TEXAS
Health and Human Services

Texas Department of State Health Services

Governor's EMS and Trauma Advisory Council

Monday, November 25, 2024

4:00 PM

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

TEXAS Health and Human Services

Texas Department of State Health Services

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

Public participation is available at:

Omni Fort Worth, 1300 Houston Street

Ft. Worth Ballroom 4 & 5

Fort Worth, Texas 76102

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. Except for GETAC Council members, all participants should have cameras turned off and mics muted 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

- August 23, 2024

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5. Chair Report and Discussion

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

New Council Members

- Rural Trauma Facility:
  - Mr. Donny Booth, MBA, MSN, RN, CEN
  - CEO of Permian Regional Medical Center

- Certified Paramedic:
  - Chief Brian Petrilla, EMT-P,
  - Assistant Chief of EMS, Fort Bend County EMS

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State Reports

6.b. EMS Trauma Systems Update

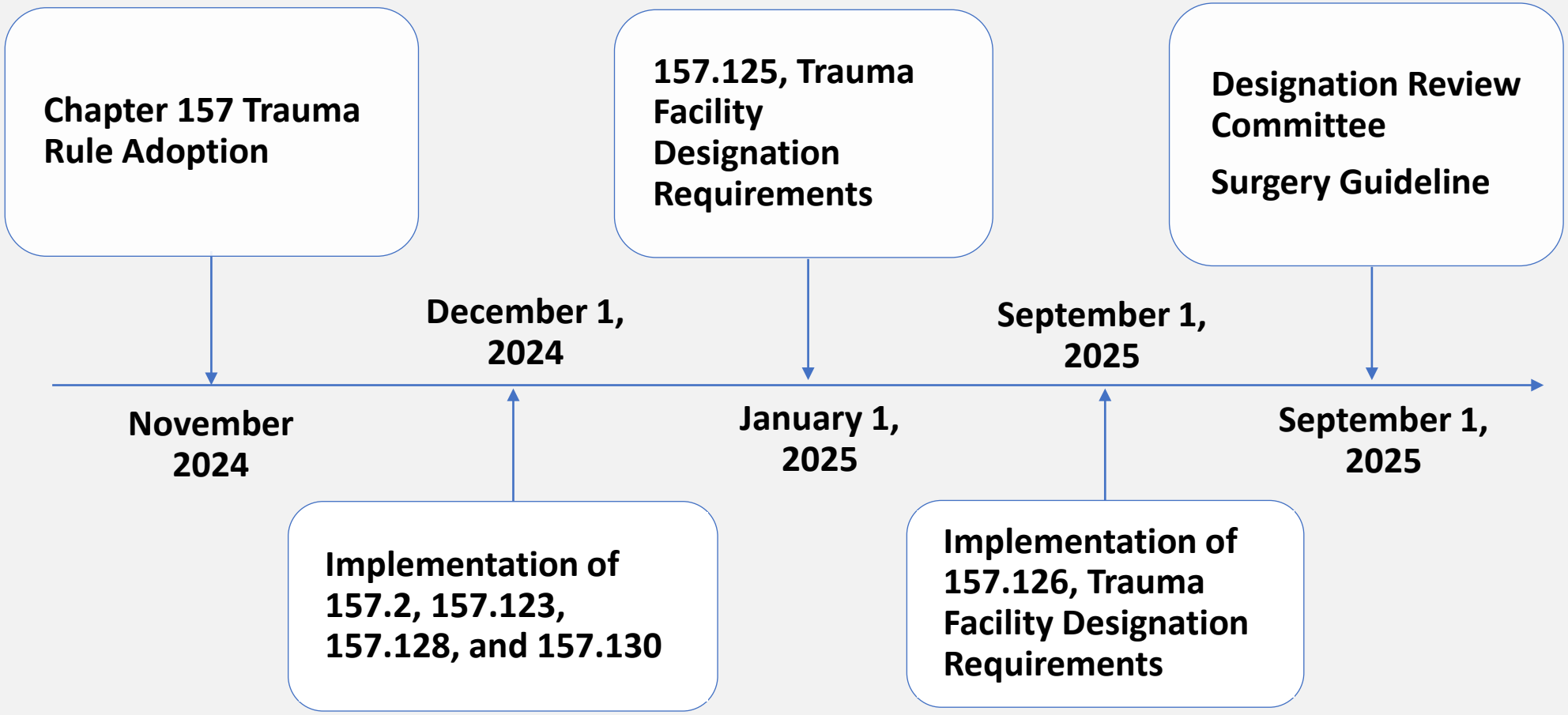
Jorie Klein, MSN, MHA, BSN, RN, Director

Thank You, GETAC Stakeholders.

Thank You, Rule Workgroup.

Your Efforts Created Change.

Chapter 157 Trauma Rule Implementation



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Facility Designation by the Numbers

Trauma

- Comprehensive (Level I): 22
- Major (Level II): 28
- Advanced (Level III): 58
- Basic (Level IV): 191
- In Active Pursuit: 7

Stroke

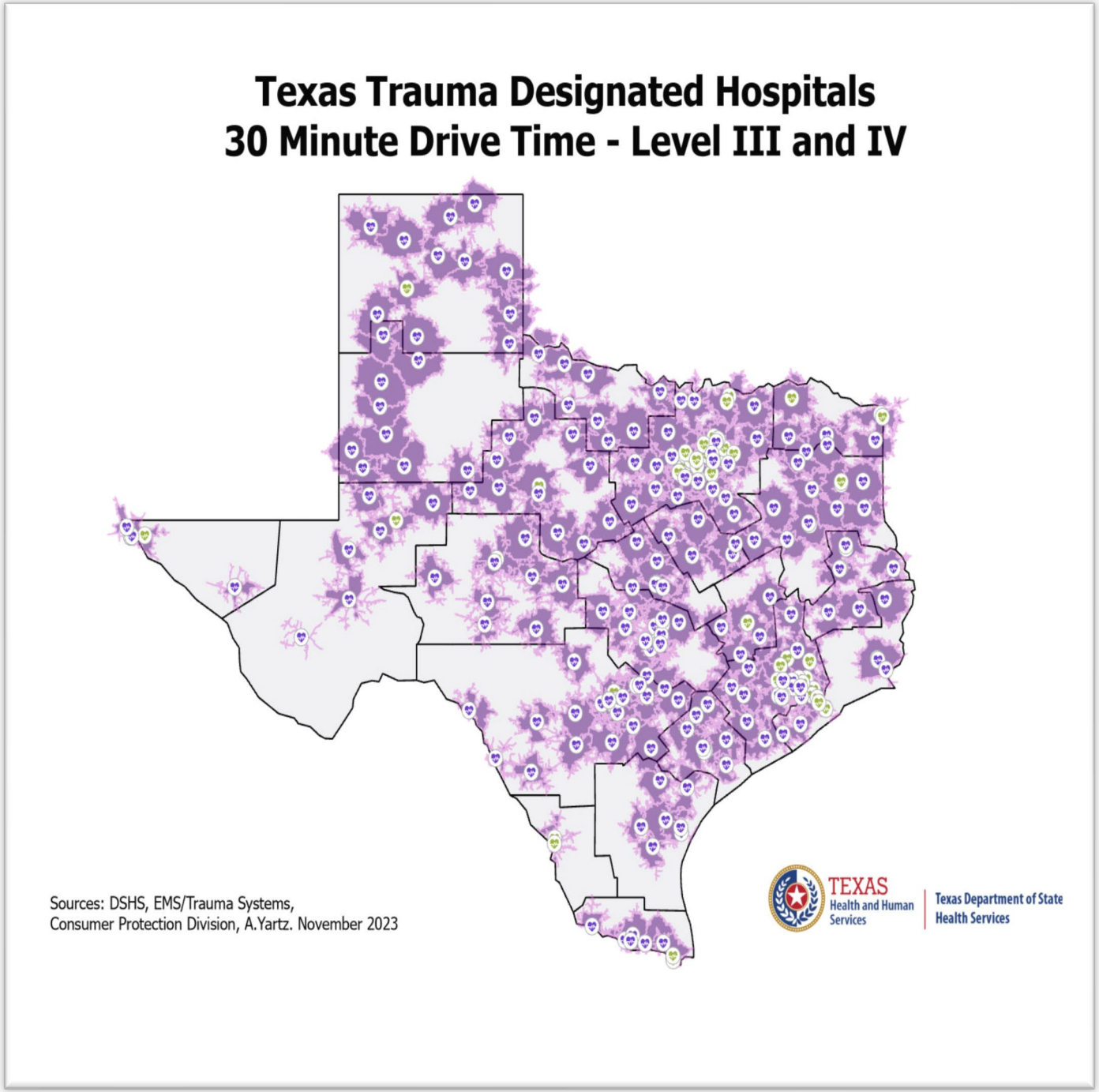
- Comprehensive (Level I): 45
- Advanced (Level II): 6
- Primary (Level III): 102
- Acute Stroke Ready (Level IV): 25

Maternal

- Comprehensive (Level IV): 32
- Subspecialty (Level III): 45
- Specialty (Level II): 85
- Basic (Level I): 55

Neonatal

- Advanced Neonatal Intensive Care (Level IV): 23
- Neonatal Intensive Care (Level III): 74
- Specialty Care (Level II): 51
- Well Care (Level I): 77



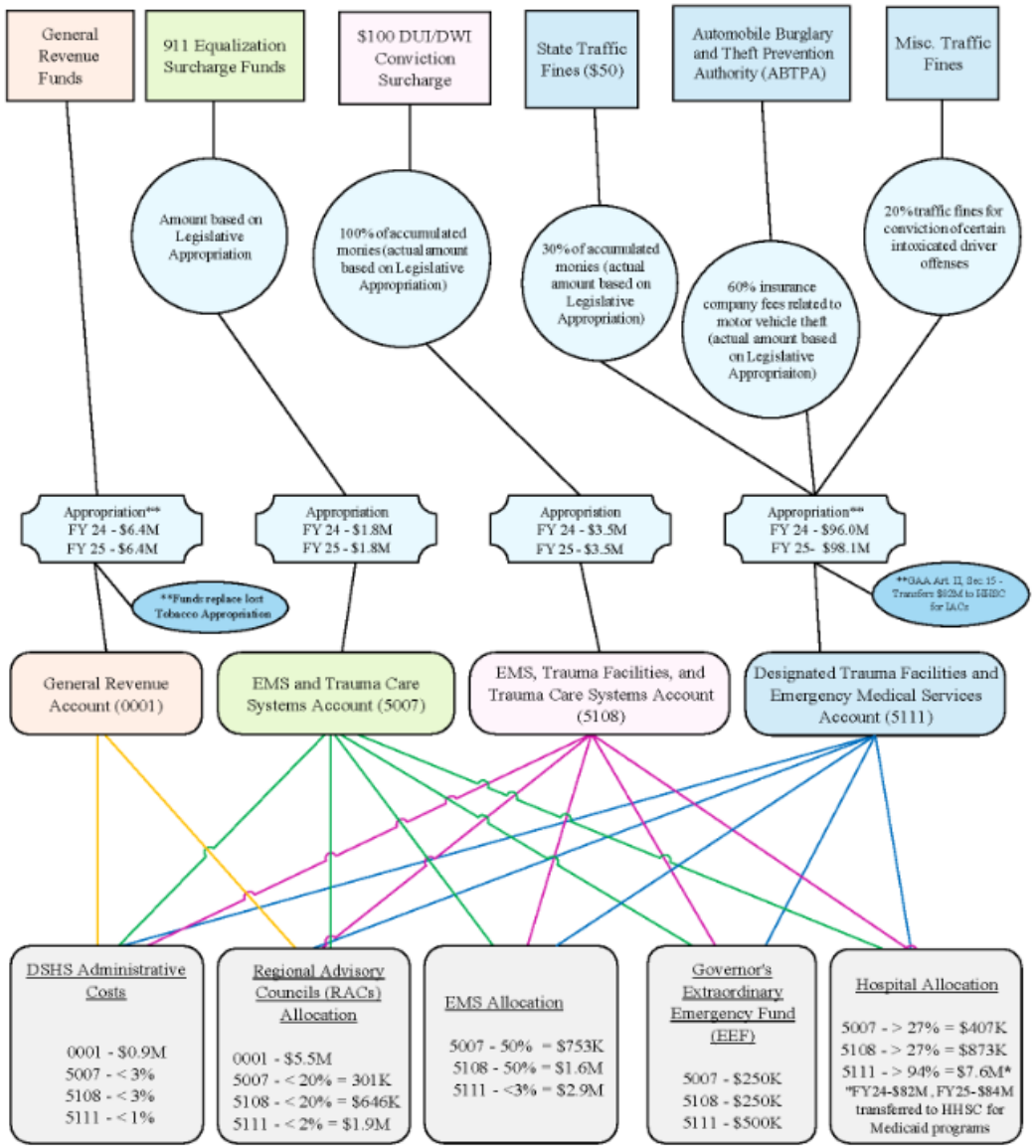
Resources vary by region, urban vs. rural

Specialty services/staff to meet designation requirements

Diversion due to staffing/specialty challenges

Transport and transfers due to capabilities, distance, diversion, etc.

Fiscal Year (FY) 2024 - 2025
Texas Department of State Health Services (DSHS)
EMS/Trauma Systems Funding Streams



Source: DSHS, Consumer Protection Division

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Types of Trauma Funding: Dedicated Funding Streams

Fund 5007

- 9-1-1 Equalization Surcharge Funds

Fund 5108

- $100 DUI/DWI conviction surcharge

Fund 5111

- 30% State Traffic Fines
- 20% of Misc. Traffic Fines (DWI Traffic funds)
- 60% of Automobile Burglary & Theft Prevention Authority (ABTPA)

EMS Trauma Funds Support

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

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

EMS Allotment Fund ($5.2M)

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

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

60% to Rural

40% to Urban

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

Support emergent, unexpected needs of:

- Licensed EMS providers
- First Responder Orgs
- Licensed Hospitals

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

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

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 Council (RAC)

Regional Advisory Council (RAC)	FY 2023	FY 2024	FY 2025	FY 2026 Projection	FY 2027 Projection
EMS Pass-Through	$4,795,847	$4,876,435	$4,941,599	$4,910,517	$4,910,517
RAC	$2,597,147	$2,650,510	$2,661,449	$2,640,727	$2,640,727
System Development	$2,278,187	$2,278,187	$2,286,357	$2,286,357	$2,286,357
Exceptional Item		$3,300,000	$3,300,000	$3,300,000	$3,300,000
TOTAL	**$9,671,181**	**$13,105,132**	**$13,189,405**	**$13,137,601**	**$13,137,601**

Funding Priorities

- **Data Submission**
  - 2023 Submissions Closed
  - Closing of 2024
- **RAC Contracts**
  - Statement of Work
  - Funding allotment
  - EMS Transports and Trauma Facility Submissions to State EMS/Trauma Registries - November 30, 2024
- **Trauma UCC Application**
  - Posted in December 2024
  - Close March 30, 2025

Extraordinary Emergency Funds (EEFs)

Fiscal Year 2024:

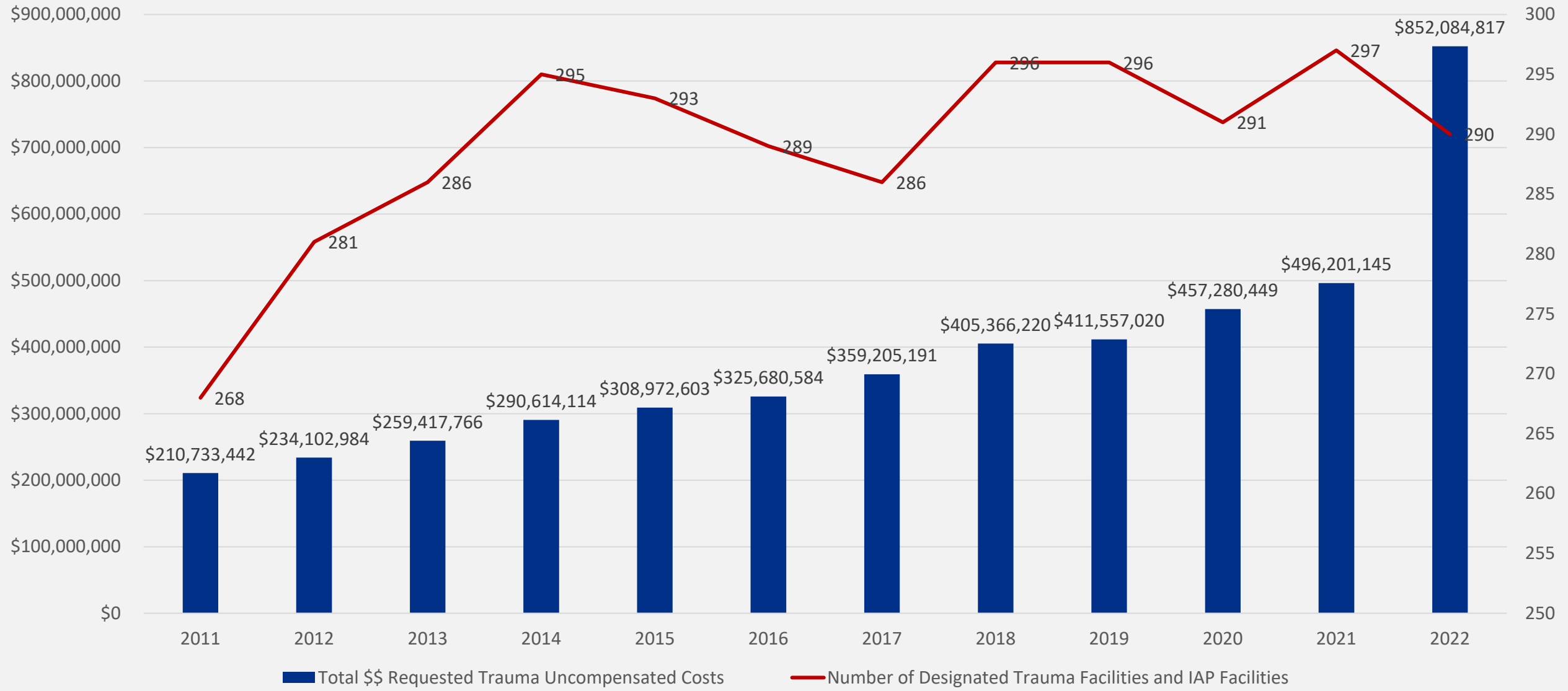
$1M was made available on 9/1/2023, including $214,000 rolled over from FY 2023

- 17 Applications received
- 8 Awarded, 5 Denied, 4 Withdrawn
- Rider request for unexpended balance authority with LBB currently

Requested items:

- 6 Ambulances
- Ice Machine
- New Engine

Uncompensated Care Charges Costs Over Time, Calendar Year 2011-2022, Compared to the Number of Qualified Facilities



Comparison from FY22 - FY24

	FY22	FY23	FY24
Facilities that Applied	290	297	290
5007 fund	$506,072.01	$555,561.86	$478,997.59
5108 fund	$574,368.85	$576,262.26	$978,883.14
5111 fund	$9,185,174.12	$6,609,925.43	$8,744,432.13
HHSC (SDA)	$172,896,402.64	$188,400,189.56	$175,159,949.74

DSHS Priorities

- **Planning for GETAC 2025 Potential Dates**
  - January 30-31 for Retreat
  - Q1: March 4-7
  - Q2: June 17-20
  - Q3: August 19-22
  - Q4: November 21-24
- **Sunset Preparation**

Reminder

- Members of GETAC and GETAC Committees
  - Cannot Advocate
  - Educate/Provide Clarity

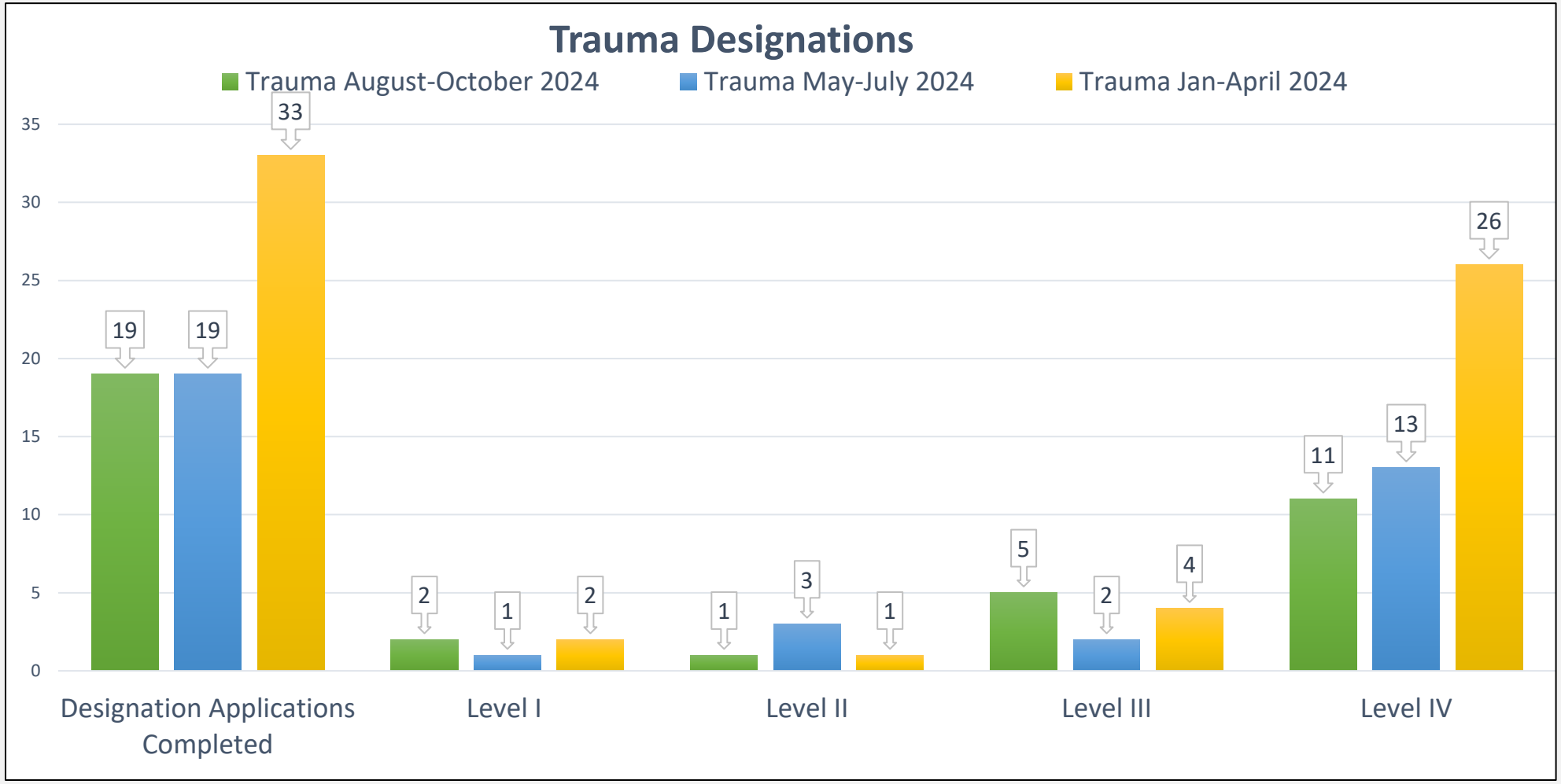
Designation Update

Elizabeth Stevenson, BSN, RN
Designation Programs Manager

Designated Trauma Facilities

Designated Trauma Facilities	October 2024	July 2024	April 2024
Total	297	299	300
Level I	22	22	22
Level II	28	28	27
Level III	56	59	60
Level IV	191	190	191

Trauma Designation Data



Trauma Designation Data

Trauma 2024	Trauma August - October 2024	Trauma May - July 2024	Trauma January - April 2024
New IAP Recognitions	**1**	**2**	**2**
Facilities In Active Pursuit	**8**	**9**	**8**
Level I	0	0	0
Level II	1	1	0
Level III	3	3	3
Level IV	4	5	5

Trauma Designation Data

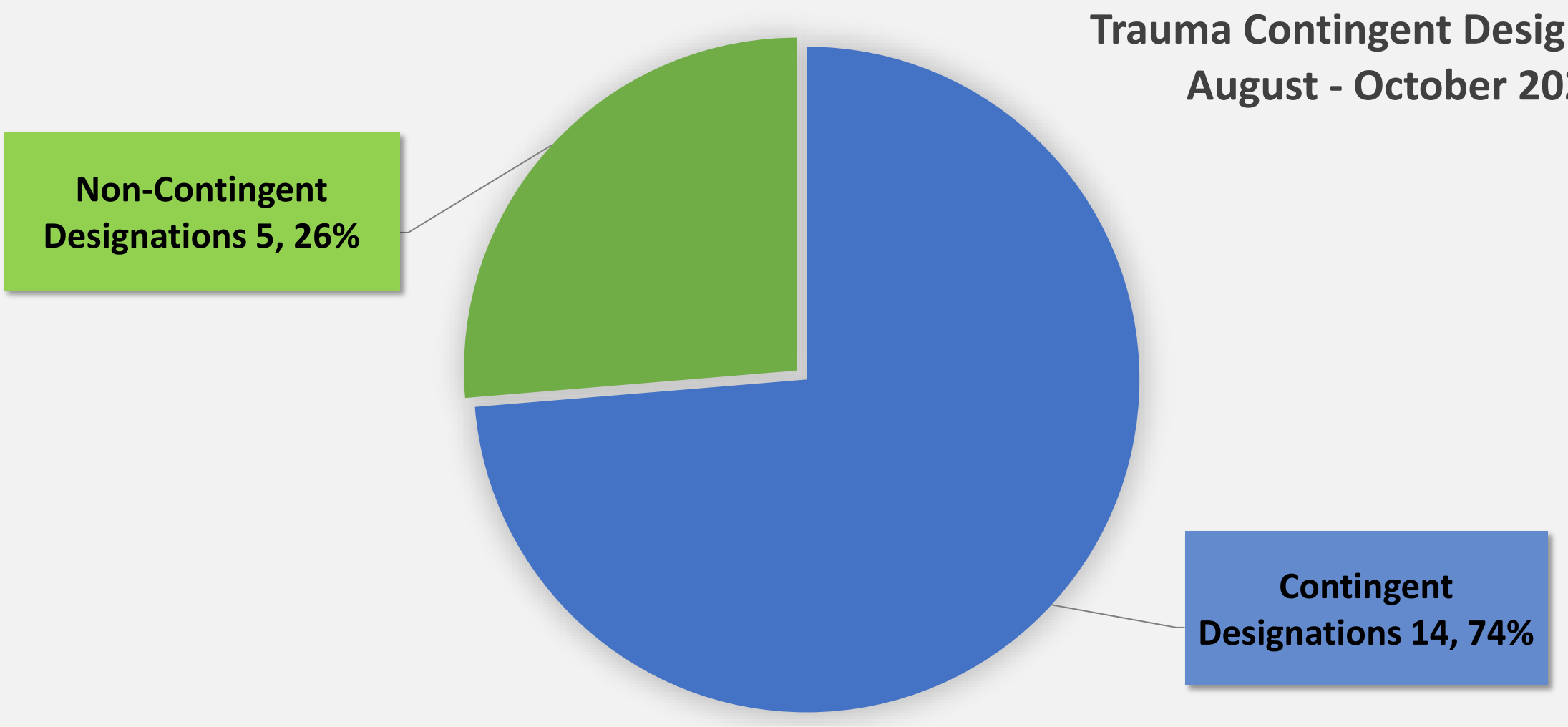
Trauma Designations
August - October 2024

19
Designations
Processed

17
Renewals

2
Initials

Trauma Designation Data



Common Deficiencies

- TPM 0.8 FTE
- Nursing documentation
- PI – Identified all variances
- TMD participation in PI
- PI – M&M Review
- PI – Special audits for deaths/complications
- Nursing orientation/Annual competencies
- PI – Actions taken
- PI – Loop closure

Trauma Designation Data

Trauma 2024	Criteria Met Facilities	Contingent Facilities
Total	30	97
Level I	1	3
Level II	4	0
Level III	6	*15
Level IV	19	*79

* 15 Level III facilities with contingent designations with 60% having new TPM/TMD
* 79 Level IV facilities with contingent designations with 53% having a new TPM or TMD

Trauma Designation Information

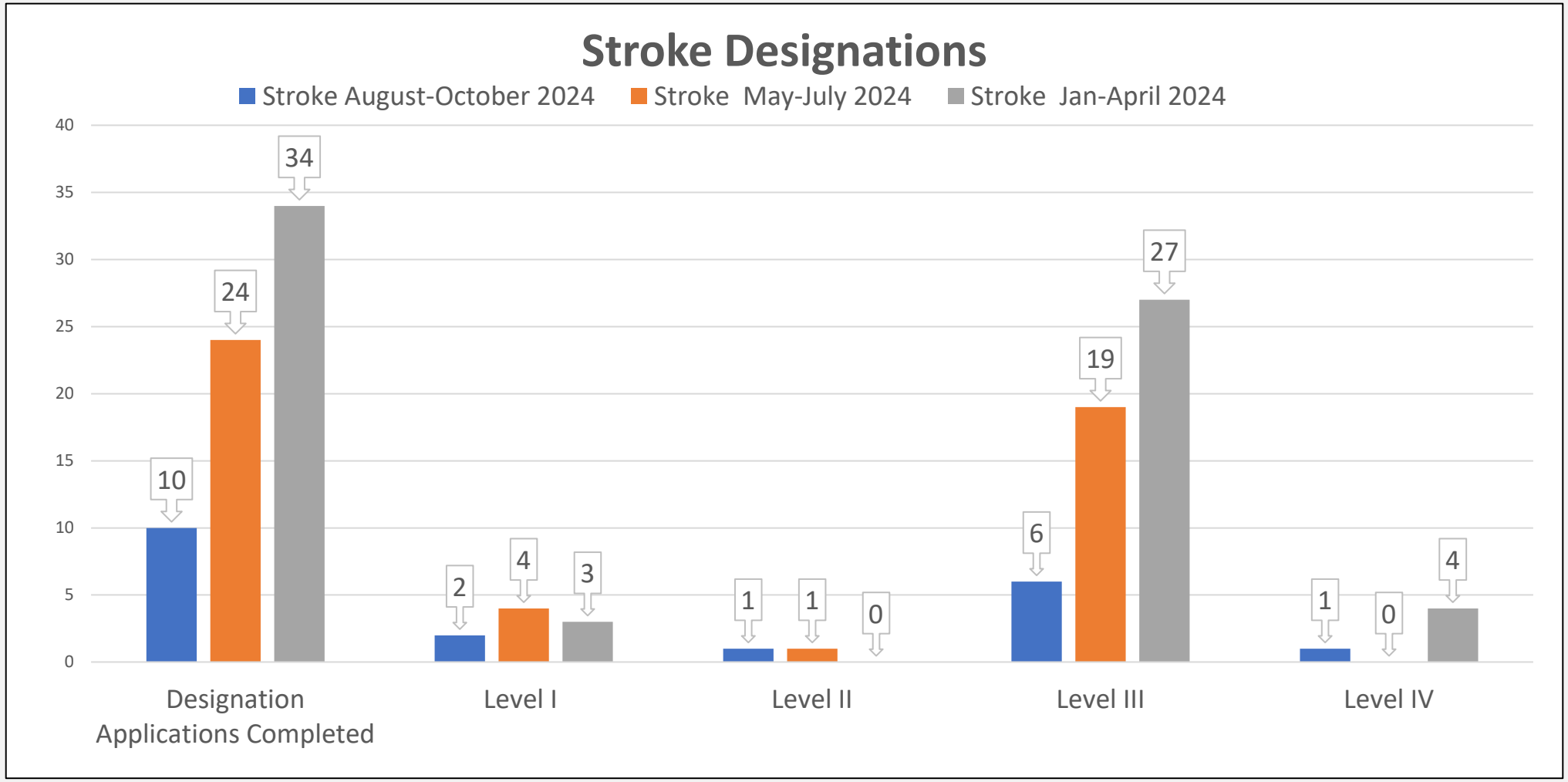
Department Activities:

- Adopted Trauma Rule Q&A meetings in December
- Section 157.125 Comparison Document
- DSHS Trauma Registry submissions at least quarterly
- Designation Survey Guidelines Appendix B: Trauma Required Screening Events
- No Trauma monthly meetings for the month of December
- Re-register for 2025 trauma monthly calls on DSHS website
- Reminder to complete DMEP online course

Designated Stroke Facilities

Designated Stroke Facilities	October 2024	July 2024	April 2024
Total	189	189	188
Comprehensive Level I	45	45	45
Advanced Level II	6	6	4
Primary Level III *Primary Level II*	*101* *12*	*93* *20*	*74* *41*
Acute Stroke Ready Level IV *Support Level III*	*25* *0*	*24* *1*	*22* *2*

Stroke Designation Data



Stroke Designation Information

Department Activities:

- Initial Level IV Acute Stroke Ready meetings held on September 12th, October 10th, and November 14th, 2024.
- No Stroke monthly meetings for the month of December
- Re-register for 2025 stroke monthly calls on DSHS website

Designation Application Process Performance Measures

Goals – 30/60 days

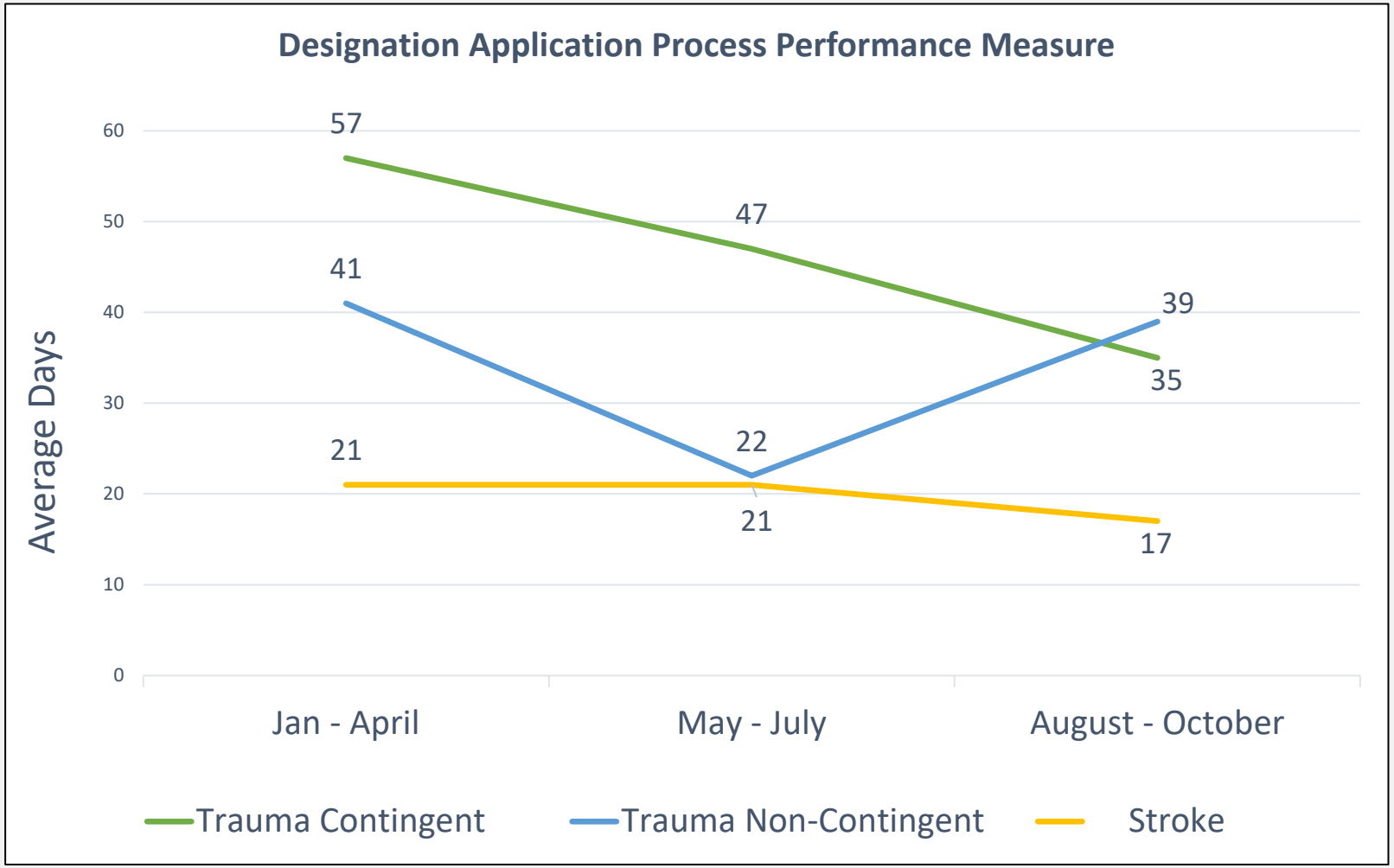
(Non-Contingent Designation 30 Days)

(Contingent Designation 60 Days)

Stroke – 17 days

Trauma – 35 days Contingent

Trauma – 39 days Non–Contingent




Any
Questions

EMS System Update

Joe Schmider
Texas State EMS Director

Senate Bill 8 Update

- Over **3,469** Education Scholarships processed or in process
- EMS Scholarships in each RAC
- $**18,570,800.** Million in scholarships processed
- **9,983** new certified EMS personnel since 10/1/22
- 2019 – 68,461 certified personnel; today – **78,457**

(As of 10-31-2024)

EMS Courses

Between November 2024 and February 2025, **395** initial EMS education courses will end; it is important to follow the process to prevent delays in the certification process!

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395 EMS Education Courses Completing November to February

- Apply when you have your NREMT certification and **on the same day of your fingerprint background check appointment.**
- Complete the process online and pay the fees!
- **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.

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EMS Licensing Processing Time Fourth Quarter FY 24 (Jun, Jul, Aug)

Overall – All Applications

- **EMS Personnel:** DSHS processed 8,309 applications; the median processing time of 9 days.
- **EMS Educators:** DSHS processed 521 applications; the median processing time of 91 days.
- **EMS Providers:** DSHS processed 88 applications; the median processing time of 68 days.
- **First responder organizations:** DSHS processed 81 applications; the median processing time of 66 days.

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Amendment to TAC 157.11

- Dialysis language updated
- Correction to liability insurance requirements
- Triage tags or participate in the RAC program
- Convert rule to plain language
- No comments received; closing date is today
- Effective March 6, 2025

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Emergency Service UT Behavioral Health survey

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Questions for EMS/Trauma Systems?

Thank You

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

Jia Benno, MPH
Office of Injury Prevention Manager

EMS and Trauma Registries
Texas EMS Data

November 25, 2024

Jia Benno, MPH

Injury Prevention Unit Director

EMS and Trauma Registries (EMSTR) Current Data Progress

About EMSTR

- Required reporting under 25 Texas Administrative Code (TAC), Chapter 103 and TAC Section 157.11:
  - EMS agencies must report all runs to EMSTR. An EMS run is a resulting action from a call for assistance where an EMS provider is dispatched to, responds to, provides care to, and may transport a person.
  - Trauma facilities must report traumatic brain injuries (TBIs), spinal cord injuries (SCIs), and other traumatic injuries that meet the National Trauma Data Bank (NTDB) criteria to EMSTR.
  - EMS agencies and hospitals must submit data to EMSTR within 90 calendar days.
- EMS providers may submit data through an authorized business associate. EMS providers must submit a business associate agreement (BAA) before EMSTR will accept records from a third-party source.

EMSTR Scope and Growth

- There are 736 EMS agencies and 299 trauma facilities in Texas.
- Texas EMSTR collection accounts for 9% of national EMS runs.
- EMS runs collected increased from 300,000 EMS runs in 2012 to nearly 5 million (projected) in 2024.

EMSTR Reporting System Upgrade

Reporting system went live November 2023. The launch included:

- Transition from NEMSIS version 3.3.4 to version 3.5.
- Update to NTDB and International Trauma Data Exchange (IDTX) 2020/2023 from 2017/ 2020.
- Implementation of Identity and Access Management Online (IAMOnline) for security purposes.

Initial Challenges

- Onboarding EMS agencies, trauma facilities, and third-party vendors.
- Establishing a Business Associate Agreement (BAA) between EMS agencies and vendors as required to allow vendors to submit for agencies:
  - Around 570 of the 736 Texas EMS agencies (>75%) submit through a vendor.
  - There are multiple available vendors and agencies can select any vendor they want.
- Provider confusion with IAMOnline security requirements and challenges getting an account and logging into the system.

On 5/31/2024, NEMSIS removed Texas from all national dashboards.

Successes

- 8/2/2024 – NEMSIS added Texas data back to their dashboards!
- BAA progress:
  - June – 151 EMS providers missing a BAA.
  - Currently – 7 EMS providers missing a BAA.
- Records per month:
  - June – collecting 80,000 records per month.
  - Currently – collecting 350,000 records per month.
- Final 2023 datasets:
  - 4,839,748 unique EMS patient care records.
  - 183,759 unique trauma patient care records.

EMSTR Current Data Status

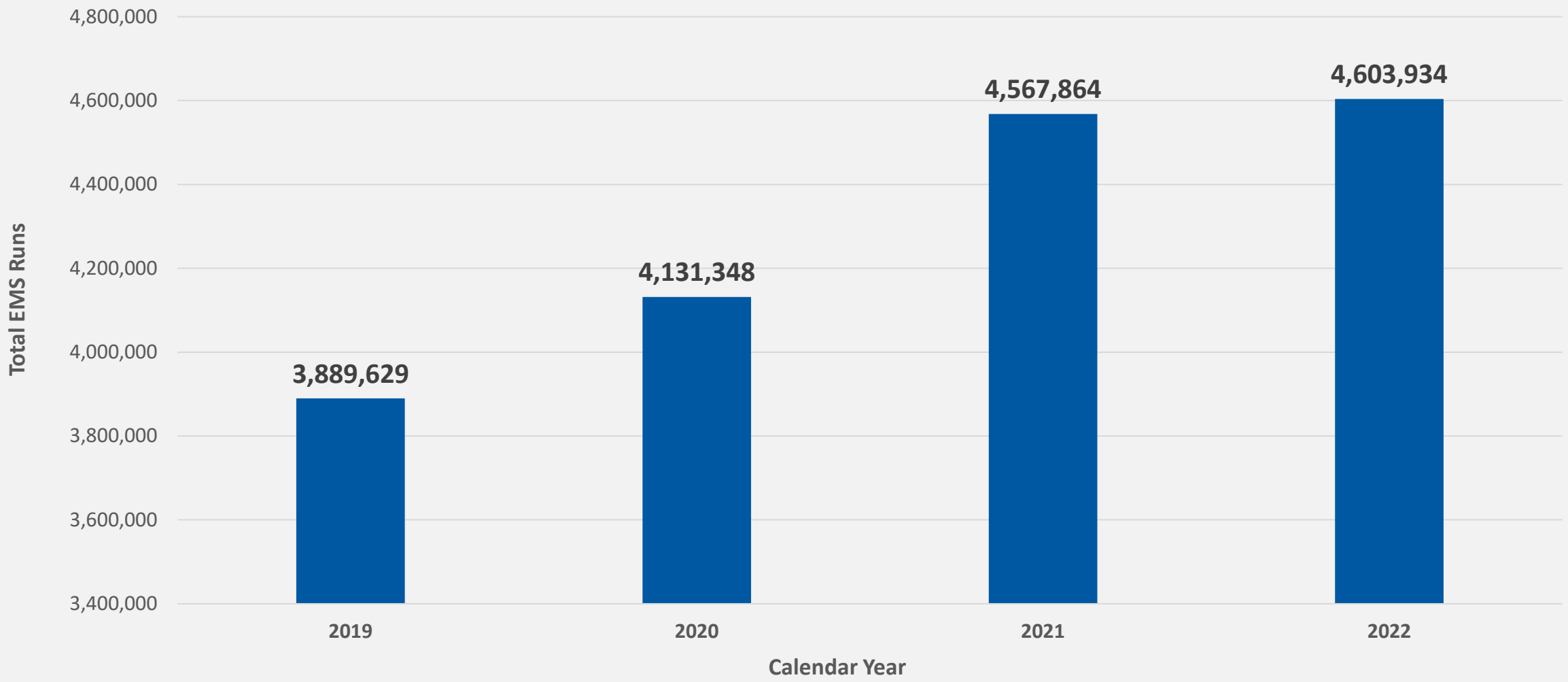
EMS 2022 Unique Records	EMS 2023 Unique Records	EMS 2024 Records*
4,603,934	4,839,748	4,049,835*

Trauma 2022 Unique Records	Trauma 2023 Unique Records	Trauma 2024 Records*
162,409	183,759	138,489*

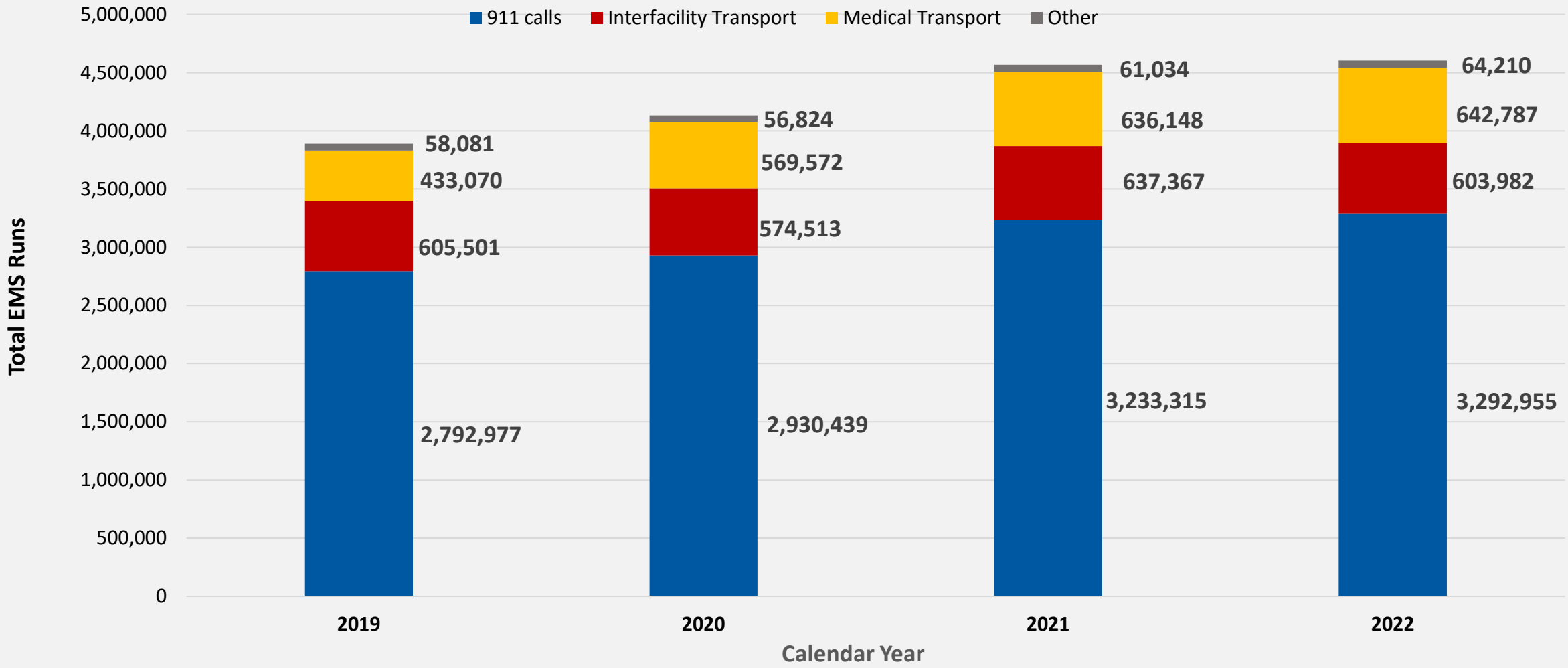
*Record count as of 11/21/2024. **NOTE:** Record counts are not final as these datasets are not closed yet.

EMS Data From EMSTR

Total EMS Runs

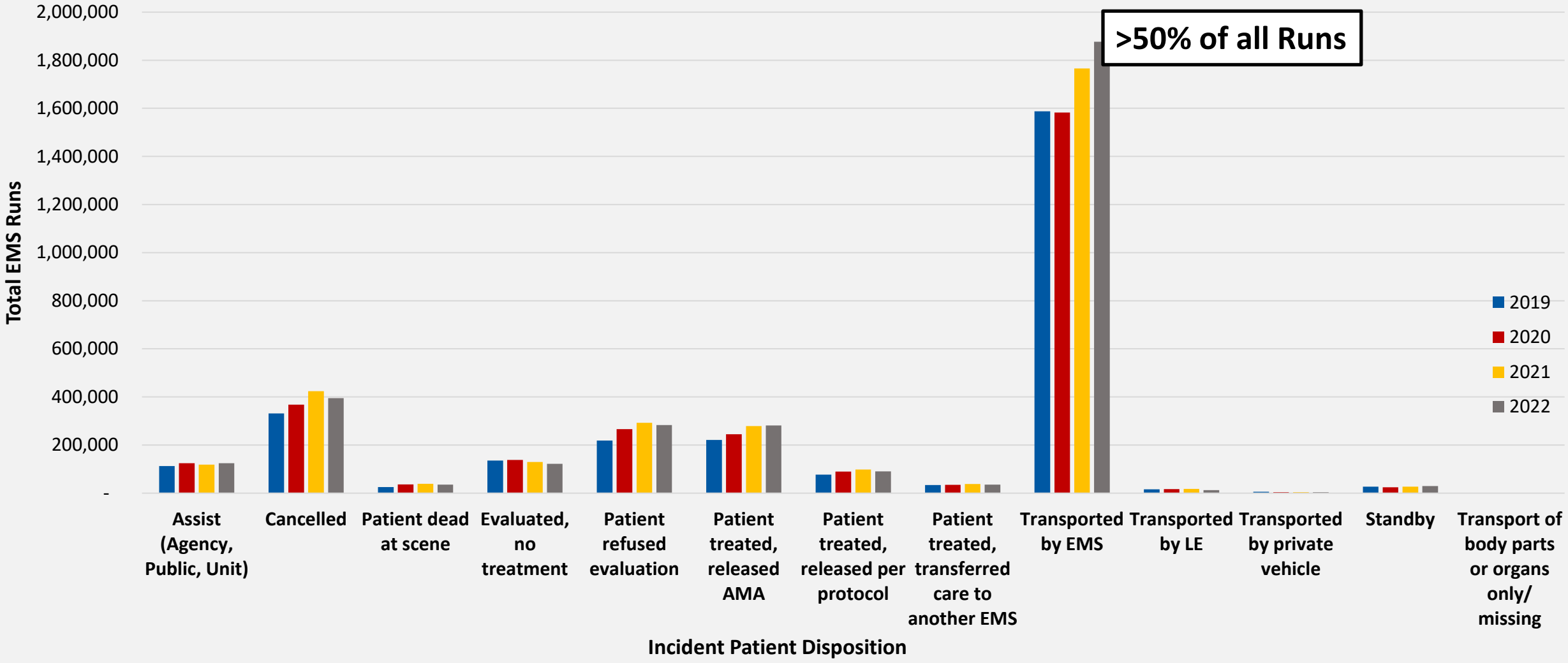


EMS Call Type

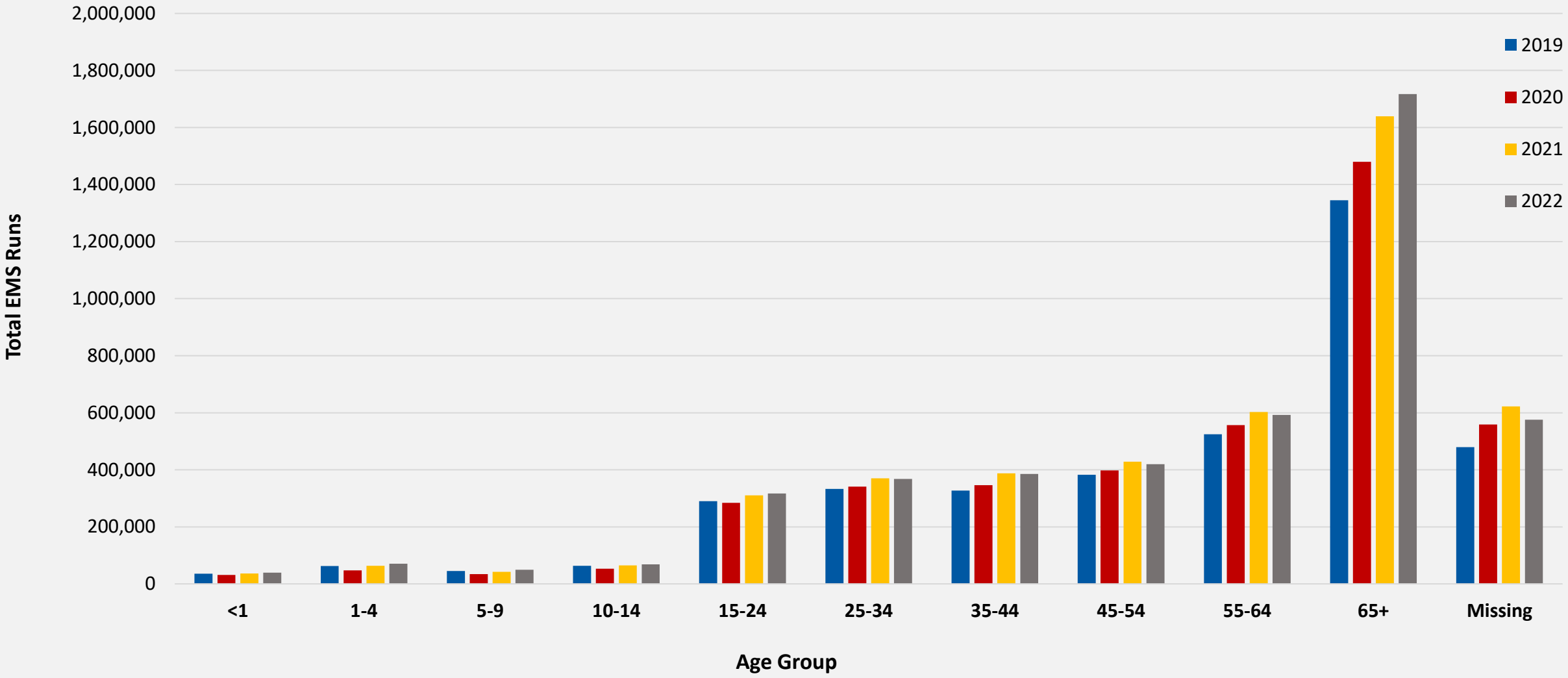


*Other includes mutual aid, intercept, public assistance, standby, and missing.

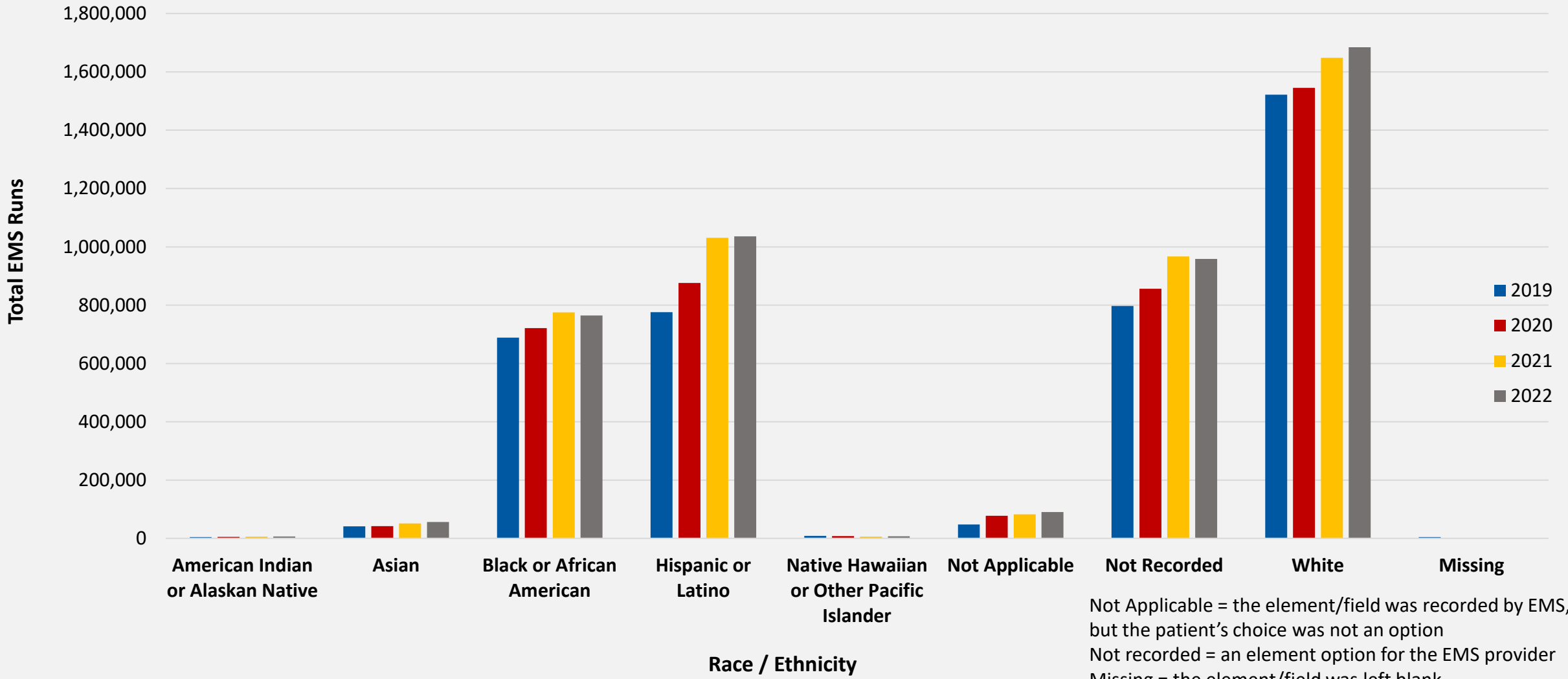
911 Call Incident Patient Disposition



EMS Data by Age

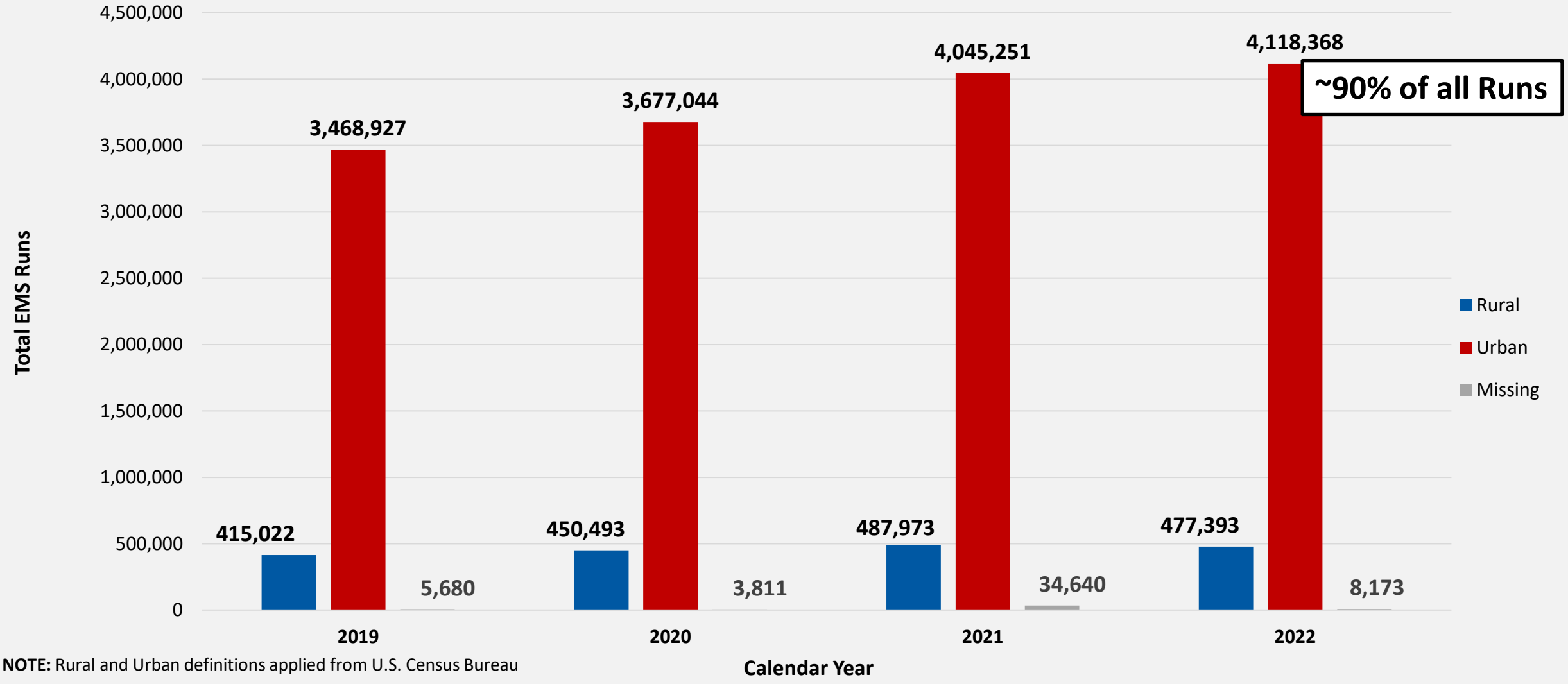


EMS Data by Race



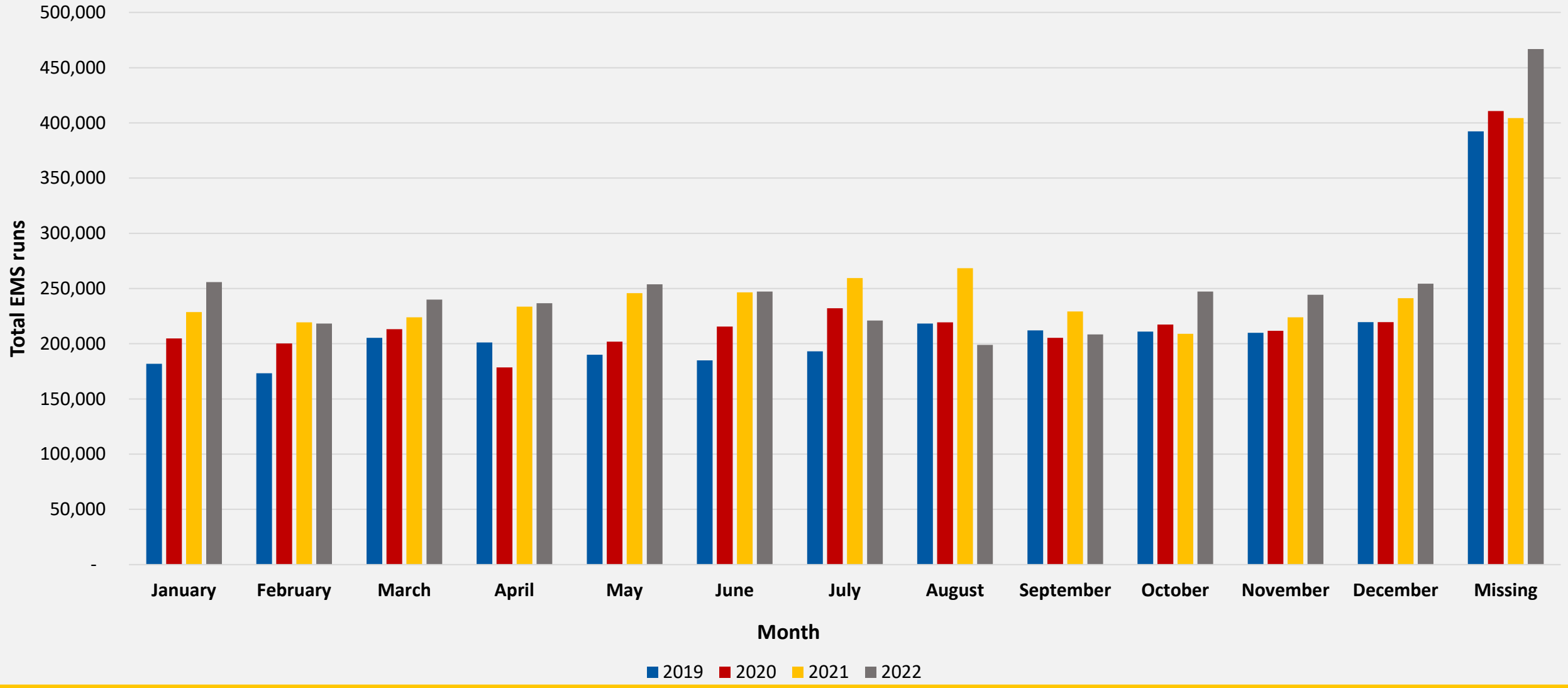
Not Applicable = the element/field was recorded by EMS, but the patient's choice was not an option
Not recorded = an element option for the EMS provider
Missing = the element/field was left blank

EMS Data by Rural and Urban

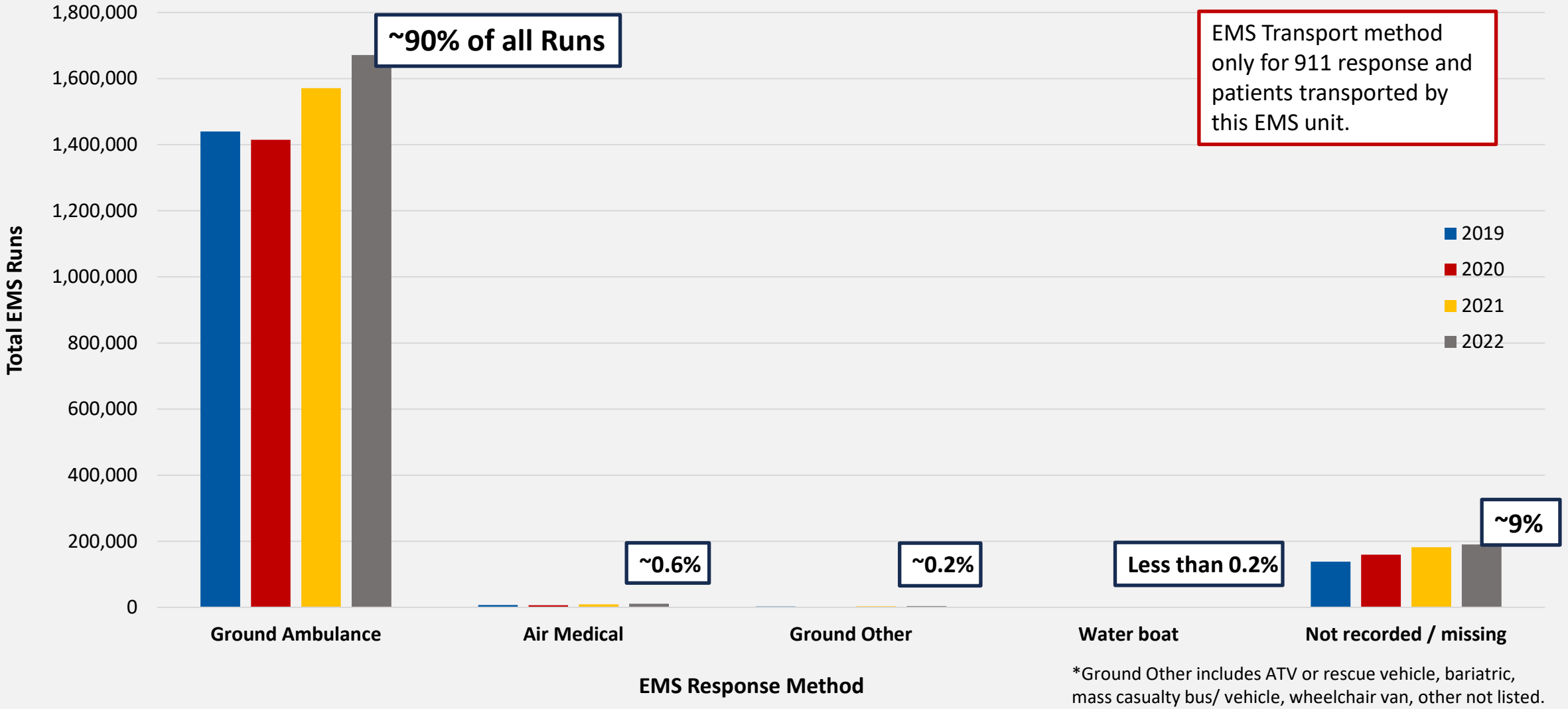


NOTE: Rural and Urban definitions applied from U.S. Census Bureau

Incident Month for 911 Calls



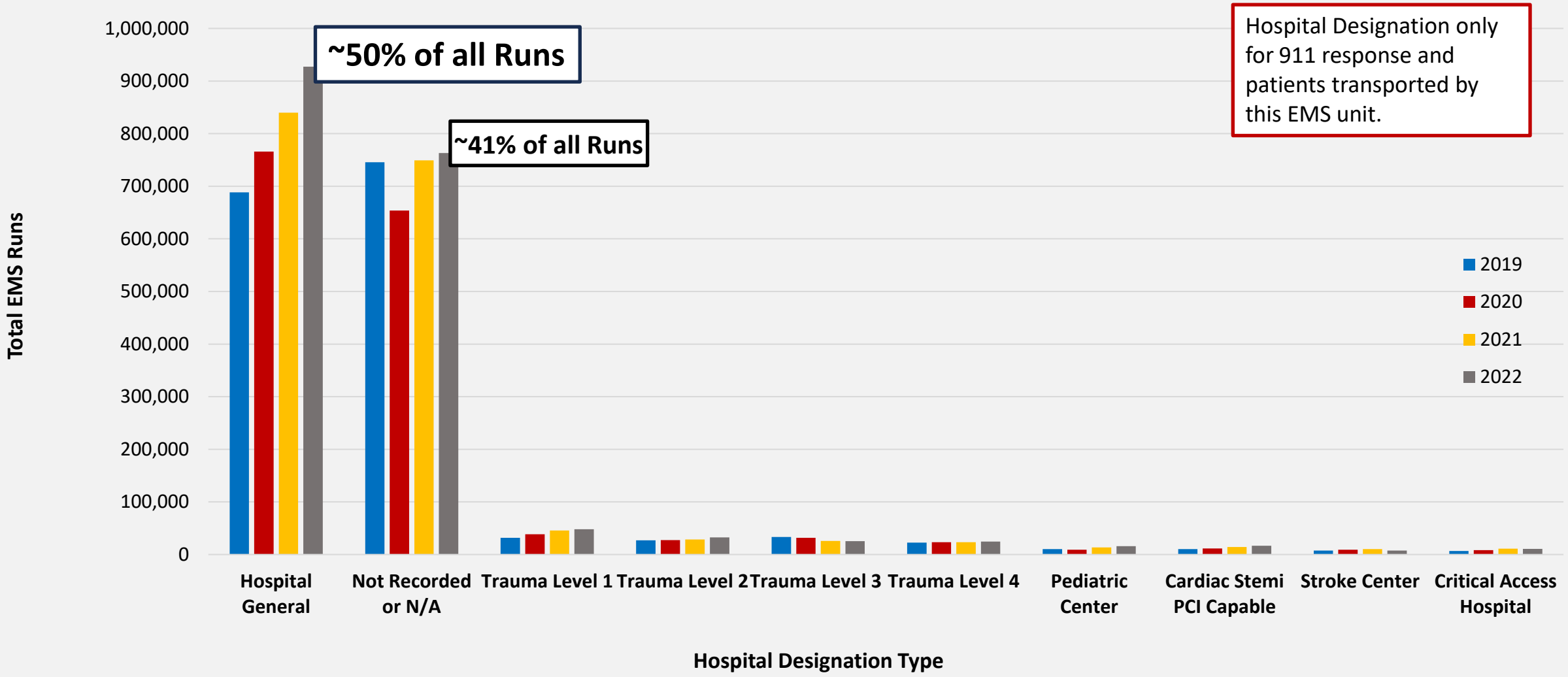
EMS Transport Method



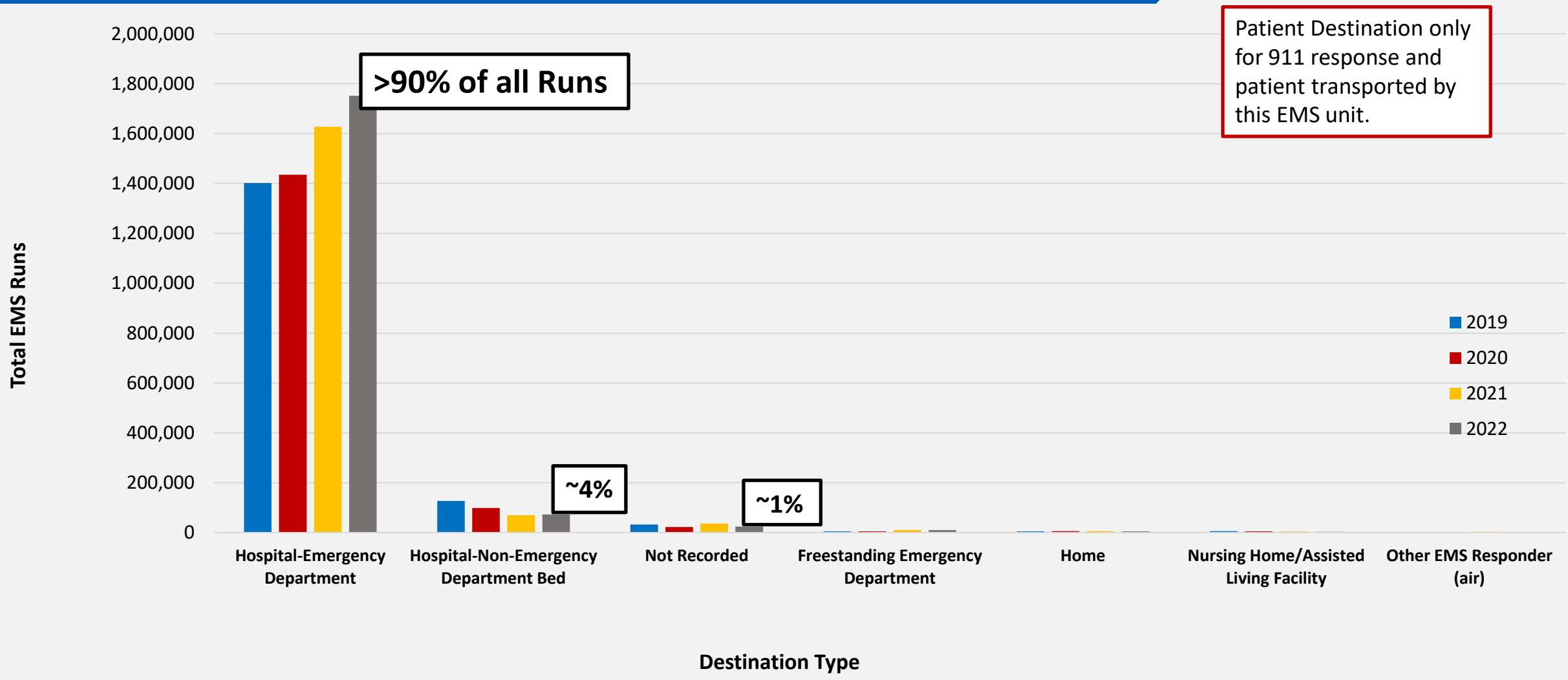
EMS Transport method only for 911 response and patients transported by this EMS unit.

*Ground Other includes ATV or rescue vehicle, bariatric, mass casualty bus/ vehicle, wheelchair van, other not listed.

Hospital Designation



Patient Destination Type



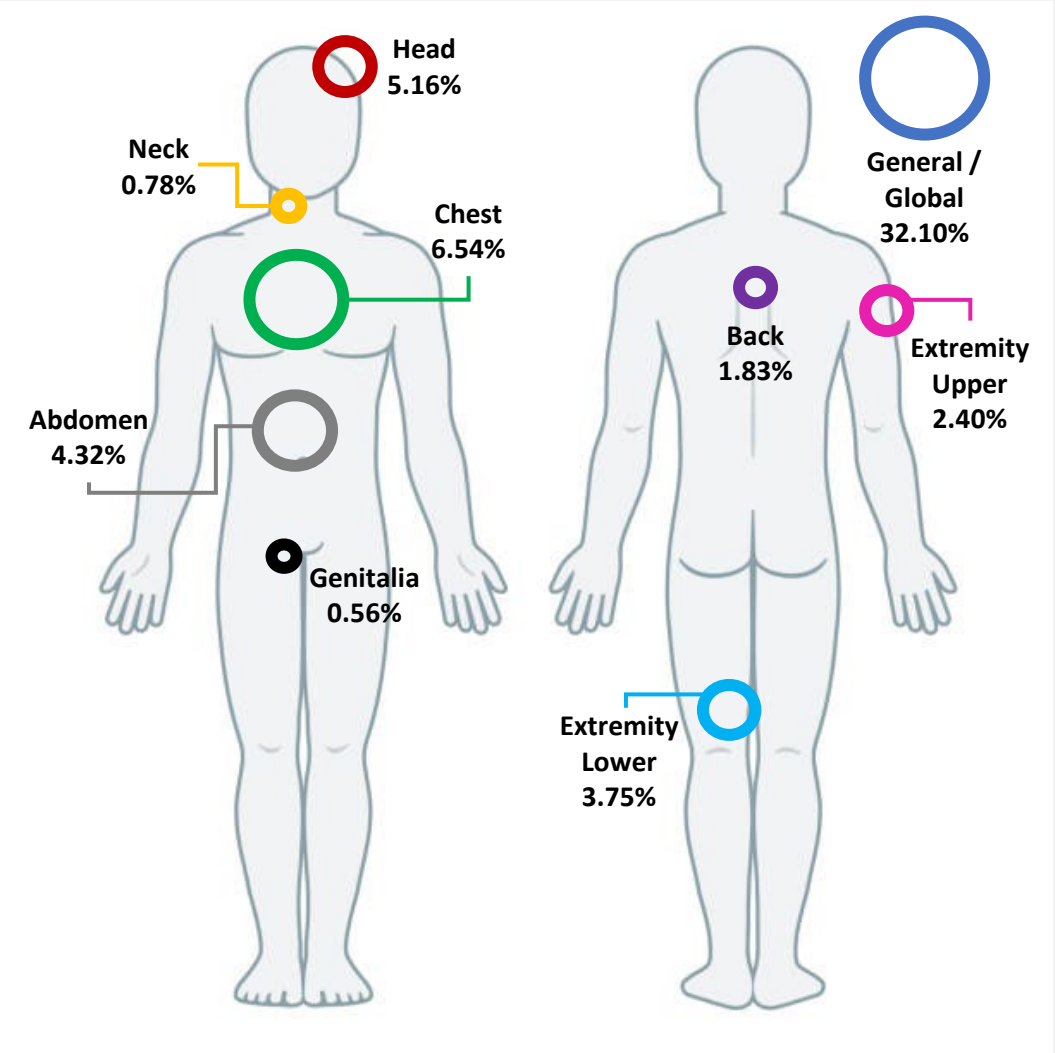
911 Call Complaint Reported Dispatch (1 of 2)

	2019	2020	2021	2022
Sick person (Undefined)	480,079 (17.2%)	506,577 (17.3%)	582,950 (18.0%)	613,275 (18.6%)
Traffic	363,116 (13.0%)	341,051 (11.6%)	393,976 (12.2%)	393,661 (12.0%)
Breathing problems	253,736 (9.1%)	291,539 (10.0%)	343,793 (10.6%)	310,293 (9.4%)
Falls	245,760 (8.8%)	263,429 (9.0%)	292,748 (9.1%)	309,749 (9.4%)
No other category	159,894 (5.7%)	141,278 (4.8%)	149,932 (4.6%)	159,743 (4.9%)
Fainting / Near fainting	142,415 (5.1%)	153,795 (5.3%)	169,683 (5.3%)	175,175 (5.3%)
Chest pain	142,095 (5.1%)	136,993 (4.7%)	152,582 (4.7%)	163,558 (5.0%)
Seizures / Convulsions	104,039 (3.7%)	102,570 3.5%)	109,476 (3.4%)	116,220 (3.5%)

911 Call Complaint Reported Dispatch (2 of 2)

	2019	2020	2021	2022
Unknown problem / Person down	86,808 (3.1%)	94,165 (3.2%)	99,908 (3.1%)	96,915 (2.9%)
Abdominal pain	75,014 (2.7%)	79,726 (2.7%)	88,818 (2.8%)	92,170 (2.8%)
Heart problems	73,934 (2.7%)	73,218 (2.5%)	77,949 (2.4%)	74,522 (2.3%)
Assault	70,855 (2.5%)	78,945 (2.7%)	75,261 (2.3%)	73,002 (2.2%)
Psychiatric problems / Abnormal behavior / Suicide attempt	62,250 (2.2%)	67,626 (2.3%)	72,498 (2.2%)	69,544 (2.1%)
Traumatic injury	57,705 (2.1%)	62,167 (2.1%)	65,640 (2.0%)	70,908 (2.2%)
Transfer interfacility palliative care	52,210 (1.9%)	62,578 (2.1%)	71,292 (2.2%)	86,381 (2.6%)
Stroke	51,749 (1.9%)	58,345 (2.0%)	62,242 (1.9%)	65,081 (2.0%)

Chief Complaint Location in 2022



In 2022, the majority of chief complaint locations reported during Texas EMS runs were **general/global (32.10%)**, followed by the **chest (6.54%)** and the **head (5.16%)**. For **42.55%** of EMS runs where patient contact was made, the chief complaint location was not recorded.

Response Times - All Runs and 911 Calls

Year	All EMS Runs	911 Calls
2019	19.40 minutes	8.87 minutes
2020	20.56 minutes	9.13 minutes
2021	18.27 minutes	8.91 minutes
2022	16.16 minutes	8.65 minutes

Thank you!

EMS and Trauma Registries Texas EMS Data

Injury.web@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	• *Priority no longer has feasibility and will be abandoned*	
2. **Coordinated Clinical Care:** Texas Department of Public Safety – State Troopers	• Collaboration with Sgt. Templeton on content • Educational offering is 90% complete - Still developing the activation criteria	
3. **Prevention:** *HEMS Specific Mental Health Awareness*	• *We are shifting gears* • *Further resource discovery & categorization* • *Discovery of most accessible/effective delivery platform*	

Action Item Request and Purpose

- The AMSCT Committee requests to be placed on the Council agenda for the Quarter 1 meeting.
- 2 action items/requests
- The purpose of the 1st request is to seek Council approval of the completed Texas DPS State Trooper educational program, as well as approval to hold the first class.

Benefit and Timeline

- Holding the first class will provide the opportunity to receive feedback from the end-user and revise the presentation as needed.

- Timeline
  - Request to be placed on Council Agenda for Q1 2025 – *completed today*
  - AMSCT Committee approval of presentation – *Q1 2025*
  - Pending AMSCT Committee approval, seek Council approval of presentation & approval to hold the first class – *Q1 2025*
  - Pending Council approval, the first class will be scheduled – *TBD with dependence on Sgt. Templeton's schedule*
  - If necessary, revisions will be made & approval again sought from AMSCTC & Council – *Q2 2025*

Action Item Request and Purpose

- The purpose of the 2nd request is to seek Council approval of the completed HEMS Specific Mental Health Resource Document which will focus on Preparation, Mental Health Emergencies & Critical Incident Management assets.

Benefit and Timeline

- Providing a comprehensive HEMS Specific Mental Health Resource document will improve the ease & efficiency of access to these resources, especially during times of crisis.

- Timeline
  - Request to be placed on Council Agenda for Q1 2025 – *completed today*
  - AMSCT Committee approval of resource document – *Q1 2025*
  - Pending AMSCT Committee approval, seek Council approval of document – *Q1 2025*
  - Pending Council approval, distribution of resource document – *Q2 2025*

    Email
    TAAMS Website
    GETAC
    AMSCT Committee page on DSHS Website
    EMS Conference Exhibit Hall

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 - Data review regarding dwell time in transferring facilities for cardiac emergencies. .	Data review
Out of Hospital Cardiac Arrest – AED access/bystander CPR - assessment	Refined data set review for 1st meeting of 2025	In progress
Telecommunicator CPR (Coordinated clinical Care/EMS).	Discussed NCTTRAC survey results – pending request to RACs for further distribution.	In progress
Dwell time in transferring facilities for time sensitive emergencies	Data review and further discussion regarding large difference in mean/median times. Future focus on bottom 50% to further delineate gaps in care.	In progress

7.c. GETAC Disaster Preparedness and Response Committee

Chair: Eric Epley, NREMT-P, CEM

Vice-Chair: Wanda Helgesen, RN

November 2024 Mtg Summary

- EMTF Program update, incl End of Year report
- Pulsara and wristband update
- Pre-hospital Whole Blood Task Force update incl WB utilization and prediction report (attached)

7.c.A. Update: Pre-hospital Whole Blood Task Force

Governor's EMS and Trauma Advisory Council

Pre-Hospital Whole Blood Task Force: State EMS Blood Utilization & Cost Estimate

Presented November 22, 2024, GETAC PHWBTF

First, we looked at the TSA-P / STRAC Whole Blood Utilization Data (robust dataset over 2-year period, all blood administered prehospital, medical and trauma)

Aggregate 2yr Total WB Utilization – pulled directly from STRAC regional utilization data; example Frontier Counties:

a. *There are 6 frontier counties in the STRAC region*
b. *We have data on 1 of the 6 frontier counties*
c. *Average = sum of units used monthly divided by 1 county*

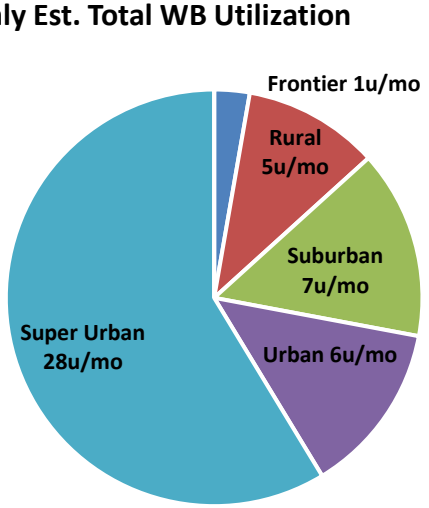
Number of counties – simple count by population category

Monthly Total WB Utilization – Sum of Monthly Average plus Air Medical Utilization*

a. **Air Medical WB Utilization is based on % of Utilization across the Frontier, Rural, and Suburban Counties.*

Estimated Monthly Cost Per Unit – (Monthly Total WB Utilization X Number of Counties) X $500.00

Estimated Annual Cost – Estimated Monthly Cost X 12



Next, we applied the same math to the State (using the robust STRAC Data Set, same math, same starting point)

Population (2023)	Population Category	Aggregate 2yr Total WB Utilization	Monthly Average WB Utilization (Agg2yr/24)	Add Air Medical WB Utilization*	Monthly Total WB Utilization (Avg+AM)	# Counties/ State (254)	Estimated Monthly Cost Per Unit $500 (Mo Ut*# Co)	Estimated Annual Cost (Mo Cost*12)
< 10,000	Frontier	12.00	0.50	0.82	1.32	92	$ 60,704.92	$ 728,459.02
10,001 - 50,000	Rural	46.00	1.92	3.14	5.06	89	$ 225,114.07	$ 2,701,368.85
50,001 - 99,999	Suburban	64.00	2.67	4.37	7.04	30	$ 105,573.77	$ 1,266,885.25
100,000 - 999,999	Urban	154.00	6.42	NA	6.42	36	$ 115,500.00	$ 1,386,000.00
1M-2.99M	Super Urban	676.00	28.17	NA	28.17	6	$ 84,500.00	$ 1,014,000.00
≥3M	HOU-BER URBAN	NA	29.50	NA	29.50	1	$ 14,750.00	$ 177,000.00
	TOTALS	**952.00**	**69.17**	**8.33**	**77.50**		**$ 606,142.76**	$ 7,273,713.11

Aggregate 2yr Total WB Utilization – pulled directly from STRAC regional utilization data; example Frontier Counties:

a. *There are 6 frontier counties in the STRAC region*
b. *We have data on 1 of the 6 frontier counties*
c. *Average = sum of units used monthly divided by 1 county*

Number of counties – simple count by population category

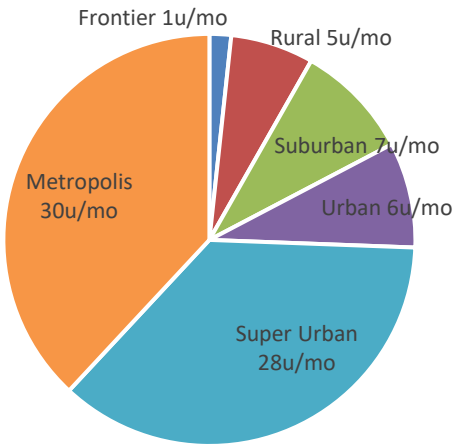
Monthly Total WB Utilization – Sum of Monthly Average plus Air Medical Utilization*

a. **Air Medical WB Utilization is based on % of Utilization across the Frontier, Rural, and Suburban Counties.*

Estimated Monthly Cost Per Unit – (Monthly Total WB Utilization X Number of Counties) X $500.00

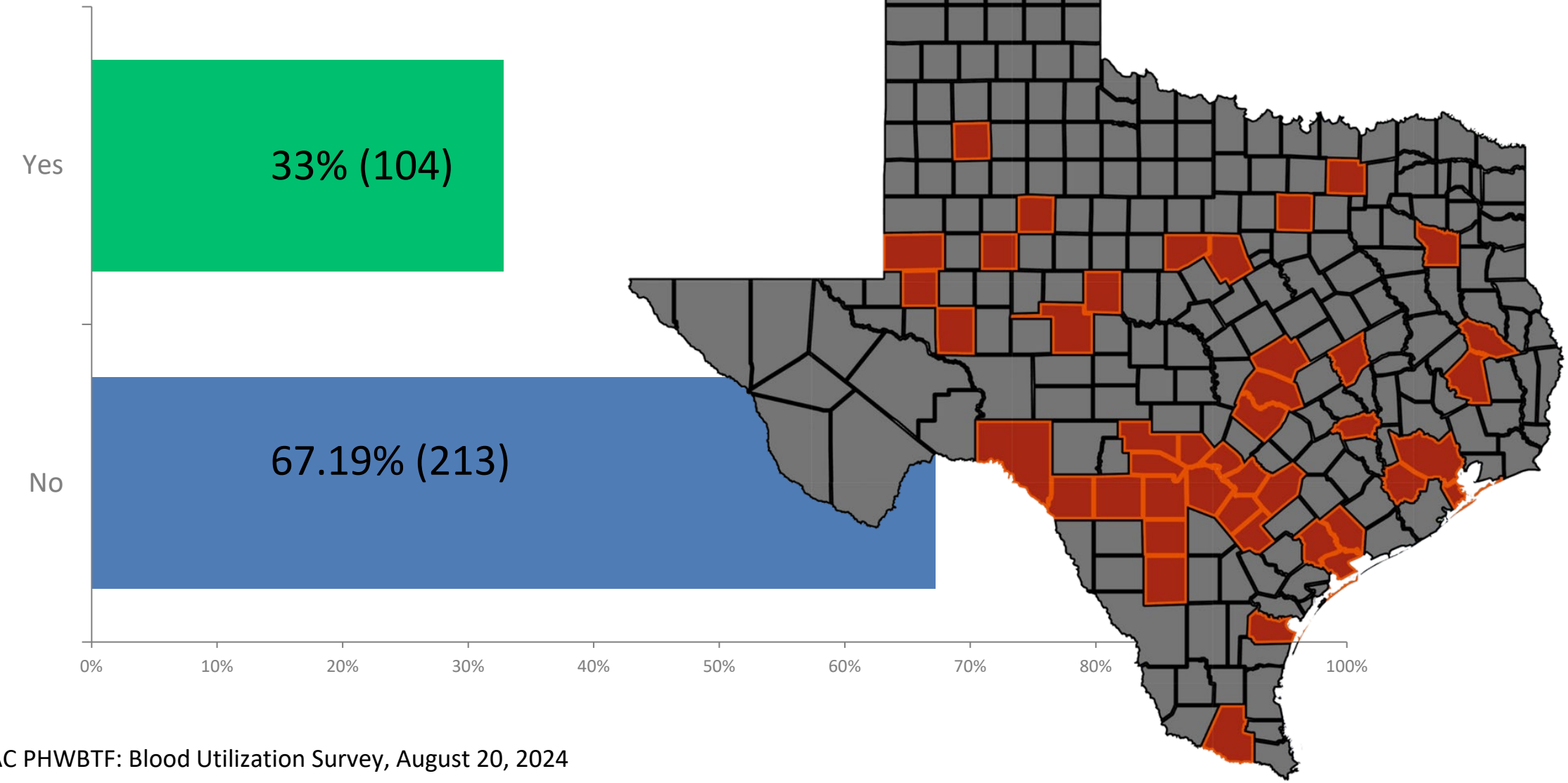
Estimated Annual Cost – Estimated Monthly Cost X 12

Monthly Est. Total WB Utilization



From the Survey Monkey data presented at the August GETAC PHWBTF, we asked how many Prehospital agencies currently have whole blood programs.

Answered: 317 Skipped: 0



Each EMTF Region has at least one Level I Trauma Center that could potentially be used as a Blood Bank:

TX EMTF 1

Lead RAC: Panhandle RAC
TSAs: A & B ~ HSR 1
www.PanhandleRAC.com

TX EMTF 2

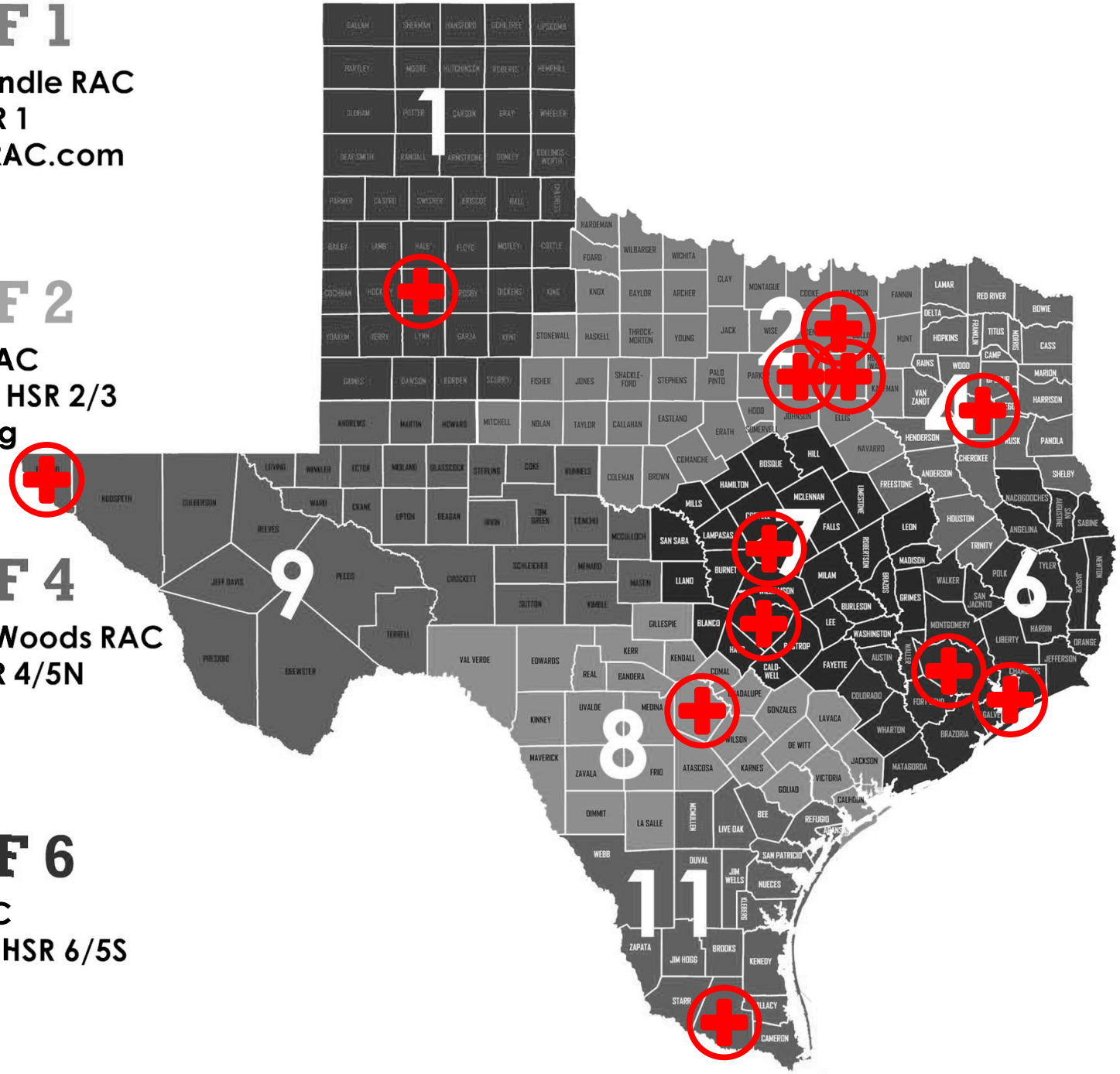
Lead RAC: NCTTRAC
TSAs: C, D, & E ~ HSR 2/3
www.NCTTRAC.org

TX EMTF 4

Lead RAC: Piney Woods RAC
TSAs: F & G ~ HSR 4/5N
www.RAC-G.org

TX EMTF 6

Lead RAC: SETRAC
TSAs: H, Q, & R ~ HSR 6/5S
www.SETRAC.org



TX EMTF 7

Lead RAC: Capital Area Trauma RAC
TSAs: L, M, N, & O ~ HSR 7
www.CATRAC.org/EMTF

TX EMTF 8

Lead RAC: STRAC
TSAs: P & S ~ HSR 8
www.STRAC.org

TX EMTF 9

Lead RAC: Border RAC
TSAs: I, J, & K ~ HSR 9/10
www.BorderRAC.org

TX EMTF 11

Lead RAC: CBRAC
TSAs: T, U, & V ~ HSR 11
www.CBRAC.org

Governor's EMS and Trauma Advisory Council

Pre-Hospital Whole Blood Task Force: State Blood Utilization & Cost Estimate

Questions?

Presented November 22, 2024

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

2024 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: Chief Hayes is leading the newly created committee workgroup to discuss the ever-increasing concern and problem of workplace violence in EMS / Public Safety. The workgroup has had two meetings this last quarter with the support of DSHS staff. Previously, the Committee's White Paper on the use of RLS. With the committee returning to full 17-member participation in 2025, we will include a workgroup that focuses on the appropriate use of RLS (red lights & sirens).	
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. Forming workgroup to lead this charge.*	
Reduction of EMS Wall Times in Texas and analyze the impact of the associated white papers on the issue.	Gained Council approval to form a wide collaborative Task Force to analyzes and make recommendations regarding “Wall time reductions” across Texas. Reduce the EMS quantity of “Wall time incidents” by measuring acceptable defined “Patient hand off times” by 80%.	

Action Item Request and Purpose

- Please provide a **single**, clear and concise statement defining your action item request:

The EMS Committee formerly request approval to collaborate with DSHS staff to submit a violence in the workplace and other safety impactful survey questions to Texas EMS providers.

- In **one** clear and concise statement, please explain the purpose for this request:

To gather data for the workgroup to provide proper analysis of the scope of the potential problem and direct the focus of the workgroup.

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.

Identify the scope of problem and goal-directed solutions for the EMS and Education Committee workgroup.

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

Survey will be completed in 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

GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Prehospital Stroke Recommendations	EMS Acute Stroke Routing Resource Documents for Urban, Suburban, and Rural. Routing Documents are recommendations to be acted on by RACs and/or Agency EMS Medical Directors as best practice per national guidelines. Mission Lifeline Algorithm Revisions. Voted on and Approved. Door in/Door out Performance Measure Revisions Voted on and Approved.	
Prehospital Stroke Recommendations	Pediatric Stroke Triage Algorithms. The Pediatric algorithms are currently being revised by GETAC Stroke Committee. In Process.	

GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
System Performance Improvement	Requirements for Trauma will require PI feedback from hospital partners prehospital system. Explanation provided by DSHS EMS/Trauma Systems Director. This feedback would preferentially be provided to and acted upon by the agency EMS Medical Director. Information discussed and no concerns.	
System Performance Improvement	All trauma certified hospitals will have a process to record wristbands placed on prehospital trauma patients. Information discussed and no concerns.	
System Performance Improvement	Recommended by GETAC EMS Medical Directors that wristband process be deployed in a way to provide continuity of registry and tracking. Multiple comments on this item. Recommend unique numbers for wristband. Recommend to hospitals wristband number is a discrete searchable field. Feedback from EMS MD Committee will be brought back to appropriate groups for consideration.	

GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
EMS Education	EMS State Director discussed success of SB 8 and education for EMTs. Potential for future funding discussed. Discussed survey organization understanding and expectations of hospital role in EMS education and training. Explanation provided by DSHS Director of State Trauma Services with follow up plan to be implemented.	
Prehospital Transfusion Recommendations	Participate in the GETAC Prehospital Whole Blood Transfusion Task Force. Active.	
Prehospital Transfusion Recommendations	Freeze dried plasma needs to be discussed at next GETAC EMS MD meeting. In Process	

GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
EMS Wall Time Recommendations	Participate in EMS Wall Time Task Force. Wall time document produced and available to public.	
Prehospital Pediatric Care	Pediatric NEMSIS is live. Examples, pediatric asthma, hypoglycemia, shock and effective pain management, and trauma vitals. Information discussed and no concerns.	
Prehospital Pediatric Care	EMS Medical Directors have asked EMSC to present on national best practice for pediatric restraint in ambulances.	
Prehospital MCI Heat Algorithm/Resource Document	Goal is to present a document, references, and resources and discuss at next GETAC EMS MD Committee Meeting.	

7.g. GETAC Injury Prevention & Public Education Committee

Chair: Mary Ann Contreras, RN

Vice-Chair: Courtney Edwards, DNP

IPPE Committee

11/2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Pediatric Concussion/Head injury Education IPPE collaboration with Pediatric Committee	*Completed- Pediatric Committee, pending Council for approval*	
2. Create Social Ecological model framework for Suicide Prevention best practice paper	Wrapping up evidence informed strategies and recommendations and effective methodologies with applicable resources and citations.	
3. Create Social Ecological model framework for Safe Storage best practice paper	Wrapping up evidence informed strategies and recommendations and effective methodologies with applicable resources and citations.	

IPPE Committee

11/2024 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**	
5. Pediatric Magnet/Battery ingestion Education IPPE collaboration with Pediatric Committee	Wrapping up	

Action Item Request and Purpose

- Requesting Council to review *Social Ecological Model of Suicide Prevention and Safe Firearm Storage* document for approval and or revisions in January 2025 Strategic Planning Retreat
- Requesting for Dr. Jeff Temple to give a VIPR project overview of the newly awarded $4.25 million dollar CDC grant in the March Council meeting.

7.h. GETAC Pediatric Committee

Chair: Christi Thornhill, DNP

Vice-Chair: Belinda Waters, RN

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 has started research and will be leading this workgroup. 2. Workgroup has held several meetings. 3. Working on a resource toolkit for website	
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.	

Action Item Request and Purpose

- Please provide a **single**, clear and concise statement defining your action item request:
  - Request the 6 simulations approved by the Pediatric Committee be approved by the GETAC Executive Council
  - 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 approved by the GETAC Council and posted to the DSHS website.
- 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.
  - November 2024

7.h.A. Action Item: Head Injury/Concussion Toolkit

7.h.B. Update: TX Pediatric Readiness Improvement Project

Pediatric Readiness Improvement Project TEXAS

Texas Pediatric Readiness Improvement Project Update

GETAC November 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

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 1-10

Education Series Stats

Session	Topic	Registrants	Webinar Attendees (unique viewers)	CE Awarded
Session 1	Overview of the Texas Pediatric Readiness Improvement Initiative	404	227	247
Session 2	ESI/Pediatric Assessment and Triage	993	351	311
Session 3	Respiratory Distress	1238	312	262
Session 4	Traumatic Brain Injury	1341	312	210
Session 5	Non-Accidental Trauma (Child Maltreatment)	1404	259	183
Session 6	Long-bone Fractures and Pain Management	1468	270	208
Session 7	Pediatric Ingestions	1488	236	212
Session 8	Shock Recognition and Management	1528	240	175
Session 9	Neonatal Resuscitation	1567	219	158
Session 10	Pediatric Resources for EDs	1590	141	N/A

IMPACT on TEXAS HOSPITALS

Find My Regional PECC

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

- Regional Pediatric Emergency Care Coordinators
  - 30 R-PECCs in 22 RACs
- Hospitals across the State with significant contacts
  - 238 in 22 RACs. All have agreed they are open to Pediatric Readiness.
- Simulations conducted in Emergency Departments
  - 692 sims in 21 RACs (all but 1 RAC has conducted sims)
- Number of staff participants in simulation scenarios
  - **2,649+ people in 21 RACs since early February**.

Texas Pediatric Readiness Project

Evaluation Summary Metrics

Sessions 1 – Sessions 9

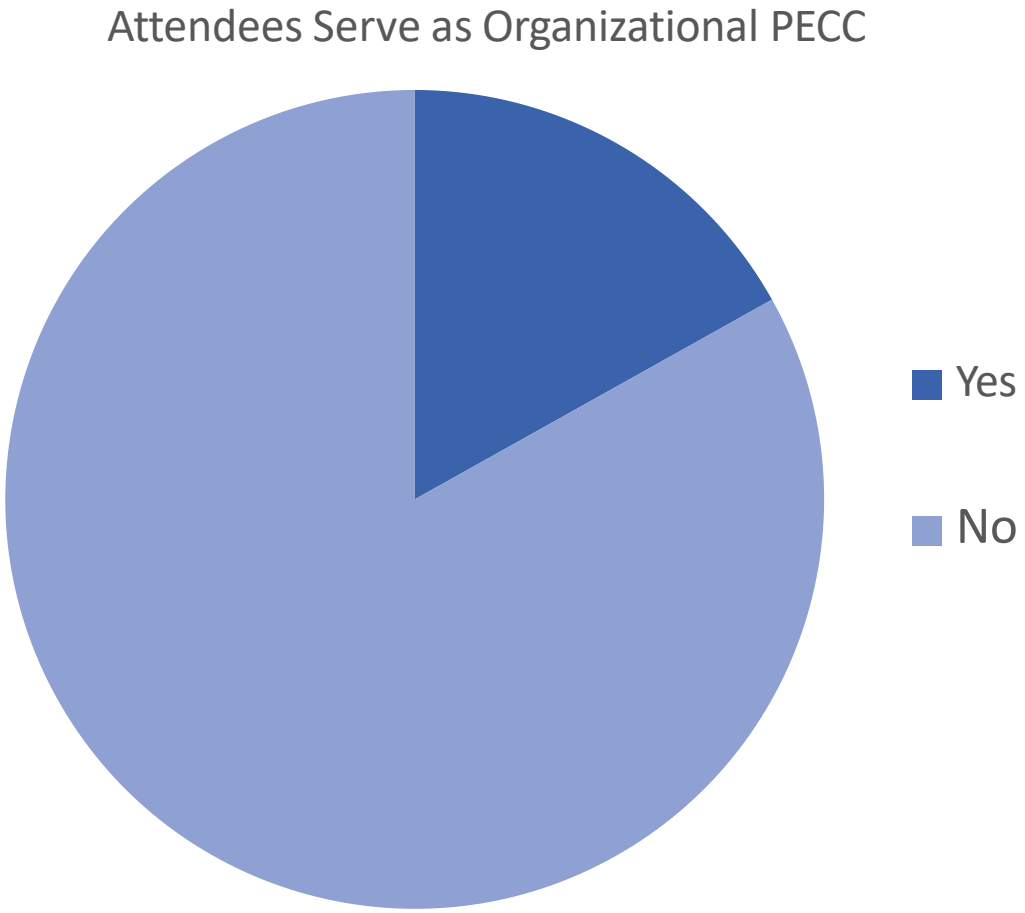
TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

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

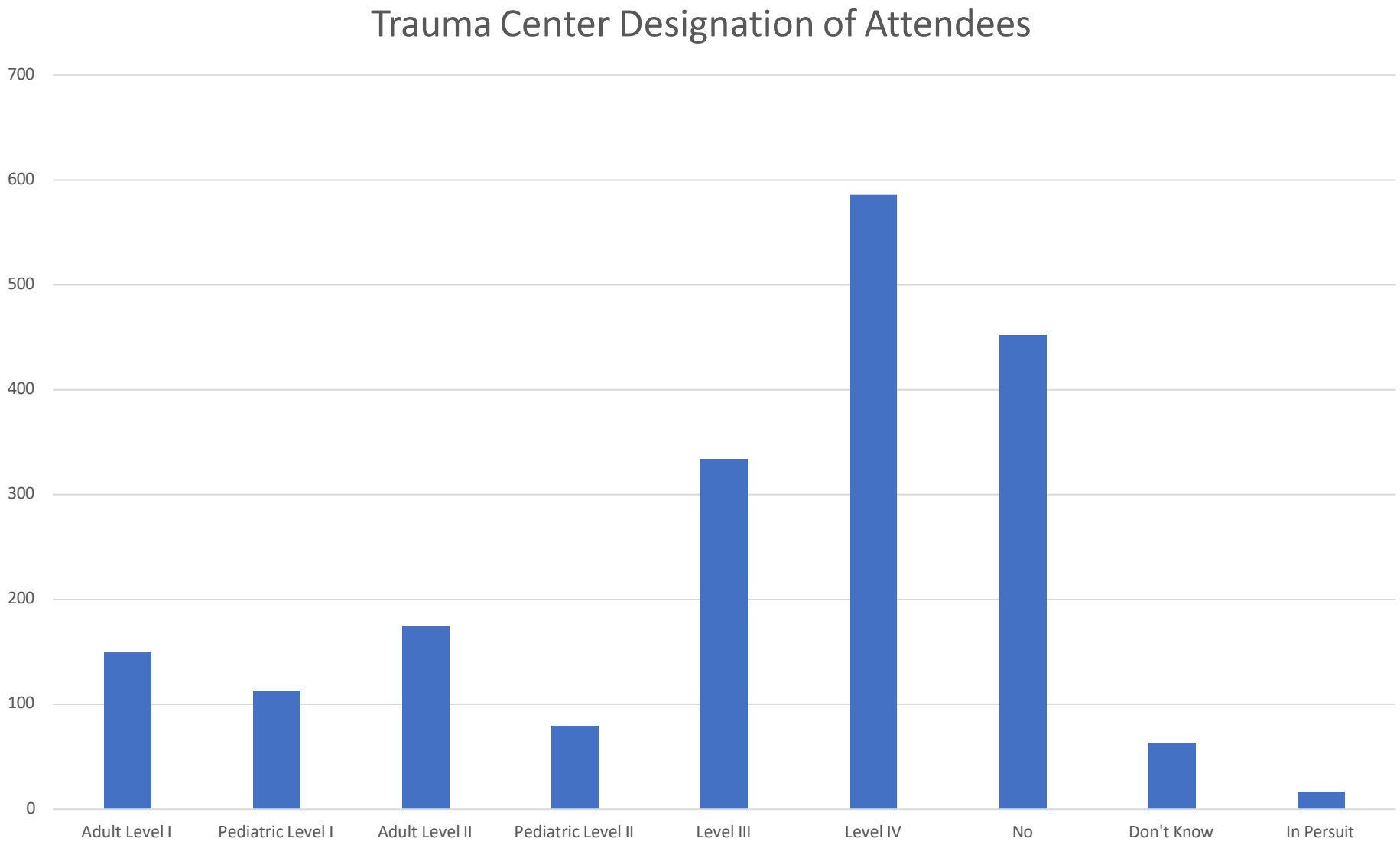
Continuing Professional Development: Summary

	Topic	NCPD Attendance	Average Evaluation Score
Session 1	Pediatric Readiness Initiative	247	4.72
Session 2	Triage & ESI	311	4.80
Session 3	Respiratory	262	4.71
Session 4	TBI	210	4.76
Session 5	Child Maltreatment	183	4.90
Session 6	Long Bone Fractures	208	4.86
Session 7	Ingestions	212	4.84
Session 8	Shock	175	4.82
Session 9	Newborn Resuscitation	158	4.81
Total Continuing Professional Development Hours Awarded		**1966**	**4.80**

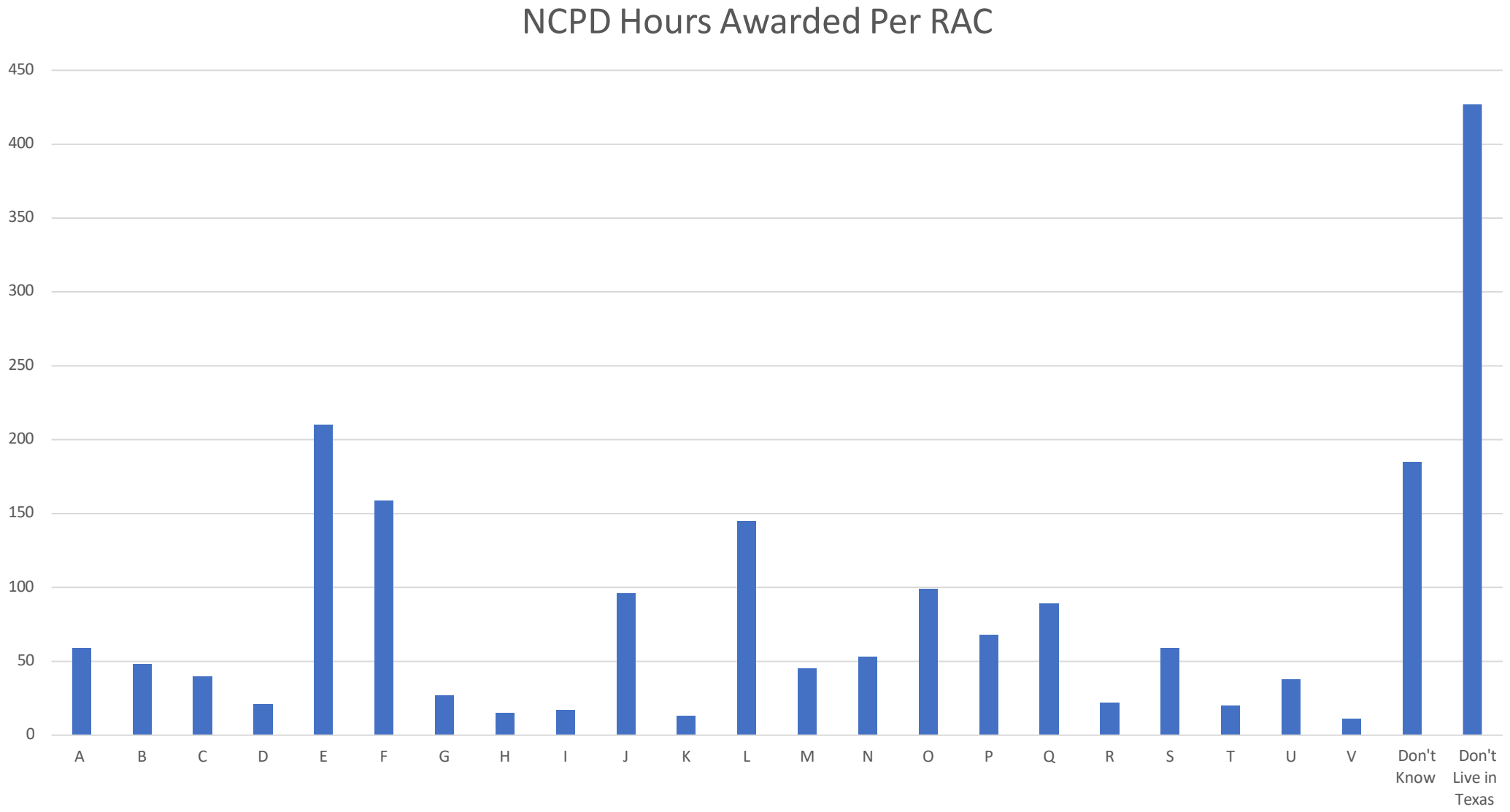
Continuing Professional Development: Summary



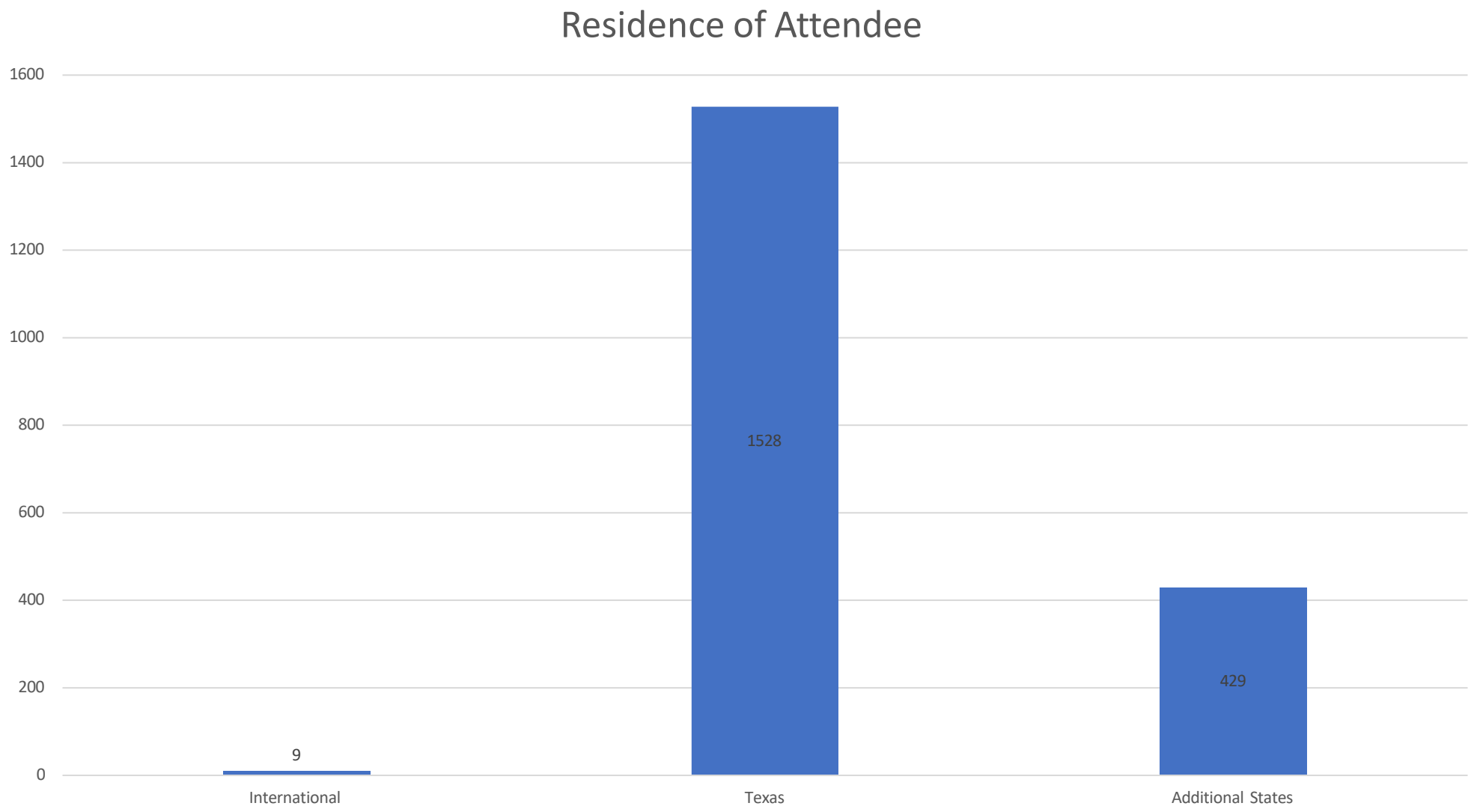
Continuing Professional Development: Summary



Continuing Professional Development: Summary



Continuing Professional Development: Summary

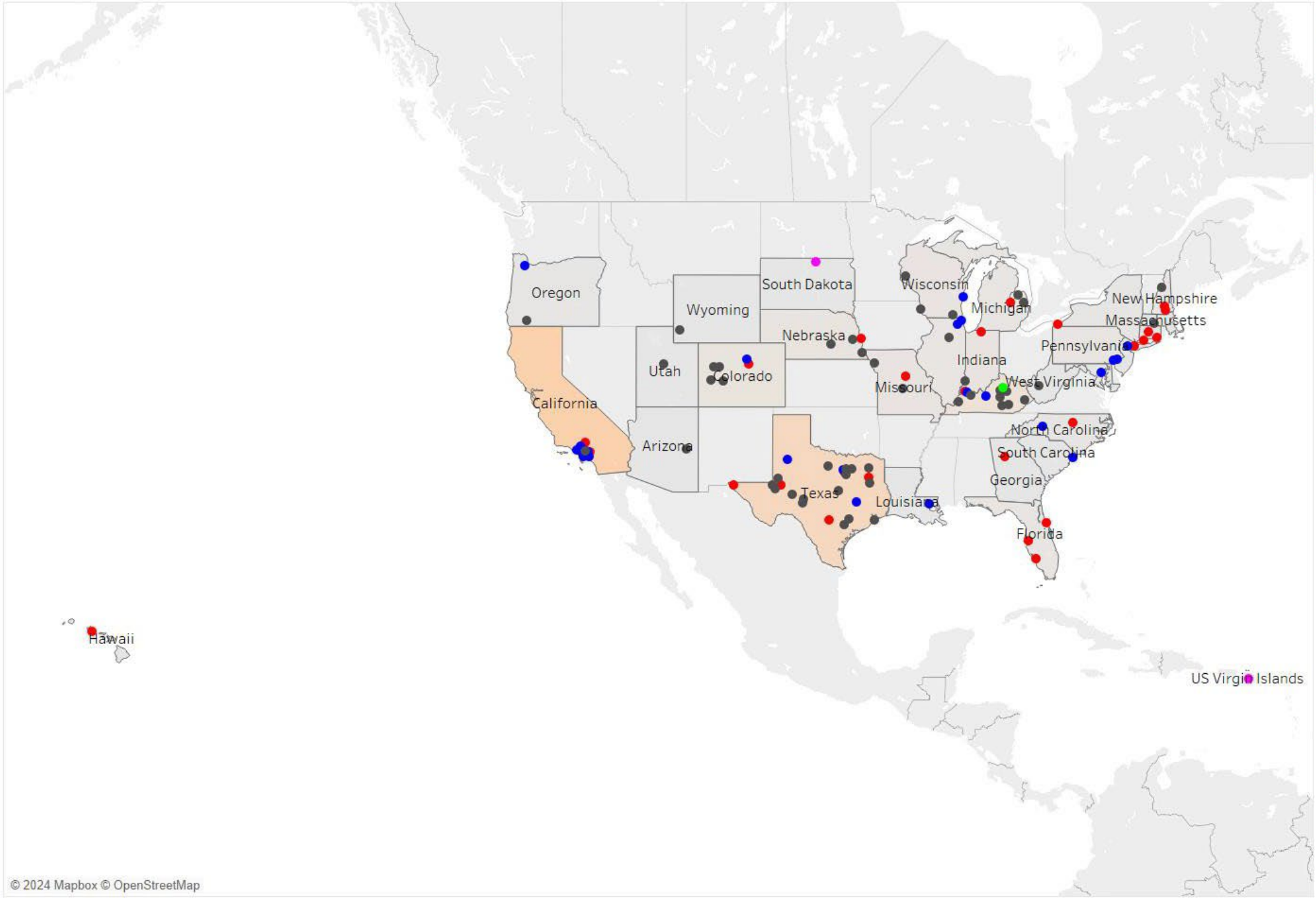


National PRQI

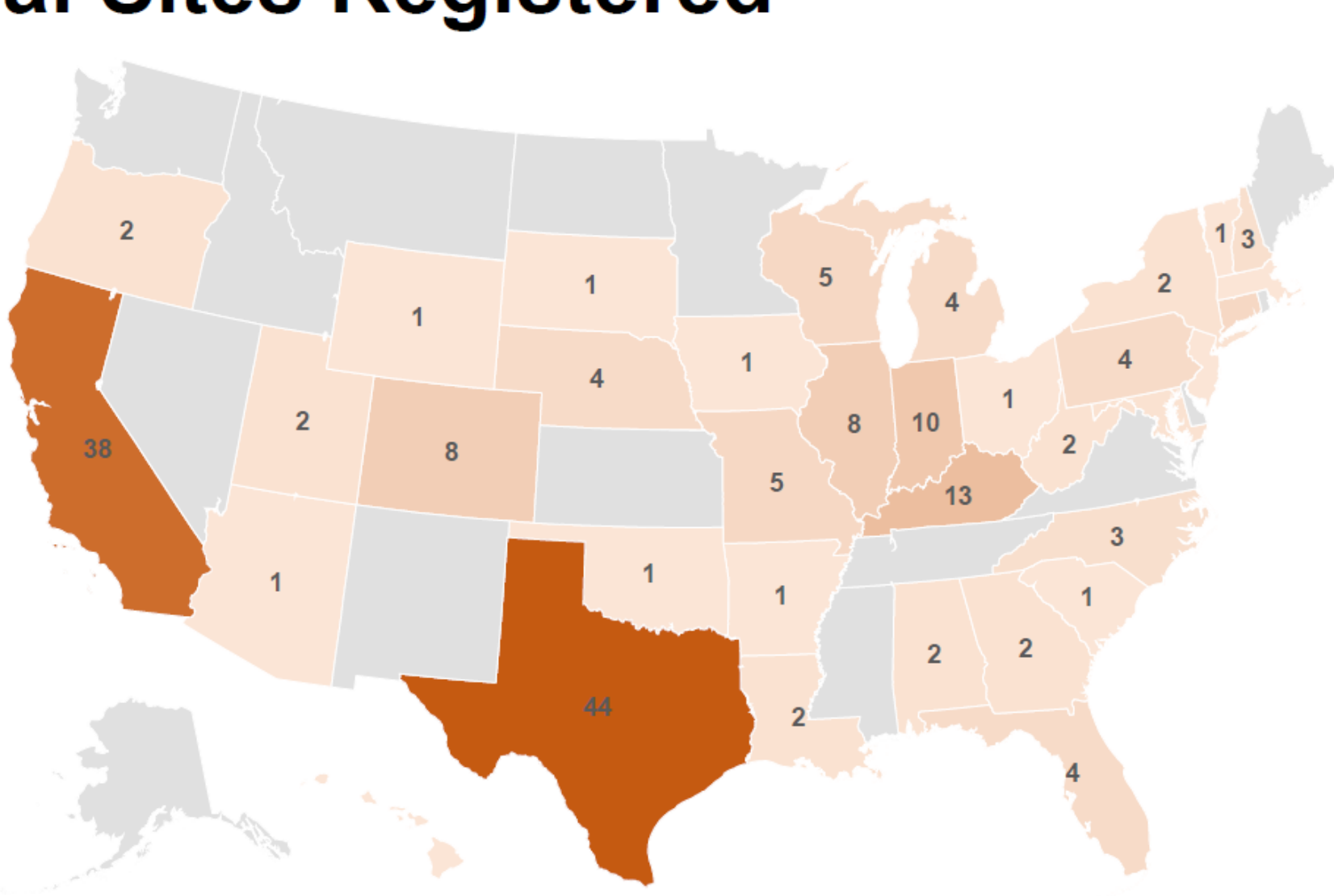
Pediatric Readiness Quality Initiative

Measure • Reflect • Improve

NPRQI Update


Distinct count of Clms Id
1
36
Geographic Location
None of these apply
Remote
Rural
Suburban
Urban
Oregon
Wyoming
South Dakota
Wisconsin
Michigan
New Hampshire
Massachusetts
Nebraska
Pennsylvania
Indiana
Utah
Colorado
Missouri
West Virginia
California
North Carolina
Arizona
South Carolina
Georgia
Texas
Louisiana
Florida
Hawaii
US Virgin Islands
© 2024 Mapbox © OpenStreetMap

National Sites Registered



National PRQI
Pediatric Readiness Quality Initiative
Measure • Reflect • Improve

Data from PRQC

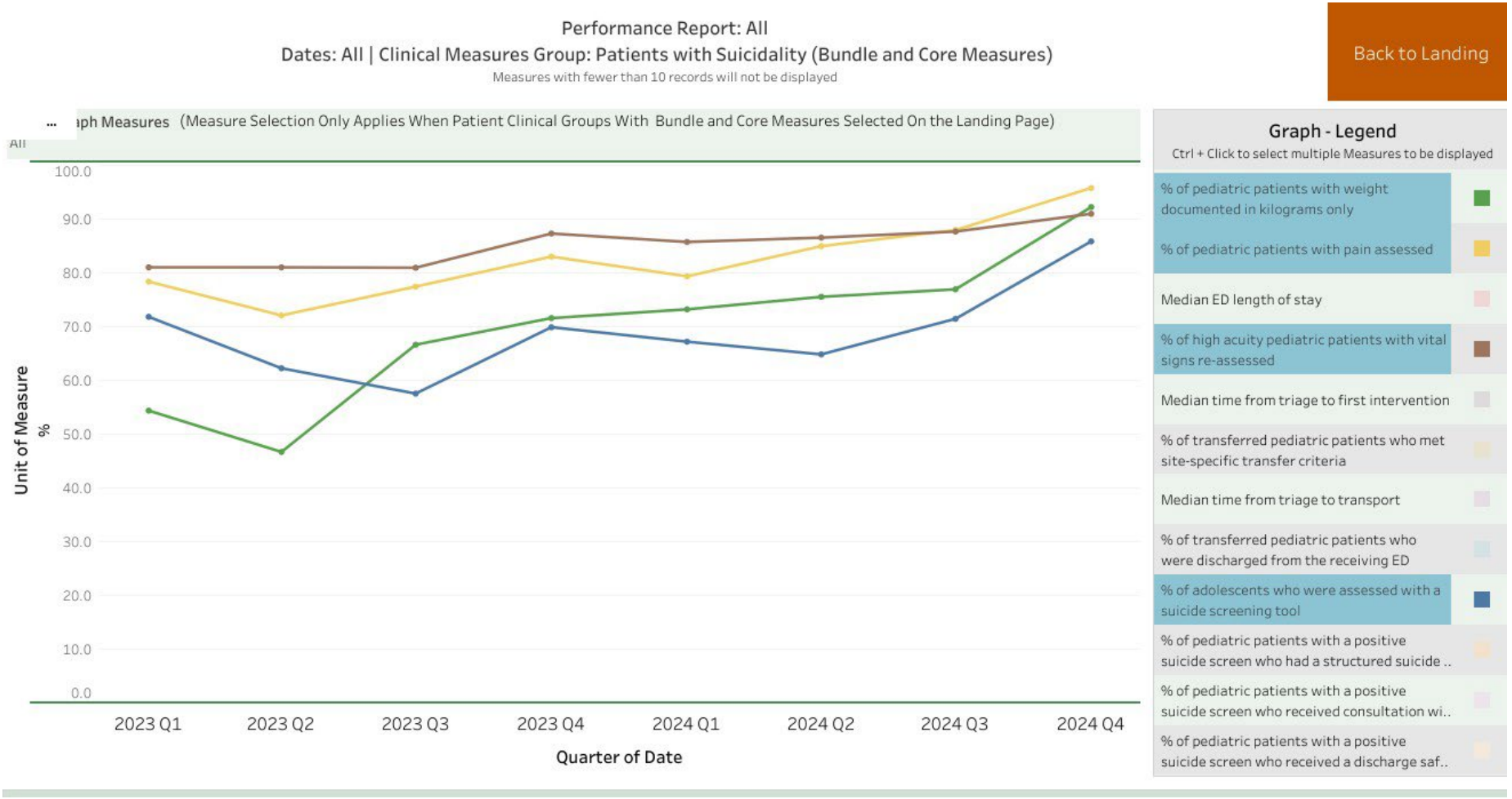
National PRQI
Pediatric Readiness Quality Initiative
Measure • Reflect • Improve

Patient Safety

Abnormal Vital Signs

Pain Assessment

Suicidality



National PRQI

Pediatric Readiness Quality Initiative

Measure • Reflect • Improve

Texas Sites Profiles

Participating Texas Sites

National PRQI
Pediatric Readiness Quality Initiative
Measure • Reflect • Improve

B-B
University Medical Center

C-North Texas
Graham Hospital District

E- North Central Texas
Baylor All Saints Medical Center at Fort Worth
Medical City ER Saginaw
Methodist Richardson Medical Center
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
Ward Memorial Hospital
Winkler County Memorial Hospital

K-Concho Valley
Lillian M. Hudspeth Memorial Hospital
Reagan Hospital District
Schleicher County Medical Center

L-Central Texas
Coryell Memorial Hospital

Sites with executed POAs as of November 14, 2024

Participating Texas Sites

National PRQI
Pediatric Readiness Quality Initiative
Measure • Reflect • Improve

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
Cuero Regional Hospital

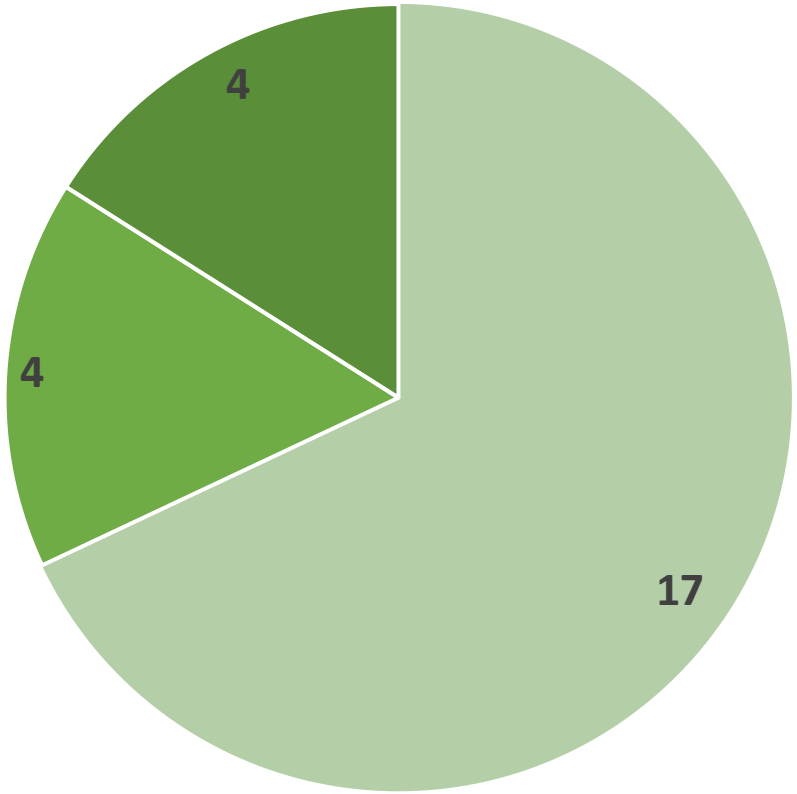
Sites with executed POAs as of November 14, 2024

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.

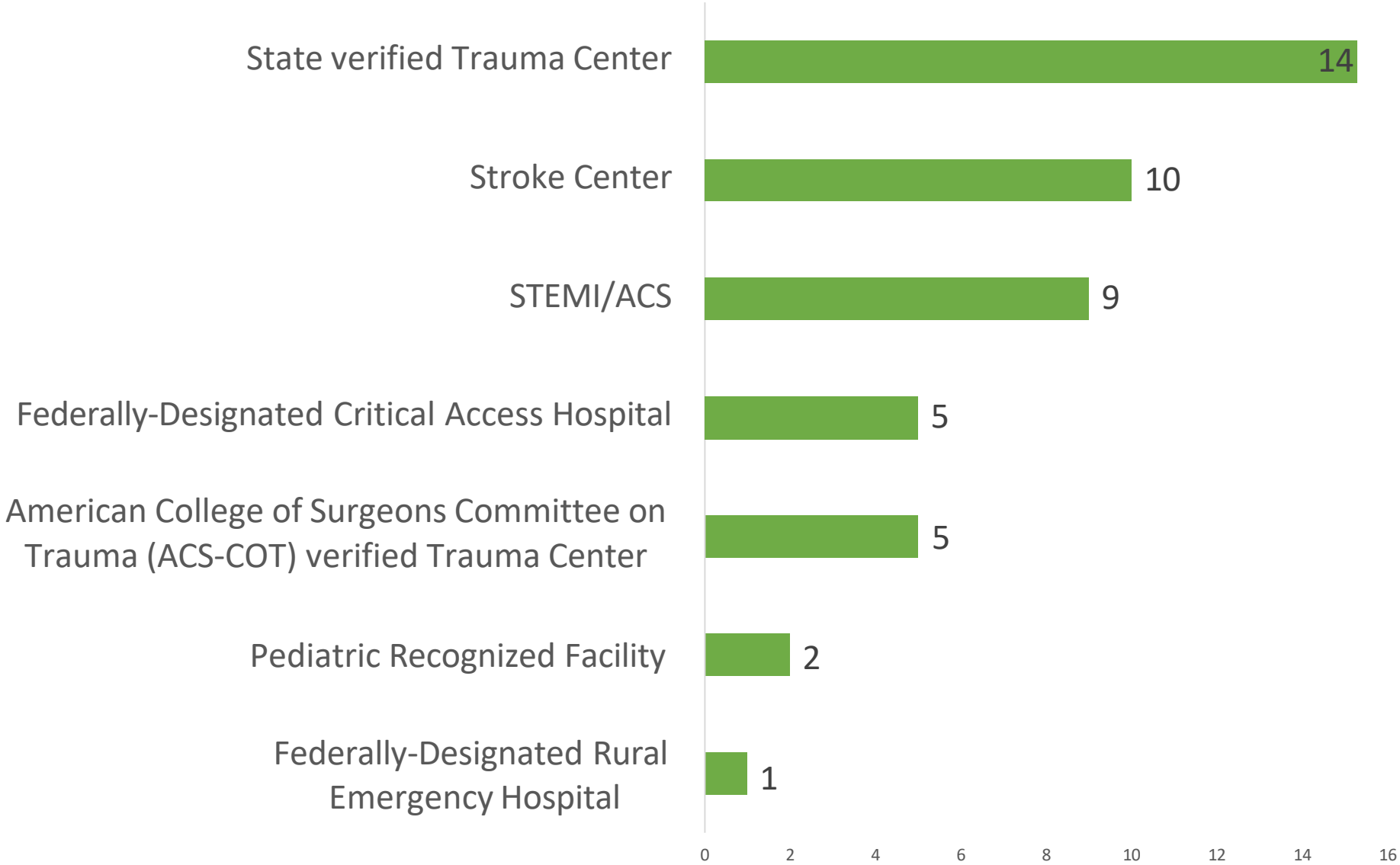
Note: NPRQI offers office hours to participating EDs regarding data sampling strategies, getting started with data entry, and data interpretation.

Texas Sites
Annual Pediatric Volume



Texas Sites Specialty Center Status

National PRQI
Pediatric Readiness Quality Initiative
Measure • Reflect • Improve



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

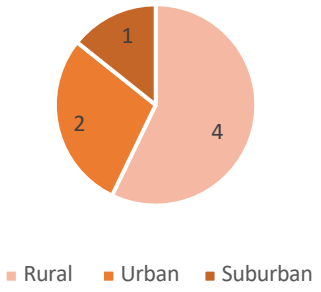
State: Texas | Region: *
7 Sites / 467 Records

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

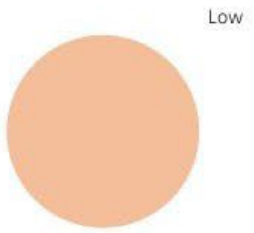
Year	Quarter	Region	Results View	Patient Clinical Group
Select all that apply	Limit the # of Quarters by selecting Year(s) first			
All	None	All	Table	All Patients (Core Measures)

GO

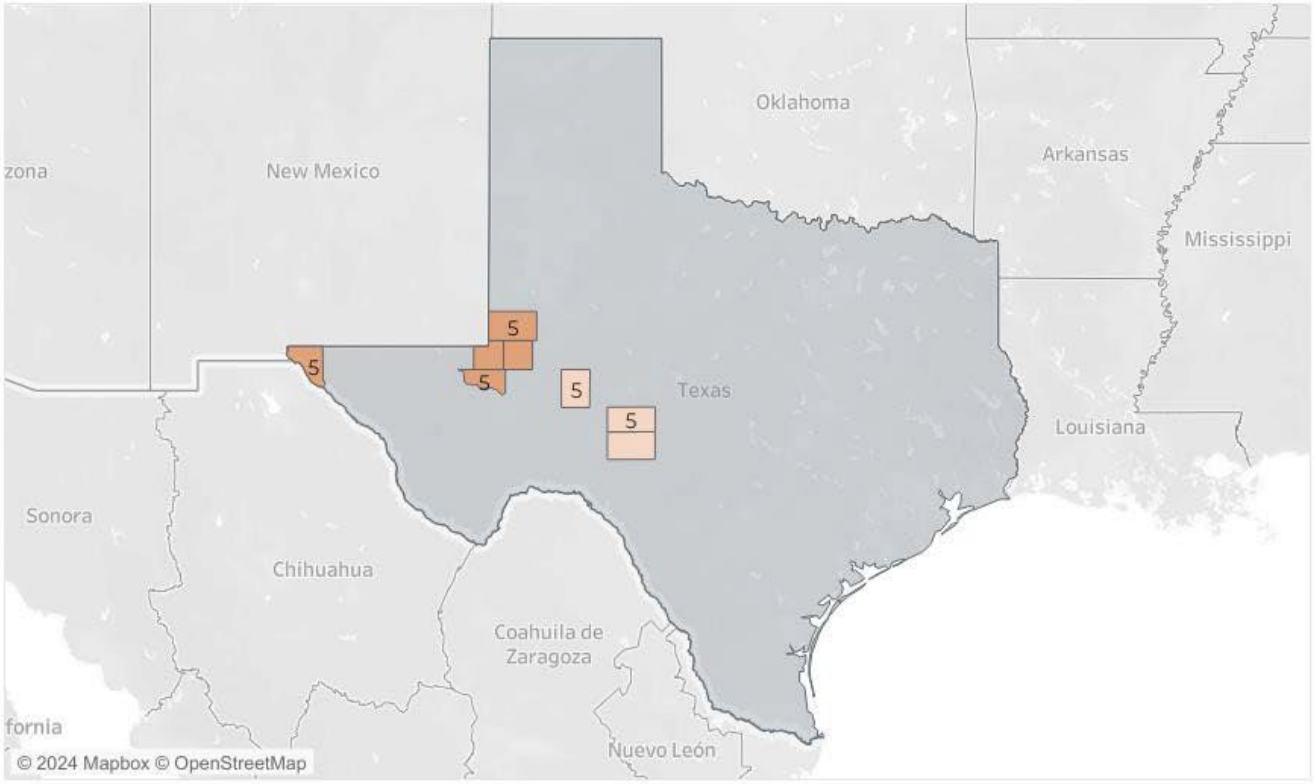
Region I, J, K Sites by Geographic Category



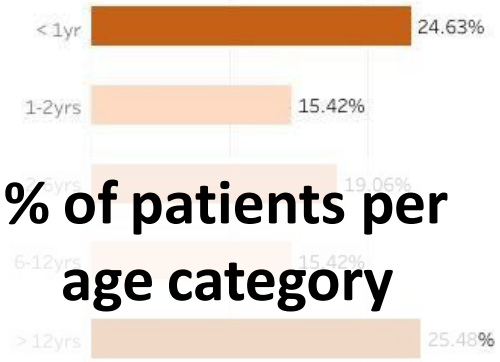
Region I, J, K Sites by Patient Volume



Participation in the National Pediatric Readiness Quality Initative

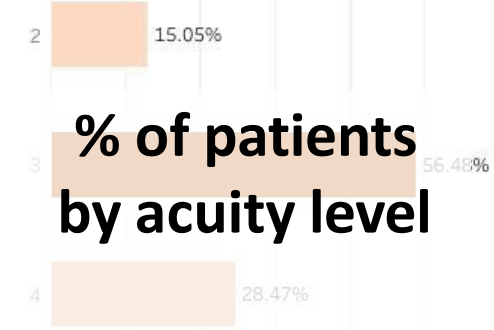


Region I, J, K Patients by Age Category



% of patients per age category

Region I, J, K 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:
11/15/2024 9:54:59 AM
Last Patient Included:
11/13/2024

Site-level dashboard

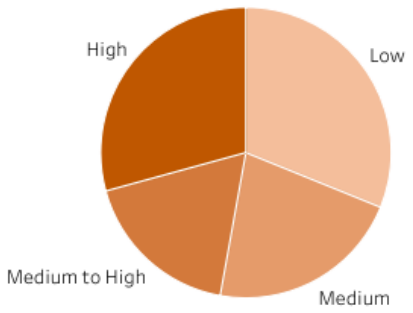
NPRQI Reporting Dashboard
106 Sites / 15,267 Records

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

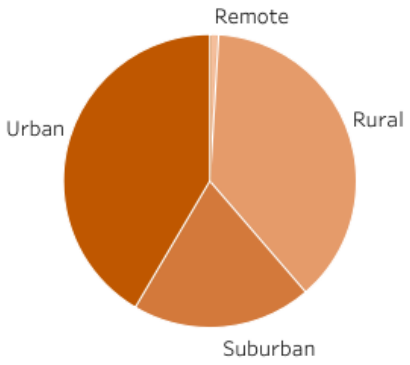
Year	Quarter	Site	Results View	Patient Clinical Group
Select all that apply	Limit the # of Quarters by selecting Year(s) first			
All	All	All	Table	All Patients (Core Measures)

GO

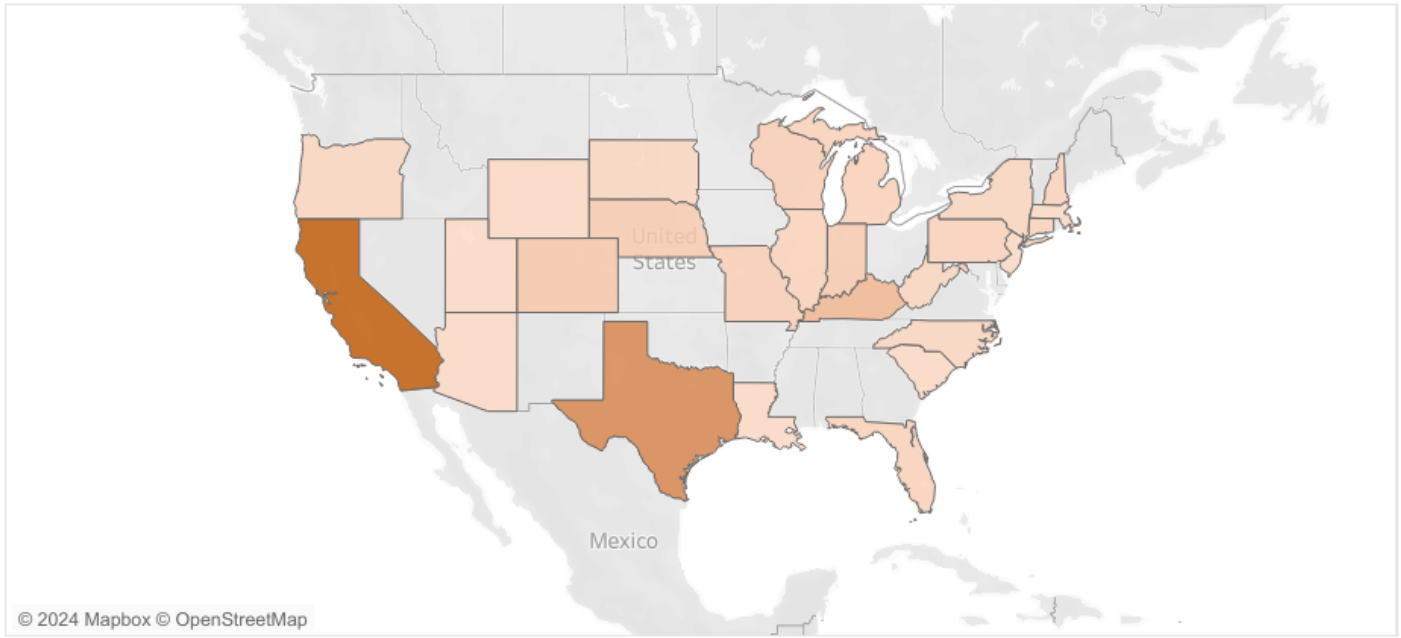
Number of Sites by Patient Volume Category

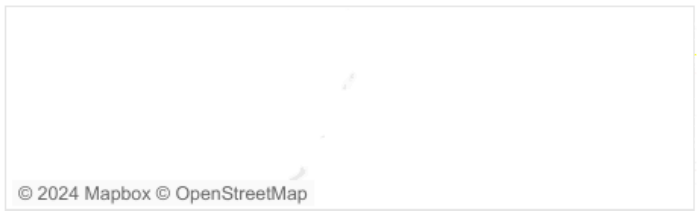


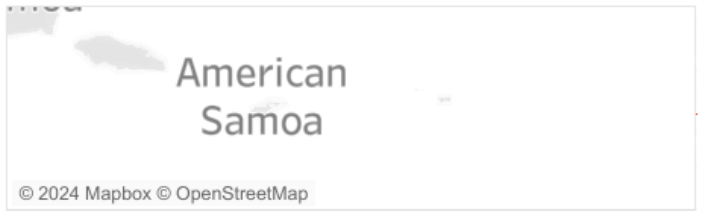
Number of Sites by Geographic Category



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:
11/14/2024 5:55:31 PM
Last Patient Included:
11/13/2024

NPRQI Site Dashboard – Table View (site must enter a minimum of 10 records before data 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

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.

NPRQI Site Dashboard – Graph View

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

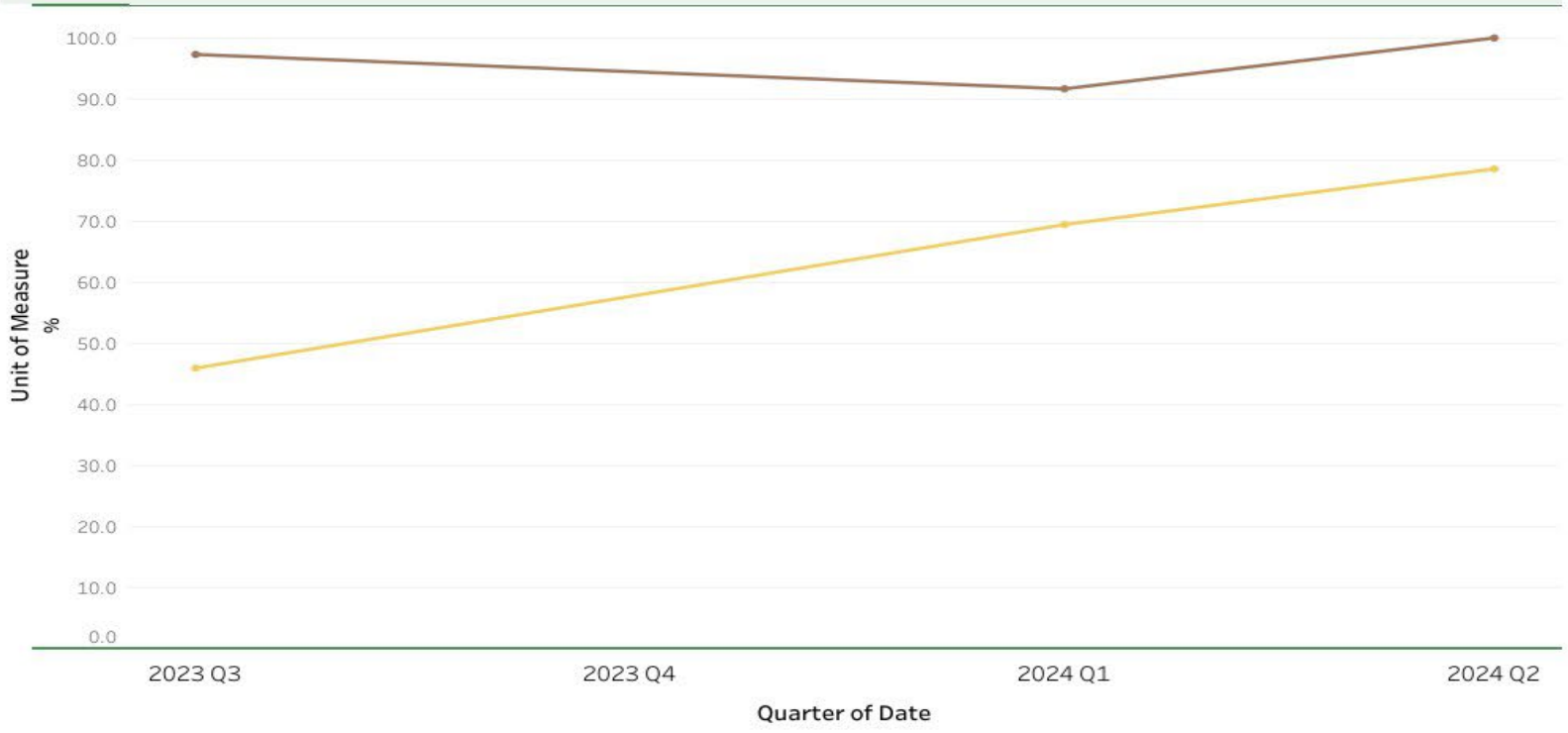
National PRQI
Pediatric Readiness Quality Initiative
Measure • Reflect • Improve

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**

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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

JAMA Network Open

Original Investigation | Emergency Medicine

State and National Estimates of the Cost of Emergency Department Pediatric Readiness and Lives Saved

Craig D. Newgard, MD, MPH; Amber Lin, MS; Jeremy D. Goldhaber-Fiebert, PhD; Katherine E. Remick, MD; Marianne Gausche-Hill, MD; Randall S. Burd, MD, PhD; Susan Malveau, MS; Jennifer N. B. Cook, GCPH; Peter C. Jenkins, MD, MSc; Stefanie G. Ames, MD, MS; N. Clay Mann, PhD, MS; Nina E. Glass, MD; Hilary A. Hewes, MD; Mary Fallat, MD; Apoorva Salvi, MS; Brendan G. Carr, MD, MS; K. John McConnell, PhD; Caroline Q. Stephens, MD, MPH; Rachel Ford, MPH; Marc A. Auerbach, MD; Sean Babcock, MS; Nathan Kuppermann, MD, MPH

Abstract

IMPORTANCE High emergency department (ED) pediatric readiness is associated with improved survival among children receiving emergency care, but state and national costs to reach high ED readiness and the resulting number of lives that may be saved are unknown.

OBJECTIVE To estimate the state and national annual costs of raising all EDs to high pediatric readiness and the resulting number of pediatric lives that may be saved each year.

DESIGN, SETTING, AND PARTICIPANTS This cohort study used data from EDs in 50 US states and the District of Columbia from 2012 through 2022. Eligible children were ages 0 to 17 years receiving emergency services in US EDs and requiring admission, transfer to another hospital for admission, or dying in the ED (collectively termed at-risk children). Data were analyzed from October 2023 to May 2024.

EXPOSURE EDs considered to have high readiness, with a weighted pediatric readiness score of 88 or above (range 0 to 100, with higher numbers representing higher readiness).

MAIN OUTCOMES AND MEASURES Annual hospital expenditures to reach high ED readiness from current levels and the resulting number of pediatric lives that may be saved through universal high ED readiness.

RESULTS A total 842 of 4840 EDs (17.4%; range, 2.9% to 100% by state) had high pediatric readiness. The annual US cost for all EDs to reach high pediatric readiness from current levels was $207 335 302 (95% CI, $188 401 692-$226 268 912), ranging from $0 to $11.84 per child by state. Of the 7619 child deaths occurring annually after presentation, 2143 (28.1%; 95% CI, 678-3608) were preventable through universal high ED pediatric readiness, with population-adjusted state estimates ranging from 0 to 69 pediatric lives per year.

CONCLUSIONS AND RELEVANCE In this cohort study, raising all EDs to high pediatric readiness was estimated to prevent more than one-quarter of deaths among children receiving emergency services, with modest financial investment. State and national policies that raise ED pediatric readiness may save thousands of children's lives each year.

Key Points

Question What are the state and national costs of raising all emergency departments (EDs) to high pediatric readiness and the potential number of lives saved?

Findings In this cohort study of 4840 EDs across the US, 842 (17.4%) had high pediatric readiness and the annual cost to reach high pediatric readiness was $207 335 302, ranging from $0 to $11.84 per child by state. An estimated 2143 pediatric lives may be saved each year through universal high ED pediatric readiness.

Meaning These results suggest that raising all EDs to high pediatric readiness would potentially save thousands of pediatric lives each year, with modest financial investment.

+ Invited Commentary

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

JAMA Network Open. 2024;7(11):e2442154. doi:10.1001/jamanetworkopen.2024.42154

The New York Times

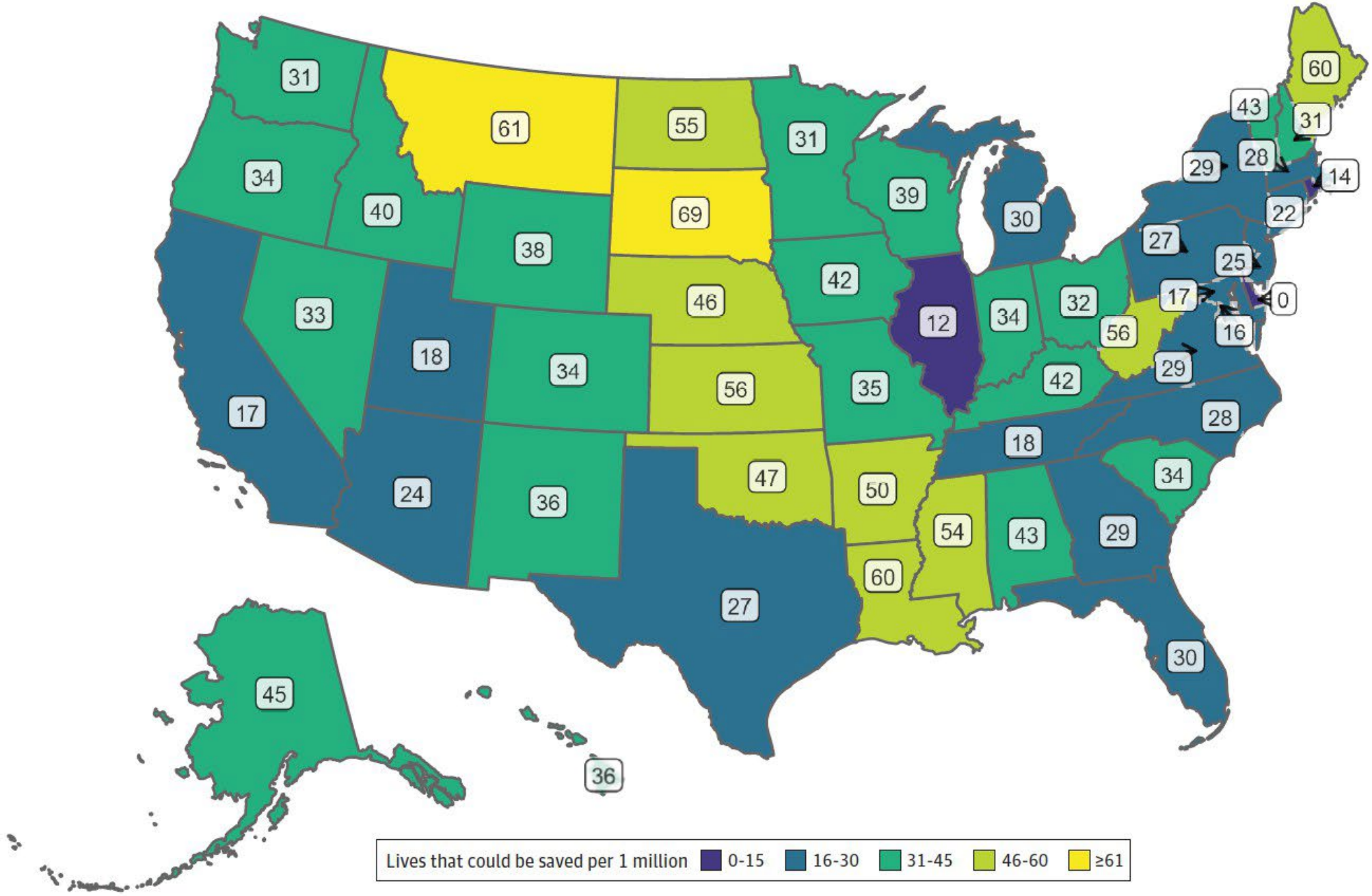
1 in 4 Child Deaths After E.R. Visits Are Preventable, Study Finds

If every emergency room in the United States were fully prepared to treat children, thousands of lives would be saved and the cost would be $11.84 or less per child, researchers found.

Data from 4,840 emergency rooms across the United States found that 842 of them — less than one-fifth — were considered well-prepared for pediatric emergencies. Hiroko Masuike/The New York Times

By Emily Baumgaertner

Figure 4. Population-Adjusted Estimates for the Annual Number of Pediatric Lives Saved Through Universal High ED Pediatric Readiness by State



Summary

- This project is impacting hospitals in every RAC
- Hospitals are identifying PECCs and participating in NPRQI
- Hospitals are completing their NPRP assessment, identifying gaps and implementing action plans
- ED staff and EMS providers are participating in pediatric trauma simulation
- Regional PECCs are making a difference in hospital engagement and handing off simulation to H-PECCs
- RAC Leaders have been invaluable to supporting this project!
- 5 RACs have purchased Laerdal simulators for all their member hospital.
- On September 1, 2025 Trauma Centers will be held to the trauma rules requiring EDs to be PEDS READY

Texas Pediatric Readiness Improvement Project Contacts

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kate.remick@austin.utexas.edu
samuel.vance@bcm.edu

7.i. GETAC Stroke Committee

Chair: Robin Novakavic-White, MD

Vice-Chair: Sean Savitz, MD

GETAC Stroke Committee

New Members

- Jennifer Burwell
- Dr. Amanda Jagolino-Cole
- Michelle Steiner
- Amanda Webb
- Chantel Molina
- Melanie Aluotto

Thank You for Service

- Dr. Johanna Morton
- Ashley Garza

Returning Members

- Candace McAlpine
- Tory Cairns

Stroke Committee

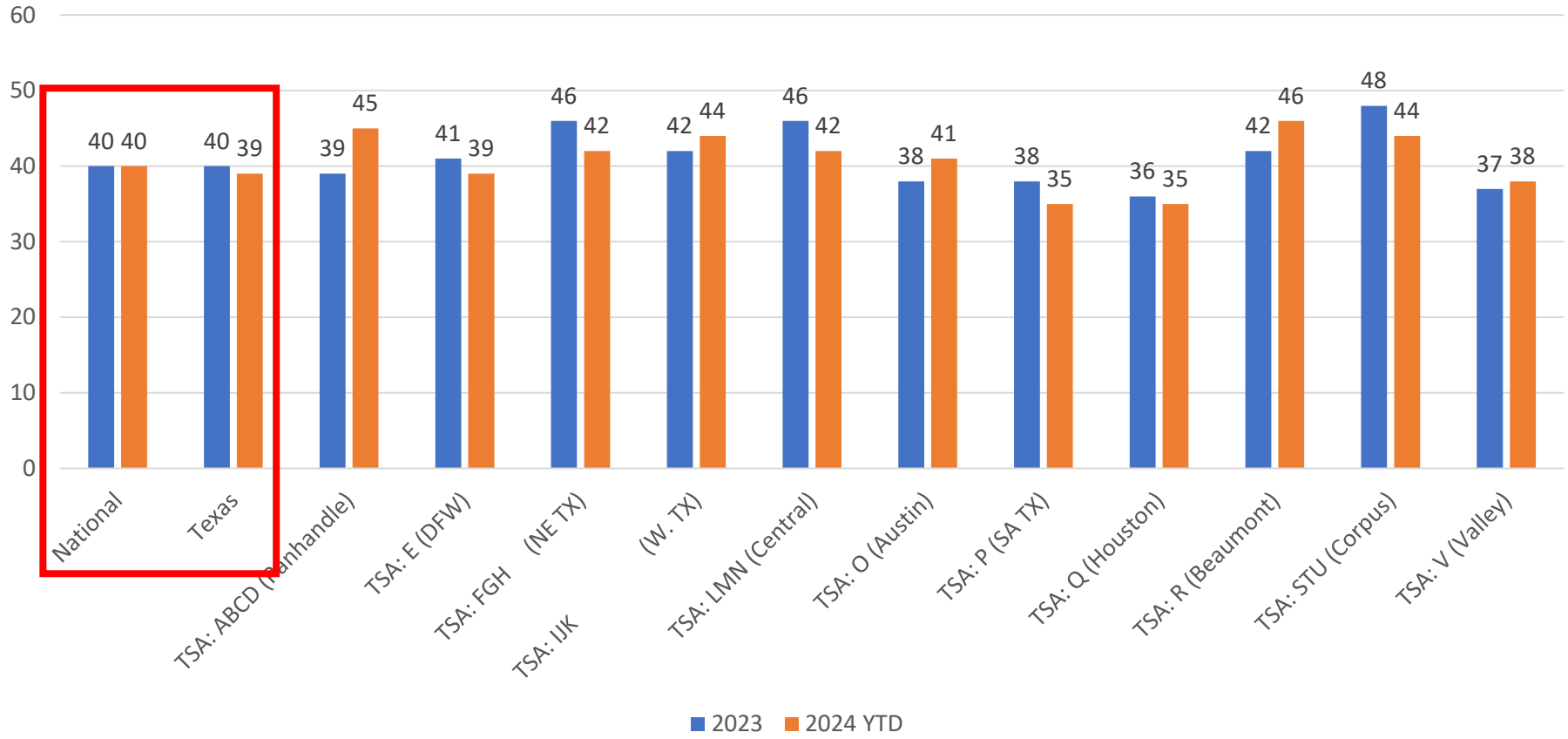
Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
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.** • **Encourage stroke facility document in the GWTG prehospital and interfacility layers.**	
RDC report	• Discussion about using RDC for performance report when 60% stroke facilities participating	
Quality and patient safety issue	• Letter presented from providers siting patient safety issue regarding Neuro IR call coverage. • Multiple providers in state of Texas gave first-hand experience supporting statements in the letter. • Stroke Committee voted to approve the concerns are a quality and patient safety issue that need to be reviewed. • Seek approval from GETAC Council	

Texas Stroke Quality Report: Q4 2024

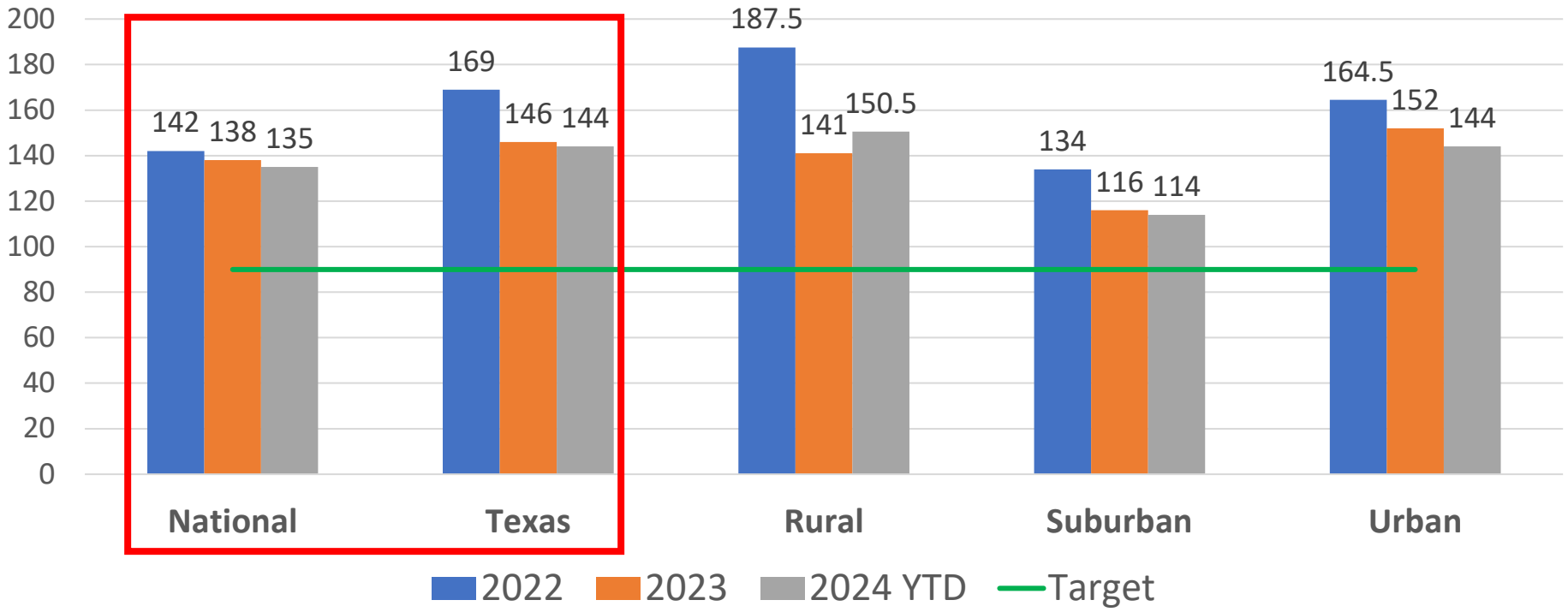
Data Sourced from Get With The Guidelines® - Stroke
October 2024

Median DTN by RAC (minutes)



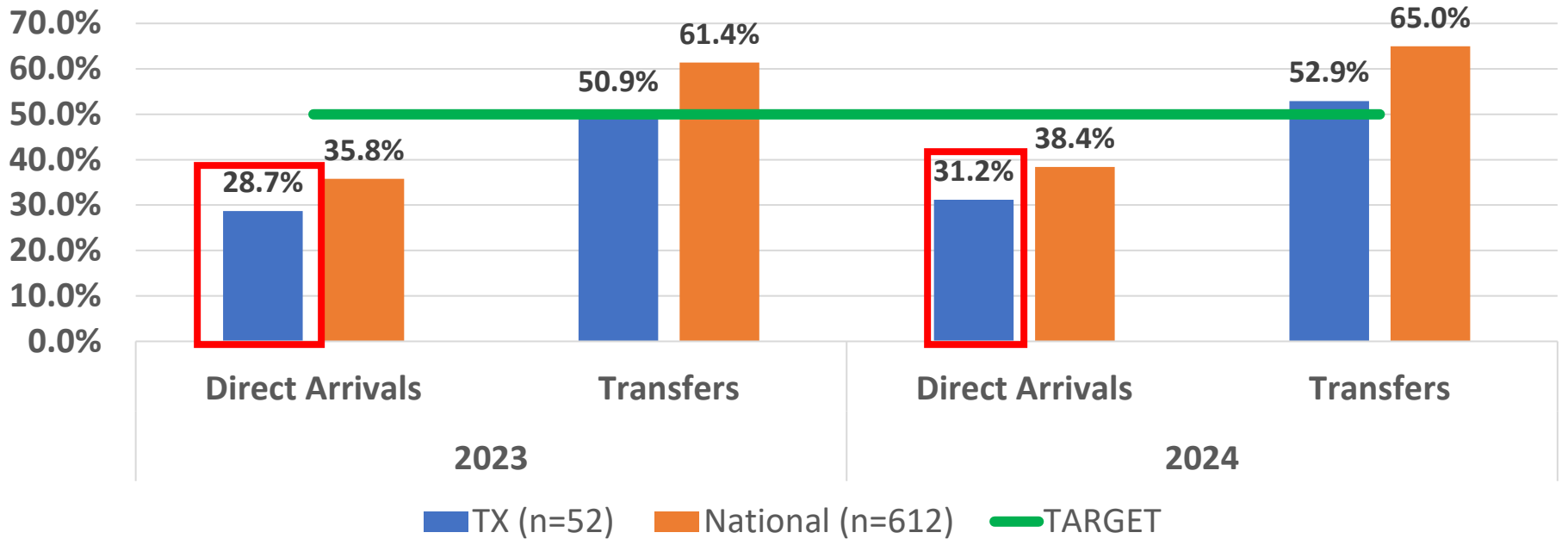
Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 10/8/24.

Median DIDO for Acute Therapy Eligible Patients



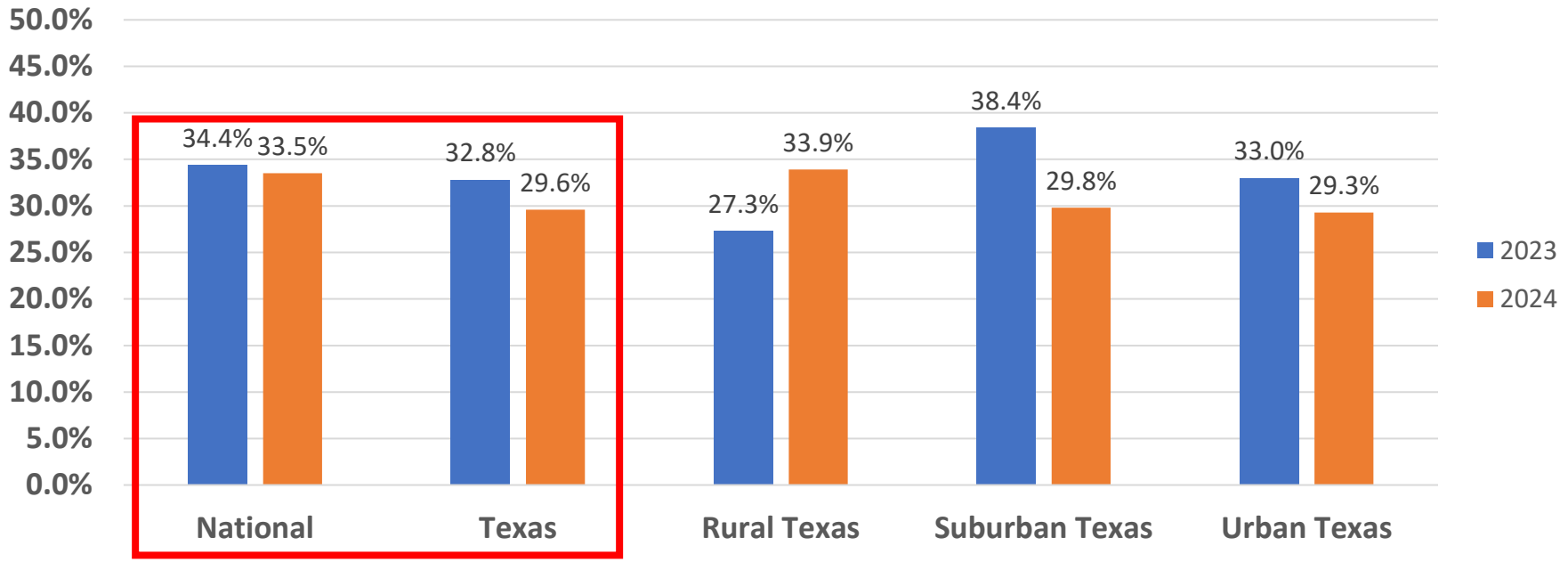
Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 10/8/24.

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



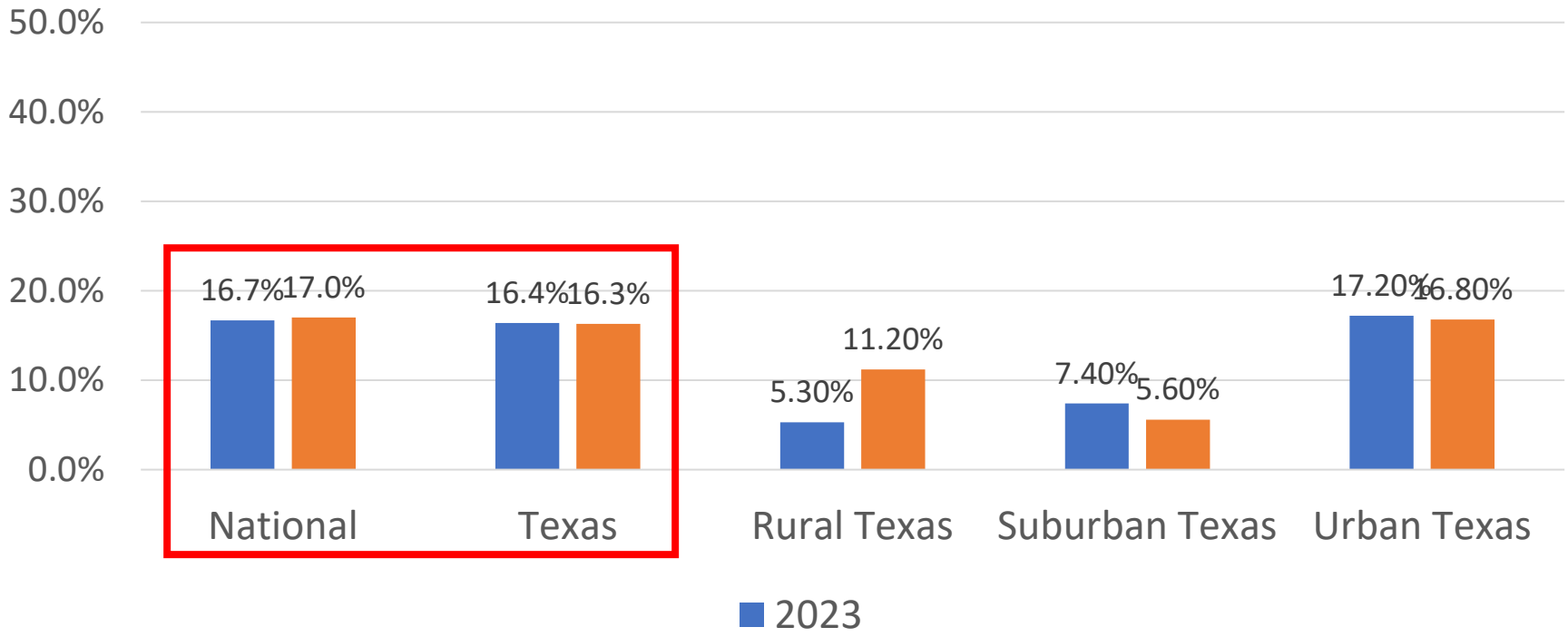
Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 10/8/24.

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 10/8/24.

EMS Stroke Severity Screening by Geographic Classification

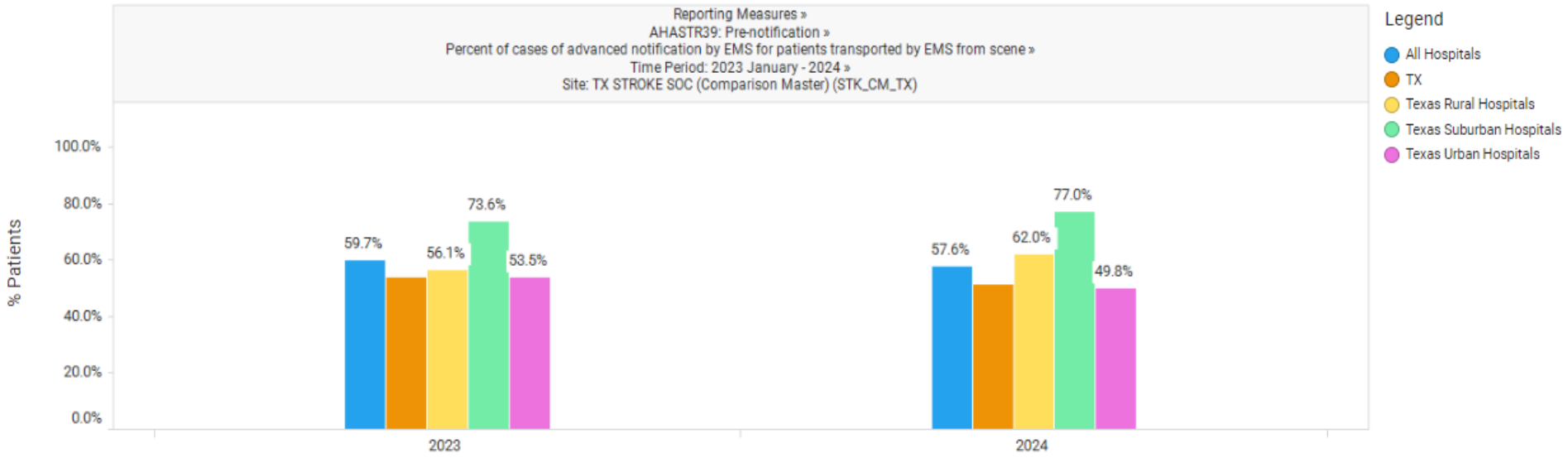


Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 10/8/24.

AHASTR39: Pre-notification

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

Measure Summary



GWTG non-required data element

Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 10/8/24.

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
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. • Encourage stroke facility document in the GWTG prehospital and interfacility layers.	
RDC report	• **Discussion about using RDC for performance report when 60% stroke facilities participating**	
Quality and patient safety issue	• Letter presented from providers citing patient safety issue regarding Neuro IR call coverage. • Multiple providers in state of Texas gave first-hand experience supporting statements in the letter. • Stroke Committee voted to approve the concerns are a quality and patient safety issue that need to be reviewed. • Seek approval from GETAC Council	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
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. • Encourage stroke facility document in the GWTG prehospital and interfacility layers.	
RDC report	• Discussion about using RDC for performance report when 60% stroke facilities participating	
Quality and patient safety issue	• **Letter presented from providers citing patient safety issue regarding Neuro IR call coverage.** • **Multiple providers in state of Texas gave first-hand experience supporting statements in the letter.** • **Stroke Committee voted to approve the concerns are a quality and patient safety issue that need to be reviewed.** • **Seek approval from GETAC Council**	

Proposed NCTTRAC Recommendation

Comprehensive and Thrombectomy Capable Stroke Centers that perform mechanical thrombectomy should have adequate coverage to meet the emergent needs of multiple strokes. Each facility should have a written call schedule readily available within the hospital system, identifying the on-call and backup on-call interventional provider privileged to perform mechanical thrombectomy (neurointerventionalist) 24 hours a day, 7 days a week, 365 days a year. The neurointerventionalist taking calls should be available by phone within 20 minutes and available on-site within 30 minutes from notification. When concurrent facilities are covered by either the primary or backup on-call provider, the following should be in place:

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

Comprehensive and Thrombectomy Capable Stroke Centers that utilize a system of care to deliver stroke care, treatment, and services may utilize the same interventionists provided the following requirements are met:

* Written call schedules are readily available within the hospital system to demonstrate how stroke care, treatment, and services are provided at all hospitals in the system 24 hours a day, 7 days a week, 365 days a year.
* If one physician is covering more than one facility or another service in the organization, there is a written plan for backup coverage.
* Protocols and processes are developed and implemented to detail the system and organizations' plans to meet the emergent needs of multiple complex stroke patients.
* Protocols and processes are developed in response to times organizations would not be able to provide mechanical thrombectomy services and subsequently transfer patients or notify Advisory -Capability with comment.

Comprehensive and Thrombectomy Capable Stroke Centers that perform mechanical thrombectomy and utilize an independent contracted provider or group for neurointerventional coverage to deliver stroke care, treatment, and services should have the following requirements met by the contracted provider or group:

*Written call schedules are readily available outlining all of the hospitals that the primary and backup on-call providers are covering for the shift.
*If one contracted physician is covering more than one facility, there is a written plan to meet the emergent needs of multiple stroke patients for each of the facilities.
*Protocols and processes are developed in response to times the primary and backup on-call providers would not be able to provide mechanical thrombectomy services and subsequently transfer patients or notify of Advisory-Capability with comment. *

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

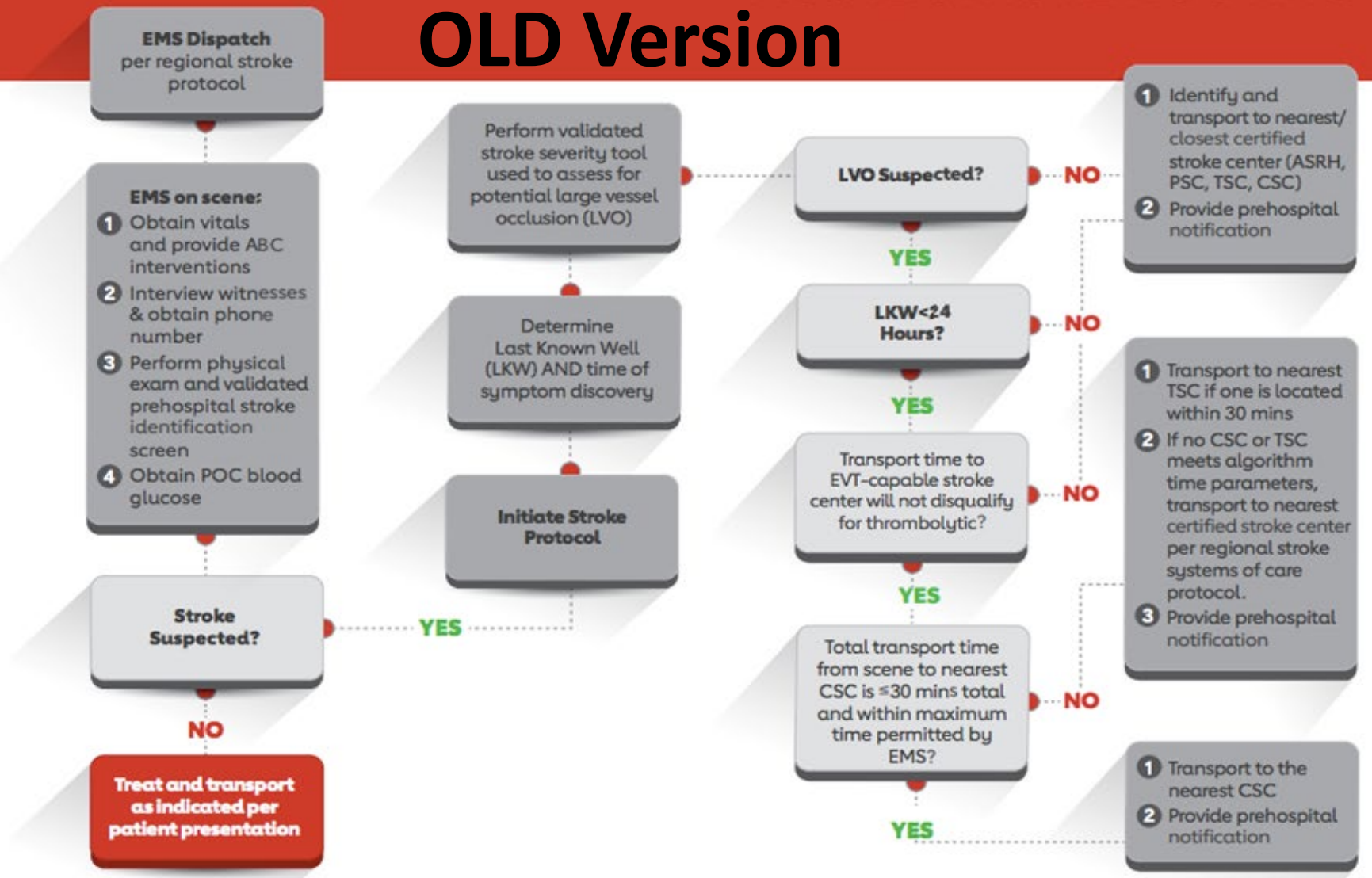
Committee Priorities	Current Activities	Status
Prehospital Stroke algorithm – Recommendation	• **Worked with Drs. Fagan and Winckler from last session, revisions were presented and approved by the Stroke, EMS, Air Medical and EMS Medical Director Committees 11/2024.** • **Present to the GETAC Council for approval.** • **Next steps if approved: work on final versions, March Session present to RACs and EMS Education Committee.** • **Is there value to have resource document going into more detail?**	
Stroke facility infrastructure and requirements	• The Stroke System of Care Work Group is outlining best practices and recommendations to present to the Stroke Committee. • On hold while moving other initiatives forward this past session.	
Pediatric Task Force	• Worked with Drs. Fagan and Winckler from last session, revisions were presented and approved by the Pediatric Committee. The Stroke Committee asked for clarification on naming for pediatric facility regionally accepted to care for pediatric stroke. Other committees deferred until have approval. • Elizabeth, Jorie, legal representative and myself meet to discuss. • Next steps, minimum capability recommendations for pediatric hospital to be recognized as capable of caring for pediatric stroke.	

7.i.A. Action Item: ASA Mission Lifeline Prehospital Stroke Algorithm

American Heart Association.
Mission:Lifeline®
Stroke

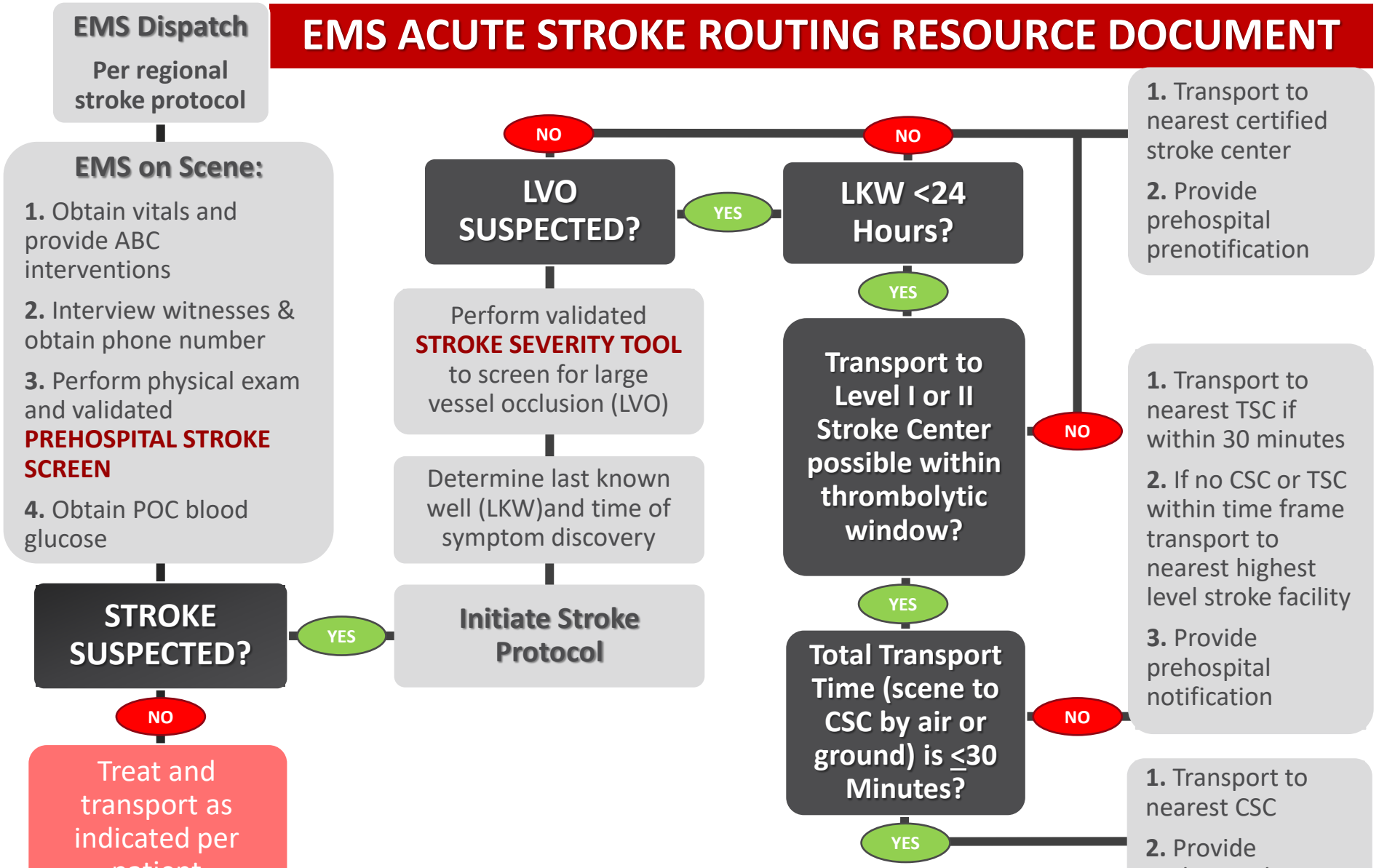
EMERGENCY MEDICAL SERVICES ACUTE STROKE ROUTING

OLD Version



Old Version

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.

EMS ACUTE STROKE ROUTING RESOURCE DOCUMENT - URBAN

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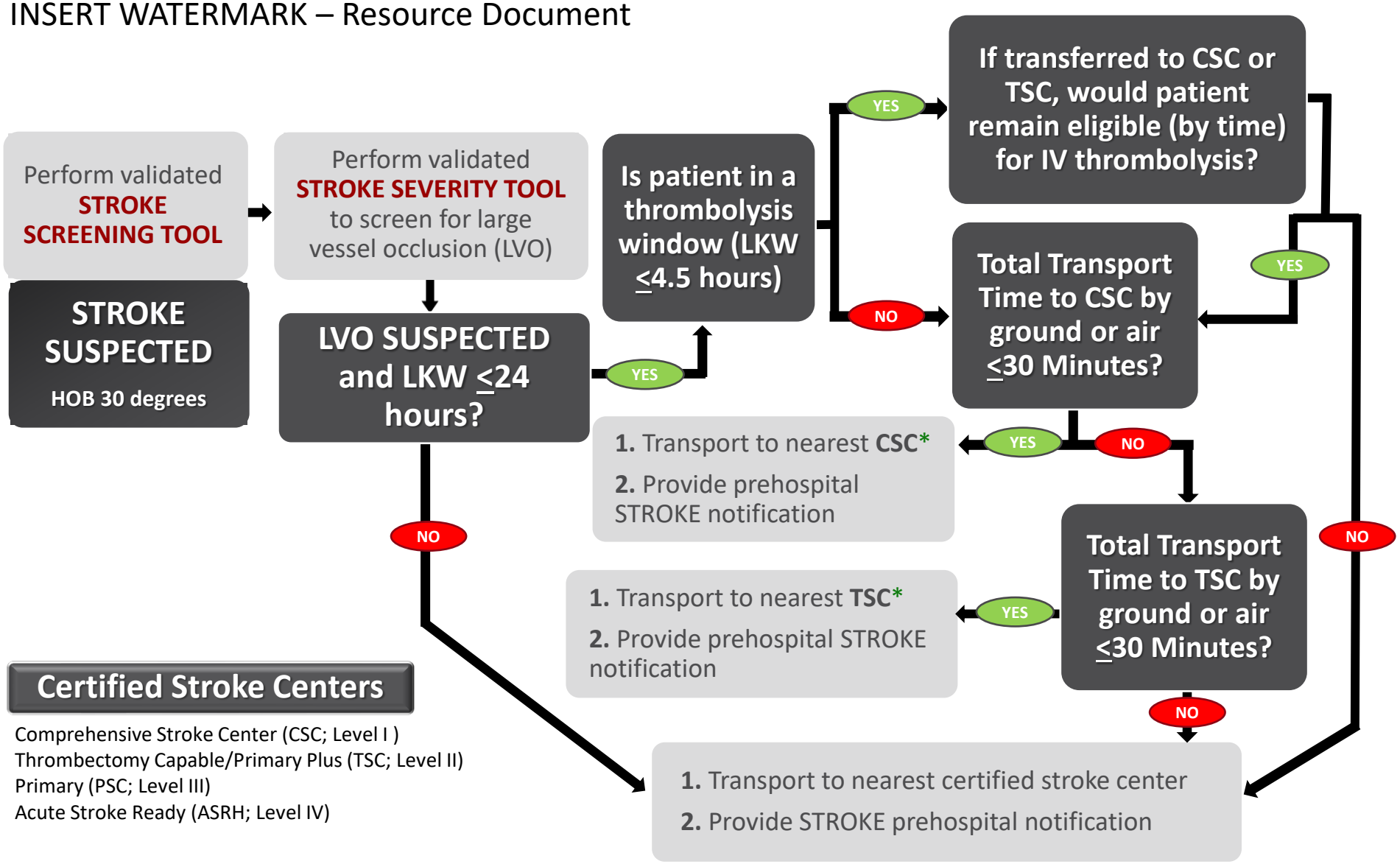

Certified Stroke Centers

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

LKW – last known well; LVO – large vessel occlusion; * If LVO suspected, consider air transport from scene response to CSC/TSC

EMS ACUTE STROKE ROUTING RESOURCE DOCUMENT - SUBURBAN

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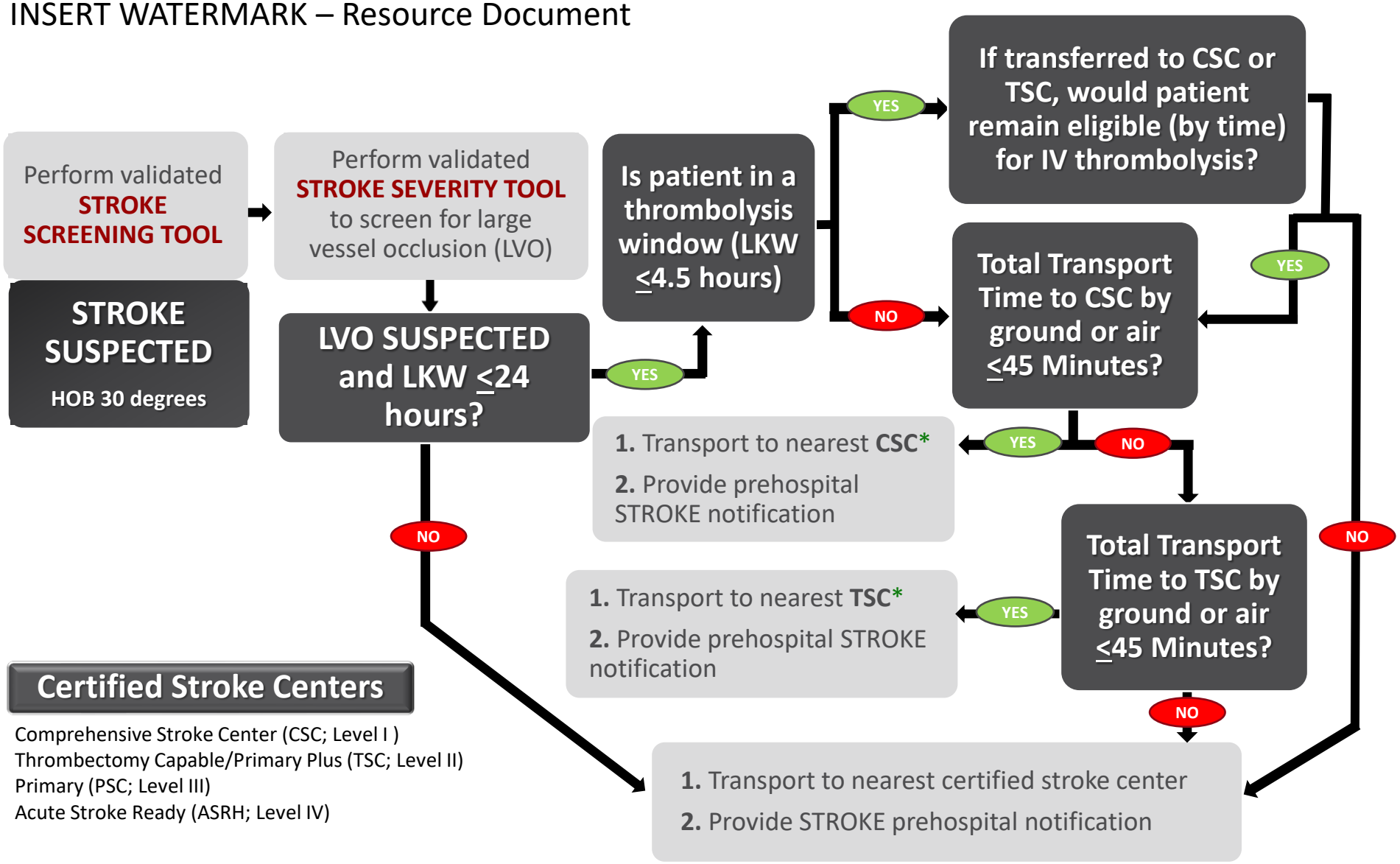

Certified Stroke Centers

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

LKW – last known well; LVO – large vessel occlusion; * If LVO suspected, consider air transport from scene response to CSC/TSC

EMS ACUTE STROKE ROUTING RESOURCE DOCUMENT - RURAL

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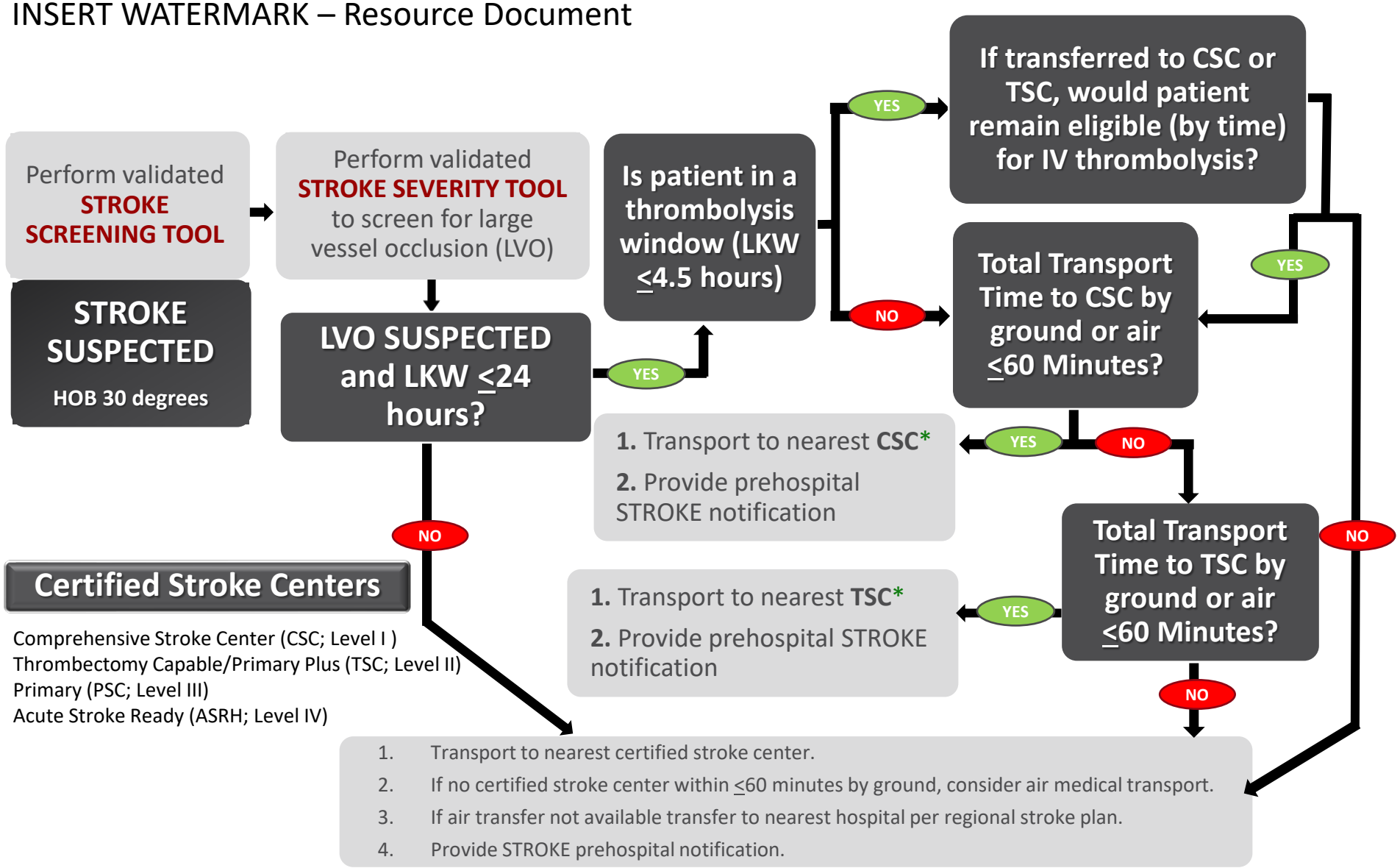

LKW – last known well; LVO – large vessel occlusion; * If LVO suspected, consider air transport from scene response

Healthcare Resources, Geography and Population Density

Urban

- RUCA code1
- Population densities (≥ 50,000 residents)
- And abundant healthcare resources, with access to one or more TSCs/CSCs within 30 minutes transport time by EMS ground

Suburban

- RUCA codes 2-3
- Large residential community adjacent to urban core
- Population density closer to the urban threshold
- May have access to both community hospitals and suburban or urban advanced stroke centers
- TSC, CSC with a 30-60 minutes transport time by EMS air or ground

Rural

- RUCA codes 4-10
- Population densities (<50,000 residents)
- Limited local general healthcare resources, few nearby ASRH or PSC
- Often no TSC/CSC within 60 minutes transport time by ground EMS, but may be one within 60 minutes by air

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Prehospital Stroke algorithm – Recommendation	• Worked with Drs. Fagan and Winckler from last session, revisions were presented and approved by the Stroke, EMS, Air Medical and EMS Medical Director Committees 11/2024. • Present to the GETAC Council for approval. • Next steps if approved: work on final versions, March Session present to RACs and EMS Education Committee. • Is there value to have resource document going into more detail?	
Stroke facility infrastructure and requirements	• The Stroke System of Care Work Group is outlining best practices and recommendations to present to the Stroke Committee. • On hold while moving other initiatives forward this past session.	
Pediatric Task Force	• **Worked with Drs. Fagan and Winckler, from the last session, revisions were presented and approved by the Pediatric Committee. The Stroke Committee asked for clarification on naming pediatric facilities that are regionally accepted to care for pediatric stroke. Other committees deferred until they have approval.** • **Elizabeth, Jorie, the legal representative, and I meet to discuss.** • **Next steps: minimum capability recommendations for pediatric hospitals to be recognized as capable of caring for pediatric stroke.**	

7.i.B. Action Item: Pediatric Stroke Task Force Triage Recommendation

EMS ACUTE PEDIATRIC STROKE RESOURCE DOCUMENT

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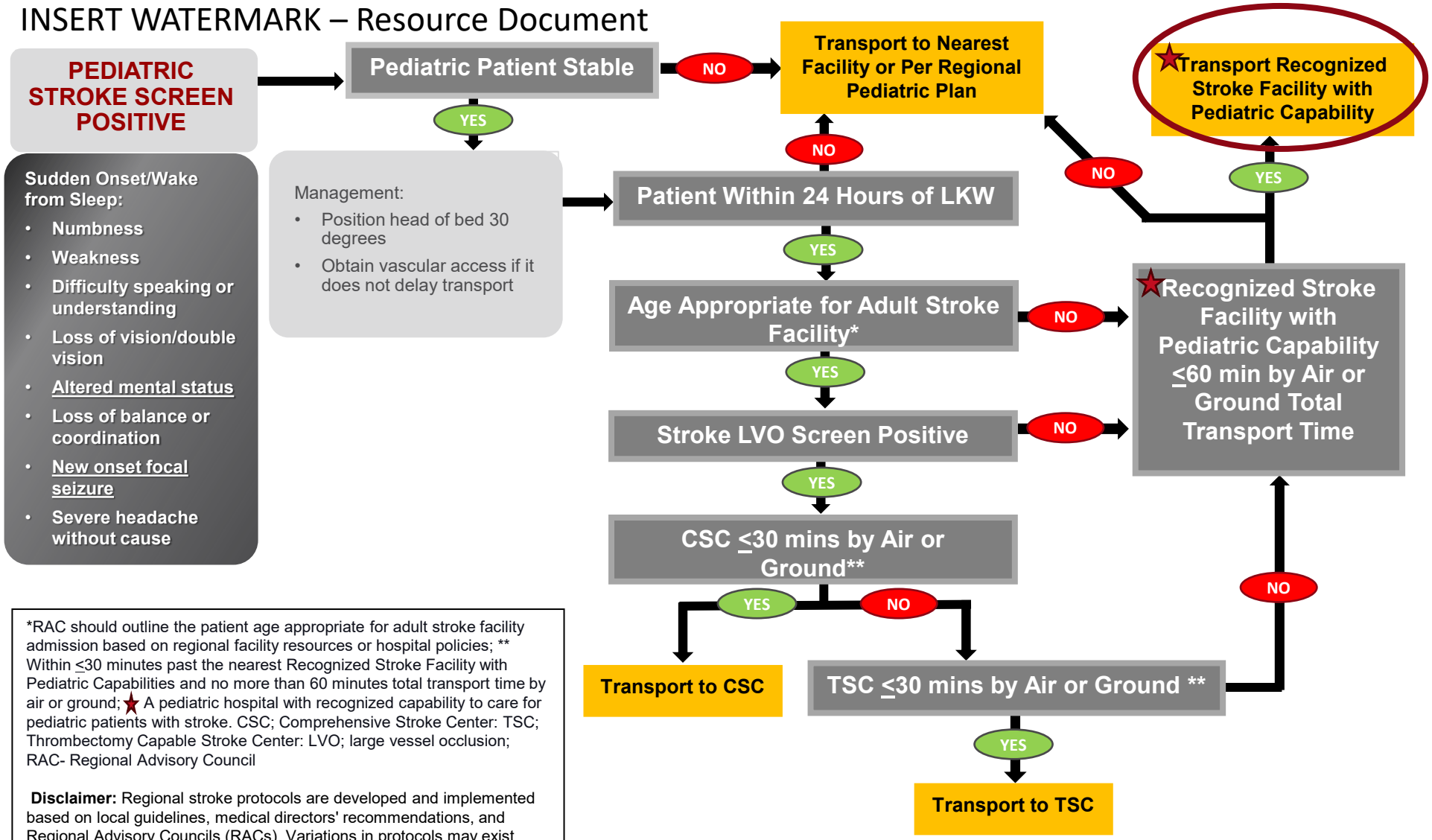


*RAC should outline the patient age appropriate for adult stroke facility admission based on regional facility resources or hospital policies; ** Within ≤30 minutes past the nearest Recognized Stroke Facility with Pediatric Capabilities and no more than 60 minutes total transport time by air or ground;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

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. LKW – last known well; LVO – large vessel occlusion

These pages are unchanged from the last meeting.

EMS Pediatric Stroke Triage Recommendations

Pediatric Stroke is a rare disease that is, nevertheless, included among the top ten causes of **death** in pediatrics.[1] However, rapid recognition and appropriate treatment of pediatric stroke can profoundly improve outcomes for these children, sparing them from decades of disability.[2,3] Thrombectomy has been shown to improve outcomes in pediatric large artery occlusion stroke.[4] This guidance document is designed to help EMS providers recognize and triage pediatric stroke patients quickly 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.[5,6]

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.[7–11]

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)

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. Treat hypotension per regional pediatric protocols.
4. Maintain blood pressure below 20% above 95th%ile for age.[12] Call online medical control if systolic blood pressure consistently above this percentile. The below table is an example of an upper limit of systolic blood pressure by age.

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

5. Hypoglycemia (blood glucose < 70 mg/dL)[13] should be treated in patients suspected of acute ischemic stroke.* Evidence indicates that persistent in-hospital hyperglycemia during the first 24 hours after stroke is associated with worse outcomes and increased risk of hemorrhagic conversion in adults than normoglycemia. You should treat hyperglycemia with a blood glucose range of 140-180 being preferred.
6. To facilitate expedited stroke workup in the ED, place two peripheral IVs so long as it does not delay transport time.

System Triage:

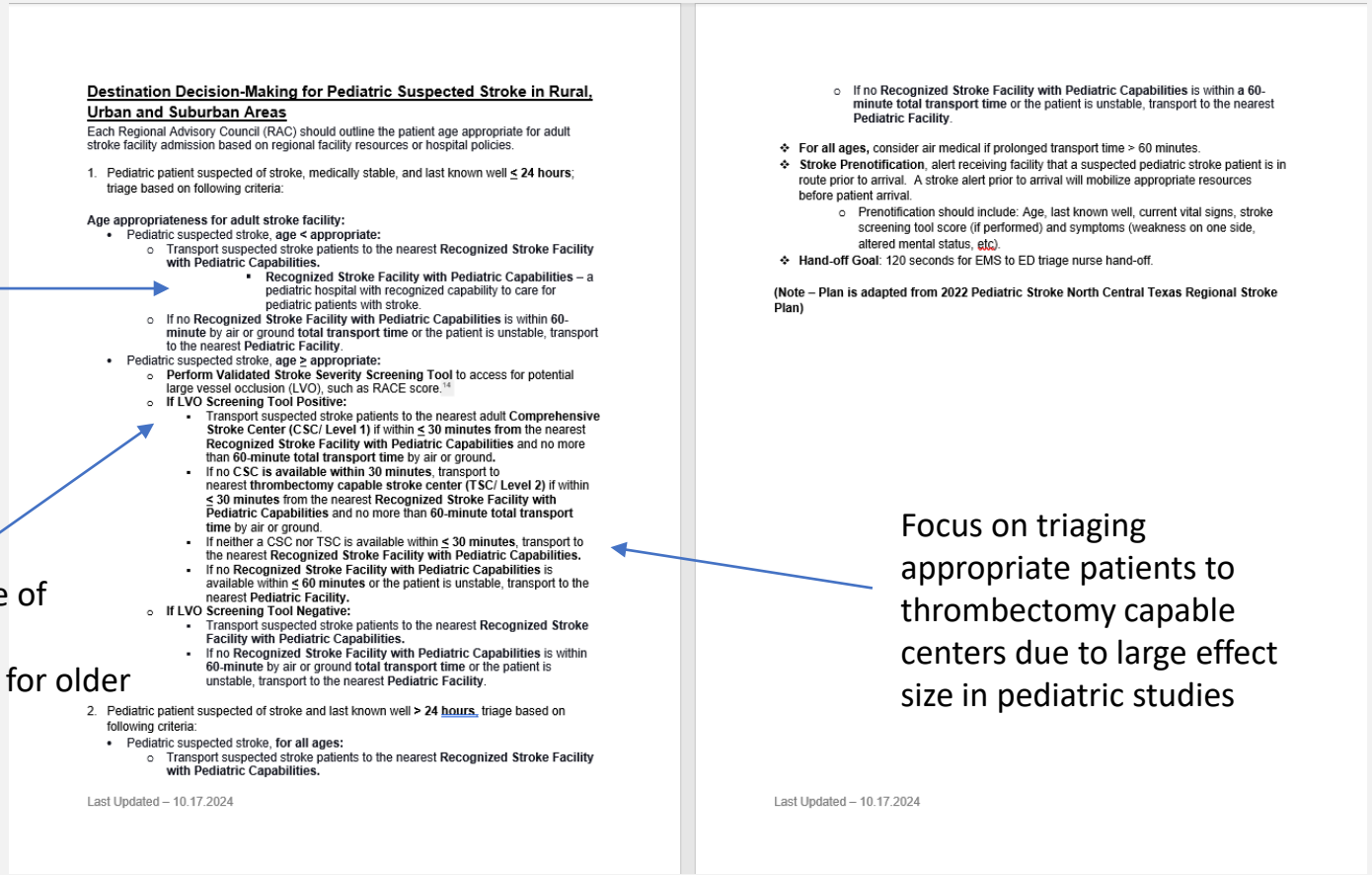
Goal on-scene time is 10-15 minutes or less. Encourage the family to go directly to the ED if not transported with the patient.

Simplified instructions and blood pressure goals

Expert consensus for blood glucose goals
70-180 in children

Consensus definition

Recommend use of screening tool (just like adults) for older children



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, medically stable, 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.[14]
  - **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.**

Last Updated – 10.17.2024

- 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)

Last Updated – 10.17.2024

Focus on triaging appropriate patients to thrombectomy capable centers due to large effect size in pediatric studies

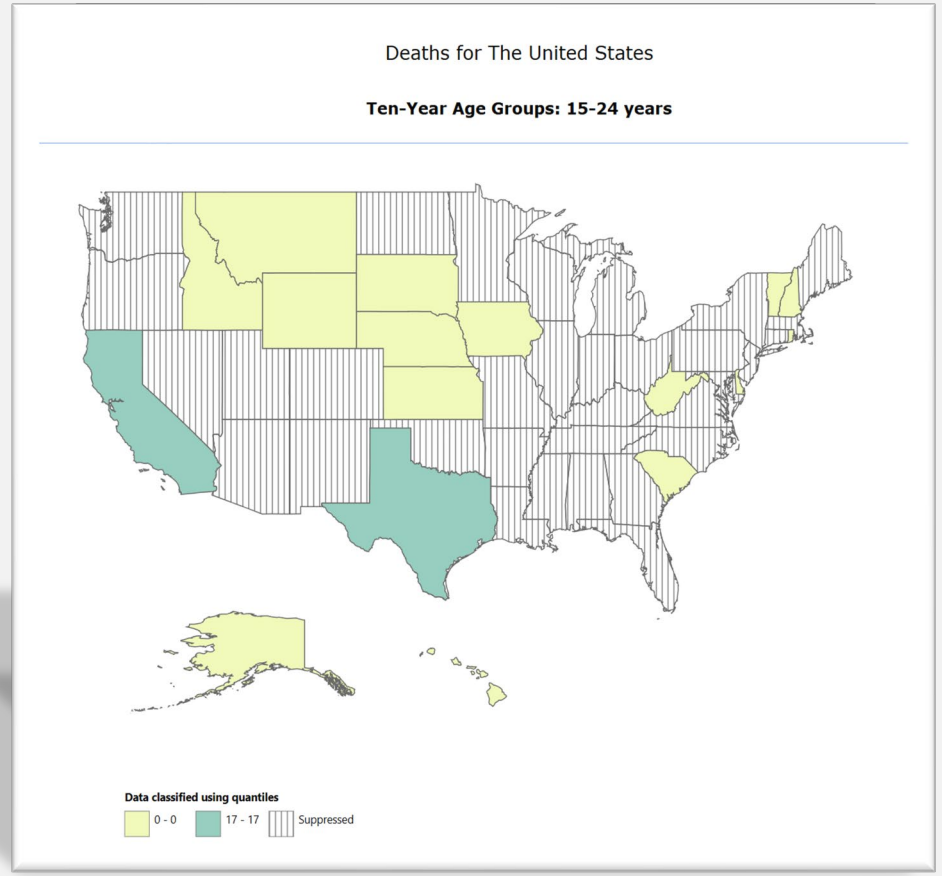
Pediatric Stroke

- Incidence of stroke in children ranges from 2.5-13 per 100,000 per year.
- Top 10 causes of pediatric death.
- Up to 80% of stroke survivors show long-term cognitive and motor deficits that affect daily function.
- Delays to diagnosis will impact a child's chance of accessing acute stroke care.
- Median time from symptom onset to diagnosis is around **20 hours**.

- Kupferman JC, et al. *J Child Neurol*, 2017. 32:408-417.
- Fullerton HJ, et al. *Neurology*. 2003;61:189–194. doi: 10.1212/01.wnl.0000078894.79866.95
- Yock-Corrales A, et al. *BMC Pediatr*. 2011;11:93. doi: 10.1186/1471-2431-11-93
- Bindslev JB, et al. *Eur Stroke J*. 2023;8:483–491. doi: 10.1177/23969873231161381
- Mallick AA, et al. *J Neurol Neurosurg Psychiatry*. 2015;86:917–921. doi: 10.1136/jnnp-2014-309188

Pediatric Stroke

- In 2022, the highest number of pediatric deaths from stroke in Texas were <1 and between 15-24 years of age.



- Centers for Disease Control and Prevention. National center for health statistics: mortality data on CDC WONDER. Available from: https://wonder.cdc.gov/mcd.html (access 11/25/2024)

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• **Worked with Drs. Fagan and Winckler from last session, revisions were presented and approved by the Stroke, EMS, Air Medical and EMS Medical Director Committees 11/2024.** • **Present to the GETAC Council for approval.** • **Next steps if approved: March Session present to RACs and EMS Education Committee.**	
DIDO performance recommendations	• **Worked with Drs. Fagan and Winckler from last session, revisions were presented and approved by the Stroke, EMS, Air Medical and EMS Medical Director Committees 11/2024.** • **Present to the GETAC Council for approval.** • **Next steps if approved: March Session present to RACs and EMS Education Committee.** • **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. • Discussed briefly Needs Assessment for EMS Stroke Education Survey.	

7.i.C. Action Item: Interfacility Stroke Terminology Document

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 ***arrival at transferring hospital*** **<30 minutes by air or ground urban/suburban and 45 minutes rural areas**.
- **Level 1 Stroke**- if ground transportation to transferring facility or transport time to receiving facility >30 minutes consider air transport.

7.i.D. Action Item: Door-in/Door-out (DIDO) Performance Recommendations

Breaking Down DIDO

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

Interfacility Transfer Layer Measures to Follow GWTG

Performance Measure	Goal
AHASTR165 Arrival to transfer request	Median ≤30 minutes
AHASTR166 Arrival to transport request	Median ≤30 minutes
AHASTR171 Transfer requested by referring hospital to transfer accepted by receiving hospital	Median ≤15 minutes
AHASTR172: Transport requested to transport arrived	50% at goal: 30 minutes by air or ground urban/suburban and 45 minutes rural
AHASTR173 Transport arrived to transfer out at referring hospital	Median ≤15 minutes

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• Worked with Drs. Fagan and Winckler from last session, revisions were presented and approved by the Stroke, EMS, Air Medical and EMS Medical Director Committees 11/2024. • Present to the GETAC Council for approval. • Next steps if approved: March Session present to RACs and EMS Education Committee.	
DIDO performance recommendations	• Worked with Drs. Fagan and Winckler from last session, revisions were presented and approved by the Stroke, EMS, Air Medical and EMS Medical Director Committees 11/2024. • Present to the GETAC Council for approval. • Next steps if approved: March Session present to RACs and EMS Education Committee. • 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.** • **Discussed briefly Needs Assessment for EMS Stroke Education Survey.**	

Texas Study

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

- Define two groups for comparison: Perform an **+intervention with** standardized stroke education and another that uses current practices (**-intervention**).
- Test knowledge with EMS survey (similar to published study) of both groups prior to study intervention and another at 3 months and 6 months.
- Would need to define how groups would be defined and seek funding
- Primary outcome:
  - knowledge demonstrated on pre and post assessment comparing “RACs/groups” that had the intervention to those that did not.
- Secondary outcomes:
  - Comparing **+intervention** to **–intervention** groups with GWTG performance measures:
    - Use and documentation stroke screening tool
    - Stroke severity screening tool
    - Prehospital notification
    - Possibly include DIDO layer (not fully active now but in near future possibly)
    - EMS notification of transfer to transferring hospital arrival.

Texas Study

Within a system of stroke care, access to prehospital stroke care requires early recognition of stroke and stroke severity, with integration of the clinical finding into a complex triage paradigm factoring in regional geography, last known well (LKW), stroke facility capability and availability. Emergency medical responders are often the first medical professional with direct patient contact. Their initial assessment, treatment and decisions on diversion and routing will have significant consequences on a patient's subsequent care and impacts outcome. The current state of emergency medical services (EMS) stroke knowledge varies widely depending on the region, resources and training protocols in place. In one US survey, EMS providers reported inadequate stroke severity training and demonstrated gaps in knowledge stroke types, stroke severity sales, and stroke center levels (asif et al). These findings highlight the need for systematic efforts to enhance and standardize the educational content and delivery of stroke education. We seek to investigate the impact of standardized stroke education on both stroke knowledge and performance within EMS in suburban, urban and rural areas. The **Texas EMS Standardized Stroke Education Study** would involve three aims: 1. A feasibility study regionally within the state of Texas 2. A national expansion of the trial focusing on rural areas with paucity of resources and 3. …

Trial Design:

1. **Study Type: Prospective, Randomized Cluster, Open-label, Blinded-Analysis Design**

- This design helps to establish causality by comparing outcomes between an intervention group (receiving standardized stroke education) and a control group (receiving usual training or no intervention) within defined regions in the state of Texas.

2. Participants:

- EMS providers: EMTs, AEMT, paramedics, and other relevant personnel.
- Both experienced and novice EMS providers across rural, urban and suburban regions will be enrolled to assess the impact across different skill levels and geographic stroke resources.

3. Intervention:

- Standardized Stroke Education Program:
  - Develop a comprehensive education program covering:
    - Anatomy and pathophysiology of stroke
    - Recognition of stroke symptoms and types
    - Recognition of stroke severity
    - Importance of time-sensitive intervention
    - Proper assessment and initial management of stroke patients
    - Acute stroke system triage for rapid transfer to stroke centers
    - Stroke facility levels and distinctions
    - Importance of prenotification and hand-off best practices
  - Ensure the education program is evidence-based, up-to-date, and aligned with established guidelines.
  - Offer training sessions, educational materials, and interactive exercises.

4. Control:

- Usual Training:
  - EMS providers in the control group receive their regular training, which may vary across different EMS agencies but typically includes basic stroke education.

5. Outcomes:

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

6. Sample Size Calculation:

- Determine the required sample size based on expected effect size, desired power, and significance level.

7. Randomization:

- Randomly assign EMS providers to either the intervention or control group to minimize selection bias.

8. Blinding:

- Given the nature of the intervention, participants will be unblinded. However, outcome assessors will be blinded to group assignment to reduce bias.

9. Data Collection:

- Use standardized surveys, performance evaluations, and GWTG to collect data on outcomes.

10. Statistical Analysis:

- Compare outcomes between the intervention and control groups using appropriate statistical tests (e.g., t-tests, chi-square tests).
- Adjust for potential confounders such as baseline knowledge or experience level of EMS providers.

11. Ethical Considerations:

- Obtain approval from relevant ethics committees or Institutional Review Boards (IRBs).
- Ensure informed consent from participants.

12. Timeline:

- The duration of the trial, including recruitment, intervention delivery, and follow-up assessments will be 2 years.

13. Budget:

- resources for education program development, training sessions, data collection, analysis, and dissemination of findings.

14. Dissemination of Results:

- Publish findings in peer-reviewed journals and present at relevant Regional Advisory Council and State level to inform EMS practice and policy.

Conclusion:

By rigorously evaluating the effectiveness of such education programs, we can contribute to improving stroke care and outcomes in prehospital settings.

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Post Acute Stroke Care Work Group	• Presented to the Stroke Committee, approved 11/2024 • Request approval from GETAC Council	
Stroke Managers Mentorship Program	• Education Work Group discussing platform and feasibility of implementation. • Elizabeth and Jorie to advise.	
STRAC Stroke Program Manager Manual	• Collect and share resources related to stroke program management, stroke coordinator & manager roles and process improvement. • Presented last session, will discuss further about dissemination at the next session.	
Texas Stroke Coordinators Collaborative Survey	• Education Work Group working on revisions to the survey seeking to pair mentor and mentee. • Plan to present next session to committee.	

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** • **Extend Deadline**	
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 next session	
Work with DSHS to outline recommendations for stroke rules for ASRH	• Pending further direction	

GETAC Stroke Screening Survey

GETAC Stroke Screening Survey: https://ais.swmed.edu/redcap/surveys/?s=FDXTM9NHWXNMKJJX

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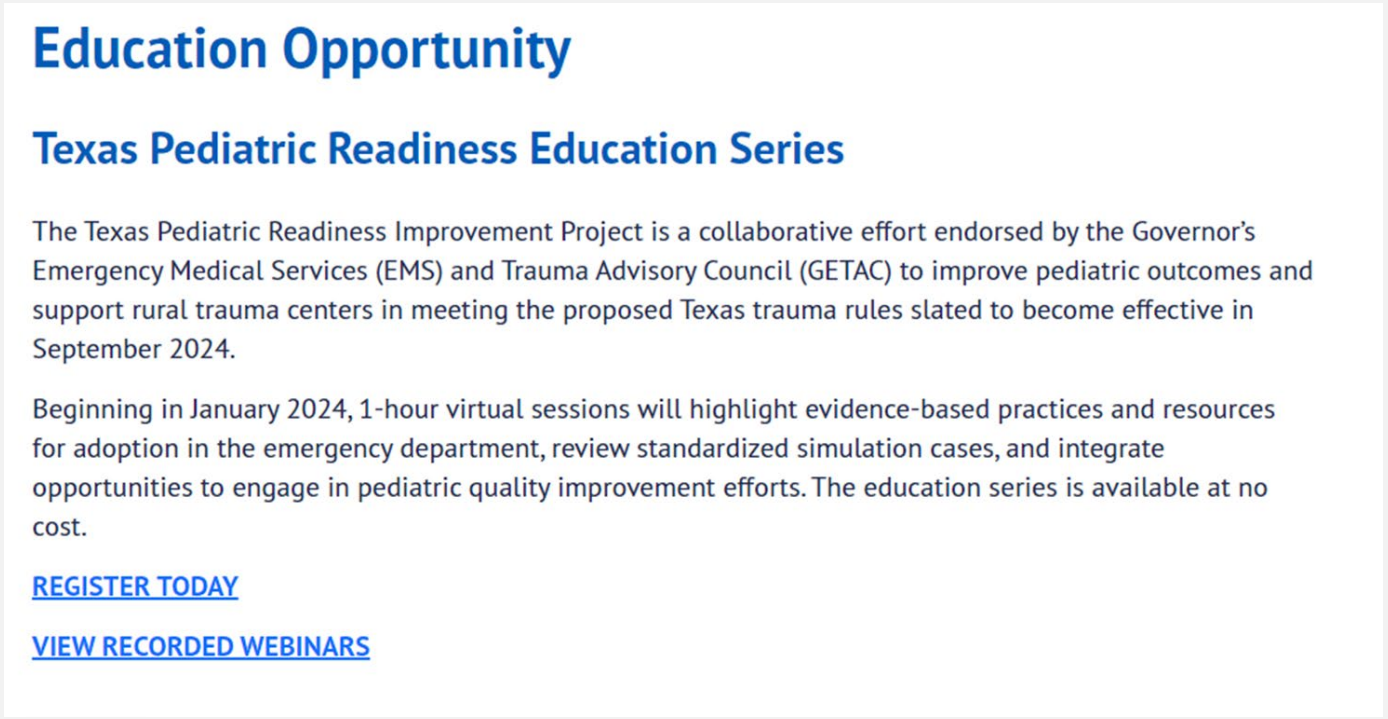
Texas EMS Stroke Survey	• Approved • Joseph assisting with disseminating survey • Extend Deadline	
Stroke Committee endorsed stroke education and certification courses	• **Ongoing effort identifying stroke educational opportunities for providers.**	
Stroke Education Resource for stroke facilities	• **Working with DSHS for website access to stroke education** • **Elizabeth to report back to the Stroke Committee next session**	
Work with DSHS to outline recommendations for stroke rules for ASRH	• Pending further direction	

EDUCATION WORK GROUP

Stroke Education Resources for Texas: DSHS is offering the opportunity to post links on the website for stroke education.



Education Opportunity

Texas Pediatric Readiness Education Series

The Texas Pediatric Readiness Improvement Project is a collaborative effort endorsed by the Governor's Emergency Medical Services (EMS) and Trauma Advisory Council (GETAC) to improve pediatric outcomes and support rural trauma centers in meeting the proposed Texas trauma rules slated to become effective in September 2024.

Beginning in January 2024, 1-hour virtual sessions will highlight evidence-based practices and resources for adoption in the emergency department, review standardized simulation cases, and integrate opportunities to engage in pediatric quality improvement efforts. The education series is available at no cost.

REGISTER TODAY

VIEW RECORDED WEBINARS

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Rural Stroke Work Group	• Provider QR code for member participation	

RURAL Stroke Work Group

GETAC Rural Stroke Work Group

Sign-up

Stroke Committee

- Committee items needing council guidance
  1. Letter stating quality and patient safety issues.
  2. Prehospital EMS stroke triage algorithm
  3. Stroke terminology for interfacility transfers
  4. DIDO performance measures

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

- Items referred to GETAC for future action
  1. Pediatric prehospital stroke algorithm

7.j. GETAC Trauma Systems Committee

Chair: Stephen Flaherty, MD, FACS

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

Trauma System Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Designation	*Assessing factors that are a barrier to designation* *Ongoing collaboration with DSHS.* *Integration with inclusive trauma system pillar and financial health pillar*	
2. RAC Communication	*Facilitates activities in the other pillars* *Hospital leadership*	
3. Inclusive trauma system	*Assess migration in and out of the system* *Enhance functionality of non-designated centers* *Educate hospital leaders (collaborate with TETAF)* *Integration with Designation and RAC Communication*	

Trauma System Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
4. Financial health	*Monitoring for upcoming governmental activity that will impact the trauma system*	
5. Pediatric injury	*Developing plan to assess duplicate imaging concern*	
6. Burn injury	*Monitoring Council project*	

8. Task Force Updates

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

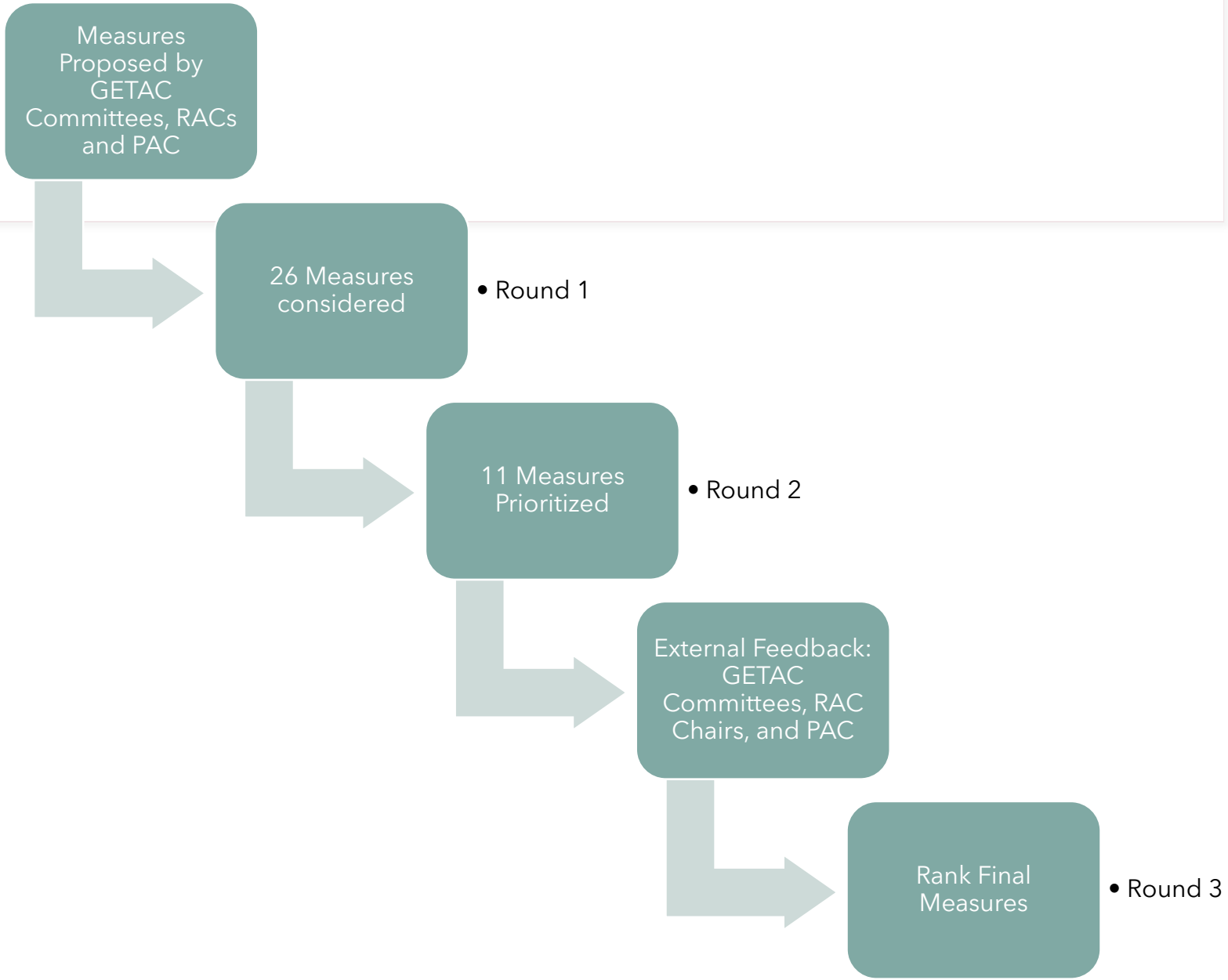
Katherine Remick, MD
Task Force Chair

Texas EMS and Trauma System Measures Development

System PI Taskforce

November 2024 Report to GETAC Council

Timeline


Measures Proposed by GETAC Committees, RACs and PAC
26 Measures considered
• Round 1
11 Measures Prioritized
• Round 2
External Feedback: GETAC Committees, RAC Chairs, and PAC
Rank Final Measures
• Round 3

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

Implementation Goal: January 2025

Reporting structure, stratification, frequency of reports, and specific aims for selected measures

Proposed SMART Aims

Measure	Baseline	Proposed SMART aim
Time from arrival to departure for unstable injured patients (transfers)	Median - 127min, 50% <120min	By December 2026, **80%** of patients are transferred in <120min.
Door-to-needle time for patients with acute ischemic stroke	Median - 39min	By December 2026, 50% <30min and 75% <45min. By December 2026, the median time <45min for both EMS and non-EMS transported patients.
Rate of severe maternal morbidity events	2020 Texas SMM rate 72.7 cases per 10,000 delivery hospitalizations.	By December 2027, 10% reduction in severe MM events.
Percent of 9-1-1 (air and ground) EMS “stroke” patients with a stroke screening scale	47.2% of suspected stroke patients had a documented stroke scale performed	By December 2026, increase to 75% of "stroke" patients have a stroke screening scale performed by EMS.
Pediatric readiness score for designated trauma centers	Median - 73	By December 2027, median wPRS of TX trauma centers is 90 or above.

Proposed SMART Aims

Measure	Stratification	Proposed SMART aim
Time from arrival to departure for unstable injured patients (transfers)	Age categories, Race/Ethnicity, Trauma center level, RAC, State overall, Blunt/Penetrating	By December 2026, **80%** of patients are transferred in <120min.
Door-to-needle time for patients with acute ischemic stroke	RAC	By December 2026, 50% <30min and 75% <45min. By December 2026, the median time <45min for both EMS and non-EMS transported patients.
Rate of severe maternal morbidity events	Age Categories, Race/Ethnicity, Maternal center type, RAC, State Overall	By December 2027, 10% reduction in severe MM events.
Percent of 9-1-1 (air and ground) EMS “stroke” patients with a stroke screening scale	Age Categories, Gender, RAC, State Overall	By December 2026, increase to 75% of "stroke" patients have a stroke screening scale performed by EMS.
Pediatric readiness score for designated trauma centers	Trauma center level, Urbanicity, RAC, State overall	By December 2027, median wPRS of TX trauma centers is 90 or above.

Reporting Schedule

Quarter	Measures
Q1	Prehospital stroke screening + Door-to-Needle time for acute ischemic stroke
Q2	Time from arrival-to-departure for unstable injured patients + Pediatric readiness score at trauma centers
Q3	Prehospital stroke screening + Door-to-Needle time for acute ischemic stroke
Q4	Time from arrival-to-departure for unstable injured patients + Rate of severe maternal morbidity events

8.b. Burn Care Task Force

Dr. Gerad Troutman and Mike Clements, Co-chairs

8.c. EMS Wall-times Task Force

9. Executive Council Activities Update

10. Texas EMS, Trauma & Acute Care Foundation (TETAF)

Dinah Welsh, TETAF President/CEO

Texas EMS, Trauma & Acute Care Foundation Update

Dinah Welsh

TETAF President/CEO

Monday, November 25, 2024

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

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

Advocacy

- Members of the TETAF Advocacy Committee meet every two weeks to prepare for the 89th Texas Legislative Session.
- Along with focusing on the TETAF Legislative Priorities, TETAF is focused on a statewide perinatal database and needs for rural trauma care.

View the TETAF Legislative Priorities by scanning the QR code

TETAF Legislative Priorities
Texas 89th Legislative Session

The Texas Legislature enacted the Texas Trauma System 35 years ago. This system has saved countless lives. The people who make up the system are why it is exceptional, but the life-saving efforts of these trauma leaders only goes as far as the resources, which continue to be tapped. The Texas Trauma System can no longer be maintained at the same level with increased demands on trauma, emergency, and disaster-related health care services in urban and rural areas.

The health care system in Texas cannot stretch its resources at the current growth pace; and when disasters hit, Regional Advisory Councils (RACs), EMS, hospitals, and the Texas Emergency Medical Task Force serve as frontline responders. Each aspect of the trauma and emergency health care system – RACs, EMS providers, and hospitals – must be adequately funded to support all Texans when unplanned needs arise.

Strengthening our health care system must encompass all aspects of time-sensitive care, including the data and resources needed to provide better quality care for mothers and newborns in Texas.

TETAF supports funding that recognizes the need to strengthen regional health care systems through the following priorities:

Acknowledgement of the Critical Role of the Regional Advisory Councils

RACs are vital and complex entities that coordinate and integrate trauma, prehospital, perinatal, stroke, cardiac and disaster readiness into the emergency health care system. Proportional funding increases are integral for the RACs to meet the demands of the fastest growing state and the expanding scope of regional health care responsibilities.

Increase Funding to the Texas Trauma System

Trauma care funding established more than 20 years ago has played a crucial role in supporting the Texas Trauma System. Uncompensated trauma care has increased at a substantial pace while reimbursements to these facilities have decreased, outpacing the dollars available. Increasing trauma funding is paramount to sustaining the Texas Trauma System.

Establish a Statewide Perinatal Database

While it is believed that levels of care designations for neonatal and maternal care have improved care for mothers and babies, Texas still lacks the granular, patient-level perinatal data to assess and improve care. Texas should fund the establishment of a statewide perinatal database to assess, implement, and evaluate best practices for better outcomes.

Improve and Fund Regional Health Care Data Collection Efforts

RACs' access to statewide data has lacked robust, timely value to truly impact responses and improve patient outcomes. Therefore, RACs have initiated regional data collection to improve trauma, cardiac and stroke outcomes. Funding should be allocated for regional registries that can align to a common statewide data set.

Advocacy

- The TETAF Legislative Workgroup is open to all stakeholders. Virtual meetings will begin in January. If you would like to be added to the email notifications for these meetings, please email Erin Moore at emoore@tetaf.org.

Surveys – Trauma, Stroke, Maternal, and Neonatal

- **Trauma Rules** – TETAF will be ready to work with its surveyors, hospital partners, and DSHS to ensure a preparedness and understanding of changes.
- **TETAF and Texas Perinatal Services Surveys** – The volume of surveys in order are currently trauma, maternal, neonatal, and stroke.
  - Perinatal surveys are slowing due to the low designation cycle year.

Education

- TETAF has submitted its renewal application to the Louisiana State Nurses Association (LSNA) as a continuing education provider.
- This year, TETAF has provided continuing professional development for the following:
  - 5 Texas Quality Care Forum virtual events
  - 3 Texas Trauma Coordinators Forum (TTCF) meetings
  - 2 Texas TQIP meetings
  - 2 TETAF Hospital Data Management Course (HDMC) virtual events
  - 1 TTCF Trauma Designation Education Course
  - 1 RAC educational symposium
  - Education has been awarded to participants representing every Regional Advisory Council in Texas
- TETAF has also awarded 1,966 continuing professional development hours through the Texas Pediatric Readiness Project.

Collaboration

- TETAF continues to provide support to Texas TQIP.
  - The collaborative recently met during the ACS TQIP national conference in Denver.
  - Quarterly meetings next year will be held the same week as GETAC meetings.
- TETAF will participate in **Giving Tuesday on December 3** to support the newly formed TETAF Rural Trauma System Development Fund. Visit www.tetaf.org/txruraltrauma for more information.
- TETAF welcomes the opportunity to be a resource, support, and/or participate in any meetings to further build the trauma and emergency care network.

11. 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

12. Discussion of Rural Priorities

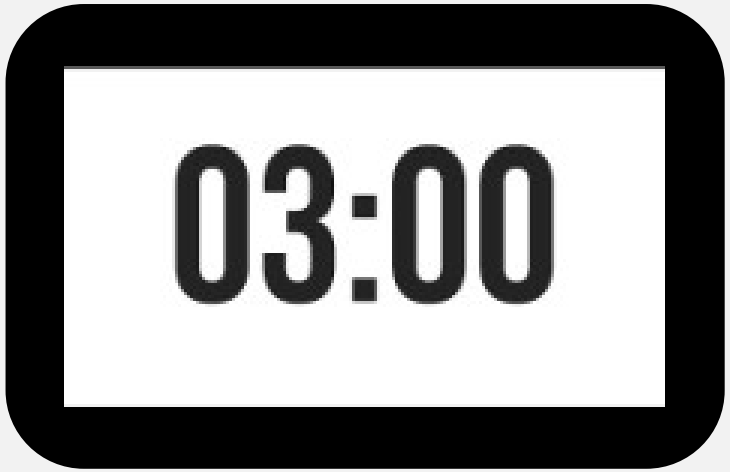
13. Discussion and possible action on initiatives, programs, and potential research that might improve the Trauma and Emergency Healthcare System in Texas.

14. 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

15. Announcements

16. Next Council Meeting Dates

Council Strategic Planning Retreat: January 30-31

Q1: March 4-7

Q2: June 17-20

Q3: August 19-22

Q4: November 21-24

17. 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!

Happy Thanksgiving!