Oregon Health Authority

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

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

Meeting Minutes

Chair	*Jim Cole, NRP*
Vice Chair	*Joanna Kamppi, NRP*
Members present	Ameen Ramzy, MD; William Foster, MD; Jim Cole, NRP; Joanna Kamppi, NRP; Gary Heigel, NRP; Richard Urbanski, MD; Russ McUne, MD; Teresa Singleton, RN, NREMT; Alicia Bond, MD; Mike Fletcher
Members not present	Casi Hegney-Bach, EMR; Brad Adams, MD; JD Fuiten; Rahul Rastogi, MD
Guests present	Matt Philbrick, NRP; Jacob Dalstra, P; Dave Lapof, EMT; Victor Hoffer, P; Jan Acebo, P; Jake Shores, P; Gregg Brown, RN; Brandon Means, RN
Public Health Division staff present	Dana Selover, MD; Candace Toyama, NRP; David Lehrfeld, MD; Rebecca Long, NRP; Nathan Jarrett; Laurel Boyd; Stella Rausch-Scott, EMT; Julie Miller; Laura Chisholm; Elizabeth Heckathorn, NRP; Laura LaLonde; Nathan Ramos; Kristin Lingman;
Members on the phone	Eric Blankenship, RN; Elizabeth Hatfield-Keller, MD
Guests on the phone	Kelly Kapri; Steve Brost

Agenda Item	*Call to Order – Jim Cole*
The meeting was called to order and roll call was taken. The committee met quorum. Jim introduced Dr. Alicia Bond, Mercy Flights, Inc's Medical Director and ED physician at Providence Medford and Asante Rogue Regional Medical Center. She is newly appointed to the State EMS Committee. Membership was reviewed. The state is reviewing and updating the process with how they will announce open positions and recruiting. OHA is continuing to diversify the boards and committees to have best representation of communities that are served. The future process will be formal.	

Agenda Item	*Approve minutes and review agenda – Jim Cole*
The agenda was reviewed, and no changes were requested.	

Dr. Willy Foster motioned to approve the minutes presented and Dr. Russ McUne seconded the motion. The motion was approved.	
Action	Post January 2019 minutes to the website.

Agenda Item	*Pulsara Presentation – Gregg Brown & Brandon Means*

Pulsara is a mobile communication network that connects EMS and Prehospital care to the Hospital. This allows EMS to start a patient's case and notify the hospital that a patient is coming to the hospital while inputting patient information and pertinent information. This allows the hospital to prepare for the incoming patient and notify the correct staff that need to participate with the patient's care.

Questions following the presentation:

Does the program have to have a cell signal to send information to the hospital? The program is cloud based but must have a signal to send and receive information. The current process for the transporting unit is to contact the hospital to notify of the call coming in. The ED can start the patient chart, on behalf of the agency, and activate the necessary team members. The agency will be able to upload the information to the chart once they have cell service. Pulsara is working with First Net and Public Safety Network to provide better coverage for agencies in rural areas.

When the crew is cleared from the call will they receive follow up information in the field?
The crew will no longer receive push notifications from the hospital once they transfer patient care in the system. The crew would have access to patient follow up. The time can be adjusted on the agency and hospital agreement. Agency administration will have access to the patient data for further use for PA/QI.

Is the program designed to link or upload the patient information to a third-party charting system?
Pulsara is an open AGI and can input the data to the ePCR but the vendor is required to create the connection.

QI study
Reduced wait time - Study from the FLORY institute found a 10-minute reduction in turnaround time in EMS service.
Currently Pulsara is free for hospitals and pre-hospital use. There is an annual fee for hospitals that decide to use Pulsara for anything outside of the Emergency Department and for live video feed.

It would be beneficial for an environmental scan of different products and capabilities before a large investment is completed.

Action Item	The state will complete an Environmental Scan of programs that are similar to Pulsara if they consider purchasing Pulsara.

Agenda Item	*OR-EMSIS – Dr. David Lehrfeld & Laurel Boyd*

Agency status update

All transition statuses are reported in real-time on OHA website **Healthoregon.org/or-emsis**. Agencies had tipped the 50% mark in December and saw another boost (~10%) in the last quarter as agencies that were working until the deadline (and a bit beyond) went live. The state is reaching out to agencies to discuss their timeline for coming on board. Agencies technically have until 12/21 to transition (at which point the option for a waiver will expire) though we are encouraging (see strategic plan), and most are choosing to, transition before then. Importantly, all transport agencies are able to transition within 2019 if they choose to do so.

Data Strategic Plan

The EMS data strategic plan was finalized for the 2018-2020 timeframe. (Work on this plan had been delayed several months due to changes in leadership.) The updated plan is posted online and includes updates to existing objectives (for instance, a goal of 90% of eligible transport agencies sending data by the end of 2019) and new goals and objectives: such as "Implementing community paramedicine reporting" on page 14. New opportunities for the next three years include new grant funding from CMS (Health Information Technology for Economic and Clinical Health (**HITECH**) Act funds to be used in one-time interoperability projects) and learning from CMS ET3 pilot funds.

We plan on updating this plan in fall 2019 for the next 3 years.

Data workgroup

The workgroup has met twice and are updating the schematron. There is a wide representation from agencies around the state. The first work project is to automate CARES information from OR-EMSIS.

Lights and Sirens Data Review

The presentation was a follow up request from the committee to review the current OR-EMSIS data collected:

ODOT has updated the Performance Plan for EMS to include:

- Performance Plan
  - Decrease response, scene, or transport times from the statewide average of 36 minutes in 2015-2016 to 32 minutes by December 31st, 2020.

NHTSA national benchmarks released in 2009:

- 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

2015 NHTSA created performance measures from already collected data. Two that were focused on:

- A rate of emergency lights and sirens responses. This includes each vehicle responding to an incident.
- A rate of emergency lights and sirens transports. This includes each vehicle transporting from an incident with one or more patients.

Published evidence stated that a small subset of patients benefit from light and sirens being used, but overall the use of lights and sirens is associated with increased risk of ambulance crashes.

NHTSA 2018 performance measures:

- Target L&S response to 911 calls to less than 50%
- Target L&S transport rate of less than 5%

ODOT data was collected and reviewed.

	Crash	Injury
L&S Only	18	20
Total	53	51

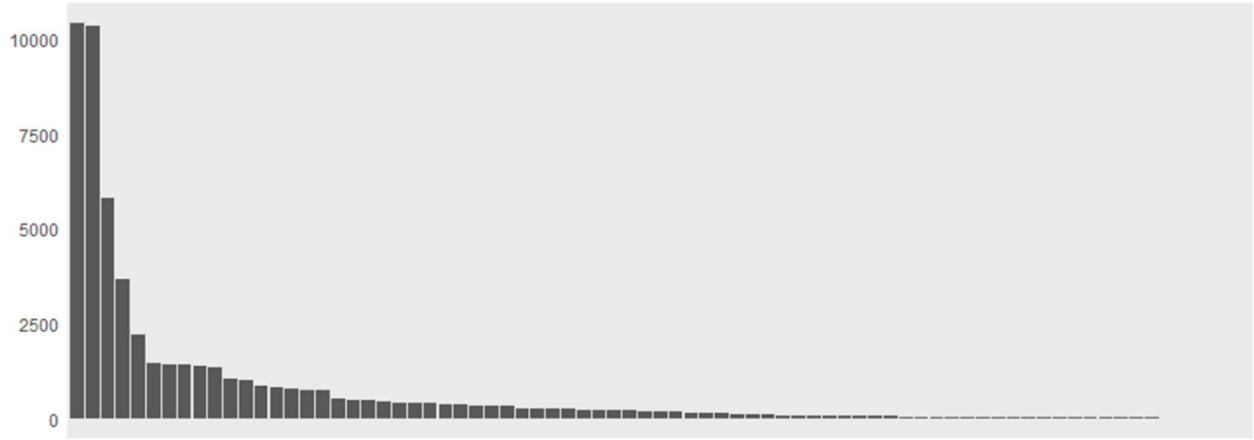
Framing the discussion around the data includes:
What is the association between response times, crashes and lights and sirens use.
The COMPASS collaborative developed a Lights and sirens process measure.
Essentially, the measure evaluates the number of EMS responses where L/S were used out of all 911 responses.
Reviewed the last six months (Oct. 2018 to March 2019) there were 156,000 ePCRs that were submitted.
The NEMSIS variables used was the type of service requested (e.g., 911, from eresponse.05), and the description of response mode (eresponse.24). A non-nemsis metric that was included was looking at the response mode (eresponse.23).
All elements are on the Oregon "State" schema and as such, all Oregon agencies should record these elements. Eresponse.05 and eResponse.23 are both mandatory and come with a predefined list of options. Mandatory means that an option from the list must be selected (a NULL value isn't required). Required elements, like eresponse.24 do allow the submission of "NULL" or not applicable values.
A consolidation of the 12 categories into 3:

- Any lights, any sirens;
- No lights or sirens
- Not recorded/not applicable

The reviewed eresponse.24 among transport agencies:

Any Lights, any Sirens		No Lights or Sirens		Not Recorded or Not Applicable		Total Calls	
N	%	N	%	N	%	N	%
68114	43%	28860	18%	59623	38%	156597	100%

More than a third of the 157 thousand ePCRs in the timeframe did not record the information. In fact, population of the variance by agency ranges 0% to 100%



Each bar represents an agency and that some agencies are wholesale not collecting this information.

Use of Lights and Sirens in ground transport, 911 calls:

	N	%
911 responses	144985	93%
Other responses	11612	7%
Total calls	156597	100%

Most ground transports are 911 responses (ereponse.05 = 911). Of these ~145 thousand calls, how many used lights and sirens?

	Any Lights, any Sirens		No Lights or Sirens		Not Recorded or Not Applicable		Total	
911 responses	**N**	**Row %**	**N**	**Row %**	**N**	**Row %**	**N**	**Row %**
	67318	46%	23583	16%	54084	37%	144985	100%

Simply using the COMPAS metric, 46% of 911 service requests reported using L/S. The suspicion is 46% is likely an underestimate. Can the team better approximate this compass metric?
We called an agency where eResponse.24 (use of LS) is not populated for any calls in the last 6 months.

The agencie stated use eResponse.23 (type of response) instead. For them, that emergent response always means use of LS.

This is an interesting finding given that current scientific evidence is increasingly nuanced in the use of LS (is no longer recommending the wholesale use across the board).

eresponse.23 – Can “emergent” response (aka, LS used) help fill in the gap where LS use is not reported? Reviewing the “type” of response half the calls without documentation of lights and sirens are EMERGENT calls. This added an extra 29,000 calls in the calculation.

Emergent (Immediate Response)		Emergent Downgraded to Non-Emergent		Non-Emergent		Non-Emergent Upgraded to Emergent		Missing		Total	
N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
29289	54%	1307	2%	23289	43%	185	0%	14	0%	54084	100

To estimate use of lights and sirens, all variables in combination:
Emergent response (where LS use is not documented) OR LS use documented.
Of 145 thousand calls, 67,000 documented use of LS.
Another 54,000 documented “not recorded” or “not applicable”, of those, 29,000 documented emergent response.14 calls had no type of response documented.

911 responses	Any Lights, any Sirens (or Emergent)		No Lights or Sirens		Not Recorded or Not Applicable		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
	94,465	65%	50,506	35%	14	0%	144985	100%

The percentage jumped from 46% to 65% by combining eresponse.23 and eresponse.24
This may be a more accurate estimate of where agencies are at about uniform use of “emergent’ response. Are these fields being used synonymously?

	Any Lights, any Sirens			No Lights or Sirens			
	N	**Col %**	**Row %**	**N**	**Col %**	**Row %**	**Total**
Emergent (Immediate Response)	68377	97%	95%	3477	14%	5%	71854
Emergent Downgraded to Non-Emergent	1962	3%	98%	33	0%	2%	1995
Non-Emergent	42	0%	0%	21165	86%	100%	21207
Non-Emergent Upgraded to Emergent	327	0%	96%	13	0%	4%	340
Total	70708	100%	74%	24688	100%	26%	95396

Where both response type (eresponse.23) and response descriptor (eresponse.24) are recorded (about 2/3 of records), reviewed when lights and sirens was recorded, the response

was overwhelmingly (97%) emergent. Where response was emergent, lights were used in 95% of calls. The understanding is that emergent shouldn't always necessitate use of lights and sirens, but initial findings indicate that this could be how EMS agencies are understanding this field. To review further looking at both a data quality initiative and education around the use of LS for emergent transport (when appropriate, etc.)
Other questions to ask (how this affects response time? What about use of L/S in patient transport? How to rank agencies with use of LS?).

How often are lights or sirens (L/S) used by EMS when responding to a scene? Approximately 65%
In patient transport? Pending
Does use of L/S align with urgency of response? Emergency responses almost always use L/S.
Is there an accepted standard or metric we can use for this analysis? Depends on how good the data is.

What are possible next steps:

- eResponse 24 is a required variable in the National and State Schema
- It is recommended by NHTSA to benchmark your performance
- Agencies will need to focus on data quality to benchmark themselves

Oregon Health Authority

- Review the percentage of eResponse.24 within agency?
- Distribution of eResponse.24 across agencies?
- Distribution between the highest and lowest performing agency and compare to NHTSA performance measures.

EMS Committee

- Develop and implement a strategic plan for increasing data quality around lights and siren use.
- Set benchmarks and timetables for Oregon EMS to achieve benchmarks.
- Involve Agency Medical Directors, OSAA, ODOT and Fire Chiefs to discuss ways of improving agency response in Oregon.

Thoughts –
County's do not have system requirements written into the ASA plan. The agencies are attempting to respond with their assets but are unable to meet requirements. Trauma response times are written into the ATAB plan. The ASA requires EMS response is written with the require Trauma response times which then reflect general guidelines for EMS times. How can first responders get to a scene quickly to provide care before the ASA provider arrives?

How many types of call triaging systems are in the PSAP centers? Can Oregon PSAPs have numerous systems designed for different types of call triaging (EMD program)?
Agencies are not mandated to provide medical dispatch. DPSST – Telecommunication Certification requires for the dispatcher to have training but is not required to keep the basic certification active.

If the relationships are good between PSAPs and the ASA provider, it is known that the agencies will continually review and update their EMD to improve patient care and response time. In larger areas it is not uncommon for private and fire-based EMS systems to study and update dispatch guidelines. OHA has applied for an Opioid grant that includes identifying which PSAP agencies give instructions to the 9-1-1 caller for opioid overdose patients. What does the committee want to do with this information? Transitioned into *EMS Committee 2018/19 Goal Review* discussion to create workgroups and action items.	
Action Item	Oregon Health Authority • Review the percentage of eResponse.24 within agency? • Distribution of eResponse.24 across agencies? • Distribution between the highest and lowest performing agency and compare to NHTSA performance measures. EMS Committee • Develop and implement a strategic plan for increasing data quality around lights and siren use. • Set benchmarks and timetables for Oregon EMS to achieve benchmarks. • Involve Agency Medical Directors, OSAA, ODOT and Fire Chiefs to discuss ways of improving agency response in Oregon.

Agenda Item	*EMS Committee 2018/19 Goal Review – Jim Cole (1:41)*
The EMS Committee has drafted work that the group would like to move forward with. The committee reviewed and prioritized this work: • Improve communication between prehospital agencies and hospitals. • 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 Next steps for these goals are identifying workgroups through stakeholders, committee members and EMS/Trauma Systems staff. *Improve communication between prehospital agencies and hospitals.* Jim Cole will facilitate this workgroup. *Surge capacity for Oregon EMS responses across the state and over state boundaries.* Chief Kamppi will facilitate this workgroup. *EMS Medical Director/Supervising Physician overview and leadership for prehospital EMS Quality Assurance and Performance Improvement.*	

Dr. Erin Burnham, National Association of EMS Physicians (NAEMSP) Oregon Chapter President, gave an overview of what NAEMSP is, the work they currently do, who the members are. The group is designed to improve EMS care by promoting meetings, publications, advocacy for legislative change, and research in the field. The Oregon chapter (2013) has 53 members including Medical Directors and EMS agency Directors. Oregon is one of the top active chapters, nationally. Some of the work the chapter has organized is EMS professional trainings and two Medical Director overview/introduction courses and Oregon EMS Forums bi-annually. Discussed Statewide systems of cares, helped develop the CARES registry in Oregon and hosted Resuscitation Academy. Could the EMS committee support the Oregon NAEMSP Chapter, and if yes, how? Currently there are 150(+) Medical Directors/ Supervising Physicians and the range of how active with their role varies. Would the workgroup consider reviewing what a regional Medical Director system would involve and currently look like for the state? The EMS Licensing system could support work and identify issues that may need further help from the committee. Why are many Medical Directors not involved in statewide group? Is it due to time, funding, unknown list of resources? The state Medical Directors are inconsistent. Many Medical Directors have not attended the training or attend Medical Director meetings. Dr. Russ McUne, Dr. Alicia Bond and Dr. Erin Burnham will work together on this workgroup. The goal for the next meeting is each group would bring to the committee a workgroup of who the stakeholders and meet one time before the July meeting.	
Action Item	Workgroups: • Improve communication between prehospital agencies and hospitals. – Jim Cole • EMS Medical Director/Supervising Physician overview and leadership for prehospital EMS Quality Assurance and Performance Improvement. – Dr. Russ McUne, Dr. Alicia Bond • Surge capacity for Oregon EMS responses across the state and over borders – Chief JoAnna Kamppi Next meeting each group will bring to the committee a list of who the stakeholders and meet one time before the July meeting. Send to the state a written update.

Agenda Item	*Ameen Ramzy Recognition – Dr. Dana Selover & Candace Toyama*
Dr. Dana Selover presented to Dr. Ameen Ramzy a plaque and recognized his contribution to the EMS Committee and to Oregon's EMS program. Dr. Ramzy has participated in the EMS Committee since 2009 and was voted as Vice Chair in 2011 and Chair in 2013. Dr. Ramzy brought in rich discussion by breaking into small groups and identifying and discussing issues in EMS around the state. Dr. Ramzy thanked the group and state for the recognition for his work.	

Agenda Item	*Rules Advisory Committee (RAC) – Candace Toyama*
RAC 333-255-0010 and _0060 The Rules changes do not include new rules but are to organize the vehicle standards. -0010(3)(c)(K) moved the vehicle building requirements out of the application requirements. This is a duplication in the rule. -0060 removed the standard requirements for newly constructed ground ambulances. Agencies were confused that the newly constructed ambulance standards were required of vehicles already on the standards. A vehicle constructed on or before June 14, 2019 are permittable to previous requirements. -0060 If an agency has a newly constructed ambulance after June 15, 2019 the agency will be required to meet standards created by Commission on Accreditation of Ambulance Services (CAAS) or National Fire Protection Association (NFPA). Gary Heigel motioned to approve the proposed rule change and Statement of Need and Fiscal Impact and Dr. Russ McUne seconded the motion. The motion passed.	

Agenda Item	*Licensing & Discipline Subcommittee appointment – Jim Cole*
The Licensing and Discipline Subcommittee has open positions that the chair will feel with the following EMS Committee members: • Alicia Bond, MD • Teresa Singleton, RN, EMT • Jim Cole, NRP • Russ McUne, MD The members will serve on the board for the term of their appointment to the committee. Teresa Singleton motioned for the approval and JoAnna Kamppi seconded the motion. The motion passed. The subcommittee has four open positions. Two physician and two EMS providers. If someone is interested in serving on the committee, please contact the State Office.	
Action Item	Office: Send out information to the EMS Committee of the positions that are open and how to apply.

Agenda Item	*Rural EMS Workgroup – Dave Lapof*
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.

The Rural EMS partnership needs a liaison to bring information to the committee. Dave Lapof will still participate and may still report. Teresa Singleton has volunteered to support the Rural EMS work and bring to the committee.

Gary Heigel motioned for the approval of Teresa Singleton representing the EMS committee for Rural EMS and Dr. Russ McUne seconded the motion. The motion passed.

Agenda Item	*EMS/TS Directors Update – Dr. Dana Selover, Dr. David Lehrfeld, Candace Toyama*

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

Dr. Selover presented pertinent bills that EMS/Trauma Systems office is tracking. A specific list was sent out before the meeting.

SB 29A OHA Housekeeping Bill – For purposes of EMS:

1

- 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.

Passed the Senate. Referred to House Health Care.

2	SB 452A	Introduced bill was gut and stuffed with -2 amendments. A-Engrossed bill requires the OHA to study responses of emergency medical services to rare medical conditions, particularly conditions requiring emergency use medications for treatment. Results of study must be presented to the legislature no later than February 1, 2020. **Referred to Ways and Means.**
2	SB 978A Section 22	Omnibus gun bill. Section 22 of the A-Engrossed bill requires the OHA to obtain from each hospital, emergency department discharge records and outcome data for any patient treated for a firearm injury. Requires the OHA to adopt by rule standards for the data obtained. Specifies outcome data required to be submitted. **Heading to Senate floor for vote. – MOVED TO A LEVEL 3**
3	HB 2011A	Requires cultural competency continuing education for initial licensure and every four years thereafter for specified licensing boards including OHA for purposes of licensing EMS providers. Licensing boards shall adopt by rule hours necessary. Boards are encouraged to adopt completion of OHA (OEI) approved continuing education, or completion of continuing education that meets the skills requirements established by the OHA (OEI) in rule. **Heading to House floor for vote.**
3	HB 2915	Establishes the Oregon Yellow Dot Program. Allows emergency responders to access the glove compartment of a vehicle to access the yellow dot folder containing medical information after motor vehicle accident. ODOT to adopt rules for administering program. Exempts personal identifying information and healthcare provider or facility information from being disclosed on public record. **Public hearing held on 3/25/19. Assigned to Joint Committee on Transportation so deadlines do not apply.**
3	HB 3030A	*Allows* professional licensing board to issue temporary authorization to provide occupational or professional service to spouse of member of Armed Forces of United States stationed in Oregon and who holds out-of-state authorization to provide occupational or professional service and the board has determined that the other state's authorization requirements are substantially similar. Boards may adopt by rule competencies that must be demonstrated. **Heading to House floor for vote.**
3	SB 688	*Allows* professional licensing board to accept as authorization to provide occupational or professional service to spouse of member of Armed Forces of United States stationed in Oregon and who holds out-of-state authorization to provide occupational or professional service. Individual must provide evidence of good standing by the other state as determined by the board. Boards may adopt rules to carry provisions of this Act. **Passed the Senate. House committee assignment pending.**
3	HB 3056	Requires agencies to adopt rules specifying time period during which agency will approve or deny application for license after applicant has amended or modified original application. **No public hearing to date. Assigned to House Rules Committee so deadlines do not apply.**
3	SB 725	Specifies charges or convictions that may not be considered in fitness determinations by DHS or OHA for purposes of licensure, certification, or registration or to hold a position, provide services or be employed. Specifies for purposes of never-never crimes under ORS 443.004, DHS or OHA cannot complete a check more than once during a two-year period unless certain criteria is met. **Passed out of committee. Heading to Senate floor for vote.**

3	SB 809	Requires OHA to prescribe by rule criteria for making fitness determinations that includes substantiated abuses for which a provider may be deemed unit. Fitness determination means the evaluation of whether a subject individual is fit to hold a position or be granted a license, certification or permitted to provide direct care services. **Bill was moved without recommendation and referred to Senate Rules Committee to allow more time to work on amendments.**
3	SB 854A	Directs professional licensing boards, in certain circumstances, to accept individual taxpayer identification number or other federally-issued identification number in lieu of Social Security number on applications for issuance or renewal of authorization to practice occupation or profession. **Heading to Senate floor for vote.**
3	SB 855A	Directs professional licensing boards to study the manner in which immigrants or refugees become licensed, certified or otherwise authorized in an occupational service and shall develop and implement methods to reduce barriers to licensure. **Heading to Senate floor for vote.**

Priority level key
1 - Major
2 - Medium
3 - Minor

Emergency Triage Treat and Transport (ET3) model
Center for Medicare and Medicaid Innovation (CMS) has designed a beta testing model to bring Medicare patients correct medical care when calling 9-1-1.
Ambulance agencies would be reimbursed at the BLS level to bring the patient to an alternate center. Ambulance suppliers and providers will focus on direct services, while local governments, its designees, or other entities that operate or have authority over one or more 911 dispatches that receive cooperative agreements will create a supportive structure to ensure successful and sustainable delivery of those services.
Medicare-Enrolled Ambulance Suppliers & Providers will support EMS innovation by transporting Medicare beneficiaries to covered destinations (e.g., ED) or alternative destinations (urgent care), and by providing treatment in place with a qualified health care practitioner (on site or via telehealth). Local Governments, its designees, or other entities that operate or have authority over one or more 911 dispatches will promote successful model implementation by establishing a medical triage line for low-acuity calls received via their 911 dispatch system.

Medical Director for EMS Agencies
EMS Agencies' Medical Directors are required to claim their eLicense account and update their contact information and affiliation. A letter has been sent to the known Medical Directors and a secondary letter will be sent to those that have not claimed their account.

Stop the Bleed training and response kits
In November 2018, HSPR awarded the EMS office with $40,000 to use on the Stop the Bleed project specifically for training and for rescue kits for rural and frontier locations. Working in partnership with HSPR, the EMS program identified how to best direct the resources. An application process for Stop the Bleed kits was directed toward Medical Reserve Corps and rural law enforcement. The response from the state Law Enforcement needs is approximately 80K worth. May 23rd is Stop the Bleed day and May is Stop the Bleed month.

Jim Cole requested that the committee officially request that EMS agencies participate in training for Stop the Bleed. Gary Heigel motioned that agencies actively participate with training their communities and Dr. Russ McUne seconded the motion. There was no discussion. The motion passed unanimously. The EMS college programs are including STB train-the-trainer with their curriculum so that students will be able to bring the programs to their community and agency.

State Conference Attendance
Program staff attended the Eastern Oregon EMS Conference, State of Jefferson EMS Conference and the Newport EMS Conference. The state is facilitating a Q and A format to allow attendees to ask questions pertinent to themselves, their agencies and regions.

2018 EMS Award nominations are due May 31, 2019. The nominations are made through the online portal available on the EMS and Trauma Systems website.

Agenda Item	*Public Comment*
The EMS Education Consortium is evaluating the Paramedic Program curriculum and accredited hours. A unanimous decision was made to increase the Emergency Medical Technician course CE to 12 from 10 credits. This will be taking place by fall 2020. The credits have not changed in over 20 years, but the expectation, requirement and content have increased over time.	

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