8.i. GETAC Stroke Committee Update to Council

Chair: Robin Novakovic, MD

Vice-chair: Sean Savitz, MD

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 semiannual quality report from GWTG and EMSTR** • **Discussion – no statute to support a state GWTG Super User Account. Some RACs are getting Super User Accounts**	
RDC report	• **Update from RDC at Stroke Committee meeting.** • 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	• **SSOC work group will start to review and make recommendations to the stroke committee for revisions 11/2025** • **Stroke Committee outlining liaisons to the GETAC Committees**	

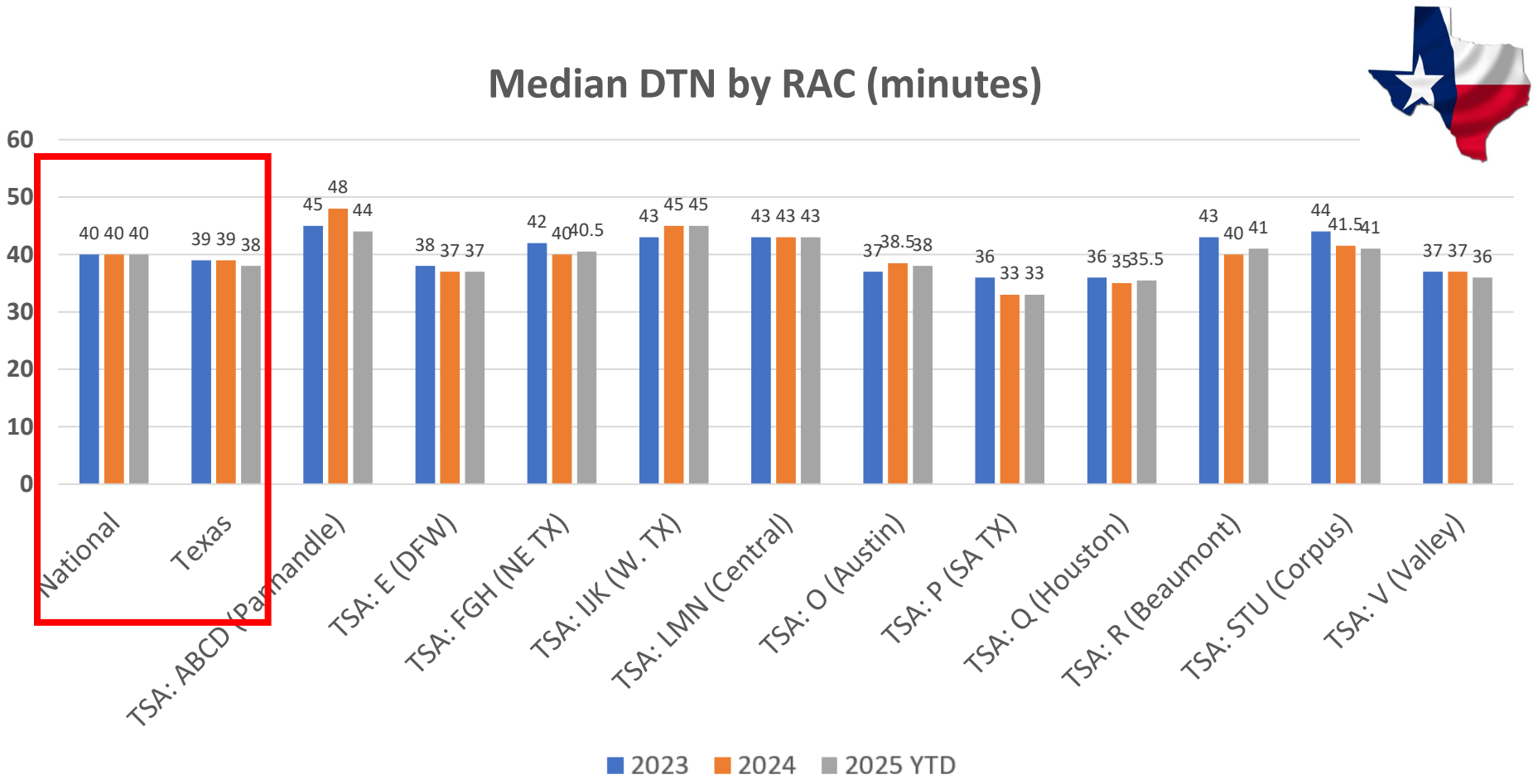
Semiannual GETAC Stroke Quality Report

Data Sourced from Get With The Guidelines® - Stroke
June 27 – July 1, 2025

Currently Participating

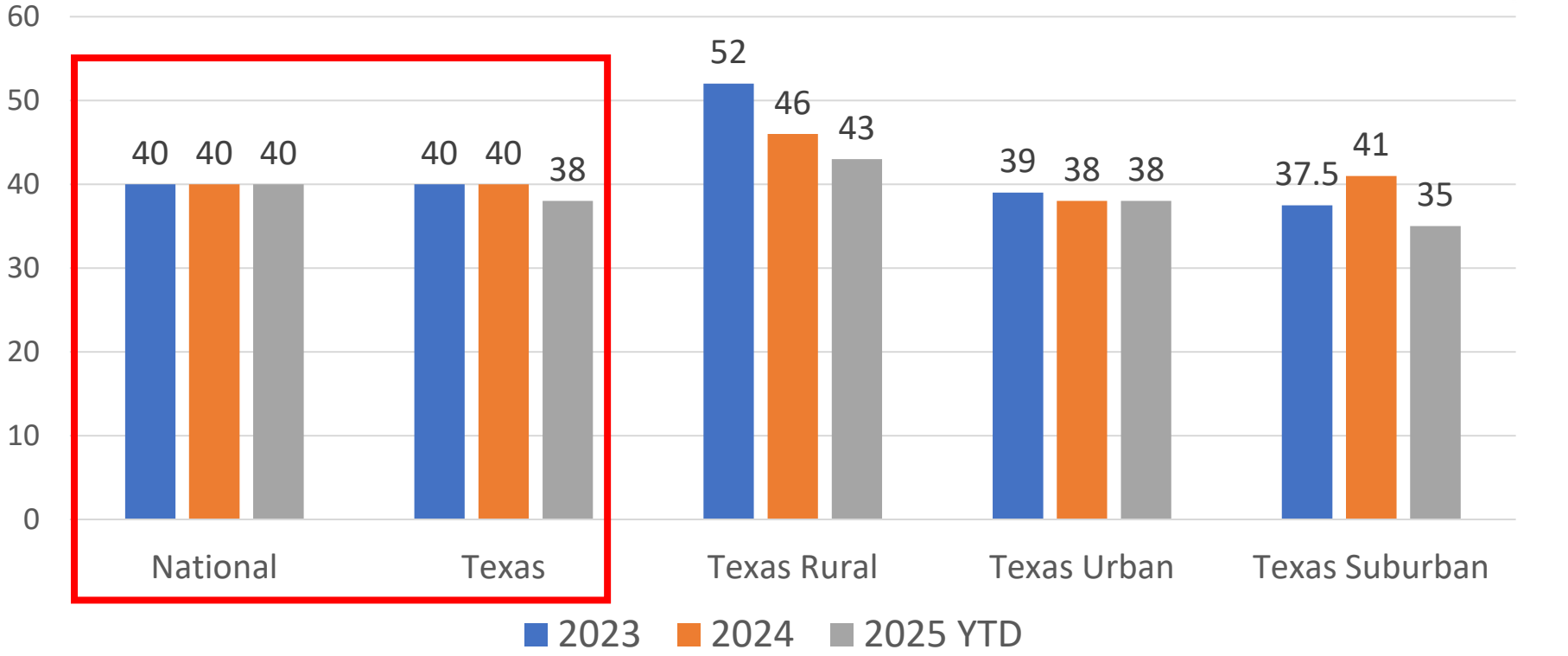
Texas Stroke GWTG Sample

- **216** TX Hospitals participating in GWTG
  - **53** participating hospitals classified as **"Rural,"** using the Rural Urban Commuting Area (RUCA) codes 4-10 and 99
    - **32** of these joined as part of the **Rural Healthcare Outcomes Accelerator** program
  - **84** participating in RDC = **39%** of TX GWTG Hospitals



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 7/1/25.

Median DTN by Geographic Size



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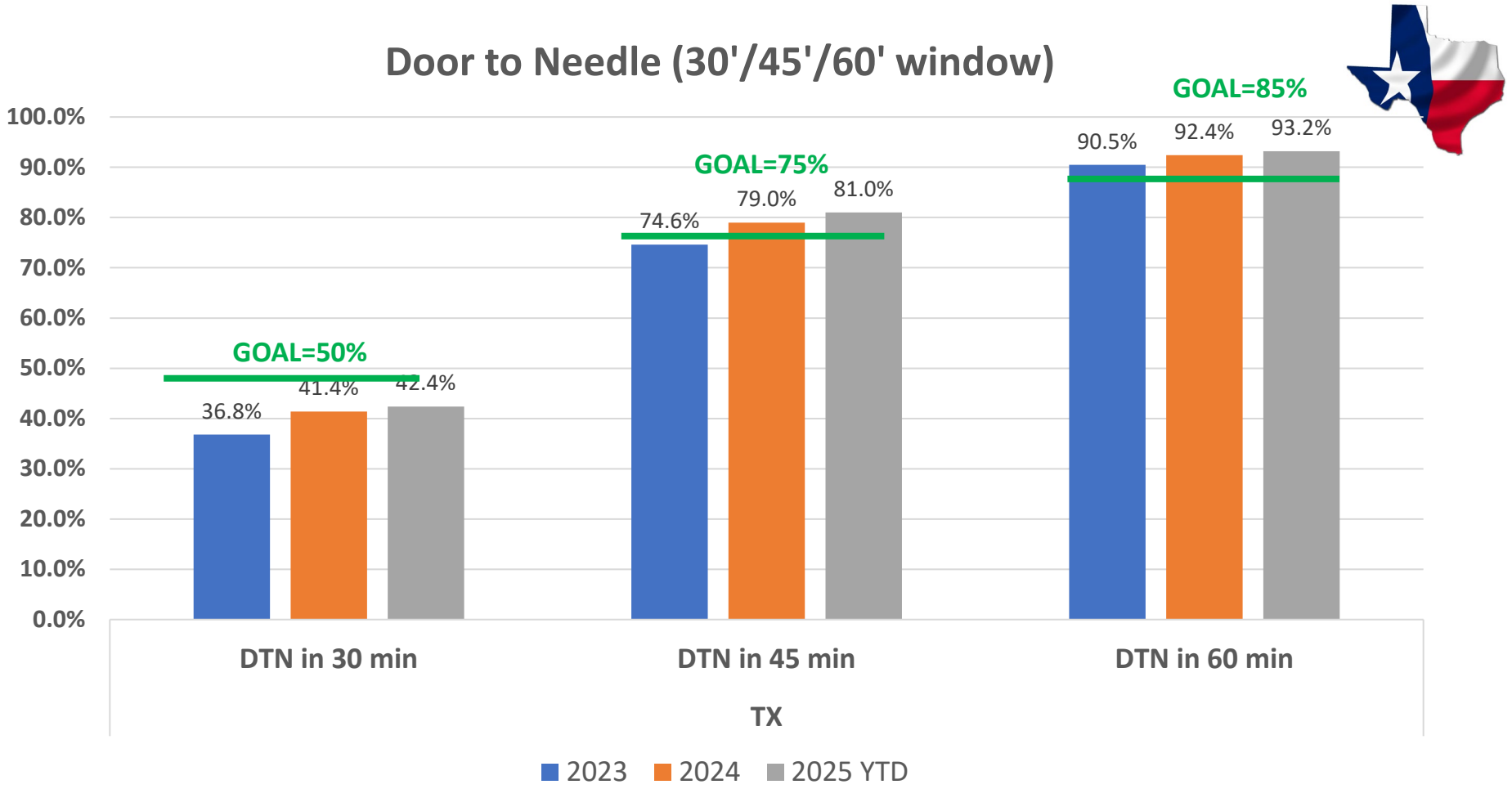

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Stroke Committee

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 as a quality and patient safety concern. • Barriers to finding objective measures to demonstrate delays, patients inappropriately denied MT and misuse of resources. • DSHS is working with DNV and TJC to review transfers out from hospitals • Stroke Committee and SSOC WG recommendation for internal performance measures to follow. • **SSOC work group and Stroke Committee with review NCTTRAC newly approved recommendation for Neuro IR coverage best practice.**	

NCTTRAC Proposed Recommendation

NCTTRAC
NORTH CENTRAL TEXAS TRAUMA REGIONAL ADVISORY COUNCIL

I. Recommendation

This recommendation serves to provide acceptable neurointerventional coverage (primary and backup call coverage) at Level I-Comprehensive and Level II-Thrombectomy Capable Stroke Centers in the NCTTRAC region and has been endorsed by the NCTTRAC Stroke Committee, the Board of Directors, the Stroke Medical Directors, and the majority of the C-Suites of the Level I and II Stroke-designated facilities in TSA-E.

A. Comprehensive and Thrombectomy Capable Stroke Centers that perform mechanical thrombectomy should have adequate coverage to meet the emergent needs of multiple strokes.
B. Each facility should have a written call schedule readily available within the hospital system, identifying the on-call and backup on-call interventional provider privileged to perform mechanical thrombectomy (neurointerventionalist) 24 hours a day, seven days a week, 365 days a year.
C. The neurointerventionalist taking calls should be available by phone within 20 minutes and available on-site within 30 minutes from notification.

i. When concurrent facilities are covered by either the primary or backup on-call provider, the following should be in place:
   1. If one neurointerventionalist is primary on-call concurrently at two (2) facilities there should be one dedicated backup on-call provider for each facility (e.g., two hospitals with shared coverage, one primary and three tier backup on-call coverage).
   2. The dedicated primary neurointerventionalist on-call at one facility may serve as backup call for no more than one hospital at any given time (e.g. primary call at one facility and backup at one additional facility).
   3. The facilities with cross coverage should be in close proximity, allowing the neurointerventionalist either serving as primary or backup on-call to be available on site within 30 minutes.

ii. Comprehensive and Thrombectomy Capable Stroke Centers that utilize a system of care to deliver stroke care, treatment, and services may utilize the same interventionists provided the following requirements are met:
   1. Written call schedules are readily available within the hospital system to demonstrate how stroke care, treatment, and services are provided at all hospitals in the system 24 hours a day, 7 days a week, 365 days a year.
   2. If one physician is covering more than one facility or another service in the organization, there is a written plan for backup coverage.
   3. Protocols and processes are developed and implemented to detail the system and organizations' plans to meet the emergent needs of multiple complex stroke patients.
   4. Protocols and processes are developed in response to situations when organizations would not be able to provide mechanical thrombectomy services and subsequently transfer patients or notify Advisory-Capability with a comment in EMResource.

iii. Comprehensive and Thrombectomy Capable Stroke Centers that perform mechanical thrombectomy and utilize an independent contracted provider or group for neurointerventional coverage to deliver stroke care, treatment, and services should have the following requirements met by the contracted provider or group:
   1. Written call schedules are readily available outlining all of the hospitals that the primary and backup on-call providers are covering for the shift.
   2. A written plan to meet the emergent needs of multiple stroke patients for each of the facilities if one contracted physician is covering more than one facility.
   3. Protocols and processes are developed in response to situations when the primary and backup on-call providers would not be able to provide mechanical thrombectomy services and subsequently transfer patients or notify of Advisory-Capability with a comment in EMResource.

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.	
Pediatric Stroke Task Force	• **Pediatric Stroke Tip Sheet is still under review by the Pediatric Stroke Task Force. Goal something to review by 11/2025** • 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 and Stroke Committee 08/2025** • **APPROVAL ITEM: Pediatric Routing resource document and guidance on the end tidal CO2**	

APPROVAL ITEM: Resource Document

PREHOSPITAL PEDIATRIC STROKE TRIAGE AND MANAGEMENT

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

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

   The **GETAC Prehospital Pediatric Stroke Triage Algorithm** was developed in consultation with EMS, EMS leaders, and local, regional, and state medical authorities. The GETAC pediatric stroke algorithm was developed in consultation with the GETAC Stroke, EMS, Pediatric, EMS Medical Directors Committees, and the Council. Available guideline statements and guidance from the GETAC Pediatric Stroke Task Force (a consensus of expert opinion based on clinical experience in the fields of Vascular Neurologists, Neuroendovascular Surgeons, and Pediatricians) were integral in the 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 rapidly diagnose and provide appropriate treatment will improve outcomes.[9-12] The prehospital pediatric stroke triage and transport recommendations serve to direct the regional triage of pediatric patients with acute stroke to the most appropriate facility. See **Annex A: GETAC Pediatric Prehospital Stroke Triage Algorithm**.

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

3. **Prehospital Triage of Stroke in Pediatric Patients**
   Pediatric stroke can present with focal neurologic signs, as well as nonspecific signs like seizure or altered mental status.[9,14-16]

   Sudden onset of any of the following suggests the possibility of acute stroke:
   - Numbness or weakness of the face, arm, and/or leg (especially on one side of the body)
   - Confusion
   - Trouble speaking or understanding language.
   - Double vision, trouble seeing in one or both eyes.
   - Altered Mental Status
   - Trouble walking
   - Dizziness
   - Loss of balance or coordination
   - Severe headache with no known cause (suggests hemorrhagic stroke), especially with altered mental status.

   ❖ For patients with any of the above neurological signs, especially with the listed conditions below, consider triaging as an acute stroke.

   Patients with any of the following are at higher risk for acute stroke:
   - Heart disease
   - History of blood vessel problems in the brain
   - History of stroke
   - Sickle cell disease
   - Cancer
   - History of blood clots

   Common pediatric stroke mimics:
   - Alcoholic intoxication
   - Cerebral infections

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APPROVAL ITEM: Resource Document

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

Basic Level

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

- **A (Airway):** Airway support and ventilation assistance are recommended for patients with acute stroke who have decreased consciousness or who have a compromised airway. Suctioning and oropharyngeal or nasopharyngeal airway as needed to ensure airway patency.
- **B (Breathing):** Supplemental oxygen should be provided to maintain oxygen saturation > 94% (continuous monitoring). Consider adding end tidal CO2.
- **NOTE:** Some patients with congenital heart disease have a different goal saturation level (80-90% in some cases). If unsure, confirm the normal level with parents or caretakers.
- **C (Circulation):** Evaluate and treat signs/symptoms of shock according to the Shock Clinical Practice Guidelines
- **D (Disability)**: Assess and document GCS, pupillary size, and reactivity.
- **E (Exposure/Environmental):** Assess for evidence of traumatic injury, especially head injury.

Stabilization and Initial Management:

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

Cardiovascular Examination:

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

Neurological Assessment for Pediatric Stroke:

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

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

History:

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

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

Additional History:

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

Medications:

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

Management:

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

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

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APPROVAL ITEM: Resource Document

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

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

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

System Triage:

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

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

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

Triage Recommendation:

1. Pediatric patient suspected of having a stroke who is medically stable and last known well **≤ 24 hours**; triage patient based on the following criteria:
   Age appropriateness for adult stroke facility:
   - Pediatric patient with suspected stroke, **age < appropriate:**
     - Transport suspected stroke patient to the nearest **Pediatric Stroke Destination***
       - **Pediatric Stroke Destination** – EMS Medical Director will recommend local pediatric stroke destinations. Typically, these are pediatric hospitals with the capability to care for pediatric patients

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

❖ **For all ages:** consider air medical if transport time is prolonged > 60 minutes.
❖ **Stroke Prenotification**: alert the receiving facility that a suspected pediatric stroke patient is en route prior to arrival. A stroke alert prior to arrival will mobilize appropriate resources before patient arrival.
   - Prenotification should include: Age, last known well, time of symptom discovery, current vital signs, stroke screening tool score (if performed), and symptoms (weakness on one side, altered mental status, etc.).

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

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

Last Update – 06.03.2025

APPROVAL ITEM: Resource Document

References:

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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. • **Will email recommendations to participate in GWTG DIDO layer and performance goals to RAC chairs and continue to share with stroke programs.** • Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO	
TEAM EMS-Ed Study	• Study endorsed by Stroke, EMS and EMS Medical Directors Committees and council 06/2025. • **Meeting with companies to identify LMS platforms, submitting for funding opportunities.** • **Informed EMS Education Committee and seeking members for writing group.**	

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

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

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

Outcomes:

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

Seeking members for the stroke standardized education writing group

https://urldefense.com/v3/__https:/forms.office.com/r/NdQ6QxSuGC?origin=lprLink__;!!MznTZTSvDXGV0Co!C1QK3XMmjus3UFh8LCg-5submcx0gSQrVbUDxXK8SYASpdnHgsOCq8c2XxM9GUNHzqlTyxbnk8ruPqposn4MlWehe7VoFXDz500zPH-KDqk1Ig$

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 will lead the work group • **Call for members, planned first meeting 09/2025**	
Stroke Managers Mentorship Program and Texas Stroke Coordinators Collaborative Survey	• Education Work Group discussing the platform and feasibility of the mentorship program. • Working on the stroke managers' survey. • Will incorporate some questions from the prior survey.	
STRAC Stroke Program Manager Manual	• Collect and share resources related to stroke program management, stroke coordinator & manager roles, and process improvement. • Presented 11/2024, approved by stroke committee as a good resource.	
Mission: Lifeline EMS Recognitions	• **Bridge gap in data EMS collects from hospitals to monitor field metrics, seek approval as content and look for opportunities to disseminate the resource** • **Stroke Committee approved endorsement as best practice 08/2025** • **APPROVAL ITEM: Approval to distribute the Mission: Lifeline EMS Recognition to committees, RACs and at DSHS stroke meetings**	

Education Workgroup - Mission: Lifeline EMS Recognition

https://www.heart.org/en/professional/quality-improvement/mission-lifeline

Measure Narratives: https://www.heart.org/en/-/media/Files/Professional/Quality-Improvement/Mission-Lifeline/2025-EMS-ML-Measure-Narratives-Final.pdf?sc_lang=en

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Rural Stroke Work Group	• Met once after the prior session, plan to meet monthly. • **Approved rural and resource-challenged regions and hospitals to be included in the scope of work group.** • **Latest heat map 60 min by air** • **Needs assessment survey approved by work group and Stroke Committee 08/2025** • **APPROVAL ITEM: Survey** • **APPROVAL ITEM: EMSTR data request**	

Rural Stroke Assessment Survey

Rural Stroke Care Barriers Survey

Estimated completion time: 5–7 minutes.

Section 1: Organization Information

1. Name of your organization (optional): _____
2. Type of organization:
   - ☐ Hospital
   - ☐ EMS Agency
   - ☐ Other (please specify): _____
3. (Branching logic based on answer) Question on position at facility:
   - Hospitals will outline: Stroke Coordinator, Stroke Manager, Medical Director of Stroke Program, ED provider, ED RN, and other.
   - EMS Agency will outline: EMT, AEMT, Paramedic, Advanced Practice Provider, RN, and other.
4. Location (RAC): _drop down list_____
5. Location County: using the defined county list provided by DSHS.
6. Approximate population your facility serves:
   - ☐ < 5,000
   - ☐ 5,000 – 10,000
   - ☐ 10,000 – 25,000
   - ☐ > 25,000

Section 2: Stroke Care Capabilities

5. Does your facility/agency have stroke protocols in place?
   - ☐ Yes
   - ☐ No
   - ☐ In development

6. Is your facility designated as a stroke center?
   - ☐ Yes
   - ☐ No
7. What DSHS Level stroke facility?
   - ☐ Level 1 (CSC)
   - ☐ Level 2 (Thrombectomy Capable Stroke Center)
   - ☐ Level 3 (PSC)
   - ☐ Level 4 (ASRH)
   - ☐ Not designated
8. Does your EMS staff receive regular stroke-specific training?
   - ☐ Yes – at least annually
   - ☐ Yes – less than annually
   - ☐ No
9. (Branching logic if answers No) What are the main challenges your hospital faces in obtaining stroke center designation? (*Check all that apply*)
   - ☐ Lack of neurology coverage
   - ☐ Limited access to telestroke networks or tele-neurology services.
   - ☐ Difficulty recruiting and retaining specialized staff in rural areas.
   - ☐ Limited availability of 24/7 stroke teams, including nurses and technologists trained in stroke care.
   - ☐ High costs associated with meeting accreditation/designation standards.
   - ☐ Inability to invest in necessary infrastructure (e.g., CT/MRI scanners, telemedicine technology).
   - ☐ Limited reimbursement for stroke care in small, rural populations, making it financially unsustainable.
   - ☐ Lack of advanced imaging capabilities (CT perfusion, MRI).
   - ☐ A small catchment area may not provide enough stroke cases to justify a designation.
   - ☐ Concerns about maintaining staff competency with low case exposure.
   - ☐ Inadequate IT systems for rapid data sharing and stroke registry participation.
   - ☐ Leadership may prioritize other accreditation efforts (e.g., trauma center designation) or have other priorities.
   - ☐ Other (please specify):_____
10. Do you have access to telestroke, remote neurology services, or ambulance-based telemedicine?
    - ☐ Yes
    - ☐ No
    - ☐ In progress

Section 3: Identifying Barriers

9. What are the main challenges you face in timely stroke identification and care? *(Check all that apply)*
   - ☐ Lack of staff training
   - ☐ Inclement weather
   - ☐ Limited access to neurologists
   - ☐ Long transport times
   - ☐ Poor interfacility communication
   - ☐ Access to ground transport
   - ☐ Access to air transport
   - ☐ Lack of advanced imaging
   - ☐ Limited EMS personnel
   - ☐ Financial/resource constraints
   - ☐ Other (please specify): _____

10. What are the most significant barriers to transferring stroke patients to higher-level care facilities?
    - ☐ Distance/transport time
    - ☐ Lack of transfer agreements
    - ☐ Limited bed availability
    - ☐ Communication delays
    - ☐ Insurance or cost-related issues
    - ☐ Physician availability at the receiving hospital (e.g., neurosurgery and neurointerventional (Neuro IR)
    - ☐ Other (please specify): _____

Section 4: Improvements & Needs

11. What would most improve your organization's ability to deliver timely stroke care? *(Check up to three)*
    - ☐ More EMS or hospital staff
    - ☐ Additional training/education
    - ☐ Access to telestroke services
    - ☐ Improved imaging capabilities
    - ☐ Faster transport options
    - ☐ Stronger regional coordination
    - ☐ Funding for equipment/resources
    - ☐ Other (please specify): _____

12. Any additional comments or suggestions?

Here are my responses to the questions you had from GETAC:

- The GREEN hospitals are in the Rural Hospitals Benchmark group
- The RED hospitals are not in GWTG
- The YELLOW Hospital is in the Suburban Hospitals Group based on the RUCA code

BAYLOR SCOTT & WHITE MEDICAL CENTER - BRENHAM	Rural	IV - Acute Stroke IV	Region 7	TSA - N	700 MEDICAL PKWY	BRENHAM	TX	77833	WASHINGTON
BAYLOR SCOTT & WHITE MEDICAL CENTER - MARBLE FALLS	Rural	IIIA - Primary (III)	Region 7	TSA - O	810 W HIGHWAY 71	MARBLE FALLS	TX	78654	BURNET
CHI ST JOSEPH HEALTH BURLESON HOSPITAL	Rural	IV - Acute Stroke IV	Region 7	TSA - N	1101 WOODSON DRIVE	CALDWELL	TX	77836	BURLESON
CHI ST JOSEPH HEALTH GRIMES HOSPITAL	Rural	IV - Acute Stroke IV	Region 7	TSA - N	210 SOUTH JUDSON	NAVASOTA	TX	77868	GRIMES
CHI ST JOSEPH HEALTH MADISON HOSPITAL	Rural	IV - Acute Stroke IV	Region 7	TSA - N	100 WEST CROSS STREET	MADISONVILLE	TX	77864	MADISON
CHRISTUS SPOHN HOSPITAL ALICE	Rural	IV - Acute Stroke IV	Region 11	TSA - U	2500 EAST MAIN STREET	ALICE	TX	78332	JIM WELLS
CHRISTUS SPOHN HOSPITAL BEEVILLE	Rural	IV - Acute Stroke IV	Region 11	TSA - U	1500 EAST HOUSTON HIGHWAY	BEEVILLE	TX	78102	BEE
CHRISTUS SPOHN HOSPITAL KLEBERG	Rural	IV - Acute Stroke IV	Region 11	TSA - U	1311 EAST GENERAL CAVAZOS BOULEVARD	KINGSVILLE	TX	78363	KLEBERG
CHRISTUS ST MICHAEL HOSPITAL - ATLANTA	Rural	IV - Acute Stroke IV	Region 4	TSA - F	1007 SOUTH WILLIAM STREET	ATLANTA	TX	75551	CASS
COLEMAN COUNTY MEDICAL CENTER COMPANY	Rural	IV - Acute Stroke IV	Region 2	TSA - D	310 SOUTH PECOS STREET	COLEMAN	TX	76834	COLEMAN
CONNALLY MEMORIAL MEDICAL CENTER	Rural	IV - Acute Stroke IV	Region 8	TSA - P	499 10TH STREET	FLORESVILLE	TX	78114	WILSON
CUERO REGIONAL HOSPITAL	Rural	IV - Acute Stroke IV	Region 8	TSA - S	2550 NORTH ESPLANADE	CUERO	TX	77954	DE WITT
NORTH TEXAS MEDICAL CENTER	Rural	IV - Acute Stroke IV	Region 3	TSA - E	1900 HOSPITAL BOULEVARD	GAINESVILLE	TX	76240	COOKE
TEXAS HEALTH HARRIS METHODIST HOSPITAL STEPHENVILLE	Rural	IV - Acute Stroke IV	Region 3	TSA - E	411 N BELKNAP ST	STEPHENVILLE	TX	76401	ERATH
TITUS REGIONAL MEDICAL CENTER	Rural	IIIA - Primary (III)	Region 4	TSA - F	2001 N JEFFERSON AVE	MOUNT PLEASANT	TX	75455	TITUS
UT HEALTH EAST TEXAS PITTSBURG HOSPITAL	Rural	IV - Acute Stroke IV	Region 4	TSA - G	2701 US HIGHWAY 271 NORTH	PITTSBURG	TX	75686	CAMP
UT HEALTH EAST TEXAS QUITMAN HOSPITAL	Rural	IV - Acute Stroke IV	Region 4	TSA - G	117 N WINNSBORO STREET	QUITMAN	TX	75783	WOOD
YOAKUM COMMUNITY HOSPITAL	Rural	IV - Acute Stroke IV	Region 8	TSA - S	1200 CARL RAMERT DRIVE	YOAKUM	TX	77995	LAVACA

Rural Counties in Texas

§157.2 Definition:

(119) Rural county--A county with a population of less than 50,000 based on the latest estimated federal census population figures.

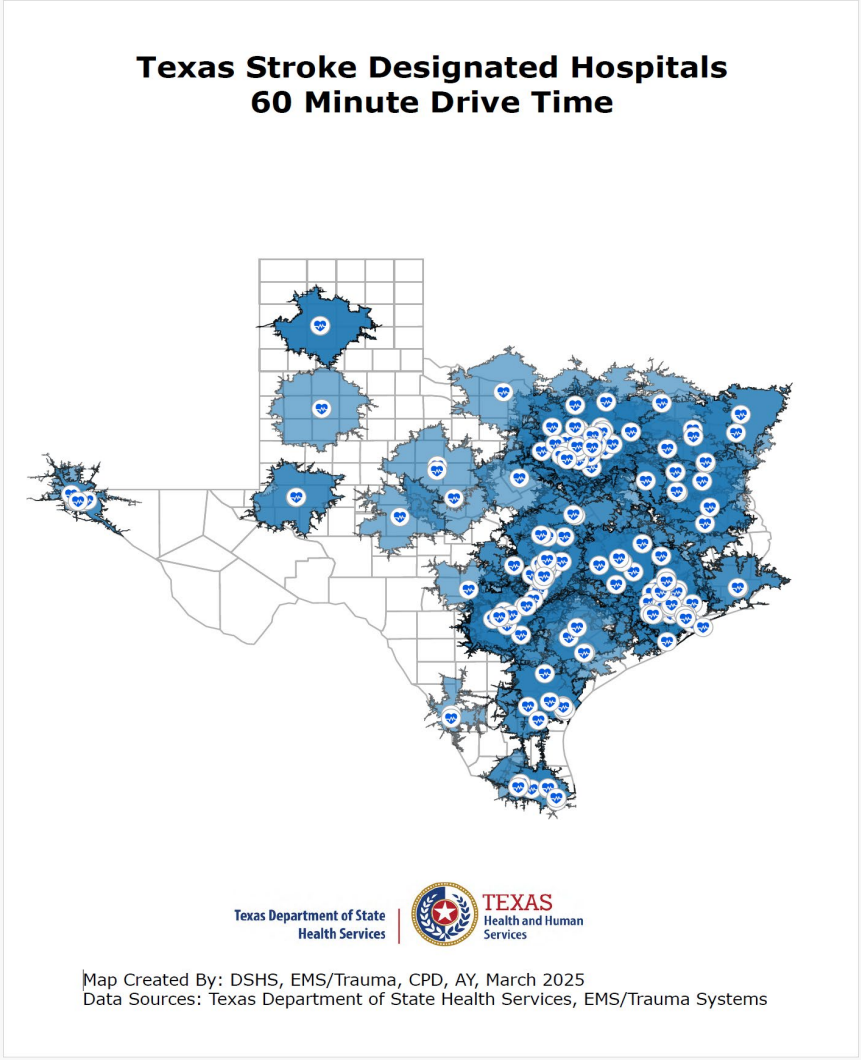
Andrews County	Hansford County	Runnels County
Aransas County	Hardeman County	Sabine County
Archer County	Hartley County	San Augustine County
Armstrong County	Haskell County	San Jacinto County
Austin County	Hemphill County	San Saba County
Bailey County	Hill County	Schleicher County
Bandera County	Hockley County	Scurry County
Baylor County	Hopkins County	Shackelford County
Bee County	Houston County	Shelby County
Blanco County	Howard County	Sherman County
Borden County	Hudspeth County	Somervell County
Bosque County	Hutchinson County	Stephens County
Brewster County	Irion County	Sterling County
Briscoe County	Jack County	Stonewall County
Brooks County	Jackson County	Sutton County
Brown County	Jasper County	Swisher County
Burleson County	Jeff Davis County	Terrell County
Caldwell County	Jim Hogg County	Terry County
Calhoun County	Jim Wells County	Throckmorton County
Callahan County	Jones County	Titus County
Camp County	Karnes County	Mitchell County
Carson County	Kenedy County	Trinity County
Cass County	Kent County	Tyler County
Castro County	Kimble County	Washington County
Childress County	King County	Wheeler County
Clay County	Kinney County	Wilbarger County
Cochran County	Kleberg County	Willacy County
Coke County	Knox County	Winkler County
Coleman County	La Salle County	Yoakum County
Collingsworth County	Lamb County	Young County
Colorado County	Lampasas County	Zapata County
Comanche County	Lavaca County	Zavala County

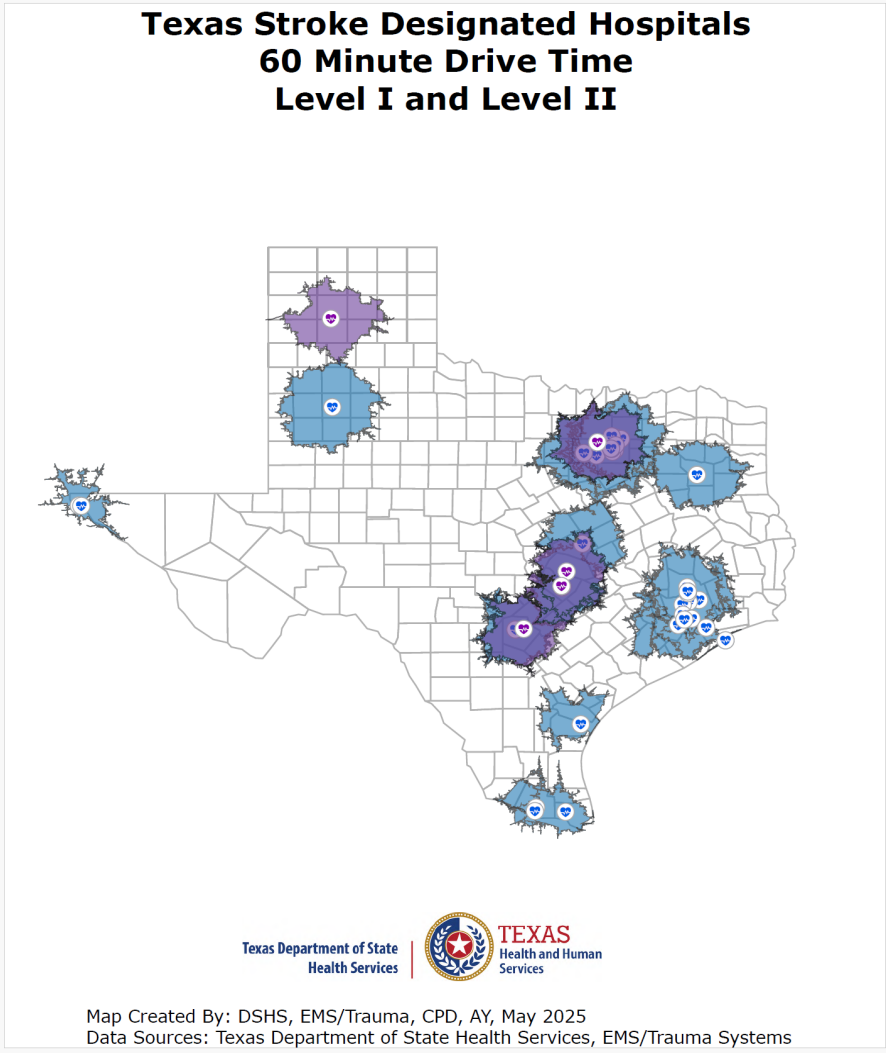
Concho County	Lee County	Upshur County
Cooke County	Leon County	Upton County
Cottle County	Limestone County	Uvalde County
Crane County	Lipscomb County	Val Verde County
Crockett County	Live Oak County	Ward County
Crosby County	Llano County	Wharton County
Culberson County	Loving County	
Dallam County	Lynn County	
Dawson County	Madison County	
DeWitt County	Marion County	
Deaf Smith County	Martin County	
Delta County	Mason County	
Dickens County	Matagorda County	
Dimmit County	McCulloch County	
Donley County	McMullen County	
Duval County	Menard County	
Eastland County	Milam County	
Edwards County	Mills County	
Erath County	Montague County	
Falls County	Moore County	
Fannin County	Morris County	
Fayette County	Motley County	
Fisher County	Newton County	
Floyd County	Nolan County	
Foard County	Ochiltree County	
Franklin County	Oldham County	
Freestone County	Palo Pinto County	
Frio County	Panola County	
Gaines County	Parmer County	
Garza County	Pecos County	
Gillespie County	Presidio County	
Glasscock County	Rains County	
Goliad County	Reagan County	
Gonzales County	Real County	
Gray County	Red River County	
Grimes County	Reeves County	
Hale County	Refugio County	
Hall County	Roberts County	
Hamilton County	Robertson County	

Update: Rural Stroke Work Group

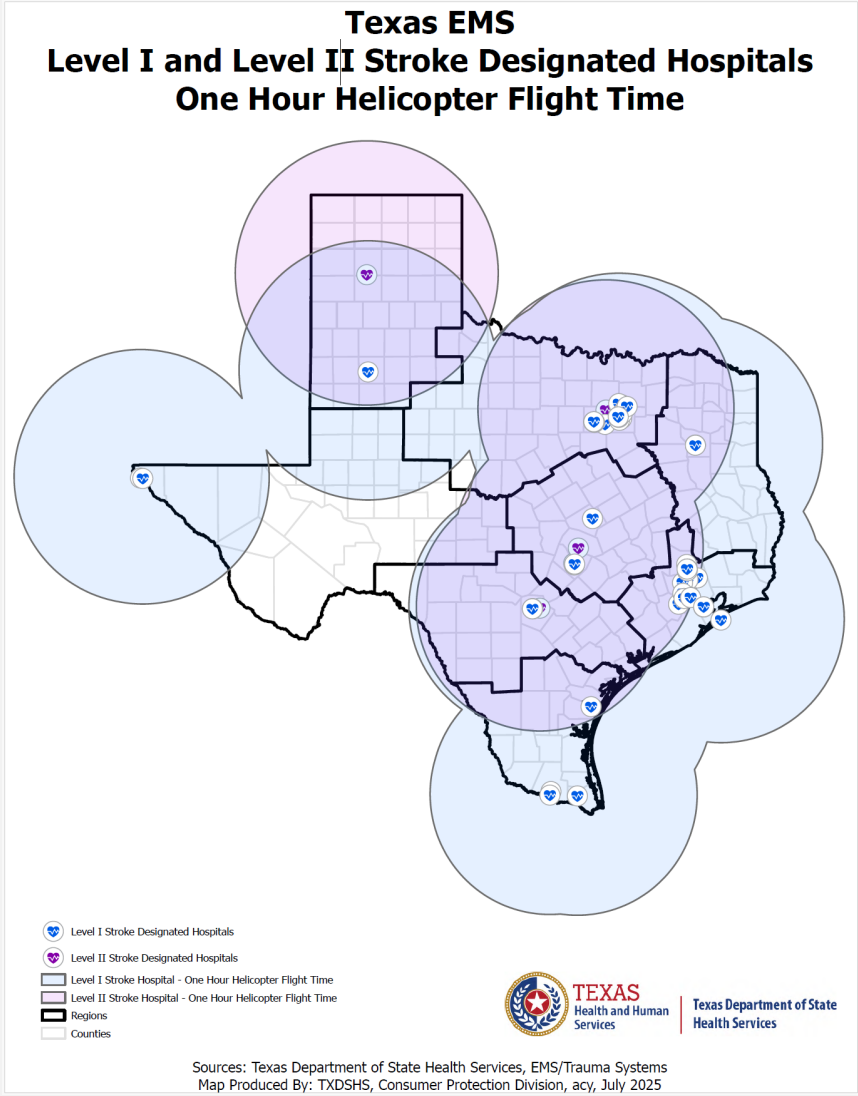
- **Last meeting 07/17/2025, next meeting 08/28/2025**.
- Martee Tebow, Sarah Hancock, Jennine Fox, Dr. Mandy Jagolino-Cole, and Janine Mazabob – working on a recommendation for public awareness and education on stroke to target rural areas (English and Spanish ideal) – the goal is to present by early September.
- GWTG- compare arrival mode by private vehicle versus EMS at rural stroke facilities regarding LKW to arrival, DTN, and LKW to thrombolytic (needle) for 2023, 2024, and 2025 YTD.
- Data request: EMSTR data 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?

Texas Stroke Heat Maps





Texas Stroke Heat Map



Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Texas EMS Stroke Survey	• **Results shared** • **Abstract submitted to ISC, working on second** • **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	• **Seeking opportunities to make documents readily available to RACs.** • **EMS Education Liaison – Dr. Jagolino-Cole** • **Met with RAC chairs 08/2025 to seek guidance, recommended email RAC chairs via Deidra** • **APPROVAL ITEM: Can endorsed stroke resources be available from the GETAC Stroke Committee website**	
Work with DSHS to outline recommendations for stroke rules for ASRH	• Pending further direction	

ITEM	ISSUE	ASK	INTENDED OUTCOME
Prehospital stroke triage algorithm	No standard or guidance on best practice for patients with suspected stroke for timely transport to the right stroke facility level.	Collaborate with GETAC Stroke Committee to outline best practice recommendation for prehospital triage of suspected stroke patients.	GETAC endorsed best practice recommendation for prehospital stroke triage in rural, urban and suburban areas
Door-In-Door-Out (DIDO) time of patient arrival to departure from the transferring facility in route to the higher-level facility	Some stroke patients will require emergent or urgent transfer to a higher-level stroke facility in order to receive a lifesaving treatment. The current recommendation is DIDO for emergent transfers to a higher level of care should take 90 minutes or less for thrombectomy eligible patients. 2024 t median DIDO for Texas **143** minutes and nationally 134 minutes. (01/2025)	1. Collaborate with GETAC Stroke Committee to outline **best stroke terminology** to improve rapid transfer of patients in need of life saving treatment. 2. Collaborate with GETAC Stroke Committee to outline best practices and **aspirational performance measures** during inter-facility transfers of patients in need of life saving treatment.	GETAC endorsed best practice recommendation for state of Texas
EMS Pediatric Stroke Recommendation	No standard practice or guidance on prehospital management and triage for pediatric patients with suspected stroke. Request made to the Stroke Committee to help outline.	Collaborate with GETAC Stroke Committee to outline best practice for prehospital triage and management of pediatric patients with suspected stroke.	GETAC endorsed best practice recommendation for state of Texas
GETAC Stroke Screening Survey	EMS providers in the US reported inadequate LVO training and demonstrated gaps in knowledge of LVO, Stroke severity scales and stroke center level in recent US survey. https://www.ahajournals.org/doi/epub/10.1161/SVIN.123.001038	Collaborate with GETAC Stroke Committee to outline a Texas EMS stroke screen survey to understand the current gaps in knowledge and training for stroke in the state of Texas.	Understanding the gaps in education and current practice can help the GETAC Stroke Committee to make recommendations on education and best practices. Long-term goal would be to execute a research trial using standardized stroke education for EMS providers to see if it can improve knowledge and performance on key prehospital stroke measures.

GETAC Stroke Committee

- **Committee items needing council approval:**
  - Data request EMSTR for rural stroke approved by the stroke committee
  - Pediatric resource document with recommendation to add edit for end tidal CO2
  - Rural stroke survey
  - Council approval for endorsed stroke resources to be on GETAC Stroke Committee website
  - Approval to distribute the Mission: Lifeline EMS Recognition to committees, RACs and at DSHS stroke meetings.

- **Action items for the next session:**
  1. Pediatric stroke tip sheet and supplement
  2. Neuro IR coverage recommendation best practice
  3. Rural Stroke Work Group recommendation on best practice 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

Items Approved

Item	Approved/Denied	Date	Tasks
Prehospital Adult Stroke Routing	Approved	03/2025	Provided to Jorie 06/2025
Prehospital Adult Stroke Resource Document	Approved	06/2025	Provided to Jorie 06/2025
Prehospital Pediatric Stroke Routing	Approved	06/2025	Provided to Jorie 06/2025
TEAM-Stroke Ed study	Endorsed	06/2025	Present to EMS Ed Committee and RACs Create Educational content
DIDO performance measure recommendation	Approved		Provided to Jorie 06/2025
Stroke Terminology	Denied	11/2025	Working with task force
Texas EMS Stroke Survey	Completed		Results submitted to committees and the council 06/2025