Oregon Emergency Medical Services for Children Advisory Committee Meeting Minutes

2024 Quarter 4 | October 10, 2024
Chairperson Justin Sales, MD
Vice Chairperson Christa Schulz, MD

Appointed Committee Members		
Committee Member Name	**Committee Position**	**Present, Absent or Vacant**
Tamara Bakewell	Family representative	Present
SunHee Chung, MD	Physician with pediatric training	Present
Jeffrey Dana	At-large member	Present
Carl Eriksson, MD	Pediatric Emergency Preparedness representative	Present
Jennifer Eskridge	Injury Prevention representative	Present
Matthew House	EMT/Paramedic currently practicing, ground level provider	Absent
Kelly Kapri	Highway Traffic Safety representative	Absent
Joann Lundberg	Behavioral Health representative	Present
Todd Luther	Emergency Department manager	Present
Danielle Meyer	Hospital Association representative	Present
Matthew Philbrick	EMS Patient Transport representative	Absent
Dana Pursley-Haner	EMS Educator	Present
Justin Sales, MD	Emergency Physician	Present
Christa Schulz, MD	Pediatric Hospitalist	Present
Jill Shipley	Hospital Trauma Coordinator	Absent
Vacant	Nurse with pediatric experience	Vacant
Vacant	Tribal EMS representative	Vacant

HRSA EMSC Grant Required Committee Members		
Committee Member Name	**Committee Position**	**Present, Absent or Vacant**
Rachel Ford, MPH	Oregon EMSC Program Manager	Present
David Lehrfeld, MD	OHA EMS Representative - Primary	Present
Dana Selover, MD	HRSA EMSC Grant Point of Contact	Present
Adam Wagner	OHA EMS Representative - Secondary	Present
Oregon Health Authority EMS & Trauma Systems Program Staff		
Robbie Edwards, Peter Geissert, Julie Miller, Nicole Perkins, Albert Ramon		

Guest Speakers and Members of the Public

Dr. Matt Hansen (Oregon Health and Science University), DeWayne Hatcher (OHA Health Security, Preparedness and Response), Kelsey Mounts (Doernbecher Children's Hospital), Abriana Smith (Arizona EMSC Program Manager), Susan Steen (Doernbecher Children's Hospital)

Call to Order | Justin Sales, Chairperson

Start Time: 9:02 a.m.
Committee Roll Call

Approve July 2024 Minutes | Chairperson

July 2024 minutes were reviewed. No changes noted.
Motion to approve minutes as written: Christa Schulz
Second: Todd Luther
None opposed. Motion carried.

Committee Membership | Chairperson

Recruitment continues for the new EMS for Children Advisory Committee (EMSCAC).
Applications received:

Position	# of Apps	Regions
(2) Physician specializing in the treatment of pediatric emergency patients	**0**	
(1) Nurse who has pediatric experience	1	1
(1) Physician with pediatric training	2	5, 7
(1) Emergency medical services (EMS) provider	**0**	
(1) Family representative	1	1
(1) Representative of a patient equity organization or an academic professional specializing in health equity	**0**	

October 31 priority deadline; decisions will be communicated to applicants by November 27.

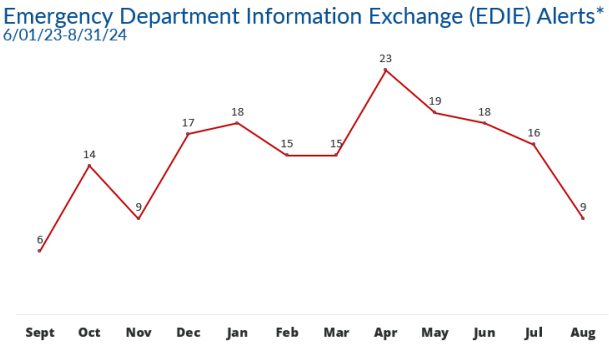
Comments/Questions:

- **SunHee Chung**: What is the difference between physician specializing in pediatric patients and physician with pediatric training? **Rachel Ford**: Pediatric training could be pediatrician, surgeon, etc. Specializing in pediatric patients is more emergency-focused.

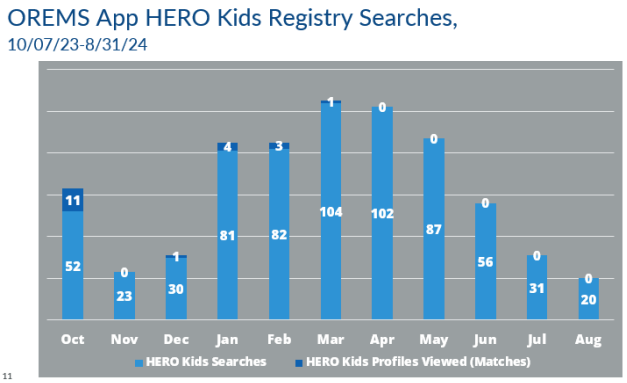
Boards & Committees webpage has more information including details on required qualifications.
To apply for committee positions: LINK

HERO Kids | Tamara Bakewell, Oregon Family-to-Family Health Information Center

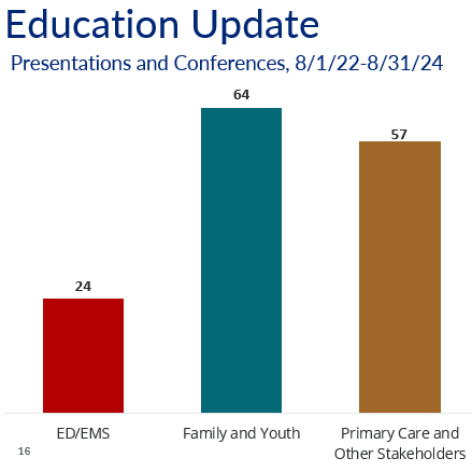
- **Registration**: April 2024 was the highest month to date (29); 415 total at the end of August.
- **County distribution of registrations**: 26/36 counties (1 more since last meeting), 3 frontier counties, 23 rural counties, includes all urban centers. Connecting with partners in counties with no registrations for help in reaching rural families.
- **Emergency Department Information Exchange (EDIE) alerts & OREMS App HERO Kids Registry searches**: EDIE alerts generated when patients with HERO Kids registration arrive in emergency departments. EMS providers search OREMS app when treating patients up through age 26. 73 agencies have an OREMS account.
    - **Rachel Ford**: Downturn in EDIE alerts and for app use; included both POLST Registry and HERO Kids searches. Plan to conduct brief survey on how EDIE and OREMS are working, what providers need, connectivity issues, etc.



- **OREMS App**:
    - **Rachel Ford**: Initially agencies enrolled individual users; now they can do mass enrollment by submitting a spreadsheet with names and email addresses to take the burden off the agency.
- **Social media campaigns**: Marketing continues to be a big focus because many people still do not know about HERO Kids. New campaign ads have been viewed 1.5 million times. Videos can be shared for others to post to their accounts.



- **New marketing**: Billboards on I-5 Portland to Ashland, and in Portland, Klamath Falls, and the Gorge; ended August 31. Google ads are running, delivered to those Google identifies as living in Oregon and having a family.
- **In-hospital marketing**: Currently up at Randall Children's, Doernbecher, and Oregon Burn Center. Team will work with any hospital on this.
- **Education/outreach update**: Will provide information and materials to any partners who want to promote HERO Kids.
- **Requests for continued support**: Volunteer to take information to colleagues and families, connect by leveraging contacts, share ideas with HERO Kids leadership team.



Comments/Questions:

- **Justin Sales**: It has been exciting hearing about its development and watching the numbers grow.

- **Tami**: Primary questions from families are, “Is it for people over 26?” and “Why is it only for kids?” Second most common is, “Is it connected to law enforcement?” There are more people saying they know about it but have not registered yet. It does take some concentrated time to complete registration. People also need to hear about it more than once. **Justin**: Why do you think they are asking about law enforcement? **Tami**: Behavioral concerns. **David Lehrfeld**: Law enforcement are not licensed healthcare providers but they are making initial triage decisions about whether something is a criminal activity or a behavioral health issue. Have met with Portland Police Bureau behavioral health unit because they are not connecting with emergency medical care providers. EMS has “one leg in public health and one leg in public safety,” which has been an ongoing challenge. **Christa Schultz**: With 988, is law enforcement still responding to the majority of behavioral incidents? **David**: Have not looked at numbers recently. 988 can provide behavioral health resources, but if it is anything else, it goes back to 911 for service dispatch.
- **Rachel Ford**: Met with the Oregon Pediatrics Society and they will push information to their members. Also sent a comprehensive HERO Kids information package to agency medical directors. Brittany received a listserv from the Oregon Medical Board and will be doing an outreach campaign.
- **Tami**: Doing a lot of outreach with early intervention and developmental disabilities (DD) programs. DD conferences may influence registration.
- **Joann Lundberg** [via chat]: Has there been any coordination with other police departments’ behavioral health units? **Tami**: No.
- **Christa**: Any updates on when the emergency protocol piece will be released? **Tami**: Not yet. **Rachel**: Undergoing last review from OHSU legal before pushing it out. **Tami**: Legal asked for changes with signatures, but do not know the details. **Christa**: Once that happens, may get uptick in searches from EDs when folks know the letters are in there.

Pediatric Research | Matt Hansen, OHSU

Pediatric Emergency Care Applied Research Network (PECARN) study led by Dr. Julie Leonard has generated and validated a new clinical decision rule for cervical spine (c-spine) clearance. Of >20,000 children included in the study, >400 had c-spine injuries. Currently for physician clearance in emergency departments; it has not yet been validated for EMS, though the study collected data for both. EMS version is likely to be quite similar if not identical. Until formally published, this should be implemented in EDs, with data soon to come for EMS.

Committee Member Roundtable | Committee

Share updates related to committee position: pediatric emergency medical, trauma, injury prevention, behavioral health, and/or family-centered.

Danielle Meyer: No updates.

Carl Eriksson, MD: Recently attended an American Academy of Pediatrics (AAP) national meeting and serve on national executive committee on children and disasters. Struck by the fact that over the past two to three years, have noticed people mentioning Oregon positively with respect to the relationship

between public health and healthcare (providers, including EMS, and acute care hospitals generally). The impression about ten years ago was that Oregon was far behind other states. Some of the newer work, like the Oregon Medical Coordination Center, is only active in a few states as an ongoing program, and it is available to help kids any day at any time. Nice to hear impression is improving.

Todd Luther: No updates.

SunHee Chung, MD: Recently worked on pediatric termination of resuscitation (TOR) protocol in regional protocol committee. OHSU receives medical resource hospital (MRH) calls from EMS for consultation or online medical control in cases involving pediatric cardiac death at outside hospitals. Lots of discrepancies between EMS providers and physicians on when to stop resuscitation, and it is causing confusion. Have come up with rules so that if the patient meets certain criteria, they can call termination of resuscitation in the field. Has been rolled out in other parts of the country: Maryland, for example, has a robust pediatric TOR protocol, which we adapted.
Medical Termination of Resuscitation protocol for tri-county area – provided by Dr. Chung:
When the patient meets all criteria below, EMS may terminate resuscitation without further consultation.

- Patient remained in asystole for duration of resuscitation. If at any time there was a shockable rhythm or PEA, they should be transported.
- **Resuscitation has been ongoing for at least 30 minutes.**
- **At least 3 doses of epinephrine have been administered.**
- **There is adequate safety/support on scene.**

If they meet all criteria, have decided regionally that yes, there can be TOR without confusion. Has just rolled out regionally. **Rachel Ford**: Can share with the committee. Just for tri-county area? **SunHee**: Yes. **Justin Sales**: Mentioned resources to support family – description of what those should be? **SunHee**: Counties have different resources, like calling in religious community leaders, but not very concretely defined. Dependent on EMS provider or clinician judgement of ability to handle in field versus going to the hospital for family support. **Christa Schulz**: Was this working with each individual agency? **SunHee**: Discussed in tri-county protocol development committee. **Tami Bakewell**: Is there an opportunity for family voices in the next steps about resources? **SunHee**: Yes, we would support that. **David Lehrfeld**: For MRH, who takes the calls? Is there specialized training? **SunHee**: Adult emergency medicine (EM) calls can go to third-year residents, but pediatric calls must go to the attending. There are pediatric EM fellowships and they go over the MRH training every year, but the attendings are not required to attend every year. **David**: OHSU has an EMS fellow now as well.

Tami Bakewell: Recently had family partners from the Family-to-Family Health Information Center (F2F) assist Dr. Trisha Wong with her new study on provision of blood products on scene. New to our group to talk about these topics with researchers. Dr. Wong thought it would be quick, needed family input for the institutional review board (IRB), but it took a lot of time as families had much to discuss with many thoughtful comments. Excited that we got to do that and would welcome doing more in the future.

Jennifer Eskridge: For injury prevention awareness, September was baby safety month and October is safe sleep month. November 18 is the fifth annual national injury prevention day. Fairly new but has support behind it, about twenty national partners. Some landmarks in Portland may be lit up in green for

the day. Only local event so far is at Randall Children's, tabling and outreach. Other seasonal focus areas from partners: pedestrian safety on Halloween; cold weather including carbon monoxide poisoning; sports safety and helmets, for sledding and other winter sports; lead poisoning prevention. Lots of resources for topics people are passionate about or their organization wants to get on board with. **Rachel Ford**: Send campaigns for distribution. Committee will not meet again until February. **Tami Bakewell**: Sounds like each topic could be its own social media campaign. Are social media materials ready to go? **Jennifer**: Yes, most topics have toolkits with suggested captions, social assets, templates, etc. **Tami**: Will connect with Facebook coordinator if we can do both English and Spanish. Should add injury prevention section to F2F newsletter.

Justin Sales, MD: No specific updates. Focusing on demand capacity curves for flow in the ED. Predicting heavy volume this winter, with more to report in February.

Christa Schulz, MD: Pediatric liaison work for trauma team at St. Charles in Bend. Have also started working as pediatric liaison with ED provider groups (Bend and Prineville/Redmond/outlying). Response has been robust – they crave pediatric education. Have already done mock codes twice. Scheduling neonatal resuscitation mock codes. Will attend quarterly meetings and provide case reviews, help to initiate educational sessions, etc. Reminded everyone of existing protocols, especially asthma and bronchiolitis. Overall, has been going very well. **Rachel Ford**: There are also recorded presentations for bronchiolitis and many other conditions on the Pediatric Readiness Program site.

David Lehrfeld: All about EMS Modernization and the work ahead including committee reorganization and accreditation for agencies and pediatric centers of excellence. Perpetual growth of data team and building infrastructure for pediatric performance measures and integration – it is like a dream come true. No longer treating pediatric patients directly due to working at the Veteran's Affairs (VA) hospital.

Jeffrey Dana: Work for Cascade Locks Fire and Emergency Services and usually see pediatric patients about once every six months. Over the summer, took role as a camp nurse with ~100 patients per day. Fortunately had no big cases, though one COVID patient on the day of the last committee meeting. Summer's over, now back to fire department. Plan for fall is to get the last three transporting agencies in Hood River signed up for HERO Kids and get the app on all ambulances.

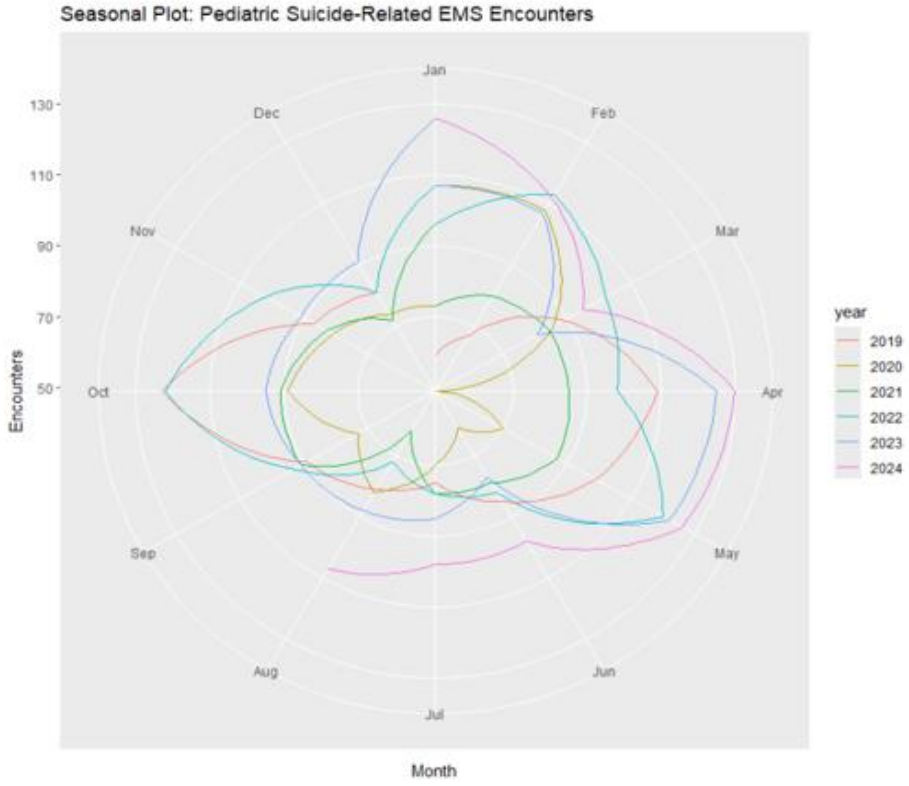
Joann Lundberg: Mental health updates in Portland Metro. Counseling clinic has seen an uptick in safety planning for suicidal ideation and self-injurious behavior. Fall and start of school bring additional academic and social stressors. [Provided case information.] Glad that paramedics are accessing HERO Kids. Case is not necessarily representative of population at large, but does demonstrate issues this family and others encounter in accessing care.

Dana Pursley-Haner: No updates.

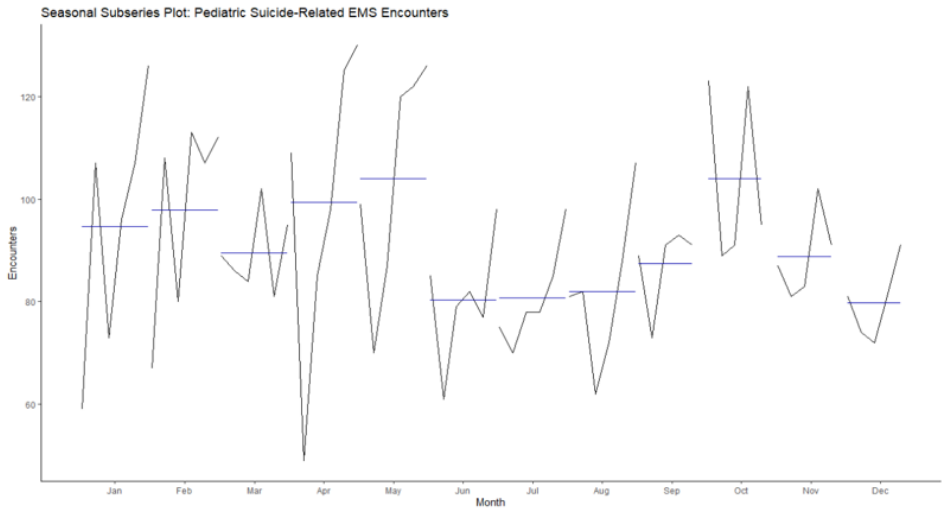
Rachel Ford: Matt Philbrick was deployed to Kentucky for an aircraft accident. Jill Shipley is on vacation. Kelly Kapri is retiring at the end of this month and had a conflicting meeting; she wanted to convey that she has enjoyed serving for many years. Matt House had a scheduling conflict as well.

Suicide Data Project | Peter Geissert

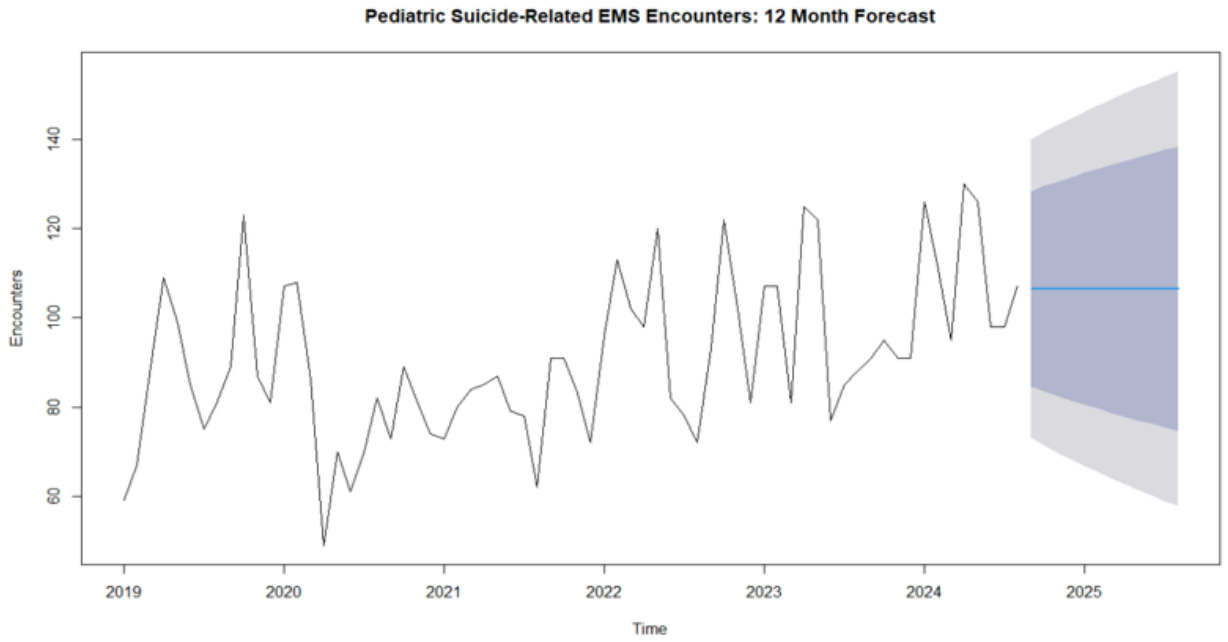
Update on data for pediatric suicide-related EMS encounters, examined in April and last year. The data is very noisy month-to-month. Many factors can impact on an individual level, community level, and statewide. To identify what is truly happening and separate signal from noise, have used time series analysis to tease apart. Can see the echo of the trend in data with upward trajectory over time.



Seasonal Plot:
Certain times of year are particularly high for numbers of suicide attempts and ideation: January, April/May, and October. In 2024, seeing unseasonably high numbers of suicide-related calls throughout the year to date. Summer, which is usually a very low season for these calls, had high numbers this year, which is an alarming pattern.



Seasonal Subseries:
Separating out seasonal versus normal expected variation. Blue horizontal lines are the mean for each month, then the black lines are a sub-series for 2020-2024. Some months, variance is small; in others, variance is considerable.



12-Month Forecast:
The last time the committee reviewed this, Oregon was coming off a period of about six months with a significant dip, which made it look like numbers were declining and made the projection for this year lower, with a mean between 80 and 90, though it did have wide confidence bars. That dip was real; however, it is rebounding and continuing to increase. It did not break the model; currently within the expected range, but on the very high end. For the end of 2024 and early 2025, the mean is over 100 again, which roughly matches early 2023. Reminder that the appearance of a shift in the trend may be real – like from mobile crisis response – and there may be a change in rate of increase, but it is not necessarily signal.

Takeaways:
- Strong seasonality: January-February, April-May, and October.
- Apparent decline in 2023 did not persist in the first half of 2024.
- Unseasonably high numbers in 2024.
- 12-month moving average indicates that pediatric suicide-related EMS calls continue to increase at a slow but steady rate.
- New 12-month forecast is higher than the last one, though with wide confidence intervals due to the noisiness of the time series.
- Next step: Turn case definition into ESSENCE query in the state syndromic surveillance system.

Comments/Questions:
- **SunHee Chung**: Do we have data on suicide mortality and deaths? Are we doing okay at keeping that down, or is it also increasing? **David Lehrfeld**: The Injury and Violence Prevention Program (IVPP) would have that data from death certificates cause of death. To get it coded is about a year-and-a-half or two-year process. We do have year-to-year data and could ask IVPP if the committee wants to see specific data. Tying that through different data sets (prehospital, ED and hospital, vital statistics) has not been done. **Rachel**: Will send most recent report to the committee.

- **Carl Eriksson**: Any sense of whether or how severity is changing? With increased numbers, are people having a lower threshold to call EMS, or is severity higher? Have you looked at different treatments or other elements from EMS records? **Peter**: At present, do not have that built out. Very difficult from narrative to separate attempts from ideation with a high degree of confidence. Interesting idea to use treatment received. **David**: It would depend on how you define population – need to do that before looking at treatments, because the raw numbers would not be informative.
- **Justin Sales**: What are you seeing for ICU admissions, given that may be a proxy measure for severity? **Carl**: Seeing more of them. Anecdotally, more benzos being given in general. Not sure if that is translating to EMS but imagine at least some of it is. **Justin**: Definitely seeing increase in ED, increasing in number of ED visits and the severity of attempts, whether size of ingestion or lethal means. **David**: Does Poison Center keep records on intentionality? **Jennifer Eskridge**: Yes, Poison Center keeps records on intentionality. Have seen an increase in suicide-related calls among children in the last five years. There have been some national studies looking at Poison Center data across the country. Worried about preteen girls as a population – hear about them more because generally females tend to use pills, medicine overdoses, whereas males use more violent means. **Adam Wagner**: Would be interesting to see if gender breakout shows significant differences. At National Association of State EMS Officials West Region meeting, there was discussion about agencies building dashboards and disaggregating data (race, ethnicity, gender) to identify interventions.
- **Christa Schulz**: Clinically, also seeing younger patients – kids as young as seven – with behavioral health issues a lot more frequently.
- **Tami**: Family group does not talk much about suicide but does talk about kids not being in school. Do the calls and emergencies have time variation, weekdays versus weekends? School absenteeism adds stress and pressure without the school day structure, which is hard on parents.
- **Carl**: Are there things this committee can do? Adding to barrage of information about a problem that is continuing to worsen. With efforts from other groups around the state, what can we do specifically given our lens and expertise to highlight in a different way or reach a different audience? **Justin**: With EMS Modernization and changing committees, there will be a behavioral health committee in May 2025. **David**: It will take a few years. EMS has always been about response and not about prevention, but it is evolving. Elements of the other OHA and Department of Human Services (DHS) behavioral health programs will be pulled into this response-type committee on behavioral health. Expect all the money is in prevention. **Justin**: Potentially interesting collaborations with the committee in 2025, to bring forward recommendations. **Carl**: It's response but it also indicates the burden of the problem in the community. May not be an early indicator – there may be earlier indicators of what is happening – but nonetheless an indicator of what is going on. **Justin**: Highlights gaps in mental health support within Oregon, which have been a problem since the 1980s.
- **Tami**: Would love to see intersection with school-based health centers (SBHCs). Not sure if there is a role for SBHCs but would encourage involvement as we go forward. **Dana Selover**: SBHCs are regulated by OHA's Public Health Division. Adolescent and child behavioral health in the Behavioral Health Division is trying to use all their tools (county mental health, 988, etc.) to close the loop on response to not only deal with the crisis but connect individuals to resources. For example, ED release for an adolescent after a suicide attempt requires certain resources and connections. With lots going on, want to make sure everyone is pulling in the same direction and collaborating.
- **Rachel**: Wondering about efforts to reach out to families. After a suicide, there are postvention efforts in communities, but wondering what is happening day-to-day.

- **Dana**: Suicide prevention, as part of IVPP, is also a group to tie in. Have worked with adolescent and children's behavioral health on various projects and legislative concepts; they will be great partners. Solid connections between future EMSCAC and behavioral health on the whole spectrum of response and prevention. **Todd Luther**: Would be good to have them as guests periodically to establish a connection. **Christa**: Is there a big meeting with all the committees together? **Rachel**: Yes, the EMS Advisory Board will have liaisons to the other committees. **Todd**: Separate from that, could be good to connect. **Rachel**: OHA Suicide Prevention team members have popped into these meetings – surprised no one is here today; when suicide is on the agenda, they usually come, but there was a conference earlier in the week. **Todd**: Would be good to give them a few minutes to talk about what they do and how they see us helping. **Justin**: That would be great, even meeting before or in-between meetings potentially with smaller groups.
- **Adam**: Would love to see social media use for this. **Justin**: Agree. Need to increase awareness at children's hospitals. Currently helping to develop pediatric behavioral health service line. Thinking about these problems daily.
- **Dana**: Adding a standing agenda item for both the behavioral health committee and EMSC would help break down silos.
- **Rachel**: Comment in chat – "Portland Public Schools have taken the initiative to contract with mental health organizations to have school-based mental health therapists at schools that do not have clinics to identify students with mental health challenges." Maybe there are similar efforts in other schools we do not know about yet.
- **Justin**: Opportunities for collaboration with growth of the behavioral health advisory committee as well to hopefully find more available resources. Great discussion.

ACTION: Peter - Turn case definition into ESSENCE query in the state syndromic surveillance system.
ACTION: Meet with SBHC and OHA Suicide Prevention staff to see if there are things this committee can do specifically; what the committee can do specifically, given the lens and expertise, to highlight in a different way or reach a different audience.

EMSC Program | Rachel Ford

Prehospital Pediatric Readiness Project Assessment

Oregon achieved a 51% response rate for the national Prehospital Pediatric Readiness Project (PPRP) assessment! For tools to improve pediatric readiness, check out the Prehospital Pediatric Emergency Care Coordinator section of the EMSC website, www.oregonemsc.org. In the future, the PPRP site will reopen; similar to the hospital assessment, it will be available for EMS agencies to use for ongoing quality improvement.

Pediatric Readiness Program (PRP)

The August education session was co-presented by Dr. Laura Bliss and Dr. Alison Christy. They covered two topics, pediatric seizures and headaches. There were 52 participants from hospitals, EMS, clinics, and more. Education sessions are sent to school-based health center folks, and there are K-12 participants. The recording and slides are available at www.pedsreadyprogram.org.

Registration is open for the November 21 education session on strategies for dealing with difficult patients and families. Open to everyone; folks from other states join as well. It will be co-presented by

Trisha Williams & Joshua K. R. Hellstrom from Oregon Providence Health & Services. Continuing education is available. Archived sessions are posted on the Education page, www.pedsreadyprogram.org.

Pediatric Emergency Preparedness Workshop
On November 4, the Pediatric Emergency Preparedness Workshop will be provided in Stayton and Independence. First time doing two workshops in one day. Area EMS, fire, and hospital providers have been invited to participate. For details, contact Rachel Ford at rachel.l.ford@oha.oregon.gov.

NEMSQA Performance Measures
Have been working on the PEDIATRICS-03 (documentation of weight when administering weight-based medications) National EMS Quality Alliance (NEMSQA) measure. Q2 (April to June) 2024 data was sent to all EMS transport agencies on August 8 and 12. There are 10 agencies (out of 130+) that require additional follow-up because they are below the 90% threshold. There are two agencies that have not been reporting data. Efforts have paid off; would like to work on more NEMSQA measures in 2025. End goal is to have public-facing dashboards for agencies to access their data.

At the August National Association of State EMS Officials Pediatric Emergency Care Council meeting, several guest speakers (Randall Eimerman, Sheree Murphy, Jay Ostby, Chad Pore, Amber Viitanen) shared information and requested feedback on the National EMS Information System (NEMSIS) pediatric transport data element. Currently, the data element is focused on using a car seat when transporting, which is not necessarily reflective of what is happening in the field nor appropriate if the car seat has been in an accident. Working to add more options: neonate restraint device, pediatric restraint device, patient's car seat, and car seat that is integrated into the ambulance. Many states want isolette added for transport of neonates; sometimes it is affixed to the bottom of the transport vehicle and sometimes to the gurney. They are also considering adding a new data element. There is work from both the NEMSQA side and NEMSIS side.

Prehospital Pediatric Recognition Program
Review and feedback for the draft Application Guide and Frequently Asked Questions documents. The program is included in EMS Modernization. Still determining initial recognition and renewal period and dates and may add some clarifying language.

Comments/Questions:

- **Christa Schulz**: At one point Peter pulled how many medications were given without a weight documented. It would be nice to see that again. A list of which medications would be helpful.

ACTION: Rachel will follow up with Albert Ramon about generating a list of medications given without weight documented and will share with Christa and Justin.

- **Christa Schulz**: With EMS Modernization, is the pediatric designation for EMS agencies only or EDs as well? **Rachel**: Eventually EDs too. Wanted to start with prehospital because it felt easier given culture/climate. It is voluntary, as written into the bill, and will remain voluntary. It will be a way to show pediatric readiness. The agency will be filling out an application and once successfully completed, they will receive a certificate and decals to put on licensed ambulances. They will have to reapply, not one-and-done. The ED program will likely be similar. The programs will be largely based on the Health Resources and Services Administration (HRSA) requirements. For the prehospital

program, also reviewed 10-12 other state programs, to see their formatting and requirements. Want the program to be attainable.

- **Christa Schulz**: It looks really good, covers pediatric readiness to a T. Not only doable things, but also baseline for what should be done for appropriate pediatric care. **Rachel**: The things that might be a step up for some agencies are community outreach, disaster preparedness, and the PPRP assessment if they did not complete it previously. **Justin Sales**: Do they have to describe outreach that has already been done or can they describe what they are planning to do? **Christa**: Will there be opportunities for smaller agencies to receive education on how to do outreach? **Rachel**: The language was changed to talk about co-hosting an event with another entity, like a hospital or community-based organization. **Jennifer Eskridge**: These events are happening in many communities in Oregon, it is more about being aware and present, partnering. **Justin**: Might be good to include language to encourage people to reach out for help connecting to groups in their area.
- **Carl Eriksson**: Do you have results yet from the survey that was just completed? **Rachel**: Not yet. **Carl**: Wondering if there are specific gaps identified that you want to target, you could call out specific issues. **Rachel**: Not sure if going to do that. Hope is that similar to hospitals, agencies will come back with gap report and then identify what they want to work on. Do not want to be overly prescriptive.
- **SunHee Chung**: Will their score on the HRSA PPRP be taken into consideration? **Rachel**: No. **SunHee**: Wondering if there should be alignment with the PPRP to follow or track? **Rachel**: Not so far. National collaborative is looking at both prehospital and ED recognition programs and it will be interesting to see what else gets added to the list. Hoping to get this program going and then can always modify going forward.
- **Carl Eriksson**: Is this assuming that having a pediatric emergency care coordinator (PECC) means you have structure in place for ongoing improvement? **Rachel**: On the hospital side, research has shown that having a PECC improves outcomes. Having personnel in place improves processes. This will likely be reflected in EMS data as well.
- **Christa Schulz**: Would be interesting to hear from EMS providers on what they think the challenges will be. **Rachel**: Planning to send to Matt Philbrick and Matt House. **Todd Luther**: Suspect EMS is similar to EDs in this sense – smaller places are resource-shy, so they will see it as a burden and will need help to realize that there are resources available. That is part of why it is important to not attach a score. Rural agencies have to add this into what they already have. **Rachel**: After eight years in current position, have had the opportunity to build relationships of support with agencies. Hopefully that is the foundation needed. Wondering about eventually publishing list to highlight rural agencies to say, “These agencies have done it, you can do it too.” **David Lehrfeld**: It would be nice for the Office of Rural Health (ORH) to provide grants to help rural and frontier agencies come into compliance. **Rachel**: Have already reached out to ORH; would like them to preferentially award grant monies to agencies reaching towards pediatric readiness and use funds for equipment required in rule. EMSC program funds are limited, and only cover nine months of the year and then kicks over to state funds.
- **Tami Bakewell**: Would like for family organizations to send agencies flowers as congratulations, a thank-you for putting in the effort. For the disaster plan section, with memoranda of understanding (MOUs), DHS has requirements about developmental disability (DD) case management entities having relationships with EMS agencies. Those who run group homes for people with DD need to have an understanding of the area’s disaster plan. **Todd Luther**: In Douglas County, county emergency management has it mapped. They coordinate and make information available to all EMS agencies, fire agencies, police, and it comes up during disaster drills with respect to additional needs

during power outages, etc. **Tami**: Who is supposed to initiate that? **Todd**: County emergency management coordinates with search and rescue and other services. **Rachel**: It is probably county-level, given that they usually set ambulance service plans (ASPs) and are responsible for emergency management.

ACTION: Tami will connect Rachel with DHS DD contact.

- **SunHee Chung**: Love the decal idea for ambulances and want to see what it looks like. **Rachel**: Will work with Stella and show at a future meeting.

ACTION: Rachel will share decal at future EMSCAC meeting.

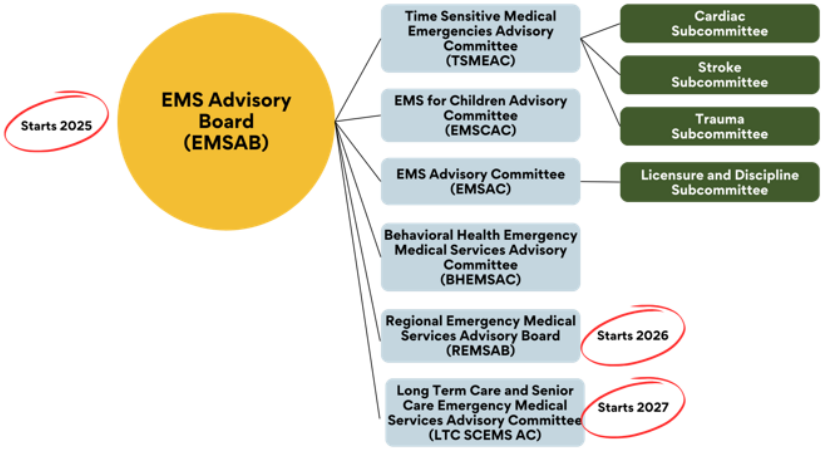
- **Justin Sales**: It is super cool; people have been talking about ideas like this for a long time, so it is nice to see it actualized.

EMS Modernization | Rachel Ford

High-level implementation timeline for the next year:

- Autumn 2024: Emergency Medical Services Advisory Board (EMSAB) applicants notified of their status in September, now processing new appointments. EMSCAC applications close October 31; applicants will be notified by November 27. Similar to EMSAB, one-to-one phone calls will be conducted with all applicants to walk through responsibilities.
- January 2025: On January 1, existing boards and committees sunset.
- February 2025: EMSAB and EMSCAC will have their first meetings. EMSAB will approve the proposed membership for the advisory committees, including additional positions for EMSCAC. Recruitment for the advisory committees will open in mid-February.
- May 2025: The other new advisory committees have their first meetings.

HB 4081 EMS Modernization Board, Advisory Committees & Subcommittees



Next steps: bill analysis continues with internal team; starting to draft administrative rules.

OHA has rebranded with a new logo and published a new Strategic Plan. The EMS office is also rebranding: current name is the EMS & Trauma Systems Program; name in the bill is the Emergency Medical Services (EMS) Program. Slogan: right patient, right place, right time.

For EMSC, meetings will still be Thursdays from 9 a.m. to noon. Meeting months have shifted, with new months being February, May, August, and November. Meetings will be held the first or second week of

the month, depending on competing national and state conferences. August meeting for 2025 runs over the federal EMSC grantee meeting Rachel is obligated to attend, so meeting date will change to accommodate.

Comments/Questions:

- **Carl Eriksson**: There will need to be a representative from EMSCAC to attend the Time-Sensitive Medical Emergencies Advisory Committee, which will otherwise be heavily adult-focused. Pediatric time-sensitive emergencies are low frequency but high consequence. Need someone to call attention to the fact that there are pediatric cases. **David Lehrfeld**: Yes, we have a pediatric trauma system as well. Hopefully not many pediatric strokes, but definitely a representative for trauma. **Justin Sales**: Actually, we have been seeing pediatric strokes, so need to make sure it is being discussed in the prehospital context.
- **Dana Selover**: The bill is built as a buffet of things. There is scaffolding with options. We will have conversations about prioritizing, with Rachel and the future committee. Rachel is looking at low-hanging fruit to get started. Program is negotiating and will be requesting additional resources – not able to do everything in the bill, EMSC and data and otherwise, without additional resources. The resources available will be determined during the legislative session through the "Part 2" legislation.
- **Rachel**: Touched base with those on the current committee whose positions are not represented on the new EMSCAC; there will be positions added in the bylaws.

State EMS and Trauma Systems Program | Adam Wagner, David Lehrfeld, Dana Selover

EMS and Trauma Systems Program – Adam Wagner

EMS and Trauma Systems Quarter Report

- Recruitment: Starting with two limited-duration positions from Oregon Department of Transportation (ODOT) grants for the data team to work on data linkage among systems.
- Data: Released first Stroke Dashboard via Posit. High hopes for producing more dashboards and using them to interface with agencies.
- Professional Standards Unit: Writing new rules and preparing to hire a new position as well for the predetermination process following Senate Bill 1552. People with criminal records can petition licensing boards to determine if they are eligible to receive a license before starting an education program and investing resources.

Comments/Questions:

- **David Lehrfeld**: Kudos to the data team. Along with other projects, supporting five research requests from OHSU as well as public health requests from counties. **Carl Eriksson**: From research side, we write grants assuming access to data, then obviously things may change or get delayed. Peter has been a tremendous resource.
- **Rachel Ford**: Comment from chat on Fall Trauma Nursing Conference with pediatric trauma topics throughout – will be presenting on hospital pediatric readiness and include HERO Kids.

Legislation – Dana Selover, David Lehrfeld

Likely topics for upcoming legislative session:

- EMS Modernization Part 2

- ED boarding as a public health problem
- Dispatch, alternate avenues to manage 911 medical calls – nurse triage, urgent care, etc.
- Behavioral health, substance use disorder, overdose responses
- EMS mobilization plan
- Workforce – may interface for behavioral health, with overlap in community paramedicine

Comments/Questions:

- **Carl Eriksson**: Can you describe what is on the horizon with ED boarding? Trying to understand what the angle will be. **David**: Physicians testified to state senate that it is a public health crisis and is solvable. Patients sitting in the ED for days create back-ups into EMS and 911. No specific model legislation introduced, but it is something we should be measuring and monitoring, which OHA uses the Oregon Capacity System (OCS) to do. Variety of opinions on solutions. There is general knowledge that in all fields of healthcare, we need more nurses of all levels. Broad conversation about how we get people into programs, pay for it, grant programs, teaching institutions, recruiting starting in high school for nursing and EMS, interstate compacts for nursing and paramedics, etc. No one overriding solution that is coming to the front. **Carl**: More about ED boarding being a signal of a system under stress rather only address ED boarding. **David**: At this point more about making legislators aware that it cannot be isolated to the ED. **Carl**: The ED has very little control over it. **Justin Sales**: That was the main hope with the testimony. People have been working vertically within their institutions to fix flow, now realizing it is an issue statewide and want to work collectively.
- **Tami Bakewell**: In the disability world, nursing crisis means fewer school nurses so kids are not able to go to school sometimes, and less availability for private duty nursing for medically involved kids. DHS has contracted with a Canadian research group to look at why we do not have nurses for kids. They are interested in perspectives on barriers. Highly interwoven problems for families.

ACTION: Tami will send nursing workforce survey to Rachel to distribute.

- **Jeffrey Dana**: Is there movement toward compacting? **David**: EMS compact has been introduced three times. Nursing compact is frequently discussed. **Danielle Meyer**: Nursing compact has been introduced the last four years and has not moved forward. Only one licensure compact in Oregon, for physical therapists from 2006. Boards testified at legislative days about their licensure processes and hesitations around compacts. **David**: In general, a good idea, but not the single solution. **Danielle**: Hospital Association is supportive of licensure compacts, but they lack political support.

Public Comments | Chairperson
None.

Next meeting is February 13, 2025.
Location: Zoom

Meeting Adjourned: 11:24 AM

These minutes are drafted and have not been reviewed and approved by the Oregon Emergency Medical Services for Children Advisory Committee.