State EMS Committee Meeting

January 11, 2017

Alpine Court Reporting
Locations in Salt Lake City and Provo
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State EMS Committee

January 11, 2017 * 1:05 p.m.

Location: Bureau of EMS and Preparedness
Highland Building

3760 South Highland Drive
3rd Floor Auditorium
Salt Lake City, Utah

Reporter: Tamra J. Berry, CSR, RPR

A P P E A R A N C E S

Guy Dansie
Laconna Davis (by phone)
Dr. Hallie Keller
Michael Moffitt
Jason Nicholl
Dr. Kristofer Mitchell
Casey Jackson
Nathan Curtis
Jeremy Hoggard

P R O C E E D I N G S

GUY DANSIE: Let's go ahead and get started. My apologies a little bit. We had our chair and our vice-chair, both who were planning to attend today, but the weather has made it so they can't travel. One had to go over Sardine Canyon. The other one had to come over Parleys. And they've closed those down or they're having problems getting over here.

So anyway, I was going to go ahead and just carry the water on conducting today. And it looks like we just have a quorum.

Laconna is on the phone, Laconna Davis. Then we will do introductions and start down there. Just introduce yourself, and then we'll go from there.

DR. HALLIE KELLER: Hallie Keller, pediatric emergency representative.

NATHAN CURTIS: Nathan Curtis, Sevier County Sheriff and public safety.

CASEY JACKSON: Casey Jackson, I'm the consumer.

JEREMY HOGGARD: Jeremy Hoggard, rural, I believe. I don't know what the official word is.

GUY DANSIE: That's the position, rural evidence provider.

JEREMY HOGGARD: Yeah, something like that.

JASON NICHOLL: Jason Nicholl, paramedic representative.

DR. KRISTOFER MITCHELL: Kristofer Mitchell, I'm the trauma surgeon.

MICHAEL MOFFITT: Mike Moffitt, Gold Cross Ambulance, private provider.

GUY DANSIE: Laconna, do you want to introduce yourself?

LACONNA DAVIS: Laconna Davis, public safety dispatch representative.

GUY DANSIE: Okay. Is there anybody else on the phone?

Okay. If somebody does join us, then we'll have them introduce themselves.

We are supposed to -- in our EMS action and in our statute, it says that January is our time where we hold our election.

Before we do that, let me look at -- I better look at the agenda. We'll follow the agenda the best we can.

The first item of business, action item,

is approval of the minutes. And we have actually the transcript from our last meeting, October 12th. I don't know if we have any issues. Suzanne usually takes a list of minutes for motions and votes. However, I don't have that today in front of me.

So I guess we can approve the transcript, and then I'll see if I can find the minutes themselves for the next meeting. Would that be acceptable to the committee members? Okay.

And so do we have anybody that has any issues with the transcripts that are in front of us in our packet?

NATHAN CURTIS: I make a motion that we accept the transcript as presented.

GUY DANSIE: Thank you.

MR. MOFFITT: Second.

GUY DANSIE: Second.

Did you get those okay, Jenny?

Okay. Then we'll go ahead and take a vote on the motion. All in favor say aye.

COMMITTEE MEMBERS: Aye.

GUY DANSIE: All opposed say nay. (Silence.) Any abstain? (Silence.)

Okay. So the motion carries. I'm not very good at Robert's rules, so bear with me.

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The next item of business, action item is selecting the EMS Committee Chair and the Vice-Chair. And I know Dr. Kemp said he would be willing to do this again, and Jay Downs said he would be willing to be the vice-chair. But I'd also solicit anybody that would be interested in doing that or any other nominations. I turn it over --

NATHAN CURTIS: I propose we leave them as they are and close nominations.

GUY DANSIE: Is that a motion?

NATHAN CURTIS: That's a motion from me.

GUY DANISE: Do I have a second?

DR. KRISTOFER MITCHELL: Second.

GUY DANSIE: Okay. Any comments or anything? Nobody else wants to do it?

JASON NICHOLL: I move to close nominations.

GUY DANSIE: Okay. We'll take a vote on it then. Everybody in support of Dr. Kris Kemp being the chair and Jay Downs being the vice-chair, manifest with aye.

COMMITTEE MEMBERS: Aye.

GUY DANSIE: Any opposition? (Silence) Nay? No opposition?

DR. HALLIE KELLER: There's a comment.

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DR. PETER TAILLAC: No opposition. But are their terms coming up? Would this be a full term for each of them to be chair and vice-chair?

GUY DANSIE: The terms actually end in January -- or begin in January. So it coincides with the chairmanship or chairperson-ship or whatever you call it.

DR. PETER TAILLAC: You turn it over every year, the chairperson-ship?

GUY DANSIE: Right. Title 26-8-A says there shall be an election for chair and vice-chair every January meeting, for the first meeting of the year. That's what it says.

DR. PETER TAILLAC: The terms are how long?

GUY DANSIE: They do it for a year. Oh, the term is a four-year term.

DR. PETER TAILLAC: Oh, he could be chair for a long time then.

GUY DANSIE: He could be possibly. But he seems like he's just getting it down so.

THE REPORTER: Your name, sir?

DR. PETER TAILLAC: Peter Taillac.

THE REPORTER: Spell you last name.

DR. PETER TAILLAC: T-a-i-l-l-a-c.

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GUY DANSIE: He'll be talking a little later too. We have an agenda; we have a name badge for you in the back.

So the next item of business, we have some rule updates. Let me just -- I'll kind of explain those. The first one is rule change 426-3-900. And we have it listed as automatic aid agreements. And there is a handout with some new language that was added in draft form, and it needs to go out for public comment through the department's approval process for public comment. But we wanted to get your opinion on it today and your vote.

And this was a task that was assigned to the EMS Rules Task Force by this EMS committee in our last meeting. And this is the language -- draft language that's in our packet today. And I believe we discussed this language a little bit in our lunch meeting, discussing some of this. There were a few little tweaks.

Does anybody have comment on this?

DR. KRISTOFER MITCHELL: We just had discussed doing the same with -- saying what the tweaks were.

GUY DANSIE: Okay. Let me just go ahead, and I'll explain that. And then we'll look for a

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motion on it.

In the first section, toward the end of the underlined portion, which is the new language, it says -- I think this is like the third-to-the-last line. It says, "...during times of unusual demand inter-facility transports or for standby events."

Can everybody see that okay? And there was discussion about removing that part and just leaving it "unusual demand" and end it there and strike out "the inter-facility transports or for standby events."

Okay. Is there any comment or any discussion on that? And the reason is, we wanted to emphasize that it was just in times for unusual demand, and that was part of the discussion we had earlier. So the aid would only be given if there was an unusual demand. It wouldn't be for these other types of event.

JASON NICHOLL: Motion to accept with the modified language.

GUY DANSIE: Wait, there's a little bit more.

JASON NICHOLL: No.

GUY DANSIE: The other part was there is confusion a little bit about the term "automatic

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aid." So the discussion we had was to change that to "mutual aid," and I think that word appears in there.

NATHAN CURTIS: It would be the second sentence.

GUY DANSIE: Down on four it appears again. Anyway we will change that term to "mutual aid." The task force felt that mutual aid was something like aid in kind. So it would be the same type of aid as they normally provide. But I think for the intent of this, "mutual aid" is probably a better choice of words than "automatic." At least that was the feeling we had in the discussion.

So I'd take a motion if you want to change it to "mutual aid," strike out --

JASON NICHOLL: Not me.

GUY DANSIE: Okay. We're proposing to strike out the "inter-facility transport for standby events" and change the term from "automatic" to "mutual aid." That would be what you would want to make a motion for.

DR. KRISTOFER MITCHELL: I'll make a motion that we make the changes as stated.

JEREMY HOGGARD: Second it.

GUY DANSIE: Any more discussion? Okay.

MICHAEL MOFFITT: I agree. I'm waiting

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for him to call it.

GUY DANSIE: We'll go ahead and take a vote on it. Everybody in favor of the motion, please indicate with aye.

COMMITTEE MEMBERS: Aye.

GUY DANSIE: Everybody opposed indicate with nay. (Silence.) Any abstain? (Silence.)

Okay. So the motion carries.

The next portion of the rule we wanted to discuss is R426-8, and there were two things that were amended in this rule, if I can find it. The first one being in R246-8-2, and we're proposing the number be changed to 200 to fit in line with the other portions of the rule. So we will be changing the number. But in part 200 or 2, under the first portion there, we've lined out the 14 percent return on average assets for a profitability ceiling. The department is charged with setting the rates, and we've found that this is a very difficult way to determine what the rates should be. So it's being proposed that we take that out of our fiscal reporting guidance and likewise take it out of the rule. So we will just be looking at the gross revenue instead of the return on the assets.

Any comments? Go ahead.

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MICHAEL MOFFITT: Based on our discussion that we had in the executive committee, I'm just wondering if as we remove the 14 percent on assets threshold, if maybe we shouldn't change the 8 percent on gross revenue to 10 percent, at least while we spend the next year reanalyzing the rate calculation structure. Because just going to one measurement might put some people in a bind that were using the other measurement, and we don't really have -- at least based on our conversations, there's a lot of work to do in the next year to come up with a new way to measure equitable rates throughout the state.

So as we take one measurement away, I think if we bump the other one 2 percent, it's not out of this world and it's probably just a good safety measure to have a little cushion there. I would just propose that we change the 8 percent to 10 percent of gross and go ahead and strike out the 14 percent return on the average assets.

GUY DANSIE: Any comments on that? Discussion? Okay. Do you want me to go ahead and do the other part, and then we'll do the motion to make those amendments.

MICHAEL MOFFITT: Yeah, because there was a lot of discussion going in there, and so I didn't

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want to get lost.

GUY DANSIE: Very good. I appreciate that, Mike. So Mike's proposed we change that to 10 percent.

JEREMY HOGGARD: Which one?

GUY DANSIE: 426-8.

JEREMY HOGGARD: Uh-huh, that's why I can't find it. It's so close.

MICHAEL MOFFITT: It's spelled out. There's no 8.

GUY DANSIE: Yeah. It's written out, so...

Okay. And then in this rule, toward the end of the rule we have added language starting with the number 12. And this portion relates to our Medicaid assessment and how we provide the numbers to the Medicaid office. In the past we have used our Polaris data or PCR counts and turned those to Medicaid for your terms for the Medicaid assessment. We've found that there's been some issues, coding errors. Some agencies have coded differently or under counted or over counted. And we report those numbers to the Medicaid office, they set the assessment and forward that out to the providers. And we're finding that those numbers are not always

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accurate.

So what the department has proposed to do, and it's gone through the rules task force to help develop some of this language, is proposed to have it be a self-reported number at the first part of the year, and we suggest 90 days. So what we would do at the end of the calendar year, you would have 90 days as a provider to report your number. And what we would expect you to do is to look at your patient care reports as submitted and verify that against your billing data. And then we would have a window of time to remedy any problems or issues before it's forwarded on to the Medicaid office for your assessment.

It gives us a little more faith in the number, a little more trust in the number if you're providing that number to us rather than having us coming up with a number.

So any comments on that? Discussion?

DR. KRISTOFER MITCHELL: The only discussion point was we talked about the 90 days. And is everybody okay with that being the length of time? We also brought up possibly 60 days.

GUY DANSIE: I think -- maybe I'd ask Felicia, but I think 90 would probably be adequate

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for us. Currently we're doing that at the end of July, and then they're making the assessment in October. So it gives us a couple of months. And we've really struggled getting those numbers to be accurate. So we're thinking if it's March, April, sometime in the spring, we'd have until the end of July still to turn those in to Medicaid. And so the length of time at the end of the calendar year is probably -- if it's 60, 90, 120. I arbitrarily chose 90. Is there any discussion on that? It probably doesn't matter to us. I think 90 is probably a comfortable time for our concern.

ANDY SMITH: Guy, that's the calendar year?

GUY DANSIE: Yes.

ANDY SMITH: So starting January you have 90 days to submit your number for the previous calendar year, and then the assessment process would start -- you said like July is when you typically turn it in?

GUY DANSIE: Correct. We've turned the data to the medical office at the end of July, and then they crunch the numbers and they come out with the assessment for the provider in October. I think it's usually in mid October they actually send out

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the bill for what you owe for the assessment. So that would roughly give us six months to work with you, to receive the data from you. And then what we would do is look at it and if we saw it was way out of our range on our PCR counts, we would work with you to audit or change or evaluate that data and hopefully work out any of the errors. So it would give us at least a half a year to work out the errors rather than just the two months.

MICHAEL MOFFITT: Well, the agency should be able to go in individually and look at your database to see what numbers are shown there, right?

GUY DANSIE: Right.

MICHAEL MOFFITT: Then they can look at what their actual billings were, and they'd know if there was something --

GUY DANSIE: -- out. Yeah.

MICHAEL MOFFITT: And maybe could explain it rather than wait for you to catch it.

GUY DANSIE: Right. So I think it's a win/win. I think it's something that would benefit the providers. We would have more accurate numbers; we'd have more time. Felicia and I worked together to try to determine what the number is, but it's -- as you all know, we've had several providers that had

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numbers that were off in the last two assessments. So hopefully this will remedy that problem.

THE REPORTER: This gentleman's name here?

GUY DANSIE: Andy Smith in the back.

TAMMY BARTON: Guy.

GUY DANSIE: Tammy.

TAMMY BARTON: Tammy Barton.

So since this is just in this role that we're talking about right now, are you wanting us to do that for this year or are you looking at that for next year?

GUY DANSIE: Yes.

TAMMY BARTON: Yes?

GUY DANSIE: And yes.

TAMMY BARTON: Okay.

GUY DANSIE: What I wanted to do -- this is my goal -- is bring it to the committee, get it voted on, and then the rule process will take us probably through March. So this rule will probably not be in effect. But with that being said, I wanted to go ahead and ask everybody to provide us a number, a run total number for those runs that qualify. Any time a patient is moved that's a billable run, we would ask you that and do it on a voluntary basis this year. And then moving forward, it would be a

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rule requirement.

There is some language in there saying that you need to do it, and we could audit it. If it's obviously -- if it's an error, that's one thing. Obviously if it became fraudulent in nature, then we would want to look at it closer and make sure that we verify those numbers, you know if we have any red flags or issues on our end. Because any time a number comes that's wrong, it impacts the rate for everybody else. So it's important that the number is accurate not only for yourself but for all the other providers in the state.

TAMMY BARTON: And so you're asking for 2016 totals?

GUY DANSIE: I will be, yes.

TAMMY BARTON: Or two-thousand -- okay.

GUY DANSIE: I will be asking for the 2016 totals in the next few weeks. Then as this rule takes effect next year, hopefully this rule will be in place and we can go ahead and it will be an expectation at that point.

Any more comments? Any motions on this rule, on those amendments?

DR. KRISTOFER MITCHELL: I motion to accept the language as we've just discussed and

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include to increase the 8 percent of the 10 percent as well.

GUY DANSIE: Okay.

DR. KRISTOFER MITCHELL: On top of what we've done.

JASON NICHOLL: Second.

GUY DANSIE: Any more discussion?

Also, just as a note before we take a vote on it, this is the rates rule, and we will be amending and looking at your fiscal reporting data that's been submitted for -- and we will amend this again for July 1st if there is a rate change. So we will bring the rate change, a proposed rate change in April to the next meeting. So we might amend this again at the next meeting. But we'll go ahead and take a vote on the amendments that are proposed at this time.

Everybody in favor say aye.

COMMITTEE MEMBERS: Aye.

GUY DANSIE: Everybody opposed say nay. (Silence.) Any abstain? (Silence.)

Okay. I think it carried, so thank you. I'm trying to make this as painless as possible.

We have two more changes in our rule section R426-5. And for the life of me, I have

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misplaced my version of it. So I will describe what the changes are. The first change -- I'm going to reverse the order slightly on the action items on the agenda. So I want to talk about the 4R -- R438 code moved to R426-5 first, because that comes in the rule first. What is happening here is through our administrative rule process, we -- I have the mic right here.

We've identified a rule number that probably should be moved from the state lab set of rules over into our EMS set of rules. So I have agreed to take that on, and this is the language that you see on the first part of the document, R426-5 starting with 2700. And this pertains to law enforcement drawing blood and becoming permitted to do that. And what we will do is we will repel the rule that it's currently in and have this rule enacted on the same day so that we can move it from their section of the rule to ours.

I've tried to change -- I've tried to change it as little as possible, but some of the language was changed and the numbers obviously were changed. And in our discussion in the lunch session, we talked a little bit about making it clear that certified individuals such as paramedics do not need

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to obtain this permit first. So I believe, Jason, you talked about adding an exemption or a reference.

JASON NICHOLL: Yeah. Taking 2800 and adding a line into 2800 that people that qualify under R426-5-2702 are exempt from R426-5-2800, which is the section about displaying of an individual permit card and that sort of thing. So as long as you have your advanced certification or your paramedic certification meaning you have met 2702, 2800 does not apply.

GUY DANSIE: Does not apply. You would not need to have that additional permit.

JASON NICHOLL: Correct.

GUY DANSIE: I believe the rest of this language in here, other than the numbering and titles, is basically in effect now. So I'm -- so we're basically just moving that over.

Okay. Any discussion on that agenda item? Okay. I'll go ahead and we'll roll that one in with the other amendments that are proposed.

The other amendments are starting with the background screening clearance for EMS certification. And the EMS task force worked with some stake holders on terming some of the language changes. Primarily it was a clean up. There were terms changed from

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like "department" to the "Bureau of Emergency Medical Services and Preparedness" in several places. The term "compliance" -- "complaint, compliance and enforcement unit" was added in several places. And this is just to direct the actual process on how we're doing it internally so that it's more specific rather than using the generic term "department" for identifying who in the department is actually committing these functions.

There is a section being added about fingerprints, having 14 calendar days to process an application. That's part 6, if you are following through there.

Dennis, if there's anything on here as I'm explaining and I'm not doing it properly --

DENNIS BANG: I was looking at the blood draw when you were reading; I worked on that about three or four years ago. So I wasn't paying attention. I apologize.

GUY DANSIE: No problem. If there's anything as I describe this, just let me know on this background clearance.

DENNIS BANG: All right.

GUY DANSIE: Dennis is actually the one that works on this directly.

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As we go through, there are some titles that were added on some of the background clearance items that we will look at. Some things were taken out that were either not in statute or were redundant -- was redundant language with -- they're found in other places in the rule.

And as we get down -- I don't want to read every change, but if there are any questions down through -- just scroll down through.

Jim Hansen.

JIM HANSEN: Jim Hansen, Bureau of EMS. I have a question on this number 6. "Once the completed application fees and fingerprints have been submitted, the bureau has 14 days to complete."

So we don't have time to necessarily get the information back from the fingerprints as submit?

GUY DANSIE: Is that going to create a burden?

JIM HANSEN: Well, I'm not sure how we're going to get fingerprints back.

DENNIS BANG: We don't always get them back in 14 days. We normally do.

However, if we do paper prints or anything like that, it takes more than 14 days to get them back.

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GUY DANSIE: Could we add the term "if possible," instead of "shall."

JASON NICHOLL: He can fix that by changing "have been submitted" to "have been received."

DENNIS BANG: Right. That would work.

JASON NICHOLL: So 14 days after the fingerprints have been received back.

GUY DANSIE: Okay. I note that change. I strike the word "submitted" and add "received back" --

NATHAN CURTIS: Bring it up.

DR. HALLIE KELLER: Yeah. No, "the fingerprint results," right, "have been received." Not the fingerprints have been received.

GUY DANSIE: Have been received back.

JASON NICHOLL: Fingerprint results. Very good. Thank you, Hallie.

NATHAN CURTIS: Much better.

GUY DANSIE: Okay. Is that acceptable, Jim?

JIM HANSEN: Yeah, that will work.

GUY DANSIE: Any other comments?

TAMMY BARTON: Guy.

GUY DANSIE: Yes, Tammy.

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TAMMY BARTON: We're not sure back here, But on the -- what would it be? Section -- I don't know which one it is. It is -- where it talks about beastiality, sexual battery, lewdness involving a child. In both of those, it lists those and then lists aggravated exploitation and prostitution. But it has an "and" on the -- between the third and fourth one that makes it look like it could be those three "and."

GUY DANSIE: When we need to change that to "or."

TAMMY BARTON: Yeah. Because otherwise it's saying they need to have two of those instead of just one of them, "lewd and aggravated." Yeah.

GUY DANSIE: Good catch.

TAMMY BARTON: I don't think it needs to be there. You've crossed it out on sexual battery, but it's not crossed out on the lewdness involving a child.

GUY DANSIE: That would be on number iii.

TAMMY BARTON: I don't think it has to be "or" I think it has to have "and" crossed out.

GUY DANSIE: Okay. So any discussion of the committee on that?

We'll go ahead and we'll make that change

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as parts of our motion.
RUSS MALONE: Guy, the same thing about three lines or five lines down. It's listed "and" also.
TAMMY BARTON: Yeah, on both of those.
RUSS MALONE: Russ Malone here.
GUY DANSIE: Yeah.
TAMMY BARTON: On both of those.
GUY DANSIE: Thanks. Say that one more time, Russ.
RUSS MALONE: Just down -- if you look down about a paragraph, the "and" is down below, listed again.
GUY DANSIE: Oh, I see it.
DENNIS BANG: It's on line 769-702.5.
GUY DANSIE: Okay. There's also a couple of things toward the very end that we probably ought to point out. On the second-to-the-last page of the rule in part H, this is about the peer-review board membership. It says "Prior to the appointment, all prospective peer-reviewed board members shall receive a background clearance as required for EMS personnel in accordance with Section 26-8-A-310. So basically what we're saying is, is before you can become a member of the peer-review board, you have to have a

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clearance as well. Is that right?
DENNIS BANG: Correct.
GUY DANSIE: Then if you turn over to the very last page, page 4, because they are dealing with sensitive personal information with criminal histories, there was some wording added. It says, "Prior to the issuance of the peer-reviewed board recommendation, the certified EMS individual shall have an opportunity to respond to the CCU findings and recommendations and provide supporting witnesses and documentation to the peer-review board."
My explanation was not right for that, but that language is going to be added.
I thought we also had to have a BCI clearance, Dennis.
NATHAN CURTIS: It's on the page before.
GUY DANSIE: Is that on the page before?
NATHAN CURTIS: Yes. Part H.
GUY DANSIE: Part H is the clearance review.
NATHAN CURTIS: Yes.
GUY DANSIE: I get them mixed up. And then you're saying in there we would give them the opportunity to respond --
DENNIS BANG: To respond.

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GUY DANSIE: -- to the findings and have their witnesses or documentation they need. Any further discussion?
So for the rule changes moving the blood draw permitting and the rule changes for the BCI peer-review board and the CCEU, any motions for those proposals?
NATHAN CURTIS: I'll make the motion that we accept these as we've presented with the modifications also.
MICHAEL MOFFITT: Second.
GUY DANSIE: Okay. We'll go ahead. Any more discussion? Okay. Everybody in favor say aye.
COMMITTEE MEMBERS: Aye.
GUY DANSIE: Any opposed say nay. (Silence.) Any abstain? (Silence.) Okay. The motion carries.
Okay. As we move on to the subcommittee reports and action items, Jeri Johnson, who is on the committee normally presents new members' applications and recommendations for subcommittee appointments. However, she was not able to come today. She had a traffic accident down in Scipio because of the weather and so forth. So I don't know, what do you think? Jason is also on the --

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JASON NICHOLL: We'll do it, yeah.
GUY DANSIE: Do you want to do it now?
JASON NICHOLL: Yeah. Let's do it now. We have three applications for subcommittee. We have Robert Stevens, who is a paramedic for Logan City fire department. It is a new application requesting position on either operations or training subcommittees.
We also have Mr. Stuart Willoughby, who works for King County Ambulance. This is a new application also and is requesting either the operations or the training subcommittee.
Then we also have a third application from Mr. Brit Clark, from Weber Fire District, specifically requesting an operations subcommittee.
We've reviewed these applications. They all seem appropriate to us. I'd like to accept these applications as members of our subcommittees and then make subsequent assignments to their committees as is demonstrated.
And we had asked at the last meeting for a report on what positions needed to be filled. So I think we approve these, accept them. And then let's let our two subcommittees figure out where they need the help. They're the closest to the ground on this

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one. So I would make a motion that we accept these three candidates for subcommittee appointment.

JEREMY HOGGARD: Second.

GUY DANSIE: All right. More discussion? No? Okay. We'll go ahead and vote on the motion. All in favor say aye.

COMMITTEE MEMBERS: Aye.

GUY DANSIE: Any opposed say nay.

JASON NICHOLL: I can't for a second, Guy. For Chris and Andy, do you guys have those rosters we talked about at the last meeting about what you need filled and what the current status of the subcommittees are?

ANDY SMITH: I don't. I don't know the number, but I know the positions.

JASON NICHOLL: Okay. Then for the next meeting let's get that figured out so we can make sure we get these folks to the right committee.

GUY DANSIE: Just a comment on that, too, I'll have Jenny work with the committees and subcommittees on that too.

JENNY ALLRED: Who sanctioned the motion?

GUY DANSIE: Jeremy.

And I think we already voted the ayes and the nays. Any abstain? (Silence.) Okay. The

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motion carries.

Okay. The next item on the agenda is the grants update. I received an e-mail today from Ron Morris saying that he did not have any updates that he felt he needed to present to the group today. Gay Brogdon is a department staff member who works with me, and I know she is not able to attend today as well. But her concern is just to let everybody know that the contacts have been made to every licensed agency and designated agency who qualifies for grants, to let them know that they need to submit the rosters. The deadline, I believe, is the 27th. Everybody is nodding their head. So the 27th of January, this month. So I would plead with everybody that wants grant money to get those in for the per capita portion. And then the competitive portion will be coming up in -- I believe it's due the end of March. I can't remember the exact date, but it's sometime at the end of March. It's on the website. So that would be my update on the grants, on their behalf.

Any comment or questions on that? Okay.

So I keep forgetting that I'm conducting. Professional development update by Chris.

CHRIS STRATFORD: Sure. The professional

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development subcommittee has three items that it's currently working with. The first one is that we did a survey with of course coordinators and training officers for EMT and advanced EMT programs and found that there is some confusion or some improvements that can be made with the education regarding automatic transport ventilators. So the committee will be working on recommendations and guidelines, tools to support training officers and of course coordinators that they can use in order to train better on automatic transport ventilator use.

It is required in EMT and AEMT education. Obviously it's included in paramedic education as well, but we've only focused on EMT education and AEMT education. So we will develop some objectives, some resources and some guidelines that they can use to improve AEMT training.

GUY DANSIE: Thank you.

CHRIS STRATFORD: Any questions by the committee on that topic?

GUY DANSIE: I have one question, Chris. Did you have any action items, anything that you needed to present to the committee for a vote?

CHRIS STRATFORD: No. Just as information that that's where we're working. Nothing will change

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there. Once we have that put together, we'll -- I think, Jason, you've been attending our meetings. I'm happy to have you look over that and see if there's anything specific that needs to be done. So just an information item that's there.

GUY DANSIE: Okay.

CHRIS STRATFORD: The second item that we've been working on is with initial certification at an EMT and EMT at a paramedic level, people receive National Registry Certification as well as Utah Certification. There are some people that want to continue and maintain their National Registry Certification, which has specific rules that document what their continuing medical education and re-certification requirements are.

Nationally -- for the national registry, Utah is -- the three options that they have to do that: One is an old traditional DOT refresher course, one is using the National Continued Competency Program, the third has been to re-certify through examination.

The guidelines for the NCCP are clearly established for national requirements for re-certification: 50 percent of the CME hours are required determined by National Registry and EMT,

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25 percent of those hours are determined by state and local requirements, 25 percent of those hours are determined by individual requirements.

Utah is an NCCP state, meaning that people that want to re-certify their National Registry need to use the NCCP requirement. It means that there is, in that 25 percent from a state regional requirement, there is nothing that's established in Utah for those hours. And this again applies only to National Registry re-certification. So the committee is working on developing continuing education requirements for that 25 percent of the required hours for National Registry re-certification.

In the process of that, we're also reexamining the Training Officer Manual for Utah's re-certification, seeing if we can align the National Registry requirements for re-certification with Utah more appropriately. Currently in Utah there is no topic specific hour requirement for re-certification. So we want to explore, through this next year, what are possible topics that are current and relevant to EMS practice today that follows the NCCP guidelines and that National Registry is using.

As we continue to work with that and develop that more, when it comes time to make changes

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to the Training Officer Manual, we'd be happy to share that with you. Again, Jason, we'd love to have your input with that and see where we can go with that.

Any questions of the NCCP project that we're working on?

JASON NICHOLL: Could I just make a follow-up comment on that?

CHRIS STRATFORD: Yes.

JASON NICHOLL: I just want the committee to understand that this is actually a big issue for our agencies. Straddling that line meeting the State re-certification and meeting the National Registry re-certification is becoming harder and harder. And so the work that Chris and the Professional Development Committee are putting into this is to get our state re-certification to the NCCP standard. And it's not that we're less than the standard; it's just different. And it's different enough that it makes recertifying -- it puts too much difficulty on the provider to make sure that they're checking all of the NCCP boxes. So this is a very important piece, and I hope that within the next year we'll have a completely new training outline really, or schedule, that will provide a lot of ease for -- I mean all of

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the providers that have national certifications, it's a pain, I know. We're trying to help with that. So just be patient with us.

And my applause to Professional Development for taking this on. It's huge.

CHRIS STRATFORD: Thank you, Jason.

One of the real advantages to the NCCP program in the way it's set up is current and relevant things as they change. With medicine changing as quickly as it is, this will keep us current and relevant to the changes that are currently happening with EMS care. So we're excited about it. It's a good thing for us to be involved in.

The third item that we're working on has to do with EMT certification at an initial level in providing the National Registry Psychomotors Skills Exam at the EMT level. With the change into National Registry as being the testing vendor that verifies written and practical skills competency, the implementation from the EMT side has been a little confusing maybe. There's been some questions about that process and how that's actually done. We're using of course coordinators currently as representatives from the Bureau of Emergency Medical

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Services to supervise and make sure that that goes well.

What we want to do is to create a process that is streamlined that has practical examples that they can use on efficient ways of administering that exam in a fair and an unbiased way that meets the standard of National Registry and verifies true competency as psychomotor skills go within EMT. So that's where our time this year is going to focus on that as well. And we're hoping to get that done as quickly as we can.

But that would necessitate rewriting, update -- not rewriting. But perhaps updating the coordinator manual and some of the requirements there as far as how to administer efficiently and appropriately and accurately the EMT psychomotor skills exam that's recognized by the State and recognized by National Registry. So that's really the three focuses of where we're going, where we're headed in the next year.

GUY DANSIE: Thank you, Chris.

CHRIS STRATFORD: I'm happy to address any questions.

DR. PETER TAILLAC: Good work.

GUY DANSIE: We appreciate that.

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Subcommittees are very valuable to the whole process, so thank you very much.

CHRIS STRATFORD: Sure.

GUY DANSIE: Andy, do you have anything else?

ANDY SMITH: I can stand because my tibia is not broken.

So the EMS operations subcommittee met on November 9th. We had a myriad of topics discussed there. First we nominated a new vice-chair, Lyndsie -- is it Hauck. H-a-c-k [sic]?

JASON NICHOLL: Hauck.

ANDY SMITH: Hauck, okay. I don't know how to say the last name, sorry. But South Salt Lake paramedic, she will be the new vice-chair, and that will automatically roll over to the chair next year. I'm looking forward to that time.

So also we discussed disease testing for bloodborne pathogen exposure. This is the second time discussing that in this meeting. I think Guy pretty much took care of it. It was really hard to kind of get all the voices heard and make any kind of conclusions in a meeting with that many people. And it sounds like we discussed kind of what Guy had come up with. And also Eric from Ogden City brought their

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kind of -- their model of what they're using, and it fit really well. So that's going to be included with information that will be available to all agencies about if you have an exposure, how is that tested? What's the process? Who pays for it? And all of those things will be there.

GUY DANSIE: Can I add just a little comment?

One of the things, I know Dr. Taillac has worked on this, and there's information on our website now. As we reached out to the lab and to our EPI folks, we wanted to update some of that information. And I wanted to go through Dr. Taillac, and it's just been one of those things that I haven't done all the way. I need to get with him and vet that through him, but we're -- our updated information is pretty much there. So thanks.

ANDY SMITH: Yep. We discussed cost quality and access. That's been something that's kind of come up two or three times in the last year in our meetings. And a suggestion was made that that rule should probably be introduced to the Utah Association of Counties as well as the Utah Leagues Cities and Towns, however you say that, for them to review. Because really the purpose is for them to

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take some ownership of the system for the county or the town or the city, whoever owns that licensure, for them to take some ownership of the system and not to put an extra burden on the EMS provider. And so that discussion came up, and I believe that will get introduced to those to at least review and look at that rule.

But that -- I think that's something that we'll probably have to keep looking at and talking about in the committee every once in a while, seeing where it's at and what we can do to help. I think Jason made that recommendation, which I think was a good thing to let them know about it. A lot of them don't know that it's their requirement to review their cost, quality and exit poles on re-certification.

Guy explained Medicaid assessment and self-reporting of numbers which was good. And we also discussed the epinephrine and anaphylaxis. Dr. Taillac's information about being able to use -- basically it's being able to draw up their own EPI and those kind of things, which I thought was great. Lots of hand-outs that he had that were fantastic. That's been e-mailed out to everybody I know. I think everybody has received that information.

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And then there's some other things we wanted to look at. I personally want to take on this financial assessment process and rate and rules regulation. Whether that's appropriate for this committee, I'm not sure. That's up to you guys to decide, or whether it's not that's fine. I'd still like to be involved in some way.

And then we also discussed state-wide sexual assault training, and that may not be our committee. That may be something for the other committee to look at. But it is something that I know our providers lack a lot in. In dealing with sexual assault and the process and handling them and those kinds of things, that is -- I know my providers lack in that. And I think all of us would say that. It's not something we deal with that often, and the guidelines aren't -- it's not clear. It's not like you can go to a protocol and say this is exactly how to handle this situation. So I think it's training that needs to be had. That might be something for the Professional Development Committee. But we discussed that in our meeting.

And that's it, unless you guys have any assignments for us.

JASON NICHOLL: We discussed in our

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pre-meeting and Mr. Moffitt brought up the need to potentially put together a task force to look at rate development -- or look at the FRG in the calculations. I think that's a good recommendation, and I think we should entertain that, putting one together as soon as possible so that it coincides with the FRG development and the other financial changes that we've already made today.

So what is the -- what's the committee's thoughts on that? What do you guys think? Something we should put together?

NATHAN CURTIS: Yeah.

DR. KRISTOFER MITCHELL: Yep.

JASON NICHOLL: Okay. So I think that that's something that -- I don't think we need an action item on that, but definitely formulate a group with that. I think that it would be appropriate to have John and Andy and Mike, myself -- Nate, do you want to participate on it too? You can say no.

NATHAN CURTIS: I might assign somebody to do it for me.

JASON NICHOLL: Okay. But I think we need to actively go down that road. And I'd like to propose that -- not as a motion, but as a --

MICHAEL MOFFITT: Well, I think what we

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probably want to do, since rates are solely under the bureau's authority, is direct the bureau to form a task force.

JASON NICHOLL: And that's what I'm getting at, and you already have some volunteers.

GUY DANSIE: Speaking for the bureau, I will agree to that. I think we actually are actively seeking out that information and what's best for the providers. So we did talk about it, that in the operations subcommittee meeting maybe they could take it on. And maybe we can bring in some of their representation, Andy and others if they desire.

ANDY SMITH: I think it would be good to have some other folks, if you looked at it a little more than just the operational folks. I'm into it pretty deep. But somebody like Mike right on the front lines, that would be good.

GUY DANSIE: So we'll go ahead and do that. I'll put together some -- maybe some membership lists, and we'll look at that. Between now and the next meeting, I -- we'll seek your input, and we'll go ahead and we'll develop that. And those that are volunteering today, we'll go ahead and add them to the list and then we'll start working on that.

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MICHAEL MOFFITT: I think we could probably get at least one meeting in before the April meeting.

GUY DANSIE: Yeah, I think that would be good, start maybe in February.

MICHAEL MOFFITT: Start to get ground work and get back where we're at.

GUY DANSIE: Let's shoot for maybe a February date, if that's okay.

MICHAEL MOFFITT: Sure.

GUY DANSIE: Have a kickoff meeting. Are you okay with that, John?

JOHN HOUSKEEPER: Yeah, that will be helpful.

GUY DANSIE: Okay.

ANDY SMITH: I should also say -- sorry, I don't know if this is part of my report technically or not -- but it was a great meeting in Moab. They brought a bunch of EMS instructors together. We had some fantastic folks from the bureau that came down. And we grilled them hard, and they answered all of our questions and helped us with the new website and helped us with the FRG. And it was just -- it was a really great meeting. We really appreciate the bureau's support with that. A lot of the EMS

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directors were able to get questions answered in a good, appropriate forum, and it worked out really, really well. So thank you to the bureau for that.

GUY DANSIE: You're welcome.

Andy, while we're on that topic, and I know it's not exactly on our agenda, but I just wanted to -- anybody that's in the room that this may pertain to, rural EMS. This may not be fire based. The ones that probably aren't as organized as some of the fire agencies. But did you set another meeting date or firm that up?

ANDY SMITH: We did. It's in Mr. Curtis's area in March.

TAMMY BARTON: End of March.

ANDY SMITH: End of March, and we'll get an e-mail out to everybody.

CASEY JACKSON: Stuff like this, to be honest, as a committee I'd love to know about it. I really would.

ANDY SMITH: Yeah, I'd be happy to send out the dates. It's open to anybody that wants to come. Moab was cold that time of year, so I didn't invite Jason. Everybody else was going though.

GUY DANSIE: And as the department we would love to help support that in any way possible.

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We do have constraints on travel and things like that. But we'd love to do that, and we appreciate your support with that.

Okay. Moving on the agenda. Dr. Taillac, we'll turn the time over to him for his informational update.

DR. PETER TAILLAC: Hi folks. I'm Peter Taillac for those who don't know me. I'm the medical director for the Bureau of EMS. I'm proud to say we have 2017 EMS Protocol Guidelines. The first set of guidelines -- the first time we did the protocol guidelines was in 2013. So this was a good time for an update. It was effectively three years later because we started -- we formed the guidelines committee, re-formed it at the beginning of 2016 and met throughout 2016 to review each one.

And the goal was to look at the national model guidelines that have been published by NASEMSO, see where ours fits against theirs, make modifications where appropriate. We're not copying them. But we took some of the good stuff that was there and incorporated them into our ours, looked at recent literature relative to EMS treatment in the field, incorporated recent literature into it.

I think they're -- as a matter of fact I

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know, because I'm intimately familiar with them, that they are updated and state of the art for now. I'm really proud of them. They were distributed to the committee ahead of the meeting for review. And I just might ask, I accidentally gave you doc Word versions. I would ask please don't share those. We keep those -- agencies are welcome to the Microsoft Word versions; we want to use them. But I would prefer that they ask for them directly so they don't end up getting excessively modified and they look like they were the State's. Does that make sense? We normally send them out in a PDF, and I'll do that after the committee gives me any input. I appreciate any input and comments you have on them.

I also wanted to take the public opportunity to thank the committee. This was a really big deal to go through each of those, and we divided them into sections. The committee was Jenny -- thank you very much, Jenny Allred, who kept herding the cats and kept us meeting on time and minutes, et cetera. Minutes that were very arcane at times I would say.

Annalyn Beers was our public member. Andy Ostler, Chuck Cruz -- Hilary Hews, who, God bless her, she and Andy and Tia Dalrymple went

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through every single pediatric guideline. So they had to look at all of them, not just one quarter of them like most of the committee members did.

Joey Mittelman, Dr. Mark Bair, Clint Smith, Dr. Russ Bradley, Dr. Scott Youngquist, Jack Meersman and Dr. Hill Stockline [phonetic]. If you need spellings after, let me know.

Everybody met and really worked hard and provided drafts back, and then I took on the job of sort of putting it all together and then going through every single one to make sure all of the formatting was the same and you know the word verbiage in each section was the same as in every other section. So we're very proud of it.

Just by way of review of what's new so to speak, overall they didn't change very much. There are some highlights that I'll tell you about, but pretty much they were up to date already and for the most part remained so. There were some technical things and some wordsmything here and there to make them more consistent.

But relative to updates, we had an updated burn protocol with a simplified fluid for EMS for burn patients that was reviewed and blessed by the burn folks at the University. We have a brand new

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general trauma protocol which I took from the national guidelines, which reviews how to look at the trauma patient as a whole. In addition to the subsections in trauma, there's a new hemorrhage control section that's been updated based on recent literature. And for the committee's information, the Trauma Systems Advisory Committee has in detail reviewed the trauma section and blessed it already.

So aside from trauma, there is a allergic reaction protocol we've rewritten to match an evidence-based guideline that has actually not yet been published but will be I hope this year, since I'm the main author of it. And hopefully the rest of team will get their shit together -- oh, sorry. Will make sure it gets published this year finally.

In BLS we mentioned epinephrine. Andy mentioned epinephrine. The cost as EPI pens, as everyone knows, has gone through the roof. It's made national news. And as part of a response to that, several states, including us, have allowed BLS providers to be trained by their agency directors and medical directors to draw up EPI in a syringe. Two simple doses to choose from: One for big people and one for little people, and to administer that IM injection.

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The administration of the injection is really no different than the EPI pen or very little different. But the drawing up is a new skill that's not actually taught in most EMT courses, so this is a new thing.

In parallel with that as part of the response is our opioid epidemic in this state, which we share with many other states, we have decided to allow EMT agencies who so desire to use Naloxone in injectable form as well and draw up the Naloxone dose as per the training of their medical director or training officer and administer that intramuscular if they prefer. It's cheaper to do it that way than to buy the nasal spray. The nasal spray works too, and so this is an optional thing for EMT agencies.

As a quick side bar, there's a new nasal spray manufacturer for Naloxone that's been knocking on my door a lot, and they would like to get their product out. So after talking to a few of the folks in the bureau, it looks like it's okay. I have offered to them to offer to every EMT agency in the state three -- three to four vials of their Naloxone product. So an e-mail is going to come out soon to say if you'd like some, contact these people. They want to get the product out there. It's cheaper than

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what's in the market right now, so I thought it was an opportunity to get a freebee and introduce another potential route for managing these opioid epidemic -- or opioid patients particularly for EMT-level agencies.

So those are kind of two big things, drawing up the medication for the epinephrine and the Naloxone.

Probably the biggest sort of highlight of new medication allowed will be Ketamine. I don't think this is new news to a lot of the agency's directors here. Everyone has been kind of waiting for this. Ketamine is a -- for layman's terms, a sedative medication that takes a patient who is going crazy, who has agitated delirium because they're on drugs or psychiatrically disturbed or both, and puts them to sleep in about three minutes, maybe five with a single IM injection, a single intramuscular injection.

Very much I think it's a safe medication. It doesn't affect airway or breathing at all, which makes it very unique. It's been around for about 50 years and has been creeping its way into EMS nationally. And I think we're ready for it here in order to protect our providers from these very, very

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dangerous and difficult patients and protect the patients themselves from self-harm.

It lasts, by IM injection in an adult or a kid, about 45 minutes. And after that they wake up just as crazy as they were before, so keep that in mind. This isn't the long-acting stuff we use in the emergency departments to knock them down for six or eight hours until they metabolize their drugs or their craziness. But this gives EMS a rapid response to help prevent injury to themselves and the patient and 45 minutes to get them to the hospital.

I want to make one comment. In all the literature published, and there's a fair amount in prehospital use of Ketamine, the patient is completely unresponsive and this scares people sometimes. So in other areas of the country where they've implemented this, initially when they bring the patients to the hospital, a large percentage of these patients got intubated by the docs in the hospital because they were so unresponsive. The GCS is like 4 or 6, okay. You don't have to do that.

And so as part of this roll-out, I'm going to try and send a message through the medical association to the ER docs and nurses in the State to say: Ketamine is coming. Patients will look like

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they are obtunded; they do not need intubation. Because as I said before, Ketamine does not affect your airway reflexes or your breathing. They will breathe, and they will protect their airways just fine even though you could drop a large boulder on them and they wouldn't notice actually. So it's a really, really good medication that way.

Andy?

ANDY SMITH: Just a quick question. Is it only going to be -- from the State's view, is it only going to be allowed for chemical sedation or can it also be used for extreme pain?

DR. PETER TAILLAC: Good question. Ketamine can also be used for pain. It's off label, not FDA. Nor is it FDA approved for what we're using it for frankly. So again, this Ketamine is an optional medication on the State protocols for paramedic use only on the State protocols. What you and your medical director decide to do with it will be up to your agency. So in other words, you'll be able to stock it. And when the inspectors come around, you'll get a blessing that you have it or don't. Either is fine. But if you have it, you guys can decide what you want to use it for like other medications. Does that make sense?

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But the State guideline is only for agitated delirium. We did not put it in the State guideline for pain. But for many reasons I'll be happy to --

DR. HALLIE KELLER: Including different doses for pain versus sedation.

DR. PETER TAILLAC: Absolutely. But it's not in the State guideline for pain at all.

DR. HALLIE KELLER: Right, right.

DR. PETER TAILLAC: My personal feeling was overall this is a brand new deal. It's going to be a relatively big deal for the ERs to see this coming in, and I thought it was better to kind of crack open the door with this indication from the State level. Whatever your agencies want to do is completely up to your medical director as per state rule and regulation and statute.

JASON NICHOLL: Does it comment on how many doses may be used as --

DR. PETER TAILLAC: One dose. In the State guideline -- now keep in mind for those who don't know, the State protocol guidelines are completely voluntary. You may use them, not use them, modify them, do whatever you want with them. They're there to help. I'm proud to say since we

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introduced the first ones, my rough estimate of 75 percent plus agencies are using them in some form, either verbatim or modified to fit their agency. So I'm very proud of that because I think it's helping improve the consistency of care in the field throughout the state. So the drug and equipment list will be updated to match the State protocol guidelines. And all of the optional things in the drug and equipment list will be reflected in the guidelines as well, just so you know. And so when the inspectors come around, Guy and I will make sure they have the latest information.

And Guy, will they have X number of months or weeks or minutes to update their rigs based on the number?

GUY DANSIE: We would need to give them an implementation period. And I don't know -- actually, Don might have an opinion on that. Do you --

DON MARRELLI: I don't have an opinion on that.

GUY DANSIE: -- stay out of it?

DR. PETER TAILLAC: I mean obviously we'll talk about it.

GUY DANSIE: Six months or something like that.

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DR. PETER TAILLAC: Six months or something to get your rigs reformatted with any new things that are in the new drug and equipment list based on this update. Fair enough?

Any -- I'd appreciate any comments from the committee about the guidelines, if you have thoughts or if you have looked through them. I'm sure you didn't read every single one.

JASON NICHOLL: I read them. They're very nice and very easy to read. I think in a pinch they'll work well on a Smartphone or a tablet for someone who may need to refer to them. I think you guys did a stellar job.

DR. PETER TAILLAC: Thank you very much. The committee worked very hard on them.

DR. KRISTOFER MITCHELL: Did the trauma committee talk about Ketamine issues with head injury patients if they don't realize there's a traumatic head injury?

DR. PETER TAILLAC: I would say that they did not ask that question specifically, no. They were made very well aware. They got the same speech about Ketamine that I just gave to them. Although in the literature, the single-dose Ketamine for a head injury patient is termed as completely safe.

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DR. KRISTOFER MITCHELL: It's just when they get to the EM, you know what I mean, the trauma surgeon will need to know. You know what I mean? Because the GCS is going to change.

DR. PETER TAILLAC: That's a very good point. That's the only down point is the GCS being low when the patient gets there.

DR. KRISTOFER MITCHELL: Because I didn't want the patients to be forced to get unnecessary procedures done to them because it was thought GCS showed a head injury versus the other.

DR. PETER TAILLAC: Very good point. I hope they don't get intubated. I would say in a trauma scenario, they might get extra CAT scan or two. But again it wears off in 45 minutes from the time of administration. So if we just wait it out a little bit, the patient is going to wake up and need something else.

DR. KRISTOFER MITCHELL: It is safe, I agree with you. It's whether they're going to get an extra procedure.

DR. PETER TAILLAC: That's good point. I can refer you to my little love note about this change.

Any other comments or questions from the

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committee?

JEREMY HOGGARD: What's your roll-out time when they'll go into effect?

DR. PETER TAILLAC: As soon as I get around to sending them out to all the agencies. My goal is February 1st, so by then. Okay. That's it. Thank you guys very much.

GUY DANSIE: It looks like I'm next on the agenda: The Legislative bill for REPLICA and dispatch background checks.

I just wanted to update the committee and the audience that the Department of Health is pursuing a legislative -- a legislative bill to look at the EMS Act. Last year the REPLICA bill passed. It was interstate compact for paramedics and EMTs who could practice in other participating states. And as we enacted that legislation last year, we also looked at our Act. And the way it's currently written, we need to change some of the terminology. We need to change the term "certified" to the term "licensed for individuals."

So Dean Penovich and myself worked a little bit on the language. We've submitted that to our legislative liaison, and it has received our EDO's blessing to move forward. And we have a

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sponsor for that: Representative Gardner. And he's looking at pushing another bill to change the wording in our Act. So be aware of that, and it will be coming out.

Also in that change, we also asked for dispatch -- emergency medical dispatchers who were already receiving background checks by the Department of Public Safety to have an exemption for a background check that we would run on them by the Department of Health. So instead of having them have to receive two background checks that they're currently required to do, they would only need to receive the one that the Department of Health and Safety is doing. And that's a cost-savings measure. And we believe that public safety is doing a good job of that, and we don't need to do an additional background check on the same people.

So those two things are in the bill that's coming up. I don't think it has a number or anything else, but we'll be sharing that and updating as needed.

If you guys hear anything as the legislative session starts, let us know. We'd be happy to discuss the reasons for that and where we're going with that.

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John, do you have -- do you want to do an update on fiscal reporting guidelines?

JOHN HOUSKEEPER: Yeah, what we've got. I'm John Houskeeper, just for the notes.

The first page of the instruction that does have the total assets on there still, that won't be included.

GUY DANSIE: Yeah.

JOHN HOUSKEEPER: This is what we want the entities that are reporting on a calendar basis to use. So that those will be reporting in March.

Some of the changes to it, there was a section there under the revenues, a big section that had revenues billed and adjustments. And that's just being collected by ambulance collections. So we're trying to simplify the form so it's more -- simplifying things down for everybody.

With the committee this morning, we did talk a little bit about some of the in kind. I don't know if there's a place on here to include that, but I would think under "other" they could include in-kind payments.

GUY DANSIE: I think maybe the committee members -- we talked about this openly in our lunch meeting about using this current fiscal reporting

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guide this year and collecting the data with this year. And then as we move into 2018, we revamp it based on the new ad hoc committee that we're going to put together in February.

JOHN HOUSKEEPER: Right.

GUY DANSIE: So...

JOHN HOUSKEEPER: So those are basically the changes. I don't know if there are any questions on this. I mean I'm welcome to help anybody who has questions as they fill out the forms, work with your accountants, whatever, so that the information provide applies to your financial statements.

GUY DANSIE: Any questions or discussion? Okay. And then we'll be looking forward to our next meeting. We'll actually present some of those findings and the recommended rates in our next meeting. So that will be an action item -- action item in the next meeting. That moves us to the round table discussion.

DR. PETER TAILLAC: I apologize. I have one alibi, so to speak. So in the new protocol guidelines, there's another whole protocol I should mention. There's a brand new cardiac arrest protocol that goes kind of from soup to nuts and follows the kind of best practice high performance CPR

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guidelines. Which is a good dovetail to me announcing publicly that we will hold either four or five high performance CPR training sessions based on the Seattle model around the state, and the dates of those will be published, Chris Stratford is in charge of the project.

We held two in Salt Lake City in the fall. Many folks participated in it from around the state, and we intend to use the folks who participated in that to be the trainers in each of their respective regions when we come around for this. So look for that, and we'll be holding classes. They'll be one day long for high performance CPR. I will be with each one, along with another medical director or two and paramedics, EMTs to use and train. We're doing this with the support of the Heart Rescue Foundation and the Seattle Resuscitation Academy and using their model.

We're really proud of this. And Blair Doll is contributing high-performance mannequins and shipping them into each one for us at no cost, which is very cool also. So look for that in these other announcements.

GUY DANSIE: Any other round table items? I have a couple. One of them, actually before I get

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started down that path, is the subcommittees. We didn't specifically assign them anything. I think we talked about it loosely. Do we want to go ahead and make sure there's any assignments. We talked about the rate setting and some of that. And then Chris, we talked a little bit about what your projects were.

Are there any other things we need to specifically assign to the subcommittees?

JASON NICHOLL: We need to get a report back on their makeup.

GUY DANSIE: Okay. And that's probably between the chairs and the bureau, and we'll get that hammered out. Also, just so you guys know, there has been a concern the last year or two with behavioral health transports, particularly with weather-related situations. We brought that to the committee two or three years ago talking about weather conditions, and today is probably an appropriate day to talk about that. This is kind of developing into something else.

We've found that Ogden and Logan have approximately doubled their number of behavioral transports that they're doing in the last five years, and they want to look at it a little more closely as a region. And I met yesterday with their health care

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coalition coordinator, Kevin Christensen, and also the fire union representative for the northern part of the State. And they want to try to alleviate or discuss some of these transports and bring the hospitals to the table and try to work out some things to make it a little more efficient, more cost effective and possibly change how we do business with moving some of these patients.

I just wanted to have you be aware of that. And we anticipate that the things that come out of there, we'll share with the group and with the state as a whole. So I just wanted to make sure you're aware of that.

Also on dispatch, the last meeting we had an action meeting and we said we probably didn't really need it as an action item. We talked about dispatch centers. And I've been working closely with the 911 advisory committee. And I know that it's probably creating a little friction or maybe some anxiety with some of the centers. And I just wanted to make sure you all knew that we have -- the 911 committee has had some directives from a legislative audit, and they're trying to work through some of those. Basically they're looking at consolidation for dispatch centers and standardization.

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Dr. Taillac and I have actually talked a little bit with some of the people from UCAN, who are part of that committee, and looked at possibly having a contract for a protocol -- or a dispatch system provider and offer some kind of a low-cost alternative for things they're doing now. That hasn't really gone very far at this point because some of the concerns on the 911 advisory committee side of things. I just want to let you know that we're looking at that. And anybody that has any concerns, we don't want to rock the apple cart too hard. If there is anything that anybody has positive, negative or otherwise, please let us know so we can look at that and take that into consideration.

ANDY SMITH: Rocking the cart.

GUY DANSIE: What's that?

ANDY SMITH: Rocking the cart.

GUY DANSIE: Rocking the cart. But as we change things, sometimes it creates negative repercussions. We don't want to do that. We want to look at it from the whole to make sure it's an advantage or something that's beneficial to the group at large. So we just wanted to make sure that that's understood.

Also Kevin left the room. We have a new contract employee, and maybe Scott -- I guess I was going to introduce him. But maybe Scott could update us a little bit on who Kevin is and what he'll be doing. I threw you under the bus a little bit, Scott.

MR. MUNSON: Scott Munson, M-u-n-s-o-n.

So we've brought on Kevin Holts, who's actually a full-time firefighter/paramedic with Sandy Fire Department. He's a part-time employee with the bureau now. Kevin has extensive experience with the Image Trend solutions, and so he's kind of -- he's going to be our trainer so to speak. So he'll be traveling around the State training the agencies that are going to use the State's three hospital system on how to utilize the application.

We feel that Kevin brings a lot of value to the bureau because he's had experience with it, hands-on in the field. And so we're excited he can be part of our team and help us roll out that system.

GUY DANSIE: Thanks. Anything else?

ANDY SMITH: Guy, can I say one thing? Sorry. I just don't know if the bureau or if this committee would be appropriate, but has there been any consideration of committing some letter or

something to our federal legislators about the Emergency Access to Medication Bill that has not passed the Senate. It's passed the House, but it hasn't pass the Senate, dealing with the DEA issue and controlled substances. I would just encourage you -- I've written letters. My county has written letters. I would encourage you guys to get some letters to your federal legislators to get their bill through this session and passed. Because that could be a serious negative impact to our patients if it doesn't, so...

GUY DANSIE: Okay. Good point. Anything else? All right.

Our next meeting will be on April 12th of this year, and I guess we can entertain a motion to adjourn if --

JEREMY HOGGARD: So moved.

NATHAN CURTIS: Second.

JASON NICHOLL: Second.

GUY DANSIE: Okay. All in favor?

COMMITTEE MEMBERS: Aye.

GUY DANSIE: All right. Thanks.

(Concluded at 2:28 p.m.)

REPORTER'S CERTIFICATE

STATE OF UTAH)
) ss.
COUNTY OF SALT LAKE)

I, Tamra J. Berry, Registered Professional Reporter in and for the State of Utah, do hereby certify:

That on January 11, 2017, the foregoing proceeding was reported by me in stenotype and thereafter transcribed, and that a full, true, and correct transcription of said proceeding is set forth in the preceding pages numbered 3 through 67;

WITNESS MY HAND AND OFFICIAL SEAL this 23rd day of January, 2017.

Tamra J. Berry, RPR, CSR

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