STATE EMS COMMITTEE MEETING
APRIL 13, 2016 AT 1:00 P.M.
3760 S. HIGHLAND DRIVE, ROOM 425
SALT LAKE CITY, UTAH 84106
3RD FLOOR AUDITORIUM

Reporter: Susan S. Sprouse

Garcia & Love Court Reporting and Videography
Susan S. Sprouse, CSR/RPR

A P P E A R A N C E S

Kris Kemp
Guy Dansie
Jason Nicholl
Jeri Johnson
Kristopher Mitchell
Mark Sanderson
Nathan Curtis
Bob Grow
Mark Adams
Russell Bradley
Laconda Davis
Mike Mathieu

April 13, 2016 1:00 p.m.

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KRIS KEMP: All right. Well, I think we'll get started.

Welcome to the State EMS Committee meeting, today, April 13th, 2016. I think agendas are available. We've already had the executive session where we kind of went through our agenda items to make sure we're familiar with some of the topics. And we'll go through them in greater detail during this meeting.

As a reminder, we are -- I think it should be stated, we're all in this for public service in one form or another, and we take our representation of who we do represent very seriously. This is a complex and diverse committee with a lot of different entities represented. And that we try to do things for the greater good of all of the State EMS agencies and just not one individual group or another as we've been requested to represent as such.

Introduction of committee members, I guess we can start on that end, and we'll just go through, and then we'll talk about vacancies and go from there.

NATHAN CURTIS: Sheriff Nathan Curtis, Utah Sheriff's Association.

MARK SANDERSON: Mark Sanderson.

KRISTOPHER MITCHELL: Chris Mitchell, Trauma Medical Director, Jordan Valley. Going to be at St. Mark's.

JERI JOHNSON: Jeri Johnson, rural EMT.

JASON NICHOLL: Jason Nicholl, paramedics.

GUY DANSIE: Guy Dansie with the Bureau of Emergency Medical Services and Preparedness.

KRIS KEMP: Kris Kemp, Chair.

BOB GROW: Bob Grow, emergency physician and a medical director.

MARK ADAMS: Mark Adams, hospital representative.

RUSSELL BRADLEY: Russell Bradley, rural physician representative.

LACONDA DAVIS: Laconda Davis, Department of public safety dispatch rep.

MIKE MATHIEU: Mike Mathieu, State Fire Chief.

KRIS KEMP: Great. And we've had -- Guy, if you wouldn't mind speaking to our committee changes.

GUY DANSIE: Yes. We have Margie Baker Swenson -- I can't remember -- anyway, she's been on our committee for several years; however, she is resigning due to change in her career path and so forth. I know she went through nursing school. So she's asked to resign. She'll no longer be involved with this committee. So we

will have a vacancy as a rural EMS representative and we will be open for applications and consideration for that. And that goes through the governor's committee appointment process. So it will be the governor who ultimately decides who that person is.

KRIS KEMP: Great. All right. We'll start right off and get into the Open Meetings Act. Brittany.

BRITTANY HUFF: The most exciting part of the meeting for sure.

I'm Brittany Huff. I'm Assistant Attorney General who advises the Department of Health and -- sure -- and Jay is going to give us a presentation.

JAY DEE DOWNS: Do whatever you want to do and say whatever you want to say.

BRITTANY HUFF: And then when you get sued, you have to go back and do it right.

So, by law every year, the AG has to advise any board that's subject to this act of the changes. So I'll do that in a little while.

The Legislature changes, so the ones that just passed in 2016, they are effective March 18th. The only change made this year, specified body does not mean several things and now it also does not mean conference committee, rules committee, or sitting committee of the legislature.

So the reason for this legislative change is to make sure that these super special legislative committees are not subject to open and public meetings, active requirements. That's it. I'm done. Thank you.

But really, you guys don't care about that. I think what you care about is what can and can't we do in these meetings. So that's what you are going to learn from me.

A couple of years ago, they changed the statute to say when the committee members are in the public meeting, you are free to text and email each other outside of the meeting. That's what the wording says. But what they mean is when you are in here, don't text each other, "How are you going to vote? I think this looks great." So that's what it's saying. Members cannot forward texts or send texts to each other during the meeting. There's no prohibition on the public. So all these guys can send all the texts and emails they want, but you guys can't.

So -- and the purpose behind that is to say let's make sure if you have a comment, you are going to say it, everyone is going to hear, they can rebut, they can understand why you are making the decisions you are making, not sending a text saying vote yes, vote yes, and then you guys just all secretly vote yes. Guys and girls.

GUY DANSIE: Just a quick question. What if it

it's not related? Just to clarify. Suppose it's, like, a family member, some other thing going on that we text somebody?

BRITTANY HUFF: You can do anything you'd like. You can act in any way you want. I know I was in trial. I was texting my legal secretary. The other side filed a complaint saying I was acting inappropriately. I had to hand over my whole phone. They copied my whole phone. Then when I was texting, came into scrutiny.

So you can do whatever you want. If you want to turn on your phone and you can, you know, see all of your texts between your spouse.

So that's what it is saying. Is it someone -- you know, those are, you know, always called and not controversial at all.

So you can do whatever you want, but this is just saying if it appears bad, someone could question it. It's not good.

So do you see the purpose behind it? Does anybody have any questions? Obviously, we're on our phones all the time, and most of the time it's not necessarily how to vote on the next meeting issue.

The moral of the story put your phone away. So, you know, you heard my spiel --

Okay. So Open Public Meetings Act just means

any committee that fits under the requirements has to be open for the purposes I've stated. Everybody wants to know why you guys are deciding what you are deciding. This includes a workshop or executive session. So I'm guessing the one upstairs was just open because EMS always follows the rules.

GUY DANSIE: It was open.

BRITTANY HUFF: Great legal counsel.

KRIS KEMP: It's always open.

GUY DANSIE: It is.

BRITTANY HUFF: So here are the -- this is who is subject to the public body, and I can read the definition if you want, you guys are subject to it. And if you are on another committee, you should know whether or not you are subject to the Open Public Meetings Act.

Does not include political parties or legislative conferences. The rules don't apply to them.

What constitutes a meeting, a quorum or a simple majority, through in-person or an electronic meeting? If you see somebody else or a couple of people on the committee at a soccer game or the grocery store, it doesn't count as a meeting.

The public notice, you have to give notice so that anyone who is interested in the issues coming up knows when and how to come and participate. Twenty-four

hours, it can be waived in an emergency, but really how often are you guys able to say this is an emergency, we have to meet sooner than 24 hours. If it comes up, great call me, I can show you how to do it. Also, the staff at DOH knows how to publish all this stuff.

You're required to give notice, and these are the things that notice must include: The agenda, date, time and place. The best way to do it is the government has come up with a website. And like I said, DOH staff handles the publication of the notice.

Emergency meetings, there has to be a really good reason, and it's -- that's if you are meeting under 24 hours. Otherwise, it's just a regular meeting. And you still have to post it as best as possible. You cannot hold an electronic meeting unless you have a rule in place. DOH has a default rule saying you can have an electronic meeting. The electronic meeting is if you guys put it on, you know, go to meetings or anyone can call in and listen. And on the notice, you have to say what phone number and how they can get ahold of that.

Closed meetings, usually this doesn't happen except for when EMS passes the Peer Review Board statute. So they do get to close the meeting. And so it's for very specific purposes. You have to hold an open meeting. You have to vote to close it. You can only close it for very

specific things, which include discussing individual's character, professional competence or physical or mental health, or these other things which probably won't apply. If you do close it, the chair has to fill out an affidavit and then that portion isn't recorded. So anyway, if you want to do it, it's very specific. Ask me.

You can't do the following things in closed meeting: Interview a person applying for an electorate position, discuss filling a mid-term vacancy, or discuss the character of the person filling a mid-term vacancy.

You can't take final action, you can't approve an ordinance, regulation rule, and in the closed portion of the meeting you can only discuss the things that you close the meeting for.

How to close a meeting, all these details if you really care, but you don't care until it affects you. There's the affidavit that Darren is going to be signing at the Peer Review Board.

The meeting minutes, the transcription is not the minutes. The minutes are just a summary. Who came, what they voted, what was discussed, all that stuff.

UDH takes care of the meeting minutes. You guys have to establish procedures for the minutes. That's just transcript versus summary.

And here is what the meeting minutes have to

include. You guys probably don't care. The staff that handles this knows what has to be included and should include it.

Also, there has to be an audio recording of the minutes -- or of the meeting. The minutes and the audio recording need to be posted on the website. Just also note, if you close a meeting for the certain purposes, that portion does not have to have audio recording or minutes.

Then they have to be posted on the website. The draft form has to be posted 30 days after the end of the meeting and the approved minutes must be available three days after they are approved.

GRAMA. Are you guys familiar with GRAMA? It's exploding. It's the way for public to find out how the government works. So they can -- anyone can request a government record. So they can decide, oh, I don't like the way the EMS Committee decided something, I want to go back to the beginning of time and get all the audio recordings and all the minutes, everything. So just be careful. What's said here stays for a long time, and then people can go back and it's wide open. They can get the transcript. They can get the minutes. They can get the audio recording. It's all on there.

GUY DANSIE: Just a note, Brittany.

BRITTANY HUFF: Uh-huh.

GUY DANSIE: Just for information, we had adopted a records retention schedule for EMS, and it's eight years.

BRITTANY HUFF: Okay.

GUY DANSIE: So we would have eight years worth of minutes --

SHARI HUNSAKER: No, that's incorrect.

GUY DANSIE: Okay.

SHARI HUNSAKER: Because this is an open meeting --

GUY DANSIE: It doesn't apply?

SHARI HUNSAKER: -- it does not apply.

GUY DANSIE: Okay. So it's only our EMS records. Okay. I just wanted to make sure.

BRITTANY HUFF: How long -- what's the record retention for open meetings? Is it forever?

SHARI HUNSAKER: Permanent.

BRITTANY HUFF: So don't do anything crazy because then in two years they are going to go back and ask for all of these minute meetings, you know. So, yay, it's forever. That's awesome.

SHARI HUNSAKER: Sorry, but I'm Shari Hunsaker if you needed my name for the transcription.

BRITTANY HUFF: When the meeting is closed for

certain purposes like collective bargaining or purchasing property, it still has to be audio recorded and minutes, but they are closed. They don't go on the public website. If someone wants it, they can -- it's a protected record under GRAMA. They can go up on appeals and go to court and get it. I know none of you guys care about this, but it's going in your reign and in case it comes up, then you'll know.

If something -- an action is taken here, someone can dispute it, go to court. And if the court says yep, you were wrong, you have to go back and redo the action. And if you are really wrong, you may have to pay attorney fees to the other side.

Disruption of a meeting, any person, anybody can be removed from a meeting if they are disrupting. That does not constitute a closed meeting.

And I don't like the wording of this one, "A member of a public body who knowingly or intentionally abets, advises or violates any of the closed meetings, provisions of the chapter is guilty of a Class B misdemeanor." How can you be guilty if the law can't determine you are guilty? But whatever. So don't violate this stuff. It's bad.

Does anybody have any questions? No questions. Just, you know, do the right thing, be on the up and up.

It's recorded. If you have any questions -- a lot of time you know ahead of time if there's a sensitive issue coming and you'll say, we might have to close this, or there might be a lot of controversy or you can ask ahead of time.

So nobody has any questions. No, today I'm not here to talk about this, but are you guys aware that SB126 previously Department of Health committees that had rule-making authority were independent and had the final say on rules? An issue came up with not an EMS Committee, and the legislature changed the law that now the department has the final say. If the department disagrees with something the committees do, and there's a dispute, the department does have a final say. So again, you don't care about that until the issue arises.

So, no other questions? Nothing? Okay. Guy knows when to call me. So call Guy and complain to him.

KRIS KEMP: Thank you. All right. So we'll jump right into our action items, including the approval of minutes. They've been sent out. And so if we've had an opportunity to review those, I'll accept a motion and a second.

MARK ADAMS: So moved.

KRIS KEMP: We have a motion.

MIKE MATHIEU: Second.

KRIS KEMP: And a second. All in favor say aye.

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? And any abstained? Thank you.

We'll move next to Mike Willits to discuss Sevier County EMS paramedic staffing waiver.

MIKE WILLITS: Mike Willits for County EMS Director.

GUY DANSIE: Hold on, Mike.

MIKE WILLITS: Mike Willits for County EMS Director.

Committee members, I came before you about a year and a half ago and expressed our desire to become a paramedic level service for Sevier County. We found that we needed to do -- accomplish quite a few things before this staffing waiver would be approved.

And since that time we've put together a paramedic course with 15 members of our EMS in that course. We're now at the very end of that course looking towards within the next few weeks or weeks to take our national registry testing.

So I'm before you today asking for the waiver to go paramedic as available in our system.

Any questions?

KRIS KEMP: I do have one specifically. Can you

discuss your plans for improving or increasing your service over the next few years?

MIKE WILLITS: We have -- in our budgeting we've set aside extra monies to continue paramedic training over the years. So as attrition or increasing, we do have the ability in our budget to continue our education.

KRIS KEMP: In the paperwork that you sent us, the plan for operation for Sevier County EMS, on page 6 you state on noted paragraph E and F some very interesting things. Do you care to comment on those?

MIKE WILLITS: We're -- what we're talking here is it talks about being able to run as a paramedic 24 hours a day.

A few things we have in place in Sevier County is we have five full-time EMTs with a part-time staff of about 85 EMTs staffed throughout our whole county. In our 15 that are in the class, four will be full-time EMS paramedic. They are on call at least two per day and at least one will be on call through the evening for any, any problems or paramedic level needs at that point. So that would be our full in-house staffing.

And then we have the benchmark of going full time in 2020. We foresee being able to get this program taken care of and implemented in our area and increasing our ability to cover it as a paramedic with either an EMT

or an advanced EMT as our secondary. We currently run as a three EMT coverage per ambulance. So does that answer your question?

KRIS KEMP: Yeah. So basically what you state here is that by no later than July 2017 you are going to have one 24 hours-a-day paramedic?

MIKE WILLITS: Paramedic and more available through on-call.

KRIS KEMP: Right. And then by July 2020, you are proposing that you will have two paramedics 24 hours a day?

MIKE WILLITS: Right. Correct.

KRIS KEMP: Points to discuss on the committee?

JASON NICHOLL: I just wanted to clarify that this is an application for a paramedic ambulance service with staffing waiver, correct?

MIKE WILLITS: Correct.

JASON NICHOLL: Okay.

MIKE WILLITS: Okay.

KRIS KEMP: Other points?

I think one thing that we mentioned in our executive session was that of all of the staffing waivers that we've made for paramedic when available, none have produced a plan that's as robust as this and is complete. And that is to be commended and hope you will be able to

accomplish these benchmark goals you've placed for yourself. It's kind of an example that we would hope to see from anyone that is going to paramedic when available to increase those service lanes in their communities.

MIKE WILLITS: Thank you.

KRIS KEMP: Any other questions or concerns? All right. So I guess we are looking for a motion and second for approval of this waiver application.

JASON NICHOLL: So moved. I make a motion that we accept.

JAY DEE DOWNS: Second.

KRIS KEMP: Motion a second. And all in favor say aye.

COLLECTIVELY: Aye.

KRIS KEMP: And any opposed? And any abstained?

NATHAN CURTIS: I abstain just because it' my agency.

KRIS KEMP: Thank you for pointing that out. All right. Thank you.

MIKE WILLITS: Thank you.

KRIS KEMP: All right. Guy, you are next with R426-5.

GUY DANSIE: All right. There were some changes made, some small changes made in this one section. It's Section 2700 of this rule. It should be in the packets so

you can follow along at home.

In the very first part of 426-5-2700, Part 1, it talks about an EMD. This is new language we wanted to add to allow EMDs who have background checks performed by the Department of Public Safety, allow them a -- to take that background check in lieu of having us perform a second background check in their behalf.

Currently the rule reads we have to perform a background check for every individual and we're just simply allowing those that have already had a background check and then have been approved through public safety to perform their duties as a certified EMD.

Any discussion?

MIKE MATHIEU: Guy?

GUY DANSIE: Yes.

MIKE MATHIEU: Just one question. Why, why the use of "may" instead of "is not required"? Why "may not be required"?

GUY DANSIE: We just --

MIKE MATHIEU: Why not just say "is not required"?

GUY DANSIE: We could make that change if you'd like.

MIKE MATHIEU: The only reason I'm saying that is it sounds like at any point in time, you could just

require it randomly.

GUY DANSIE: Maybe cut it down and keep it a little clearer?

MIKE MATHIEU: Yeah, because it says if they've already gone and cleared with a background screen by Utah Department of Public Safety is not required to have an additional background screening, rather than maybe. I don't know why you want maybe. Because then you can always just randomly require it.

BRITTANY HUFF: "May not require" doesn't mean the department gets to randomly say we change our mind on you. It means -- it's allowed. So they cannot randomly say, well, the rule says may not, but we're going to require it of you. So changing it to "shall not ever" means they can never run a background screen. So leaving it as "may" gives them more flexibility.

MIKE MATHIEU: I asked what was wrong with "is not required". I didn't say "shall." Why do you have "is not required"?

BRITTANY HUFF: Because "may" is the correct terminology for rule writing.

MIKE MATHIEU: Confusing.

BRITTANY HUFF: I know. Try this. Actually this works.

MARK ADAMS: Arguing with the lawyer?

MIKE MATHIEU: Why not?

KRIS KEMP: Okay. Any other comments or questions from the floor?

TAMMY BARTON: Tammy Barton representing ambulance. So does that only go for EMDs or what if we have, like, our police officers that take an EMT class? Will they also be?

GUY DANSIE: We had that discussion in the Rules Task Force, but we weren't comfortable in adding that at this point. I -- I'm not sure if our department feels comfortable with that idea at this point. I think it's a future thing that we would consider.

This -- I think the problem we had with this is we're moving to the new live scan fingerprinting background check. It's quite cost prohibitive for dispatch services and they are already performing that for their individuals. So it doesn't make a lot of sense for us to do it again for the same people.

Jason did bring that up in the Rules Task Force, I point that out. And we discussed that, but I don't think anybody was ready to make a suggestion on language. So --

JASON NICHOLL: Patient care. Also EMDs are not involved in direct patient care.

GUY DANSIE: Yes. Correct. We feel there's

probably less risks in department oversight for EMDs than there would be for other individual patient care.

KRIS KEMP: As a counter point and along those same lines, as a physician, I get a background check every hospital I try to go to. So even though they are working for two different agencies that maybe have some similar oversight, it's expected that they are going to have background checks done through each one of those. With the EMDs it seems to be there's not as much risk if they've already produced one from that public safety -- services -- or safety entity. So...

GUY DANSIE: Right. And we're requiring verification from the centers on the individuals as they've passed. So we have to have that validation from them before we're allowing them inception to the background check rules.

KRIS KEMP: That's an excellent point, though. Thank you for bringing that up. All right.

GUY DANSIE: Okay. Next part of the rule, if you'll -- it's a couple of pages over. And this portion of the rule, the numbering is very complicated. But you can see we highlighted it yellow, I hope. All the copies that you have, have yellow highlighting. It's a capital A is where it starts. It's struck out. It says, "Any felony or Class A under the Utah Criminal Code not listed

in R426-5-2700, Part 6(A)(I)," that was asked to be struck out. The Rules Task Force agreed to this because they felt it was a catchall kind of a one of those clauses that may be a little ambiguous because the other titles and things are -- were specified in here, and they felt that that was adequate.

And I'd invite Darren Park if you have any comments to -- not saying you need to, but if you -- if we have questions or anything on that.

DARREN PARK: Absolutely.

GUY DANSIE: As I move down, there's a part C that's been struck out, any felony or Class A, B, C under the following Utah criminal codes. There's a big I portion, a big double I, and a big triple I. Those have all been struck out feeling that it was redundant language because these things are already described in the language above.

I'm leaning toward Darren because he's actually the one that helped develop these concepts.

DARREN PARK: It's actually G not C.

GUY DANSIE: G. Okay.

DARREN PARK: And because the specific offenses listed are all covered under F, which encompasses the entirety of Chapter 10 under Title 76 --

GUY DANSIE: Okay.

DARREN PARK: -- it's redundant.

BRITTANY HUFF: Yeah. So F says anything under 76-10 and then G talks about things under 76-10.

DARREN PARK: Yes.

GUY DANSIE: Correct. All right. So that's then approved to be struck out by the Task Force.

And then if we move down, there was another phrase, L. It's a little bit confusing because we drafted this once and approved it, and now it's being redrafted. So it's been moved to strike out that language in the old part L that said, "Any criminal conviction or pattern of convictions that may represent an unacceptable risk to the public health and safety." And I believe the argument for that was it was -- it was a kind of a catchall ambiguous type language in the rule.

And those are all the changes that are proposed for this rule at this time. Any discussion or?

KRIS KEMP: Anything from the Committee? Points to be made? And anything from the public? Clear as to why these are made? It's mostly redundancy that we are just taking it out.

All right. This is an action item for approval of these from the Rules Task Force?

GUY DANSIE: Yes. And also just for note, on the agenda there is a discussion about criteria for

patient observation. And there has been a project that the Rules Task Force has been working on. I put that on the agenda thinking that maybe we would be ready for that as an action item, but we were not. Therefore, I'm not proposing that we add any criteria for patient observation at this time, or that's not part of our rule change at this point.

KRIS KEMP: All right. So do we have a motion to accept the Rules Task Force recommendations?

JERI JOHNSON: I make a motion.

KRIS KEMP: A motion. And second?

NATHAN CURTIS: I'll second.

KRIS KEMP: Thank you. All in favor say aye.

COLLECTIVELY: Aye.

KRIS KEMP: And any opposed? Any abstained? All right. Thank you.

Let's see, Cost Quality and Access Goals. Guy.

GUY DANSIE: Okay. This is an assignment that I was given in our past EMS Committee meeting. It was proposed that we simplify the existing rule for cost quality and access goals. And that rule is R426-3-600. And we have a copy in the handouts in your packet.

And in order to simplify, the intent was to put the onus onto the municipalities rather than on the EMS providers. And so the language reflects that change. You

can see that we struck out some of the existing language and clarified that with the underlying language. Basically, it is -- it's allowing a little more flexibility and not as much detail on what is required for these goals.

KRIS KEMP: All right. Anything to discuss along those lines from the Committee?

JAY DEE DOWNS: Did this come from the state law, didn't it, where they wanted us to work on it?

GUY DANSIE: Yes. The statute was passed a year ago. We passed administrative rule in October of last year, was made effective. And then with some of the discussion we had after the rule was placed into effect, we felt that maybe it was a little too stringent on some of the detail. So it was proposed in our meeting last -- in January that we adopt a version.

And Jason actually -- Jason had worded some of that and then proposed some of the changes to the committee. And I have, like, reworded some of that to be consistent with rule language.

JAY DEE DOWNS: Okay. I just wanted -- the rule is effective because of the law.

GUY DANSIE: Yes. Yes.

JAY DEE DOWNS: That's what I was thinking.

GUY DANSIE: This isn't based on changing the

statute.

JAY DEE DOWNS: Right.

MIKE MATHIEU: So Guy?

GUY DANSIE: Yes.

MIKE MATHIEU: In practical terms, a service provider that has a service area of multiple governmental jurisdictions upon their need, relicensure will need to go in and ensure that those local governments have to -- they only adopt one set of how many goals related to EMS in regards to cost quality and access, and they would have to get those approved by those government entities in order to be relicensed.

GUY DANSIE: In the existing language, that's how it's worded. In this new language, we're putting the onus back on the municipalities.

MIKE MATHIEU: Well, it wouldn't be just municipalities. It would be counties, any government entities served by a provider?

JASON NICHOLL: No.

GUY DANSIE: I believe the statute is municipalities, but we'll look into that further. The point of this change is we did not want to withhold somebody's license as a provider if they are having difficulties with a municipality or government agency doing their part. And if there is an issue, then they are

the ones that are on the hook for not doing it in statute, not the provider.

And also the existing language we've recommended that they do it every two years, and this simply says they need to do it upon every license cycle. It takes the burden off of the provider to some extent. You still are encouraged to do it, but the responsibility lies with the municipality or the government agency.

BRITTANY HUFF: So does the provider not get their license renewed if the municipality hasn't done it?

GUY DANSIE: That -- in the effective language we currently have, that's how it's done.

BRITTANY HUFF: But the new language changes it to say --

GUY DANSIE: That it's the responsibility of the government agency, not the provider.

BRITTANY HUFF: And the provider will get relicensed?

GUY DANSIE: Yes. Yes. We don't want to create a hardship for the provider if there's a difficulty in getting the -- their cost quality and access goals.

KRIS KEMP: Okay. Any further discussion on the cost quality and access goals as in rule to discuss?

MARK ADAMS: Do these changes require public posting?

GUY DANSIE: Yes, 30 days.
MARK ADAMS: So just like any rule change. Okay.
KRIS KEMP: Anything else? From the public?
Okay. Well, these are proposed changes to the cost quality and access goals, Rule R426-3-2600 for ground ambulance providers. We have these changes. Do we have a motion to accept?
JAY DEE DOWNS: So moved.
KRIS KEMP: And a second?
MARK ADAMS: Second.
KRIS KEMP: All right. All in favor say aye.
COLLECTIVELY: Aye.
KRIS KEMP: And any opposed? And any abstained? Thank you.
Moving on. Shari, R426-9, Trauma Rule.
SHARI HUNSAKER: My name is Shari Hunsaker. I'm with the Bureau of EMS and Preparedness. And one of my responsibilities is to work with the trauma program managers forum and to the trauma user group in the maintenance of all our state trauma registry. I'm going to give you a brief primer on the trauma registry itself. And I promise will be more than you ever wanted to know, but you'll need that context to be able to fully consider the change in the rule that is before you.

Historically we have followed the national trauma data standard data dictionary for our trauma registry. We've also maintained a separate Utah trauma registry data dictionary. And there was an awful lot of duplication between them.
We, in our Utah data dictionary, included the national elements as well. And rather than being a comprehensive source for our hospitals to use, it became exceedingly frustrating for them because maintaining two separate documents and having them coalesce is virtually impossible.
About a year and a half ago, the trauma program managers forum as well as the trauma user group agreed to change the format of our data dictionary in the state. So we adhere to the national trauma data standard. And now all our data dictionary is only addendum for those additional state required elements for our trauma registry.
That prompted a discussion about aligning our inclusion criteria with the inclusion criteria of the national trauma data standard. So for a patient to be included in the national trauma registry, they have to have been transferred via EMS. They have to have a diagnosis within a certain range.
Utah had added some additional criteria such as

if they were transported by air ambulance at any point in time, they were automatically in the trauma registry. And what we proposed to the trauma system advisory committee is aligning our inclusion criteria with that of the national standard.
The point that became a major source of discussion was that the NTDS leaves up to each state to define a hospital admission. And we had faced the fact that different hospital systems were defining hospital admissions their own way. And so if we -- our previous definition was if the patient was admitted for 24 hours or longer, and the ambiguity there was that at the University of Utah they may be in an observation bed for more than 24 hours, but they are never formally admitted at the hospital and so they were not being included in the trauma registry, even if all other criteria was met.
And so what the Trauma System Advisory Committee proposed is that we define a hospital admission as any stay in the hospital from the moment you arrive in the emergency department until you leave the hospital of 12 hours or longer. We did a data analysis and determined that that will increase the population of our trauma registry by roughly 1300 records per year. Last year we had 13,000 records -- well, in 2014 we had 13,000 records that were input into the registry. With this change we

would anticipate that that number would go up between 14,000 and 15,000.
So, the change before you in Rule 426-9 basically replaces all references to ICD-9 codes with ICD-10 codes. It eliminates the inclusion criteria that if you are transferred at any point via air ambulance, you're automatically included in the registry. And it defines a hospital admission as being in the door and out the door greater than 12 hours. The State is declaring that an admission for the purposes of the trauma registry inclusion criteria. For those of you not asleep now, I'm done.
MIKE MATHIEU: It was clear.
KRIS KEMP: All right. Thank you.
Any questions for Shari?
DR. PETER TAILLAC: Kris, if I may. Peter Taillac.
I -- oh, I just wanted to mention to the group as well that these changes were discussed at length and passed by the Trauma Advisory Committee. You probably said that earlier.
SHARI HUNSAKER: That happened before I took these to the Rules Task Force.
MARK SANDERSON: I just have one quick question for clarification. Prior to the 12 hours the patient

expires, they are still included in the trauma data?

SHARI HUNSAKER: Any death related to trauma, yes.

KRIS KEMP: All right. Any other questions, concerns, points from the Committee and from the public?

MARK SANDERSON: One more question -- clarification. From a facility's standpoint, if the patient's transferred out but admitted, if we fly a patient from mountain point and fly them to IMC, they are admitted there, who's responsible for the trauma registry data information? Is it IMC or would it be the transferring facility?

SHARI HUNSAKER: They may both be responsible for inputting a record. If the patient arrived at the initial facility via EMS and they stabilized and transported to definitive care, then -- and the patient met all other criteria, then the initial facility would input a record into the trauma registry, and the receiving facility would do the same.

We do have situations where, especially with pediatric patients, they meet the inclusion criteria at the initial facility, but they don't meet the initial criteria at Primary's because Primary discharges them.

MARK SANDERSON: Right.

SHARI HUNSAKER: And that's a whole other issue

that we need to address with over and under triage. But there is a possibility that when I look at these records, I'm not looking at distinct patients, I'm looking at the total number of records. So just like with EMS where there may be more than one patient care report, because more than one agency was involved in the transfer of that patient, or in the care of that patient on scene, so too in our trauma registry, we may have more than one record for the same exact incident because they were seen at two different hospitals and met the inclusion criteria at each.

KRIS KEMP: Okay. Any other concerns, questions, comments? All right. Well, these are proposed changes --

SHARI HUNSAKER: Thank you.

KRIS KEMP: -- to R426-9, I believe 700. So do we have a motion to accept?

MIKE MATHIEU: So moved.

KRIS KEMP: Second.

RUSSELL BRADLEY: Seconded.

KRIS KEMP: Great. And all in favor say aye.

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? And any abstained? Thank you.

Next is our proposed EMS rates, R426-8.

GUY DANSIE: While this is setting up, I just wanted to preface for a presentation about the rates with some wording changes to the Rule R426-8. If you'll look at that in your packet. The changes were designed to have the rule read similarly to the rest of our rules. This particular rule has been perpetuated year after year as rates have been changed without any changes to the wording.

We've done an extensive change to the other portions of rule. So we've made the following -- the changes noted in here to bring the wording into agreement with other language. Thanks. Brittany is over there smiling at me.

BRITTANY HUFF: Yes.

GUY DANSIE: And then also there's one other thing before Alisa begins. I have a couple of typos on strikeouts. I just want to point those out. Those were not on purpose.

Down on the bottom of the front page it says -- it's R426-8-2, Part 4. Well, excuse me. There's Part 3 right at the bottom. On Roman Numeral IV there is a strikeout of the transportation rate. That -- no, it's a paramedic board.

JASON NICHOLL: That's the --

GUY DANSIE: Yeah, the paramedic board fee.

That has not changed. We're not -- the strikeout should not be there. I won't put it in as it goes out to public comment.

And then also the mileage rate Part 4(A), there's an inadvertent strikeout that was left in there. I just wanted to let you know that those two rates are not changing.

Now I'll turn it over to Alisa.

ALISA HARDIN-LAPP: Thanks. My name is Alisa Hardin-Lapp. I am with financial resources in the Division of Family Health and Preparedness. And this year we had a new updated fiscal reporting guide, an FRG, which I'm sure most of you are aware of.

So our ambulatory rates were set according to those new FRGs that were submitted. So this year it was a smaller sample size. And like I said, that's due to the new rates. So next year we will have a larger data set for that.

So we used 40 percent of the agency's data. Because we had a smaller sample size, we used a larger limitation range. And that is so we could include more of the data. And we also had a larger limitation range in order to weed out some of the outliers. So there were some agencies that, for example, showed an extreme deficit or a large profit. And so we -- we set this limitation

range so it couldn't skew the data.

This year in the FRG, some of you may have noticed, that we requested total asset information. And because we request that -- we requested that because we needed to look at the net income limitation test. And so according to rule, an agency is not able to go over 8 percent of gross revenue or 14 percent of their return on average assets. And so this year we tested that, and 29 percent of the agencies who turned in an FRG failed that income limitation test.

So, this is an example of -- kind of this graph right here is what my data sheet looks like. So for each of these boxes, these line items, you'll recognize from the FRG. And this box is actually the average of all of the data put together.

And so really the only thing that changed this year, in order to compute the ambulatory rate is we had a different data from the updated FRG. And this formula right here changed. So previously we only used the billed transports and we didn't include mileage or surcharges or other revenue sources that go into a billed transport. So we did the total of billed revenue and then took out the adjustments and divided that by the number of annual transports that that -- that you record on the FRG.

So we got a number from that, and then we -- we

take that number and put it into a percentage. So that 1 percent right there, that's averaged out from every single FRG. So the increase rate this year is 1.5 percent.

So on this slide, it shows the current rates that they are right now. We took the one and a half percent and now we have the new proposed rates. And there it shows the percentage change from the prior year. And like I was saying, this third line is a new rate that we -- that we have for this year. All of the other rates are staying the same just due to the fact that we had two small of a sample size and next year all of the other rates will be looked at.

And this slide just goes and shows some historical data. So you can see this year the rate increase is not the lowest it's ever been, but it certainly isn't the highest either. And we are proposing to have these new rates in effect by July 1st for the state fiscal year. We'll have the filing deadline on Monday, May 5th. And then this will be opened for a 30-day public comment and that will close June 14th to have a July 1st effective date.

Are there any questions? Perfect.

GUY DANSIE: Thank you. I failed to mention one part that we discussed at our previous meeting and Alisa

alluded to that. There was a new rate that was set with the intermediate advanced agencies or providers that we have. There are two of those in the state, and historically we've allowed them to operate and function as intermediate advanced licensed levels. They've agreed to lower their license level to an AEMT level to combine license. So license types will be combined and consolidated.

However, they did not want to give up their skill set. They have people that are trained to do additional skills. And as part of that compromise to bring them to the AEMT license level and still allow them to do this extra skill set, we added language in 426-8-2, Part C. It's underlined. It says, "Advanced EMT ground ambulance" -- it should be -- the S on there, EMS, who was prior -- who were prior to June 30th, 2016, licensed as an EMT-IA provider, we set a rate at $1,149. That's the mid point between an AEMT licensed rate and a paramedic rate. And that was part of our compromise to bring them down to that level and still let them do those extra skills and provide those services to their communities.

ALISA HARDIN-LAPP: I have one other thing to say. Sorry. This sheet has all of the proposed -- the new rates on it, and it's in right when you walk into the room. So you all can take one. We'll also post this on

the website as well.

GUY DANSIE: And I'll send that out to all the directors as well through our email server.

KRIS KEMP: All right. Any discussion about the rates, rate's changes, how we got to this rate change, implications? There seemed to be a healthier discussion upstairs.

NATHAN CURTIS: There's a lot that went into it.

RUSSELL BRADLEY: We did have a discussion about the data set. It seems pretty small at only 40 percent, but, you know, that would be rectified in the future, too, when we get more of the agencies reporting that fiscal data and then reassessment will be done.

GUY DANSIE: Correct. And let me just expand on that a little bit. Part of the issue is we have to set rates by July 1st for the fiscal year. Our Medicaid reimbursement rates are now predicated on our base rates that are in rule. So we only would like to have that rule updated annually and starting July 1st of each year. So that's part of our problem. We wanted to go ahead and offer the rate increase and get the ball rolling, so to speak, and then next year we'll look at the full set of data to set a rate.

KRIS KEMP: Other discussion points?

NATHAN CURTIS: Thanks for the hard work.

KRIS KEMP: Anything from the --

RUSSELL BRADLEY: We did also have a discussion that, you know, that 29 percent of the agencies that failed the income limitation test, that those monies go back to governments. So it -- so we did have a discussion as to the -- when failing, that doesn't necessarily mean, except a profit entity that that might be monies that are wound back into government. We had a pretty big discussion about that. So with that people should be aware that this failure doesn't mean that somebody is making an awful profit. Is that money is then given back to the local governments for nonprofit agencies. I felt that was important to know.

KRIS KEMP: And that's where the challenge comes because we haven't yet done anything in the past with anyone that may be going above the rule as in noted R426-8-2, Part A, where it says the net income limit shall be greater -- the greater of 8 percent of gross revenue or 14 percent return on average assets is what to do with anyone that falls outside of that rule on the top end. And I think that most agencies that are -- how did you put it, Jason, generally funded.

JASON NICHOLL: A general fund under --

KRIS KEMP: General fund through a municipality. That that money goes back into the municipality and is

very difficult for us to ascertain that that is specific to the agency. A lot of agencies aren't set up to where they have total control over those dollars unless you are in enterprise?

JASON NICHOLL: Enterprise, yeah.

KRIS KEMP: Set up that way. And so that's something to consider as well. So we haven't yet done anything about anyone that falls outside those rules except to note them. So there will be more information to come. We feel like the dataset wasn't complete based on those fiscal limitations, but yet this is at least a move in a safe and measurable, explainable direction because otherwise there wouldn't be a rate increase for two years.

Any other questions or concerns?

TAMMY BARTON: Tammy Barton representing ambulance. One of the things we were talking about is because on the new FRG, it had appreciation. That might have skewed this first time around because that was something new to all of us. So we're hoping you get it right.

KRIS KEMP: And that's noted. There's a lot of moving parts to this. We're looking at new data. That's why we're not really making any big jumps. As we saw on the slide presentation, you can see that there have been years where your -- yeah, up to 15 percent rate increases

back in 2010. So we're obviously not making any large jumps on a rate increase. We're only going to 1.5 percent or there about. But at least it's safe based on a reasonable level of reporting agencies with 40 percent. They were actually relatively large agencies from what I gather.

So with that, is there any other discussion points or clarifications needed? All right. Well, this is an action item as well for a rate increase.

GUY DANSIE: And the rule.

KRIS KEMP: And the rule changes as noted with those strikeout typos being changed. Do we have a motion to accept.

RUSSELL BRADLEY: So moved.

KRIS KEMP: All right. And a second.

KRISTOPHER MITCHELL: Second.

KRIS KEMP: All right. And any opposed -- or wait. Excuse me. All in favor say aye.

COLLECTIVELY: Aye.

KRIS KEMP: And any opposed? Any abstained? Thank you.

All right. Subcommittee reports and action items. Eric, would you like to discuss operations update and ventilator guidelines?

ERIC BAUMAN: Hi. Eric Bauman with the

operations subcommittee. And we were tasked as a subcommittee to look at transport ventilators and the committee has been doing extensive research on what transport ventilators are out there, what's being used, and what capacity they are being used in. And what we are finding is that they range anywhere from simple to complex. And it's really based off the needs of the committee and medical directors.

And so, we've done some research and we have ready to present to you three particular transport ventilators that we've researched. And I got that. I can present that to you shortly after we leave.

KRIS KEMP: Okay. I think part of the question specifically was, is this something that can be done safely, routinely? Is this something -- because again, some of the questions that I have specifically about ventilators, was operating a ventilator might be more difficult than just being trained on how to operate a ventilator. Whereas, I think as any of the physicians in this room note, a lot of things that go wrong with patients that have airway compromise and need ventilator assistance. And I think that most other EMTs and paramedics also can recognize that there's a lot of bells and whistles that happen, and I've yet ever to see a ventilator operate without some form of alarm going off.

And with the data that's very clear out there that states a ventilated patient does better on short and long-term outcomes than someone who's just being bagged, is there a safe methodology that we can have to support ventilated patients by ground ambulance?

And I think that was part of the specific question, not necessarily what ventilators are out there and could be used. I think that is useful information, but I think that the specific task question was, is this something that should be promoted in paramedic or nonparamedic or ground ambulance personnel in general? Because I hear even from nurses that work around ventilators quite often and the physicians, that they are not comfortable with that concept but yet others are.

ERIC BAUMAN: And I'll let Von speak to -- I'll let Von -- I know the Professional Development Committee has done a lot of work on the education behind that and answer that question. I'll include with you some of the education that we've looked at per ventilator and the critical specialist and what they provide. But I think it's probably best if I let Von speak to that question in terms of curriculum and recognition of whether or not that's the best role for ambulance.

KRIS KEMP: Terrific.

ERIC BAUMAN: Just real quickly not to -- it's

not on the agenda, but I think important to mention, I made a commitment to all of you in the last meeting and over the last year that we would have the SFA catastrophic earthquake plan completed by this meeting. I'm happy to tell you that it is completed. It's been a tremendous amount of work on behalf of the committee. And so huge thanks to them.

The -- all of the work is completed. It's been turned over to Andrea Baxter who is an intern with the Bureau. She's completing the actual writing of the plan. But I think it's a very quality product and you'll be happy with it and that will be completed. So I think from this point forward the committee will be finished with that.

KRIS KEMP: All right. Thank you. Is there anything specific about that summary or is there going to be a presentation involved with that or --

ERIC BAUMAN: Yeah. So after Andrea writes the plan, it will go back to Mindy Colin for a final review, and we'll present that to you. So we could physically present that to you at the next meeting if that's something you would like to see.

KRIS KEMP: I think that's reasonable.

JASON NICHOLL: Mr. Chair, if I could.

KRIS KEMP: Yeah.

JASON NICHOLL: I sit on the Operations Committee also with these as the committee advisor. And I want to say that I'm exceptionally proud to be able to work with Eric and Chris Delamare who have done the lion share of the work on this. And I just want to make sure that all the committee members know how hard this project has been and that these -- specifically these two gentlemen -- Chris, stand up Chris. Come on. That Chris and Eric have done a marvelous job and they deserve our gratitude for it. That's all I've got to say.

KRIS KEMP: Thank you for that comment. Thank you very much. Any other questions? Any questions? Comments?

GUY DANSIE: Just of note, Andrea was going to come today to present, and I didn't get her on the agenda, and she's running a little bit behind on a couple of projects, so I will have her here in the July meeting to present on injury, control cert of prevention injury -- I can't even -- my tongue is getting tied. She has a presentation on injury prevention that she's performed a survey throughout the state. And so we could probably have her and you or whoever present as well on the plan, the EFSA plan.

ERIC BAUMAN: Okay. Thanks.

GUY DANSIE: Thanks.

KRIS KEMP: All right. Professional development update on critical care transport certification guidelines review and disease testing of individuals exposed to blood borne pathogens. Von Johnson.

VON JOHNSON: Von Johnson with the operations subcommittee. First of all, let me address the second issue first and the fact that we weren't aware that we had been tasked with that. We believe that that should be an operations committee as far as the blood borne pathogen testing. So --

GUY DANSIE: It may have been I just did an agenda error. I apologize for that.

VON JOHNSON: So if we need to look at that, we'd be happy to do that, but up to this point we haven't approached that at all.

So coming back to the critical care transport issue. We've talked that the Bureau had decided quite a while ago that there would not be any licensure of any individuals or agencies in regards to critical care transport. And so because of that, it was discussed. There is a curriculum that has been discussed and prepared. And this was based on the, I believe it was the University of Maine's program that would be approved to use for agencies that so desired, but that we didn't really have anything in place that we would want to say

yes the Bureau is approving this particular thing for that purpose.

So the other discussion that we had in regard to that was the fact that even agencies who accept that if they trained to that level, if there were an audit then on that agency by anybody, Medicare, Medicaid, that they would be able to say this is where we stand with our training. So the discussion was it's kind of an individual agency thing.

The other side to that is the fact that our state ambulance rates are much higher than Medicare and Medicaid for reimbursement for critical care transports anyway. So we felt like since that was the case, most agencies would not be billing for that level of service.

In addition to that, we were discussing the use of transport ventilators and the requirements for that. We felt like that it kind of became a moot point with the -- with what type of ventilators and that kind of thing. The 2009 EMS education standards have included transport ventilators at the EMT level as far as monitoring those, but it doesn't say what type of ventilator or anything like that. So we're going to revert back to the Operations Committee to continue their research on which types of ventilators are out there, what's available, and at what level we should kind of

address that. And I think that's all.

KRIS KEMP: Okay. Any specific questions then? Thanks for looking into that.

I think the question to still answer -- that is left unanswered about ventilators and transport with different certification levels. I see it as a gaping hole in service lines. We do have agencies who are doing it and have done it, and I'm assuming safely, but has there -- you know, I guess I look back at the data and that's where I would see a gaping hole as looking for, you know, opportunities for improvement, quality improvement and is it necessarily something that we need to know as a committee or is this an individual medical director decision? And I think that's where it ultimately lands right now. Because it is part of the optional equipment that you can have on your ambulances, is a transport ventilator.

And I think we're just -- I don't know what to do with that. I still don't know what to do with that amount of information because I go to nurses, I go to other EMTs, I go to other paramedics, and they feel amazingly uncomfortable with it, but yet there's agencies out there still doing it, doing it, and have been doing it. It's not a new thing. You know, there's recently another agency that's just picked up using transport

ventilators. And I just -- I'm -- I'm curious as to see how that process can be maintained in a higher quality and safe environment. Peter.

DR. PETER TAILLAC: Peter Taillac. So I think, Chris, this has been treated like other things that agencies do when they take on inter-hospital capabilities. And several -- quite a few agencies in the state have requested formal variances with an expanded list of sort of transported medication and transport devices in order to facilitate our hospital work.

I think the intermountain program that trains the ED nurses to actually work with and on board with the medics, ambulance for transports is really laudable, and I'd like to see -- personally like to see that replicated more and more in agencies around the state that do this.

But ultimately, I think you're right. It's the medical director's responsibility and the training officer's responsibility to make sure all medications and devices are -- medics are trained up to use them properly, know how to manage complications, know when to turn them off and on, et cetera. There really is no overall arching state guidance for this at this point. Like many things, it rests with the medical director.

That being said, I personally am not aware of any ventilator related issues in transports that have come

up, like ever, that I'm aware of, but other people may be.

KRIS KEMP: And that's -- that -- I hear exactly the same things. My concern is I see a patient sitting there or laying there with a ventilator, and I see those things happen. I know that they happen. So whether there's not a reporting of it or that, you know, minor alarms and then just turning the vent off and then bagging the rest of the way isn't considered a feasible negative reporting outcome as I would think it would be, that's, I guess, the question. And that's -- it still seems to be in question that's unanswered, other than having to fall back on the medical director saying understand that liability is there.

And I just in a critical care world as an ER physician I live in, you live in, Bob lives in, it's hard to divorce the criticality of the patient from the tool that we're using to keep that person semi-staffed.

DR. PETER TAILLAC: Your point is well taken. These are by definition critically ill patients. So the vent is one piece of an otherwise complex critically ill patient treated in the back of an ambulance for an extended period of time. The point is well taken.

KRIS KEMP: So from the professional development, the issue of critical care transports is as it was before, the State, you're not making any

recommendations to change the way it has been --
VON JOHNSON: Correct.
KRIS KEMP: -- to improve or increase the level of critical care transports?
VON JOHNSON: Our recommendation is that there is a curriculum available if individual agencies choose to use it.
KRIS KEMP: Okay.
VON JOHNSON: But not from the State?
KRIS KEMP: Comments?
KYLE LINDSAY: Yeah. Kyle Lindsay, Logan City Fire Department. I just want to address, Dr. Kemp, one issue we did identify in training our guys on ventilators and to show how we do and hopefully give a little bit more confidence to this, but that's where on training our department on ventilators, they noticed they could run the ventilator but something simple as tidal volumes were vastly -- were big large tidal volumes and met with my medical director and says, look, we've got to address -- we added a module on, you know, hey, this is really an ideal body weight, simply learn from our guys, what a true tidal volume should be. We identified that weakness in our program and added a module, hopefully make us more safer. I just want to share that, that's something we've done.

KRIS KEMP: And that's specific to your agency, which is why I think this is --
KYLE LINDSAY: This agency.
KRIS KEMP: Yeah, to your agency. I think that's really important that we have that level of oversight.
And Peter, does that fall back on your desk, then, as to determine if there is that robust level of training or is it still left --
DR. PETER TAILLAC: Typically when someone -- when an agency provides or requests this sort of expanded scope for inter-hospital work for transports, I don't sort of nitpick the training module and that sort of thing. I leave it, again, up to the medical director, but they have to demonstrate that a training program will be in place. What that exactly involves would be up to the individual agency, which makes sense because there will be different equipment and different techniques and that sort of thing.
KRIS KEMP: I guess another point behind this, is that with that Intermountain program of using the local rural nurses to do transports, it's amazing the adversity in the amount of information and training and education experience that they have from, you know, running a DKA patient with no insulin with a gap of approaching 30 and near comatose.

It just -- it's frightening to me that now that I'm looking at these agencies that are doing these, and I am looking at these charts specifically to do QA and process improvement to increase the level of service of these critical care transports with this back to a method of using the nurses, I can't believe that it's not happening in every agency that's not also running these. It's -- it was just -- it's not -- babbling to see that, it wouldn't be happening, and vents are just being managed all honky dory and A-OKAY.
I just think the more perhaps, and I'm not saying anything about medical directors. I want to give them as much credit as they deserve. I just don't know if that's -- I'm being open and honest here with the 10 or so different plus agencies that I'm looking at with this program. And it's not even the EMTs. It's the nurses that do have more training, more education in a different line than EMT. And as team members it's impressive to see how much more work there is yet to be done out there. And these are ER and ICU nurses that are doing this.
So I guess that's my only main concern out there, is should there still be a critical care transport. The recommendation is there's one out that may, and we can give variances to get to that level, I guess that's where it goes.

DR. PETER TAILLAC: I recommend we keep thinking about it, you know. I don't know that I have a good answer to sort of declare a roof on the floor over the whole system because rural agencies vary so much, resources are typically limited, and they do good work with the resources they have. I mean to try and say you have to have this certain level of experience on the rig, et cetera, to do transports would be crippling for a lot of them.
KRIS KEMP: Yeah.
DR. PETER TAILLAC: Interested in the rural folks speaking about that. I think being cognizant of the fact that these are critically ill patients and treating them appropriately within their resources is the key. You know, many of these would be flown, these kind of patients from rural areas, but sometimes you can't fly.
KRIS KEMP: It goes back to the adage, we don't know what we don't know until we start to look.
DR. PETER TAILLAC: It's really true.
KRIS KEMP: Chris.
CHRIS DELAMARE: Dr. Kemp, Chris Delamare with Gold Cross.
Hey, listening to some of your comments from the last meeting when you asked us to do this, there's a lot of agencies that use these vents in different situations.

I think what you are referring to are pretty much interfacility type transports in maintaining that stability of that patient. I think we had Wayne Edginton that stood up and said South Jordan uses the vent, but uses it in a cardiac arrest situation to free up hands.

So I think -- I guess where I'm looking at this is it's so broad because there's so many different uses for different style vents, that I don't think you can just say this vent for this type of situation on anything.

But going back to, I would almost say, I think the data that we need to look at is where are these vents being used? Are they more in the urban areas, or are they also in the rural, and I'm not saying that they don't. I think what Dr. Taillac has said, the rural may not have that many -- that many opportunities. I think it was Tammy that brought it up last time. I think she said she did two in over seven years. Was that you?

TAMMY BARTON: And it wasn't even us. It was our anesthesiologist that went with us.

CHRIS DELAMARE: Right. So kind of going back to that is, I think from my personal feeling, and I've talked to Eric about this and shared it, at a minimum, I think it should be a paramedic level deal, nothing below paramedic, if you ask me. That's just my opinion.

But given that, I mean Gold Cross, we do a lot

of vent transports which are going from snips to doctor appointments. And some of these are just maintaining their current situation.

KRIS KEMP: Absolutely. And I agree with those because that is someone that -- I mean, you have patients that are trached and vented, you know, driving around in their wheelchairs around Primary Children's, and those are chronically vented patients. It's a different situation than one that is acutely and critically ill.

CHRIS DELAMARE: And that's where, I guess, my confusion is what you are trying to get at, is are you just talking about these that are coming -- critical patients coming out of ER going to a higher level of care for stability?

KRIS KEMP: That's the -- exactly the case.

CHRIS DELAMARE: Okay.

KRIS KEMP: The ones that are done in the field, if they are being put on a vent in transport en route to, to free up a set of hands, I mean, you've got to do what you've got to do. And if there's a basic vent that can be easily operated and hooked up and set up and makes things at least a little more standardized for that patient than just someone's randomly changing volumes and rates as with back valve masks, then so be it. But there's just so many complexities to these critically ill patients in

interfacility transports that it -- I just -- I think it's a big huge -- it's a huge topic out there that we just haven't addressed well enough.

Now the solution currently -- and I don't have the answers for it either. I'm not pro and I'm not against. I am trying to find answers that are affecting patients directly every day, two to three under my purview, and that's just kind of where I'm stuck, because I have a lot of pressures from one side saying shouldn't be doing it unless you've got these criteria and they take it even beyond the paramedics saying it shouldn't even be a nurse. It should be a respiratory therapist or CRNA or anesthesiologist or another physician.

And so there's pressures that way and there's other pressures saying, oh, we do these all the time. It's no big deal. Why are you making such a big deal? And I'm having a hard time trying to divorce those two things, the critical of the patient and the ventilator itself with experience.

DR. PETER TAILLAC: So Chris, one way to, if the committee was interested to look at this, you said you don't know what you don't know, which is comforting sometimes, don't ask questions you don't want to know the answers to, but the Committee could task -- don't yell at me -- the Bureau with perhaps looking at a group of

interfacility transports with specific -- looking for specific details and come up with a report for the Committee about the potential complications that one reported or were reported or were noticed, et cetera. In other words, do a survey again, see is there a problem out there or not.

MARK SANDERSON: Along those same lines, which or how many agencies actually use them, we may be talking about three or four agencies in the state and it's not -- you know, maybe a much easier controlling factor than if it's 60 agencies.

DR. PETER TAILLAC: Uh-huh.

CHRIS DELAMARE: And just another follow up. If I remember from the previous meeting, again, your concern was coming as going by ground when air was not available due to weather or whatever; is that correct?

KRIS KEMP: That's part of it.

CHRIS DELAMARE: Okay. Because I mean honestly --

KRIS KEMP: Or even if air is available and it's thought as a cost of savings issue for this patient, because sometimes that is a driving force by some physicians when they are making that transport decision. Well, I have a crew here that's got a vent and they are on the ground and it's going to cost a couple of thousand as

opposed to I have to use this helicopter that could charge in some areas around the state a lot of money.

RUSSELL BRADLEY: 10 times that.

KRIS KEMP: 10 times that or more. And they may be making those decisions to say, well, this patient in those -- in, you know, with some diesel fuel instead of jet fuel is a better economical case, and I -- I'm struggling with that.

CHRIS DELAMARE: I would be too especially if I'm the patient. They're going to save me a couple of thousand dollars versus my death? That's unfortunate that we look at it that way. That shouldn't be the driving factor, I mean plain and simple.

KRIS KEMP: Right.

CHRIS DELAMARE: I mean none of our EMS agencies look at that factor. I hope not anyway. So I mean, it's just --

KRIS KEMP: There are probably just a handful that use ventilators, right, Peter?

DR. PETER TAILLAC: I don't know, to be honest with you. We don't necessarily --

JAY DEE DOWNS: Maybe that is something where we task that.

DR. PETER TAILLAC: -- track that. Those who have submitted variances, it's a handful actually, but I

think there's others out there doing it.

CHRIS DELAMARE: We actually brought that up in our committee meeting. There's not a way for us to find out because if they haven't gone for a variance, and it's not -- a variance is not required because it's an optional equipment list. I'm not sure, unless we do a survey of all EMS agencies, I don't know how you find out.

KRIS KEMP: Again, I'm not trying to put a stop to the practice that's already out there. I'm not. That has to be very clear. I'm trying to find a safe, appropriate way to do this and replicate it because that's what medicine is all about. If you've figured it out, share it and replicate it. And that's what I'm looking for. Because it's a very real need with the patients that I'm experiencing with.

NATHAN CURTIS: Dr. Kemp, just one more -- just one more clarification for the Committee as well as the audience. Having worn both hats, having been a paramedic for 23 years, now a nurse, I feel that paramedics, EMTs manage hundreds more airways than nurses ever do. In the hospital where nurses work, respiratory is there, the physician's there, they don't intubate, they don't bag, where that's the primary responsibility of our EMS community is. They intubate, they bag the patient, and so I think they are much more competent in managing an airway

than nursing staff ever would be because of the experiences that they've had.

KRIS KEMP: That's a very good point, and it's one that I definitely appreciate. Again, I'm just trying to voice because of the things that I've experienced, the concerns that I have, and it's not based on pro or con. It is purely just I'm interested in trying to find the safest and highest quality way to maintain that patient's safety and that patient improvement in therapy when there's some very real data that says bagging is the worst thing when you have any ventilator on hand, but should we be transporting some of these patients by ground or should we wait for the weather to clear, which is ultimately the final answer that I'm looking for. Keep them in place even if it's that rural facility that has very limited resources and we have to buy them a vent to give them to use in the future, circumstance where we say you can't or we shouldn't be sending this person by ground for all of these factors.

Now, again, that might be completely different for an urban setting and likely is based on experience of volume numbers.

CHRIS DELAMARE: Right.

KRIS KEMP: But in trackers. Just, I don't think we know what we don't know.

Anyway, we've beat this dead horse. And I appreciate your input, Von, and from the Committee as well. I think all of us do appreciate that. Significantly. Thanks, Jason. That was good.

JASON NICHOLL: Couldn't help it.

KRIS KEMP: All right. So we do have some tasks to assign. We'll wait til the round table to do that and we'll move onto new ambulance standards. Guy.

GUY DANSIE: Actually this falls into that category, I believe.

Recently -- let me back up a little bit before I even start. Historically, the federal government had a standard for ambulances. States have followed that standard for years and years. It's called a Triple K; many of you are familiar with that. We've actually -- I've been aware there was a new standard developed, I believe it was two or three years ago. We had our operation subcommittee look at that a couple of times. We weren't ready to move on it. It was quite cost prohibitive. There were increased costs, things that -- new requirements. And like us, all the other states have not moved to that as well.

Since that time, CAAS, the accrediting body for ground ambulances, developed a standard, and that was published probably a little less than a year ago. And as

a result, the National Fire, NFA, revised their criteria for ambulances. And so we have these two different standards that were proposed. And both of these standards are based on new science, new technology. They've been -- there's been testing done by -- testing, like third-party, you know, accrediting agencies and so forth to make sure that some of the new changes actually have merit.

Long story short, the old standard is going away. It was not based on science. They've revised it a little bit and tried to keep it out there for states. However, the federal government is not comfortable with renewing that over and over because it's not based on the scientific findings.

What I've proposed to do is now that we have those two documents and they seem to be quite firm and seem to be quite well established, is that we relook at those standards and then possibly adopt either standard or both of them so that when we order ambulances in the future, the manufacturers will have a clearer understanding of the requirements that we expect from them. Currently there is quite a bit of confusion by the ambulance manufacturers knowing how to build an ambulance because of the standard -- the old standard probably isn't as good as the two new standards. However, nobody has -- when I say nobody, other states have not moved away from

the old standard.

So, you know, in my dealings with some of my counterparts in other states, some of the states are adopting rule language stating that instead of having the GSA, the KKK standard that we currently have or mentioning that -- our rule doesn't mention it by name, but it does -- it is the general -- the GSA standard is referenced in there.

I would suggest that we change the language and look again at those two new standards, and either determine which of the two we prefer, or if both of them are acceptable, that we adopt both of those as standards for ambulances. And that's an operational thing, I believe.

KRIS KEMP: Operations and Rules?

GUY DANSIE: Yeah. What I propose is Operations reviews the information. And then whatever findings they have or opinions that they would like to bring forth, bring those and we'll present those to rules and we'll develop language that reflects those opinions. And then in the next meeting we can bring that back here for approval. That -- kind of long --

KRIS KEMP: Sounds like a reasonable assignment.

GUY DANSIE: It's kind of something that's been burning on the back burner for several years. I know Eric

is back there nodding his head because Operations has looked through this extensively in the past and I don't want to create a burden for them again, but there are crosswalks developed now and there's some national helps, if you will, things that will help us in deciding which of those two, or both, of the standards we choose to adopt.

KRIS KEMP: All right.

CHRIS DELAMARE: Hey, a quick question on that, Guy. So you are saying no other states have adopted either one of these or they have, or is everybody still -- or are most of the states still waiting to see what --

GUY DANSIE: I believe it is Virginia. One of the states that the director there has been chair for NASEMSO on this project. And what they have done in their state is just basically the rule that they have now allows either standard.

CHRIS DELAMARE: Okay.

GUY DANSIE: And that's the discussion I've had with him. And that's probably the department's view at this point, is probably to allow either standard, either the FPA standard or the CAAS standard. But by declaring that we'll allow either one of those, then you can choose as a provider which one you feel is best suited to your needs and still we're making some progress in getting away from this old standard that hadn't had the science behind

it.

CHRIS DELAMARE: Okay. Thank you.

KRIS KEMP: All right. Any other discussion points around those standards, assignment to the operations subcommittee? All right.

Image Trend update. Scott Munson, Felicia Alvarez.

GUY DANSIE: Let you introduce yourselves.

SCOTT MUNSON: Yeah. You decide.

Scott Munson, Bureau of EMS and Preparedness. Just wanted to take this opportunity to give you a brief introduction to some -- Felicia and myself, as well as a status update on the Image Trend project, so.

I've actually worked in the Bureau for over 10 years primarily with the public health preparedness information systems. So EMS is new to me, but I'm excited for the opportunity to get to know and work with the EMS community.

Felicia Alvarez. Raise your hand, Felicia. Felicia just joined the Bureau. She actually came within the department from the Bureau of Epidemiology, so she has experience working with disease surveillance and some other information systems there. So we're excited to have her as part of the Bureau. And she will serve as the assistant administrator for both the licensure and

certification system as well as the prehospital data system.

So as far as a brief status update for Image Trend, the last insurance certification system is actually up and running. But what we're currently doing is working on the configuration of the system as well as developing some of the -- of our Bureau internal -- business processes into the application itself and migrating legacy data over from the old system to the Image Trend solution. So that's where we're currently at with that.

The prehospital data system, based on Image Trend's implementation practice will come on secondary to the licensure system because of some of the data integrations between the two applications.

So that's where we're at right now. We're working as hard as we can to get that implemented and get that moving forward. So any questions that I might be able to address for the group?

LAUARA SNYDER: Lauara Snyder, Wendover Ambulance. What's your timeline?

GUY DANSIE: I warned you, Scott.

SCOTT MUNSON: I knew that question would come up. I'm reluctant to give you a time frame at this point just because of some of the complexities with developing some of the internal configurations with the systems.

We've made a lot of progress in the last few weeks, but I'm not certain -- you know, I can't tell you a goal live date at this point.

LAUARA SNYDER: Less than a year?

SCOTT MUNSON: I would think so. I'm hoping for late summer, or before that for the systems to be up and running. But once again, that's an estimate at this point, so.

Any other questions that are easier than that one?

CHAD PASCUA: Chad Pascua, Murray City Fire. I'm just wondering, when are you -- are you guys able to accept the NEMSA data yet or what's the timeframe on that?

SCOTT MUNSON: So we're not able to accept that data yet until the Image Trend solution is implemented. So, you know, once the Elite system is up and running, then we'll be able to accept that data. So once again, we'll communicate as quickly as we can when we think that will be available and work towards that, so.

I know there's some agencies out there that are ready to submit that data, and those obviously will be the ones we'll work with first as we get the system up and running. So...

SHARI HUNSAKER: In the meantime, if you are converting over to a new system, or if you're upgrading

your software to version 3.4, there is a waiver available. If you contact Dean Penovich, you can apply for a data submission waiver. And once that's approved, then you can upgrade your system to 3.4 or 3, and not submit data to the State until we are ready to accept it.

CHAD PASCUA: We're on Image Trend only right now. I'm just wondering what's the State's plan for other, like the small -- like a form to the smaller agencies? What's the plan with you guys using Image Trend, like for the rest of the state?

SCOTT MUNSON: Yeah, so I think, if I understand your question correctly, it will be similar to the way the Polaris application is set up now, where obviously a lot of the agencies have their own software solution that they use and then that data is passed from your solution to the state system.

Our Image Trend application will also have an interface for the agencies that don't have their own solution, so they'll be able to enter their data directly into that application, so.

KRIS KEMP: All right. Anything else? Thank you.

SCOTT MUNSON: Thank you.

KRIS KEMP: Round table discussions. I think we can put some assignments out at this point.

The disease testing of individuals exposed to blood borne pathogens, you felt that should go to Operations; is that correct? Von?

VON JOHNSON: Yes.

KRIS KEMP: Yeah. All right. Any concerns with that, making that assignment?

And then --

GUY DANSIE: Eric has one. Look at his face.

ERIC BAUMAN: It's not a concern, just a clarification on the specifics of the assignment.

CHAD PASCUA: Chad Pascua again. I just -- on that one, I was curious on this one why we've -- I'm not sure who instigated this right here. It works pretty good right now. So I'm not sure who's wanting to change what's already in place.

GUY DANSIE: Can I give a little background?

KRIS KEMP: Yeah.

GUY DANSIE: We were approached by Intermountain Healthcare -- gosh, I think it was back in January -- and they were concerned that some of our -- like our forms were outdated and there wasn't a good standard that was available to providers. And some providers were not clear on the process.

And then as -- through the legislative process there was a bill that was passed. And there's -- there is

a Dr. Redd from Cache actually proposed a bill and got it passed that requires inmates or others that are not volunteering their blood to be able to draw that blood quickly and improve that process.

We were kind of waiting to see how that was -- if it passed or not. But now that it has passed, I think that helps. And maybe we need to just update our policies, our forms. I don't know if it's a rule thing that we need to change the rule or if it's important to do that or not, but I believe that there's some updating and awareness that needs to take place.

We had attempted to address it in our Rules Task Force at one point, but the rules are not under the Department of Health rules. Therefore, we don't have the authority to change those rules. It was under Workman's Comp -- anyway, it's in a different area, and we don't have the authority to change that. That was primarily for the payment. And that's -- that's something that we probably ought to have the awareness about those rules and the changes in the statute and then the process, maybe something we post on our website saying this is how we do it if you are exposed to blood borne pathogens and these are the resources you need to take care of.

So that's our concern --

CHAD PASCUA: There is a flow chart --

GUY DANSIE: -- on the front side.

CHAD PASCUA: -- right now. I'm not sure if it's through Workman's Comp. I know one of the forms allowed it if there is an exposure, you know, a Workman's Comp form. I know there's a flow sheet, and the flow sheet that we follow, and we work with IMC with exposures and we get the results pretty fast.

GUY DANSIE: And part of the thing is you're an urban agency and you probably deal with needle sticks more frequently than the rural providers. So when a rural provider has a needle stick, or a new director, they don't know what to do, so we want to provide those resources quickly so the person can have prophylaxis if possible. That's -- that's the reasoning behind it. So that's...

KRIS KEMP: Eric, did you have a comment?

ERIC BAUMAN: No. I was just looking -- I can get with Guy after. I was just looking for clarification on the assignment, specifically what we needed to address.

KRIS KEMP: Fair enough.

ERIC BAUMAN: I'll get with Guy after.

KRIS KEMP: All right. Other assignments? We're going to the new ambulance standards discussion; take that to Operations as well, have them review it. Those possible choice of one or two or both that either or situation for those standards.

Anything else for round table?

Okay. Well, then it looks like our next meeting is July 13th.

JAY DEE DOWNS: TG has something.

TAMI GOODIN: Regarding the next meeting, I just would like to invite everybody -- oh, Tami Goodin with the Bureau of EMS -- invite everybody to the EMS week award's ceremony -- EMS award ceremony which will be July 13th at the Viridian Center. So it will not be held here.

In the past we've had the Committee meet at the Viridian Center. They have their meetings and then we welcome you to attend the ceremony before, and then we have the meeting, the EMS Committee Executive and the Committee meeting right after that in the same building. So just put that on your calendar that it's at the Viridian Center at South -- West Jordan. Thanks.

KRIS KEMP: All right. Is there anything else? Peter.

DR. PETER TAILLAC: Another announcement to everyone. The -- we're proud to present the Utah Resuscitation Academy, which will be held at the Salt Lake Public Service building, two courses, May 8th -- no, apologize -- May 9th and May 10th, which should be Monday and Tuesday. They will be training medics, medical

directors and training officers for agencies around the state in high performance CPR techniques, the new concepts in cardiac arrest management, integration of dispatch with cardiac arrest management, and tracking of your agency's cardiac arrest success using the CARES database. All this will be modeled after the Seattle Resuscitation Academy which is widely respected. And in fact, we have three faculty from Seattle coming to help us with the program having already sent six or eight folks from Utah to the Resuscitation Academy in Seattle.

The idea is to look at agencies, see these best practices and try to emulate them in their own agencies to improve cardiac arrest care in the state. The results are dramatic in the number of neurologically intact patients that are resuscitated.

So we invite, particularly for this class, training officers, medical directors, or agency directors to come and participate and then take this back to your agencies. We hope also to be having regional resuscitation academies around the state beginning late this year and early next year as well and would like some folks who train at this first one to participate in those as trainers also.

So if you have any more questions, there should -- there was an announcement that went out to all

agencies and all medical directors. I'm happy to take questions about it. We're super excited about it. It's a big deal. It should be a lot fun and informative.

KRIS KEMP: Where is it and what time?

DR. PETER TAILLAC: It will be from 8 a.m. until 4 p.m. May 9th and May 10th at the Salt Lake Public Service building. What's that? Thank you.

It's a one-day course and you can go to one or the other. Yeah. Thank you. It's not a two-day course. It's a one-day course, all day.

We will be giving EMS credits, CME credits and I'm working on doc's CA credits. They are way more complicated, but working on it. We'll see.

So talk to your medical directors, encourage them to come please. I'll send out some more reminders as well.

KRIS KEMP: Great. Shari.

SHARI HUNSAKER: I just want to clarify one thing. That as long as Polaris is still our operating prehospital system, you can still contact me for support. The decision was made to not overwhelm Felicia with learning the system that was sunsetting. So I'm taking care of Polaris and the licensure system that we call BEMS now, and then as we migrate over to Image Trend, I'll be stepping out of that role and Felicia will be taking care

of that.

KRIS KEMP: Great. Thank you. Any other last comments? All right. We have a motion to adjourn?

JAY DEE DOWNS: So moved.

JASON NICHOLL: Seconded.

KRIS KEMP: Do I need for all in favor. Look at that. Before three o'clock.

(Meeting was concluded at 2:45 p.m.)

C E R T I F I C A T E

STATE OF UTAH)
)
COUNTY OF UTAH)

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

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

DATED this 25th day of APRIL, 2016.

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