TEXAS
Health and Human Services

Texas Department of State Health Services

Governor's EMS and Trauma Advisory Council

Friday, August 23, 2024

8: 00 AM (CDT)

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

1. Call to Order

2024 Governor's EMS and Trauma Advisory Council Meeting

3rd Quarter

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Texas Department of State Health Services

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

Public participation is available at:

DoubleTree by Hilton Austin, Phoenix Central Ballroom

6505 N Interstate 35

Austin, TX 78752

Virtual Rules of Participation

Rules of Participation

- Please be respectful during the meeting to ensure all members can be heard.
- Please do not monopolize the time with your comments.
- Please limit comments to three minutes or less.
- Please allow others to voice their opinion without criticism.
- Everyone’s voice and opinion matters.

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

Rules of Participation

- If you would like to make a statement or ask a question, please put your question in the chat with your name and entity you represent.

  Please note: Anonymous entries in the chat are unable to be shared.

- Please do not put your phone on hold at any time if you are using your phone for audio.

To mute/unmute if not using the computer for audio, press	
***6** on Android phones	***6#** on iPhones

Rules of Participation

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

2. Roll Call

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

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

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3. Governor's EMS and Trauma Advisory Council Vision and Mission

Vision:

A unified, comprehensive, and effective Emergency Healthcare System.

Mission:

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

Moment of Silence

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

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4. Approval of Minutes

Review and Approval of Minutes

- June 14, 2024

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5. Chair Report and Discussion

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

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State Reports

6.a. EMS Trauma Systems Update

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

Priorities

- Data Submission
  - Closing of 2023
  - Closing of 2024
- RAC Contracts
  - Statement of Work
  - Funding allotment – September 1, 2024
- Trauma UCC Payments

Priorities

- Planning for GETAC 2025
  - January 30-31 for Retreat
  - Q1: March 4-7 (possibly 3-7, if retreat occurs simultaneously)
  - Q2: June 17-20
  - Q3: August 19-22

- Sunset Preparation

Trauma Rules

August 2, 2024, Formal Public Comment Opens

August 15, 2024, Executive Council Meeting

September 3, 2024, Formal Public Comment Ends

Formal Public Comment Review

- Comment Review
  - September 4
  - September 5
- Adoption Packet
- Designation Survey Guidelines

Contingent Designations

Trauma Level III and IV Facilities			
Level and Year	Total Contingent Facilities	Focused Surveys (Contingent)	Full Surveys (Probationary)
Level III 2023	11	1	3
Level III 2024	11	0	2
Level IV 2023	32	1	4
Level IV 2024	42	3 (DSHS Review)	0

Thank You, TETAF

Recognition of a 35 Year Journey of the EMS/Trauma System

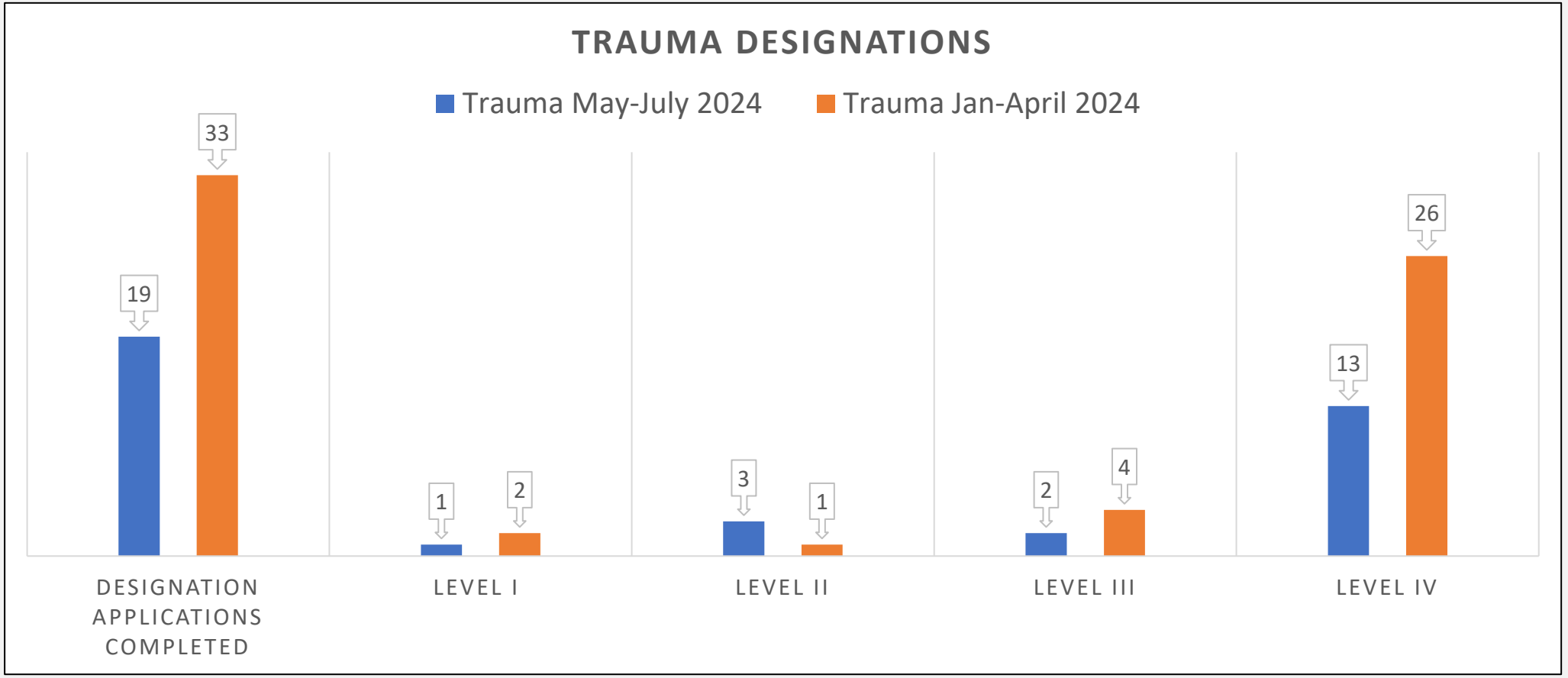
Designation Update

Elizabeth Stevenson, BSN, RN
Designation Programs Manager

Designated Trauma Facilities

Designated Trauma Facilities	July 2024	April 2024
Total	299	300
Level I	22	22
Level II	28	27
Level III	59	60
Level IV	190	191

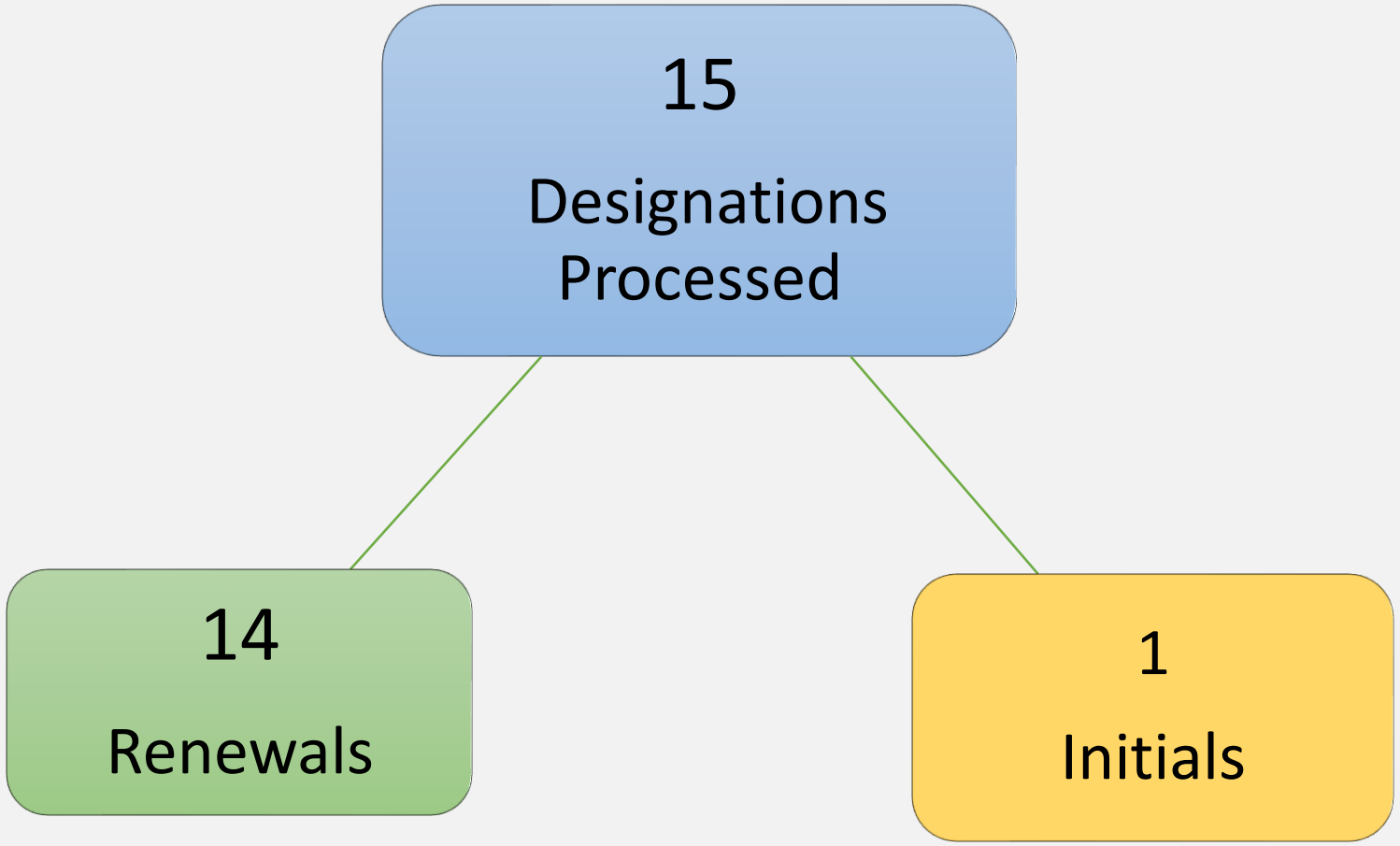
Trauma Designation Data



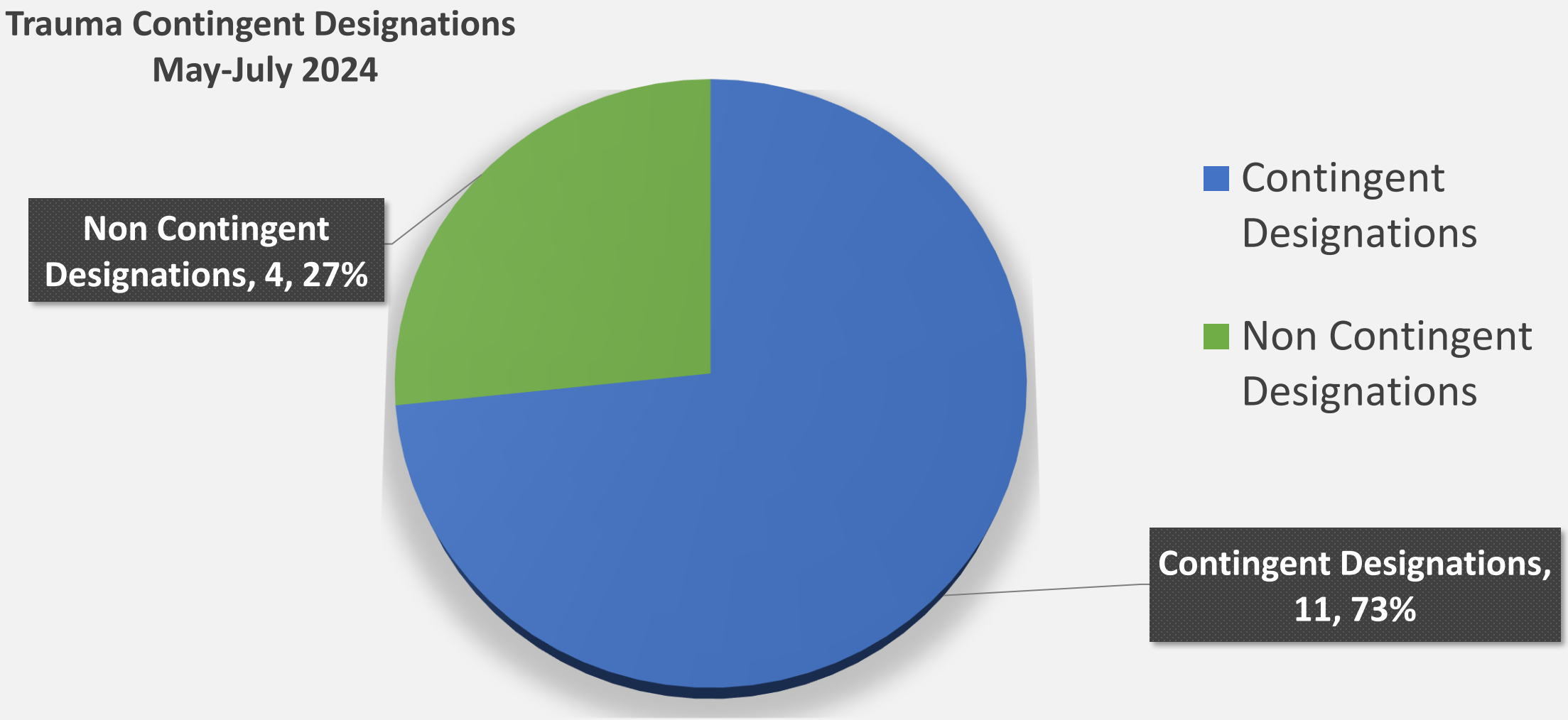
Trauma Designation Data

Trauma 2024	Trauma May - July 2024	Trauma January - April 2024
New IAP Recognitions	**2**	**2**
Facilities In Active Pursuit	**9**	**8**
Level I	0	0
Level II	1	0
Level III	3	3
Level IV	5	5

Trauma Designation Data



Trauma Designation Data



Common Deficiencies

- TPM 0.8 FTE
- Nursing documentation
- PI – Identified All Variances and Actions taken
- TMD participation in PI
- PI – M&M Review
- PI – Loop Closure

Trauma Designation Information

Department Activities:

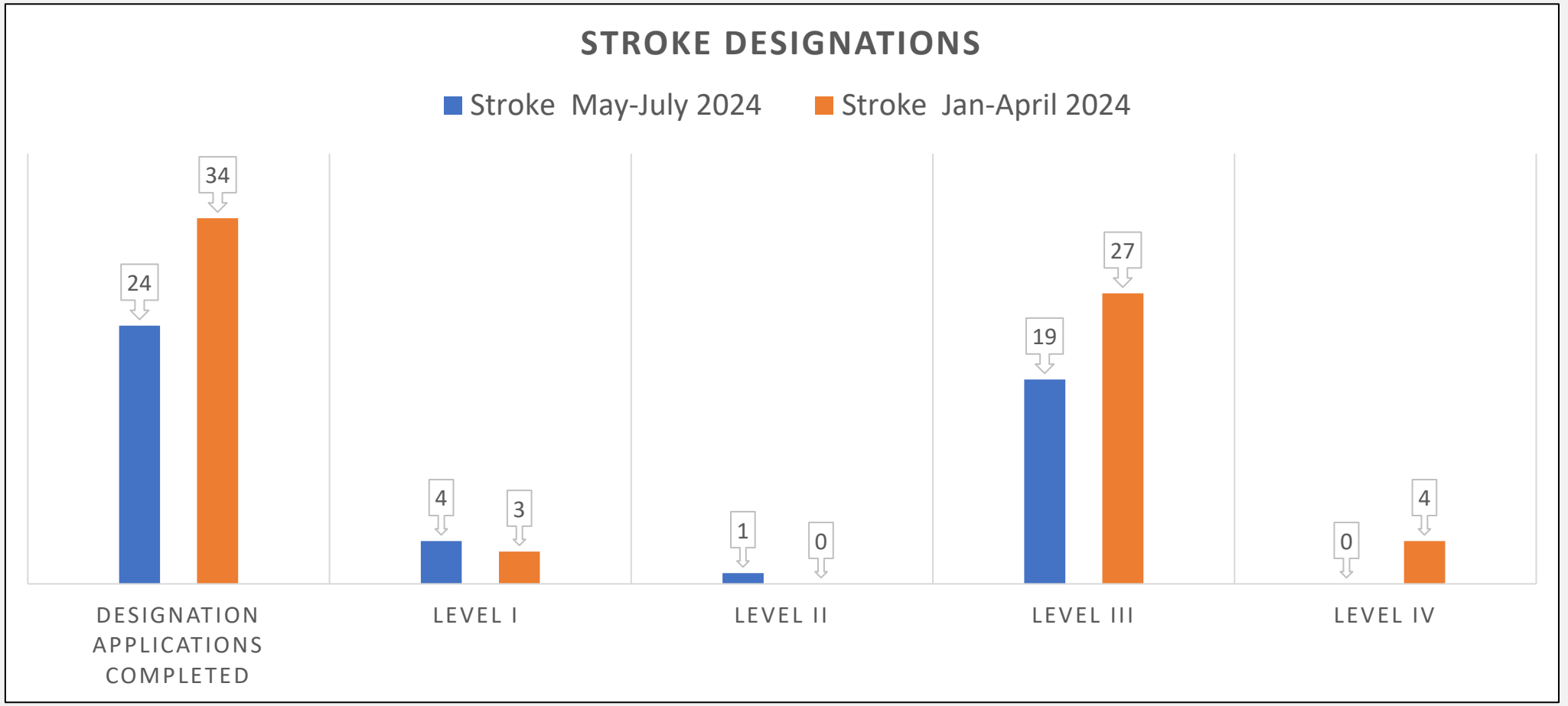
- DSHS meetings on Proposed Trauma Rules held July 23 and August 21, 2024
- Revised TOPIC Course provided on August 20, 2024
- DMEP course registration (309 slots for TPMs; 309 slots for TMDs)
- Rural Level IV and Level I/II Facility designation calls occur on the 2nd Wednesday of each month.
- Non-Rural Level IV and Level III Facility designation calls occur the 4th Wednesday of each month.

Trauma meeting calls are now on the GoToWebinar platform

Designated Stroke Facilities

Designated Stroke Facilities	July 2024	April 2024
Total	189	188
Comprehensive Level I	45	45
Advanced Level II	6	4
Primary Level III *Primary Level II*	*93* *20*	*74* *41*
Acute Stroke Ready Level IV *Support Level III*	*24* *1*	*22* *2*

Stroke Designation Data



Stroke Designation Information

Stroke Workgroup Projects

- Stroke Application Data - Completed
- Level IV Acute Stroke Ready designation calls to begin on September 12, 2024, at 2:00 PM, on TEAMS platform
- Stroke designation calls occur the 2nd Tuesday of each month on the GoToWebinar platform

Designation Application Process Performance Measures

Goals – 30/60 days

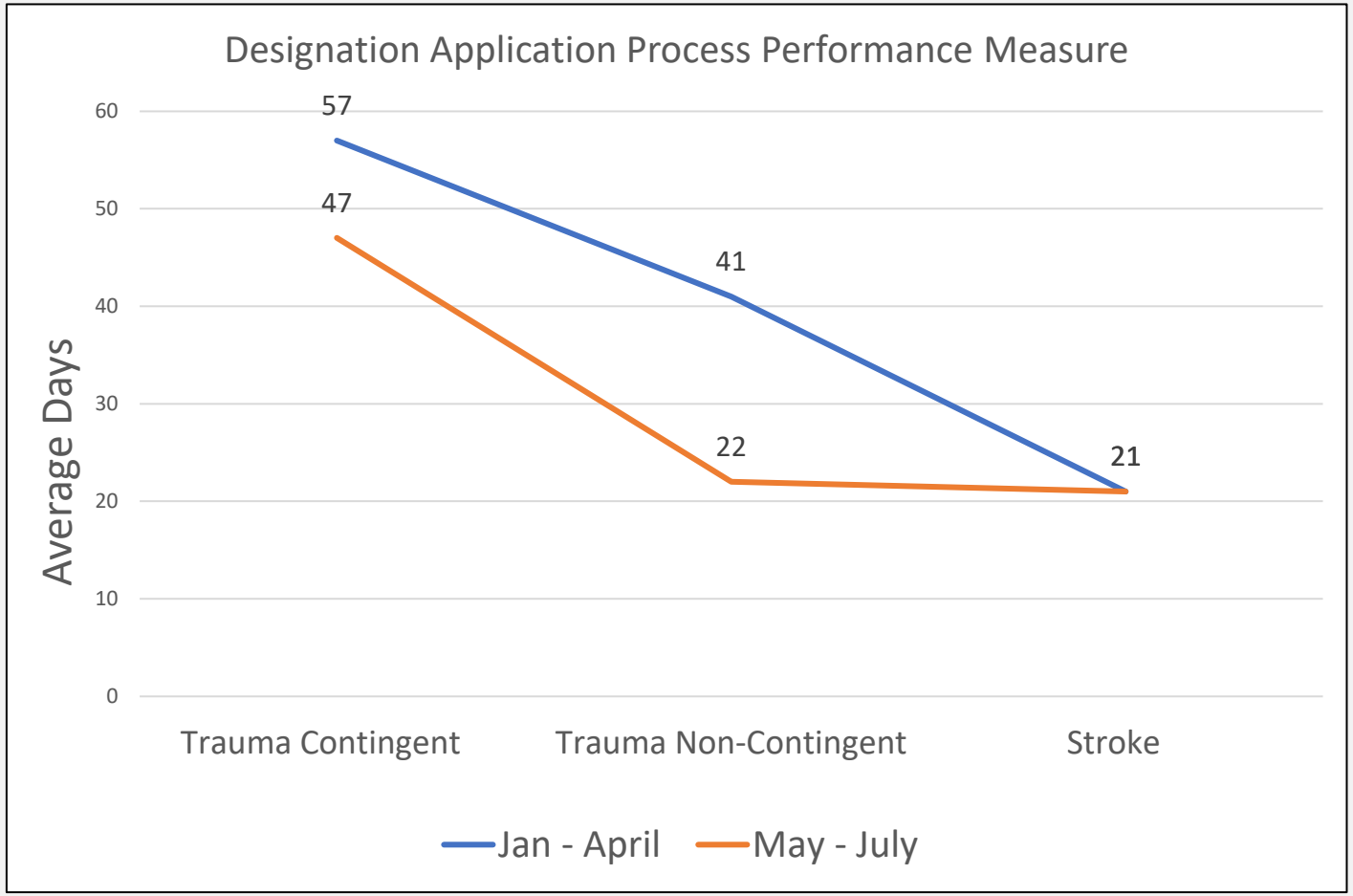
(Non-Contingent Designation 30 Days)

(Contingent Designation 60 Days)

Stroke – 21 days

Trauma – 47 days
Contingent

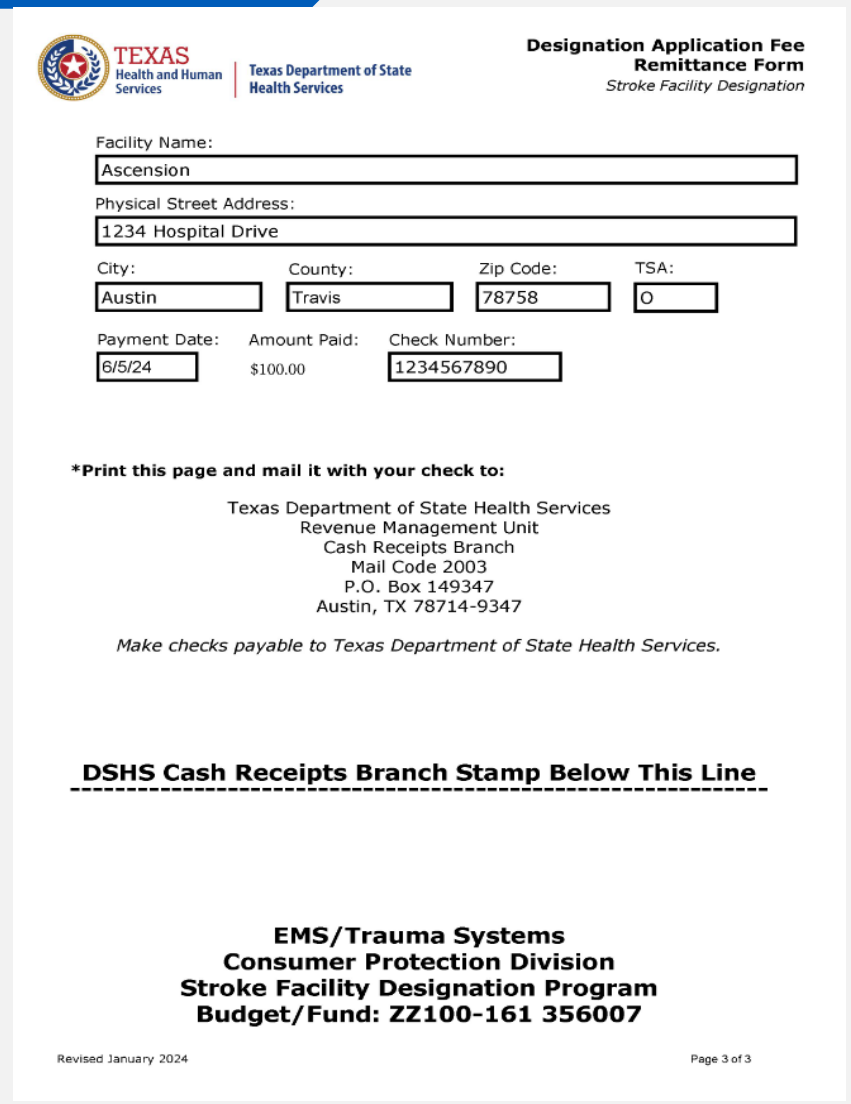
Trauma – 22 days
Non–Contingent



Application Fee Payments

- Paper checks must be **mailed** *with the fee remittance form*
- Provide check number on application or soon after submission

ACH payments could delay your application being processed



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Designation Application Fee Remittance Form
Stroke Facility Designation

Facility Name: Ascension

Physical Street Address: 1234 Hospital Drive

City: Austin | County: Travis | Zip Code: 78758 | TSA: O

Payment Date: 6/5/24 | Amount Paid: $100.00 | Check Number: 1234567890

***Print this page and mail it with your check to:**

Texas Department of State Health Services
Revenue Management Unit
Cash Receipts Branch
Mail Code 2003
P.O. Box 149347
Austin, TX 78714-9347

Make checks payable to Texas Department of State Health Services.

DSHS Cash Receipts Branch Stamp Below This Line

EMS/Trauma Systems
Consumer Protection Division
Stroke Facility Designation Program
Budget/Fund: ZZ100-161 356007

Revised January 2024

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EMS System Update

Joe Schmider
Texas State EMS Director

Senate Bill 8 Update

- Over **3,069** Education Scholarships processed or in process
- EMS Scholarships in each RAC
- $**16,204,400.** Million in scholarships processed
- **9,108** new certified EMS personnel since 10/1/22
- 2019 – 68,461 certified personnel; today – **77,582**

(As of 8-1-2024)

NEMSIS: V5 switch over Continues to move Forward!

For more information on NEMSIS and national dashboards go to

hhtps://NEMSIS.org.

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Please remember...

ECAs, EMTs, AEMTs, and Paramedics all work under the authority of a medical director.

We are not independent practitioners!

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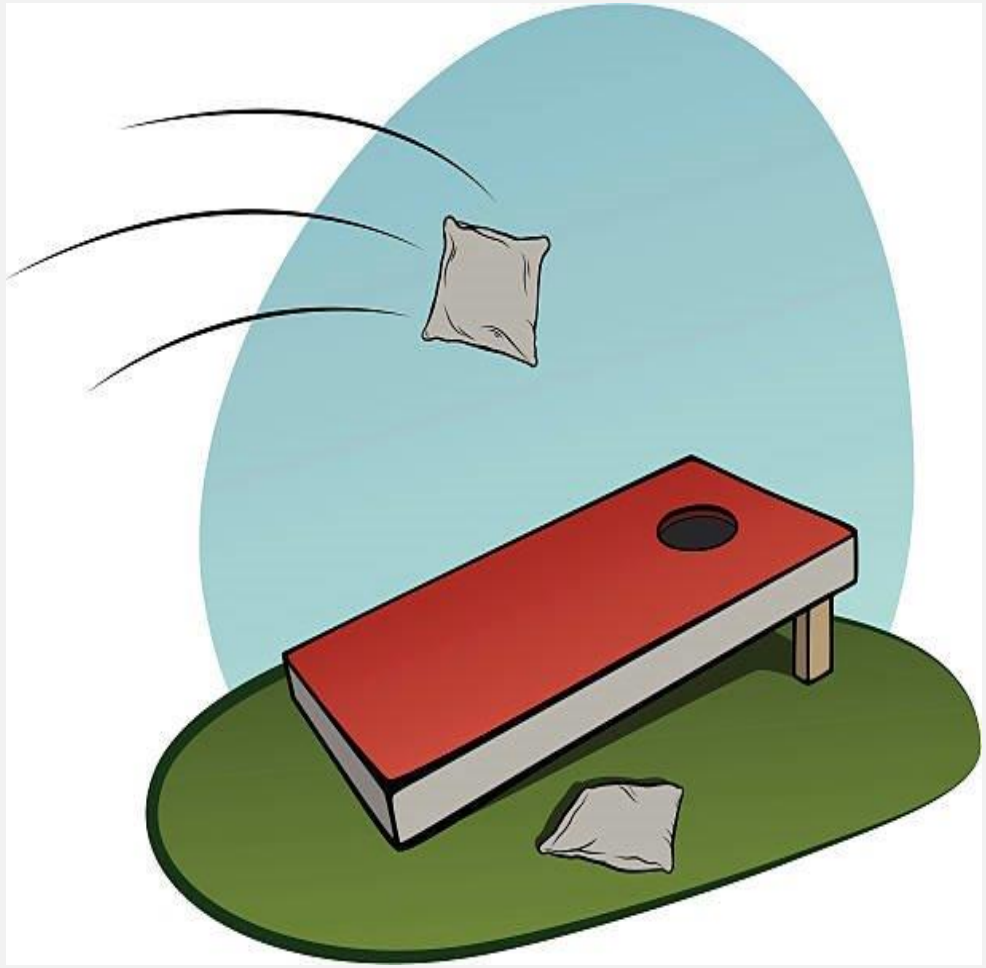
Texas EMS Conference

- November 23-26
- Fort Worth Convention Center
- Cornhole on Sunday Night!!



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EMS Licensing Processing Time Third Quarter FY 24 (Mar, Apr, May)

Overall – All Applications

- **EMS Personnel:** DSHS processed 7,031 applications; the median processing time of 14 days.
- **EMS Educators:** DSHS processed 518 applications; the median processing time of 116 days.
- **EMS Providers:** DSHS processed 74 applications; the median processing time of 71 days.
- **First responder organizations:** DSHS processed 66 applications; the median processing time of 69 days.

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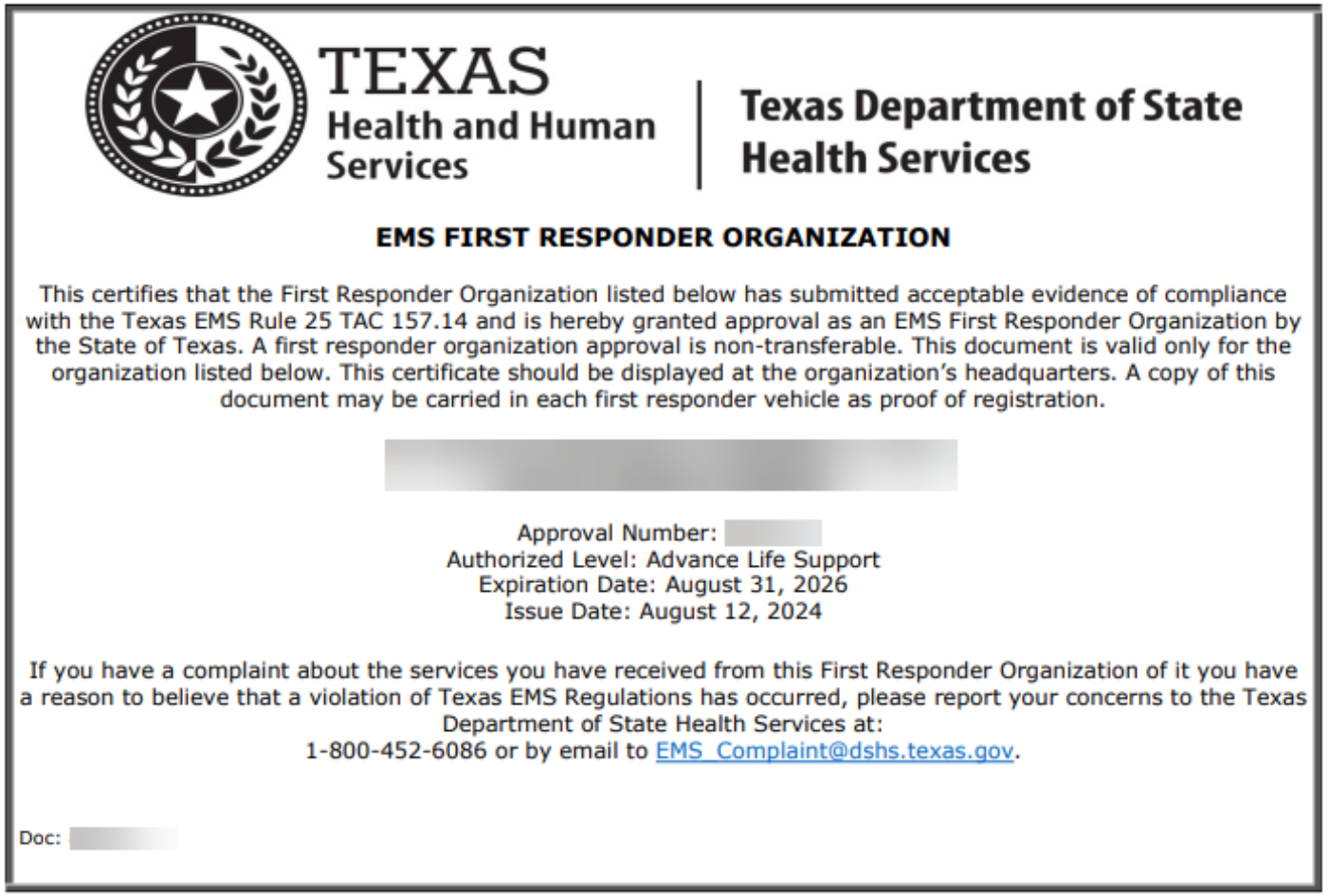
What Delays Application Processing (ECA, EMT, AEMT & Paramedic)

- Initial applicants applying **early** and **not** having your NREMT information on your application or applying too **early** before completing the fingerprint background check.
- Apply when you have your NREMT certification and about two days before your background check fingerprint appointment.
- Generally, this allows DSHS to work your application once and grant your certification/license faster.
- Watch your email for deficiency notices. Check your spam/junk folders. Failure to respond to a deficiency email causes delays for most renewal applications.
- List **@dshs.texas.gov** in your safe sender list.

First Responder Organization Certificate New Look



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EMS FIRST RESPONDER ORGANIZATION

This certifies that the First Responder Organization listed below has submitted acceptable evidence of compliance with the Texas EMS Rule 25 TAC 157.14 and is hereby granted approval as an EMS First Responder Organization by the State of Texas. A first responder organization approval is non-transferable. This document is valid only for the organization listed below. This certificate should be displayed at the organization's headquarters. A copy of this document may be carried in each first responder vehicle as proof of registration.

[redacted]

Approval Number: [redacted]
Authorized Level: Advance Life Support
Expiration Date: August 31, 2026
Issue Date: August 12, 2024

If you have a complaint about the services you have received from this First Responder Organization of it you have a reason to believe that a violation of Texas EMS Regulations has occurred, please report your concerns to the Texas Department of State Health Services at:
1-800-452-6086 or by email to EMS_Complaint@dshs.texas.gov.

Doc: [redacted]

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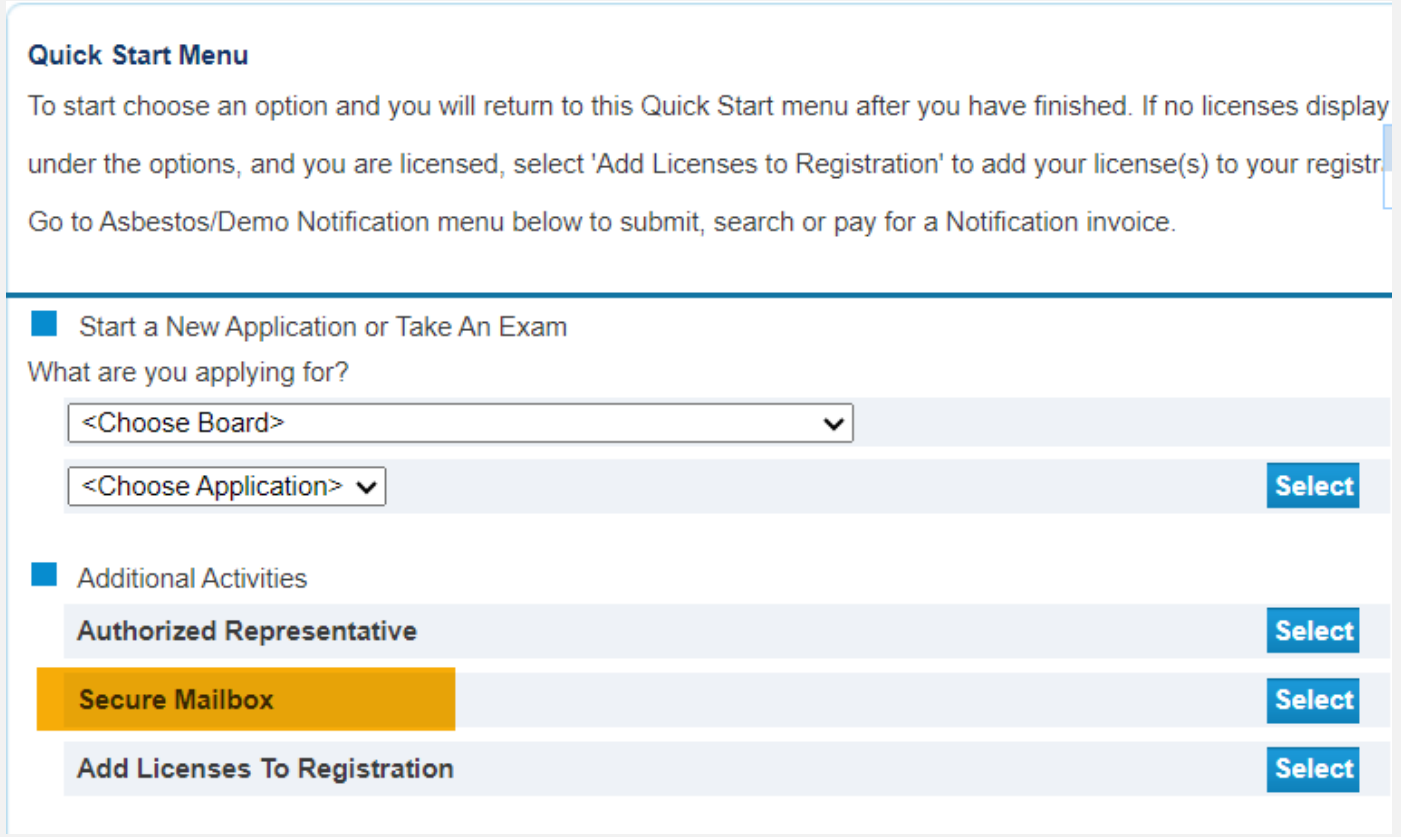
Certificates delivered to secure mailbox within DSHS online account

- EMS Personnel
- EMS Educators
- First Responder Organizations

- **In the Quick Start menu, look for Secure Mailbox.**



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Personnel Updates Now Online for EMS Providers and First Responder Organizations

- You are now able to **update personnel** through the online licensing system. You simply log in to your account and make the necessary changes to your roster.
- If you are renewing your provider license and have updated your personnel roster through the licensing system, you are **not required to submit the paper personnel roster.**
- As always, if you have any questions related to EMS provider forms or processing, please email: **EMSProviderFRO@dshs.texas.gov**

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EMS/Trauma Systems Funding

Sunita Raj, EMS/Trauma Systems Manager

EMS Trauma Funds Support

Hospital Uncompensated Care Allocation ($82.1M)FY24 & (84.2M)FY25

IAC to HHSC for Standard Dollar Amount (SDA Add-On) Programs

- Trauma Care ($68.6M)

Extraordinary Emergency Funding Requests (EEFs) ($1.0M)

Support emergent, unexpected needs of:

- Licensed EMS providers
- First Responder Org
- Licensed Hospitals

EMS Allotment Fund ($5.2M)

Funds for EMS Providers of 9-1-1 services and/or emergency transfers

Distributed to RACs on behalf of eligible recipients per county (pass-thru funds)

Emergency Care Attendant Training (ECAT) ($25K)

Facilitate initial training in rural/underserved areas

Communities lacking local EMS training resources

*EMS funds – retention/recruitment (SB 8, 3rd Special Session)

Regional Advisory Councils (RACs) Allocation ($8.3M)

Support EMS/ Trauma Care System – Advancements

Reduce morbidity & mortality from injuries

Additional directives:

- Stroke
- Maternal
- Neonatal
- Centers of Excellence for Fetal Diagnosis
- Data collection

DSHS Administrative Costs ($2M)

Oversight/integration of TX EMS Trauma Health Care Systems:

- Designation (4 programs)
- Funding/Allocation Distribution
- Emergency Medical Services (EMS)
- Regional Advisory Councils (RACs)
- Medical Advisory Board (MAB)
- 77 FTEs

Extraordinary Emergency Funds (EEFs):

FY24: $1M was made available on 9/1/2023 - $214,000 rolled over from FY 2023

- 17 Applications received
- 8 Awarded, 5 Denied 4 Withdrawn
- Total Expended: $$1,213,994.89
- Funds available: $5.11

Requested items:

- 6 Ambulances
- Ice Machine
- New Engine

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Regional Advisory Council (RAC) Contracts

- RAC Contracts include:
  - EMS Allotment
  - RAC Allotment
  - RAC Systems Development
- Contract dates:
  - Start 9/1/2023
  - End 8/31/2024
- EI payments
  - Start 9/1/2023

	FY 2023	FY 2024	FY 2025
EMS	$4,795,847	$4,876,435	$4,941,600
RAC	$2,597,147	$2,650,510	$2,661,449
System Dev.	$2,278,187	$2,278,187	$2,278,187
EI		$3,300,000	$3,300,000
Total:	**$9,424,118**	**$13,105,132**	**$13,181,236**

FY21 UCC Funding Update

- Applications closed on May 15, 2024
- $89,684,544.86 Allocated for Hospital
- $175,159,949.74 from SDA Trauma Add-On

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Uncompensated Charges

290 Hospitals Applied

5 – IAP

- $ 2,968,946,363 total Uncompensated Charges Requested
- $ 852,084,816.63 Uncompensated Costs

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Uncompensated Charges vs Fund Distributed

Two facilities had over $200 millions in UncompensatedCharges requested. Their actual approved fund distributed is less than $200,000 each from DSHS.

Five facilities are between $150 millions-$100 millions in Uncompensated Charges requested. Their actual approved fund distributed is $55,000 or less each.

Uncompensated Charges Negative Dollar amount In part "C"

	S	T	U
9	Uncompensated Charges	Original Amount Billed to Patient	Collections on These Accounts
32	(3.00)	50,473.16	$50,476.16
35	(8,929.15)	18,249.30	$27,178.45
123	(5.00)	18,921.51	$18,926.51
149	(4,756.92)	6,816.96	$11,573.88
346	(1,555,044.70)	(1,555,044.70)	$0.00
363	(38,276.75)	49,321.25	$87,598.00
743	(8,219.15)	3,660.85	$11,880.00
888	(44,412.43)	18,675.00	$63,087.43
900	(43,373.08)	19,780.93	$63,154.01
1017	(69,365.88)	39,865.45	$109,231.33
1140	(823.05)	4,883.29	$5,706.34
1255	(8,210.76)	32,617.67	$40,828.43

Uncompensated Charges
Ineligible Discharge Dates

	H	I	J	K
9	Admitted?	Admit Date and Time: *mm/dd/yy hh:mm am/pm*	Discharge Date and Time: *mm/dd/yy hh:mm am/pm*	Admitted At Least 23 Hours?
1285	Yes	12/1/22 9:15 PM	1/6/23 1:50 PM	Yes
1331	Yes	12/10/22 10:54 PM	1/12/23 8:57 PM	Yes
1366	Yes	12/18/22 2:22 AM	1/5/23 9:28 PM	Yes
1372	Yes	12/20/22 8:49 PM	1/6/23 4:13 PM	Yes
1373	Yes	12/20/22 5:42 PM	1/5/23 9:29 PM	Yes
1384	Yes	12/23/22 5:27 AM	1/2/23 2:49 PM	Yes
1386	Yes	12/23/22 10:35 AM	1/6/23 2:55 PM	Yes
1389	Yes	12/24/22 2:03 PM	1/1/23 1:58 PM	Yes
1394	Yes	12/25/22 2:39 PM	1/9/23 1:05 PM	Yes
1396	Yes	12/26/22 5:48 PM	1/2/23 6:05 PM	Yes
1397	Yes	12/27/22 3:33 PM	1/13/23 6:31 PM	Yes
1399	Yes	12/28/22 6:41 PM	1/13/23 5:00 PM	Yes
1400	Yes	12/28/22 12:00 PM	1/5/23 8:09 PM	Yes
1401	Yes	12/28/22 3:43 AM	1/5/23 3:30 PM	Yes
1402	Yes	12/28/22 7:30 PM	1/10/23 7:27 PM	Yes

Questions for EMS/Trauma Systems?

Thank You

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6.b. Texas EMS and Trauma Registry Office of Injury Prevention

Jia Benno, MPH
Office of Injury Prevention Manager

Emergency Medical Services and Trauma Registries (EMSTR) Emergency Medical Services (EMS) Stroke and Cardiac Data

August 23, 2024

Jia Benno, MPH
Texas Department of State Health Services (DSHS) Injury Prevention Unit Director

About EMSTR

- EMSTR collects reportable event data from EMS providers, hospitals, justices of the peace, medical examiners and rehabilitation facilities.
- EMS providers and trauma facilities must report all runs and trauma events to EMSTR under Texas Administrative Code, Title 25, Chapter 103.

NOTE – An EMS run is a resulting action from a call for assistance where an EMS provider is dispatched to, responds to, provides care to, or transports a person.

Per epidemiology best practice, EMSTR suppressed data with less than five records to protect identifiable information; noted with an asterisk (*).

Presentation includes data from 2019-2022. Staff prepared data analyses based on “closed” EMS datasets.

EMSTR Current Status

EMS 2022 Unique Records	EMS 2023 Records*	EMS 2024 Records*
4,603,934	4,887,247	2,429,971

Trauma 2022 Unique Records	Trauma 2023 Records*	Trauma 2024 Records*
162,409	236,890	68,536

*Record count as of 8/14/2024. NOTE – record counts are not final as these datasets are not closed yet. There may be some duplicate 2023 and 2024 records until the dataset is final and cleaned.

Stroke Data Request 2019-2022

Inclusion Criteria – All Suspected Strokes

- Primary symptom, other associated symptom, provider's primary impression or provider's secondary impression variables included International Classification of Diseases Tenth Revision (ICD-10) codes:
  - G45 – Transient cerebral ischemic attacks and related syndromes;
  - G46 – Vascular syndromes of brain in cerebrovascular diseases;
  - I60 – Nontraumatic subarachnoid hemorrhage;
  - I61 – Nontraumatic intracerebral hemorrhage; and
  - I63 – Cerebral infarction.
- Protocols used were "Medical – Stroke/TIA"**.
- Stroke Scale Result was "Positive".

**TIA = transient ischemic attack

Suspected Stroke Numbers

	2019	2020	2021	2022	Total
Suspected Strokes Total Count	45,731	48,626	57,278	59,752	**211,387**

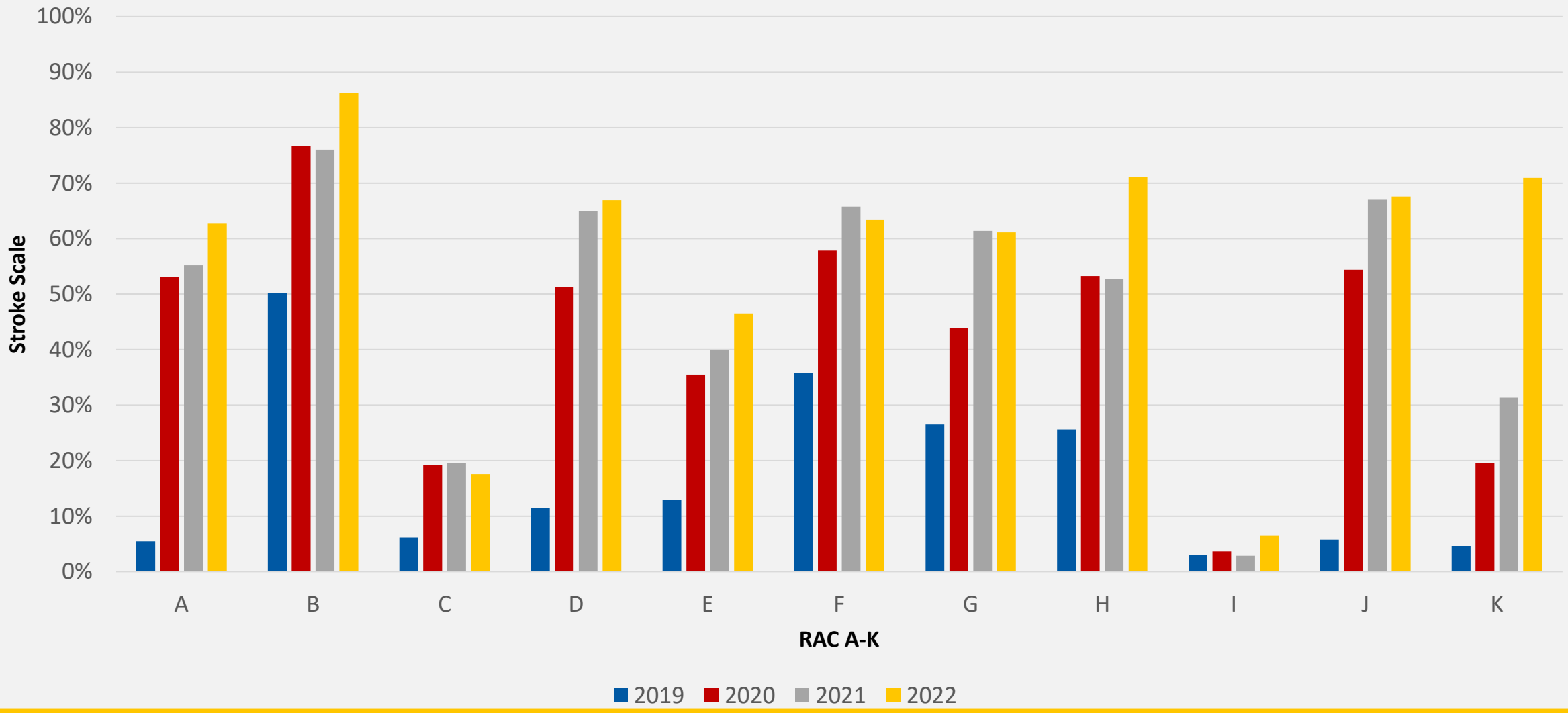
Suspected Stroke by Age

Age	2019	2020	2021	2022	Total
Less than 18	147	143	165	184	**639**
Age 18+	45,471	47,757	56,359	59,105	**208,692**
Missing	113	726	754	463	**2,056**

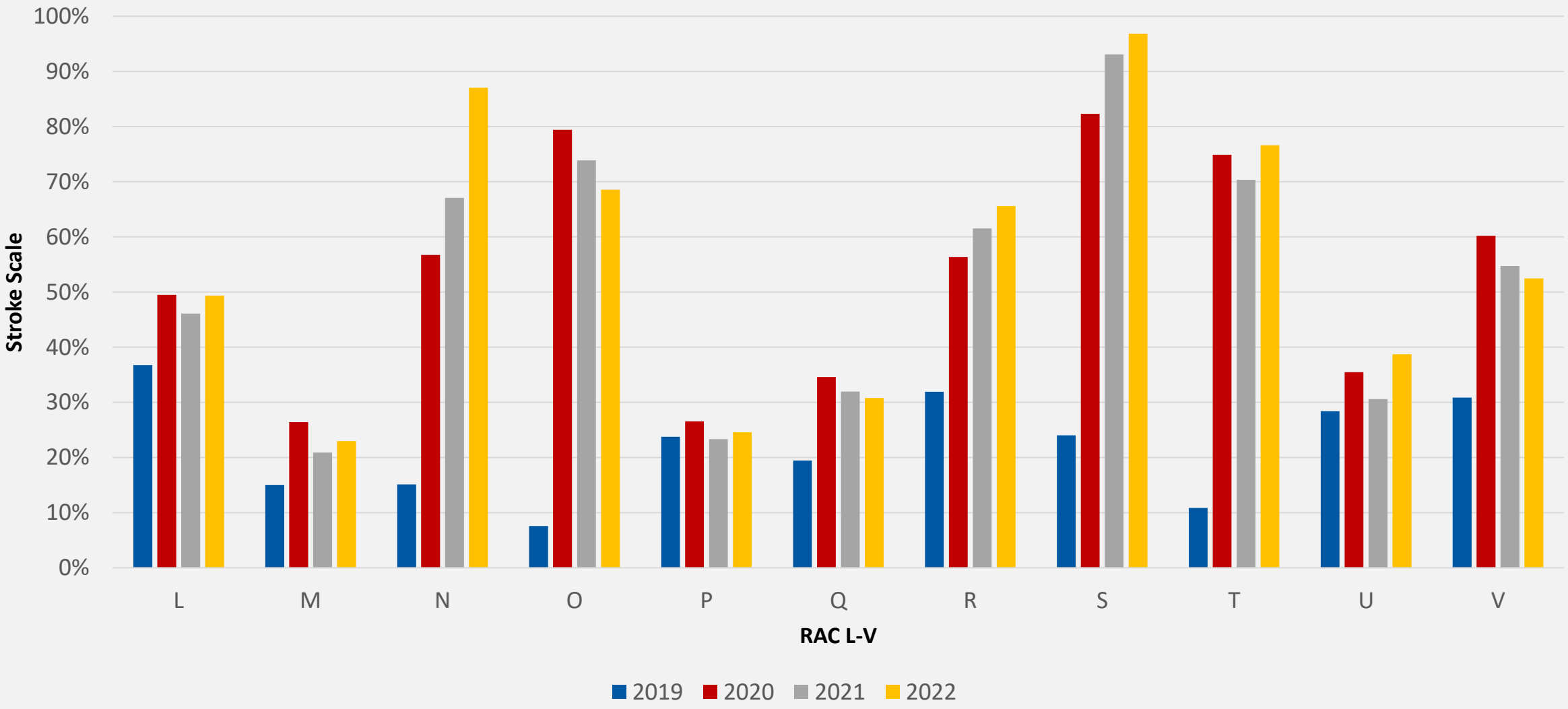
Stroke Scale Status

Status	2019	2020	2021	2022	Total
Stroke Scale Performed	8,657	21,012	25,438	28,192	**83,299**
Percentage	18.93%	43.21%	44.41%	47.18%	**39.41%**
Not Applicable	5,039	5,605	9,766	11,326	**31,736**
Percentage	11.02%	11.53%	17.05%	18.96%	**15.01%**
Not Recorded	32,035	22,009	22,074	20,234	**96,352**
Percentage	70.05%	45.26%	38.54%	33.86%	**45.58%**
Totals	**45,731**	**48,626**	**57,278**	**59,752**	**211,387**

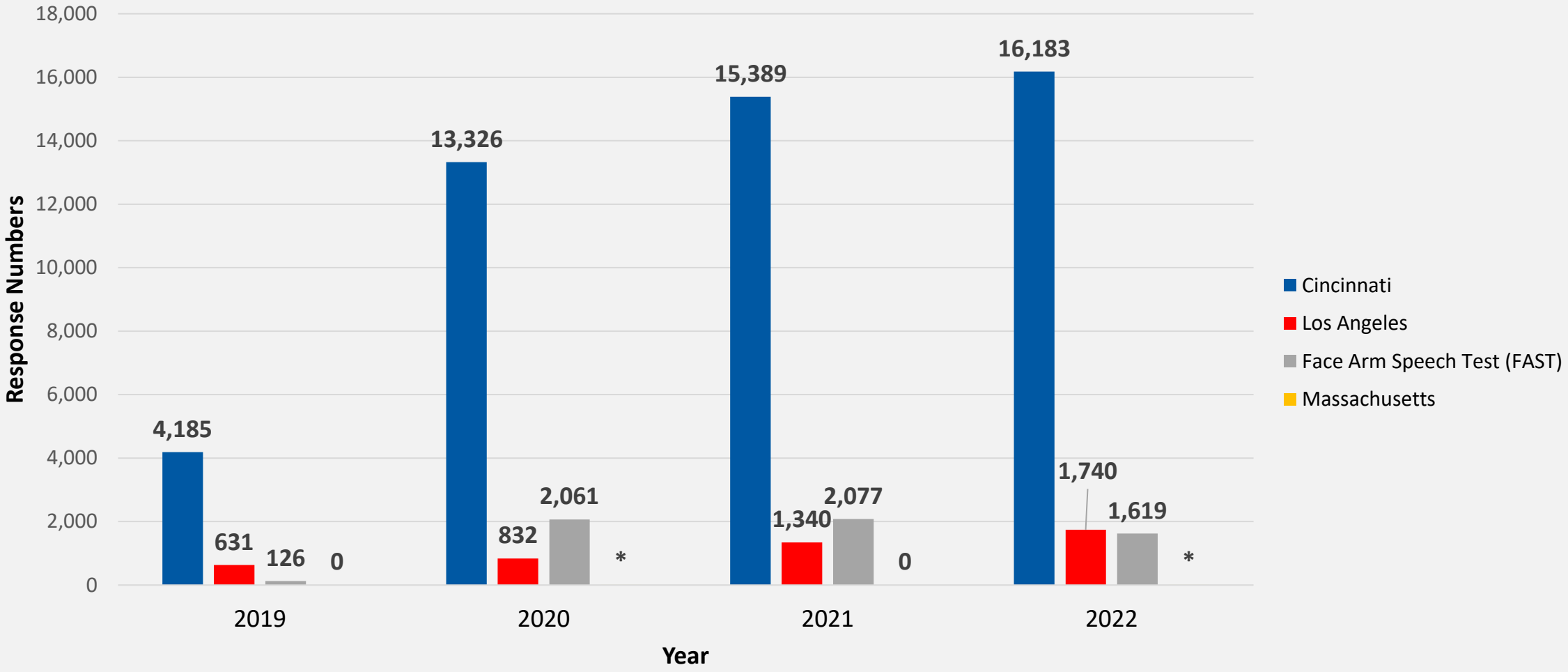
Stroke Scale Performed by Regional Advisory Council (RAC) A-K



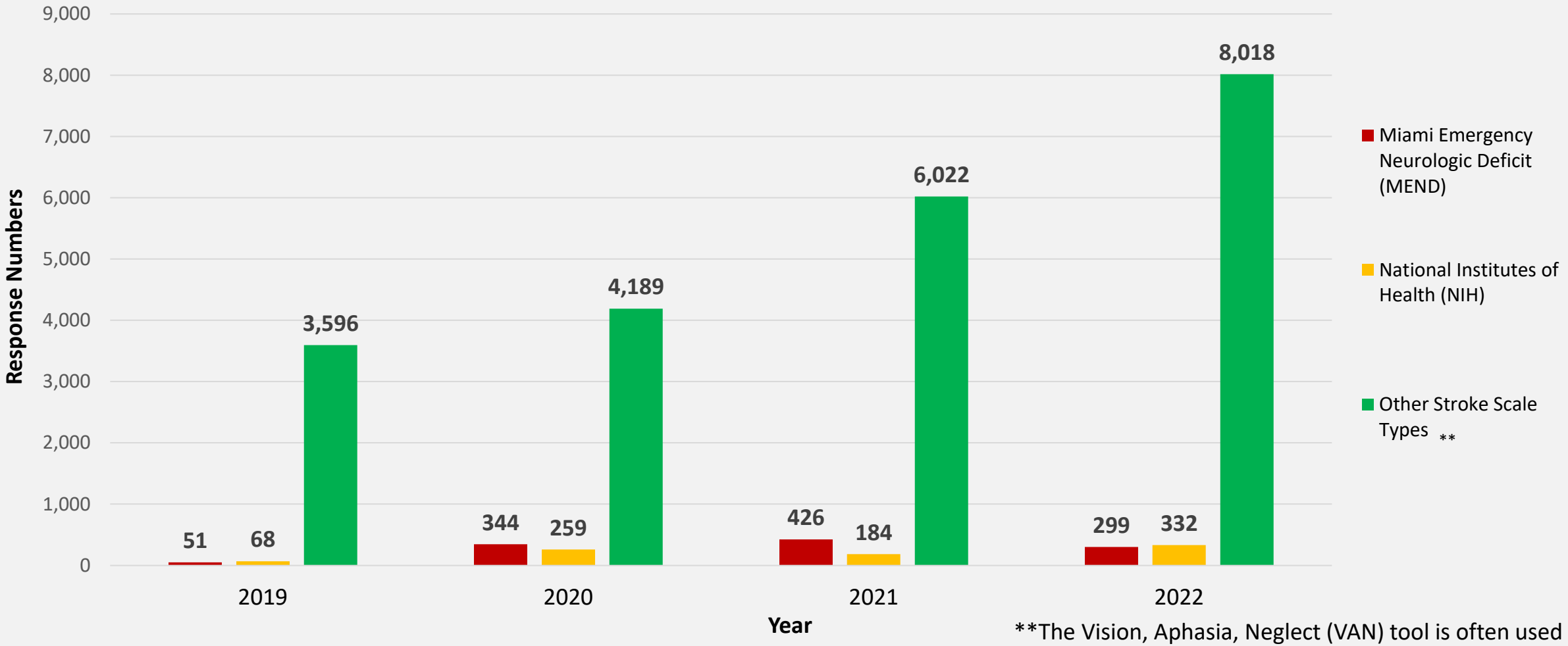
Stroke Scale Performed by RAC L-V



Stroke Scale Type Performed



Stroke Severity Scale Type Performed



**The Vision, Aphasia, Neglect (VAN) tool is often used in Texas and could be a part of the "Other Stroke Scale Types"

Stroke Scale Results

Result	2019	2020	2021	2022	Total
Positive	11,901	12,585	15,598	16,775	**56,859**
Negative	2,016	5,711	6,506	7,515	**21,748**
Non-Conclusive	1,207	1,896	2,325	2,527	**7,955**
Not Applicable	3,627	5,647	9,775	11,340	**30,389**
Not Recorded	25,787	21,983	22,100	20,628	**90,498**
Refused	*	8	30	41	**82**
Unable to Complete	1,190	796	944	926	**3,856**
Totals	**45,731**	**48,626**	**57,278**	**59,752**	**211,387**

Stroke Scale Results by Test

Result	Cincinnati	%	Los Angeles	%	FAST	%
Positive	29,918	61.0%	1,398	30.8%	4,407	74.9%
Negative	12,485	25.4%	1,075	23.6%	1,018	17.3%
Non-Conclusive	4,615	9.4%	1,217	26.8%	232	3.9%
Not Applicable	398	0.8%	48	1.1%	12	0.2%
Not Recorded	607	1.2%	776	17.1%	21	0.4%
Refused	31	0.1%	0	0.0%	8	0.1%
Unable to Complete	1,029	2.1%	29	0.6%	185	3.2%
Totals	**49,083**	**100%**	**4,543**	**100%**	**5,883**	**100%**

Stroke Severity Test by Results

Result	MEND	%	NIH	%	Other	%
Positive	315	28.1%	706	83.7%	11,457	52.5%
Negative	254	22.7%	51	6.0%	6,575	30.1%
Non-Conclusive	524	46.8%	56	6.6%	911	4.2%
Not Applicable	0	0.0%	15	1.8%	5	0.1%
Not Recorded	0	0.0%	12	1.4%	1,276	5.8%
Refused	0	0.0%	0	0.0%	28	0.1%
Unable to Complete	27	2.4%	*	*	1,573	7.2%
Totals	**1,120**	**100%**	**843**	**100%**	**21,825**	**100%**

Cardiac Data Request 2019-2022

Response and Request times for patients transferred between facilities

Inclusion Criteria and Definitions - Cardiac

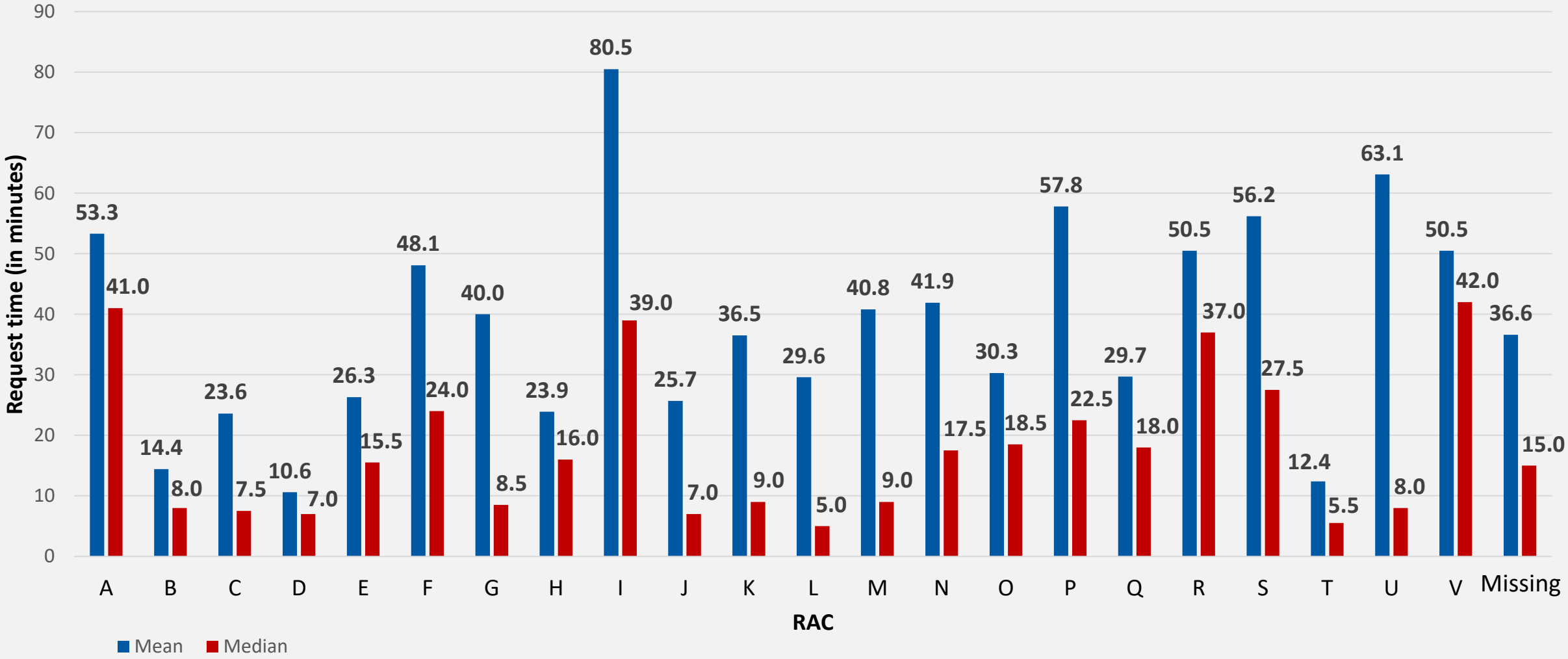
- Patients within Texas EMS dataset:
  - Incident location of hospital – emergency department (ED), hallway or inpatient.
  - Destination type – hospital ED or hospital non-ED bed.
- Cardiac patients – Protocols used were any cardiac arrest or cardiac-related events.
- Request time – Time recorded between Public Safety Answering Point (PSAP) and unit arrival on scene.
- Response time – Time recorded between unit notified of dispatch and unit arrival on scene time.

Texas Transfer Request and Response Times

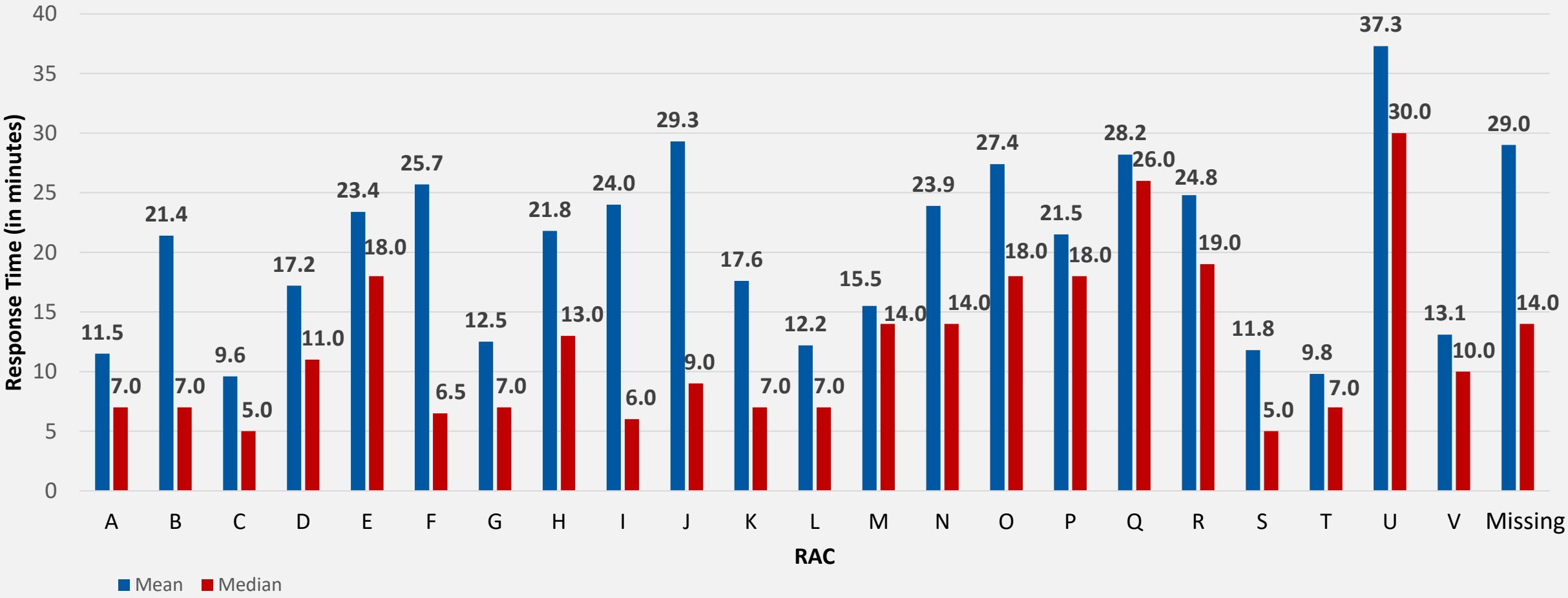
All Patients	Total Number	Mean	Median
Request Time	382,120	80.6 minutes	36 minutes
Response Time	382,120	28.0 minutes	21 minutes

Cardiac Patients	Total Number	Mean	Median
Request Time	6,262	41.3 minutes	19 minutes
Response Time	6,262	22.8 minutes	16 minutes

Cardiac Patient Request Times by Regional Advisory Council (RAC)



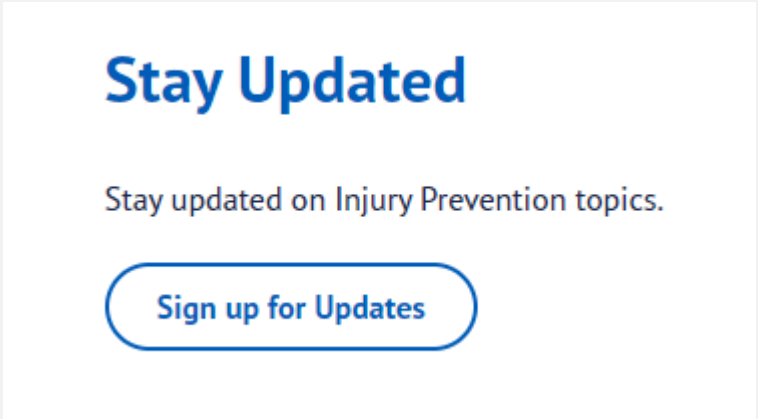
Cardiac Patient Response Times by RAC



Receive Injury Prevention Unit Updates

Sign up to receive periodic injury prevention-related updates:

- Go to dshs.texas.gov/injury-prevention and **click "Sign up for Updates" button** on the left navigation; or
- **Scan the QR code** to go directly to the sign-up page.
- Enter your email address when prompted.
- You'll begin receiving updates.



Thank you!

EMSTR EMS Stroke and Cardiac Data

Injury.Prevention@dshs.texas.gov

TEXAS
Health and Human Services

Texas Department of State Health Services

7. GETAC Committee Reports

7.a. GETAC Air Medical & Specialty Care Transport Committee

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

Vice-Chair: Cherish Brodbeck, RN, LP

AMSCT Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. **Performance Improvement**: Pediatric Airway Management by Air Medical & Specialty Care Providers	With the support & monetary sponsorship of TAAMS, the GETAC AMSCTC will perform a 2-year retrospective and real-time (quarterly) Ground Air Medical qUality Transport (GAMUT) data analysis of Air Medical & Specialty Care Pediatric RSI success without hypoxia, and first pass intubation success rate, in Texas throughout 2024, with the intent of comparing Texas providers to peer performance in other states.	*DSHS mtg *TAAMS sponsorship *GAMUT Agreement *Identifying GAMUT agencies *MedServe for Non-GAMUT *Invitations
2. **Coordinated Clinical Care:** Texas Department of Public Safety – State Troopers	The GETAC AMSCTC will develop an educational program, designed specifically for DPS Troopers, outlining the criteria for requesting an air medical asset and how to achieve that goal.	*Course outline complete *Trooper approval of course content/outline *Helo activation criteria development

AMSCT Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
3. **Prevention:** *HEMS Specific Mental Health Awareness*	*In an effort to increase mental preparedness and wellness among Air Medical & Specialty Care Transport Providers in Texas, the GETAC AMSCTC will work collaboratively with an EMS focused mental health professional/organization (TBD) and the Regional Advisory Committee Chairs, to provide a HEMS focused mental health awareness program to AMSCT providers, in all EMT-F regions in the state, over the next 2 years.*	*Brainstorming *Mental health professional engagement *Resource discovery *Shift gears?

Air Medical & SCT Committee
2023 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Emergency Preparedness & Response **Safe & Effective Statewide Ground to Air Communication** **Finalize/Materialize the Air Medical Strike Team (MIST) Concept & Process**	Collaboration with EMT-F & COGs – State Interoperability Plan review Collaboration with FD & Law Enforcement – channel access Create frequency resource document reflecting current regional channels in use *Will remain a living document, intended to have routine review *Intended as a resource document *Education & distribution via RAC Chairs – November 2024 *Resource on GETAC website ***presentation to GETAC Council Aug 2024** Continued collaboration with EMT-F leadership, resource document to be presented and utilized within EMT-F structure	Pending GETAC Council Approval & RAC Chair Education

Air Medical & SCT Committee
2023 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Prevention **Statewide Educational Campaign to Mitigate Risks for Air Medical Transport**	• LZ Presentation revisions complete • LZ presentation was approved by AMOA • Loading videos - complete *Roll out to RAC Chairs – August 22, 2024 **Approved by GETAC Council in Q3 meetings (June)**	
System Integration **Real-Time Status Reporting, by all Air Medical Providers, in all 22 Regions of the State**	• Collaboration with Juvare to ensure all TX air providers' CAD systems are "talking" to the nationwide system being created • Approximately 90% of air agencies are participating **RAC Chairs educated & system live on 8/22/2024**	

7.b. GETAC Cardiac Care Committee

Chair: James J. McCarthy MD

Vice-Chair: Craig Cooley, MD

Cardiac Care Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
Partner with DSHS to identify cardiac data elements currently available in the National Emergency Medical Service Information System (NEMSIS)	Reviewed dataset from DSHS on “emergent” cardiac patient transfers. Good start, but will need to look at definitions more closely for true time dependent patients.	Data review
Out of Hospital Cardiac Arrest – AED access/bystander CPR - assessment	Partnering with DSHS on areas of low AED use and CPR delays – now pending GETAC PI decision on in will be included as a topic to explore for for CCC to continue to work on. In progress Made the final GETAC PI list and process is moving forward	In progress
Telecommunicator CPR (Coordinated clinical Care/EMS).	Brief update that information has been obtained – will be reviewed at November meeting.	In progress
Dwell time in transferring facilities for	Partnering with DSHS to evaluate opportunities to	In progress

Action Item Request and Purpose

- No requests at this time.

7.c. GETAC Disaster Preparedness and Response Committee

Chair: Eric Epley, NREMT-P, CEM

Vice-Chair: Wanda Helgesen, RN

Disaster Committee Summary

- Reviewed Air Medical Committee Interoperability Document
- EMTF updates, including Hurricane Beryl
- Prehospital Whole Blood Task Force report
- EMS Wall Times at Hurricane Beryl, briefed EMS Committee for possible need for a “Wall Times Task Force”

7.d. GETAC Emergency Medical Services (EMS) Committee

Chair: Kevin Deramus, LP

Vice-Chair: James Campbell, NREMT-P

EMS Committee

2024 Committee Priorities

Strategic Plan Pillar & Objective	Corresponding Strategic Plan Pillar Strategy
1. Coordinated Clinical Care (Objective 5 & 8.0) Effects of EMS Wall Times on system performance and patient throughputs.	*3. Define data elements necessary to evaluate emergency healthcare system effectiveness.* *4. Promote prevention education and timely access to definitive care and rehabilitation services*
2. Coordinate Clinical Care (Obj #6) Discuss and provide guidance on the effects SB8 funding on EMS Vacancies in Texas. Specifically paramedic vacancies.	*3. Define data elements necessary to evaluate necessary to evaluate healthcare system effectiveness*
3. Pillar -Performance Improvement Obj- 1.0 Focus on reducing the use of Red Lights and Sirens (RLS) statewide. Using the approved Committee white paper as a guiding document.	*2. Utilize evidence-based best practices to improve outcomes for patients, as well as healthcare providers, and promote the Culture of Safety across all entities of the system.*

EMS Committee

2023 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
Hall time / Wall time white paper	*COMPLETED*	
Safety / Security EMS Personnel	Work in Progress: Discussion on personal safety on volatile scenes. Previously, the Committee's White Paper on the use of RLS	
Discussion and preparation for the next active shooter / MCI	Presentation regarding recent Texas incidents and provided a "lessons learned" opportunity. Working with private for-profit technology vendors to improve system response (Pulsara) demonstrations and implementation.	

EMS Committee

2024 Recommended Performance Improvement Initiatives

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee PI Initiatives	Recommended Performance Measure	Accepted
Reduction of RLS (Red Lights & Sirens) usage during EMS responses to 911 calls and transportation of patients to definitive care.	*Reduce the use of RLS by 50% for nonpriority 1 responses. Using existing EMD priority determinants to identify universal priority response.* *Reduce the transport of patients while using RLS by 80% for nonpriority 1 patients.*	
Reduction of EMS Wall Times in Texas and analyze the impact of the associated white papers on the issue.	Reduce the EMS quantity of “Wall time incidents” by measuring acceptable defined “Patient hand off times” by 80%.	

GETAC Committee/Stakeholder Action Item Request for Council August 2024

Kevin Deramus, LP

EMS Committee

Action Item Request and Purpose

- Please provide a **single**, clear and concise statement defining your action item request:
  - Formation of a Task Force to analyze the impact of EMS Wall Time data across Texas

- In **one** clear and concise statement, please explain the purpose for this request:
  - The Task Force in collaboration with the RAC's, Medical Directors, and other identified stakeholders, will collect comparative data across all regions of Texas to identify any impacts and work to identify, uses existing, or share novel approaches to reduce the impact on EMS Wall Times across Texas.

Benefit and Timeline

- What is the intended impact or benefit resulting from this request? Please provide a clear and concise response in a single statement.
  - To meet the goals that were identified in the recently GETAC approved and released EMS Wall Times White paper.

- Please provide the timeline or relevant deadlines for this request.
  - 2024-2025

7.e. GETAC EMS Education Committee

Chair: Macara Trusty, LP

Vice-Chair: Christopher Nations, LP

7.f. GETAC EMS Medical Directors Committee

Chair: Christopher Winckler, MD

Vice-Chair: Elizabeth Fagan, MD

7.g. GETAC Injury Prevention & Public Education Committee

Chair: Mary Ann Contreras, RN

Vice-Chair: Courtney Edwards, DNP

IPPE Committee

8/2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Identify data-driven opportunities to reduce the burden of fall injury and death	*Data analysis pending*	
2. Compose the Spectrum of Prevention/best practice paper for secure firearm storage utilizing effective methodologies including applicable resources and evidence informed strategies	*Document completed. To submit to Council for review and approval for vote in November's GETAC meeting*	
3.Compose the Spectrum of Prevention /best practice paper for prevention strategies to reduce suicide and increase individual's capacity for a safe and healthy lifestyle.	*Next workday for final revisions*	

IPPE Committee

8/2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
4. Increase the number of certified Child Passenger Safety Technicians in Texas. The goal is to • Gain well-rounded perspective of the system issues in Texas from stakeholders and data sources • Identify opportunities to improve these issues and associated barriers • Establish a set of statewide CPST capacity goals for 2030 • Utilize a series of data indicators to measure progress	• First workday meeting held, >100 participants/stakeholders present • Next steps- identifying goals and aligning strategies • Date for meeting TBD *Initial data compiled identified:* • 1,854 Technicians to 4,741,075 children • 1 Technician to every 2,557 children; • Conduct ~**10 inspections a day**	

Action Item Request and Purpose

- Please provide a **single**, clear and concise statement defining your action item request:
  - Requesting Council to review *Spectrum of Prevention Safe Firearm Storage* document for approval and or revisions in November's GETAC meeting.

7.h. GETAC Pediatric Committee

Chair: Christi Thornhill, DNP

Vice-Chair: Belinda Waters, RN

Pediatric Committee

2024 Committee Priorities

Strategic Plan Pillar & Objective	Corresponding Strategic Plan Pillar Strategy
1. Coordinated Clinical Care: *Develop and implement Pediatric Readiness and Simulation throughout the state by the end of the year as reported by the regional PECC's/RAC's.*	*1. Workgroup has developed 4 pediatric simulation scenarios* *2. Workgroup currently developing an additional 10 simulation scenarios* *3. Regional PECC's have been trained and will complete simulation training with at least 2 facilities within their RAC by April 2024*
2. Performance Improvement: Identify 2-3 measurable pediatric performance improvement Texas PI initiatives.	1. Pediatric Readiness participation by Texas Hospitals and EMS Agencies as per the 2024 revised trauma rules in accordance with designation. 2. Trauma Center compliance with quarterly pediatric simulations as per the 2024 revised trauma rules in accordance with designation. 3. EMS Agency compliance in utilizing pediatric equipment in skills training/competency.

Pediatric Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Coordinated Clinical Care: *Pediatric Readiness and Simulation*	*1. Workgroup has developed **7** pediatric simulation scenarios* *2. Workgroup currently developing an additional **8** simulation scenarios* *3. Regional PECC's have been trained and will complete simulation training with at least 2 facilities within their RAC by April 2024*	
2. Performance Improvement: Identify 2-3 measurable pediatric performance improvement Texas PI initiatives.	1. Pediatric Readiness participation by Texas Hospitals and EMS Agencies-EMSC is meeting with RAC's 2. Trauma Center compliance with quarterly pediatric simulations-EMSC is meeting with RAC's 3. EMS Agency compliance in utilizing pediatric equipment in skills training/competency	

Pediatric Committee

2024 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Outcomes	Status
Research Sudden Cardiac Arrests/Deaths (SCA/SCD) in pediatrics and ECG opt-out vs opt-in for sports physicals	1. Tabitha Selvester and started research and will be leading this workgroup. 2. Requests for interested parties to join the workgroup.	
Pediatric Committee continues to work with the Stroke Committee to develop pediatric stroke guidelines.	1. Reviewing children's hospitals pediatric stroke protocols and reviewing evidence based practice guidelines. 2. Development of a pediatric stroke guideline	
Pediatric Committee continues to collaborate for 2 workgroups (pediatric concussion/head injury and magnet/battery ingestion).	1. Development of pediatric concussion/head injury toolkit 2. Development of pediatric magnet/battery ingestion toolkit.	

GETAC Pediatric Committee/Stakeholder Action Item Request for Council August 2024

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

Vice Chair: Belinda Waters, RN

Pediatric Committee

Action Item Request and Purpose

- Please provide a **single**, clear and concise statement defining your action item request:
  - Request the 4 simulations approved by the Pediatric Committee be approved by the GETAC Executive Committee
  - Requests that the simulation cases are posted to the DSHS website following final formatting.
  - Request that the Head Injury/Concussion Toolkit approved by the Pediatric Committee be added to the November GETAC Council Committee Agenda for approval.
- In **one** clear and concise statement, please explain the purpose for this request:
  - To move forward with publication of pediatric simulation cases
  - To move forward with publication and dissemination of the Head Injury/Concussion Toolkit

Benefit and Timeline

- What is the intended impact or benefit resulting from this request? Please provide a clear and concise response in a single statement.
  - Improving pediatric outcomes through the utilization of pediatric simulation in designated trauma centers in Texas.
  - Creating an educational and resource toolkit for parents, schools, and athletic programs regarding head injuries and concussions.

- Please provide the timeline or relevant deadlines for this request.
  - August 2024
  - November 2024

Pediatric Readiness Improvement Project TEXAS

Texas Pediatric Readiness Improvement Project Update

GETAC August 2024

Texas Pediatric Readiness Project

Project Arms:

- Pediatric virtual education series
- 12 standardized pediatric trauma simulations
- Regional pediatric emergency care champions within each of 22 trauma service regions
- Pediatric QI performance measures and dashboards to drive pediatric QI efforts

Supported by:

- Governor’s EMS and Trauma Advisory Council
- Texas EMS for Children
- Texas Emergency Nurses Association
- Texas Trauma Coordinators Forum
- Texas EMS and Trauma Acute Care Foundation
- National Pediatric Readiness Quality Initiative

IMPACT on TEXAS

- Regional Pediatric Emergency Care Coordinators
  - 31 R-PECCs in 22 RACs
- Hospitals across the State with significant contacts
  - 232 in 22 RACs. All have agreed they are open to Pediatric Readiness.
- Simulations conducted in Emergency Departments
  - 105 sims in 15 RACs (not all RACs have conducted sims)
- Number of staff participants in simulation scenarios participated in simulation
  - **1,056 people in 14* RACs since early February**.

* One RAC missing the number of participants

Find My Regional PECC

https://txena.org/wp-content/uploads/2024/08/Texas-R-PECC-Directory-rev-8.15.24.pdf

ED Pediatric Readiness Improvement Education Series

- 1-hour virtual sessions held 3rd Thursday every month @7am
- Pediatric-specific topics
- Highlight evidence-based practices and resources for adoption
  - Applicable simulation exercises offered
  - Emphasis on evaluating ED performance using NPRQI platform

- January 18
- February 15
- March 21
- April 18
- May 16
- June 20
- July 18
- August 15
- September 19
- October 17
- November 21
- December 19
- January 16, 2025
- February 20, 2025

Scan to Register

Data from sessions 1-8

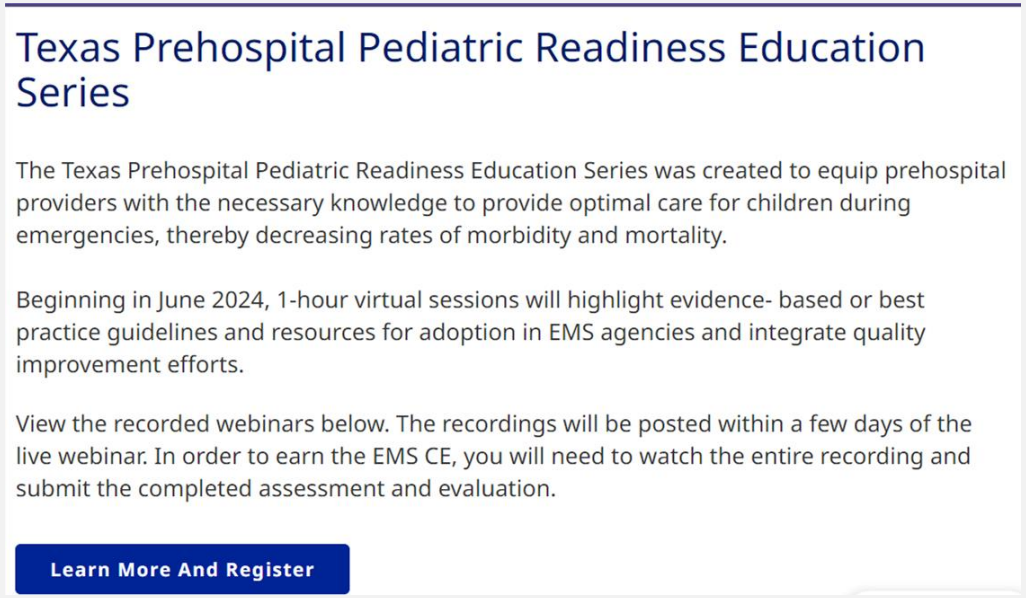
Education Series Stats

Session	Topic	Registrants	Webinar Attendees (unique viewers)	CE Awarded
Session 1	Overview of the Texas Pediatric Readiness Improvement Initiative	404	227	193
Session 2	ESI/Pediatric Assessment and Triage	993	351	245
Session 3	Respiratory Distress	1238	312	221
Session 4	Traumatic Brain Injury	1341	312	173
Session 5	Non-Accidental Trauma (Child Maltreatment)	1404	259	181
Session 6	Long-bone Fractures and Pain Management	1468	270	187
Session 7	Pediatric Ingestions	1488	236	183
Session 8	Shock Recognition and Management	1528	240	126

EMS Pediatric Readiness Education Series

- 1-hour virtual sessions held 1st Wednesday every month @ 4pm

•June, 133 people registered, 32 attended, and 19 completed the CE evaluation.
•August session, 235 registered, 44 attended, and 32 completed the CE evaluation.



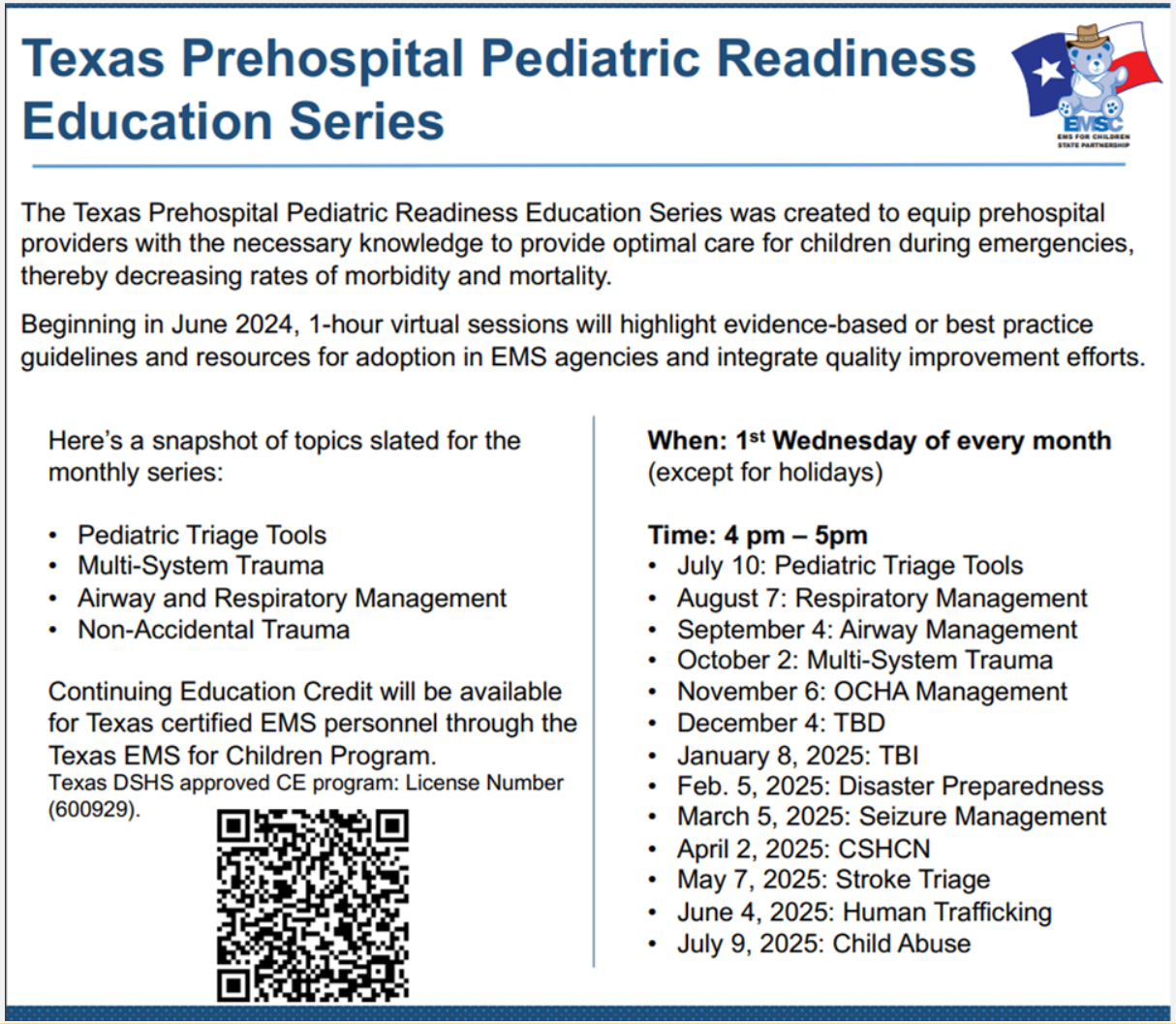
Texas Prehospital Pediatric Readiness Education Series

The Texas Prehospital Pediatric Readiness Education Series was created to equip prehospital providers with the necessary knowledge to provide optimal care for children during emergencies, thereby decreasing rates of morbidity and mortality.

Beginning in June 2024, 1-hour virtual sessions will highlight evidence- based or best practice guidelines and resources for adoption in EMS agencies and integrate quality improvement efforts.

View the recorded webinars below. The recordings will be posted within a few days of the live webinar. In order to earn the EMS CE, you will need to watch the entire recording and submit the completed assessment and evaluation.

Learn More And Register



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Beginning in June 2024, 1-hour virtual sessions will highlight evidence-based or best practice guidelines and resources for adoption in EMS agencies and integrate quality improvement efforts.

Here's a snapshot of topics slated for the monthly series:

- Pediatric Triage Tools
- Multi-System Trauma
- Airway and Respiratory Management
- Non-Accidental Trauma

Continuing Education Credit will be available for Texas certified EMS personnel through the Texas EMS for Children Program.
Texas DSHS approved CE program: License Number (600929).

When: 1st Wednesday of every month (except for holidays)

Time: 4 pm – 5pm

- July 10: Pediatric Triage Tools
- August 7: Respiratory Management
- September 4: Airway Management
- October 2: Multi-System Trauma
- November 6: OCHA Management
- December 4: TBD
- January 8, 2025: TBI
- Feb. 5, 2025: Disaster Preparedness
- March 5, 2025: Seizure Management
- April 2, 2025: CSHCN
- May 7, 2025: Stroke Triage
- June 4, 2025: Human Trafficking
- July 9, 2025: Child Abuse

Texas Pediatric Readiness Project

Evaluation Summary Metrics

Sessions 1 – Sessions 8

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

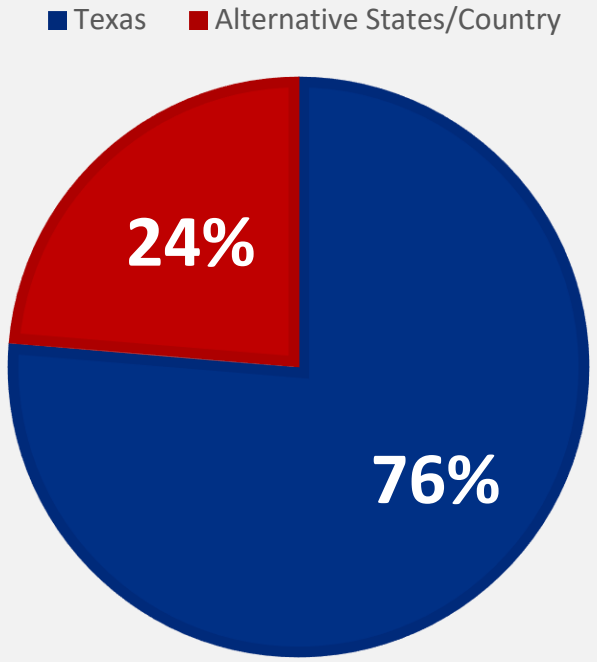
Texas Perinatal Services
A Program of the Texas EMS Trauma & Acute Care Foundation

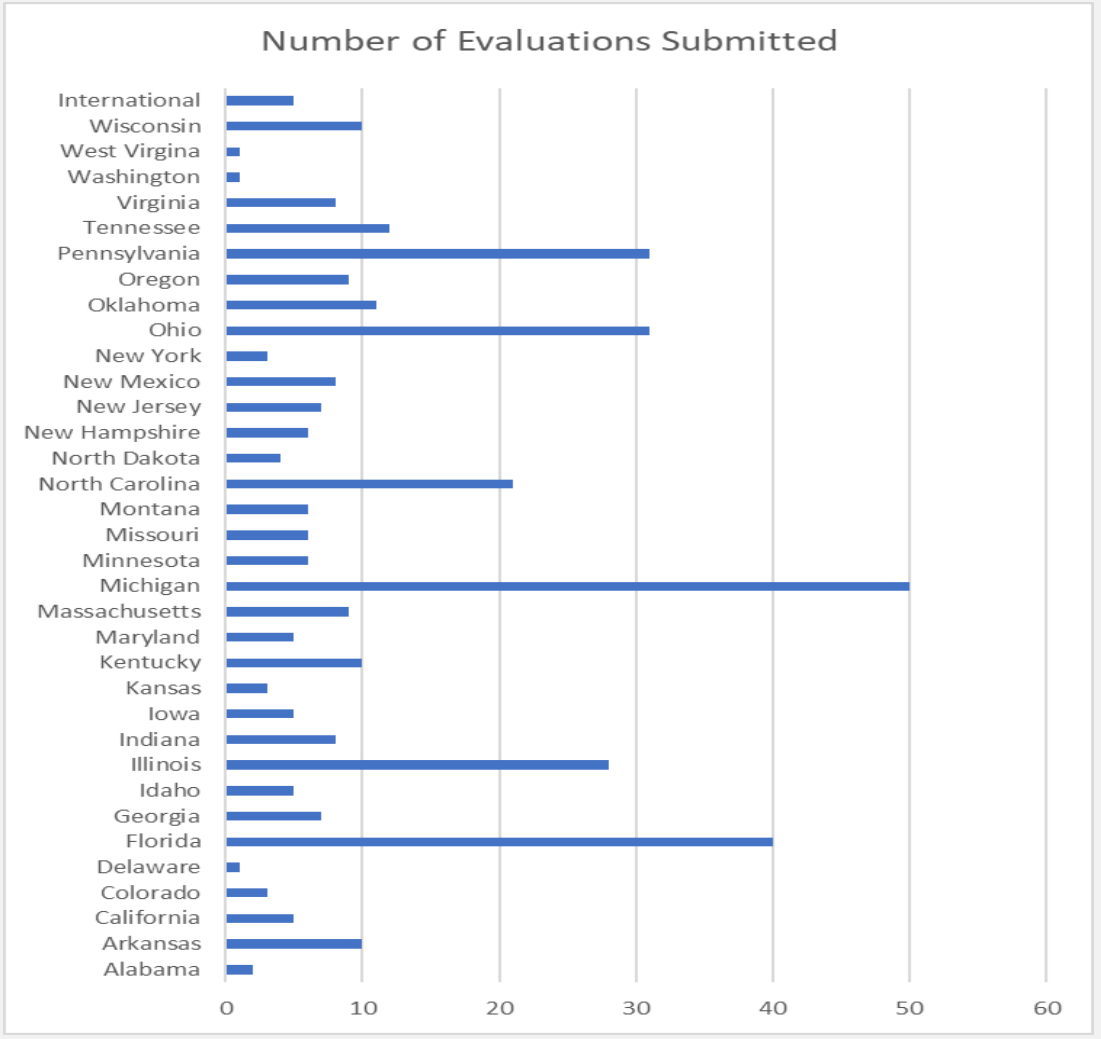
2024 QTR 3 GETAC Meeting

Continuing Professional Development : Summary

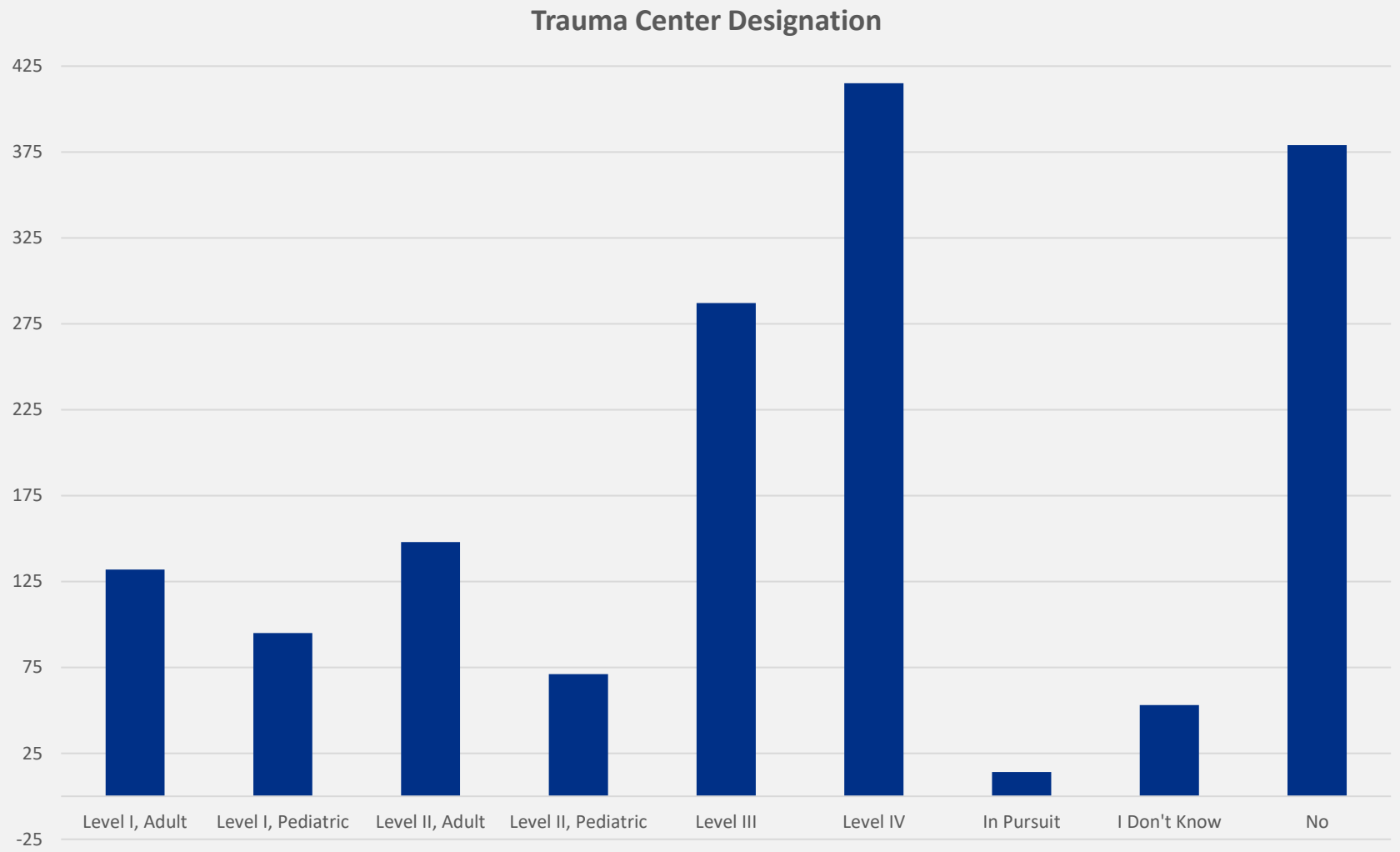
	Topic	Attendance	Average Evaluation Score
Session 1	Pediatric Readiness Initiative	216	4.75
Session 2	Triage & ESI	279	4.83
Session 3	Respiratory	236	4.73
Session 4	TBI	186	4.80
Session 5	Child Maltreatment	183	4.90
Session 6	Long Bone Fractures	187	4.89
Session 7	Ingestions	183	4.88
Session 8	Shock	126	4.84
Total Continuing Professional Development Hours Awarded		**1,596**	**4.83**

Continuing Professional Development: Summary

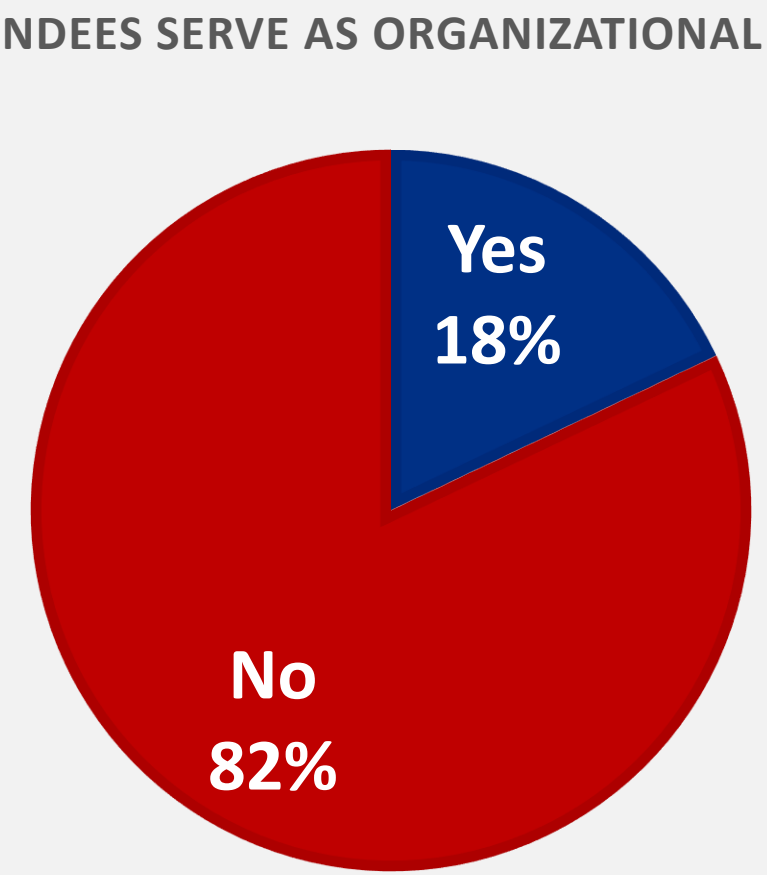




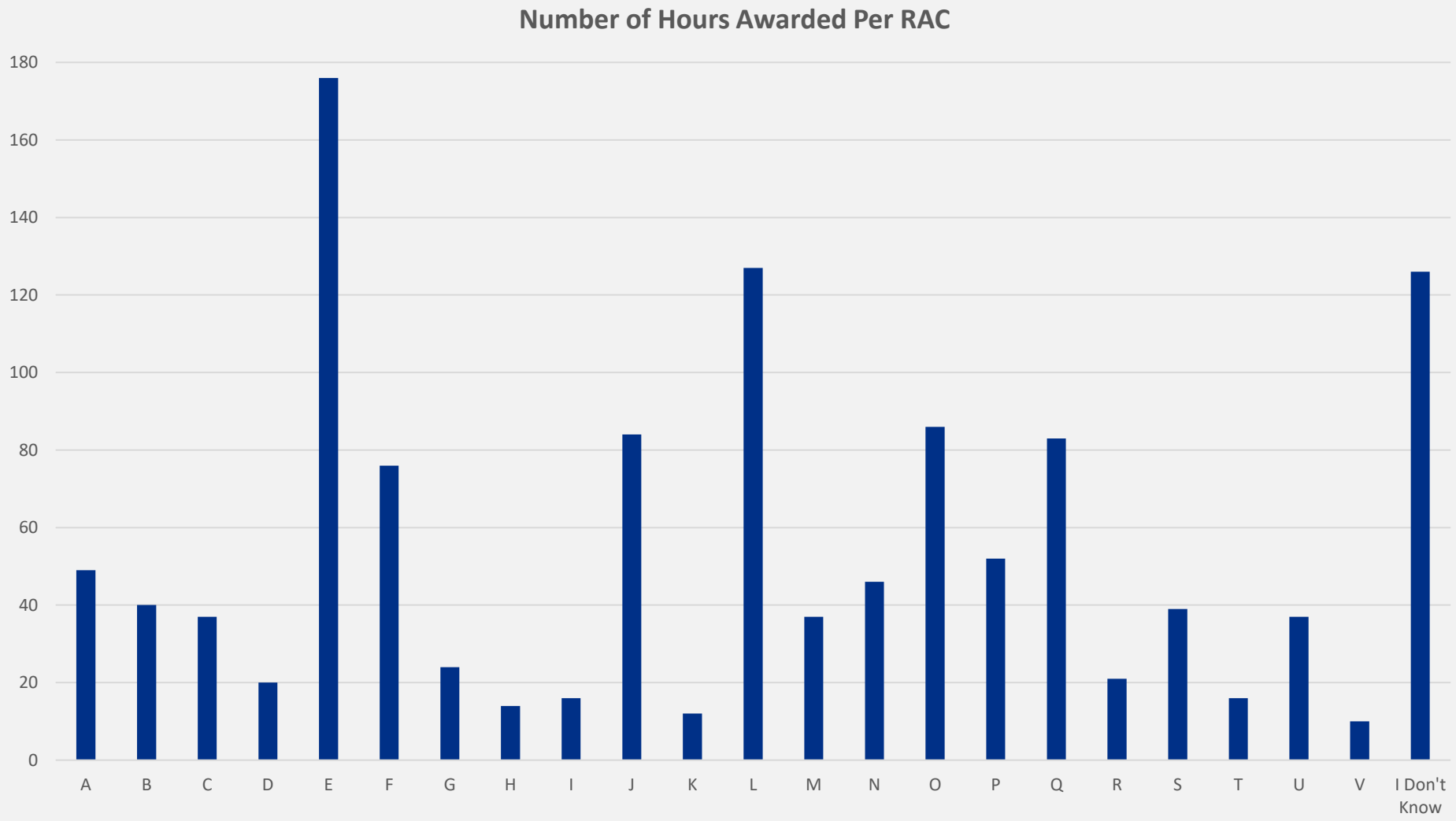
Continuing Professional Development: Summary



Continuing Professional Development: Summary

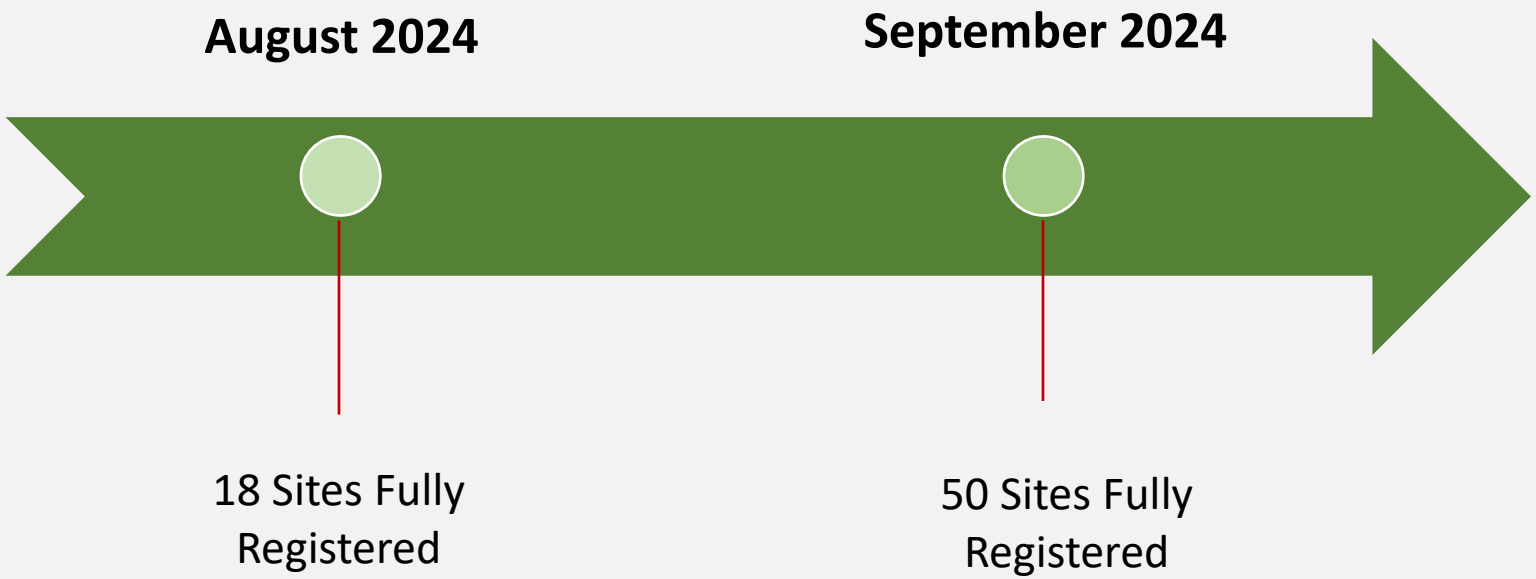


Continuing Professional Development: Summary



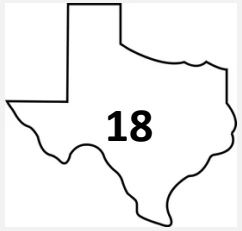
Texas Site Profiles

Texas Sites - Recruitment Goals



*21 sites have registered – still need participant organization agreement (POA)

Participating Texas Sites



C-North Texas
Graham Hospital District

E- North Central Texas
Baylor All Saints Medical Center at Fort Worth
Methodist Southlake Hospital
Texas Health Hospital Mansfield

G-Piney Woods
Christus Mother Frances Hospital - Jacksonville
Christus Mother Frances Hospital - Tyler
Christus Mother Frances Hospital - Winnsboro

I-Border
El Paso Children's Hospital
University Medical Center of El Paso

J-Texas
Medical Center Health System
Permian Regional Medical Center

L-Central Texas
Coryell Memorial Hospital

N-Brazos Valley
Baylor Scott and White Medical Center - College Station

P-Southwest Texas
Christus Children's

R-East Texas Gulf Coast
HCA Houston Healthcare Mainland

S-Golden Crescent
Lavaca Medical Center
Lillian M. Hudspeth Memorial Hospital
Cuero Regional Hospital

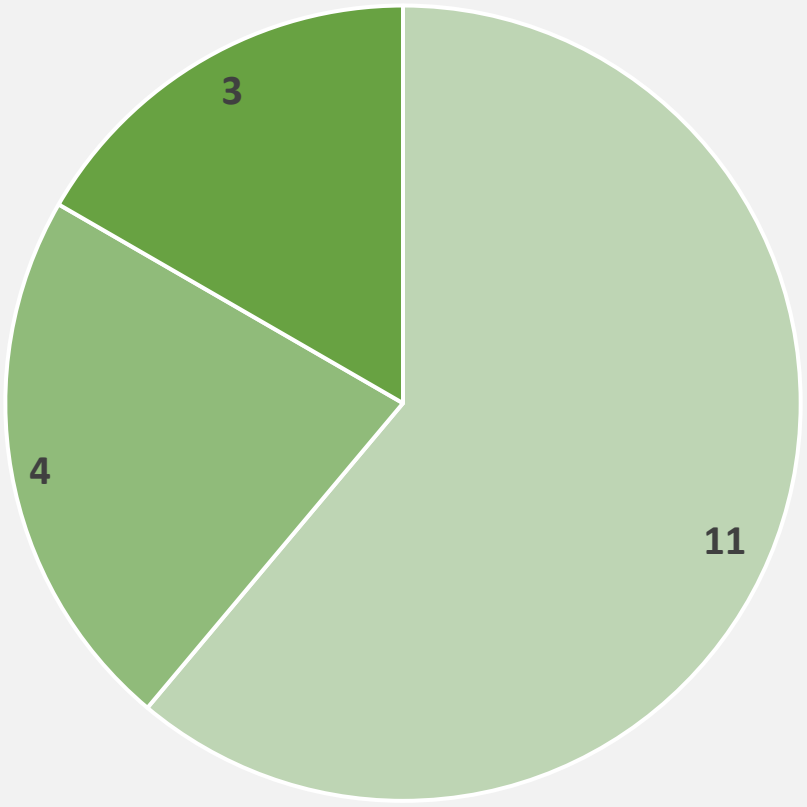
Sites with executed POAs as of August 1, 2024

Clarification on Chart Requirement for NPRQI

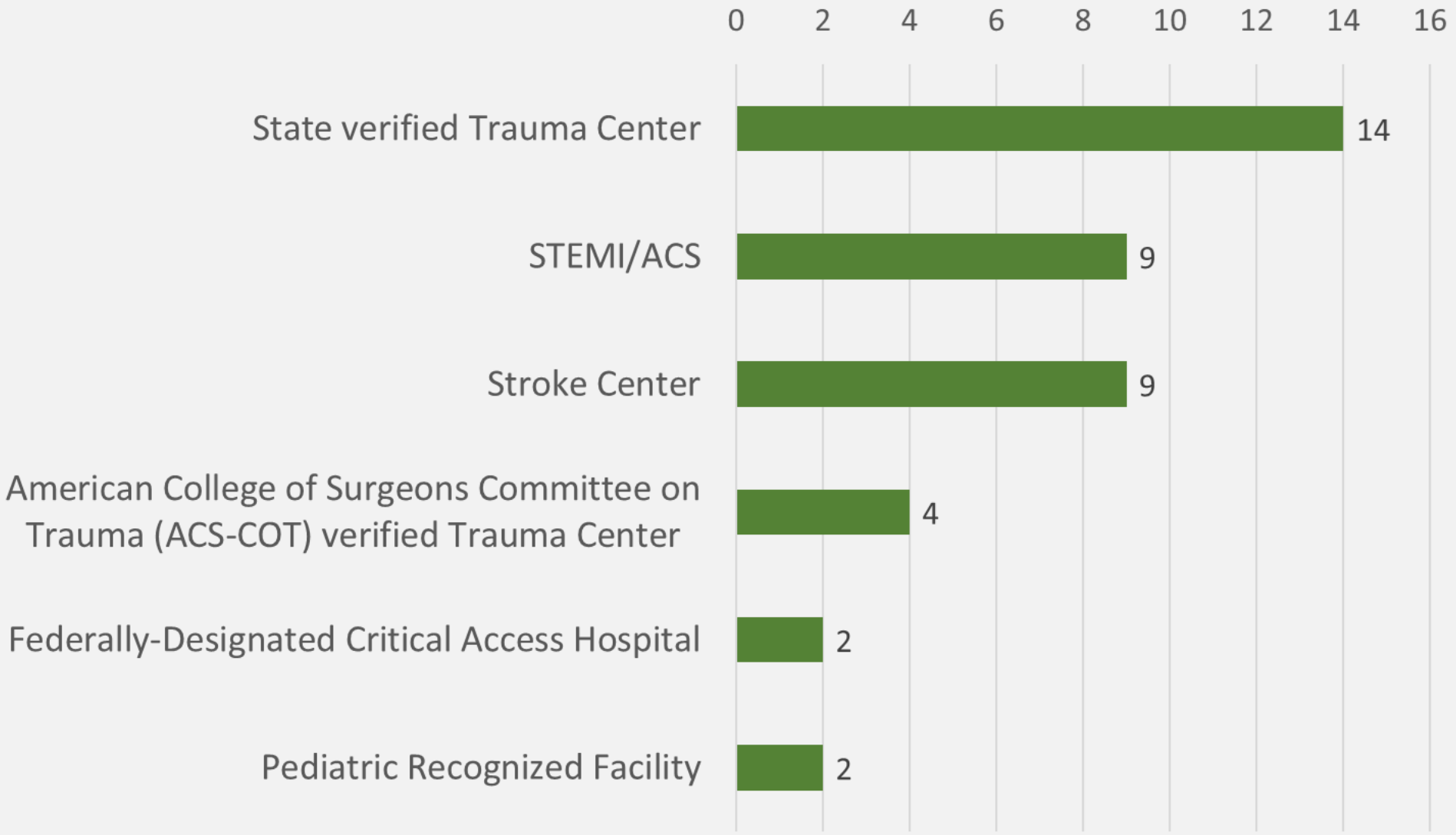
NPRQI Data Collection Targets	
Initial Data Entry	To ensure confidentiality of the first set of patient encounters entered into the platform, a **minimum of 10 patient charts must be submitted** before performance will be displayed on dashboards.
Baseline Performance Data Entry	For a realistic view of the ED's baseline performance, a **minimum of 30 patient encounters should be entered in the platform**. This allows for 3 data points that reflect baseline performance. These may be entered over a few days, weeks, months, or quarter depending on patient volume and the ED team's bandwidth.
Ongoing Data Entry	To **maximize the benefits** of the NPRQI platform, **patient charts should be entered at regular intervals**, based on the ED team's bandwidth and patient volume. Each ED has sole discretion when deciding which patients should be selected for data entry and which metrics should be targeted for improvement efforts. It is recommended that ED's consider pulling every 5th, 10th, 20th or other scheduled frequency for patient chart selection.

Note: NPRQI offers office hours to participating EDs regarding data sampling strategies, getting started with data entry, and data interpretation.

Texas Sites
Annual Pediatric Volume



TeTexas Sites Specialty Center Status



Performance Groupings

National PRQI

Pediatric Readiness Quality Initiative

Measure • Reflect • Improve

EDs and Hospitals

Healthcare Networks

Trauma Service Areas

State/ National Aggregate

RAC Dashboard

NPRQI Regional Reporting Dashboard

State: Texas | Region: I

2 Sites / 97 Records

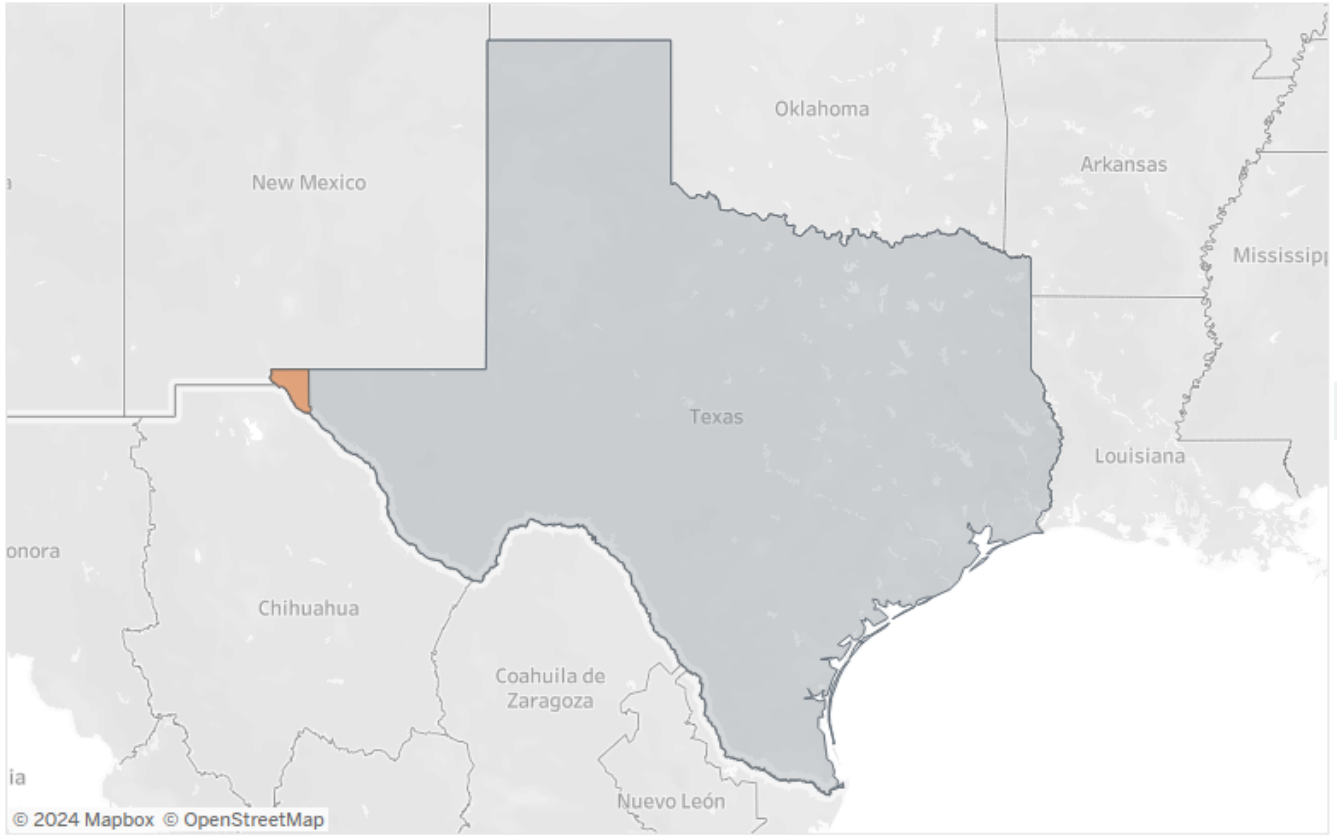
Make your selections from the green filter bar, and Click "GO" to return your report

Year	Quarter	Region	Results View	Patient Clinical Group	
Select all that apply	Limit the # of Quarters by selecting Year(s) first				
(All)	(None)	I	Table	All Patients (Core Measures)	GO

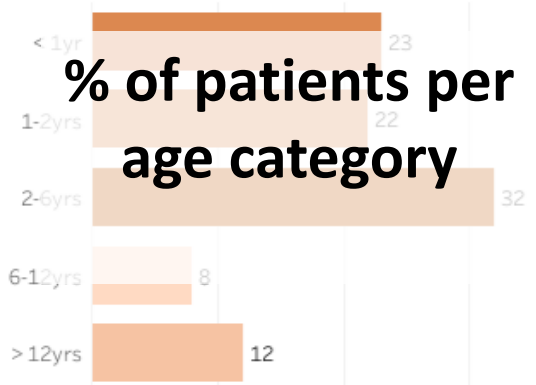
Region I Sites by Geographic Category

Region I Sites by Patient Volume

Participation in the National Pediatric Readiness Quality Initative

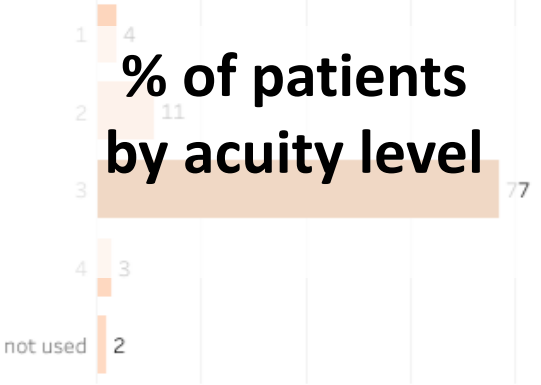


Region I Patients by Age Category



% of patients per age category

Region I Patients by Triage Level



% of patients by acuity level

The NPRQI is supported in part by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). Additional funding is provided by the Toyota Way Forward Fund.

Last Dataset Refresh: 8/15/2024 10:21:00 AM

Last Patient Included: 3/18/2024

Site-level dashboard

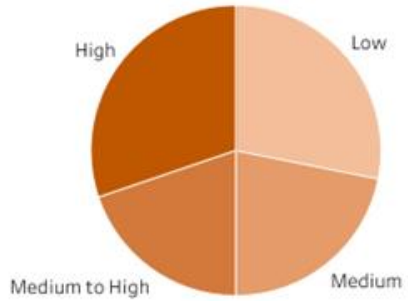
NPRQI State Reporting Dashboard
96 Sites / 11,168 Records

Make your selections from the green filter bar, and Click "GO" to return your report

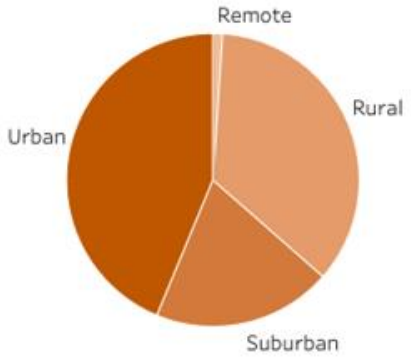
Year	Quarter	State	Results View	Patient Clinical Group
Select all that apply	Limit the # of Quarters by selecting Year(s) first			
All	All	All	Table	All Patients (Core Measures)

GO

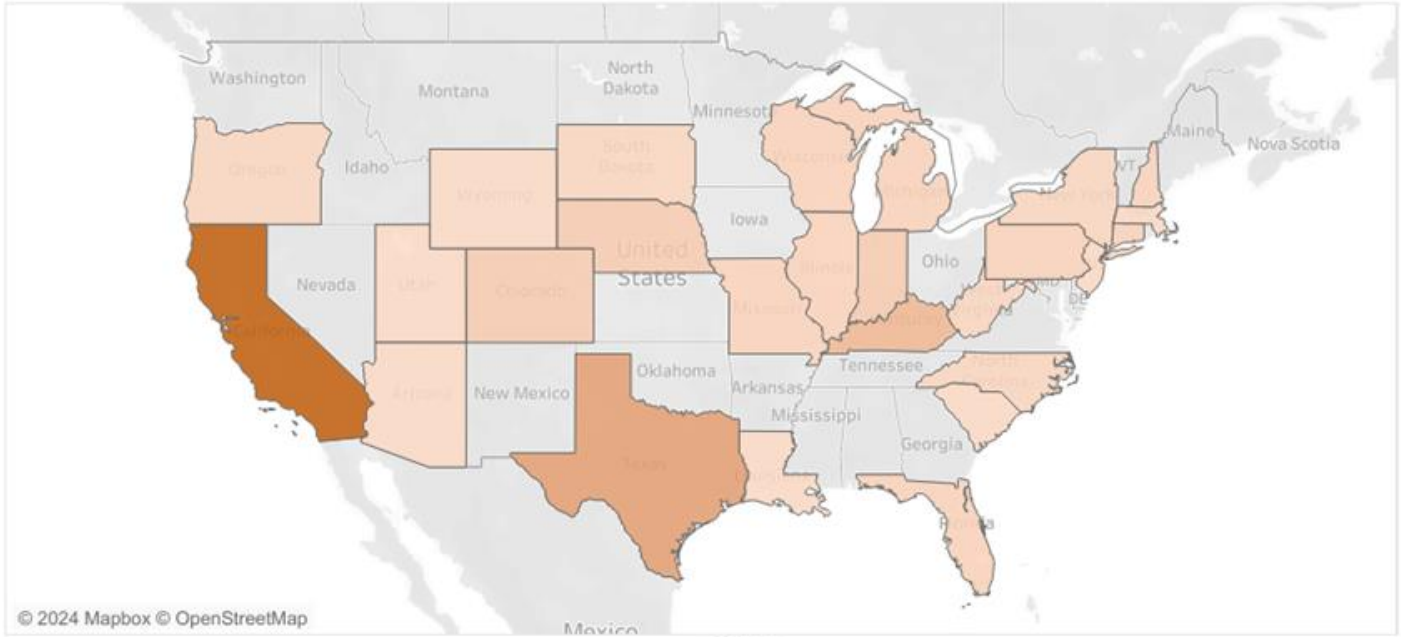
Number of Sites by Patient Volume Category



Number of Sites by Geographic Category



Participation in the National Pediatric Readiness Quality Initative



The NPRQI is supported in part by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). Additional funding is provided by the Toyota Way Forward Fund.

Last Dataset Refresh:
6/27/2024 1:08:10 PM
Last Patient Included:
6/26/2024

NPRQI Site Dashboard – Table View (site must enter a minimum of 10 records before will appear on dashboard)

National PRQI
Pediatric Readiness Quality Initiative
Measure • Reflect • Improve

Performance Report:
Dates: 2023 Q1 to 2024 Q1 | Clinical Measures Group: All Patients (Core Measures)

Measures with fewer than 10 records will not be displayed

*Cohort performance represents the average of site performances for sites within the same patient volume category (displayed with minimum of 5 sites)

**National performance represents the average of site performances across all participating sites (displayed with a minimum of 5 sites)

Back to Landing

Last Dataset Refresh:
4/23/2024 3:26:58 AM
Last Patient Included:
2/3/2024

Patient Volume
Low: < 1,800 pediatric patients

Bundle	# of Records	Quality Measure	Your Performance	National Performance **	Cohort Performance *
ASSESSMENT	280	% of pediatric patients with weight documented in kilograms only	95.0 %	60.7 %	43.5 %
		% of pediatric patients with pain assessed	71.8 %	78.5 %	83.6 %
	277	Median ED length of stay	93.0 minutes	187.7 minutes	116.1 minutes
ABNORMAL VITAL SIGNS	92	% of high acuity pediatric patients with vital signs re-assessed	88.0 %	82.1 %	79.6 %
	60	Median time from triage to first intervention	43.0 minutes	60.9 minutes	49.6 minutes
TRANSFER OF PATIENTS	5	% of transferred pediatric patients who met site-specific transfer criteria	--	99.7 %	--
		Median time from triage to transport	--	460.1 minutes	--
	0	% of transferred pediatric patients who were discharged from the receiving ED	--	--	--

Patient Demographics

Patient level filters are not applied to the National or Cohort Performance Metrics.

Age Category
All

Triage Level
All

Ethnicity
All

Race
All

Gender
All

Payor Source
All

Geography: **All** | Patient Volume: **All** | ED Configuration: **All** | Specialty Center Status: **All**
Age Category: **All** | Triage Level: **All** | Ethnicity: **All** | Race: **All** | Gender: **All** | Payor Source: **All**

The NPRQI is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1.2M with 0% percentage financed with nongovernmental sources.
The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

CLARIO.

NPRQI Site Dashboard – Graph View

(a minimum of 10 records must be entered to be displayed on the dashboard)

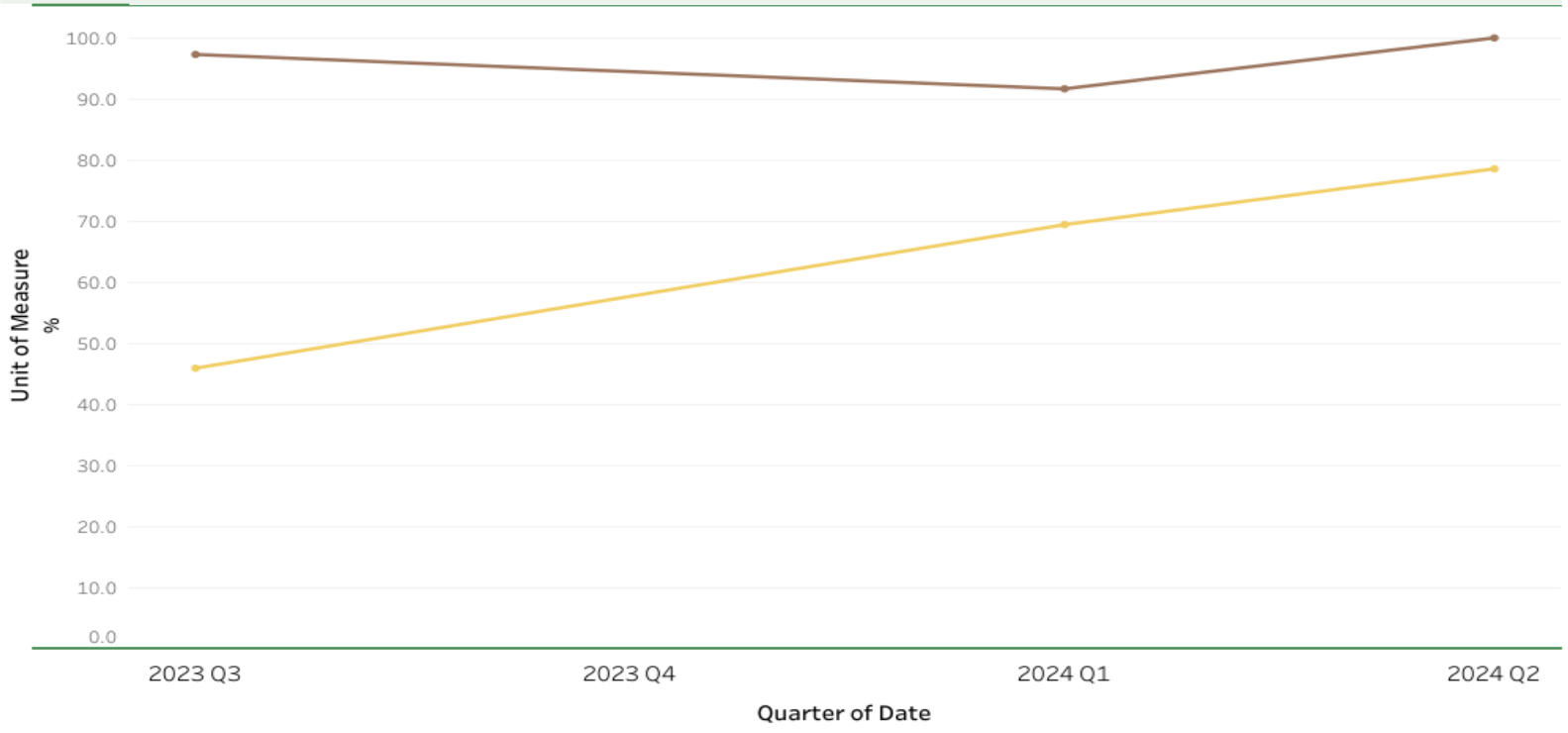
National PRQI
Pediatric Readiness Quality Initiative
Measure • Reflect • Improve

Performance Report:
Dates: 2023 Q3 to 2024 Q2 | Clinical Measures Group: All Patients (Core Measures)
Measures with fewer than 10 records will not be displayed

Back to Landing

Last Dataset Refresh:
4/23/2024 1:46:19 PM
Last Patient Included:
4/12/2024

Show Graph Measures (Measure Selection Only Applies When Patient Clinical Groups With Bundle and Core Measures Selected On the Landing Page)
All



Graph - Legend
Ctrl + Click to select multiple Measures to be displayed

- % of pediatric patients with weight documented in kilograms only
- % of pediatric patients with pain assessed
- Median ED length of stay
- % of high acuity pediatric patients with vital signs re-assessed
- Median time from triage to first intervention
- % of transferred pediatric patients who met site-specific transfer criteria
- Median time from triage to transport
- % of transferred pediatric patients who were discharged from the receiving ED

Patient Demographics

Age Category
All

Triage Level
All

Ethnicity
All

Race
All

Gender
All

Payor Source
All

National PRQI

Geography: **All** | Patient Volume: **All** | ED Configuration: **All** | Specialty Center Status: **All**
Age Category: **All** | Triage Level: **All** | Ethnicity: **All** | Race: **All** | Gender: **All** | Payor Source: **All**

The NPRQI is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1.2M with 0% percentage financed with nongovernmental sources.
The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

CLARIO.

National PRQI

Pediatric Readiness Quality Initiative

Measure • Reflect • Improve

- Free, self-paced platform
- Ensures site confidentiality
- Web-based data entry and data visualization tools
- Measures performance over time
- Benchmarking against National Aggregate Performance
- Benchmarking against EDs with similar profiles

Pediatric Readiness Save Lives

Newgard et al. (2023). Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care. *JAMA Open Network, 6* (1), 1-14. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800400

Register Now to Start Your Quality Improvement Journey
https://redcap.link/NPRQIRegistration

Learn More About NPRQI
www.nprqi.org

Summary

- This project is impacting hospitals in every RAC
- Hospitals are identifying Pediatric Emergency Care Coordinators and participating in NPRQI
- Hospitals are completing their National Pediatric Readiness Project assessment and identifying their gaps in readiness
- ED staff are participating in pediatric trauma simulation
- Regional Pediatric Emergency Care Coordinators are making a difference in hospital engagement in pediatric readiness
- RAC Leaders have been invaluable to supporting this project!

Texas Pediatric Readiness Improvement Project Contacts

sallyksnow@gmail.com
kate.remick@austin.utexas.edu
samuel.vance@bcm.edu

7.i. GETAC Stroke Committee

Chair: Robin Novakavic-White, MD

Vice-Chair: Sean Savitz, MD

Stroke Committee

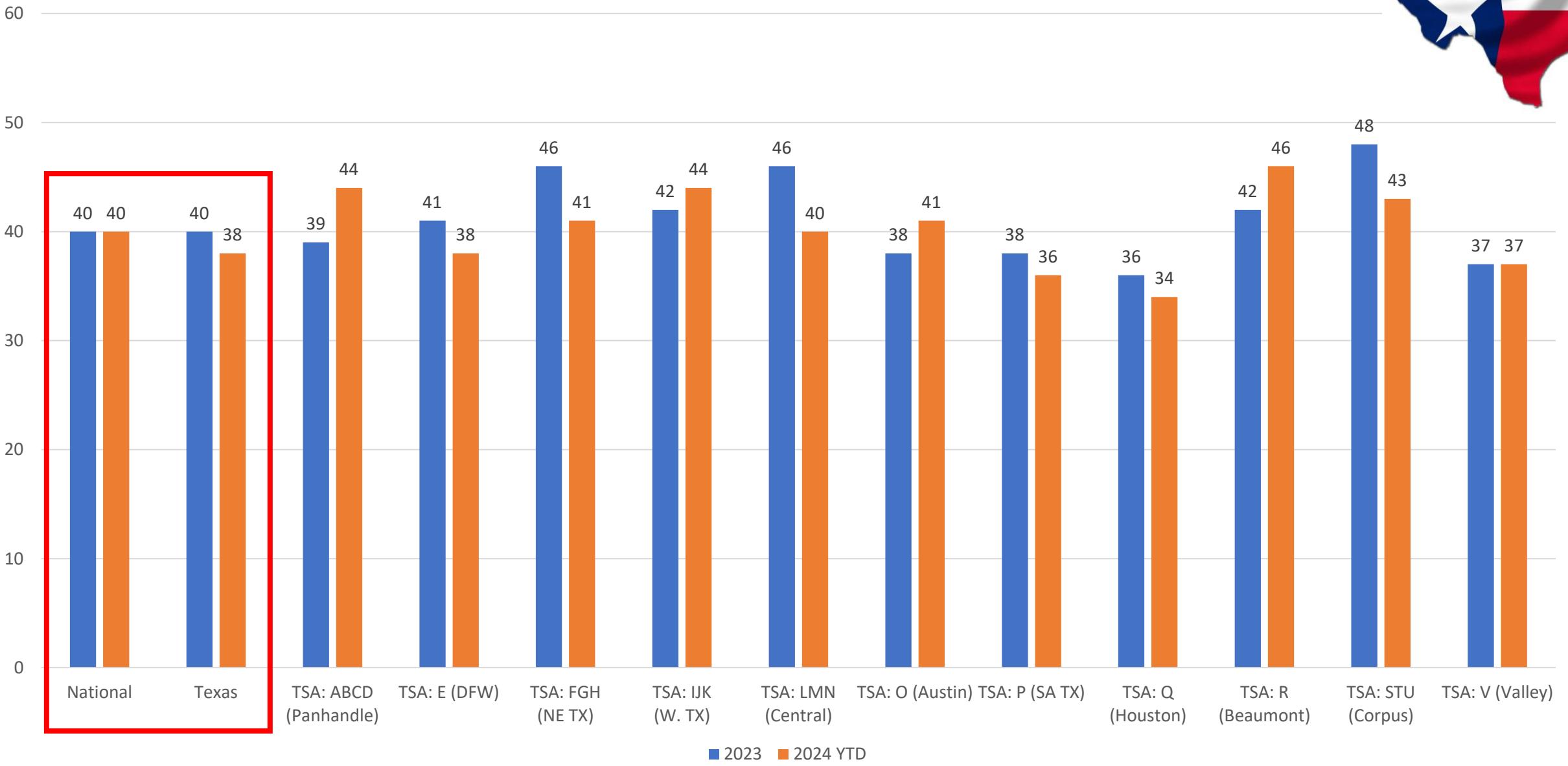
Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
GETAC Stroke Committee Purpose	• Reviewed and approved Stroke Committee purpose 03/2024	
Report and share quarterly 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.**	
GETAC Stroke Committee Performance Measures	• **Approved: Median DTN, Median DIDO, Percentage Stroke Screening Tool Performed and Documented submitted** • **Review data from NEMSIS on EMS stroke screen performance.**	
NEMSIS/EMSTR Stroke Collaboration	• **GETAC Council approved 06/2024** • **The Stroke Committee PI Work Group worked with Jia on reviewing the data.** • **Jia presented the initial results**	

GETAC Stroke Metrics

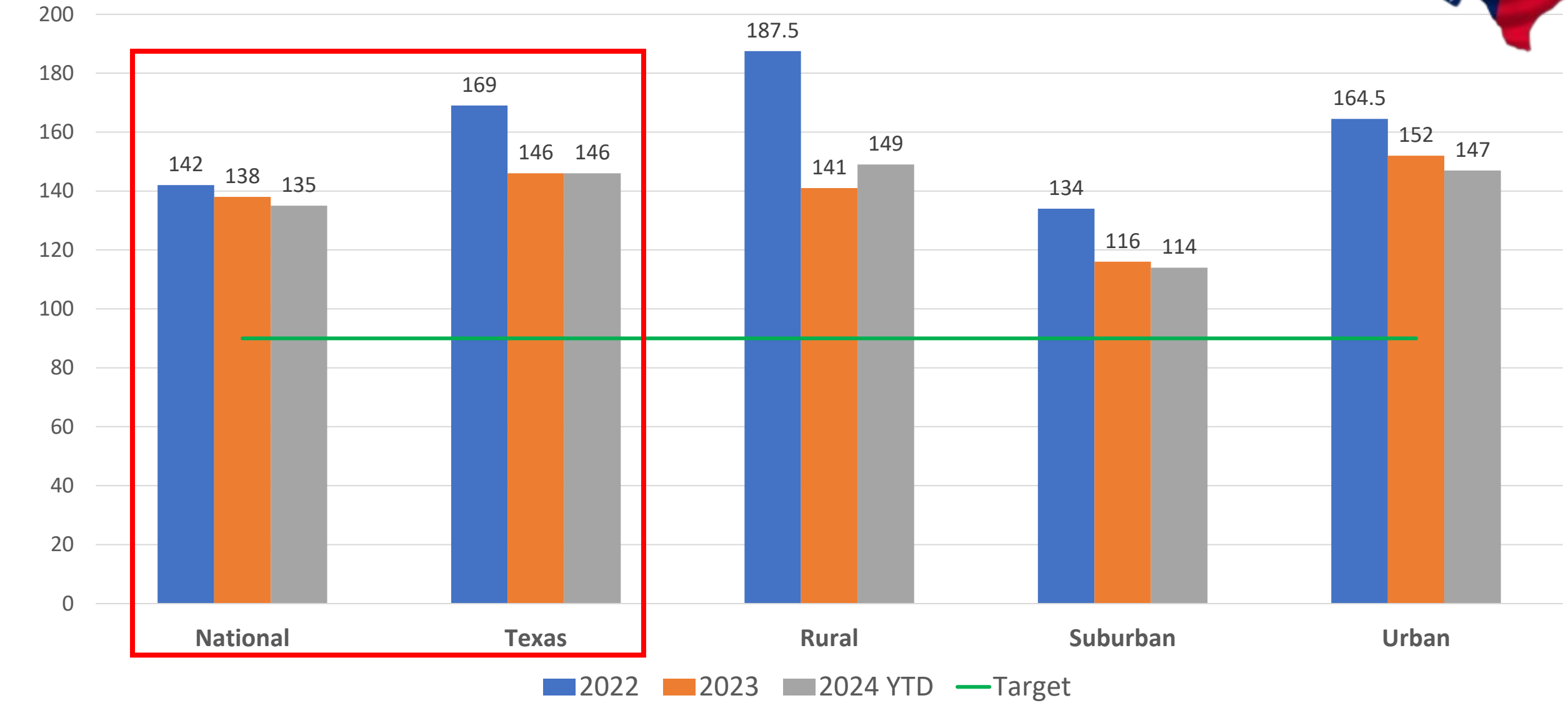
- Median Door to Needle
- Median DIDO for Acute Therapy Eligible Patients
- EMS Stroke Severity Screening for LVO
- EMS Pre-arrival Notification

Median DTN by RAC (minutes)



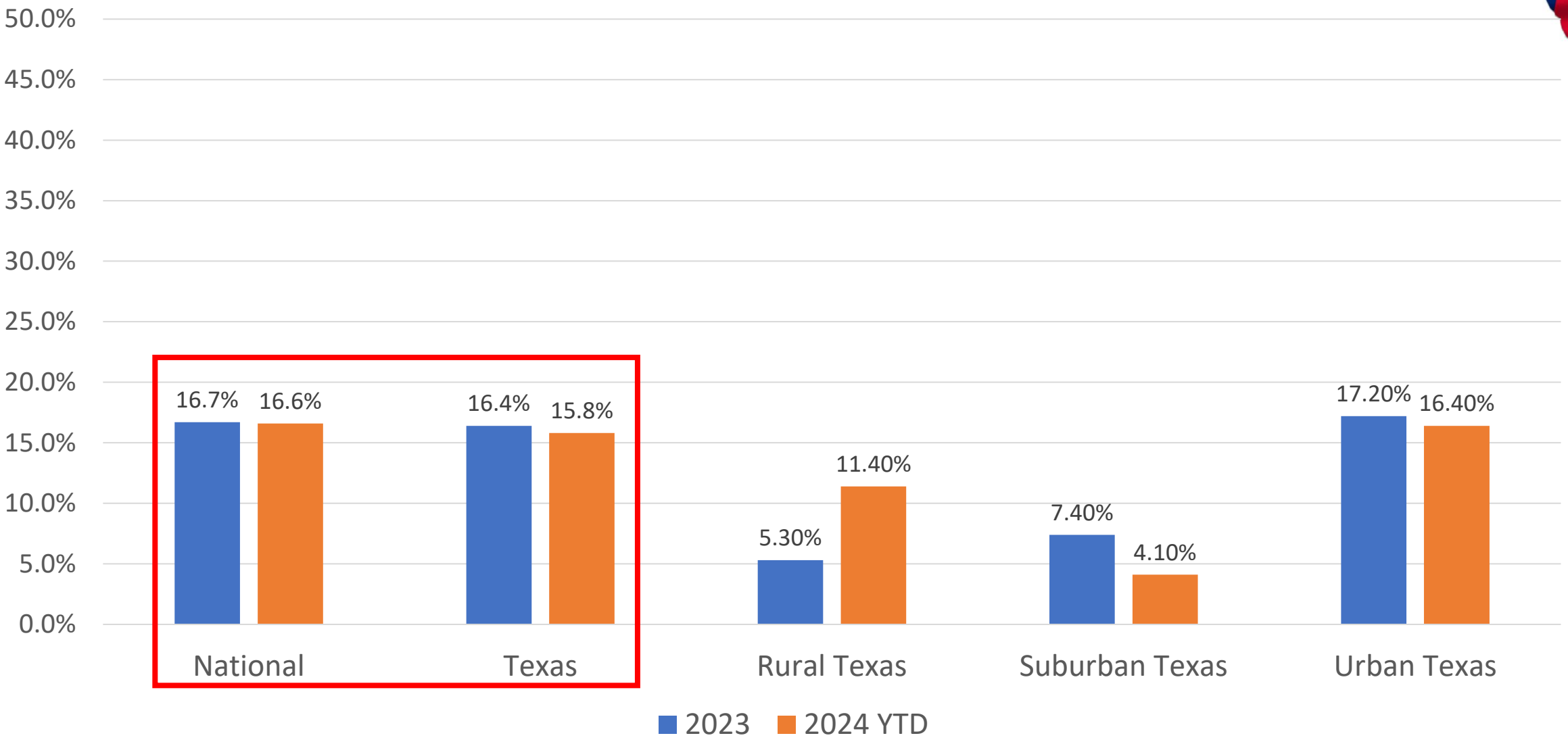
Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 7/31/24.

Median DIDO for Acute Therapy Eligible Patients



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 7/31/24.

EMS Stroke Severity Screening by Geographic Classification

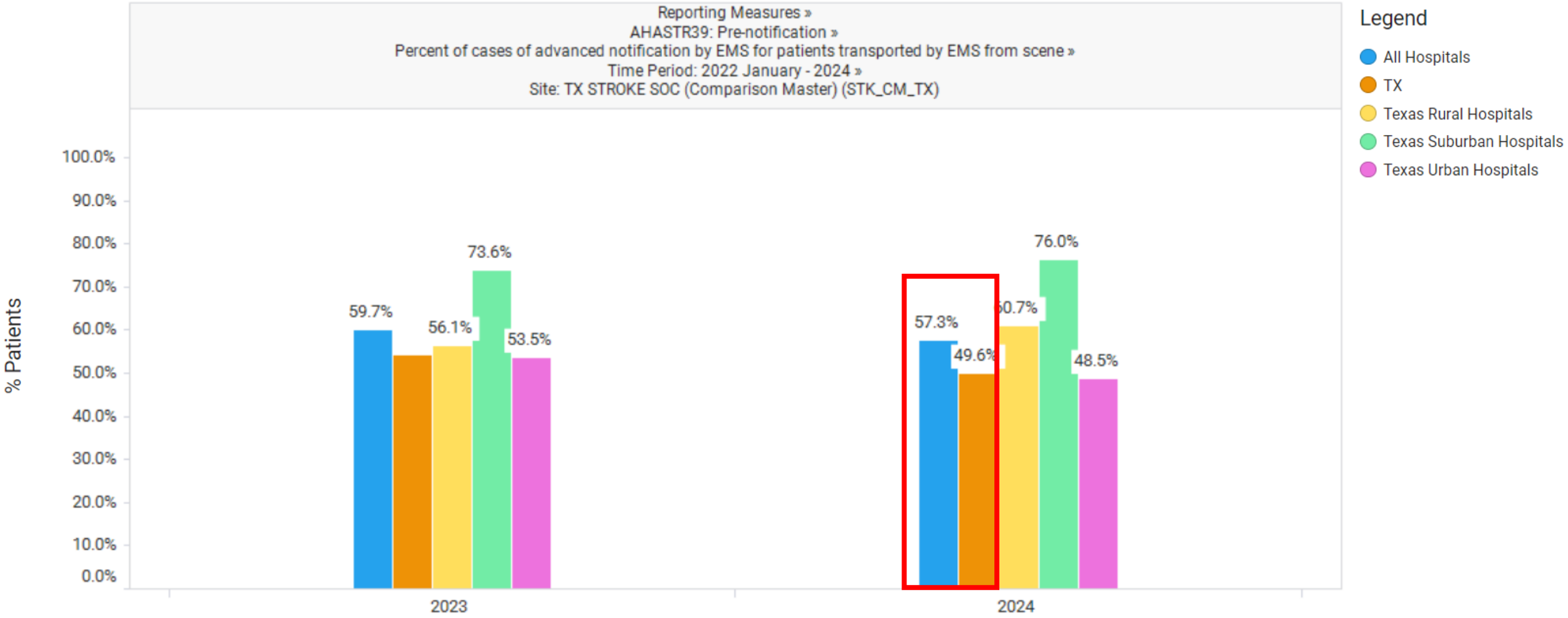


Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 7/31/24.

AHASTR39: Pre-notification

Percent of cases of advanced notification by EMS for patients transported by EMS from scene

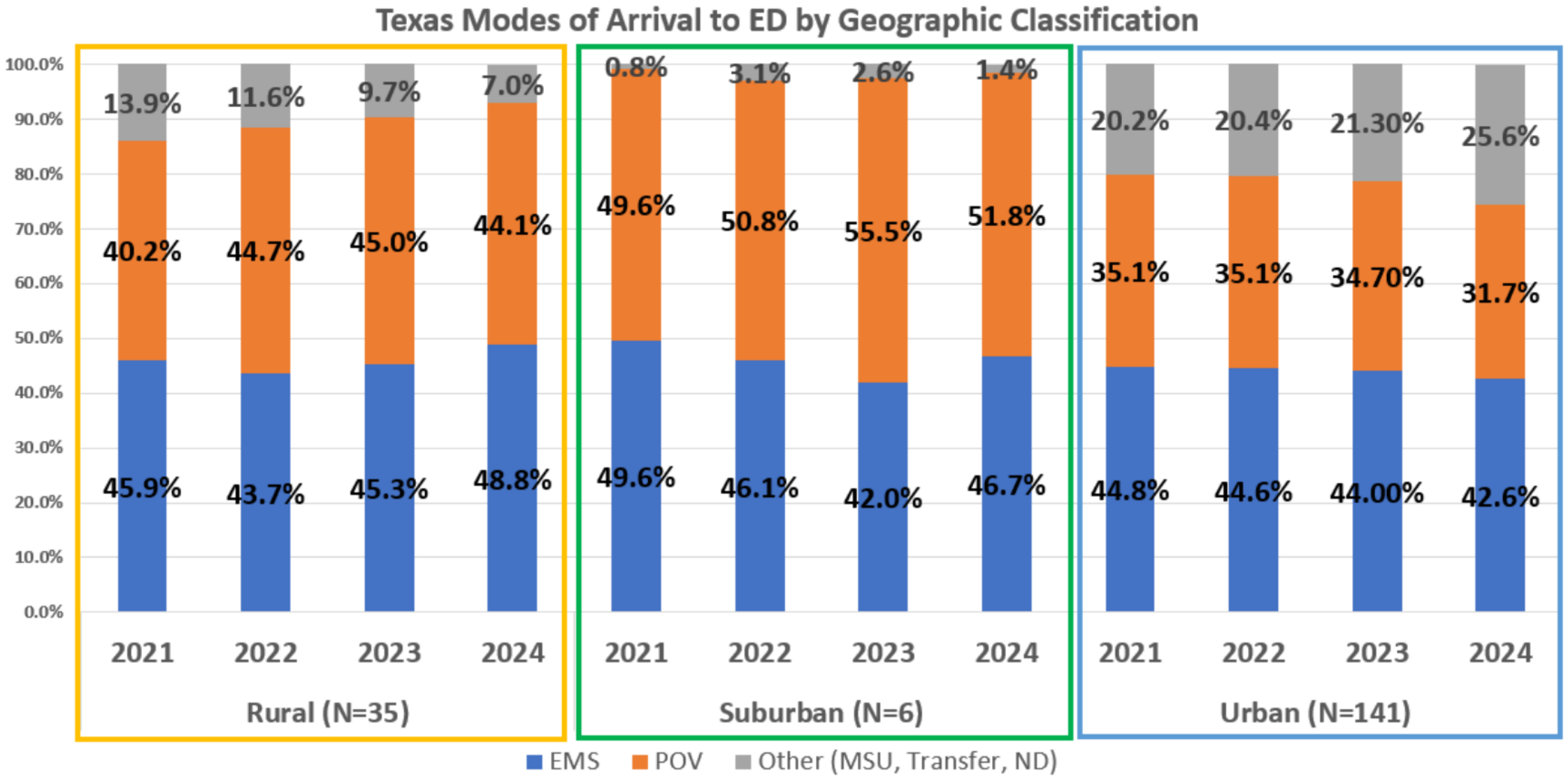
Measure Summary



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 7/31/24.

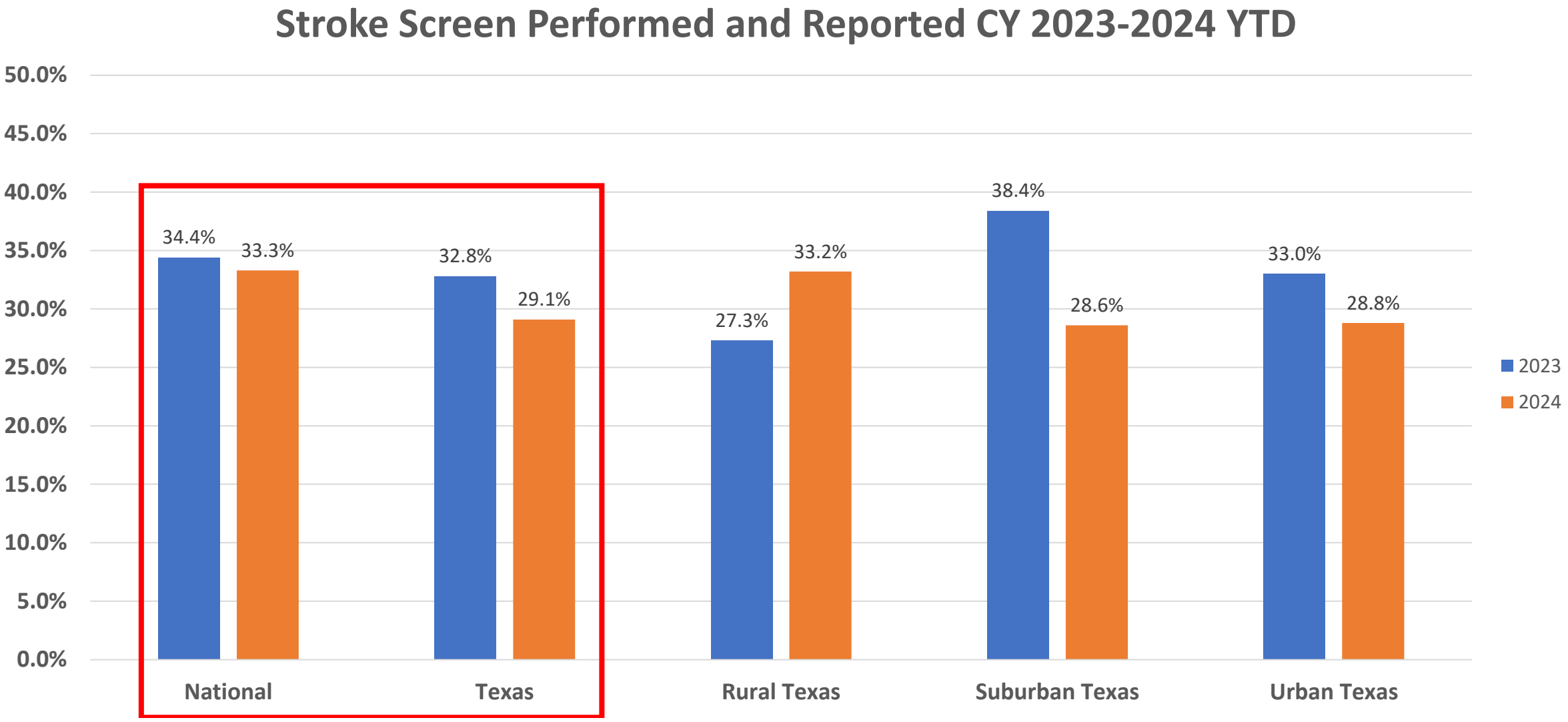
Other Stroke PI Measures

- tPA vs. TNK Usage
- Median Time LKW to Arrival by Geographic Region
- Modes of Arrival by Geographic Classification
- % DTN in 30', 45', and 60' in TX
- DTD in Direct Arrivals vs. Transfers
- EMS Stroke Screen Performed and Reported
  - GWTG vs. NEMSIS data
- EMS On-Scene time <15 min



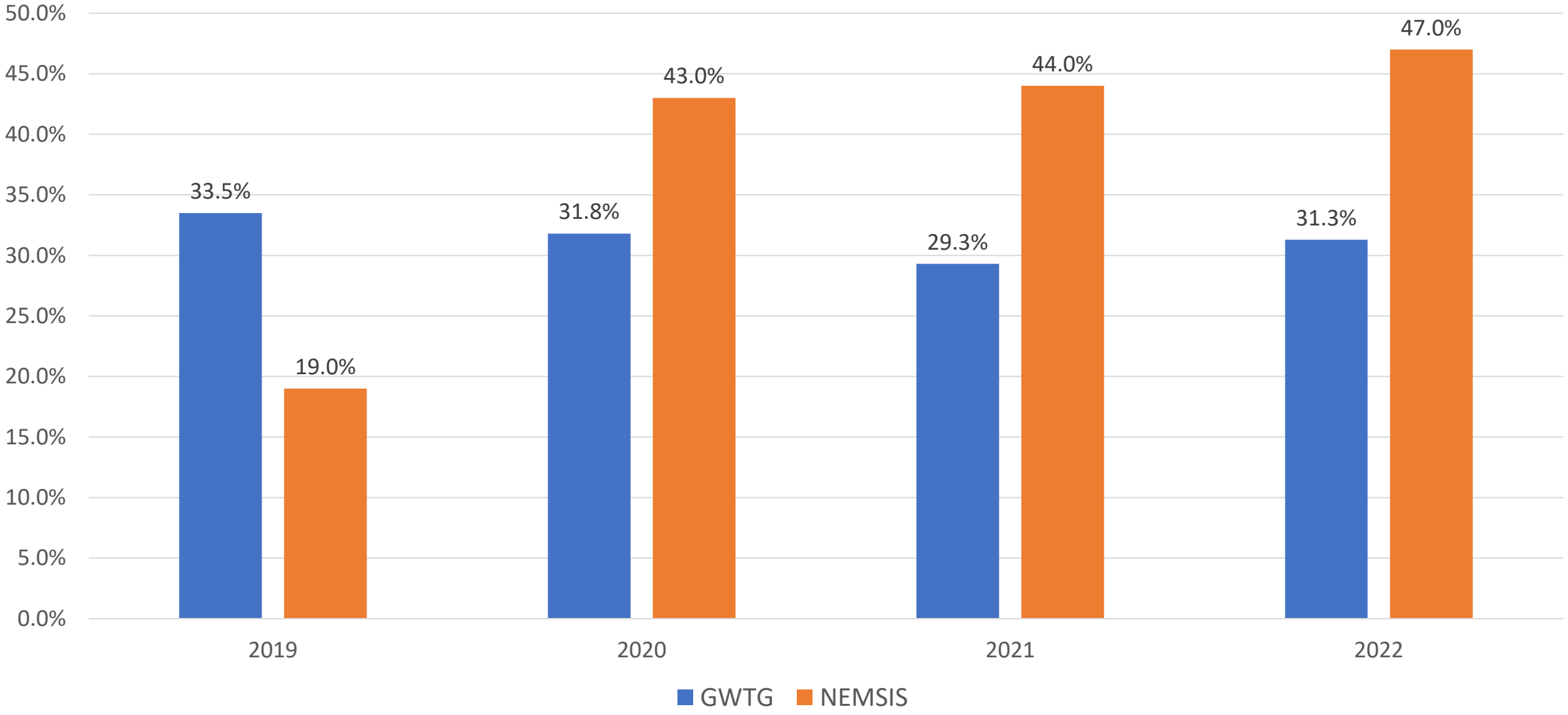
Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 4/12/24.

Percentage of confirmed stroke patients transported to your hospital by EMS and for whom a validated regional or national stroke screen tool was used with documentation of the outcome.



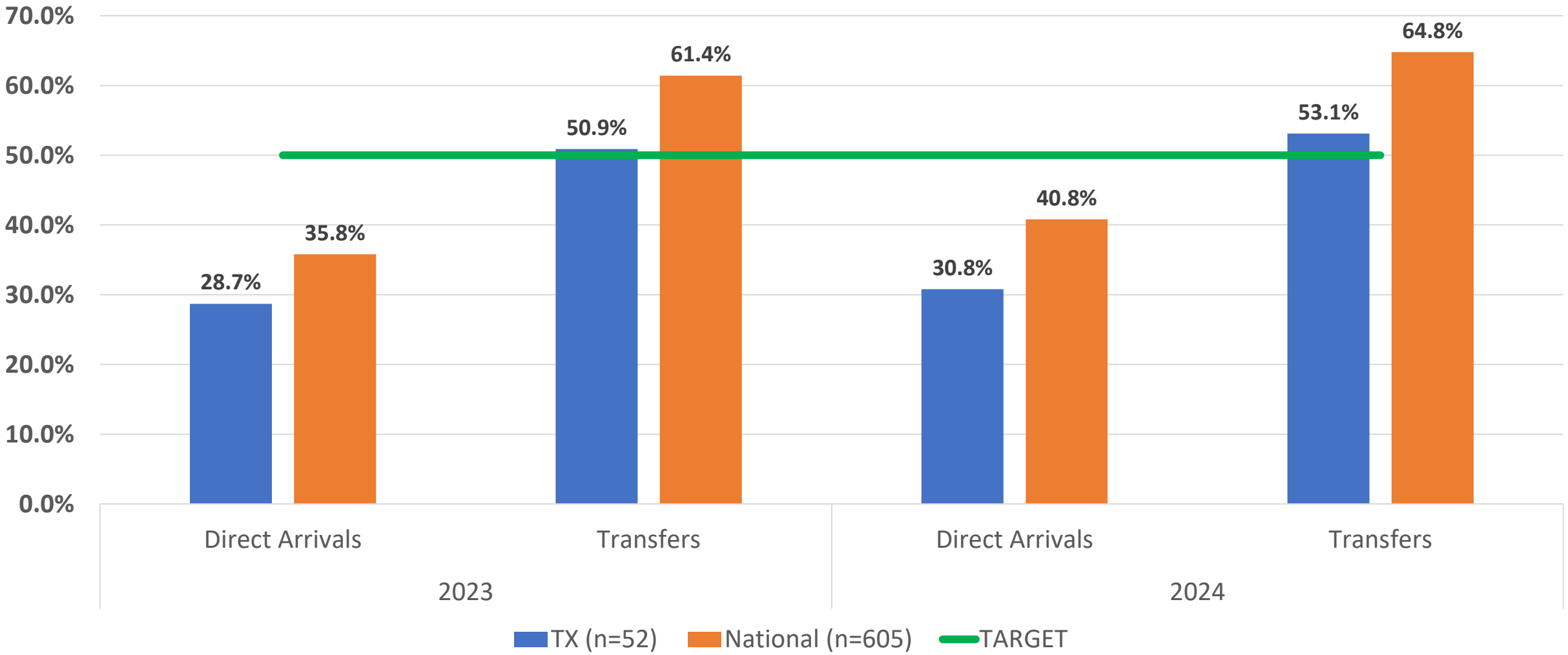
Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 7/31/24.

GWTG vs. NEMSIS: EMS Stroke Screen Performed and Reported



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 8/20/24.

DTD <60 min. for Transfers; DTD <90 min. for Direct Arrivals (LKW w/i 24 hours)



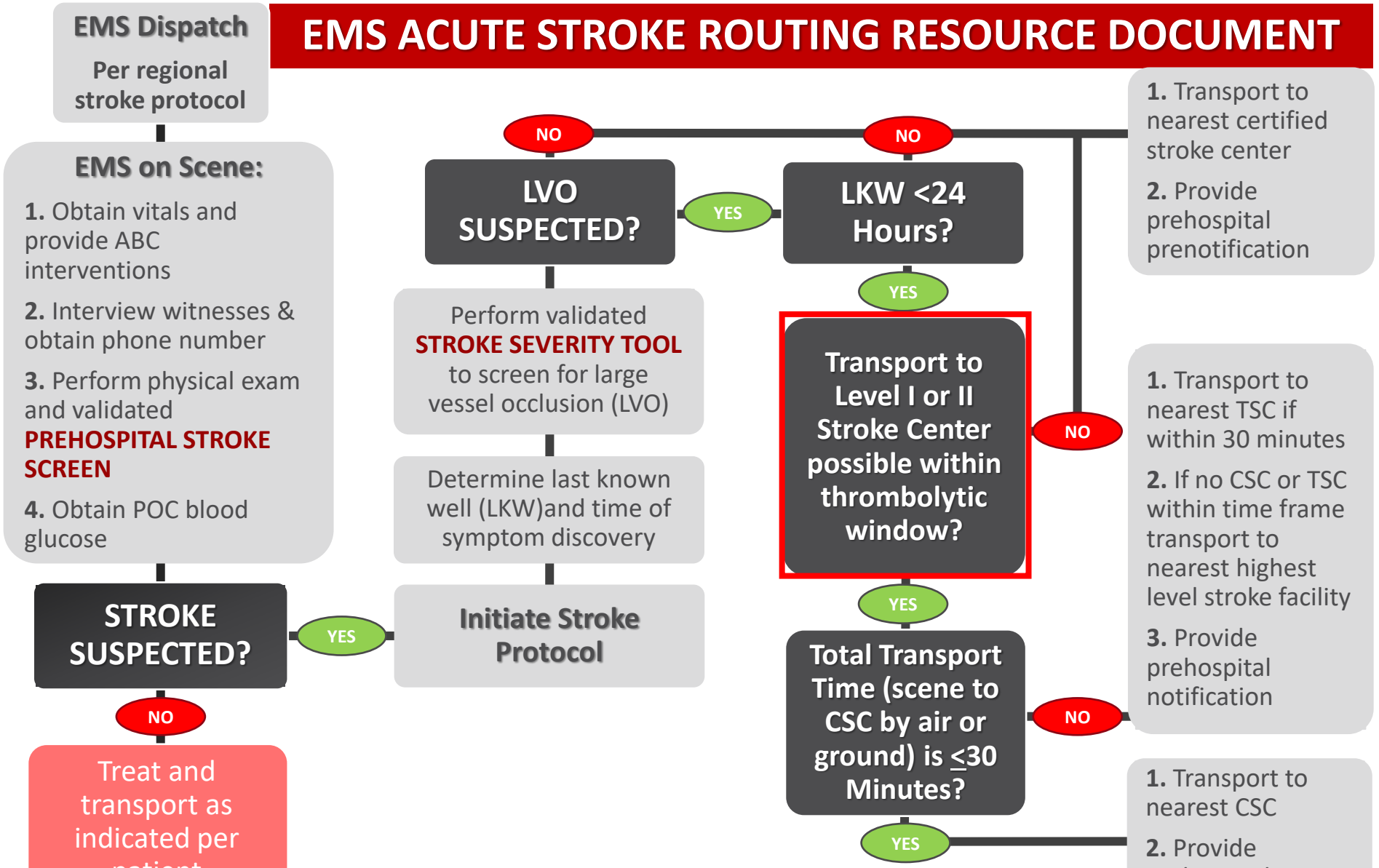
Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 7/31/24.

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

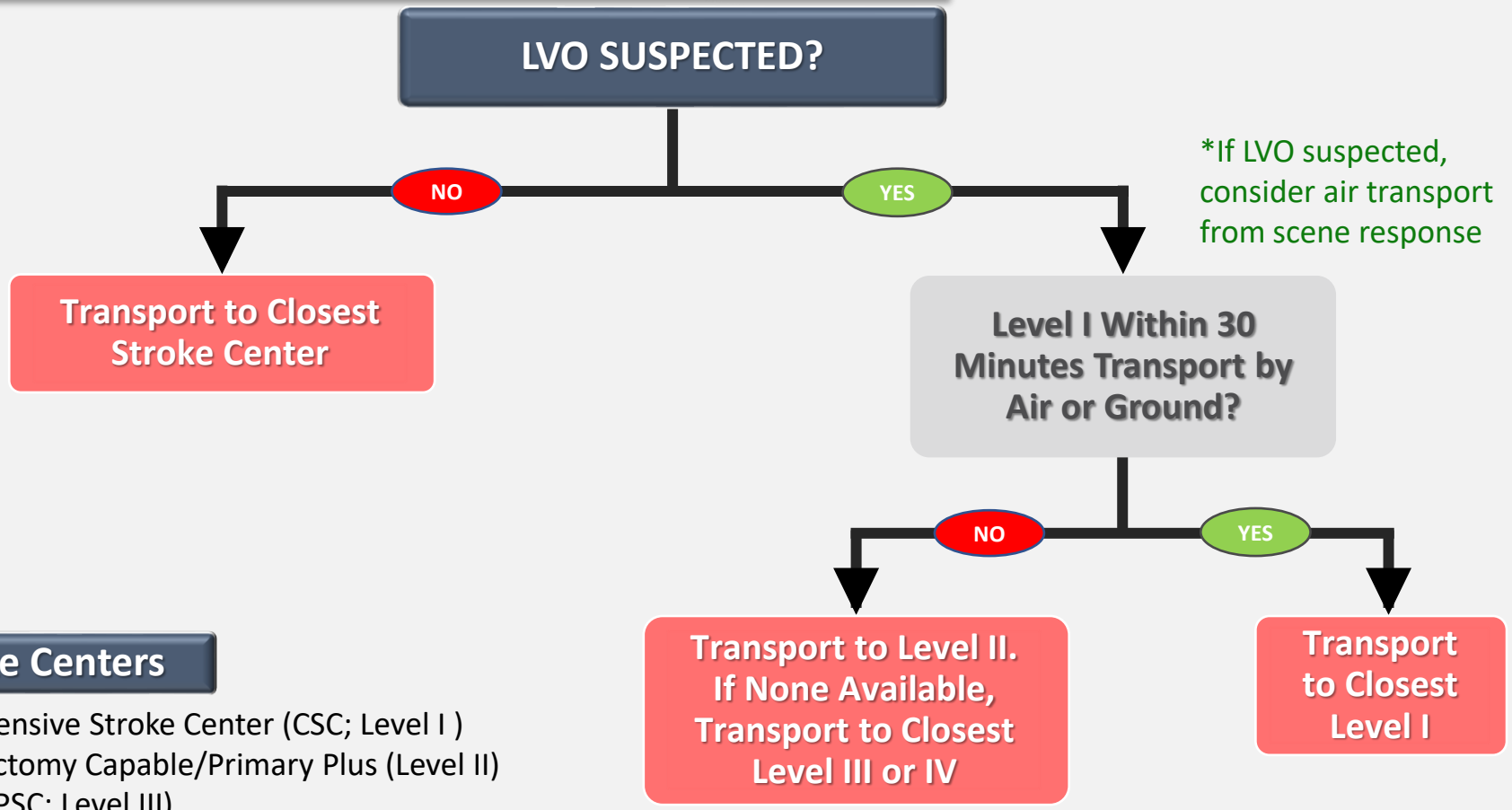
Committee Priorities	Current Activities	Status
Prehospital Stroke algorithm – Recommendation	• **Approved by Stroke, EMS and Air Medical Committees.** • **Presented to EMS Medical Directors, revisions recommended.** • **Dr. Winkler, Dr. Fagan and myself will meet to review initiatives. Plan to present 11/2024 for approval.**	
Stroke facility infrastructure and requirements	• The Stroke System of Care Work Group is outlining best practices and recommendations to present to the Stroke Committee. • SSOC Work Group will review BAC guidelines and alternatives, make recommendation to the Stroke Committee 08/24.	
Pediatric Task Force	• Reviewed and approved latest revisions to prehospital best practices for management, transport and interfacility transfers approved by stroke committee and Pediatric Committee. • Submitted to EMS, Air Medical, EMS MD committees, RAC. Seek approval 11/2024. If approved GETAC Council. • Next steps, minimum capability recommendations for pediatric hospital to be recognized as capable of caring for pediatric stroke.	

EMS ACUTE STROKE ROUTING RESOURCE DOCUMENT



Disclaimer: Regional stroke protocols are developed and implemented based on local guidelines, medical directors' recommendations, and Regional Advisory Councils (RACs). Variations in protocols may exist between different regions. For the most accurate and applicable guidelines, please consult the specific protocols established by your local health authorities and medical professionals.

Stroke Urban Transport Recommendation

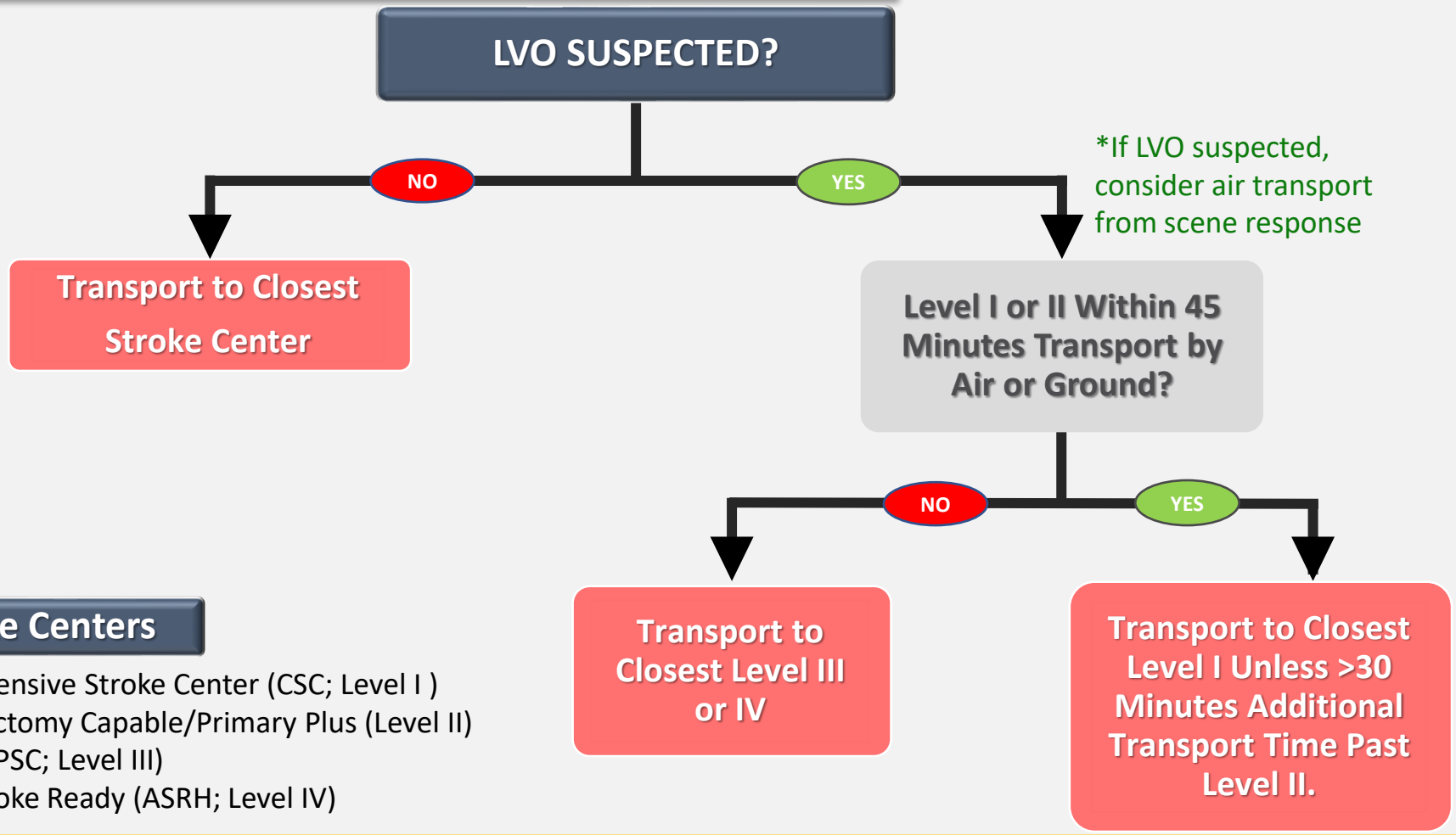


*If LVO suspected, consider air transport from scene response

Stroke Centers

Comprehensive Stroke Center (CSC; Level I)
Thrombectomy Capable/Primary Plus (Level II)
Primary (PSC; Level III)
Acute Stroke Ready (ASRH; Level IV)

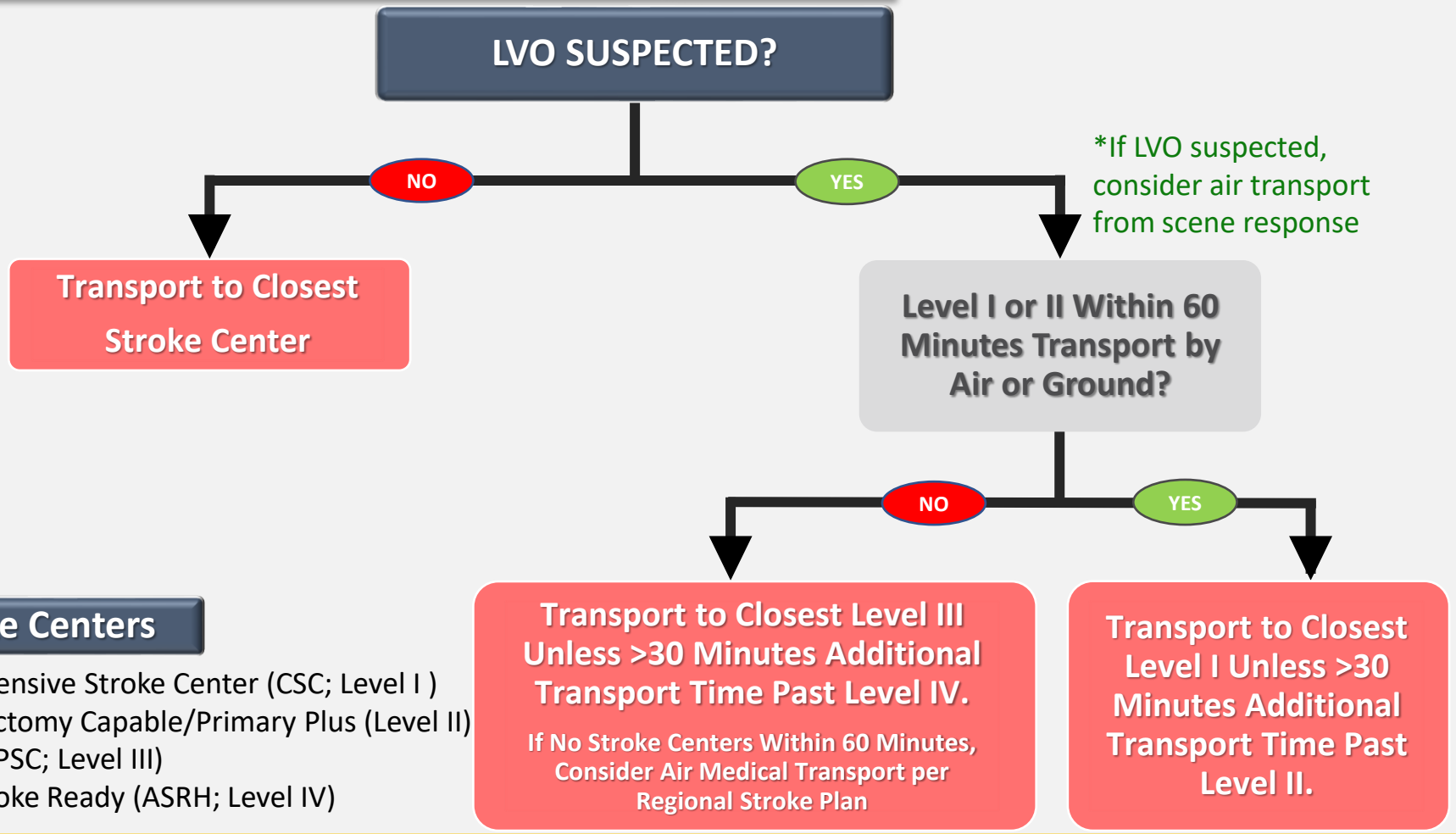
Stroke Suburban Transport Recommendation



Stroke Centers

Comprehensive Stroke Center (CSC; Level I)
Thrombectomy Capable/Primary Plus (Level II)
Primary (PSC; Level III)
Acute Stroke Ready (ASRH; Level IV)

Stroke Rural Transport Recommendation



Stroke Centers

Comprehensive Stroke Center (CSC; Level I)
Thrombectomy Capable/Primary Plus (Level II)
Primary (PSC; Level III)
Acute Stroke Ready (ASRH; Level IV)

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Prehospital Stroke algorithm – Recommendation	• Approved by Stroke, EMS and Air Medical Committees. • Presented to EMS Medical Directors, revisions recommended. • Dr. Winkler, Dr. Fagan and myself will meet to review initiatives. Plan to present 11/2024 for approval.	
Stroke facility infrastructure and requirements	• The Stroke System of Care Work Group is outlining best practices and recommendations to present to the Stroke Committee. • SSOC Work Group will review BAC guidelines and alternatives, make recommendation to the Stroke Committee 08/24.	
Pediatric Task Force	• **Reviewed and approved latest revisions to prehospital best practices for management, transport and interfacility transfers approved by stroke committee and Pediatric Committee.** • **Submitted to EMS, Air Medical, EMS MD committees, RAC. Seek approval 11/2024. If approved GETAC Council.** • **Next steps, minimum capability recommendations for pediatric hospital to be recognized as capable of caring for pediatric stroke.**	

EMS Pediatric Stroke Recommendations

PEDIATRIC STROKE SCREEN POSITIVE

Sudden Onset/Wake from Sleep:

- Numbness
- Weakness
- Difficulty speaking or understanding
- Loss of vision/double vision
- Altered mental status
- Loss of balance or coordination
- New onset focal seizure
- Severe headache without cause

Stabilize – ABCDEs Pediatric Guidelines

Airway - Ensure airway patency with suctioning and OPA or NPA, as needed.
Breathing – goal O2 sat > 94% (may be lower in congenital heart disease)
Circulation – Evaluate and treat for shock
Disability – GCS, pupillary size/reactivity, blood glucose
Exposure – evidence of traumatic injury

Pediatric Patient Stable

YES / NO

Transport to Nearest Pediatric Facility

Exam:

- Blood pressure
- Rate
- Rhythm
- Respiratory Rate
- Oxygen Saturation
- Assess for seizures
- Hypoglycemia
- Shock

History to Obtain:

- Last Known Well
- Time of Symptom Discovery
- Seizure at onset
- Head trauma
- Recent surgery
- Possible drug ingestion
- Pre-existing disability
- Device/implant history
- Medical Problems with High Stroke Risk
  - Heart Disease
  - Blood vessel problems in the brain (e.g., aneurysms, moyamoya)
  - Stroke
  - Sickle cell disease
  - Cancer
  - Blood clots

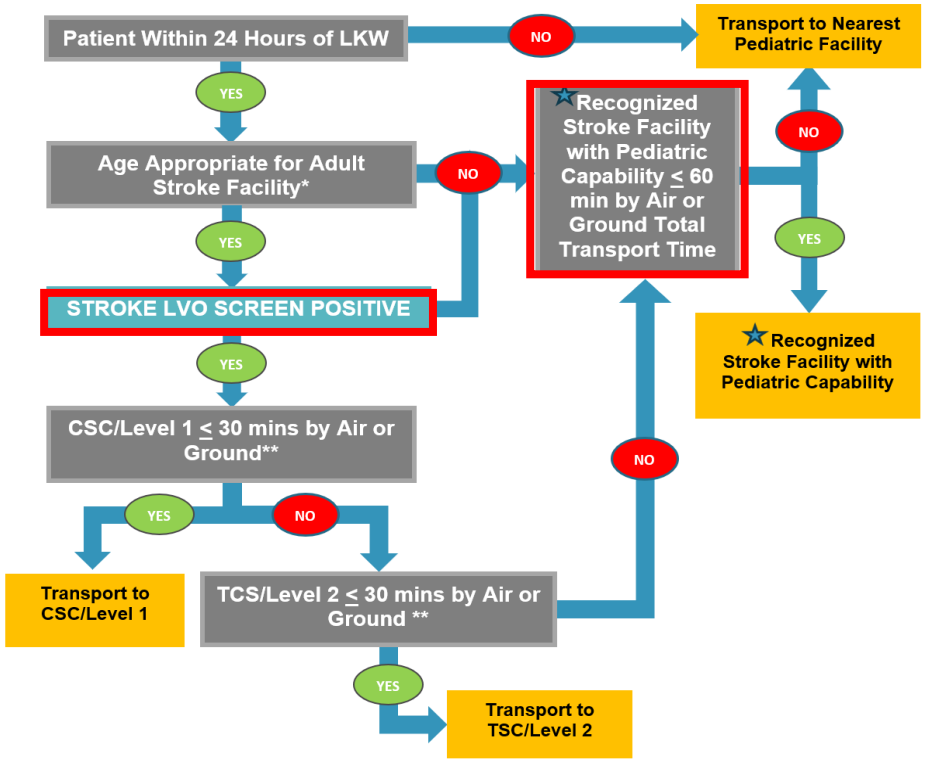
Management:

- Position head of bed to 30 degrees
- Continuous cardiac monitoring
- Place two PIV's if possible
- Avoid Hypotension
- SBP goal >50%-ile for age[1]

SBP Parameters[1]

Female		Male	
Age	50%-ile	Age	50%-ile
1-4 years	90mmHg	1-4 years	90mmHg
5-10 years	96mmHg	5-10 years	96mmHg
11-17 years	105mmHg	11-17 years	110mmHg

EMS Pediatric Stroke Recommendations



*Each Regional Advisory Council (RAC) should outline the patient age appropriate for adult stroke facility admission based on regional facility resources or hospital policies: ** Within ≤ 30 minutes past the nearest Recognized Stroke Facility with Pediatric Capabilities and no more than 60 minutes total transport time by air or ground: CSC; ★A pediatric hospital with recognized capability to care for pediatric patients with stroke. Comprehensive Stroke Center: TSC; Thrombectomy Capable Stroke Center: LVO; large vessel occlusion

Reference

1. Rivkin MJ, Bernard TJ, Dowling MM, Amlie-Lefond C. Guidelines for Urgent Management of Stroke in Children. Pediatr Neurol. 2016 Mar;56:8-17. doi: 10.1016/j.pediatrneurol.2016.01.016. Epub 2016 Jan 21. Erratum in: Pediatr Neurol. 2016 Nov;64:105. PMID: 26969237.

Last Updated 08/21/2024

EMS Pediatric Stroke Triage GuidanceRecommendations

Pediatric Stroke is a rare disease that is, nevertheless, included among the top ten causes of **death** in pediatrics.[11] However, rapid recognition and appropriate treatment of pediatric stroke can profoundly improve outcomes for these children, sparing them from decades of disability.[2,32,3] This guidance document is designed to help EMS providers recognize and triage pediatric stroke patients quickly to facilitate improved outcomes throughout the state.

Goal:
To enhance EMS identification of strokes in the pediatric population (infants and children less than 18 years of age), as well as to increase rapid triage and transport to the nearest appropriate facility.

Purpose:
In consultation with EMS, ER, stroke, pediatric neurology, and pediatric leaders from around the state and current American Heart Association recommendations, we have developed the below EMS guidelines for pediatric patients with a known or suspected stroke.[4,54,5]

General Information on Pediatric Stroke

Pediatric stroke can present with focal neurologic signs, as well as non-specific signs like seizure or altered mental status.[6–106–10]

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

- Numbness or weakness of face, arm and/or leg (especially on one side of the body)
- Confusion
- Trouble speaking or understanding language
- Trouble seeing in one or both eyes or double vision
- 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
- Drug overdose
- Hypoglycemia
- Hyperglycemia
- Genetic/metabolic disorders
- Atypical migraines
- Neuropathies (e.g. Bell's palsy)
- Seizure
- Post-ictal state
- Tumors

Prehospital Triage of Stroke Patients

Basic Level – in suspected stroke cases, as with all other pediatric patients, 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 compromised airway. Ensure airway patency with suctioning and OPA or NPA, as needed.
- **B (Breathing):** Supplemental oxygen should be provided to maintain oxygen saturation > 94% (continuous monitoring).
- **NOTE:** some patients with congenital heart disease have a different goal saturation level (80-90% in some cases). Confirm normal level with parents/caretakers if unsure.
- **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 < 60 mg/dL), treat according to diabetic emergencies clinical practice guidelines.
- If there are seizures, 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 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
- Trouble seeing in one or both eyes or double vision
- 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)

❖ **NOTE - There are no validated pre-hospital screening tools for pediatric stroke.**

History:

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

❖ **NOTE:** For "wake up strokes" the last known well time is the last time that they were witnessed to be at their baseline, which may be the night before. The time they are found is not the last known well time.

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, factor Xa inhibitors, low molecular weight heparin [enoxaparin/ Lovenox], unfractionated heparin, warfarin [Coumadin], rivaroxaban [Xarelto], dabigatran [Pradaxa], apixaban [Eliquis], edoxaban [Savaysa]).

- If possible, record when the last dose was taken.

Management:

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

1. Prevent aspiration, HOB > 30. Ensure airway patency with suctioning and OPA or NPA as needed.
2. Provide supplemental oxygen if needed to keep oxygen saturation > 94%.
   a. (Adjust if the patient has known congenital heart disease with a different goal oxygen saturation)
3. Avoid hypotension. Maintain systolic blood pressure ≥50%ile for age.

Systolic Blood Pressure Parameters[11]

Female			**Male**		
Age	50%ile	20% above the 95%ile	Age	50%ile	20% above the 95%ile
1-4 years	90mmHg	133mmHg	1-4 years	90mmHg	134mmHg
5-10 years	96mmHg	145mmHg	5-10 years	96mmHg	145mmHg
11-17 years	105mmHg	157mmHg	11-17 years	110mmHg	168mmHg

4. Call online medical control for severe hypertension (persistent systolic BP that is ≥20% above the 95th percentile).
5. Hypoglycemia (blood glucose < 60 mg/dL) should be treated in patients suspected of acute ischemic stroke.
6. To facilitate expedited stroke workup in the ED, place two peripheral IVs so long as it does not delay transport time.

System Triage:

Goal on-scene time is 10-15 minutes or less. Encourage the family to go directly to the ED if not transported with the patient.

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

Each Regional Advisory Council (RAC) should outline the patient age appropriate for adult stroke facility admission based on regional facility resources or hospital policies.

1. Pediatric patient suspected of stroke and last known well **≤ 24 hours**; triage based on following criteria:

Age appropriateness for adult stroke facility:

- Pediatric suspected stroke, **age < appropriate:**
  - Transport suspected stroke patients to the nearest **Recognized Stroke Facility with Pediatric Capabilities.**
    - **Recognized Stroke Facility with Pediatric Capabilities** – a pediatric hospital with recognized capability to care for pediatric patients with stroke.
  - If no **Recognized Stroke Facility with Pediatric Capabilities** is within **60-minute** by air or ground **total transport time** or the patient is unstable, transport to the nearest **Pediatric Facility**.
- Pediatric suspected stroke, **age ≥ appropriate:**
  - **Perform Validated Stroke Severity Screening Tool** to access for potential large vessel occlusion (LVO), such as RACE score.[12]
  - **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 **Recognized Stroke Facility with Pediatric Capabilities** and no more than **60-minute total transport time** by air or ground**.**
    - If no **CSC is available within 30 minutes,** transport to nearest **thrombectomy capable stroke center (TSC/ Level 2)** if within ≤ **30 minutes** from the nearest **Recognized Stroke Facility with Pediatric Capabilities** and no more than **60-minute total transport time** by air or ground.
    - If neither a CSC nor TSC is available within ≤ **30 minutes,** transport to the nearest **Recognized Stroke Facility with Pediatric Capabilities.**
    - If no **Recognized Stroke Facility with Pediatric Capabilities** 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 **Recognized Stroke Facility with Pediatric Capabilities.**
    - If no **Recognized Stroke Facility with Pediatric Capabilities** is within **60-minute** by air or ground **total transport time** or the patient is unstable, transport to the nearest **Pediatric Facility**.

2. Pediatric patient suspected of stroke and last known well **> 24 hours**, triage based on following criteria:
   - Pediatric suspected stroke, **for all ages:**
     - Transport suspected stroke patients to the nearest **Recognized Stroke Facility with Pediatric Capabilities.**
     - If no **Recognized Stroke Facility with Pediatric Capabilities** 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 prolonged transport time > 60 minutes.

❖ **Stroke Prenotification**, alert receiving facility that a suspected pediatric stroke patient is in route prior to arrival. A stroke alert prior to arrival will mobilize appropriate resources before patient arrival.
  - Prenotification should include: Age, last known well, 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 2022 Pediatric Stroke North Central Texas Regional Stroke Plan)

References:

1. National Center for Injury Prevention and Control, CDC. 10 leading causes of death by age group. [Internet]. 2018 [cited 2022 May 10];Available from: https://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2015-a

2. Bhatia KD, Briest R, Goetti R, et al. Incidence and Natural History of Pediatric Large Vessel Occlusion Stroke: A Population Study. JAMA Neurol 2022;79(5):488–97.

3. Lauzier DC, Galardi MM, Guilliams KP, et al. Pediatric Thrombectomy. Stroke 2021;52(4):1511–9.

4. Ferriero DM, Fullerton HJ, Bernard TJ, et al. AHA / ASA Scientific Statement Management of Stroke in Neonates and Children. 2019.

5. Jauch EC, Schwamm LH, Panagos PD, et al. Recommendations for Regional Stroke Destination Plans in Rural, Suburban, and Urban Communities From the Prehospital Stroke System of Care Consensus Conference: A Consensus Statement From the American Academy of Neurology, American Heart Association/American Stroke Association, American Society of Neuroradiology, National Association of EMS Physicians, National Association of State EMS Officials, Society of NeuroInterventional Surgery, and Society of Vascular and Interventional Neurology. Stroke 2021;52(5).

6. Elbers J, Wainwright MS, Amlie-Lefond C. The Pediatric Stroke Code: Early Management of the Child with Stroke. J Pediatr 2015;167(1):19-24.e4.

7. Phelps K, Silos C, De La Torre S, et al. Establishing a pediatric acute stroke protocol: experience of a new pediatric stroke program and predictors of acute stroke. Front Neurol 2023;14.

8. Harrar DB, Benedetti GM, Jayakar A, et al. Pediatric Acute Stroke Protocols in the United States and Canada. In: Journal of Pediatrics. Elsevier Inc.; 2022. p. 220-227.e7.

9. Wharton JD, Barry MM, Lee CA, Massey K, Ladner TR, Jordan LC. Pediatric Acute Stroke Protocol Implementation and Utilization Over 7 Years. In: Journal of Pediatrics. Mosby Inc.; 2020. p. 214-220.e1.

Last Updated – 08.21.24

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• **Approved revisions by Stroke, EMS and Air Medical.** • **Presented to EMS Medical Director, and RAC leadership in past.** • **EMS Medical Directors deferred approval until 08/2024. Did not have time to review.** • **Will seek approval 11/2024 from EMS MD and RAC, then GETAC Council**	
DIDO performance recommendations	• Approved revisions by Stroke, EMS and Air Medical. • Plan to present to EMS MD 08/2024. Did not have time to review. • Will seek approval 11/2024 from EMS MD and RAC, then GETAC Council • Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO	
Establish research opportunity in the state of Texas to help advance stroke care in the state	• Working on Texas study evaluating if providing standardized stroke education improves performance. • Dr. Savitz resented on opportunities for IRB approval for statewide study.	

Current
INTERFACILITY STROKE TERMINOLOGY

1

Level 1 Stroke = Patient with an ischemic or hemorrhagic stroke in need of an emergent intervention

2

Level 2 Stroke = Patient with an ischemic or hemorrhagic stroke in need of an urgent transfer for higher level of care but without emergent need of an intervention

3

Level 3 Stroke = Patient with an ischemic or hemorrhagic stroke in need of transfer but without emergent or urgent needs

- **Level 1 and 2 Stroke**- time from ***agency notification*** to transportation ***arrival at the transferring hospital*** ≤ 30 minutes.
  Level 1 Stroke- if ground transportation to transferring facility or transport time to receiving facility > 30 minutes consider air transport.

Stroke Committee

Priority Not Implemented
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Committee Priorities	Current Activities	Status
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New Proposal Breaking Down DIDO

DIDO Median Time Metrics for patients with LVO in need of thrombectomy Goal 90 minutes	
Transferring Facility Door to Notification of receiving facility and ground or air medical transport	**30 minutes or less** **(call as soon as possible)** *Consider early activation if auto-accept with receiving facility is not in place.
Receiving Facility to Notification of acceptance or not	**15 minutes or less**
EMS arrival	**50% at goal 30 minutes by air or ground urban/suburban and 45 minutes rural**
EMS arrival to Door out	**15 minutes or less**

Stroke Committee

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Establish research opportunity in the state of Texas to help advance stroke care in the state	• **Working on Texas study evaluating if providing standardized stroke education improves performance.** • **Dr. Savitz resented on opportunities for IRB approval for statewide study.**	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Texas EMS Stroke Survey	• **Approved** • **Joseph assisting with disseminating survey**	
Stroke Committee endorsed stroke education and certification courses	• Ongoing effort identifying stroke educational opportunities for providers.	
Stroke Education Resource for stroke facilities	• Working with DSHS for website access to stroke education • Elizabeth to report back to the Stroke Committee 11/2024	
Work with DSHS to outline recommendations for stroke rules for ASRH	• Ongoing	

Stroke Committee

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Work with DSHS to outline recommendations for stroke rules for ASRH	• Ongoing	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Stroke Coordinator/Manager Mentorship Survey	• **Stroke Committee Education Work Group developing survey to help pair mentor/mentee** • **Elizabeth and Jorie advising** • **Seek approval GETAC Council 11/2024**	
Rural Stroke Work Group	• Provider QR code for member participation	
BAC Gap Analysis	• SSOC Work Group reviewed BAC guidelines and compared to other options. • Recommendation to use ASA as resource over BAC approved by Stroke Committee	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Stroke Coordinator/Manager Mentorship Survey	• Stroke Committee Education Work Group developing survey to help pair mentor/mentee • Elizabeth and Jorie advising • Seek approval GETAC Council 11/2024	
Rural Stroke Work Group	• **Provider QR code for member participation**	
BAC Gap Analysis	• SSOC Work Group reviewed BAC guidelines and compared to other options. • Recommendation to use ASA as resource over BAC approved by Stroke Committee	

RURAL Stroke Work Group

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Stroke Coordinator/Manager Mentorship Survey	• Stroke Committee Education Work Group developing survey to help pair mentor/mentee • Elizabeth and Jorie advising	
Rural Stroke Work Group	• Provider QR code for member participation	
BAC Gap Analysis	• **SSOC Work Group reviewed BAC guidelines and compared to other options.** • **Recommendation to use ASA as resource over BAC approved by Stroke Committee**	

Vote:

SSOC Meeting Monday August 19th 2024

Objective: The GETAC stroke committee seeks to recommend a different set of stroke standards to the department. The recommendation is to use the AHA/ASA Guidelines.

1. SSOC will serve as the working group to review and discuss the standards to be recommended.
2. Develop a gap analysis of the BAC standards to the current AHA recommendations
   a. Why AHA standards would be best for Texas to follow.
   b. Evidence that the current stroke survey organizations utilize the standards for their certification evaluation.
   c. Are there any conflict of interests or down sides to remaining with the BAC

standards

AHA/ASA standards for their certification evaluation. When considering the various societies that have purview in the field of stroke and cerebrovascular disease, the AHA provides the most comprehensive, current guidelines across the continuum of care for stroke patients. When the BAC publishes a new statement, we could re-evaluate returning to the BAC as our source for standards.

These are a sample of AHA Publications as References

Ideal Foundational Requirements for Stroke Program Development and Growth: A Scientific Statement From the American Heart Association. Stroke
Volume 54, Number 4 https://doi.org/10.1161/STR.0000000000000424

Recommendations for the Establishment of Stroke Systems of Care: A 2019

Gap Analysis

The published Brain Attack Coalition (BAC) guidelines for stroke care are out of date; the BAC have not published updated guidelines. From their website, the BAC have published 1)"Formation and Function of Acute Stroke-Ready Hospitals in 2013; (2)"Revised and Updated Recommendations for the Establishment of Primary Stroke Centers (2011); (3)"Recommendations for Comprehensive Stroke Centers" in 2005.

a new level of care for stroke center certification has also been introduced by several accrediting bodies pertaining to thrombectomy capability. However, the BAC has not published updated standards to incorporate these transformative changes in stroke care. Staying with the outdated BAC publication places Texas more than 10 years behind in standards of care.

What is an alternative neutral party that we could reference as a source?
The proposal is to refer to the American Stroke Association under the American Heart Association as the main source for stroke care guidelines. The AHA has updated its guidelines through multiple publications on the most recent evidence from clinical trials to support best practices in stroke care. Current stroke survey organizations utilize the

GETAC Stroke Committee Item Request for Council August 2024

Robin Novakovic-White, MD

Stroke Committee

Stroke Committee

- Committee items needing council guidance
  1. ASA recommendation to replace BAC

- Stakeholder items needing council guidance
  1. None at this time

- Items referred to GETAC for future action
  1. Near future will seek approval for the adult and pediatric prehospital stroke algorithm, stroke terminology and DIDO performance measures best practice recommendation

7.j. GETAC Trauma Systems Committee

Chair: Stephen Flaherty, MD, FACS

Vice-Chair: Lori Adams, MHA, BSN-RN, TCRN, NHDP-BC

Trauma Systems Committee

Matagorda Regional Medical Center

On the morning of March 22nd, around shift change time, the ER staff were notified that there had been a serious car wreck close to the hospital.

As the EMS Chief was giving the hospital the information about the injured, a second wreck happened in the same place due to rubbernecking.

MRMC received 5 critical patients from EMS – including one of their own nurses who had just finished her shift.

Injuries included multiple patients with fractured pelvis and femurs. Being a small facility, they did not have enough supplies and splints, so they had to make do with sheets etc.

All 5 critical patients were transferred to a level I in Houston and all survived!!

Trauma Program Manager is Krisann Shoemaker
ED Director is Christy Hoke
TMD is Dr Young

Trauma Systems Committee

- **Trauma rules process**
  - Tracking with DSHS staff
  - This committee will be prepared to support with a workgroup-sized element to assistant the Department in reviewing comments.

Trauma Systems Committee

- **Trauma System Committee Pillars**
  - Data Pillar
  - Inclusive Trauma System Pillar
  - RAC communication Pillar
  - Financial Health Pillar
  - Pediatric injury Pillar

Trauma Systems Committee

- **Data Pillar (Barreda)**
  - Trauma transfers
    - Collaborative with RAC Communication Pillar
  - Migration in and out of the trauma system
    - Collaborative with Financial Health Pillar
  - Inclusive trauma system
    - Collaborative with RAC Communcation

Trauma Systems Committee

- **Inclusive Trauma System Pillar (Scherer)**
  - Migration in and out of the trauma system
    - Collaborative with Financial Health Pillar
  - Inclusive trauma system
    - Designation survey hotspots
    - Designation survey consistency
      - Collaborative with RAC Communication
      - Collaborative with DSHS
      - Collaborative with DSHS and TETAF
  - Education to administrative teams.

Trauma Systems Committee

- **RAC communication Pillar (Adams)**
  - Migration in and out of the trauma system
    - Collaborative with Financial Health Pillar
  - Inclusive trauma system
    - Collaborative with RAC Communcation
  - Designation survey hotspots
    - Collaborative with DSHS

Trauma Systems Committee

- **Financial Health Pillar (Rodgers)**
  - Migration in and out of the trauma system
    - Collaborative with Financial Health Pillar
  - Inclusive trauma system
    - Collaborative with RAC Communcation
  - Designation survey hotspots
    - Collaborative with DSHS

Trauma Systems Committee

- **Pediatric Injury Pillar (Pryor and Evans)**
  - Radiographic imaging duplication
    - Data Pillar
    - RAC Communication Pillar
    - Key Stakeholders (TBD)

Trauma Systems Committee

- Items needing Council guidance
  - The Council previously approved our request for that state registry to provide data reports related to transfer delays. We request renewal of the approval to receive that data stream.

Trauma Systems Committee

Items referred to the Council for future action

None

8. Task Force Updates

8.a. Texas System Performance Improvement (PI) Plan and PI Task Force Update

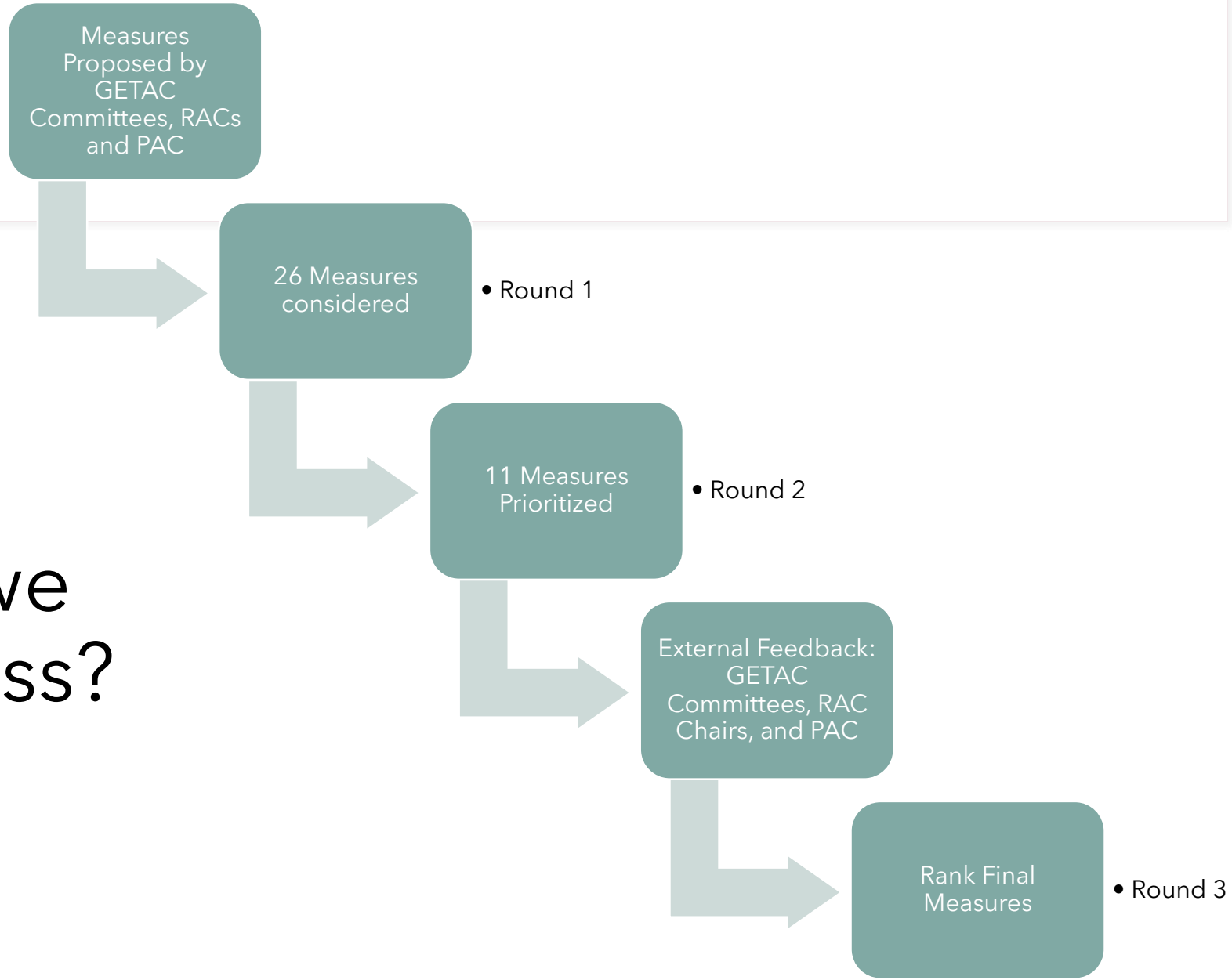
Katherine Remick, MD
Task Force Chair

Texas EMS and Trauma System Measures Development

System PI Taskforce

August 2024 Report to GETAC Council

Timeline



Where are we in the process?

Top 11 Measures: Approve Revised Language

1. For injured adult patients <65yrs with a GCS <9 or SBP<90mmHg, time from arrival to departure from sending facility
2. # of severe maternal morbidity events (21 ICD-10 codes) per 1000 live births
3. For patients with acute ischemic stroke, door-to-needle time
4. Percent of EMS patients with primary impression of "stroke" who have a stroke screening scale documented by EMS
5. Percent of OHCA patients that received bystander CPR prior to EMS arrival
6. Percent of OHCA patients in public locations where AED was applied prior to EMS arrival
7. Mean or Median pediatric readiness score for designated trauma centers
8. Percent of trauma centers that took the pediatric readiness assessment in a given calendar year
9. Percent of patients greater than or equal to 12 years of age who are screened for suicide
10. Percent of admitted injured patients greater than or equal to 12 years of age who are screened for substance use/misuse
11. Percent of newborns (<28 days) transported by EMS who arrive at the hospital with a temperature <36.5 Celsius

Eight Measures for Ranking

1. For injured adult patients <65yrs with a GCS <9 or SBP<90mmHg, time from arrival to departure from sending facility (>65yrs with SBP<110mmHg, <15yrs SBP <70 + 2(age))
2. # of severe maternal morbidity events (21 ICD-10 codes) per 1000 live births
3. For patients with acute ischemic stroke, door-to-needle time
4. Percent of EMS patients with primary impression of "stroke" who have a stroke screening scale documented by EMS
5. Percent of OHCA patients that received bystander CPR prior to EMS arrival
6. Percent of OHCA patients in public locations where AED was applied prior to EMS arrival
7. Mean or Median pediatric readiness score for designated trauma centers
8. Percent of trauma centers that took the pediatric readiness assessment in a given calendar year

Measure	Data Source	Frequency of Reporting	Baseline Data	National Average	Source
For injured patients with a GCS <9 or SBP<90mmHg (adults), SBP < 110 for geriatric population > 65yrs, or SBP <70 + 2(age in yrs) for children <15yrs time from arrival to departure from sending facility	Texas EMS and Trauma Registry	Quarterly	Median transfer time = 127min, mean transfer time = 157min Transferred in <2 hours = 43.7% Transferred in greater than or equal to 2 hours - 49.4% Missing time = 6.9%	Median transfer time is 126 min (92-172 minutes), every 30min delay beyond 90min associated with increased odds of mortality at 24 hrs (1.042) and in-hospital mortality (1.077) (adults only)	Journal of the American College of Surgeons 2 35(5):p S285-S286, November 2022.
Percent of EMS patients with primary impression of "stroke" who have a documented stroke screening scale	Texas EMS and Trauma Registry	Quarterly	47.2% of suspected stroke patients had a documented stroke scale performed	55% of stroke patients with documented PSS; adj OR 1.4 [1.2-1.6] for door-to-CT <25min	Stroke.2023 ; 55(1). https://doi.org/10.1161/STROKEAHA.123.043846

Measure	Data Source	Frequency of Reporting	Baseline Data	National Average	Source
Percent of OHCA patients that received bystander CPR prior to EMS arrival	Texas EMS and Trauma Registry	Quarterly	44.5% of OHCA patients received bCPR prior to EMS arrival,	2023 national average is 41.2% (CARES 2023)	CARES
Percent of OHCA patients in public locations where AED was applied prior to EMS arrival	Texas EMS and Trauma Registry	Quarterly	17.0% AED applied without defibrillation 4.0% AED applied with defibrillation 21% AED applied with or without defibrillation (combined)	2023 national average is 11.7% (CARES 2023)	CARES

Measure	Data Source	Frequency of Reporting	Baseline Data	National Average	Source
For patients with acute ischemic stroke, door-to-needle time	Get with the Guidelines	Quarterly	45.5min (mean), SD 140min, 39 (median) - Q1 2024 (997pts)	44min (mean), SD 58.6min, 40 (median) Q1, 2024 (11,618pts)	Get with the Guidelines
Percent of trauma centers that took the pediatric readiness assessment in a given calendar year	Texas EMSC	Semi-annual	59% (N=176)	National participation: 71%	NPRP
Mean or Median pediatric readiness score for designated trauma centers	Texas EMSC	Semi-annual	73 (mean), 73 (median)	National median 69.5, survival benefit is above 90	NPRP, *JAMA Netw Open*. 2023;6(1):e2250941. doi:10.1001/jamanetworkopen.2022.50941 *and* Annals of Surgery. October 2023. DOI:10.1097/SLA.00

Measure	Data Source	Frequency of Reporting	Baseline Data	National Average	Source
# of severe maternal morbidity events (21 ICD-10 codes) per 10,000 live births	MMMRC DSHS Joint Biennial Report in Appendix G and the Healthy Texas Mothers and Babies Data Book	Quarterly	The provisional 2020 Texas SMM rate related to in-hospital deliveries is 72.7 cases per 10,000 delivery hospitalizations. The rate increased from 58.2 in 2018 (TX MMMR Committee Biennial report)	National mean for SMM rates is 79.7 per 10 000 in 2019.	JAMA Network Open. 2022;5(7):e2222966. doi:10.1001/jamanetworkopen.2022.22966

Record ID	For injured adult patients < 65yrs with a GCS < 9 or SBP< 90mmHg, time from arrival to departure from sending facility	# of severe maternal morbidity events (21 ICD-10 codes) per 1000 live births	For patients with acute ischemic stroke, door-to-needle time	Percent of EMS patients with primary impression of 'stroke' who have a stroke screening scale documented by EMS	Percent of OHCA patients that received bystander CPR prior to EMS arrival	Percent of OHCA patients in public locations where AED was applied prior to EMS arrival	Mean or Median pediatric readiness score for designated trauma centers	Percent of trauma centers that took the pediatric readiness assessment in a given calendar year
1	3	8	2	1	7	6	4	5
2	1	3	5	4	2	6	7	8
3	8	3	5	7	6	4	1	2
4	3	4	5	7	2	6	1	8
5	3	1	2	6	7	4	5	8
6	1	4	2	3	8	7	5	6
7	1	2	4	3	7	5	6	8
8	1	2	3	6	7	8	4	5
9	1	2	3	6	5	4	8	7
10	6	8	7	3	1	2	5	4
11	1	3	4	2	5	8	6	7
12	7	1	2	3	4	6	8	5
13	1	8	2	4	6	7	5	3
14	1	2	3	7	8	4	5	6
15	1	4	3	7	6	8	5	2
	39	55	52	69	81	85	75	84
ale was 1-8 |	Rank 1	Rank 3	Rank 2	Rank 4			Rank 5	

Lowest Value = Highest Priority (scale was 1-8 | calculated sum for each measure)

Texas EMS and Trauma System Quality Measure Final Rankings (n=15)

Measure	Total Score	Ranking
For injured adult patients < 65yrs with a GCS < 9 or SBP< 90mmHg, time from arrival to departure from sending facility	**39**	**1**
For patients with acute ischemic stroke, door-to-needle time	**52**	**2**
# of severe maternal morbidity events (21 ICD-10 codes) per 1000 live births	**55**	**3**
Percent of EMS patients with primary impression of 'stroke' who have a stroke screening scale documented by EMS	**69**	**4**
Mean and Median pediatric readiness score for designated trauma centers	**75**	**5**
Percent of OHCA patients that received bystander CPR prior to EMS arrival	81	
Percent of trauma centers that took the pediatric readiness assessment in a given calendar year	84	
Percent of OHCA patients in public locations where AED was applied prior to EMS arrival	85	

Top 5 Measures

1. Time from arrival to departure for unstable injured patients (transfers)
2. Door-to-needle time for patients with acute ischemic stroke
3. Rate of severe maternal morbidity events
4. Percent of EMS “stroke” patients with a stroke screening scale
5. Pediatric readiness score for designated trauma centers

Next Steps

GETAC Council: **Vote on top 5 measures for approval**

Future discussion topics: Reporting structure, stratification, frequency of reports, data transparency, and specific aims for selected measures

Implementation goal: January 2025

8.b. Burn Care Task Force

Dr. Alan Tyroch, GETAC Chair

8.c. Pre-hospital Whole Blood Task Force

Eric Epley, NREMT-P, CEM

Task Force Chair

Pre-Hosp WB Task Force Summary

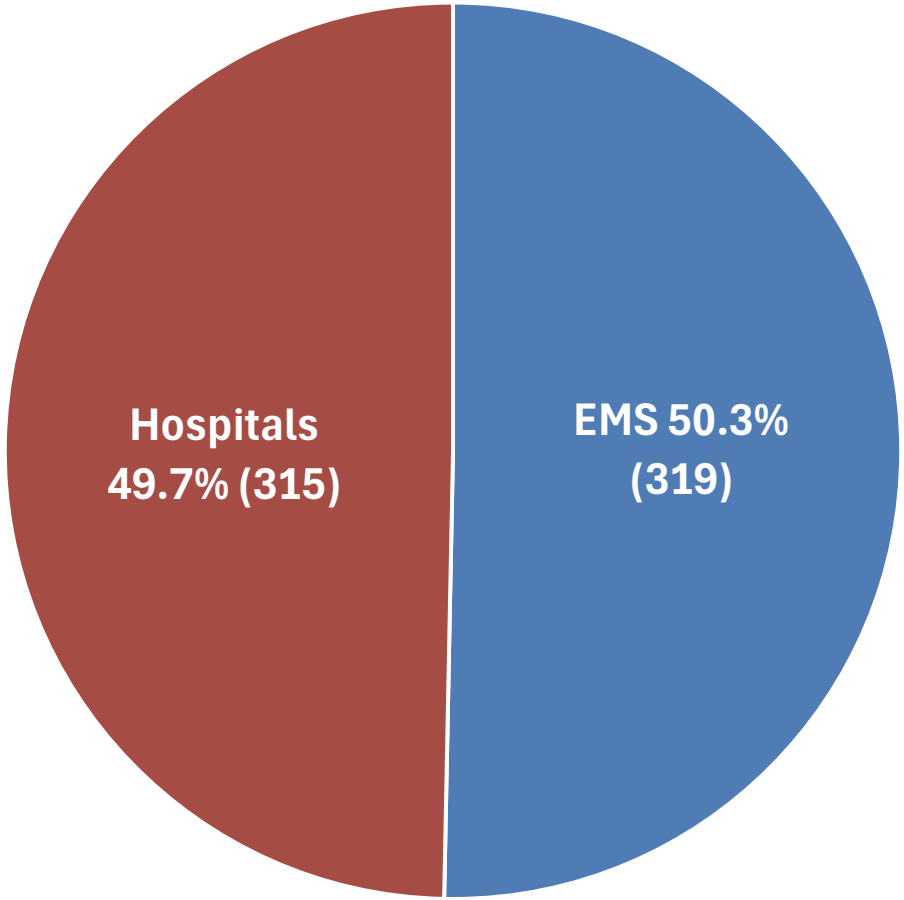
- CMS rules comments thru PHBTIC due Sept 5th
- Whole Blood EMS and Hospital Survey Results
- Deep dive on Blood Center Operations and Methodologies; understanding everyone's perspective
- Utilizing NCTTRAC equipment EMS unit kit list pricing and Survey results for Legislative Ask
- Bradford Ray, UMC EP to present Component Vs. Whole Blood Business case
- Visit the South and North Chapters of ACS COT mtgs

Governor's EMS and Trauma Advisory Council

Pre-Hospital Whole Blood Task Force: Blood Utilization Survey

August 2024

Pre-Hospital Whole Blood Task Force: Blood Utilization Survey



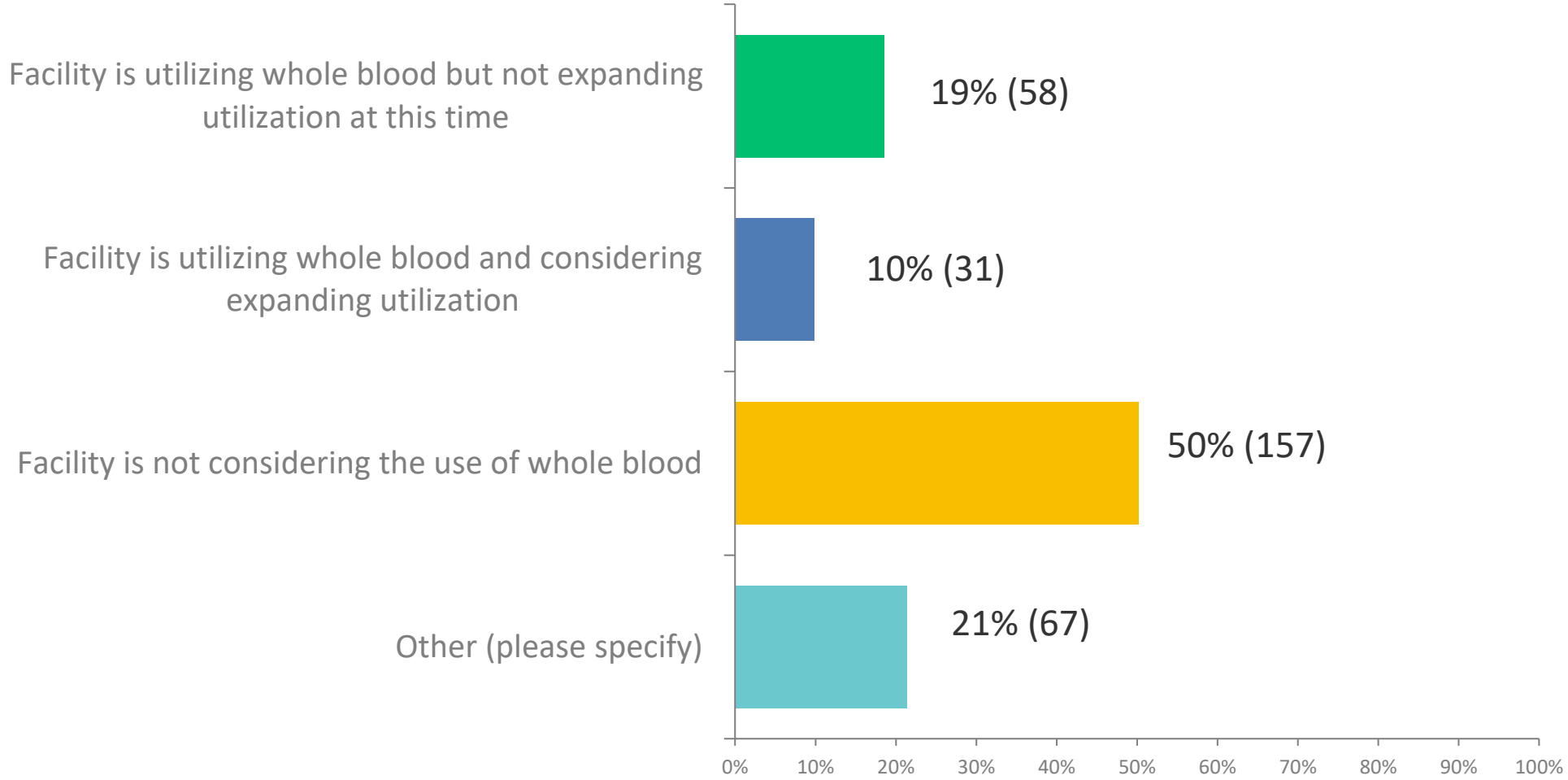
Overwhelming response to the survey on short order (<10 days):

- ❑ 20 of 22 RAC(s) participated
- ❑ 634 Respondents
  - 319 Prehospital Providers
  - 315 Hospitals

Thank you!

Q1: Is your facility considering the use of whole blood (or expanding WB utilization)?

Answered: 313 Skipped: 0



Q1: Is your facility considering the use of whole blood (or expanding WB utilization)?

Answered: 313 Skipped: 0

of 313 respondents
or 28%

Facility is utilizing whole blood but not expanding utilization at this time

+

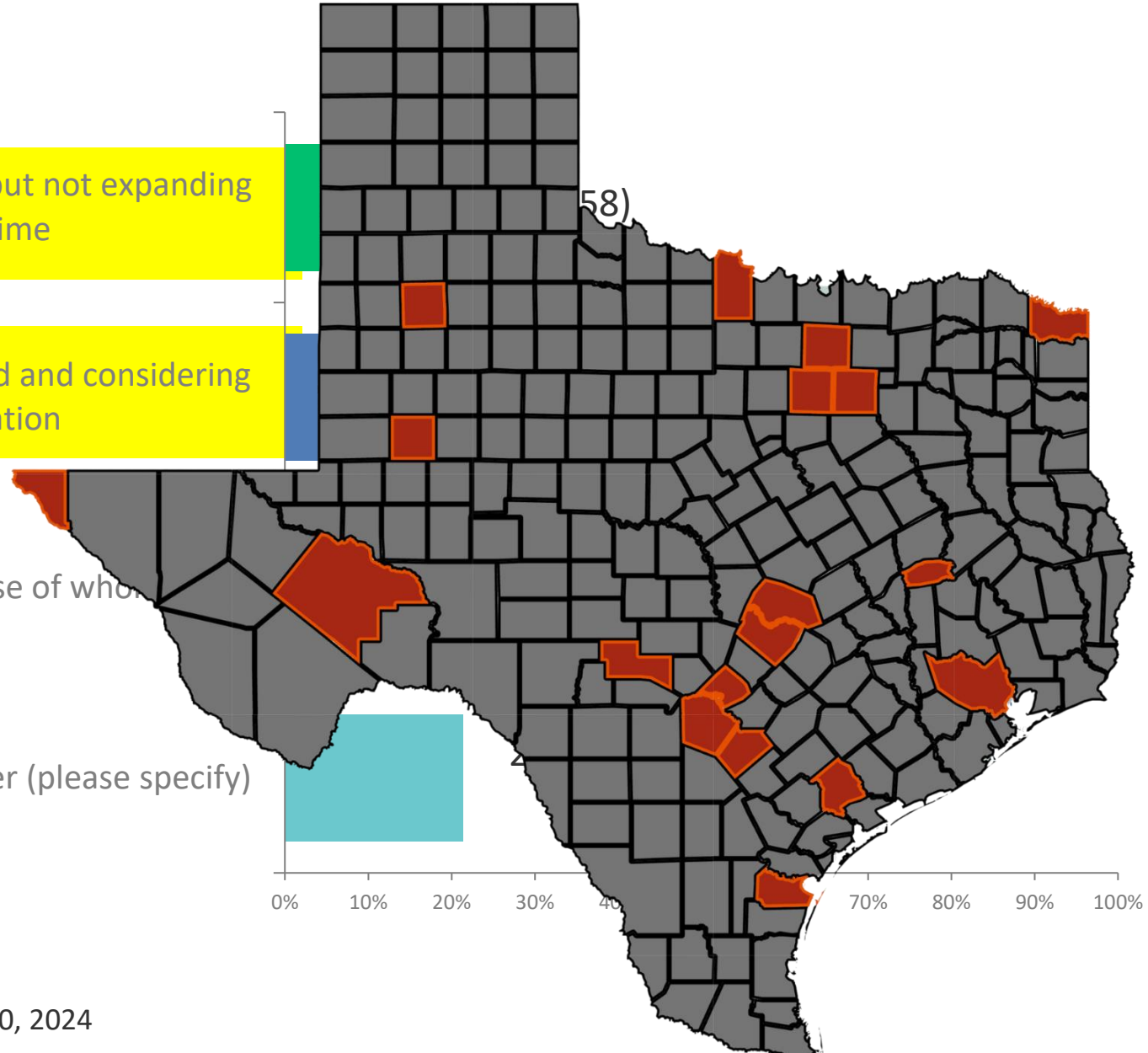
Facility is utilizing whole blood and considering expanding utilization

58)

Facility is not considering the use of whol

Other (please specify)

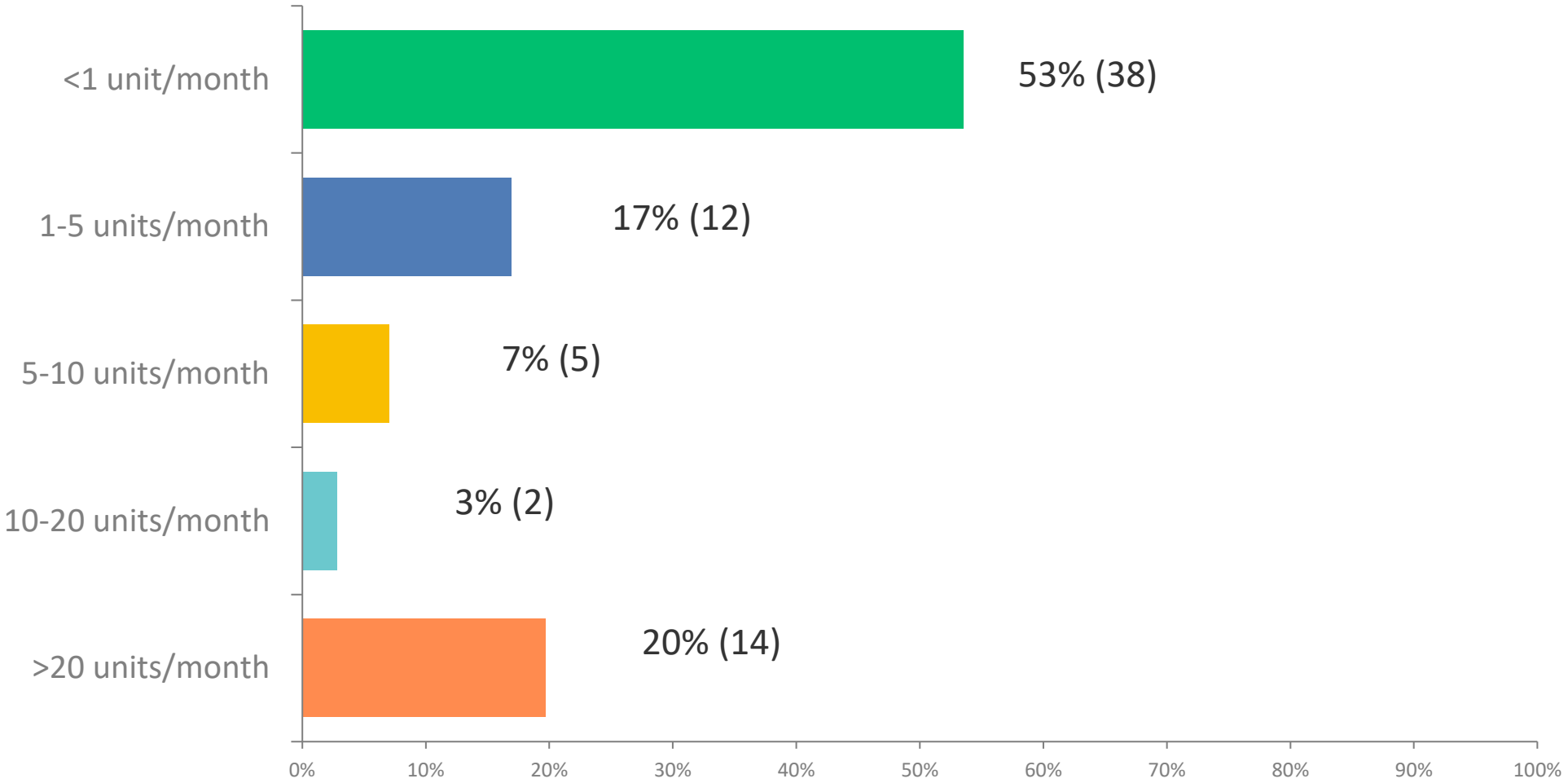
0% 10% 20% 30% 40% 70% 80% 90% 100%



HOSPITAL SURVEY

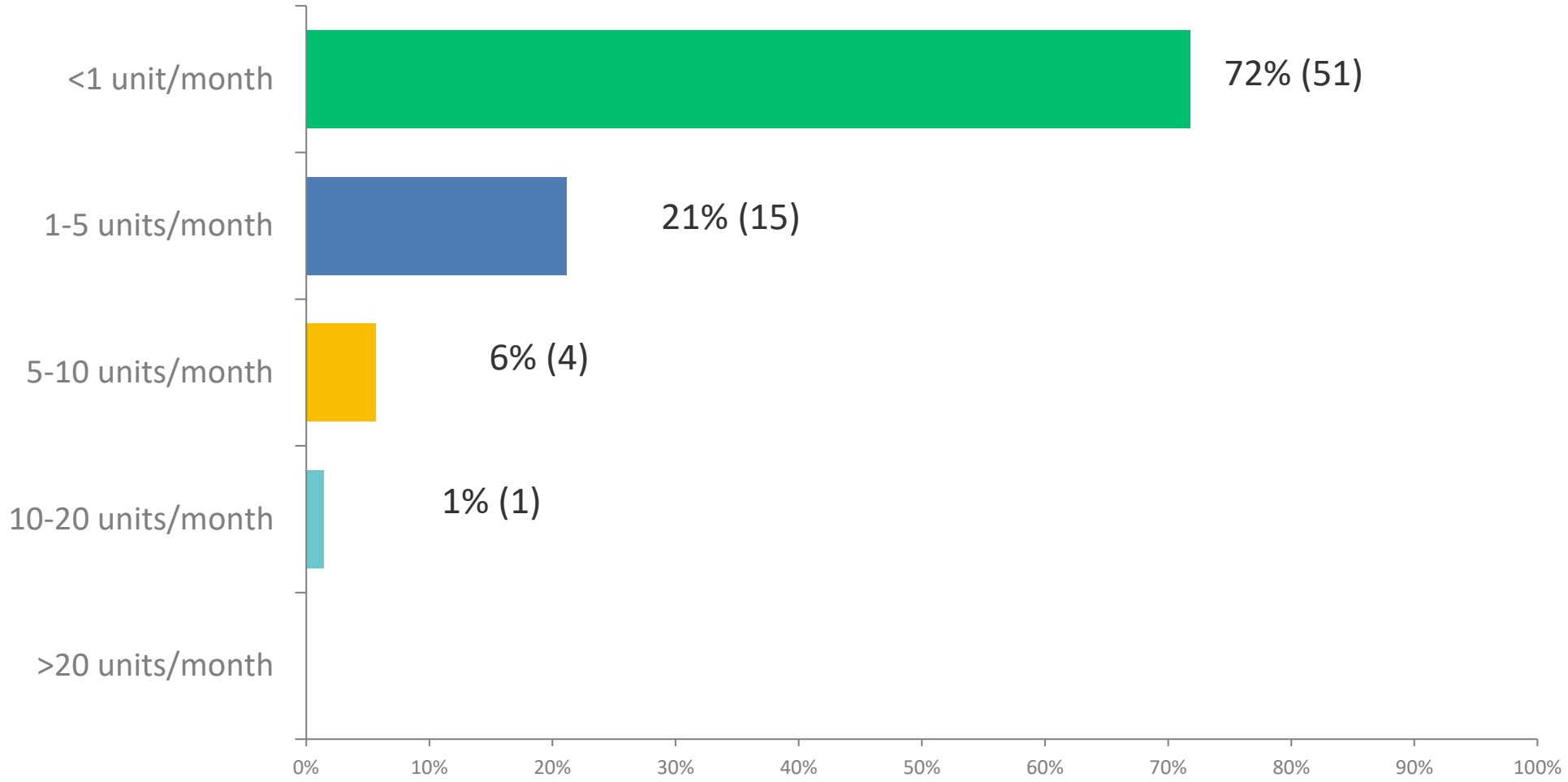
Q2: How much whole blood is used monthly (number of units)?

Answered: 71 Skipped: 242



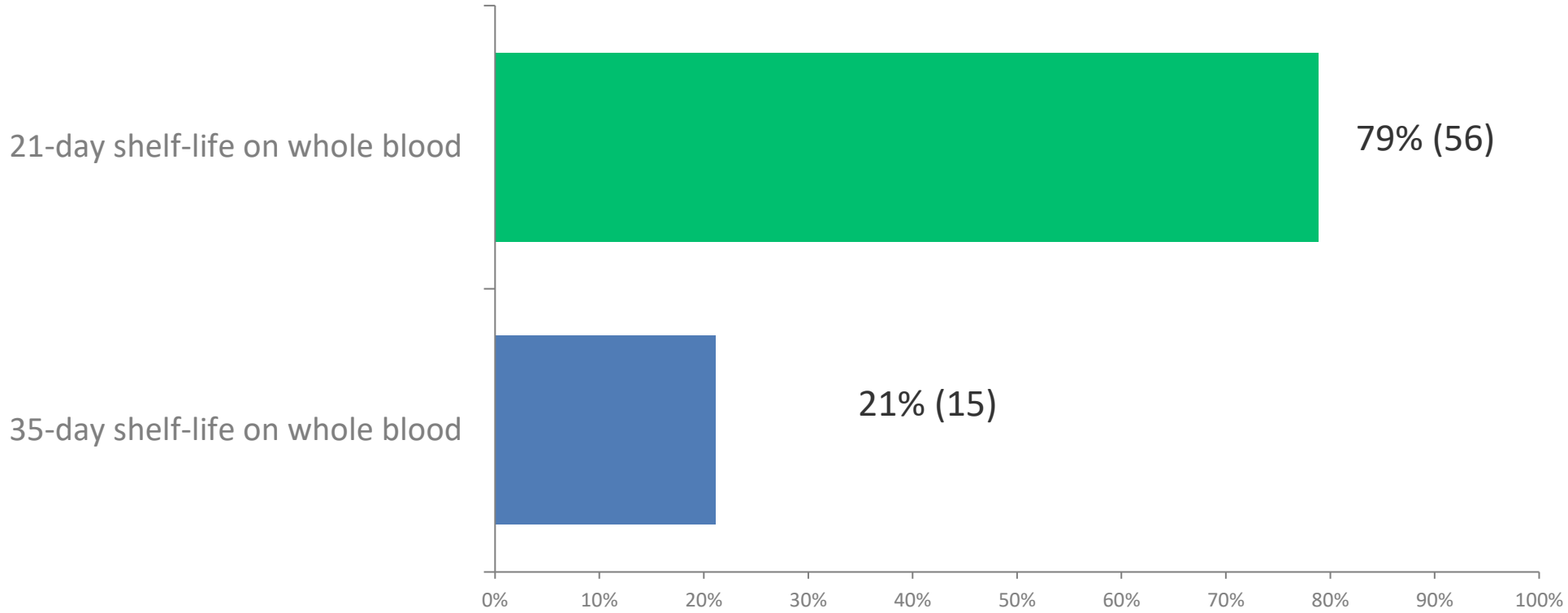
Q3: In your facility, how many units of whole blood expire per month?

Answered: 71 Skipped: 242



Q4: Is your whole blood shelf-life 21 or 35 days?

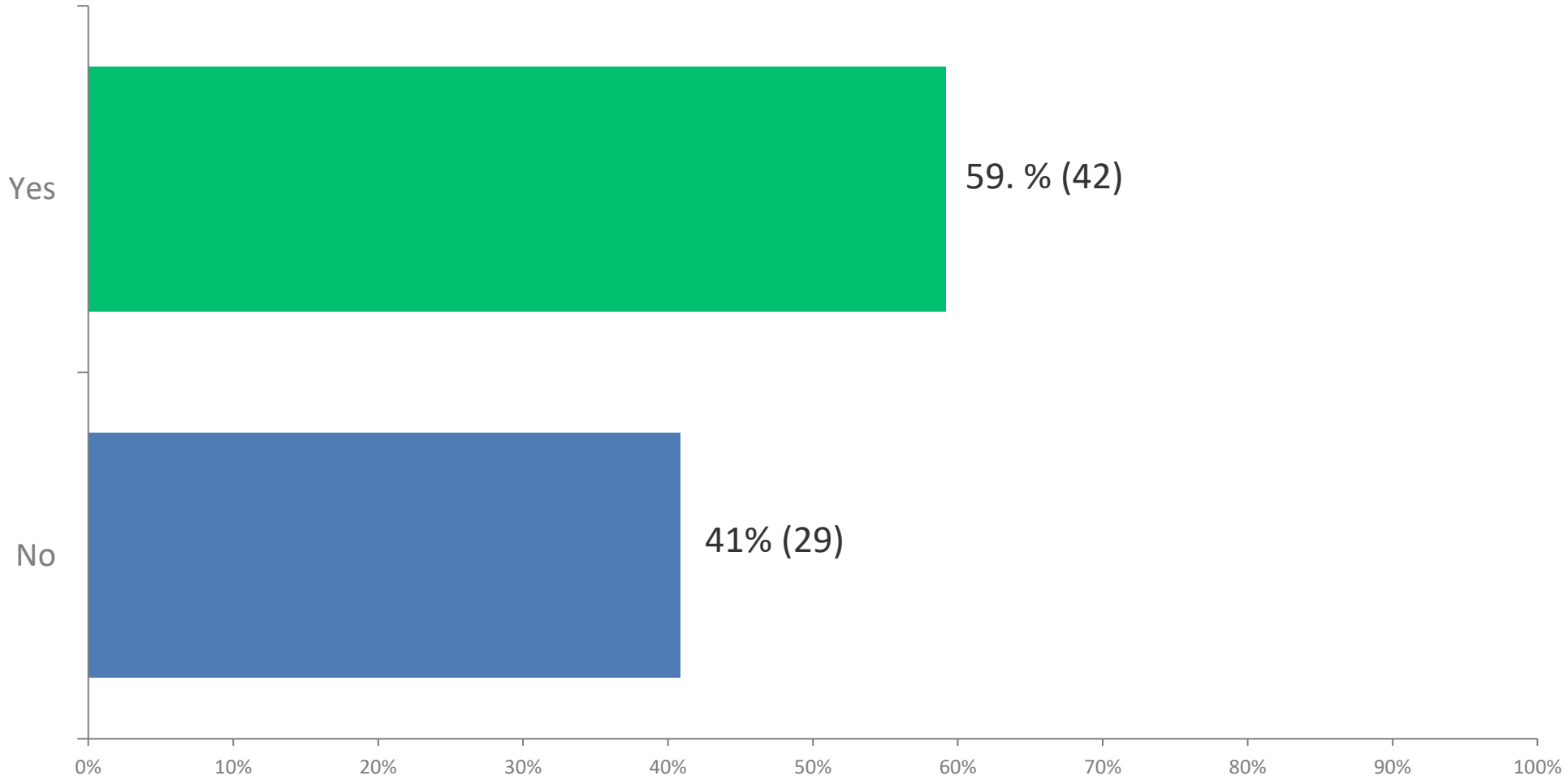
Answered: 71 Skipped: 242



HOSPITAL SURVEY

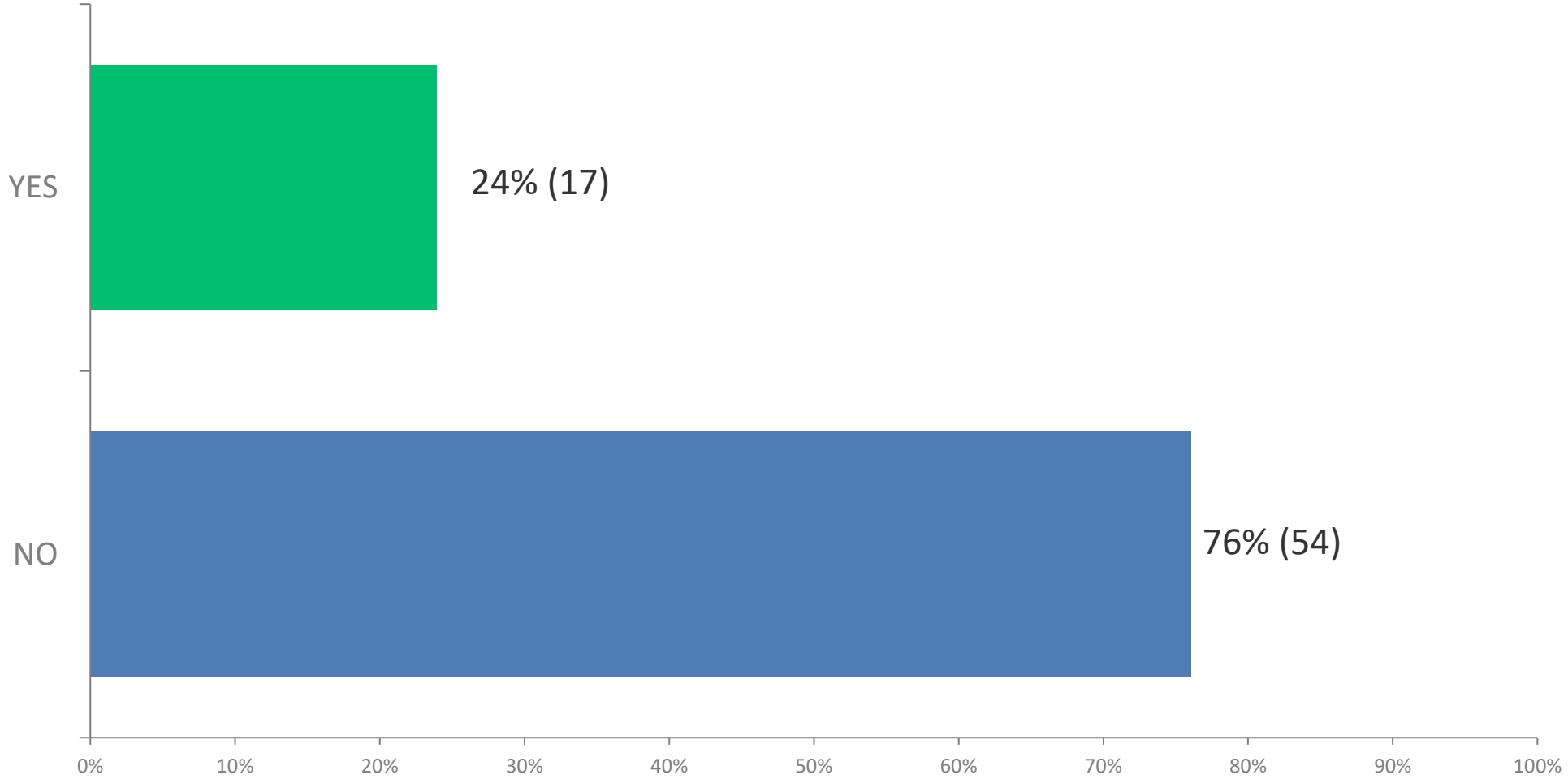
Q5: Is your facility willing to be a Rotation Center for prehospital utilization of whole blood?

Answered: 71 Skipped: 242



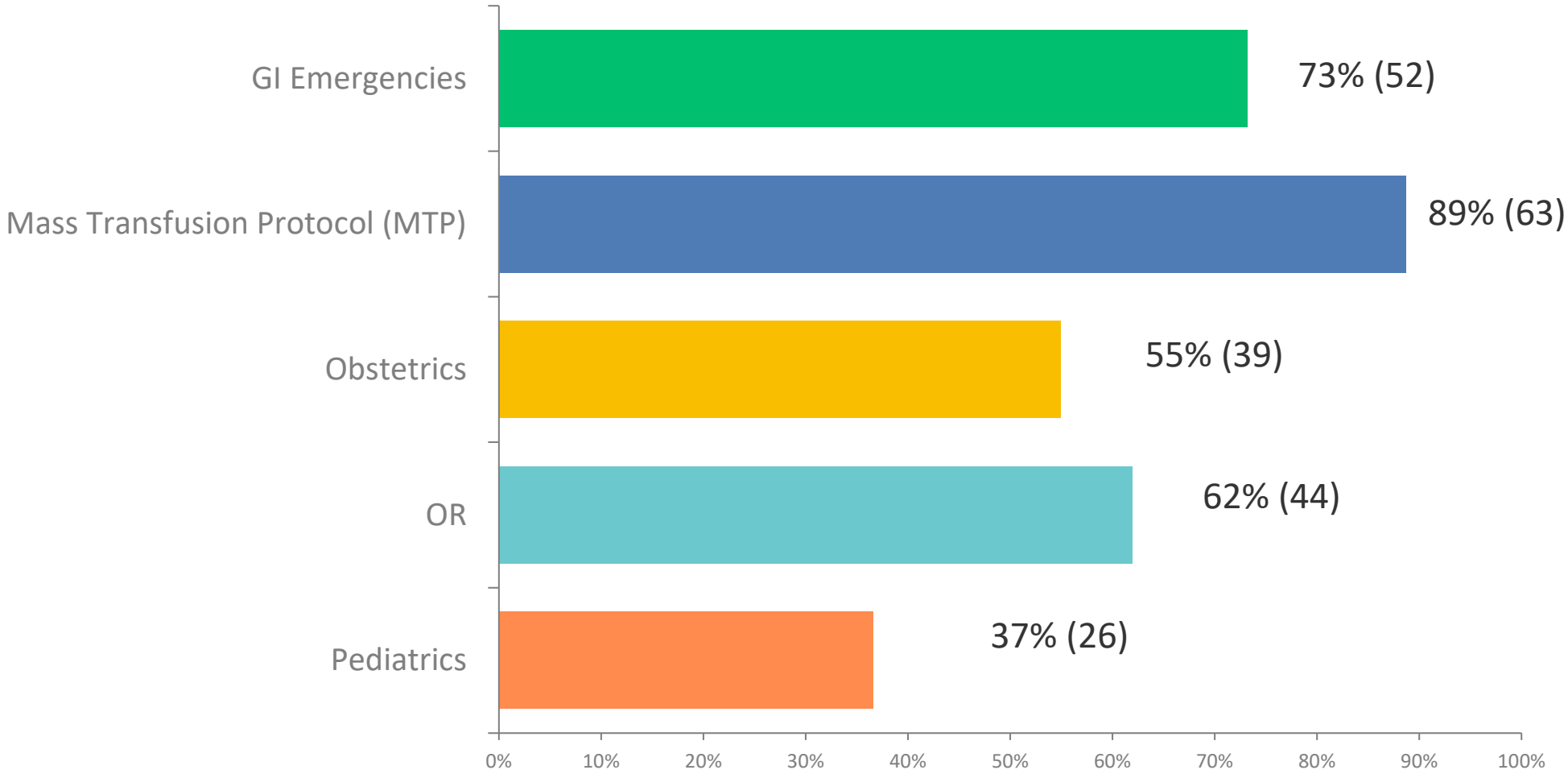
Q6: Does your facility have an internal blood collection process?

Answered: 71 Skipped: 242



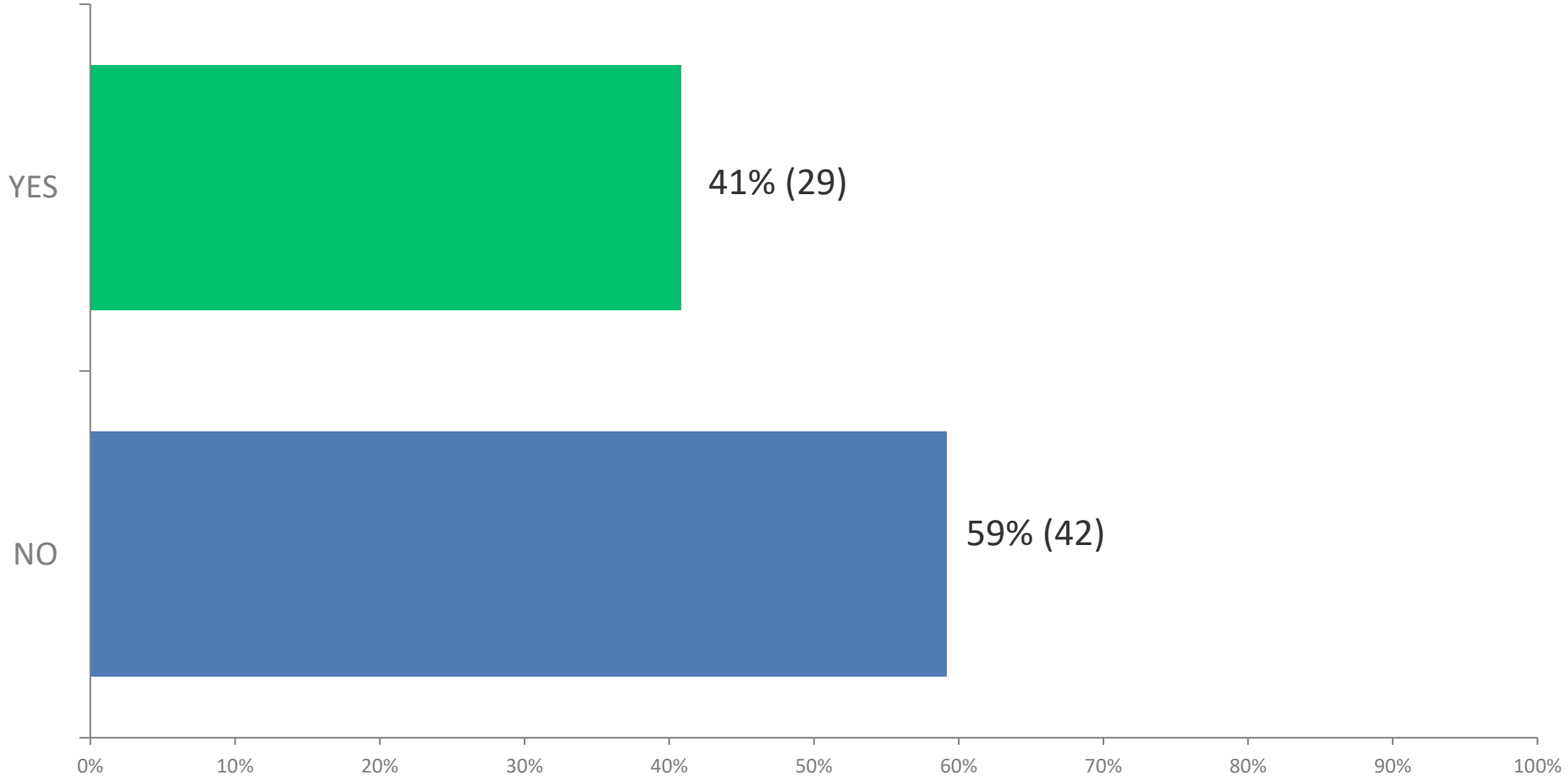
Q7: Are you considering utilizing whole blood for the following populations (check all that apply)?

Answered: 71 Skipped: 242



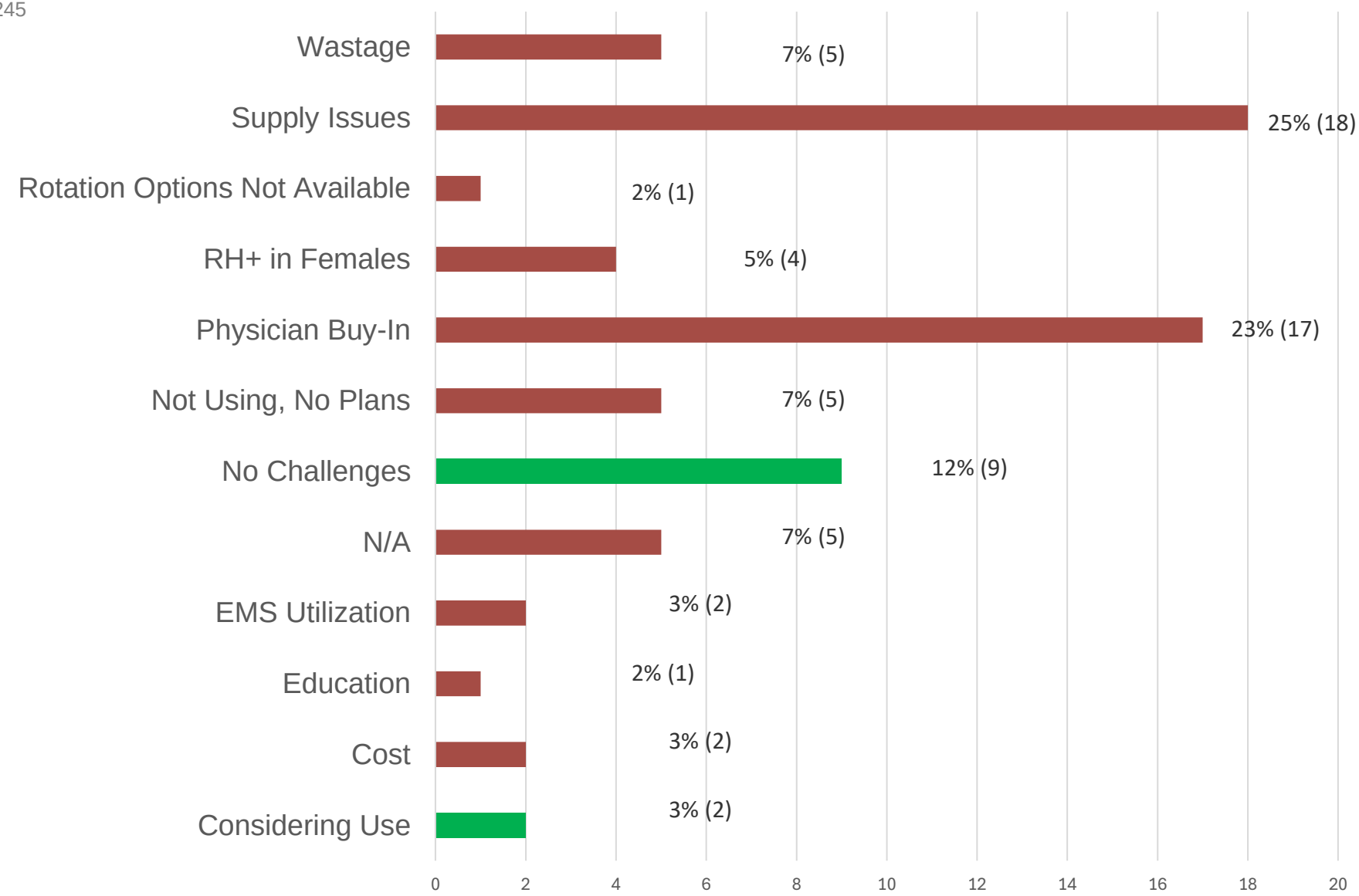
Q8: Is whole blood a part of your facility's Massive Transfusion Protocol?

Answered: 71 Skipped: 242



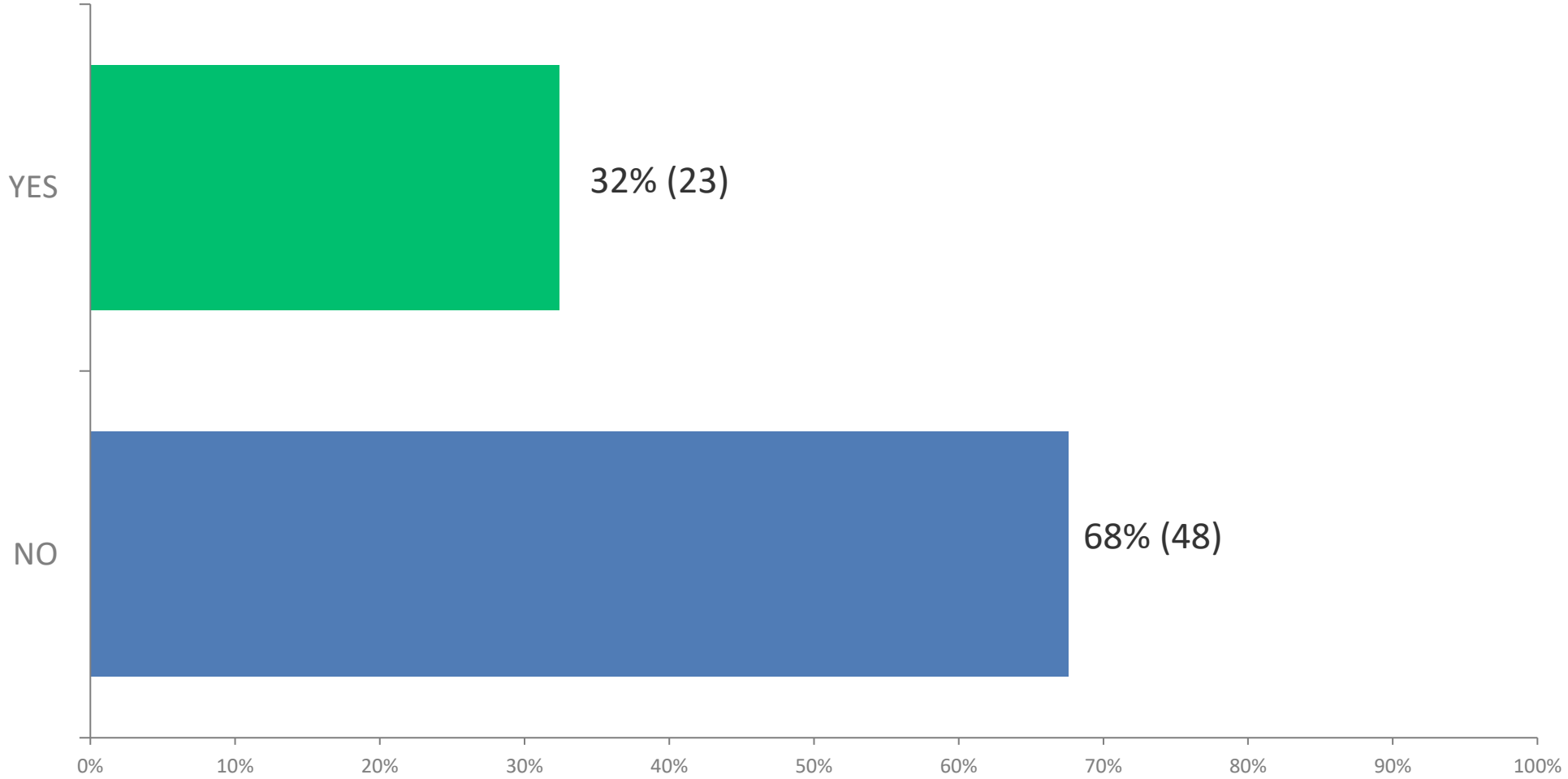
Q9: What are the challenges for using whole blood outside of trauma? (comment field, these are general categories of the comments)

Answered: 74 Skipped: 245



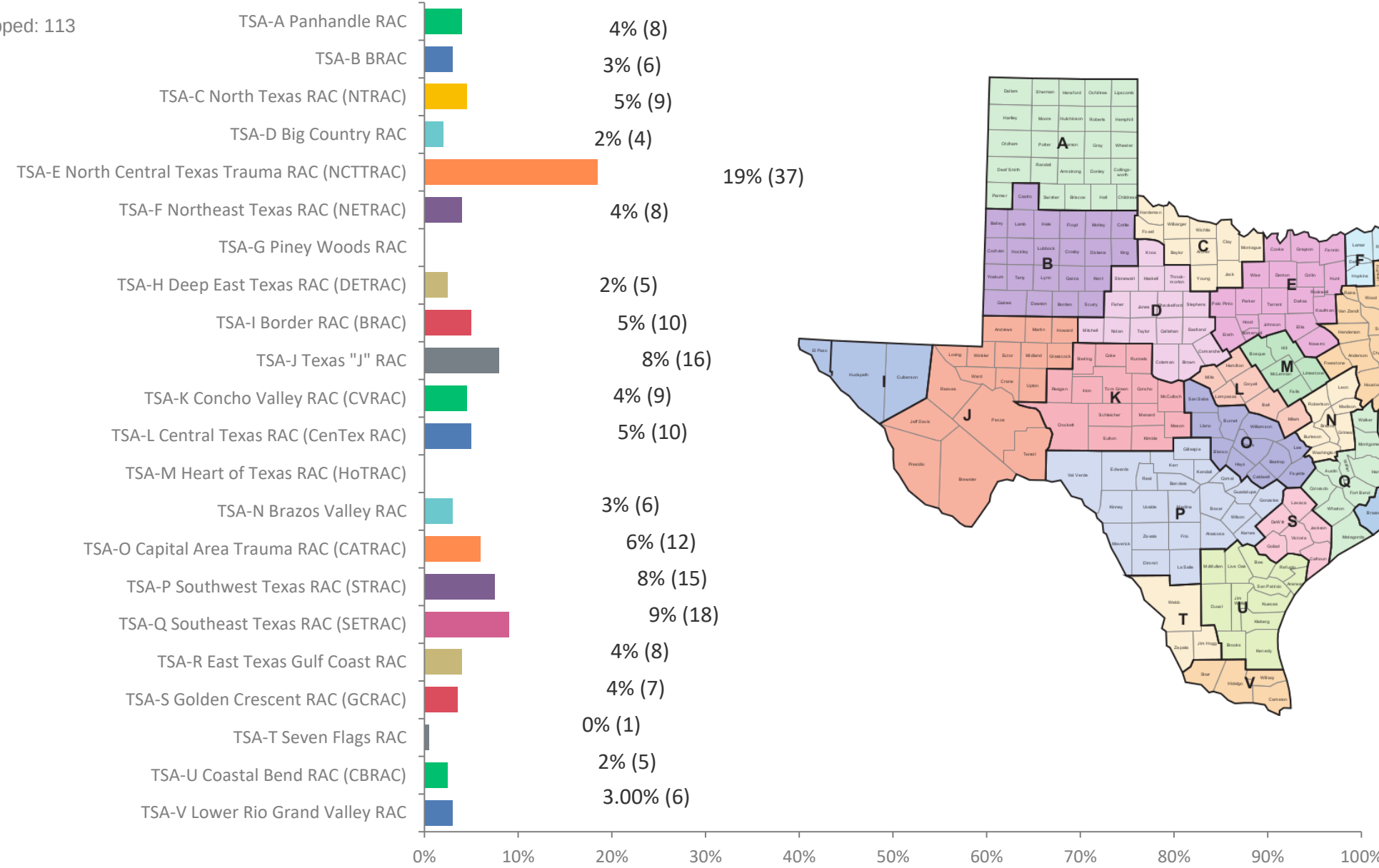
Q10: Does your facility use or manufacture non-leuko reduced whole blood?

Answered: 71 Skipped: 242

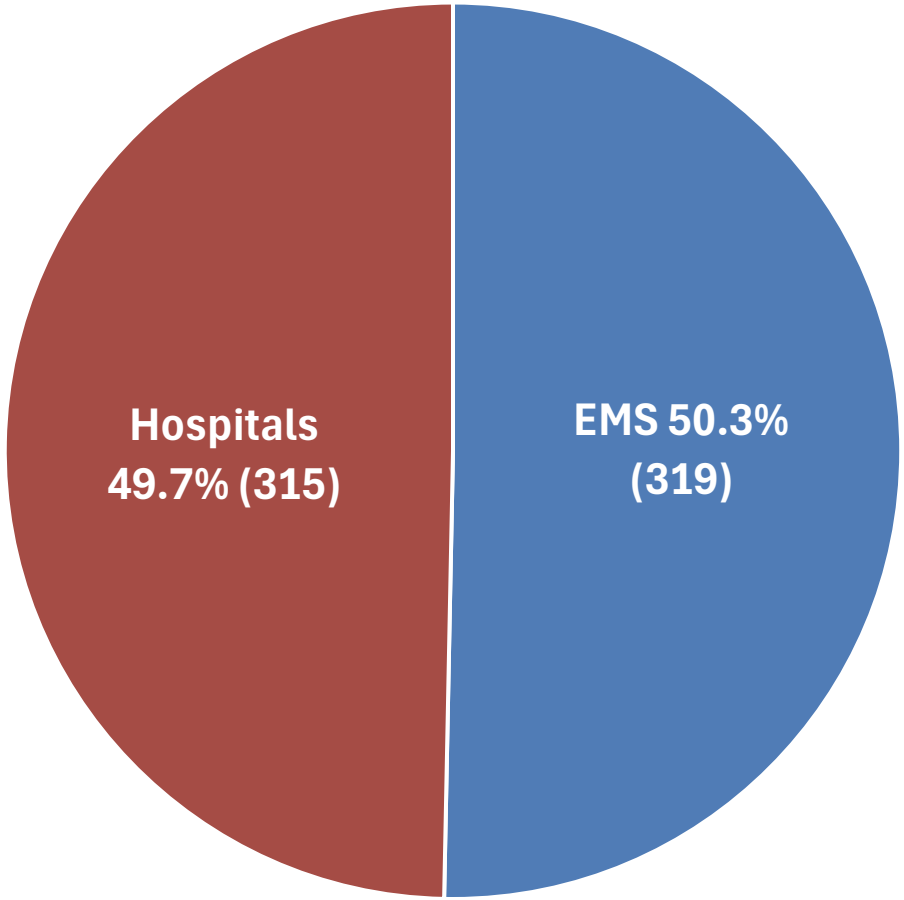


Q12: What RAC (Trauma Service Area) are you in?

Answered: 200 Skipped: 113



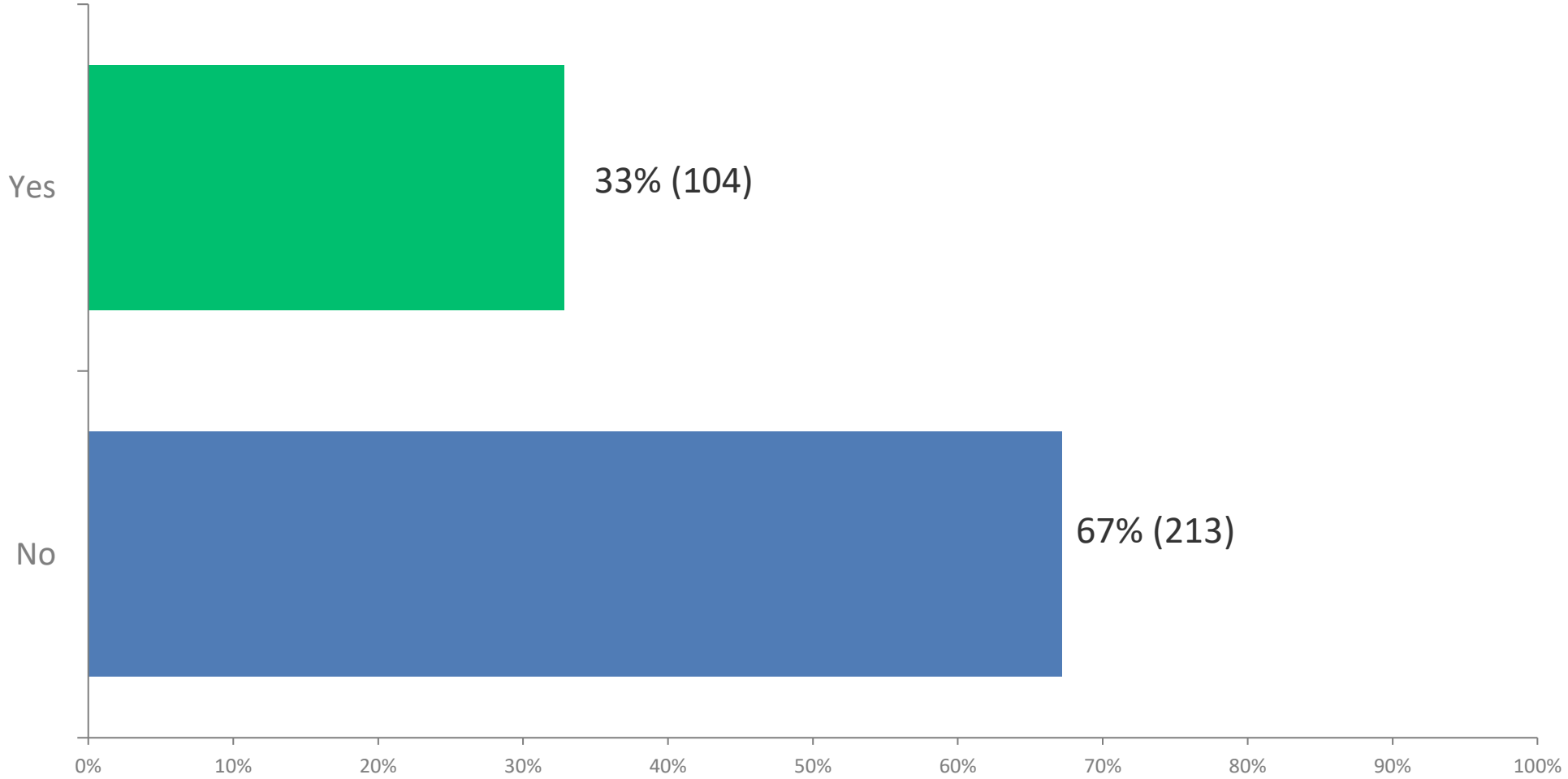
Pre-Hospital Whole Blood Task Force: Blood Utilization Survey



Switching gears to Prehospital (EMS) Data

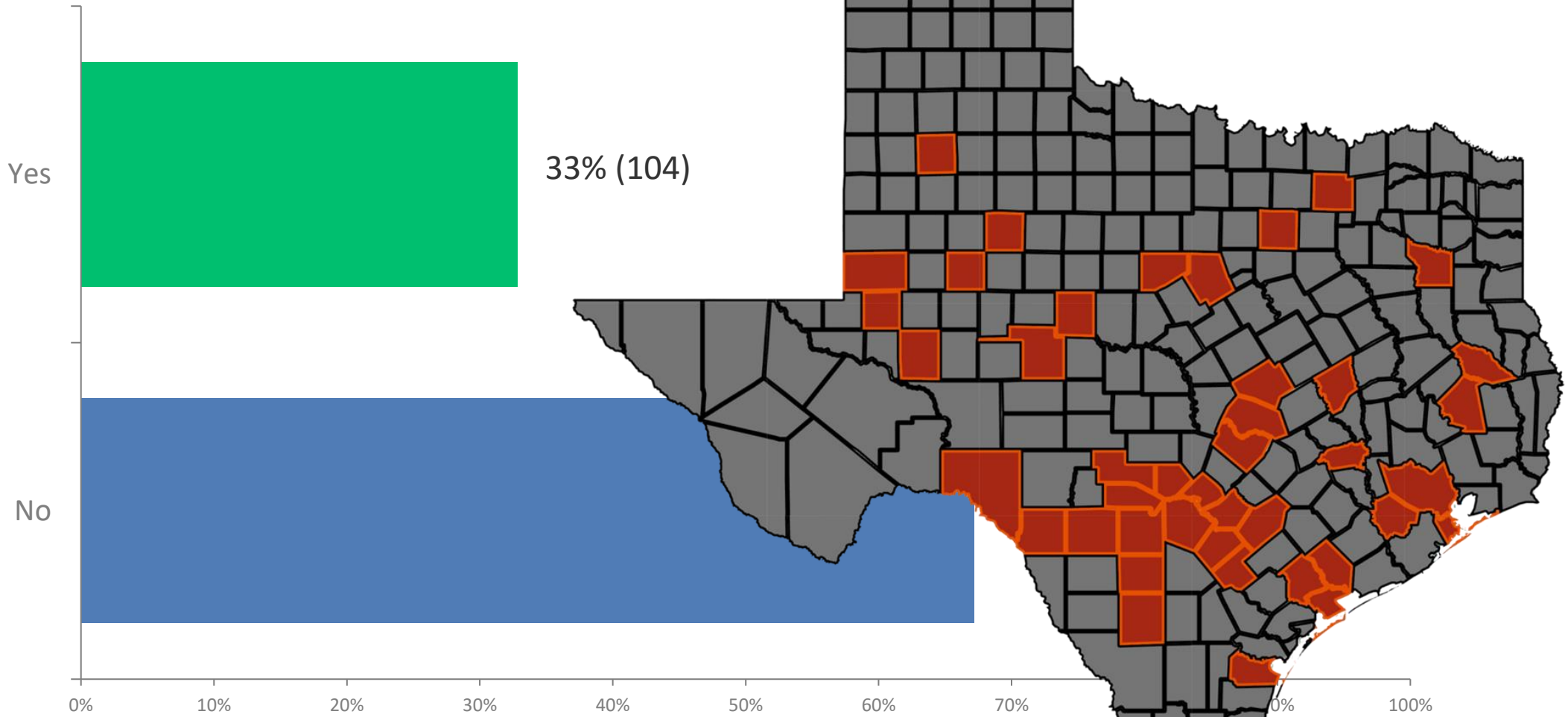
Q1: Does your agency currently have a Prehospital whole blood program?

Answered: 317 Skipped: 0



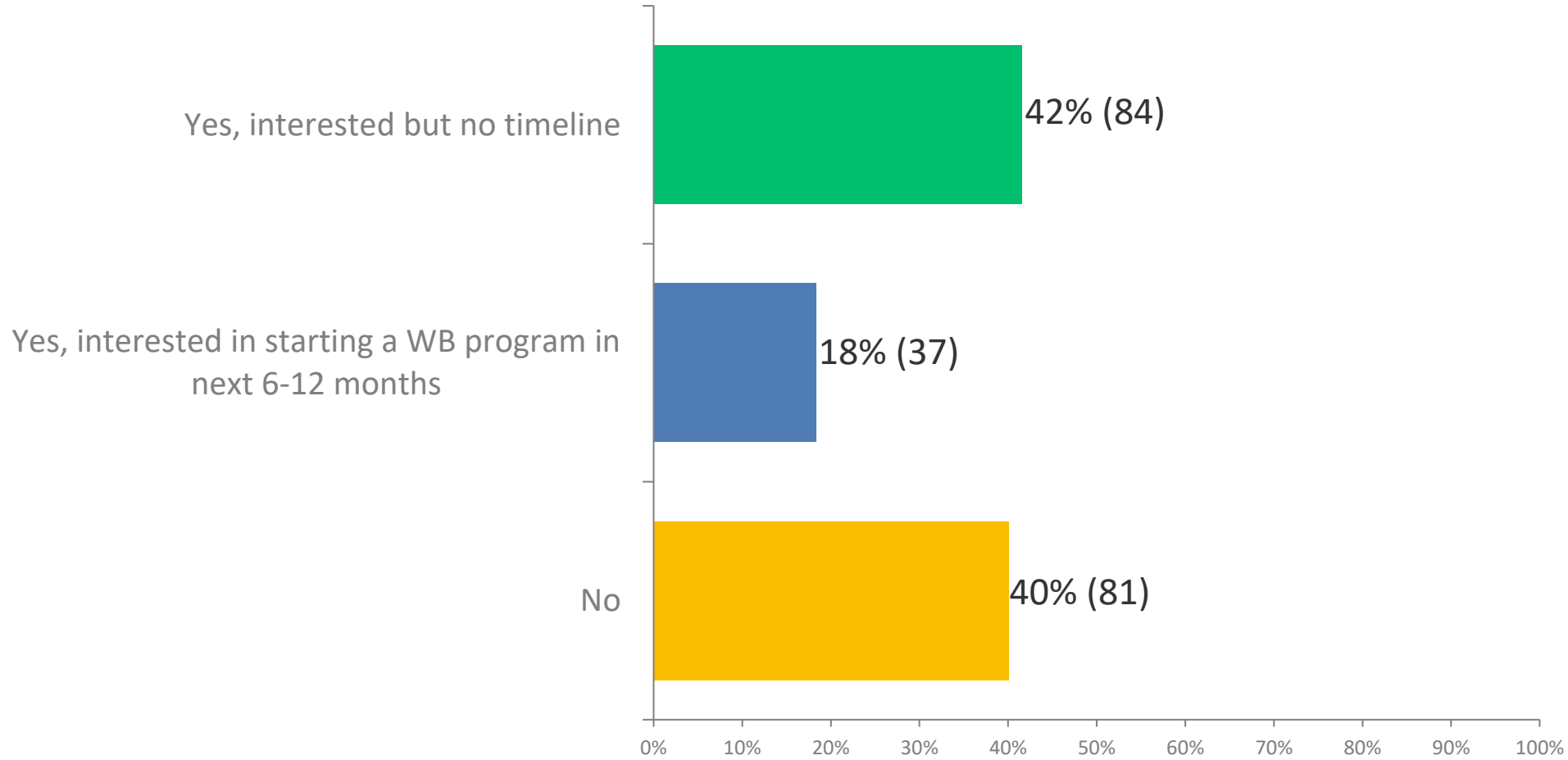
Q1: Does your agency currently have a Prehospital whole blood program?

Answered: 317 Skipped: 0



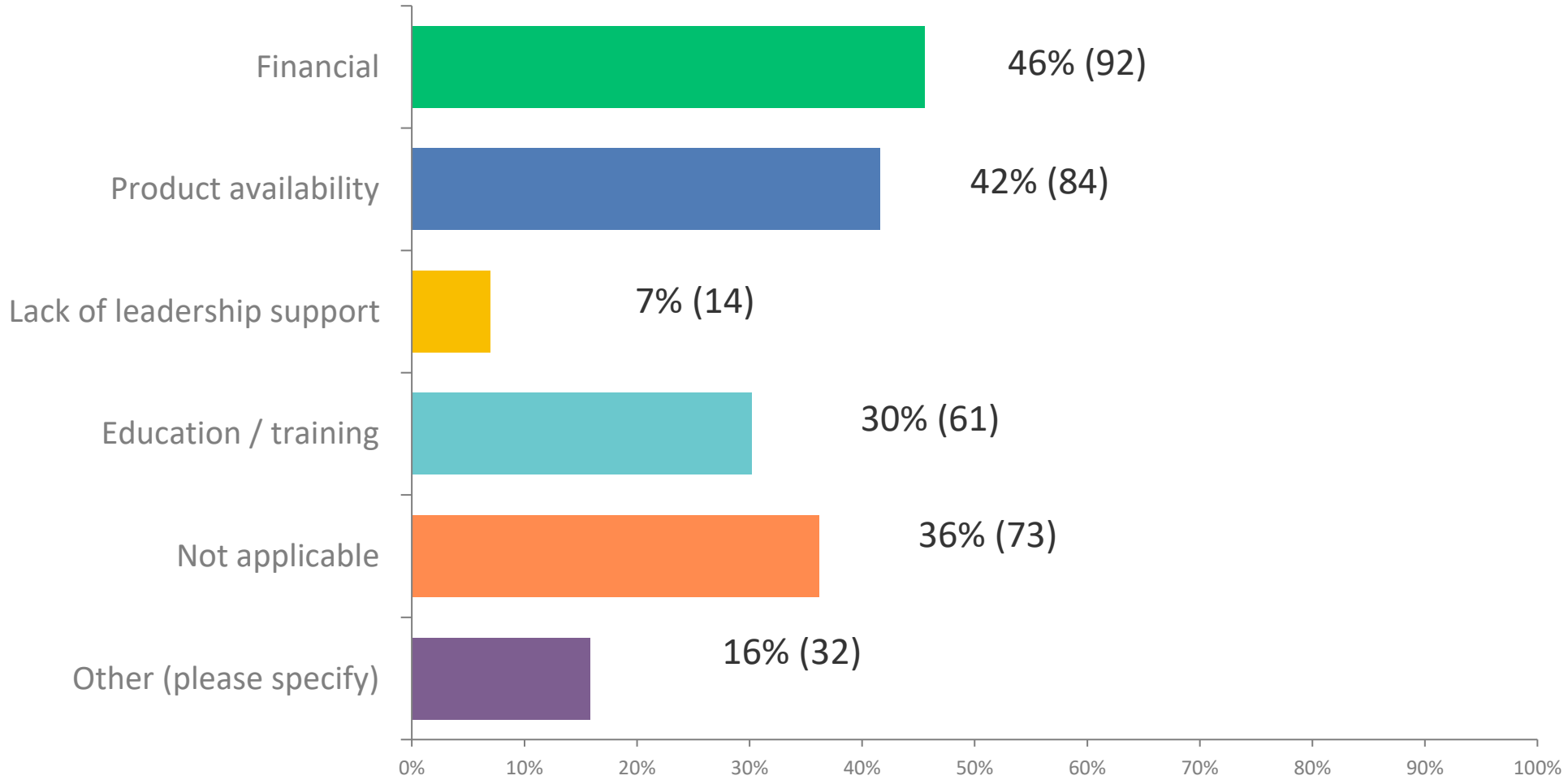
Q2: If you answered "no" in question-1, are you interested or do you have plans to start a whole blood program next 6-12 mos?

Answered: 202 Skipped: 115



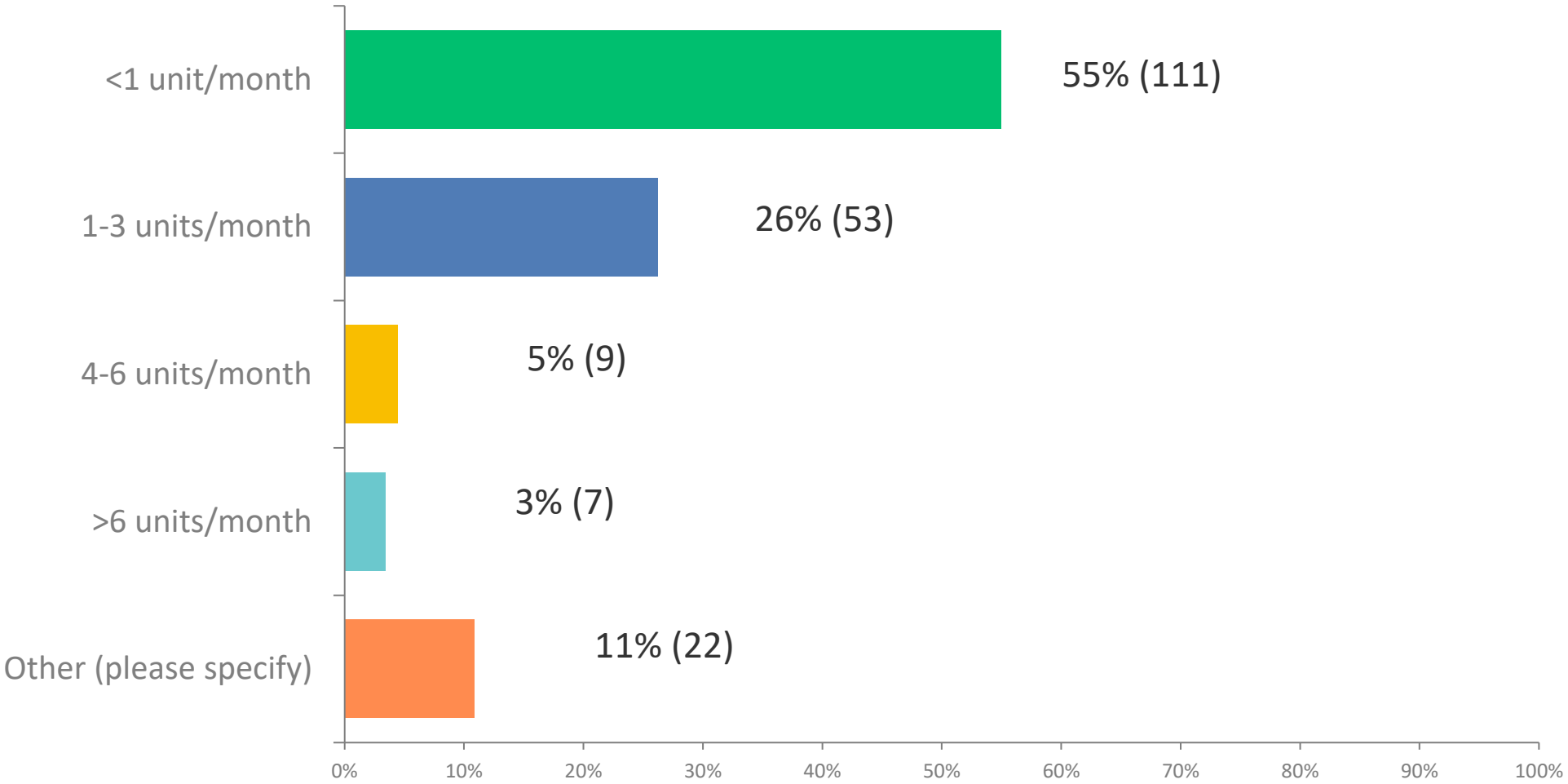
Q3: If you answered "yes" to question 2, please indicate any challenges you may have to start a whole blood program (check all that apply).

Answered: 202 Skipped: 115



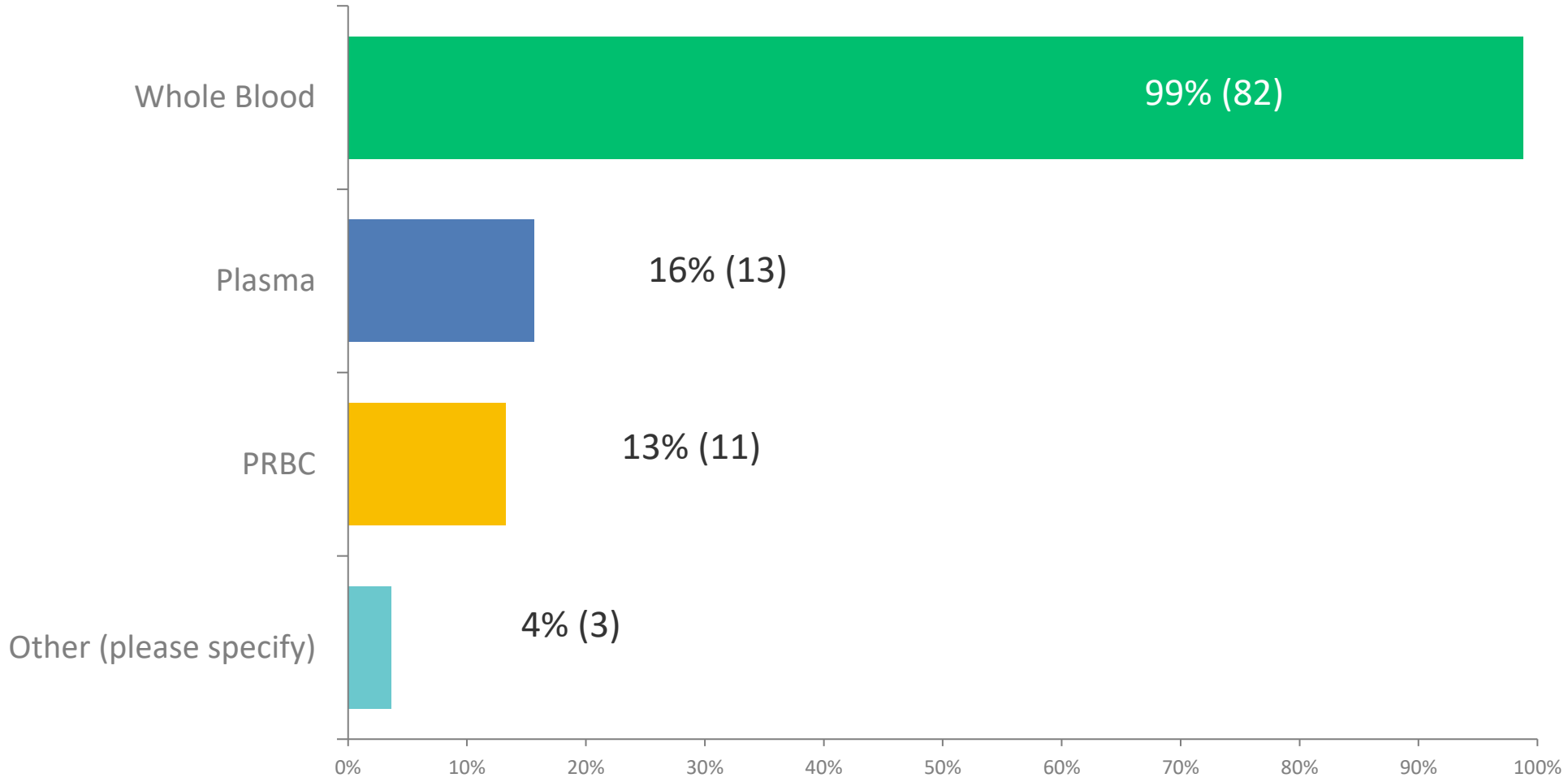
Q4: If not utilizing whole blood, how much whole blood do you think you would utilize (if you had a blood program)?

Answered: 202 Skipped: 115



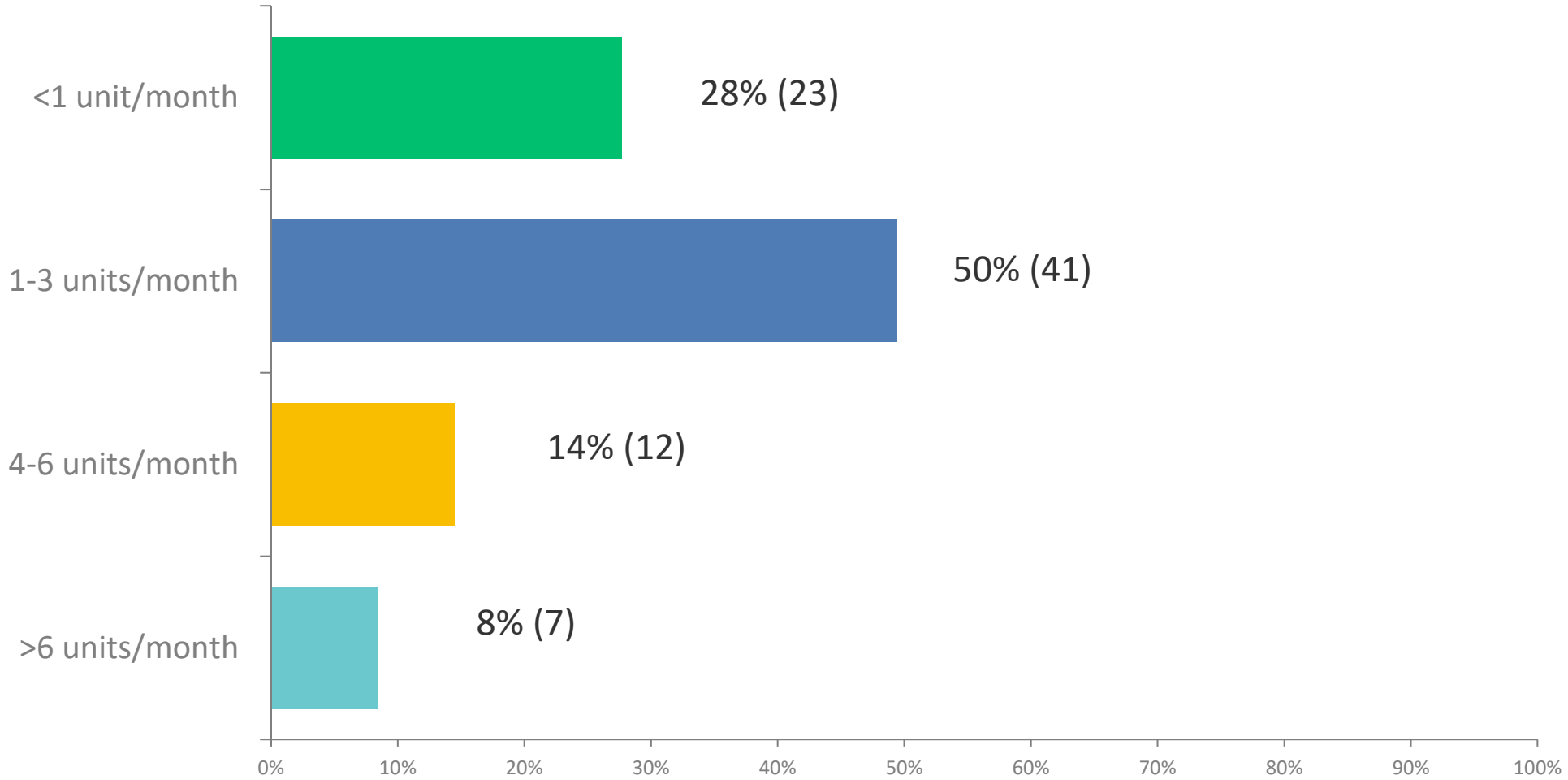
Q5: Please indicate what products you currently carry (check all that apply)

Answered: 83 Skipped: 234



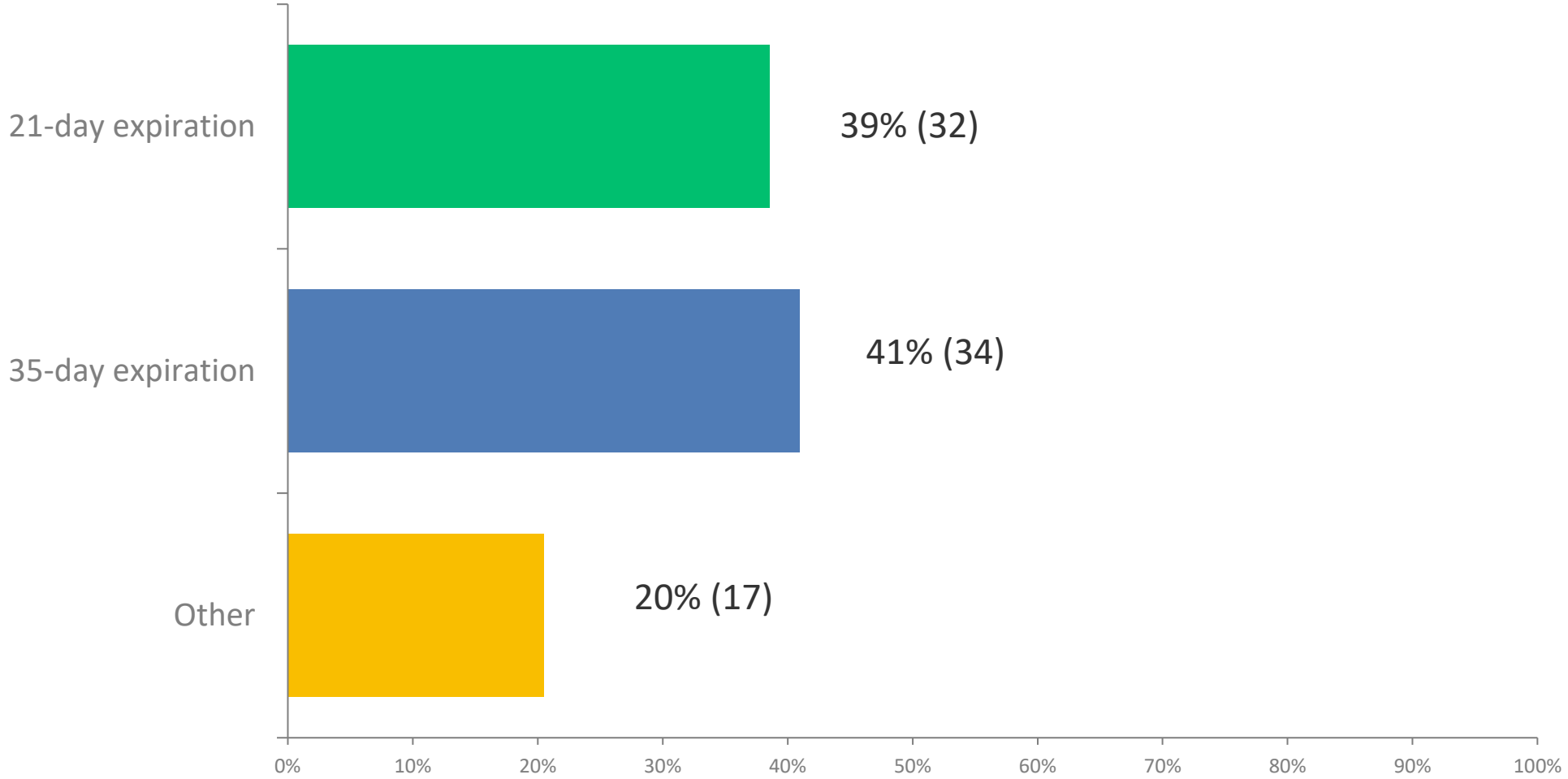
Q6: How much blood product(s) is used weekly (number of units)?

Answered: 83 Skipped: 234



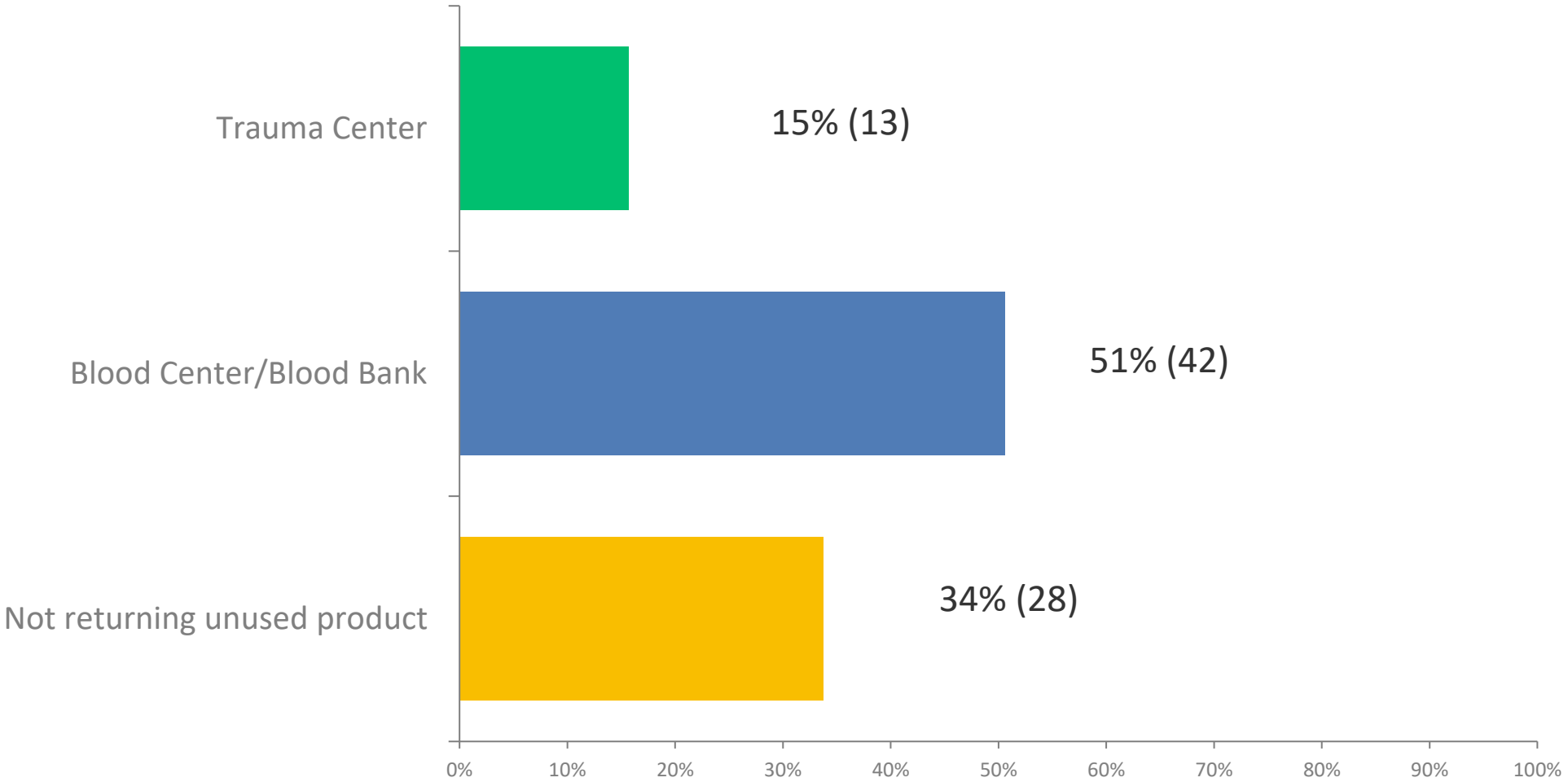
Q7: Is the blood product you are using in your agency have a 21-day or 35-day expiration?

Answered: 83 Skipped: 234



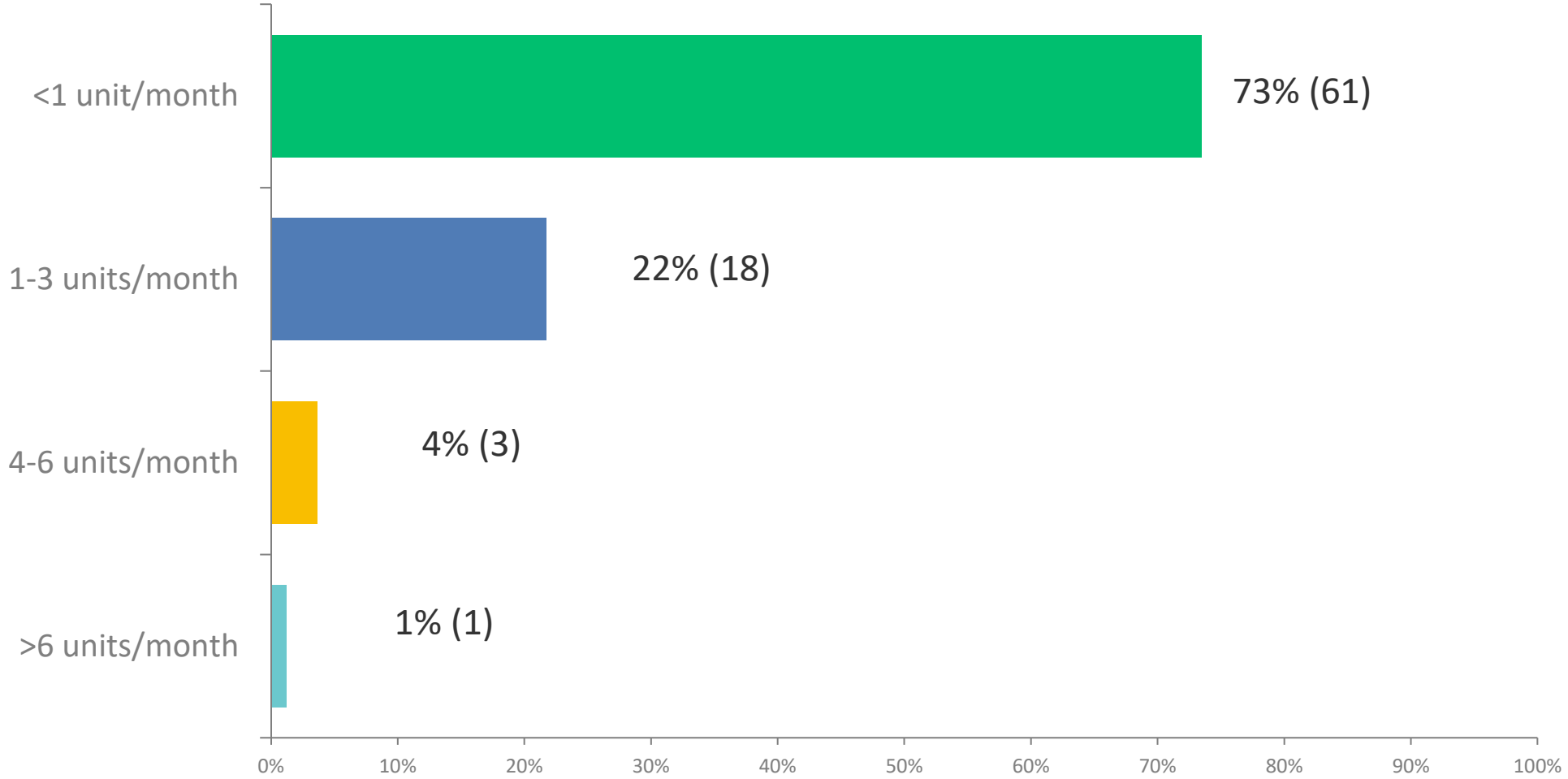
Q8: Are you returning your blood products to a trauma center or back to the blood center?

Answered: 83 Skipped: 234



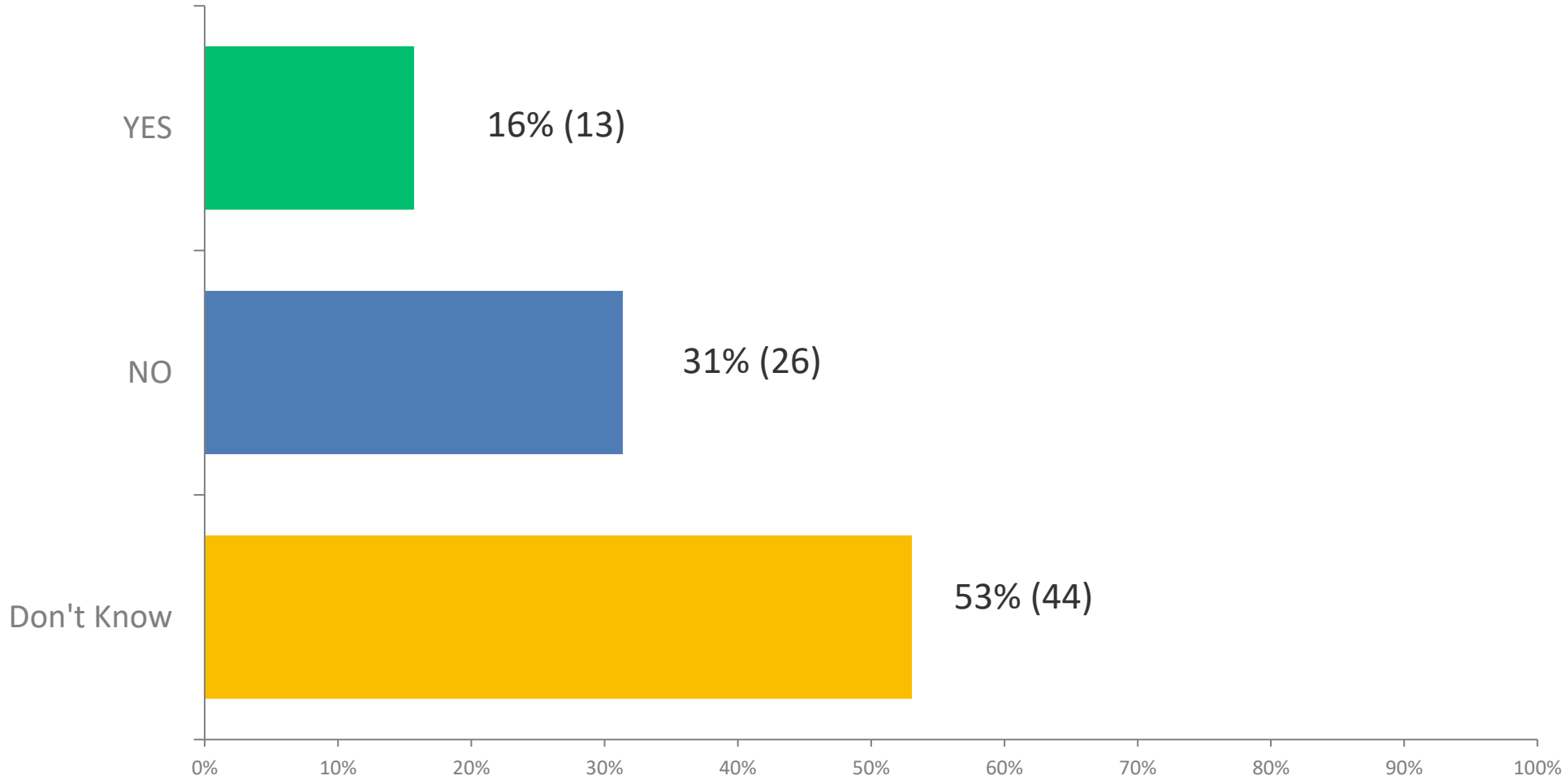
Q9: How many units/month of blood product(s) expire?

Answered: 83 Skipped: 234



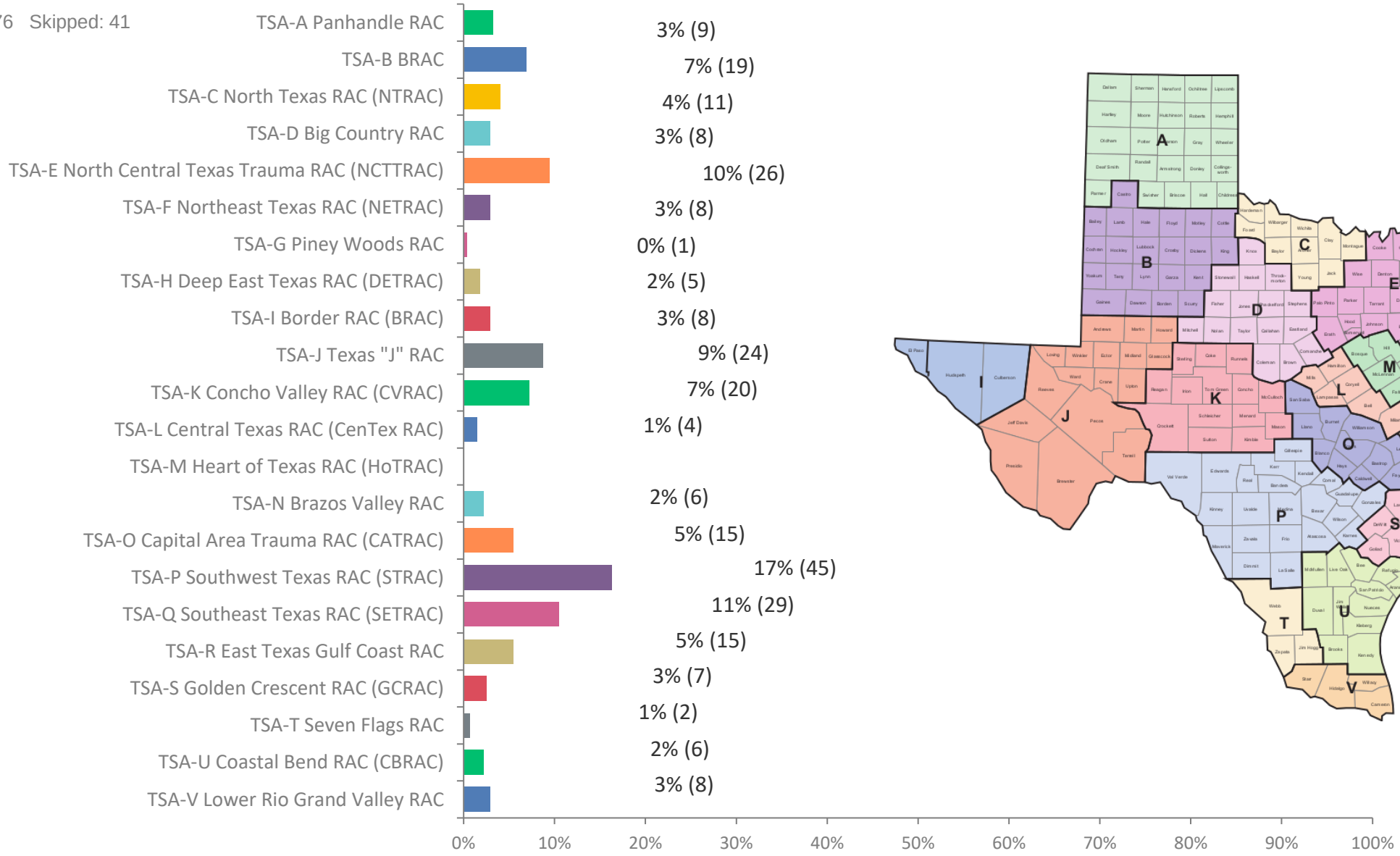
Q10: Is the product you are using leuko-reduced?

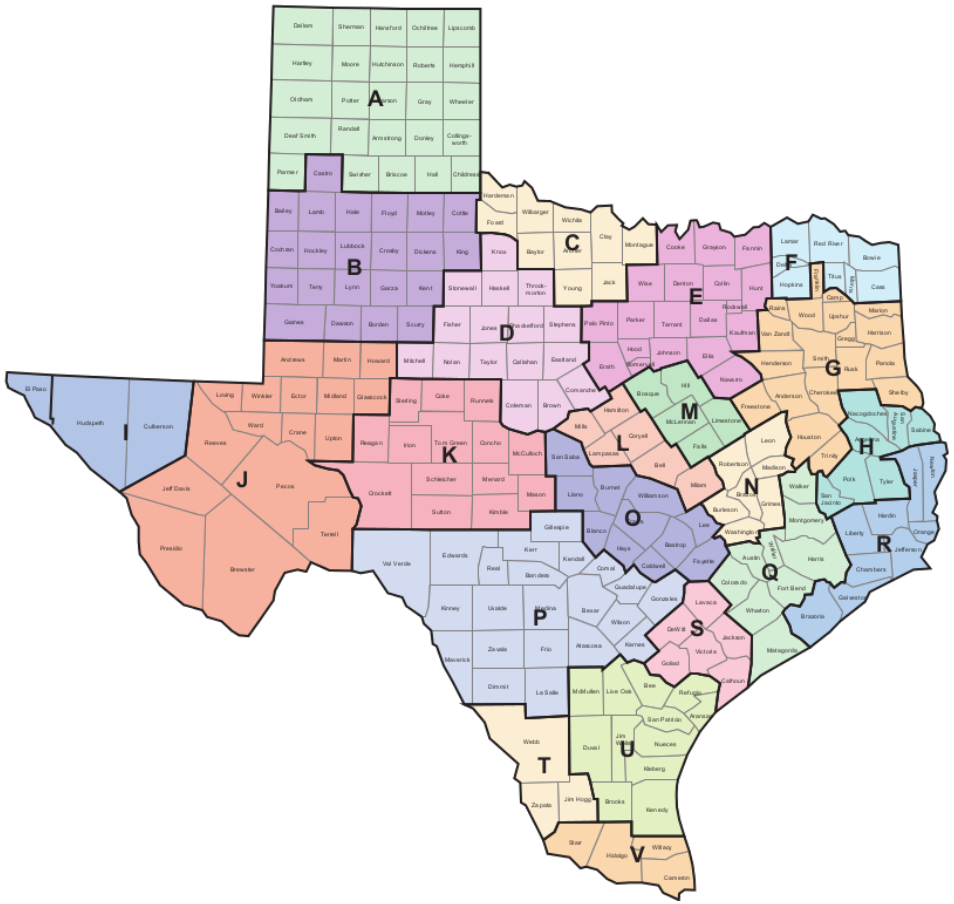
Answered: 83 Skipped: 234



Q12: What RAC (Trauma Service Area) are you in?

Answered: 276 Skipped: 41





PREHOSPITAL (EMS) SURVEY

Governor's EMS and Trauma Advisory Council

Pre-Hospital Whole Blood Task Force:

Blood Utilization Survey

Questions?

August 2024

9. Proposed Rule Amendments

9.a. Trauma Rules, Title 25 Chapter 157 concerning Emergency Medical Care 157.2, 157.123, 157.125, 157.125, 157.128, 157.130

Jorie Klein, MSN, MHA, BSN, RN

EMS/Trauma Systems Director

9.b. EMS Rules, Title 25 Chapter 157, concerning Dialysis Transport, 157.11 Draft Dialysis Rules

Joseph Schmider

State EMS Director

Amendment to §157.11, Requirements for an Emergency Medical Services Provider License

- **To comply with Senate Bill (S.B.) 2133, 88th Legislature, Regular Session, amended Texas Health and Safety Code (HSC) §773.050**
- Transport dialysis patient in declared disaster.

TEXAS Health and Human Services

Texas Department of State Health Services

- **Plan for how the provider will respond to disaster incidents, including mass casualty situations in coordination with local and regional plans.**
- (i) An EMS provider must have a plan for providing transport for a dialysis patient who places an emergency 9-1-1 telephone call during a declared disaster. An alternative mode of transport may be used to move the patient directly to and from an outpatient end stage renal disease facility if the patient's normal and alternative modes of transportation cannot be used during the disaster. The plan will include a communication plan with the receiving facility prior to the patient being transported to a receiving facility.
- **(ii) An EMS provider's plan under this subsection may prioritize providing transportation for a patient suffering from an acute emergency condition over transportation for a dialysis patient.**

- (I) A "disaster" has the meaning assigned by Texas Government Code §418.004 and §418.014.

- **(II) "End stage renal disease facility" has the meaning assigned by Texas Health and Safety Code §251.001(7).**

- (iii) Liability of a unit of local government under this chapter is limited to money damages in a maximum amount of $100,000 for each person and $300,000 for each single occurrence for bodily injury or death and $100,000 for each single occurrence for injury to or destruction of property, as described in Texas Civil Practice and Remedies Code §101.023(d).

3 amendments

- (J) 25 triage tags, or participation in the RAC triage plan.

- **Clean up throughout the rule to address the “Plain Language” policy**

Plan forward

- Reviewed by GETAC August 2024
- **Official public comment dates: 11-1-2024 until 12-2-2024**
- Rule effective date 3-6-2025
- **Rule can be re-open to address any other change after these rules are adopted**

Any questions or comments

10. Executive Council Activities

- Pediatric Scenarios: Newborn Resuscitation, Penetrating Trauma, Intentional Overdose, and Hanging Scenario

11. Texas EMS, Trauma & Acute Care Foundation (TETAF) March 2024

Dinah Welsh, TETAF President/CEO

Texas EMS, Trauma & Acute Care Foundation Update

Dinah Welsh

TETAF President/CEO

Friday, August 23, 2024

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

Texas Perinatal Services
A Program of the Texas EMS Trauma & Acute Care Foundation

Advocacy

- TETAF held a virtual stakeholder meeting with more than 120 attending on August 6 to discuss the proposed trauma rules. Additionally, Dinah Welsh, Wanda Helgesen (TETAF Board Chair and BorderRAC Executive Director), and Dr. Craig Rhyne (Retired Trauma Surgeon, TETAF Surveyor, Former TETAF Board Chair) provided oral comments regarding the rules during the August 15 meeting of the Texas Health and Human Services Executive Council. TETAF will provide formal written comments on the newly proposed trauma rules.
- The TETAF Advocacy Committee is meeting regularly to prepare for the 89th Texas Legislative Session and focused on the TETAF Legislative Priorities.

Surveys – Trauma, Stroke, Maternal, and Neonatal

- The number of surveys continues at a steady pace for all survey service lines in the last quarter. Trauma and maternal continue to be the two busiest service lines, followed by neonatal and stroke.
- TETAF is anticipating a slightly slower fiscal year with the perinatal survey cycles.

Education

- The next virtual TETAF Hospital Data Management Course (HDMC) will be October 29-30. This course meets the current state rule requirements for Level III and Level IV trauma registrars and is designed to improve the skill sets of the data entry specialist. Contact hours can be earned upon completion of the course. Go to www.tetaf.org/hdmc to sign up and be notified of the next course.
- TETAF and Texas Perinatal Services continue to offer exclusive, free educational opportunities to our hospital partners via Mighty Networks.

Scan with the camera on your phone to join Mighty Networks or visit www.tetaf-tps.mn.co

Collaboration

- TETAF continues to provide support to Texas TQIP.
  - Texas TQIP membership is growing. Membership is currently open to Level I and Level II participating TQIP trauma centers in Texas. The collaborative hopes to expand its membership to Level III hospitals next year. Anyone from a Level III trauma center can attend the meetings, but they are not voting members, yet, of the collaborative.
- TETAF continues to provide all continuing education for the Texas Trauma Coordinators Forum and participate in their educational activities.
- TETAF welcomes the opportunity to be a resource, support, and/or participate in any meetings to further build the trauma and emergency care network.

Thank you to our sponsors!

- TETAF hosted the 35th Anniversary Celebration of the Texas Trauma System
  - Thank you to 42 sponsors and more than 200 people who attended
  - Proceeds will benefit the TETAF Rural Trauma System Development Fund

12. Discussion, review, and recommendations for initiatives that instill a culture of safety for responders and the public with a focus on operations and safe driving practices

13. Discussion of Rural Priorities

14. Discussion and possible action on initiatives, programs, and potential research that might improve the Trauma and Emergency Healthcare System in Texas.

15. Final Public Comment

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

Please state the following when making comments:

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

TEXAS Health and Human Services

Texas Department of State Health Services

16. Announcements

17. Next Council Meeting Dates

Quarterly Meetings:

- **Q4 –** November 23-25, 2024, in conjunction with the Texas EMS Conference in Ft. Worth.

18. Adjournment

Alan Tyroch, MD, GETAC Chair

TEXAS Health and Human Services

Texas Department of State Health Services

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