STATE EMS COMMITTEE MEETING AGENDA

January 8, 2014

State EMS Committee Meeting Agenda	¹ January 8, 2014 1:00 p.m.
January 8, 2014	² PROCEEDINGS
1:00 p.m.	3 ***
	4 JAY DOWNS: Let's go ahead and get things
Location: 3760 South Highland Drive	⁵ started here. Welcome everybody to our new year EMS
Salt Lake City, Utah 84106	6 committee meeting. Just so we everybody knows right
3rd Floor Auditorium	7 now on the action items, we do not have a quorum. We just
Boportor: Gugon & Corougo	⁸ need one more to have a quorum. So we have eight. So
Reporter: Susan S. Sprouse	⁹ just kind of keep that in mind.
	¹⁰ Everybody as you speak today, whoever has
	¹¹ something to say, make sure you state your name so that
	¹² she can get it properly recorded so she can do her little
	¹³ bouncy thing, okay.
	14 JOLENE WHITNEY: Susan.
	¹⁵ JAY DOWNS: Jolene just reminded me that we just
	¹⁶ need we have a new member who sits on the board today,
	¹⁷ Dr. Tom White.
	18 TOM WHITE: Right here.
	¹⁹ JAY DOWNS: Nice to meet you. My name's Jay
	20 Downs. And we'll just go around real quick and just
	²¹ introduce ourselves. So we'll start off with Tom since he
	²² is the new guy.
	²³ TOM WHITE: Hi, Tom White, I'm a trauma surgeon.
	²⁴ I was this is I just finished a stint on the state
	²⁵ trauma advisory committee and got kicked off of that
	i o
	Page 3
A P P E A R A N C E S	¹ committee and got asked to for this. I'm pleased to be
Terr Decement	² here.
Jay Downs	3 JOLENE WHITNEY: You were recruited.
Jolene Whitney	4 DR. PETER TAILLAC: You're not a hell raiser, 5 are you?
Bob Grow	 ⁵ are you? ⁶ JAY DOWNS: Welcome.
Jeri Johnson Lynne Yeates	
	STIL DOWNS. WECOME.
-	7 TOM WHITE: Thanks.
Tom White	 TOM WHITE: Thanks. JAY DOWNS: Pleased to have you. Let's go here
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1	go ahead now and we'll just start off with the agenda.	¹ video laryngoscopy as our primary intubating method on
2	Let's go ahead and the minutes, has anybody had a	² every intubation. Layton Fire purchased GlideScopes for
3	chance to read the minutes? We can't approve them,	³ their video laryngoscopy. We're doing this study in
4	though, because we don't have a quorum. So we'll move on	4 conjunction with the Davis County Sheriff's Office. They
5	until we get another person here.	⁵ started out with King Vision and they've also moved to
6	Let's let's go ahead and let's just have a	6 GlideScopes for their video laryngoscopy.
7	hearing on the Davis County advanced airway medic. We	7 Additionally, we said we would do an extensive
8	can't act on the elections. So who's representing Davis	⁸ initial and ongoing training program. That included a
9	County? Is Dr. Mark	⁹ very intensive upfront training where all the medics went
10	MARK ORASKOVICH: I guess that's us.	¹⁰ through the difficult airway course on a national level.
11	JAY DOWNS: Now, from what I understand, Jolene,	¹¹ We did a three-day very intensive course before we ever
12	this is a renewal of a a presentation they did last	¹² started the program. We do 48-hour QA on every intubation
13	year; is that correct?	¹³ that is done. We do twice yearly training and updates,
14	MARK ORASKOVICH: It is. It's a two-year pilot	¹⁴ testing, and we have continued through that through the
15	project that is	 ¹⁵ whole project vigorous quality assurance with intensive
16	JAY DOWNS: Is this the rapid intubation?	¹⁶ medical oversight. I essentially review data Danny Wyman
17	MARK ORASKOVICH: This is the RSI project,	17 who represents the Sheriff's Office as their physician
18	correct.	 director, reviews every intubation that's done within a 24
19	JAY DOWNS: RSI, okay. Cool.	¹⁹ to 48-hour period and then collect comprehensive data and
20	MARK ORASKOVICH: Advanced airway medic.	 ²⁰ eventual consideration of publication of these study
21	Well, for those of you who don't know who I am,	21 results.
22	I'm Mark Oraskovich. I'm an attending ER physician here	22 This was essentially the data that we're going
23	in Salt Lake City with Intermountain Healthcare. I work	 to talk about here today. We're going to review the
24	at Intermountain Medical Center and at Alta View Hospital.	 cost and about need today. We regoing to revew the cases, demographics, attempts, where we intubated, how
25	And I represent Layton Fire as their medical director, and	 we've done scene times. That's just the summary of what I
-	And Prepresent Layton Pire as then incultar uncettor, and	we ve done scene times. That's just the summary of what I
	Page 5	Page 7
1	The Land	¹ would like to show you
2	I've been with them since 1998.	would like to show you.
3	We approached your committee about two years	We had the IT people within Edyton Oxy create a
4	ago, a little over two years ago, requesting permission to	und buse for use find s un online und buse that s
5	do a pilot project looking at a novel airway team concept	 ⁴ accessible to those who are within the study, where we ⁵ record all our data and have it available for review.
6	where ground paramedics employ the use of RSI, which is	
7	rapid sequence intubation, to establish a definitive	 All right. Our hope in this two-year period was we would have probably 75 to a hundred intubations that
8	airway in patients that they are transporting by ground	
9	ambulance.	
10	That project commenced October 1st, 2011. This	 ⁹ There were probably at least that many that in the ¹⁰ decision-making of the paramedic on scene, the decision
11	this last October, we completed our our two-year	
12	study period. We had initially done one year when we came	 was made not to do an RSI and go to the ER instead. So our numbers could have been a little higher, but overall I
13	back to the committee. After one year, we were extended	 ¹³ think you'll see that the results are very favorable for
14	for a second year and that that year has now commenced.	 think you if see that the results are very favorable for the numbers we did have.
14	So we come before you today to kind of give you	15 This is a demographic of the age group of the
16	the results of what our pilot project has shown and to	¹⁶ patients that were enrolled into this pilot project. We
17	kind of stimulate some further discussion as to what the	 ¹⁷ had several 90 year old's and we had them as low as age
	future holds.	 ¹⁸ ¹⁸ 16. And sixteen was the bottom age cut off for this pilot
18	So when we presented our pilot project, we had a	¹⁹ project. Average age was 54.
19 20	description, and the description consisted of several	20 Whom do we intubate? About three quarters are
20	items that we would use an advanced airway team consisting	 whom do we intubate? About three quarters are medical and about one quarter are trauma, which is a
21	of a limited number of highly experienced and trained	 22 Intercar and about one quarter are trauma, which is a 22 little surprising. I think if you look at a lot of
22	paramedics. So we were taking a very select group of	 national studies on pre-hospital RSI, there's more of an
23	paramedics and only training a few to be a member of this	 and the structures on pre-nospital KSI, there is more of an emphasis on trauma than there perhaps is on medical. If
24 25	elite airway team.	 ²⁵ emphasis on trauma than there per haps is on metucal. If ²⁵ you break down those medical cases, you'll find that they
20	We also proposed that we would use video	Jou show as the close incurcal cases, you if find that they
	Page 6	Page 8

1	really fall into three categories: Severe respiratory	¹ teaching on both a local, regional and a national level.
2	distress and failure, altered level of consciousness	 Some of our medics have been asked to go to other cities
3	many of those elderly patients and overdoses, which we	 ³ in the country and present lectures on the use of video
4	have plenty of in Utah.	4 laryngoscopy. I know Jason has done teaching with AirMed
5	I want to talk about intubation attempts,	 ⁵ with Salt Lake City on the use of video laryngoscopy and
6	because this is something that comes up in the literature	 ⁶ pick tricks, tools, techniques that can enhance success.
7	a lot. And before I show you our results, I wanted to	 RSI initial intubating sats, we have initial
8	kind of hit on a study that came out last year, which is	 ⁸ intubating pre-intubation sat of 83 percent. We have
9		 intubating pre-intubation sat of 85 percent. We have intubating sat of 92 percent and post intubation sat of
10	very surprising.	
11	This is a study that talks about number of	F - F
	intubation attempts and complication rates that ensue with	J
12	subsequent attempts. You can find that with one pass	12 where the trend is in the wrong direction, but there were
13	success rate, you still have a 14 percent incidence of	¹³ very, very few cases like that.
14	adverse events. And those can include anything from	14 We put a large emphasis in this study on the
15	desaturation to esophageal intubation, aspiration.	¹⁵ importance of oxygenating the patient well. It's not just
16	Once you fail on your first attempt, and attempt	about putting the tube in. It's about getting oxygen.
17	is defined as blade in through the lips blade out, and you	¹⁷ And so we put a strong emphasis on bag valve ventilation
18	get into a second pass attempt, your rate of incidence of	¹⁸ when indicated and pre-oxygenating patients before our RSI
19	adverse events goes up to 47, and then with the third it	¹⁹ is done.
20	goes all the way up to 63 percent. So it's not just being	20 Where do we intubate? 61 percent in the
21	able to establish a tube without failing, it's being able	ambulance. This is en route to the hospital. Twenty-nine
22	to establish a tube on the first attempt.	22 percent are done at scene. Most of these occurred early
23	In our study, we had a 75 percent first pass	²³ on in the study. And interesting, you'll see that there
24	success rate, 22 percent third two attempts and and	²⁴ were some done in the ED.
25	only 4 percent did we go to three attempts. That's	25 This was a corroboration mainly with the Davis
		David 11
	Page 9	Page 11
1	probably just one if you run the numbers. We had none	1 FR where the docs had been very recentive to this
1 2	probably just one, if you run the numbers. We had none that went beyond three attempts, which would be our	1 ER, where the docs had been very receptive to this 2 program And as our medics would arrive with a patient
2	that went beyond three attempts, which would be our	² program. And as our medics would arrive with a patient
2 3	that went beyond three attempts, which would be our definition of a failed airway.	 ² program. And as our medics would arrive with a patient ³ that they knew required intubation but had a very short
2 3 4	that went beyond three attempts, which would be our definition of a failed airway. This is another study that was I think we	 program. And as our medics would arrive with a patient that they knew required intubation but had a very short transport time, they worked together with the ER docs and
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1	put the public at risk, but put our providers and patients	1	the whole
2	at risk and really don't necessarily transfer into a	2	MARK ORASKOVICH: It is.
3	benefit. But when you have a flailing 18 year old with a	3	TOM WHITE: the whole game.
4	severe head injury who's got a sat of 70, and you need to	4	MARK ORASKOVICH: It is, and I think this is one
5	get them to the hospital because your only option is to	5	of the things that we felt very strongly from well before
6	get there and intubate them, you tend to drive as fast as	6	we ever came to this committee, is that it's a game
7	you can and have lights and siren.	7	changer.
8		8	TOM WHITE: Can you did you go back and look
9	Whereas, if it's a controlled setting and they're intubated and you're avygenating and youtilating	9	
	they're intubated and you're oxygenating and ventilating	10	and see if those there were a couple of days there
10	them well, you have the benefit of not having to use the	11	where you failed once or twice?
11	light and siren response.	12	MARK ORASKOVICH: And went to
12	HALLIE KELLER: So they're not putting these		TOM WHITE: Any chance that was a person you
13	patients in the back of the ambulance and intubating them	13	had one bad guy, one one one person in your team
14	there; they're actually putting them in the back of the	14	that needed more education, or was it possible that
15	ambulance and while they're driving, stopping, going	15	MARK ORASKOVICH: It didn't really come down to
16	over I mean going over bumps, physically moving, that's	16	individual. Some one of them came down, I know, at the
17	when they are intubating?	17	scene. We were intubating in the street as opposed to
18	MARK ORASKOVICH: They're doing both. They're	18	putting him in the back of the ambulance in a more
19	doing both.	19	controlled setting where lighting is better and you have
20	JASON: But 69 percent of the time, that's an	20	suction. And that actually changed how we approach them
21	accurate description, yes.	21	from then forward.
22	HALLIE KELLER: When they're moving, they're	22	Each time we have cases that we feel are worthy
23	physically moving?	23	of review, whether they meet any set criteria or not, we
24	MARK ORASKOVICH: Yes. It's added advantage of	24	would use those as part of the biannual training and
25	the laryngoscopy.	25	review those cases one-on-one with the entire airway team
	Page 13		Page 15
1	HALLIE KELLER: Right. Absolutely.	1	present, both from the Layton Fire and Davis.
2	HALLIE MELLER, RIght, Absolutely,		
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3	TOM WHITE: Mark, what's the definition of a failure? If the lens is smeared and they take the thing	2 3	JASON: To clarify, though, under your definition of a failure, we have not had a failure yet.
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1	do, to blade in, blade out. Now, you could have that	1	one looks disturbing, but there's an explanation behind
2	blade in there for a hell of a long time and be looking	2	this one. If you look at this data, this comes out to
3	around and monkeying around, the sats can be plummeting.	3	seven patients out of 52 in this study. And five of those
4	But as soon as you pull it out, you're into attempt No. 2	4	were intubated in an ER setting. Two of those were
5	the next time you go in.	5	intubated and the tube was secured and taped in place just
6	TOM WHITE: Good. Thank you.	6	as they rolled up to the deck of the ER. Of those seven
7	MARK ORASKOVICH: We pulled some data from our	7	patients, they did not employ the use of R-capnography.
8	non-RSI scene times within Layton Fire from previous years	8	These were confirmed by devices that the ER uses in their
9	and compared average scene time to what we find now in our	9	setting to confirm. And I'm not sure what you're using at
10	RSI study, and I think it's interesting that we did not	10	Davis for for confirmation of tube, but since five of
11	extend scene times by employing RSI.	11	those were done in the ER setting and two were done as
12	So let's get into our sentinel events. We	12	they were rolling up to the ER, we did not employ our use
13	identified several sentinel events prior to initiating	13	of capnography because there wasn't time. And compliance
14	this project. Incidence of hypoxemia or hypotension with	14	of reporting we were 100 percent.
15		15	
16	head injury, obviously a harbinger of could cause much	16	These were just our quality assurance measures
17	more significant brain injury. We had no incidence of	17	that we had identified at the onset. We don't need to go too much into that.
18	that. We certainly tracked our sats both before, during	18	
19	and after intubation, as well as blood pressure.	19	So in looking back, this is kind of the mantra
	Use of a rescue airway or surgical cric, none of	20	that I think sums up my feelings the best. Intubation
20	those were required in this study. Medication errors,	20	done well is safe. Intubation that is done poorly is not
21	adverse reactions, none.	21	safe. It doesn't matter where you do the intubation.
22	Unrecognized or failed or misplaced tube, we had		I feel that if you put the right tools, the
23	none. We had one where there was a patient who was	23	right techniques, the right training, the right oversight
24	intubated non-RSI, required a paralytic and rode to the	24 25	in the hands of capable paramedics, you'll get the same
25	hospital to maintain the tube position and prevent them	25	results as you do when you put those tools in the hands of
	Page 17		Page 19
1	from ortubating the world. It was a sit was a series	1	ED destars on thomas guargeous And and I think we
2	from extubating themself. It was a it was a severe	2	ER doctors or trauma surgeons. And and I think we showed that in the results of first pass success rate and
3	trauma patient.	3	
4	And in transferring from our gurney onto the trauma bed, there was a brief extubation that was	4	ability to secure an airway. We didn't do outcome studies in here. There are
5		5	
6	recognized immediately. It went under a vigorous review	6	outcome studies that have been in the literature for years and there are continuing outcome studies that are coming
7	and it was felt to be factors that happened in that year.	7	
8	JASON: It's mine. I apologize. MARK ORASKOVICH: So here's some more quality	8	out.
9	assurance data. We said at the onset we would maintain an	9	I threw this one in here because when we began this program we presented the San Diago study, which I
10			this program, we presented the San Diego study, which I think everybody has heard of. It put RSI for trauma
11	intubation success rate greater than 90 percent. We hit	10	
12	100 percent, meaning we had no failed airways. Compliance	12	patients in a bad light in a pre-hospital setting. This is a much more recent study coming out of
13	with training, 100 percent. Confirmation of intubation with video	13	• 0
14		14	Australia that had 312 randomized perspective traumatic
15	laryngoscopy. This means either at the time we had the	15	brain injury patients who were either randomized to be intubated by a paramedia using BSL in the field on brought
16	blade in or at the time of transfer of care, or the time	16	intubated by a paramedic using RSI in the field or brought to the EB and intubated in the EB. And their goal was to
17	they were arrived at the ER, we would take a picture and	17	to the ER and intubated in the ER. And their goal was to
	show that that tube was in the proper position. We didn't	18	determine their neuro outcome at six months with the two
18	hit 95. We didn't record that picture 95 percent of the		arms of the study, and they found favorable outcomes;
19 20	time. But you'll notice 80 percent, we had over	19	51 percent favorable outcome with medics, 39 percent when they were intubated in the ED
20	80 percent where video was the final device. So we're	20	they were intubated in the ER.
21	using it. It's just that they didn't always record it as	21	They're conclusion, and there's a great
22	they should have.	22	discussion in this article, that adults with severe TBI,
23	Confirmation by receiving M.D. was 100 percent	23	pre-hospital RSI by paramedics increases rate of favorable
24 25	on AirMed crew.	24 25	neurologic outcome.
20	Application of qualitative capnography. This	20	Intuitively, I think we all believe that. It's
	Page 18		Page 20

1	not good to have decreased sats. It's just that we've had	¹ study is complete. We plan to continue using RSI, and we
2	a hard time getting studies to prove it. And they are out	² just need to work with the Bureau on getting a variance
3	there, you just got to find them, and there's more that	³ for the meds that we carry, and then we would apply as a
4	are coming out there with time.	 4 variance to carry additional meds should we choose to do
5	DR. PETER TAILLAC: Mark, I would just	⁵ that.
6		
7	editorialize the reason they do well, and you do well, is	Totil Whill. Mark, can you explain the rationale
8	because you do it well, as you said in your slide. Some	for utuning mose two incurrentions, making mose utunuoter
9	of the other studies that have been out there, I think,	
	are with agencies that don't maintain the same QA	one that is worth taking about the most The reason
10	oversight in training.	¹⁰ behind that is you have a pretty good subset of patients
11	MARK ORASKOVICH: I think you cannot treat	11 that have contraindications to succinylcholine. Now in
12	pre-hospital intubation and RSI like just any other	12 reality the numbers aren't big in the patients that fall
13	paramedic skill, like putting in an IV. It requires	¹³ out of that, but there are contraindications that have
14	intensive training up front, intensive ongoing training.	¹⁴ very significant consequences if they're missed. Those
15	There's a lot of expense to this. This is not something I	¹⁵ patients those contraindications don't exist with
16	think every agency should or should want to do. It is	¹⁶ rocuronium.
17	it's it takes a lot of investment from the physician,	17 Rocuronium not only has equal success rates in
18	from the city that pays the bills for that fire department	¹⁸ terms of favorable intubating conditions, but in some more
19	or EMS agency, and for the paramedics to come into that	¹⁹ recent studies also show that your saturations are
20	rigorous level of training. We think it's successful.	²⁰ maintained at an appropriate level longer, meaning during
21	Our two-year study period is up. We are at a	²¹ the apnea period, patients tend not to de-saturate quite
22	point now where we are in discussions with the Bureau.	as quickly, the thought being they don't fasciculate, so
23	And we really have two different directions we'd like to	²³ there's less oxygen demand. And we feel that should be a
24	go and we'd like the input from this council or this	²⁴ med that we consider. I think we've seen it gain a lot of
25	committee as to what you feel would be our best course of	²⁵ traction in the ER setting. And I don't know what your
	Page 21	Page 23
1		
	action.	¹ use is at primary but
2		1 use is at primary but 2 UNKNOWN: Rocuronium.
2 3	We have been approached by the Bureau to extend	² UNKNOWN: Rocuronium.
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(Pages 21 to 24)

20 21	the vial. It's got to be dissolved. And all of that takes time in a potentially very critical situation. So	20 21	up. At least that's my vote. JAY DOWNS: Okay. Another question I have is,
19	somebody's got to draw the dilio in. It's got to go into	19	the age issue is successful, et cetera, before we open it
18	come ready to use. So it has to be reconstituted and	18	things work well. You can train the medics to do it well,
17	practical advantage and that is that rocuronium doesn't	17	continue to serve the state, if you will, by proving these
16	I'm the ED pharmacist at Primary Children. There is a	16	So to me it's benefits us to have them
15	RICHARD THOMAS: So my name is Richard Thomas.	15	training that they have done to this time.
14	in the back. Please state your name for the	14	benchmark sort of at that point is succinylcholine and the
13	JAY DOWNS: Excuse me, Doc. We got a question	13	other drugs and extend it, is one option. But the
12	in the ER.	12	now and then they say, oh, yes, and we'd like to use these
11	which would be likely wearing off soon after their arrival	11	for other agencies to then replicate. So for them to stop
10	health life than using rocuronium right from the start,	10	that will establish sort of the benchmark for the state
9	we're resorting to vecuronium, which has a much longer	9	bit for the kids, is that when they're really done, then
8	the tube, we're using sedation first, but in some cases	8	Utah, pre-hospitally, potentially extending the age down a
7	that patient starts to buck the tube or try to pull out	7	drugs, which aren't new nationally, but are very new for
6	longer transport, if you're giving succinylcholine and	6	extending a year, in my opinion, and including the new
5	MARK ORASKOVICH: And there is some benefit in a	5	The advantage to them, to answer your question,
4	frequently used in the pre-hospital.	4	training, et cetera.
3	So that's been another reason that it hasn't been as	3	if they can reproduce the same level of oversight,
2	more frequent turnover cycle for carrying that medication.	2	similar projects, I have a feeling, and that will be great
1	issue, and it requires either refrigeration or requires a	1	project, there will be other agencies who want to take on
	Page 25		Page 27
	-		
25	HALLIE KELLER: For storage. So that's an	25	they have. When they're finished with their pilot
23	three-month cycle that a lot of people MARK ORASKOVICH: For storage.	23	few years, doing things fast sometimes is not the right way to go. They've done a great job with the protocol
23		23	I I guess, as I've been with the Bureau for a few years, doing things fast sometimes is not the right
21	HALLIE KELLER: There's also how long it lasts, right? Roc only lasts two months instead of a typical	21	state.
20	TOM WHITE: reinventing the wheel again.	20	established potentially a new standard of care in our
20		20	done very, very well, and I congratulate you, has really established potentially a new standard of core in our
19	MARK ORASKOVICH: I know.	19	
18	like you're	18	I my bias a little bit is that what these guys have
17	has never been used. TOM WHITE: I ask the question again. It seems	17	Dr. Taillac, what's your feelings on it? DR. PETER TAILLAC: And we've discussed this and
15	MARK ORASKOVICH: ten years. Succinylcholine	15	JAY DOWNS: You feel like you're done? Okay.
14	JASON: Ten years.	14	MARK ORASKOVICH: I feel like we're done.
13	the state of New Mexico for what	13 14	would you like to have another year to continue the pilot?
12 13	come right out and say he hasn't used anything but roc in	12	you think do you feel like your study is complete or would you like to have another your to continue the pilet?
11	difficult airway course and heads up the EMS portion, will	11	got a question for you. Do you feel like you're done? Do
10	I know Darren Brody who also heads up that	10	quorum here today, so we can't really act on it. But I
	course.	1	JAY DOWNS: Unfortunately, we don't have a
8 9	roc?" And Eric sits on the board for the difficult airway	9	up.
8	the study was even done and said, "Why aren't you doing	8	state and say we'll ask for a variance and we'll write it
о 7	had here with Eric Barton, he came forward to us before the study was even done and said "Why aren't you doing	7	the form of a pilot project, then we take this back to the
6	even from the start. I know in our early training that we	6	council doesn't feel that this needs to be looked at in the form of a pilot project, then we take this back to the
5	MARK ORASKOVICH: And we we've been pressured	5	So again, open to discussion. If if this
4	with. MARK ORASKOVICH: And we we've been pressured	4	good marriage.
3	medications, what is the best patient group to do this	3	of their half life, their same dose and they seem to be a
	going forward for everybody, and what are the best	2	conjunction with ketamine, since the two match up in terms
1 2		1	conjunction with katamina since the two metch up in terms

7

(Pages 25 to 28)

1	MARK ORASKOVICH: Yeah.	¹ the ground work for a protocol for the state. And I think
2	DR. PETER TAILLAC: Jolene, let you answer, the	² you ought to you know, I would support you going
3	rule expert. I think they would apply for a variance to	 ³ further with different medications and lowering the age
4	continue doing what they're doing essentially.	4 for another year so that we cover all that and we don't
5	JOLENE WHITNEY: I was looking at the pilot	 ⁵ come back with a with an approved protocol and then
6	project rules and the department or committee as	 ⁶ somebody else comes in with those same questions. So
7	appropriate shall allow the EMS provider involved in the	 while we're here, while we're in the blender, let's just
8	study to appear before the department or committee as	 ⁸ keep going.
9	appropriate to explain and express its views before	9 MARK ORASKOVICH: My question for you, Hallie,
10	determining to rescind the waiver for the project. And	¹⁰ was: What are your thoughts on the age criteria?
11	then all it says after that is, at six months there before	11 Certainly, this would be in discussion with your
12	the project is supposed to be completed, the medical	12 attendings.
13		utteriaing.
14	director will submit their preliminary findings and	
15	recommendations for change in the project requirements.	interior solutioning i tank that would be a benefit for
16	So that's all the rules state about where we go from here.	
	DR. PETER TAILLAC: Yeah, my sense was, it ends,	
17	and then you sort of in a sense become like everyone	¹⁷ is historically quite broad. And so to find, you know, an
18	else, and if you want to do the extra thing, you apply for	18 area that we can improve this, I think would be fantastic.
19	a variance, which obviously given your track record would	¹⁹ So lowering that age limit, I think, would definitely be
20	be favorably viewed, I'm sure.	20 something that we should look into, and would be a benefit
21	JAY DOWNS: It would take time to do it,	²¹ of extending this.
22	correct?	22 MARK ORASKOVICH: Do you have an age in mind?
23	DR. PETER TAILLAC: Given the fact that, you	23 HALLIE KELLER: I need to think about it.
24	know, a variance required a training plan and key	24 MARK ORASKOVICH: Okay.
25	JAY DOWNS: That's all done.	²⁵ HALLIE KELLER: I mean, I I agree with you,
	Page 29	Page 31
	Paye 25	Page 31
1	DR. PETER TAILLAC: that's all done	¹ definitely not less than age eight.
2	essentially. So, no, frankly, I mean, it's not up to me	² MARK ORASKOVICH: That would be our absolute
3	completely, but if it were up to me, they could start	³ minimum.
4	their variance tomorrow.	4 HALLIE KELLER: But I I'd have to think about
5	JAY DOWNS: Tomorrow.	⁵ that. But I'd be very interested.
6	DR. PETER TAILLAC: Or the day after they submit	6 JASON: Are you using the GlideScope routinely
7	it, because they've done all the ground work already.	7 in the
8	JAY DOWNS: Sure. Yeah, it they've done	8 HALLIE KELLER: Yeah, we have GlideScope in the
9	everything they need to.	⁹ ER.
10	DR. PETER TAILLAC: Yeah.	10 TOM WHITE: Routinely might be a stretch.
11		· 8
1 I I	JAY DOWNS: Members. I mean, can't vote on	11 HALLIE KELLER: Routinely, it's not our first.
12	JAY DOWNS: Members. I mean, can't vote on anything, but, however, we can give them our feeling and	 HALLIE KELLER: Routinely, it's not our first. I mean, we do direct.
	anything, but, however, we can give them our feeling and	¹² I mean, we do direct.
12	anything, but, however, we can give them our feeling and then take care of it at the next action at our next	12 I mean, we do direct. 13 MARK ORASKOVICH: So one one thing to add to
12 13	anything, but, however, we can give them our feeling and then take care of it at the next action at our next meeting. Or do we do that over telephonic or what can we	12 I mean, we do direct. 13 MARK ORASKOVICH: So one one thing to add to 14 that question specific to pediatrics, the GlideScope we
12 13 14 15	anything, but, however, we can give them our feeling and then take care of it at the next action at our next meeting. Or do we do that over telephonic or what can we do with that?	12I mean, we do direct.13MARK ORASKOVICH: So one one thing to add to14that question specific to pediatrics, the GlideScope we15have now, the way that we use it, we can go down to age
12 13 14	anything, but, however, we can give them our feeling and then take care of it at the next action at our next meeting. Or do we do that over telephonic or what can we do with that? Jolene, what's your thoughts on that?	12I mean, we do direct.13MARK ORASKOVICH: So one one thing to add to14that question specific to pediatrics, the GlideScope we15have now, the way that we use it, we can go down to age16eight without buying additional equipment to do that. But
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1	through that GlideScope blade, and some of them you can't	1	especially in the trauma setting, where airways already
2	thread if you don't have the right equipment. I mean, it	2	established, requires a confirmation on arrival in the ER
3	does require	3	and you proceed immediately with your primary, secondary
4	MARK ORASKOVICH: We can go down to age eight	4	survey and imaging studies. And that delay of
5	with what we have with no problem right now.	5	establishing a definitive airway, which even in, I think
6	JAY DOWNS: Bob.	6	the best of trauma circumstances can be 10, 15 10
7	BOB GROW: So, you know, I work with a group of	7	minutes in our trauma rooms, that's already done en route
8	about 20 docs. We're at two other receiving hospitals	8	to the hospital, so there's a time savings there. And
9	that you routinely take patients to, and, you know, it's	9	then that patient arrives in a very controlled state for
10	kind of these issues have percolated through our group.	10	you guys.
11	There's been a fair amount of concern about rocuronium.	11	There is going to be that time where that still
12	I'm sure this is not the first you're going to hear this,	12	has to wear off before you can get a competent neuro exam,
13	but	13	but I think we're already seeing that when rocuronium's
14	HALLIE KELLER: About what?	14	been employed; in fact, having to wait longer.
15	BOB GROW: About using roc.	15	But I'd really like to hear from the group as to
16	HALLIE KELLER: Roc.	16	what concerns they have and and how they would like to
17	BOB GROW: I guess my question is: Are you	17	see us proceed with it. Is is it something you're
18	planning to use it as your primary paralytic or as a	18	using routinely up there now?
19	second paralytic when there's contraindications to sucs,	19	BOB GROW: I think that's part of the issue. I
20	or are you just going to use roc for everybody?	20	mean, you've got, like I said, 20 of us or so who, you
21	MARK ORASKOVICH: I would say if we are going to	21	know, we've trained all over the country, you know, people
22	continue this and and do the third year of the pilot	22	like me who read the literature, I'm at the meetings. For
23	project, I would like to see us go primarily to	23	me roc is not standard of care.
24	rocuronium. That would be my preference. And and I	24	MARK ORASKOVICH: Uh-huh.
25	don't know if we've really discussed that formally yet in	25	BOB GROW: And so for you know, the vibe in
			-
	Page 33		Page 35
1	terms of how we would do that. Do you have a thought,	1	this room is very different than what our clinical
2	Peter?	2	practice is at the moment. And I guess it it just
3	DR. PETER TAILLAC: Um, I think your medics have	3	slaps us a little bit the wrong way to say you guys don't
4	matured to the point where you can give them more tools,	4	know your own standard of care in the field you trained
5	and they can design their paralytic program, treatment	5	and practiced in. You know, we're just going to kind of
6	plan that day to that patient. And if for some reason roc	6	go down this route regardless.
7	under as you develop the protocol for roc, you come up	7	But I mean, I've probably been in Utah for five
8	with the times you'd use it and the times where you might	8	years and, you know, granted I haven't practiced out of
9	look at sucs instead, and I'd suggest putting it on as an	9	the state for quite a while. So if everybody else in the
10	additional tool, not taking sucs off, so you have all	10	country is routinely using roc, and we're the last group
11	those tools in your toolbox, and then design the protocol	11	left behind, then then I guess we've got issues to
12	for when you want to use roc, whether it's going to be	12	address beyond what's happening at the committee.
13	primary, secondary. I mean, I would go for primary, based	13	But I I guess my my sense of things
14	on my experience as well.	14	generally, both in the EMS field and in emergency medicine
15	But part of that is also negotiating with the	15	in general, is that using roc primarily is certainly not
16	docs, I think, to some extent that are going to receive	16	standard of care. At least it's at least not locally.
17	the patients. If they want to have potentially a	17	And and you can show me the studies and maybe
18	paralyzed patient come into the ED instead of an awake	18	that's what we need is some education, but you know, our
19	patient, you know, quote, unquote, awake. But, you know,	19	clinical practice is not that.
20	since your patients are getting that anyway, does it	20	JAY DOWNS: There's someone raising their hand
21	matter. But I'd suggest a conversation with the docs	21	over there.
22	receiving the patients to kind of come up with, you know,	22	ROB BRYAN: I'm Rob Bryan. I work at IMC. I
23	a plan that everyone's comfortable with.	23	have an interest in ED and critical care and I'd be happy
24	MARK ORASKOVICH: The literature tends to spin	24	and come and educate your group about rocuronium worldwide
25	it as a benefit that that patient roles into the ER,	25	and nationally. Roc has no contraindications, so there's
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(Pages 33 to 36)

1	not the issue of having to forget that someone was in a	1	medics. And which is helps out in the final numbers.
2	wheelchair and you could kill them by making them	2	But if an agency does choose to take on a project like
3	hyperkalemic. There is significant benefit to prolonging	3	this, they would be prepared for the financial and effect
4	the safe apnea iteration in someone that's already sick	4	of that so administrative support is absolutely paramount.
5	anyway.	5	MARK ORASKOVICH: We've tried to set the bar at
6	And I think a lot of people historically have	6	an extremely high level realizing we were under intense
7	clung to a false safety blanket in the use of	7	scrutiny, and we've been swimming upstream in the arrow of
8	succinylcholine thinking that it will wear off before your	8	some literature 10 years ago. And so we would hope that
9	critically ill patient will start breathing again. And	9	the state recognizes that and keeps that bar equally high
10	there's ample evidence to show that in eight minutes that	10	for any others who would want to consider it because we
11	it takes for a healthy patient to metabolize their sucs	11	think that's what's contributed to our success.
12	and start moving again, is a lot longer than the four	12	JAY DOWNS: Okay. So
13		13	SCOTT YOUNGQUIST: Scott Youngquist, Salt Lake
14	minutes it takes for a sick person to get profoundly	14	
15	apneic and to get profoundly hypoxic. And so I think roc is safer. I haven't used suc	15	City Fire. I was just going to second what Rob was saying from our emergency department at the U. We use almost
16		16	
17	in two years. It requires less thinking and less	17	exclusively, I think, rocuronium in place of using sucs.
18	remembering of rules.	18	DR. PETER TAILLAC: I haven't seen it in quite a
	And the one other drug supply in all of the	19	while.
19	recent drug shortages we've had, is that it was two years	20	SCOTT YOUNGQUIST: I think think there is
20	ago that there was a national shortage of sucs and we	1	kind of a tidal wave of rocuronium out there.
21	had had nothing. So roc has been a much better agent.	21	The other question I have for you was: How many
22	JAY DOWNS: Dr. Taillac, you had a comment?	22	eight to eight through 13 year eight through 15
23	DR. PETER TAILLAC: I think that's a	23	years old do you think you'll have in the next year?
24	conversation that you guys can put together with the	24	HALLIE KELLER: Trauma. But other than trauma
25	receiving docs and kind of decide personally, because I	25	not a whole lot. I mean, our intubations are with the
	Page 37		Page 39
1	think the receiving facility should have some input into	1	tiny kids, but trauma. But there's not going to be a ton.
2	how the care takes place in the field. That's part of the	2	I guess that is the bummer.
3	EMS system between pre-hospital and the in-hospital care.	3	MARK ORASKOVICH: If I may, we had a patient who
4	I I just wanted to mention one other thing	4	was RSI recently, that had she been six months different
5	unrelated, not to take too long. Cory, you had a	5	in age we would not have been able to manage her.
6	conversation about the expense of this program so far. Do	6	Anatomically she wasn't any different, physiologically she
7	you mind telling the audience how much you think this	7	wasn't any different, and we've been constrained by not
8	program has cost so far to do?	8	being able to do for her what we were sure we could have
9	JAY DOWNS: That would be excellent to share	9	by a barrier set by this study. And I think what allowing
10	with us. Thank you.	10	us to have a wider inclusion range does, is we're not
11	CORY COX: Cory Cox, Davis County Sheriff's	11	looking to go out and find kids to slam tubes into.
12	office. When we first took on this pilot project, I mean,	12	HALLIE KELLER: Right.
13	one of the expenses was the initial equipment costs, the	13	MARK ORASKOVICH: But what we are looking to do
14	medication costs, the training costs just to even put on a	14	is based on technology with video, based on the experience
15	class for the equipment and then the personnel expenses.	15	that we've gained from this, our confidence of airway
16	I mean, we have to pay our people overtime to come in	16	managers, we now have patients that you so well said that
17	to come in and train and then cover their shifts.	17	maybe didn't get managed well before, that we feel we have
18	And based on my prelim preliminary analysis	18	the tools and the knowledge and the ability and the
19	so far, this this training program is up into the	19	maturity to manage better now. And that we think that
20	hundreds of thousands of dollars that these agencies have	20	this is absolutely a patient driven thing, which by the
21	been committed to this program and and not necessarily	21	way I will add to Dr. Grow's concern, I don't want anybody
22	directly to this program but indirectly to this program as	22	here or elsewhere to think that we're adding rocuronium
23	well.	23	because it's the in Vogue thing to do, just like swimming
24	So even the non-RSI medics are getting	24	upstream against pre-hospital RSI.
25	substantial amounts of training to help support the RSI	25	At the onset of this, we've recognized as we've
	substantial amounts of training to neep support the KSI		are the onset of this, we we recognized as we ve
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(Pages 37 to 40)

1	gone through this that the thought of pre-hospital RSI has	¹ algorithms, decision-making better than a significant
2	evolved elsewhere. And that includes the use of maybe	² portion of my colleagues because they are held to a
3	drugs that are new to this area but not new elsewhere.	³ standard that we've set higher. And the physicians don't
4	And it's a patient care issue for us, not a keeping up	4 have to necessarily be held to that standard other than
5	with the Jones' issue.	⁵ having M.D. after their name.
6	So we believe that we're heading in the right	⁶ JAY DOWNS: Is it is it the consensus of the
7	direction for the right reasons with what we're coming to	⁷ committee or that they want we want to go for a
8	you to ask to continue to do in both of these	⁸ third year on this pilot project, or are you guys thinking
9	circumstances, certainly with input from both, so.	⁹ it's done now, or what would you like what would the
10	SCOTT YOUNGQUIST: Obviously you guys have shown	¹⁰ committee like to do? I know we don't have the quorum.
11	you can perform this very well and successfully. I guess	¹¹ But what's the consensus of everybody here?
12	the the remaining question is: Is it benefiting your	¹² Hallie, what do you think? What
13	patients? In other words, are they surviving when they	¹³ HALLIE KELLER: I I mean, it's difficult
14	wouldn't have or suffering less neurologic injury, which I	¹⁴ when, you know, he says he feels like the study's done and
15	don't think you can answer with the study, obviously, if	 ¹⁵ he's in the process of doing the study and you say you
16	we don't get through people. So the Bernards study, I	¹⁶ feel like we're done, and it's hard for me to say, oh, you
17	guess, has to stand for proxy is the only randomized trial	¹⁷ have to do more. To me, it sounds like between roc and
18	that we have.	 lowering the patient age limit, there is more information
19	But you could certainly look at pre and post	¹⁹ to gain. So
20	airway management, desaturations; did you compare those to	20 MARK ORASKOVICH: And maybe I was very blunt in
21	bag mask ventilation or anything like that?	 saying that. I think in terms of what we were looking at
22	MARK ORASKOVICH: We did. We didn't have a	 22 saying that. I think in terms of what we were looking at 22 for variables, we've accomplished that.
23	control group. And that's you know, that's going to be	·································
24	the million dollar question is, are we making a difference	g
25	by improving outcomes? And I think we could apply that	24 set out to do? 25 MARK ORASKOVICH: Can we help the state now in
20	by improving outcomes. And I timik we could appry that	MARK ORASKOVICII. Can we neip the state now in
	Page 41	Page 43
1	some question to what we do in the amongonau norm W/han	¹ acquiring more data. I'm more than happy to do that.
2	same question to what we do in the emergency room. When we intubate, are we improving survival, because I don't	 acquiring more data, I'm more than happy to do that. We're already technically three months into this third
	we intudate, are we improving survival, because I don t	² we re arready technically three months into this third
3	know of any studies that show when we do RSI versus, say,	³ year since it ended September 30th. And so this makes a
4	know of any studies that show when we do RSI versus, say, having anesthesiology or somebody else now manage airway	 ³ year since it ended September 30th. And so this makes a ⁴ nice transition for us to move into looking at age group
4 5	know of any studies that show when we do RSI versus, say, having anesthesiology or somebody else now manage airway versus not doing airway that we've actually improved	 ³ year since it ended September 30th. And so this makes a ⁴ nice transition for us to move into looking at age group ⁵ differences and medications, because we can move forward
4 5 6	know of any studies that show when we do RSI versus, say, having anesthesiology or somebody else now manage airway versus not doing airway that we've actually improved survival and and mortality.	 year since it ended September 30th. And so this makes a nice transition for us to move into looking at age group differences and medications, because we can move forward right into that phase within a month.
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11

(Pages 41 to 44)

1	to see it go another year with the changes.	1	LYNN YEATES: And I'll second it.
2	JAY DOWNS: Bob?	2	JAY DOWNS: All in favor say aye.
3	BOB GROW: Well, I think with an entered 52,	3	COLLECTIVE: Aye.
4	you're pretty much obligated to continue the study. I	4	JAY DOWNS: Any nay? No. So it looks
5	mean, if we're talking about making a precedent for the	5	JOLENE WHITNEY: No abstentions.
6	rest of the state and we're going to base it on an entered	6	JAY DOWNS: Any abstained?
7	52 airways, you got to do more.	7	BOB GROW: I guess I'm not we're voting on
8	JAY DOWNS: Sure. I agree with Bob.	8	the motion to do what?
9	Well, we don't have a quorum to vote on I	9	JAY DOWNS: To make a recommendation that they
10	said that before. So now I'm going to refer back to	10	continue the study. It's confusing because we don't have
11	Jolene.	11	a quorum.
12	What can we do, Jolene?	12	BOB GROW: I don't think we I don't think we
13	JOLENE WHITNEY: You can make a recommendation.	13	understand what continuing the study entails yet, because
14	And you can vote on that recommendation.	14	they haven't told us that. I mean, that's right, Mark?
15	JAY DOWNS: Okay. So basically we're making the	15	Are we still
16	recommendation that you continue the study and the next	16	MARK ORASKOVICH: What?
17	meeting we'll vote on the recommendation; is that right?	17	BOB GROW: Under what terms are we continuing
18	JOLENE WHITNEY: Well, I'll find out the	18	for it? Are we lowering the age? Are we changing the
19	mechanism by which you can formalize your recommendation	19	drugs, or are we continuing as is?
20	as a formal vote.	20	MARK ORASKOVICH: So the study would continue as
21	JAY DOWNS: Okay. Does everybody got that? Are	21	is with the addition of writing up a protocol for the use
22	we going to be telephonic	22	of rocuronium, ketamine, and lowering our age criteria.
23	JOLENE WHITNEY: It's complicated. We have	23	And if you want to have those documents for your review
24	we have to make sure that we're operating within the open	24	before you vote on it, that would be fine. We can get
25	meetings.	25	that to you, and we will just continue the protocol under
	Page 45		Page 47
1	IAV DOWNS: Ves absolutely. So on behalf of	1	the ontion extending for a third year
1 2	JAY DOWNS: Yes, absolutely. So on behalf of the of the committee and everything you guys have done	1	the option extending for a third year.
2	the of the committee and everything, you guys have done	2	JERI JOHNSON: I'd agree. I think we should
2 3	the of the committee and everything, you guys have done fantastic. It's something that, I agree, I think you are	2 3	JERI JOHNSON: I'd agree. I think we should have more specifics before.
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(Pages 45 to 48)

1	November of 2012 to begin the thought process of community	¹ bother to tell me, the	ey already had a C.T. of their
2	health.		er. So there's some unfortunate
3	So we we've been working on this community		ces that occurs in the emergency
4	health program. And at this time we are ready to move	•	atients go all over the place in
5	forward. So we're here in discussions that we've had with		EMS for care that's a chronic
6	some of the members of the Bureau of EMS. It's been	⁶ condition.	
7	suggested that even though community health ideas are a	conditionit	t care environment, and we also
8	little bit fuzzy as far as whether it falls under the	it s a high cost	ng our emergency departments. And you
9	guise of emergency medicine or not, we believe that having	ena ap eversaraem	e emergency department is full and
10	the support of the Bureau of EMS and moving forward with	guys mon that it th	one comes in with a heart attack or
11		-	
12	that with that idea that it is an extension of		ith a massive trauma, their survival has
13	emergency medicine in more of a preemptive strike rather	gone do an statistica	lly, not by very much, but by a few
	than dealing with it immediately, it still will work	sinun percentuge po	ints or something like that. And
14	through the 911 system.		ue to the staff being diverted and
15	At this time I'm going to turn the time over to	-	erted to care for these other patients.
16	Dr. Scott Youngquist, and he's going to review our our		who seek emergency care if the
17	program initiative. Thanks.		ents are overburdened with these nonacute
18	SCOTT YOUNGQUIST: Thanks. This is kind of the	8 complaints.	
19	problem that we got into, why we got into mobile health	· · · · · · · · · · · · · · · · · · ·	e, it's provider burnout. We
20	paramedics. Anyone who practices emergency type care	0	s, paramedics, EMTs, who have seen
21	realizes that not everything, not every call for help is	-	on at three in the morning on every
22	an emergency. We certainly realize that in Salt Lake		red of the lifestyle. So it's no
23	City.	³ wonder people burn	out from this.
24	This is some these are some of our most	4 We looked at o	our top 10 users to try and see if
25	frequent callers here; you can see the top four here. We	⁵ there were some sor	t of themes that emerge from the people
	5 40		
	Page 49		Page 51
1	have in 2013, we had 150 unique callers that called 911	¹ who call us the mo	ost. And not surprisingly, these themes
2	at least six times. The top person in 2013 was, I think,		
3	43 at that time. So these are people who either have		l problems. We're sort of the tip of comes to unsolved problems in society.
4	terrible luck and have run into problems all the time, or	une spear when he	ccurred 90 percent of the time among
5	=		
6	there's some other unmet need going on. Anybody who	mose enses, meone	b) and drug abuse in seven out of 10,
7	practices emergency medicine knows, that's probably what		in a large proportion, and chronic
8	it is.	uiscuse. Those we	ere the things we noticed were
9	So even though I didn't sign up to see three	reoccurring them	es among these top 10 users. So these are
	months of back pain that's been seen by five other	problems that soe	iety hasn't figured out, so who are we to
10	providers as an emergency physician, that's the reality of	-	s emergency providers, of course.
11	the practice environment which we're in. We've got a 911		roblem starts at dispatch, of
12	system that's open and free to all people, and so it's		have non-medically call centers taking
13	going to be used appropriately and inappropriately	-	ow in our system. The the Pro QA
14	sometimes. And sometimes it's naive inappropriate use and		method of prioritizing calls and
15	sometimes it's frank abuse of the EMS system.		type of response is required, is it
16	When someone calls 911, of course, this is going		is a BLS or ALS response. But they
17	to lead to some cascading of health care costs. This is		pability for figuring out is this truly
18	the first domino when they're taken to the emergency	^{.8} an emergency or r	
19	department. EMTALA law applies, and I have to figure out		available in emergency
20	whether this is a true emergency or not using some		nurse specialist which we're adding to
21	testing, C.T. scans, whatever it might be to figure out if	-	e idea here is that the lowest acuity
22	this person is truly dying from their complaint or not.	calls would be tran	nsferred after they've been screened to
23	And sometimes it's apparent later that they've been seen	this emergency ca	re nurse who would take a more in depth
24	yesterday at another emergency department that they went	⁴ history using prot	ocols that come from the American
25	to by ambulance for the exact same thing, and they didn't	⁵ Academies of Eme	ergency Dispatch. They're all QA. The
	5 50		
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(Pages 49 to 52)

1	person is trained by the academy as well. And that that	1	So these are two mobile health paramedics,
2	person then determines using a directory of services what	2	Captain Ty Shepard, who's here who's overseeing helping
3	is the right response, if any, to the person, or can they	3	oversee the program, and Josh Diamond, who's another
4	arrange for alternative means of transportation, a taxi	4	paramedic visiting these people.
5	cab, something like that, to an urgent care center, the	5	So this goes from a very simple what so called
6	patient's primary care doctor.	6	you call, we haul, that's all, type of model of 911 to a
7		7	more complicated one by, as I admit, but one that will
8	So this person is a nurse navigator who helps	8	help these patients keep from falling through the cracks
9	this undifferentiated 911 caller who seems to have a nonacute complaint get to the right level of care through	9	
10	• • • • •	10	cracks further, I think.
11	the right transportation means.	11	So these require partnerships with people.
12	And then, in addition to that, we're adding	12	We're not trying to replace any existing services, but
13	what's called a mobile health paramedic. This is someone	13	we're trying to form a nexus with these people that
14	that is well-trained as a paramedic, but also has the	14	doesn't exist previously.
	people person skills to be something more. Something like		Primary care doctors have no idea how often
15	a life coach, a helper, a boy scout, and this is someone	15	their patients are calling 911. That information is not
16	who we say you go and find out why this person is calling	16	fed back to them in any fashion. So they're unless the
17	us so often and see if you can fix the problem, whether it	17	patient mentions it to them, they're oblivious to this
18	be an unstable condition, they need more in-home health	18	information. And they're sometimes surprised when we tell
19	care, whether it's psychiatric illness that's not being	19	them about it. But these are the people we've we've
20	treated well, whatever the problem may be, let's figure	20	been working with and we're hoping to expand this so that
21	this out and try and get them the help that they need.	21	this will be multiple slides and not just one in the
22	So these are the boy scouts we send out. And	22	future.
23	they do all sorts of things, but they're they're still	23	Here's a case study for you. This patient had
24	operating within their scope of practice. They're not	24	cerebral palsy, had a traumatic brain injury, wheelchair
25	giving any new medications, not giving any additional	25	bound, independently living alone and had 22 calls between
	Dago 53		Daga FF
	Page 53		Page 55
1	treatments that home health or a nurse would provide.	1	January and October of 2013. Most of these calls did not
2	And they respond in a smaller vehicle. Every	2	require transport and had to do with falls at home. So we
3	time someone calls 911, two of these may show up and an	3	sent the in-home the mobile health paramedic to their
4	ambulance. That's a lot of diesel fuel, it's a lot of	4	home to do a kind of needs assessment, a case management
5	pollution in our environment, it's a lot of wear and tear	5	type of thing from our side, and found that most of these
6	on apparatus and on the streets of Salt Lake City, and	6	calls resulted from problems with mobility and transfers;
7	that goes out from you and I as taxpayers to fix that kind	7	the person just couldn't get in and out of their
8	of problem every year, and we all pay for the consequences	8	wheelchair to the bed or whatever.
9	of too much CO2 emissions.	9	And so this community paramedic worked with case
10	So these mobile health paramedics would respond	10	management to arrange for home health, occupational
11	in two fashions: One would be the frequent user program.	11	therapy, and that resulted from two calls a month on
12	These they would go out and try to find these people,	12	average to zero over the last couple months of the year.
13	as I said, and try to fix whatever problem is going on.	13	We did have one more call from him recently I just heard,
14	It means taking ownership of some people who are just	14	but we've certainly decreased that frequency of calls and
15	slipping through the cracks of society, and then a	15	this the financial impact can be estimated from our
16	dispatch response through the this emergency nurse	16	restitution cost of just responding on scene to these
17	that's in dispatch who can say it sounds like your runny	17	calls. And it adds up over time as you can see.
18	nose does not require an ambulance and two fire trucks and	18	Here's another one. This is a homeless patient
19	a trip to the emergency department right away. Why don't	19	with traumatic brain injury, seizures, frequent calls to
20	we send our mobile health paramedic to come check you out,	20	911 by bystanders who would see the patient seize multiple
21	see if you're okay to wait for a visit to your primary	21	times a day on the street. Had a history of substance
22	care doctor tomorrow.	22	abuse, 22 calls to 911 over three mon over six months.
23	So that's the kind of response that they would	23	So we initiated an interdisciplinary review with
24	do as well. They would assess the person and figure out,	24	the help of the Fourth Street Clinic. We found this
25	make sure they're not sick.	25	patient had actual insurance and could receive care
	man but they to not stent		runnin haa arraan mourance and could receive care
	Page 54		Page 56

Page 54 14

1	through through IHC Hospitals and so we established LDS	¹ you want us to bring? I think it's an action on our	
2	Hospital as the single receiving center when this patient	² agenda for the board to possibly send back down to our	
3	needed transport.	³ subcommittees to to review more for what can be don	
4	In the meantime, we worked with homeless	⁴ more with the state, if that's so what the board decide	
5	resources to get a judicial review of this person. And	⁵ desires to do. We would send it down to the professional	
6	they determined through Adult Protective Services that	⁶ development.	-
7	this person shouldn't be living out on the street	7 Yes, Chief.	
8	unprotected, that they are a danger to themselves and so	8 CLARE BALDWIN: I just want to add one more	
9	was placed in a group home. So he went from living on the	9 thing. One of the things with these programs nationwid	
10	street here to living in a group home and wouldn't have	¹⁰ there have been others that have initiated these. The	,
11	happened without this type of program. The person we'd	11 continued problem of everybody is sustainability. Whet	her
12	still be going on on runs to this person. So it went	 it no matter what it is, it's it's us proving to the 	
13	from four-and-a-half per month to zero.	 ¹³ hospitals, to the insurance providers, to everyone 	
14	This is the financial impact that was estimated	 ¹⁴ involved that the cost savings will be there so that we 	
15	from the Fourth Street Clinic. This was a little over	¹⁵ can reclaim a share of that cost savings, so a cost share,	
16	three years. You can see the total cost of caring for	 ¹⁶ if you will, of those savings. 	
17	this individual who is slipping through the cracks was	17 There's some examples around the country where	
18	substantial. Now it's about \$40,000 a year to the	 this is working very well. Fort Worth is one of the 	
19	taxpayers for the person to live in this group setting.	 ¹⁹ one of the frontrunners here where they have shown that 	.t
20	So this can have a big impact, I think, on the	 this works. And they're using a program with both of 	u
21	quality of life for our providers because they could have	these, both pieces. There are other pieces in the country	17
22	the satisfaction of knowing that when they're going on	that are only doing a mobile health by the way we car	
23	someone frequently, they can pass that information along	 ²³ say community paramedic, because it's been copyrighte 	
24	to our mobile health paramedic, that something will be	²⁴ it's a mobile health paramedic is our program. That's v	
25	done and that we will do all that we can to to reduce	 that term's being used in MHP. So it's already we 	viiy
	uone and that we will do an that we can to to reduce		
	Page 57	Page	59
1	this.	1 we don't want to have to pay the residuals.	
2	Before we kind of said, we stood and watched in	 But if if if we can't, if we can't find a 	
3	horror as these things happened. I think we can make a	³ way to share or or to save money, then we're we'r	
			е
4		⁴ kind of looking at it, it's the right thing to do. We	e
4 5	difference now. So any questions on that?	initia of footing at 1, it 5 the right uning to dot the	e
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1	skills, they're going to be an evaluation type thing, and	1	emphasis with our community paramedics on the mental
2	it's pathway management to coin an old term.	2	health aspect, because most of the patients that we're
3	I would be supportive of a motion maybe to send	3	dealing with do have that that mental health piece
4	the overall topic to our subcommittees, to just have them	4	that that's not being addressed. And and the
5	look at that and and see if there's anything they need	5	overall general training of paramedic's role doesn't cover
6	or the committee ourselves need to do, but I would not	6	mental health the way it should.
7	want to place any any barriers or delays in front of	7	JAY DOWNS: So so Chief, I would assume then
8	Salt Lake City to move forward with this, because I just	8	you'd be willing to have, like, either yourself or one
9	don't see you know, we're not we're not talking RSI	9	of some of your staff come in and meet with the
10	or just, you know, drugs or an expanded role for	10	committees
11	paramedics. We're not trying to have them be something	11	CLARE BALDWIN: Absolutely.
12	they aren't already.	12	JAY DOWNS: subcommittees and introduce them
13	JAY DOWNS: Jolene?	13	to the idea and kind of like what you guys have done
14	JOLENE WHITNEY: Just to clarify, too, the	14	already. That way
15	reason it's on the committee under an action item is for	15	CLARE BALDWIN: Yes.
16	that very reason is for the committee	16	JAY DOWNS: it kind of gets to it. They're
17	MIKE MOFFITT: Oh, I got one right.	17	they're not redoing it, is what I'm trying to say.
18	JOLENE WHITNEY: for the committee to	18	CLARE BALDWIN: Correct. Correct. There's
19	consider the concept and push it down to the subcommittees	19	no yeah, we're not reinventing the wheel either. We're
20	for discussion and so they can talk about any concerns or	20	we're stealing, borrowing from everybody else that's
21	issues that might apply with this concept on a statewide	21	already laid the ground. Okay?
22	basis and the development of rules. I mean, there's	22	JAY DOWNS: We don't have to have a vote on
23	it's it's seen nationally in a lot of places and it's	23	that, we can just make that recommendation to the
24	it's taking hold. We're seeing it now in Utah. We	24	subcommittees. With the consensus of the committee.
25	need to look at it as an EMS community and see how it	25	Good?
			0004.
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1	fits. And if there are protections that we can have in	1	CLARE BALDWIN: Thank you.
2	place for the providers and for the public, we need to	2	JAY DOWNS: Okay. So we will take that to the
3	start having discussions in appropriate forums for that	3	subcommittees, both of them, the operations and the
4	kind of for this concept.	4	professional development to look into that.
5	So the committee doesn't have to consider this	5	ANDY SMITH: Can I ask one more question?
6	proposal as a pilot project, because they're not having	6	JAY DOWNS: Yeah, sure, go ahead. State your
7	any kind of a waiver or variance for anything that they're	7	name again, please.
8	not already doing within their scope of practice. So just	8	ANDY SMITH: Andy Smith.
9	to clarify.	9	JAY DOWNS: Sorry for that, Andy.
10	CLARE BALDWIN: I think it's important that we	10	ANDY SMITH: You said there's two different ways
11	collaborate, that we're willing to share our information	11	that individuals are identified for this program.
12	as we go to help everybody else along the way. And that's	12	CLARE BALDWIN: Uh-huh.
13	kind of why we're here, is we're going down into new	13	ANDY SMITH: And either they are dispatched
14	territory and everyone has a lot of questions. And so I	14	through the the nursing side of it or dispatch a
15	I would agree with with Mike that what we are doing	15	community paramedic out there?
16	is really not new.	16	CLARE BALDWIN: Yes.
17	There are some community paramedic programs in	17	ANDY SMITH: Or you've identified frequent
18	the country that are just short of being P.A.'s. And	18	abusers or callers or whatever you want to call them.
19	we're not looking at that. We don't believe that that	19	CLARE BALDWIN: Correct.
20	there's value in us going down that road. So we're	20	UNKNOWN: Loyal users.
21	there may be in the rural setting, but but for us there	21	ANDY SMITH: Loyal users. So then your your
22	is not that value. For us, just getting into the home in	22	community paramedics just have a list of folks that they
23 24	that so social interaction with the patient is where	23	visit then?
24 25	it's at and not and not adding new skills or new new techniques that that meetly it's there will be	24	CLARE BALDWIN: Well, in this collaboration with
ر ک	techniques that that mostly it's there will be	25	the hospitals, they are providing us names of people that
		1	

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1	are on their list that they need us to go out and visit.	1	was is there's five of us that we have. Generally
2	ANDY SMITH: Okay. Okay.	2	speaking, we can have one of us on all the time to cover
3	CLARE BALDWIN: So we are working with all the	3	our three ambulances. We have stations throughout our
4	hospitals in the valley that you know, that that	4	area, and that paramedic would respond in a quick response
5	have that those frequent users that live in Salt Lake	5	vehicle to any paramedic level calls as is determined
6	City proper, because right now this program is only Salt	6	through dispatch.
7	Lake City proper.	7	So generally we we have a paramedic go on
8	ANDY SMITH: Okay.	8	every call, not every call, but we have a paramedic
9	CLARE BALDWIN: So then we we get those names	9	available most of the time to to respond to these
10	and we work on those referrals as well, as well as the	10	calls, but that paramedic would be alone with an advanced
11	referrals that our crews give us. They'll go on a call.	11	EMT and an EMT or advanced EMT's depending on how the
12	They'll for right now because we don't have the ECNS in	12	ambulance is actually staffed. So we would be a lone
13	place and they'll give us the referrals through we have	13	paramedic but we'd we'd still we could still
14		14	*
15	an Adobe forms, so we get those referrals that way also.	15	function as a paramedic.
16	ANDY SMITH: Okay.	16	JAY DOWNS: So I understand what you are saying
17	BRIAN DALE: So we can meet them before they	17	is you'd have them like in a suburban or a truck or
18	have crisis.	18	something.
	JAY DOWNS: Excuse me, sir, what's your name?	19	TRACY BRAITHWAITE: Yeah.
19	BRIAN: Brian Dale, Salt Lake City Fire.		JAY DOWNS: And then if it was an appropriate
20	ANDY SMITH: Is there a formal report back to	20	level of call for a paramedic, that individual would
21	that referring physician or hospital of the condition of	21 22	respond with the advanced EMTs on the ambulance?
22	the patient?		TRACY BRAITHWAITE: Yeah, the ambulances are
23	CLARE BALDWIN: Yes.	23	staffed as is currently under our advanced EMT license and
24 25	ANDY SMITH: Okay. All right.	24	that they will make no continue to be staffed that way,
25	TY SHEPHERD: So that's being Ty Shepherd,	25	and the paramedic would just be an additional provider
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1	Salt Lake City Fire. We usually right now so far we're	1	that is coming on these calls that we require paramedic
2	working with the case managers, not as much the primary	2	level.
3	physicians yet we're going to start contacting them but	3	JAY DOWNS: Okay. So with five people, you feel
4	a lot of case management interaction.	4	you can staff paramedic, at least one single paramedic on
5	JAY DOWNS: I'll have more of this information	5	most calls, unless that paramedic's tied up on another
6	coming through the subcommittees. So thank you.	6	call, is that what you're saying?
7	The next item was on a digital, the previous	7	TRACY BRAITHWAITE: Yeah, unless they're if
8	agenda, and we figured out it wasn't on this one, so we	8	they're on another call, obviously they're tied up, but
9	added it to this one, and that was was Tami, North	9	generally speaking how our work schedules work, is we all
10	Sanpete ambulance waiver, is that you?	10	work different jobs. There's usually at least one of us
11	TAMI GOODIN: Well, it's not I'll introduce	11	around seven days a week.
12	Tracy Braithwaite from North Sanpete. North Sanpete is	12	JAY DOWNS: Okay.
13	requesting a paramedic schedule order for the committee	13	TRACY BRAITHWAITE: That we can manage to get at
14		14	least maybe maybe not all seven days, but maybe at
15	for their consideration for their paramedic application. I'm going to turn it over to Tracy.	15	least five five out of seven days a week we would have
16	I III YOIIIY IO IIIFII II OVEFIO I FACV.	1 13	least live live out of seven days a week we would have
10		16	a nanomodia available to normand
17	JAY DOWNS: Tracy.	16 17	a paramedic available to respond.
17	JAY DOWNS: Tracy. TRACY BRAITHWAITE: Yeah. I'm Tracy	17	JAY DOWNS: Committee? What's what what's
18	JAY DOWNS: Tracy. TRACY BRAITHWAITE: Yeah. I'm Tracy Braithwaite, North Sanpete Ambulance. We've also got	17 18	JAY DOWNS: Committee? What's what what's your thoughts? Any questions? You got anything else? Is
18 19	JAY DOWNS: Tracy. TRACY BRAITHWAITE: Yeah. I'm Tracy Braithwaite, North Sanpete Ambulance. We've also got Bryan Bench here with me. We're two of the paramedics	17 18 19	JAY DOWNS: Committee? What's what what's your thoughts? Any questions? You got anything else? Is that
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1	cost to us isn't that much, it's just a matter of adding a	1	JOLENE WHITNEY: Uh-huh.
2	few drugs and some airway supplies.	2	JERI JOHNSON: I'll make a motion.
3	JAY DOWNS: Okay. Anybody got any questions or	3	JAY DOWNS: Okay. Motion is?
4	concerns for them? Of course, we're not a quorum.	4	JERI JOHNSON: To accept
5	TRACY BRAITHWAITE: Yeah.	5	JAY DOWNS: To approve? To grant it?
6	JAY DOWNS: I mentioned that several times	6	JERI JOHNSON: to approve their proposal.
7	earlier. However, the committee can make a recommendation	7	JAY DOWNS: Okay.
8	like we did with the other one; is that correct, Jolene?	8	LYNN YEATES: I'll second.
9	JOLENE WHITNEY: Correct.	9	JAY DOWNS: Seconded by Sheriff. Okay. Any
10	JERI JOHNSON: Do they have to have a letter	10	further discussion on the motion? I see none. Call for a
11	from the government so they're aware of	11	vote. All in favor say aye.
12	TRACY BRAITHWAITE: We we we are a Special	12	COLLECTIVE: Aye.
13	Service District. We are our own kind of quasi government	13	JAY DOWNS: Any opposed? Any abstained? Good.
14	agency. So we make our own we we submit budgets to	14	Okay. Next action. Thank you.
15	the Auditor's office every year. You know, so we operate	15	TRACY BRAITHWAITE: I was going to stay up here,
16	independent of any government agency.	16	I think I'm next.
17	JAY DOWNS: I think what Jeri's referring to is	17	JOLENE WHITNEY: He gets to stay.
18	some of the other agencies that we've had them do, is the	18	JAY DOWNS: Are you next?
19	support of the communities they serve, that they're	19	JOLENE WHITNEY: He's next, yeah. Operations.
20	they're	20	JAY DOWNS: Oh, good. There you go, Trace.
21	JERI JOHNSON: They're knowledgeable.	21	You're up next. Wow us and woo us.
22	JAY DOWNS: Yeah. That they're	22	TRACY BRAITHWAITE: So the things I have to
23	TRACY BRAITHWAITE: Our our our Board of	23	report from the Operations Subcommittee is this emergency
24	Directors is made up of representatives from each city.	24	vehicle operators rule that's gone into effect. We had
25	So each city already kind of has a say in what we're	25	a kind of our own little task force that we had kind of
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1	doing. So that's kind of so	1	make up this rule. It's gone into effect.
2	JAY DOWNS: Okay. Tami in the back.	2	We subsequently decided that there's things
3	TAMI GOODIN: Just for clarification, the agency	3	that the New Rules Task Force that is coming on board
4	that you require the government support letter, that was	4	would would like to maybe look at taking out, and
5	for a current license provider that all that	5	that's what we had to strike through here on our stuff.
6	information will come into their for their license	6	So as it is written currently, without the strike through,
7	application. So right now they're just discussing for the	7	that's what is in the rule currently. So, but we would
8	staffing waiver. So that was a difference between the	8	recommend that this new Rules Task Force strike the
9	two.	9	what we have decided to take out, but it's kind of
10	JAY DOWNS: Thank you. Okay. Committee?	10	unnecessary.
11	JERI JOHNSON: It calls in just as the others.	11	JAY DOWNS: Okay. So what you're saying is
12	MARK ADAMS: Mark Adams, just one question. Did	12	you're making a recommendation to be taken back to the
13	the proposal include protocols keeping paramedic drugs and	13	Rules Task Force to strike out what you're asking?
14	things safe and secure	14	TRACY BRAITHWAITE: Yeah, pretty much.
15	TRACY BRAITHWAITE: Yes.	15	JAY DOWNS: Okay.
16	MARK ADAMS: and locked so that there's no	16	TRACY BRAITHWAITE: Let the Rules Task Force
17	access to them outside of the paramedic?	17	take it over now 'cause it's base it's in rule. So
18	BRYAN BENCH: Bryan Bench, North Sanpete. We've	18	it's kind of up to the task force now.
19	both done this together. Yes, everything will be	19	JAY DOWNS: Committee agree? Send it back to
20	separate. So we would actually have separate lock boxes	20	the rules?
21	for any narcotics that are paramedic based versus AEMT.	21	MARK ADAMS: Agree.
22	So everything would be completely separate.	22	JAY DOWNS: Okay. Okay. Anything else?
23	JAY DOWNS: Good. Well, we can make a motion to	23	TRACY BRAITHWAITE: Nothing else from our
24	make a recommendation, am I right? And then we would take	24	committee, no.
25	it up at a later date for the final vote, right?	25	JAY DOWNS: Okay.
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1	TRACY BRAITHWAITE: We would like some, you	1	from this committee or the Bureau for them to work on. I
2	know, maybe some more input from the overall, the EMS	2	need to clarify with everybody to understand how that
3	committee from you guys on things that we can can do	3	rules task force works. They are not the the end all.
4	because we can't find ourselves sometimes, not really	4	They they what rules they make, does not make it the
5	having anything to discuss, so.	5	rule. What they do now is they bring it back either
6	JAY DOWNS: You want more work to do?	6	depending on whether it's the Bureau or the EMS committee,
7	TRACY BRAITHWAITE: We would certainly well,	7	they'll make a recommendation that comes back to either
8	yeah, you know, if we're going to take the time to come up	8	one of those two agencies. They work for both agencies,
9	to these meetings, yeah, I think it's the consensus of our	9	but they don't they just make recommendations back.
10	committee members, let's have something to actually	10	But it's the Bureau rule or if it's an EMS committee rule,
11		11	they bring those information back to those two committees.
12	discuss when we come up here.	12	• •
13	JAY DOWNS: Okay. TRACY BRAITHWAITE: Other than that, I have	13	Just so everybody knows, we made this this
		14	really emphasize it to those people who are on the
14	nothing else.	14	rules committee, that they represent the discipline that
15	JAY DOWNS: Okay. We'll take that under		they've been chosen from. They do not represent the
16	advisement. Thank you.	16	agency that they work for. Okay?
17	The next line item is is myself. It was	17	So if you have somebody from the sheriff's
18	actually Dean was Dean York? Yeah, from Provo, he	18	office and the Sheriff's Association, they don't
19	was he is the newly elected chair of the rules	19	represent, like like, they wouldn't come in and
20	committee.	20	represent Box Elder County. They represent the Sheriff's
21	JOLENE WHITNEY: He's actually the liaison.	21	Association for the State of Utah as a whole. And by
22	JAY DOWNS: Liaison, that's right. Correct.	22	doing that, we're looking at the rules as a state of Utah
23	Let me kind of give you a little history what's	23	rules and not necessarily agency.
24	happened with the rules committee. It's kind of like in	24	And I think that was some of the things that was
25	statute, there's a rules committee.	25	discussed on how we can make the rules committee better.
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1	So what we did is as you may recall from the	1	So that's one of the things that we are working on within
2	So what we did is, as you may recall from the	2	So that's one of the things that we are working on within the rules committee.
3	last year of going through the rules process and different	3	
4	committees and stuff, so what we did is we were tasked by	4	But it is up and going. Next meeting is on the
5	this committee to go and make a Rules Task Force and put	5	22nd, I believe, Susan, 22nd. So it's an open meeting. Anybody wants to come and attend. They've they've
6	it together. And we actually have done that. And we've	6	
7	had our first meeting, which was in December. Our next	7	voted to go four-hour meetings with a break in the middle.
	meeting's coming up in January. That Rules Task Force		So they plan on working hard on it. So it's up and going.
8	meets every month.	8	That's all I have to report on that.
9	To kind of give you an idea what we did, is we	9	Grants. The next line item is grants and Allan.
10	went through and we solicited a membership from the	10	ALLAN LIU: That was fast, Jay.
11	different organizations that EMS interacts with, i.e.,	11	JAY DOWNS: Good. Make yours.
12	like, some like the Fire Chief's Association, the EMT	12	ALLAN LIU: I'm Allan Liu, financial analyst for
13	Association, the Police Association the Sheriff's	13	the Bureau. There's three items on the table. I don't
14	Association, wasn't it?	14	know if the committee has received. There is a
15	JOLENE WHITNEY: Uh-huh.	15	subcommittee meeting that we had on November 20th. It was
16	JAY DOWNS: The Utah League of Cities and Towns.	16	an emergency one. What happened is we had audits of
17	Just a there was several other ones that we had to make	17	various EMS agencies, and there was an audit finding with
18	up this committee. This committee is made up of all these	18	Carbon County in their competitive grants.
19	different members. And what they do now, is they're	19	They purchased a training mannequin for \$800.
20	tasked right now going through the rules that were during	20	They submitted us for reimbursement, and they get
21	the the process where we were looking for public	21	reimbursed 50 percent. That's the matching portion they
22	opinion, they're going through those rules that people had	22	have to pay.
23	questions on. And that's what the Rules Task Force is	23	We processed that. With the audit auditor,
24	currently working on.	24	they noticed that the payment, the actual cost of the
25	There will be other things that will come down	25	mannequin was 499. So in turn the Bureau of EMS has paid
	Page 74		Page 76

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(Pages 73 to 76)

 with grant funds more than they should have. Fromit hoods tike it was an unintentional cherical error based on whole the firming edgeratment pays and what they received. And very ditentizes when people are purchasing, there's adiscount that's no noticed or applied. So, you know, the grant subcommitte had to make a recommendation on what to do moving forward. They recommendation on comit for fiscal year: 13 and 14. And they's wast to addi the grants for tow be and make a recommendation is to change the deadlines. This addit things that the and/ors found that is everyhody get reminues dinking characterization is the dual fiscal year '14. What they was to addit the grants for tow to and make a recommendation is to change the deadlines. They are currently in fiscal year '14. and financially we don't andit things in the future. That jake to service we're they the fit and the 'n the pays to use and make a recommendation. JACENE WITNENY: Well - the deadlines. They are there one of the reasons for bumping it up also wes the somer they can determine the allocation for the next year. So that somer they can determine the allocation for the next year. So the somer they can determine the allocation for the next year. So that somer they can determine the allocation for the next year. So they some they can but the irrolling is up allow wast to form that in a motion? JERI JOINSON: Yes. JAY DOWNS: That Allan presented for us? JERI JOINSON: Yes. JAY DOWNS: That was an action it may they are used the proposed discussion on that? So hostically what we're doing is we're marking a recommendation that the - the audif, the years '11 and '13, dright, and they we're form again. Gays, 50 any discussion on the motion? Second '14 and they need in a set im or you con it in the new first, second. '14, and first, they are they			1		
2 From - it looks like it was an unintentional in the second down in price, and they feed that that's not so in the deallines to have the advecting award on the grants. 3 and what they received. And very oftentimes when poople are purchasing, there's a discount that's not noticed or applied. So, you know, the grant subcommittee had to make a recommendation on what to do moving for sural. They and they frame and withing that her and unit first aly are '13. and this parts for sural '13 and first '14 and they are the function on. So, you know, the grant subcommittee had to make a recommendation on. 11 Was for fiscal '14. So over they want to addit they grants for the years. 13 Lo over and make a recommendation on. JOLENE WHITNEY: Yeah, Jolene. 14 Infect year '14. With and hit is not addit they grants for the year. JOLENE WHITNEY: Yeah, Jolene. 14 Infect year '14. Nith and hit is not so over yoby gets reinhoursed. JOLENE WHITNEY: Yeah, Jolene. 15 because fiscal year '14 and and thit is not so over yoby gets reinhoursed. JOLENE WHITNEY: Yeah, Jolene. 16 Internation of the cart year. So had year '14. So over yoby gets reinhoursed. 16 Internation on the year. JOLENE WHITNEY: Yeah, Jolene. 17 Internation on the year. JOLENE WHITNEY: Yeah, Jolene. 18 JOLENE WHITNEY: Yeah, Jolen	1	with grant funds more than they should have.	1	we're not reimbursing for projectors anymore. Projectors	
 derictal error based on what their finance department pays and what they received. And very ofteutines when people are purchasing, there's a discount that's not noticed or applied. So, you know, the grant subcommittee had to make a recommendation on what to 60 moving forward. They recommendation for fiscal '213. Both Star Yamue and thing saturation if fiscal year '14. This and that's what you need to vot and make a recommendation on. LotENE WHITNEY: Wel ~ JAY DOWNS: Yeah, Jolfiscal '14. JAY DOWNS: Yeah, Johnson: Hor years were hack to the recommendation. JAY DOWNS: That Johnson: His is awkard. JAY DOWNS: That Johnson: Yea. JAY DOWNS: That Johnson: Yea. JAY DOWNS: That Johnson: Yea. JAY DOWNS: Yeak, Johnson: The years the recommendation accept Alan's recommendation for the and the fiscal year' '14, and '13. JAY DOWNS: That Johnson: Yea. JAY DOWNS: Yeak, Janse see the add to for us? JAY DOWNS: Yeak, Johnson: Yea. JAY DOWNS: That Johnson: Yea. JAY DOWNS: Yeak, Janse see the addition of the second of the sec	2		2		
and what they received. And very offectimes when peak ar proximality of applied. Another item is the deadlines. We're changing the deadlines to have all receives and things submitted to our offecs ow can apprecisely and the protocol that so everybody gets reinbursed. 1 Carebor forsel 113 and 114. And that's what you need to vote and make a recommendation on. JOLENE WHITNEY: Well – JOLENE WHITNEY: Vell – JOLENE WHITNEY: Vell – JOLENE WHITNEY: Vell – JOLENE WHITNEY: Vell for a source of the ence year. 1 JOLENE WHITNEY: Vell in the - in the point to vote and make a recommendation is to change the integration of the ence year. 1 JOLENE WHITNEY: Vell in the - in the point to vote and make a recommendation is to change the integration of the ence year. 1 JOLENE WHITNEY: Vell in the - in the point the example of the ence year. 1 JAY DOWNS: Makes serse. 1 JAY DOWNS: Makes aresended on us? 3 JAY DOWNS: This is arkward. 2 JAY DOWNS: This is arkward. 3 JAY DOWNS: This is arkward. 3 JAY DOWNS: This is arkward. 3 JAY DOWNS: The data meet of the and the areading a recommendation. 3 <t< th=""><th>3</th><th></th><th></th><th></th></t<>	3				
5 are purchasing, there's a discount that's not moticed or applied. the deadlines to have all receipter and things submitted to 6 6 our office so we can process by end of the fiscal year 3 May 150t. That humps it up several weeks. However, for processing and things it's just accessary for us to do 1 7 is a process by and thing. Submitted to 5 our process by and things submitted to 5 8 are commendation on were want to add the grants for to we and make a recommendation an 12 Carbon for fiscal '13 and '14. And that's what you need 10 JOLENE WITTNEY: 'U = - 14 1 - during that time, I had a liftle heartburn 10 JOLENE WITTNEY: 'U = - 14 1 - during that time, I had a liftle heartburn 10 JOLENE WITTNEY: 'U = - 14 1 a fittle bit, is to and fift fiscal year '11 and addit 11 fiscal year '14. and fiscal year '14 and finactal year '14 and year wereas wereasta and thing's stand year '14 and finactal					
6 applied. 5 our office so we can process by end of the fiscal year by solutions on what to do moving forward. They recommend auditing Cardon County for fiscal year '13 and fiscal year '14. This audit thing that the auditors found '14. And that's what you need to vote and make a recommendation on. 7 May 15th. That height resons for barnpuised instead of getting caught without height resons for barnpuised instead of getting caught without height resons for barnpuised instead of getting caught without height resons for barnpuised instead of getting caught without height resons for barnpuised in stead of getting caught without height resons for barnpuised					
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24 JAY DOWNS: This is awkward. 24 processed and nothing's just a lax simply because of the volume of grants we get at the end of the year. 25 JERI JOHNSON: It is. I accept your Page 77 Page 79 1 recommendation. 1 JAY DOWNS: That Allan presented for us? JERI JOHNSON: Yes. 3 JERI JOHNSON: Yes. 1 Anybody got anything else? Thanks, Allan. 4 JAY DOWNS: You want to form that in a motion? 3 JERI JOHNSON: Yes. 4 JAY DOWNS: Statk like to make a motion to accept Allan's recommendations for the audit, fiscal year 1 AlLAN LU: I think you need a motion to - to 7 'I1 and 'I3. JAY DOWNS: Sconded? 3 JERI JOHNSON: This is an ection ig is we're making a 10 JAY DOWNS: Sheriff, second. 9 JERI JOHNSON: I's toomuch to say. 11 JAY DOWNS: Sheriff, second. 9 JAY DOWNS: Sheriff, second. 12 So basically what we're doing is we're making a 10 JAY DOWNS: Anything else for Allan for the grants commendation that the the audit, the years 'I1 and 'I3, right, and then we're going to make a recommendation that the the audit, the years 'I1 and 'I3, right, and then we're going to make a recommendation that the the audit in favor say ave. 12 12 So bascically what we're doing i	22	recommendation of recommendation.	22	agency reminders to try to submit things early, because	
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Page 77 Page 79 1 recommendation. 1 JAY DOWNS: That Allan presented for us? 1 JAY DOWNS: That Allan presented for us? 2 Anybody got anything else for Allan for the grants committee? Okay. I guess that's it. 4 JAY DOWNS: Yes. 3 grants committee? Okay. I guess that's it. 4 JAY DOWNS: Yes. 3 grants committee? Okay. I guess that's it. 5 JERI JOHNSON: I'd like to make a motion to accept Allan's recommendations for the audit, fiscal year 7 7 '11 and '13. 3 AY DOWNS: Sconde? 9 LYNN YEATES: I'll second. 9 JERI JOHNSON: I's too much to say. 10 JAY DOWNS: Sheriff, second. Okay. So any 10 JAY DOWNS: Sheriff, second. Okay. So any 11 discussion on that? 9 JERI JOHNSON: It's too much to say. 12 So basically what we're doing is we're making a '12 MARK ADAMS: So move that we adopt the proposed 13 recommendation that the the audit, the years '11 and '13, right, and then we're going to make a recommendation 14 guidelines from the grants committee. 14 Ware accept it as an action item next time or vote on 14 guidelines from the grants committee. 15	24	JAY DOWNS: This is awkward.	24	processed and nothing's just a lax simply because of the	
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Page 78 Page 80	25	is, like, competitive. For example, under computers,	25	RICHARD THOMAS: Well, thank you all very much	
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		Page 78		Page 80	

(Pages 77 to 80)

1		1	
2	for giving me a few minutes to talk about a project that	2	started in a hospital and were just used basically were
3	we've been working on in the EMSC Advisory Committee.	3	reported during transport.
4	By way of introduction, my name is Richard Thomas. I'm the team leader for the ED pharmacists at	4	We ended up with a list of 30 drugs. And then
5	-	5	what we did is, we tabulated the drugs based upon route of expose route of administration and on outcome.
6	Primary Children's. This all started actually back in 1970 when I	6	•
7	This all started actually back in 1979 when I had the privilege of being the first ED phormagist in	7	So hopefully you picked up these two rather
8	had the privilege of being the first ED pharmacist in California working at the University Hospital in Orange	8	small printed spreadsheets which are on the back table.
9	County. And the hospital had the contract for paramedic	9	The white one basically talks about routes of exposure and the purple one talks about outcomes.
10	training. And so I very quickly became involved in EMS.	10	So when we look at these drugs, we kind of
11	I was on the county EMS committee, as well as on the drug	11	grouped them into pharmacologic or therapeutic categories.
12	and equipment committee, which basically did all the drugs	12	We have basically some oral analgesic, antipyretics with
13	and equipment commutee, which basically durant the drugs and protocols for the Orange County paramedic system. And	13	Acetaminophen and Ibuprofen. We had some IV analgesics,
14	I chaired that committee for a number of years.	14	which are all opiates, fentanyl, meperidine and morphine.
15	After 12 years, I moved to Arizona where I was	15	We have a couple of what I loosely use this term anecdote,
16	quickly recruited to beyond the state EMS paramedic drug	16	but basically activated charcoal and naloxone,
17	and equipment committee, and I chaired that for a number	17	antiemetics, ondansetron, promethazine; drugs for
18	of years. I spent two years on the EMSC Advisory	18	seizures, lorazepam, midazolam; an antihistamine, even
19	Committee in Arizona and I've been on the EMSC Advisory	19	though promethazine is an antihistamine, it's not usually
20	Committee here for five years. That's almost 30 years of	20	used that way. Diphenhydramine is usually the agent of
21	involvement in pre-hospital care. And almost continually	21	choice for that. One antipsychotic, a variety of
22	for those 30 years, I've been frustrated by the inability	22	different cardiovascular agents, adenosine, dopamine,
23	to answer some very simple basic questions. How are drugs	23	epinephrine, nitroglycerine, et cetera; some glycemic
24	used in the pre-hospital care setting? And do they make a	24	agents, glucagon and dextrose; a couple of respiratory
25	difference? What are the outcomes of using those drugs?	25	drugs for inhalation, albuterol and ipratropium. And then
	Page 81		Page 83
1	Well, obviously we'd love to have a double-blind	1	
		1	RSI agents. Atomadig. sudsonel and vecuronium.
2		2	RSI agents, Atomadig, sudsonel and vecuronium. So what are the drugs that are given to kids?
2 3	randomized controlled study to answer those kind of		So what are the drugs that are given to kids?
	randomized controlled study to answer those kind of questions, but we don't have those kind of resources. I	2	So what are the drugs that are given to kids? Well, you could probably have guessed this, but it's nice
3	randomized controlled study to answer those kind of questions, but we don't have those kind of resources. I was very pleased and delighted when I got here to Utah and	2 3	So what are the drugs that are given to kids? Well, you could probably have guessed this, but it's nice to have some actual data to support what was your guess.
3 4	randomized controlled study to answer those kind of questions, but we don't have those kind of resources. I	2 3 4	So what are the drugs that are given to kids? Well, you could probably have guessed this, but it's nice to have some actual data to support what was your guess. So we can see that there are two drugs, morphine
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you can see what the percentages are, and they don't vary
 a lot. Although, again, you can see ondansetron here has

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of the analysis. We also eliminated any drugs that were

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1	gone up significantly in its use, over just this five-year	¹ whatever I say, first of all, is from Richard Thomas.
2	time period.	² This is not IHC speaking, this is not Primary Children's
3	HALLIE KELLER: Richard, is that inhaled	³ speaking, but I'm going to show you three very quick
4	epinephrine?	4 examples that might be a way to utilize this data.
5	RICHARD THOMAS: That is all forms of	5 So the first question is: How's fentanyl being
6	epinephrine.	⁶ used? Well, 81 percent of the time when fentanyl is being
7	HALLIE KELLER: All forms.	 ⁷ given, it's being given IV. But we know it can also be
8	RICHARD THOMAS: All forms of epinephrine. And	⁸ given intranasally. So how well since we introduced the
9	if you look on the sheet where it shows routes of exposure	 ⁹ guidelines almost five years ago for using fentanyl
10	routes of administration, you can see all the different	¹⁰ intranasally is it being used?
11	types of ways in which epinephrine is being administered	11 Well, in the first study period it was used 13
12	in a pre-hospital setting.	¹² times. In 2012, it was used 16 times. That would
13	Now outcomes. I cannot find anywhere in any of	¹³ probably suggest an under utilization of this very simple
14	the literature excuse me, any of the documentation that	14 and effective route for delivering fentanyl, particularly
15	I have about Polaris and NEMSIS as to exactly what these	¹⁵ in kids where it is difficult to establish an IV.
16	defin what the definitions of these things are. I have	¹⁶ Why aren't we using more intranasal fentanyl?
17	to assume that when a medic is filling out a report run	17 Well, you'll have to be the ones to answer that question.
18	and they get to the field that asks the question, what was	18 But it would suggest that maybe we need to review our
19	the outcome, there's a little bit of subjective decision	 ¹⁹ local protocols for how we're using it and look at our
20	making going on here.	 20 education for our medics.
21	So improved, unchanged, worse, those are	21 Another one would be, we've got two antiemetics
22	probably the three that we are most interested in. The	 that are on our on our formula here. We got
23	good thing is, is that if you look at worse, that is a	 ²³ ondansetron or Zofran and promethazine or Phenergan. How
24	very rare outcome.	 are those being used?
25	On the other hand, we see what seems to be an	25 Well, we clearly saw earlier in the list of the
	On the other hand, we see what seems to be an	weight of clearly but carrier in the list of the
	Page 85	Page 87
1	increasing improvement in the outcome of patients who are	¹ drugs that we're seeing an increasing use of ondansetron.
2	receiving pre-hospital outcomes. Again, you have to be	² Are we seeing a decreased use of promethazine and
3	very careful when you look at definitions and understand	³ reciprocate as a reciprocal? Well, let's see.
4	the subjectivity of this database. But it looks like for	4 Ondansetron, 442 times in this almost three-year
5	the most part, at least almost two-thirds of the time when	⁵ period. In one year it was almost 580 times.
6	we give a drug, we're getting some kind of observable	⁶ Consequently, promethazine has now gone from 61 times down
7	benefit in pre-hospital care.	7 to 28 times. Twenty-eight times is not very often to
8	Now it would be really nice to better define	⁸ maintain a drug on a paramedic formular.
9	what that is for the different drugs and their uses, but	⁹ And so one could ask or make the recommendation
10	at least now we have a tool when we begin to look at that.	¹⁰ why don't we Peter.
11	Now, I have to frankly say that these are a	11 DR. PETER TAILLAC: Is this peds only, Richard? 10 DESUMPTION OF COMPACT AND ADDRESS OF COMPACT ADDRESS OF COMPAC
12	little bit confusing as to when a medic would code the	12 RICHARD THOMAS: This is peds only. 13 DD DETED TABLES G. (1)
13	response to a medication using one of these terms: Not	13 DR. PETER TAILLAC: Gotcha. Okay. Because it's
14	applicable, not available, not known, not recorded, not	14 used for adults as well?
15	reporting. It would be interesting to see how those are	15 RICHARD THOMAS: Yes. Absolutely. And, you
16	all used.	¹⁶ know, when you look at a paramedic formulary, and I've
17	The good thing is that they're not used an awful	¹⁷ spent, as you can tell, a lot of years discussing how
18	lot, maybe one out of every five cases. This area right	¹⁸ drugs are are get on those lists, you have to,
19	here obviously speaks to the QA of the process. At least	¹⁹ again, have a balance between what makes sense
20	when I get the data, if if it doesn't have any one of	²⁰ pharmacologically, what are the medical what are the
21	those, and it's just completely blank, I have to assume	21 preferences of medical control, what they're comfortable
22	that no information was ever entered. So it would really	²² with and so forth.
0.0		
23	be nice to get these numbers much lower and having at	23 So this is just pediatrics. And again, this is
24	be nice to get these numbers much lower and having at least something up here that would be useful to us.	 So this is just pediatrics. And again, this is Richard Thomas speaking, and you can attribute these only
	be nice to get these numbers much lower and having at	23 So this is just pediatrics. And again, this is

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1	can get rid of promethazine all together for something	1	when we started the transition, we had 3,500 EMTI's in the
2	that is used so, so infrequently, at least in pediatrics.	2	state. Yesterday when I looked, we had 461 that had not
3	Now the same kind of analysis can easily be done in adults	3	done the transition that were still certified. So those
4	as well.	4	actually became as of December 1, they became EMTs. So
5	And last but not least, let's look at our two	5	we have basically 561 that went back to becoming an EMT.
6	anti oral antipyretic, anti or analgesic agents. We	6	Now we did we tried to give them every
7	have Motrin or Ibuprofen and Acetaminophen. Now, again,	7	opportunity to make that switch because you know how they
8	you have to be careful in analyzing looking at this	8	are. They they either didn't hear about it or even
9	data, but it is very interesting that when you compare	9	though it's been going on for a year. So we have made it
10	Acetaminophen in this first time period, it was improved	10	still an option for them. They can't take the short
11	42 percent. The second time period it was 43 percent,	11	transition testing any longer, but they can come back in,
12	compared to 60 percent for Ibuprofen and 64 percent in the	12	take the 150 question AEMT test, redo all their
13	second time period. Do you really need two oral	13	everything else, and still pick up that AEMT certification
14	antipyretic oral analgesics? Again, a question that needs	14	until the end of their certification date. So they won't
15	probably further research and further evaluation.	15	be able to carry it on forever, but up until the end of
16	So there are a number of these kind of questions	16	their certification period, they can still pick up that
17	that we now have the ability to analyze this data and you	17	AEMT if they want to do that. We figure that's every
18	start to address those issues. Clearly, they need further	18	opportunity that we can have to give to them to be able to
19	study in some cases. This can't be the beginning and end	19	do that.
20	of our analysis, but the data is there. I would highly	20	One other thing, then, we have, just to let you
21	recommend that if someone isn't doing this for adults,	21	know how many AEMTs we now have in the state, we have
22	that we begin to do that, because I think there is much to	22	3,053 AEMTs now. So we we feel pretty good about that.
23	be gained from it. And if all it does is raise more	23	We feel like the transition went pretty flawlessly.
24	questions and cause us to be more accurate in our	24	Paul came to me not too long ago and said he had
25	documentation, and raise more questions about how we can	25	only one complaint from people on it, which I thought was
	, 1		
	Page 89		Page 91
1	better capture the real outcomes, it will only make us	1	good, and I knew he was going to get that one, because I
2	better in our delivery pre-hospital care to our patients.	2	sent it to him. So we really felt really, really pretty
3	Any questions? All right.	3	good about that, when there's some of the states that
4	JAY DOWNS: Thank you. That was very	4	haven't even hardly started it and very few have even
5	informational. Good information.	5	completed it. So we feel actually really good about that.
6	Professional development EMR testing and	6	Any other questions? Okay. Thank you.
7	national registry. Dennis.	7	JAY DOWNS: Thanks, Dennis. Okay. The next on
8	DENNIS BANG: I'll make mine quick. Dennis	8	the agenda is Dr. Taillac. State EMS guidelines, protocol
9	Bang, Bureau of EMS. Ours is just kind of an update. We	9	guidelines.
10	when you guys sent us back to look at the EMR testing	10	DR. PETER TAILLAC: I don't probably have too
11	with National Registry, we had our committee look at that,	11	much new news. We did launch officially and put on the
12	think about it, talk about it, we discussed it for quite a	12	website the Utah EMS protocol guidelines is the official
13	bit. They felt like it was better to leave EMR with the	13	word. It's formatted like it could be like like they
14	Bureau rather go with with National Registry due to the	14	are, protocols, so if an agency wanted to just adopt them
15	it would be it would be more costly for for them	15	and put their name at the top, they could do so. But the
16	to do that. And we felt we're struggling with it now.	16	intent is for them to be guidelines for agencies to
17	We're not getting that many courses and we're trying to	17	utilize or to emulate or to adjust such that it meets the
18	build that program rather than kill it. We feel like that	18	needs of their agency specifically. Comments are welcome.
19	one actually would be a negative rather than a positive to	19	They will be updated on a regular basis at a minimum
20	do that. We are going to go ahead with the AEMT in July,	20	every two years and then republished. We're kind of proud
21	and send that over to the National Registry, but we want	21	of them. I've gotten very good feedback.
22	to keep EMR with National Registry or not with National	22	I'd like to, again, thank publicly Dr. Mark Bear
23	Registry.	23	and the rest of the committee, some of whom are on this
24	The other item we had was an update for the	24	committee here, for helping us with it and I think turning
25	transition from the AEMT. We had at the beginning of this	25	out a pretty good product. So I'm real interested in
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23

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		1	
1	feedback. So please let me know. And feel free to use	1	the Bureau of EMS. And 2014 is going to be a strategic
2	them. If you want them, they're all yours.	2	planning year. In 2015, we'll be launching a new
3	Yes, sir.	3	five-year strategic plan. So the basic discussion for
4	ANDY SMITH: Are they in Word format so I can	4	this year, and for this committee specifically, is going
5	literally just copy and paste my information on them?	5	forward what do we want the EMS system in Utah to look
6	DR. PETER TAILLAC: Great question. So what	6	like the next five years? And specifically what do we
7	I've asked, just to sort of do version control, is if	7	want the priorities of this committee to be for the next
8	you'd like them in Word format, I will send them to you	8	five years? So we want to have that discussion. We are
9		9	
10	specifically. I don't want to publish them on the web in	10	looking at having a retreat, kind of a half day thing to
	Word format, though.	11	to discuss these issues. The proposed date for that is
11	ANDY SMITH: Okay.	12	March 24th 25.
12	DR. PETER TAILLAC: Does that make sense? So		JOLENE WHITNEY: Twenty-five.
13	send me an email if you haven't sent me one. And when you	13	WHITNEY LEVANO: March 25. It's a Tuesday, kind
14	do that, then if you're going to change them at all, you	14	of half day in the morning. And so we'd like to get that
15	know, just be sure you put your name on it so it	15	on your agenda or on your calendars now. And if you have
16	doesn't be on the original, if you will.	16	any objections or any conflicts, we'd like to know about
17	JAY DOWNS: Jolene.	17	that. So hopefully we can get a quorum there. But
18	JOLENE WHITNEY: I just wanted to mention, too,	18	between now and then take some time to think about what
19	that the medical directors meeting we're having in	19	what you think for our EMS system, and to hear from the
20	ALLAN LIU: March.	20	people that you represent on this committee as well.
21	JOLENE WHITNEY: March 17th in Springdale, if	21	The second thing I wanted to mention also is
22	I remember right. So just to encourage the agencies to	22	we've been conducting a statewide assessment of EMS
23	get their medical directors to attend.	23	agencies. It's basically a survey asking some questions
24	DR. PETER TAILLAC: Yeah, if you want we're	24	about online and offline medical direction, a few optional
25	going to have our annual medical directors workshop	25	questions about child safety restraints in ambulances and
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1	Manah 17th, which is a honofit to them because it's great	1	nucleaned einmen devices. Very may have seen this on the
2	March 17th, which is a benefit to them because it's great	2	preferred airway devices. You may have seen this on the
3	information in collegiality. It will be in Springdale.	3	front table. You can pick one up. All these smiley faces
4	The date was changed, and I haven't actually sent it out	4	of the 116 EMS agencies in our state, we've had 75 percent
5	to the docs yet. It just changed the other day from	5	complete the assessment already. So we're very pleased
	April 7th to March 17th because of conflicts in the		and thank you to all of you who completed it. There's a
6	calendar.	6	handful that we're going to follow up with and they're all
7	JOLENE WHITNEY: What time?	7	listed on here with the contact.
8	DR. PETER TAILLAC: All day. So it will start	8	If you do have one of these sheets and you have
9	at 8 o'clock. We'll be done by two or three. We will pay	9	a chance, take a look through the contact list. I'm
10	the docs to travel and give them housing the night before	10	finding the ones that haven't filled it out, I generally
11	at the Zion Inn, I think, right, Allan?	11	have the wrong contact, that person hasn't worked there in
12	ALLAN LIU: Zion Park Inn.	12	two years, or I've been sending something to the wrong
13	DR. PETER TAILLAC: Zion Park Inn. So they are	13	address. So if you know these people and they're not the
14	welcome to make it a weekend if they want or just go to	14	right contacts for these agencies, let me know. If you
15	the meeting. So please encourage your docs to come. It's	15	know these people and they are the right contacts and you
16	a good meeting and it does also count for their annual	16	know them well enough to talk to them, feel free to tell
17	every four-year required updates to stay certified by the	17	them that this is an important survey and we'd love for
18	way.	18	them to fill it out. If you are one of these people,
19	JAY DOWNS: Good. Thank you.	19	come talk to me and we'll get the survey done for you.
20	DR. PETER TAILLAC: We're working on some CME	20	So again, there's little less than 30 left that
21	for it. I don't know if we'll pull it off for this year.	21	need to complete this survey and we have a couple weeks.
22	I would love to.	22	So, yeah, any questions? Okay. Thank you.
23	JAY DOWNS: Another informational item, the	23	JAY DOWNS: Okay. Last informational item.
24	strategic planning retreat. Whitney?	24	Tammy, EMS week.
25	WHITNEY LEVANO: Yes, I'm Whitney Levano, with	25	TAMI GOODIN: Yes, we wanted you to know the EMS
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1	awards ceremony for July 9th to coincide with the EMS	CERTIFICATE
2	Committee so it's helpful to have them both together. So	
3	we'll have the nomination forms online by the end of this,	STATE OF UTAH)
4	hopefully next week, but no later by the end of January.) County of utah)
5	So we just look forward to everybody submitting their	COUNT OF OTAM)
6	nominations. We have nominations for individual and	This is to certify that the foregoing proceedings were
7	incident of the year. So just to let you know that's when	taken before me, Susan S. Sprouse, a Certified Shorthand
8	we'll have our award ceremony.	Reporter in and for the State of Utah, residing in Salt
9	Can I ask one question for clarification	Lake County, Utah;
10	regarding North Sanpete? For the North Sanpete, what	
11	direction do they go? Can they apply now for their	That the proceedings were reported by me in stenotype, and
12	application or do they wait?	thereafter caused by me to be transcribed into printed
13	HALLIE KELLER: They still have to wait for	form, and that a true and correct transcription of said
14	approval.	testimony so taken and transcribed is set forth in the
15	JAY DOWNS: Jolene.	foregoing pages, inclusive.
16	JOLENE WHITNEY: We'll be able to get the	DAMED this 22 day of Jonuary 2014
17	recommendations from the committee today out to the other	DATED this 22 day of January, 2014.
18	committee members that were not present for their input.	
19	If they vote favorably for those	
20		
21	TAMI GOODIN: Okay.	SUSAN S. SPROUSE, RPR, CSR
22	JOLENE WHITNEY: then they can move forward.	LICENSE NO. 5965543-7801
23	TAMI GOODIN: Okay. Thank you.	
23	JAY DOWNS: We got that information during the	
24	meeting. We're efficient up here.	
25	Anyway, other than that, next meeting is	
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	rage y,	1490 77
1	April 9th at 1 p.m. here in this area. Otherwise, we'll	
2	look for an adjournment. Motion?	
3	MIKE MOFFITT: Motion to adjourn.	
4	•	
5	JAY DOWNS: Okay. Second.	
6	LYNN YEATES: Recommendation to adjourn.	
7	JAY DOWNS: Recommendation to adjourn. We are	
8	adjourned. Thank you everybody.	
9	(Meeting adjourned at 3:00 p.m.)	
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