House Bill 3572

Sponsored by Representative GRAYBER, Senator REYNOLDS

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 tells the EMS Program to make a 10-year plan and give money to some EMS providers. The Act also makes Oregon join a compact to let EMS providers from other states work in this state. The Act also tells the program to give money to some areas of the state to make EMS better. The Act lets the Governor use EMS resources for emergencies in this state. (Flesch Readability Score: 76.6).

Directs the Emergency Medical Services Program to develop a state emergency medical services 10-year strategic plan. Sunsets on January 2, 2037.

Directs the program to provide loan repayment subsidies to licensed emergency medical services providers. Directs the program to subsidize the cost of obtaining an emergency medical services provider license. Enacts the EMS Personnel Licensure Interstate Compact. Permits the Oregon Health Authority to disclose specified information to the Interstate Commission for EMS Personnel Practice. Exempts individuals authorized to work as emergency medical services providers from the requirement to obtain a license from the authority. Allows the authority to use moneys to meet the financial obligations imposed on the State of Oregon as a result of participation in the compact. Requires an entity to provide a labor peace agreement prior to engaging certain individuals authorized under compact privilege to practice as emergency medical services providers. Sunsets on January 2, 2030.

Allows the program to award funding to each regional emergency medical services advisory board for innovation proposals to improve emergency medical services within the emergency medical services regions. Accepts specified emergency medical services training programs and apprenticeships as sufficient for meeting certain emergency medical services provider education requirements for licensure. Allows the Governor to assign and make available for use any emergency medical services resources and equipment in response to an emergency for which emergency medical services are required. Establishes the Emergency Medical Services Mobilization Advisory Board to advise the Governor on the mobilization of emergency medical services in this state. Changes the "Pediatric Emergency Medical Services Advisory Committee" to the "Emergency Medical Services for Children Advisory Committee."

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

A BILL FOR AN ACT

Relating to emergency medical services; creating new provisions; amending ORS 676.177, 682.204, 682.208 and 682.216 and sections 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 31 and 32, chapter 32, Oregon Laws 2024; and prescribing an effective date.

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

EMERGENCY MEDICAL SERVICES STRATEGIC PLAN

SECTION 1. Sections 2 and 3 of this 2025 Act are added to and made a part of ORS chapter 682.

SECTION 2. (1) The Emergency Medical Services Program established in section 2, chapter 32, Oregon Laws 2024, shall develop a state emergency medical services 10-year strategic plan to support emergency medical services operations for time-sensitive medical emergencies in this state. The strategic plan must provide for full operational capacity in all emergency medical services regions designated under section 11, chapter 32, Oregon Laws

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.

2024, and include defined minimum quality standards that are consistent with any relevant federal guidance regarding time-sensitive medical emergencies.

(2) The strategic plan must:

(a) Prioritize the coordination of any existing efforts and technologies related to emergency medical services; and

(b) Strive to employ a variety of funding sources in addition to the General Fund.

(3) The strategic plan must provide specific recommendations, and suggest vehicles for implementation of the recommendations, including legislation, rulemaking and policy development, regarding the following topics:

(a) Emergency medical services workforce, including metropolitan, rural and volunteer staffing targets and recommendations for closing any gaps in staffing targets.

(b) Assurance of rural access to emergency medical services, including:

(A) The definition of an operational minimum for emergency medical services presence in each designated emergency medical services region based on population trends and average commuter traffic;

(B) An analysis of any gap between the current emergency medical services presence and the operational minimum; and

(C) Recommendations for ensuring that rural areas in this state meet or exceed the operational minimum for emergency medical services presence.

(c) The rates of reimbursement offered by federal Centers for Medicare and Medicaid Services, including an analysis of the gap between current reimbursement rates and the emergency medical services operating costs in each designated emergency medical services region and a schedule for reimbursement rate adjustment submission requests.

(d) The improved implementation of existing reimbursement programs, including the intergovernmental transfer program developed under ORS 413.235.

(e) Collaborative educational guidance, including:

(A) Standards, best practices and reimbursement guidance for treat-in-place protocols, alternative emergency medical services treatment destinations, alternative emergency medical services transport methods, emergency medical services provider career improvement opportunities, tiered emergency medical services response options and emergency calls, as defined in ORS 403.105, made to the 9-1-1 emergency reporting system, as defined in ORS 430.105, for medical emergencies;

(B) Recommendations for best practices for hospital infrastructure, technology and operations in order to support an efficient and robust relationship between hospitals and emergency medical services providers;

(C) Educational outreach plans; and

(D) An implementation support plan that addresses how the public sector can financially and operationally support the implementation of the best practices described in this paragraph.

(4) The recommendations provided in the strategic plan developed under this section are not binding. The recommendations must be modeled on existing state best practices and account for a variety of hospital sizes and capacities.

(5) The program shall publish the strategic plan developed under this section on a publicly available website operated by or on behalf of the Oregon Health Authority.

(6) Not later than December 31, 2026, the program shall, in the manner provided in ORS

192.245 for reporting, submit the strategic plan and a summary of the program's recommendations for carrying out the plan to the interim committees of the Legislative Assembly related to health care.

(7) The Emergency Medical Services Advisory Board established in section 4, chapter 32, Oregon Laws 2024, shall revise the strategic plan as necessary when national data on community paramedicine are available in standard emergency medical services data technology. The program shall, as soon as practicable, publish the revised strategic plan in the manner described in subsection (5) of this section and submit the revised strategic plan to the interim committees of the Legislative Assembly related to health care.

(8) Until the time at which the strategic plan development is complete, the program shall provide staffing sufficient to support:

(a) The establishment and maintenance of the emergency medical services data system described in section 12, chapter 32, Oregon Laws 2024; and

(b) The operation of the Time-Sensitive Medical Emergencies Advisory Committee established in section 6, chapter 32, Oregon Laws 2024, the Emergency Medical Services Advisory Committee established in section 7, chapter 32, Oregon Laws 2024, the Emergency Medical Services for Children Advisory Committee established in section 8, chapter 32, Oregon Laws 2024, and the Behavioral Health Emergency Medical Services Advisory Committee established in section 9, chapter 32, Oregon Laws 2024.

SECTION 3. (1) In order to inform the strategic plan described in section 2 of this 2025 Act, the Emergency Medical Services Program shall:

(a) Study the rate of utilization of licensed emergency medical services providers, including:

(A) The total number of licensed emergency medical services providers who are actively employed to perform work that requires, or that is related to work that requires, a valid license to provide emergency medical services;

(B) The number of licensed emergency medical services providers described in this paragraph who are employed in the private sector and who are employed in the public sector;

(C) The number of licensed emergency medical services providers described in this paragraph employed in each care setting; and

(D) The extent to which the number of licensed emergency medical providers described in this paragraph meets the needs of the state.

(b) Create a list of all agencies in this state that use licensed emergency medical services providers to respond to emergency calls, as defined in ORS 403.105, made to the 9-1-1 emergency reporting system, as defined in ORS 403.105, including the location of the agencies and the emergency medical services region designated under section 11, chapter 32, Oregon Laws 2024, in which the agencies operate.

(c) Compile statistics on the total number of emergency calls made to the 9-1-1 emergency reporting system for medical emergencies, the number of emergency calls made to the 9-1-1 emergency reporting system for medical emergencies in each county, and the average response time to emergencies by emergency medical services providers. The program may request and receive data from public safety answering points, as defined in ORS 403.105, for the purpose of carrying out this paragraph.

(d) Study the holistic impact of health care delivery system functions on the provision of emergency medical services during the immediately preceding five years, including study-

ing response times to emergency medical services needs, rules relating to the transfer of patients between health care facilities, any reduction in emergency medical services provided by hospitals, county ambulance service area policies and uncompensated requests for emergency medical services.

(2) In carrying out its duties under this section, the program may use any existing relevant data and other information that the program or the Oregon Health Authority has compiled or otherwise possesses.

(3) Not later than September 15, 2026, the program shall, in the manner provided in ORS 192.245, submit a report that includes the information described in subsection (1) of this section to the interim committees of the Legislative Assembly related to health care.

SECTION 4. Sections 2 and 3 of this 2025 Act are repealed on January 2, 2037.

EMERGENCY MEDICAL SERVICES PROGRAM

SECTION 5. Sections 6 to 8 of this 2025 Act are added to and made a part of ORS chapter 682.

SECTION 6. The Emergency Medical Services Program may create the staff position of grants manager to secure and coordinate grant funding for the program and the program's partners. The grants manager shall collaborate with local workforce development boards.

SECTION 7. (1) The Emergency Medical Services Program may award, from moneys in the Emergency Medical Services Program Fund established under section 8 of this 2025 Act, funds in an amount up to $1 million to each regional emergency medical services advisory board established under section 11, chapter 32, Oregon Laws 2024, that submits an innovation proposal under subsection (2) of this section. A regional emergency medical services advisory board that receives funds under this section shall use the funds for the purpose of developing and implementing emergency medical services workforce pilot programs, improving emergency medical services infrastructure or making investments in emergency medical services equipment within the advisory board's designated emergency medical services region.

(2) The Emergency Medical Services Advisory Board established under section 4, chapter 32, Oregon Laws 2024, shall establish a process to review and approve innovation proposals. In reviewing and approving innovation proposals, the board shall consider whether an innovation proposal includes quality assurance metrics and performance measurements. The board may not approve an innovation proposal for a workforce pilot program unless the innovation proposal includes consultation with local workforce development boards in the designated emergency medical services region in order to maximize existing funding options and work in conjunction with any existing efforts.

(3) The Emergency Medical Services Program shall, in partnership with the regional emergency medical services advisory boards, implement the approved innovation proposals. The program may contract as necessary with third parties to implement an innovation proposal.

SECTION 8. The Emergency Medical Services Program Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Emergency Medical Services Program Fund shall be credited to the fund. The moneys in the fund are continuously appropriated to the Oregon Health Authority for the purposes of:

(1) Carrying out ORS 682.208 and 682.216 and sections 7 and 14 of this 2025 Act; and

(2) Meeting the financial obligations imposed on the State of Oregon as a result of the state's participation in the EMS Personnel Licensure Interstate Compact described in section 42 of this 2025 Act.

SECTION 9. Section 8 of this 2025 Act is amended to read:

Sec. 8. The Emergency Medical Services Program Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Emergency Medical Services Program Fund shall be credited to the fund. The moneys in the fund are continuously appropriated to the Oregon Health Authority for [*the purposes of:*]

[*(1)*] carrying out ORS 682.208 and 682.216 and [*sections 7 and 14*] **section 7** of this 2025 Act.[*; and*]

[*(2) Meeting the financial obligations imposed on the State of Oregon as a result of the state's participation in the EMS Personnel Licensure Interstate Compact described in section 42 of this 2025 Act.*]

SECTION 10. ORS 682.208 is amended to read:

682.208. (1) [*A person desiring*] **In order** to be licensed as an emergency medical services provider**, an applicant** shall submit an application for licensure to the Oregon Health Authority. The application must be upon forms prescribed by the authority and must contain:

(a) The name and address of the applicant.

[*(b) The name and location of the training course successfully completed by the applicant and the date of completion.*]

(b)(A) Proof of completion of a training course, approved by the authority pursuant to subsection (2) of this section, that includes the training course name and location and date on which the applicant completed the training course; or

(B) If the authority requires, by rule, an applicant to have earned at least an associate degree in order to be eligible for the level of licensure for which the applicant submits an application, proof that the applicant successfully completed an emergency medical services:

(i) On-the-job training program, as defined in ORS 660.143, or registered apprenticeship program approved under ORS 660.002 to 660.210; or

(ii) Training program offered by the United States Department of Defense or the Oregon National Guard.

(c) Evidence that the authority determines is satisfactory to prove that the applicant's physical and mental health is such that it is safe for the applicant to act as an emergency medical services provider.

(d) Other information as the authority may reasonably require to determine compliance with applicable provisions of this chapter and the rules adopted under this chapter.

(2) The authority shall adopt a schedule of minimum educational requirements in emergency and nonemergency care for emergency medical services providers. The authority may approve training courses that meet the minimum educational requirements and that are designed to:

(a) Protect the welfare of out-of-hospital patients;

(b) Promote the health and well-being of out-of-hospital patients; and

(c) Reduce the pain and suffering, and save the lives, of out-of-hospital patients.

(3) If an extended period of time, as determined by the authority, has elapsed since the date on which an applicant completed a training course approved under subsection (2) of this section, the authority may require the applicant to provide proof of completion of continuing

education as further specified by the authority.

[*(2) The application must be accompanied by proof as prescribed by rule of the authority of the applicant's successful completion of a training course approved by the authority and, if an extended period of time has elapsed since the completion of the course, of a satisfactory amount of continuing education.*]

[*(3) The authority shall adopt a schedule of minimum educational requirements in emergency and nonemergency care for emergency medical services providers. A course approved by the authority must be designed to protect the welfare of out-of-hospital patients, to promote the health, well-being and saving of the lives of such patients and to reduce their pain and suffering.*]

SECTION 11. ORS 682.216 is amended to read:

682.216. (1) When application has been made as required under ORS 682.208, the Oregon Health Authority shall license the applicant as an emergency medical services provider if [*it*] **the authority** finds:

(a) The applicant has successfully completed a training course approved by the authority.

(b) The applicant meets the physical and mental qualifications required under ORS 682.208.

(c) No matter has been brought to the attention of the authority which would disqualify the applicant.

(d) A nonrefundable fee has been paid to the authority pursuant to ORS 682.212.

(e) The applicant for an emergency medical services provider license:

(A) Is 18 years of age or older if the applicant is applying for a license at a level higher than emergency medical responder; or

(B) Is 16 years of age or older if the applicant is applying for a license at the emergency medical responder level.

(f) The applicant has successfully completed examination as prescribed by the authority.

(g) The applicant meets other requirements prescribed by rule of the authority.

(2) The authority may provide for the issuance of a provisional license for emergency medical services providers.

(3) The authority may issue an emergency medical services provider license by indorsement without proof of completion of an approved training course **described in ORS 682.208** to an emergency medical services provider who is licensed to practice emergency care in another state **or jurisdiction** of the United States or [*a foreign*] **another** country if[*, in the opinion of the authority,*] **the authority determines** the applicant meets the requirements for licensure in this state and can demonstrate to the satisfaction of the authority competency to practice emergency care. The authority is the sole judge of credentials of any emergency medical services provider applying for licensure without proof of completion of an approved training course.

(4) A person licensed under this section shall submit, at the time of application for renewal of the license to the authority, evidence of the applicant's satisfactory completion of an authority approved program of continuing education and other requirements prescribed by rule by the authority.

(5) The authority shall prescribe criteria and approve programs of continuing education in emergency and nonemergency care to meet the requirements of this section.

(6) The authority shall include a fee pursuant to ORS 682.212 for late renewal and for issuance of any duplicate license. Each license issued under this section, unless sooner suspended or revoked, expires and is renewable after a period of two years. Each license must be renewed on or before June 30 of every second year or on or before such date as may be specified by authority rule. The authority by rule shall establish a schedule of license renewals under this subsection and shall

prorate the fees to reflect any shorter license period.

(7) Nothing in this chapter authorizes an emergency medical services provider to operate an ambulance without a driver license as required under the Oregon Vehicle Code.

SECTION 12. The amendments to ORS 682.208 and 682.216 by sections 10 and 11 of this 2025 Act apply to applications for licensure received by the Oregon Health Authority on or after the operative date specified in section 16 (1) of this 2025 Act.

SECTION 13. Section 14 of this 2025 Act is added to and made a part of ORS chapter 682.

SECTION 14. (1)(a) The Emergency Medical Services Program shall provide loan repayment subsidies to licensed emergency medical services providers. In awarding the subsidies under this subsection, the program shall consider the requirements for health care provider eligibility described in ORS 676.454.

(b) The program may provide up to $500,000 in total per biennium in loan repayment subsidies described in this subsection.

(2)(a) The program shall reimburse an individual who obtains an initial emergency medical services provider license under this chapter for up to 100 percent of the cost of obtaining the emergency medical services provider license.

(b) The program may provide up to $500,000 in total per biennium in reimbursement as described in this subsection.

SECTION 15. Section 14 of this 2025 Act is repealed on January 2, 2030.

SECTION 16. (1) Sections 6 to 8 and 14 of this 2025 Act and the amendments to ORS 682.208 and 682.216 by sections 10 and 11 of this 2025 Act become operative on January 1, 2026.

(2) The amendments to section 8 of this 2025 Act by section 9 of this 2025 Act become operative on January 2, 2030.

(3) The Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority by sections 6 to 8 and 14 of this 2025 Act and the amendments to ORS 682.208 and 682.216 by sections 10 and 11 of this 2025 Act.

EMERGENCY MEDICAL SERVICES MOBILIZATION

SECTION 17. Sections 18 to 24 of this 2025 Act are added to and made a part of ORS chapter 682.

SECTION 18. (1) The Governor may assign and make available for use and duty in any county, city or district in this state any emergency medical services resources and equipment of any emergency medical services agency in this state in response to an emergency for which emergency medical services are required.

(2) If the Governor is unavailable to timely exercise the authority under sections 18 to 24 of this 2025 Act, the State Fire Marshal, in consultation with the Emergency Medical Services Program, may exercise the authority. Any order, rules or regulations issued by the State Fire Marshal pursuant to this subsection have the same force and effect as if issued by the Governor.

(3)(a) An order under this section may be issued in writing or, if in the discretion of the Governor the delay in issuing a written order would be dangerous to the welfare of the people of this state, may be issued orally.

(b) If the order is issued in writing, a copy of the order must be filed with the office of the Secretary of State and a second copy must be provided to the affected county, city or district.

(c) If the order is issued orally, a written copy of the order must be made as soon as practicable and filed in the manner described in paragraph (b) of this subsection.

SECTION 19. (1) Pursuant to an order issued under section 18 of this 2025 Act, a regional emergency medical services advisory board established under section 11, chapter 32, Oregon Laws 2024, shall assign and make available for use and duty in any county, city or district the emergency medical services resources and equipment of any emergency medical services agency that normally operates within the designated emergency medical services region advised by the board.

(2) A privately operated ambulance service may contribute any available emergency medical services resources at the disposal of the ambulance service in response to an emergency described in section 18 of this 2025 Act.

SECTION 20. The state shall be liable for any loss of or damage to equipment used under sections 18 to 24 of this 2025 Act and shall pay any expense incurred in the operation or maintenance of the equipment. In order to claim reimbursement under this section, a person shall file a notice of claim of reimbursement with the Emergency Medical Services Program not later than 60 days after the date of the equipment loss, damage or expense, unless otherwise provided by the Oregon Health Authority by rule. A loss, damage or expense described in this section is payable from the Emergency Medical Services Mobilization Fund established under section 24 of this 2025 Act.

SECTION 21. (1) When the personnel of a county, city, district or ambulance service provide aid under sections 18 to 24 of this 2025 Act, the state shall reimburse the county, city, district or ambulance service for the following, as related to the provision of aid:

(a) The compensation of the personnel during the time the provision of aid under sections 18 to 24 of this 2025 Act prevents the personnel from performing their regular duties; and

(b) The actual cost of the personnel's travel and maintenance.

(2) As used in this section, "personnel" means an emergency medical services provider licensed under this chapter, regardless of whether the emergency medical services provider is paid, volunteer or on call.

SECTION 22. The state, or a county, city, district or ambulance service, or an emergency medical services provider acting as the agent of any of the foregoing, is not liable for any injury to person or property resulting from the performance of a duty imposed under sections 18 to 24 of this 2025 Act. In carrying out sections 18 to 24 of this 2025 Act, or while acting within the scope of a duty imposed under sections 18 to 24 of this 2025 Act, a person is not subject to civil liability unless the injury is the result of the person's willful misconduct or gross negligence.

SECTION 23. (1) There is established within the Emergency Medical Services Program the Emergency Medical Services Mobilization Advisory Board. The board consists of members including but not limited to the following:

(a) The State Fire Marshal;

(b) A representative of the Emergency Medical Services Advisory Board;

(c) A representative from each regional emergency medical services advisory board established under section 11, chapter 32, Oregon Laws 2024;

(d) A representative from the Oregon Health Authority Public Health Division;

(e) A representative from the Oregon Department of Emergency Management;

(f) A representative from an association that represents fire chiefs in this state;

(g) A representative from an association that represents ambulance services in this state; and

(h) A representative from an association that represents counties in this state.

(2) The Emergency Medical Services Mobilization Advisory Board shall prepare a plan to carry out sections 18 to 24 of this 2025 Act and provide advice and counsel to the Governor for the most practical utilization under sections 18 to 24 of this 2025 Act of the emergency medical services resources in this state. In developing the plan described in this subsection, the board shall ensure that the plan reflects the capabilities and resources of state agencies, counties, cities, districts and public and private ambulance services.

(3) The Emergency Medical Services Mobilization Advisory Board shall provide advice to the Oregon Health Authority regarding the adoption of rules to carry out sections 18 to 24 of this 2025 Act. The rules must:

(a) Provide that the State Fire Marshal, in consultation with the program, is responsible for the activation of the plan described in subsection (2) of this section, resource management and incident command.

(b) Specify how the State Fire Marshal incident command interacts with ambulance services in this state.

SECTION 24. The Emergency Medical Services Mobilization Fund is established in the State Treasury, separate and distinct from the General Fund. The Emergency Medical Services Mobilization Fund consists of moneys appropriated by the Legislative Assembly for deposit in the fund, and any gifts, grants or donations to the fund. Moneys in the fund are continuously appropriated to the Oregon Health Authority for carrying out the provisions of sections 18 to 24 of this 2025 Act.

SECTION 25. (1) Sections 18 to 24 of this 2025 Act become operative on January 1, 2027.

(2) The Oregon Health Authority and the State Fire Marshal may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority and the State Fire Marshal to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority and the State Fire Marshal by sections 18 to 24 of this 2025 Act.

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SECTION 26. Section 2, chapter 32, Oregon Laws 2024, is amended to read:

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

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

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

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

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

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

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

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

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

(a) Is responsible for conducting emergency medical services system oversight and implementing the recommendations of the advisory board.

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

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

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

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

(D) Implementation of quality improvement programs; and

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

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

(3) The program shall have a State EMS Medical Director who is the chairperson of the Emergency Medical Services Advisory Board established under [*section 4 of this 2024 Act*] **section 4, chapter 32, Oregon Laws 2024,** and who is responsible for:

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

(b) Implementing emergency medical services quality improvement measures;

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

(d) Serving as a liaison with emergency medical services agencies, emergency medical services centers, hospitals, state and national emergency medical services professional organizations and state and federal partners.

(4) The authority shall:

(a) Adopt rules to establish statewide emergency medical services objectives and standards; and

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

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

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

SECTION 27. Section 3, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 3. (1) The Emergency Medical Services Program, with the advice of the Emergency Medical Services Advisory Board, the Time-Sensitive Medical Emergencies Advisory Committee, the Emergency Medical Services Advisory Committee, the [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee established under section 8, chapter 32, Oregon Laws 2024,** and the Behavioral Health Emergency Medical Services Advisory Committee, shall:

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

processes;

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

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

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

(e) Provide stroke, cardiac, trauma, pediatric and behavioral health care data, and recommendations for improvement to care, to coordinated care organizations.

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

SECTION 28. Section 4, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 4. (1) The Emergency Medical Services Advisory Board is established within the Oregon Health Authority. The authority shall provide staffing for the board. The board consists of 19 members appointed by the Director of the Oregon Health Authority. Of the members of the board:

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

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

(c) One must be [*an emergency medical services provider licensed under ORS 682.216 who represents*] **a representative of** a private emergency medical services agency licensed under ORS 682.047;

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

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

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

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

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

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

(j) One must be a hospital administrator in a hospital that operates an emergency department;

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

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

(m) One must be an emergency medicine physician;

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

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

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

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

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

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

(2)(a) The physician members of the board must be physicians licensed under ORS chapter 677 who are in good standing.

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

(c) The members of the board [*who represent emergency medical services agencies*] **described in subsection (1)(d) and (g) of this section** must hold valid licenses in good standing.

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

(3) Board membership must reflect the geographical, cultural, linguistic and economic diversity of this state and must include at least one representative from each emergency medical services region designated under [*section 11 of this 2024 Act*] **section 11, chapter 32, Oregon Laws 2024**.

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

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

(6) The board may adopt rules as necessary to carry out its duties under [*sections 2 to 16 of this 2024 Act*] **sections 2 to 16, chapter 32, Oregon Laws 2024**.

SECTION 29. Section 5, chapter 32, Oregon Laws 2024, is amended to read:

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

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

(b) Evidence-based practices and standards for emergency medical services care for defined patient types;

(c) Emergency medical services workforce needs;

(d) Coordination of care between health care specialties;

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

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

(g) Approval of the regional emergency medical services plans described in [*section 11 of this 2024 Act*] **section 11, chapter 32, Oregon Laws 2024**.

(2) The **Emergency Medical Services Advisory** Board may convene temporary subcommittees for matters related to emergency medical services in order to inform and make recommendations to the board.

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

(a) Time-Sensitive Medical Emergencies Advisory Committee, as described in [*section 6 of this 2024 Act*] **section 6, chapter 32, Oregon Laws 2024**;

(b) Emergency Medical Services Advisory Committee, as described in [*section 7 of this 2024 Act*] **section 7, chapter 32, Oregon Laws 2024**;

(c) [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee**, as described in [*section 8 of this 2024 Act*] **section 8, chapter 32, Oregon Laws 2024**; and

(d) Behavioral Health Emergency Medical Services Advisory Committee, as described in [*section 9 of this 2024 Act*] **section 9, chapter 32, Oregon Laws 2024**.

SECTION 30. Section 6, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 6. (1) The Time-Sensitive Medical Emergencies 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 who practices general surgery and specializes in the treatment of trauma patients;

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

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

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

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

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

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

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

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

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

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

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

(B) The designation, using nationally recognized classifications where possible, of emergency medical services centers for the provision of care for time-sensitive 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) The committee shall:

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

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

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

emergencies;

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

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

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

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

SECTION 31. Section 7, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 7. (1) The 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 equity.

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

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

(b) The designation, using nationally recognized classifications where possible, of emergency medical services centers for the provision of care for 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.

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

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

(4) The committee may:

(a) Assist the Time-Sensitive Medical Emergencies Advisory Committee, the [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee established under section 8, chapter 32, Oregon Laws 2024,** and the Behavioral Health Emergency Medical Services Advisory Committee in coordination and planning efforts; and

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

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

SECTION 32. Section 8, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 8. (1) The [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children 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) Two members who are physicians specializing in the treatment of pediatric emergency patients;

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

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

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

(e) One member who is a representative of the Emergency Medical Services Program**, who shall serve as an ex officio member**;

(f) One member who has experience as the project director of a statewide committee related to emergency medical services for children**, who shall serve as an ex officio member**;

(g) One member who has experience as the program manager of a statewide committee related to emergency medical services for children**, who shall serve as an ex officio member**;

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

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

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

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

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

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

(3) With the advice of the [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee**, the authority shall:

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

(b) Provide technical assistance to the Emergency Medical Services Advisory Committee on the integration of pediatric emergency medical services into the Emergency Medical Services Program.

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

(d) Establish guidelines for:

(A) The voluntary categorization of emergency medical services agencies and hospital **emergency** departments that meet the [*requirements of the*] United States Health Resources and Services Administration **Emergency Medical Services for Children State Partnership** program **requirements** for pediatric readiness, as adopted by the authority by rule.

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

(C) Necessary pediatric patient care equipment for prehospital and [*pediatric critical care*] **hospital emergency medical care**.

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

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

(F) Continuing education programs for emergency medical services personnel, including training in the emergency care of pediatric patients across different demographics and physical demon-

strations of pediatric-specific patient care equipment.

(G) [*A public education program promoting*] **The promotion of** pediatric emergency medical services, including information on emergency and crisis telephone numbers.

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

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

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

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

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

(c) The member of the committee who is an emergency medical services provider must hold a valid license in good standing.

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

SECTION 33. Section 10, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 10. (1)(a) The Emergency Medical Services Advisory Board, upon the advice of the Time-Sensitive Medical Emergencies Advisory Committee, the Emergency Medical Services Advisory Committee, the [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee established under section 8, chapter 32, Oregon Laws 2024,** and the Behavioral Health Emergency Medical Services Advisory Committee, shall determine the nationally recognized classification standards to recommend to the Oregon Health Authority to adopt as rules for categorization and designation of emergency medical services centers for the provision of trauma, stroke, cardiac, pediatric and behavioral health care and other identified time-sensitive emergencies.

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

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

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

(c) If no relevant nationally recognized classification standard is available for a specific type of emergency medical services center, the authority shall consider the recommendations of the board

for one or more new classifications of a type of emergency medical services center.

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

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

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

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

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

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

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

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

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

SECTION 34. Section 11, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 11. (1) The Oregon Health Authority shall, with the advice of the Emergency Medical Services Advisory Board, designate emergency medical services regions that are consistent with local resources, geography, current patient referral patterns and existing regionalized health care structures and networks. The authority and the Emergency Medical Services Advisory Board shall establish a regional emergency medical services advisory board for each designated emergency medical services region. The authority and the Emergency Medical Services Advisory Board may determine the membership of each regional emergency medical services advisory board, and shall ensure that the membership reflects the geographic, cultural, linguistic and economic diversity of the emergency medical services region.

(2) Each emergency medical services region must include at least one hospital categorized according to the emergency medical services region's emergency medical services capabilities as determined by standards adopted by the authority by rule.

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

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

(b) Central medical direction for all field care and transportation consistent with geographic and current communications capability; and

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

(4) Each regional emergency medical services system plan:

(a) Must include the following:

(A) A recommendation of hospitals in the emergency medical services region to be designated by the authority as emergency medical services centers under [*section 10 of this 2024 Act*] **section 10, chapter 32, Oregon Laws 2024**;

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

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

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

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

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

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

(5) The authority may, with the advice of the Emergency Medical Services Advisory Board, implement the regional emergency medical services plans and may coordinate with a regional emergency medical services advisory board to make changes desired by the authority to the regional emergency medical services advisory [*board*] **plan**.

SECTION 35. Section 12, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 12. (1) The Emergency Medical Services Program, upon the recommendation of the Emergency Medical Services Advisory Board, shall establish and maintain an emergency medical services data system. In formulating recommendations, the board shall consider the advice of the Time-Sensitive Medical Emergencies Advisory Committee, the Emergency Medical Services Advisory Committee, the [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee established under section 8, chapter 32, Oregon Laws 2024,** and the Behavioral Health Emergency Medical Services Advisory Committee. The Oregon Health Authority shall adopt rules for the data system described in this subsection to establish:

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

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

(c) The form and frequency of reporting information:

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

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

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

(2) In determining the information described in subsection (1)(a) of this section, the authority shall require the reporting of information recommended by the board following consultation with the committees.

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

(a) Use nationally accredited data registry systems approved by the authority where available **or, if nationally accredited data registry systems are not available, use existing established data systems authorized and managed by the authority**;

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

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

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

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

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

(5) The authority may not require:

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

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

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

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

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

(b) Emergency medical services providers for the adoption of specific registries and services from the data system established under this section for the purpose of sharing emergency medical services data with the authority.

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

(a) Age;

(b) Sex;

(c) Gender;

(d) Race and ethnicity;

(e) Status as a disabled person;

(f) Status as a veteran; and

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

(9) As used in this section, "individually identifiable information" means:

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

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

SECTION 36. Section 31, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 31. 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 (2023 Edition).

(3) [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee established under section 8, chapter 32, Oregon Laws 2024,** members of the Emergency Medical Services for Children Advisory Committee established under ORS 431A.105.

SECTION 37. Section 32, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 32. (1) The Emergency Medical Services Advisory Board, the Time-Sensitive Medical Emergencies Advisory Committee, the [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee established under section 8, chapter 32, Oregon Laws 2024,** and the Behavioral Health Emergency Medical Services Advisory Committee may hold their first meetings no earlier than January 1, 2025.

(2)(a) The emergency medical services regions established under [*section 11 of this 2024 Act*] **section 11, chapter 32, Oregon Laws 2024,** 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.

SECTION 38. Section 3, chapter 32, Oregon Laws 2024, as amended by section 37, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 3. (1) The Emergency Medical Services Program, with the advice of the Emergency Medical Services Advisory Board, the Time-Sensitive Medical Emergencies Advisory Committee, the Emergency Medical Services Advisory Committee, the [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee established under section 8, chapter 32, Oregon Laws 2024**, the Behavioral Health Emergency Medical Services Advisory Committee and the Long Term Care and Senior Care Emergency Medical Services Advisory Committee, shall:

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

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

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

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

(e) Provide stroke, cardiac, trauma, pediatric, behavioral health and long term and senior care data, and recommendations for improvement to care, to coordinated care organizations.

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

SECTION 39. Section 5, chapter 32, Oregon Laws 2024, as amended by section 38, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 5. (1) The Emergency Medical Services Advisory Board shall provide advice and recom-

mendations to the Emergency Medical Services Program on the following:

(a) A definition of "patient" for purposes of time-sensitive medical emergencies, pediatric medical emergencies, behavioral health medical emergencies and long term and senior care medical emergencies;

(b) Evidence-based practices and standards for emergency medical services care for defined patient types;

(c) Emergency medical services workforce needs;

(d) Coordination of care between health care specialties;

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

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

(g) Approval of the regional emergency medical services plans described in [*section 11 of this 2024 Act*] **section 11, chapter 32, Oregon Laws 2024**.

(2) The **Emergency Medical Services Advisory** Board may convene temporary subcommittees for matters related to emergency medical services in order to inform and make recommendations to the board.

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

(a) Time-Sensitive Medical Emergencies Advisory Committee, as described in [*section 6 of this 2024 Act*] **section 6, chapter 32, Oregon Laws 2024**;

(b) Emergency Medical Services Advisory Committee, as described in [*section 7 of this 2024 Act*] **section 7, chapter 32, Oregon Laws 2024**;

(c) [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee**, as described in [*section 8 of this 2024 Act*] **section 8, chapter 32, Oregon Laws 2024**;

(d) Behavioral Health Emergency Medical Services Advisory Committee, as described in [*section 9 of this 2024 Act*] **section 9, chapter 32, Oregon Laws 2024**; and

(e) Long Term Care and Senior Care Emergency Medical Services Advisory Committee, as described in [*section 36 of this 2024 Act*] **section 36, chapter 32, Oregon Laws 2024**.

SECTION 40. Section 7, chapter 32, Oregon Laws 2024, as amended by section 39, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 7. (1) The 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 equity.

(2) The committee shall provide advice and recommendations to the board regarding emergency medical services, for the care of time-sensitive medical emergencies, pediatric medical emergencies, behavioral health medical emergencies and long term and senior care medical emergencies, including the following objectives:

(a) The regionalization and improvement of emergency medical services, including the coordi-

nation and planning of emergency medical services efforts.

(b) The designation, using nationally recognized classifications where possible, of emergency medical services centers for the provision of care for 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.

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

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

(4) The committee may:

(a) Assist the Time-Sensitive Medical Emergencies Advisory Committee, the [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee established under section 8, chapter 32, Oregon Laws 2024**, the Behavioral Health Emergency Medical Services Advisory Committee and the Long Term Care and Senior Care Emergency Medical Services Advisory Committee in coordination and planning efforts; and

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

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

SECTION 41. Section 10, chapter 32, Oregon Laws 2024, as amended by section 40, chapter 32, Oregon Laws 2024, is amended to read:

Sec. 10. (1)(a) The Emergency Medical Services Advisory Board, upon the advice of the Time-Sensitive Medical Emergencies Advisory Committee, the Emergency Medical Services Advisory Committee, the [*Pediatric Emergency Medical Services Advisory Committee*] **Emergency Medical Services for Children Advisory Committee established under section 8, chapter 32, Oregon Laws 2024**, the Behavioral Health Emergency Medical Services Advisory Committee and the Long Term Care and Senior Care Emergency Medical Services Advisory Committee, shall determine the nationally recognized classification standards to recommend to the Oregon Health Authority to adopt as rules for categorization and designation of emergency medical services centers for the provision of trauma, stroke, cardiac, pediatric, behavioral health and long term and senior care and other identified time-sensitive emergencies.

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

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

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

(c) If no relevant nationally recognized classification standard is available for a specific type

of emergency medical services center, the authority shall consider the recommendations of the board for one or more new classifications of a type of emergency medical services center.

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

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

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

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

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

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

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

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

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

EMS PERSONNEL LICENSURE INTERSTATE COMPACT

SECTION 42. The provisions of the EMS Personnel Licensure Interstate Compact are as follows:

EMS PERSONNEL LICENSURE INTERSTATE COMPACT

SECTION 1. PURPOSE

In order to protect the public through verification of competency and ensure accountability for patient care related activities, all states license emergency medical services (EMS) personnel, such as emergency medical technicians (EMTs), advanced emergency medical technicians (AEMTs) and paramedics. This Compact is intended to facilitate the day-to-day movement of EMS personnel across state boundaries in the performance of their EMS duties as assigned by an appropriate authority and authorize state EMS offices to afford immediate legal recognition to EMS personnel licensed in a member state. This Compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of EMS personnel and that such state regulation shared among the member states will best protect public health and safety. This Compact is designed to achieve

the following purposes and objectives:

1. Increase public access to EMS personnel;

2. Enhance the states' ability to protect the public's health and safety, especially patient safety;

3. Encourage the cooperation of member states in the areas of EMS personnel licensure and regulation;

4. Support the licensing of military members who are separating from an active duty tour, and the licensing of their spouses;

5. Facilitate the exchange of information between member states regarding EMS personnel licensure, adverse action and significant investigatory information;

6. Promote compliance with the laws governing EMS personnel practice in each member state; and

7. Invest all member states with the authority to hold EMS personnel accountable through the mutual recognition of member state licenses.

SECTION 2. DEFINITIONS

As used in this compact:

A. "Advanced emergency medical technician (AEMT)" means an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

B. "Adverse action" means any administrative, civil, equitable or criminal action permitted by a state's laws, which may be imposed against licensed EMS personnel by a state EMS authority or state court, including, but not limited to, actions against an individual's license such as revocation, suspension, probation, consent agreement, monitoring or other limitation or encumbrance on the individual's practice, letters of reprimand or admonition, fines, criminal convictions and state court judgments enforcing adverse actions by the state EMS authority.

C. "Alternative program" means a voluntary, nondisciplinary substance abuse recovery program approved by a state EMS authority.

D. "Certification" means the successful verification of entry-level cognitive and psychomotor competency using a reliable, validated and legally defensible examination.

E. "Commission" means the national administrative body of which all states that have enacted this Compact are members.

F. "Emergency medical technician (EMT)" means an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

G. "Home state" means a member state where an individual is licensed to practice emergency medical services.

H. "License" means the authorization by a state for an individual to practice as an EMT, AEMT or paramedic or at a level in between EMT and paramedic.

I. "Medical director" means a physician licensed in a member state who is accountable for the care delivered by EMS personnel.

J. "Member state" means a state that has enacted this Compact.

K. "Privilege to practice" means an individual's authority to deliver emergency medical services in remote states as authorized under this Compact.

L. "Paramedic" means an individual licensed with cognitive knowledge and a scope of

practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

M. "Remote state" means a member state in which an individual is not licensed.

N. "Restricted" means the outcome of an adverse action that limits a license or the privilege to practice.

O. "Rule" means a written statement by the Commission promulgated pursuant to Section 12 of this Compact that is of general applicability, that implements, interprets or prescribes a policy or provision of this Compact or is an organizational, procedural or practice requirement of the Commission and that has the force and effect of statutory law in a member state and includes the amendment, repeal or suspension of an existing rule.

P. "Scope of practice" means defined parameters of various duties or services that may be provided by an individual with specific credentials. Whether regulated by rule, statute or court decision, it tends to represent the limits of services an individual may perform.

Q. "Significant investigatory information" means:

1. Investigative information that a state EMS authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proved true, would result in the imposition of an adverse action on a license or privilege to practice; or

2. Investigative information that indicates that the individual represents an immediate threat to public health and safety regardless of whether the individual has been notified and had an opportunity to respond.

R. "State" means any state, commonwealth, district or territory of the United States.

S. "State EMS authority" means the board, office or other agency with the legislative mandate to license EMS personnel.

SECTION 3. HOME STATE LICENSURE

A. Any member state in which an individual holds a current license shall be deemed a home state for purposes of this Compact.

B. Any member state may require an individual to obtain and retain a license to be authorized to practice in the member state under circumstances not authorized by the privilege to practice under the terms of this Compact.

C. A home state's license authorizes an individual to practice in a remote state under the privilege to practice only if the home state:

1. Currently requires the use of the National Registry of Emergency Medical Technicians (NREMT) examination as a condition of issuing initial licenses at the EMT and paramedic levels;

2. Has a mechanism in place for receiving and investigating complaints about individuals;

3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding an individual;

4. No later than five years after activation of this Compact, requires a criminal background check of all applicants for initial licensure, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation with the exception of federal employees who have a suitability determination in accordance with 5 C.F.R. 731.202 and submit documentation of such as promulgated in the rules of the Commission; and

5. Complies with the rules of the Commission.

SECTION 4. COMPACT PRIVILEGE TO PRACTICE

A. Member states shall recognize the privilege to practice of an individual licensed in another member state that is in conformance with Section 3 of this Compact.

B. To exercise the privilege to practice under the terms and provisions of this Compact, an individual must:

1. Be at least 18 years of age;

2. Possess a current unrestricted license in a member state as an EMT, AEMT or paramedic or state-recognized and licensed level with a scope of practice and authority between EMT and paramedic; and

3. Practice under the supervision of a medical director.

C. An individual providing patient care in a remote state under the privilege to practice shall function within the scope of practice authorized by the home state unless and until modified by an appropriate authority in the remote state as may be defined in the rules of the Commission.

D. Except as provided in Section 4.C of this Compact, an individual practicing in a remote state will be subject to the remote state's authority and laws. A remote state may, in accordance with due process and that state's laws, restrict, suspend or revoke an individual's privilege to practice in the remote state and may take any other necessary actions to protect the health and safety of its citizens. If a remote state takes action, it shall promptly notify the home state and the Commission.

E. If an individual's license in any home state is restricted or suspended, the individual shall not be eligible to practice in a remote state under the privilege to practice until the individual's home state license is restored.

F. If an individual's privilege to practice in any remote state is restricted, suspended or revoked, the individual shall not be eligible to practice in any remote state until the individual's privilege to practice is restored.

SECTION 5. CONDITIONS OF PRACTICE IN A REMOTE STATE

An individual may practice in a remote state under a privilege to practice only in the performance of the individual's EMS duties as assigned by an appropriate authority, as defined in the rules of the Commission, and under the following circumstances:

1. The individual originates a patient transport in a home state and transports the patient to a remote state;

2. The individual originates in the home state and enters a remote state to pick up a patient and provide care and transport of the patient to the home state;

3. The individual enters a remote state to provide patient care or transport within that remote state;

4. The individual enters a remote state to pick up a patient and provide care and transport to a third member state; or

5. Other conditions as determined by rules promulgated by the Commission.

SECTION 6. RELATIONSHIP TO EMERGENCY MANAGEMENT ASSISTANCE COMPACT

Upon a member state's Governor's declaration of a state of emergency or disaster that activates the Emergency Management Assistance Compact (EMAC), all relevant terms and provisions of EMAC shall apply and, to the extent any terms or provisions of this Compact conflicts with EMAC, the terms of EMAC shall prevail with respect to any individual prac-

ticing in the remote state in response to such declaration.

SECTION 7. VETERANS, SERVICE MEMBERS SEPARATING FROM ACTIVE DUTY MILITARY, AND THEIR SPOUSES

A. Member states shall consider a veteran, an active military service member, and a member of the National Guard and Reserves separating from an active duty tour, and a spouse thereof, who holds a current valid and unrestricted NREMT certification at or above the level of the state license being sought as satisfying the minimum training and examination requirements for such licensure.

B. Member states shall expedite the processing of licensure applications submitted by veterans, active military service members, and members of the National Guard and Reserves separating from an active duty tour, and their spouses.

C. All individuals functioning with a privilege to practice under this Section remain subject to the adverse actions provisions of Section 8 of this Compact.

SECTION 8. ADVERSE ACTIONS

A. A home state shall have exclusive power to impose adverse action against an individual's license issued by the home state.

B. If an individual's license in any home state is restricted or suspended, the individual shall not be eligible to practice in a remote state under the privilege to practice until the individual's home state license is restored.

1. All home state adverse action orders shall include a statement that the individual's Compact privileges are inactive. The order may allow the individual to practice in remote states with prior written authorization from both the home state and remote state's EMS authority.

2. An individual currently subject to adverse action in the home state shall not practice in any remote state without prior written authorization from both the home state and remote state's EMS authority.

C. A member state shall report adverse actions and any occurrences that the individual's Compact privileges are restricted, suspended or revoked to the Commission in accordance with the rules of the Commission.

D. A remote state may take adverse action on an individual's privilege to practice within that state.

E. Any member state may take adverse action against an individual's privilege to practice in that state based on the factual findings of another member state, so long as each state follows its own procedures for imposing such adverse action.

F. A home state's EMS authority shall investigate and take appropriate action with respect to reported conduct in a remote state as it would if such conduct had occurred within the home state. In such cases, the home state's law shall control in determining the appropriate adverse action.

G. Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the member state's laws. Member states must require individuals who enter any alternative programs to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

SECTION 9. ADDITIONAL POWERS INVESTED IN A MEMBER STATE'S EMS AU-

THORITY

A member state's EMS authority, in addition to any other powers granted under state law, is authorized under this Compact to:

1. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a member state's EMS authority for the attendance and testimony of witnesses, and the production of evidence from another member state, shall be enforced in the remote state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing state's EMS authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and evidence are located; and

2. Issue cease and desist orders to restrict, suspend or revoke an individual's privilege to practice in the state.

SECTION 10. ESTABLISHMENT OF THE INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE

A. The Compact states hereby create and establish a joint public agency known as the Interstate Commission for EMS Personnel Practice.

1. The Commission is a body politic and an instrumentality of the Compact states.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting and Meetings

1. Each member state shall have and be limited to one delegate. The responsible official of the state EMS authority, or their designee, shall be the delegate to this Compact for each member state. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the member state in which the vacancy exists. In the event that more than one board, office or other agency with the legislative mandate to license EMS personnel at and above the level of EMT exists, the Governor of the state will determine which entity will be responsible for assigning the delegate.

2. Each delegate shall be entitled to one vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

4. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Section 12 of this Compact.

5. The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

a. Noncompliance of a member state with its obligations under this Compact;

b. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened or reasonably anticipated litigation;

d. Negotiation of contracts for the purchase or sale of goods, services or real estate;

e. Accusing any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to this Compact; or

j. Matters specifically exempted from disclosure by federal or member state statute.

6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

C. The Commission shall, by a majority vote of the delegates, prescribe bylaws and rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this Compact, including but not limited to:

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings, and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the membership votes to close a meeting in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed;

4. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any member state, the bylaws shall exclusively govern the personnel policies and programs of the Commission;

6. Promulgating a code of ethics to address permissible and prohibited activities of Commission members and employees;

7. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of this Compact after the payment and reserving of all of its debts and obligations;

8. The Commission shall publish its bylaws and file a copy thereof, and a copy of any amendment thereto, with the appropriate agency or officer in each of the member states, if any.

9. The Commission shall maintain its financial records in accordance with the bylaws.

10. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

D. The Commission shall have the following powers:

1.a. The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all member states.

b. Notwithstanding Section 10.D.1.a. of this Compact, the Oregon Health Authority shall review the rules of the Commission. The authority may approve and adopt the rules of the Commission as rules of the authority. The State of Oregon is subject to a rule of the Commission only if the rule of the Commission is adopted by the authority;

2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state EMS authority or other regulatory body responsible for EMS personnel licensure to sue or be sued under applicable law shall not be affected;

3. To purchase and maintain insurance and bonds;

4. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a member state;

5. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this Compact and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

6. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety or conflict of interest;

7. To lease, purchase, accept appropriate gifts or donations of or otherwise to own, hold, improve or use, any property, real, personal or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;

8. To sell convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

9. To establish a budget and make expenditures;

10. To borrow money;

11. To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

12. To provide and receive information from, and to cooperate with, law enforcement agencies;

13. To adopt and use an official seal; and

14. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of EMS personnel licensure and practice.

E. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations and grants of money, equipment, supplies, materials and services.

3.a. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

b. An assessment levied, or any other financial obligation imposed, under this Compact is effective against the State of Oregon only to the extent that moneys necessary to pay the assessment or meet the financial obligation have been deposited in the Emergency Medical Services Program Fund established under section 8 of this 2025 Act.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

F. Qualified Immunity, Defense and Indemnification

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining their own counsel, and provided further that the actual or alleged act,

error or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 11. COORDINATED DATABASE

A. The Commission shall provide for the development and maintenance of a coordinated database and reporting system containing licensure, adverse action and significant investigatory information on all licensed individuals in member states.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the coordinated database on all individuals to whom this Compact is applicable as required by the rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Significant investigatory information;

4. Adverse actions against an individual's license;

5. An indicator that an individual's privilege to practice is restricted, suspended or revoked;

6. Nonconfidential information related to alternative program participation;

7. Any denial of application for licensure and the reason for such denial; and

8. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

C. The coordinated database administrator shall promptly notify all member states of any adverse action taken against, or significant investigative information on, any individual in a member state.

D. Member states contributing information to the coordinated database may designate information that may not be shared with the public without the express permission of the contributing member state.

E. Any information submitted to the coordinated database that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the coordinated database.

SECTION 12. RULEMAKING

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Section and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt this Compact, then such rule shall have no further force and effect in any member state.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a notice of proposed rulemaking:

1. On the website of the Commission; and

2. On the website of each member state EMS authority or the publication in which each state would otherwise publish proposed rules.

E. The notice of proposed rulemaking shall include:

1. The proposed time, date and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least 25 persons;

2. A governmental subdivision or agency; or

3. An association having at least 25 members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time and date of the scheduled public hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

4. Nothing in this Section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this Section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. Upon determination that an emergency exists, the Commission may consider and

adopt an emergency rule without prior notice, opportunity for comment or hearing, provided that the usual rulemaking procedures provided in this Compact and in this Section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety or welfare;

2. Prevent a loss of Commission or member state funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

SECTION 13. OVERSIGHT, DISPUTE RESOLUTION AND ENFORCEMENT

A. Oversight

1. The executive, legislative and judicial branches of state government in each member state shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of this Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this Compact which may affect the powers, responsibilities or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact or promulgated rules.

B. Default, Technical Assistance and Termination

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from this Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in this Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature and each of the member states.

4. A state that has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated from this Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

C. Dispute Resolution

1. Upon request by a member state, the Commission shall attempt to resolve disputes related to this Compact that arise among member states and between member and non-member states.

2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

D. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.

2. By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of this Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

SECTION 14. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE AND ASSOCIATED RULES, WITHDRAWAL AND AMENDMENT

A. This Compact shall come into effect on the date on which this Compact statute is enacted into law in the 10th member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of this Compact.

B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

C. Any member state may withdraw from this Compact by enacting a statute repealing the same.

1. A member state's withdrawal shall not take effect until six months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's EMS authority to comply with the investigative and adverse action reporting requirements of this Compact prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any EMS personnel licensure agreement or other cooperative arrangement between a member state and a nonmember state that does not conflict with the provisions of this Compact.

E. This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

SECTION 15. CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the Constitution of any state member thereto, this Compact shall remain in full force and effect as to the remaining member states. Nothing in this Compact supersedes state law or rules related to licensure of EMS agencies.

SECTION 43. The Legislative Assembly of the State of Oregon hereby ratifies the EMS Personnel Licensure Interstate Compact set forth in section 42 of this 2025 Act.

SECTION 44. In order to employ or otherwise engage a person who is authorized to work as an emergency medical services provider by privilege to practice, as defined in section 42 of this 2025 Act, and who is not licensed under ORS chapter 682, an entity shall provide a labor peace agreement developed in partnership with labor organizations representing emergency medical services providers licensed under ORS chapter 682 and approved by the Emergency Medical Services Advisory Board established under section 4, chapter 32, Oregon Laws 2024.

SECTION 45. Sections 42 to 44 of this 2025 Act are repealed on January 2, 2030.

SECTION 46. ORS 676.177 is amended to read:

676.177. (1) Notwithstanding any other provision of ORS 676.165 to 676.180 and except as provided in subsection (5) of this section, a health professional regulatory board, upon a determination by the board that it possesses otherwise confidential information that reasonably relates to the regulatory or enforcement function of another public entity, may disclose that information to the other public entity.

(2) Any public entity that receives information pursuant to subsection (1) of this section shall agree to take all reasonable steps to maintain the confidentiality of the information, except that the public entity may use or disclose the information to the extent necessary to carry out the regulatory or enforcement functions of the public entity.

(3) For purposes of this section, "public entity" means:

(a) A board or agency of this state, or a board or agency of another state with regulatory or enforcement functions similar to the functions of a health professional regulatory board of this state;

(b) A district attorney;

(c) The Department of Justice;

(d) A state or local public body of this state that licenses, franchises or provides emergency medical services; or

(e) A law enforcement agency of this state, another state or the federal government.

(4) Notwithstanding subsections (1) to (3) of this section[,]**:**

(a) The Oregon Board of Physical Therapy may disclose information described in subsection (1) of this section to the Physical Therapy Compact Commission [*established*] **described** in ORS 688.240.

(b) The Oregon Health Authority may disclose information described in subsection (1) of this section to the Interstate Commission for EMS Personnel Practice described in section 42 of this 2025 Act.

(5) A health professional regulatory board may not disclose the information described in subsection (1) of this section to another public entity **or to a commission described in subsection (4) of this section** if the information relates to the provision of or referral for reproductive or gender-affirming health care services.

SECTION 47. ORS 676.177, as amended by section 46 of this 2025 Act, is amended to read:

676.177. (1) Notwithstanding any other provision of ORS 676.165 to 676.180 and except as provided in subsection (5) of this section, a health professional regulatory board, upon a determination by the board that it possesses otherwise confidential information that reasonably relates to the regulatory or enforcement function of another public entity, may disclose that information to the other public entity.

(2) Any public entity that receives information pursuant to subsection (1) of this section shall agree to take all reasonable steps to maintain the confidentiality of the information, except that the public entity may use or disclose the information to the extent necessary to carry out the regulatory or enforcement functions of the public entity.

(3) For purposes of this section, "public entity" means:

(a) A board or agency of this state, or a board or agency of another state with regulatory or enforcement functions similar to the functions of a health professional regulatory board of this state;

(b) A district attorney;

(c) The Department of Justice;

(d) A state or local public body of this state that licenses, franchises or provides emergency medical services; or

(e) A law enforcement agency of this state, another state or the federal government.

(4) Notwithstanding subsections (1) to (3) of this section**,**[*:*]

[*(a)*] the Oregon Board of Physical Therapy may disclose information described in subsection (1) of this section to the Physical Therapy Compact Commission described in ORS 688.240.

[*(b) The Oregon Health Authority may disclose information described in subsection (1) of this section to the Interstate Commission for EMS Personnel Practice described in section 42 of this 2025 Act.*]

(5) A health professional regulatory board may not disclose the information described in subsection (1) of this section to another public entity [*or to a commission described in subsection (4) of this section*] if the information relates to the provision of or referral for reproductive or gender-affirming health care services.

SECTION 48. ORS 682.204 is amended to read:

682.204. (1)**(a) Except as provided in paragraph (b) of this subsection,** a person may not act as an emergency medical services provider unless the person is licensed under this chapter.

(b) Paragraph (a) of this subsection does not apply to a person who is authorized to work as an emergency medical services provider by privilege to practice as defined in section 42 of this 2025 Act.

(2) A person or governmental unit which operates an ambulance may not authorize a person to act for it as an emergency medical services provider unless the emergency medical services provider is licensed under this chapter.

(3) A person or governmental unit may not operate or allow to be operated in this state any ambulance unless it is operated with at least one emergency medical services provider who is licensed at a level higher than emergency medical responder.

(4) It is a defense to any charge under this section that there was a reasonable basis for believing that the performance of services contrary to this section was necessary to preserve human life, that diligent effort was made to obtain the services of a licensed emergency medical services provider and that the services of a licensed emergency medical services provider were not available or were not available in time as under the circumstances appeared necessary to preserve such human life.

(5) Subsections (1) to (3) of this section are not applicable to any individual, group of individuals, partnership, entity, association or other organization otherwise subject thereto providing a service to the public exclusively by volunteer unpaid workers, nor to any person who acts as an ambulance attendant therefor, provided that in the particular county in which the service is rendered, the county court or board of county commissioners has by order, after public hearing, granted exemption from such subsections to the individual, group, partnership, entity, association or organization. When exemption is granted under this section, any person who attends an individual who is ill or injured or who has a disability in an ambulance may not purport to be an emergency medical services provider.

SECTION 49. ORS 682.204, as amended by section 48 of this 2025 Act, is amended to read:

682.204. (1)[*(a) Except as provided in paragraph (b) of this subsection,*] A person may not act as an emergency medical services provider unless the person is licensed under this chapter.

[*(b) Paragraph (a) of this subsection does not apply to a person who is authorized to work as an emergency medical services provider by privilege to practice as defined in section 42 of this 2025 Act.*]

(2) A person or governmental unit which operates an ambulance may not authorize a person to act for it as an emergency medical services provider unless the emergency medical services provider is licensed under this chapter.

(3) A person or governmental unit may not operate or allow to be operated in this state any ambulance unless it is operated with at least one emergency medical services provider who is licensed at a level higher than emergency medical responder.

(4) It is a defense to any charge under this section that there was a reasonable basis for believing that the performance of services contrary to this section was necessary to preserve human life, that diligent effort was made to obtain the services of a licensed emergency medical services provider and that the services of a licensed emergency medical services provider were not available or were not available in time as under the circumstances appeared necessary to preserve such human life.

(5) Subsections (1) to (3) of this section are not applicable to any individual, group of individuals, partnership, entity, association or other organization otherwise subject thereto providing a service to the public exclusively by volunteer unpaid workers, nor to any person who acts as an ambulance attendant therefor, provided that in the particular county in which the service is rendered, the county court or board of county commissioners has by order, after public hearing, granted exemption from such subsections to the individual, group, partnership, entity, association or organization. When exemption is granted under this section, any person who attends an individual who is ill or injured

or who has a disability in an ambulance may not purport to be an emergency medical services provider.

SECTION 50. (1) The amendments to ORS 676.177 by section 46 of this 2025 Act apply to information disclosed on or after the operative date specified in section 51 (1) of this 2025 Act.

(2) The amendments to ORS 682.204 by section 48 of this 2025 Act apply to persons authorized to work as emergency medical services providers by privilege to practice, as defined in section 42 of this 2025 Act, on or after the operative date specified in section 51 (1) of this 2025 Act.

SECTION 51. (1) Sections 42 to 44 of this 2025 Act and the amendments to ORS 676.177 and 682.204 by sections 46 and 48 of this 2025 Act become operative on January 1, 2026.

(2) The amendments to ORS 676.177 and 682.204 by sections 47 and 49 of this 2025 Act and the amendments to section 8 of this 2025 Act by section 9 of this 2025 Act become operative on January 2, 2030.

(3) The Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority by sections 42 to 44 of this 2025 Act and the amendments to ORS 676.177 and 682.204 by sections 46 and 48 of this 2025 Act.

APPROPRIATION

SECTION 52. There is appropriated to the Emergency Medical Services Program Fund, for the biennium beginning July 1, 2025, out of the General Fund, the amount of $8,750,000 for the purpose of carrying out the provisions of ORS 682.208 and 682.216 and sections 7, 14 and 42 of this 2025 Act.

CAPTIONS

SECTION 53. The unit captions used in this 2025 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2025 Act.

EFFECTIVE DATE

SECTION 54. This 2025 Act takes effect on the 91st day after the date on which the 2025 regular session of the Eighty-third Legislative Assembly adjourns sine die.