Oregon Time-Sensitive Medical Emergencies Advisory Committee: Cardiac Subcommittee Meeting Summary
2025 Quarter 2 | May 7, 2025

Slides and recording available upon request.

Appointed Cardiac Subcommittee Members		
Name	**Position**	**Attendance**
SunHee Chung	Emergency medicine physician	Absent w/o notice
Mo Daya	EMS supervising physician	Present
Jeff Marbach	Interventional cardiologist	Present
Erin Nunes	EMS provider	Present
Megan S.	Nurse	Present
Kelsey Truong	Nurse	Absent w/ notice
Patrick Vogelsong	Hospital administrator	Present

1. **Call to Order and Introductions (Adam Wagner, Oregon Health Authority Emergency Medical Services Program) (Timestamp: 0900)**
   a. Adam discussed the new subcommittee structure and staff roles for the day.
   b. Roll call was conducted. OHA staff introduced themselves.
   c. Adam reviewed the group expectations and meeting agenda.
   d. Committee members introduced themselves with their names, professional titles, and positions on the committee.

2. **Bylaws Review (Adam Wagner) (Timestamp: 0917)**
   a. Adam gave an overview of the purpose of bylaws and explained that the subcommittee is embedded within the bylaws of the Time-Sensitive Medical Emergencies Advisory Committee (TSMEAC).
   b. Instead of a traditional chair structure, the subcommittee will have a liaison representing the subcommittee to the TSMEAC and who will lead the subcommittee meetings. Mo Daya suggested that the liaison role should be shared in cased someone is absent or unable to fulfill the duties.

3. **Cardiac Systems of Care (Dana Selover and David Lehrfeld, OHA EMS Program) (Timestamp: 0954)**
   a. David reviewed a brief history of EMS in the state and the push for EMS modernization, including the 2024 legislation (Oregon Laws 2024 Chapter 32). David explained the OHA EMS Program's work and how it contributes to public health.
   b. Regionalized systems of care intend to maximize patient outcomes over a geographic area. Regionalized systems of care have six domains: capability, capacity, and access; recognition and diagnosis; resource matching and use; medical care; coordination of care; outcomes.
      - Mo Daya asked about other states/countries that have regionalized systems of care. David responded that there are significant regional differences, so comparison is not

always helpful. The complexity of other states' systems are proportional to how much money the state has. Dana added that it also depends on who has championed the systems; legislators and politicians can matter as much as resources.

c. Building statewide time-sensitive medical emergency systems will require several steps: determining statewide standards; codifying standards into administrative rule; developing regional plans; certification and categorization of facilities; regional implementation; and system monitoring and ongoing improvement.
d. The subcommittee will need to select oversight and approval options for facilities seeking to become specialty care centers.
    - External – single national standard + state data and quality assurance (QA)
    - External – multiple similar national standards + state data and QA
    - State certification – OHA surveys, state data and QA, complaint investigation
        - Megan S. asked whether OHA would need more funding for the state certification option. David responded yes, it will be dependent on legislation and funding. David encouraged the subcommittee to make recommendations based on what they think is best for the public, not what may or may not be funded since the resources are unpredictable.
        - Mo Daya asked whether the subcommittee can learn what facilities are already doing and what standards are currently being used, potentially conducting a survey to gather this information. Dana encouraged Mo and the other members to specify their outstanding questions and data needs.
    - Mixed – external certification or state certification + state data and QA
        - This is the setup for Oregon's trauma system, with standards for Levels I, II, and III largely matching the national standards from the American College of Surgeons and state surveys for Level IV critical access hospitals.
    - Megan S. asked whether there are EMS certification programs or only hospital programs. David responded that hospital programs are more comprehensive; EMS programs are based on data.
e. The subcommittee will need to define a cardiac patient as part of setting inclusion criteria for the cardiac system. Two examples were provided: out of hospital cardiac arrest and ST-Elevation Myocardial Infarction (STEMI).
    - Mo Daya commented on the importance of having input from all regions of the state, particularly less-resourced areas. David responded that the TSMEAC structure will help reconcile differences across specialties and that the regions will work on implementation.
    - Nancy Leach (commenting on behalf of absent subcommittee member Kelsey Truong) commented that a lot of facilities in the Salem area don't use STEMI and instead use Occlusive Myocardial Infarction activation. Nancy would like this considered as an option for potential definitions.
f. Nationally available cardiac data systems include the American College of Cardiology's National Cardiovascular Data Registry (NCDR), the American Heart Association's Get With The Guidelines (GWTG) registry, and the Center for Disease Control and Prevention's Cardiac Arrest Registry to Enhance Survival (CARES). Each of these systems cover different patient types and elements of cardiac care.

g. Data system options are often linked to the choice of national standard. The subcommittee will make a recommendation.
    - External certification with an accrediting organization data vendor
        - For example, Joint Commission stroke with GWTG (state is granted superuser access)
    - External certification with a state-operated patient registry
        - For example, American College of Surgeons Committee on Trauma with Oregon Trauma Registry
    - Dana added that EMS data is reported through the National EMS Information System at the state level.
h. Because this is the beginning of development of a formal statewide cardiac system, OHA-EMS has limited knowledge of the current cardiac care landscape in Oregon.
    - There are 58 hospitals in Oregon with emergency departments.
        - 5 hospitals currently hold some national cardiac certification.
        - 42 hospitals are currently reporting cardiac arrest outcomes for CARES.
        - 43 hospitals are trauma centers (2 more applying currently), though no data is provided from these facilities for acute myocardial infarctions.
        - 25 are critical access hospitals (low occupancy acute care hospitals).
        - Dana added that some hospital information is collected at the state level during applications for licensure. There are federal reporting requirements.
    - Erin Nunes asked if OHA has data from ambulance providers on cardiac arrests. David responded that greater than 95% of transport agencies report data on cardiac arrests (almost 99% of patients).
    - David showed a spreadsheet of national cardiac certifications held by 5 Oregon hospitals. Mo Daya commented that there may be more hospitals not listed. Dana Selover added that some of the data on the hospital websites might be outdated.
    - Subcommittee expressed that it would be helpful to have spreadsheet with cardiac certification, level, etc., in order to see the current hospital landscape for time-sensitive emergencies. Members also expressed the need to use inclusive language and were in favor of a tiered system that has four levels of care, similar to trauma and stroke.

4. Regional Roundtable Updates (Adam Wagner) **(Timestamp: 1108)**

a. Members were asked to share cardiac care, emergency services, community outreach, quality improvement, or system coordination updates from their facilities/regions.
    - Megan S. provided several examples of initiatives she supports, including teaching CPR at events like the Eugene marathon, providing community education at the YMCA to talk about healthy eating, and starting a cardiac arrest survivor group.
    - Mo Daya added that there are different levels of engagement and that public events have been difficult following the COVID pandemic. Mo gave examples of middle school CPR education, law enforcement partnership programs, and a cardiac arrest survivor breakfast held biennially. He emphasized investing in projects that are sustainable longer-term and can be taken over by others.

- Nancy Leach (commenting on behalf of Kelsey Truong) shared concerns from the Salem area, which has a central acute care hospital surrounded by smaller rural hospitals. Their principal project has been to encourage patients to call 911 for chest pain because field activation can save 15 minutes during time-sensitive emergencies.

5. **Regional Boundaries and Referral Patterns (Adam Wagner)** **(Timestamp: 1125)**
   a. OHA-EMS has established Area Trauma Advisory Boards (ATABs), which serve as referral regions for trauma care, but does not know whether or how the boundaries may need to change to reflect cardiac care. The subcommittee will be involved in recommending regional boundaries.
   b. Megan S. recommended looking at the presence of catheterization labs, particularly with 24/7 availability, when determining regional boundaries and resource hospitals.
   c. Patrick Vogelsong suggested asking regional representatives how they refer for cardiac patients. Regions 1 and 6 regularly hold joint meetings.
   d. Mo Daya has access to data from the Portland Metro area in ATAB 1. Some patient referrals happen within health systems, such as Providence or Kaiser. Cardiac patients at the Veterans Affairs (VA) hospital can get lost data-wise because the VA doesn't always share information.
      - Megan S. added that sometimes patients are sent out of state, including to Washington from Portland Metro.
   e. Patrick Vogelsong added that cardiac transfers in many cases require intensive care unit levels of care. The Oregon Medical Care Coordination Center at Oregon Health & Science University (OHSU) is the pathway for critical care transport placements within Oregon and they might have information to share.
   f. Mo Daya emphasized the need to engage with air ambulance services and that it may be helpful to have an air-based EMS representative on the subcommittee. When transferring patients within Oregon, distances are long and time is short, so the state can't be covered geographically in a timely manner without air transport.
   g. Mo Daya asked Megan S. if her region holds a STEMI meeting. Megan responded that she holds a regional STEMI coordinator meeting, with all facilities invited. Invitees share information on processes and data with the goal of learning from each other. Mo commented that if regional contact is already occurring, the subcommittee should build on what is already happening rather than reinvent systems.
   h. Adam Wagner added that rural connections are going to be important, especially in areas like Eastern Oregon.

6. **Key Takeaways (Adam Wagner)** **(Timestamp: 1140)**
   a. Adam discussed ongoing recruitment for committees and subcommittees, including the desire to get representation from regions 6, 7, and 9 and from hospital systems not currently represented among the membership.
   b. Next meeting will be held Wednesday August 13, 2025, 0900-1200, in Portland.

7. **Public Comments** **(Timestamp: 1150)**
    a. Brian Gross commented on the evolution of time-sensitive emergency care in Oregon over time, including changes in treatment that have led to reduced mortality from STEMI and the 2009 House Joint Resolution 54 on a statewide commitment to cardiac care. He emphasized the need for a communicative, collaborative effort to coordinate a system of care for time-sensitive emergencies.
    b. Subcommittee has asked for OHA-EMS program to provide the following:
        - Information about hospitals in the state:
            - Names
            - Capabilities
            - What they do for STEMI
            - Who they transfer to, specific to cardiac
            - Cath labs (including operating hours, on-call hours)
            - Ground versus air transfers
            - Populations/demographic data
            - Certification standards/accreditations
                - Nicole Perkins stated that OHA-EMS can start the process of collecting this information, though can't promise it all will be available by the next meeting.
        - Background on national datasets, particularly what data items/measures they use.
            - Jeff Marbach can share some data because OHSU uses NCDR for percutaneous coronary intervention tracking.
            - Mo Daya can comment on CARES data.
    c. OHA-EMS will share action items with the group when available. Subcommittee members will receive preparatory materials before the next meeting.

Meeting adjourned at 1205.

Next Meeting:
August 13, 2025, 0900-1200
Portland State Office Building, Room 1E
800 NE Oregon Street, Portland, OR, 97232