

# Governor's EMS and Trauma Advisory Council (GETAC)

## Department of State Health Services (DSHS)

Friday, August 22, 2025  
 DoubleTree Hotel by Hilton Austin  
 Phoenix Central Ballroom  
 6505 N IH 35, Austin, TX 78752

### Meeting Minutes

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

[Link to Meeting Presentation](#)

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<b>Agenda Item</b>	<b>Discussion</b>	<b>Action Plan/ Responsible Individual</b>	<b>Status</b>	<b>Comments/ Targeted Completion Date</b>
<b>1. Call to Order from Recess</b>	Dr. Tyroch called the GETAC Q3 meeting to order at 8:00 AM. The meeting was conducted in compliance with the Texas Open Meetings Act and was webcast for public record.			
<b>2. Roll Call</b>	The meeting opened with instructions regarding public recording, use of chat for attendance, guidelines on language and confidentiality, and the process for public comments from both virtual and in-person attendees. Sabrina Richardson (DSHS) called the roll for GETAC and noted a quorum of members had been achieved.			
<b>3. Welcome</b>	Dr. Tyroch read the GETAC vision and mission statements.			
<b>4. Review and Approval of Minutes</b>	The June 6, 2025, Q2 minutes were presented for approval. Chief Daniel Ramirez moved to approve Q2 minutes, and Dr. Kate Remick provided a second. The motion carried, and the minutes were approved without further discussion.		Minutes approved.	
<b>5. Chair Announcements</b>	Dr. Tyroch introduced the newest council member, Aundrea Young. He announced the members whose terms expire in January 2026 and provided information about the application process. Mike Clements, Judge Mike DeLoach, Dr. Brian Eastridge, Della Johnson, Aundrea Young, Cassie Potvin, and Dr. Troutman all have terms expiring in January. Dr. Tyroch provided information about the upcoming GETAC committee application period open from September 1 to September 30, 2025. The upcoming terms will all be three-year terms moving forward, with the elimination of the one-year term for new applicants. Committee member proposals will be presented to Council by committee years at the upcoming strategic planning retreat in October. Dr. Tyroch reported the EMS/Trauma Annual Awards nomination period is now open. Visit <a href="https://www.dshs.texas.gov/dshs-ems-trauma-systems/texas-ems-conference">https://www.dshs.texas.gov/dshs-ems-trauma-systems/texas-ems-conference</a> for more information.			Share Committee and Council application information with council and committee chairs.
<b>6. State Reports</b>				

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<p><b>6.a. DSHS EMS/TS</b></p>	<p>➤ <b>Jorie Klein, Director of EMS/Trauma Systems (EMS/TS) Section,</b> provided an update on the activities occurring since the last GETAC meeting.</p> <p><b>Trauma Rules</b> Director Klein reported that the Designation Unit has been focusing on the implementation of 157.126 in September. The unit has developed a gap analysis and revised the survey guidelines. The gap analysis was pushed about 5 months ago, and the survey guidelines are expected to be released next week.</p> <p><b>Designation Review Committee</b> The application period has closed. Two applicants have been chosen and are going through the participation validation process. Once that is complete, selection letters go to Dr. Shuford for an appointment. Applicants who were not selected at this time will receive a notification letter.</p> <p><b>Trauma Designation Questionnaire</b> The Trauma Designation Questionnaire is ready to go. It will work like it does with the American College of Surgeons. When a facility submits its application for verification designation review, it is received by the department. The department will send the questionnaire for them to begin to fill out. Additionally, the department will also have monthly webinars to walk people through how to fill out the questionnaire. The department has reviewed all of the designation standards, as well as the requirements, with all four levels of trauma facilities.</p> <p><b>New Initiative – PI: Ask the Experts</b> Director Klein discussed a new initiative where attendees on the PI: Ask the Experts call can ask questions about PI in an open dialogue forum. Dr. Don Jenkins, former chair of the ACS Performance Improvement Committee, leads the meeting with Dr. Tyroch, Dr. Greenberg, and Texas TOPIC instructors on the call. Director Klein acknowledged Danielle Sherer from John Peter Smith and Leanne Young from Texas Children's for their contributions to the call last month. Ms. Shearer presented on</p>	<p>Information only. No action items identified.</p>		<p>Continue quarterly updates to Council.</p>

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	<p>how her facility provides feedback to EMS and transferring facilities. Director Klein noted that a best practice model that is utilized by JPS is their quarterly visits to those hospitals to share information on the transfers that came to JPS. Ms. Young shared their process for EMS, as well as for anybody in or outside of the hospital, to send referrals into their trauma performance improvement process. Additionally, Texas Children’s has developed a recognition program specifically for the nurses involved in trauma care. These calls occur on the second Tuesday of the month at 3 PM. Cheryl Cloud from JPS will present on data quality plans at the next meeting.</p> <p><b>Designation Review Committee</b> This group will look at all the designation appeals and waivers that are submitted through a designation review via this process. Applications closed June 2, 2025.</p> <p><b>EMS Funding Overview</b> Director Klein shared that \$112.3M was budgeted for FY 25, with \$96M for grants/passthrough provision for either EMS, trauma facilities, or RACs. Director Klein stated 5111 is the largest account, and it is where money is allocated for uncompensated care, RACs, and RAC EMS Pass-through money comes from. Currently, the fund receives 30% of what is collected from traffic fines, with 70% going to the state General Revenue (GR) fund. Senate Bill (SB) 1018 allows for the redistribution of the percentage of traffic fines collected and allocated to the department to increase from 30% to 50%. Currently, it is not well-understood how this will affect program funding – will this replace the amount that was taken from GR to cover the funding lost when the tobacco endowment went away, or will this be in addition to what is received? Any potential increase in funding will not be seen until FY26.</p> <p>Director Klein explained the factors used in calculating the RAC funding allotment: size of the RAC, population of the RAC, and percentage of trauma care provided in the RAC (the number of EMS responses and the trauma submissions to the registry). Director Klein addressed questions</p>			

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	<p>received regarding the exceptional item (EI) funding that the RACs received (\$150K each year of the biennium). Any funds not spent in the first year of the biennium may roll over to the second year, but any funds not expended by the end of the second year must be returned; therefore, any funds remaining at the end of the state FY25 must be returned. She shared the total projected funding allotments for the RACs - \$13,219,560 for FY 2026.</p> <p><b>Extraordinary Emergency Fund (EEF)</b> Director Klein commended the work of Joe Schmider and Sunita Raj who worked diligently to review applications. Thirteen applications were received (nine awarded, four denied), and \$999,999.34 has been expended, with \$0.66 remaining. She noted that eight grants were awarded to rural counties, and one was awarded to a provider who serves both rural and urban counties. The most common needs are related to an ambulance.</p> <p><b>Emergency Care Attendant Training (ECAT)</b> One grant application (rural county) was received and awarded for sixteen students. Total expended was \$5,049.57, with \$19,950.37 remaining funds for ECAT.</p> <p><b>Trauma Uncompensated Care (UCC) Funding</b> Director Klein reported that everyone has received their payment. There are two hospitals that have not refunded their Medicaid overpayment (unrelated to trauma), so until those funds are recouped, the Trauma UCC payments will not be posted on the department website. The new application will be posted in November for 2026. Director Klein reported that 287 trauma-designated hospitals applied for trauma UCC in 2025, with three of them in active pursuit (IAP) of designation. Over \$3.67B requested, and after validation, \$859M met the criteria for uncompensated charges. She mentioned that 176 Level IV hospitals have requested funding for this year, ninety-two of them rural. Director Klein explained the HHSC trauma funding process regarding the standard dollar amount (SDA) and Medicaid reimbursement. She added that the important thing to remember with the SDA is that increasing the Medicaid reimbursement</p>			

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	<p>rate for Medicaid trauma patients increases the reimbursement rate for all Medicaid patients. Director Klein asked for questions or comments. Dr. Tyroch commented on how the amount of charges for trauma care has doubled.</p> <p>.</p> <ul style="list-style-type: none"> <li>➤ <b>Designation Unit:</b> Elizabeth Stevenson, RN, Designation Unit Manager stated there would be a report at the November meeting since the current quarter has not yet concluded.</li> </ul> <p>September- November 2024 and January-February 2025. Monthly call discussion included diversion versus acceptance of transfers, survey organization requirements for higher-level certification differences, program manager mentoring resources, and suggestions for future meeting content.</p> <ul style="list-style-type: none"> <li>➤ <b>Joey Ancelet, EMS East Group Manager, provided EMS Unit updates.</b></li> </ul> <p>Mr. Ancelet reported that ambulances are being stolen at a rapid rate – approximately one ambulance every two weeks. This is occurring at emergency departments or on scene. Providers were advised to have a plan in place so that they do not become part of that statistic.</p> <p><b>Hurricane Season</b></p> <p>Mr. Ancelet reminded attendees that we are in peak hurricane season and to plan accordingly, as it is expected to be an active season.</p> <p><b>Workforce</b></p> <p>It was reported that the EMS workforce has increased by 12,811 certified personnel since 2022, and while it appears that there has been a loss of ECAs, the hope is that those decreased numbers are reflected in the increased certification numbers as certification upgrades.</p> <p><b>NEMSIS V5 Patch</b></p> <p>Gavin Sussman, EMSTR, stated the patch was rolled out in early July to make the patient’s biological sex available. He added that the element will become required reporting beginning October 21, 2025. Mr. Sussman</p>			

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	<p>stated it was imperative that agencies get the patch because not doing so would fail the record.</p> <p><b>89<sup>th</sup> Legislative Session Rule Updates</b></p> <p>Sabrina Richardson provided a brief rule update. Senate Bill 1818, which is the military licensing for a provisional license for military members, veterans, and military member spouses, is going in front of the Executive Council on September 18, 2025. It will be available for public comment via the <i>Texas Register</i> on October 5 and will be effective November 30. Ms. Richardson reported that there would be an update to Occupations Code Sections 55.004 and 55.0041 and shared the application requirements. Senate Bill 1818 is the priority right now, and then once that's done, the department will move on to the other amendments that are going to be required. The following bills and related rules will be updated per bill requirements and plain language standards, with a target completion date of fall 2026.</p> <ul style="list-style-type: none"> <li>○ 157.11 - HB 33 Active Shooting Education: Schools, EMS, fire, police, and Emergency Management will be required to plan together and conduct drills. It will be added to the 157.11 rules. There is a reporting requirement with this.</li> <li>○ 157.36 - House Bill (HB) 35 Peer Support System: This bill ensures that each organization has somebody looking after their staff. Law enforcement passed this a few years ago and implemented a process.</li> <li>○ 157.32/33/34 - HB 743 Human Trafficking Education: Requires EMS and emergency departments (ED) to be educated on human trafficking and how to recognize it.</li> <li>○ 157.37 - SB 1021 Stalking Conviction: A stalking conviction can disqualify someone from certification. This applies to all arrests for stalking after September 1, 2025.</li> </ul> <p><b>2025 EMS Conference</b></p> <p>Ms. Richardson shared that this year marks the 40th anniversary of the Texas EMS Conference. Dr. Ed Racht will be the keynote speaker. There will be an updated Advanced AOR class with six presentations from EMS</p>			

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	<p>leaders. The Conference will run from November 23 to 26 in Fort Worth, Texas. For more information, visit <a href="https://texasemsconference.com">https://texasemsconference.com</a>.</p>			
<p><b>6.b. DSHS Injury Prevention Unit</b></p>	<p><b>Jia Benno, manager of the Injury Prevention Unit, provided a presentation on trauma death data and general registry updates.</b></p> <p>Gavin Sussman, EMS &amp; Trauma Registries, provided a Registry update and highlighted several data quality issues, including low completion rates for fields like 'who performed the procedure' (30%), hospital notification for stroke patients (40%), and cardiac arrest details (44%). Data submission timeliness has significantly improved, from a 10-day lag in 2022 to 35 hours currently. Data volume for 2025 is also higher than in previous years. A data quality webinar series will be held in September to address underperforming areas, such as stroke assessment and severity scoring (currently at 68% completion). The goal is to increase this to nearly 90%. Continuing education credits will be offered for these EMS sessions.</p> <p><b>Texas Transfer Trauma Deaths Over Time: 2013-2024</b></p> <p>For this presentation, urban, rural, and frontier data were based on rural/urban criteria from the Texas Demographic Center, Texas populations estimate.</p> <ul style="list-style-type: none"> <li>• Urban included large central metro, large fringe metro, medium metro, and small metro areas.</li> <li>• Rural included micropolitan (10,000-50,000 people) and noncore (&lt;10,000 people) areas.</li> <li>• Frontier was defined as six or fewer people per square mile.</li> </ul> <p>Gio Benno presented data on Texas transfer trauma deaths by area characterization (urban, rural, frontier), as well as rates based on trauma record submissions and population. She demonstrated further characterizations of rural trauma deaths by overall age groups, signs of life upon arrival at the emergency department, signs of life by age group, and injury severity score limited to signs of life in the 65+ age group. This data demonstrated deaths that occurred in the trauma facility trauma records, not prehospital trauma deaths or deaths where EMS was not responding. Key findings included a steady increase in total trauma deaths</p>	<p>Information only. No action items identified.</p>		<p>Continue quarterly update to Council.</p>

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	<p>from 2013-2023, with a slight decline in 2024. The death rate decreased overall in urban and rural areas between 2023 and 2024. When looking at total death rates by trauma records, the numbers have decreased since 2020 from 27.96 to 21.21 per 1,000 trauma records; however, when looking by population in Texas, the rate has slightly increased during that time period. The majority of rural deaths occur in the 15-64 age group, and most victims arrive with no signs of life (dead on arrival or DOA). For patients who arrive at the facility with signs of life but then die at the facility, the majority are in the 65+ age group and are moderately injured (ISS 9-15). The majority of deaths are occurring in urban and frontier facilities. It was discussed that there are a lot of factors that could impact why they're arriving at the facility with no signs of life, such as the amount of time it could take for them to arrive at the facility, the severity of the injury, resource availability, and access to care.</p> <p><i>Council Comments: Chief Petrilla asked if there was a way to look at EMS data since a significant number of deaths are left on scene. Ms. Benno stated they could look at EMS data separately, but they are not able to link EMS to trauma. She added that the linkage could be made if the wristband is uniformly applied. Mrs. Potvin stated that the ISS score may not be an accurate indication of the injury since they may not have a full workup if they are dead on arrival or shortly thereafter. Dr. Eastridge asked if the number of patients who were transferred from a rural facility but died in an urban facility was known. Ms. Benno stated that information was presented at the June meeting, and they found that most deaths in urban facilities were rural transfers at about 70%. Dr. Tyroch asked for the slides to be sent again from the June meeting.</i></p> <p>Ms. Benno will add EMS data for the next meeting. Dr. Remick asked if data could be presented by facility level, as well as age breakdown with specific rates per trauma records, not just the overall number. The discussion highlighted the critical need to link EMS and hospital trauma data using the Texas wristband number. Implementation is inconsistent across regions, with hospitals generally performing better than EMS providers. The number should be recorded in the 'eOutcome 03' and</p>			

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	<p>'eOutcome 04' fields. The support of RACs is considered critical for improving compliance, mentioning that if the entire state started recording the wristband number in the records, the registry would be able to link between EMS and trauma and more clearly see those patients from the time when EMS picked them up through their outcomes at the hospital. Mr. Sussman reported that the hospitals are more consistent, especially with trauma patients, with inputting the number into the patient record; EMS is not consistently inputting the number into the patient care record (PCR) when picking up patients. Mr. Eric Epley commented that the EMS agencies should not be chastised, as the RACs are trying to exhaust the original wristband supply that was purchased prior to the new standardized national taxonomy format developed with the NASEMSO group. The new format includes a 'TX' prefix and a base-33 alphanumeric system to avoid character confusion. It was noted that using Pulsara should ensure the wristband information integrates seamlessly into patient care reports across all vendors. Dr. Tyroch requested a report demonstrating compliance across the state – Ms. Benno stated she would provide one. EMSTR will be at the EMS Conference and will have information about the topic available at their booth in the exhibit hall.</p>	<p>EMSTR to provide wristband compliance report at the Q4 meeting.</p>		
<p align="center"><b>7. Health Information Exchanges</b></p>	<p>Dr. Tyroch reported that this topic – getting images from a transferrin facility to a receiving facility – was discussed at the August 21 RAC Chair/Executive Director meeting. He noted the issues with double imaging: over radiation, additional costs, and delays in patient care. Dr. Tyroch asked the RACV chairs to review how it’s done in their individual RACs and mentioned PowerShare as a possible route. The RACs will bring back information in November. Dr. Remick stated that Dr. Aaron Jensen provided a lecture on over-imaging as part of the Texas Pediatric Readiness Education Series, and it is available for viewing.</p>	<p>No action items were identified for the Council.</p>		<p>Add to RAC Q4 agenda.</p>
<p><b>8. GETAC Committee Action Items</b></p>				
<p align="center"><b>8.a. Air Medical and Specialty Care</b></p>	<p><b>Air Medical and Specialty Care Transport Committee (AMSCT), Lynn Lail, RN, Chair</b></p>			



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	<p>The course has been completed and received American Nurses Credentialing Center (ANCC) nursing credit approval. It is now live on the TETAF and DSHS websites, with 14 people having already taken it. The course will be available on the Texas Trauma Coordinators Forum (TTCF) and Texas Emergency Nurses Association (ENA) platforms by August 25, 2025.</p> <p><b>Pulsara Implementation Guidelines for the Air Medical Provider- ACTION ITEM</b></p> <p>Mrs. Lail reported that the GETAC Disaster Committee approved this document in June, and the AM&amp;SCT Committee is now seeking Council approval. Mr. Ramirez motioned to approve, and Mr. Petrilla provided the second. No further discussion, and no opposition. Motion carried and document approved as presented.</p> <p><b>OLOS Dispatch System Project</b></p> <p>An air medical and EMS workgroup has been formed to review the OLOS Dispatch System, conducting three meetings so far. The group has received a presentation from STRAC on HELOS, and an OLOS presentation from the OLOS VP is scheduled for the Q4 AM&amp;SCT Committee meeting.</p>	<p>Mr. Ramirez– motion to approve. Mr. Petrilla – second. No opposition – all in favor.</p> <p>No additional action items were identified for the Council.</p>	<p>Approved.</p>	<p>Add resource to webpage?</p> <p>Continue Quarterly report to Council.</p>
<p><b>8.b. Cardiac Committee</b></p>	<p><b>Cardiac Care Committee, James McCarthy, MD, Chair</b></p> <p>Dr. Cooley, committee vice chair, provided an update.</p> <p><b>Timely Cardiac Transfers</b></p> <p>The Committee discussed the proposed DSHS form for transfer data collection and will provide feedback to DSHS, as well as work to connect current EMS NEMESIS data with new data sets. The plan is to start with STEMI, which is currently tracked through other accreditation programs, to further explore data elements to look for opportunities for improvement in timely transfers. Will send data to RACs.</p> <p><b>CPR Instructions Before EMS Arrival</b></p> <p>Dr. McCarthy will provide the previous survey to RAC chairs for consideration to conduct a statewide survey. The plan is to discuss with the RAC chairs in November.</p>	<p>No action items were identified for the Council.</p>		<p>Continue quarterly report to Council.</p> <p>Add to RAC Q4 Agenda.</p>

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	<p><b>Educate Policymakers on the Texas Emergency Healthcare System</b> The committee will continue to support and educate on the benefits of using the RAC Data Collaborative across the state, as well as collaborate with other relevant cardiac organizations to educate state leaders and legislature on the importance of data sharing and state cardiac designation.</p> <p><b>Out of Hospital Cardiac Arrest – AED Access/Bystander CPR Assessment</b> The committee plans to provide a data request to DSHS and CARES for the report during the next meeting, including looking at the barriers agencies face in joining TX CARES.</p>			
<p align="center"><b>8.c. Disaster Committee</b></p>	<p><b>Disaster Preparedness and Response Committee, Eric Epley, CEM, Chair</b> <b>Emergency Medical Task Force (EMTF) Program</b> Mr. Epley opened with a request for a moment of silence for the loss of life in the hill country flooding event. A thank you was extended to all EMS and hospital agencies for their support during the Kerrville and Central Texas flooding. The response involved over a thousand individuals from the mass casualty incident in Pulsara. Mr. Epley reported the response was phenomenal, showcasing a significant transformation in disaster response with excellent integration and flexibility. Pulsara leadership team was on site during this event to assist with modifications, such as creating a separate decedent management care area.</p> <p><b>Pulsara and Wristband Utilization</b> The Committee briefly discussed the Air Medical Committee's presentation on the Pulsara air implementation guidelines for the air medical providers, which is in conjunction with the CAMTS guidelines for mobile devices.</p> <p><b>GETAC Pre-Hospital Whole Blood Task Force</b> Mr. Epley reported that the Pre-hospital Whole Blood Task Force met for four hours on 8/19. A quorum issue arose at prior meetings because</p>	<p>No action items were identified for the Council.</p>		<p>Continue quarterly report to Council.</p>

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	<p>members initially signed up for a quarterly meeting, but the frequency increased, so there were many absences with the increased frequency of meetings. The task force now has 35 members.</p> <p><b>Blood Provider Survey on Program Costs</b> A survey was sent to nine blood providers regarding the costs for rolling out pre-hospital whole blood; six responded: South Texas Blood and Tissue, We are Blood, Vitalent, Coastal Bend, Carter, and Gulf Coast. The survey focused on coalescing around a single model, the rotation model, where blood is rotated through trauma centers.</p> <p><b>Logistics, Courier Costs, and Provider Responsibility</b> The group discussed the logistics of blood distribution, including courier costs. The expectation is that blood providers, not EMS agencies, should manage the courier process. Some providers are resistant, asking EMS to drive long distances.</p> <p><b>Blood Bag Supply Chain Risks and Standardization</b> Dr. Ratcliff raised a critical issue regarding the 35-day blood bag, which has only one manufacturer. This poses a national security risk. The alternative 21-day bag increases logistical complexity and waste risk. Mr. Epley commented that there's a company in pursuit of FDA approval for a 56-day bag. He added that a 56-day bag would be a game changer.</p> <p><b>Funding Eligibility Recommendations</b> The task force began working on recommendations for the department. The primary recommendation is that funding eligibility should be tied to active participation in the RAC regional whole blood committee. That committee needs to manage all aspects of whole blood utilization in the field in their areas, including criteria development, performance improvement, and blood rotation processes that will ensure low wastage. Mr. Epley reiterated that the task force is committed to the rotation model for this pilot. He added that the task force recommends that the MOUs run through the RACs similarly to how they did for SB8 scholarship funding. Wristband utilization is mandatory for reimbursement.</p> <p><b>Follow-up Process for Women of Childbearing Age</b></p>			

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	<p>A dedicated PI process must be established to follow up on all females of childbearing age (defined as 0-50) who receive whole blood to manage potential Rh sensitization. This includes counseling, testing, and ensuring they receive RhoGAM, if needed.</p> <p><b>Existing Pre-hospital Whole Blood Programs</b> The task force recommends that these entities not be penalized or left behind just because they were early adopters, so that they should be eligible for equipment upgrades or other things in the pilot.</p> <p><b>National Standards</b> It is recommended that EMS programs doing prehospital whole blood follow the AABB guidelines for prehospital use and any national standard should be the pilot’s goal as well.</p> <p><b>System-Wide Participation and Expanding Blood Use</b> Dr. Remick asked if the whole blood task force would be developing a recommended set of roles and responsibilities for the whole blood coordinator at a regional level to propose some kind of standard. She requested that it include not just the usage of blood, but also tracking the number of trauma centers that are using whole blood and that are participating in the exchange, and then report back centrally at a state level to see if there's a need to promote it more broadly across the trauma community. Mr. Epley concurred and stated that the system requires buy-in from all partners. Trauma centers must be willing to use rotated blood for various patients (e.g., OB, GI) to support the availability of blood for EMS, fostering a broader system of care.</p> <p><b>Blood Donation Strategy and Walking Blood Banks</b> A strategy was proposed to increase the supply of low-titer O-positive blood by having small and medium-sized public safety agencies host one or two targeted blood drives per year, respectively. This would help identify and regularly engage special donors. Dr. Tyroch asked if the task force is looking at the small Level IV trauma centers in the frontier counties, adding that “we cannot forget those people out there.” Mr. Epley responded that the prescreened, pretested donor walking blood banks are an important aspect of this.</p>			



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	<p>Discussion ensued in the meeting on mechanisms to track all issues, not just those that rise to the level of “reporting.” Survey approval deferred to Q4.</p> <p><b>Reduction of Red Lights and Sirens usage</b> This workgroup has begun to evaluate the earlier position statement on L&amp;S usage. Other committees are reviewing that position statement as well and will deliver feedback to the workgroup. The workgroup will now collaborate with the Medical Director’s Committee to coordinate a position statement on RLS use from the Medical Directors.</p> <p><b>Data Request</b> The workgroup is requesting access to Texas NEMSIS data related to EMS response categories, transport disposition, use of lights and sirens on response and transport, and any related data that the RLS Workgroup deems appropriate for the research and potential recommendations to allow the committee to continue research on reducing high-risk, low acuity responses for 911 EMS-related calls for service. Mr. Sussman, EMSTR, stated this was an easy request and they could provide the data for the next meeting. Dr. Ratcliff stated that one of the challenges with this data request is going to be the normalization of what the priority system is in Texas. Not all agencies are using the same medical priority dispatch codes, and so what gets put into the PCR is not the same. He added that data definitions would help. Mr. Petrilla asked Mr. Sussman to identify the code for “lights and sirens” and “lights without sirens.” Mr. Sussman stated there’s an additional response mode descriptor to indicate whether lights and sirens were used, use of lights and sirens was downgraded, no use of lights and sirens was upgraded, or no use whatsoever. Mr. Petrilla suggested the RLS goal be reworded. Dr. Tyroch suggested Mr. Petrilla and Dr. Ratcliff work with the EMS committee chair on this committee priority. Mr. Sussman committed to attending the RLS workgroup meetings to iron out the details. Mr. Tidwell commented that very small rural areas don’t have EMD, so their numbers would be skewed for rural EMS services that run Code 3 to most calls. He added that 90% of his calls out of Post, Texas, 500 transports a year, are dispatches to a call with very little information, such as “elderly male unknown health</p>			<p>deferred this quarter) and the EMS committee agenda.</p> <p>Follow up – is this the next RLS WG meeting or the Q4 EMS meeting?</p> <p>The RLS workgroup will ensure Gavin has an invite to their monthly meetings.</p>



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	<p>director in the state, as well as to supply an alternate to the missing online education and one that would be derived from the NAEMSP educational course, which is present already, adding Texas-specific content. Mr. Matthews stated that DSHS already can make the change in the rules to accommodate an updated need without a GETAC approval, to which Director Klein agreed.</p> <p><b>The Red Lights and Sirens (RLS) Position Statement</b></p> <p>Dr. Fagan reported that this was delayed, allowing for consultation with the EMS committee.</p>			
<p><b>8.g. Injury Prevention &amp; Public Education Committee</b></p>	<p><b>Injury Prevention &amp; Public Education (IPPE) Committee, Mary Ann Contreras, RN, Chair</b></p> <p><b>Child Passenger Seat Technician Program</b> Mary Ann Contreras reported on efforts to expand the number of child passenger seat technicians in Texas, as they are losing more technicians than they can train. The committee is collaborating with the National Safe Kids of Hawaii and the National Safety Council to update the instructor curriculum and make it easier for professionals to become instructors.</p> <p><b>Drowning Prevention Initiatives</b> The committee is collaborating with national organizations to reduce drowning incidents in Texas. This involves creating a public education plan based on data about drowning rates and water body types. A key finding from a non-fatal drowning incident in June was the lack of a reporting system for life jacket failures. A public education plan is being created, and collaboration with the Coast Guard is underway. The committee is exploring the development of a system for reporting life jacket or flotation device failures.</p> <p><b>Public Education on Whole Blood Usage</b> The committee has been tasked with creating public education materials regarding whole blood usage in prehospital settings. These materials will be designed for RACs to brand and distribute.</p> <p><b>Workplace Violence in Healthcare – ACTION ITEM</b></p>	<p>No additional action items were identified for the Council.</p>	<p>Approved.</p>	<p>Continue quarterly report to Council.</p>

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	<p>A comprehensive workplace violence position statement has been created and approved. It defines workplace violence, advocates for a zero-tolerance policy, and suggests preventative measures like risk assessments, environmental controls, staff training in de-escalation and trauma-informed care, and robust, blame-free reporting systems. The statement is supported by literature from organizations like OSHA and The Joint Commission and calls for strengthening legal protections for healthcare workers.</p> <p>Danny Ramirez moved to accept the IPPE Committee’s workplace violence position statement. Della Johnson provided a second. No additional discussion and no opposition. Motion passed by a show of hands, and the statement was approved.</p>	<p>Mr. Ramirez – motion to approve. Ms. Johnson – second. No opposition – all in favor.</p>		<p>Post to IPPE webpage as a resource.</p>
<p><b>8.h. Pediatric Committee</b></p>	<p><b>Pediatric Committee, Christi Thornhill, DNP, Chair</b></p> <p><b>Committee Projects</b></p> <p>Ms. Thornhill provided an update on the projects the committee is undertaking; these include guidelines for pediatric imaging (completed), pediatric transfusion/massive transfusion, and pediatric pain assessment and appropriate pain management for transferring facilities, EMS transfers, and EMS on scene. Ms. Thornhill reported that the data from the state registry and the National Pediatric Readiness Improvement Project regarding vital signs and weight in kilograms for pediatric patients has shown improvement with compliance. Sam Vance will provide a report twice a year.</p> <p><b>Pediatric Simulations</b></p> <p>The committee continues to monitor utilization of 13 pediatric simulations by regional PRISMs. These simulations are being used throughout the state. The committee will request data from the state regarding trauma center compliance with bi-annual simulations after Rule 157.126 is in effect.</p> <p><b>Action Items</b></p> <p>Public resource for the Pediatric Imaging Guideline – the request is for approval of the ALARA guidelines. The committee will add a statement to</p>			

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	<p>the guidelines that the recommendation is not to image if it's not necessary when a facility is going to transfer a pediatric patient. This will help to cut transfer delays or eliminate poor-quality images that need to be repeated. Dr. Remick moved to approve the adoption of the ALARA guidelines and committee statement. Dr. Eastridge provided a second. No additional discussion and no opposition. Motion passed.</p> <ul style="list-style-type: none"> <li>• <i>Public resource for the Consideration for Pediatric Consultation and Transfer Guideline – deferred to Q4</i></li> <li>• <i>Public resource for the Magnet/Button Battery Ingestion Toolkit – deferred to Q4</i></li> <li>• <i>Public resource for the Sudden Cardiac Arrest/Death Toolkit – deferred to Q4</i></li> </ul> <p>Dr. Tyroch asked if there was pediatric representation on the Prehospital Whole Blood Task Force. Director Klein responded in the affirmative, explaining that the pediatric guidelines are assigned to Dr. Don Jenkins, Dr. Katie Wiggins, and Dr. Barbara Gaines.</p> <p>Ms. Thornhill mentioned that the committee will have a pediatric TQIP agenda item going forward.</p> <p><b>Texas Pediatric Readiness Project</b> Ms. Thornhill provided a report on behalf of Sally Snow: The regional training of hospital PECCs continues. Three more events were held in June and July. A dashboard for the hospital PECCs to track their activity has been developed, and it's available for every hospital PECC. If any PECC needs more information, they can either get it from their PRISM or from Sally. The education series continues to be a great success. They've reached a lot of people in this state. Dr. Tyroch asked for clarification between a PECC and PRISM. Dr. Remick stated that the idea of the PRISM role was to broaden the regional support to integrate pediatric readiness and regulation and do some training and support for hospital-based PECCs. It is not a position that's intended to take on the role of a hospital-based PECC.</p>	<p>Dr. Remick - motion to approve. Dr. Eastridge–second. All in favor. No opposition.</p> <p>No additional action items were identified for the Council.</p>	<p>Approved.</p>	<p>Add to Peds page?</p> <p>Add bulleted items to council Q4 agenda.</p> <p>Continue quarterly report to the Council.</p>

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	<p><b>Texas Head Trauma Measures</b>                      Dr. Remick provided an update on the sites, by RAC, participating in NPRQI. She shared data on Texas Head Trauma Measures. The data indicate a little bit of work to do for those patients who come in with blunt head trauma: 71% of pediatric patients with a full set of vital signs obtained, and 57% of pediatric patients receive a GSC reassessment. Dr. Remick indicated a huge win with 0% of pediatric patients receiving hypotonic saline when many previously received it. She also stated that the new imaging guidelines that the pediatric committee just pushed out will help with improving adherence to PECARN criteria, with the data showing that currently 72% of pediatric patients with a head CT met one or more PECARN criteria.</p> <p><b>Texas Suicide Measures</b>                      Dr. Remick reported that 51.6% of adolescent patients 12 and up were assessed with a suicide screening tool in the emergency department, compared with 65.3% nationally.</p> <p><b>Patients Impacted and Future Plans</b>                      Dr. Remick reported that NPRQI has impacted 158,000 total pediatric patients in Texas. She added that NPRQI plans include sustained funding through 2027, system upgrades, electronic data entry exploration, an upcoming Texas-centric collaborative (launching in January 2026), and Obstetrical Emergency Care Measures.</p>			
<p align="center"><b>8.i. Stroke Committee</b></p>	<p><b>Stroke Committee, Robin Novakovic, MD, Chair</b>                      Dr. Novakovic shared the Stroke Committee’s 2025 Q3 activities.</p> <p><b>GETAC Stroke Quality Report and System Performance</b>                      Dr. Novakovic reviewed the GETAC stroke quality report with the Council and reported encouraging improvement in door-to-needle times across various geographic areas. In Texas, 216 hospitals participate in Get with the Guidelines, but only 39% participate in the RDC. The median door-to-needle time has improved from 42.5 minutes to 38 minutes in the current year, with suburban areas reaching a median of 35 minutes. Performance goals are being approached: 85% of patients treated within 60 minutes and 75% within 45 minutes.</p>			<p>Continue quarterly report to the Council.</p>

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	<p><b>Stroke Committee 2026 Priorities</b> The Stroke System of Care (SSOC) workgroup will start to review and make recommendations to the stroke committee for revisions 11/2025, and the committee will outline liaisons to the GETAC Committees.</p> <p><b>Patient safety and quality concern: Neuro IR coverage</b> The SSOC workgroup and Stroke Committee will review NCTTRAC’s newly approved recommendation for Neuro IR coverage best practice. It is modeled after some of the standards that are in use with the accrediting bodies, like the Joint Commission and DNV.</p> <p><b>Pediatric Stroke Task Force – ACTION ITEM</b> The Pediatric Stroke Tip Sheet is still under review by the Pediatric Stroke Task Force. The goal is something to review by 11/2025. The Pediatric Routing Resource Document was revised with the Pediatric Committee’s recommendation to add end tidal CO2. Dr. Remick moved to approve the Pediatric Routing Resource Document. Dr. Eastridge provided a second. No further discussion and no opposition. Approved.</p> <p><b>Interfacility Stroke Terminology</b> Dr. Novakovic is participating with the EMS Time Sensitive Transfer Deconfliction Workgroup.</p> <p><b>DIDO Performance Recommendations</b> Will email recommendations to participate in the GWTG DIDO layer and performance goals to RAC chairs and continue to share with stroke programs.</p> <p><b>TEAM EMS-Ed Study</b> Dr. Novakovic explained that this is a study looking at standardized education for stroke and whether that can improve knowledge and performance. The committee is currently assessing the feasibility and funding for the study and is recruiting individuals for an education writing group via a QR code. <i>Timestamp 2:55:11 for QR code to sign up for the writing group.</i></p> <p><b>Post Acute Stroke Care Work Group</b> Dr. Novakovic stated there is now a call for members, with the first meeting planned for 09/2025. Interested individuals can email <a href="#">Deidra Lee (DSHS)</a> or Dr. Sean Savitz.</p>	<p>Dr. Remick - motion to approve. Dr. Eastridge – second. All in favor. No opposition.</p>	<p>Approved.</p>	

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	<p><b>Mission: Lifeline EMS Recognitions</b> The committee discussed a new EMS awards program to improve data collection alignment between EMS and hospitals. Data shows that only 31% of patients have a documented stroke screening tool, and pre-hospital notification only occurs 52% of the time. This positive reinforcement tool could help bridge the gap in data that EMS collects from hospitals to monitor field metrics. The Stroke Committee endorsed the program and requests approval to distribute the Mission: Lifeline EMS Recognition to committees, RACs, and at DSHS stroke meetings. <i>Timestamp 2:56 for QR code.</i></p> <p><b>Rural Stroke Work Group</b> Dr. Novakovic reported that this workgroup meets monthly. Rural and resource-challenged regions and hospitals are to be included in the scope of the workgroup. They have received the latest heat map of 60 minutes by air, as requested by Dr. Tyroch, and Dr. Novakovic will circulate the map. The workgroup requested approval for a rural stroke assessment survey to identify challenges in rural stroke management and center designation. The survey will be disseminated through RACs via email, per RAC suggestion. Mr. Petrilla moved to approve the workgroup's request to disseminate the rural survey. Chief Lail provided the second. A minor format flaw was pointed out. Motion carried, and the survey was approved with no opposition. A request was made for an EMSTR data report for DSHS-recognized rural counties: median prehospital run times (call-to-hospital arrival), median call for transport to hospital arrival (for emergent stroke transfers), median interfacility transfer times for emergent stroke transfers, and call stroke types in rural regions. Dr. Tyroch confirmed with Ms. Benno and Mr. Sussman that this was a doable request – they confirmed in the affirmative.</p> <p><b>Texas EMS Stroke Survey</b> Results shared with Council and committee chairs. The committee has created an abstract, one of two submitted for the International Stroke Conference, based on the data. They will have a second one that will get submitted as well, and then try and get a paper from it.</p> <p><b>Stroke Education Resources for Stroke Facilities</b></p>	<p>Mr. Petrilla - motion to approve survey. Lail – second. All in favor. No opposition.</p> <p>Request for data from EMSTR.</p>	<p>Approved.</p>	<p>Council requested Mission: Lifeline EMS Recognitions be brought back in November. Add to Agenda.</p>

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	<p>Seeking opportunities to make documents readily available to RACs. Requesting approval to have GETAC-approved resource documents available on the Stroke Committee’s webpage. Council had no objections to the documents being made available on the committee’s webpage. Dr. Novakovic met with RAC chairs 08/2025 to seek guidance on how to best distribute documents, and they recommended emailing RAC chairs via Deidra Lee.</p> <p>Items approved for Q4 Council agenda:</p> <ol style="list-style-type: none"> <li>1. Pediatric stroke tip sheet and supplement</li> <li>2. Neuro IR coverage recommendation best practice</li> <li>3. Rural Stroke Work Group recommendation on best practice 2026</li> </ol>	<p>No additional action items were identified for the Council.</p>		<p>Post GETAC-approved Stroke documents on the Committee’s webpage as publicly available resources.</p>
<p><b>8.j. Trauma Systems Committee</b></p>	<p><b>Trauma Systems Committee, Stephen Flaherty, MD, Chair</b> Dr. Flaherty provided an update.</p> <p><b>The Southern Border - Military and Civilian Healthcare Integration</b> There continue to be significant military operations working to ensure the integrity of the southern border, but there have been no injuries that have involved the trauma system.</p> <p><b>Transfer Delays for Trauma Patients</b> An update was provided on the SCOR project, with the next data infusion expected in November, which will include a full assessment of 2024. Discussions are ongoing about adding data fields. This committee recommends only limited requirement for new data fields but supports encouraging facilities to include a robust data set that characterizes this problem. Committee recommended to RAC Chairs that this PI concern, along with a concern about duplicated pediatric radiology studies, would be appropriate RAC PI projects. The RACs were offered the opportunity to report their RAC PI project at the Trauma Systems Committee meetings.</p> <p><b>Mission Zero</b> The Mission Zero project has expanded to improve military-civilian partnerships. It has infused a lot of money into the system to allow small military teams to be embedded within trauma centers in the United States.</p>	<p>No action items were identified for the Council.</p>		<p>Continue quarterly report to the Council.</p>

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<p align="center"><b>9. SCOR</b></p>	<p><b>Kate Remick, MD, and Shawn Salter, RN, LP – SCOR Co-chairs</b>                      Dr. Remick reported that the collaborative is continuing to track the top five clinical quality measures. Dr. Novakovic shared the data for this quarter relative to door-to-needle times for stroke during the Stroke Committee update above, and Ms. Benno will share a report on the prehospital stroke screening measure.  <b>Stroke Scale Documentation Analysis (2022-2024)</b>                      Ms. Benno shared the total stroke numbers for 2022 through 2024. She further characterized them according to sex, overall stroke scale status, stroke scale status by sex, and stroke scale performed, broken down by RAC. Analysis of data showed a significant increase in the documentation of stroke scales for suspected stroke patients, rising from 47% in 2022 to 65% in 2024. There were no real differences when looking at the stroke scale performed by patient sex. When looking at the data by RAC, Ms. Benno reported significant increases across the board. She noted that RAC F showed exceptional improvement, reaching nearly 96% documentation. Efforts are ongoing to work with agencies that are documenting less than 70% of the time. Dr. Remick stated SCOR had planned to ask the RAC chairs how SCOR could get this data to them on a regular basis at the regional level, but due to the robust discussion the opportunity was not available, so they will try again in November. The next SCOR meeting to discuss the Q4 data will be on October 6, from 4 to 5 PM.</p>	<p>No additional action items were identified for the Council.</p>		<p>Continue quarterly report to the Council.</p>
<p><b>10. Task Force Action Items</b></p>				
<p align="center"><b>10.a. Burn Care</b></p>	<p>Dr. Ratcliff, task force co-chair, reported that the task force has discussed the availability of data. Discussions including burn disaster plans and the use of Pulsara, as well as burn annexes in the RACs. The next meeting will include discussions on burn telemedicine. The next meeting is September 8<sup>th</sup> at 3 PM on Teams.</p>	<p>No action items were identified for the Council.</p>		<p>Continue quarterly report to the Council.</p>
<p align="center"><b>10.b. EMS Wall-Times</b></p>	<p>Chief Wait, task force chair, stated there was nothing to report this quarter.</p>	<p>No action items were identified for the Council.</p>		<p>Continue quarterly report to the Council.</p>

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<p align="center"><b>11. Executive Committee Activities</b></p>	<p>The Executive Committee had no activities to report this quarter.</p>			
<p align="center"><b>12. TETAF</b></p>	<p><b>Dinah Welsh, TETAF President/CEO Advocacy</b>                      Ms. Welsh reported that the 89th Texas Legislature convened for a special session on July 21. During the special session, TETAF closely monitored the Select Committee on Disaster Preparedness and Flooding as it relates to the Regional Advisory Councils (RACs) and other funding bills. There was a brief discussion on Senate Bill 8, the 'bathroom bill,' and its broad definition of 'multiple occupant space,' which could have unintended consequences for hospitals. The bill has passed the Senate and is now in the House. TETAF is working with the bill author of HB7, which relates to abortion-inducing drugs. Ms. Welsh stated that while TETAF does not take a position on abortion, its concern as a perinatal organization relates to the “unintended consequences” from the prohibition of the drugs that are needed for legitimate medical purposes that are unrelated to illegal abortions. TETAF will continue to monitor these items and be ready during the 89(2) Legislative Session that began on Friday, August 15. TETAF is also looking further into the allocation of funds from the One Big Beautiful Bill Act as it relates to concerns of HPP funding cuts and the rural health transformation program.</p> <p><b>Surveys – Trauma, Stroke, Maternal, &amp; Neonatal</b>                      TETAF and Texas Perinatal Services Surveys – The current volume of surveys in order is trauma, maternal, neonatal, and stroke. Ms. Welsh said that this was the busiest month for trauma they’ve had to get surveys done before the new rules take effect on September 1.</p> <p>Trauma Rules – TETAF is working with surveyors, hospital partners, and DSHS to ensure rules are understood and followed. TETAF is recruiting additional trauma surgeon surveyors to meet the increased survey participation requirement. Dr. Tyroch asked about the stipulation regarding trauma surgeons and surveys. Ms. Welsh responded that there is a</p>	<p>Information only. No action items identified.</p>		

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	<p>contiguous RAC prohibition, which changed from the former 100-mile prohibition. She added that while the department has granted exceptions where a RAC has “a pinky nail that touches” another RAC, this has created more travel and time for the surveyors. Ms. Welsh stated that traditionally, their surveyors would spend one night in the city that they were surveying, but are now, at times, spending two nights to be able to arrive early enough. She added that they are encouraging physician surveyors because of the change in the rule; they are going to need additional physician surveyors, which they will begin training starting in September or October. Interested physicians should reach out to Ms. Welsh or Ms. Rowden. Dr. Tyroch asked if TETAF could use EM physicians, too, and Ms. Welsh responded that while there is a place in the rule where they can be utilized, TETAF is looking primarily for surgeons.</p> <p><b>TETAF Education</b> TETAF continues to offer continuing education through its virtual Texas Quality Care Forum (TQCF). The next forum is on Monday, August 25, at 10:00 a.m. CDT. The topic is “From Findings to Fixes: Closing the Quality Loop in Mother and Infant Units.” <i>Timestamp 3:36:40 for QR code to register for the TQCF.</i></p> <p><b>TETAF Collaboration</b> TETAF continues to provide support to the Texas TQIP Collaborative. The Texas TQIP held its third quarterly meeting this week and submitted trauma data earlier this year. Ms. Welsh stated the Pediatric TQIP is finally going to launch. Texas TQIP has met with interested trauma facilities to establish a pediatric collaborative. Dr. Tyroch asked how many trauma centers are now in the collaborative, and Ms. Welsh reported approximately 30 paying and participating members. Questions about Texas TQIP can be sent to <a href="mailto:texastqip@tetaf.org">texastqip@tetaf.org</a>. TETAF welcomes the opportunity to be a resource, support, and/or participate in any meetings to further build the trauma and emergency care network.</p>			

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<p align="center"><b>12. 2026 Meeting Dates</b></p>	<p>DSHS proposed the following dates for 2026 based on hotel availability:                      Q1: March 10-13, Doubletree                      Q2: June 2-5, Doubletree                      Q3: August 25-28, Doubletree                      Retreat &amp; Committee Selection: October 14-15, Doubletree                      After discussion about possible dates in May for Q2, these dates were approved by GETAC.</p>			
<p align="center"><b>13. Public Comment</b></p>	<p>Wanda Helgesen (RAC I) stated it would be helpful if there's some way that we as members of the audience could see some of the documents prior to the meetings because it's hard to make comments if all they see is a quick flash on screen. She added that it would be helpful if they could be posted with the agendas. Dr. Tyroch asked for clarification on the process. Mrs. Lee stated that the documents up for review and/or approval at the council meeting were posted with the agenda in a PDF binder. Dr. Tyroch sought additional clarification if that was for everyone or just council. Mrs. Lee confirmed that the binder was on the GETAC webpage for public consumption. Mr. Salter expressed appreciation for the binder of documents to review. Dr. Tyroch inquired how the public accesses the binder. Mrs. Lee responded that the binder is a clickable link on the GETAC webpage with the meeting link and agenda. Ms. Helgesen stated she didn't realize the council documents were available and asked for the committee document process to be discussed instead. Dr. Tyroch requested that this be an item for discussion at the post-GETAC debriefing.</p> <p>Ms. Helgesen had a second comment regarding the inability of RACs to get specific, line-level data about the agencies they oversee. She stated this prevents them from identifying and helping underperforming agencies, particularly with issues like stroke documentation. Mr. Sussman responded by stating that their legal department's position is that EMSTR cannot release agency-level data without the permission of the agency. Ms. Helgesen stated that this is the reason why the regions are going out and getting their own registries because they can't get the data to improve care. Mr. Matthews suggested a solution to alleviate concerns: When</p>			<p>Add document access to post-GETAC debriefing agenda.</p> <p>Review OMA public comment process.</p>

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	<p>agencies get a report specifically for that agency, they could turn around and give the report to the RAC as a condition of the PI process. Ms. Benno added that every agency is receiving various reports, such as the stroke scale, and it’s up to them to share with whomever they choose. Ms. Helgesen stated she was unaware that those reports were emailed to the agencies.</p> <p>Steve Dralle of Global Medical Response shared information on their investment in mental health and peer support for their 3,000 employees since 2019. He added that investment in this area can be extremely impactful. Mr. Dralle shared that he is thrilled to see the conversation about mental health support and encouraged every EMS provider to work either internally on their own or through other agencies to identify some of these first responder-specific resources.</p> <p>There were no pre-registered public comments.</p>			
<b>14. Final Announcements</b>	None.			
<b>15. Next Meeting Dates</b>	<p>Strategic Planning Retreat – Council decided to hold the retreat on October 28, 2025, 8 AM-5 PM, at the Doubletree.</p> <p>Q4 – November 21-25, 2025, in conjunction with the Texas EMS Conference in Fort Worth.</p>			
<b>16. Adjournment</b>	Dr. Tyroch thanked everyone for the hard work that went into the last few days and adjourned the GETAC 2025 Q3 meeting at 12:08 PM.			