

PROFESSIONAL DEVELOPMENT SUBCOMMITTEE MEETING  
BUREAU OF EMS AND PREPAREDNESS  
May 14, 2014  
10:00 a.m.

Location: Bureau of EMS and Preparedness  
3750 South Highland Drive  
4th Floor Conference Room 425  
Salt Lake City, Utah 84114

Reporter: Katie Harmon

1 May 14, 2014 10:00 a.m.  
2 PROCEEDINGS  
3 **ROSS FOWLKS:** Officially welcome you to the  
4 Professional Development Committee.  
5 Alicia Gleave on the phone. Right? Anybody  
6 else on the besides Alicia? Nope. Officially nobody  
7 else.  
8 Well, for Alicia's benefit, let's go around  
9 the table and just say who is here.  
10 I'm Ross Fowlks, I'm chair of the Professional  
11 Development Committee.  
12 **DENNIS BANG:** Dennis Bang, Bureau of EMS and  
13 Preparedness.  
14 **VON JOHNSON:** Von Johnson from the UBMC EMS.  
15 **PAULA FULLER:** Paula Fuller from Grand County  
16 EMS.  
17 **CHRIS STRATFORD:** Chris Stafford, University  
18 of Utah.  
19 **JENNY ALRED:** Jenny Allred, Bureau of EMS and  
20 Preparedness.  
21 LaRAE THORPE: LaRae Thorp, Mountainland ATC.  
22 **JIM HANSEN:** Jim Hansen, Bureau of EMS.  
23 **RUSSELL MALONE:** Russ Malone, Salt Lake  
24 Community College.  
25 **ROSS FOWLKS:** And we heard another beep on the

A P P E A R A N C E S

Ross Fowlks  
Dennis Bang  
Jenny Allred  
Russel Malone  
Jim Hansen  
Dr. Peter Taillac  
Dr. Terri Hoffman  
Von Johnson  
Shellie Young  
Guy Dansie  
Tami Goodin  
Cindy Huish  
Paula Fuller  
Mike Willits  
Alicia Gleave [Telephonically]  
Mark Oraskovich [Telephonically]  
Kristine Warren

1 phone so either someone joined or -- Alicia, you still  
2 there?  
3 **ALICIA GLEAVE:** Alicia is here.  
4 **ROSS FOWLKS:** All right. Just must have been  
5 a tone on the phone.  
6 So anyway, we will start with our action  
7 items. No. 2 on there is approval of the -- my mouth  
8 isn't working. Approval of the minutes for our past  
9 meeting. Has everybody had a chance to review them?  
10 Any concerns or questions regarding the minutes? We're  
11 polite because we appreciate how detailed they are.  
12 **DENNIS BANG:** Scary.  
13 **ROSS FOWLKS:** Very detailed. Thank you.  
14 So do we have a motion to approve the minutes  
15 from last meeting?  
16 **RUSSELL MALONE:** I move that we approve the  
17 meeting.  
18 **ROSS FOWLKS:** That's Russ Malone.  
19 Do we have a second?  
20 **VON JOHNSON:** I will second that.  
21 **ROSS FOWLKS:** And Von seconds it.  
22 All those in favor say aye.  
23 **COLLECTIVELY:** Aye.  
24 **ROSS FOWLKS:** Unanimous, they're approved.  
25 We will go on to our informational items and

1 also would welcome Dr. Peter Taillac to the meeting.  
 2 **DR. PETER TAILLAC:** Hi everybody.  
 3 **ROSS FOWLKS:** So No. 3 is the national  
 4 registry to AEMT. Dennis and Jim have that item.  
 5 **DENNIS BANG:** Not much has changed with the  
 6 national registry. We're going to be switching over to  
 7 national registry, hopefully in July any course -- any  
 8 AEMT would be a national registry course and we will  
 9 test by national registry standards. After that we will  
 10 go ahead and go with EMT as well as EMR, will also  
 11 switch.  
 12 Even though I know we discussed in our last  
 13 meeting that we would try to get that and keep it  
 14 in-house, it will still probably be a year to a year and  
 15 a half before we get the EMR switched over. But they're  
 16 trying to get a compact organized. Which to be part of  
 17 the compact, to be able to move your license from state  
 18 to state, little bit easier. That's kind of an easy way  
 19 of saying it.  
 20 They want -- we have to be an national  
 21 registry state, everything -- all our testing has to be  
 22 done by national registry. So that's why Paul is kind  
 23 of pushing us to go ahead and switch everything over.  
 24 So as much as that for national registry, that's the way  
 25 that goes.

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1 The other part of it, I'm going to turn over  
 2 to Jim. We're going to talk about programs since we're  
 3 switching over to national registry and actually  
 4 doing -- rather doing courses, to do -- switch it over  
 5 to programs.  
 6 **JIM HANSEN:** Yeah --  
 7 **VON JOHNSON:** Can I ask one question really  
 8 quick?  
 9 **JIM HANSEN:** Sure.  
 10 **VON JOHNSON:** What's the time line on the EMT  
 11 transition?  
 12 **DENNIS BANG:** It will be after we get the AEMT  
 13 done and get it running smoothly, which I'm projecting  
 14 approximately a year.  
 15 **VON JOHNSON:** Oh, okay.  
 16 **DENNIS BANG:** Until we switch it over.  
 17 **JIM HANSEN:** And as a side note on that, we've  
 18 discussed the fact that EMT doesn't -- national registry  
 19 doesn't have a practical for the EMT so we will use our  
 20 own --  
 21 **DENNIS BANG:** Yeah, we will still be using our  
 22 practical. The only change on that is actually the  
 23 written test.  
 24 **VON JOHNSON:** Okay.  
 25 **JIM HANSEN:** Anything else?

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1 Do you have a little flier thing that we're --  
 2 we put together. Most of it is just cut and pasted off  
 3 of the national registry site regarding their testing.  
 4 But there are a couple of those that are the same as  
 5 what we're doing. So if you have any questions, there  
 6 is some questions and answers.  
 7 The national registry, as well as many of us,  
 8 consider AEMT an advanced level certification. Their  
 9 practical test is paramedic minus rather than something  
 10 else, it's an advanced test without the innovation  
 11 portion, without this portion or that portion, but it is  
 12 an advanced program or an advanced course. And they're  
 13 also looking at some other changes in the way they're  
 14 going to be doing practical testing.  
 15 So therefore, we feel like that we need to  
 16 take that same attitude and have our AEMT courses be  
 17 AEMT programs. I think we've mentioned this before, but  
 18 there is a process that we will need to go through to  
 19 make that happen. And so rather than Dennis and I just  
 20 pounding our head against the wall trying to figure out  
 21 how best to do that, we would like to see if we couldn't  
 22 get some people from this committee to work on a task  
 23 force to see how we could make that work.  
 24 **DR. PETER TAILLAC:** What's the between a  
 25 course and a program, Jim?

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1 **JIM HANSEN:** A program would be accredited  
 2 either by the state or by -- CoAEMSP does the  
 3 accreditation for paramedic programs. And they would  
 4 be -- have to be sponsored by a higher education, a  
 5 hospital, or an agency and they would have to meet  
 6 requirements that we would establish as a subcommittee  
 7 work -- or actually, call it a task force to work on  
 8 developing what that would look like. But yeah, that's  
 9 basically --  
 10 **DR. PETER TAILLAC:** What would the advantages  
 11 be?  
 12 **JIM HANSEN:** Better control of what is being  
 13 taught and who is doing the teaching, having --  
 14 basically, we already have in place a non-agency  
 15 teaching and a testing non -- we don't have to know what  
 16 to call it, but many of them on this table belong to  
 17 that element of it and they could be part of that.  
 18 So it would actually be a -- what do we call  
 19 it?  
 20 **LaRAE THORPE:** What it creates --  
 21 **DENNIS BANG:** Basically what it will do is you  
 22 get better control over it, you're increasing the  
 23 quality of the course that you're going to be producing  
 24 because we can sit in and we can actually go ahead and  
 25 require that they have a certain amount of space to be

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1 able to have the program, they've got the equipment that  
 2 they need, they've got their certified -- you know, they  
 3 would have instructors that we would know. They would  
 4 have to be all state certified instructors in the  
 5 course.  
 6 And what we're trying to do is increase the  
 7 quality of what they have because we feel that the AEMT  
 8 actually needs that little step up. We're not planning  
 9 on doing it with the EMT because we don't want put --  
 10 the agencies that want to start a program and run an EMT  
 11 program, we don't want to eliminate that but we want to  
 12 increase the quality of our courses.  
 13 We feel like we're actually falling behind a  
 14 little bit from what some of the other states are --The  
 15 majority of your states actually right now run program  
 16 rather than run courses. We're one of the few states  
 17 that still runs courses. And we haven't wanted to  
 18 change that because we did not want to -- the rural  
 19 areas, we did not want to put them out of business or  
 20 have to send somebody somewhere else. But a lot of  
 21 states actually -- and that's why we're still leaving it  
 22 with agencies, you can still be an agency and actually  
 23 run as a program.  
 24 But we want to be able to -- probably we're  
 25 going to have to run more than one course a year or, you

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1 know, there is going to be some stipulations of what you  
 2 have to be able to do to be able to get to that point to  
 3 be able to be a program. And then you have to maintain  
 4 that or else you will lose that status.  
 5 **DR. PETER TAILLAC:** CoAEMSP from paramedics  
 6 does have programs that run less than one year that are  
 7 accredited.  
 8 **DENNIS BANG:** And they may do and that's fine.  
 9 **JIM HANSEN:** A course is pretty much a year.  
 10 **DENNIS BANG:** A year course.  
 11 **JIM HANSEN:** But see, these are --  
 12 **DR. PETER TAILLAC:** But they don't run one  
 13 every year, I guess is my point.  
 14 **JIM HANSEN:** Yeah.  
 15 **DR. PETER TAILLAC:** Sometime they don't to, if  
 16 there is a need in the community.  
 17 **DENNIS BANG:** Yeah. And we're not saying  
 18 that's going to be one of them that we will have to  
 19 have.  
 20 **JIM HANSEN:** Those are things we need to work  
 21 on. Because like I say, so far it's been Dennis and I  
 22 brainstorming.  
 23 **DR. PETER TAILLAC:** I'm just thinking out loud  
 24 and, of course, the group is welcome to speak up, you  
 25 know more about this than me. But are we graduating

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1 from these courses students that are substandard and  
 2 can't pass tests and that sort of things? Is it broke?  
 3 I mean, is there a problem?  
 4 **DENNIS BANG:** We feel like we need to increase  
 5 the quality of the courses and the knowledge that are  
 6 coming out of some of the courses. And it's hard to be  
 7 able to regulate a course. It's easier to regulate a  
 8 program than it is a course.  
 9 When it's -- especially when you start looking  
 10 at the other states that they've switched to this a long  
 11 time ago. And so they're coming out of a higher  
 12 education facility which to me increases the quality of  
 13 the course just by name.  
 14 **LaRAE THORPE:** So are you asking for  
 15 volunteers? Is that -- for the task force?  
 16 **JIM HANSEN:** Right.  
 17 **LaRAE THORPE:** Yeah, I'd be willing to sit on  
 18 a task force.  
 19 **VON JOHNSON:** I would be interested in that as  
 20 well.  
 21 **RUSSELL MALONE:** I definitely would.  
 22 **JIM HANSEN:** I like it.  
 23 **DENNIS BANG:** We'll have to get a paper and --  
 24 you got a paper there, Russ. Would you send a paper  
 25 around that we can --

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1 **ROSS FOWLKS:** So if you go from a course to a  
 2 program, is that going to require -- on accreditation  
 3 they're not going to be lined up a college, correct?  
 4 **DENNIS BANG:** They can either be -- what we're  
 5 looking at and what Jim and I just -- because we're  
 6 brainstorming, it would have to be with a college, like  
 7 the MATCs, we'll also -- we're looking at letting  
 8 agencies do it as well as long as they have, you know --  
 9 they meet the requirements that we come up with. So  
 10 we're trying not to lock anybody out, but they're going  
 11 have to be either an agency or --  
 12 **ROSS FOWLKS:** So who will they do their  
 13 accreditation through?  
 14 **DENNIS BANG:** The accreditation will be  
 15 through us.  
 16 **ROSS FOWLKS:** Through the State?  
 17 **DENNIS BANG:** Uh-huh.  
 18 **JIM HANSEN:** Not CoAEMSP but just the state.  
 19 **DENNIS BANG:** No, CoAEMSP, the only one that  
 20 CoAEMSP will do is if they're connected to a paramedic  
 21 program then CoAEMSP will actually accredit an AEMT  
 22 course. But they do not accredit an AEMT course on its  
 23 own, yet. They're looking at doing that but they have  
 24 not -- they don't do it yet.  
 25 **JIM HANSEN:** They're not cheap.

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1           **DENNIS BANG:** Yeah, when you're looking at  
2 what? I think it's \$10,000 to do an accreditation with  
3 CoAEMSP for a paramedic program. And when I was talking  
4 with them and they're saying the problem they got right  
5 now is we'd cost about the same to do an AEMT course.  
6 So they said it's just cost prohibitive so...

7           **JIM HANSEN:** But again, those are things we'd  
8 would like to work out with these folks.

9           **ROSS FOWLKS:** Okay.

10          LaRAE THORPE: Can I make a comment? I can  
11 see one advantage in looking at what other states are  
12 doing, is that you already a built-in regulation going  
13 on when there is accreditation because your standard  
14 already has to be at a certain level or you don't get  
15 your accreditation. So it will be easier for the state  
16 to add to that or require less than that because you  
17 have a maximum amount of requirements that you have to  
18 account for yearly for accreditation.

19          So I mean, it's a long and it's a hard process  
20 and a lot of regulations. So they can only see that our  
21 courses will increase in the quality.

22          **DENNIS BANG:** And that's what we're looking  
23 at. Anything else?

24          **ROSS FOWLKS:** Got your list of names?

25          **JIM HANSEN:** Yup. I got Russ, LaRae and Von.

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1           Good enough.

2           **ROSS FOWLKS:** Sounds good. All right. So  
3 that's it for that item.

4           Next item, let's see, is the strategetic plan.  
5 And once again --

6           **DENNIS BANG:** We'll let Jim talk about  
7 strategetic plan.

8           **JIM HANSEN:** Yeah, sure. I bet.

9           **DENNIS BANG:** Hey, I took the heat on the  
10 other one, you can have it.

11          **JIM HANSEN:** Well, all I can say about it is  
12 that the bureau is working on a strategic plan. Last  
13 month or so when the EMS committee met, they met the day  
14 before and worked on a strategetic plan. And then on  
15 the day of the EMS committee meeting, they again worked  
16 on the strategetic plan and then had the EMS meeting.  
17 That's what I know.

18          **DENNIS BANG:** And I think that's -- really I  
19 think that's about where it stands. We're going to see  
20 what comes out of that strategetic plan, but we haven't  
21 gotten any further than that, Jim.

22          **JIM HANSEN:** It was really mostly a  
23 brainstorming session.

24          **DENNIS BANG:** Yeah.

25          **JIM HANSEN:** Those two meetings, it wasn't

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1           really -- a plan was not developed.

2           **DR. PETER TAILLAC:** I think it's designed  
3 ultimately to be sort of the goals, long term goals, for  
4 the next five plus years for the State -- for EMS and  
5 the State.

6           And you know, this conversation about courses  
7 versus programs and the testing, et cetera of EMR, EMT  
8 would all be part of that, obviously, as this  
9 subcommittee helps develop those programs and visions so  
10 to speak.

11          **ROSS FOWLKS:** Any questions on the strategic  
12 plan?

13          **DENNIS BANG:** Well, what it amounted to is our  
14 other strategic plan is actually coming to an end. So I  
15 think they -- I think Dr. Taillac hit it on the head  
16 that it's just -- it was of more a brainstorming.

17          **DR. PETER TAILLAC:** They had, like, a five  
18 year plan. It's a lot like that.

19          **SHELLIE YOUNG:** How much people are on the  
20 committee, this strategic planning committee?

21          **DR. PETER TAILLAC:** It's really -- the EMS  
22 committee is kind of most of responsible for it  
23 different parts are sort of being worked on by different  
24 people within the bureau and other committees also. And  
25 then it's all assembled in a coherent plan

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1           theoretically.

2           **DENNIS BANG:** That's all.

3           **ROSS FOWLKS:** That's it?

4           Okay. That's really the things we have for  
5 today to cover those things. Is there any other items  
6 that need to be brought up that anyone has?

7           **SHELLIE YOUNG:** When does this strategic plan  
8 plan to be strategized, finished?

9           **DR. PETER TAILLAC:** I don't know exactly.  
10 Jolene is kind of in charge of it and I don't know  
11 exactly. Do you have any --

12          **DENNIS BANG:** I don't know either.

13          **DR. PETER TAILLAC:** It's something that's kind  
14 of always being worked on internally but the -- I think  
15 this year or next year is the last year of the current  
16 five-year plan. I think it's 2015, it's like on the  
17 zeros and fives. So presumably, by the first of, you  
18 know, 2015, I suspect.

19          **SHELLIE YOUNG:** Well, is it a constant work in  
20 progress or is -- does it have a drop dead date where we  
21 have to finish?

22          **DR. PETER TAILLAC:** Well, each plan, as I  
23 understand it -- I've only seen one in my five years  
24 here but -- is from this date to this date here is our  
25 goals and within the plan there is benchmarks. By, you

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1 know, March of 2015 this will be accomplished, by  
 2 September of 2015 this will be accomplished. And that's  
 3 in all of the realms, in the realm of training, testing  
 4 and medical direction and, you know, kind of everything  
 5 that the bureau oversees, licensing, certification, all  
 6 those things, benchmarks for where the bureau feels like  
 7 it should be at a date in the future to kind of move  
 8 forward.  
 9 **SHELLIE YOUNG:** I see.  
 10 **DR. PETER TAILLAC:** It's kind of like the  
 11 roadmap for where we want to go as a state, the EMS  
 12 agency.  
 13 **DENNIS BANG:** And they will produce it --  
 14 well, the last one they did anyway, they produced a  
 15 booklet. But I think everybody has either gotten one or  
 16 seen one at one time or another.  
 17 **DR. PETER TAILLAC:** So it's kind of like to  
 18 do -- it ends up a to do list really, for each part of  
 19 the bureau. For example, medical direction stuff, I'm  
 20 supposed to facilitate to be sure that we meet those  
 21 benchmark along the way. You know, training, there will  
 22 be sections for training and professional development in  
 23 there also.  
 24 So the results of the subcommittee we talked  
 25 about for courses versus programs would be a perfect

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1 addition to the strategetic plan.  
 2 **ROSS FOWLKS:** Okay.  
 3 **DR. PETER TAILLAC:** And thank you for that,  
 4 didn't have think we would have any question about that.  
 5 **SHELLIE YOUNG:** Still a little fuzzy about --  
 6 I mean, who writes -- aren't you kind of the -- who  
 7 writes your assignments? I mean, I don't want to jot  
 8 down what you're supposed to be doing.  
 9 **DR. PETER TAILLAC:** No, but you can make  
 10 suggestions. And ultimately I think Jolene writes it,  
 11 ultimately based on the input of everybody. I think she  
 12 is the final author who kind of presents --  
 13 **DENNIS BANG:** Yeah. See, I don't know that  
 14 but -- not high enough on the food chain.  
 15 **GUY DANSIE:** We had a small internal group  
 16 that went through some national guidance and we picked  
 17 out -- gleaned out some of the things in there that we  
 18 felt like we were either doing well or not doing well.  
 19 **SHELLIE YOUNG:** That's the answer. I was  
 20 wondering, you got national guidelines somewhere and --  
 21 **GUY DANSIE:** Right. I think it's --  
 22 **SHELLIE YOUNG:** Someone who is doing this.  
 23 Okay.  
 24 **GUY DANSIE:** Anyway, we went through the  
 25 strategic planning part of it in March in the EMS

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1 committee. There was a couple things and one of them  
 2 was assigned out to Operations Subcommittee to develop  
 3 some benchmark for the EMS agencies on improving so we  
 4 can measure baseline like response times, a few  
 5 different things. And we're going to be working on  
 6 those a little bit today though we're reporting on those  
 7 back in July.  
 8 And I'm not sure I think in July they will  
 9 informally adopt the strategic plan. I might be  
 10 mistaken. I'm not sure the effective date from when it  
 11 begins. Not sure if it's the calendar year or July 1.  
 12 That's -- we're almost to the process of formalizing.  
 13 I'd have to look at the plan to get the exact dates.  
 14 So that hopefully gives you a little more  
 15 clarity on it.  
 16 **SHELLIE YOUNG:** That does. That answers my  
 17 questions completely. You have some guidelines you're  
 18 working with.  
 19 **GUY DANSIE:** Yeah, and I'm not sure -- I'm not  
 20 sure if the dates start January 1, 2015 or if it's  
 21 July 1 of 2014, you know. But they aren't meeting until  
 22 the second Wednesday of July to adopt it. So I'm not  
 23 sure of the effective date if that makes sense. I would  
 24 have to find out.  
 25 **SHELLIE YOUNG:** Thank you.

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1 **ROSS FOWLKS:** Okay. You all good on that?  
 2 Okay. Anything other items that need to be  
 3 brought up from anywhere?  
 4 This kind of brings up a thought that I have.  
 5 As a subcommittee we obviously get assignments from the  
 6 EMS committee on what to discuss and talk about in here.  
 7 But what is our responsibility as a subcommittee?  
 8 Maybe Jim and Dennis can answer this: Are we  
 9 along those same lines supposed to have a five-year plan  
 10 or just some kind of plan of where we want to go as a  
 11 professional development committee?  
 12 **DENNIS BANG:** I don't know that we need one  
 13 because we're supposed to get things from the EMS  
 14 Committee. And I'm thinking really what's happened now  
 15 is I think they're looking at this new strategic plan  
 16 that they're looking at and I think that's kind of  
 17 slowed some of the things that they're doing now to be  
 18 able to give us something to do.  
 19 But I think we will be getting -- and we  
 20 still -- if we have something, if you guys know of  
 21 something or something becomes an issue, we can still  
 22 look at it and then present it to the EMS committee. So  
 23 that's why we leave this opened on the agenda for other  
 24 items because if there is something that you guys see  
 25 that's happening out in the field that needs to be

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1 brought to the attention, we can bring it here, we can  
 2 review it and then send it on up to -- you know, to the  
 3 EMS Committee.  
 4 I know they changed it so that we're supposed  
 5 to get things from them, but we still can run things the  
 6 other way, as well and run them back up to the EMS  
 7 committee.  
 8 **JIM HANSEN:** Do we want to talk any about the  
 9 dispatch?  
 10 **DENNIS BANG:** I don't think so, no.  
 11 **JIM HANSEN:** No.  
 12 **ROSS FOWLKS:** Okay. So I guess my thought  
 13 would be, those of us as committee members, maybe we  
 14 could take this next -- as we leave this meeting, for  
 15 the next meeting we come back, think about some ideas  
 16 that you want to bring up to hear, that you want to talk  
 17 about it on the table. Maybe the direction we want to  
 18 talk things with the professional development.  
 19 If you feel like we're going the right  
 20 direction and doing the right thing, then great. If  
 21 there is some ideas you want to change and move around,  
 22 at least we could talk about it around the table. I  
 23 just don't want to be a waste of time for people to  
 24 drive all the way here for a half hour meeting, you  
 25 know, actually have some things to discuss.

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1 So does that sound right to everybody?  
 2 **SHELLIE YOUNG:** Can you tell me, who brought  
 3 up the Car 54 Program? Who's --  
 4 **ROSS FOWLKS:** West Jordan is running that  
 5 right now.  
 6 **SHELLIE YOUNG:** How is it going?  
 7 **ROSS FOWLKS:** They seem to enjoy it. You  
 8 know, it's -- I can't give a full report because I'm not  
 9 from West Jordan but I work closely with them.  
 10 **SHELLIE YOUNG:** Well, is it saving money? I  
 11 mean, is it financially --  
 12 **ROSS FOWLKS:** It's saving money as far as the  
 13 maintenance of the vehicle and, you know, their gas and  
 14 things like that, the responses. Because they're  
 15 sending the one car out, it's -- I think on an average  
 16 from what I hear, I can't -- it's not accurate numbers,  
 17 but about one out of every four they end up calling for  
 18 an engine anyway. You know, to come and help them out.  
 19 **SHELLIE YOUNG:** Who is manning the Car 54?  
 20 **ROSS FOWLKS:** It's extra personnel. Yeah,  
 21 whether it be a paramedic -- whether it be a  
 22 paramedic/engineer or just a paramedic or -- sometimes  
 23 they even herd a captain on there, a paramedic caption.  
 24 Whoever they have extra on shift for the day is who they  
 25 put on that. If they don't have any extras, they don't

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1 run it.  
 2 **SHELLIE YOUNG:** I see.  
 3 **DR. PETER TAILLAC:** So it's got one person on  
 4 it?  
 5 **ROSS FOWLKS:** Yeah. So like I say, that's  
 6 just going off my weak knowledge of what they're doing  
 7 in West Jordan.  
 8 **DR. TERRI HOFFMAN:** How long have they been  
 9 running that program?  
 10 **ROSS FOWLKS:** I think they started about --  
 11 what? Six, seven months ago.  
 12 **DR. TERRI HOFFMAN:** So they should getting be  
 13 some data collected from that standpoint as far as the  
 14 success of it and what is going on patient-wise as well?  
 15 **ROSS FOWLKS:** Yeah. In fact, if you'd like, I  
 16 will get ahold of West Jordan and have -- see if they  
 17 can put a report together for us for our next meeting.  
 18 **SHELLIE YOUNG:** I would like to know how it's  
 19 running.  
 20 **DR. PETER TAILLAC:** Great idea.  
 21 **ROSS FOWLKS:** Okay. Anything else? So quiet  
 22 you can hear the vibrating of the phone.  
 23 **DR. PETER TAILLAC:** Well, Ross, along with  
 24 what you said, I have to be careful stepping out too  
 25 much, but I really think it is important that if you

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1 folks as the experts on the training professional  
 2 development certification do have ideas, concerns,  
 3 questions that you bring them up.  
 4 I'm afraid the pendulum swung a little far  
 5 into the wait for the EMS Committee to tell us what to  
 6 do and then we will it do thing. Because they don't  
 7 always have issues that are immediately present for, you  
 8 know, for this body, I guess.  
 9 So I think knowing what they're doing and  
 10 feeling like you can comment upon what they're doing and  
 11 make recommendations to them from one thing and then  
 12 bringing up completely new ideas for another makes sense  
 13 to me, it make a lot of sense. If they have issues with  
 14 that we can discuss it internally, I don't think they  
 15 will.  
 16 **ROSS FOWLKS:** I think in order for us to  
 17 function as a real committee to make things work --  
 18 **DR. PETER TAILLAC:** Agreed --  
 19 **ROSS FOWLKS:** -- we need to have input rather  
 20 than just wait for someone to tell us what to do.  
 21 And I know Russ has plenty to say.  
 22 **RUSSELL MALONE:** No, because I always get in  
 23 trouble. I'm on the blacklist all the time. But I'm  
 24 going to say it anyway. Something that we -- they put  
 25 me up front so they could hit me if I get talking too

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1 much.  
 2 I've had this discussion with Jim and Dennis  
 3 and I know there is a lot of controversy. But on the  
 4 state test team, without violating any confidentiality  
 5 and so forth, I see a major problem that there is a lot  
 6 of courses out there that are teaching in their own --  
 7 what they feel off the books and so forth and not -- the  
 8 manuals don't match. They really don't match.  
 9 And example, OPQRST, which, you know, we teach  
 10 or the five rights for medical, for medications, DOT put  
 11 out in their curriculum five rights. I have had  
 12 students come up -- with our testees come up with eight  
 13 rights and so forth. And they don't match and so it's  
 14 confusing for the students. I don't fault the students,  
 15 I fault the coordinators and the trainers that don't  
 16 have a set guidelines that they're following.  
 17 Because I guarantee you, I could take AOS,  
 18 Brady, any of the books -- and there are so many  
 19 differences in there. And unfortunately, I have to be  
 20 honest, the State doesn't say that -- you know, they're  
 21 caught between the rock and the hard spot, they can't  
 22 dictate which book to use.  
 23 When I first took my course -- which I don't  
 24 want to date myself -- but you used to get the page  
 25 number in AOS that told you the answer to the question

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1 you missed. And it made a difference because you could  
 2 look and see what you missed.  
 3 As a coordinator, I get back that my students  
 4 are lousy in this category or this category, this  
 5 percentage, it doesn't really help me to -- because for  
 6 example, medical, anyone who has coordinated a course  
 7 when you get back your results you see medical and you  
 8 may have a 70 percent pass rate in that one category,  
 9 but medical is half of the book.  
 10 It's -- you know, it's hard to keep  
 11 confidentiality of the test written and practice, but  
 12 you also need to give back to us coordinators some, you  
 13 know, valuable feedback.  
 14 And the other thing is, the TTGs we used to  
 15 have, the TTPs or the skill sheets, whatever you want to  
 16 call them, I still think that the State should have a  
 17 set skill sheet that every course is -- a bottom  
 18 standard for every course, not for an agency.  
 19 The agency, we have the ones that the  
 20 committees put out which are really good. And if you  
 21 find mistake Dr. Taillac is really good about correcting  
 22 little minor mistakes that I found. But we don't have  
 23 anything set for all of the courses to be on the same  
 24 standard.  
 25 And this is going to burn me really bad right

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1 now, but I may say it anyway, in the state testing of  
 2 EMTs, there is no guidance for the test team members on  
 3 what standards that they are to be tested to in writing.  
 4 There is a guideline, but as far as any skill sheets or  
 5 protocols to say they're doing it right, they pulled  
 6 them all out of the book because they were the old TTGs.  
 7 And so it's something that needs to be  
 8 addressed --  
 9 **VON JOHNSON:** Well, doesn't that fall back to  
 10 moving to national registry now where those national  
 11 registries skills sheets and that are established  
 12 already?  
 13 **RUSSELL MALONE:** That will help. There is no  
 14 argument there. That will help. But I'm talking for  
 15 the EMT. Because we need to get to the basic level EMT  
 16 first because then --  
 17 **VON JOHNSON:** But those things are there for  
 18 the EMT courses as well.  
 19 **RUSSELL MALONE:** Right. And the majority of  
 20 them do match. They are some but they're not as in  
 21 depth as some that we've used to use, TTPs and TTGs.  
 22 But the point is, it's not a requirement for  
 23 any course to use those. They can use whatever they  
 24 want and that's where the confusion factor comes in.  
 25 **LaRAE THORPE:** So you want consistency, is

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1 that what you're looking for?  
 2 **RUSSELL MALONE:** Consistency. So everyone who  
 3 comes off that -- that goes through the state testing  
 4 has the same standard. I work part time at Lagoon and  
 5 they take a lot of new EMTs from different courses. And  
 6 I have had a gal a couple weeks ago that could not turn  
 7 on a O2 tank with her certification. She never seen a  
 8 peds cuff and several other things like that.  
 9 And granted, experience is something, but when  
 10 they can't turn on an O2 tank. I've had them not know  
 11 how to fill an non-rebreather mask.  
 12 **DR. PETER TAILLAC:** You're making a good  
 13 argument for this program versus courses.  
 14 **RUSSELL MALONE:** There is big -- there is  
 15 because there is so many people -- I've had people come  
 16 up to me and say, I want to talk about your course, how  
 17 much of it is online on CD that my son gets to do at  
 18 home and say he's done it versus classroom time and  
 19 there is a lot of it.  
 20 The people that come up and say, yeah, I've  
 21 never seen an EpiPen, we use magic markers in class. I  
 22 know Dennis and Jim have been to death on that  
 23 screaming, but we still have courses out there using the  
 24 black tipped EpiPens that have been out of -- not made  
 25 for four years, five years. And we see that on the test

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1 team. Oh, I've never seen the new styles.  
 2 LaRAE THORPE: Yeah, they shouldn't be getting  
 3 through courses and being deficient in those areas.  
 4 **RUSSELL MALONE:** But it's not the student,  
 5 it's coordinators that aren't doing their jobs. I can  
 6 only own bite my finger so many times before I have to  
 7 stop.  
 8 **ROSS FOWLKS:** That's good. I saw the blood  
 9 coming out. So we're good.  
 10 **RUSSELL MALONE:** But that's something that  
 11 needs to be addressed. I know the legal concerns and  
 12 this is where the State needs to look at because we had  
 13 talks that how much legal liability does the State have  
 14 if they put out saying you will follow these skill  
 15 sheets. And I go back to: How much legal liability are  
 16 you going to get if you don't have standards?  
 17 **ROSS FOWLKS:** So at the paramedic and now  
 18 we're going to AEMT national registry, those have the  
 19 standards built into them right there. But as far as  
 20 the EMT, we haven't gone to national registry with that  
 21 one yet.  
 22 **DENNIS BANG:** Well, we will with the national  
 23 standard though and the national standards are there.  
 24 And we have adopted the national standards. So they  
 25 actually are supposed to use the national standard to be

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1 able to teach from.  
 2 **RUSSELL MALONE:** But for like example taking a  
 3 blood pressure or a pulse --  
 4 **DENNIS BANG:** We don't have -- we have an  
 5 office of three, there is no way we can get out there  
 6 and we can look and see what everyone is teaching, what  
 7 they're doing. We send them through course coordinator  
 8 course. We tell them what they need to do. We tell  
 9 them what they're supposed to do. We test them as  
 10 closely as we can.  
 11 The TTGs were wonderful in their day, we don't  
 12 have any -- they don't have any objectives anymore, they  
 13 went away from the objectives in the new curriculum, the  
 14 way they're done. It makes it extremely almost  
 15 impossible, I think, to come up with any TTGs because we  
 16 have the national standard and that's what we're trying  
 17 to go by is the national standard.  
 18 **VON JOHNSON:** But those national standards  
 19 are --  
 20 **DENNIS BANG:** They are vague.  
 21 **RUSSELL MALONE:** They are very vague. It says  
 22 take a pulse; it doesn't say how long. It doesn't  
 23 specify how long you take a pulse on a patient. We  
 24 taught for a years 15 seconds. And then we taught 30  
 25 seconds and then you can go a minute if you feel the

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1 need for it. But there is no standard saying what we're  
 2 supposed to be doing.  
 3 Now I will tell you, I teach my students, very  
 4 simple, he's competent, he's alert, oriented, you can go  
 5 15 seconds unless you find something else if you're  
 6 moving on. Otherwise, you go 30 seconds or a minute.  
 7 But it's -- you know, there is still people out there  
 8 teaching straight --  
 9 **DENNIS BANG:** There is a variance right there.  
 10 There is a variance right there. You're saying right  
 11 there if it was a TTG you would have to teach it for  
 12 either 15 or 30 because that's what it is. You're  
 13 actually doing -- we're wanting you to think outside of  
 14 the box. We're trying get you to do critical thinking,  
 15 Russ.  
 16 **RUSSELL MALONE:** And I agree. I agree.  
 17 **DENNIS BANG:** And so, you know, it depends on  
 18 the situation. And I'm sure you have the same in the  
 19 ER. You don't have -- you have a set rule but you vary  
 20 according to what your patient is.  
 21 **DR. PETER TAILLAC:** Yeah. Right.  
 22 **DENNIS BANG:** And we're trying to do critical  
 23 thinking here. We're not teaching little robots anymore  
 24 to say, gee, you do this if this happens. We're saying,  
 25 hey, look at the situation and see what you really need

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1 to do. I mean, I grant you it's a new concept but I  
 2 think it's a better concept than what we've had before.  
 3 **DR. PETER TAILLAC:** Yeah, it's challenging to  
 4 teach integrative or integrative sort of thinking,  
 5 integrate the whole patient with a sense of  
 6 understanding the situation and responding appropriately  
 7 to the whole picture as opposed to teaching it.  
 8 An example on the emergency medicine side is  
 9 when I was India, a brand emergency medicine residency  
 10 program just started and I went to visit them. And they  
 11 asked me: Do you have a book with all of your  
 12 protocols? And I'm like: What protocols? They're  
 13 like: Well, how you treat asthma and how you treat this  
 14 and how you treat this. And I'm like: Well, that's in  
 15 the textbook but no, we don't have anything written down  
 16 to say how you treat because every patient is similar  
 17 but a little different and treatment is kind of tailored  
 18 to them. You know, they got this sort of confused look  
 19 because they were really hoping that I had a big binder  
 20 full of, you know, if you learn all this then you will  
 21 be an emergency physician.  
 22 You know, so it is that sort of -- there is a  
 23 little tension because there is -- you need to learn how  
 24 to take a pulse properly or how to use a blood pressure  
 25 cuff or open an oxy tank. If you can't do those things

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1 you can't go to step B which is to evaluate the whole  
 2 patient's treatment. So there is the fundamental things  
 3 they have to learn and some of those are rules, but then  
 4 you try to teach them to think to apply those principals  
 5 to any one patient.  
 6 LaRAE THORPE: So we're saying two things here  
 7 though. Because he's looking for a core, a base --  
 8 **DR. PETER TAILLAC:** A base.  
 9 LaRAE THORPE: -- for the medical that they  
 10 need, but then we're talking about critical thinking.  
 11 So there is two conversations going here. Because we  
 12 need some real firm foundation.  
 13 **DENNIS BANG:** If you remember, we used to call  
 14 them teaching and testing protocols. We had to go away  
 15 from that because you can't use the word "protocols."  
 16 **RUSSELL MALONE:** Then we went to guidelines.  
 17 **DENNIS BANG:** Then we went to teaching and  
 18 testing guidelines. Well, so now you go into the  
 19 teaching and testing environment, you use those, you get  
 20 out into the real -- which I hate the word -- the real  
 21 world and out there and work, and all of sudden, well,  
 22 this is what I was taught, I was taught I had to do it  
 23 this way. And it -- to me, it creates some issues, you  
 24 know.  
 25 LaRAE THORPE: Yeah.

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1 **DENNIS BANG:** Yeah. You can't tell me that  
 2 either one of you don't know how to teach someone how to  
 3 take a blood pressure, how to take a pulse. Do you  
 4 really need something that says you have to take it  
 5 exactly this way or exactly this way? I just don't -- I  
 6 don't see where that really is the issue.  
 7 **ROSS FOWLKS:** If every instructor was like  
 8 these guys we wouldn't have a problem.  
 9 **DENNIS BANG:** Right.  
 10 **ROSS FOWLKS:** But the problem is we don't have  
 11 every instructor out there like that. So with some of  
 12 our schools -- some of our courses that we have out  
 13 there, you are getting courses that are being taught at  
 14 the subpar level because they're doing the bare minimum  
 15 and the bare minimum is not set. So that's where we  
 16 have -- that's where we have the problem. As far as --  
 17 Because we used to use the TT -- the teaching  
 18 and testing protocols also for our CME and for our  
 19 recerts.  
 20 **DENNIS BANG:** Right.  
 21 **ROSS FOWLKS:** But we're no longer doing that.  
 22 But I do understand you're saying there needs to be a  
 23 base for those courses.  
 24 LaRAE THORPE: Base knowledge that they go  
 25 through.

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1 **ROSS FOWLKS:** When you're going through the  
 2 course you got to do this and when you go to take your  
 3 state test, you have to do this. Then you go out to the  
 4 real world, at least now you can turn on an O2 bottle,  
 5 at least now you can take a pulse.  
 6 LaRAE THORPE: Or you get your standardized  
 7 patients where we have a scenario going and they have to  
 8 critically think.  
 9 **ROSS FOWLKS:** Yeah.  
 10 **RUSSELL MALONE:** And I agree, there is things  
 11 where you're doing your initial training. But  
 12 unfortunately, and I -- you know, if I'm out of line,  
 13 you two tell me. But when --  
 14 **DENNIS BANG:** No, this is -- I think it's a  
 15 great discussion.  
 16 **RUSSELL MALONE:** When I'm on the state test  
 17 team and I see a person come in and they do an actual  
 18 1985 blood sweep and they're sliding down and they find  
 19 an injury, they control the bleeding, then they log roll  
 20 the patient immediately, put them on a backboard, say  
 21 we've strapped him down and now we're putting him in the  
 22 ambulance now we're going to take and do an assessment  
 23 of the patient and now we're going to do the vitals and  
 24 so forth.  
 25 They have no concept what the injury is on the

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1 patient other than maybe a bleed or something. And  
 2 they've already loaded -- log rolled him and put him in  
 3 an ambulance. They're thinking that when they go out in  
 4 that real world that's exactly what they're going to do.  
 5 Is they're going to throw them -- log roll them out,  
 6 throw them on the back of the -- before they assess  
 7 them, before they do any vitals or anything else and get  
 8 them in the back of that ambulance because that's what  
 9 they were taught in the course. No critical thinking at  
 10 all.  
 11 **JIM HANSEN:** Then they weren't taught national  
 12 education standards.  
 13 **RUSSELL MALONE:** They were not and that's the  
 14 problem that we're getting into that there a lot of  
 15 courses out there that unfortunately -- I shouldn't say  
 16 a lot. There is some courses out there that are  
 17 teaching it. And the advantage or disadvantage,  
 18 whichever way you want to look at it, being on the state  
 19 test teams is I get to look at this.  
 20 **DENNIS BANG:** And Russ, it comes back to the  
 21 same thing, why do you think we're looking at programs?  
 22 **RUSSELL MALONE:** I agree. I'm just saying --  
 23 **DENNIS BANG:** It's not that we don't see it,  
 24 but it takes time to make those changes.  
 25 **RUSSELL MALONE:** Takes times. And the other

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1 thing -- the bottom line I'm saying, I agree with LaRae  
 2 is that if we had a core, bottom core, that this is the  
 3 minimum, that you have to, you know, standard with like  
 4 the old TTGs and so forth, but the minimums. This is  
 5 the way that you would start. I don't want them to when  
 6 they walk out the door to be, you know, holding that --  
 7 you know, memorize that that's the book -- the exact  
 8 way.

9 This is the basics as you go through the  
 10 course and you learn the different techniques and little  
 11 tricks and so forth that those instructors should be  
 12 teaching you.

13 **CHRIS STRATFORD:** Russ, I think the standard  
 14 is there. I mean, I hear what you're saying about this  
 15 core of where that is, but if you write that core and  
 16 the minimum that they need, that will take that critical  
 17 thinking, that flexibility away from them.

18 So I tend to agree with Dennis that I think  
 19 the foundation of the standards is there, I just don't  
 20 think that the instructors are teaching it. It sounds  
 21 like they're teaching -- some of the problems you've  
 22 seen, they're teaching oxygen administration but the  
 23 students aren't getting it or they may not be teaching  
 24 it as well. That's in the standard that they're able to  
 25 do that.

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1 So my -- I guess we're going back to the  
 2 question of the instructors, that coordinators aren't  
 3 doing it, but I don't see you guys as being able to  
 4 monitor them and go in and see them with the resources  
 5 that you have. It sounds like they need that, that  
 6 monitoring or that mentoring or something to see what  
 7 they're actually teaching and not using the old EpiPens.

8 I don't think it's an issue with the standards  
 9 not being there. I think it's an issue with the  
 10 coordinators and instructors not teaching it.

11 **RUSSELL MALONE:** And I don't argue that.  
 12 It's -- again, I agree what you're saying. Also the  
 13 books, the difference in the books and difference in the  
 14 coordinators and training -- or the instructors, they're  
 15 taking their interpretation.

16 If you look at the advanced book, for example,  
 17 for an EMT advance it calls six rights. If you look DOT  
 18 educational standards, it calls five rights. And so you  
 19 get those conflicts and so where do you go. And some of  
 20 the people out there are still teaching such old  
 21 technique and so forth it's -- it's sad.

22 **CHRIS STRATFORD:** See, I'm okay with that.  
 23 I'm okay with five rights or six rights or eight rights  
 24 or however many rights you want. I think that gives  
 25 them the variability to think critically about where

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1 they're at. They're going to see the same variation  
 2 between the agencies once they go on.

3 And if they're not prepared to think about,  
 4 wow, there is six rights, not five or there is eight and  
 5 not four, then they won't be able to problem solve when  
 6 they get to a real agency.

7 **ROSS FOWLKS:** Which acronym are they going to  
 8 follow?

9 We had a comment back in the back.

10 **MIKE WILLITS:** As a coordinator, I've seen all  
 11 of this. Mike Willits, Sevier County EMS. Jones and  
 12 Bartlett is completely different than Brady. One is  
 13 teaching more of a siff do that we used to do, but just  
 14 renames it as a primary, secondary.

15 My concern would be because we've changed, do  
 16 we have a testing environment that's not open to what  
 17 we're able to be teaching. And so if you're testing to  
 18 a certain criteria and then they're saying, well, that's  
 19 wrong, how do we know where your teaching -- where your  
 20 testing is at compared to what we're -- our information  
 21 that we can teach. It is little bit convoluted, if you  
 22 will, and hard to decide which one to pick up.

23 An assessment process right now is one of my  
 24 most difficult things to try to extrapolate out of these  
 25 books. And when you look at the national standard and

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1 it's completely different than what the books are  
 2 saying. As in, primary is pretty close, now you go into  
 3 in the national standard it says, okay, do monitoring  
 4 and history and then you go into your secondary; the  
 5 books don't show it that way. Like I say one is more  
 6 like old siff do.

7 So some of those standards aren't exactly the  
 8 same and my concern would still be what is -- what are  
 9 the steps that we have to pass as far as the testing  
 10 compared to what we're getting from our books and data.  
 11 They can be -- if they're different, we're in trouble.

12 And right, the six rights, the five rights,  
 13 the old four rights, I mean -- that -- if you're marking  
 14 down, okay, they have six rights or they've done five  
 15 rights and that's points, that's a problem.

16 **ROSS FOWLKS:** So I could see a couple issues  
 17 here. No. 1, you got the different levels of training  
 18 that are out there with each course, you know, okay,  
 19 there is -- you're teaching this, you're teaching that.  
 20 But whole thing comes down to at one point they have to  
 21 go through a state test to pass.

22 **MIKE WILLITS:** Right.

23 **ROSS FOWLKS:** So if we're getting people that  
 24 are coming through the state test and passing it that  
 25 don't know how do to an oxygen bottle or don't know how

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1 to do the very basics or what we do, then we got a --  
 2 we've got a problem there. Okay.  
 3 And then if we are getting them through or  
 4 maybe they're not seeing what's going on or maybe you're  
 5 not teaching to the right level of the State, you need  
 6 feedback from the State to tell you where you're not  
 7 teaching.  
 8 **MIKE WILLITS:** Right. Specific information  
 9 like you're saying.  
 10 **ROSS FOWLKS:** If the State sat down and said  
 11 look, all right, you can't put an oxygen -- you can't  
 12 set up an oxygen bottle, you don't pass, that person  
 13 doesn't pass their practical, they got to go back to the  
 14 course and say, hey look, I didn't pass because you  
 15 didn't teach me this. Eventually as the State holds  
 16 their standard on the testing side, the courses will  
 17 come up to par. Or they will go away because they're  
 18 not teaching the right way because people aren't going  
 19 to go to a course that's not going to teach them out to  
 20 get passed that test.  
 21 But we don't want them teaching just to the  
 22 test level either.  
 23 **MIKE WILLITS:** No, that would be -- that would  
 24 be even worse.  
 25 **ROSS FOWLKS:** Yeah.

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1 **DENNIS BANG:** The test is generic enough that  
 2 I don't care which book you use, the test is -- our test  
 3 is not going to be so specific to a book that it's going  
 4 to make a difference. We've got them generic enough  
 5 that they can do that. All we're doing really -- what  
 6 really -- if you want to get really right down to it,  
 7 the -- our state test is just taking a cut across to see  
 8 if they know -- if they learned anything in that class  
 9 at all.  
 10 If you want to get right down to it, what  
 11 really tells me whether they're ready to go out into the  
 12 world or not, is from the course coordinator's letter  
 13 that they send us that says this person is competent to  
 14 be an EMT or AEMT.  
 15 Now we get back to something else totally  
 16 different now since we've opened up this can of worm and  
 17 that is -- so we have -- I have a student that comes in  
 18 and says, gee, I've taken this test twice and I can't  
 19 pass it. I say, well go back and talk to your  
 20 coordinator. Well, they said they're done.  
 21 This is why we're looking at programs again,  
 22 guys. Because we've got coordinators that don't want to  
 23 accept the responsibility of what they are. Once that  
 24 course is done, their job is really not done and yet  
 25 they want to say, well, I'm done, I signed the letter, I

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1 did whatever.  
 2 They actually don't want to step up to the  
 3 plate and take the responsibility of this person really  
 4 isn't ready to take the state test, but I don't want to  
 5 deal with them any longer or I don't want -- I just want  
 6 to pass them on and if they can't pass then that's their  
 7 problem.  
 8 **RUSSELL MALONE:** It goes back the courses  
 9 versus programs. I fully support that 100 percent  
 10 because there is people out there that just want the  
 11 money and it -- unfortunately it shows. They don't want  
 12 to put out the extra effort to --  
 13 **LaRAE THORPE:** Yeah, my accreditation  
 14 standard, I have to follow them a year.  
 15 **DENNIS BANG:** Right.  
 16 **LaRAE THORPE:** The 120 days after is nothing  
 17 compared to -- I have to follow them clear through to  
 18 the following year.  
 19 **DENNIS BANG:** Yeah.  
 20 **ROSS FOWLKS:** I think their comment of saying  
 21 they're done is correct. I think if they're -- at that  
 22 point, if they've taught them what they need to know and  
 23 they've said this is it, but they're not willing to help  
 24 them, they should be done, they should be done as a  
 25 coordinator.

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1 **DENNIS BANG:** Right.  
 2 **ROSS FOWLKS:** Not done with the course.  
 3 **DENNIS BANG:** Well, that opens up a whole  
 4 another issue but we don't want to go into that one.  
 5 **RUSSELL MALONE:** Unfortunately maybe the EMS  
 6 committee needs to make the State come up with some more  
 7 funding for the training side of the house to get some  
 8 people --  
 9 **LaRAE THORPE:** To monitor.  
 10 **RUSSELL MALONE:** To monitor, to come out. I  
 11 love when someone comes out and monitors my course,  
 12 looks at my equipment. You know, I love it when a  
 13 student says, your equipment sucks. And I look at it  
 14 go, okay.  
 15 **CINDY HUIISH:** The problem is, when I go out  
 16 they're on their best behavior, they're doing everything  
 17 right, they have everything out there. And I can't go  
 18 out to every class they hold. When I go out there,  
 19 everything is great, they have their instructors, they  
 20 have everything going good, but that's one class. I  
 21 can't go out every night.  
 22 **RUSSELL MALONE:** I think Cindy should show up  
 23 or whoever the State sends out should show up a -- I'm  
 24 here to see what you're actually doing, your schedule  
 25 says this. Let's see do you have the number of

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1 instructors and so forth.  
 2 **DENNIS BANG:** And we do that, Russ, but just  
 3 what you very said, we have Cindy.  
 4 **RUSSELL MALONE:** That's what I said --  
 5 **CINDY HUISH:** Funding.  
 6 **RUSSELL MALONE:** Maybe we need to get --  
 7 **CINDY HUISH:** But I have the problem, I have  
 8 to have the coordinator there, I have to be able to have  
 9 access to their records. That's my problem.  
 10 **RUSSELL MALONE:** Yeah, but even so, if you  
 11 show up and --  
 12 **CINDY HUISH:** And I have done that a couple of  
 13 times on some problem classes.  
 14 **RUSSELL MALONE:** But I was there, okay. I  
 15 just throw that because, you know --  
 16 **DENNIS BANG:** I think it's great. I think  
 17 it's been a good discussion.  
 18 **RUSSELL MALONE:** You know, and I would still  
 19 like to see a core. Because, yeah, I have the national  
 20 standards and everything else, I've developed my own  
 21 skill sheets I've shared with a lot of people because it  
 22 goes to basic level. And then about half way through  
 23 the course, I don't -- you know, they have them, but  
 24 they've better read them and understand them.  
 25 But then into that critical thinking mode

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1 where I throw things at them from a terrorist, to throw  
 2 a grenade in the middle of the room and see how much run  
 3 out and leave their patients.  
 4 **DENNIS BANG:** And you said the right thing,  
 5 Russ. You made a set of them yourself. There is not a  
 6 coordinator in there that can't do that. To me that's  
 7 the responsibility of the coordinator to make them.  
 8 **JIM HANSEN:** Do have a samples right on the  
 9 website.  
 10 **DENNIS BANG:** Everyone teaches the course  
 11 differently. And that -- you can set up your own set of  
 12 teaching and testing protocols, whatever you want to  
 13 call them, that you use in your course. Because they're  
 14 not going to use them when they get out and work for an  
 15 agency. They're not going to be using those.  
 16 **RUSSELL MALONE:** No, they're not going to use  
 17 those. They have the other set that -- and the agency  
 18 will have their set.  
 19 **DENNIS BANG:** That's correct. Just that --  
 20 **UNKNOWN:** Pretty much old guys that says, oh,  
 21 we don't do it that way, here is how you do it.  
 22 **LaRAE THORPE:** Yeah.  
 23 **ROSS FOWLKS:** If you look at this, when we  
 24 started EMS years ago, when we started the first  
 25 paramedics and the first EMTs here in the State of Utah,

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1 we had everything spelled out exactly what they do,  
 2 every little thing. Okay. We grew up. We got to a  
 3 point to where, you know, we don't want to be told  
 4 exactly how to do every little thing, we want to  
 5 critically think.  
 6 However, those of us who have been around for  
 7 a while are at that level, but those at the basic EMT  
 8 level are not at that level yet. They haven't got  
 9 there. So they're trying to live within our world of  
 10 critically thinking when they haven't even got past that  
 11 point of figuring out, you know, the robot style.  
 12 **DENNIS BANG:** Right. But you don't want --  
 13 you also don't want to train them, to me, in that robot  
 14 style because they don't get out of it.  
 15 **SHELLIE YOUNG:** Do you think they do --  
 16 **VON JOHNSON:** They eventually do.  
 17 **SHELLIE YOUNG:** They do.  
 18 **VON JOHNSON:** They do but it take a long time.  
 19 **DENNIS BANG:** But it takes a long time though.  
 20 **SHELLIE YOUNG:** Everybody goes in a robot at  
 21 first.  
 22 **DENNIS BANG:** They do.  
 23 **SHELLIE YOUNG:** But if they stick with it and  
 24 eventually -- not even eventually, early on, they go  
 25 whoa, that doesn't work they -- I think they come out of

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1 the robot stage pretty early.  
 2 **ROSS FOWLKS:** I've got paramedics that have  
 3 gone through other programs that come through the UFA  
 4 and I can watch them on scene. And I can watch them sit  
 5 there for 20 minutes on scene trying to figure out  
 6 what's going on with this person because they're looking  
 7 at every aspect of -- you know, all the way down to the  
 8 cellular level of what's going to happen with this.  
 9 When you can walk in there and look at the  
 10 patient and in the 60 seconds decide whatever you need  
 11 to go to the hospital right now or not. That's where  
 12 the critical thinking comes in, when you can walk in and  
 13 you can see what's happening. But there are so many out  
 14 there that are, you know -- I'm talking on the paramedic  
 15 level now.  
 16 They go in there and they start thinking about  
 17 every little thing that could be going wrong, what's  
 18 happening here. Rather than just look at the patient  
 19 taking care of them. So there is --  
 20 **SHELLIE YOUNG:** Comes that with experience.  
 21 **ROSS FOWLKS:** You have to have both. You have  
 22 to have the initial -- okay. It's a skill set that you  
 23 automatically just kick into and do. Then you have to  
 24 have the critical thinking on that to decide which skill  
 25 set you're going to go with. So I think we've gone from

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1 one to the other.  
 2 LaRAE THORPE: Ross, can you usually tell  
 3 pretty much what class they took?  
 4 **ROSS FOWLKS:** I'm not going to say it at this  
 5 table. Thank you.  
 6 **RUSSELL MALONE:** I can on the state testing  
 7 that's sad, you know. You can tell sometimes. And I  
 8 don't -- I have never asked a student where they have  
 9 taken their class from; I don't want to know.  
 10 But, you know, Dennis and Jim, to their  
 11 support, on the form that the student brings in to the  
 12 testing member there is a block in the bottom. And I  
 13 write down specific notes if I see a class doing the  
 14 same thing. But the ones who were doing -- and they  
 15 call it "blood sweep." Did they a bleed sweep and moved  
 16 a patient, so forth.  
 17 I put those notes down so these guys can give  
 18 some feedback to the coordinators. Again, and I'm not  
 19 saying it's right, wrong, or indifferent, I'm just  
 20 making my point of view that some of these kids come in  
 21 are doing the robot thing that they didn't look at the  
 22 patient, they did a blood sweep, they -- backboard and  
 23 they're on the ambulance and now they have them strapped  
 24 down, oh, I'm going to log roll this patient, I'm going  
 25 to do this and this.

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1 I really wanted to say, how can you do this  
 2 while I'm tied down a backboard already? Or I've had  
 3 people stand at the door way, I'm going to strip my  
 4 patient and then see what injuries they have.  
 5 LaRAE THORPE: Well, he's made a good case  
 6 over the last, like, 20 minutes for us looking at  
 7 programs versus --  
 8 **RUSSELL MALONE:** I totally agree.  
 9 **VON JOHNSON:** But we have some issues here  
 10 though, we've already established that we are doing  
 11 programs for the EMT level.  
 12 **RUSSELL MALONE:** Yet.  
 13 **VON JOHNSON:** And this is the level that he's  
 14 talking about. So that kind of puts us in a bind, too.  
 15 We're thinking, okay, we're going to fix this by  
 16 establishing programs but we're not establishing a  
 17 program that's going to encompass what he is --  
 18 **DR. PETER TAILLAC:** Maybe the model at the  
 19 higher levels of the programs and finding and -- you,  
 20 know what validating and using the national standards  
 21 will also help spinoff the EMT program. So you know,  
 22 we've discovered there are these standards that are  
 23 published and we will use them in EMT. And by way, here  
 24 they are for EMT also.  
 25 Maybe after the -- or as part of the program

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1 discussion suggestions can be made to the courses for  
 2 materials that the group -- can be given to those EMT  
 3 programs to say these are suggested best practices.  
 4 Maybe they just kind of need to be guided a bit more at  
 5 the state level.  
 6 **JIM HANSEN:** I think another point is that --  
 7 and I'm not going say, unfortunately, the gold standard  
 8 for the State of Utah is AEMT. That's the larger  
 9 practitioner group in the state is AEMT and not EMT.  
 10 EMT is a pretty small number that are either paired up  
 11 with paramedics in the larger agencies or they are  
 12 paired up with AEMTs in the smaller agencies.  
 13 But AEMT is kind of a gold standard anyway.  
 14 So I think that's why I see a focus on AEMT programs.  
 15 And like you say, then it will get down to the paramedic  
 16 level.  
 17 **ROSS FOWLKS:** So EMT --  
 18 **JIM HANSEN:** EMT should be the gold standard,  
 19 should be.  
 20 **ROSS FOWLKS:** If the gold standard is AEMT  
 21 then as a paramedic then we're platinum level then?  
 22 **RUSSELL MALONE:** That doesn't work at all.  
 23 **ROSS FOWLKS:** So I think what you're saying  
 24 there is the paramedics have got established, they're  
 25 set, they're running, they're doing fairly well. With

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1 the few exceptions of those critical thinking versus,  
 2 you know, that.  
 3 But the EMTs are the basis of what we do.  
 4 That's where everybody gets their start. And if you  
 5 don't have it right there, I can see it follow them all  
 6 the way through. Because if you're a lousy EMT, you're  
 7 going to be lousy paramedic.  
 8 **JENNY ALRED:** Isn't this an age old problem  
 9 that's been around forever. Teaching doesn't always  
 10 match the testing. And we've --  
 11 **RUSSELL MALONE:** You know, let me throw  
 12 something out, and interrupt for just a second. Being a  
 13 state testing member, being a course coordinator and  
 14 being an advanced EMT, all this stuff, you name all  
 15 this -- I won't say crap because I'm being professional  
 16 here -- fecal material.  
 17 The bottom line to it is -- she's smiling up  
 18 here -- the state test, I see courses that teach to the  
 19 state test, I see courses that teach beyond the state  
 20 test to the critical thinking. The state test is to me  
 21 almost just a formality.  
 22 If you've taught a quality course, your  
 23 students pass the state test, the practical test.  
 24 Because it is -- at that level. It cannot test putting  
 25 the oxygen tank together. It can't test bagging your

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1 patient. Because you don't have the time and the  
 2 resources and, you know, it's not feasible for the  
 3 number of people we put through there. So it's just a  
 4 formality test that tests the very basics.

5 And I'm sorry, when I see people come in that  
 6 can't even badange a wound or open an airway properly,  
 7 that offends me as a course coordinator that someone out  
 8 there is not doing their job. Now granted, every one of  
 9 us, and Chris will tell you this, and so will everyone  
 10 else, you've had the students that panic when they get  
 11 into the testing situation; they go totally blank.

12 You know, that happens, but you can tell the  
 13 difference of someone who is nervous versus someone who  
 14 really doesn't know what they're doing. And it does  
 15 occur but the test is fairly simple. So you should be  
 16 testing -- training to that test. If you aren't, you're  
 17 training really substandard to be very honest with you.

18 **ROSS FOWLKS:** I think the reality is you're  
 19 not going to test to a perfect EMT, but if you can test  
 20 to basic skills the perfect EMT comes from the continued  
 21 education, comes from the skill, the experience. That's  
 22 what we do as agencies to take care of them, make sure  
 23 we follow through after the testing process.

24 **RUSSELL MALONE:** After they get hired.  
 25 **ROSS FOWLKS:** We do have to have a basis for

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1 the testing when they come in but --

2 **SHELLIE YOUNG:** I supervised the ambulance for  
 3 Davis County for years, had dozen of newbies come in and  
 4 you could tell, you know, first day whether they were  
 5 going to -- whether they knew their stuff or not and we  
 6 did have a few that didn't. They passed the background  
 7 we did and, you know, but they didn't know their stuff.

8 And I just put them with a senior for a few  
 9 days and said teach them what you know and let me know  
 10 if they're going to get it. So I think you're right, a  
 11 lot of agencies do teach differently but the student  
 12 will come around out of the robot stage or -- either  
 13 that he doesn't make it in this line of work.

14 **DENNIS BANG:** There we go.

15 **SHELLIE YOUNG:** And sometimes it's left up to  
 16 the employer to put them with someone and help them  
 17 teach -- get them out of the robot stage. Sometimes  
 18 they don't make it, that's why they're on probation for  
 19 three months or six months or whatever.

20 **DENNIS BANG:** And that's human nature. You  
 21 can't get away from that. I don't care how much you  
 22 try, you can get Dr. Taillac to verify this, there is  
 23 people who make it through medical school that he  
 24 wouldn't want to touch him.

25 **DR. PETER TAILLAC:** Well, you know, as you're

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1 talking about this, I've been trying to put it in the  
 2 same, you know, does it apply --

3 **DENNIS BANG:** Maybe not to that point but --  
 4 **DR. PETER TAILLAC:** To some extent it's true.  
 5 But really, I'm not sure how this would carry into the  
 6 training that an EMT gets. But essentially medical  
 7 school is where doctors learn the ropes really. And the  
 8 basics like the physiology and stuff. But really, it's  
 9 in your residency training where you really do the  
 10 integration.

11 It's almost two separate phases. One is to  
 12 establish a basic fund of knowledge from which you can  
 13 then grow up and learn to put the pieces together, you  
 14 know, what's important and what's not. The actual  
 15 treatment part, you doesn't learn that much treatment in  
 16 medical school, that's more your residency training.  
 17 I'm not sure how that would play into paramedic --

18 **ROSS FOWLKS:** Well, I think it correlates in  
 19 here, you're looking -- as an EMT you learn your skills  
 20 and you learn how to do those skills, learn how to  
 21 bandage, learn how to -- those mechanical portions, you  
 22 are the robot at that point in the EMT school.

23 Once you get out, it's the agency's  
 24 responsibility, I think more than anything else to teach  
 25 the critical thinking.

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1 **VON JOHNSON:** And that's exactly what I tell  
 2 all my students the very first night of class. I tell  
 3 them: You will leave this course with a minimum skill  
 4 set to go out there and learn to become an EMT. We  
 5 cannot in the length of time that we have from these  
 6 classes, we cannot provide a 100 percent competent,  
 7 competent people out there.

8 They pass a minimum competency level and a  
 9 minimum skill set and then time, experience, and work  
 10 with the agency that they work with or whatever else  
 11 makes them that good EMT. We have to provide the  
 12 minimum skill set for them to go out and do that.

13 That's where the moving from the robot to the  
 14 critical thinking part works. But the frustration that  
 15 I have is as we go through these courses, I don't know  
 16 how many times a night I end up saying, okay, this is --  
 17 this what your textbook says, this what we -- this is  
 18 what you're going to be tested on, but this is real  
 19 world. You know, and that's the part that frustrates me  
 20 is the difference between the two.

21 And a lot of it comes from -- I'm sorry, but  
 22 it comes from those TTGs and things that we used to use  
 23 because you have to test at this standard. But this is  
 24 what you're really going to do. You know, you have to  
 25 take a blood pressure for 30 seconds. A lot of --

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1 **DENNIS BANG:** You don't have to take a blood  
 2 pressure for 30 seconds.  
 3 **VON JOHNSON:** Previously that was -- that was  
 4 what was in the TTGs.  
 5 **DENNIS BANG:** And to me that's why to me there  
 6 shouldn't be a TTG for that very reason.  
 7 **VON JOHNSON:** Well, that's why I'm saying,  
 8 there is -- we had to teach that because that was the  
 9 procedure they were going to be tested on. And now, I  
 10 mean, a lot of people it's accurate to take a blood  
 11 pressure in 15 seconds. Some of them it takes longer.  
 12 **ROSS FOWLKS:** A pulse.  
 13 **VON JOHNSON:** You're right, sorry.  
 14 **CHRIS STRATFORD:** Pretty quick at it.  
 15 **RUSSELL MALONE:** I agree with you a  
 16 hundred percent. And to interrupt you for a second,  
 17 mine I tell my students, you have an option, it's part  
 18 of this critical thinking. It's spells that you take it  
 19 15 seconds, 30 seconds or longer as your patient  
 20 condition determines.  
 21 And that's the thing where it comes us as  
 22 coordinators and instructors to make them think, not --  
 23 you know, they have to understand they have to do it for  
 24 a minimum of 15 seconds. In my course it's a minimum of  
 25 15 seconds. I've had pulses taken for six seconds and

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1 people call it good, you know.  
 2 But -- and then the big thing I want to say  
 3 about yours is you're right, experience is the biggest  
 4 teacher that we have and we can't do that in a  
 5 classroom.  
 6 **VON JOHNSON:** Right.  
 7 **ROSS FOWLKS:** Right.  
 8 **DENNIS BANG:** I would like to have a dollar  
 9 for every time I have had a student either be paramedic  
 10 or EMT come in and say, you know, I wasn't sure when  
 11 they were ever going to teach me how to be a paramedic  
 12 or how to be an EMT.  
 13 Because it's not, you put it all together and  
 14 it's -- and then it -- you get out in the field and you  
 15 learn how to be one. We've given you the tools but you  
 16 have to go learn how to be one.  
 17 **SHELLIE YOUNG:** You know, Dennis, one thing we  
 18 found -- a problem we found in Davis County on the  
 19 ambulance division and again when I taught at Weber  
 20 State in the paramedic division, is nowadays you can't  
 21 get a student that's had a lot of riding experience  
 22 either. I mean, we used to hire kids who were going  
 23 through EMT school, we let them ride with us a full six  
 24 months and by the time they finished taking their test,  
 25 they were seasoned EMTs; they'd seen a lot of stuff.

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1 **DENNIS BANG:** Right.  
 2 **SHELLIE YOUNG:** And same with paramedic, we  
 3 put them on a truck and they've got, you know, a year of  
 4 experience before they came to paramedic school.  
 5 Nowadays with the liability as it is nobody will take  
 6 them.  
 7 **DENNIS BANG:** No.  
 8 **SHELLIE YOUNG:** We can't find -- Weber State  
 9 finally opened up a little course where we got Ogden  
 10 Fire to take a few of the students to give them some  
 11 experience before they came to class. It was -- it's  
 12 difficult now. You can't get them in the ERs either.  
 13 **DENNIS BANG:** No.  
 14 **SHELLIE YOUNG:** There is too much liability,  
 15 the privacy acts.  
 16 **DENNIS BANG:** I know it's difficult.  
 17 **SHELLIE YOUNG:** It is difficult.  
 18 **DENNIS BANG:** Well, and that's why we took  
 19 away -- if you remember quite a few years ago, you used  
 20 to be able to -- you had to take an EMT class and then  
 21 you had wait I think it was six months before you can --  
 22 **RUSSELL MALONE:** A year.  
 23 **DENNIS BANG:** You could do it with six months  
 24 if they needed you, but it was a year you had to wait.  
 25 Well, my theory on that was, they're getting

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1 no experience at all. I would rather have them go right  
 2 into an AEMT course at least with the knowledge that  
 3 they had from the EMT.  
 4 **SHELLIE YOUNG:** Right. Not just forget  
 5 everything they learned.  
 6 **DENNIS BANG:** Yeah, they learned -- they'd  
 7 forgotten everything. And so it is a problem, there is  
 8 no doubt. And that's the problem, you've got, nothing  
 9 takes place of the experience that you get. You can  
 10 teach them. I don't -- if you have the TTGs, whether  
 11 you don't have the TTGs, it still comes back to the  
 12 responsibility of the coordinator teaching the material  
 13 that they feel like they need to know. Our testing is  
 14 not that difficult that you can -- that you're going to  
 15 fail if you have some of the knowledge.  
 16 Now, I grant you we've got some poor course  
 17 coordinators, that's why we're looking at the programs  
 18 because the AEMT is a higher standard.  
 19 **SHELLIE YOUNG:** You're right though. But  
 20 nevertheless, no matter what the course coordinator  
 21 does, the ultimate EMT -- polished EMT is the result of  
 22 the employer because --  
 23 **DENNIS BANG:** That's correct.  
 24 **SHELLIE YOUNG:** Because they have to send them  
 25 to continuing medical --

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1 **DENNIS BANG:** Absolutely.  
 2 **SHELLIE YOUNG:** Put them with seasoned --  
 3 someone who can teach them.  
 4 **ROSS FOWLKS:** In response to the question you  
 5 received regarding when do I learn to become a paramedic  
 6 or an EMT, our paramedics in our paramedic school,  
 7 they're learning skills on how to be paramedic while  
 8 they're in classroom. They're learning how to be  
 9 paramedic when they're sitting on that rig next to  
 10 another -- to a preceptor. Okay.  
 11 And when I get guys that I hire that come out  
 12 of a paramedic somewhere else, they're a certified  
 13 paramedic the State of Utah. However, we will teach  
 14 them to be a paramedic when we hire them on. Because  
 15 they've learned the skills and they learned the  
 16 knowledge but they don't know how to function as a  
 17 paramedic until they start working on the rigs.  
 18 **DR. PETER TAILLAC:** It's their residency,  
 19 their internship.  
 20 **ROSS FOWLKS:** It goes back to your doctor  
 21 statement, they went through school but they're not  
 22 functioning anywhere. So I mean, so a lot of this, I  
 23 mean --  
 24 **DR. PETER TAILLAC:** And that's all on the  
 25 apprentice -- you know, master and the apprentice model

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1 basically. You pair them up with somebody who knows  
 2 what they're doing and they teach them, you know, how to  
 3 integrate all that information that they did learn  
 4 before.  
 5 **ROSS FOWLKS:** But see that's -- as far as when  
 6 I say that, that's all an opinion from me from my guys.  
 7 According to the State, you take the certification test,  
 8 you're a paramedic. You're paramedic, you can go out  
 9 and stop on the street and help somebody. Okay.  
 10 **DR. PETER TAILLAC:** Graduate medical school,  
 11 you're an MD.  
 12 **ROSS FOWLKS:** Yeah, I don't want them touching  
 13 me. I will let you, you're good. How do we solve this?  
 14 What -- we've put a lot stuff on the table. Where do we  
 15 need to focus ourselves at this point?  
 16 **DR. PETER TAILLAC:** I think the  
 17 subcommittee -- this is great framing conversation for  
 18 the subcommittee to look at, you know, at the AEMT level  
 19 right now. And I think that's going to help frame it  
 20 for the EMT level also.  
 21 **RUSSELL MALONE:** And I think the ultimate goal  
 22 that I've heard from Dennis and Jim, programs versus  
 23 courses, so you eliminate some of these people that are  
 24 doing it for the money so we get the quality in there.  
 25 And that, I think, is the ultimate solution to the

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1 problem.  
 2 Whether they use skill sheets or not, I'm just  
 3 saying right now for the EMT level we have some  
 4 problems. When we get the AEMT into programs and so  
 5 forth, I would love to see EMT into programs, you know,  
 6 too, because then that would help eliminate some of the  
 7 courses that are not -- I'm trying to tactful, okay,  
 8 it's hard. They're not doing their job.  
 9 **SHELLIE YOUNG:** You said though, you're  
 10 looking into this. What is it you're doing?  
 11 **DENNIS BANG:** For?  
 12 **SHELLIE YOUNG:** The coordinators. You're  
 13 looking into the coordinators, to what --  
 14 **DENNIS BANG:** Well, that's why we're starting  
 15 off with the AEMT to turn into programs because we can  
 16 actually -- that's we why want this to look at -- we  
 17 want this task force, whatever you want to call it, to  
 18 be able to see what standards they feel that we need to  
 19 be able to do that, to be able to -- I don't have the  
 20 manpower to send people out to see all these courses.  
 21 **LaRAE THORPE:** But adding accreditation is  
 22 adding eyes to monitor.  
 23 **DENNIS BANG:** Yeah. Now, the EMT level is  
 24 going to have to come later. We have to start somewhere  
 25 and so we're going to start there at the AEMT because we

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1 feel it's a higher standard and we need -- that's where  
 2 we really need to start. Then we'll go -- maybe -- we  
 3 will never do course coordinator. Maybe we will never  
 4 change from course coordinators for the EMT. Maybe we  
 5 will see that this has worked out so well that we will  
 6 want to change it and actually go with programs for EMT  
 7 as well.  
 8 We're an extremely rural state though. I  
 9 don't want to do it on programs to the point where some  
 10 of these outlying agencies are having a hard time  
 11 putting on some EMT courses and getting people. I have  
 12 to look at both sides of it. You know, where do I hit  
 13 that happy medium that that we can still get EMTs and  
 14 yet we can still keep the quality up. And it's a hard  
 15 balance to make, but that's what I have to it look at  
 16 and try to do.  
 17 **ROSS FOWLKS:** So I guess all this discussion  
 18 we've gone through in the last bit goes back to the  
 19 committee you set up to deal with the program versus  
 20 through coordinator.  
 21 **DENNIS BANG:** I think it's been a great  
 22 discussion because it's brought up a lot of things that  
 23 we can look at.  
 24 **ROSS FOWLKS:** Just leave this here with that  
 25 committee and let you guys bring it together, your task

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1 force.  
 2 **CHRIS STRATFORD:** Jim, I would like to join  
 3 your task force.  
 4 **JIM HANSEN:** Okay. Thanks.  
 5 **SHELLIE YOUNG:** You know, just as a last  
 6 thought, I have a daughter with a central auditory  
 7 processing problem. And she could sit in this  
 8 discussion and think we're speaking in French, she can't  
 9 process the words. She wanted to be an EMT so she went  
 10 through a program. And she did pretty good and she  
 11 missed passing by one point, she didn't pass the state  
 12 test by one point.  
 13 And she cried and cried and came home. She  
 14 had worked so hard, you know. And I said, well, honey,  
 15 maybe, you know, with your -- she's aware of her  
 16 disability. And I said, maybe with your disability it's  
 17 a good idea to take another course. So she did, the one  
 18 just down the street.  
 19 The night and day difference in those courses;  
 20 oh, my word. One was fun and they ran relays and they  
 21 learned to bandage fast. And they learned it, but it  
 22 was fun and they brought treats and it was you know --  
 23 and other class was bookwork, straight read it and pass  
 24 the test. And I mean, the two classes together she  
 25 passed with flying colors finally.

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1 But the difference in the two classes. I  
 2 mean, she learned about the same in each but you could  
 3 not believe the difference in those two courses.  
 4 **DENNIS BANG:** And that's why you have the  
 5 different courses because she did well in one and you  
 6 can have somebody else --  
 7 **SHELLIE YOUNG:** True.  
 8 **DENNIS BANG:** -- say, I didn't like that, all  
 9 they did was do treats, do relays, do this and this.  
 10 You know, I want a program like that.  
 11 **SHELLIE YOUNG:** Didn't learn a thing.  
 12 **DENNIS BANG:** I can't direct everyone to which  
 13 program is the better for them, you know. And I'm not  
 14 saying the one is not better than the other because they  
 15 can be, it depends on the student. But how we gage  
 16 that?  
 17 **SHELLIE YOUNG:** Well, I asked her. I said,  
 18 which one did you learn most from? And she said both, I  
 19 learned a lot from both.  
 20 **ROSS FOWLKS:** Yeah, she probably wouldn't have  
 21 passed with just the book work one because you need the  
 22 skill side.  
 23 **SHELLIE YOUNG:** She didn't. That was the  
 24 first one, she didn't pass with that. But the hands-on  
 25 she did.

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1 **ROSS FOWLKS:** Okay. Any further discussion?  
 2 **RUSSELL MALONE:** Not from me. You asked for a  
 3 half hour, I gave you a half hour.  
 4 **ROSS FOWLKS:** I did. You guys were awesome.  
 5 I appreciate the comments that have been made  
 6 in going over all this and for the input that everybody  
 7 has brought to the table. This is what this committee  
 8 should be about, this kind of discussion.  
 9 So as we come to our next meeting, if you have  
 10 any ideas, don't be afraid to say them. I mean, Russ  
 11 has been working on this one for quite some time. I'm  
 12 glad to see he finally --  
 13 **JIM HANSEN:** Spit it out.  
 14 **ROSS FOWLKS:** He's been hitting me behind, you  
 15 know, the doors over here for quite a while. But this  
 16 wasn't planned so I appreciate you bringing it up.  
 17 Anyways, so next meeting let's have some more  
 18 ideas, talk some more things so we can take this back to  
 19 the -- leave it to Jim or Dennis or we can take it to  
 20 the EMT committee. But with that being said, is there  
 21 any other topics anybody wants to talk about?  
 22 **SHELLIE YOUNG:** Just a reminder of Car 54, I'd  
 23 really like to know how that program is going and  
 24 what's -- is it saving a lot of money.  
 25 **ROSS FOWLKS:** I will find out for you.

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**SHELLIE YOUNG:** Okay.  
**ROSS FOWLKS:** Bring a report.  
**DR. PETER TAILLAC:** Invite one of them to  
 come.  
**SHELLIE YOUNG:** Yeah.  
**DR. PETER TAILLAC:** Give a little  
 presentation. That would be great.  
**ROSS FOWLKS:** Okay.  
**DR. PETER TAILLAC:** Very helpful.  
**LaRAE THORPE:** I will make a motion to  
 adjourn.  
**ROSS FOWLKS:** Perfect, I was just going to ask  
 for that.  
**RUSSELL MALONE:** I will second.  
**ROSS FOWLKS:** LaRae made the motion, I will  
 second it. All in favor.  
**COLLECTIVELY:** Aye.  
**ROSS FOWLKS:** We're adjourned.  
 (End of meeting at 11:15 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 )

THIS IS TO CERTIFY that the meeting of PROFESSIONAL DEVELOPMENT SUBCOMMITTEE in the foregoing meeting named, was taken before me, Katie A. Harmon, a Registered Professional Reporter, Certified Court Reporter, and Notary Public in and for the State of Utah:

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

WITNESS MY HAND and official seal at Salt Lake City Utah, 5th this day of June, 2014.

\_\_\_\_\_  
Katie Harmon, RPR, CSR