Multnomah County
Ambulance Service Plan
2028

Multnomah County
Health Department

TABLE OF CONTENTS

1. CERTIFICATION BY GOVERNING BODY OF COUNTY AMBULANCE SERVICE PLAN

The undersigned certify that pursuant to Oregon Administrative Rules 333-260-0020 through 333-260-0072 that:

- Each subject or item contained in the plan was addressed and considered in the adoption of the plan; and
- In the governing body's judgment, the ASA established in the plan provides for the efficient and effective provision of ambulance services; and
- To the extent they are applicable, the County has complied with ORS 682.205(2)(3) and 682.335 and existing local ordinances and rules.

Dated at Multnomah County, _____.

_____
Jessica Vega Pederson
Chair, County Board of Commissioners

Reviewed:

_____
Jenny M. Madkour
County Attorney

2. OVERVIEW OF COUNTY (DEMOGRAPHIC AND GEOGRAPHIC DESCRIPTION)

Multnomah County represents a unique intersection of dense urban infrastructure and rugged, isolated rural geography, covering approximately 1256 square kilometers in the northwestern portion of Oregon. As the smallest and most populous county in the state, it serves as the cultural, economic, and healthcare nucleus of the Pacific Northwest.

Current Census information on population (*2024 Census data*)

The demographic profile of the County is heavily weighted toward its urban centers. Approximately 98.7% of the residents live within the Urban Growth Boundary (UGB) creating a high-density environment that is concentrated in the City of Portland and the City of Gresham.

Jurisdiction	Population	Percentage of County
City of Portland	635,749	79.9%
City of Gresham	111,507	14.0%
Unincorporated Areas	16,318	2.0%
City of Troutdale	15,749	2.0%
City of Fairview	10,888	1.4%
City of Wood Village	4,866	0.6%
City of Maywood Park	820	0.1%
Total Multnomah County	**795,897**	**100.0%**

Geography

The County is geographically defined by its placement along the south side of the Columbia River and its bifurcation by the Willamette River. The western portion includes the steep, winding terrain of the West Hills, which presents significant challenges for heavy ambulance navigation and response consistency. To the east, the County encompasses the foothills of the Cascade Mountains and the Columbia River Gorge, an area characterized by limited access points and significant travel distances to Level 1 Trauma Centers.

The Willamette and Columbia Rivers are the primary geographic constraints.

- Bridges: Willamette River bridges are critical for patient and resource distribution. If key spans fail or are congested, the Westside and Eastside systems become isolated.
- The Island Barrier: Sauvie Island is connected by a single bridge (Wapato Bridge). This isolation necessitates its own self-sufficient fire district.

Subzones

The following table breaks down the county's 1256 square kilometers of land based on OAR 333-200 specific criteria.

Category	Definition	Estimated Land Area	% of County
Urban	Incorporated city of 50,000+	429 sq km	34.2%
Suburban	<10 mi from Urban OR 1,000+ /sq. mi.	216 sq km	17.2%
Rural	>10 mi from Urban AND >6 /sq. mi.	204 sq km	16.3%
Frontier	Population density of ≤ 6 /sq. Mi. + paved roads	143 sq km	11.4%
Search & Rescue	Population density of ≤ 6 /sq. Mi. - paved roads	264 sq km	21%

Subzone Description

Urban (34.2%)

This zone is comprised of **Portland** and **Gresham**. These two cities function as a contiguous urban mass. As of 2026, Gresham maintains its status as an "Urban" center with a population of ~110,015, while Portland remains the primary anchor.

- **Portland Fire & Rescue:** Provides fire protection, EMS first response, and specialized rescue for the City of Portland and unincorporated areas of Multnomah County.
- **Gresham Fire Department:** Acts as the anchor for the eastern urban zone. It

shares **Station 31** with Portland Fire to ensure seamless coverage across city borders.
- **Port of Portland (PDX):** Operates a dedicated, highly specialized ARFF (Aircraft Rescue & Firefighting) department. It utilizes a separate 911 dispatch center.

Suburban (17.2%)

This category captures the "East County" cities of **Troutdale, Fairview, Wood Village,** and **Maywood Park**. While these cities have populations under 50,000, they are contiguous to Gresham/Portland and have high densities (averaging 2,500–5,000 people per sq. mi.). This zone also includes unincorporated residential pockets like **Dunthorpe** and parts of the **West Hills** that are within 10 miles of Portland's center.

- **Gresham Fire Department:** Provides fire response for all 9-1-1 calls to the cities of Troutdale, Fairview, and Wood Village.
- **Portland Fire & Rescue:** Provides fire response for all 9-1-1 calls to Maywood Park.
- **Dunthorpe/Riverdale:** Though geographically in Multnomah County, these neighborhoods are served via agreement by Lake Oswego Fire (LOFD) and Clackamas ambulance Provider.

Rural (16.3%)

The Rural zone is defined by the transition from residential grids to agricultural and low-density forest land. It primarily consists of **Sauvie Island** (northern portion) and the **Corbett** (eastern portion) corridor. These areas are far enough from the urban core to lose the "contiguous" suburban feel but still maintain a residential presence higher than the frontier threshold.

- **Sauvie Island Fire District:** The Sauvie Island Fire District (RFPD 30J) provides fire and EMS services to the entire 32-square-mile island. Sauvie Island is unique as the island is split between Multnomah County (southern/central portions) and Columbia County (northern portion).
- **Mutual Aid:** Sauvie Island Fire District maintains mutual agreements with Scappoose Fire (in Columbia County) and Portland Fire & Rescue (Station 22/St. Johns) to provide backup for large-scale incidents or water rescues. Tualatin Valley Fire & Rescue (TVF&R) provides mutual aid response to the western hills portion of the County.
- **Corbett Fire District:** The Corbett Fire District covers an approximate 40 square mile area bordered on the west by the Sandy River, to the north by the Columbia River, to the east by the community of Bridal Veil, and the Clackamas County line is the southern boundary. The Corbett Fire District has three stations located in the communities of Aims, Corbett (main station), and Springdale.

Frontier (11.4%)

This area is almost exclusively located in the **Columbia River Gorge National Scenic Area** and the **Mt. Hood National Forest**. East of the Sandy River, the terrain becomes steep and federally protected, resulting in a density often reaching 0 people per square mile.

- **Cascade Locks Fire & EMS:** Is a Hood River County department providing fire, EMS, and rescue services. It serves the city of Cascade Locks, the Columbia River, and surrounding areas, including contracted coverage in parts of Multnomah County.

Search & Rescue Area (21%)

The Search & Rescue Area is defined as the areas of the state that are primarily forest, recreational or wilderness lands that are **not accessible by paved roads** or not inhabited by six or more persons on a year round basis. Despite being the most populous county in Oregon, nearly one-quarter of Multnomah County is considered "Search and Rescue."

Major Industries

Multnomah County's major industries include healthcare, advanced manufacturing, and athletic/outdoor apparel.

Demographics (*2024 Census data)*

Race	Population	% of Total
White	507,298	63.7%
Hispanic or Latino	114,235	14.3%
Asian	62,011	7.8%
Two of More Races	60,445	7.6%
Black or African American	41,140	5.2%
Native Hawaiian or Pacific Islander	5,415	0.7%
Other Race	3,161	0.4%
American Indian and Alaska native	2,192	0.3%
Total	795,897	100%

Multnomah County, Oregon, is experiencing a demographic shift toward an older population, with over 163,000 residents aged 60+. The median age is approximately 39 years. The largest age demographic is young adults (25–44), while the 65+ population has been the fastest-growing group.

Age	Population	% of Total
Under 18	135,291	17%
18-24	62,422	8%
25-44	278,251	35%
45-64	197,248	25%
65 and older	122,685	15%
Total	795,897	100%

3. DEFINITIONS

The following definitions establish the regulatory and operational vocabulary for this plan, ensuring alignment with ORS 682, OAR 333-250, OAR 333-260, OAR 333-265, and MCC Chapter 21.

“9-1-1 medical call” means a call requesting medical response received at the Primary Public Safety Answering Point (PSAP) that is determined by the Emergency Medical Dispatcher (EMD) to require medical triage be performed in order to determine the nature of medical need, and the appropriate response to, or disposition of, the call. All calls involving but not limited to apparent medical conditions and trauma are considered a “9-1-1 medical call.”

“Active Call Management” (ACM) means a system where non-life-threatening 911 calls are actively managed by a paramedic to determine appropriate resource allocation or delayed response.

“Advanced Care Paramedic” (ACP) means a clinician holding a valid Oregon State Paramedic license who has attained specialized **County-level credentialing** through a formal demonstration of advanced knowledge, clinical skills, and field experience. Authorized by the Multnomah County EMS Medical Director, the ACP is tasked with performing high-acuity "additional procedures" and interventions to stabilize patients during the most critical phases of pre-hospital care.

"Advanced Life Support" (ALS) means those medical services that may be provided within the scope of practice of a person licensed as a Paramedic by the Oregon Health Authority.

“Ambulance" means any privately or publicly owned motor vehicle, aircraft, or water craft that is regularly provided or offered to be provided for the transportation of persons suffering from illness, injury, or disability. All vehicles capable of providing transportation to the sick or injured and staffed with personnel trained to care for such individuals and equipped with supplies and equipment necessary for the care of the sick or injured shall be considered an ambulance.

“Ambulance Service” means a person, governmental unit, or other entity that operates ambulances and that holds itself out as providing prehospital care or medical transportation to persons who are ill or injured or who have disabilities.

"Ambulance services" means the transportation of an ill, injured, or disabled individual in an ambulance and, in connection with, the administration of prehospital medical or emergency care, if necessary.

"Ambulance Service Area" (ASA) means a geographic area which is served by one ambulance service provider, and may include all or a portion of a County, or all or portions of two or more contiguous counties.

"Ambulance Service Plan" (ASP) means a written document which outlines a process for establishing a county emergency medical services system. A plan addresses the need for and coordination of ambulance services by establishing ambulance service areas for the entire county and by meeting the other requirements of the Oregon Administrative Rules (OAR).

"Ambulance Service Provider" means a licensed ambulance service that responds to 9-1-1 dispatched calls or provides pre-arranged non-emergency transfers or emergency or non-emergency interfacility transfers.

"Authority" means the Emergency Medical Services Program, within the Oregon Health Authority, Public Health Division.

"Basic Life Support" (BLS) means those medical services that may be provided within the scope of practice of a person licensed as an EMT by the Oregon Health Authority.

"Bureau of Emergency Communications" (BOEC) means the Bureau within the City of Portland that maintains the Primary Public Safety Answering Point (PSAP) 9-1-1 telephone answering system, and provides dispatch services for police, fire and EMS for the County.

"Code 1" means a no lights and sirens response to a 9-1-1 medical call.

"Code 3" means a lights and sirens response to a 9-1-1 medical call.

"Contract Ambulance" means a private or public ground ambulance that is authorized by the County to respond to 9-1-1 medical calls.

"County" means Multnomah County, Oregon.

"Critical Care Transport" (CCT) means an ambulance providing transport between medical care facilities and providing care at the level of a hospital critical care unit.

"Dispatcher" means a public safety professional whose primary duty is receiving, processing, and transmitting emergency or public safety information through a 9-1-1 system.

"Effective provision of ambulance services" means ambulance services provided in compliance with the County ambulance service plan provisions for boundaries, coordination, and system elements.

"Efficient provision of ambulance services" means effective ambulance services provided in compliance with the county ambulance service plan provisions for provider selection.

“Eight Hundred MHz” (800 MHz) means a radio system used for communications by 9-1-1 and ambulance services throughout the county.

"Emergency" means a non-hospital occurrence or situation involving illness, injury, or disability requiring immediate medical services, wherein delay of such services is likely to aggravate the condition and endanger personal health or safety.

“Emergency Care” means the performance of acts or procedures under emergency conditions in the observation, care and counsel of persons who are ill or injured or who have disabilities; in the administration of care or medications prescribed by a licensed physician or naturopathic physician, insofar as any of these acts is based upon knowledge and skills required of an EMS provider.

"Emergency Medical Dispatcher" (EMD) means a person who is certified by the Board on Public Safety Standards and Training.

“Emergency Medical Responder” (EMR) means a person who is licensed by the Authority as an Emergency Medical Responder.

"Emergency Medical Services" (EMS) means those prehospital functions and services whose purpose is to prepare for and respond to medical and traumatic emergencies, including rescue and ambulance services, patient care, communications, evaluation, and public education.

"Emergency Medical Services Agency" means any person, partnership, corporation, governmental agency or unit, sole proprietorship or other entity that utilizes emergency medical services providers to provide prehospital emergency or non-emergency care. An emergency medical services agency may be either an ambulance service or a non-transporting service.

"Emergency Medical Services Agency Medical Director" means a physician licensed by the State of Oregon, licensed and in good standing with the Oregon Medical Board as a Medical Doctor (MD) or Doctor of Osteopathic (DO) Medicine. The Physician must also be approved by the Oregon Health Authority, EMS Program as a Medical Director agent. The EMS Agency Medical Director reports directly to and operates as an agent under the authority of the County EMSMD and is specifically assigned to an EMS agency.

"Emergency Medical Services Associate Medical Director" means a physician licensed by the State of Oregon, licensed and in good standing with the Oregon Medical

Board as a Medical Doctor (MD) or Doctor of Osteopathic (DO) Medicine. The Physician must also be approved by the Oregon Health Authority, EMS Program as a Medical Director agent. The EMS Associate Medical Director reports directly to and operates as an agent under the authority of the County EMSMD and provides specialty consultation and services.

"Emergency Medical Services Medical Director" (EMSMD) means a physician licensed by the State of Oregon, licensed and in good standing with the Oregon Medical Board as a Medical Doctor (MD) or Doctor of Osteopathic (DO) Medicine. The Physician must also be approved by the Oregon Health Authority, EMS Program as a Medical Director.

"Emergency Medical Services Provider (EMS Provider)" means a person who has received formal training in pre-hospital and emergency care and is state-licensed to attend to any ill, injured, or disabled person. Police officers, fire fighters, funeral home employees, and other personnel serving in a dual capacity, one of which meets the definition of "emergency medical services provider" are "emergency medical services providers" within the meaning of ORS chapter 682 and Oregon Administrative Rule. For the purposes of this Plan, the term 'EMS Provider' only applies to licensed individuals who are actively responding to 9-1-1 medical calls or operating on a licensed ambulance.

“Emergency Medical Technician” (EMT) means a person who is licensed by the Authority as an Emergency Medical Technician.

"EMS Program Office" means the organizational unit within the County Health Department that is responsible for the administration of the Ambulance Service Plan and EMS system in the County.

“Emergency Response” means an immediate response to a 9-1-1 medical call. An immediate response is one in which the EMS providers on an ambulance or other EMS unit begin as quickly as possible to take the steps necessary to respond to the call. An Emergency Response may involve responding with or without lights and siren.

"Expeditious (Best Effort) response" means responding to medical calls as soon as possible upon dispatch, but without a set response time requirement. An Expeditious Response may involve responding with or without lights and siren.

"First Responder" means a person or an organization that provides rapid response to 9-1-1 emergency medical calls utilizing licensed EMS provider personnel. First responders aim to arrive and provide care prior to arrival of an ambulance.

“Frontier” means the areas of the state with a population density of six or fewer persons per square mile and are accessible by paved roads.

"HEAR" means the radio frequency that may be used for ambulance-to-hospital and hospital-to-hospital radio communications.

"MCC 21.400” means the current Emergency Medical Services section of the Health chapter of the Multnomah County Code. Also cited as the Multnomah County Emergency Medical Services Code.

"Mass Casualty Incident" (MCI) means an emergency medical incident with enough injured or ill persons to meet the requirements for scene and medical management as defined in Multnomah County EMS Administrative Rules, MCI Plan.

"MED NET" means those radio frequencies that may be used for EMS dispatch, on-line medical control, and MCI communications.

"Medical Resource Hospital" (MRH) means a hospital operating under contract with the County to provide on-line medical control and advice to EMS Providers.

“Mobile Data Computer” (MDC) means an in-vehicle computer system that enables real-time data exchange between the PSAP and ambulance crews.

"Non-Emergency Ambulance" means an ambulance, licensed by the County and the Oregon Health Authority, that provides medical transportation to patients who do not require an emergency response. The level of care provided is dependent upon the patient's need.

"Notification time" means the length of time between the initial receipt of the request for emergency medical service by either a provider or an emergency dispatch center (9-1-1), and the notification of all responding emergency medical service personnel.

"On-line Medical Control" means medical direction and advice given by a physician over radio, telephone, or similar means to an EMS Provider as a supplement to written patient care protocols.

“Oregon Capacity System (OCS)” (also referred to as “HOSCAP & CHORAL") means an on-line computer system that is provided and managed by the Oregon Health Authority. The purpose of HOSCAP is to create linkages among receiving hospitals for the purpose of communicating information on the status and capacity of those hospitals for receiving patients transported by ambulance.

“Paramedic” means a person who is licensed by the Authority as a Paramedic.

“Prehospital Care” means care rendered by EMS providers or MIH as an incident of the operation of an ambulance and care rendered by EMS providers or MIH as incidents of other public or private safety duties, and includes, but is not limited to, “emergency care.”

"Provider" means any public, private, or volunteer entity providing Emergency Medical Services (EMS) or ambulance services. Also referred to as “provider agency."

"Provider selection process" means the process established by the County for selection of an emergency ambulance service provider.

"Public Safety, Answering Point" (PSAP)/ 9-1-1 means the organization that answers calls for police, fire, and emergency medical assistance that are received from persons accessing 9-1-1.

“Qualified Driver” means an individual who is not licensed by the Authority and who meets Authority requirements to operate a ground ambulance vehicle.

“Regional Hospital” means a medical facility designated to coordinate Mass Casualty Incident (MCI) or disaster situations co-located with Trauma Center Communications (TCC) and Medical Resource Hospital (MRH) which provides online medical consult for Multnomah, Clackamas, Washington, and Clark Counties, currently located within Oregon Health Science University (OHSU).

"Response Time" means the length of time between the notification of each provider and the arrival of each provider's emergency medical service unit(s) at the incident scene.

"Rural" means a geographic area 10 or more miles from a population center of 50,000 or more, with a population density of greater than six persons per square mile.

“Scope of Practice” means the maximum level of emergency or nonemergency care that an emergency medical services provider may provide.

“Search and Rescue area” means the areas of the state that are primarily forest, recreational, or wilderness lands that are not accessible by paved roads or not inhabited by six or more persons on a year-round basis.

“Standing Orders” means the written detailed procedures for medical or trauma emergencies and nonemergency care to be performed by an EMS provider issued by an EMS medical director in conformance with the scope of practice and level of licensure of the EMS provider.

“Suburban” means an area which is not urban and which is contiguous to an urban community. It includes the area within a 10-mile radius of that community’s center. It

also includes areas beyond the 10-mile radius which are contiguous to the urban community and have a population density of 1,000 or more per square mile.

“Time-critical medical call” means a request for medical service that is known or likely to represent a medical condition that could result in death or severe disability if effective treatment is not immediately provided. Examples include, but are not limited to, cardiac arrest, stroke, severe heart attack- ST Elevation Myocardial Infarction (STEMI), and severe trauma.

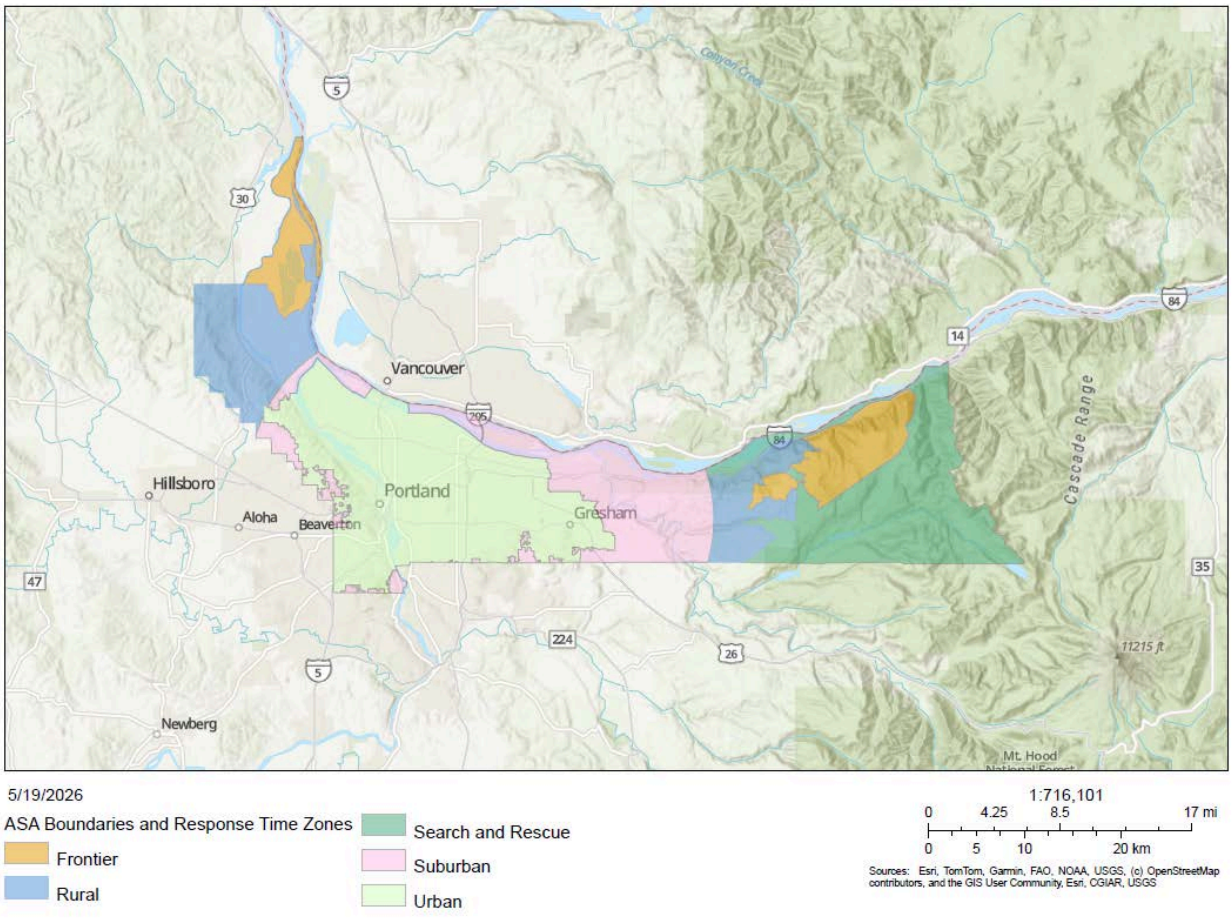
“Trauma Patient” means a person who at any time meets field triage criteria for inclusion in the Oregon Trauma System.

"Urban" means an incorporated community of 50,000 or more population.

4. BOUNDARIES

Multnomah County maintains a single, countywide Ambulance Service Area (ASA), ensuring that the administration of the 911 ambulance contract remains centralized and coordinated.

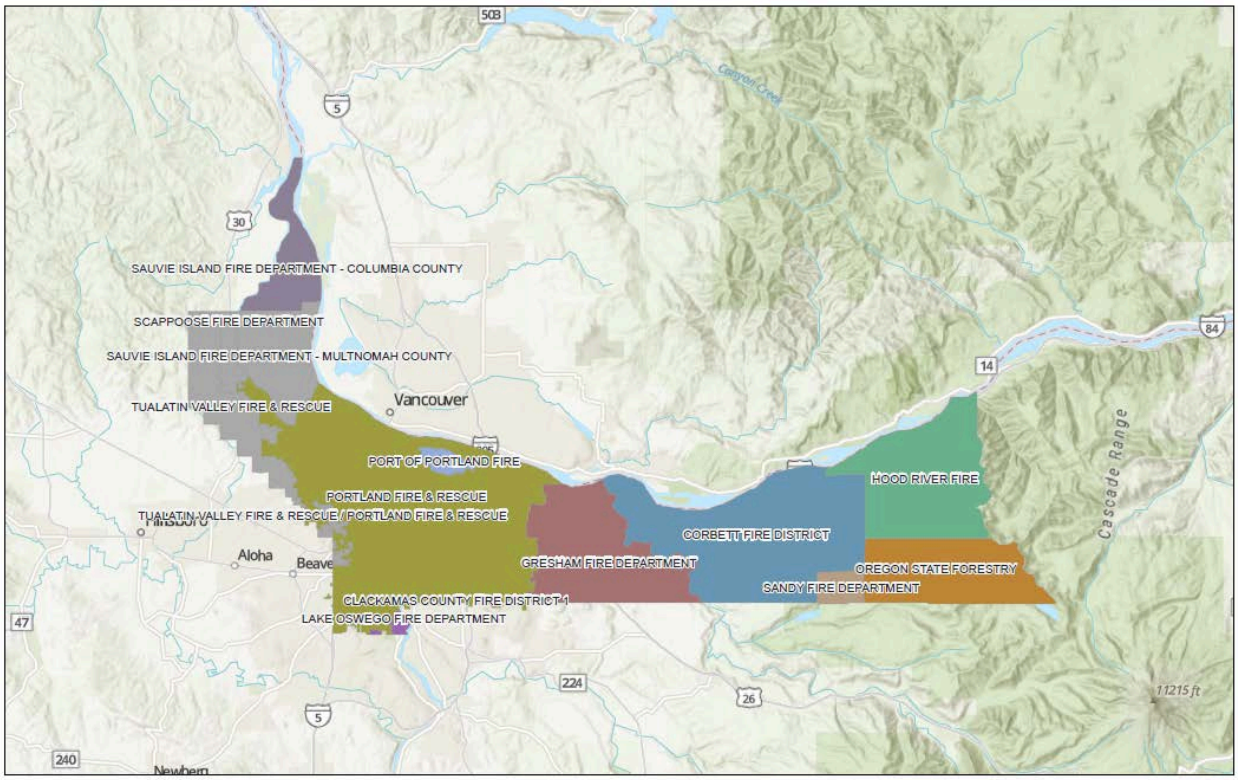
(1) A map showing ASA boundaries and response time zones



(2) ASA Narrative Description

All of Multnomah County comprises a single ambulance service area (ASA). The ASA covers the entirety of Multnomah County, from the western border with Washington County to the eastern border with Hood River County. The northern boundary is the Columbia River/Washington State line, and the southern boundary is the Clackamas County line.

(3) A map depicting all "9-1-1" fire districts and incorporated city boundaries within the county



5/21/2026

FIRE_RESPONDER_FOR_EMS_2026_03

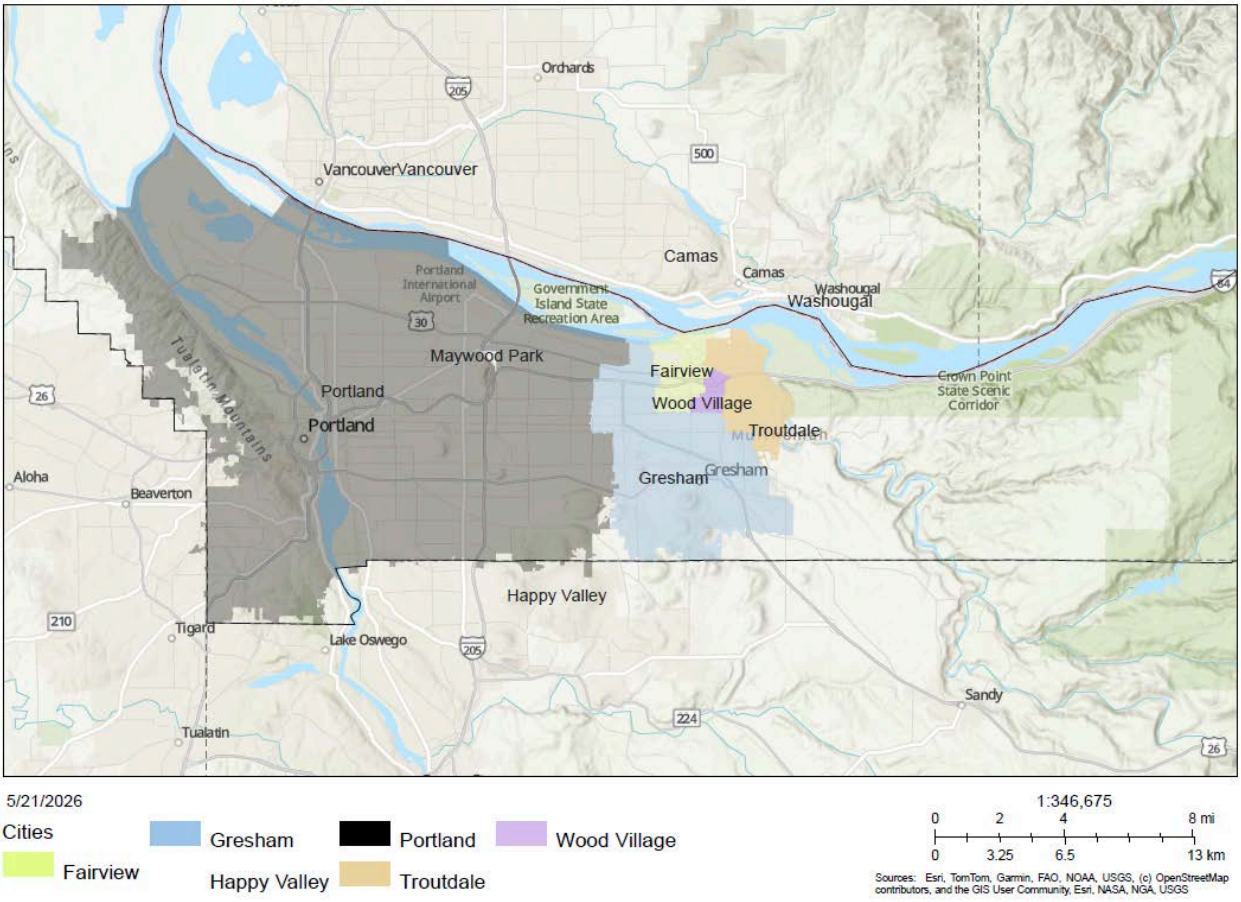
- CLACKAMAS COUNTY FIRE DISTRICT 1
- CORBETT FIRE DISTRICT
- GRESHAM FIRE DEPARTMENT
- HOOD RIVER FIRE
- LAKE OSWEGO FIRE DEPARTMENT
- OREGON STATE FORESTRY
- PORT OF PORTLAND FIRE
- PORTLAND FIRE & RESCUE
- SANDY FIRE DEPARTMENT
- SAUVIE ISLAND FIRE DEPARTMENT - COLUMBIA COUNTY
- Other

1:688,475

0 4 8 16 mi

0 5 10 20 km

Sources: Esri, TomTom, Garmin, FAO, NOAA, USGS, (c) OpenStreetMap contributors, and the GIS User Community, Esri, CGIAR, USGS



(4) Alternatives Considered for reducing the effects of artificial and geographical barriers on response times

Because of the need to provide efficient and effective service to people within Multnomah County, certain areas of the County have been deemed better served by agencies responding from outside the County. These areas are considered to be within the County ambulance service area and intergovernmental agreements specify the details of service for each of these areas. The areas affected are:

- The community of Dunthorpe.
- Portions of Multnomah County located in Lake Oswego.
- The area adjacent to Columbia County served by Highway 30.
- Eastern areas of Multnomah County contiguous to Clackamas and Hood River Counties.

In addition, Multnomah County EMS serves areas in other jurisdictions by similar agreements. These areas are:

- The north end of Sauvie Island located in Columbia County.
- Portions of the City of Portland located in Washington County.

It is the intent of this plan to foster cooperative inter-jurisdictional approaches to ambulance service area planning, management, and service to reduce negative effects on service that may be caused by jurisdictional boundaries.

5. SYSTEM ELEMENTS

(a) 9-1-1 Dispatched Calls

Access to emergencies requiring an ambulance service provider in Multnomah County is available through a 9-1-1 Public Service Answering Point (PSAP). The Bureau of Emergency Communications (BOEC) continues to serve as the PSAP for Multnomah County.

- BOEC's contact information is:
  9911 SE Bush St, Portland, OR 97266
  503-760-6911 (10-Digit Emergency)
  503-823-3333 (Non-Emergency)

The ASA contracted ambulance service provider is required to respond to all 9-1-1 medical calls when dispatched in accordance with the standards outlined in this ASP including emergency (lights and sirens) to all code 3 responses and non-emergent (no lights and no sirens) to all code 1 responses.

The responsibilities of BOEC when receiving a request for EMS services includes triaging all 9-1-1 medical calls and the dispatch of public and private safety services in the 9-1-1 service area or the relay or transfer of emergency calls to an appropriate public or private safety agency.

The PSAP, or a secondary PSAP, may be contracted to perform subsequent emergency medical triage of calls. Regardless of the entity performing emergency medical triage, triage for all calls will use the triage system approved by the County EMSMD. The triage system will include systematic mechanisms to determine the type and severity of medical emergency, provide pre-arrival instructions, and incorporate provisions to ensure the appropriate type and number of resources are used in a response. The system will include a comprehensive qualitative and quantitative quality improvement process that evaluates and addresses various aspects of medical call triage and dispatch.

Dispatch Interoperability and CAD Integration

BOEC and ambulance providers use Computer-Aided Dispatch (CAD) systems. This plan mandates the following:

- **Two-Way CAD Interface:** Implementation of a real-time data exchange between the BOEC CAD system and the ambulance provider CAD system to eliminate duplicate data entry and reduce dispatcher fatigue.
- **Co-Location of Specialized Dispatchers:** The ambulance provider System Status Plan Coordinator (SSPC) and the Active Call Management (ACM) Paramedic must

be physically located within the dispatch center to facilitate face-to-face communication and unified resource management.
- **Command Presence:** Designation of an EMS Operations Supervisor at BOEC during mass-casualty incidents (MCIs) or periods of "Level Zero" status to coordinate system-wide relief.

(b) Pre-arranged Non-emergency Transfers and Inter-facility Transfers

Ambulance services for requests other than 9-1-1 medical calls, including pre-arranged non-emergency transfers and inter-facility transfers, will be provided by ambulance providers licensed by the Oregon Health Authority using ambulances licensed and regulated by Multnomah County. This does not include life-threatening transfers that end at the Emergency Department.

See Section 6 (f) (B) for requirements for triage of request for ambulance services received by ambulance providers through channels other than 9-1-1.

Responsibility for pre-arranged non-emergency ambulance transfers and inter-facility ambulance transfers is that of the sending facility. The County ASA provider does not have the right of first refusal regarding these ambulance transports. The Board of County Commissioners may, at their sole discretion, grant the exclusive rights for non-emergency and inter-facility transfers to the contracted ambulance Provider.

Through regulation of all ambulances in the County, the EMS Program Office ensures that the primary ASA provider, or other ambulance service providers, respond to requests for inter-facility transfers and non-emergency transfers in a manner that reduces risk of patient harm.

Specialty care transfers and transfers that occur when non-contract ambulance providers cannot accept requests for transfers due to call volume are processed through the 9-1-1 system and the appropriate level and response by the ASA provider is dispatched.

(c) Notification and Response Times

Notification
BOEC’s receipt of initial call to dispatch time, or relay or transfer, for 9-1-1 medical calls shall be within 80 seconds or less 90% of the time, and measured on a monthly basis. This time will be periodically evaluated by the County EMSMD and the EMS Administrator to consider whether the standard is appropriate in light of changes in triage, dispatch, response, and other EMS system characteristics.

- Clock Start: When the 9-1-1 call is answered by the dispatcher.

- Clock Stop: When the unit is notified (tones dropped/message sent) to respond to the incident.

The 9-1-1 PSAP (BOEC) will notify ASA providers by a combination of over the air radio report, radio tones, CAD-to-CAD interface, and Mobile Data Computer (MDC) alert or other methods as appropriate. Once notified, the responding Provider units must acknowledge the call and place themselves enroute to the call.

Response Time Standards

Response time will be measured from the time BOEC dispatches, relays, or transfers a call and the unit reports arrival at the scene of the incident. Response time performance will be evaluated using data recorded by the BOEC dispatch computer. The following response time standards apply only to 9-1-1 medical calls and are compliant with the Trauma System Patient Response times as outlined in OAR 333-200-0080 (2)(b)(A)(B)(C)(D)(E). The county does not have different response times for non-trauma patients.

Response Code	Compliance	Urban	Suburban	Rural	Frontier	Search & Rescue
Life-Threatening	90%	≤ 8:00	≤ 15:00	≤ 45:00	≤ 120:00	Best Effort
Non-Immediate	90%	≤ 20:00	≤ 30:00	≤ 60:00	Best Effort	Best Effort
Non-Emergency	N/A	ACM	ACM	ACM	ACM	ACM
Non-Response	N/A	No standard	No standard	No standard	No standard	No standard
Advanced Care Paramedic	90%	≤ 12:00	≤ 22:00	≤ 60:00	Best Effort	Best Effort

Ambulance Response

Urban Response Zone

- **Life-Threatening**- Contract ambulances will be required to arrive on scene within eight (8) minutes, zero (0)seconds or less 90% of the time, and measured on a monthly basis.
- **Non-Immediate-** Contract ambulances will be required to arrive on scene within twenty (20) minutes, zero (0)seconds or less 90% of the time, and measured on a monthly basis.

Suburban Response Zone

- **Life-Threatening**- Contract ambulances will be required to arrive on scene within fifteen (15) minutes, zero (0)seconds or less 90% of the time, and measured on a monthly basis.

- **Non-Immediate-** Contract ambulances will be required to arrive on scene within thirty (30) minutes, zero (0)seconds or less 90% of the time, and measured on a monthly basis.

Rural Response Zone

- **Life-Threatening**- Contract ambulances will be required to arrive on scene within forty five (45) minutes, zero (0)seconds or less 90% of the time, and measured on a monthly basis.
- **Non-Immediate-** Contract ambulances will be required to arrive on scene within sixty (60) minutes, zero (0)seconds or less 90% of the time, and measured on a monthly basis.

Frontier Response Zone

- **Life Threatening**- Contract ambulances will be required to arrive on scene within one hundred and twenty (120) minutes, zero (0)seconds or less 90% of the time, and measured on a monthly basis.
- **Non-life Threatening**- Contract ambulances will respond in an expeditious "best effort" manner as soon as dispatched.

Search & Rescue Zone

Areas designated as Search & Rescue, contract ambulances will respond in an expeditious "best effort" manner as soon as dispatched.

Active Call Management (ACM)

In order to optimize response to severely or critically ill and injured patients, 9-1-1 medical calls that meet the requirements identified by the County EMSMD, and triaged by the PSAP dispatcher as Low Acuity, may be sent to Active Call management (ACM). Low acuity calls will be held in a separate queue within the PSAP CAD system and transferred to the ambulance provider for continued triage and monitoring. This queue will be monitored 24 hours a day, 7 days a week by a paramedic(s) who will actively manage the caller/patient to identify any change in their condition and obtain further information (when available).

(d) Level of Care

The level of service that is expected by all ASA providers is a combination of ALS and BLS when appropriate based on triage and response configurations.

The Multnomah County EMS system will utilize a combination of non-transporting first responders and transporting ambulances. There will be a single response plan for the entire ASA. The appropriate first responder if needed, appropriate ACP if needed, and

appropriate ambulance if needed, will be dispatched to each call. Need shall be determined by the County EMSMD.

The requirement is to have a minimum of two (2) Paramedics on every Life-Threatening call with one (1) of those being an ACP.

In consideration of specialty care transport services and air ambulance services, the PSAP may utilize air ambulance (helicopter) for remote rural, frontier, and search & rescue area 9-1-1 medical calls. Helicopter transport may reflect the best approach to patient care in remote areas because a patient can reach definitive care sooner than by ground ambulance when combining all time factors.

(e) Personnel

All EMS Personnel must be licensed by OHA in accordance with OAR 333-265.

First Response- Rural/ Frontier/ Search & Rescue Areas
It is the goal of this system to have all first responders trained, at a minimum, to the EMT level. Rural/ Frontier/ Search & Rescue area first responders are encouraged to have at least one (1) EMT at the scene of a medical call. It is recognized that because of the size and the volunteer nature of the Rural Fire Protection Districts serving parts of Multnomah County, this training level may not be feasible. The EMS Program Office will assist rural providers in the development and provision of training necessary to meet this goal.

First Response Urban/ Suburban Areas
Portland Fire, Gresham Fire, and Port of Portland Fire currently have all responders trained, at a minimum, to the EMT level and provide ALS first response units.

Emergency Ambulances
All ambulances providing 9-1-1 emergency medical response will be staffed to the following standards:

- **Advanced Life Support (ALS)** units will be staffed with at least one (1) person licensed to practice at the Paramedic level. The other person staffing the ambulance must, at a minimum, be licensed at the EMT level. Licensed EMS clinicians accompanying patients in the patient compartment of an ambulance must be licensed at a level appropriate for any treatment interventions initiated on scene or likely to be required during transport.
- **Basic Life Support (BLS)** units will be staffed with both persons, at a minimum, must be licensed to practice at the EMT level.

Advanced Care Paramedic (ACP)
The ACP represents the highest tier of clinical privilege within the County, ensuring that advanced interventions allowed by Oregon law are delivered by clinicians who have met the highest standards of local medical oversight.

- Operational Role and Utilization
    - The ACP serves as a required responder for all life-threatening emergencies to augment the capabilities of base BLS and ALS responders. As a versatile clinical resource, the ACP may be deployed across various platforms—including but not limited to fire-based units, quick response vehicles (QRVs), field supervisors, or as a member of a transport ambulance crew—depending on current jurisdictional deployment strategies and the availability of this provider level.
- Licensure and Scope Authority:
    - Must maintain active licensure as a Paramedic with the Oregon Health Authority (OHA).
    - Clinical authority is strictly governed by the Oregon Medical Board (OMB). While the ACP is credentialed to perform specific "additional procedures" within the county, these interventions cannot exceed the maximum paramedic scope of practice established by the State of Oregon.
- Credentialing and Competency:
    - Status is granted only after a rigorous evaluation of the clinician's knowledge, skills, and experience.
    - Candidates must demonstrate proficiency in high-risk, low-frequency interventions through a county-approved assessment.
    - Maintenance of the ACP designation requires ongoing clinical performance reviews and participation in advanced quality improvement initiatives.
- System Integration:
    - The ACP provides a consistent tier of advanced clinical expertise regardless of the initial response unit's staffing configuration.
    - They are utilized to ensure that advanced procedural mastery is present at the scene of high-consequence events, providing clinical leadership and specialized care to improve patient outcomes.

Quick Response Vehicles (QRV's)
Primarily designed as a medical response unit with at least one (1) person credentialed to practice at the Advanced Care Paramedic (ACP) level.

Active Call Management (ACM)
Will be staffed with dedicated personnel licensed to practice at the Paramedic level, and trained to the level identified and credentialed by the County EMSMD.

Non-Emergency Ambulances
Multnomah County licensed non-emergency ambulances may be staffed with EMT or Paramedic personnel, according to the level of service provided.

Additional staffing standards may be set by the County EMSMD for Critical Care Transports (CCT) or other specialized ambulance services.

(f) Medical Supervision

Each EMS agency utilizing EMS Providers must be supervised by a Physician Advisor / Supervisor licensed by the State of Oregon, licensed and in good standing with the Oregon Medical Board as a Medical Doctor (MD) or Doctor of Osteopathic (DO) Medicine. The Physician must also be approved by the Emergency Medical Services Program, within the Oregon Health Authority, Public Health Division, as a Medical Director.

The County maintains unified medical direction through the “Office of the Medical Director”, under a single County EMS Medical Director (EMSMD), who holds the ultimate authority ensuring standardization and high-quality care across the entire system. Under this model, MCEMS Agency and Associate Medical Directors work together under the County EMSMD in a formal structure with areas of focus in:

- Agency medical direction
- Dispatch
- Education and training
- Continuous Quality Assurance & Quality Improvement (QA/QI)
- Protocol development
- Credentialing

The County has developed medical supervision standards that are above the minimum standards cited in OAR 847-035 including but not limited to:

- The EMSMD will provide medical direction and advice to all components of the EMS system including but not limited to agency medical direction, dispatch, first response, and ambulance transport.
- The EMSMD will have specific authority to set uniform standards for EMS patient care for the County. These standards will include, but not be limited to:
    - Agency medical direction,
    - Dispatch and pre-arrival protocols,
    - Transport triage criteria and protocols,
    - County specific EMS Provider requirements, approved equipment, supplies, and medications,
    - Credentialing standards,
    - Patient care protocols,

    - Medical criteria for response times, including designation of calls as Life-Threatening, Non-Immediate, Non-Emergency, and Non-Response.
    - Patient transfer criteria.
- The EMSMD will assist rural volunteer fire districts in meeting the state standards for EMS Provider training.
- The EMSMD will ensure that all providers within the system participate in a quality management program designed to provide for continuous quality improvement in patient care and all other aspects of emergency medical services. This process will provide the basis for changes in medical care protocols, and for the educational and training standards set forth by the EMSMD.
- The EMSMD may, at his or her discretion, appoint Agency and Associate Medical Directors to help carry out the duties assigned to the EMSMD. The EMSMD however, retains the sole responsibility for all assigned duties.
- The EMS program will provide office and administrative support to the office of the EMSMD.

EMS Medical Direction is further defined in the Multnomah County Code 21.400, and EMS Administrative Rules.

Each EMS agency may be supervised by an EMS Agency Medical Director who reports directly to the County EMS Medical Director. EMS Agency Medical Directors are dedicated to providing medical consultation services directly to a specific EMS agency. EMS Agency Medical Directors are employed by the County and are expected to work directly with the EMS agency to adopt and implement standards and ensure expectations set by the County EMSMD. All Agency Medical Directors will meet regularly with the County EMSMD or their designee.

On-Line Medical Control
On-line medical control will be provided by a Medical Resource Hospital (MRH). Standards for on-line medical control and MRH operations will be set forth by the County EMSMD and implemented through a performance contract with the hospital chosen as MRH. The County EMSMD will monitor the performance of the MRH contract.

(g) Patient Care Equipment

Requirements for equipment and supplies will be determined by the County EMSMD according to the level of service provided (e.g. emergency ALS & BLS, non-emergency ALS & BLS, CCT, and ACP) and are above the minimum standards cited in OAR 333-255-0072. First Responders, ambulances, and medical response units are required

to carry equipment, medications, and supplies in quantities determined by the County EMSMD consistent with the approved protocols.

Additional County-specific requirements are outlined in the ambulance inspection form which is divided by the OHA requirements and the EMS Program Office requirements. Ambulance inspection forms are available on the EMS Program Office website.

(h) Vehicles

All ambulances must be licensed by the Oregon Health Authority and the EMS Program Office, meeting the standards for ALS, BLS, or CCT vehicles. Ambulances shall be in good condition and, at a minimum, comply with the standards set forth in OAR 333-255-0060, OAR 333-255-0065, and OAR 333-255-0072.

(i) Training

All EMS Providers must meet minimum standard initial education and licensing requirements as set forth in OAR 333 Chapter 265, and any additional education or training required by the County EMSMD.

Continuing education required by the County EMSMD will be carried out through a coordinated educational program that meets the minimum requirements set forth in OAR 333-265-0110 and OAR 333-265-0140.

The County EMSMD will establish system-wide criteria that meet the training needs of all levels of EMS Providers. These criteria will also help ensure that all personnel receive appropriate and consistent training. The content offered will reflect the outcomes and findings of the quality improvement process. In-service training may also address a range of equity issues, including ethnic and cultural diversity, as determined by the EMS Program Office.

The EMS Program Office will provide mandatory joint in-service sessions between first response and ambulance personnel to introduce changes in patient care protocols, state and local administrative rules, state requirements, and other pertinent information. All EMS Providers will be required to attend mandatory training to maintain credentialing as approved by the County EMSMD.

The County or Agency EMSMD may require individual EMS Providers to obtain additional training and education based on performance.

Provider agencies will offer training and education to their employees and other EMS Providers in the system, as approved by the County EMSMD, and as part of the coordinated EMS educational program.

(j) Quality Improvement

The EMS Program Office Quality Improvement process is in compliance with OAR 333-260-0050(3)(a), (b) and (c).

(A) Structure:
The basis for EMS system quality improvement in the County will be a Continuous Quality Improvement (CQI) process. The CQI program is an inclusive, multidisciplinary process that focuses on identification of system-wide opportunities for improvement and monitors compliance with pertinent protocols, clinical care statutes, ordinances, and rules.
The EMS Program Office will monitor and track systems as part of the EMS quality improvement program as outlined in OAR 333-250-0320.

The County EMS CQI process utilizes evaluation methods that are based on system structure, processes, and outcomes to monitor the quality improvement program's quality and standards. The County's response to when quality or standards fail to meet requirements focus on identification of the root causes of problems. The EMS Program Office's Quality Improvement Plan includes interventions to mitigate or eliminate these root causes, and to develop steps to correct or improve inadequate or faulty processes.

County efforts are both proactive and retrospective, and draw upon quality improvement efforts from a variety of industries including the published sources of the National Association of EMS Physicians.

The EMS Program Office CQI program is administered by the County EMSMD, or delegated to the Agency, and Associate EMSMD's.

- **Program Name:** Multnomah County EMS CQI Committee
- **Members:** Representatives of
    - EMS Program Office
    - EMS & first response agencies,
    - County EMSMD,
    - Agency EMSMD,
    - Associate EMSMD, and
    - Local hospitals and specialty care.
- **Roles & Duties:**
    - To discuss clinical quality issues.
    - To enhance and improve County treatment protocols and overall care delivery.
    - To review pertinent EMS topics (e.g., trauma, cardiac, stroke/seizure, respiratory distress, airway management, pediatric, OB, behavioral health, etc.) and correlate to current treatment protocols.

    - To provide feedback and education to Providers as appropriate.
- **Meeting Frequency:** Monthly

(B) Process:
Implementation of CQI will involve the education of EMS personnel in the CQI process, development of data, and implementation of data analyses to support the process.

The CQI process for monitoring compliance includes analyzing operational and clinical data on all aspects of the EMS system including dispatch, prehospital provider notification times, response times, medical supervision and control, patient care, EMS Provider and EMD performance, and other components. The data will come from a variety of sources including but not limited to: triage, dispatch, first responder and ambulance provider agencies, and hospitals. Specific data can include computer databases, patient care charts, chart reviews and audits, incident reports, patient complaints and patterns of complaints, and patient outcomes. The results of the process are information, problem-solving, and system improvement. These outcomes will serve as the basis for system change.

It is not the purpose of the CQI process to impose sanctions or other remedies on non-compliant providers. It is the purpose of the Quality Assurance (QA) process to ensure compliance with EMS clinical care standards, County laws, and rules that may result in sanctions or other remedies as described below.

The EMS office will provide staff support for the CQI process.

(C) Sanctions for Non-Compliant Personnel or Providers:
Sanctions imposed for inadequate performance on the part of provider agencies or individual EMS providers for violations of EMS clinical care standards, County laws, and rules are identified in the contracts with providers, or MCC 21.441. Any remedies directed to individual EMS Providers will be the primary responsibility of the County EMSMD.

The contracts with first response and the single contracted emergency ambulance provider will specify fines or other sanctions that will be imposed if certain contract conditions are not met. In addition, the contracts will identify conditions that will constitute a breach of contract, and the conditions and procedures for termination of the agreements.

MC Code and EMS administrative rules currently allow for sanctions for non-compliance. Sanctions include fines, license suspension, and license revocation. These sanctions may continue as part of the licensing process for both contract and non-emergency ambulances.

6. COORDINATION

(a) The Entity That Shall Administer and Revise the ASA Plan

Multnomah County Code 21.400 delegates authority and responsibility for the implementation, regulation, coordination, and enforcement of the ASP to the Health Department's EMS Administrator. Similarly, MCC 21.400 establishes the position of County EMS Medical Director and outlines the duties, authorities, and responsibilities of that position. The County EMS Medical Director oversees clinical standards.

(b) Complaint Review Process

Each EMS provider agency is required to forward any complaints it receives regarding its actions or services to the EMS Program Office, regardless of the source of the complaint. The EMS Program Office will forward any complaint received about an EMS provider agency to that agency on a timely basis. EMS provider agencies are required to notify the EMS Program Office of the agency's final resolution or disposition of the complaint within thirty (30) days.

The EMS Program Office will also track each complaint. The EMS Program Office may conduct an independent review of the complaint, and take additional steps to resolve the complaint if appropriate. Information relevant to the complaint will be collected and reviewed by EMS Program Office staff. Information may include dispatch records, patient care reports, invoices for service, incident reports, hospital records, interviews, and other information.

The EMS Program Office will resolve complaints through three mechanisms:

1. Medical care complaints will be referred for Medical Case Review, currently conducted by the EMS Quality Assurance Committee. This Committee reviews the case from an EMS system perspective, and makes procedural and system-level recommendations.
2. Dispatch and system response complaints will be initially reviewed by EMS Program Office staff. Complaints may be referred to the Dispatch Committee for review and recommendation. Individual case dispositions will be handled by the EMS Program Office.
3. Complaints about ambulance charges and other non-medical provider-related complaints will be reviewed by the EMS Program Office staff, who will be responsible for the disposition of each case.

If the EMS Program Office determines that it is appropriate, it may refer a complaint to other agencies for review and resolution (e.g., complaints that may involve criminal conduct may be referred to the District Attorney).

The EMS Program Office can receive complaints, concerns, or other input from the community, prehospital care providers, consumers, or others by emailing the appropriate EMS Program Office staff listed on the EMS Program Office website, calling the EMS Program Office at 503-988-3220, or mailing to:
Emergency Medical Services
619 NW 6th Ave, 6th Floor
Portland, Oregon 97209

(c) Mutual Aid Agreements

The EMS Program Office recognizes the importance of both receiving and providing ambulance mutual aid. The County's emergency ambulance provider shall maintain mutual aid agreements with surrounding ambulance providers. The agreements must specify the duties and responsibilities of the agreeing parties.

All requests for mutual aid to the ambulance provider may be honored as long as minimum county ambulance coverage level is met. Requests and coordination for mutual aid assistance shall be the responsibility of the ambulance service area ambulance provider.

All mutual aid agreements must be approved by the EMS Program Office.

All mutual aid agreements among ASA providers within the County and neighboring counties, will be on file with the EMS Program office. These agreements can be accessed by contacting the EMS Program Office at: 503-988-3220.

(d) Disaster Response

Multnomah County's disaster response will vary depending on the nature, size, and scale of the event. Direction for the County's overall EMS response will come from the Multnomah County EMS Operations Protocols, Mass Casualty Incident (MCI) plan, and Emergency Management disaster plans.

(A) County Resources Other Than Ambulances
Cities, fire departments, and fire districts providing coordinated response with EMS will operate using Multnomah County EMS Operations Protocols, Mass Casualty Incident (MCI) plan, and Emergency Management disaster plans.

(B) Out of County Resources
The EMS Administrator (or BOEC, per protocol) may request out-of-county resources through those jurisdiction's emergency managers. A resource list of potential responders is maintained at BOEC.

(C) Mass-Casualty Incident Plan
The County's Mass Casualty Incident (MCI) plan is developed by a multidisciplinary, tri-county committee and is adopted and codified in MCC 21.439. This plan, and similarly adopted plans used by the counties surrounding Multnomah County, provide the direction for the organization and use of resources if there is an MCI. This plan is also incorporated as an appendix in the emergency management disaster plans of the County and other local jurisdictions.
In an MCI, medical communication and patient destination is the responsibility of the Regional Hospital. The Regional Hospital is designated by the EMS Program Office in conjunction with other affected counties.
The County's Mass Casualty Incident (MCI) plan can be accessed by contacting the EMS Program Office at: 503-988-3220.

(D) Response to Terrorism
EMS providers have established roles and responsibilities under the National Incident Command System (ICS).

(e) Personnel and Equipment Resources

Requirements for personnel, equipment, and supplies will be determined by the County EMSMD according to the level of service provided. All EMS personnel must be licensed by OHA in accordance with OAR 333-265, and all equipment and supplies are above the minimum standards cited in OAR 333-255-0072.

(A) Non-transporting EMS Provider
City fire departments, rural fire protection districts, ambulance providers, and jurisdictions provide first response services for the entire county. Each fire department, district, and jurisdiction determines deployment patterns necessary to provide emergency responses for fires, rescue situations, and medical calls. It is the goal of the County to have medical first response on all time-critical 9-1-1 medical calls, and all calls that require specialty rescue, extrication, or non-medical technical response. The scope and intensity of medical services provided by fire departments, districts, and jurisdictions may evolve over time.

(B) Hazardous Materials
HAZ-MAT response is the responsibility of the fire districts and departments within Multnomah County. HAZ-MAT response plans include identifying the hazard, its effect on people, and the appropriate actions for neutralizing the hazard, decontaminating exposed people and environments, and providing necessary medical care in the pre-hospital setting. Transport and receiving hospital standards for exposed patients are coordinated through HAZ-MAT, special operations teams, and the receiving hospitals. Hazard evaluation is done on a frequent basis with involvement from the specialty

teams, County EMSMD, and hospital representatives. The standards and procedures vary based on the nature of the exposure.
During a hazardous materials incident, ASA provider(s) would contact the PSAP to access the resources needed.
In the event the PSAP is inoperable, the direct contact information for each HAZ-MAT agency is:

- Portland Fire HazMat- 503-823-3946
- Gresham Fire HazMat- 503-618-2355
- State Fire Marshal HazMat- 503-563-8819

(C) Search and Rescue
Search and rescue operations are the responsibility of the Multnomah County Sheriff. The Sheriff's Office serves as incident commander for search and rescue operations. EMS and fire responders provide resources as required by the incident commander.
During a search and rescue incident, ASA provider(s) would contact the PSAP to access the resources needed.
In the event the PSAP is inoperable, the direct contact information for each search and rescue agency is:

- Multnomah County Sheriff- 503-988-4300

(D) Specialized Rescue
Multnomah County, through the fire departments and districts, has the following specialized rescue abilities:

- High Angle Rescue
- Trench Rescue
- Dive Rescue

There are no specialized medical components to these rescue services. Medical care is provided by Fire EMS Providers assigned to the rescue teams.
During a specialized rescue incident, ASA provider(s) would contact the PSAP to access the resources needed.
In the event the PSAP is inoperable, the direct contact information for each specialty rescue agency is:

- High Angle Rescue
    - Portland Fire- 503-823-3700
    - Gresham Fire- 503-964-4777
- Trench Rescue
    - Portland Fire- 503-823-3700
    - Gresham Fire- 503-964-4777
- Dive Rescue
    - Portland Fire- 503-823-3700

(E) Extrication
Multnomah County, through the fire departments and districts, has access to extrication capabilities.
During an extrication incident, ASA provider(s) would contact the PSAP to access the resources needed.
In the event the PSAP is inoperable, the direct contact information for each extrication agency is:

- Portland Fire- 503-823-3700
- Gresham Fire- 503-618-2355

Other
Special Emergency Response Team (SERT)
Fire-based paramedics provide dedicated tactical medical support to law enforcement operations. This is a function controlled by the police and not part of the normal EMS response. SERT Liaisons coordinate with the EMS Program Office.

(f) Emergency Communication and System Access

Multnomah County is served through a single Public Safety Answering Point (PSAP, 9-1-1 center) accessible by callers through 9-1-1. The Port of Portland operates a secondary PSAP.

(A) Telephone
The City of Portland Bureau of Emergency Communications (BOEC) provides emergency medical triage and pre-arrival instructions. In addition, BOEC provides similar telephone services for all police departments and fire departments and districts in the county.

- Centralized access numbers available to the public
  311 (Non-Emergency)

- BOEC
  503-760-6911 (10-Digit Emergency)
  503-823-3333 (Non-Emergency)

- Port of Portland Communications Center
  Non-emergency: 503-460-4747
  Emergency: 503-460-4000

(B) Dispatch Procedures
The dispatch of ambulance services according to established protocols and medical standards of Multnomah County. The County EMSMD is responsible for all dispatch and pre-arrival protocols as defined in the Multnomah County Code 21.400, and EMS Administrative Rules.

9-1-1 medical calls are initially processed using a “criteria based" triage system by a call-taker who is certified as an Emergency Medical Dispatcher (EMD). The call-taker determines the nature of the call and the level of emergency or non-emergency response required. Call information is then sent (via computer) to an EMS dispatcher who is also EMD-certified. Through a computer aided dispatch system (CAD), the status of all fire units and ambulances are available to the dispatchers. The dispatchers will send fire and/or ambulance units, as appropriate per protocol, depending on the location of the incident/request.

(C) Radio System
All EMS providers must have the capability of operating on the BOEC radio frequencies. This is an 800 MHz system and is used as the primary communication mode for day-to-day operations. Backup capability is available through a Very High Frequency (VHF) radio system.

Agencies will ensure that interoperability (access to the same radio frequencies) with neighboring mutual aid responders is accessible at all times - i.e., in addition to the normal everyday operations on the 800 MHz radio system.

All EMS Providers will ensure they have access to the Medical Resource Hospital (MRH) radio frequency.

All Ambulances will have access to the Hospital Emergency Access Radio (HEAR) system.

All EMS personnel will have access to the VHF disaster interoperability frequencies as directed by the EMS Program.

Non-Emergency providers are required to ensure at a minimum HEAR and MRH interoperability with emergency providers for the coordination of activities in the event of a disaster within the County.

(D) Emergency Medical Services Dispatcher Training
All Emergency Medical Dispatchers (EMDs) are trained to meet Emergency Medical Dispatcher standards set forth by the Oregon Department of Public Safety Standards and Training (DPSST).

The County EMSMD is responsible for the medical supervision, medical protocols used by dispatchers and may set forth additional requirements.

7. PROVIDER SELECTION

(This section intentionally left blank and will be completed after review by Purchasing)

8. COUNTY ORDINANCES AND RULES

The Multnomah County Board of County Commissioners established Multnomah County Code 21.400 to specifically address Emergency Medical Services and County EMS Administrative Rules.