State EMS Committee Committee

January 13, 2016
1:02 p.m.

Location: Bureau of EMS and Preparedness
Highland Building
3760 South Highland Drive
3rd Floor Auditorium
Salt Lake City, Utah

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

A P P E A R A N C E S

Kris Kemp, Chair
Guy Dansie
Nathan Curtis
Marc Sanderson
Russell Bradley
Casey Jackson
Jason Nicholl
Michael Moffitt
Bob Grow
Jeri Johnson
Margy Swenson
Mark Adams
Laconna Davis

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P R O C E E D I N G S

KRIS KEMP: All right. A couple of ground rules as we're getting started. We ask that anyone that presents anything to the committee, we all have our name tags. Unfortunately, most of you do not have your name tags.

If you wouldn't mind, we have a court reporter, court recorder here that will need your name, and we would like to be able to hear you. We don't have microphones, so we ask that you come to one of the two front ends of the auditorium here to state your name if you have something to present or discuss.

If you -- you know, if we have a lot of random conversations or people that are trying to put in their points, it's going to be difficult to put that on record. And so in order for us to recognize it, we need you to stand and be recognized. So that's kind of a little bit of housekeeping for us.

Before we get started, I do want to reiterate the point of our executive session that we just had upstairs. We do this executive session to try to expedite this meeting for everyone else. So we spend an hour and a half upstairs going over the topics of the agenda to start some discussions but obviously not make

any decision. It's just to start the conversation so that we can start to get a feel for what's going to require more time or less time.

And we recognize this is an open meeting, and we welcome anyone's opinion and discussion, as long as it is an appropriate time and it's been recognized. With those bit of housekeeping items, we will get started.

I am Kris Kemp. I'm the chair for this EMS committee for the state. So welcome all guests. Committee members, we'll do a quick introduction. We do have a couple of new committee members with us, and so we'll start down here. We'll introduce ourselves briefly, and we'll get moving in that direction. Go ahead.

LACONNA DAVIS: Laconna Davis, Department of Public Safety, dispatch representative.

MARK ADAMS: Mark Adams, hospital representative.

MARGY SWENSON: Margy Swenson, rural EMS representative.

JERY JOHNSON: Jery Johnson, rural EMT.

BOB GROW: Bob Grow, I'm an emergency physician.

MIKE MOFFITT: Mike Moffitt with Gold Cross

Ambulance.

KRIS KEMP: Kris Kemp, rural physician and department -- or committee chair.

JASON NICHOLL: Jason Nicholl, paramedic representative.

CASEY JACKSON: Casey Jackson, citizen representative.

RUSSELL BRADLEY: Russell Bradley, rural physician representative.

MARC SANDERSON: I'm Marc Sanderson representing registered nurses.

NATHAN CURTIS: Sheriff Nathan Curtis representing the sheriff's association.

GUY DANSIE: I'm Guy Dansie representing the Bureau of EMS and Preparedness. Oh, there's a chair.

JASON NICHOLL: There's a chair here.

KRIS KEMP: All right. Thank you. Again, I think it's important to point out that this committee is comprised by members of the community of the state of Utah, that we all have representation by certain entities and that we -- I believe it's important to point out that we do represent the State of Utah and its EMS agencies in various formats.

And so this is a diverse committee, and that we are always moving towards making the rules of our

agencies function in a safe fashion for all the patients that we interact with on a day-to-day basis.

We will move into our action items. First of all the approval of the minutes as have been handed out. If there's anything to discuss, this is your opportunity to do so. Otherwise, I will accept a motion and second for approval.

JASON NICHOLL: Moved.

BOB GROW: Second.

KRIS KEMP: In all favor say eye.

COMMITTEE MEMBERS: Eye.

KRIS KEMP: Any opposed?

(Silence.)

KRIS KEMP: And any abstain?

MARC SANDERSON: I didn't have a chance to read them, I apologize.

NATHAN CURTIS: Sheriff Curtis also.

KRIS KEMP: Thank you. All right. Guy, verbiage change for prehospital data.

GUY DANSIE: Yes. Last time we met we actually approved our rule for data, R426-7 with a couple of noted changes that we needed to amend before it went through as a rule for the department to approve and to put out for public comment. And we also put together a small working ad hoc review committee. And

they worked with Shari Hunsaker and reviewed that, and I'm going to go ahead and turn the time over to her to discuss that.

We just wanted to bring it to the table again, make sure everybody understood and was clear on the changes that were put together. And then we approve those as an action item so that they can go forth in the rule making process. Go ahead, Shari.

SHARI HUNSAKER: Guy, do you want me to cover the entire thing or just that one modification?

GUY DANSIE: Just that one modification. I think we covered it quite well last time we had our meeting.

SHARI HUNSAKER: Okay. For the record my name is Shari Hunsaker, S-H-A-R-I, H-U-N-S-A-K-ER, and I work for the Bureau of EMS and Preparedness.

There was some discussion at the last meeting regarding the department's need for notification for those agencies that may not be using the state-provided prehospital reporting system. What ultimately we have boiled it down to is found on the second page of the rule. I -- so it would be in No. 5, letter B.

Emergency medical services providers shall provide the department 90 days notice when changing reporting systems. That's generic enough. It's not

singling out any particular agencies or identifications. If you are going to change reporting systems, we need 90 days notice. That's the only modification that we made from the last meeting.

KRIS KEMP: Okay. Anything further, Guy, that you need to discuss in that regard?

GUY DANSIE: No, I think we -- like I said, we went over it last meeting. I think everybody was okay with it.

SHARI HUNSAKER: The motion last time was --

GUY DANSIE: That we change this.

SHARI HUNSAKER: -- to accept the rule change with the exception of the verbiage there on letter B.

GUY DANSIE: Right. So we're just -- this is just a formality to make sure everybody is okay with that before I put it out for public comment.

KRIS KEMP: Okay. Do we have a motion to approve the changes as noted?

JERI JOHNSON: I'll make a motion.

KRIS KEMP: All right. And a second?

BOB GROW: I'll second.

KRIS KEMP: Have a second. All in favor say eye.

COMMITTEE MEMBERS: Eye.

KRIS KEMP: All opposed, any?

(Silence.)
KRIS KEMP: And any abstain?
(Silence.)
KRIS KEMP: All right. Motion carries.
JASON NICHOLL: If I can for a moment.
KRIS KEMP: Please.
JASON NICHOLL: I just wanted to thank you, Shari. This was really hard work and some heavy lifting getting all the way through this, and you were a champion, and it was a pleasure to serve on the committee with you.
SHARI HUNSAKER: Thank you.
JASON NICHOLL: As much as of a pain as I am, I do appreciate your work.
SHARI HUNSAKER: You know, I had a nerve ablation yesterday, so I am not feeling much pain any more, so you are okay.
JASON NICHOLL: Took that right out, huh?
(Laughter.)
KRIS KEMP: Good. That's great. All right. Shari, you had the next action item, final list of NEMSIS 3.4 data elements.
SHARI HUNSAKER: This was actually heavier lifting, Jason, than the pool change.
JASON NICHOLL: Well, I meant the whole thing,

not just that.
SHARI HUNSAKER: Oh, okay. So we've been working on our transition to the NEMSIS version 3.4 data standard. When we go live with Image Trend, it will be with version 3.4. We organized a task force to meet and go over all of the data elements and decide of those that were optional or state -- up to the state, which elements we were going to include.
So the document that the members have in front of them is a list of all of the data elements, whether they are national, state, or optional. And you have actually got them divided into two sections. The last four pages or so, starting on page 11, those are the demographic data set elements. And pages 1 through 10 are the patient care reporting or PCR level of elements.
So there are two different data sets in NEMSIS. One is for the patient care report, and the other one is for the agency demographics.
The highlighting that you see and the color of the rows is only to help you differentiate between the various sections. So all of the elements that are in the E record section are in blue. The next section is E response. Those are not shaded. And then the next section, E dispatch is shaded.
That's the only reason that there is any

color. It's not to bring your attention to one element or the other.
Whether or not it is a national Utah or optional element is now in this column A. And the greatest discussion that we had was regarding the collection of patient name and address. That is left to the states to re -- to require. It's not reported to the national database. Ultimately we decided that we would leave it turned on and make it a state-required element.
However, the greatest concern was, if we can't get the patient's name, you are going to have a lot of patient records in there with a name of John Doe. There is actually a pertinent negative value for that. If you cannot obtain the patient's name, that we will encourage agencies to use that appropriate value for "couldn't obtain" or "not recorded."
And in addition to that, I am including a business rule in Image Trend that will flag any -- it will be a nonfatal edit because there might be somebody out there whose mom and dad had a sense of humor and really did name the kid John Doe.
But if a record comes across with John Doe or Jane Doe, it's going to return a warning back to the agency that says, if the patient's name is unknown,

please use this pertinent negative value so we'll not have a myriad of PCRs recorded under the patient name of John Doe.
KRIS KEMP: Okay. Any specific questions about this list?
SHARI HUNSAKER: Oh, one other thing. I'm sorry, Kris. I did include some element notes here for what the default return would be and when that element would be required. So if E disposition dot 12, if you look at that in the list of elements, if that is treated and transported by this EMS agency, then we will require odometer readings for on-scene and designation for billing purposes.
So that's what those notes are for, and I am willing to add any notes to this document that you feel are necessary.
KRIS KEMP: All right. Thank you. Any further discussion about the -- this list of data elements? All right. Then I would entertain a motion for approval of this final list of NEMSIS 3.4 data elements.
JASON NICHOLL: So moved.
MARK ADAMS: I second.
KRIS KEMP: All right. All in favor say eye.
COMMITTEE MEMBERS: Eye.

KRIS KEMP: Any opposed? Any abstain?
(Silence.)
KRIS KEMP: Okay. Thank you. Subcommittee reports and action items starting with -- well, I guess we -- it looks like only operations will be giving us an update today. Eric?
ERIC BAUMAN: Hello. I'm Eric Bauman. E-R-I-C, B-A-U-M-A-N, chair of the operation subcommittee. So a couple issues. So we met -- or informational.
So we met last month, and again discussed -- we had a presentation from Jason Nicholl on mobile integrated health. We'll continue to monitor the three systems that are being -- are in place within the state and their progress. So we'll continue to report to you on that.
Secondly, we're on target for our completion date for our catastrophic earthquake portion of the ESF-8 plan, and we're anticipating to finish that in February. We're meeting next week. The template is all finished. All the components of that plan are complete, and so it's just a matter of writing that plan, which will start on the 19th of January. Should have it finished in February and ready to present to you easily before the next meeting. So that's really positive.

Ambulance standards. We had a industry representative come and talk to us about more ambulance specs, standards. There's still a lot of questions, and we'll continue to monitor that as well. Still don't have anything real concrete on a particular standard that's going to be adopted or --
GUY DANSIE: Yeah. I just wanted to comment on this. This is a national problem. All of the states are dealing with this, and everybody's kind of in a holding pattern on the wait-and-see kind of approach. And I appreciate the -- what the operations subcommittee has done. But it seems to be a problem nationwide, and I think if we learn anything on the -- like from other states or things like that, we will certainly share that immediately with you as we try to hash this out.
ERIC BAUMAN: Great. Okay. And vice versa. Yeah. We are just kind of in the information gathering stage right now and trying to follow what other states were doing, so we'll pass that on to you.
And then the bulk of our time was spent discussing the cost, quality and access template for the licensure process, and we -- there was some, not concerns but questions that required some clarification. Jason Nicholl, our representative, took that back to you, I believe. And I see that's an agenda item today,

and I believe discussed that earlier. So we'll wait for further clarification from the EMS committee on that, and we'll move forward.
KRIS KEMP: All right.
ERIC BAUMAN: Any questions? Okay.
KRIS KEMP: Thanks for your work. There will be some assignments coming up, I believe.
ERIC BAUMAN: Great.
KRIS KEMP: During our discussion and informational items.
ERIC BAUMAN: Perfect. Thank you.
KRIS KEMP: As a point of note, there was a bit of a change to our -- or what we would have hoped to have had on our agenda was a report from professional development as well, but for some reason it fell off the agenda. So we'll put that off, and we'll continue on with our informational items at this point.
Information items can be somewhat more modified. We just can't vote on anything that's not on our formal agenda. So we can add a few things that also didn't make it to this agenda. We have to ask for a little bit of an allowance and forgiveness because Suzanne's out with a medical condition that she is trying to get over, and she put the agenda together before she had -- before she left, and a few things

didn't get quite glued together as we had hoped to.
In that regard, there will be a couple of adds to the informational items, and so we'll discuss those in a few minutes.
Starting off, in our informational items, I am -- I brought forth a question, specifically about ventilators and EMS transports. There -- to give some background, as an ER physician, and dealing with critical patients that require ventilation, person is not breathing for themself, right now the options are -- you know, obviously we need to try to breathe for them.
And there are certain standards in medicine that need to be met. And ideally someone who isn't breathing for themself, once their airway is protected, they should be put on some form of a ventilator so that appropriate gas exchange can be made and the other conditions the person is dealing with can also be worked on as far as the stabilization.
If you don't have a ventilator, then typically bagging a patient, using a bag valve mask or bag valve with intubation, is kind of the temporary standard. There are plenty of studies out there that show that bagging patients are variable.
Even the greatest respiratory therapists and pulmonologists that are out there working in ICUs, it's

been well studied and well documented in the literature that to bag a patient, basically you have a lot of variability in the amount of pressure you are providing, the rate, the volume, all the different parameters that we're trying to control to stabilize a person who is no longer breathing for themself, whether it's primarily a lung problem or something else that's making it so that they are not breathing for themself.

All of those variables are not managed well by a human being. That's why we put people on ventilators in hospitals. The challenge comes from when we have a transport, an interfacility transport where there is a patient that is otherwise intubated, and they require some form of oxygenation and ventilation.

In some circumstances the solution has been on these critical patients to put them on a ventilator and transport. Now, there's some agencies around the state that have done this for quite some time and have a lot of experience, which is difficult to train. Taking a weekend course does not generally prepare you for managing a patient on a ventilator. And I think just about any physician would attest to that.

And so it's difficult as a physician to take a step back and say, okay, as a committee member for the state EMS, is the safest thing for a patient to be

bagged from one hospital to the next, when we have data that says that probably not?

Is the safest thing to stay in place where they have a greater amount of resources until a critical care transport can be made? Or do we put that person in the back of an ambulance without a ventilator, with limited resources, and say just go; just get them there fast? An ample amount of diesel fuel will take the place of any time spent in an emergency department.

And I struggle with that, those three principles that are potentially at odds with each other. We all want in EMS to do what we're being told as far as, we got to get this patient from this hospital to this hospital. We got to do it now. You know, we can't fly helicopters in snow storms. We can drive. We'll drive behind that snowplow. We'll do everything we can to save that person and get them to that next level, right?

We've had these discussions around safety in the past, but ultimately our role and responsibility as a state EMS committee is to come up with rule and regulation to make the process fair and safe. And I am struggling with safety when it comes to ventilators in noncritical care transport or people that may or may not have a significant amount of experience with

ventilators.

Just because a piece of equipment is on the optional list for the state does not necessarily mean that everyone needs to have that piece of equipment. There's a lot more to it, and I don't see that we've got a lot of regulation other than saying it's up to the local medical director to make sure that the training is good.

And we also have to have our department medical director, Dr. Taillac, who I do not see here today, sign off on the use of ventilators by EMS agencies. And so I am kind of at an odds. And so I open this up as a discussion, first among the committee and then anyone that is in the open forum here, to discuss points of view on this topic.

Because I struggle with having agencies be able to be trained to using a ventilator with -- without much regulation other than a medical director saying, yeah, they're okay. They've got it all figured out. Because I know as an ER physician that practices critical care, I am barely comfortable managing patients on ventilators.

And to say that to do it every now and again in the back of an ambulance with an agency, EMT, advanced EMT, paramedic or otherwise, is problematic

without a lot more training than what we currently try to regulate in the state. So discussions?

MICHAEL MOFFITT: Yeah. I got a couple of comments. I agree with you. It's a very difficult skill set to maintain. We have been doing it clear back to, you know, the late eighties. We have developed from there over the years with our medical directors and with a lot of input from anesthesiologists, respiratory therapy departments, the best protocols that we feel we can develop.

I think as a company we transport patients on ventilators every day. Yet we still, we still utilize flight teams, Life Flight and Air Med, and we still sometimes take respiratory therapists from a hospital with difficult patients.

Being on a respirator is one thing that runs the gamut from, they just presented to the ER; they chuck them on a respirator, to someone's been vent dependent for days or weeks in the ICU. And people are very sensitive to that.

We have gone all the way from bagging patients en route to, you know, using very sophisticated ventilators nowadays. But it's very difficult to -- it's a very difficult procedure to monitor and take care of, A, without enough people in the truck that know what

they're doing. And to just say that anybody can go out and get a vent out of the catalog and watch some video and start doing that stuff, it gets a little scary.

So I would -- I would think, you know, we done -- we have done things where we spent a lot of years working on a critical care certification in this state that I think addressed ventilators and respiratory stuff. That never got completed.

I -- maybe it's time to have some guidelines at least drawn up as to what, what's required of an agency in their training so that medical directors of these agencies have a much clearer idea of what they need to train their people on and how they need to maintain that training.

You know, I know years ago when we were doing intubations as an intermediate service in Uintah County, our medical director had to sign off on their skills on a mannequin every month just to do intubations. So there are some things out there that probably need to have some good oversight. Anyway, that's my two bits worth.

KRIS KEMP: Other discussion points?

MARC SANDERSON: I think there's definitely a time and a place and the need. I think it's all based on the patient's acuity. Those transports out of

facilities to get to a higher level, it frees up a paramedic in the back of the ambulance. If it's a tool and they are trained, and there's protocols and everything is in place, I would completely support paramedics using ventilators with some guidelines.

KRIS KEMP: Other comments?

JASON NICHOLL: I think guidelines and training are the big key, guidelines for how much vent is too much vent, for a paramedic. How -- what vents we can use. We know that, you know, there are dozens of vent styles out there that all have different capabilities, different quality.

I mean, if you talk to a vendor, theirs is the best. You talk to the other vendor, and they will point out all the deficiencies of the other one. Now, I am not saying that the state should choose which vents. But I think that having the state, from perhaps an operations committee standpoint, look at it and say when is it appropriate for us to be using these vents and to what degree.

I believe the operations is a very smart committee with very smart people, and they could help guide us in answering the question of how much vent is too much. Because that's what plagues me. There's a reason why there's pulmonologists and respiratory

therapists. They are specialists in this.

A two week -- just to go with you, Dr. Kemp, a weekend course in vent does not an RT make. So I think that's one thing, and then like Mr. Moffitt said, the professional development, the training aspect is vital. And although there are multiple manufacturers of vents, vents primarily work the same way, primarily.

And I think that professional development should be looking at what standard we, as a state, will adopt for the training on vents. Is it enough to have a 20 minute video that's provided by the manufacturer to count for being able to be a vent specialist? I don't know. But I think professional development should come up with what they think we should be training so we have a standard of care when it comes to the operation of mobile or portable ventilators.

KRIS KEMP: Okay. Other discussion points?

JASON NICHOLL: Bob looks like he wants to say something.

BOB GROW: I'm pensive, I guess. You know, as a medical director of two agencies that do interfacility transports with vents, I am thinking back over, you know, five year experience I have with them. And I can't recall a single episode, incident, problem. Chief Bauman, I mean, you want to pipe in? Have we had issues

with our vents in the last few years? I mean I don't recall any.

ERIC BAUMAN: We haven't had issues, but I think -- I think the others bring up some really good points. And I think it's really training. We've done pretty extensive training both with vent manufacturers with respiratory therapists through Dr. Grow, and I think that's the real key.

And we have done that yearly because it's a -- I don't want to say a low frequency piece of equipment for us, but it's a medium frequency. So -- and there's a lot to it. And so we found just that, that an initial video or a short amount of training just wasn't enough for us to continue with feeling confident with it.

So I think that's -- for us, the key has just been the continual training, and with that it's been very successful. And we, you know -- because we do the interfacility transports, and there's a percentage of patients that are on them, so...

BOB GROW: Yeah. I mean, I think we're talking about the minority of agencies, right, that use vents as interfacility transports. I mean, if someone is coming in on a vent, primarily by occurrence, that's the rare occasion.

I guess I am just -- I am wondering why, what

prompted the discussion for one. If there's been recent issues or if this is stemming from your work with the transport stuff with IHC.

And two, I guess I am wondering, are there other areas with pieces of equipment, medications, protocols where we have gone beyond just leaving it up to the medical director and actually trying to dictate some type of guidelines? I mean, that seems kind of a first to me as I think about the other -- the paradigm we work within with these providers.

But, you know, I agree. It would be nice if there was some type of critical care certification in the state. You know, in the absence of that, we have kind of taken that upon ourselves to do sort of critical care courses, primarily directed towards the guys that are doing -- guys and gals that are doing the interfacility transports, trying to make sure they feel capable and competent.

And I think the other piece in the puzzle in all this, too, is realizing that, you know, putting a medic in the back of a truck with a ventilator, they are not isolated with that. Right? I mean, they have got an off-line medical director. They have got on-line medical direction both from where they are going from, to the receiving hospital.

You know, they are not operating in a vacuum where they don't have assistance with a piece of equipment that may be beyond their scope. I mean, we send people on drips and pumps and stuff that are beyond the scope of most paramedics all the time. I mean, I don't know that we can set up guidelines and protocols to say, you know, for this particular pump or this medication, this is how you got to do it.

KRIS KEMP: There are variances that you have to apply for, and anything that's outside the scope of certification, so using pumps and using drips that aren't on the approved --

BOB GROW: You can't conceivably apply for a variance for every medication we send a patient out on that's being transferred, every type of presser, every type of --

MICHAEL MOFFITT: Yeah. You guys come up with new stuff all the time.

KRIS KEMP: They do because they have to have proof training.

MICHAEL MOFFITT: I think the key is not to go back to agencies that have created a well grounded training system and have been doing this legitimately for years. But the prices are dropping on these pieces of equipment. The proliferation is now starting to

spread to -- you know, the earlier discussion was, you know, it's a rural or remote service. They buy a vent for a thousand bucks, they watch a video, and now they are going to take a patient for an hour and a half to the front.

Is that where you want to be? And in light of that, you know, seeing the tide rising, how do you mitigate it? And well, you just put into place some guidelines for training, you know, for the medical director so that some of us have already figured it out. Maybe we can put that in writing and have Dr. Taillac look at it, say, yeah, that's good so the people coming along and see, oh, this is how in-depth this training is and this is what you need to do. And what do you do when it doesn't work and those kind of things.

So that their people have their training and comfort level as well and, you know, you can't protocolize every medication and everything that's going to come out of a hospital, but something as critical and low frequency as a ventilator.

JASON NICHOLL: Temperamental.

MICHAEL MOFFITT: And temperamental as well. Maybe there ought to at least be guidelines for the agency that's thinking about it to say, what do I got to do before I buy this piece of equipment and go from

there.

KRIS KEMP: So when I say that it's difficult for me to divorce a person, the patient from a piece of equipment like a ventilator, once a person's on that ventilator, there is a lot of things that are going on. You and I know this. On the front end and on the receiving end of patient transfers that, you know, ABG, a basic parameter of how well the person is being oxygenated, ventilated, before and after can answer a lot of questions about how well they did in the interim. That's why we do -- so many are repeated.

When you say that you have not had an incident of a problem, no alarms have ever gone off? No lines have ever been obscured? You have never run out of oxygen? A patient has never had an ET tube dislodged? There's been none of that that's ever occurred on any of your transports of ventilator patients?

Because I see that happen on a day in and day out basis in every emergency department across this country. Every experience that I have had with ventilators is, they are not just plug and go. It is not like a drip on a pump where if it starts to go bad, you turn off. There is a lot going on with ventilator.

That's why it brings up some anxiety in my mind about just saying, it's on an option list and

anyone can say, I have got a medical director that signed off on our training, and we as the EMS committee sit back and say, oh, yeah, we approved that those are on the option list, so all is well.

And then it's up to Peter Taillac to say, they said they have got great training. I think that's fine. That's on the local medical director's liability then to do that.

Well, I think that as this committee's primary responsibility is to keep it fair and safe for the entire state, I don't think we have answered that question. Personally, I do wear the hat of being a medical director for rural ground transport with nurses being involved with the local EMS. And it's working very well.

This question keeps coming up with what about those ventilated patients in the middle of a snowstorm where we are not going to have a helicopter in for two or three days. We can't keep that patient here, you know, in whatever small facility that is. We have got a three hour drive to the next largest facility.

What do we do? Do we wait for the flight team that's very used to using ventilators and very sick patients? Do we wait for them to drive down, pick up the patient, and then go back, which has been some

practice? Other practices, as was pointed out before, that it's, you grab your local whoever and maybe a respiratory therapist and put them in and say, these are what the settings were, so this is what the settings can be during the transporting route. And say all is well if they receive on the other end a person that is still alive.

The definition of, how is that patient may be as dependent upon simple parameters that we look at as, they are alive, and so all is well. But as was also pointed out, people on vents often deteriorate over time, and we may not know that just because they are looking at them and they are stable and they are breathing on their own or breathing with the vent and they haven't lost their oxygenation.

There is more to it than just how they look on a monitor. There is the before and the after, and if we really dug in deep, and this is something that really hasn't been done, is what was your pretransport ABG, vital signs or otherwise? And what was your post transport? Was this a patient that was expected to deteriorate because they were dying anyway and they ended up expiring a few days later, a few hours later?

Or was this something that we would expect them to be at least maintained, if not improved, just as

if they were sitting in a facility that was being run by a respiratory therapist?

And these are the questions that I am asking. I am asking because I would like to see it happen safely for all the agencies that I am involved with personally, all the ERs that I am involved with personally, and then all of the other agencies that this could be open to for the state because of the role here. So I am wearing multiple hats, and I just don't know if we have got the best system put together.

Throwing regulation isn't always the answer. I totally admit that as well. But I think some guidelines from agencies that are doing this will help any future agencies that want to, as their populations grow and their acuity grows and they find the need and the necessary -- you know, they find it necessary in their community that they want to bring this on line. I think there needs to be some level of guidance, and that's where this is coming from.

Did you have a point?

JACK MEERSMAN: Jack Meersman, Gold Cross Ambulance. When I was chair of the professional development committee, we actually created the 84 hour critical care certification, template. But it was turned by the state that that's all we -- they needed --

we needed to create for CMS for agencies that you have to show that you taught so CMS would allow for that upper level billing for using the Benzol and stuff.

The education standard's out there. Actually ventilators are actually in the basic advanced EMT and paramedic national standard curriculum.

(Reporter asked him to repeat.)

JACK MEERSMAN: So we developed a critical care transport curriculum for -- (inaudible.)

And then the national standard curriculum actually has an EMT, advanced EMT and paramedic and ventilator usage. And so it's based on what you're coming from and where you are guys.

How good are we at using these tools? How often are we training on them? So the standards are out there. It's just, do we want to regulate it? Or how do we regulate it? So the basis is there.

I think it's a good direction to go, but I just wanted to make the committee aware of that. This has actually been passed through this committee probably six years ago, that there is this curriculum that was developed and approved that just sits on the shelf which I still happen to have on my shelf, so I could send it to you.

Because it was something that we worked hard

on for years to develop that as a certification. And that would be a good place to go is to move that forward and bring it out because there's validation through the flight paramedics. Some national flight paramedics association has the exams that you can base it off of. I know several universities have been teaching the critical care concept courses through UMBC here in Utah.

So it's like, the foundation has been set. We just need to have the regulation to say, yeah, if you are going to do this, this is where you go with it. And then those people can do it. And we have the quality assurance to do it.

Because would I agree with Eric on issues. There aren't any adverse events is how we look at it. So yeah, there's been blocked tubes, dislodged tubes that have been corrected, but the paramedics were skilled enough and have the training to correct them. So it doesn't show up as an adverse event to me, as a quality assurance person, because the problem was corrected.

If I get the call that, hey, this patient desatted and passed away because a tube is discharged, that's an adverse event that's going to be reviewed by myself, medical director and QA department. So I agree with your statement like, did anything -- these things

happen? It depends on how the agency defines an adverse event. Does it have to result in fatality or harm to the patient, or just this happened and that's an adverse event? So...

KRIS KEMP: Great.

JACK MEERSMAN: That's all I have.

KRIS KEMP: Can you send that to Guy, if you still have a copy of it? Because we brought this up in the executive session where these critical care transport certification guidelines were. We knew that they existed somewhere. It was a little bit of an enigma, so I'm glad you have got access to them because we need to dust it off.

I think that -- you know, this comes up about every couple of years where someone has questions regarding something along these lines, and I think the state's kind of getting to that point where we need something formalized.

JACK MEERSMAN: I'll send them to Guy.

KRIS KEMP: Great, thanks. You had a question.

KYLE LINDSEY: Yeah, Kyle Lindsey, Logan Fire Department. I have also worked for AirMed as a flight medic about eight, ten years.

Just a couple quick questions. And Dr. Kemp,

every experience you noted with the ventilator, I have had those failures. But most of them have been in a helicopter, you know. But you kind of got to work through them. And I think the guys on the ground would work through them, and eventually when all else fails, all roads lead to bagging.

And I don't know if that's -- I'm like you. I wish we had ABGs before and after because I don't think you can mark a critical event just by somebody desatting. We -- you know as well as I do, we can take you in with good SATS and not know the harm we have done.

My question is, I think we just need to define the simplicity events. Most of the vents in the EMS system on the ground are simple volume control vents. Stuff that you fly with would be more pressure support type vents. A volume control vent, the one we have at Logan is literally three dials. The only three adjustments you can do is title, volume, rate and adult or pediatric. Those are the only three adjustments you can make.

Now, that's not a fine tune vent. You wouldn't want to take an ARDS patient, somebody that's really sick. That vent is not sustainable for them.

So I would like them to maybe, when they are

developing training or whatever, I don't know how we break that down to say, a simple auto vent 4000, honestly, I can train you in an hour. I mean, there's only three dials.

You know, I can't train you a whole lot longer than an hour on auto vent 4,000. I can tell you how to convert weight to kilograms and 6 to 8 mills per kilo. But I mean, it's pretty simple. Now, a pressure support vent, you know, I have been using them a long time, and I have screwed up a lot with them. And I have had a lot of success with them too. I don't want to tell on myself.

But I have seen them fail in every manner, and so I think training would be good. But I think maybe looking at what types of vents we're going to let these people use is pretty important because that kind of -- you know, simple volume control vent is pretty standard and would be easy to use in the field.

And then the only problem we're having in Logan is, so the rural ground transport team, our nurses there's some concern over, so we're going to send our paramedics with a vent. The nurse, who is ultimately in charge of the patient, is not familiar with a ventilated patient, would like an RT with them. So we're just looking for direction eventually from them.

We haven't implemented our vents. We have purchased some and I have done some training, but we're just trying to get ahead of the curve and then we'll see whatever everyone recommends and go that route. But that's just my experience with them, and I appreciate you guys taking a look at it.

KRIS KEMP: Great. I'd like to get with you after if you don't mind as well.

KYLE LINDSEY: Okay. I might have to bug out early.

KRIS KEMP: Okay. Other comments in this regard?

WAYNE EDGINTON: Yeah.

KRIS KEMP: Please.

WAYNE EDGINTON: Wayne Edginton from South Jordan Fire. We also do interfacility transport. We do it from South Jordan Health Care up to the university facility. We carry the same auto vent. I think ours is the 3,000. But it is an excellent stopgap. We are not taking people -- this is a broad scope discussion.

We are not going to an ICU. There's no ICUs out there in that facility, and so all of the mixtures and the things that really you have to deal with a more sophisticated vent, we don't deal with. But our transfers are only still 20 minutes, and it's a great

stopgap.

We have done it in good weather and bad weather, whether the helicopters could fly or not, depending on that sending physician's opinion on the condition of the patient. It works really well. We haven't had any adverse effects with that type of pump.

So I love this discussion. I just think the committee needs to realize there's -- it's so broad scope between rural and urban and ICU, and maybe just the ED needs to get them to the other ED. So I would just -- if you are looking at this, kind of look at all of those aspects of the transport.

Would it behoove me to train all my guys in vent settings and everything like that? No, it doesn't. I have actually encouraged them to put the auto vent on a cardiac arrest. Free up a hand who is bagging, and it would work very well in that situation.

And again, it's a rate, volume, adult, pediatric vent. And I think most of Eric -- I don't know what you guys are using, but I think there are also a variety of vents from that simplicity to, you know, 20 dials on there that honestly, yeah, you are absolutely right. We don't have a clue on how to dial that patient in.

Before we leave, we talk to the respiratory

therapists at the hospital, get the vent settings. If they need to be on PEEP, you can do that. And then we send them off. And again, it's 15 or 20 minutes that they are on it. So ABGs from before and after, I don't know if they are getting them or not.

KRIS KEMP: Go ahead.

MICHAEL MOFFITT: I think, Jack, correct me if I'm wrong, but I think the guideline -- training guidelines that were created a few years ago kind of cover all different level of vents, because we use three different levels now. And so it doesn't exclude or say you got to have this many dials or do this feature. It teaches more theory and how to take care of your patient.

You remember the old school stuff, rather than just plug them into a machine. And I would actually -- I'd like to make a motion that we get and distribute the training guidelines that were produced and have our professional development committee look at it and see if it's current and updated, that maybe we could just have guidelines out there that people can refer to, medical directors can refer to, that can help shape training so that at least --

And I'm certainly in no way trying to limit anybody, either to tell what vents you got to use or say

you can't use it in a certain situation. But I think what, as a committee our responsibility is to make sure that state-wide everybody is at least training at the same level. Maybe not off the same page, but that, you know, you are getting the same stuff through your medical directors.

And you know, I'd just like to -- so my motion is that we dust off the old critical care training and have the professional development committee take a look at that and see how relevant it is today and make a recommendation back to our next meeting.

KRIS KEMP: I think we are in the informational, so we can make assignments.

MICHAEL MOFFITT: Assignment, okay. Instead of a motion, an assignment.

KRIS KEMP: Okay. And we're making note of these, Guy, as well?

GUY DANSIE: Sure.

KRIS KEMP: I want loop closure on this, and sometimes our assignments have been a little bit vague, and I want to make sure that we've got pretty good communication and loop closure on this.

GUY DANSIE: Noted. We have our --

KRIS KEMP: We don't have our rural person back there?

GUY DANSIE: Eric is our -- and Chris deal with our operations, and Jack so...

KRIS KEMP: Right, right.

GUY DANSIE: They're all involved in that.

KRIS KEMP: Good. We'll make sure these assignments get documented well. But does anyone have a rural perspective, someone that, you know, perhaps not necessarily, you know, an hour plus transport to interfacility? Logan probably does, but even more rural perhaps?

(Discussion off the record about coming to the front.)

TAMMY BARTON: Tammy Barton, Garfield County ambulance. Very rural. We don't use vents. If we take a patient on a vent, our anesthesiologist goes with us, so we don't really have a dog in the fight. I don't know if a lot of the rural places do, as far as what you are talking about. So that's kind of our perspective.

KRIS KEMP: Were there to be some guidance in training, would that be something that would be -- something your agency would be entertaining at all?

TAMMY BARTON: Probably not. You know, when you first brought this up, I thought in my last -- oh, I don't know, seven or eight years, as I am thinking back, two cases. Yeah. So not really, not really for us.

I don't know. I can't speak for all rural, but it really -- if a patient is that critical, they come in. The helicopter or plane comes in, and they are taken care of at the hospital until it happens.

MICHAEL MOFFITT: The big driver on transport time or rural distance is oxygen capacity, because they burn a lot of oxygen and compressed air. And Jack, what's our range? I mean, we have gone to Montana before with a vent, but that's taken --

CHRIS DELAMARE: Well, we just did one today from Pocatello down, so on an M tank on your vent, it would last two and a half hours, so if you had a full M tank. H tank is probably four hours and our --

KRIS KEMP: And what was your name again for the record?

CHRIS DELAMARE: I'm Chris DeLaMare, Gold Cross Ambulance.

(Discussion off the record about identity of speakers.)

KRIS KEMP: Okay. Well, I think we've got enough to make an assignment. Do you have one last comment?

KYLE LINDSEY: Well, this is Kyle Lindsay again. I was curious, what size tank was that? How many liter tank?

CHRIS DELAMARE: That was on an M tank. So the big, the tall, 2200 pounds psi.

KYLE LINDSEY: Okay. My confusion was, I thought an E tank would last about 45 minutes. Just running the math, or 540 and -- or 340 liters. So that would be 34,000 and you are delivering 6 mills. I could be wrong. I thought an E cylinder would last 45 minutes, so I would think your cylinder would last longer than that.

CHRIS DELAMARE: Yeah, two and a half hours.

KRIS KEMP: And then again, back to the vent discussion. There are vents that were piston drive and not pneumatic driven, and they are much more sparing on a rig's individual O2 requirement. What's that one you were talking about that's like that 65 disposable?

MARC SANDERSON: Yeah, it's a brand-new device. It's just barely out on the market. Single patient use, billable to the patient. Throw it away when you are done, and it's an amazing piece of equipment. I will have some information for us, for everybody next meeting.

KRIS KEMP: Please do. And do you know if it's pneumatic or if it's piston driven?

MARC SANDERSON: I think it's pneumatic.

KRIS KEMP: Okay. All right. Well, thank you

for that discussion. I think it's important to bring up, and you know, it's all about the patient safety. And I think we're all in it for the same reasons. It's just, I think, better definition and guidance is really what we are looking for.

One add to our informational items was -- is Clare still here? Clare, you are in the back. Was a discussion about IA and variances. For some reason you didn't make it onto the informational items agenda. But we opted to add you during the executive session just so that we could have this discussion because I know it was supposed to happen. It just didn't make it be into this agenda before Suzanne left.

So Clare, do you want to present to us about the IA variances and system? Come on up, Clare, front and center.

(Discussion off the record.)

CLARE PROVOST: I didn't know that I was going to be presenting today so...

SHARI HUNSAKER: Surprise.

CLARE PROVOST: Thanks for letting us be on the program.

KRIS KEMP: And Don Murelli.

(Discussion off the record about speaker identification.)

KRIS KEMP: Clare, some background.

CLARE PROVOST: So we, myself from Wasatch County, Don from Carbon County, we're the only two agencies in the state that moved forward with the intermediate advanced certification. So in meeting with Guy and Paul Patrick with Dr. Kemp, Don and I, we felt like that we'd like to continue that. And yet, it's kind of a certification that the state has kind of let -- we're kind of a -- am I recorded? We're kind of a bastard child.

Anyway, with all due respect, we felt like we'd like to continue to be able to do those things that we have done as an intermediate advanced agency. And so in meeting with Guy and Paul, we asked for a waiver to be able to continue to do those things that we have done in the past as intermediate advanced. So they felt like what we should do was present to, I don't know which committee, a waiver requesting that we're allowed to continue to do that in the future. Was that --

KRIS KEMP: Did you have something, Don?

DON MURELLI: I'm not sure if it was corrected as a waiver. I think it was just a suggestion to the state because it didn't have to go through a committee; is that correct?

GUY DANSIE: What was the question? Sorry,

Don, I was --

DON MURELLI: As far as, we don't really need a waiver to ask to continue because it's already in the rule that we are there.

GUY DANSIE: I think the issue was, if we take the license level from an intermediate advanced to an advanced EMT license level, to get you in the same license group of agencies; you know, same as everybody else, standardize your license level, that you would still be allowed to perform those things, and that's really the thing.

We would have to get a waiver from the committee, from my understanding, to allow -- to do things beyond their normal licensure level, and probably Dr. Taillac's approval as well. We wanted to bring it here to discuss it openly and make sure that we do it clearly in a way that meets everybody's needs.

KRIS KEMP: So in history, this was something that was initially offered by the state. Your two agencies took the state up on it. That process became IA, where other agencies opted not to do that, and then as the state decided to go to a different national certification level, it left you two out as grandfathered, as was promised in rule, you would be grandfathered as intermediate advanced. You could

continue your agency in that regard.

The challenge comes from, there's no additional support from the state to continue that process for you. And so from what I understand, you want to certify all of your members as advanced, ask for waivers to get to the intermediate advanced so you can continue to train new members to intermediate advanced.

But yet, if they move to a different agency or different state, their certification would carry with them as an advanced EMT and not an enigma of what an intermediate advanced, which is not well understood among other agency or states. Am I --

CLARE PROVOST: That's correct.

DON MURELLI: Correct.

KRIS KEMP: -- describing that? So what you have for us is essentially a request for a waiver.

CLARE PROVOST: Right.

KRIS KEMP: To be able to go to advanced for your agency but apply intermediate advanced skills and training for each of your members.

CLARE PROVOST: So as far as the state is concerned, we would be advanced intermediate. But within our communities and our counties, we would maintain that intermediate advanced level. Does that make sense?

KRIS KEMP: So you're advanced EMT, but your communities are being treated by EMTs that are of what was described as an intermediate advanced.

CLARE PROVOST: Correct.

MICHAEL MOFFITT: Question for Guy.

GUY DANSIE: Sure.

MICHAEL MOFFITT: Under our waiver rules, this is -- since this isn't staffing or anything, don't they just go through the bureau and Dr. Taillac? It doesn't need to come -- this is just like adding a new truck.

GUY DANSIE: Yeah. I would have to ask Brittany honestly, who has the power or authority to grant that.

MICHAEL MOFFITT: Really all they are asking for is a couple of advanced procedures over and above the advanced.

GUY DANSIE: What I would like to suggest is that we actually spell out what those differences are, maybe like a --- would that be appropriate? To say what those things are that you need to have as a waiver, and then we'll ask Brittany is what -- legally if we need to go through a department approval or a committee approval.

Typically we do the licensing end. The criteria is set by the committee for training, staffing,

those types of things. So we wanted to make sure that the committee knew what we were doing and do it in a way that was -- you know, that everybody understood why we were doing it. So that's why we brought it as an informational item at this time.

And we're still working on this. Still work in progress, but it sounds like if we're ready to move forward, we'd like to have the committee's blessing on it and then move forward by getting those things delineated, the waiver, the things that the intermediate advanced perform above and beyond what an advanced EMT performs.

And then we can then go ahead, and if it's okay with Brittany and the department, we would go ahead and approve that. We would just change the license to an advanced EMT and allow you to, with Dr. Taillac's approval, allow you to continue the practice that you are doing with your unique situation.

And then anybody that's an advanced, or excuse me, intermediate advanced would be allowed to transfer if they would like at that certification level of advanced or EMT.

DON MURELLI: Right.

GUY DANSIE: Did I say all that right?

DON MURELLI: I think that's correct.

GUY DANSIE: Okay. And we'll work off-line with this, because we wanted to bring it out, see what the feelings were of everybody, make sure everybody is okay and understood why we're doing it. Do you have anything else, Mike?

MICHAEL MOFFITT: I don't -- I understand. I know what you are doing. They kind of got cut off, cut the branch behind them, and they are hanging out there, no way back. The only thing I would like to see is that your IA program stays in conformance with what was the IA program, not something -- sliding off, well, that was too hard. We are going to kind of morph into something new. As long as it's consistent then -- and you know, and you waiver up to it, then fine.

CLARE PROVOST: Yeah, and I think that's all that Don and I are asking for is that, you know, we took the time to achieve that certification. We just want to be able to continue to provide that level of service for our community.

MICHAEL MOFFITT: Yeah. I think -- I mean, as far as I understand, unless something I am not seeing in the rules is, that would just -- once you get, this is where -- this is the waiver we want. Here is the differences between the two certifications. This is what we want to do above. Then I think that -- I could

be wrong, but I think it goes through the bureau and Dr. Taillac.

GUY DANSIE: I am pretty sure it does too. We just wanted politically to make sure everybody understood where we were coming with.

MICHAEL MOFFITT: As one member of the committee, I am okay with that.

KRIS KEMP: And again, the reason behind it is that they were grandfathered into it, and that was a promise from the department and from this committee for years that we wouldn't take away what they worked so hard to gain. But this just helps them fit in better with the rest of the state as far as the advanced level, and then they waiver up for those intermediate advanced skills.

And on the only reason why they would be granted this waiver and other agencies wouldn't is because of the grandfathering that they had of being an IA agency to begin with. Whereas no other agencies got that.

So it's not like today, one other agency that wasn't Wasatch or Carbon County, they couldn't just come in and say, "Well, now I want to do the same thing that you guys are doing." Well, that's not what was promised both in history and in rule. Okay. Great. Thanks.

CLARE PROVOST: Thank you.

KRIS KEMP: Disease testing of individuals exposed to blood-borne pathogens. Guy.

GUY DANSIE: Okay. Intermountain Health Care approached the department recently about some of our -- their concerns with blood-borne pathogen exposure. Originally some of the rules that were written were put under the labor, and they're not under the Department of Health's rules, which is okay. It was primarily addressing reimbursement costs for individuals that are exposed on duty to blood-borne pathogens and how that would be paid.

I have contacted them to discuss possibly updated or revising those rules as needed. We have also taken this to our rules task force and had a discussion. And we wanted your blessing and have you understand what the issues are.

Some of the concerns are that the intake form, the processing form, is dated or has problems. We need to update that. Also, the legal system is quite slow to get a court-ordered test if needed, if a patient refuses to submit a blood sample. That's actually -- I found out just last week that that's being addressed by a house bill. I believe it's 68, being sponsored by Dr. Redd from -- Representative Redd from Cache County.

And so we're looking at that and hoping that will alleviate some of the concern. I just wanted to bring it to your attention if anybody has any concerns or issues.

Part of the issue that was discussed is notification process. That's not very clear in most people's minds how the notification and being HIPAA compliant, how that works. Who is to be notified by the lab or whoever does the testing and how that chain of notification takes place to the individual that was exposed. So those are some of the issues we are grappling with.

We just wanted to just put it down on paper. It has -- I believe it was a policy or something that existed somewhere sometime ago. But it's become so dusty, nobody knows what that is any more. So we wanted to put together some type of guidelines, guidance or possibly change some rules to make that clearer and updated. So...

KRIS KEMP: Okay. Any questions in regards to this point?

GUY DANSIE: I might -- we would look at that with the rules task force. But it obviously goes probably as an operational issue as well. And if that's okay with the committee, if there's some things that

spill over, we could task that to operations, if that's okay. If we could as we start to dig into it.

KRIS KEMP: Any concerns or questions from the committee? Okay. Anything else on that, Guy?

GUY DANSIE: No.

KRIS KEMP: All right. Fiscal reporting guide, Alisa.

ALISA HARDIN-LAPP: Yeah. My name is Alisa, A-L-I-S-A, Hardin-Lapp, H-A-R-D-I-N, hyphen, L-A-P-P. And I am in financial resources with the Bureau of Maternal and Child Health. And primarily I work with the WIC program. However, due to a recent internal audit of the EMS fiscal reporting guide, I am going to be taking over Allan Liu's responsibilities on the FRG and also creating this year's ambulatory rates.

So we had a few changes made from suggestions from our internal state auditors, and I just wanted to go over the new FRG that you guys will be filling out. You can actually find the new FRG on the EMS website, and I also created a sheet that just explains what we have changed exactly.

So first of all, we have added a glossary. This is just to really clarify the line items on the FRG, both old and new line items. We have also added three new revenue categories. So on the previous FRG,

we recognized that we were only recognizing one revenue stream, which was billed transports.

And we realize that EMS agencies collect other revenue streams other than billed transports, so we've added EMS grant revenue, interest and special events. And then we have also added just an other category where you can fill that in if that applies to you.

We have condensed some expense categories and then also added two new expense categories. So we have added depreciation and then medicaid assessment.

The most significant change, I think, I feel that we have added is an asset column at the bottom. So for our net income limit testing, previously we were only testing gross revenue. And we -- the auditors found that we also need to be testing the return on assets ratio. So that's why we have added that information on there.

And then lastly we have added just a signature line at the bottom. This is really just for accountability purposes, and it also gives me the information I need of who to contact if I have any questions.

KRIS KEMP: Okay. Any questions?

RUSSELL BRADLEY: Is this stuff available on the website?

ALISA HARDIN-LAPP: It is. All of it's on the EMS website.

SHARI HUNSAKER: I had to reboot my computer, so I am getting you there.

KRIS KEMP: Oh. So you were going to demonstrate this. Okay.

ALISA HARDIN-LAPP: It's under the EMS laws and rules tab, so if you just click on that. It replaced the old FRG, and my contact information is also listed on there. So if anybody has any questions about the new changes, you can feel free to contact me.

KRIS KEMP: Okay. Anything else, Guy?

GUY DANSIE: I just wanted to compliment Alisa. She is new to the process, and she's jumped right in and taken this by the horns. This was one of the things that we were obligated by an audit, like she mentioned. And I just wanted to appreciate her publicly and let you know that we support her.

And if there's anything that anybody feels strongly about, please get with us, and we'll discuss that and consider, you know, it. Or if there's points that are not clear or, you know, in any way that we can help you move through this change, let us know. So thanks.

TAMMY BARTON: I have a question. Tammy

Barton, Garfield County ambulance. But we still have the same time frame to submit everything.

ALISA HARDIN-LAPP: Right. So this new FRG is effective as of January 1. So those of you with the fiscal year end date of 12-31, you will use this new form. And then there are still some agencies with their fiscal year end June 30th. The reports that were due on September 30th, there are still some that have not been submitted, so they will also be required to use the new form.

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

ALISA HARDIN-LAPP: Okay.

KRIS KEMP: Allan, EMS grants information.

ALLAN LIU: Good afternoon. My name is Allan Liu, here at the Bureau of EMS. I am here to talk about --

(Mr. Liu was asked to speak up.)

ALLAN LIU: Here to talk about grants for fiscal year '17. The deadline for per capita is January 29th. And for competitive grants for fiscal year '17, the deadline is March, March 28th. It's on the bureau website.

Anybody who applies for per capita or competitive will get 1500 for CME. It's a flat 1500 for

CME. We used to give CME in competitive grants, and since we always give it, we just -- it's a flat given. And on the competitive we only have defibrillators or medical equipment to compete for. We don't have the funds, unfortunately, for ambulances or for communication equipment, other items that we used to have. So I just want to let people know. We did send out rosters to EMS agencies, and the deadline is January 29th for per capita.

I want to talk now about 2016, our current grants right now. Those agreements have been sent out. For reimbursement for per capita or competitive, we need receipts. Some people have received per capita assuming they will automatically get money, a check in the mail. We need to have proof that items purchased is for EMS because a lot of EMS agencies are aligned with fire, and fire equipment is not allowed. Only EMS equipment. This is to help the EMS system.

That's all I had. I just wanted to remind people that. Any questions?

KRIS KEMP: No. Okay. Thank you. Template for guidance for cost, quality and access for licensure process. Jason.

JASON NICHOLL: Okay. As Eric brought up, the operations committee was looking at the cost, quality

and access goal for ground ambulance providers. The new version, I believe, that you have now is R 426-3-600. Slightly different than the 1200 that was the R 264-1200 that was passed out at the operations meeting, but still has primarily the same information.

This particular rule stems from statute Title 26-8a-408-7, which essentially says that the, the municipal or the city, the municipal, the political subdivision shall establish cost, quality and access goals and submit to the department.

That's it. It's one sentence. Has nothing to do with agencies whatsoever. And the rule that was then subsequently written is basically an inventory for agencies. Asks for a ton of data that's provided elsewhere by an agency, and essentially can only be filled out by a provider agency.

It doesn't have anything to do with the particular political subdivision's cost, quality, or access goals for EMS.

Now, I realize that most political subdivisions will ask their providers to write goals, and they will get turned in. But that doesn't always happen that way. I want to use a hypothetical where, say, the -- there's a political subdivision that doesn't provide emergency medical services. They contract for

emergency medical services. And they have one line item expense within their budget for emergency medical services.

Say the United Fire Department works with Sprucewood Heights City. Well, Sprucewood Heights contracts with the United Fire Department for service. They don't provide the service. So the agency that provides the service doesn't have to set cost, quality, and access goals. The municipality does. The legislation is quite clear on this.

So when this came out, it seemed like something that was really missing the point of cost, quality and access goals. I asked that it be brought back here. All of you members of the committee have the proposed adjustments that I wrote that just simply outline a cost goal that needs to be set, a quality goal and an access goal that needs to be set. That's it.

And it should be done by the municipality or the political subdivision, not the agency. So I think that this satisfies what the legislation is, doesn't create an overreach and doesn't create a work burden for providing data and information that a municipality may not be able to provide.

So what I ask is that we ask the bureau to take the language that I have written, modify R426-3-600

and then bring a modified R-426-600, sorry, 3-600 back to the committee for the next meeting so that we can put it out to public comment. That's it. Questions?

KRIS KEMP: Anyone from the open forum? Want us to repeat all that? You can read the transcript.

SHARI HUNSAKER: Quite eloquent.

KRIS KEMP: Okay. Thank you, Jason. I think that that assignment can be made.

GUY DANSIE: Yeah, for the department, we will do that. That's not a problem.

JASON NICHOLL: Excellent.

KRIS KEMP: Great. Demo on EMS mapping tool, Shari.

SHARI HUNSAKER: Aren't you glad that I came today?

KRIS KEMP: Yes, we are.

SHARI HUNSAKER: The meeting would be so much shorter without me. Okay. So at the last meeting, I was supposed to do this demo, and I spaced it. And so I am doing it today. Good luck reading the monitors, but there is a handout available for everybody that is here on the user's guide. But I am going to show you how to access the user's guide from within the mapping tool.

The one thing that has not been updated on the user's guide on the website is the header of the actual

URL that you can go to. So I am going to start by showing you how you can get to the mapping tool from the bureau's website.

If you go to Health.Utah.gov/EMS and click on the link for EMS providers, then click on the link for licensed and designated EMS agencies, at the very top of the screen you will see a link for the EMS agencies' interactive map.

And we have worked with the AGRC for a number of months fine-tuning this. So basically what this allows you to do is put in your agency's -- select your agency from the drop-down list or input any one of these various filters that are available to you. So if you wanted to see a list of all of the AEMT agencies, you would select that as your service level filter.

And you would see that Carbon County and Wasatch County are the two agencies in the state that are still listed as of a level of service at 2009 AEMT.

KRIS KEMP: That should be IM.

SHARI HUNSAKER: I know that it should, but we had to stick with what was acceptable NEMSIS values. And NEMSIS does not have an intermediate advanced or an advanced intermediate. They have one or the other.

GUY DANSIE: We're working on fixing that, right?

SHARI HUNSAKER: Nationally, no. So I just need some direction, when that's all nailed down, how you want them classified. But I'm going to address that a little bit later.

So if I look for the EMT basic agencies, this data table below changes. So you can now see a list of all of the agencies that are EMT basics. If you input an address -- well, hang on a second. Let me do this first. I need to reset. I am going to reset the map and clear my filters. And then I am going to put in an address and click on find.

Oh, so old. Hello. I don't even know my own address. The map is going to indicate where that address is located and then update the data list with a list of any agency that may respond to a call at that particular address.

Now, I want everyone to write that address down and send me a Christmas card next year.

MICHAEL MOFFITT: You are brave using your own. Do you want to put your cell phone number up there, too?

SHARI HUNSAKER: You know, I am so wired that I have learned that I can't hide from anybody. So let me take you through this user's guide one step at a time.

The user's guide is actually available to you if, when you first get to the map, you click on the link for user guide. And that will allow you to print out a hard copy of exactly what I have given you all today.

Your filter boundaries, by default, so for your filtering you can use multiple filters for a search. But you can only have one value per filter. And if you look at the numbers on the user guide, number one is to see the color coded boundary down here. If you click on the show legend, it's not as dynamic as I want it to be. We are working with AGRC to improve the color coding visibility.

So agencies that are a 911 response with transport are light green. Those that are without transport are yellow. If they are a search and rescue, they would be a different color. So once you apply all the filters that you want to and you get the map looking exactly how you want it to look, you can give the map a name and then print it.

So if you wanted to find your service area, for example, I am going to choose American Fork city. Here is -- and that's -- we're working on the colors, trust me. But you can see the service area boundaries now for American Fork city. They are a 911 response with transport, and they have EMT intermediate and the

2009 paramedic levels.

We are going to be sending out an e-mail next week to all of the EMS agencies explaining to them exactly what we need them to do to make sure that their service area boundaries are represented correctly and that their type of service and level of service is accurate for this data.

And if they have any problems that they need to report, they will click on this link to report a problem, and it will immediately send me an e-mail. So if you don't know my e-mail address, and you want to really get in touch with me, this is another way. Go to the map.

JASON NICHOLL: If we don't send it to your house.

(People talking at once.)

SHARI HUNSAKER: The email is coming to me.

JASON NICHOLL: Or we could just send you a letter, to your house.

SHARI HUNSAKER: Yes, or you could send me a letter to my house. Either way works. I'm happy to serve.

You can zoom in and out of the map using this plus and minus symbol. You can shake the topography by clicking here and then selecting from the drop-down menu

to terrain or streets. For my purposes, I generally just leave it at light. Hill shade. AGRC is just really into mapping, and they wanted to give you every option available.

KRIS KEMP: Great. Well, it looks like we -- we thank -- you know, thanks for the walkthrough on that mapping tool. You know, it looks like it's pretty easy to use, overall pretty straightforward. So thanks for that walkthrough.

SHARI HUNSAKER: You're welcome.

KRIS KEMP: Any questions for Shari? Okay. Thanks. It looks like we're getting close to the end here. I see on the agenda, change the date for April EMS committee meeting. I am assuming that it was scheduled for April 13th, or that was what I had on my calendar. Was there a problem, Guy? Did we have a problem?

GUY DANSIE: I don't know.

AMY MELTON: There's something else going on that day too, and I cannot remember. They talked about it.

SHARI HUNSAKER: It's here in the auditorium.

GUY DANSIE: Oh, it's an auditorium conflict?

KRIS KEMP: Could we just go somewhere else? Crown Burger?

GUY DANSIE: We could possibly go to Cannon. Do you think that would be -- maybe, maybe not. Would you rather change the location or the date honestly?

KRIS KEMP: Personally the 13th looks good.

VOICES: Location.

KRIS KEMP: So just change location.

GUY DANSIE: I'll see what we can do.

KRIS KEMP: We'll get that sent out.

GUY DANSIE: I'll have to figure something out, but we'll do something.

SHARI HUNSAKER: What was the date originally?

KRIS KEMP: It's still April 13th.

MARGY SWENSON: We'd like to change the location.

KRIS KEMP: Yeah, we'd rather change the location than the date.

AMY MELTON: You can try that room next to the dock.

GUY DANSIE: I'll see if I can find something. They don't know our acronyms. Possibly at Cannon is what I am thinking off the top of my head, Cannon Health Building.

KRIS KEMP: We'll look at that and get it sent out. Round table discussion. Any issues from the committee need to be brought up?

MARC SANDERSON: No.

KRIS KEMP: To my left, any other issues from the committee from this direction? Okay. Well, we've got some assignments that have been made along the way for operations and professional development, I think, as well as to the department. So hopefully we can get some answers, and we'll have those good discussions at our next meeting in April. Do I have a motion to adjourn?

JASON NICHOLL: Do you want to go over the assignments first before we go just to make sure that --

KRIS KEMP: Our assignments?

JASON NICHOLL: Yeah.

KRIS KEMP: Okay. We can go over assignments. So I have a few listed specifically. From operations, how will vents be used? What's out there? The effectiveness. Which vents and three different type levels that we've discussed. And the guidance for equipment.

Professional development, to get the critical care transport certification guideline that was mentioned and review that. If there's any -- to try to develop any form of state standards for vents that might be approved and then the training to cover the ventilators.

Let's see. Other -- professional development,

any other assignments that I am missing there? And for operations?

ERIC BAUMAN: Did I understand that we were going to work with Guy on the disease testing of individuals exposed to --

GUY DANSIE: Yes. We are still premature on that on exactly what we need help with, but we will probably be sharing something with you on that.

ERIC BAUMAN: Okay.

KRIS KEMP: And then I would like to make a recommendation that as we get the records of this meeting, that the professional development and operations subcommittees review and read these in detail so that they fully understand the discussions that were made around these assignments because I think sometimes the committee, subcommittees have lost a little in translation.

So I think that it's all there in the transcripts, and if we can just focus on those points and read them as a group primarily first, it may answer some of the questions as to what the assignments truly are and which direction we wanted to go from the committee. So we try to make that as clear as possible. Is that okay as a recommendation?

ERIC BAUMAN: Yeah, absolutely.

KRIS KEMP: All right. Anything else?

GUY DANSIE: Just for the rules task force, I have three upcoming agenda items for the 27th of this month. I just want to share those quickly with you. One of those will be the blood-borne pathogens we talked about.

KRIS KEMP: Is this for rules?

GUY DANSIE: Yeah, the rules task force.

KRIS KEMP: Okay.

GUY DANSIE: And so we were going to continue that discussion. There is a gentleman that had some concerns about special events and how those are done, and I know we have beat that one up before, but we're going to go look at that a little bit.

The other one is the issue that was brought to the committee, and this is probably the one that maybe last month or last meeting we had a discussion about. Van service, and it got a little heated on what they say they are doing versus what they are allowed to do, so we were looking at possibly trying to delineate that a little bit clearer, make a clearer distinction between what an ambulance is and what an ambulance is for, and when it's appropriate to use an ambulance and when it's appropriate to use a van.

We don't regulate the van service, but make

that a little bit clearer, more understood.

KRIS KEMP: Okay. All right. Any other issues?

JASON NICHOLL: You will get the cost quality access.

GUY DANSIE: We'll do that internally and bring that back to the committee.

KRIS KEMP: And that was assigned to the department, not to one of the subcommittee.

JASON NICHOLL: Motion to adjourn.

KRIS KEMP: We have a motion to adjourn. Do I have a second?

BOB GROW: Second.

KRIS KEMP: All in favor, say eye.

COMMITTEE MEMBERS: Eye.

(Meeting adjourned at 2:35 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 71 are a full, true, and correct transcription.

WITNESS MY HAND and official seal at Salt Lake City, Utah, this 26th day of January, 2016.

My commission expires:
January 19, 2019

_____
Teri Hansen Cronenwett, CRR, RMR
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