



State EMS Committee
Friday, April 15, 2016
8:30 a.m. – 12:00 p.m.

Meeting Minutes

Chair	Ameen Ramzy, M.D.
Vice Chair	Greg Marlar, Paramedic
Members present	Ameen Ramzy, M.D.; JD Fuiten; Paul Rostykus, M.D.; Dave Lapof, EMT; Gary Heigel, Paramedic; Doug Gruzd, MD; William Foster, M.D; Greg Marlar, Paramedic; Melissa Doherty, M.D.
Members not present	Ed Freysinger; Leslie Terrell, R.N.; Jim Thomas, Paramedic; Bradley Adams, M.D.
Guests present	Jonathan Chin, Paramedic; Mohamud Daya, MD; Jessica Gilham; Margaret Strokzyk-Hayes, EMT; Jamie Kennel
PHD staff present	Dana Selover, M.D.; David Lehrfeld, M.D.; Candace Hamilton, Larry Torris, Paramedic; Stella Rausch-Scott, EMT; Dagan Wright; Lisa Millet; Mellony Bernal; Brandon Klocko, Paramedic; Jara Poppinga
Members on the phone	Eric Blankenship, RN; Elizabeth Heckathorn, Paramedic; Elizabeth Hatfield-Keller, M.D
Guests on the phone	Kelly Kapri; Victor Hoffer, Paramedic

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

Agenda Item	<i>Approve minutes and review agenda– Ameen Ramzy</i>
<p>Dr. Ramzy requested the committee review and approve the minutes for the January 8th meeting.</p> <p>Dr. Rostykus requested the following changes to the January minutes:</p> <ul style="list-style-type: none"> • Pg 7, Par 4 – clarifying OIM • Pg 7, Par 6 – “The committee was informed that the Public Health Director.” 	

JD Fuiten motioned to approve the minutes with proposed changes and Dr. Doherty seconded the motion. The motion was approved.

Dr. Ramzy reviewed the agenda, and no request for changes were made.

Agenda Item	<i>CARES presentation – Jessica Gilham</i>
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Jessica Gilham, EMS and Trauma Office intern for the OIT BS Paramedic program, presented the current Oregon CARES program, options to continue the CARES program and how to fund the program in Oregon.

An overview of the CARES program and data currently collected was reviewed. Oregon's CARES program has been funded by a grant that will end at the close of 2016.

Options were presented to the committee that would fund the CARES program:

- Option 1: The state would purchase new software that state staff would monitor and manage. The estimated cost for the software is \$25,000 for initial setup and an annual fee of \$6,250.
- Option 2: The CARES program fee is \$15,000/year without adding the cardiac information to NEMSIS. The cost could be supported by grants, hospital donations, county bills and/or university programs. Every state that has a CARES program is paired with a University that has a Medical Academic Program.
- Option 3: Take no action once the grant expires. The state would lose momentum, and counties and EMS agencies voluntarily submitting data to CARES would have to pay individual fees. Potentially, smaller agencies would opt out due to the fee and the data would become distorted.

Information about other states actions for the CARES program was presented.

- Utah created its own state data system.
- New York has two separate data programs, one for EMS and one for the hospital.
- Washington uses CARES which is funded by a grant.

Dr. Daya presented the 2015 Oregon CARES report to the committee. The data showed about 2,000 non traumatic cardiac arrests which is about 85-90% of the cardiac arrests in the state. The data is owned by the supplying agency so they are able to create their own reports and compare their data to national data. Agencies currently submitting data work with the King County Coordinator to run the agency data.

Compared to the national standards Oregon has high numbers of survival rates and credit is given to public outreach and training as well as prehospital agency training. AED survival rates were low compared to national numbers and this may be due to availability of AEDs and the population per square mile in Oregon.

In Oregon, a person is 1.5 times more likely to survive cardiac arrest compared to national numbers. A request was made for the data presented by Dr. Daya to be emailed to the EMS committee members.

Lisa Millet informed the committee that data already being collected could include the CARES data sets. Dr. Daya thinks that both data collections are useful, but emphasized that staff should be dedicated to reviewing the CARES data to ensure that it is being inputted properly for accurate data.

Dr. Rostykus explained that funding for the past 3 years has been provided by a CDC grant which will no longer be available. All states are reviewing how to pursue a new source of funding. Clarification was requested of detailed funding and cost information.

The Heart Rescue grant provided funds for:

- High Performance CPR mannequins (Approximately \$3,000 each) to 10 Oregon EMS agencies; and
- Consultation fees to provide resuscitations academies in the state.

Dr. Ramzy requested Candace Hamilton and Dr. Daya review the options presented and report back to the committee with recommendations.

Action Item	Email Dr. Daya’s CARES presentation to the committee. State staff and Dr. Daya will review options that could be implemented to help support the CARES program and present at the next EMS meeting.
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Agenda Item	<i>Rural EMS subcommittee – Dave Lapof</i>
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A written report was presented to the committee. The subcommittee has not gathered or contacted outside agencies since the last meeting. The subcommittee is waiting for EMS rules to open in order to work on changes that will be helpful to Rural EMS.

The Oregon EMS conference (September, 2016/ Bend, OR) will include a short seminar on best practices for rural EMS providers.

House Bill 4030 requires the Oregon Health Authority to increase reimbursements paid to public EMS agencies who serve OHP patients and, if approved by CMS, to private providers who contract with a local government. The bill directs OHA to amend Oregon’s current state Medicaid plan and implement two reimbursement programs, with the aim of leveraging federal matching funds that will be used to provide increased payment — closing the gap between inadequate current rates and the actual cost of service — to public EMS providers and private providers contracting with a local government. The bill also requires OHA to convene a workgroup to develop recommendations for implementing reimbursement and aligning reimbursement of emergency medical services with Oregon’s Integrated and Coordinated Health care Delivery System goals of driving down cost and reducing unnecessary emergency medical care utilization.

Online EMS courses were discussed including clarification on how the course may be structured. A student would still have on-site didactic training but would be able to attend the cognitive studies and quizzes through online courses. Issues discussed were how the labs are offered and if the agency providing the labs are qualified and meet the standards that are set

by the school. The integration of the cognitive studies and the didactic skill sets is an important part of the traditional classes that helps a student be successful in the field. A hybrid class will need to address all of the issues identified. Critical thinking skills will need to be supported and implemented as EMT licensees are expected to have a higher standard of understanding in the field.

Action Item	Issue of driver requirements be discussed in the breakout conversation. Subcommittee will continue to work on Rural EMS support issues and report further discussion and recommendations.
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Agenda Item	<i>EMS & Trauma System update – Dr. Dana Selover, Dr. David Lehrfeld, Candace Hamilton</i>
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The OHA EMS/TS office has 3 vacant positions:

- General administrative support
- Professional Standards Unit administrative support
- EMS for Children program manager

The new licensing system’s timeline was presented to the committee showing complete integration by fall 2016.

- Ambulance agency annual renewals will not be completed using eLicense this year but is slated to be used next year. E-PCR and eLicense will eventually have one account so agencies will not need multiple accounts.
- During EMS license renewal, the licensee must state that he or she has completed CE requirements even though it has not been the two full years. Concern was raised at past meetings that it is unreasonable for licensees to not have all the time allotted to complete their CE requirements. Candace Hamilton, Brandon Klocko, Greg Marlar and Dave Lapof will review the requirements and include Shannon O’Fallon for legal clarification. Their review will be shared at the next meeting.

The EMS/TS office will be working with wildland firefighters from other states to provide them with a temporary 90 day EMS license. These providers would only be able to use their license in camp and on wildfires, and not for general 911 calls. The office is still creating an Oregon EMS Supervising Physician list who would be willing to cover the responders while in Oregon. The office will be creating process and guidelines for outside agencies contacting the Supervising Physician.

An ODOT grant for NEMSIS data share has been awarded. The grant will be used to upgrade the Oregon Trauma Registry (OTR) and link the OTR to crash data (ODOT, State Police, etc.), EMS data, emergency room data, hospital data and vital records in order to track and trend patients in the system.

Hands-only CPR training is being provided in schools now given passage of Senate Bill 79 in 2015.

There are still gaps in cardiac prehospital medical care. Not all counties have High Performance CPR protocols and it is a goal to have all counties have dispatch instructor CPR

protocols and rapid dispatch training. The MTUs have taught five High Performance CPR classes and instructed a train-the-trainer at the Oregon State Police annual in-service training.

The OHA Stroke Committee has been working on guidelines for stroke care which would be similar to CARES data and cardiac outcome. The committee is working on triage guidelines that would link the data with outcomes. The goal is to identify the stroke and transport the patient to the appropriate facility. Tracking a patient through stages of care will be challenging as they will not have a unique identifier, such as a trauma band.

The EMS mobilization plan is continuing. Oregon has 1 of the 3 components completed and ready for activation. The components are:

- Bring medical supplies to the patient.
- Patient movement from the disaster site (EMS Mobilization Plan).
- Relocate the patient for definitive care.

The EMS office has identified agencies, groups and personnel that will be dispatched with medical supplies to disaster zones (ODMT, ORARNG, MRC).

The last two components do not have finalized activation plans. The work group will be creating the plan for patient movement from a disaster site. As the workgroup moves forward other stakeholders may be added for input.

The hearing for secure transport for a psychiatric patient in licensed ambulances occurred on March 9, 2016 and the hearing officer report and final rules are under review. OHA received substantial feedback from the Mental Health and existing secure transport stakeholders. OHA rules should be completed and effective in May 2016. The OHA-Addictions and Mental Health rules are being considered in a separate process and will proceed and should be complete by fall 2016.

Dr. Selover reviewed the EMS and Trauma System’s rule update timeline.

- Rules pertaining to epinephrine need to be updated.
- Rules pertaining to EMS provider licensing (333-265) and ambulance service licensing (333-250) need to be updated.

Volunteers for an EMS rules subcommittee was requested. The next steps for the rule changes is to convene each subcommittee to review the rules in detail and recommend changes. The rules will be presented to the EMS committee for final input.

Action Item	<ul style="list-style-type: none"> • EMS Office – Review CE and renewal timeline. Candace Hamilton, Brandon Klocko, Greg Marlar and Dave Lapof. • David Lehrfeld- Provide updates about the Supervising Physician wildland fire list at the next meeting. • Schedule meetings for Rules Subcommittee sessions to review and edit rule changes. <ul style="list-style-type: none"> - 333-265 EMS Provider Rules: <ul style="list-style-type: none"> ○ Dave Lapof
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	<ul style="list-style-type: none"> ○ Paul Rostykus ○ Liz Heckathorn ○ Doug Gruzd <p style="margin-left: 40px;">- 333-250/255 Ambulance vehicles/ Ambulance agencies:</p> <ul style="list-style-type: none"> ○ JD Fuiten ○ Paul Rostykus ○ Liz Heckathorn ○ Dave Lapof
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Agenda Item	<i>Group Breakout Session – EMS Committee</i>
	<p>Dr. Ramzy requested the committee and attendees break into groups to discuss the following issues:</p> <ul style="list-style-type: none"> A. The CARES program is looking at Cardiac outcome measures. What other measures should the committee review and investigate for the EMS system? B. Should drivers (variance issue) be medically licensed (EMR/EMT) in order to transport a patient to the hospital? <p>Group 1:</p> <ul style="list-style-type: none"> A. Recommend that available data be reviewed and made easier to access and submit patient information to the system. The data team should consider placing an identification number on each patient so that all information can be tracked. B. It is recognized that rural and frontier agencies have staffing issues. The state should be willing to accommodate these agencies in order to have coverage in the area. If the agency must apply for a waiver, they should be accommodated, but the state should set clear standards so that other agencies do not use the waiver as an easy way to not meet the requirements. <p>Group 2:</p> <ul style="list-style-type: none"> A. A list of outcome measures was suggested: <ul style="list-style-type: none"> Basic identification points for all patients (name, medication list, medical history) Time intervals - time on scene vs. time to scene vs. time to transport Utilization rates – ambulance usage and time Sepsis outcomes Agency financial liability and responsibility (Medicaid patient cared for/ billed for) B. A specific EMS license should not be required for a person to drive, but the driver should be required to have EVOC and background check. This would be limited to specific situations.

Group 3:	
<p>A. More data should be shared with STEMI and Stroke. If a new data collection is considered it should be studies that have not been reviewed or discussed.</p> <p>B. Agencies should require the ambulance driver to have some medical skills, i.e. CPR course, agencies vehicle training, Oregon Driver license and background check. Waivers should be limited based on either agency size or community size.</p>	
Action Item	No action necessary.

Agenda Item	<i>Legislative Concepts – Dr. Dana Selover</i>
<p>Dr. Selover presented a list of 2016 Oregon legislative bills related to EMS and Trauma that passed.</p> <ul style="list-style-type: none"> House Bill 4124 allows naloxone and necessary supplies to be prescribed by licensed pharmacists to persons who have successfully completed opiate overdose training. The training is available on the Public Health website. These changes were backed by a CDC Opioid prevention grant. Input on administrative rules relating to this bill may be sought from an EMS advocate and/or provider. <p>A committee member asked how the state will be able to monitor when and why the drug was used. The underlying assumption of the distribution of the drug is that the person requesting the drug knows that a friend or family member uses an opioid. Any time a layperson administers Naloxone they are advised to contact EMS and EMS calls may be monitored by Public Health through the EMS prehospital data base.</p> <p>A housekeeping bill will be submitted for the 2017 session that addresses the following:</p> <ul style="list-style-type: none"> The POLST Registry Advisory committee (PRAC) will sunset as they have completed the tasks that they were given. STAB membership changes will request an <i>ex-officio</i> member from the EMS committee and the same for the EMS Committee. ATAB membership will no longer require an anesthesiologist; an EMS Supervising Physician will be required. Statutes pertaining to Epinephrine training need to be updated based on comments received during rulemaking. <p>The EMS/TS office has submitted a legislative concept to mandate EMS data submission. There may be a timeline for phased implementation. The goal is to require vendors to provide support for their data programs since the data will be required. The state data system is being updated in order to allow the data that is being submitted to automatically be entered into the hospital data forms.</p> <p>Dr. Selover requested that the EMS committee create a subcommittee to work on future Legislative concepts.</p>	
Action Item	<p>Present an update on Naloxone rules when available.</p> <p>Legislative concepts subcommittee:</p> <ul style="list-style-type: none"> Dr. William Foster Dr. Paul Rostykus

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Agenda Item	<i>Federal Legislation – Dr. Paul Rostykus</i>
<p>HR (House of Representative – Federal) 4365 is requesting two changes. The first would allow EMS providers to administer controlled substances with standing orders from the supervising physician. The second change is the DEA registration requirements of narcotics would change from the Supervising Physician to the Agency.</p> <p>Three of the five Oregon State Representatives are supporting the bill. Dr. Paul Rostykus is requesting that attendees email their State Representatives in support of this bill.</p>	
Action Item	Committee members were requested to email congressional Representative to support HR 4365

Agenda Item	<i>Public Comments</i>
<p>Resuscitation Academy is May 13-14th in Hood River. A fall academy will be held in Bend during the State EMS conference.</p>	

Agenda Item	<i>Meeting adjourned</i>
<p>Next scheduled State EMS Committee Meeting - July 8, 2016 PSOB Building, Room 1B from 8:30am to 12pm.</p>	