



TEXAS
Health and Human
Services

**Texas Department of State
Health Services**

Governor's EMS and Trauma Advisory Council

Friday, June 5, 2026
8:00 AM (CDT)

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

I.A. Call to Order

Governor's EMS and Trauma Advisory Council Meeting

FY26 – 3rd Quarter



Texas Department of State
Health Services

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

DoubleTree by Hilton Austin
6505 N Interstate 35
Austin, TX 78752

Virtual Rules of Participation



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Rules of Participation

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

Rules of Participation

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

I.B. Roll Call

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

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

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



Texas Department of State
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I.C. Governor's EMS and Trauma Advisory Council Vision and Mission

Vision:

A unified, comprehensive, and effective Emergency Healthcare System.

Mission:

To promote, develop, and advance an accountable, patient-centered Trauma and Emergency Healthcare System.



Texas Department of State
Health Services

Moment of Silence

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



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I.D. Approval of Minutes

Review and Approval of Minutes

- March 13, 2026



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I.E. Chair Announcements

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



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II.A. State Reports



Governor's EMS and Trauma Advisory Council Quarterly Meeting

Varun Shetty, MD, MBA, MS
Chief State Epidemiologist
Texas Department of State Health Services
June 5, 2026

DISCLAIMER

The information presented today is based current preliminary data and on CDC's recent guidance. Information is subject to change.

June 4, 2026

Ebola Bundibugyo Outbreak



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Ebola Disease

- Ebola disease: Umbrella term to describe clinical disease due to infection with any of the 4 viruses within the genus *Orthoebolavirus* that cause disease in humans:
 - Ebola virus (species *Orthoebolavirus zairense*)
 - Sudan virus (species *Orthoebolavirus sudanense*)
 - Bundibugyo virus (species *Orthoebolavirus bundibugyoense*)
 - Taï Forest virus (species *Orthoebolavirus taiense*)
- Illnesses caused by infection with these viruses are clinically indistinguishable
- Bundibugyo virus disease (BVD): Term used to describe clinical disease due to infection with Bundibugyo virus
- Vast majority of data on Ebola disease in humans come from Ebola virus (*Orthoebolavirus zairense*) cases and are considered applicable to all human-disease-causing orthoebolaviruses.
- Serious, highly transmissible, often rapidly fatal
- Without treatment, Ebola disease has a high mortality rate
- Bats are the likely reservoir

Ebola Virus - Person-to-Person Transmission

- In acutely infected persons, the virus can be found in **all body fluids**:
 - Blood
 - Feces/Vomit
 - Urine
 - Tears
 - Saliva
 - Breast milk
 - Amniotic fluid
 - Vaginal secretions
 - Sweat
 - Semen
- Virus transmitted through:
 - Direct contact with the body fluids of a person who is sick with or has died from Ebola disease
 - Contact with contaminated items (clothes, bedding, needles, or medical equipment)
 - Sexual activity with someone who has recovered from Ebola disease (no evidence that virus spreads through vaginal fluids)
- **Ebola is not spread through airborne transmission.**

Ebola Disease in Humans

- Signs and symptoms of Ebola disease include:
 - Headache
 - Fatigue
 - Muscle pain/joint pain
 - Anorexia
 - Sore throat
 - Abdominal pain
 - Rash
 - Diarrhea
 - Vomiting
 - Conjunctivitis
 - Unexplained bleeding/bruising*
- No sign or symptom is pathognomonic for Ebola disease.
- Fever is not universally present.
- Bleeding/bruising not universally present.

* Includes bleeding from the gums, mouth, nose, bloody vomit, bloody stools, bleeding from injection sites, vaginal bleeding outside of a menstrual cycle Available at: [COCA Call Ebola Bundibugyo Virus](#), accessed on June 2, 2026.

Ebola Outbreak: Background

- In early May, a hospital in Bunia Health Zone in northeastern Democratic Republic of the Congo (DRC) identified a cluster of severe illnesses affecting healthcare workers.
- Using genetic fingerprinting, the illnesses were identified as **Bundibugyo virus**.
- There is **no FDA-licensed vaccine** against Bundibugyo virus
- There have been 2 previous outbreaks of Bundibugyo virus, 1 in Uganda and 1 in DRC, with death rates of 25% and 50%, respectively.
- This is the 17th outbreak of Ebola in DRC since 1976. The most recent outbreak ended in December 2025.

Ebola Outbreak: Current Situation

- To date, no Ebola cases associated with this outbreak have been reported in the United States, and the risk to the general public remains low.
- The overall risk to the American public and travelers remains low.
- The DRC and Uganda Ministries of Health reported cases are shown in the table.

Reported cases

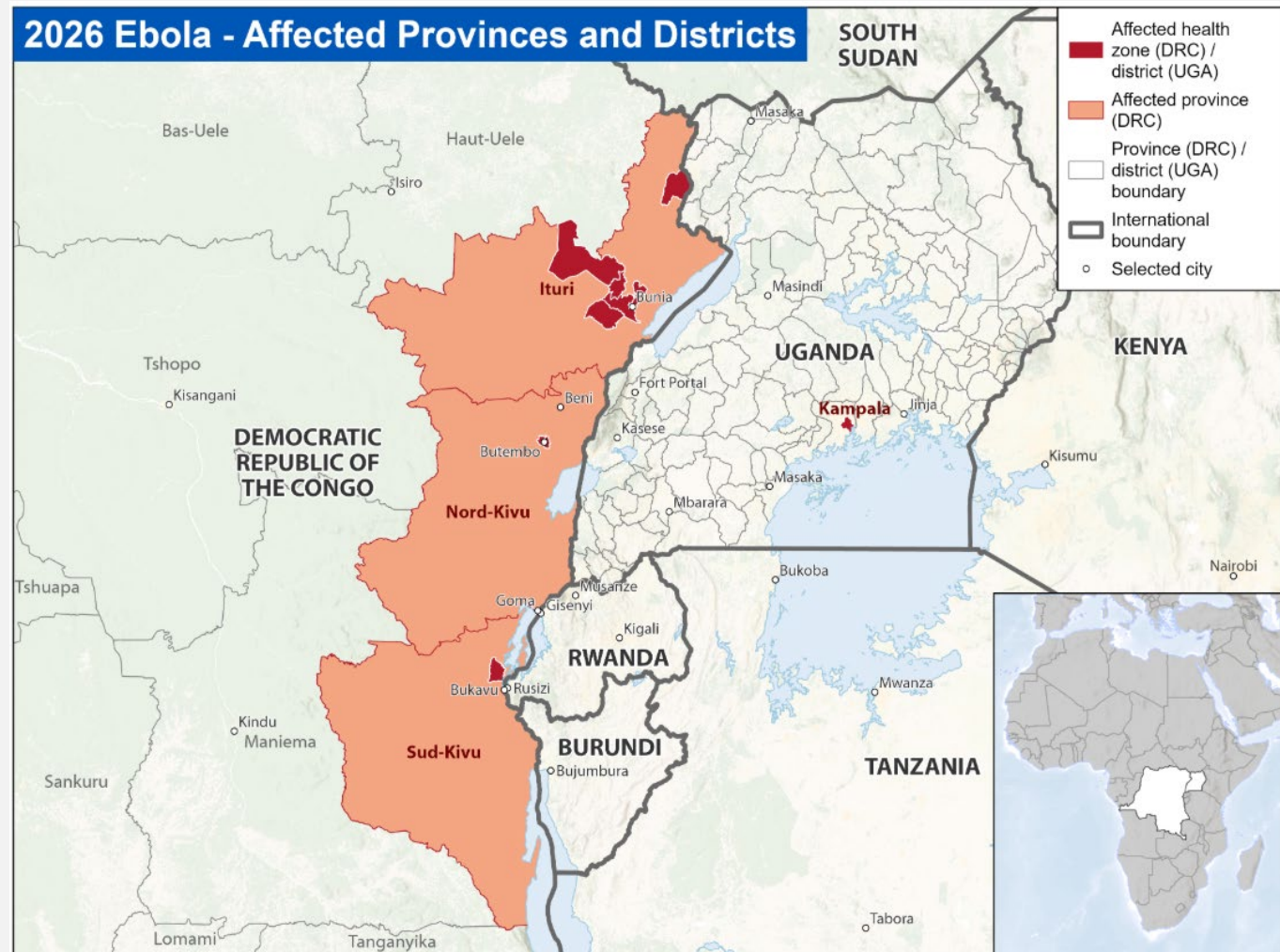
This is a rapidly evolving situation, and case counts are subject to change.

The DRC and Uganda Ministries of Health report the following:

DRC (As of June 2)	• 363 confirmed cases • 62 confirmed deaths • NA - probable cases • NA - probable deaths • NA - suspected cases* • NA - suspected deaths*
Uganda (As of June 4)	• 16 confirmed cases • 1 confirmed death • 1 probable case • 1 probable death

*On May 29, the DRC Ministry of Health updated their total suspected case count to remove suspected cases and deaths that were ruled out after investigation and/or laboratory testing.

Ebola Outbreak: Current Situation



Available at: [Ebola Outbreak: Current Situation](#) | [Ebola](#) | [CDC](#), accessed on June 4, 2026.

CDC and DSHS Ebola Disease Outbreak Health Advisories



Health Alert Network (HAN)

EXPLORE THIS TOPIC

Available at: [Ebola Disease Outbreak in the Democratic Republic of the Congo and Uganda | HAN | CDC](#), accessed on June 4, 2026.

SEARCH

Ebola Disease Outbreak in the Democratic Republic of the Congo and Uganda

MAY 19, 2026

AT A GLANCE

- Distributed via the CDC Health Alert Network
- May 19, 2026
- CDCHAN-00530



Summary

The Centers for Disease Control and Prevention (CDC) is issuing this Health Alert Network (HAN) Health Advisory to alert clinicians, public health practitioners, and travelers about a new outbreak of Ebola disease in the Democratic Republic of the Congo (DRC) and Uganda caused by the Bundibugyo virus (species *Orthoebolavirus bundibugyoense*). The risk of spread to the United States is considered low at this time. As a precaution, this Health Advisory summarizes CDC recommendations for U.S. health departments, clinical laboratories, and healthcare workers about potential Ebola disease case identification, testing, and biosafety considerations in clinical laboratories.

Background

On May 15, 2026, the Ministry of Health of the Democratic Republic of the Congo (DRC) confirmed an outbreak of [Ebola disease in Ituri Province in northeastern DRC](#). As of May 16, 2026, a total of 246 suspected cases and 80 deaths have been reported. Laboratory analysis conducted by the National Institute of Biomedical Research (INRB) confirmed the cause as Bundibugyo virus infection in 8 of 13 samples collected from suspected cases associated with clusters of severe illness and deaths in the Maniema and Basoko

ON THIS PAGE

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Health Advisory: Ebola Disease Outbreak in the Democratic Republic of the Congo and Uganda

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HEALTH ADVISORY

May 20, 2026

The CDC has issued the Health Advisory linked below about the ongoing Ebola Bundibugyo outbreak in the Democratic Republic of the Congo (DRC) and Uganda.

Clinicians in Texas should remain vigilant while treating patients with symptoms compatible with Ebola virus disease. As outlined in the health advisory, clinicians should take a complete travel history, consider Ebola virus disease in patients who have been in affected areas and have other risk factors, isolate and test patients as indicated, and immediately report any suspected cases of Ebola virus disease to their local health department or DSHS. Clinicians should also consider and test for more common causes of gastrointestinal and febrile illness such as malaria, influenza, and COVID-19.

As part of the outbreak response, CDC has implemented restrictions prohibiting entry into the United States of non-US passport holders who have been in the DRC, Uganda, or South Sudan in the previous 21 days. It has also implemented enhanced screening and monitoring of people arriving in the US from affected areas. (See more at [CDC Statement on the Use of Public Health Travel Restrictions to Prevent the Introduction of Ebola Disease into the United States | Ebola | CDC](#).)

Of note, the DRC soccer team is scheduled to train in Houston and play one game there during the group stage of the World Cup next month. DSHS is working closely with the CDC, FIFA, and local health departments to ensure the health and safety of the teams, spectators, and all Texas residents.

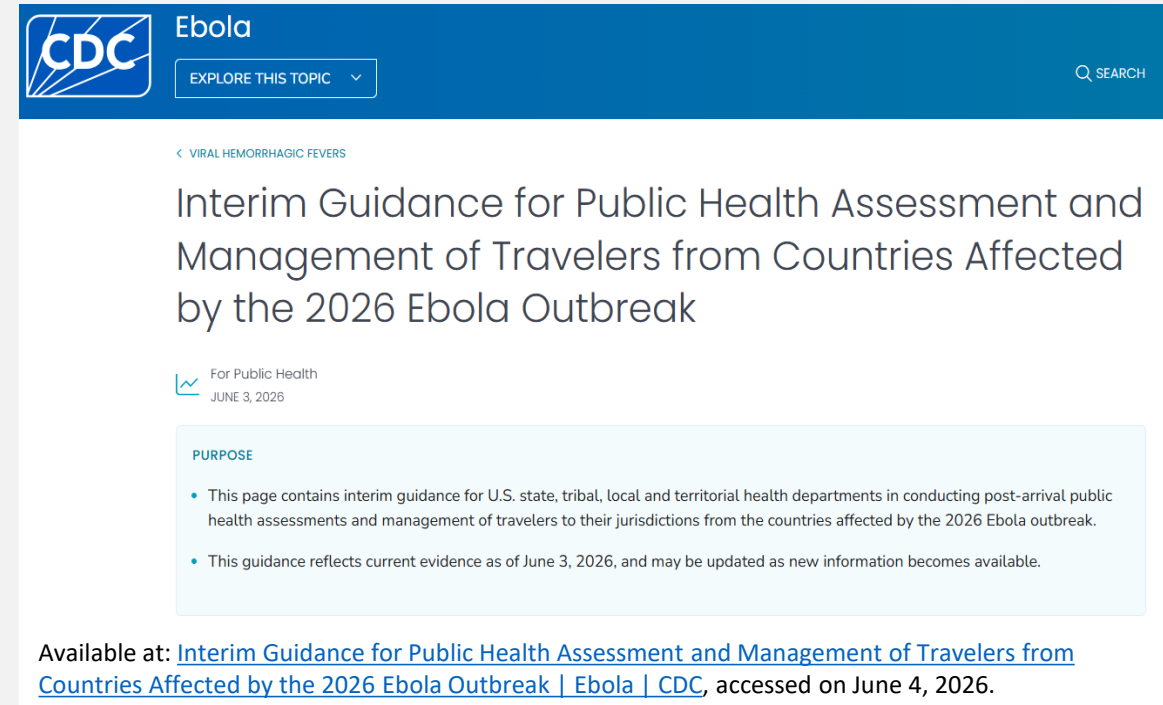
The complete health advisory can be found here: [Ebola Disease Outbreak in the Democratic Republic of the Congo and Uganda | HAN | CDC](#)

Travel and Enhanced Monitoring

- CDC has travel health notices in place for [DRC](#) and [Uganda](#) to help Americans planning travel to either country in the near future learn how to keep themselves safe from Ebola.
 - [DRC](#) Level 3: Reconsider Nonessential Travel
 - [Uganda](#) Level 2: Practice Enhanced Precautions
- CDC is taking [proactive public health measures to prevent Ebola](#) from entering the United States.
 - CDC temporarily restricted entry for certain travelers who were recently in DRC, Uganda, or South Sudan.
 - As of Friday, May 22, 2026, U.S. citizens may still enter but will undergo enhanced public health screening.
 - Travelers should monitor for Ebola symptoms for 21 days after leaving affected countries.
 - Anyone who develops symptoms should avoid travel and contact public health authorities immediately.

Travel and Enhanced Monitoring

- Under a CDC [Order](#) effective May 18, 2026, certain non-U.S. citizens who were in DRC, South Sudan, or Uganda, within the past 21 days are temporarily prohibited from entering the United States.
- Travelers permitted to enter the United States who have recently been in DRC, South Sudan, or Uganda will undergo enhanced public health entry screening.
 - These travelers will have their air travel re-routed to arrive at select airports. Airlines will work with affected travelers to rebook flights.
 - Washington-Dulles International Airport (IAD)
 - Hartsfield-Jackson Atlanta International Airport (ATL)
 - George Bush Intercontinental Airport (IAH)
 - John F. Kennedy International Airport (JFK)



The screenshot shows the CDC website's Ebola page. At the top, there's a blue header with the CDC logo, the word "Ebola", a button that says "EXPLORE THIS TOPIC", and a search icon. Below the header, there's a breadcrumb trail: "< VIRAL HEMORRHAGIC FEVERS". The main title is "Interim Guidance for Public Health Assessment and Management of Travelers from Countries Affected by the 2026 Ebola Outbreak". Below the title, it says "For Public Health" and "JUNE 3, 2026". There's a section titled "PURPOSE" with two bullet points: "This page contains interim guidance for U.S. state, tribal, local and territorial health departments in conducting post-arrival public health assessments and management of travelers to their jurisdictions from the countries affected by the 2026 Ebola outbreak." and "This guidance reflects current evidence as of June 3, 2026, and may be updated as new information becomes available." At the bottom, it says "Available at: [Interim Guidance for Public Health Assessment and Management of Travelers from Countries Affected by the 2026 Ebola Outbreak | Ebola | CDC](#), accessed on June 4, 2026."

Texas Bundibugyo Monitoring

Public Health Region (Data as of 6/4/2026, 3:30pm)	Total PUMs In Texas*	% of PUMs
PHR 1	3	1.5%
PHR 2/3	110	56.7%
PHR 4/5N	2	1.0%
PHR 6/5S	44	22.7%
PHR 7	18	9.3%
PHR 8	11	5.7%
PHR 9/10	0	0.0%
PHR 11	3	1.5%
Pending/Unknown	3	1.5%
Grand Total	194	100.0%

* Three additional PUMs were received by Texas and transferred out of the state.

Expectations for Hospitals

- Texas does not have designated hospitals for triage of viral hemorrhagic fever suspects.
- Hospitals must assess the patient and look for other causes of the symptoms, (i.e., malaria).
- If other conditions are ruled out, physicians can request testing at a Laboratory Response Network site (Austin or Houston.)
- Consultation is required with DSHS and CDC to receive approval to run Ebola test.
- It is not an automatic transfer to UTMB's biocontainment unit. Only DSHS can approve transport/transfer to biocontainment unit.

Ebola Virus Resources

- [Ebola Outbreak: Current Situation | Ebola | CDC](#)
- [Ebola Disease Outbreak in the Democratic Republic of the Congo and Uganda | HAN | CDC](#)
- [What Clinicians Should Know about Ebola Bundibugyo Virus | COCA | CDC](#)
- [Public Health Guidance for Ebola Disease | Ebola | CDC](#)
- [Information for Travelers Returning from Ebola-Affected Areas | Ebola | CDC](#)
- [About the Current Ebola Outbreak | Ebola | CDC](#)
- [Signs and Symptoms of Ebola Disease | Ebola | CDC](#)
- [How Ebola Disease Spreads | Ebola | CDC](#)
- [Ebola and Bundibugyo Virus Frequently Asked Questions | Ebola | CDC](#)
- [Ebola: What to Do After Travel | Ebola | CDC](#)

Questions

Please send any questions to EAIDUMonitoring@dshs.texas.gov

Thank you

II.A.1. Center for Health Emergency Preparedness and Response (CHEPR)

Chris Medina, Director
DSHS Operations Branch, Response and Recovery Unit



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DSHS World Cup Activities

June 3, 2026

**Chris Medina, Director,
DSHS Operations Branch, Response and Recovery Unit**

Outline

- Match Schedules
- Base Camp Locations
- DSHS Preparedness and Response Activities
- SMOC WC26 Events



Texas Department of State
Health Services

Texas Match Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
June	5 TBD – Exhibition Match Austin Saudia Arabia vs. TBD	9 1800 – Exhibition Match San Antonio Saudia Arabia vs. Senegal	10 FanFest Begins	11 1 st Game ★ in Mexico ★ SMOC Day 0	12 1 st US Game ★ in LA	13	14 1500 - DFW Netherlands vs. Japan 1200 - HOU Germany vs. Curacao
	6 1900 – Exhibition Match Kyle Field Argentina vs. Honduras						
	15	16	17 1500 - DFW England vs. Croatia 1200 - HOU Portugal vs. DRC	18	19	20 1200 - HOU Netherlands vs. Sweden	21
	22 1200 - DFW Argentina vs. Austria	23 1200 - HOU Portugal vs. Uzbekistan	24	25 1800 - DFW Japan vs. Sweden	26 1900 - HOU Cape Verde vs. Saudi Arabia	27 2100 - DFW Jordan vs. Argentina	28
July	29 1200 - HOU	30 1200 - DFW	1	2	3 1300 - DFW	4 ★ 1200 - HOU	5
	6 1400 - DFW	7	8	9	10	11	12
	13	14 1400 - DFW	15	16	17	18	19 ★ Final Game in New Jersey

Notes:

- 1. Stadiums will be open 3hrs prior and 2hrs after schedules games
- 2. Soccer games average 2hrs

Base Camp Locations

Confirmed locations

- Austin:
 - Team: Saudi Arabia
 - Hotel: Four Seasons Hotel Austin
 - Stadium: Austin FC Stadium (Q2 Stadium)
- Frisco:
 - Team: Sweden
 - Hotel: Westin Stonebriar Golf Resort and Spa
 - Stadium: Toyota Stadium (Home of FC Dallas)
- Houston
 - Team: DR Congo
 - Hotel: Hotel-Houston Omni
 - Stadium: SaberCat Stadium
- Mansfield:
 - Team: Czechia
 - Hotel: Sheraton Fort Worth Hotel
 - Stadium: Texas Health Mansfield Stadium

Timeline of DSHS epidemiologic and preparedness activities in preparation for the 2026 FIFA World Cup

Early 2025

Host cities, local health entities, and regional public health partners begin planning and engagement for 2026 FIFA World Cup Games

Early fall 2025

DSHS began developing list of Health Conditions/Incidents of Interest (HCI) for the 2026 FIFA World Cup Games in Texas

December 2025

DSHS begins working group discussions

March 2026

DSHS distributes HCI list to partners

May 2026

- DSHS Conducts Preparedness Exercises
- World Cup Infectious Disease Consultation Hotline developed

June 2026

-  June 5,6,9: Exhibition matches in College Station, Austin, San Antonio
- June 14: First match in Dallas and Houston



July 2026

- July 14: Semi-final game in Dallas (last game in Texas)
- July 19: Final game in New York/New Jersey

2026 FIFA World Cup DSHS Workgroups

Central Office

Coordination among each division at central Office DSHS

Regional

Coordination of representatives from DSHS Public Health Regions 2/3 and 6/5s, the South East Texas Regional Advisory Council (SETTRAC), and the North Central Texas Trauma Regional Advisory Council (NCTTRAC)

State/Federal (external)

Coordination with representatives from the Centers of Disease Control and Prevention (CDC), Administration for Strategic Preparedness and Response (ASPR), Department of Homeland Security (DHS) BioWatch program, and the Texas Department of Emergency Management (TDEM)

Preparedness and Training

- State Medical Operations Center
 - Preparedness tabletop exercises
 - Radiation
 - Mass casualty
 - Food-borne outbreak
 - High-Consequence Infectious Diseases
 - Annual SMOC Hurricane exercise
- 2026 Epidemiology and Laboratory Capacity (ELC) Conference
 - Tabletop exercises
 - Panel discussions
- Statewide Epi weekly calls
 - Selected World Cup HCIs

State-wide Monitoring Activities

- DSHS is engaging in heightened monitoring for prioritized health conditions and incidents.
- Bringing together key existing data streams, including electronic laboratory reports, epidemiologic surveillance, syndromic surveillance, wastewater surveillance, EMS/trauma reporting, and poison center reporting.
- Developed processes for early/near real-time identification and communication of any unusual epidemiological activity statewide that may require public health action.

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

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

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

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

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

¹Filoviruses (Ebola, Marburg), New World Arenaviruses (Chapare, Guanarito, Junin, Sabia), Old World Arenaviruses (Lassa, Lujo), Bunyavirales (Crimean-Congo Hemorrhagic Fever), Nipah, Smallpox, Monkeypox

²Influenza (seasonal), Novel influenza (e.g., H5N1), Respiratory Syncytial Virus Infection (RSV), Tuberculosis, Middle Eastern Respiratory Syndrome (MERS)/Other novel Coronaviruses, Legionellosis, COVID-19

³Measles, Diphtheria, Polio, *Neisseria meningitidis*, Pertussis, Hepatitis A

⁴Botulism, *Listeria*, *Salmonella* Typhi/Paratyphi, Shiga toxin-producing *E. coli* (STEC), Cholera (toxigenic *Vibrio cholerae* O1 or O137), *Vibrio* (*Vibrio parahaemolyticus*, *vulnificus*, and other *Vibrio* infections), *Shigella*, *Salmonella*, *Cryptosporidium*, *Campylobacter*, *Yersinia enterocolitica*, Norovirus

⁵Anthrax, Tularemia, *Yersinia pestis* (Plague), Melioidosis, Dengue, Chikungunya, Yellow Fever, West Nile, Oropouche, Zika, St. Louis Encephalitis

⁶If a determination is made that incidents are intentional and/or targeted (and not naturally occurring) then they are considered human-made disasters. These types of disasters trigger involvement from the Center for Health Emergency Preparedness and Response (CHEPR) for disaster epidemiology surveillance activities. For more information, please see the CHEPR Disaster Response & Recovery website at: [Disaster Response & Recovery | Texas DSHS](https://dshs.texas.gov/disaster-response-recovery)

⁷The State Medical Operation Center (SMOC) serves as the Emergency Support Function (ESF)-8 (Public Health & Medical) lead to support the Texas State Operations Center (SOC). The SMOC provides operational support and coordination of state-level ESF-8 response activities during disasters. During a SMOC activation, any impacts to human health based on these incidents could trigger involvement from CHEPR (see footnote 6).

⁸Mass casualty incidents, such as active killer who actively engages in killing through use of firearms, vehicles or other means, could result in mass fatalities. High density crowd incidents, such as stampedes, trampling or civil disturbances could also lead to mass casualties and fatalities. Natural disasters and CBRNE incidents may also produce mass casualties and fatalities. Disaster mortality surveillance can be conducted for mass fatalities.

⁹HIV, Syphilis, Chlamydia, Gonorrhea, Chancroid

¹⁰*Candida auris*, Carbapenem-resistant *Enterobacterales*, Vancomycin-resistant *Staphylococcus aureus* (VRSA), Vancomycin-intermediate *Staphylococcus aureus* (VISA), Carbapenem-resistant *Acinetobacter baumannii* (CRAB), Carbapenem-resistant *Pseudomonas aeruginosa* (CRPA)

DSHS Preparedness & Response Activities

- EAIDU Weekly Statewide Epi Call created to discuss infectious disease updates relevant to public health, ensuring that epidemiologists across Texas stay informed
- DSHS conducting wastewater testing around game areas in Arlington and where fans congregate. Collecting baseline data, to detect differences in infectious disease in those areas.
- Coordinating with local, state and federal partners on radiation detection, radiation surveys around FIFA locations and response support
- DSHS and the University of Texas System collaborated in developing a World Cup Infectious Diseases Consultation Hotline.
 - Provider-to-provider 24/7 ID consultative service staffed by ID specialists within the UT Health System
 - Hotline available now through July 31, 2026
 - Designed to support Texas licensed physicians and other clinicians during a period of anticipated high volume of movement and travel in Texas on diagnosis, management, and navigation to public health when necessary.
 - This will not replace normal public health notification pathways but will serve to augment or provide surge capacity during peak World Cup activities.



WORLD CUP

Infectious Diseases Consultation Hotline

The Texas Department of State Health Services is offering a free hotline to assist physicians and other clinicians with diagnosis, management, and/or public health navigation for suspected infections during the 2026 FIFA World Cup events.

Available 24/7 through July 31, 2026

866-213-3368



Staffed by adult and pediatric infectious disease specialists within the University of Texas Health System



Designed for licensed Texas physicians and other clinicians, and World Cup team providers in Texas



Provides clinical recommendations to treating physician, who retains full clinical decision-making authority



Recommends clinical or public health escalation when necessary

Get support with:*

- Concerns about viral hemorrhagic fever (e.g., Lassa fever, Ebola) or high-consequence infectious disease (e.g., MERS)
- Diagnosis when evaluating a febrile patient with recent foreign or domestic travel
- Clinical management or treatment for a suspected travel-associated infection
- Antimicrobial resistance related to a recent traveler
- Severe respiratory illness with recent animal or travel exposures

*Note: The hotline does not replace existing infectious disease consultation processes or the requirement to report suspected disease cases to public health. Referring physicians and other clinicians retain clinical responsibility for all patient care decisions and responsibility for prompt notification to public health entities.

Have ready when you call:

- Treating physician or clinician name, title, and facility
- Reason for World Cup-related consultation
- Patient location and demographic information
- Detailed patient travel history with dates and locations
- Clinical presentation and relevant findings

Scan QR code for more information



World Cup Information for Physicians and Other Clinicians in Texas

Texas Department of State Health Services (DSHS) is offering a free hotline to assist providers in Texas with diagnosis, management, and/or public health navigation for suspected infections related to the 2026 FIFA World Cup events.

World Cup Infectious Diseases Consultation Hotline

Call the hotline: 866-213-3368

Available 24/7 through July 31, 2026

- Staffed by adult and pediatric infectious disease specialists within the University of Texas Health System
- Designed for licensed Texas physicians and World Cup team providers in Texas
- Provides clinical recommendations to treating physician or other clinician, who retains full clinical decision-making authority
- Recommends clinical or public health escalation when necessary

Note: The hotline does not replace existing infectious disease consultation processes or the requirement to report suspected disease cases to public health. Treating physicians and other clinicians retain clinical responsibility for all patient care decisions and responsibility for prompt notification to public health entities.

Get support with:

- Concerns about viral hemorrhagic fever (e.g., Lassa fever, Ebola) or high-consequence infectious disease (e.g., monkeypox, MERS, hantavirus)
- Diagnosis when
- Clinical manage
- Antimicrobial re
- Severe respirato

The hotline i

- Patients or mem
- Physicians and c
- your health

Scan QR code for more information



Hotline is LIVE

- Email communications, flyer, and website have been shared with public health, medical, and emergency management partners on May 27th.

- TDEM
- HPPs
- RACs
- Trade Organizations (TMA, TPS, THA, etc.)

DSHS 2026 FIFA World Cup Web Pages

Available at: [World Cup 2026 | Texas DSHS & World Cup Information for Physicians and Other Clinicians in Texas](#) | [Texas DSHS](#), accessed on May 27, 2026



Texas Department of State Health Services



Center for Health Emergency Preparedness and Response (CHEPR)

Public Health Emergency Preparedness

Disaster Response & Recovery

World Cup 2026

World Cup Information for Physicians and Other Clinicians in Texas

Disaster Epidemiology

Hospital Preparedness Program

Preparedness Coordinating Council

Texas Medical Reserve Corps (MRC)

Jurisdictional Preparedness Support (IPS)

Planning Resources

Project Public Health Ready

Training and Exercise

TxHAN Emergency Alert Services

Useful Links

Hundreds of thousands of domestic and international visitors will be visiting Texas for the [2026 FIFA World Cup](#). The Texas Department of State Health Services (DSHS) [Center for Health Emergency Preparedness and Response \(CHEPR\)](#) is preparing to support one of the largest international events ever hosted in our state.

About the World Cup in Texas

[Dallas](#) and [Houston](#) are hosting multiple World Cup matches in June and July. There will also be large-scale FIFA Fan Festival events in both cities.

Team Basecamp Locations

These cities will serve as basecamp for national teams:

- Austin – Saudi Arabia
- Frisco - Sweden
- Fort Worth – Czechia
- Houston – Democratic Republic of the Congo

DSHS is Ready for the World Cup

The [Center for Health Emergency Preparedness and Response \(CHEPR\)](#) is working alongside local, state, and federal partners to get ready. Preparation efforts ahead of game days ensure a consistent, statewide approach to any response.

During Texas match days, the State Medical Operations Center (SMOC) will operate under a limited activation status, ready for a full activation if needed.

CHEPR and other DSHS programs are also working with local health departments to help strengthen and support epidemiologic surveillance and investigations. They are monitoring hospital and emergency services trends as well.

These public health preparedness efforts will help make sure that Texas is ready to safely welcome visitors from around the world.

Related Resources

[Texas Ready](#)

[Extreme Heat Preparations](#)

[Poison Control](#): If you are concerned because you were exposed to a harmful substance or are having an adverse reaction, contact 1-800-222-1222. This Poison Help Line is free and confidential. You can also contact a health care provider.

Center for Health Emergency Preparedness and Response (CHEPR)

World Cup 2026

World Cup Information for Physicians and Other Clinicians in Texas

World Cup Information for Physicians and Other Clinicians in Texas

Texas Department of State Health Services (DSHS) is offering a free hotline to assist providers in Texas with diagnosis, management, and/or public health navigation for suspected infections related to the 2026 FIFA World Cup events.

World Cup Infectious Diseases Consultation Hotline

Call the hotline: 866-213-3368

Available 24/7 through July 31, 2026

- Staffed by adult and pediatric infectious disease specialists within the University of Texas Health System
- Designed for licensed Texas physicians and World Cup team providers in Texas
- Provides clinical recommendations to treating physician or other clinician, who retains full clinical decision-making authority
- Recommends clinical or public health escalation when necessary

Note: The hotline does not replace existing infectious disease consultation processes or the requirement to report suspected disease cases to public health. Treating physicians and other clinicians retain clinical responsibility for all patient care decisions and responsibility for prompt notification to public health entities.

Get support with:

- Concerns about viral hemorrhagic fever (e.g., Lassa fever, Ebola) or high-consequence infectious disease (e.g., monkeypox, MERS, hantavirus)
- Diagnosis when evaluating a febrile patient with recent foreign or domestic travel
- Clinical management or treatment for a suspected travel-associated infection
- Antimicrobial resistance related to a recent traveler
- Severe respiratory illness with recent animal or travel exposures

The hotline is *not* for:

- Patients or members of the public
- Physicians and other clinicians treating patients outside of Texas (In such situations, please consult your local health department.)
- Routine illnesses or illnesses not related to World Cup
- Administrative or billing questions

What to Expect When You Call

Step 1: A nurse will answer the hotline and obtain basic information and will then route the physician or other clinician to an appropriate infectious disease consultant. The nurse will remain on the line to document the call.

Step 2: The infectious disease consultant will provide clinical recommendations, which may include a recommendation to notify local health authorities. The physician or other clinician retains full clinical decision-making authority.

Step 3: If referral to public health entity is appropriate, the treating physician or other clinician will be directed to contact the appropriate entity ([see list of Texas Local Public Health Organizations](#)). If requested, the infectious disease consultant may provide additional clinical or public health escalation guidance.

Information to Have Ready When You Call:

- Treating physician or other clinician name, title, and facility
- Reason for suspected World Cup-related consultation
- Patient location and demographic information (i.e., patient age, date of birth, sex, patient location and address. If the patient resides outside of Texas, location of the treating facility will be used to notify public health.)
- Detailed patient travel history with dates and locations
- Clinical presentation and relevant findings

[Download the DSHS List of Health Conditions or Incidents for World Cup](#)

[Download the World Cup Infectious Disease Consultation Hotline flyer](#)

DSHS Preparedness & Response Activities

- State Medical Operations Center will mirror State Operations Center and will be activated on match days in Texas and monitor throughout 34 days (June 11 – July 14)
- Regional ESF-8 partners plan to support or activate in various Emergency Operations Centers
- Public Health Regions working with jurisdictions to ensure CHEMPACKs are fully stocked and available
- Receiving, Staging & Storage sites for secure, state-designated warehouses that receive, manage, and distribute Strategic National Stockpile medical countermeasures (vaccines, drugs, PPE) have been identified
- Continue to monitor Biowatch operational capability and enhanced support for matches



Texas Department of State
Health Services

Questions?



Texas Department of State
Health Services

II.A.2. Emergency Medical Services and Trauma Registries (EMSTR) Update

Jia Benno, MPH
Injury Prevention Unit Director



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EMS and Trauma Registries (EMSTR) Updates

Jia Benno

Newborn Screening and Injury Prevention Section Director

EMSTR Program Updates

June 2026



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EMSTR Updates

EMSTR Data Dictionary Standards

- **EMS:**

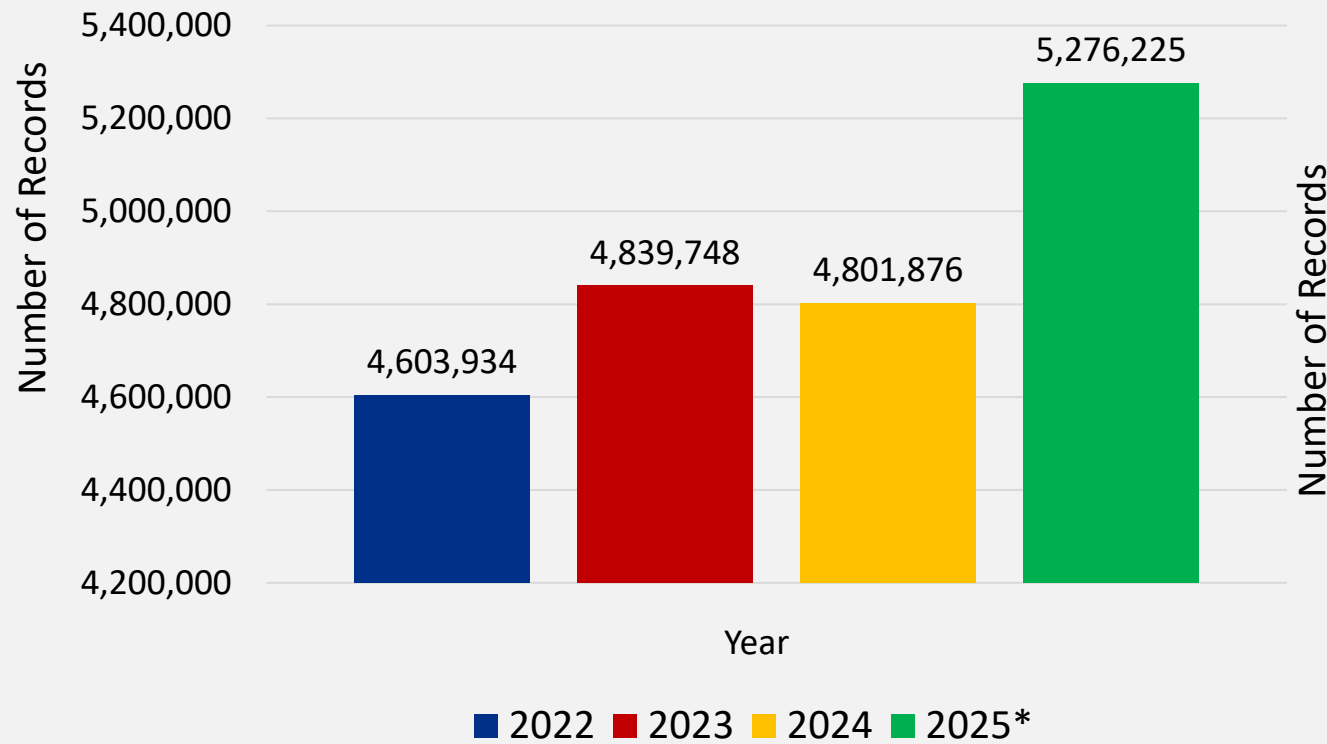
- ▶ EMSTR will continue to follow the National EMS Information System (NEMSIS) version 3.5.0.
- ▶ EMSTR will not transition to version 3.5.1 or 3.5.2. The next data dictionary change will be version 3.6.0.

- **Trauma:**

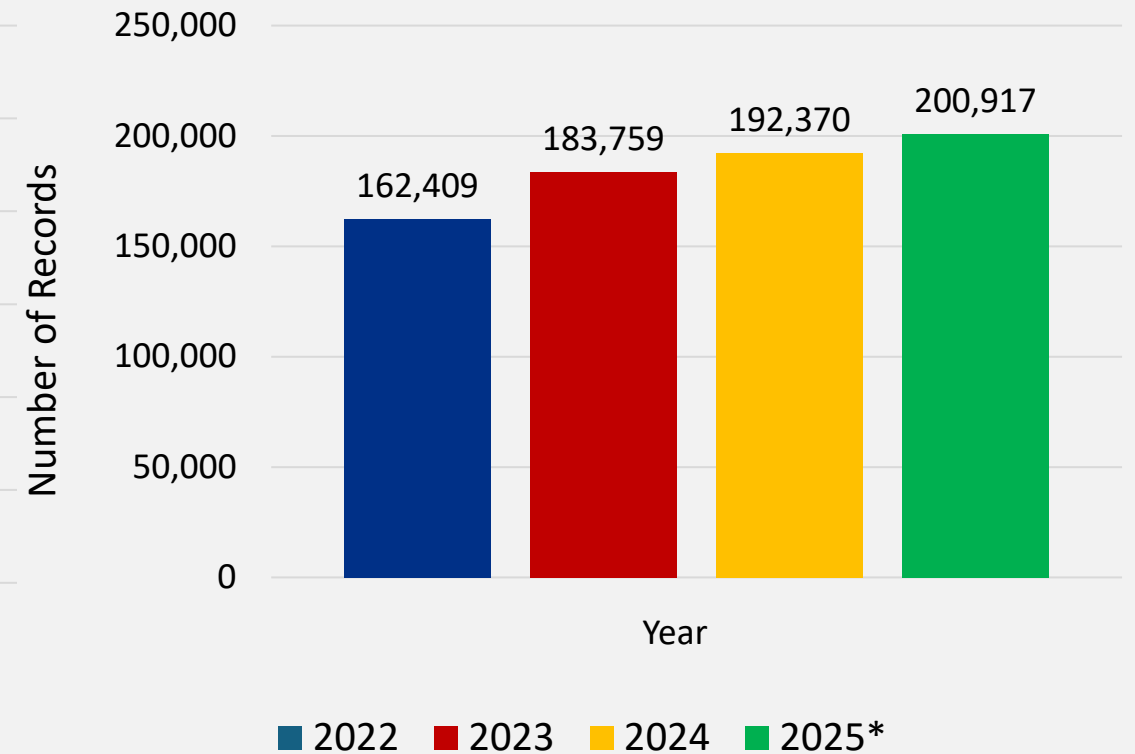
- ▶ EMSTR retired the International Trauma Data Exchange (ITDX)/ National Trauma Data Standard (NTDS) version 2020 at the close of the 2025 dataset (April 30, 2026).
- ▶ EMSTR will continue collecting data in version 2023 until further notice.

EMSTR Data Completeness

EMS



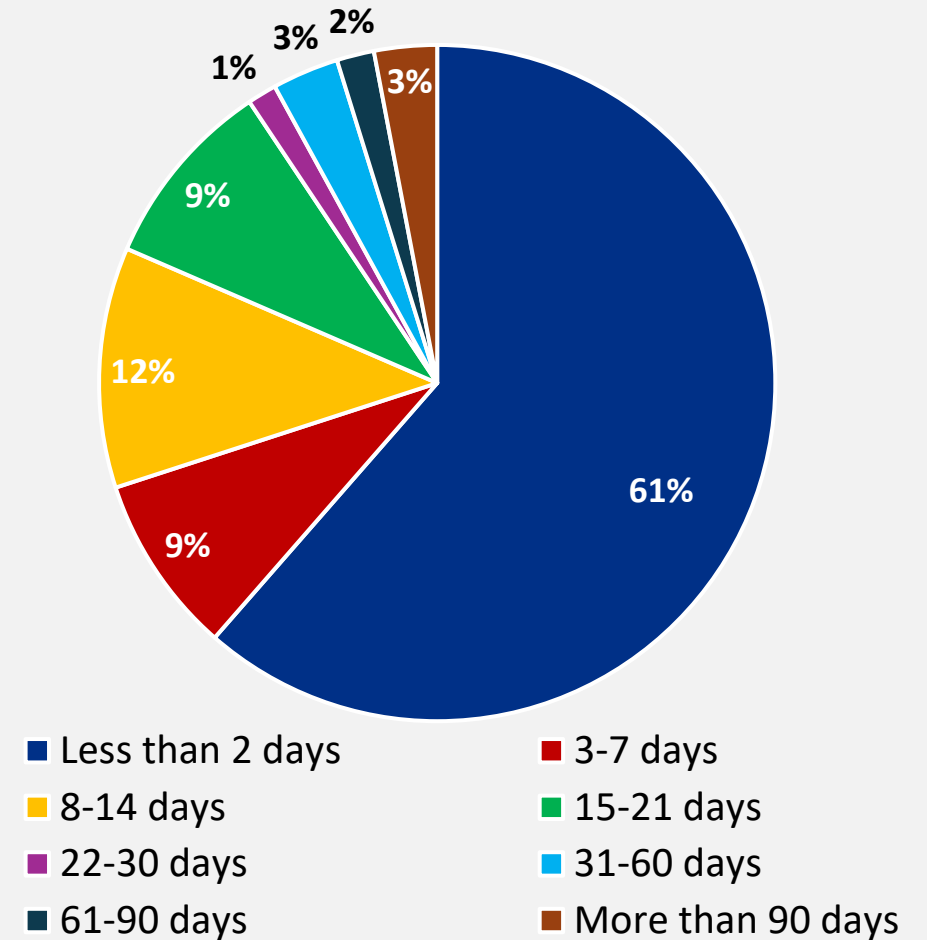
Trauma



EMS Data Timeliness

EMS data timeliness increased significantly in recent years. Preliminary 2025 data* shows:

- Median time from response to submission in EMSTR: **one (1)** day.
- Mean time from response to submission in EMSTR: **11.9** days.
- EMS agencies submitted **70%** of EMS patient care records to EMSTR within **seven (7)** days.
- Note: This excludes data that had a missing Public Safety Answering Point (PSAP) call time.



EMSTR Dashboards

- EMS Non-fatal drug poisoning dashboard - healthdata.dshs.texas.gov/dashboard/drugs-and-alcohol/all-drugs/ems-reported-non-fatal-drug-poisonings
- EMS dashboard (in production)
- Trauma dashboard (in production)



World Cup Data Utilization

- DSHS developed an interest list of health conditions for monitoring during the FIFA 2026 World Cup.
- EMS data from EMSTR will be used to track the conditions in the table to the right.

Health Conditions	Monitoring Frequency
Heat-Related Illnesses	Daily
Drug Poisonings	Daily
EMS Responses	Daily
EMS Responses to Trauma Incidents	Daily
Injuries (Motor Vehicle Crashes, Pedestrian Injuries, Falls, and Drownings)	Daily

Partnerships

- EMSTR is working with the **American Heart Association** to benchmark state performance in 10 areas of Cardiac and Stroke care (i.e., percent documentation of last known well date/time for suspected stroke patients).
- The National Association of State EMS Officials (NASEMSO) Data Managers Council is working to provide an outline to state and agency officials on connecting EMS (NEMSIS) and hospital (HL7) data to allow for analyzing outcomes and quantifying the benefits of pre-hospital whole blood transfusion.
- Staff submitted a submersion/drowning case definition for analyzing EMS Data which received endorsement from NASEMSO and will be posted on the **National EMS Information System** Webpage in May 2026. This algorithm has been applied to the Texas dataset and is already used by the Texas Water Safety Coalition (approximately 250 partner organizations).

EMS Workforce

2019-2024



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EMSTR Updates

EMS Workforce (1 of 2)

Year	Number of Licensed EMS Providers	Number of EMS Providers submitting PCR*s*	Percent of EMS Providers submitting PCRs
2019	748	578	77.3%
2020	748	599	80.1%
2021	757	598	79.0%
2022	738	619	83.9%
2023	738	662	89.7%
2024	743	669	90.0%

*PCRs = patient care records

Data retrieved from EMSTR

EMS Workforce (2 of 2)

Year	Unique ID on PCR ^s *	Number of certified licensed personnel	Percent of certified personnel submitting PCR ^s
2019	31,418	68,461	45.9%
2020	30,992	71,778	43.2%
2021	32,540	75,733	43.0%
2022	34,824	72,643	47.9%
2023	39,047	75,407	51.8%
2024	44,367	75,952	58.4%

*PCR^s = patient care records

Data retrieved from EMSTR

Thank You!

EMS and Trauma Registries (EMSTR) Updates
Injury.prevention@dshs.texas.gov

Jia Benno
Newborn Screening and Injury Prevention Section Director

II.A.3. DSHS Mobile Integrated Health (MIH) Community of Practice

Colin Crocker, MPA



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DSHS Mobile Integrated Health Community of Practice (MIH-CoP)

Project Overview and Updates

Colin Crocker, MPA, CNM

Senior Policy Analyst, Office of Public Health Policy

Texas Department of State Health Services

June 2026

MIH Roundtable

- Roundtable hosted by DSHS, State Office of Rural Health and Episcopal Health Foundation in November 2024
- ~60 multidisciplinary partners in attendance
 - EMS practitioners
 - Hospital administrators
 - Health insurance plans
 - Health Information Exchanges
 - Philanthropy
 - Subject matter experts
- Discussions focused on:
 - Different program models
 - Implementation challenges
 - Program data needs
 - Lessons learned and best practices
 - Challenges to sustainability



MIH-CoP Purpose and Goals

Purpose

Serves as a collaborative forum for MIH stakeholders from different sectors to share best practices, develop and curate practical resources, explore strategies to support long-term sustainability, and support evidence-informed decision-making.

Overarching Goals

- Generate evidence to support statewide rural health initiatives
- Increase information sharing among stakeholders
- Improve coordination and alignment of resources

MIH-CoP Structure

MIH-CoP Workgroups



Resources Workgroup

- Landscape of current and past MIH programs in Texas
- Develop an information repository on best practices:
 - Implementation resources
 - Data management & reporting standards
 - Evaluation metrics
 - Communication materials
- Create additional resources



Rural Issues Workgroup

- Explore sustainability issues unique to programs in rural settings (e.g., financial sustainability, client/patient recruitment)
- Identify common local partners that can support or complement MIH programs
- Develop best practices guides, training materials, and other resources for rural settings



Policy Workgroup

- Explore current and potential policies to support sustainability
- Examine reimbursement models
- Establish metrics for demonstrating the public health and financial value
- Develop resources, policy briefs, or other education materials for stakeholders

Key Participating Stakeholders

- DSHS CPHPP and EMS & Trauma
- HHSC Delivery System Quality & Innovation
- State Office of Rural Health
- Mobile Integrated Health Program Staff
- Universities
- Health Plans
- Health Information Exchanges
- Foundations
- Subject Matter Experts

Contact Information

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Cristina Garcia, PhD, MHS

Director, Office of Public Health Research Advancement

Center for Public Health Policy and Practice

Cristina.Garcia@dshs.texas.gov

II.A.4. EMS Trauma Systems Update

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



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Prehospital Whole Blood Program



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ACS Level I and II Verification Visit Review



Failures in Trauma PIPS Processes

- Failure to have a written trauma PIPS plan that can be followed
- Failure to follow the plan
- Failure to build a culture of safety, just culture, engage staff
- Failure to identify variance in care or the system – events
- Event identification not timely
- Failure to define the level of harm to assist with communication and defining the urgency of review
- Failure to have documentation process for tracking
- Lack of, or insufficient time for TMD to fill role in PIPS process

Failures in Trauma PIPS Processes

- Lack of insufficient dedicated time for TPM / PI coordinator time to complete case reviews and review data to identify variances
- Failures in trauma registry to capture data to support trauma PIPS process
- Superficial reviews, closed without appropriate level of review
- CPG that are long and not easy to review and follow or lack of education regarding role in the guidelines
- Guideline compliance not moved to secondary level of review

Failures in Trauma PIPS Processes

- Discussion in secondary and tertiary levels of review are lacking with minimal documentation
- Documentation is lacking overall
- Lack of integrated resources
- Action plans are not clearly written, or not implemented, or not followed with no data analysis
- Trauma PIPS meetings are inconsistently held or there is lack of authority and oversight at meetings
- Issues are not consistently discussed or reviewed at PIPS meetings

Failures in PIPS Processes

- Issues removed from the agenda
- Failure to integrate with hospital quality
- Failure to engage medical staff
- Reviews lack critical discussion to determine contributing factors and OFI
- Failure to reach event resolution (loop closure)

ACS Standards Not Met

- 2.3 Disaster management planning
- 2.7 Trauma multidisciplinary PIPS
- 2.8 Trauma medical director requirements
- 3.1 OR availability
- 4.5 Specialty liaison
- 4.15 Interventional radiology response
- 4.22 Ophthalmology service +
- 4.31 Trauma registry staffing requirements
- 4.32 Certified abbreviated injury scale specialist
- 4.33 Trauma registry course

ACS Standards Not Met

- 5.3 Levels of trauma activation
- 5.21 Orthopedic surgeon response
- 5.7 Assessment of children for nonaccidental trauma +
- 5.9 Anticoagulation reversal protocol
- 5.11 Emergent airway management
- 5.15 Trauma diversion
- 5.17 Neurosurgery response
- 5.20 Treatment guidelines for orthopedic injuries
- 5.21 Orthopedic surgeon response time

ACS Standards Not Met

- 5.30 Alcohol misuse screening +
- 5.31 Alcohol misuse intervention +
- 6.2 Trauma registry record completion +
- 7.3 Documented effectiveness of PIPS program +
- 7.4 Participating in risk-adjusted benchmarking program
- 7.6 Trauma multidisciplinary PIPS committee attendance
- 7.7 Trauma mortality review
- 8.2 Nursing trauma orientation and education

Designation Assessment Questionnaire (DAQ)



Once application is submitted to the department – DAQ and Self-Assessment will be sent to the facility



DAQ will not be posted to align and comply with the ACS process



Training, questions and answer sessions regarding the DAQ are scheduled for each level.



DAQs continue to be discussed during the monthly calls.

Trauma Physician Credentialing and OPPE



Facility must have a procedure for the TMD to credential physicians participating in the trauma program call schedule (all phases of care)



The Ongoing Professional Practice Evaluation (OPPE) is designed to review the physician being credentialed, compliance to the trauma program procedures and trauma management guidelines, designation requirements



The TMD utilizes the OPPE to credential

Additional Training



SURVEY PLANNING



SURVEYOR TRAINING

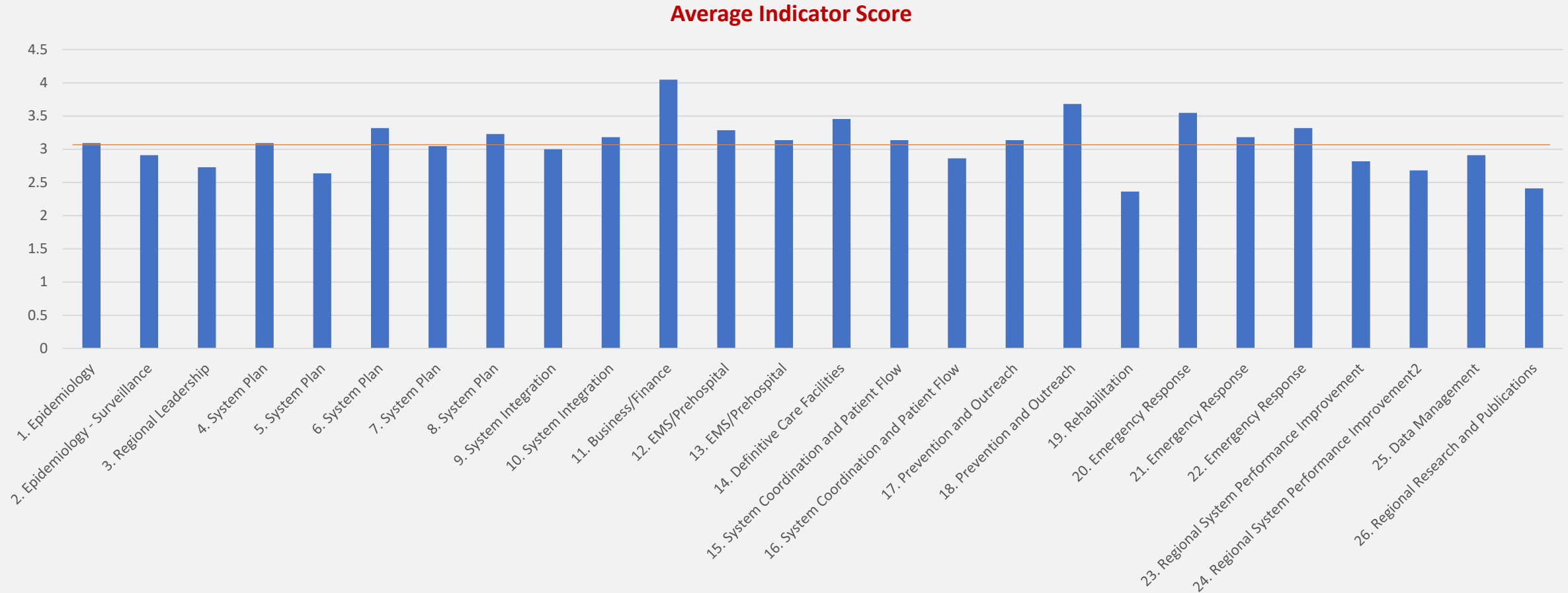


REQUIRES PRE
REGISTRATION

Transfers

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

RAC Self-Assessment Average Indicator Score



Trauma Uncompensated Care Funding

Year	Total Amount Requested by Trauma Facilities (Uncompensated Charges)	Total Uncompensated Costs used for Calculations	DSHS 5111 fund transferred to HHSC	DSHS 5007, 5108, 5111 Fundings Total (without HHSC SDA)	Total Funding Amount Available for Distribution (DSHS 5007, 5108, 5111 and HHSC SDA)
2026	\$4,306,794,071.40	\$624,641,982.47	\$80,127,880.00	\$9,814,036.80	\$221,701,084.82
2025	\$3,666,585,511.33	\$859,091,294.91	\$84,261,535.00	\$9,978,264.56	\$220,769,549.43
2024	\$2,968,946,363.00	\$852,084,816.63	\$82,189,313.00	\$10,202,312.86	\$185,362,262.60
2023	\$1,983,695,650.84	\$496,201,144.66	\$82,189,315.00	\$9,995,174.66	\$200,713,789.74
2022	\$1,921,294,591.69	\$457,280,449.49	\$82,189,317.00	\$9,835,747.67	\$199,907,698.71
2021	\$1,596,824,932.43	\$411,557,019.85	\$82,189,316.00	\$9,800,683.44	\$189,701,686.47



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Designation Update

Elizabeth Stevenson, BSN, RN
Designation Programs Manager

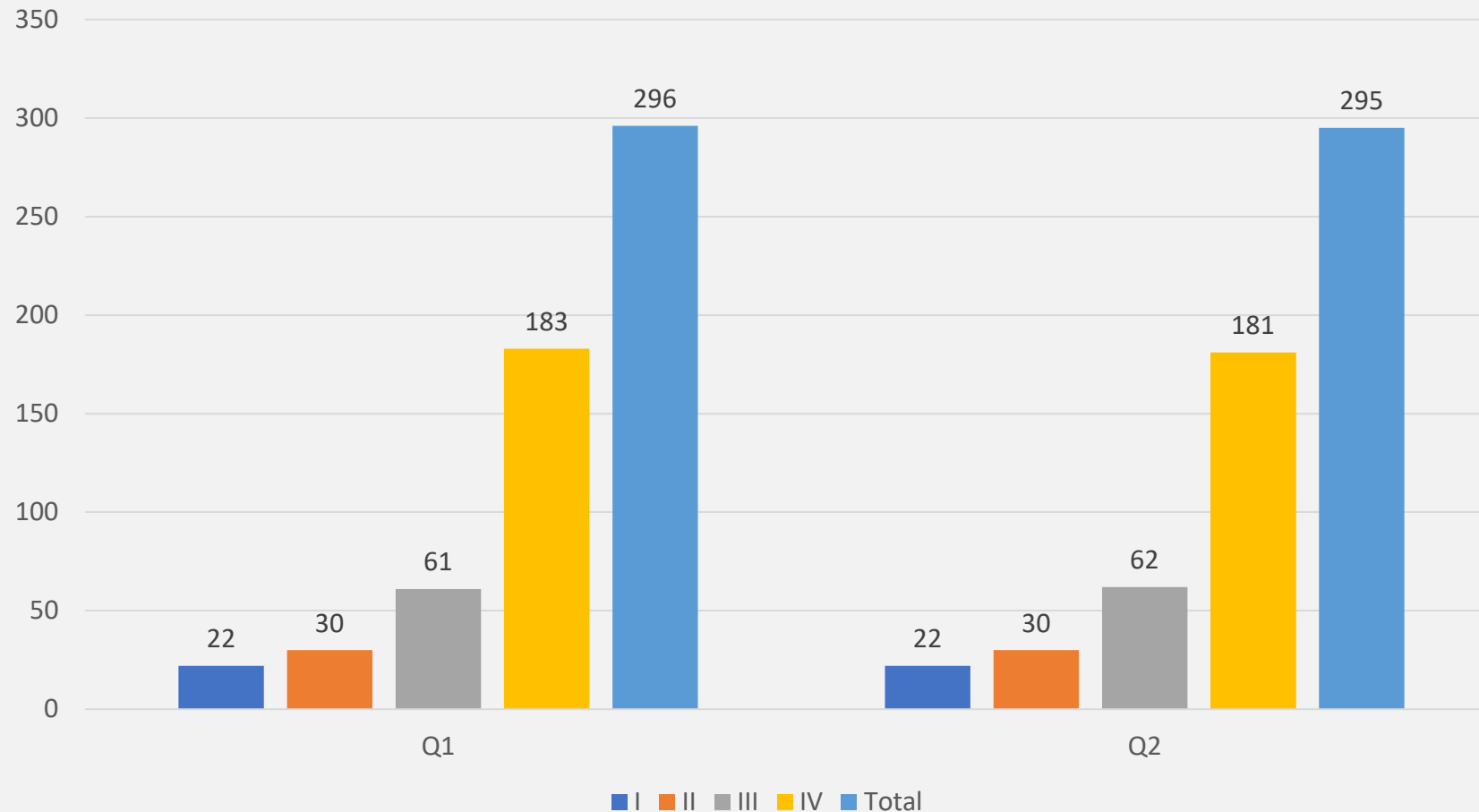


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Designated Trauma Facilities

Trauma Designated Facilities
FY26 Q2 (12/1/25 – 2/28/26)

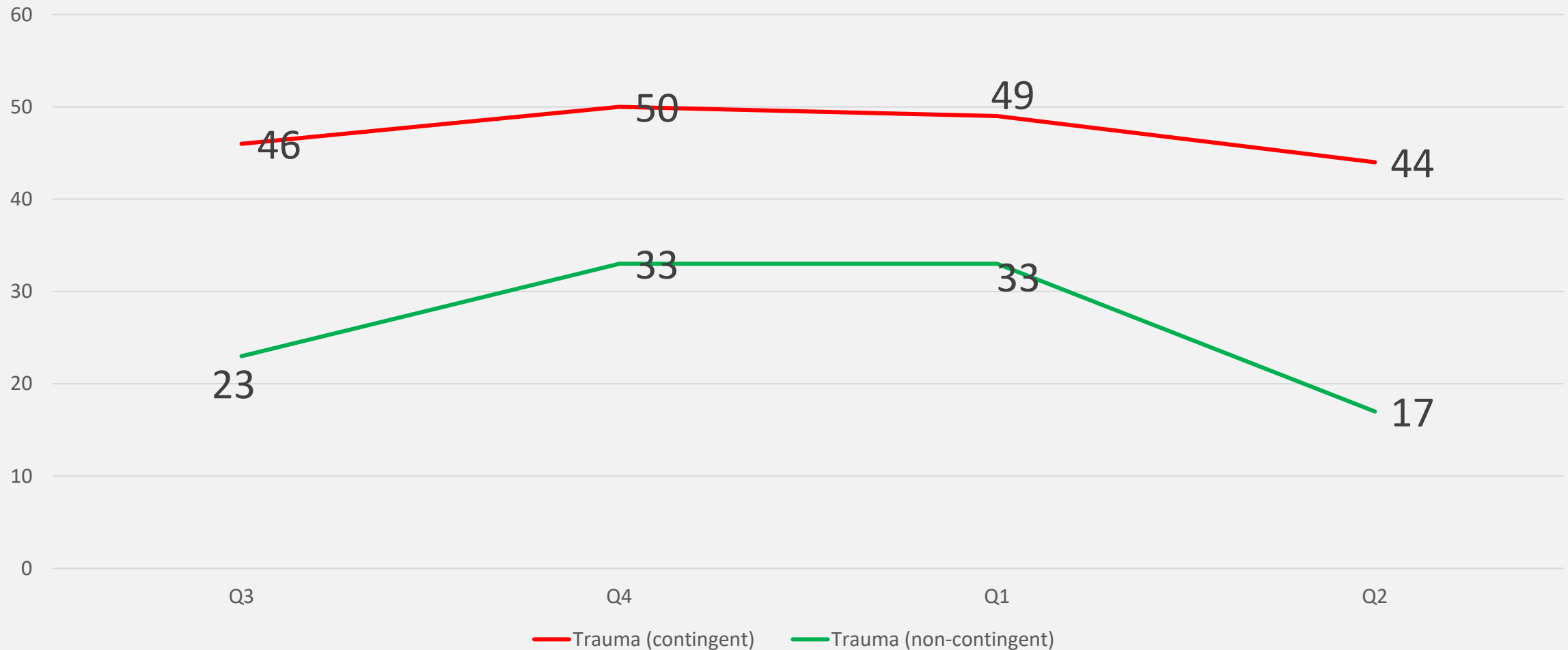


Trauma Application Statistics Q2

FY26 Q2 Application Statistics	Trauma Applications
Complete Applications Received	14
Designations Awarded	12
Initial Designations	1
Upgrade to Higher Level	1
Re-Designations	11
Contingent Designations	6
Contingent-Probationary Designations	3

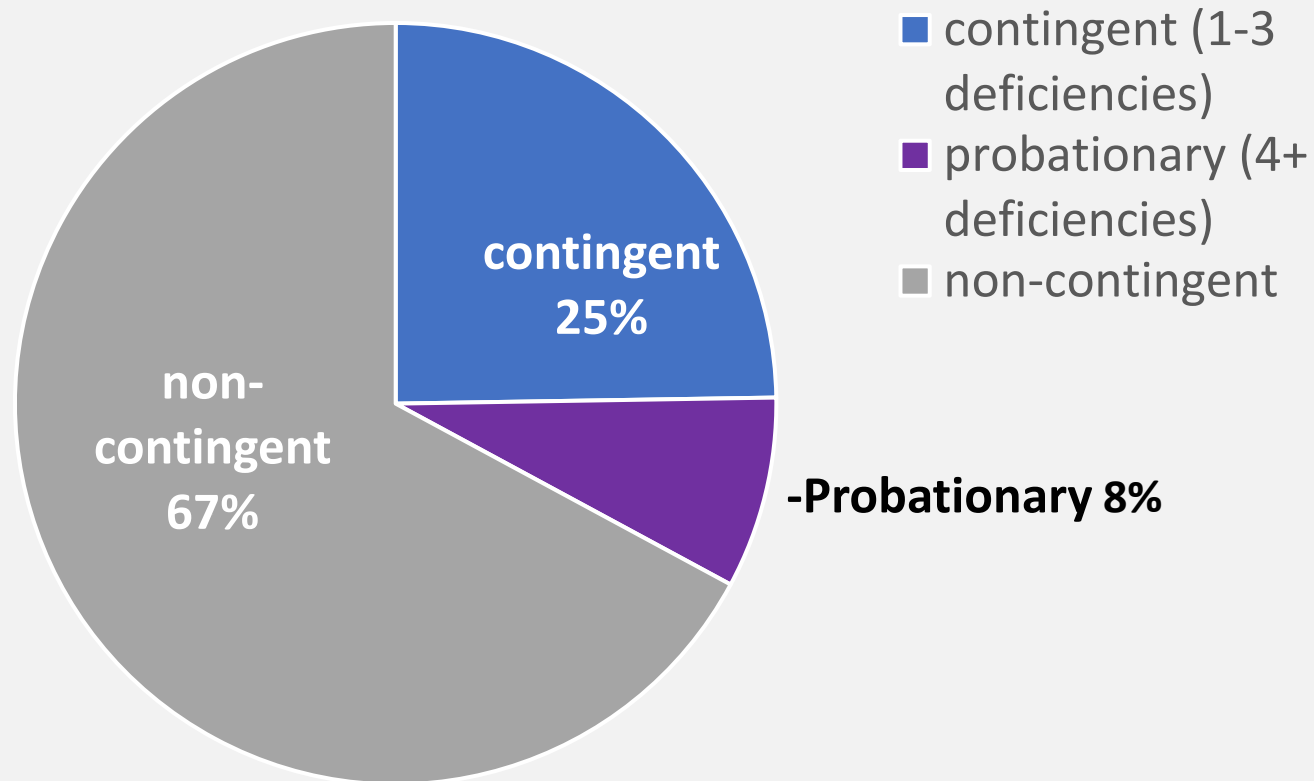
Designation Application Performance Measures

Average Days from Complete Application to Award



Trauma Designation Data

Currently Designated Trauma Facilities

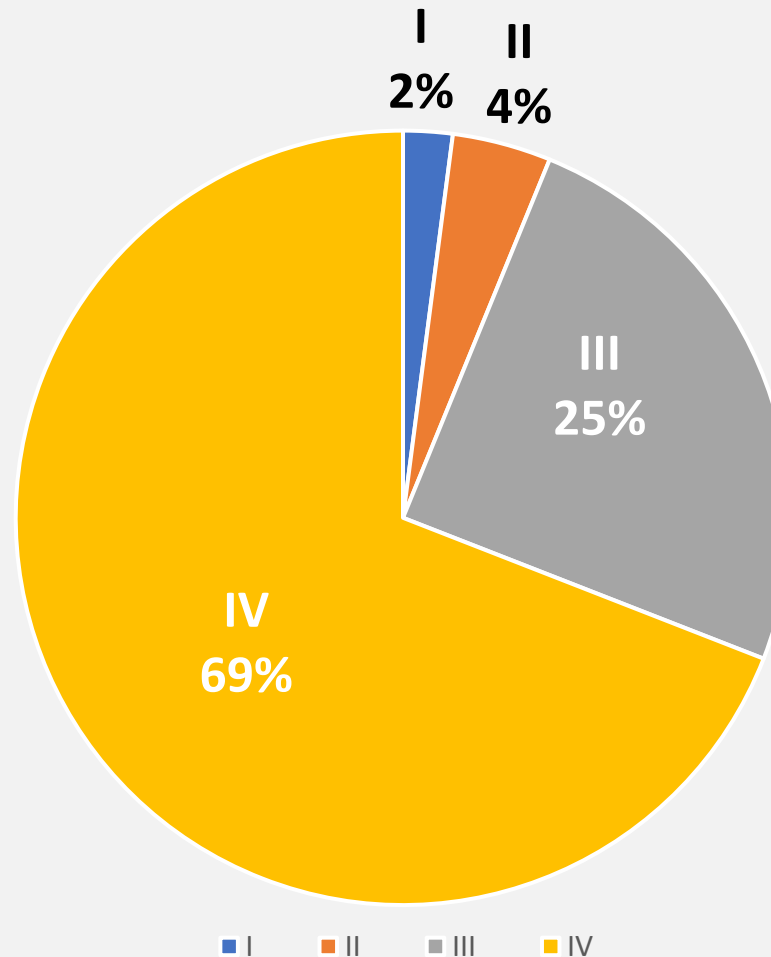


Common Deficiencies

- 1 (h)(32) Continuous PI Plan (Level IV <100)
- 2 (h)(18) Medical record documentation
(h)(8)(B) Management guidelines for resuscitation and documentation
- 3 (h)(23)(F) PIPS – Evidence of corrective actions
- 4 (h)(23)(G) PIPS – Loop closure
- 5 4.31, 4.32 Registry Staffing and CAISS
- 6 5.31 Alcohol Misuse Intervention
- 7

Trauma Designation Data

**33% of All Trauma
Facilities were
contingent at the
end of Q2**



Designation Coordinator Activities



Activity	Number
Program Assistance Site Visits	1
Contingent Site Visits	0
Surveys Attended	30
Other Facility Assistance Meetings	21
Corrective Action Reviews	47
Designation Determination Meetings	15

Trauma Program Activities

Department Activities:

- Monthly calls dedicated to Clarification on Meeting Requirements in the Trauma Rules §157.126
- Trauma Transfers and Example Spreadsheet
- Designation Assessment Questionnaire (DAQ)
- DAQ Trainings
- PI: Ask the Experts

Trauma PI: Ask the Experts



Date	Attendees
March 3	239
April 7	272
May 5	143

**Thank
You!**

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

Texas Trauma DAQ Training

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

Additional trainings will be offered weekly and are available to facilities who are eligible to receive the DAQ document.



Upcoming Events

Meeting	Date, Time
Rural Level IV	<u>June 10, 2-3 pm</u>
Level I & II	<u>June 10, 3:15-4:15 pm</u>
Trauma Surveyor Training	<u>June 18, 3-4:30 pm</u>
Level III & Non-Rural Level IV	<u>June 24, 2-3 pm</u>
PI: Ask the Experts	<u>July 7, 3-4 pm</u>
Rural Level IV	<u>July 8, 2-3 pm</u>

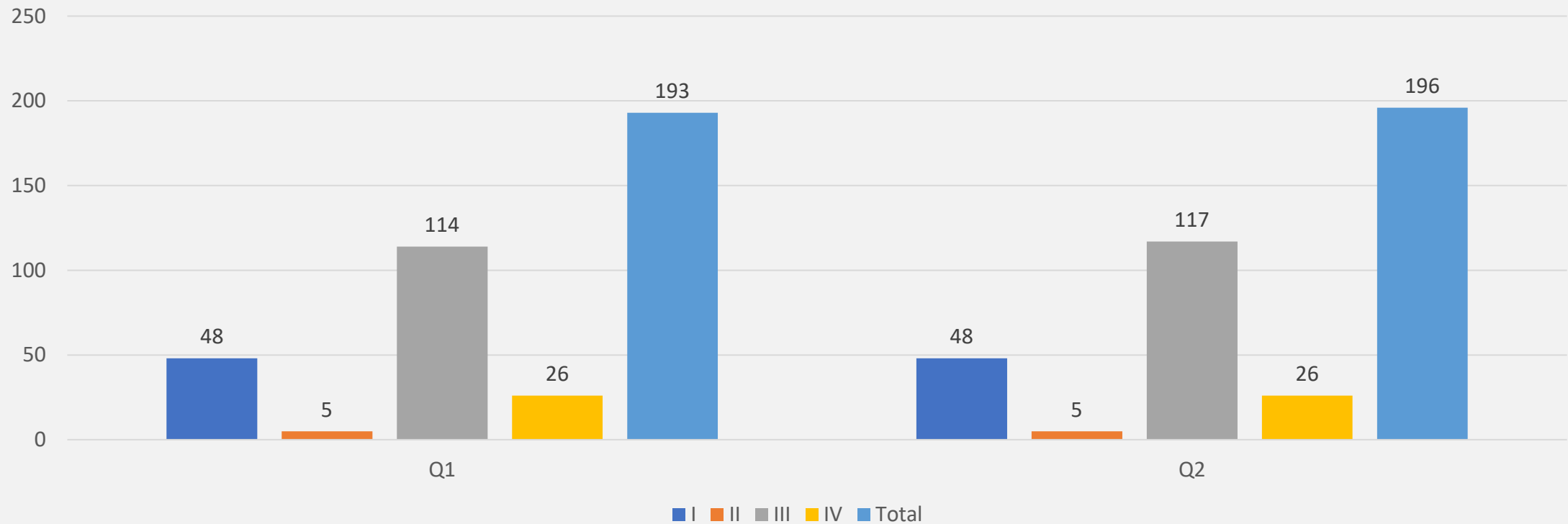


Designation Staff Update

- Katie Foarde, MSN, RN
- Trauma/Stroke Designation Coordinator
- Retired effective Friday, May 29th
- Thank you for the past 3 years of dedication to the designation program and the trauma facility staff. She had a positive impact on so many trauma programs and our designation team.

Designated Stroke Facilities

Stroke Designated Facilities
FY26 Q2 (12/1/25 – 2/28/26)

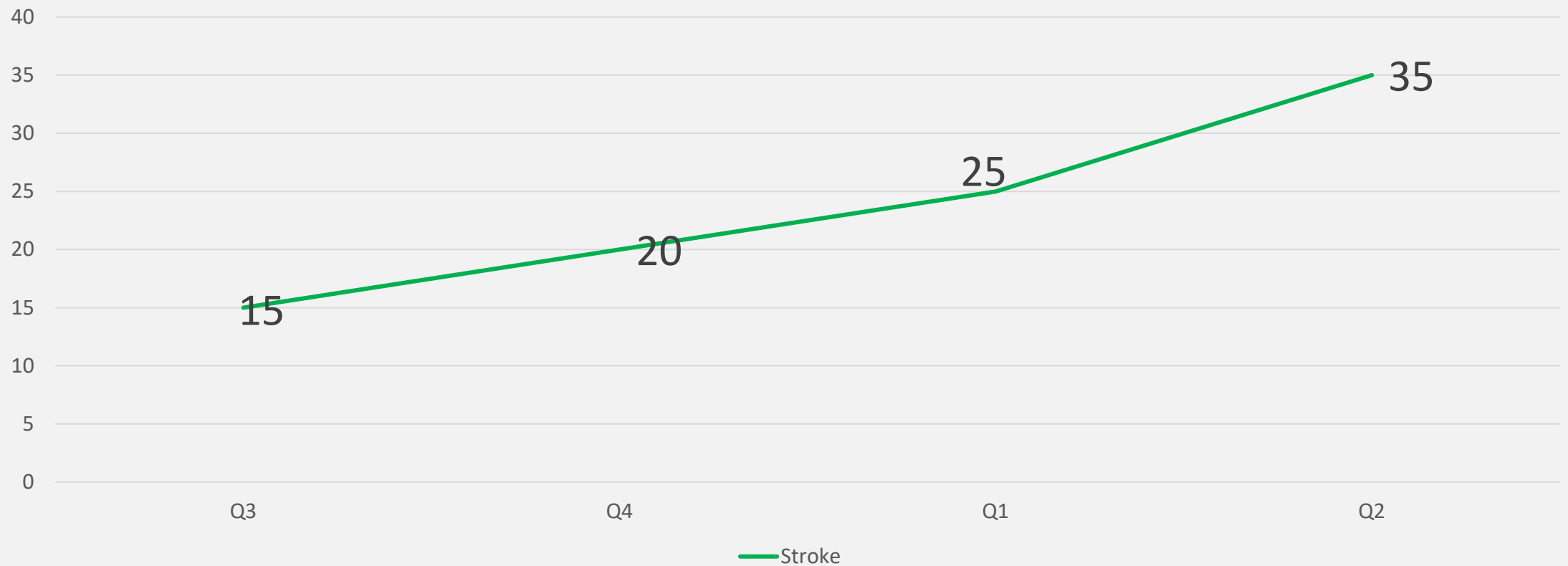


Stroke Application Statistics Q2

FY26 Q2 Application Statistics	Number of Applications
Complete Applications Received	31
Designations Awarded	35
Initial Designations	3
New Facility	3
Re-Designations	32

Designation Application Performance Measures

Average Days from Complete Application to Award



Stroke Designation Information

Department Activities:

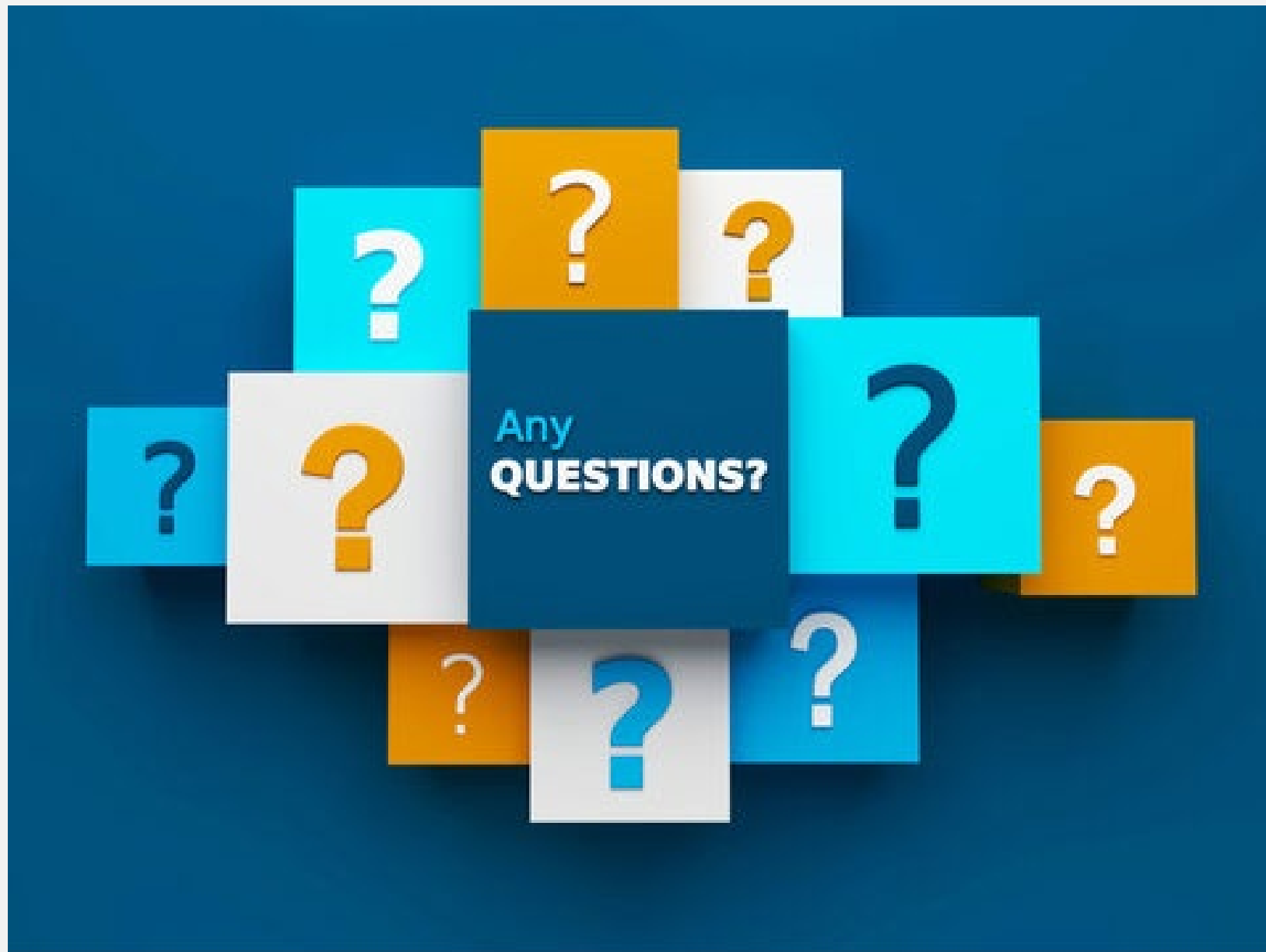
- Monthly call discussions:
 - Survey expectations and tips
 - Reminders on redesignation process
 - Educational opportunities
 - Rural stroke workgroup
 - New thrombolytic guidelines
 - Discussion of an increase in atypical stroke patients

Spotlight on Performance Improvement

Stroke Designation Meeting, guest presentations:

- Amanda L. Jagolino-Cole, MD
The University of Texas Health Science Center at Houston, the new AHA guidelines
- DaiWai Olson, PhD RN on nurse driven research





EMS System Update

Joe Schmider
State EMS Director



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Health Services

Workforce continues to grow!

Currently **84,918**

...up from

68,461 in 2019



EMS Licensing Contact Information

- EMS Professional and Educators with questions contact EMS Licensing by email at: emscert@dshs.texas.gov
- EMS Providers and First Responders with questions contact EMS Licensing by email at: emproviderfro@dshs.texas.gov
- Please ensure you add the following to your safe sender list: @partner.hhs.texas.gov and @dshs.texas.gov

Number of Unique Personnel Submitting Patient Care Records						
Year	Unique ID on PCRs	EMS Providers submitting PCRs	Number of Licensed EMS Providers	Percent of EMS Providers submitting PCRs	Number of certified licensed personnel	Percent of certified personnel submitting PCRs
2019	31,418	578	748	77.27%	68,461	45.89%
2020	30,992	599	748	80%	71,778	43.18%
2021	32,540	598	757	89.30%	75,733	27.43%
2022	34,824	609	738	82.50%	72,643	47.90%
2023	39,047	693	738	93.90%	75,407	51.80%
2024	44,367	701	743	94.30%	75,952	58.40%
2025	TBD	TBD	740*	TBD	79,376*	TBD
2026	TBD	TBD	786 **	TBD	84,561**	TBD
* 7/1/2025						
** 5/4/2026						
Report as of 5/27/2026						

EMS Scholarships



The website for the Texas Workforce Commission (TWC) scholarships is up: www.twc.texas.gov/emergency-medical-response-service-staffing-program.

Plan to move forward on rules:

- Review August GETAC and Committees
- Upcoming webinars
 - July 29 at 10 am**
 - July 29 at 1 pm**
- Public comments 10/2026
- Adoption of rules March 2027



National EMS Compact

For more information, go to our website at:

<https://www.dshs.texas.gov/dshs-ems-trauma-system>

Click on the tab on the upper left side of the page.



REPLICA ™
Recognition of EMS Personnel Licensure Interstate Compact

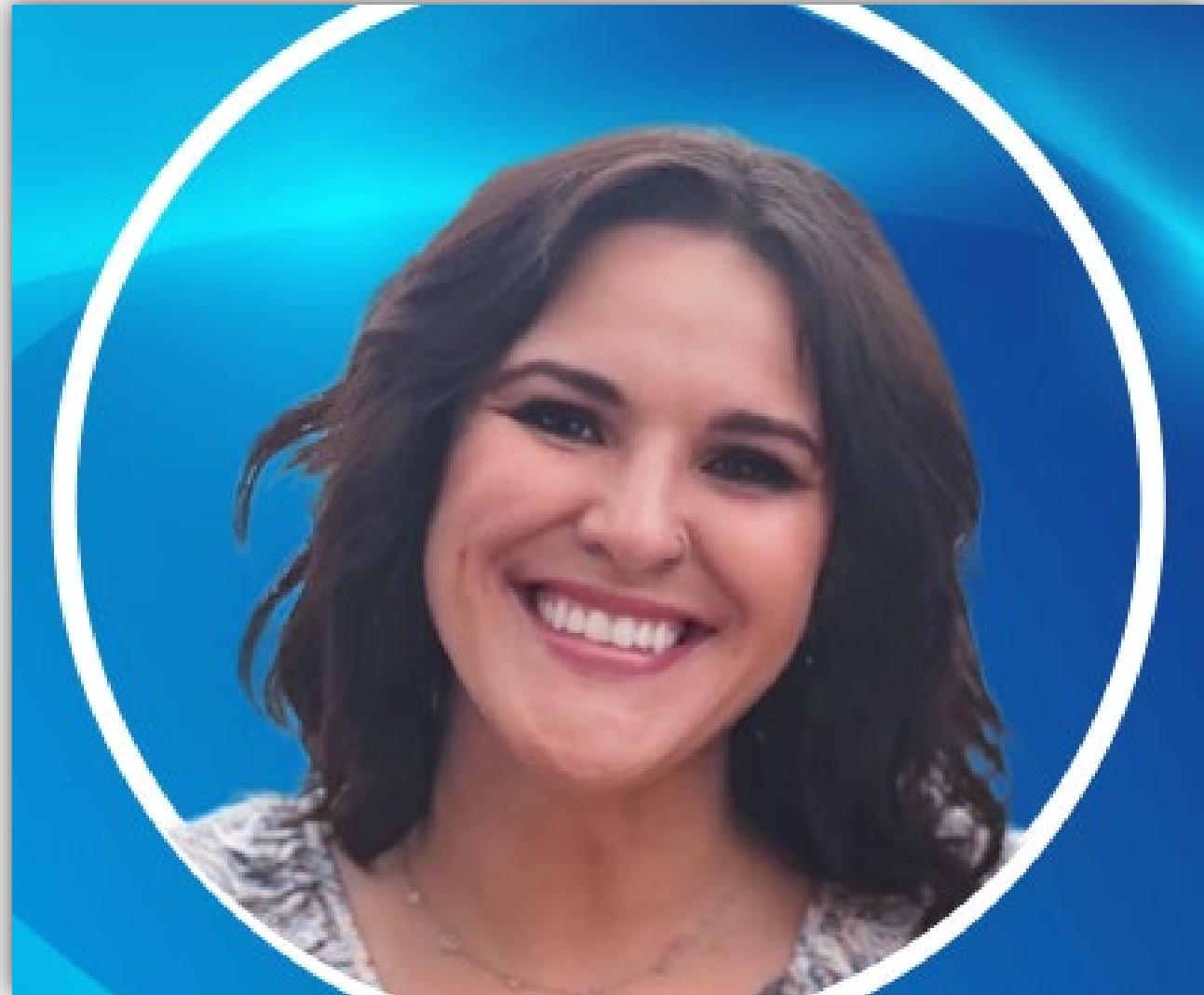
 **NEMSCD**™
NATIONAL EMS COORDINATED DATABASE

 INTERSTATE COMMISSION FOR™
EMS PERSONNEL PRACTICE

New EMS Education Coordinator

**Please
welcome**

Sabrina Lee Richardson



New Licensure Manager

Please
welcome
Lorena Rangel



EMS Licensing Processing Time

FY26 – 3rd Quarter (Mar, Apr, May)

License	Total Applications Processed
EMS Personnel	8,028
EMS Educators	520
EMS Providers	84
First Responder Organizations (FRO)	60

EMS Licensing Processing Time

License	Initial Applications	Average Processing Time (days)
EMS Personnel	4,394	9
EMS Educators	134	14
EMS Providers	7	94
First Responder Organizations (FRO)	6	64

Most common deficiencies delaying approval:

- Missing Fingerprint Background Check submission (Personnel)
- No instructor course completion certificate (Educators)
- Incomplete/incorrect documentation (Providers)
- No equipment/supplies (FRO)

Questions for
EMS/Trauma Systems?

Thank You



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II.B.1. System Collaborative for Outcome Review (SCOR) Update to Council

Chair: Kate Remick, MD

Vice Chair: Shawn Salter, RN



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Health Services

Trauma Transfer Delay and Cardiac Data

Emergency Medical Services and Trauma Registries
(EMSTR)

Jia Benno

Newborn Screening and Injury Prevention Section Director

EMSTR

- EMSTR collects reportable event data from EMS providers, hospitals, justices of the peace, medical examiners, Long Term Acute Care (LTAC) facilities, and rehabilitation facilities.
- All submitters must report all EMS responses and reportable trauma events to EMSTR under Texas Administration Code, Title 25, Chapter 103.
- Data must be submitted to EMSTR within 90 calendar days.

Severe Trauma Transfer Delay

Performance Improvement (PI) Data, Texas

January 1, 2022 – June 30, 2025



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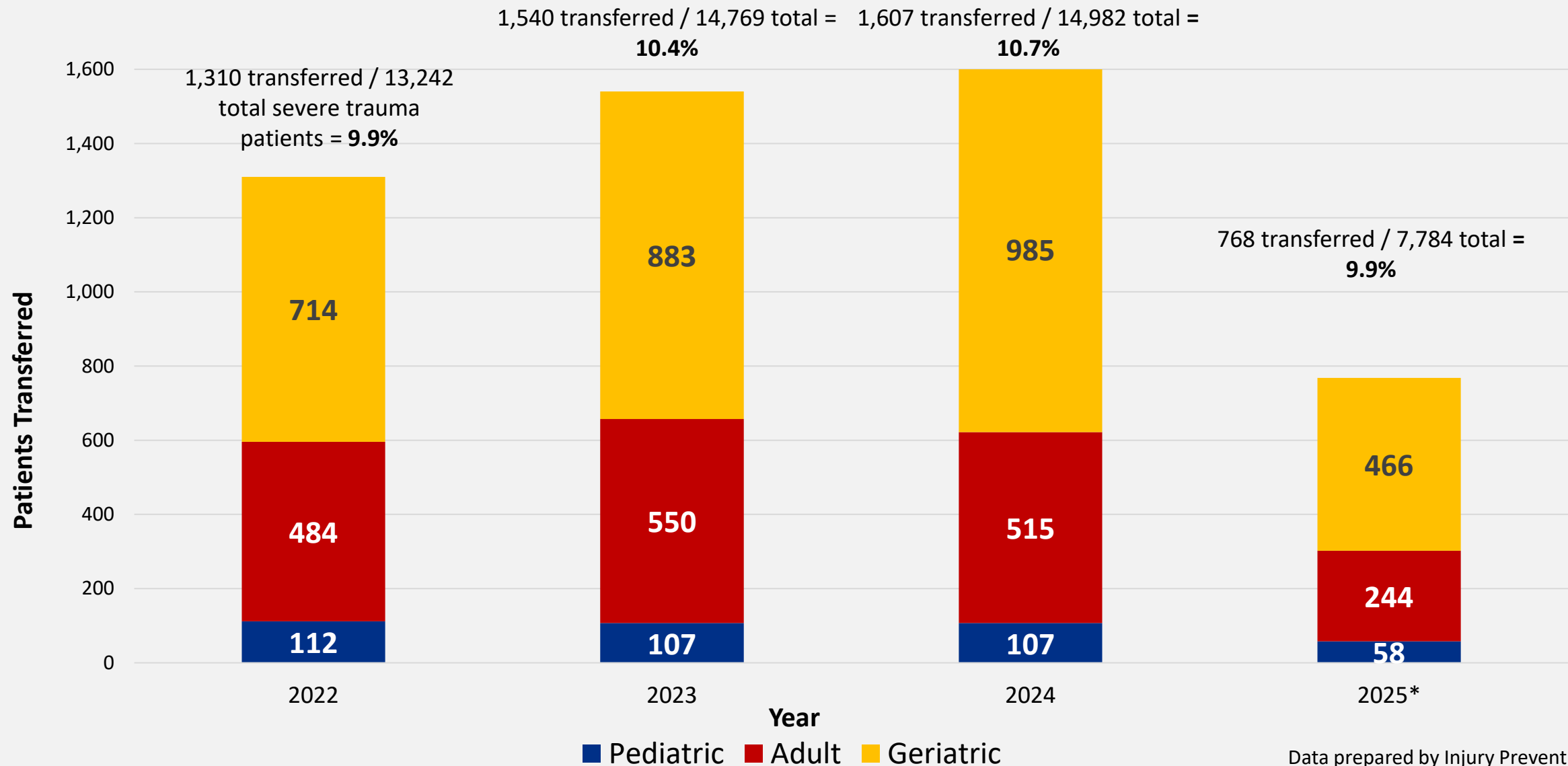
Texas Department of State
Health Services

EMSTR Trauma Transfer Delay and Cardiac Data

Transfer Delay Definitions

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

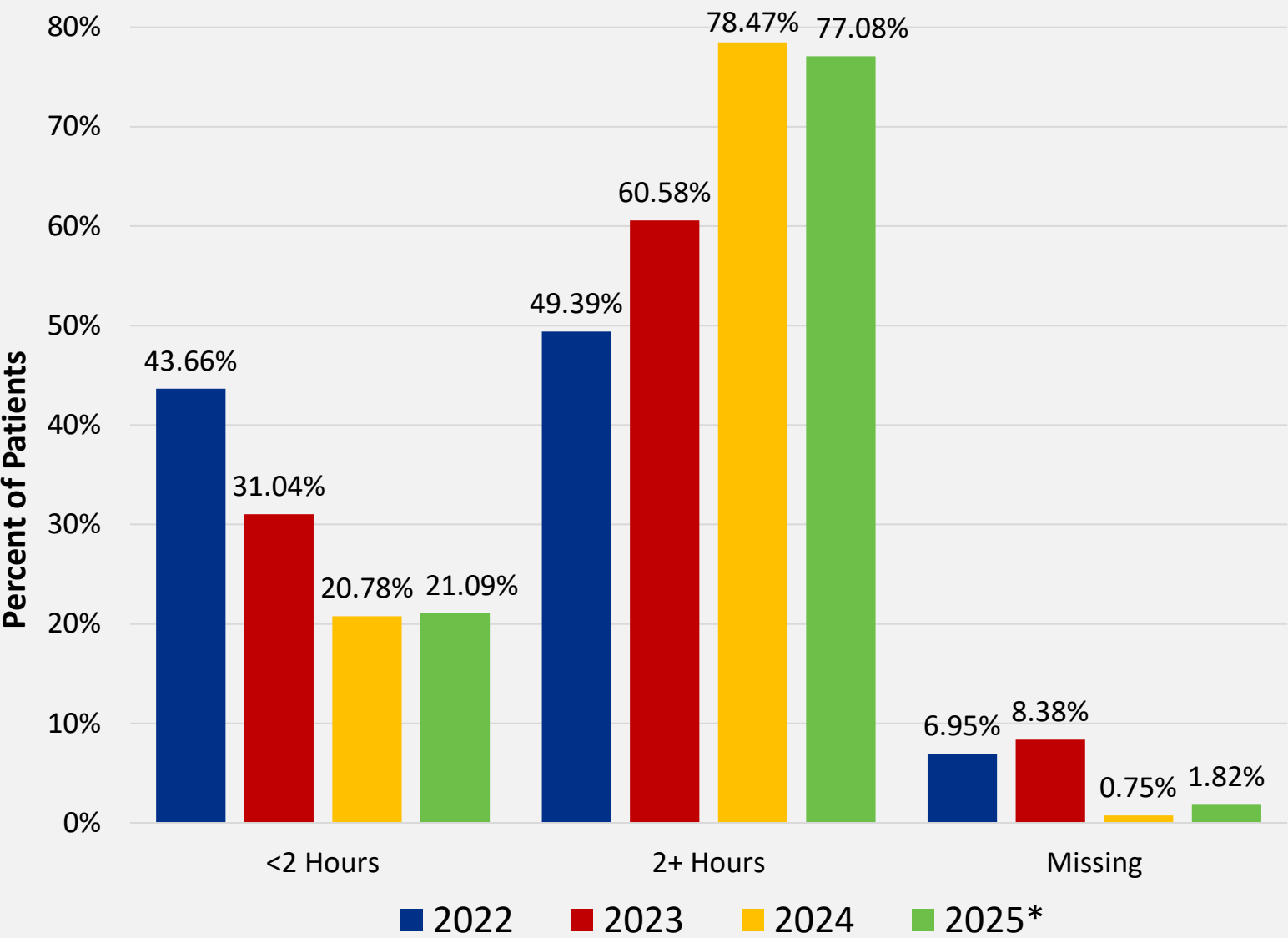
Severe Trauma Patients, Total Number Transferred



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

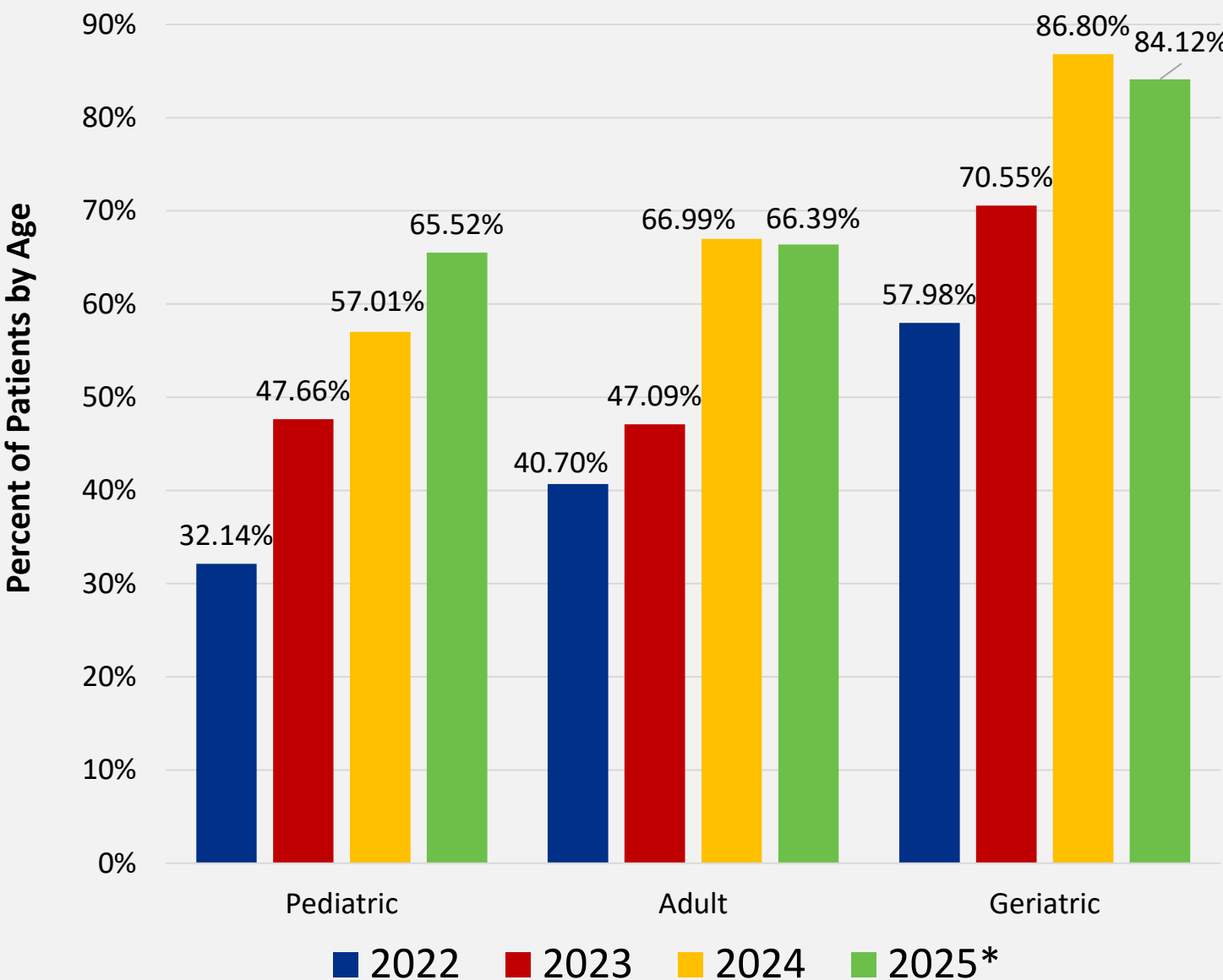
*2025 data is from January 1-June 30, 2025

Severe Trauma Transfer Times, All Ages



Number of Severe Trauma Transfers				
	2022	2023	2024	2025*
<2 Hours	572	478	334	162
2+ Hours	647	933	1,261	592
Missing	91	129	12	14

Severe Trauma Transfer, 2+ Hours by Age Category



Number Transferred in 2+ Hours / Number Severe Trauma Transfers				
	2022	2023	2024	2025*
Pediatric	36/112	51/107	61/107	38/58
Adult	197/484	259/550	345/515	162/244
Geriatric	414/714	623/883	855/985	392/466

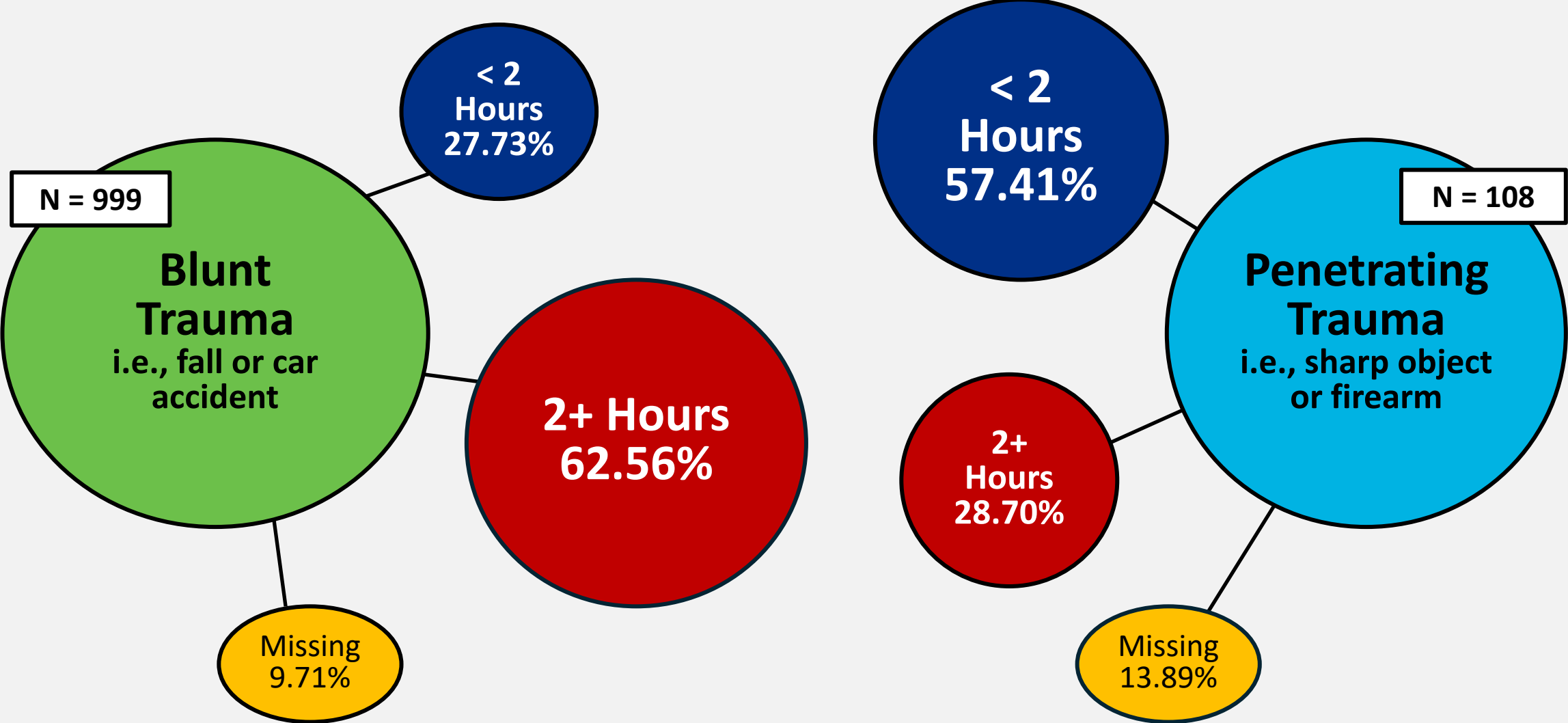
Severe Trauma Transfer Time by Sex

Sex	Transfer Time	2022	2023	2024	2025*
Male	Less than 2 hours	46.56%	33.95%	23.35%	98/402 (24.38%)
	2+ hours	47.67%	57.70%	76.14%	298/402 (74.13%)
Female	Less than 2 hours	38.91%	26.11%	16.98%	39/275 (14.18%)
	2+ hours	52.22%	65.35%	81.92%	230/275 (83.64%)

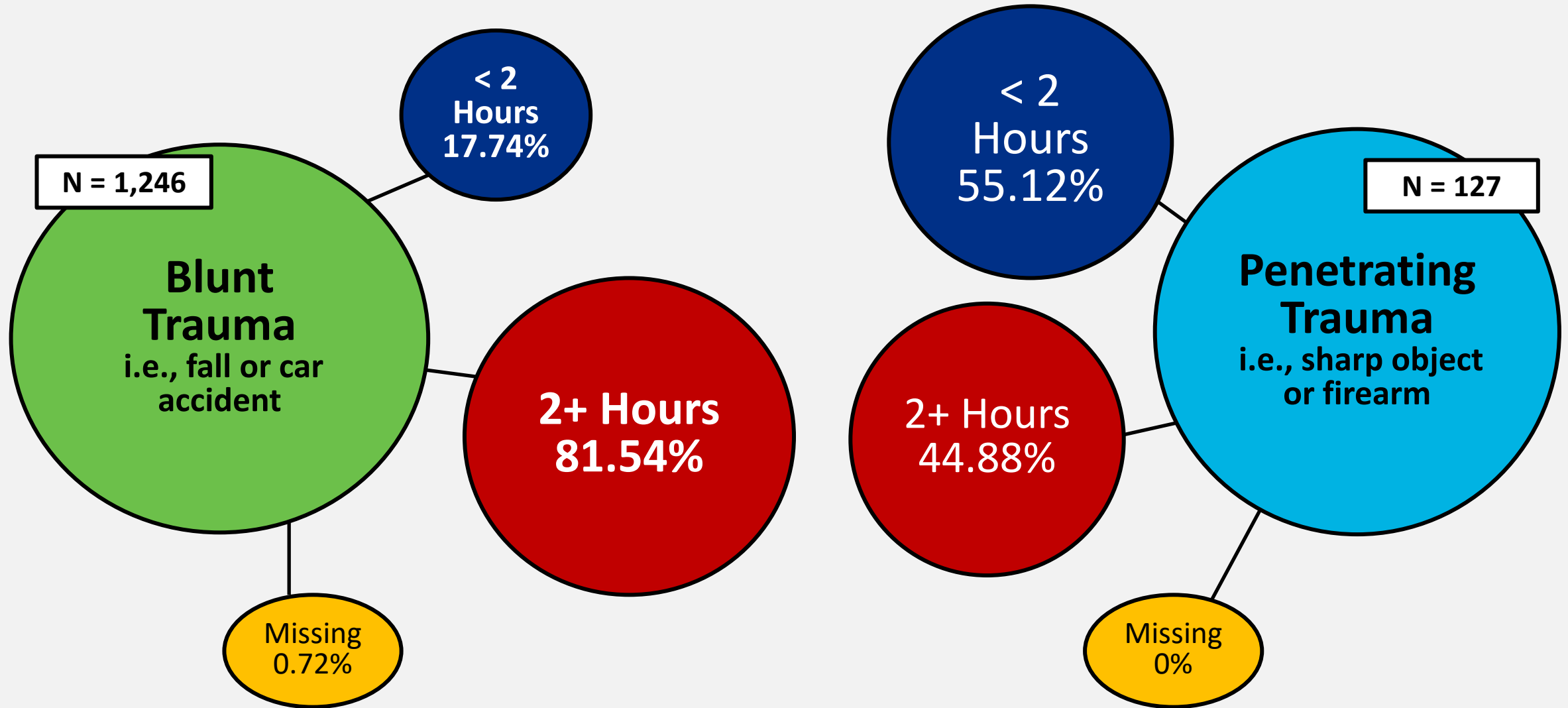
NOTE: Data excludes missing times, so totals will not equal 100%.

*2025 data is from January 1-June 30, 2025

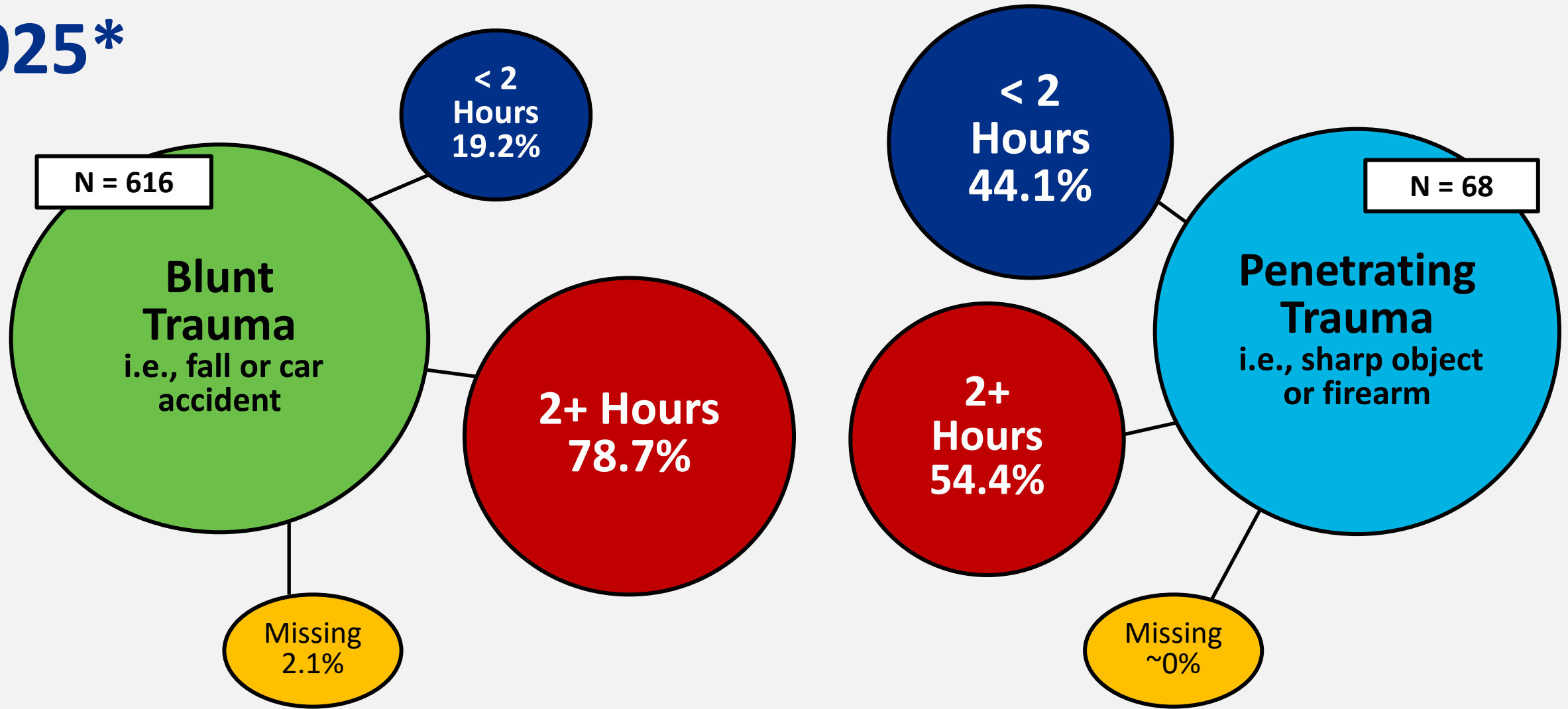
Severe Trauma Transfer Time by Trauma Type, 2023



Severe Trauma Transfer Time by Trauma Type, 2024



Severe Trauma Transfer Time by Trauma Type, 2025*



*2025 data is from January 1-June 30, 2025

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

Severe Trauma Transfer Numbers by Designation Level

Trauma Designation	2022	2023	2024	2025*
Level I	27	33	18	15
Level II	61	61	84	34
Level III	330	354	406	215
Level IV	714	840	820	356

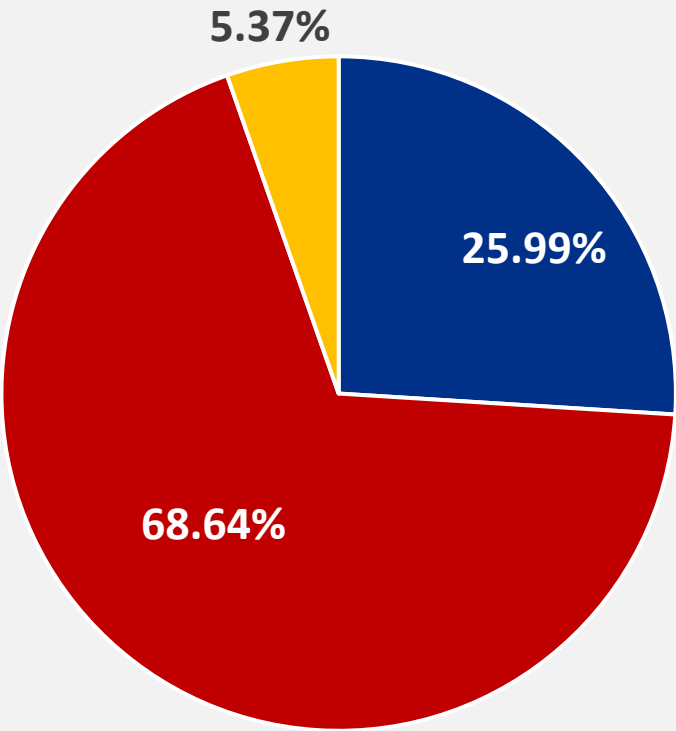
NOTE: This data includes designated facilities only and does not include not designated or missing.

*2025 data is from January 1-June 30, 2025

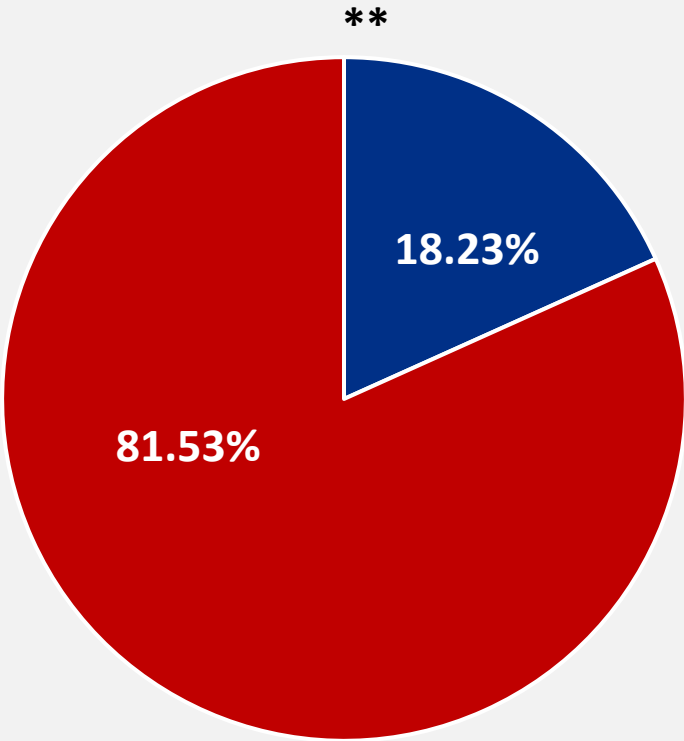
Data prepared by Injury Prevention Unit
Epidemiologists using EMSTR data, April 2026.

Severe Trauma Transfer Time by Trauma Designation Level III

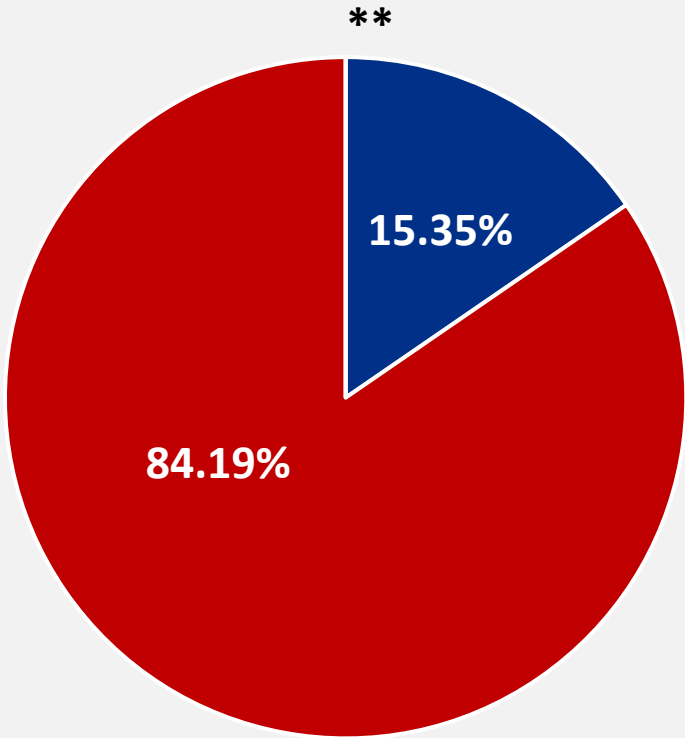
2023, N=354



2024, N=406



2025*, N=215



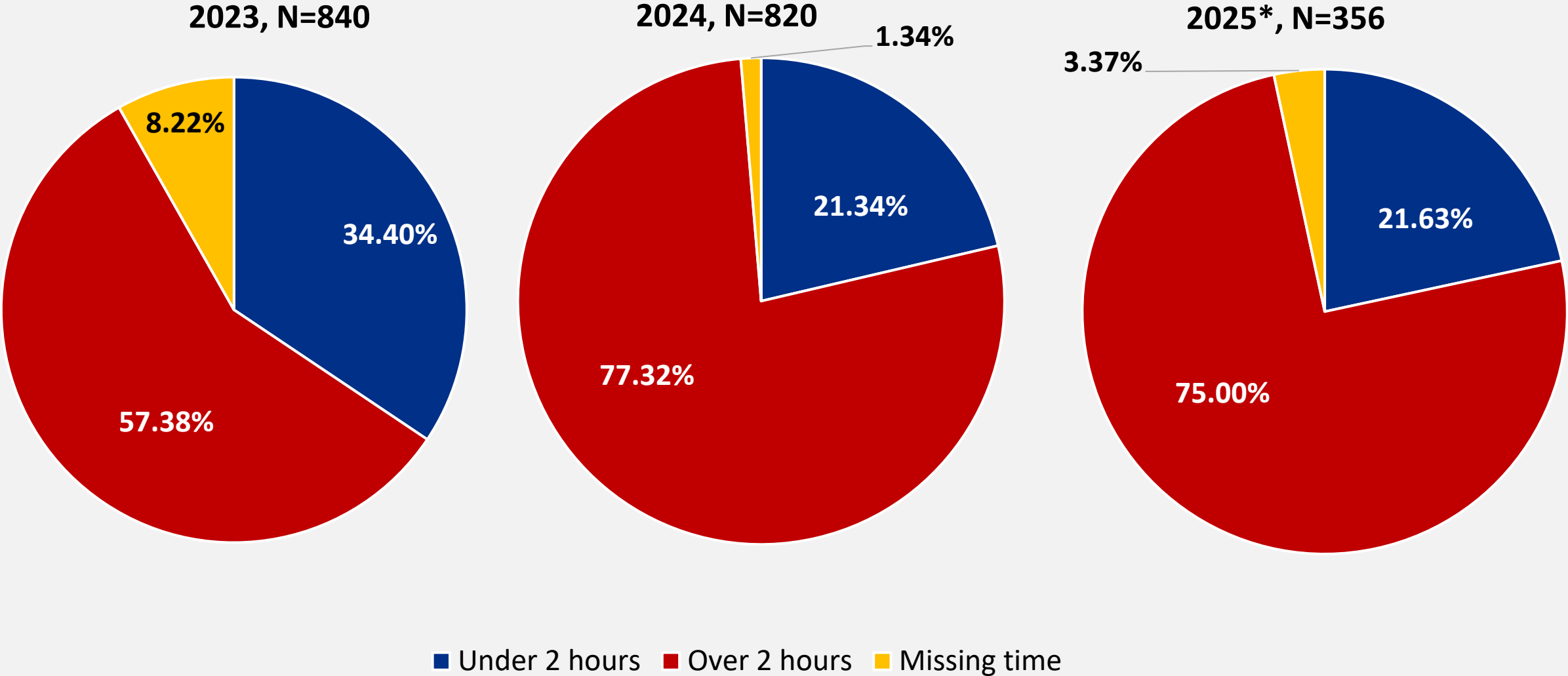
■ Under 2 hours ■ Over 2 hours ■ Missing time

*2025 data is from January 1-June 30, 2025

**Number suppressed due to low count.

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

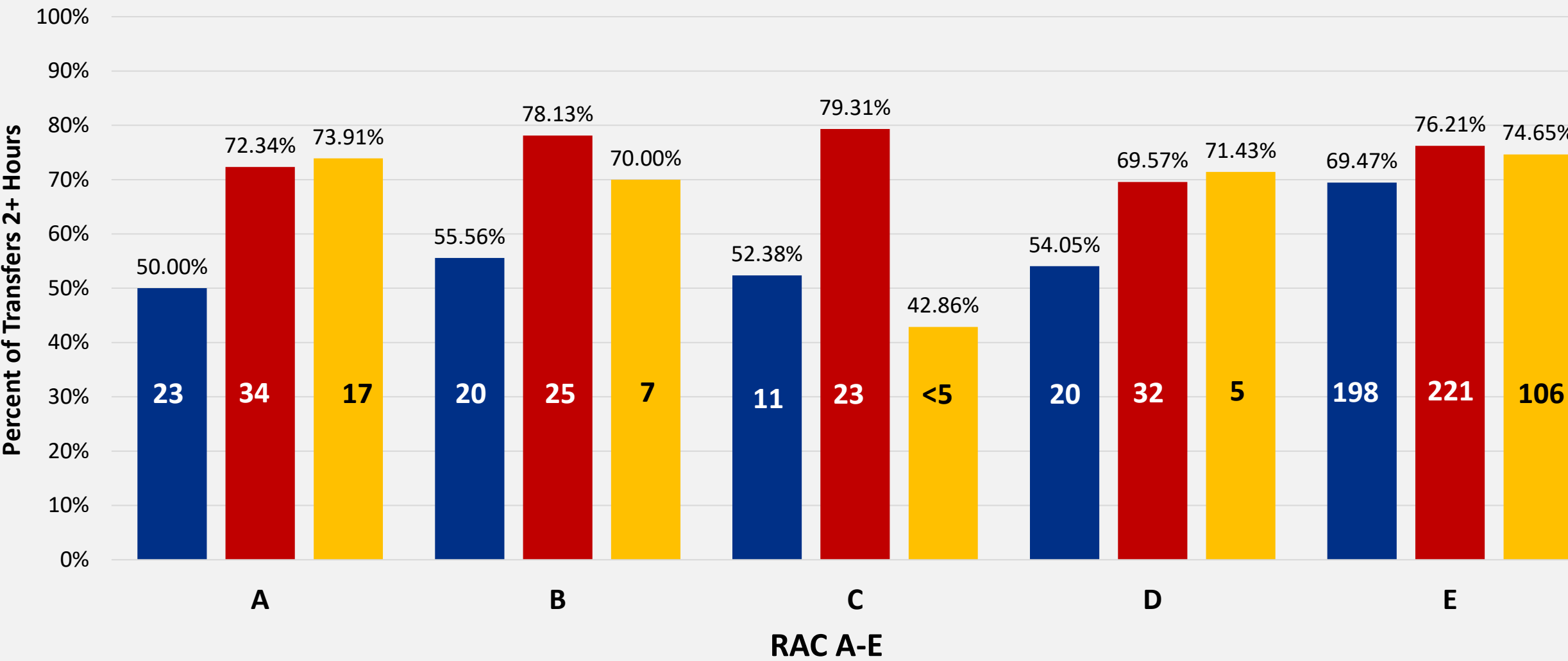
Severe Trauma Transfer Time by Trauma Designation Level IV



*2025 data is from January 1-June 30, 2025

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

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

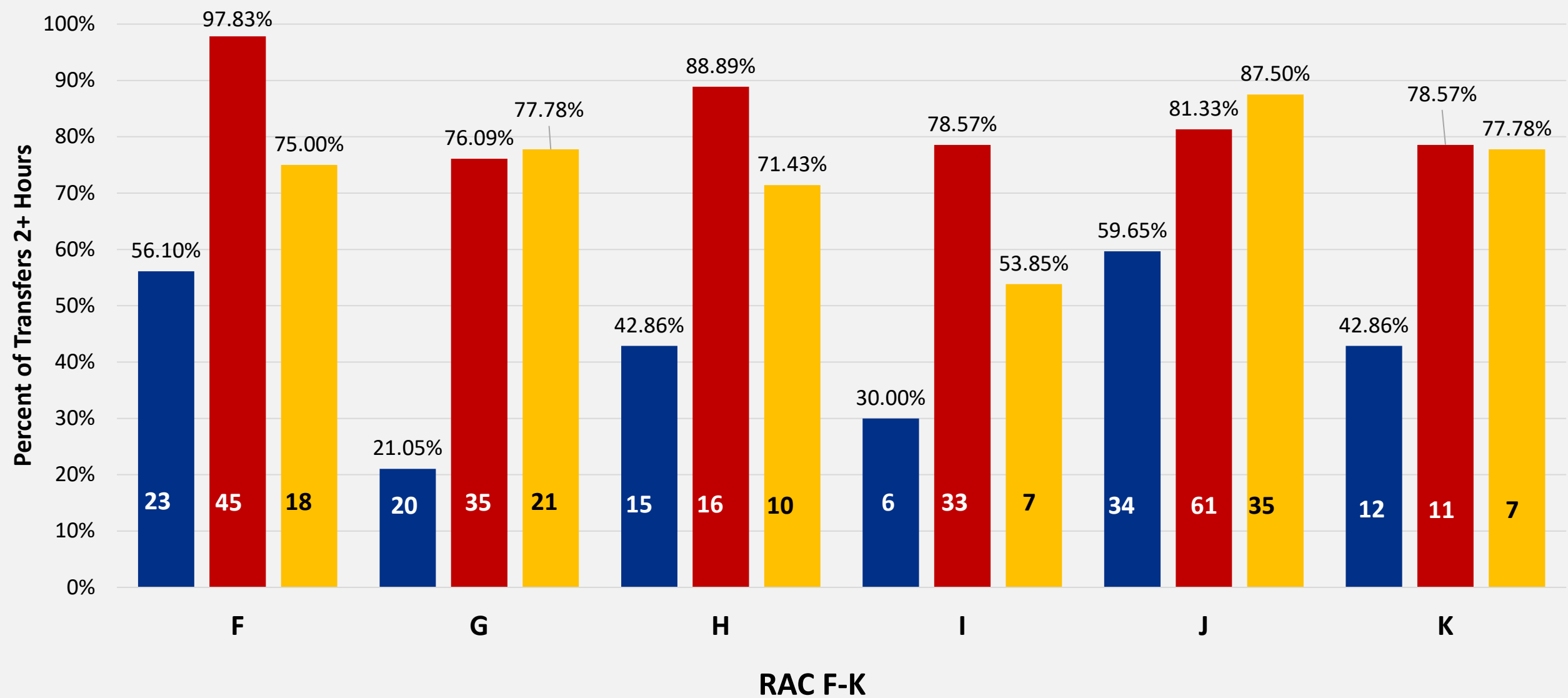


*2025 data is from January 1-June 30, 2025

■ 2023 ■ 2024 ■ 2025*

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

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

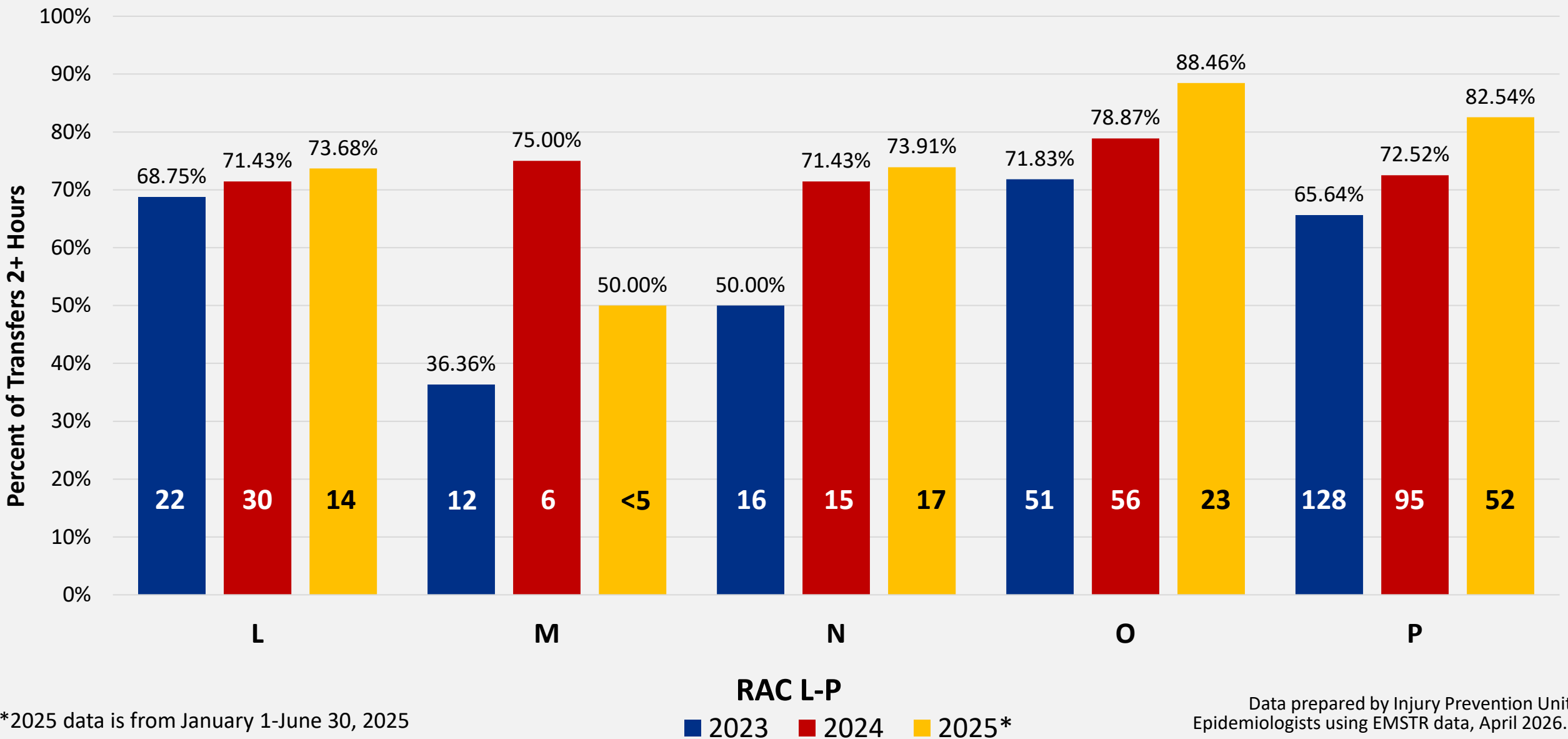


*2025 data is from January 1-June 30, 2025

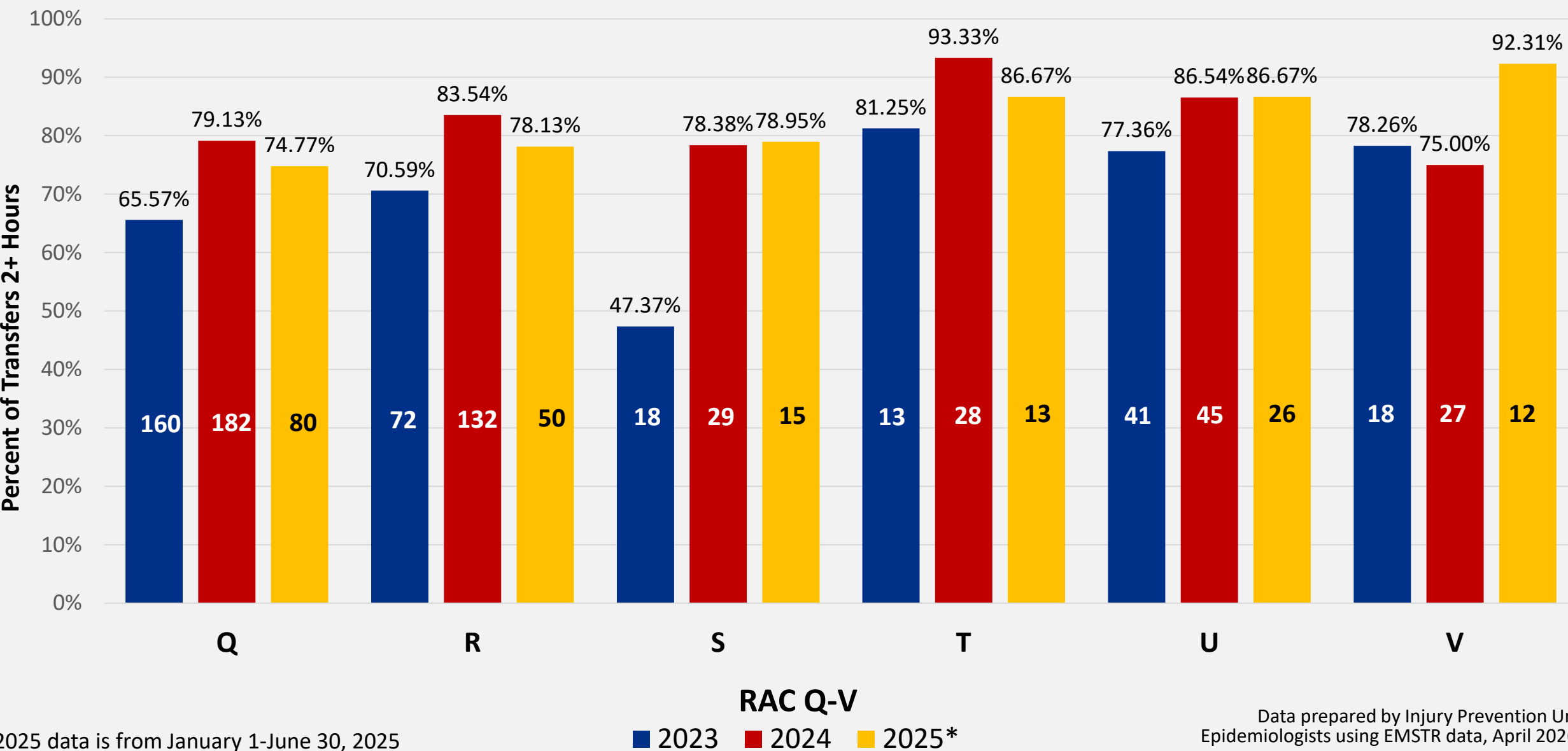
■ 2023 ■ 2024 ■ 2025*

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

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



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



Median Trauma Transfer Delay, 2023, Transfer Time

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

Median Trauma Transfer Delay, 2024, Transfer Time

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

Median Trauma Transfer Delay, 2025*, Transfer Time

Age Group	Median Time	Number of People
Less than 15	2.5 hours	58
Age 15-64	2.7 hours	244
Age 65+	4.0 hours	466

*2025 data is from January 1-June 30, 2025

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

Median Trauma Transfer Delay Comparison

Age Group	2023	2024	2025*
Less than 15	1.90 hours	2.45 hours	2.5 hours
Age 15-64	2.13 hours	2.65 hours	2.7 hours
Age 65+	3.15 hours	3.82 hours	4.0 hours

*2025 data is from January 1-June 30, 2025

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

Cardiac Arrest Data

CPR and AED provided prior to EMS arrival



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Trauma Transfer Delay and Cardiac Data

Cardiac Data Overview

- Evaluation of when cardiopulmonary resuscitation (CPR) was provided prior to EMS arrival and who provided CPR.
- Evaluation of when automated external defibrillator (AED) was provided prior to EMS arrival and who first applied AED. For this measure, we limited the dataset to incident scene location or not as a residential home.

Cardiac Definitions

Age Categories: Pediatric = Less than age 15; Adult = Between ages 15 and 64;
Geriatric = 65+

Who First Initiated CPR = National EMS Information System (NEMSIS)-defined variable. Options are:

- ▶ Bystander
- ▶ Family member
- ▶ Health care provider (non-911 responder)
- ▶ First Responder (EMS)
- ▶ First Responder (Fire)
- ▶ EMS Responder (transport-EMS)

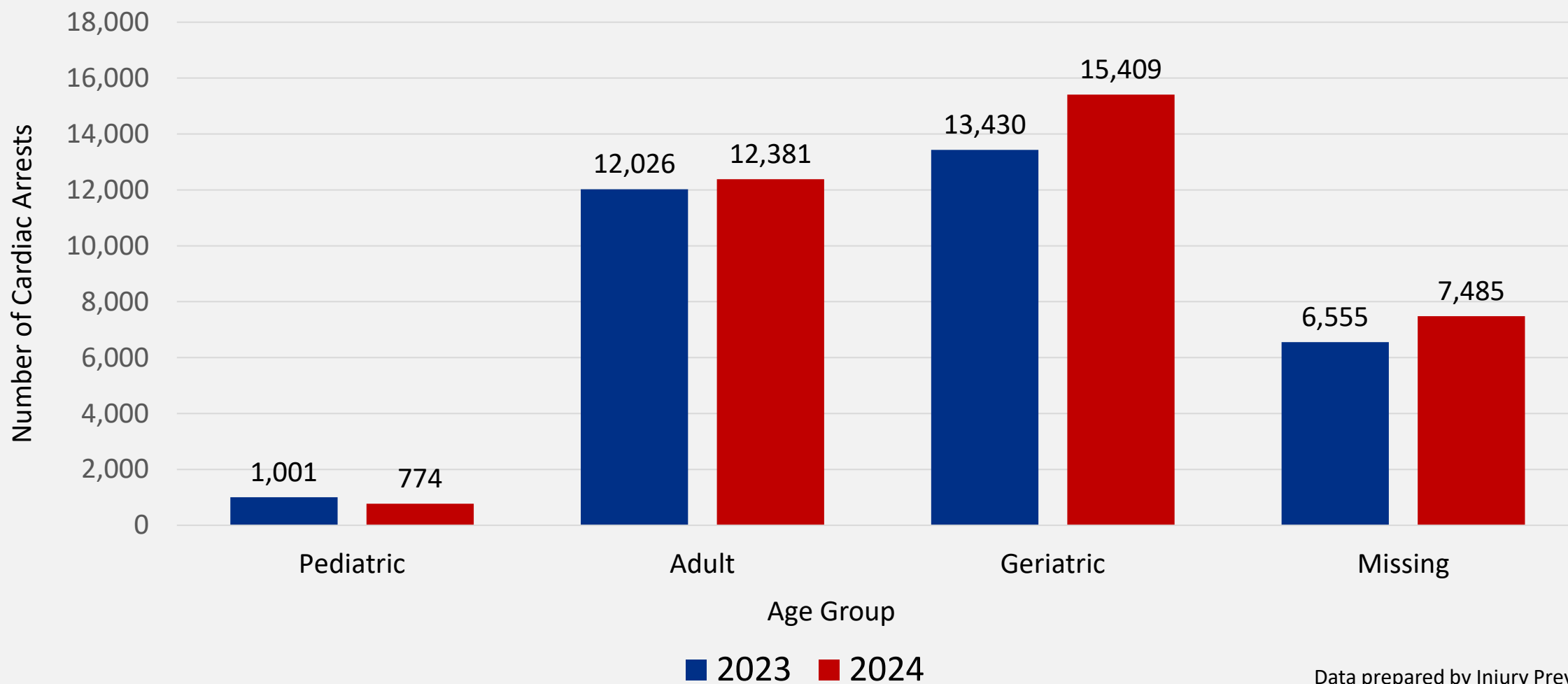
EMSTR defined "Yes, CPR" if CPR was initiated by:

- ▶ Bystander
- ▶ Family member
- ▶ Health care provider (non-911 responder)

Cardiac Arrest Prior to EMS Arrival

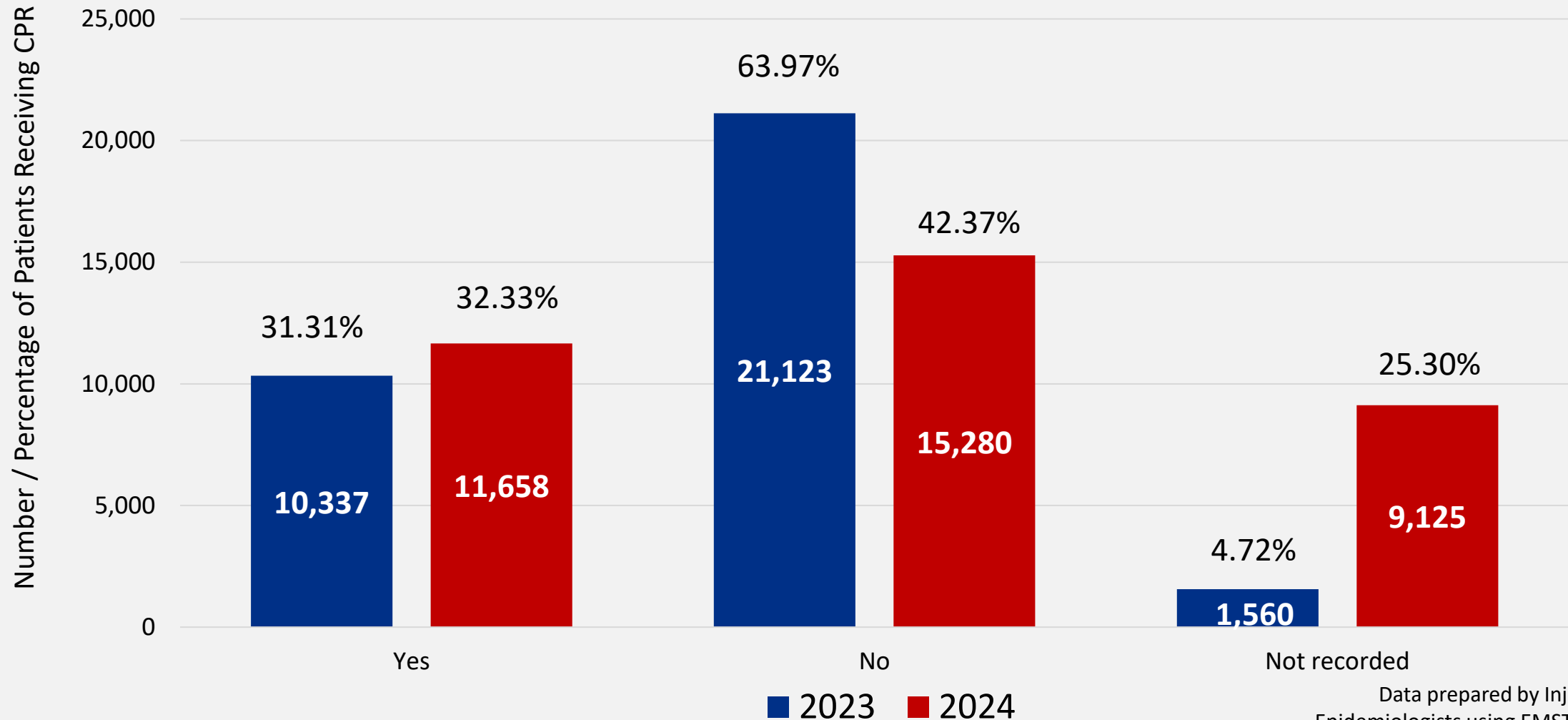
Year	Yes, Prior to EMS Arrival
2023	33,020
2024	36,063

Cardiac Arrest by Age Group



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

CPR Provided Prior to EMS Arrival

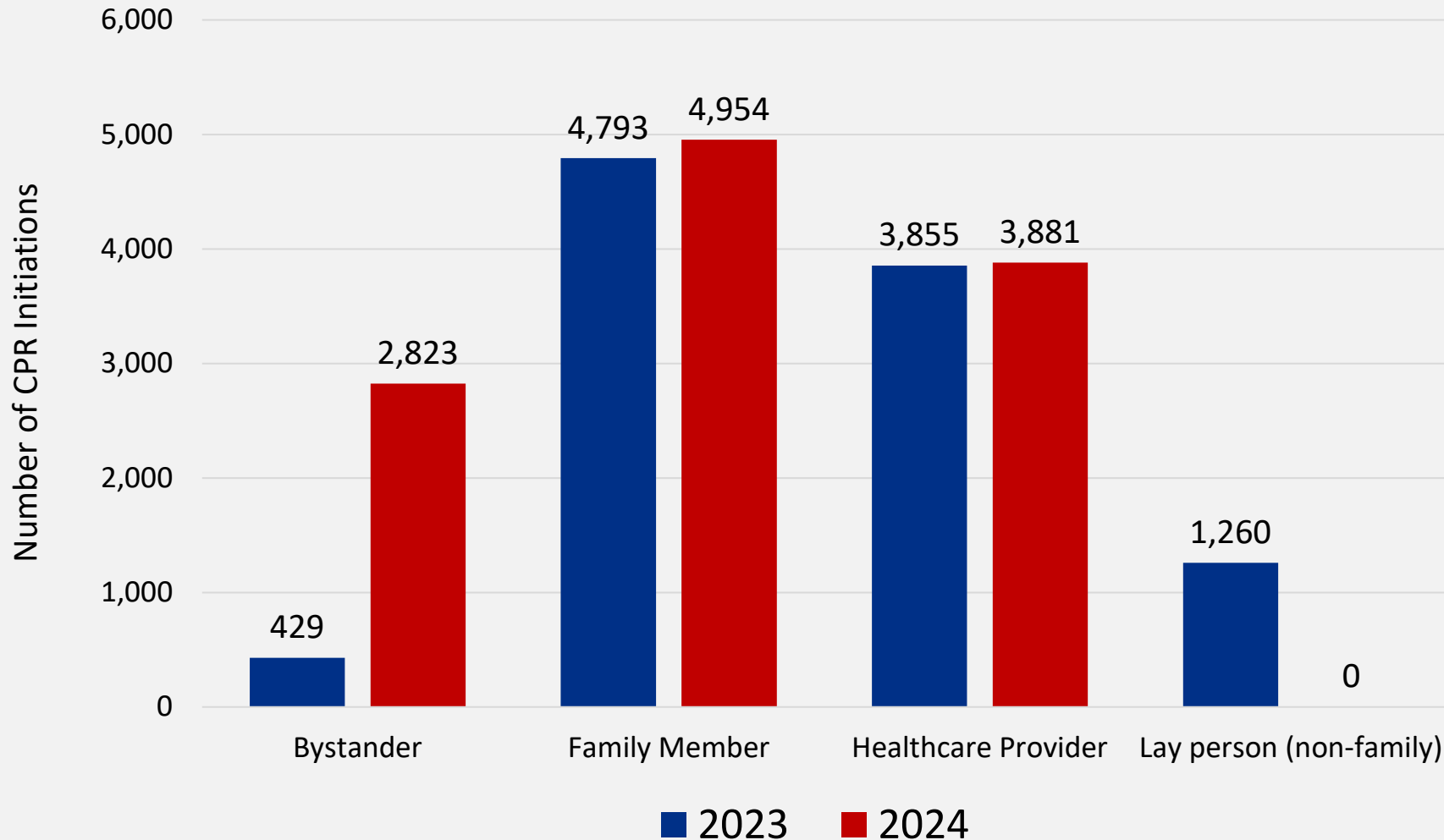


Data prepared by Injury Prevention Unit
Epidemiologists using EMSTR data, April 2026.

Response Time Based on CPR Provided

CPR Provided	2023	2024
Yes	6.0 minutes	6.4 minutes
No	7.0 minutes	6.6 minutes
Unknown	6.2 minutes	6.0 minutes

Who First Initiated CPR

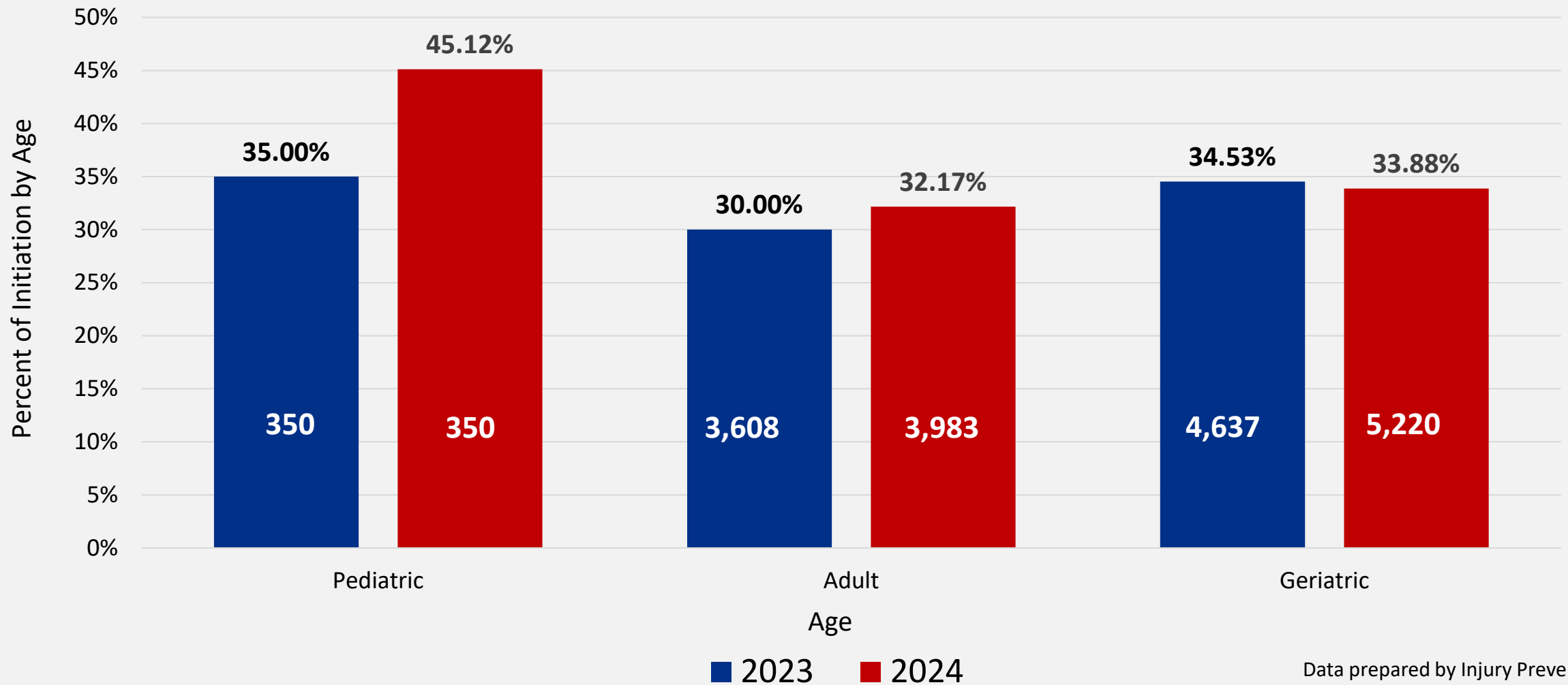


2023 – 33,020 total cardiac events

2024 – 36,063 total cardiac events

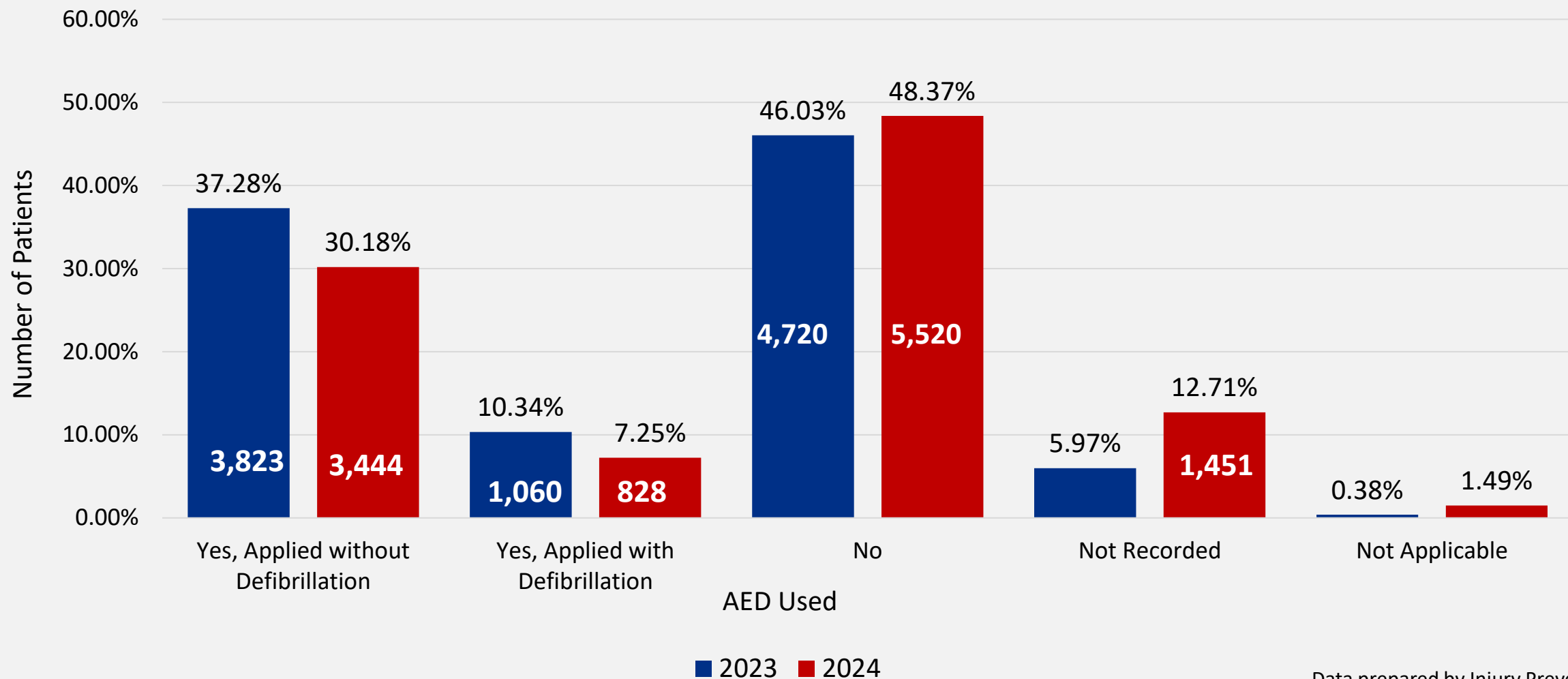
Note: Lay person was no longer listed as an option in NEMESIS 3.5 (2024 data dictionary). EMSTR believes responses from lay person are included in bystander.

CPR Initiated Prior to EMS Arrival by Patient Age

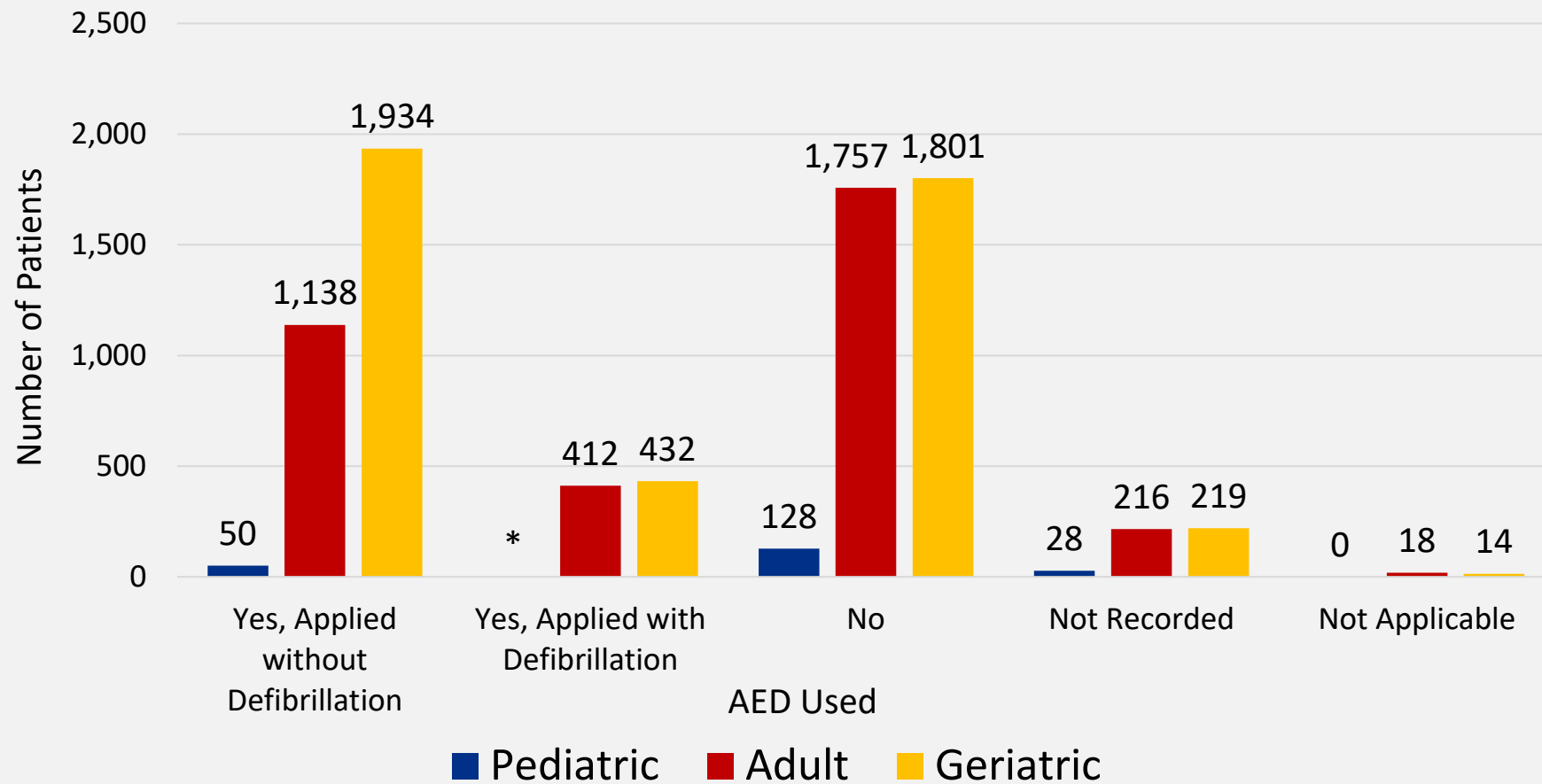


Data prepared by Injury Prevention Unit
Epidemiologists using EMSTR data, April 2026.

AED Used Prior to EMS Arrival



AED Used Prior to EMS Arrival by Age, 2023



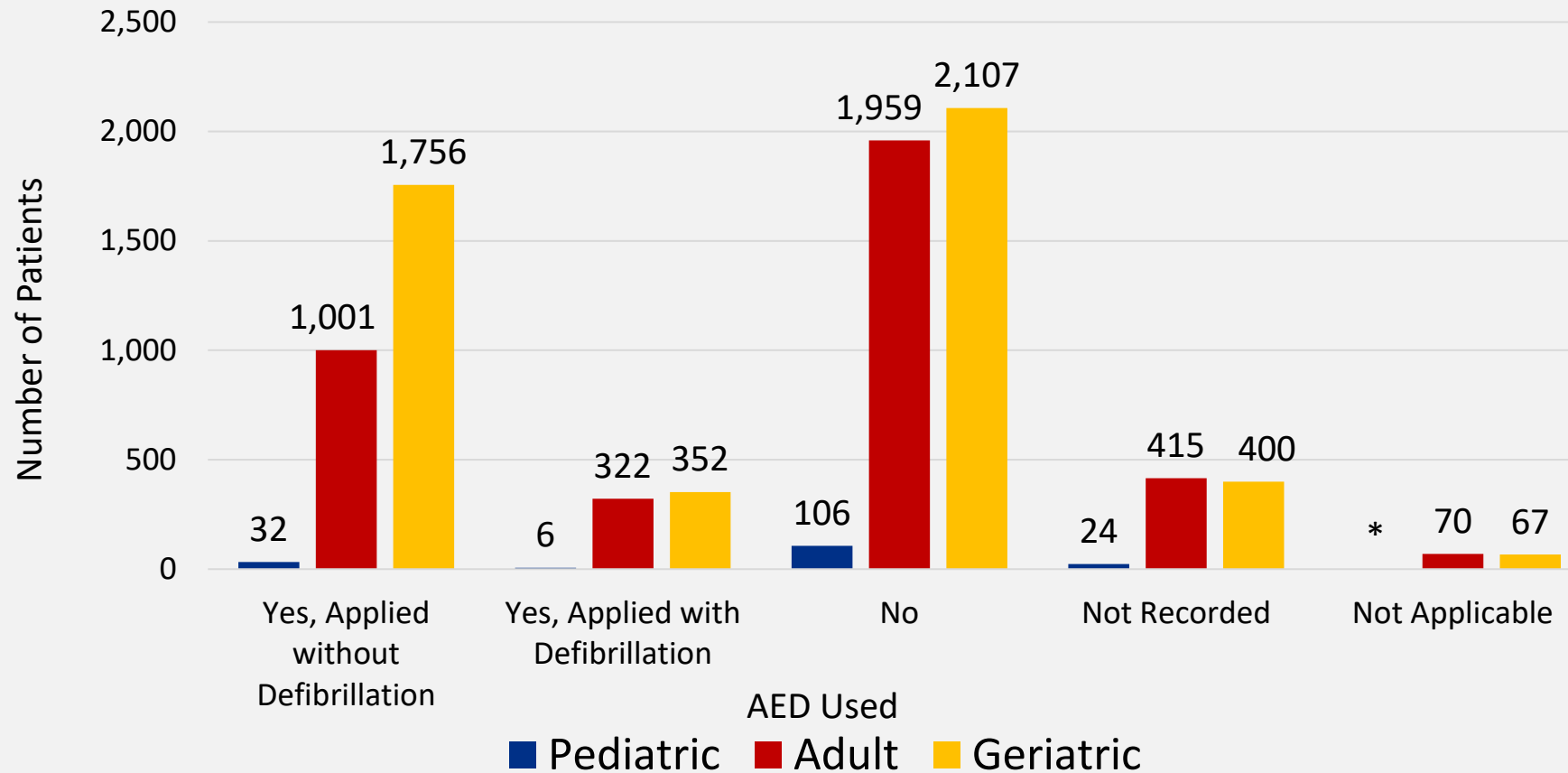
In reviewing 2023 data for AED used prior to EMS arrival:

- 25.00% of pediatrics;
- 43.77% of adults; and
- 53.77% of geriatric patients had an AED used with or without defibrillation.

*counts less than 5 are suppressed to protect patient confidentiality.

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

AED Used Prior to EMS Arrival by Age, 2024



In reviewing 2024 data for AED used prior to EMS arrival:

- 22.49% of pediatrics;
- 35.12% of adults; and
- 45.02% of geriatric patients had an AED used with or without defibrillation.

Thank you!

Injury.prevention@dshs.texas.gov

Jia Benno

Newborn Screening and Injury Prevention Section Director

II.C. GETAC Committee Action Items



II.C.2. GETAC Disaster Preparedness Update to Council

Chair: Eric Epley

Vice-chair: Dr. Emily Kidd



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June 2026 Meeting Summary

- DSHS Briefing—Ebola (Dr. Varun Shetty)
- Emergency Medical Task Force (EMTF) Program Updates
 - Continuing to respond to activations while expanding program components and training opportunities
- Statewide Peer Support Network
- Pulsara-Missing Persons Form & Reunification Process
 - Application for FIFA World Cup
- Pre-Hospital Whole Blood Task Force Updates

Disaster Preparedness Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

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

Disaster Preparedness Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
2. Pulsara Rollout for Mass Casualty Incidents (MCI), School Shooting Roster Uploads, and General Population Sheltering Modules <i>Implement the Pulsara platform throughout Texas for MCIs and school roster upload for family reunification processes, and in general population shelters within Texas. Success will be measured by the number of entities trained and actively using the platform during drills and actual events</i>	Continue to expand and build upon the Pulsara Reconciliation Plan for mass casualty incidents and post-incident family support	

Disaster Preparedness Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

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

Disaster Preparedness Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

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

GETAC Committee/Stakeholder Action Item Request for Council

Mr. Eric Epley

GETAC Disaster Preparedness



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Action Item Request and Purpose

Request:

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

Purpose:

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

Benefit and Timeline

Benefit:

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

Timeline:

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

II.D.1. Prehospital Whole Blood Task Force

Chair: Mr. Eric Epley

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

June 2026 Meeting Summary

- **CPDA-1 Blood Bags**
- **Economics of Prehospital Whole Blood Transfusions Conference**
- **National Blood Summit & Whole Blood Academy—July 20th & 21st**
- **Spray Dried Plasma (SDP)**
- **Walking Blood Banks**
 - Pilot Sites: UMC El Paso, Peterson Regional
 - Military Application: Training Model for Walking Blood Banks
- **BLOOD Portal**
- **Air Medical**
 - EMI testing—FSDO standards
 - 510(k) Coolers—Contract funding
 - SRFTAC Air Med Map
- **Blood Provider Planning**
 - Needs, estimates, and public outreach
- **Meeting Schedule Change**
 - Bi-weekly 2nd & 4th Mondays

Prehospital Whole Blood Task Force

2026 Committee Priorities Update

Priority Not Implemented

Priority Activities Recorded

Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. PHWBTF – Planning for the PHWB pilot program	<i>Ongoing coordination and implementation efforts continue statewide following contract execution, with active collaboration among participating RACs and stakeholders</i>	
2. PHWBTF – Tasks	<i>Continued review and resolution of operational questions, identified gaps, and implementation challenges</i> <i>Task completion and status updates are submitted and tracked by participating RACs.</i>	
3. Texas Whole Blood pilot deployment Resources	<i>PI processes and supporting documentation continue to be refined for statewide implementation</i> <i>Blood provider planning, donor estimates, and resource needs remain ongoing areas of focus.</i>	

II.C.1. GETAC Air Medical and Specialty Care Transport Committee Update to Council

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

Vice-Chair: Cherish Brodbeck, RN, LP



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AMSCT Committee

2025 Committee Assignments

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Assignments	Current Activities	Status
Trauma Facility Helipad Safety & Landing Zone Training Presentation	- Presentation creation - Complete - AMSCT Committee approval received 6/4/2025 Council approval received 6/6/2025	To date: 1062 Nursing CEs have been awarded
EMS Helicopter Safety & Landing Zone Training Presentation	CE's being granted every Monday	To date: 970 DSHS CEs have been provided

AMSCT Committee

2026 Committee Priorities Update

Priority Not Implemented

Priority Activities Recorded

Priority Completed and Monitored

Committee Priorities	Current Activities	Status
Emergency Preparedness and Response <i>Develop an integrated, cross-regional information-sharing process to enhance statewide visibility and awareness of NOTAM alerts</i>	• Statewide visibility permissions • Standardized NOTAM categories/definitions • Consistent formatting language • List serve for notifications • Pilot the program with select RAC regions	To Council In August
Performance Improvement & Patient Safety: <i>Fatigue Risk Management Programs for Air Medical & Specialty Care Transport Providers</i>	• Supporting research & data collection - Complete • Development of a White Paper supporting the implementation & utilization of a FRMP continues	To Council In August
System Integration <i>Develop criteria for the minimum requirements of a transport team when accepting and conducting an adult critical care transport by ground, with the goal of ensuring and enhancing the overall safety, quality of service, and level of care provided to patients being treated and transported by critical care ground providers.</i>	• Develop goals for the requesting facility • Revise verbiage & terms with feedback from SMEs • Cross reference TAC, Chapter 157, Rule §157.11 to avoid duplicity • Send to Mr. Schmider for initial review & feedback • Final draft revision to be sent to EMS & Medical Directors' Committee for feedback. • Further revisions PRN	To Council In August

II.C.3. GETAC Cardiac Care Committee Update to Council

Chair: Dr. Craig Cooley

Vice-chair:



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Cardiac Care Committee

2026 Committee Priorities Update

Priority Not Implemented

Priority Activities Recorded

Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Evaluate challenges to the use of T-CPR instructions prior to EMS arrival for public safety answering points (PSAPS) and work to overcome barriers to increase T-CPR across Texas.	Workgroup now formed. First step with August meeting report goal is to determine resources for all PSAP and secondary PSAPs in Texas and begin to determine best way to assess current state of T-CPR. Contact EMS Medical Directors committee (other committees also welcome) for interested members to join workgroup.	In progress
2. Provide recommendations guiding regulatory and legislative decision-making relevant to Texas emergency healthcare system	Cardiac Center Designation (CCD) workgroup now formed. First step with August meeting report goal is to evaluate current cardiac center designation processes along with processes for other service lines (trauma/maternal/stroke) to begin to build framework.	In progress
3. Partner with DSHS using EMS statewide data to evaluate AED and CPR across the state and then identify gaps and opportunities for improvement.	Continue to work with DSHS for additional refinement of bystander CPR and AED use and potential for addition to SCORE process.	In progress

II.C.4. GETAC Pediatric Committee Update to Council March 2026

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

Vice-chair: Belinda Waters, BSN, RN



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II.C.5. GETAC Stroke Committee Update to Council

Chair: Robin Novakovic, MD

Vice-chair: Sean Savitz, MD



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Stroke Committee

Priority Not
Implemented
Priority Activities
Recorded
Priorities Completed
and being Monitored

Committee Priorities	Current Activities	Status
Texas Stroke Quality Performance Report	- Review and disseminate Texas Stroke Quality report. - Share with TCCVDS. - Use the quality report to identify barriers to stroke care and opportunities for improvement. - Stroke Committee endorses data elements that are highly recommended for completion in GWTG Presented PDF of quality report from GWTG, and Jia reviewed rural stroke data from EMSTR	
RDC report	- Update from RDC at Stroke Committee meeting 11/2025. - Previously discussed more rural hospitals participating than higher levels I and II. - RDC will not be the ultimate source for the performance report. Need to continue with GWTG	
Stroke Committee 2026 Priorities	- Stroke Committee 2026 Priorities approved by the Stroke Committee and Council 11/2025 Stroke Committee liaisons with GETAC Committees provided updates - Stroke Committee liaisons from AHA, DNV and JC. Brittany Henson provided updates on new AHA 2026 stroke guidelines.	

Stroke Committee

Priority Not
Implemented
Priority Activities
Recorded
Priorities Completed
and being Monitored

Committee Priorities	Current Activities	Status
Patient safety and quality concern – Neuro IR coverage	• Letter citing patient safety concern regarding Neuro IR call coverage discussed. • Multiple TX providers gave first-hand experience supporting statements in the letter 11/2024. • Stroke Committee and GETAC Council approved it as a quality and patient safety concern. • Barriers to finding objective measures to demonstrate delays, patients are inappropriately denied MT, and misuse of resources. • DSHS is working with DNV and TJC to review transfers out from hospitals • Stroke Committee and SSOC WG recommendation for internal performance measures to follow. • SSOC work group and Stroke Committee endorsed using the NCTTRAC Neuro IR coverage best practice recommendation as the GETAC recommendation. • NCTTRAC approved that it can be branded as the GETAC resource. • GETAC Council did not approve 11/2025 • Stroke Committee voted to leave as NCTTRAC best practice recommendation. • Discussed the process for anonymous reporting of concerns to DSHS 03/2026	

Stroke Committee

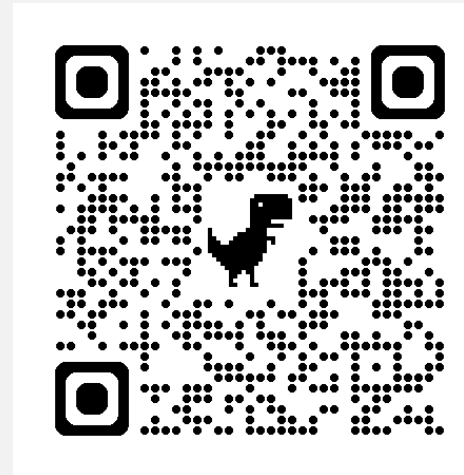
Priority Not Implemented
 Priority Activities Recorded
 Priorities Completed and being
 Monitored

Committee Priorities	Current Activities	Status
Adult Prehospital Stroke Resource	- Final routing algorithm approved through GETAC Council 03/2025 - Resource document for adult algorithm revisions approved by required committees and Council 06/2025. - Resources available from the GETAC Stroke Committee webpage. New AHA Stroke Guidelines based revisions. Resource document presented and approval 06/2026 by: Stroke, Air Medical committees. Not approved by EMS 06/2026 Triage Algorithm presented and not approved by Stroke Committee 06/2026	
Pediatric Stroke Task Force	- Next steps, minimum capability recommendations for pediatric hospitals to be destinations for pediatric stroke. - Algorithm approved by required committees, pediatric stroke task force and Council 06/2025. - Revisions approved by Pediatric, Stroke Committee and Council 08/2025 - Resources available from the GETAC Stroke Committee webpage. <u>Triage Algorithm</u> no changes Pediatric Stroke Tip Sheet by the Pediatric Stroke Task Force: approved by Pediatric, Stroke, Air Medical, EMS Committees 06/2026 New AHA Stroke Guidelines based revisions. Resource document presented and approval 06/2026 by: Pediatric, Stroke, Air Medical, EMS committees Request for Council approval 06/2026	

2026 AHA/ASA Acute Ischemic Stroke Guidelines

Pediatric and Prehospital Considerations

Recommendations for Stroke Awareness (Population Level) Referenced studies that support recommendations are summarized in the online data supplement .		
COR	LOE	Recommendations
1	B-R	1. For the general public, implementation of educational programs on stroke recognition in patients of all ages and the need to seek emergency care (calling 9-1-1) is recommended and should be implemented by public health and community leaders and medical professionals to reduce gaps in knowledge about stroke warning signs and to improve stroke preparedness. ¹⁻¹⁰
1	B-NR	2. For the general public, educational programs on stroke recognition should be designed to reach diverse communities and populations (ie, diversity by age, race and ethnicity, sex and gender, and other social determinants of health such as education, income, and neighborhood) to reduce knowledge gaps in stroke warning signs and improve stroke preparedness across all demographics. ^{1-4,9-12}



1	B-NR	3. For the general public, educational programs on stroke recognition should be sustained over time to improve long-term knowledge of stroke warning signs and stroke preparedness. ^{4,7,11}
1	B-NR	4. In addition to the general public, emergency medical services (EMS) professionals, physicians (including primary care professionals), and other health care personnel should receive targeted stroke educational programs to reduce prehospital delays and maximize eligibility for acute treatment of ischemic stroke (eg, thrombolysis). ¹³⁻¹⁶

Pediatric Stroke

WHAT IS NEW AND OF HIGH IMPACT

This Table highlights selected new and practice-changing recommendations since the last iteration of the guideline and is not a comprehensive list of all updates.

Section title	2025 Recommendation
New and impactful pediatric recommendations	
2.3. Prehospital Assessment and Management	COR 2b. In pediatric patients with suspected stroke transported by ambulance, the usefulness of common adult stroke screening tools is uncertain because they perform poorly for identification of stroke. Newer pediatric stroke screening tools demonstrate good interrater reliability; however, their sensitivity, specificity, and predictive value in the prehospital setting remain to be determined, and their usefulness is unknown.
3.2. Initial, Vascular, and Multimodal Imaging Approaches	COR 2a. In pediatric patients with suspected AIS, emergent brain and vascular imaging with MRI/MRA of the cervical and intracranial vessels is reasonable to identify patients with large vessel occlusion and to differentiate arterial ischemic stroke from hemorrhagic stroke or stroke mimics.
3.2. Initial, Vascular, and Multimodal Imaging Approaches	COR 2a. In pediatric patients with suspected AIS, emergent brain and vascular imaging with CT/CTA of the cervical and intracranial vessels is reasonable if MRI/MRA imaging is not available immediately (within 25 minutes) to identify patients with large vessel occlusion.
4.6.1. Thrombolysis Decision-Making	COR 2b. In pediatric patients aged 28 days to 18 years with confirmed AIS presenting within 4.5 hours of symptom onset and disabling deficits, IVT with alteplase may be considered as it is safe, but efficacy is uncertain.
4.7.5. Endovascular Thrombectomy in Pediatric Patients	COR 2a. In pediatric patients ≥6 years with acute neurological symptoms and ischemic stroke due to LVO and within 6 hours from symptom onset , EVT can be effective if performed by experienced neurointerventionalists to improve functional outcomes.
4.7.5. Endovascular Thrombectomy in Pediatric Patients	COR 2a. In pediatric patients ≥6 years with acute neurological symptoms and ischemic stroke due to LVO, 6 to 24 hours from symptom onset, and with potentially salvageable brain tissue, EVT can be effective to improve functional outcomes.
4.7.5. Endovascular Thrombectomy in Pediatric Patients	COR 2b. In pediatric patients aged 28 days to 6 years with acute neurological symptoms, including first-time seizure and AIS due to LVO, within 24 hours from symptom onset , and with potentially salvageable brain tissue , EVT performed by neurointerventionalists with pediatric experience may be reasonable to improve functional outcomes.

Abbreviations: EMS indicates emergency medical services; and IVT, intravenous thrombolytics.

MAJOR CHANGES:

EXPLICITLY ADDRESS PEDIATRIC STROKE FOR THE FIRST TIME EVER

INTRODUCES PEDIATRIC THROMBOLYSIS (CLASS 2B)

SUPPORTS THROMBECTOMY IN SELECT CHILDREN

EMPHASIZES SYSTEMS-BASED CARE AND AVOIDING DELAYS WHENEVER POSSIBLE

BIG NEWS: PEDIATRIC ADVANCED THERAPIES ARE NO LONGER BASED ONLY ON CONSENSUS – THEY HAVE AHA/ASA LANGUAGE

AHA GUIDELINES – IMAGING AND BLOOD PRESSURE

AHA:

**AVOID PROLONGED IMAGING THAT
DELAYS REPERFUSION THERAPIES**

CTA IS REASONABLE

**MRI PREFERRED WHEN AVAILABLE
WITHOUT DELAY**

**AVOID AGGRESSIVE LOWERING BP IN
ACUTE ISCHEMIC STROKE**

IMPACT ON PRIMARY STROKE CENTERS

CT +/- CTA IS REASONABLE

MRI SHOULD NOT DELAY TRANSFER

**AVOID AGGRESSIVELY NORMALIZING
BP IN ACUTE ISCHEMIC STROKE**

**“EARLY TRANSFER SHOULD BE
PRIORITIZED WHEN ANY OF THE
FOLLOWING APPLY:**

- **STRONG SUSPICION FOR STROKE
WITH LIMITED LOCAL PEDIATRIC
EXPERTISE**
- **NEED FOR PEDIATRIC NEUROLOGY,
NEUROSURGERY, OR PEDIATRIC ICU
MONITORING**
- **CONSIDERATION OF ENDOVASCULAR
EVALUATION, ADVANCED STROKE
THERAPIES, OR VASCULAR IMAGING**
- **TRANSFER PLANNING SHOULD
OCCUR IN PARALLEL WITH
STABILIZATION AND IMAGING”**

**PRIMARY STROKE CENTERS
SHOULD:**

**STABILIZE AND TRANSFER
EARLY**

NOT WAIT FOR CERTAINTY

**NOT FEEL OBLIGATED TO
PROVIDE PEDIATRIC
THROMBOLYSIS LOCALLY**

**FOLLOW REGIONAL
PEDIATRIC STROKE PLAN**

Pediatric Stroke Tip Sheet

APPROVAL ITEM

Pediatric Stroke Tip Sheet: Initial ED Recommendations for Receiving Facilities

Audience: Emergency Departments receiving children with *suspected* stroke (Primary Stroke Centers, freestanding EDs, Comprehensive Stroke Centers)

Purpose: Provide a practical, early action orientation for the first 30–60 minutes of care when a child presents with *suspected* stroke. This document emphasizes early recognition, stabilization, imaging, consultation, and timely transfer.

Important: Pediatric stroke cannot be definitively diagnosed in the field and is rare. This tip sheet is not a guideline, mandate, or standard of care. Local policies, resources, and clinician judgment apply.

1) When to Suspect Pediatric Stroke

Maintain stroke on the differential when a child has sudden-onset neurologic symptoms, including:

- Focal weakness or numbness (face/arm/leg)
- Speech or language difficulty
- Vision loss or diplopia
- Ataxia and imbalance
- Vertigo in combination with other symptoms
- New seizure with persistent focal deficit
- Altered mental status with lateralizing signs
- Severe headache with neurologic change

Note: Stroke mimics are common (>50%) in children, but many stroke mimics are neurologic emergencies.^{1–3} Early stroke activation is appropriate when concern exists.

2) Immediate Actions on Arrival (First 10–15 Minutes)

Focus on medical stabilization and timely transfer:

- Activate the local stroke process or equivalent rapid response
- Support airway, breathing, circulation; provide oxygen as needed
- Check glucose promptly
- Establish IV access (do not delay imaging/transfer)
- Position head of bed ~30° if tolerated
- Document Last Known Well (LKW) clearly (for wake-up events, LKW is last time at baseline)
- Brief neurologic assessment (e.g., BE-FAST; severity screen if used locally)

- Avoid aggressive blood pressure lowering in the acute setting unless medically indicated for another reason.⁴

3) Imaging: What Is Reasonable

Non-contrast head CT is appropriate, widely available, and used to identify intracranial hemorrhage and large, established infarcts.

CTA head/neck is reasonable when ischemic stroke is suspected, and can diagnose large artery occlusions in children.

MRI may be preferred at pediatric centers when readily available without delay, **but should not delay transfer.**

Vascular imaging should be obtained when feasible without delaying transfer, particularly when large artery occlusion is suspected. Avoid prolonged or sequential imaging that delays consultation or transfer.

4) Early Decision-Making: Stabilize and Move Forward

When there is a strong clinical suspicion of pediatric stroke, many [designated stroke centers and non-stroke designated Primary Stroke Centers hospitals](#), and freestanding EDs may not have rapid access to immediate pediatric neurology consultation. In these settings, the priority should be early stabilization and timely transfer to a facility with expertise in pediatric stroke.

- Initiate local stroke processes and complete initial stabilization and imaging
- Begin transfer planning early rather than waiting for a definitive diagnosis
- Consultation with a pediatric neurologist or regional pediatric stroke-capable center is encouraged when readily available, but should not delay transfer
- Immediate specialty phone consultation may not be feasible in all locations. When in doubt, early transfer is appropriate and preferred
- Transfer planning should not wait for MRI confirmation in cases of suspected pediatric stroke

5) Transfer: When to Prioritize Early Transfer

Early transfer should be prioritized when any of the following apply:

- Strong suspicion for stroke with limited local pediatric expertise
- Need for pediatric neurology, neurosurgery, or pediatric ICU monitoring
- Consideration of endovascular evaluation, advanced stroke therapies, or vascular imaging

Pediatric Stroke Tip Sheet

APPROVAL ITEM

- Transfer planning should occur in parallel with stabilization and imaging

6) Where to Transfer

There is no formal national or statewide certification system for pediatric stroke centers. Facilities most appropriate to receive children with suspected or confirmed stroke should be determined locally based on available resources, expertise, and established regional plans.

In many countries, particularly near large metropolitan areas, the most appropriate destination will be a tertiary-care children's hospital with capabilities in pediatric neurology, neurosurgery, hematology, and pediatric intensive care.

Some Comprehensive Stroke Centers (CSCs) may be willing to accept older adolescents (e.g., age ≥ 16 years), but this varies by institution and should be determined at the local or regional level.

In general:

- Transfer to the nearest large children's hospital is often the best course of action for suspected stroke in younger children
- Consider CSC transfer for older adolescents, particularly when a large artery occlusion is suspected, and local agreements support this pathway

7) Advanced Stroke Therapies: Key Principles

Endovascular thrombectomy may benefit carefully selected children and adolescents with large artery occlusion and disabling stroke.⁵⁻⁸ Evaluation and treatment should occur at centers with appropriate pediatric and neurointerventional expertise. Transfer to comprehensive stroke centers willing and able to treat pediatric patients may be reasonable for older children with confirmed large artery occlusion.

Per 2026 AHA guidelines,⁴ intravenous thrombolysis *may be considered* for children and adolescents younger than 18 years with confirmed arterial ischemic stroke, disabling neurologic deficits, and treatment initiation within 4.5 hours of last known well. When considered, thrombolytic therapy should be given by, or in consultation with, clinicians with expertise in managing pediatric stroke.

Decisions regarding advanced therapies should not delay stabilization or transfer to an appropriate receiving facility.

8) Key Reminders

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Minor Edits

Pediatric resource document changes:

- Page 1, Paragraph 3 - “Hematologist” changed to **“Hematologists”**
- Page 4, ECG changed to **12-Lead ECG**
- Page 5, Management Added: **Advanced airway management should be performed per pediatric guidelines**

Prehospital Stroke Triage and Management **APPROVAL ITEM**

PREHOSPITAL PEDIATRIC STROKE TRIAGE AND MANAGEMENT

1. Goals:

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

2. Purpose:

Pediatric Stroke is a rare disease that is, nevertheless, included among the top ten causes of death in pediatricschildren.¹ However, rapid recognition and appropriate treatment of pediatric stroke can profoundly improve outcomes for these children, sparing them from decades of disability.^{2,3} Thrombectomy has been shown to improve outcomes in pediatric large-arterypatients with large-artery occlusion stroke, and current American Heart Association guidelines now support consideration of mechanical thrombectomy and IV thrombolysis in appropriately selected pediatric patients.^{4,5} This guidance document is designed to help EMS providers recognize and triage pediatric stroke patients quickly, facilitating improved quickly recognize and triage pediatric stroke patients, thereby improving outcomes throughout the state.

The **GETAC Prehospital Pediatric Stroke Triage Algorithm** was developed in consultation with EMS, EMS leaders, and local, regional, and state medical authorities. The GETAC pediatric stroke algorithm was developed in consultation with the GETAC Stroke, EMS, Pediatric, EMS Medical Directors Committees, and the Council. Available guideline statements⁹ and guidance from the GETAC Pediatric Stroke Task Force (a consensus of expert opinion based on clinical experience in the fields of Vascular Neurologists, Neuroendovascular Surgeons, and Pediatricians) were integral in among Vascular Neurologists, Neuroendovascular Surgeons, Hematologists, and Pediatricians) were integral to the development of this resource document and algorithm.⁵⁻¹³ The recommendations were developed to ensure that all pediatric patients with a known or suspected stroke are rapidly identified, assessed, and triaged as outlined below. Standardizing care to enable rapidly diagnosisse and timelyprovide appropriate treatment will improve patient outcomes.⁹⁻¹² The prehospital pediatric stroke triage and transport recommendations serve to direct the regional triage of pediatric patients with acute stroke to the most appropriate facility. See **Annex A: GETAC Pediatric Prehospital Stroke Triage Algorithm**. There are currently no formal national or statewide guidelines, certification programs, or designation systems for pediatric stroke centers. As such, EMS Medical Directors should identify and designate appropriate receiving facilities for pediatric patients with suspected or confirmed stroke based on local resources and capabilities. These recommendations can serve as a resource to support that process and guide regional decision-making. There are no formal national or statewide guidelines, certifications, or recognition systems for Pediatric Stroke Destinations. EMS Medical Directors should determine which nearby facilities they will direct pediatric patients with suspected or confirmed stroke.

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A pediatric stroke destination should have personnel available to care for pediatric stroke patients, including access to and a pediatric intensive care unit. These centers should maintain a multidisciplinary team capable of managing pediatric stroke and its complications, with the ability to administer antiplatelet and anticoagulant therapies, as well as provide thrombolytic treatment and perform endovascular thrombectomy when indicated. In addition, pediatric stroke destinations should have the necessary technical capabilities, including advanced imaging with MRI when available, as well as established policies and procedures to ensure timely, coordinated, and high-quality care for pediatric stroke patients. Pediatric stroke destinations should have a multidisciplinary team to care for pediatric stroke patients, the capability to administer antiplatelet drugs, anticoagulants, thrombectomy, and thrombolytic therapies, and the ability to treat complications. Pediatric stroke destinations should have the technical capabilities (including imaging capability, MRI if possible), policies, and procedures to facilitate optimal care of a pediatric stroke patient.⁹⁻¹² Pediatric hospitals that do not meet lacking these above capabilities should establish protocols to rapidly identify, stabilize, consult, and transfer pediatric stroke patients to centers with appropriate treatment and rehabilitative resources, be able to identify, stabilize, consult, and transfer patients to a center that can provide the appropriate care and rehabilitative resources.⁹⁻¹²

In regions where a Mobile Stroke Unit is available and operational, and when age-appropriate, based on local protocols, EMS should consider MSU dispatch for suspected pediatric stroke patients. MSUs may facilitate rapid on-scene imaging, specialist consultation, and early treatment, potentially reducing time to diagnosis and intervention. Use of MSU should be guided by regional protocols and resource availability.

3. Prehospital Triage of Stroke in Pediatric Patients

Pediatric stroke can may present with age-dependent and often nonspecific symptoms, including focal neurologic deficits, seizures, altered mental status, or unexplained headache or irritability, requiring a high index of suspicion for timely recognition focal neurologic signs, as well as nonspecific signs like seizure or altered mental status.^{9,14-16}

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

- ❖ — Numbness or weakness of the face, arm, and/or leg (especially on one side of the body)
- ❖ + Confusion
- ❖ + Trouble speaking or understanding language.
- ❖ + Visual disturbances, including double vision or loss of vision in one or both eyes. Double vision, trouble seeing in one or both eyes.
- —
- ❖ + Altered mMental sStatus
- ❖ + Trouble walking
- — Dizziness
- —

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- Loss of balance or coordination
- Severe headache with no known cause, particularly when associated with altered mental status, which may suggest hemorrhagic stroke.
- ❖ Severe headache with no known cause (suggests hemorrhagic stroke); especially with altered mental status.
- ❖ Patients presenting with any of the above neurologic signs, especially in the presence of relevant risk factors or underlying conditions, should be triaged and managed as a suspected acute stroke. For patients with any of the above neurological signs, especially with the listed conditions below, consider triaging as an acute stroke.

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

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

Common pediatric stroke mimics:

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

Basic Level

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

- **A (Airway):** Airway support and ventilation assistance are recommended for patients with acute stroke who have decreased consciousness or who have a compromised airway. Suctioning and oropharyngeal or nasopharyngeal airway as needed to ensure airway patency.
- **B (Breathing):** Provide Supplemental oxygen should be provided to needed to maintain oxygen saturation > 94% with continuous

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monitoring (continuous monitoring). Consider adding the use of end-tidal CO2 monitoring when available.

- **NOTE:** Some patients with congenital heart disease may have lower baseline oxygen saturation targets (e.g., 80–90%). If the patient's baseline is unclear, confirm typical saturation levels with parents or caregivers when possible have a different goal saturation level (80–90% in some cases). If unsure, confirm the normal level with parents or caretakers.

- **C (Circulation):** Evaluate and treat signs/symptoms of shock according to the Shock Clinical Practice Guidelines
- **D (Disability):** Assess and document GCS, pupillary size, and reactivity.
- **E (Exposure/Environmental):** Assess for evidence of traumatic injury, especially head injury.

Stabilization and Initial Management:

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

Cardiovascular Examination:

- Record blood pressure, rate, rhythm, respiratory rate, and oxygen saturation.
- Obtain a 12-lead ECG when feasible, provided it does not delay transport. Obtain an EKG if it will not delay transport.

Neurological Assessment for Pediatric Stroke:

- Weakness of the face, arm, and/or leg, particularly (especially) on one side of the body.
- Numbness on affecting one side of the face or body.
- Confusion
- Trouble speaking or understanding language.
- Visual disturbances, including double vision or loss of vision in one or both eyes. Double vision, trouble seeing in one or both eyes.
- Altered Mental mental status
- Trouble walking

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Prehospital Stroke Triage and Management **APPROVAL ITEM**

- Dizziness
- Loss of balance or coordination
- Severe headache with no known cause, particularly when associated with altered mental status, which may suggest hemorrhagic stroke (suggests hemorrhagic stroke), especially with altered mental status.
- Seizure with a persistent postictal focal deficit (e.g., weakness) that does not resolve within approximately 15 minutes. Seizure with post-ictal focal deficit (like weakness) that does not resolve quickly (~15 minutes).

History:

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

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

Additional History:

- Obtain relevant past medical history, including prior and and history of past and recent surgeries.
- Document Allergies (e.g., iodinated contrast)
- Obtain history of Pre-existing substantial/significant disability (e.g., unable inability to walk independently).
- Obtain Device and implant history (e.g., left ventricular assist device, pacemaker, valve replacement, Vpprothetic valve, ventriculoperitoneal shunt).

Medications:

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

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Management:

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

- Prevent aspiration by positioning the patient with HOB > at 30 degrees. Ensure airway patency with suctioning and the use of an oropharyngeal or nasopharyngeal airway OPA or NPA as needed.
 - Advanced airway management should be performed per pediatric guidelines.
- Provide supplemental oxygen if as needed to keep/maintain oxygen saturation > 94%.
 - (Adj/Adjust targets in patients with known congenital heart disease who may have different baseline oxygen saturation goals, ust if the patient has known congenital heart disease with a different goal oxygen saturation)
- Treat hypotension per according to regional pediatric protocols.
- Maintain blood pressure within appropriate age-based parameters, avoiding levels greater than 20% Maintain blood pressure below 20% above the 95th percentile for age.^{5,12} Contact online medical control if systolic blood pressure remains persistently above this range Call online medical control if the systolic blood pressure is consistently above this percentile. The table below is an example of/provides an example of the upper limit of systolic blood pressure by age.

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

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

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System Triage:

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

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

Age Criteria and Appropriateness for ADULT Stroke Facility: [Adult stroke centers may vary in their capabilities and willingness to evaluate and treat patients under 18 years of age. EMS Medical Directors, in collaboration with stroke facility leadership, should define age-appropriate destination protocols based on regional resources, institutional capabilities, and hospital policies. Please note that different adult stroke facilities will have different capabilities and willingness to evaluate and treat stroke patients under 18. EMS Medical Directors and stroke facility leadership should outline the age-appropriateness for adult stroke facility admission based on regional facility resources and hospital policies.](#)

Triage Recommendation:

- Pediatric patient [with suspected of having a stroke](#) who is medically stable and last known well [≤ 24 hours](#); triage [patient](#)-based on the following criteria:

Age appropriateness for adult stroke facility:

- [For P](#)pediatric patient with suspected stroke, [who are below the age threshold for evaluation at adult stroke centers](#), [age < appropriate](#):
 - Transport suspected stroke patient to the nearest **Pediatric Stroke Destination**
 - Pediatric Stroke Destination** – EMS Medical Director will [identify and recommend local pediatric stroke destinations. These are typically, these are, pediatric hospitals with the capability to care capable of caring for pediatric patients with stroke. Please note that: there are currently NO formal national or statewide guidelines, certifications, accreditations, or recognition systems for 'Pediatric Stroke Destinations' or pediatric stroke center certification.](#)
 - If [no a](#) Pediatric Stroke Destination is [not accessible](#) within [≤ 60 minutes total transport time by air or ground, or if the patient is unstable, transport to the nearest appropriate pediatric facility by air or ground total transport time, or the patient is unstable, transport to the nearest Pediatric Facility.](#)
- [For pediatric patients with S](#)suspected [pediatric stroke](#), [age ≥ appropriate](#):
 - Perform [a V](#)alidated [S](#)stroke [S](#)everity [S](#)creening [T](#)ool to assess for potential large vessel occlusion (LVO), such as [the RACE score](#).^{5,18}
 - If **LVO Screening Tool is Positive**:
 - Transport [suspected stroke patients the patient](#) to the nearest adult Comprehensive Stroke Center (CSC/ Level 1) if [it is](#) within [≤ 30 minutes](#) from the nearest Pediatric Stroke Destination and [no](#)

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[more within a total transport time of < 60 minutes total transport time by air or ground.](#)

- If [no a](#) CSC is [not](#) available within 30 minutes, transport to the nearest [Thrombectomy Capable Stroke Center \(TSC/ Level 2\)](#) if [it is](#) within [≤ 30 minutes](#) from the nearest Pediatric Stroke Destination and [within a total transport time of no more than ≤ 60 minutes total transport time by air or ground.](#)
 - If neither a CSC nor TSC is available within [≤ 30 minutes](#), transport to the nearest Pediatric Stroke Destination.
 - If no Pediatric Stroke Destination is available within [≤ 60 minutes](#), or the patient is unstable, transport to the nearest [appropriate P](#)pediatric [F](#)acility.
 - If **LVO Screening Tool Negative**:
 - Transport suspected stroke patients to the nearest Pediatric Stroke Destination.
 - If [no a](#) Pediatric Stroke Destination is [not accessible](#) within [a total transport time of < 60 minutes by air or ground total transport time, or the patient is unstable, transport to the nearest Pediatric pediatric Facility facility](#) or most appropriate facility.
- Pediatric patient [with suspected of having a stroke who is medically stable](#) and last known well [> 24 hours](#); triage based on the following criteria:
 - [For Suspected pediatric patients with suspected stroke, for all ages:](#)
 - Transport [suspected stroke the](#) patients to the nearest Pediatric Stroke Destination.
 - If [no a](#) Pediatric Stroke Destination is [not accessible](#) within [a total transport time of < 60-minute, total transport time](#) or the patient is unstable, transport to the nearest [appropriate P](#)pediatric [F](#)acility.
 - ❖ **For all ages:** consider air medical if transport [if total transport time is anticipated to exceed prolonged > 60 minutes.](#)
 - ❖ **Stroke Prenotification:** [Notify alert](#) the receiving facility [as early as possible](#) that a suspected pediatric stroke patient is en route prior to arrival. [Early prenotification allows for activation of appropriate resources prior to patient arrival. A stroke alert prior to arrival will mobilize appropriate resources before patient arrival.](#)
 - Prenotification should include: [Age patient age](#), last known well, time of symptom discovery, current vital signs, stroke [screening tool score](#) (if performed), and [key symptoms \(e.g., weakness on one side, altered mental status, etc.\).](#)

Hand-off Goal: [Target a streamlined EMS-to-ED handoff time of < 120 seconds to facilitate rapid triage and continuation of care for EMS-to-ED triage nurse hand-off.](#)



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Prehospital Stroke Triage and Management **APPROVAL ITEM**

(Note – [This document represents a revision of the 2025 GETAC Pediatric Stroke Triage Recommendations, updated to align with the latest guideline statements and adapted from the North Central Texas Trauma Regional Advisory Council \(NCTTRAC\) Regional Stroke Plan.](#))

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

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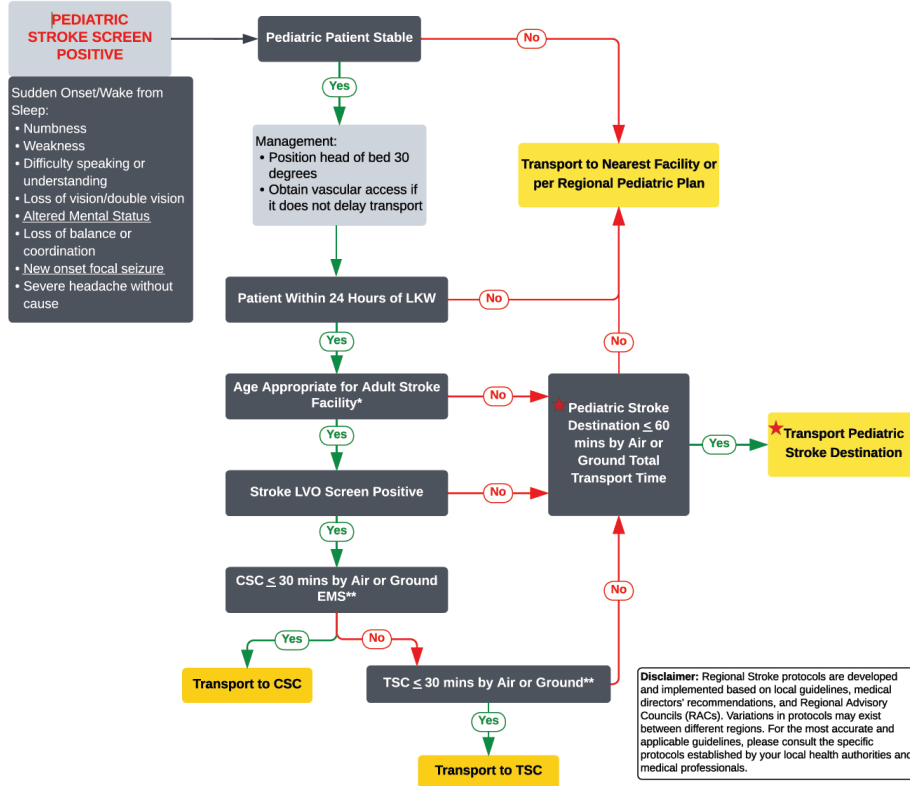
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APPROVED: Pediatric Algorithm Recommendation

EMS Acute Pediatric Stroke Routing Resource Document

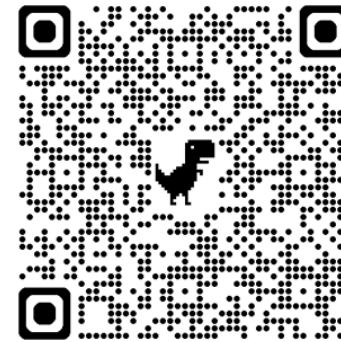
INSERT WATERMARK - Resource Document



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

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

GETAC Stroke Committee Page:



(Scroll to the bottom of the page)



Texas Department of State Health Services

GETAC Stroke Committee

Chair: Robin Novakovic-White, MD

Vice Chair: Sean Savitz, MD

HIGHLIGHTS OF MAJOR 2026- guideline DRIVEN CHANGES

- **Imaging-based eligibility window** acknowledgement
- Explicit inclusion of tenecteplase
- Add **MSU integration language**
- **Strengthened DIDO target language**
- Shift from rigid 45/60-minute bypass thresholds to **performance-based regional thresholds and advanced imaging capability**

Recommendations for EMS Destination Management Referenced studies that support the recommendations are summarized in the online data supplement .		
COR	LOE	Recommendations
General principles		
1	B-NR	1. In patients with suspected acute stroke, EMS professionals should prioritize transport to the closest appropriate facility (acute stroke-ready hospital [ASRH], primary stroke center [PSC], thrombectomy-capable stroke center [TSC], or comprehensive stroke center [CSC]) to reduce time to treatment compared with transport to a nonstroke capable hospital. ¹⁻⁵
Areas with local access to thrombectomy-capable stroke center(s)		
2a	B-NR	2. In patients identified by EMS professionals as having a suspected LVO stroke, direct transport to a TSC can be beneficial to increase EVT rates and reduce time to treatment compared with initial transport to a non-TSC with secondary hospital-to-hospital transfer. ⁶⁻⁸
Areas without local access to thrombectomy-capable stroke center(s)		
2b	B-NR	3. In areas without well-coordinated stroke systems of care (SSOC) and local hospital(s) proficient in thrombolysis delivery and secondary interhospital transfer, it may be reasonable for EMS professionals to consider direct transport of suspected LVO patients to the closest appropriate TSC (if transport will not disqualify the patient from IVT) to increase rates of EVT and reduce time to treatment, compared with initial transport to a local stroke center with secondary hospital-to-hospital transfer for treatment. ⁹
Recommendations for EMS Destination Management (Continued)		
COR	LOE	Recommendations
3: No Benefit	B-R	4. In areas with well-coordinated SSOC and local hospital(s) proficient in thrombolysis delivery and secondary interhospital transfer, direct transport of patients with suspected LVO to a distant (eg, 45–60 min) TSC compared with transport to a local stroke center does not improve 3-month clinical outcomes. ¹⁰⁻¹⁴

Recommendations for Stroke Awareness (Population Level) Referenced studies that support recommendations are summarized in the online data supplement .		
COR	LOE	Recommendations
1	B-R	1. For the general public, implementation of educational programs on stroke recognition in patients of all ages and the need to seek emergency care (calling 9-1-1) is recommended and should be implemented by public health and community leaders and medical professionals to reduce gaps in knowledge about stroke warning signs and to improve stroke preparedness. ¹⁻¹⁰
1	B-NR	2. For the general public, educational programs on stroke recognition should be designed to reach diverse communities and populations (ie, diversity by age, race and ethnicity, sex and gender, and other social determinants of health such as education, income, and neighborhood) to reduce knowledge gaps in stroke warning signs and improve stroke preparedness across all demographics. ^{1-4,9-12}
1	B-NR	3. For the general public, educational programs on stroke recognition should be sustained over time to improve long-term knowledge of stroke warning signs and stroke preparedness. ^{4,7,11}
1	B-NR	4. In addition to the general public, emergency medical services (EMS) professionals, physicians (including primary care professionals), and other health care personnel should receive targeted stroke educational programs to reduce prehospital delays and maximize eligibility for acute treatment of ischemic stroke (eg, thrombolysis). ¹³⁻¹⁶
1	B-NR	3. In patients with suspected stroke transported by ambulance, prehospital personnel should provide advance notification to the receiving hospital of an inbound suspected stroke to reduce in-hospital evaluation times, increase thrombolytic use, and decrease mortality. ^{5,8}

EMS Destination Management

Areas without local access to TSCs	
COR	RECOMMENDATIONS
3 No Benefit	In areas with well-coordinated SSOC and local hospital(s) proficient in thrombolysis delivery and secondary interhospital transfer , direct transport of patients with suspected LVO to a distant (eg, 45–60 min) TSC compared with transport to a local stroke center does not improve 3-month clinical outcomes.

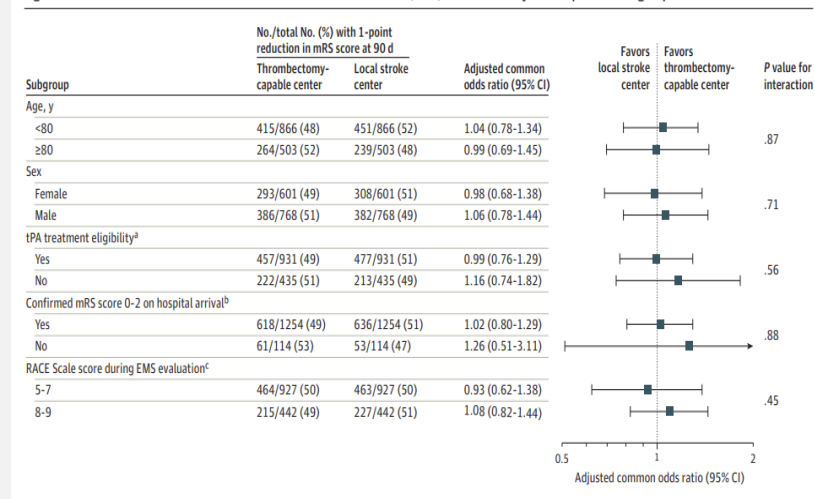
Interhospital Transfer	
COR	RECOMMENDATIONS
1	Hospitals and EMS professionals should establish agreements and protocols to prioritize interhospital transfer of patients with acute stroke needing a higher level of care to reduce door-indoor-out (DIDO) times.



Destination Strategy for LVO

- **RACECAT** (Catalonia) found no 90-day outcome difference between direct-to-EVT center (“mothership”) vs nearest stroke center (“drip-and-ship”) in a highly efficient network.
- Times were extremely fast in both arms, even in transferred patients.
 - **Median DTN 33 minutes**
 - **DIDO 78 minutes**
 - Only 56 minutes difference in total time from onset-to-EVT between the 2 groups

Figure 3. Odds Ratios of a 1-Point Reduction in the Modified Rankin Scale (mRS) Score at 90 Days in Prespecified Subgroups



- Perez de la ON, et al. Effect of direct transportation to local stroke center vs thrombectomy-capable center on neurological outcomes in patients with suspected large vessel occlusion stroke in non-urban areas: the RACECAT randomized clinical trial (JAMA 2022).

APPROVAL ITEM: Adult Stroke Prehospital Recommendation

PREHOSPITAL ADULT STROKE TRIAGE AND MANAGEMENT

- 1. **Goal**
 - The GETAC endorsed a triage recommendation to assist pre-hospital providers with the rapid identification, assessment, and triage of all suspected stroke patients in Texas. This recommendation aims to lower barriers to seeking emergency care for stroke and ensure that stroke patients receive care at appropriate facilities promptly.
- 2. **Purpose**
 - In consultation with emergency medical services (EMS) leaders, local, regional, and state agencies, as well as medical authorities, current national guideline statements, and local experts, the following recommendations seek to ensure that all patients with a known or suspected stroke are rapidly identified, assessed, and triaged as outlined below.¹⁻¹⁵ 9-1-1 call centers and EMS dispatchers are encouraged to use standardized approaches to prehospital stroke assessment, triage, management, and interfacility documentation.
 - **Dispatcher Best Practices:** Consistent with the 2026 AHA/ASA AIS Guideline, EMS dispatchers and 9-1-1 call centers should: (1) use a validated telephone stroke assessment tool (e.g., CPSS, FAST, or MPDS) to identify stroke, reduce on-scene time, and prioritize transport (Class IIa, Level B-NR), as stroke-specific tools yield substantially higher sensitivity than unstructured interviews; (2) dispatch EMS within 90 seconds of the 9-1-1 call and relay all stroke-relevant information (symptom onset/last known well, deficits, patient baseline) to responding units; (3) activate the highest-priority response and, for suspected large vessel occlusion (LVO) where ground transport exceeds regional thresholds, consider early air medical notification; (4) complete stroke-specific dispatcher training with validated recognition scripts; and (5) participate in regional quality improvement (QI) programs that monitor dispatch performance metrics and provide feedback to sustain improvement (Class IIa, Level B-NR).²
 - The prehospital acute stroke triage and transport recommendations serve to direct the triage of adult patients (greater than ≥ 18 years of age) to the most appropriate facility based on the duration and severity of symptoms. The **GETAC Adult Prehospital Stroke Triage Algorithm** is based on multi-society endorsed guideline statements and recommendations,¹⁻¹⁵ consensus of expert opinion (Vascular Neurologists, Neuroendovascular Surgeons, and Neurosurgeons) based on clinical experience and in consultation with the GETAC council, EMS, EMS Medical Directors, Air Medical, and Stroke Committees. See **Annex A, B, and C: GETAC Adult Prehospital Stroke Triage Algorithm**
 - Regional stakeholders should collaborate to consider local prehospital and health care resources, individual stroke center performance, and geographic considerations to create an optimal stroke system of care (SSOC) and destination protocol to ensure effective and efficient stroke care.^{1,4,10,13-15} Ideal destination plans should factor in all available data sources, including traffic patterns, site-specific performance data, and associated clinical outcomes.^{1,4,15} EMS agencies should implement destination plans based on time and severity for patients with suspected large vessel occlusion (LVO) within 24 hours of the last known well. These plans should prioritize a nearby comprehensive stroke

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- center (CSC) over other centers of lower capability when available within acceptable transport times.^{1,14-16}
- Consistent with the 2026 AHA/ASA Guideline for the Early Management of Patients with Acute Ischemic Stroke, EMS destination protocols should give priority to high-performing certified stroke centers that demonstrate efficient reperfusion delivery and interhospital transfer performance. High-performing certified stroke centers are those that consistently achieve rapid door-to-needle times (e.g., median ≤33 minutes) and short door-in-door-out (DIDO) times for interhospital transfers (e.g., ≤78 minutes, consistent with RACECAT trial benchmarks).¹⁷ Regional stakeholders should use site-specific performance data to define high-performing centers within their systems of care. The 2026 AHA/ASA Guideline further specifies that in areas with well-coordinated stroke systems of care and local hospitals proficient in thrombolysis and secondary interhospital transfer, direct transport of patients with suspected LVO to a distant (e.g., 45–60 min) stroke center certified for thrombectomy compared with transport to a capable local stroke center does not improve 3-month clinical outcomes (Class III: No Benefit). EMS and hospital systems should establish formal agreements and protocols to prioritize interhospital transfer and minimize DIDO times for patients with acute stroke needing a higher level of care (Class I; 2026 AHA/ASA AIS Guideline).²
 - In response to the perceived need for greater access to thrombectomy, several of the accrediting agencies for stroke centers introduced a fourth level of certification for facilities that can effectively perform endovascular treatment (EVT) but do not meet all the criteria of a CSC, the Thrombectomy Capable Stroke Center (TSC). The American Stroke Association 2019 SSOC Recommendations and the American Heart Association (AHA) Mission: Lifeline Stroke outline that the TSC certification is intended for regions of the country that are not readily accessible to CSCs; a CSC is the preferred destination for patients with suspected LVO when they are able that the TSC certification is intended for regions of the country that are not readily accessible to CSCs; a CSC is the preferred destination for patients with suspected LVO when within acceptable transport times.^{1,4,14} If no CSC is available, a TSC should be the preferred destination for these patients from among all nearby primary stroke centers (PSCs).^{1,2,4,14}
 - The AHA Lifeline Stroke Committee felt it was best to err on the side of caution and initially set the total transport time from the scene to CSC at 30 minutes for an urban area, 45 minutes in a suburban area, and 60 minutes in a rural area. However, patients eligible for IV thrombolysis (0-4.5 hours from last known well) should be routed to the nearest stroke facility if transport to the nearest CSC or TSC would make them ineligible for thrombolysis due to the additional transport time. In suburban and rural settings, prehospital destination plans and interfacility transport policies should prioritize transporting suspected LVO patients to a facility with well-defined evaluation and stabilization protocols to minimize Door-In-Door-Out (DIDO) times for patients requiring transfer to a higher level of care.^{1,10,14} Additional transport time, including air medical transport, may be reasonable in rural communities or where large distances separate stroke centers.^{1,4,13,14}
 - 3. **SSOC Modification for Metropolitan, Non-Metropolitan, and Frontier Regions**

APPROVAL ITEM: Adult Stroke Prehospital Recommendation

- The following is adapted from the AHA Mission: Lifeline Stroke recommendation for Emergency Medical Services for acute stroke triage and routing.^{1,2,4,13,14} These modifications to transport time thresholds are suggested to help EMS agencies adjust their regional stroke triage protocols in collaboration with local resources and key stakeholders.^{4,13,14}
- A Metropolitan SSOC modification is appropriate for a metro region (Urban/RUCA code 1)^{4,18} These areas have a high population density (50,000+ inhabitants) and abundant healthcare resources, with EMS access to one or more TSC/CSC within 30 minutes [of ground transport time by ground transport](#).^{4,14}
- A Non-Metropolitan SSOC modification is appropriate for large residential communities adjacent to an urban core (Suburban/RUCA codes 2-3).^{4,18} These areas generally have a population density closer to the urban threshold. They may have access to nearby community hospitals and [suburban or urban advanced stroke centers within a 30–60 minute](#) transport by EMS, either by air or ground.^{4,14} Patients with suspected LVO should be routed directly to a CSC if the maximum transport time from the scene to the CSC does not exceed 45 minutes. If no CSC is within 45 minutes, then EMS should go directly to a TSC if the maximum total transport time from the scene to the TSC does not exceed 45 minutes. If no TSC or CSC [exists within 45 minutes of is available within 45 minutes of the](#) total travel time, EMS should go to the nearest acute stroke-ready hospital (ASRH) or PSC.^{4,14}
- A Frontier SSOC modification is appropriate for a small or non-metropolitan region (Rural/RUCA codes 4-10).^{4,18} These areas generally have low population density (<50,000 inhabitants), limited local general healthcare resources, few nearby ASRH or PSC, and often no TSC/CSC within 60 minutes [of transport time by EMS ground transport](#), although there may be one within 60 minutes by air.^{4,14} Patients with suspected LVO should be routed directly to a CSC if the maximum total transport time from the scene to the CSC does not exceed 60 minutes.^{4,14} If no CSC is within 60 minutes, then EMS should go directly to a TSC if the maximum total transport time from the scene to the TSC does not exceed 60 minutes.^{4,14} Consider air medical transport if no certified stroke center is within 60 minutes by ground. If air transfer is unavailable, transfer the patient to the nearest hospital per the regional stroke plan.^{4,14}
- [The COVID-19 pandemic further emphasized the need for flexible prehospital triage and interfacility transport adaptation in response to local and regional factors. Preferential routing of suspected LVO patients to centers with thrombectomy capability may be of even greater importance when in-hospital and interfacility delays are amplified even more important when in-hospital and interfacility delays are exacerbated, as in conditions such as the COVID-19 pandemic.](#)¹⁹
- [Role of Mobile Stroke Units \(MSUs\): In regions where Mobile Stroke Units \(MSUs\) are available, their use over conventional EMS is recommended \(Class I, Level A; 2026 AHA/ASA AIS Guideline\) for the transport and management of thrombolytic-eligible patients to ensure the fastest achievable onset-to-treatment](#)

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[time and improve functional outcomes.² MSUs are specialized ambulances staffed by interdisciplinary teams \(including paramedics, nurses, and physicians or telemedicine consultants\) equipped to perform point-of-care neuroimaging, initiate intravenous thrombolysis in the field, and provide comprehensive prehospital notification to receiving stroke teams. When available, MSUs can also identify and triage EVT-eligible patients \(Class IIa, Level B-NR; 2026 AHA/ASA AIS Guideline\) to the appropriate thrombectomy-capable facility with advanced activation of receiving stroke and interventional teams. Regional EMS systems and stroke networks should integrate MSU protocols into their destination plans where operationally feasible.](#)

4. Prehospital Triage of Stroke in Adult Patients
- **Basic Level:**
 - Assess and support ABCEs according to UNIVERSAL CARE – ADULT:
 - **A (Airway):** Airway support and ventilator assistance are recommended for patients with acute stroke who have decreased consciousness or a compromised airway. Suctioning and oropharyngeal or nasopharyngeal airway as needed to ensure airway patency.
 - **B (Breathing):** Supplemental oxygen should be provided to maintain oxygen saturation >94% (continuous monitoring).²
 - **C (Circulation):** Evaluate, document, and treat signs/symptoms of shock according to the Shock Clinical Practice Guidelines (CPG).
 - **D (Disability):** Assess and document GCS, pupillary size, and reactivity.
 - **E (Exposure/Environmental):** Assess for evidence of traumatic injury, especially head injury.
 - **Positioning and Stabilization:**
 - Place the patient in a supine position, with the head of the bed elevated at 30 degrees, if the patient can tolerate.^{2,10} Keeping the patient at 30 degrees can improve blood flow to the brain^{20,21} and is recommended if the patient can tolerate.^{2,10} Avoid lying the patient flat unless an LVO is documented,^{22,23} and the patient is not at risk for elevated intracranial pressure or herniation.²¹
 - Ensure airway patency with suctioning and oropharyngeal airway or nasopharyngeal airway as needed.
 - Cardiac monitoring during transport is recommended. Obtaining an EKG during workup is acceptable as long as it does not delay transport to the appropriate stroke facility.²
 - Treat hypotension. Evaluate, document, and treat signs/symptoms of shock according to the **Shock CPG**.
 - If hypoglycemia is present (POC glucose <60mg/dL),² treat according to **Diabetic Emergencies CPG**. Hyperglycemia in acute ischemic stroke is associated with worse clinical outcomes,^{24,25} including greater infarct growth^{26,27} and hemorrhagic infarct conversion.^{28,29}
 - If there is Seizure activity, treat according to the **Seizure CPG**.
 - **Management:**
 - EMS personnel should begin the initial management of stroke in the field as outlined in this document.
 - Provide supplemental oxygen if needed to keep oxygen saturation

APPROVAL ITEM: Adult Stroke Prehospital Recommendation

- >94%.²
- Treatment of hypertension is **NOT** recommended unless blood pressure is >220/120 mmHg.²
- Per the 2026 AHA/ASA AIS Guideline, both alteplase (0.9 mg/kg IV, max 90 mg) and tenecteplase (0.25 mg/kg IV, max 25 mg) are now recommended (Class I) for eligible patients within the 4.5-hour thrombolytic window.² EMS should document and communicate the patient's weight to the receiving facility to facilitate rapid dosing.
- Avoid dextrose-containing fluids in non-hypoglycemic patients.²
- Perform and document a POC Glucose analysis and treat according to the ASA 2019-2026 Guidelines for Management of Acute Ischemic Stroke.²
 - Hypoglycemia (blood glucose <60 mg/dL) should be treated in patients suspected of acute ischemic stroke.²
- To facilitate expedited stroke workup in the ED, place at least one 18 or 20-gauge IV in the antecubital fossa or forearm (right preferred).
- To facilitate the fastest Door-to-Needle and stroke care, collect blood samples to provide the receiving facility, as long as it does not delay the transfer.
- **Assessment:**
 - **History** - Interview patients, family members, and other witnesses to determine symptoms, time of symptom discovery, and last known well or last time patient without symptoms:
 - Obtain a mobile number for the next of kin and witnesses.
 - **NOTE:** For "wake-up strokes," the time documented is the time the patient was last known well, not the time the patient was found.
 - **NOTE:** Sudden onset of any of the following suggests the possibility of acute stroke:
 - Numbness or weakness of the face, arm, and/or leg (especially on one side of the body)
 - Confusion
 - Trouble speaking or understanding language
 - Double vision, trouble seeing in one or both eyes
 - Trouble walking
 - Dizziness
 - Loss of balance or coordination
 - Sudden onset of severe headache with no known cause (suggests hemorrhagic stroke)
 - Any asymmetry of the neurological exam
 - **Additional History:**
 - Obtain the patient's history, including co-morbid conditions, past medical history, recent surgeries, prior strokes, and allergies (iodinated contrast).
 - Items to report: seizure at onset of stroke symptoms, head trauma, history of recent surgeries, history of bleeding problems, history of recent stroke, signs of possible brain hemorrhage [severe headache of sudden onset, nausea/vomiting with headache or loss of consciousness (LOC)].
 - Obtain dates for **recent events:** surgery, stroke, bleed, or

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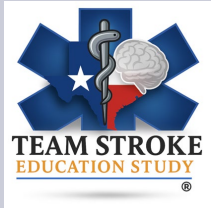
- trauma.
- Additional history: ask if symptoms are associated with a severe headache of sudden onset, loss of consciousness, nausea/vomiting, or the worst headache of their life.
- Be alert to common stroke mimics*.
- Determine if the patient has a substantial pre-existing disability (e.g., need for nursing home care or unable to walk independently).
- Obtain a list of all medications including: antiplatelet agents (e.g., aspirin, clopidogrel [Plavix]) and blood thinners (direct thrombin inhibitors [dabigatran/Pradaxa], factor Xa inhibitors [fondaparinux/Arixtra, rivaroxaban/Xarelto, apixaban/Eliquis, edoxaban/Savaysa], low molecular weight heparin [enoxaparin/Lovenox], unfractionated heparin, bivalirudin, argatroban, or warfarin [Coumadin]).
 - If possible, record when the patient took the last dose.
- Device/implant history (e.g., left ventricular assist device, pacemaker, valve replacement).
- **Examination:**
 - Assess and record blood pressure, rate, rhythm, respiratory rate, and oxygen saturation.
 - Apply a validated and standardized instrument for stroke screening, such as: FAST (Face, Arm, Speech, Test), Balance Eyes Face Arm Speech Time Tool (BEFAST), Los Angeles Prehospital Stroke Screen, Melbourne Ambulance Stroke Screen, or Cincinnati Prehospital Stroke Scale.^{1,2,4,10,30-37}
 - In prehospital patients who screen positive for suspected stroke, apply a standard prehospital stroke severity assessment tool such as: the Cincinnati Stroke Triage Assessment Tool (CSTAT), Field Assessment Stroke Triage for Emergency Destination (FAST-ED), Rapid Arterial Occlusion Evaluation Scale (RACE), Prehospital Acute Stroke Severity (PASS), Gaze-Face-Arm-Speech-Time (G-FAST), Conveniently-Grasped Field Assessment Stroke Triage (CG-FAST), Vision, Aphasia, Neglect (VAN) Assessment, Austrian Prehospital Stroke Scale, and Ventura Emergent LVO Score.^{1,2,4,10,30,34,35,37-42}
- **System Triage:**
 - The goal for on-scene time is 10-15 minutes or less. If the family is not transported with the patient, encourage them to go directly to the ED.
 - See **Annex A, B, and C: Adult Prehospital Stroke Triage Algorithm** for the adult prehospital stroke triage algorithm.
 - **Call stroke alert** and pre-notify the receiving facility that a suspected stroke patient is en route so that the appropriate resources may be mobilized before the patient's arrival.^{10,43}
 - **Pre-notification** should include the patient's name, age, LKW, time of symptom discovery, vitals, blood glucose, stroke screen and severity score, blood thinner history and last dose, sudden severe headache or loss of consciousness with symptom onset, and the phone number for the next of kin.¹⁰
 - Goal: 30 seconds for EMS to ED triage nurse hand-off.
 - **Bypass Exclusions:**
 - If severe or life-threatening trauma is suspected in addition to

APPROVAL ITEM: Adult Stroke Prehospital Recommendation

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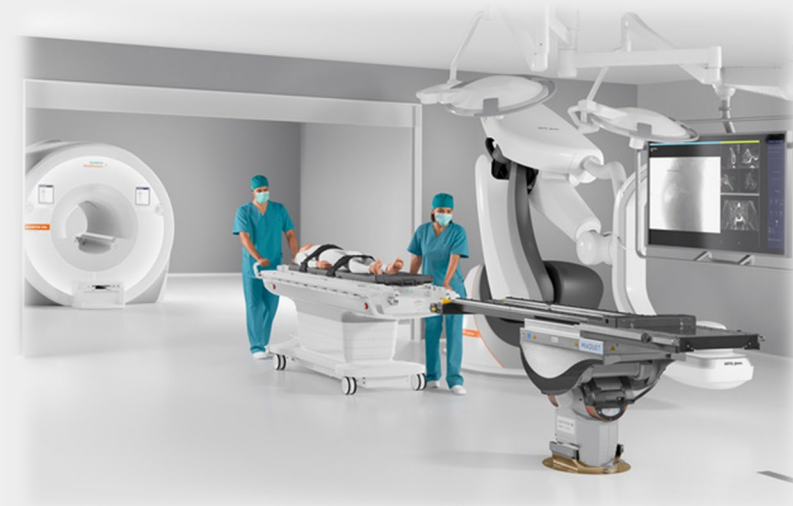
Stroke Committee

Priority Not Implemented
 Priority Activities
 Recorded
 Priorities Completed and
 being Monitored

Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	- Drs. Fagan and Winckler provided input on terminology, approved by the Stroke, EMS, Air Medical, and EMS Medical Director Committees in 11/2024. - Presented to the GETAC Council but not approved 11/2024. Participating with the EMS Time Sensitive Deconfliction Task Force.	
DIDO performance recommendations	- Approved by Committees and the GETAC Council 11/2024. - Recommendation to participate in the GWTG DIDO layer. - AHA GWTG outlines new recommendations for performance steps in DIDO Working on Best Practice recommendation for DIDO. Goal to present for approval 08/2026. Revision to DIDO Performance Goal approved by Stroke, Air Medical, EMS Committees 06/2026 Request for Council approval 06/2026	
TEAM EMS-Ed Study 	- Study endorsed by Stroke, EMS and EMS Medical Directors Committees and council 06/2025. - Informed EMS Education Committee and seeking members for writing group 08/2025. Seeking funding Working on the standardized education after revisions approved	

Optimizing DIDO

2026 Revisions



EMS Destination Management

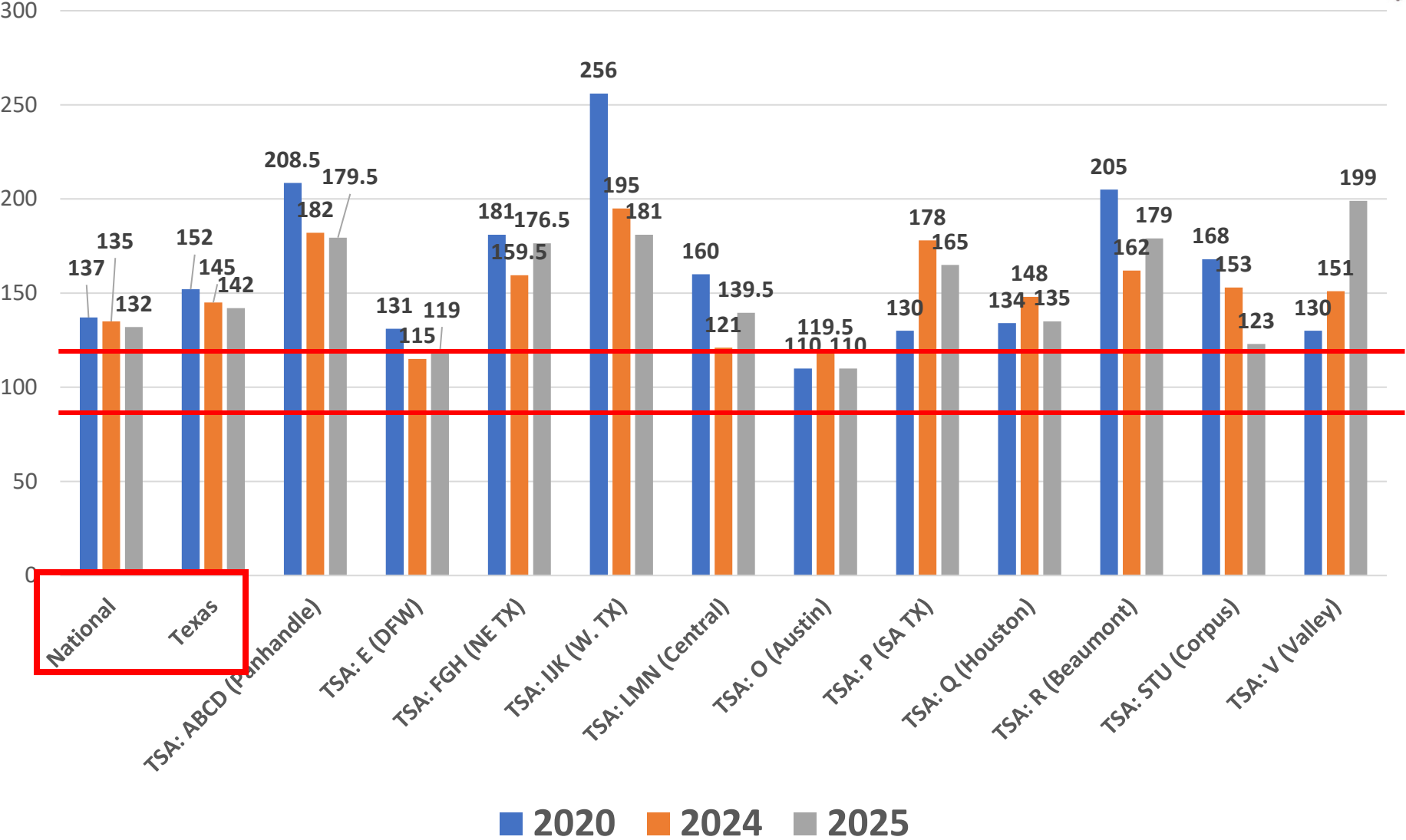
Areas without local access to TSCs	
COR	RECOMMENDATIONS
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Interhospital Transfer	
COR	RECOMMENDATIONS
1	Hospitals and EMS professionals should establish agreements and protocols to prioritize interhospital transfer of patients with acute stroke needing a higher level of care to reduce door-indoor-out (DIDO) times.





Median DIDO in minutes



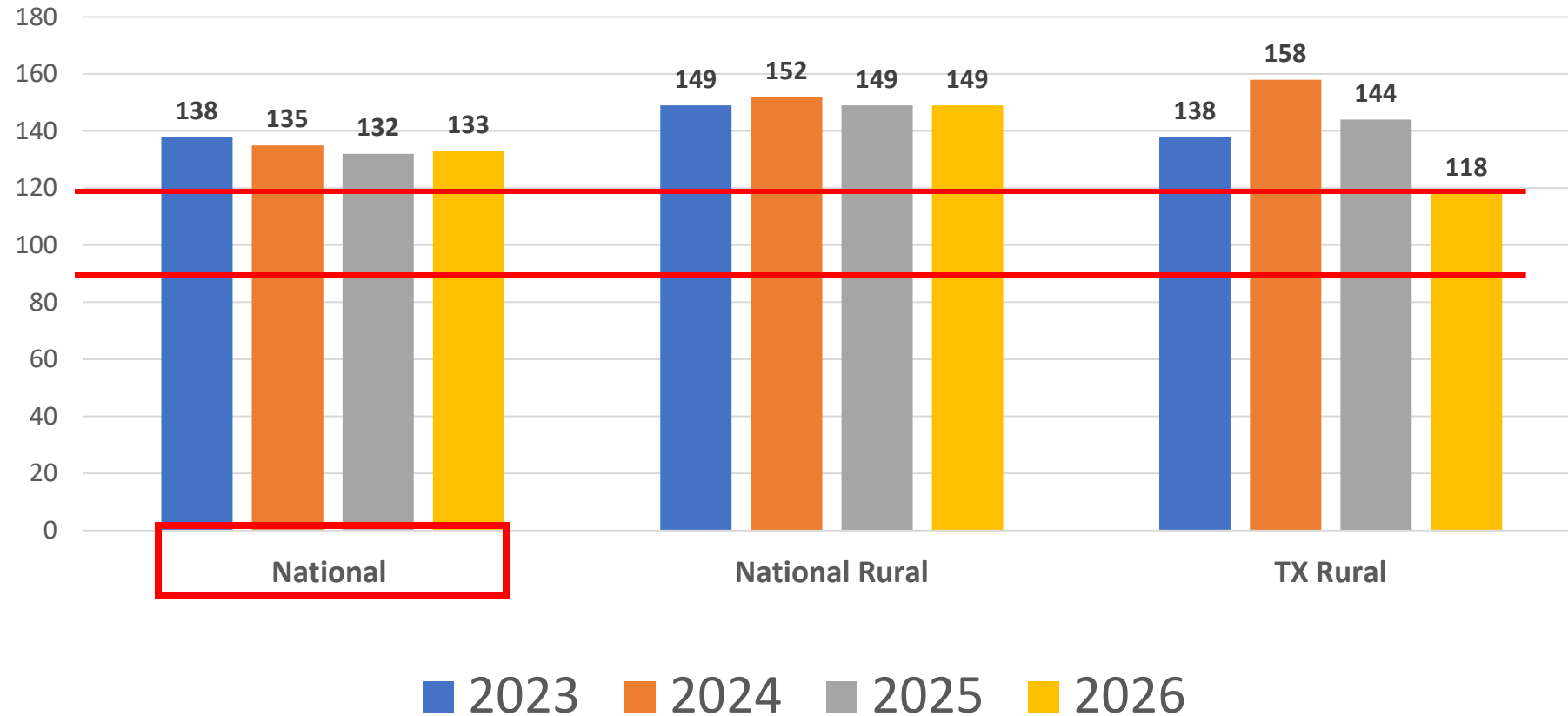
Disclaimer: Get With The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 03/10/26.

This work represents the authors' independent analysis of local or multicenter data gathered using the AHA Get With The Guidelines® (GWTG) IQVIA Registry Platform but is not an analysis of the national GWTG dataset and does not represent findings from the AHA GWTG National Program.



Rural Hospitals – DIDO

Median in Minutes



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 03/10/26.

This work represents the authors' independent analysis of local or multicenter data gathered using the AHA Get With The Guidelines® (GWTG) IQVIA Registry Platform but is not an analysis of the national GWTG dataset and does not represent findings from the AHA GWTG National Program.

DIDO Performance Goals

DIDO Metrics for patients with LVO in need of thrombectomy Goal $\leq$ 90 minutes

Transferring facility Door to Transfer Request to receiving facility and ground or air medical transport	Median 30 minutes or less (call as soon as possible) *Consider early activation if auto-accept with receiving facility is not in place
Receiving Facility Notification to Decision (acceptance or denial)	Median 15 minutes or less
Transfer Request to Transport Arrival	50% at goal: 30 minutes by air or ground urban/suburban and 45 minutes rural
Transport Arrival to Door Out	Median 15 minutes or less

OPTIMIZING DIDO GWTG

AHA STR 367, 368, 381-391 Measure %; 369-377, 380 Distribution

- Door → Stroke Team (≤ 10 min)
- Door → ED Provider (≤ 10 min)
- Door → Brain Imaging Initiated (≤ 15 min)
- Door → Brain Imaging Reported (≤ 30 min)
- Door → Advanced Imaging Initiated (≤ 45 min)
- Door → Advanced Imaging Reported (≤ 60 min)
- Door → IVT (≤ 45 min)
- Door → Transfer & Transport Requested (≤ 75 min)
- Transfer Request → Accepted (≤ 10 min)
- Transfer Request → Transport Arrived (≤ 60 min)
- DIDO ≤ 90 min
- DIDO ≤ 120 min
- Distribution of DIDO times



Get With The Guidelines®-Stroke
DIDO for EVT Transfer Measure Descriptions
Updated February 2026



[DIDO for EVT Transfer Measure
Document Feb 2026.pdf](#)

Proposed Revisions – Approval Item

Tiered Performance Framework

DIDO for EVT Evaluation $\leq$ 90 minutes AHASTR367 Goal 50%		AHASTR
Door to Transfer Requests	30 minutes or less (call as soon as possible) *Consider early activation if auto-accept with receiving facility is not in place	376 Group 6: 26-30 min
Door to ground or air medical Transport Requests	30 minutes or less (call as soon as possible)	377 Group 6: 26-30 min
Transfer Request to Accepted	10 minutes or less	390
Transfer Request to Transport Arrival	30 minutes by air or ground urban/suburban and 45 minutes rural	380 Group 6: 26-30 min Group 9: 41-45 min
Transport Arrival to Door Out	Median 15 minutes or less	173

Proposed Revisions – Approval Item

Tiered Performance Framework

DIDO for EVT Evaluation $\leq$ 120 minutes AHASTR368 Goal 80%		AHASTR
Door to Transfer Requests	75 minutes or less (call as soon as possible) *Consider early activation if auto-accept with receiving facility is not in place	388
Door to ground or air medical Transport Requests	75 minutes or less (call as soon as possible)	389
Transfer Request to Accepted	10 minutes or less	390
Transfer Request to Transport Arrival	60 minutes or less	391
Transport Arrival to Door Out	Median 15 minutes or less	173

Stroke Committee

Priority Not
Implemented
Priority Activities
Recorded
Priorities Completed
and being Monitored

Committee Priorities	Current Activities	Status
Post Acute Stroke Care Work Group	- Approved by Stroke Committee 11/2024 - Dr. Sean Savitz leads the work group - Had second meeting 02/2026 Request made at 11/2025 that the work group look into financial barriers to post-acute care. Planning to recommend best practice and performance goals to monitor 08/2026.	
Stroke Managers Mentorship Program and Texas Stroke Coordinators Collaborative Survey	- Education Work Group discussing the platform and feasibility of the mentorship program. - Working on the stroke managers' survey. - Will incorporate some questions from the prior survey.	
STRAC Stroke Program Manager Manual	- Collect and share resources related to stroke program management, stroke coordinator & manager roles, and process improvement. - Presented 11/2024, approved by stroke committee as a good resource. - Available resource from the GETAC Stroke Committee Webpage.	
Mission: Lifeline EMS Recognitions	- To bridge the gap between data EMS collects to what the hospitals collect for GWTG metrics an EMS recognition was created. - Stroke Committee approved endorsement to promote 08/2025 <u>APPROVED 11/2025:</u> Approval to distribute the Mission: Lifeline EMS Recognition to committees, RACs and at DSHS stroke meetings	

Stroke Committee

Priority Not
Implemented
Priority Activities
Recorded
Priorities Completed
and being Monitored

Committee Priorities	Current Activities	Status
Rural Stroke Work Group	- Meeting 2-3 times per quarter. Next 07/16/2026 3pm - Approved rural and resource-challenged regions and hospitals to be included in the scope of work group. - Reviewed heat maps 08/2025. - Reviewed EMSTR and GWTG rural stroke quality report semiannually (April and October). - Needs assessment survey approved by work group, Stroke Committee, and Council 08/2025. Survey closed by Rural Stroke WG 03/2026. Plan to present results 08/2026. Plan to submit abstracts and publications. Updated on the best practice recommendation for DIDO. Plan to present for approval 08/2026	

Stroke Committee

Priority Not
 Implemented
 Priority Activities
 Recorded
 Priorities Completed
 and being Monitored

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

GETAC Stroke Committee

- **Committee items needing council approval:**

1. Pediatric stroke tip sheet – 06/2026
2. DIDO Performance goals – 06/2026

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

1. DIDO Best Practice Recommendation – 08/2026
2. Revision Adult Prehospital Triage Algorithm Recommendation – 08/2026
3. Revision Adult and Pediatric Prehospital Resource Documents – 08/2026

Stroke Committee

- **Committee items needing council guidance**
 1. None at this time
- **Stakeholder items needing council guidance**
 1. None at this time
- **Items referred to GETAC for future action**
 1. None at this time

Stroke Committee GETAC Approved Recommendations

Committee Resources

[GETAC EMS Acute Pediatric Stroke Routing Resource Document](#) 

[GETAC Prehospital Pediatric Stroke Triage and Management Resource Document](#) 

[GETAC Door-in/Door-out \(DIDO\) Performance Goals](#) 

[GETAC Prehospital Adult Stroke Triage and Management Resource Document](#) 

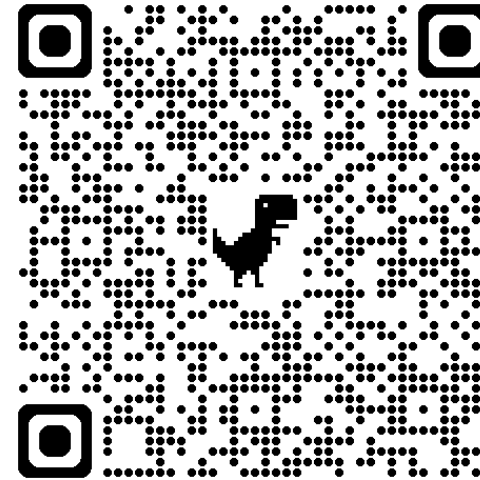
[GETAC EMS Acute Stroke Routing Resource Document - Urban](#) 

[GETAC EMS Acute Stroke Routing Resource Document - Suburban](#) 

[GETAC EMS Acute Stroke Routing Resource Document - Rural](#) 

[Southwest Texas Regional Advisory Council \(STRAC\) Stroke Program Manager Manual](#) 

GETAC Stroke Committee Page:



(Scroll to bottom of the page)

II.C.6. GETAC Injury Prevention & Public Education Committee Update to Council

Chair: Mary Ann Contreras, RN

Vice-Chair: Courtney Edwards, DNP



TEXAS
Health and Human
Services

Texas Department of State
Health Services

Injury Prevention Public Education Committee

6/2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1.Pillar: Clinical Elements Objective #4 Identify evidence-based prevention strategies that increase capacity for a safe and healthy lifestyle	<i>Translate Texas Trauma Registry data that focuses on the top 3 mechanisms of injury resulting in fatality: Falls, MVC (including CPST expansion) and GSW. -Include: the development of:</i> <i>Discussion of broad methods identifying effective prevention strategies</i> - ACTFAST: adopting Comprehensive Training for Firearm Safety in Trauma Centers. Johns Hopkins University Research in 3 Pediatric trauma Centers and 3 Adult Trauma Centers. -Invited speaker for August meeting: Katherine Hoops, MD, JD, MPH Associate Professor and Division Chief Anesthesiology and Critical Care Medicine - Pediatric Critical Care Medicine Director of Clinical Programs and Practice Health Policy and Management - Center for Gun Violence Solutions Johns Hopkins University will speak on the current project and findings in the August GETAC meetings. https://publichealth.jhu.edu/center-for-gun-violence-solutions/actfast	

Injury Prevention Public Education Committee

6/2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1.Pillar: Clinical Elements Objective #4 Identify evidence-based prevention strategies that increase capacity for a safe and healthy lifestyle	<i>Translate Texas Trauma Registry data that focuses on the top 3 mechanisms of injury resulting in fatality: Falls, MVC (including CPST expansion) and GSW. -Include: the development of:</i> <i>Discussion of broad methods identifying effective prevention strategies</i> <i>-Continuing work with the national strategy sessions for increasing expansion of Child Passenger Safety Professionals via Safe Kids. Exploring systemic changes and updates in addressing workforce expansion, educational standards and delivery.</i>	

Injury Prevention Public Education Committee

6/2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
2. Pillar: System Support Objective #2 Explore innovations for providing interactive, collaborative, and targeted public education.	Strategy: 4 Promote and provide information to local agencies related to bystander education and training so that they can provide timely and appropriate interventions. - Drowning Prevention Workgroup: in progress with partnering in the development of the Texas Water Safety Prevention Plan to align with existing state and national plans to promote drowning prevention strategies for public consumption across the State of Texas. Editing Texas boating safety document, working to standardize requirements for floatation devices with the national organizations. - Facilitated educational sessions with Texas Policy makers regarding water safety plans for the state	

Injury Prevention Public Education Committee

6/2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1.Pillar: Clinical Elements Objective #2 <i>Incorporate safety and injury prevention into the fabric of organizational culture and operations utilizing effective methodologies</i>	Strategy #3: Develop current messaging for stakeholders and policy makers providing relevant data surrounding: Evidence-informed strategies to prevent injuries. - Report from Lisa Sullivan Texas Suicide Prevention Coalition: Findings of recent American Association of Suicidology: Nurses are the #1 Licensed healthcare professional lost to suicide. - JAMA reports nurses have the highest risk for suicide, both male and female -American Nurses Association- the highest risk for licensed clinical group for suicide is nursing- Contributing risk factors include: • High burnout/emotional labor • Exposure to death and trauma • Shift work/sleep deprivation • Workplace stress	

Injury Prevention Public Education Committee

6/2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
2. Pillar: System Support Objective #4 Identify evidence-based prevention strategies that to increase capacity for a safe and healthy lifestyle.	Strategy: 3 Develop current messaging for stakeholders and policy makers providing relevant data surrounding: Evidence-informed strategies to prevent injuries -Electric bicycles are an increasingly popular mode of transportation and recreation. Their use is associated with a growing number of serious injuries, particularly among children and adolescents. -What mechanisms are available to report crashes, injuries, and deaths involving electric bicycles, including those not treated at trauma centers? -What methods are validated to identify/report specific e-bike devices -Need for consistency in identifying injury patterns -What current ICD codes are assigned to e-bike MOI/types of devices	

Action Item Request and Purpose

- Review of state/trauma and EMS databases on the prevalence of micro- mobility injuries in the state of Texas over a 5-year period.
- Micro-mobility devices are an increasingly popular mode of transportation and recreation. Their use is associated with a growing number of serious injuries, particularly among children and adolescents. There is a need to address this emerging public safety problem through evidence-based policy and injury prevention strategies.
- Data from the DSHS trauma and EMS systems will provide a foundation to identify opportunities to reduce harm and improve outcomes.

II.C.7. GETAC EMS Committee Update to Council

Chair: Chief Kevin Deramus, LP

Vice-chair: Chief James Campbell, LP



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Health Services

II.C.8. GETAC EMS Medical Directors Committee Update to Council

Chair: Christopher Winckler MD, LP

Vice Chair: Elizabeth Fagan MD,



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Texas Department of State
Health Services

EMS Medical Director Committee

[2026] Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

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

EMS Medical Director Committee

[2026] Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

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

EMS Medical Director Committee

[2026] Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
6. Review GETAC Air Medical documents regarding process and care for inter-facility transfers.	Reviewed documents and made recommendations for these documents. Dr. Wentling is liaison for this project	
7. Approve stroke Committee documents. Two pediatric resource documents and update door in door out.		
8. Participate in the EMS Committee’s review of 157.11 and 157.14. Completed 2025 activities include:	<i>Participation in committee review. Planned upcoming Panel Discussion on 157.11 at TX NAEMSP</i>	

II.C.9. GETAC Trauma System Committee Update to Council

Chair: Stephen Flaherty, MD, FACS

Vice Chair: Raul Barreda, MD, FACS



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Services

Texas Department of State
Health Services

Trauma Systems Committee

2025 Committee Priorities Update

Priority Not Implemented

Priority Activities Recorded

Priority Completed and Monitored

Committee Priorities	Current Activities	Status
SCOR Project Transfer delays for patients with severe hypotension or GCS < 9	• Project is track is longer than expected, but progressing • Effective PI projects at the RAC level have developed • PI project by RAC U (Corpus Christi) showed that almost all the patients identified by this project to be a transfer delay received appropriate care without transfer delay. Further PI analysis to be performed at the RAC level. • Project continues	

Becker Hospital Review

- Recent publication suggesting a potential loss of 20+ rural hospitals in Texas due to financial hardships
- TETAF is engaged
- This committee will follow developments

Pre-hospital Blood Project

- Don Jenkins provided an overview of the Texas prehospital blood project
- Committee would like to develop a PowerPoint presentation in conjunction with Dr. Jenkins that can be used by members as an educational tool for hospital leadership and also medical staffs. Education program would be developed in conjunction with RAC chairs.

GETAC Committee/Stakeholder Action Item Request for Council

Stephen Flaherty, MD, FACS
Trauma Systems Committee



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Services

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Health Services

Action Item Request and Purpose

- Develop and implement an education offering for hospital staff and leadership that would be offered as education in conjunction with RAC Chairs.

II.C.10. GETAC EMS Education Committee

Chair: Macara Trusty, LP

Vice-Chair: Christopher Nations, LP



TEXAS
Health and Human
Services

Texas Department of State
Health Services

EMS Education Committee

2026 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

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

II.D. Task Force Updates and Action Items



II.D.2. Burn Care Task Force

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

II.D.3. Time-sensitive Transfer Deconfliction Task Force

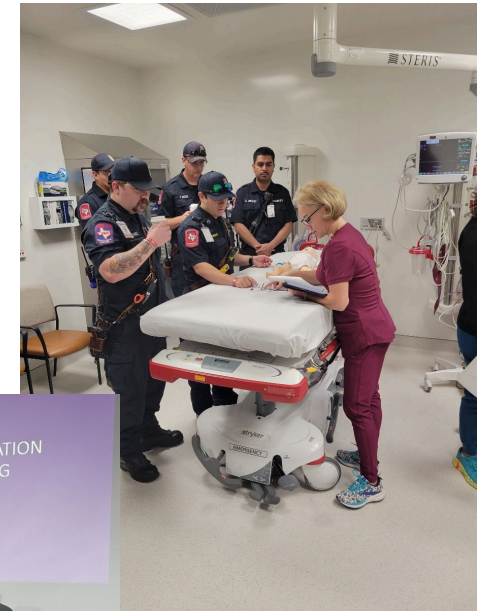
Ryan Matthews

II.E. Updates



II.E.1. Update: TX Pediatric Readiness Improvement Project

Sally Snow



Texas Pediatric Readiness Improvement Project Update
GETAC June 2026

Texas Pediatric Readiness Improvement Project (TPRIP)

Project Arms:

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

Supported by:

GETAC

Texas EMS for Children

Texas ENA

Texas Trauma Coordinators
Forum

TETAF

NPRQI

Everyday Pediatric Readiness



For EDs

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

Est.
2012



For EMS

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

Est.
2019





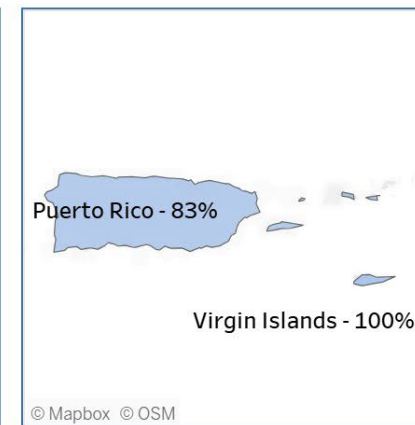
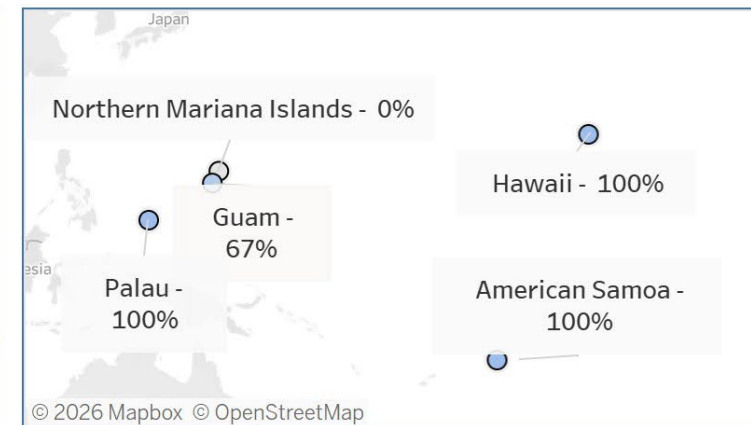
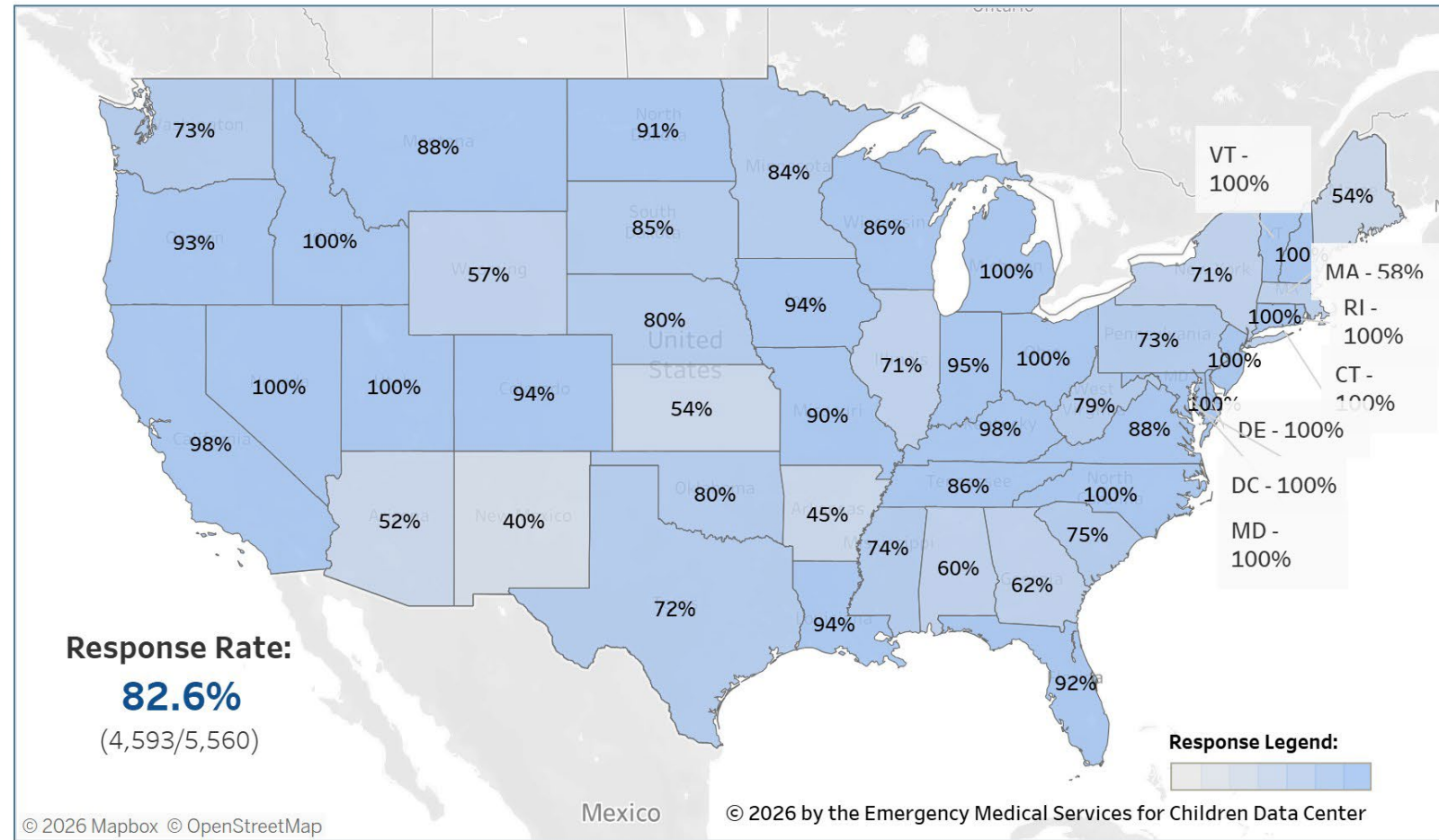
NPRP is funded by the Health
Resources and Services
Administration EMSC Program

2026 National Pediatric Readiness Project (NPRP)

Response Rate by State/Territory

Last Updated: 6/1/2026 9:55:43 AM

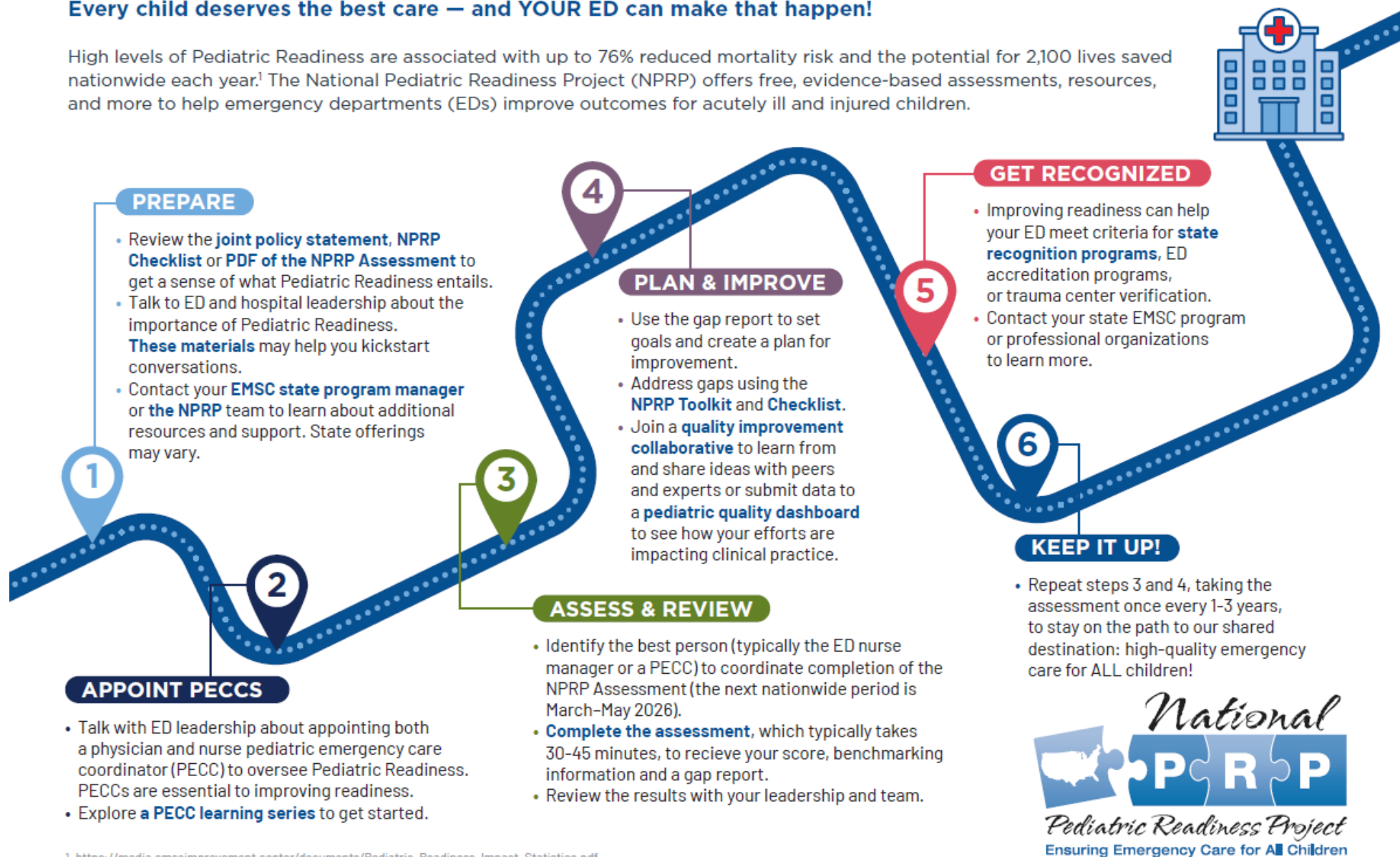
State Name	Numerator	Denominator	Response Rate
NEW YORK	137	192	71%
North Carolina	138	138	100%
North Dakota	40	44	91%
Northern Mariana I..	0	1	0%
Ohio	222	223	100%
Oklahoma	94	118	80%
Oregon	54	58	93%
Palau	1	1	100%
Pennsylvania	125	172	73%
Puerto Rico	39	47	83%
Rhode Island	12	12	100%
South Carolina	60	80	75%
South Dakota	47	55	85%
Tennessee	106	123	86%
Texas	448	623	72%
Utah	60	60	100%
Vermont	14	14	100%
Virgin Islands	3	3	100%
Virginia	105	119	88%
Washington	74	102	73%
West Virginia	37	47	79%
Wisconsin	119	138	86%
Wyoming	16	28	57%
Grand Total	4,593	5,560	83%



The Route to Pediatric Readiness in Emergency Departments

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

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



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

Checklist

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

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

Download checklist 



Pediatric Readiness in the ED Checklist

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

Administration and Coordination ☐ Physician Pediatric Emergency Care Coordinator (PECCP) • Board certified/eligible in EM or PEM (preferred but not required) • If not board certified in EM or PEM, meets qualifications for credentialing by the hospital as an emergency clinician specialist with special training and experience in the evaluation and management of the critically ill/injured child • Role may be shared with an advanced practice provider who is credentialed to care for patients in the ED ☐ Nurse PECC* • Has special interest, knowledge, and skill in the emergency nursing care of children • Certified Emergency Nurse (CEN)/Certified Pediatric Emergency Nurse (CPEN) is desired • Other credentials (CPN, CCRN) are acceptable. *The Physician and Nurse PECCs work collaboratively on Pediatric Readiness initiatives. See the technical report for detailed roles and responsibilities.	Competencies for Physicians, Advanced Practice Providers, Nurses, and Other ED Health Care Clinicians ☐ Health care providers who staff the ED have baseline and interval updates of skills and procedures to maintain pediatric competencies for neonates, infants, children, adolescents, and children with special health care needs. Continuing education may be used to fulfill certain competencies, but interval updates of skills and procedures are strongly encouraged. Areas of pediatric competencies and professional performance evaluations may include but are not limited to: • Assessment and treatment (e.g., triage, illness and injury, pain, mental/behavioral health emergencies) • Medication administration and delivery • Device/equipment safety (e.g., low-volume infusion pumps) • Critical procedures • Resuscitation (neonatal and pediatric) • Trauma resuscitation and stabilization • Patient- and family-centered care • Team training and effective communication
Support Services ☐ Evidenced-based imaging and laboratory testing policies and guidelines (e.g., Choosing Wisely) are used. • Medical imaging capabilities and protocols address age- or weight-appropriate dose reductions. • The laboratory has the skills, personnel, and capability to perform laboratory tests for children of all ages, including obtaining samples and the availability of microtechnique for small sample sizes. ☐ All efforts are made to transfer completed images and laboratory results when a patient is transferred from one facility to another. ☐ There is collaboration with other ED support services to meet the needs of children in the community. ☐ There are personnel capable of providing supportive, family-centered, trauma-informed care, including specially trained social workers, nurses, chaplains, mental health professionals, or child life specialists.	Quality/Performance Improvement (QI/PI) ☐ A defined QI/PI plan that involves chart review of all pediatric deaths and pediatric-specific indicators where: • Data are collected and analyzed. • Process improvement strategies are implemented. • System changes are implemented based on performance. • Performance is monitored over time. Please see the guidelines and NPRP toolkit for recommended quality metrics for pediatric emergency care.

Toolkit

National Pediatric
Readiness Project

About

Assessment

Checklist

Toolkit

Prepare

Appoint PECCs

Assess and Review

Improve

Publications

Spread the Word

FAQs

Contact

Questions or Feedback on the
NPRP Toolkit?

Contact us

Sign Up for Updates

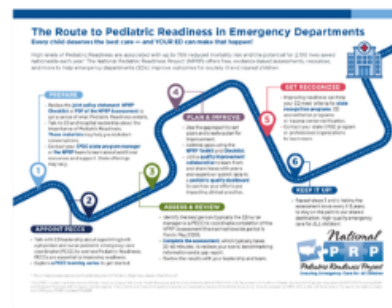
The NPRP Toolkit has been redesigned to align with the [NPRP Roadmap](#), making it easier to navigate resources in a structured, step-by-step way. If you have trouble finding something, please [contact us](#).

The National Pediatric Readiness Project Toolkit

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

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

To submit content or feedback for this toolkit, [use this form](#). Questions about the toolkit? Contact us.



To submit content or feedback for this toolkit, [use this form](#). Questions about the toolkit? Contact us.



Section 1: Prepare
Build Awareness and Get Leadership Buy-In



Section 2: Appoint PECCs
Establish and Develop Nurse and Physician Coordinator Roles



Section 3: Assess and Review
Measure Your ED's Readiness and Understand Your Results



Section 4: Plan and Improve
Implement Changes to Advance Pediatric Readiness



Section 5: Get Recognized - COMING SOON!
Validate and Celebrate Your Progress



Section 6: Keep It Up - COMING SOON!
Sustain Your Progress through Continuous Improvement



Section 7: More to Explore - COMING SOON!
Expand Your Impact and Pediatric Readiness Beyond

Pediatric Readiness Virtual Education Series

January - no session

February - Head Trauma

- Registrants: 1460
- Unique Viewers: 596

March – Mental Health

- Registrants: 1732
- Unique Viewers: 550

April – Fever

- Registrants: 1921
- Unique Viewers: 543

May – Submersion Injuries

- Registrants: 2152
- Unique Viewers: 521

Upcoming Topics

July 16 - Disaster Preparedness in the ED

Deanna Dahl-Grove, MD & Michelle Moegling, MBA-HM, BSN, RN, CPN

August 20 - Use of whole blood/blood products in pediatric trauma

Barbara Gaines

September 17 - Management of Pediatric Asthma

Kaileen Jafari, MD

October 15 - Neonates in the ED

Patricia Padlipsky, MD

November 19 - Pain Management

Corrie Chumpitazi, MD

December 17 - Evidence Supporting Pediatric Readiness

Craig Newgard, MD

Pediatric Readiness Education Series



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

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

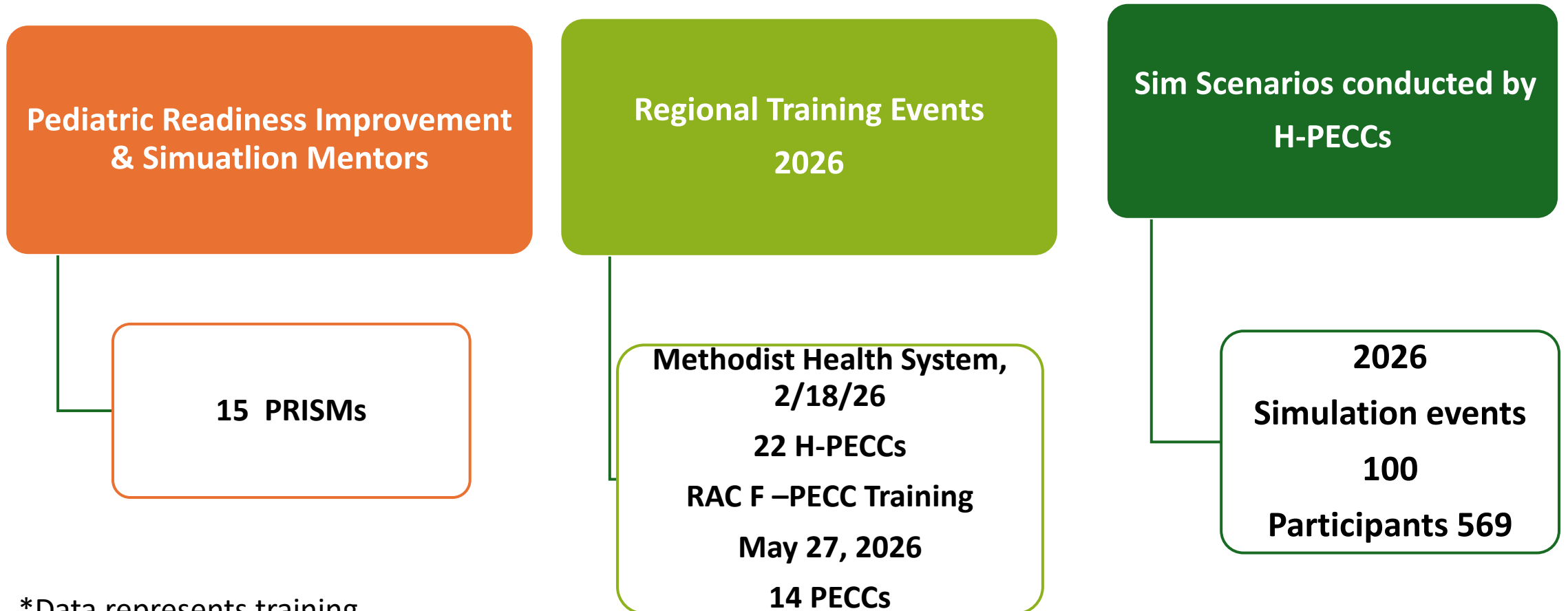
All webinars are free. The series is not affiliated with the Texas EMSC State Partnership Program. Participation is currently limited to the first 1,000 attendees. If you are unable to attend, the event will be recorded.

- The archive link : <https://utexas.box.com/v/txprieducationseries>. The sessions from round 1 are now in one folder. The new sessions will just be added to the existing folder.



**Scan QR Code
or click here
to register.**

PRISMs with Hospital PECCs



*Data represents training
done Jan-June 2026

PRISMS by RAC

John and Glenda Sappington RAC-A

Vicente Martinez RAC-B

Belinda Waters RAC-B

Spencer Jackson, RAC-D

Barry Hudson RAC-E

Amy Tucker RAC-E

Brittany Ray RAC-G

Heather Casebeer RAC J/K

Verline Steptoe RAC I

Robin Hazlett RAC Q

Eric Parmley RAC Q

Ronnie Hamilton RAC R

Santana Olvera RAC R

Jules Boatright RAC U

Samantha Martinez RAC V

Simulation Videos Status

Complete and Available:

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

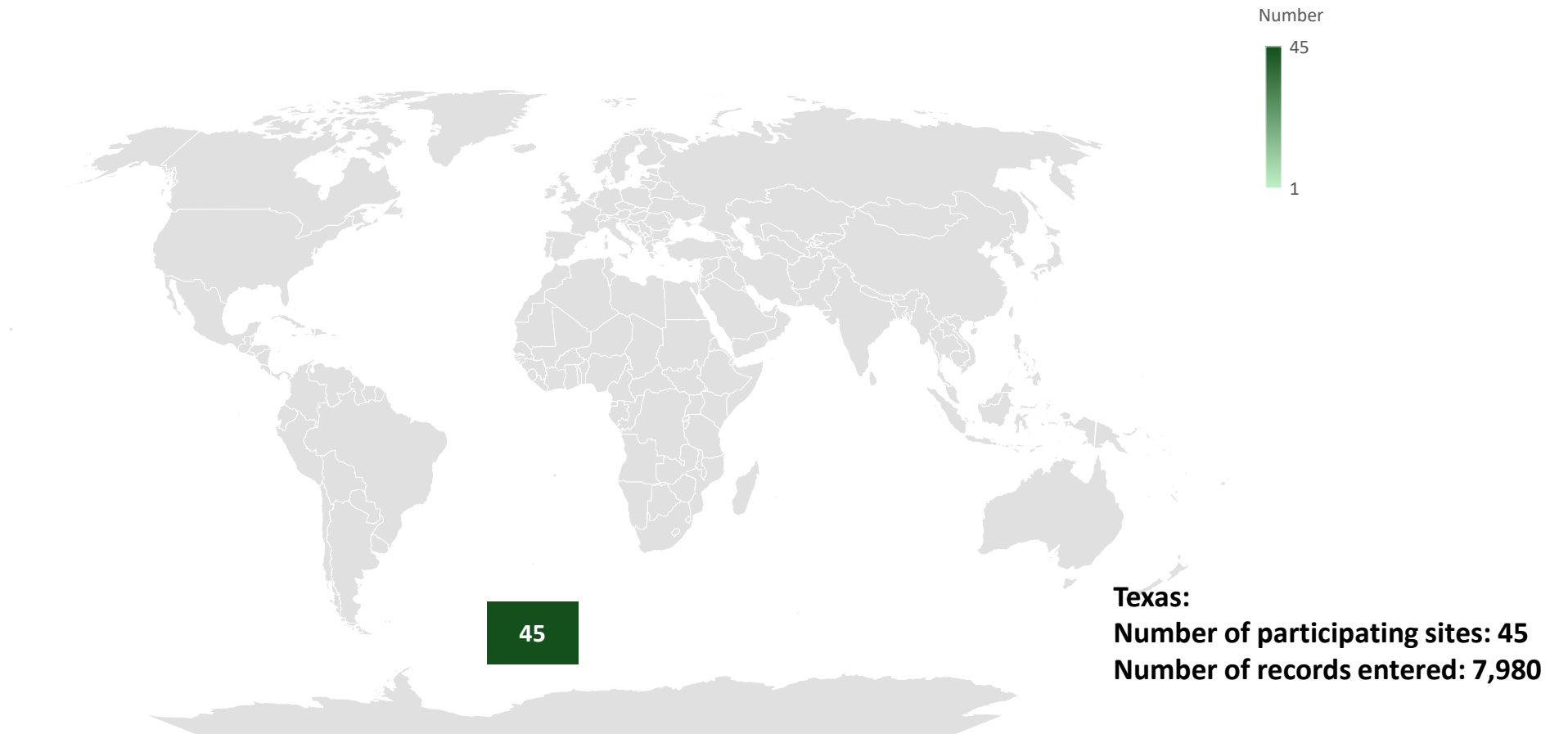
Still in Production:

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

www.emergencysimbox.com

NPRQI: Participating Sites

Executed Nexus POAs

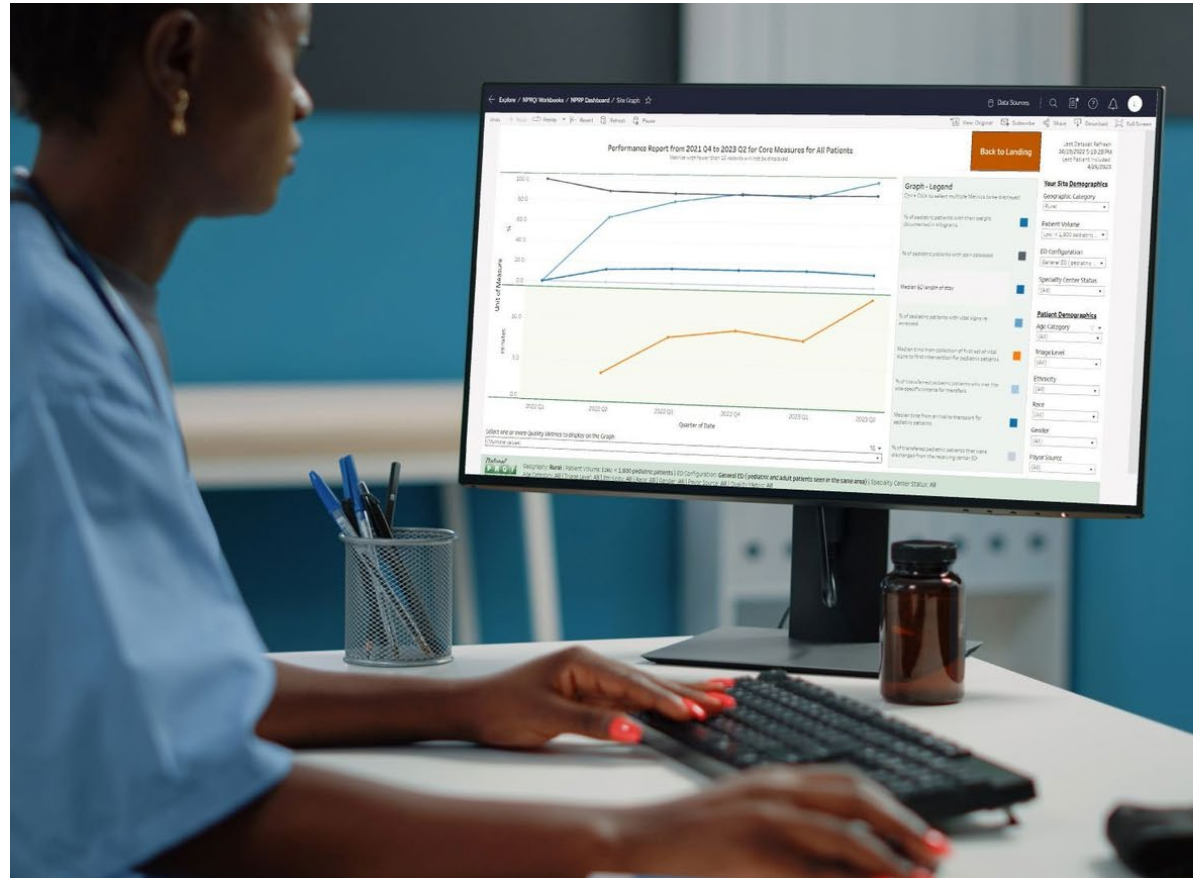


NPRQI: Texas Participating Sites

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

Enhanced Engagement

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



II.E.2. Texas EMS, Trauma & Acute Care Foundation (TETAF)

Dinah Welsh, TETAF President/CEO

TEXAS EMS, TRAUMA AND ACUTE CARE FOUNDATION UPDATE

Dinah Welsh
TETAF President & CEO
June 5, 2026



TETAF Rural Trauma System Fund

- **THANK YOU** to all who attended the TETAF Rural Trauma System Fundraiser on Tuesday at Tumble 22.
 - Couldn't attend? Another opportunity to contribute to the fund and win either a \$300 YETI Coolers merchandise package or a \$250 gift card to Tecovas. Scan the QR code to participate in our raffle.
- Because of the fundraiser, the TETAF Board of Directors meeting will be via Zoom on Thursday, June 11 at 3:00 p.m. CDT. Zoom link is on the homepage of the TETAF website under Events or under the Board of Directors tab at the bottom of the webpage.



TETAF Surveys

Trauma, Stroke, Maternal, and Neonatal

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

TETAF Advocacy

- The 90th Texas Legislative Session begins January 12, 2027. (221 days away)
 - Interim charges have been released. TETAF is monitoring meetings and discussions taking place.
 - The TETAF Advocacy Committee will have the TETAF Legislative Priorities finalized by late summer.

TETAF Education

- **SAVE THE DATE:** The next TETAF Hospital Data Management Course (HDMC) will be **Thursday, September 24** and **Friday, September 25**. Registration details will be released in late summer via the TETAF newsletter, social media, Mighty Networks, and website.

TETAF Collaboration

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

II.F.1. American College of Surgeons (ACS) Consultative Visit



II.F.2. Texas State Trauma System Plan



II.F.3. Executive Committee Activities Summary

Executive Committee:

Alan Tyroch, MD, GETAC Chair

Ryan Matthews, GETAC Vice-Chair

Scott Lail, GETAC Council Member



TEXAS
Health and Human
Services

Texas Department of State
Health Services

III.A. Next Council Meeting Dates



Quarterly Meetings:

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

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

FY27 Q1: November 20-23, 2026 (Fort Worth)

2027:

FY27 Q2: March 9-12 (Austin)

FY27 Q2: June 15-18 (Austin)

FY27 Q3: August 17-20 (Austin)

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

FY28 Q1: November 19-22, 2027 (Fort Worth)

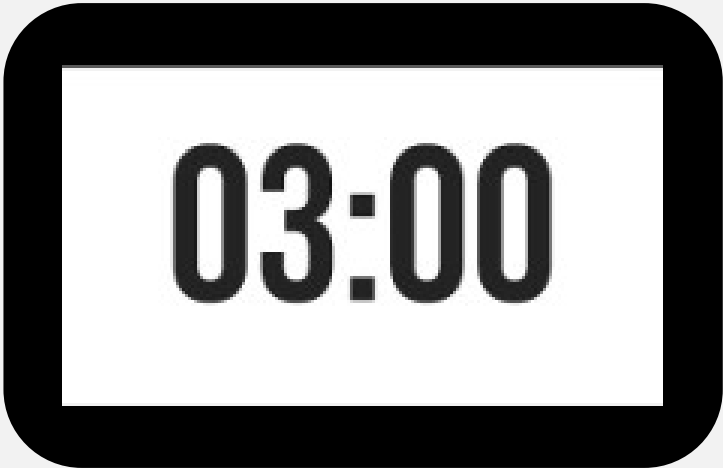


III.B. Final Public Comment

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

Please state the following when making comments:

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



03:00



Texas Department of State
Health Services



III.C. Adjournment - **Alan Tyroch, MD, GETAC Chair**

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