TEXAS
Health and Human Services

Texas Department of State Health Services

Governor's EMS and Trauma Advisory Council

Friday, June 14, 2024

8: 00 AM (CST)

Alan Tyroch, MD, FACS, FCCM, Chair

Ryan Matthews, LP, Vice Chair

1. Call to Order

2024 Governor's EMS and Trauma Advisory Council Meeting

2nd 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 Central Ballroom

6505 N Interstate 35

Austin, TX 78752

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

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

2. Roll Call

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

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

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

Vision:

A unified, comprehensive, and effective Emergency Healthcare System.

Mission:

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

Moment of Silence

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

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4. Approval of Minutes

Review and Approval of Minutes

- March 8, 2024
- March 20, 2024

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5. Chair Report and Discussion

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

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State Reports

Dr. Timothy Stevenson

Associate Commissioner for Consumer Protection

Texas Department of State Health Services

6.a. EMS Trauma Systems Update

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

Uncompensated Care Application

2022 CALENDAR YEAR FOR UCC

FY23 COST OF TRAUMA CARE

INSTRUCTIONS PLACED ONLINE

RAC EMS Allotment

- Calendar Year 2022
- Validate EMS eligibility – RAC participation
- EMS Runs entered into registry
- Trauma facility submissions

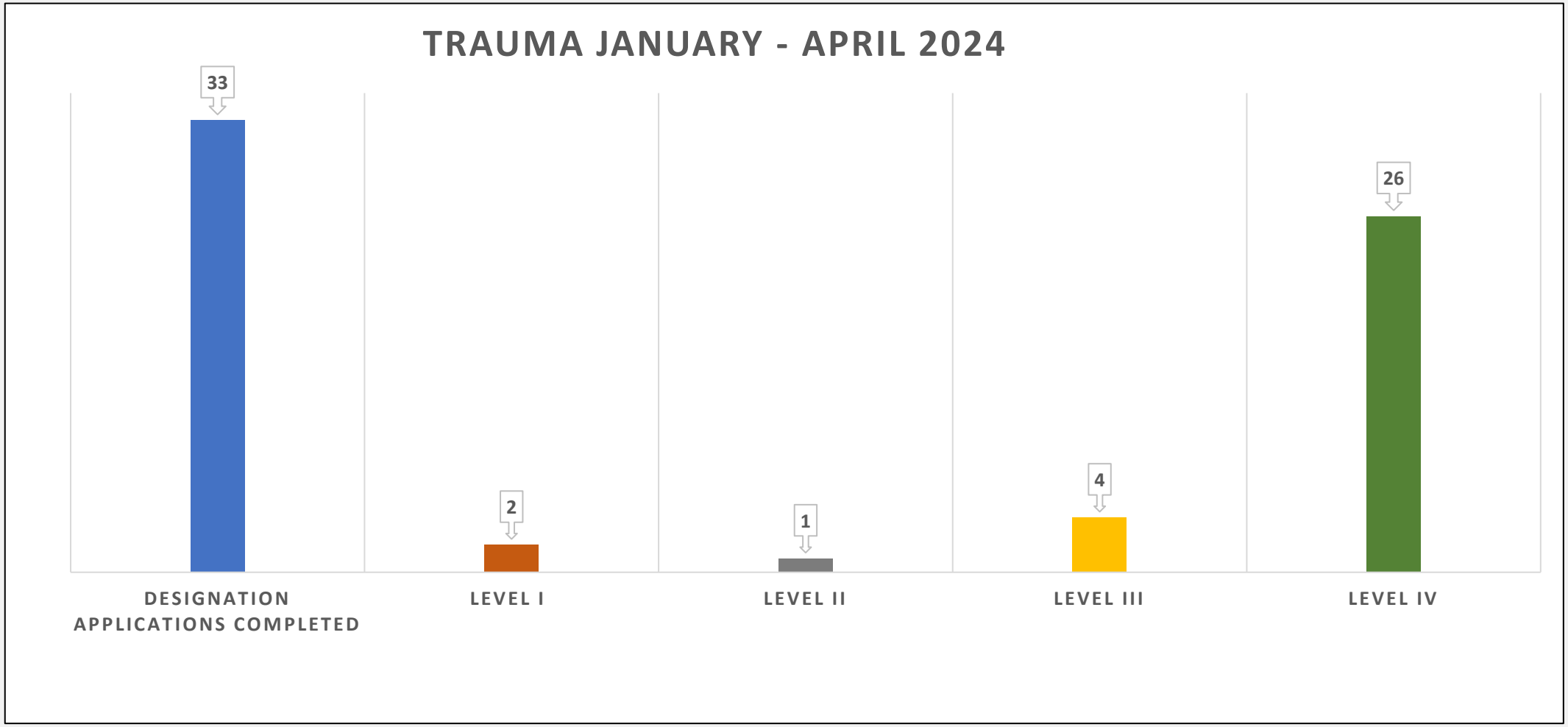
Designation Update

Elizabeth Stevenson, BSN, RN
Designation Programs Manager

Designated Trauma Facilities

Designated Trauma Facilities	April 2024	December 2023
Total	300	302
Level I	22	22
Level II	27	28
Level III	60	58
Level IV	191	194

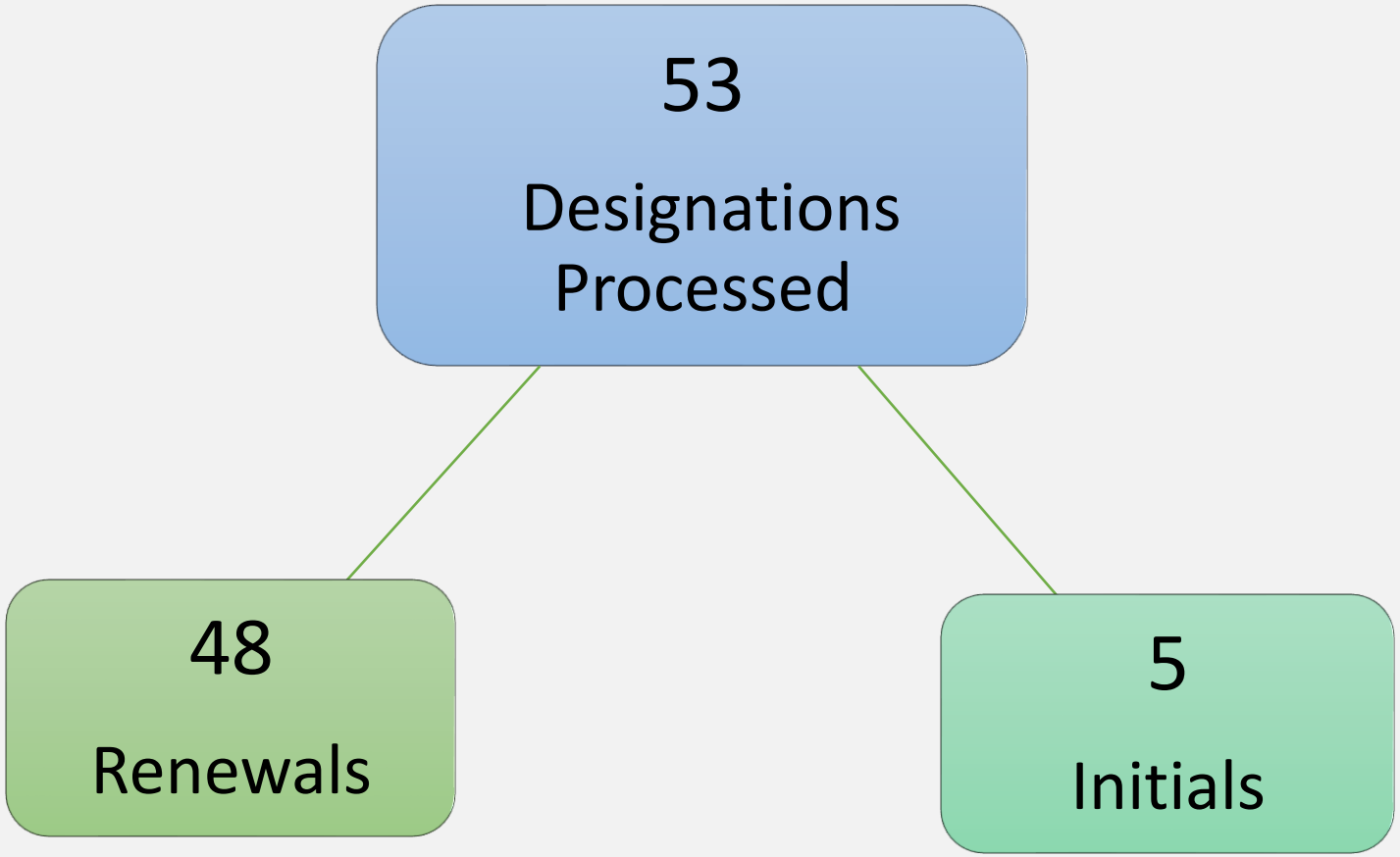
Trauma Designation Data



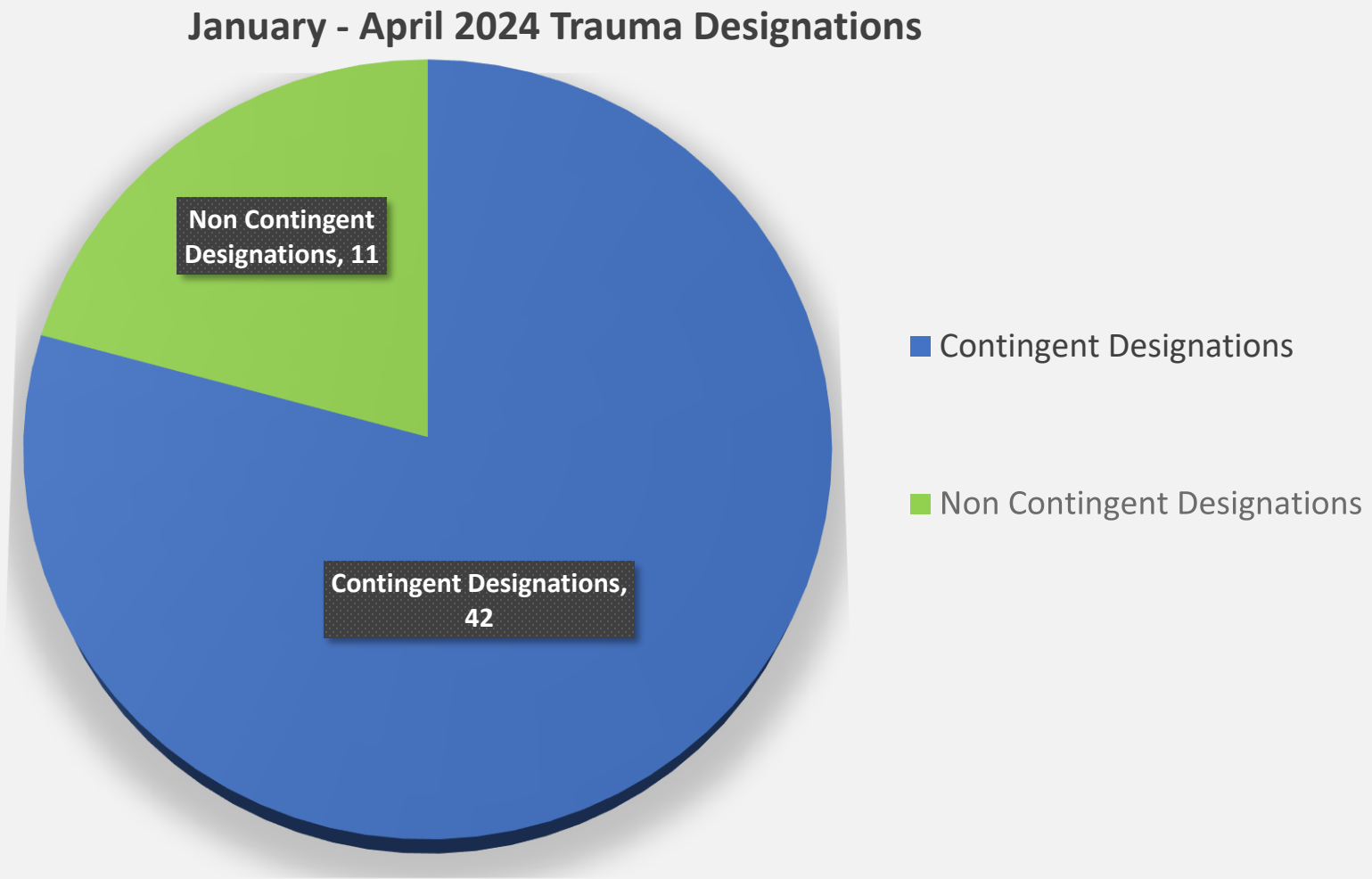
Trauma Designation Data

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

Trauma Designation Data



Trauma Designation Data



Common Deficiencies

- Performance Improvement
- Nursing documentation
- TMD/ED Physician Credentialing – CME/ATLS
- Surgeon Emergent/Urgent Criteria and Monitoring
- Orthopedic Credentialing/CME
- Neurosurgeon Emergent Criteria and Monitoring

Trauma Designation Assistance

Department Activities:

- Level I/II Trauma Facility monthly calls began in January 2024
- RAC Chairs and EDs invited to monthly facility calls
- Trauma meeting calls are now on the GoToWebinar platform

Designated Stroke Facilities

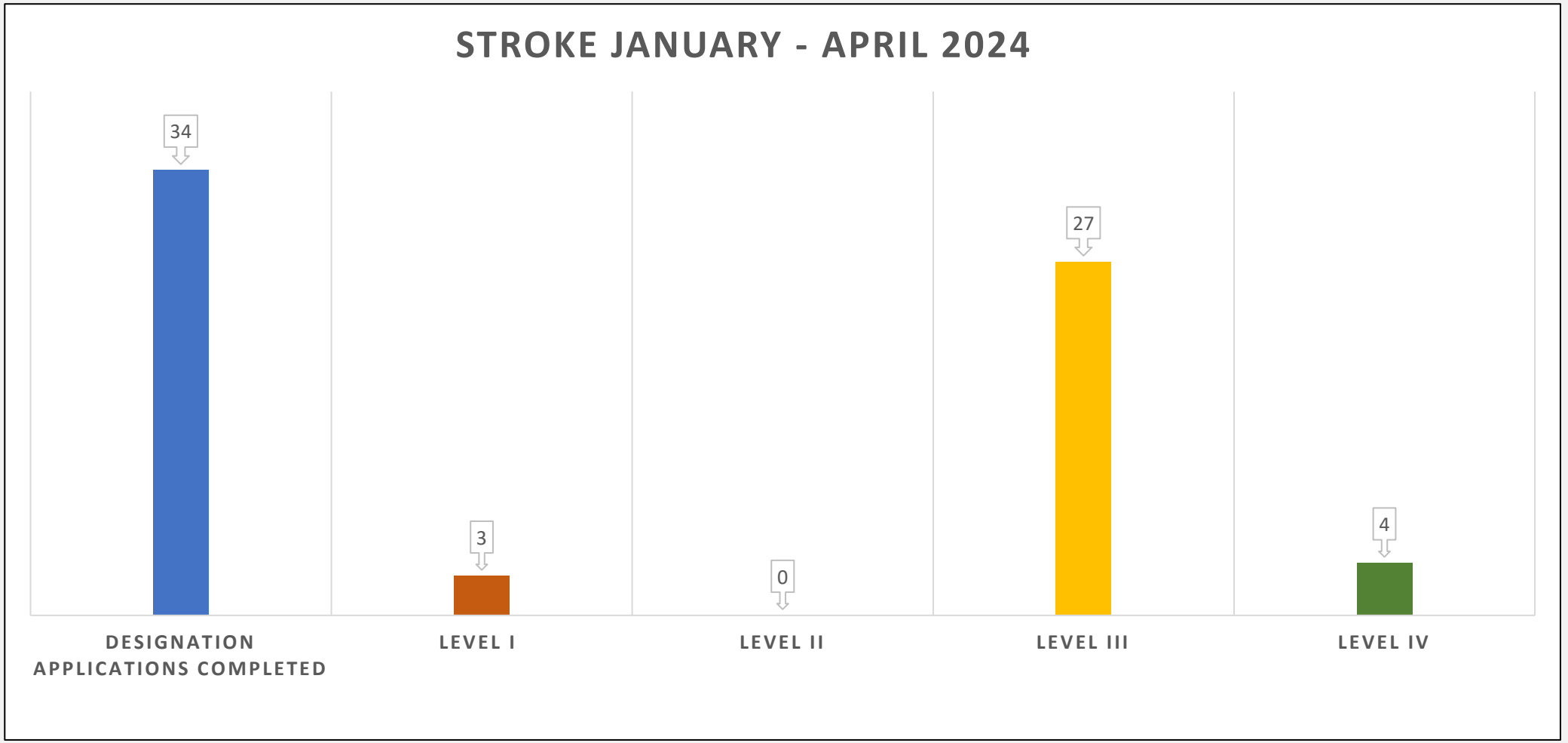
Designated Stroke Facilities	April 2024	December 2023
Total	188	188
Comprehensive Level I	45	43
Advanced Level II	4	4
Primary Level III *Primary Level II*	*74* *41*	51 *66*
Acute Stroke Ready Level IV *Support Level III*	*22* *2*	19 *5*

Designated Stroke Facilities

Designated Stroke Facilities	Totals
January - April 2024	188
4th Quarter 2023	188

- Withdrew:
  - 2 Primary Center (CHOW)
- Initial Designations:
  - 2 Primary

Stroke Designation Data



Designation Application Process Performance Measures

Goals – 30/60 days

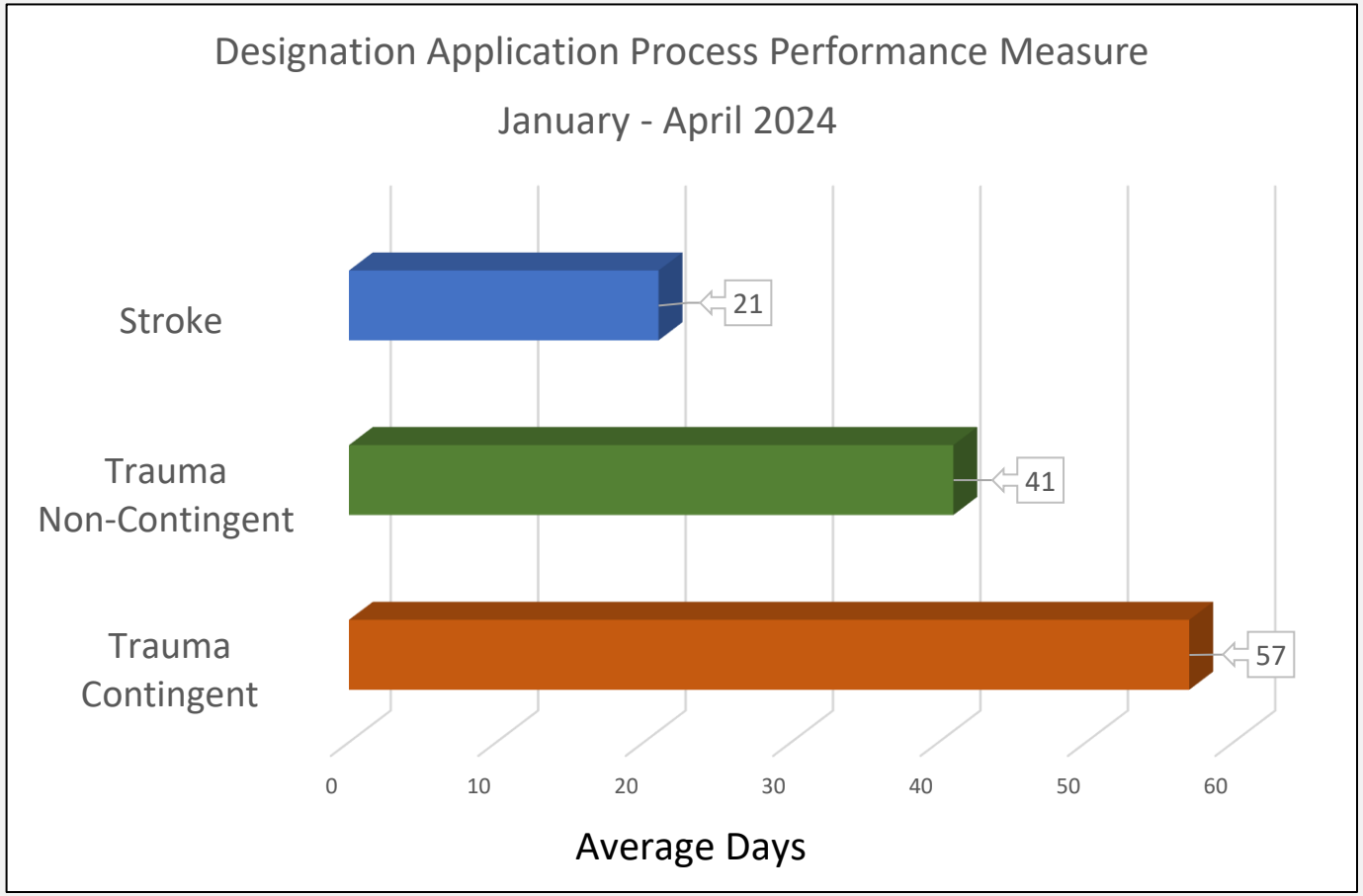
(Non-Contingent Designation 30 Days)

(Contingent Designation 60 Days)

Stroke – 21 days

Trauma – 41 days
Non–Contingent

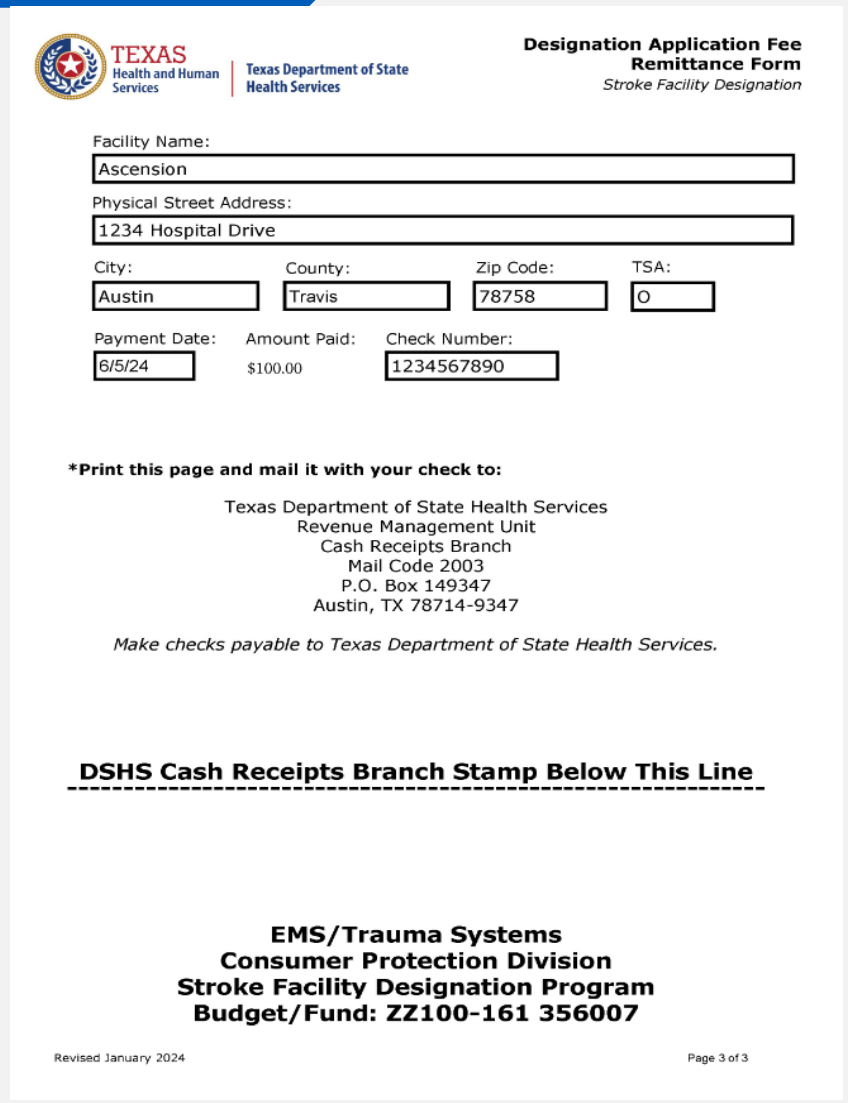
Trauma – 57 days
Contingent



Application Fee Payments

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

ACH payments could delay your application being processed



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

Designation Application Fee Remittance Form
Stroke Facility Designation

Facility Name: Ascension

Physical Street Address: 1234 Hospital Drive

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

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

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

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

Make checks payable to Texas Department of State Health Services.

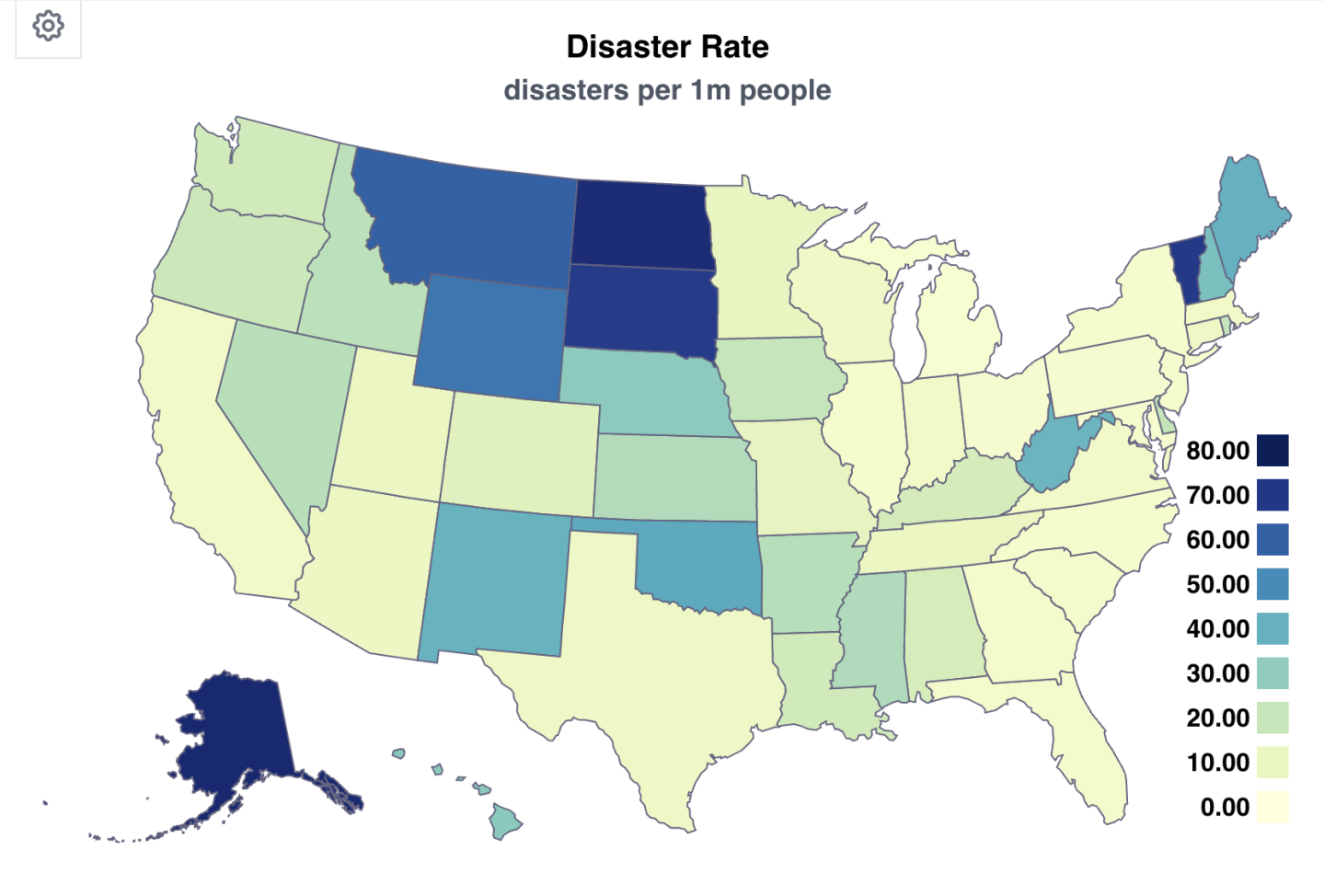
DSHS Cash Receipts Branch Stamp Below This Line

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

Revised January 2024

Page 3 of 3

Disaster Events Are Not Infrequent



32 Texas Declared Disasters January 2017 – June 13, 2024

Incident Statistics

Active Shooter Incidents 2017–2021

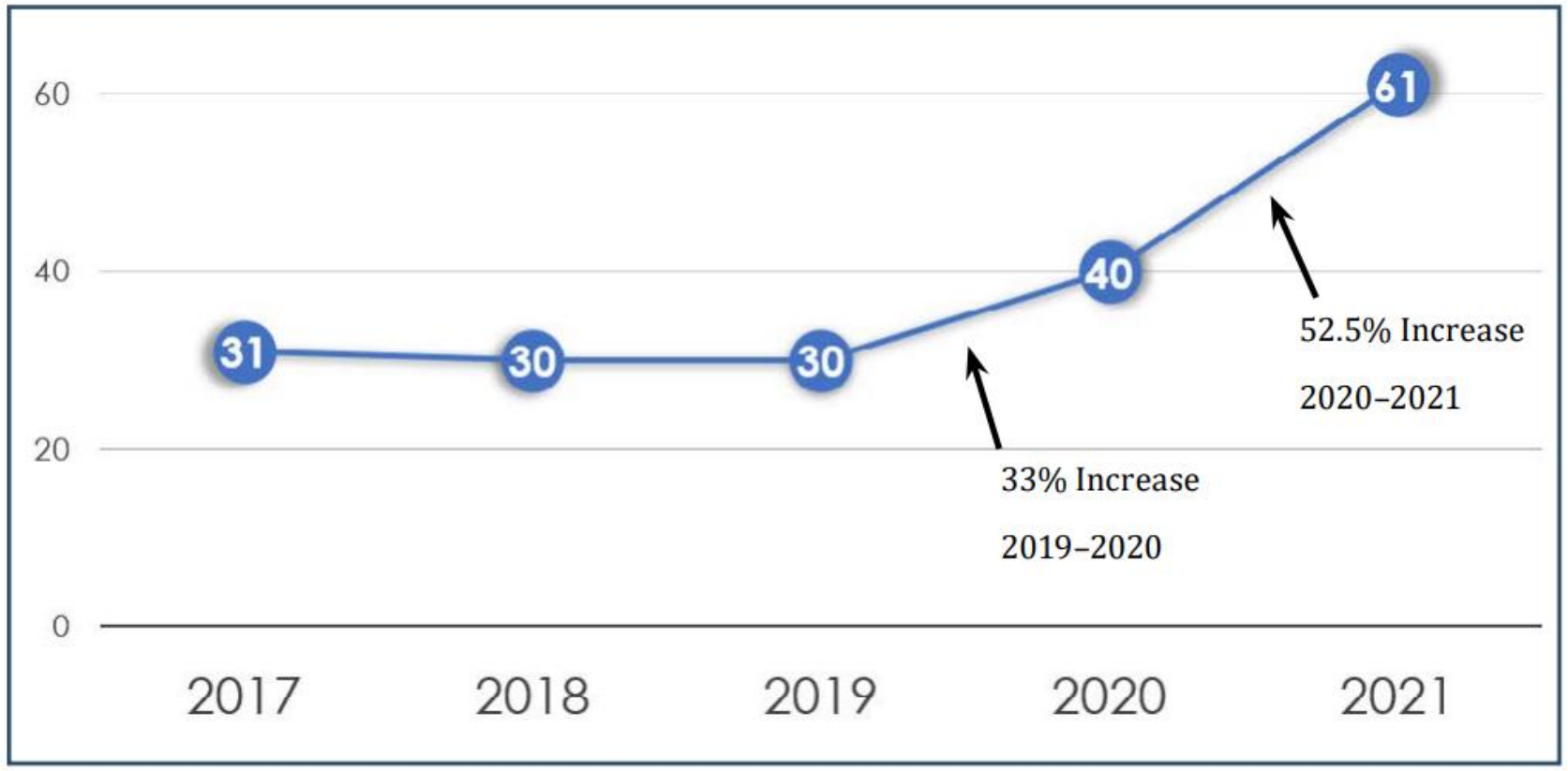


Figure 1

Texas - 9 Mass Shootings in 14 years 2009 - 2022

Rural Trauma Care Challenges

- Disparities in access to trauma care in United States (2017)
  - 309 million people in US (2010 census) 29.7 lack access to trauma care
  - Level I or Level II within 60 minutes by ground or air medical services
  - Rurality associated with lower access to trauma care overall

- Rural populations overall are disproportionately affected

Carr, B, et all. (2017). Disparities in Access to Trauma Care in the United States: A Population-Based Analysis. *Injury*. February; 48(2) 332-338. doi: 10:1016/j.injury.2017.01.008.

Rural Trauma Care Risk

- Rural population – 14% more likely to die
- Disparity greatest for injuries in the South or Midwest US
- Variabilities
  - Distance and time to treatment
  - Regional variations in pre-hospital and trauma systems
  - Trauma center designation
  - Injury severity

Jarman, M. (2016). Rural Risk: Geographic Disparities in Trauma Mortality. *Surgery*. December; 160(6) 1551-1559. doi: 10.1016/j.surgery.2016.06.020.

Hospital Closures

- 2010 to 2015 – 120 hospitals closed in the US, approximately half are located in rural communities
  - Creates a challenge and change in patient destination
  - Potentially impacts the next patient needing EMS services
- Hospital closure – patients spend more time in an ambulance
- Individuals 64 and older in rural areas spend an additional 27.6 minutes in an ambulance
- Transport time increased 25 minutes after hospital closure
- Trauma and time-sensitive emergencies – greater challenges

Troske.S., Davis, A. (2019) Do Hospital Closures Affect Patient Time in an Ambulance? *Rural & Underserved Health Research Center Publications*. 8. Available at https://unknowledge.uky.edu/ruhrc_reports8

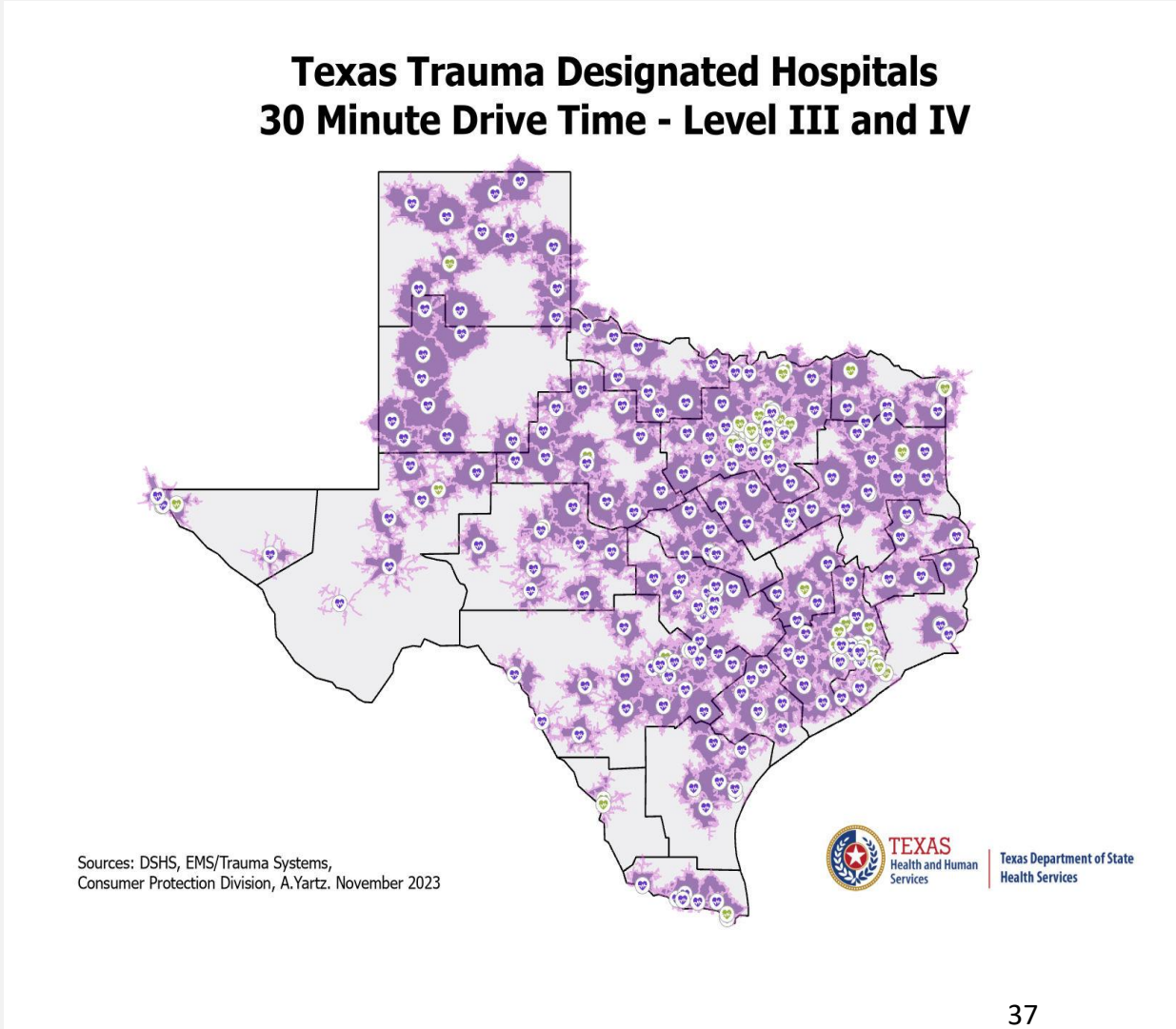
Rural Hospital Closures| TORCH - TEXAS ORGANIZATION OF RURAL & COMMUNITY HOSPITALS (torchnet.org)

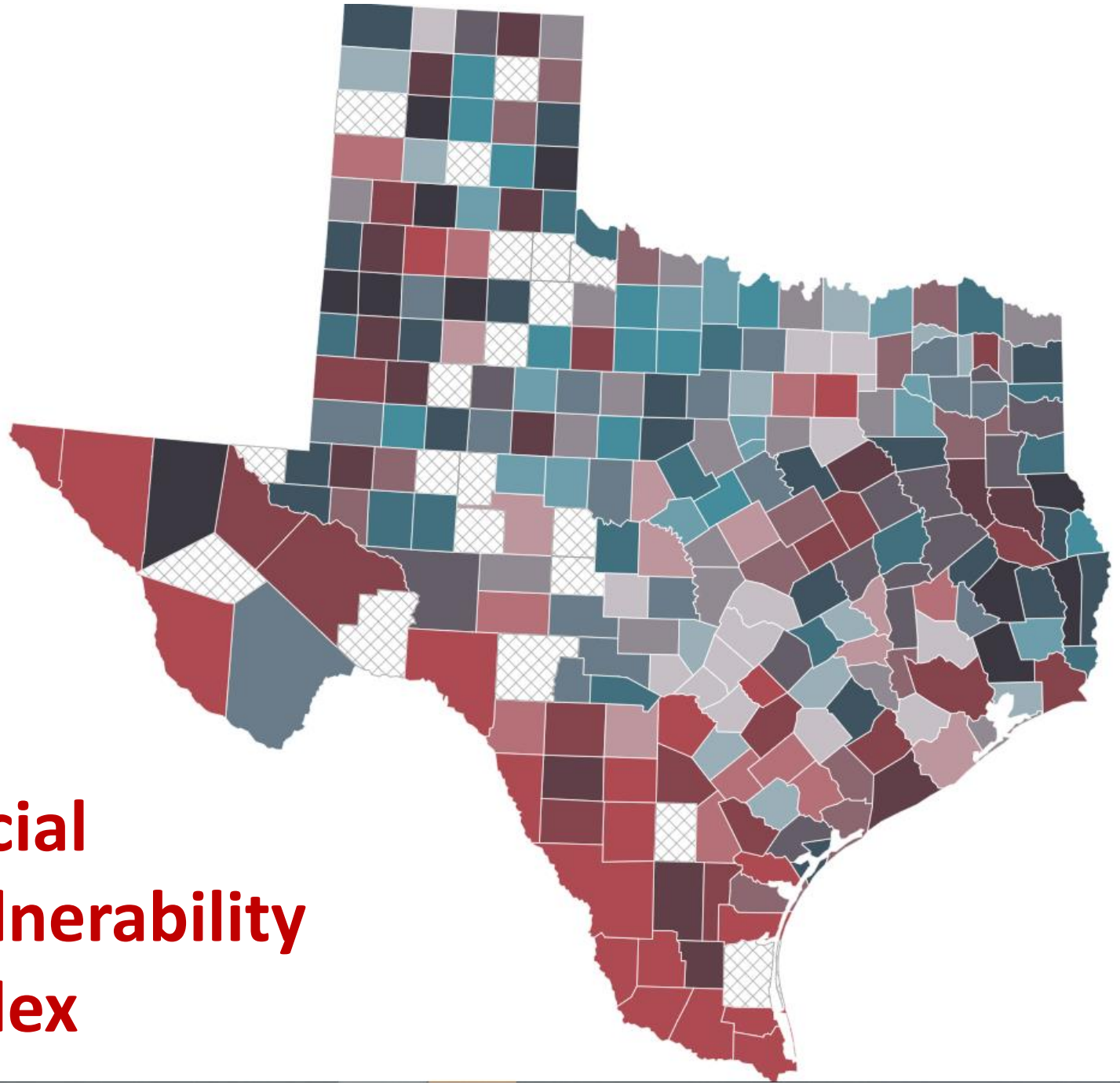
System Challenges

Variations in regional resources
Variations in population
Growing population

- Challenges in access
- Diversion times
- Challenges with specialties services
- Challenges in transport
- Challenges in transfers
- Greatest challenge in Rural areas
- Opportunities
  - Community Paramedicine
  - Telemedicine

State System Performance Improvement Plan

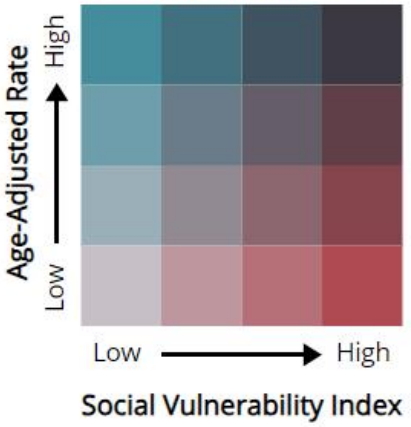




91,288
Number of Deaths
144,647,976
Population
2017 - 2021

Social Vulnerability Index

Select boxes in legend to limit the counties shown.



Suppressed Data

Proposed Rules 2019 -2024

- Formal Comment Period – Over 4,000 Comments
- Themes
  - Align Requirements with the ACS
  - Provide more time for trauma facility implementation of requirements
  - Decrease the cost burden of being a trauma facility
  - Decrease the cost burden of rural Level IV facilities achieving trauma facility designation and maintaining trauma facility designation
- Rules were pulled in April 2024

Trauma Rules

- Department Submitted New Trauma Rule Proposal
- Proposed Rules are Shared with Stakeholders
- No Informal Comment Period
- Formal Comment Period

Proposed Trauma Rules

- 157.2 – Definition
- 157.123 – Regional Advisory Council
- 157.125 Requirements for Trauma Facility Designation Requirements – Revised and **Terminates on August 31, 2025**
- 157.126 New Rule – Trauma Facility Designation Requirement – **Effective September 1, 2025**
- 157.128 Denial, Suspension, and Revocation of Trauma Facility Designation
- 157.130 Funding (Integrates 157.131 which is repealed)

EMS/Trauma Systems Funding

Appropriation: FY 24 – 111 M

0001 – General Revenue: $7,549,524

0512 – Bureau of Emergency Management Account: FY 24 - $3,1 M

5007 – Commission on State Emer Comm Account: FY24 - 1.75 M

5108 – EMS, Trauma Facilities/Care System: FY24 - $3.5 M

5111 – Trauma Facility and EMS Account: FY24 - $96M

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RAC EMS Allotment

- Calendar Year 2022
- Validate EMS eligibility – RAC participation
- EMS Runs entered into registry
- Trauma facility submissions

Extraordinary Emergency Funds (EEFs):

- FY24: $1M was Allocated plus $214,000 Rolled over from FY23
  - 5 Applications received
  - 5 Awarded
  - 1 Application is under Review
  - Total Expended: $990,114.17
  - Funds available: $223,885.83

Requested items:

- Repair Ambulance And Replace Ambulance
- Cardiac Monitor / Defibrillator
- New Ambulance
- Ambulance Radio

UCC Funding Application

- Application opened on May 16th, 2024
- The CY 2022 Data is used for calculations for FY2025 allocation
- 291 Hospital submitted applications
- $2,988,230,798 requested uncompensated funds
- $95,543,482 Allocated for Hospital
- $82,189,313 Moved to HHSC
- $179,621,746 from SDA Trauma Add-On
- $8,245,879 for Facilities that Do Not Meet SDA Criteria

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EMS System Update

Joe Schmider
Texas State EMS Director

Senate Bill 8 Update

- Over 2,811 Education Scholarships processed or in process
- EMS Scholarships in each RAC
- $**15,055,200**. Million in scholarships processed
- **8,052** new certified EMS personnel since 10/1/22
- 2019 – 68,461 certified personnel; today – **76,526**

(As of 5-1-2024)

Opening Up TAC 157.11

- To add SB 2133 language Dialysis Transports
- Edits of the rule into "plan language" format.
- Correct insurance amounts for local governments to $100,000/$300,000
- 25 triage tags or participate in the RAC triage plan

OASH | Office of Climate Change and Health Equity

Heat-Related EMS Activation Surveillance Dashboard

NHTSA National Highway Traffic Safety Administration | NEMSIS Better Data. Better Care.

May 18, 2024 – May 31, 2024

Dashboard Updated On: June 3, 2024 (Updated Weekly)

Select Time Period: Previous 14 Days | **Select U.S. Climate Region:** (All) | **Select Level of Geographic Detail:** Counties | **Select to View Specific State/District/Territ...:** (All) | **Select Heat-Related Measure:** Rate of Heat-Related EMS Activations

National Statistics

Average EMS Time to Patient

13.1 minutes — % Change -5.0%

Number of Heat-Related EMS Activations

1,919 — % Change +48.6%

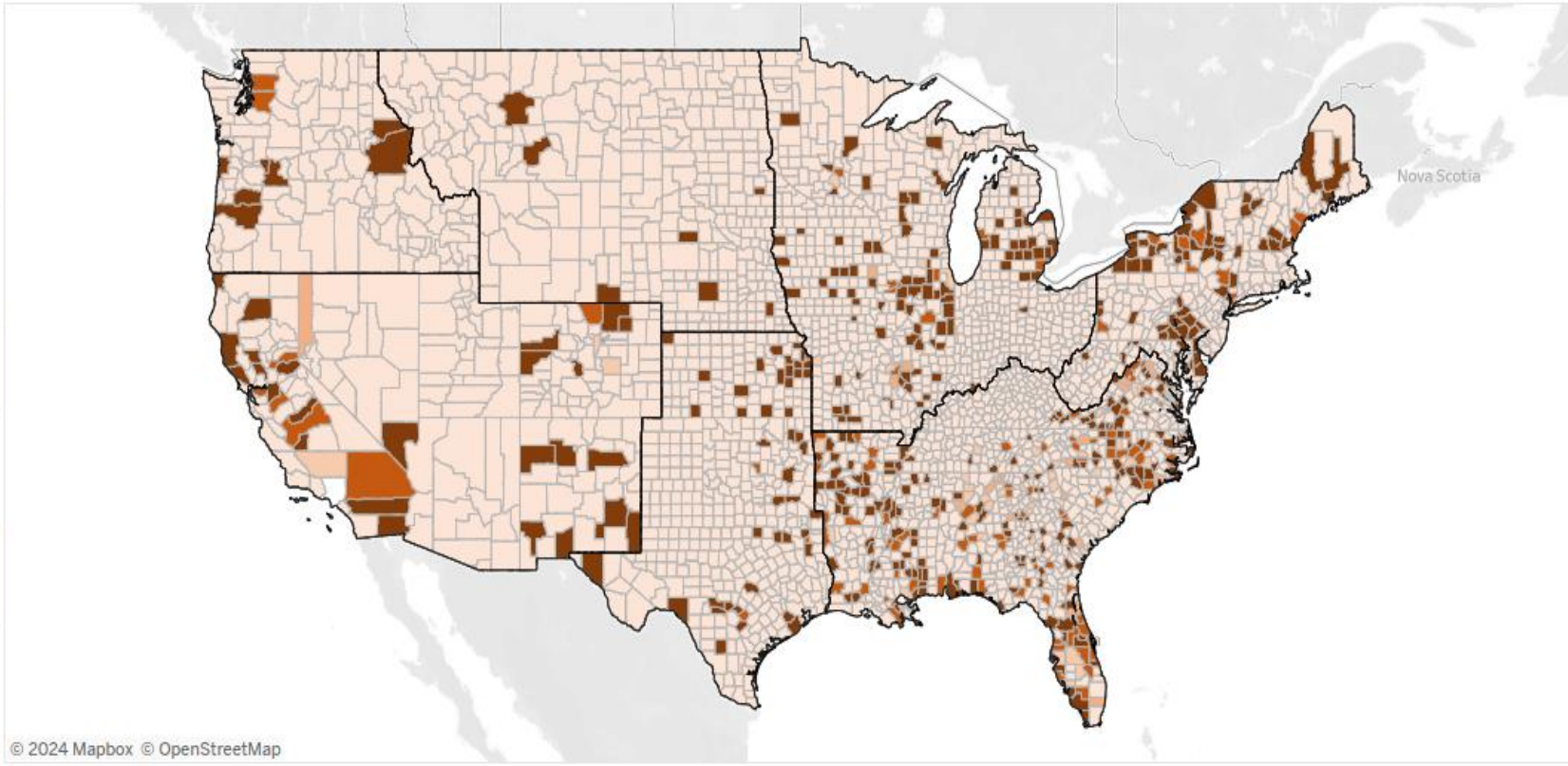
Rate of Heat-Related EMS Activations per 100K Population

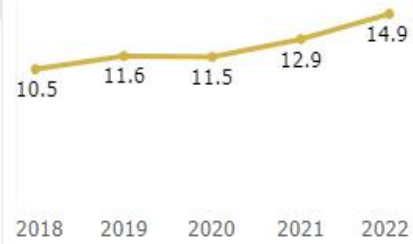
0.6 — % Change +284.4%

Number of Heat-Related Deaths Among EMS Activations

1.0 — % Change -66.7%

Patients Transported to a Medical Facility





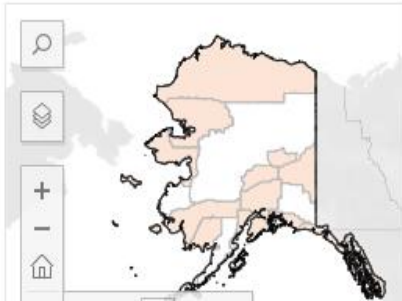
Top Jurisdictions
Rate of Heat-Related EMS Activations

District of Columbia
Arkansas
Florida
Mississippi
North Carolina
Delaware
Alabama
Kansas
Virginia
Georgia

Top Counties
Rate of Heat-Related EMS Activations

Highland County, Virginia
Perry County, Mississippi
Cheyenne County, Kansas
Ness County, Kansas
Hamlin County, South Dakota
Hudspeth County, Texas
Desha County, Arkansas
Meade County, Kansas

No/Limited Data Available
Zero or Much Lower Than Average
Lower than Average
Near Regional Average
Higher than Average
Much Higher than Average



HEAT related responses

- NEMSIS Dashboard updated weekly: https://nemsis.org/
- STRAC and other RACs have plans developed, here is STRAC link: https://www.strac.org/?s=heat
- NASEMSO Guidelines: https://nasemso.org/wp-content/uploads/National-Model-EMS-Clinical-Guidelines_2022.pdf

OOH-DNR Education Opportunity

- **Go to the state website at:** www.dshs.texas.gov/dshs-ems-trauma-systems

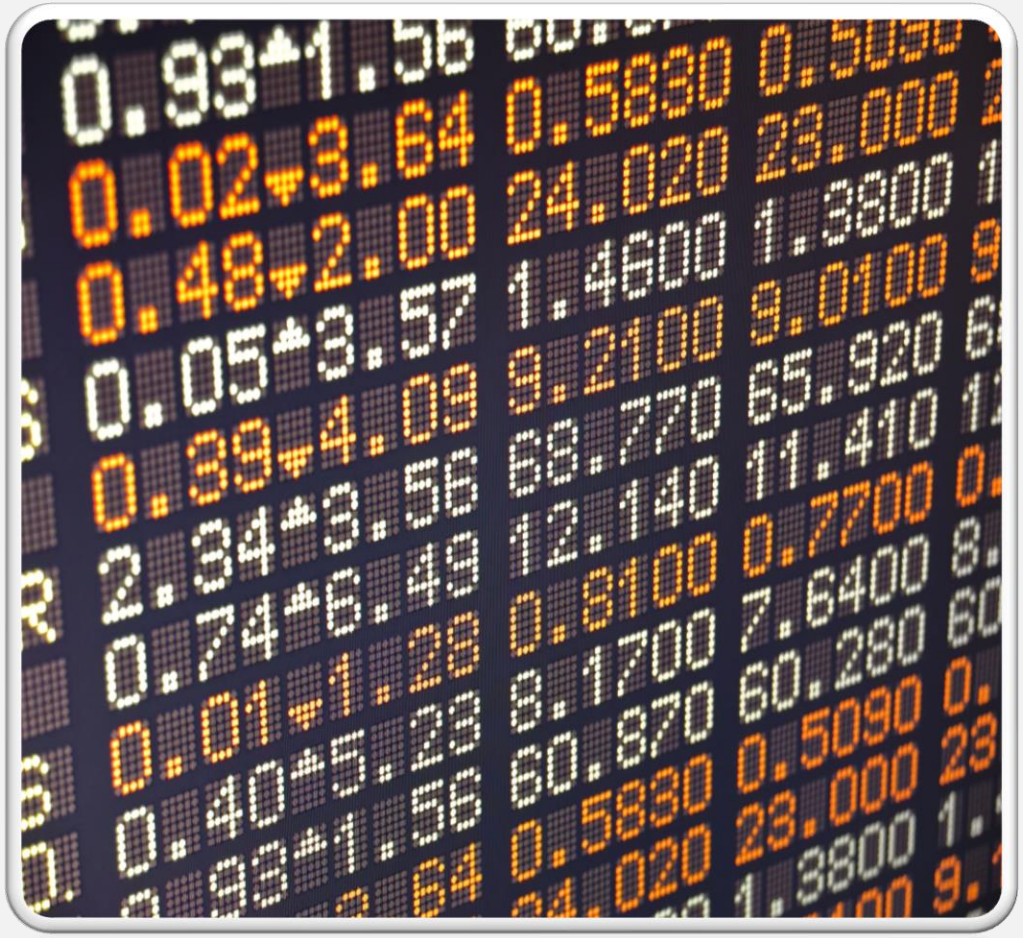
Page down on left tabs to:

- Out of Hospital Do Not Resuscitate Program | Texas DSHS

NEMSIS: V5 switch over
PLEASE complete the Process!

For more information on NEMSIS and national dashboards go to

hhtps://NEMSIS.org.



The 2023 EMS Data set will be closed August 1, 2024.

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Questions for EMS/Trauma Systems?

Thank You

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

Jia Benno, MPH
Office of Injury Prevention Manager

Emergency Medical Services (EMS) Non-Fatal Drug Poisoning Data 2019-2022 Texas Overdose Data to Action (TODA)

June 14, 2024

Jia Benno, MPH
Injury Prevention Unit Director

Emergency Medical Services and Trauma Registries

- The Emergency Medical Services and Trauma Registries (EMSTR) collects data from EMS providers, hospitals, justices of the peace, medical examiners, and rehabilitation facilities.
- EMS providers and trauma facilities must report all runs and trauma events to EMSTR under Texas Administrative Code, Title 25, Chapter 103.
- 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 when there were less than 5 records to protect identifiable data, is noted with an asterisk (*).
- This presentation includes data from 2019-2022.

Inclusion Criteria – All Non-Fatal Drug Poisonings

All Non-Fatal drug poisoning criteria:

- Primary Symptom, Other Associated Symptom, Provider's Primary Impression, or Provider's Secondary Impressions variables include International Classification of Diseases Tenth Revision (ICD-10) codes associated with all types of:
  - Poisonings;
  - Opioids;
  - Cannabis;
  - Sedatives;
  - Stimulants;
  - Cocaine;
  - Hallucinogens;
  - Inhalants; or
  - Other psychoactive substances.
- Protocols used are:
  - General overdose / poisoning / toxic ingestion;
  - Medical beta-blocker poisoning / overdose;
  - Medical calcium channel blocker poisoning / overdose;
  - Medical opioid poisoning / overdose; or
  - Medical stimulant poisoning / overdose.

Note – fatal drug poisonings are excluded from this presentation.

Inclusion Criteria – Non-Fatal Opioid Drug Poisonings

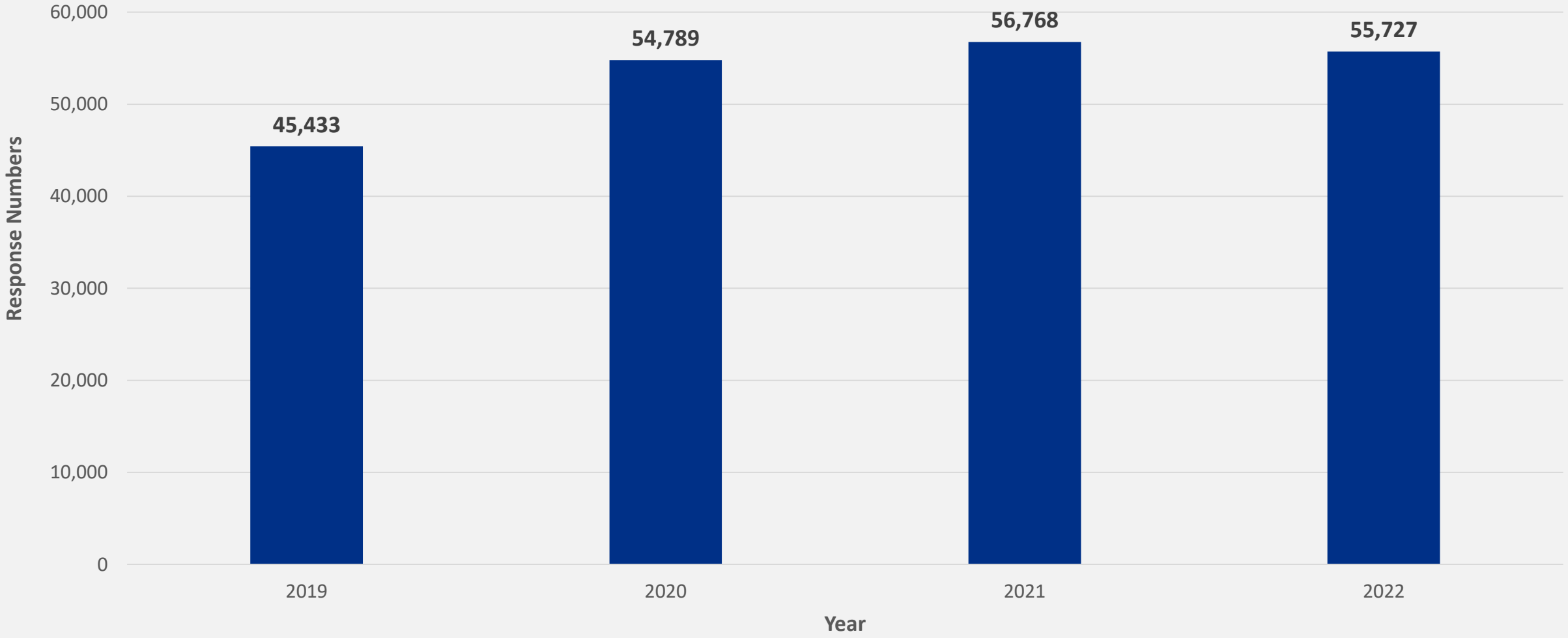
Non-fatal opioid drug poisoning criteria:

- Primary Symptom, Other Associated Symptom, Provider's Primary Impression, or Provider's Secondary Impressions variables include ICD 10 codes associated with poisonings by:
  - Opium;
  - Heroin;
  - Opioids;
  - Methadone;
  - Synthetic narcotics;
  - Unspecified narcotics; or
  - Other narcotics.
- Primary Symptom, Other Associated Symptom, Provider's Primary Impression, or Provider's Secondary Impressions variables include ICD 10 codes associated with:
  - Opioid abuse;
  - Opioid dependence; or
  - Opioid use.
- Protocols used are medical opioid poisoning / overdose.

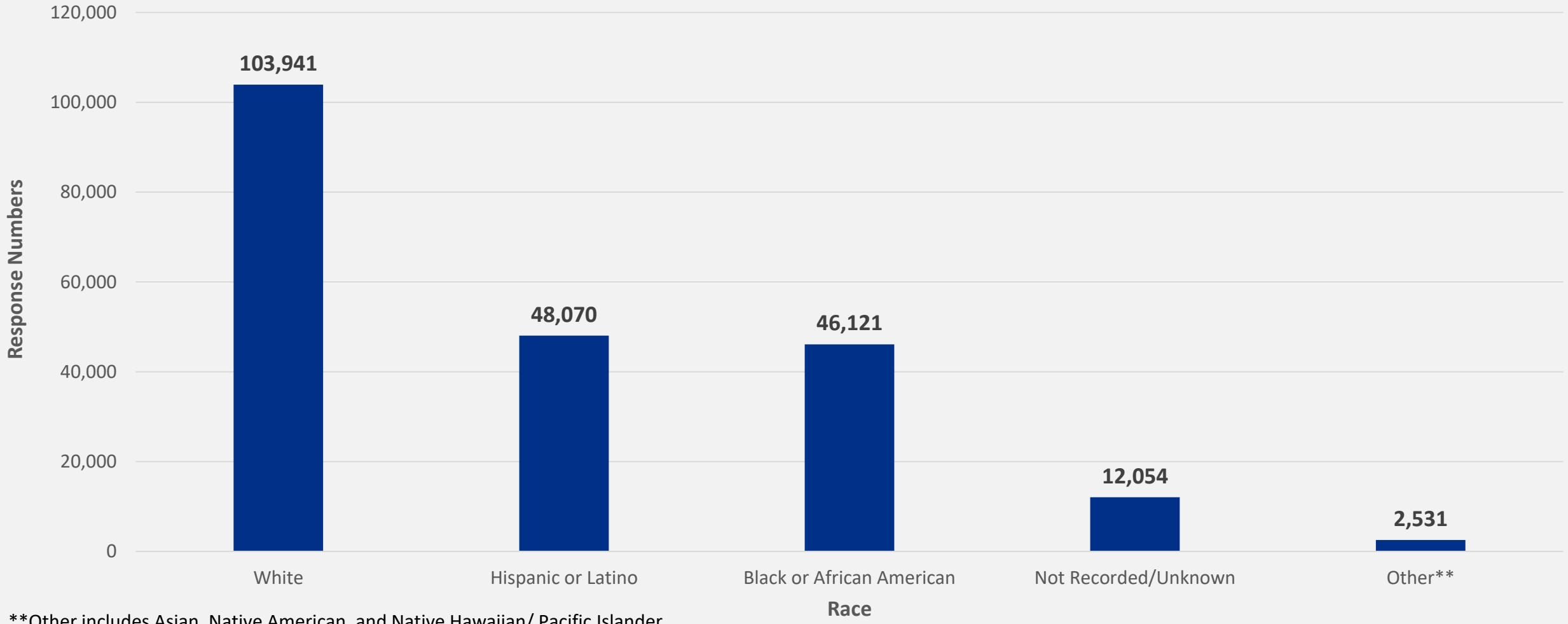
Note – fatal drug poisonings are excluded from this presentation.

2019-2022
All Non-Fatal Drug Poisoning EMS Data

All Non-Fatal Drug Poisoning EMS Responses by Year

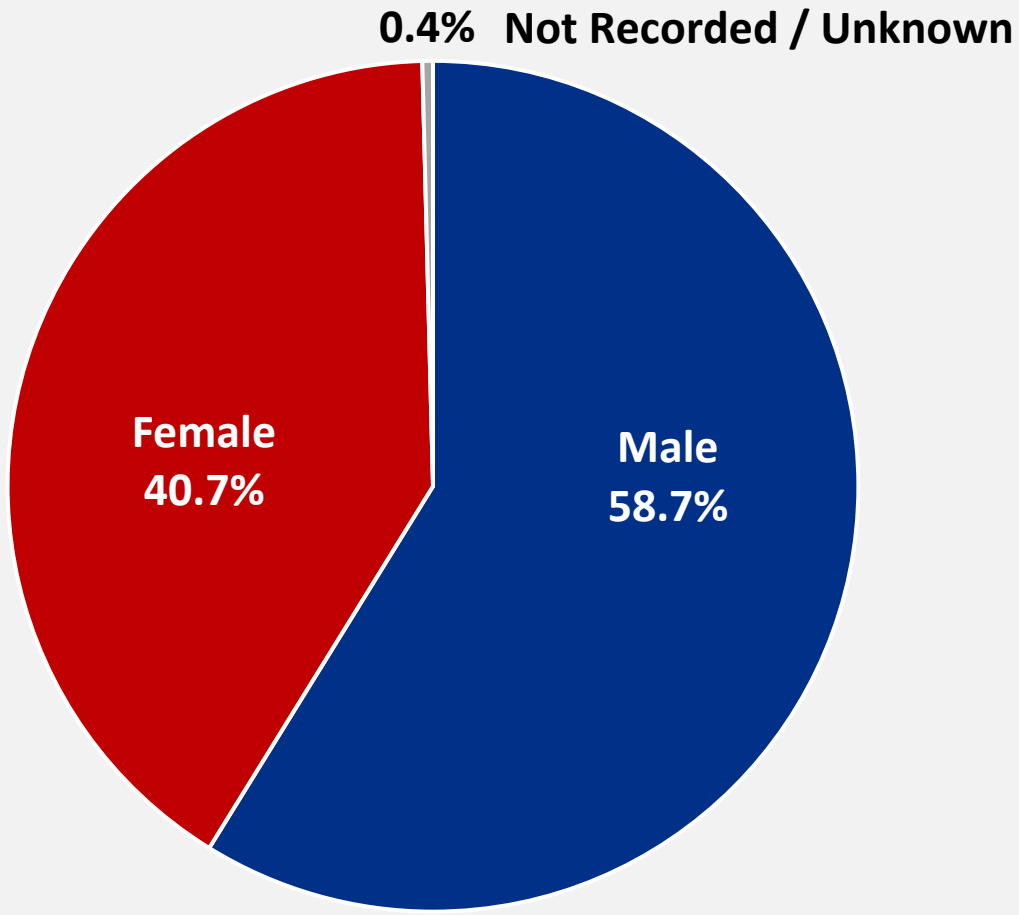


All Non-Fatal Drug Poisoning EMS Responses by Race

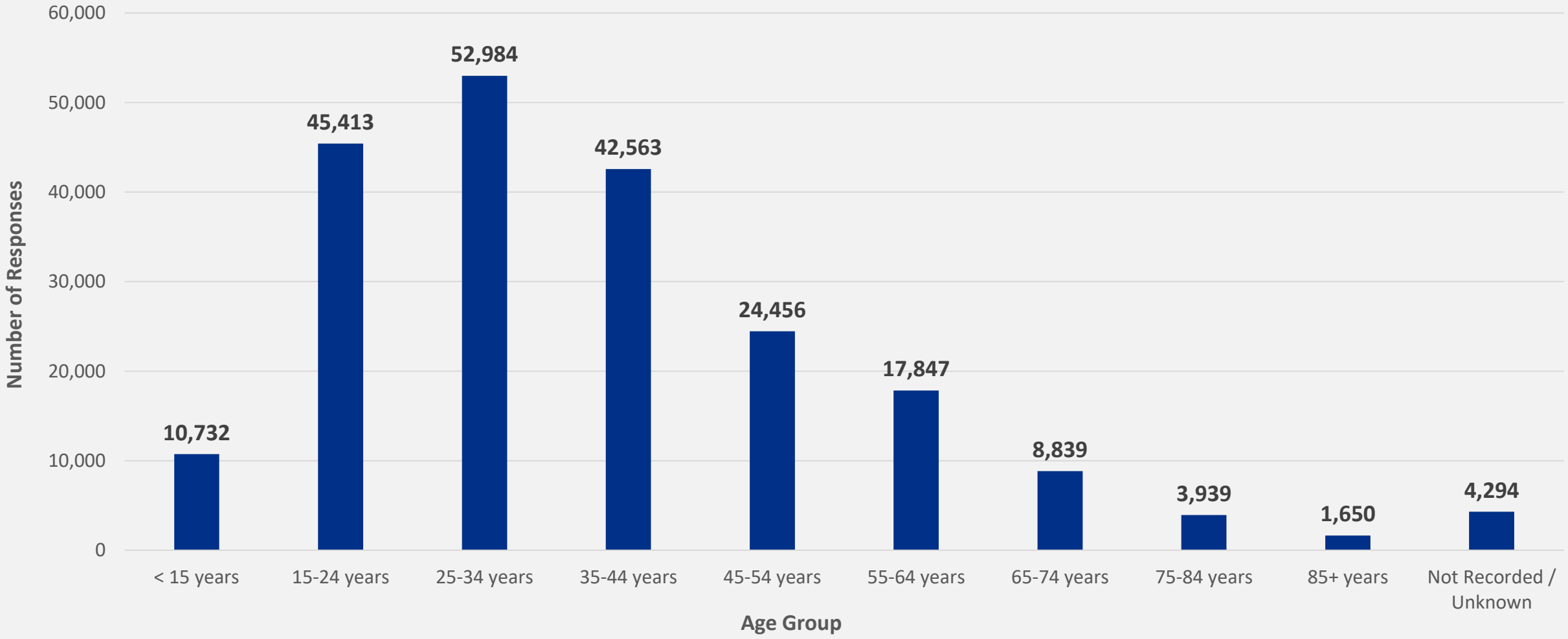


**Other includes Asian, Native American, and Native Hawaiian/ Pacific Islander.

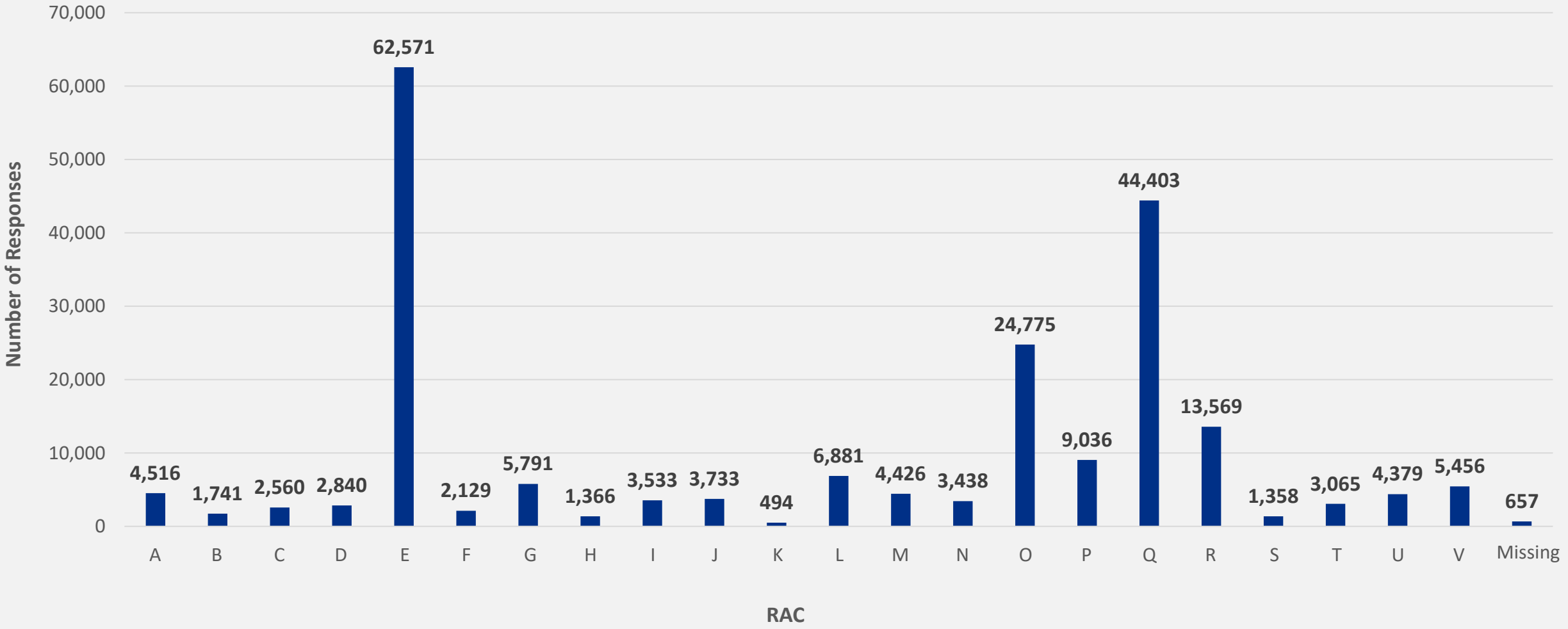
All Non-Fatal Drug Poisoning EMS Responses by Sex



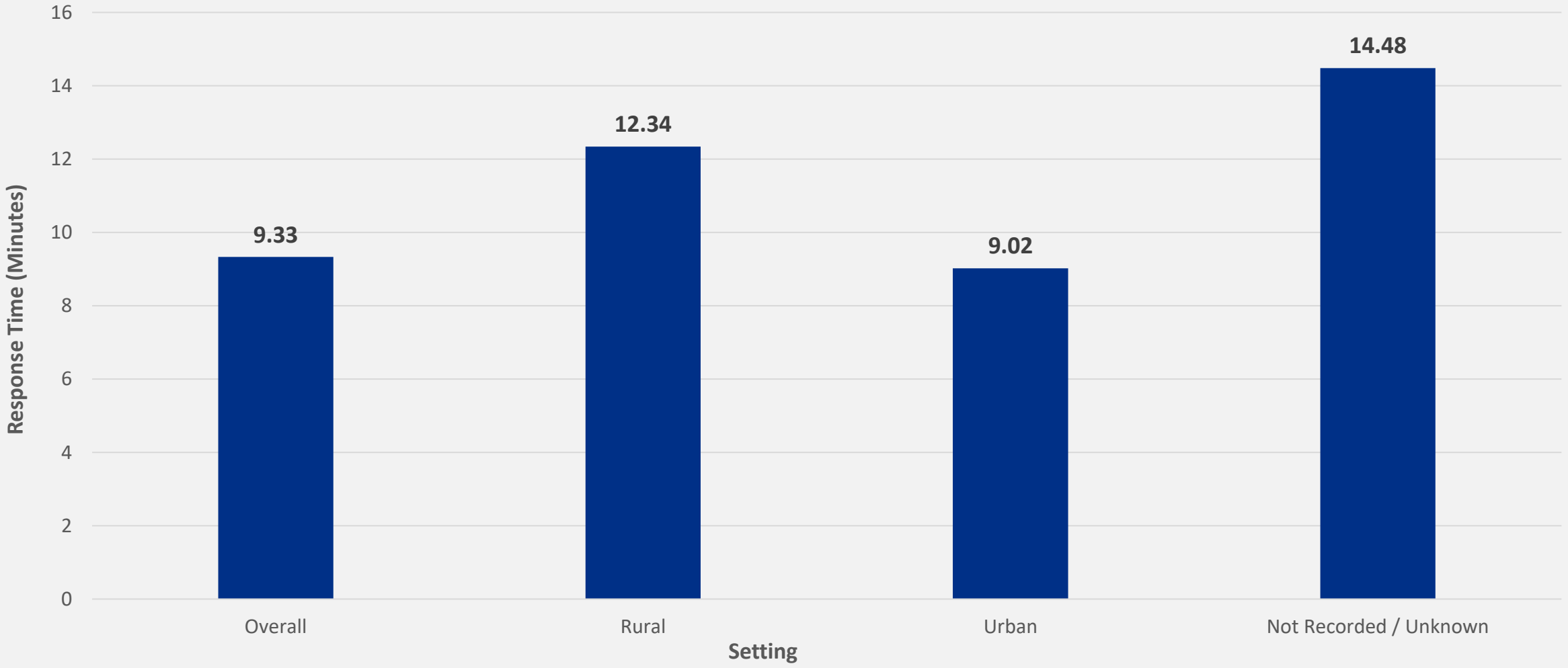
All Non-Fatal Drug Poisoning EMS Responses by Age



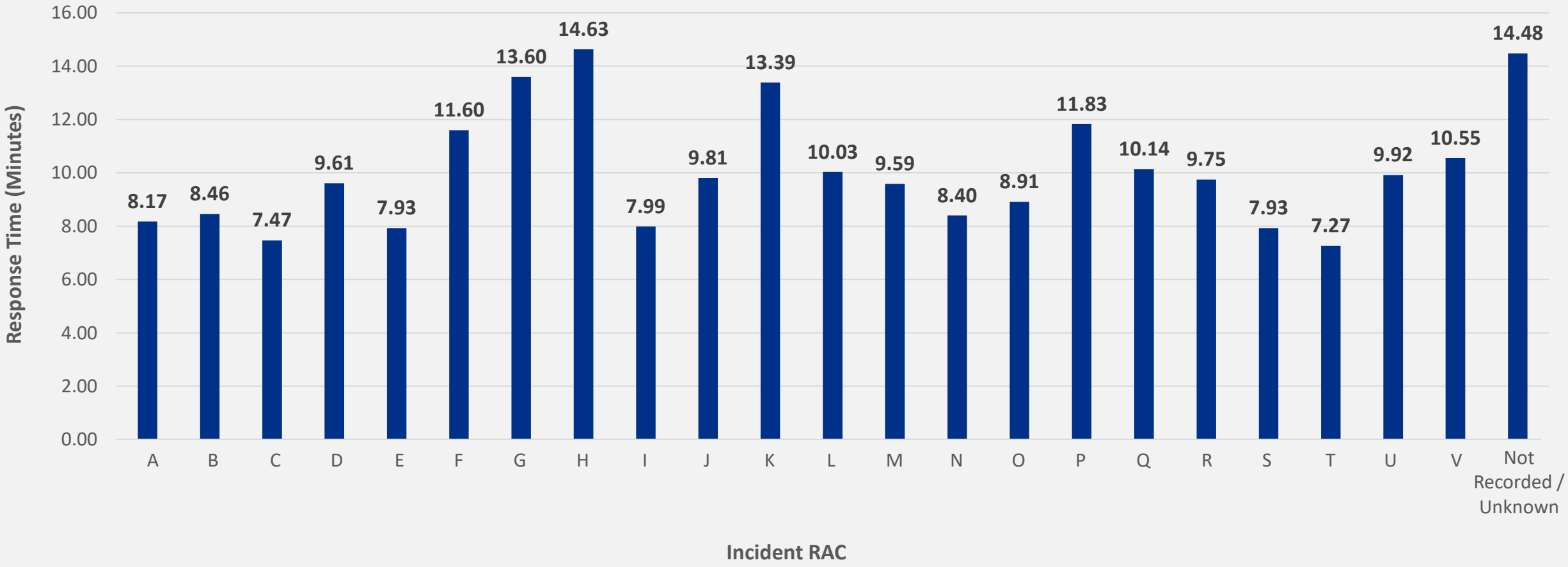
All Non-Fatal Drug Poisoning EMS Responses by RAC



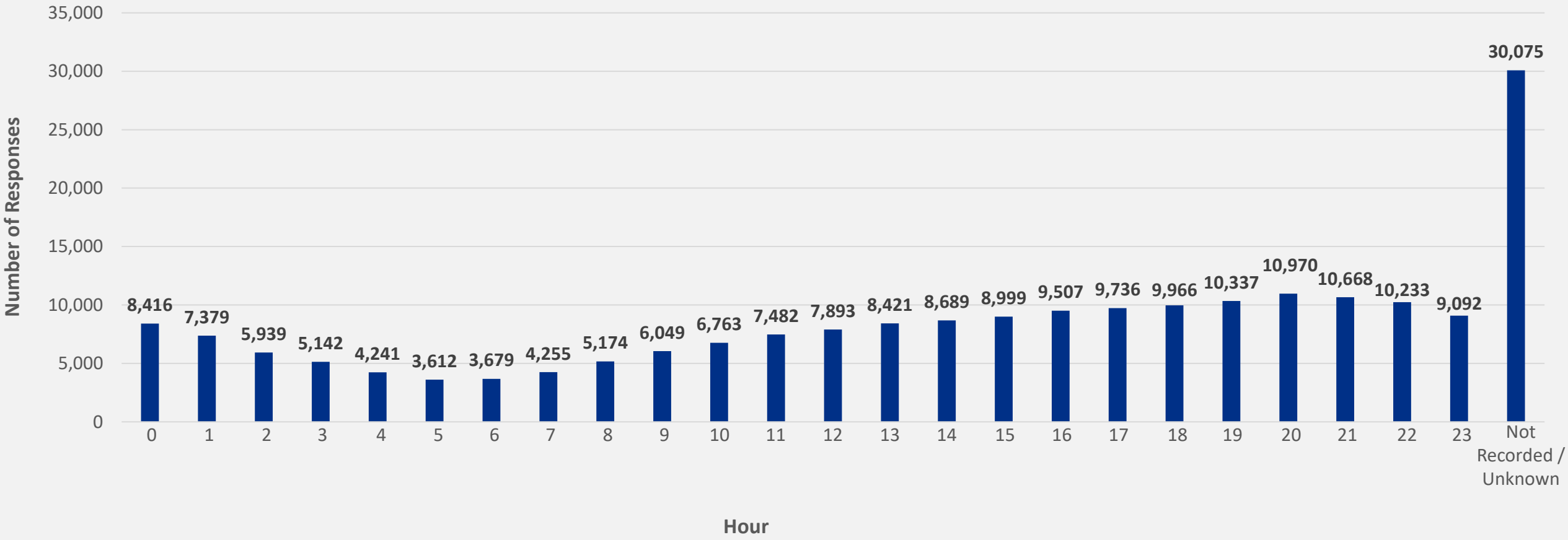
All Non-Fatal Drug Poisoning
EMS Average Response Time by Setting



All Non-Fatal Drug Poisoning
EMS Average Response Time by RAC

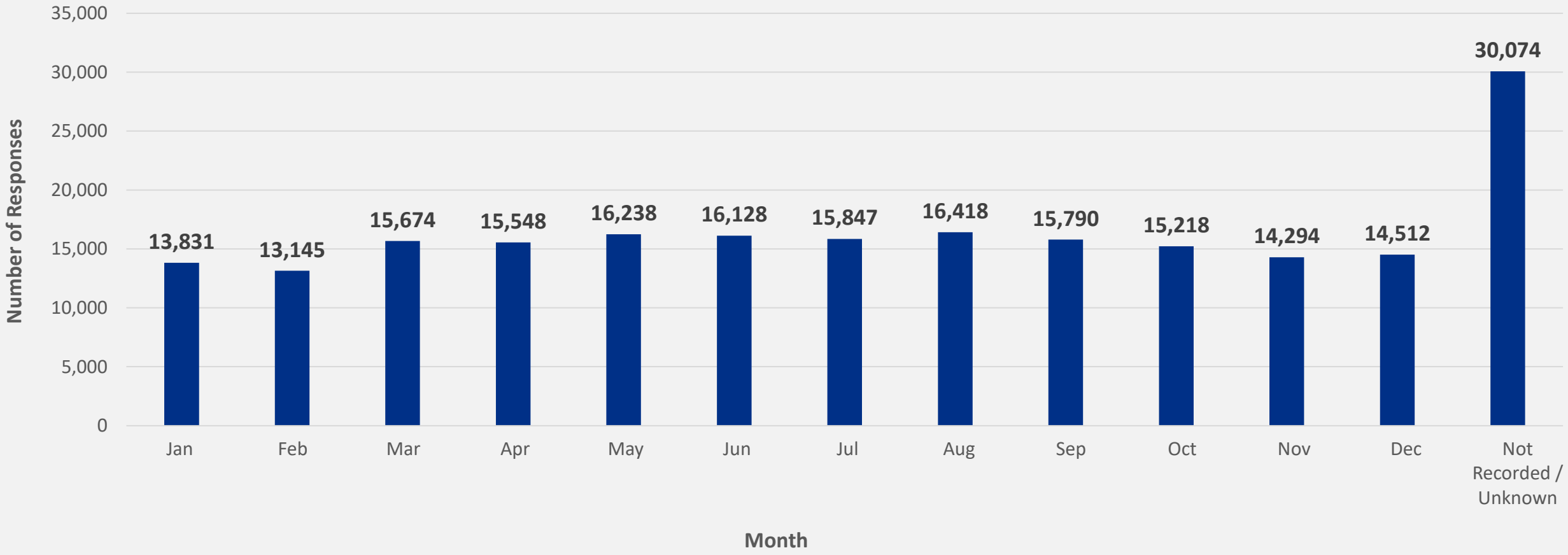


All Non-Fatal Drug Poisoning EMS Responses by Hour

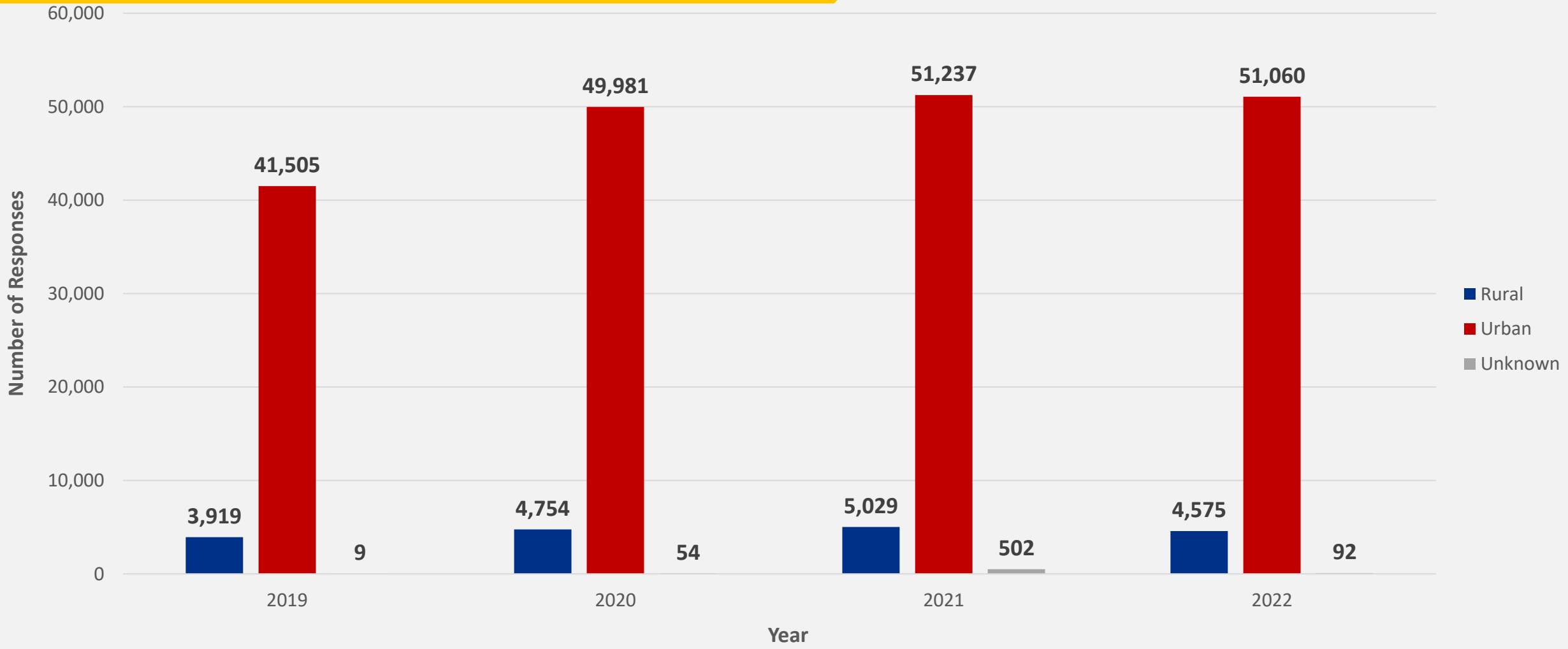


Based on a 24-hour timeline with “0” as midnight.

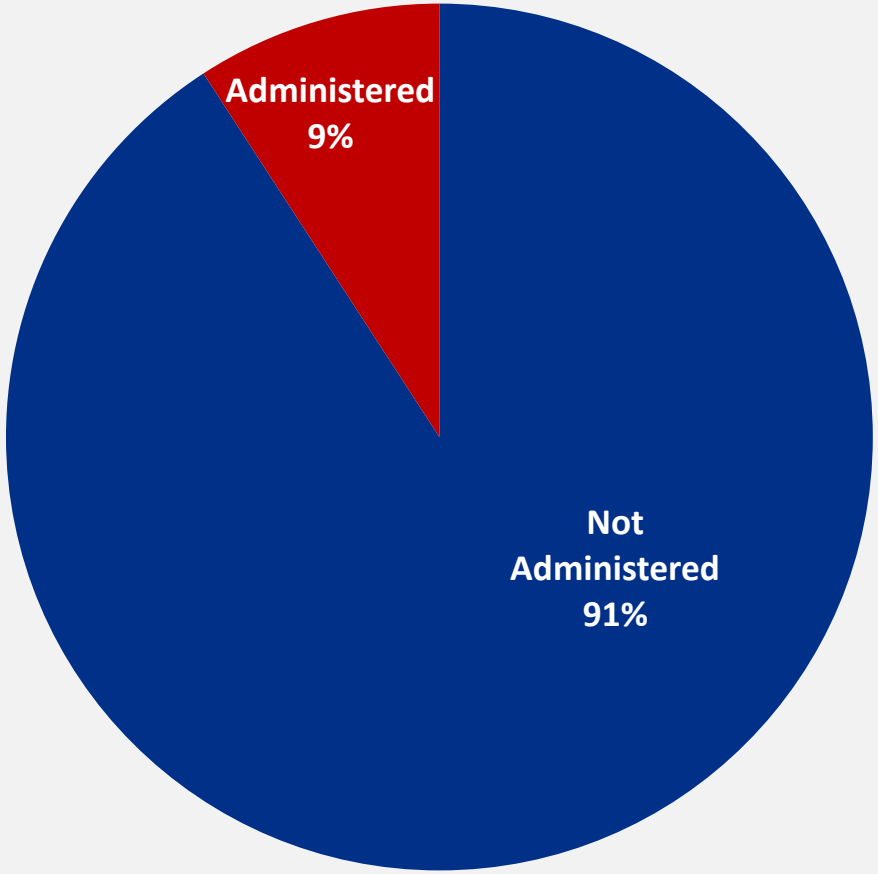
All Non-Fatal Drug Poisoning EMS Responses by Month



All Non-Fatal Drug Poisoning EMS Responses by Year and Setting



All Non-Fatal Drug Poisoning
EMS Responses by Narcan Administration

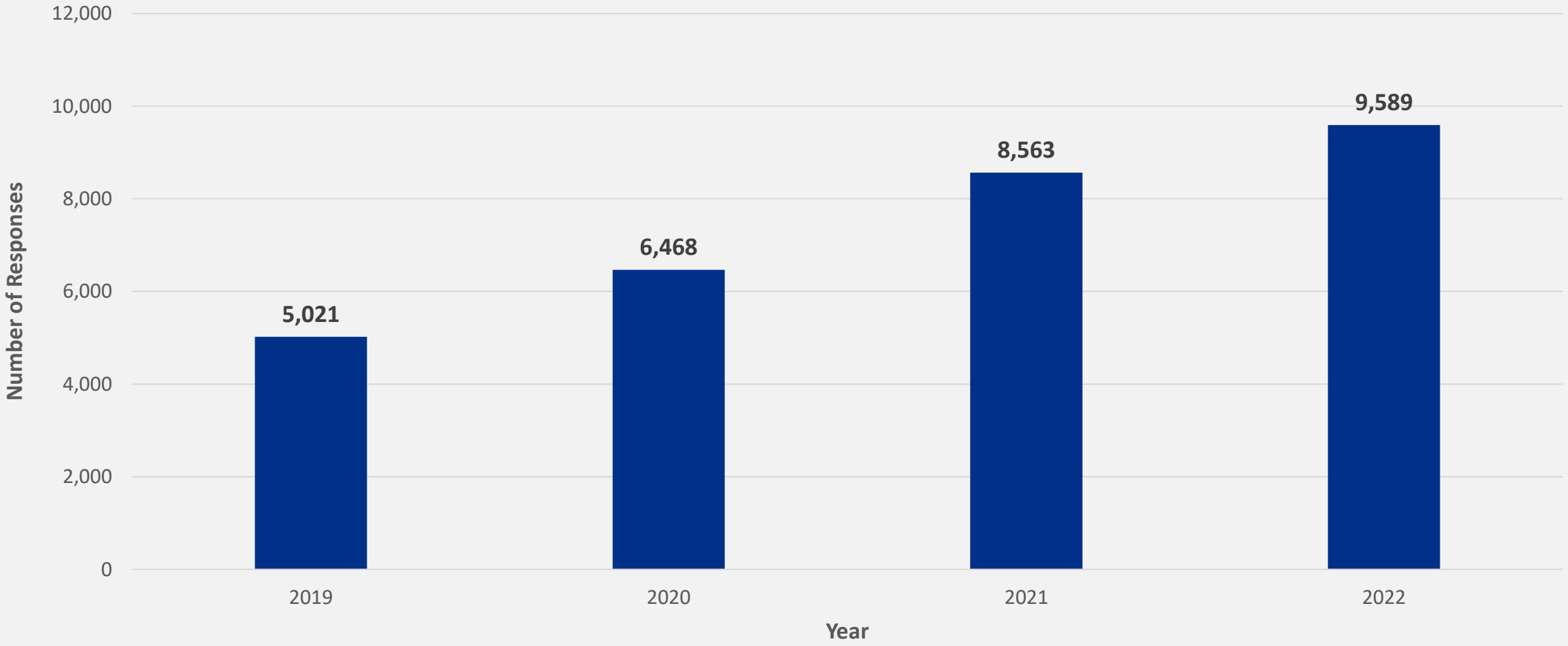


2019-2022
Non-Fatal Opioid Drug Poisoning EMS Data

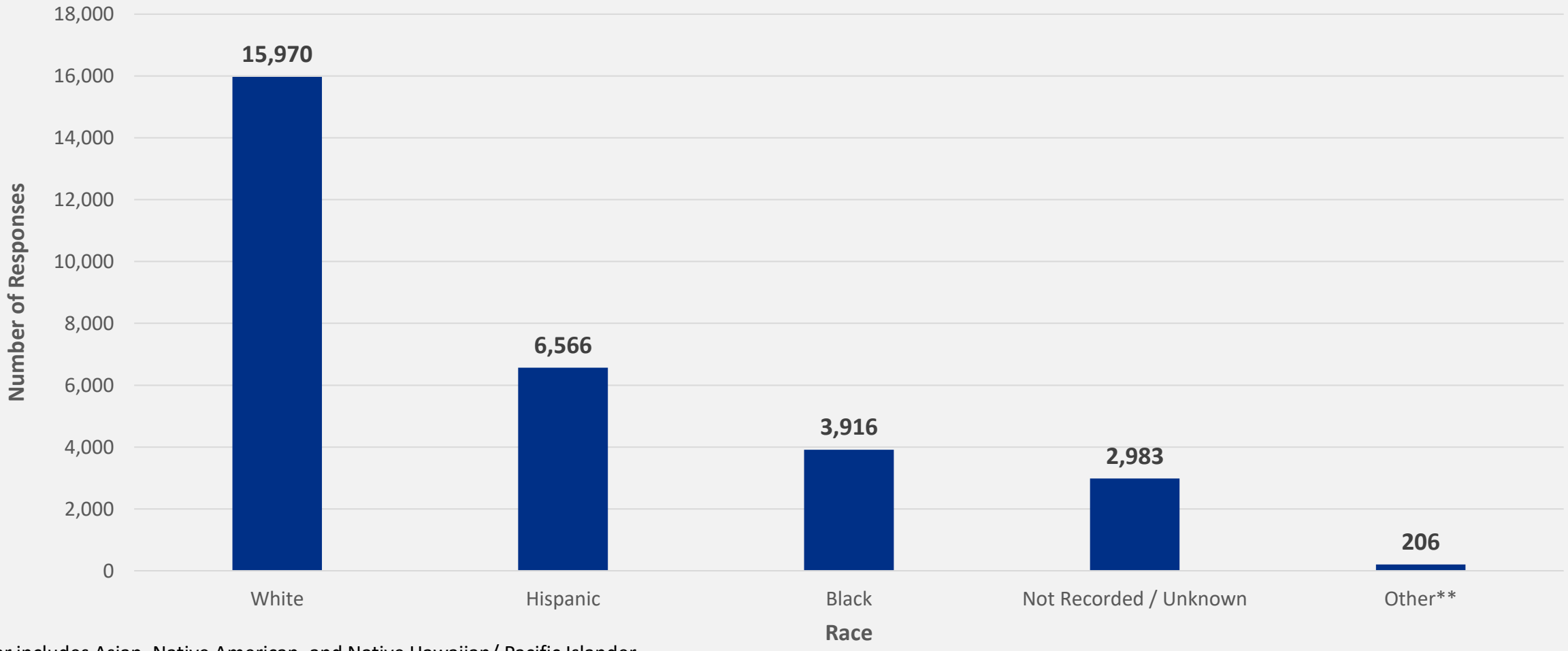
Opioid Percentage of All Non-Fatal Drug Poisoning 2019-2022

Year	Percent
2019	11.05%
2020	11.81%
2021	15.08%
2022	17.21%

Non-Fatal Opioid Drug Poisoning EMS Responses by Year

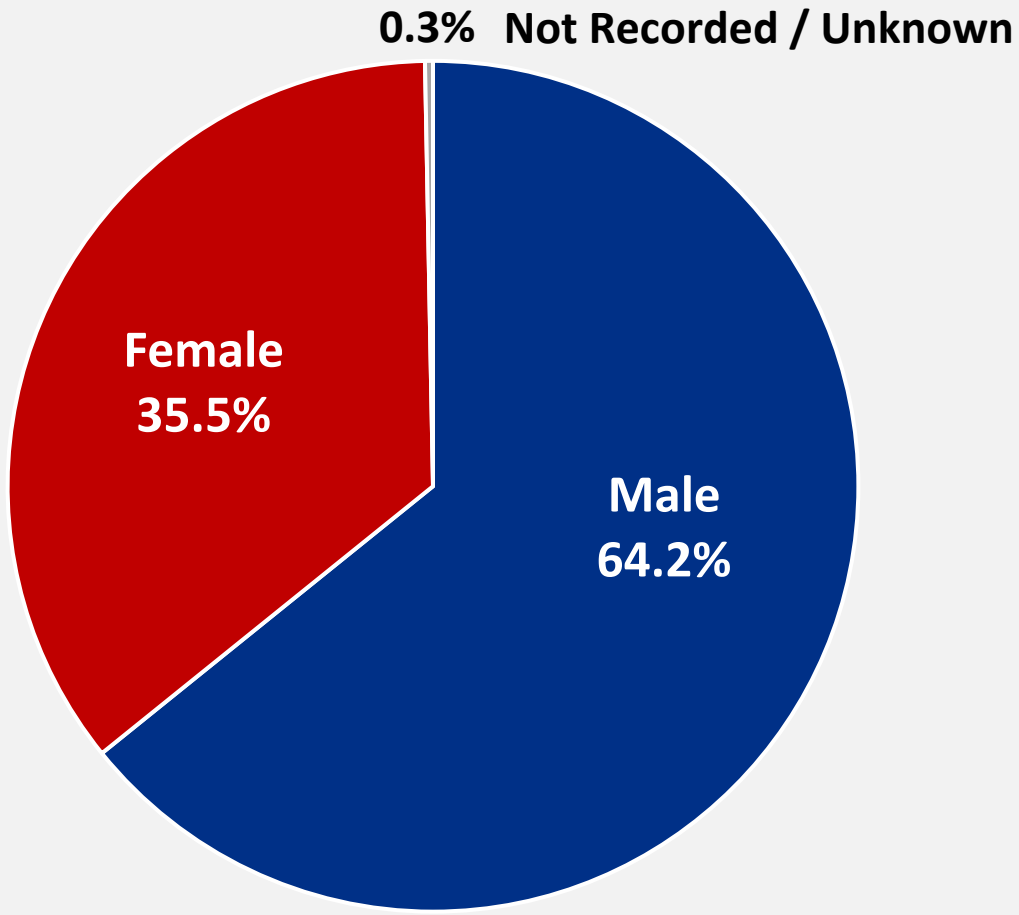


Non-Fatal Opioid Drug Poisoning EMS Responses by Race

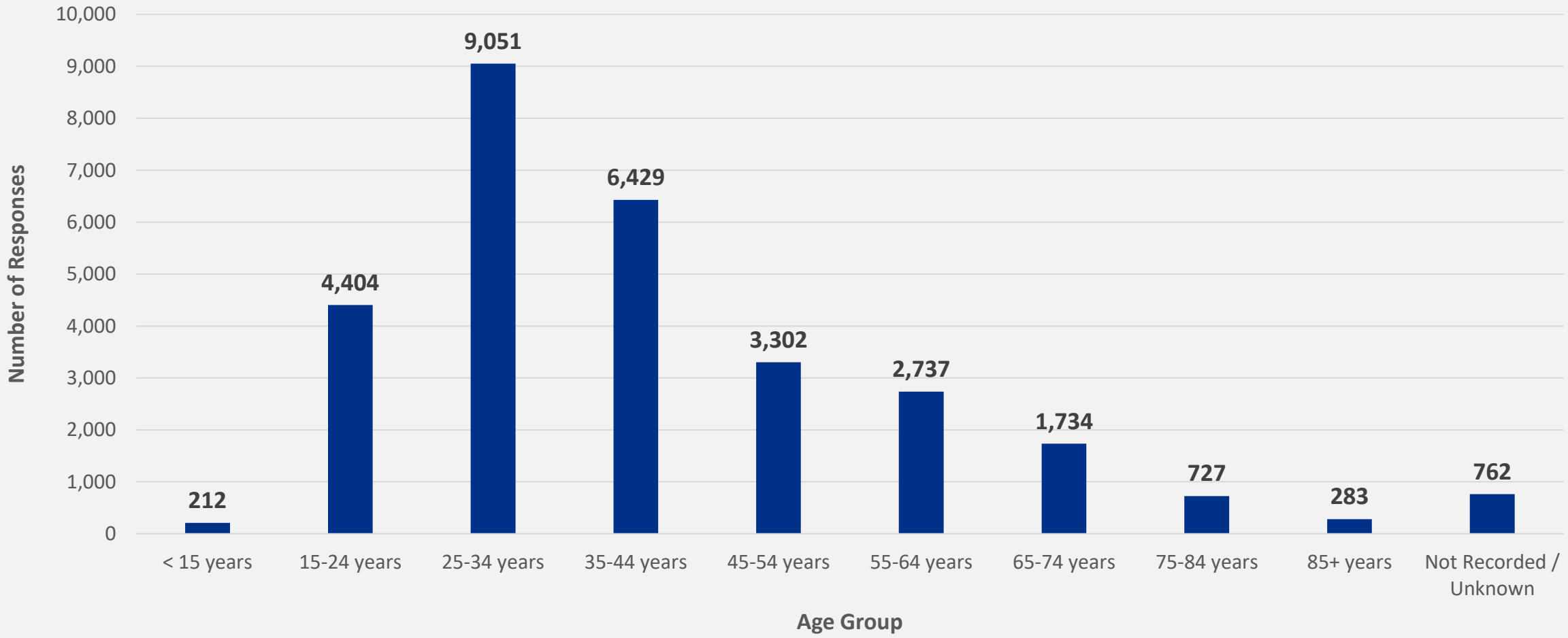


**Other includes Asian, Native American, and Native Hawaiian/ Pacific Islander.

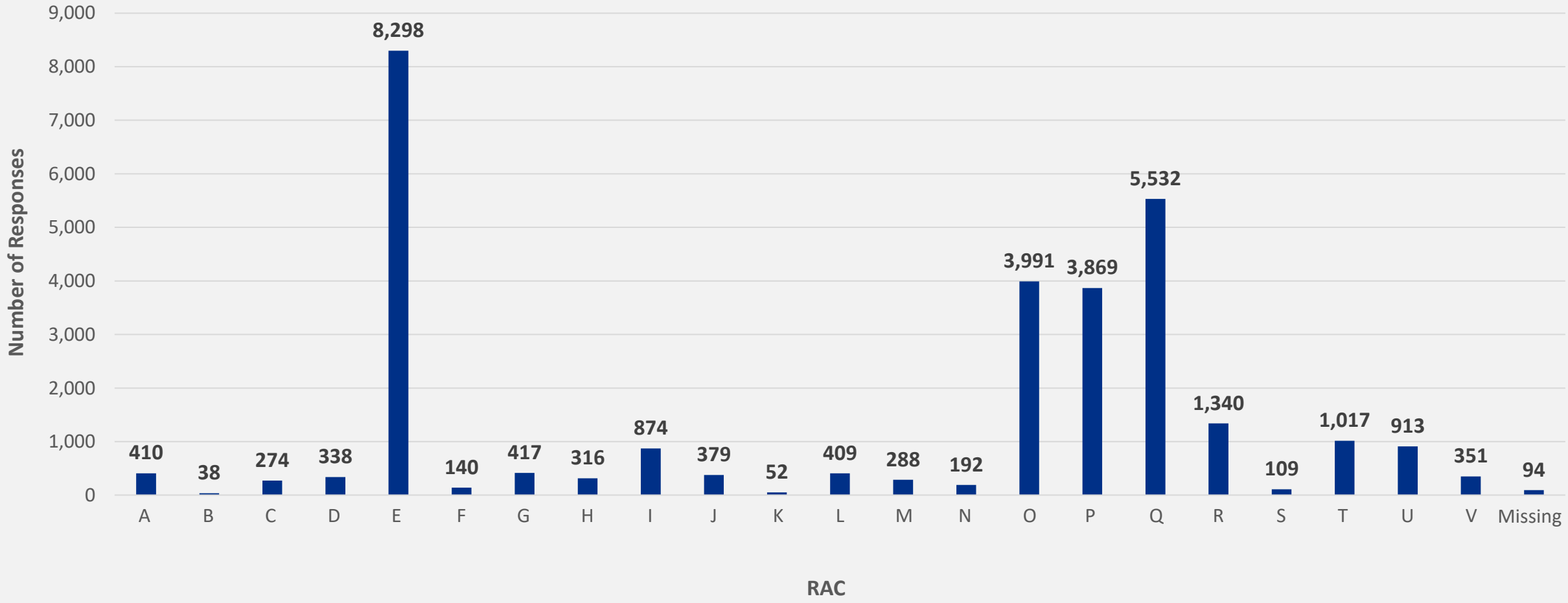
Non-Fatal Opioid Drug Poisoning
EMS Responses by Sex



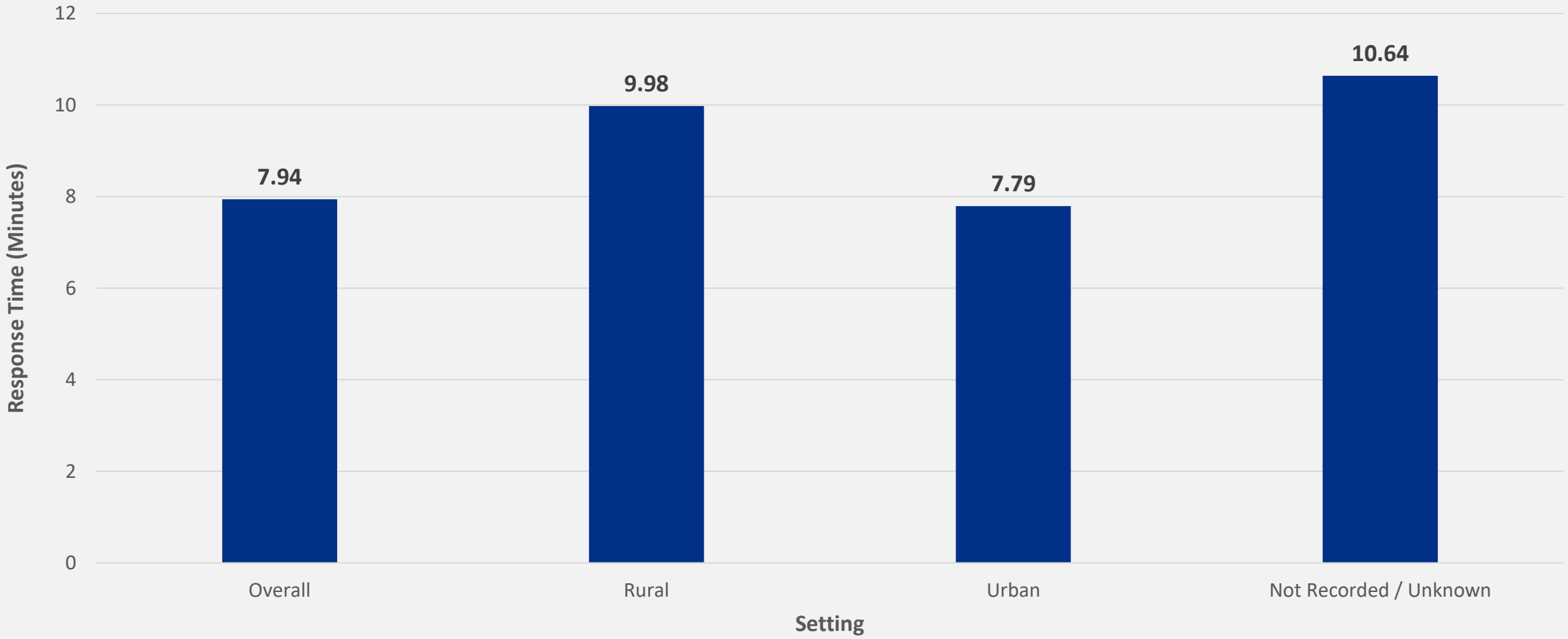
Non-Fatal Opioid Drug Poisoning EMS Responses by Age



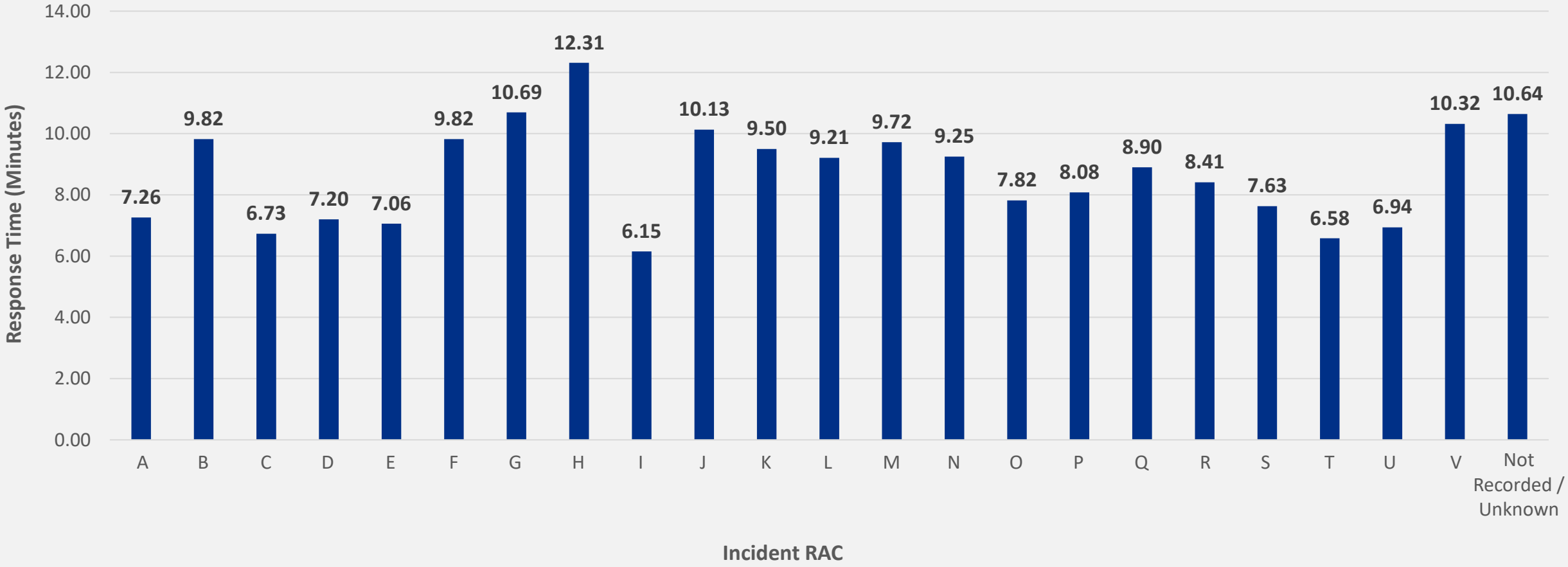
Non-Fatal Opioid Drug Poisoning
EMS Responses by Regional Advisory Council (RAC)



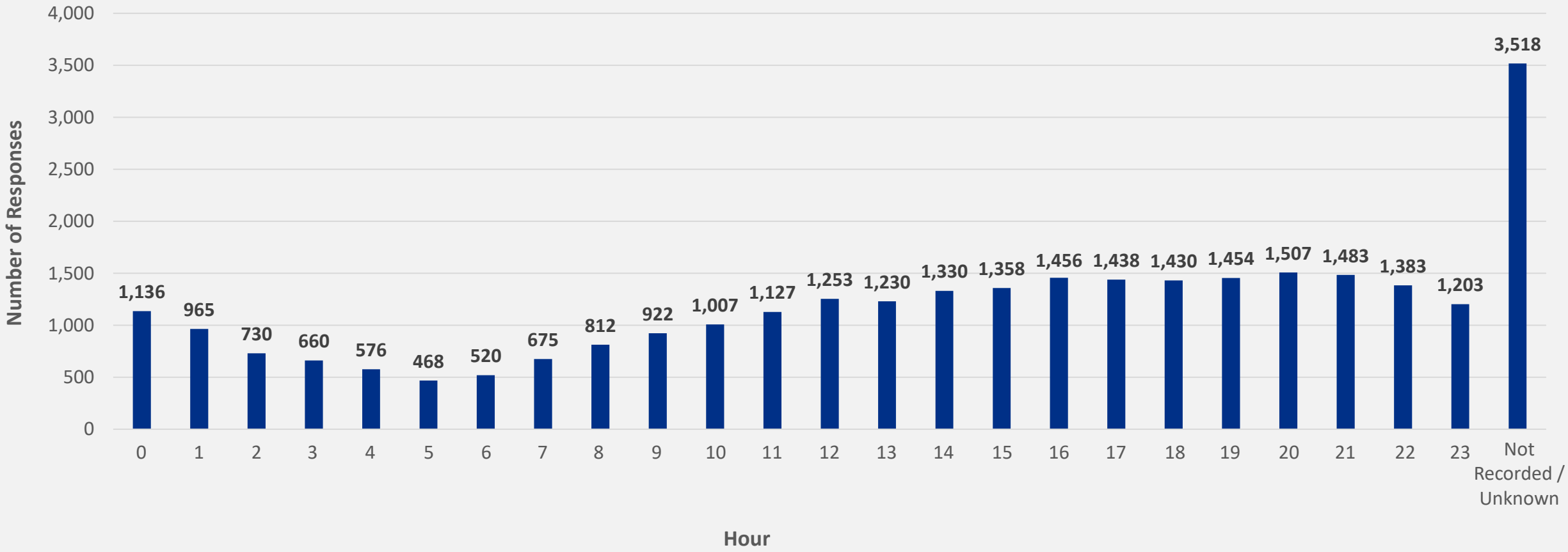
Non-Fatal Opioid Drug Poisoning
EMS Average Response Time by Setting



Non-Fatal Opioid Drug Poisoning
EMS Average Response Time by RAC

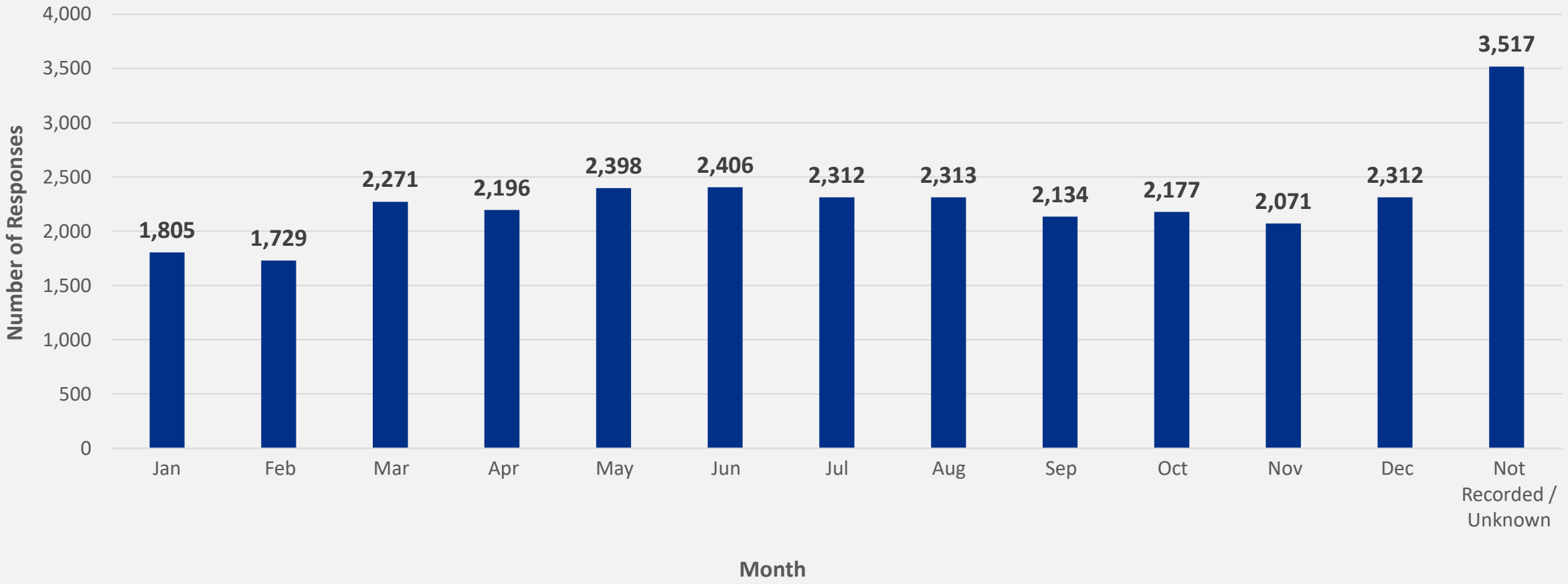


Non-Fatal Opioid Drug Poisoning EMS Responses by Hour

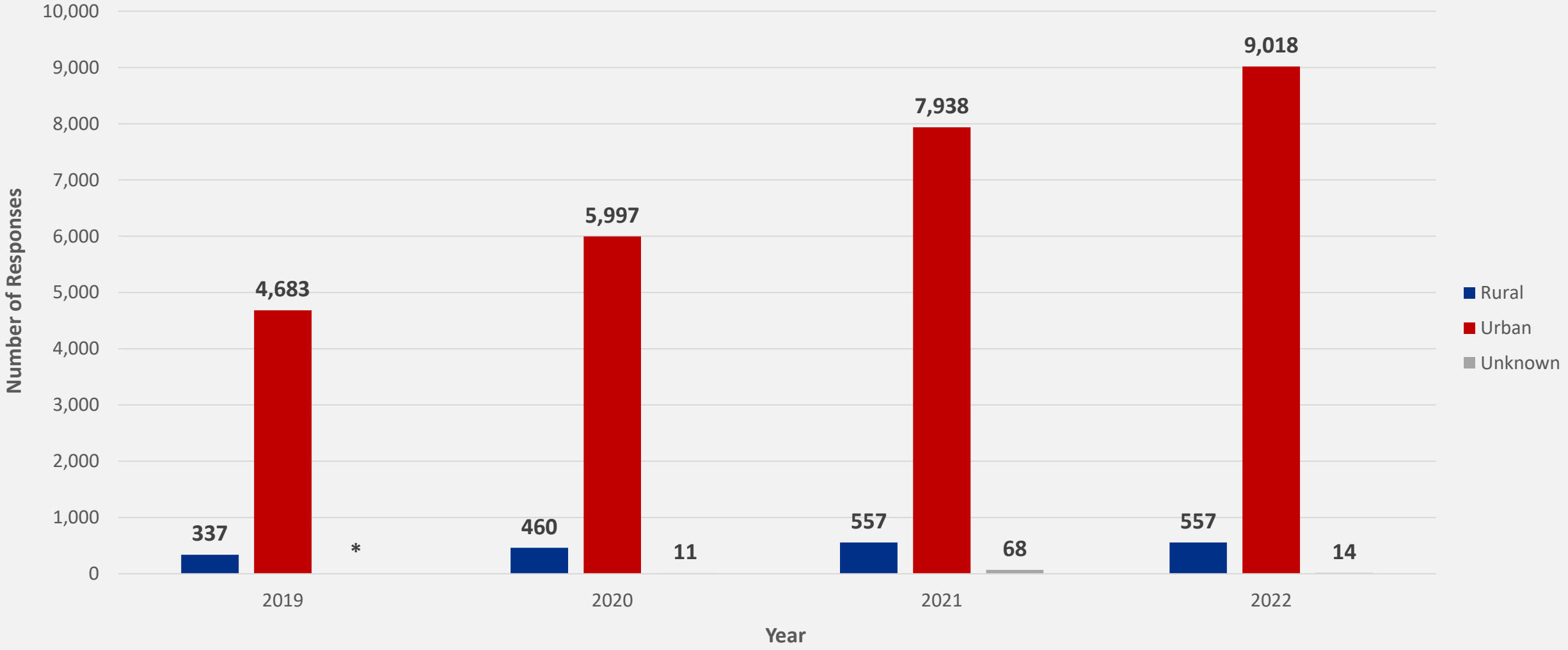


Based on a 24-hour timeline with “0” as midnight.

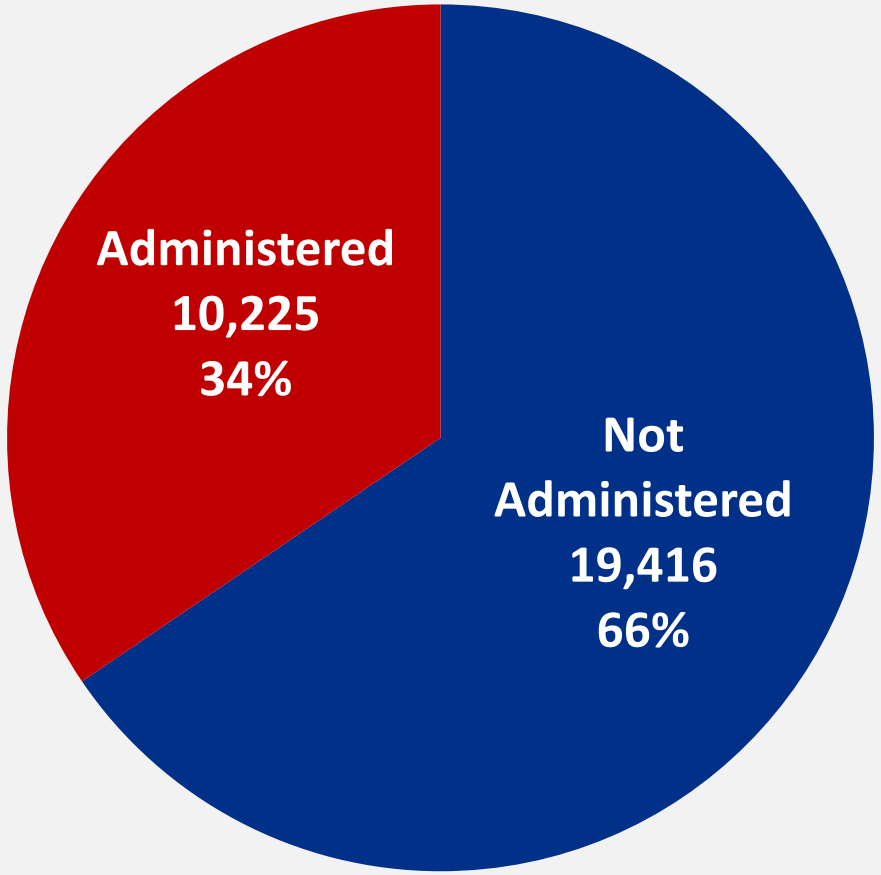
Non-Fatal Opioid Drug Poisoning EMS Responses by Month



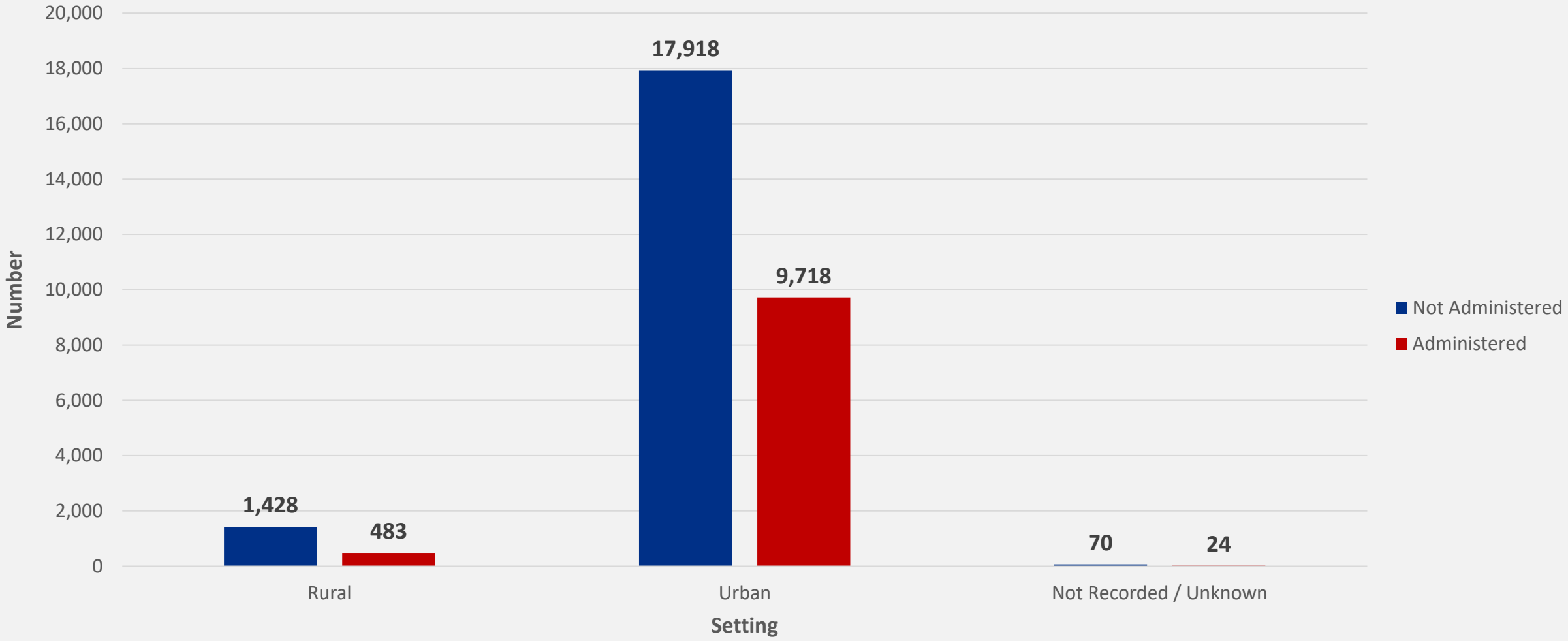
Non-Fatal Opioid Drug Poisoning EMS Responses by Year and Setting



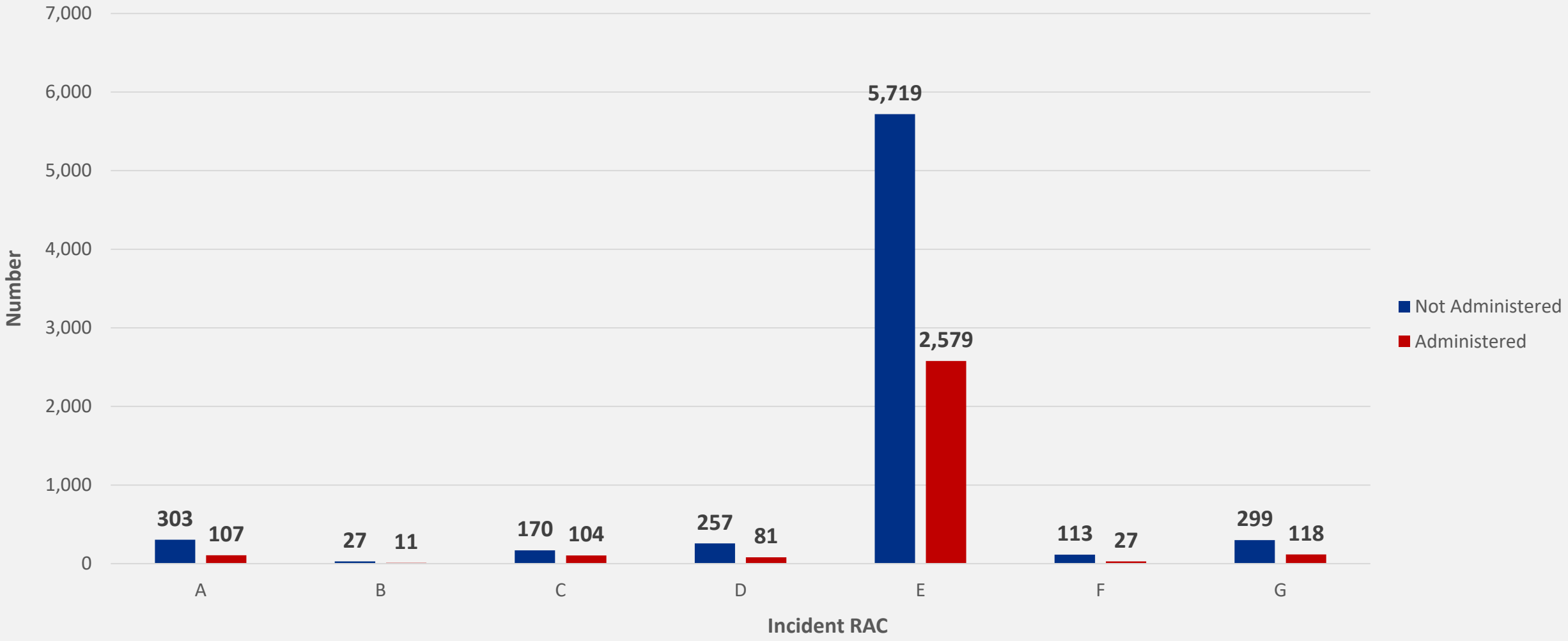
Non-Fatal Opioid Drug Poisoning
EMS Responses by Narcan Administration



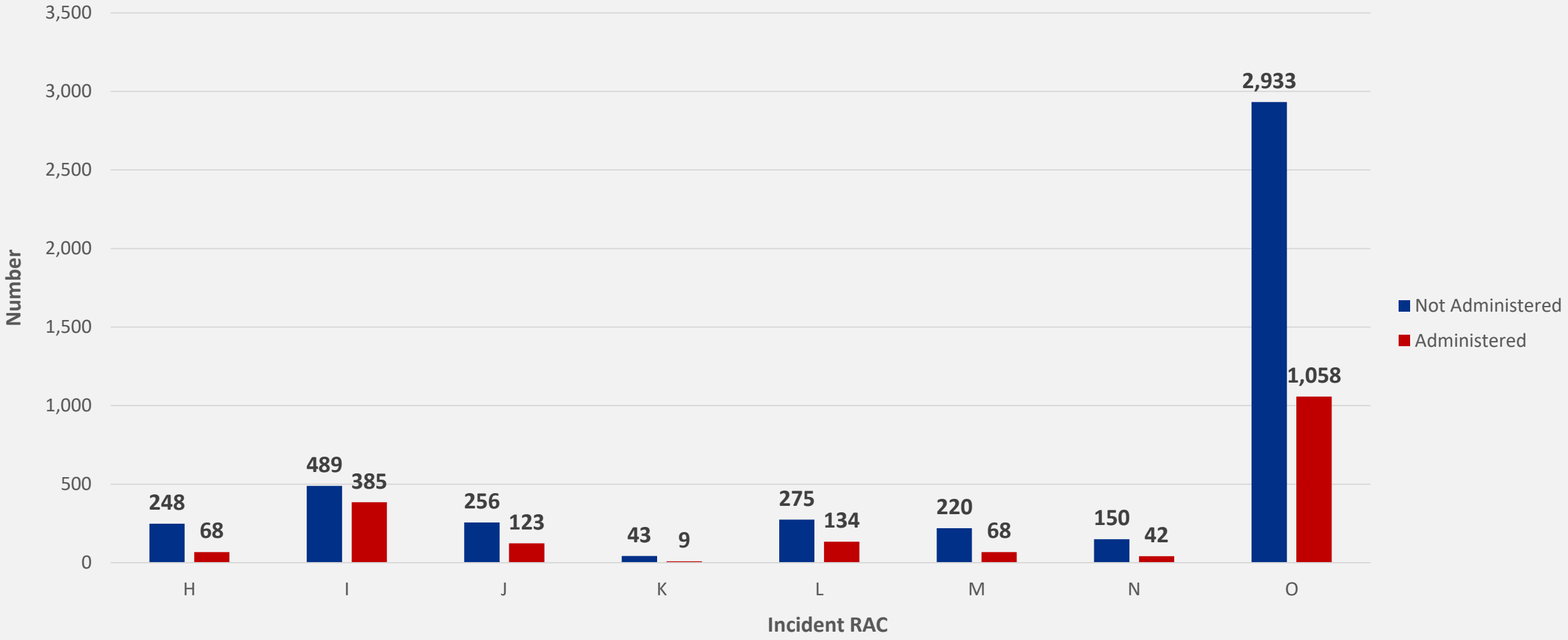
Non-Fatal Opioid Drug Poisoning
EMS Narcan Administration by Setting



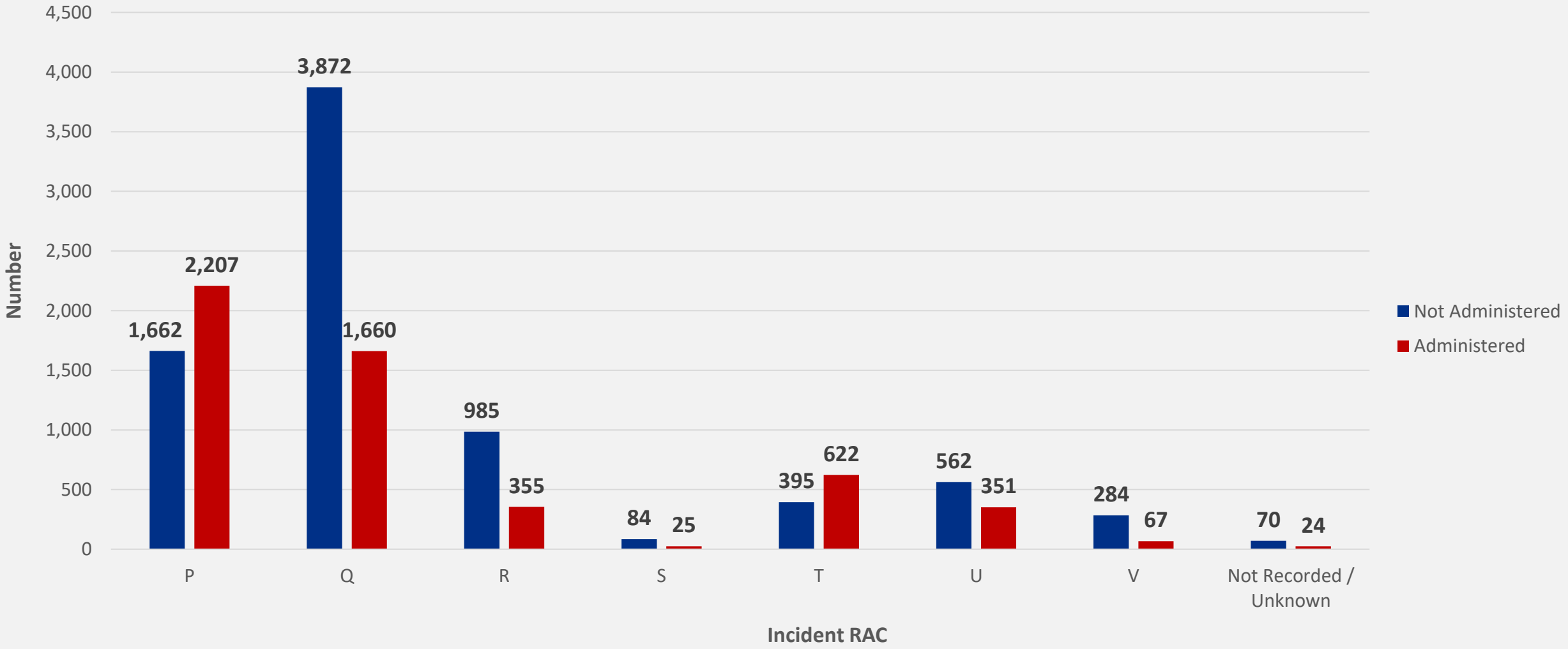
Non-Fatal Opioid Drug Poisoning
EMS Narcan Distribution by RACs A-G



Non-Fatal Opioid Drug Poisoning
EMS Narcan Distribution by RACs H-O



Non-Fatal Opioid Drug Poisoning
EMS Narcan Distribution by RACs P-V



Texas Overdose Data to Action (TODA)

TODA Overview

Grant Activity	Funding Information
Funding Agency	The Centers for Disease Control and Prevention (CDC)
Primary Grant	Overdose Data to Action in States (OD2A-S)
Award Date	September 2023 – August 2028
Funding Cycle	Five (5) years
Objective	Using surveillance and prevention strategies, TODA will: • Track fatal and non-fatal, intentional and unintentional drug poisonings; • Identify emerging drug threats; and • Use data to drive drug poisoning prevention strategies.

Surveillance Strategies

- **Strategy 1 – Surveillance Infrastructure:** Improve and enhance overall capacity to conduct surveillance.
- **Strategy 2 – Morbidity Surveillance:** Collect and disseminate timely data from emergency departments and hospital admissions for suspected drug poisonings.
- **Strategy 3 – Mortality Surveillance:** Collect and disseminate timely data on unintentional and undetermined intent drug poisoning deaths.

Prevention Strategies (1 of 3)

Strategy 6 – Clinician/Health System Engagement and Health IT/Prescription Drug Monitoring Program (PDMP) Enhancement:

- Support clinician education on pain management, focusing on dissemination to all clinicians who may treat acute, subacute, and chronic pain;
- Identify clinician education on screening and diagnosis of substance use disorders;
- Support emergency department linkages via multidisciplinary teams including navigators;
- Support and expand PDMP data integration; and
- Promote health IT systems, intrastate, and bi-directional interstate data sharing.

Prevention Strategies (2 of 3)

Strategy 7 – Public Safety Partnerships/Interventions: Develop and maintain public health and public safety (PH/PS) partnerships, including the initiation or expansion of the public health and safety team (PHAST) toolkit.

Prevention Strategies (3 of 3)

Strategy 8 – Harm Reduction: Use navigators to connect people to services (drug poisoning prevention and reversal tools, and treatment options).

Strategy 9 – Community-Based Linkage to Care: Initiate linkage to care activities, support retention in care, and maintain recovery.

Next Steps:

- Landscape Analysis conducted by Texas A&M Public Policy Research Institute (PPRI);
- Collect and disseminate fatal and nonfatal drug poisoning data;
- Identify what additional data points are needed;
- Identify additional partners and opportunities; and
- Identify gaps in services and needed resources.

Thank you!

EMS Non-Fatal Drug Poisoning Data
2019-2022
TODA

injury.web@dshs.texas.gov

TEXAS
Health and Human Services

Texas Department of State Health Services

7. GETAC Committee Reports

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

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

Vice-Chair: Cherish Brodbeck RN, LP

AMSCT Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. **Performance Improvement**: *Pediatric Airway Management by Air Medical & Specialty Care Providers*	*The GETAC AMSCTC will perform a 2 year retrospective and real-time (quarterly) Ground Air Medical qUality Transport (GAMUT) data analysis of Air Medical & Specialty Care Pediatric RSI success without hypoxia, and first pass intubation success rate, in Texas throughout 2024, with the intent of comparing Texas providers to peer performance in other states.*	In Progress
2. **Coordinated Clinical Care:** *Texas Department of Public Safety – State Troopers*	*The GETAC AMSCTC will develop an educational program, designed specifically for DPS Troopers, outlining the criteria for requesting an air medical asset and how to achieve that goal.*	In Progress

AMSCT Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

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

Air Medical & SCT Committee
2023 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

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

Air Medical & SCT Committee
2023 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Prevention **Statewide Educational Campaign to Mitigate Risks for Air Medical Transport**	• LZ Presentation revisions complete • LZ presentation has been sent to AMOA for approval *Waiting for response from AMOA *Loading videos partially complete *Roll out to RAC Chairs – March 7th, 2024 ***Today requesting to be placed on Q2 Council agenda**	Complete Complete Complete
System Integration **Real-Time Status Reporting, by all Air Medical Providers, in all 22 Regions of the State**	• Collaboration with Juvare to ensure all TX air providers' CAD systems are "talking" to the nationwide system being created • Approximately 90% of air agencies are complete ***Anticipated completion date = prior to Q3 GETAC meeting**	**In Progress**

GETAC Committee/Stakeholder Action Item Request for Council June 2024

Cherish Brodbeck MSN, APRN, FNP-BC, RNC-OB, LP, CMTE

Air Medical & Specialty Care Transport Committee

Action Item Request and Purpose

- The AMSCT Committee is requesting to be placed on the GETAC Council agenda for the Quarter 3, Aug 23, 2024, meeting.

- The purpose of this request is to seek Council approval of the completed Interop Radio Communications presentation, as well as approval to begin education of, and distribution to, the RAC Chairs for end-user access as a resource document.

Benefit and Timeline

- Distribution of the Interop Radio Communications presentation, for use by EMS/FD/Law Enforcement end users, is intended to aid in mitigating the risks of air medical transport for responders, patients, and air medical providers.

- Timeline
  - Presentation to RAC Chairs complete on 6/13/2024
  - Request to be placed on Council Agenda for Q3 – to be completed on 8/23/2024
  - If Council approves, education of RAC Chairs at Q4 meeting
  - RAC chair distribution at their next monthly/quarterly meeting.

7.b. GETAC Cardiac Care Committee

Chair: James J. McCarthy MD

Vice-Chair: Craig Cooley, MD

Cardiac Care Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
Partner with DSHS to identify cardiac data elements currently available in the National Emergency Medical Service Information System (NEMSIS)	Refining DSHS request for ongoing collaboration – further discussion about data elements.	Data review
Out of Hospital Cardiac Arrest – AED access/bystander CPR - assessment	Partnering with DSHS on areas of low AED use and CPR delays – now pending GETAC PI decision on in will be included as a tipic to explore for for CCC to continue to work on.	In progress
Telecommunicator CPR (Coordinated clinical Care/EMS).	To review North Central RAC survey tool on Telecommunicator CPR	In progress
Dwell time in transferring facilities for time sensitive emergencies	Partnering with DSHS to evaluate opportunities to determine dwell times in EDs for patients requiring	In progress

Action Item Request and Purpose

- Requesting approval to work with DSHS on data regarding
  - Out of Hospital Cardiac Arrest
  - Dwell time in Eds for cardiac emergencues requiring transfer for higher level of care.

7.c. GETAC Disaster Preparedness and Response Committee

Chair: Eric Epley, CEM

Vice-Chair: Wanda Helgesen, RN

Committee Summary

- Emergency Medical Task Force Update
  - EMTF Radiological Response Unit (RRU) Coordinator hired
- PreHospital Whole Blood Task Force
  - AABB and AHRQ Draft rules re: Prehospital Whole Blood
  - Walking Blood Bank discussion
  - Blood Center Donor challenges
  - Rotation Systems
- Pulsara report and MCI Test Incident Live Demo
- Hurricane Season Prediction Report from TDEM Meteorologist

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

Chair: Kevin Deramus, LP

Vice-Chair: James Campbell

EMS Committee

2024 Committee Priorities

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

EMS Committee

2023 Committee Priority Outcomes

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

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

EMS Committee

2024 Recommended Performance Improvement Initiatives

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

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

7.e. GETAC EMS Education Committee

Chair: Macara Trusty, LP
Vice-Chair: Christopher Nations, LP

7.f. GETAC EMS Medical Directors Committee

Chair: Christopher Winckler, MD

Vice-Chair: Elizabeth Fagan, MD

7.g. GETAC Injury Prevention & Public Education Committee

Chair: Mary Ann Contreras, RN

Vice-Chair: Courtney Edwards, DNP

IPPE Committee

6/2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Identify data-driven opportunities to reduce the burden of fall injury and death	*Data analysis pending*	
2. Compose the Spectrum of Prevention/best practice paper for secure firearm storage utilizing effective methodologies including applicable resources and evidence informed strategies	*Workday meeting held in April adding resources to the Spectrum of Prevention Paper.*	
3.Compose the Spectrum of Prevention /best practice paper for prevention strategies to reduce suicide and increase individual's capacity for a safe and healthy lifestyle.	*Workday meeting held in April adding resources to the Spectrum of Prevention Paper*	

IPPE Committee

6/2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
4. Increase the number of certified Child Passenger Safety Technicians in Texas. The goal is to • Gain well-rounded perspective of the system issues in Texas from stakeholders and data sources • Identify opportunities to improve these issues and associated barriers • Establish a set of statewide CPST capacity goals for 2030 • Utilize a series of data indicators to measure progress	*Initial data compiled identified:* • 1,854 Technicians to 4,741,075 children • 1 Technician to every 2,557 children; • Conduct ~**10 inspections a day** • Scan the QR to participate in a series of workgroup roundtable meetings (virtually)	

Action Item Request and Purpose

- Please provide a **single**, clear and concise statement defining your action item request:
  - What is the process for the IPPE committee to submit injury prevention performance improvement measures to the System PI Workgroup in the future

- In **one** clear and concise statement, please explain the purpose for this request:
  - Ascertain and align the current state of injury and violence prevention strategies across the trauma system in the state of Texas

7.h. GETAC Pediatric Committee

Chair: Belinda Waters, RN

Vice-Chair: Christi Thornhill, DNP

Action Item Request and Purpose

- Please provide a **single**, clear and concise statement defining your action item request:
  - Request the 3 simulations approved by the Pediatric Committee be approved by the GETAC Executive Council
  - Requests that the simulation cases are posted to the DSHS website following final formatting.
  - Request data regarding out of hospital pediatric cardiac arrests to include age and location with ROSC and death.

- In **one** clear and concise statement, please explain the purpose for this request:
  - To move forward with publication of pediatric simulation cases
  - To assist with identification of out of hospital pediatric cardiac arrests associated with sports.

Benefit and Timeline

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

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

7.i. GETAC Stroke Committee

Chair: Robin Novakavic-White, MD

Vice-Chair: Sean Savitz, MD

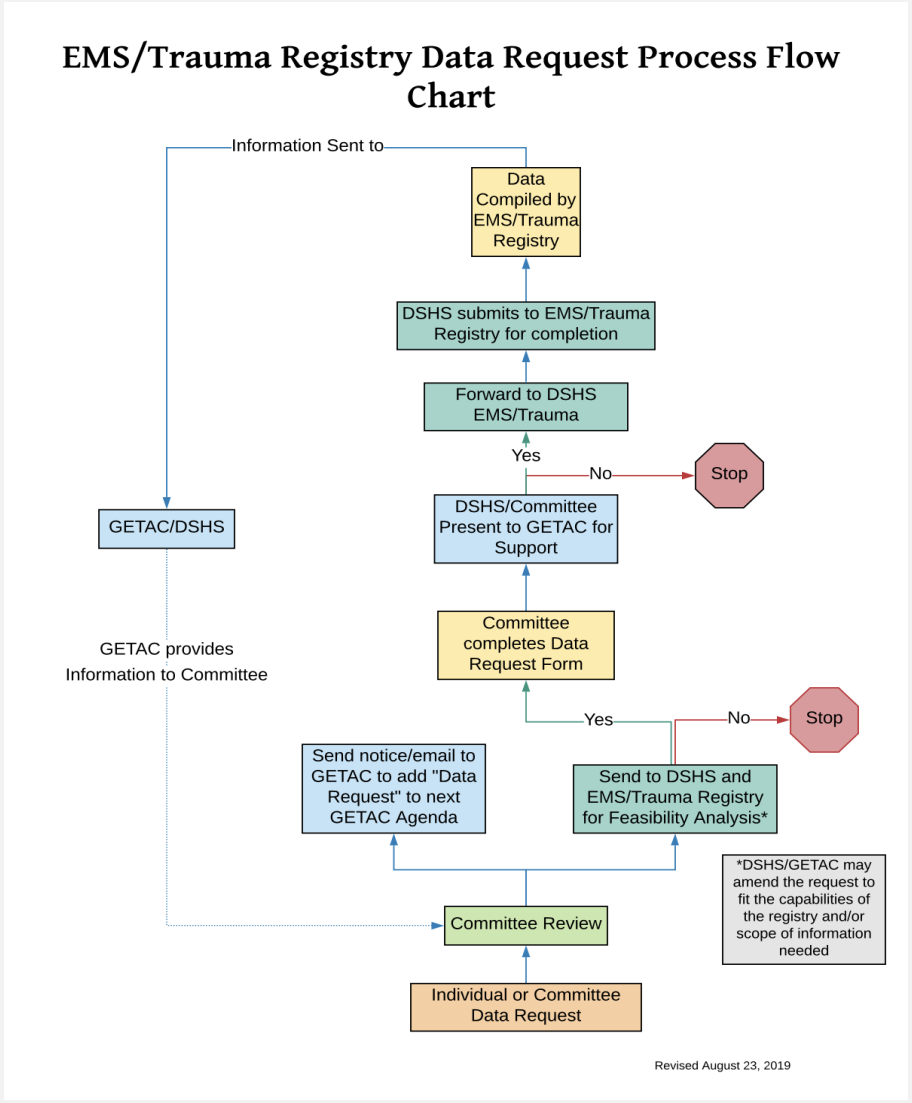
Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
GETAC Stroke Committee Purpose	• Reviewed and approved Stroke Committee purpose 03/2024	
Report and disseminate quarterly Texas Stroke Quality Performance Report	• Review and disseminate Texas Stroke Quality report. • Share with TCCVDS. • Use the quality report to identify barriers to stroke care and opportunities for improvement.	
GETAC Stroke Committee Performance Measures	• Approved: Median DTN, Median DIDO, Percentage Stroke Screening Tool Performed and Documented submitted • Reviewed and Stroke Committee approved data request from NEMSIS.	

Vote: NEMSIS Data Request

Stroke Committee Approved 06/12/2024



- Percentage and raw number transports that have:
  - Stroke screening tool performed/documented
  - Stroke severity tool performed/documented
  - Type of stroke severity tool used
  - Prenotification for patients suspected stroke

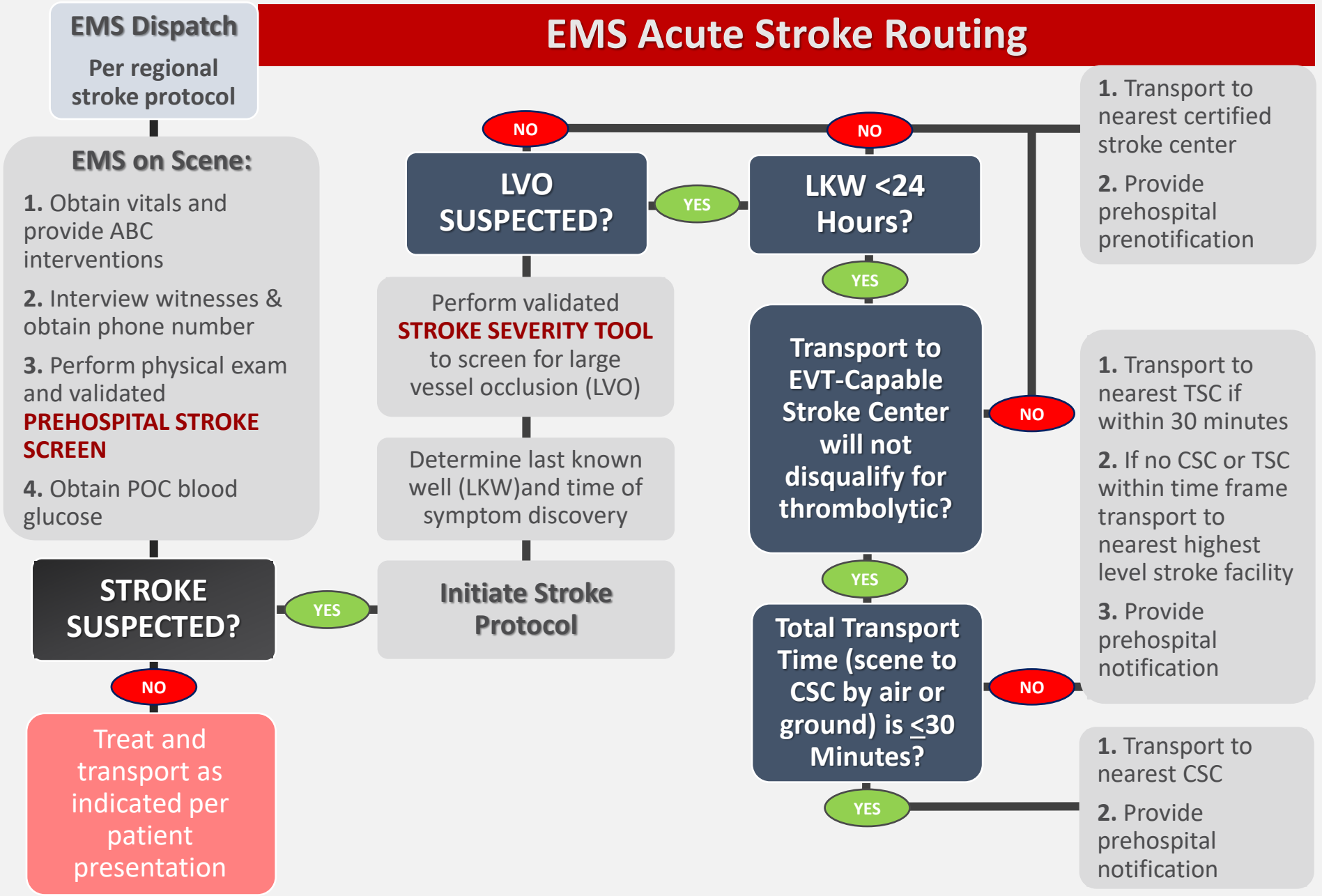
Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

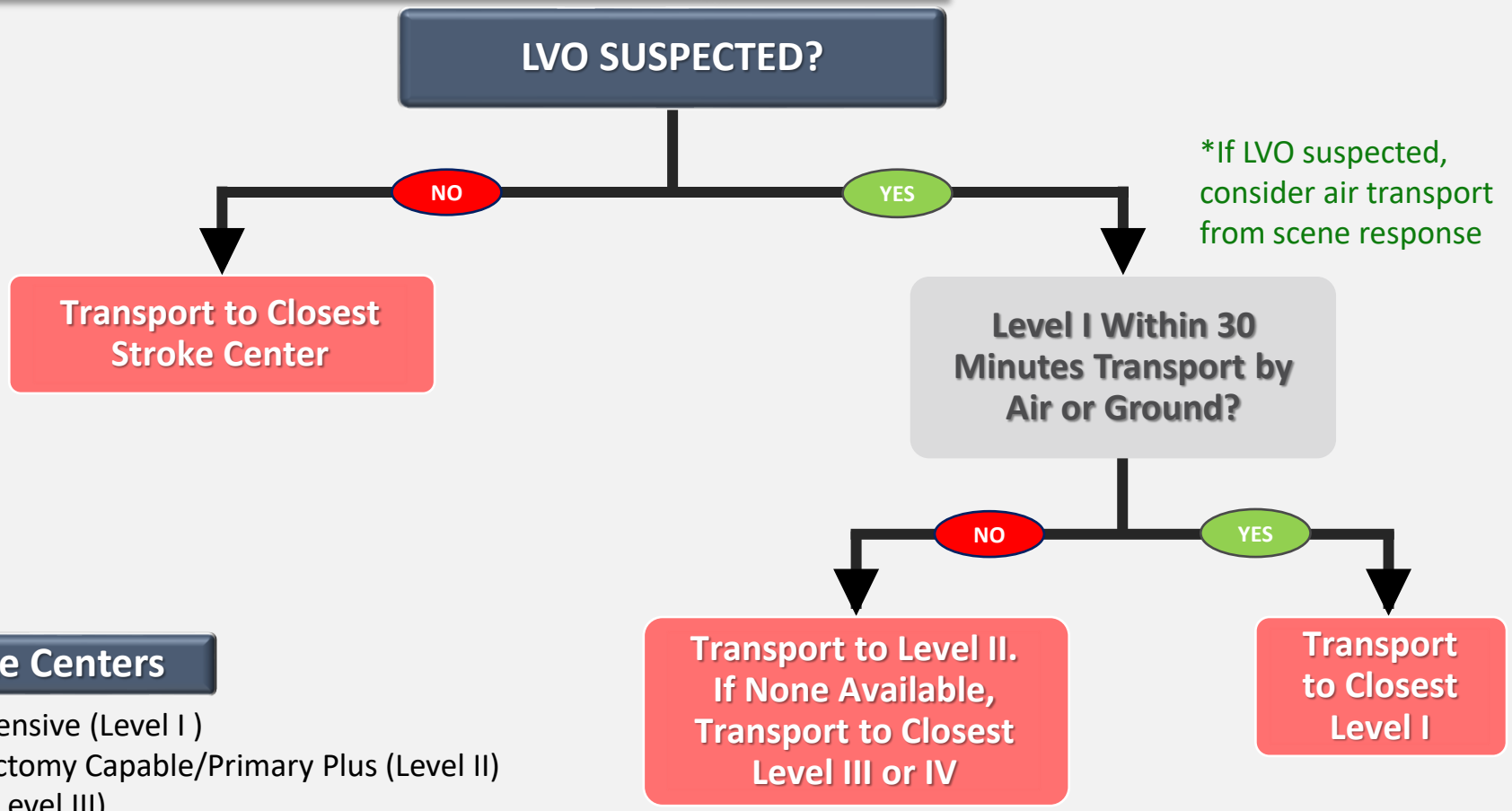
Committee Priorities	Current Activities	Status
ASA Mission Lifeline Prehospital Stroke algorithm – Recommendation	• **Reviewed revisions and approved by Stroke Committee and Air Medical.** • **Presented to EMS, EMS Medical Director, and RAC leadership. EMS Medical Directors deferred approval until 08/2024. EMS Committee reviewed and gave Donald Janes rights to approve revisions.**	
Stroke facility infrastructure and requirements	• The Stroke System of Care Work Group is outlining best practices and recommendations to present to the Stroke Committee. • SSOC Work Group will review BAC guidelines and alternatives, make recommendation to the Stroke Committee 08/24.	
Pediatric Task Force	• Reviewed and approved latest revisions to prehospital best practices for management, transport and interfacility transfers approved by stroke committee. • Submitted to Pediatric Committee plan present 08/2024. • Reviewed by Air Medical, request for revisions submitted to Task Force. • Next steps, minimum capability recommendations for pediatric hospital to be recognized as capable of caring for pediatric stroke.	

Revised

EMS Acute Stroke Routing



Stroke Urban Transport Recommendation

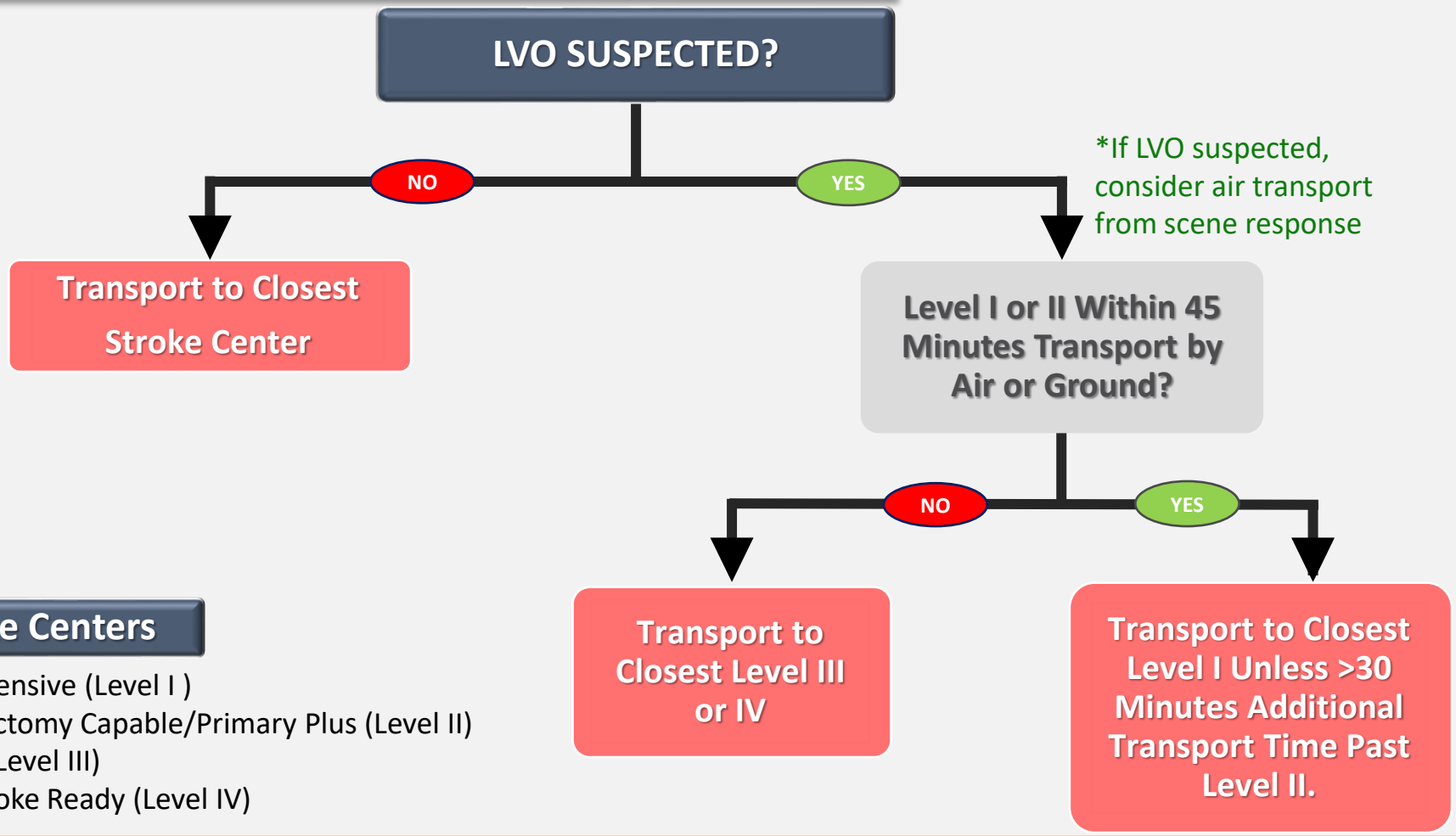


*If LVO suspected, consider air transport from scene response

Stroke Centers

Comprehensive (Level I)
Thrombectomy Capable/Primary Plus (Level II)
Primary (Level III)
Acute Stroke Ready (Level IV)

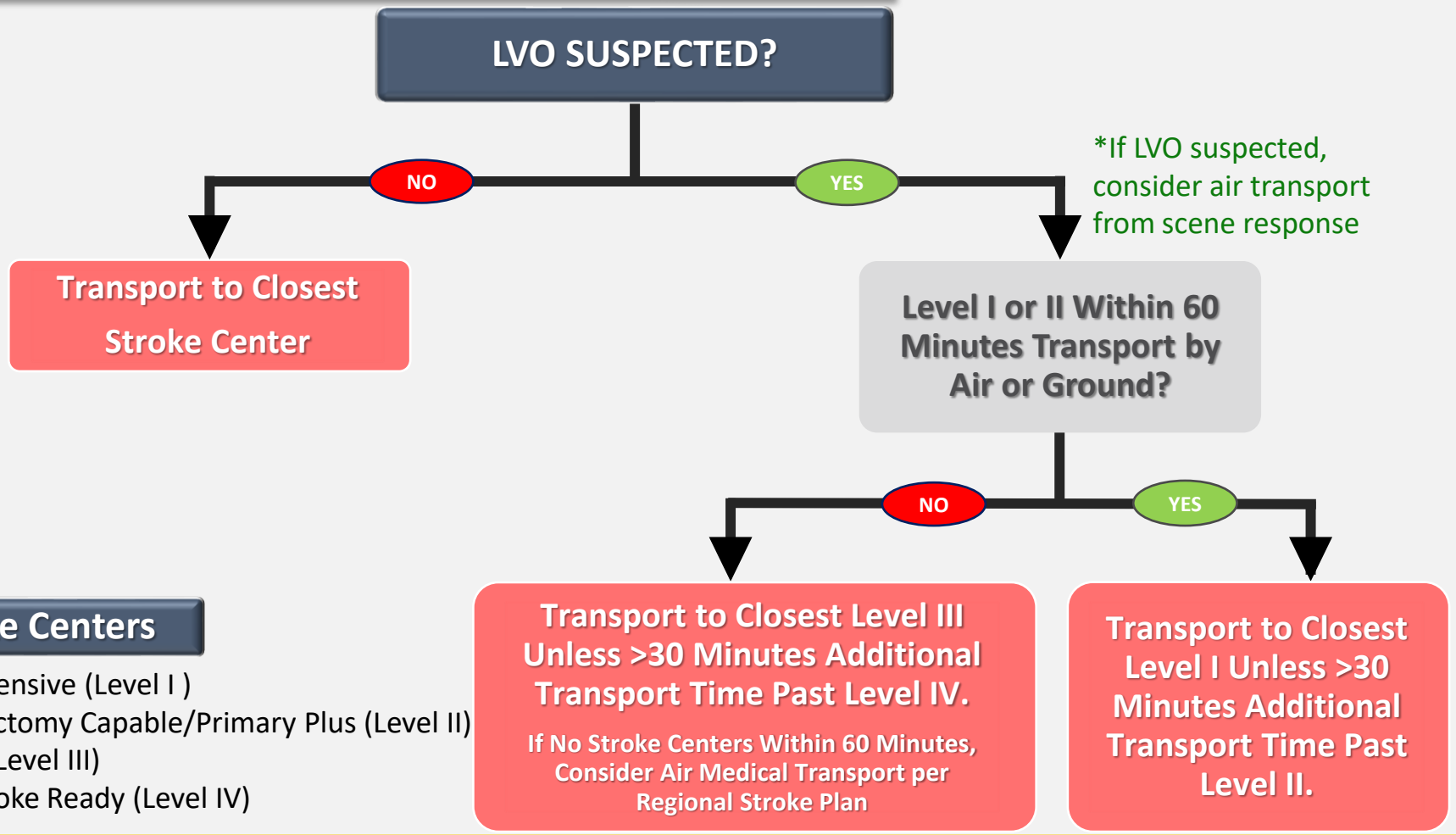
Stroke Suburban Transport Recommendation



Stroke Centers

Comprehensive (Level I)
Thrombectomy Capable/Primary Plus (Level II)
Primary (Level III)
Acute Stroke Ready (Level IV)

Stroke Rural Transport Recommendation



Stroke Centers

Comprehensive (Level I)
Thrombectomy Capable/Primary Plus (Level II)
Primary (Level III)
Acute Stroke Ready (Level IV)

Healthcare Resources, Geography and Population Density

Urban

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

Suburban

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

Rural

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

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
ASA Mission Lifeline Prehospital Stroke algorithm – Recommendation	• Reviewed revisions and approved by Stroke Committee and Air Medical. • Presented to EMS, EMS Medical Director, and RAC leadership. EMS Medical Directors deferred approval until 08/2024. EMS Committee reviewed and gave Donald Janes rights to approve revisions.	
Stroke facility infrastructure and requirements	• **The Stroke System of Care Work Group is outlining best practices and recommendations to present to the Stroke Committee.** • **SSOC Work Group will review BAC guidelines and alternatives, make recommendation to the Stroke Committee 08/24.**	
Pediatric Task Force	• Reviewed and approved latest revisions to prehospital best practices for management, transport and interfacility transfers approved by stroke committee. • Submitted to Pediatric Committee plan present 08/2024. • Reviewed by Air Medical, request for revisions submitted to Task Force. • Next steps, minimum capability recommendations for pediatric hospital to be recognized as capable of caring for pediatric stroke.	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
ASA Mission Lifeline Prehospital Stroke algorithm – Recommendation	• Reviewed revisions and approved by Stroke Committee and Air Medical. • Presented to EMS, EMS Medical Director, and RAC leadership. EMS Medical Directors deferred approval until 08/2024. EMS Committee reviewed and gave Donald Janes rights to approve revisions.	
Stroke facility infrastructure and requirements	• The Stroke System of Care Work Group is outlining best practices and recommendations to present to the Stroke Committee. • SSOC Work Group will review BAC guidelines and alternatives, make recommendation to the Stroke Committee 08/24.	
Pediatric Task Force	• **Reviewed and approved latest revisions to prehospital best practices for management, transport and interfacility transfers approved by stroke committee.** • **Submitted to Pediatric Committee plan present 08/2024 if approved present to other committees.** • **Reviewed by Air Medical, request for revisions submitted to Task Force.** • **Next steps, minimum capability recommendations for pediatric hospital to be recognized as capable of caring for pediatric stroke.**	

EMS Pediatric Stroke Protocol

SUSPECT STROKE

Sudden Onset/Wake from Sleep:

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

Stabilize – ABCDEs Pediatric Guidelines

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

Pediatric Patient Stable

YES

Exam:

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

NO

Transport to nearest pediatric ED

Management:

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

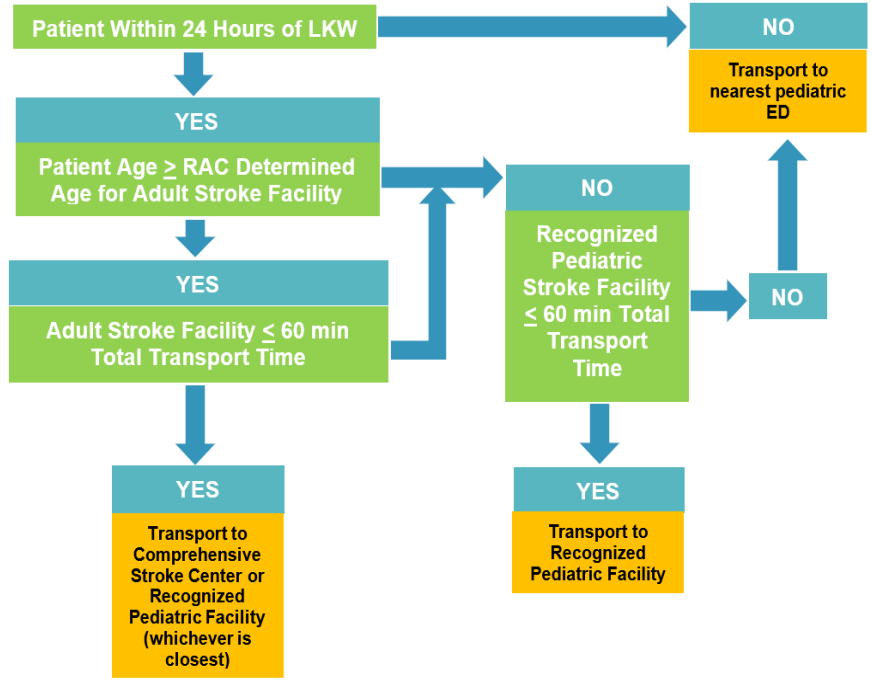
SBP Parameters[1]

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

History to Obtain:

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

EMS Pediatric Stroke Protocol



Reference

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

Last Updated 6/6/2024

EMS Pediatric Stroke Triage Guidance

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] This guidance document is designed to help EMS providers recognize and triage pediatric stroke patients quickly to facilitate improved outcomes throughout the state.

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

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

General Information on Pediatric Stroke

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

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

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

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

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 and 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/Initial Management:
If there is evidence of shock, treat according to the Shock clinical practice guidelines
If there is hypoglycemia (POC glucose < 60 mg/dL), treat according to Diabetic Emergencies clinical practice guidelines.
If there are Seizures, treat according to the Seizure clinical practice guidelines
Place the patient in a supine position, head of the bed elevated 30 degrees.
Cardiac monitoring during transport is recommended.

Assessment for Pediatric Stroke
There are no validated pre-hospital screening tools 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)

Last Updated – 2.6.2024

Related medical conditions include: Heart disease, history of blood vessel problems in the brain, history of stroke, sickle cell disease, cancer, history of blood clots

History -

If you are concerned for stroke:
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 if possible: Past medical history, allergies (iodinated contrast).

Determine if patient has a pre-existing substantial disability (e.g. unable to walk independently).

Medications – obtain a list of all medications including antiplatelet agents such as Aspirin and blood thinners such as direct thrombin inhibitors, factor Xa inhibitors, low molecular weight heparin such as enoxaparin (Lovenox), unfractionated heparin, warfarin (Coumadin), rivaroxaban (Xarelto), dabigatran (Pradaxa), apixaban (Eliquis), edoxaban (Savaysa). If possible, record when last dose was taken.

Device/implant history (i.e. left ventricular assist device, pacemaker, valve replacement, VP shunt)

Examination
Record blood pressure, rate, rhythm, respiratory rate and oxygen saturation.

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

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

Systolic Blood Pressure Parameters[11]:

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

4. Consider online medical control for severe hypertension
5. Hypoglycemia (blood glucose < 60 mg/dL) should be treated in patients suspected of acute ischemic stroke.
6. To facilitate expedited stroke workup in the ED two peripheral IVs can be placed, however, this should not delay transport time.

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

Destination decision-making for pediatric patients less than 18 years of age with possible stroke:

Consult local RAC guidelines for age cut off for transport to comprehensive stroke center. If patient's age is greater than or equal to RAC determined age for comprehensive stroke center, transport patient to nearest comprehensive stroke center or pediatric tertiary care emergency department (whichever is closest).

If no comprehensive stroke center or

For patients less than RAC determined age for adult comprehensive stroke center:

1. If last known well <24 hours, prioritize arrival to nearest tertiary care pediatric emergency department. Consider calling in to facility as emergent stroke patient
2. If last known well >24 hours, prioritize arrival to nearest pediatric emergency department for evaluation.

For all ages, consider air medical if prolonged transport time.
Call stroke alert, pre-notify receiving facility that a suspected pediatric stroke patient is in route so that the appropriate resources may be mobilized before patient arrival.

Pre-notification should include: Age, last known well, current vital signs, stroke screening tool score (if done) and symptoms (weakness on one side, altered mental status, etc)
Goal: 120 seconds for EMS to ED triage nurse hand-off.

(Note – Plan is adapted from 2022 Pediatric Stroke North Central Texas Regional Stroke Plan)

References:

1. National Center for Injury Prevention and Control, CDC. 10 leading causes of death by age group. [Internet]. 2018 [cited 2022 May 10];Available from: https://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2015-a
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3. Lauzier DC, Galardi MM, Guilliams KP, et al. Pediatric Thrombectomy. Stroke 2021;52(4):1511–9.
4. Ferriero DM, Fullerton HJ, Bernard TJ, et al. AHA / ASA Scientific Statement Management of Stroke in Neonates and Children. 2019.
5. Jauch EC, Schwamm LH, Panagos PD, et al. Recommendations for Regional Stroke Destination Plans in Rural, Suburban, and Urban Communities From the Prehospital Stroke System of Care Consensus Conference: A Consensus Statement From the American Academy of Neurology, American Heart Association/American Stroke Association, American Society of Neuroradiology, National Association of EMS Physicians, National Association of State EMS Officials, Society of NeuroInterventional Surgery, and Society of Vascular and Interventional Neurology. Stroke 2021;52(5).
6. Elbers J, Wainwright MS, Amlie-Lefond C. The Pediatric Stroke Code: Early Management of the Child with Stroke. J Pediatr 2015;167(1):19-24.e4.
7. Phelps K, Silos C, De La Torre S, et al. Establishing a pediatric acute stroke protocol: experience of a new pediatric stroke program and predictors of acute stroke. Front Neurol 2023;14.
8. Harrar DB, Benedetti GM, Jayakar A, et al. Pediatric Acute Stroke Protocols in the United States and Canada. In: Journal of Pediatrics. Elsevier Inc.; 2022. p. 220-227.e7.
9. Wharton JD, Barry MM, Lee CA, Massey K, Ladner TR, Jordan LC. Pediatric Acute Stroke Protocol Implementation and Utilization Over 7 Years. In: Journal of Pediatrics. Mosby Inc.; 2020. p. 214-220.e1.
10. Harrar DB, Benedetti GM, Jayakar A, et al. Pediatric Acute Stroke Protocols in the United States and Canada. J Pediatr 2022;242:220-227.e7.
11. Rivkin MJ, Bernard TJ, Dowling MM, Amlie-Lefond C. Guidelines for Urgent Management of Stroke in Children. Pediatr Neurol 2016;56:8–17.

Last Updated – 2.6.2024

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• **Reviewed and approved revisions by Stroke Committee and Air Medical.** • **Presented to EMS, EMS Medical Director, and RAC leadership. EMS Medical Directors deferred approval until 08/2024. EMS Committee reviewed and gave Donald Janes rights to approve revisions.**	
DIDO performance recommendations	• Reviewed and approved revisions by Stroke Committee and Air Medical. • Plan to present to EMS MD 08/2024. • Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO	
Establish research opportunity in the state of Texas to help advance stroke care in the state	• Working on Texas study evaluating if providing standardized stroke education improves performance.	

New Proposal
INTERFACILITY STROKE TERMINOLOGY

1

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

2

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

3

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

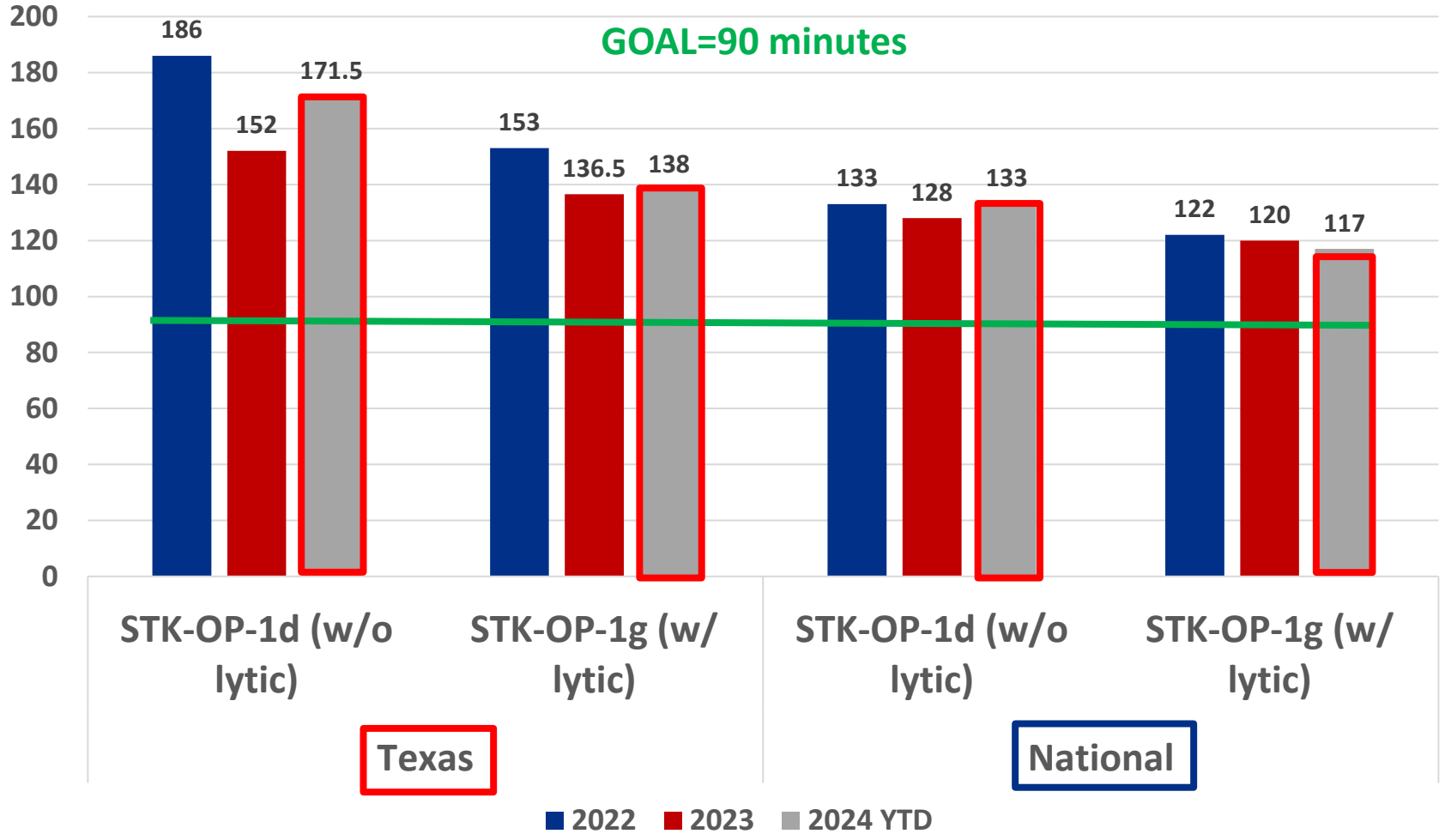
- **Level 1 and 2 Stroke**- time from ***agency notification*** to transportation ***arrival at the transferring hospital*** ≤ 30 minutes.
  Level 1 Stroke- if ground transportation to transferring facility or transport time to receiving facility > 30 minutes consider air transport.

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• Reviewed and approved revisions by Stroke Committee and Air Medical. • Presented to EMS, EMS Medical Director, and RAC leadership. EMS Medical Directors deferred approval until 08/2024. EMS Committee reviewed and gave Donald Janes rights to approve revisions.	
DIDO performance recommendations	• **Reviewed and approved revisions by Stroke Committee and Air Medical.** • **Plan to present to EMS MD 08/2024.** • **Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO**	
Establish research opportunity in the state of Texas to help advance stroke care in the state	• Working on Texas study evaluating if providing standardized stroke education improves performance.	

Median DIDO for Thrombectomy Eligible Patients (Minutes)



Disclaimer: Get with The Guideline reports are generated from a live registry. All data is subject to change. Report generated on 4/16/24.

New Proposal Breaking Down DIDO

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

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Interfacility Stroke Terminology	• Reviewed and approved revisions by Stroke Committee and Air Medical. • Presented to EMS, EMS Medical Director, and RAC leadership. EMS Medical Directors deferred approval until 08/2024. EMS Committee reviewed and gave Donald Janes rights to approve revisions.	
DIDO performance recommendations	• Reviewed and approved revisions by Stroke Committee and Air Medical. • Plan to present to EMS MD 08/2024. • Long-term goal, collect the data to outline barriers for interfacility transfers and opportunities to facilitate faster DIDO	
Establish research opportunity in the state of Texas to help advance stroke care in the state	• **Working on Texas study evaluating if providing standardized stroke education improves performance.**	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Texas EMS Stroke Survey	• **Stroke Committee, EMS Medical Director and Air Medical approved. EMS and EMS Medical Directors helped with language.** • **EMS Committee reviewed and gave Donald Janes rights to approve revisions.** • **RAC leadership prelim approval**	
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/GETAC to find best way to provide a stroke education resource. Link to a facilities stroke education page current suggestion.	
Work with DSHS to outline recommendations for stroke rules for ASRH	• Ongoing	

GETAC Stroke Committee Stroke Screening Survey

GETAC Stroke Screening Survey

Please complete the survey below.

Thank you!

The following survey will be used to collect submissions regarding the current use of both Stroke severity screening tools and Stroke assessment tools among our organizations. The Stroke committee hopes to collect the data needed to analyze which tools are being utilized, and how we can improve the prompt mobilization of resources to the patients in our region.

If you have multiple agencies you assist, please label them all within the comment box for the first question.

Survey will remain open until COB April 1st, 2022.

For administrative purposes only, please provide your first and last name: _____

What is your level of emergency medical provider?

- ☐ EMT
- ☐ AEMT
- ☐ Paramedic
- ☐ EMS Medical Director
- ☐ Advanced Practice Provider
- ☐ RN
- ☐ Other

Do you hold a leadership position?

- ○ Yes
- ○ No

What position do you hold? (Select all that apply):

- ☐ EMS Leadership
- ☐ EMS Medical Director

At which facilty or company are you employed? _____

In which Regional Advisory Council(s) (RAC) are you employed? (Select all that apply):

- ☐ TSA-A Panhandle RAC
- ☐ TSA-B RAC (BRAC)
- ☐ TSA-C North Texas RAC
- ☐ TSA-D Big Country RAC
- ☐ TSA-E North Central Texas Trauma RAC
- ☐ TSA-F Northeast Texas RAC
- ☐ TSA-G Piney Woods RAC
- ☐ TSA-H Deep East Texas RAC
- ☐ TSA-I Border RAC
- ☐ TSA-J Texas "J" RAC
- ☐ TSA-K Concho Valley RAC
- ☐ TSA-L Central Texas RAC
- ☐ TSA-M Heart of Texas RAC
- ☐ TSA-N Brazos Valley RAC
- ☐ TSA-O Capital Area Trauma RAC
- ☐ TSA-P Southwest Texas RAC
- ☐ TSA-Q Southeast Texas RAC
- ☐ TSA-R East Texas Gulf Coast RAC
- ☐ TSA-S Golden Crescent RAC c/o Citizens Medical Center
- ☐ TSA-T Seven Flags RAC
- ☐ TSA-U Coastal Bend RAC
- ☐ TSA-V Lower Rio Grande Valley RAC

Does your EMS agency utilize electronic patient care reporting (ePCR)?

- ○ Yes
- ○ No

Which electronic patient care record do you use? (Select all that apply):

- ☐ Intermedix
- ☐ ESO
- ☐ Zoll
- ☐ ImageTrend
- ☐ EMSCharts
- ☐ MedsViewer
- ☐ Other

Other electronic patient care record (please specify):

_____

Are you instructed to use a prehospital stroke screening tool to assess patients with suspected stroke?

- ○ Yes
- ○ No

What stroke screening tool do you use to screen for stroke? (Select all that apply):

- ☐ Cincinnati Prehospital Stroke Scale
- ☐ Los Angeles Prehospital Stroke Screen
- ☐ Los Angeles Motor Scale (LAMS)
- ☐ FAST (Face, Arm, Speech, Test)
- ☐ NIHSS
- ☐ Other or uncertain of the name

Other assessment tool (please specify):

_____

GETAC Stroke Committee Stroke Screening Survey

From your most current year of operations, what percentage of EMS responses originated from a 911 request for patients suffering from a suspected stroke who had a stroke assessment performed during the EMS response?"

- ◯ Never (0%)
- ◯ Less than 25% of the time
- ◯ Between 25% to less than 50% of the time
- ◯ Between 50% to less than 75% of the time
- ◯ More than 75% of the time

How confident do you feel using your stroke screening tool?

- ◯ Not confident at all, try to avoid
- ◯ Somewhat confident
- ◯ Confident
- ◯ Very confident

How often do you receive formal training on this tool at the agency where you are employed?

- ◯ I have never received training
- ◯ Only one time
- ◯ Every 2-5 years
- ◯ At least once every two years
- ◯ Once a year
- ◯ More than once a year

Are you instructed to use a prehospital stroke severity/large vessel occlusion (LVO) screening tool to assess patients suspected of having a stroke?

- ◯ Yes
- ◯ No

What LVO screening tool do you use to assess patients suspected of having a stroke? (Select all that apply):

- ◯ Cincinnati Prehospital Stroke Severity Scale (CSTAT)
- ◯ Los Angeles Prehospital Stroke Screen
- ◯ Los Angeles Motor Scale (LAMS)
- ◯ RACE Scale
- ◯ Field Assessment Stroke Triage for Emergency Destination (FAST-ED)
- ◯ Vision Aphasia Neglect (VAN)
- ◯ Weakness, Inattention/neglect, Repetition, Eye deviation/vision loss (WIRE)
- ◯ NIHSS
- ◯ Other or uncertain of the name

Other (please specify):

From your most current year of operations, what percentage of EMS responses originate from a 911 request for patients suffering from a suspected stroke who had a stroke severity (LVO) assessment performed during the EMS response?

- ◯ Never (0%)
- ◯ Less than 25% of the time
- ◯ Between 25% to less than 50% of the time
- ◯ Between 50% to less than 75% of the time
- ◯ More than 75% of the time

How confident do you feel using your stroke severity (LVO) screening tool?

- ◯ Not confident at all, try to avoid
- ◯ Somewhat confident
- ◯ Confident
- ◯ Very Confident

How frequently do you receive official training on this tool at the company where you are primarily employed?

- ◯ I have never received training
- ◯ Only one time
- ◯ Every 2-5 years
- ◯ At least once every two years
- ◯ Once a year
- ◯ More than once a year

Among patients suspected of having an acute stroke, in what proportion is a hospital pre-notification made (e.g., Stroke Alert)?

- ◯ Never (0%)
- ◯ Less than 25% of the time
- ◯ Between 25% to less than 50% of the time
- ◯ Between 50% to less than 75% of the time
- ◯ More than 75% of the time

How are the results of stroke screens documented in your chart?

- ◯ They are not documented
- ◯ In the narrative
- ◯ In a discrete "pull down" section of the chart

How do you document hospital stroke pre-notification (e.g., Stroke Alert)?

- ◯ They are not documented
- ◯ In the narrative
- ◯ As a time-stamped procedure

If you would like to leave a comment, please feel free to do so. Thank you.

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Texas EMS Stroke Survey	• Stroke Committee, EMS Medical Director and Air Medical approved. EMS and EMS Medical Directors helped with language. • EMS Committee reviewed and gave Donald Janes rights to approve revisions. • RAC leadership prelim approval	
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/GETAC to find best way to provide a stroke education resource. Link to a facilities stroke education page current suggestion.**	
Work with DSHS to outline recommendations for stroke rules for ASRH	• **Ongoing**	

Stroke Committee

Priority Not Implemented
Priority Activities Recorded
Priorities Completed and being Monitored

Committee Priorities	Current Activities	Status
Stroke Coordinator/Manager Survey on mentorship	• Stroke Committee Education Work Group developing survey. Provided preview.	
Rural Stroke Work Group	• Provider QR code for member participation	

RURAL Stroke Work Group

GETAC Stroke Committee Item Request for Council March 2024

Robin Novakovic-White, MD

Stroke Committee

Stroke Committee

- Committee items needing council guidance
  1. NEMSIS request for performance measures
  2. Prehospital EMS Survey
- Stakeholder items needing council guidance
  1. None at this time
- Items referred to GETAC for future action
  1. Near future will seek approval for the algorithm, pediatric stroke algorithm, terminology and DIDO performance measures best practice recommendation

Action Item Request and Purpose

- Currently, prehospital performance is reported from GWTG. Data in GWTG is entered with information gathered by stroke facilities. We seek to do a direct comparison between NEMSIS reported performance and GWTG performance for prehospital measures.
- Stroke Committee is seeking approval for the EMS prehospital stroke survey to better understand what is the current state of stroke education and utilization of stroke scales.

Benefit and Timeline

- The direct comparison between NEMSIS performance to GWTG, while not the exact same data, may still allow to was is the actual performance of these measures.
- The survey may highlight opportunities for improvement for EMS prehospital stroke education.
- Please provide the timeline or relevant deadlines for this request.
  - TBD

7.j. GETAC Trauma Systems Committee

Stephen Flaherty, MD, FACS

Lori Robb, MHA, BSN-RN, TCRN, NHDP-BC

Trauma Spotlight

St. David's North Austin Medical Center

Level 4 Trauma
441 bed
32 ED beds

One vehicle drove through ER of children's hospital entrance
1 DOS
Admitted and ED patients were successfully transported to a sister hospital in Round Rock
The AMBUS was utilized for transport
Emergency operations were returned back to normal within 24 hours of incident

Trauma Program Manager –
Cassie Cummongs/Britani Thorn

Trauma System Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
1. Support the Trauma Rules process	Standing by as the new rules process evolves	
2. Workgroup identification	**We continue with the following workgroups** Assess the rural trauma gap --- Transfer delays Facilitate RAC communication --- Rules process Monitor trauma center designation process. --- Gains/losses Advocacy for funding issues --- OIG report **Add two new elements** Burn centers Pre-hospital blood program	
3. Funding	OIG is auditing programs for over and under charging trauma activation fees Funding workgroup will monitor and report quarterly	

Trauma System Committee

2024 Committee Priorities Update

Priority Not Implemented
Priority Activities Recorded
Priority Completed and Monitored

Committee Priorities	Current Activities	Status
4. Designation process	No changes Recommended developing specific requirements for TMD mentoring when appropriate.	
5. State PI Plan	Awaiting actions of the System PI Task Force Monitor transfer of severely injured patients GCS < 9 or… Hypotension using age-specific SBP guidelines 80% < 2 hours All variances reviewed at RAC system PI	
6.Stop the Bleed	*ACS version 3 delayed to "later"*	

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

Katherine Remick, MD

Task Force Chair

Proposed Texas EMS and Trauma System Measures

System PI Workgroup

Measures Selection Process

- GETAC Systems Performance Improvement Taskforce charged with establishing an **initial set of 5 performance measures** for the State of Texas EMS and Trauma System

- 26 measures were proposed by GETAC committee members, RAC Chairs, and other stakeholder groups

- Modified-Delphi Process: each measure rated using National Quality Forum criteria on a 5-point Likert scale (Round 1)
  - **Importance** to achieving optimal patient outcomes
  - **Scientific Acceptability** or Level of Evidence that supports the measures
  - **Usability** – degree to which the measure is actionable
  - **Feasibility** – degree to which the data can be easily collected

Measures Selection Process

- The final set of measures should reflect:
    1. Health outcomes and clinical care across the system,
    2. System efficiency and/or effectiveness,
    3. Degree of equity, and
    4. Priority conditions

- Stratification at the patient, facility, region, and/or state level **will be addressed later**.

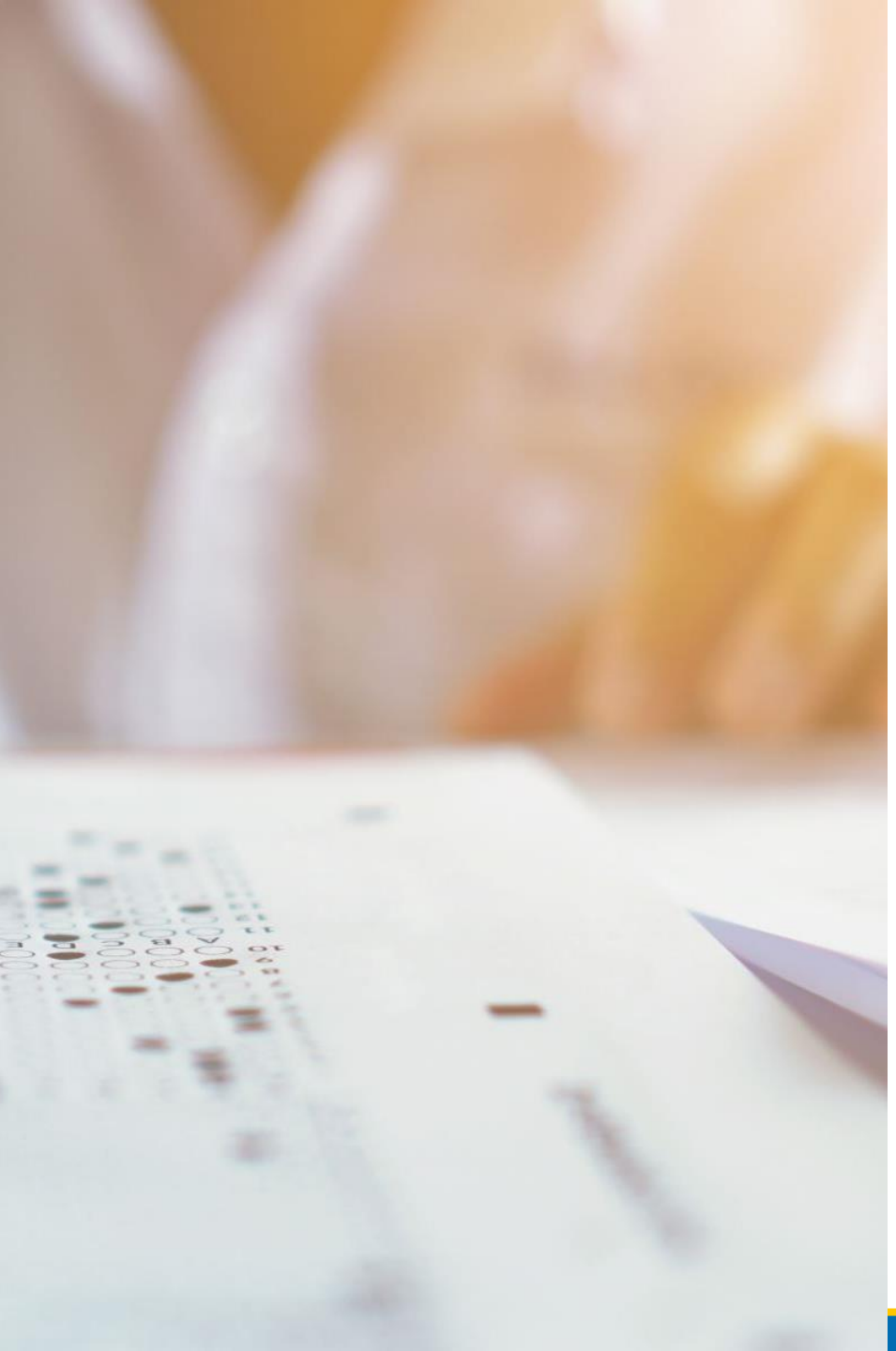
Rating Threshold for Inclusion/Exclusion

- Calculated mean for each NQF category, average for each measure, and standard deviation (max score = 5)
- Average Score below 4.0 (n=10) - eliminated
- Average Score >4.2 (n = 5) - approved
- Average Score 4.0 - 4.2 (n=11) – discussed, round 2 vote
  - 6 additional measures approved

11 measures approved

Top 11 Measures for Vote to Accept/Eliminate

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



Next Steps

Committee and RAC Chairs will be asked to attend one of the follow-up sessions, either **June 17 at 3 PM (CST) or June 24 at 2 PM (CST)** to vote on each of the 11 measures.

- Accept +/- minor comments
- Eliminate

9. Burn Care Task Force

10. Proposed Trauma Rule Amendments

11. Executive Council Activities

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

Dinah Welsh, TETAF President/CEO

Texas EMS, Trauma & Acute Care Foundation Update

Dinah Welsh

TETAF President/CEO

Friday, June 14, 2024

TETAF
TEXAS EMS TRAUMA & ACUTE CARE FOUNDATION

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

Advocacy

- The TETAF Advocacy Committee is meeting regularly to prepare for the 89th Texas Legislative Session.
- This week, the TETAF Board of Directors approved the TETAF Legislative Priorities.
- TETAF continues to follow the progress of the revisions to the proposed trauma rules and will provide formal comments on the newly proposed trauma rules once the 30-day period begins.

Surveys – Trauma, Stroke, Maternal, and Neonatal

- The number of surveys continues at a steady pace for all survey service lines in the last quarter. Trauma and maternal continue to be the two busiest service lines, followed by neonatal and stroke.
- TETAF recently hired a part-time survey operations associate, Alexandria Anderson-Spivey, to assist with survey scheduling operations.

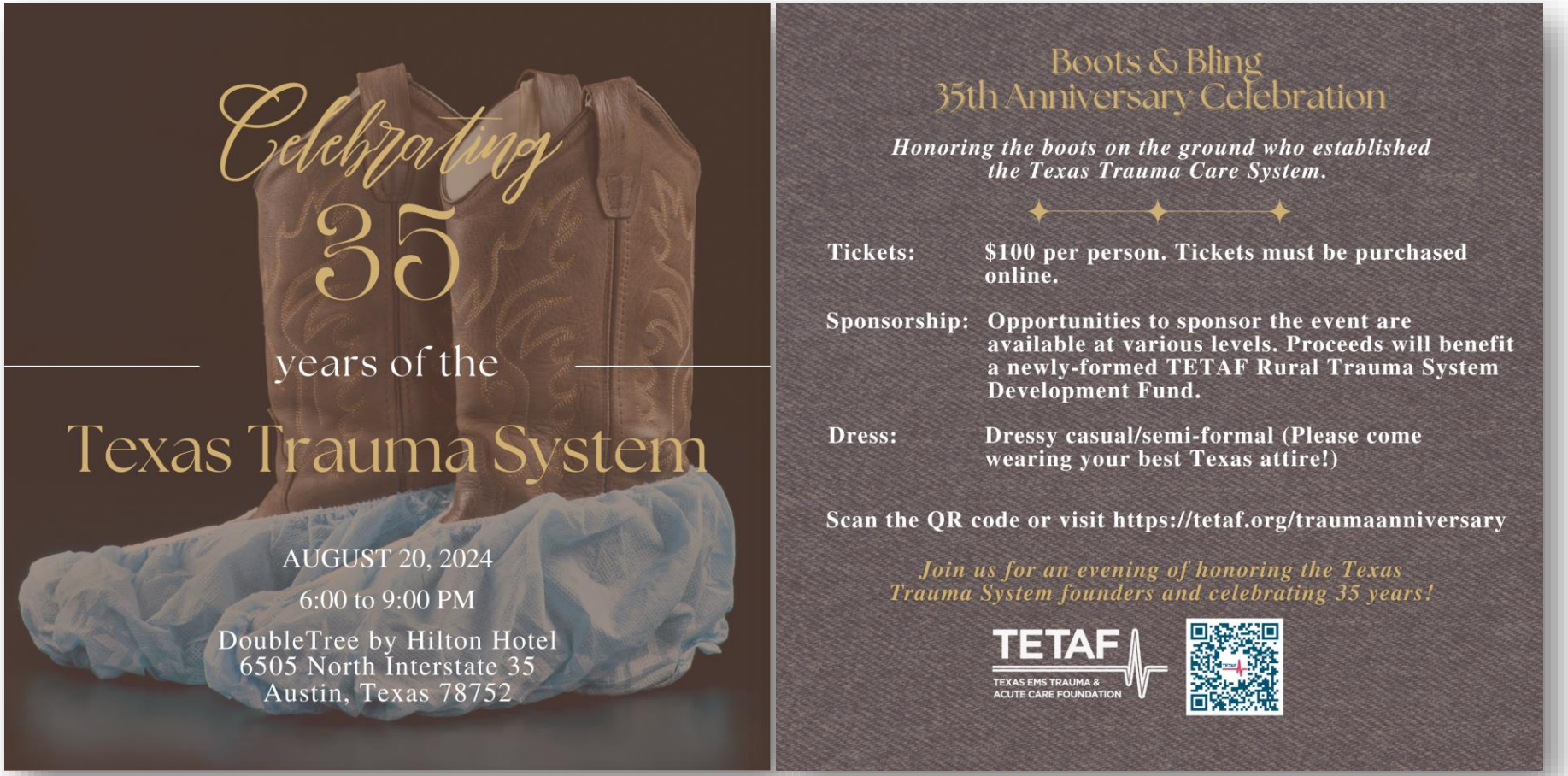
Education

- Last week, TETAF conducted another successful virtual offering of the TETAF Hospital Data Management Course (HDMC). The next course will be in Fall 2024. Go to www.tetaf.org/hdmc to sign up and be notified of the next course.
- TETAF and Texas Perinatal Services continue to offer the Texas Quality Care Forum (TQCF) each month with topics focused on trauma, stroke, maternal, neonatal, and acute care, as well as EMS topics. The next TQCF is on **Wednesday, July 17 at 10:00 a.m. CDT**. This month, TETAF will offer CE for those who complete the forum and final questionnaire. Go to the TETAF website under Events to register via Zoom.
- TETAF and Texas Perinatal Services continue to offer exclusive, free educational opportunities to our hospital partners via Mighty Networks.

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

Collaboration

- TETAF continues to provide support to Texas TQIP.
  - A new Executive Committee has been named:
    - Chair – Dr. Carlos Palacio, Trauma Surgeon at South Texas Health System, McAllen
    - Vice Chair – Dr. Michael Wandling, Trauma Medical Director at Memorial Hermann Medical Center, Houston
    - Vice Chair – Cassie Lyell – Executive Director of Trauma & Burn Services at University Health, San Antonio
    - Member – Danielle Sherar – Executive Director of Trauma, Acute Care Surgery & Forensics at JPS Health, Ft. Worth
    - Member – Anne Feeler – Trauma Service Manager-Registry at Parkland Health, Dallas
- TETAF continues to provide all continuing education for the Texas Trauma Coordinators Forum and participate in their educational activities.
- TETAF welcomes the opportunity to be a resource, support, and/or participate in any meetings to further build the trauma and emergency care network.



https://tetaf.org/traumaanniversary/

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

15. Discussion of Rural Priorities

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

17. 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

18. Announcements

19. Next Council Meeting Dates

Quarterly Meetings:

- **Q3 –** August 21-23, DoubleTree Hotel
- **Q4 –** November 23-25, 2024, in conjunction with the Texas EMS Conference in Ft. Worth.

20. 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!