EMS RULES TASK FORCE MEETING
DECEMBER 9, 2015 AT 1:00 PM
3760 S. HIGHLAND DRIVE, ROOM 241
SALT LAKE CITY, UTAH 84106

Reporter: Susan S. Sprouse

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

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A P P E A R A N C E S

Guy Dansie
Jay Dee Downs
Jason Nicholl
Lauara Synder
Randy Wilden
Don Marrelli
Tami Goodin
Raul Garcia
Dean York (Telephonically)
Teresa Brunt (Telephonically)

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1 December 9, 2015 1:00 p.m.
2 * * *
3 **JAY DEE DOWNS:** Okay. Let's go ahead and call
4 the meeting to order. We've got Randy here today.
5 **RANDY WILDEN:** Whoo hoo.
6 **JAY DEE DOWNS:** He's alive.
7 **RANDY WILDEN:** It's not just the voice.
8 **JAY DEE DOWNS:** It's not the voice? You look
9 different than the other meetings, Randy.
10 **RANDY WILDEN:** I showered.
11 **JAY DEE DOWNS:** You look kind of like a
12 triangular thing.
13 **RANDY WILDEN:** Hovercraft.
14 **JAY DEE DOWNS:** Hovercraft, yeah. Welcome
15 anyway.
16 Who do we have on the phone today? Teresa, I
17 hear.
18 **DEAN YORK:** Dean York.
19 **JAY DEE DOWNS:** Dean. Hello, Dean.
20 **TERESA BRUNT:** Yes, I'm here.
21 **JAY DEE DOWNS:** Anybody else? Nobody else.
22 So...
23 **GUY DANSIE:** Let's do introductions. We have
24 some gentlemen with us, some guests, so let's --
25 **JAY DEE DOWNS:** Do you want to introduce the

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1 board or do you want them to introduce themself?
2 **GUY DANSIE:** Well, let's introduce and then
3 they'll know who we are and what we represent.
4 **JAY DEE DOWNS:** Okay. Okay.
5 **GUY DANSIE:** If that's worth anything.
6 **JAY DEE DOWNS:** We'll start with Don Marrelli
7 and go around the table.
8 **DON MARRELLI:** Don Marrelli with rural EMS
9 directors.
10 **JAY DEE DOWNS:** This is the tigger lady.
11 **GUY DANSIE:** Susan. And I'm Guy Dansie. I'm
12 with the Bureau of EMS and Preparedness.
13 **SUZANNE BARTON:** Suzanne Barton with the Bureau
14 of Emergency Medical Services and Preparedness.
15 **RANDY WILDEN:** Randy Wilden, fire chief, North
16 Tooele Fire representing fire base EMS.
17 **TAMI GOODIN:** Tami Goodin with the Bureau of
18 EMS.
19 **RAUL GARCIA:** I'm also with the Bureau of EMS,
20 Raul Garcia.
21 **JASON NICHOLL:** Jason Nicholl. I'm representing
22 the State EMS Committee.
23 **DAN DITTO:** Should we introduce ourselves?
24 **GUY DANSIE:** Yeah, please do.
25 **DAN DITTO:** I'm Dan Ditto, senior legal counsel

1 for Intermountain Healthcare.
2 **ARTHUR PETERSEN:** Arthur Peterson. I'm the
3 regulatory compliance manager for Intermountain Healthcare
4 supporting the emergency departments and the trauma teams.
5 **ROGER KEDDYTON:** And Roger Keddyton. I'm the
6 regional education consultant for the Emergency
7 Departments of Intermountain Healthcare in the valley.
8 **JAY DEE DOWNS:** Cool. All right.
9 **LAUARA SYNDER:** Lauara Synder, Wendover
10 Ambulance representing private ambulance.
11 **RUS MALONE:** Rus Malone, I'm actually on the
12 Professional Development Committee, but also Salt Lake
13 Community College course coordinator, still on the EMS
14 test team.
15 **JAY DEE DOWNS:** And I'm Jay Downs. I represent
16 EMS Committee, also the vice chair liaison. Welcome
17 everybody.
18 **GUY DANSIE:** And I believe we have our phone
19 folks.
20 **JAY DEE DOWNS:** And you phone folks. Dean?
21 **DEAN YORK:** Dean York, Provo EMS Division
22 representing the paramedics.
23 **JAY DEE DOWNS:** Teresa Brunt.
24 **TERESA BRUNT:** This is Teresa Brunt. I
25 represent the Emergency Nurses Association. Sorry I can't

1 be there for the...
2 **GUY DANSIE:** Oh, that's all right.
3 **JAY DEE DOWNS:** You and Dean look the same to us
4 today.
5 **TERESA BRUNT:** Sweet. Just don't tell me I look
6 like Roger.
7 **ROGER KEDDYTON:** Thanks Teresa.
8 **TERESA BRUNT:** I say that with love.
9 **GUY DANSIE:** A little bad blood there, huh?
10 **JAY DEE DOWNS:** Go get on the phone, Roger. You
11 look just the same to us.
12 Okay. Let's go ahead and get -- right off the
13 bat, let's go to No. 2. Guy.
14 **GUY DANSIE:** Okay. I was contacted by our
15 guests today about -- and Paul Patrick about blood borne
16 pathogen exposure for EMS. And maybe you -- would you
17 mind explaining your concerns and some of the things we
18 talked about the other day?
19 **DAN DITTO:** We now made Arthur to be our
20 spokesperson --
21 **GUY DANSIE:** Okay.
22 **DAN DITTO:** -- with some great backup help.
23 So...
24 **GUY DANSIE:** We'll back you up on anything you
25 need to.

1 **ARTHUR PETERSEN:** So Intermountain Hospitals in
2 the Salt Lake valley are working on a streamline process
3 to handle any blood borne pathogen exposure, and whether
4 that be an employee -- and am I loud enough for the phone?
5 **GUY DANSIE:** What?
6 **JAY DEE DOWNS:** Why don't you sit at the table.
7 **ARTHUR PETERSON:** Can you hear me on the phone,
8 Teresa?
9 **TERESA BRUNT:** Yeah, I'm good. I can hear you.
10 **JAY DEE DOWNS:** She's just tuning you out.
11 **SUZANNE BARTON:** Dean, can you hear okay?
12 **DEAN YORK:** Loud and clear.
13 **ARTHUR PETERSON:** So we're working on -- Roger,
14 actually, has been taking the lead on this the last year
15 or two.
16 **ROGER KEDDYTON:** The last six months in
17 particular.
18 **ARTHUR PETERSEN:** Six months in particular.
19 He's working on a streamline process to get that
20 evaluation done for an exposed patient as soon as possible
21 so we can know whether or not that patient needs
22 prophylactic treatment for HIV, prophylactic treatment for
23 Hepatis B, if they are not already immune, and then also
24 from follow-up monitoring in case they are exposed to Hep
25 C.

1 And as we were working -- as he's working on
2 that process, he said, "Well, are there any regulations
3 that we need to be aware of?" And that's where I found
4 that there is a regulation, an administrative rule based
5 on the statute that talks about this for EMS exposures as
6 well as for others.
7 So we were really looking at what was our duty
8 as a hospital. And as we reviewed that, and I talked with
9 Dan, he brought up some ideas that we had some privacy
10 concerns. And we had questions about the rule, trying to
11 understand the rule, interpret it. And we brought those
12 questions to Guy.
13 And then earlier this week, we found, we found
14 the statute itself and read through that. And that
15 statute addressed some of the concerns and questions that
16 we had, but it left some additional questions on -- the
17 statute seemed to be quite broad, but the EMS rule was
18 fairly narrow focused on EMS staff and certain scenarios.
19 And so we were trying to reconcile the two and just
20 bringing to this group a discussion of how's the best way
21 for us to interpret the rule and the statute. Dan.
22 **DAN DITTO:** I'll just wheel up here.
23 It appears to us that the rule as it currently
24 is constituted, and we had this discussion a little
25 earlier, looks like it might be a bit outdated in terms of

1 how it relates to the actual code. And so our
2 recommendation, I guess it was Paul's or your
3 recommendation, would be come to this group since you are
4 the brain trust behind the -- updating the regulations or
5 where there's a differential is to make a recommendation
6 to update that regulation so it's more consistent with the
7 statute.
8 We were going to have some specific suggestions,
9 but as we went through the code, we felt like it's pretty
10 clear and may just be the regulation itself that needs to
11 be adjusted. So we're happy to give any input from our
12 side of things, happy to assist in any way, but mostly
13 we're just bringing it to your attention and giving you a
14 hospital perspective in this situation.
15 **GUY DANSIE:** All right. There's some things as
16 we read through the administrative rule. One thing just
17 upfront, it is under the Labor Commission's authority.
18 **DAN DITTO:** Yeah, that was a question too.
19 **GUY DANSIE:** And I've sent them an email, I
20 haven't heard back, but I would like to have them, you
21 know, and I don't have the authority to change their rule.
22 **ARTHUR PETERSEN:** Sure. Right.
23 **GUY DANSIE:** But what we probably would like to
24 do is go through and make a draft and suggest some changes
25 and then propose that to them, and hopefully they can

1 adopt those. Or we could, this is another option, this
2 seems to be more on the reporting side, on the
3 compensation side, if there's any additional operational
4 type issues, we can put that in our rule and reference it,
5 cross reference it back to this, as long as it's in
6 harmony with whatever the Labor Commission has on theirs.
7 So either -- probably one or the other.
8 And Paul even suggested maybe we speak to them
9 and see if they would allow us to strike this portion of
10 their rule out and just to put it in our operational rule,
11 and then we would have ownership of that.
12 I don't know how -- as far as the specific
13 things that pertain to -- for insurance purposes or for
14 the cost, if they'll let us do that or not, but that's
15 kind of where we are at on things on our end.
16 **DAN DITTO:** One of the things that might make
17 that a challenge, is the code basically puts it in there,
18 in their stewardship, I guess. But it just seems like
19 there's some things that really ought to be within this
20 EMS stewardship other than just the financial side.
21 **GUY DANSIE:** Right. Right.
22 So that's why we brought it here today. We gave
23 it to you on kind of short notice and maybe you haven't
24 had a chance to look through it.
25 Are there any things as you look at the -- I'm

1 having issues up here, but as we look through it, is there
2 anything that jumps out at you as being outdated or needs
3 to be reviewed today? Maybe we could look at a few of
4 those things now. And if you would like to suggest some
5 wording changes we can go ahead and add it to the rule and
6 go from there.
7 Did you have something?
8 **LAUARA SYNDER:** I had a question. I saw the
9 email came through about, I think it was a link to the
10 code, actually the statute.
11 **GUY DANSIE:** Yeah.
12 **LAUARA SYNDER:** But without really -- and I
13 didn't have the time to read it, I'm sorry, but without
14 really knowing what that says, aren't we kind of working
15 in the blind trying to change it or without knowing what
16 that says?
17 **GUY DANSIE:** A little bit.
18 **ARTHUR PETERSEN:** And that link is -- actually
19 looks like this document here that we bring.
20 **LAUARA SYNDER:** Okay.
21 **ARTHUR PETERSEN:** The first link was the statute
22 and the second link was this rule.
23 **DAN DITTO:** And since we just met last week with
24 you folks, we really haven't had a chance to thoroughly
25 vet everything ourselves. But there's a couple of things

1 that we struggled with in terms of the EMS service
2 provider exposure report form which is --
3 **GUY DANSIE:** I know it's referenced in the rule.
4 **DAN DITTO:** Right.
5 **ARTHUR PETERSEN:** Right.
6 **DAN DITTO:** And particularly since the way that
7 this actually works, we are disclosing certain
8 information. And the form itself says to the -- to the
9 person who is -- correct me if I say anything wrong or if
10 you should be saying it.
11 **ARTHUR PETERSEN:** Go ahead.
12 **DAN DITTO:** But one thing that I was
13 particularly concerned about was the statement that we had
14 in here that I give my permission to the facility, and
15 that's us, so that's why it concerns me, to draw and test
16 my blood for any of the following: HIV antibody, HIV
17 certain pathogens, and HEP C antibody.
18 And then this statement is concerning. "I
19 understand that the results of this testing are private
20 information and will be confidential." Where in reality,
21 of course, that information is shared with a number of
22 people.
23 And so I've just advised our people we have to
24 cross that out because we aren't -- we do share it with
25 critical -- first of all, we share it with the State,

1 which is required by law. Second, the actual results
2 currently are shared with the EMS people, right?
3 And so -- so anyway that's just one kind of
4 glaring issue.
5 Arthur, do you have some? I believe you had
6 some other issues.
7 **ARTHUR PETERSEN:** A couple other ones was on
8 provision D. So D, Section D, where receiving facility
9 responsibility. And so D, Section 3, there is a reference
10 to a case I.D. number. Seeing it almost up on the screen
11 there.
12 **GUY DANSIE:** Yeah, right there. I'll just
13 scroll it up so you can see it right at the bottom of the
14 rule.
15 **ARTHUR PETERSEN:** Section D, so a little higher
16 on the document a little bit. Just also a side note.
17 There is no Section E. It seems to go from E to F,
18 skipping E completely. I don't know if that's just -- I
19 don't know if there was a piece that's left out or not,
20 but -- so that was just a side note.
21 **GUY DANSIE:** Yeah.
22 **ARTHUR PETERSEN:** In D, Section 3, the lab, so
23 the lab that receives the sample is asked to send -- to
24 send these disease test results by case I.D. number. It
25 wasn't really clear to us, was that a case I.D. number

1 that -- do we use the EMS run number? Do we create our
2 own case I.D. number in the lab? It was not real clear to
3 me if we just devise our own strategy of what case I.D.
4 number is used, or is there some sort of State I.D. number
5 that is associated with this. That was one of the
6 questions we had.
7 **GUY DANSIE:** That's a good point.
8 **ARTHUR PETERSEN:** And then from the hospital
9 perspective, and Roger can speak to this more, more
10 pointedly, but we really wanted to share the results with
11 the healthcare provider of the EMS worker. We wanted to
12 share those results, and then their healthcare provider
13 could help interpret the results and help them know what
14 the results mean to them, to that person who was exposed.
15 And the way it states here is the results are
16 given to the EMS agency or the EMS agency director. So we
17 were -- we were hoping to make some change there where
18 rather than giving it directly to the agency, we give it
19 to the healthcare provider of the exposed person. We
20 thought that might speed up the counseling and the
21 decision of whether or not prophylactic treatment needed
22 to be made.
23 **RANDY WILDEN:** You are talking their primary
24 care physician for -- at that point as a patient, right?
25 **ARTHUR PETERSEN:** Yes.

1 **ROGER KEDDYTON:** For the exposed person.
2 **RANDY WILDEN:** Yeah, right. They are a patient.
3 **ROGER KEDDYTON:** Exactly. Part of the challenge
4 with this, and we've run into this -- we've discussed this
5 with infection control and some of our clinicians. They
6 are uncomfortable releasing this results just to the
7 department, because there isn't the medical patient client
8 relationship to say now you've got the results, let's talk
9 about the care.
10 Now it's assumed that if there is an issue, that
11 the EMS provider or pre-hospital provider would seek that
12 clinical care. But from releasing the information, the
13 hospital has been very uncomfortable just giving it to the
14 supervisor instead of giving it to the workmen's
15 compensation, physician, work-clinic physician, or even
16 the medical director, but somebody who might have a
17 patient/client relationship with those results.
18 We typically don't release information unless
19 it's to somebody because we have that patient kind of
20 relationship.
21 **ARTHUR PETERSEN:** Right, somebody in that
22 provider stream. And Dan was, was really clear on,
23 because of the sensitive nature of HIV status and even
24 B -- Hep B or C status, that is really protected health
25 information that we need to make sure it goes to like a

1 provider who can really help make those decisions for the
2 patient.
3 **LAUARA SYNDER:** When you are talking provider,
4 I'm guessing you are talking about doctors or whatever.
5 But in my thinking of, you know, my level of stuff, the
6 provider is the EMT who gave care to that person. So who
7 provider are you talking to?
8 **ARTHUR PETERSEN:** The provider we're speaking of
9 is the provider's provider physician, the physician who is
10 taking care of that EMS worker who was exposed.
11 **ROGER KEDDYTON:** So it could be a family -- the
12 family physician they would have. Or if they go, or if
13 they have a relationship with the workman's net clinic or
14 something like that. And I think most agencies have some
15 guideline or direction about who they see for injuries.
16 Is that true, that you've got some sort of connection? So
17 it would be whoever is in the clinic that provides care,
18 for example.
19 **DAN DITTO:** And the time limits of that care is
20 really critical. And that's why we thought it was
21 important to get to the providers's provider so that they
22 could give whatever care to ward off possibly, you know,
23 the impacts of that incident.
24 **ARTHUR PETERSEN:** And to emphasize that point,
25 I'm not an infectious disease physician, but from the

1 research that I did, the HIV prophylaxis, prophylaxis is
2 really best administered within two hours of exposure,
3 from two hours to 72 hours, but most effective within two
4 hours of exposure.
5 So that's kind of the time window that we are
6 shooting for as far as best care for an exposed person
7 who's been truly exposed to an HIV blood or something.
8 **GUY DANSIE:** Just kind of a side question. So
9 if, say, we have a patient that is known to have HIV and
10 they -- and then a person is exposed and the EMT or
11 paramedic is exposed, would it make sense to go ahead and
12 administer them prophylaxis automatically --
13 **ARTHUR PETERSEN:** Sure.
14 **GUY DANSIE:** -- if there is exposure?
15 **ARTHUR PETERSEN:** Absolutely.
16 **ROGER KEDDYTON:** Sure. Let me give --
17 **GUY DANSIE:** I mean, it's disclosed at that
18 level.
19 **ROGER KEDDYTON:** Let me give you a couple of
20 case scenarios then. So an EMS provider is exposed to a
21 patient being transported to the hospital, and if they
22 know that that is an HIV, our recommendation would be that
23 they be seen immediately either in the workman's clinic or
24 in the ED or even by their private physician with the
25 intent to say I've had an exposure, it's a known Emmett.

1 It's a known HIV. And currently CBC recommendations are
2 that you begin prophylaxis now. And as Arthur said, the
3 sooner the better.
4 And if the patient is unknown, then what we're
5 recommending is that the source patient be tested if at
6 all possible. And we now have the ability, which we
7 didn't have when this started, to do a rapid turn around
8 on those tests. It used to be a 24- to 48-hour turn
9 around. Now it's within two hours. It's actually about
10 half an hour to 40 minutes to get an initial result on
11 HIV. Hepatitis is still 24 to 48 hours.
12 But with that information, you can make a more
13 informed decision as to whether or not you start treatment
14 for HIV right then. So we do want whoever is exposed to
15 get medical help right away for that initial decision.
16 Now, if EMS were to come into the emergency
17 department, for example, at Intermountain Medical Center,
18 we could do that initial screening, we could facilitate
19 the source testing, get those results and make a decision
20 very quickly, do we need to begin HIV?
21 But now we also need to figure out hepatis and
22 that's not going to be for 24-plus hours. So we want you
23 as an EMS provider to make sure you coordinate with your
24 physician and then we can make sure they get those
25 results. And then any further care, you would coordinate

1 with your own primary care physician rather than returning
2 to the emergency department, which is a more expensive
3 care for Workmen's Comp, for you and across the board.
4 **ARTHUR PETERSEN:** Yeah. So to your point Guy,
5 when the infectious status of the source patient is known,
6 we know they are HIV positive, yes, prophylaxis can take
7 place right away. The testing, of course, is only
8 required when we don't know the status. We don't know if
9 this motor vehicle accident victim who bled all over the
10 EMS worker, we don't know their status. Maybe they don't
11 know their status. We wouldn't know, right?
12 **LAUARA SYNDER:** There's something in here about
13 if they give consent, you are all fine. If they don't
14 give consent, then what?
15 **ARTHUR PETERSEN:** Sure. Good point. So that's
16 probably the third scenario is -- first scenario, status
17 is known, and then the two sub-narrows is status is not
18 known, patient gives consent, we can do testing right
19 away. When they don't give consent, when they refuse
20 consent, that, that, that process is more difficult to
21 deal with.
22 And I think that's what the statute was really
23 working on was, what do we do when that source patient
24 refuses consent? And then the statute goes over a whole
25 detail of how to get a court order and how to get a judge

1 hearing, and in order to get a -- what is it called, Dan?
2 **DAN DITTO:** Probably basically a mandatory
3 injunction from a judge or court order. But, you know,
4 the last sort of expedited process so that you can get in
5 front of a judge much quicker, which is good. None of
6 that process by the way is laid out in the rule. It's in
7 the code, but it's not in the rule.
8 And I think the better known that is the more
9 likely is that people could get, you know, ineffective and
10 quick resolution of these kinds of issues.
11 **LAUARA SYNDER:** So can you -- you go under the
12 assumption that there's an implied consent of that
13 scenario you just said, you know, the auto accident, the
14 person may have bled all over everybody, and they are
15 unconscious, and you don't know that there's been an
16 exposure to the worker, and that patient is still
17 unconscious, can we assume that that's implied consent,
18 that we can test their blood?
19 **ARTHUR PETERSEN:** Dan, correct me. I think we
20 have implied consent to treat their medical emergency.
21 **LAUARA SYNDER:** I know, but what about that
22 blood testing?
23 **DAN DITTO:** I don't know the law has been
24 developed there yet. Certainly is I like the argument.
25 Unfortunately, you know, of course when you don't know,

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1 it's hard to argue implied consent. When imply reaches,
2 it's usually a case when someone is going to die or have
3 some serious bodily injury. So basically you are left
4 with whatever history you have about that patient.
5 And I might add if a patient is Hep C positive,
6 there's also a possibility that they may have HIV. You
7 know, the odds go up pretty dramatically. So if you know
8 that, that may give you one pointer. So the patient or
9 the provider -- we keep calling him a patient but --
10 **ARTHUR PETERSEN:** The exposed.
11 **DAN DITTO:** The exposed.
12 **LAUARA SYNDER:** That's good.
13 **DAN DITTO:** So the exposed EMS worker is left
14 with the decision, okay, I have this much information and
15 we don't have consent. We don't have a legal implied
16 consent. You know, what do I do? And the exposed can
17 always make the decision to go ahead and get prophylactic
18 treatment.
19 **LAUARA SYNDER:** Does the Workers' Comp laws
20 speak to that? Because I would imagine that you have
21 patients paid for and those are expensive prophylactic
22 treatments. So as a Workers' Comp, say, okay start it
23 when maybe if it's me, I'm going oh, my gosh there's a
24 good chance I'm going to get the prophylactic treatment,
25 and then I'm stuck with the bill because Workers' Comp

1 doesn't approve it?
2 **DAN DITTO:** I don't think it does, not in the
3 situation you've just described.
4 **ROGER KEDDYTON:** And in the cases that we've
5 had, I cannot think of a case where we initiated the
6 prophylaxis. So it really hasn't been tested.
7 When the law was first set up, they set up some
8 guidelines, the testing would be done through and billed
9 to the State. That didn't last very long. And it has all
10 sorts of confusion and havoc. And for years, a lot of the
11 hospitals were eating the costs because they didn't know
12 where it would go to.
13 Now, what most facilities are doing is they are
14 running the source blood testing somehow as an anonymous
15 test but then is billed to Workman's Comp or the
16 individual who was exposed, the exposed person. I don't
17 have enough history to know how that works out on billing,
18 but I know that's where it's getting billed to, so the
19 responsibility goes back either to Workman's Comp or to
20 the individual and their insurance, if possible, because
21 they were exposed.
22 One of the key parts of this is that we cannot
23 bill this lab test to the source patient unless it
24 pertains directly in their care. So doing a screening
25 because some -- a worker was exposed, that's not enough

1 reason to run it under the patient's own name and part of
2 their care.
3 **JAY DEE DOWNS:** Insurance would say, since it's
4 not your blood, we are not going to pay for it and they
5 are saying --
6 **ARTHUR PETERSEN:** Yeah.
7 **JAY DEE DOWNS:** Yeah.
8 **ROGER KEDDYTON:** And I don't know what's
9 happened. And like I said, that's something we are trying
10 to research because we've certainly done a number of cases
11 this way to find out if insurance will pay for source
12 testing if it is related to an exposed person who they
13 insure. I just don't know.
14 **DAN DITTO:** The statute does go a long way. It
15 doesn't resolve all of these questions. You know, and it
16 provides an expedited legal process, but expedited means
17 within 10 days. So frankly, that's helpful to a point,
18 but not, not with HIV, for example.
19 **ARTHUR PETERSEN:** And I think the expedited
20 process is more on the reporting end, more on the Workers'
21 Comp end. It's really speaking to let's -- the exposed
22 EMS provider, what's their baseline infectious status
23 before the exposure because it also speaks to them getting
24 tested. What's my baseline? And then test the source
25 patient so that they can really draw the lines to say if

1 this EMS -- EMS worker contracts HIV, was it because of
2 this exposure? And if so, then it should be covered under
3 Workers' Comp.
4 **LAUARA SYNDER:** I think we have something about
5 that, right? Anytime a worker --
6 **RANDY WILDEN:** Legislation.
7 **LAUARA SYNDER:** Yeah, anytime somebody comes to
8 work for an EMS agency, they have to have an initial HIV
9 test, and then that's it. One and done. And then later
10 if they get HIV or have Hep B or C, then it's presumed
11 that it's during the course of their employment. They
12 don't have to say, oh, it was their lifestyle or this or
13 whatever, it's their -- presumably during the course of
14 employment.
15 **ARTHUR PETERSEN:** Yeah. That presumptive
16 statement is exactly what that bill was making some
17 changes to where it did require some additional testing of
18 your exposure.
19 **JAY DEE DOWNS:** Second page there where it talks
20 about it.
21 **ARTHUR PETERSEN:** So the statute that you are
22 thinking of is this very statute.
23 **ROGER KEDDYTON:** Which makes a lot of sense. I
24 think it's a good way to have it.
25 **DAN DITTO:** And that helps them with coverage

1 once they have it.
2 **GUY DANSIE:** Yeah.
3 **DAN DITTO:** It would be nice if we had a process
4 to --
5 **JAY DEE DOWNS:** Prevent it.
6 **DAN DITTO:** Precisely. So far superior to
7 covering it.
8 **JAY DEE DOWNS:** Yeah. You know you look at a
9 Workman's Comp situation too, you'd want -- if you can get
10 the shot within like two hours afterwards, prevent a
11 long-term, it's going to be a lot cheaper in the long run.
12 Is that what you are saying?
13 **DAN DITTO:** How much does that cost, do you
14 know?
15 **ROGER KEDDYTON:** I don't know the cost on that.
16 I'm sure it's a cost. It is fairly expensive.
17 **JAY DEE DOWNS:** Don just asked what's the
18 availability of that drug? Does every hospital have that
19 drug?
20 **ARTHUR PETERSEN:** I believe every hospital does.
21 **ROGER KEDDYTON:** Every hospital does have that
22 drug.
23 **JAY DEE DOWNS:** Do they?
24 **ARTHUR PETERSEN:** The one article I read stated
25 that the retro vials that they use for HIV prophylaxis, if

1 they use one drug, it's about $750 for a 28-day course.
2 If the recommendation is to use a three drug, you know a
3 triple whammy effect, that was more of $2,000 for a
4 28-day. But that was just one article that I read, so...
5 **JAY DEE DOWNS:** The question --
6 **ARTHUR PETERSEN:** There are actual side effects
7 to those too that you have to weigh out risk benefit.
8 **JAY DEE DOWNS:** Let me to interrupt you, but one
9 of the things I was listening to you say, so the question
10 comes back is if, say you have a question come back, you
11 have a person comes in, it's questionable whether they are
12 HIV, so they go ahead and start the prophylactic, and then
13 all of a sudden you're talking mega bucks, 2800 bucks,
14 right?
15 **ARTHUR PETERSEN:** Sure. About 2000.
16 **JAY DEE DOWNS:** Okay, 2000 bucks. Then all of a
17 sudden, the guy comes back after the process and comes
18 back negative, and who pays that money? The provider?
19 The person? Who?
20 **RANDY WILDEN:** That's a good question.
21 **ROGER KEDDYTON:** Whoever is financially
22 responsible, would actually be either the insurance or the
23 individual, but the exposed individual.
24 **LAUARA SYNDER:** Actually not the individual. If
25 they are working, it's going to go back to their employer.

1 **ROGER KEDDYTON:** Well, it's whoever is
2 financially responsible.
3 **ARTHUR PETERSEN:** Right. And those billing
4 battles happen all the time. You know, the insurance
5 company will say, well, it wasn't medically indicated, and
6 the hospital will have to say, well, yes, it was medically
7 indicated. We didn't know the status of the source
8 patient, so this is the best care to treat
9 prophylactically and I mean, those go back and forth. Dan
10 can probably speak more to some of those billing legal
11 appeals, but...
12 **DAN DITTO:** They are nasty.
13 **ARTHUR PETERSEN:** They are nasty.
14 **JAY DEE DOWNS:** Which could hurt the volunteer,
15 victim.
16 **ARTHUR PETERSEN:** So that was another aspect --
17 aspect that we were looking at, was we were just really
18 focused on the rule, which is the labor code rule, which
19 really focus on EMS providers. And we were wondering how
20 come it doesn't cover the, you know, the good samaritan,
21 you know, the boy scout who gives CPR at the scene and
22 gets exposed. And the statute actually broadens it to any
23 volunteer who helps at the scene. It gives pre-hospital
24 care. So we didn't know if the rule needed to be
25 broadened as well to match the statute.

1 **ROGER KEDDYTON:** You know, with this form that
2 we use, the emergency medical service provider form, it
3 has been confusing. And even in the sense, does this
4 apply to police officers? Now, we're told it does, and we
5 treat them like any other pre-hospital provider, but the
6 way this form is set up, it is not clear. It's confusing
7 who this really applies to. Is it only EMS providers?
8 And that would be a more limited focus.
9 The other thing that Arthur mentioned is this
10 whole case series. There is a way to set up a case code
11 using this form, but it's not necessarily specific to
12 everybody. And it probably is, but our hospitals don't
13 have the ability to use numbers and letters in a name.
14 So we can't use this kind of coding internally
15 at all. We have to rely on our own coding so we can keep
16 the patients straight and the testing straight. And I
17 have not been able to find anyone that can explain how
18 this form is used. I believe it goes back to the agency.
19 I don't believe it goes to the State or is tracked at all
20 there.
21 So we do need a way that if -- if a provider is
22 in one facility and the source patient is in another, we
23 do need a way to share information to coordinate and say
24 we need to get source testing. But I'm not sure that this
25 particular form has helped as much as perhaps it was

1 thought to have.
2 **DAN DITTO:** I ended up developing some of our
3 own forms so we can bridge in the gap.
4 **GUY DANSIE:** They are having a dispute on just
5 where it goes to the State. It might go to the state
6 health lab.
7 **LAUARA SYNDER:** I don't think I get it back.
8 That's what we were saying.
9 **JAY DEE DOWNS:** It doesn't go back to the
10 employer because I've never seen them.
11 **GUY DANSIE:** We don't get it here.
12 **ROGER KEDDYTON:** So the agency, do you see where
13 these go?
14 **LAUARA SYNDER:** I have a file --
15 **JASON NICHOLL:** I assume they go to -- into the
16 personnel file and maybe even Workers' Comp.
17 **ROGER KEDDYTON:** Yeah, I don't think there's a
18 clear process that the State has linked into this at all.
19 **LAUARA SYNDER:** I think it goes to the Health
20 Department. The last time I used it was probably -- I'll
21 bet that's over 20 years old. Because I think that's back
22 when my last exposure was.
23 But speaking about what number to keep them, we
24 all have to do the EMS reports to whatever, employers or
25 whatever, and the hospitals now have access to that

1 because of all the sharing of information. So wouldn't
2 that be a good number tracking because that's that patient
3 care form? And the EMS workers have access to it and the
4 hospitals all have access to it.
5 **ROGER KEDDYTON:** Access is different than
6 actually running tests.
7 **LAUARA SYNDER:** Well, I know, but you want to
8 assign -- to assign a number to that patient.
9 **ROGER KEDDYTON:** Well, currently what we are
10 doing is the source patient, we are setting up as a
11 special source code with a name that says source with that
12 source patient's real birth date and we do have to name --
13 we need to be able to identify the person we are drawing
14 the blood is who they say they are. But it's run
15 anonymously. And it does have an encounter number. So I
16 can find that lab test by a certain coded name or by an
17 encounter number. But I can't take a number given to me
18 externally and assign it and be able to find it in my
19 system. I can only find by birth date --
20 **LAUARA SYNDER:** Your own numbers.
21 **ROGER KEDDYTON:** -- by our own numbers or by
22 name. And so for the exposed person, we are registering
23 those people under their own name and under their own
24 demographics so we can do the tests and get it to work
25 because it's patient care for --

1 **LAUARA SYNDER:** You know, that kind of brings up
2 the point, I think it's real similar to this whole law
3 enforcement sharing information, some of you guys were
4 saying, this is a really critical thing, but we can't
5 share information on a timely basis because your hospital
6 system uses a separate thing. I bet the U of U uses a
7 separate thing. So now what?
8 **ROGER KEDDYTON:** Well, if we had a situation --
9 we've had this where we've had an EMS provider at the
10 University of Utah and the source patient's been at
11 Intermountain Medical Center. They've called us and said
12 you've got a source patient there. We said great. We
13 work through the process and draw on the source
14 information. Then we called up to the Emergency
15 Department up at, up at the University and said, here are
16 the source results.
17 There is a way to do that. I mean, we -- we
18 share information all the time between facilities.
19 However, it's going to the clinician. It's not going to
20 the EMS worker.
21 **LAUARA SYNDER:** Right.
22 **ROGER KEDDYTON:** We can't call the EMS worker
23 and say, I'm sorry, the source case was HIV positive. I'd
24 recommend you get seen. That's not how we work within the
25 hospitals at all.

1 **DAN DITTO:** So the privacy rule, HIPPA, if I can
2 bring up that nasty acronym, that does allow us to share
3 information with other healthcare providers. That's why
4 as Roger is talking about this and as Arthur mentioned,
5 we'd like to share it with the provider's provider because
6 we can do that, the law permits us to do that. We have no
7 problem doing that.
8 But as we looked at this, it seemed to us that
9 there's quite a few gaps. You know, there's the Workers'
10 Comp piece that is -- they've tried to cover fairly
11 thoroughly. But we're looking at what's the best for the
12 patient and what's the best for the exposed. That's what
13 our -- that's what our primary concern is, as a healthcare
14 provider what can we do to help this individual.
15 And we can act and we can treat them. But
16 there's not a mechanism really in place for -- to give us
17 the authority to share information, to communicate, to do
18 everything we need to do to get them compensated, you
19 know, those kind of things.
20 And that's why it -- to us it makes sense to
21 step back and take a global view of this, and say, okay,
22 maybe part of this piece is in place and maybe there's a
23 piece over here that's in place. But if we take, if we
24 take a step back and say what can we do to resolve the
25 financial issues, to resolve the healthcare issues for the

1 exposed, to resolve the information for the Department of
2 Health that they need, it seems like there's a few, a
3 number of pieces that are missing in order to have that
4 full -- fully resolve all those issues.
5 **RANDY WILDEN:** I don't remember what my title
6 was at the time, but I considered it bad timing when I
7 received that information and then I was told to counsel
8 with my EMT firefighter. I'm not a counselor. I think
9 that that, that part of it was broke for me. I was a fire
10 battalion chief. I was told we had an exposure, go visit
11 with your firefighter. I was the Grand Poobah for the
12 exposure and I was no way prepared for it.
13 So I agree, it needs to go back to a healthcare
14 provider. Is it their private care physician, ED,
15 medical, medical director? Some place where that can be
16 shared quickly, but also with somebody who can provide
17 that information.
18 **LAUARA SYNDER:** Randy, I disagree with you, not
19 entirely, because it has to be a key person, but you don't
20 know who my doctor that I'm going to send my employee to
21 or who my Workers' Comp is. So you don't initially know
22 who to send it to.
23 So I, as the EMT worker's employer, that's my
24 ball I have to get rolling. And I may not be the one to
25 do the exposure counseling, but I'm going to send them to

1 a physician and get that information to you so you can do
2 that connection, give them the separate. It's got to come
3 to the providers to start with.
4 **RANDY WILDEN:** That's a communication piece.
5 **ROGER KEDDYTON:** Well, let me clarify --
6 **LAUARA SYNDER:** Providers, we're talking
7 providers. A designated person has to be licensed or
8 provider.
9 **ROGER KEDDYTON:** In the process we've been
10 setting up, we're setting up within Intermountain
11 Healthcare, and I can't speak for the other facilities.
12 Every ED, every hospital has their own internal process.
13 But we've actually set up a form, because that doesn't
14 capture here at all, so we've got a separate form that we
15 ask the exposed person to fill out. And one of the
16 questions is: Who is your healthcare provider? And if
17 you say, well, I don't have one, then we say great. Let
18 me tell you who's on call, who would you like? Because we
19 are not moving forward until you can identify who your
20 healthcare provider is.
21 Now, if they come in and say, you know, we have
22 a contract with the University Clinic and this is it, then
23 we're going to go great. We're going to give this to the
24 University Clinic.
25 So that's part of the broken process that the

1 statute doesn't really identify, that whoever is exposed,
2 needs to identify who their follow-up physician is.
3 **LAUARA SYNDER:** And the worker may not know.
4 It's their employer who's going to tell them which
5 direction, where they get the care. And, you know, if
6 it's mine and Tami saying get your care, but leave you
7 where you are right now, I'll contact Workers' Comp, I'll
8 do the paperwork and everything going, and then that's the
9 way that would work.
10 **ROGER KEDDYTON:** And that would be great. So
11 then they might say I have no idea, let me call my
12 supervisor or let me call the main office, but I need to
13 find out. Until we have that information, it's really
14 hard to release the results.
15 **RANDY WILDEN:** My argument is the counseling
16 part. I just don't think that's a role we should be in.
17 **ROGER KEDDYTON:** Well, there's a privacy part
18 too which is, is it fair to the EMS employee, suddenly now
19 a supervisor who knows they were tested and it's come back
20 Hep C positive, is that fair to the employee?
21 **RANDY WILDEN:** Well, we should know that,
22 though, as their employer --
23 **LAUARA SYNDER:** If they are going to let me use
24 our employee Workers' Comp stuff, then we have to know,
25 whether it's fair or not.

1 **ROGER KEDDYTON:** It should come to you from
2 their physician, not as a sidebar.
3 **LAUARA SYNDER:** No. But I have to send them
4 where they are going to go. As my employee I have to tell
5 them you can go up on the hill to a doctor or you go to ED
6 or whatever. They -- my employees don't get to just go,
7 oh, you know, I hurt my knee. I'm going to go to the
8 doctor today. They report it and then they are sent to
9 someplace.
10 **DAN DITTO:** I think you raise a very good point
11 because to be able to respond to these situations in a
12 timely fashion, I mean, we're setting the bar way, way up
13 here if we're saying we want to respond in two hours.
14 That is so far from where we are today. That's a moon
15 shot compared to where we are today, frankly. Because
16 we're nowhere near that.
17 **RANDY WILDEN:** I remember mine was five days out
18 after the exposure. We didn't know for five days. So,
19 and I agree.
20 **JASON NICHOLL:** Two hours on, you're going to do
21 the same thing as a supervisor. You may not get a middle
22 manager within two hours.
23 **JAY DEE DOWNS:** Let's take this a little bit
24 back. I had some questions that we need to -- I think
25 these are all good points and sounds like the system. And

1 I have some concerns of my own about the infectious
2 control. I mean, I look at different units out there, and
3 you say, what do you got for your infectious control. And
4 the only thing they do is what they are mandated and
5 that's baseline. And they don't have -- some of the
6 smaller units out there have no idea how to handle
7 infectious control problems. They don't know how to, you
8 know, inoculations or any of that preventive stuff. They
9 don't know how to do it. All they know is what they are
10 required to do by the State and that's the baseline. Some
11 aren't even doing the baseline, to be totally honest with
12 you. Okay. So I agree, the system is broke.
13 My question, I got to ask you, Guy, going back
14 to the State, first of all, this sounds like to me you
15 said this was under the Labor Commissions. This is the
16 Labor Commission's policy; is that correct?
17 **GUY DANSIE:** That's correct.
18 **JAY DEE DOWNS:** Is our legal counsel the same
19 legal counsel for the Labor Commission?
20 **GUY DANSIE:** It's all through the Attorney
21 General's Office, but no, they are different attorneys.
22 Brittany is ours, is assigned to us. And I don't know who
23 their attorney is.
24 **JAY DEE DOWNS:** Because I'm kind of wondering if
25 this is something that needs to be brought -- bring

1 Brittany in on also and say here's a problem. Because it
2 is a legal beagle problem too, because if you are talking
3 about getting tests done in two hours, well if you got a
4 person who is not going to give you that, you are going to
5 have to wake up a judge and do a process really quickly.
6 Is that not true?
7 **DAN DITTO:** Well, the way it is now, you
8 couldn't do that. So, yeah, we'd require a fairly
9 radical -- so let me just share a big picture concern I
10 have with this.
11 As a healthcare advocate wanting to do the best
12 thing for the patient, I'm 100 percent for this. And --
13 however, from a changing legislation perspective and
14 putting this into administrative rule, I just want to
15 throw out a realistic concern. And that is, if we are
16 trying to inoculate everyone within two hours, I have a
17 feeling that the HIV positive lobby, if you will, would
18 feel like that's hysteria, you know.
19 And so they're -- the way this is approached, I
20 think is going to have to be sensitive.
21 **JAY DEE DOWNS:** Absolutely.
22 **DAN DITTO:** Going to have to be carefully
23 thought through. But I definitely feel like, you know,
24 it's not -- it's certainly far better than it was. The
25 legislation we have now is light-years ahead of where it

1 was 15 years ago. But if we want to be honest with
2 ourselves, it's just not hitting the mark.
3 And so, if we -- instead of having one group,
4 which is Workers' Comp, and Workers' Comp is a very
5 proactive legislative -- you know, they go after
6 legislation. They are not a state agency. They are an
7 insurance body and they are private. But they are very
8 proactive in getting legislation to cover these
9 situations. So they've kind of tried to cover their
10 situation.
11 But EMS workers are still exposed. And the
12 process that -- to get a judicial order is good, it just
13 misses the mark a bit. So you are right; we would have to
14 wake up a judge. We have processes to do that right now
15 in search warrants and other things.
16 **JAY DEE DOWNS:** They can do telephonic search
17 warrants.
18 **DAN DITTO:** Absolutely.
19 **JAY DEE DOWNS:** I seen the police go in in one
20 minute. Next minute they got it telephonic and they are
21 in the door.
22 **DAN DITTO:** Absolutely.
23 **JAY DEE DOWNS:** I mean, so there's a way to do
24 it. I agree with you.
25 My concern is also is being on the end of, oh,

1 wait a minute, you can't basically do anything for five
2 days until we get all the test results back. So that puts
3 your life on hold. So being an advocate for the
4 responder, you know, you could turn their world upside
5 down by that. And just the sheer terror of going through
6 and say, oh, by the way you've been exposed to HIV. All
7 of a sudden now you are putting them through a lot of
8 anguish and the department through anguish that you
9 wouldn't normally have to put them through if there was a
10 process with more -- definitive I guess is what I'm trying
11 to come across.
12 **DAN DITTO:** Absolutely.
13 **JAY DEE DOWNS:** So, but I'm not really -- I go
14 back to Guy at the state level and think where do we go
15 from here and what can be done? And I mean, it kind of
16 sounds like there's this rule, but it's made by the Labor
17 Commission. It's not made by EMTs --
18 **GUY DANSIE:** Right.
19 **JAY DEE DOWNS:** -- to be in favor of them. The
20 law was made by legislation. I remember when this went
21 into effect. This was the result of a broken problem
22 before. This is light-years ahead of where it was. I --
23 I don't know -- I personally don't know where to go. I'm
24 looking back to the State saying, where can we go or what
25 can we do?

1 **GUY DANSIE:** Well, one thing we need to do is
2 talk to the Labor Commission and get their buy in. I
3 mean, we can't alter their rule.
4 **JAY DEE DOWNS:** Absolutely.
5 **GUY DANSIE:** But we need to go look at it and
6 suggest possible changes and see if they will allow us to
7 do that, or even to take this part, and migrate it over to
8 our rules.
9 I think we do have a duty to make some kind of
10 rule in our, in our system, in our purview so that we
11 address the communication issues internally. So if you
12 have a worker who's exposed, what's your role and how does
13 that get to the physician? Those kind of things we can
14 address in our rule. I think we need to have that, at
15 least that in our rule, if not all of it.
16 **LAUARA SYNDER:** And it could mirror what the
17 Labor Commission has written a lot.
18 **GUY DANSIE:** It seems like this is mostly about
19 the exposure and the payment. They are mostly worried
20 about who's going do pay.
21 **DAN DITTO:** That piece is sort of covered.
22 **GUY DANSIE:** Our worry is mostly about making
23 sure that the EMT or paramedic is properly managed --
24 **ARTHUR PETERSEN:** Facilitate that
25 communication --

1 **GUY DANSIE:** Right.
2 **ARTHUR PETERSEN:** -- between the EMS worker
3 exposed and the hospital and the lab and help make --
4 **GUY DANSIE:** And see that part I think we can --
5 we can say yes, we -- you know --
6 **DAN DITTO:** That's a gap.
7 **GUY DANSIE:** -- we ought to put that in our
8 rule.
9 **JAY DEE DOWNS:** Well, I think you ought to -- I
10 think you ought to take on, if we are going to do that,
11 the flavor of also prevention. You know what, what
12 testings involved, what inoculations they should get. You
13 see what I mean? I think that should be part of it before
14 the exposure. And then if they are exposed, what happens
15 during exposure and then what happens after exposure. So
16 to me it's a three-prong deal.
17 **GUY DANSIE:** Right.
18 **DAN DITTO:** It's a really nice ambitious
19 concept. I don't know if it's politically feasible but
20 would be to have them pay for that, you know. The
21 employer -- the employer's insurance is not going to want
22 to pay for something that wasn't medically necessary.
23 **JAY DEE DOWNS:** Right.
24 **DAN DITTO:** The hospital has no interest in
25 treating somebody who doesn't have anything. The worker,

1 the exposed, has a huge interest in making sure he gets --
2 he or she gets the right care in a timely fashion.
3 And so to bring those interests together, I
4 think it would be -- it would be an ambitious project, but
5 I think it's a worthy one.
6 **JAY DEE DOWNS:** Jason, yes.
7 **JASON NICHOLL:** Just, I'm trying to put myself
8 through this situation in my head. Meaning about primary
9 care physicians and this and the provider and the exposed,
10 put myself at 3 o'clock in the morning, someone calls and
11 says, "Hey, Chief, just got this exposure." That's always
12 going to be the first -- the first phone call.
13 So it's going to be the senior level supervisor
14 that right out of the shoot, Lauara like you said, okay
15 get tested, whatever, or go that direction.
16 So the test gets done. It's authorized by a
17 representative of that organization. So the organization,
18 to address your point about who's going to pay for this,
19 whether or not it was medically necessary or not, you now
20 have a representative of that organization, a senior
21 representative of the organization that is, you know,
22 understandably entrusted with the authority to make these
23 kind of financial decisions for the organization. That's
24 taken care of.
25 Now you get to the medical necessity of it. If

1 this information that is then given, not to whoever, this
2 primary care physician or that primary care physician, but
3 to address Lauara's concern, we're going to determine
4 where we send these people or Workers' Comp is going to
5 tell us.
6 So we need to have a single point of contact
7 that -- from what I understand you are saying, should not
8 be a non-provider supervisor. Is that correct?
9 **DAN DITTO:** I wouldn't say that we've gone that
10 far. I would just say this is a point of discussion.
11 **JASON NICHOLL:** So, so all of us have, these
12 people that work for us that are employees, that are
13 physicians, they are offline medical control. And they
14 may be contract, but they are employees and they are all
15 physicians. Why can't that be our first point of contact
16 because our physicians, and I know a lot of medical
17 directors in the State of Utah, and every single one of
18 them cares immensely for the people that work for them.
19 Why can't that be the prime or the first initial point of
20 contact to send the test results? Because now we're
21 sending test results to a physician that, to address your
22 concern, is capable of having a provider, you know, type
23 of conversation with an exposed and is able to have a
24 doctor to doctor conversation with someone's primary care
25 physician after they've been identified and is able to

1 communicate with Workers' Compensation from a physician to
2 a physician's standpoint. And the State knows all 164 or
3 168, however many -- how many are there?
4 **GUY DANSIE:** Well, maybe director wise it's a
5 smaller pool.
6 **JASON NICHOLL:** Yeah, how many of these offline
7 medical directors. Now, now you are talking about the
8 State just needing to have the offline medical director
9 level having to put this together and saying this is what
10 will happen. This is the process that we've come up with
11 as part of your offline medical control responsibilities.
12 This is new. This is part of it. And so we've
13 streamlined it, targeted it and kept it within a higher
14 level or advanced practitioner level.
15 **DAN DITTO:** Good talk.
16 **LAUARA SYNDER:** I hate to have to admit, Jason,
17 but that makes sense.
18 **JASON NICHOLL:** Do it. Do it. Watch this.
19 Watch this. I just high fived myself. Lauara agreed with
20 me.
21 **LAUARA SYNDER:** It doesn't happen very often,
22 but I do do it.
23 **JASON NICHOLL:** It doesn't.
24 **LAUARA SYNDER:** It's almost near the end of the
25 year. So it's a gift.

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1 **JASON NICHOLL:** It's a Merry Christmas to Jason.
2 **RANDY WILDEN:** It doesn't really count.
3 **JAY DEE DOWNS:** This is in the minutes. That is
4 in the minutes.
5 **JASON NICHOLL:** And did you get my high five in
6 the minutes?
7 **JAY DEE DOWNS:** Her hands came up off the
8 computer.
9 **DAN DITTO:** By the way, although the statute
10 says that it's the Labor Commissions, it does say in
11 consultation with EMS.
12 **LAUARA SYNDER:** Yes.
13 **DAN DITTO:** So you definitely have input on this
14 process. You have some other thoughts?
15 **ARTHUR PETERSEN:** I was -- I was going to agree
16 with both of you as well. Logistically it makes sense.
17 And when we ask the exposed provider who is
18 your, who is your -- who is your provider, they always
19 say, oh, it's our offline medical director. This is who
20 it is. And we can send the results there.
21 If a given agency wants to designate the
22 Workers' Comp physician, I don't know if that has to be
23 regulated, I guess is the question, the point I was going
24 to make. I don't know if we have to write into the rule
25 that we have to give results to the medical director of

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1 the EMS.
2 **LAUARA SYNDER:** You could just put who the
3 current designee --
4 **ARTHUR PETERSEN:** Yeah, the agency designee,
5 whoever it is. It just simply makes sense to make it
6 offline.
7 **JASON NICHOLL:** Well, and that also provides a
8 backup because, you know, my medical director, if
9 something happens to my medical director and I'm left
10 without an offline medical director, the backup is always
11 the state medical director. I mean, we -- there's
12 always -- we are always too deep in that level. You know,
13 Dr. Taillac is always there as the safety net.
14 Now, you know, and that's -- that's a reach for
15 something like that to happen, but it adds redundancy and
16 it still keeps things streamlined and not 10,000 different
17 providers in the system but only 168 or however many.
18 **DAN DITTO:** At three o'clock three in the
19 morning --
20 **JASON NICHOLL:** And at three o'clock in the
21 morning, my medical director is going to answer the phone
22 for me.
23 **ROGER KEDDYTON:** It makes a lot of sense. And
24 one of the things we put into our instructions, whoever is
25 exposed should contact their supervisor immediately.

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1 **RANDY WILDEN:** That's a given.
2 **ROGER KEDDYTON:** It is. And it doesn't always
3 happen. But it is -- you think it was a given. And then
4 that supervisor can help identify who that is.
5 Now, I would like this group also to think more
6 broadly than just EMS, because as I mentioned, we've got
7 all those pre-hospital providers, the fire, the fire, the
8 police and so forth. Somehow we need to have a process
9 that is sensitive to all the groups. But I love the
10 concept that you identify who that care provider is and it
11 makes a lot of sense to do it internally.
12 **JAY DEE DOWNS:** I think I read it in one of
13 these rules, it does take into that, it takes into
14 firefighters, EMTs, police. It was somewhere I read that
15 where it talks about --
16 **ARTHUR PETERSEN:** I found that in the statute,
17 but I didn't find it in the rule, the Labor Commission
18 rule.
19 **DAN DITTO:** Again, I know you consider yourself
20 EMS and wouldn't necessarily do police and fire chief, you
21 know, fire chief, but I don't know, I still think it's
22 appropriate to take a shot at it. We can include those in
23 our groups. It's the Department of Labor's rule, but you
24 can get input on it.
25 **JASON NICHOLL:** It would make sense. So two

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1 things. First is, what happens if there's an exposure
2 for -- we do a mutual aid call to North Tooele and one of
3 our people is exposed while performing mutual aid in North
4 Tooele. Okay. Is there an issue there being extra
5 jurisdictional or anything like that?
6 **RANDY WILDEN:** That has to go back to our aid
7 agreements and your aid agreements always say your people
8 are covered by either.
9 **JASON NICHOLL:** So carrying that forward, we
10 start talking about the good samaritans, the boy scouts,
11 the police officers tell me that it's reasonable to expect
12 that because boy scouts, good samaritans and police
13 officers don't have offline medical control, that it
14 would -- it would default to the agency having primary
15 responsibility for the EMS call for -- to be that initial
16 point.
17 Now we're just talking a clearinghouse. They
18 just get the information, but that gives those exposed
19 people a singular point of contact also.
20 **ROGER KEDDYTON:** What if EMS is not involved?
21 **DAN DITTO:** Yeah, what if it's just the police?
22 **LAUARA SYNDER:** Yeah, I was going to say, I'm
23 not going to be responsible for the firefighter, police
24 department or first responders.
25 **ROGER KEDDYTON:** Yeah, I would recommend that

1 you not be this clearinghouse for everyone. I'd rather
2 that we identify -- you need to identify a physician. And
3 hopefully they've got a contact physician like EMS does,
4 but if they don't, then they still need to identify a
5 physician to do follow-up.
6 **JASON NICHOLL:** Just a thought.
7 **DAN DITTO:** I really liked your suggestion and
8 if we could get agencies to all designate a physician. So
9 if a policeman comes in and we say, who is your primary
10 care provider, not me, I haven't been to the doctor for
11 three years, and we looked on our list and say, oh, it's
12 Dr. Smith, you're with Unified, right? Dr. Smith is the
13 guy who's your medical director for, you know, the Unified
14 Police, it might give us, you know, somebody that we could
15 work with immediately. Now the boy scout is a more
16 difficult problem. A good samaritan is a difficult
17 problem.
18 **GUY DANSIE:** I think -- I think we could write
19 the rule, though, that would cover most of our
20 professional type providers and then have the exception be
21 those -- the good samaritans.
22 **JASON NICHOLL:** I only brought those up because
23 you brought them up.
24 **JAY DEE DOWNS:** You could write the rule because
25 they are providing an EMS service.

1 **ROGER KEDDYTON:** For the good samaritan we would
2 just set them up for a physician referral, like we do for
3 anybody that comes for care that doesn't have a private
4 physician.
5 **JAY DEE DOWNS:** Is it something that we can take
6 to the EMS Committee? Maybe develop a task force to take
7 this to the beginning to end.
8 **LAUARA SYNDER:** Definitely needs one.
9 **GUY DANSIE:** Possibly the operation
10 subcommittee. I don't know.
11 **JAY DEE DOWNS:** I think this is bigger than I --
12 to be honest with you.
13 **LAUARA SYNDER:** I was just going to say that as
14 a provider, I want -- I'm going to be responsible for all
15 of my people. But if I interface with a fire department
16 who doesn't provide EMS and they have exposure, I don't
17 want to take -- I don't want to have to pay my doctor for
18 handling their stuff. So I don't agree, but just because
19 they are a firefighting agency or police officer, that
20 they need to default to my agency and I'm paying for my
21 medical director's time and whatnot. I don't think
22 that's --
23 **JASON NICHOLL:** Well, do we have any fire
24 departments in the state that -- that do not do EMS at
25 all?

1 **JAY DEE DOWNS:** Yes, you do. There's quite a
2 few actually.
3 **JASON NICHOLL:** That don't have any --
4 **JAY DEE DOWNS:** You get past --
5 **JASON NICHOLL:** Not even first responders?
6 **LAUARA SYNDER:** Wendover Utah's Fire Department
7 doesn't have --
8 **JAY DEE DOWNS:** You got them in Carbon.
9 **LAUARA SYNDER:** They may go do some EMS, but
10 they don't have a medical director.
11 **DON MARRELLI:** The entire Emery County doesn't
12 respond to any medical. None of their fire groups are
13 even --
14 **JAY DEE DOWNS:** You get a lot -- you get past
15 Utah County and there's a lot of agencies --
16 **DON MARRELLI:** Grand County is the same way.
17 There is nothing attached.
18 **ROGER KEDDYTON:** But the advantage of having
19 something come down from the State is at least it would be
20 something that each of these agencies could consider and
21 look at. And I -- I suspect that even if they don't have
22 a medical control, most have a process where they say if
23 you are hurt, this is where I want you to go. And if they
24 don't have that, it would be a great opportunity to
25 clarify that for the employer.

1 **JAY DEE DOWNS:** Well, I kind of going through
2 here in my mind, you know, that might be something that
3 you bring up. Might be something that's where Jess comes
4 into play. It might be something the Fire Chief's
5 Association would want to tackle on. I think -- it ought
6 to go back to the EMS Committee. I think -- I'm thinking
7 that the Operation's Committee, subcommittee could take on
8 some of this, that we could divide it out.
9 The rules we should because there's rules we
10 would have to play in. The Professional Development,
11 there's some things that they can do for it because that
12 is professional -- they could probably do all your
13 prevention.
14 **GUY DANSIE:** So, and I'm going to add lab and
15 EPI to this too, because I know our lab people are the
16 ones that deal with the testing and EPI does the tracing
17 and things like that. And I know they've had issues with
18 some of this stuff too.
19 **LAUARA SYNDER:** And determine unfunded mandates
20 too as we're going in through these things.
21 **JAY DEE DOWNS:** And then you're -- also your
22 attorney, she's going to have to get involved with it
23 because now you move into, like your -- how fast you want
24 to move on these things in the process.
25 Question: How often do you guys run into

1 somebody who won't give their blood? Is it quite often?
2 **ARTHUR PETERSEN:** We think it's very rare that
3 consent is refused.
4 **ROGER KEDDYTON:** We usually -- if the person is
5 unconscious, we try to get consent from the family. I
6 cannot think of an immediate situation where they have
7 denied consent, but I can think of several situations
8 where there was a delay in trying to get consent. So the
9 family was in the waiting room and now we don't know where
10 they are and we're trying to call and so forth. So
11 usually people will consent, but we need to get
12 somebody --
13 **JAY DEE DOWNS:** What happens if you have a
14 patient who's deceased? Like a traffic accident, you
15 don't know -- you don't have -- there's no family with
16 them, how's that situation?
17 **DAN DITTO:** There's a statute that allows for
18 surrogate decision makers. And it basically goes from,
19 you know, spouse, family members, and finally a friend.
20 So arguably you can go down as far as a friend. If you
21 can't find any other surrogate decision maker, they can
22 actually be involved in that process.
23 **LAUARA SYNDER:** What about if you can't find
24 anybody like that, that there's been an exposure, now that
25 person is dead, you can't find the family. Maybe they are

1 transient or maybe they are just passing through, but if
2 there's been an exposure, can't that dead person draw labs
3 and just put them on hold and say we're going to put them
4 on hold until we can get consent or something but
5 otherwise --
6 **GUY DANSIE:** Maybe the doctor's their friend at
7 that point.
8 **ROGER KEDDYTON:** A more likely --
9 (All talking.)
10 **JAY DEE DOWNS:** I had a bonding with the
11 Monseen, let me tell you.
12 **ROGER KEDDYTON:** A more likely situation in that
13 case would be a physician who's caring for the exposed
14 person right there and saying, what is the risk? Is this
15 somebody who appears to be a drug user, or is this -- what
16 is their risk that we can determine. Based on that, let's
17 start treatment now, or I wouldn't start treatment if it's
18 a pretty low risk.
19 **DAN DITTO:** And you can always make the decision
20 without data, which is not the optimum way to make
21 decisions, but the hospital, unfortunately, the privacy
22 rule, for example, extends beyond people's death. So
23 we're limited on some things that we can do.
24 And so, having said that, there are times when
25 we might say patient safety is more important than

1 anything else here. But probably the result would be
2 something to the effect of you have to make a decision
3 based on the information we have and here's the
4 information we have.
5 **ROGER KEDDYTON:** And those that are
6 incarcerated, my understanding is they still can be drawn
7 without their consent.
8 **LAUARA SYNDER:** I'm aware of that.
9 **ARTHUR PETERSEN:** And the statute speaks to
10 that.
11 **LAUARA SYNDER:** Right. I'm aware of that.
12 **ROGER KEDDYTON:** I guess you could arrest them.
13 **ARTHUR PETERSEN:** Correction facility gives
14 consent for them.
15 **DAN DITTO:** The problem is they have to be
16 booked already to do that.
17 **JAY DEE DOWNS:** I'm glad this came -- I'm glad
18 this came up because this has been something that's been
19 in the back of my mind for quite a while. As I said, the
20 questions I have, you know, if all you require is
21 baseline, that's it, I think that's something that we as
22 EMS providers need to tackle and take on.
23 **GUY DANSIE:** So --
24 **JAY DEE DOWNS:** I guess the question is, is
25 probably where do we go from here?

1 **GUY DANSIE:** How do we deal with it?
2 **JAY DEE DOWNS:** Yeah. You know Jason and I can
3 certainly bring it up with the EMS group, actually put it
4 as its own agenda on it. I could bring it from there and
5 make recommendations to the Committee to make some
6 assignments to their subcommittees.
7 **GUY DANSIE:** And I will on behalf of the
8 department, I will talk to Brittany and the Labor
9 Commission and I'll work through and see what their issues
10 are, you know -- you know, we can work with them, and
11 maybe even bring them to this group or discuss some of our
12 concerns with them.
13 **JAY DEE DOWNS:** Would you guys be willing to be
14 like resources and stuff of this as our committees work
15 through it?
16 **DAN DITTO:** Absolutely.
17 **JAY DEE DOWNS:** We could say, hey, you know
18 what, ask these guys. They are dealing with it everyday.
19 **LAUARA SYNDER:** What is that thing?
20 **JAY DEE DOWNS:** Yeah, I mean --
21 **GUY DANSIE:** Let me ask one other, like,
22 question that I -- this is embarrassing for me because I'm
23 a state employee, but where is that form housed? Where do
24 you get the forms?
25 **ARTHUR PETERSEN:** I have looked for it online.

1 It says it's maintained by the Labor Commission.
2 **GUY DANSIE:** Okay.
3 **LAUARA SYNDER:** I think we have some blank forms
4 in my --
5 **GUY DANSIE:** We do too.
6 **LAUARA SYNDER:** -- with our -- the things that
7 they have to sign for childbirth and all that stuff.
8 **GUY DANSIE:** It seems to me it's so obscured
9 that we need to have some type of ownership.
10 **JAY DEE DOWNS:** It did come down. I think it
11 said that. I do remember it coming from the Labor
12 Commission. I remember that.
13 **ARTHUR PETERSEN:** The EMS, one page, has a link
14 to it, but that link is broken. So I haven't been able to
15 access it. So it's there somewhere. I guess we have
16 copies somewhere.
17 **ROGER KEDDYTON:** It used to be a valid link and
18 we got copies then. And then most of the trucks carry a
19 copy. There's probably a copy of a copy.
20 **RANDY WILDEN:** It's multiple.
21 **GUY DANSIE:** Yeah. It sounds like we need to
22 start with -- that probably would be the easiest piece to
23 attack. Maybe operations or something, we can work on
24 developing a form.
25 **ARTHUR PETERSEN:** Yeah.

1 **DAN DITTO:** If we could get resolved the form
2 issues right away, that would be helpful because we have
3 them sign our own authorization that leaves information
4 separate from that, but now we have conflicting
5 authorizations.
6 **LAUARA SYNDER:** Before we find out, does the
7 Labor Commission actually approve that form and use that
8 form anymore?
9 **GUY DANSIE:** Right. They may or may not.
10 **ARTHUR PETERSEN:** Are they maintaining that
11 form? Are they updating it?
12 **GUY DANSIE:** Probably not.
13 **DAN DITTO:** I'm suggesting we just cross this
14 out and cross that out and if they sign it, great.
15 **LAUARA SYNDER:** It might be a simple quick fix.
16 **ROGER KEDDYTON:** Or do you let the facility run
17 their own consent process for each facility? Because I
18 can tell you every ED has a consent form they use for care
19 and a consent process.
20 **GUY DANSIE:** That's a possibility.
21 **ROGER KEDDYTON:** Do we need to duplicate it?
22 **GUY DANSIE:** Maybe we can survey the hospitals
23 and find out if that's an issue.
24 **JAY DEE DOWNS:** Would everyone -- would everyone
25 be okay if maybe Jason and I and Guy got together and

1 make -- kind of make up a plan of operation, who does
2 what? And then that way when we meet with the EMS meeting
3 in January, we can say this is what we discussed, this is
4 our recommendation, we take this part to the office
5 committee, this part to the professional development, and
6 this part to the rules? I mean, what do you think Jason?
7 **JASON NICHOLL:** Yeah.
8 **JAY DEE DOWNS:** If we take it like we're taking
9 it right now, it's going -- you know what I'm saying?
10 **LAUARA SYNDER:** It's all over the place.
11 **JAY DEE DOWNS:** Yeah. Because they are going to
12 be going like, well, what's your recommendation? So I
13 think we'll do legwork beforehand.
14 **JASON NICHOLL:** Yeah, let's sketch out some --
15 what we see as the grand vision here, and with your help
16 obviously, and divide and concur.
17 **JAY DEE DOWNS:** Absolutely.
18 **JASON NICHOLL:** Because I mean Professional
19 Development that may be, you know, well, well into the
20 future, not an immediate need to tackle right now.
21 **GUY DANSIE:** But we could do a form very quickly
22 and I think a rule we could do within a few months pending
23 Labor Commission's cooperative, you know, mind-set and how
24 they want to work with us on that.
25 **DAN DITTO:** And that would be awesome. We could

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1 fix it, we could fix it now, that would at least help us
2 in the dealing with the day-to-day situations.
3 And then I really do like looking at the grand
4 vision because even if we have EMS people but we don't
5 have the policeman who gets in a tussle, the guy has got
6 syringes in his pocket and gets a stick or something like
7 that, that hasn't helped us quite enough. So...
8 **JAY DEE DOWNS:** And you know, it could be the
9 Labor Commission might have some questions of their own
10 now that they've been dealing with it, you know, saying we
11 can deal with, and if we approach them. I just don't
12 think the EMS Committee will come out with what we've just
13 got now. They'll come up and say, yeah, it sounds great.
14 Then it'll be another three months making assignments.
15 **JASON NICHOLL:** Or farm it out and have no
16 direction unless it gets farmed out, yeah.
17 **JAY DEE DOWNS:** So I think if we go in with a
18 game plan beforehand, this is what we'd like to do, what
19 do you guys think, that's the best way.
20 **JASON NICHOLL:** The three of us should meet --
21 **JAY DEE DOWNS:** Yeah.
22 **JASON NICHOLL:** -- either later this week or
23 next week, early next week and hammer something out so we
24 have it in form.
25 **GUY DANSIE:** Sounds good. Anything else? I

1 mean maybe we could do some conference calling.
2 **DAN DITTO:** Anything we can do to help we're
3 more than happy. Just appreciate --
4 **GUY DANSIE:** Likewise.
5 **DAN DITTO:** -- the opportunity to come and talk
6 about it and appreciate your receptive approach to this.
7 **JAY DEE DOWNS:** I think for me it has been in
8 the back of my mind. I think it's something that needs to
9 be addressed. We need to form a proactive --
10 **DAN DITTO:** Yeah, Roger has lived with this
11 project, and Roger has been -- Roger is drinking and
12 eating this, so he --
13 **ROGER KEDDYTON:** We've got to get this better.
14 **JAY DEE DOWNS:** So you can retire.
15 **ROGER KEDDYTON:** Not this week.
16 **JAY DEE DOWNS:** Not this week.
17 **JASON NICHOLL:** Just out of curiosity, what's
18 the volume we're talking about? On an annual basis, how
19 many exposures do you think we are dealing with?
20 **ROGER KEDDYTON:** In checking with infection
21 control, who I think was aware of all the situations we
22 had in the urban central region, so that's LDS, Alta View,
23 Riverton, IMed, they had a dozen in 2014. My guess is in
24 looking at the numbers, I'll bet we've got closer to 20 in
25 2015.

1 **JASON NICHOLL:** Just in the Intermountain
2 Center?
3 **ROGER KEDDYTON:** Just in those hospitals. But
4 it's a low volume. You know, one or two a month is what
5 we're looking at.
6 **GUY DANSIE:** But it's a life or death issue.
7 **ROGER KEDDYTON:** If you are the one that's
8 stuck --
9 **GUY DANSIE:** Low volume, high serious.
10 **ROGER KEDDYTON:** And that's part of the
11 challenge. We see it rare enough that it's easy to screw
12 up. That's --
13 **DAN DITTO:** That's all professions, right?
14 **ROGER KEDDYTON:** No, that's just the
15 pre-hospitals. Now if you look at hospital employees,
16 they have several a week easily. It's very, very common.
17 **JASON NICHOLL:** This doesn't cover that?
18 **DAN DITTO:** Is that employees of police or fire?
19 **ROGER KEDDYTON:** No, the police and fire would
20 be like --
21 **DAN DITTO:** That doesn't include Ogden, Provo?
22 **ROGER KEDDYTON:** No, that's just our four
23 hospitals.
24 **GUY DANSIE:** The question about hospital folks
25 that may be exposed, is that rule Department of Health

1 rules, or rules that already exist somewhere on dealing
2 with some of that?
3 **ARTHUR PETERSEN:** I don't know.
4 **DAN DITTO:** Internally --
5 **GUY DANSIE:** You have your internal policy.
6 **DAN DITTO:** Internal processes. I don't know
7 that there's a regulation.
8 **ROGER KEDDYTON:** I don't know if OSHA
9 regulates --
10 **ARTHUR PETERSEN:** Oh, yeah. OSHA has some
11 recommendations --
12 **GUY DANSIE:** It's not a state rule or anything?
13 **DAN DITTO:** OSHA has recommendations and I think
14 some joint commission and CDC.
15 **GUY DANSIE:** Just curious if there was somebody
16 we needed to coordinate with on state level.
17 **ARTHUR PETERSEN:** So that -- because we do have
18 some joint commission standards of care that we need to
19 follow, and we have OSHA requirements, we do have -- I
20 don't know if the hospital per se needs more regulation on
21 this, but --
22 **GUY DANSIE:** Well, I was going to look at it as
23 a model or something they could look at.
24 **JAY DEE DOWNS:** He's going to plagiarize off of
25 it.

1 **ARTHUR PETERSEN:** Yeah, for sure.
2 **DAN DITTO:** We are so regulated, you'd have to
3 probably pick which set of regulations you want to model.
4 You know, we could certainly -- we can share our process,
5 though, couldn't we?
6 **ROGER KEDDYTON:** Sure. Absolutely.
7 **DAN DITTO:** Because I think that's something
8 we'd be happy to --
9 **GUY DANSIE:** It just seems like we could mirror
10 that is in my mind. If you have a system that you use
11 internally, maybe we could use that as a pre-hospital
12 requires for.
13 **JAY DEE DOWNS:** Guy, would you be willing to
14 take on and facilitate what we just talked about with
15 Jason?
16 **GUY DANSIE:** Yeah.
17 **JAY DEE DOWNS:** Okay. And could you -- you're
18 really kind of a key --
19 **GUY DANSIE:** A what?
20 **JAY DEE DOWNS:** A key person. You're really
21 different.
22 **GUY DANSIE:** Oh, well, thank you. I appreciate
23 the compliment.
24 **JAY DEE DOWNS:** Oh, Guy.
25 **GUY DANSIE:** I think we've got the gist of it

1 now though and maybe we'll work on it. We've got a few
2 other things. Do you guys have anything else?
3 **ROGER KEDDYTON:** That's not enough?
4 **GUY DANSIE:** That's plenty.
5 **JAY DEE DOWNS:** We've been going an hour and a
6 half. Let's take a break for like 10 minutes. Your
7 fingers need some help, right?
8 **ROGER KEDDYTON:** Thank you all very much.
9 **GUY DANSIE:** Okay. We're on break then.
10 (Break taken.)
11 **JAY DEE DOWNS:** Are you there Teresa? Are you
12 there Dean? Anybody there?
13 **RUS MALONE:** Anyone on the phone?
14 **JAY DEE DOWNS:** Okay. Let's get going. The
15 next person on the agenda is Rus changing testing periods
16 and everything.
17 **RUS MALONE:** We ready then?
18 **JAY DEE DOWNS:** Yeah.
19 **RUS MALONE:** Okay. Let me give you a background
20 a little bit real quick, super quick.
21 The Bureau has gone away from testing anyone as
22 far as certifications for EMT, EMR, all the way up. It's
23 now done by the National Registry, as far as the written
24 test is 100 percent done by the National Registry. So our
25 20 fee -- $20 fee for EMTs went up to $70. But -- and

1 it's handled through the National Registry and Pearson Vue
2 Testing. So that's the written test.
3 The practical test for an EMR or an EMT is done
4 at the course, by the course themselves. Very, very
5 little quality control, but that's a whole other issue.
6 So they run their own tests and the Bureau gives them some
7 guidance and so forth.
8 It just changed. Supposedly one January they
9 are going to make them do the seven station EMT test from
10 the National Registry. But they've also said we're going
11 to let you space it out through the whole course so you
12 don't have to do it in one day. So's that the EMT portion
13 of it.
14 The advanced EMT and paramedic are controlled by
15 the National Registry. You have to have a rep on site.
16 You do the full testing that day and so forth. And you
17 follow specifically their rules for the testing, the
18 multiple stations and so forth.
19 What I got involved in this is under the
20 certification, I started looking at these rules. I
21 highlight in yellow so it was easy to follow through all
22 of this.
23 On Rule 5-300 certification, it still listed the
24 five -- the five-year requirement which goes away one
25 January. Everyone has to be fingerprinted. Once they are

1 fingerprinted, then there's no more further checks,
2 background checks, it's all automatic. So -- and it's a
3 $65 fee just an FYI, which Jason just found out, for
4 everyone to go through initially.
5 And so -- and I added to that one as per the
6 rule, 426-5-2700, which requires the fingerprints now. So
7 that took out that five years is what I'm recommending
8 there.
9 Next.
10 **GUY DANSIE:** I was just going to add, as we go
11 through these, if anybody has any questions or want to
12 discuss any of those, let us know. Otherwise, we'll
13 assume you are okay with that. Is that -- sounds okay for
14 everybody?
15 **RUS MALONE:** And I can't make decisions. I'm
16 just throwing everything out there.
17 **GUY DANSIE:** I just want them to be aware that
18 if everybody's okay with the changes as we go through,
19 we'll just assume and leave those in and we'll not revisit
20 those if we don't need to.
21 **RUS MALONE:** The only thing we discussed was
22 eliminating the five-year rule outside.
23 The next page, item No. 4, shows -- and Guy's
24 will be just slightly different because I made a couple of
25 minor changes because I couldn't sleep last night to make

1 sure I got everything right.
2 The 120 days has been in rule, and that's what
3 started this whole thing, is they've given 120 days in the
4 past to get all the certification testing completed. And
5 we actually had some people get denied certification
6 because they went over the 120 even though by National
7 Registry standards, you have two years.
8 And so instead of trying to say National
9 Registry in here, what I did put on there was as per the
10 designated testing agency. Because that gives them, the
11 State, the option which is in rule here that they
12 designate who's their testers. So it says, say, National
13 Registry, if they want to change to Jason's Testing
14 Service down the road, they can do that without having to
15 rechange the rules.
16 **JAY DEE DOWNS:** You're in that business too?
17 **JASON NICHOLL:** It's a subcommittee.
18 **RUS MALONE:** So --
19 **JAY DEE DOWNS:** You're close.
20 **RUS MALONE:** On No. 4 I just dropped off the 120
21 days because that -- it should no longer be a factor
22 because the National Registry -- they actually have
23 multiple rules when you get into it. If I give my
24 students a test, a practical test at the end of my EMT
25 course, they actually have one year that that test stays

1 valid, the practical test. And they have that one year to
2 take their tests, their written test by the National
3 Registry.
4 At the end of that one year, they can retest the
5 practical and go for another full year. And the National
6 Registry actually allows six tests, written tests. Three
7 tests, then they have to do a remediation, and then they
8 can do three more tests. So -- at $70 a whack for the
9 EMT. So they make some good money.
10 So on four, we just dropped the 120 days. Then
11 I went down to Item 6 on your copies --
12 **TAMI GOODIN:** Sorry. On No. 4, where it says,
13 "As per the designated testing agency," can we change that
14 or even --
15 **RUS MALONE:** I deleted that off on this copy.
16 **TAMI GOODIN:** Okay. What does it say?
17 **RUS MALONE:** Nothing. It says within -- after
18 official course end date applicant shall successfully
19 complete department written practical, so forth. That one
20 I gave to him last week. And when I look at it, I felt
21 that was a little bit redundant right there.
22 **GUY DANSIE:** So -- so whoops.
23 **RUS MALONE:** Just take that last red line right
24 there totally off.
25 **GUY DANSIE:** This is --

1 **RUS MALONE:** It does come into play for the --
2 **GUY DANSIE:** What -- how about what I do, since
3 we've got the chart changes and everything, why don't you
4 send me your clean copy of this --
5 **RUS MALONE:** Because it's on two different
6 sheets.
7 **GUY DANSIE:** -- instead of me trying to mirror
8 all your changes.
9 **RUS MALONE:** There's only a couple on this one,
10 but I will get it for you, yeah.
11 **GUY DANSIE:** Okay.
12 **RUS MALONE:** So we took that off, left
13 everything down to No. 6, which an individual who fails
14 any part of it, EMR, EMT, I'm not showing an EMD. I'm not
15 an expert on EMD. But practical exam may take the exam
16 twice without further course work.
17 The reason I dropped AEMT, EMT-IA and paramedic
18 is because by National Registry rules after a second test,
19 they have to have remediation before they can have their
20 third test. Where the EMT and the EMR, there's no
21 remediation per se required unless you want to throw that
22 in there. But then who's going to provide it too?
23 **LAUARA SYNDER:** Do we need to leave in the
24 EMT-IA since we have a couple of agencies that still
25 maintain that level of service?

1 **RUS MALONE:** You know what, I --
2 **LAUARA SYNDER:** Do you have to retest? I know
3 you're not going to have any new ones.
4 **RUS MALONE:** Well, they may have -- they can
5 have new ones.
6 **JASON NICHOLL:** We can have new ones. They have
7 to work for the agency.
8 **LAUARA SYNDER:** And I read -- I read all that.
9 Does this still need to be in here?
10 **RUS MALONE:** How many tests are you giving under
11 the IAs? That's the question. Do they fall under the 99
12 rules where they get the three tests and they have to --
13 after the second failure, they have to do remediation?
14 That's why I dropped them off of this one. Because this
15 one says EMR and EMT.
16 **JASON NICHOLL:** Twice.
17 **RUS MALONE:** Can have three total tests and then
18 they have to retake the course.
19 **DON MARRELLI:** I think that's all right.
20 **RUS MALONE:** And so further down, you can add
21 the IA. I wasn't sure on that one.
22 **JAY DEE DOWNS:** So the question is the EMD.
23 **RUS MALONE:** EMD, I'm not sure what their
24 testing requirements are to be honest with you.
25 **JASON NICHOLL:** Do they have a practical?

1 **GUY DANSIE:** They have a meeting on Tuesday. I
2 can ask them.
3 **JASON NICHOLL:** Because six and seven need to be
4 clarified. Because six leaves the AEM in that, but seven
5 takes them out.
6 **RUS MALONE:** Seven takes them out. It says, "If
7 the EMR or AEMT fails both practical re-examinations, they
8 have to re-" -- they have to take the whole course over
9 again.
10 **JAY DEE DOWNS:** So just need to clarify the EMD
11 part.
12 **RUS MALONE:** The EMD portion of that.
13 **GUY DANSIE:** Okay.
14 **JAY DEE DOWNS:** It looks like to me they are
15 doing some national stuff, that they are just submitting
16 their applications here in the state to get recertified.
17 **GUY DANSIE:** Pretty much.
18 **JASON NICHOLL:** And then eight should probably
19 include EMD also.
20 **DEAN YORK:** Hey, listen, Dean, I have a
21 question.
22 **JAY DEE DOWNS:** Okay. Go ahead, Dean.
23 **DEAN YORK:** So are we saying that remediation is
24 retaking the entire course?
25 **RUS MALONE:** No. By the National Registry

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1 standards, remediation depends on the level and so forth.
2 And they do -- they actually spell it out, some of the
3 hours and so forth.
4 **DEAN YORK:** Okay. Thank you.
5 **RUS MALONE:** And they call it a cognitive is the
6 written test and then the psychomotor is the practical
7 test on the National Registry site.
8 Again, eight just says you can take as many --
9 the course as many times as you want, but you have to pass
10 the exams to be certified.
11 And then on your copies I added No. 10 in there.
12 Took out 10, which is the -- allowing the department to
13 extend it the 120 days. I felt if you had a two-year
14 period, if you can't test in that two-year period, you
15 don't need an extension. So I added in there AEMT and
16 paramedic must follow the retest requirements of the
17 designated testing agency. Which makes -- you know, puts
18 that to the National Registry.
19 Certification lower level we left.
20 Certification challenges, again, you can
21 challenge through the National Registry. And then down at
22 10, it had the 120 days. Again, do we need 120-day time
23 limit? D and E, extending it for the challenges.
24 **JASON NICHOLL:** Actually, I think that we -- we
25 may challenge, because a challenge is someone that's

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1 coming for, basically for reciprocity.
2 **RUS MALONE:** No. Reciprocity is totally
3 different. Reciprocity is covered later. So it's --
4 **JASON NICHOLL:** Okay. So this is a physician
5 assistant.
6 **RUS MALONE:** This is the registered nurse.
7 **JASON NICHOLL:** Okay. So they may not have gone
8 through any EMT or paramedic class or whatever within the
9 last two years which is what this is based on. So --
10 **RUS MALONE:** Up above it says that they have to
11 meet the standards and the testing requirements for the
12 level they want to go to. So they have to go through the
13 National Registry. They have to do a practical test and a
14 written test by the National Registry standards, which
15 when you get into all their rules, they spell it out
16 pretty heavy.
17 **JASON NICHOLL:** Okay.
18 **RUS MALONE:** The 120 days is something that is
19 held over from 20 years ago.
20 **GUY DANSIE:** I talked to Jim about that a little
21 bit and his feeling was it was mostly just they had a
22 cutoff, an arbitrary cutoff time.
23 **RUS MALONE:** And with -- as long as they are
24 using a National Registry which has that year, two-year
25 requirements, they list everything. Plus the fact that

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1 the papers that -- we used to keep everything hard copy
2 paper and they didn't want stuff stacked up for two years,
3 now it's on the computer. So it shouldn't be an issue.
4 Recertification requirements, we go to E. There
5 is no written and practical recertification exam within
6 one year of expiration. So deleted that totally.
7 The rest of that pretty well stays the same, all
8 the hours of recertification and so forth. Now this is
9 the state requirements. This does not address the
10 National Registry requirements which maintain both dual
11 certifications. But if you are going to recertify at the
12 National Registry, you follow their rules. But this is
13 strictly talking Utah rules. So that's the hours for
14 them.
15 The next major changes, feel free to read
16 through all this, it's so exciting, is reciprocity. And
17 again, it says the agency seeking reciprocity shall do all
18 the fees, so forth, to the department. It lists 120 days
19 again. And I didn't know if you wanted to keep that
20 reciprocity again.
21 When you talk reciprocity now, there's no
22 written test. There's no practical test. There's 25
23 hours of CME hours and the background checks and so forth.
24 Other than that, if you look down, E says
25 successfully complete the exams. There is none. And then

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1 No. 4 and No. 5, I totally took out because again it talks
2 about the written test, failing it, and then it talks
3 about paramedic. It actually states in there that if they
4 fail a test, they can go out of State for five years and
5 come back and try again, which I always loved that.
6 **JAY DEE DOWNS:** Oh.
7 **RUS MALONE:** Three of the five years. Sorry.
8 So again, that's not a requirement. You walk in with your
9 National Registry card or a card from a recognized state,
10 have your hours, they'll give you four years to go from
11 there.
12 **JASON NICHOLL:** Is there a problem between 2(a)
13 and 2(c) where 2(a) indicates you need 120 days from
14 submitting the application, but (c) says you just have to
15 have the valid CPR which is two years? Can someone come
16 back and say, well, you expire in six months or you've had
17 this for 18 months, which doesn't fall into the 120-day
18 requirement above? Follow me?
19 **RUS MALONE:** Yeah. The rules say that you have
20 to up in certification and everything else. You have to
21 maintain your CPR to keep your certification.
22 **JASON NICHOLL:** So instead of all of them,
23 complete all of the following, it should be, you must
24 complete a background check, TB test and 25 hours of CME
25 and have a current CPR.

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1 **RUS MALONE:** Maintain and submit documentation
2 of having completed a CPR course within the prior two
3 years.
4 **JASON NICHOLL:** Yeah, but they contradict each
5 other. 120 has to be --
6 **RUS MALONE:** Right.
7 **JASON NICHOLL:** -- it has to be within 120 or --
8 **RUS MALONE:** Because they take the 120 days out
9 is my recommendation, but I left that --
10 **GUY DANSIE:** So strike that?
11 **RUS MALONE:** I would strike the complete within
12 120 days. You know, the discussion with Jim Hansen we had
13 was a little bit on that 120 days was the paperwork for
14 reciprocity and so forth. And so I actually recommend
15 that we take out the 120 days everywhere because it
16 doesn't really -- everything is on the computer. It
17 doesn't apply. So, you know.
18 **GUY DANSIE:** So I'll just read, to the
19 department and complete all of the following.
20 **LAUARA SYNDER:** To the department, period.
21 **RUS MALONE:** Submit applications and complete
22 application including Social Security number and
23 signature.
24 **LAUARA SYNDER:** To the department.
25 **RUS MALONE:** To the department. And then

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1 period.
2 **GUY DANSIE:** Period. And then just strike all
3 that that's in yellow?
4 **RUS MALONE:** Yeah, to complete within 120 days.
5 **JASON NICHOLL:** Yeah, because even G gives you a
6 year.
7 **RUS MALONE:** Right, within the prior year.
8 And then when you get down to four and five,
9 just take those totally out. Lab certification doesn't
10 change, but the next page does. One thousand are 220 --
11 question?
12 **LAUARA SYNDER:** Just going back to that. At the
13 end of the department, it's not a period. It's a
14 semicolon.
15 **RUS MALONE:** It's a semicolon.
16 **LAUARA SYNDER:** I thought you said period. It
17 doesn't include any of that.
18 **GUY DANSIE:** No, I actually wrote a semicolon on
19 there.
20 **LAUARA SYNDER:** Okay.
21 **GUY DANSIE:** Housekeeping.
22 **RUS MALONE:** The transition on the next page to
23 the 2009 National EMS Education Standards, the deadline
24 for the last part of that is end of this month, or
25 January 1st to EMT to EMT basics. So does that really --

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1 we've already should have transitioned all the EMTs or all
2 the advanced EMTs, paramedics, everything to these new
3 standards.
4 **GUY DANSIE:** Is this expired, why would we have
5 this in here?
6 **RUS MALONE:** Well --
7 **JASON NICHOLL:** It's not even going to make it
8 to the Committee until January 1st.
9 **GUY DANSIE:** Yeah.
10 **JASON NICHOLL:** So just take it out.
11 **GUY DANSIE:** So all of this 1,000 we would
12 strike.
13 **RUS MALONE:** Other than if you look at (b) on
14 here, (c) and (b) at the very bottom, 5(c) and 6(b) talks
15 about IAs.
16 **GUY DANSIE:** Could we just move that somewhere
17 else? That's not really a transitional thing.
18 **RUS MALONE:** No. And that could go -- it's just
19 somewhere to designate -- it really doesn't say back up in
20 here or anywhere that address the --
21 **LAUARA SYNDER:** Well, it is a transition of
22 their license on 6(b) because they are not going to be an
23 EMT-IA anymore. They don't work for a provider now that
24 they are out on their own, so they do transition to an
25 AEMT.

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1 **JASON NICHOLL:** But that could be in the
2 definitions of certifications in the other part of the
3 rule that defines what an EMT is, what a paramedic is.
4 Put those lines, EMT-IA must work for EMT-IA agency or
5 they are --
6 **JAY DEE DOWNS:** Yeah, if you look at it too, you
7 only work at a level licensed agency. So if you are not
8 with an IA agency, you can't work an IA level anyway.
9 **GUY DANSIE:** Yeah, you are an A, an AEMT.
10 **RUS MALONE:** And I know in Professional
11 Development they were talking about investigating, doing
12 away with IA totally and have them as an A with the
13 waivers to do everything that they are currently doing.
14 **GUY DANSIE:** That's -- I think we have floated
15 that idea a little bit.
16 **RUS MALONE:** And that would solve a lot of the
17 hassles because then you don't have to have the separate
18 designations. And it's no different. They'll have the
19 waivers so they can do the skills that they are doing
20 right now as an IA.
21 The big reason in two task forces that go on
22 rules was Dr. Kemp said that, well, politically they
23 wanted to keep the IA terminology. And we actually had
24 people say, well, we don't want to change our patches as
25 justification. So realistically, IA versus AEMT. It's --

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1 all it is is waivers anyway. We're wavering -- National
2 Registry doesn't recognize an IA.
3 **LAUARA SYNDER:** Well, I think that all really
4 just goes back to the Paul Patrick absolutely made
5 promises to those agencies so they wouldn't change them.
6 So unless those agencies are willing to give it up, I
7 don't think we should arbitrarily say it goes away.
8 **RUS MALONE:** Well, yeah, and that's a
9 discussion --
10 **LAUARA SYNDER:** Whether it should or shouldn't,
11 that's not the discussion. It was promised to them.
12 **RUS MALONE:** I think they are promised to us
13 too.
14 **LAUARA SYNDER:** Well, yeah, like --
15 **JASON NICHOLL:** I was promised a short meeting.
16 **GUY DANSIE:** It's not going to four?
17 **RUS MALONE:** So that can be put anywhere in the
18 rule where you want to designate that.
19 **GUY DANSIE:** Okay. I propose we move the 5(b),
20 (c) and 6(b), and I'll put those in a different section.
21 And we'll look at -- I'll go back through and see what's
22 most -- what the best fit is.
23 **RANDY WILDEN:** And strike the rest of it.
24 **GUY DANSIE:** Yeah, and the rest --
25 **RANDY WILDEN:** The rest of it can go away.

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1 **GUY DANSIE:** The rest is absolute.
2 **RUS MALONE:** Yeah. It should be gone because it
3 no longer is applicable. And basically that's the big
4 thing that I had there.
5 **GUY DANSIE:** Okay.
6 **RUS MALONE:** The rest of the rule as I read
7 through it, including the stuff you worked on on Peer
8 Review and everything at the back seems to have -- be
9 right on the money as far as what I can see.
10 **GUY DANSIE:** Okay.
11 **JASON NICHOLL:** Cost quality access.
12 **GUY DANSIE:** The other parts of this rule, I
13 know you are looking at it kind of through your view of
14 certification issues. Some of the other things in here,
15 do we want to have anybody else look at this -- or I mean,
16 I'm just wondering if there's any other updates.
17 **LAUARA SYNDER:** I think it looks pretty
18 straightforward. So I think it's fine.
19 **GUY DANSIE:** I know Jim was thinking maybe the
20 Professional Development or somebody might want to just
21 grind on it, but you think it's good?
22 **RUS MALONE:** Once we clean up so that it fits
23 into that National Registry guidelines, and I did attach
24 the back, the re-exam, you know, information is on the
25 back on that second part of all this, it gets into -- you

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1 could spend hours going through the National Registry and
2 so forth, but this cleans up, makes us -- that's why it
3 doesn't say National Registry. It says Designated Testing
4 Agency. That way the State has the freedom to change if
5 they want to.
6 **GUY DANSIE:** Yeah, we don't want to -- we don't
7 like to put -- it says privately owned entity into the
8 rule.
9 **RUS MALONE:** Right.
10 **JASON NICHOLL:** Like American Health.
11 **RUS MALONE:** Yeah.
12 **LAUARA SYNDER:** Or National Registry. They are
13 a private --
14 **RUS MALONE:** Nonprofit entity.
15 **LAUARA SYNDER:** -- nonprofit, but -- okay,
16 nonprofit. What are their wages? They can change their
17 wages to whatever the,y want and call it still a
18 nonprofit.
19 **GUY DANSIE:** One other question, the TB
20 requirements. That's probably a Dr. Taillac thing. Do
21 you want me to have him look at that?
22 **JAY DEE DOWNS:** I just think we need to look at
23 that as part of the infectious control.
24 **GUY DANSIE:** Well, that's kind of what I
25 wondered too. This might be pulled and put in with

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1 infectious control and deal with the blood exposure stuff.
2 **JAY DEE DOWNS:** I think that's where it all --
3 that ought to be pulled too. I mean -- what does the
4 Committee think?
5 **GUY DANSIE:** Because this is a --
6 **LAUARA SYNDER:** You're right. We haven't looked
7 at that stuff for a long time and I think it needs
8 attention. Right?
9 **GUY DANSIE:** How about that? I'll talk to
10 Dr. Taillac and maybe we'll look -- I know Gold Cross and
11 our EPI folks have been working on infectious control
12 practices and doing some studies and all kinds of stuff on
13 that end. And we were going to actually present that in
14 the Rural EMS Leadership Conference, I think a year ago,
15 but then they didn't get their act together and weren't
16 able to present. I know that there's some things that we
17 probably ought to put in rule as best practice. We don't
18 need to make it like harsh language that everybody has to
19 do this, but we probably ought to put guidance in there.
20 I mean, things that help un- -- so people understand what
21 the expectation is or what the standard is.
22 I kind of think the same way with the blood
23 borne exposure thing. I think that that is something that
24 probably should go in rule, and not to be punitive or to
25 hold everybody's feet to the fire, but just to say, hey,

1 this is the expectation. Do you know what I am saying?
2 We could soften the language so it's a may or should kind
3 of thing. But I don't know.
4 **JAY DEE DOWNS:** Like we did --
5 **GUY DANSIE:** I'm just blowing hot air out right
6 now, so yeah.
7 **RUS MALONE:** He wants to stay till four.
8 **GUY DANSIE:** No, no. I'm just brainstorming. I
9 think that the TB thing seems like it's an odd ball in
10 here for me. And as we clean up this piece of rule, the
11 top end of it, we looked at the bottom end extensively,
12 but this top part we probably ought to maybe look at
13 pulling the TB thing out and putting it elsewhere.
14 **JAY DEE DOWNS:** I remember when the TB was put
15 into this. And I don't know what committee I was on with
16 it. But the reason why they put it in there, because if
17 somebody wanted certification, they wanted to make sure it
18 got done.
19 **GUY DANSIE:** It's true. And it's an individual
20 issue.
21 **JAY DEE DOWNS:** Yeah. And that's really why
22 they put it in there.
23 **GUY DANSIE:** And all this rule pertains to is
24 individuals and not to organizations.
25 **JAY DEE DOWNS:** It was a way that they could

1 hold people's feet to the fire on an issue.
2 **GUY DANSIE:** And maybe it will stay there. I
3 don't know. But the other part, we need to probably mesh
4 with the infectious disease stuff.
5 **JAY DEE DOWNS:** Absolutely. Anything else?
6 **RUS MALONE:** That's all I have. I appreciate
7 you listening.
8 **JAY DEE DOWNS:** No, this is great. This is
9 great.
10 **GUY DANSIE:** You've done a lot of hard work.
11 **JAY DEE DOWNS:** This is something that's needed
12 to be done with the change in curriculum. It's
13 interesting.
14 **JASON NICHOLL:** Good luck, Rus.
15 **JAY DEE DOWNS:** I don't think they realize how
16 much that curriculum changes, is going to change things.
17 **GUY DANSIE:** No, that's why -- we were venting
18 on the break, and I think it's been as painful on -- I
19 know for you guys and the Bureau certainly has been under
20 water on a lot of this stuff. So...
21 **RUS MALONE:** There's a lot of problems as far as
22 the -- getting the course coordinators on the same sheet
23 of music. It is a.
24 **GUY DANSIE:** Oh, it is.
25 **RUS MALONE:** It is a nightmare right now because

1 there's no current guidance.
2 **JAY DEE DOWNS:** Yeah.
3 **GUY DANSIE:** Right. We're kind of all without a
4 rutter right now. Just trial and error mostly.
5 **RUS MALONE:** And I talked to Jim Hansen and in
6 relation to this, the EMS applications still lists the old
7 requirements, 120 days and everything else. And they are
8 in the process of updating --
9 **GUY DANSIE:** The application.
10 **RUS MALONE:** -- the application front page, and
11 now Jim has talked to me about let's update the back page,
12 get rid of that 120 days from all that once this is
13 approved.
14 **GUY DANSIE:** Yeah. And hopefully can be a
15 reminder that -- turn on the system and things like that.
16 **LAUARA SYNDER:** Has the date been set for the
17 spring instructor conference? Because a lot of this stuff
18 will be talked about there, right?
19 **RUS MALONE:** I don't know.
20 **GUY DANSIE:** It might be. I'd have to look it
21 up. Maybe after the meeting we'll find out.
22 Are you good with this item? There's one last
23 item on the agenda.
24 **JAY DEE DOWNS:** I'm good with this unless
25 everybody else wants to do it.

1 **LAUARA SYNDER:** Do we need a motion that we
2 accept these changes?
3 **GUY DANSIE:** Sure.
4 **LAUARA SYNDER:** I'll make a motion we accept the
5 changes as written in what we discussed.
6 **RANDY WILDEN:** I will second.
7 **JAY DEE DOWNS:** Any further discussion on the
8 motions? Seeing none. All in favor say aye.
9 **COLLECTIVELY:** Aye.
10 **JAY DEE DOWNS:** Any opposed?
11 How do you vote, Dean?
12 **DEAN YORK:** Aye from Dean on the phone.
13 **JAY DEE DOWNS:** Aye, Dean?
14 **DEAN YORK:** Correct.
15 **JAY DEE DOWNS:** Okay. The next on the agenda is
16 certification to licensed individuals, certified to
17 licensed individuals. That's Mr. Guy.
18 **GUY DANSIE:** Right. And I -- this is just a
19 theoretical, hypothetical thing that we're working on.
20 I'm not prepared to go through the rules and make all the
21 changes or show you what needs to be done today. But I
22 just wanted a heads up. We've discussed this before.
23 As we go to -- if legislation passes to become a
24 replica state, the interstate compact for paramedics and
25 EMTs, then our terminology has to shift and -- in order to

1 align with theirs. And part of that is changing from a
2 certified individual to a licensed individual.
3 So what I'm proposing is we have a project. We
4 probably have to go through at least the first five
5 sections of our rule, the definitions, the designations,
6 licensure, all of those operations and the certification
7 and change the terminology. So it will affect several
8 pieces of rule, but it's -- you know, hopefully it won't
9 change anything.
10 **JASON NICHOLL:** It's a uniformed change.
11 **GUY DANSIE:** Yeah. The intent and the way
12 things are written probably won't have to be altered other
13 than changing the terms.
14 **JASON NICHOLL:** Now does DOPL get involved with
15 that at all?
16 **GUY DANSIE:** No. We've been clear. We found
17 out -- that's always been an issue in the back of our
18 minds, is DOPL has something to do with licensing, the
19 Bureau has to do with certification. But there is not a
20 problem, there's not a conflict, and I don't know what I
21 need to do to reassure you of that, or what -- if we need
22 to get any proof or whatever. But Paul's reassured us
23 that DOPL will not have anything to do with our licensing,
24 licensing individuals.
25 The reason we wanted to call it licensing is

1 because the National Registry does certifications. And we
2 have to offset or differentiate what we do and what we do,
3 plus a certification, and we wanted to change the term to
4 licensing.
5 **JASON NICHOLL:** So do we have to do this before
6 we become compact or are we waiting?
7 **GUY DANSIE:** No, probably wait. But I think,
8 honestly as we wind down on some of the big rule issues,
9 this is one of the things of housekeeping that we are
10 going to have to do. I would assume that we would
11 probably have to do it after the legislation takes effect,
12 and that would put us on a timeframe of October.
13 **JASON NICHOLL:** Then I would recommend just
14 bypassing this group --
15 **GUY DANSIE:** And just change it.
16 **JASON NICHOLL:** -- into that wholesale change.
17 Because if it's a change that's dictated by legislation,
18 then --
19 **JAY DEE DOWNS:** Nothing we can do about it.
20 **JASON NICHOLL:** Nothing we can do. So just do
21 the -- find replace, present it to the committee --
22 **GUY DANSIE:** Yeah.
23 **JASON NICHOLL:** -- and we're done with it.
24 **LAUARA SYNDER:** What legislation is going to say
25 that we're changing the terminology from certification to

1 licensure? What -- is there a statute?
2 **GUY DANSIE:** I don't know if it's going to be in
3 the bill spelled out that clearly. But the other compact
4 states -- well, Colorado and Texas and then the others
5 that are proposing legislation, the term consistently is
6 licensed individual and not certified. Certified is what
7 the National Registry does. And so what we have called
8 certification would become licensing.
9 **JAY DEE DOWNS:** Your --
10 **LAUARA SYNDER:** So just to clarify, in order to
11 participate in this compact, we have to have some
12 statute --
13 **GUY DANSIE:** Yes. Yes.
14 **LAUARA SYNDER:** -- in there?
15 **GUY DANSIE:** Yes. And Paul is working on a bill
16 right now. I don't know the number. Fire guys might
17 know, but there's a push for that. There's some long
18 legislation that's on the SEMSCO's website if you'd like
19 to look at that. And I don't know where the bill is right
20 now as far as where it's at in the process. I don't know
21 if it's been numbered.
22 **RANDY WILDEN:** And I don't know who was going to
23 carry it, but I know they got -- it's somebody to carry
24 it.
25 **GUY DANSIE:** Yeah, it's -- and Paul knows all of

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1 it, but I don't. I think it's -- is it Paul Lee -- I'm
2 just pulling names out of my -- anyway, he's working with
3 legislature to draft language on this.
4 But it's just something I wanted you guys to
5 have a heads up on. We'll have to go through and glean
6 out the term certification in all the rules and put
7 licensed individual.
8 **JAY DEE DOWNS:** I'm like Jason. I think once
9 the legislation is done, we can't do anything about it
10 anyway. So just do a wholesale change. I'm not sure it
11 has to go to the EMS Committee other than rule change.
12 **GUY DANSIE:** It might not be a non-substantive
13 change. I can never say that word.
14 **JASON NICHOLL:** I agree. I think it's a
15 non-substance -- see you got me on it.
16 **GUY DANSIE:** Like saying cinnamon, huh?
17 Anyway, so I just wanted -- that's just a heads
18 up.
19 **JAY DEE DOWNS:** Are you saying substantial? Is
20 that what you are trying to say?
21 **GUY DANSIE:** Something like that.
22 **JAY DEE DOWNS:** Try getting that in the minutes.
23 **GUY DANSIE:** The last half hour is jack Susan
24 around, huh?
25 So anyway, I just wanted to put that on the

1 agenda because I didn't want anybody to -- you know, and I
2 obviously thought the agenda would be pretty light today.
3 The blood borne thing was longer, and we were not planning
4 on holding this meeting, but -- because Rus had his thing
5 and this IMC thing or Intermountain issue came up, like I
6 said, within -- go ahead and hold it.
7 **JAY DEE DOWNS:** You know, I still --
8 **DON MARRELLI:** I'd like to round it up.
9 **JAY DEE DOWNS:** So moved. Second it?
10 **RANDY WILDEN:** Yeah.
11 **JAY DEE DOWNS:** All in favor say bye.
12 **DON MARRELLI:** Bye.
13 **JASON NICHOLL:** Bye.
14 (Meeting was concluded at 3:09 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 22nd day of DECEMBER, 2015.

SUSAN S. SPROUSE, RPR, CSR
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