



State EMS Committee
 Friday, January 18, 2019
 8:30 a.m. – 12:00 p.m.

Portland State Office Building
 800 NE Oregon Street
 Portland, OR 97232

Meeting Minutes

Chair	<i>Ameen Ramzy, MD</i>
Vice Chair	<i>Jim Cole, NRP</i>
Members present	Ameen Ramzy, MD; William Foster, MD; JD Fuiten; Jim Cole, NRP; Elizabeth Heckathorn, NRP; Joanna Kamppi, NRP; Gary Heigel, NRP; Richard Urbanski, MD; Dave Lapof, EMT; Rahul Rastogi, MD; Russ McUne, MD; Brad Adams, MD; Teresa Singleton, RN, NREMT
Members not present	Elizabeth Hatfield-Keller, MD; Casi Hegney-Bach, EMR;
Guests present	Gregg Lander, NRP; Matt Philbrick, NRP; Jacob Dalstra, P; Gary Zeigler; Victor Hoffer, NRP; Nancy Bea, RN;
Public Health Division staff present	Dana Selover, MD; Candace Toyama, NRP; Brandon Klocko, NRP; David Lehrfeld, MD; Rebecca Long, NRP; Yvan Saastamoinen; Nathan Jarrett; Laurel Boyd; Peter Mackwell, NRP; Stella Rausch-Scott, EMT; Julie Miller; Laura Chisholm
Members on the phone	Eric Blankenship, RN
Guests on the phone	Kelly Kapri

Agenda Item	<i>Call to Order – Dr. Ameen Ramzy</i>
The meeting was called to order and roll call was taken. The committee met quorum.	

Agenda Item	<i>Approve minutes and review agenda – Dr. Ameen Ramzy</i>
The agenda was reviewed.	
Elizabeth Heckathorn motioned to approve the minutes presented and Russ McUne seconded the motion. The motion was approved.	
Action	Post October 2018 minutes to the website.

Agenda Item	<i>Bylaw Review & Chair Vote – Dr. Dana Selover</i>
The committee reviewed the current membership. There are two vacant EMS Supervising Physician positions. Dr. Paul Rostykus finished his appointment and has decided to not be	

reappointed for a second term. Dr. Alicia Bond (ATAB 5/ Mercy Flights Inc. Medical Director) has agreed to serve on the board and is awaiting her appointment.

The EMS bylaws were reviewed with quorum and officer appointed term.

ARTICLE IV - Officers

(A) The officers shall consist of the Chairperson and Vice Chairperson.

(B) The Committee shall elect the Chairperson from its membership. The Chairperson shall hold office for a period of two years and may be reelected for a maximum of two consecutive terms. Elections shall be held on a biennial basis (odd years) during the first meeting of the year. The Chairperson will preside at all meetings and conduct the business brought before the Committee.

(C) The Vice Chairperson shall be elected by the Committee. The Vice Chairperson shall hold office for a period of two years and may be reelected for a maximum of two consecutive terms. The Vice Chairperson's duty is to act as Chairperson in the absence or incapacity of the Chairperson or at the Chairperson's request. The Vice Chairperson shall hold office for a period of two years. Elections shall be held on a biennial basis (even years) during the first meeting of the year.

It was confirmed that there were 14 members present to meet quorum. Dr. Ramzy opened the floor for nominations for Chair position.

Chair nomination:

Jim Cole – Dave Lapof motioned. Gary Heigel seconded.

No other nominations were made. Dave Lapof made a motion for a unanimous vote to be cast. JoAnna Kamppi seconded the motion. Motion passed.

Jim Cole will start his role as Chair at the April 2019 meeting.

Jim Cole is currently serving as the Vice Chair and with his new position will need to have a committee member serve the remainder of the Vice Chair position. The person will serve one year.

Liz Heckathorn nominated Gary Heigel to serve as Vice Chair. Dave Lapof seconded the nomination. Gary Hegel declined the nomination.

Jim Cole nominated JoAnna Kamppi for Vice Chair and Gary Heigel seconded the nomination. JoAnna Kamppi accepted the nomination. The motion was approved.

Jim Cole will serve as Chair for two years (April 2019 – 2021).

JoAnna Kamppi will serve as Vice Chair for one year to fill the remaining time on Jim's term (April 2019 – 2020).

Action Item	Update the website with 2019 Committee members.
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Agenda Item	<i>EMS Parking – JoAnna Kamppi</i>
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Agencies are experiencing periods of delay when arriving to the hospital to transfer patient care to the hospital. Chief Kamppi submitted a letter to OHA describing the delays for Eugene-Springfield Fire and Rescue and requested a discussion at the State EMS Committee meeting:

...since the spring of 2015 on the issues surrounding hospital diversion. At that time, there was a committee made up of representatives from both hospital systems and local EMS providers that developed a shared policy. PeaceHealth and McKenzie Willamette Hospital both adopted the policy and it was followed until June of 2018 when the decision was made by one of the hospitals to no longer go on divert, including non-critical hospital divert. This decision resulted in increased wait times for ambulances to offload patients of greater than 60 minutes in some cases.

Other agencies shared that they are also dealing with the same delays at hospitals. Jim Cole stated that hospitals are also delayed due to the wait for ambulances to transport patients out of the hospital to free up beds.

Dr. Rastogi noted that the healthcare system is also creating an issue due to a lack of alternatives to treat patients. Patients are being transported to hospitals/emergency departments that may not be an emergency but have no other way of being seen. Hospital leadership have identified barriers. Some hospitals are creating more space by adding towers. Salem Hospital has created a position that oversees the ED Patient Flow, and it is staffed by a nurse that helps triage the severity of the patient’s medical needs.

It was suggested to look at healthcare partners and other support. Each group has their perspective of the strain and bringing each group together can start the conversation and work together to alleviate the stress and understand the global system.

Dr. Selover offered to invite hospital groups, CCOs and other groups to continue the conversation, after Legislative session. Dr. Lehrfeld requested that there be a consensus of what “EMS Parking” means (universally measurable way).

The committee agreed to further review possible ways of supporting agencies and hospitals by:

1. Collect data and review the wait time. What is an appropriate wait time for patient handoff?
2. What are ways to help mitigate this issue?
3. If the hospital is already at their capacity and there are major surges what will the system do if they cannot currently meet the demands without the surge?
4. Is there a toolkit for agencies and hospitals to use to help with this issue? If not, what should be created?

Action Item	Continue discussion at a later meeting.
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Agenda Item	OR-EMSIS – Laurel Boyd
Waiver process for OR-EMSIS reporting compliance	

Since Jan 1, 2019, with implementation of Senate Bill 52, we have seen a 10% increase in agencies going live and expect to see another large increase in the next month or two as we reach out to agencies that are not currently compliant with the reporting rule.

Incident review

In mid-December there was an issue where an independent contractor for the state, working on helping an agency transition to the current NEMESIS data standard, accidentally migrated personnel permissions for the entire state instead of for this single agency. This effectively overwrote personnel permissions for system users with more than 2 years of history in the platform. This had the potential to add or drop personnel from agencies and enable increased or decreased permissions for viewing or creating records.

The state worked with partners (State Fire Marshal, Public Health Communications, Health Security Preparedness & Response, Database Vendor) to evaluate risk of data breach (deemed low), create a plan for fixing access and permissions, and to contact all agencies with a summary of what happened and action steps to take to correct access for their users.

OR-EMSIS

To help kick-off the first year of the new state mandate for EMS data reporting, the state created a video featuring personnel from two Oregon EMS agencies talking about successes using electronic data. See video here: <https://youtu.be/FGrLQwJKECQ>

This video will be posted online: <http://www.Healthoregon.org/or-emsis>

Other changes to the website include:

- Addition of chart which tracks the status of transport agencies (How many are live? How many are in progress? How many haven't started)
- A list of agencies and vendors with active/live projects in the state.

OHA offered the State EMS Committee the opportunity to prioritize the first EMS data for 2019 by selecting two topic areas of focus for the EMS Data workgroup, which will create metrics for each topic. These topics will also inform the development of the first annual EMS report.

The two topics:

- Opioid Overdose
- Lights and Sirens use for EMS response and transport

2019 OR-EMSIS project priorities

- Update OR-EMSIS strategic plan for 2019-2020 and post online.
- Align statewide performance measures and post online.
- Reduce agency administrative effort by integrating eLicense with agency and personnel information in Elite.
- Offer more EMS agency trainings; next planned EMS training in October 2018 at the Portland State Office Building.
- Build reporting tools for agencies on the State's ePCR product in the report writer section.

Agenda Item	<i>EMS Committee Goals small group discussions– Dr. Ameen Ramzy</i>
	<p>Group 1-</p> <ul style="list-style-type: none"> • Create a QI subcommittee to support and standardize the process for agencies and providers. • How to engage Oregon EMS Medical Directors and review the current system. The group discussed what it would look like to start the entire process from scratch, regional EMS medical direction and how the position could be compensated if the position was regionalized. • Identify what legislation needs to be supported to include non-transporting agency under the EMS office. • To improve and shift the culture in EMS with performance issues and reviews of care. <p>Group 2-</p> <ul style="list-style-type: none"> • QI Subcommittee. • Medical director expectations. • Need to improve the culture of teamwork from dispatch to the hospital administration. <p>Group 3-</p> <ul style="list-style-type: none"> • Communication and handoff with patient care from transporting agency to the hospital. Strategic plan needs to be drafted to include the data points that providers will collect. Start with small metric standards and build on this. The process would have a robust guidance with step-by-step guide on what is being identified and why. This entire process would be over a five-year plan. • Capacity of different regions of the state. This would include surge planning, equity of treatment for different types of conditions and disparity of care in Oregon. <p>The committee reviewed the above topics and prioritized work:</p> <ul style="list-style-type: none"> • EMS Medical Director/Supervising Physician overview and leadership for prehospital EMS Quality Assurance and Performance Improvement • Surge capacity for Oregon EMS responses across the state and over borders. • Improve communication between prehospital agencies and hospitals.
Action Item	Review next steps at the April 2019 meeting.

Agenda Item	<i>Higher Education Coordinating Commission (HECC) – Elizabeth Heckathorn</i>
	<p>HECC was created in 2016 for the accreditations for EMS and Paramedic Programs. Elizabeth Heckathorn, KC Andrew and Suzanne Schmidt State EMS Advisory Committee requested an update on HECC's work:</p> <ol style="list-style-type: none"> 1. A brief explanation about who/what HECC is and how they interface/work with Oregon Education Department, Work Force Development and OHA EMS and Trauma, and provide financial support for the EMS Education Programs (Grants/Loans). 2. What work/accreditations have been completed since 2016 and accreditations in 2018/19.

- 3. Changes to the accreditation process.
- 4. Highlights of rule changes and a timeline.

Elizabeth Heckathorn will present in October an update on the work and the rule changes.

Agenda Item	<i>Rural EMS Workgroup – Dave Lapof & Yvan Saastamoinen</i>
	<p>Rural Ambulance Billing Workshop A 4-hour post-conference Rural Ambulance Best Practices session was hosted at the EMS Conference in Salem last September. 14 people representing 12 agencies attended. Hosts learned that holding a workshop on Sunday was difficult for both the conference staff and the attendees. Dave Lapof reached out to the Oregon State Ambulance Association for input and support for the rural agencies and with their and other groups' support, a Rural Ambulance Billing workshop will be held in April or May 2019 at St. Charles Medical Center- Bend on a Saturday. System Design West, who supports billing for rural providers in Oregon, Metro West Ambulance, and ImageTrend have all been invited to teach and support Oregon's rural agencies. Staff from OHA/EMS& Trauma office and other guests will also be attending. This will be an all-day event and free to the attendees with lunch provided.</p> <p>SIREN Act SIREN Act, a bill supported by the National Volunteer Fire Council (NVFC) that creates a grant program within the Department of Health and Human Services (HHS) for rural EMS agencies. The SIREN Act reauthorizes the Rural EMS Training and Equipment Assistance Program at \$20 million per year through FY 2023. Eligible entities include local and tribal government EMS agencies, as well as nonprofit EMS agencies, that are in and/or serve residents of rural areas. Funds can be used to train/educate personnel, obtain/maintain licenses and certifications acquire EMS equipment (including PPE), recruit and retain personnel, or develop new methods for educating emergency health care providers using technology. Individual awards will be capped at \$200,000 and grantees will be required to put up a 10 percent local match.</p> <p>National Discussion National EMS License conversation is discussing paramedic licensure requiring a degree. All national fire associations are opposed to this. The NVFC also joined to oppose promoting the requirement as they believe it will be a financial hardship to volunteer EMS agencies and make having paramedics more difficult.</p> <p>Differences in Access to EMS Resources Across the Urban-Frontier Spectrum The VISTA project analysis of rural and frontier EMS agencies update was presented.</p> <p>Background As a state, we are starting to review the difference in access to resources between rural and urban areas. Work is taking place around disparity concerning rural hospitals and other</p>

branches of healthcare, but it affects pre-hospital care as well – EMS needs to be included in this conversation.

Objectives

Create a measure that could be applied to all licensed agencies that would determine the health of the agency.

- Gather data on EMS agencies in Oregon.
 - We first needed to gather data on EMS agencies in Oregon.
- Create a process of assessing the health of EMS agencies based on data
 - With the data we can create a measurement tool.

Method (Office of Rural Health Urban-Frontier Defined Areas)

- Used Office of Rural Health definitions of Urban, Rural, Frontier to categorize agencies
- Urban: City with 40,000 or more people + 10 miles from the center
- Rural: >10 miles from a center of 40,000 or more
- Frontier: 6 or fewer people per square mile

Method – Survey

Survey was sent out as a component of license renewal with questions related to response, staffing, funding, variances, etc.

- Sent to all licensed agencies in Oregon (N=134)
 - 23 Frontier
 - 83 Rural
 - 28 Urban
- 16 questions: 15 multiple choice) and some with multiple parts
- 15 objective questions
- 1 subjective question
- All self-reported

Method – Sources

- Accessed several sources to learn about each agency
- Sources included:
 - eLicense survey
 - Oregon EMS Information System (OR-EMIS) and Oregon Trauma Registry (OTR)
 - eLicense
 - Oregon Health Authority internal data
 - Previous OHA surveys
 - Ambulance Service Area (ASA) plans

Method – Assessment

- Develop scoring system using information that may be indicators of the health of an agency.
- Each item is weighted based on its objectivity or subjectivity. Those items known to be true are weighted more heavily than those based on opinions of agency staff.
- Lower total scores as an outcome of the scoring system may indicate agencies with a less stable infrastructure.

Results – Assessment

Used Office of Rural Health definitions of Urban, Rural, Frontier to categorize agencies. Sent out survey on eLicense as a component of license renewal with questions related to response, staffing, funding, variances, etc.

Data Points

- Annual call volume
- Primary ASA holder
- Type of service
- Number of ambulances and personnel
- Sources of funding

Four categories

- Green – positive
 - Score of 86-100
 - 55 agencies
- Yellow
 - Score of 68-84
 - 36 agencies
- Orange
 - Score of 48-65
 - 30 agencies
- Red – negative
 - Score of 29-47
 - 12 agencies (including one that has since closed)
- Many of the red agencies are near urban areas
- Many of the orange are in frontier counties
- All orange and red agencies are in rural and frontier areas

Assessment

- Develop scoring system based off certain survey responses that we determined were indicators of the health of an agency.
- Assessment method used data points that are objectively positive or negative.
- Each item is weighted based on how essential it is to the adequate functioning of an agency.
- Lower total scores indicate agencies with less stable infrastructure.

Conclusion

- 41 rural services are demonstrating weak infrastructures according to the scoring system and are likely in need of additional support.
- The top concerns reported by Oregon services are recruitment and equipment challenges.

Moving Forward

- Look for trends in the data and determine if there are identifiable contributing factors and create a strategic plan to address any identified contributing factors.
- Identify a county with EMS services that are among the highest at risk for closure and work with stakeholders to create a plan that identifies opportunities for improvement within that community and assist them with taking action.

- Look at which factors exist among many of the high-scoring services and offer these promising practices as ideas to other county leaders and EMS stakeholders.
- Developed and Distributed the Oregon EMS Resource Guide
 - Print version with selected resources/webpage with much more content
 - Online – resources for billing, Community Paramedicine, active grant opportunities, mental health resources, recruitment, and more
 - Will have a large focus on updates to Recruitment and Equipment

Agenda Item	<i>EMS/TS Directors Update – Dr. Dana Selover, Dr. David Lehrfeld, Candace Toyama</i>
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Office of Rural Health Grant

The Oregon Office of Rural Health (OORH) in partnership with Oregon Health Authority (OHA) EMS & Trauma Systems (EMS&TS) program is actively seeking information regarding current challenges and emerging beneficial practices in EMS. Funding to support this work was received by OORH from the HRSA Medicare Rural Hospital Flexibility Grant program. Information from these meetings will be used to inform EMS regulatory bodies to create sustainable support for rural EMS. Topics of discussion may include but are not limited to:

- ASA planning and compliance
- Billing for EMS services (including lift assistance, standby services and Community Paramedic Services or Mobile Integrated Healthcare)
- Connecting with county government, local healthcare partners or your community
- Understanding, implementing and using data from Electronic Patient Care Reports (PCRs/PCRFs)
- Equipment and Education requirements and needs
- Medical Direction (recruitment, cost, availability, contracts)

Legislation Update

Priority	Bill #	Bill Summary
1	SB 29	OHA Housekeeping Bill – For purposes of EMS: <ul style="list-style-type: none"> • Amends State Trauma Advisory Board, Area Trauma Advisory Board and State EMS Committee membership. • Revises definition of term "patient" for purposes of emergency medical services by eliminating requirement that person must be transported by ambulance to be a patient. • Clarifies that both ambulance vehicles and EMS providers operating vehicles under control of the US Government are exempt from Oregon licensure requirements. • Removes outdated EMS provider physical and mental health language for licensure and updates language to align with other health care professional licensing boards.
3	HB 2620	Reference sections 25-28 and 51-56 Authorizes cities and rural fire protection districts to adopt plans to provide ambulance and emergency care services to city or rural fire protection district.

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| 3 | SB 452 | Directs Oregon Health Authority to develop triage, treatment and transportation protocols for patients who carry emergency use medications. Allows emergency medical services provider to administer to patient emergency use medication carried by patient. |
| 3 | SB 544 | Requires ambulances to carry emergency treatment medication for adrenal insufficiency disorder. Authorizes Oregon Health Authority to adopt rules. |
| 4 | HB 2065 | Directs each manufacturer of covered drugs that are sold within this state to participate in drug take-back program for purpose of collecting from certain persons those drugs for disposal. |
| 5 | HB 2082 | Requires Class II and Class IV all-terrain vehicle operator 16 years of age or older to carry and present both driver license and all-terrain vehicle operator permit. Requires Class II and Class IV all-terrain vehicle operator to complete safety education course or pass equivalency examination to obtain all-terrain vehicle operator permit. Limits Class II all-terrain vehicle operator permits to persons 15 years of age or older. Directs State Parks and Recreation Department to adopt rules to provide for Class II all-terrain vehicle safety education courses and to issue operator permit to person who has taken course. |
| 5 | HB 2138 | Extends sunset for tax credit for provision of volunteer emergency medical services in rural area. |

Priority level key

- 1 - Major
- 2 - Medium
- 3 - Minor
- 4 - Relating Clause Only
- 5 - Lurking Only

Oregon Department of Transportation - Oregon Traffic Safety Performance Plan

Data visualization

Oregon's EMS Workforce 2014-2015, 2017

EMS Level	2014	2015	*2017
Emergency Medical Responders (EMR)	1,596	1,932	2,394
Emergency Medical Technician (EMT)	5,366	4,407	4,762
Advance/Emergency Medical Technician (A/EMT)	60	83	162
Emergency Medical Technicians-Intermediate (EMT-I)	918	795	748
Paramedics	3,617	3,347	3,779
Total	11,557	10,564	11,845

Data according to Oregon Health Authority. All EMT's are expected to renew their license once in two years.
 *2016 Data does not exist, during this year Oregon transitioned their licensure levels to match national levels.

Oregon's Average Response Times 2015-2017

	2015	2016	2016 Difference
Response time	7	6	-1
Time on Scene to stabilize and prepare for transport	14	16	2
Transport time to medical facility	13	15	2
Total Incident time	34	37	3

Data according to Oregon Health Authority. 2015 reported in median minutes.

Goals

Increase knowledge of EMS Personnel by increasing the numbers of EMTs in Oregon's workforce from 11,845 (2017) to 15,004 (2025).

Decrease response, scene and transport times, through training and appropriate equipment, form the statewide average of 36 minutes (2015-16) to 32 minutes (2020). Data is suggesting that Lights and Sirens emergency response time is overused and should be reviewed.

Correct triage of trauma patients from motor vehicle Trauma

- Risk adjusted mortality in motor vehicle traffic.
- Patients meeting CDC Step 1 or 2 field triage criteria originating from a 911 request transported directly to a level I or II trauma hospitals.
- Patients meeting CDC Step 3 or 4 field triage criteria originating from a 911 request transported directly to a level I, II, III or IV trauma hospitals.

Vehicle Safety

- Delay-Causing Crash Rate per 1,000 EMS Responses
- EMS Crash Rate per 100,000 Fleet Miles
- EMS Crash Injury Rate per 100,000 Fleet Miles
- EMS Crash Death Rate per 100,000 Fleet Miles
- Lights and Sirens Response to Scene Rate
- Lights and Sirens Transport Rate

Proposed Performance Measures

- Increase the number of scholarships and online training for individual rural EMS personnel from 99 (2017) to 108 (2020).

- Decrease response, scene and transport times, through training and appropriate equipment, form the statewide average of 36 minutes (2015-16) to 32 minutes (2020).

National Cardiovascular Data Registry (NCDR) – 2019 eReports EMS STEMI

EMS and system of care performance metrics, including:

- First Medical Contact (FMC) to first 12 Lead time interval;
- First STEMI positive 12 Lead to hospital notification time interval;
- Percent of STEMI cases with and without field request for cardiac catheterization lab activation;
- Symptom to device time interval;
- FMC to device time interval;
- Metrics filtered with or without cases transferred in from non-PCI hospitals or both

NCDR has stated that if an EMS transporting agency takes a patient to a hospital that participates in NCDR then the EMS agency will receive patient outcomes.

Oregon Surge Plan – HSPR

Peter Mackwell updated the committee on the current work that is taking place with the state ambulance surge plan. He will update the committee as the work moves forward.

Agenda Item	<i>Public Comment</i>
	<p>Candace Toyama presented a certificate of recognition to Elizabeth “Liz” Heckathorn. Liz served as a committee member and this was her final meeting. The office wanted to thank her for her work and participation.</p> <p>Candace invited everyone to a celebration of service at the April meeting for Dr. Ameen Ramzy. It will be Dr. Ramzy’s final meeting as an appointed member.</p>

Agenda Item	<i>Meeting adjourned at 11:55 a.m.</i>
	<p>Next scheduled State EMS Committee Meeting - April 12, 2019 / PSOB Building / 8:30 a.m. – 12:00 p.m.</p>