TEXAS
Health and Human Services

Texas Department of State Health Services

# Governor's EMS and Trauma Advisory Council

**Friday, March 7, 2025**
**8:00 AM (CST)**

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

# 1. Call to Order

## 2025 Governor's EMS and Trauma Advisory Council Meeting

### 1st 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:

DoubleTree by Hilton Austin, Phoenix South Ballroom

6505 N Interstate 35

Austin, TX 78752

# Virtual Rules of Participation

# Rules of Participation

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

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

# Rules of Participation

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

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

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

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

# Rules of Participation

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

# 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

- November 25, 2024
- January 30-31, 2025 – *deferred until Q2*

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# 5. Chair Announcements

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

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# State Reports

# 6.a. Center for Health Emergency Preparedness and Response (CHEPR)

Jeff Hoogheem, Director

# 6.b. EMS Trauma Systems Update

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

# Session

- SB 1018 Increase funds in 5111 (Fines 50/50)
- SB 6721 (Diversion)
- HB 1231 (MAB)
- HB 2587 (UCC)
- HB 2058 Perinatal Bereavement Care (new HB 37)
- HB 33 (Active Shooter) (Multihazard)
- Riders

# EMS/Trauma

- Designation Unit's Focus
  - §157.125 Comparison Document – January and February
  - §157.126 Gap Analysis – March
  - §157.126 Survey Guidelines – April
  - §157.126 Designation Review Committee Application – April
  - §157.126 Trauma Designation Assessment Questionnaire – April and May
  - §157.126 Review of Designation Standards / Requirements – May

# eDMEP Follow Up

- 620 eDMEP Courses Provided
- All TPMs
- All TMD
- 1 year to complete
- Reports from ACS reflecting status
- Share June report

# ACS Standards

| ACS Visit Results | Verification Outcomes |
| --- | --- |
| Compliant with all standards | Verified, 3- year certificate |
| Noncompliant with up to 3 Type IIs | Verified, 1 – year certificate |
| Noncompliant with any Type I<br>or<br>Noncompliant with more than 3 Type II Standards | Not verified |

# Texas Trauma Designation Process

- All standards and requirements met – 3-year designation
- One to three requirements not met – CAP; Focus review or work with state
- Four or more requirements not met – CAP; Re-review or work with state
- Goal – all requirements are met

**Priority 1 – Not currently in place**
**Priority 2 – In place but not appropriately monitored or needs some revision**
**Priority 3 – In place and data demonstrates requirement is met**

# Gap Analysis for Level IV Trauma Facilities Managing 100 or Less National Trauma Data Bank (NTDB) Patients

Trauma Facility Designation Requirements effective on September 1, 2025

Texas Administrative Code §157.126

| Rule | Met | Not Met | Priority | Comments |
|---|---|---|---|---|
| **General Designation Requirements** | | | | |
| (b)(4) evidence of documented data validation and quarterly submission to the State Trauma Registry and National Trauma Data Bank (NTDB) (if applicable) for the past 12 months;<br>Also found in (g)(4)(B)(iv), (h)(2), (h)(28), and (h)(32)(I). | | | | |
| (b)(5) evidence of the facility's trauma program and Trauma Medical Director (TMD) or designee participation at Regional Advisory Council (RAC) meetings throughout the designation cycle;<br>Also found in (g)(4)(B)(ii), (h)(1), and (h)(32)(M). | | | | |
| (c) The facility must display its trauma designation certificate in a public area of the licensed premises that is readily visible to | | | | |

# Texas Administrative Code §157.126 Trauma Facility Designation Requirements & ACS 2022 Standards Quick Reference Guide (Revised December 2023)

| ACS Standard # | Standard | Type | LI | LII | LIII (LIII-N)* | PTCI | PTCII | Compliance |
|---|---|---|---|---|---|---|---|---|
| **1 \| Institutional Administrative Commitment** | | | | | | | | |
| 1.1 | In all trauma centers, the institutional governing body, hospital leadership, and medical staff must demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistently with the level verification, throughout the verification cycle.<br><br>Human resources include physicians, registered nurses, advanced practice providers, physician assistants, coordinators, | TYPE I | x | x | x | x | x | Documentation that demonstrates compliance, including:<br>-Hospital Board of Directors (or other administrative governing authority) approval of the establishment of the trauma center at the level specified and of the application for verification.<br>-Commitment to adherence to the standards required for the level of verification.<br>-Commitment to ensuring that the necessary personnel, facilities, and equipment are |

| | | | | | | |
|---|---|---|---|---|---|---|
| | allotments, and equipment needed for a trauma center to function. | | | | | |
| (h)(19) | Level I, II, and III facilities must have an organized, effective trauma service recognized in the medical staff bylaws or rules and regulations and approved by the governing body. Medical staff credentialing must include a process for requesting and granting delineation of privileges for the trauma medical director (TMD) to oversee the providers participating in trauma call | | x | x | x | |

# ACS Standards

- 4.22 Ophthalmology Services – Type II
- 4.26 Medical Specialist – Type II
- 4.30 Advanced Practice Providers – Type II
- 4.31 Trauma Registry Staffing Requirements – Type II
- 4.32 CAISS Specialist – Type II
- 4.35 Performance Improvement Staffing requirements – Type II
- 5.3 Trauma Activation Guidelines – Type II
- 5.9 Anticoagulation Reversal Protocol – Type II
- 5.11 Emergency Airway Management – Type I
- 5.15 Trauma Diversion Protocol – Type II
- 5.16 Trauma Diversion Hours – Type II

# ACS Standards

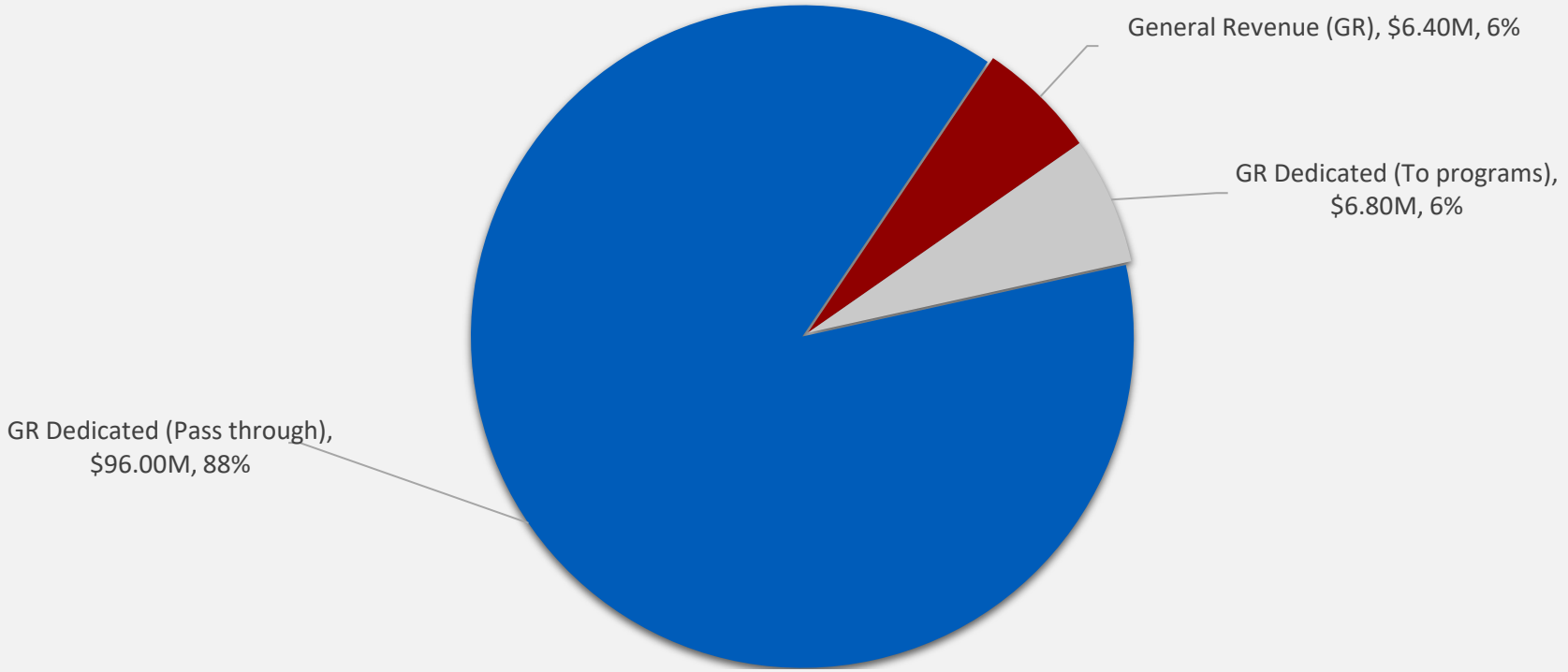
- 5.17 – 5.19 Neurosurgeon Response – Type II
- 5.20 – 5.21 Orthopedics – Type II
- 5.23 Surgical Evaluation of ICU Patients – Type II
- 5.27/28 Rehab – Type II
- 5.30/31 Alcohol Misuse – Type II
- 6.1 Data Quality Plan – Type II
- 7.2 PIPS Plan – Type II
- 7.4 Participation in Risk –Adjusted Benchmarking Program – Type II
- 7.5 Physician Participation in Prehospital PI – Type II
- 7.8 Nonsurgical Trauma Admission Reviews – Type II
- 7.9 Trauma Diversion Review – Type II
- 7.10 Prehospital Care Feedback – Type II

# ACS Standards

- 8.2 Nursing Trauma Orientation and Education – Type II
- 8.3 Prehospital Provider Training – Type II
- Important to read and review the “Additional Information” and “Compliance” data

# EMS Funding Overview

**EMS and Trauma Care Systems, Strategy B.2.1**
**FY 25 Budgeted ($112.3M - $96M is for grants/pass through)**
**amount in millions**



# Types of Trauma Funding: Dedicated Funding Streams

## Fund 5007

- 9-1-1 Equalization Surcharge Funds

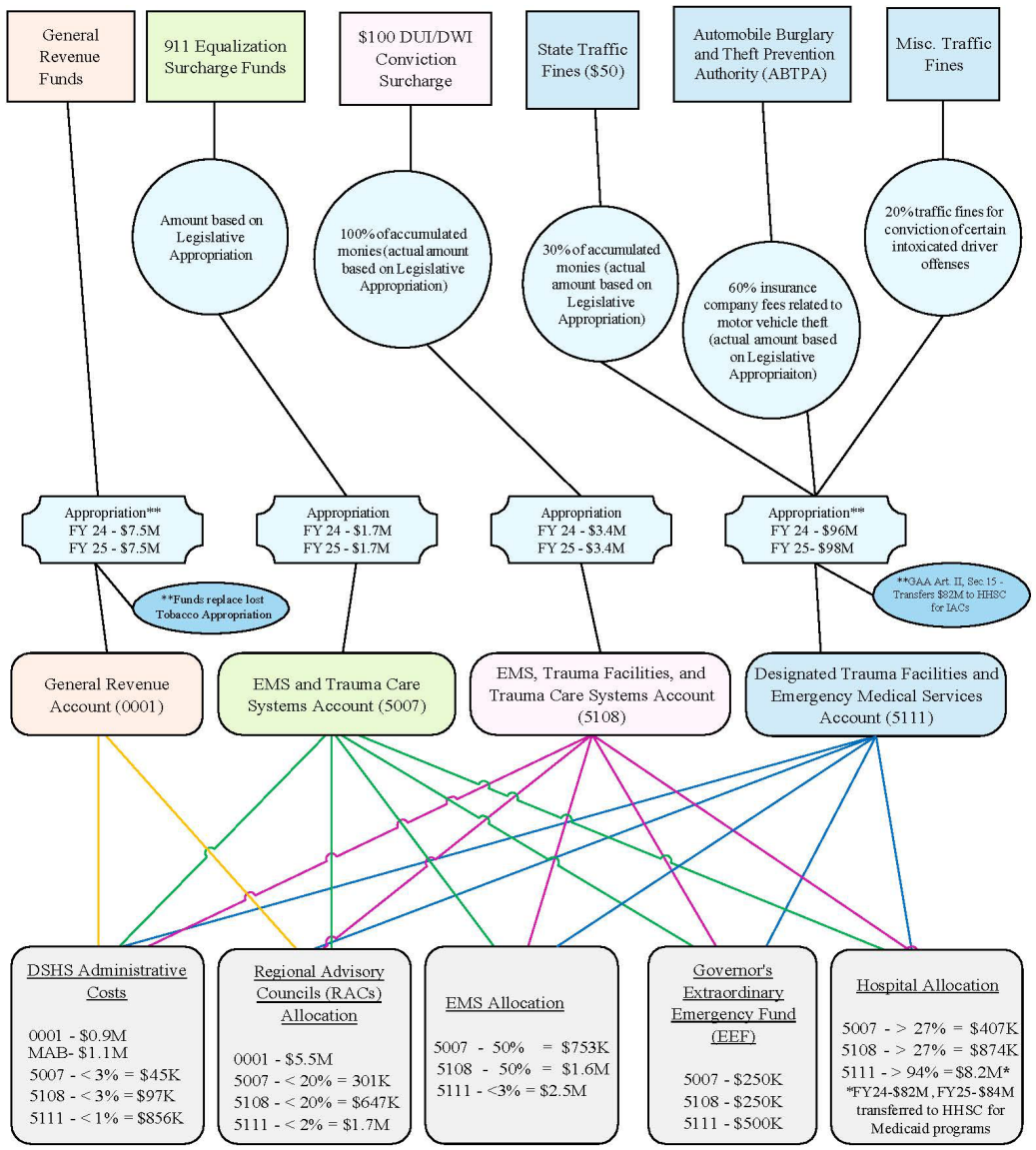
## Fund 5108

- $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)

# 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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# EMS Trauma Funds Support

### DSHS Administrative Costs ($1M)

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 ($7.6M) FY26

Support EMS/Trauma Care System – Advancements

Reduce morbidity and mortality from injuries

Additional directives:

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

### EMS Allotment Fund ($4.9M) FY26

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 FY24 ($82.1M) and FY25 (84.2M)

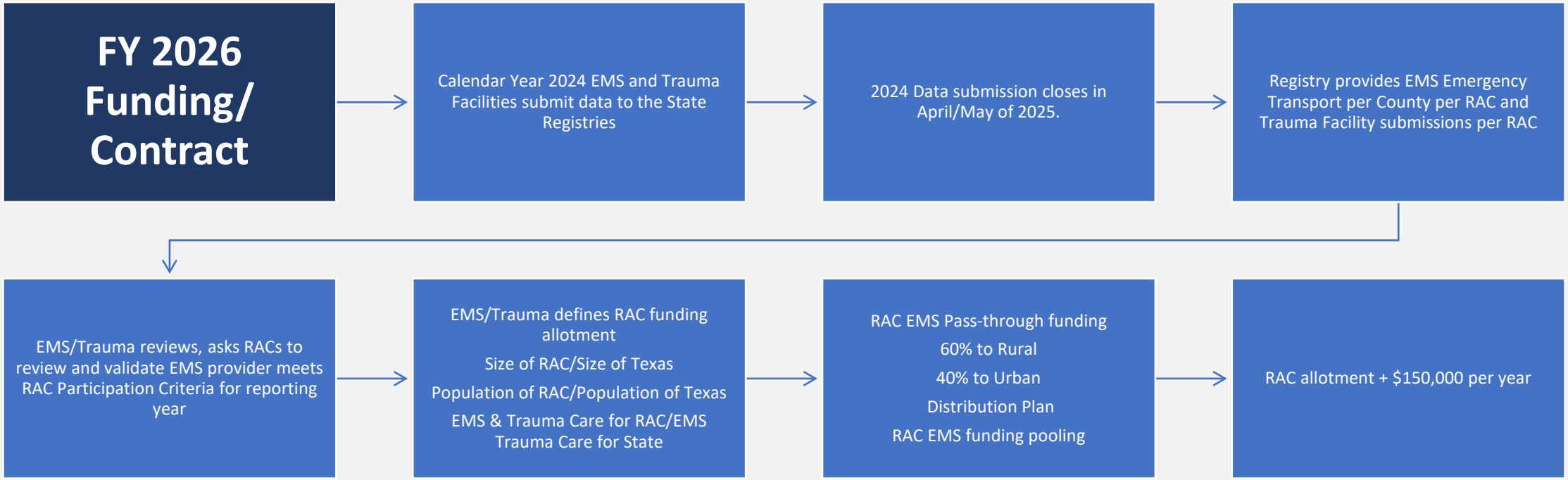
IAC to HHSC for Standard Dollar Amount (SDA Add-On) Programs

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

Facilitate initial training in rural/underserved areas

Communities lacking local EMS training resources

# RAC Funding Allotment



# Regional Advisory Council (RAC)

| Regional Advisory Council (RAC) | FY 2023 | FY 2024 | FY 2025 | FY 2026 | FY 2027 Projection |
|---|---|---|---|---|---|
| EMS Pass-Through | $4,795,847 | $4,876,435 | $4,941,600 | $4,964,594 | $4,967,295 |
| RAC | $2,597,147 | $2,650,510 | $2,661,449 | $2,676,779 | $2,678,580 |
| System Development | $2,278,187 | $2,278,187 | $2,278,187 | $2,278,187 | $2,286,357 |
| Exceptional Item | | $3,300,000 | $3,300,000 | $3,300,000 | $3,300,000 |
| **TOTAL** | **$9,671,181** | **$13,105,132** | **$13,181,236** | **$13,219,560** | **$13,232,232** |

# Extraordinary Emergency Funds (EEFs):

FY25:  $1M was made available on 9/1/2024

- 11 Applications received
- 7 Awarded, 4 Denied
- Total Expended:  $967,379.34
- Funds available: $32,620.66

**7 grants were awarded to the rural counties.**

Approved items:

- 1 remount
- 1 ambulance repair
- 1 new transmission
- 1 CPR device
- 1 set of cots
- 1 ambulance
- 1 ambulance chasse

# Trauma UCC Funding Two-Step

**Background:** Texas Health and Safety Code §780.004 & §773.122

- Trauma Designated and In Active Pursuit Facilities: 94% of funds in the Designated Trauma Facility/Emergency Medical Services (DTF/EMS) Account (Fund 5111) to fund a portion of **uncompensated trauma care**
- Trauma Designated Facilities: 27% of funds in the Emergency Medical Services, Trauma Facilities, and Trauma Care Systems Account (Fund 5108) and 27% of funds in the Emergency Medical Services and Trauma Care Systems Account (Fund 5007) to fund a portion of **uncompensated trauma care**

# Trauma Funding Two-Step: UCC

**2025 Application Cycle**

Application on-line January through April 20, 2025: Data requested from facilities (submit calendar year 2023 data)

Spring/Summer 2025: HHSC reviews designated trauma facilities.

Facilities must identify if there is an error in level of designation and appeal

Summer 2025: DSHS transfers GRD 5111 EMS Trauma funds per Rider – these funds will be used by HHSC first then DSHS (two years later)

HHSC uses the GRD 5111 to draw down Medicaid and distributes via reimbursement rate adjustments to applicable hospitals per TAC §355.8052

HHSC provides data back to DSHS

DSHS completes calculations based on the SDA funding to hospitals and distribution based on the trauma uncompensated care per trauma facilities/total trauma uncompensated care for Texas

DSHS UCC payments usually occur between August and September, using funds from two years prior

# TAC §355.8052

(D) Trauma add-on.

(i) Eligibility.

(I) If an urban hospital meets the definition of a trauma hospital, as defined in subsection (b) of this section, it is eligible for a trauma add-on.

(II) HHSC initially uses the trauma level designation associated with the physical address of a hospital's TPI. A hospital may request that HHSC, under the process described in subparagraph (F) of this paragraph use a higher trauma level designation associated with a physical address other than the hospital's TPI address (multi-location license).

# TAC §355.8052

(ii) Add-on amount. To determine the trauma add-on amount, HHSC multiplies the base SDA:

(I) by 28.3 percent for hospitals with Level 1 trauma designation;

(II) by 18.1 percent for hospitals with Level 2 trauma designation;

(III) by 3.1 percent for hospitals with Level 3 trauma designation; or

(IV) by 2.0 percent for hospitals with Level 4 trauma designation.

(iii) Reconciliation with other reimbursement for uncompensated trauma care. Subject to General Appropriations Act and other applicable law:

# 2024 Uncompensated Charges

**Applicants:**

- 290 Trauma-Designated Hospitals
- 5 In Active Pursuit Hospitals

**Requested/Costs Documented:**

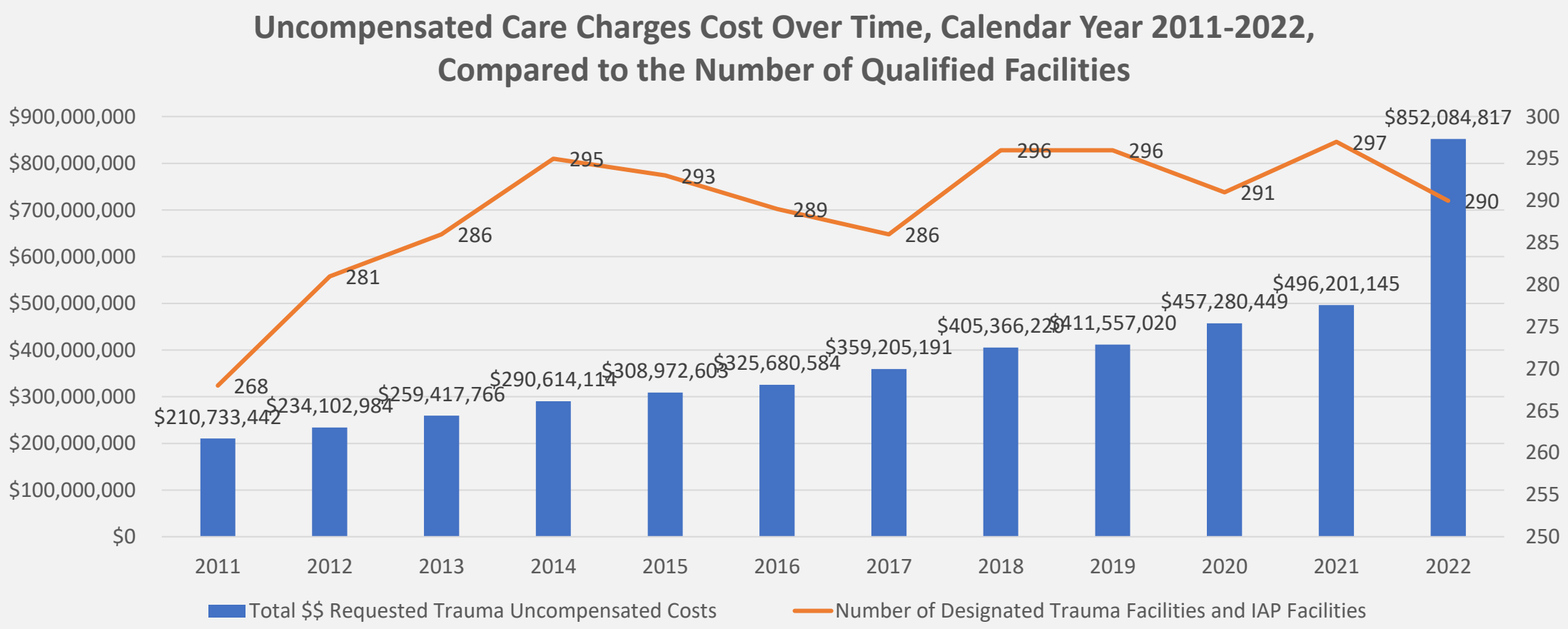
- Charges Requested: $2,968,946,363
- Charges validated and met criteria
- Uncompensated Costs: $852,084,816.63

# 2025 Uncompensated Charges

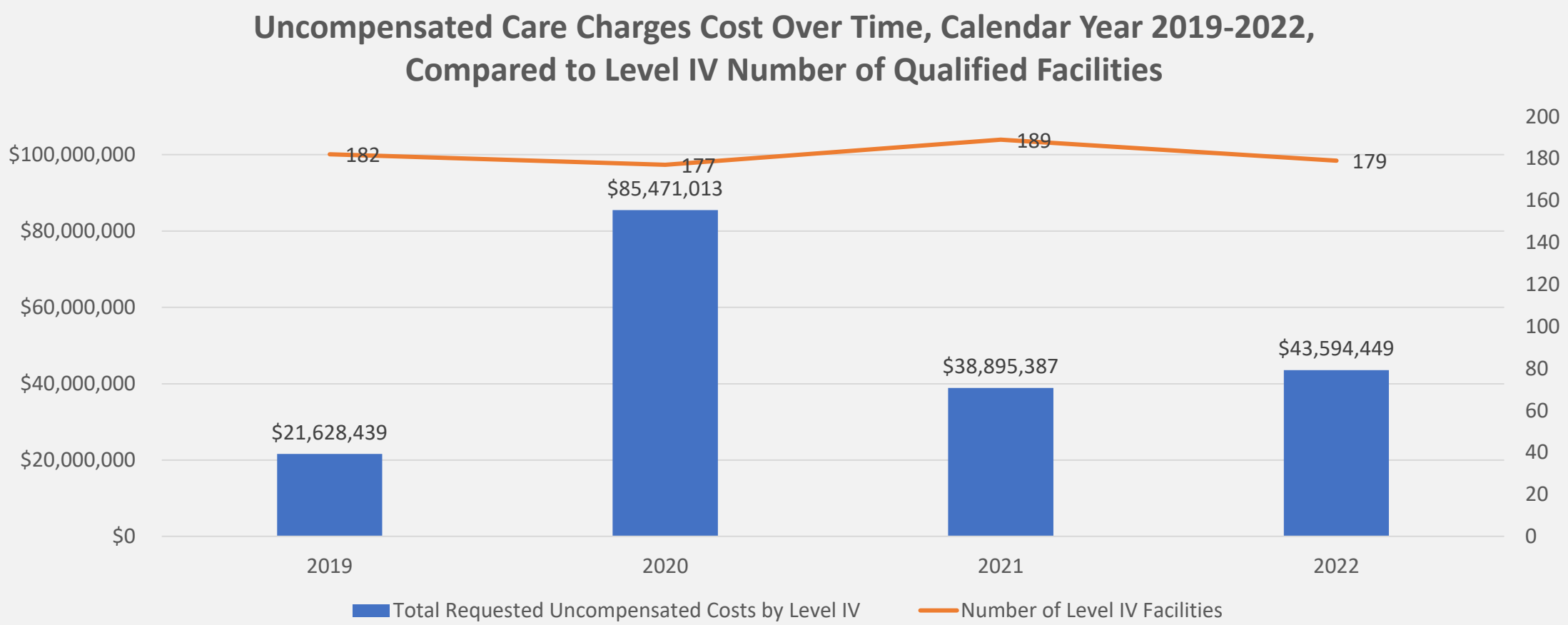
**Applications:**

- Opened January 20th 2025.
- Trauma UCC data Calendar Year 2023
- Trauma Facility Readiness Cost FY24
- Closes April 20th 2025.
- $89,810,873.00
- 84.2M moved HHSC Trauma UCC Trauma Add-On
- Remaining Funds Distribution
  - All Trauma Facilities
  - Percentage of Trauma UCC compared to total Trauma UCC

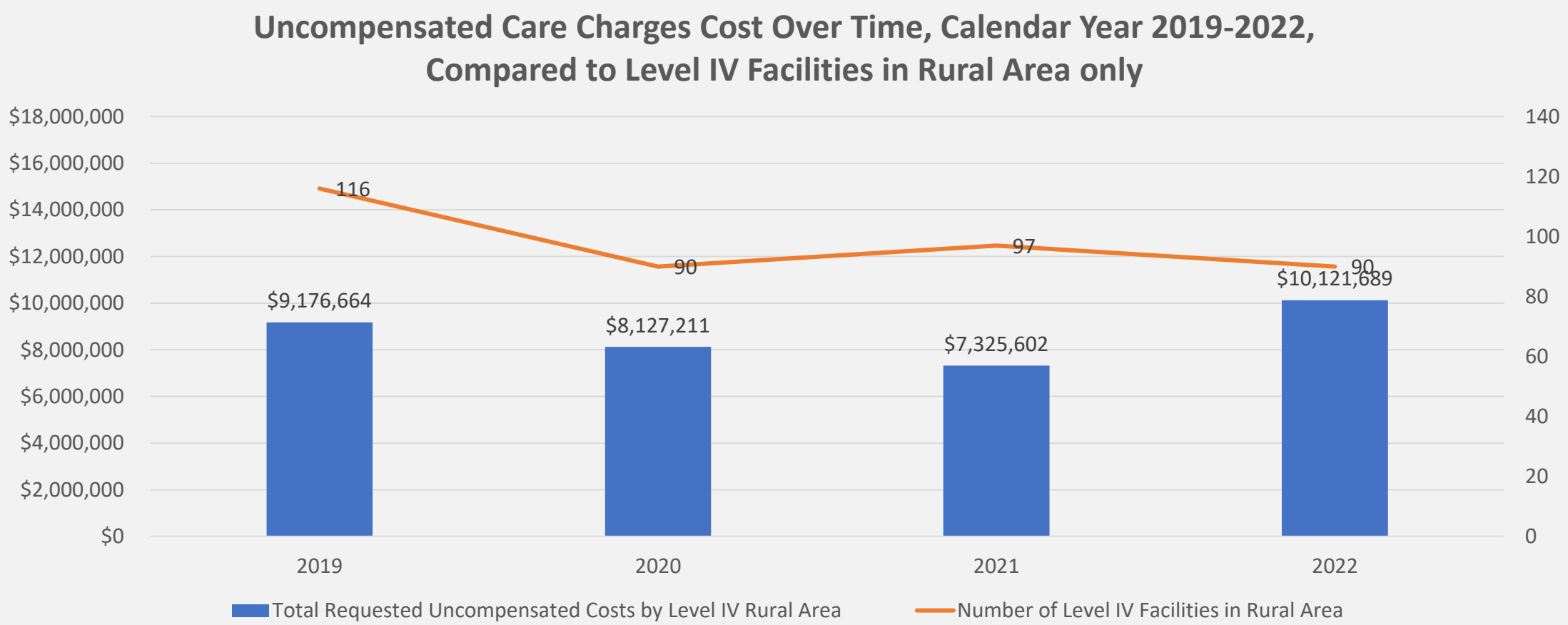
# Trauma UCC


Uncompensated Care Charges Cost Over Time, Calendar Year 2011-2022, Compared to the Number of Qualified Facilities
$900,000,000
$800,000,000
$700,000,000
$600,000,000
$500,000,000
$400,000,000
$300,000,000
$200,000,000
$100,000,000
$0
300
295
290
285
280
275
270
265
260
255
250
$210,733,442
$234,102,984
$259,417,766
$290,614,114
$308,972,603
$325,680,584
$359,205,191
$405,366,220
$411,557,020
$457,280,449
$496,201,145
$852,084,817
268
281
286
295
293
289
286
296
296
291
297
290
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
Total $$ Requested Trauma Uncompensated Costs
Number of Designated Trauma Facilities and IAP Facilities

# Trauma UCC Level IV Facilities



# Trauma UCC Rural Level IV Facilities



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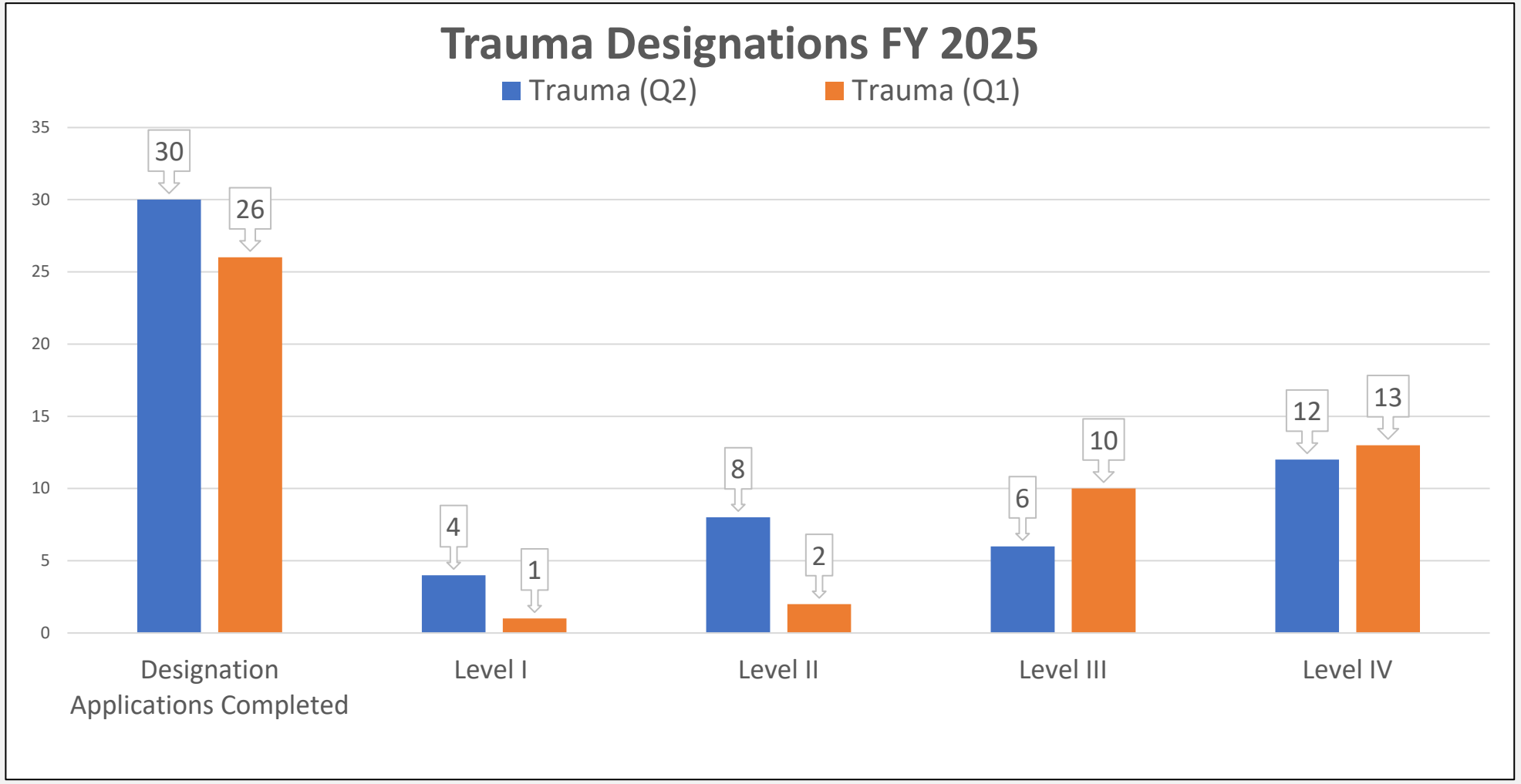
# Designation Update

Elizabeth Stevenson, BSN, RN
Designation Programs Manager

# Designated Trauma Facilities

| Trauma Facilities FY2025 | 2nd Quarter | 1st Quarter |
|---|---|---|
| Total | 296 | 296 |
| Level I | 22 | 22 |
| Level II | 28 | 28 |
| Level III | 60 | 56 |
| Level IV | 186 | 190 |

# Trauma Designation Data



# Trauma Designation Data

| Trauma 2024 | 2nd Quarter | 1st Quarter |
|---|---|---|
| **New IAP Recognitions** | **4** | **1** |
| **Facilities In Active Pursuit** | **9** | **7** |
| Level I | 0 | 0 |
| Level II | 1 | 1 |
| Level III | 3 | 3 |
| Level IV | 5 | 3 |

# Trauma Designation Data

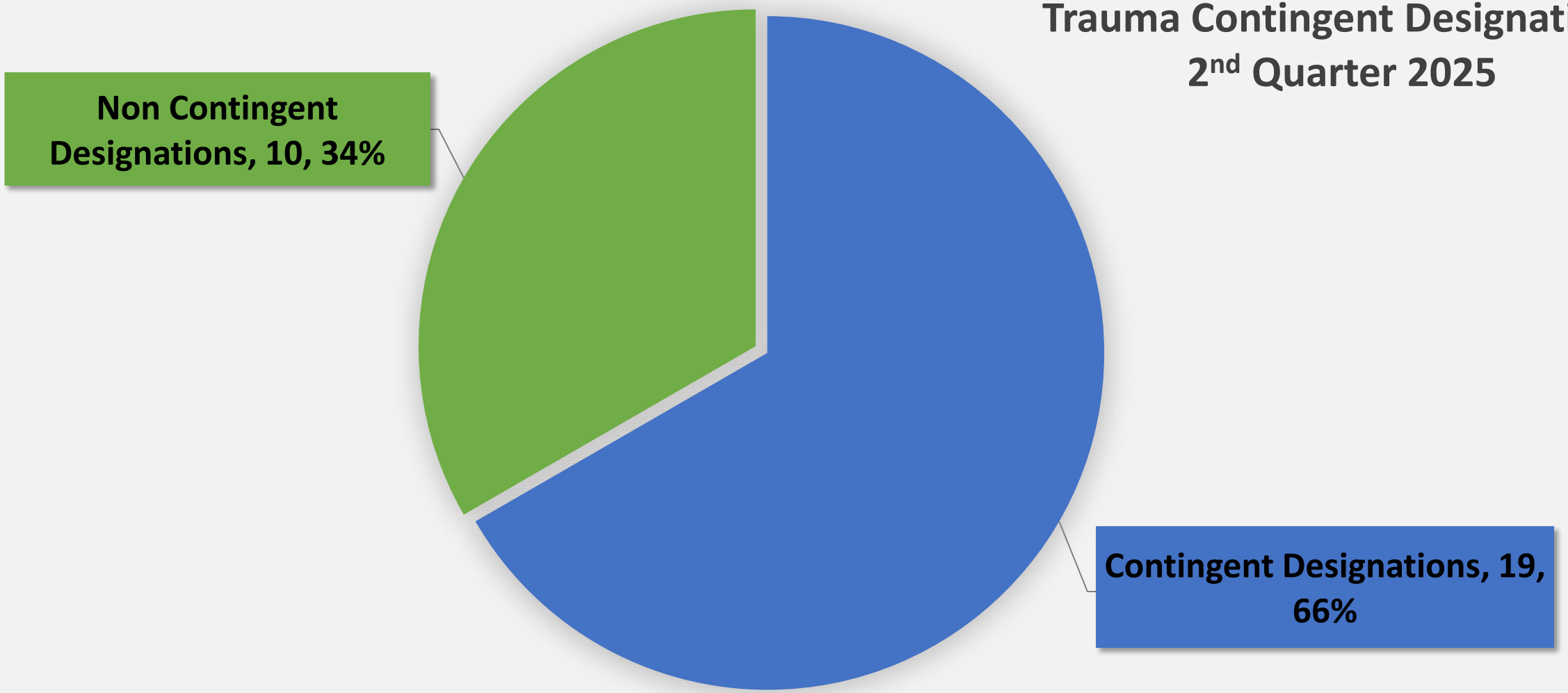
**Trauma Designations**
**2nd Quarter 2025**

29
Designations
Processed

23
Renewals

6
Initials

# Trauma Designation Data



# Common Deficiencies

- Nursing documentation
- Evidence of loop closure
- Identification of all variances
- TMD participation in PI
- Monitoring of Trauma Surgeon 60 min response
- TPM 0.8 FTE
- Trauma Registry

# Trauma Designation Information

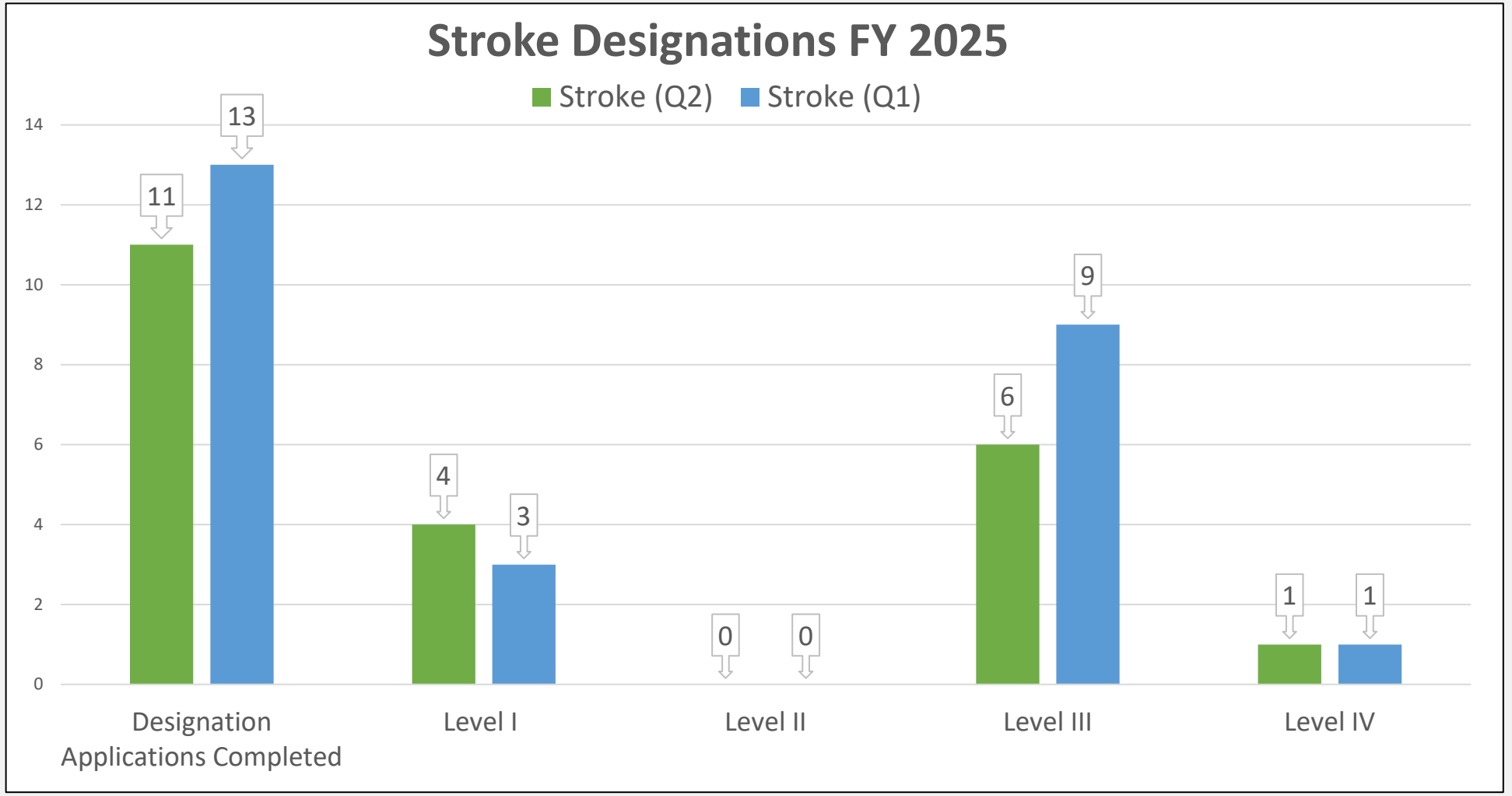
Department Activities:

- Adopted Trauma Rule Q&A meetings in December
- Section 157.125 Adopted Trauma Rule Comparison Documents for Level III and IV available on DSHS website
- Trauma monthly calls top two topics:
  Trauma UCC application and Adopted Trauma Rules
- Survey following monthly meeting calls to receive stakeholder feedback on benefits and suggestions for future meeting content

# Designated Stroke Facilities

| Designated Stroke Facilities FY 2025 | 2nd Quarter | 1st Quarter |
|---|---|---|
| Total | 191 | 189 |
| Comprehensive<br>Level I | 47 | 45 |
| Advanced<br>Level II | 5 | 6 |
| Primary Level III<br>*Primary Level II* | *111*<br>*3* | *101*<br>*12* |
| Acute Stroke Ready Level IV<br>*Support Level III* | *25*<br>*0* | *25*<br>*0* |

# Stroke Designation Data



# Stroke Designation Data

**Stroke Designations**
**2nd Quarter 2025**

14
Designations
Processed

10
Renewals

4
Initials

# Stroke Designation Information

Department Activities:

- Initial Level IV Acute Stroke Ready meetings held on September 12th, October 10th, November 14th, 2024. January 9th, and February 13th, 2025.
- Monthly call discussion:

  Diversion versus acceptance of transfers

  Survey organization requirements for higher level certifications differences

  Program manager mentoring resources

  Suggestions for future meeting content

# Designation Application Process Performance Measures

**Goals – 30/60 days**

**(Non-Contingent Designation 30 Days)**

**(Contingent Designation 60 Days)**

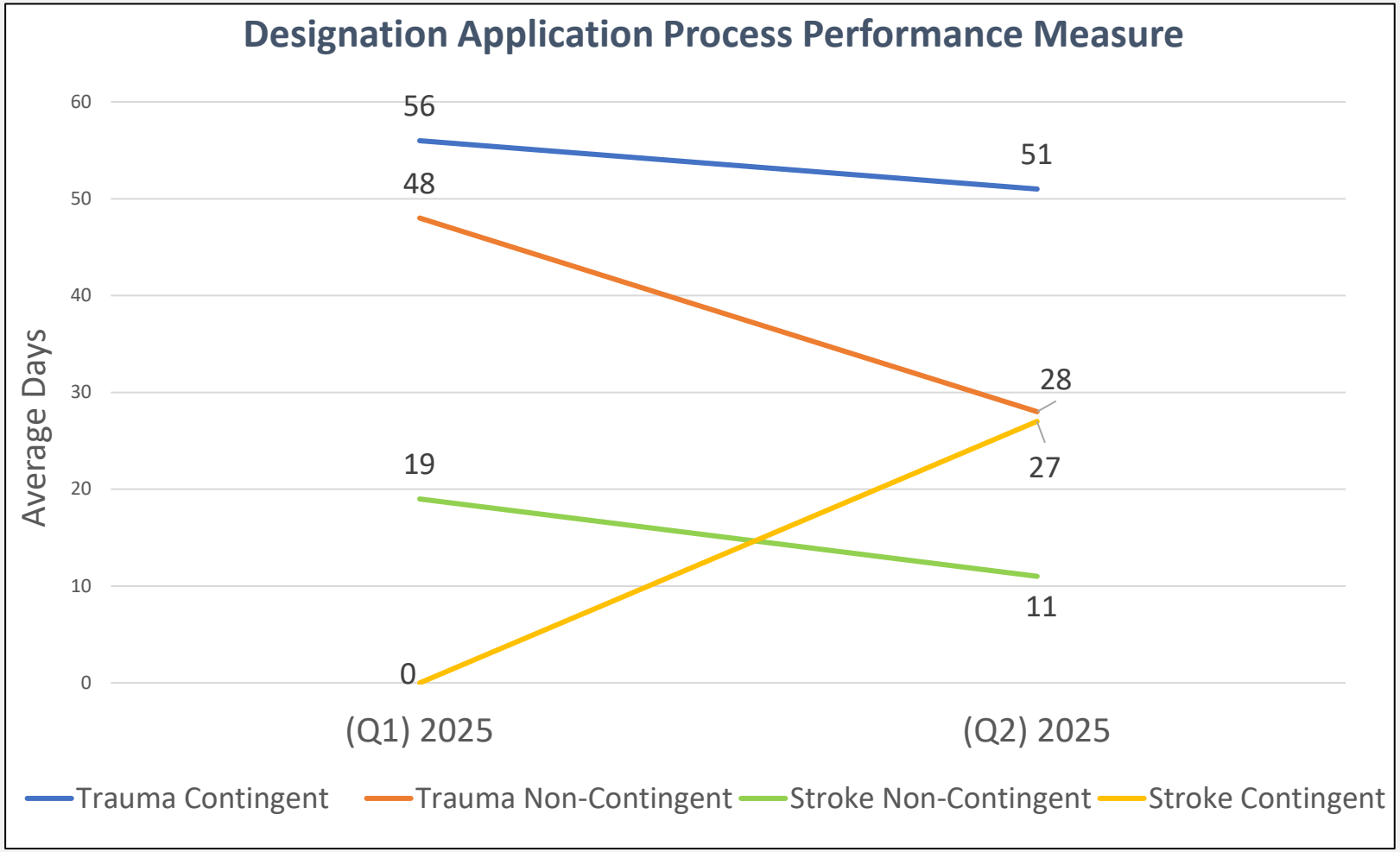
(2nd Quarter)

Stroke – 27 days
Contingent

Stroke – 11
Non–Contingent

Trauma – 51 days
Contingent

Trauma – 28 days
Non–Contingent




Any
Questions

# EMS System Update

Joe Schmider
Texas State EMS Director

# Senate Bill 8 Final Update


- Over **3,252** Education Scholarships processed or in process
- EMS Scholarships in each RAC
  - 1068 EMT
  - 347 AEMT
  - 1837 Paramedics
- 2019 – 68,461 certified personnel; today – **79,376**

(As of 2-22-2025)

# NEMSIS: V5 switch over Continues to move Forward!

For more information on NEMSIS and national dashboards, visit

**https://NEMSIS.org.**

**Watch for a major patch coming soon from NEMSIS.**

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# TAC 157.11 update adopted 2-10-2025

- Dialysis Transport Plan
- Liability Amount Corrected
- Triage Tags or participate in Regional Triage Plan
- Extension of "Letter of Credit" required for another 10 years
- Plain language clean up

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# EMS Licensing Processing Time
# First Quarter FY 25 (Sept, Oct, Nov)

## Overall – All Applications

- **EMS Personnel:** DSHS processed 7,315 applications; the median processing time of 12 days.
- **EMS Educators:** DSHS processed 493 applications; the median processing time of 108 days.
- **EMS Providers:** DSHS processed 88 applications; the median processing time of 75 days.
- **First responder organizations:** DSHS processed 88 applications; the median processing time of 68 days.

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# EMS Licensing Processing Time Second Quarter FY 25 (Dec, Jan, Feb)

## Overall – All Applications

- **EMS Personnel:** DSHS processed 7,987 applications; the median processing time of 8 days.
- **EMS Educators:** DSHS processed 591 applications; the median processing time of 116 days.
- **EMS Providers:** DSHS processed 96 applications; the median processing time of 72 days.
- **First responder organizations:** DSHS processed 74 applications; the median processing time of 68 days.

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# Applications and Background Checks

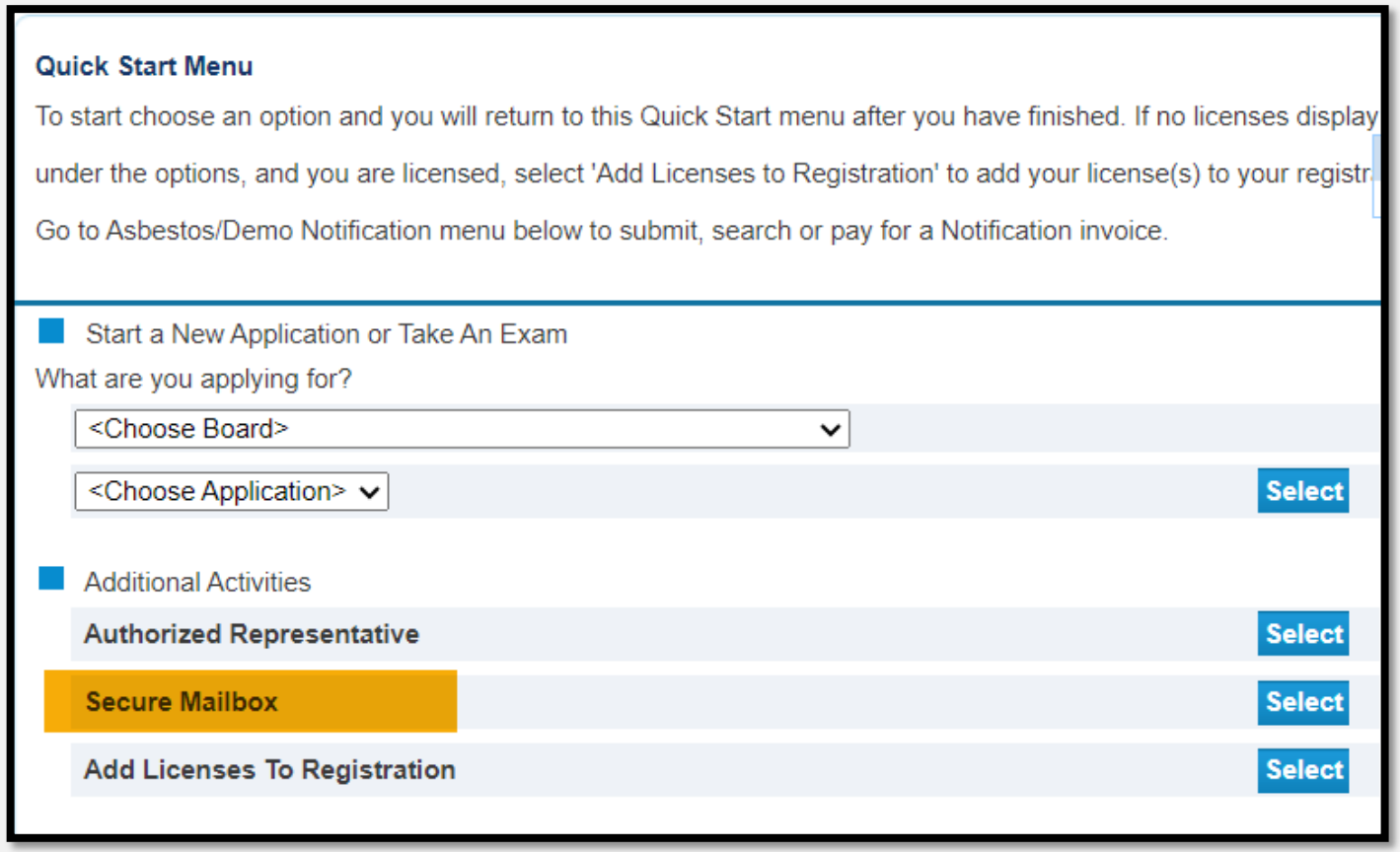
- 2019 vs 2024 - 50% reduction in processing times.
- Apply after you have your NREMT certification.
- Complete your DSHS application BEFORE your fingerprint background check.
- Watch your email for deficiency notices. Check your spam/junk folders.
- List @DSHS.TEXAS.GOV in your safe sender list.
- Renewal applicants ask about certification extensions; no authority to grant extensions.

# EMS Providers

The License Wall Certificate and Vehicle Authorization will be delivered to your DSHS online account Secure Mailbox starting in March.

# Secure Mailbox

- Log in to your account.
- Look in the Quick Start menu.
- Look for Secure Mailbox.

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# Vehicle Authorization

The Vehicle Authorization will be a single document that can be printed and copied for each of your vehicles.

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This certifies that the EMS provider listed below has submitted acceptable evidence of compliance with the Texas Emergency Health Care Act, Chapter 773, of the Health and Safety Code, and is hereby granted an EMS Provider License by the State of Texas. An EMS provider license is non-transferable. This document is valid only for the EMS Provider named below.

[redacted]

License Number: [redacted]
Expiration Date: May 31, 2025
Issue Date: May 16, 2023

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

## EMS PROVIDER VEHICLE AUTHORIZAION

A copy of this document is to be prominently displayed in the patient compartment of each authorized EMS vehicle while in service or response ready.

For this document to be valid, the license plate number must be written in by the EMS provider in the space below.

| | |
|---|---|
| Doc Number: [redacted] | Mobile Intensive Care Unit<br>**Highest Level of Care Designation** |
| | _____<br>**Vehicle License Plate Number** |

# Vehicle Authorization

To make the Vehicle Authorization valid. Write in the License Plate number of the vehicle.

# Questions?

**EMS PROVIDER VEHICLE AUTHORIZAION**

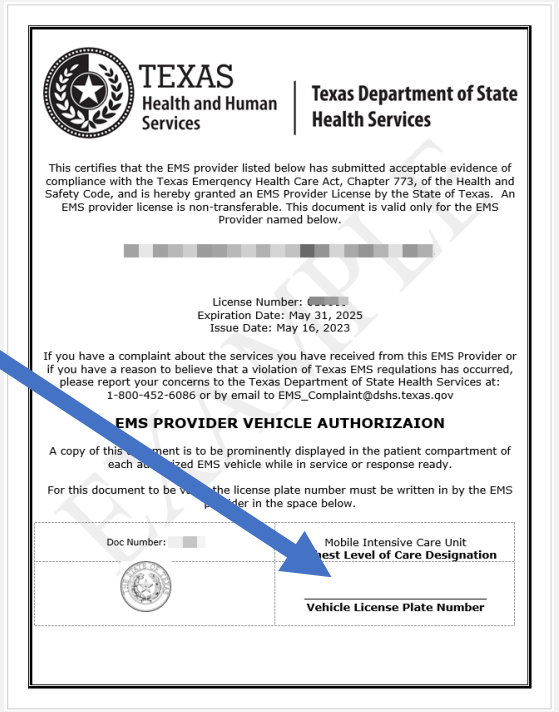
A copy of this document is to be prominently displayed in the patient compartment of each authorized EMS vehicle while in service or response ready.

For this document to be valid, the license plate number must be written in by the EMS provider in the space below.

Doc Number: [redacted]

Mobile Intensive Care Unit
**Highest Level of Care Designation**

**Vehicle License Plate Number**



TEXAS Health and Human Services | Texas Department of State Health Services

This certifies that the EMS provider listed below has submitted acceptable evidence of compliance with the Texas Emergency Health Care Act, Chapter 773, of the Health and Safety Code, and is hereby granted an EMS Provider License by the State of Texas. An EMS provider license is non-transferable. This document is valid only for the EMS Provider named below.

[redacted]

License Number: [redacted]
Expiration Date: May 31, 2025
Issue Date: May 16, 2023

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

**EMS PROVIDER VEHICLE AUTHORIZAION**

A copy of this [illegible]ment is to be prominently displayed in the patient compartment of each a[illegible]zed EMS vehicle while in service or response ready.

For this document to be v[illegible] the license plate number must be written in by the EMS p[illegible]der in the space below.

Doc Number: [redacted]

Mobile Intensive Care Unit
[illegible]hest Level of Care Designation

**Vehicle License Plate Number**

TEXAS Health and Human Services

Texas Department of State Health Services

# Certificates Delivered Online

- EMS Personnel
- Educators
- EMS Providers (Starts March 2025)
- First Responder Organizations

Certificates are available in the secure mailbox within three days of application approval.

# Questions for EMS/Trauma Systems?

*Thank You*

TEXAS
Health and Human Services

Texas Department of State Health Services

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

March 7, 2025

**Gavin Sussman**
**EMS and Trauma Registries Manager**

# About EMSTR

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

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

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

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

# Cardiac Data Request 2022

Response and Request Times for Patients Transferred Between Facilities

TEXAS Health and Human Services
Texas Department of State Health Services

# Inclusion Criteria and Definitions

- Patients within Texas EMS dataset:
  - Incident location type of hospital.
  - Destination type – hospital emergency department (ED) or hospital non-ED bed.
- Request time – Time between Public Safety Answering Point (PSAP) and Unit Arrival on Scene.
- Response time – Time between Unit Notified of Dispatch and Unit Arrival on Scene time(s).

# Cardiac Inclusion Criteria and Definitions

- All Cardiac patients – Protocols used for any cardiac arrest or cardiac-related event.
- Limited Cardiac dataset – Protocols used:
  - Medical-Cardiac Chest Pain
  - Medical-Hypotension/Shock (Non-Trauma)
  - Medical-Pulmonary Edema/CHF
  - Medical-ST-Elevation Myocardial Infarction (STEMI)
- ST-elevation myocardial infarction (STEMI) cardiac dataset – Protocols used were 'Medical-ST-Elevation Myocardial Infarction’.

# Cardiac Transfer Request and Response Times

| All Cardiac Patients | Total Number | Mean | Median |
|---|---|---|---|
| Request Time | 6,262 | 41.32 minutes | 19 minutes |
| Response Time | 6,262 | 22.78 minutes | 16 minutes |

| Limited Cardiac Dataset | Total Number | Mean | Median |
|---|---|---|---|
| Request Time | 5,618 | 40.40 minutes | 18 minutes |
| Response Time | 5,618 | 22.30 minutes | 16 minutes |

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2025.

# STEMI* Transfer Request and Response Times

| STEMI Cardiac Dataset | Total Number | Mean | Median |
|---|---|---|---|
| Request Time | 115 | 19.99 minutes | 8 minutes |
| Response Time | 115 | 17.25 minutes | 7 minutes |

*ST-Elevation Myocardial Infarction (STEMI) – a subset of all cardiac patients

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2025.

# Request Time Over Mean – Time

997 total patients with a request time **over** 40.4 minutes (mean) of the 5,618 total cardiac patients.

| Request time | Number | Percent |
|---|---|---|
| Less than one hour (40.4 minutes - 1 hour) | 342 | 34.30% |
| One to two hours | 384 | 38.52% |
| Two to three hours | 146 | 14.64% |
| Three to four hours | 53 | 05.32% |
| Greater than four hours | 72 | 07.22% |
| **TOTAL** | **997** | **100%** |

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2025.

# Request Time Over Mean – Rural / Urban

- Of all rural cardiac transfers, 14.01% of request times **are greater than** 40.4 minutes.
- Of all urban cardiac transfers, 18.66% of request times **are greater than** 40.4 minutes.

| Rural / Urban | Number | Percent |
|---|---|---|
| Rural | 176 | 14.01% |
| Urban | 804 | 18.66% |
| Missing | 17 | N/A |

N = 997

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2025.

# Request Time Over Mean (40.4 minutes) – Regional Advisory Council (RACs) A-K

| RAC | Percent of patients greater than the mean |
|---|---|
| A | 04.42%* |
| B | 15.38%* |
| C | 00.00% |
| D | 13.99%* |
| E | 29.38%* |
| F | 25.00% |
| G | 06.45%* |
| H | 36.00% |
| I | 00.00% |
| J | 21.58%* |
| K | 03.33% |

* = RACs with 100 or more patients in the data subset.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2025.

# Request Time Over Mean – RACs L-V

| RAC | Percent of patients greater than the mean |
|---|---|
| L | 11.35%* |
| M | 16.67% |
| N | 18.31% |
| O | 26.02%* |
| P | 10.83%* |
| Q | 15.35%* |
| R | 20.04%* |
| S | 01.85%* |
| T | 10.00% |
| U | 23.21%* |
| V | 20.72% |

* = RACs with 100 or more patients in the data subset.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2025.

# Response Time Over Mean – Time

2,116 total patients (37.66%) with a response time **over 22.3 minutes** (mean) of the 5,618 total cardiac patients.

| Request time | Number | Percent |
|---|---|---|
| Less than one hour (22.3 minutes - 1 hour) | 1,780 | 84.12% |
| One to two hours | 292 | 13.80% |
| Two to three hours | 34 | 01.61% |
| Greater than three hours | 10 | 00.47% |
| **TOTAL** | **2,116** | **100%** |

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2025.

# Response Time Over Mean – Rural / Urban

- Of all rural cardiac transfers, 25.56% of response times **were greater** than 22.3 minutes.
- Of all urban cardiac transfers, 41.17% of response times **were greater** than 22.3 minutes.

| Rural / Urban | Number | Percent |
|---|---|---|
| Rural | 321 | 25.56% |
| Urban | 1,774 | 41.17% |
| Missing | 21 | N/A |

N = 2,116

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2025.

# Response Time Over Mean – RACs A-K

| RAC | Percent of patients greater than the mean |
|---|---|
| A | 09.94%* |
| B | 23.08%* |
| C | 05.88% |
| D | 20.28%* |
| E | 41.98%* |
| F | 31.25% |
| G | 18.06%* |
| H | 30.00% |
| I | 00.00% |
| J | 31.65%* |
| K | 15.56% |

* = RACs with 100 or more patients in the data subset.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMSTR, January 2025.

# Response Time Over Mean – RACs L-V

| RAC | Percent of patients greater than the mean |
|---|---|
| L | 11.89%* |
| M | 13.33% |
| N | 39.44% |
| O | 44.10%* |
| P | 37.74%* |
| Q | 58.23%* |
| R | 43.25%* |
| S | 10.19%* |
| T | 10.00% |
| U | 64.88%* |
| V | 14.09% |

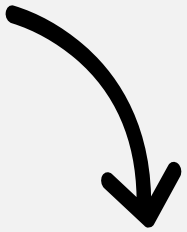
* = RACs with 100 or more patients in the data subset.

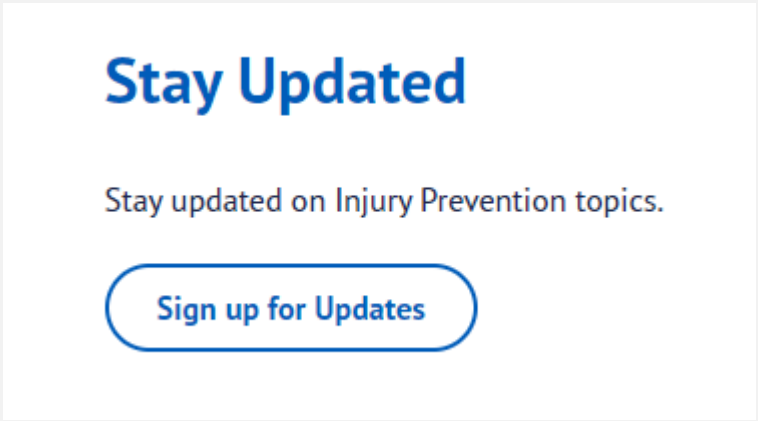
Data prepared by Injury Prevention Unit Epidemiologists.
Data from EMSTR, January 2025.

# Receive Injury Prevention Updates

Sign up to receive periodic injury prevention-related updates:

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





# Thank you!

EMSTR EMS Cardiac Data

Injury.Prevention@dshs.texas.gov

TEXAS
Health and Human Services

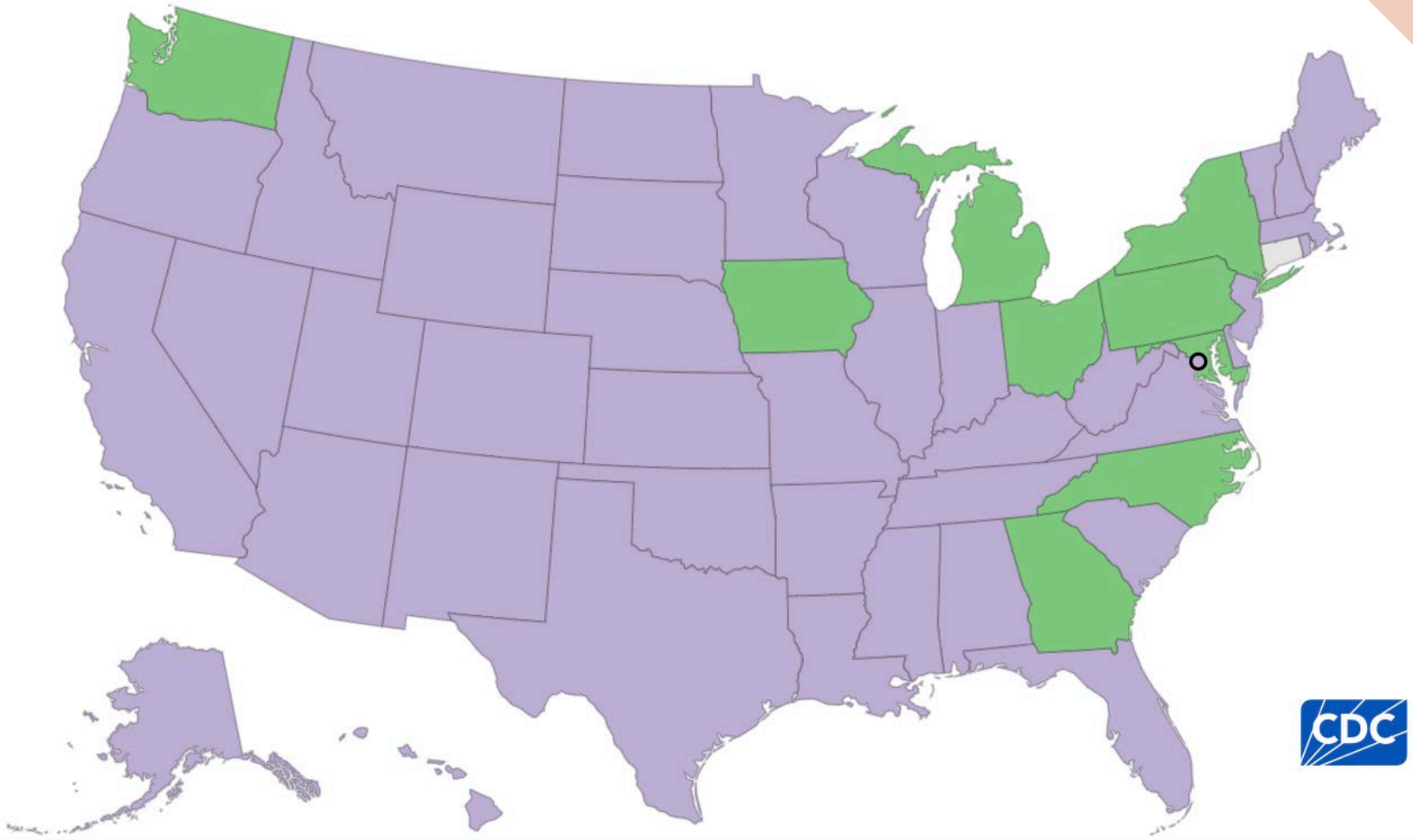
Texas Department of State Health Services

# 7. Violence and Injury Prevention Research Center (VIPR) project

Jeffrey Temple, PhD, McGovern Medical School, University of Texas Health Science Center at Houston


VIPR
TEXAS VIOLENCE AND INJURY PREVENTION RESEARCH CENTER

# Map of Injury Control Research Centers 2019-2024



ICRCs

Funded ICRC

Not Funded

# CDC Violence and Injury Prevention Research Center

**External Advisory Board**
Chair, TBD

**Jeff R. Temple, PhD**
Center Director

**Melissa Peskin, PhD**
Co-Director

**Christopher Greeley, MD, MS**
Co-Director

**Internal Advisory Board**
Chair, Mary E. Aitken, MD, MPH

## Administrative

**Jeff R. Temple, PhD**
Center Director

**Co-Directors and Leads**

**Susan Gillespie, MD, PhD**
Social Justice Lead

**Shannon Guillot-Wright, PhD**
Policy Lead

**Cary Cain, PhD**
Evaluation Lead

**Elizabeth Baumler, PhD**
Biostatistician

## Research Core

**Leila Wood, PhD**
Research Lead

**Keisha S. Ray, PhD**
Bioethicist

**Research Projects**
Hernandez; Cummings; McKay; Cain

## Training & Education Core

**Christine Markham, PhD**
Training & Edcation Lead

**Howard Pryor, MD**
Professional Healthcare Continuing Education

**Annalyn DeMello, PhD**
Classroom Education

**Alexander Testa, PhD**
Continuing Education

## Outreach Core

**Kimberly Kay Lopez, DrPH**
Outreach Lead

**Milke Wilkerson, PhD**
Communication & Dissemination

**Youth Advisory Board**
Chair, TBD

# Violence and Injury Prevention Research Center: A Texas Medical Center Collaborative

## Vision

To be a worldwide leader in equity-focused violence and injury prevention through research, outreach, training, and education.

## Mission

To eliminate the burden of violence and injury by promoting health equity and increasing the number of researchers, practitioners, policymakers, and community agencies who detect, attend to, and support the development and implementation of effective prevention and intervention programs.

VIPR
TEXAS VIOLENCE AND INJURY PREVENTION RESEARCH CENTER

**Overarching aim:** Advance the science and reduce the burden of injury and violence in children and young adults in Southeast Texas and throughout the state (initially) and across bordering states and the nation (long-term). The VIPR approach is mixed methods, participatory, health equity focused, centering research to practice to policy.

| | | |
|---|---|---|
| Training and Education Focus | Professional development and education for practitioners, students, trainees, community members | Courses, webinars, seminars, and certificate programs to develop content knowledge and program development related to injury and violence detection, prevention, and intervention |
| | Training and technical assistance to community partners and healthcare facilities | Resources and training (e.g., intervention mapping, adaptive action methods, telehealth) will be offered to community and healthcare partners to improve their new and existing programs |
| | Leadership development | Annually, twelve graduate trainees from health-related fields will be selected for a mentored leadership training experience across the three academic institutions. |

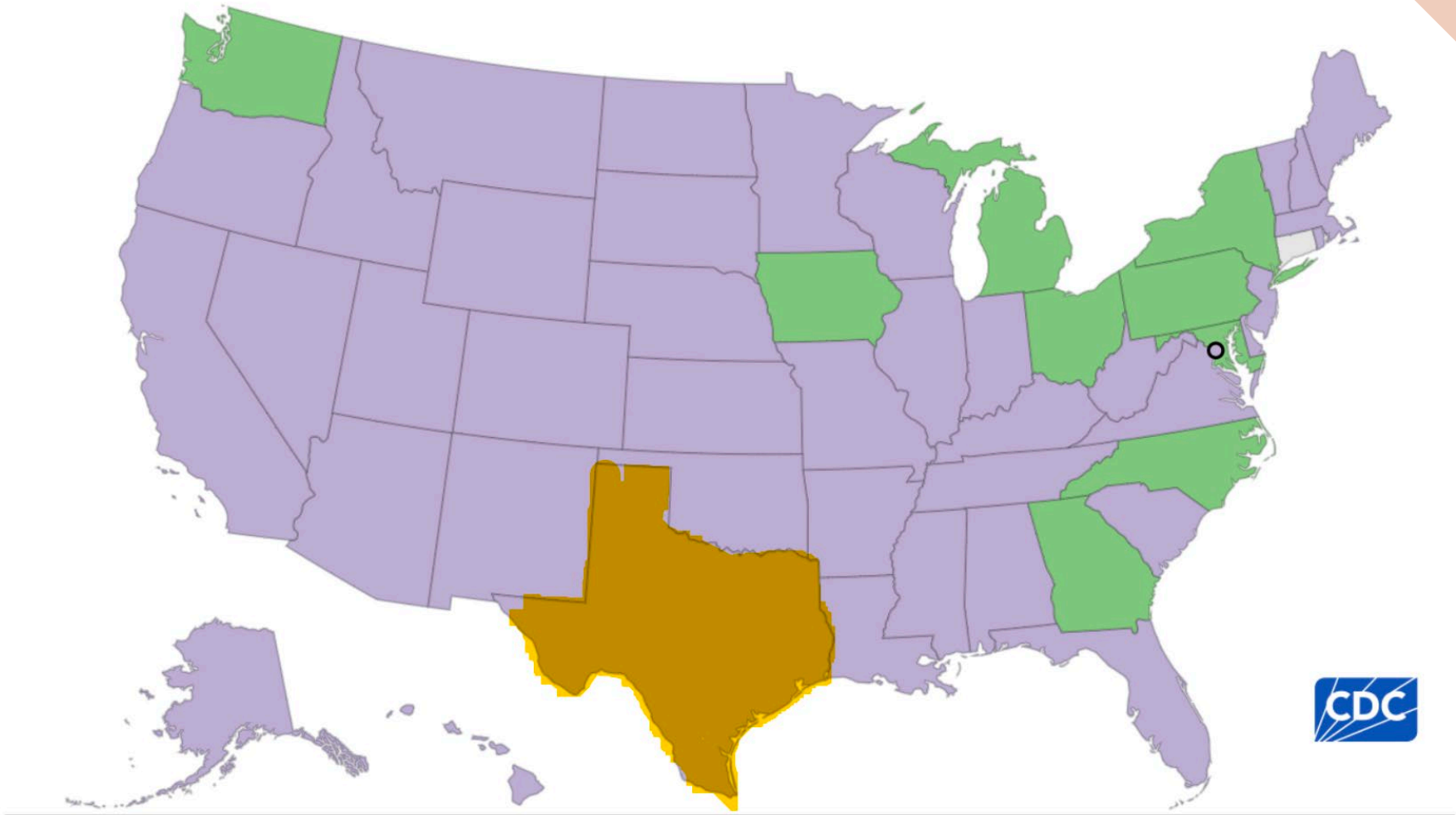
| | | |
|---|---|---|
| Outreach Focus | Integrate outreach into VIPR Center-sponsored research | Translate findings from VIPR investigators into practical solutions, disseminate research findings and recommendations to appropriate audiences, and work towards systems change through collective impact models |
| | Create and disseminate communication products and education/training materials | The outreach team will use a community-based participatory research approach to develop dissemination print, broadcast, and digital media materials that are tailored to segments of our target market |
| | Facilitate community capacity building | Outreach grants (4 per FY) will be awarded to organizations to extend the Center's reach and ensure that community leaders are able to sustain and fund projects that are important to their communities. |

# Violence and Injury Prevention Research Center: A Texas Medical Center Collaborative


VIPR
TEXAS VIOLENCE AND INJURY PREVENTION RESEARCH CENTER

| PI | | Project Title | NCIPC Research Priority & Years |
|---|---|---|---|
| 1<br>**Sandra McKay, MD**<br>Associate Professor<br>UT Health<br>**Policy focus:**<br>Firearm sale legislation |  | Target Safety: A collaboration of firearm retailers and health care to address suicide prevention | Suicide Prevention; Urgent Threat; Director Priority<br>Years 1-2<br>Human Participants: Yes |
|  | 2<br>**Belinda Hernandez, PhD, MPH**<br>Assistant Professor, UT Health<br>**Policy focus:**<br>School-based policy prevention programs | Using an innovate implementation strategy to increase the translation of effective youth violence prevention programs in schools | Youth Violence; Translation Project<br>Years 1-3<br>Human Participants: Yes |
| 3<br>**Angela Cummings, DrPH**<br>Assistant Professor, Baylor College of Medicine<br>**Policy focus:**<br>Pediatric primary care suicide screening |  | Timing of Suicide Screening in Pediatric Primary Care | Suicide Prevention; Urgent Threat; Director Priority<br>Years 3-5<br>Human Participants: Yes |
|  | 4<br>**Cary Cain, PhD, MPH, RN**<br>Assistant Professor, Baylor College of Medicine<br>**Policy focus:**<br>Well-child visit reimbursements | Examination of perinatal depression symptom trajectories and associated maternal and child predictors and short and long-term outcomes | Adverse Childhood Experiences; Urgent Threat; Director Priority<br>Years 4-5<br>Human Participants: Yes |

# Map of Injury Control Research Centers 2019-2024




ICRCs

Funded ICRC

Not Funded

# 8. Document review and approval

*a. GETAC Strategic Plan*

*b. GETAC Standard Operating Procedures*

*c. GETAC Committee Guidelines*

# 9. GETAC Committee Action Items

# 9.a. GETAC Air Medical & Specialty Care Transport Committee Update to Council - March 2025

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 |
|---|---|---|
| **Coordinated Clinical Care:**<br>*Texas Department of Public Safety – State Troopers* | • Awaiting approval of content from DPS leadership<br>- Delays due to leadership changes & restructuring<br>• Final presentation anticipated to be ready for Q2 committee & Council approval | |
| **Prevention:**<br>*HEMS Specific Mental Health Awareness* | • Resource content is complete<br>• Design options created. Refinement in progress<br>• Anticipate final product presentation in Q2 with request for committee & Council approval | |

# AMSCT Committee

## 2025 Committee Priorities Update

**Priority Not Implemented**
**Priority Activities Recorded**
**Priority Completed and Monitored**

| Committee Priorities | Current Activities | Status |
|---|---|---|
| **Prevention & Injury:**<br>*Proper security of pediatric patients during air & ground transport* | • Data gathering – What is the compliance percentage?<br>- Is there really an issue?<br>• Resource, education, or motivation issue?<br>• Determine additional activities PRN | |
| **Performance Improvement & Patient Safety:**<br>*Fatigue Risk Management Programs for Air Medical & Specialty Care Transport Providers* | • Supporting research & data collection<br>• Development of a White Paper supporting the implementation & utilization of a FRMP | |
| **Coordinated Clinical Care:**<br>*Develop and disseminate education on how the No Surprises Act (NSA) is protecting patients from exorbitant air medical transport bills.* | • *Air Medical resource utilization guidelines emphasis*<br>• *NSA data compilation*<br>• *Resource document creation* | |

# GETAC Committee/Stakeholder Action Item Request for Council June 2025

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

Air Medical & Specialty Care Transport Committee

# Action Item Request and Purpose

- The AMSCT Committee requests to be placed on the Council agenda for the Quarter 2 meeting.
- 3 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 Q2 2025 – *completed today*
  - AMSCT Committee approval of presentation – *Q2 2025*
  - Pending AMSCT Committee approval, seek Council approval of presentation & approval to hold the first class – *Q2 2025*
  - Pending Council approval, the first class will be scheduled – *TBD with dependence on Sgt. Templeton's schedule & new academy schedule*
  - If necessary, revisions will be made & approval again sought from AMSCTC & Council – *Q3 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 Q2 2025 – *completed today*
  - AMSCT Committee approval of resource document – *Q2 2025*
  - Pending AMSCT Committee approval, seek Council approval of document – *Q2 2025*
  - Pending Council approval, distribution of resource document – *Q3 2025*

Email
TAAMS Website
GETAC

AMSCT Committee page on DSHS Website
EMS Conference Exhibit Hall

# Action Item Request and Purpose

- The purpose of the 3rd request is to seek Council approval of the completed “Trauma Facility Helicopter Safety & LZ Training” presentation, which has been developed to fulfill requirement (h)(6) of the ***Texas Administrative Code Chapter 157, Rule 157.126 Trauma Facility Designation Requirements*** which will be effective on September 1, 2025.

  *“Facilities must have landing zone capabilities or system processes to establish a landing zone (when rotor-wing capabilities are available)* ***with appropriate staff safety training.”***

# Benefit and Timeline

- Providing a comprehensive and standardized educational presentation will not only fulfill, but facilitate, the “appropriate staff safety training” requirement for all Texas trauma facilities.

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

# 9.a.A. Approval: DPS trooper education program document

*Deferred until Q2*

# 9.a.B. Approval: Helicopter Emergency Medical Services (HEMS)-specific mental health awareness resource document

*Deferred until Q2*

# 9.b. GETAC Cardiac Care Committee Update to Council - March 2025

Chair: Dr. Jamie McCarthy

Vice-chair: Dr. Craig Cooley

# Cardiac Committee

## 2025Committee Priorities Update

**Priority Not Implemented**
**Priority Activities Recorded**
**Priority Completed and Monitored**

| Committee Priorities | Current Activities | Status |
|---|---|---|
| 1. *Promote timely transfer of cardiac emergencies to higher level of care when required.* | *Data reviewed from DSHS.*<br>*Plan to further explore data elements to look for opportunities for improvement in timely transfers* | In progress |
| 2. *Evaluate penetration of CPR instructions prior to EMS arrival Evaluate PSAP centers to determine if pre-arrival, life-saving instructions are being provided* | *Review survey done previously and share with committee and other RACs.*<br>*Plan for formal ask from RACs in June meeting* | In progress |
| 3. *Educate policymakers on the Texas Emergency Healthcare System.* | *Support use of RAC Data Collaborative across the state*<br>*Collaborate with other relevant cardiac organizations*<br>*Educate state leaders and legislature on importance of data sharing and state designation* | Initial discussion |

# Cardiac Committee

## 2025 Committee Priorities Update

**Priority Not Implemented**
**Priority Activities Recorded**
**Priority Completed and Monitored**

| Committee Priorities | Current Activities | Status |
|---|---|---|
| 4. Out of Hospital Cardiac Arrest – AED access/bystander CPR - assessment. (continued from 2024) | *Review previous data and consider additional years of data for comparison* | Initial discussion |

# 9.c. GETAC Disaster Preparedness & Response Committee Update to Council - March 2025

Chair: Eric Epley, CEM, NREMT-P

Vice-chair: Wanda Helgesen, RN

# GETAC Disaster Preparedness & Response Committee

## 2025 Committee Priorities Update

**Priority Not Implemented**
**Priority Activities Recorded**
**Priority Completed and Monitored**

| Committee Priorities | Current Activities | Status |
|---|---|---|
| 1. Emergency Medical Task Force Development and Review of performance | *Received quarterly performance summary from EMTF State Coordination Office (SCO) showing doubling of deployment tempo, esp. relating to Wildland Fire Medical Support missions.* | |
| 2. TX EMS Wristband and Pulsara app deployment and improvement | *Discussed utilization of EMS wristbands and value of national format standard, and also discussed Pulsara new feature for Family Reunification and ingestion of Raptor and other attendance/accountability systems at schools, hospitals, etc* | |
| 3. Prehospital Whole Blood Initiative, development of Rotation Systems, Walking Blood Banks and MCI Whole Blood Push Packs. | *Reviewed summary of PHWBTF, walking blood banks, 35 vs 21 day blood bags and concerns of 35 day bag going away in 2026. Discussed the riders that TEMSA and STRAC have pursued for $4M funding for whole blood, equip and training, esp for rural areas* | |

# 9.c.A. GETAC Pre-Hospital Whole Blood Task Force Update to Council - March 2025

Chair: Eric Epley, CEM, NREMT-P

Vice-chair(s): Donald Jenkins, MD, FACS; C.J. Winckler, MD

# GETAC Pre-Hospital Whole Blood Task Force

## 2025 Task Force Priorities Update

**Priority Not Implemented**
**Priority Activities Recorded**
**Priority Completed and Monitored**

| Committee Priorities | Current Activities | Status |
|---|---|---|
| 1. Implement Pre-Hospital Whole Blood Programs in every county in Texas using a regional guidelines approach emphasizing a system of rotation to prevent waste. | • *Identifying scope, cost, and building on existing prehospital whole blood programs.*<br>• *Building consensus on regional processes.* | |
| 2. Establish Funding from the State Legislature in support of Pre-Hospital Whole Blood Programs | • *Establishing relationships with key State Representatives to carry asks to the Legislature.* | |
| 3. Identify alternative collection processes for whole blood ensuring adequate resources across the state. | • *Identifying research on walking blood bank programs.*<br>• *Identifying Level I and Level III Trauma Centers as Blood Centers.* | |

# 9.d. GETAC EMS Committee Update to Council - March 2025

Chair:  Chief Kevin Deramus, LP

Vice-chair: Chief James Campbell, LP

# EMS Committee

## 2025 Committee Priorities

| Strategic Plan Pillar & Objective | Strategy and Implementation Activity |
|---|---|
| 1. Clinical Elements - Coordinated Clinical Care: *Improve timely access to care for urgent conditions regardless of geographic location across the state.* | **a. Strategy:** *Develop standards to minimize the time from the onset of illness or injury to definitive care.* (This is Strategy 2 under the Coordinated Clinical Care section of the Clinical Elements Pillar.)<br>**b. Implementation Activity:** Review and implement best practice guideline that have proven to reduce EMS Wall Times and improved throughputs of patient which ultimately improve care for community EMS departments as well. |
| 2. **Clinical Elements – Emergency Medical Services:**<br>Evaluate PSAP centers throughout the state to determine if pre-arrival, lifesaving instructions are being provided. If it is determined that pre-arrival instructions are not being provided, advise the DSHS on strategies to ensure that all 911 callers are afforded this service. Overall goal to reduce RLS responses when not indicated. | **a. Strategy:** Develop a survey for PSAP centers, or the Council of Governments (COGs) that oversee PSAP centers to determine if any pre-arrival instructions are provided when a caller accesses 911. If it is determined that the need exist, advise the DSHS on strategies for partnering services to assist in filling the need or advise the DSHS on contracting opportunities for this service<br>**b. Implementation Activity:** The committee formed a workgroup in 2024 to address this concern. Initially the workgroup with support of the Regional Advisory Councils will collect data on the use of RLS and those using EMD to triage the use of RLS. The committee will address gaps in statewide coverage of EMD use and overuse of RLS due to that impact. Recommendation strategies for correction may include statewide initiative (much like whole blood TF) to address this growing concern. Workgroup formation underway with Workgroup Chair – Arron Clouse chairing |

# EMS Committee

## 2025 Committee Priorities

| Strategic Plan Pillar & Objective | Strategy and Implementation Activity |
|---|---|
| 3. System Support – Essential emergency Healthcare Systems: Encourage review of legislation and/or regulations supporting further innovation and enhanced integration of EMS into the Texas emergency healthcare system. | **a. Strategy:** Provide recommendations guiding regulatory and legislative decision-making relevant to the Texas Emergency Healthcare. (This is Strategy 1 under the Essential Emergency Healthcare Systems of the System Support Pillar)<br>**b. Implementation Activity:** Review current 157.11 rules in conjunction with statewide EMS participation and guidance from DSHS using a workgroup format that will update the EMS Committee on a quarterly basis and thereby updating the council on the progress of the review in preparation for the rule change process.. |
| | |

# EMS Committee

## 2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

| Committee Priorities | Outcomes | Status |
|---|---|---|
| Rule Revision 157.11 and 157.14 | *Dwayne Howerton is chairing our workgroup on rule revision to provide a framework for recommendations to DSHS / GETAC Council for revision recommendations.* | |
| Workplace Violence on EMS Personnel<br><br>Reduction of Red, Lights and Sirens usage. | Chief Hayes is leading the newly created committee workgroup to discuss the every increasing concern and problem of worquarter support of DSHS staff. Finalizing data survey to EMS providers for next GETAC Quarterly Meetings.<br><br>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). The workgroup work is underway. | |
| Stroke Workgroup | Donald Janes – Chair our workgroup that is corresponding and working directly with the Stroke Committee provided updates and continues to work to approve stroke recommendations | |

# EMS Committee

## 2025 Committee Priority Outcomes

**Priority Not Implemented**
**Priority Activities Recorded**
**Priority Completed and Monitored**

| Committee Priorities | Current Activities | Status |
|---|---|---|
| **Strategy:** *Develop standards to minimize the time from the onset of illness or injury to definitive care.* (This is Strategy 2 under the Coordinated Clinical Care section of the Clinical Elements Pillar.) | *Committee petitioned GETAC Council in late 2024 for broad collaborative TASK FORCE that will bring all affected into proactive discussions to identify problematic area and initiate proven strategies to increase patient throughput and return EMS units to serve their communities timely and efficiently. Last years Committee work on the Wall Time white paper will serve as a primary source document for the Task Force work and understanding of definition and time parameters associated with an EMS response call. Chief Wait – is Chairing our Task Force - coordinating* | |
| **Strategy:** Develop a survey for PSAP centers, or the Council of Governments (COGs) that oversee PSAP centers to determine if any pre-arrival instructions are provided when a caller accesses 911. If it is determined that the need exist, advise the DSHS on strategies for partnering services to assist in filling the need or advise the DSHS on contracting opportunities for this service. | *The GETAC EMS Committee has created a workgroup to work monthly on this initiative that will initially gather data from the council of governments and by the assistance of the regional advisory councils to provide a clear state-wide picture of the current problems of what we believe to be an overuse of RLS (red lights and sirens) usage by EMS and First Responders in the State of Texas. This is believed to be a parallel problem of lack of EMD dispatching initiatives that leaves TCO's with limited options of triaging 911 responses. This data and workgroup initiative is in progress. – Aaron Clouse chairing workgroup meeting monthly for data collection.* | |
| **Strategy:** Provide recommendations guiding regulatory and legislative decision-making relevant to the Texas Emergency Healthcare. (This is Strategy 1 under the Essential Emergency Healthcare Systems of the System Support Pillar)<br>**b. Implementation Activity:** Review current 157.11 and 157.14 rules in conjunction with statewide EMS participation and guidance from DSHS using a workgroup format that will update the EMS Committee on a quarterly basis and thereby updating the council on the progress of the review in preparation for the rule change process.. | *Committee has formed a working workgroup that is meeting monthly in conjunction with DSHS representation to review and make recommendations for rule changes. Our initial meeting was held January 14th, 2025. Follow-up discussion was also held and Dwayne Howerton is chairing this workgroup. We have discussed time-lines and will receive an rule revision update process from DSHS State EMS Director at our February meeting. The workgroup will provider quarterly updates and concepts of rule revisions to the public at our quarterly GETAC EMS Committee Meeting and further update this council at those meetings.* | |

# EMS Committee

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

## 2025 Recommended Performance Improvement Initiatives

| 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.*<br><br>*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.<br><br>Chief Wait has been assigned our Chair for this Task Force and is organizing. | |

# GETAC Committee/Stakeholder No Action Item Request for Council March 2025

Kevin Deramus, LP

EMS Committee

# 9.d.A. Approval: Workplace Violence in EMS Survey

Deferred until Q2

# 9.e. GETAC EMS Education Committee

Chair: Macara Trusty, LP

Vice-Chair: Christopher Nations, LP

# 9.f. GETAC EMS Medical Directors Committee Update to Council - March 2025

Christopher Winckler MD, LP Chair

Elizabeth Fagan MD, Vice Chair

# 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 Pediatric Stroke. 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.<br>EMS Acute Stroke Routing Resource Documents for Pediatric Stroke. Voted on and Approved. | |
| Pediatric Consideration for Consultation and Transfer Documents to Review | Will review and make recommendations on the following resource documents:<br>a) Child Physical Abuse Toolkit<br>b) American Burn Association Transfer Guideline<br>c) Pediatric Interfacility Transfer Quality Improvement Plan | |

# GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

| Committee Priorities | Current Activities | Status |
|---|---|---|
| Emergency Transport Task Force Discussion | Will assist with staffing of task force to develop and recommend interfacility transfer terminology. | |
| Update on Wall Times in NCTTRAC | North Central Texas Trauma Registry Regional Advisory Council presented wall time performance/times for EMS/hospitals. This information and process will help advise other RACs on how to implement similar programs in their respective systems. Information shared with other RACs/EMS agencies. | |

# GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

| Committee Priorities | Current Activities | Status |
|---|---|---|
| Discussion on Safe Transport of Pediatrics in Ambulance | Discussed best practices throughout the county on safe transport of pediatrics. GETAC EMS MD Committee discussed what is legal vs best practice, does this need to be an advisory or resource document, or does this need to go into 157.11? Lengthy discussion on what the current law is and what that means practically for EMS implementation. First step for this committee is to try and determine what the current law is regarding safe transport of pediatrics in an ambulance. | |
| Discussion on Practice of EMS Medical Direction under Texas Medical Board Rule 169 | Develop a list of duties and expectation of Texas EMS Medical Directors, previously found in TMB Chapter 197. It would be best to place these duties and expectation in 157.11. This may also be an advisory or resource document. | |

# GETAC EMS Medical Directors

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

| Committee Priorities | Current Activities | Status |
|---|---|---|
| Develop a list of prehospital best practices | Develop resource documents for the State of Texas regarding prehospital care. Topics under consideration include but are not limited to treatment for hemorrhagic shock, MCI for heat, ultrasound, sepsis, etc. Strong consideration will be given to evidence-based prehospital practice. These would be resource documents and would not replace or appropriate any EMS Medical Director's practice of medicine withing their EMS agency as prescribed by Texas Administrative Code 169 or 157. | |
| Discuss acceptable EMS medical director requirements/ courses | This rule was previously in TMB Chapter 197. A Texas Medical Director must within two years of becoming an off-line medical director: have 12 hours of formal CE; be EMS Board certified or complete a DSHS approved medical director course, and completed one hour of formal EMS CME every two years. It is unclear if this language is contained or carried over in TAC 169, or somewhere else in administrative code. The Committee will work to determine the standing of this past requirement. | |

# 9.g. GETAC Injury Prevention & Public Education Committee Update to Council - March 2025

Chair: Mary Ann Contreras, RN

Vice-Chair: Courtney Edwards, DNP

# IPPE Committee 2025 Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

| Committee Priorities | Current Activities | Status |
|---|---|---|
| 1. **Clinical Elements** : Identify evidence-based prevention strategies that to increase capacity for a safe and healthy lifestyle. (Objective 4 of Clinical Elements/Injury)<br>1. Promote coordinated capacity expansion of Child Passenger Seat Technicians in the State of Texas | Workgroup identification of strategic plan to increase CPST availability from technician population ration from 1:1279 to 1:1000 by December 2028. Initial steps include:<br>• increasing technician courses,<br>• partnering with community organizations,<br>• establishing technician incentives,<br>• developing mentorship programs, and<br>• developing regional hubs for instructor led training. | |
| 2. **System Support**: Explore innovations for providing interactive, collaborative, and targeted public education. (Objective 2 of System Support/Public Education)<br><br>1. Develop innovative and applicable knowledge content in drowning prevention strategies for public consumption across the State of Texas | Workgroup identification of means to collaborate with existing agencies including the Texas Drowning Prevention Coalition to develop a tailored statewide plan aligning with the national plan that promotes drowning prevention strategies for public consumption across the State of Texas.<br>• Assess current rates of drowning in specific types of bodies of water in the State of Texas<br>- Explore best practice strategies<br>- Create a plan of implementation of public education and bystander intervention for drowning prevention | |

# IPPE Committee 2025 Priorities Update

**Priority Not Implemented**
**Priority Activities Recorded**
**Priority Completed and Monitored**

| Committee Priorities | Current Activities | Status |
|---|---|---|
| 1**Clinical Elements** :<br>Involve stakeholders in strategic discussions. (Objective 2 under Clinical Elements/System Integration)<br>Identify and incorporate all patient populations, including children, into system design. (Objective 3 under Clinical Elements/System Integration)<br><br>1. Create a workplace violence position statement paper in which various stakeholders cooperate and build upon shared ideologies and values to enhance clinical performance and reduce injury of healthcare professionals. | • Review literature of current state of workplace violence in the healthcare system, including successful measures to mitigate harm<br>• Develop recommendations for uniform standards of practice to reduce workplace violence that can be integrated into healthcare systems<br>• Focus areas include worker wellness fostering reduction of occupational stress | |

# 9.h. GETAC Pediatric Committee Update to Council - March 2025

Chair: Christi Thornhill, DNP

Vice-chair: Belinda Waters, RN

# Pediatric Committee

## 2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

| Committee Priorities | Outcomes | Status |
|---|---|---|
| *Develop a pediatric imaging guideline for transferring facilities following the ALARA principles* | *1. Research and develop best practice guideline for imaging in pediatric patients following the ALARA principles for the pediatric patient.*<br>*2. Provide education for transferring and receiving facilities regarding over imaging of children and delay of transfer due to unnecessary imaging at referring facility.*<br>*3. Utilize Regional PECC's and RAC's to disseminate guideline and education.* | |
| Develop a pediatric transfusion/massive transfusion guideline for transferring facilities | 1. Research and develop best practice guideline for pediatric transfusion/massive transfusion guideline.<br>2. Provide education for transferring facilities regarding pediatric transfusion/massive transfusion guideline.<br>3. Utilize Regional PECC's and RAC's to disseminate guideline and education. | |

# Pediatric Committee

## 2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

| Committee Priorities | Outcomes | Status |
|---|---|---|
| Develop a pediatric guideline for transferring facilities for pediatric pain assessment and appropriate pain management | 1. Research and develop best practice guideline for pediatric specific pain assessment and pain management.<br>2. Provide education for transferring facilities regarding pediatric pain assessment and pain management.<br>3. Utilize Regional PECC's and RAC's to disseminate guideline and education. | |
| *Request and review data from the state registry and National Pediatric Readiness Improvement Project regarding vital signs and weight in kilograms obtained on pediatric patients.* | *1. Utilize Regional PECC's and RAC's to disseminate best practices regarding complete set of vital signs and weight in kilograms for pediatric patients.*<br>*2. Increase compliance.* | |
| Complete 2024 priority of developing a toolkit regarding pediatric magnet/button battery ingestion. | 1. Complete toolkit<br>2. Present to GETAC for approval<br>3. Utilize Regional PECC's and RAC's to disseminate information. | |

# Pediatric Committee

## 2025 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

| Committee Priorities | Outcomes | Status |
|---|---|---|
| Complete 2024 priority of developing a toolkit regarding Sudden Cardiac Arrests/Deaths in Pediatrics | 1. Complete toolkit<br>2. Present to GETAC for approval<br>3. Utilize Regional PECC's and RAC's to disseminate information. | |
| *Pediatric Simulations* | *1. Monitor utilization of 13 pediatric simulations by regional PECC's.*<br>*2. Request data from state regarding trauma center compliance with bi-annual simulations after rule 157.126 is in effect.* | |
| | | |

# GETAC Committee/Stakeholder Action Item Request for Council March 225

Christi Thornhill, DNP, APRN, CPNP-AC

Pediatric Committee

# 9.h.A. Approval: Head Injury/Concussion Toolkit

# Action Item Request and Purpose

- Request the approval of the GETAC council for the Head Injury/Concussion Toolkit presented last quarter.
  - To be able to post the approved toolkit to the Pediatric Committee website

- Request the council to discuss and evaluate recommendations regarding the use of health information exchanges (HIEs) for radiological image sharing for patient transfers.
  - To enhance patient care by enabling secure, efficient, and real-time access to diagnostic imaging, reducing duplication of studies, and facilitating advanced care planning at receiving facilities.

# Benefit and Timeline

- Request the approval of the GETAC council for the Head Injury/Concussion Toolkit presented last quarter.
  - Requesting approval today

- Request the council to discuss and evaluate recommendations regarding the use of health information exchanges  (HIEs) for radiological image sharing for patient transfers.
  - 6-12 months to assess platforms available, cost, gaps, and readiness

# 9.h.B. Approval: Pediatric Consideration for Consultation and Transfer document

Deferred until Q2

# 9.h.C. Update: TX Pediatric Readiness Improvement Project

Dr. Kate Remick

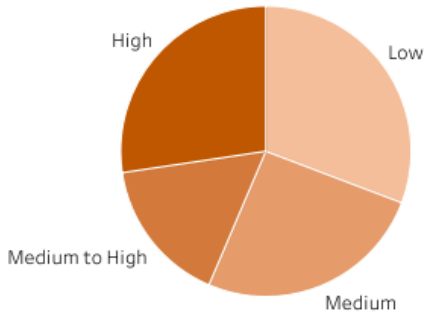
# NPRQI Reporting Dashboard
## 117 Sites / 20,936 Records

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

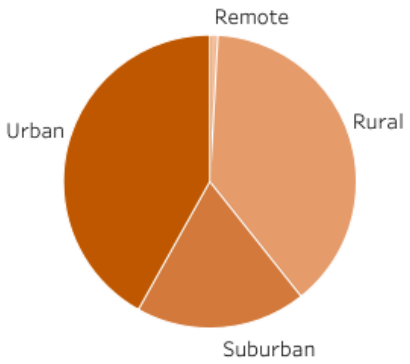
| Year | Quarter | Site | Results View | Patient Clinical Group |
|---|---|---|---|---|
| Select all that apply | Limit the # of Quarters by selecting Year(s) first | | | |
| All | All | Multiple values | Table | All Patients (Core Measures) |

GO

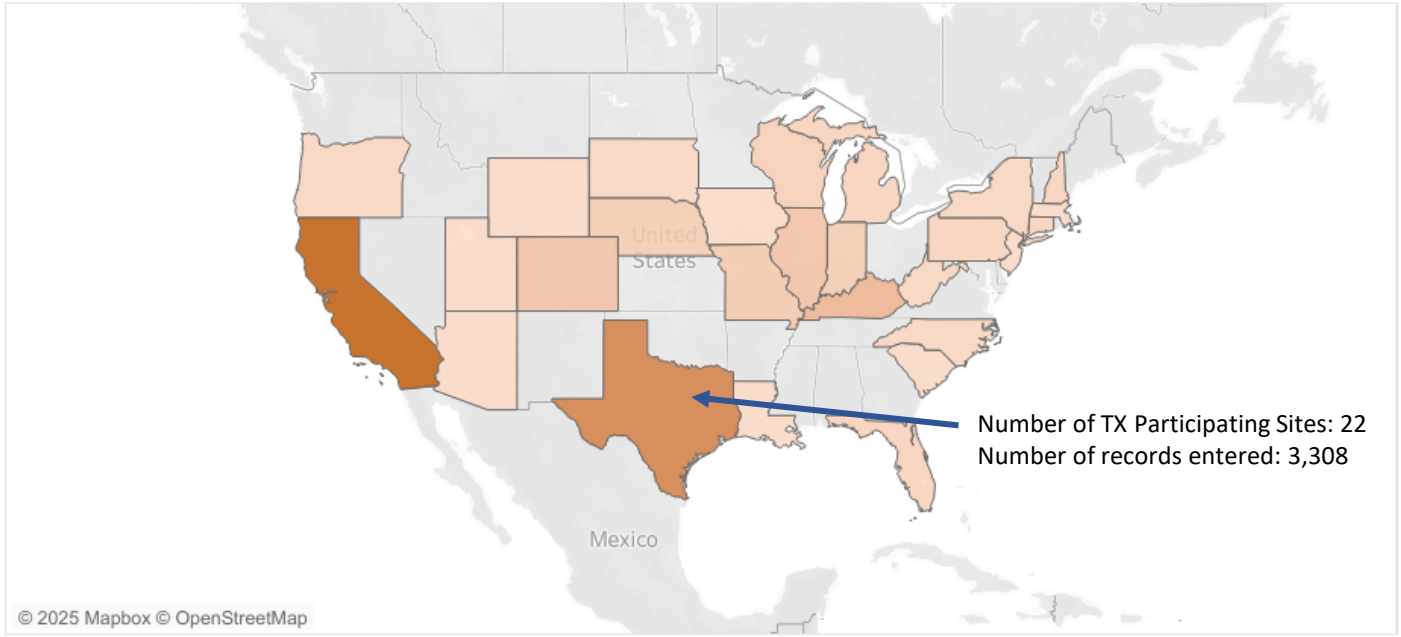
### Number of Sites by Patient Volume Category



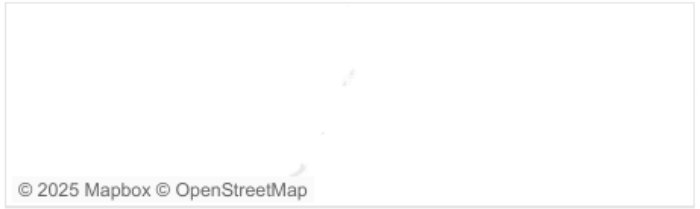

### Number of Sites by Geographic Category

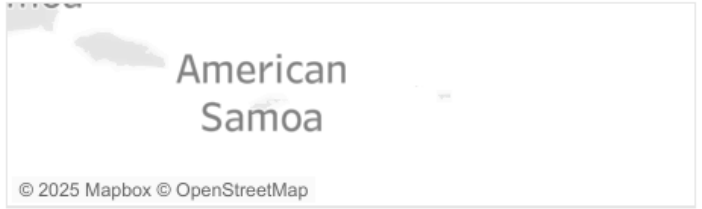



### Participation in the National Pediatric Readiness Quality Initative






# Texas Participating Regional Advisory Councils

NPRQI Regional Reporting Dashboard

**State: Texas**

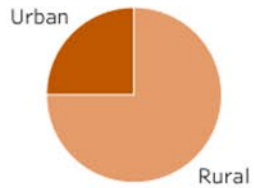
**22 Sites / 3,308 Records**

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

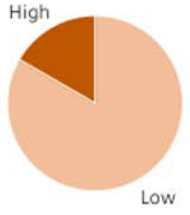
| Year | Quarter | Region | Results View | Patient Clinical Group |
|---|---|---|---|---|
| Select all that apply | Limit the # of Quarters by selecting Year(s) first | | | |
| All | None | All | Table | All Patients (Core Measures) |

GO

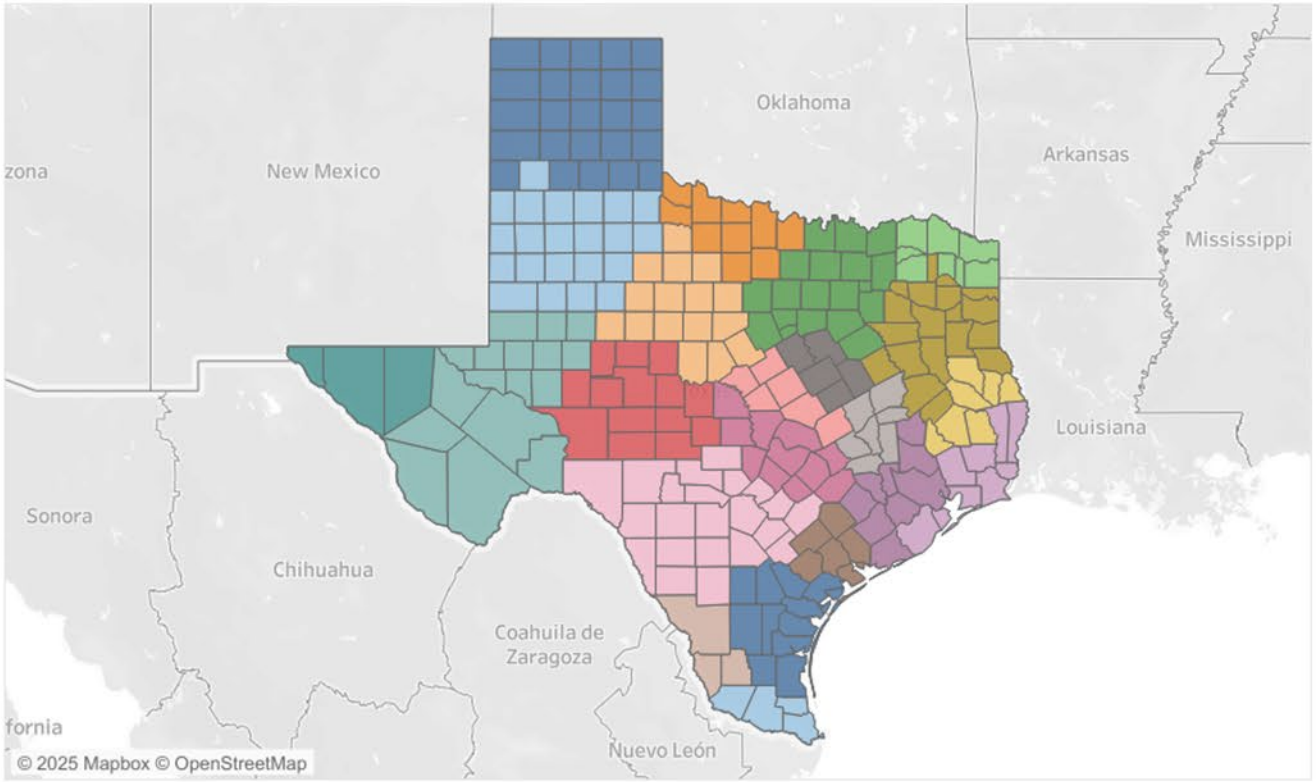
## Sites by Geographic Category



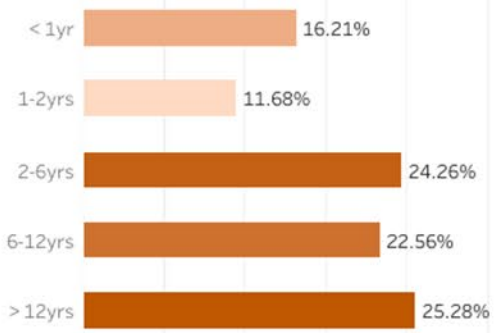

## Sites by Pediatric Patient Volume



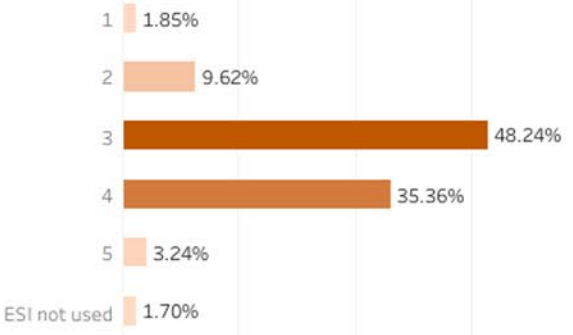

## Participation in the National Pediatric Readiness Quality Initative




## Patients by Age Category




## Patients by Triage Level



# NPRQI: Texas Participating Sites

| Texas Registered Sites | 52 |
| --- | --- |
| Texas Sites with Executed POA | 29 |
| Texas Sites Entering Data | 22 |
| Texas Registered RACs | 4 (I, J,K,0) |

# Texas **Participating Sites** By Regional Advisory Council (RAC) With Executed Agreement

| B-B |
| --- |
| University Medical Center * |

| C-North Texas |
| --- |
| Graham Hospital District * |

| E-North Central Texas |
| --- |
| Baylor All Saints Medical Center at Fort Worth * |
| Methodist Southlake Hospital * |
| Texas Health Hospital Mansfield * |
| Methodist Richardson Medical Center * |
| Palo Pinto General Hospital * |
| Medical City ER Saginaw |

| G-Piney Woods |
| --- |
| Christus Mother Frances Hospital – Jacksonville * |
| Christus Mother Frances Hospital - Winnsboro * |
| Christus Mother Frances Hospital - Tyler |

| 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 * |
| Big Bend Regional Medical Center |

| K-ConchoValley |
| --- |
| Schleicher County Medical Center * |
| Lillian M. Hudspeth Memorial Hospital * |
| Reagan Hospital District |

| L-Central Texas |
| --- |
| Coryell Memorial Hospital * |

| M- Heart of Texas |
| --- |
| Hill Regional Hospital |

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

| O-Capital Area |
| --- |
| Baylor Scott and White Medical Center - Marble Falls |

| P- Southwest Texas |
| --- |
| Christus Children's * |

| R- East Texas Gulf Coast |
| --- |
| HCA Houston Healthcare Mainland |

| S- Golden Cresent |
| --- |
| Lavaca Medical Center * |
| Cuero Regional Hospital * |

* Denotes sites entering data

Minimum of 5 sites needed to see RAC dashboard

# Texas Sites By Regional Advisory Council (RAC) – **Registration Started**

| B-B |
| --- |
| W.J. Mangold Memorial Hospital |

| C- North Texas |
| --- |
| Faith Community Hospital |

| E- NorthCentral Texas |
| --- |
| Texas Health Arlington Memorial Hospital |
| Methodist Mansfield Medical Center |
| Ennis Regional Medical Center |
| Lake Granbury Medical Center |

| F- NorthEast Texas |
| --- |
| Christus Mother Frances Hospital - Sulphur Springs |
| Titus Regional Medical Center |

| G- Pineywoods |
| --- |
| Longview Regional Medical Center |
| UT Health East Texas Pittsburg Hospital |

| J- Texas |
| --- |
| Iraan General Hospital |
| Reeves County Hospital |

| O- Capital Area |
| --- |
| Ascension Seton Bastrop Hospital |
| Ascension Seton Medical Center Austin |
| St. David's South Austin Medical Center |

| P- Southwest Texas |
| --- |
| Guadalupe Regional Medical Center |

| Q-SoutheastTexas |
| --- |
| Houston Methodist West Hospital |
| Woman's Hospital of Texas |

| R- East Texas Gulf Coast |
| --- |
| Christus Southeast Texas - St Elizabeth and St Mary |
| Memorial Hermann Pearland Hospital |

| S- Golden Cresent |
| --- |
| Memorial Medical Center |
| Yoakum Community Hospital |

| T- Seven Flags |
| --- |
| Laredo Medical Center |

# State Dashboard: Core Measures Table View

Performance Report: Texas

Year(s): All, Quarter(s): All | Clinical Measures Group: All Patients (Core Measures)

Measures with fewer than 10 records will not be displayed

State Performance (As Filtered) represents the average of site performances in Texas and responds to site and patient level filters (displayed with minimum of 5 sites)

*State-Wide Performance represents the average of site performances for ALL hospitals in Texas (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

| Bundle | # of Records | Quality Measure | State Performance (As Filtered) | State-Wide Performance* | National Performance ** |
|---|---|---|---|---|---|
| ASSESSMENT | 3,308 (21 sites) | % of pediatric patients with weight documented in kilograms only | 55.1 % | 55.1 % | 60.1 % |
| | | % of pediatric patients with pain assessed | 83.5 % | 83.5 % | 80.9 % |
| | 3,238 (21 sites) | Median ED length of stay | 138.6 minutes | 138.6 minutes | 172.9 minutes |
| ABNORMAL VITAL SIGNS | 1,979 (17 sites) | % of high acuity pediatric patients with vital signs re-assessed | 91.6 % | 91.6 % | 83.8 % |
| | 1,250 (16 sites) | Median time from triage to first intervention | 39.5 minutes | 39.5 minutes | 52.6 minutes |

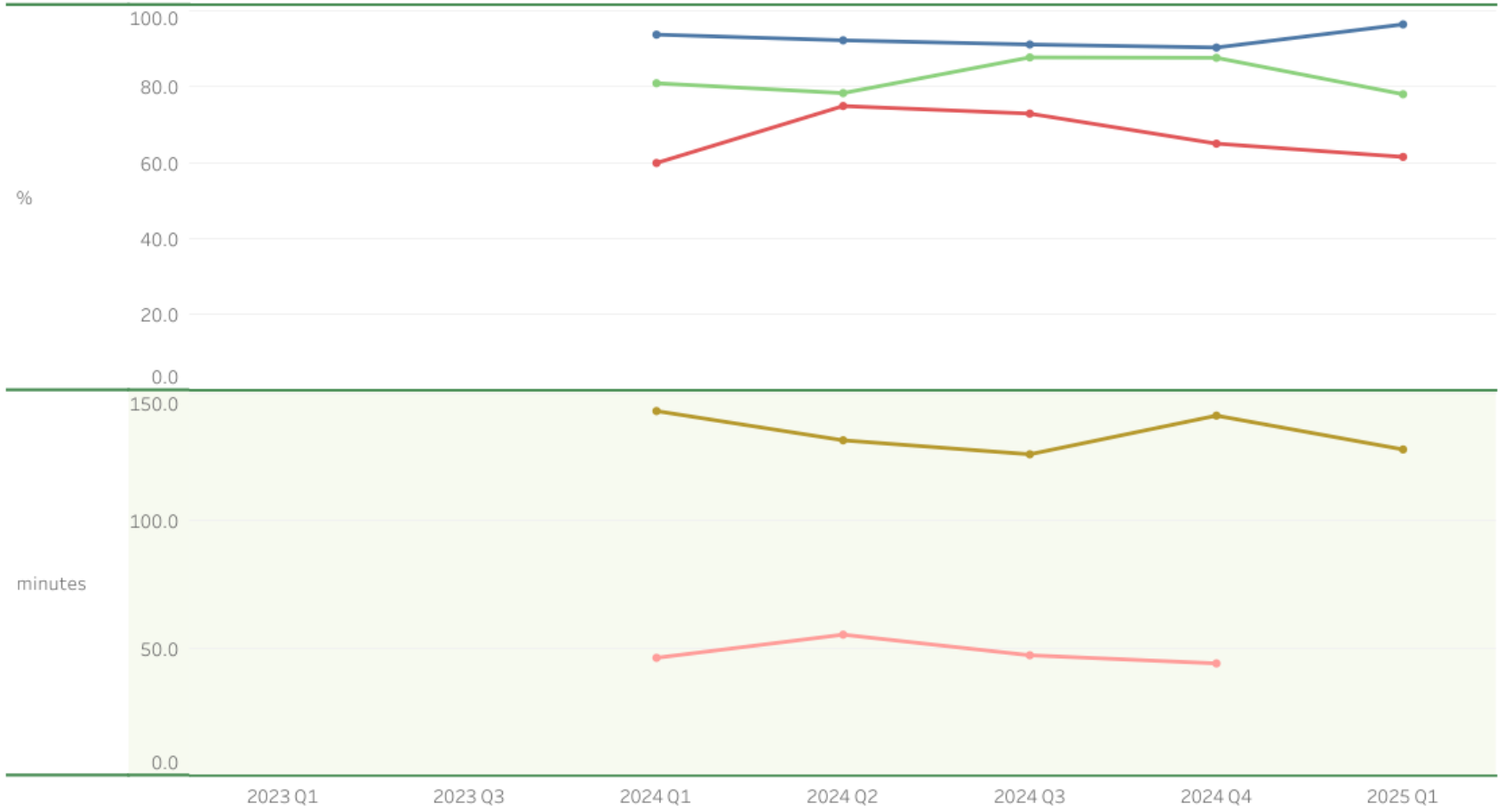
# State Dashboard: Core Measures Graph View

Texas
Performance Report
Year(s): All, Quarter(s):All | Clinical Measures Group All Patients (Core Measures)
Measures with fewer than 5 Sites with Less than 10 records will not be displayed

Back to Landing

Last Dataset Refresh:
2/23/2025 5:44:36 PM
Last Patient Included:
2/14/2025

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 crite..
- Median time from triage to transport
- % of transferred pediatric patients who were discharged from the recei..

# NPRQI: Texas Head Trauma Measures

Performance Report: Texas

Year(s): All, Quarter(s): All | Clinical Measures Group: Patients with Head Trauma (Bundle only)

Measures with fewer than 10 records will not be displayed

State Performance (As Filtered) represents the average of site performances in Texas and responds to site and patient level filters (displayed with minimum of 5 sites)

*State-Wide Performance represents the average of site performances for ALL hospitals in Texas (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

| Bundle | # of Records | Quality Measure | State Performance (As Filtered) | State-Wide Performance* | National Performance ** |
|---|---|---|---|---|---|
| HEAD TRAUMA | 354 (12 sites) | % of pediatric patients with a full set of vital signs obtained (i.e. temperature, heart rate, respiratory rate, oxygen saturation, blood pressure, mental status) | 70.8 % | 70.8 % | 61.0 % |
| | | % of pediatric patients with GCS re-assessment | 61.4 % | 61.4 % | 31.3 % |
| | | % of pediatric patients who received hypotonic saline | 0.0 % | 0.0 % | 0.2 % |
| | 89 (6 sites) | % of pediatric patients with a head CT that met one or more PECARN criteria | 96.1 % | 96.1 % | 75.8 % |

# NPRQI: Texas Suicide Measures

Performance Report: **Texas**

Year(s): All, Quarter(s): All | Clinical Measures Group: Patients with Suicidality (Bundle only)

Measures with fewer than 10 records will not be displayed

State Performance (As Filtered) represents the average of site performances in Texas and responds to site and patient level filters (displayed with minimum of 5 sites)

*State-Wide Performance represents the average of site performances for ALL hospitals in Texas (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

| Bundle | # of Records | Quality Measure | State Performance (As Filtered) | State-Wide Performance* | National Performance ** |
|---|---|---|---|---|---|
| SUICIDALITY | 812 (17 sites) | % of adolescents who were assessed with a suicide screening tool | 46.5 % | 46.5 % | 65.0 % |
| | -- | % of pediatric patients with a positive suicide screen who had a structured suicide assessment | -- | -- | 97.4 % |
| | | % of pediatric patients with a positive suicide screen who received consultation with a licensed mental health professional | -- | -- | 90.3 % |

**Note**: cannot display performance for metrics 2 and 3 because there are less than 5 Texas hospitals entering at least 10 charts each for these measures.

# Rough draft slides to follow

# Texas Participating Regional Advisory Councils

NPRQI Regional Reporting Dashboard

**State: Texas**

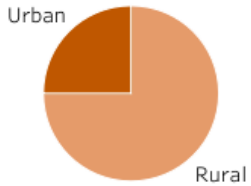
**22 Sites / 3,308 Records**

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

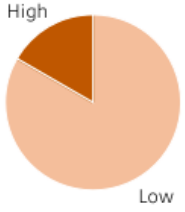
| Year | Quarter | Region | Results View | Patient Clinical Group |
|---|---|---|---|---|
| Select all that apply | Limit the # of Quarters by selecting Year(s) first | | | |
| All | None | All | Table | All Patients (Core Measures) |

GO

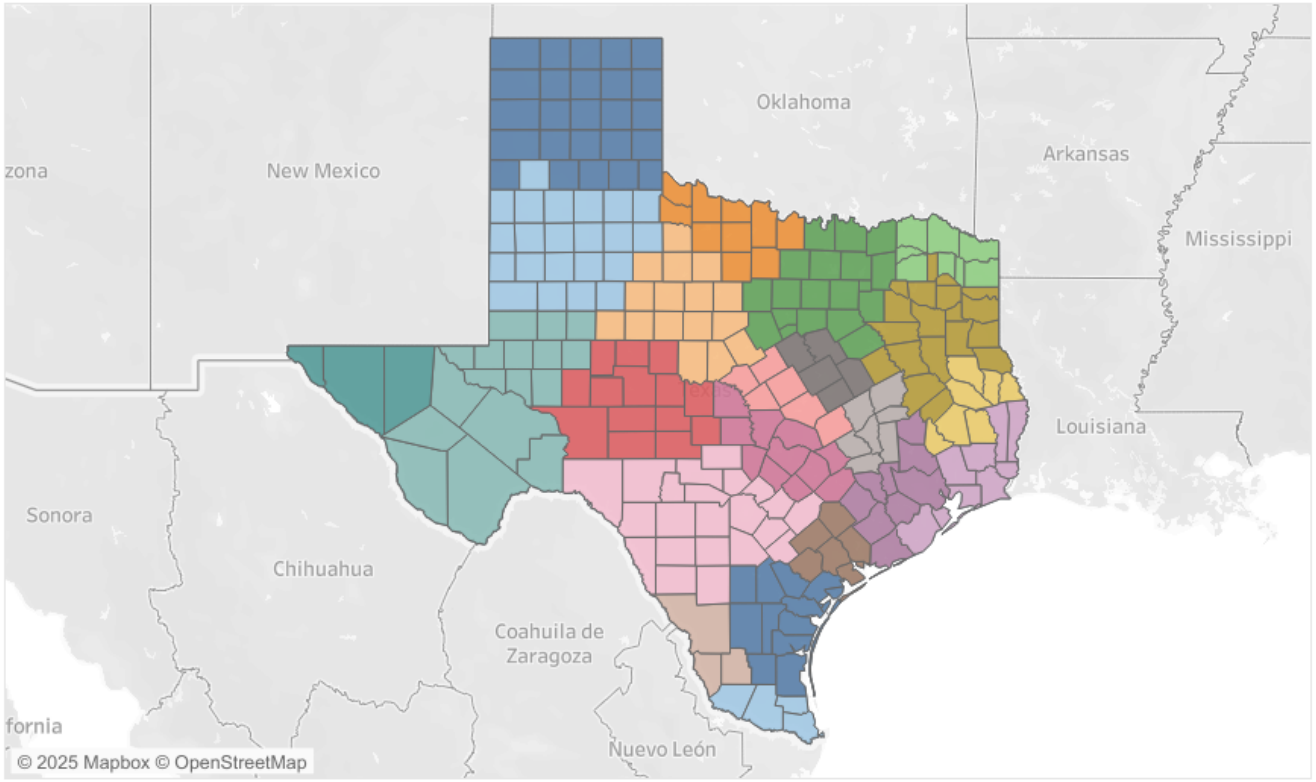
## Sites by Geographic Category



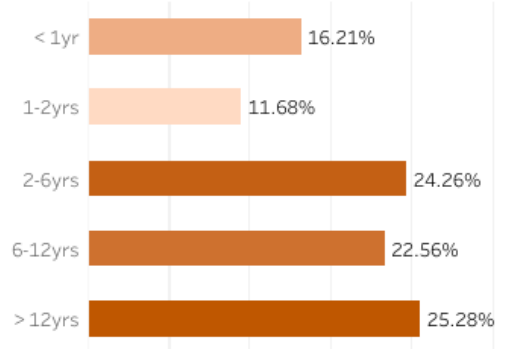

## Sites by Pediatric Patient Volume



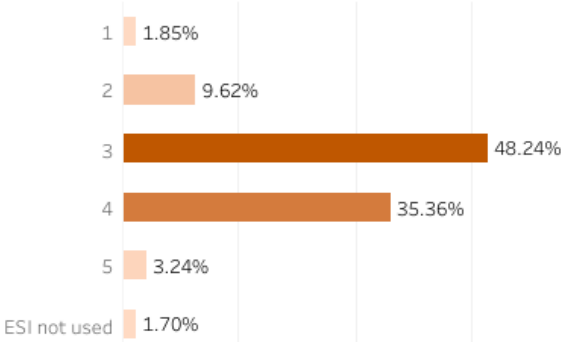

## Participation in the National Pediatric Readiness Quality Initative




## Patients by Age Category




## Patients by Triage Level



# State Dashboard: Core Measures Table View

Performance Report: **Texas**

Year(s): All, Quarter(s): All | Clinical Measures Group: All Patients (Core Measures)

Measures with fewer than 10 records will not be displayed

State Performance (As Filtered) represents the average of site performances in Texas and responds to site and patient level filters (displayed with minimum of 5 sites)

*State-Wide Performance represents the average of site performances for ALL hospitals in Texas (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

| Bundle | # of Records | Quality Measure | State Performance (As Filtered) | State-Wide Performance* | National Performance ** |
|---|---|---|---|---|---|
| ASSESSMENT | 3,308 (21 sites) | % of pediatric patients with weight documented in kilograms only | 55.1 % | 55.1 % | 60.1 % |
| | | % of pediatric patients with pain assessed | 83.5 % | 83.5 % | 80.9 % |
| | 3,238 (21 sites) | Median ED length of stay | 138.6 minutes | 138.6 minutes | 172.9 minutes |
| ABNORMAL VITAL SIGNS | 1,979 (17 sites) | % of high acuity pediatric patients with vital signs re-assessed | 91.6 % | 91.6 % | 83.8 % |
| | 1,250 (16 sites) | Median time from triage to first intervention | 39.5 minutes | 39.5 minutes | 52.6 minutes |

# NPRQI: Texas Head Trauma Measures

Performance Report: Texas

Year(s): All, Quarter(s): All | Clinical Measures Group: Patients with Head Trauma (Bundle only)

Measures with fewer than 10 records will not be displayed

State Performance (As Filtered) represents the average of site performances in Texas and responds to site and patient level filters (displayed with minimum of 5 sites)

*State-Wide Performance represents the average of site performances for ALL hospitals in Texas (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

| Bundle | # of Records | Quality Measure | State Performance (As Filtered) | State-Wide Performance* | National Performance ** |
|---|---|---|---|---|---|
| HEAD TRAUMA | 354 (12 sites) | % of pediatric patients with a full set of vital signs obtained (i.e. temperature, heart rate, respiratory rate, oxygen saturation, blood pressure, mental status) | 70.8 % | 70.8 % | 61.0 % |
| | | % of pediatric patients with GCS re-assessment | 61.4 % | 61.4 % | 31.3 % |
| | | % of pediatric patients who received hypotonic saline | 0.0 % | 0.0 % | 0.2 % |
| | 89 (6 sites) | % of pediatric patients with a head CT that met one or more PECARN criteria | 96.1 % | 96.1 % | 75.8 % |

# NPRQI: Texas Suicide Measures

Performance Report: Texas

Year(s): All, Quarter(s): All | Clinical Measures Group: Patients with Suicidality (Bundle only)

Measures with fewer than 10 records will not be displayed

State Performance (As Filtered) represents the average of site performances in Texas and responds to site and patient level filters (displayed with minimum of 5 sites)

*State-Wide Performance represents the average of site performances for ALL hospitals in Texas (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

| Bundle | # of Records | Quality Measure | State Performance (As Filtered) | State-Wide Performance* | National Performance ** |
|---|---|---|---|---|---|
| SUICIDALITY | 812 (17 sites) | % of adolescents who were assessed with a suicide screening tool | 46.5 % | 46.5 % | 65.0 % |
| | -- | % of pediatric patients with a positive suicide screen who had a structured suicide assessment | -- | -- | 97.4 % |
| | | % of pediatric patients with a positive suicide screen who received consultation with a licensed mental health professional | -- | -- | 90.3 % |

**Note**: cannot display performance for metrics 2 and 3 because there are not currently 5 Texas hospitals entering at least 10 charts each for these measures.

# 9.i. GETAC Stroke Committee

Chair: Robin Novakavic-White, MD

Vice-Chair: Sean Savitz, MD

# Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

| Committee Priorities | Current Activities | Status |
|---|---|---|
| **Report and share quarterly Texas Stroke Quality Performance Report** | • **Review and disseminate Texas Stroke Quality report.**<br>• **Share with TCCVDS.**<br>• **Use the quality report to identify barriers to stroke care and opportunities for improvement.**<br>• **Encourage stroke facility participate with GWTG prehospital and interfacility layers and the RDC.**<br>• **Present DTN performance report** | |
| **RDC report** | • **Update from RDC at Stroke Committee meeting.**<br>• **36% TX stroke facilities participating with RDC** | |
| Patient safety and quality concern | • Letter citing patient safety concern regarding Neuro IR call coverage discussed.<br>• Multiple providers in the state of Texas gave first-hand experience supporting statements in the letter 11/2024.<br>• Stroke Committee and GETAC Council approved as a quality and patient safety concern.<br>• **Seek Guidance**: Request to identify objective measures of impact.<br>• Stroke committee and SSOC WG made recommendations for internal review for hospitals. | |

# Stroke Committee

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| RDC report | • Update from RDC at Stroke Committee meeting.<br>• 36% TX stroke facilities participating with RDC | |
| **Patient safety and quality concern** | • **Letter citing patient safety concern regarding Neuro IR call coverage discussed.**<br>• **Multiple providers in the state of Texas gave first-hand experience supporting statements in the letter 11/2024.**<br>• **Stroke Committee and GETAC Council approved as a quality and patient safety concern.**<br>• **Seek Guidance: Request to identify objective measures of impact.**<br>• **Stroke committee and SSOC WG made recommendations for internal review for hospitals.** | |

# Patient Safety and Quality Concern

- Neuro IR coverage of multiple facilities without adequate backup is a patient safety and quality concern.
  - Concerns:
    - Leads to delays in care
    - Patients inappropriately denied care
    - Inappropriate use of resources (when patient is transferred from one capable CSC to another CSC to accommodate neuro IR)
- Request for **objective measures to demonstrate the delays, patients denied and misuse of resources.**

# SSOC Work Group Discussion

- **SSOC work group recommendations:**
  - **Internal quality review:**
    - Encourage hospitals to perform internal multispecialty review of denied thrombectomy and provide feedback on patients deemed inappropriately denied treatment.
  - **Monitor required and internal performance measures:**
    - Neuro IR notification (page) to response
    - Neuro IR notification to angio team activation
    - Neuro IR notification to hospital arrival
    - Neuro IR notification to patient arrival to angio door
    - Angio door to groin puncture
    - Groin puncture to device deployed

- **Seek Guidance** – How best to demonstrate interfacility stroke transfers from CSC to CSC for thrombectomy/higher level of care.
  - May come from GWTG but would not capture all patients

# NCTTRAC Proposed 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** | • **Approved through GETAC Council 11/2024.**<br>• **Request for clean versions and resource document.**<br>• **Algorithm approved by Stroke, Air Medical, EMS and EMS MD Committees.**<br>• **Resource document for adult algorithm approved by these committees except EMS MD Committee.**<br>• **Pending final approval will present to GETAC Council for approval, RAC Chair meeting and EMS Education Committee.**<br>• **Approval items: Algorithm final version** | |
| Pediatric Task Force | • Worked with Drs. Fagan and Winckler prior to last session.<br>• Ms. Jorie Klein and DSHS approved terminology for pediatric facility.<br>• 03/2025 session - algorithm and resource document approved by Pediatric, Stroke, Air Medical and EMS MD Committees.<br>• 03/2025 revisions requested by EMS Committee and wished to seek input from EMS MD Committee before voting.<br>• Prior to next session will submit minor revisions to the Pediatric Stroke Task Force for final approval.<br>• Pediatric Stroke Tip Sheet and Supplement Resource approved by Stroke Committee. I have asked Dr. Stuart Fraser to submit the documents to the Pediatric Stroke Task Force for approval.<br>• Next steps, minimum capability recommendations for pediatric hospital to be destinations for pediatric stroke. | |

# Resource Document

**PREHOSPITAL STROKE TRIAGE AND MANAGEMENT**

1. **Goal**
   - The GETAC endorsed a triage recommendation to assist pre-hospital providers with the rapid identification, assessment, and triage of all suspected stroke patients in Texas. This recommendation aims to lower barriers to seeking emergency care for stroke and ensure that stroke patients receive care at appropriate facilities promptly.
2. **Purpose**
   - In consultation with EMS leaders, local, regional, and state agencies, as well as medical authorities, current national guideline statements, and local experts; the following recommendations seek to ensure that all patients with a known or suspected stroke are rapidly identified, assessed and triaged as outlined below.[1-9] Standardized approaches to prehospital stroke assessment, triage, management, and interfacility documentation are encouraged for 9-1-1 call centers and EMS dispatchers.
   - The prehospital acute stroke triage and transport recommendations direct the triage of adult patients (greater than ≥ 18 years of age) to the most appropriate facility based on the duration and severity of symptoms. Multi-society endorsed guideline statements and recommendations,[1-9] as well as the consensus of expert opinion (Pediatric Neurologist, Vascular Neurologists, Neuroendovascular Surgeons, and Neurosurgeons) based on clinical experience and in conferment with GETAC council, EMS, EMS Medical Directors, Air Medical and Stroke Committees, are outlined in these recommendations. See Annex A: *Prehospital Stroke Triage Algorithm*.
   - Regional stakeholders should collaborate to consider local prehospital and health care resources, individual stroke center performance, and geographic considerations to create an optimal SSOC and destination protocol to ensure effective and efficient stroke care.[1, 4, 8, 9] Ideal destination plans should factor in all available data sources, including traffic patterns, site-specific performance data, and associated clinical outcomes.[1, 4, 8] EMS agencies should implement destination plans based upon both time and severity for patients with suspected LVO within 24 hours of last known well that prioritize a nearby CSC over other centers of lower capability when available within acceptable transport times.[4, 7, 8]
   - In response to the perceived need for greater access to thrombectomy, several of the accrediting agencies for stroke centers introduced a fourth level of certification for facilities that can effectively perform EVT but do not meet all the criteria of a CSC, the Thrombectomy Capable Stroke Center (TSC). The American Stroke Association 2019 SSOC Recommendations and the American Heart Association Mission: Lifeline Stroke outline that the TSC certification is intended for regions of the country that are not readily accessible to CSCs; CSCs are the preferred destination for patients with suspected LVO when they are within acceptable transport times.[1, 4, 7] If no CSC is available, a TSC should be the preferred destination for these patients from among all nearby PSCs.[1, 2, 4, 7]
   - Lifeline Stroke Committee felt it was best to err on the side of caution and initially set the total transport time from the scene to CSC at 30 minutes for an urban area, 45 minutes in a suburban area, and 60 minutes in a rural area. However, patients eligible for IV thrombolysis (0-4.5 hours from last known well) should be routed to the nearest stroke facility if transport to the nearest CSC or TSC would make them ineligible for thrombolysis due to additional transport time. In suburban and rural settings, prehospital destination plans and interfacility transport policies should prioritize transporting suspected LVO patients to a facility with well-defined evaluation and stabilization protocols to minimize Door-In-Door-Out (DIDO) times for patients requiring transfer to a higher level of care.[4, 7] In rural communities or where large distances separate stroke centers, additional transport time, including air medical transport, may be reasonable.[1, 4, 7]
3. **Stroke System of Care Modification for Metropolitan, Non-Metropolitan and Frontier Communities**
   - The following is adapted from the American Heart Association (AHA) Mission: Lifeline Stroke recommendation for Emergency Medical Services for acute stroke triage and routing.[1, 2, 4, 7] These modifications to transport time thresholds are suggested to help EMS agencies adjust their regional stroke triage protocols according to local resources in collaboration with key stakeholders.[4, 7]
   - A Metropolitan SSOC modification is appropriate for a metro region (Urban/RUCA code 1)[4, 10] These areas have a high population density (50,000+ inhabitants) and abundant healthcare resources, with EMS access to one or more TSC/CSC within 30 minutes of ground transport time.[4, 11]
   - A Non-Metropolitan SSOC modification is appropriate for large residential communities adjacent to an urban core (Suburban/RUCA codes 2-3).[4, 10] These areas generally have a population density closer to the urban threshold. They may have access to nearby community hospitals and suburban or urban advanced stroke centers within a 30–60-minute transport by EMS air or ground.[4, 11] Patients with suspected LVO should be routed directly to a CSC if the maximum transport time from the scene to the CSC does not exceed 45 minutes. If no CSC is within 45 minutes, then EMS should go directly to a TSC if the maximum total transport time from the scene to the TSC does not exceed 45 minutes. If no TSC or CSC exists within 45 minutes of total travel time, EMS should go to the nearest ASRH or PSC.[4, 11]
   - A Frontier SSOC modification is appropriate for a small or non-metropolitan region (Rural/RUCA codes 4-10).[4, 10] These areas generally have low population density (<50,000 inhabitants), limited local general healthcare resources, few nearby ASRH or PSC, and often no TSC/CSC within 60 minutes of transport time by EMS ground, although there may be one within 60 minutes by air.[4, 11] Patients with suspected LVO should be routed directly to a CSC if the maximum total transport time from the scene to the CSC does not exceed 60 minutes.[4, 11] If no CSC is within 60 minutes, then EMS should go directly to a TSC if the maximum total transport time from the scene to the TSC does not exceed 60 minutes.[4, 11] Consider air medical transport if no certified

# Resource Document

stroke center is within 60 minutes by ground. If air transfer is unavailable, transfer the patient to the nearest hospital per the regional stroke plan.[4, 11]

- The COVID-19 pandemic further emphasizes the need for flexible prehospital triage and interfacility transport adaptation in response to local and regional factors. Preferential routing of suspected LVO patients to centers with thrombectomy capability may be of even greater importance when in-hospital and interfacility delays are amplified in conditions such as the COVID-19 pandemic.[12]

4. **Prehospital Triage of Stroke Patients**
   - Basic Level
     - Assess and support ABCs according to UNIVERSAL CARE– ADULT:
       - A (Airway): Airway support and ventilator 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).[2]
       - C (Circulation): Evaluate, document, and treat signs/symptoms of shock according to the Shock Clinical Practice Guidelines (CPG).
       - D (Disability): Assess and document GCS, pupillary size, and reactivity.
       - E (Exposure/Environmental): Assess for evidence of traumatic injury, especially head injury.
   - Positioning/stabilization:
     - Place the patient in a supine position, with the head of the bed elevated at 30 degrees, if the patient can tolerate.[2, 9] Keeping the patient at 30 degrees can improve blood flow to the brain[13, 14] and is recommended if patient can tolerate.[2, 9] Avoid lying the patient flat unless an LVO is documented[15], and the patient is not at risk for elevated intracranial pressure and herniation.[14]
     - Cardiac monitoring during transport is recommended. If there is evidence of shock, treat according to the Shock CPG.
     - If hypoglycemia is present (POC glucose <60 mg/gL)[2], treat according to Diabetic Emergencies CPG. Hyperglycemia in acute ischemic stroke is associated with worse clinical outcomes,[16, 17] including greater infarct growth[18, 19] and hemorrhagic infarct conversion.[20, 21]
     - If there is Seizure activity, treat according to the Seizure CPG.
   - Assessment:
     - History - Interview patient, family members, and other witnesses to determine symptoms, time of symptom discovery, and last known well or last time patient without symptoms:
       - Obtain a mobile number of next of kin and witnesses.
       - NOTE: For "wake-up strokes," the time documented is the time last known well, not the time the patient was found.
       - NOTE: Sudden onset of any of the following suggests the possibility of acute stroke:
         - Numbness or weakness of 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
         - Trouble walking
         - Dizziness
         - Loss of balance or coordination
         - Sudden onset of severe headache with no known cause (suggests hemorrhagic stroke)
         - Any asymmetry of the neurological exam
     - Additional History:
       - Obtain patient history, including co-morbid conditions.
       - Items to Report: seizure at onset, head trauma, history of recent surgeries, history of bleeding problems, signs of possible brain hemorrhage [severe headache of sudden onset, nausea/vomiting with headache or loss of consciousness (LOC)].
       - Additional history: Past medical history, allergies (iodinated contrast).
       - Be alert to common stroke mimics*.
       - Determine if the patient has a substantial pre-existing disability (e.g., need for nursing home care or unable to walk independently).
       - Medications – obtain a list of all medications, including blood thinners such as direct thrombin inhibitors, factor Xa inhibitors, low molecular weight heparin, and unfractionated heparin [e.g., warfarin (Coumadin), rivaroxaban (Xarelto), dabigatran (Pradaxa), apixaban (Eliquis), edoxaban (Savaysa), enoxaparin (Lovenox)]. (If possible, record when the patient took the last dose.)
       - Device/implant history (e.g., left ventricular assist device, pacemaker, valve replacement)
   - Examination:
     - Assess and record blood pressure, rate, rhythm, respiratory rate, and oxygen saturation.
     - Apply a validated and standardized instrument for stroke screening such as FAST (Face, Arm, Speech, Test), BEFAST. Los Angeles Prehospital Stroke Screen, Melbourne Ambulance Stroke Screen, or Cincinnati Prehospital Stroke Scale.[1, 2, 4, 9, 22-25]
     - In prehospital patients who screen positive for suspected stroke, apply a standard prehospital stroke severity assessment tool, Cincinnati Stroke Triage Assessment Tool (CSTAT), Field Assessment Stroke Triage for Emergency Destination (FAST-ED), Rapid Arterial Occlusion Evaluation Scale (RACE) or Vision, Aphasia, Neglect (VAN) Assessment.[1, 2, 4, 9, 22-24]
   - Management:
     - EMS personnel should begin the initial management of stroke in the field as outlined in this document.
     - Prevent aspiration, HOB at 30 degrees.[2] Ensure airway patency with suctioning and OPA or NPA, as needed.
     - Provide supplemental oxygen if needed to keep oxygen saturation >94%.[2]
     - Treatment of hypertension is NOT recommended unless blood pressure

# Resource Document

>220/120 mmHg.[2]
  - Treat hypotension. Evaluate, document, and treat signs/symptoms of shock according to the Shock CPG. Obtain EKG during workup, as long as it does not delay transport to the appropriate stroke facility.[2]
  - Avoid dextrose-containing fluids in non-hypoglycemic patients.[2]
  - Perform and document a POC Glucose analysis and treat according to the ASA 2019 Guidelines for Management of Acute Ischemic Stroke.[2]
    - Hypoglycemia (blood glucose <60 mg/dL) should be treated in patients suspected of acute ischemic stroke.[2]
  - To facilitate expedited stroke workup in the ED, place at least one 18 or 20-gauge IV in the antecubital fossa or forearm (right preferable).
  - To facilitate the fastest Door-to-Needle and stroke care, collect blood samples to provide the receiving facility, as long as it does not delay the transfer.
- System Triage:
  - Goal for on-scene time, 10-15 minutes or less. Encourage the family to go directly to the ED if not transported with the patient.
  - See Annex A: *Prehospital Stroke Triage Algorithm* for the Acute Stroke Triage Algorithm.
  - Call stroke alert and pre-notify the receiving facility that a suspected stroke patient is en route so that the appropriate resources may be mobilized before the patient's arrival.
  - Pre-notification should include the patient's name, LKW, vitals, blood glucose, stroke severity score, and the phone number for next of kin.
  - Goal: 30 seconds for EMS to ED triage nurse hand-off.
  - Bypass Exclusions:
    - If severe or life-threatening trauma is suspected in addition to stroke, transfer to the appropriate level trauma center.
    - Patients under hospice care or with Medical Orders for Scope of Treatment (MOST) that outline no emergency measures should go to the nearest appropriate hospital.
  - Common ischemic stroke mimics: alcoholic intoxication, cerebral infections, drug overdose, hemorrhagic stroke, hypoglycemia, hyperglycemia, metabolic disorders, atypical migraines, neuropathies (e.g., Bell's palsy), seizure, post-ictal state, and tumors.

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# Resource Document


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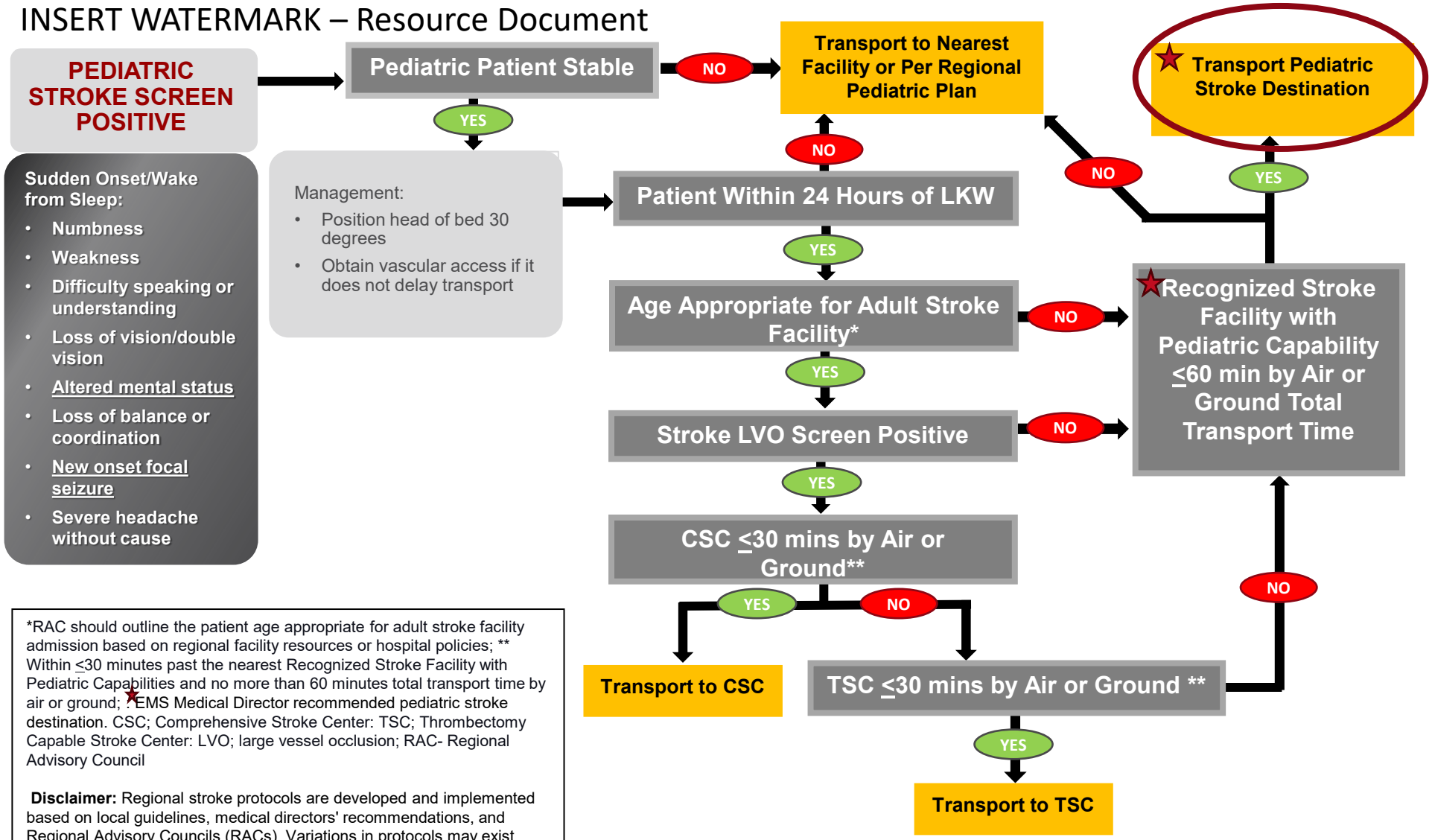
# Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

| Committee Priorities | Current Activities | Status |
|---|---|---|
| Prehospital Stroke algorithm – Recommendation | • Approved through GETAC Council 11/2024.<br>• Request for clean versions and resource document.<br>• Algorithm approved by Stroke, Air Medical, EMS and EMS MD Committees.<br>• Resource document for adult algorithm approved by these committees except EMS MD Committee.<br>• Pending final approval will present to GETAC Council for approval, RAC Chair meeting and EMS Education Committee.<br>• Approval items: Algorithm final version | |
| **Pediatric Task Force** | • Worked with Drs. Fagan and Winckler prior to last session.<br>• Ms. Jorie Klein and DSHS approved terminology for pediatric facility.<br>• **03/2025 session - algorithm and resource document approved by Pediatric, Stroke, Air Medical and EMS MD Committees.**<br>• **03/2025 revisions requested by EMS Committee and wished to seek input from EMS MD Committee before voting.**<br>• **Prior to next session will resubmit minor revisions to the Pediatric Stroke Task Force for final approval.**<br>• **Pediatric Stroke Tip Sheet and Supplement Resource approved by Stroke Committee. I have asked Dr. Stuart Fraser to submit the documents to the Pediatric Stroke Task Force and other Texas pediatric stroke experts for approval.**<br>• **Next steps, minimum capability recommendations for pediatric hospital to be destinations for pediatric stroke.** | |

# EMS ACUTE PEDIATRIC STROKE RESOURCE DOCUMENT

INSERT WATERMARK – Resource Document




*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; ★ EMS Medical Director recommended pediatric stroke destination. 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

## 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 < 70 mg/dL)[12], 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.

Last Update – 03.06.2025

**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 95$^{th}$%ile for age.[13] 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)[12] 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.

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

**AGE CRITERIA and AGE APPROPRIATENESS FOR ADULT STROKE FACILITIES:** Please note that different adult stroke facilities will have different capabilities and willingness to evaluate and treat stroke patients under 18. EMS Medical Directors should outline the patients that are age appropriate for adult stroke facility admission based on regional facility resources and hospital policies.

Recommended triage:

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 **Pediatric Stroke Destination***
    - **Pediatric Stroke Destination – EMS Medical Director will recommend local pediatric stroke destinations.** These are typically pediatric hospitals with capability to care for pediatric patients with stroke. Please note that there are **NO** formal national or statewide guidelines, certifications, or recognition systems for 'Pediatric Stroke Destinations'. We outline a list of suggested features for these centers in a separate document.
  - If no **Pediatric Stroke Destination** 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 **Pediatric Stroke Destination** 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 **Pediatric Stroke Destination** 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 **Pediatric Stroke Destination**
    - If no **Pediatric Stroke Destination** is available within **≤ 60 minutes** or the patient is unstable, transport to the nearest **Pediatric Facility.**
  - **If LVO Screening Tool Negative:**
    - Transport suspected stroke patients to the nearest **Pediatric Stroke Destination**



    - If no **Pediatric Stroke Destination** is within **60-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 **Pediatric Stroke Destination**
     - If no **Pediatric Stroke Destination** is within **a 60-minute total transport time** or the patient is unstable, transport to the nearest **Pediatric Facility**.

- **For all ages,** consider air medical if 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 Update – 03.06.2025

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# Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

| Committee Priorities | Current Activities | Status |
|---|---|---|
| **Interfacility Stroke Terminology** | • 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.<br>• Present to the GETAC Council but not approved.<br>• **Requested to be a part of the Task Force looking at interfacility transfer terminology.** | |
| **DIDO performance recommendations** | • Worked with Drs. Fagan and Winckler from last session, revisions were presented and approved by the Stroke, EMS, Air Medical, EMS Medical Director Committees and the GETAC Council 11/2024.<br>• **Next steps disseminate to Stroke programs and RAC chairs.**<br>• **Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO**<br>• **Seek Guidance: Stroke Committee liaison with EMS Education Committee** | |
| **TEAM EMS-Ed Study** | • **Have informed committees of intent, no major objections voiced at preliminary idea.**<br>• **Dr. Sean Savitz discussed IRB options at past meeting**<br>• **Proposal drafted, working to submit for funding from LSSC.** | |

# TEAM EMS-Ed Study

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

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

**Outcomes:**

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

# Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

| Committee Priorities | Current Activities | Status |
|---|---|---|
| **Post Acute Stroke Care Work Group** | • Approved by Stroke Committee 11/2024<br>• **Dr. Sean Savitz will lead the work group**<br>• **Call for membership** | |
| **Stroke Managers Mentorship Program and Texas Stroke Coordinators Collaborative Survey** | • **Education Work Group discussing platform and feasibility of implementation of mentorship program.**<br>• **Will propose Stroke managers survey at next session.**<br>• **I can present idea at DSHS stroke meetings to gauge interest.**<br>• **Will incorporate some questions from prior survey to assess current state.** | |
| **STRAC Stroke Program Manager Manual** | • Collect and share resources related to stroke program management, stroke coordinator & manager roles and process improvement.<br>• Presented last session, will discuss further about dissemination at the next session. | |
| **Rural Stroke Work Group** | • **Had first meeting**<br>• **Approval Item: conduct needs assessment survey in rural and resource challenged regions, EMSTR data, creating map to identify stroke care deserts in TX** | |

# RURAL Stroke Work Group

- First meeting 02/20/2025
  - 27 members
- Tasks:
  - Define rural and resource challenged areas
    - Accepted definition as outlined but with flexibility on population volume.
    - Classify regions by counties and RACs
  - DSHS Shared the state recognized rural regions.
  - Work with GWTG to look at which hospitals defined as rural.

# RURAL Stroke Work Group

- Once regions/hospitals defined as rural/resource challenged:
  - Request for PI work group look at LKW to hospital arrival, mode of arrival and discharge disposition at rural hospitals from GWTG.
  - Promote RDC, prehospital and DIDO layers in registries.
  - Request EMSTR rural data for median run times, call to arrival (hospital or home), call type, interfacility times.
  - Map to identify stroke care deserts in TX
- GOAL: outline a recommendation for patient access to acute care in remote areas (example call 911/meet EMS).
- **Approval item:** Conduct needs assessment survey in rural/resource challenged regions.

# Stroke Care Mapping

Contents lists available at ScienceDirect

Journal of Stroke and Cerebrovascular Diseases

journal homepage: www.elsevier.com/locate/jstroke

## Navigating stroke care: Geospatial assessment of regional stroke center accessibility

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ARTICLE INFO

*Keywords:*
Geospatial analysis
Public health
Accessibility
Cardiovascular/stroke

ABSTRACT

*Introduction:* Reducing time between stroke onset and hospital intervention is crucial for positive outcomes in stroke patients. While EMS utilization decreases time to intervention, many US regions are not within timely proximity to an advanced-care-capable stroke center (ASC), defined as a comprehensive or thrombectomy-capable center. This study aims to utilize geographic methodology to identify regions in Wisconsin with both high stroke mortality and low physical accessibility to certified stroke centers (SCs), particularly ASCs.

*Methods:* Geocoded mortality records for stroke death between 2015 and 2020 were accessed from the Wisconsin Department of Health Services. Indirectly age-standardized mortality ratios (SMRs) were estimated continuously across Wisconsin using adaptive spatial filtering and mortality records at the census block group level; the surface was then averaged by census tract for tract level SMRs. Addresses for SC locations within Wisconsin and bordering states were collected, and drive times from Wisconsin census tract centroids to the nearest SC subtypes were estimated. Drive times and mortality ratios were evaluated at the tract level alongside Rural-Urban Commuting Area (RUCA) codes. Spatial error regression modeling was used to determine RUCA classifications with the highest stroke risk independent of accessibility to stroke centers.

*Results:* Approximately 50%, 68%, and 78% of Wisconsin residents resided within 30, 45, and 60 minutes of an ASC, respectively. Median drive time from census tract centroids to the nearest ASC were highest for rural tracts ($M$=90 minutes, $IQR$=68-115) compared to small-town ($M$=82 minutes, $IQR$=49-113), micropolitan ($M$=53 minutes, $IQR$=43-77), and metropolitan tracts ($M$=19 minutes, $IQR$=11-35; $p<0.001$). Clusters of high stroke SMRs were found in urban centers as well as rural areas irrespective of county declinations. Spatial regression modeling suggested small-town census tracts had the highest SMR irrespective of physical accessibility to care and spatial correlation. In small-town census tracts >45 minutes from the nearest ASC, the median stroke SMR was 1.12 ($IQR$=0.94-1.40) with 226,000 residents and 150 stroke deaths per year.

*Conclusion:* Small-town areas are associated with both long drive distance to ASC locations and high stroke mortality. Geographical analyses reveal apparent stroke care deserts and may inform strategic allocation of emergency medicine resources and coverage.

### Introduction

Cerebrovascular accidents, also known as strokes, are significant contributors to the overall cardiovascular disease burden and require timely and, often, specialized interventions[1]. Various medical interventions are available for acute stroke management including thrombolytic therapy, mechanical thrombectomy, and neuro-endovascular procedures. Minimizing the time between stroke symptoms and definitive medical interventions is crucial for optimizing neurocognitive ability and achieving overall positive outcomes. Thus,

*Abbreviations:* SC, Certified Stroke Center; ASC, Advanced-Care-Capable Stroke Center; ASRH, Acute Stroke Ready Hospital; PSC, Primary Stroke Center; TSC, Thrombectomy-Capable Stroke Center; CSC, Comprehensive Stroke Center; RUCA, Rural-Urban Commuting Area; CMR, Crude Mortality Rate; SMR, Standardized Mortality Ratio; ASF, Adaptive Spatial Filtering.

* Corresponding author.



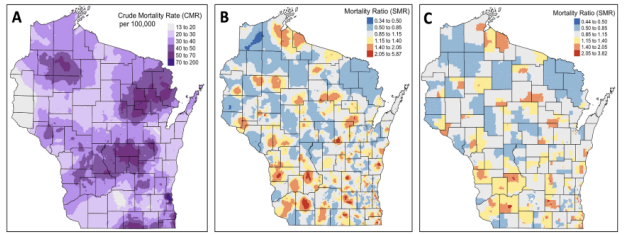


**Fig. 2.** Continuous crude stroke morality rate in Wisconsin **(A)**; indirect age-sex standardized stroke mortality ratio (SMR) maps in Wisconsin with **(B)** continuous distribution and **(C)** distribution averaged by surface area per census tract. SMR over 1 indicates regional ratios higher than the expected rate.

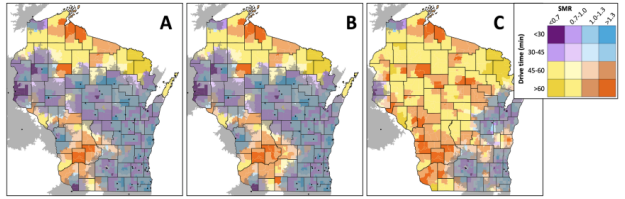


**Fig. 3.** Heat maps by Wisconsin census tract of categorized indirect age-sex standardized stroke mortality ratios alongside <30, 30-45, 45-60, and >60 minute drive times to the nearest **(A)** certified stroke center, **(B)** basic center, and **(C)** advanced-care-capable center with respective 45-minute drive catchment zone overlay.

performed the study in accordance with this protocol. Collection, recording, and reporting of data was accurate and ensured the privacy, health, and welfare of research subjected during and after the study.

### Declaration of Generative AI in Scientific Writing

The authors did not use a generative artificial intelligence (AI) tool or service to assist with preparation or editing of this work. The authors take full responsibility for the content of this publication.

### Funding sources

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National Heart, Lung, And Blood Institute of the National Institutes of Health Award Number T35HL072483.

administration, Funding acquisition, Conceptualization.

### Declaration of competing interest

Research was conducted in the absence of commercial or financial conflicts. There are no disclosures.

### Data availability

The data that support the findings of this study are available on request from the corresponding author, SH. The data are not publicly available due to presence of identifiers (i.e. geocoded addresses, etc).

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# Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

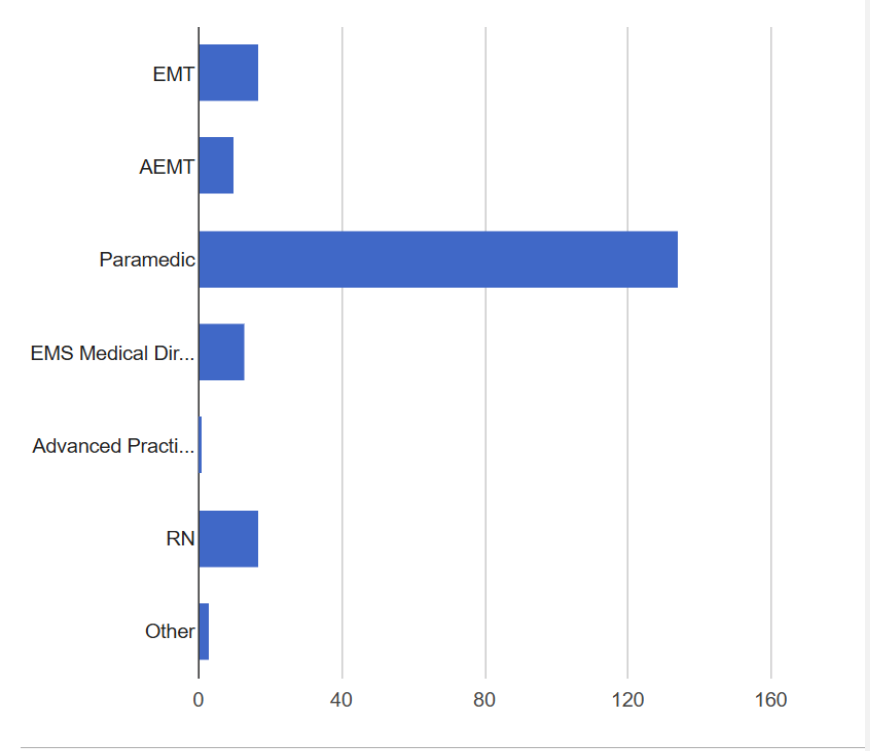
| Committee Priorities | Current Activities | Status |
|---|---|---|
| **Texas EMS Stroke Survey** | • **Approved**<br>• **Joseph assisting with disseminating survey**<br>• **Extend Deadline** | |
| Stroke Committee endorsed stroke education and certification courses | • Ongoing effort identifying stroke educational opportunities for providers | |
| Stroke Education Resource for stroke facilities | • Working with DSHS for website access to stroke education<br>• Elizabeth to report back to the Stroke Committee next session | |
| Work with DSHS to outline recommendations for stroke rules for ASRH | • Pending further direction | |
| **Presentation on Wake-Up Stroke Study** | • **UT Health system study with LSSC**<br>• **PI's Drs. Sidarth Prasad and Daiwai Olson**<br>• **Approved by Stroke Committee**<br>• **Approval item: present to the DSHS stroke meetings in effort to encourage participation** | |

# EMS Survey Results

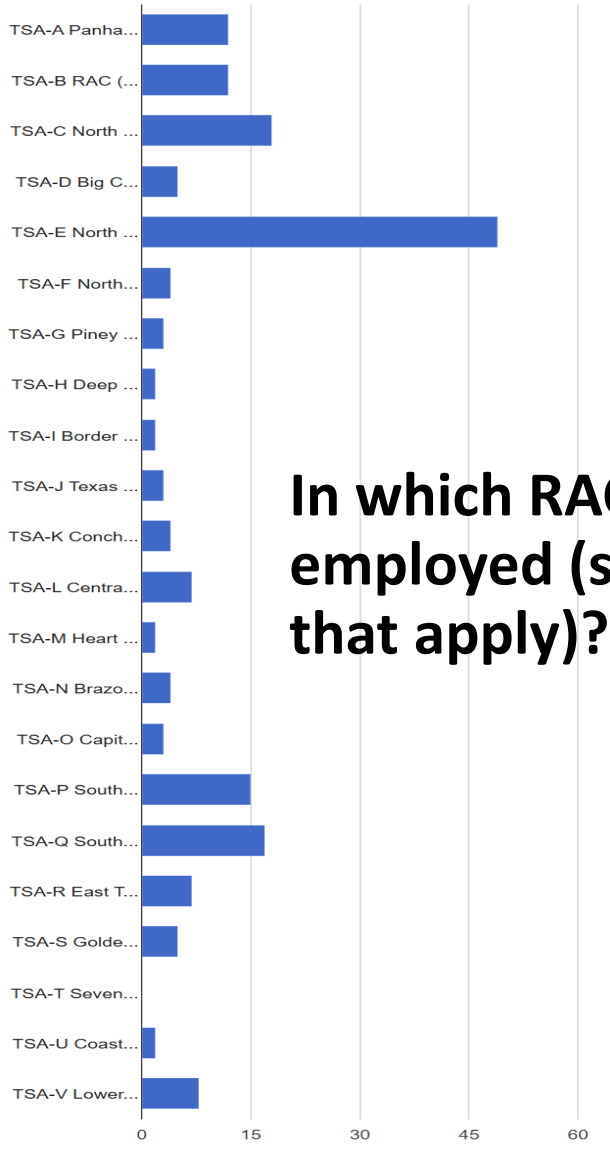
## What is your level of emergency medical provider?

| Total Count (N) | Missing* | Unique |
|---|---|---|
| 183 | 6 (3.2%) | 7 |

**Counts/frequency:** EMT (17, 9.3%), AEMT (10, 5.5%), Paramedic (134, 73.2%), EMS Medical Director (13, 7.1%), Advanced Practice Provider (1, 0.5%), RN (17, 9.3%), Other (3, 1.6%)



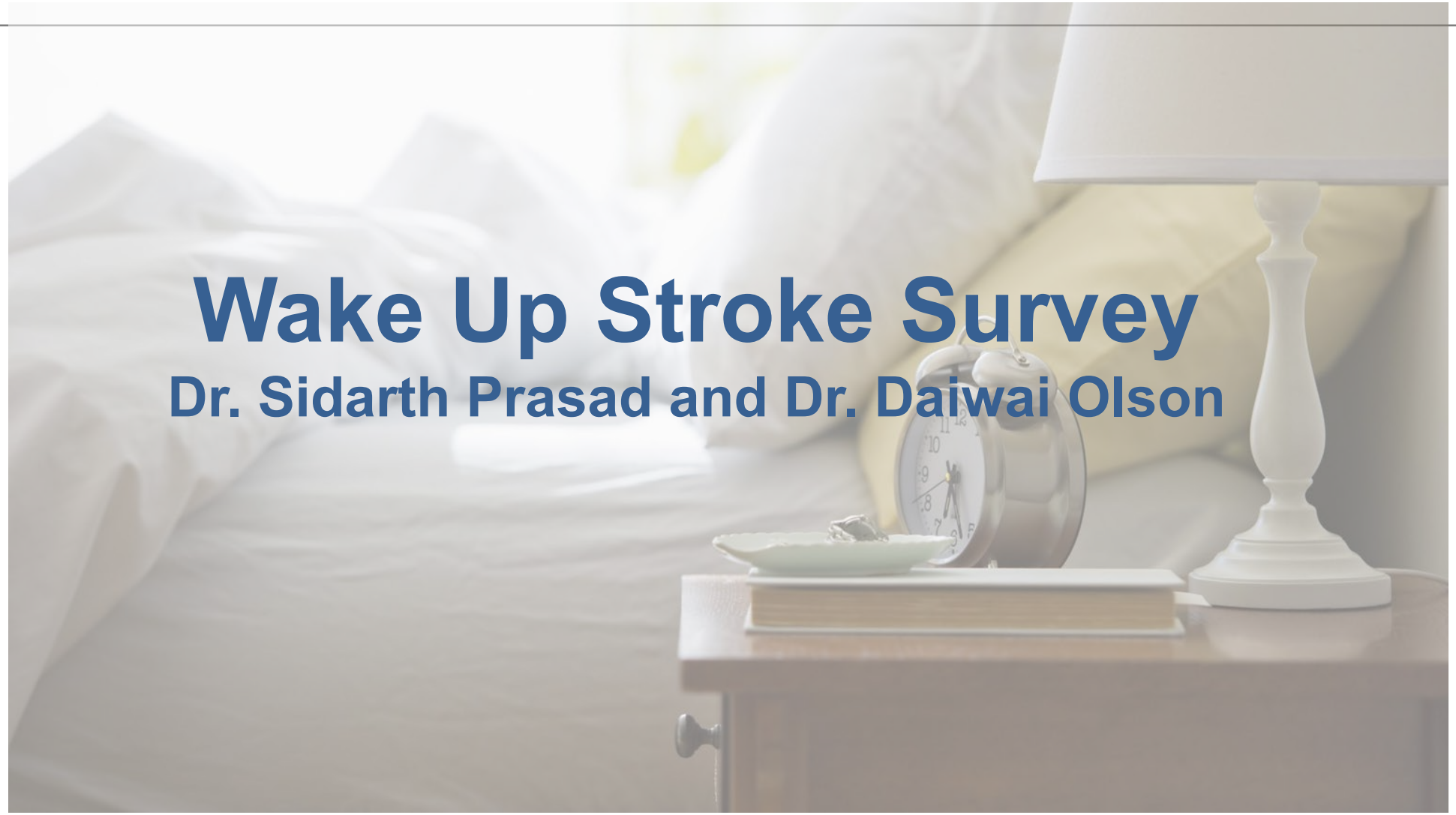

**Counts/frequency:** TSA-A Panhandle RAC (12, 7.0%), TSA-B RAC (BRAC) (12, 7.0%), TSA-C North Texas RAC (18, 10.5%), TSA-D Big Country RAC (5, 2.9%), TSA-E North Central Texas Trauma RAC (49, 28.5%), TSA-F Northeast Texas RAC (4, 2.3%), TSA-G Piney Woods RAC (3, 1.7%), TSA-H Deep East Texas RAC (2, 1.2%), TSA-I Border RAC (2, 1.2%), TSA-J Texas "J" RAC (3, 1.7%), TSA-K Concho Valley RAC (4, 2.3%), TSA-L Central Texas RAC (7, 4.1%), TSA-M Heart of Texas RAC (2, 1.2%), TSA-N Brazos Valley RAC (4, 2.3%), TSA-O Capital Area Trauma RAC (3, 1.7%), TSA-P Southwest Texas RAC (15, 8.7%), TSA-Q Southeast Texas RAC (17, 9.9%), TSA-R East Texas Gulf Coast RAC (7, 4.1%), TSA-S Golden Crescent RAC c/o Citizens Medical Center (5, 2.9%), TSA-T Seven Flags RAC (0, 0.0%), TSA-U Coastal Bend RAC (2, 1.2%), TSA-V Lower Rio Grande Valley RAC (8, 4.7%)




## In which RAC are you employed (select all that apply)?

| Total Count (N) | Missing* | Unique |
|---|---|---|
| 172 | 17 (9.0%) | 21 |

UT Southwestern
Medical Center



# Wake Up Stroke Survey

Dr. Sidarth Prasad and Dr. Daiwai Olson

# Survey Overview

UT Southwestern Medical Center

**Mission statement:** This survey aims to evaluate wake-up stroke protocols implemented in hospitals across Texas. Findings will support a grant application to NINDS and contribute to an implementation science toolkit. The goal is to develop a standardized, evidence-based protocol for wake-up stroke management, promoting best practices across Texas hospitals.

**Benefit to State of Texas:** The implementation toolkit will help improve and standardize wake-up stroke protocols, ensuring consistent and optimized patient care for those presenting as a code stroke in the ED.

**Inclusion Criterion:** All Texas hospitals involved in stroke care, regardless of whether they currently follow a wake-up stroke protocol. Survey can be completed preferably by the stroke coordinators.

**Data Analysis:** All collected information will be de-identified during analysis and presentation to ensure privacy and confidentiality.

**Survey Duration:** The survey will take less than 5 minutes to complete.

SCAN ME

# Stroke Committee

- **Committee items needing council guidance**
  1. Patient safety and quality concern
  2.Stroke member liaison with EMS Education Committee

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

- **Items referred to GETAC for future action**
  1. None at this time

# GETAC Stroke Committee

- **Committee items needing council approval:**
  1. Adult EMS stroke triage algorithm
  2. Rural stroke needs assessment survey
  3. EMSTR rural data request
  4. Wake-up Stroke Study
  5. Map to outline stroke access deserts in TX
- **Action items for the next session:**
  1. Pediatric Stroke triage algorithm and resource document.
  2. Adult Stroke triage resource document.
  3. TEAM EMS-Ed study
  4. Pediatric stroke tip sheet and supplement

# 9.i.A. Approval: Pediatric Stroke Triage Algorithm

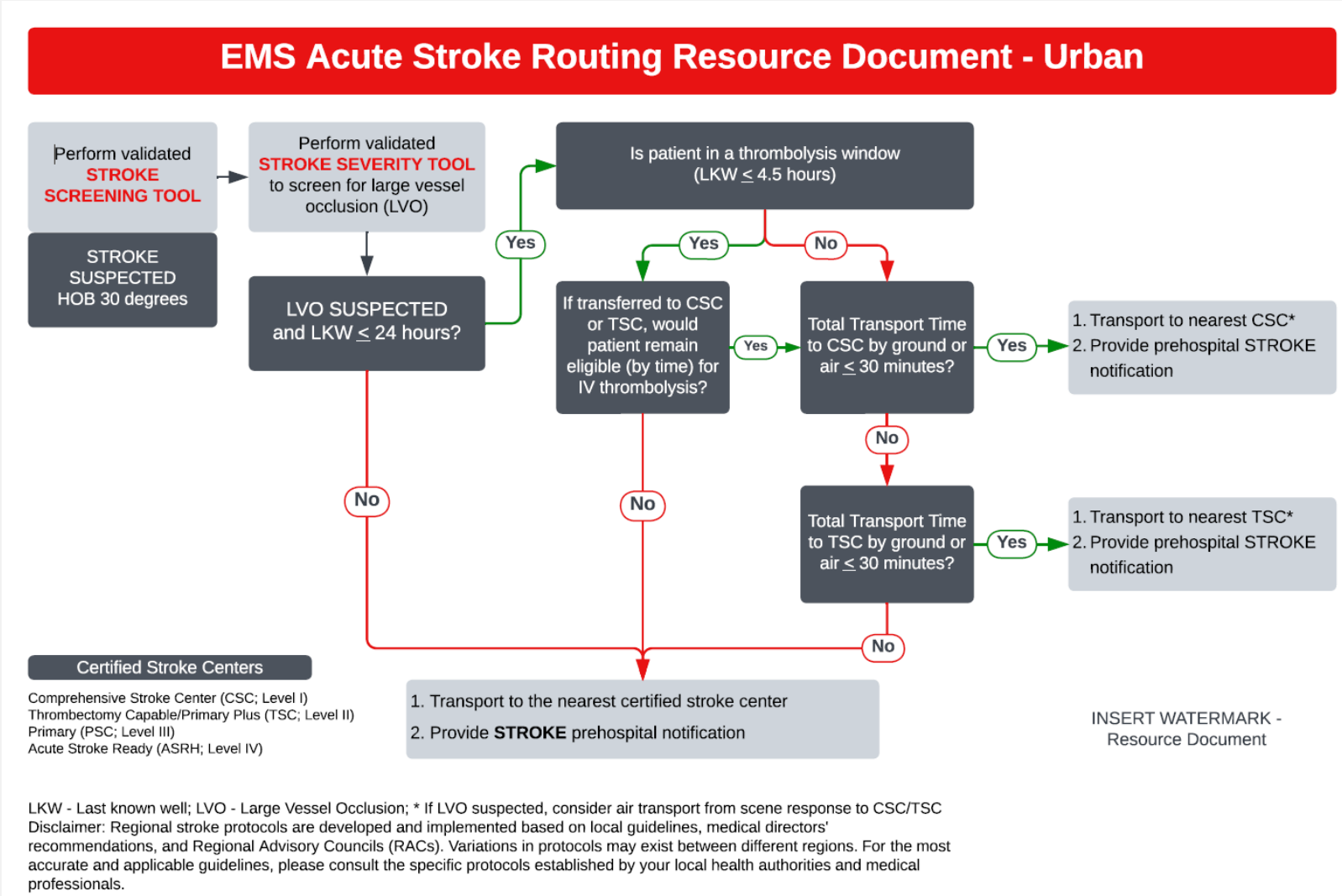
Deferred until Q2

# 9.i.B. Approval: Adult stroke triage algorithm resource document

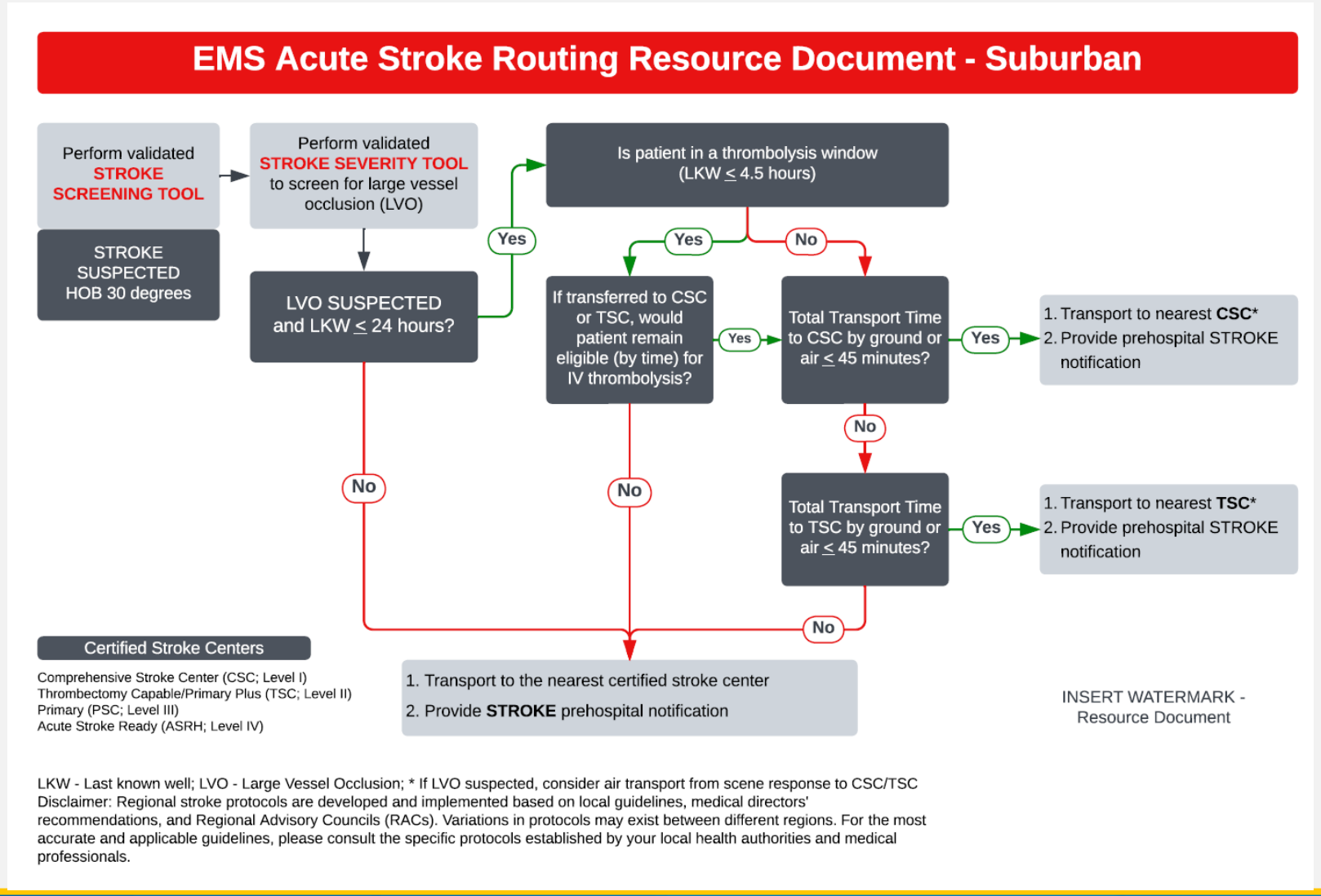
Deferred until Q2

# 9.i.C. Approval: Formalized Adult Stroke Algorithm

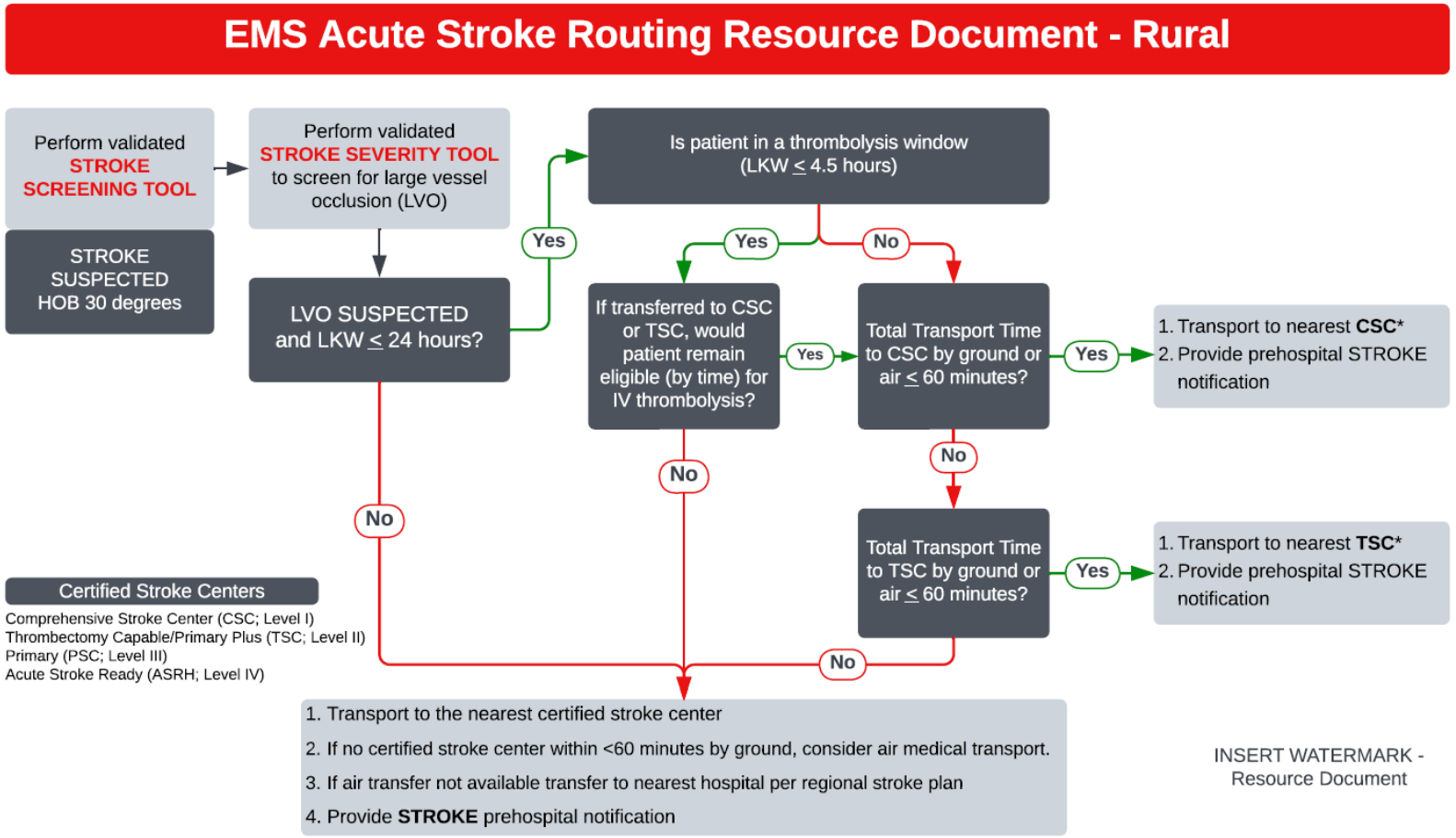
# APPROVAL ITEM: Adult Algorithm



# APPROVAL ITEM: Adult Algorithm



# APPROVAL ITEM: Adult Algorithm



# 9.i.D. Approval: Pediatric Stroke Task Force Tip Sheet

Deferred until Q2

# 9.j. GETAC Trauma System Committee Update to Council - March 2025

Chair: Stephen Flaherty, MD, FACS

Vice-chair: Raul Barreda, MD, FACS

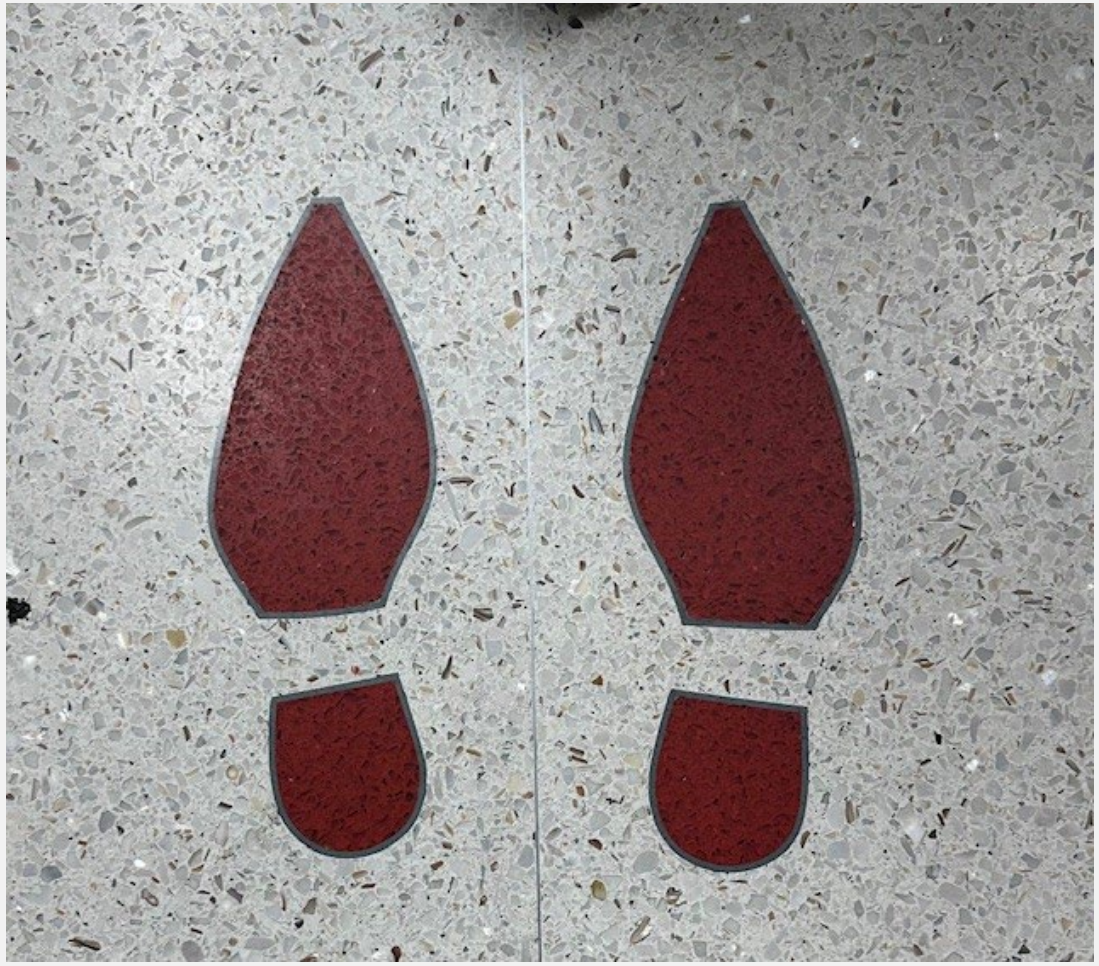
# Trauma Systems Committee

## Trauma Spotlight

**Toni von Wenckstern**- Vice President, Trauma Service Line
**Meg Michael**- Trauma program manager
**Michael Wandling**- Assistant Trauma Medical Director
**Adam Fitzhenry**- Director, EMS Operations

# Trauma Systems Committee

## Trauma Spotlight

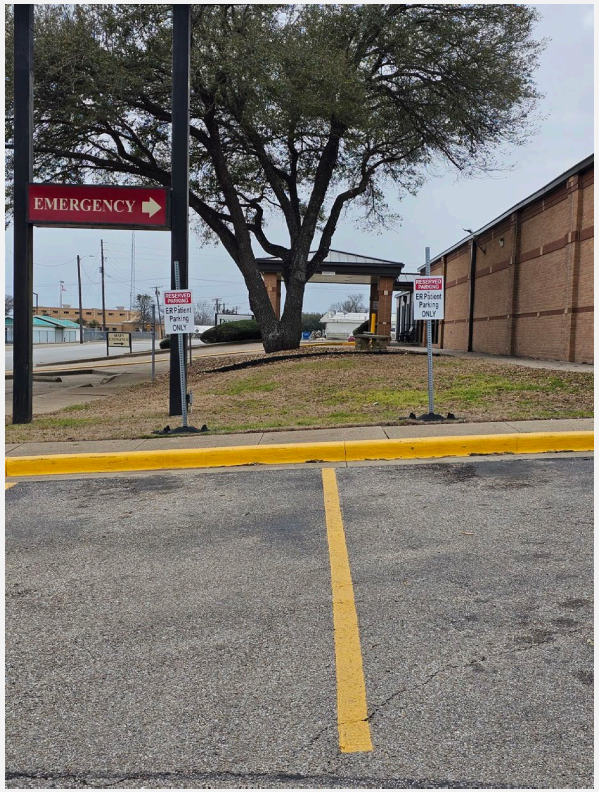


# Trauma Systems Committee

## Trauma Spotlight

# Trauma Systems Committee

## Trauma Spotlight




7 bed ER
1 MD
2 RN
9,000+ ED visits
61 registry patients
Level IV Trauma Center
Community integration



Dena Looney, RN - ER Director, TPM
Mackenzie Tomanek, RN - ER Manager, trauma registry
Shelby Bosley, RN
Stacey Allen, RN
Dr. Samuel Lightsey - ER Physician
Dr. Erik Martin (not pictured) - TMD

# The Southern Border MIL-CIV Integration

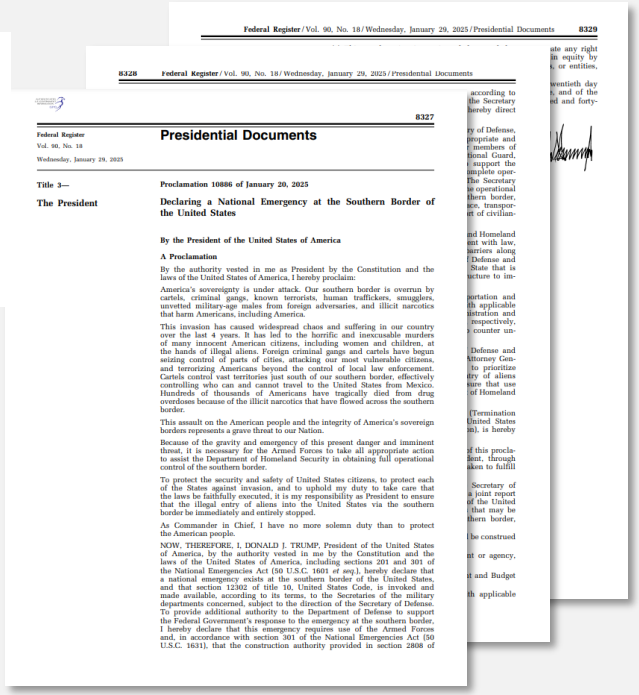
Stephen Flaherty, MD, FACS
Chair, Trauma System Committee
GETAC

# Proclamation 10886

- Title: “Declaring a National Emergency at the Southern Border of the United States ”

America's sovereignty is under attack. Our southern border is overrun by cartels, criminal gangs, known terrorists, human traffickers, smugglers, unvetted military-age males from foreign adversaries, and illicit narcotics that harm Americans, including America.

Because of the gravity and emergency of this present danger and imminent threat, it is necessary for the Armed Forces to take all appropriate action to assist the Department of Homeland Security in obtaining full operational control of the southern border.



Federal Register / Vol. 90, No. 18 / Wednesday, January 29, 2025 / Presidential Documents 8329

8328 Federal Register / Vol. 90, No. 18 / Wednesday, January 29, 2025 / Presidential Documents

8327

Federal Register
Vol. 90, No. 18
Wednesday, January 29, 2025

Presidential Documents

Title 3—
The President

Proclamation 10886 of January 20, 2025

Declaring a National Emergency at the Southern Border of the United States

By the President of the United States of America

A Proclamation

By the authority vested in me as President by the Constitution and the laws of the United States of America, I hereby proclaim:

America's sovereignty is under attack. Our southern border is overrun by cartels, criminal gangs, known terrorists, human traffickers, smugglers, unvetted military-age males from foreign adversaries, and illicit narcotics that harm Americans, including America.

This invasion has caused widespread chaos and suffering in our country over the last 4 years. It has led to the horrific and inexcusable murders of many innocent American citizens, including women and children, at the hands of illegal aliens. Foreign criminal gangs and cartels have begun seizing control of parts of cities, attacking our most vulnerable citizens, and terrorizing Americans beyond the control of local law enforcement. Cartels control vast territories just south of our southern border, effectively controlling who can and cannot travel to the United States from Mexico. Hundreds of thousands of Americans have tragically died from drug overdoses because of the illicit narcotics that have flowed across the southern border.

This assault on the American people and the integrity of America's sovereign borders represents a grave threat to our Nation.

Because of the gravity and emergency of this present danger and imminent threat, it is necessary for the Armed Forces to take all appropriate action to assist the Department of Homeland Security in obtaining full operational control of the southern border.

To protect the security and safety of United States citizens, to protect each of the States against invasion, and to uphold my duty to take care that the laws be faithfully executed, it is my responsibility as President to ensure that the illegal entry of aliens into the United States via the southern border be immediately and entirely stopped.

As Commander in Chief, I have no more solemn duty than to protect the American people.

NOW, THEREFORE, I, DONALD J. TRUMP, President of the United States of America, by the authority vested in me by the Constitution and the laws of the United States of America, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*), hereby declare that a national emergency exists at the southern border of the United States, and that section 12302 of title 10, United States Code, is invoked and made available, according to its terms, to the Secretaries of the military departments concerned, subject to the direction of the Secretary of Defense. To provide additional authority to the Department of Defense to support the Federal Government's response to the emergency at the southern border, I hereby declare that this emergency requires use of the Armed Forces and, in accordance with section 301 of the National Emergencies Act (50 U.S.C. 1631), that the construction authority provided in section 2808 of

# U.S. NORTHERN COMMAND

February 28, 2025

## Sustainment support units set to enhance southern border mission

**U.S. Northern Command Public Affairs**

**PETERSON SPACE FORCE BASE, Colo. –** By the order of the Department of Defense and under the direction of U.S. Northern Command, additional troops will deploy to enhance the capacities of Customs and Border Protection as part of the mission along the U.S. southern border.

The DoD continues to work with the Department of Homeland Security to fill critical capabilities gaps at the southern border in accordance with President Trump's Executive Order "Protecting the American People Against Invasion."

The additional tranche will provide sustainment support to the already announced Joint Task Force for southern border operations, including: command and control of sustainment units and coordination of logistical support; field feeding support sites; and control of logistical movement.

Army units preparing to deploy include:

- 101st Division Sustainment Brigade, Fort Campbell, Kentucky
- Alpha Company, 189th Division Sustainment Support Battalion, Fort Bragg, North Carolina
- Bravo Company, 68th DSSB, Fort Carson, Colorado
- Charlie Company, 129th DSSB, Fort Campbell, Kentucky
- Headquarters and Headquarters Company, 264th Combat Sustainment Support Battalion, Fort Bragg, North Carolina
- 70th Movement Control Team, Joint Base Langley-Eustis, Virginia
- 564th Quartermaster Company, Joint Base Lewis-McChord, Washington

**Lead Agency**

**Support Agency**

# Possible Area of Response

**200 mile distance**

**100 mile distance**

# Support Requirements

- Housing
- Water
- Fuel
- Communications
- Healthcare
  - Routine
  - Time-critical

# Importance of MIL-CIV Integration for Emergent Care

- **Faster Access:** Civilian hospitals may be nearer to operation sites, reducing transport time, which is vital for emergencies.
- **Golden Hour Impact:** Getting to care within the golden hour can improve survival rates, and civilian integration can help achieve this, as seen in studies showing time to care affects outcomes (Impact of Time to Definitive Care on Survival Rates).
- **Resource Availability:** Civilian facilities often have advanced equipment and specialists, potentially offering better care for complex injuries.
- **Flexibility:** In emergency situations, the primary goal is saving lives, and flexibility is key. TRICARE coverage allows active duty service members to seek emergency care at any hospital, including civilian ones, without prior authorization, facilitating rapid response. This flexibility ensures that the nearest appropriate medical facility is used, whether military or civilian, which is crucial for time-sensitive cases.
- **Challenges:** Security concerns and differing protocols between military and civilian systems may complicate integration, requiring careful coordination.

# Joint Trauma System (JTS): Coordinating Communication


The Joint Trauma System (JTS), the DoD's trauma care authority, coordinates communication with Regional Advisory Councils (RACs) and Regional Medical Operations Centers (RMOCs) in border states to integrate military and civilian trauma systems. Through frameworks like the Trauma System Support branch, JTS shares guidelines, data, and expertise—e.g., collaborating with the Southwest Texas Regional Advisory Council—to enhance rapid patient care within the golden hour. This strengthens DoD-civilian interoperability, aligning with national mandates for improved trauma outcomes.

# Civilian System Implications

- Optimized Use of Civilian Infrastructure:
  - Civilian hospitals will serve as the primary destination for time-critical conditions (STEMI, stroke, sepsis, severe trauma), leveraging their established expertise and proximity to reduce time to definitive care
- Military Air Medical as a Force Multiplier
  - In austere or remote border regions, military air medical assets (e.g., MEDEVAC helicopters) can bridge gaps where civilian evacuation is limited, enhancing access to care by transporting patients to civilian facilities efficiently.
- Systemic Resilience Gains
  - Collaboration enhances regional emergency response capacity, as military evacuation support and civilian hospital expertise combine to create a more responsive network for both populations, especially in border or rural zones.

# Summary

- Executive Order declaring national emergency on the southern border enables the use of DoD resources to support the Lead Agency.
- Anticipate 1000 personnel involved along the entire course of the border
- DoD plans routine healthcare within the DoD system (TriCare)
- Time-critical injury/illness will be managed in the civilian healthcare system
- Awareness is preparation
- Military-civilian integration of trauma systems is essential to defense of the homeland

# Trauma Systems Committee

## 2025 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

| Committee Priorities | Current Activities | Status |
|---|---|---|
| 1. Designation Pillar: Assess for barriers to designation. | Continual communications with workgroups focusing on the inclusive trauma system pillar, the financial health pillar and RAC communication and with DSHS team to assess the flow of trauma centers in and out of the system, identify weak areas in the system, identify barriers to designation and participate with these groups to improve the trauma system. | |
| 2. Improve communication with RAC Chairs to facilitate early awareness of challenges in the trauma system. | Committee members assigned to this pillar are developing regular communication with the individual RAC Chairs. | |
| 3. Inclusive trauma system pillar (to include military-civilian integration) | *Facilitating military civilian integration for DoD activity along the southern border* | |

# Trauma Systems Committee

## 2025 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

| Committee Priorities | Current Activities | Status |
|---|---|---|
| 4 Financial health pillar | Monitoring news, social media and other platforms to identify financial developments that may impact trauma centers or the trauma system. | |
| 5. Pediatric injury pillar | Reviewing recommendations from the pediatric committee<br><br>Developing facts and recommendations about transmission of radiographs between facilities | |
| 6. Burn Injury Pillar | Monitoring the Burn Care Task Force<br><br>Request to add Dr. Edabat to email lists regarding task force activity. | |

# GETAC Committee/Stakeholder Action Item Request for Council March 2025

Stephen Flaherty, MD, FACS

Trauma Systems Committee

# Action Item Request and Purpose

- Approve Dr. Barreda as vice-chair
- Add Dr. Ebadat to the Burn Care Task Force

# 10. Task Force Updates

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

Katherine Remick, MD

Task Force Chair

# System PI Taskforce Report

Governor's EMS and Trauma Advisory Council

March 6th 2025

# System PI Taskforce Report

- Renaming of the Taskforce: System Collaborative for Outcome Review (SCOR)
  - Request GETAC approval
- Mission statement in development - Request GETAC approval in June
- Member Representation:
  - GETAC Committees, RAC Chairs, Burns taskforce, Trauma TQIP, Perinatal Advisory Council
- Taskforce voted to write-up measures prioritization process
- Scope of activities and process map to be developed – Request GETAC approval in June
  - Clinical patient outcomes
  - Data quality and analysis, IT support
  - System infrastructure

# 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

# 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, asked for transferred patients but reportedly not available | 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<br>+<br>Door-to-Needle time for acute ischemic stroke |
| Q2 | Time from arrival-to-departure for unstable injured patients<br>+<br>Pediatric readiness score at trauma centers |
| Q3 | Prehospital stroke screening<br>+<br>Door-to-Needle time for acute ischemic stroke |
| Q4 | Time from arrival-to-departure for unstable injured patients<br>+<br>Rate of severe maternal morbidity events |

# Data Reporting

Quarter 1 2025

American Heart Association.

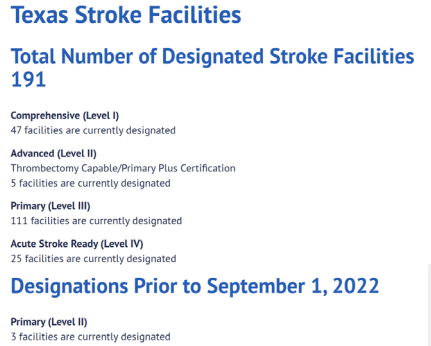
American Heart Association.
Get With The Guidelines.
Stroke

# Texas Stroke Quality Report: Q1 2025

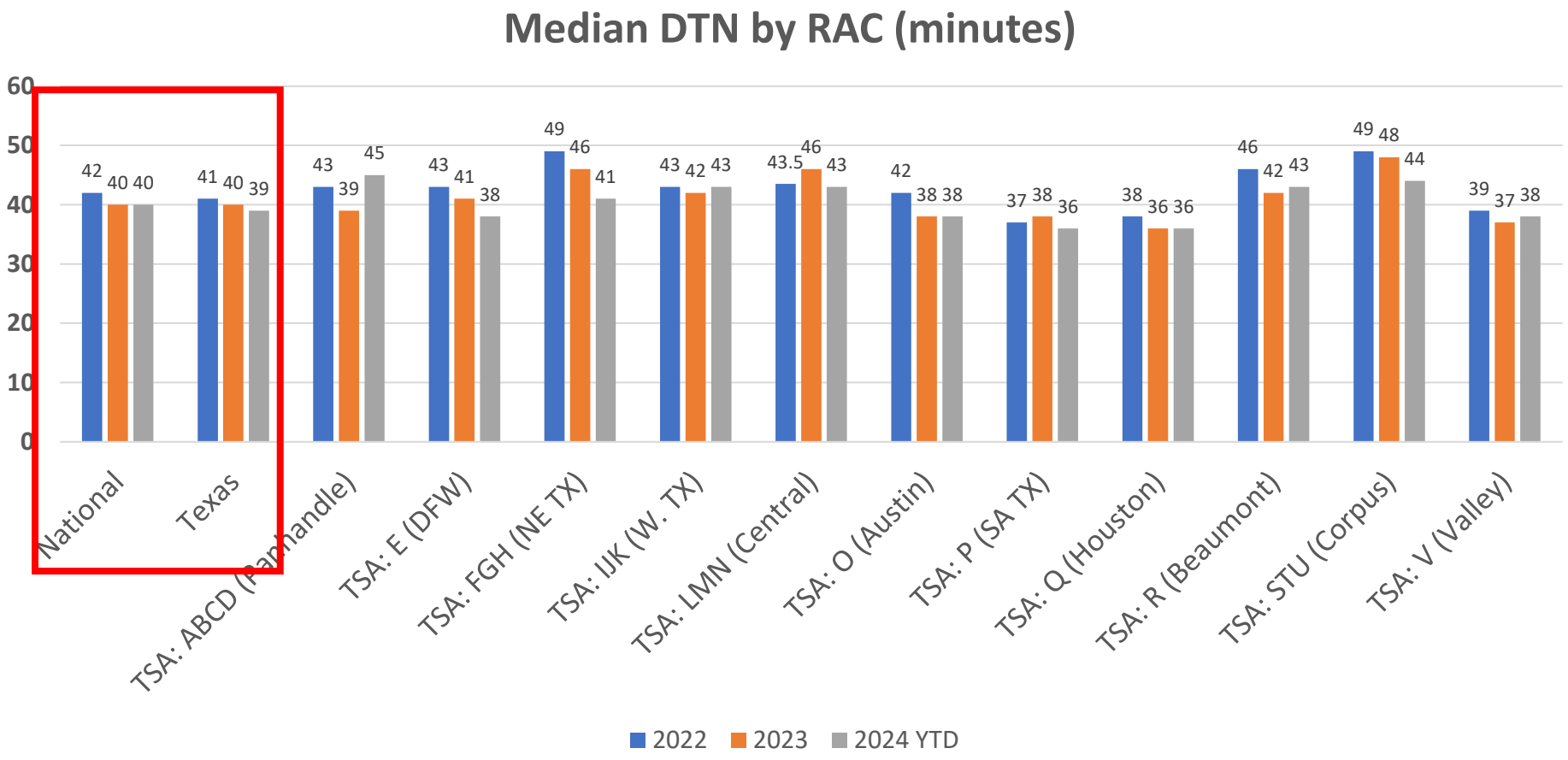
## Data Sourced from Get With The Guidelines® - Stroke
January 2025

# Currently Participating

## Texas Stroke GWTG Sample

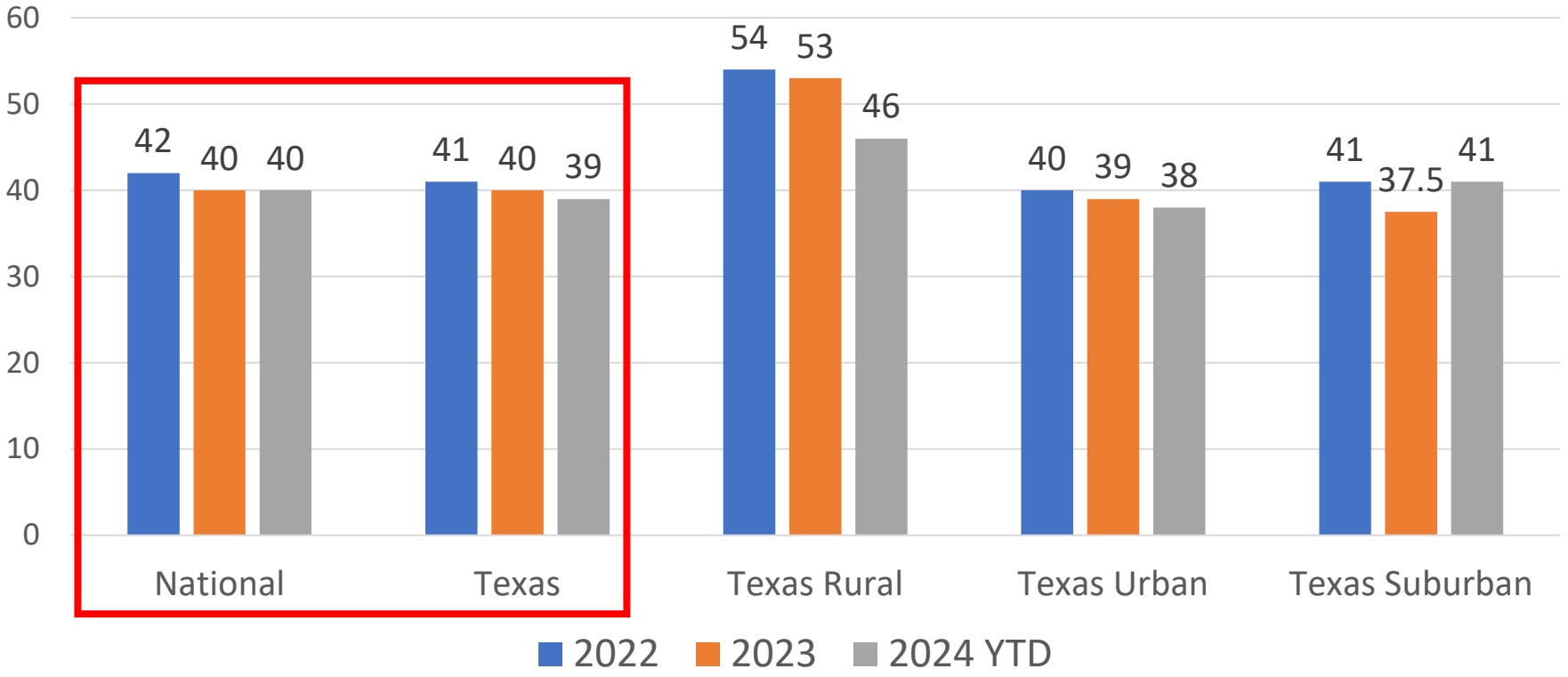



- **196** TX Hospitals participating in GWTG
  - 40 participating hospitals classified as **"Rural,"** using the Rural Urban Commuting Area (RUCA) codes 4-10 and 99
    - https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/
  - 17 Rural sites joined as part of the **Rural Healthcare Outcomes Accelerator** program
    - www.heart.org/ruralaccelerator




Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 1/29/25.

# Median DTN by Geographic Size

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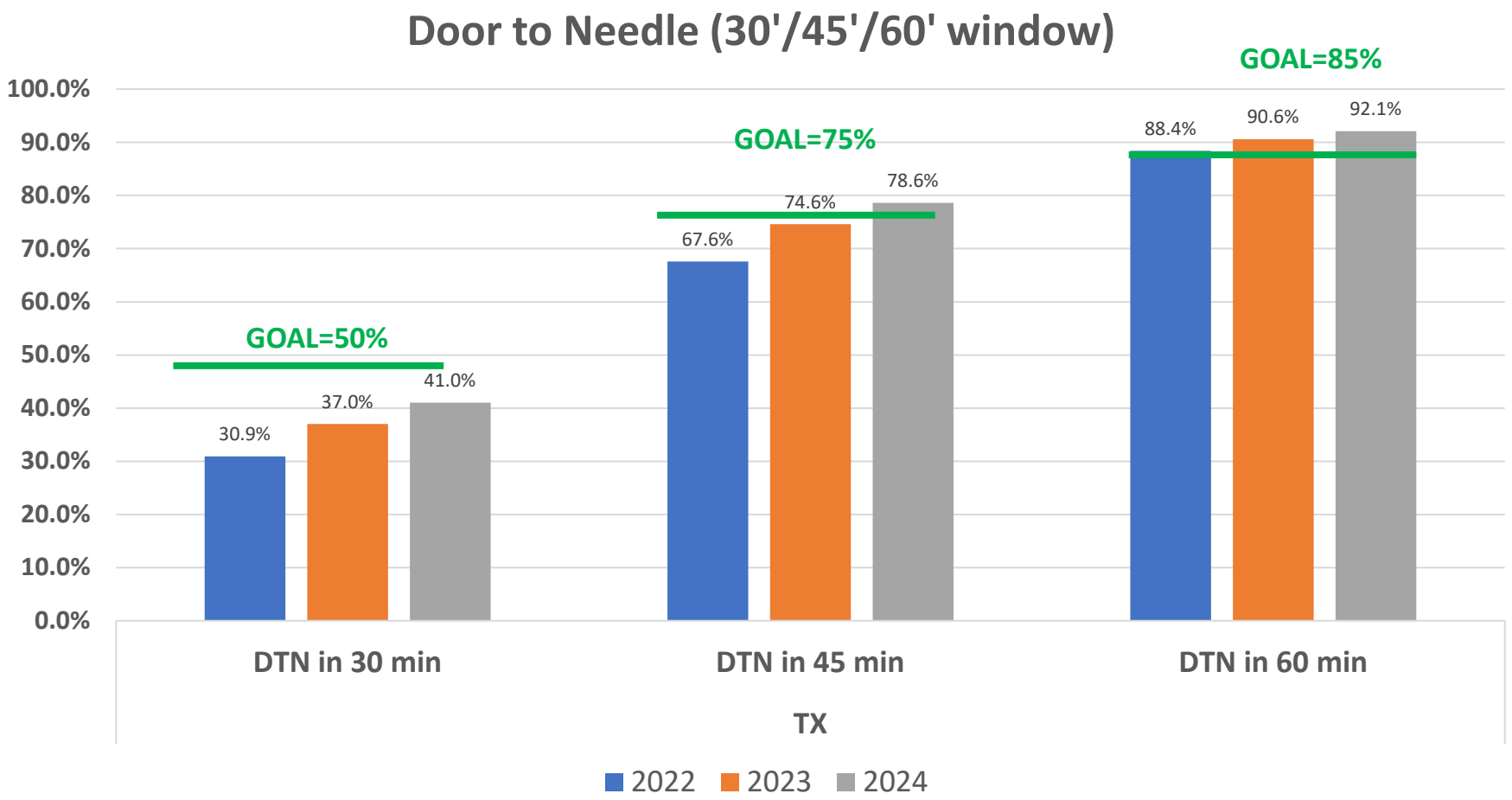


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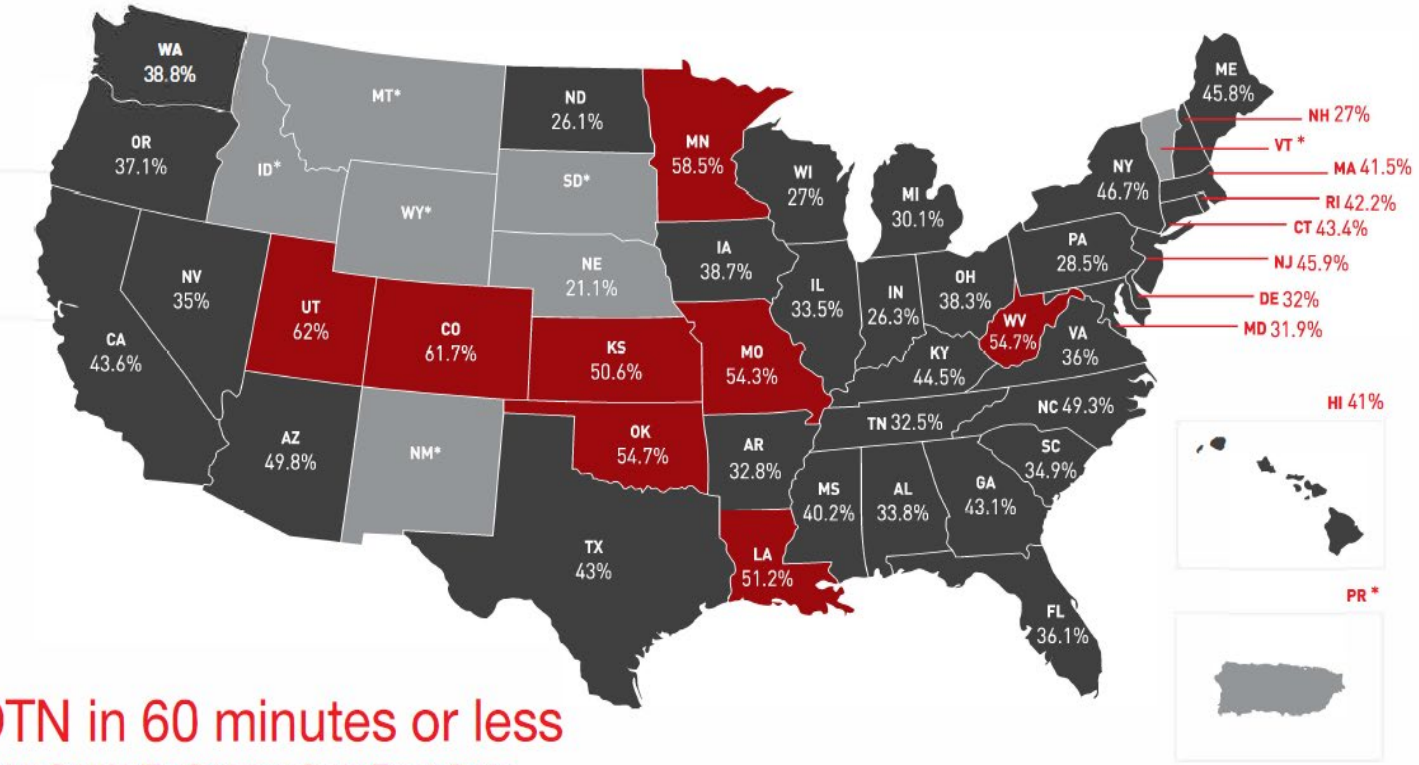
2012

American Heart Association | American Stroke Association.

GET WITH THE GUIDELINES. STROKE

TARGET: STROKE




GOAL 50%

# DTN in 60 minutes or less

Eligible Get With The Guidelines-Stroke/Target: Stroke acute ischemic stroke patients January 2012 to December 2012

state numerator/denonimator (number of hospitals participating per state)

**0-24%**

Alaska *
Idaho *
Montana *
New Mexico *
Nebraska 12/57 (12)
Puerto Rico *
South Dakota *
Vermont *
Wyoming *

* fewer than 6 hospitals, too few to report

**25-49%**

Alabama 45/133 (28)
Arizona 255/452 (25)
Arkansas 21/64 (36)
California 766/1755 (131)
Connecticut 102/235 (21)
Delaware 21/66 (6)
Florida 467/1294 (127)
Georgia 270/627 (55)
Hawaii 41/100 (11)
Illinois 170/507 (71)
Indiana 61/232 (30)
Iowa 36/93 (14)
Kentucky 61/137 (22)
Maine 22/48 (7)
Maryland 130/408 (37)
Massachusetts 214/516 (71)
Michigan 142/471 (48)
Mississippi 45/112 (11)
Nevada 48/137 (12)
New Hampshire 10/37 (8)
New Jersey 234/517 (45)
New York 667/1428 (112)
North Carolina 264/536 (27)
North Dakota 6/23 (9)
Ohio 149/389 (45)
Oregon 78/210 (26)
Pennsylvania 246/862 (77)
Rhode Island 57/135 (9)
South Carolina 90/258 (23)
Tennessee 41/126 (12)
Texas 490/1147 (96)
Virginia 87/241 (37)
Washington 137/353 (45)
Wisconsin 63/233 (45)

**50-74%**

Colorado 150/243 (29)
Kansas 83/164 (12)
Louisiana 131/256 (20)
Minnesota 131/224 (21)
Missouri 259/477 (27)
Oklahoma 70/128 (8)
Utah 106/171 (17)
West Virginia 47/86 (7)

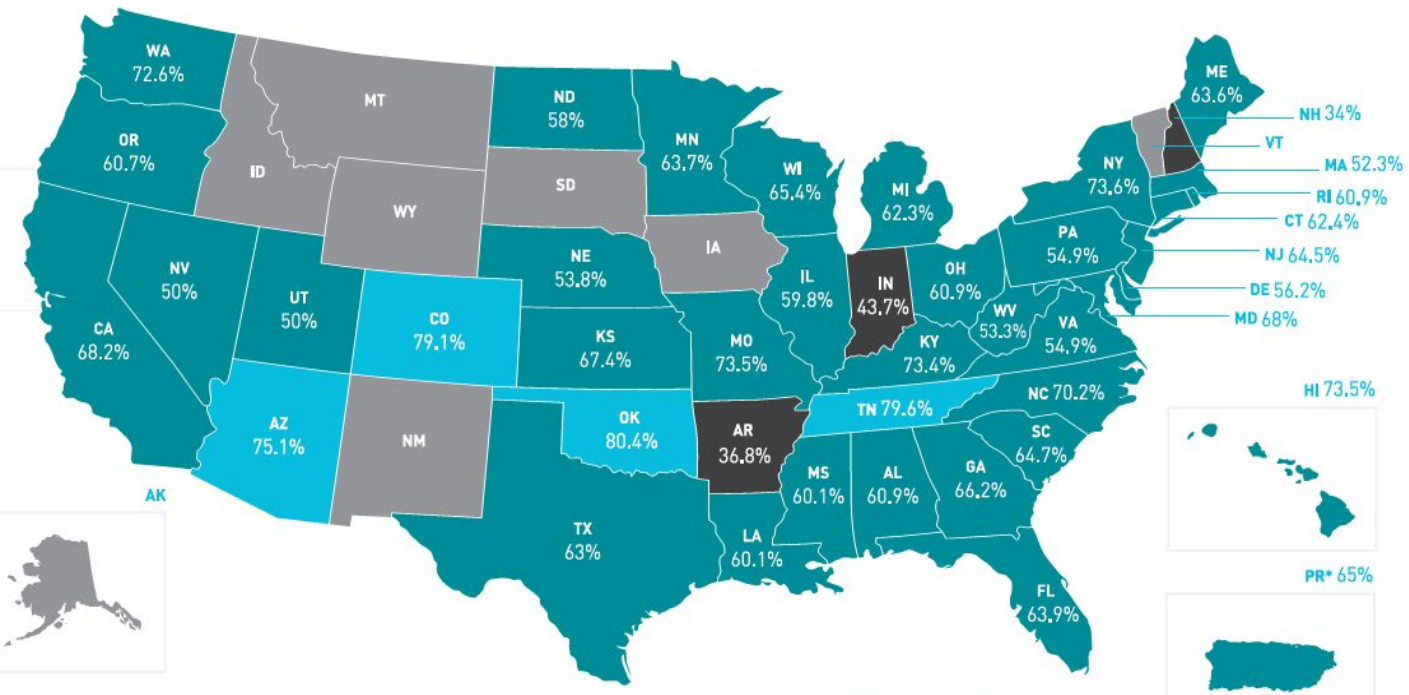
**75-100%**

2014

American Heart Association | American Stroke Association
life is why

GET WITH THE GUIDELINES. STROKE

TARGET: STROKE




GOAL 75%

**Target: Stroke Phase II aims to achieve Door-to-Needle Times within 60 minutes in 75% or more of acute ischemic stroke patients treated with IV tPA.***

*Eligible Get With The Guidelines-Stroke/Target: Stroke acute ischemic stroke patients treated between January 2014 to December 2014

state — eligible patients treated with IV tPA within 60 minutes (numerator)/all eligible patients (denominator) — (number of hospitals participating per state)

**FEWER THAN 6 HOSPITALS PER STATE** (too few to report)

Alaska
Idaho
Iowa
Montana
New Mexico
South Dakota
Vermont
Wyoming

**25-49%**

Arkansas 42/114 (18)
Indiana 129/295 (22)
New Hampshire 16/47 (6)

**50-74%**

Alabama 84/138 (19)
California 1436/2105 (134)
Connecticut 133/213 (12)
Delaware 59/105 (6)
Florida 1005/1573 (99)
Georgia 492/743 (49)
Hawaii 75/102 (9)
Illinois 298/498 (53)
Kansas 97/144 (13)
Kentucky 199/271 (18)
Louisiana 110/183 (10)
Maine 35/55 (7)
Maryland 300/441 (36)
Massachusetts 334/639 (64)
Michigan 271/435 (27)
Minnesota 107/168 (6)
Mississippi 107/178 (14)
Missouri 436/593 (33)
Nebraska 21/39 (7)
Nevada 79/158 (13)
New Jersey 439/681 (45)
New York 1228/1668 (115)
North Carolina 417/594 31
North Dakota 29/50 (10)
Ohio 377/619 (50)
Oregon 193/318 (26)
Pennsylvania 584/1063 (82)
Puerto Rico (FL-PR Stroke Registry) 859/1321 (65)
Rhode Island 81/133 (7)
South Carolina 257/397 (23)
Texas 884/1403 (95)
Utah 16/32 (7)
Virginia 123/224 (22)
Washington 318/438 (37)
West Virginia 57/107 (10)
Wisconsin 185/283 (34)
North Carolina 417/594 (31)

**75-100%**

Arizona 398/530 (28)
Colorado 291/368 (20)
Oklahoma 144/179 (6)
Tennessee 257/323 (17)

Chiesi

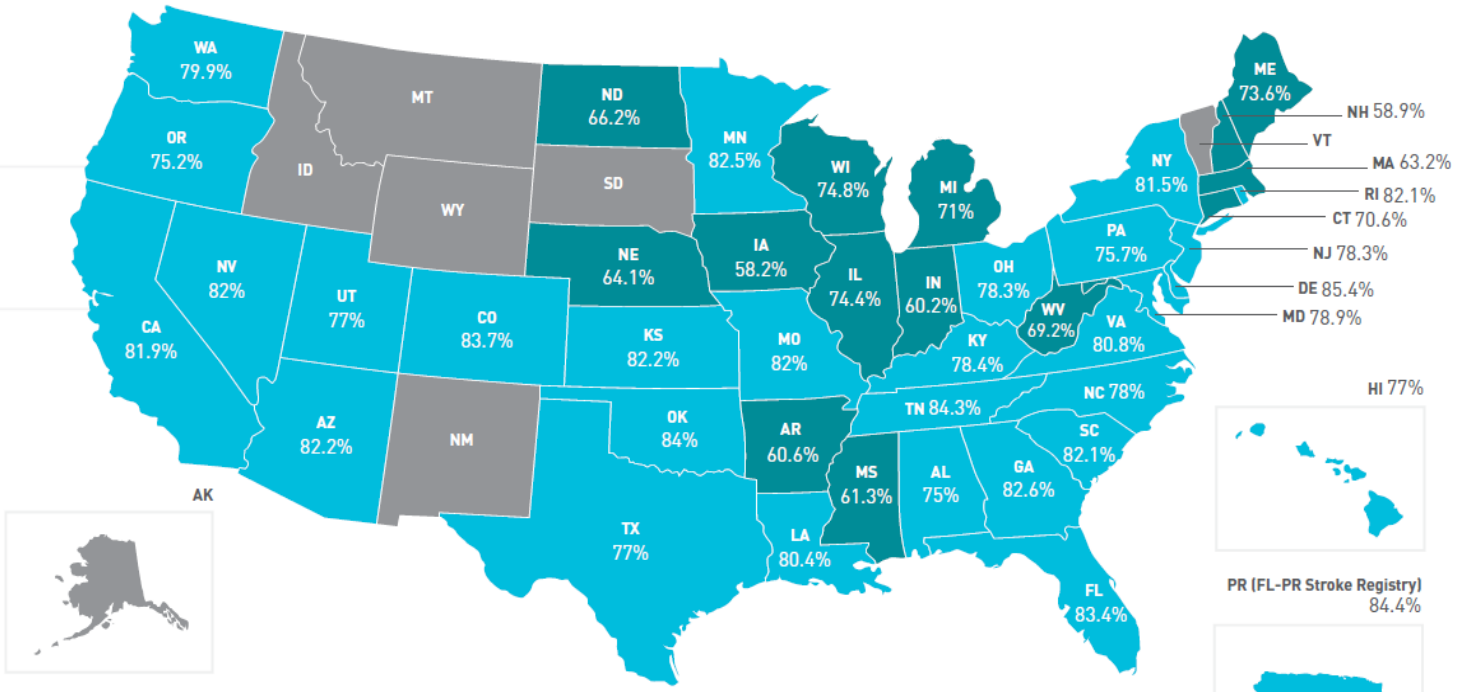
Chiesi is proud to support the American Heart Association's Target: Stroke℠ quality initiative.

American Heart Association | American Stroke Association
life is why

GET WITH THE GUIDELINES. STROKE

TARGET: STROKE

# 2016




**GOAL 75%**

Target: Stroke Phase II aims to achieve Door-to-Needle Times within 60 minutes in 75% or more of acute ischemic stroke patients treated with Alteplase.*

*Eligible Get With The Guidelines-Stroke/Target: Stroke acute ischemic stroke patients treated between January 2016 to December 2016

state numerator/denonimator (number of hospitals participating per state)

**FEWER THAN 6 HOSPITALS PER STATE** (too few to report)

Alaska
Idaho
Montana
New Mexico
South Dakota
Vermont
Wyoming

**50-74%**

Arkansas 140/231 (27)
Connecticut 202/286 (16)
Illinois 873/1173 (85)
Indiana 234/389 (26)
Iowa 71/122 (9)
Maine 67/91 (7)
Massachusetts 492/779 (62)
Michigan 562/792 (38)
Mississippi 225/367 (30)
Nebraska 50/78 (7)
New Hampshire 43/73 (8)
North Dakota 45/68 (15)
West Virginia 128/185 (8)
Wisconsin 314/420 (48)

**25-49%**

No hospitals in this range.

**75-100%**

Alabama 168/224 (18)
Arizona 633/770 (26)
California 3235/3950 (168)
Colorado 518/619 (27)
Delaware 246/288 (6)
Florida 2146/2572 (105)
Georgia 895/1084 (61)
Hawaii 137/178 (11)
Kansas 315/383 (17)
Kentucky 388/495 (27)
Louisiana 333/414 (18)
Maryland 512/649 (40)
Minnesota 293/355 (9)
Missouri 787/960 (41)
Nevada 273/333 (15)
New Jersey 832/1062 (48)
New York 1868/2292 (119)
North Carolina 871/1117 (54)
Ohio 748/955 (53)
Oklahoma 304/362 (12)
Oregon 304/404 (28)
Pennsylvania 1155/1526 (95)
Puerto Rico (FL-PR Stroke Registry) 1879/2226 (74)
Rhode Island 124/151 (8)
South Carolina 564/687 (28)
Tennessee 836/992 (33)
Texas 1906/2474 (131)
Utah 164/213 (12)
Virginia 422/522 (30)
Washington 525/657 (43)

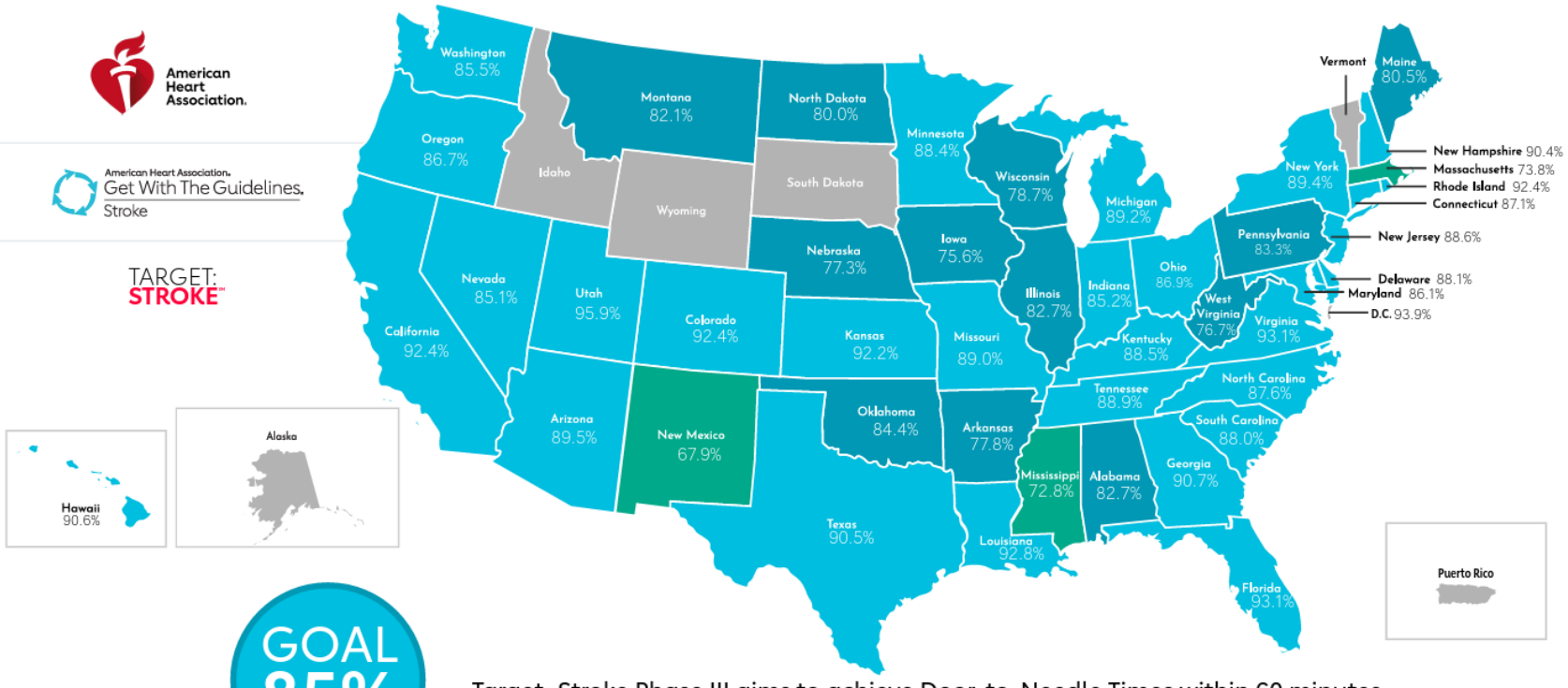
# Target: Stroke® Phase III: Door-to-Needle within 60 Minutes

2023

American Heart Association.

American Heart Association. Get With The Guidelines. Stroke

TARGET: STROKE™




GOAL 85%

Target: Stroke Phase III aims to achieve Door-to-Needle Times within 60 minutes in 85% or more of acute ischemic stroke patients treated with intravenous thrombolytics.

*Eligible acute ischemic stroke patients treated between January 2023 - December 2023 per Get With The Guidelines®-Stroke

*gray states denominator too small to report

state numerator/denominator (number of hospitals participating per state)

**25-49%** — No hospitals in this range

**50-75%**

New Mexico 106/156 (14)
Massachusetts 540/732 (61)
Mississippi 351/482 (47)

**76-84%**

Alabama 486/588 (29)
Arkansas 597/767 (70)
Illinois 1223/1479 (100)
Iowa 269/356 (30)
Maine 103/128 (7)
Montana 119/145 (18)
North Dakota 120/150 (21)
Nebraska 198/256 (33)
Oklahoma 453/537 (25)
Pennsylvania 1656/1987 (121)
Wisconsin 609/774 (73)
West Virginia 198/258 (17)

**85-100%**

Arizona 553/618 (30)
California 4790/5186 (228)
Colorado 745/806 (34)
Connecticut 390/448 (24)
Delaware 215/244 (6)
Florida 4173/4480 (175)
Georgia 1555/1714 (84)
Hawaii 259/286 (13)
Indiana 698/819 (45)
Kansas 270/293 (19)
Kentucky 626/707 (49)
Louisiana 669/721 (31)
Maryland 736/855 (40)
Michigan 1250/1401 (75)
Minnesota 622/704 (31)
Missouri 1210/1360 (62)
North Carolina 1475/1684 (78)
New Hampshire 161/178 (12)
New Jersey 1045/1179 (56)
Nevada 371/436 (18)
New York 2229/2494 (131)
Ohio 1472/1694 (87)
Oregon 576/664 (32)
Rhode Island 159/172 (7)
South Carolina 891/1013 (49)
Tennessee 1312/1476 (52)
Texas 3761/4155 (169)
Utah 325/339 (17)
Virginia 1048/1126 (44)
Washington 815/953 (56)

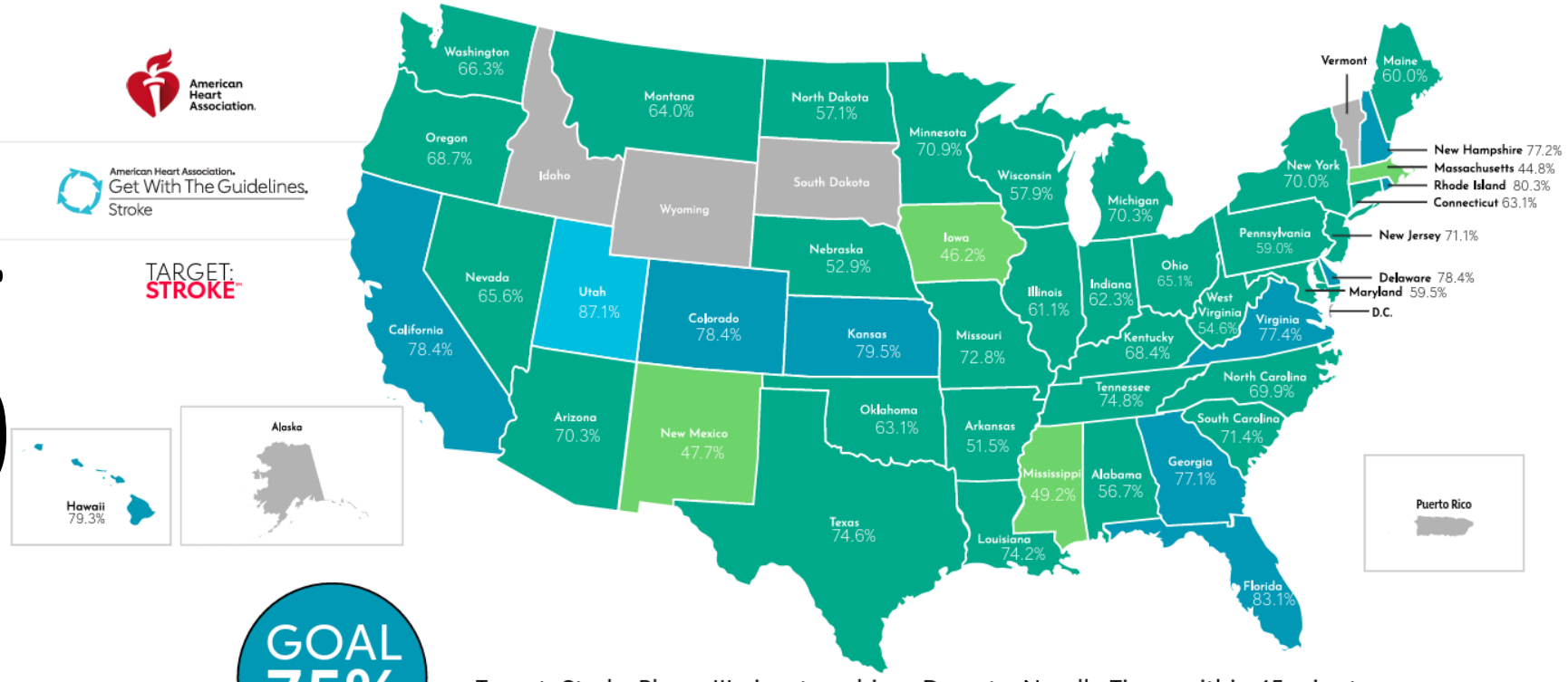
# Target: Stroke℠ Phase III: Door-to-Needle within 45 Minutes

2023

American Heart Association.

American Heart Association. Get With The Guidelines. Stroke

TARGET: STROKE™




GOAL 75%

Target: Stroke Phase III aims to achieve Door-to-Needle Times within 45 minutes in 75% or more of acute ischemic stroke patients treated with intravenous thrombolytics.

*Eligible acute ischemic stroke patients treated between January 2023 - December 2023 per Get With The Guidelines®-Stroke

*gray states denominator too small to report

state numerator/denominator (number of hospitals participating per state)

**25-49%**

Iowa 151/327 (30)
Massachusetts 296/661 (61)
Mississippi 209/425 (46)
New Mexico 72/151 (14)

**50-75%**

Alabama 315/556 (28)
Arizona 351/499 (30)
Arkansas 353/686 (70)
Connecticut 245/388 (24)
Illinois 810/1326 (100)
Indiana 451/724 (45)
Kentucky 414/605 (49)
Louisiana 482/650 (31)
Maine 75/125 (7)
Maryland 432/726 (40)
Michigan 818/1163 (75)
Minnesota 436/615 (31)
Missouri 889/1221 (62)
Montana 80/125 (18)
Nebraska 119/225 (32)
Nevada 259/395 (18)
New Jersey 725/1019 (55)
New York 1438/2055 (129)
North Carolina 1080/1545 (77)
North Dakota 84/147 (22)
Ohio 996/1530 (87)
Oklahoma 309/490 (24)
Oregon 408/594 (32)
Pennsylvania 1018/1726 (120)
South Carolina 652/913 (49)
Tennessee 981/1312 (52)
Texas 2683/3597 (168)
Washington 536/808 (55)
West Virginia 125/229 (17)
Wisconsin 404/698 (74)

**76-84%**

California 3449/4401 (227)
Colorado 562/717 (33)
Delaware 171/218 (6)
Florida 3390/4081 (175)
Georgia 1138/1476 (84)
Hawaii 214/270 (13)
Kansas 210/264 (19)
New Hampshire 115/149 (12)
Rhode Island 110/137 (7)
Virginia 762/984 (44)

**85-100%**

Utah 264/303 (17)

# Emergency Medical Services and Trauma Registries (EMSTR) Stroke Performance Improvement Data

March 7, 2025

**Gavin Sussman**
**EMS and Trauma Registries Manager**

# About EMSTR

- EMSTR collects reportable event data from EMS providers, hospitals, justices of the peace, medical examiners, and rehabilitation facilities.
- All submitters must report all runs and reportable trauma events to EMSTR under Texas Administrative Code, Title 25, Chapter 103.
- Per epidemiology best practice, EMSTR suppressed data with less than five records to protect identifiable information; noted with an asterisk (*).

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

# Stroke Performance Improvement (PI) Data

January 1, 2022 - June 30, 2024

# Inclusion Criteria – All Suspected Strokes

- Primary symptom, other associated symptom, provider's primary impression or provider's secondary impression variables included International Classification of Diseases Tenth Revision (ICD-10) codes:
  - G45 – Transient cerebral ischemic attacks and related syndromes
  - G46 – Vascular syndromes of brain in cerebrovascular diseases
  - I60 – Nontraumatic subarachnoid hemorrhage
  - I61 – Nontraumatic intracerebral hemorrhage
  - I63 – Cerebral infarction
- Protocols used were "Medical – Stroke/TIA".[1]
- Stroke Scale Result was "Positive".
- 2024 data is from January 1–June 30, 2024. This data is preliminary as of January 7, 2025. Preliminary data is subject to change.

[1] TIA = transient ischemic attack

# Suspected Stroke Numbers

| | 2022 | 2023 | 1st half 2024* |
|---|---|---|---|
| Total Suspected Stroke Patients | 59,752 | 57,082 | 32,973 |

*2024 data is from January 1–June 30, 2024. This data is preliminary as of January 7, 2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMS and Trauma Registries (EMSTR). January 2025.

# Suspected Stroke by Sex

| Sex | 2022 | 2023 | 1st half 2024* |
|---|---|---|---|
| Male | 28,521 | 27,275 | 16,144 |
| Female | 30,894 | 29,632 | 16,755 |
| Missing / Not Recorded | 337 | 175 | 74 |

*2024 data is from January 1–June 30, 2024. This data is preliminary as of January 7, 2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMS and Trauma Registries (EMSTR). January 2025.

# Stroke Scale Status for Suspected Stroke Patients

| Status | | 2022 | 2023 | 1st half 2024* |
|---|---|---|---|---|
| **Stroke Scale Performed** | | 28,192 | 32,863 | 21,650 |
| | Percentage | 47.18% | 57.57% | 65.66% |
| **Not Applicable** | | 11,326 | 0 | 0 |
| | Percentage | 18.96% | 0.00% | 0.00% |
| **Not Recorded** | | 20,234 | 24,219 | 11,323 |
| | Percentage | 33.86% | 42.43% | 34.34% |
| **Totals** | | **59,752** | **57,082** | **32,973** |

*2024 data is from January 1–June 30, 2024. This data is preliminary as of January 7, 2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMS and Trauma Registries (EMSTR). January 2025.

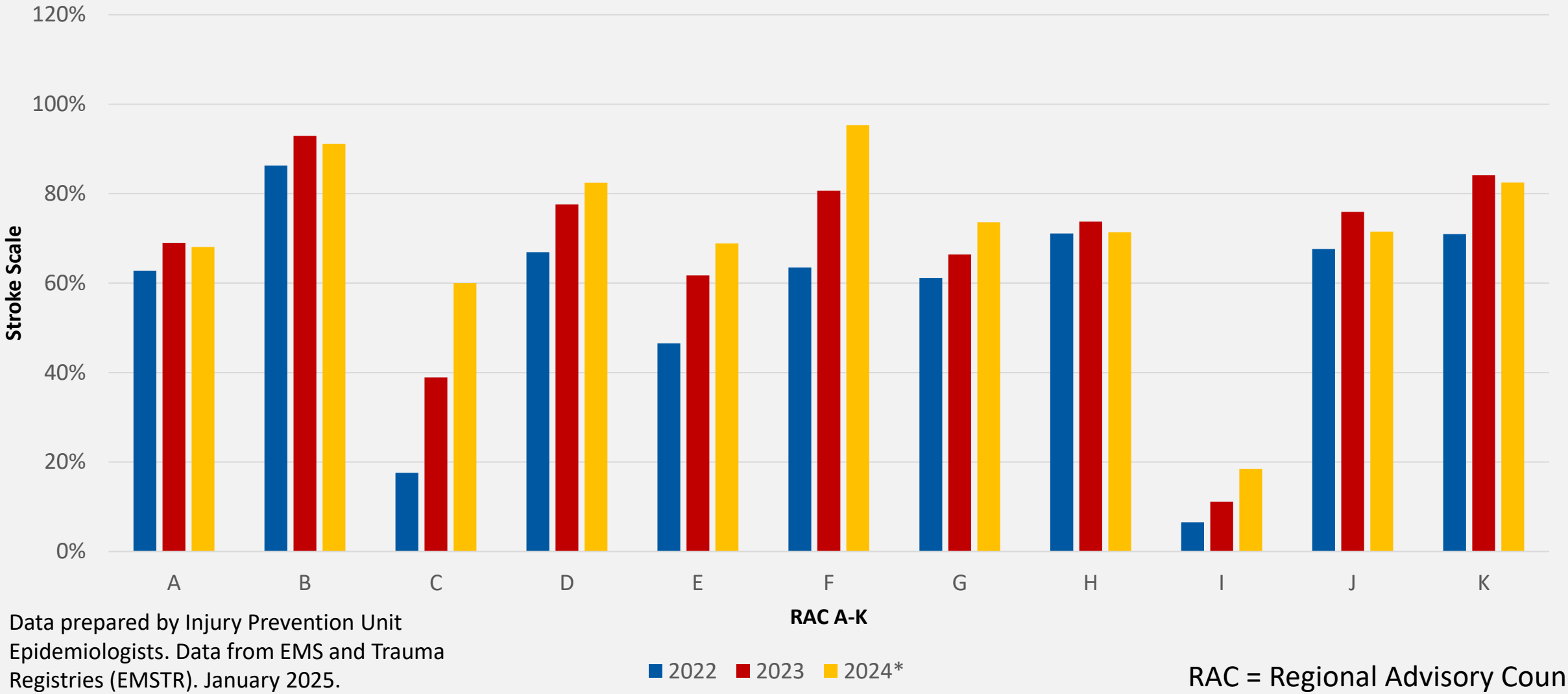
# Stroke Scale Performed by Sex for Suspected Stroke Patients

| Sex | 2022 | 2023 | 1st half 2024* |
|---|---|---|---|
| **Male** | 13,346 | 15,733 | 10,597 |
| Percentage | 46.79% | 57.68% | 65.64% |
| **Female** | 14,772 | 17,070 | 11,004 |
| Percentage | 47.82% | 57.61% | 65.68% |

*2024 data is from January 1 – June 30, 2024. This data is preliminary as of January 7, 2025.

Data prepared by Injury Prevention Unit Epidemiologists. Data from EMS and Trauma Registries (EMSTR). January 2025.

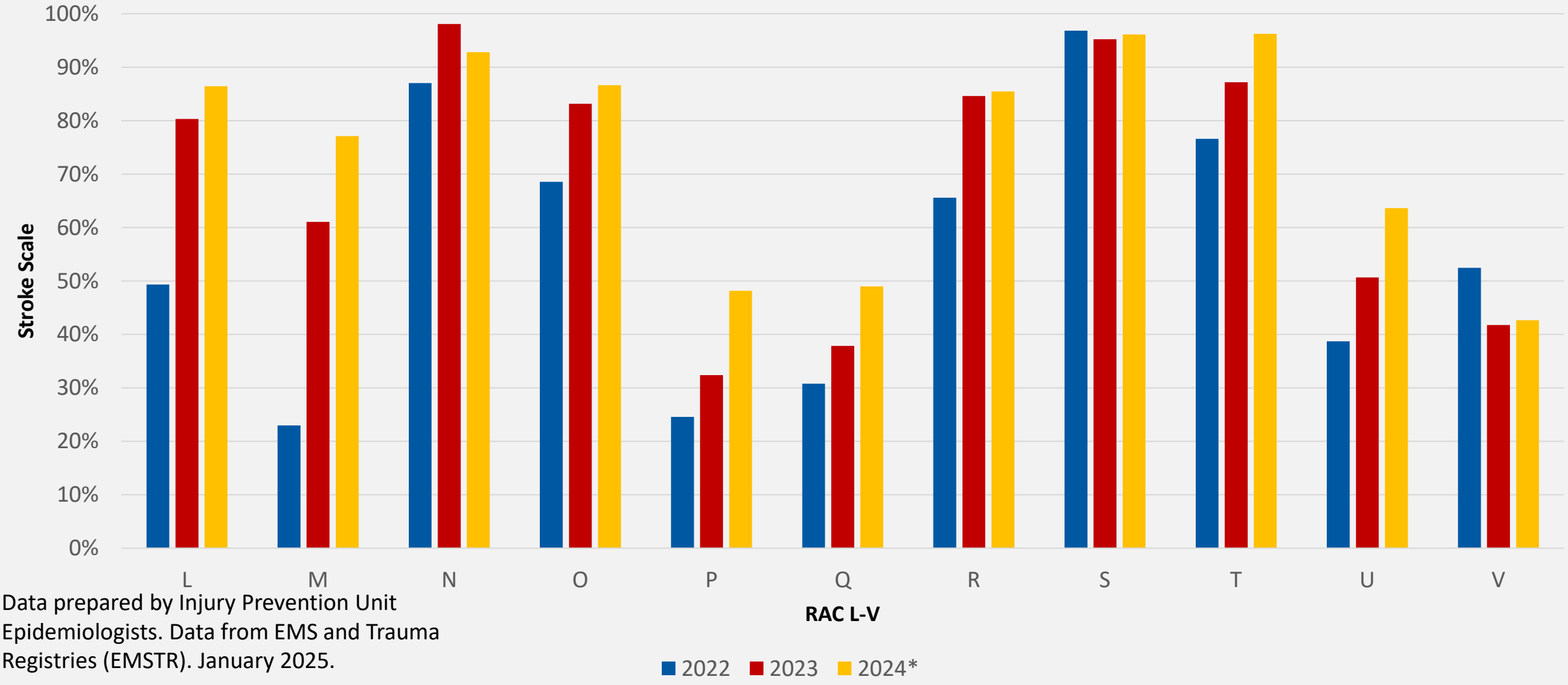
# Stroke Scale Performed by RAC* A-K for Suspected Stroke Patients




Data prepared by Injury Prevention Unit Epidemiologists. Data from EMS and Trauma Registries (EMSTR). January 2025.

RAC = Regional Advisory Council

# Stroke Scale Performed by RAC L-V for Suspected Stroke Patients




Data prepared by Injury Prevention Unit Epidemiologists. Data from EMS and Trauma Registries (EMSTR). January 2025.

# Thank you!

EMSTR Stroke PI data

Injury.Prevention@dshs.texas.gov

# 10.b. Burn Care Task Force

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

# 10.c. EMS Wall-times Task Force

# 11. Executive Council Activities Summary

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

Dinah Welsh, TETAF President/CEO

# Texas EMS, Trauma & Acute Care Foundation Update

**Dinah Welsh**

*TETAF President/CEO*

Friday, March 7, 2025

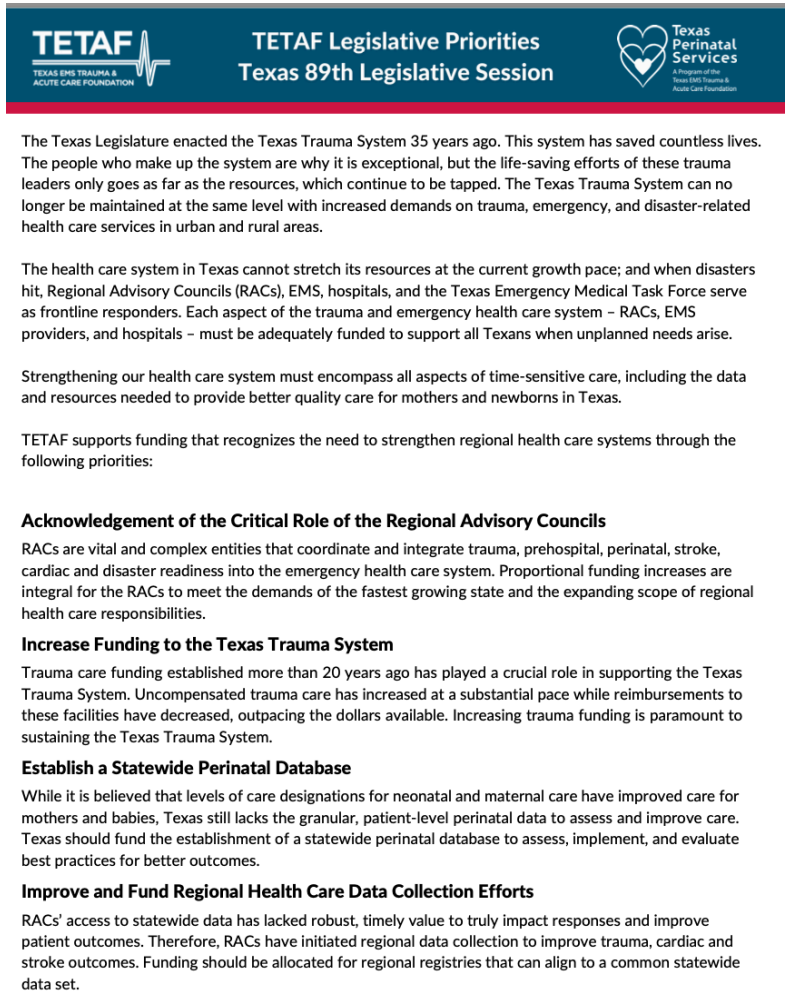
TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

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

# Advocacy

- TETAF is focused on its Legislative Priorities, along with closely monitoring more than 100 bills. Bill filing deadline is next week, March 14.
- Every other week, TETAF hosts the TETAF Legislative Work Group via Zoom. All stakeholders are welcome to attend. Next meeting is today at 2:00 p.m.

Register to attend the TETAF Legislative Work Group 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.

# Surveys – Trauma, Stroke, Maternal & Neonatal

- **Trauma Rules** – TETAF is preparing for the changes to trauma designation requirements effective 9/1/2025. TETAF is working with surveyors, hospital partners, and DSHS to ensure rules are understood and followed. TETAF will recruit additional trauma surgeon surveyors.
- **TETAF and Texas Perinatal Services Surveys** – The volume of surveys in order are currently trauma, maternal, neonatal, and stroke.
  - Perinatal surveys have slowed down due to the low designation cycle year.

# Education

- TETAF has been approved for another three years as a provider of nursing continuing professional development by the Louisiana State Nurses Association. TETAF would like to thank Courtney Edwards DNP, MPH, RN, CCRN, CEN, TCRN, NEA-BC for her hard work and diligence in ensuring TETAF can continue providing important and beneficial educational opportunities for our stakeholders.
- In 2024, TETAF provided more than 4,000 continuing professional development hours to learners in all 22 Regional Advisory Councils (RACs).
- The next TETAF Hospital Data Management Course (HDMC) will be held virtually this summer. Visit https://tetaf.org/hdmc/ to be notified of the dates.

# Collaboration

- TETAF continues to provide support to the Texas TQIP Collaborative.
  - First meeting of the quarter was on Wednesday, March 5.
  - Questions? Email texastqip@tetaf.org.
- TETAF is proud to once again be a sponsor for the upcoming Texas Organization of Rural and Community Hospitals (TORCH) Spring Conference on April 14-17 in Arlington, TX. Additionally, TETAF/Texas Perinatal Services is a sponsor for the Texas Collaborative for Healthy Mothers and Babies (TCHMB) Summit, June 16-17 in Austin.
- TETAF welcomes the opportunity to be a resource, support, and/or participate in any meetings to further build the trauma and emergency care network.
- Lastly, TETAF released its 2024 TETAF Annual Report. (Great to browse on a flight back home!)

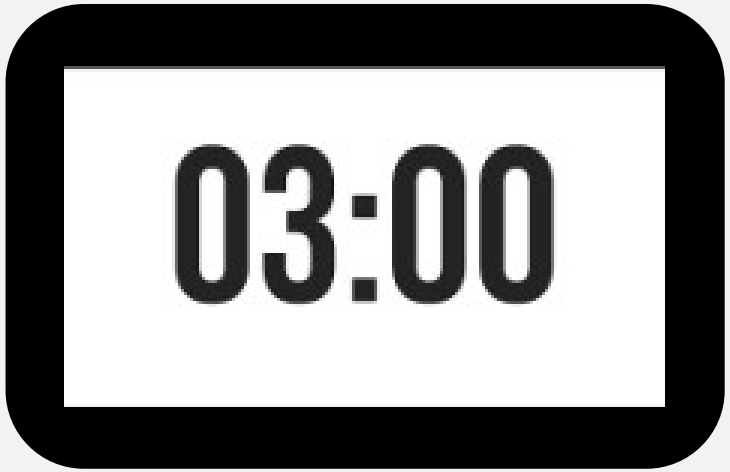
Scan the QR code to view the TETAF Annual Report.

# 13. 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

# 14. Announcements

# 15. Next Council Meeting Dates

**Quarterly Meetings:**

- **Q2 –** June 3-6, 2025
- **Q3 –** August 19-22, 2025
- **Q4 –** November 21-25, 2025, in conjunction with the Texas EMS Conference in Ft. Worth.

# 16. 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!*