

House Bill 4081

Sponsored by Representative GRAYBER, Senator STEINER; Representatives DEXTER, 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 **as introduced**. 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.

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

A BILL FOR AN ACT

1
2 Relating to emergency medical services; creating new provisions; amending ORS 146.015, 181A.375,
3 353.450, 441.020, 442.507, 442.870, 682.017, 682.051, 682.056, 682.059, 682.068, 682.075 and 682.079;
4 repealing ORS 431A.050, 431A.055, 431A.060, 431A.065, 431A.070, 431A.075, 431A.080, 431A.085,
5 431A.090, 431A.095, 431A.100, 431A.105, 431A.525, 431A.530 and 682.039; and prescribing an ef-
6 fective date.

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

EMERGENCY MEDICAL SERVICES PROGRAM 2025

10
11 **SECTION 1. Sections 2 to 16 of this 2024 Act are added to and made a part of ORS**
12 **chapter 682.**

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

18 (a) **The development of state and regional standards of emergency medical care;**

19 (b) **The development of state, regional and interstate protocols for patient transfers using**
20 **emergency medical services;**

21 (c) **The training and licensing of emergency medical services providers;**

22 (d) **The development and management of emergency medical services data systems;**

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

25 (f) **The regulation and administration of state reimbursement systems for emergency**
26 **medical services; and**

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

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

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

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

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

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

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

10 (D) Implementation of quality improvement programs; and

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

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

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

17 (a) Providing specialized medical oversight in the development and administration of the
18 program;

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

20 (c) Undertaking research and providing public education regarding emergency medical
21 services; and

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

25 (4) The authority shall:

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

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

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

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

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

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

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

45 (c) Encourage the sharing of information among health care providers on practices that

1 improve the quality of stroke, cardiac, trauma, pediatric and behavioral health care;

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

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

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

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

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

16 (b) One must be a patient advocate or an education professional who specializes in health
17 equity;

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

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

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

23 (f) One must be a representative of a labor union that represents emergency medical
24 services providers;

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

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

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

30 (j) One must be a hospital administrator in a hospital that operates an emergency de-
31 partment;

32 (k) One must be a manager of nursing staff in a hospital emergency department;

33 (L) One must be a representative of a public safety answering point, as defined in ORS
34 403.105;

35 (m) One must be an emergency medicine physician;

36 (n) One must be a person who works in a long term care facility, as defined in ORS
37 442.015, or who represents employees of long term care facilities;

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

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

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

42 (r) One must be a representative of a hospital system that includes a rural hospital as
43 defined in ORS 442.470; and

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

45 (2)(a) The physician members of the board must be physicians licensed under ORS chap-

1 ter 677 who are in good standing.

2 (b) If the member described in subsection (1)(k) of this section is a nurse, the nurse must
3 be licensed under ORS 678.010 to 678.410 and in good standing.

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

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

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

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

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

19 (6) The board may adopt rules as necessary to carry out its duties under sections 2 to
20 16 of this 2024 Act.

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

23 (a) A definition of “patient” for purposes of emergency medical services;

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

26 (c) Emergency medical services workforce needs;

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

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

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

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

33 (2) The board may convene temporary subcommittees for matters related to emergency
34 medical services.

35 (3) In addition to the duties described in subsection (1) of this section, the board shall
36 convene the following permanent advisory committees:

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

39 (b) Emergency Medical Services Advisory Committee, as described in section 7 of this
40 2024 Act;

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

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

45 **SECTION 6.** (1) The Time-Sensitive Medical Emergencies Advisory Committee is estab-

1 lished in the Emergency Medical Services Advisory Board. The committee shall consist of
 2 members determined by the board and the Oregon Health Authority and must include at
 3 least:

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

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

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

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

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

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

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

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

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

19 (2)(a) The committee shall provide advice and recommendations to the board and the
 20 authority regarding systems of care related to time-sensitive medical emergencies, including
 21 at least cardiac, stroke, airway, sepsis and trauma emergencies. The commission shall also
 22 consider other time-sensitive emergencies including but not limited to sepsis, infectious dis-
 23 eases, pandemics, active seizures and severe respiratory emergencies.

24 (b) The committee shall provide recommendations to the board and the authority on:

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

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

32 (3) The committee shall:

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

35 (b) Advise the board and the authority on the adoption of rules related to care for
 36 cardiac, stroke, trauma and other identified time-sensitive emergencies;

37 (c) Analyze data related to care for cardiac, stroke, trauma and other identified time-
 38 sensitive emergencies;

39 (d) Recommend to the board and the authority improvements to the Emergency Medical
 40 Services Program regarding care for cardiac, stroke, trauma and other identified time-
 41 sensitive emergencies; and

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

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

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

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

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

8 (b) One member who is an emergency medical services provider licensed under ORS
9 682.216; and

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

12 (2) The committee shall provide advice and recommendations to the board and the au-
13 thority regarding emergency medical services, including the following objectives:

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

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

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

23 (3) The chairperson of the committee shall appoint an advisory subcommittee on the
24 licensure and discipline of emergency medical services providers. The subcommittee shall
25 advise the authority and the board on the adoption of rules under this section.

26 (4) The committee may:

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

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

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

33 **SECTION 8.** (1) The Pediatric Emergency Medical Services Advisory Committee is es-
34 tablished in the Emergency Medical Services Advisory Board. The committee shall consist
35 of members determined by the board and the Oregon Health Authority and must include at
36 least:

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

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

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

41 (d) One member who is an emergency medical services provider licensed under ORS
42 682.216;

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

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

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

3 (h) One member who is a physician who practices emergency medicine or emergency
4 medical services medicine;

5 (i) One member who is an emergency medical services provider licensed under ORS
6 682.216; and

7 (j) One member who represents a patient equity organization or is an academic profes-
8 sional specializing in health care equity.

9 (2) The committee shall provide advice and recommendations to the board and the au-
10 thority regarding pediatric medical emergencies, including the following objectives:

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

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

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

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

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

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

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

27 (d) Establish guidelines for:

28 (A) The categorization of specialized regional pediatric critical care centers and pediatric
29 trauma care centers.

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

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

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

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

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

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

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

45 (I) The establishment of cooperative interstate relationships to facilitate the provision

1 of appropriate care for pediatric patients who must cross state borders to receive critical
2 care and trauma care services.

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

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

8 (b) The member of the committee who is a nurse must be licensed under ORS 678.010 to
9 678.410 and in good standing.

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

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

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

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

20 (c) One member who is an emergency medical services provider licensed under ORS
21 682.216; and

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

24 (2) The committee shall provide advice and recommendations to the board and the au-
25 thority regarding time-sensitive behavioral health medical emergencies, including the fol-
26 lowing objectives:

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

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

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

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

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

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

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

1 (d) Establish guidelines for:

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

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

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

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

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

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

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

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

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

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

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

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

30 **SECTION 10.** (1)(a) The Emergency Medical Services Advisory Board, with the advice of
31 the Time-Sensitive Medical Emergencies Advisory Committee, the Emergency Medical Ser-
32 vices Advisory Committee, the Pediatric Emergency Medical Services Advisory Committee
33 and the Behavioral Health Emergency Medical Services Advisory Committee, shall determine
34 the nationally recognized classification standards to recommend to the Oregon Health Au-
35 thority to adopt as rules for categorization and designation of emergency medical services
36 centers for the provision of trauma, stroke, cardiac, pediatric and behavioral health care and
37 other identified time-sensitive emergencies.

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

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

1 months in which to demonstrate 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
 3 system or registry must be adopted, if the emergency medical services center is a critical
 4 access or rural health care facility or hospital, with an additional six months in which to
 5 demonstrate compliant usage of the data system or registry.

6 (c) If no relevant nationally recognized classification standard is available for a specific
 7 type of emergency medical services center, the authority shall convene an advisory com-
 8 mittee of stakeholders, including but not limited to state and community partners, to develop
 9 a proposal for the establishment of classification standards for the designation of an emer-
 10 gency medical services center.

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

13 (2)(a) An emergency medical services center is not required to obtain categorization or
 14 designation as described in subsection (1) of this section.

15 (b) An emergency medical services center described in this subsection is not required to
 16 adopt and use a specific data system or registry.

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

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

23 (4) The authority shall adopt rules to carry out this section, and may adopt as rules of
 24 the authority any relevant nationally recognized classification standards and proposed clas-
 25 sification standards described in subsection (1) of this section.

26 **SECTION 11.** (1) The Oregon Health Authority shall, with the advice of the Emergency
 27 Medical Services Advisory Board, designate emergency medical services regions that are
 28 consistent with local resources, geography, current patient referral patterns and existing
 29 regionalized health care structures and networks. The authority and the Emergency Medical
 30 Services Advisory Board shall establish a regional emergency medical services advisory board
 31 for each designated emergency medical services region. The authority and the Emergency
 32 Medical Services Advisory Board may determine the membership of each regional emergency
 33 medical services advisory board, and shall ensure that the membership reflects the ge-
 34 ographic, cultural, linguistic and economic diversity of the emergency medical services re-
 35 gion.

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

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

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

45 (b) Central medical direction for all field care and transportation consistent with ge-

1 **ographic and current communications capability; and**

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

3 **(4) Each regional emergency medical services system plan:**

4 **(a) Must include the following:**

5 **(A) A recommendation of hospitals in the emergency medical services region to be des-**
6 **ignated by the authority as emergency medical services centers under section 10 of this 2024**
7 **Act;**

8 **(B) A description of the patient triage protocols to be used in the emergency medical**
9 **services region;**

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

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

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

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

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

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

21 **SECTION 12. (1) The Emergency Medical Services Program, upon the recommendation**
22 **of the Emergency Medical Services Advisory Board, the Time-Sensitive Medical Emergencies**
23 **Advisory Committee, the Emergency Medical Services Advisory Committee, the Pediatric**
24 **Emergency Medical Services Advisory Committee and the Behavioral Health Emergency**
25 **Medical Services Advisory Committee, shall establish and maintain an emergency medical**
26 **services data system. The Oregon Health Authority shall adopt rules for the data system**
27 **described in this subsection to establish:**

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

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

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

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

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

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

37 **(2) The data system established under this section must:**

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

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

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

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

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

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

6 (4) The Emergency Medical Services Program shall make recommendations to:

7 (a) Health care facilities for the adoption of specific registries and services from the data
 8 system established under this section for the purpose of health care facility categorization;
 9 and

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

13 (5) The authority may request the inclusion of demographic data from patients who re-
 14 ceive emergency medical care from a health care facility or emergency medical services
 15 provider, including but not limited to the patients’:

16 (a) Age;

17 (b) Sex;

18 (c) Gender;

19 (d) Race and ethnicity;

20 (e) Status as a disabled person;

21 (f) Status as a veteran; and

22 (g) Zip code and emergency medical services region of residence.

23 (6) As used in this section, “individually identifiable information” means:

24 (a) Individually identifiable health information as that term is defined in ORS 179.505; and

25 (b) Information that could be used to identify a health care provider, emergency medical
 26 services agency or health care facility.

27 **SECTION 13.** The Emergency Medical Services Program may create internal data sys-
 28 tems in addition to the emergency medical services data system established and maintained
 29 under section 12 of this 2024 Act. The program may not require an emergency medical ser-
 30 vices center to adopt and use an internal data system created under this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

45 **SECTION 16.** (1) An emergency medical services provider may not be held liable for act-

ing in accordance with approved emergency medical services plans.

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

SECTION 17. 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 are repealed.

SECTION 18. (1) Sections 2 to 16 of this 2024 Act and the repeal of 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 by section 17 of this 2024 Act become operative on January 1, 2025.

(2) The Oregon Health Authority may take action before the operative date specified in subsection (1) of this section that is necessary to enable the authority to exercise, on or after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority by sections 2 to 16 of this 2024 Act and the repeal of 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 by section 17 of this 2024 Act.

SECTION 19. (1) Notwithstanding the term of office specified in section 4 of this 2024 Act, of the members first appointed to the Emergency Medical Services Advisory Board under section 4 (1)(b) to (q) of this 2024 Act:

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

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

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

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

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

SECTION 20. The Director of the Oregon Health Authority may appoint to the:

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

(2) Emergency Medical Services Advisory Committee members of the State Emergency Medical Service Committee established under ORS 682.039.

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

SECTION 21. (1) The Emergency Medical Services Advisory Board, the Time-Sensitive Medical Emergencies Advisory Committee, the Pediatric Emergency Medical Services Advisory Committee and the Behavioral Health Emergency Medical Services Advisory Committee may hold their first meetings no earlier than January 1, 2026.

(2)(a) The emergency medical services regions established under section 11 of this 2024 Act may hold their first meetings no earlier than January 1, 2026.

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

EMERGENCY MEDICAL SERVICES PROGRAM 2027

SECTION 22. Section 23 of this 2024 Act is added to and made a part of sections 2 to 16 of this 2024 Act.

SECTION 23. (1) The Long Term Care and Senior Care Emergency Medical Services Advisory Committee is established in the Emergency Medical Services Advisory Board. The committee shall consist of members determined by the board and the Oregon Health Authority and must include at least:

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

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

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

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

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

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

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

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

(a) Employ or contract with professional, technical, research and clerical staff to implement this subsection.

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

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

(d) Establish guidelines for:

(A) The categorization of specialized regional critical care centers and trauma care centers for long term care and senior care patients.

(B) Referring long term care and senior care patients to appropriate emergency or critical care centers.

(C) Necessary prehospital and other emergency and critical care medical service equipment for long term care and senior care patients.

(D) Developing a system that will allow long term care and senior care patients to receive appropriate initial stabilization and treatment with the timely provision of, or referral to, the

1 appropriate level of care, including critical care, trauma care or subspecialty care.

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

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

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

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

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

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

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

22 **SECTION 24.** Section 3 of this 2024 Act is amended to read:

23 **Sec. 3.** (1) The Emergency Medical Services Program, with the advice of the Emergency Medical
24 Services Advisory Board, the Time-Sensitive Medical Emergencies Advisory Committee, the Emer-
25 gency Medical Services Advisory Committee, the Pediatric Emergency Medical Services Advisory
26 Committee [*and*], the Behavioral Health Emergency Medical Services Advisory Committee **and the**
27 **Long Term Care and Senior Care Emergency Medical Services Advisory Committee**, shall:

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

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

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

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

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

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

45 **SECTION 25.** Section 5 of this 2024 Act is amended to read:

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

3 (a) A definition of “patient” for purposes of emergency medical services;

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

6 (c) Emergency medical services workforce needs;

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

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

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

11 (g) Approval of the regional emergency medical services plans described in section 11 of this
12 2024 Act.

13 (2) The board may convene temporary subcommittees for matters related to emergency medical
14 services.

15 (3) In addition to the duties described in subsection (1) of this section, the board shall convene
16 the following permanent advisory committees:

17 (a) Time-Sensitive Medical Emergencies Advisory Committee, as described in section 6 of this
18 2024 Act;

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

20 (c) Pediatric Emergency Medical Services Advisory Committee, as described in section 8 of this
21 2024 Act; *[and]*

22 (d) Behavioral Health Emergency Medical Services Advisory Committee, as described in section
23 9 of this 2024 Act[.]; **and**

24 **(e) Long Term Care and Senior Care Emergency Medical Services Advisory Committee,**
25 **as described in section 23 of this 2024 Act.**

26 **SECTION 26.** Section 7 of this 2024 Act is amended to read:

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

30 (a) One member who is a physician licensed under ORS chapter 677 who practices emergency
31 medicine or emergency medical services medicine;

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

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

35 (2) The committee shall provide advice and recommendations to the board and the authority
36 regarding emergency medical services, including the following objectives:

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

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

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

45 (3) The chairperson of the committee shall appoint an advisory subcommittee on the licensure

1 and discipline of emergency medical services providers. The subcommittee shall advise the authority
 2 and the board on the adoption of rules under this section.

3 (4) The committee may:

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

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

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

11 **SECTION 27.** Section 10 of this 2024 Act is amended to read:

12 **Sec. 10.** (1)(a) The Emergency Medical Services Advisory Board, with the advice of the Time-
 13 Sensitive Medical Emergencies Advisory Committee, the Emergency Medical Services Advisory
 14 Committee, the Pediatric Emergency Medical Services Advisory Committee *[and]*, the Behavioral
 15 Health Emergency Medical Services Advisory Committee **and the Long Term Care and Senior**
 16 **Care Emergency Medical Services Advisory Committee**, shall determine the nationally recog-
 17 nized classification standards to recommend to the Oregon Health Authority to adopt as rules for
 18 categorization and designation of emergency medical services centers for the provision of trauma,
 19 stroke, cardiac, pediatric *[and]*, behavioral health **and long term and senior** care and other iden-
 20 tified time-sensitive emergencies.

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

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

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

34 (c) If no relevant nationally recognized classification standard is available for a specific type
 35 of emergency medical services center, the authority shall convene an advisory committee of
 36 stakeholders, including but not limited to state and community partners, to develop a proposal for
 37 the establishment of classification standards for the designation of an emergency medical services
 38 center.

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

41 (2)(a) An emergency medical services center is not required to obtain categorization or desig-
 42 nation as described in subsection (1) of this section.

43 (b) An emergency medical services center described in this subsection is not required to adopt
 44 and use a specific data system or registry.

45 (c) An emergency medical services center may concurrently adopt and use data systems or

1 registries in addition to any data systems or registries required for a specific categorization or
2 designation.

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

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

8 **SECTION 28. (1) Section 23 of this 2024 Act and the amendments to sections 3, 5, 7 and**
9 **10 of this 2024 Act by sections 24 to 27 of this 2024 Act become operative on January 1, 2027.**

10 (2) **The Oregon Health Authority may take any action before the operative date specified**
11 **in subsection (1) of this section that is necessary to enable the authority to exercise, on or**
12 **after the operative date specified in subsection (1) of this section, all of the duties, functions**
13 **and powers conferred on the authority by section 23 of this 2024 Act and the amendments**
14 **to sections 3, 5, 7 and 10 of this 2024 Act by sections 24 to 27 of this 2024 Act.**

15 **SECTION 29. The Director of the Oregon Health Authority may appoint to the Long**
16 **Term Care and Senior Care Emergency Medical Services Advisory Committee members of**
17 **the Senior Emergency Medical Services Advisory Council established under section 1, chapter**
18 **616, Oregon Laws 2021.**

19
20 **CONFORMING AMENDMENTS**

21
22 **SECTION 30.** ORS 682.017 is amended to read:

23 682.017. The Oregon Health Authority shall adopt rules in accordance with ORS chapter 183
24 that include, but are not limited to:

25 (1) Requirements relating to the types and numbers of emergency vehicles, including supplies
26 and equipment carried.

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

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

30 (4) Procedures for summoning and dispatching aid.

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

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

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

39 **SECTION 31.** ORS 682.051 is amended to read:

40 682.051. (1) A person or governmental unit commits the offense of unlawful operation of an un-
41 licensed ambulance or the offense of unlawful operation of an unlicensed ambulance service if the
42 person or governmental unit advertises or operates in this state a motor vehicle, aircraft or
43 watercraft ambulance that:

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

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

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

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

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

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

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

15 **SECTION 32.** ORS 682.056 is amended to read:

16 682.056. (1)(a) Ambulance services shall report patient encounter data to the [*electronic emer-*
17 *gency medical services data system managed by the Oregon Health Authority*] **emergency medical**
18 **services data system established under section 12 of this 2024 Act** for each patient care event
19 in accordance with rules adopted by the **Oregon Health** Authority under ORS 682.017.

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

23 (2)(a) The patient outcome data described in subsection (3) of this section about a patient who
24 an ambulance service transported to a hospital, and that the hospital entered into the [*Oregon*
25 *Trauma Registry*] **emergency medical services data system established under section 12 of this**
26 **2024 Act**, must be available to the designated official of the ambulance service that transported the
27 patient.

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

30 (3) Patient outcome data includes:

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

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

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

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

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

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

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

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

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

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

45 (6)(a) A nontransporting prehospital care provider may report patient encounter data to the

1 electronic emergency medical services data system.

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

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

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

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

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

12 (c) Define “nontransporting prehospital care provider.”

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

14 682.059. (1) The Oregon Health Authority shall make publicly available on a website operated
15 by or on behalf of the authority an annual report of the data collected by the authority under ORS
16 682.056.

17 (2) The authority shall consult with the [*State Emergency Medical Service Committee*] **Emer-**
18 **gency Medical Services Advisory Committee** to determine the data to include in the report re-
19 quired under this section.

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

23 **SECTION 34.** ORS 682.068 is amended to read:

24 682.068. (1) The Oregon Health Authority, in consultation with the [*State Emergency Medical*
25 *Service Committee*] **Emergency Medical Services Advisory Committee**, shall adopt rules specify-
26 ing minimum requirements for ambulance services, and for staffing and medical and communications
27 equipment requirements for all types of ambulances. The rules must define the requirements for ad-
28 vanced life support and basic life support units of emergency vehicles, including equipment and
29 emergency medical services provider staffing of the passenger compartment when a patient is being
30 transported in emergency circumstances.

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

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

36 **SECTION 35.** ORS 682.075 is amended to read:

37 682.075. (1) Subject to any law or rule pursuant thereto relating to the construction or equip-
38 ment of ambulances, the Oregon Health Authority shall, with the advice of the [*State Emergency*
39 *Medical Service Committee appointed under ORS 682.039*] **Emergency Medical Services Advisory**
40 **Committee** and in accordance with ORS chapter 183, adopt and when necessary amend or repeal
41 rules relating to the construction, maintenance, capacity, sanitation, emergency medical supplies and
42 equipment of ambulances.

43 (2) In order for an owner to secure and retain a license for an ambulance under this chapter,
44 it shall meet the requirements imposed by rules of the authority. The requirements may relate to
45 construction, maintenance, capacity, sanitation and emergency medical supplies and equipment on

1 ambulances. Such requirements shall include, but are not limited to, requirements relating to space
 2 in patient compartments, access to patient compartments, storage facilities, operating condition,
 3 cots, mattresses, stretchers, cot and stretcher fasteners, bedding, oxygen and resuscitation equip-
 4 ment, splints, tape, bandages, tourniquets, patient convenience accessories, cleanliness of vehicle
 5 and laundering of bedding.

6 **SECTION 36.** ORS 682.079 is amended to read:

7 682.079. (1)(a) The Oregon Health Authority may grant exemptions or variances from one or
 8 more of the requirements of ORS 820.330 to 820.380 or this chapter or the rules adopted under ORS
 9 820.330 to 820.380 or this chapter to any class of vehicles if the authority finds that compliance with
 10 the requirement or requirements is inappropriate:

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

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

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

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

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

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

21 (3) Rules under this section shall be adopted, amended or repealed in accordance with ORS
 22 183.330.

23 **SECTION 37.** ORS 146.015 is amended to read:

24 146.015. (1) There is hereby established the State Medical Examiner Advisory Board.

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

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

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

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

32 (b) The State Health Officer;

33 (c) A sheriff;

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

36 (e) A pathologist;

37 (f) A district attorney;

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

40 (h) A chief of police;

41 (i) A member of the defense bar;

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

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

44 (5) The members described in subsection (4)(a) and (b) of this section may serve as long as they
 45 hold their respective positions. The term of office of each member described in subsection (4)(c), (f)

1 and (h) of this section is for four years, except that the position becomes vacant if the member
 2 ceases to be a sheriff, district attorney or chief of police, respectively. The terms of office of the
 3 other members of the State Medical Examiner Advisory Board are for four years.

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

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

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

9 **SECTION 38.** ORS 181A.375 is amended to read:

10 181A.375. (1) The Board on Public Safety Standards and Training shall establish the following
 11 policy committees:

- 12 (a) Corrections Policy Committee;
- 13 (b) Fire Policy Committee;
- 14 (c) Police Policy Committee;
- 15 (d) Telecommunications Policy Committee; and
- 16 (e) Private Security Policy Committee.

17 (2) The members of each policy committee shall select a chairperson and vice chairperson for
 18 the policy committee. Only members of the policy committee who are also members of the board are
 19 eligible to serve as a chairperson or vice chairperson. The vice chairperson may act as chairperson
 20 in the absence of the chairperson.

21 (3) The Corrections Policy Committee consists of:

- 22 (a) All of the board members who represent the corrections discipline;
- 23 (b) The chief administrative officer of the training division of the Department of Corrections;
- 24 (c) A security manager from the Department of Corrections recommended by the Director of the
 25 Department of Corrections; and

26 (d) The following, who may not be current board members, appointed by the chairperson of the
 27 board:

- 28 (A) One person recommended by and representing the Oregon State Sheriffs' Association;
- 29 (B) Two persons recommended by and representing the Oregon Sheriff's Jail Command Council;
- 30 (C) One person recommended by and representing a statewide association of community cor-
 31 rections directors;
- 32 (D) One nonmanagement corrections officer employed by the Department of Corrections;
- 33 (E) One corrections officer who is employed by the Department of Corrections at a women's
 34 correctional facility and who is a member of a bargaining unit;

35 (F) Two nonmanagement corrections officers; and

36 (G) One person representing the public who:

- 37 (i) Has never been employed or utilized as a corrections officer or as a parole and probation
 38 officer; and
- 39 (ii) Is not related within the second degree by affinity or consanguinity to a person who is em-
 40 ployed or utilized as a corrections officer or parole and probation officer.

41 (4) The Fire Policy Committee consists of:

- 42 (a) All of the board members who represent the fire service discipline; and
- 43 (b) The following, who may not be current board members, appointed by the chairperson of the
 44 board:

45 (A) One person recommended by and representing a statewide association of fire instructors;

- 1 (B) One person recommended by and representing a statewide association of fire marshals;
- 2 (C) One person recommended by and representing community college fire programs;
- 3 (D) One nonmanagement firefighter recommended by a statewide organization of firefighters;
- 4 (E) One person representing the forest protection agencies and recommended by the State
- 5 Forestry Department; and
- 6 (F) One person representing the public who:
 - 7 (i) Has never been employed or utilized as a fire service professional; and
 - 8 (ii) Is not related within the second degree by affinity or consanguinity to a person who is em-
 - 9 ployed or utilized as a fire service professional.
- 10 (5) The Police Policy Committee consists of:
 - 11 (a) All of the board members who represent the law enforcement discipline; and
 - 12 (b) The following, who may not be current board members, appointed by the chairperson of the
 - 13 board:
 - 14 (A) One person recommended by and representing the Oregon Association Chiefs of Police;
 - 15 (B) Two persons recommended by and representing the Oregon State Sheriffs' Association;
 - 16 (C) One command officer recommended by and representing the Oregon State Police;
 - 17 (D) Three nonmanagement law enforcement officers; and
 - 18 (E) Two persons representing the public:
 - 19 (i) Who have never been employed or utilized as a police officer, certified reserve officer, reserve
 - 20 officer or regulatory specialist;
 - 21 (ii) Who are not related within the second degree by affinity or consanguinity to a person who
 - 22 is employed or utilized as a police officer, certified reserve officer, reserve officer or regulatory
 - 23 specialist; and
 - 24 (iii) One of whom is a member of a marginalized or historically underrepresented community.
 - 25 (6) The Telecommunications Policy Committee consists of:
 - 26 (a) All of the board members who represent the telecommunications discipline; and
 - 27 (b) The following, who may not be current board members, appointed by the chairperson of the
 - 28 board:
 - 29 (A) Two persons recommended by and representing a statewide association of public safety
 - 30 communications officers;
 - 31 (B) One person recommended by and representing the Oregon Association Chiefs of Police;
 - 32 (C) One person recommended by and representing the Oregon State Police;
 - 33 (D) Two persons representing telecommunicators;
 - 34 (E) One person recommended by and representing the Oregon State Sheriffs' Association;
 - 35 (F) One person recommended by and representing the Oregon Fire Chiefs Association;
 - 36 (G) One person recommended by and representing the [*Emergency Medical Services and Trauma*
 - 37 *Systems Program*] **Emergency Medical Services Program** of the Oregon Health Authority;
 - 38 (H) One person representing emergency medical services providers and recommended by a
 - 39 statewide association dealing with fire medical issues; and
 - 40 (I) One person representing the public who:
 - 41 (i) Has never been employed or utilized as a telecommunicator or an emergency medical dis-
 - 42 patcher; and
 - 43 (ii) Is not related within the second degree by affinity or consanguinity to a person who is em-
 - 44 ployed or utilized as a telecommunicator or an emergency medical dispatcher.
 - 45 (7) The Private Security Policy Committee consists of:

- 1 (a) All of the board members who represent the private security industry; and
 2 (b) The following, who may not be current board members, appointed by the chairperson of the
 3 board:
- 4 (A) One person representing unarmed private security professionals;
 - 5 (B) One person representing armed private security professionals;
 - 6 (C) One person representing the health care industry;
 - 7 (D) One person representing the manufacturing industry;
 - 8 (E) One person representing the retail industry;
 - 9 (F) One person representing the hospitality industry;
 - 10 (G) One person representing private business or a governmental entity that utilizes private se-
 11 curity services;
 - 12 (H) One person representing persons who monitor alarm systems;
 - 13 (I) Two persons who are investigators licensed under ORS 703.430, one of whom is recommended
 14 by the Oregon State Bar and one of whom is in private practice; and
 - 15 (J) One person representing the public who:
 - 16 (i) Has never been employed or utilized as a private security provider, as defined in ORS
 17 181A.840, or an investigator, as defined in ORS 703.401; and
 - 18 (ii) Is not related within the second degree by affinity or consanguinity to a person who is em-
 19 ployed or utilized as a private security provider, as defined in ORS 181A.840, or an investigator, as
 20 defined in ORS 703.401.
 - 21 (8) In making appointments to the policy committees under this section, the chairperson of the
 22 board shall seek to reflect the diversity of the state's population. An appointment made by the
 23 chairperson of the board must be ratified by the board before the appointment is effective. The
 24 chairperson of the board may remove an appointed member for just cause. An appointment to a
 25 policy committee that is based on the member's employment is automatically revoked if the member
 26 changes employment. The chairperson of the board shall fill a vacancy in the same manner as
 27 making an initial appointment. The term of an appointed member is two years. An appointed member
 28 may be appointed to a second term.
 - 29 (9) A policy committee may meet at such times and places as determined by the policy commit-
 30 tee in consultation with the Department of Public Safety Standards and Training. A majority of a
 31 policy committee constitutes a quorum to conduct business. A policy committee may create sub-
 32 committees if needed.
 - 33 (10)(a) Each policy committee shall develop policies, requirements, standards and rules relating
 34 to its specific discipline. A policy committee shall submit its policies, requirements, standards and
 35 rules to the board for the board's consideration. When a policy committee submits a policy, re-
 36 quirement, standard or rule to the board for the board's consideration, the board shall:
 - 37 (A) Approve the policy, requirement, standard or rule;
 - 38 (B) Disapprove the policy, requirement, standard or rule; or
 - 39 (C) Defer a decision and return the matter to the policy committee for revision or reconsider-
 40 ation.
 - 41 (b) The board may defer a decision and return a matter submitted by a policy committee under
 42 paragraph (a) of this subsection only once. If a policy, requirement, standard or rule that was re-
 43 turned to a policy committee is resubmitted to the board, the board shall take all actions necessary
 44 to implement the policy, requirement, standard or rule unless the board disapproves the policy, re-
 45 quirement, standard or rule.

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

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

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

6 353.450. (1) It is the finding of the Legislative Assembly that there is need to provide programs
7 that will assist a rural community to recruit and retain physicians, physician assistants and nurse
8 practitioners. For that purpose:

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

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

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

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

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

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

26 (c) Review requests for training funds with input from the [*State Emergency Medical Service*
27 *Committee*] **Emergency Medical Services Advisory Committee** and other individuals with exper-
28 tise in emergency medical services.

29 **SECTION 40.** ORS 441.020 is amended to read:

30 441.020. (1) Licenses for health care facilities, except long term care facilities as defined in ORS
31 442.015, must be obtained from the Oregon Health Authority.

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

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

37 (4)(a) Each application submitted to the Oregon Health Authority must be accompanied by the
38 license fee. If the license is denied, the fee shall be refunded to the applicant. If the license is issued,
39 the fee shall be paid into the State Treasury to the credit of the Oregon Health Authority Fund for
40 the purpose of carrying out the functions of the Oregon Health Authority under and enforcing ORS
41 441.015 to 441.119, 441.761 to 441.795 and 441.993; or

42 (b) Each application submitted to the Department of Human Services must be accompanied by
43 the application fee or the annual renewal fee, as applicable. If the license is denied, the fee shall
44 be refunded to the applicant. If the license is issued, the fee shall be paid into the State Treasury
45 to the credit of the Department of Human Services Account for the purpose of carrying out the

1 functions of the Department of Human Services under and enforcing ORS [431A.050 to 431A.080,]
 2 441.015 to 441.119 and 441.993.

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

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

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

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

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

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

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

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

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

14 (8) For long term care facilities with:

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

16 (b) Sixteen to 49 beds, the application fee shall be \$3,000 and the annual renewal fee shall be
 17 \$1,500.

18 (c) Fifty to 99 beds, the application fee shall be \$4,000 and the annual renewal fee shall be
 19 \$2,000.

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

22 (e) More than 150 beds, the application fee shall be \$6,000 and the annual renewal fee shall be
 23 \$3,000.

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

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

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

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

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

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

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

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

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

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

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

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

44 (16) Notwithstanding subsection (4) of this section, all moneys received for approved applications
 45 pursuant to subsection (8) of this section shall be deposited in the Quality Care Fund established in

1 ORS 443.001.

2 (17) As used in this section:

3 (a) “Hospital satellite” has the meaning prescribed by the authority by rule.

4 (b) “Procedure room” means a room where surgery or invasive procedures are performed.

5 **SECTION 41.** ORS 442.507 is amended to read:

6 442.507. (1) With the moneys transferred to the Office of Rural Health by ORS 442.870, the office
7 shall establish a dedicated grant program for the purpose of providing assistance to rural commu-
8 nities to enhance emergency medical service systems.

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

11 (3) The office shall make the final decision concerning which entities receive grants, but the
12 office may seek advice from the Rural Health Coordinating Council, the [*State Emergency Medical*
13 *Service Committee*] **Emergency Medical Services Advisory Committee** and other appropriate in-
14 dividuals experienced with emergency medical services.

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

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

21 **SECTION 42.** ORS 442.870 is amended to read:

22 442.870. (1) The Emergency Medical Services Enhancement Account is established separate and
23 distinct from the General Fund. Interest earned on moneys in the account shall accrue to the ac-
24 count. All moneys deposited in the account are continuously appropriated to the Department of
25 Revenue for the purposes of this section.

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

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

31 (b) 25 percent of the moneys in the account shall be transferred to the [*Emergency Medical*
32 *Services and Trauma Systems Program established under ORS 431A.085*] **Emergency Medical Ser-**
33 **VICES Program established under section 2 of this 2024 Act.**

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

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

38 **SECTION 43.** (1) **The amendments to ORS 146.015, 181A.375, 353.450, 441.020, 442.507,**
39 **442.870, 682.017, 682.051, 682.056, 682.059, 682.068, 682.075 and 682.079 by sections 30 to 42 of this**
40 **2024 Act become operative on January 1, 2025.**

41 **(2) The Board on Public Safety Standards and Training, the Department of Human Ser-**
42 **VICES, the Department of Revenue, the Office of Rural Health, the Oregon Health Authority,**
43 **the Oregon Health and Science University and the State Medical Examiner Advisory Board**
44 **may take any action before the operative date specified in subsection (1) of this section that**
45 **is necessary to enable the authority, the boards, the departments, the offices and the uni-**

1 versity to exercise, on or after the operative date specified in subsection (1) of this section,
2 all of the duties, functions and powers conferred on the authority, the boards, the depart-
3 ments, the office and the university by the amendments to ORS 146.015, 181A.375, 353.450,
4 441.020, 442.507, 442.870, 682.017, 682.051, 682.056, 682.059, 682.068, 682.075 and 682.079 by
5 sections 30 to 42 of this 2024 Act.

6
7 **CAPTIONS**

8
9 **SECTION 44.** The unit captions used in this 2024 Act are provided only for the conven-
10 ience of the reader and do not become part of the statutory law of this state or express any
11 legislative intent in the enactment of this 2024 Act.

12
13 **EFFECTIVE DATE**

14
15 **SECTION 45.** This 2024 Act takes effect on the 91st day after the date on which the 2024
16 regular session of the Eighty-second Legislative Assembly adjourns sine die.

17
