

2019

Oregon Rural & Frontier
Emergency Medical Services

LISTENING TOUR



The Oregon Office of Rural Health (ORH) coordinated a Listening Tour of licensed rural and frontier Emergency Medical Services (EMS) agencies to discuss operational sustainability within a rapidly changing health care delivery model. This report is a summary overview of the issues heard during the Listening Tour, including agency-reported effective practices and challenges to program success.

More detail, including current opportunities and activities to address challenges, is available at the ORH website at: www.ohsu.edu/orh.



The 2019 Rural and Frontier EMS Listening Tour report was made possible with funding from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under a Medicare Rural Hospital Flexibility Program EMS Supplement award.

If you have any questions or suggestions, please contact:

REBECCA DOBERT, Field Services Program Manager
Oregon Office of Rural Health
dobert@ohsu.edu | 503.494.6627

EMERSON ONG, Data and GIS Analyst
Oregon Office of Rural Health
ong@ohsu.edu | 503.494.5226

LIZ HECKATHORN
EMS and Trauma Systems Professional Standards
Public Health Division, Oregon Health Authority
elizabeth.e.heckathorn@state.or.us | 971.673.0532

CONTENTS

Acknowledgements	3
2019 EMS Listening Tour Meeting Locations	4
ORH Defined Urban, Rural, and Frontier Areas	5
What is Rural and Frontier?	6
ASAs and Health Districts	7
Oregon Ambulance Service Areas	8
Tour Logistics	9
Consistent Challenges and Reported Benefits	10
Personnel	11
Overview	11
Education and Training	12
Oregon EMS Education and Training	13
Overview	13
EMS Education in Tour Counties	13
Education Programs Available in Tour Counties	14
Billing and Reimbursement	15
Overview	15
Electronic Patient Care Reporting	16
Participating Rural County Demographics	17
Participating Frontier County Demographics	18
Action Items and Follow Up	19
Advocacy	19
Program Grants	19
Community Paramedicine and EMS	20
EMS Provider Resources	21
Data Sources and Maps	22

Acknowledgements

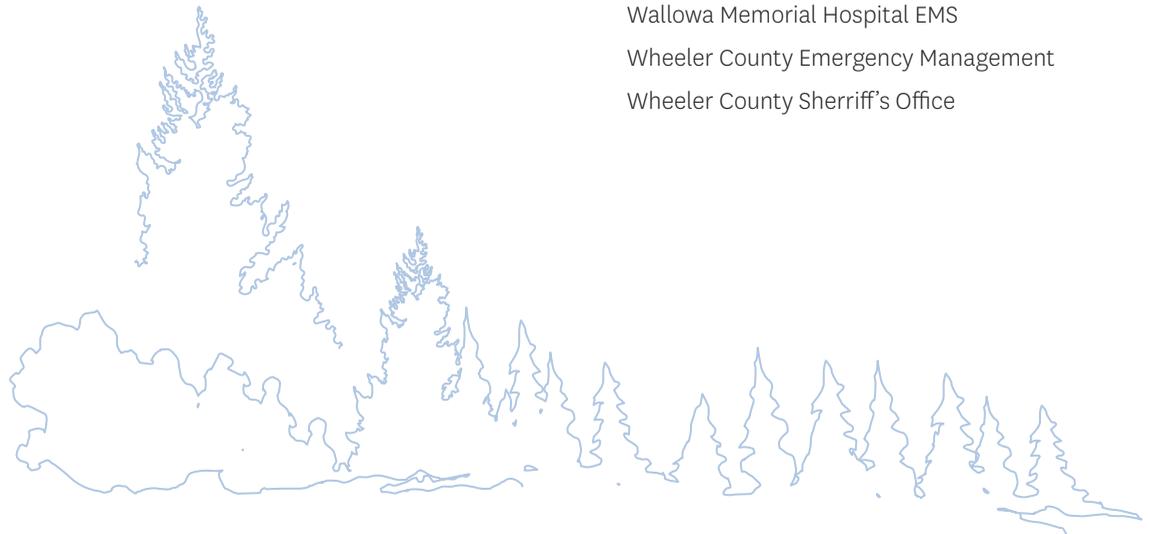
Thank You Agency Participants

**BETWEEN FEBRUARY
AND JUNE 2019,
EMS LISTENING TOUR MEETINGS OCCURRED
ON-SITE IN 10 OF OREGON'S 36 COUNTIES,
INCLUDING 5 RURAL AND 5 FRONTIER COUNTIES.**

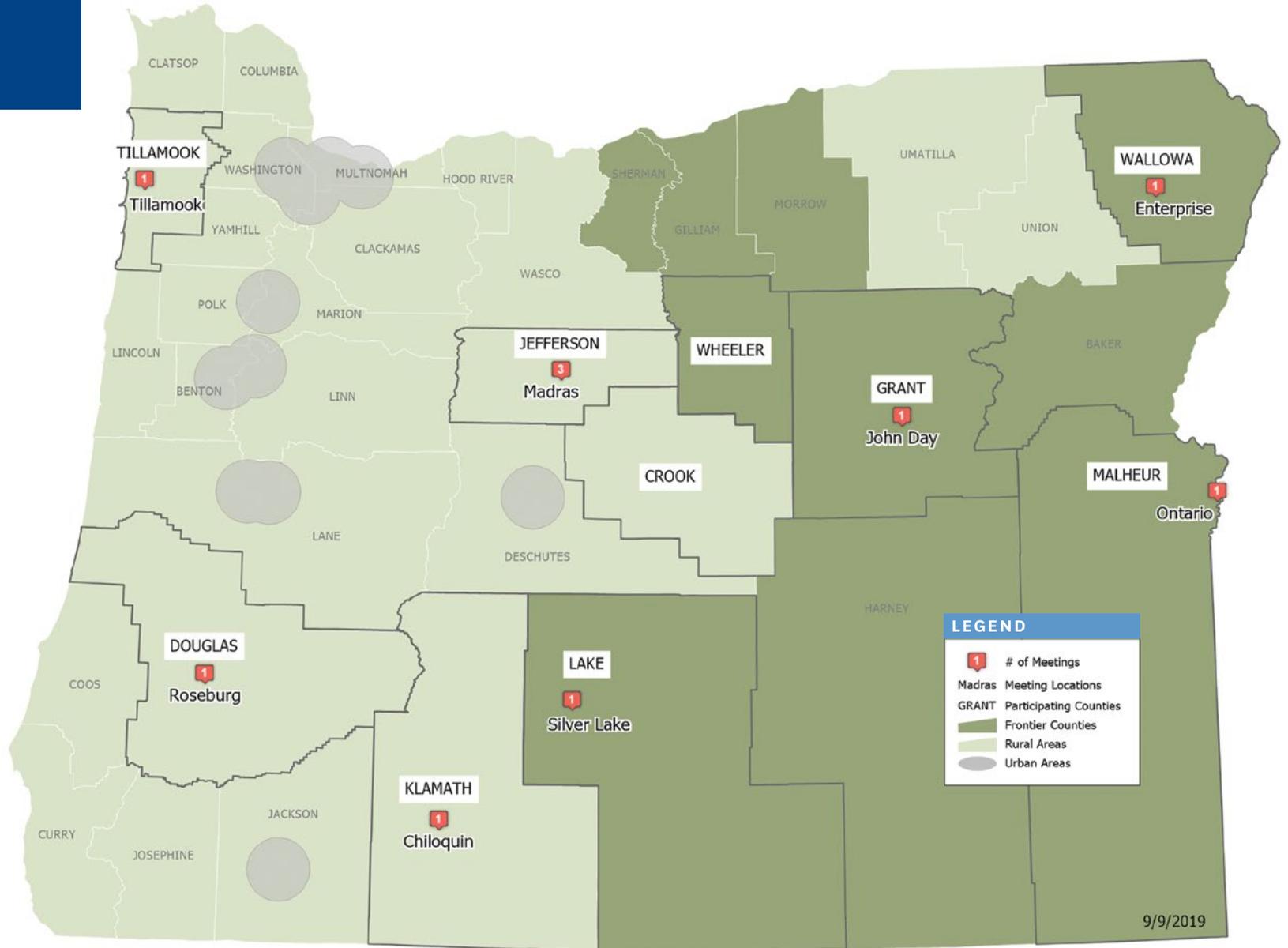
Participants represented licensed transporting and non-transporting EMS and fire agencies, Critical Access and Rural Hospitals, county and public health agencies and law enforcement.

We appreciate the 36 organizations who made time to attend and share with us.

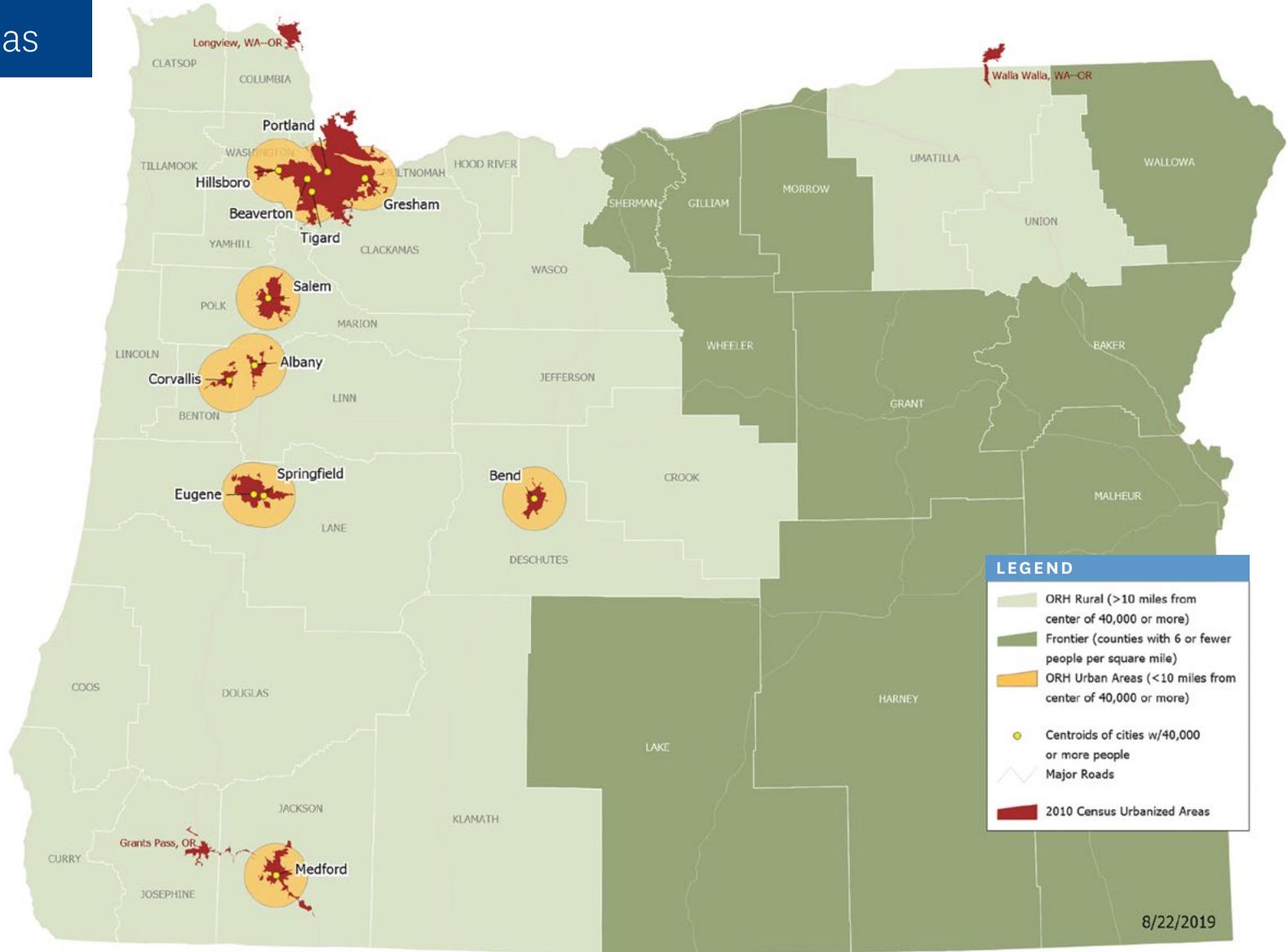
Adrian Quick Response Unit
Adventist Health Tillamook EMS
Adventist Health Tillamook
Bay Cities Ambulance
Blue Mountain Health District EMS
Blue Mountain Health District Hospital
Bonanza Ambulance
Chiloquin Fire and Rescue
Crescent Rural Fire Protection District
Crook County Emergency Preparedness
Crook County Fire and Rescue
Douglas County Fire District Number 2
Fossil Ambulance
Glide Rural Fire Protection District
Grant County Health Department
Jefferson County EMS District
Jefferson County Public Health
Jordan Valley Ambulance Service
Klamath County Fire District Number 1
Lake Chinook Fire and Rescue
Lake County Sheriff's Office
Lake District Hospital
Lakeview Disaster Unit
Malheur County Ambulance Service District
Malheur County Emergency Management
Mitchell Ambulance
Mitchell Fire Department
North Lake County EMS
Ontario Fire and Rescue
Rager Emergency Services
Silver Lake Rural Fire Protection District
Spray Ambulance
Treasure Valley Paramedics
Wallowa Memorial Hospital EMS
Wheeler County Emergency Management
Wheeler County Sherriff's Office



2019 EMS
LISTENING TOUR
Meeting
Locations



ORH Defined Urban, Rural, and Frontier Areas



What is Rural and Frontier?

*33% (1,166,154)
and 2% (94,669)
of Oregon's
population lives
in rural and in
frontier communities,
respectively.*

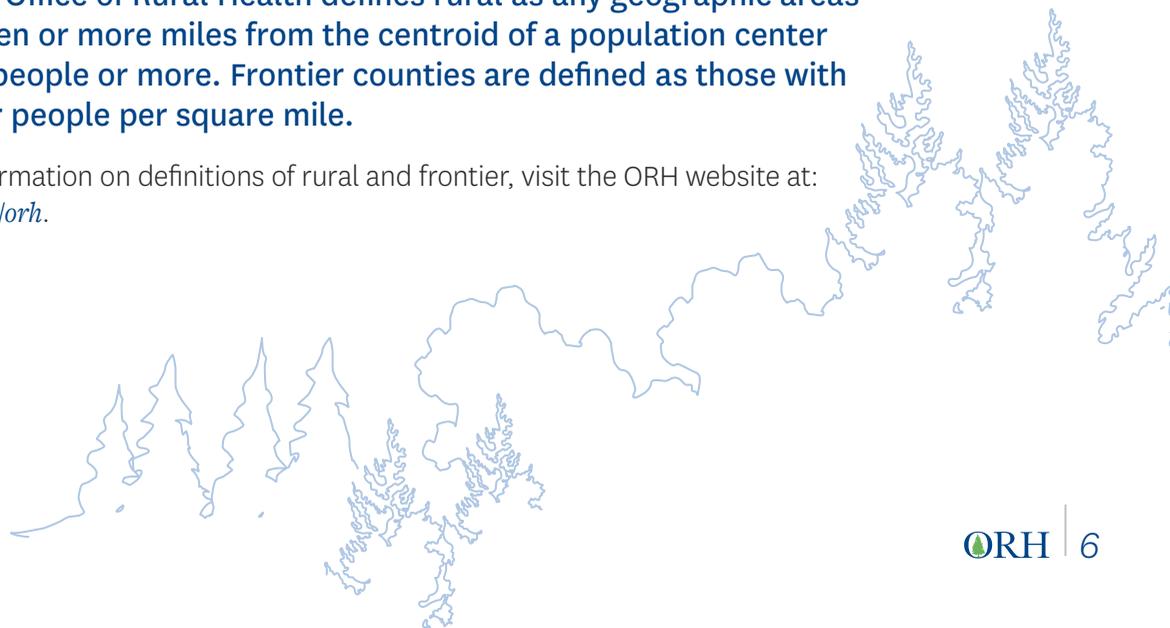
*10 of Oregon's 36
counties are frontier.*



Marion County

The Oregon Office of Rural Health defines rural as any geographic areas in Oregon ten or more miles from the centroid of a population center of 40,000 people or more. Frontier counties are defined as those with six or fewer people per square mile.

For more information on definitions of rural and frontier, visit the ORH website at: www.ohsu.edu/orh.



69% of Oregon's Ambulance Service Areas are in rural and frontier communities.

What is an ASA?

As defined in Oregon Administrative Rule (OAR) 333-260-0000,¹ an **Ambulance Service Area Plan (ASA Plan)** outlines a process for establishing a county emergency medical services system. An ASA Plan addresses the need for, and coordination of, ambulance services by establishing ambulance service areas for the entire county.

An **Ambulance Service Area (ASA)** is a geographic area which is served by an ambulance service provider and may include all or a portion of a county, or all or portions of two or more contiguous counties.

Oregon has **36 ASA Plans** and **152 ASAs**. There are 49 individual ASAs within the 10 counties that participated in the EMS Listening Tour.

For additional OAR and ORS pertaining to EMS visit <https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1356> and www.oregonlaws.org/oregon_revised_statutes.

¹ https://oregon.public.law/rules/oar_333-260-0000

What is a Health District?

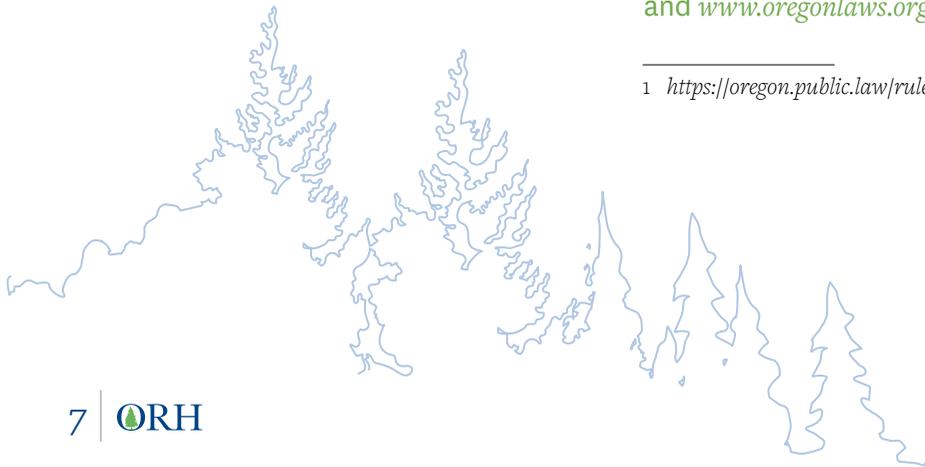
Chapter 440 of the Oregon Revised Statutes (ORS) regulates the creation and management of health districts in Oregon. Health districts are municipal entities, authorized by the State of Oregon, that create local, non-operational revenue streams to fund health services.² Health districts in rural Oregon are often used to fund EMS service. Under ORS 440.320,³ health districts are authorized to:

- 1a. Be incorporated as municipal corporations for the purposes of: providing clinically related diagnostic, treatment and rehabilitative services on an inpatient or outpatient basis; providing outreach programs in health care education, health care research and patient care; serving as a resource for health providers in the district; and promoting the physical and mental well-being of district residents.

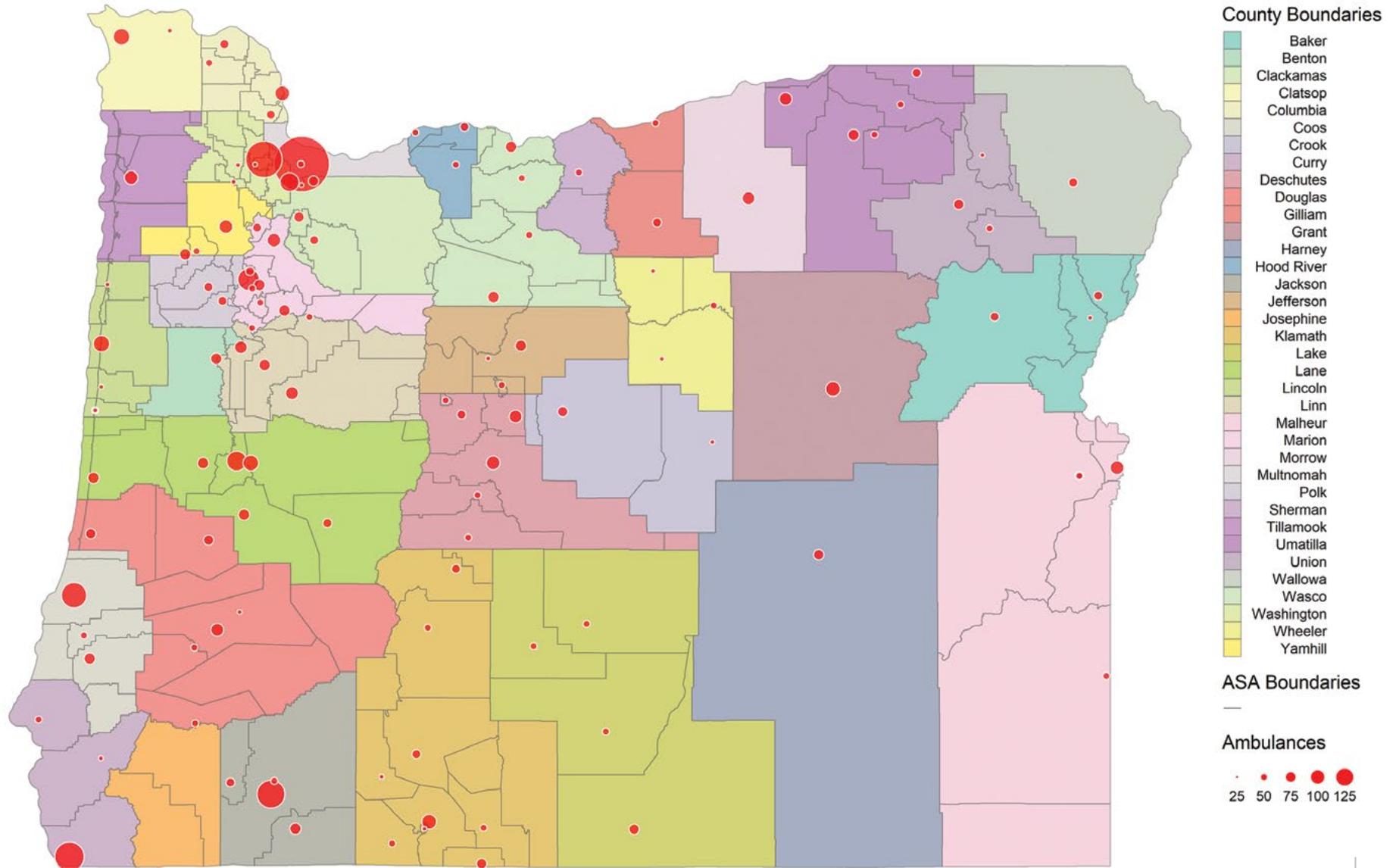
Health districts generate revenue based on voter-approved tax rates per \$1,000 of assessed property value within the district's defined service area. Health districts may also issue public works bonds and levies. Finally, providers operating in health districts are authorized to charge fees for people who use the district's facilities or services.

² McGinnis, Paul B. MPA, Howk, Sonya, MHA:HA, Ong, Emerson, Simeon, Jennifer, MPH. Health Districts in Oregon. 2016. www.ohsu.edu/sites/default/files/2018-08/Health%20Districts%20in%20Oregon%202016.pdf

³ www.oregonlaws.org/ors/440.320



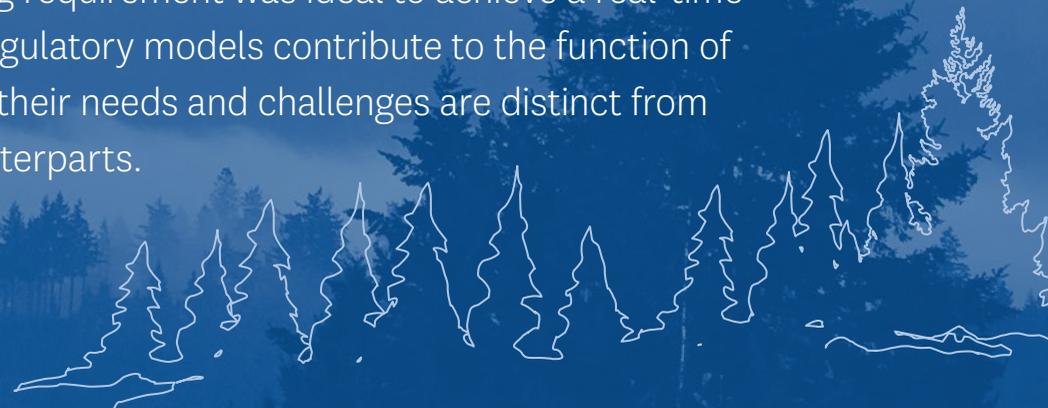
Oregon Ambulance Service Areas



TOUR LOGISTICS

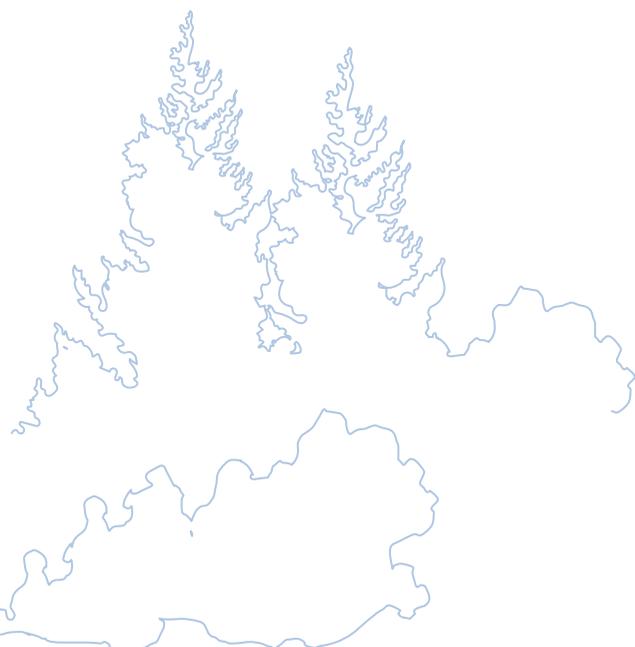
The Oregon Office of Rural Health, in collaboration with the Oregon Health Authority (OHA) EMS & Trauma Systems Program (EMSTS), conducted the Rural and Frontier EMS Listening Tour to directly discuss operational strengths and challenges with the agencies and personnel who provide and support first responder services. Approximately 20% of Oregon's licensed transporting agencies participated, representing organizations which operate across 10 rural and frontier counties. These participating counties contain nearly 50,000 of Oregon's 98,000 square miles of territory—slightly larger than the state of Pennsylvania and home to geographic peaks averaging 4,900 feet higher. The tour was designed to help identify impactful and relevant ways to support sustainable access to high-quality emergency medical care for Oregon's rural and frontier communities.

Meeting site locations were based on analysis of transporting EMS agency licensure survey data. The analysis assessed operational stability, and inclusion in the Tour was targeted to balance participation by agencies experiencing system stability along with agencies experiencing instability. The on-site meeting requirement was ideal to achieve a real-time view of how current funding, staffing and regulatory models contribute to the function of rural and frontier agencies. In many cases, their needs and challenges are distinct from those of their urban and metropolitan counterparts.



“Being a rural or frontier EMS agency means trying to be everything to everybody.”

— FRONTIER COUNTY
EMS MANAGER



Consistent Challenges

Personnel - Recruitment, Training and Retention

National analysis consistently shows that, compared with urban agencies, rural EMS agencies typically rely more on volunteers with lower-level training, and have less access to oversight and skill maintenance.⁴ Oregon is no different; two of the participant counties do not have EMS educational catchments. Among the EMS provider agency participants, 100% reported difficulty with recruitment, training and retention of personnel. This included paid career and casual staff, and volunteer or unreimbursed licensed staff.

Revenue - Billing and Reimbursement

Reimbursement barriers were reported by 80% of the EMS provider agency participants, including Medicare reimbursement and often unbillable but commonplace calls, such as lift assists, standby events and non-emergency calls.

Challenges Unique to Rural EMS

Listening Tour participants reported that the extreme distances and geography of Oregon’s rural and frontier ASAs contribute to additional, distinctly rural and frontier challenges. Excessive wear on response vehicles, high fuel costs

⁴ Patterson DG, Skillman SM, Fordyce MA. Prehospital Emergency Medical Services Personnel in Rural Areas: Results from a Survey in Nine States. Final Report #149. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, August 2015.

and remote communications challenges were commonly cited as needing consideration by EMS planning and policy bodies.

A more recent phenomenon was reported primarily in southern and southwestern Oregon. As rural communities scale back law enforcement budgets there can be unintended consequences—such as police officers not being first on scene to establish safety. This can mean that EMS responders are the first uniformed personnel to arrive, potentially encountering a violent response. In some communities, where there is no overnight law enforcement, citizens will activate the 911 system to summon any responder, even though medical response is not what is needed or appropriate.

Reported Benefits

Rural EMS Providers are Resourceful

It is clear that rural and frontier EMS personnel are extremely independent and skilled at making the most of scarce resources. Operationally stable agencies described a capacity to focus on improving quality of care and allocating appropriate assets to do so.

Being a hospital-based EMS agency, with at least some paid staff, and being located within a health district were consistently reported as beneficial. In particular, hospital-based agencies reported that having hospital resources to help with billing, medical direction, and supplemental programming—such as a Community Paramedic—were essential to their sustainability.

Overview

Volunteers Are Crucial but Decreasing in Number

While many agencies have a mix of paid and unpaid staff, licensed volunteers remain essential to rural and frontier 911-responding EMS organizations in Oregon. Many rural and frontier agencies are staffed solely by community volunteers, even while the model is generally recognized as unsustainable. A national EMS assessment noted that just one-third of U.S. states rely on majority volunteer EMS agencies.⁵ Review of the national certification registry shows that 87% of professionals who recertified their National EMS Certification between October 1, 2017, and March 31, 2018, were paid personnel.

Listening Tour participants reported increasing difficulty remaining operationally stable within a volunteer model. They cited major challenges

including a scarcity of volunteers and, in some cases, qualified career staff. When candidates are found, they often must complete certification and licensure at their own cost. For rural and frontier students this can include travel to education and training programs far outside their home areas, especially for those seeking advanced-level training. Additionally, as with other rural health care staff, EMS personnel increasingly must not only be licensed and provide medical response, but also need to complete patient care data tracking, quality improvement, equipment maintenance and submit billing. In larger agencies, or agencies in urban and metropolitan areas, these duties are often completed by dedicated paid staff.

Recruitment challenges also occur when paid positions are available. Rural agencies face losing staff to regional urban services with higher pay and benefit scales. Frontier agencies noted that cost of living and the need to travel to maintain and obtain additional certification(s) and licensure can be prohibitive to students looking to EMS as a career.

⁵ Patterson DG, Skillman SM, Fordyce MA. Prehospital Emergency Medical Services Personnel in Rural Areas: Results from a Survey in Nine States. Final Report #149. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, August 2015.

“We hire good people who love doing this and want to help and like living here. No one says I don’t want to live in [a frontier county]. They say I want to be able to make a living here.” —FRONTIER PARAMEDIC



Lake County

Education and Training

Licensure Is Required but Access to Education Is a Challenge

The public's emergency medical safety net often begins with EMS. Providers are a hybrid of public health and public safety officers, with the expectation that they will be educated and trained to serve a wide range of health care needs for the community. This includes basic, first-aid level response, through primary care style education and care, to highly complex trauma and medical interventions using advanced training and skillsets along with the ability to manage cases in a wide range of pre-hospital settings.

All tour participants reported that accessing both initial and continuing education courses in order to gain or renew licensure is a challenge. Many rural and frontier counties in Oregon are not covered by an education service district. This means that in addition to the price of tuition and materials, there is the expense of travel and time to gain the required education and training for licensure. Those who would volunteer, or even those seeking a paid career position, often change course due to the inaccessibility and price tag of obtaining and maintaining the required education.

In other cases, when a community college is accessible, participants reported the schedules offered often do not provide courses or timeframes to meet the needs of working adults—those who make up the bulk of many volunteer pools. While basic levels of EMS education may be available in both traditional and non-traditional (internet or online) settings, the paramedic level of EMS licensure in Oregon requires an associate degree. Of the 10 counties that hosted Listening Tour meetings, seven do not have a community college paramedic level program.

Tour participants also reported that community colleges that do offer paramedic programs can have difficulty recruiting candidates to fill class cohorts. Meanwhile, nursing programs at the same institutions have waiting lists. It was related that a paramedic wage is often less than half that of a registered nurse and the opportunities for paid employment are more limited. Students are choosing health care careers with greater flexibility and prospects.

*“Volunteerism
is dying.”*

—FRONTIER EMS AGENCY DIRECTOR



Harney County



Coos County

Overview

Updated Educational Models Are Needed

A majority of participants reported a desire for updated educational models to meet the non-standard needs of rural and frontier EMS agencies and their potential recruits. They seek less reliance on community college systems' physical locations for training and certification. This includes the ability for local agencies to run more of their own training, refining of hybrid programming—online classroom components paired with onsite practicum—and rolling admissions. Such models could help to:

- Reduce travel time and expense for trainees residing between/outside educational catchments;
- Match programs to trainee availability (rather than them waiting for a semester to begin);
- Increase agencies' ability to recruit new staff and help current staff maintain licensure;
- Address technological difficulties and quality issues with distance programming; and
- Increase agencies' ability to cross-train as many other local personnel as possible, such as public works or public safety workers.

For agencies offering paid, career-path positions, the need for high quality local education was seen as crucial. As with other rural health providers, it was noted “if they train rural, they stay rural.” Programs that have been used to successfully increase enrollment in nursing and mid-level provider education could be implemented to inform prospective students that EMS is a viable career path.

EMS Education in Tour Counties

EMS Is a Health Career, Not a Single Class

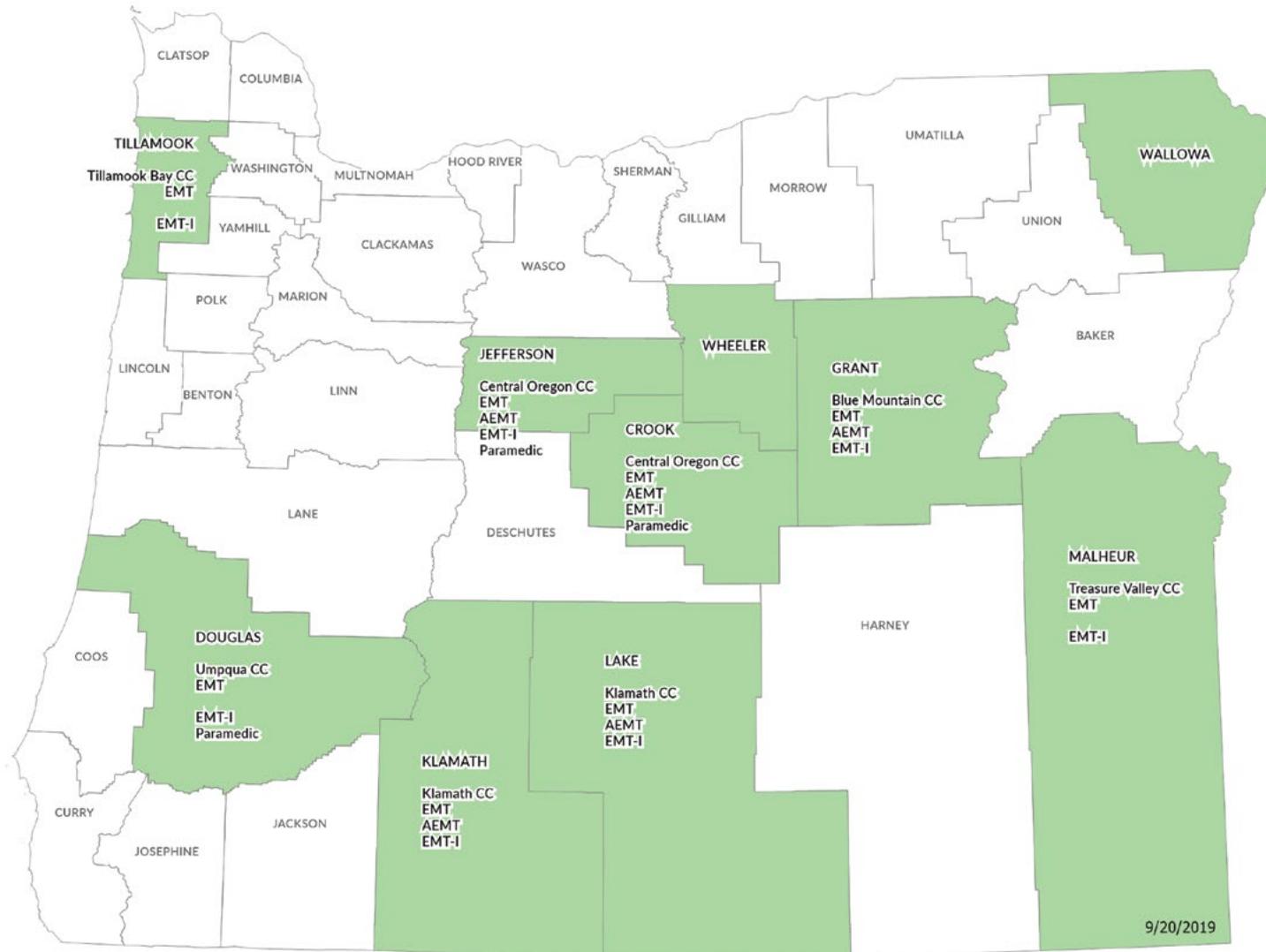
The responsibilities and educational requirements for initial licensure and continuing education have increased since many EMS agencies began offering ambulance services in the 1960s and 1970s. At the same time, the rural workforce and volunteerism have decreased. To be licensed in Oregon as an Emergency Medical Technician (EMT), candidates must generally complete a course of study over two terms, meeting weekly for 8 hours of lecture and lab work. Add another 15-20 hours of study per week and a licensing exam for an all-inclusive average cost of \$1,975 in tuition and fees to be able to staff a basic life support ambulance as a volunteer. In other words—to become an uncompensated healthcare professional.

Advanced-level responders such as paramedics are least available in rural communities where they are often most needed.⁶ As educational and quality reporting requirements increase, volunteer staffing with mostly EMTs in rural EMS agencies may be difficult to sustain long term. Rural agencies, which reported less public funding than urban agencies, may need to find more robust sources of funding to recruit and retain an adequate workforce, which in turn could require a shift from volunteer to paid staffing.

⁶ Advanced Level Availability. Freeman, Victoria A., Slifkin, Rebecca T., Patterson, P. Daniel. Recruitment and Retention in Rural and Urban EMS: Results for a National Survey of Local EMS Directors. *J Public Health Management and Practice*. 2009 May-June; 15(3): 246-52.

Personnel—volunteer or paid—still need to be properly trained and ready to respond at a moment’s notice. As the average age of rural residents has increased, many agencies also

rely on volunteers who are in or near retirement to respond to calls and manage programs. To attract and retain skilled working-age employees, agencies will need to offer paid positions.



EMS LISTENING TOUR COUNTIES Available Education Programs

Shown are the Community Colleges in Tour counties offering Emergency Medical Technician (EMT), Advanced EMT (AEMT), EMT-Intermediate (EMT-I) and Paramedic programs.

“We are frontier. We are self-sufficient, but cannot manage it all.”

—FRONTIER EMS AGENCY DIRECTOR

Overview

Lack of Billing Staff

Challenges with billing and reimbursement were reported by 80% of the participant EMS provider agencies. Agencies are responsible for completing and submitting their own billing and reimbursement to all payers. A common billing challenge is that rural and frontier agencies don't have dedicated billing staff. Personnel are providing both first responder care and completing administrative work.

Many volunteers report simply lacking the time to maintain certification, provide medical and trauma responder services and complete full billing submissions—an often complex and time consuming process.

Agency requests to increase billing capacity included: partner programs with larger agency billing staff and the creation of regional billing networks to help small agencies. Funding for billing technology was also suggested as a way to enhance the ability of agencies to submit billing.

Need for Reimbursement Reform

Pre-hospital care and transport provided for by EMS personnel is paid for in a variety of ways. Reimbursement amounts vary dependent on payer type, region of service, and level of service.

Though Centers for Medicare and Medicaid Services (CMS) reimbursement for EMS agency mileage and payment formulas take into consideration transports that begin in rural areas and offer a “super-rural bonus” payment rate,⁷ agencies reported that the

reimbursement still does not always cover actual costs. The price of fuel, equipment replacement and maintenance, as well as users who request multiple call-outs in place of primary care, often is simply more than is reimbursed for.

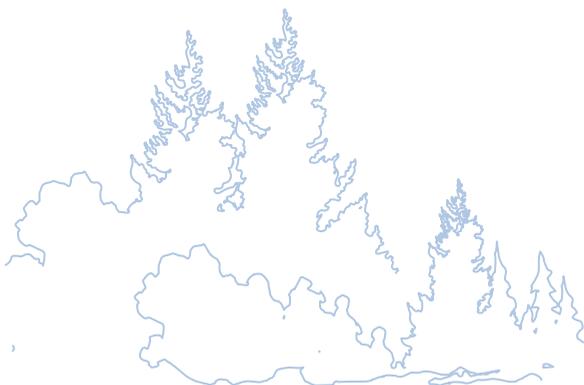
Pilots to test reimbursement for treatment without transport, or transport to appropriate alternate site (such as a primary care doctor's office or urgent care clinic) is underway with programming such as the Emergency Triage, Treat and Transport (ET3) voluntary payment model.⁸ Even with recognition of needed improvement, challenges continue to impact rural and frontier agencies: initial ET3 pilot eligibility requires a minimum annual transport volume of 7,500 patients.

Medicare

The challenges of receiving reimbursement for care from Medicare was noted often. Currently, Medicare reimbursement is only made to EMS agencies completing transport to an approved care facility. Reimbursement is not made for agencies who begin transport and hand off to a final destination transporting agency due to geographic extremes, nor is reimbursement available for care provided on site to patients calling for non-transport issues or who refuse transport. Counties represented at meetings have an average of 29% Medicare patients.

⁷ Centers for Medicare and Medicaid Ambulance Fee Schedules www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspf.html

⁸ Centers for Medicare and Medicaid Emergency Triage, Treat and Transport (ET3) Model <https://innovation.cms.gov/initiatives/et3/>



Electronic Patient Care Reporting in Oregon

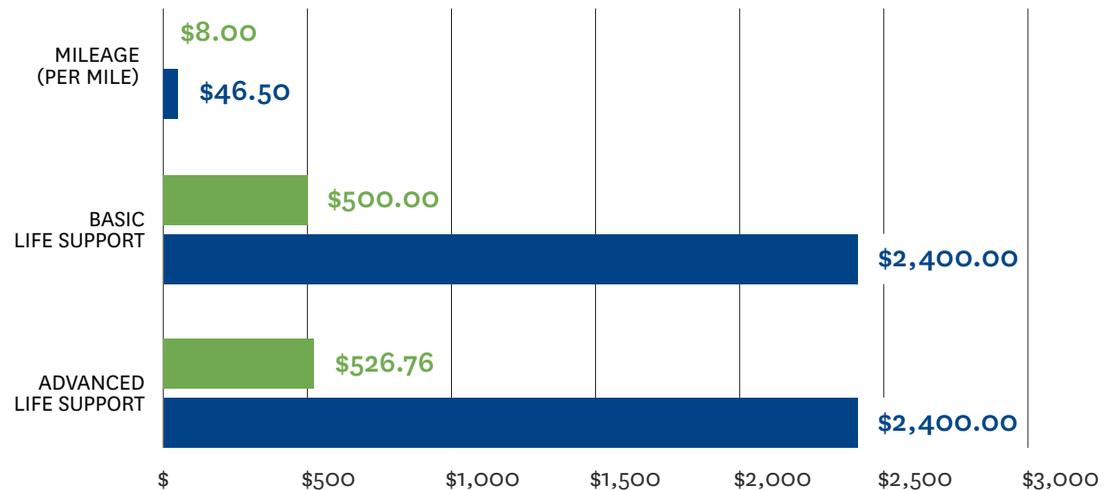
In addition to transitioning to electronic billing methods, as required by Medicare, as of January 1, 2019, licensed transporting EMS agencies in Oregon are required per Senate Bill 52⁹ to submit electronic Patient Care Reports (ePCRs) to a statewide database. At print, the Oregon EMS Information System reported that 89% of licensed agencies had implemented the new standard, with 11% remaining to comply.

A survey of the EMS Listening Tour responder agencies provided a snapshot of the non-standardized billing structures in place at EMS agencies on Oregon. With a 100% response rate, the information gathered shows a wide range of base rates billed for Advanced Life Support (ALS) and Basic Life Support (BLS), and per mile services—with a \$1,900 difference between the highest and lowest ALS and BLS rates. The highest mileage rates being charged were nearly six times higher than the lowest.

When asked about their overall billing collection rates, 47% of the agencies reported collecting on bills at a rate of 50% or less.

With regard to full transition to electronic billing, 12% of the agencies reported continued sole use of paper billing, and 29% reported using paper for a portion of the billing process. The sole paper users reported that it was due to billing staff being most comfortable with, and having the resources to complete, paper billing over electronic.

Oregon EMS Learning Tour Agency Base Rate Ranges



Baker County

⁹ <https://olis.leg.state.or.us/liz/2017R1/Measures/Overview/SB52>

Participating Rural County Demographics

	Crook	Douglas	Jefferson	Klamath	Tillamook
SIZE IN SQUARE MILES:	2,988	5,074	1,791	6,146	1,104
TOTAL POPULATION 2018:	22,710	111,735	23,560	67,960	26,395
PERCENT BELOW POVERTY LEVEL 2017:	13.3%	14.9%	17.2%	19.2%	13.9%
UNEMPLOYMENT 2018:	6.0%	5.4%	5.5%	6.4%	4.4%
PER CAPITA INCOME 2017:	\$38,366	\$38,752	\$31,543	\$38,446	\$41,677
MEDICARE ENROLLEES 2018:	29%	30%	27%	26%	29%
TOTAL OREGON HEALTH PLAN (OHP) ELIGIBLES 2019:	30%	32%	44%	36%	28%
UNINSURANCE RATES 2017:	5.7%	5.9%	3.1%	6.8%	10.4%
NUMBER OF ASAs:	3	9	5	12	12
NUMBER OF LICENSED TRANSPORTING EMS AGENCIES*: ..	2	5	4	8	1

* Does not include non-911 responder transporting or Air Ambulance agencies.



Participating Frontier County Demographics

	Grant	Lake	Malheur	Wallowa	Wheeler
SIZE IN SQUARE MILES:	4,529	8,371	9,941	3,151	1,715
TOTAL POPULATION 2018:	7,400	8,115	31,925	7,175	1,450
PERCENT BELOW POVERTY LEVEL 2017:	15.3%	18.9%	22.2%	13.5%	20.6%
UNEMPLOYMENT 2018:	7.3%	5.7%	4.6%	6.1%	3.5%
PER CAPITA INCOME 2017:	\$39,797	\$38,091	\$30,231	\$42,926	\$34,414
MEDICARE ENROLLEES 2018:	31%	27%	20%	33%	34%
TOTAL OHP ELIGIBLES 2019:	25%	30%	40%	28%	28%
UNINSURANCE RATES 2017:	5.7%	10.5%	10.5%	9.0%	5.7%
NUMBER OF ASAs:	1	4	6	1	3
NUMBER OF LICENSED TRANSPORTING EMS AGENCIES*: ...	1	4	3	1	3

* Does not include non-911 responder transporting or Air Ambulance agencies.



Wallowa County



Malheur County

*Legislative
and policy
champions are
needed to help
source funding
and staffing for
Oregon's rural
and frontier
EMS agencies.*

Advocacy

Independent, primarily volunteer run EMS agencies are at risk. The reality of this risk, and the potentially devastating impacts of these closures, was illustrated during one of the first Listening Tour meetings. The Mitchell ASA in Wheeler County was losing its certified responders as of June 2019. This would leave the entire southern third of the county without EMS providers. The reason? The retirement of two volunteers who had served for decades. It was noted that an increase in tourism due to the “7 Wonders of Oregon” ad campaign also brings thousands of visitors to this remote part of the state. Without a local EMS education program, and with nearly 35% of the County population over the age of 65, recruitment was proving a challenge. A lone EMT was shifted to cover the ASA but could not adequately cover all calls. The County Emergency Manager (and Undersheriff) reported that during the July 4th, 2019, holiday neighboring Spray Ambulance was called out to cover three “significant medical/trauma calls inside the Mitchell Service Area—while also covering their own ASA.”

Legislative and policy champions are needed to help source sustainable funding and staffing for Oregon's rural and frontier EMS agencies. Current payment and reimbursement models are often insufficient for rural and frontier agencies facing extreme distances for patient transport

to care. Support is needed for reimbursement reform and updated payment models that allow rural and frontier agencies to recover costs for all care provided.

Support for further exploration of the health district model as a sustainable program application is also desired. Hospital and fire-based agencies with financial staff able to submit comprehensive billing and offer career-trajectory positions provide a glimpse of what can be achieved with staff who are enabled to focus on being the best EMS providers that they can.

Program Grants

At the conclusion of the Listening Tour, ORH was able to provide nine mini-grants to participating agencies who had scored as operationally vulnerable during the site selection analysis. The following organizations received awards for EMS agency training and resources in support of sustainable program improvements:

- Adrian Quick Response Unit
- Bonanza Ambulance
- Chiloquin Fire and Rescue
- Crescent Rural Fire Protection District
- Jordan Valley Ambulance
- Lakeview Disaster Unit
- North Lake County EMS
- Silver Lake Rural Fire Protection District
- Wheeler County Emergency Management

Community Paramedicine and EMS

Community Paramedicine (CP) or Mobile Integrated Health (MIH) continues to evolve as an important care model within EMS. Programs work to redirect patients from using emergency response to meet their primary care or post-inpatient needs, or to address social determinant of health issues. Community paramedics complete home visits to help patients with medications, run tests, make living spaces safer and determine whether they need mental health or other support. The goal is to improve patient care, avoid unnecessary and expensive ambulance calls and emergency room visits and reduce hospital readmissions. Community Paramedics are EMS personnel with the ability to help with this kind of preventive and primary care more efficiently and cost effectively than a full emergency response unit. The Jefferson and Tillamook County participants reported successful implementation of CP/MIH programming, with programs being supported by grant funding and the service's hospital system, respectively. A similar CP/MIH program in rural Oregon enrolled 55 patients. After one year, analysis showed Medicaid spent 46% less on ambulance rides and 11% less on emergency care per patient per month. There are currently 21 pilot CP/MIH programs in Oregon.

“My role is to empower patients to take better care of themselves. We’re trying to help them become better self-managers...I try to be a navigator for services they may benefit from in the community”

—RURAL COMMUNITY PARAMEDIC



Malheur County



Deschutes County

EMS Provider Resources



Clackamas County

No-Cost Training and Continuing Education

OHA EMS & Trauma Webinar Series

To subscribe, access archived webinars, and watch webinars for CEUs: go.usa.gov/xUh96 > “OHA EMS & Trauma Webinar Series”

Free, live online and recorded EMS webinars.

Oregon Mobile Training Unit

www.oregon.gov/oha/ph/providerpartnerresources/emstraumasystems/mobiletrainingunit/pages/index.aspx
971-673-0533

Free, in-person EMS training on any topic, including new skills, techniques and education required for recertification.

Bound Tree University

www.boundtreeuniversity.com/classroom/

Free, online continuing education for EMTs and Paramedics. Courses are accredited by EMS1 Academy and are approved for ALS and BLS providers.

Recruitment and Staffing

Oregon Fire Recruitment Network

www.oregonfirerecruitmentnetwork.com
www.facebook.com/OregonFireRecruitmentNetwork

Resources for fire and EMS agencies to help recruit and retain firefighters and emergency responders.

Rural EMS Initiative (REMSI)

www.remsi.org | (541) 233-6355

Raises funds to promote initiatives for rural EMS agencies. Focused on training and education, financial solvency and clinical staffing.

Equipment

CPR Savers and First Aid Supply Automated External Defibrillator (AED) Grant Program

www.cpr-savers.com

Grant program covers all or part of the costs associated with purchasing an AED. Applications accepted throughout the year.

Firehouse Subs First Responder Grant

www.firehousesubsfoundation.org

Foundation provides grants for first responders and public safety organizations. Focused on Equipment, Prevention Education, Scholarships, Continuing Education, Disaster Resources, and Military Member Support. Application deadlines quarterly.

OHA EMS for Children (EMSC) Pediatric Equipment

rachel.l.ford@state.or.us | 971-673-0564

Need-based pediatric equipment distribution program for Oregon EMS agencies.

Oregon Rural Volunteer EMS Provider Tax Credit

www.ohsu.edu/xd/outreach/oregon-rural-health/

Oregon tax credit available to rural volunteer providers through Senate Bill 31. Effective through December 31, 2026.

For additional EMS resource links and information, visit the OHA EMS/TS online resource guide at: www.oregon.gov/oha/ph/providerpartnerresources/emstraumasystems/pages/resources.aspx

Data Sources and Maps

Page 4

2019 EMS Listening Tour Meeting Locations

Ong, Emerson, Data and GIS Analyst, Oregon Office of Rural Health, 2019

Page 5

ORH Defined Urban, Rural and Frontier Areas

www.ohsu.edu/media/881

Page 6

Percentage of Population in Rural and Frontier Oregon

Population numbers by zip code: Claritas 2019

Page 8

Oregon Ambulance Service Areas

Edwards, Robbie, Oregon Health Authority, EMS & Trauma Systems, 2019

geo.maps.arcgis.com/apps/webappviewer/index.html?id=1085b8a318ba4a3ba7c1e26900549077

Page 14

EMS Tour Counties: Available Education Programs

Ong, Emerson, Data and GIS Analyst, Oregon Office of Rural Health, 2019

Page 15

Medicare Enrollees By County

2018 Yearly CMS Medicare Enrollment Dashboard

www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.html

Page 16

Oregon EMS Information System (OR-EMSIS)

www.oregon.gov/oha/ph/providerpartnerresources/emstraumasystems/pages/or-emsis.aspx

Pages 17-18

EMS Listening Tour County Demographic Data

County Size: Environmental Systems Research Institute 2019

Total Population By Zip: Claritas 2019

Percent Below Poverty Level By County 2017: Census Small Area Income & Poverty Estimates

www.census.gov/programs-surveys/saipe.html

Unemployment By County 2018: Oregon Employment Department, Unemployment Rates

www.qualityinfo.org

Per Capita Income By County 2017: Census Small Area Income & Poverty Estimates

www.census.gov/programs-surveys/saipe.html

Medicare Enrollees By County 2018:

CMS Medicare Enrollment Dashboard

www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.html

Total OHP Eligible By Zip: Oregon Health Authority, Health Policy and Analytics Division, Health Analytics/HPAM Unit

Uninsurance Rate By County 2017: 2017 Oregon Health Insurance Survey

www.oregon.gov/oha/hpa/analytics/pages/insurance-data.aspx

Number of Licensed Transporting EMS Agencies: ImageTrend ePCR data, Oregon Health Authority, EMS and Trauma Systems, 2019



Marion County



Get in touch

1.866.674.4376
503.494.4450
www.ohsu.edu/orh

MAILING ADDRESS
Oregon Office of Rural Health
Oregon Health & Science University
3030 S Moody Ave, Suite 200
Portland, OR 97201

ON SOCIAL

 @ORHruralOregon
 /Oregon-Office-of-Rural-Health
 /oregon_office_of_rural_health