funds not expended by the end of the second year must be returned; therefore, any funds remaining at the end of the state FY25 must be returned. She shared the total projected funding allotments for the RACs - $13,219,560 for FY 2026 **EEFs:** Director Klein reported on the current EEF status: eleven applications were received (7 awarded, four denied), and $967,379.34 has been expended, with $32,620.66 remaining. She noted that all seven grants were awarded to rural counties. She reiterated that the EEFs are intended for entities that already have a program in place and end up having an urgent need for resources; it is not to build a new program. The most common needs are related to an ambulance. **Trauma Funding** Director Klein explained the HHSC trauma funding process regarding the standard dollar amount (SDA) and Medicaid reimbursement. She added that the important thing to remember with the SDA is that increasing the Medicaid reimbursement rate for Medicaid trauma patients increases the reimbursement rate for all Medicaid patients. **UCC:** Director Klein reported that 287 trauma-designated hospitals applied, with three of them in active pursuit (IAP) of designation. Over $3.67B requested, and after validation, $859M met the criteria for uncompensated charges. Sha demonstrated how trauma UCC requests have risen over the years since 2004, with request amounts nearly doubling since 2014. She mentioned that 176 Level IV hospitals have requested funding for this year, ninety-two of them rural. Director Klein asked for questions or comments.			

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	➢ **Designation Unit:** Director Klein provided an update for the Designation Unit since Elizabeth Stevenson was attending a Perinatal Advisory Council (PAC) meeting. **Trauma Designation and Deficiencies** She reported 296 total trauma-designated facilities, with an increase in the number of Level IIIs: 22 Level I, 27 Level II, 62 Level III, and 185 Level IV. There were twenty-nine applications in Q2: twenty-three renewals and six initials. Of the twenty-nine applications, 66% were contingent designations and 34% were non-contingent. Common deficiencies include nursing documentation as number one, followed by trauma performance improvement's evidence of loop closure, identification of all variances, and TMD participation in the secondary level of review. **Stroke Designation** Director Klein reported 191 stroke-designated facilities, with only three remaining facilities needing to transition to new levels. There were fourteen applications: ten renewals and four 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** Director Klein 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. ➢ **Joseph Schmider, State EMS Director, provided EMS Unit updates.**			

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	NEMSIS Update Director Schmider reported that the NEMSIS V5 patch continues to move forward and requested that all entities have the patch installed by July 5, 2025. He added that the vendors have the fix and should be pushing out to entities. This is in response to the directive from the White House. He emphasized the need to get this done to avoid calls from the department. For more information on NEMSIS and national dashboards, visit https://NEMSIS.org. **89th Legislative Session** Mr. Schmider reported that the EMSTS section followed sixty-five bills, with fourteen making it on the final day. He provided information on a few bills that impacted EMS: ○ HB 33 Active Shooting Education: Schools, EMS, fire, police, and Emergency Management will be required to plan together and conduct drills. It will be added to the 157.11 rules. There is a reporting requirement with this. *Council Comment: Mr. Salter asked if there was required content for this and who would be responsible for developing a standardized course. Director Schmider stated TDEM was the lead with this, but the EMS/TS program would collaborate with TDEM.* ○ House Bill (HB) 35 Peer Support System: This bill ensures that each organization has somebody looking at their staff. Law enforcement passed this a few years ago and implemented a process. ○ HB 742 Human Trafficking Education: Requires EMS and emergency departments (ED) to be educated on human trafficking and how to recognize it. ○ HB 3000 Funding (Rural): Director Schmider commended Judge Mike DeLoach on his efforts to move this legislation forward. This bill provides funding for ambulances in rural parts of Texas. Director Schmider mentioned that ensuring that an ambulance is			

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	available for anyone who calls 9-1-1 is something that keeps him up at night, as well as a video shared by Mr. Salter discussing the challenges with EMS. ○ SB 1021 Stalking Conviction: A stalking conviction can disqualify someone from certification. ○ SB 1818 Military EMS License: If coming from another state with a similar state certification, military members can be provisionally or fully certified in Texas, depending on the agency. ○ SB 672 Hospital Diversion: This bill requires hospitals to have a disaster plan for a cyber-attack or a power outage. They must file that plan with HHSC by December 2025. ○ HB 3749 Clinic: Paramedics working as standalone practitioners in IV clinics. Legislation passed requires paramedics to be under the direction of a medical director. Director Schmider stated there had been much discussion about the impact of this bill on community paramedicine, but he assured there is no impact, as EMS practitioners are not free-standing practitioners and must always work under the delegated practice of a medical director. He reiterated that this bill does not change current rules. Director Schmider stated that the priority for rule development will be the recently passed legislation. He recognizes the work being done in committees to review rules, but due to the current rule requirements, it will be about nine months to a year before the department can introduce any additional rule notifications. Director Schmider advised the committees to continue what they are doing because it will help speed the process when he can provide notification. *Council Comment: Mr. Salter asked if there was any discussion about whether the completion of the training required by HB 742 could be shared across the different entities that are required to track or review it, unlike what happened with fingerprinting. Mr. Schmider responded that the difference was that the fingerprinting was a federal issue, and they would not allow the sharing of information between agencies. He added that*			

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	likely the department would support and accept evidence of completion, just like any other CE course. **2025 EMS Conference** This year marks the 40th anniversary of the Texas EMS Conference. Dr. Ed Racht will be the keynote speaker. Director Schmider reported that there were around five hundred submissions for courses, and they chose eighty. He added that there are some great educational opportunities lined up for the conference. There will also be an updated Advanced AOR class with six presentations from EMS leaders. The Cornhole Tournament will be held on Sunday night, but Director Schmider did advise that this year was going to be his and Sabrina's year, and they planned to win. The Conference will run from November 23 to 26 in Fort Worth, Texas. For more information, visit https://texasemsconference.com. **Licensing and Processing Times** The licensing team processed 8,418 applications in the third quarter of FY25. The median processing time to receive a license is 10 days. The team has reduced the processing time by 50% in the last three years. Director Schmider shared a reminder to EMS personnel to wait until after receiving NREMT certification before completing the DSHS application. A DSHS application must be on file to receive the DSHS background check code, so that must be done before getting the fingerprint background check. He added that it is important to keep an eye on email for deficiency notices (check SPAM/junk folders) and add @DSHS.Texas.gov and @partner.hhs.texas.gov to the safe sender list. For questions regarding certification, contact EMS Licensing by email at emscert@dshs.texas.gov.			
6.c. DSHS Injury Prevention Unit	**Jia Benno, manager of the Injury Prevention Unit, provided a presentation on trauma death data and general registry updates.** She reported considerable progress in EMS and trauma data collection. The 2024 EMS data set closed April 30th with 4.99 million unique records and trauma data at 193,000 (not yet cleaned). The expectation is that the	Information only. No action items identified.		Continue quarterly update to Council.

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	Registry will reach five million in 2025, with staff outreach to providers aiding in increased data collection. **NEMSIS Patch** Ms. Benno encouraged providers to reach out to their vendors, asking for this fix to be implemented, as vendors and teams must be ready to implement the removal of gender variables by July 6th. The patient's and provider's biological gender must be provided in the PCR. Files will not technically fail on July 6th, but they will start failing with gender variables. The EMS & Trauma Registries (EMSTR) team will review data over the summer to check what percentage of providers are still submitting gender variables. **Data Requests** Ms. Benno reported that there is increasing interest and requests for drug poisoning and overdose data, so the team is working on a dashboard for non-fatal EMS responses to drug poisonings is under development and will be shared later this summer. EMSTR is also working on data requests for falls and drowning. **Texas Trauma Deaths Over Time: 2013-2023** For this presentation, urban, rural, and frontier data were 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 fewer people per square mile. Trauma death rates and data completeness have improved, but urban centers see more severe cases and deaths, while rural centers see deaths among less severely injured patients. Ms. Benno reported that trauma deaths in trauma centers have steadily increased, but this may be due to increased data collection.			

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	Total trauma deaths for 2023 were 4,297 compared to 3,113 in 2013. When looking at the rates for trauma deaths per trauma records, the lowest was in 2016 (2,626), and the highest was in 2020 (3,853); however, it was almost the same rate in 2013 and 2023. Most trauma patients and deaths occur in urban areas. Trauma death rates in urban areas match state rates. The frontier areas have sparse numbers, causing great variability when compared to urban and rural areas. Comparisons to other states are difficult due to differences in reporting methods. *Council Comment: Dr. Tyroch asked if someone dies on scene, whether they would be counted in these numbers, and Ms. Benno stated they would not be counted. Chief Petrilla asked if there was some reason there was a huge dip in rates in 2016 and then a huge spike in 2018. Director Schmider stated it was likely due to data collection at the time. He added that there have been great improvements over the last few years and anticipates more accurate trends beginning with 2021 data reports. Chief Petrilla clarified his initial question and stated he was wondering if there was some big initiative that occurred that resulted in the decrease in rates. Mr. Salter responded that the state had been implementing cable barricade systems on bidirectional highways in 2015 and added that it may have had a positive impact on the numbers. Ms. Suzanne Curran (SETRAC) mentioned there was an injury prevention initiative aimed at high school students regarding texting and driving.* *Council Comment: When compared to other states, Dr. Tyroch mentioned that Texas is doing very well. The national average is sixty deaths per 100,000, and some states are at 90. Ms. Benno stated she tried to pull Texas data to compare nationally, but it was difficult due to the difference in how other states report this information. Dr. Remick asked if the reason Ms. Benno was not reporting death rates based on population was due to insufficient data. Ms. Benno responded that reporting by trauma patients at a trauma center would give more realistic data on whether patients are being kept alive or dying before discharge.*			

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	Ms. Benno stated that urban facilities would see higher numbers of trauma deaths because patients in rural and frontier due to patients transferred into higher-level trauma centers. The death rate in rural trauma centers is approximately 5% compared to 18.64% in urban trauma facilities in 2023. When asked about the number of trauma records collected, Ms. Benno stated she is confident that the 193K records represent close to 100%. She added that EMSTR is working closely with Director Klein and her team to reach out to trauma facilities not sending in data. Gavin Sussman added that data completeness has improved, with 94% of licensed EMS providers submitting data last year. A recent NHTSA project showed 96.5% data completeness, with the other 3.5% only running approximately ten calls a year. **Injury Severity** Ms. Benno reported that most trauma patients are dying at urban trauma centers, where most trauma patients are seen; the severity of trauma deaths differs between urban and rural centers. About 50% of urban trauma deaths have an ISS of 25 (profound trauma); rural trauma deaths mostly have an ISS of one to fifteen (mild to moderate). **Future areas of focus** Director Klein requested that the data reviewed today be further explored based on the pediatric, adult, and geriatric populations. Ms. Benno stated she could also show the rate by population. Dr. Remick stated concern over the higher rate of deaths in rural areas for ISS 1-8. Ms. Benno will also look at the length-of-stay. EMSTR will continue monitoring trauma data trends, consider additional focus on rural trauma deaths with low ISS, and possibly show rates based on population in future presentations. *Council Comment: Mr. Salter offered his praise for the tremendous improvement in data reporting and updates provided to the council.*			
7. Health Information Exchanges	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-	No action items were identified for the Council.		Add to RAC agenda in August for further discussion.

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	time access to diagnostic imaging, reducing duplication of studies, and facilitating advanced care planning at receiving facilities. Dr. Tyroch stated this item was a placeholder for discussion (at the request of the GETAC Pediatric Committee) and asked the council how they thought this should be addressed. He added that the request was related to the sharing of information from one facility to another so that CT scans do not have to be repeated, especially on kids. Dr. Tyroch mentioned this is an ACS expectation, and he does not feel there has been much progress made in Texas. He asked if this was possibly a RAC-level initiative to address regionally. Chief Ramirez mentioned the use of Pulsara for this purpose but noted that there are costs associated with sharing data between facilities. Dr. Remick asked if it was more of a facility education need regarding HIE services in Texas, as she does not know if all hospitals are even engaged with HIE. Mr. Salter stated that when the issue was discussed several years ago, there was a radiology "read" reimbursement barrier, as only the first read was typically paid for. He added it may require legislation and rules. *Public Comment: Chief Dudley Wait stated it is a highly complex effort regarding file and system compatibility and quality. He added that exploring at the regional level is best and suggested a survey into how it is currently being done. Douglas Havron (CATRAC) suggested a joint conversation with the Texas Health Services Authority. It was also noted that the problem worsens when transferring from one RAC to another.* Director Schmider asked Nathan Ramon from RAC V about an effort years ago between hospitals in the RAC to set up a local HIE. Mr. Ramon stated the effort "fizzled out," but they are now looking at it again using Pulsara. He added that there was nothing they could take from the previous effort. Mr. Ramon stated that some of their stroke facilities are using Vis AI to transmit stroke information between facilities. Mrs. Helgesen from Border RAC stated they have an HIE in El Paso that has some image sharing capability, but that it is not great. She added that they recently discovered there is a system within most of the PAC's systems			

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	that will allow image sharing, and they are now investigating opportunities there. Mrs. Helgesen stated that she does not feel this is what Pulsara is meant to do, but asking what the RACs are doing is reasonable. Mr. Havron added information about the Texas Health Services Authority in the chat and indicated that they are tasked under Chapter 182 of the Texas Health and Safety Code with topics such as this. He added that Catherine Lusk, the new CEO, has been working on the integration of HIEs across the state, specifically regarding images, so having a conversation with this group might prove valuable. Mr. Havron agreed to send an email to Dr. Tyroch and connect him with Ms. Lusk.			
8. GETAC Committee Action Items				
8.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. The final DPS trooper education program presentation is expected to be ready for council review next quarter. The plan is for Mrs. Lail and Michael Mock to hold two classes, one in North Central Texas and one in Houston, for two sergeants (academy instructors) and the troopers that work under them. The committee will receive feedback and prepare the final presentation for GETAC in Q3. Once approved, the education will be handed over to DPS to use as they see fit. The Helicopter Emergency Medical Services (HEMS)-Specific Mental Health Awareness resource document was presented to the council for approval. Mrs. Lail stated this document is available for all EMS providers, not just air medical. Mr. Salter sought clarification that the previously suggested edits were made. Mrs. Lail confirmed the edits were included in the document. Mr. Salter moved to approve the document shown and noted it was different than the one received in their packet because changes were made during a meeting after packets were printed. Chief Lail provided a second. No opposition. Motion passed. Document approved. No further discussion.	Mr. Salter moved to approve the HEMS-Specific Mental Health Awareness resource document as presented. Chief Lail with the second.	Approved	Add DPS Trooper Education to Q3 Council agenda. Post to EMS/TS Webpage. - AK

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	Mrs. Lail shared an update on the 2025 Q1 AMSCT Committee activities. The committee completed a survey regarding the proper security of pediatric patients, looking at compliance percentage and determining if there is an issue to address. The committee was surprised to learn that 58% of children were not properly restrained using a device, so a workgroup is being formed with representatives from the AMSCT, Pediatric, EMS, & EMS Medical Directors Committees to address this and create specific language regarding pediatric patients in 157.11 and strategies to increase usage compliance. The Fatigue Risk Management Programs (FRMP) for Air Medical and Specialty Care Transport providers workgroup has gathered supporting research and data and will now develop a white paper supporting the implementation and utilization of an FRMP. The committee gathered a great deal of data regarding the No Surprises Act (NSA) and developed a resource document that includes air medical utilization guidelines and education on how the NSA is protecting patients from exorbitant air medical transport bills. The committee presented to the EMS Medical Directors Committee on Thursday, and they offered additional edits. The edited document was provided to Dr. Tyroch and Dr. Winckler for review. Mrs. Lail requested 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 Code Chapter 157, Rule 157.126 Trauma Facility Designation Requirements, which will be effective on September 1, 2025. The committee is currently working with Courtney Edwards at Parkland to provide nursing CE with this education; DSHS CE will be provided as well. Chief Ramirez moved to approve the trauma facility helicopter safety and landing zone presentation. Mr. Salter provided the second. No opposition. Motion passed. Document approved.	Chief Ramirez moved to approve the trauma facility helicopter safety and landing zone presentation. Mr. Salter provided the second.	Approved	Add the NSA/Aircraft Utilization Guidelines to Council Q3 agenda. Post to EMS/TS Webpage. - AK

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
	No further discussion. Chief Lail did add that it is a very useful product with a lot of valuable information. Mrs. Lail discussed the Pulsara Implementation Guidelines for the Air Medical Provider. She stated this was a task given by the GETAC Disaster Preparedness and Response Committee. The document is complete but will need to be placed on the GETAC Q3 Council agenda for Council approval. Director Schmider charged the committee with preparing education on the online ordering system (OLOS) dispatch. A workgroup will be formed to research and compile information about the OLOS system. The committee will have a presentation at the Q3 meeting. Mr. Salter advised that there were several online ordering systems, that OLOS was a specific brand, and encouraged the review to be of the type of product in general, not a specific brand of product. Director Schmider clarified that the concern presented to him was whether the closest resource is being dispatched, and his request to the committee was to review the issue to determine if the closest appropriate resource is being sent when requested.	No additional action items were identified for the Council.		Add Pulsara Implementation Guidelines for the Air Medical Provider to Council Q3 agenda. Add OLOS to the Council Q3 agenda. Continue Quarterly report to Council.
8.b. Cardiac Committee	**Cardiac Care Committee, James McCarthy, MD, Chair** Director Schmider reported there was robust discussion regarding TX-CARES but that there were no specific action item requests at this time.	No action items were identified for the Council.		Continue quarterly report to Council.
8.c. Disaster Committee	**Disaster Preparedness and Response Committee, Eric Epley, CEM, Chair** **Emergency Medical Task Force (EMTF) Program** Mr. Epley reported that the committee reviewed the Emergency Medical Task Force (EMTF) deployment and quarterly performance summary from the EMTF State Coordination Office (SCO). The EMTF program received an additional $3M over the next biennium to bring the total to $10M for funding the EMTF program. There was a 10% increase in activations since last year (FY24 to FY25 to date), which saw a 40% increase from	No action items were identified for the Council.		Continue quarterly report to Council.

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
	the year before. EMTF Medical Directors came to a consensus on pain management. **Pulsara and Wristband Utilization** The committee continues to look for ways in which wristband utilization can benefit EMS. One of the ideas is to get billing information from the hospital registration back to the EMS agencies to improve billing. **Mobile Device Use in Air Medical Units** The Committee reviewed Lynn Lail's document on the Commission on Accreditation of Medical Transport Systems (CAMTS) guidelines on mobile devices in the air medical environment and the risk matrix presented. **National Disaster Medical System (NDMS) 2.0 Pilot Project** Mr. Epley commented on the National Disaster Medical System (NDMS) 2.0 Pilot Project. He stated San Antonio is one of eight sites. The other sites are Washington DC, Omaha, Denver, Sacramento, Puget Sound, Shreveport, and Hawaii, and all sites are working on large-scale combat operations, bringing back war-wounded. Mr. Epley stated that if we do have to go to war, it is going to result in a lot of casualties. He added that we are not going to have air superiority, and that is a terrifying thing. The planning factor for that entire exercise or effort is 1,000 patients a day, back to the United States for one hundred days or more. He explained that it is a type of COVID-19 plus. **Agenda Item Recommendation** Mr. Epley stated the committee would add burn care and the 2026 World Cup as standing agenda items. He stated the World Cup will be affecting Dallas, Houston, San Antonio, and Austin, and there will be a high threat level. There will be a match on the day before and the day of July 4, 2026, which is the 250th anniversary of American Independence, and there will be many international attendees here. Mr. Epley commented that the World Cup's 16 matches are like 16 Super Bowls. Director Schmider stated he is already received calls asking about staffing waivers. **GETAC Pre-Hospital Task Force**			

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
	Mr. Epley provided an update on the Prehospital Whole Blood Task Force. The group discussed legislative updates, including the $10M biennial award for prehospital whole blood. The goal is to have a unit of blood or more available in every single county of Texas. Mr. Epley stated that the Pre-Hospital Blood Transfusion Coalition (PHBTC) is working at the national level to get CMS and others to increase reimbursement. The task force meeting included a presentation by Matt Zavadsky discussing how the private third-party payer blood reimbursement looks like now. The task force continues to review and discuss the financial barriers for blood centers. Mr. Epley reported that there was robust discussion regarding alternative collection processes. The UT Health - San Antonio Emergency Medicine Fellows did a presentation under Dr. Jenkins' guidance to look at trauma traffic deaths by county. The data demonstrated that while the overall rate of deaths was highest where more populated, the inverse occurred when looking at the rate per capita, showing an increase in traffic deaths in the most rural places. Mr. Epley stated it is vital to figure out how to get blood in rural areas with no wastage. **National Whole Blood Summit** Mr. Epley encouraged everyone to attend the summit on July 15, 2025, at the Henry B. Gonzalez Center in San Antonio. He provided a QR code for registration information. He added that the Whole Blood Academy would occur on July 14, 2025. It is an 8-hour hands-on "boot camp." *Council Comment: Daniel Ramirez commended the task force on the great work done even before money was awarded, and stated he was proud that Texas was leading the nation on this effort.* *Council Comment: Mr. Salter asked how many counties only had BLS service. Mr. Epley stated that he shared his concern that the most rural areas are likely to have all volunteer BLS services. He added that he hopes that interagency agreements with nearby counties could help support a regional concept of ALS support or intercepts.*			

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8.d. Emergency Medical Services Committee	**Emergency Medical Services Committee, Kevin Deramus, LP, Chair** Chief Dudley Wait shared an update on the EMS Committee's Q2 activities. Dwayne Howerton is chairing the workgroup on 157.11 and 157.14 rule revision to provide a framework for the DSHS/GETAC Council for revision recommendations. This workgroup meets monthly. Chief Wait stated that these are open meetings, and everyone is invited. Chief Hayes is leading a 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 Q3 GETAC meeting. The survey's purpose is to better understand how often workplace violence against EMS personnel occurs in Texas and to reduce it. *Council Comment: Mr. Salter asked if the department must have legislation to require mandatory reporting on all events. Director Schmider asked Gavin Sussman, EMSTR, if NEMSIS was looking at collecting that data on the PCR. Mr. Sussman stated that NEMSIS is, but it probably wouldn't occur until the next major revision in 2027. He added that there is an element (e Outcome 05) that is not being used, and that if the whole state agreed to use it for reporting violent events, they could start analyzing the data. Chief Wait stated that the committee's focus will be on looking at what can be tracked now in the interim, and they will explore a variety of options. He added that the big events get reported and supervisors know about those, but it is the "near misses" that are not getting reported, and there needs to be a way to track to see the broader story of what EMS personnel face. Director Schmider responded to Mr. Salter's previous question about rules and stated that the department does not need legislation to add a reporting requirement. He added there is a lot of activity around behavioral health, and this is something to look at from that standpoint as well.*	No action items were identified for the Council.		Continue quarterly report to the Council. Add survey to Q3 GETAC (previously approved but deferred this quarter) and EMS committee agenda.

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	The committee has a workgroup focusing on reducing the use of red lights and sirens in emergency responses. There is a position statement drafted that the workgroup and other committees are reviewing. The committee approved all the Stroke Committee documents. It is also in support of the TEAM EMS-ED study and will name a couple of committee members to assist. The committee also approved the Pediatric Committee's Pediatric Consideration for Consultation and Transfer documents as presented. Additionally, the committee will name participants to assist the Pediatric Committee with two initiatives: Pediatric Pain Management and Pediatric Criteria for Blood Transfusions. 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.			
8.e. EMS Education Committee	**EMS Education Committee, Macara Trusty, LP, Chair** Director Schmider reported that the committee discussed one test going from "zero to hero." They are looking at rules, a mentor program, and want to explore putting mental health in the rules as a requirement. Director Schmider stated that mental health may be covered under the recent peer support legislation. No action items for Council.	No action items were identified for the Council.		Continue quarterly report to Council.
8.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	No action items were identified for the Council.		Continue quarterly report to Council.

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
	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. The pediatric stroke resource document is close, but it still needs a little work. Dr. Winckler commented that a rural EMS doctor stated they use the documents and thanked Dr. Novakovic for her efforts. Dr. Elizabeth Fagan, EMS Medical Directors Committee vice-chair, will participate in the Stroke Committee's TEAM EMS-ED Study, which the EMS MD Committee endorsed. The committee reviewed and made 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. Winckler stated they would be happy to take the lead on this if needed. The committee voted to approve the American Burn Association Transfer Guidelines and the Heat Stroke Resource documents. The Heat Stroke Resource documents cover the approach for addressing heat-related mass casualty incidents (MCI); they are currently on the STRAC website and will be on the GETAC website. Dr. Winckler will reach out to the EMS Committee to collaborate on the RLS position statement. Dr. Tyroch asked for this to go on the GETAC Q3 agenda. Dr. Winckler and the committee are working to ensure the new TMB rule lines up with the GETAC Strategic Plan regarding the practice of EMS medical direction.			Send link to STRAC's website regarding MCI Heat documents. AORs & medical directors - AK; RACs – DL Add RLS position statement to council Q3 agenda.

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	The committee discussed best practices for air medical transport and voted to approve the Aircraft Utilization resource document with minor edits as agreed upon in the EMS MD Committee meeting. The Pediatric Committee requested assistance with pediatric pain assessment and management – Dr. Ratcliff will assist with this. The committee also asked for assistance with the Pediatric Blood Transfusion Guidelines – Dr. Winckler will assist with this document. Dr. Winckler discussed pediatric safe transports in ambulances; Dr. Mark Sparkman volunteered to work with the Air Medical and Specialty Care Transport Committee on this topic. Dr. Winckler stated that regarding Prehospital whole blood transfusions, there is a huge need for not just pediatric items, but more importantly, for education, training, compliance, operations, performance improvement, and resource documents. He added that a focus on performance improvement will be key. Dr. Winckler stated that regarding Prehospital whole blood transfusions, there is a huge need for not just pediatric items, but more importantly, for education, training, compliance, operations, performance improvement, and resource documents. He added that a focus on performance improvement will be key. No action items.			
8.g. Injury Prevention & Public Education Committee	**Injury Prevention & Public Education (IPPE) Committee, Mary Ann Contreras, RN, Chair** Courtney Edwards presented an update on the committee's 2025 Q2 activities. The committee is continuing 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	No action items were identified for the Council.		Continue quarterly report to Council.

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
	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 two hundred people at the last workgroup meeting. The committee is looking to improve course attendance options to increase attendance. This workgroup will also collaborate with the other committees on the safe transport of children in ambulances. *Council Comment: Chief Ramirez asked if there had been in progress made in the conversation around Hybrid technician courses. Dr. Edwards stated it is still an ongoing conversation.* The committee is also exploring best practices for drowning prevention, aligning with national programs, and implementing bystander intervention education. The workgroup is identifying ways to collaborate with existing agencies, including the Texas Drowning Prevention Coalition, to develop a tailored statewide plan that aligns with the national plan and promotes drowning prevention strategies for public consumption across the State of Texas. Dr. Edwards reported that there have already been thirty deaths in bodies of water in Texas, and the summer is just beginning. A position statement on workplace violence is being developed, focusing on reducing violence and promoting worker wellness and stress reduction strategies. The workgroup will collaborate with Chief Hayes from the EMS Committee. The committee has been working with the Texas Transportation Institute at Texas A&M to highlight regional bike and pedestrian safety programs. No action items.			Add workplace violence position statement to the Q3 council agenda.
8.h. Pediatric Committee	**Pediatric Committee, Christi Thornhill, DNP, Chair** Chrissy Richardson shared the committee's Q2 2025 activities. The committee is doing research and working on developing best practice guidelines for pediatric imaging, pediatric transfusion/massive transfusion,			Continue quarterly report to the Council.

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	and pediatric pain assessment and appropriate pain management. They are in the initial stages for these three priorities and are getting workgroups together to focus on those items. They are also gathering data on vitals and weight in kg from EMSC to review and get a baseline on the situation; they will request Registry data once the new rules go into effect to monitor and increase compliance. The committee has completed the toolkits on pediatric magnet/button battery ingestion and Sudden Cardiac Arrests/Deaths in Pediatrics. The committee will bring both items to the Council for approval in August. The committee is requesting that the following items be placed on the GETAC agenda in August for consideration and approval: • Public resource for the Consideration for Pediatric Consultation and Transfer Guideline (deferred from this quarter to next quarter) • Public resource for the Pediatric Imaging Guideline • Public resource for the Magnet/Battery Ingestion Toolkit • Public resource for the Sudden Cardiac Arrest/Death Toolkit Dr. Remick provided an update on the TX Pediatric Readiness Improvement Project. The TX Pediatric Readiness Improvement Virtual Education Series is held on the 3rd Thursday of each month at 10 AM. Information can be found on the DSHS EMS/TS website. Around two hundred people attend each of the sessions. TETAF has provided CE credits for the pediatric readiness education. She stated that most in attendance are not Pediatric Emergency Care Coordinators, that the audience is composed of a wide range of staff from emergency departments and hospitals, with the majority from Level III and Level IV facilities. There is participation from facilities outside of Texas as well. Dr. Remick shared the Pediatric Readiness Improvement and Simulation Mentor (PRISM) model, which is intended to elevate regional pediatric champions. Their role is to reach out to the hospital based PECCs in their region to support across four stages: *Forming, Storming, Norming,* and			Add all **FOUR** items to council Q3 agenda.

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	Performing (Timestamp 2:40:00). She explained the four stages and how they empower the PECCs to become self-sustaining. Dr. Remick stated that there have been ongoing training events across Texas. The simulations are in the process of being converted to video. Completed items include TBI, Pediatric Burn, Non-Accidental Trauma (vomiting baby), Abdominal Trauma, Newborn Resuscitation, and Respiratory Distress-Bronchiolitis. Conversions in production: C-Spine injury, Hanging-suicide attempt, Long-bone fracture, Penetrating trauma, Pediatric (child) sepsis, and DKA. Dr. Remick shared the **National Pediatric Readiness Quality Initiative (NPQRI)** dashboard as a mechanism to assist with becoming pediatric-ready and adhering to the new rules that go into effect in September. Texas has thirty-seven sites with fully executed agreements, and twenty-five sites entering data. Records can be viewed on the 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 twenty-eight shared across seven bundles of measures. All measures can be viewed in a graph format. For pediatric head trauma patients in Texas, 72.5% of patients are getting a full set of vitals, 63.9% are getting a GCS reassessment, and 71.6% of patients with a head CT met one or more PECARN criteria. Regarding the suicidality bundle, about 50.2% of pediatric patients in Texas are assessed with a suicide screening tool. Dr. Remick reported that 151,300 Texas pediatric patients are impacted by the twenty-five hospitals participating in NPQRI. She added the following future plans for NPQRI: • Sustained funding through 2027 • System Upgrades underway, to make more user-friendly • Electronic Data Entry Exploration	No additional action items were identified for the Council.		

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
	• Upcoming Texas-centric Collaborative - Launch January 2026 • Obstetrical Emergency Care Measures Dr. Tyroch confirmed that pediatric patients are supposed to be weighed in kilograms, not both pounds and kilograms.			
8.i. **Stroke Committee**	**Stroke Committee, Robin Novakovic, MD, Chair** Dr. Novakovic shared the Stroke Committee's 2025 Q2 activities. The Stroke Committee has seven actively engaged workgroups. She reported that the Stroke Committee approved endorsing participation with GWTG prehospital and interfacility layers. The committee discussed that since there are more rural hospitals participating in RDC than there are higher levels of designation, RDC will not be the ultimate source for the performance report, and they will continue with GWTG for performance reports. Dr. Novakovic shared highlights from the Texas Stroke Quality Report. Texas continues to hold below the national median DTN at 39 minutes; however, it continues to lag in the national average for DIDO, with a median of 142 minutes. Texas is experiencing continued improvement in compliance with documentation of the EMS Stroke Severity Screening element and is slightly ahead of the national compliance rate at 18.9%. There appears to be a full transition to TNK in thirteen additional RACS. The percentage of cases where EMS is spending more than 15 minutes on scene before transfer is increasing. There are 212 hospitals in Texas that utilize GWTG. Of the 191 Texas-designated stroke hospitals, 168 utilize GWTG (87.9%). For the rural hospitals, there is a program that allows them to join GWTG for free for the first three years; Texas has forty-nine rural hospitals currently participating in this program. The committee discussed the Patient safety and quality concerns regarding Neuro IR coverage, including barriers to finding objective measures to demonstrate delays, patients inappropriately denied mechanical thrombectomy (MT), and misuse of resources. DSHS is working with DNV and TJC to review transfers out from hospitals. The committee has worked on recommendations for internal review for hospitals so that they can try to capture the delays and report to the state			Continue quarterly report to the Council.

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
	if they feel there are concerns. Dr. Novakovic shared the NCTTRAC proposed recommendation for addressing the issue. The Adult Prehospital Stroke Resource document (for adult routing algorithm) revisions were approved by the required committees, and it is ready for council approval. Mr. Salter moved to approve the Adult Prehospital Stroke Resource document. Dr. Malone provided the second. No opposition. Motion passed. Document approved. No further discussion. The pediatric stroke routing algorithm was put into final form and approved by the required committees and the pediatric stroke task force, and it is ready for council approval. Dr. Remick moved to approve the pediatric stroke algorithm. Mr. Salter provided the second. No opposition. Motion passed. Document approved. No further discussion. The resource document needs final approval from the Pediatric Committee, but it was approved by the task force and the required committees. The Pediatric Stroke Tip Sheet is still under review by the Pediatric Stroke Task Force. Dr. Novakovic plans to bring these two items to the council in August. The committee is continuing to work with the EMS Time Sensitive Deconfliction Task Force, and they have established a Stroke Committee liaison to the EMS Education Committee. They are also working to disseminate the DIDO performance recommendations to Stroke programs and RAC chairs. The long-term goal is to collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO. The TEAM Stroke-Ed Study (mistakenly referred to as the TEAM EMS-Ed Study) has been endorsed by the endorsed by Stroke, EMS, and EMS Medical Directors Committees, and the committee now requests endorsement by the council. The purpose of the study is to determine if EMS stroke knowledge would improve if standardized stroke education were provided. (timestamp 3:01:00). Mr. Salter moved to endorse the	Mr. Salter moved to approve the Adult Prehospital Stroke Resource document. Dr. Malone provided the second. Dr. Remick moved to approve the pediatric stroke routing algorithm. Mr. Salter provided the second. Mr. Salter moved to approve the TEAM Stroke-Ed Study. Chief Ramirez	Approved Approved Approved	Add Document to Stroke webpage. AK Add Document to Stroke webpage. AK Add Pediatric Resource Document **and** Pediatric Stroke Tip Sheet to council Q3 agenda. Add to the Q3 RAC agenda.

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
	TEAM Stroke-Ed Study. Chief Ramirez provided the second. No opposition. Motion passed. Document approved. No further discussion. Dr. Novakovic reported that the Post Acute Stroke Care Workgroup is looking for members. This group will be led by Dr. Savitz, and the first meeting is planned for July. The Education Work Group is discussing the platform and feasibility of a Stroke managers' mentorship program. The Rural Stroke Workgroup has met twice and plans to continue to meet monthly. They are working on defining rural and resource-challenged regions and hospitals to be included in the scope of the workgroup and working on questions for a needs assessment survey. Dr. Novakovic shared a heat map showing areas with 60-minute drive times to a Texas stroke-designated hospital and compared it to a map demonstrating 60-minute drive times to Level I and Level II stroke-designated hospitals.	provided the second. No additional action items were identified for the Council.		Add Rural Stroke Needs Assessment Survey to Q3 council agenda.
8.j. Trauma Systems Committee	**Trauma Systems Committee, Stephen Flaherty, MD, Chair** No report or action items for council at this time.	No action items were identified for the Council.		Continue quarterly report to the Council.
9. SCOR	Dr. Remick reported on the System Collaboration for Outcome Review (SCOR) activities for Q2. The collaborative continues to track the top five clinical quality measures to identify trends and discuss the best mechanisms for dissemination that support improvement efforts. Mrs. Helgesen requested clarification on the process between SCOR and the RACs. Dr. Remick provided more information for a shared understanding. The RAC chairs/EDs asked SCOR to create a single data collection form regarding transfer delays in unstable trauma patients, as there are several different forms in use. She added that the discussion has been that SCOR cannot assist with the implementation at the regional level, only guide in terms of best practice for data management. Dr. Remick stated SCOR would, with GETAC's approval, create a standardized data collection spreadsheet. Dr. Remick presented three items for council approval:	Chief Ramirez moved to approve the SCOR statement of purpose,	Approved	Continue quarterly report to the Council.

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
	a. Statement of Purpose b. Scope of Activities c. Process Map Chief Ramirez moved to approve the SCOR statement of purpose, scope of activities, and process map. Della Johnson provided the second. No opposition. Motion passed. Document approved. No further discussion. Jia Benno presented the severe trauma transfer delay data to SCOR. This data was for Texas from January 1, 2022, to June 30, 2024. She shared Transfer delay definitions: • Severe trauma patients are injured patients with: o Geriatric (65+) = Glasgow Coma Scale (GCS) <9 or Systolic Blood Pressure (SBP) <110. o Adults (15-64) = GCS <9 or SBP <90. o Pediatric (children less than 15) = GCS <9 or SBP <70 + 2 x (the child's age in years). o Note: SBP is the arrival SBP at the hospital. • Transfer time = the time from arrival to departure from the sending facility for transferred patients. • Transfer delay = defined as two (2) or more hours from arrival to departure. Roughly 10% of the total severe trauma patients are transferred each year, with the majority being geriatrics, followed by adults, and then pediatrics. For severe trauma transfer times of all ages combined, the majority were at 2+ hours, with that number increasing each year by about 10%. (timestamp 3:35:44). When breaking the 2+ hours down by age category, 91.84% of severe trauma geriatric patients were transferred after 2+ hours, followed by adult at 60.82%, and pediatric at 42.22%. These percentages increased each year, except for the pediatric, which fell about 5.5% in 2024. This was also broken down by sex and race. Most blunt trauma in 2023 and 2024 was transferred in 2+ hours, but most penetrating trauma was transferred in under 2 hours. Looking at the data by trauma designation level, most transfers are from Level III and Level IV. For Level IIIs in 2022, 56.97% of patients were transferred in 2+ hours,	scope of activities, and process map. Della Johnson provided the second.		

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	and that rose to 76.99% in 2024; Level IVs saw an increase from 46.36% to 71.24%. Dr. Remick reminded council that the established SMART aim for this was 80% transferred in under 2 hours by December 2026, the inverse of what the data is showing. The data was also shown by RAC. Dr. Remick stated that this data was what spurred the RAC request for a form to standardize the data coming from hospitals because they felt this data was not granular enough. Director Klein stated this trend is alarming, and Dr. Remick concurred adding that the concern of SCOR is that if there is not an implementation effort to reverse this, the trends will stabilize at this level which would be unfortunate for our communities. Dr. Remick walked through the pediatric readiness data reviewed by SCOR. The NPRP Assessment summaries had a response rate of 51% in 202 and 35% in 2024. She anticipates that there will be much higher participation percentages going forward with the upcoming national assessment and the implementation of the new trauma rules. There were no real significant differences in the pediatric readiness score by year, with all being in the 72-74 range. Most participants in the state were trauma centers. The mean weighted Peds Ready score data was broken out by each RAC; most were under 80%. Dr. Tyroch mentioned that to make a big significant impact, peds-ready scores need to be above 90%. Dr. Remick showed readiness scores by trauma level designation, which were 88eighty-eight and below in 2024, with no significant improvement from 2021. She also showed what percentage of facilities had a PECC, with a significant drop in 1012 and 2024, with the number of sites that have a PECC. Dr. Remick stated that while much of the healthcare system has embraced quality when it comes to trauma, STEMI, and stroke, we are not seeing as much adoption in the pediatric world; less than 50% of hospitals had a QI plan that looked at pediatric patients.	No additional action items were identified for the Council.		
10. Task Force Action Items				

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10.a. Burn Care	Amber Tucker, Burn Care Task Force co-chair, shared an update. Task force members have been identified, with representation from all seven ABA-verified burn centers in Texas. Data is hard to come by, but the group is working on it from different angles. The task force is putting together a needs assessment for educational resources available in Texas. Establishing a process for identifying burn transfer trends and barriers goes back to the data that the group can collect. That data may need to come directly from the burn centers and other hospitals around the state if the group cannot pull it from somewhere else. A needs assessment will be produced to identify all burn care resources available in Texas and adjacent states. The group will establish burn care guidelines from injury to being received at a verified burn center. Ms. Tucker stated that the ABA has some good transfer guidelines that can be helpful. The group will identify telemedicine options for burn care and outline strategies and resources to manage a burn disaster. Ms. Tucker shared some insight from the grain mill explosion that occurred in Sunrise, TX. She added that while the group is in the initial stages of working through the objectives, there seems to be good buy-in from the burn centers around the state.	No action items were identified for the Council.		Continue quarterly report to the Council.
10.b. 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 start meeting and working to find best practices and ways to implement the Wall Times white paper.	No action items were identified for the Council.		Continue quarterly report to the Council. Follow up regarding TF meeting. DL
11. Executive Committee Activities	The Executive Committee had no activities to report this quarter.			
12. TETAF	Terri Rowden provided an update regarding the TETAF activities. She discussed the busy legislative session and thanked Director Klein for explaining how SB 1018 ties into 5111.	Information only. No actin items identified.		

Agenda Item	Discussion	Action Plan/ Responsible Individual	Status	Comments/ Targeted Completion Date
	Ms. Rowden discussed that TETAF was highly active during the session. They monitored more than one hundred bills, particularly with a budget focus for trauma, RAC, rural health, perinatal, EMTF, and whole blood. They hosted eight virtual meetings with stakeholders to provide legislative updates. Additionally, they provided oral and written testimony before the Texas Senate and Texas House and developed and submitted formal letters sharing concerns regarding legislation. TETAF developed and distributed a one-page stating concerns regarding perinatal palliative care. TETAF also advocated at the federal level regarding concerns of potential HPP cuts. The TETAF Advocacy Report will be released later this month via email and the TETAF website with a complete overview of legislative activity. The survey volume is steady, but they expect a busy time in August due to new rules. 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. TETAF continues to prepare for the changes to trauma designation requirements effective 9/1/2025. They are 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 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. This is a two-day course. (QR registration codes available at timestamp 3:24:16) 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			

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	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. (QR for questionnaire at timestamp 3:26:10). Dr. Tyroch asked Dr. Palacio to talk about growing TQIP membership. Dr. Palacio stated that the challenge they are facing is about the data because they are given one report for the entire collaborative, so they do not know "who is who" on the report. The collaborative needs resources. They need member participation for resources. The fee is $1,000 per year per hospital. They are currently working on an abstract to demonstrate the usefulness of the collaborative at the TQIP Conference, including a dashboard created by Garret Hall. Dr. Palacio stated he would like to have a subgroup for the Level III facilities with the new rules coming out. 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 participant in any meetings to further build the trauma and emergency care network.			
13. Public Comment	Ms. Richardson called the names of individuals registered to provide public comment, but none came forward.			
14. Final Announcements	None.			
15.	Q3 – August 19-22, 2025			

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Next Meeting Dates	*The retreat will occur in Austin in October, but date is yet to be determined.* Q4 – November 21-25, 2025, in conjunction with the Texas EMS Conference in Fort Worth.			
16. Adjournment	Dr. Tyroch adjourned the GETAC 2025 Q2 meeting at 11:34 AM.			