EMS Rules Task Force Meeting

EMS MEETING

April 04, 2018

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EMS Rules Task Force Meeting
Bureau of EMS and Preparedness

April 4, 2018 * 1:07 p.m.

Bureau of EMS and Preparedness

3760 South Highland Drive
Highland Office
Salt Lake City, Utah

Reporter: Tamra J. Berry, CSR, RPR

A P P E A R A N C E S

Guy Dansie

Jay Dee Downs

Lauara Snyder

Gay Brogdon

Jean Lundquist (via phone)

Teresa Brunt (via phone)

Dean York (via phone)

Regina Nelson (via phone)

ALSO PRESENT:

Alton Giles
Brook Barnson
Brett Cross

P R O C E E D I N G S

JAY DEE DOWNS: Just for guys on the phone, we've heard you were here for who was on the phone. This is Jay Downs. Then we also have Lauara Snyder here, also Alton Giles.

And who is with you, Alton?

ALTON GILES: Brook Barnson.

JAY DEE DOWNS: Brook Barnson.

And then the man with the plan.

GUY DANSIE: Brett Cross.

JAY DEE DOWNS: Brett. And Guy and the Tigger lady and Gay. The bouncy-bounce.

THE REPORTER: I see.

GUY DANSIE: Okay. I'm going to go ahead, and let's just flip the agenda a little bit. I had R-426-5 last.

But Brett is here to talk a little bit about a couple of the issues. We've talked last time. The committee wanted us to mirror the National Registry's training requirements. In Rule 426-5 currently, it's set up on the four-year cycle with: Every four years you shall do X, Y and Z for CME.

What we would like to do is reference -- I didn't give you a copy of that one, by the way.

But what we would like to do is just change the four-year to two and then refer to the national -- what do you want to call it, Brett? The National core --

BRETT CROSS: The National Continued Component -- or Continued Competency Program.

GUY DANSIE: Okay. We'll refer to whatever their current requirement is. So if you guys are okay with that, with the rule, we'll just go in -- it's already in draft, and we approved a bunch of stuff already. It hasn't gone through public comment. But what we could do is change the four-year to two and then refer to that as the requirement rather than describe it in rule. That way there's only one keeper of the requirements, and that will be the National Core. Is that good?

JEAN LUNDQUIST: Are you talking licensing of the agency or the individuals?

GUY DANSIE: Individuals.

Let me back up just a little bit. Last July in our EMS committee, we were told that it's become problematic for many of the larger services, especially who have two different requirements: One for National Registry if they're National Registry certified, and the other for the state. So we can't

change National Registry. So we were eliminating our requirements that are different. We were going to adopt their CME requirements. We already do their testing for new EMTs. And then they're on a two-year cycle, so we were going to adopt the two-year cycle to mirror their requirement. And part of the reason we're doing that is to streamline our end. For anybody who is National Registry certified, all they have to do -- or even if you're not, we can have their people manage the records so that we know how much training has been done. And then they can tell us immediately through their database that you meet the training requirements, whether you're certified with them or not. So it creates a repository for training for the state. So we have this free ability to have all of our training records managed by them for free, and then we merely get their approval back that you've met those training requirements.

Am I saying that correctly, Brett?

BRETT CROSS: (Witness nods head).

GUY DANSIE: And so if we mirror them, we can have them do everybody in the state if we have the same cycle. So that's what our purpose in moving to that is. It actually reduces the amount of CME hours that are required for the --

JEAN LUNDQUIST: That's what I was going to ask, it doesn't put any extra burden on them or anything?

GUY DANSIE: It reduces it, as far as hours of CME. We're also removing -- Brett wanted to talk about this, removing the -- right now we have verification on our end. Before we issue a license or formally a certificate, we had to verify CPR, TB -- what else, Brett? Training?

BRETT CROSS: PALS, ACLS.

GUY DANSIE: PALS, ACLS. What we want to do is take that out of our end and leave it at the provider end. So whoever hires that individual would need to verify they had those things.

DEAN YORK: Will the price for re-certification stay the same for two years as it was for four years or --

GUY DANSIE: No.

DEAN YORK: -- drop in price because it's every two years?

GUY DANSIE: Correct. We're dropping the price. It was 60; we're going to 40. And the fingerprint requirement, this is for re-cert, there will be no fingerprint requirement anymore. You already have that submitted once, and you're done.

You do not need to do that every time.

DEAN YORK: Thank you.

JAY DEE DOWNS: The next question: You drop PALS, you drop CPR, you drop TB, right?

GUY DANSIE: That's on -- no. We're saying you still need to do it.

JAY DEE DOWNS: But you don't have to submit it.

GUY DANSIE: Yeah. You don't have to submit.

BRETT CROSS: Yeah. So it will be an honor system for non-affiliated and then the honor system for the affiliated as well in that they will say, "Yes, I have a current CPR card. Yes, I have a current PEPP or PALS. Yes, I have current ACLS."

And then the Bureau then reserves the right to audit those records. So when we come out to look at your training records, we'll say, "Show us Guy Dansie's PEPP card," and you'll have to produce it.

And then it's just saving some uploading and some letters and things like that to -- we're trying to make this as painless as possible for the providers too.

JAY DEE DOWNS: That's right, because the

doc has to go on National to prove -- for the individual. So why should they have to have a letter twice?

BRETT CROSS: Yeah, they don't. We're trying to eliminate that letter. And this would do that by saying, "It's an honor system. Do you have these things? Yes or no?"

JAY DEE DOWNS: So non-affiliated, what do you do with those guys? Do you --

BRETT CROSS: We would audit them individually. So we'll have -- like a member of our staff will send out a letter to them saying, "You have been randomly selected for audit and submit all of your stuff."

JAY DEE DOWNS: Most of your advanced paramedics are associated with an agency, I would imagine.

BRETT CROSS: Yeah, they're affiliated.

LAUARA SNYDER: So with the price of this, in the past it would be $60 for four years. And now it's going to be $80 for two years. So we're still having --

JAY DEE DOWNS: No, 40.

GUY DANSIE: It would be $80 for four.

LAUARA SNYDER: 80 for four; that's what I

meant. I'm sorry. So you still have like a 25 percent increase that these agencies with maybe 100 people are going to have to somehow budget for; is that right?

GUY DANSIE: Yeah.

ALTON GILES: But you are dropping off the fingerprint price.

GUY DANSIE: Yeah, fingerprints are all one and done. So initial you need that, but then you don't need it again.

LAUARA SNYDER: Is this part of the process for moving to that National or --

BRETT CROSS: REPLICA.

LAUARA SNYDER: Huh?

BRETT CROSS: National Registry is this process.

LAUARA SNYDER: Well, I know what National Registry is, which I don't really like anyway.

But is this towards that compacting thing where --

GUY DANSIE: This helps --

LAUARA SNYDER: -- the states aren't really going to have that much and we have to hire administrative people for the compacting? Remember this was discussed a couple of years ago, and like

how is that going to be funded?

JAY DEE DOWNS: Compact?

LAUARA SNYDER: Isn't that the compact?

GUY DANSIE: Actually, there are some travel costs. But most of what I do with the compact, REPLICA is over-the-phone conferencing. We have two meetings --

LAUARA SNYDER: No, I don't just mean you or the state of Utah in particular. But it was talking about how the compacting would relieve the states of a lot of processes, and that they would need to have legal and secretarial and all of these kinds of things.

My question then was: Who's going to pay for all of that? So I guess that drills down to: Are some of the reduced things at the state office, the money savings there, going to help pay for the things on that National compacting level? How is each state going to pay for their portion?

GUY DANSIE: For REPLICA?

LAUARA SNYDER: Not for REPLICA. For their management as -- aren't we moving forward toward this compacting thing?

GUY DANSIE: Yeah, yeah. In fact, we've already adopted it.

LAUARA SNYDER: Yeah. That's what I thought.

JAY DEE DOWNS: That's REPLICA.

GUY DANSIE: Yeah, that's REPLICA.

LAUARA SNYDER: Who funds that? Where does the money for the legal and the secretarial and all of that come from?

GUY DANSIE: Most of it is done -- REPLICA is contracted with National Registry for part of it with AMSI who does the NASEMSO, the National Association for State EMS Officials. Those two organizations are providing the support to REPLICA to function.

LAUARA SNYDER: Okay.

GUY DANSIE: And currently they have an attorney. We can talk about that more extensively.

LAUARA SNYDER: I just wondered if this was part of that with all the funding and stuff.

GUY DANSIE: No. I -- it's not directly tied to it. There is a small cost the state incurs with REPLICA due to my travel and my participation. But the database that will manage all of the records is actually being provided by National Registry, so...

LAUARA SNYDER: So if you have an agency

that is not National Registry, so you're just an EMTI or A agency and you've been that way for a long time, now some of the newer people being certified are National Registry but maybe your core group of people are not. Like I'm not, and I'm never going to be.

GUY DANSIE: Right.

LAUARA SNYDER: Do I still have to give National Registry all of my training record?

GUY DANSIE: Yes, if we move to that. It's called the Mark King Initiative. What it is, is they agree with the state to house -- to have the database, the system that holds the records.

And then they turn around to the state and verify, "Yes, you have the training or, no, you don't," as a service back to the state.

LAUARA SNYDER: Is there going to be a cost for myself or for my agency --

GUY DANSIE: No.

LAUARA SNYDER: -- for them to manage my records?

GUY DANSIE: Well, there's still a cost as far as like your licensing, and there's a cost to be National Registry certified. But the State will migrate those records over, and from what I understand there is no cost. We're not initiating

any new fees to house that. And it will help the State so we don't have to manage it on our end.

GAY BROGDON: So for her to put her records into National Registry, it's not going to cost her to --

GUY DANSIE: No, not what --

GAY BROGDON: -- put in or to pay for an account?

GUY DANSIE: I don't know. Brett is going -- I don't know. I don't believe --

BRETT CROSS: We haven't had that conversation.

LAUARA SNYDER: Nobody does anything for free.

BRETT CROSS: Yeah. To be registered, you have to pay the fees. And I don't know if there's going to be a fee associated for it. So the way that -- so if you're Nationally registered, you'll stay Nationally registered. If you're -- the Mark King Initiative is actually saying if you've ever been Nationally registered, they will let you have it back for their fee of 10, 15, 20 bucks, whatever it is for the re-certification. But you won't have to test as long as you've maintained a state license and a whole bunch of other things.

Then the third pot of people are like yourself, the pot of people that are not Nationally registered, don't want to be Nationally registered, will never be Nationally registered. You will go into the system, and you will have like 25 years to either become Nationally registered or vacate the system or something like that. And then -- somewhere in that ballpark.

And then once that happens, well then everybody's training records will be managed by National Registry. And I don't know what that -- what the fee will look like for National Registry, if there will be one.

GUY DANSIE: One thing, we have Donnie Woodyard coming next week to the EMS committee meeting, and he's going to be here to answer all of those types of questions. So if you can and you have some of those, you know, he's going to do a presentation and try to do a work-through for everybody so that we understand what's going on with that.

LAUARA SNYDER: Okay. So I just wanted to be clear in my mind. Because right now, current statuses for agencies like myself, we maintain all of our CMEs. And then we send a letter to the state

that says we've all -- you know, these people have all complied; our doctor signs off. And you know, you give us our stuff. So we can't just send a letter to National Registry and say, "We have all of our stuff in-house" --

GUY DANSIE: I don't --

BRETT CROSS: Kind of.

LAUARA SNYDER: We have to give them all of our stuff, like copies and everything?

BRETT CROSS: Kind of. So as a training officer, you will be able to go in and add all of the trainings and --

LAUARA SNYDER: So it does need to be on their thing.

BRETT CROSS: -- associate with them. Yeah.

LAUARA SNYDER: Okay. I don't like that.

DEAN YORK: This is York.

GUY DANSIE: Go ahead, York.

JAY DEE DOWNS: Go ahead, Dean.

DEAN YORK: So the way it works, I've got both. I've got Nationally-registered medics, and then I have just state of Utah medics. But I am a trained officer on both sides. So my medics log their hours. We do the mandatory BLS, ACLS, PALS and

PEPPs and PHTLS. And in the end it's just a push button on the National side saying, "Yes, they've done this." And then on the doctor's end, the same thing. He goes online and basically presses a button saying, "Yes," that they've done this. And that's all it takes for me for my National people right now.

LAUARA SNYDER: So you don't have to give them, like they said, the cards and show your records and all of that --

DEAN YORK: No.

LAUARA SNYDER: -- like we do now? We maintain them ourselves and certify --

JAY DEE DOWNS: You'll still maintain them yourself. It's just that you might get audited. You're going to get audited anyway.

LAUARA SNYDER: Well, yeah.

GUY DANSIE: Well, and it's a liability issue mostly. If somebody has a problem --

DEAN YORK: And technically with American Heart Association, I would guess that National has access to see. Because where everything is done electronically now with American Heart Association, they can look to see who's currently current or not.

BRETT CROSS: So the National Registry actually doesn't care about the cards. They allow

you to use the -- the hours from the cards to meet the NCCP requirements, but they don't -- so when you go in, if you go to register a course, you'll say, "I took BLSCPR provider." You'll say the day you took it. You can upload a document if you want; you can upload the card if you want. You push submit. It will automatically fill in the hours that NCCP has allowed for that. So it will do one hour of adult CPR, one hour of PEDs CPR, one hour of this, an hour of this and an hour of this. And then PALS, ACLS, PHTLS, AMLS, all the NAEMT courses, all of the -- all of those all have pre-identified hours in there.

GAY BROGDON: So individual people would will go in and put their stuff in, and then she just approves it.

BRETT CROSS: Yeah. Or as a training officer --

LAUARA SNYDER: Training officer probably.

BRETT CROSS: Training officer can go in and push it to their folks.

GAY BROGDON: But the individual, all of the courses have to be entered by somebody.

BRETT CROSS: Yes.

ALTON GILES: So with me as a paramedic that's only in Utah, do I have to go create an

account with National Registry?

BRETT CROSS: No. We're not asking anyone to do anything yet. Because we will -- you will eventually have to create an account, yes. But we're going to give them records. They're going to do back-end things with -- from our data from ImageTrend. And we don't --

GAY BROGDON: Unless you already have an account.

JAY DEE DOWNS: It's not that big of a deal to create an account though.

BRETT CROSS: Yeah. It's just like signing up for an e-mail account. Give them your name and there you go.

JAY DEE DOWNS: Yeah.

LAUARA SNYDER: But you do not have to be nationally registered either to be the training officer. So that's not a requirement. You can still sign up and get those rules without having it.

JAY DEE DOWNS: Yeah.

DEAN YORK: So, Brett, this is York again. I have another question.

JAY DEE DOWNS: Okay. Go ahead.

DEAN YORK: So our state medics who are not national, will they still have to pay a national

price plus the state price?

BRETT CROSS: We're not sure.

JAY DEE DOWNS: They're not sure yet.

DEAN YORK: Okay. Okay.

REGINA NELSON: This is Regina Nelson with a question.

JAY DEE DOWNS: Go ahead, Regina.

REGINA NELSON: I'm just wondered is this affects EMDs at this point or will this be something that will come later? Is this EMT only?

BRETT CROSS: EMR to paramedics.

GUY DANSIE: Let me answer that one. We're -- the National Registry side of it is for EMTs and paramedics, EMR, and AEMTs.

The EMDs are not managed by National Registry. They will still be managed by the state. However, all we need from you is verification that you've done your vendor training. So --

REGINA NELSON: Okay. So nothing has changed. I wasn't sure how -- when you guys were talking National Registry, what that meant. Because we are nationally certified, so -- okay.

GUY DANSIE: Correct.

REGINA NELSON: Okay. That answers it. Thank you, Guy.

GUY DANSIE: And I don't know what that process is going to look like. But we will issue you a two-year license based on the fact that you have that certification.

JAY DEE DOWNS: And you're certified to your vendor.

GUY DANSIE: Right.

JAY DEE DOWNS: So if you're using PowerPhone, you do their training. If you're using Spillman, you use theirs or whoever.

GUY DANSIE: Correct.

REGINA NELSON: Right. And we go two years on our national certification, and we have been four years on our re-cert with you guys. So it would make sense we would line up as well. But we're not -- you're not talking EMD right now, correct?

JAY DEE DOWNS: No. That's correct.

REGINA NELSON: All right. Thank you.

GUY DANSIE: One other thing, Regina. In the draft language that still needs to go out, the requirement for a training officer goes away for dispatch centers. The supervisor can act as the training officer, or you can still manage a training person or have a training person be a training officer. Either way is okay.

BRETT CROSS: The one other change is in 5-300, there's a -- it's in here that says that they have to complete their testing and everything within 120 days, but National Registry gives them two years. So we need to eliminate the 120 days because it will conflict with --

GUY DANSIE: That's in the draft language. We've already vetted that.

BRETT CROSS: Okay. And then the other one is for reciprocity, we ask for a practical exam for people who come over. But we don't have a mechanism to do that anymore with National Registry. Because in order to take an Advanced or Paramedic National Registry practical, you have to be eligible to take that. And most of those people coming over on reciprocity are not eligible for that exam from National Registry because they don't -- they're not -- they don't hold a National Registry certification or it's not necessary because they currently hold a card from National Registry. So they say they don't need a psychomotor exam.

So we probably need to eliminate the psychomotor exam piece of that and just say they have successfully complete the assessment, written exam, and stop there. We don't have a mechanism anymore to

do it.

LAUARA SNYDER: You don't require something that you can't --

BRETT CROSS: Yeah, that we can't do.

LAUARA SNYDER: It scares people.

BRETT CROSS: Yeah, yeah. So if you're okay with that. And then it would be up to the agencies, you know when you hire somebody.

JAY DEE DOWNS: But if they're National registered, you already know they've taken their practicum.

BRETT CROSS: They've already taken it, yeah.

So like one example, a guy from Colorado comes over, and he's not National Registry. But he is a Colorado paramedic. We require them to go take the National Registry assessment exam, which is the same test as the cognitive exam just in a completely different isolated spot. And we contract with them to provide that written test.

JAY DEE DOWNS: Right.

BRETT CROSS: The challenge is, is that the next line of that says they have to complete a practical exam, but they're not eligible for that. I mean we could get some schools somewhere to put them

on or something, but that just is a lot of extra work.

JAY DEE DOWNS: You would think the National assessment would be good there.

BRETT CROSS: Yeah, yeah. If you take the written exam and you pass that, then we're --

JAY DEE DOWNS: Yeah. The 120 days, that's just for new certs, right?

BRETT CROSS: Yeah.

JAY DEE DOWNS: But on the advanced and paramedic if they wait more than a year, then they have to retake the practical exam again.

BRETT CROSS: Yeah, retake that.

JAY DEE DOWNS: On the basic I think they just have to --

BRETT CROSS: It's a year too. We required a year.

JAY DEE DOWNS: So they have a year. And if they haven't done the basic, then they have to take a practical exam again.

BRETT CROSS: Uh-huh (affirmative).

JAY DEE DOWNS: But there's no assessment because you don't have the instructors from National come out. They've just got to do it with the course instructor; is that right?

BRETT CROSS: Yes. Well, we -- the Bureau says that course coordinators are --

JAY DEE DOWNS: The testers.

BRETT CROSS: -- our National Registry reps for EMR and EMT exams. And then AEMT and paramedics, you have to have a National Registry rep.

JAY DEE DOWNS: Okay. That's how you worked it. Okay. I knew there was something about that, but I wasn't sure.

BRETT CROSS: So we just need to eliminate that, the practical exam as well.

JAY DEE DOWNS: Yeah. What he said, put it in there. Put it in there, Guy.

GUY DANSIE: So maybe what I ought to do is have -- we just kind of did a last-minute thing. But maybe we ought to have you look at the rule, Brett, and go through it and identify those problems with our current draft version that needs to go out.

JAY DEE DOWNS: I think it would be a great idea.

GUY DANSIE: And then bring that back. If we could do it -- we could just present it to the committee if you think we can have it by next week or tweak it a little bit. And then we could send it out to everybody on the task force for review.

JAY DEE DOWNS: Does anybody have any problems with that? Dean? Jean? Regina?

This is where you respond.

JEAN LUNDQUIST: This is Lundquist. I'm good with it.

JAY DEE DOWNS: Regina Nelson?

REGINA NELSON: I'm good too.

JAY DEE DOWN: Dean?

DEAN YORK: Yeah, that sounds good.

TERESA BRUNT: Brunt is okay with it too. It sounds good.

JAY DEE DOWNS: Okay. Anything else, Guy?

GUY DANSIE: Are you good, Brett?

BRETT CROSS: Good.

GUY DANSIE: So let's look at the review -- at the rule. And then maybe in the next day or two if we can hurry and tweak it, we will send it out to everybody on the task force. And then we can push it out for comment after it goes through the committee.

And Donnie will come, and we'll address it. Maybe there will be issued that we identify with National Registry while they're here to make sure that we don't say something in the rule that doesn't work.

JAY DEE DOWNS: Okay. The next one.

GUY DANSIE: Do you want to look at definitions?

JAY DEE DOWNS: Let's give updates on the new legislation before everybody gets off the phone. Then we'll move into 426-1. So those guys on the phone can pull out their documentation.

So you guys, pull out your documentation and go to 426. Guy will give us an update on everything that's happened with the legislature. There's been a lot of stuff that's kind of happened and then didn't happen.

GUY DANSIE: Right, right.

Okay. Originally Dr. Redd, Representative Ed Redd from Cache County, was concerned about fatigue and late night, weather travel and inter-facility transports. Primarily those coming out of Cache County or St. George or far away places that go for a long distances in the middle of the night.

We know the hospitals have bed issues with -- especially behavioral health beds. And sometimes those transfers have to happen in the middle of the night to accommodate the hospitals with their available beds. It's an ongoing problem. He

attempted to address it but creating this bill.

LAUARA SNYDER: And who is this?

GUY DANSIE: Dr. Ed Redd, House Bill 322.

So the initial -- the initial idea behind the bill was: Hey, we need to have the hospitals have a legal requirement to hold a bed for up to six hours. And that if it was -- and the transfer occurred between the hours of 12:00 midnight to 6:00 a.m. in the morning, if you had weather problems, staffing shortages, or if the transfer was -- ended up being more than 55 miles, that you could delay that transfer and notify the hospital and say, "Hey, we can't do it right now, but we'll do it at 6:00 in the morning."

That was the intent when he started. Along the way he was contacted, and there was concern about inter-facility transfers. And a definition was added to the bill. And the definition said that you had to be a licensed ambulance provider to do an inter-facility transfer, more or less, you know.

And then we talked -- Alton Giles and I had a conversation. Alton talked to Representative Redd about their concerns about having a piece of their business, you know, that this affects.

So Representative Redd made the suggestion

that we create a new license or designation or something to allow behavioral health transfers for people that didn't have the medical conditions described in Title 26-8-A-305, I believe it is.

ALTON GILES: I think it's 305.

GUY DANSIE: Anyway, so if a person doesn't meet those medical conditions and they are being transferred, that we could create this new entity to do that. And base it on a free, open market system to keep the cost down. He felt that was a benefit to the -- to these behavioral health patients and the hospitals to keep the cost down. So that language was added.

There was a lot of massaging and heart-felt discussion on the Hill up until like 10:30 at night the last day. The bill got passed. There were final adjustments and tweaks and some wording changes and things like that as it went to that final forum.

After it got passed, it became apparent that there were some issues with the bill itself and the way it was worded. So Representative Redd asked Governor Herbert to veto the bill. So he vetoed it.

But in the meantime between the time it passed until the time it vetoed, we had a couple of

workgroups where we talked with all the stakeholders who were in that legislative arena talking about how this would work and what kinds of rules we would need to implement it.

It was decided that the statute didn't need to be amended if we did it as a designation under the committee's authority to create designation types. So we ended up with -- calling it a designated something. And the term originally in the bill was a nonemergency secured medical transport.

And at the second meeting Mike Mathieu chaired representing the EMS committee, he felt the term "medical" was confusing. So he opted to drop that out. I know that's still a point of contention, and that's something that we can revisit.

Ultimately the committee has the authority to make that call, not the department, because it's an authority granted in statute to the committee.

Okay. So there's that. That's kind of the part where we're still having issues.

The other parts are things that we pretty much agreed on, and that being the definitions. We had some of the mental health experts as a part of that workgroup talk about what they felt was important. The first one being deescalation

training. If we're moving behavioral health patients, they felt it was important to have whoever interphases with them have training on how to deescalate hostility or patient concerns or things of that nature. And so we attempted to put a definition. We'll put that in R-426-1.

And that's that first definition. "Deescalation training means training approved by the committee for a licensed or other type designated service personnel who might be providing any services to be able to help patients."

The two members that were present on the committee actually felt that this would be a good thing for all of the ambulance providers as well to have some type of deescalation training. It's usually, I believe, a two-hour module, or it could be longer than that. Our friends at the mental health -- or substance abuse and mental health say that they have a list of different types of training that would be considered appropriate. And so we would need our committee basically to say that those were okay. And then we could list those as similar to EVO training. It's just something you would need to do if you provided this type of designation.

So I didn't put that in the rules as a

requirement for ambulances, but that was kind of the scuttle when we met and talked about it. But right now it's not in rule anywhere that we have that requirement for ambulance providers.

So the other definition, IV administration in Title 26-8-A -- is it 305? I believe it's 305. It talks about medical criteria. One of those refers to IV administration. There are patients sometimes that have a hep-lock or have a shunt or something else that are routinely moved in vans or private vehicles. And so we felt we had to add an IV administration definition because it is in statute and there's no definition in statute.

And that just means that if there is actually something being actively pushed through the IV, that then you're administering an IV, or if you're doing a procedure to the equipment or, you know.

So what we said is it means, "Operation of intervenous device where a fluid or medication is flowing to a patient, a maintenance procedure is performed, or if a fluid or medication is directly connected to a supply of any fluid or medication."

Meaning that if it's just a shunt, that we were okay with that. As long as it wasn't being --

something wasn't being pushed or connected to it.

LAUARA SNYDER: So, yeah, I have a question. So are these definitions ones that we're looking at specific to having this -- this company --

GUY DANSIE: Yes.

LAUARA SNYDER: -- be able to do this?

So the IV administration, that's concerning to me. Because for a very long time -- and I don't know if it should be thought of any differently -- but if medication is going into a patient we've always said that the people who are monitoring that need to be medically trained --

GUY DANSIE: Right.

LAUARA SNYDER: -- in order if there's a problem with it or something needs to be done. And not just, you know --

GUY DANSIE: That's --

LAUARA SNYDER: -- a Handi-Van transport type of thing.

GUY DANSIE: That's part of the criteria that's in statute.

LAUARA SNYDER: Okay. So --

GUY DANSIE: If they have an IV administration, then they have to go by ambulance. That's what it says.

ALTON GILES: Any fluid, even LR. It has to be hep-locked off.

GUY DANSIE: So he's not fighting for that. He's just -- we just wanted to clarify that having a hep-lock or a device doesn't necessarily mean they're receiving medication. So that's what this attempts to do is to say, "Hey, a device isn't the issue. A needle in somebody's arm is not the issue. It's the use of the needle or the use of the IV."

LAUARA SNYDER: For any IV fluid hanging is a no-no.

GUY DANSIE: Yeah. That's what we tried to say there. And I think everybody was good with that. If it was connected to any fluid or medication, like if there's a direct tube that connects the two, then that's over the line and it needs to go by ambulance.

So is it -- do you think it's worded okay?

Okay. Let's move down to the next one. This is the name --

ALTON GILES: Guy?

GUY DANSIE: Yeah.

ALTON GILES: I thought we were going to say something about as far as transports with

patients who have their own pump. You know, they have a self-administered pump. Because there are some transportations that do go on, they pick them up from their home and they take them, you know even a pain pump that's patient-operated.

GUY DANSIE: We could put on there this does not include a patient-operated prescribed --

ALTON GILES: Yeah. Because they're doing those now. You know, they might be going to a doctors' appointments or things like that. But it's completely patient-operated. It has nothing to do --

LAUARA SNYDER: And is that something that the Handi-Vans do?

ALTON GILES: Yeah.

LAUARA SNYDER: Is that something you do?

ALTON GILES: No.

GUY DANSIE: It does not include what?

GAY BROGDON: Patient-operated.

GUY DANSIE: Patient-operated?

ALTON GILES: Yeah.

GAY BROGDON: Equipment.

GUY DANSIE: Medication devices?

ALTON GILES: I don't know.

GUY DANSIE: Equipment? Pumps?

GAY BROGDON: What about --

GUY DANSIE: That are prescribed by a physician prior to transport.

ALTON GILES: Yeah. I just know they're -- I've seen them. They're patient-operated. They can push the button themselves.

GUY DANSIE: I'll just call it a device.

JAY DEE DOWNS: Number 7, 305 says -- actually, 26-8-A-305, looking at number 7, "Requires IV administration or maintenance oxygen that is not patient-operated or other emergency medical services during transport."

LAUARA SNYDER: So it already says that.

ALTON GILES: Uh-huh (affirmative). It does.

LAUARA SNYDER: So why do we need this then?

JAY DEE DOWNS: This designation?

LAUARA SNYDER: Why do we need that definition if it's already in the --

ALTON GILES: Because that's on the ambulance side though, isn't it? On the licensed side? And this would be on the designation side.

GUY DANSIE: Right. I think it was just to clarify at what point was it allowed to go by a designated vehicle versus requiring an ambulance.

JAY DEE DOWNS: So the Title 26-8-A-305, "Ambulance license required for emergency medical transport." So those are the things that a patient or a person need or is supposed to have.

LAUARA SNYDER: Or an ambulance licensing. And we're talking about designation.

GUY DANSIE: Yeah.

JAY DEE DOWNS: Yeah. If they don't have that, they don't need that, then it could be a designation from what I understand. Is that right?

GUY DANSIE: Yeah, that's what we're saying. It would be the designated service could do this if it has none of that IV administration stuff going on.

LAUARA SNYDER: So is the Bureau then going to start regulating and designating Handi-Van type services.

GUY DANSIE: No. It's not the intent.

LAUARA SNYDER: Well, wouldn't that be the next logical thing?

GUY DANSIE: I guess that would be driven by the legislature if the EMS committee desired to designate it.

Right now the bill didn't pass. It was vetoed. There is no requirement to do this, other

than what we --

JAY DEE DOWNS: Let me see if I can explain it.

So the bill didn't pass. So basic -- well, it was passed then vetoed. Which means, whew, okay. I don't know how you spell that.

So now the committee -- although the committee, the EMS committee has the right to do any designation that it sees fit under the law. So in the meeting, as I understand it, that Mike and Mike were there, and they were -- there was a lot of work done already on the designation. Because in the bill it said that a designation will be provided for this type of service; is that correct?

GUY DANSIE: (Witness nods head).

JAY DEE DOWNS: So then there was a lot of work done in this two weeks before it was brought to Dr. Redd's attention that there was something in there that wasn't complying to what he wanted. So he called the governor to veto it. However the train was already going down the tracks. And it was felt by members of the EMS committee, "Hey, wait a minute, we should still follow through with this designation."

Which means that since it's there, now

that it's not in the bill, it's there, the designation, by the EMS committee. So now it's being driven by the EMS committee and not necessarily by the bill that Dr. Redd provided. Is that right?

GUY DANSIE: Correct. And the other thing is, is if -- the feeling is if we do it right by the committee and the department, that there won't necessarily have to be another bill next year.

Senator Bramble and Representative Redd both felt strongly this is something that we needed to do. And our feeling is we would rather be proactive and do it through rule than have them come back in another bill.

JAY DEE DOWNS: I think the big thing was, amongst all the players, was -- and maybe I'm wrong and correct me if I am -- but I think what happened is it got on the Hill and started to have the legislation fixing a problem that could easily have be fixed by the people who are part of it. And we can come in and say, "Okay, yep, this will work; this won't work." Otherwise it will end up back on the hill next year. So --

GUY DANSIE: Correct.

JAY DEE DOWN: And I think that's what the EMS committee thought, "You know what, this is

something that is a designation. It's something that probably, you know, needs to be brought under the fold of the EMS committee." And now the EMS committee has been charged to do that.

LAUARA SNYDER: Okay. So then following up on that, the Bureau regulates the area that -- it's a monopolistic service.

GUY DANSIE: Exclusive area.

LAUARA SNYDER: And by doing so, you set the rates. Now are the rates going to be regulated by the Bureau since they're offering the designation and essentially overseeing it?

GUY DANSIE: No. The promise made was, by Paul Patrick to Senator Bramble and Representative Redd, that we would do this similar to air ambulance. It would be a designation that would be open to any area by any number of providers, and there wouldn't be a cost associated that's set by the department. It would be through contractual agreements that they have with the hospitals or the facilities.

LAUARA SNYDER: Okay.

JAY DEE DOWNS: So the key to it is -- the whole key to it is, is this -- the way I break it down when you look at 26-8-A-305 and you look at the other law, is this patient medically required to go

by ambulance? Okay. And probably your docs are going to be the ones who determine that. And if that patient doesn't have an IV hanging or whatever, you know, or doesn't -- I think the big key to it is: Is this patient going to deteriorate in transport? If this patient is going to be stable by his professional opinion, then it could be downgraded from an ambulance to a -- this type of service that's next. And the doc will have to do that. The key to it is there is if the doc says it's okay and that patient crashes on the way somewhere, then that's where the liability is going to come in for the doc.

ALTON GILES: Which is where it is right now anyway.

JAY DEE DOWNS: Absolutely.

GUY DANSIE: And one of the things on the designation is they have a plan of operations that they will have to say that if something happens medically, that if they need to turn that patient over -- call 911 and have that patient turned over.

JAY DEE DOWNS: They'll have to have contact with 911 as they're going through the state, or whatever.

GUY DANSIE: Currently that's not a requirement.

LAUARA SNYDER: So is it that the agencies that do nonemergency transports, inter-facility transports -- that's been a really big and hot issue --

GUY DANSIE: Uh-huh (affirmative).

LAUARA SNYDER: -- so do they see your service as in competition with theirs? Is that part of that contention?

JAY DEE DOWNS: You know, I can answer that. But --

LAUARA SNYDER: Yes or no?

JAY DEE DOWNS: But in my end of it -- go ahead, Guy.

GUY DANSIE: I'll give you the down-and-dirty.

South Jordan felt like this was an infringement upon their inter-facility, and that was part of the reason we had the legislative discussion about what the issues were.

Guardian's feeling -- and I'm speaking for them, and you can speak for yourself maybe -- but their feelings is these patients don't meet the criteria in 305. Therefore, they're not regulated to go by ambulance. We're not allowed to regulate those. Our discussions with the attorney general's

office is: We don't want to get involved in trying to regulate a physician's decision.

LAUARA SNYDER: But still there's rules about inter-facility transports --

GUY DANSIE: Right.

LAUARA SNYDER: -- and EMS transports. And now we have another agency type in the mix, right?

GUY DANSIE: Right.

However, after we all got in the room and it all shook out, South Jordan is very supportive and they are very involved in this actual process. Their city attorney, who helped draft the language, some of the language in the bill along with Guardian and some of the other players felt -- I think it was pretty well decided that this is probably the best route to go. South Jordan is involved with it. They're supportive of this. They're part of the effort to move this forward. Because if they feel that it defines what it is and therefore there's not as much gray area so that they won't be infringe upon -- I'm speaking for South Jordan and a little bit for Guardian. Does that sound right to you, Alton?

ALTON GILES: Yeah. You know, it comes down to -- you know, you were talking about

infringement. We've been doing this five years. And as Guy knows, the attorney general had looked into this, you know, five years ago. As multiple complaints had come in four years ago, they looked at it and found that, yes, we are not infringing.

And Gay -- Guy has referred to as a gray area. So we've been doing this for five years. It hasn't been infringing on the license. But, you know, because of the legislative stuff and South Jordan bringing -- you know, we're in favor of this. I don't have a problem with this. You know, it does provide some rules that I have to follow, which a lot of them I'm doing that already. You know, there are some minor things that I'll have to change.

LAUARA SNYDER: Okay. So maybe you could answer this for me. My understanding is that this is for mental health patients. That's how you started off, right? This is a mental health patient transport service.

ALTON GILES: A lot of what I do is, yes.

LAUARA SNYDER: Oh, that's not the focus?

ALTON GILES: This is.

LAUARA SNYDER: Is that not what you do?

ALTON GILES: I'd say 94 percent of my business is all mental health.

LAUARA SNYDER: Okay. What's the other 6?

GUY DANSIE: We'll do some transports. Say a hospital, they need a patient that goes home in the middle of the night. Some of the other transport companies don't operate in the middle of the night. You know, if they pay my price, I'll go take them from the ER home.

We do transport some that go -- that are considered a nonmedical. We'll take them from one facility, and we'll take them up to, you know, the U of U main for that.

LAUARA SNYDER: Okay. All right.

JAY DEE DOWNS: I think the other thing, too, is to remember that any ambulance agency, if they want to, they can get their own service. They can get their own designation and do their own thing. So if they had a sweep that said, "Okay, you don't want an ambulance. I can offer you an a van service."

I mean that's true.

ALTON GILES: A secured --

JAY DEE DOWNS: A secured van. I mean that's the thing, anybody can --

LAUARA SNYDER: So there's no overlapping. It will -- it will get to be Jetson speed trying to

get whoever getting wants that business.

GUY DANSIE: It's whoever contracts or whoever the hospital prefers.

LAUARA SNYDER: I think it probably meets a need. My concern is that when we started hearing about this a few years ago, that it was only mental health services. And I think we had somebody from the U come and talk about that.

But truly other people have been -- well, I'll just say it. My -- and I told these guys earlier. My husband needed to be transported from South Jordan, somewhere out there, to the U for surgery. And he had a bunch of stuff hanging. And the doctor was ordering your service, Guardian.

And I said "Are you sure? He's got an IV hanging. He's got meds."

"Oh, yeah, we do it all the time."

So how do I know that --

ALTON GILES: We don't do that.

LAUARA SNYDER: Well, I don't know that because I'm just listening to the doctor who --

ALTON GILES: You know, when they call into our dispatch center and say, "Hey, this is what I need," they might not mention that. But when my employees show up, they know. Because there's a

line, and I know you can't cross that. That would -- you know, that would push it to an ambulance.

So if my people show up, maybe they did -- maybe we accepted the call because they didn't say, "Hey, there's IVs." We show up, we get out there, and there's IVs and pumps. That doesn't qualify for us. I can't do that transport. I would get in trouble.

GUY DANSIE: The one thing our rule hasn't ever really drilled down into this. So this is not just a Guardian rule. We want to have some kind of regulation over anybody doing this and make sure the standard is fairly high that -- I asked the same thing about if it was just behavioral health or not. As long as the person doesn't meet the medical criteria in 26-8-A-305, then it doesn't matter what the person -- most of the time they're going to be behavioral health. If it's a discharged patient, they're no longer considered a patient anyway.

ALTON GILES: And that's how we're ruling out all the other transport vehicles because they're discharged. Typically those type of companies.

GUY DANSIE: Yeah. The unregulated vans are -- those people are not a patient at that point, so we don't regulate that. Okay.

LAUARA SNYDER: So just to clarify, all of the agencies that have inter-facility licenses, they're okay with what you do and don't feel that there's a --

ALTON GILES: Are they okay it? I can't speak for them on that.

GUY DANSIE: Let me add my two bits to that though.

South Jordan has been heavily involved with this and likes it, and they have an inter-facility. Gold Cross, Mike Moffitt, who has been heavily involved with this and Mike Mathieu has inter-facility and has been heavily involved. So I think the big players that do inter-facility are okay with it.

Now, there are probably -- like you do inter-facility as well. You don't have a facility to speak of. But technically if you had one, you would do the inter-facility portion.

I can't speak for all the other services. But Mike Mathieu, Mike Moffitt, and South Jordan, who all do, are very much involved in this process. And they will be the ones that vote on it next week if it's -- so we're kind of just trying to wordsmith it. And hopefully this is the directive they've given me

to do.

ALTON GILES: Now, in your situation where you don't have a hospital and you're talking mental health, I -- this designation could not go out to Wendover and pick up a mental health patient because they're not -- they haven't been evaluated by a doctor. So if you're picking them up from the home and, "Hey, do you know what, we need to bring hem here to Salt Lake," this designation would not allow that because they haven't been evaluated by a doctor.

GUY DANSIE: I think most of Lauara's patients would all be considered a 911 or seen patient, right? Even though you would have the right if a nursing home came to your community, then a patient -- you'd still be the person that provided that.

LAUARA SNYDER: (Witness nods head).

GUY DANSIE: That was actually part of the attempt of the bill to clarify that inter-facility had to be done by ambulance if the person was indeed a patient that needed medical observation.

So anyway, let's look at these last couple of definitions. I feel like pulling teeth here.

JAY DEE DOWNS: That's all right.

You guys okay on the line?

GUY DANSIE: Does anybody need a break? Are we good?

DEAN YORK: York is still good.

JEAN LUNDQUIST: Lundquist is good.

TERESA BRUNT: Brunt is still good. I feel a little Pandora's Box there with that bill, but I've got to read it a little bit better to understand it.

GUY DANSIE: I think it is a Pandora's Box to some extent, but we tried not to get down into the van market on purpose. If the patient is discharged --

JAY DEE DOWNS -- it's none of our business.

GUY DANSIE: Yeah, it isn't. We don't regulate it at that point.

Currently all I'm allowed to regulate as a regulator is the --

JAY DEE DOWNS: -- medical side of it.

GUY DANSIE: Right, the medical side of it.

JEAN LUNDQUIST: This is Lundquist. Are we just going to talk about the licensing and that kind of stuff? We're not going to talk about the extended wait in the ERs? Is that not our --

GUY DANSIE: Oh, no. Because -- okay, let me address that quickly before we go on to the next thing on definitions.

This workgroup that's been dealing with this bill and the aftermath of the bill, there were two parts. One being the van transport part; the other part being that hospital bed issue and the delayed transport. What we pro-- what they preferred to do is that part is a little -- probably a little political messy because of the hospital side of it.

Currently there is nothing in the EMS Act, Title 26-A, that requires response in a certain time. It's traditionally understood that they'll do their best to be there and to move those patients for you. But there isn't anything in there that specifically regulates that response time. So what we're trying to do is educate both the hospitals and the EMS services and develop some policies; one of them being a fatigue policy and one of them being a weather-related policy. And say, hey, so we're all on the same page, hey, if there is a true weather issue, then let's wait. The hospital and the EMS service should have that conversation. Let's -- we're putting our people in danger; we had need to wait. The road is closed, or whatever it is.

The other part of that being fatigue. Air ambulance uses fatigue guidance, and we've never done that on ground. But what we're saying is, is if there there's a fatigue issue for the EMS provider, that possibly they could do it through mutual aid, send another ambulance by a mutual aid agreement or work something out and let the EMS service be responsible to take care of that if fatigue is a factor. So that's where we're approaching that.

I don't have any language today. And that may be another thing maybe down the road a few months we can work on specific language there. What we're working on is just the policies. And I was going to have the operation subcommittee refine those policies a little bit. And then maybe down the road we could put language in the rule saying, "Hey, you need to use these policies as an EMS service to determine if the weather situation is okay or if fatigue is an issue."

And then the onus would be on the EMS provider to provide the mutual aid through a neighboring partner or service.

JAY DEE DOWNS: They couldn't provide the service, but they could use their mutual aid partners to provide the service.

GUY DANSIE: Right. And I actually did put one little piece of rule in the operations rule, and we'll look at that in just a second that talks about EMS being responsible to get the mutual aid for you as a hospital.

JAY DEE DOWNS: You know, most of that bill also as it was proposed, go look it up, it was like even for it to go into effect it had to be over, what, 55 miles?

GUY DANSIE: 55 miles. It had to have a weather -- like weather problems. There had to be staffing shortages so that the local provider was not able to do the 911 side of their service. Like if there was a time of unusual demand. Like say they had like a car rollover or something big and they had multiple patients, then they could delay that transfer. But they do that already, honestly.

JAY DEE DOWNS: Yeah. See, the problem was also -- and speaking from the Cache end of it -- so you have these guys, they take a mental patient in and like -- this is one thing they were having a rough time with. They'd take a mental patient in at like 1:00 in the afternoon. Now it 3:00 in the morning, and it becomes an emergency transport to take them to Salt Lake at 3:00 in the morning. So

they're saying, well, why does it have to be such a -- why at 3:00?

GUY DANSIE: Right.

JAY DEE DOWNS: That's where -- that's where it all got started.

GUY DANSIE: Right, right.

So I think the awareness became much higher on both sides, the hospital and the ambulance side. And we're trying to do our part on the ambulance side to clean it up a little bit. We don't regulate the hospital side of it. So the holding the bed thing is not a -- I can't address that issue.

JAY DEE DOWNS: I can't either.

GUY DANSIE: That's a hospital issue.

JEAN LUNDQUIST: Okay. Thank you.

JAY DEE DOWNS: Okay.

GUY DANSIE: Okay. The next definition was -- and this is one I think Alton has a problem with.

ALTON GILES: Yeah.

GUY DANSIE: Is not having the term "medical" out procedure.

ALTON GILES: So I want to bring this up to you, Guy. So this is from Centers for Medicare and Medicare Service. Here's what they call it.

GUY DANSIE: And that's fine. And that's what the bill said.

ALTON GILES: Yes.

GUY DANSIE: And we can -- I will -- we need to beat the drums at the EMS committee meeting and call it whatever they vote on and decide.

ALTON GILES: I mean, see, this is "medical," the booklet for these people.

GUY DANSIE: And the bill used the term "medical." And I know Mathieu's issue was -- Mike Mathieu's issue was we didn't want to confuse behavioral health and a medical patient. So that term is probably still to be determined by the committee. I think you have a good argument, Alton, and we can present that to the entire committee --

ALTON GILES: Okay.

GUY DANSIE: -- rather than just Mike Mathieu and Mike Moffitt who were there at the meetings.

ALTON GILES: Well, it seems like the one that -- Mike Mathieu was the one that had the problem with the term.

GUY DANSIE: Yeah, yeah.

ALTON GILES: It seems like Gold Cross was fine with the term.

GUY DANSIE: Yeah. I honestly think it was just mostly Mike Mathieu's thing. So we'll propose it both ways and see how it flies, okay?

But the body of it, it means an entity -- this is basically -- I took it from the quick response unit definition. So I tried to word it as closely to that definition as I could. We did throw in the medical observation as defined as UCA26-8-A-305 just to make sure that it's clear. "That may have a need for behavioral health observation during transport between licensed acute care, hospitals, emergency patient receiving facilities, or licensed mental health facilities."

So they're doing inter-facility for people who are not medical patients or need medical observation basically.

Does it read okay?

ALTON GILES: I think so.

GUY DANSIE: Okay. Then as we move down. The vehicle, I tried to mirror the quick response vehicle language that's already in the definition. It just -- it means, "A vehicle which is properly equipped, maintain, permitted, and used to perform nonemergency secured transports."

We can put the word "medical" back in or

leave it out depending on what is --

LAUARA SNYDER: What kind of proper equipment is needed for your medical -- or on your --

ALTON GILES: We did hit on that a little bit, not a ton.

GUY DANSIE: Right, right.

LAUARA SNYDER: Do you have a gurney?

ALTON GILES: Yes.

GUY DANSIE: We're going to put it in our equipment list that's required for the other vehicles, the ambulances and the quick response. And then we will add another category. So we will do it under policy and just have the rule refer back to the policy.

Basically I have some language in the operations rule, and I'll show you that in just a minute, that says it needs to be cleanable, secure, just the generic stuff, maintained.

LAUARA SNYDER: What about staffing?

GUY DANSIE: Staffing?

LAUARA SNYDER: Are you going to require regulations for staffing if we're going to do this?

GUY DANSIE: We will. Let's get to those. And maybe I should have done the definitions last.

Patient-operated oxygen, that was one of

the other areas. Basically if a patient carries -- is able to administer their own -- I helped to draft and define that. Now, what we allow there is like still a committee decision to be made. But the definition means something that was prescribed before the transport was arranged that they already have oxygen.

ALTON GILES: So essentially we're not carrying cannulas or masks or anything.

LAUARA SNYDER: So you're carrying oxygen?

ALTON GILES: Yes.

LAUARA SNYDER: So you --

ALTON GILES: Which is very common in nonemergency medical transports. Like Gold Cross even had it when they had their van service. They had oxygen tanks on them.

GUY DANSIE: I think the vans carry it too.

BROOK BARNSON: Handi-Van does too, MedVan.

LAUARA SNYDER: They carry their own?

BROOK BARNSON: Uh-huh (affirmative).

GUY DANSIE: Just to resupply it. If they're in transport for two to three hours or something, then --

BROOK BARNSON: It's just a courtesy so they don't have to drain their tank while they go to their appointment. We're not putting them on oxygen. We're just putting them -- hooking their cannula to another oxygen source.

GUY DANSIE: So think about it. Anything?

JAY DEE DOWNS: Do you have a medical control then?

ALTON GILES: What?

JAY DEE DOWNS: Do you have a medical control?

ALTON GILES: No.

JAY DEE DOWNS: Do you have to have a prescription for the oxygen then?

ALTON GILES: No.

JEAN LUNDQUIST: This is Lundquist. What is the supply tank or other source? What would that be, the other source? Are you talking -- is that where your pumps fit in or what --

GUY DANSIE: I just put it on there as a catchall. We can take it off if you don't think it needs it on there.

ALTON GILES: I guess on some long distance ones, some people do have a concentrator. You can plug concentrators in.

GUY DANSIE: Rebreathing kind of an apparatus or something.

JEAN LUNDQUIST: Oh, okay. All right.

GUY DANSIE: I just threw that on there because I -- and I don't know. I'm not a patient care person. But I just thought if there was a tank or other type of supply. There might be some other type of supply. If there's not, then --

ALTON GILES: The only other one I can think of is a concentrator.

GUY DANSIE: Do we leave it on there or not?

JEAN LUNDQUIST: This is Lundquist. I don't feel strongly either way. I think it's fine as long as you know what that is. And that's -- concentrator is the only thing I can think of.

LAUARA SNYDER: I have another question for you.

ALTON GILES: Yes.

LAUARA SNYDER: Can you bill insurance companies?

ALTON GILES: Yes.

LAUARA SNYDER: And do they pay for you?

ALTON GILES: Yes.

LAUARA SNYDER: And what's your codes that

you bill?

ALTON GILES: I do a base rate code and a mileage code.

LAUARA SNYDER: Of the EMS? Like A0425 and --

ALTON GILES: It's not EMS. It's CPT codes.

LAUARA SNYDER: So 80425?

ALTON GILES: IBC10 codes is mileage.

LAUARA SNYDER: So then would you 80425 is milage that you bill? So then would you --

ALTON GILES: So essentially those codes are set up when I do the contracts with the insurance companies.

LAUARA SNYDER: Well, I'm just curious because those are ambulance codes, and they're not --

ALTON GILES: They're not ambulance codes. Their IBC10 codes that ambulances are using, correct?

LAUARA SNYDER: Okay. All right.

GUY DANSIE: All right.

Unless you guys have any issues with the definitions, I'm going to go on to the -- this is the designation requirements. I took the term "prehospital" out on one of the titles because this is not a prehospital. It could be inter-facility.

So we just call it "EMS provider designation types." And I'm looking at 200 -- 426-2-200.

JAY DEE DOWNS: Do you have something, Jean?

JEAN LUNDQUIST: No. That's what my question was is where were we. Thank you.

GUY DANSIE: And, yeah, I jumped ahead. Actually in 426-2 at the very top, I also took out the word "prehospital" and put "EMS," just thinking it's probably a more accurate term.

JAY DEE DOWNS: I'd maybe take that out and just put "provider."

GUY DANSIE: We could. Do you want me to?

I could take -- it's already says, "emergency medical services provider," and that's because that's an addition that I made up. Let me just take it back out.

JAY DEE DOWNS: Yeah.

GUY DANSIE: Should I take out this one down here?

JAY DEE DOWNS: Uh-huh (affirmative). Just "providers" is all they are.

GUY DANSIE: Maybe it's redundant to have it in there.

JAY DEE DOWNS: Everybody is a provider.

GUY DANSIE: And then I added a third. In 200, R-426-2-200, I added a number 3. Which is the name of this thing, which we still are kind of on the fence with as far as it has "medical" or not, right?

ALTON GILES: Yeah.

GUY DANSIE: I'll put it in there just so we don't forget.

Okay. I was just scrolling down through the rule, getting down past -- okay. And this copy that I used is the copy that has currently gone out for comment.

JAY DEE DOWNS: That's why the change.

GUY DANSIE: That's why I have the old changes that we adopted sometime ago in it, because the new official effective rule has not been published yet. And the term "certified" has all been canceled out to "licensed." This is actually the copy that I sent in for comment.

Okay. So we added a section R-426-2-800, which is a nonemergency secured -- I'm going to put "medical," just as a -- I'll go back and make it consistent. And then we can decide on that in the committee. But the requirements basically followed the same things we do for our quick response unit designations with a few exceptions.

Okay. As we read down through it, it says -- part 1 says, "Have a vehicle or vehicles, equipment, supplies that meet the current requirements for the department for the designated nonemergency secured transport providers as found on the Bureau of EMS and Preparedness's website to carry out its responsibilities under its designation."

The same thing we have for quick response and ambulances. And we have it referred to on our website; we have it published there.

In their application they have to have the locations so that we know roughly where they're serving and those kinds of things. They have a current dispatch acknowledgement. So they basically let the 911 medical dispatch center know that they provide that service in the area. And that we -- originally we had other wording in there. It has different wording for a designated service because they are dispatched by 911. The van is not; their -- this carrier is not.

JAY DEE DOWNS: I know this is off the beaten path, but it just dawned on me. So since they're a designation, are they going to be eligible for grants?

GUY DANSIE: We'll have to make sure that

that grant language says that or reflects that. The grant language already says that it has to be a primary 911 provider, right?

Gay and I are nodding our heads.

GAY BROGDON: Uh-huh (affirmative).

GUY DANSIE: Basically -- and we actually had this dispute with some of the private area -- because they're covered by private service if they're qualified or not. If you're a municipal provider, yes, you qualify if you're doing the primary scene response. If you're private and you do the scene response, then you qualify. If you don't, like if you're a secondary, then you don't. Does that make sense?

JAY DEE DOWNS: Uh-huh (affirmative).

GUY DANSIE: But if you just did inter-facility, then you wouldn't.

JAY DEE DOWNS: Right. Scene response.

GUY DANSIE: Yeah. If you're a primary -- if you're dispatched to scenes, then you qualify.

JAY DEE DOWNS: Okay. Just curious, number 4, have a current plans of operations, A?

GUY DANSIE: Yeah. This is where we say the mental health patient deescalation training, you know that you have to have a policy for that. You

have to have American Heart Association Cardio Pulmonary Resuscitation or equivalent for all personnel. That's basically the same as it is for the other services.

Operational procedures, how -- just basically a description of how you're operating.

LAUARA SNYDER: I have another question.

GUY DANSIE: Sure.

LAUARA SNYDER: Is the deescalation training, is that some in-the-box kind of thing, or is that just something you make up yourself to --

GUY DANSIE: Well, we're saying --

LAUARA SNYDER: I mean, because --

JAY DEE DOWNS: Well, I don't know.

LAUARA SNYDER: Well, I'm just saying in EMS agencies if you have a need for something, you can have your --

GUY DANSIE: Find it.

LAUARA SNYDER: Well, you can add this piece, that piece, whatever, to accomplish what it is you want to train the people for. But it doesn't have an official designation or name.

GUY DANSIE: If you go back to that definition, that's what we attempted to do in there, to say that it had to be approved by the committee.

LAUARA SNYDER: Okay. So it's something that is not like you go buy an ACLS or a PALS or a PEPP or --

GUY DANSIE: I don't think there's a canned training. There might be.

ALTON GILES: There's several different nationally recog-- so these behavioral centers, that's what we've got. So the U, they use one. IASIS hospital, they have one called CPI, which the brand name. And it's called Nonviolent Crisis Intervention. So there's several different types out there --

LAUARA SNYDER: Okay.

ALTON GILES: -- and that's what we had talked about is saying which one is --

GUY DANSIE: With the mental health professionals.

LAUARA SNYDER: So there's some sort of standardization?

ALTON GILES: Yes, there is.

LAUARA SNYDER: Okay.

GUY DANSIE: The mental health -- yeah, the mental health people say, "Yeah, we have that."

LAUARA SNYDER: Okay.

GUY DANSIE: And they'll share that with

us. And then we'll say, "This is the list of training. Take one of these and you're good to go."

LAUARA SNYDER: Okay.

GUY DANSIE: Okay. The description in number -- I'm looking at F. Oh, okay. Maybe I jumped ahead.

We talked about operation. Okay. C, talks about a description of how the designated nonemergency secured transmedic rule will be made. "Will interface with hospitals, emergency receiving facilities." These are the people that do the inter-facility work with. They need to have a description on how they interface with them. Like if they have a phone call or a phone number that they use that they can call each other, or whatever.

D says, "A written policy that describes how patients who require an ambulance will be refused for transport."

So like you have to have some type of criteria to exclude the medical patients.

JAY DEE DOWNS: So a patient that says, "I'm supposed to go by the ambulance, and I want to go by the van service," they say we have to refuse you.

GUY DANSIE: Right. They have to

acknowledge it in their submission or application that they have some criteria to say no. And that their people are trained to say "no" if it's appropriate.

E says, "Have a written description of the service area for the coordination with other licensed and designated providers."

We aren't going to say that you have a certain area you can or can't practice in, but you should describe -- at least tell us what your intent is and try to work with those providers in that area so they know you're there.

JAY DEE DOWNS: In other words, play nice.

GUY DANSIE: Yeah. It's a play nice thing. Let your neighbors know you're in their area.

JAY DEE DOWNS: I think also this would be very beneficial to know that so if there's an MCA going on or disaster going on.

GUY DANSIE: Yeah. Just for that coordination.

JAY DEE DOWNS: If you need people for transport --

ALTON GILES: You're right. You know me, I'm a paramedic. If that was the case, I'm more than willing to --

JAY DEE DOWNS: That's why I think it would be important, for that.

GUY DANSIE: Yeah. The other thing I could see is if you do have that 911 scene issue going on and you know there's a behavioral health patient or something that you don't really want to do and they don't -- they don't have the medical criteria, then you should probably just kick it over to -- do you know what I'm saying? That's an out for you to let those other patients off.

JAY DEE DOWNS: It just makes everybody play together.

GUY DANSIE: Okay. Any objections to that? I think Alton kind of grimaced a little.

ALTON GILES: Okay. So right there where it says "letter of acknowledgement" under 5.

GUY DANSIE: Five, "Provide operations plan to the local EMS council, if one exists. The local" -- Tammy actually had a hand in this drafting, and I think she probably --

ALTON GILES: I thought we'd said something that we just had to provide it to them. We didn't have to have --

GUY DANSIE: Yeah, because --

JAY DEE DOWNS: That's pretty well stated

the language in there because it's --

ALTON GILES: Okay. More or less, I just need to submit -- or the designation needs to submit something. I'm not looking for approval. I just need to submit something --

GUY DANSIE: Yeah. It could be an e-mail.

JAY DEE DOWNS: Just acknowledge it.

GUY DANSIE: Just as long as you guys know and they know you're in town.

ALTON GILES: Okay.

JAY DEE DOWNS: Another side to that, I've been on the other side too even to the point where designation is a little bit different. But even if you say, "Do you know what, I've provided this letter to them. You have documentation that says I provided it to them, and they've never acknowledged it back," you can actually use that. You made good effort.

GUY DANISE: Yeah.

ALTON GILES: So is it something I need to sent as a certified letter just so --

JAY DEE DOWNS: All you have to have is some sort of documentation that they received it.

GUY DANSIE: Right. And you can e-mail them or do something like that if you prefer, just so that they know you're in town.

ALTON GILES: Okay.

GUY DANSIE: I think "council" is spelled wrong there too. Isn't it c-i-l, that type of council? The other counsel is like legal counsel, right?

JAY DEE DOWNS: Yeah, "council."

GUY DANSIE: Okay. Six, "Have written operational procedures to provide secure patient care," which is just generic language. I think you already had in part "B" up above, you already had operational procedures. But that's just how it's worded in the other part, so we just left it.

Seven, "A written policy of how the designated" -- whatever we're calling it -- "will submit patient care data to the department."

That was another one that the workgroup kicked around is: If these people are being moved, how do we know what's going on out there and how can we study it or how can we improve it? So currently all designated providers or licensed providers submit data. And we've talked to our data person, Felicia. And she says we can simplify the PCR so that it's just a few pertinent fields. Like just basic, like we moved Jane Doe at this time of day, this night, to this facility. It's pretty basic stuff.

ALTON GILES: Okay. And I guess they explain to them why. Like we don't check vitals; we don't do that. So that was why that was --

GUY DANSIE: So PCRs are designed for patients, medical patients.

ALTON GILES: Yeah.

GUY DANSIE: And so we were going to have a template that just eliminates all of the medical information. And it's just statistical information primarily. Most of the NEMSIS elements don't pertain to what you're doing.

If you go down, it talks about -- 8 says, "Provide the department with a copy of its certificate of insurance."

ALTON GILES: Did we decide on the limits on that yet?

GUY DANSIE: For the others it's 1 million.

ALTON GILES: Yeah. Is that what we're going with? I'm fine with that. I'm just curious what we're going with.

GUY DANSIE: It doesn't spell it out for the other designated services, but that's what it is for the ambulance services is 1 million. So maybe we need to add that at a later date.

Nine is "Prior to approval for the application, all vehicles will be inspected and permitted by the department and shall meet the requirements of 426-4-300-5." Which means that the vehicles are checked out by us, and they're given a sticker.

Ten says, "Not to be disqualified for any of the following reasons" -- and this is standard language -- "violation of subsection 26-8-A-504 or a history of disciplinary action related to the EMS license permit designation or certification in this or any other state."

Basically if you have criminal problems, you're -- you know, then you have to address those, and we have a process for that. That's -- that's standard language to all the other services.

I believe that's it for the changes. The rest of those are changes that we've already sent out for comment. So I will save that document. We'll -- if there's no changes here, we'll submit it to the committee that way.

Do you want to look at the last document?

JAY DEE DOWNS: Yeah.

GUY DANSIE: Okay.

JAY DEE DOWNS: Any questions on the other

one? If not, let's keep moving.

GUY DANSIE: Okay. And this one I think will be easy. I don't think there's much in here. We did -- as you can see, this is the other language that we already added. It says, "See department policy for ground ambulance standards." That is actually already in -- that's part of the draft language already that's been approved. And so we're doing the same thing for this designation.

We're -- this is where it talks about it for ambulances. I just wanted to point it out so you knew it was in there.

Okay. Here I added one line. This goes back to the hospital part of this bill. So Jean, this is the one you were concerned about. 426-4-500, the one thing we added, and I just did this. This was at the direction of the workgroup. It is to put, "The mutual aid request for a licensed designated EMS provider shall be made at the request" -- and I don't know if I like the language -- "shall be made at the request of licensed designated EMS."

Maybe I need to put geographical service area provider. Should I put exclusive geographical? This one I just added, and it was one of those things that I forgot to do earlier.

Basically the concern was we didn't want the hospital shopping for providers. We wanted to make it known that it was the EMS that covers that area's responsibility to get mutual aid, you know. And they can work it through the dispatch center or whatever they need to do.

Mutual aid requests. "Mutual" -- I don't like how it's worded though. "Mutual aid" -- what shall we call it? Response? I have the word "request" in there twice. Should we say "mutual aid assistance"?

JAY DEE DOWNS: Uh-huh (affirmative).

GUY DANSIE: Does that work?

ALTON GILES: Request for assistance.

GUY DANSIE: I just wanted to get away from having the same word in there twice. It just doesn't read very well.

JAY DEE DOWNS: Yeah, that's good.

GUY DANSIE: "Mutual aid assistance for a licensed or designated EMS provider shall be made at the request of the licensed or designated" -- I should put "licensed" because designated doesn't pertain. They're not exclusive.

Okay. Are you okay with that? Does that read right?

JAY DEE DOWNS: It says, "Mutual aid assistance for licensed or designated EMS providers shall be made at the request of the licensed EMS exclusive geographical service provider."

JEAN LUNDQUIST: This is Lundquist. Are we talking about -- is this the same thing we're talking about these psych patients basically, or are we talking about any patient?

GUY DANSIE: No, this is bigger. This is if you have an ambulance service that's bogged down because they're on a 911 scene response and they can't respond to the hospital, then it's the EMS provider -- it's that ambulance services's responsibility to tell the dispatch, "No, we can't go. We need to get somebody else here."

That burden on falls on the EMS provider. What it is an attempt to do is prevent the hospitals from going outside of the EMS system and getting a different provider that's not authorized.

LAUARA SNYDER: So it would need to be still be another ambulance, right?

GUY DANSIE: Yeah. If it's a medical need, it's still another ambulance.

LAUARA SNYDER: Okay. So their transport service is not EMS, right? You're designating --

GUY DANSIE: Yeah. It's not an ambulance.
LAUARA SNYDER: Well, it's not EMS, Emergency Medical Services.
GUY DANSIE: Right.
LAUARA SNYDER: So -- but they're designated, but they're it's not EMS.
GUY DANSIE: Right. It's not medical, right, in the sense that it's a physical need, a medical need.
LAUARA SNYDER: Okay. So they're not classified under emergency medical services?
GUY DANSIE: No, no. This phrase doesn't really pertain to the designation stuff we're talking about. This just tells the hospitals and it tells the EMS, the ambulance people that we already have in existence that it's their discretion on using the mutual aid provider, which I think we've always understood that. But part of the issue was when this bill went through, there was a concern by the ambulance providers that, "Hey, if we delay, then they're going to go backdoor on us and get a different ambulance to come in and do it."
LAUARA SNYDER: Okay.
GUY DANSIE: So what this is an attempt to do is tell the other ambulance services and the

hospitals that the way to do this is to get the dispatch, you know, the one that normally sends the EMS provider. If the EMS providers says, "I can't go."

Then the dispatch center will turn around and say, "Hey, can we send your neighbor."

They'll say, "Sure, go send them."

And that's how it's always operated. But we're just trying to say that in the rule. That was actually a Moffitt thing.

JEAN LUNDQUIST: This is Lundquist. I don't know about other hospitals, but that's not been the process in the past. We're doing that better now. But the process has been that you'd just call whoever you want and --

GUY DANSIE: That's why we're saying it so that --

JEAN LUNDQUIST: So what I'm saying is as this rules goes out, it will be a change of rules for hospitals, correct?

GUY DANSIE: Well, and you guys are unique in Utah County in the fact that you have two different licensed providers in your county. So you can have -- you can go the non-911 route and call Gold Cross because they're licensed, or you can call

Provo Fire Department through the 911 system. And either one of those two can respond, correct?

JEAN LUNDQUIST: Right. Correct.

GUY DANSIE: But you're not going out and you're not calling, you know --

JEAN LUNDQUIST: Okay. I --

GUY DANSIE: You're not calling Nephi. You know, you're not calling Juab ambulance to come up there. You're not doing that.

JEAN LUNDQUIST: Yeah, okay.

GUY DANSIE: You guys have a more complex issue because you do have the two providers, and you're okay to use either one of those.

If you're in Wendover, you only have one. Or if you're in Cache County, then really you don't have another option. Gold Cross or somebody else is not allowed to come in there without Jay's approval of that or request for that.

JEAN LUNDQUIST: Okay. So what you're saying is if I'm at the emergency room, I can call either Gold Cross or Provo without this affecting this rule because they're both licensed, right?

GUY DANSIE: Correct, correct.

JEAN LUNDQUIST: Okay. Perfect, thanks.

GUY DANSIE: And that's -- this is just to

help so that we don't have somebody bypassing the one that they're supposed to be using. And they're -- technically, they're not supposed to do that anyway.

JEAN LUNDQUIST: That makes sense.

GUY DANSIE: Then if I scroll down, I'm getting down into the 426-4-900. It is a new section. And it's just generic language, very similar to the quick response vehicle language.

"Quantities, supplies and equipment as described in the department inspection requirements." That's part of that policy we referred to earlier. "A designated nonemergency secured transport is required to provide procedure training and oversight for individuals performing duties for their respective designation."

It means that people need to be trained. They can carry different equipment. If they want to do like a variation or a waiver from what the standard is, then they have a process to do that. So they would take that to the committee because the committee has the authority over the designation requirements, and they would petition the EMS committee. So that's what I attempted to say there.

Four is "Non-disposable equipment shall be designed and constructed of materials that are

durable and capable, withstanding repeated cleaning."

We don't want any cardboard products in the back of your van, or whatever. I'm just saying that it has to be a durable and decent and at the discretion of the department making sure that it's -- you know, it isn't crap. We're not dealing with junk.

Four A talks about having equipment that meets OSHA standards. They should be able to sanitize and sterilize equipment prior to re-use if something is being re-used. This is all standard language for the other vehicles.

Five, if we jump down to there. I ain't reading all of it. It's pretty generic. "The providers shall have all equipment tested, maintained, and calibrated according to manufacture standards." Just saying if you have any equipment, it needs to be done properly.

"The provider shall document all the equipment inspections, testing, and maintenance and calibrations. Testing and calibration conducted by an outside service shall be documented." Just maintaining service records.

Seven, this is one that we actually talked about quite a bit in the group: The ability to

secure personal items. It's commonly done in the business that you take items and you put them in a secured area so they don't fly around or the patient may --

ALTON GILES: So the patient doesn't have access to them.

GUY DANSIE: Have access to them. If they had a knife or something.

ALTON GILES: In the majority of the patients they're taking all of their clothes away from them and they're wearing scrubs or a hospital gown.

GUY DANSIE: Okay. So personal belongings.

ALTON GILES: I know originally we said like a container. Which I mean we've picked up patients, homeless people that have ten bags.

GUY DANSIE: That's why we left it more generic is because the concern -- well, I did have a box in there originally, a secure box or a container. But it was felt that sometimes if -- what if it's a blanket or something like that or something bulky that's soft. Then maybe "secure" just means having it on the front seat.

ALTON GILES: Yeah.

JAY DEE DOWNS: Just basically you want it away from the patient.

GUY DANSIE: Yeah. We leave that kind of open-ended.

And eight says, "The department shall maintain and publish requirements for the designated nonemergency secured" -- we'll change that if we need to -- "vehicles on the department's website."

So we will post the requirements so you understand or are anybody else that may be in a similar business so they understand what those requirements are and they have access to them. And that's it.

ALTON GILES: Guy, what type of time frame? Say this, you know, goes next week to the committee, what kind of time frame do we have to, you know --

GUY DANSIE: To get it -- to make it effective?

ALTON GILES: Yeah.

GUY DANSIE: Let me tell you a long, sad story about my job. It has to go through administrative approval.

ALTON GILES: Okay.

GUY DANSIE: Okay. Once the committee

approves it, it goes through administrative approval. That's usually not too bad. It does have like the AG office has to have their eyes on it and make sure that it complies with our existing statute so that we don't have conflict between rule and statute. They usually are pretty good about that.

ALTON GILES: Well, the thing I worry about is like vehicle inspection, hey, you've got to have this; you've got to have these things in place. You know, that's my concern.

GUY DANSIE: Well, this is the method -- the madness behind my method. We make it into rule first, and then the policies can be developed at a later date.

ALTON GILES: Okay.

GUY DANSIE: So if we make it -- the rule process is -- and then there's a 30-day public comment period. And then they have another mandatory waiting week, a cool-off week. And then it can be made effective. Part of the issue is when it's submitted to the --

JAY DEE DOWNS: AG.

GUY DANSIE: -- AG or when it goes into the journal for comment, they only put -- post the journals every two weeks. So depending on how it

lands on that submission date, that will slow it down a little bit sometimes.

The other thing is fiscal impact. There's a new state requirement that started last July, everything that we do has to show what fiscal impacts we anticipate based on real data. Not just what Guy things, but like I have to document how that's going to impact.

So there's a little bit of a work end of mine. It will probably take another few days to develop that. So honestly I would say two or three months is a pretty --

ALTON GILES: So once that's done though, but how much time when this is all done do I have to get the vehicles inspected to submit?

GUY DANSIE: Once it's made effective, then -- well, we can put a window in there.

ALTON GILES: Okay.

GUY DANSIE: That was discussed earlier, and I didn't put it in there. But when we talked to Redd about the bill --

ALTON GILES: Yeah, it was November 30th that --

GUY DANSIE: Well, the statute is November 30th. But the implementation date for rule

is usually 120 days after that. So you could actually have started at end of November, but the rules would have to be in effect. That's why we moved it back to November is to hurry and get the rules in effect.

ALTON GILES: Okay.

GUY DANSIE: Okay. But because we don't have that statutory issue, it's just whenever we decide it needs to take effect. We could put language in there that, "This shall be in effect as of July 1, 2019," or we can do it January 1 of 2019 or --

JAY DEE DOWNS: In the past you've had like 90 days. 90 days from when rule goes into effect, everybody has to be in compliance or six months or -- for example, when we did the fingerprint rule, we did that one up to four years.

GUY DANSIE: Yeah. Because we implemented it over a four-year process of time.

LAUARA SNYDER: So would it be better to have a date/time, not a specific date? Because maybe another company is going to come in and give these guys competition.

JAY DEE DOWNS: The problem is setting a date like right now, you don't know when the rule is

going to be completed.

LAUARA SNYDER: I know. But what I'm saying is like 90 days from the time the rule is completed, instead of --

JAY DEE DOWNS: I see what you're saying.

LAUARA SNYDER: Yeah. Then you don't have to worry about it.

JAY DEE DOWNS: 90 days of the rule --

LAUARA SNYDER: Or 120 days, or whatever.

JAY DEE DOWNS: 90 days of the rule approval.

LAUARA SNYDER: Yeah. Or 120 or whatever you wanted to decide.

GUY DANSIE: Yeah. Honestly, don't know what other employers are out in the marketplace, but maybe we ought to look at what we consider a fair amount of time.

JAY DEE DOWNS: Well, you're going to have the time also for Tammy to do her gig. Because you're going to have the applications come in, and you're going to have to have them --

GUY DANSIE: -- review, internal review.

JAY DEE DOWNS: It's going to take a little while to make the letters and --

LAUARA SNYDER: You probably couldn't

accomplish it in less than 120 days then, could you, four months? That's a pretty short governmental time.

GUY DANSIE: Let's go back to this. Let's add -- should we add a date here --

LAUARA SNYDER: Not a date.

GUY DANSIE: -- or a time?

LAUARA SNYDER: An amount of time.

GUY DANSIE: After this designation is made effective, designate it within 120 days. Should we add that?

LAUARA SNYDER: I'm just throwing that out as a rule. I don't know how long it really takes you to accomplish the Bureau side of things that you're going to do. Like you said, Tammy has got to do some things. What's realistic?

GUY DANSIE: Well --

LAUARA SNYDER: You don't want to give them nine months, but --

ALTON GILES: Well, you have the option too if you got close to the 120 days and we could --

LAUARA SNYDER: Yeah, ask for an extension.

ALTON GILES: Yeah.

LAUARA SNYDER: Yeah. But if you don't

put a time limit, then it's like, "Well, I'll get to it next week."

JAY DEE DOWNS: I'll get around to it when I get around to it. Or on the other hand, hey, the rule is already in place; you're in violation.

ALTON GILES: That right there is what I was worried about.

GUY DANSIE: Here's -- This may or may not comfort you. The department has the discretion whether to enforce a rule or not. So we can delay our enforcement until a certain time. We're allowed to do that. So I can put it in the rule to make it clear, or we can just say --

ALTON GILES: I just want to make sure I have --

JAY DEE DOWNS: Do you know what, let's take it before the committee.

GUY DANSIE: Should we just leave it for the committee's decision?

JAY DEE DOWNS: Uh-huh (affirmative).

GUY DANSIE: I'm glad you brought up the point though.

JAY DEE DOWNS: That way you can also get the timeline, ask Tammy how long would it take. She's also got flooded with five or six services out

there and --

GUY DANSIE: Yeah. And it -- when we talked about -- when the bill was there, we actually said we'd give them until like July 1 of 2019, I think is what we proposed.

JAY DEE DOWNS: That's six months, seven months.

GUY DANSIE: So think about it. We'll kick it out to the committee.

ALTON GILES: I'm fine with that. I just would like to know a time so that I make sure that, you know --

JAY DEE DOWNS: That's only fair.

ALTON GILES: Cross my T's dot my i's on everything.

GUY DANSIE: And we're not going to come after you if you're in the process of applying. I mean, if you were two or three years down the road and you weren't --

ALTON GILES: Yeah.

GUY DANSIE: And honestly, this is a volunteer designation. Nobody has to be designated. But if you're going to do this inter-facility piece, then you have to be designated.

LAUARA SNYDER: I can see that down the

road maybe these hospitals who are contracting with inter-facility ambulances or their service to be doing these, why wouldn't they just start their own? Because they're actually not charging the patient, but they're paying the provider.

GUY DANSIE: They could.

LAUARA SNYDER: And just like down in Dixie, there was like this big war of, you know, who can charge the least amount. And they were underbidding each other so far that -- you know, a huge problem. What's to stop them from, you know, a big hospital like IHC, or whatever, to start their own and have them --

JAY DEE DOWNS: Nothing.

LAUARA SNYDER: -- in all of their little facilities.

GUY DANSIE: It's an open market.

LAUARA SNYDER: And that's really going to affect the ambulance service, inter-facility stuff. It really --

GUY DANSIE: The behavioral piece?

LAUARA SNYDER: Well, because we're not saying it's only behavioral.

GUY DANSIE: True.

LAUARA SNYDER: True.

GUY DANSIE: But the other part of the business, I think, is primarily the discharge of patients.

LAUARA SNYDER: Well, I know.

GUY DANSIE: If they have any medical observation, then they're not. And theoretically they shouldn't be in an ambulance if they don't need any medical observation anyway, right? Do you have the ability to charge somebody if it doesn't meet the criteria? I mean, if I went and -- well --

JAY DEE DOWNS: Medicare and Medicaid you would be.

GUY DANSIE: Yeah. So if it's not a patient, then we don't regulate it. If it's a behavioral health patient or if it's inter-facility --

JAY DEE DOWNS: Well, so like if you have a Medicare or Medicaid patient or you have another patient, you have to have a transfer sheet charge, okay. And the transfer sheet is signed by the doctor saying that this is patient has to go like that. So that's the only way you would have it.

GUY DANSIE: And I think by this designation it gives them a legitimate option to use that instead of -- right?

ALTON GILES: Yeah.

GUY DANSIE: Instead of some fly-by-night van that doesn't have any requirements. So hopefully we're making it better for the patient by regulating.

ALTON GILES: Which to be honest, I mean when you're dealing with hospitals, you know, you've got to jump through a lot of hoops. You know, Intermountain is not just going to grab some -- you know, probably be more of the care centers and stuff, which is already in the van -- uses vans and --

GUY DANSIE: True. True.

Yeah, but back to Lauara's thing though, there isn't anything. It's an open market. And at one point Dixie Regional did offer a van. If you remember --

LAUARA SNYDER: I do remember. That kind of sparked the whole hostile takeover business.

GUY DANSIE: We had problems with that at that time because they were probably going over the line on patients. And since then they've actually been granted a license to do that. So they could actually drop down to their behavioral people and just do a van.

LAUARA SNYDER: Sure. A lot less expense.

GUY DANSIE: Yeah. And that was the

reason that Redd wanted to do it is because of the cost. He thought it would be the good option for the hospitals to reduce costs.

REGINA NELSON: Alton, can I break in? I just wanted to let you guys know I have a 3:00 meeting, so I have to go. It's been great.

JAY DEE DOWNS: Thanks, Regina.

REGINA NELSON: Thank you.

JAY DEE DOWNS: I think we're about done, aren't we?

GUY DANSIE: Yeah.

JAY DEE DOWNS: Thanks, Regina.

REGINA NELSON: Okay. Thank you. Bye-bye.

JAY DEE DOWNS: Bye.

GUY DANSIE: So just in concluding, I'm going to have Brett -- we'll e-mail out those changes to the training requirements, and then the rest of it we'll push on out to the EMS committee.

JAY DEE DOWNS: Which is next week.

GUY DANSIE: Yeah. It's Wednesday.

LAUARA SNYDER: Is there not already an agenda for that?

JAY DEE DOWNS: I haven't seen one.

GUY DANSIE: Not a firm agenda. There's a

draft, but not a final. This is part of the final. That's why I wanted to do this.

So we calling it?

Jay, are we officially ending the meeting?

JAY DEE DOWNS: I'm just --

GUY DANSIE: I make a motion that we end the meeting.

JAY DEE DOWNS: All in favor? Or second?

DEAN YORK: Aye.

GUY DANSIE: See you guys. Thanks for calling. Thank you.

(Concluded at 2:43 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 25, 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 95;

WITNESS MY HAND AND OFFICIAL SEAL this 5th day of May, 2018.

Tamra J. Berry, RPR, CSR

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