EMS Committee Quarterly Meeting Minutes

2024 Quarter 2 | April 12, 2024

Chair: Jim Cole, RRP | Vice Chair: Sheila Clough

Appointed Committee Attendance

Absent	Physician	Christopher Van Tilburg, MD
Present	Physician	SunHee Chung, MD
Present	Physician	David Rosenburg, MD
Present	Physician (Supervising)	Luke Welle, MD
Present	Physician (Supervising)	Alicia Bond, MD
Present	Physician (Pediatric Emergency Care)	Daniel Hull, MD
Present	EMS Provider	Michael Cool, Paramedic
Excused	EMS Provider (EMR)	Casi Hegney, EMR
Present	EMS Provider	Rebekah Rand, Paramedic
Present	EMS Provider	Jim Cole, Paramedic
Excused	Vol. Ambulance Provider	Tiffany Peterson, EMT
Excused	Public Ambulance	JoAnna Kamppi, Paramedic
Present	Private Ambulance	Sheila Clough
Vacant	Emergency Department Nurse	Vacant
Present	911 Com Dispatch	Mike Fletcher
Present	Community College	Michele Claassen
Present	Hospital Administrator	Eric Swanson, Paramedic
Absent	STAB Representative	Ron Barbosa, MD

Oregon Health Authority (OHA) Attendance
Stella Scott, EMT; Peter Geissert, MS, MPH; Rebecca Long, P; Madeleine Parmley, RN; Rachel Ford, MPH; Veronica Seymour, EMR; Yesenia Rosario; Robbie Edwards; Amani Atallah, P; Leslie Huntington, P; Justin Hardwick, P; Kimberly Aubrey; Dana Selover, MD; Julie Miller; Mellony Bernal; Laxmi Pallathadka; Albert Ramon.

Public Attendance
None.

Call to Order – Jim Cole
The meeting was called to order and roll call of committee members was taken. Quorum was met. The agenda was reviewed, and no changes were requested.

Amani Atallah introduced Albert Ramon, new Research Analyst 3 filling the trauma registry role previously occupied by Andey Nunes, who moved to Health Policy & Analytics.

Interviews were completed last week for an Administrative Specialist 2, a new position supporting committees and EMS Modernization work. The program hopes to have this person hired by early May.

Amani Atallah will be stepping down from her position as EMS & Trauma Systems Program Manager effective May 17, 2024. She thanks the committee for the opportunity to serve them. Interviews for a new EMS & Trauma Systems Program Manager will be held next week.

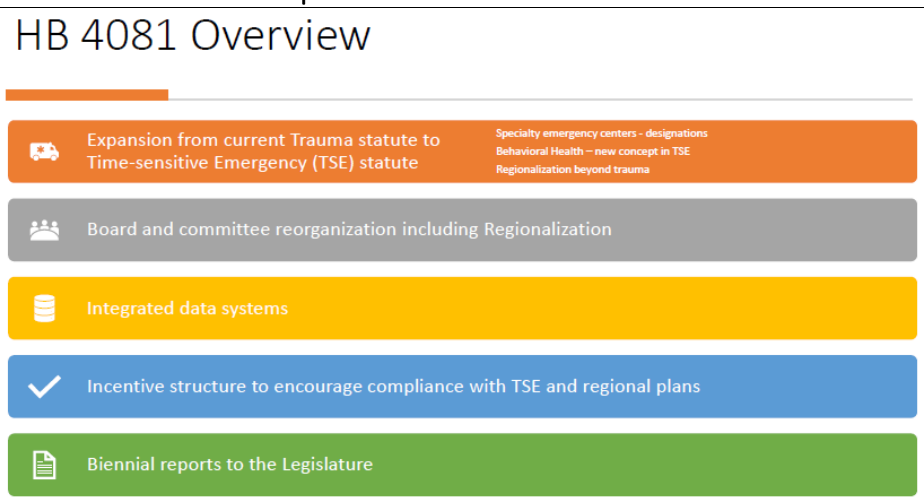
Membership Review – Stella Rausch-Scott

House Bill 4081 (EMS Modernization) passed, which will change the current Oregon Health Authority EMS & Trauma Systems (OHA EMS/TS) committee structure effective January 2025. There are a few vacant positions, but recruitment has ceased for this committee because new members would join for only two meetings. At this time committee will stand with the current members.

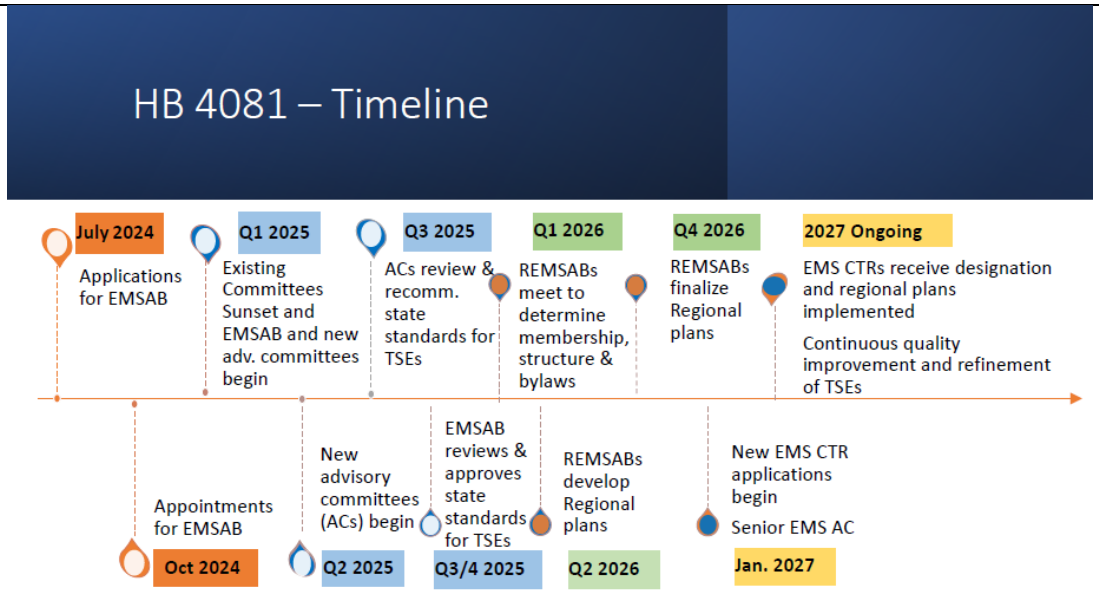
2024 Quarter 1 Minutes – Jim Cole

2024 Quarter 1 EMS Committee meeting minutes were reviewed.
Mike Fletcher made a motion to accept the minutes. Sheila Clough seconded the motion and the motion passed with all members in favor. No changes were requested.

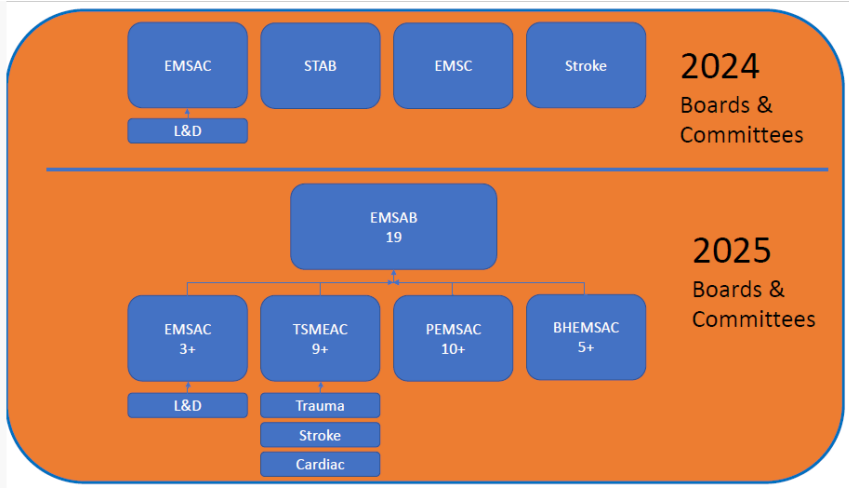
House Bill 4081 EMS Modernization Implementation Plan – Dana Selover



EMS Modernization Bill Phase 1 (House Bill 4081): the long-awaited 'starter package' of updating Oregon's emergency medical services, emergency healthcare, and time-sensitive emergencies. OHA EMS/TS thanks Representative Grayber and her chief of staff, Barrett Johnson, for their work on this.



- 2024: Establish EMS Advisory Board (EMSAB). Members anchored in statute. All existing boards and committees will get information to apply. Appointments in Q4 for first meeting Q1 of 2025.
- 2025: Committees sunsetting and new advisory committees (ACs) begin. The EMS Advisory Board has to review the new advisory committees and approve charge and membership.
- Throughout 2025: Advisory committees meet to set state standards, which are the minimum. Regional plans can add local flavor, then create local protocols to implement.
- Beginning in 2027: EMS centers comply with state standards and regional plans. Senior long-term care committee is currently housed at ODHS and will come to OHA in 2027.

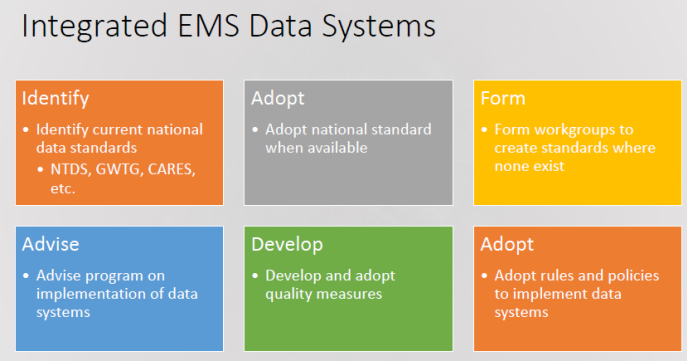


- Numbers listed are the members anchored in statute. Quite variable – EMS Advisory Committee only three members in statute. Time-Sensitive Medical Emergencies has nine members in statute, and it is likely that trauma, stroke, cardiac will end up as subcommittees. Pediatrics has 10 members in statute, which comes from HRSA and federal grant requirements. Behavioral health has five anchored members.
- There will need to be geographic representation across regions.

EMS Centers:

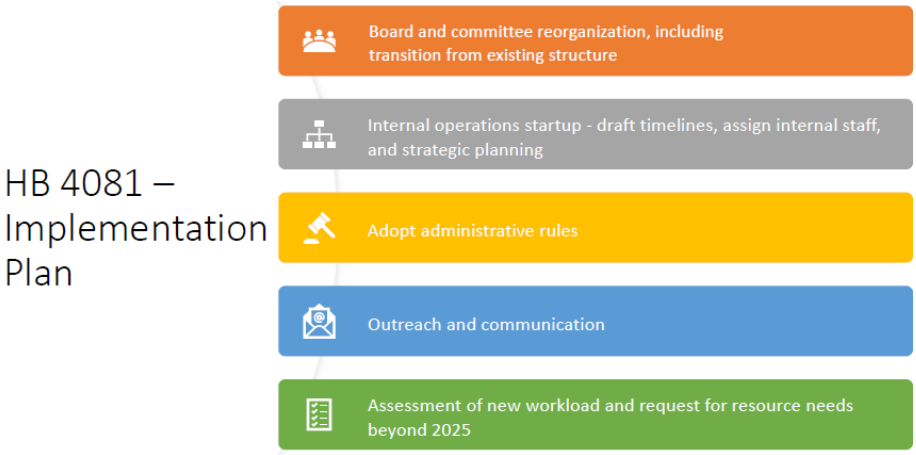
- Functionally, for this purpose, hospitals.
    - There's a lot of non-hospital behavioral health care: the Behavioral Health and Health Systems Divisions are improving the 988 system, crisis care, SUD care, mostly in non-acute, non-hospital settings. However, this discussion principally applies to hospitals.

    - This doesn't preclude patients from receiving care at other types of facilities.
- A system modeled on the current trauma system for stroke, cardiac, and behavioral health care, that prevents duplication and conflict with other systems.
- Regions will likely want to build systems with requirements for categorization but for now it is voluntary, which was important to partners who worked on the bill.



- National standards will be preferred if there are national standards available. Not likely the case with behavioral health; that will be a slow build. State standards will likely go into Oregon Administrative Rules and into regional plans. There is flexibility for hospitals on how they become compliant and adopt data systems.

Implementation:



- OHA will work on the reorganization, transition from existing structure to new while maintaining existing systems, especially trauma.
- Adopting administrative rules – that will be partly for boards and committees, though mostly about new TSE systems; it will be a large production.
- Assessment of new workload and request for resource needs beyond 2025 – this will take place throughout 2024 and into Q1 and Q2 of 2025 to inform legislature's next step in writing and passing Phase 2 of the EMS Modernization legislation, which includes funding appropriately.
    - Legislature also wants to do work on workforce.

Board and Committee Reorganization:

- Membership for the advisory committees needs to be reviewed and finalized by EMSAB.
    - OHA EMS/TS will consider how to communicate about applications for the advisory committees with quick turnaround time.
- Ironing out the relationship of the advisory board with each of the advisory committees and how that will flow. Some is in statute, some is not – decision flow, including to the OHA.
- Advisory Committees will have membership, bylaws, projects, and workgroups.

- For example, EMSAC will have a Licensing & Discipline subcommittee and will also be discussing mobile integrated health and community paramedicine.

Regional Boards:

- Area Trauma Advisory Boards (ATABs) continue. Trauma system will continue through the end of 2026. Will need to figure out the best way to maintain the trauma system while moving under Time-Sensitive Medical Emergencies.
- Implementing state standards with regional plans will be the activity of regional boards. Like the trauma system, there will be local and regional quality projects and coordinating state grants. There will be more conversation about this in planning for 2025 session.

Next Steps:

- Wrapping up all existing boards and committees.
- Communication of implementation plan in meetings with partners – education consortium, fire chiefs, ambulance association, etc.
- Preparing ATABs for transitions.
- Working with existing vendors for data systems to see how we can make that transition.
- Report to partners, public, and legislature.
- Analysis for administrative rules.

Comments/Questions:
Sheila Clough: What type of communication will be going out to public health agencies and counties so that they can help align their planning processes with this new modernization?
Dana Selover: Not on primary communication list. ASP rules are in sore need of updating, which might be the conduit for conversation, integrating EMS modernization into the ASP rules. Video on website about ASPs – mostly for county emergency managers and county public health, but also county EMS.
Jim Cole: Since we already have ATABs, are we looking at a potential redistricting since the system is considering much more than trauma now, or do you think they might hold to the current ATAB areas?
Dana Selover: Very good question, came up in stroke meeting as well. Yes, we already have set regions. In going beyond trauma, there will need to be discussion about areas that have a bifurcated referral systems. No plans to change it right now, but it will be a conversation.
Alicia Bond: Does an individual EMS center have to be an EMS center for all of the specialties or can they only be some?
Dana Selover: It's voluntary and regional. Some hospitals can focus on one specialty designation, some hospitals on others.

Medford EMS Tiered Response Pilot Project – Sheila Clough and Alicia Bond

Sheila Clough, Dr Alicia Bond, and Chief Eric Thompson from the Medford Fire Department previously presented at the EMS conference at State of Jefferson. Chief Thompson is not able to join today; however, he is available for questions and Sheila can provide a connection.

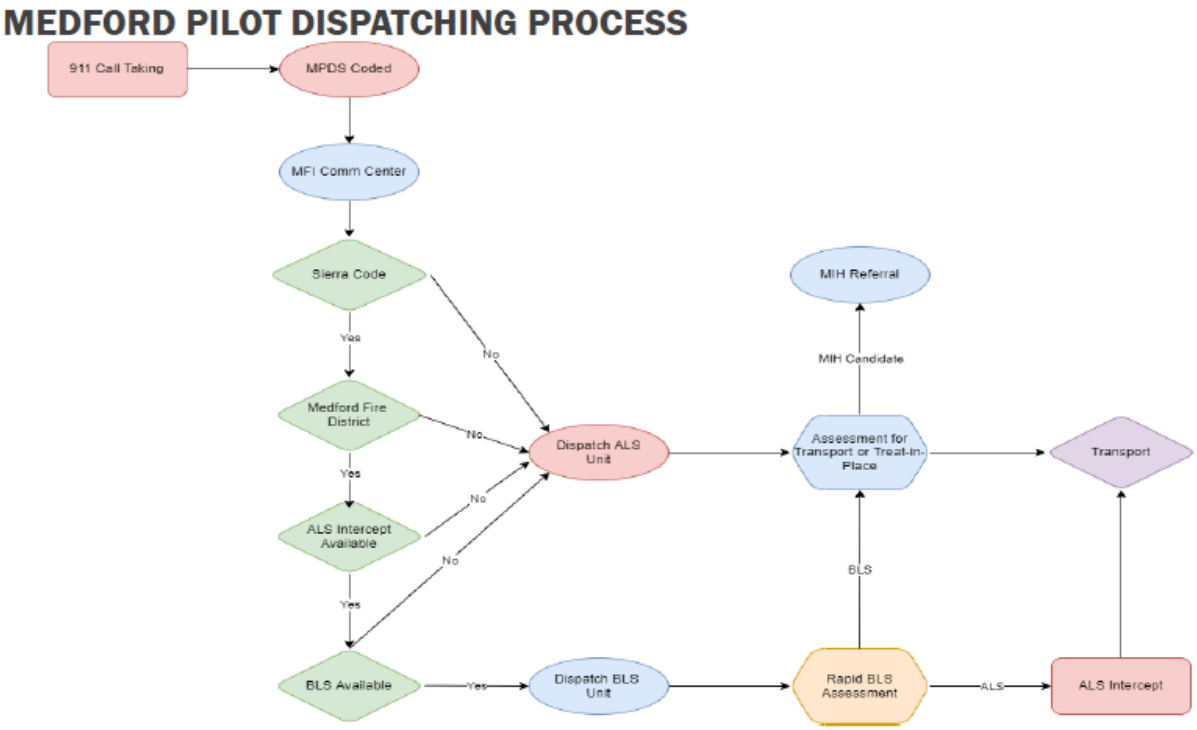
Project started in late 2021. This was in the middle of the pandemic; the demands for medical services were high. Even before the pandemic, there was about a 5% annual increase in requests for EMS services. The region had just gotten through unprecedented wildfires. The community was on edge and concerned about availability of fire resources. Current design to provide services wasn't working.

Initial Research:

- Cannot be the only community dealing with these challenges.
- Looked broadly across the nation. Not surprised to find other communities with similar challenges that were ahead in finding models to solve those problems.
    - Tiered responses: matching the level of medical professionals assigned to a call with the acuity of the patient. For low acuity patients, using basic life support (BLS) resources; for higher acuity patients, using advanced life support (ALS).
    - Communities using those models then also moved onto something more advanced, thinking about nurse navigation, mobile integrated health, and use of telehealth.

Prior to the project, model was single-level, similar to others across the state: ALS unit with one paramedic and one EMT; fire department partners were first responders and were responding to most calls. For the pilot, Mercy Flights added different resources: a quick response unit (QRU) which is an EMT BLS unit deployed for lower acuity minor illness patients, and an ALS interceptor dedicated to the quick response units if situations escalated requiring ALS support. The fire first responders and additional ambulance services were reserved for higher acuity patients.

Tried to be as safe as possible. Ambulance service plan for the county states that ambulance services will provide paramedic level of care. Sheila worked extensively with county leaders to be transparent about setup to prove the concept.



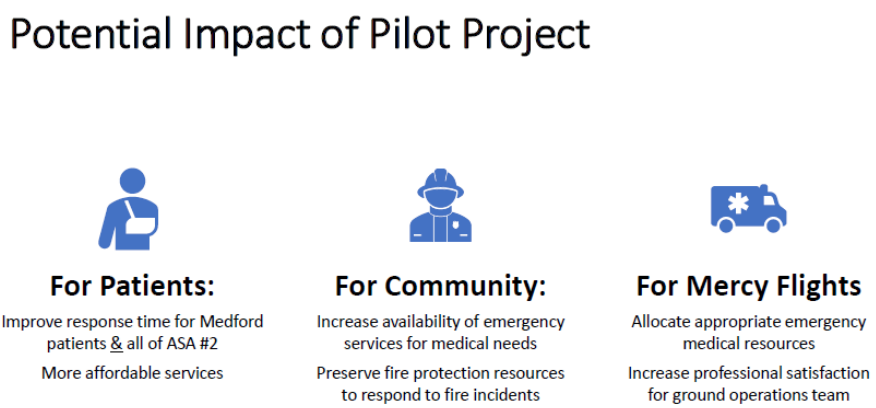
Determining Eligible Calls:

- Mercy Flights chose a subset of Medical Priority Dispatch System (MPDS) codes based on local data. When a call comes into 911 public service answering point (PSAP) dispatch, it is coded with an MPDS code. Mercy Flights has a dispatch center that dispatches their ambulances but doesn't take primary medical calls. The MPDS codes from PSAP go to the Mercy Flights communication center. If it is one of the MPDS codes that had been chosen based on data, it goes into the rest of the system (flow chart).
- Codes were chosen by looking at a year of data and for each of the call types under consideration, asking what percentage of the time they required ALS intervention, and if so,

what was it? Generally used cutoff of about 3% -- if they had less than 3% rate of true ALS emergency, the codes were put in the eligible bucket (Sierra codes). There also needed to be an adequate number of calls to enter into the project; if sample size was too small, it was not included. Dr Bond reviewed every call where ALS intervention was anything other than cardiac monitoring and intravenous access to ensure that they could safely be handled by BLS.

Dispatch Process:

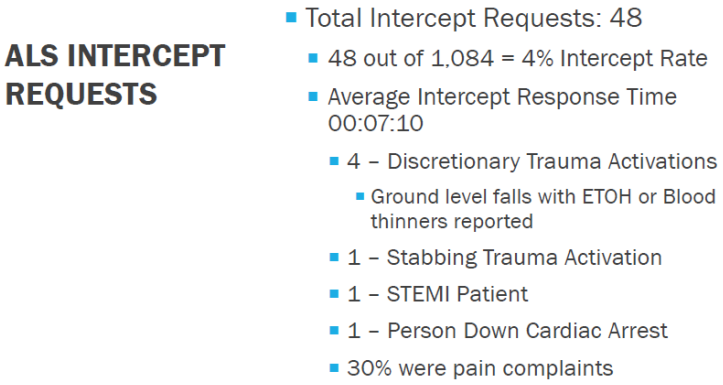
- When a Sierra code is entered into Mercy Flights' system, if it is in Medford Fire's response area, an ALS intercept is available, and the BLS QRU is available, then it is dispatched as BLS.
    - But if any one of those things are missing – if it's outside of Medford, if there's no interceptor available, or the BLS unit is not running – it is dispatched ALS.
- When the BLS crew responds, they determine whether or not they need an intercept, whether they can transport safely, and then transport can take place.
    - Mercy Flights has specific guidelines and training about when BLS units need to activate ALS intercept, when BLS can transport, and what to do for the 1% of calls that require something time-sensitive and emergent.



The pilot was run as an official project for an entire year, measuring outcomes internally. There was an oversight committee, comprising fire chiefs from other parts of the region as well as public health and county agencies, for accountability. Mercy Flights continues to use this model since the pilot period has ended and the outcomes continue to show positive metrics.

Internal Measures/Metrics:

- In the pilot project timeframe, there were about 3900 eligible calls with Sierra codes. The BLS QRU was staffed only for peak hours, about 12h per day, so was only able to capture ~30% of the calls. As more quick responder unit capacity is added, potential for more positive outcomes.
- Of the patients who qualified for QRU, about 61% were code 1 and 39% were code 3.
    - The MPDS system is designed that there is in theory a hot (code 3) BLS response: conditions that require urgent intervention, but the intervention is BLS-level. This was done to set the groundwork for a more robust tiered response system in the future.
    - Dr Bond is doing a larger revision of responses to all MPDS codes based on data. She didn't want to change the programmed response for the entire system based just on codes in the project without doing a complete review. Some Sierra codes that are currently code 3 will be downgraded to code 1 once the database project is completed.
- About 40% of patients did not need transport. It is reasonable to expect that as more of the patients are lower acuity, this will set the stage for treat-in-place protocols. It may help lower the cost of care as well.



- Most of the times intercept requests were non-emergent and often for hip fracture patients the BLS team couldn't move comfortably without IV analgesics.
- There were trauma activations for which they called for backup out of an abundance of caution that did not need ALS intervention.
- There were 3 calls that were true emergencies, but the system worked well. Fire response arrived on scene shortly before the Mercy Flights backup. ALS was available, BLS started lifesaving interventions, and things happed exactly as they are supposed to.

City of Medford was concerned about the impact on fire resources during the pilot. The unit availability for fire responders was improved, wait time was lowered, and overlapping calls decreased, so other area fire districts had to respond to support the district less because of the project.

External Oversight Measures/Metrics:

- Wanted to monitor ambulance service availability: 42% increase in staffed ambulance hours. Instead of reducing resources, resources available increased for the entire county.
- Response times: compliance has increased 1% to 5% in each of the areas. That continues to increase and has been over 90% in every sector's response categories since late 2023.
    - Medford Fire's response times improved as well as code 3 response times.
- Maintain or reduce patient expenses: small, slight decrease in cost to patients.
    - Some challenges in collecting this information; hypothetically it should be a more significant decrease.
- For patient experience, ensure that services were not declining, increase patient satisfaction: 100% of patients who received care from the QRU got a phone call; about 14% of those patients were willing to respond to survey questions. High satisfaction from patients.

Overall, the pilot project was a success. Mercy Flights and Medford Fire are continuing to have this model in their region. The other two ASA providers are considering putting this in their ASAs as well. This has set the foundation and the county is now having conversations on how to build on this.

Comments/Questions:

Michael Cool: For the BLS units that did require transport, are you taking standard ambulance units out of service, or how did you facilitate the transports?

Alicia Bond: The BLS unit has their own ambulance, fully equipped with all the ALS stuff except opioids. The chaser is in a response vehicle that's not a transport vehicle, but they carry the opioids with them. In one case, there was a fire paramedic on scene that wanted to go with the BLS unit, so they jumped in and went to the hospital without a Mercy Flights ALS provider. In another case, the chase ALS provider swapped out with one of the BLS unit people and they drove both units in together, the chase car and

the ambulance. ALS backup also sometimes ends up being an ALS ambulance, so they've swapped crews. There are lots of different ways you could set it up, depending on what your fire department does and doesn't want to do. We left it open for our fire departments, our first responders. We did a bunch of education and said this is what it's going to look like, if you end up on one of these scenes and you're the first one there, totally your call. There's no expectation that you ride in, but if you want to assume care for that patient and ride in with the BLS unit, you're welcome to. Depending on how much those people like EMS, they'll probably do it differently.

Mike Fletcher: I think your program is incredible. We've been trying to do stuff like that in Metro for a while. If the BLS quick response responds on a Sierra call, is that patient being billed for the contact? Whereas with fire when we respond, there's no bill if there's no ambulance transport.

Alicia Bond: Yes. Mercy Flights has a policy regardless of whether BLS or ALS responds. In general, it's similar to the way an ALS unit bills. If the BLS unit transports the patient, they get billed for a BLS level transport rather than an ALS level transport. If they do a refusal, it follows Mercy's policy for refusals. If anyone wants to look at our list of codes and the process we've gone through, I'm happy to share.

Michael Cool: Are you thinking about additions or changes?

Sheila Clough: We're having some conversations with our health systems regarding some other potential options for delivery of care like virtual emergency departments. With our PSAP and fire agencies, we're discussing nurse navigation in trying to triage before sending out resources.

Alicia Bond: Trying to add capacity to the QRU. The other model out there is that in addition to having a BLS transport unit respond, they have even sub-selected further and have a BLS non-transport unit for codes with really low transport rates. That may be something we could look at in the future.

Sheila Clough: From the fire department perspective, they redesigned some of their response, starting to do single role paramedic situations, for even some higher acuity patients, so it improves use of resources.

Dana Selover: With the system infrastructure, it's changing staffing, decreasing one resource while increasing the quick response unit, right? It's right-sizing the workforce, the vehicles – you might need more of the vehicles that can do some of those quick responses versus the full ambulances and that kind of thing. How has the fire department thought about that right-sizing? Because you can't change things like that that are anchored into budgets for years.

Sheila Clough: Chief Thompson has helped the city understand that they need to modify their staffing levels to ensure there are enough resources available for potential fire response versus medical. There's a bit of a challenge in that it starts taking some of the paramedics and EMTs from our agency, but we're working on another project, an apprenticeship project, to collaboratively increase the workforce for those EMTs and paramedics.

Alicia Bond: As we think about expanding this program outside of the Medford area into some of our other response areas, it will look different because the fire agencies will have different needs. Medford really wanted to stop going on low acuity calls. That was part of why this partnership came about. Other agencies don't feel that same pressure and want to do things differently, but still have the appropriate level of care. It's dependent on the agency, their staffing, their needs, their budget.

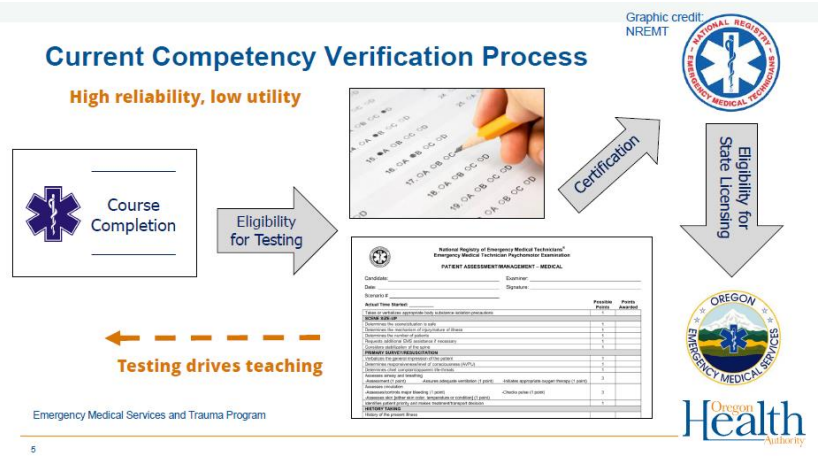
Dana Selover: This will be an important opportunity for change for the statewide workforce considerations in 2025.

Alicia Bond: It has really been like, what else do we need? We can't add all the paramedics we want to sustain the model, but we can add EMTs and some other things. We haven't found that this is making paramedics obsolete. Instead, we can add resources that are easier to get.

Dana Selover: Changes trickle down to educational institutions to make sure they can move people between the levels to right-size. That's a slower conversation but more holistic in terms of implications.

EMS Education Update – Leslie Huntington

National Registry is making changes, especially with practical examinations: isolated skills testing for all EMS provider levels will go away by late 2024 or early 2025. Moving to a competency-based model.



- Current competency verification process has not changed for >30yrs.
    - Standardized testing provides high reliability, but utility has become low.
    - To conduct skills testing now in accordance with National Registry, students do isolated skill stations in a classroom, scored on a scoresheet. While that was probably useful when EMS were more technician-oriented providers, it is not helpful in determining the entry level of competency needed for today's work.
    - In literature: testing drives teaching. Potential conflicts of what needs to be taught for the test versus what is needed to be effective in practice.
- Focus groups with educators in 2021 – feedback was used to look for models and methods of assessment for developing entry-level competence.
- Conflict between standardized testing and more holistic methods of competency is not unique to EMS. There have been some experts able to bring the two worlds together to create a competency assessment system, which is what OHA is using to develop its program.

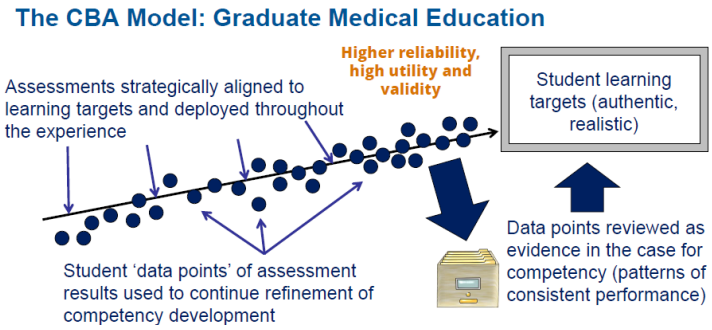
Capturing Competency: NREMT Examination Changes

Paramedic and AEMT	EMR and EMT

July 1, 2024
• Expanding the written (cognitive) exam to capture enduring ('soft') skills
• Dropping the practical (psychomotor) exam requirement
• Expanding eligibility requirements for testing
  • Verification of student minimum competencies (SMC)
  • Paramedic – CAAHEP
  • AEMT- 'State approved'
	2021
	• Discontinued EMR and EMT practical examination materials
	• 'State-approved' practical exam requirement remained
	Late 2024 – Early 2025
	• Similar changes as AEMT are expected

- National Registry will expand their cognitive exam beyond simple multiple-choice format. Drag and drop, prioritizations, reorganizations: interactive technology in exams starting July 1.
    - Looking beyond declarative knowledge and assessing critical thinking, prioritization, scene management, leadership, communication.
- At the end of this year, National Registry will be completely removing psychomotor testing and instead looking for competency verification that has to be done in classes.

Competency-based assessment program goal: align educational and certification practices to assure a statewide assessment system that facilitates student development and achievement of realistic expectations for entry-level competence. Put testing and education on the same plane.



Learning Targets:

1. Patient care.
2. Clinical knowledge and rationale.
3. Interpersonal (and technical) communication
4. Systems knowledge.
5. Professionalism and professional development.

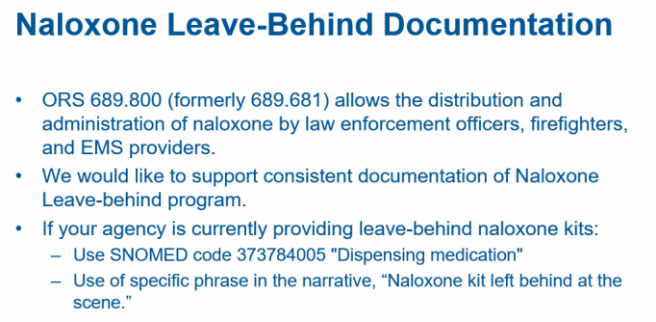
Using learning taxonomies from the literature to embed in learning frameworks. For standardization, there will be a scoring scale. Based on a portfolio of assessment: multiple options for instructors for activities and evaluations to assess whether students are meeting targets.

On track to start implementation by the beginning of the 2024-2025 academic year.

OR-EMSIS Update – Peter Geissert, Laxmi Pallathadka

Update on NEMSIS 3.5 Transition:

- Nationally, significant progress: 40 states are now live and submitting data.
- In Oregon, 128 agencies are live and have submitted at least one patient care report (ePCR); 47 agencies have scheduled or initiated transition.
- Resources are available on the OHA EMS/TS website.
- Brief video tour of new ImageTrend Elite form .



- There has not been consensus about how to document naloxone leave-behind in patient records. OHA EMS/TS supports using a combination of procedure code and narrative.
- NEMSIS is currently reviewing a proposed national custom element for naloxone leave-behind, which will be added to the state data set when NEMSIS review is complete.

Trauma System Integration:

- As NEMSIS 3.5 transition proceeds, it becomes increasingly important to have a working integration with the Oregon Trauma Registry (OTR) that is compatible with the NEMSIS data standard.
- Many discussions within OHA about this; have been working with ImageTrend in the past to develop a solution but there have been some significant delays and complications.
- Working on a solution utilizing Rhapsody to convert NEMSIS 3.5 records into a format compatible with the Oregon Trauma Registry.
- Once additional components are completed and the route tested, it can move to production.
    - Currently 60-70% of the way there, "down payment" has been made but more to go.

EMS & TS Director's Update – Dana Selover, Amani Atallah

EMS/TS Quarter 1 Report ***(see below)***

- Some bills beyond EMS Modernization.
    - Senate Bill 1552, License Prequalification Determination
        - For people who have a criminal record, before starting an educational program and pursuing education and licensure, they can do a prequalification determination to assess whether the existing criminal record would be a disqualifier for licensing later on.
        - Not binding, if additional crimes are committed in period before applying for licensure or if more information comes to light.
        - Not coming into effect until 2025.
    - House Bill 4122, Rap Back
        - "Pulse oximeter for your background check"
        - Opt-in for agencies, but if you opt in, have to use for all licensees; at this time, OHA EMS/TS is not committing to doing that.
        - Moves away from intermittent system of background checks during renewal to a new system of constant management such that regulating agencies and licensing boards will act when something pops up.
    - House Bill 4136, Lane County
        - Somewhat in response to the Sacred Heart University District Hospital closure and changes in that region. Focused on urgent and emergent care innovation. Plan for the learning to go out to other counties, regions, localities as well.
- CARES presentation to come in July meeting; 20 agencies onboarded within the past year.
- Administrative rules:
    - Ambulance rules are in progress. Recruitment for the Rules Advisory Committee has been completed.
    - Education rules are soon to be revised, in line with Leslie's presentation earlier.
    - Exhibit 2 and 3 rules for the trauma system are out. Exhibit 4 rules are pending.
    - Rules information is available on the OHA EMS/TS website.
- SAMHSA grant funding opportunity for first responders and the naloxone leave-behind program.
- Adjustments to trauma band process
- Graduate-level paramedic as federally recognized practitioners
    - NEMSAC is asking for public comment on the draft recommendations.
    - Recommendations
    - Comment/feedback survey

EMS for Children Update – Rachel Ford

• New Prehospital Pediatric Readiness Project Assessment will be sent out in May to all EMS transport agencies.
  ○ Before completing, agencies should collect their annual call volume, their annual pediatric call volume, and the number of personnel in their agency.
  ○ Assessment takes 30-45 minutes to complete. At the end, agencies will receive a report that identifies specific gaps in pediatric readiness.
• Tourniquet distribution: 317 tourniquets to 15 rural or frontier sheriff offices.
• Agencies are encouraged to sign up for the HERO Kids Registry app.
  ○ 65 EMS agencies have accounts.
  ○ Enables access to HERO Kids and POLST registry.

Public Comment – Jim Cole
No public comment.

QUARTER 1 REPORT | PUBLISHED APRIL 2024

Data timeline for this report: December 1, 2023 – February 29, 2024

EMS & TRAUMA SYSTEMS

PORTLAND STATE OFFICE BUILDING | 800 NE OREGON STREET, SUITE 465, PORTLAND, OREGON 97232-2162

Oregon Health Authority

EMS & Trauma Systems Contact information:
www.healthoregon.org/ems | 971-673-0520

Oregon EMS & Trauma Systems | EMS.TRAUMA@odhsoha.oregon.gov
Oregon EMS Professional Standards Unit | EMS.PSU@odhsoha.oregon.gov

CONTENT:

EMS & Trauma Systems Manager's Update

Happy Spring, EMS & Trauma Systems Community

Welcome Albert Ramon, our new Research Analyst 3! Albert comes to us with experience in data analytics, marketing, planning, and research. He is a recent graduate from Willamette University with a Master's in Business Administration. He is currently in his 6th week and learning all there is to know about his new role, especially the Oregon Trauma Registry, the database he will be most supporting. We are very excited to have him join our team and are already so grateful for how he's contributed to our program!

Congratulations to the EMS & Trauma Systems Program, the EMS Community, and Representative Grayber for the nearly 20-years-in-the-making EMS Modernization Bill passing! Our program is excited to start the planning process and we hope to engage the committees in Q3 and Q4.

We are in the final stages of recruitment and hiring for a new position with our program, an Administrative Specialist 2. This position will be supporting general committee duties, Time Sensitive Emergency work that is associated with the EMS Modernization bill, and the exciting Competency Based Education work that our program has been committed to launching for Oregon EMS education programs. We hope to have an introduction of our new staff member in Q3.

It is with bittersweet sentiment that I announce my departure from the EMS & Trauma Systems Program, effective May 17th, 2024. I have had some personal life changes that have contributed to my decision. I want to thank everyone for the opportunity to let me serve you in the capacity that I have, and I am confident that the next person who holds this role will be stellar. We hope to have the new manager hired by May and look forward to introducing them to the EMS & Trauma Systems Community during the Q3 committee week as well.

Thank you again and I leave you all in the best of hands.

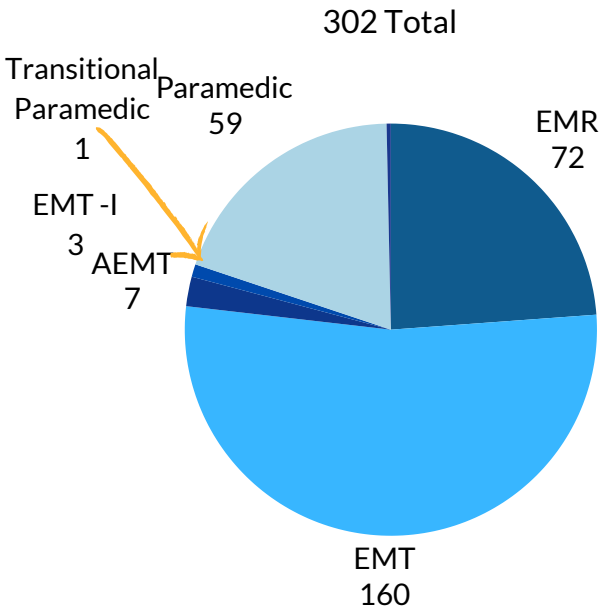
Happy Spring & Be Safe,
Amani

Professional Standards Unit (PSU)

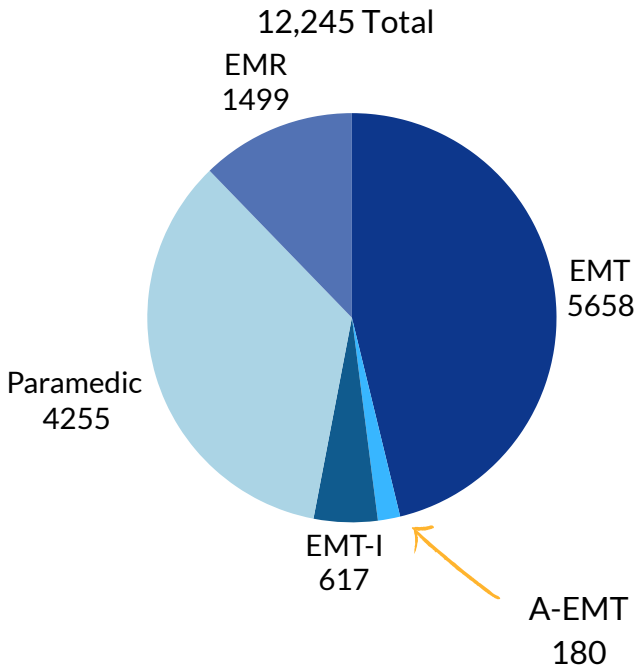
Data timeline for this report: December 1, 2023 – February 29, 2024

EMS Licensing and Relicensing Review

EMS Initial License Issued



Total Active EMS Providers



Summary of regulatory activities

- Investigations opened: 15
- Investigations closed: 27

- Investigations pending: 123
- Licensees currently on probation: 8
- Licensees reinstated:
  - EMR : 0
  - EMT: 8
  - AEMT: 1
  - EMT - Intermediate: 0
  - Paramedic: 1

- Continuing education audits completed: 10

Actions

- Letters of concern issued: 12
- No action taken/Background cleared for approval: 8
- Stipulated Agreement, Probation: 0
- Stipulated Agreement, License Surrender: 0
- Letters of Reprimand: 1
- Civil Penalty: 0
- Closed Inactive: 6
- License Expired Under PSU Review: 0
- Merged with another case: 0

Ambulance and Services Licensing

Data timeline for this report: December 1, 2023 – February 29, 2024

New Ambulance Services

- Initial Service License Applications received: 0
- Initial Service License Applications issued: 2

New Ambulance Vehicles

- Initial License Applications received: 13
- Initial Licenses issued: 8
- Exception documents reviewed: 4

Ambulance Service Surveys

- Initial ambulance service survey conducted: 1
- Annual ambulance service surveys conducted: 2
- 2024 Ambulance Service Surveys scheduled: 32

Corrective Action Plans:

Licensed ambulance services receiving a deficiency letter after a routine ambulance service survey are required to submit a corrective action plan to OHA-EMS.

- Deficiency letters issued: 2
- Corrective action plans reviewed and approved: 2
- Corrective action plan revisions reviewed and approved from previous quarter surveys: 7

Variance/Waiver

- Number of ambulance services currently utilizing rural staffing OAR 333-255-0070 (4) : 14

The requirements of this Rule are to be meant annually if needed. In this quarter, 2 of the 14 services have submitted the requirements to OHA-EMS to use this Rule for another year.

- Volunteer licensed ambulance service approved to respond to an emergency scene without a full crew, per OAR 333-255-0070 (6): 1

Agency Application and Form Updates

- The Initial Ambulance Service License application is available by request in the License Management System.
- Survey checklists for ground and air ambulance services can be found on the Ambulance Service and Licensing Forms and Application webpage
- Ambulance services are now able to use a secure SharePoint process to upload pre-survey documentation for OHA-EMS review during an ambulance service survey. This process will be followed by a virtual or on-site survey of the facility, records, and ambulance vehicles.

PSU Projects

Assisted with bill analysis during the legislative session. See OAR Legislative Update.

Working with the EMS team to revise and update:

- EMS Provider applications for improved design, function, and value.
- EMR renewal application, opening April 1, 2024.

Current rule revision and new rule development projects

- Initial EMS Provider education
- Ambulance service and vehicle licensure requirements
- Oregon Medical Board Scope of Practice changes

Working with the Subcommittee on Licensure and Discipline to revise current investigative policies and procedures.

Staff converted the previous Complaint Form from a fillable PDF to a Smartsheet document. This new form can be found on the main EMS/TS webpage, under Submit a Complaint. This new format will assist staff with the intake, processing, and tracking of complaints as they are submitted.

Rebecca Long serves on the following:
Department of Public Safety, Standards, and Training (DPSST) Telecommunications Policy Committee and attends quarterly meetings.
PSU representative on quarterly National Association of EMS Officials (NASEMSO) meetings, including the Personnel Licensure Committee.

Veronica Seymour represents the PSU on quarterly National Association of EMS Officials (NASEMSO) meetings, including HITS (Highway Incident Transportation Systems), AVL (Agency and Vehicle Licensure), and Air Medical.

Medical Director & Supervising Physician Application

- **Sarah McClure DO (DO211710):** Timberline Medical Services, LLC (0923)
- **David Lehrfeld MD (MD161989):** DPSST Safety Program (2443)
- **Laurene E Reed DO (DO214960):** Douglas County Fire District No. 2 (1016), Glendale Ambulance District (1007), MedCom Ambulance Authority (1011), Umpqua Valley Ambulance (3638), Winston-Dillard Fire District (1014)
- **Patrick Hudson MD (MD193002):** White Bird Clinic/CAHOOTS (2060)

Committee Information

Vacant Committee positions and recruitment
HB 4081 will go into effect Jan1, 2025. With the reconstruction of the committees and boards our office will focus our efforts into recruiting the new boards starting Summer 2024.
More information will be provided for the opportunity to serve on the different boards and committees in the coming months.

2024 Meeting Dates:
April 11-13
July 11-13 | October 10-12
Meeting information - Attendance

Trauma Program

COMPLETED

- Full trauma reverification survey: 0
- Focused review trauma survey: 5

- Scheduling for 2024 is in progress:
  - 14 full reverification surveys
  - 6 focused review surveys
  - 1 ACS verification survey

- Quarterly meetings for trauma program managers, coordinators and registrars are ongoing, with good attendance and participation.

- The RAC for Exhibits 2 and 3 met on December 5, 2023, and the proposed exhibits were presented at that time. Please see the Legislative and Rule Update for more information.

- Work has begun on updates for Trauma System Rules including Exhibit 4 and the preparation of a crosswalk to the new Resources for the Optimal Care of the Injured Patient 2022 Standards. At this time, there is no new information that ACS will add an addendum to the 2022 Standards for Level IV trauma centers. As such, the program will commence with plans to convene a RAC addressing Exhibit 4 in 2024.

Education & Examinations

Data Timeline for this Report: December 1, 2023 – February 29, 2024

EMR Course Applications Approved: 16

College course applications (2023-2024 academic year)
College course applications were processed

- EMT:39
- AEMT: 4
- EMT-I: 3
- Paramedic: 9

National Registry Psychomotor Exams Conducted: 1 AEMT | 1 Paramedic

NREMT examination transition
On July 1, 2024, NREMT will discontinue all psychomotor testing for the AEMT and paramedic levels and implement a new computer-based performance exam with the cognitive exam. EMT and EMR examinations are slated for a similar transition in late 2024 or early 2025. Changes to the NREMT EMT and EMR examination processes are expected in late 2024 or early 2025.
Eligibility for NREMT paramedic testing will require course-level verification of student competencies, as determined by the Commission on Accreditation of EMS Educational Programs for the EMS Professions (CoAEMSP). Eligibility for the NREMT AEMT examination will require course-level verification of student competencies, as determined by state EMS offices.
OHA-EMS/TS is implementing a Competency-based Assessment Program for EMT and AEMT courses.

Competency-based assessment (CBA) program for initial education
College EMS instructors and program coordinators are continuing to incorporate CBA processes and infrastructure into their EMT courses. Biweekly workgroup sessions with instructors are ongoing as well. These sessions focus on technical support for instructors, shared learning, instructional development, and feedback. Development of state accountability processes and tools for the program is ongoing. AEMT competencies and outcomes are developed and under review.

2024 Oregon EMS Conferences:
Oregon EMS Conference – September 27-29

Oregon Emergency Medical Services for Children (EMSC)

Prehospital Pediatric Readiness Project Assessment
In May 2024, EMS transport agencies will be asked to complete the PPRP Assessment.

Before completing the assessment, agencies should collect the following data:

- Annual call volume
- Annual pediatric call volume
- Number of personnel in your agency at each level of certification

The assessment will take 30-45 minutes, and you will receive a report that identifies specific gaps in the EMS agency's pediatric readiness. For tools to improve pediatric readiness, check out the Prehospital Pediatric Emergency Care Coordinator section of the EMSC website, www.oregonemsc.org.

NEW PRP PEDIATRIC READINESS PROGRAM SERVING OREGON & SW WASHINGTON

www.pedsreadyprogram.org

Register for this FREE class!

Registration is open for the May 9th 1200-1300 education session, ***Pediatric Readiness in the Emergency Department: Does it translate to better outcomes?*** presented by Dr. Beech Burns. CME for physicians and CE for nurses and other medical professionals is available.

Check out the ***Pediatric Fentanyl Exposures education session*** posted on the Pediatric Readiness Program website.

Tourniquet Distribution
To strengthen Oregon's EMS system, the EMSC Program offered life-saving tourniquets to Sheriff's offices that serve rural and frontier communities. They were instructed to only request the exact number that would be immediately deployed. **There were 15 offices that submitted requests and 317 tourniquets were distributed.**

EMSC Advisory Committee Vacancies
The EMSC Advisory Committee is recruiting to fill the *Nurse with pediatric experience* and *Tribal EMS representative* positions.

For more information, contact Rachel Ford at 971-673-0564 or rachel.l.ford@oha.oregon.gov. Apply here: www.surveymonkey.com/r/EMSTSCOMMITTEE

Oregon EMS Information System (OR-EMSIS)
Oregon Trauma Registry (OTR)

Data Quality Assurance
The 2024 NTDB updates were implemented January 10th, 2024. A system back up was performed prior to the updates. The Office of Information Services was involved to provide technical support for the implementation. Only one small bug was detected impacting a very limited number of picklists and was promptly fixed.
Oregon EMS & Trauma Systems has received a grant from ODOT to fund the Data Quality Monitoring Plan. In the coming year the team will be adding positions to support this work.

NEMSIS 3.5 Implementation
As of the end of the Q1 2024, 119 agencies are submitting NEMSIS 3.5 data to OR-EMSIS, and 60 more are in process. We expect the percentage of ePCRs in 3.5 format to increase as we move into the next quarter. The data team continues to reach out to agencies that have not yet scheduled their transition date and support agencies in process. Resources with more information about NEMSIS 3.5 and the Oregon implementation plan are available through our web site.

Oregon Trauma Registry
Contract negotiations with ImageTrend for their Patient Registry product are currently underway. This new Trauma registry solution is expected to be implemented in production before January 2026.

Reporting
The contract with Procogia for Posit (R-Studio) Team Implementation and Hosting was executed in Q1 2024. This programming and web-based collaboration platform will help us meet grant-related deliverables while aligning with the programs' strategic goals. We are currently planning for implementation, initiated on March 15th.

Data Requests and Partnerships
In Q4 2023, the Oregon EMS & Trauma Data Team paused review of new project proposals in order to complete projects already in process. In Q1 2024 the data team has received new data requests from external researchers including:

- **OHSU - Reducing disparities for children in rural emergency resuscitation (RESCU-ER)**
- **OHSU - Surveillance of health outcomes among American Indians and Alaska Natives in OR EMS data**

A new data governance process for granting access to deidentified EMS data to local public health jurisdictions for public health practice through ESSENCE complete and will be going online in Q2.

Data Integration Projects

Work to implement the integration between the License Management System and OR-EMSIS is ongoing. Since the beginning of the project, 316 agencies have been synced. During work on deduplication of users in Elite, a bug in the user merge process was discovered which was disrupting user information. Because of this, work on user accounts has been placed on hold. Work on this project will resume in late March.

The project with Oregon-Idaho High Intensity Drug Trafficking Area (HIDTA) to integrate EMS data into the Overdose Detection Mapping Application Program (ODMAP) system is under development using the Rhapsody Integration Engine. This project implements an EMS specific definition for drug overdose, geocodes scene locations, masks the precise location of the incident to protect patient confidentiality, maps NEMSIS data elements to ODMAP data elements, formats an output file, and sends this deidentified data to the ODMAP system. The Rhapsody route is currently under development. Testing of the connection to the ODMAP system is currently underway in Q1 2024.

Ambulance Service Plans (ASP) Review

In accordance with OAR 333-260-0020(7), the OHA EMS & Trauma Systems Program reviews county Ambulance Service Area (ASA) plans for compliance with state regulations at least once every five years. The OHA EMS & Trauma Systems Program is working with counties to ensure all ASA plans have been determined to be compliant with state rules within the past five years. Counties with outdated approvals are being prioritized for review.

Currently Under OHA Review

Clackamas
Harney
Lane

Counties with approved plans

Clatsop
Columbia
Gilliam
Josephine
Lincoln
Linn
Malheur
Marion
Morrow
Sherman
Wasco
Washington

Counties with outdated ASPs - older than 5 years

Benton
Coos
Curry
Deschutes
Douglas
Grant
Jackson
Jefferson
Multnomah
Polk
Tillamook
Union
Wheeler

Returned for Requested Revisions

Baker
Crook
Hood River
Klamath
Lake
Umatilla
Wallowa
Yamhill

Cardiac Arrest Registry to Enhance Survival (CARES)

Congratulations to all our 2023 CARES participants. The Oregon 2023 data is completed with NO lost-to-follow-up cases. Thank you for prioritizing the CARES data timelines to keep our state in compliance for 2023.

For 2023, 71 agencies submitted to the CARES registry. This is the highest group of Oregon agencies with a jump of over 20 agencies from 2022.

Participants will receive their final 2023 CARES reports the first part of May 2024. GEMT CMS Supplemental Payment Program for agencies participating in CARES is open to all Private and Public transporting agencies. Information on GEMT payments and to confirm your enrollment can be found on the GEMT website.

Mobile Intergrated Care / Community Paramedicine

International Board of Specialty Certification – Community Paramedic Certification.

Oregon's Mobile Integrated Health/Community Paramedicine coalition is meeting and working to support the different programs in Oregon. If you are interested in attending the meetings or would like to receive current notifications and updates from the coalition submit your contact information to the coalition: Coalition Signup

MIH/CP Coalition has partnered with OHSU Knight Community Outreach and Engagement Program to identify the current state of Oregon's MIH/CP programs. This survey is intended for **ALL agencies, even those without MIH/CP programs**. To participate in the survey, scan or click on the QR code.

Rule and Legislation Update

Legislative Update

The 2024 Oregon Legislative Session convened on February 5, 2024 and adjourned on March 7, 2024. Legislative measures that were tracked by the program that may be of interest to the EMS community are summarized in the attached legislative report. The following measures passed and will have a direct impact on the EMS and Trauma Systems program:

- HB 4081 – EMS Modernization Act
- SB 1552 (Section 44) - License Prequalification Determination
- HB 4136 – Lane County Innovation for Emergency/Urgent Care

Helpful links and information relating to the Oregon Legislature:

- Oregon Legislative Information System (OLIS) (2024)
- Status Report for all legislative measures (2024)
- Viewing legislative public hearings (scheduled or archived):
- How Ideas Become Law

Sign up to receive email updates on legislative news and other information through Capitol e-Subscribe.

Administrative Rules

Field Triage (Exhibit 2) and Trauma Team Activation (Exhibit 3) - A Rulemaking Advisory Committee (RAC) was initially convened in October 2022 to discuss proposed changes to Trauma Rules (OAR 333-200-0080). The proposed changes under consideration included adopting the revised 2021 National Guideline for Field Triage of Injured Patients (Exhibit 2) and amending the Trauma Team Activation Criteria (Exhibit 3) by incorporating changes based on the revised field triage criteria. The RAC met in October and November 2022 and reconvened in December 2023. Meeting notes are available on the EMS Rulemaking Activity page, under 'Rulemaking Advisory Committees in Progress.' A Notice of Proposed Rulemaking was filed and posted in the January 1, 2024, Oregon Bulletin and a public hearing was held on January 17, 2024. The written comment deadline closed at 5:00 p.m. on January 22, 2024. Staff are considering both the oral and written comments and final rules will be filed within the next couple of weeks.

Rule and Legislation Update

Ambulance Service/Vehicle Licensing Requirements - An Ambulance Service/Ambulance Vehicle RAC is being planned for late spring 2024 to discuss amendments to ambulance service and ambulance vehicle licensing requirements. Information regarding this RAC was shared via email with all ambulance service agencies, State EMS Committee members, as well as persons who had previously expressed interest in serving on a RAC. The RAC recruitment closed on December 15, 2023, and persons selected to serve have been notified. The proposed rules are currently being considered by the Department of Justice for legal sufficiency and more information will be forthcoming.

Interested in Serving on Rulemaking Advisory Committee?

Persons and communities interested in serving on future EMS related Rulemaking Advisory Committees (RAC) are encouraged to complete and submit the RAC Interest Form. RACs are an important process that allow members of the public and communities who are affected by administrative rules relating to EMS regulatory functions to provide input. For more information, please visit the EMS Rulemaking Activity web page under 'General Interest in Participating in Rulemaking Advisory Committees.