

State EMS Committee Meeting

July 13, 2016  
1:00 p.m.

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

Reporter: Susan S. Sprouse

**A P P E A R A N C E S**

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- Dr. Kris Kemp
- Guy Dansie
- Nathan Curtis
- Casey Jackson
- Laonna Davis
- Dr. Russell Bradley
- Suzanne Barton
- Dr. Peter Taillac
- Michael Moffitt
- Mike Mathieu
- Jeri Johnson
- Jay Dee Downs
- Kristopher Mitchell
- Jason Nicholl
- Dr. Hallie Keller

1 July 13, 2016

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3 **DR. KRIS KEMP:** All right. We're going to be  
4 starting here pretty soon so we can hopefully get out on  
5 time or perhaps a little bit early. We've all got places  
6 we need to be, even if it's just outside to enjoy the  
7 weather.

8 So we'll call to order. We've already had our  
9 executive session. I'm going to lead this session as  
10 usual, apparently, as the chair of the committee. My name  
11 is Dr. Kris Kemp. We're going to go around and introduce  
12 ourselves mainly to the public here and jump right into  
13 our agenda.

14 And just for reviews sake, please understand the  
15 executive session is an open session as well. We do  
16 typically about an hour before we have this session. It's  
17 really just to chew on a couple of nuts and bolts issues  
18 that we work on in the official meeting of which we're now  
19 starting. It just helps us become a little more  
20 efficient. Before we started doing the executive  
21 sessions, we were going well after the 3 o'clock hour on  
22 many of our committee meeting days and that that was a  
23 little bit of taxing for a lot of people. So it seems to  
24 be pretty efficient to do it this way. Ultimately, they  
25 are open meetings, so you all are more than welcome to

1 attend the executive sessions. It's just the sauce of  
2 making the process for this committee. So it's not,  
3 not -- you're not missing out on anything.

4 So with the introductions, we'll just go around  
5 the table here and we'll go through it.

6 **NATHAN CURTIS:** I'm Sheriff Nathan Curtis with  
7 public safety.

8 **CASEY JACKSON:** Casey Jackson, and I'm a  
9 consumer.

10 **LACONNA DAVIS:** Laconna Davis, Department of Work  
11 Safety.

12 **DR. RUSSELL BRADLEY:** Russel Bradley, rural  
13 physician representative.

14 **MIKE MOFFITT:** Mike Moffitt with Gold Cross  
15 Ambulance.

16 **MIKE MATHIEU:** Mike Mathieu, fire chief  
17 representative.

18 **HALLIE KELLER:** Hallie Keller, pediatric  
19 representative.

20 **JERI JOHNSON:** Jeri Johnson, EMT representative.

21 **JAY DEE DOWNS:** Jay Downs, fire chief. Guy.

22 **GUY DANSIE:** I'm Guy Dansie with the Bureau of  
23 EMS and Preparedness. I'm the representative from that  
24 group.

25 **KRISTOPHER MITCHELL:** Kris Mitchell, private

1 surgeon at St. Marks.

2 **MARK SANDERSON:** Mark Sanderson, nursing  
3 representative.

4 **JASON NICHOLL:** Jason Nicholl, paramedics.

5 **DR. KRIS KEMP:** All right. Thank you. Whenever  
6 we are here, I always feel like Oprah or something, like  
7 running around. Does anyone even know who Oprah is?

8 Okay. Because this is kind of a large spacious  
9 room, we'll be asking that everyone who presents to please  
10 use a mic so that our recorder can get all of our  
11 information. And please introduce yourself as well.

12 To start with our agenda, we have a few of our  
13 EMS Committee members that their term has been completed,  
14 the eight years.

15 **GUY DANSIE:** Yeah. There's two terms of four.  
16 So those are for people finishing out their second term.

17 **DR. KRIS KEMP:** Thanks for using the mic. Just  
18 had to -- so we've got three here. And so we -- these are  
19 a mark of recognition for the dedication service for the  
20 State EMS Committee. And the first one is for Jay Downs.

21 **JAY DEE DOWNS:** No thanks.

22 **DR. KRIS KEMP:** And we have Mike Moffitt.

23 **MIKE MOFFITT:** Thank you.

24 **SPEAKER:** He wanted to give one, though.

25 **DR. KRIS KEMP:** Oh, he wanted to give a speech?

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**MIKE MOFFITT:** No. No.

**DR. KRIS KEMP:** And Mike Matthieu.

**MIKE MATHIEU:** Thank you.

**GUY DANSIE:** Do I need to use the microphone?  
There's one more for Margie Baker -- or Swenson Baker. I  
can't remember now. Anyway, she's from Grand County. She  
was on our EMS Committee for several years and she just  
recently resigned. So we have one for her. Andrew, if  
you can take it back to her.

**DR. KRIS KEMP:** Great. Thank you.

All right. Action items. We can jump right in.  
We'll go for the approval of the minutes. The minutes, I  
believe, the recordings, the documentation is in front of  
you. You've had the opportunity to review these. If you  
have any questions or concerns, otherwise I'd accept a  
motion for approval.

**MIKE MATHIEU:** I so move.

**MIKE MOFFITT:** Second.

**JAY DEE DOWNS:** A motion to second. All in  
favor say aye.

**COLLECTIVELY:** Aye.

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

Guy, you have the next step. Some rules to go  
over for us.

1           **GUY DANSIE:** I will use the microphone. Thank  
2 you.

3           First, let's look at R426-4. I'm trying to find  
4 it here. There's a handout for that. This pertains to  
5 the ambulance manufacturing specifications. Recently  
6 there were two new ambulance standards that were developed  
7 and recognized. They've been tested. They have science  
8 backing. Therefore, the State, we wanted to implement  
9 those standards if possible.

10           There is an old standard that was used for years  
11 and years by a federal general purchasing and it was not  
12 backed by any scientific data or testing of the rules or  
13 anything. So in order to bring our state up to that new  
14 level, we wanted to, to change the wording in the rule.  
15 And the new wording would say, in the copy, that "All  
16 ground ambulances manufactured after July 1, 2017" --  
17 geez, have so much strikeout here -- "they must meet  
18 specifications of standards." And then put "see  
19 department policy for ground ambulance standards."

20           Basically, we would take the standard and put it  
21 as the department policy like we've done some of the other  
22 rule with equipment and so forth. And we would adopt by  
23 policy the NFPA 1917 standard and the CAAS, I think, it's  
24 the GVS. I'm looking at the acronym wrong, version 1.0.  
25 Anybody remember the name of that standard? But we will

1 use those two new standards for department policy  
2 starting -- the Rules Task Force figured July 1st of next  
3 year would be a fair time to implement that in case  
4 anybody has to order ambulances at this point, go ahead  
5 and purchase, meet the requirements as is, and starting  
6 next July we would require those new standards as policy.

7 So any discussion on the rule change for ground  
8 ambulance? This has been through the Operations  
9 Subcommittee and also part of their report and also the  
10 language came from the Rules Task Force. Open to any  
11 comments or changes or suggestions.

12 **JAY DEE DOWNS:** Not after that.

13 **GUY DANSIE:** Okay. So do you want to approve  
14 that rule change?

15 **DR. KRIS KEMP:** All right. So for the first  
16 one, R426-4-300, do we have a motion for approval?

17 **KRISTOPHER MITCHELL:** I move to approve.

18 **DR. KRIS KEMP:** And do we have a second?

19 **MIKE MOFFITT:** Second.

20 **DR. KRIS KEMP:** Any opposed? Oh, I should say  
21 all in favor.

22 **COLLECTIVELY:** Aye

23 **DR. KRIS KEMP:** It's a long day already. And  
24 any opposed? All right. And any abstained?

25 **CASEY JACKSON:** I don't know about the matter,

1 so I'm abstaining.

2 **DR. KRIS KEMP:** You're abstaining. Okay. Thank  
3 you. Motion carries.

4 Go ahead, Guy.

5 **GUY DANSIE:** Okay. So does Mike too.

6 R426-5-3000, this is -- this is A new rule that  
7 was just recently made effective. It's for the EMS Rules  
8 Task Force. They wanted to have -- and it came before  
9 this body in the past -- to have the positions clarified  
10 in rule for the EMS Rules Task Force.

11 We did not, however, have a representative from  
12 a designated patient-receiving facility on that list.  
13 Currently we do not have any designated patient-receiving  
14 facilities. However, there is that provision in the  
15 future, we may have basically a rule that I think is  
16 approved to receive patients in certain situations from  
17 ambulance providers.

18 And there was feelings that that position should  
19 be represented on the Rules Task Force as well. So we've  
20 just added that. I put a new letter or number M and just  
21 added that position to the EMS Rules Task Force, the body  
22 of the membership on that. Are there any --

23 **DR. KRIS KEMP:** Any questions for Guy in regards  
24 to that?

25 **MIKE MOFFITT:** Is this -- yes, I have a

1 question.

2 **GUY DANSIE:** Here.

3 **MIKE MOFFITT:** Yes. Is this how the task force  
4 is currently constituted or is there going to be -- going  
5 to have to fill in these positions now or moving forward,  
6 or what's the status?

7 **GUY DANSIE:** The current positions are filled.  
8 We would just add one more position --

9 **MIKE MOFFITT:** Okay.

10 **GUY DANSIE:** -- to allow them to have voice  
11 since they are a designated agency. Or not -- there's not  
12 a medically-designated agency, but they could be -- there  
13 could be a designated agency that's a patient-receiving  
14 facility. So we just want to let them have voice.

15 **MIKE MOFFITT:** So it's just adding now one  
16 position?

17 **GUY DANSIE:** Adding one position.

18 **MIKE MOFFITT:** All right. Thanks.

19 **DR. KRIS KEMP:** Any further questions?

20 All right. Do we have a motion to approve Rule  
21 R426-5-3000?

22 **DR. RUSSELL BRADLEY:** I will.

23 **DR. KRIS KEMP:** Motion to second?

24 **JERI JOHNSON:** Second.

25 **DR. KRIS KEMP:** All right. All in favor say

1 aye.

2 **COLLECTIVELY:** aye.

3 **DR. KRIS KEMP:** Any opposed? And any abstained?

4 Thank you.

5 Okay, Guy.

6 **GUY DANSIE:** Thank you. One more rule change,  
7 R426-1-1000. Resource hospital minimum designation  
8 requirements, this is an oversight by the department, and  
9 possibly myself, kind of repenned this wrong. We actually  
10 had this approved about a year ago to -- we added the  
11 Part 14 that says, "Designated trauma centers are deemed  
12 to meet the resource hospital standards and are exempt  
13 from requirements outlined in this section."

14 Basically a resource hospital designation is  
15 our, our lowest designation for hospitals that receive  
16 patients, patients from ambulances. And we're basically  
17 wanting anybody that's designated at a higher level to be  
18 deemed that lower level status.

19 We've kind of honored this anyway. It's already  
20 taking place, but we just wanted to clarify that in rule.  
21 And this was before the committee previously, but it was  
22 in error. It wasn't put in the current rules. So I just  
23 want to bring it back to the table to make sure everybody  
24 was okay with it before we put it into the rule.

25 **DR. KRIS KEMP:** So is this the entire rule that

1 you say was --

2 **GUY DANSIE:** Just the underlined part, the Part  
3 14.

4 The other part of the rule, 1 through 13, are  
5 current effective rule, and it talks about the  
6 requirements for resource hospitals. What those  
7 requirements are. That's been in rule for years and it  
8 was modified slightly, I believe, in this last year. So  
9 we went through the rules, part of the EMS Task Force and  
10 it was presented here. But this one portion at the bottom  
11 was left off. So I just wanted to add that back in.

12 **DR. KRIS KEMP:** I guess the other question I  
13 have is who determines what resource hospital is for what  
14 agency? Is it the agency's responsibility to determine  
15 which resource hospital is their resource hospital?

16 **GUY DANSIE:** Typically in the rural areas, it's  
17 the closest hospital.

18 **DR. PETER TAILLAC:** It's the other way around,  
19 really. It's a hospital that is allowed to legally  
20 receive ambulances and participate in the EMS system. So  
21 any hospital that wants to get ambulances from anywhere  
22 has to meet these requirements.

23 **DR. KRIS KEMP:** Okay, hospital -- can the EMS  
24 agency have two resource hospitals?

25 **DR. PETER TAILLAC:** Sure. Yeah.

1           **DR. KRIS KEMP:** So there's no limit?

2           **DR. PETER TAILLAC:** No, it's not like, I have  
3 that one. It's like I can bring my patient to any one  
4 that is designated.

5           **JAY DEE DOWNS:** Okay. Great.

6           **DR. PETER TAILLAC:** Guy, I have a problem with  
7 the trauma center standards. I don't have any trouble  
8 with what's written in the trauma center standards because  
9 to be a trauma center you are required to basically do all  
10 these things already. So it's a little redundant for the  
11 trauma centers.

12                   But No. 4, that says, "Create and abide by  
13 prehospital emergency care, care protocols," I don't think  
14 the hospitals create the protocols for EMS. I'm not sure  
15 why that's there. Every agency, you know, the medical  
16 directors create the protocols at the hospital. So I'm  
17 not sure what was meant by that.

18           **GUY DANSIE:** I don't know -- what we can do is  
19 take it back to the Rules Task Force with the advice from  
20 our trauma personnel and find out if we can modify that if  
21 you'd like to do that.

22           **DR. PETER TAILLAC:** Yeah. The trauma centers,  
23 that's a good point. The trauma centers are required to  
24 participate in the development of the prehospital  
25 protocols in the areas.

1           **JASON NICHOLL:** That's --

2           **DR. PETER TAILLAC:** And that would probably be  
3 better for something along those lines for this.

4           **GUY DANSIE:** We'll take it back. I feel like  
5 Oprah now.

6           **JASON NICHOLL:** I agree, Dr. Taillac. I don't  
7 think -- I actually don't think we need to send this to  
8 rules. I think we can come up with the language right now  
9 and substitute it in.

10           I also think that we should strike "exempt from  
11 requirements outlined in this section" because it's a --  
12 you are saying it twice.

13           **DR. PETER TAILLAC:** I kind of agree with that  
14 along the same lines.

15           **JASON NICHOLL:** If you deem to meet these  
16 requirements, then why are you exempting them from them?

17           **DR. PETER TAILLAC:** You're not exempt from it.

18           **JASON NICHOLL:** So I recommend that in No. 4 we  
19 modify the language to reflect that it is "participate in  
20 the development of protocols." And then in 14 strike  
21 everything after standards. So those would be my  
22 suggestions. Oprah.

23           **DR. KRIS KEMP:** Would that be your motion?

24           **JASON NICHOLL:** Yes. That would be my motion.

25           **DR. KRIS KEMP:** Do we have a second?

1           **KRISTOPHER MITCHELL:** Second.

2           **DR. KRIS KEMP:** All in favor say aye.

3           **COLLECTIVELY:** Aye.

4           **DR. KRIS KEMP:** Any opposed? And any abstained?  
5 Okay.

6           **DR. PETER TAILLAC:** So Guy, this doesn't have to  
7 go back to the Rules Committee. It's a done deal.

8           **GUY DANSIE:** The change on Part 14 is considered  
9 a done deal. If we wanted to develop the language for  
10 Part No. 4, as per the motion, then we can take that to  
11 the rules task -- it should actually go to our Trauma  
12 System Advisory Committee, but -- okay.

13           **DR. PETER TAILLAC:** But okay. 4 works.

14           **GUY DANSIE:** Well, just so they have volume -- I  
15 think that --

16           **DR. PETER TAILLAC:** That's not trauma. That's  
17 resource hospital.

18           **GUY DANSIE:** Okay. Our staff, we discuss it,  
19 take it to the Rules Task Force. Typically --

20           **DR. KRIS KEMP:** Rules Task Force is -- they have  
21 to report to both the Bureau and the Committee; is that  
22 correct?

23           **GUY DANSIE:** Correct. I sit on that as the  
24 Bureau representative. And then it goes through our legal  
25 vetting process, through our Attorney General's Office.

1 It goes through Paul, Dr. Babbitts and through Dr. Miner,  
2 the Executive Director's Office. So I have to get all  
3 those internal approvals to put it out for comment.

4 **DR. KRIS KEMP:** But this would be, at least, our  
5 motion for approval of our modified language from this  
6 committee's standpoint, right?

7 **DR. PETER TAILLAC:** The question is, does it go  
8 to you and Dr. Babbitts from here, or does it have to go  
9 to the Rules Task Force, come back here, and then go --

10 **GUY DANSIE:** For Part 14, we can go ahead and  
11 bring that through the internal approval process that goes  
12 out to public comment. If I don't receive substantial  
13 public comment, we can make it effective. That's Part 14.

14 Part 4, we would need to go through that  
15 development process and having the language vetted and  
16 decided upon and then bring it back to this committee for  
17 approval.

18 **DR. RUSSELL BRADLEY:** Approve what? We just  
19 said --

20 **DR. PETER TAILLAC:** This committee just approved  
21 it.

22 **GUY DANSIE:** Okay. We can change it over if you  
23 want, but the language needs to be developed and approved  
24 by the department and possibly TSAC or the EMS Rules Task  
25 Force. But typically it goes through the EMS Rules Task

1 Force for language. So it would be a minor thing. We  
2 could easily put it through. But that is the process.

3 **DR. KRIS KEMP:** That was the motion.

4 **JASON NICHOLL:** Yes, it was.

5 **DR. KRIS KEMP:** It carried.

6 **GUY DANSIE:** It carried. So we're done.

7 Any more explanation? Ready for the next agenda  
8 item? You're getting me off my game here.

9 **DR. KRIS KEMP:** Is that it? Oh, you got the  
10 next one. So Guy, please, carry on.

11 **GUY DANSIE:** That's what I'm saying.

12 It was proposed by the department for air  
13 ambulance subcommittee creation. We talked about that  
14 extensively in our executive session. We feel that maybe  
15 it's premature at this point, that air ambulance providers  
16 are going through some turbulent times so to speak, in  
17 what's federally regulated versus what's state, what state  
18 authority we have with that. So we're waiting for further  
19 direction pending federal regulation change at this point.  
20 I believe that's -- and so.

21 **DR. KRIS KEMP:** Should we expand --

22 **GUY DANSIE:** I brought it to a vote, but I don't  
23 think we agreed to go ahead and shelf that for --

24 **DR. KRIS KEMP:** I think for public comment and  
25 discussion points, I think it would be valuable to let

1 them understand why we got to that conclusion.

2           **GUY DANSIE:** Why? We -- formally we had air  
3 ambulance -- I think at one point they were a  
4 subcommittee. It changed to a task force. It was later  
5 changed to an air ambulance committee. There's been  
6 lawsuits in other states involving state's rights versus  
7 federal requirements due to the Airline Deregulation Act.  
8 The states have lost.

9           Internally, the department and the Attorney  
10 General's Office felt it would be better if we backed off  
11 and abolished the E -- the Air Ambulance Committee because  
12 it's not in our EMS Act. We don't have statutory  
13 authority for that committee.

14           They were thinking that in order to give the air  
15 ambulance providers voice, that we could develop a  
16 subcommittee and have them report to this EMS Committee  
17 and do that -- for legal sake, that would be sound.

18           However, most of the issues right now are -- are  
19 of the nature that involves federal regulations. The  
20 states are not allowed to regulate that. Anything to do  
21 with lights, rates, coverage areas, those kinds of things,  
22 like staffing. We can regulate the training  
23 certifications or licenses of the people that provide the  
24 medical services and the medications and the medical  
25 devices. But because it's such a limited scope, it is

1 quite complicated. For us to have anything meaningful at  
2 this point, I think was our feeling earlier in our  
3 executive session. So with that in mind, do you want to  
4 make a motion?

5 **DR. KRIS KEMP:** It's listed as an action item  
6 for air ambulance subcommittee creation. The discussion  
7 was just what you made mention of. That we're talking  
8 about the regulation between what the states can do and  
9 what the federal government can regulate. And we have  
10 very little control outside of the control of the  
11 certification of the medical crew.

12 And so because of that, it makes it so if we  
13 create a subcommittee for air ambulances, there's very  
14 little work they are actually going to be doing other than  
15 saying, yep, we've got the staffing. So that's a bit of a  
16 challenge, I think, for us to say we want to create a  
17 subcommittee. And that was generally the consensus.

18 Any further discussion from the Committee?

19 **MIKE MATHIEU:** Guy, I think the comment that I  
20 would make is that we give the EMS Committee in the state  
21 of Utah a false sense of assumption that we have a higher  
22 degree of regulatory authority for air ambulance than we  
23 actually do. And I think that this creates disenchantment  
24 for us, especially in front of all of us, that we even  
25 have some legal authority when we don't, other than

1 staffing and giving medications and care and I would  
2 rather send the message out for our EMS community that we  
3 have very little regulatory authority, therefore, we are  
4 not going to have an area in the subcommittee for this.  
5 And everything we do essentially with the air ambulance  
6 community is a negotiation, not setting the standard or  
7 requirement, except for staffing and medication. And to  
8 state otherwise would be wrong.

9           And I think we should -- if we want to have  
10 further regulation of the air ambulance community, then  
11 efforts ought to be focused with our federal  
12 representatives to change federal law, to enhance or  
13 delegate some of that authority to states. Otherwise I  
14 think we're spinning our wheels in frustration with  
15 something we don't have much authority over.

16           **DR. KRIS KEMP:** Thank you for that. I think  
17 that the other part in combination with that is key, is  
18 that with our regulation EMS Committee we get reports to  
19 and we approve the rate increases for ground ambulances,  
20 we would have no control over that. Even if we made this  
21 subcommittee for air ambulances, we would have no control  
22 over their rates.

23           So here, exorbitant fees or otherwise coming  
24 from air ambulance services, this would not be the entity  
25 that could control that whatsoever.

1           And so we can't control the routes, the lights,  
2 the teams on the flights, except the medical staff  
3 training and certification, so why create a subcommittee  
4 that gives us a sense that we actually can regulate  
5 something we can't.

6           **HALLIE KELLER:** So like, who has influence over  
7 the medical teams? It's a simple one. Sorry, I answered  
8 my own question. So you're saying we have influence over  
9 that, in other words we don't have control in regulation  
10 over that side --

11           **DR. KRIS KEMP:** The Bureau does. They are  
12 responsible for retaining certification levels and  
13 staffing, right?

14           **GUY DANSIE:** Currently -- yes. Currently it's  
15 in rule and it went through the Air Ambulance Committee at  
16 that time and through this body for a second approval. So  
17 the staffing and the medical requirements are already  
18 there in rule. If there is a change needed in that area,  
19 we can obviously bring it here and amend the rule.

20           **DR. KRIS KEMP:** And we can create a subcommittee  
21 at that time --

22           **GUY DANSIE:** Correct.

23           **DR. KRIS KEMP:** -- if we felt it was necessary.  
24 It's just it creates something to have reporting to us  
25 quarterly about meetings that don't really matter, and we

1 can't really say anything about it. I should say status  
2 quo versus not.

3 And I think the point was made in our executive  
4 session, if someone identifies an air ambulance service  
5 that's falling below that staffing certification  
6 requirement, being maybe there's one with the pilot and an  
7 EMT in the back, that we fall below that staffing  
8 requirement standard, that's when we could act and do  
9 something at that point. But other than that, we have  
10 very little control, very little regulation. It's mostly  
11 they would be reporting to us all is well and they would  
12 have to -- we really wouldn't have much authority to do  
13 anything else with that.

14 So the action item here for either creation or  
15 not, do we have a motion?

16 **DR. RUSSELL BRADLEY:** I move not to create one.

17 **NATHAN CURTIS:** I'd second that.

18 **DR. KRIS KEMP:** So we have a motion to not  
19 create an air ambulance subcommittee at this time.

20 **DR. PETER TAILLAC:** We don't need a motion to  
21 not.

22 **DR. KRIS KEMP:** Well, it's an action item to  
23 create one. So what we are saying is we don't want one  
24 right now.

25 **JASON NICHOLL:** I offer a substitute motion that

1 we table this item until the time that we need to do it,  
2 that way we can keep it back on action items whenever  
3 necessary without notice.

4 **CASEY JACKSON:** Because there is a committee,  
5 well, at least there was --

6 **DR. PETER TAILLAC:** Was.

7 **CASEY JACKSON:** It is a was. So it's officially  
8 dismantled?

9 **DR. PETER TAILLAC:** It is.

10 **CASEY JACKSON:** Okay. That answers my question.

11 **DR. KRIS KEMP:** So we have a motion.

12 **JASON NICHOLL:** We have a motion and a  
13 substitute motion.

14 **DR. KRIS KEMP:** All right.

15 **NATHAN CURTIS:** We're good with either one.  
16 Tabling it is probably the better one.

17 **DR. KRIS KEMP:** So we're sending the original  
18 motion for the amended motion of tabling. It's doing  
19 nothing, but still doing something. So we have a motion.  
20 Do we have a second?

21 **DR. RUSSELL BRADLEY:** Does it matter if we have  
22 a bunch of action items that we're not going to take any  
23 action on? Is this the first of a whole list of them?

24 **JASON NICHOLL:** I'm not a true parliamentarian,  
25 so I can't say it. But with it being an action item --

1           **DR. RUSSELL BRADLEY:** We don't need a  
2 subcommittee, we don't need a subcommittee. We don't have  
3 to have it pending in the wings waiting as a future action  
4 item. Because if it comes up again, we will bring it up  
5 again anyway, so as a new item without the spectra of the  
6 must. How does that sound?

7           **JASON NICHOLL:** I just like the way you say it.

8           **DR. PETER TAILLAC:** Yes. It's our spectrum.

9           **DR. KRIS KEMP:** So in this regard we have a  
10 motion to table it. We can have that discussion later.  
11 Do we have a second? Yes, you'll second?

12           **NATHAN CURTIS:** I'll second.

13           **DR. KRIS KEMP:** Okay. All in favor say aye.

14           **COLLECTIVELY:** Aye.

15           **DR. KRIS KEMP:** Any opposed?

16           **DR. RUSSELL BRADLEY:** I'll oppose.

17           **CASEY JACKSON:** I'll oppose.

18           **DR. KRIS KEMP:** Two opposers. And any  
19 abstaining? Motion carries.

20           Great. Subcommittee reports and action items.  
21 Operations update. Eric Bauman.

22           **ERIC BAUMAN:** Okay. Hello. I'm Eric Bauman,  
23 the chair of the Operations Subcommittee. The Operations  
24 Subcommittee has been working on the EMS-8 portion of the  
25 catastrophic earthquake plan. Mike Stever from the Bureau

1 is going to be representing that to you later today.

2 The second item Guy touched on, and that was the  
3 ambulance specs. And so are there any questions on that?  
4 It sounds like you covered that thoroughly, so.

5 Our next assignment that we'll be starting on is  
6 the Infectious Disease Policy. And we have a meeting --  
7 our next meeting will have a representative from  
8 epidemiology, the Medical Examiner's Office, and  
9 Intermountain Healthcare. And we'll work together to put  
10 together a policy on infectious disease testing.

11 And the last thing is, this is my -- my term is  
12 coming to a close. And so our new chair of this committee  
13 will be Andy Smith from Grand County. And so he'll be  
14 reporting to you at the next meeting.

15 Any questions on anything? Okay. Thank you.

16 **DR. KRIS KEMP:** Yes, there's a question.

17 **MIKE MOFFITT:** I just want to say to Eric, thank  
18 you for your kindness and chairing. We appreciate your  
19 service.

20 **ERIC BAUMAN:** Thank you very much.

21 **JASON NICHOLL:** Are you staying on?

22 **ERIC BAUMAN:** Oh, yeah. Absolutely.

23 **JASON NICHOLL:** Good, good, good.

24 **DR. KRIS KEMP:** All right. Thank you.

25 Professional development update. Von.

1           **VON JOHNSON:** Von Johnson for the Professional  
2 Development Subcommittee. We have been discussing a few  
3 items. And one of the first things that we were tasked  
4 with or asked to look at in our last meeting was rules  
5 concerning EpiPens and their use and the training thereof.

6           We were looking at specifically R426-5 and this  
7 was brought up due to Dr. Davis, I guess, at the  
8 University of Utah asking what was appropriate training  
9 for situations where non-EMS personnel were going to be  
10 using these EpiPens in wilderness rescue situations or  
11 whatever.

12           So we have decided we're going to have all the  
13 members of our committee looking at that, and we'll  
14 discuss this further in our next meeting, see what's  
15 appropriate there.

16           Our next item that we --

17           **DR. PETER TAILLAC:** Question about that. I'll  
18 talk loud. I don't think we regulate non-EMS personnel  
19 that I know of. So I don't know that an EpiPen in the  
20 hands of non-911 licensed provider is within our purview.

21           **VON JOHNSON:** That was something that we  
22 discussed at length. And we've -- we had decided as a  
23 subcommittee that that was the case, but we were still  
24 asked to look at it. So I tend to agree with you that we  
25 really don't have any regulatory, you know --

1           **DR. PETER TAILLAC:** If they are a licensed  
2 emergency medical responder or certified, then we would  
3 have purview for training guidelines. But for, you know,  
4 a cub scout leader who wants to carry an EpiPen, that's  
5 not our department.

6           **LACONNA DAVIS:** Even in dispatch protocol, we're  
7 instructed to have an EpiPen to utilize it.

8           **VON JOHNSON:** True. And, you know, our, our  
9 take on this also was the fact that American Heart  
10 Association, Red Cross, all of their First-Aid training  
11 programs include Epi-Pens in their programs as available  
12 to lay rescuers.

13           So, again, we -- we would recommend -- I think  
14 we're still going to look at it, but I feel like our  
15 recommendation is going to be that we don't touch it, we  
16 recommend to these different providers or different  
17 agencies or groups, whatever they are, that they develop  
18 their own training and suggest to them probably either  
19 American Heart, Red Cross, and things to go from.

20           **DR. KRIS KEMP:** I have a question. Are EpiPens  
21 only by prescription only?

22           **DR. PETER TAILLAC:** Yes.

23           **JERI JOHNSON:** They are, yes.

24           **DR. KRIS KEMP:** So it's ultimately up to the  
25 prescriber to make sure that proper training is

1 performed --

2 **HALLIE KELLER:** -- and pharmacy to dispense  
3 with.

4 **DR. KRIS KEMP:** Yeah. And so ultimately if it's  
5 a non-EMS provider that can work that, then someone  
6 brought up -- Dr. Davis from the University of Utah School  
7 of Medicine brought up appropriate training, that goes  
8 back to the person writing the prescription and the  
9 pharmacy dispensing the medication to make sure that  
10 there's proper education. It has nothing to do with the  
11 local EMS.

12 **JIM HANSEN:** Jim Hansen for the Bureau of EMS.  
13 I'll talk real loud.

14 But this was really a -- legislatively brought  
15 about. But it was the school programs that wanted to use  
16 Epi-Pens. And there were more -- the state legislature  
17 said, well, then EMS needs to be the ones that decide what  
18 training is necessary. So that's where this all came  
19 from.

20 **DR. KRIS KEMP:** So legislation says that we need  
21 to do it, wouldn't we just make a recommendation to put it  
22 back on the prescriber and the pharmacists who are  
23 dispensing it for that training? Why would that not be --  
24 that's the most appropriate, as I see it.

25 **DR. PETER TAILLAC:** Is that legislation

1 directing us to do this or just are legislatures saying it  
2 would be nice?

3 JIM HANSEN: It was legislation. And,  
4 therefore, we did change the rule.

5 GUY DANSIE: Right.

6 JASON NICHOLL: Jim, if I can, I think part of  
7 the discussion that we had also on this was there were  
8 scout groups and other community groups that would  
9 continually come to providers and say, "Hey, how can we  
10 train on this?" And part of the discussion was that we  
11 could put together something that we could give to the  
12 public and say these are -- this is a training outline or  
13 some guidelines in how to do these things, because not  
14 everyone can be trained by the prescriber. There's a lot  
15 of times that they are given by a complete and total  
16 stranger, bystander.

17 And the school is specifically, the nursing  
18 staff at the schools brought up that they wanted to have  
19 something from the state that related to the legislation  
20 and said this is the proper way to do this. So --

21 DR. PETER TAILLAC: I apologize. I didn't -- I  
22 spoke out of turn. I didn't realize this was from our  
23 office.

24 JIM HANSEN: Yeah.

25 JASON NICHOLL: So I think it's basically trying

1 to put together a community education piece that we can  
2 offer to people. And we tasked the Professional  
3 Development to handle that.

4 **HALLIE KELLER:** And I'm sorry. I'm still trying  
5 to understand. The EMS Committee is in charge of the  
6 training of school nurses? I'm not understanding that.

7 **DR. KRIS KEMP:** I'm sure they could find  
8 something on YouTube, but --

9 **JASON NICHOLL:** Sorry, Von. I took your mic.

10 **VON JOHNSON:** You're fine.

11 **DR. KRIS KEMP:** So the recommendation?

12 **VON JOHNSON:** So our recommendation is we will  
13 continue to look at it and discuss it again in our R426-5.  
14 That's what we asked our members to do, was to go through  
15 it. It's still -- and I agree we're -- we're a little  
16 confused as to why we're looking at this, but since we've  
17 been told to, we will, so.

18 Okay. Our second item of discussion that we  
19 had, after our last EMS Committee meeting, we went back to  
20 our subcommittee and continued to delve into the transport  
21 ventilator issue. And so what we have done with this, we  
22 discussed it for a little bit. We decided to put together  
23 a survey that we would send out to all the agencies  
24 throughout the state and find out what they are using,  
25 what their protocols are, that type of thing.

1           So we put together a task force that is in the  
2 process of building that survey right now, and we will be  
3 sending that out shortly. Hopefully before our next  
4 subcommittee meeting, we'll have some results back from  
5 that so that we can further discuss this and see what's  
6 actually being used out there and what we -- what we need  
7 to look at any further. Any questions about that?

8           Okay. Our next item that we discussed was the  
9 EMT practical testing, skills testing for the EMT courses.  
10 It was discussed at length. There's still concern over a  
11 lack of quality review and that type of thing for those  
12 courses.

13           We, again, discussed this pretty intensively for  
14 a little bit, decided to go ahead and put together a work  
15 group to study this and see what we can do to, to improve  
16 the quality assurance side of that and see if we can make  
17 some recommendations to better improve that.

18           We're looking at the EMT student handbook and  
19 skills certifications that the State has put out, looking  
20 to possibly revise those just a little bit, tweak them a  
21 little bit so they are a little more useful.

22           And then our last item, the National Registry is  
23 changing their certification protocols. They are moving  
24 to the new NCCP program. And basically they're saying  
25 50 percent of the training for recertification needs to be

1 at a national level, 25 percent of it needs to be at a  
2 state level, and 25 percent of it needs to be at a local  
3 level.

4 So we are going to study that a little more, see  
5 if we need to do anything or make any changes to make our  
6 recertification protocols more in line with that or if  
7 what we already have in place is going to meet those  
8 requirements with those wanting to keep their national  
9 registry as we go ahead.

10 So that was our total discussion for the  
11 meeting. And like Eric, my term is coming to an end on  
12 the subcommittee as well. So Chris Stratford will be  
13 addressing you the next time.

14 Any questions?

15 **MIKE MOFFITT:** Thank you again as well for your  
16 service in getting that back all times.

17 **VON JOHNSON:** Thank you. It's been a good  
18 experience.

19 **DR. KRIS KEMP:** Thank you, Von.

20 EMS Grants Committee. Chief Ron Morris.

21 **GUY DANSIE:** No, Don Marrelli is going to  
22 present.

23 **DON MARRELLI:** My name is Don Marrelli. I'm the  
24 vice chair of the EMS Grants Subcommittee. Chief Morris  
25 is unavailable to be here today.

1           First, I'll explain some of the changes we've  
2 made from the last grants cycle to this grants cycle. The  
3 last grants cycle we had, I believe, five or six  
4 categories to choose from to -- for grant items. And  
5 we've reduced those two categories. And also you could  
6 only choose one item from either category. That was a  
7 change from what we had in the previous years.

8           So we removed the CME request bracket. And by  
9 removing that, and that was one of our largest requests  
10 for money. So what we have chosen to do was to give any  
11 grant applicant, whether you applied for a per capita  
12 grant or a competitive grant, you would -- initially you  
13 would receive \$1,500 for CME automatically. So you  
14 wouldn't actually have to put in for CME as in the past.  
15 You would just automatically get some CME money. So that  
16 was one of the changes.

17           One of the other changes we had was the spending  
18 time. We've had to be by May 15th and the paperwork had  
19 to be in by, like, the 17th, which didn't give most of us,  
20 or some of us I should say, time to even get the paperwork  
21 from the vendors or such. So we've extended the time to  
22 turn in the paperwork to May 31st and/or I'm assuming the  
23 next business day if it happens to be a weekend.

24           The spend date is still September -- excuse  
25 me -- May 15th. So all the grants have to be spent by the

1 15th of May. All the paperwork has to be turned in by the  
2 31st of May.

3 I believe those are the changes that I can think  
4 of unless --

5 **GUY DANSIE:** We've had a little additional  
6 money, so we upped the CME to 2200.

7 **DON MARRELLI:** Yeah, we'll go over the  
8 additional money on the CME. Are there any other changes  
9 in that, Guy, you can think of that I've missed on the  
10 actual grants?

11 Okay. And I'm missing his name, a gentleman  
12 from finance came in and talked to us about the amount of  
13 money that we had in the grants program this year, which  
14 was \$900,000. The Grants Committee voted to do a 50/50  
15 split on the per capita and the competitive grant money.  
16 And it was -- it was split that way.

17 As Guy was mentioning that the CME, in the end  
18 of the grants discussion, I guess, for the money, there  
19 was enough to bump up the \$1,500 of CME to \$2200 of CME to  
20 each agency that applied for either grant. So that again,  
21 that would just be an automatic, the amount of money if  
22 you applied for one or the other grant.

23 There were numerous agencies that applied for  
24 two items, a few agencies that didn't apply for either of  
25 the categories which was defibrillators and accessories or

1 upgrades, that was one category. And the other category  
2 was medical equipment. Some agencies applied for things  
3 that didn't fit either category.

4 So going through the process as we always do,  
5 we, of course, eliminated some of those grant requests.  
6 And I believe that's it. Unless there's something else.

7 **GUY DANSIE:** Did you want to speak about the  
8 size of the subcommittee?

9 **DON MARELLI:** Okay. I wasn't sure if we were  
10 going to go over that. Our Grants Subcommittee, and I  
11 don't really recall. I believe it was our size -- our  
12 total size was like members, I'm going to say seven to  
13 nine. And that was really quite a workable group.

14 In the past, I'll say a year and a half, when  
15 all the committees were increased to a much larger size,  
16 we're still finding with our Grants Committee that we're  
17 still working with just enough to get a quorum to get this  
18 done. So we're asking to -- I'll have Chief Morris get  
19 with the Bureau. We're asking to reduce that subcommittee  
20 size. It's just -- it's just too large, we believe, and  
21 so we're asking to reduce that size back to where we were  
22 at.

23 **GUY DANSIE:** I believe it was nine.

24 **DON MARRELLI:** I think it was nine in the past.  
25 So anyway, that was one, one other thing we did discuss

1 that -- just so you guys are aware that we'll be --

2 **GUY DANSIE:** We could propose that in the  
3 October EMS Committee meeting. Why don't we -- we plan to  
4 have another grant subcommittee in September, I believe?

5 **DON MARELLI:** Yes, September.

6 **GUY DANSIE:** We could finalize that proposal and  
7 make it to the Committee in October, if that's  
8 appropriate.

9 **DR. KRIS KEMP:** And if I recollect, the reason  
10 why we increased the number was to standardize among all  
11 the subcommittees --

12 **GUY DANSIE:** Correct.

13 **DR. KRIS KEMP:** -- the different roles and  
14 responsibilities so that everyone in the community has the  
15 opportunity --

16 **GUY DANSIE:** To serve.

17 **DR. KRIS KEMP:** -- to fulfill a role if they so  
18 desire. And what I'm hearing is that we're not getting  
19 those positions filled.

20 **DON MARELLI:** Correct. Even the ones we feel  
21 they are not being attended whatsoever, so it's -- we're  
22 asking, you know -- and as Guy said, we'll put a formal  
23 proposal as far as -- we'll go back and see what our  
24 committee was prior to the increase where it really worked  
25 well and it -- just since the change, it just hasn't done

1 well.

2 Are there any questions or comments? Mike,  
3 or --

4 **MIKE MATHIEU:** One comment. We talked about  
5 this earlier, meaning that has come up with in a couple of  
6 EMS Grant Committees, as well as I received phone calls  
7 from some of the providers out there over the frustration  
8 over the last five or six years in the reduction of funds  
9 available for grant funding. There's been a significant  
10 drop upwards of more than 50 percent of what money has  
11 been made available, which has also driven some changes in  
12 our grant rule guidelines to where we've eliminated even  
13 the prioritization at the local levels within the EMS  
14 committees.

15 Frankly, there's been a minimal amount of money  
16 to give out. It's minimized the Grants Committee as well  
17 because we just don't have as many decisions to make  
18 because there's so little money.

19 The chair met with Guy and Paul to try to  
20 determine what were all the factors. Over the last five  
21 or six years we've heard explanations that may have  
22 impacted some of the collection of the fines and  
23 forfeitures. But at the end of the day, the real root  
24 cause here is that if you look at the statute, the statute  
25 says the EMS Bureau of the Department of Health could use

1 some of the grant funding. And what I mean by -- use the  
2 word lightly some, they can use grant funding for  
3 administration. And there's no limiting factor on the  
4 amount that they can use for administration.

5 So what's happened over the years, is some of  
6 the programs within the Bureau have basically been funded  
7 from the EMS grant funding. That's probably been the  
8 largest contributor to the decrease in the amount of funds  
9 available to give out the former grants.

10 As much frustration as that may create amongst  
11 us as providers, the Bureau is being underfunded for their  
12 organization and programs. It's a problem. And rather  
13 than pointing fingers, I think the best solution would be  
14 something to the tune of tasking the EMS Grants Committee  
15 through our chair to look for statutory options of trying  
16 to restore EMS grant funding as we once knew it.

17 And I think that that would be a much more  
18 productive process in all of us trying to identify first  
19 the problem of what's happened. Two, what are the  
20 potential solutions. And then if we do come up with one,  
21 we know legislatively, we make a proposal, one option of  
22 how to solve it, they make -- as our elected officials  
23 they find another way of trying to solve it.

24 From my standpoint, I just want to solve it and  
25 get EMS grant funding back to where it was. We're going

1 to see a complete erosion over time. We're not going to  
2 be able to afford to give any funding, especially in rural  
3 Utah, in those areas where it's so badly needed.

4 So I think we can pool our efforts in trying to  
5 explore, once we get something identified, then we bring  
6 it back to the EMS Committee and ask all of us in the EMS  
7 community to campaign our legislatures and representatives  
8 to help restore this funding in some form or fashion.

9 **DON MARELLI:** Okay. Thanks. Guy, is there  
10 anything else that you can think of that we need to go  
11 over or not? Is that basically it as far as you remember?

12 **GUY DANSIE:** Yeah.

13 **DR. KRIS KEMP:** Okay.

14 **DON MARELLI:** Thank you.

15 **DR. KRIS KEMP:** Thank you. So it sounds like  
16 that's an assignment to the Grants Subcommittee.

17 **MIKE MATHIEU:** Yes, I would like -- especially  
18 since Ron's not here, I would love to make a motion to  
19 assign the chair of the EMS Grants Committee to champion a  
20 cause to restore EMS grant funding for all of us to enjoy.

21 **DR. KRIS KEMP:** That's a motion.

22 **NATHAN CURTIS:** I'll second.

23 **DR. KRIS KEMP:** I have a second. All in favor  
24 say aye.

25 **COLLECTIVELY:** Aye.

1           **DR. KRIS KEMP:** Any opposed? I was going to  
2 say, I don't know if we actually have to make a vote on  
3 that because it's an action item. We can assign our  
4 subcommittees anyway. But we still --

5           **MIKE MATHIEU:** That's so good.

6           **DR. KRIS KEMP:** We have a motion. Great. And I  
7 guess if it does come down to where we have to lobby our  
8 legislatures to make the change, you know, since we're now  
9 over the school nurse program for Epi-Pens, anything can  
10 happen.

11          **MIKE MATHIEU:** Maybe we need some money for that  
12 too.

13          **DR. KRIS KEMP:** Yeah, maybe. Maybe. Oh, boy.  
14 Okay. On to informational items. EMS  
15 earthquake disaster plan. Mike Stever.

16          **MIKE STEVER:** I'm a pretty lucky guy that I have  
17 my boss come and set me up for my computers, though. I'm  
18 thanking my lucky stars today.

19                 My name is Mike Stever. I'm the emergency  
20 manager for the EMS Preparedness Bureau, Utah Department  
21 of Health. And part of my responsibilities are disaster  
22 planning, exercise preparedness, those sorts of things.  
23 And this catastrophic earthquake plan falls under that  
24 bailiwick. So that's why I'm here today, to kind of give  
25 you an overview and a briefing of the role that EMS had in

1 this particular responsibility here. And --

2 Brace yourself, you may want to cover your ears.

3 So what I've decided to do in this presentation,  
4 in respect for people's time is that we're going to kind  
5 of provide the Reader's Digest version of a very  
6 complicated process. And of all of those complications,  
7 mostly it turns out to be BFOs or blinding flashes of the  
8 obvious. So there's not a real lot of technical things in  
9 here, but a lot of things that we need to gather in, put  
10 under the umbrella and then share so that everybody can be  
11 a part of it and understood what we are doing.

12 **GUY DANSIE:** We're getting our tech help.

13 Sorry.

14 **MIKE STEVER:** Okay. I'm just going to go ahead  
15 and talk while this gets going so we don't have to waste  
16 much time on this.

17 The catastrophic earthquake plan targets the  
18 Wasatch Fault and the metropolitan area from the Salt Lake  
19 Valley. That's not the only place that's going to suffer,  
20 but that's where the primary -- the big damage is going to  
21 be. Okay, this is going to be the bad actor.

22 And so what FEMA did is put together a private  
23 contractor to come in and write this terrific earthquake  
24 plan, and they did it, and they did it pretty well. Are  
25 we good to go? Oh, wow.

1           My fingers are crossed. Drum role. Ta-da.

2       Wow, that was easy.

3           Okay, so that -- a part of that old plan was  
4       that it was a lot of very good words and a lot of  
5       strategic, interesting things, but it didn't really cross  
6       the bridge that is so tough in the world of disasters, in  
7       catastrophic events between what we can really do and what  
8       somebody says.

9           So basically decided to redo it and to try to  
10       make it more functional and more appropriate for local  
11       response. We have a saying, you know, there may be a  
12       storm from one end of the country to the other, but it  
13       only rains at the local level. So trying to bridge that  
14       gap. And that's what this catastrophic earthquake plan  
15       was meant to do.

16           And part of it was that we wanted it to be  
17       stakeholder oriented and they decided that emergency  
18       support function A, which is help in medical, should be  
19       the first part of that plan. So it's going to be a  
20       gridded plan from transportation, utilities, and schools  
21       and everything else, but we've got a pretty good track  
22       record of getting things done. And so they decided that  
23       the ESFA, which is health and medical, Emergency Support  
24       Function A would kind of take the lead in this. This is  
25       part of a much larger plan.

1           What we decided at the State Department of  
2 Health was to pool the teams together and create basically  
3 a work plan. Our goals, our objectives, what do we want  
4 to do, strategies, and decide certain tasks that were  
5 common to all. So that's what kind of brings us to this  
6 point.

7           The different work groups that we decided for  
8 ESFA, that's only health and medical, were situational  
9 awareness, support life-saving functions and operations,  
10 life supporting, which means that the life saving is kind  
11 of the red lights and siren part of it, life supporting is  
12 the healthcare part of it, the hospitals that have to  
13 continue providing care, and then mass fatality  
14 operations.

15           So for us right now that was the big four. And  
16 if you get a chance when we get this finally done, you  
17 would see lots of things under each one of those. In  
18 particular, for example, on the situational awareness, the  
19 challenge with that is -- I don't even know a good way to  
20 say it. We ought to be the best information sharers on  
21 the planet, and we don't always do that. The platforms  
22 are there, but we never ever practice them. So that  
23 becomes a paramount corridor for us.

24           The EMS and preparedness part of it, which fell  
25 to the Operations Subcommittee, we kind of recruited them,

1 and they were phenomenal in getting things done and  
2 providing good information. So we're talking mainly about  
3 the life-saving operations at the very beginning.

4 Now, I put this time line up here and you can  
5 see it's been going for quite a while. And you can also  
6 see that we are a little bit -- not a little bit, we are  
7 behind in getting it done.

8 Part of the reason for that is that assignment  
9 came to the Utah Department of Health, and I know a lot of  
10 you can relate to this, with no money. And so everything  
11 that we did, we basically had to take out of our hide.  
12 And we recruited a lot of local individuals to help us, a  
13 lot of state individuals to help us that weren't  
14 necessarily in our particular bailiwick. And when you  
15 depend on volunteers, sometimes that time becomes very --  
16 it's paramount to make it happen. Okay?

17 And then, I'll be damned -- I'll be darned,  
18 okay, if Ebola didn't come around. And that literally  
19 consumed us. Okay? And so we had Ebola. And then the  
20 Zika and all these other little -- our real jobs kept  
21 getting in the way. And so we're a little bit behind  
22 overall, but not with the EMS part of it. They did a good  
23 job of kind of spearheading too. Eric and company, they  
24 were a big encouragement.

25 So what we decided to do in our prehospital and

1 patient-moving operations was to basically decide what our  
2 mission was, who's going to be the players, and this is  
3 where it starts getting complicated, folks. What are our  
4 current capabilities? And part of the reason for that is  
5 after the earthquake, the variables are endless on what  
6 our capabilities are going to be. We just don't know. So  
7 a lot of it was best guess. Okay?

8           Keep in mind that when that earthquake occurs,  
9 it's not just one thing. It's that series of catastrophic  
10 events. You know, and almost everybody in our valley will  
11 also be victims. Not necessarily casualties, but there  
12 will also be victims. They have families, the disruptions  
13 of utilities and everything will affect them too. So that  
14 became a real challenge.

15           Next is resources. And we have good lists of  
16 resources, but we've got more lists than you can shake a  
17 stick at. So to try and bring those all together and put  
18 in one particular annex of how many ambulances do we have,  
19 how many backups, who owns them, who has responsibility  
20 for dispatching them, how will we make them work, and what  
21 can we expect after the earthquake?

22           Scenario impacts, I'm not going to make your day  
23 when I say this, it's gotten worse. The possibility of a  
24 catastrophic earthquake in our valley has been increased.  
25 Okay? And the latest stuff that comes out of the

1 geological service is that we're overdue.

2           And so we have to approach this and try to avoid  
3 what I call the chicken little syndrome. You know, why  
4 are all those guys running around tomorrow, but I would  
5 submit to you folks if we have a window of vulnerability,  
6 then we have a moral obligation to prepare ourselves and  
7 be ready. And so a lot of times there are runs that need  
8 to be made today, and this catastrophic planning gets  
9 pooh-poohed and put on the back burner. So it's an  
10 endless sales job of the importance of it.

11           Once we got that, we had to think of possible  
12 courses of action. And we did that in those phases that  
13 you can see up there, what needs to be done immediately,  
14 what do we report doing a 24/48-hour duty? And all of  
15 that needed to be put in there with a dose of reality.  
16 Okay? It's easy to say, well, we could do this, this and  
17 this. Well, can you do it if you only have 40 percent  
18 show up for work? And not that they necessarily will be  
19 dead, but they could have real serious problems in just  
20 getting around the valley. So that's kind of what our  
21 marching orders were and how we approached that.

22           The particular annex for prehospital care or  
23 patient movement should have been done for today. And I  
24 feel very confident, comfortable in saying it's about  
25 95 percent done. And this is through no fault of the

1 operations subcommittee. They were, like, cracking the  
2 whip to get things done. We just didn't have the staff,  
3 time to go and dig things out.

4           What we are missing in particular are some  
5 details, names, addresses of facilities and things like  
6 that. So when you find that, we can bring it in, but it's  
7 a little bit right now of a void that we need to fill.

8           When we get that done, you'll be able to take  
9 that annex and then we start looking at challenging  
10 ourselves to make sure it will really work. And the way  
11 to do that is with exercises, making people aware of the  
12 plan. We've identified staging areas and we actually took  
13 the valley and divided it up into four areas. There may  
14 very well be islands in the valley caused by the canals  
15 and the freeway collapses and stuff like that. So how are  
16 we going to get in from north, south, east, west? You  
17 catch my drift. And so all of that has been completed.  
18 it's in the plan. Because the collection points have been  
19 identified and put in the plan, but we as a State Health  
20 Department own none of that. So what we have to do is  
21 coordinate with locals.

22           And just very quick, and I know time is  
23 precious, but a war story in a previous assignment when I  
24 was with Salt Lake City, we decided that we were going to  
25 use golf courses for a -- volunteer coordination centers.

1 As you know, after a disaster these volunteers come out of  
2 the woodwork and imagine these golf courses, they've got  
3 parking lots, they've got lights. A lot of them have a  
4 kitchen there. You know, it's going to be great.

5           And boy, I tell you what, I thought that was the  
6 cat's meow, but we forgot to tell the golf courses. Okay?  
7 And then when we went to the golf courses and said this is  
8 what we want to do, they says oh, not only no, but hell no  
9 because we're a golf course. We said, look, if we have a  
10 7.5 earthquake, that goes away. And they says, okay, yeah  
11 we agree with that. But also the police are going to use  
12 this as a staging area.

13           So a lot of things that we never thought of when  
14 we did this initial planning, and we've got it all down,  
15 but it's going to be hammered out and there will be some  
16 changes made to the staging areas and stuff like that.

17           So we don't know what's going to survive. So  
18 with two of five staging areas, and hope we have two of  
19 them that we can use. You kind of catch my drift with  
20 that.

21           And the requesting protocols, there's a slug of  
22 things out there, that CDC, HHS and FEMA will bring to us,  
23 how do we ask for it? And how do we get it here? And so  
24 all of that is in the plan. And it's going to be tested  
25 once we make those few final fill in the blank sorts of

1 things. Okay?

2 And then it will be -- a final copy made and  
3 we'll see if we can get that out and get it printed and,  
4 you know, out to everybody, and then we can exercise it.

5 So it's a FEMA plan. It's their plan, but it  
6 means nothing without our support and our participation.  
7 And at this point in time as of today, the prehospital EMS  
8 part of it, like I said, is probably 99 percent done.  
9 There's some filling in that's just going to take staff  
10 time and legwork to get done. And that's where we're at.

11 If you have any questions or anything, I'll be  
12 happy to help as best I can with that. Seeing none, thank  
13 you. I do appreciate your time.

14 **DR. KRIS KEMP:** All right. Thank you.

15 EMS injury prevention survey, Andrea Baxter.

16 **GUY DANSIE:** I just wanted to introduce Andrea  
17 Baxter to all of you. She's an intern. She's probably  
18 the best intern I've ever had and she's been very  
19 instrumental in actually developing the EMS earthquake  
20 plan.

21 And she also did a project for me earlier. One  
22 of our strategic goals for the Department of Health,  
23 Bureau of EMS and Preparedness was to assess the injury  
24 control or injury prevention things that are going on in  
25 the state for ambulance providers as well as hospitals.

1 So I'm just going to have Andrea give you a quick rundown  
2 on her survey that she performed for the State.

3 Is that good? If you want to say anything else,  
4 you can. Is it working? No signal? Back, back.

5 **ANDREA BAXTER:** Well, in the meantime as  
6 everything is getting set up, we started this survey back  
7 in February. Many of you probably answered the survey for  
8 us, and so I'm going to talk a little bit about it.

9 This survey was first given out in 2004 and we  
10 decided it's 2016, it's time to redo the survey. The  
11 first time this was sent out, it was done paper. And now  
12 we have the wonderful use of technologies like Survey  
13 Monkey that we were able to send this out electronically  
14 and we were able to have an increase in responses.

15 So we sent this out to 46 hospitals and the 92  
16 EMS agencies. Once we got all of our responses back, we  
17 had 11 hospitals respond and 24 EMS agencies respond back  
18 to us. And we sent that out for about two and a half  
19 weeks, just waited for everything to come in. And once we  
20 got those responses, we were able to assemble a little bit  
21 more information from those questions.

22 These questions varied from if you had an injury  
23 prevention coordinator to what you do in injury  
24 prevention, what other ways that you use injury  
25 prevention, and we went from there.

1           The current thing that we noticed was hospitals  
2 only had -- half of them that were surveyed had injury  
3 prevention coordinators. Many of them were filling other  
4 positions as well.

5           And this was also the same with our EMS  
6 agencies. Eighteen out of the 24 were not -- did not have  
7 injury prevention coordinators, and those that were injury  
8 prevention coordinators also filled other duties such as  
9 captains or they were for part of training or health  
10 safety.

11           When we looked into promotion for injury  
12 prevention activities, hospitals mostly used Facebook,  
13 radio and local newspapers. And they would love to have  
14 some more help in creating programs and activities.

15           This was also the same for our EMS agencies.  
16 And EMS agencies tend to focus a little more on local  
17 television, newspapers and city websites, as well as  
18 Facebook.

19           And then as we further looked into it, we  
20 noticed that both hospitals and EMS agencies would love to  
21 have a best practices resources guide so that they were  
22 able to pull ideas for injury prevention activities from  
23 that way, and they would love to be more involved in  
24 legislature. Hospitals were mostly involved with helmet  
25 laws, seat belt laws, and child safety seat laws.

1           And EMS agencies have been mostly involved with  
2 seat belt laws and sledding hill restrictions.

3           And one of our personal favorite things that we  
4 found as we were doing this survey, was we got a response  
5 back from one of the hospitals that said in an answer to  
6 this question, "Share any successful strategies or ideas  
7 for injury prevention in your area," and they responded,  
8 "None. The elderly just keep falling."

9           So we are going to continue to try to assemble  
10 things for the injury prevention programs, and thank you.

11           **DR. KRIS KEMP:** All right. Thank you. All  
12 right. RSI report on the pilot program with Layton City  
13 Fire Department and Davis County Sheriff's Department, Dr.  
14 Oraskovich. I started this morning's meeting since 7 a.m.  
15 with Dr. Oraskovich and have yet to go home. Poor me.

16           All right, take it away, Mark.

17           **DR. MARK ORASKOVICH:** Let's see if this computer  
18 will work. See if we are two for three here.

19           Do you want me to air play it or do you want me  
20 to hook up?

21           **UNKNOWN:** You can now.

22           **DR. MARK ORASKOVICH:** If only it could be that  
23 simple in our health care.

24           So I'm Mark Oraskovich. I don't know if  
25 anyone -- everyone knows me. I've been in front of this

1 committee a couple of times with the pilot project that  
2 we've done with the State Bureau of EMS on doing rapid  
3 sequence intubation in ground-based EMS crews.

4 I'm coming back to you after having last been  
5 here about two years ago where we talked about doing a  
6 pilot project looking at rocuronium and ketamine as our  
7 sedation and paralytic agent and also expanding our age  
8 group to include more of the pediatric age criteria.

9 So this is just an informational presentation  
10 that I wanted to go through with you. Our program has now  
11 been in place for about four to five years. We continue  
12 to have a very successful RSI program. We have a variance  
13 from the State. I've been performing RSI now under that  
14 variance for, oh, just over the last two years.

15 Between Layton City Fire and Davis County  
16 paramedics, we've probably done -- is it coming up? Did  
17 we lose it? I spoke too soon. Anyway, I'll let him mess  
18 with that and see if he can get it going.

19 So overall the program has been a very  
20 successful program. I would say we have just under 100  
21 intubations using rapid sequence intubation between the  
22 two programs. Our success rate is in the 98 to 99  
23 percentile, which would be compatible with what you would  
24 find in an emergency department setting.

25 Our first pass success rate in terms of getting

1 the tube in on the first try is currently at 82 percent.  
2 When we were before you last time, we were at about  
3 75 percent. So we've improved on that.

4 We are going to video overall about 83 percent  
5 of the time right now. If you look at just the last two  
6 years, we're going to video, so GlideScope or King Vision  
7 over 90 percent of the time now. So that has definitely  
8 become kind of the go-to airway management tool.

9 And we continue to be mainly medical indications  
10 for doing RSI. Similar to what we had two years ago when  
11 we were here, about three quarters of the RSIs are  
12 performed on medical patients. Ultra level of  
13 consciousness of your stroke, overdoses comprise a lot of  
14 those, and then about one quarter of those are trauma  
15 patients.

16 We still have a vigorous ongoing training and QA  
17 program. This was kind of the tenant of our program right  
18 from the start, that we would do aggressive training  
19 upfront. That's all been in place.

20 We continue to send paramedics into the  
21 operating room to get extra experience because in a  
22 program like this, the numbers aren't huge. And so the  
23 ongoing educational program is a big component of it.

24 We do annual airway training days where we  
25 dedicate an entire day to training on airway, both

1 practical sessions and didactic training. We do ongoing  
2 bedside testing where we take a crew and pull them aside  
3 and test them on the spot. And then we do impromptu  
4 written testing as well.

5 We're also still sending crews to the difficult  
6 airway course as we have done right at the beginning.

7 In terms of QA, we continue to maintain an  
8 aggressive database where we're kind of placing all this  
9 data, things like intubating saturations before, during  
10 and after the intubation. In title CO2 measurements every  
11 case is a hundred percent QA by myself as well as Jason or  
12 Cory. Cory is with Davis County Sheriff and Jason is with  
13 Layton City Fire. And so there's 100 percent oversight on  
14 every one of these. And any cases that come up that we  
15 feel are worthy of review are then brought up for a review  
16 on a -- is it coming up -- the slides really aren't that  
17 interesting, so --

18 **JASON NICHOLL:** That's pretty cool.

19 **DR. MARK ORASKOVICH:** Don't go far.

20 Two of the things that are newer with the  
21 program, we have at Layton City Fire purchased two  
22 transporting ventilators. We're using the Zoll EV-Plus  
23 Transport ventilators. And so we've instituted a training  
24 program with these. But any patient who is intubated is  
25 now being transported with this ventilator in place.

1           We've also instituted a checklist. This has  
2 come from Jason's work at AirMed. And anytime a crew is  
3 employing use of RSI, one person in that, back of that  
4 ambulance is going through the checklist one by one to  
5 make sure nothing is being missed and we're completing  
6 things in the order they should be done.

7           So when we came before you two years ago, we  
8 proposed that we would look at rocuronium and ketamine as  
9 an adjunct to succinylcholine and etomidate, which were  
10 the original two agents that were approved for our use.

11           And so two years now we have under our belt with  
12 experience with ketamine and rocuronium. And the second  
13 thing we'd also come before this committee was to talk  
14 about expanding our age group down into the pediatric  
15 category.

16           So talking about rocuronium and ketamine, when  
17 we first started those, March of 2014 when we came before  
18 this committee, it took a while to actually get the  
19 ketamine. There were some issues with, I think, Jason, it  
20 was with my DEA to be able to purchase ketamine. So there  
21 was probably a six-month delay between when we got  
22 approved to do this and when we could actually purchase  
23 it.

24           And we've left it up to the medical providers in  
25 the field to decide if they are going to go with etomidate

1 and succ or they are going to go with rocuronium and  
2 ketamine. And I think we saw looking at the data that  
3 there was a little bit of an adoption curve. Early on  
4 people were sticking more with etomidate and succ and now  
5 we've seen much more use of roc and ketamine. Probably to  
6 the level of almost 100 percent of the last six months are  
7 with rocuronium and ketamine.

8           So overall between the two agencies, 58 percent  
9 of the cases involve the use of rocuronium and ketamine.  
10 Of those, 100 percent were deemed successful RSIs, meaning  
11 the tube was established either on the first, second, or I  
12 think we had one case on the third attempt. We had an  
13 88 percent first pass success rate on passing the tube,  
14 which is up from 75 percent when we came before you two  
15 years ago. We had no complications whatsoever with our  
16 use of rocuronium and ketamine.

17           And I would say this mirrors what we see in the  
18 emergency department setting. That there has been a move  
19 in the last few years to adopt more Roc and ketamine use  
20 in RSI for a multitude of reasons. Probably the most  
21 important, you don't have to remember that big laundry  
22 list of contraindications when it comes to  
23 succinylcholine.

24           In terms of pediatric RSI, we had taken our age  
25 from 16 down to 8 and above after last coming before this

1 committee. We do not have any pediatric RSI cases to  
2 report in a two-year time frame. We would have hoped for  
3 some. There may have been some opportunities that were  
4 there that were missed, but in reality we didn't have any  
5 pediatric RSIs.

6 In going forward from this point, I propose that  
7 we change that age group from 8 and above to 12 and above.  
8 And that has come about in discussions with Peter and also  
9 with some of the pediatric providers from Primary. And  
10 Hallie, if you have any comments on that, I would welcome  
11 it, but...

12 **HALLIE KELLER:** Specific comments for this in  
13 general, has to be a problem again of --

14 (Reporter interjected she can't hear.)

15 **DR. KRIS KEMP:** She mentioned that this is an  
16 ongoing problem with pediatric intubations in that it's a  
17 continual problem that you don't get enough.

18 Anything else to add?

19 **HALLIE KELLER:** I don't have anything else to  
20 add. I'm curious why the age. I don't have a problem  
21 with the age going up at all, but I'm just curious why  
22 that is changing.

23 **DR. MARK ORASKOVICH:** I think it was a  
24 decision -- Peter and I talked about it, and there was  
25 some discussions in terms of the way -- there's been some

1 national movement in some states to up, to just do away  
2 with pediatric intubation altogether, and I know there's  
3 been some discussions in this state about whether that  
4 becomes an optional item or not.

5           The educational component is huge. It's huge  
6 for this program overall. Twelve and above isn't much  
7 different than what we're doing with adults. Eight and  
8 above does have, I think, a stronger educational component  
9 that has to be there. When you don't have any cases in  
10 two years even to review, I felt it was worthwhile going  
11 to an older age group that's more similar to an adult  
12 population.

13           **HALLIE KELLER:** Sure.

14           **DR. MARK ORASKOVICH:** Is there any questions?  
15 That's really all I have for you today. This would  
16 conclude our two-year pilot project and then I'll be  
17 working with Peter going forward. Thank you for your  
18 time.

19           **DR. KRIS KEMP:** All right. Thank you.

20           **DR. PETER TAILLAC:** Real quick.

21           **DR. KRIS KEMP:** Yeah, Peter.

22           **DR. PETER TAILLAC:** I just want to congratulate  
23 these two agencies for sending out with what -- like  
24 there's never a simple project -- like sending out what  
25 would seem like a fairly simple concept but really taking

1 care of every single detail and doing that continuously  
2 for the several years it's been going on. Very nice  
3 work -- I want to mention Dr. Liden as well. Lyon,  
4 sorry. And by the two worker bees Jason and -- is Cory  
5 here? Stand up Cory, okay. So thanks, nice work.

6 I think this has proven in my mind the theory  
7 that if you train a few people to do something very well  
8 and keep them trained, that they can do it very well. And  
9 we'll see where it goes from here.

10 **DR. KRIS KEMP:** And I would add to those  
11 sediments. I think the biggest point that all of us in  
12 the state and with our own agencies that we have to  
13 realize is that the high level of training and education  
14 that was required and accomplished as tasked, this was not  
15 a fly by night, you know, let's take 15 minutes and do  
16 intubations on a mannequin head and call it good and put  
17 it in the hands of everyone in the ambulance service.  
18 That will be disastrous, and I don't think it's a wise  
19 decision.

20 So to replicate these results requires  
21 replication of the entire process. And that's the way  
22 medicine should be. We don't want to extrapolate, well,  
23 they did an intubation program and they had great success,  
24 so, so can we if we don't follow all of the additional  
25 details. Because that's where this became successful.

1 And that's where I think the accolades should reside, is  
2 the detailed work that was maintained to uphold that  
3 really high level of standard.

4 And so moving forward, were this to be a  
5 variance that comes across the desk for any agency, expect  
6 that you will be under the same scrutiny for training.

7 Thank you.

8 Round table discussion. Guy.

9 **GUY DANSIE:** We're just feeling a little proud  
10 of our Image Trend finally taking some steps forward. And  
11 I would just like to give you a quick update on our data  
12 system.

13 **SCOTT MUNSON:** So we launched our new license  
14 and certification management system on July 1st. So that  
15 system went into production. All the legacy data from the  
16 previous application formally known as BEMS was moved over  
17 to that system. So we're working with that right now.  
18 Felicia and I are just working through a few bugs and some  
19 issues with Image Trend to make sure we've got that, all  
20 those addressed.

21 Some of the benefits with that, though, is now  
22 when providers go to update their license, it's all  
23 online, so there's no more mailing paperwork or anything  
24 and you can just go to the system online, upload all of  
25 your documentation, fill out the application there. So

1 there's some real benefits that come along with that.

2           As far as the prehospital data system, we're --  
3 so the license management system had to be implemented  
4 first and so now we're starting the process to get the  
5 prehospital data system up and running. So we're on a bit  
6 of an accelerated time line to get that done quickly. I'm  
7 hoping in the next couple of months we'll have that  
8 environment up and we can start providing training to  
9 agencies that will be interfacing directly with that  
10 system and then also working with agencies that use a  
11 third-party vendor to pass their data to the system.

12           So that's where we are today. Any questions  
13 from the group? Okay. Thank you.

14           **DR. KRIS KEMP:** All right. Additional round  
15 table, I guess there's a notary available; is that  
16 correct --

17           **SUZANNE BARTON:** Yes.

18           **DR. KRIS KEMP:** -- for those individuals that  
19 are marked on the agenda for disclosure statements.

20           Any further discussion from the Committee?

21           All right. With that I think I'll accept a  
22 motion to adjourn.

23           **JAY DEE DOWNS:** So moved.

24           **DR. KRIS KEMP:** All right. We will adjourn.

25           Next meeting October 12th.

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(Meeting was adjourned at 2:30 p.m.)

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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 26 day of July, 2016.

\_\_\_\_\_  
SUSAN S. SPROUSE, RPR, CSR  
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