

STATE EMS COMMITTEE MEETING

April 1, 2015

1:00 p.m.

Location: 3760 South Highland Drive

Third Floor Auditorium

Salt Lake City, Utah

Reporter: Angela L. Kirk

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A P P E A R A N C E S

Kris Kemp

Paul Patrick

Michael Moffitt

Laonna Davis

Casey Jackson

Russell Bradley

Mike Mathieu

Jason Nicholl

Brett Kay

Mark Adams

Margy Swenson

Jeri Johnson

Jay Dee Downs

Hallie Keller

Suzanne Barton

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Wednesday, April 1, 2015; 1:06 p.m.

P R O C E E D I N G S

KRIS KEMP: All right. We're ready to get started, and so if everybody wouldn't mind please taking your seats, and we'll get things going for our state EMS committee meeting for today. Sorry, we're just running a little bit late. We're going to try to end early, although there are some -- how do I put this -- interesting topics that we need to discuss in some level of detail.

Again, you know, welcome to all of you that are in attendance. I think you can all see who we are. And hopefully we can have our court reporter see who we are as well. That's why our name tags are at a bit of an angle.

With that, we can review and -- the minutes from our last meeting, dated January 21st, 2015. We have the minutes in front of us. Any points to discuss versus approval of the minutes?

JASON NICHOLL: Motion to approve.

KRIS KEMP: We have a motion to approve the minutes.

MICHAEL MOFFITT: Second it.

KRIS KEMP: And a second. All in favor, say aye.

1 **COLLECTIVELY:** Aye.

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

4 Trauma rule change, Bob Jex.

5 **BOB JEX:** Okay. You have in your packet --

6 **PAUL PATRICK:** There's a microphone at the
7 back of the podium. Do you want to use it, or...

8 **BOB JEX:** Where would you like me?

9 **BOB GROW:** Just keep turning circles.

10 **BOB JEX:** That's what I feel like. You want
11 me back here? It sounds like the back row can't hear
12 me very well.

13 **UNIDENTIFIED MALE:** That's our fault.

14 **PAUL PATRICK:** You have to push the button
15 and it will come on.

16 **BOB JEX:** So if the green light works, it's
17 on?

18 **PAUL PATRICK:** Yeah.

19 **BOB JEX:** Okay. The rule change that you
20 have in front of you is the additions that we're
21 suggesting to R426. Let me give you a little bit of
22 background on this.

23 There are essentially three elements of this
24 rule change that we're proposing that are there. First
25 of all, in -- well, let me give you a little history.

1 Typically, the rules governing trauma center
2 designations, they follow American College of Surgeons
3 criteria. And the American College of Surgeons has
4 changed their criteria for designation -- designating
5 trauma centers. And we're proposing that our rule be
6 changed to reflect the changes that are there.

7 The first one that we're asking for your
8 approval of is R426-9-3, which is entitled "Trauma
9 Center Categorization Guidelines." And in essence,
10 what we're saying is that instead of the ACS guidelines
11 of 1996, we're proposing that we adopt the ACS
12 guidelines dated 2015.

13 That would have two effects. Number one, it
14 would change the criteria which we use for the
15 designation process, and it would do away with the
16 level V designations that we've had in the past,
17 because the criteria for level V under the new ACS
18 guidelines are incorporated in the level IV guidelines
19 in the new book. So we're asking for that.

20 Additionally, we're asking that the rule be
21 changed to direct the bureau on an annual basis of the
22 need for additional trauma centers based upon trauma
23 system needs.

24 And then we're asking that the rule be
25 changed, or rule be amended, to reflect that process

1 change.

2 And finally, the National Trauma Center
3 Databank, the NTCD, has changed their dictionary, and
4 we're asking that the rule be changed to reflect that
5 so that our trauma -- so that our data complies with
6 the new data standards nationally. Excuse me.

7 The other changes that we're asking for is a
8 change in process and designation criteria. Beginning
9 in 2013, the Trauma System Advisory Committee started
10 looking at criteria to more fully designate
11 appropriately, based upon need, trauma centers in the
12 state.

13 They directed the Department to develop a
14 white paper that proposed that change, and which we
15 did, and presented to them. And in the last year we've
16 been developing rules to reflect that direction from
17 the Trauma System Advisory Committee.

18 We're asking that R426-9-4 be changed to
19 reflect the process that the Trauma System Advisory
20 Committee recommended, and that the designation process
21 R426-9-6 be amended to reflect trauma center
22 designation based upon need of level I and level II
23 trauma centers in the state, in addition to what we
24 have now.

25 **KRIS KEMP:** Okay. Discussion? Mark.

1 **MARK ADAMS:** Yeah, thank you, Bob. One
2 question, you mentioned there was a white paper that
3 was presented to the Trauma System Advisory Committee.

4 **BOB JEX:** That's correct.

5 **MARK ADAMS:** Have we been able to see that?
6 Have we -- is that -- have we been privy to that at
7 this level?

8 **BOB JEX:** You -- you didn't receive it. The
9 short answer to that is, you're privy to it, but we
10 didn't disseminate it to you.

11 **MARK ADAMS:** One of the things I want to -- I
12 want to recognize, Bob, I know that the Trauma Center
13 Advisory Committee has been working on this issue, and
14 I appreciate and respect that. I -- I just need to
15 share with you a couple of significant concerns about
16 specifically 9-4, the trauma review process amended
17 rule changes, and 9-6, the designation process.

18 I think what the committee is recommending
19 really represents a fundamental change in how we will
20 review trauma center designations and the process for
21 designating new ones, as well as review existing trauma
22 centers.

23 And the thing that concerns me is that it
24 almost looks like it is a quasi-certificate of need
25 process, which, you know, there may or -- may be a lot

1 good reasons for that, but to me, it's such a
2 fundamental change that I'm concerned that without
3 further review and understanding, almost, behind that
4 that we're going to make a knee-jerk decision here and
5 not really understand everything that's behind that.
6 So that's one of my specific concerns.

7 But when I look at these rule changes and
8 proposed processes, it appears to me that it's less
9 about new centers and existing centers representing the
10 quality of care that they can provide, and it speaks
11 more to what will be the impact on other centers. And
12 to me, that's a fundamental shift.

13 And so I have some real concerns about
14 quickly implementing these without studying that
15 further and understanding, and asking to find out if
16 there has been really good input from the level I and
17 II trauma center hospital representatives throughout
18 the state.

19 I know there's some representation on the
20 advisory committee, but I don't know that it's
21 necessarily a good reflection of the existing level I
22 and II trauma centers in the state. So that's one
23 concern that I have.

24 And -- and I have some specific questions. I
25 think some of the criteria are somewhat nebulous and

1 it's hard to understand exactly how they would be
2 applied and what they mean.

3 For example, one of the criteria is it gives
4 new trauma centers decrease the competency or training
5 available of existing centers. How do we define that?
6 You know, is that going to be an objective criteria?

7 And then there's a few other details that I
8 just have concerns about that I think we'd be -- we'd
9 be remiss to not understand the science behind what
10 this is about and understanding from the Trauma System
11 Advisory Committee why they're specifically
12 recommending these very specific process changes.

13 **BOB JEX:** Okay. I -- I understand your
14 concerns. Let me just say to you that the American
15 College of Surgeons does outline specific criteria for
16 volumes of level I trauma centers, and that volume is a
17 minimum of 1200 trauma admissions a year.

18 They don't -- they don't outline criteria for
19 level II trauma centers, although there has been some
20 of that discussion on a -- on a national level.

21 As the Trauma System Advisory Committee
22 looked at these recommendations, they did take that
23 into effect. And it's our -- it's our desire to ensure
24 that existing trauma centers providing definitive care,
25 namely our level I and level II trauma centers, don't

1 have their volumes depleted to the point that they're
2 no longer able to provide effective trauma care.

3 The national data are pretty -- is pretty
4 clear that the more trauma you do, the better you are
5 at it. And if you were to decrease that volume to a
6 certain point -- and I don't know what that is -- we're
7 afraid that the quality of trauma care would suffer.

8 Right now, our level I and level II trauma
9 centers do an outstanding job in providing definitive
10 care to your trauma patients.

11 We are prepared, though, to provide
12 additional information as -- as you outline.

13 **KRIS KEMP:** Other comments?

14 **MARK ADAMS:** Well, let me just say I can
15 understand and appreciate the need to make sure we're
16 ensuring the high-level definitive trauma care in this
17 state. We've done a great job. We don't want to lose
18 that.

19 I think where I have concerns is, I want to
20 make sure we're balancing the market approach and we
21 don't eliminate potentially new providers that want to
22 come and provide trauma care, if they can demonstrate
23 they can do it in a quality way and have the outcomes.
24 That's just something I think we need to --

25 **BOB JEX:** Well, and then --

1 **MARK ADAMS:** -- assess further and clarify.

2 **BOB JEX:** I understand that, and I respect
3 that. The issue that brought this to the forefront
4 over the last two years with the Trauma System Advisory
5 Committee is literature coming out of specifically
6 Florida that talks about hospitals in a -- in, quite
7 frankly, large metropolitan areas developing multiple
8 trauma centers within a small geographic area of
9 existing trauma centers, and resulting in multiple --
10 multiple transfers, unfettered trauma activation
11 charges, and quite frankly, taking unfair advantage in
12 the free market system of the trauma system. And we're
13 just anxious that that not happen here in Utah.

14 Utah is a maturing trauma system. We have 23
15 trauma centers in the state now. We have six level I
16 and level II trauma centers. We think that based upon
17 our population that that is sufficient for us at this
18 particular time.

19 We recognize that in the future our
20 population may increase to the point that we are
21 required to have additional trauma centers to meet the
22 need, and we certainly want our rule to reflect that.
23 And we want the EMS Committee to be satisfied that the
24 rule does indeed do that.

25 But to base it solely upon the fact that a

1 hospital wants to become a level I or level II trauma
2 center and are willing to spend -- and are willing to
3 spend the money to do it, I don't think that the
4 community is well served by strictly market forces
5 providing that.

6 **KRIS KEMP:** Okay. Any additional comments?

7 And then, since this is an action item, I
8 guess we're looking for a motion in one form or
9 another.

10 **MIKE MATHIEU:** I'll make a motion for
11 consideration. How about if under these rules --
12 because there seems to be significant question about
13 9-4 and 9-6, I'll make a motion that we adopt Rule
14 R426-9-3 and R426-9-7 as stated, but exclude R426-9-4,
15 426-9-6, which also implicates excluding 426-9-1
16 because they're the same as 426-9-4, exclude those
17 three until which time the administrators from level II
18 trauma centers and I's, level II and level I's, can
19 maybe meet with TCA and go over these sections, get
20 further clarification or maybe further understanding of
21 the meaning behind them, because it sounds like there's
22 a couple of statements in there that might be vague in
23 terms of "may" or "will." Until we can get those
24 clarified, I don't think we feel comfortable with going
25 with the whole document. So that would be my motion.

1 **KRIS KEMP:** Okay.

2 **JASON NICHOLL:** Second.

3 **KRIS KEMP:** We have a second to the motion.

4 All right. And all in favor, say aye.

5 **COLLECTIVELY:** Aye.

6 **KRIS KEMP:** Any opposed? And any abstained?

7 Thank you. Thanks, Bob.

8 Dispatch rule, Guy.

9 **GUY DANSIE:** Okay. This particular sentence
10 has caused us a lot of heartburn for the last several
11 months, actually, with our rules task force, and we
12 brought it to the committee to discuss. And as a
13 courtesy to the task force, it was felt that their
14 voice hadn't been heard, so we're bringing it back
15 again for -- for another time and to have some comment
16 on this. This is the only part of our operations rule
17 that hasn't been agreed to and hasn't been finalized
18 so we can send it through.

19 Basically, I have a little sheet with three
20 different versions of what was stated in our draft
21 rule, and I inadvertently flip-flopped the first two.
22 Chronologically, the second one -- I always have to
23 throw an error in there somewhere -- the second one,
24 which says, "As approved by the EMS Rules Task Force on
25 July 23rd of 2014, it says, all emergency medical

1 incidents shall be coordinated through a designated
2 emergency manual dispatch center who dispatches for the
3 exclusive licensed provider." And that was what the
4 task force had come up with, and felt that that was the
5 original intent of their work.

6 As it came through to the EMS Committee for
7 review, and on December 3rd, the committee modified it
8 slightly and said, "All emergency medical condition
9 patient transports shall be coordinated through a
10 department designated emergency medical dispatch
11 center."

12 When that went back to the EMS task force,
13 there were -- there were people that were feeling like
14 it hadn't been represented fairly, and so as one of the
15 action items of that group, I went to the 911 committee
16 of the state to get the take of the dispatch community
17 as a whole. And I have a couple of them here today to
18 report on what their -- their sense is for this.

19 And then, thirdly, before I turn the time
20 over to them, I've discussed this with Brittany Huff,
21 our legal counsel, and then her supervisor, and they
22 came up with the following as just an option. It's
23 nothing -- it hasn't been vetted before, so just this
24 is something to think about, is, "All emergency medical
25 condition patient transports shall be coordinated

1 through a designated emergency medical dispatch center
2 except, (a) when directed by a physician or other
3 designee for a specific patient's medical incident, or
4 (b) when there is a written agreement approved by the
5 Department between a licensed provider and a designated
6 dispatch center."

7 The feeling behind that was, is that it
8 allowed a physician to do something that they have
9 done, and part (b) would allow Salt Lake County to
10 continue to operate with agreements, but those would
11 have to be approved through the Department, rather than
12 just, you know, a floating agreement between two
13 parties.

14 Anyways, I'll turn the floor over to Justin.
15 Would that be all right?

16 **JUSTIN GRENIER:** And I've got --

17 **GUY DANSIE:** And Eric -- and Eric Parry. And
18 they represent the 911 committee for the state.

19 **JUSTIN GRENIER:** All the way back here, huh?
20 I'm Justin Grenier. I'm the assistant manager for the
21 St. George Washington County 911 center, and currently
22 the chairman of the state 911 committee. I have with
23 me Mr. Eric Parry, who is the program manager for the
24 state 911 committee as well.

25 I've been participating and listening in, as

1 much as time allows, and communicating with Mr. Dansie
2 as well regarding these rule changes. I think it's at
3 a point now where he's got it kind of settled.

4 As far as the specifics, I really like and
5 would encourage the third one on the list. I'm not
6 sure where that is in your pecking order because you
7 said that changed, but the R426-4-600 that says, "All
8 emergency medical condition basic transports shall be
9 coordinated through designated emergency 911 dispatch
10 center, with exceptions."

11 And I think the exceptions are important,
12 that they really are -- it's exactly what we have
13 working in Washington County. We've worked with Gold
14 Cross in that regard. It has suited our needs, but
15 suited theirs as well, I believe, and not imposed any
16 undue burden on our call center. We don't have any
17 additional calls that we can't handle, and everything
18 is, like I say, status quo or business as usual, but it
19 is consistent with what we would expect in EMS.

20 So it works best for us. It allows us to
21 tailor what -- what our fire chiefs, what our EMS
22 chiefs have asked for, and that it seems to allow
23 everyone enough wiggle room to make things work for
24 them, as far as rural or urban or the specifics of
25 their agencies.

1 And do you have anything?

2 **ERIC PARRY:** No, that summarizes it.

3 **JUSTIN GRENIER:** If there's any questions, I
4 was -- I was asked to come in case there were questions
5 on anything 9-1 related, and I'm happy to do that, but
6 I think that third rule, or at least on the page that I
7 got from Guy it was the third one, allows us enough
8 latitude for everyone to do what's best in the interest
9 of the citizens.

10 **KRIS KEMP:** So, for clarification, what you
11 have in Washington County is effectively what's listed
12 here as the third option. And you're doing that
13 without rule, without someone saying you have to do it?

14 **JUSTIN GRENIER:** Correct.

15 **KRIS KEMP:** You're just doing it because
16 that's better business?

17 **JUSTIN GRENIER:** I wouldn't even classify it
18 as far as without rule. The City of St. George adopted
19 an agreement with Gold Cross specifically that's
20 hammered this out. And I didn't ask Mr. Moffitt if he
21 had any clarification, but that's exactly what we
22 agreed to with them. It seems to work just fine.

23 **KRIS KEMP:** But you essentially did that --

24 **JUSTIN GRENIER:** Correct.

25 **KRIS KEMP:** -- on your own, working together?

1 **JUSTIN GRENIER:** Yes.

2 **KRIS KEMP:** Comments?

3 **JASON NICHOLL:** I -- Mr. Chair?

4 **KRIS KEMP:** Yeah.

5 **JASON NICHOLL:** Turn on my microphone because
6 I'm not loud enough. I have to echo something that you
7 just said. So, essentially, give or take, 28 of the 29
8 counties in the state, the current language, as it is
9 written, not this stuff, but the current way things
10 work, is working. Salt Lake, Box Elder, Cache,
11 Washington County, the system tends to be working. And
12 there's really kind of one county where this is not
13 working. Is that correct?

14 **JUSTIN GRENIER:** I wouldn't classify it as
15 that. I don't -- I don't know what data you're using
16 to classify it as correct or working. I would just say
17 that in past meetings where there have been comments
18 about two separate EMS systems, or perhaps maybe the
19 closest unit not being sent, I believe there is some
20 truth to that. We certainly had it.

21 I think it would probably be a misstatement
22 to say it doesn't work here in Washington County and
23 works everywhere else. I don't have facts to support
24 that.

25 **JASON NICHOLL:** And that's not what I'm

1 saying, that it doesn't work in Washington County.

2 **JUSTIN GRENIER:** Okay.

3 **JASON NICHOLL:** I'm just saying, by and
4 large, the system works statewide, as it is current --
5 as it is currently written in rule.

6 And the example that you gave about how
7 Washington -- or the City of St. George and Gold Cross
8 entered into an agreement, you inferred that it was
9 like a rule solution, but it is in fact not a rule
10 solution at all. It's an independent agreement between
11 two providers.

12 **JUSTIN GRENIER:** It is, yeah. We felt that
13 would be best.

14 **JASON NICHOLL:** Excellent. You thought that
15 would be best. So why not have a statewide suggestion
16 or a rule solution that is have the providers work
17 things out, instead of forcing a rule change that may
18 have unintended consequences on, you know, I'm going to
19 spitball here, 28 out of 29 counties to solve problems
20 in one county?

21 **JUSTIN GRENIER:** I wouldn't classify it that
22 way, to be honest with you.

23 **JASON NICHOLL:** Well, you didn't classify it
24 that way. I did.

25 **JUSTIN GRENIER:** Yeah. Yeah. What I'd

1 probably suggest is meeting with the local stakeholders
2 to determine what's best and allowing them that
3 latitude to find out what's most efficient, to look at
4 the data to see what calls they are receiving, what
5 calls they aren't receiving, maybe looking to see which
6 units are being attached to calls and in the most
7 efficient, effective manner, would probably allow you
8 to make that decision. I don't think that's been done
9 in the past.

10 **JASON NICHOLL:** And I can't agree with you
11 more. I think that that's an excellent idea. And I
12 think that that solution that you just talked about is
13 outside of us changing a rule.

14 I think the rule, as it is currently written,
15 works, for the most part. And the problems that we run
16 into with the rule tends to be providers not getting
17 together and working out differences.

18 And I'm hesitant to support a rule change
19 that forces a handful of people to get together, when
20 everyone else seems to be playing okay in the sandbox,
21 my observations, based on conversations that I've had
22 with other members of this committee, as well as other
23 people in the one EMS system who do have a stake.

24 **JUSTIN GRENIER:** And that makes sense. I
25 wouldn't classify it, again, as force. When I was

1 asked to describe or basically summarize this, I think
2 it's best characterized as allowing the local
3 stakeholders, the counties, with jurisdictional
4 responsibilities, the PSAP, whomever, to get together
5 and try to figure out a model that is most efficient
6 for them.

7 And as you pointed out, in some places, if
8 it's -- if it's not broke, don't fix it. If there is
9 data to support, perhaps, some minor alterations, or
10 maybe just a reconfiguration, a slight reconfiguration,
11 that's all we're talking about here -- in our case, it
12 was less than one half of one percent of our call
13 volume -- if some minor changes were allowed, you would
14 see an increase in efficiency.

15 And I hate to go back to the cliché, but if
16 it can only save one life, I mean, that -- that's kind
17 of the rule that we use, and it works. It's working
18 well. We've been -- I can't speak highly enough about
19 our relationship with Gold Cross and how that has --
20 has worked.

21 So if everyone else is fine and they don't
22 see any more improvements, perhaps, as you suggest, you
23 know, if it's not broke, don't fix it.

24 What I would suggest, probably the only
25 thing, is how do you know if it's broke or not if

1 you've never looked at it, you don't have any data to
2 support one way or the other.

3 When we looked, we did find that there was
4 some improvements, and that's what spurred our, you
5 know, one-county change.

6 **JASON NICHOLL:** And all I'm saying is that I
7 think that that's a -- that's the appropriate way to
8 approach the situation, is to look at it on a
9 case-by-case basis, without putting it into a rule that
10 does, in fact, require everyone to do it.

11 So that's sort of the concern that I have
12 with making a rule change -- it's actually not a rule
13 change, I believe, it's a rule addition -- that doesn't
14 exist that doesn't seem to be a problem in most places.
15 That's all I have to say.

16 I like the approach that you have with your
17 other providers in St. George, and I applaud you for
18 that.

19 **JUSTIN GRENIER:** It works. And, again, when
20 we looked through the data, we found -- we found room
21 for improvements. We're always looking for that.

22 **JASON NICHOLL:** Awesome.

23 **KRIS KEMP:** Jay.

24 **JAY DEE DOWNS:** You know, out of respect to
25 the rules task force community -- you've got several of

1 the members here today -- and I would like to see --
2 hear from their point of view, express -- I'd like to
3 have the committee hear what they have to say too.

4 I know Jess is part of our committee too. If
5 we could entertain that.

6 **KRIS KEMP:** I think that's appropriate.

7 Jess, do you have something? Jay, thank you.

8 **JESS CAMPBELL:** I do. Thank you. My name is
9 Jess Campbell, Fire Chief, Saratoga Springs, and also a
10 representative of the Utah State Fire Chiefs
11 Association on the rules and review task force.

12 To Mr. Nicholl's point, it is the desire and
13 the consensus of the state fire chiefs to, in his
14 words, add the rules so that we are properly vetting
15 calls for service through an EMD process through a
16 emergent dispatch facility that is taking those calls
17 and putting them through the proper process and
18 dispatching the most appropriate unit in the quickest
19 amount of time.

20 It was solely, and is always solely, patient
21 care at the heart of everything we are considering, and
22 that is the entire intent behind the recommendations
23 that we made.

24 As far as the changes that the AG's office
25 put in there, I do have a concern with the word

1 "designee." I think that needs to be defined. Is that
2 physician's designee? The receptionist at the front
3 desk? Or is that a physician's assistant? An R.N.?
4 Just what is -- what is that designee?

5 But again, I'm here speaking for the Utah
6 State Fire Chiefs, and it is the consensus of that body
7 that all emergent calls be routed through a PSAP
8 facility and allow the process that's been in place for
9 many years to be able to go through and prioritize the
10 calls and apply them to the appropriate units and the
11 closest units to be able to properly respond.

12 **KRIS KEMP:** Okay. Thank you for that input.

13 Any other comments or any other members from
14 the rules task force?

15 **CASEY JACKSON:** Yeah. One of -- one of my
16 concerns is really making sure we're engaging certain
17 bodies of government, and that with a lot of the
18 concern here it's between cities, cities not coming to
19 agreements. Most of the cities around the state come
20 to agreements, and it has been fairly more grass roots
21 in that way.

22 But in some of the cases where it's not, I
23 think we really need to make sure that the counties are
24 engaged, the county commissioners, the county councils,
25 make sure that they are doing it.

1 When I look at this, I want to make sure that
2 as we are designated as a state, it is the counties
3 that typically take care of a lot of these things. The
4 counties can also, if we do it right and engage them in
5 the process, can referee in between a lot of these
6 arguments, you know, between the cities. They know
7 their counties better than we do upon this board.

8 And the county commissioners and councils are
9 often -- they're -- they're more accountable to the
10 people who are there.

11 So the only thing in this process that I want
12 to make sure is, with this rule, that we are doing the
13 counties a service by not overstepping our bounds too
14 much, by going -- you know, saying the cities are
15 having a problem. The cities come to us. We're going
16 straight to the state.

17 I do think we need to respect and make sure
18 the counties and those elected representatives are a
19 part of the process.

20 **KRIS KEMP:** Okay. Further comment?

21 **MICHAEL MOFFITT:** Mr. Chair?

22 **KRIS KEMP:** Yes.

23 **MICHAEL MOFFITT:** Just a quick comment.

24 As -- as a provider that has -- not only are we
25 multiple jurisdictions, but we have multiple levels of

1 service and we interact and overlap with many other
2 EMS providers, particularly in Salt Lake County. We
3 have used agreements between departments between
4 licensed agencies for a number of years that seem to
5 address each individual location, like Mr. Grenier from
6 Washington -- from St. George City Dispatch, sorry,
7 Washington County, that refer to we have an agreement
8 that addresses our individual uniqueness in Washington
9 County.

10 We have agreements in Salt Lake County with
11 multiple cities that agree -- that address individual
12 agreements and how they operate. We have an agreement
13 with a city in Utah County that addresses their needs
14 and our needs cooperatively.

15 I don't believe that a one-size-fits-all rule
16 stuck in R426-4-600 scene and patient management
17 addresses that issue.

18 I believe something a little more nuanced and
19 developed in rules where -- something to reflect that
20 where there's multiple providers providing different
21 services in a given geographic area, that they shall
22 have written agreements on how those things -- how both
23 providers interact would be much more to the point and
24 much more capable of addressing a local issue, and like
25 was just brought up, would put this back to the local

1 elected officials in counties and cities -- and cities
2 at that level, rather than try to make a one-size-fits-
3 all statement at the state level.

4 **JESS CAMPBELL:** Mr. Chair, to Mr. Moffitt's
5 concerns, we're trying to politicize patient care. And
6 again, I will reiterate, and I will -- I will ask the
7 question why would not a physician from any facility
8 that needs a patient transferred what -- regardless of
9 reason or circumstance, why would not a physician want
10 that call to be vetted through a PSAP center in an EMD
11 process to, again, make sure that the closest and most
12 appropriate unit is dispatched to take care of the
13 needs of that individual?

14 The recommendations to politicize and to take
15 this back to individuals that have no idea or
16 understanding of the impact or the ripple effect of
17 such a recommendation is -- is -- is ludicrous.

18 You as a board, you as a committee, can make
19 this decision, and it is our expectation as fire chiefs
20 that a decision is made. And I understand that it may
21 not be a unanimous decision.

22 But in reading the recommendations here, we
23 can live with the third recommendation to the rules
24 change, as put out by the attorney -- attorney
25 general's office. I think that we need to quit trying

1 to delay, stall, or create -- this isn't a one-size-
2 fits-all. This is a -- this is about process, and this
3 is about patient care, not a county, singular county,
4 not a singular city issue. This is about a statewide
5 application to what is best for patient care.

6 And I would challenge anybody to defend doing
7 anything different than this and coming up with some
8 sort of objective reasoning and supporting what is best
9 for patient care doing anything else other than this.

10 **KRIS KEMP:** Thank you. I think those are
11 very, very valid points. Do you have something?

12 **JEAN LUNDQUIST:** Yes.

13 **KRIS KEMP:** Please present yourself to the
14 podium.

15 **JEAN LUNDQUIST:** My name is Jean Lundquist.
16 I'm from -- I'm a trauma program manager up at Utah
17 Valley Hospital, and I'm on the rules task force. To
18 me, it seems like we're talking about two different
19 things here. We're talking about agreements that EMS
20 agencies make about who does what.

21 As the task force, what we've talked about is
22 who should be making the decision to send what
23 ambulance. And what -- what -- what our conversation
24 has been is the most -- the people that are most
25 qualified to do that are people who are at a dispatch

1 center because that's what they do every day. They
2 make that decision. When they get a call, they say,
3 "Okay. Here's the patient. Here's the problem. Who
4 can get there the fastest?" Just like Chief Campbell
5 talked about. It's about patient care. Who can get
6 there the fastest? What kind of care do they need?

7 Instead of various different people or
8 facilities or whatever making those -- making those
9 decisions, our -- our thought is to take it to a place
10 who makes those decisions every day and as a whole have
11 them make that decision for all the patients who need
12 the care. Thank you.

13 **KRIS KEMP:** Thank you for that comment.

14 Any further comments? Please.

15 **PAUL PATRICK:** Can you get a microphone?

16 Have we used them all?

17 **MIKE MATHIEU:** I very much understand the
18 medical nature of this discussion in terms of patient
19 care. And where the confusion gets created is when
20 some patients reside in certain types of medical
21 facilities. And oftentimes we determine an
22 interfacility transport as one that resides in a
23 medical facility. And there's a variety of medical
24 facilities. Those medical facilities range from a care
25 center that has very little emergent response capacity

1 to an InstaCare that may have everything and even more
2 than what EMS providers can provide, even at the
3 highest level.

4 And so we struggle with what provider type
5 best fits those patient types and conditions when some
6 are BLS interfacility type, not requiring much. Some
7 may even be advanced life support, but are not urgent.
8 We see that all the time, where the very sophisticated,
9 nonemergent, but very advanced life support transport
10 exists, and the interfacility transport provider
11 provides that service.

12 Where you might have, in a care facility,
13 someone that's there for aging illness and they begin
14 to have chest pain, you want to treat that as a 911
15 call because this heart condition that is happening is
16 not something of the norm for why -- the reason they're
17 in that care facility.

18 It creates a real dichotomy and problems in
19 terms of coordination amongst -- a new term I'd like to
20 use which they have in Utah County -- an overlay. It's
21 not necessarily an overlap, but it's an overlay, where
22 two providers exist and have to coexist. They have to
23 coordinate delivery of service, whether it be to 911
24 provider in the emergent condition that was just
25 mentioned, versus an interfacility nonurgent, and the

1 response time piece is not as critical, and that way --
2 that way the provider in that particular area is not
3 required to meet such stringent response time criteria.

4 But for us to solve that issue, for us to
5 determine market destination of activity amongst two
6 providers is a very dangerous thing, I believe, in
7 terms of saying, "We're going to classify this call as
8 this entity's or this entity's." And I'm not sure we
9 want to put a 911 center in that particular
10 predicament, in that gray area where sometimes we may
11 not be able to distinguish between whether that's an
12 interfacility type of nonemergent call or a 911 call
13 that goes to this provider. And we could, I think, be
14 fraught with some real problems.

15 What my suggestion would be is to task the
16 operation subcommittee for those areas in this state
17 that have overlay areas, which means the only ones that
18 have multiple providers in the same area, a nonemergent
19 interfacility transport provider and a 911 provider,
20 require that through their license -- licensing
21 process, similar to the requirement that they have
22 mutual-aid agreements with adjacent providers, they
23 have to have an agreement with their overlay providers.

24 And within that agreement, it has to be
25 driven by the best interest of patient care, and that

1 agreement between those two parties will articulate the
2 parameters in which those two providers will operate in
3 providing service in that overlay area.

4 And I think there -- that's where the rubber
5 meets the road. That's -- that's where those -- those
6 two entities are going to have to figure that out. We
7 as a board, the bureau as a rulemaking body and
8 administrator of that, the county commission, it's very
9 difficult for those other parties to administer that
10 because it's a dynamic environment.

11 There's going to be situations where an
12 interfacility provider went to a care center because it
13 was for general malaise, and it turned into shortness
14 of breath and a heart attack. There's going to be the
15 reverse happen, when a 911 provider is called and it's
16 for chest pain, and it turns out that the reason she
17 says chest pain, or he says chest pain, is because I
18 get them here quicker, I get to the hospital quicker.

19 If you had those kind of dynamics that occur,
20 I think you're going to have mistakes being made, but I
21 think if an articulated agreement is required between
22 the two overlay providers, submitted to the bureau,
23 that we don't regulate how they're going to operate.
24 We require them by rule that they regulate themselves
25 and they figure out and solve this problem themselves

1 as two overlay providers. That's what my motion would
2 be.

3 **KRIS KEMP:** So is that not what 1B is?
4 Because we're all basically talking about this. The
5 comment, from my perspective, is we've got most
6 counties doing this, where there are multiple agencies
7 that may have this overlay. And we have a couple of
8 instances where it's not working well. But the
9 counties that have made it work well have got some form
10 of agreement out there, and that's basically what's
11 asked -- being asked for in 1B here.

12 **MIKE MATHIEU:** As I read 1B, a written
13 agreement between a provider, an ambulance provider,
14 and a licensed -- sorry, a designated dispatch center,
15 that's not an agreement between the two overlay
16 providers.

17 That's saying that South Salt Lake has an
18 agreement with VECC, their 911 service provider, that
19 doesn't include Gold Cross in the equation, who
20 provides the nonemergent transports within South Salt
21 Lake.

22 It needs to be between the two overlay
23 providers, not between the designated 911 center.

24 **KRIS KEMP:** And your motion would be that
25 this goes back to the ops committee for revision?

1 **MIKE MATHIEU:** Well, I originally thought ops
2 committee, but we have a rules task force. Why not use
3 them to -- with the -- with the direction of saying
4 help us with a rule that requires that the overlay
5 providers have an operational agreement between them on
6 how they will work these issues out, that they will
7 have to define these issues, and they will solve the
8 problem of the overlay calls in distinguishing who goes
9 on what.

10 And those two parties have to submit an
11 agreement to the bureau as part of a licensure
12 requirement -- requirement. So they can't get their
13 license unless they have an agreement. They have to
14 pound it out between the two providers, instead of us
15 being the referee.

16 And what I fear is if we go one way or the
17 other, we are determining market share for one or the
18 other provider, and I think that's a dangerous area to
19 be in.

20 **KRIS KEMP:** All right. So, to restate your
21 motion?

22 **MIKE MATHIEU:** My motion would be that we
23 task the -- excuse me -- rules task force to come up
24 with a rule recommendation to this body that
25 recommends, within the licensing requirements, an

1 agreement, not only that they have with their aid
2 partners for their neighboring agencies, but with their
3 overlay providers, that distinguishes on how they will
4 operate in determining which provider provides which
5 services to which calls.

6 **KRIS KEMP:** Okay. We have a motion.

7 **GUY DANSIE:** A point of clarification.

8 **KRIS KEMP:** Okay.

9 **GUY DANSIE:** So we would not include this in
10 the operational rule, is that what you're saying?

11 **MIKE MATHIEU:** No, I think we would have a
12 rule that requires this coordinating agreement between
13 overlay providers, and they have to have this agreement
14 as two overlay providers. As a condition of being an
15 overlay provider, you have to have an agreement with
16 that partner illustrating how you will coordinate these
17 issues.

18 **GUY DANSIE:** Okay. And so we're not -- we're
19 striking this in our rule?

20 **MIKE MATHIEU:** It wouldn't be in the dispatch
21 rule. This would be a separate rule under licensing
22 requirements, that it would be a requirement that if
23 I'm an overlay provider, part of my application
24 submission will be here's my coordinating agreement
25 with the other overlay provider, and that they will --

1 those two parties will administer the agreement, not
2 the bureau.

3 **MARK ADAMS:** So, specifically, we're not
4 tasking them to come up with a brand-new R426-4-600?

5 **MIKE MATHIEU:** No.

6 **MARK ADAMS:** We're tasking them to come up
7 with really a licensing agreement?

8 **MIKE MATHIEU:** Requiring a -- if you want to
9 call it an overlay coordinating agreement.

10 **KRIS KEMP:** Mr. Campbell?

11 **JESS CAMPBELL:** I just wanted to add that
12 Chief Mathieu is talking about using the term
13 "overlay," which was a result of -- I believe it was
14 the hearing officer that -- Mr. Bates, had ruled on the
15 Utah County Gold Cross overlap issue, and "overlap" got
16 changed to "overlay." And currently there is not a
17 definition for "overlay" and what exactly that means.

18 Again, I still feel -- and I understand Chief
19 Mathieu's concerns and -- completely, but I still think
20 that -- that the recommendation of the third choice,
21 using the 1A and B, meets a lot of basically the meat
22 of what is being required, because I'll also throw out
23 what do you do if those agencies can't come to some
24 sort of agreement, or some agencies just simply refuse
25 to even have that discussion?

1 And again, there -- there are arguments going
2 on that -- that private ambulance companies don't
3 belong and don't have any right to any of their needs
4 in their communities. And this is -- this is kind of
5 bolstering that position, and that recommendation
6 bolsters it.

7 I think that, again, 1A and B meets -- meets
8 that. I think you can change some of the verbiage from
9 "designated dispatch center" to, again, an
10 "emergent" -- an "emergent dispatch center," but...

11 **MIKE MATHIEU:** Mr. Chair, do we have a motion
12 on the floor that --

13 **KRIS KEMP:** Yeah. We had a couple points of
14 clarification, so I thought it was appropriate to hear
15 that. Anything further, Chief?

16 **JESS CAMPBELL:** No.

17 **KRIS KEMP:** So we do have an open motion. Do
18 we have any -- this is an opportunity for a counter
19 motion.

20 **BOB JEX:** Can I clarify that just a little
21 bit too?

22 **KRIS KEMP:** Okay. Further point.

23 **BOB JEX:** I really appreciate Chief Mathieu's
24 comments, I really do. I would submit also, though,
25 there isn't just an issue of overlay between providers,

1 but what you're facing, and perhaps even more
2 important, is an issue with overlay between your
3 centers, between your dispatch centers, between your
4 call centers.

5 If you can sort out the one, the other
6 becomes, as in our case, a nonissue. That's with we've
7 done. You know, agreeing like, you know, you're on
8 this side of the sandbox and you're on this side,
9 that's all well and good, but if you can sort out the
10 call centers, the source of the information of the
11 incidents, then all the other ancillary information,
12 all the calls, the jurisdictional nonsense, all of that
13 falls by the wayside. That's what we have done, and it
14 works well.

15 But I would say that the third option here,
16 to me, in my opinion, seems most applicable to that.
17 So, thank you.

18 **KRIS KEMP:** Okay. Did you have a point that
19 you want to make?

20 **REGINA NELSON:** I just wanted to let you guys
21 know I'm Regina Nelson from Salt Lake County Sheriff's
22 Office, and I sit on the EMS Rules Task Force as the
23 EMD representative. And just wondered if maybe there's
24 still a little bit of confusion about what it is that
25 an EMD can contribute to a call and how our process

1 goes. It might vary from dispatch center to dispatch
2 center, but for the majority of the dispatch centers in
3 the state of Utah, we are certified through the Bureau
4 of EMS.

5 I've been dispatching for 25 years. I hold
6 an EMD certification. I value that EMD certification
7 and feel that I am the first first-responder on those
8 calls and can provide quicker response, given the
9 knowledge that I have gained through my training and my
10 certifications, and just wondered if anybody had any
11 questions as far as what an EMD can offer, and if maybe
12 they don't view the EMD as a -- as a resource that is a
13 valuable tool or -- do you have any -- kind of what I
14 was feeling as I was listening to some of the comments
15 that...

16 **KRIS KEMP:** Questions or comments for --
17 about EMDs?

18 **MIKE MATHIEU:** My only comment to EMDs, when
19 we started ambulance service back in 1991, EMD had
20 never even dealt with interfacility transport issues.
21 We designed our own medical priority call, determining
22 between BLS and ALS interfacility transport calls. It
23 wasn't until recently that they've come up with that.
24 So there's a complex environment with interfacility
25 transfers that create a whole new dynamic.

1 But I think it -- Justin, speaking to your
2 point, and correct -- clear me up if I'm wrong, but
3 even down in St. George, you don't determine -- or
4 maybe you do, maybe in Hurricane, but isn't St. --
5 isn't Gold Cross the only ambulance provider? So
6 you're not really distinguishing, even in your worked
7 out agreement, between using two different ambulance
8 providers.

9 This is where this problem in Utah County is
10 and resides, is whether to divert it to one ambulance
11 provider or the other, based on this determination, and
12 that's market share.

13 So none of the examples that have been
14 mentioned have addressed that. And I don't know who
15 best to better determine that. And I agree with Jess
16 saying maybe two providers can't work it out, but at
17 our level, if we require them to work it out, I'm not
18 so sure that's not the best way, rather than having us
19 work it out and have a winner and loser in determining
20 market distribution, because the interfacility
21 definition and 911, there is a gray area between those
22 two.

23 And depending on who you talk to, by statute,
24 we could end up in court over this, and I think it's
25 problematic.

1 **MICHAEL MOFFITT:** I think -- quick comment to
2 address -- and Chief Campbell, I think, in his most
3 recent comments, brought up a couple of different what
4 ifs. And I think the motion that Chief Mathieu's got
5 on the table right now, the motion was to go back to
6 the rules committee and come up with this agreement
7 language, coordinating language, within the licensing
8 rules and address those questions that he brought up.
9 That's a totally applicable discussion point in the
10 rules committee -- or the rules task force, and to
11 bring those up, and bring it back to this committee,
12 and hopefully we can approve that.

13 But the Bureau of EMS is a regulatory agency.
14 The providers, the licensed providers, are the next
15 level down, and that's where these agreements most
16 effectively get solved, not in the dispatch agreement,
17 but with the providers coming to agreement, and then
18 including the dispatch center. In any community in any
19 county, that's the way that we've addressed them.

20 You know, in Salt Lake County, where we have
21 multiple providers, we have -- we have agreements with
22 those providers, and then we go to one of the two
23 dispatch agencies and then say, "This is the
24 agreement." And then we answer their questions.

25 We don't run it from dispatch up to the

1 providers. We run it from the providers to dispatch.
2 Providers are the ones that are on the hook. They're
3 the licensees. They're the ones that have to perform.
4 And they're the ones, I think, that need to have this
5 in front of them and be required to do it.

6 You're required under licensing to have
7 mutual-aid agreements and to have other things. You're
8 required under licensing to have, in the event of an
9 overlap overlay -- if we need to create a definition
10 for "overlay," since the attorney did it for us, then
11 we do that -- but in that situation, then it must be
12 part of the licensed providers' requirement to have
13 those solutions worked out.

14 So I think that's the appropriate way. I
15 think it's a long-term solution that gets to the point
16 of the matter and that -- if need be, I second Chief
17 Mathieu's motion that's on the table.

18 **BOB GROW:** Mr. Chair?

19 **KRIS KEMP:** Yeah.

20 **BOB GROW:** I think there's a level of detail
21 here that I don't understand, to be very honest. It's
22 making me struggle with this issue. I guess I'm
23 wanting a little bit of clarification.

24 So, in Utah County, you've got sort of the
25 jurisdictional agencies, city, county, whatever, and

1 you've got Gold Cross. And under the state's license
2 with each of those entities, is the license the same?
3 For example, is Gold Cross able to respond to any
4 incident level of acuity that comes in to their
5 dispatch center, or is there a certain level of acuity
6 they're required by their license to dump back off into
7 the -- the PSAP?

8 **MICHAEL MOFFITT:** We are a whole --

9 **BOB GROW:** If we've got two equivalent
10 licensed providers in an area, I guess I'm not quite
11 sure how we'd sort that out. But if their licenses are
12 different and contingent on different things, then I
13 think pushing this back to the interaction between
14 those entities makes sense. But if we have two very
15 equivalent licensees in a certain jurisdiction, it may
16 need some regulation from us.

17 **MICHAEL MOFFITT:** Gold Cross's license is for
18 interfacility paramedic level, but we respond to
19 facility -- health care facilities. The --

20 **BOB GROW:** What is considered a health care
21 facility for you guys? Is it a nursing home?

22 **MICHAEL MOFFITT:** Well, there's -- there's a
23 definition in the rules that we follow. It's nursing
24 homes, clinics, hospitals, things like that. But
25 the --

1 **BOB GROW:** Is there anything about the acuity
2 of the call?

3 **MICHAEL MOFFITT:** No, there's not acuity set
4 for any of the calls.

5 **BOB GROW:** So if it's cardiac arrest in a
6 nursing home, you guys will respond to that?

7 **MICHAEL MOFFITT:** Well, no. That's -- that's
8 where we have --

9 **BOB GROW:** Why -- why shouldn't they?

10 **MICHAEL MOFFITT:** Well, because a cardiac
11 arrest is not an ongoing medical condition being
12 treated. It's a sudden onset change in a patient's
13 condition.

14 **BOB GROW:** What's your protocol, then, if
15 that kind of call comes in?

16 **MICHAEL MOFFITT:** If that kind of call comes
17 in, we refer that to the local 911 providers to
18 their -- for their dispatch.

19 However, you know, you can respond to a
20 long-term care center on a patient that's got altered
21 level of consciousness and difficulty breathing, but
22 they've been that way for a year. It's not all of a
23 sudden an emergency for that.

24 So -- so there's a very clear delineation in
25 services provided. Fire departments are providing the

1 911 service, as well as they can go in interfacility in
2 Utah County, and we provide interfacility. That's
3 where the agreement gets to the specifics, who's going
4 to do what? How's it going to -- how's it going --
5 going to be split? What's -- what's going to be the
6 local input on -- you know, on that call for call
7 types? How is it going to be differentiated?

8 And we don't have the same agreement from
9 city to city. They -- they vary. Some -- some are
10 different.

11 **BOB GROW:** But should those agreements matter
12 if it's sort of contingent on your license, in terms of
13 what you can and cannot do? I mean, if you get a scene
14 call into your dispatch center for Gold Cross, you just
15 dump that back to the PSAP, I assume.

16 **MICHAEL MOFFITT:** That's right.

17 **BOB GROW:** And if you have a high acuity call
18 from something that could be, in theory, considered an
19 interfacility transport, in theory, are those getting
20 dumped back into the PSAP process as well?

21 **MICHAEL MOFFITT:** Well, I guess in theory --
22 depends. I mean, if you're talking about a patient in
23 ICU that's on a ventilator and is pretty critical, no,
24 we don't dump those to 911.

25 **BOB GROW:** Sure.

1 **MICHAEL MOFFITT:** We're better to handle --
2 able to handle that, and we handle that.

3 If you're talking about somebody at an
4 InstaCare or, you know, a patient walks into an
5 InstaCare and says, "I'm having chest pain," and then
6 goes into cardiac arrest, just because there's --
7 they're in InstaCare doesn't mean that -- you know, it
8 still should be a 911 call.

9 **BOB GROW:** Right.

10 **MICHAEL MOFFITT:** And that -- if that come to
11 us, it would get dumped to the 911 center. So the
12 difference is in that narrow gray area, and that's --
13 that's where it, in my opinion, is best worked out
14 through agreement.

15 **BOB GROW:** Yeah. I mean, it seems to me we
16 have -- even in areas where there's overlay with two
17 concurrent providers, if their licensing is different
18 in terms of what they can and cannot do as part of
19 their license, I guess I'm still not sure why we're
20 even addressing this issue as a committee. I mean, if
21 we designate -- you know, we don't have the original
22 language of the rule written here.

23 **GUY DANSIE:** There isn't any. This is a new
24 rule.

25 **BOB GROW:** There isn't any. Okay. Do you

1 want to say something?

2 **HALLIE KELLER:** No. I mean, my concern was
3 just if there's this gray area, I still have a hang-up
4 on 1A, "When directed by a physician or their
5 designees." And if there's this gray area in who's the
6 designee, I'm still -- somebody mentioned that as a
7 problem.

8 And I still find that as a problem, because
9 that designee may be making decisions in that gray
10 area, which to me is an issue with that rule.

11 **KRIS KEMP:** The way that plays out is that a
12 doc may hear that a patient is getting worse and a
13 condition -- and their condition is changing, and they
14 say, "Well, get an ambulance and get them over to the
15 hospital." And the designee might be the receptionist.
16 I don't think you're making most of your own ambulance
17 calls, I think it's the receptionist or your clerk or
18 your -- whoever we want to call it. That designee
19 would be then acting in your behalf to activate the
20 system.

21 The concern is that at times they've been
22 overmarketed --

23 **HALLIE KELLER:** Yes, absolutely, and make
24 those decisions based on the top phone number.

25 **KRIS KEMP:** -- and -- and they -- they see

1 the phone number, just call this number --

2 **HALLIE KELLER:** Absolutely.

3 **KRIS KEMP:** -- instead of calling a 911,
4 because they're not basing it on a -- the physicians
5 aren't being clear enough that this is a 911 call
6 versus an interfacility transport.

7 **HALLIE KELLER:** And that's my concern.

8 **KRIS KEMP:** So we're trying to add regulation
9 to the rule, we're adding to this rule, which will add
10 regulations so that it minimizes that occurrence from
11 happening.

12 **BOB GROW:** I don't know that making a rule
13 changes that. If you have a receptionist sitting at a
14 desk with a phone number, I mean, how do we regulate
15 which number she calls? They just have to be educated
16 to the point they understand if this is a high acuity
17 911 call, make the right phone call, versus this is a
18 routine transfer to a dialysis center, call that
19 number.

20 **MICHAEL MOFFITT:** We do -- we do coordinate
21 education at the facility level, but our dispatch
22 center is staffed with the same EMD trained personnel
23 that every other dispatch center in the state is
24 staffed with.

25 And if a call does come through that's

1 inappropriate for our own response, we can respond to
2 any local 911 system in the same manner. We give the
3 same prearrival instructions. We handle the call
4 basically in the same fashion. So...

5 **BOB GROW:** So what is the consequence to your
6 license if you respond to a call that you know you
7 shouldn't, if you -- it's a higher acuity call, even if
8 it's from a nursing home, that should dump into the 911
9 system, but you don't?

10 **MICHAEL MOFFITT:** That falls under state
11 rules, then, operating outside of my license. If
12 I'm -- if I'm truly operating -- willfully operating
13 outside of my license, that is something that's subject
14 to disciplinary action by the Bureau of EMS.

15 **BOB GROW:** And maybe I'm just way out in left
16 field here, but I guess I'm just -- I don't quite
17 understand the rationale for us as a committee to be
18 making this type of new rule language to govern this.
19 I sort of agree that, you know, if we've got two
20 appropriately licensed providers who are concurrently
21 serving areas, but their licenses are different, then
22 they need to operate within the restraints of those
23 licenses. And if they don't, then the disciplinary
24 process needs to follow. But is creating a new rule
25 going to change that?

1 **KRIS KEMP:** Chief Campbell.

2 **JESS CAMPBELL:** I'm sorry, Dr. Kemp. I just
3 wanted to -- so to your point, as far as the training,
4 level of training, and how do you get all of those
5 people that are making that phone call dialed up or
6 spun up to that level that they need to understand
7 what's taking place within their facility, again, that
8 was the desire of us putting this through a PSAP
9 center, because they have the process in place that
10 those calls go through the screening process, the
11 questions that get answered, and that determination and
12 that prioritization is made in that process.

13 And that was the intent of it going through a
14 PSAP facility, so that -- so that that decision making
15 is taken from, or that liability is taken from that --
16 not to -- from the receptionist or -- or somebody that
17 doesn't have that level of training. And so that was
18 the reason.

19 And the other thing, you know, you talk about
20 this gray area, but what you're missing is, as these
21 calls transfer, it's time. And we're in -- we are in
22 the business of time, and we're -- what you're
23 proposing or what you're suggesting that we do is that
24 we add time to a response that somebody needs a higher
25 level of definitive care. That should be concerning to

1 all of you.

2 So, with that, I know you have a motion on
3 the floor, but I don't think it's a good one.

4 **BRETT KAY:** And when we talk about the
5 designee, I don't think it's a problem at the -- at the
6 interfacility level, like a Timpanogos to a University
7 of Utah, because the call logs are going to have the
8 physician very specifically request what they need for
9 that transport, that designated nursing home, that I
10 think quite clearly warrants the question.

11 All I know is when I send somebody out based
12 on ABALA laws I have to specifically state what the EMS
13 provider needs to bring and be prepared to use on my
14 patient to transport to the definitive care, or higher
15 level of care, versus the nursing home wouldn't have
16 that.

17 So I don't think it's an interhospital
18 problem, and that's usually going to come with the
19 physician basically standing in the room, saying, "We
20 need to transfer this guy out of here because of a head
21 bleed," or whatever the case may be.

22 **KRIS KEMP:** So, to summarize, a couple of
23 things. First of all, this rule came about because
24 people were concerned that calls were going to the
25 wrong entities for either interfacility, when it should

1 have been 911, or the other way around. And so that it
2 was enough of a concern, even though for the vast
3 majority of the time, like it was mentioned, less than
4 half of one percent of the time, it was working well,
5 but if there is room for improvement, then it's worth
6 some energy.

7 The question is, is how much energy does this
8 require, or is this really that we're trying to
9 regulate communication and trust? And that, I think,
10 is a different philosophical concern that all of us
11 should have.

12 When we're dealing with patient lives, as
13 mentioned from the physician perspective, where we're
14 actively standing over a person, saying, "This one
15 needs to go here or there, and I need this service to
16 do so," there is an intent that I think all of us have
17 to keep this patient centered, to speed time, to make
18 it efficient, and all work well in this ever-changing
19 environment of EMS in the state.

20 This rule has been gone -- reviewed at least
21 in two other entities, and now a third, and now we're
22 taking it potentially back to the rules task force to
23 ask them to review it again in this motion that's open,
24 to add specific language, or to incorporate specific
25 language, about having the agreements need to be in

1 place between the two specific agencies, instead of
2 from a licensed provider in a dispatch center. That's
3 the motion that's currently open.

4 And so before we move on that motion, I would
5 like to entertain any other counter motions or
6 additional motions from the committee.

7 All right. We have a motion. And did I hear
8 a second earlier? Who was the second?

9 **JASON NICHOLL:** Me, originally.

10 **KRIS KEMP:** Originally, Mr. Nicholl. Okay.

11 **BOB GROW:** Could we have a restatement of the
12 motion?

13 **KRIS KEMP:** I put you to sleep, didn't I?

14 **BOB GROW:** No. I was just -- just so we're
15 very clear about where the motion is sitting.

16 **MIKE MATHIEU:** The motion is that we refer
17 back to the rules task force with direction to come up
18 with a rule recommendation that as part of the
19 licensing requirement, if you have a license within an
20 overlapped area, overlaid area, that you are required
21 to have a coordinating agreement with the other fellow
22 or other ambulance provider in that area which
23 articulates, with speed in mind, patient care that
24 drives focus about who is called for which types of
25 calls within that gray area.

1 So my envision of this agreement is that
2 these two parties sit down and say, regardless of the
3 type of medical facility you're in, these type of calls
4 go to 911. These type of calls, interfacility. This
5 is our operating agreement. We'll trust each other.
6 We'll communicate. If we have problems, we'll sit down
7 and work it out."

8 I don't know what better way to have than
9 have those two coordinating departments work their
10 issues out, versus having us here and the bureau doing
11 it, with patient care in mind.

12 **KRIS KEMP:** That was the motion. We had a
13 second.

14 **JASON NICHOLL:** With -- with emphasis.

15 **MIKE MATHIEU:** Thank you.

16 **KRIS KEMP:** All in favor of the motion, say
17 aye.

18 **COLLECTIVELY:** Aye.

19 **KRIS KEMP:** Any opposed? Any abstained?
20 Thank you. Motion carries.

21 Do you believe we're only halfway?
22 Subcommittee reports and action items. Approval of new
23 subcommittee policy and application forms, Jason
24 Nicholl.

25 **BRETT KAY:** Motion to approve.

1 **JASON NICHOLL:** All right. So, as requested
2 by the committee and the bureau, we undertook a quick
3 review of the current subcommittee and task force that
4 report directly or indirectly to the EMS Committee.
5 That was Guy Dansie, Jeri Johnson, and myself that
6 worked on this.

7 And what we've come up with is a couple of
8 minor changes for housekeeping. First, is the document
9 that you -- you see in front of you. It is a
10 strike-out document that starts with guidelines for the
11 Bureau of Emergency Medical Services & Preparation, EMS
12 committee, subcommittee task force, and then also
13 includes peer review board.

14 This document was created when the peer
15 review rules were still on the agenda. So we'll skip
16 quickly over those. But what this document basically
17 does is clean up a lot of the language that exists
18 between the existing committees. And I have a
19 presentation here for you that will go through that.

20 It also introduces a new application form,
21 which you should have a copy of also. Let me see if I
22 can find my copy. Yes, right here. It says,
23 "Emergency Medical Services Subcommittee Application
24 Form." Previous versions of this application form have
25 basically asked whoever is volunteering for this

1 committee, for committee use, to select the committee
2 that they would like to serve on, and then give a
3 rough -- a rough outline of what qualifications they
4 have.

5 In discussion with Guy and Jeri, we came up
6 with the idea that it really would probably be better
7 for people to apply in general to assist on one of the
8 groups or task forces or subcommittees, and then based
9 on application and merit, be assigned to a
10 subcommittee, which is why that application has
11 changed.

12 It also -- we also included two instances for
13 references. There are occasionally applications that
14 we get in that a lot of people don't know. And so by
15 having some references there, we were able -- were able
16 to go through and find out a little bit more about
17 these people and what their expertise is for committee
18 assignments.

19 So those are the two main documents to -- to
20 review. So this presentation, that you'll be able to
21 see up on the board here, we -- we should be able to
22 see them on our TVs, but apparently --

23 **UNIDENTIFIED MALE:** Somebody stole them.

24 **JASON NICHOLL:** -- they're not here today
25 because someone stole them.

1 All right. So, very briefly, it's only like
2 a 55-slide presentation, so -- all right. Let's hit
3 it, go for it. Okay. What we found is that the rural
4 population is overrepresented based on population
5 breakdowns. That's urban versus rural counties, and
6 what percentage of the population live in those areas.
7 Rural population is overrepresented, and hence, urban
8 population is underrepresented.

9 15 counties within the state had zero
10 representation on any of the subcommittees, the peer
11 groups -- or not the peer group, but -- or the task
12 force. And there is also a hodgepodge of different
13 physician categories in --

14 **MICHAEL MOFFITT:** Did you say "hodgepodge"?

15 **JASON NICHOLL:** "Hodgepodge" is a word, isn't
16 it? Okay. Oh, it's the word of the day, "hodgepodge,"
17 just so you know.

18 So we have 39 different position categories
19 for 64 different positions. So we have a whole bunch
20 of positions for this guy or this girl or this -- you
21 know, this person or that person.

22 And essentially, having been around for a
23 while, I know that that's happened because we get some
24 person that applies, but they don't really fit
25 anywhere, so we create a new category and stick it on a

1 subcommittee, or when we create a new task force or a
2 different subcommittee, we rearrange things to make
3 things, I don't know, politically expedient or whatever
4 to represent best.

5 Well, that comes up with a whole bunch of
6 different categories for people and 64 positions.
7 Currently, on all of our task -- task forces and
8 subcommittees we have 19 vacancies. Let's go.

9 So here's our EMS Committee, those people
10 sitting right here, and here's where we're at. There
11 we go. It's not as dramatic as I thought it would be
12 when I was building this.

13 Okay. Move on. Here's our grants
14 subcommittee. Yeah, that's Lane.

15 Okay. Next. And the rules task force.

16 **MARGY SWENSON:** Sound effects would have
17 helped.

18 **JASON NICHOLL:** You're right, sound effects
19 would have been much better. So this is -- you know
20 what? I know we've gone forward a few, but this is a
21 population density map of the state. The key is up at
22 the top, and each of the stars represent one -- one
23 person that is on that committee. So it's not a
24 position, it's a particular person.

25 Next. Here's an operations subcommittee.

1 Next. Our professional development
2 subcommittee. There you go.

3 Now, if you were looking close, you'd see
4 down at the bottom, it says that we have 16 positions
5 in one, 17 in another, 20 in one, and 10 in another.
6 So there's not a lot of consistency amongst our
7 committees.

8 So move to the next one. This is the grand
9 total for each county. For instance, Salt Lake -- Salt
10 Lake County, we have eight members of the subcommittee
11 are from Salt Lake County. Four from Sevier. Gives us
12 a total of 34 percent of the members currently are from
13 a rural area, which only represents 24 percent of the
14 state's population, where 76 percent of the state's
15 population is in urban areas and is represented by 36
16 percent of the members of the subcommittee. And at
17 present, we have 30 percent vacancies.

18 Next. So this is what it breaks down to with
19 our four. This is professional development,
20 operations, rules, and grants. Each of the individual
21 categories in the second column over on the left,
22 yeah -- no, next one, there we go -- those are all the
23 individual categories. Who's got the laser pointer?
24 Oh, you're awesome.

25 Okay. So you can see that there are areas

1 where it only appears in one group, and that happens
2 quite a bit, so that really creates some problems for
3 organization and -- and keeping things uniform along
4 all of the committees.

5 So let's move on. All right. So these are
6 the applications that we've received since our last
7 meeting. This is more than we've had in a long time,
8 and it's a pretty good mix of people.

9 So go ahead, next. This is where their
10 locations are from. We have four that have come
11 from -- or six that have come from the urban areas and
12 four from rural areas, which really kind of works well
13 with our population percentage.

14 Next. Okay. These are the counties in the
15 state that are under -- are -- and what their
16 represent -- representation is. Red counties are
17 underrepresented according to population percentages.
18 Green counties are overrepresented. And the white
19 counties that you see, or the white areas that you see,
20 have no representation at all.

21 Next. This is the data that backs up that
22 previous map. Go on.

23 So with our new change -- or with the app --
24 ten applications that we have, this is what the
25 breakdown looks like. So it's still -- we're able to

1 add a couple more in rural areas, we're able to add a
2 couple more in urban areas, but as you can see, the
3 difference between a 36 and a 34 percent, it changes,
4 but not much. We still have 47 percent and 42 percent,
5 they're still close, when you compare them to
6 population being 76 -- or 74 and 26. And takes us down
7 to only 11 vacancies on our existing committees.

8 So let's move on. Okay. So now this is a
9 quick area. I'm going to really go over this fast
10 because it was pulled out, but during the rule
11 committee we talked -- the rules committee got together
12 and had recommended these 16 positions for the peer
13 review group. So in the next slides you'll see peer
14 review group incorporated into this, not by way of the
15 committee taking it over, because they can't because
16 it's statutorily not that way, but trying to keep
17 things, again, uniform across all the committees.

18 Move on. So this is what the new list looks
19 like. You can see that a lot of the black that existed
20 on the previous rosters is gone. And where there are
21 only singular instances of -- of positions occurs only
22 in the peer review column, which is that very far right
23 column, and those areas are for requested
24 nonsupervisory personnel, which is not a specific
25 requirement or request for any of the other committees.

1 It brings a lot of the positions in line. No
2 one loses their position, but it just makes things
3 easier, more condensed, and more streamlined.

4 So we move on to the next. Okay. So here we
5 have -- currently, professional development, we have
6 one -- one vacancy. Operations, eight. Rules, two.
7 Grants, seven. We'll skip peer review.

8 The applications that we have, now Kevin Rose
9 is a current member of the rules committee, and he's in
10 parenthesis there because we're -- we're toying with
11 asking him -- don't anybody tell him, though -- we're
12 going to ask him to be on the professional development
13 committee also. That's a secret.

14 Yeah, anyway, but that will take us down to
15 zero vacancies on professional development, a fully
16 filled committee.

17 Operations, these people have applied. We're
18 recommending them to fill certain positions. Mr. Adams
19 has applied, as well as these other four, for grants,
20 which takes it from having six -- I'm sorry, 19
21 positions to only having nine vacant positions, and
22 also meets the needs of each individual committee.

23 So next slide. So our -- my recommendations
24 are that we streamline the position categories from 39
25 to 23, create uniform subcommittee side at 16, and then

1 aggressively recruit for volunteer applications. And
2 this is a process that we've discussed with the bureau,
3 that during recertification, when everyone is mailed
4 out their -- their notice of recertification, they will
5 receive an invitation to apply for a subcommittee,
6 which is something that apparently hasn't been done in
7 the past.

8 And then we will also seek appropriate
9 population representation, which means that we'll focus
10 on a lot of those places that are underrepresented or
11 have no representation at all. And that is -- that can
12 all be done by adopting the changes made to the
13 subcommittee guidelines, which is that first document
14 that -- that I talked to you about. All of these
15 changes are outlined in this document.

16 And the last thing that it does is it
17 formally assigns an EMS committee member to each of the
18 groups as a voting member, as that 16th member of the
19 group. So that is the essence of it. And as --

20 (Reporter can't hear.)

21 **JASON NICHOLL:** You know, that's already been
22 tried. And as such, before we move on to the
23 assignments with Jeri, in order for the assignments
24 that we've talked about, we need to adopt the
25 guidelines. So, questions about adoption of

1 guidelines or changes? Yes.

2 **LACONNA DAVIS:** Yeah, I had one about the
3 changes. Do I need a mic? I'll just talk loud. I
4 would encourage you -- I like this form a lot -- to
5 have a place where people could specify which ones they
6 were interested in. They could check them all, but
7 we've had problems on some of the subcommittees with
8 getting enough people to show up.

9 **JASON NICHOLL:** Sure.

10 **LACONNA DAVIS:** If you get assigned to one
11 that you're not really interested in, you might come to
12 one meeting and then not go. So I still think if I
13 chose operations, and that's all I put down, not as an
14 EMS committee member, someone could e-mail me and say,
15 "Hey, no room on ops, but would you be interested in
16 professional development?" I think that would -- I
17 could say yea or nay. But I'd like to give people a
18 chance to show what they're interested in, in that.

19 **JASON NICHOLL:** Okay. Guy, did you want to
20 address that, about having people ask for specific --

21 **GUY DANSIE:** Yeah. One of the thoughts was
22 the -- well, we didn't -- we didn't want to introduce
23 somebody that was just coming on because of a bias, or
24 if they were being fickle, so to speak. That was the
25 reason we didn't put it on there. It's certainly open

1 to discussion, though.

2 **LACONNA DAVIS:** How are you going to know if
3 they're coming on bringing bias?

4 **GUY DANSIE:** Well, it just seems like when
5 they're -- sometimes it's hurt self-interest generated,
6 and that was the one of the reasons. We thought that
7 if it was -- they were coming on for the good of the
8 whole, that they would be happy or willing to serve
9 where they landed. It's just a philosophical argument.
10 It's not a problem. We can discuss it or -- it's --
11 it's a policy, we're -- we're not opening for --

12 **LACONNA DAVIS:** Yeah. I feel like some
13 people are more passionate about some things.

14 **GUY DANSIE:** True. True.

15 **LACONNA DAVIS:** And maybe that also means
16 they've got a bone to pick, too --

17 **GUY DANSIE:** Sure.

18 **LACONNA DAVIS:** -- but -- yes.

19 **GUY DANSIE:** Sure. And I -- it's hard to
20 take a vote on that.

21 **LACONNA DAVIS:** I'm okay either way.

22 **GUY DANSIE:** Okay.

23 **JASON NICHOLL:** Yeah. And maybe I'll just
24 make an example. Mr. Meersman is here, and his is one
25 of the applications that we have vacant. He's the

1 training director for Gold Cross. He's very heavy into
2 training, specifically wants to be on the professional
3 development committee. There's no room, so we would
4 like him to be -- you know, the recommendation will be
5 for him to be on operations committee. I think that he
6 will be okay with that. Will you, Jack?

7 **JACK MEERSMAN:** Yeah.

8 **JASON NICHOLL:** But, you know, we don't want
9 to go back to square one if someone says, "Oh, no, I
10 don't want -- I only wanted to do this. I don't want
11 to participate in anything other than training." I
12 don't know, I'm kind of with Guy.

13 **KRIS KEMP:** Any other comments? Do we have a
14 motion?

15 **MICHAEL MOFFITT:** I would, Mr. Chair, make a
16 motion that we adopt the guidelines for the
17 committee -- hold still. Let me read that -- the
18 committee for BEMSP and EMS committee subcommittee,
19 task force -- task forces, excepting the peer review
20 board, that we adopt those guidelines as presented by
21 Mr. Nicholl.

22 **KRIS KEMP:** Okay.

23 **MICHAEL MOFFITT:** And that's it.

24 **KRIS KEMP:** Do we have a second?

25 **JERI JOHNSON:** I'll second.

1 **KRIS KEMP:** And all in favor, say aye.

2 **COLLECTIVELY:** Aye.

3 **KRIS KEMP:** Any opposed? Any abstained?

4 Thank you.

5 Okay. Next is Jeri with applications.

6 **GUY DANSIE:** Just as a point of business, we

7 wanted to move Matthew Christensen, if that's okay,

8 maybe to the end of the agenda, in the interest of

9 time, if we do get through.

10 **MATTHEW CHRISTENSEN:** That's fine.

11 **GUY DANSIE:** Okay. My apologies for that.

12 Thanks.

13 **JERI JOHNSON:** Do I need to go back from

14 then?

15 **MATTHEW CHRISTENSEN:** Sorry, one forward.

16 There we are. Got it. It has the names of the

17 applicants on it.

18 **JERI JOHNSON:** So, I'd like to say -- make a

19 motion that we accept the applications and the

20 positions they've been appointed to.

21 **MARK ADAMS:** Second.

22 **KRIS KEMP:** Okay. We have a motion and a

23 second. All in favor, say aye.

24 **COLLECTIVELY:** Aye.

25 **SUZANNE BARTON:** Who seconded?

1 **MARK ADAMS:** I did.

2 **SUZANNE BARTON:** Okay.

3 **KRIS KEMP:** Any opposed? Any abstained?

4 Thank you.

5 **JASON NICHOLL:** And then, Mr. Chair, we have
6 one more housekeeping item.

7 **KRIS KEMP:** Yep.

8 **JASON NICHOLL:** I'd like to task the bureau
9 to -- or ask the bureau, we don't task the bureau, but
10 we're going to ask Guy nicely to look at all of the
11 positions for our current members and ensure that we
12 have them in the right allocations, in the right
13 places, just as a double check.

14 **KRIS KEMP:** Okay.

15 **JASON NICHOLL:** It's not a motion, just a
16 request to ask the new --

17 **GUY DANSIE:** We'll do that as a quality
18 assurance review --

19 **JASON NICHOLL:** Thank you.

20 **GUY DANSIE:** -- make sure the memberships fit
21 the categories they're assigned to.

22 **KRIS KEMP:** All right. Professional
23 development update, Dennis.

24 **PAUL PATRICK:** I'm sorry, that was Von.

25 **KRIS KEMP:** Okay, Von, apparently.

1 **VON JOHNSON:** Okay. I'm Von Johnson,
2 representing the professional development committee,
3 chairman. Basically, we were tasked in our last EMS
4 committee meeting to approach the transition period or
5 transition process from our current standings to the
6 NREMT for EMT level. And we were told to put together
7 a task force for that. We, in fact, did that. We met
8 once, and then met with our whole committee or
9 subcommittee. And at that point we were taking
10 feedback from all of the members of the subcommittee.

11 And then we were basically, what, at a moot
12 point when the state went ahead and announced the
13 process that was going to be in place at the semiannual
14 instructor's seminar in St. George.

15 So, basically, I'm here to report that we --
16 we did our job. We met. We got feedback from several
17 people. And there were some concerns and things, but
18 that has gone ahead and there is a process in place
19 that is going to enable testing for the EMT level for
20 the practical test for NREMT. So that's -- that's
21 basically where -- were we're at. Any questions?

22 **KRIS KEMP:** Questions from the committee?

23 All right. So that was the -- your update,
24 then. Okay, great. Thank you.

25 All right. Paul, it looks like you've got

1 several things to discuss.

2 **PAUL PATRICK:** And I won't take as long as
3 we've had so far. The -- Sean Reyes, the attorney
4 general -- you should have it in your form -- in your
5 packet from him, from the attorney general, some
6 clarification on this committee.

7 This committee is considered public officers
8 because the statute was changed, but it was way back in
9 1989. I'm going to start out by saying I'm not Lyle
10 Odendahl. Remember Lyle used to come and do this
11 presentation? And I'll be through a lot faster than he
12 ever was.

13 But anyway, you are considered public
14 officers, and -- under the statute, and as a public
15 officer, if you are an officer, director, agent,
16 employee, or owner with a substantial interest, from
17 something that we regulate, then you're required to
18 fill out and give back to us -- and we do have notaries
19 that can help you -- a disclosure statement that you
20 disclose the position that you hold, a committee
21 member, and the precise nature or value of your
22 interest.

23 So, for example, Mike Mathieu is the chief of
24 Ogden Fire. Ogden Fire is an entity that we license or
25 regulate, so he would need to disclose that he is --

1 fill out the form, and that he does have a value to
2 Ogden Fire more than \$2,000, because I'm sure they
3 value you more than that, right, Chief?

4 **MIKE MATHIEU:** I don't know.

5 **MR. PATRICK:** Okay. So, the point is to fill
6 out the form, and then there are -- to disclose. Then
7 there are prohibitions, things you can't do. You can't
8 disclose confidential information. I'm on the second
9 page under "Prohibitions." You can't talk about
10 protected information. You can't talk about things
11 that will help your personal or economic interests.
12 You can't interfere with the ethical performance of
13 your duties. You can't take gifts of substantial
14 value.

15 If you turn the page to the third page, it
16 goes on and talks about the improperly influence to
17 get -- improper influence, different things you can't
18 do, a conflict between any private interests, or you
19 can't donate or demand that people donate to you and
20 get something back in return.

21 Then to the committee, the fact is, you have
22 to -- you have to decide as a committee that if there
23 is a potential conflict of interest that may come up
24 that you direct the immediate interest of the
25 relationships or either financially of whoever it is

1 that your main employer is.

2 Now, with all of your positions being in
3 statute, and most of you are working for entities that
4 we regulate, but some of you aren't, like the consumer,
5 we don't regulate you, and the hospitals are resource
6 hospitals, fall in -- and, you know, depends on how you
7 work -- how you fit in there, the whole point is how
8 you would approach a conflict.

9 You've done really well in the past through
10 this, but as a committee, you need to decide if you're
11 going to allow the oral disclosure before, at the
12 beginning of, or if the person wants to leave the
13 meeting when you're discussing something that they feel
14 may be a conflict.

15 I can remember back to several meetings where
16 you have taken the stand, someone has said, "I need to
17 recuse myself because I have a conflict with this
18 particular issue."

19 So as you read through that and the potential
20 conflicts and the procedures, the important part is
21 that as a committee you meet the definition of a public
22 officer from your appointment from Governor Herbert.

23 And with that, if you also work for an entity
24 that we regulate, you need to fill out the back two
25 pages, which is the disclosure statement. And we do

1 have notaries that we can notarize that for you at no
2 cost here, so you don't need to do that. Once that is
3 in, then we just have it on record and we've met the
4 requirement.

5 And then, I don't know, Dr. Kemp, if you want
6 to get more into what's prohibited or what's a
7 conflict, but it's pretty well outlined in the document
8 that came from Attorney General Reyes. So any
9 questions?

10 **KRIS KEMP:** No questions from the committee,
11 then? Okay.

12 **MR. PATRICK:** We could arrange to have a
13 notary here at the July meeting, if you would like to
14 fill the forms out, bring them back, and we could have
15 them notarized at that meeting. For those who feel
16 that they need that to happen, we'll be glad to make
17 that...

18 The next thing, a legislative wrap-up. There
19 were a couple of things that -- three bills that
20 impacted us at the legislature this year. The first
21 one is on reimbursement. We were able to get the
22 assessment that will be -- will happen in July for all
23 of the ambulance providers to be able to allow us to
24 then make it so that the ambulance services can be
25 reimbursed at the basic life support rate. Allan Liu

1 is going to talk about the proposed rates in just a
2 second.

3 So the new rate for basic is \$696 with the
4 proposed increase. So instead of getting the 142,
5 you'd be getting the \$696. And every three months
6 Medicaid will do an assessment back on a percentage of
7 that to draw down the federal match.

8 Thanks to all the support from the State Fire
9 Chiefs and other groups, we were able to get that
10 through the house and senate and signed by the governor
11 into statute. And I think that's one of those landmark
12 things that's really going to be influential for our
13 providers, you, in being able to continue your service,
14 because you'll see a great increase in revenue.

15 We've looked at every EMS agency out there
16 with the call volumes, and no one, after paying the
17 assessment, will pay more than they receive back.
18 There will be a huge amount of revenue that will come
19 back through Medicaid, and it will also be because of
20 the federal match that's being drawn down. So thank
21 you and kudos to everybody. That's a real big win for
22 us.

23 And I hope that that doesn't fall to the, you
24 know, discussions you've had about trauma and dispatch
25 rules, because this is really significant for all of

1 you as providers, and you'll see a great increase in
2 your revenue from that, so appreciate that.

3 The other one was mentioned briefly with the
4 peer review representative. McCay passed a bill that
5 will bring a peer review board to help with our dealing
6 with the criminal fines -- or not criminal fines, but
7 dealing with conviction fines -- not fines, dealing
8 with people with -- why can't I think of the word?
9 That have -- oh, BCI, background criminal
10 investigation. And we're in the process of working
11 that out. We did have it on your agenda today, and
12 appreciate all the great work the task force has had
13 and will continue to have.

14 But the third piece of legislation was Paul
15 Ray's bill, which brings the FBI background fingerprint
16 into the mix as well. So, currently, in R426, under
17 the background screening rules, there are the two
18 sections. One will be dealing with the current Rule
19 2600. The other will be a new rule, 2700, with a peer
20 review. We're going to bring both of those together
21 and we'll bring them all back to you at your July
22 committee meeting, which will allow us to bring them to
23 the task force, both parts, and bring them back to you
24 just in one rule, and not bring them back piecemeal,
25 half, and then have to come back with another one.

1 So those were the three legislation. Paul
2 Ray's passed -- his bill passed as well. So after July
3 1 of this year, and during the next two years, we'll be
4 doing FBI fingerprints on everybody. We'll have you
5 part of a better database that will help to secure
6 that. And there are some other requirements dealing
7 with cost, quality, and access as being mandatory
8 instead of optional that will also have a rule that
9 will go to the task force and then to you to take care
10 of that.

11 So those are the three items from the
12 legislature. Any questions on those?

13 The last one is dealing with what is called
14 REPLICCA. This is the interstate compact legislation
15 for EMS. This is the -- currently in the Nevada
16 legislative process. I gave some testimony
17 electronically for their legislative session on Friday.
18 And, well, I don't know if you've been involved. It's
19 out of Wendover. But it's going to the legislature in
20 Nevada this year. It's also on -- going to the
21 legislature in Texas, and Colorado is moving forward
22 there.

23 Once it's an interstate compact, similar to
24 what the nursing compact is, it allows for EMS
25 personnel to be able to move from state to state

1 without having to jump through all the licensure hoops.
2 It allows for wildland fire folks to move from state to
3 state. It allows for military who come into the state
4 to be certified at all of the levels that are licensed,
5 all of our levels. So I'm pretty excited about this
6 compact.

7 There need to be 11 states adopt it before it
8 becomes effective. We might have three or four in the
9 United States that do it this year. And then the next
10 year we're looking at legislation and doing -- and
11 getting that sponsored so that we can get our state to
12 adopt it as will.

13 Nevada meets every two years. This is a one
14 year, so it's their year they're meeting, so it's
15 critical that they do that, as well as in Texas.

16 But this will have a huge impact on the
17 individual, individual certified at any level that we
18 certify to. That's why we're not testing anymore.
19 That's why we went to the national registry. That's
20 why we're doing the FBI fingerprints, because all of
21 those are requirements to be an interstate compact
22 member, and also to have Utah pass it through our
23 legislature, and that was what the REPLICA system would
24 do.

25 And I'm very excited about it, especially for

1 military personnel coming into the state, if they --
2 they're certified, they can get their credential here
3 in Utah and become paramedics, EMDs, or anybody who
4 wants to go down that road.

5 So any questions on REPLICA? Okay. Thank
6 you.

7 **KRIS KEMP:** All right. Thank you.

8 Bob Jex, stroke center update.

9 **BOB JEX:** Since our last EMS committee
10 meeting, we've certified one additional stroke
11 receiving facility in the state, Castleview Hospital.
12 That brings our total up to 23 stroke receiving
13 facilities and nine primary and comprehensive stroke
14 centers, for a total of 32 in the state -- or, I'm
15 sorry, thirty -- yeah, 32.

16 Also, by way of information, we designated
17 Heber Valley Medical Center as a level V trauma center.
18 That will probably be the last level V that we do this
19 year, or forever, because beginning January -- or July
20 1st, we'll start using ACS criteria, which will allow
21 for level V to be folded into level IV.

22 Any questions?

23 **KRIS KEMP:** Okay. Thank you.

24 And Allan for ambulance rates.

25 **PAUL PATRICK:** Is he here?

1 **KRIS KEMP:** Yes.

2 **PAUL PATRICK:** Fine.

3 **ALLAN LIU:** Good afternoon. My name is Allan
4 Liu, financial analyst here at the Bureau of EMS. Jay
5 is passing out information regarding the ambulance
6 rates that we are trying to get changed for the summer.
7 The first possible effective date is June 28.

8 I analyzed the fiscal reporting guides, which
9 is the revenues, the adjustments, and the expenses EMS
10 agencies have on an annual basis.

11 The glaring thing, and it's always the case,
12 is the adjustments that EMS agencies have to write off
13 because of Medicaid, Medicare, or uncollectibles.
14 Again, it's about the usual rate of 48 percent. So 48
15 cents on every dollar, EMS agencies statewide cannot
16 collect on that. And that drives the rates, drives the
17 costs, and then hence the ambulance rates, to
18 compensate.

19 So with this, the rate increase is going to
20 be about 6.25 percent, and this affects the base rates
21 for ambulance. So \$41 will be increased for basic life
22 support, for the basic ambulance. Intermediate is \$54.
23 \$79 for paramedics. The monitory will still remain the
24 same, 31.65. The rate is a little high, but the rates
25 were not changed since March 24th of last year.

1 That's what I have for you guys.

2 **PAUL PATRICK:** Any questions? Anybody want
3 less?

4 **KRIS KEMP:** Okay. Thank you.

5 **PAUL PATRICK:** Mr. Chair?

6 **KRIS KEMP:** Yeah.

7 **PAUL PATRICK:** I forgot one thing. I
8 appreciate what Allan's done for that. Most of you
9 have been involved in our strategic plan, and it ended
10 on January of 2015. And I have a copy of our new
11 strategic plan, which is from January 5th -- 1st of
12 2015 to December 31st of 2019, and we've done some
13 modifications.

14 As a committee, you've been involved in this.
15 When we were at the Viridian Center, you helped us with
16 it as well, so thank you for your help throughout. But
17 I just thought I'd give you a printed copy so you have
18 your own. And there's some extras.

19 And Dean, you said you have how many more.

20 **DEAN PENOVICH:** Lots.

21 **PAUL PATRICK:** If everybody here would like
22 one, we can make sure we have a -- Dean, will you go
23 get some more? We don't have enough. We'll bring them
24 down.

25 And also, as far as the rule Allan was just

1 talking about, we've already sent that forward from the
2 Department. That's a Department rule. We sent it
3 forward in the rule-making process for the public
4 comment period so we can try to get it effective as
5 quickly as possible. So thank you for allowing me to
6 give you that.

7 **KRIS KEMP:** Thank you. Was there a question?
8 No.

9 **UNIDENTIFIED FEMALE:** I'm getting Jay's
10 attention, but...

11 **KRIS KEMP:** All right. Matthew Christensen.

12 **MATTHEW CHRISTENSEN:** I was asked to present
13 on the trauma report. I'm Matthew Christensen, Bureau
14 of EMS. And it's a -- what I've got together is a
15 30-minute presentation.

16 **KRIS KEMP:** Do you want to wait or do you
17 want to do it?

18 **MATTHEW CHRISTENSEN:** That's what I want to
19 ask you. It's -- you know, I could rush through it in
20 ten minutes, or would you rather wait and see it in
21 three -- three months, when I can go through a little
22 more detail?

23 **KRIS KEMP:** Is this part of what you
24 demonstrated at the last --

25 **MATTHEW CHRISTENSEN:** It's the same -- same

1 report.

2 **KRIS KEMP:** I think it's really worth the
3 time, so maybe we can table it 'til the next time.

4 **MATTHEW CHRISTENSEN:** Okay. Yeah, so we have
5 the --

6 **KRIS KEMP:** Because I think it's worthy of
7 spending some time on it to kind of review it and this
8 entity to really understand kind of some interesting
9 detail, okay?

10 **MATTHEW CHRISTENSEN:** That's fine.

11 **PAUL PATRICK:** So, if that's the case, Mr.
12 Chair, I have one thing, that -- the handout that Allan
13 passed out says "intermediate," but the rule that we
14 sent over said AEMT, so that's just a typo on the one
15 page that you have. The actual rule calls it -- so the
16 AEMT rate is 9.19. It's not "intermediate" anymore.
17 But the one that we're putting forward doesn't say
18 "intermediate."

19 **KRIS KEMP:** Okay. Thank you. All right. So
20 with that, we have our next meeting July 15th at 1:00
21 p.m. held here. Do we have a motion to adjourn?

22 **MARGY SWENSON:** Make a motion.

23 **JAY DEE DOWNS:** Second.

24 **JASON NICHOLL:** Subcommittee report.

25 **KRIS KEMP:** Oh, subcommittee, that fell off

1 our --

2 **JASON NICHOLL:** It did.

3 **KRIS KEMP:** -- agenda. We've got to make
4 sure that stays on the agenda so we can make
5 assignments. We made one already, correct?

6 **JASON NICHOLL:** We've made two.

7 **KRIS KEMP:** Okay.

8 **JASON NICHOLL:** All right. I ask that the
9 subcommittee chairs look at their rosters also and come
10 up with documentation. If there are people that don't
11 show up, that they look at the new guidelines and make
12 sure that their participants are meeting the
13 guidelines, because we may be having an influx of new
14 applications. It is a 75 percent attendance.

15 And then second is to task the operations
16 committee to look into a strategic plan for moving
17 towards mobile integrated health, or at least
18 developing information to bring to the committee on
19 what mobile integrated health looks like from -- from a
20 committee standpoint so we can get out ahead of it.

21 **KRIS KEMP:** Okay. Any other assignments?

22 **LAUARA SNYDER:** I have a question or
23 clarification, and I'm sorry, I should have asked it
24 sooner. With the new subcommittee positions, if there
25 are currently people in positions that aren't on the

1 new positions, are we just kicking them off?

2 **JASON NICHOLL:** No. No one lost their
3 position at all. Everyone --

4 **LAUARA SNYDER:** But will -- if they're in a
5 position, where do we put them?

6 **JASON NICHOLL:** They fit into one of the
7 other categories.

8 **LAUARA SNYDER:** Okay. So we're not kicking
9 anybody off of anything?

10 **JASON NICHOLL:** No. There were actually two
11 people that will need to be moved from one committee to
12 another committee, but that committee had 19 members,
13 and so it needed to be -- or 18 members -- needed to be
14 pared down a little bit.

15 **LAUARA SNYDER:** So they'll just fill a
16 position on the same committee?

17 **JASON NICHOLL:** On a different committee.

18 **LAUARA SNYDER:** On a different committee.

19 **JASON NICHOLL:** No. There -- there are two
20 people that are on professional development, when we
21 pare it down to 16 members, that will have to be moved
22 to another committee, and we're going to be moving
23 them, and they'll be notified who they are. It's not
24 you.

25 **LAUARA SNYDER:** Okay. But on ours, we have a

1 designated agency person, and there's no position for
2 him now.

3 **JASON NICHOLL:** Correct.

4 **LAUARA SNYDER:** So where is he going to go?
5 In another position on the same subcommittee?

6 **JASON NICHOLL:** Yeah.

7 **LAUARA SNYDER:** Okay. That's all I need to
8 know. Thank you.

9 **KRIS KEMP:** Okay. Any other assignments for
10 our subcommittees and our committees? No. Okay. So
11 we had a motion to adjourn. Do we have a second?

12 **JAY DEE DOWNS:** Second.

13 **KRIS KEMP:** All in favor, say aye.

14 **COLLECTIVELY:** Aye.

15 **(Meeting adjourned at 2:55 p.m.)**

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C E R T I F I C A T E

STATE OF UTAH)
 :ss
COUNTY OF SALT LAKE)

I, Angela L. Kirk, a Registered Professional Reporter, Certified Court Reporter, and Notary Public in and for the State of Utah, do hereby certify:

That the foregoing proceedings were taken on April 1st, 2015;

That the proceedings were reported by me in stenotype and thereafter transcribed by computer, and that a full, true, and correct transcription, to the best of my ability, of said proceedings so taken is set forth in the foregoing pages;

That the Original transcript of the same was mailed to Suzanne Barton, Bureau of EMS and Preparedness, 3760 South Highland Drive, Salt Lake City, 84114.

I further certify that I am not of kin or otherwise associated with any of the parties to said cause of action, and that I am not interested in the event thereof.

WITNESS MY HAND and official seal at Salt Lake City, Utah, this 4th day of May, 2014.

Angela L. Kirk, RPR, CCR
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