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AMBULANCE SERVICE PLAN RULE ADVISORY COMMITTEE

May 12, 2026
1:00 pm via Microsoft Teams

RAC MEMBER ATTENDEES

Amy Hanifan	Oregon Fire Chiefs Association
Ben Sorenson	Tualatin Valley Fire and Rescue
Charles Hodge	ComTrans of Oregon
Dan Brattain	Cal-Ore Life Flight/Reach/Airlink
Daniel Chase	Eugene Springfield Fire
Danny Freitag	Santiam Hospital and Clinics
David Jensen	Special Districts Association of Oregon
Heather Land	Treasure Valley Paramedics
Jackson Bauers	Jackson County Public Health
Jerimiah Kenfield	Crook County Fire and Rescue
Josh Beckner	Mid-Columbia Fire and Rescue
Justin Gibbs	Clatsop County; EMS Advisory Board
Katie Harris	Hospital Association of Oregon
Laurie Smallwood	Clackamas Fire District
Marissa Isaak	Adventist Health Columbia Gorge
Mark Fitzwater	Lebanon Fire District
Matt Dale	Canby Fire
Nick Vora	Union County Emergency Services
Robert McDonald	AMR Oregon
Robert Mock	Grand Ronde Tribal Emergency Services
Rose Douglass	Lane Fire Authority
Sabrina Riggs	Oregon State Ambulance Association
Selene Jaramillo	Lane County
Shannon Edgar	St. Charles Health System
Sheila Clough	Mercy Flights
Tiffany Miller	Oregon APCO/NENA
Tim Dooley	Association of Oregon Counties
Tim Hennigan	Scappoose Fire Department

Toni Grimes	Woodburn Ambulance
Trish Weber	Samaritan Lebanon Community Hospital

OTHER INTERESTED PARTY ATTENDEES

Amy Down-Maul	Hospital Association of Oregon
Annie Herbert	Kaiser Permanente
Charles Miller	Washington County EMS
Dawn OpBroek	Adventist Health
Haley Smoot	Legacy Health
John Kubasak	Marion County Health and Human Services

OHA ATTENDEES

Dana Selover	PHD-HCRQI
David Lehrfeld	PHD-EMS Program
Julie Miller	PHD-EMS Program
Justin Hardwick	PHD-EMS Program
Mellony Bernal	PHD-HCRQI

WELCOME AND MEETING PROCEDURES

Mellony Bernal welcomed RAC members, reviewed the agenda, and went over meeting procedures and expectations.

- It was noted that the meeting is being recorded and all information shared is a matter of public record and may be disclosed.
- Per OHA policy, members of the public may observe only. Should public members have information they would like to share, they can send information by email to mellony.c.bernal@oha.oregon.gov or to julie.k.miller@oha.oregon.gov following the meeting. Any information received will be shared with RAC members and OHA staff.
- Microsoft Teams features such as Chat and Raise Hand features were reviewed and instructions on how to communicate during the RAC were shared.
- Information about the EMS Program's rulemaking activity website was shared including where people can find information about new and amended rules, temporary rules, proposed rules, and other relevant information.

Due to the number of participants in the RAC meeting and to save time, roll call and introductions were not completed. RAC members were asked to identify themselves in the Chat.

APRIL 7th MEETING FOLLOW-UP

Dana Selover provided a brief overview of the April 7 meeting which focused on content of the ambulance service plan and the review process. D. Selover also acknowledged receipt of comments from the Association of Oregon Counties which was distributed to RAC members with the May 12 meeting material. It was noted that staff will consider all comments, including from today's meeting, and will consider possible edits.

ADMINISTRATIVE RULE REVIEW

OAR 333-260-0040 – D. Selover acknowledged that comments were received during the April 7 meeting regarding "Boundaries" and making it as easy as possible. She asked whether there were any additional comments.

No additional comments from RAC members.

OAR 333-260-0050 – This rule prescribes the system elements that must be addressed and included in an ambulance service plan including under section (1), public safety answering point dispatch calls, prearranged non-emergency transfers and inter-facility transfers, level of care (basic/advanced life support), staffing, supervising physicians, equipment, and training; section (2) notification and response times; and section (3) quality improvement. It was noted that these items are from a county system wide perspective, not just the ambulance system. The link to the Oregon Health Authority (OHA) Ambulance Service Plan Compliance Review Tool was shared via Chat (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EMS/Documents/Oregon-Ambulance-Service-Plan-Compliance-Tool.pdf). This review tool provides general guidance and examples for development of ambulance service plans.

Staff remarked that the rules have been updated to state that the county must "address and include" information in the ASP versus use of term "consider." It was noted that historically some counties, through their legal counsel, choose not to put specific details in the plan. The intent is to have the county articulate in the ASP how it plans to address this issue of non-emergency transports and interfacility transfers. The county is still able to design their system in the way that they see fit based on their resources and providers, but they must articulate how they're going to do it. Staff further stated that the program is trying to increase clarity and reduce ambiguity.

Discussion:

Section (1)(b) – pre-arranged non-emergency transfer and interfacility transfer (IFT):

- Oregon State Ambulance Association (OSAA) RAC member shared that a survey distributed to its members resulted in a wide range of feedback relating to non-emergency transfer and interfacility transfer with no consensus. Comments received included the hospital should be in charge, free market, partner with anyone they choose, ASA holder should have first right of refusal, support for both current and proposed rules. It was noted that members would be sharing their own individual positions today.
- Via Chat, RAC member commented, that for purposes of 0050(1)(b), their organization recommends leaving the definition of this element up to the individual county to define how each Ambulance Service Area (ASA) provider interfaces with non-emergency and interfacility transports, noting that community resources vary, relationships with ASA providers and community health systems vary, and these relationships and resources may also vary over time.

- RAC member asked whether the system elements cover the entire EMS system, not just ambulance service providers, recognizing that interfacility transfers and non-emergency transports go outside of just ambulance services. D. Selover responded that while the focus is on the ambulance service providers based on the requirement in statute, it's for the entire county *system* which includes a number of things.
- RAC member expressed concern about scope creep and commented that there is ambiguity about exactly what the county has authority to mandate. They commented that based on how the system is built now, the need for prearranged and emergency interfacility transfers is competing with the 9-1-1 system. Concern was expressed about the legality of the county having authority to mandate another government agency such as a special district to perform interfacility transfers; limited public-private partnerships; and a cumbersome complaint process through a county ASA plan. It was recommended that further work be done by OHA on how it interprets this to provide consistency. It was further stated that interfacility transfers should be up to the hospital or the provider.
- The Association of Oregon Counties (AOC) RAC member stated that like the OSAA, there is no uniform position with its members. Appreciation was expressed for keeping the language as is and allowing the local county to define in the ASA plan what the prearranged, non-emergency and interfacility environment should look like. It was expressed that it is the county's responsibility to define and regulate the EMS system, including both emergent and non-emergent care.
- RAC member stated that they are in full support of the county having the ability to regulate non-emergency interfacility transfers.
- Via Chat, RAC member indicated that ambulance service rules should include a clearly defined urgent interfacility transport category for patients who fall between emergent and non-emergent status. They further indicated that rural hospitals frequently care for patients who require timely transfer to a higher level of care or specialty service not available locally, where delays can negatively impact outcomes. The rules should establish a defined timeframe for a local provider’s first right of refusal, after which the hospital may immediately access the next available qualified transport resource to meet the patient’s clinical needs.
- RAC member concurred with the above comment via Chat and noted that as a rural facility, not being able to transfer patients out can negatively impact the patients of the community and those seeking acute emergency services within the ED. They expressed appreciation for the focus of EMS being 911, the Emergency Department must have adequate resources for any patients that arrive via EMS or arrival by private vehicle. Due to limitation from EMS not transporting patients between certain hours 2000-0800, patients are at great risk of deterioration due to not getting definitive care and patients have lost their beds at the receiving organizations. When ASAs cannot be agreed upon between the organization and ASA holder, the county is needed to help reach an agreement.

- RAC member via Chat stated support to leave the current language and the non-e/IFT service up to the County to work with the local provider and stakeholders to ensure all needs are being met. In their area, IFTs are a key component to the ambulance deployment of 5 ambulances, 24/7 to cover the County of 22,000 residents.
- RAC member stated support for language that would prevent the 9-1-1 system from being used as a pathway to circumvent interfacility transport when resources are not available.
- RAC member representing a hospital system expressed support for proposed rule language regarding interfacility transport.
- RAC member reiterated the impact that interfacility transports can have on rural communities.

Section (1)(d):

- RAC member asked whether language could be adopted that prohibits a county from requiring additional continuing education beyond what is required for an EMS provider's license renewal. Staff responded that the state does not have the authority to prohibit the county from setting additional standards. **Follow-up: The Oregon Legislature can create laws to expressly forbid counties from regulating an issue more strictly than the state.**

Section (1)(e):

- RAC member asked for clarification whether the language regarding supervising physicians would include non-transporting EMS agencies. Staff responded that the intent is to have counties specify in the ASP that any EMS provider providing EMS services in the county must have a supervising physician. RAC member further questioned whether non-transporting EMS providers should be considered part of the EMS system considering ORS 682.062 and 682.031, specifically, 'When a political subdivision enacts an ordinance regulating ambulance services or emergency medical services providers, the ordinance must comply with the county plan for ambulance services and ambulance service areas adopted under ORS 682.062.' D. Selover responded that non-transporting EMS agencies are neither licensed nor regulated by the state but are considered part of the EMS system. It was noted that for purposes of the rules, the focus is on the EMS provider who is required by the Oregon Medical Board to have a supervising physician when providing EMS services. The EMS Program sets requirements for ambulance agencies to have one or more medical directors responsible for the quality of care, among other things. The EMS Program does not have authority to require a non-transporting EMS agency to have a supervising physician, so it is up to the non-transporting agency to choose how to meet that requirement.
- Staff further shared that counties are encouraged to develop an EMS system plan, however, the EMS Program has only the authority to regulate ambulance services and EMS providers. This is why the scope is limited to ambulance services and EMS providers in the ASP. The state regulations set the "floor" and counties may choose to implement above and beyond.

Section (2):

- With respect to identifying response times, RAC member asked whether only trauma response times were necessary to identify. Staff clarified that response times for trauma are specified in OAR chapter 333, division 200 so it is expected that ambulance services will comply. Language has been added to rule to incorporate this existing standard into the ASP. A county may choose to adopt additional response times for non-trauma patients, and if so, those response times should be identified in the ASP. It was noted that many ASPs identify trauma response times for general population medical emergencies which are tight standards. The purpose of the rule language is to clarify that counties may consider developing additional response times. Staff further noted that when a stroke or cardiac system is adopted in the future, any response times adopted for those systems would further affect ASPs.
- OSAA representative remarked that several members have commented that the state should move away from adopting response times.
- The AOC representative inquired about how the work of the Time Sensitive Medical Emergencies Advisory Committee would be incorporated in the future and concurred with remark about moving away from response times and focusing more on outcomes. D. Selover responded that if no response times, RAC members should provide recommendations on what language to use.
- RAC member remarked that the language about response times could be applied beyond ambulance services. Staff responded that the purpose of the ASP rules is relating to providing ambulance services.
- RAC member representing a hospital system expressed interest in shifting focus away from response-time metrics as the primary measure of performance. Concern was noted about specifically calling out trauma cases based solely on response times as many trauma-related conditions are not identifiable until crews arrive on scene, making these evaluations retrospective. Response-time data represents only a narrow slice of what matters in time-sensitive emergencies. Example: A ground-level fall may later be identified as a trauma injury, but crews do not know this until on scene. Focusing on this narrow subset can create an incomplete picture of system performance. Emphasis should shift from response-time monitoring to evaluating outcomes of these emergencies.
- RAC member expressed concern about eliminating the response times and allowing an application for an ambulance service that may not have capacity to serve the system.
- RAC member reiterated remarks about response times and stated that the evolution of EMS is falling further away from onerous response times that add costs but aren't necessarily contributing to patient outcomes. It was stated that contracts will migrate towards adjudicating clinical outcomes rather than response times.
- RAC member expressed that they don't have the luxury to wait until clinical outcomes deteriorate and would like to advocate for a standard that holds some leverage for timeliness and for access.

- RAC member via Chat shared that measuring success based on clinical outcomes alone is not sufficient when evaluating ASA timeliness and access performance. Timely access to higher levels of care and specialty services should be measured through defined notification, acceptance, and transport response standards.

Section (3)

- RAC member inquired about the responsibility of a county to monitor compliance with state rules and regulations. Staff responded that the intent is that the county monitor their ambulance service providers to make sure they are following the rules that are outlined in the ASP. If violations were found, then the county would report the violation to the state. Example: The county should identify in the ASP that the ambulance service is required to carry the minimum equipment required by state administrative rule. If the county were to identify that the ambulance service is not carrying the proper equipment, the county would notify the state that they are in violation. RAC members were encouraged to share possible language that ensures a collaboration between the state and county. If there is knowledge of non-compliance and it's not only non-compliant with the county, but non-compliance with administrative rules, there should be reporting requirement.
- RAC member noted that for their county they prefer not to list state rule in ordinances because there's already an expectation that the agency is complying with state laws. The county is not trying to monitor the agency for state violations.
- RAC member asked for clarification specific to subsection (3)(b) specifying a description of monitoring compliance with "overall ambulance service delivery." Another RAC member also inquired under subsection (3)(b) the language about medical review and whether the intent was specific chart review and further inquired how prescriptive the quality improvement (QI) program needed to be. It was noted that each county will have a varied level of capacity based on what they would be able to do in a QI program. Staff responded that they would consider these comments further.
- RAC member via Chat remarked that if "overall ambulance service delivery" doesn't have specific items it's referring to then it should be removed. Ambiguity leads to some county's adding and including a lot more than others who do the minimum. If there is something specific, then spell it out here or in guidance.
- RAC member asked that language under subsection (3)(e) be reconsidered. It was noted that language regarding enforcement may be more punitive than intended for a QI program. The focus should be on provider education.
- RAC member asked if the purpose of the quality improvement program is for ambulance service only or additional elements of the EMS system noting that there can still be poor patient outcomes even if the ambulance is performing at a high level. They further asked if QI is encouraged to happen at a system level with all the various elements coming together and looking towards improving patient outcomes or if it's just focused on the ambulance.

- RAC member shared a potential approach relating to QI specifying that OAR 333-250-0320 prescribes that an ambulance service agency is responsible for creating quality assurance and quality improvement program. The rule does not include a reference to the county. The current proposed language for an ASP references ambulance service delivery and medical review, which appears to infringe on an ambulance service agency's EMS provider and medical director relationship, as well as the QA/QI process. It was suggested that perhaps the language to consider is having the county describe how it will ensure that each ambulance service provider has a QA/QI process in place that is compliant with OAR 333-250-0320, and then the county can have a process in which they just monitor and make sure that each agency has the QA/QI process in place. This could include providing evidence of holding in-house QA/QI processes and showing that the medical director is involved in patient care delivery and medical reviews. This would alleviate concerns about whether the county should be looking at patient care reports or whether they just need to know that patient care reports are being reviewed. It was further stated that not every county has medical personnel with pre-hospital experience. It is counterproductive to have somebody with no pre-hospital experience deciding whether patient care delivery is being applied appropriately. Staff will consider further to avoid redundancy.
- RAC member concurred with comments above and stated they are worried about both scope creep with the county and overlapping responsibilities with the Supervising Physician on roles and responsibilities in the QI process.
- RAC member suggested that language allows EMS system wide agencies coming together and having conversations about improvements. This would not need to entail county review of charts but creating a forum in which all the various agencies providing patient care are having conversations.

OAR 333-260-0060 – This rule is specific to coordination with consumers and ASA providers including mutual aid agreements and ambulance service provider responsibilities in the event of a disaster. It was noted that the county may delegate authority for the development and administration of the ASP to an intergovernmental body. It is expected that the county will receive input from pre-hospital care consumers, ambulance service providers, the medical community and other special populations.

Discussion:

Section (1)

- OSAA representative via Chat noted that reference to "any other special population" is too broad and would appreciate clarification.
- RAC member reiterated ambiguity between transport and non-transport in terms of ambulance service area providers. **Follow-up: the following definitions are included in the proposed rules under OAR 333-260-0010 – (6) Ambulance service provider means an ambulance service licensed in accordance with ORS 682.045 and OAR chapter 333, division 250 that responds to 9-1-1 dispatched calls or provides prearranged non-emergency transfer or emergency or nonemergency interfacility transfers; and (7)**

Ambulance service area provider means an ambulance service provider that has been selected by the county to serve as the primary ambulance service provider in an ASA.

- RAC member noted that since ambulance service plans are adopted in county code, any changes that are necessary due to changes to rule will need to be readopted in code. D. Selover noted that staff will be adding a time frame to rule on when a county will be required to comply and will consider possible options.
- Via Chat, RAC member suggested that existing ASPs stay in effect until they are up for renewal.

Section (4)

- RAC member inquired why 'response to terrorism' was added considering there are a myriad potential events of disaster that could be listed. Staff will reconsider the addition of this language.
- Via Chat the AOC agreed with removing 'response to terrorism.'

Section (6)

- RAC member shared that the requirement to include contact phone numbers for accessing PSAP besides dialing 9-1-1 is problematic if phone numbers changes and require readoption of the plan. It was suggested that consideration be given to how this information may be obtained but not requiring readoption. Another RAC member suggested having an appendix with contact information details that would not require readoption. Another shared having the county give specific authority to an individual to make certain changes that does not require readoption.
- Via Chat, RAC member stated that because most ASPs are in ordinance/code, they'd like to exclude phone numbers from the requirements.
- Another RAC member via Chat agreed to not provide specific contact information that if changed it would require the entire adoption process to update such as phone numbers.

OAR 333-260-0070 – This rule specifies that the county is solely responsible for designating and administering the process for selecting an ambulance service area provider and includes criteria that must be included in the ASP including process for initial assignment, renewal, and reassignment of an ambulance service area provider; application to serve an existing ambulance service area or creation of a new area; responder ambulance service area provider termination; and continuation of existing level of service after an ambulance service area provider vacates an ambulance service area.

Discussion:

Section (2)

- RAC member noted that language was stricken, indicating that an ASP must address a process for responding to an application by a provider. It was stated that most counties

probably do this, but it was requested that the language remain in place. Staff will review and consider.

- RAC asked for interpretation of the language "continuation of existing level of service." It was noted that there are some frontier counties where a volunteer ambulance service just stopped providing services and there was no county level capability to ensure the continuation of service. RAC member asked from an OHA perspective, what is OHA looking for to plan for continuation of service. D. Selover responded that the OHA is looking for a type of contingency plan such as mutual aid agreements where neighboring county may take on services for a period of time. Staff also offered perhaps a change to the level of service provided.
- RAC member shared that one option counties could consider having bonding in place for the contractor, so if they default on performance, there's a way to call that bond and potentially pay or at least cover expenses related to coverage during the interim until another provider is selected.
- RAC member asked if a county has the authority to operate an ambulance service. Staff responded yes, however, the ambulance service would have to be licensed and meet all the requirements in rule to be eligible for a license. This can take a lot of time.

STATEMENT OF NEED AND FISCAL IMPACT

Staff reviewed the Statement of Need, Fiscal and Equity Impact (SNFI) noting that depending on any changes made to the rules may further affect the SNFI. It was noted that the fiscal and economic impact is based on changes from the current requirements. The proposed rule changes include process improvements designed to reduce the number of persons responsible for reviewing an ASP. As such, the OHA identified a possible reduction in the cost to counties. The OHA further noted that the changes do not include any new reporting requirements, nor do they increase the frequency of review for local counties. The impact will be limited to either a reduction in costs or no change at all in the development of an ASP.

- RAC members were encouraged to review the equity impact statement and provide additional comments or feedback.
- RAC member noted possible additional impact given that changes required will mean additional staff time to update the plan, which will need to be readopted by the county. D. Selover asked RAC members to consider how long it would take to make the suggested changes.
- Staff noted that questions related to small business do not apply as the county is not considered a small business as that term is defined.

NEXT STEPS

Staff shared that a third meeting has been scheduled for June 2, 2026 at 9:00 a.m. or the RAC could consider conducting the rest of its work by electronic mail. It was requested that the June 2 meeting remain scheduled and that OHA be prepared to share changes.

RAC members were asked to submit their final comments and proposed rule language by Noon, May 22, 2026.

ACTION ITEMS

- Clarify interfacility transport responsibilities. Consider specifying right of first refusal, outlining when hospitals may seek alternative transport, distinguishing emergent vs. urgent vs. non-emergent transfers.
- Clarify whether non-transporting EMS providers should be included as EMS system element and how they interface with county requirements.
- Clarify or add language that clearly limits requirements in an ASP to ambulance services only, not other EMS system components.
- Clarify expectations regarding response-time standards, including distinguishing trauma vs. non-trauma expectations, recognizing emerging interest in outcome-based metrics, addressing concerns about removing response times altogether.
- Provide clearer guidance for counties on their role in monitoring and reporting compliance including what constitutes “overall ambulance service delivery,” how medical review intersects with agency QA/QI responsibilities, avoiding overlap with supervising physician/medical director roles.
- Consider updating QI language to emphasize education and system improvement, not punitive enforcement. Consider alignment with OAR 333-250-0320.
- Consider language supporting systemwide QI collaboration and provide clarification on ‘medical review’ so not a county driven chart review.
- Remove reference to response to terrorism due to lack of clarity and inconsistency with other disaster language.
- Provide clarity on what is meant by "any other special population" to prevent overly broad or subjective interpretations.
- Reconsider requirements for listing PSAP contact phone numbers, recommending use of an appendix, delegated authority for updating contact information, or removal from ordinance required content.
- Establish a clear time frame for when counties must adopt updated plans and consider allowing existing ASPs to remain valid until their scheduled renewal.
- Provide guidance for counties on planning for continuation of existing service levels including contingency planning, use of mutual aid, potential bonding requirements for contractors.