Minutes of the
EMERGERNCY MEDICAL SERVICES BOARD
Wednesday June 20th, 2018

The meeting of the Emergency Medical Services Board opened at 9:00 am in the Iris Room at 665 Mainstream Drive, Nashville, Tennessee.

CALL TO ORDER/ROLL CALL

Members of the Board present:

The Board Chair opened the meeting with a Roll Call and the following is the results:

Chris Brooks, MD	Present	James Ross, RN	Present
Jeffrey Davis	Present	Dennis Rowe	Present
Kappu Deshpande	Absent	Chrm. Sullivan Smith, MD	Present
Thomas Dunavant	Present	Tim Strange	Present
Donald Mosby	Present	Tyler White	Present
Greg Patterson	Absent	Jeanne Yeatman , RN	Present
Brian Robinson	Present		

Eleven (11) members were in attendance, a quorum was declared.

Also present:
Donna G. Tidwell Director Office of Emergency Medical Services
Hansel Cook Assistant EMS Director
Joe Holley MD State Medical Director
Paul Richard Legal Counsel
Steve Hamby Region 2 EMS Consultant
Nita Jernigan Region 3 EMS Consultant
Brian Tompkins Region 4 EMS Consultant
Dwight Davis Region 5 EMS Consultant
Teddy Myracle Region 7 EMS Consultant
Kevin Cagle Region 8 EMS Consultant
Randall Kirby EMS Consultant at Large
Tory Ferguson Regulatory Board Administrative Assistant 2

APPROVAL OF THE MARCH 28th, 2018 MINUTES – Motion by Mr. Mosby to accept and seconded by Mr. Strange. Motion passed on voice vote.

OGC Report
Mr. Paul Richardson reviewed the Conflict on Interest Policy with the Board members.

Mr. Richardson reported there were nineteen (19) open cases, two (2) consent orders, there are no agreed or contested cases. The Board was reminded they have a Rule Making Hearing at 10:00 am CDST today. There are 2 new rule in review by OGC: Community Paramedic and Aero-Medical Rules.

TnPAP Report

Mark Harkredder came to the Board and presented the TnPAP report. The some questions from the Board were directed to Mr. Harkredder in which he answered and he also reported TnPAP is going to attend the TEMSEA Conference in July.

School Approval

Director Tidwell came forward with a request from the University of Alaska Fairbanks Technical College to do field internships at Memphis Fire Department. She reported that Dr. Joe Holley will be the local EMS Medical Director. Director Tidwell recommended approval. Motion by Mr. Strange to approved and seconded by Mr. Rowe.

Roll Call Vote

Chris Brooks, MD	Aye	James Ross, RN	Aye
Jeffrey Davis	Aye	Dennis Rowe	Aye
Kappu Deshpande	Absent	Chrm. Sullivan Smith, MD	Aye
Thomas Dunavant	Aye	Tim Strange	Aye
Donald Mosby	Aye	Tyler White	Aye
Greg Patterson	Absent	Jeanne Yeatman, RN	Aye
Brian Robinson	Aye		

Opioid Crisis Best Practices

Dr. Joe Holley introduced Dr. David Stern, Vice Chancellor of Health Affairs for Statewide Initiatives at the University of Tennessee Health Service Center. He reviewed past projects were EMS was a part, e.g. their Mobile Stoke Unit. He related the success of those projects and how such successes have inspired their involvement in another projects.

He outlined a project that he feels EMS would play an important part in. This project is to have the EMS agency to act as a referral agent for the victims of opioid overdose into Peer Support Program. The general consensus of the Board was that it was a role that EMS could play. The Program is in the process of starting in Memphis. Chairman Smith requests for Dr. Stern to keep the Board updated on the Program.

Legislative Update

Mr. Patrick Powell came forward and introduced himself as the Legislative Liaison for the Department of Health. He was here today to update the Board on recently passed legislation.

He reviewed Public Chapters 6-11 (Rule Hearings); 6-26 (Trauma Service Codes); 6-71 (STEMI Centers) 6-75 (Opioid Use and Diversion); 7-22 (Stroke Centers); 7-44 (Student Loan Discretion); 7-54 (Freedom of Speech); 8-61 Reporting of Convictions, Pending Charges, and/or Arrest); 9-29 (Redefines Rules and Policies); 9-54 (Licensure Fee); 9-64 (Child Safety Training Programs); 9-98 (EMT and AEMT Training at the Service Level); and 10-21 (Appeals to Chancery Court). Mr. Powell did outline Public Chapters 7-45 and 7-93 but it is unsure of these apply to the EMS Board. His suggestion was to defer to General Counsel.

At this point the Board Meeting went into recess before the Board could go into the Rule Making Hearing.

Rule Making Hearing

Mr. Paul Richardson (Office of General Counsel) introduced himself as the facilitator of the Hearing. All the Board Members were asked to introduce themselves as was the EMS Staff. Mr. Richardson announced what Rules are going to be considered: 1200-12-01-.02 Ambulance Safety, Design, and Construction Standards; 1200-12-01-.13 EMT, AEMT, and Paramedic Education Programs; 1200-12-01-.14 Categories for Emergency Medical Services and/or Ambulance Service and Mobile Pre-Hospital Emergency Care; and 1200-12-01-.21 Destination Determination.

Summary of Factual Information of the Rule Changes was presented by Mr. Richardson for each Rule. He also related the definition of what a Rule is and the process of approval.

Director Tidwell was ask to describe what other methods were used to inform the public of this hearing.

Public Comment:
Dr. Roger Nagy was called to the podium by Mr. Richardson. He made comments concerning 1200-12-01-.21 Destination Determination changes.

Mr. Richardson read into the record of the Rule Changes:

Rule 1200-12-01-.02 Ambulance Safety, Design, and Construction is amended by deleting subparagraph (3)(h) and paragraph (4) in their entirety and substituting instead the following language, so that as amended the new subparagraph shall read:

(h) Each ambulance service placing ambulances in service or obtaining an initial permit in the state of Tennessee shall ensure that ambulances are manufactured and maintained according to the ambulance safety, construction and design standards that were adopted by the board as of the date of final manufacture. Current board-approved standards are posted on the Division's web page at http://tn.gov/health/article/ems-about , or at any successor web address, and are hereby incorporated into this rule as if they were fully set out and stated herein. The effective date of any changes in the posted standards will be determined by the board.

(4) Specialty Care Vehicle Requirements

Vehicles used exclusively for the provision of specialty care response and/or transport shall conform with the board-approved ambulance safety, construction and design standards, with the following exceptions:

(a) Additional markings, legends, or logos may be used to identify the provider and purpose for specialty care vehicles, except that no letter shall exceed six inches in height. Legends identifying the specialty care provided, such as "Neonatal Intensive and Critical Care Transport," may be substituted for the word "Ambulance" in exterior markings.

(b) Vehicle electrical systems shall be sufficient to sustain specialized equipment as verified by manufacture's certificate. Units shall be equipped with a back-up power system sufficient to operate life support equipment in the event the main power system fails.

(c) Patient compartments, based on the vehicles' specialty care response, shall conform with the current Tennessee Perinatal Care System Guidelines for Transportation posted at https://www.tn.gov/contenUdam/tn/health/documents/GuidelinesTransportationPAC.pdf or any successor site.

Rule 1200-12-01-.13 EMT, AEMT and Paramedic Education Programs is amended by deleting part (2)(h)5 and only subpart (2)(h)5(i) including items in their entirety, and substituting instead the following language, and is further amended by inserting new subpart (2)(h)5(ii) and renumbering the remaining part accordingly, so that as amended, the new part and subparts shall read:

5. Student Admissions and Conduct.

(i) EMS Educational Institution admission requirements shall be clearly defined and published by the institution, and shall be non-discriminatory with respect to race, color, creed, sex, age, handicaps, or national origin.

(ii) Persons seeking admission to an EMT, AEMT, or Paramedic education program shall:

SS-7037 (September 2017)

(I) Meet the admission requirements of the EMS educational institution;

(II) Possess an academic or equivalent high school diploma or general education equivalent (GED); or

(III) Be a high school senior who is eligible for dual enrollment for college credit, and who will be eighteen (18) years of age within ninety (90) days of completing the training for which admission to a program is sought.

Rule 1200-12-01-.14 Categories for Emergency Medical Services and/or Ambulance Service and Mobile Pre-Hospital Emergency Care is amended by deleting the rule in its entirety, including the rule title, and substituting instead the following language, so that as amended, the new rule and rule title shall read:

1200-12-01 -.14 Emergency Medical Services Standards and Categories for Licensed Ambulance Service and Mobile Prehospital Emergency Care. The following rules are promulgated to establish minimum standards and categorical capabilities for emergency medical services and/or ambulance services licensed in Tennessee and to govern emergency medical services provided to a patient.

(1) Definitions.

(a) "Advanced Life Support" means advanced emergency medical technicians, or other EMS personnel having a higher level of licensure, who treat life-threatening or aggravating medical emergencies under medical control.

(b) "Basic Life Support" means EMS personnel, authorized through the appropriate level of licensure, who treat life-threatening medical emergencies under medical control.

(c) "Base of Operations" means the principal location and physical structure (i.e. building), having a street address, city and zip code, from which ambulances and/or personnel operate to provide ambulance service within a service area.

(d) "Division" means the Division of Emergency Medical Services of the Tennessee Department of Health

(e) "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that it could put the patient's health in serious jeopardy, cause serious impairment to bodily function, or cause serious dysfunction of any body organ, system or part without immediate medical attention.

(f) "Emergency Run" means a transport or response, occurring or accomplished without delay, to the perceived need for care for an emergent, trauma or medical condition in order to prevent loss of life or aggravation of illness or injury, including but not limited to the following:

1. Cardiac arrest;

2. Difficulty breathing/shortness of breath/airway impairment;

3. Severe chest pain or heart attack;

4. Severe motor vehicle crashes/entrapment or pin-in;

5. Decreases in level of consciousness/diabetic emergencies;

6. Heat emergencies;

7. Severe lacerations or possible amputations; severe burns (thermal, chemical or electrical);

8. Possible stroke; and

9. Complications of childbirth.

(g) "Emergency Medical Service Director" ("Service Director") means an individual who directs the planning, development, implementation, coordination, administration, monitoring and evaluation of services provided by a licensed ambulance service.

(h) "Emergency Medical Service Medical Director" ("Medical Director") means an individual who has an active, unencumbered license to engage in the practice of medicine pursuant to title 63, chapter 6, or chapter 9, and who provides medical advice, direction, oversight, quality assurance and authorization to emergency medical services personnel at a licensed ambulance service, and/or emergency medical services educational institution.

(i) "Medical Control" means the instruction, advice or orders given by a physician in accordance with locally or regionally approved practices.

U) "Minimum Standards" means the minimum requirements for ambulance and emergency medical services established by law, regulation, and prevailing standards of care.

(k) "Service Area" means the political and geographical area with a population that can be expected to use the services offered by a specific provider.

(I) "Specialty Care Transport" ("SCT") means the inter-facility transportation of a critically injured or ill patient by a ground ambulance vehicle, including the provision of medically necessary supplies and services, which requires a level of service beyond the scope of a paramedic.

(m) "Substation" means the physical structure from which ambulances and personnel operate on a day-to-day basis to provide ambulance services, which are supplementary to the services provided from the base of operations for the specified city or county.

(n) "Volunteer ambulance service" means a not-for-profit service that uses volunteer personnel and restricts emergency operations to scheduled events or serves as a relief organization under the constraint of the main or governmental emergency medical services provider within a service area.

(2) Ambulance Operations.

(a) Each base of operations must hold a State-issued service license for the county in which it is located.

(b) No ambulance service shall position, post, stage or otherwise offer or make an ambulance available within the service area where the county, municipality or special purpose district or authority has current ordinances or resolutions preventing such without prior authorization of the governing body of the service area.

(c) Notwithstanding any other provision, nothing shall preclude an ambulance provider with federal contracts from providing service as required under those contracts.

(3) Classification of Services.

(a) Each ambulance service license the Division issues must indicate the minimum clinical level of service that the ambulance service can provide.

(b) The Division shall grant an ambulance service license only after it verifies that the service is in compliance with Division rules for immediate or scheduled patient transport.

(c) The Division recognizes the following classes of service for licensing or authorization of ambulances and/or emergency medical services:

1. Category A: Primary emergency provider. Each ambulance service the local government designates as the primary provider by recognizing it as such or contracting with it to provide initial response to scene emergencies shall operate advanced and/or basic life support ambulances within the service area 24 hours a day. The service may also provide ambulance transport services under its license for its county specific service area. It shall coordinate licensed volunteer ambulance services as well as coordinate and oversee emergency medical response agencies within its jurisdiction.

(i) Level 1: 100% of Emergency runs shall be made with an Advanced Life Support equipped ambulance and staffed with a paramedic and a minimum of an EMT.

(ii) Level 2: 90% of Emergency runs shall be made with an Advanced Life Support equipped ambulance and staffed with a paramedic and a minimum of an EMT.

(iii) Level 3: 100% Emergency runs shall be made with a Basic Life Support equipped ambulance and staffed with two AEMTs.

(iv) Level 4: 90% of Emergency runs shall be made with a Basic Life Support equipped ambulance and staffed with an AEMT and an EMT.

2. Category B: Licensed Ambulance Transport Services. Each licensed ambulance service shall operate ambulances for unscheduled or scheduled transportation of patients. The level of the licensed ambulance service must be consistent with their issued service license level.

(i) Level 1: 100% of transports shall be made with an Advanced Life Support equipped ambulance and staffed with a paramedic and a minimum of an EMT.

(ii) Level 2: 90% of transports shall be made with an Advanced Life Support equipped ambulance and staffed with a paramedic and a minimum of an EMT.

(iii) Level 3: 100% of transports shall be made with a Basic Life Support-equipped ambulance and staffed with a two AEMT 100% of time.

(iv) Level 4: 90% of transports shall be made with a Basic Life Support-equipped ambulance and staffed with a minimum of two EMTs.

3. Category C: Volunteer not-for-profit ambulance services using volunteer personnel shall restrict emergency operations to scheduled events or serve as a relief organization under the coordination of the primary emergency provider. Volunteer ambulance services may, in times of disaster, be used in their communities as deemed necessary by local authorities and/or primary service providers. All Category C services shall be Category B, Level 4 transport services at a minimum.

(d) Conditional Ambulance Services. The Division may place a new service or a service having deficiencies in a conditional license category for up to ninety (90) days from the date of the deficiency or issuance of the license. Placing the license in a conditional license category is not disciplinary action.

(4) Personnel. Each ambulance or emergency medical service shall assign qualified persons to perform functions to ensure compliance with its licensure as follows:

Each ambulance service shall retain an Emergency Medical Services Medical Director ("Medical Director") who serves as medical authority for the ambulance service and functions as a liaison to the medical community, medical facilities, and governmental entities. His or her duties shall include, but not be limited to, the following:

(a) Quality management and improvement of patient care, including the following:

1. Development of protocols, standing orders, training, procedures, approval of medications and techniques permitted for field use by service personnel in accordance with regulations of the Division;

2. Quality management and improvement of field performance as may be achieved by direct observation, field instruction, in-service training or other means including, but not limited to:

(i) Ambulance run report review;

(ii) Review of field communications tapes;

(iii) Post-run interviews and case conferences;

(iv) Critiques of simulated or actual patient presentations; and

(v) Investigation of complaints or incidents reports.

(b) The medical director shall have disciplinary and/or corrective action authority sufficient to oversee quality management and improvement of patient care as the service director of the ambulance service deems appropriate.

(5) Each ambulance service shall require and document continuing education of at least fifteen (1 5) contact hours annually for ninety-five percent (95%) of emergency care personnel. Each service shall implement a competency-based evaluation program in accordance with board policy.

(6) Each ambulance service shall also conduct training for new procedures or remedial instruction as ordered by the medical director and or emergency medical service director.

(7) EMS/Ambulance Services who do not use educational institutions or other educational accrediting bodies to provide continuing education contact hour credit for in-service training hours for renewal of personnel licenses may count such in-service training hours as continuing education contact hours as required for renewal of personnel licenses, provided the service meets the following requirements:

(a) The service must have an individual who maintains, at a minimum, an authorization of an EMT instructor/coordinator authorized by the Division of EMS to maintain educational records and coordinate in-service education for the service's personnel.

(b) The service must maintain all educational records for five (5) years.

(c) The service's educational records must contain:

1. A curriculum vitae establishing the instructor's expertise in the content for each lesson plan;

2. Lesson plans shall include, but not be limited to:

(i) A list of course objectives, and

(ii) A course outline;

3. Course evaluations by students;

4. An evaluation of each student's performance in the course; and

5. A sign-in sheet bearing the signatures of all students who attended the course.

(d) The service's training records will be randomly audited annually for compliance.

(8) Service permits issued by the Division shall be specific to the county in which the service has its base of operations. The service owner may maintain records for such operations at a central location. The service owner shall maintain records to detail all activities at the county base of operations.

(9) Licensing Procedures

(a) No person, partnership, association, corporation, or state, county or local government unit, or division, department, board or agency thereof, shall establish, conduct, operate, or maintain as a business in the state of Tennessee any ambulance, invalid vehicle service or vehicle operated with a patient cot for transport of persons without having a license.

1. A license shall only be issued to the applicant named and only for the base of operations and substations listed in the application for licensure.

2. Licenses are not transferable or assignable and shall expire annually on June 30.

3. The license shall be conspicuously posted at the base of operations.

(b) Initial Licensure

1. In order to make application for a new license, applicants shall have service names that are unique and the business name shall be registered with the Department of State, Division of Business Services.

2. The applicant shall submit an application on a form prepared by the Division. The service shall report the names, titles and summary of responsibilities of the service director and those persons who will be supervising the ambulance service as officers, directors or other ambulance service officials, and information as to any misdemeanor or felony convictions, or disciplinary sanctions against licenses, certifications, or other authorizations to practice a health care occupation or profession, that have been imposed against them in this or any other state.

3. Each applicant for a license shall pay the annual license fee and permit fees based on the number of ambulances or permitted invalid vehicles. The fees must be submitted with the application and are non-refundable.

4. The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the Division. Patients shall not be transported until a license has been issued. Applicants shall not hold themselves out to the public as being an ambulance service until the license has been issued. A license shall not be issued until the service is in substantial compliance with these rules and regulations, including submission of all information required by T.C.A. § 68-140-306, or as later amended, and of all information required by the Division.

5. The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a license, had a license disciplined, or has attempted to avoid the inspection and review process in this or any other state.

6. An applicant shall allow the premises, the service, and its vehicles to be inspected by a representative of the Division.

7. In the event that deficiencies are noted, the applicant shall submit a plan of corrective action to the Division. Once the deficiencies have been corrected, then the Division shall reconsider the application for licensure. If vehicles have failed inspection, a repeat inspection fee must be submitted to the Division.

(c) License Renewal

1. In order to renew a license, each service shall subject its premises, operational procedures, records, equipment, personnel and vehicles to periodic inspections by representatives of the Division for compliance with these rules. If deficiencies are noted, the licensee shall submit an acceptable plan of corrective action, remedy the deficiencies and pay any repeat inspection fees. In addition, each licensee shall submit a renewal form approved by the Division and any applicable renewal fees prior to the expiration date of the license.

2. Upon reapplication, the licensee shall submit its base of operations, stations, and vehicles to inspections by representatives of the Division for compliance with these rules.

3. Ambulance services must show documented proof of annual mandatory random drug screening for licensed employees.

4. An ambulance service may renew the service license within sixty (60) days following the license expiration date upon payment of the renewal fee, in addition to a late penalty established by the board for each month or fraction of a month that payment for renewal is late, provided that the late penalty shall not exceed twice the renewal fee. If the ambulance service license is not renewed within sixty (60) days following the license expiration date, then the licensee shall reapply for licensure in accordance with the rules established by the board.

(d) Changes of address, insurance agents or policies, service director, officers, or other service officials, EMS medical director, or bankruptcy filings must be reported to the Division no later than five (5) business days after the change or date of effective action.

(e) A proposed change of ownership, including a change in a controlling interest, must be reported to the Division a minimum of thirty (30) days prior to the change. The Division must receive a new application and fee before the license may be issued.

Rule 1200-12-01 -.21 Destination Determination is amended by deleting the rule in its entirety, but not the rule title, and substituting instead the following language, so that as amended, the new rule shall read:

(1) Trauma patients - The goal of the pre-hospital component of the trauma system and destination determination rules is to minimize injury through the safe and rapid transport of the injured patient. The patient shall be taken directly to the center most appropriately equipped and staffed to handle the patient's injury, as defined by the region's trauma system. These destinations shall be clearly identified and understood by regional pre-hospital personnel and shall be determined by triage protocols or by direct medical direction. Ambulances shall bypass those facilities not identified by the region's trauma system as appropriate destinations, even if they are closest to the incident.

(2) Following the designation of a trauma center in any region, persons in that region who have suffered a traumatic injury as determined by triage at the scene shall be transported according to the following rules:

(a) Adult (i.e. persons fifteen (15) years of age or older) and pediatric (i.e. persons under fifteen (15) years of age) trauma patients shall be triaged and transported according to the flow chart labeled "2011 Guidelines for Field Triage of Injured Patients," or any successor publication. Copies of the charts are available from the Division of EMS.

1. Step One and Step Two adult patients shall be transported to a Level 1 Trauma Center.

2. Step One and Step Two pediatric patients shall be transported to a Comprehensive Regional Pediatric Center ("CRPC") or to an adult Level 1 Trauma Center if no CRPC is available. In regions with two CRPC's or one CRPC and another facility with Level 1 adult trauma capability, local destination guidelines shall ensure that pediatric trauma patients are transported to the facility most appropriate for their injuries.

3. Local or regional medical control may establish criteria to allow for non-transport of clearly uninjured patients.

4. Medical control shall determine patient destinations within thirty (30) minutes by ground transport of a Level 1 Trauma Center or CRPC.

(b) Exceptions apply in the following circumstances:

1. For ambulances, Step One and Step Two adult and pediatric trauma patients shall be transported to the most rapidly accessible Level 1 Trauma Center or CRPC, taking safety and operational issues into consideration. Step Three and Four patients shall be transported to a trauma center which need not be the highest level center or as determined by the ambulance's Medical Control.

2. Air ambulances shall not transport chemical or radiation contaminated patients prior to decontamination.

3. If the trauma center chosen as the patient's destination is overloaded and cannot treat the patient, medical control shall determine the patient's destination. If medical control is not available, the patient's destination shall be determined pursuant to regional or local destination guidelines.

4. A transport may be diverted from the original destination:

(i) If a patient's condition becomes unmanageable or exceeds the capabilities of the transporting unit; or

(ii) If medical control deems that transport to a Level 1 Trauma Center is not necessary.

(c) Transports made under any of the exceptions listed above shall be reviewed through the EMS provider's quality improvement process and by the medical director of the EMS provider.

(d) Medical control can be accomplished by a trauma or emergency physician on duty at a designated trauma center or by protocols established in conjunction with a regional Level 1 Trauma Center.

(3) Patients with time sensitive illnesses shall be transported to the most appropriate facility based on their condition or illness according to the following destination guidelines:

(a) Any patient who does not have a time sensitive illness shall be transported to the most appropriate facility in accordance with regional or local destination guidelines.

(b) Any patient transport may be diverted from the original destination if the patient's condition becomes unmanageable or exceeds the capability of the transporting unit, in which case the patient should be treated at the closest appropriate facility.

(c) There are circumstances in adult emergency care as determined by local medical control where it may be appropriate to bypass a basic or a primary care facility for a higher level of care. Examples of such circumstances include, but are not limited to the following:

1. Acute Cardiac event such as STEMI

2. Acute change of mental status

3. Cardiac arrest

4. Significant toxin ingestion history

5. Massive gastrointestinal (GI) bleed

6. Life threatening dysrhythmias

7. Compromised airway

8. Signs or symptoms of shock

9. Severe respiratory distress

10. Respiratory arrest

11. Acute cerebrovascular event

(4) Pediatric Medical Emergency - Pediatric patients represent a unique patient population with special care requirements in illness and injury. Tennessee has a comprehensive destination system for pediatric emergency care facilities as defined in rule 1200-08-30-.01.

(a) There are circumstances in pediatric emergency care as determined by local medical control where it would be appropriate to bypass a basic or a primary care facility for a general or comprehensive regional pediatric center.

1. Examples of such circumstances include, but are not limited to the following

(i) On-going seizures

(ii) A poorly responsive infant or lethargic child

(iii) Cardiac arrest

(iv) Significant toxin ingestion history

(v) Progressive respiratory distress (cyanosis)

(vi) Massive gastrointestinal (GI) bleed

(vii) Life threatening dysrhythmias

(viii) Compromised airway

(ix) Signs or symptoms of shock

(x) Severe respiratory distress

(xi) Respiratory arrest

(xii) Febrile infant less than two months of age

2. Pediatric medical emergency transport may be diverted from the original destination if the patient's condition becomes unmanageable or exceeds the capability of the transporting unit, in which case the patient may be triaged at the closest facility.

3. Pediatric medical emergency air ambulance transports must go to a Comprehensive Regional Pediatric Center.

(b) Pediatric trauma patients should be taken to trauma facilities as provided in paragraph (2).

(5) Any patient who does not qualify for transport to a Trauma Center or a Comprehensive Regional Pediatric Center should be transported to the most appropriate facility in accordance with regional or local destination guidelines.

(6) Adults or children with specialized health care needs beyond those already addressed should have their destination determined by Medical Control, or by regional or local guidelines, or by previous arrangement on the part of patient (or his/her family or physician).

(7) A transport may be redirected or an alternate destination requested. If so, non-transport of the patient, or transport of the patient to an alternate destination shall not violate this rule and shall not constitute refusal of care.

Mr. Richardson asked the Board to discuss the comments of Dr. Nagy.

A motion by Mr. White to change:

a (1). Step One and Step Two adult patients shall be transported to a Level I Trauma Center to *(1). Step One and Step Two adult patients shall be transported preferably the highest level in the Trauma System.*

Also a (2). Step One and Step Two pediatric patients shall be transported to a Comprehensive Regional Pediatric Center ("CRPC") or to an adult Level 1 Trauma Center if no CRPC is available to a *(2).Step One and Step Two pediatric patients shall be transported to a Comprehensive Regional Pediatric Center ("CRPC") or the highest level of care within the system if no CRPC is available.*

Also b (2) Step One and Step Two pediatric patients shall be transported to a Comprehensive Regional Pediatric Center ("CRPC") or to an adult Level 1 Trauma Center if no CRPC is available be changed *to b (2) Step One and Step Two pediatric patients shall be transported to a Comprehensive Regional Pediatric Center ("CRPC") or to highest level of care within the system if no CRPC is available.*

And change a (4) Medical control shall determine patient destinations within thirty (30) minutes by ground transport of a Level 1 Trauma Center or CRPC to *a (4) Medical control shall determine patient destinations within thirty (30) minutes by ground transport to the highest level of trauma care within the system or CRPC.*

Also change a (2) In regions with two CRPC's or one CRPC and another facility with Level 1 adult trauma capability, local destination guidelines shall ensure that pediatric trauma patients are transported to the facility most appropriate for their injuries to *a (2) In regions with two CRPC's or one CRPC and another facility with highest level trauma care, local destination guidelines shall ensure that pediatric trauma patients are transported to the facility most appropriate for their injuries.*

In b (4) ii If medical control deems that transport to a Level 1 Trauma Center is not necessary be changed to *b (4) ii If medical control deems that transport to the highest level of care is not necessary.*

In (d) Medical control can be accomplished by a trauma or emergency physician on duty at a designated trauma center or by protocols established in conjunction with a regional Level 1 Trauma Center to *(d) Medical control can be accomplished by a trauma or emergency physician on duty at a designated trauma center or by protocols established in conjunction with a Level I or Level II trauma center.*

Rob Seesholtz (Tennessee Trauma System Manager) was asked to come to the podium and answer specific questions about Tennessee Trauma System. Mr. Seesholtz was to reference a resource or answer any question that was asked.

Mr. White offered to amend his motion in that:

A motion by Mr. White to change: a (1). Step one and Step Two adult patients shall be transported to a Level I Trauma Center to *(1). Step one and Step Two adult patients shall be transported to a Level I or II.*

Also a (2). Step One and Step Two pediatric patients shall be transported to a Comprehensive Regional Pediatric Center ("CRPC") or to an adult Level 1 Trauma Center if no CRPC is available to a *(2).Step One and Step Two pediatric patients shall be transported to a Comprehensive Regional Pediatric Center ("CRPC") or to an adult Level I or II if no CRPC is available.*

Also b (2) Step One and Step Two pediatric patients shall be transported to a Comprehensive Regional Pediatric Center ("CRPC") or to an adult Level 1 Trauma Center if no CRPC is available be changed *to b (2) Step One and Step Two pediatric patients shall be transported to a Comprehensive Regional Pediatric Center ("CRPC") or to a Level I or II adult trauma capability within the system if no CRPC is available.*

And change a (4) Medical control shall determine patient destinations within thirty (30) minutes by ground transport of a Level 1 Trauma Center or CRPC to *a (4) Medical control shall determine patient destinations within thirty (30) minutes by ground transport of a Level I or II within the system or CRPC.*

Also change a (2) In regions with two CRPC's or one CRPC and another facility with Level 1 adult trauma capability, local destination guidelines shall ensure that pediatric trauma patients are transported to the facility most appropriate for their injuries to *a (2) In regions with two CRPC's or one CRPC and to a Level I or II, local destination guidelines shall ensure that pediatric trauma patients are transported to the facility most appropriate for their injuries.*

In b (4) ii If medical control deems that transport to a Level 1 Trauma Center is not necessary be changed to *b (4) ii If medical control deems that transport to a Level I or II is not necessary.*

Change (b) Exceptions apply in the following circumstances:

1. For ambulances, Step One and Step Two adult and pediatric trauma patients shall be transported to the most rapidly accessible Level 1 Trauma Center or CRPC to *For ambulances, Step One and Step Two adult and pediatric trauma patients shall be transported to the most rapidly accessible Level 1 or level II Trauma Center or CRPC.*

In (d) Medical control can be accomplished by a trauma or emergency physician on duty at a designated trauma center or by protocols established in conjunction with a regional Level 1 Trauma Center to *(d) Medical control can be accomplished by a trauma or emergency physician on duty at a designated trauma center or by protocols established in conjunction with a Level I or II.*

The amended motion was by Mr. Ross.

A roll call vote was taken:

Roll Call Vote

Chris Brooks, MD	Aye	James Ross, RN	Aye
Jeffrey Davis	Aye	Dennis Rowe	Aye
Kappu Deshpande	Absent	Chrm. Sullivan Smith, MD	Aye
Thomas Dunavant	Aye	Tim Strange	Aye
Donald Mosby	Aye	Tyler White	Aye
Greg Patterson	Absent	Jeanne Yeatman, RN	Aye
Brian Robinson	Aye		

Motion carried.

Motion by Mr. Rowe to accept the proposed Rules with the changes as voted on previously and remove the second 100% in 1220-12-.01-14 (3) (c) 2 iii and seconded by Mr. Davis.

A roll call vote was taken:

Roll Call Vote

Chris Brooks, MD	Aye	James Ross, RN	Aye
Jeffrey Davis	Aye	Dennis Rowe	Aye
Kappu Deshpande	Absent	Chrm. Sullivan Smith, MD	Aye
Thomas Dunavant	Aye	Tim Strange	Aye
Donald Mosby	Aye	Tyler White	Aye
Greg Patterson	Absent	Jeanne Yeatman, RN	Aye
Brian Robinson	Aye		

Motion carried.

Mr. Richardson read the Statement of Economic Impact to Small Businesses. Mr. Ross motioned for the Statement to be accepted as presented and was seconded by Mr. White. A voice vote was taken and motion carried.

Mr. Richardson presented the Regulatory Flexibility Analysis. Mr. Davis motioned to accept the Analysis as presented and Dr. Brooks seconded. A voice vote was taken and motion carried.

Mr. Richardson announced that this concluded the Rulemaking hearing.

The now announced the Board meeting was now back in session. The Chairman announced a break for lunch.

After the lunch break the session resumed.

OGC Cases

Consent Order

Respondent: Joshua Cole Anderson, AEMT, License No. 25518

The Consent Order for Case No. 2017004341 was presented by Mr. Paul Richardson. The Respondent has a history of opioid dependence, and suffered from Post-Traumatic Stress Disorders (PTSD), which the Millington Airport Fire Department has documented. Between the dates of February 25th, 2016 and November 8, 2016, Respondent used his position as Fire Chief of the Millington Airport Fire Department to place multiple orders for personal use, totaling 7- vials of diphenhydramine and 25 vials of ondansetron – he did use personal funds to pay for a portion of these orders. Ordering these medications is beyond the scope of practice of the Respondent's AEMT license and that of the Millington Airport Fire Department. Respondent has served as Fire Chief while impaired due to drug use on multiple occasions. Respondent maintains he at no time served patients while impaired. Respondent tested positive for various drugs on two (2) separate drug screenings dated on or August 17, 20116 and October 20, 2016.

Respondent has completed an Employer Assistance Program (November 2016), Parkland Behavioral Health System Detoxification Program (January 2017), participates in a PTSD support group, and has organizes Narcotic Anonymous (NA) meeting as his church. He has letters of support from Pastor David Harlon and Associate Pastor Mike Coker attesting to his effort of continuous improvement.

Respondent requested the services of TnPAP, on March 27, 2018, entered a monitoring agreement and has been compliant as of June 4, 2018. He entered the Intensive Outpatient Program at Journey Pure Southaven, am addiction recovery treatment facility on April 16, 2018. Respondent has since tested negative for all non-prescribed substances, including alcohol.

STIPULATED DISPOSITION

For the purpose of avoiding further administrative action with respect to this cause, Respondent agrees to have their EMS license to practice in the State of Tennessee place on **SUSPENSION**, to be effective one hundred and twenty (120) days following the ratification of this Order if Respondent fails to schedule or undergo evaluation by the Tennessee Professional Assistance Program (TnPAP).

Respondent shall undergo an evaluation approved by TnPAP. Should the results of the TnPAP-approved evaluation recommend monitoring, then Respondent may sign a TnPAP monitoring agreement and obtain the advocacy of TnPAP.

Upon receipt by the Division of notification from TnPAP that Respondent has signed a monitoring agreement prior to or during the period of suspension, the suspension shall be **STAYED** and the license shall be immediately placed on **PROBATION** on the following terms and conditions:

A. The period of probation of Respondent's license shall run concurrent with their monitoring agreement with TnPAP, but in no event shall the period of probation be less than three (3) years from the date this **ORDER** is entered. Should Respondent's monitoring agreement with TnPAP be extended, the term of their license's probation shall be extended to run concurrent with the new term of the TnPAP monitoring agreement.
B. Respondent's failure to maintain compliance with all of the terms of the monitoring agreement and the advocacy of TnPAP until the completion of the monitoring agreement and agreement thereto will be a violation of this **ORDER**, and shall result in the immediate lifting of the **STAY OF SUSPENSION** of the Respondent's license upon receipt by the Division of notification from TnPAP. If thereafter Respondent wishes to have their license reinstated, they must appear before the Board and demonstrate their present ability to engage in the safe practice of emergency medical services. The Board reserves the right to impose other reasonable conditions of reinstatement at the time of Respondent's appearance.

Upon receipt by the Division of notification from TnPAP that Respondent underwent a TnPAP-approved evaluation but monitoring was not recommended, the suspension shall be immediately lifted and the license placed on **PROBATION** for a period of no less than three (3) years from the date this **ORDER** is entered.

Motion by Mr. Ross to accept the consent order and seconded by Mr. Davis.

Roll Call Vote

Chris Brooks, MD	Aye	James Ross, RN	Aye
Jeffrey Davis	Aye	Dennis Rowe	Aye
Kappu Deshpande	Absent	Chrm. Sullivan Smith, MD	Aye
Thomas Dunavant	Aye	Tim Strange	Aye
Donald Mosby	Aye	Tyler White	Aye
Greg Patterson	Absent	Jeanne Yeatman, RN	Aye
Brian Robinson	Aye		

Motion carried.

Consent Order
Respondent: Kyle D. Fisher, Paramedic 38963

The Case Number 2016039431 was presented by Mr. Richardson. Respondent was at all times pertinent hereto employed by Macon County EMS. On or about August 24, 2016 he was found to have administered morphine without a physician's order. A review of his transports were done by the service Director and it was found that one record revealed that the transferring physician was present on the date of service but did not give orders for administering narcotics. The other physicians listed on the reports were not working on the dates of transport.

STIPULATED DISPOSITION
For the purpose of avoiding further administrative action with respect to this cause, Respondent agrees to have their EMS license to practice in the State of Tennessee place on **SUSPENSION**, to be effective one hundred and twenty (120) days following the ratification of this Order if Respondent fails to schedule or undergo evaluation by the Tennessee Professional Assistance Program (TnPAP).

Respondent shall undergo an evaluation approved by TnPAP. Should the results of the TnPAP-approved evaluation recommend monitoring, then Respondent may sign a TnPAP monitoring agreement and obtain the advocacy of TnPAP.

Upon receipt by the Division of notification from TnPAP that Respondent has signed a monitoring agreement prior to or during the period of suspension, the suspension shall be **STAYED** and the license shall be immediately placed on **PROBATION** on the following terms and conditions:

A. The period of probation of Respondent's license shall run concurrent with their monitoring agreement with TnPAP, but in no event shall the period of probation be less than three (3) years from the date this **ORDER** is entered. Should Respondent's monitoring agreement with TnPAP be extended, the term of their license's probation shall be extended to run concurrent with the new term of the TnPAP monitoring agreement.
B. Respondent's failure to maintain compliance with all of the terms of the monitoring agreement and the advocacy of TnPAP until the completion of the monitoring agreement and agreement thereto will be a violation of this **ORDER**, and shall result in the immediate lifting of the **STAY OF SUSPENSION** of the Respondent's license upon receipt by the Division of notification from TnPAP. If thereafter Respondent wishes to have their license reinstated, they must appear before the Board and demonstrate their present ability to engage in the safe practice of emergency medical services. The Board reserves the right to impose other reasonable conditions of reinstatement at the time of Respondent's appearance.

Upon receipt by the Division of notification from TnPAP that Respondent underwent a TnPAP-approved evaluation but monitoring was not recommended, the suspension shall be immediately lifted and the license placed on **PROBATION** for a period of no less than three (3) years from the date this **ORDER** is entered.

Respondent shall also complete three (3) hours of continuing education on Ethics as approved by the Tennessee Emergency Medical Services Board and submit proof of completion to the Division within one (1) year from the date of ratification of this Order.

Motion by Dr. Brooks to accept the Order as presented and was seconded by Mr. White.

Roll Call Vote

Chris Brooks, MD	Aye	James Ross, RN	Aye
Jeffrey Davis	No	Dennis Rowe	Aye
Kappu Deshpande	Absent	Chrm. Sullivan Smith, MD	Aye
Thomas Dunavant	Aye	Tim Strange	No
Donald Mosby	Aye	Tyler White	Aye
Greg Patterson	Absent	Jeanne Yeatman, RN	Aye
Brian Robinson	Aye		

The vote result was 9 Aye and 2 No. Motion carried.

COMMITTEE REPORTS

A. Clinical Issues Committee and Medical Director's Report

Dr. Holley presented a breakdown of the current drug shortage situation and that it is worsening. Dr. Holley asked for the Board's direction to write a letter to the Board of Pharmacy for a meeting about Rules on using drug past expiration date. Board endorsed these efforts. Dr. Holley also related that Form 222 for narcotics only has a 60 day timeframe.

He also related questions and responses to questions on use of capnography cannulas, can capnography replace end-tidal colorimetric devices/EDD, and use of air splints.

Dr. Holley outlined questions on Fistula Clamps and Continuous Infusion of Sedation Agents. He describe the response to those questions and recommended that they be added to the Clinical Practice document.

Mr. Strange made the motion to do so and Ms. Yeatman seconded. Motion carried on a voice vote.

Dr. Holley also covered Scope of Practice changes by NEMSIS. He also discussed equipment issues that have arisen and that the 2018 State Protocols are complete (on web site).

B. COPEC

Ms. Rhonda Philippi presented the Report on the Status of Emergency Medical Services for Children for 2018.

Motion by Mr. Davis to accept the report as presented and was seconded by Mr. Strange. Motion carried on voice vote.

C. Initial Education Committee

Mr. Strange gave the report of the Committee. He present the development of a liaison between the Initial and Continuing Education Committees and the development of a sub-committee to revisit the Gap-Analysis of the EMT to Paramedic.

D. Continuing Education Committee

Director Tidwell presented the activities of the Committee at their last meeting. The Committee is starting to review policy changes to accepting on-line education, refresher courses requirement, CE requirements, clarify requirements between NREMT and State renewal requirements. Also, the current updating of the web sites was done. There is no recommendations at this time.

E. Degree Task Force

Mr. Strange gave a presentation of the Task Force's Survey and from this survey the Task Force recommended based on the data received they feel a degree is not recommended at this time.

Motion to accept the survey and recommendation by Mr. White and seconded by Mr. Mosby. The motion carried on voice vote.

F. Director's Report

The Director presented her report: a report on the 1st/2nd quarter pass rate was discussed, new NREMT Director, and NREMT test was improving.

Ms. Tidwell gave a status report on the COMPACT.

She also related activities of the Office: Training for Ambulance Strike Team Leader Training, funding for the Infectious Disease Transport Network, sending individuals to Infectious Disease training, and Image-Trend 3.4 implementation by January 1st, 2018, attendance to NAESO meeting in Rhode Island.

Director Tidwell deferred to Dr. Holley and he announced that the Mobile Stroke Unit received accreditation.

There were no questions from the Board.

Mr. Mosby address the Board that this was his last meeting. He has served his eight (8) year term and had enjoyed being a part of the body.

The next meeting of the Board is scheduled for September 19th, 2018.

A motion by Mr. Mosby was received to adjourn with multiple seconds. Motion carried on voice vote.