STATE EMS COMMITTEE MEETING

July 15, 2015
1:00 p.m.

Location: Viridian Event Center
8030 South 1825 West
West Jordan, Utah 84088

Reporter: Teri Hansen Cronenwett
Certified Realtime Reporter, Registered Merit Reporter

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A P P E A R A N C E S

Kris Kemp, Chair
Jay Dee Downs, Vice-Chair
Guy Dansie
Mark Adams
Jeri Johnson
Hallie Keller
Mike Mathieu
Michael Moffitt
Jason Nicholl
Casey Jackson
Peter Taillac
Lauara Snyder
Tami Goodin
Suzanne Barton
Jim Hansen
Eric Bauman
Angie Adams
Mathew Christensen
Shari Hunsaker
Paul Patrick
Dennis Bang
Tammy Barton
Jamie Rossborough
Dan Camp

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Rachelle Rhodes
Jeremy Schultz
Ron Morris
Allan Liu
Jim Gordan
(And numerous others in the audience)

KRIS KEMP: All right. Can everyone hear me? Everyone in the back? Through the screen? All right. Great. Welcome to the state EMS committee for today, July 15th. We have a couple of things we're going to be doing a little bit of out of order on our agenda. So I ask you for forgiveness to move things around a little bit based on some time constraints some of our presenters have today.

A couple of rules, house rules that we use for this committee, especially because of our court reporter situation. We want to make sure that only one person is talking at a time and you introduce yourself by name before you begin addressing the committee, once we've recognized you in your role.

We'll start today with a little -- I think we can forego the introduction. We can all see our name tags. If there's any questions, we can address those at the round table level. But we'll jump right into the action items with the approval of the minutes. We've had an opportunity to review those. I would accept a motion and a second or indication.

MICHAEL MOFFITT: Move to accept.

KRIS KEMP: Have a motion. Second?

JERI JOHNSON: (Raised hand.)

KRIS KEMP: All in favor say, aye.

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VOICES: Aye.
KRIS KEMP: And any opposed?
(Silence.)
KRIS KEMP: Any abstain?
(Silence.)
KRIS KEMP: All right. Thank you. Our other first -- or our second item of business, I guess, will be a little bit out of order. And it's by request that the Green River staffing waivers presented by Jim Gordan. So I'll have you come up here and present to us at this time, if that's all right.
JIM GORDAN: Thanks for allowing me to go a little earlier than was scheduled. It helps me with my time constraints. First EMS meeting I've been to, so I apologize. I'm not sure of all your rules and orders, but as you -- as you mentioned, we cover Green River area in Emery County, and geographically it's located by itself way off in the Eastern part of Emery County.
And there really isn't anything within an hour either direction of there, to Price or Moab or going up I-70 west to the town of Emery. So it's a very isolated area on its own.
We have some, as mentioned in our waiver request, some staffing issues there. It's difficult. Green River is not a large town, and the people there

have one or two jobs and make it difficult for them to volunteer to be out on the ambulance at all times. So we're having some issues staffing an ambulance there. We have two ambulances stationed in Green River right now.
There have been times where we have needed both ambulances and sometimes all three. And so as we move forward, it's becoming more difficult for us to find volunteers. Green River city has taken an interest, gratefully, that they are working to promote the EMS system in Green River and find ways to entice their citizens to help provide coverage on the ambulance.
In the interim, however, there are times when we do -- we have a driver and one EMT at the advanced level in the area. As I mentioned for Carbon County or Grand County to respond, it's about 60 miles one direction to Green River.
We had an incident last week where there was a one-car rollover just at the exit to Green River, had absolutely no one in Green River available to respond. I sent one of our ambulances from the town of Emery there, which is about 50 minutes, it took them from Page to on-scene time. Thankfully the -- there weren't really any serious injuries and the people waived their

right to service. But that's what we are looking at.
So what we have requested is in times that we do have at least one driver and one EMT available that we can initiate patient care and initiate a transport where we could rendezvous with Grand County or Carbon County or another agency, other ambulance from Emery County, to intercept, and with a fully staffed crew, transport that patient.
That's what we are asking for. Again, not a permanent solution to a problem, but a temporary fix until we're able to better staff the ambulance there.
KRIS KEMP: Okay. Thank you. Questions from the committee?
JASON NICHOLS: I'm not going first.
JIM GORDAN: Nobody else going. So you will be last and first.
JASON NICHOLS: Okay. Thank you very much, Mr. Gordan, for bringing this information in. A couple questions that I have for you is, No. 1, how often do you anticipate doing this? And what is your plan to get -- if this waiver were approved, what is your plan to move out of this waiver? Because quite frankly, I think this is a pretty slippery slope.
JIM GORDAN: Agreed, and as I mentioned, this is not -- this is a temporary fix to a permanent

problem. And the action plan that we have in place, I mentioned Green River City has taken a very serious look at this. They are willing and looking to put up funds to help educate new EMTs and pay for that course, as well as Emery County will be doing that. The problem has been finding the people.
And so Green River is taking that interest or that initiative more so than they have in finding -- putting on the class. Putting on an EMT class will not be the issue and hope to have that by the end of this year or the first of next depending on how quickly Green River can help, as well as Emery County, get people.
MIKE MATHIEU: What training do your non-EMT drivers go through to be eligible to be employed for your county or for Green River? What training do they have in terms of EMS training? Any skill training? Any driver training?
JIM GORDAN: We do have a driver training. We do the defensive driving course as well as emergency vehicle operators for ambulance. We use the CVO course that's there, and they're trained in emergency vehicle operations and driving. But as far as medical training, they do not have any right now.
MIKE MATHIEU: So my question, I think for the bureau, I know recently there's some legislation because

of a significant accident that occurred killing a civilian by an ambulance driver and some new statutory requirements that all EMTs or ambulance personnel will become certified in driver training, emergency driver operations.

If these drivers are not certified EMS personnel, do you have any jurisdiction over this organization's drivers, or is it driven just by policy of their department of what they decide and determine to put their drivers through? I guess what I'm saying is, is there a loophole in the state statute that they don't have to meet our statute requirements of ambulance driving that was recently passed?

GUY DANSIE: Just to answer your question, we have actually addressed that in administrative rule, that if they are a non-certified EMS person, that they have to have a EVO course by the department. Does that answer your question?

MIKE MATHIEU: Yeah, that's basically what I want.

JIM GORDAN: And that was my understanding. And like I said, each of the drivers there in Green River, some have been there for 15 years or better. So they have all taken that emergency vehicle operator's course that the EMS -- through the National Safety

Council or -- anyway, it's -- so they are certified as EMS drivers, yes.

MIKE MATHIEU: Okay. Second question would be related to comments to Jason. What you're saying is that an ambulance is going to arrive on scene with one medically trained EMT and driver with no medical training and the considering of not even having a second pair of hands that's medically trained, I guess, what you're asking for.

And I agree with Jason in terms of saying, if you have a long-range plan or even a short-term plan. Is this a temporary request that you're asking? I would feel much more comfortable if you put some time specifics to it, saying, "We would like this request for six months or nine months, after which we will meet the minimum staffing requirements."

I would feel much more comfortable as an EMS committee member rather than leaving it open-ended that you will just operate in perpetuity with one driver and one EMT, because I feel it's a misconception or a --

JAY DEE DOWNS: It's a loophole.

MIKE MATHIEU: Not only a loophole but it's misleading the community that you have minimum trained personnel just by looking at the side of the ambulance and there's just one trained person and somebody that's

a driver. That's what my worry is by not doing a time specific allowance for something like that.

JIM GORDAN: Agreed, and I did not put a time specific there, but I think that is a valid concern, and I would be perfectly comfortable in saying that nine months would be sufficient time for us for recruit enough people to have an EMT class and no longer need this waiver.

JASON NICHOLS: I have something else as I was here just thinking and reading your paperwork. It says that you have 35 -- 38 certified EMS personnel; is that correct?

JIM GORDAN: In Emery County in general, not just in Green River.

JASON NICHOLS: Okay. But total for your agency is 38 people and 9 drivers?

JIM GORDAN: Correct.

JASON NICHOLS: And you just said that the drivers have 15 years, some of them, experience.

JIM GORDAN: Some of them, yes.

JASON NICHOLS: It seems to me that there's your EMTs. Why -- I guess I don't -- I guess I don't get it. The drivers want to go drive the ambulance, licensed sirens. That was mean. I'm sorry. What I mean is that they're not willing to become EMTs.

JIM GORDAN: I don't get it either. I'm just -- it is -- I understand your question.

JASON NICHOLS: To me that seems like an internal, you know, agency policy where it takes 120 hours to train an EMT and you can get that done in maybe 10 weeks, 12 weeks, for a little bit of class setup.

JIM GORDAN: Agree.

JASON NICHOLS: And in that 12 weeks, that's in between committee meetings, you could have yourself a solution in-house potentially without needing a waiver because it will be between the next committee meeting. I'm just spit balling here. Anybody else think that we can train drivers to be EMTs, or is it just me? Jeri?

KRIS KEMP: I think that's a valid point, Jason, that you're bringing up. I think the question is that we need to ask ourselves, 10 weeks, 12 weeks, regardless. What is better for that community, an EMT and a driver or 50 minutes waiting for two EMTs? And I think that's the crux of the question we have to ask ourselves. And this is a slippery slope. This is a direction we don't want to go.

I think this is even a bigger issue than having two paramedics in the back of an ambulance, because ultimately if you have a nonmedically trained driver, how is that person on a back board getting in

the back of the ambulance? You're recruiting the driver to do that. And although it doesn't take a whole lot of rocket science to learn how to pick up a back board, it's just those two.

And were the driver to slip and fall and drop the person, I mean there's a lot of ramifications there because technically they're just supposed to be there as a chauffeur and not to have patient contact. And so that is a much larger issue than two medically trained personnel, one with greater skills than the other.

JIM GORDAN: Agree.

KRIS KEMP: Question specifically from the community? Sure. Come on up. Lauara come up. Oh, yeah.

LAUARA SNYDER: I'd just like to make a comment. Oh, Lauara Snyder, Wendover Ambulance. I'd just like to make a comment on this. It's very important, I think, that you are able to come up to two. That's what the requirement is. However, I would like to say, and Jason said he didn't understand this, but across the country in rural areas, especially in farming areas or remote areas, it is difficult to get volunteers as most of us know.

And even though people may volunteer to be a driver, they don't have the time or inclination to

become EMTs because they're busy running their farm or they have two other jobs to support their family. And that's not a priority, but they will volunteer as much as they can.

So while we would want to encourage people to be drivers and become EMTs after that, sometimes that's all we can get. And I think we ought to take advantage of that. And maybe in addition to the EVO that's required, I know in our area we require that they have CPR training, and then we also train them in lifting and moving patients.

You know, that may be something you could also do. But internally, just to answer Jason, this is a problem, and not everybody wants to be an EMT. But we're glad for what they can do. So I would just like to add that.

KRIS KEMP: Thank you. I think those are some important points. Peter, do you have something you want to address us with?

PETER TAILLAC: Peter Taillac. I'm with the Bureau of EMS. Mr. Gordan, I apologize upfront, but I do not support this at all.

JIM GORDAN: I understand.

PETER TAILLAC: I understand your problem. This problem has been going on for a long time. I have

been down, met you guys, you know, and inspect the area, etc. I just feel like -- a couple of points. One, I think this will actually hurt your recruiting not help, because this EMT is at the scene of a critically ill child who was thrown through a windshield and is semiconscious and vomiting on the side of the road is no help at all.

That may permanently scar that EMT when the child does poorly. Okay. Permanently scar. Screw this. I don't have to do this. Okay. That's a scary situation to be in. With two EMTs, at least they've got somebody else to sort of share the decision making, not to mention a pair of hands to actually know how to help put pressure on the wounds while you address the airway, etc.

I feel strongly this is a problem that your agency needs to fix by whatever means. Let me say, if you had one of your buildings that was on fire and burning down, you wouldn't say, "Well, we're just going to let it burn down and then we'll figure out, like take the take care of the problem six months from now."

I think this is a an equivalence issue. Your population expects that when they pick up that phone that an appropriate number of medically trained people will arrive. And if that can't happen, your county --

this is, I'll say, Peter's opinion at this point, not state's -- your county needs to fix the problem. Do a root cause analysis to see why can I not hire people. Do you not pay them enough? Is the working conditions not good? Are there employer support issues that you could help with? Try to fix the problem.

I'm afraid that just putting it off and during that interim not providing the same level of service that your public expects is not a good idea. I would rather see you say, "We have a problem and we have to fix it today," than to say, "We'll try and get a class."

I can say on behalf the bureau, we would be happy to help you put on a class, provide instructors, provide support for the class, waive -- I discussed with Paul already, waive EMT certification fees, those kind of things.

But it may be that your county just needs to fess up and pay them two bucks an hour or 2.50 instead of a dollar an hour to be on call to make it a little more worth their while. I don't know what the best thing is. You need to fix it.

I just don't feel good about the public and from a medical standpoint, that a single can provide adequate coverage at the scene of a critical accident or a critically ill patient. So I just want to speak

against it. I apologize for that. I know you're trying hard. I just think this is the wrong -- to lower the standard is not the right approach to the problem.

KRIS KEMP: Other questions, concerns from the committee? Let me speak with the committee real quick and then we'll...

CASEY JACKSON: Does the county commissioners and the city councils, have they expressively endorsed this?

JIM GORDAN: Yes. And the other thing that we -- that I did not mention and Dr. Taillac is aware and some of the EMS Bureau, we do have a medical center with a PA in Green River that has been very beneficial to Green River City and Green River ambulance service in caring for patients. And so we use them as a resource.

They are not our control hospital, and we've had some issues with that in the past. But I think that's resolved. We do have that resource that is closer, and they have a few more abilities, and they can stabilize a patient there.

And I agree with you, Dr. Taillac. This is not the best solution. I agree, and at the same time, I don't agree that having no service there is the solution in the interim either, just telling the citizens of Green River, hey, we can't run with one, so you can't

have an ambulance for an hour. I don't know that that's the best answer either, so...

MIKE MATHIEU: Jim, can I just ask you to make sure I am understanding everything?

JIM GORDAN: Sure.

MIKE MATHIEU: In Green River are you currently not operating an ambulance, so the ambulance comes from one of these remote locations?

JIM GORDAN: At certain times that's correct. On my way up here today -- it is a unique situation there. And I don't have the ability to express it or even understand it on a level that makes sense to me there. They had a call today, no one on the schedule. I made two phone calls and immediately had two EMTs that would respond. And when I go there and ask them why they can't, I don't get a satisfactory answer as to why they won't just automatically take that and fill the schedule.

So I -- whether it's morning, night, weekends it doesn't matter. Any time the pager goes off for Green River, I'm on the phone, going down the roster saying, "Can you respond? Will you respond?" And usually I can find somebody that way.

But what -- again, as Peter said, there is something more at the core here, and we haven't really

been able to sort that out as much as we've tried. So why they won't just --

MIKE MATHIEU: So an administrative matter. So is it operated by you on behalf of Emery County, or is it Green River separate --

JIM GORDAN: It's operated by Emery County.

MIKE MATHIEU: So you are in charge it?

JIM GORDAN: Correct.

MIKE MATHIEU: But you don't know why -- I mean not to put you on the spot. You don't know why it's dysfunctional?

JIM GORDAN: I don't.

MIKE MATHIEU: I mean that might be the heart of -- I think the question that's coming up is that maybe it needs a little more attention administratively to determine its functionality.

JIM GORDAN: And I agree. And we have been there as a county commission. We have been there as -- we went there with the clinic issue and the same thing. There are some concerns that they have that when we address those concerns, that doesn't seem to be the real issue, and we just keep addressing concerns.

And it doesn't seem like we are able to get at the heart of the issue. They bring up concerns. When we ask them for ways to resolve and help them, they

don't seem to want to present those resolutions, and so we're left spit balling, if you will. It's a frustrating situation.

MIKE MATHIEU: Ambulance come to respond to that area until they can return to minimum qualifications to provide an ambulance service.

COURT REPORTER: Excuse me. Will you say that again. I was having a little bit of trouble hearing you.

MIKE MATHIEU: I said, maybe they ought to revert to letting that become a first responder unit area with the minimum requirements of one EMT to respond as a first responder. Not take an ambulance. Have an ambulance fully staffed come from another location until the time is sufficient you can figure out the administrative matters and staff it fully as it should be.

JIM GORDAN: And that is -- I guess that's what I'm asking for here, but a variation on that, so...

KRIS KEMP: If the schedule -- whose responsibility is it in filling that schedule?

JIM GORDAN: Mine.

KRIS KEMP: And so you know of holes ahead of time that can't be filled?

JIM GORDAN: Correct.

KRIS KEMP: But yet when there's a call-out on a day when there's holes, you're able to fill it at that moment?

JIM GORDAN: At that moment. I make phone calls, I send out text messages all throughout the week asking to be able to fill that schedule, get no response. And yet when the pager goes off, magically the spots can be filled.

JERI JOHNSON: I feel your pain. I know exactly. In Hanksville, I have that somewhat geographical -- and there will be times that we have to. I just line it up with our dispatch center that we're going to be a first response only and page the closest, whether it be Loa or Emery County or whatever it be, to start coming that way.

I just feel a huge liability for one person to be put in a rig, especially as far away as we are from care. I think with air ambulances that are available, I think there's more resources versus just putting one person in an ambulance and taking off. So I think it's more at a county level.

I moved to Loa because my service was not functioning up there, just to help be there to support, you know, so I think you need to look towards the county and just...

MICHAEL MOFFITT: I have to kind of echo what Chief Matthew and Jeri said. Having service areas that are extremely remote in my department, we've had to create some, you know, first response units and other methods. But I just can't, in all good faith to the public, sell an ambulance that doesn't have at least two EMTs on it.

Drop it down to a first responder and send out that one EMT that you've got. Have somebody come in from outside. Maybe that will help your community realize you have an issue. Maybe there will be people to step up. Unfortunately, I've got people that their full-time job is texting, e-mailing and calling people every day.

And it's just, it's the nature of the beast nowadays. But there are workarounds. And going to a QRU response unit or first responder unit that one EMT running out there, A, the community will know what it's getting when they show up in a, you know, different vehicle. With equipment they can do stuff. But they'll realize, you know, this isn't an ambulance. They won't have that expectation of an ambulance. Why aren't we going to the hospital yet?

And you won't have the liability, which regardless of which way this committee goes, if you run

a single EMT and a driver, that's going to open up liability. That would come down the road. So I kind of have to agree with some of the other committee members that maybe we need to look into that first response service to fill the gap.

JIM GORDAN: Thank you.

TAMMY BARTON: Tammy Barton. It is kind of weird for me to stand up here now. Exactly what I was going to say the same thing is, have you looked into having first responders? I know in a couple of my remote areas -- because sometimes we have enough people there to run an ambulance with them and other times we don't.

And we've dropped them down to a first responder, and we provide them with jump kits with radios to talk with each other, incorporated the firemen to help with back boarding and getting a patient packaged until the ambulance can get there.

And each time we have done that, we've actually seen a higher recruitment. One, because the community no longer has an ambulance, and some of them who were sitting on the fence decide, yes, I can do it. Because they keep seeing the ambulance, and so they say they don't -- When they're no longer seeing an ambulance, some of the community members kick in a

little bit better.

But also made it easier on those people in those remote areas. They know that now they respond, and they take care of the patient. They turn that patient over. And now they are no longer on a transport for six and seven hours a day. They're with a patient for an hour and a half, two hours until the ambulance gets there and takes them out.

And a lot of them said, "I can donate this much time. I just cannot donate that seven and eight hours each time that it takes me to transport the patient." And it's helped us tremendously in a couple of our areas. And so I was wondering if that was an option you had looked at.

JAY DEE DOWNS: Mr. Chair, I think for the reasons stated and also I think there are some solutions that are out there, I move that we deny the motion for staffing waiver.

KRIS KEMP: We have a motion. Do we have a second?

HALLIE KELLER: Second.

KRIS KEMP: All right. We can call a vote. We have a motion and a second. All in favor of the motion as presented...

VOICES: Aye.

KRIS KEMP: And any opposed?
(Silence.)
KRIS KEMP: And any abstain?
(Silence.)
KRIS KEMP: All right. Do we have -- with that motion being carried, I think that you have some options to deal with and to work through. I think that it's very telling that the community understands this problem. We understand this problem.
We want to present some solutions for you to take back to your community and say, look, they're not going to allow us to do this. They are not going to allow us to take a step down even if it's a time frame of five months or ten weeks. They are not going to allow us to do this. So we have to ramp it up. We have to improve our recruitment and we have to come up with these solutions, and some of which have been offered here.
I think especially from those of us who have worked in rural areas, those are the solutions that you need to try to incorporate. So we want to show you that support. I think that it's very well understood. This was, as noted by the committee, a step that's just not something we would support at this point.
So hopefully that's something we can have you

take back to your county commission and work through with your community there in Green River.
JIM GORDAN: Perfect. Thank you so much, and thank you for the suggestions. That will be truly helpful, and we'll work on it from there. Thank you.
KRIS KEMP: All right. Rules task force, Jay Downs and Guy.
GUY DANSIE: I am actually going to -- I believe we have -- I think Paul was going to present on R426. I think you are first on the agenda, and then I will discuss the other piece.
PAUL PATRICK: Do you want to talk, Jay?
JAY DEE DOWNS: No, I don't want to talk.
KRIS KEMP: All right. Paul, it's all up to you.
PAUL PATRICK: Thank you very much, and it is a pleasure to be here. First of all, I want to thank the rules task force. They've exceeded my expectations in their ability to function. I also want to recognize Jason and Jay who have been members of that task force and involved with them and also encourage them as they are working forward on coming up with some more guidelines on their membership and how they can move forward. So a big thanks to them.
We have been working on a -- three legislative

requirements that mandate rule change. And in order to meet the statute, the rules need to go out and become effective before an October deadline. So the last place on the list of everyone who's seen these -- and it's gone to the rules task force a couple of times for revision.
It's gone through the department. I even had Brittany, the attorney, take it through Stephanie who is the final approving attorney to look at the language and come up with, yeah, this will work. I will move this forward to Dr. Patton unless it goes to him after July 1, whoever the acting new executive director of the new department is.
So we've done all our steps, but one process we need you as a committee to also give your blessing and potentially recommend any changes to have this go out for public comment. We would then, if successful in getting your vote to send it out for public comment, we would ask Guy to send it out immediately, and it would go out for the 30 day public comment period and then become effective.
So I'm going to talk about the training rules, R426-5, training and certification. There are three major revisions that you've had that were sent to you. R426-5-2600 is about the epinephrine auto injector. And

you do have a one page with a little yellow highlighted part at the bottom, because as we reviewed the rule, we found that the statute that was passed by the last Utah legislative session and signed into law also required that we address the issue of storing and disposing of the epinephrine pens.
So R426-5-2600 talks about the epinephrine pens with the last part being added, and this didn't go to the rules task force. I'll bring that up right now. But the language is simple. It says, "All epinephrine auto injectors must be stored and disposed following the current manufacturer's specifications, period."
So I don't think that's a huge objection, and Jay, and -- who else chairs the -- and Guy. I don't think you have any -- hopefully you don't have any issues with that, but I'm told --
GUY DANSIE: Just the word "must." We'll put shall.
PAUL PATRICK: Shall, okay. Oh, that's right.
GUY DANSIE: Just to be consistent.
PAUL PATRICK: So we'll change and do shall. So that's the first thing for the rules is, we're requesting that that be added. Now, Mr. Chair, do you want to do each section in the motion or just have me talk about the other two amendments and do in motion

that part for R426-5-2600?
KRIS KEMP: Let's do each section as a motion.
PAUL PATRICK: Okay. So then I would seek any discussion or a motion on R426-5-2600 epinephrine injectors.
KRIS KEMP: Committee, community, any questions?
MIKE MATHIEU: Just a point of clarification on one word. Spell check should be manufacturers.
PAUL PATRICK: Yeah, that's right. We'll fix that. That was Paul doing it.
MIKE MATHIEU: R-E-R-S.
PAUL PATRICK: So it will be shall and manufacturers spelled differently.
KRIS KEMP: All right. Do we have a motion to approve with those notations, manufacturers and shall?
JAY DEE DOWNS: So moved.
JASON NICHOLS: Second.
KRIS KEMP: Motion and second. All in favor say aye.
VOICES: Aye.
KRIS KEMP: And any opposed?
(Silence.)
KRIS KEMP: And any abstaining?
(Silence.)

KRIS KEMP: All right. Motion carries. Go ahead, Paul.
PAUL PATRICK: Thank you. The second one is R426-5-2700, which has to do with the compliance unit that was passed in the legislative session. I have at this time no recommended changes to the draft that you have in front of you.
But I do want to let the committee know that it is the intent that this go to the -- after it is passed, that we have this language looked at by the committee again in three months to see if there are any little tweaks that we need to make as we may have forgotten something, even though we worked really hard on it.
But we're recommending it go forward as is. So I'd like to ask for a motion for that.
JASON NICHOLS: Clarification first.
PAUL PATRICK: I turn over to Kris, so...
JASON NICHOLS: Language on the 2700-3 or (iii)(f). And in this section it talks about criminal -- or decency crimes and specifically highlights under (iii) and (iiii), bestiality, sexual battery and lewdness involving a child, which I think is self-explanatory. During the rules discussion, we did go through that. Everything was great.

However, the next page over on F, it then takes in everything else in Title 76, Chapter 9, which includes offenses against the flag and other things like that that was not part of, nor intended in the initial discussion. And so I'd like to open that up to discussion. I think it's covered well under what we intended with bestiality, sexual battery and lewdness involving a child. But I think the others are an overreach.
PAUL PATRICK: So are you just proposing we deleted Section F?
JASON NICHOLS: I am proposing we strike F.
PAUL PATRICK: I have no problem with that, we just strike F. So the motion -- whoever makes a motion to have these sent out would say, "I move that these be sent out, and in that motion we strike F."
KRIS KEMP: Correct.
PAUL PATRICK: I have no problem with that. Do you, Jay?
JAY DEE DOWNS: I don't think we even discussed that part.
PAUL PATRICK: Dr. Kemp, we're fine with that if someone wanted a motion to send that out and striking out.
GUY DANSIE: Just a comment. I think that was

added inadvertently by Brittany as she did her review, and I'll discuss that with her. And then also for the committee, I think everybody is looking for a hard copy of this rule, and I don't know if it got in the packet. I don't see it in mine. So apologize. But we did send it out.
PAUL PATRICK: I have a hard copy if you want to read it.
GUY DANSIE: You have a hard copy? Okay.
KRIS KEMP: So again, I would be asking for a motion to move that this section be sent out and strike F as mentioned.
JAY DEE DOWNS: So moved.
KRIS KEMP: Second?
MIKE MATHIEU: I'll second.
KRIS KEMP: Okay. All in favor of the motion on the table say aye.
VOICES: Aye.
KRIS KEMP: And any opposed?
JAY DEE DOWNS: He was saying all those ayes before.
JASON NICHOLS: I know. III. You don't have to put that down.
KRIS KEMP: Any opposed?
(Silence.)

KRIS KEMP: None. Any abstained?
(Silence.)
KRIS KEMP: All right. Thank you.
PAUL PATRICK: Okay. The last one is section 2800, which has to do with the establishing of the peer review board, and again I would like to -- my desire as quickly as Guy can get this board established, we get the peer review board established and functional. They then would look at the rules for anything that we may have missed, bringing those back to you, the committee, and the department for some modifications.
But if you -- again it's section F, which is in -- under No. 4, and all the I -- actually it's like four, section F says, "Any class B or C under Title 76, Chapter 8 offense against public order and decency Utah criminal code."
I would propose that that -- someone in their motion move that that be stricken as well. That's the only recommended change that I have in 2700. And I seek a motion.
KRIS KEMP: Do we have a motion?
JASON NICHOLS: So moved.
KRIS KEMP: And a second?
MIKE MATHIEU: Second.
KRIS KEMP: And all in favor say aye.

VOICES: Aye.
KRIS KEMP: Any opposed?
(Silence.)
KRIS KEMP: And any abstained?
(Silence.)
KRIS KEMP: All right. Thank you.
JAY DEE DOWNS: There was some really good work done in that period.
PAUL PATRICK: Yeah, and I want to also recognize Darren Park and Jeremy Robertson here, and they were very involved in that as well as many others. In fact, start mentioning names and half the people out there. But appreciate the collaboration there and also with Dennis Bang and Kyle Bushnell and their staff in getting this developed to this point.
And to the task force, awesome work. Thank you very much. And so we'll just -- I'll have Guy task himself to get this out quickly. So thanks.
GUY DANSIE: Okay. Along the same lines with what Paul has discussed there were some legislative changes this past session. We needed to write some new rule. In R426-3 in the licensure piece, you'll look at R426-3-600. There was a bill passed that required all EMS -- or ambulance services have a cost quality and access goals for ground ambulance services.

And this outlines some administrative rule that was created and approved by the EMS rules task force. We tried to stick to three basic categories, and that's cost, quality and access as stated.
Give you a minute to look through those. That was sent out to the committee earlier. Hopefully there's no surprises there. And this is also one of the things we are mandated to have in place by October. So we're hoping for a quick passage of this. And then if there are issues, we will come back and visit it again.
One of the things the task force did, as this was drafted, was put the word "may" in several areas. That they may do this, may do that, just to make a little less painful for the first time in going through this process. Also, it is noted that the cost, quality and access goals should be reviewed every two years and then will be required to be reviewed upon licensure and approved by the cities or the municipalities for the political bodies that are involved.
I recognize this is probably going to create a little bit of a workload issue for several of the agencies that serve many political subdivisions, so we are trying to implement a process that will make this painless or at least less painful.
KRIS KEMP: All right. Questions about this

R426-3-600?
LAUARA SNYDER: I just have a question. I can talk loud enough. Lauara Snyder. We don't have a copy of the statutes here. But does the statute say shall or may? Because like you just said, in the task force, we use the word "may," and now it says shall. What does the statute say?
GUY DANSIE: To my best recollection, it is a shall, that all ground ambulance providers shall have cost quality and access goals. We provided some -- these rules outline a process that give you ideas on what those should include.
And I don't know if you were part of that discussion in the task force, Lauara. But we didn't want it to be too constricting at the beginning, to make sure that we have a little wiggle room in the rule to allow this to take place first.
And then we would come back if it needs to be tightened up. Maybe we can do that at a later date. Our primary intent is to make sure that we meet the legislative mandate in getting some rules in place, and then we can work with those rules down the road if we need to.
KRIS KEMP: It looks as if -- as I am reading through that, that "may" as far as the language only

shows up as an example.

GUY DANSIE: Correct. We still expect this to be done. It's just some of the items, the lists of items we're saying it may include these things. So we will require the cost, quality, access goals. And that is a mandate. However, the content we wanted to be a little flexible with. Does that satisfy your --

KRIS KEMP: That's how it appears to me.

GUY DANSIE: Okay. And also, what I would like to do is make this an assignment for the subcommittee, the operations subcommittee, to maybe develop some kind of guidance or template that we can use in our licensing process, so that we have a standard, something that we can hand out to the people in our licensure packets so that they will have a guideline to follow.

KRIS KEMP: All right. That's a good idea for something we can bring up in a little bit. Other questions?

CASEY JACKSON: I just have one. Who has access to -- in the future when this is done, who can read this, just the cities, citizens or what not? Who has access to see these numbers and what not?

GUY DANSIE: As part of the licensure application, it's public record. So it could be GRAMA

requested. Or you know, we would share that willingly with any providers or people that are interested. The city fathers or mothers or whatever you call the people that are involved in the process, yes, we share that with. It's a public document.

KRIS KEMP: All right. Further questions, comments?

MARK ADAMS: No question. I'd like to make a motion that we accept R426-3-600.

KRIS KEMP: I have a motion.

MIKE MATHIEU: Second.

KRIS KEMP: Second. All in favor say aye.

VOICES: Aye.

KRIS KEMP: Any opposed?

(Silence.)

KRIS KEMP: And any abstained?

(Silence.)

KRIS KEMP: Thank you.

GUY DANSIE: Okay. Thanks. Also, as we peruse through this rule, there were some strikeouts and some underlined items in here. This rule was brought to the committee in the past, but we held back on pushing it through the process because we needed to add additional things such as the cost, quality and access goals. So you will notice that there are other changes

that have been made, mostly wordsmithing, trying to make things clear and consistent throughout.

However, I want to just point out in R426-3-710, the air ambulance application, I've actually -- if you look through that section, there are parts of the rule that are highlighted in yellow in this hard copy that you received. Those were added just this last week by the air ambulance committee. They had a special meeting.

Their concern is that we have air ambulance providers out of state that are re-branding, saying they're a new provider and under a different corporation as they come into the state, and therefore, getting a provisional license for a period of one year before they can meet their accreditation requirements.

And they felt that this needed to be tightened up so that if anybody is operating an air ambulance outside of Utah, and they bring that service to Utah, that they already have accreditation in place. Also, there is a -- on Part 6 -- I kind of got the cart before the horse.

Part 6, we have learned that the U.S. Department of Transportation and the Federal Aviation Administration has come out in a ruling, or a position paper in a court decision in Colorado, stating that

accreditation bodies are -- if we endorse that in rule fully that we are overstepping our bounds as a state because we are regulating some of the flight issues involved with flight crews and so forth.

So we added some language to help deflect that, so we're not requiring accreditation for things that involve flight only. Not the medical portion. And that's reflected in Part 6. It's legal jargon to make sure that we are not overstepping our bounds as a state. And that's the difficult issue, and we will be revisiting this the issue for, I'm sure, the next year or two, trying to hash out problems.

It's being dealt with on a national level on what the states are allowed to do and what they're not allowed to do as far as regulating through the accreditation process. So any questions on the highlighted portions in yellow? Jason.

JASON NICHOLS: Yes. As I am reading this -- and forgive me. I'm not as familiar with the air ambulance application. What do these changes do for the most recent air service that has come into town? Does it take away their ability to provide a service?

GUY DANSIE: They were granted a provisional license.

JASON NICHOLS: So does this language change

the license?

GUY DANSIE: No. They would be grandfathered in, because they already hold a license. So this is to prevent something similar from happening again. If they come into the state, that they meet the accreditation requirements prior to operation instead of granting a -- currently the rule, there is a barrier to entry issue.

We cannot as a state not allow fair competition for a new provider. However, if that provider is already operating elsewhere, then we can hold their feet to the fire in saying you must meet these accreditation requirements. Does that make sense?

JASON NICHOLS: Yes, that does. Thank you.

GUY DANSIE: And this was -- this was their -- we granted them the authority to help write the rules, so in all fairness to them, this is kind of their thing. And I realize that we need to bring it here for your buy-in and your support. But they feel very strongly about this, and I think Dr. Taillac is going to have some comments about it as well.

PETER TAILLAC: Yeah, I have been, along with Guy, painfully part of this process with the air ambulance committee, who is a truly dedicated group of folks who want to maintain the level of excellence we currently have in the state.

The air ambulance committee, just to clarify, is made up of participating members of all of the agencies who service our state who currently hold licenses. After a great deal of work, this is actually -- these small highlights represent, what, a year and a half of work?

GUY DANSIE: At least.

PETER TAILLAC: Trying to update our guidelines. I'm sorry, our rules so that they do not inhibit new providers from starting up but still requiring them to maintain the level of certification and accreditation that we've come to have. We've had to change the rules because of federal changes in their guidelines.

The Department of Transportation, the FAA have been an issue for years trying to figure out what the states can regulate and what the FAA regulates relative to rates, routes and that kind of thing. So bottom line is, this is an attempt to update our rules to meet the federal guidelines while still maintaining the accreditation standards that we've had for a long time. And I support all the changes that we've all talked about.

KRIS KEMP: Thank you. Any other questions? Comments?

MARK ADAMS: Yeah. I just wanted to clarify, an outside agency that's accredited outside the state, they can come in, and if they already have that accreditation, they will meet that requirement here? There's no requirement they have to operate for a certain period of time --

GUY DANSIE: Correct. If they are already accredited by -- we had to go through a vendor procurement process to evaluate the accreditation agencies, which there are two, primarily in the United States. And we have gone through, and we've accepted one at this point, and we're still evaluating the other.

If they -- but in the middle of this is when we found out some of the federal issues with us requiring accreditation. So we can only require the things that pertain to the medical care of the patient, such as staffing, treatment protocols, those kinds of things.

So this is an attempt to kill two birds with one stone. We're trying to maintain that high standard, and yet not overstep our bounds as a state with the federal government. Did that answer your question?

MARK ADAMS: Yes.

GUY DANSIE: Okay.

KRIS KEMP: Any other questions or comments

before we move to a motion?

(Silence.)

KRIS KEMP: Okay. No further discussion. Do we have a motion to approve? Now, is this just this one section we're talking about, or are we --

GUY DANSIE: That's fine, yeah.

KRIS KEMP: Because this is a lot -- action here. So we're looking for a motion to approve the air ambulance application R426-3-710.

HALLIE KELLER: I'll make that motion.

KRIS KEMP: We have a motion.

MICHAEL MOFFITT: Second.

KRIS KEMP: Second. All in favor say aye.

VOICES: Aye.

KRIS KEMP: Any opposed?

(Silence.)

KRIS KEMP: And any abstained?

(Silence.)

KRIS KEMP: Thank you. All right, Guy, keep going.

GUY DANSIE: Okay. As we move through the rule, you will see that there are other changes. Like I said, most of these changes were adopted and approved previously. There were terms that we've changed, such as the word "licensee" to "licensed provider" to be

consistent with other parts of the rule.
There is -- we scratched the last section of penalties. We're doing that with all of our sections of rule because we feel that it's redundant. It's just referencing back to the code. Any other discussion points? Okay.
KRIS KEMP: Okay. And if there's no other further discussion, a motion to approve the rest of --
MICHAEL MOFFITT: I make a motion to approve the rest of the rules.
KRIS KEMP: All right. We have a motion.
MARK ADAMS: Second.
KRIS KEMP: Second. And all in favor say aye.
VOICES: Aye.
KRIS KEMP: And any opposed?
(Silence.)
KRIS KEMP: Any abstain?
(Silence.)
KRIS KEMP: Thank you.
GUY DANSIE: Okay. One other piece of rule -- and I don't have a hard copy. Are the hard copies for the definitions here, Suzanne, or... We sent those out. There were a few additional definitions. We've held the definition rule back. It's been through this committee several times.

We've held it back because our attorney general felt that there needed to be definitions in the R426-5 that Paul discussed, part of that being a restrictive license. And I can't remember. What was the other term? Dennis, do you remember the terms that we added? Restricted license and provisional license, I think it was. In dealing with discipline cases, we added those definitions.
JASON NICHOLS: The PAPs.
GUY DANSIE: And what?
JASON NICHOLS: The PAPs, the primary affiliated providers.
GUY DANSIE: Yeah, and the primary affiliated provider. And that has to do with -- we used the term and felt it was needed to be defined for an individual that works for several different providers and might have a disciplinary action taken against them.
And they are required to notify and work with their primary affiliated provider. So we've add a few new definitions. Any further discussion? Mostly added for clarity in supporting these other pieces of rule that we are asking you to approve today.
KRIS KEMP: And these were sent out electronically.
GUY DANSIE: Yeah. I honestly didn't feel any

were controversial. I mean, if you do want to hold back or wait until the public comment fizzles out, that would be perfectly, you know --
KRIS KEMP: Questions about R426-1 general definitions in the rule? Do we have a motion to approve?
JASON NICHOLS: So moved.
KRIS KEMP: Second. Got a second?
MICHAEL MOFFITT: (Raised hand.)
KRIS KEMP: And all in favor -- oh, do you have a question?
MARK ADAMS: Question. So is a QRV and a QRU the same thing as a first responder?
GUY DANSIE: I'm actually glad you brought that up, because that was one of the definitions we did add to support our operational rule that's actually sitting on the table waiting for the definitions to be approved. And I apologize, but I forgot the QRV definition was added by Brittany. Basically a QRV refers to a vehicle.
She felt that when we say "ambulance," it wasn't clear. So we defined a quick response vehicle and defined an ambulance, like a ground ambulance. For most of the providers, we all know it's the big thing with a box, has the lights and sirens.

But in order to clarify it for the lay person, she wanted to add the definition so that it was clear that a response vehicle is different than a ground ambulance, and we added that definition.
It includes trucks. I think we put ATVs in there. They can transport a patient to rendezvous with an ambulance if necessary. We didn't -- obviously they aren't designed to take the patient to the hospital. And I think we added water craft in there for like boat rescues, water rescues.
So that's a good catch. I appreciate that. And I don't -- I think of the definitions, I don't think there's any significant ones there.
KRIS KEMP: So that was further clarification. But it doesn't change the motion that's currently open, correct? So we have a motion, a second to approve the general definitions. All in favor say aye.
VOICES: Aye.
KRIS KEMP: Any opposed?
(Silence.)
KRIS KEMP: And any abstained?
(Silence.)
KRIS KEMP: Thank you.
GUY DANSIE: Thank you.
KRIS KEMP: All right. We are to the pilot

program for mobile integrated health care for DRMC. And we'll have you introduce yourselves up at the podium.

RACHELLE RHODES: Hello. I'm Rachelle Rhodes. I'm the nurse manager of the emergency department at Dixie Regional Medical Center. And this is Jeremy Schultz, who is our pilot program manager for mobile integrated health. And I am going to turn the time over to him, and I'll pass out this PowerPoint presentation to each of you.

JEREMY SCHULTZ: All right. Well, thanks for letting us come and present this. And we're really excited about the progress we've made down in St. George. We'll kind of dive into, you know, what a mobile integrated health care is, kind of what we've identified in our community are. This is down in St. George. And kind of the progress we have made.

The reasons why we're here is, we're seeking support from the committee because we need some waivers on our licensure in order to provide the service. We don't want to be providing any 911 service. We just want to be able to have paramedics in the home that are there for non-911 non-transporting services.

We also want to work, collaborate with you, as we go throughout this problem to kind of develop a mobile integrated health care license for the state of

Utah. So that way other programs that want to, you know, launch in other areas across our state will kind of have the road paved for them to make this happen.

So the mobile integrated health care program really focuses around that triple aim. We want to improve the patient experience. We want to decrease those outcomes, and we want to overall improve the patient health of our area.

So what is mobile integrated health? As I said, it's going to be a paramedic based system. It will be non-911, non-transporting. We're going to focus on doing home assessments, falls, risks, things like that in the home. We also want to provide education to the patient specific to their disease process. This will be educated through physician liaisons that have been identified for each individual program that we'll end up developing.

Primarily, we're focusing on congestive heart failure at this point. We'll also have a referral card that we give to the patient so that they can call, you know, 24 hours a day, to get in touch with the provider, to help avoid those unnecessary transports, to keep those resources where they need to be.

And then we'll have specific clientele based on certain criteria that they have to meet. So you

know, they have to have congestive heart failure, obviously is one. They need to be Medicare, Medicaid, uninsured patient, and then also they need to be identified as being high risk for readmission.

Yeah, and they need to be discharged home so we're not going to be seeing patients who go to skilled nursing facilities, things like that. It'll be home or assisted living where they don't have that skilled care to render the service they need at the moment.

So nationally EMS agencies, they've been doing this across the country. I'm sure a lot of the providers here have heard kind of the wind of what mobile integrated health care is and the success that it's had. And we're hoping we can kind of demonstrate that same thing in the state of Utah.

So this is kind of a map showing where mobile integrated health care programs are currently operating. The big one that we are kind of piloting our program after is based out of Texas. MedStar, Mat Zavadsky allowed us to come down and be educated about what they're doing down there, and go out with some of their providers.

It's a really cool program. We were really excited about it. And this is kind of the reason why we want to start developing these programs. We look on

this graph, and we can see it's -- life expectancy as opposed to health care costs. And as the costs go up, we're hoping life expectancy should go up. But the USA is -- we're the No. 1 as far as what it costs, and our life expectancy isn't that high.

So we're trying to develop these programs to really, one, impact the per capita cost, to decrease that so we are kind of more in that cluster with the rest of the world. And also, hopefully to help improve the quality of life of those patients, increase their life expectancy and really effect some change.

So these are the programs that are currently being used across the country. They're really focussing on those CMS measures, the 30 day readmission penalties that hospitals are currently experiencing for heart failure, pneumonia, stroke, orthopedic surgeries, MI, things along those nature. But there's also programs that you can focus on like asthma, care transitions from hospital to home, preventive care. You can do employee immunizations.

There's a lot of module things you can do. So really it's community dependent. So each community needs to do, you know, a community needs assessment to identify the issues related to their community specifically. And then you can really target those

areas along with community members to make sure that there's collaboration with everybody.

So for our heart failure program, which is what we're hoping to pilot, we're going to identify high risk patients through some metrics that we've identified through the hospital. We have -- it's called BOOST. It's the program that our case managers use. And heart failure would be a positive BOOST score.

And then there is some other things like education, payor source, things like that, that also will boost them up as being more at high risk. So if they're identified with heart failure, and they are also identified with these other things, we can really tailor a care plan to identify and address those specific needs.

The first handout we're hoping to be done in the hospital prior to patient discharge. Where we are a hospital-based system, we will be able to collaborate closely with case management on this. And then we'll schedule that first intake assessment then, hopefully with within the first 24 to 48 hours post discharge.

So the goals of the visits will be, you know, to help them manage their heart failure. It'll be focussing on diet and nutrition. We can do -- we've been working on developing a diuresis protocol with our

heart failure specialist down there, Dr. Carrie Willis, and then we have point care testing so we can safely do those diuresis, the ITaP machine, then also EKGs, and then really following closely up with their primary care physician.

So this is the support that we've gotten so far. Dixie Regional Medical Center and Intermountain, the corporation, has kind of gotten behind us on this program. The community is excited about this program. They've been looking for some way to manage -- this patient population has kind of fallen through the gaps. So the primary care doctors are excited because we're hoping to increase access and help decrease the loads both in the hospitals and on the EMS system.

So this is just talking about MedStar's numbers and their heart failure readmission reduction program. And from 21 percent to 8.6 percent which is a cost savings about 26,000 per patient enrolled in the program. We're hoping that we can see a similar trend in that with our program. So this is our local community impact.

Each patient that currently is discharged with a diagnosis of congestive heart failure has an average cost of almost 24 -- or $28,000, and our current readmission rate is 17.1 percent. If we were to see a

similar decrease in that percentage, we'd drop down to 8.6. That would be a total Medicare charge avoidance of $1.2 million for just the CHF patients alone.

And that's a significant amount of money from our local community. So we're hoping to really use that as a -- to get this program up and going.

KRIS KEMP: Is that an annual avoidance?

JEREMY SCHULTZ: That's 2014, yeah. And we also want to decrease unnecessary utilization. We want to make sure that those 911 ambulances are available for the patients that really need them. Those of us that work 911, we've experienced those patients where you just go over and over and over again for the same chronic ailment, really just kind abusing that resource.

And we're hoping that we can, with education and utilizing those existing community resources, really teach that patient how to manage their health care. Then we also want to decrease the ED utilization. Dixie Regional Medical Center sees a lot of patients. Our acceptance has just been continually going up. So we're hoping that also will have impact on ED throughput to the hospital, make sure we're decreasing wait times and getting patients through a lot quicker.

So this is kind of showing our readmission rate down at Dixie Regional in comparison to the

national average. As you can see, we're still operating below as -- as these programs start developing, we're going to see a trending down in that national percentage.

So in order to stay below that readmission penalty, we really have to start innovating and creating new ways of utilizing both EMS and other community resources to really target those specific areas, because it's not too far down the pike that other people are going to be getting those penalties as well. So that's kind of an overall broad view of what the program is.

I'd be happy to answer any specific questions that you have. I believe you have a document that kind of overviews what the program is in a little bit more detail. So I open up to the committee for questions.

MICHAEL MOFFITT: Doesn't Intermountain Health already have a mobile home health service within their organization?

JEREMY SCHULTZ: Yeah, they do have a home health service. But this is a little different because the patients that we're targeting are the ones who don't qualify for home health. So these are patients who are not homebound. So they're ones that are still identified as high risk that need some additional resources or some additional help transitioning home but

do not meet that qualification.

MICHAEL MOFFITT: So the next question is, since they already provide some form of in-home health, what is it exactly you're asking us to give you a waiver for? We don't license MIH --

JEREMY SCHULTZ: Right. So what we're asking for is a waiver for, one, the geographic area to broaden our geographic area, and also to have the ability to provide a rescue-type service. It's not going to be a 911 rescue. But we need to have the ability to have our paramedics in the home, and our current license doesn't support that. There's no real license specific to mobile integrated health care through the state Utah.

MICHAEL MOFFITT: I have one more question. There is not a license, so how do we waiver a nonexisting license?

JEREMY SCHULTZ: Well, what we have to do is waiver an existing license.

MICHAEL MOFFITT: Which is?

JEREMY SCHULTZ: Well, currently we're licensed as an interfacility transport. But we, in talking with Tami, I was told to come up and present this as a pilot for two reasons. One, if we can waiver that license, or do we need to apply for like a paramedic rescue license and waiver that. And two, to

start discussion as far as developing mobile integrated health care license specific for the state of Utah.

MICHAEL MOFFITT: Well, the discussion, I believe, should probably take place before the request for waiver since we ought to have our subcommittees address mobile integrated health, its needs, whether it even should reside within the bureau of EMS, whether it's EMS or EMS or other health care, whether we're going to license it or waiver it or not.

There's also national debate whether paramedics are even the right method of delivery. A lot of things that can be done can be done by EMTs, CNAs, LPNs, and you're -- I think in one way the cart is before the horse because you're asking for a waiver for something that doesn't exist. And we need to have a conversation as a statewide body. Do we want it to exist? Do we want it to exist in this form, and how do we proceed?

Secondarily, your interfacility, on-campus transport license was specifically asked and granted under the conditions that that's all it would be. And now you're asking to take that and expand it outside the campus into other areas, which now is going to make people that supported the license a little bit nervous.

A lot nervous, because it was -- Intermountain

clearly said, "We're not interested in them going off our campus. We're going to do that, building to building and to the airport." And that was the sole scope of that license, and a lot of people in that community and throughout the state, their fears to rest by saying, "This is all we want ever." And now you want to expand it.

I'm not saying that MIH is not an unworthy goal to go for. But until we as a committee and a bureau and our subcommittees evaluate MIH and come back with something to say, "Yeah, we want to do this. Yeah, paramedics need to do it," we have doctors and physicians that need to weigh in. What should they do? How should it interact with EMS?

I'm very -- I'm very supportive of MIH. I think there's a role out there. But I'm very concerned about getting this train going down the track, and the track's not laid yet. We can run -- you're going to be interfacing with EMS. You're going to be interfacing with 911. Are you going out in a Prius, or are you going out in an ambulance?

There's a whole bunch of questions that I think are still out there that we as a larger body need to address in order to get to a point where we're ready for this.

RACHELLE RHODES: So okay. So that was great information. I really appreciate that. We were taking our first step at coming here in front of this body, so we would request then direction on what you would want us to do. And I know that -- with Dixie Regional, I know that there are interfacility ambulance. And in transporting patients, you are absolutely correct. This program has nothing to do with transportation of patients or doing any sort of 911 services for that patient.

MICHAEL MOFFITT: And the whole basis of MIH is just that. It's not transportation or anything else. But you're asking to waive a transport license which now starts to muddy the water. And what would you be going out and making house calls in? The ambulance?

RACHELLE RHODES: No. We're going to be using a retired fleet vehicle. Our ambulance would not be taken out at all.

MICHAEL MOFFITT: That's great. And what I'm saying is, this conversation needs to go to our subcommittees and to this committee to have all these questions answered. Do you need a waiver? Do you need a license? Do you need anything? Maybe it's just expanding paramedics scope or maybe it's developing some training criteria for people.

RACHELLE RHODES: Great questions.

MICHAEL MOFFITT: Be you also need to -- you know, I mean -- and don't take this the wrong way. Because I do support MIH, and I think there's an appropriate place for that. But we're discussing ten minutes ago a QRV versus a QRU, so we're really starting to get the rules into some very specific stuff, and we need to keep doing that with this.

And somebody had to bring it up. I'm glad you guys brought it up. But we just need to get this whole process rolling before we can tell you that you need a waiver or --

RACHELLE RHODES: Or a license or not. Do we even need anything at all? Can we just do this program without even getting anything?

MICHAEL MOFFITT: You know, maybe the next three months until our next meeting, maybe we just expand what paramedics can do under medical direction. So there's a lot of questions still out there to go, and you've obviously thought about this, been around and talked with people. You know what's going on.

You really have a microcosm down there of a community built around one hospital, somewhat self contained, to experiment with this in. Great. But still a lot of unanswered questions that I think,

nowadays, we got to get those answers before we go too much further.

KRIS KEMP: I have a quick question, and Peter, maybe you can help me answer this. We were presented something similar for Salt Lake where paramedics and social workers and a few other local agencies, I don't know if it was through United or whatever the service was here in Salt Lake. Can you expand on that and then perhaps maybe we elicit if there is much of a difference in what we're looking at here.

PETER TAILLAC: So Salt Lake Fire -- who's here? So I'll speak on their behalf. Their project was different, although they have an intention to begin potentially doing the same thing. Their project was to send out a paramedic to a low acuity call on effectively a frequent flyer, and then pass that through a nurse triage system before they decide that the patient has to be transported to the hospital versus a clinic, appointment to be made, etc., that sort of thing.

So kind of a nurse navigator model, but utilizing the current dispatch system. But integrating it into a dispatch system. So a little different than what you're doing. May I ask a question? If you were to do the same thing with a nurse instead of a paramedic, would you be here today?

RACHELLE RHODES: No.

KRIS KEMP: So I think those are a couple of key points that need to be brought up. I mean what you've described is, there's a problem in your community. Readmission costs a lot, and it's money that's going to be very difficult to account for in the very near future, if it's not already.

Your process is specifically about heart failure and trying to limit your readmission program, but you make mention of several others, including pneumonia, orthopedic surgery, MI, COP, CVA, asthma. The whole list is there. So this could potentially grow.

The pilot, as far as I understand, is that you're interested in taking a non-rescue vehicle, nontransport vehicle to a scene utilizing a paramedic. And the thought was, as a suggestion, that you bring it here to perhaps ask for a waiver to utilize these employed paramedics to go into a home and try to prevent these, with education and all your other tools, to try to prevent further readmission of these chronic conditions.

JEREMY SCHULTZ: Correct.

KRIS KEMP: And their acute decompensation. So ultimately I think that the point that Mr. Moffitt

has brought up specifically is, does this actually fall within the scope of what this committee is designed to do in offering a waiver?

Or is there something you can do based on your own medical control and perhaps just report to us the findings and perhaps at that point also give us some idea of direction to move forward, because this is potentially uncharted territory. So I think those are questions that have been brought up. Anything else?

GUY DANSIE: Yeah, just a clarification. I think Dr. Taillac actually clarified a little bit about what I was going to say about Salt Lake's program. Just one, they approached us for a pilot project, and in our operational rule, that's something they can do. And the committee is approved to accept that as a pilot project with the idea that they report back and we learn from that.

And that's why I had them present today. It wasn't for a waiver. I think the term waiver, license, got thrown out there. But it was to bring to the table so we knew what they were doing, and we would learn from that. And that was our intent as a department.

RACHELLE RHODES: Great. Thank you.

MIKE MATHIEU: I think license, Dr. Kemp, chair, the question in my mind is, is it a modification

of EMS regulation in terms of service provision, some form of licensure? Or is it a modification of the, you know, old adage of paramedic certification versus licensure that affects solo practice?

And so is it really truly an EMS provision of service which is regulated by the EMS committee, EMS Bureau performance standards related to EMS services? Or is it simply a question of allowing a paramedic to work in an environment that's not under EMS jurisdiction?

PETER TAILLAC: Which many places do. Private corporations have paramedics that work for them. It's not under our purview because they don't respond to the 911 system.

MIKE MATHIEU: Performing totally non-911 function.

PETER TAILLAC: I think it falls under that same sort of preview.

MIKE MATHIEU: That's the question. That's the Y in the road.

KRIS KEMP: So is this really something the EMS or state needs to regulate, or is this something someone can do under their own license just as if a paramedic is working in a hospital ER room?

MIKE MATHIEU: Yeah, but the problem for the

patient is, the paramedic is certified, not licensed.

PETER TAILLAC: That's a good point. Nothing -- I've read this. I think nothing they're asking their paramedics to do fall outside the Utah scope of practice. At this point they're doing basics. They're evaluating patients, calling medical control, using a drug that they're already approved to use.

So from the paramedic standpoint, it seems fine to me. In my opinion this is -- Guy, you know, you are more the rule guy than I am. But this is Dixie Regional hiring paramedics as a private company and sending them out to do a job that they train them to do, which is not EMS related. Because I don't really see them using your license for this.

MIKE MATHIEU: Doesn't correlate with their ambulance license at all.

RACHELLE RHODES: Great.

KRIS KEMP: Other comments? And this was brought up as an action item, which suggests some form of action by us as EMS committee members.

GUY DANSIE: And that was upon my request because they were doing something different, and I thought this might be beneficial to have it as a pilot project.

JEREMY SCHULTZ: Yeah, I think that's why we

were asked to come up, is to get approval from the committee for a pilot. And we'd love to report back and --

GUY DANSIE: So we can share best practices in the future. That was our intent as a department.

MICHAEL MOFFITT: I'll make a motion. I'd like to make a motion that we as a committee task operations subcommittee to examine this and bring this back their findings. No roads trips to Texas, guys. Just examine it and let us know at the next meeting where they feel this lies.

MIKE MATHIEU: I think one of the questions is certification versus license.

MICHAEL MOFFITT: That's a good question, and the other part of my motion would be to task Dr. Taillac with kind of where you see them crossing into the EMS paramedic line, and if they're just working for a hospital or another organization under medical direction, is it something we need to be concerned about.

PETER TAILLAC: My take, and I am not a lawyer. I don't pretend to be one. But my take is, because Intermountain can hire whoever they want to do the jobs that they want them to do, and this doesn't fall out of the individual paramedic scope of practice

in our state for this project, with heart failure, I think as far as I can determine, it doesn't really affect the EMS committee. I don't think we have input with the bureau.

I do totally agree with you, Mike, that we need to develop better rules, because it could be your agency or your agency wanting to do something similar things next time, and we do regulate you. We don't regulate Dixie Regional. So it's a great conversation. Operations, it's a good place to start.

MICHAEL MOFFITT: So that's my motion, is that we kick it over. I know you guys made a long trip up, and you made a good presentation, and you had to go to a lot of effort to do that. We appreciate that. You got a conversation started. All I can say is, based on what I've heard is thank you. And you can kind of under of scope of the hospital.

JEREMY SCHULTZ: Okay.

RACHELLE RHODES: Perfect. Thank you.

MICHAEL MOFFITT: Hopefully my motion will go forward and we can actually have the discussion on this later.

KRIS KEMP: Any further discussion? We have a motion. Do we have a second?

MIKE MATHIEU: I'll second.

KRIS KEMP: We have a second. All in favor say aye.
VOICES: Aye.
KRIS KEMP: Any opposed?
(Silence.)
KRIS KEMP: Any abstained?
(Silence.)
KRIS KEMP: All right. Thank you.
RACHELLE RHODES: We would be happy to be a part of your discussions in the future or give us -- us to give you follow-up. Thank you.
KRIS KEMP: All right. Next on the agenda is Dennis Bang and Paul Patrick speaking about the reciprocity approval for paramedic certification.
DENNIS BANG: I'm speaking for Paul here kind of. He had to actually go to another meeting so he asked me to come up. I'd just like to introduce Jamie Rossborough. He is --
COURT REPORTER: Could you come up to the microphone. It's hard to hear you.
DENNIS BANG: Usually I talk too loud. Anyway Jeremy -- Jamie Rossborough, his information is in your packet. He would like you to review that. He put it in there earlier. He is a paramedic. He's a nationally registered paramedic.

He has some issues that he would like to discuss with you to see if you would override it. As I was talking to Paul, Paul told me to apologize that he wasn't here, but that he would go for the approval of this if he were here talking to you. I will now turn the time over to Jamie so he can explain to you the situation that he has, and you can make the decision on what he has.
KRIS KEMP: All right. Go ahead, Jamie.
JAMIE ROSSBOROUGH: Thank you guys, giving me an opportunity to speak here on this behalf. So I have been trying to be certified here in the state of Utah for quite some time now. Running into some difficulty based on some legislative statute that you guys have to be licensed as a paramedic here. I do practice currently in Denver and Oklahoma, and I have been practicing as a medic for 19 years.
And since I've been trying to get back here, you have some concern or issues that I've seen, I noticed in that legislation, that is stating that I have to take a paramedic national registry exam even though I'm already certified at that exam. So I'm trying to understand, by taking this exam that I already currently hold, what is it going to prove being able to get licensed in here so I can practice.

I moved here strictly just to care for my parents that are dying. That's it. Otherwise, I would be in Denver or Oklahoma working where I had built up credentials and experience and reputation and lost -- or gave up job opportunities and advancements to be out here. And I'd like to stay. I do not want to put them in a home. I don't want to leave them without some type of availability resource from family.
But it's hard for me to get a job because people look at my credentials and experience, and I'm too overqualified. And I constantly get these applications that say, "Thank you for applying, but you are overqualified."
So I come to you guys today asking your advice or your recommendations on -- to get a waiver saying that -- because in the rules it states, if I can demonstrate that my experiences and qualifications are equal to or greater than that of Utah, that I should be granted a license under that 426-5-800. And then in a subsection there it states in 2-E, "Must take the paramedic -- or the examination or written examination if necessary," which now you guys hold a national registry standard.
So I'm asking for some type of waiver saying that I shouldn't have to or I don't have to take that

test again, that I already hold competency on. It's like a motor skills test. So I can get certification and stay here and practice in the state of Utah.
KRIS KEMP: Questions from the committee?
JASON NICHOLS: How long have you been trying to get certified?
JAMIE ROSSBOROUGH: Since 2006.
JASON NICHOLS: And the -- again, what's holding you back is the national registry test? And so since 2006, so nine years, and what's been holding you back is the national registry test, just not having taken it?
JAMIE ROSSBOROUGH: No, I'm already national registered. I've been national register for about 12 years now. It's your state saying I have to take the CBT test to meet the standards to get certified here even though I already hold that test.
JASON NICHOLS: So you're talking about the computer adaptive test.
JAMIE ROSSBOROUGH: That's correct. And I've already had the new requirements and national standards of curriculum of their new transitional period of the national registry.
DENNIS BANG: The thing was, is we switched over -- national registry in 2007 switched over to

computer in 2007.

COURT REPORTER: Do you want this on the record, sir? You're going to need a mic.

DENNIS BANG: In 2007, we quit doing a test. National registry switched over to the computer adaptive test. At that time we said that to be able to come in -- their old test had been compromised. We said that anyone that came into the state needed to pass the computer adaptive test.

And that was -- that's where the problem has come in, is there, so... That was the reason. That's what he is waiting for. He passed, is certified as a paramedic in I think Colorado and Oklahoma both. He has current certifications there. But our rule states that, and that's where the hang-up is.

JASON NICHOLS: So the question that I have is, why don't you just go take the computer adaptive test and be done with it? I mean we are talking about nine years here. To me it seems like more making a point about my state, to use, loosely, your words earlier, having an issue.

JAMIE ROSSBOROUGH: I just -- I'm trying to figure out why. I have already proven myself. What more is the test going to prove that I don't already know?

JASON NICHOLS: Well, I guess I don't know. I don't know what else it would prove other than, speaking as the paramedic representative on this, on this committee, I want every paramedic that gets certified in the state of Utah to meet the same criteria. And that's what we require.

The two paramedics that I know that are on this committee, myself and Chief Matthew, we would be in the exact same boat as you would be, and we, even being on the EMS committee, would have to go and take the computer adaptive test, so...

JAMIE ROSSBOROUGH: But you're already a paramedic here.

JASON NICHOLS: You're right. I am. But if I wasn't, then -- my point being is, it's been nine years. Just go take the test. If you have all this -- these credentials and all of this ability, go take the test. It's nine years. Go take the test. That's all I have to say.

KRIS KEMP: Further comments? All right. Do we have a motion on the application for waiver and certification and also for the taking of the test or not to take the test from the committee?

MIKE MATHIEU: I'll make the motion with the qualification why, is that it's not just about this

particular individual. It's about setting a standard for any individual and trying to come up with some criteria of -- and I'll be honest with you. I evaluated the paperwork. A lot of great paperwork.

But on the other hand, I can criticize some paperwork. Two letters of recommendations that have no dates or signatures. I question the validity. They are from Oklahoma which you left back in 2009. You've got two more recent ones, one of which is signed and dated. The other one is dated but unsigned.

So we're trying to put up a bunch of information on paper against why that should be justification to not require what we require. And before I get into the -- it's not about the individual characteristics. It's about whether it makes sense to even entertain this. Why would we even entertain it? And I agree with Jason.

I have been trying to do this for nine years. It takes a couple hours to take a test. And I believe he's got the competency. A lot of people believe they have the competency, but they take a test to show they have the competency.

Everyone single EMT in the state, every single paramedic is required to successfully pass something before they become certified. Why would we change that

requirement? So my motion would be to deny the request for waiver.

KRIS KEMP: We have a motion. Do we have a second?

HALLIE KELLER: Second.

KRIS KEMP: And all in favor of the motion to deny the request say aye.

VOICES: Aye.

KRIS KEMP: Any opposed?

CASEY JACKSON: (Raised hand.)

KRIS KEMP: We have one opposed. Any abstain? And I'll abstain. All right. I believe the motion carries.

JAMIE ROSSBOROUGH: Thank you.

KRIS KEMP: All right. Rescind the policy for EMS rules task force membership. Guy, good to see you again.

GUY DANSIE: Thank you. It's good to be here. I'm going to throw Paul under the bus a little bit on this one. So he's gone now. It's okay to do that.

As we have met with the EMS task force, Paul's vision of this has been to have it parallel our peer review board in composition and so forth. And he's directed them to set up rule describing their membership. In our recent meeting, I think it was the

meeting before last, we voted on new policy for subcommittees that Jason and I worked on and --

JASON NICHOLS: Jeri too.

GUY DANSIE: And Jeri. I can't forget Jeri. Anyway, but the feeling was is they wanted to put their membership policy, if you will, into rule and approach it that way, rather than have it as a policy under the committee. So I just brought that as a -- we just wanted to clarify, make sure that you were okay with that decision to put it into rule instead of policy for that.

KRIS KEMP: So what is the action you are asking for?

GUY DANSIE: So because we did vote it, approve it, just to vote on it to rescind that part of the policy for the -- maintain the policy for the subcommittees, the operations and professional development that we've worked on, but move that the EMS rules task force membership policy be developed by the department in conjunction with the task force and put -- and then we will bring the rule to you.

It's just a formality, since we voted on it before. I would like to move that we exclude them in the motion that we passed earlier.

KRIS KEMP: Okay. Any questions? Do we have

a motion to rescind the policy for EMS rules task force membership?

JAY DEE DOWNS: So moved.

KRIS KEMP: We have a motion. Second?

MICHAEL MOFFITT: Second.

KRIS KEMP: And all in favor sigh aye.

VOICES: Aye.

KRIS KEMP: And opposed?

VOICES: Aye.

KRIS KEMP: Two opposed. And any abstained? All right. Motion carries. Thank you. Subcommittee reports and action items. Grant subcommittee. Allan, Ron.

RON MORRIS: Thank you, Mr. Chair.

COURT REPORTER: Excuse me. Could you please tell me your name.

RON MORRIS: Ron Morris, grants committee chair. This poor lady trying to keep up with who's talking. It's a tough deal. She's doing very well.

Grants committee report. We met in June, and as you know, we talked in years past. The allocation for the grants is continually gone down. This year the grant allocation was $875,000 -- or 675. Sorry. And that is down from to my recollection a high of nearly $2.2 million.

At this point at 675, the grants committee took into consideration the time, the effort, the process of doing the competitive grant process as opposed to awarding the money on the per capita process. We did about three years ago, I believe, we awarded them on strictly per capita. If we would go with competitive, there would be a few winners in the state and there would be a bunch of losers.

So the grant committee has decided this year to recommend to the EMS committee that we simply take the 675,000 and put it all in the per capita grant fund and have it allocated as per the rules that are existing today. Realizing in the future that this is going to be an issue, we would like to look at, in our meeting in September, a different way of doing the per capita money and make it a little fairer.

There we spent considerable amount of time at the committee meeting trying to come up with a better, more fair way of doing it for everybody involved, and simply did not come up with anything that was suitable. We tried to do it by county. If you do it by -- for example, if we did it by county as a second class, you take Weber County, the small city of Uintah would get practically nothing because they reside in a large county.

We tried to cut back on the counties, the first second or even third class. So I think we're going to need to come up with something by population, by population served or something of a combination of the others. I've talked with Paul Patrick. He doesn't really see the grant amount increasing dramatically over the next several years.

So we even talked with the committee. If we don't get somewhere over the one million mark for grants, that competitive grants is probably not a viable option any longer for the grants committee. So in short, the recommendation this year from the grants committee would be to take the 675,000, put it into a per capita grant and send it out as that. I would be happy to answer any questions.

KRIS KEMP: Questions from the committee?

CASEY JACKSON: As far as allocating -- I actually being a citizen, I actually have some dealings with this. Mainly with two things with schools and how we allocate very different based on rural, and I've worked with a lot of pill payments and know, especially in the rural counties, the volatility and uncertainty that they have. You guys look at this.

The only thing I would say from talking with many commissioners I've talked to over several years is,

a lot of the times they feel that tourism isn't necessarily really looked into. And I am someone who goes out there a lot and everything. And I will be honest. I bring six -- on a short hike, about three miles, but I bring six or seven drinks of water. Because I usually give three out. Because the tourists don't know.

And I know it's a little grand standing, but when we look at that, I really want to make sure that you guys look at the tourism and people coming in. Because you go to Garfield, there's no population that lives there. But they are almost all tourists. A lot of the times, they're going to be stuck.

I was there in a terrible rain storm the other day, and I saw the storm coming. And I told the people on the trails, "We need to get out," there in Bryce Canyon, and they didn't listen. And that's a severe cost, and I know to them. And I really want to make sure that you guys in the grant process make sure you look at that.

RON MORRIS: I will be recognizing you when you introduce legislation for a tourist package to go to EMS. That would be awesome.

KRIS KEMP: Other comments from the committee? Any from the community?

RON MORRIS: Allan needs to talk about a rule change and, yeah, we need to vote first, Mr. Chair. Sorry I interrupted you.

KRIS KEMP: All right. So we have the proposition for -- and in the rule we can have, what is it? We have a minimum requirement for per capita. But you don't have a minimum on competitive. So we can put it all in per capita.

RON MORRIS: Yes, in rule we can put it all in per capita. We could not go the other way, but we can go this way.

KRIS KEMP: And what did we do last year? We had a mix, didn't we?

RON MORRIS: Last year we had a 50-50 like we've historically done, fifty in competitive and fifty in per capita. And there's no secret. The competitive has always been weighted heavily towards rural Utah. So it's probably going to harm rural Utah a little bit this year.

But it kind of makes up for last year when urban got hit with the 50 percent cut in the per capita grant in the last minute, so... The committee kind of saw it as even Steven, and we'll start fresh now.

KRIS KEMP: Okay. Do we have a motion to approve the recommendations by the grant subcommittee?

JAY DEE DOWNS: So moved.

KRIS KEMP: We have a motion. Second?

MICHAEL MOFFITT: Second.

KRIS KEMP: All right. And all in favor say aye.

VOICES: Aye.

KRIS KEMP: Any opposed?

(Silence.)

KRIS KEMP: And any abstain?

(Silence.)

KRIS KEMP: Great. Thank you. Allan.

ALLAN LIU: I'm Allan Liu with certification. I have the housekeeping items for 426-6-3. Just changing dates on the grant awards effective dates. The dates have July 1 to June 30th, and that's just the fiscal year that the state has. And the realistic thing is, we won't get grants until end of July, early August. And I'd like to change this to reflect that July 31st.

And we have in our grants guidelines to have receipts and proof of payment by May 15th, and we'd like to extend that on to the rule so that everything's consistent. So I hope this will work. If you have questions on this rule change.

KRIS KEMP: Questions specifically about this rule change and modifying the dates? And I'm assuming

it's to fit what really should happen, as opposed to just having some hard and fast physical dates.

ALLAN LIU: Yes.

KRIS KEMP: Yes, sir. Do we have a motion to approve that rule change?

JERI JOHNSON: I'll make a motion.

KRIS KEMP: Jeri makes the motion. Second?

JASON NICHOLS: Jason.

KRIS KEMP: Jason, thank you. All in favor say aye.

VOICES: Aye.

KRIS KEMP: Any opposed?

(Silence.)

KRIS KEMP: And any abstained?

(Silence.)

KRIS KEMP: Thank you, Allan.

ALLAN LIU: While I'm up here, I would like to skip over to information items on EMS subcommittee membership reduction. I'd just like for the EMS committee and the subcommittees just to look at who we have currently on membership and just how hard it is for us to have an EMS physician on the grant subcommittee.

We're really worried about having a quorum. And something for you guys to think about and discuss for next EMS committee on subcommittee membership for

the grant subcommittee.

KRIS KEMP: So who are you looking for? How many members are you looking to fill?

ALLAN LIU: Nine or ten. Right now we have 16. And the list on the packet I have has nine or ten we'd like to have. We have reached out to some folks, and they have never replied back and things, so...

KRIS KEMP: So up to 16 vacancies, but you'd like to have nine or ten.

ALLAN LIU: Membership is 16, and we have six vacancies.

KRIS KEMP: Oh, so six vacancies.

ALLAN LIU: Or no shows for our last meeting in June. I've contacted them, e-mails, but we didn't hear anything.

KRIS KEMP: So does that mean they are off the subcommittee?

ALLAN LIU: Well, I'd still like them on to fill the 16, but if I can't get a quorum, it's really hard for the grant subcommittee to get anything done.

KRIS KEMP: So you have 16 members.

ALLAN LIU: Uh-huh.

KRIS KEMP: With names for each of those 16 positions?

ALLAN LIU: Actually 12 members currently, 12

names.

KRIS KEMP: Oh, okay. Before we go filling more than what you're required to have or what you would like to have, you need to make sure those people have resigned their role, and it's not just by a no show that they're no longer part of the committee.

So I would make a solid effort even further still to try to shore that up and maybe give them a timeline, is what my recommendation would be, before we go and fill that. But as far as this being an informations item, I think this is useful for our community members to hear that we need more people on this subcommittee and upwards of between four and six members are needed.

JASON NICHOLS: Mr. Chair --

KRIS KEMP: Jason.

JASON NICHOLS: We discussed this just shortly before the meeting. And oh, I'd like to task the bureau with getting together with Jeri and I again to go through this and look at specifically the grants committee for populating their roster and determining whether or not we need to make any adjustments there.

I think that we could come back for the next committee meeting with a good solid plan to move forward with grants. We knew when we made the changes that

grants was going to be the most problematic committee, and of course, it's come to fruition. So that's -- I'd just like to task that to the bureau.

KRIS KEMP: All right. Anything else for Allan? Thank you for helping us stay out of order.

ALLAN LIU: Thank you.

KRIS KEMP: All right. Jeri, do you want to give the report on the subcommittee application approval?

JERI JOHNSON: Yeah. We've received just one application that we'd like to recommend. Stuart Willoughby to the grants committee. He's from Kane County. And that's spelled S-T-U-A-R-T. And that's all I have is just to recommend him to the grants committee.

KRIS KEMP: Okay.

JERI JOHNSON: So make a motion.

KRIS KEMP: We need, I guess, a motion to approve that member.

JAY DEE DOWNS: So moved.

MARK ADAMS: Second.

KRIS KEMP: We have a second. All in favor say aye.

VOICES: Aye.

KRIS KEMP: Any opposed?

(Silence.)

KRIS KEMP: Any abstained?

(Silence.)

KRIS KEMP: Great. Thank you Jeri. Please look down -- I think we set a precedence for how fast we are going to go through these other items, right? All right. Is Von Johnson here for professional development updates?

JIM HANSEN: No, he's not. He asked to be excused.

KRIS KEMP: Okay. Are you going to present then?

JIM HANSEN: Yes. I'm Jim Hansen from the Bureau of EMS. So Von just couldn't make it down for this. But basically we had quite a short meeting. Chris Stratford did contact -- part of our mandate was to find out who is and is not going to be on our committee, and so he contacted most everybody on the committee.

And we had a Shawn Lund who stated that no, he would not be able to serve on the committee. We had Jack Meersman was supposed to be but now apparently is moved over to the operations committee. And then a Dr. Mark Oraskovish.

KRIS KEMP: Oraskovich.

JIM HANSEN: Oraskovich. There we go. He did write a very nice letter stating that he would love to be able to serve, but he isn't able to. And so we do have at least three positions opened on our committee. And so that's where we are at with that. The other thing that we was tasked by the rules committee initially to look into the epinephrine, public use epinephrine, that this committee already passed that rule.

And so we did put together a little task force to look into that, but it's been handled anyway. So that's where we're at with that. And other than that, we talked a little bit about the transition to national registry. And otherwise, we're -- that's our report for now. Looking for other things to do.

KRIS KEMP: All right. Thank you. Operations subcommittee. Eric.

ERIC BAUMAN: Hi. I'm Eric Bauman. I'm chair of the operations subcommittee. The operations subcommittee has been working very closely with Mindy Colling from the Department of Health. And we are putting together a state-wide catch-up earthquake EMS plan, focussing particularly on EFS 8 with the triage, transport and movement of patients.

And we've got six meetings planned, three of

which we've already had. And it's going very well. Our plan is to be able to have that finished and present it in February of 2016. Other items, we're currently looking at body cameras and box cameras for ambulances. Andy Smith, our vice chair is looking into that. We should be able to report to you in the October meeting on that.

Ambulance specs, we are continuing to look at the triple K and the departure from triple K, seeing what states are doing nationally. There's not a lot of information right now, but we'll have a full report on that in the next meeting as well.

And then integrated care is something that we are starting our preliminary research on. We're going to extend invitations to the agencies in the state that are doing integrated care and have them come and share their programs with us.

In terms of future tasks, today we had two. Did the mic just go off?

(Discussion off the record.)

ERIC BAUMAN: Okay. So two future tasks that we talked about today and same involved Jennifer in that next meeting. We're going to develop a template for guidance on cost quality and access for the licensure process and also look at -- we had to have her put the

integrated care for Mobile Integrated Health on the agenda.

So those will be two items that we will be looking at. So are there any questions for operations? Okay. Thank you.

KRIS KEMP: All right. Thank you. So to the subcommittee and bureau assignments, looks like we've made a couple already. You just mentioned the two that I had made note of for the operations subcommittee.

As far as the grant subcommittee, it looks like you have already self-tasked the idea of potentially a way to review and make more fair the dollar amounts for grants, if it's something other than the per capita versus competitive. I think there are some interesting ways that you could review that.

Other subcommittee assignments from the committee? Anything for professional development? I may have one for professional development, specifically in regards to the IA designation. And I believe this would be under professional development. Especially with the national registry and what we've gone to through the state with EMT, advanced EMT and paramedic levels with IA being somewhat grandfathered in two counties.

It's been brought up that there might be an

option to potentially do away with the actual certification or the licensure, I guess it would be, for IA in at least one, maybe both of those counties if everything works out.

And what we're talking about specifically doing -- and these are again just ideas to try to work through the different rules -- would be to reduce those two counties or one county agency.

Specifically I can speak on behalf of Wasatch County as something that we are considering -- and reduce to an advanced EMT level, but then ask for variances to operate those individuals that are qualified as intermediate, advanced to utilize the skills as intermediate, advanced.

And that is something we are working on, considering we haven't approached others on the committee about. But perhaps something that professional development subcommittee can review is how that would work out in detail so that one or both of the counties that are interested in it may have that as an easier transition, because it seems like both -- at least from Wasatch County -- perhaps also from the other county that's in this same scenario, we have looked at potentially going to paramedic leveling.

There's a lot of barriers in that regard, and

the reality is sometimes it's just going to be difficult to maintain that IA certification with the environment that it is. But if we have some support and the professional development subcommittee has an opportunity to review that support and the structure, then it might be something that is palatable by our members of those two agencies.

So that's one task that I would put back on professional development subcommittee. Do you have anything to add to that specifically?

(Silence.)

KRIS KEMP: All right. So that would be something I would add to assign for the professional development subcommittee. Anything else for bureau assignments, subcommittee assignments? Great. We will move into the informational items.

COURT REPORTER: Excuse me. Could we take a five minute break?

KRIS KEMP: Yes. We can have five minute break.

(Recess from 2:59 p.m. to 3:04 p.m.)

KRIS KEMP: All right. So we will reconvene now with our informational items. We're going to present the year in review for our rural ground transport project. And recognize it was to come up with

a solution for in the rural setting how we can bridge some of the skills gap between what local EMS has and nursing skills.

And there are several, including IV medications, drips, blood, ventilator support and a few other conditions.

And some areas there was more need than others based on the local EMS skill level and licensure level, and this is basically just an informational because we said we would report on how the first year's worth of data has been. And so I asked Angie Adams to come from Life Flight and to discuss this project.

ANGIE ADAMS: Let me start my presentation backwards. So let me start it by highlighting a patient transport that was done by Millard County EMS, Delta and also Delta Community Hospital. This was a 40-year-old male patient who essentially was diagnosed with a STEMI. And what Intermountain has done for the most part on all STEMI'S, because we all know that there's a short balloon time of less than 90 minutes.

Unfortunately, this is one of those cases where weather was a factor and we couldn't fly the patient, and it was going to take too long for us to go flight by Utah Valley designation route.

Long story short, the patient ended up being

transported and was met by EMS folks and our transport nurse from Delta in the emergency department, taken straight to the cath lab. And if -- you can kind of see a little bit of the outcomes that they have on there. The picture is him in the middle. With the EMS providers and the nurse.

And he -- I actually spoke with him a week ago, and he's doing fantastic. So this is one of the reasons why we came up with this program, is to try and bridge some of those areas when either the flight team can't get there or the patient was on some sort of treatment that was not available to be continued on by the local EMS. I think this patient was actually on TNK.

So challenges of our transport, as many of us know, we have training, medical guidelines, safety documentation, knowledge of equipment, process improvement, standard equipment and meds, and staff.

Staffing is a big thing, and I can certainly appreciate what some of the rural folks are going through just learning throughout the last year how difficult it's been to even get some of our nurses to go on a transport.

So the hospitals in our EMS partners, just to highlight them again, we have Cassia Regional Medical

Center in Burley, Idaho, for those of you who don't know where that is, in conjunction with Life Run Ambulance. We have Logan Regional Hospital, Logan Fire and EMS that came up April 1st. Bear River Valley Hospital and Tremonton Fire and EMS. Park City Medical Center, Park City Fire and EMS, Heber Valley Medical Center, Wasatch County EMS, San Pete Valley Hospital with North San Pete, Manti and Ephraim Ambulance.

We have Sevier Valley Medical Center with Sevier County EMS, Fillmore Community Medical with Fillmore County Ambulance out of Fillmore. Delta Community Medical, again, with Delta County Ambulance out of Delta, and Garfield Memorial Hospital with Garfield County EMS came up with April 1st as well.

I don't know if you can see this. I like this comic strip because it really just says, "Which unnecessary procedure would you be referring to?" And there is a patient in our hospital bed and everybody trying to siphon out money from them.

So what did we do? We added to the process that was currently happening a year ago. Whereas, nurses are asking to go on a transport with a patient. This allowed for development of the training plan which included communication, medical guidelines.

Again, we added equipment and medication and

provided some sort of safety training for them as far as vehicle orientation, ambulance training, so that when they did go on interfacility transport that wasn't the first time they were in the back of an ambulance.

We also added some documentation piece and process improvement. We host quarterly transport review meetings with their medical director. On occasion we have two or three medical directors with us trying to drive the kind of care that the nurses are giving our patients.

So team configuration, this was kind of one of those -- like well, when would a patient need to go by a nurse or with a nurse. That again, is driven by the referring providers or the sending doc. And this was just a guideline on which patient should be transported with the nurse. I am going to skip that so you guys can kind of get out of here.

So over the last year, this is just a slide that shows you a percentage of transport per diagnosis. So I'm going to -- that patient age, so 84 percent of our transports are adult, 12 percent are OB and 4 percent are pediatrics.

With a little bit more of a breakdown in that is 27 percent have been cardiac, 28 percent medical. 11 percent are neuro. 10 percent surprisingly is trauma.

I did add sepsis which would be 3 percent, respiratory 6 percent. Even though it says zero percent on there, we did have one psych patient and the rest pediatric.

So what are some of the lessons that we've learned? I know I've learned a great amount of making sure that communication, communicating with everybody, all the people that are involved in this process is very key.

Staffing is still a big issue. You know, we do anywhere from 35 to 40 transports a month between 10 facilities. How do I staff that? How do we make sure that we have a nurse that's available? Billing was a big thing, at least from my perspective, and from what I -- I've not heard anything different from my EMS partners as far as whether or not they're having a hard time getting their bills submitted and also whether or not they're getting revenues from that.

Documentation, again, some of the training needs that the nurses are needing, and just making sure we are doing the right thing by the patient. Skip the videos for time sake. Any questions?

DAN CAMP: I have one question. Are you guys doing reviews with EMS agencies?

ANGIE ADAMS: Yes, we invite them on occasion. And I include them on all the quarterly reviews. We ask

them to come and participate with us.

GUY DANSIE: And for the record, what was your name?

DAN CAMP: Dan Camp. D-A-N, C-A-M-P.

KRIS KEMP: I think that -- and I appreciate Angie coming and putting this together for us. There's a couple of things that I would like to illustrate. First of all, most of these cases, barring the weather events, are cases that potentially should have flown, if it wasn't this program. And we know the cost associated that goes back to the patient or the insurers, the health care dollars for flying a patient. It's very significant.

Instead we're taking that high level of monetary value, and we're handing back the skills value. And if anything, capturing those -- that revenue and giving it back to the local EMS, because that would have been a patient that would have otherwise bypassed local EMS and been given to the air service lines.

And we recognize this as the Intermountain -- as potentially something that could harm our Life Flight brand or even Air Med if there was a flight team that needed to go in one location and one helicopter was closer than the other.

We recognize that as a possibility, but we are

willing to accept that based on a few principles. One was that we were going to maintain high levels of quality, which in our quality reviews have been -- we've seen an amazing amount of success, some very positive outcomes and very few cliff hangers, where we take it back to them and we do this.

Again quarterly, at each of the 10 facilities, we are going back to each one saying, "Okay. Here's the cases you have done in the last quarter. Here's what we need to review. Here's some points that need to improve."

Sometimes it's just, hey, did you think about the next 10 steps down the road? In this case, that never even got to that point. Other times there are some care issues. We say hey, we need to go back and address this. So we learn from that, just like we do in other forms of medicine.

But we recognize that high level of quality was going to be something we were going to hand back to the communities and also making their process more efficient. So quality, safety, efficiency, all those points that she brought out were important, and I think at the end of the day, there is some health care dollars that are saved. And of those saved dollars, those that are still brought in are given back to the local EMS at

a higher rate.

They're in the process of writing this up so that we can present it nationally. We're going to try to put it out, a general "how to" publication into a few different medical journals and a couple of different forums. We've asked to potentially present it at the next air medical transport conference that's held annually.

We are not quite certain we're going to have it completely ready for that point. But we are in the process of writing this up where there will be more details including cost savings and efficiency and outcomes data, more than what we were able to put together for this presentation.

We told you we would give you this information a year after we went live, which wasn't it about in June.

ANGIE ADAMS: July 1st.

KRIS KEMP: So it's been a year. And even though there's just been two new ones that came on in April, it's been very positive. The concerns about Intermountain coming in and buying up ambulances seems to have calmed down. People have realized we really were just trying to do the right thing in helping the situations out. And I think there is some very positive

examples that could be found here even locally in the community.

There's still a couple of things that occasionally happen like when we're sending a ground team up because there's a patient very critical to a location, and they're also trying to meet in route with the local ground, sometimes that hasn't quite worked out well.

And we had an incident in Logan where Ogden Fire showed up because they were bringing the ground flight team, and the patient got too critical for the ground rural team to head out of the hospital. So Ogden fire looked like they showed up for a transport, and that kind of ruffled the feathers with Logan.

But ultimately it's just a communication thing, saying we thought we were going to get on the road with the rural ground nurse, and the patient crashed, and a storm was there. So we just kept that same process. You know, that may occasionally happen with Gold Cross and a couple of these communities as well. Peter.

PETER TAILLAC: I'll speak loud. Any non-Intermountain hospitals participating?

ANGIE ADAMS: No, sir.

PETER TAILLAC: Is that an option?

KRIS KEMP: It is. We've taken it to Kanab.

ANGIE ADAMS: To Kanab, yes.

KRIS KEMP: We took it to Kanab. They asked us to come and present. We gave them the options of what they felt would be the best package. And shortly thereafter they got a flight service to plant a helicopter right there. So it kind of negated the need for that process in that facility.

But it is open to others. We just -- you know, this is not ever intended to be just Intermountain and Intermountain facilities only. In fact, we do transport from an originating hospital that is Intermountain to a non-Intermountain hospital. So we go to Timp Regional. We go down to St. Mark's. We've gone to Ogden Regional, University.

So the destination hospitals are varied. But we just are waiting to finalize a few of those other details. And if anyone wants to know more about it, we're more than happy to present it. All right. Thank you, Angie.

ANGIE ADAMS: Thank you.

KRIS KEMP: Results from the trauma system outcomes report. Matthew.

MATTHEW CHRISTENSEN: Matthew Christensen with the Bureau of Emergency Medical Service and

Preparedness. How are we doing on time?

KRIS KEMP: We're doing all right.

MATTHEW CHRISTENSEN: Okay. I'll go through this quickly. This is --

KRIS KEMP: We've got hours, hours to go.

MATTHEW CHRISTENSEN: Well, this is only a 30 minute presentation, but I know we are already past our three o'clock time. So I'll go through quickly.

SHARI HUNSAKER: You might go faster if you're not connected to the computer.

MATTHEW CHRISTENSEN: The specifics I'm going to share with you come from our trauma report. It's been recently available on our website. So all of this information you can download. There's a lot more explanation, analysis than I am going to be able to cover with you right now. But I'm going to give you the highlights from this report.

This first graph is -- if you have any -- I'm going to go quick, and I'll summarize the main points. If you have questions, you know, ask them as they come. State map, this shows our 45 acute care hospitals in Utah. All 45 hospitals report trauma registry data. And that's the primary basis of the trauma report, is it's coming from those patients that are receiving care throughout the state in our 45 hospitals.

About half of the hospitals are trauma designated, 22 of them are. Three level 1s, three level 2s, four Level 3s, ten Level 4s, and two Level 5 trauma centers. So broadly across the state, about half of them are designated and half are not designated. Our data collection started in 2001. And we're going to look across the 13 year period whenever it's feasible. The report does that as well.

And in that case we're looking at about a hundred thousand trauma patients. And the case fatality rate for that 100,000 across the entire registry is four percent. Or four percent of patients, around 4,000 did not survive the injury.

Just a brief note on this. This is a simple concept. It's used across many diseases, in epidemiology, public health. The percent of the population that contracted the disease that did not survive the disease is all we're looking at. It's simply a way to look at mortality risk specific to a disease.

So when we're talking about trauma in this most recent year of data that we have, in 2013, 35 percent of patients with the most severe injuries did not survive the injury. That's what we're looking at on this slide. We commonly break up injury severity scores

into four groups. Minor injuries, moderate injuries, severe injuries and very severe injuries.

This graph represents around 7,000 patients that had very severe injuries ranging from scores of 25 to 75. So our case fatality rate across our trauma centers and our Level 1 trauma centers was just under 30 percent during this 13 year period. And our Level 2 trauma centers is about 31 percent.

Level 3 trauma centers, 40 percent of patients did not survive the injury. Level 4 trauma centers, about 55 percent. And then our non-designated hospitals, or about half of the hospitals that aren't designated, right around 50 percent of patients didn't survive the injury.

These are the other three injury severity groups, representing around 94,000 patients during this 13 year period. And minor scores go from one to eight. Moderate injury severity scores go from 9 to 15, and then shown in blue the severe scores go from 16 to 24.

So with our Level 1 trauma centers we can see that around four percent or just under four percent of patients that had severe injuries survived -- or did not survive, Excuse me. Six percent in our Level 2 trauma centers, seven percent in Level 3, and about eight and a half in Level 4, and 8 percent in our non-designated

acute care hospitals.

Within each of these categories, there is in some cases wide variation hospital to hospital. But by and large across the entire registry, a hundred thousand patients, 13 years, we're seeing a consistent pattern of increased mortality risk or case fatality rates as our trauma center level increase. It's somewhat intuitive. We would expect something along these lines. But to see the magnitude in the actual numbers, it's meaningful to see what those look like.

The next four slides are going to look at age group comparisons looking at mortality risk, and we're going to bring in a couple other data systems to our trauma -- our trauma registry data to help clarify what we've got and also bring some credibility to our data systems.

This is from our state's death certificates. It's showing injury mortality rates. The red line is for adults in Utah from 2000 to 2013. Injury mortality increased substantially and is increasing in Utah among adults 25 years of age and older. The blue line is for children and young adults, 0 to 24 years of age, and it was a relatively flat line until about 2007, and then it also decreased from about 28 per hundred thousand down to about 21 per hundred thousand dying every year.

So I've given this presentation a couple of times, and when this slide, there's always an initial reaction of why. What's increasing among adults? What's decreasing among youth? And so we'll cover it in a couple slides down the road, looking at the leading cause of death. So we will get there.

This slide compares the trauma registry data and our death certificate data. It's asking a simple question but a very important question in terms of, does our trauma registry data really capture what's happening in the state. And so we're bringing in two independent data systems to see if we're seeing the same patterns.

The blue line is looking at adults, the number of adults coming into our trauma registry. The red line is look at the number of youth that had traumatic injuries coming into our registry. So you can see the blue line is increasing substantially which is similar to what we saw on the previous slide. The red line is pretty much a flat line.

That big jump in 2007, between 2007 and 2008, is a reflection of our registry inclusion criteria changing to include falls among adults 65 years of age and older. So prior to 2008 we weren't collecting information about falls among adults 65 years of age and older. That's something that we need to know, and we

didn't have it before so we made that change. And we are collecting that information since 2008.

Get out my pointer. So this is pretty much a flat line. We're seeing about 2,000 young adults coming into the trauma registry every year. This is a clear increase even before 2007 and after 2008. This is our death certificate data, looking at the number of adults that died from injury during this time. This is also a flat line. This is the youth. This is 0 to 24. No change. It's consistent and striking how consistent that is.

This line on the other hand is our 25 plus on our death certificate dying from injury. The difference between these two lines is three fold. In the year 2000, three times as many adults died from injury as did youth. Now it's six times, at least in 2013, a couple years ago. Six times as many adults were dying from injury as there was youth.

But the broad question in terms of putting this slide together was, however, are we seeing the same thing in two independent surveillance systems, trauma registry and our vital records? And we are. So it provides a lot of confidence in our trauma registry data that it's actually capturing what's happening in the population.

This slide now compares our Utah data to the national trauma data bank. And we're back looking at the case fatality rate. So five percent of patients here in the year 2003 did not survive the injury in Utah. And in the national trauma data bank, this is our line. This is -- the red line is Utah. The blue line is the national trauma data bank. This is a very large gap, and every year but a couple years, we're below what the national data are showing.

So when you're seeing this, that we're consistently lower -- and the gap, we're talking about a half a percentage point, and that translate to hundreds of lives year to year. So this is a large difference. It's certainly a very positive result in terms of our trauma data having consistently lower case fatality rates.

When we look at youth, however, here is our 0 to 19 years olds, it's the opposite pattern. This is the case fatality rate from national trauma data bank. About three percent of patients die from the injury. This is our Utah data. And so we're seeing -- when we look at adults, our overall case fatality rate compared to the national data is lower. When we look at youth, it's higher pretty consistently.

This goes one step further along that same

path of thinking. This is just our Utah trauma data, and we're looking at the 0 to 14 year olds now particularly. We're breaking out the 15 to 19 year olds. But the reason we're looking at 0 to 14 years of age is because that population in Utah and nationally is specifically identified as recommending receipt of trauma care at a designated pediatric trauma center.

So we have one. Primary Children's Hospital is our one pediatric trauma center. This is their data during this time period in terms of the case fatality rate for 0 to 14 years old. It's ranging from the mid two percentages down to about 1.6 percent in 2013. It's decreasing over this time period, which is what we want to see.

This represents about 80 percent of 0 to 14 year olds receiving definitive care at Primary Children's Hospital. The blue lines represents the other 20 percent of 0 to 14 years old receiving definitive care outside of Primary Children's Hospital, and this is their case fatality rate.

It's got wide fluctuation because we're talking about smaller numbers. But pretty much the majority of years are higher than what we're seeing at Primary Children's, and some are quite a bit higher. This however, was surprising and nice to see. So we're

interested to see over the next few years, if this is just a fluctuation, and if this is going to bounce back up. Or if this is a significant change in our trauma system in terms of pediatric mortality.

Okay. Moving right along. Looking at the leading causes of trauma in Utah among youth 0 to 19 years of age. The leading cause is falls. Motor vehicle crash No. 2. Sports injuries, ATV injuries, all terrain vehicles, and bicycle crashes. This explains about 80 percent of all youth trauma.

In the first three years, we're pretty close together. We had two leading causes, falls and motor vehicle crashes. Since then falls have increased. Motor vehicle crashes have decreased.

I want to talk just a little bit on this red line because this is significant. That's a substantial decrease in motor vehicle crashes, and it carries with it much greater risk of mortality and higher injury severity scores than other mechanisms of injury like falls. So when we're seeing a decrease like this, this is reflecting a very positive change in our state population among youth 0 to 19 years of age.

This is looking at child mortality. The previous slide was at the number of children coming into the registry. This is looking at the number of children

in the registry that actually died. So here is motor vehicle crashes. And this is a representation of what I was talking about. The No. 1 cause of youth trauma is falls during this time period. But falls doesn't even make the top four.

This is explaining about 70 percent of all mortality in youth trauma in the state. Far and away the leading risk factor for youth mortality has been motor vehicle crashes. Twenty-seven in 2001 and eight now in 2013. Again, it shows very positive trend.

A lot of things have contributed to this. Child car seats. Parents using those, graduated driver's licensing. Seatbelt laws, seatbelt compliance during this time period. Gas prices also increased substantially. Gas price increase, miles driven decrease, traffic decreases overall. And so there are multiple things that are probably contributing to this.

Looking at adults now. Same thing. Top five causes of adult registry, trauma registry included in the state. Falls is the leading cause of trauma injury in the state. Motor vehicle crashes, No. 2, motorcycle, three, all terrain vehicle and sports. There is our big jump when we changed our inclusion criteria in the registry.

Falls is far and away the leading cause of

injury, trauma injury among adults. Sixty-two percent in 2013 of all of our adults coming into our emergency departments were coming in as a result of a fall. So almost two in every three that comes in the doors.

This was motor vehicle crashes. It was pretty steady around a thousand until we got to 2006. And it's also showing a slight decline. Not quite as dramatic as among our young adult population, but also showing a positive direction there.

This is mortality. Top four causes of mortality among adults, and I'll just keep moving on to the last couple of slides now. We're stepping back. I'm getting a broader perspective with these last couple of slides. This is our vital records data for the state.

Similar time period. We're grouping years into three year cohorts. 2002, 2003, 2004 represented here. This is '5, '6, '7; '8, '9, '10; '11, '12, '13. Poisoning, which is drug and alcohol poisoning mortality has increased substantially in the past decade. Motor vehicle crashes, No. 2 overall, has decreased substantially. Firearms is No. 3. It's increasing. Falls are increasing and suffocation. The top five causes of injury mortality as reported in our state death certificate.

When we're seeing this particular cause as the No. 1 cause and it's increasing so much, it's of particular concern because we already know that the leading behavioral risk factor for injury is drug and alcohol use. And so there's a lot of overlap in what we're seeing here and every other mechanism that we're seeing in trauma and also our non-trauma injuries.

And I'll just talk a little bit about this. When the attending physician has a patient that's died, they have to fill out the cause of death section of the death certificate. And they're tasked with identifying the underlying cause of death.

Whenever you're looking at death certificate data like we are looking at here, you're looking at what's called the underlying cause of death. But the physician can list multiple things. So for example, in a car crash, the driver had a skull fracture. He hit his head, which was caused by a car accident at an intersection, which was caused by drug and alcohol use.

So in each case the attending physician has to take all the information, wrest out what this chain of events is, and specifically identify what we refer to as the underlying cause. The thing that triggered and set in motion the chain of events.

So when we're seeing this kind of an increase,

this means that more often that underlying cause is being recognized drug and alcohol use across -- by itself, but like I said, we already know that it's contributing in a lot of these other situations.

Okay. My last data slide, this a statewide perspective. This is published last year in CDC's morbidity and mortality report. At it shows data, death certificate data for 2011 in group states that were significantly below the national age, states that were not significantly different, and then in dark blue, states that were significant above the national average.

Utah is in the dark blue category. In 2011 we had the fifth highest drug and alcohol poisoning mortality rate in the state. So we aren't out in front, but we are pretty close in terms of this across the United States. So it's important to see it from this broad population perspective and particularly where Utah fits.

Okay. That's it. I summarized really data from three sections of the report. It's available online. Any questions? Thank you very much for your time.

KRIS KEMP: Thank you. Where is it found online?

MATTHEW CHRISTENSEN: It's in our bureau

website. We've got a link right at the top. So if you go right to the front page of the bureau website, right at the top there's a link, and it'll take you where it is.

KRIS KEMP: Great. Thank you.

PETER TAILLAC: If I may, I just want to recognize Matthew's work in putting this together. This is an enormous effort, this report. He's a brilliant analyst of these very esoteric statistics, and this gives us a foundation from which we can work to help analyze and improve our trauma system and do better performance improving. So thank you, Matthew.

KRIS KEMP: All right. Shari, system acquisition update.

SHARI HUNSAKER: It's going to take me longer to walk up than it would for me to stand here. Shari Hunsaker, Bureau of EMS and Preparedness. We found out in late January that we had to delay the acquisition of our new data system until the current fiscal year that started on July 1st. That same week, I found out, I had to have spinal fusion. So it made sense that we postpone the process.

The RFP has been written. We've had a kick-off meeting with our RFP team. It includes a representative from the department of technology

services, Scott Munson from the bureau and Cameron Cooper from Health Data Security.

And the only thing I'm waiting for right now is an opinion from our assistant attorney general, because we are paying for the system with grant funding I received from the highway safety office. We're waiting for an opinion to be rendered as to whether or not this is a directed procurement or we go through state purchasing.

Either way we have to adhere to the procurement code. We anticipate an RFP filed by the end of the month. It will be open for 30 days. As of today there are at least three vendors that are certified to process and do direct data correction or analysis. So we have increased our competition pool.

KRIS KEMP: All right. Thank you. Any questions from the committee? No. Conflict of interest forms. Notary.

SUZANNE BARTON: Yours. Whoever hasn't done theirs.

KRIS KEMP: We just need to get these notarized? So we can do that on the way out.

SUZANNE BARTON: You're the only one.

KRIS KEMP: Okay, great. Anything else for round table discussion before we adjourn?

JERI JOHNSON: No.

KRIS KEMP: All right. Move to adjourn?

JASON NICHOLS: We don't have a motion.

KRIS KEMP: Okay. We're adjourned then.

(Meeting adjourned at 3:42 p.m.)

C E R T I F I C A T E

STATE OF UTAH)
COUNTY OF SALT LAKE)

THIS IS TO CERTIFY that the foregoing proceedings were taken before me, Teri Hansen Cronenwett, Certified Realtime Reporter, Registered Merit Reporter, and Notary Public in and for the State of Utah.

That the proceedings were reported by me in stenotype, and thereafter transcribed by computer, and that the foregoing pages, numbered 3 through 119 are a full, true, and correct transcription.

WITNESS MY HAND and official seal at Salt Lake City, Utah, this 23rd day of July, 2015.

My commission expires:
January 19, 2019

_____
Teri Hansen Cronenwett, CRR, RMR
License No. 91-109812-7801