

# A-Engrossed House Bill 4081

Ordered by the House February 16  
Including House Amendments dated February 16

Sponsored by Representative GRAYBER, Senator STEINER; Representatives DEXTER, NOSSE, PHAM H, REYNOLDS (Pre-session filed.)

## SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act makes a program and an advisory board in the Oregon Health Authority to make it easier to get fast health care. (Flesch Readability Score: 61.4).

Establishes the Emergency Medical Services Program and Emergency Medical Services Advisory Board within the Oregon Health Authority. Directs the authority to designate emergency medical services regions within the state. Directs the authority to designate emergency medical services centers for the provision of specific types of emergency care. Requires the program to establish and maintain an emergency medical services data system.

Becomes operative on January 1, 2025.

**Repeals existing State Trauma Advisory Board and related boards.**

**Becomes operative on January 1, 2027.**

Takes effect on the 91st day following adjournment sine die.

## A BILL FOR AN ACT

Relating to emergency medical services; creating new provisions; amending ORS 146.015, 181A.375, 353.450, 441.020, 442.507, 442.870, 682.017, 682.051, 682.056, 682.059, 682.068, 682.075 and 682.079; repealing ORS 431A.050, 431A.055, 431A.060, 431A.065, 431A.070, 431A.075, 431A.080, 431A.085, 431A.090, 431A.095, 431A.100, 431A.105, 431A.525, 431A.530 and 682.039; and prescribing an effective date.

**Be It Enacted by the People of the State of Oregon:**

## EMERGENCY MEDICAL SERVICES PROGRAM 2025

**SECTION 1.** Sections 2 to 16 of this 2024 Act are added to and made a part of ORS chapter 682.

**SECTION 2.** (1) **The Emergency Medical Services Program is established within the Oregon Health Authority for the purpose of administering a comprehensive statewide emergency medical services system developed by the Emergency Medical Services Advisory Board and focused on emergency medical services and time-sensitive emergencies. The system includes:**

- (a) **The development of state and regional standards of emergency medical care;**
- (b) **The development of state, regional and interstate protocols for patient transfers using emergency medical services;**
- (c) **The training and licensing of emergency medical services providers;**
- (d) **The development and management of emergency medical services data systems;**

**NOTE:** Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

1 (e) The management and administration of state workforce, recruitment and retention  
2 programs related to emergency medical services;

3 (f) The regulation and administration of state reimbursement systems for emergency  
4 medical services; and

5 (g) Requirements for reporting out measurable performance and equity indicators of  
6 emergency medical services within this state.

7 (2) The program is administered by a director who:

8 (a) Is responsible for conducting emergency medical services system oversight and im-  
9 plementing the recommendations of the advisory board.

10 (b) Shall apply funds allocated to the program in the following order of priority:

11 (A) Development of state and regional standards of care;

12 (B) Strengthening the state's emergency medical services workforce;

13 (C) Development of statewide educational curriculum to teach the standards of care;

14 (D) Implementation of quality improvement programs; and

15 (E) Support for and enhancement of the state's emergency medical services.

16 (c) May adopt rules as necessary to carry out the director's duties and responsibilities  
17 described in this subsection.

18 (3) The program shall have a State EMS Medical Director who is the chairperson of the  
19 Emergency Medical Services Advisory Board established under section 4 of this 2024 Act and  
20 who is responsible for:

21 (a) Providing specialized medical oversight in the development and administration of the  
22 program;

23 (b) Implementing emergency medical services quality improvement measures;

24 (c) Undertaking research and providing public education regarding emergency medical  
25 services; and

26 (d) Serving as a liaison with emergency medical services agencies, emergency medical  
27 services centers, hospitals, state and national emergency medical services professional or-  
28 ganizations and state and federal partners.

29 (4) The authority shall:

30 (a) Adopt rules to establish statewide emergency medical services objectives and stan-  
31 dards; and

32 (b) Publish a biennial report regarding the program's activities.

33 (5)(a) The establishment of the program does not affect the contracting authority of  
34 counties and county ambulance service areas.

35 (b) The objectives and standards established under subsection (4) of this section do not  
36 prohibit a local jurisdiction from implementing objectives and standards that are more rig-  
37 orous than those established under subsection (4) of this section.

38 **SECTION 3.** (1) The Emergency Medical Services Program, with the advice of the Emer-  
39 gency Medical Services Advisory Board, the Time-Sensitive Medical Emergencies Advisory  
40 Committee, the Emergency Medical Services Advisory Committee, the Pediatric Emergency  
41 Medical Services Advisory Committee and the Behavioral Health Emergency Medical Services  
42 Advisory Committee, shall:

43 (a) Coordinate with national health organizations involved in improving the quality of  
44 stroke, cardiac, trauma, pediatric and behavioral health care to avoid duplicative information  
45 and redundant processes;

1       **(b) Use information related to stroke, cardiac, trauma, pediatric and behavioral health**  
2 **care to support improvement in the quality of care in accordance with guidelines that meet**  
3 **or exceed nationally recognized standards;**

4       **(c) Encourage the sharing of information among health care providers on practices that**  
5 **improve the quality of stroke, cardiac, trauma, pediatric and behavioral health care;**

6       **(d) Facilitate communication about data trends and treatment developments among**  
7 **health care providers and coordinated care organizations that provide services related to**  
8 **stroke, cardiac, trauma, pediatric and behavioral health care; and**

9       **(e) Provide stroke, cardiac, trauma, pediatric and behavioral health care data, and rec-**  
10 **ommendations for improvement to care, to coordinated care organizations.**

11       **(2) Not later than the beginning of each odd-numbered year regular session of the Leg-**  
12 **islative Assembly, the program shall submit to the Legislative Assembly a report in the**  
13 **manner provided in ORS 192.245 summarizing the program's activities under this section.**

14       **SECTION 4. (1) The Emergency Medical Services Advisory Board is established within the**  
15 **Oregon Health Authority. The authority shall provide staffing for the board. The board con-**  
16 **sists of 19 members appointed by the Director of the Oregon Health Authority. Of the**  
17 **members of the board:**

18       **(a) The State EMS Medical Director of the Emergency Medical Services Program is an**  
19 **ex officio member and serves as the chairperson;**

20       **(b) One must be a patient advocate or an education professional who specializes in health**  
21 **equity;**

22       **(c) One must be an emergency medical services provider licensed under ORS 682.216 who**  
23 **represents a private emergency medical services agency licensed under ORS 682.047;**

24       **(d) One must be an emergency medical services provider licensed under ORS 682.216 who**  
25 **represents a public emergency medical services agency licensed under ORS 682.047;**

26       **(e) One must be a representative of a nontransport emergency medical services agency;**

27       **(f) One must be a representative of a labor union that represents emergency medical**  
28 **services providers;**

29       **(g) One must be an emergency medical services provider licensed under ORS 682.216 who**  
30 **works for an emergency medical services agency licensed under ORS 682.047 within a rural**  
31 **emergency medical services system or a rural hospital as defined in ORS 442.470;**

32       **(h) One must be a representative of county ambulance service area administrators;**

33       **(i) One must be a representative of special districts that operate ambulances;**

34       **(j) One must be a hospital administrator in a hospital that operates an emergency de-**  
35 **partment;**

36       **(k) One must be a nurse who works in a hospital emergency department;**

37       **(L) One must be a representative of a public safety answering point, as defined in ORS**  
38 **403.105;**

39       **(m) One must be an emergency medicine physician;**

40       **(n) One must be a person who works in a long term care facility, as defined in ORS**  
41 **442.015, or who represents long term care facilities, or who works in a residential facility,**  
42 **as defined in ORS 443.400, or who represents residential facilities;**

43       **(o) One must be a public member who is, or has been, a frequent user of emergency**  
44 **medical services;**

45       **(p) One must be a representative of a third-party payer of health care insurance;**

1 (q) One must be a representative of a patient health care advocacy group;

2 (r) One must be a representative of a rural hospital, or a hospital system that includes  
3 a rural hospital, as defined in ORS 442.470; and

4 (s) One must be an emergency medical services physician.

5 (2)(a) The physician members of the board must be physicians licensed under ORS chap-  
6 ter 677 who are in good standing.

7 (b) The member described in subsection (1)(k) of this section must be licensed under ORS  
8 678.010 to 678.410 and in good standing.

9 (c) The members of the board who represent emergency medical services agencies must  
10 hold valid licenses in good standing.

11 (d) The members of the board who are emergency medical services providers must hold  
12 valid licenses in good standing.

13 (3) Board membership must reflect the geographical, cultural, linguistic and economic  
14 diversity of this state and must include at least one representative from each emergency  
15 medical services region designated under section 11 of this 2024 Act.

16 (4) The term of each member of the board is four years, but a member serves at the  
17 pleasure of the Director of the Oregon Health Authority. Before the expiration of a term of  
18 a member, the director shall appoint a successor whose term begins on January 1 next fol-  
19 lowing. A member is eligible for reappointment for no more than two consecutive terms. If  
20 there is a vacancy for any cause, the director shall make an appointment to become imme-  
21 diately effective for the unexpired term.

22 (5) A member of the board is entitled to compensation and expenses as provided under  
23 ORS 292.495.

24 (6) The board may adopt rules as necessary to carry out its duties under sections 2 to  
25 16 of this 2024 Act.

26 **SECTION 5.** (1) The Emergency Medical Services Advisory Board shall provide advice and  
27 recommendations to the Emergency Medical Services Program on the following:

28 (a) A definition of “patient” for purposes of time-sensitive medical emergencies, pediatric  
29 medical emergencies and behavioral health medical emergencies;

30 (b) Evidence-based practices and standards for emergency medical services care for de-  
31 fined patient types;

32 (c) Emergency medical services workforce needs;

33 (d) Coordination of care between health care specialties;

34 (e) Other issues related to emergency medical services as determined by the Oregon  
35 Health Authority and the program;

36 (f) The appointment of the regional emergency medical services advisory boards; and

37 (g) Approval of the regional emergency medical services plans described in section 11 of  
38 this 2024 Act.

39 (2) The board may convene temporary subcommittees for matters related to emergency  
40 medical services in order to inform and make recommendations to the board.

41 (3) In addition to the duties described in subsection (1) of this section, the board shall  
42 convene the following permanent advisory committees that shall inform and make recom-  
43 mendations to the board, in addition to other specified duties:

44 (a) Time-Sensitive Medical Emergencies Advisory Committee, as described in section 6  
45 of this 2024 Act;

1 (b) Emergency Medical Services Advisory Committee, as described in section 7 of this  
2 2024 Act;

3 (c) Pediatric Emergency Medical Services Advisory Committee, as described in section 8  
4 of this 2024 Act; and

5 (d) Behavioral Health Emergency Medical Services Advisory Committee, as described in  
6 section 9 of this 2024 Act.

7 **SECTION 6.** (1) The Time-Sensitive Medical Emergencies Advisory Committee is estab-  
8 lished in the Emergency Medical Services Advisory Board. The committee shall consist of  
9 members determined by the board and the Oregon Health Authority and must include at  
10 least:

11 (a) One member who is a physician who practices general surgery and specializes in the  
12 treatment of trauma patients;

13 (b) One member who is a physician who practices neurology and specializes in the  
14 treatment of stroke patients;

15 (c) One member who is a physician who practices cardiology and manages acute cardiac  
16 conditions;

17 (d) One member who is a physician who practices critical care medicine;

18 (e) One member who is a physician who practices emergency medicine;

19 (f) One member who is a physician who practices emergency medical services medicine;

20 (g) One member who is a physician who practices in neurological surgery and  
21 neurocritical care and manages both trauma and stroke patients;

22 (h) One member who is an emergency medical services provider licensed under ORS  
23 682.216; and

24 (i) One member who represents a patient equity organization or is an academic profes-  
25 sional specializing in health equity.

26 (2)(a) The committee shall provide advice and recommendations to the board regarding  
27 systems of care related to time-sensitive medical emergencies, including at least cardiac,  
28 stroke, airway, sepsis and trauma emergencies. The commission shall also consider other  
29 time-sensitive emergencies including but not limited to sepsis, infectious diseases,  
30 pandemics, active seizures and severe respiratory emergencies.

31 (b) The committee shall provide recommendations to the board on:

32 (A) The regionalization and improvement of care for time-sensitive medical emergencies.

33 (B) The designation, using nationally recognized classifications where possible, of emer-  
34 gency medical services centers for the provision of care for time-sensitive medical emer-  
35 gencies. If no nationally recognized classifications exist, the committee shall undertake a  
36 public deliberation process to establish classifications and submit the established classifica-  
37 tions to the board for approval. In establishing and approving classifications, the committee  
38 and the board shall prioritize patient care.

39 (3) The committee shall:

40 (a) Advise the board with respect to the board's duties related to care for cardiac, stroke,  
41 trauma and other identified time-sensitive emergencies;

42 (b) Advise the board on potential rules that the board may recommend to the authority  
43 for adoption related to care for cardiac, stroke, trauma and other identified time-sensitive  
44 emergencies;

45 (c) Analyze data related to care for cardiac, stroke, trauma and other identified time-

1 sensitive emergencies;

2 (d) Recommend to the board improvements to the Emergency Medical Services Program  
3 regarding care for cardiac, stroke, trauma and other identified time-sensitive emergencies;  
4 and

5 (e) Identify inequities in the provision of care and provide recommendations to the board  
6 and program to resolve the identified inequities.

7 (4) The members of the committee who are physicians must be physicians licensed under  
8 ORS chapter 677.

9 (5) The authority may adopt rules as necessary to carry out this section, including rules  
10 to adopt the nationally recognized classifications described in subsection (2) of this section.

11 **SECTION 7.** (1) The Emergency Medical Services Advisory Committee is established in  
12 the Emergency Medical Services Advisory Board. The committee shall consist of members  
13 determined by the board and the Oregon Health Authority and must include at least:

14 (a) One member who is a physician licensed under ORS chapter 677 who practices emer-  
15 gency medicine or emergency medical services medicine;

16 (b) One member who is an emergency medical services provider licensed under ORS  
17 682.216; and

18 (c) One member who represents a patient equity organization or is an academic profes-  
19 sional specializing in health equity.

20 (2) The committee shall provide advice and recommendations to the board regarding  
21 emergency medical services, for the care of time-sensitive medical emergencies, pediatric  
22 medical emergencies and behavioral health medical emergencies, including the following ob-  
23 jectives:

24 (a) The regionalization and improvement of emergency medical services, including the  
25 coordination and planning of emergency medical services efforts.

26 (b) The designation, using nationally recognized classifications where possible, of emer-  
27 gency medical services centers for the provision of care for medical emergencies. If no na-  
28 tionally recognized classifications exist, the committee shall undertake a public deliberation  
29 process to establish classifications and submit the established classifications to the board for  
30 approval. In establishing and approving classifications, the committee and the board shall  
31 prioritize patient care.

32 (c) The adoption of rules related to emergency medical services.

33 (3) The chairperson of the committee shall appoint an advisory subcommittee on the  
34 licensure and discipline of emergency medical services providers. The subcommittee shall  
35 advise the board on potential rules that the board may recommend to the authority for  
36 adoption under this section.

37 (4) The committee may:

38 (a) Assist the Time-Sensitive Medical Emergencies Advisory Committee, the Pediatric  
39 Emergency Medical Services Advisory Committee and the Behavioral Health Emergency  
40 Medical Services Advisory Committee in coordination and planning efforts; and

41 (b) Provide other assistance to the board as the board requests.

42 (5) The authority may adopt rules as necessary to carry out this section, including rules  
43 to adopt the nationally recognized classifications described in subsection (2) of this section.

44 **SECTION 8.** (1) The Pediatric Emergency Medical Services Advisory Committee is es-  
45 tablished in the Emergency Medical Services Advisory Board. The committee shall consist

1 of members determined by the board and the Oregon Health Authority and must include at  
2 least:

3 (a) Two members who are physicians specializing in the treatment of pediatric emergency  
4 patients;

5 (b) One member who is a nurse who has pediatric emergency experience;

6 (c) One member who is a physician with pediatric training;

7 (d) One member who is an emergency medical services provider licensed under ORS  
8 682.216;

9 (e) One member who is a representative of the Emergency Medical Services Program;

10 (f) One member who has experience as the project director of a statewide committee  
11 related to emergency medical services for children;

12 (g) One member who has experience as the program manager of a statewide committee  
13 related to emergency medical services for children;

14 (h) One member who is a family representative; and

15 (i) One member who represents a patient equity organization or is an academic profes-  
16 sional specializing in health equity.

17 (2) The committee shall provide advice and recommendations to the board regarding  
18 pediatric medical emergencies, including the following objectives:

19 (a) The integration of pediatric emergency medical services into the Emergency Medical  
20 Services Program;

21 (b) The regionalization and improvement of care for time-sensitive pediatric medical  
22 emergencies; and

23 (c) The designation, using nationally recognized classifications where possible, of emer-  
24 gency medical services centers for the provision of care for time-sensitive pediatric medical  
25 emergencies.

26 (3) With the advice of the Pediatric Emergency Medical Services Advisory Committee,  
27 the authority shall:

28 (a) Employ or contract with professional, technical, research and clerical staff to ad-  
29 minister a statewide program related to emergency medical services for children.

30 (b) Provide technical assistance to the Emergency Medical Services Advisory Committee  
31 on the integration of pediatric emergency medical services into the Emergency Medical Ser-  
32 vices Program.

33 (c) Provide technical assistance to the Time-Sensitive Medical Emergencies Advisory  
34 Committee on the regionalization of pediatric emergency medical services.

35 (d) Establish guidelines for:

36 (A) The voluntary categorization of emergency medical services agencies and hospital  
37 departments that meet the requirements of the United States Health Resources and Services  
38 Administration program for pediatric readiness, as adopted by the authority by rule.

39 (B) Referring pediatric patients to appropriate emergency medical services centers or  
40 critical care centers.

41 (C) Necessary pediatric patient care equipment for prehospital and pediatric critical care.

42 (D) Developing a coordinated system that will allow pediatric patients to receive appro-  
43 priate initial stabilization and treatment with timely provision of, or referral to, the appro-  
44 priate level of care including critical care, trauma care and pediatric subspecialty care.

45 (E) An interfacility transfer system for critically ill or injured pediatric patients.

1 (F) Continuing education programs for emergency medical services personnel, including  
2 training in the emergency care of pediatric patients across different demographics and  
3 physical demonstrations of pediatric-specific patient care equipment.

4 (G) A public education program promoting pediatric emergency medical services, includ-  
5 ing information on emergency and crisis telephone numbers.

6 (H) The collection and analysis of statewide pediatric prehospital, critical care and  
7 trauma care data from prehospital, critical care and trauma care facilities for the purpose  
8 of quality improvement, subject to relevant confidentiality requirements.

9 (I) The establishment of cooperative interstate relationships to facilitate the provision  
10 of appropriate care for pediatric patients who must cross state borders to receive critical  
11 care and trauma care services.

12 (J) Coordination and cooperation between a statewide program for emergency medical  
13 services for children and other public and private organizations interested or involved in  
14 pediatric prehospital and critical care.

15 (4)(a) The members of the committee who are physicians must be physicians licensed  
16 under ORS chapter 677 and in good standing.

17 (b) The member of the committee who is a nurse must be licensed under ORS 678.010 to  
18 678.410 and in good standing.

19 (5) The authority may adopt rules as necessary to carry out this section, including rules  
20 to adopt the nationally recognized classifications described in subsection (2) of this section.

21 **SECTION 9.** (1) The Behavioral Health Emergency Medical Services Advisory Committee  
22 is established in the Emergency Medical Services Advisory Board. The committee shall con-  
23 sist of members determined by the board and the Oregon Health Authority and must include  
24 at least:

25 (a) Two members who are physicians specializing in the treatment of time-sensitive be-  
26 havioral health medical emergencies;

27 (b) One member who is a physician who practices emergency medicine or emergency  
28 medical services medicine;

29 (c) One member who is an emergency medical services provider licensed under ORS  
30 682.216; and

31 (d) One member who represents a patient equity organization or is an academic profes-  
32 sional specializing in health equity.

33 (2) The committee shall provide advice and recommendations to the board regarding  
34 time-sensitive behavioral health medical emergencies, including the following objectives:

35 (a) The integration of behavioral health emergency medical services into the Emergency  
36 Medical Services Program.

37 (b) The regionalization and improvement of care for time-sensitive behavioral health  
38 medical emergencies.

39 (c) The designation, using nationally recognized classifications where possible, of emer-  
40 gency medical services centers for the provision of care for time-sensitive behavioral health  
41 medical emergencies. If no nationally recognized classifications exist, the committee shall  
42 undertake a public deliberation process to establish classifications and submit the established  
43 classifications to the board for approval. In establishing and approving classifications, the  
44 committee and the board shall prioritize patient care.

45 (3) With the advice of the committee, the authority shall:



1 (a) Employ or contract with professional, technical, research and clerical staff to imple-  
2 ment this section.

3 (b) Provide technical assistance to the Emergency Medical Services Advisory Committee  
4 on the integration of emergency medical services for behavioral health patients into the  
5 Emergency Medical Services Program.

6 (c) Provide advice and technical assistance to the Time-Sensitive Medical Emergencies  
7 Advisory Committee on the regionalization of emergency medical services for behavioral  
8 health patients.

9 (d) Establish guidelines for:

10 (A) The designation of specialized regional behavioral health critical care centers.

11 (B) Referring behavioral health patients to appropriate emergency or critical care cen-  
12 ters.

13 (C) Necessary prehospital and other behavioral health emergency and critical care med-  
14 ical service equipment.

15 (D) Developing a coordinated system to allow behavioral health patients to receive ap-  
16 propriate initial stabilization and treatment with the timely provision of, or referral to, the  
17 appropriate level of care, including critical care and behavioral health subspecialty care.

18 (E) An interfacility transfer system for critically ill or injured behavioral health patients.

19 (F) Continuing professional education programs for emergency medical services person-  
20 nel, including training in the emergency care of behavioral health patients across different  
21 demographics.

22 (G) A public education program concerning the emergency medical services for behav-  
23 ioral health patients, including information on emergency access telephone numbers.

24 (H) The collection and analysis of statewide behavioral health emergency and critical care  
25 medical services data from emergency and critical care medical services facilities for the  
26 purpose of quality improvement by those facilities, subject to relevant confidentiality re-  
27 quirements.

28 (I) The establishment of cooperative interstate relationships to facilitate the provision  
29 of appropriate care for behavioral health patients who must cross state borders to receive  
30 emergency and critical care services.

31 (J) Coordination and cooperation between providers of emergency medical services for  
32 behavioral health patients and other public and private organizations interested or involved  
33 in emergency and critical care for behavioral health.

34 (4) The members of the committee who are physicians must be physicians licensed under  
35 ORS chapter 677 who are in good standing.

36 (5) The authority may adopt rules as necessary to carry out this section, including rules  
37 to adopt the nationally recognized classifications described in subsection (2) of this section.

38 **SECTION 10.** (1)(a) The Emergency Medical Services Advisory Board, upon the advice of  
39 the Time-Sensitive Medical Emergencies Advisory Committee, the Emergency Medical Ser-  
40 vices Advisory Committee, the Pediatric Emergency Medical Services Advisory Committee  
41 and the Behavioral Health Emergency Medical Services Advisory Committee, shall determine  
42 the nationally recognized classification standards to recommend to the Oregon Health Au-  
43 thority to adopt as rules for categorization and designation of emergency medical services  
44 centers for the provision of trauma, stroke, cardiac, pediatric and behavioral health care and  
45 other identified time-sensitive emergencies.

1 (b) If a nationally recognized classification standard used by the authority under this  
2 subsection requires that an emergency medical services center use a specific data system  
3 or registry in order to obtain a specific categorization or designation, the authority shall  
4 require an emergency medical services center that intends to obtain the categorization or  
5 designation to adopt the data system or registry not later than:

6 (A) Eighteen months after the date on which the Emergency Medical Services Advisory  
7 Board and the authority determine the data system or registry must be adopted, if the  
8 emergency medical services center is a large facility or hospital, with an additional six  
9 months in which to demonstrate compliant usage of the data system or registry.

10 (B) Three years after the date on which the board and the authority determine the data  
11 system or registry must be adopted, if the emergency medical services center is a critical  
12 access or rural health care facility or hospital, with an additional six months in which to  
13 demonstrate compliant usage of the data system or registry.

14 (c) If no relevant nationally recognized classification standard is available for a specific  
15 type of emergency medical services center, the authority shall consider the recommen-  
16 dations of the board for one or more new classifications of a type of emergency medical  
17 services center.

18 (d) The board and the authority may grant, at the request of an emergency medical  
19 services center, an extension to the timeline described in paragraph (b) of this subsection.

20 (2)(a) An emergency medical services center is not required to obtain categorization or  
21 designation as described in subsection (1) of this section but may, at the discretion of the  
22 emergency medical services center, strive to obtain a specific categorization or designation.

23 (b) An emergency medical services center described in this subsection is not required to  
24 adopt and use a specific data system or registry unless the data system or registry is re-  
25 quired in order to obtain the categorization or designation that the emergency medical ser-  
26 vices center strives to obtain.

27 (c) An emergency medical services center may concurrently adopt and use data systems  
28 or registries in addition to any data systems or registries required for a specific categori-  
29 zation or designation.

30 (3) An emergency medical services center that uses any data system or registry shall  
31 grant to the authority permission to extract data subject to relevant confidentiality re-  
32 quirements.

33 (4) An emergency medical services center may not hold itself out, or operate, as having  
34 obtained a specific categorization or designation until:

35 (a) The emergency medical services center meets all requirements for the categorization  
36 or designation within the timelines specified in subsection (1)(b) of this section; and

37 (b) The authority, through the Emergency Medical Services Program, recognizes that the  
38 emergency medical services center meets the categorization or designation requirements.

39 (5) The authority shall adopt rules to carry out this section and may adopt as rules of  
40 the authority any relevant nationally recognized classification standards and proposed clas-  
41 sification standards described in subsection (1) of this section.

42 **SECTION 11.** (1) The Oregon Health Authority shall, with the advice of the Emergency  
43 Medical Services Advisory Board, designate emergency medical services regions that are  
44 consistent with local resources, geography, current patient referral patterns and existing  
45 regionalized health care structures and networks. The authority and the Emergency Medical

1 Services Advisory Board shall establish a regional emergency medical services advisory board  
2 for each designated emergency medical services region. The authority and the Emergency  
3 Medical Services Advisory Board may determine the membership of each regional emergency  
4 medical services advisory board, and shall ensure that the membership reflects the ge-  
5 ographic, cultural, linguistic and economic diversity of the emergency medical services re-  
6 gion.

7 (2) Each emergency medical services region must include at least one hospital categor-  
8 ized according to the emergency medical services region's emergency medical services ca-  
9 pabilities as determined by standards adopted by the authority by rule.

10 (3) The authority, with the advice of the Emergency Medical Services Advisory Board,  
11 shall appoint the members of the regional emergency medical services advisory boards.  
12 Members serve at the pleasure of the authority. Each regional emergency medical services  
13 advisory board is responsible for:

14 (a) The development and maintenance of a regional emergency medical services system  
15 plan as described in subsection (4) of this section;

16 (b) Central medical direction for all field care and transportation consistent with ge-  
17 ographic and current communications capability; and

18 (c) Patient triage protocols for time-sensitive emergencies.

19 (4) Each regional emergency medical services system plan:

20 (a) Must include the following:

21 (A) A recommendation of hospitals in the emergency medical services region to be des-  
22 igned by the authority as emergency medical services centers under section 10 of this 2024  
23 Act;

24 (B) A description of the patient triage protocols to be used in the emergency medical  
25 services region;

26 (C) A description of the transportation of patients, including the transportation of pa-  
27 tients who are members of a health maintenance organization, as defined in ORS 442.015;

28 (D) Information regarding how the emergency medical services region will coordinate  
29 with state and regional disaster preparedness efforts; and

30 (E) Any other information required by the authority by rule.

31 (b) Must be approved by the authority prior to implementation.

32 (c) May be revised with the approval of the authority.

33 (5) The authority may, with the advice of the Emergency Medical Services Advisory  
34 Board, implement the regional emergency medical services plans and may coordinate with a  
35 regional emergency medical services advisory board to make changes desired by the author-  
36 ity to the regional emergency medical services advisory board.

37 **SECTION 12.** (1) The Emergency Medical Services Program, upon the recommendation  
38 of the Emergency Medical Services Advisory Board, shall establish and maintain an emer-  
39 gency medical services data system. In formulating recommendations, the board shall con-  
40 sider the advice of the Time-Sensitive Medical Emergencies Advisory Committee, the  
41 Emergency Medical Services Advisory Committee, the Pediatric Emergency Medical Services  
42 Advisory Committee and the Behavioral Health Emergency Medical Services Advisory Com-  
43 mittee. The Oregon Health Authority shall adopt rules for the data system described in this  
44 subsection to establish:

45 (a) The information that must be reported to the data system;

1       **(b) A process for the oversight of the data system and the reporting of information to**  
2 **the data system;**

3       **(c) The form and frequency of reporting information:**

4       **(A) To the data system, the authority and the board; and**

5       **(B) From the data system to health care facilities and providers that report information**  
6 **to the data system; and**

7       **(d) The procedures and standards for the administration and maintenance of the data**  
8 **system.**

9       **(2) In determining the information described in subsection (1)(a) of this section, the au-**  
10 **thority shall require the reporting of information recommended by the board following con-**  
11 **sultation with the committees.**

12       **(3) The data system established under this section must:**

13       **(a) Use nationally accredited data registry systems approved by the authority where**  
14 **available;**

15       **(b) Have security measures in place to protect individually identifiable information;**

16       **(c) Allow the authority to export data stored in the system;**

17       **(d) Be used for quality assurance, quality improvement, epidemiological assessment and**  
18 **investigation, public health implementation, critical response planning, prevention activities**  
19 **and other purposes as the authority determines necessary; and**

20       **(e) Meet other requirements established by the authority by rule.**

21       **(4) If no relevant nationally accredited data registry system is available, the authority**  
22 **shall convene an advisory committee of stakeholders, including but not limited to state and**  
23 **community partners, to develop a proposal for the establishment of a data system. The ad-**  
24 **visory committee convened under this subsection shall prioritize high-quality patient care**  
25 **outcomes in all decision-making.**

26       **(5) The authority may not require:**

27       **(a) That a health care facility adopt a specific registry unless that registry is required**  
28 **for the specific categorization or designation that the health care facility seeks to obtain.**

29       **(b) The reporting of data that is not otherwise required of a health care facility in order**  
30 **for the health care facility to obtain a specific categorization or designation that the health**  
31 **care facility seeks to obtain.**

32       **(6) The authority may access and extract data from any registry that a health care fa-**  
33 **ility has adopted for purposes of obtaining a specific categorization or designation, and may**  
34 **use data described in this subsection in the data system established under this section.**

35       **(7) The Emergency Medical Services Program shall make recommendations to:**

36       **(a) Health care facilities for the adoption of specific registries and services from the data**  
37 **system established under this section for the purpose of health care facility categorization;**  
38 **and**

39       **(b) Emergency medical services providers for the adoption of specific registries and ser-**  
40 **vices from the data system established under this section for the purpose of sharing emer-**  
41 **gency medical services data with the authority.**

42       **(8) The authority may request the inclusion of demographic data from patients who re-**  
43 **ceive emergency medical care from a health care facility or emergency medical services**  
44 **provider, including but not limited to the patients':**

45       **(a) Age;**

- 1 (b) Sex;
- 2 (c) Gender;
- 3 (d) Race and ethnicity;
- 4 (e) Status as a disabled person;
- 5 (f) Status as a veteran; and
- 6 (g) Zip code and emergency medical services region of residence.
- 7 (9) As used in this section, “individually identifiable information” means:

- 8 (a) Individually identifiable health information as that term is defined in ORS 179.505; and
- 9 (b) Information that could be used to identify a health care provider, emergency medical
- 10 services agency or health care facility.

11 **SECTION 13.** The Emergency Medical Services Program may create internal data sys-  
12 tems in addition to the emergency medical services data system established and maintained  
13 under section 12 of this 2024 Act. The program may not require:

14 (1) An emergency medical services center to adopt and use an internal data system cre-  
15 ated under this section.

16 (2) Reporting of data that is not otherwise required of an emergency medical services  
17 center in order for the emergency medical services center to obtain a specific categorization  
18 or designation that the emergency medical services center seeks to obtain.

19 **SECTION 14.** (1) All findings and conclusions, interviews, reports, studies, communi-  
20 cations and statements procured or provided by the Oregon Health Authority, the Emer-  
21 gency Medical Services Advisory Board or a regional emergency medical services advisory  
22 board in connection with obtaining data necessary to perform patient care quality assurance  
23 functions are confidential pursuant to ORS 192.338, 192.345 and 192.355.

24 (2)(a) All data, including written reports, notes, records and recommendations, received  
25 or compiled by the Emergency Medical Services Advisory Board or a regional emergency  
26 medical services advisory board in conjunction with the authority’s duties under subsection  
27 (1) of this section are confidential, privileged, nondiscoverable and inadmissible in any pro-  
28 ceeding.

29 (b) A person serving on or communicating with the Emergency Medical Services Advisory  
30 Board or a regional medical services advisory board may not be:

31 (A) Examined as to any communications with, or findings or recommendations of, the  
32 Emergency Medical Services Advisory Board or regional emergency medical services advi-  
33 sory boards; or

34 (B) Subject to an action for civil damages for actions taken or statements made in good  
35 faith.

36 (3) Nothing in this section affects the admissibility of evidence of a party’s medical re-  
37 cords dealing with the party’s medical care that are not otherwise confidential or privileged.

38 (4) Notwithstanding subsection (2)(a) of this section, and except as otherwise required,  
39 all final reports by the authority, the Emergency Medical Services Advisory Board and the  
40 regional emergency medical services advisory boards must be available to the public. The  
41 final reports may not contain any personally identifiable information.

42 (5) This section does not limit the discoverability or admissibility of any information that  
43 is available from any source other than the Emergency Medical Services Advisory Board or  
44 a regional emergency medical services advisory board in a judicial, administrative, arbi-  
45 tration or mediation proceeding.

1       **SECTION 15.** (1) The Emergency Medical Services Program shall establish an incentive  
2 structure to encourage compliance with the classification standards described in section 10  
3 of this 2024 Act and the regional emergency medical services system plans established under  
4 section 11 of this 2024 Act. The structure must specify that:

5       (a)(A) Except as provided in subparagraph (B) of this paragraph, any statewide grant or  
6 program related to emergency medical services, including any federal program related to  
7 emergency medical services that is required to be administered by a state agency, must be  
8 administered by the Emergency Medical Services Program.

9       (B) A local emergency medical services program or other emergency medical services  
10 program that is not required to be administered by a state agency is exempt from the re-  
11 quirement described in this paragraph.

12       (b)(A) An emergency medical services region, as described in section 11 of this 2024 Act,  
13 or other entity related to emergency medical services must be in compliance with relevant  
14 classification standards in order to receive grants or participate in programs administered  
15 by the Emergency Medical Services Program.

16       (B) An emergency medical services region or entity that is not in compliance with the  
17 classification standards may be subject to a corrective action plan developed by the Emer-  
18 gency Medical Services Program.

19       (2) An emergency medical services region or entity that is not in compliance with rele-  
20 vant classification standards may apply to the Emergency Medical Services Program for  
21 special consideration to receive grants and participate in programs administered by the  
22 Emergency Medical Services Program. Subject to the availability of funding and other re-  
23 sources and any requirements of the Emergency Medical Services Program, an emergency  
24 medical services region or entity described in this subsection may receive grants or partic-  
25 ipating in programming.

26       (3) The Emergency Medical Services Program may enter into agreements with third  
27 parties to administer any grants or programs on behalf of the Emergency Medical Services  
28 Program.

29       (4) Unless specifically requested by an agency or entity, the Emergency Medical Services  
30 Program may not interfere with the attainment and administration of any federal emergency  
31 medical services grants or programs operating in this state that are required to be admin-  
32 istered by specific entities or agencies.

33       (5) An entity that administers a federal or state grant that is related to emergency  
34 medical services, but that is not operated by or on behalf of the Emergency Medical Services  
35 Program, shall coordinate with the program for the purposes of maintaining complete in-  
36 formation on emergency medical services support throughout this state.

37       **SECTION 16.** (1) An emergency medical services provider may not be held liable for act-  
38 ing in accordance with approved emergency medical services plans.

39       (2) A person who in good faith provides information to an emergency medical services  
40 data system is immune from any civil or criminal liability that might otherwise be incurred  
41 or imposed with respect to provision of the information.

42       **SECTION 17.** ORS 682.017 is amended to read:

43       682.017. The Oregon Health Authority shall adopt rules in accordance with ORS chapter 183  
44 that include, but are not limited to:

45       (1) Requirements relating to the types and numbers of emergency vehicles, including supplies

1 and equipment carried.

2 (2) Requirements for the operation and coordination of ambulances and other emergency care  
3 systems.

4 (3) Criteria for the use of two-way communications.

5 (4) Procedures for summoning and dispatching aid.

6 (5) Requirements that ambulance services report patient encounter data to [*an electronic emer-*  
7 *gency medical services data system managed by the authority*] **the emergency medical services data**  
8 **system established under section 12 of this 2024 Act**. The requirements must specify the data  
9 that an ambulance service must report, the form and frequency of the reporting and the procedures  
10 and standards for the administration of the data system.

11 (6) Levels of licensure for emergency medical services providers. The lowest level of emergency  
12 medical services provider licensure must be an emergency medical responder license.

13 (7) Other rules as necessary to carry out the provisions of this chapter.

14 **SECTION 18.** ORS 682.051 is amended to read:

15 682.051. (1) A person or governmental unit commits the offense of unlawful operation of an un-  
16 licensed ambulance or the offense of unlawful operation of an unlicensed ambulance service if the  
17 person or governmental unit advertises or operates in this state a motor vehicle, aircraft or  
18 watercraft ambulance that:

19 (a) Is not operated by an ambulance service licensed under this chapter;

20 (b) Is not licensed under this chapter; and

21 (c) Does not meet the minimum requirements established under this chapter by the Oregon  
22 Health Authority in consultation with the [*State Emergency Medical Service Committee*] **Emergency**  
23 **Medical Services Advisory Board** for that type of ambulance.

24 (2) This section does not apply to any ambulance or any person if the ambulance or person is  
25 exempted by ORS 682.035 or 682.079 from regulation by the authority.

26 (3) Authority of political subdivisions to regulate ambulance services or to regulate or allow the  
27 use of ambulances is limited under ORS 682.031.

28 (4) The offense described in this section, unlawful operation of an unlicensed ambulance or am-  
29 bulance service, is a Class A misdemeanor. Each day of continuing violation shall be considered a  
30 separate offense.

31 (5) In addition to the penalties prescribed by subsection (4) of this section, the authority may  
32 impose upon a licensed ambulance service a civil penalty not to exceed \$5,000 for each violation of  
33 this chapter and the rules adopted thereunder. Each day of continuing violation shall be considered  
34 a separate violation for purposes of this subsection.

35 **SECTION 19.** ORS 682.056 is amended to read:

36 682.056. (1)[(a)] Ambulance services shall report patient encounter data to the [*electronic emer-*  
37 *gency medical services data system managed by the Oregon Health Authority*] **emergency medical**  
38 **services data system established under section 12 of this 2024 Act** for each patient care event  
39 in accordance with rules adopted by the **Oregon Health Authority** under ORS 682.017.

40 [(b) *The authority by rule shall specify the patient encounter data elements to be transferred from*  
41 *the electronic emergency medical services data system to the Oregon Trauma Registry and shall es-*  
42 *tablish the procedures for the electronic transfer of the patient encounter data.*]

43 (2)(a) The patient outcome data described in subsection (3) of this section about a patient who  
44 an ambulance service transported to a hospital, and that the hospital entered into the [*Oregon*  
45 *Trauma Registry*] **emergency medical services data system established under section 12 of this**

1 **2024 Act**, must be available to the designated official of the ambulance service that transported the  
2 patient.

3 (b) The authority by rule shall specify the method by which the patient outcome data will be  
4 made available to the designated official of an ambulance service.

5 (3) Patient outcome data includes:

6 (a) The health outcomes of the patient who was the subject of the prehospital care event from  
7 the emergency department or other intake facility of the hospital, including but not limited to:

8 (A) Whether the patient was admitted to the hospital; and

9 (B) If the patient was admitted, to what unit the patient was assigned;

10 (b) The patient's chief complaint, the diagnosis the patient received in the emergency depart-  
11 ment or other intake facility and any procedures performed on the patient;

12 (c) The emergency department or hospital discharge disposition of the patient; and

13 (d) Demographic or standard health care information as required by the authority by rule.

14 (4) Data provided pursuant to this section shall be:

15 (a) Treated as a confidential medical record and not disclosed; and

16 (b) Considered privileged data under ORS 41.675 and 41.685.

17 (5) Data provided pursuant to this section may be used for quality assurance, quality improve-  
18 ment, epidemiological assessment and investigation, public health critical response planning, pre-  
19 vention activities and other purposes that the authority determines necessary.

20 (6)(a) A nontransporting prehospital care provider may report patient encounter data to the  
21 electronic emergency medical services data system.

22 (b) A nontransporting prehospital care provider that reports patient encounter data shall comply  
23 with the reporting requirements that apply to ambulance services.

24 (c) The patient outcome data described in subsection (3) of this section must be available to the  
25 designated official of the nontransporting prehospital care provider that provided care and reported  
26 patient encounter data about the patient.

27 (7) The authority may adopt rules to carry out this section, including rules to:

28 (a) Establish software interoperability standards and guidance to assist in reporting the patient  
29 encounter data required by this section;

30 (b) Specify the method by which the patient outcome data will be made available to  
31 nontransporting prehospital care providers; and

32 (c) Define "nontransporting prehospital care provider."

33 **SECTION 20.** ORS 682.059 is amended to read:

34 682.059. (1) The Oregon Health Authority shall make publicly available on a website operated  
35 by or on behalf of the authority an annual report of the data collected by the authority under ORS  
36 682.056.

37 (2) The authority shall consult with the [*State Emergency Medical Service Committee*] **Emer-**  
38 **gency Medical Services Advisory Board** to determine the data to include in the report required  
39 under this section.

40 (3) The report required under this section may not contain individually identifiable health in-  
41 formation, as defined in ORS 192.556, or other information protected from public disclosure by state  
42 or federal law.

43 **SECTION 21.** ORS 682.068 is amended to read:

44 682.068. (1) The Oregon Health Authority, in consultation with the [*State Emergency Medical*  
45 *Service Committee*] **Emergency Medical Services Advisory Board**, shall adopt rules specifying



1 minimum requirements for ambulance services, and for staffing and medical and communications  
2 equipment requirements for all types of ambulances. The rules must define the requirements for ad-  
3 vanced life support and basic life support units of emergency vehicles, including equipment and  
4 emergency medical services provider staffing of the passenger compartment when a patient is being  
5 transported in emergency circumstances.

6 (2) The authority may waive any of the requirements imposed by this chapter in medically dis-  
7 advantaged areas as determined by the Director of the Oregon Health Authority, or upon a showing  
8 that a severe hardship would result from enforcing a particular requirement.

9 (3) The authority shall exempt from rules adopted under this section air ambulances that do not  
10 charge for the provision of ambulance services.

11 **SECTION 22.** ORS 682.075 is amended to read:

12 682.075. (1) Subject to any law or rule pursuant thereto relating to the construction or equip-  
13 ment of ambulances, the Oregon Health Authority shall, with the advice of the [*State Emergency*  
14 *Medical Service Committee appointed under ORS 682.039*] **Emergency Medical Services Advisory**  
15 **Board** and in accordance with ORS chapter 183, adopt and when necessary amend or repeal rules  
16 relating to the construction, maintenance, capacity, sanitation, emergency medical supplies and  
17 equipment of ambulances.

18 (2) In order for an owner to secure and retain a license for an ambulance under this chapter,  
19 it shall meet the requirements imposed by rules of the authority. The requirements may relate to  
20 construction, maintenance, capacity, sanitation and emergency medical supplies and equipment on  
21 ambulances. Such requirements shall include, but are not limited to, requirements relating to space  
22 in patient compartments, access to patient compartments, storage facilities, operating condition,  
23 cots, mattresses, stretchers, cot and stretcher fasteners, bedding, oxygen and resuscitation equip-  
24 ment, splints, tape, bandages, tourniquets, patient convenience accessories, cleanliness of vehicle  
25 and laundering of bedding.

26 **SECTION 23.** ORS 682.079 is amended to read:

27 682.079. (1)(a) The Oregon Health Authority may grant exemptions or variances from one or  
28 more of the requirements of ORS 820.330 to 820.380 or this chapter or the rules adopted under ORS  
29 820.330 to 820.380 or this chapter to any class of vehicles if the authority finds that compliance with  
30 the requirement or requirements is inappropriate:

31 (A) Because special circumstances exist that would render compliance unreasonable, burden-  
32 some or impractical because of special conditions or cause; or

33 (B) Because compliance would result in substantial curtailment of necessary ambulance service.

34 (b) Exemptions or variances granted under this subsection may be limited in time or may be  
35 conditioned as the authority considers necessary to protect the public welfare.

36 (2) In determining whether or not a variance shall be granted, the authority:

37 (a) May receive the advice of the [*State Emergency Medical Service Committee*] **Emergency**  
38 **Medical Services Advisory Board**; and

39 (b) In all cases, shall weigh the equities involved and the advantages and disadvantages to the  
40 welfare of patients and the owners of vehicles.

41 (3) Rules under this section shall be adopted, amended or repealed in accordance with ORS  
42 183.330.

43 **SECTION 24.** ORS 181A.375 is amended to read:

44 181A.375. (1) The Board on Public Safety Standards and Training shall establish the following  
45 policy committees:

- 1 (a) Corrections Policy Committee;
- 2 (b) Fire Policy Committee;
- 3 (c) Police Policy Committee;
- 4 (d) Telecommunications Policy Committee; and
- 5 (e) Private Security Policy Committee.
- 6 (2) The members of each policy committee shall select a chairperson and vice chairperson for
- 7 the policy committee. Only members of the policy committee who are also members of the board are
- 8 eligible to serve as a chairperson or vice chairperson. The vice chairperson may act as chairperson
- 9 in the absence of the chairperson.
- 10 (3) The Corrections Policy Committee consists of:
- 11 (a) All of the board members who represent the corrections discipline;
- 12 (b) The chief administrative officer of the training division of the Department of Corrections;
- 13 (c) A security manager from the Department of Corrections recommended by the Director of the
- 14 Department of Corrections; and
- 15 (d) The following, who may not be current board members, appointed by the chairperson of the
- 16 board:
- 17 (A) One person recommended by and representing the Oregon State Sheriffs' Association;
- 18 (B) Two persons recommended by and representing the Oregon Sheriff's Jail Command Council;
- 19 (C) One person recommended by and representing a statewide association of community cor-
- 20 rections directors;
- 21 (D) One nonmanagement corrections officer employed by the Department of Corrections;
- 22 (E) One corrections officer who is employed by the Department of Corrections at a women's
- 23 correctional facility and who is a member of a bargaining unit;
- 24 (F) Two nonmanagement corrections officers; and
- 25 (G) One person representing the public who:
- 26 (i) Has never been employed or utilized as a corrections officer or as a parole and probation
- 27 officer; and
- 28 (ii) Is not related within the second degree by affinity or consanguinity to a person who is em-
- 29 ployed or utilized as a corrections officer or parole and probation officer.
- 30 (4) The Fire Policy Committee consists of:
- 31 (a) All of the board members who represent the fire service discipline; and
- 32 (b) The following, who may not be current board members, appointed by the chairperson of the
- 33 board:
- 34 (A) One person recommended by and representing a statewide association of fire instructors;
- 35 (B) One person recommended by and representing a statewide association of fire marshals;
- 36 (C) One person recommended by and representing community college fire programs;
- 37 (D) One nonmanagement firefighter recommended by a statewide organization of firefighters;
- 38 (E) One person representing the forest protection agencies and recommended by the State
- 39 Forestry Department; and
- 40 (F) One person representing the public who:
- 41 (i) Has never been employed or utilized as a fire service professional; and
- 42 (ii) Is not related within the second degree by affinity or consanguinity to a person who is em-
- 43 ployed or utilized as a fire service professional.
- 44 (5) The Police Policy Committee consists of:
- 45 (a) All of the board members who represent the law enforcement discipline; and

1 (b) The following, who may not be current board members, appointed by the chairperson of the  
2 board:

3 (A) One person recommended by and representing the Oregon Association Chiefs of Police;

4 (B) Two persons recommended by and representing the Oregon State Sheriffs' Association;

5 (C) One command officer recommended by and representing the Oregon State Police;

6 (D) Three nonmanagement law enforcement officers; and

7 (E) Two persons representing the public:

8 (i) Who have never been employed or utilized as a police officer, certified reserve officer, reserve  
9 officer or regulatory specialist;

10 (ii) Who are not related within the second degree by affinity or consanguinity to a person who  
11 is employed or utilized as a police officer, certified reserve officer, reserve officer or regulatory  
12 specialist; and

13 (iii) One of whom is a member of a marginalized or historically underrepresented community.

14 (6) The Telecommunications Policy Committee consists of:

15 (a) All of the board members who represent the telecommunications discipline; and

16 (b) The following, who may not be current board members, appointed by the chairperson of the  
17 board:

18 (A) Two persons recommended by and representing a statewide association of public safety  
19 communications officers;

20 (B) One person recommended by and representing the Oregon Association Chiefs of Police;

21 (C) One person recommended by and representing the Oregon State Police;

22 (D) Two persons representing telecommunicators;

23 (E) One person recommended by and representing the Oregon State Sheriffs' Association;

24 (F) One person recommended by and representing the Oregon Fire Chiefs Association;

25 (G) One person recommended by and representing the [*Emergency Medical Services and Trauma*  
26 *Systems Program*] **Emergency Medical Services Program** of the Oregon Health Authority;

27 (H) One person representing emergency medical services providers and recommended by a  
28 statewide association dealing with fire medical issues; and

29 (I) One person representing the public who:

30 (i) Has never been employed or utilized as a telecommunicator or an emergency medical dis-  
31 patcher; and

32 (ii) Is not related within the second degree by affinity or consanguinity to a person who is em-  
33 ployed or utilized as a telecommunicator or an emergency medical dispatcher.

34 (7) The Private Security Policy Committee consists of:

35 (a) All of the board members who represent the private security industry; and

36 (b) The following, who may not be current board members, appointed by the chairperson of the  
37 board:

38 (A) One person representing unarmed private security professionals;

39 (B) One person representing armed private security professionals;

40 (C) One person representing the health care industry;

41 (D) One person representing the manufacturing industry;

42 (E) One person representing the retail industry;

43 (F) One person representing the hospitality industry;

44 (G) One person representing private business or a governmental entity that utilizes private se-  
45 curity services;

1 (H) One person representing persons who monitor alarm systems;

2 (I) Two persons who are investigators licensed under ORS 703.430, one of whom is recommended  
3 by the Oregon State Bar and one of whom is in private practice; and

4 (J) One person representing the public who:

5 (i) Has never been employed or utilized as a private security provider, as defined in ORS  
6 181A.840, or an investigator, as defined in ORS 703.401; and

7 (ii) Is not related within the second degree by affinity or consanguinity to a person who is em-  
8 ployed or utilized as a private security provider, as defined in ORS 181A.840, or an investigator, as  
9 defined in ORS 703.401.

10 (8) In making appointments to the policy committees under this section, the chairperson of the  
11 board shall seek to reflect the diversity of the state's population. An appointment made by the  
12 chairperson of the board must be ratified by the board before the appointment is effective. The  
13 chairperson of the board may remove an appointed member for just cause. An appointment to a  
14 policy committee that is based on the member's employment is automatically revoked if the member  
15 changes employment. The chairperson of the board shall fill a vacancy in the same manner as  
16 making an initial appointment. The term of an appointed member is two years. An appointed member  
17 may be appointed to a second term.

18 (9) A policy committee may meet at such times and places as determined by the policy commit-  
19 tee in consultation with the Department of Public Safety Standards and Training. A majority of a  
20 policy committee constitutes a quorum to conduct business. A policy committee may create sub-  
21 committees if needed.

22 (10)(a) Each policy committee shall develop policies, requirements, standards and rules relating  
23 to its specific discipline. A policy committee shall submit its policies, requirements, standards and  
24 rules to the board for the board's consideration. When a policy committee submits a policy, re-  
25 quirement, standard or rule to the board for the board's consideration, the board shall:

26 (A) Approve the policy, requirement, standard or rule;

27 (B) Disapprove the policy, requirement, standard or rule; or

28 (C) Defer a decision and return the matter to the policy committee for revision or reconsider-  
29 ation.

30 (b) The board may defer a decision and return a matter submitted by a policy committee under  
31 paragraph (a) of this subsection only once. If a policy, requirement, standard or rule that was re-  
32 turned to a policy committee is resubmitted to the board, the board shall take all actions necessary  
33 to implement the policy, requirement, standard or rule unless the board disapproves the policy, re-  
34 quirement, standard or rule.

35 (c) Disapproval of a policy, requirement, standard or rule under paragraph (a) or (b) of this  
36 subsection requires a two-thirds vote by the members of the board.

37 (11) At any time after submitting a matter to the board, the chairperson of the policy committee  
38 may withdraw the matter from the board's consideration.

39 **SECTION 25.** ORS 353.450 is amended to read:

40 353.450. (1) It is the finding of the Legislative Assembly that there is need to provide programs  
41 that will assist a rural community to recruit and retain physicians, physician assistants and nurse  
42 practitioners. For that purpose:

43 (a) The Legislative Assembly supports the development at the Oregon Health and Science Uni-  
44 versity of an Area Health Education Center program as provided for under the United States Public  
45 Health Service Act, Section 781.

1 (b) The university shall provide continuing education opportunities for persons licensed to  
2 practice medicine under ORS chapter 677 who practice in rural areas of this state in cooperation  
3 with the respective professional organizations, including the Oregon Medical Association and the  
4 Oregon Society of Physician Assistants.

5 (c) The university shall seek funding through grants and other means to implement and operate  
6 a fellowship program for physicians, physician assistants and nurse practitioners intending to prac-  
7 tice in rural areas.

8 (2) With the moneys transferred to the Area Health Education Center program by ORS 442.870,  
9 the program shall:

10 (a) Establish educational opportunities for emergency medical services providers in rural coun-  
11 ties;

12 (b) Contract with educational facilities qualified to conduct emergency medical training pro-  
13 grams using a curriculum approved by the [*Emergency Medical Services and Trauma Systems Pro-*  
14 *gram*] **Emergency Medical Services Program**; and

15 (c) Review requests for training funds with input from the [*State Emergency Medical Service*  
16 *Committee*] **Emergency Medical Services Advisory Board** and other individuals with expertise in  
17 emergency medical services.

18 **SECTION 26.** ORS 442.507 is amended to read:

19 442.507. (1) With the moneys transferred to the Office of Rural Health by ORS 442.870, the office  
20 shall establish a dedicated grant program for the purpose of providing assistance to rural commu-  
21 nities to enhance emergency medical service systems.

22 (2) Communities, as well as nonprofit or governmental agencies serving those communities, may  
23 apply to the office for grants on forms developed by the office.

24 (3) The office shall make the final decision concerning which entities receive grants, but the  
25 office may seek advice from the Rural Health Coordinating Council, the [*State Emergency Medical*  
26 *Service Committee*] **Emergency Medical Services Advisory Board** and other appropriate individ-  
27 uals experienced with emergency medical services.

28 (4) The office may make grants to entities for the purchase of equipment, the establishment of  
29 new rural emergency medical service systems or the improvement of existing rural emergency med-  
30 ical service systems.

31 (5) With the exception of printing and mailing expenses associated with the grant program, the  
32 Office of Rural Health shall pay for administrative costs of the program with funds other than those  
33 transferred under ORS 442.870.

34 **SECTION 27.** ORS 442.870 is amended to read:

35 442.870. (1) The Emergency Medical Services Enhancement Account is established separate and  
36 distinct from the General Fund. Interest earned on moneys in the account shall accrue to the ac-  
37 count. All moneys deposited in the account are continuously appropriated to the Department of  
38 Revenue for the purposes of this section.

39 (2) The Department of Revenue shall distribute moneys in the Emergency Medical Services En-  
40 hancement Account in the following manner:

41 (a) 35 percent of the moneys in the account shall be transferred to the Office of Rural Health  
42 established under ORS 442.475 for the purpose of enhancing emergency medical services in rural  
43 areas as specified in ORS 442.507.

44 (b) 25 percent of the moneys in the account shall be transferred to the [*Emergency Medical*  
45 *Services and Trauma Systems Program established under ORS 431A.085*] **Emergency Medical Ser-**

1 **vices Program established under section 2 of this 2024 Act.**

2 (c) 35 percent of the moneys in the account shall be transferred to the Area Health Education  
3 Center program established under ORS 353.450.

4 (d) 5 percent of the moneys in the account shall be transferred to the Oregon Poison Center  
5 referred to in ORS 431A.313.

6 **SECTION 28. ORS 682.039 is repealed.**

7 **SECTION 29. (1) Sections 2 to 16 of this 2024 Act, the amendments to ORS 181A.375,  
8 353.450, 442.507, 442.870, 682.017, 682.051, 682.056, 682.059, 682.068, 682.075 and 682.079 by  
9 sections 17 to 27 of this 2024 Act and the repeal of ORS 682.039 by section 28 of this 2024 Act  
10 become operative on January 1, 2025.**

11 **(2) The Board on Public Safety Standards and Training, the Department of Revenue, the  
12 Office of Rural Health, the Oregon Health Authority and the Oregon Health and Science  
13 University may take any action before the operative date specified in subsection (1) of this  
14 section that is necessary to enable the authority, board, department, office and university  
15 to exercise, on and after the operative date specified in subsection (1) of this section, all of  
16 the duties, functions and powers conferred on the authority, board, department, office and  
17 university by sections 2 to 16 of this 2024 Act, the amendments to ORS 181A.375, 353.450,  
18 442.507, 442.870, 682.017, 682.051, 682.056, 682.059, 682.068, 682.075 and 682.079 by sections 17 to  
19 27 of this 2024 Act and the repeal of ORS 682.039 by section 28 of this 2024 Act.**

20 **SECTION 30. (1) Notwithstanding the term of office specified in section 4 of this 2024 Act,  
21 of the members first appointed to the Emergency Medical Services Advisory Board under  
22 section 4 (1)(b) to (q) of this 2024 Act:**

23 **(a) Four shall serve for a term ending December 31, 2025.**

24 **(b) Four shall serve for a term ending December 31, 2026.**

25 **(c) Four shall serve for a term ending December 31, 2027.**

26 **(d) Four shall serve for a term ending December 31, 2028.**

27 **(2) The Director of the Oregon Health Authority may appoint to the Emergency Medical  
28 Services Advisory Board members of the State Trauma Advisory Board established under  
29 ORS 431A.055, the Stroke Care Committee established under ORS 431A.525 and the State  
30 Emergency Medical Service Committee established under ORS 682.039 (2023 Edition) who  
31 meet the membership requirements described in section 4 of this 2024 Act.**

32 **SECTION 31. The Director of the Oregon Health Authority may appoint to the:**

33 **(1) Time-Sensitive Medical Emergencies Advisory Committee members of the State  
34 Trauma Advisory Board established under ORS 431A.055 and the Stroke Care Committee es-  
35 tablished under ORS 431A.525.**

36 **(2) Emergency Medical Services Advisory Committee members of the State Emergency  
37 Medical Service Committee established under ORS 682.039 (2023 Edition).**

38 **(3) The Pediatric Emergency Medical Services Advisory Committee members of the  
39 Emergency Medical Services for Children Advisory Committee established under ORS  
40 431A.105.**

41 **SECTION 32. (1) The Emergency Medical Services Advisory Board, the Time-Sensitive  
42 Medical Emergencies Advisory Committee, the Pediatric Emergency Medical Services Advi-  
43 sory Committee and the Behavioral Health Emergency Medical Services Advisory Committee  
44 may hold their first meetings no earlier than January 1, 2025.**

45 **(2)(a) The emergency medical services regions established under section 11 of this 2024**

1 Act may hold their first meetings no earlier than January 1, 2026.

2 (b) The emergency medical services regions shall develop the regional emergency medical  
3 services system plans not later than January 1, 2027.

4 **SECTION 33.** Not later than December 31 of each even-numbered year, the Oregon Health  
5 Authority shall submit, in the manner provided in ORS 192.245, a report to the Legislative  
6 Assembly on the progress of implementing the provisions of sections 2 to 16 of this 2024 Act.  
7 The report must include detailed information regarding any challenges in implementing the  
8 provisions of sections 2 to 16 of this 2024 Act.

9 **SECTION 34.** Section 33 of this 2024 Act is repealed on December 31, 2030.

10  
11 **EMERGENCY MEDICAL SERVICES PROGRAM 2027**

12  
13 **SECTION 35.** Section 36 of this 2024 Act is added to and made a part of sections 2 to 16  
14 of this 2024 Act.

15 **SECTION 36.** (1) The Long Term Care and Senior Care Emergency Medical Services Ad-  
16 visory Committee is established in the Emergency Medical Services Advisory Board. The  
17 committee shall consist of members determined by the board and the Oregon Health Au-  
18 thority and must include at least:

19 (a) One member who is a physician licensed under ORS chapter 677 who practices emer-  
20 gency medicine or emergency medical services medicine;

21 (b) One member who is an emergency medical services provider licensed under ORS  
22 682.216;

23 (c) One member who represents a patient equity organization or is an academic profes-  
24 sional specializing in health equity; and

25 (d) One member who is a hospital administrator in a hospital that operates an emergency  
26 department.

27 (2) The committee shall provide advice and recommendations to the board regarding  
28 time-sensitive long term care and senior care medical emergencies on:

29 (a) The integration of long term care and senior care emergency medical services into  
30 the Emergency Medical Services Program.

31 (b) The regionalization and improvement of care for time-sensitive long term care and  
32 senior care medical emergencies.

33 (c) The designation, using nationally recognized classifications where possible, of emer-  
34 gency medical services centers for the provision of care for time-sensitive long term care  
35 and senior care medical emergencies. If no nationally recognized classifications exist, the  
36 committee shall undertake a public deliberation process to establish classifications and sub-  
37 mit the established classifications to the board for approval. In establishing and approving  
38 classifications, the committee and the board shall prioritize patient care.

39 (3) With the advice of the Long Term Care and Senior Care Emergency Medical Services  
40 Advisory Committee, the authority shall:

41 (a) Employ or contract with professional, technical, research and clerical staff to imple-  
42 ment this subsection.

43 (b) Provide technical assistance to the Emergency Medical Services Advisory Committee  
44 on the integration of emergency medical services for long term and senior care patients into  
45 the Emergency Medical Services Program.

1 (c) Provide advice and technical assistance to the Time-Sensitive Medical Emergencies  
2 Advisory Committee on the regionalization of emergency medical services for long term care  
3 and senior care patients.

4 (d) Establish guidelines for:

5 (A) The categorization of specialized regional critical care centers and trauma care cen-  
6 ters for long term care and senior care patients.

7 (B) Referring long term care and senior care patients to appropriate emergency or crit-  
8 ical care centers.

9 (C) Necessary prehospital and other emergency and critical care medical service equip-  
10 ment for long term care and senior care patients.

11 (D) Developing a system that will allow long term care and senior care patients to receive  
12 appropriate initial stabilization and treatment with the timely provision of, or referral to, the  
13 appropriate level of care, including critical care, trauma care or subspecialty care.

14 (E) An interfacility transfer system for critically ill or injured long term care and senior  
15 care patients.

16 (F) Continuing professional education programs for emergency medical services person-  
17 nel, including training in the emergency care of long term care and senior care patients  
18 across different demographics.

19 (G) A public education program concerning emergency medical services for long term  
20 care and senior care patients, including information on emergency access telephone num-  
21 bers.

22 (H) The collection and analysis of statewide emergency and critical care medical services  
23 data from emergency and critical care medical services facilities for the purposes of quality  
24 improvement by those facilities with respect to long term care and senior care patients,  
25 subject to relevant confidentiality requirements.

26 (I) The establishment of cooperative interstate relationships to facilitate the provision  
27 of appropriate care for long term and senior care patients who must cross state borders to  
28 receive emergency and critical care services.

29 (J) Coordination and cooperation between providers of emergency medical services for  
30 long term care and senior care patients and other public and private organizations interested  
31 or involved in emergency and critical care for long term care and senior care patients.

32 (4) The authority may adopt rules as necessary to carry out this section, including rules  
33 to adopt the nationally recognized classifications described in subsection (2) of this section.

34 **SECTION 37.** Section 3 of this 2024 Act is amended to read:

35 **Sec. 3.** (1) The Emergency Medical Services Program, with the advice of the Emergency Medical  
36 Services Advisory Board, the Time-Sensitive Medical Emergencies Advisory Committee, the Emer-  
37 gency Medical Services Advisory Committee, the Pediatric Emergency Medical Services Advisory  
38 Committee [*and*], the Behavioral Health Emergency Medical Services Advisory Committee **and the**  
39 **Long Term Care and Senior Care Emergency Medical Services Advisory Committee**, shall:

40 (a) Coordinate with national health organizations involved in improving the quality of stroke,  
41 cardiac, trauma, pediatric [*and*], behavioral health **and long term and senior** care to avoid  
42 duplicative information and redundant processes;

43 (b) Use information related to stroke, cardiac, trauma, pediatric [*and*], behavioral health **and**  
44 **long term and senior** care to support improvement in the quality of care in accordance with  
45 guidelines that meet or exceed nationally recognized standards;



1 (c) Encourage the sharing of information among health care providers on practices that improve  
2 the quality of stroke, cardiac, trauma, pediatric *[and]*, behavioral health **and long term and senior**  
3 care;

4 (d) Facilitate communication about data trends and treatment developments among health care  
5 providers and coordinated care organizations that provide services related to stroke, cardiac,  
6 trauma, pediatric *[and]*, behavioral health **and long term and senior** care; and

7 (e) Provide stroke, cardiac, trauma, pediatric *[and]*, behavioral health **and long term and sen-**  
8 **ior** care data, and recommendations for improvement to care, to coordinated care organizations.

9 (2) Not later than the beginning of each odd-numbered year regular session of the Legislative  
10 Assembly, the program shall submit to the Legislative Assembly a report in the manner provided in  
11 ORS 192.245 summarizing the program's activities under this section.

12 **SECTION 38.** Section 5 of this 2024 Act is amended to read:

13 **Sec. 5.** (1) The Emergency Medical Services Advisory Board shall provide advice and recom-  
14 mendations to the Emergency Medical Services Program on the following:

15 (a) A definition of "patient" for purposes of time-sensitive medical emergencies, pediatric med-  
16 ical emergencies *[and]*, behavioral health medical emergencies **and long term and senior care**  
17 **medical emergencies;**

18 (b) Evidence-based practices and standards for emergency medical services care for defined pa-  
19 tient types;

20 (c) Emergency medical services workforce needs;

21 (d) Coordination of care between health care specialties;

22 (e) Other issues related to emergency medical services as determined by the Oregon Health  
23 Authority and the program;

24 (f) The appointment of the regional emergency medical services advisory boards; and

25 (g) Approval of the regional emergency medical services plans described in section 11 of this  
26 2024 Act.

27 (2) The board may convene temporary subcommittees for matters related to emergency medical  
28 services in order to inform and make recommendations to the board.

29 (3) In addition to the duties described in subsection (1) of this section, the board shall convene  
30 the following permanent advisory committees that shall inform and make recommendations to the  
31 board, in addition to other specified duties:

32 (a) Time-Sensitive Medical Emergencies Advisory Committee, as described in section 6 of this  
33 2024 Act;

34 (b) Emergency Medical Services Advisory Committee, as described in section 7 of this 2024 Act;

35 (c) Pediatric Emergency Medical Services Advisory Committee, as described in section 8 of this  
36 2024 Act; *[and]*

37 (d) Behavioral Health Emergency Medical Services Advisory Committee, as described in section  
38 9 of this 2024 Act[.]; **and**

39 **(e) Long Term Care and Senior Care Emergency Medical Services Advisory Committee,**  
40 **as described in section 36 of this 2024 Act.**

41 **SECTION 39.** Section 7 of this 2024 Act is amended to read:

42 **Sec. 7.** (1) The Emergency Medical Services Advisory Committee is established in the Emer-  
43 gency Medical Services Advisory Board. The committee shall consist of members determined by the  
44 board and the Oregon Health Authority and must include at least:

45 (a) One member who is a physician licensed under ORS chapter 677 who practices emergency

1 medicine or emergency medical services medicine;

2 (b) One member who is an emergency medical services provider licensed under ORS 682.216; and

3 (c) One member who represents a patient equity organization or is an academic professional  
4 specializing in health equity.

5 (2) The committee shall provide advice and recommendations to the board regarding emergency  
6 medical services, for the care of time-sensitive medical emergencies, pediatric medical emergencies  
7 [and], behavioral health medical emergencies **and long term and senior care medical emergen-**  
8 **cies**, including the following objectives:

9 (a) The regionalization and improvement of emergency medical services, including the coordi-  
10 nation and planning of emergency medical services efforts.

11 (b) The designation, using nationally recognized classifications where possible, of emergency  
12 medical services centers for the provision of care for medical emergencies. If no nationally recog-  
13 nized classifications exist, the committee shall undertake a public deliberation process to establish  
14 classifications and submit the established classifications to the board for approval. In establishing  
15 and approving classifications, the committee and the board shall prioritize patient care.

16 (c) The adoption of rules related to emergency medical services.

17 (3) The chairperson of the committee shall appoint an advisory subcommittee on the licensure  
18 and discipline of emergency medical services providers. The subcommittee shall advise the board on  
19 potential rules that the board may recommend to the authority for adoption under this section.

20 (4) The committee may:

21 (a) Assist the Time-Sensitive Medical Emergencies Advisory Committee, the Pediatric Emer-  
22 gency Medical Services Advisory Committee [and], the Behavioral Health Emergency Medical Ser-  
23 vices Advisory Committee **and the Long Term Care and Senior Care Emergency Medical**  
24 **Services Advisory Committee** in coordination and planning efforts; and

25 (b) Provide other assistance to the board as the board requests.

26 (5) The authority may adopt rules as necessary to carry out this section, including rules to adopt  
27 the nationally recognized classifications described in subsection (2) of this section.

28 **SECTION 40.** Section 10 of this 2024 Act is amended to read:

29 **Sec. 10.** (1)(a) The Emergency Medical Services Advisory Board, upon the advice of the Time-  
30 Sensitive Medical Emergencies Advisory Committee, the Emergency Medical Services Advisory  
31 Committee, the Pediatric Emergency Medical Services Advisory Committee [and], the Behavioral  
32 Health Emergency Medical Services Advisory Committee **and the Long Term Care and Senior**  
33 **Care Emergency Medical Services Advisory Committee**, shall determine the nationally recog-  
34 nized classification standards to recommend to the Oregon Health Authority to adopt as rules for  
35 categorization and designation of emergency medical services centers for the provision of trauma,  
36 stroke, cardiac, pediatric [and], behavioral health **and long term and senior** care and other iden-  
37 tified time-sensitive emergencies.

38 (b) If a nationally recognized classification standard used by the authority under this subsection  
39 requires that an emergency medical services center use a specific data system or registry in order  
40 to obtain a specific categorization or designation, the authority shall require an emergency medical  
41 services center that intends to obtain the categorization or designation to adopt the data system or  
42 registry not later than:

43 (A) Eighteen months after the date on which the Emergency Medical Services Advisory Board  
44 and the authority determine the data system or registry must be adopted, if the emergency medical  
45 services center is a large facility or hospital, with an additional six months in which to demonstrate

1 compliant usage of the data system or registry.

2 (B) Three years after the date on which the board and the authority determine the data system  
3 or registry must be adopted, if the emergency medical services center is a critical access or rural  
4 health care facility or hospital, with an additional six months in which to demonstrate compliant  
5 usage of the data system or registry.

6 (c) If no relevant nationally recognized classification standard is available for a specific type  
7 of emergency medical services center, the authority shall consider the recommendations of the board  
8 for one or more new classifications of a type of emergency medical services center.

9 (d) The board and the authority may grant, at the request of an emergency medical services  
10 center, an extension to the timeline described in paragraph (b) of this subsection.

11 (2)(a) An emergency medical services center is not required to obtain categorization or desig-  
12 nation as described in subsection (1) of this section but may, at the discretion of the emergency  
13 medical services center, strive to obtain a specific categorization or designation.

14 (b) An emergency medical services center described in this subsection is not required to adopt  
15 and use a specific data system or registry unless the data system or registry is required in order to  
16 obtain the categorization or designation that the emergency medical services center strives to ob-  
17 tain.

18 (c) An emergency medical services center may concurrently adopt and use data systems or  
19 registries in addition to any data systems or registries required for a specific categorization or  
20 designation.

21 (3) An emergency medical services center that uses any data system or registry shall grant to  
22 the authority permission to extract data subject to relevant confidentiality requirements.

23 (4) An emergency medical services center may not hold itself out, or operate, as having obtained  
24 a specific categorization or designation until:

25 (a) The emergency medical services center meets all requirements for the categorization or  
26 designation within the timelines specified in subsection (1)(b) of this section; and

27 (b) The authority, through the Emergency Medical Services Program, recognizes that the emer-  
28 gency medical services center meets the categorization or designation requirements.

29 (5) The authority shall adopt rules to carry out this section and may adopt as rules of the au-  
30 thority any relevant nationally recognized classification standards and proposed classification stan-  
31 dards described in subsection (1) of this section.

32 **SECTION 41.** ORS 146.015 is amended to read:

33 146.015. (1) There is hereby established the State Medical Examiner Advisory Board.

34 (2) The board shall make policies for the administration of ORS 146.003 to 146.189 and the De-  
35 partment of State Police shall adopt rules to effectuate the policies.

36 (3) The board shall recommend the name or names of pathologists to the Superintendent of State  
37 Police from which the superintendent shall appoint the Chief Medical Examiner.

38 (4) The board consists of 11 members appointed by the Governor who are:

39 (a) The Chair of the Department of Pathology of the Oregon Health and Science University, who  
40 is the chairperson of the board;

41 (b) The State Health Officer;

42 (c) A sheriff;

43 (d) A trauma physician recommended by the [*State Trauma Advisory Board*] **Emergency Med-**  
44 **ical Services Advisory Board**;

45 (e) A pathologist;

1 (f) A district attorney;

2 (g) A funeral service practitioner and embalmer licensed by the State Mortuary and Cemetery  
3 Board;

4 (h) A chief of police;

5 (i) A member of the defense bar;

6 (j) A member of the public at large; and

7 (k) A member of one of the federally recognized Oregon Indian tribes.

8 (5) The members described in subsection (4)(a) and (b) of this section may serve as long as they  
9 hold their respective positions. The term of office of each member described in subsection (4)(c), (f)  
10 and (h) of this section is for four years, except that the position becomes vacant if the member  
11 ceases to be a sheriff, district attorney or chief of police, respectively. The terms of office of the  
12 other members of the State Medical Examiner Advisory Board are for four years.

13 (6) A member of the board is entitled to compensation and expenses as provided in ORS 292.495.

14 (7) The board shall meet annually at a time and place determined by the chairperson. The  
15 chairperson or any four members of the board may call a special meeting upon not less than one  
16 week's notice to the members of the board.

17 (8) Six members of the board constitute a quorum.

18 **SECTION 42.** ORS 441.020 is amended to read:

19 441.020. (1) Licenses for health care facilities, except long term care facilities as defined in ORS  
20 442.015, must be obtained from the Oregon Health Authority.

21 (2) Licenses for long term care facilities must be obtained from the Department of Human Ser-  
22 vices.

23 (3) Applications shall be upon such forms and shall contain such information as the authority  
24 or the department may reasonably require, which may include affirmative evidence of ability to  
25 comply with such reasonable standards and rules as may lawfully be prescribed under ORS 441.025.

26 (4)(a) Each application submitted to the Oregon Health Authority must be accompanied by the  
27 license fee. If the license is denied, the fee shall be refunded to the applicant. If the license is issued,  
28 the fee shall be paid into the State Treasury to the credit of the Oregon Health Authority Fund for  
29 the purpose of carrying out the functions of the Oregon Health Authority under and enforcing ORS  
30 441.015 to 441.119, 441.761 to 441.795 and 441.993; or

31 (b) Each application submitted to the Department of Human Services must be accompanied by  
32 the application fee or the annual renewal fee, as applicable. If the license is denied, the fee shall  
33 be refunded to the applicant. If the license is issued, the fee shall be paid into the State Treasury  
34 to the credit of the Department of Human Services Account for the purpose of carrying out the  
35 functions of the Department of Human Services under and enforcing ORS [431A.050 to 431A.080,]  
36 441.015 to 441.119 and 441.993.

37 (5) Except as otherwise provided in subsection (8) of this section, for hospitals with:

38 (a) Fewer than 26 beds, the annual license fee shall be \$1,250.

39 (b) Twenty-six beds or more but fewer than 50 beds, the annual license fee shall be \$1,850.

40 (c) Fifty or more beds but fewer than 100 beds, the annual license fee shall be \$3,800.

41 (d) One hundred beds or more but fewer than 200 beds, the annual license fee shall be \$6,525.

42 (e) Two hundred or more beds, but fewer than 500 beds, the annual license fee shall be \$8,500.

43 (f) Five hundred or more beds, the annual license fee shall be \$12,070.

44 (6) A hospital shall pay an annual fee of \$750 for each hospital satellite indorsed under the  
45 hospital's license.

1 (7) The authority may charge a reduced hospital fee or hospital satellite fee if the authority  
2 determines that charging the standard fee constitutes a significant financial burden to the facility.

3 (8) For long term care facilities with:

4 (a) One to 15 beds, the application fee shall be \$2,000 and the annual renewal fee shall be \$1,000.

5 (b) Sixteen to 49 beds, the application fee shall be \$3,000 and the annual renewal fee shall be  
6 \$1,500.

7 (c) Fifty to 99 beds, the application fee shall be \$4,000 and the annual renewal fee shall be  
8 \$2,000.

9 (d) One hundred to 150 beds, the application fee shall be \$5,000 and the annual renewal fee shall  
10 be \$2,500.

11 (e) More than 150 beds, the application fee shall be \$6,000 and the annual renewal fee shall be  
12 \$3,000.

13 (9) For ambulatory surgical centers, the annual license fee shall be:

14 (a) \$1,750 for certified and high complexity noncertified ambulatory surgical centers with more  
15 than two procedure rooms.

16 (b) \$1,250 for certified and high complexity noncertified ambulatory surgical centers with no  
17 more than two procedure rooms.

18 (c) \$1,000 for moderate complexity noncertified ambulatory surgical centers.

19 (10) For birthing centers, the annual license fee shall be \$750.

20 (11) For outpatient renal dialysis facilities, the annual license fee shall be \$2,000.

21 (12) The authority shall prescribe by rule the fee for licensing an extended stay center, not to  
22 exceed:

23 (a) An application fee of \$25,000; and

24 (b) An annual renewal fee of \$5,000.

25 (13) During the time the licenses remain in force, holders are not required to pay inspection fees  
26 to any county, city or other municipality.

27 (14) Any health care facility license may be indorsed to permit operation at more than one lo-  
28 cation. If so, the applicable license fee shall be the sum of the license fees that would be applicable  
29 if each location were separately licensed. The authority may include hospital satellites on a  
30 hospital's license in accordance with rules adopted by the authority.

31 (15) Licenses for health maintenance organizations shall be obtained from the Director of the  
32 Department of Consumer and Business Services pursuant to ORS 731.072.

33 (16) Notwithstanding subsection (4) of this section, all moneys received for approved applications  
34 pursuant to subsection (8) of this section shall be deposited in the Quality Care Fund established in  
35 ORS 443.001.

36 (17) As used in this section:

37 (a) "Hospital satellite" has the meaning prescribed by the authority by rule.

38 (b) "Procedure room" means a room where surgery or invasive procedures are performed.

39 **SECTION 43. ORS 431A.050, 431A.055, 431A.060, 431A.065, 431A.070, 431A.075, 431A.080,**  
40 **431A.085, 431A.090, 431A.095, 431A.100, 431A.105, 431A.525 and 431A.530 are repealed.**

41 **SECTION 44. (1) Section 36 of this 2024 Act, the amendments to sections 3, 5, 7 and 10**  
42 **of this 2024 Act by sections 37 to 40 of this 2024 Act, the amendments to ORS 146.015 and**  
43 **441.020 by sections 41 and 42 of this 2024 Act and the repeal of ORS 431A.050, 431A.055,**  
44 **431A.060, 431A.065, 431A.070, 431A.075, 431A.080, 431A.085, 431A.090, 431A.095, 431A.100,**  
45 **431A.105, 431A.525 and 431A.530 by section 43 of this 2024 Act become operative on January**

1 1, 2027.

2 (2) The Department of Human Services, the Oregon Health Authority and the State  
3 Medical Examiner Advisory Board may take any action before the operative date specified  
4 in subsection (1) of this section that is necessary to enable the authority, board and depart-  
5 ment to exercise, on and after the operative date specified in subsection (1) of this section,  
6 all of the duties, functions and powers conferred on the authority, board and department by  
7 section 36 of this 2024 Act, the amendments to sections 3, 5, 7 and 10 of this 2024 Act by  
8 sections 37 to 40 of this 2024 Act, the amendments to ORS 146.015 and 441.020 by sections 41  
9 and 42 of this 2024 Act and the repeal of ORS 431A.050, 431A.055, 431A.060, 431A.065, 431A.070,  
10 431A.075, 431A.080, 431A.085, 431A.090, 431A.095, 431A.100, 431A.105, 431A.525 and 431A.530 by  
11 section 43 of this 2024 Act.

12 **SECTION 45.** The Director of the Oregon Health Authority may appoint to the Long  
13 Term Care and Senior Care Emergency Medical Services Advisory Committee members of  
14 the Senior Emergency Medical Services Advisory Council established under section 1, chapter  
15 616, Oregon Laws 2021.

16  
17 **CAPTIONS**

18  
19 **SECTION 46.** The unit captions used in this 2024 Act are provided only for the conven-  
20 ience of the reader and do not become part of the statutory law of this state or express any  
21 legislative intent in the enactment of this 2024 Act.

22  
23 **EFFECTIVE DATE**

24  
25 **SECTION 47.** This 2024 Act takes effect on the 91st day after the date on which the 2024  
26 regular session of the Eighty-second Legislative Assembly adjourns sine die.  
27