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

Slides and recording available upon request.

Appointed Subcommittee Members		
Name	**Position**	**Attendance**
SunHee Chung	Emergency medicine physician	Absent w/ notice
Josh Davis	Rehabilitation specialist	Present
Mo Daya	EMS supervising physician	Present
Jeff Marbach	Interventional cardiologist	Absent w/o notice
Erin Nunes	EMS provider	Present
Megan S.	Nurse	Present
Kelsey Truong	Nurse	Present
Dan Westerdahl	General cardiologist	Present

1. **Call to Order (Stella Scott and Megan S.)** **(Timestamp: 19m)**
   a. Stella introduced the artificial intelligence features that the EMS Program is piloting.
   b. Roll call was conducted. OHA staff introduced themselves.
   c. Megan discussed the public comment process and reviewed the agenda.

2. **Approve August 2025 Meeting Notes (Megan S.)** **(Timestamp: 28m)**
   a. The group reviewed the written summary from the previous meeting. Subcommittee members did not request any changes to the document.

3. **Patient Definitions (Adam Wagner and Megan S.)** **(Timestamp: 29m)**
   a. Adam presented the steps for patient definition work and the breakdown of the process that will take for the patient definition to become a description used for a statewide system. He informed the group that the meeting discussion should focus on a definition for use by prehospital providers.
      - The group had previously collaboratively drafted a working definition for out-of-hospital cardiac arrest which was approved by the Time Sensitive Medical Emergencies Advisory Committee (TSMEAC) during the Quarter 3 2025 meeting.

        Out-of-hospital Cardiac Arrest Patient Definition:
        "An out-of-hospital cardiac arrest is defined as an event where chest compressions and or defibrillation were administered by a dispatched first responder, or a defibrillation shock was given at any time before EMS arrival."
   b. Megan gave a presentation on defining ST-Elevation Myocardial Infarction (STEMI) for EMS field triage, referencing national guidelines and addressing symptoms and electrocardiogram (ECG) criteria. The subcommittee then launched into a detailed discussion.
      - Megan emphasized the importance of using the latest American Heart Association and American College of Cardiology guidelines and the fourth universal definition of myocardial infarction (MI) for STEMI, ensuring the definition is nationally recognized and specific to ECG findings.

- Members debated the inclusion of symptoms in the definition, with suggestions to use broad terms like 'acute ischemic signs or symptoms' to capture varied presentations, especially for women and atypical cases.
- Members discussed whether to include STEMI equivalents, ultimately agreeing to keep the state-level definition simple and allow regions to expand as needed, with education to support local adaptation.

c. After extensive discussion, the group reached consensus on a definition:

STEMI Patient Definition:
A STEMI (ST-Elevation Myocardial Infarction) patient is defined as an Acute Coronary Syndrome (ACS) patient who exhibits:

- Acute ischemic signs or symptoms suggestive of myocardial ischemia.
- **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.

There was a discussion on including an "and" in the definition of STEMI. The participants debated whether to include both symptoms and ECG findings in the definition. The final consensus was to define a STEMI patient as one who exhibits both acute ischemic signs or symptoms **and** specific ST-segment elevation on ECG. This approach ensures that both clinical presentation and ECG criteria are considered in the diagnosis.

d. Dana Selover (EMS Program director) explained the process for the definition's adoption: recommendation to the TSMEAC, then to EMS Advisory Board, followed by a public Rules Advisory Committee for finalization and statewide implementation.

4. Roundtable Updates (Megan S.) **(Timestamp: 2h34m)**

a. Committee members shared their perspectives and professional updates on equity, access, and system gaps in cardiac care.
   - Josh Davis described the need for transportation services to improve access to cardiac rehabilitation for patients in rural areas. He referenced existing successful models from urban centers.
   - Dan Westerdahl discussed the need for statewide systems to recognize and triage cardiogenic shock, drawing on national registry efforts and emphasizing the importance of early intervention and regionalized care.
   - Mo Daya highlighted the lack of prehospital extracorporeal cardiopulmonary resuscitation systems in Oregon. This suggests a need for coordinated protocols like those in other states.
   - Megan noted a trend in increased patient transfers to her hospital due to limited catheterization lab availability in some regions. This will be supported longer-term by clearer facility designation standards and improved timeliness of interventions.

5. Administrative Updates (Stella Scott) **(Timestamp: 2h49m)**

a. The EMS Program continues its efforts to fill vacant positions on the subcommittee.
b. All meetings in 2026 will be virtual due to fiscal constraints. In-person meetings may be reconsidered if funding becomes available. Day of the week for meetings will change from Wednesday to Monday.
c. Stella introduced Basecamp as the new document sharing platform for committee members.

6. Public Comments **(Timestamp: 3h00m)**

a. One written public comment was received and read aloud:

Fran Munkenbeck, MD: I agree that we need to keep criteria in the field simple for paramedics and use current ACC criteria. I also agree with Mr Lehrfeld's comments when he talked about approaching a car off the road- sometimes you just have to use your head. In terms of EKG reads-research points to the future use of AI-based ECG analysis to reduce false activations. (ACC News Story 10/28/2025). I am sure over time AI will be used in the EKG criteria. If the EKG in the field reads LBBB- then the ED can be alerted, and the ED can look up old EKGs(if there are any) on the chest pain pt on the way to the hospital and it can be decided by the ED doc whether to proceed to the Cath lab. I cannot talk at public comment time as I have to be somewhere by 12:30P, and I need to take a detour due to a bad accident so need extra time. Thank you.

7. **Key Takeaways (Megan S.)** **(Timestamp: 3h02m)**
   a. Of the eleven subcommittee seats, eight are currently filled. Open positions are the cardiothoracic surgeon, patient advocate/educator, and hospital administrator.
   b. The proposed STEMI patient definition will be brought to the Time-Sensitive Medical Emergencies Advisory Committee for approval.

Meeting adjourned at 12:00 PM.

Next meeting:
February 9, 2026, 9:00-11:00 AM
Virtual only

****An initial draft of this summary was prepared using artificial intelligence tools (Microsoft Copilot). The document was reviewed, reformatted, edited, and checked for factual accuracy by Oregon Health Authority EMS Program staff prior to distribution.****