State EMS Committee Meeting
July 13, 2016
1:00 p.m.

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

Reporter: Susan S. Sprouse

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

A P P E A R A N C E S

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

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

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

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

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

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

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

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

LACONNA DAVIS: Laconna Davis, Department of Work Safety.

DR. RUSSELL BRADLEY: Russel Bradley, rural physician representative.

MIKE MOFFITT: Mike Moffitt with Gold Cross Ambulance.

MIKE MATHIEU: Mike Mathieu, fire chief representative.

HALLIE KELLER: Hallie Keller, pediatric representative.

JERI JOHNSON: Jeri Johnson, EMT representative.

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

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

KRISTOPHER MITCHELL: Kris Mitchell, private

surgeon at St. Marks.

MARK SANDERSON: Mark Sanderson, nursing representative.

JASON NICHOLL: Jason Nicholl, paramedics.

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

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

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

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

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

JAY DEE DOWNS: No thanks.

DR. KRIS KEMP: And we have Mike Moffitt.

MIKE MOFFITT: Thank you.

SPEAKER: He wanted to give one, though.

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

MIKE MOFFITT: No. No.

DR. KRIS KEMP: And Mike Matthieu.

MIKE MATHIEU: Thank you.

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

DR. KRIS KEMP: Great. Thank you.

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

MIKE MATHIEU: I so move.

MIKE MOFFITT: Second.

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

COLLECTIVELY: Aye.

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

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

GUY DANSIE: I will use the microphone. Thank you.

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

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

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

use those two new standards for department policy 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 and purchase, meet the requirements as is, and starting next July we would require those new standards as policy.

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

JAY DEE DOWNS: Not after that.

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

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

KRISTOPHER MITCHELL: I move to approve.

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

MIKE MOFFITT: Second.

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

COLLECTIVELY: Aye

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

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

so I'm abstaining.

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

Go ahead, Guy.

GUY DANSIE: Okay. So does Mike too.

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

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

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

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

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

question.

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, or what's the status?

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

MIKE MOFFITT: Okay.

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

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

GUY DANSIE: Adding one position.

MIKE MOFFITT: All right. Thanks.

DR. KRIS KEMP: Any further questions?

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

DR. RUSSELL BRADLEY: I will.

DR. KRIS KEMP: Motion to second?

JERI JOHNSON: Second.

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

aye.

COLLECTIVELY: aye.

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

Okay, Guy.

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

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

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

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

you say was --

GUY DANSIE: Just the underlined part, the Part 14.

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

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

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

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

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

DR. PETER TAILLAC: Sure. Yeah.

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

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

JAY DEE DOWNS: Okay. Great.

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

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

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

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

JASON NICHOLL: That's --

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

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

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

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

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

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

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

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

DR. KRIS KEMP: Would that be your motion?

JASON NICHOLL: Yes. That would be my motion.

DR. KRIS KEMP: Do we have a second?

KRISTOPHER MITCHELL: Second.

DR. KRIS KEMP: All in favor say aye.

COLLECTIVELY: Aye.

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

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

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

DR. PETER TAILLAC: But okay. 4 works.

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

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

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

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

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

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

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

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

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

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

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

DR. PETER TAILLAC: This committee just approved it.

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

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

DR. KRIS KEMP: That was the motion.

JASON NICHOLL: Yes, it was.

DR. KRIS KEMP: It carried.

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

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

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

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

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

DR. KRIS KEMP: Should we expand --

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

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

them understand why we got to that conclusion.

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

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

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

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

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

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

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

Any further discussion from the Committee?

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

staffing and giving medications and care and I would rather send the message out for our EMS community that we have very little regulatory authority, therefore, we are not going to have an area in the subcommittee for this. And everything we do essentially with the air ambulance 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 efforts ought to be focused with our federal representatives to change federal law, to enhance or delegate some of that authority to states. Otherwise I think we're spinning our wheels in frustration with something we don't have much authority over.

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

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

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

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

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

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

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

GUY DANSIE: Correct.

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

can't really say anything about it. I should say status 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 EMT in the back, that we fall below that staffing requirement standard, that's when we could act and do something at that point. But other than that, we have very little control, very little regulation. It's mostly they would be reporting to us all is well and they would have to -- we really wouldn't have much authority to do anything else with that.

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

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

NATHAN CURTIS: I'd second that.

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

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

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

JASON NICHOLL: I offer a substitute motion that

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

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

DR. PETER TAILLAC: Was.

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

DR. PETER TAILLAC: It is.

CASEY JACKSON: Okay. That answers my question.

DR. KRIS KEMP: So we have a motion.

JASON NICHOLL: We have a motion and a substitute motion.

DR. KRIS KEMP: All right.

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

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

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

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

DR. RUSSELL BRADLEY: We don't need a 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?

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

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

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

NATHAN CURTIS: I'll second.

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

COLLECTIVELY: Aye.

DR. KRIS KEMP: Any opposed?

DR. RUSSELL BRADLEY: I'll oppose.

CASEY JACKSON: I'll oppose.

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

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

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

is going to be representing that to you later today.

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

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

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

Any questions on anything? Okay. Thank you.

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

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

ERIC BAUMAN: Thank you very much.

JASON NICHOLL: Are you staying on?

ERIC BAUMAN: Oh, yeah. Absolutely.

JASON NICHOLL: Good, good, good.

DR. KRIS KEMP: All right. Thank you. Professional development update. Von.

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

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

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

Our next item that we --

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

VON JOHNSON: That was something that we 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 --

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

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

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

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

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

DR. PETER TAILLAC: Yes.

JERI JOHNSON: They are, yes.

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

performed --

HALLIE KELLER: -- and pharmacy to dispense with.

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

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

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

DR. KRIS KEMP: So legislation says that we need to do it, wouldn't we just make a recommendation to put it back on the prescriber and the pharmacists who are 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

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

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

GUY DANSIE: Right.

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

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

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

JIM HANSEN: Yeah.

JASON NICHOLL: So I think it's basically trying

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

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

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

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

VON JOHNSON: You're fine.

DR. KRIS KEMP: So the recommendation?

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

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

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

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

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

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

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

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

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

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

Any questions?

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

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

DR. KRIS KEMP: Thank you, Von.

EMS Grants Committee. Chief Ron Morris.

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

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

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

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

One of the other changes we had was the spending 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, 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 turn in the paperwork to May 31st and/or I'm assuming the next business day if it happens to be a weekend.

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

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

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

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

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

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

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

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

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

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

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

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

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

GUY DANSIE: I believe it was nine.

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

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

GUY DANSIE: 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?

DON MARELLI: Yes, September.

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

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

GUY DANSIE: Correct.

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

GUY DANSIE: To serve.

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

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

well.

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

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

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

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

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

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

As much frustration as that may create amongst us as providers, the Bureau is being underfunded for their 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 through our chair to look for statutory options of trying to restore EMS grant funding as we once knew it.

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

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

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

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

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

GUY DANSIE: Yeah.

DR. KRIS KEMP: Okay.

DON MARELLI: Thank you.

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

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

DR. KRIS KEMP: That's a motion.

NATHAN CURTIS: I'll second.

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

COLLECTIVELY: Aye.

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

MIKE MATHIEU: That's so good.

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

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

DR. KRIS KEMP: Yeah, maybe. Maybe. Oh, boy.

Okay. On to informational items. EMS earthquake disaster plan. Mike Stever.

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

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

this particular responsibility here. And --
Brace yourself, you may want to cover your ears.
So what I've decided to do in this presentation, in respect for people's time is that we're going to kind of provide the Reader's Digest version of a very complicated process. And of all of those complications, mostly it turns out to be BFOs or blinding flashes of the obvious. So there's not a real lot of technical things in here, but a lot of things that we need to gather in, put under the umbrella and then share so that everybody can be a part of it and understood what we are doing.
GUY DANSIE: We're getting our tech help. Sorry.
MIKE STEVER: Okay. I'm just going to go ahead and talk while this gets going so we don't have to waste much time on this.
The catastrophic earthquake plan targets the Wasatch Fault and the metropolitan area from the Salt Lake Valley. That's not the only place that's going to suffer, but that's where the primary -- the big damage is going to be. Okay, this is going to be the bad actor.
And so what FEMA did is put together a private contractor to come in and write this terrific earthquake plan, and they did it, and they did it pretty well. Are we good to go? Oh, wow.

My fingers are crossed. Drum role. Ta-da. Wow, that was easy.
Okay, so that -- a part of that old plan was that it was a lot of very good words and a lot of strategic, interesting things, but it didn't really cross the bridge that is so tough in the world of disasters, in catastrophic events between what we can really do and what somebody says.
So basically decided to redo it and to try to make it more functional and more appropriate for local response. We have a saying, you know, there may be a 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.

What we decided at the State Department of Health was to pool the teams together and create basically a work plan. Our goals, our objectives, what do we want to do, strategies, and decide certain tasks that were common to all. So that's what kind of brings us to this point.
The different work groups that we decided for ESFA, that's only health and medical, were situational awareness, support life-saving functions and operations, life supporting, which means that the life saving is kind of the red lights and siren part of it, life supporting is the healthcare part of it, the hospitals that have to continue providing care, and then mass fatality operations.
So for us right now that was the big four. And if you get a chance when we get this finally done, you would see lots of things under each one of those. In particular, for example, on the situational awareness, the challenge with that is -- I don't even know a good way to say it. We ought to be the best information sharers on the planet, and we don't always do that. The platforms are there, but we never ever practice them. So that becomes a paramount corridor for us.
The EMS and preparedness part of it, which fell to the Operations Subcommittee, we kind of recruited them,

and they were phenomenal in getting things done and providing good information. So we're talking mainly about the life-saving operations at the very beginning.
Now, I put this time line up here and you can see it's been going for quite a while. And you can also see that we are a little bit -- not a little bit, we are behind in getting it done.
Part of the reason for that is that assignment came to the Utah Department of Health, and I know a lot of you can relate to this, with no money. And so everything 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

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

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

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

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

geological service is that we're overdue.

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

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

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

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

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

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

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

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

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

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

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

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

things. Okay?

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

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

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

DR. KRIS KEMP: All right. Thank you.

EMS injury prevention survey, Andrea Baxter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

All right, take it away, Mark.

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

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

UNKNOWN: You can now.

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

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

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

I'm coming back to you after having last been here about two years ago where we talked about 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.

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

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

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

Our first pass success rate in terms of getting

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

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

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

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

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

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

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

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

In terms of QA, we continue to maintain an aggressive database where we're kind of placing all this data, things like intubating saturations before, during and after the intubation. In title CO2 measurements every case is a hundred percent QA by myself as well as Jason or Cory. Cory is with Davis County Sheriff and Jason is with Layton City Fire. And so there's 100 percent oversight on 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 --

JASON NICHOLL: That's pretty cool.

DR. MARK ORASKOVICH: Don't go far.

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

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 ambulance is going through the checklist one by one to make sure nothing is being missed and we're completing things in the order they should be done.

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

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

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

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

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

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

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

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

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

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

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

(Reporter interjected she can't hear.)

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

Anything else to add?

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

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

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

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

HALLIE KELLER: Sure.

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

DR. KRIS KEMP: All right. Thank you.

DR. PETER TAILLAC: Real quick.

DR. KRIS KEMP: Yeah, Peter.

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

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

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

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

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

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

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

Round table discussion. Guy.

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

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

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

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

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

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

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

SUZANNE BARTON: Yes.

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

Any further discussion from the Committee?

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

JAY DEE DOWNS: So moved.

DR. KRIS KEMP: All right. We will adjourn. Next meeting October 12th.

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

C E R T I F I C A T E

STATE OF UTAH)
)
COUNTY OF UTAH)

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

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

DATED this 26 day of July, 2016.

SUSAN S. SPROUSE, RPR, CSR
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