#### STATE EMS COMMITTEE MEETING

	1
State EMS Committee Meeting	1 July 13, 2016
July 13, 2016	2 ***
1:00 p.m.	3 <b>DR. KRIS KEMP:</b> All right. We're going to be
	4 starting here pretty soon so we can hopefully get out on
Location: Viridian Event Center	5 time or perhaps a little bit early. We've all got places
8030 South 1825 West	6 we need to be, even if it's just outside to enjoy the
West Jordan, Utah 84088	7 weather.
	8 So we'll call to order. We've already had our
Reporter: Susan S. Sprouse	9 executive session. I'm going to lead this session as
	10 usual, apparently, as the chair of the committee. My name
	11 is Dr. Kris Kemp. We're going to go around and introduce
	12 ourselves mainly to the public here and jump right into
	13 our agenda.
	14     And just for reviews sake, please understand the
	15 executive session is an open session as well. We do
	16 typically about an hour before we have this session. It's
	17 really just to chew on a couple of nuts and bolts issues
	18 that we work on in the official meeting of which we're now
	19 starting. It just helps us become a little more
	20 efficient. Before we started doing the executive
	21 sessions, we were going well after the 3 o'clock hour on
	22 many of our committee meeting days and that that was a
Caraia & Lowe Court Deporting and Mideography	23 little bit of taxing for a lot of people. So it seems to
Garcia & Love Court Reporting and Videography Susan S. Sprouse, CSR/RPR	be pretty efficient to do it this way. Ultimately, they
Suban S. Spiouse, Convin	are open meetings, so you all are more than welcome to
	Page 3
	1 attend the executive sessions. It's just the sauce of
Dr. Kris Kemp	1       attend the executive sessions. It's just the sauce of         2       making the process for this committee. So it's not,
Guy Dansie	<ul> <li>a not you're not missing out on anything.</li> </ul>
Nathan Curtis	4 So with the introductions, we'll just go around
Casey Jackson	5 the table here and we'll go through it.
Laconna Davis	6 <b>NATHAN CURTIS:</b> I'm Sheriff Nathan Curtis with
Dr. Russell Bradley	7 public safety.
Suzanne Barton	8 CASEY JACKSON: Casey Jackson, and I'm a
Dr. Peter Taillac	9 consumer.
Michael Moffitt	10 <b>LACONNA DAVIS:</b> Laconna Davis, Department of Work
Mike Mathieu	11 Safety.
Jeri Johnson	12 DR. RUSSELL BRADLEY: Russel Bradley, rural
Jay Dee Downs	13 physician representative.
Kristopher Mitchell	14         MIKE MOFFITT: Mike Moffitt with Gold Cross
Jason Nicholl	15 Ambulance.
Dr. Hallie Keller	16 <b>MIKE MATHIEU:</b> Mike Mathieu, fire chief
	17 representative.
	18         HALLIE KELLER: Hallie Keller, pediatric
	<ul> <li>18 HALLIE KELLER: Hallie Keller, pediatric</li> <li>19 representative.</li> </ul>
	<ol> <li>HALLIE KELLER: Hallie Keller, pediatric</li> <li>representative.</li> <li>JERI JOHNSON: Jeri Johnson, EMT representative.</li> </ol>
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1	surgeon at St. Marks.	1	GUY DANSIE: I will use the microphone. Thank
2	MARK SANDERSON: Mark Sanderson, nursing	2	you.
3	representative.	3	First, let's look at R426-4. I'm trying to find
4	JASON NICHOLL: Jason Nicholl, paramedics.	4	it here. There's a handout for that. This pertains to
5	DR. KRIS KEMP: All right. Thank you. Whenever	5	the ambulance manufacturing specifications. Recently
6	we are here, I always feel like Oprah or something, like	6	there were two new ambulance standards that were developed
7	running around. Does anyone even know who Oprah is?	7	and recognized. They've been tested. They have science
8	Okay. Because this is kind of a large spacious	8	backing. Therefore, the State, we wanted to implement
9	room, we'll be asking that everyone who presents to please	9	those standards if possible.
10	use a mic so that our recorder can get all of our	10	There is an old standard that was used for years
11	information. And please introduce yourself as well.	11	and years by a federal general purchasing and it was not
12	To start with our agenda, we have a few of our	12	backed by any scientific data or testing of the rules or
13	EMS Committee members that their term has been completed,	13	anything. So in order to bring our state up to that new
14	the eight years.	14	level, we wanted to, to change the wording in the rule.
15	GUY DANSIE: Yeah. There's two terms of four.	15	And the new wording would say, in the copy, that "All
16	So those are for people finishing out their second term.	16	ground ambulances manufactured after July 1, 2017"
17	DR. KRIS KEMP: Thanks for using the mic. Just	17	geez, have so much strikeout here "they must meet
18	had to so we've got three here. And so we these are	18	specifications of standards." And then put "see
19	a mark of recognition for the dedication service for the	19	department policy for ground ambulance standards."
20	State EMS Committee. And the first one is for Jay Downs.	20	Basically, we would take the standard and put it
21	JAY DEE DOWNS: No thanks.	21	as the department policy like we've done some of the other
22	DR. KRIS KEMP: And we have Mike Moffitt.	22	rule with equipment and so forth. And we would adopt by
23	MIKE MOFFITT: Thank you.	23	policy the NFPA 1917 standard and the CAAS, I think, it's
24	SPEAKER: He wanted to give one, though.	24	the GVS. I'm looking at the acronym wrong, version 1.0.
25	<b>DR. KRIS KEMP:</b> Oh, he wanted to give a speech?	25	Anybody remember the name of that standard? But we will
	Page 5		Page 7
1	MIKE MOFFITT: No. No.	1	use those two new standards for department policy
1	MIKE MOFFITT: No. No. DR KRIS KEMP: And Mike Matthieu	1	use those two new standards for department policy
2	DR. KRIS KEMP: And Mike Matthieu.	2	starting the Rules Task Force figured July 1st of next
2 3	<b>DR. KRIS KEMP:</b> And Mike Matthieu. <b>MIKE MATHIEU:</b> Thank you.	2 3	starting the Rules Task Force figured July 1st of next year would be a fair time to implement that in case
2 3 4	<ul><li>DR. KRIS KEMP: And Mike Matthieu.</li><li>MIKE MATHIEU: Thank you.</li><li>GUY DANSIE: Do I need to use the microphone?</li></ul>	2 3 4	starting the Rules Task Force figured July 1st of next year would be a fair time to implement that in case anybody has to order ambulances at this point, go ahead
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1	so I'm abstaining.	1 aye.
2	DR. KRIS KEMP: You're abstaining. Okay. Thank	2 <b>COLLECTIVELY:</b> aye.
3	you. Motion carries.	3 <b>DR. KRIS KEMP:</b> Any opposed? And any abstained?
4	Go ahead, Guy.	4 Thank you.
5	GUY DANSIE: Okay. So does Mike too.	5 Okay, Guy.
6	R426-5-3000, this is this is A new rule that	6 <b>GUY DANSIE:</b> Thank you. One more rule change,
7	was just recently made effective. It's for the EMS Rules	7 R426-1-1000. Resource hospital minimum designation
8	Task Force. They wanted to have and it came before	8 requirements, this is an oversight by the department, and
9	this body in the past to have the positions clarified	9 possibly myself, kind of repenned this wrong. We actually
10	in rule for the EMS Rules Task Force.	10 had this approved about a year ago to we added the
11	We did not, however, have a representative from	11 Part 14 that says, "Designated trauma centers are deemed
12	a designated patient-receiving facility on that list.	12 to meet the resource hospital standards and are exempt
13	Currently we do not have any designated patient-receiving	13 from requirements outlined in this section."
14	facilities. However, there is that provision in the	14   Basically a resource hospital designation is
15	future, we may have basically a rule that I think is	15 our, our lowest designation for hospitals that receive
16	approved to receive patients in certain situations from	16 patients, patients from ambulances. And we're basically
17	ambulance providers.	17 wanting anybody that's designated at a higher level to be
18	And there was feelings that that position should	18 deemed that lower level status.
19	be represented on the Rules Task Force as well. So we've	19 We've kind of honored this anyway. It's already
20	just added that. I put a new letter or number M and just	20 taking place, but we just wanted to clarify that in rule.
21	added that position to the EMS Rules Task Force, the body	21 And this was before the committee previously, but it was
22	of the membership on that. Are there any	22 in error. It wasn't put in the current rules. So I just
23	DR. KRIS KEMP: Any questions for Guy in regards	23 want to bring it back to the table to make sure everybody
24	to that?	24 was okay with it before we put it into the rule.
25	MIKE MOFFITT: Is this yes, I have a	25 <b>DR. KRIS KEMP:</b> So is this the entire rule that
	Page 9	Dage 11
	Page 9	Page 11
1	question.	1 you say was
1 2	question. GUY DANSIE: Here.	<ol> <li>you say was</li> <li>GUY DANSIE: Just the underlined part, the Part</li> </ol>
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2 3 4	GUY DANSIE: Here. MIKE MOFFITT: Yes. Is this how the task force is currently constituted or is there going to be going	2       GUY DANSIE: Just the underlined part, the Part         3       14.         4       The other part of the rule, 1 through 13, are
2 3 4 5	GUY DANSIE: Here. MIKE MOFFITT: Yes. Is this how the task force is currently constituted or is there going to be going to have to fill in these positions now or moving forward,	<ul> <li>GUY DANSIE: Just the underlined part, the Part</li> <li>14.</li> <li>The other part of the rule, 1 through 13, are</li> <li>current effective rule, and it talks about the</li> </ul>
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1	<b>DR. KRIS KEMP:</b> So there's no limit?	1	KRISTOPHER MITCHELL: Second.
2	DR. PETER TAILLAC: No, it's not like, I have	2	DR. KRIS KEMP: All in favor say aye.
3	that one. It's like I can bring my patient to any one	3	COLLECTIVELY: Aye.
4	that is designated.	4	DR. KRIS KEMP: Any opposed? And any abstained?
5	JAY DEE DOWNS: Okay. Great.	5	Okay.
6	DR. PETER TAILLAC: Guy, I have a problem with	6	DR. PETER TAILLAC: So Guy, this doesn't have to
7	the trauma center standards. I don't have any trouble	7	go back to the Rules Committee. It's a done deal.
8	with what's written in the trauma center standards because	8	GUY DANSIE: The change on Part 14 is considered
9	to be a trauma center you are required to basically do all	9	a done deal. If we wanted to develop the language for
10	these things already. So it's a little redundant for the	10	Part No. 4, as per the motion, then we can take that to
11	trauma centers.	11	the rules task it should actually go to our Trauma
12	But No. 4, that says, "Create and abide by	12	System Advisory Committee, but okay.
13	prehospital emergency care, care protocols," I don't think	13	<b>DR. PETER TAILLAC:</b> But okay. 4 works.
14	the hospitals create the protocols for EMS. I'm not sure	14	GUY DANSIE: Well, just so they have volume I
15	why that's there. Every agency, you know, the medical	15	think that
16	directors create the protocols at the hospital. So I'm	16	<b>DR. PETER TAILLAC:</b> That's not trauma. That's
17	not sure what was meant by that.	17	resource hospital.
18	<b>GUY DANSIE:</b> I don't know what we can do is	18	GUY DANSIE: Okay. Our staff, we discuss it,
19	take it back to the Rules Task Force with the advice from	19	take it to the Rules Task Force. Typically
20	our trauma personnel and find out if we can modify that if	20	<b>DR. KRIS KEMP:</b> Rules Task Force is they have
21	you'd like to do that.	21	to report to both the Bureau and the Committee; is that
22	<b>DR. PETER TAILLAC:</b> Yeah. The trauma centers,	22	correct?
23	that's a good point. The trauma centers are required to	23	GUY DANSIE: Correct. I sit on that as the
24	participate in the development of the prehospital	24	Bureau representative. And then it goes through our legal
25	protocols in the areas.	25	vetting process, through our Attorney General's Office.
	Page 13		Page 15
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1	LACON NICILOL L. That's	1	It goes through Doul Dr. Dabbitts and through Dr. Minar
1	JASON NICHOLL: That's	1	It goes through Paul, Dr. Babbitts and through Dr. Miner,
2	DR. PETER TAILLAC: And that would probably be	2	the Executive Director's Office. So I have to get all
2 3	<b>DR. PETER TAILLAC:</b> And that would probably be better for something along those lines for this.	2 3	the Executive Director's Office. So I have to get all those internal approvals to put it out for comment.
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	Force for language. So it would be a minor thing. We	1	quite complicated. For us to have anything meaningful at
2	could easily put it through. But that is the process.	2	this point, I think was our feeling earlier in our
3	DR. KRIS KEMP: That was the motion.	3	executive session. So with that in mind, do you want to
4	JASON NICHOLL: Yes, it was.	4	make a motion?
5	DR. KRIS KEMP: It carried.	5	DR. KRIS KEMP: It's listed as an action item
6	GUY DANSIE: It carried. So we're done.	6	for air ambulance subcommittee creation. The discussion
7	Any more explanation? Ready for the next agenda	7	was just what you made mention of. That we're talking
8	item? You're getting me off my game here.	8	about the regulation between what the states can do and
9	DR. KRIS KEMP: Is that it? Oh, you got the	9	what the federal government can regulate. And we have
10	next one. So Guy, please, carry on.	10	very little control outside of the control of the
11	GUY DANSIE: That's what I'm saying.	11	certification of the medical crew.
12	It was proposed by the department for air	12	And so because of that, it makes it so if we
13	ambulance subcommittee creation. We talked about that	13	create a subcommittee for air ambulances, there's very
14	extensively in our executive session. We feel that maybe	14	little work they are actually going to be doing other than
15	it's premature at this point, that air ambulance providers	15	saying, yep, we've got the staffing. So that's a bit of a
16	are going through some turbulent times so to speak, in	16	challenge, I think, for us to say we want to create a
17	what's federally regulated versus what's state, what state	17	subcommittee. And that was generally the consensus.
18	authority we have with that. So we're waiting for further	18	Any further discussion from the Committee?
19	direction pending federal regulation change at this point.	19	MIKE MATHIEU: Guy, I think the comment that I
20	I believe that's and so.	20	would make is that we give the EMS Committee in the state
21	DR. KRIS KEMP: Should we expand	21	of Utah a false sense of assumption that we have a higher
22	GUY DANSIE: I brought it to a vote, but I don't	22	degree of regulatory authority for air ambulance than we
23	think we agreed to go ahead and shelf that for	23	actually do. And I think that this creates disenchantment
24	<b>DR. KRIS KEMP:</b> I think for public comment and	24	for us, especially in front of all of us, that we even
25	discussion points, I think it would be valuable to let	25	have some legal authority when we don't, other than
	Page 17		Page 19
1	them understand why we got to that conclusion.	1	staffing and giving medications and care and I would
2	GUY DANSIE: Why? We formally we had air	2	rather send the message out for our EMS community that we
3	ambulance I think at one point they were a	3	have very little regulatory authority, therefore, we are
4	subcommittee. It changed to a task force. It was later	4	not going to have an area in the subcommittee for this.
-	changed to an air ambulance committee. There's been	5	
5		5	And everything we do essentially with the air ambulance
5 6	lawsuits in other states involving state's rights versus	6	And everything we do essentially with the air ambulance community is a negotiation, not setting the standard or
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6	lawsuits in other states involving state's rights versus	6	community is a negotiation, not setting the standard or
6 7	lawsuits in other states involving state's rights versus federal requirements due to the Airline Deregulation Act.	6 7	community is a negotiation, not setting the standard or requirement, except for staffing and medication. And to
6 7 8	lawsuits in other states involving state's rights versus federal requirements due to the Airline Deregulation Act. The states have lost.	6 7 8	community is a negotiation, not setting the standard or requirement, except for staffing and medication. And to state otherwise would be wrong. And I think we should if we want to have further regulation of the air ambulance community, then
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1	And so we can't control the routes, the lights,	1	we table this item until the time that we need to do it,
2	the teams on the flights, except the medical staff	2	that way we can keep it back on action items whenever
3	training and certification, so why create a subcommittee	3	necessary without notice.
4	that gives us a sense that we actually can regulate	4	CASEY JACKSON: Because there is a committee,
5	something we can't.	5	well, at least there was
6	HALLIE KELLER: So like, who has influence over	6	DR. PETER TAILLAC: Was.
7	the medical teams? It's a simple one. Sorry, I answered	7	CASEY JACKSON: It is a was. So it's officially
8	my own question. So you're saying we have influence over	8	dismantled?
9	that, in other words we don't have control in regulation	9	DR. PETER TAILLAC: It is.
10	over that side	10	CASEY JACKSON: Okay. That answers my question.
11	DR. KRIS KEMP: The Bureau does. They are	11	<b>DR. KRIS KEMP:</b> So we have a motion.
12	responsible for retaining certification levels and	12	JASON NICHOLL: We have a motion and a
13	staffing, right?	13	substitute motion.
14	<b>GUY DANSIE:</b> Currently yes. Currently it's	14	DR. KRIS KEMP: All right.
15	in rule and it went through the Air Ambulance Committee at	15	NATHAN CURTIS: We're good with either one.
16	that time and through this body for a second approval. So	16	Tabling it is probably the better one.
17	the staffing and the medical requirements are already	17	<b>DR. KRIS KEMP:</b> So we're sending the original
18	there in rule. If there is a change needed in that area,	18	motion for the amended motion of tabling. It's doing
19	we can obviously bring it here and amend the rule.	19	nothing, but still doing something. So we have a motion.
20	<b>DR. KRIS KEMP:</b> And we can create a subcommittee	20	Do we have a second?
21	at that time	21	<b>DR. RUSSELL BRADLEY:</b> Does it matter if we have
22	GUY DANSIE: Correct.	22	a bunch of action items that we're not going to take any
23	<b>DR. KRIS KEMP:</b> if we felt it was necessary.	23	action on? Is this the first of a whole list of them?
24	It's just it creates something to have reporting to us	24	JASON NICHOLL: I'm not a true parliamentarian,
25	quarterly about meetings that don't really matter, and we	25	so I can't say it. But with it being an action item
	Page 21		Page 23
		1	
1	can't really say anything about it. I should say status	1	<b>DR. RUSSELL BRADLEY:</b> We don't need a
2	quo versus not.	2	subcommittee, we don't need a subcommittee. We don't have
2 3	quo versus not. And I think the point was made in our executive	2 3	subcommittee, we don't need a subcommittee. We don't have to have it pending in the wings waiting as a future action
2 3 4	quo versus not. And I think the point was made in our executive session, if someone identifies an air ambulance service	2 3 4	subcommittee, we don't need a subcommittee. We don't have to have it pending in the wings waiting as a future action item. Because if it comes up again, we will bring it up
2 3 4 5	quo versus not. And I think the point was made in our executive session, if someone identifies an air ambulance service that's falling below that staffing certification	2 3 4 5	subcommittee, we don't need a subcommittee. We don't have to have it pending in the wings waiting as a future action item. Because if it comes up again, we will bring it up again anyway, so as a new item without the spectra of the
2 3 4 5 6	quo versus not. And I think the point was made in our executive session, if someone identifies an air ambulance service that's falling below that staffing certification requirement, being maybe there's one with the pilot and an	2 3 4 5 6	subcommittee, we don't need a subcommittee. We don't have to have it pending in the wings waiting as a future action item. Because if it comes up again, we will bring it up again anyway, so as a new item without the spectra of the must. How does that sound?
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1	is going to be representing that to you later today.	1	<b>DR. PETER TAILLAC:</b> If they are a licensed
2	The second item Guy touched on, and that was the	2	emergency medical responder or certified, then we would
3	ambulance specs. And so are there any questions on that?	3	have purview for training guidelines. But for, you know,
4	It sounds like you covered that thoroughly, so.	4	a cub scout leader who wants to carry an EpiPen, that's
5	Our next assignment that we'll be starting on is	5	not our department.
6	the Infectious Disease Policy. And we have a meeting	6	LACONNA DAVIS: Even in dispatch protocol, we're
7	our next meeting will have a representative from	7	instructed to have an EpiPen to utilize it.
8	epidemiology, the Medical Examiner's Office, and	8	VON JOHNSON: True. And, you know, our, our
9	Intermountain Healthcare. And we'll work together to put	9	take on this also was the fact that American Heart
10	together a policy on infectious disease testing.	10	Association, Red Cross, all of their First-Aid training
11	And the last thing is, this is my my term is	11	programs include Epi-Pens in their programs as available
12	coming to a close. And so our new chair of this committee	12	to lay rescuers.
13	will be Andy Smith from Grand County. And so he'll be	13	So, again, we we would recommend I think
14	reporting to you at the next meeting.	14	we're still going to look at it, but I feel like our
15	Any questions on anything? Okay. Thank you.	15	recommendation is going to be that we don't touch it, we
16	<b>DR. KRIS KEMP:</b> Yes, there's a question.	16	recommend to these different providers or different
17	MIKE MOFFITT: I just want to say to Eric, thank	17	agencies or groups, whatever they are, that they develop
18	you for your kindness and chairing. We appreciate your	18	their own training and suggest to them probably either
19	service.	19	American Heart, Red Cross, and things to go from.
20	ERIC BAUMAN: Thank you very much.	20	DR. KRIS KEMP: I have a question. Are EpiPens
21	JASON NICHOLL: Are you staying on?	21	only by prescription only?
22	ERIC BAUMAN: Oh, yeah. Absolutely.	22	<b>DR. PETER TAILLAC:</b> Yes.
23	JASON NICHOLL: Good, good, good.	23	JERI JOHNSON: They are, yes.
24	DR. KRIS KEMP: All right. Thank you.	24	<b>DR. KRIS KEMP:</b> So it's ultimately up to the
25	Professional development update. Von.	25	prescriber to make sure that proper training is
	Page 25		Page 27
1	VON JOHNSON: Von Johnson for the Professional	1	performed
2	Development Subcommittee. We have been discussing a few	2	HALLIE KELLER: and pharmacy to dispense
3	items. And one of the first things that we were tasked	3	with.
4	with or asked to look at in our last meeting was rules	4	<b>DR. KRIS KEMP:</b> Yeah. And so ultimately if it's
5	concerning EpiPens and their use and the training thereof.	5	a non-EMS provider that can work that, then someone
6	We were looking at specifically R426-5 and this	6	brought up Dr. Davis from the University of Utah School
7	was brought up due to Dr. Davis, I guess, at the	7	of Medicine brought up appropriate training, that goes
8	University of Utah asking what was appropriate training	8	back to the person writing the prescription and the
9	for situations where non-EMS personnel were going to be	9	pharmacy dispensing the medication to make sure that
10	using these EpiPens in wilderness rescue situations or	10	there's proper education. It has nothing to do with the
11	whatever.	11	local EMS.
12	So we have decided we're going to have all the	12	JIM HANSEN: Jim Hansen for the Bureau of EMS.
13	members of our committee looking at that, and we'll	13	I'll talk real loud.
14	discuss this further in our next meeting, see what's	14	But this was really a legislatively brought
15	appropriate there.	15	about. But it was the school programs that wanted to use
16	Our next item that we	16	Epi-Pens. And there were more the state legislature
17	DR. PETER TAILLAC: Question about that. I'll	17	said, well, then EMS needs to be the ones that decide what
18	talk loud. I don't think we regulate non-EMS personnel	18	training is necessary. So that's where this all came
19	that I know of. So I don't know that an EpiPen in the	19	from.
20	hands of non-911 licensed provider is within our purview.	20	DR. KRIS KEMP: So legislation says that we need
21	VON JOHNSON: That was something that we	21	to do it, wouldn't we just make a recommendation to put it
	discussed at length And we've we had desided as a	1 22	had an the more without and the inhome side and a sur-

- back on the prescriber and the pharmacists who are
- 23 dispensing it for that training? Why would that not be -
  - that's the most appropriate, as I see it.
  - **DR. PETER TAILLAC:** Is that legislation

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discussed at length. And we've -- we had decided as a

subcommittee that that was the case, but we were still

asked to look at it. So I tend to agree with you that we

really don't have any regulatory, you know --

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25

1	directing us to do this or just are legislatures saying it	1	So we put together a task force that is in the
2	would be nice?	2	process of building that survey right now, and we will be
3	JIM HANSEN: It was legislation. And,	3	sending that out shortly. Hopefully before our next
4	therefore, we did change the rule.	4	subcommittee meeting, we'll have some results back from
5	GUY DANSIE: Right.	5	that so that we can further discuss this and see what's
6	JASON NICHOLL: Jim, if I can, I think part of	6	actually being used out there and what we what we need
7	the discussion that we had also on this was there were	7	to look at any further. Any questions about that?
8	scout groups and other community groups that would	8	Okay. Our next item that we discussed was the
9	continually come to providers and say, "Hey, how can we	9	EMT practical testing, skills testing for the EMT courses.
10	train on this?" And part of the discussion was that we	10	It was discussed at length. There's still concern over a
11	could put together something that we could give to the	11	lack of quality review and that type of thing for those
12	public and say these are this is a training outline or	12	courses.
13	some guidelines in how to do these things, because not	13	We, again, discussed this pretty intensively for
14	everyone can be trained by the prescriber. There's a lot	14	a little bit, decided to go ahead and put together a work
15	of times that they are given by a complete and total	15	group to study this and see what we can do to, to improve
16	stranger, bystander.	16	the quality assurance side of that and see if we can make
17	And the school is specifically, the nursing	17	some recommendations to better improve that.
18	staff at the schools brought up that they wanted to have	18	We're looking at the EMT student handbook and
19	something from the state that related to the legislation	19	skills certifications that the State has put out, looking
20	and said this is the proper way to do this. So	20	to possibly revise those just a little bit, tweak them a
21	<b>DR. PETER TAILLAC:</b> I apologize. I didn't I	21	little bit so they are a little more useful.
22	spoke out of turn. I didn't realize this was from our	22	And then our last item, the National Registry is
23	office.	23	changing their certification protocols. They are moving
24	JIM HANSEN: Yeah.	24	to the new NCCP program. And basically they're saying
25	<b>JASON NICHOLL:</b> So I think it's basically trying	25	50 percent of the training for recertification needs to be
23	<b>JASON NETIOLE.</b> So I think it's busically trying		so percent of the duming for recertification needs to be
	Page 29		Page 31
1	to put together a community education piece that we can	1	at a national level, 25 percent of it needs to be at a
2	offer to people. And we tasked the Professional	2	state level, and 25 percent of it needs to be at a local
2 3	offer to people. And we tasked the Professional Development to handle that.	2 3	state level, and 25 percent of it needs to be at a local level.
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1	First, I'll explain some of the changes we've	1	upgrades, that was one category. And the other category
2	made from the last grants cycle to this grants cycle. The	2	was medical equipment. Some agencies applied for things
3	last grants cycle we had, I believe, five or six	3	that didn't fit either category.
4	categories to choose from to for grant items. And	4	So going through the process as we always do,
5	we've reduced those two categories. And also you could	5	we, of course, eliminated some of those grant requests.
6	only choose one item from either category. That was a	6	And I believe that's it. Unless there's something else.
7	change from what we had in the previous years.	7	GUY DANSIE: Did you want to speak about the
8	So we removed the CME request bracket. And by	8	size of the subcommittee?
9	removing that, and that was one of our largest requests	9	<b>DON MARELLI:</b> Okay. I wasn't sure if we were
10	for money. So what we have chosen to do was to give any	10	going to go over that. Our Grants Subcommittee, and I
11	grant applicant, whether you applied for a per capita	11	don't really recall. I believe it was our size our
12	grant appreard, whether you appred for a per capital grant or a competitive grant, you would initially you	12	total size was like members, I'm going to say seven to
13	would receive \$1,500 for CME automatically. So you	13	nine. And that was really quite a workable group.
14	wouldn't actually have to put in for CME as in the past.	14	In the past, I'll say a year and a half, when
15	You would just automatically get some CME money. So that	15	all the committees were increased to a much larger size,
16	was one of the changes.	16	we're still finding with our Grants Committee that we're
17	One of the other changes we had was the spending	17	still working with just enough to get a quorum to get this
18		18	done. So we're asking to I'll have Chief Morris get
19	time. We've had to be by May 15th and the paperwork had to be in by, like, the 17th, which didn't give most of us,	19	with the Bureau. We're asking to reduce that subcommittee
20		20	size. It's just it's just too large, we believe, and
21	or some of us I should say, time to even get the paperwork from the vendors or such. So we've extended the time to	20	so we're asking to reduce that size back to where we were
22		22	-
23	turn in the paperwork to May 31st and/or I'm assuming the next business day if it happens to be a weekend.	23	at. GUY DANSIE: I believe it was nine.
23	• • • • • • • • • • • • • • • • • • • •	23	
25	The spend date is still September excuse me May 15th. So all the grants have to be spent by the	24	<b>DON MARRELLI:</b> I think it was nine in the past. So anyway, that was one, one other thing we did discuss
20	me May 15th. So an the grants have to be spent by the	25	So anyway, that was one, one other thing we did discuss
	Page 33		Page 35
1	15th of May. All the paperwork has to be turned in by the	1	that just so you guys are aware that we'll be
2	31st of May.	2	GUY DANSIE: We could propose that in the
2 3	31st of May. I believe those are the changes that I can think	2 3	<b>GUY DANSIE:</b> We could propose that in the October EMS Committee meeting. Why don't we we plan to
2 3 4	31st of May. I believe those are the changes that I can think of unless	2 3 4	<b>GUY DANSIE:</b> We could propose that in the October EMS Committee meeting. Why don't we we plan to have another grant subcommittee in September, I believe?
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1	well.	1	to see a complete erosion over time. We're not going to
2	Are there any questions or comments? Mike,	2	be able to afford to give any funding, especially in rural
3	or	3	Utah, in those areas where it's so badly needed.
4	MIKE MATHIEU: One comment. We talked about	4	So I think we can pool our efforts in trying to
5	this earlier, meaning that has come up with in a couple of	5	explore, once we get something identified, then we bring
6	EMS Grant Committees, as well as I received phone calls	6	it back to the EMS Committee and ask all of us in the EMS
7	from some of the providers out there over the frustration	7	community to campaign our legislatures and representatives
8	over the last five or six years in the reduction of funds	8	to help restore this funding in some form or fashion.
9	available for grant funding. There's been a significant	9	DON MARELLI: Okay. Thanks. Guy, is there
10	drop upwards of more than 50 percent of what money has	10	anything else that you can think of that we need to go
11	been made available, which has also driven some changes in	11	over or not? Is that basically it as far as you remember?
12	our grant rule guidelines to where we've eliminated even	12	GUY DANSIE: Yeah.
13	the prioritization at the local levels within the EMS	13	DR. KRIS KEMP: Okay.
14	committees.	14	DON MARELLI: Thank you.
15	Frankly, there's been a minimal amount of money	15	DR. KRIS KEMP: Thank you. So it sounds like
16	to give out. It's minimized the Grants Committee as well	16	that's an assignment to the Grants Subcommittee.
17	because we just don't have as many decisions to make	17	MIKE MATHIEU: Yes, I would like especially
18	because there's so little money.	18	since Ron's not here, I would love to make a motion to
19	The chair met with Guy and Paul to try to	19	assign the chair of the EMS Grants Committee to champion a
20	determine what were all the factors. Over the last five	20	cause to restore EMS grant funding for all of us to enjoy.
21	or six years we've heard explanations that may have	21	DR. KRIS KEMP: That's a motion.
22	impacted some of the collection of the fines and	22	NATHAN CURTIS: I'll second.
23	forfeitures. But at the end of the day, the real root	23	DR. KRIS KEMP: I have a second. All in favor
24	cause here is that if you look at the statute, the statute	24	say aye.
25	says the EMS Bureau of the Department of Health could use	25	COLLECTIVELY: Aye.
	Page 37		Page 39
1	some of the grant funding. And what I mean by use the	1	<b>DR. KRIS KEMP:</b> Any opposed? I was going to
1 2	word lightly some, they can use grant funding for	2	say, I don't know if we actually have to make a vote on
3	administration. And there's no limiting factor on the	3	that because it's an action item. We can assign our
4	amount that they can use for administration.	4	subcommittees anyway. But we still
5	So what's happened over the years, is some of	5	MIKE MATHIEU: That's so good.
6	the programs within the Bureau have basically been funded	6	<b>DR. KRIS KEMP:</b> We have a motion. Great. And I
7	from the EMS grant funding. That's probably been the	7	guess if it does come down to where we have to lobby our
8	largest contributor to the decrease in the amount of funds	8	legislatures to make the change, you know, since we're now
9	available to give out the former grants.	9	over the school nurse program for Epi-Pens, anything can
10	As much frustration as that may create amongst	10	happen.
11	us as providers, the Bureau is being underfunded for their	11	MIKE MATHIEU: Maybe we need some money for that
12			
	· ·	12	
13	organization and programs. It's a problem. And rather	12 13	too.
13 14	organization and programs. It's a problem. And rather than pointing fingers, I think the best solution would be	13	too. <b>DR. KRIS KEMP:</b> Yeah, maybe. Maybe. Oh, boy.
14	organization and programs. It's a problem. And rather than pointing fingers, I think the best solution would be something to the tune of tasking the EMS Grants Committee		too. <b>DR. KRIS KEMP:</b> Yeah, maybe. Maybe. Oh, boy. Okay. On to informational items. EMS
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		T	
1	this particular responsibility here. And	1	What we decided at the State Department of
2	Brace yourself, you may want to cover your ears.	2	Health was to pool the teams together and create basically
3	So what I've decided to do in this presentation,	3	a work plan. Our goals, our objectives, what do we want
4	in respect for people's time is that we're going to kind	4	to do, strategies, and decide certain tasks that were
5	of provide the Reader's Digest version of a very	5	common to all. So that's what kind of brings us to this
6	complicated process. And of all of those complications,	6	point.
7	mostly it turns out to be BFOs or blinding flashes of the	7	The different work groups that we decided for
8	obvious. So there's not a real lot of technical things in	8	ESFA, that's only health and medical, were situational
9	here, but a lot of things that we need to gather in, put	9	awareness, support life-saving functions and operations,
10	under the umbrella and then share so that everybody can be	10	life supporting, which means that the life saving is kind
11	a part of it and understood what we are doing.	11	of the red lights and siren part of it, life supporting is
12	GUY DANSIE: We're getting our tech help.	12	the healthcare part of it, the hospitals that have to
13	Sorry.	13	continue providing care, and then mass fatality
14	MIKE STEVER: Okay. I'm just going to go ahead	14	operations.
15	and talk while this gets going so we don't have to waste	15	So for us right now that was the big four. And
16	much time on this.	16	if you get a chance when we get this finally done, you
17	The catastrophic earthquake plan targets the	17	would see lots of things under each one of those. In
18	Wasatch Fault and the metropolitan area from the Salt Lake	18	particular, for example, on the situational awareness, the
19	Valley. That's not the only place that's going to suffer,	19	challenge with that is I don't even know a good way to
20	but that's where the primary the big damage is going to	20	say it. We ought to be the best information sharers on
21	be. Okay, this is going to be the bad actor.	21	the planet, and we don't always do that. The platforms
22	And so what FEMA did is put together a private	22	are there, but we never ever practice them. So that
23	contractor to come in and write this terrific earthquake	23	becomes a paramount corridor for us.
24	plan, and they did it, and they did it pretty well. Are	24	The EMS and preparedness part of it, which fell
25	we good to go? Oh, wow.	25	to the Operations Subcommittee, we kind of recruited them,
	D		Dama (2)
	Page 41		Page 43
1	My fingers are crossed. Drum role. Ta-da.	1	and they were phenomenal in getting things done and
2	Wow, that was easy.	2	providing good information. So we're talking mainly about
3	Okay, so that a part of that old plan was	3	the life-saving operations at the very beginning.
4	that it was a lot of very good words and a lot of	4	Now, I put this time line up here and you can
5	strategic, interesting things, but it didn't really cross	5	see it's been going for quite a while. And you can also
6	the bridge that is so tough in the world of disasters, in	6	see that we are a little bit not a little bit, we are
7	catastrophic events between what we can really do and what	7	behind in getting it done.
8	somebody says.	8	Part of the reason for that is that assignment
9	So basically decided to redo it and to try to	9	came to the Utah Department of Health, and I know a lot of
10	make it more functional and more appropriate for local	10	
		1 - 0	you can relate to this, with no money. And so everything
11	response. We have a saying, you know, there may be a	11	you can relate to this, with no money. And so everything that we did, we basically had to take out of our hide.
11 12	response. We have a saying, you know, there may be a storm from one end of the country to the other, but it		
		11	that we did, we basically had to take out of our hide.
12	storm from one end of the country to the other, but it	11 12 13 14	that we did, we basically had to take out of our hide. And we recruited a lot of local individuals to help us, a lot of state individuals to help us that weren't necessarily in our particular bailiwick. And when you
12 13	storm from one end of the country to the other, but it only rains at the local level. So trying to bridge that gap. And that's what this catastrophic earthquake plan was meant to do.	11 12 13 14 15	that we did, we basically had to take out of our hide. And we recruited a lot of local individuals to help us, a lot of state individuals to help us that weren't necessarily in our particular bailiwick. And when you depend on volunteers, sometimes that time becomes very
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12 13 14 15 16 17 18 19 20 21 22	storm from one end of the country to the other, but it only rains at the local level. So trying to bridge that gap. And that's what this catastrophic earthquake plan was meant to do. And part of it was that we wanted it to be stakeholder oriented and they decided that emergency support function A, which is help in medical, should be the first part of that plan. So it's going to be a gridded plan from transportation, utilities, and schools and everything else, but we've got a pretty good track record of getting things done. And so they decided that	11 12 13 14 15 16 17 18 19 20 21 22	that we did, we basically had to take out of our hide. And we recruited a lot of local individuals to help us, a lot of state individuals to help us that weren't necessarily in our particular bailiwick. And when you depend on volunteers, sometimes that time becomes very it's paramount to make it happen. Okay? And then, I'll be damned I'll be darned, okay, if Ebola didn't come around. And that literally consumed us. Okay? And so we had Ebola. And then the Zika and all these other little our real jobs kept getting in the way. And so we're a little bit behind overall, but not with the EMS part of it. They did a good
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12 13 14 15 16 17 18 19 20 21 22 23 24	storm from one end of the country to the other, but it only rains at the local level. So trying to bridge that gap. And that's what this catastrophic earthquake plan was meant to do. And part of it was that we wanted it to be stakeholder oriented and they decided that emergency support function A, which is help in medical, should be the first part of that plan. So it's going to be a gridded plan from transportation, utilities, and schools and everything else, but we've got a pretty good track record of getting things done. And so they decided that the ESFA, which is health and medical, Emergency Support Function A would kind of take the lead in this. This is	11 12 13 14 15 16 17 18 19 20 21 22 23 24	that we did, we basically had to take out of our hide. And we recruited a lot of local individuals to help us, a lot of state individuals to help us that weren't necessarily in our particular bailiwick. And when you depend on volunteers, sometimes that time becomes very it's paramount to make it happen. Okay? And then, I'll be damned I'll be darned, okay, if Ebola didn't come around. And that literally consumed us. Okay? And so we had Ebola. And then the Zika and all these other little our real jobs kept getting in the way. And so we're a little bit behind overall, but not with the EMS part of it. They did a good job of kind of spearheading too. Eric and company, they were a big encouragement.
12 13 14 15 16 17 18 19 20 21 22 23	storm from one end of the country to the other, but it only rains at the local level. So trying to bridge that gap. And that's what this catastrophic earthquake plan was meant to do. And part of it was that we wanted it to be stakeholder oriented and they decided that emergency support function A, which is help in medical, should be the first part of that plan. So it's going to be a gridded plan from transportation, utilities, and schools and everything else, but we've got a pretty good track record of getting things done. And so they decided that the ESFA, which is health and medical, Emergency Support	11 12 13 14 15 16 17 18 19 20 21 22 23	that we did, we basically had to take out of our hide. And we recruited a lot of local individuals to help us, a lot of state individuals to help us that weren't necessarily in our particular bailiwick. And when you depend on volunteers, sometimes that time becomes very it's paramount to make it happen. Okay? And then, I'll be damned I'll be darned, okay, if Ebola didn't come around. And that literally consumed us. Okay? And so we had Ebola. And then the Zika and all these other little our real jobs kept getting in the way. And so we're a little bit behind overall, but not with the EMS part of it. They did a good job of kind of spearheading too. Eric and company, they
12 13 14 15 16 17 18 19 20 21 22 23 24	storm from one end of the country to the other, but it only rains at the local level. So trying to bridge that gap. And that's what this catastrophic earthquake plan was meant to do. And part of it was that we wanted it to be stakeholder oriented and they decided that emergency support function A, which is help in medical, should be the first part of that plan. So it's going to be a gridded plan from transportation, utilities, and schools and everything else, but we've got a pretty good track record of getting things done. And so they decided that the ESFA, which is health and medical, Emergency Support Function A would kind of take the lead in this. This is	11 12 13 14 15 16 17 18 19 20 21 22 23 24	that we did, we basically had to take out of our hide. And we recruited a lot of local individuals to help us, a lot of state individuals to help us that weren't necessarily in our particular bailiwick. And when you depend on volunteers, sometimes that time becomes very it's paramount to make it happen. Okay? And then, I'll be damned I'll be darned, okay, if Ebola didn't come around. And that literally consumed us. Okay? And so we had Ebola. And then the Zika and all these other little our real jobs kept getting in the way. And so we're a little bit behind overall, but not with the EMS part of it. They did a good job of kind of spearheading too. Eric and company, they were a big encouragement.
12 13 14 15 16 17 18 19 20 21 22 23 24	storm from one end of the country to the other, but it only rains at the local level. So trying to bridge that gap. And that's what this catastrophic earthquake plan was meant to do. And part of it was that we wanted it to be stakeholder oriented and they decided that emergency support function A, which is help in medical, should be the first part of that plan. So it's going to be a gridded plan from transportation, utilities, and schools and everything else, but we've got a pretty good track record of getting things done. And so they decided that the ESFA, which is health and medical, Emergency Support Function A would kind of take the lead in this. This is part of a much larger plan.	11 12 13 14 15 16 17 18 19 20 21 22 23 24	that we did, we basically had to take out of our hide. And we recruited a lot of local individuals to help us, a lot of state individuals to help us that weren't necessarily in our particular bailiwick. And when you depend on volunteers, sometimes that time becomes very it's paramount to make it happen. Okay? And then, I'll be damned I'll be darned, okay, if Ebola didn't come around. And that literally consumed us. Okay? And so we had Ebola. And then the Zika and all these other little our real jobs kept getting in the way. And so we're a little bit behind overall, but not with the EMS part of it. They did a good job of kind of spearheading too. Eric and company, they were a big encouragement. So what we decided to do in our prehospital and

1	patient-moving operations was to basically decide what our	1	operations subcommittee. They were, like, cracking the
2	mission was, who's going to be the players, and this is	2	whip to get things done. We just didn't have the staff,
3	where it starts getting complicated, folks. What are our	3	time to go and dig things out.
4	current capabilities? And part of the reason for that is	4	What we are missing in particular are some
5	after the earthquake, the variables are endless on what	5	details, names, addresses of facilities and things like
6	our capabilities are going to be. We just don't know. So	6	that. So when you find that, we can bring it in, but it's
7	a lot of it was best guess. Okay?	7	a little bit right now of a void that we need to fill.
8	Keep in mind that when that earthquake occurs,	8	When we get that done, you'll be able to take
9	it's not just one thing. It's that series of catastrophic	9	that annex and then we start looking at challenging
10	events. You know, and almost everybody in our valley will	10	ourselves to make sure it will really work. And the way
11	also be victims. Not necessarily casualties, but there	11	to do that is with exercises, making people aware of the
12	will also be victims. They have families, the disruptions	12	plan. We've identified staging areas and we actually took
13		13	
14	of utilities and everything will affect them too. So that	14	the valley and divided it up into four areas. There may
14	became a real challenge.		very well be islands in the valley caused by the canals
	Next is resources. And we have good lists of	15	and the freeway collapses and stuff like that. So how are
16	resources, but we've got more lists than you can shake a	16	we going to get in from north, south, east, west? You
17	stick at. So to try and bring those all together and put	17	catch my drift. And so all of that has been completed.
18	in one particular annex of how many ambulances do we have,	18	it's in the plan. Because the collection points have been
19	how many backups, who owns them, who has responsibility	19	identified and put in the plan, but we as a State Health
20	for dispatching them, how will we make them work, and what	20	Department own none of that. So what we have to do is
21	can we expect after the earthquake?	21	coordinate with locals.
22	Scenario impacts, I'm not going to make your day	22	And just very quick, and I know time is
23	when I say this, it's gotten worse. The possibility of a	23	precious, but a war story in a previous assignment when I
24	catastrophic earthquake in our valley has been increased.	24	was with Salt Lake City, we decided that we were going to
25	Okay? And the latest stuff that comes out of the	25	use golf courses for a volunteer coordination centers.
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1	geological service is that we're overdue.	1	As you know, after a disaster these volunteers come out of
2	And so we have to approach this and try to avoid	2	the woodwork and imagine these golf courses, they've got
3	what I call the chicken little syndrome. You know, why	3	parking lots, they've got lights. A lot of them have a
4	are all those guys running around tomorrow, but I would	4	kitchen there. You know, it's going to be great.
5	submit to you folks if we have a window of vulnerability,	5	And boy, I tell you what, I thought that was the
6	then we have a moral obligation to prepare ourselves and	6	cat's meow, but we forgot to tell the golf courses. Okay?
7	be ready. And so a lot of times there are runs that need	7	And then when we went to the golf courses and said this is
8	to be made today, and this catastrophic planning gets	8	what we want to do, they says oh, not only no, but hell no
9	pooh-poohed and put on the back burner. So it's an	9	because we're a golf course. We said, look, if we have a
10	endless sales job of the importance of it.	10	7.5 earthquake, that goes away. And they says, okay, yeah
11	Once we got that, we had to think of possible	11	we agree with that. But also the police are going to use
12	courses of action. And we did that in those phases that	12	this as a staging area.
13	you can see up there, what needs to be done immediately,	13	So a lot of things that we never thought of when
14	what do we report doing a 24/48-hour duty? And all of	14	we did this initial planning, and we've got it all down,
15	that needed to be put in there with a dose of reality.	15	but it's going to be hammered out and there will be some
16	Okay? It's easy to say, well, we could do this, this and	16	changes made to the staging areas and stuff like that.
17	this. Well, can you do it if you only have 40 percent	17	So we don't know what's going to survive. So
18	show up for work? And not that they necessarily will be	18	with two of five staging areas, and hope we have two of
19	dead, but they could have real serious problems in just	19	them that we can use. You kind of catch my drift with
20	getting around the valley. So that's kind of what our	20	that.
21	marching orders were and how we approached that.	20	And the requesting protocols, there's a slug of
22	The particular annex for prehospital care or	21	things out there, that CDC, HHS and FEMA will bring to us,
23	patient movement should have been done for today. And I	22	how do we ask for it? And how do we get it here? And so
24			
24 25	feel very confident, comfortable in saying it's about	24	all of that is in the plan. And it's going to be tested
24 25			

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1	things. Okay?	1	The current thing that we noticed was hospitals
2	And then it will be a final copy made and	2	only had half of them that were surveyed had injury
3	we'll see if we can get that out and get it printed and,	3	prevention coordinators. Many of them were filling other
4	you know, out to everybody, and then we can exercise it.	4	positions as well.
5	So it's a FEMA plan. It's their plan, but it	5	And this was also the same with our EMS
6	means nothing without our support and our participation.	6	agencies. Eighteen out of the 24 were not did not have
7	And at this point in time as of today, the prehospital EMS	7	injury prevention coordinators, and those that were injury
8	part of it, like I said, is probably 99 percent done.	8	prevention coordinators also filled other duties such as
9	There's some filling in that's just going to take staff	9	captains or they were for part of training or health
10		10	
11	time and legwork to get done. And that's where we're at.		safety.
12	If you have any questions or anything, I'll be	12	When we looked into promotion for injury
	happy to help as best I can with that. Seeing none, thank	1	prevention activities, hospitals mostly used Facebook,
13	you. I do appreciate your time.	13	radio and local newspapers. And they would love to have
14	DR. KRIS KEMP: All right. Thank you.	14	some more help in creating programs and activities.
15	EMS injury prevention survey, Andrea Baxter.	15	This was also the same for our EMS agencies.
16	GUY DANSIE: I just wanted to introduce Andrea	16	And EMS agencies tend to focus a little more on local
17	Baxter to all of you. She's an intern. She's probably	17	television, newspapers and city websites, as well as
18	the best intern I've ever had and she's been very	18	Facebook.
19	instrumental in actually developing the EMS earthquake	19	And then as we further looked into it, we
20	plan.	20	noticed that both hospitals and EMS agencies would love to
21	And she also did a project for me earlier. One	21	have a best practices resources guide so that they were
22	of our strategic goals for the Department of Health,	22	able to pull ideas for injury prevention activities from
23	Bureau of EMS and Preparedness was to assess the injury	23	that way, and they would love to be more involved in
24	control or injury prevention things that are going on in	24	legislature. Hospitals were mostly involved with helmet
25	the state for ambulance providers as well as hospitals.	25	laws, seat belt laws, and child safety seat laws.
	Page 49		Page 51
1	So I'm just going to have Andrea give you a quick rundown	1	And EMS agencies have been mostly involved with
2	on her survey that she performed for the State.	2	seat belt laws and sledding hill restrictions.
3	Is that good? If you want to say anything else,	3	And one of our personal favorite things that we
4	you can. Is it working? No signal? Back, back.	4	found as we were doing this survey, was we got a response
5	ANDREA BAXTER: Well, in the meantime as	5	back from one of the hospitals that said in an answer to
6	everything is getting set up, we started this survey back	6	this question, "Share any successful strategies or ideas
7	in February. Many of you probably answered the survey for	7	for injury prevention in your area," and they responded,
8	us, and so I'm going to talk a little bit about it.	8	"None. The elderly just keep falling."
9	This survey was first given out in 2004 and we	9	So we are going to continue to try to assemble
10	decided it's 2016, it's time to redo the survey. The	10	things for the injury prevention programs, and thank you.
11	first time this was sent out, it was done paper. And now	11	DR. KRIS KEMP: All right. Thank you. All
12	we have the wonderful use of technologies like Survey	12	right. RSI report on the pilot program with Layton City
13	Monkey that we were able to send this out electronically	13	Fire Department and Davis County Sheriff's Department, Dr.
14	and we were able to have an increase in responses.	14	Oraskovich. I started this morning's meeting since 7 a.m.
15	So we sent this out to 46 hospitals and the 92	15	with Dr. Oraskovich and have yet to go home. Poor me.
16	EMS agencies. Once we got all of our responses back, we	16	All right, take it away, Mark.
17	had 11 hospitals respond and 24 EMS agencies respond back	17	DR. MARK ORASKOVICH: Let's see if this computer
18	to us. And we sent that out for about two and a half	18	will work. See if we are two for three here.
19	weeks, just waited for everything to come in. And once we	19	Do you want me to air play it or do you want me
20	got those responses, we were able to assemble a little bit	20	to hook up?
21	more information from those questions.	21	<b>UNKNOWN:</b> You can now.
22	These questions varied from if you had an injury	22	<b>DR. MARK ORASKOVICH:</b> If only it could be that
23	prevention coordinator to what you do in injury	23	simple in our health care.
24	prevention, what other ways that you use injury	24	So I'm Mark Oraskovich. I don't know if
25	prevention, and we went from there.	25	anyone everyone knows me. I've been in front of this
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			Pages 49 to 52

<ul> <li>committee a couple of times with the full terman of FMS on obing rulet sequence intubution in ground-based FMS crews.</li> <li>To coming back to you after having last bean bere about two years ago where we taked about doing age group to include more of the pediatric age criteria.</li> <li>Bot is just an informational presentation that watere to proto firm and termine as our solution and paralytic agent and also copaning our age group to include more of the pediatric age criteria.</li> <li>Bot is just an informational presentation that watere to group of the set on the set of the pediatric age criteria.</li> <li>Bot is just an informational presentation that watere to firm of the yeak if a couple of about for the pediatric age criteria.</li> <li>Bot is just an informational presentation that watere to firm of the yeak if a couple of about for the yeak if a couple of the set on yeak.</li> <li>Bot is just an informational presentation that watere to yeak if a couple of the pediatric age criteria.</li> <li>Bot is just an informational presentation watere that a set of the an way watere we take of the presentation watere is a set of the an way watere we take of the presentation watere is a set of the an way watere we take of the presentation watere watere watere were have of origin firm and basis in the more that watere is the presentation watere wate</li></ul>				
3         sequence intubation in ground-base EMS crews.         3         and test them on the spot. And then we do impromput           4         The coming back to you after having last been         4         written testing as well.           5         here about two years ago where we talked about doing a pilot project looking at roturonium and ketamine as our set is is yast an informational presentation         4         Written testing as well.           6         more of the pedatric age criteria.         8         group to include more of the pedatric age criteria.         8           10         that I vanied to go through with you. Our program has now         10         10         that I vanied to go through with you. Our program has now           13         from the State. I ve been performing RSI now under that         12         taskes where we're kind find al Jason o' co' Cay. Cay is with Davis County Bern and Davis County         10         11         taskes them: on the shots really aren't that           14         variance for. Ahy its over the last two years.         13         Layton City Fire: and Davis County         10         11         13         13         taskes them: one we're kind be one have the shots really aren't that           15         more that was one aren's we're have have and any cases that one ever with that and see if the cannot and the shot area we're have that the set them one that we're have and that the set them one that we're have and that that that ano that we're have and that the set				
4         In coming back, oy on after having last been         4         written testing as well.           5         here about two years ago where we takk and doing a pilot project looking at rocuronium and ketamine as our sedation and paralytic agent and also expanding our age group to include more of the pediatric age criteria.         5           9         group to include more of the pediatric age criteria.         6           9         to have a variance to about four to five years. We continue to have a variance for. oh, just over the last two years.         10           10         have a vary successful RSI program. We have a variance for. oh, just over the last two years.         10           11         barea tvery successful RSI program. We have a variance for. oh, just over the last two years.         11           12         to have a very successful RSI program. We have a variance for. oh, just over the last two years.         11           13         traiter the intrubation in the start. I've been performing RSI now under har variance for. oh, just over the last two years.         11           14         wellow if 1' poke to soon. Anyway, I' It him mess         11           15         metrosen fayton CI is mad Davie Coming up?         12           16         normershift, which would be compatible with what you would         16           17         precentile, which would be compatible with what you would         17         17           18 </td <td></td> <td></td> <td></td> <td></td>				
5       here about two yeas, ago where we talked about doing a pilot look at neuronium and karning as subation and paralytic agent and also expanding our age group to include more of the pediatric age criteria.       5       We're also still sending crews we know done right at the beginning.         8       group to include more of the pediatric age criteria.       6       airway croses as we have done right at the beginning.         9       No this is just at nifrormational presentation       aggressive database where we know that is alson or cort have as xwe continue to maintain an aggressive database where we know that is alson or cort have as xwe consider the weak and the status. The here performing SR1 norm other that is submit on the cort have a very successful RS1 program. We have a variance for, ch, just over the last two years.       10       that is submit on the pediatric age criteria.         10       that is submit on the pediatric age criteria.       10       that is submit on the pediatric age criteria.       10         12       that we aver submit on the weak availance in that is submit on the status. The here performing SR1 norm in the pediatric age criteria.       11       11       12       that the intubation. It hild CO2 are is it corning up - he sides really aren't that interesting. So -       12       13       14 <td< td=""><td></td><td></td><td></td><td></td></td<>				
6       pilot project looking af recuronium and keramine as our sedation and paralytic agent and also expanding our age group to include more of the pediatric age criteria.       a interms of QA, we continue to maintain an aggressive database where we're kind of placing all this data, things like intubating sutarements every icase is a hundred percent QA by mosel fas well as Jason or core, Cory is with basis Courty Sheriff and Jason is with that and see if he can get it going.       interms of QA, we continue to basis Courty Sheriff and Jason is with that and see if he can get it going.         7       sector of the pediatric age criteria.       into the State. I've been pedforming RSI now under that variance for, oh, just over the last two years.       into the State. I've been pedforming RSI now under that and see is 'the comparing set its last core up that we every one of these. And any cases that come up that we every one of these. And any cases that come up that we every one of these. And any cases that come up that we every one of these. And any cases that come up that we every one of the set one of the time state one of the organin. Low contains the organing up – the shafts pretty cool.         7       Bo overall the program has been a very successful program. I would say we have just under 100 introbations using rapid sequence intubation between the two two or the first true success rate in the 98 to 99       may meet been applicat the best on the first true is carrently at 82 percent.         8       Page 53       We're valso instituted a techkist. This has come form Javon's work at AirMed. And any time a crew is an alpunct to successing have meet one years of the RSI are orthy or you two years ago. we from Javon's work at AirMed. And any time a crew is an alpunct to successing hane meet pering the we're ap				-
7       sectation and paralytic agent and also expanding our age group to include more of the pediatric age criteria.       7       In terms of QA, we continue to maintain an aggressive database where we're kind of placing all this database were were kere and bate from the Sine. Proceener were were were were were were were				
a       group to incluke more of the pediantic age criteria.       aggressive duabase where were lind of placing all this         9       So this is just an informational presentation       idata, things like intubation. In title CO2 measurements every         11       to have a very successful RSI program. We have a variance       program los success fail or not. Size performing RSI now under that         12       to have a very successful RSI program. We have a variance       program los before, during and after the intubation. In title CO2 measurements every         13       Between Layton City Fire and Davis Comy       program los before, during and after the intubation successful program. The basis coon. Anyway, III let him mess         14       we lose if 2 lopekto soon. Anyway, III let him mess       program. Cor sizes in the program has been a very         15       Between Layton City Fire and Davis Comy       program. Cor sizes rate in the program has been a very         15       scccessful program. Twoold say we have just under 100       program. Cor sizes rate in the 98 to 99         16       two ref her things spaceses rate in the 98 to 99       program. Cor sizes rate in the 98 to 99         16       the tube in on the first try is currently at 82 percent.       Program Size         17       the tube in on the first try is currently at 82 percent.       Program Size spaces         18       Marker a vigoroas ongoing training and QA       program. We have at vigoroas ongoing tr				
9     So this is just an informational presentation     image: http://withubdit.solution.     image: http://withubdit.solution.       10     that I wanted to go through with you. Our program has now     image: http://withubdit.solution.     image: http://withubdit.solution.       12     to have a very successful RSI program. We have a variance     image: http://withubdit.solution.     image: http://withubdit.solution.       13     Image: http://withubdit.solution.     image: http://withubdit.solution.     image: http://withubdit.solution.       14     variance for. doi.just over the last two years.     image: http://withubdit.solution.     image: http://withubdit.solution.       14     welcose it? I spoke too soon.     Anyway, I'I I et him mess     image: http://withubdit.solution.       15     successful program.     We loss it? I spoke too soon.     Anyway, I'I I et him mess       15     souccessful program.     We loss it? I spoke too soon.     Anyway, I'I I et him mess       16     souccessful program.     We loss it? I spoke too soon.     Anyway. I'I I et him mess       17     we loss it? I spoke too soon.     Anyway. I'I I et him mess     iii I an emergency department setting.       18     program it hat is a set a nord?     JASON NICHOLL:     That's any for a review on a - is it coming up - the shids really aren't hat       19     portering the it mess with they too mode and were were stool.     Than thimess with thas tor it hat				
10       that I wanted to go drough with you. Our program has now       10       and after the intubation. Thit id CO2 measurements every         11       to have a vary successful RSI program. We have a variance       10       and after the intubation. Thit id CO2 measurements every         12       to have a vary successful RSI program. We have a variance       10       case is a hundred present QA by myself as well as Jason or         13       transfer the intubation. Thit id CO2 measurements every       11       case is a hundred present QA by myself as well as Jason or         14       variance for, ch, just over the last twoy vars.       12       Cory. Cory is with Davis County Sheriff and Jason is with Layton City Fire parthees 100 percent oversight on         16       well set if 1 styck to soon. Anyway, I'll H him mess       14       Layton City Fire parthees to the immess         16       with that and see if he can get igoing.       JASON NICHOL I: That's pretty cool.       DR, MARK ORASKOVICH: Don'to far.         17       miteresting, soo -       JASON NICHOL I: That's pretty cool.       DR, MARK ORASKOVICH: Don'to far.         18       well set if he on the first try is currently at 82 percent.       10       Transporting ventilators. And as we'te instituted a training         19       Dar first pass success rate in therms of getting       20       Transporting ventilators. And as we'te any patient who is intubated is now being of the go-to urinay ont iny paramandia trainge				
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<ul> <li>to have a very successful RSI program. We have a variance from the State. I've been performing RSI now under that variance for, db, jist over the last two years.</li> <li>Between Layton City Fire and Davis County performing up - the slides really aren't that indexes if he can get i going.</li> <li>So overall the program has been a very successful program. It would asy me have just under 100 transporting up - the slides really aren't that interesting, so</li></ul>				-
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14       variance for, oh, just over the last two years.       14       every one of these. And any cases that come up that we feel are worthy of review are then brought up for a review on a - is it coming up - the slides really aren't that interesting, so -         15       paramedics, we've program. Anyway, TII let him mess with that and see if he can get it going.       18         16       on overall the program has been a very successful program. The vold say we have just under 100 intubations using rapid sequence intubation between the two programs. Our success rate is in the 98 to 99       18       JASON NICHIOLL: That's pretty cool.         20       Do overall the program has been a very successful program. The vold say we have just under 100 intubations using rapid sequence intubation between the two programs. Our success rate is in the 98 to 99       19       Two of the times and so we've instituted a training program with these. But any patient who is intubated is now being transport eventilates. And so we've instituted a training program with these. But any patient who is intubated is now being transport eventilates.       10       Decent 54         21       the tube in on the first try is currently at 82 percent.       11       We've also instituted a thecklist the by one to make sure nothing is being missed and we're completing things in the order they should be doon.       20       Transport ventilators. AlitMed. And anytime a crew is endpring the two indications in for doing RSI. Similar to what we had two years ago when we were here, about three quarters of the RSIs are program. This was kind of the tenant of our program right from the starut, that we would to agergressive training upformed. Two would be				
15       Between Layton City Fire and Davis County       15       feel are worthy of review are then brought up for a review         16       paramedics, we've probably done – is it coming up – Da bitles really aren't that         17       we loss if 1 Spoke to soon. Anyway. Ill et him mess         18       with that and see if he can get it going.         19       So overall the program has been a very         10       successful program. I would say we have just under 100         10       intubations using rapid sequence intubation between the         10       two program. Our scores rate is in terms of getting         12       percentile, which would be compatible with what you would         14       find in an emergency department setting.         15       Our first pass success rate in terms of getting         16       or first pass success rate in terms of getting         17       We new were before you last time, we were atbout         18       We are going to video, overall about 35 percent.         19       percome don medical patients.         10       for doing RSI. Similar to what we hat has definitely         12       performed on medical patients.         13       we were here, about three quarter of hose are trauma         14       the start, that we would do agersive training         15				
16       paramedics, we've probably done is it coming up? Did       16       on a is it coming up the slides really aren't that         17       with that and see if the can get it going.       16       on a is it coming up the slides really aren't that         18       with that and see if he can get it going.       17       intubation suing rapid sequence in that had how the can get it going.         19       So overall the program. I void say we have just under 100       10       DR. MARK ORASKOVICH: Don't go far.         20       successful program. I void say we have just under 100       10       DR. MARK ORASKOVICH: Don't go far.         21       program. Nor success rate is in the 98 to 99       Transport ventilators. We're using the Zoll EV-Plus         22       Transport ventilators. Mere using the Zoll EV-Plus       Transport ventilators. And so we've instituted a training         25       Our first pass success rate in terms of getting       23       Transport ventilators. And so we've instituted a checklist. This has         26       Our first pass ouce our proved on that.       24       We've also instituted a checklist. This has         27       program is we're going to video, so GlideScope or King Vision       75       Ref we're going to video, so GlideScope or King Vision         30       for doing RSI. Similar to what we had two years ago whe       70       So whe we came before you taw, which were <t< td=""><td></td><td></td><td>1</td><td></td></t<>			1	
17       we lose it? I spoke too soon. Anyway, I'll let him mess with that and see if he can get it going.       17       interesting, so         18       with that and see if he can get it going.       18         19       So overall the program. Na been a very successful program. I would say we have just under 100 intubations using rapid sequence intubation between the two program. So verseces rate in the 98 to 99 percentile, which would be compatible with what you would 24       17       Interesting, so         25       Our first pass success rate in terms of getting       23       Transport ventilators. Were using the ZoII EV-Plus roor program. Site was success rate in terms of getting         26       Dur first pass success rate in terms of getting       24       Transport ventilators. Were using the ZoII EV-Plus roor makes must hat were the start. This has         27       When we were before you last time, we were at about 75 percent. So we've improved on that.       24         4       We are going to video overall about 83 percent of the time right now. If you look at just the last two roer 90 percent of the time now. So that has definitely become kind of the got to airway management tool.       1       We've also instituted a checklist. This has come from Jason's work at AirMed. And anytime a crew is employing use of RSI, ome person in that, back of that ambulance is going through the checklist one by one to make are mothing is being missed and we're completing things in the order they should be done.         10       And we continue to be mainly medical indications patients.       10       So				
18       with that and see if he can get if going.       18       JASON NICHOLL: That's pretty cool.         19       So overall the program has been a very       19       DR. MARK ORASKOVICH: Don't go far.         20       success ful program. It would say where we have just under 100       10       DR. MARK ORASKOVICH: Don't go far.         21       intubations using rapid sequence intubation between the two programs. Our success rate is in the 98 to 99       22       Transporting veniliators. Wafve using the Zoll EV-Plus         23       precentle, which would be compatible with what you would find in an emergency department setting.       23       Transporting veniliators. Mafve using the Zoll EV-Plus         24       program with these. But any patient who is intubated is now being transported with this ventilator in place.       24       program with these. But any patient who is intubated is now being transported with this ventilator in place.         25       Our first pass success rate in terms of getting       25       We've also instituted a checklist. This has come from Jassi's work at AirMed. And anytime a crew is employing use of RSI, one person in that, back of that ambulance is going through the checklist one by one to make sure nothing is the and tornidate. Which were the yer 0 percent of the time now. So that has definitely       7         8       program like this, the about one quarter of those are trauma patients.       7       So whan we came before you to voy years ago, we proposed that we would look a rocuronium and ketamine as an adjunct to succinytcholine				
19So overall the program has been a very1920successful program. I would say we have just under 1002021intubations using rapid sequence intubation between the2022two programs. Our success rate is in the 98 to 992223percentile, which would be compatible with what you would2324find in an energency department setting.2425Our first pass success rate in terms of getting2526Dur first pass success rate in terms of getting2527Page 53Page 5528Very easies of RSI, one person in that, back of that375 percent. So we've improved on that.34We are going to video overall about 83 percent.15of the time right now. If you look at just the last two296years, we're going to video, so GlideScope or King Vision67over 90 percent of the time now. So that has definitely78become kind of the go-to airway management tool.99And we continue to be mainly medical indications910for doing RSI. Similar to what we had two years ago when1011we were here, about three quarters of the RSIs are1112performed on medical patients. Utra level of1213experime with keatmine and rocuronium. And the second1314those, and then about one quarter of those are trauma1415patients.1516Tord ing RSI. Similar to what we had two years ago when <td></td> <td></td> <td></td> <td>-</td>				-
20       successful program. I would say we have just under 100       20       Two of the things that are newer with the         21       intubations using rapid sequence intubation between the       21       program, we have at Layton City Fire purchased two         23       percentile, which would be compatible with what you would       1       Transport entilators. And so we've instituted a training         24       Transport entilators. And so we've instituted a training       program. we have at Layton City Fire purchased two         25       Our first pass success rate in terms of getting       26       Transport entilators. And so we've instituted a training         26       Dur first pass success rate in terms of getting       27       Transport entilators. And so we've instituted a training         27       Dur first pass success rate in terms of getting       28       Page 53       Page 55         1       the tube in on the first try is currently at 82 percent.       1       We've also instituted a checklist. This has       come from Jason's work at AirMed. And anytime a crew is       employing use of RSI, one person in that, back of that         3       75 percent. So we've improved on that.       4       ambulance is going through the checklist one by one to       5         6       years, we're going to video, so GlideScope or King Vision       7       5       So when we care before you two years ago, we         9			1	
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24We do annual airway training days where we24And we've left it up to the medical providers in25dedicate an entire day to training on airway, both25the field to decide if they are going to go with etomidate			23	it.
25dedicate an entire day to training on airway, both25the field to decide if they are going to go with etomidate	24		24	And we've left it up to the medical providers in
Page 54 Page 56	25		25	the field to decide if they are going to go with etomidate
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1	and succ or they are going to go with rocuronium and	1	national movement in some states to up, to just do away
2	ketamine. And I think we saw looking at the data that	2	with pediatric intubation altogether, and I know there's
3	there was a little bit of an adoption curve. Early on	3	been some discussions in this state about whether that
4	people were sticking more with etomidate and succ and now	4	becomes an optional item or not.
5	we've seen much more use of roc and ketamine. Probably to	5	The educational component is huge. It's huge
6	the level of almost 100 percent of the last six months are	6	for this program overall. Twelve and above isn't much
7	with rocuronium and ketamine.	7	different than what we're doing with adults. Eight and
8	So overall between the two agencies, 58 percent	8	above does have, I think, a stronger educational component
9	of the cases involve the use of rocuronium and ketamine.	9	that has to be there. When you don't have any cases in
10	Of those, 100 percent were deemed successful RSIs, meaning	10	two years even to review, I felt it was worthwhile going
11	the tube was established either on the first, second, or I	11	to an older age group that's more similar to an adult
12	think we had one case on the third attempt. We had an	12	population.
13	88 percent first pass success rate on passing the tube,	13	HALLIE KELLER: Sure.
14	which is up from 75 percent when we came before you two	14	<b>DR. MARK ORASKOVICH:</b> Is there any questions?
15	years ago. We had no complications whatsoever with our	15	That's really all I have for you today. This would
16	use of rocuronium and ketamine.	16	conclude our two-year pilot project and then I'll be
17	And I would say this mirrors what we see in the	17	working with Peter going forward. Thank you for your
18	emergency department setting. That there has been a move	18	time.
19	in the last few years to adopt more Roc and ketamine use	19	DR. KRIS KEMP: All right. Thank you.
20	in RSI for a multitude of reasons. Probably the most	20	DR. PETER TAILLAC: Real quick.
21	important, you don't have to remember that big laundry	21	DR. KRIS KEMP: Yeah, Peter.
22	list of contraindications when it comes to	22	DR. PETER TAILLAC: I just want to congratulate
23	succinylcholine.	23	these two agencies for sending out with what like
24	In terms of pediatric RSI, we had taken our age	24	there's never a simple project like sending out what
25	from 16 down to 8 and above after last coming before this	25	would seem like a fairly simple concept but really taking
	Page 57		Page 59
1	committee. We do not have any pediatric RSI cases to	1	care of every single detail and doing that continuously
2	report in a two-year time frame. We would have hoped for	2	for the several years it's been going on. Very nice
3	some. There may have been some opportunities that were	3	work I want to mention Dr. Liden as well. Lyon,
4	there that were missed, but in reality we didn't have any	4	sorry. And by the two worker bees Jason and is Cory
5	pediatric RSIs.	5	here? Stand up Cory, okay. So thanks, nice work.
6	In going forward from this point, I propose that	6	I think this has proven in my mind the theory
7	we change that age group from 8 and above to 12 and above.	7	that if you train a few people to do something very well
8	And that has come about in discussions with Peter and also	8	and keep them trained, that they can do it very well. And
9	with some of the pediatric providers from Primary. And	9	we'll see where it goes from here.
10	Hallie, if you have any comments on that, I would welcome	10	DR. KRIS KEMP: And I would add to those
11	it, but	11	sediments. I think the biggest point that all of us in
12	HALLIE KELLER: Specific comments for this in	12	the state and with our own agencies that we have to
13	general, has to be a problem again of	13	realize is that the high level of training and education
14	(Reporter interjected she can't hear.)	14	that was required and accomplished as tasked, this was not
15	DR. KRIS KEMP: She mentioned that this is an	15	a fly by night, you know, let's take 15 minutes and do
16	ongoing problem with pediatric intubations in that it's a	16	intubations on a mannequin head and call it good and put
17	continual problem that you don't get enough.	17	it in the hands of everyone in the ambulance service.
18	Anything else to add?	18	That will be disastrous, and I don't think it's a wise
19	HALLIE KELLER: I don't have anything else to	19	decision.
20	add. I'm curious why the age. I don't have a problem	20	So to replicate these results requires
21	with the age going up at all, but I'm just curious why	21	replication of the entire process. And that's the way
22	that is changing.	22	medicine should be. We don't want to extrapolate, well,
23	DR. MARK ORASKOVICH: I think it was a	23	they did an intubation program and they had great success,
24	decision Peter and I talked about it, and there was	24	so, so can we if we don't follow all of the additional
25	some discussions in terms of the way there's been some	25	details. Because that's where this became successful.
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1	And that's where I think the accolades should reside, is	1 (Meeting was adjourned at 2:30 p.m.)
2	the detailed work that was maintained to uphold that	2
3	really high level of standard.	3
4	And so moving forward, were this to be a	4
5	variance that comes across the desk for any agency, expect	5
6	that you will be under the same scrutiny for training.	6
7	Thank you.	7
8	Round table discussion. Guy.	8
9	<b>GUY DANSIE:</b> We're just feeling a little proud	9
10	of our Image Trend finally taking some steps forward. And	10
11	I would just like to give you a quick update on our data	11
12	system.	12
13	SCOTT MUNSON: So we launched our new license	13
14	and certification management system on July 1st. So that	14
15	system went into production. All the legacy data from the	15
16	previous application formally known as BEMS was moved over	16
17	to that system. So we're working with that right now.	17
18	Felicia and I are just working through a few bugs and some	18
18	issues with Image Trend to make sure we've got that, all	19
20	those addressed.	20
20		21
21	Some of the benefits with that, though, is now when providers go to update their license, it's all	22
22	online, so there's no more mailing paperwork or anything	23
23 24		24
24 25	and you can just go to the system online, upload all of	25
25	your documentation, fill out the application there. So	25
	Page 61	Page 63
	1030 01	
1	there's some real benefits that come along with that.	CERTIFICATE
2	As far as the prehospital data system, we're	
3	so the license management system had to be implemented	STATE OF UTAH )
4	first and so now we're starting the process to get the	)
5	prehospital data system up and running. So we're on a bit	COUNTY OF UTAH )
6	of an accelerated time line to get that done quickly. I'm	
7	hoping in the next couple of months we'll have that	This is to certify that the foregoing proceedings were
8	environment up and we can start providing training to	taken before me, Susan S. Sprouse, a Certified Shorthand Reporter in and for the State of Utah, residing in Salt
9	agencies that will be interfacing directly with that	Lake County, Utah;
10	system and then also working with agencies that use a	
11	third-party vendor to pass their data to the system.	That the proceedings were reported by me in stenotype, and
12	So that's where we are today. Any questions	thereafter caused by me to be transcribed into printed
13	from the group? Okay. Thank you.	form, and that a true and correct transcription of said
14	<b>DR. KRIS KEMP:</b> All right. Additional round	testimony so taken and transcribed is set forth in the
15	table, I guess there's a notary available; is that	foregoing pages, inclusive.
16	correct	
17	SUZANNE BARTON: Yes.	DATED this 26 day of July, 2016.
18	<b>DR. KRIS KEMP:</b> for those individuals that	
19	are marked on the agenda for disclosure statements.	
20	Any further discussion from the Committee?	
21	All right. With that I think I'll accept a	SUSAN S. SPROUSE, RPR, CSR
22	motion to adjourn.	LICENSE NO. 5965543-7801
23	JAY DEE DOWNS: So moved.	
24	<b>DR. KRIS KEMP:</b> All right. We will adjourn.	
25	Next meeting October 12th.	
	Dage 62	Dage 64