

<p>EMS Operations Subcommittee Meeting  Bureau of EMS and Preparedness  Wednesday, February 12, 2014  1:00 p.m.</p> <p>Location: Bureau of EMS and Preparedness  3750 South Highland Drive  4th Floor Conference Room 425  Salt Lake City, Utah 84114  Reporter: Susan S. Sprouse</p>	<p>1 February 12, 2014 1:00 p.m.  2 PROCEEDINGS  3 ***  4 TRACY BRAITHWAITE: I'd like to welcome  5 everybody. I'm Tracy Braithwaite from North Sanpete  6 Ambulance. Let's go around and introduce ourselves. Make  7 sure you speak clearly so Susan can record everything that  8 we are doing. So I'll go to my right here.  9 ERIC BAUMAN: I'm Eric Bauman from Ogden City  10 Fire Department.  11 CHRIS DELAMARE: Chris Delamare from Gold Cross  12 Ambulance.  13 ANDY SMITH: Andy Smith, Grand County EMS.  14 DENNIS WYMAN: Dennis Wyman, paramedic adviser  15 for Davis County Sheriff.  16 GUY DANSIE: Guy Dansie, Bureau of EMS.  17 JENNY ALLRED: Jenny Allred, EMS.  18 KRIS KEMP: Kris Kemp, Chair, EMS Committee.  19 TRACY BRAITHWAITE: And then do you want us  20 to --  21 GUY DANSIE: I don't care. What do you think,  22 Tracy?  23 TRACY BRAITHWAITE: And then those on the phone?  24 GUY DANSIE: Joseph Bach from Logan Fire and  25 Shelly Peterson from Logan Dispatch.</p> <p style="text-align: right;">Page 3</p>
---	---

<p style="text-align: center;">A P P E A R A N C E S</p> <p>Guy Dansie  Tracy Braithwaite  Dr. Peter Taillac  Suzanne Barton  Dennis Wyman  Andy Smith  Chris Delamare  Eric Bauman  Kris Kemp  Jenny Allred  Joseph Bach (Phone)  Shelley Peterson (Phone)</p> <p style="text-align: right;">Page 2</p>	<p>1 TRACY BRAITHWAITE: All right. We'll jump right  2 in to look at our minutes from the last meeting. We  3 didn't have a quorum, but we still managed to get some  4 things done, I think. Everybody have a chance to read  5 through those?  6 CHRIS DELAMARE: I move to approve again, but do  7 we -- is this considered a quorum?  8 TRACY BRAITHWAITE: I don't think so at this  9 point. So we will say okay, we'll take that  10 recommendation to move that to accept the minutes.  11 Anybody second?  12 CHRIS DELAMARE: Do you want to second that?  13 ERIC BAUMAN: I will second that. Yes, I'll  14 second that. Sorry.  15 CHRIS DELAMARE: Appreciate that.  16 TRACY BRAITHWAITE: Okay. Anybody opposed?  17 Okay. So we'll just table that for now.  18 GUY DANSIE: Recommend they are approved?  19 TRACY BRAITHWAITE: Recommend they are approved  20 once we get a quorum, and then we'll just move on to Guy  21 with the paramedic thing.  22 GUY DANSIE: Yeah, before I get started on that,  23 just let me just say that we're at that time of year where  24 we probably need to reexamine, I know we've had quite a  25 few members that are absentee and we probably need to go</p> <p style="text-align: right;">Page 4</p>
--	---

1 back through the list and those that are not participating  
 2 anymore reappoint new folks for those positions so we'll  
 3 have our quorums back.  
 4 And also, you know, any agenda items, things  
 5 like that, I know a couple of years ago we were told that  
 6 the EMS Committee should direct our agenda and we've been  
 7 doing that. But if there are items that you can see and  
 8 know that we need to discuss, let's bring that and I will  
 9 suggest that to the EMS Committee and we can hopefully  
 10 make this a little bit more meaningful for everybody. So  
 11 we'll work on that a little bit just for why?  
 12 As we start into this paramedic in the  
 13 community -- it's called something else -- I want to  
 14 introduce Clare Baldwin. He's city fire. I guess, you're  
 15 kind of the point person for this program. Maybe you can  
 16 just explain what it's about, some of the operational  
 17 issues, give us an overview.  
 18 CLARE BALDWIN: Do you want me to stand or --  
 19 GUY DANSIE: Anything that's comfortable for you  
 20 to sit, stand, whatever.  
 21 CLARE BALDWIN: There's -- we've been working on  
 22 the project for a little over a year. It's going on close  
 23 to a year and a half now. We started off by evaluating  
 24 what's already been going on in the rest of the country.  
 25 And we also looked at the needs that we had that were

Page 5

1 peculiar to Salt Lake City.  
 2 And what we're doing won't necessarily work for  
 3 the rest of the State. It -- it -- a lot of it has to do  
 4 with the demographics of each city. And we identified  
 5 through, going through the ACOs that are existing in the  
 6 state already, that's the Medicaid Program how that's  
 7 operated, and we found out that 67 percent of the  
 8 demographics, either low income, low pay or no pay  
 9 patients reside within Salt Lake City proper. So we know  
 10 that we've got a big problem. We know that we're having a  
 11 lot of recidivism with people calling all the time and  
 12 trying to figure out what to do. And everyone who has  
 13 been involved with EMS for any number of years knows that  
 14 the problem has always been there, and us taking people to  
 15 the hospital in the back of an ambulance is really a waste  
 16 of resources and a waste of money.  
 17 And one of the things, you know, right now the  
 18 legislature is looking at allocating more money to the  
 19 Medicaid system to pay for ambulance rides. And I would  
 20 advocate that that is not a good idea. I believe that  
 21 there are alternative methods that we could use. And Jim  
 22 Hansen and I discussed this a little bit last week. But  
 23 the alternative methods of transport that are out there,  
 24 other than ambulance, is really where we need to direct  
 25 our efforts and our resources because we know that we

Page 6

1 transport at least 40 percent of the people unnecessarily.  
 2 They do not need to go in an ambulance. We're  
 3 transporting them because they don't have other means of  
 4 transportation.  
 5 And if you look at the No. 1 reason that people  
 6 call 911 unnecessarily, it is because they don't have  
 7 transportation. And No. 2 is they don't have access to a  
 8 PCP in a reasonable timeframe. So they try to get into a  
 9 PCP. They can't. They're three, four months out. So  
 10 they call 911. And we know that that's -- that's a bad  
 11 thing too.  
 12 So we started to develop in two pieces. We've  
 13 got Emergency Communication Nurse System. The Utah  
 14 Hospital Association with the graciousness of the four  
 15 hospital organizations within the state are supporting our  
 16 Emergency Communication Nurse System in a pilot program  
 17 for two years.  
 18 We -- the money has -- it's been approved. It's  
 19 not all been collected, but it's close and the City  
 20 Council in Salt Lake approved for us to move forward and  
 21 use those funds to institute the nurse into our dispatch  
 22 center.  
 23 Part of it -- one of the things we didn't bring  
 24 out when we presented this to the EMS Committee is that in  
 25 order to do the ECNS nurse, you have to have an accredited

Page 7

1 dispatch center. And right now there's only one in the  
 2 state of Utah. And so you -- and the reason is because in  
 3 order to move -- the way it works is a call comes in, it  
 4 goes through the normal dispatcher. The dispatcher ends  
 5 up coding the call as a low acuity call or an omega call.  
 6 Then that call is transferred out of the CAD to the nurse.  
 7 Then the nurse takes the call, and this is  
 8 called -- it doesn't necessarily even need a response but  
 9 it may need just what we call a directory of resources.  
 10 So with the directory resources, we have some  
 11 clinics, I guess, that have agreed with us as partners to  
 12 take X number of patients per day as referral from the  
 13 nurse so that the nurse will be able to actually get PCP  
 14 appointments and make the arrangements to get them there.  
 15 The other resources we have are -- they are  
 16 vast. They are -- there are some of the ACOs, there's  
 17 keep -- making sure we keep people in network. We're not  
 18 doing case management per se. We're still using case  
 19 managers in the individual hospitals.  
 20 And then the other thing is that the nurse can  
 21 send out our mobile health paramedics. Right now we have  
 22 one unit. We only go out on Tuesdays and Wednesdays. So  
 23 making appointments is really the only way for this to  
 24 work.  
 25 We found that if we go out and do cold calls, we

Page 8

1 just show up on their doorstep, our chances of getting in  
 2 are only about 20 percent. So we're trying to get  
 3 everyone that's making referrals to us for our mobile  
 4 health paramedics to go out, to get a phone number for the  
 5 patient that we're going to see.  
 6 So we looked at the things that we're going to  
 7 do or try to do while we're there making these home  
 8 visits. And primarily it's not so much patient care as it  
 9 is psychological, mental health, social issues. These are  
 10 the things that are getting people to call 911 on a  
 11 regular basis, not so much -- they may have chronic health  
 12 issues that are underlying everything, but they are  
 13 calling because of either a lack of support or finding  
 14 that they don't have identification. So when they try to  
 15 get help in other ways, they hit a stone wall and they are  
 16 not able to get that help because they don't even have  
 17 I.D. So we're -- we've even gone so we're helping to  
 18 research out of state with birth certificates and all  
 19 kinds of stuff to -- to help them with those types of  
 20 things.  
 21 Others are getting them to the proper level of  
 22 care. Do they need home health? Home health quite often  
 23 is available but a vast number of people that we are  
 24 dealing with, either there's a literacy to a degree or  
 25 there are other issues that are keeping them from being

Page 9

1 able to gain access to the help they need. So our mobile  
 2 health paramedics are taking the time to do that.  
 3 So an average call when they go out and get in  
 4 is taking anywhere from an hour to two hours. It's not  
 5 something where you just show up. It's not normal  
 6 emergency medicine. So it takes a particular skill set by  
 7 the paramedic. It takes a tremendous amount of patience.  
 8 It may take 10 visits of once a week or maybe once every  
 9 other day.  
 10 And so that's where we are right now in this.  
 11 And we feel like it's not really necessary to go down the  
 12 road that some others have; where there's a program out of  
 13 Colorado that is actually to the point where it's a full  
 14 year, and when you are done, it's -- you're just a little  
 15 bit short of being a physician's assistant. And we do not  
 16 believe that's where we need to go, because it's those  
 17 social, psychological mental health issues that are --  
 18 seem to be the things that are the commonality of our  
 19 patients.  
 20 So we work with the MCOT team that works out of  
 21 UNI. We use them a lot to help us with the mental health  
 22 issues as well as we -- we rely on Fourth Street also.  
 23 And right now we're not focusing on homeless without  
 24 addresses. We're letting the team from Fourth Street,  
 25 they have their own team that goes out and deals with that

Page 10

1 populace. And they've got that dialed in. So we didn't  
 2 feel like it was good to duplicate services.  
 3 When I say homeless without an address, we have  
 4 four housing units in the valley that are permanent  
 5 homeless housing and we do go there. So that home court  
 6 is one of the major places that we go into on a regular  
 7 basis, as well as we go into corrections, some of the  
 8 correction facilities that are in the cities also.  
 9 So anyone have any questions, anything that's --  
 10 I'm not explaining or haven't explained that are wondering  
 11 about?  
 12 GUY DANSIE: One thing that we discussed this  
 13 morning with the Professional Development Subcommittee was  
 14 the dispatch and how that took place. I guess, do you  
 15 have to do some specific dispatch protocols or how are you  
 16 dealing with that?  
 17 CLARE BALDWIN: Well, what we are doing is we go  
 18 on the air, mobile health responding to such and such an  
 19 address. So we're not being dispatched by dispatch.  
 20 We make the appointments and we go on the air.  
 21 And the reason we are going on the air and telling them  
 22 where we are going and that we have arrived and then when  
 23 we are clear is for accountability purposes, not for  
 24 dispatch purposes. So we're not going through the CAD on  
 25 the mobile health paramedic side at all.

Page 11

1 So we're either getting referrals from the  
 2 emergency departments at the respective hospitals, we're  
 3 getting referrals from the crews themselves, or we're  
 4 getting referrals eventually from the nurse.  
 5 PETER TAILLAC: But you're not taking an echo or  
 6 omega call and shifting that from dispatch to the nurse  
 7 navigator?  
 8 CLARE BALDWIN: Omega calls will be shifted from  
 9 the -- from the dispatcher to the nurse. The nurse will  
 10 be a certified dispatcher.  
 11 So the first thing they have to do is be a  
 12 dispatcher. Then the second part is they have to go  
 13 through a special training course. And it's done through  
 14 priority dispatch with us. And then you also have to  
 15 install a new version of ProQA on every single dispatch  
 16 console in the entire center.  
 17 So instead of having ProQA, you have it on LOCO.  
 18 And LOCO is just a different version that includes the  
 19 nurse navigator in the system.  
 20 And the -- the biggest thing as the call comes  
 21 down and gets transferred out to the nurse, once it  
 22 transfers out, it removes that call from the CAD. So  
 23 essentially it's like it ends the call because it's been  
 24 resolved by sending it to the nurse.  
 25 Now if the nurse decides, hey, this call needs

Page 12

1 to be upgraded and put back into the CAD and be dispatched  
 2 as an emergency, then they -- they run it back up. And  
 3 all of the information that's been gathered by the initial  
 4 dispatcher, call taker, and then whatever the nurse has  
 5 added to that, you know, to the dialogue, at that point  
 6 that's all saved and moved back up. And then they can go  
 7 ahead and dispatch.

8 PETER TAILLAC: That's not in place yet  
 9 obviously?

10 CLARE BALDWIN: It's not. It's not. And we're  
 11 looking -- we were approved to use the funds. The funds  
 12 aren't completely here yet. We're still probably looking  
 13 at about four to five months before it is up and running.  
 14 That's the -- the reality is that everything you want to  
 15 do takes, like, 10 times longer than what you anticipate.  
 16 And those are -- so exercise in patience.  
 17 Anyone that has worked with me for a number of years,  
 18 that's something I've acquired over the years, not  
 19 something I had.

20 So, yeah, it's -- this is -- it's a moving  
 21 target. And I think that one of the things we see  
 22 nationwide is that almost everyone sees a need. And the  
 23 system that we have in place is like, it's like a  
 24 roadblock. Because everything that we have right now,  
 25 you've got to have 72 hours notice to use a cab that's

Page 13

1 paid for by Medicaid. Well, we know in our situation, we  
 2 don't have 72 hours; we need to ask for it now. So and  
 3 for me to use a cab to send someone to -- even go to the  
 4 PCP is a lot -- a lot more cost effective than sending the  
 5 ambulance, which, you know, we're looking -- we know that  
 6 the Medicaid rates on ambulance transports are way -- way  
 7 below what's billed, but still it's way more expensive  
 8 than a cab ride.

9 So this is one of the things where we get into  
 10 what is good for the patient? What's the outcome we want?  
 11 Is the outcome satisfactory? Is taking someone to an  
 12 emergency department for a tooth ache going to have a  
 13 satisfactory outcome? And the answer is no.

14 And we do that. We do these kinds of things all  
 15 the time. And everyone that's been involved for any  
 16 number of -- even anyone that's been involved for a couple  
 17 of years knows that we're doing the wrong thing for our  
 18 patients. And it's costing the system a lot of money.  
 19 And it's causing frustrations with us.

20 And I -- this -- so there's a lot of motivation  
 21 personally of wanting this to work. Plus, I've, you know,  
 22 I've got a lot invested in it now. And I'm hoping that  
 23 we're going to see positive results.

24 And that's the big thing right now. It's tried  
 25 and tested in some areas, but we haven't done it here. So

Page 14

1 now we've got to prove here -- I've got to prove to the  
 2 Hospital Association that it's worth their while to  
 3 continue to support it after we get it up and running. Is  
 4 it saving money? Can we prove it? I've got to do -- I've  
 5 got to collect data all the way too.

6 So the data collection is going to be critical  
 7 for us to succeed because, you know, we've got to either  
 8 go to the City Council and ask for money to support it  
 9 because we can prove we are saving money by responding to  
 10 light fleet instead of heavy fleet. Or however we prove  
 11 it, we have to -- all of us -- we're involved with it  
 12 whether we like it or not. The economics of what we do  
 13 when we're out -- when we're the guy in the back of  
 14 ambulance or in the front seat of the engine, we're not  
 15 worried about that kind of stuff.

16 But the cold hard facts are we should all be  
 17 concerned because it's going to affect all of us in the  
 18 future. That's --

19 ERIC BAUMAN: What kind of additional training  
 20 did you do for the paramedics? You said you have one  
 21 squad, right?

22 CLARE BALDWIN: We do. So the focus -- one  
 23 piece is going in and learning what to look for in the  
 24 house that are safety issues. You know, do they have  
 25 handrails? Do they have rugs down that are trip hazards?

Page 15

1 Do they have food in the fridge? Do they -- so we have  
 2 one -- one segment that focuses on that. We have another  
 3 segment that focuses purely -- well, and it's a long  
 4 one -- on the mental health. And UNI is helping us with  
 5 that.

6 We have another section that goes into what to  
 7 look for as far as do they have colostomy bags? Do they  
 8 have, you know, those special need things of what to look  
 9 for for infection and those types of things?

10 But as far as, once again, the scope of a normal  
 11 paramedic, there's not a whole lot of difference other  
 12 than just an emphasis and also the safety issues that may  
 13 or may not be there. A lot of people that we argue with  
 14 because they are unstable, there's great potential to have  
 15 an issue while you're there.

16 ERIC BAUMAN: Has it been receptive in the  
 17 department? Is there a lot of interest?

18 CLARE BALDWIN: There is a lot of interest. I  
 19 think there's a lot of curiosity right now because they  
 20 are not sure how it's going to work. And we've got some  
 21 other ideas down the road of how to run the program and  
 22 satisfy our other issue, which is using heavy fleet.  
 23 Everyone's -- I don't know about you guys, anyone's that's  
 24 used heavy fleet or we're getting pressured by people:  
 25 Why are you showing up in a fire engine on a medical call?

Page 16

1 So I know I just came back from Spokane and they  
 2 are doing some stuff up there that is really interesting  
 3 as well.  
 4 ERIC BAUMAN: Great. Thank you.  
 5 CLARE BALDWIN: Okay. Anything else?  
 6 GUY DANSIE: One quick question from this  
 7 morning, I think, that was brought up by Dr. Taillac is  
 8 these paramedics or whoever are responding, is there going  
 9 to need to be some additional training on use of different  
 10 types of meds?  
 11 CLARE BALDWIN: No.  
 12 GUY DANSIE: You don't find any of that?  
 13 CLARE BALDWIN: I don't think so. I think  
 14 that's an area -- I mean, we can go down that road, but I  
 15 don't see the necessity of -- that's a home health issue.  
 16 That's getting them the resources that they need to take  
 17 care of that.  
 18 Now, we talked about doing telemedicine where we  
 19 actually have the ability for the paramedics to make  
 20 contact with the doctor through a tough book type  
 21 situation, and that is -- we have a grant applied for with  
 22 the University. And from what I understand, the  
 23 University, whether they get the grant or not, we're going  
 24 to do that.  
 25 So if our medics go out and there is a question

Page 17

1 with medications like that, they can get the doctor  
 2 immediately on a two-way conference, and then the doctor  
 3 can make the order on the medication.  
 4 But as far as like administering or other than  
 5 checking their meds, making sure that they've got all the  
 6 prescriptions that they need, no, not right now.  
 7 GUY DANSIE: Not an issue?  
 8 CLARE BALDWIN: No.  
 9 GUY DANSIE: Are there any follow-up questions  
 10 to that? Are there any other rules that you can see that  
 11 are obstacles for you at this point as far as state  
 12 administrative rules?  
 13 CLARE BALDWIN: Well, the one thing that still  
 14 comes up, and we talked about a little bit, is this a  
 15 preemptive emergency medical role? Is it like a  
 16 preemptive strike? Are we trying to -- is prevention by  
 17 calling 911 truly a piece of emergency medicine? And  
 18 that -- that's not been answered completely.  
 19 But having the support of the state is, is vital  
 20 to us, even though the state decided they didn't need to  
 21 really approve what we are doing. And it's because of  
 22 that immunity clause that exists in delivering emergency  
 23 medicine versus not. So that's one thing that has been  
 24 of concern to a degree.  
 25 GUY DANSIE: I think our concern is making sure

Page 18

1 when you do your pilot project, that we get feedback and  
 2 eventually if other organizations would like to do the  
 3 same thing, we have the best, best practice --  
 4 CLARE BALDWIN: We'll be more than willing to  
 5 share because everything that we are going to do is -- I  
 6 think that we don't want to reinvent the wheel. Fort  
 7 Worth has shared with us. Louisville has shared with us.  
 8 Reno is now doing their thing, and they are sharing.  
 9 It's vital that we -- that we do that and then  
 10 modify to meet our own needs.  
 11 GUY DANSIE: Thanks.  
 12 ANDY SMITH: Just one question. And you touched  
 13 on it briefly, but how are you going to measure success of  
 14 the program? You mentioned data collection. What sorts  
 15 of numbers are you looking for?  
 16 CLARE BALDWIN: Well, one of the things that  
 17 we're looking at is to see if we've been able to succeed  
 18 in getting them not to call 911 anymore. That's one  
 19 measure, or at least to decrease that.  
 20 And another would be whether we can show that --  
 21 we know what it's costing to go out and make the visits.  
 22 We have an individual, \$987,000 for a two and a half year  
 23 period. We were able to get that person into a nursing  
 24 home facility at \$38,000 a year. So \$38,000 a year versus  
 25 \$987,000 in two and a half years. So we can show that,

Page 19

1 you know, if we can get that type of health, then we can  
 2 show we're saving money to the system.  
 3 Now we've got to show are we saving monies for  
 4 the hospital by not going to the emergency department?  
 5 Because once again, they are low pay or no pay patients,  
 6 and that's the cold hard reality. It's not like we're  
 7 trying to pick on anybody, but that's what we are talking  
 8 about.  
 9 DENNIS WYMAN: What do you use for  
 10 documentation?  
 11 CLARE BALDWIN: Well, we're able to do our  
 12 inquiries with the ESO. So our ESO or ePCR -- that's our  
 13 ePCR company. So we do queries on there to get the number  
 14 of runs, how many of these runs by evaluation could have  
 15 been coded lower than an alfa? How many of these could  
 16 have been omega calls? So we looked at that.  
 17 We also look at the amount of money that it  
 18 costs to send someone to an emergency department versus an  
 19 alternative destination like Fourth Street. We're already  
 20 doing that. We already transport to Fourth Street Clinic.  
 21 So we've got permission to do that.  
 22 So by transporting to Fourth Street versus  
 23 University ED per visit saves an after of about \$1,600.  
 24 DENNIS WYMAN: I was speaking more of the  
 25 documentation of a call from a medical care --

Page 20

1 CLARE BALDWIN: Every call will still be entered  
 2 into ESO on our ePCR. So they will document all the calls  
 3 the same way as we do now. So they'll be a narrative.  
 4 There will be a flow of everything that they did while  
 5 they're there: Any vitals they took, anything they found  
 6 in the house that was of concern, the fact if they didn't,  
 7 if they did have their medication, whatever it is they, do  
 8 they put it in their narrative.  
 9 And then they also will have the entire ePCR  
 10 chart that they can use as well. So it's going to be  
 11 charted the same way as it is on any other call.  
 12 DENNIS WYMAN: Okay.  
 13 CLARE BALDWIN: And then --  
 14 DENNIS WYMAN: Is that through a fire house or  
 15 something like that?  
 16 UNKNOWN: ESO.  
 17 CLARE BALDWIN: I'm trying to remember what  
 18 ESO -- ESO is one -- there's several companies that do the  
 19 electronic data reporting form. So it's like the smurf,  
 20 like the smurfs that we all use the paper smurf but  
 21 instead it's an electronic version. And ESO is just a  
 22 company that we've contracted with to do it.  
 23 Anything else?  
 24 GUY DANSIE: Thanks.  
 25 CLARE BALDWIN: I've got to go to another

Page 21

1 meeting.  
 2 DENNIS WYMAN: I sure appreciate you showing up  
 3 on short notice.  
 4 CLARE BALDWIN: Well, it's okay. I'm sorry  
 5 Mr. Email.  
 6 GUY DANSIE: No problem.  
 7 TRACY BRAITHWAITE: So do we need to do anything  
 8 with that?  
 9 GUY DANSIE: I don't think so. It's a pilot  
 10 project. I was -- I missed the EMS Committee, but I  
 11 believe they just wanted to make sure we understood the  
 12 scope of the project and then think about operationally  
 13 how this might impact other agencies or things that we  
 14 might need to adjust in rule or policy down the road as  
 15 we -- more agencies come aboard on these kind of things.  
 16 Is there anything else that maybe --  
 17 KRIS KEMP: Yeah, I think that was the gist of  
 18 it, is we wanted to make sure that it fit well with where  
 19 we're at. And it almost sounds like they are mobile  
 20 social workers than they are a need for a paramedic level  
 21 of skill. In -- I mean, there is data out there. It's  
 22 called hot spotting, when they find that one, you know,  
 23 those hot spots of resource allocation where they are  
 24 going in trying to put out that fire before it gets to be  
 25 the blaze. And that's what they're doing. So I think

Page 22

1 it's terrific. It sounds like they are planning.  
 2 PETER TAILLAC: They are really starting in a  
 3 very basic level with this. I mean, the other more  
 4 advanced agencies, the cities are doing a lot more. They  
 5 are doing hospital follow-ups. They do cardiology, you  
 6 know, on line with them when they are listening to the  
 7 patient's heart and that, adjusting medications. We're  
 8 not there yet.  
 9 So I think they are starting with, you know,  
 10 kind of low hanging fruit to prove a concept as much as  
 11 anything. I think the information they get is going to be  
 12 valuable to other agencies, there's no question about it.  
 13 JOSEPH BACH: I have a question. Joe from  
 14 Logan. Can you hear me?  
 15 GUY DANSIE: Yeah.  
 16 JOSEPH BACH: Yeah, I've got a question. I'm  
 17 just trying to differentiate, what's the comparison to  
 18 home healthcare? How does this relate to home healthcare?  
 19 PETER TAILLAC: I'll take a stab at that. They  
 20 are not doing home healthcare per se in the sense of, you  
 21 know, home healthcare is contracted and paid for, I might  
 22 add, and, you know, has a specific time for a patient, for  
 23 a specific need after the discharge from the hospital  
 24 typically.  
 25 This is initially for them trying to figure out

Page 23

1 why these frequent flyers are calling the ED's or the EMS  
 2 so much and to address whatever that need is in a better  
 3 fashion than going to the emergency room over and over  
 4 again. So it's really different than home healthcare.  
 5 Although, some of the stuff you might say overlaps, if  
 6 they find out they are not eating well or they are not --  
 7 you know they are tripping over rugs or that sort of  
 8 thing. That's the kind of things that home health does  
 9 do.  
 10 But this is not funded by the way either. No  
 11 one is paying them for this at this point.  
 12 JOSEPH BACH: Yeah, okay.  
 13 ANDY SMITH: My understanding is that if they  
 14 find those needs, they are going to route them to the  
 15 appropriate -- back to home healthcare at least. They are  
 16 not going to -- they may take care of the need  
 17 temporarily, but they are going to route them to the  
 18 appropriate resources. That's kind of what I understood.  
 19 PETER TAILLAC: Yeah. They are using sort of  
 20 the published resource manuals, if you will, for, you  
 21 know, the department of aging and the home healthcare  
 22 resources and all of these resources, the Meals on Wheels.  
 23 So they'll have access to all of these agencies to try to  
 24 refer and plug into these folks. Again, to try to meet  
 25 where the need is that results in the need.

Page 24

1 JOSEPH BACH: I see. It makes sense.  
 2 TRACY BRAITHWAITE: Any other questions?  
 3 CHRIS DELAMARE: Just my one thought that just  
 4 came to my mind, he talked about the low payers or no-pay  
 5 client or patient, if you will, but do they take into  
 6 account the cultural -- how do I want to say, different  
 7 ethnicities that are out there that aren't really, I  
 8 guess, Medicaid patients, but they are going to be adult  
 9 patients not knowing about the health insurance that is  
 10 available to them or not having it at all? I didn't hear  
 11 him talk about that. I'm just not sure -- I assume Salt  
 12 Lake City has a high diversity.  
 13 PETER TAILLAC: Yeah. You are saying patients  
 14 that could possibly have health insurance or resources,  
 15 but they don't know about it, they are not connected to  
 16 the system.  
 17 CHRIS DELAMARE: The other side I'm just curious  
 18 on the translation or how they are dealing with the  
 19 cultural ideas if that isn't coming to play in this.  
 20 Because, you know, you can get, honestly, an English  
 21 speaking person that those resources you know, but if you  
 22 are not able to understand what they are asking for or  
 23 knowing what their needs are, how do you get them into  
 24 that system for that diversity.  
 25 PETER TAILLAC: I guess, when they got to that

Page 25

1 problem, they would look and see which community resource  
 2 might help provide translation services and that sort of  
 3 thing and come back and make an appointment to discuss it  
 4 potentially. It's another roadblock but...  
 5 TRACY BRAITHWAITE: We're good? All right.  
 6 We'll just keep moving on. I don't think we need to do  
 7 anything on it.  
 8 So we'll just move on the Rules Task Force and  
 9 subject.  
 10 GUY DANSIE: Okay. As many -- I think I  
 11 explained this last meeting, but I just wanted to kind of  
 12 refresh everybody. We have a new EMS Rules Task Force  
 13 that was established to advise the department and to the  
 14 EMS Committee on any of the rule changes. And currently  
 15 we're reviewing all the public comment received on the  
 16 rules that were made effective in October. And we're  
 17 going through each part of the rule and adding or taking  
 18 out some of the public comment that was received.  
 19 The reason I want to bring it here is we are  
 20 currently discussing operations, R426-4, which applies  
 21 specifically to operations, which is the area that we have  
 22 you here to give us advice on that. And I wanted to make  
 23 sure we coordinate your wishes with the direction that the  
 24 task force is going.  
 25 One of the things that we did talk about last

Page 26

1 month was the emergency vehicle operator's rule, the new  
 2 rule. And one of the comments -- when we presented that  
 3 to you to develop policy language, the criteria language  
 4 for the new requirements for training, we had some  
 5 strikeouts and things that I told you about that the fire  
 6 chiefs wanted. Well, apparently the task force agrees  
 7 with that, and that looks like that's the direction we're  
 8 headed. We'll probably strike out the need to have a  
 9 registry by the Bureau or maintained by the department.  
 10 We still want to -- they still are in favor of  
 11 doing background checks on noncertified drivers. All  
 12 drivers will be required to have training provided by the  
 13 agency.  
 14 We're still looking at a July deadline for  
 15 implementation to have the agency submit their plan,  
 16 training plans to us. Tami and I are working on that now  
 17 sending out a request for the agencies to provide their  
 18 training summary or their description, their training  
 19 program. And we will evaluate that based on the criteria  
 20 that the EMS Committee approved, all of these helped us  
 21 develop. So I just wanted to give you a quick update on  
 22 that.  
 23 But as that task force moves through that piece  
 24 of rule, I mentioned this to Dr. Taillac earlier, that one  
 25 of the things we'll be working on is the drug and

Page 27

1 equipment list. And there's some other things in there,  
 2 including standby staffing, some of those other issues  
 3 that were key to the rule and people had a hard time with  
 4 or maybe a little anxiety as we passed that new rule.  
 5 One of the other areas is medical control. I  
 6 just wanted to kind of bring you up to speed on that. And  
 7 that's probably where we are going to be looking at making  
 8 some changes, is definitions and the role of the medical  
 9 control and seeing management and how the crews operate  
 10 and so forth. Just wanted to you give you a little heads  
 11 up on that.  
 12 And also do you have any wishes or input on the  
 13 rules at this time? If there's anything that you guys can  
 14 see -- what I plan to do is I'll share the language of the  
 15 rule with all of you before it goes to the EMS Committee  
 16 for our final approval before it goes out for public  
 17 approval. I just wanted to lay the stage, ground work for  
 18 you so you know where we are headed with that. But be  
 19 thinking of any issues or things that you might want to  
 20 bring to us before we go through and push those rules out.  
 21 Okay?  
 22 PETER TAILLAC: Is there anything in the rule  
 23 that you think is outdated or doesn't apply anymore that  
 24 needs to be updated? And there's a lot of stuff there,  
 25 frankly.

Page 28

1 GUY DANSIE: Yeah. So I'm asking --  
 2 PETER TAILLAC: Bring this -- email it to Guy.  
 3 GUY DANSIE: Yeah, and I will send out as we  
 4 grind through the -- adding the public comment and then  
 5 voting on whether to accept that or reject that. As we  
 6 get that document, that 426-4 completed, I'll send that  
 7 out to the Operation's Subcommittee for your review. And  
 8 then we will provide any feedback to the EMS Committee  
 9 before it's voted on for approval. Does that sound fair?  
 10 Okay.  
 11 After we get through with operations, we'll  
 12 probably move back into the -- some of the designation and  
 13 licensure requirements for agencies. That seemed to be  
 14 probably the second, third tier of interest and where we  
 15 received comment, public comment.  
 16 So over the next month or two as we finish up  
 17 operations, we'll probably go back and look at the  
 18 designation. That's R426-2 and then licensures is R426-3.  
 19 So that's kind of where we're heading with that.  
 20 The meeting is on February 26th at noon in this  
 21 room. So if anybody has any concerns, or if you would  
 22 like to just come and be part of the audience, participate  
 23 in the discussion, feel free. We would love to have your  
 24 input or feedback on things as they go. So just kind of  
 25 wanted to make sure you're aware of that.

Page 29

1 I think that's probably it for my piece. I know  
 2 Dr. Taillac had a little information on drug shortages he  
 3 shared this morning with the other group.  
 4 PETER TAILLAC: Yeah, just by way of update, it  
 5 doesn't necessarily affect the committee as operations per  
 6 se, but the emergency use of expired medications for six  
 7 months passed the expiration date policy is still in  
 8 effect. And yesterday Tami sent out to all the agencies  
 9 the updated list. And I based the updated list on two  
 10 national sources for what's short.  
 11 And frankly, I'm very liberally that if one list  
 12 has it short and the other doesn't, I include it because  
 13 it might affect your agency depending on your supply  
 14 chain, et cetera.  
 15 So the list is about the same length, although  
 16 the overall national list has shrunk for drug shortages in  
 17 the EMS meds, at least from my perspective. Utah's  
 18 perspective hasn't changed much. One or two things came  
 19 off, but a couple of things came on, including probably  
 20 most remarkably normal saline you probably heard is in  
 21 shortage now and Lactated Ringer's is on the list as well.  
 22 A lot of agencies are substituting ringers or potentially  
 23 substituting ringers for normal saline which is fine, but  
 24 that's also a little short also.  
 25 So fortunately, we're not giving as much IV

Page 30

1 fluids in trauma, so that will help a little bit, No. 1.  
 2 No. 2, you might just consider some of the  
 3 conservation measures. And I think that was out of Reno  
 4 that sent out to the medical directors saline locks and  
 5 TKO IVs and that kind of thing, just to preserve that.  
 6 That's supposed to get better by the end of March, or so  
 7 they say, the normal saline shortage. We'll see. But  
 8 there's a new list out and that policy is still in effect.  
 9 Hopefully, that helps a little bit.  
 10 TRACY BRAITHWAITE: Anybody else have anything?  
 11 I know Chris wanted to say something.  
 12 CHRIS DELAMARE: Well, I was just asked by my  
 13 boss if you will -- Medicaid -- there's a committee up at  
 14 the state right now for appropriations on Medicaid  
 15 reimbursement for ambulance services. We know it's low,  
 16 but they would just like -- tomorrow, I guess, they are  
 17 meeting -- maybe defer to Eric on this, but he knows a  
 18 little bit more about it than I do. It was just brought  
 19 up to me before I came to this meeting.  
 20 There's some representatives and senators on  
 21 this paper you were handed. If you fall -- if these are  
 22 one of your representatives, would you get ahold of them  
 23 and let them know you would like to support the funding of  
 24 Medicaid -- or the reimbursement of ambulance services  
 25 under Medicaid and for the appropriations you put out. He

Page 31

1 gave me a number. I don't remember what -- the dollar  
 2 figure.  
 3 ERIC BAUMAN: Yeah, there's three -- I think the  
 4 first thing is to look at this not as a Medicaid expansion  
 5 but to look at this as taking care of our current Medicaid  
 6 population. I think that's where -- but what it is, is  
 7 that the federal government -- if the state can come up  
 8 with for every one dollar, then the federal government  
 9 would come up with, I think, it's 2.4 dollars and that  
 10 money would then go back into the system to help with  
 11 Medicaid and reimbursement for ground ambulance support.  
 12 They did a survey of 16 hard months, looked at  
 13 Medicaid, what Medicaid is paying. And what they are  
 14 trying to do is to get that amount up to the ALS1 level of  
 15 Medicare so -- which is roughly 31 percent of the bill.  
 16 So right now the average was anywhere from 29 and  
 17 11 percent for Medicaid reimbursement. We'd like to get  
 18 it up to that 31 percent mark.  
 19 So that's where that money would be appropriated  
 20 for. There's three numbers they've thrown out there. And  
 21 the first one -- I don't have it in front of me, I wish I  
 22 did. The first one was trying to come up with a million  
 23 dollars and the government would kick in their share and  
 24 that would bring it up to, I think it's 74 percent of that  
 25 amount. So -- and I can certainly provide that. I didn't

Page 32

1 know you were going to talk about that.  
 2 CHRIS DELAMARE: I didn't know what I was  
 3 talking about either.  
 4 ERIC BAUMAN: But I just looked at it yesterday  
 5 at the Capitol and some of the presentations was made at  
 6 the appropriation committee. They may meet tomorrow.  
 7 PETER TAILLAC: But that bill is good for EMS?  
 8 That's the bottom line of the bill?  
 9 ERIC BAUMAN: It's not a bill. It's an  
 10 appropriation, I guess.  
 11 CHRIS DELAMARE: It's appropriations and  
 12 there's -- there's certain -- there's appropriations for  
 13 different area, CHIP, ambulance. Reimbursement is one of  
 14 those.  
 15 PETER TAILLAC: They are trying to actually  
 16 raise it a little bit?  
 17 CHRIS DELAMARE: Yes.  
 18 ERIC BAUMAN: The reason it's good for EMS, it's  
 19 a cost shifting basically. So local government is  
 20 subsidizing. You know, obviously the rate instead of \$142  
 21 that's being collected, and so it's just trying to put  
 22 more money into the system to help bring it up and help  
 23 out EMS. So yeah. So I believe they go to prioritization  
 24 tomorrow.  
 25 CHRIS DELAMARE: Right. So the request is just

Page 33

1 if you can contact, just even email saying you support  
 2 this or you want them to kind of make that a priority, is  
 3 if you'd contact one of the committee members if they are  
 4 one of your representatives that are on this list and just  
 5 let them know it's important to you.  
 6 And like Eric said, Medicaid reimbursement for  
 7 an ambulance trip is 142 bucks. Medicare is about 390.  
 8 So there's a significant difference on what you are  
 9 putting into that system.  
 10 And as Eric said, local governments are  
 11 really -- if they have their own service, they are paying  
 12 that bill to get that person in the hospital.  
 13 ERIC BAUMAN: I wish I had the numbers because  
 14 they are quite astounding. For instance, we've billed out  
 15 I believe it's \$2.1 million. Medicaid patients in Ogden  
 16 are about 20 percent of our transports. We billed out  
 17 just over \$2 million. We billed out 1.9. Some have been  
 18 collected. So billing out 2.1 million, we've collected  
 19 about 200,000, I believe. So it's -- there's quite a bit  
 20 of write-off there. And so it would help everyone.  
 21 GUY DANSIE: Quick question. We don't -- can't  
 22 lobby for or against bills as a Bureau, but what -- I was  
 23 just curious if you had contact -- I'm sure the Fire  
 24 Chiefs Association is aware of this --  
 25 ERIC BAUMAN: Yep.

Page 34

1 GUY DANSIE: -- and I don't know if you have  
 2 dealt with some of the rule agencies or disseminated --  
 3 CHRIS DELAMARE: I can't tell you. I have no  
 4 idea who they contacted and who they dealt with.  
 5 GUY DANSIE: I just know there's a network of  
 6 rural providers. You know, maybe that would be a good way  
 7 to get the thing out.  
 8 CHRIS DELAMARE: Well, the thing about this is  
 9 it's statewide. It's not just Salt Lake city. It's not  
 10 just Ogden. It's statewide. Every neighborhood is  
 11 affected.  
 12 GUY DANSIE: Right. What I am wondering, you  
 13 are dealing with the fire chiefs and the fire base  
 14 agencies are probably aware of this but maybe some of the  
 15 rule agencies are not. So maybe we could --  
 16 CHRIS DELAMARE: Because you can't lobby, how  
 17 would you suggest we get this out?  
 18 GUY DANSIE: Well, you could contact -- Don  
 19 Marrelli is kind of acting as the point person for the  
 20 rule association for EMT or EMS.  
 21 ANDY SMITH: If I can, Guy, we did talk about  
 22 this in the meeting we had.  
 23 GUY DANSIE: Okay. So they are aware of that.  
 24 ANDY SMITH: Yeah. And a lot of our -- at least  
 25 my information was submitted. I know Gold Cross kind of

Page 35

1 took the lead on this in trying to get this. And we  
 2 really appreciated that. So they sent me, I think,  
 3 through -- somebody else emailed it out, sent me the  
 4 actual form that they were using to collect data to, to go  
 5 to the state to see if we need to raise this. So I know a  
 6 lot of agencies are aware.  
 7 GUY DANSIE: Good. That's great.  
 8 ANDY SMITH: Yeah. I've been -- I've already  
 9 talked to my representatives. None of them are on the  
 10 list.  
 11 ERIC BAUMAN: Representative Ray, he's kind of  
 12 the point person for this. He's the one.  
 13 GUY DANSIE: I just know how this has affected  
 14 all the agencies and I just wanted to make sure they were  
 15 all contacted on this.  
 16 ANDY SMITH: Right. Like, you know, Salt Lake  
 17 City, when he said, well, 40 percent of our patient don't  
 18 need to go and, you know, out of that 40 percent,  
 19 90 percent of them are Medicaid or whatever would be my  
 20 thought. Man, I wish 40 percent of my patients didn't  
 21 need to go. I wish they weren't 90 percent Medicaid. But  
 22 you know, it's very different demographics throughout the  
 23 whole state. So while this may only raise my income by  
 24 \$20,000, that's a big amount to my small budget.  
 25 ERIC BAUMAN: Absolutely.

Page 36

1 TRACY BRAITHWAITE: Anything else before we --  
 2 ALLAN LIU: I do. I'm Allan Liu with the  
 3 Bureau, just a reminder, EMS Director's Conference. Some  
 4 people have signed up. March 17th.  
 5 Let's see, EMS agencies who have fiscal year  
 6 ending December 31st, 2013, the fiscal reporting guides  
 7 are due April 1. And we need that data for ambulance  
 8 rates. It also affects your eligibility for EMS grants.  
 9 With EMTs grants fiscal year '15 applications  
 10 and guidelines are now on Bureau website. So you guys can  
 11 go down those now.  
 12 Also because of the rules being delayed for  
 13 approval and things, ambulance rates will be increasing  
 14 about 6 percent in April. It's right now in rules -- I  
 15 think, it's out for public comment next week or so. It's  
 16 not on the rules website for public comment but it will be  
 17 shortly. If there aren't any substantial comments, they  
 18 can be effective in April. So I wanted to give you guys  
 19 all a heads up.  
 20 Any questions for me?  
 21 PETER TAILLAC: And encourage your medical  
 22 directors to come to the workshop on March 17th. I've  
 23 sent out a bunch of reminders, but I don't know where they  
 24 go.  
 25 GUY DANSIE: I got mine.

Page 37

1 PETER TAILLAC: Awesome. Good. Are you?  
 2 Great. It should be nice whether.  
 3 TRACY BRAITHWAITE: Anybody else have anything?  
 4 TAMI GOODIN: One more thing. Tami Goodin with  
 5 the Bureau. We're having our EMS awards ceremony July 9th  
 6 at 10 o'clock. We don't know the place yet but we just  
 7 wanted you to save the date for that.  
 8 CHRIS DELAMARE: Is that a new date versus -- it  
 9 used to be May, right?  
 10 TAMI GOODIN: It used to, but May's been so  
 11 crazy for everybody that we're looking at July to be a  
 12 happier month.  
 13 ERIC BAUMAN: Fireworks?  
 14 GUY DANSIE: Yeah, something like that.  
 15 DENNIS WYMAN: I've got a question about, you  
 16 know, all the data we send in to the State that's NEMSIS  
 17 data, is that all warehoused here or is it in a federal  
 18 warehouse.  
 19 PETER TAILLAC: Denny, we keep -- what you send  
 20 in actually called -- we call it Polaris data because  
 21 that's our state database. Then Polaris sends a subset of  
 22 that to the national NEMSIS database, which actually is  
 23 housed, I think it's in Salt Lake, as a matter of fact.  
 24 NEMSIS is actually at the U. Yeah, it's actually housed  
 25 at the U. But the data you send in, we keep, and a small

Page 38

1 part of that goes to NEMSIS.  
 2 DENNIS WYMAN: That's a lot of data.  
 3 CHRIS DELAMARE: There's a big building out on  
 4 Redwood in Bluffdale.  
 5 PETER TAILLAC: I'm sure they have a suit.  
 6 (All talking)  
 7 PETER TAILLAC: So Denny, there is a lot of  
 8 data. And part of my goal as state medical director is to  
 9 help agencies get their data back. I like the term "give  
 10 me back my data", you know, musical form that actually  
 11 does good. So if you have any ideas about that.  
 12 Part of our trauma performance improvement  
 13 initiative that we're doing last year and now this year, a  
 14 bigger roll out of it, will be to give agencies back their  
 15 trauma data in a useable form so they can see how to do it  
 16 in IV fluid use and vital signs and that kind of thing to  
 17 help drive their performance improvement.  
 18 The CARES database, C-a-r-e-s, which is a  
 19 national database for cardiac arrest, is also being hosted  
 20 now in Utah. And all of your agencies, and we thank you,  
 21 are giving cardiac arrest data. And we will this year, I  
 22 hope for the first time, be giving that back to you in  
 23 your cardiac arrest resuscitation rates compared to state  
 24 and national sort of baselines, if you will. So trying to  
 25 give you data back.

Page 39

1 CHRIS DELAMARE: And you've done that start --  
 2 that's been a year, right?  
 3 PETER TAILLAC: That started last year, but it  
 4 took really a year to get all the agencies to start  
 5 understanding what to put in. And it's hospital data also  
 6 in CARES. It gives us the actual outcomes. So the harder  
 7 part, frankly, was not the EMS agencies; it was getting  
 8 the hospitals to give us their data on the patients you  
 9 bring to them.  
 10 UNKNOWN: They are doing it now?  
 11 PETER TAILLAC: They are, yeah.  
 12 CHRIS DELAMARE: Is CARES providing back to you  
 13 at all in their findings off of this?  
 14 PETER TAILLAC: Yeah. They -- we have access to  
 15 all of that. And we will be giving you again agency by  
 16 agency, and hopefully by fall, we'll have the reports  
 17 together to give you a year's worth of your cardiac arrest  
 18 resuscitation data and each hospital will get their data  
 19 also. And then we'll compare it to a state baseline  
 20 average, a national average.  
 21 ERIC BAUMAN: And CARES is getting their data  
 22 from Polaris' database?  
 23 PETER TAILLAC: Correct, from EMS side. The two  
 24 sides to CARES is the EMS data and the hospital. So you  
 25 actually are not doing much work. There is some as you

Page 40

1 guys know.  
 2 ERIC BAUMAN: We're doing our normal reporting.  
 3 PETER TAILLAC: Yeah, you are doing your normal.  
 4 We're sucking that data for CARES from Polaris. But  
 5 sometimes we don't understand it or it doesn't make sense.  
 6 We have to call and say, can you explain this run and what  
 7 happened on this run.  
 8 So thanks for that. It's been a big project,  
 9 but we're really proud. We're actually the first state in  
 10 the country to take it on statewide and it's worth taking  
 11 on as a statewide project.  
 12 CHRIS DELAMARE: What kind of numbers are we  
 13 giving them, from the State? It seems like it was low  
 14 nationally, but I was just curious as far as the state.  
 15 PETER TAILLAC: We run approximately a thousand  
 16 cardiac arrests a year in the state that would be reported  
 17 to CARES. So about three a day, roughly, two to three a  
 18 day. So not all of those make it to the hospital. Only  
 19 about two-thirds -- only about one-third make it to the  
 20 hospital. About two-thirds roughly are pronounced at the  
 21 scene. And then our interest is really in the one-third  
 22 that make it to the hospital, what are their outcomes.  
 23 DENNIS WYMAN: CARES is strictly cardiac arrest?  
 24 PETER TAILLAC: Yeah. It's a CDC funded  
 25 project. Well, it's actually -- no, that's wrong. It's

Page 41

1 CDC sponsored project. There's no one funding it, but  
 2 they are happy to keep on doing it.  
 3 TRACY BRAITHWAITE: Anybody else have anything?  
 4 Then I will make a recommendation to adjourn.  
 5 CHRIS DELAMARE: I'll second.  
 6 TRACY BRAITHWAITE: All in favor?  
 7 COLLECTIVELY: Aye.  
 8 TRACY BRAITHWAITE: Any opposed? Okay. I  
 9 didn't think so.  
 10 (Meeting was adjourned at 1:58 p.m.)  
 11  
 12  
 13  
 14  
 15  
 16  
 17  
 18  
 19  
 20  
 21  
 22  
 23  
 24  
 25

Page 42

C E R T I F I C A T E

STATE OF UTAH            )  
                                   )  
 COUNTY OF UTAH        )

This is to certify that the foregoing proceedings were taken before me, Susan S. Sprouse, a Certified Shorthand Reporter in and for the State of Utah, residing in Salt Lake County, Utah;

That the proceedings were reported by me in stenotype, and thereafter caused by me to be transcribed into printed form, and that a true and correct transcription of said testimony so taken and transcribed is set forth in the foregoing pages, inclusive.

DATED this 25th of February, 2014.

\_\_\_\_\_  
 SUSAN S. SPROUSE, RPR, CSR  
 LICENSE NO. 5965543-7801

Page 43

11

(Pages 41 to 43)