Oregon Time-Sensitive Medical Emergencies Advisory Committee Meeting Summary
2025 Quarter 4 | November 5, 2025

Slides and recording available upon request.

Appointed Committee Members		
Name	**Position**	**Attendance**
Jessica Bailey	Physician - pediatrics	Present
Natalie Booker	Hospital administrator EMS Advisory Board liaison	Present
Jeremy Buller	Nurse coordinator - trauma Trauma Subcommittee lead	Present
Mac Cook	Physician - critical care Committee chair	Present
Mo Daya	Physician - emergency medical services	Present
Matt Edinger	Patient equity organization representative Committee vice chair	Present
Tracy Holliday	Nurse coordinator - stroke Stroke Subcommittee lead	Present
Jeff Marbach	Physician - cardiology	Absent w/o notice
Alexis Moren	Physician - trauma surgery	Present
Megan S.	Nurse coordinator - cardiac Cardiac Subcommittee lead	Present
Megan Sanders	Nurse coordinator - emergency department	Present
Melissa Tom	Physician - emergency medicine	Present
Victor Walco	Emergency medical services provider	Absent w/o notice
James Wright	Physician - neurosurgery and neurocritical care	Present
Anudeep Yelam	Physician - stroke neurology	Present

1. **Call to Order (Mac Cook)** **(Timestamp: 00:00:12)**
   a. Roll call was conducted; quorum was met.
   b. The group went over expectations for participation during virtual meetings.
   c. Oregon Health Authority staff members introduced themselves.

2. **Subcommittee Updates (Subcommittee Leads)** **(Timestamp: 00:09:20)**
   a. Jeremy Buller gave a brief overview of the Trauma Subcommittee's meeting.
      - The group discussed issues with the new Oregon Trauma Registry and formed a workgroup to help troubleshoot.
      - The subcommittee also formed a second workgroup on decreasing unnecessary transfers to keep patients in their home communities. They may look at the Rib Injury Guidelines.
      - Mac Cook asked about the consequences of delays with the registry for hospitals submitting to the American College of Surgeons (ACS). Jeremy affirmed that this is an issue his facility is dealing with as well. Peter Geissert, EMS Program data team lead, shared that hospitals have until December 15 for data upload and he is hopeful about meeting that deadline. Jeremy confirmed that the newly-created workgroup is intended to tackle these issues.

- Jeremy mentioned potential changes to data upload windows for ACS in 2026. Matt Edinger added that the new registry will likely require additional steps for upload.
- Mac emphasized the impacts of Level I trauma centers risking loss of certification.

b. Megan S. provided the Cardiac Subcommittee report.
- The group's meeting primarily focused on a patient definition for ST-Elevation Myocardial Infarctions (STEMI), which will be discussed later in this meeting.
- The roundtable discussion revealed gaps in access for rural patients, especially in receiving adequate care for cardiogenic shock and cardiac rehabilitation services.

c. Tracy Holliday summarized the Stroke Subcommittee's meeting.
- The group discussed prehospital assessments for patients with suspected stroke. They narrowed to two options to cover both screening and severity.
- Peter Geissert presented a data dashboard, which initiated conversations about data collection limitations and quality improvement.

3. 2026 Goals (Mac Cook) (Timestamp: 00:18:33)

a. Mac opened by reminding the committee that resources are limited, as the EMS Program did not receive new funding during the legislative session earlier this year.

b. One potential focus area for 2026 is understanding regionalization of care: which patients get transferred where, when, from where. Mac posed a "ten-thousand-foot view" question about (1) seeking to align cardiac and stroke care with existing geographic boundaries of the Area Trauma Advisory Boards, versus (2) drawing new Regional EMS Advisory Board boundaries and working to align all specialties within them, versus (3) using distinct regions and referral catchments for cardiac, stroke, and trauma care.
- Natalie Booker asked whether the transition to Regional EMS Advisory Boards would redraw boundaries anyway, especially given population changes in the state. Mac stated that the committee has limited resources and authority, but can give recommendations, which will likely depend on how they stratify hospital capabilities.
- Matt Edinger commented that an initial step will be figuring out how disparate the transfer patterns and maps currently are. If there is underlying similarity, Matt sees a benefit in aligning the specialties to simplify (consolidate meetings and logistics). However, if there is no standardization, Matt believes that consolidation into one map may not be possible. Mo Daya supported Matt's point to use what is already working and acknowledged that redrawing creates disruptions to the system.
- Jeremy Buller added that he does not foresee changes in central Oregon as many higher-acuity patients needing specialty care are already sent to Bend. Mac argued that changes may occur if Bend becomes the main referral center for a different or larger geographic area. Jeremy stated that the mountains create a natural boundary such that many patients come to them anyway.
- Dana Selover (EMS Program director) commented that the EMS Program has been aware of potential discrepancies between cardiac, stroke, and trauma transfer patterns, but unsure whether they constitute substantial changes. Dana acknowledged that the systems being built may not be "one-size-fits-all."
- Alexis Moren emphasized the need to engage the affected hospitals and regions. The committee will need to understand facilities' capacity and resourcing to understand the feasibility of proposed changes.
- Matt brainstormed about how to collect information on transfer patterns with mapping or spatial techniques to visualize patient flow. Collection of the initial information could happen at the Area Trauma Advisory Board level.

c. Mac summarized the conversation in saying that there seems to be agreement on needing more data about where and how patients are moving on a hospital-to-hospital or region-to-region level (vis-à-vis the Area Trauma Advisory Boards). He asked the committee to confirm whether this data set would be helpful to have, and if so, who they should recommend to collect it.
    - David Lehrfeld (state EMS medical director) indicated that the American Heart Association had undertaken a similar effort for STEMI patients. The EMS Program can easily gather data for trauma given the state registry, but is harder to access for stroke and cardiac care because patient identifiers are assigned at the hospital level. The state's EMS data is unlikely to show reasons for transfer in the charts.
    - Matt said that his personal approach would be to ask the STEMI and stroke coordinators at his facility to estimate ratios of patients sent elsewhere (such as 90% to one destination and 10% to another). This disseminates pieces over many individuals rather than concentrating the bulk of the work on one committee, though requires oversight and coordination.
    - Jeremy stated that he is unsure whether the Gorge (region 6) and eastern Oregon (region 9) have regional cardiac referral centers for STEMI. He expressed a need to know existing capabilities before determining regionality. Megan S. indicated that for cardiac care, times of availability for catheterization labs are as or more important than the presence of the facilities. She added the importance of treatment at closer facilities in some cases for thrombolytics before extended transport for transfer.
    - Mo added that this does not need to be all-or-none and can instead be a combination. Since some of the regions are small and were created years ago, they already have systems that this committee may not be aware of, and which could be subsumed into a larger statewide model. Stroke referral patterns are often based on facilities' membership in health systems.
d. Mac reflected that this is operating under an assumption of different referral patterns that are not currently well-understood. He sees the need to understand these before drawing official lines that mimic what already exists. He posed a question to the subcommittee leads on generating a referral map before the end of 2026.
    - Nicole Perkins (EMS Program operations analyst) added considerations from the Stroke Subcommittee's meeting: gathering data from receiving centers and the potential to miss patients sent out of state. Tracy Holliday echoed and said that Pendleton sends STEMI patients to Walla Walla as their nearest referral center.
    - David mentioned a map produced by the American Heart Association showing STEMI patterns from 10-15 years ago.
    - Mac asked the subcommittee leads to comment on the workload involved in ballparking where patients are and where they go.
    - Megan S. commented that part of the workload will be in finding the right contacts to ask for information. She wants to "work smarter, not harder" and use existing data systems to guide information-gathering where possible.
    - Mac asked for someone to argue against this prospect. Nicole commented that the level of detail expected will significantly change the workload involved.
    - Melissa Tom asked whether the purpose of drawing maps was for funding. Mac clarified that it is part of the committee's statutory mandate. Melissa also asked whether the system used for emergency department divert status had a correlate for catheterization lab availability. Megan S. responded that catheterization lab availability can be entered into the divert system, but it is used differently outside of the Portland metro and depending on hospital accreditation requirements. Mo stated

that he sees diversion as a separate problem and that the focus should be on transfer patterns generically. Stroke patterns are more complicated than STEMI because a smaller subset of stroke patients need intervention.
    - Natalie asked to confirm whether the initial mandate was to have this work completed by the end of next year. Mac confirmed, and stated the timeline changed due to lack of funding. Natalie then commented that resourcing is the major pushback point given legislative uncertainty.
    - Jeremy wondered whether the committee was approaching this wrong, because EMS patient care reports indicate destinations. He asked whether the state could pull that transfer data. David answered that the data does exist, but drilling down on details would be difficult and get messy.
    - Melissa suggested starting with hospital transfer centers because they keep records of who has called in requesting to send patients. Megan S. said that transfer centers' records and patient labelling may not align with patients' ultimate diagnoses. Megan suggested starting with larger facilities to "not let perfect be the enemy of the good."
    - Anudeep Yelam echoed Megan's point. He added that some hospitals may be reticent to share their data because they have transfers arranged under contractual obligations. He sees destination protocols that build on prehospital assessment tools as a potential longer-term step to reduce unnecessary facility bypassing.
    - Mac asked about the committee's ability to encourage or compel facilities to share data. David responded that workload would be involved, with rulemaking for requirements about data-sharing, to compel hospitals to give data. Dana agreed.
  e. Mac moved to conclude the discussion. He acknowledged that collecting information will be voluntary and limited to what partner facilities choose to share. Alexis commented that before the committee voted, it may make sense to assess initial feasibility.
    - Mac framed his motion as: "By the end of 2026, each subcommittee will present pertinent transfer patterns to the TSMEAC with enough detail to allow us to plan regional referrals."
    - Matt added that most projects usually begin with a feasibility study and he thinks it is appropriate to ask the subcommittees to figure that out. Mac added that this is a goal for the next thirteen months and inherent to it are progressive steps. If the committee receives updates early next year that it is not feasible, that is okay. Mac's intention with the phrasing was to allow the subcommittees to have room to maneuver for feasibility and account for factors raised earlier in this conversation.
    - Peter Geissert added that universally unique identifier (UUID) portability will increase the feasibility of pulling data to support this project. Outcomes registries that use EMS UUIDs can link data across systems without requiring personally identifiable information to track patient movement.
    - Mo amended Mac's motion to "with enough detail to allow us to guide the development of Regional EMS Advisory Boards." This focuses on future work.
    - Matt seconded Mo's motion. A roll call vote was held; of the members present in the meeting, Megan Sanders's vote was not audible and all others voted in favor.
    - Mac reiterated that he would like the subcommittees to provide reports to the committee on progress, including to assess feasibility.

4. **Patient Definitions (David Lehrfeld and Subcommittee Leads)** **(Timestamp: 01:11:15)**
  a. David summarized the purposes of different types of patient definitions: prospective for field triage, retrospective for dataset inclusion, and rule/policy to codify.

b. Megan S. and Stella Scott (EMS Program committees coordinator) presented the Cardiac Subcommittee's definitions.
    - ST-Elevation Myocardial Infarction (STEMI)
        - Proposed definition uses both symptomatic and electrocardiogram (ECG) criteria:
            "A STEMI patient is defined as an Acute Coronary Syndrome (ACS) patient who exhibits: (1) Acute signs and symptoms suggestive of myocardial ischemia. (2) ST-segment elevation on ECG: New or presumed new ST-elevation of ≥1 mm in ≥2 anatomically contiguous leads (measured at the J-point) in all leads other than V2-V3 and ≥2 mm in men ≥40 years, ≥2.5 mm in men <40 years, and ≥1.5 mm in women regardless of age in leads V2-V3."
        - This aligns with the new 2025 guidelines from the American College of Cardiology and American Heart Association. The Cardiac Subcommittee had a robust discussion about inclusion of symptom-based criteria.
        - Mac Cook asked whether the definition could be applied effectively by EMS given the numerical specificity and different patient groups. Megan responded that providers who can read ECGs should be able to apply it, and that it represents the "top cutoff" for a heart attack medical emergency. Mo Daya added that this standard has been updated for teaching based on available machine algorithms. Mac asked about whether this could or should be broadened. Megan stated that this was the broadest option.
        - Anudeep Yelam asked whether field providers would know all the signs and symptoms, because there are many possible. Megan stated that the Cardiac Subcommittee elected not to go into greater detail on signs and symptoms because it is part of EMS training. The group may examine that in the future. Mo added that the group had discussed STEMI equivalents and pointed out that those within the state can add to this definition, but it is the foundation.
        - Mac motioned to adopt the definition. Jessica Bailey seconded. All members present voted in favor.
    - Out-of-hospital cardiac arrest (OHCA)
        - During the committee's last meeting, the group voted to affirm the proposed OHCA definition and decided to wait to send it forward to the EMS Advisory Board until the STEMI definition was available. Natalie Booker is the committee's EMS Advisory Board liaison, but she will be absent for the board's meeting on Friday, so Alexis Moren volunteered to present both definitions to the board.
c. Jeremy Buller presented the Trauma Subcommittee's definition.
    - Proposed definition:
        "A trauma patient is defined as any individual who meets one or more of the following: (1) The field triage criteria outlined in Exhibit 2, or (2) The hospital trauma team activation criteria outlined in Exhibit 3, or (3) The Oregon Trauma Inclusion Criteria for trauma registry inclusion."
    - The Trauma Subcommittee had discussions on differentiating between what a hospital trauma program would consider a trauma patient and the field triage definition of a trauma patient. They ultimately decided that the definition above was appropriate.
    - Mac motioned to adopt the definition. Natalie seconded. Vote passed by unanimous consent with no objections. Alexis will bring this to the EMS Advisory Board as well.
d. The Stroke Subcommittee is still working on their patient definition for field triage and will bring it to the committee in a future quarter. Mac commented that the work for stroke is

challenging given lack of national consensus. Tracy Holliday added that the subcommittee had settled on a temporal criterion of symptoms less than 24 hours.

5. **EMS Program Update (Adam Wagner, Oregon Health Authority Emergency Medical Services Program) (Timestamp: 01:29:40)**
   a. The Professional Standards Unit has been implementing Senate Bill 1552 (2024), predetermination for individuals with past criminal convictions.
   b. Emergency Medical Responder license renewals are upcoming and will involve a workforce survey.
   c. The EMS education team is working on quality improvement for the new competency-based assessment program.
   d. Oregon EMS for Children launched Peds Ready EMS, a pediatric readiness recognition program for EMS transport agencies. Four agencies have already been recognized.
   e. The Cardiac Arrest Registry to Enhance Survival auto-upload feature is live.
   f. The EMS data team is working on data migration for the Oregon Trauma Registry.

6. **Administrative Updates (Stella Scott, Oregon Health Authority Emergency Medical Services Program) (Timestamp: 01:35:30)**
   a. Stella gave an overview of vacant positions across the EMS Program's statewide advisory groups and requested the committee's continued help with recruitment.
   b. Stella presented the EMS Program's 2026 statewide meetings calendar. Due to fiscal constraints, all EMS Program statewide meetings for 2026 will be held virtually.
   c. The EMS Program will be using Basecamp as a new platform to share documents between meetings.

7. **Public Comment (Timestamp: 01:43:05)**
   a. No public comments were submitted.

8. **Key Takeaways (Mac Cook) (Timestamp: 01:44:05)**
   a. Mac gave highlights from the meeting discussion and decision-making.
   b. Natalie Booker is the liaison to the Emergency Medical Services Advisory Board, though Alexis Moren will be presenting updates this quarter.

Meeting adjourned at 3:01 PM.

Next meeting:
February 10, 2026, 1:00-4:00 PM
Virtual only