

TN EMS

Clinical Issues Committee

11 SEPT 2024

- 1. Roll call – @ 1000 quorum met, Wood filling secretary in Spratlin absence.
- 2. Approve minutes- June 12 meeting, Revelle, /cox, no corrections, no objections, approved
- 3. UVC Placement
 - Placement & equip request presented by kayla Hixon, Williamson Health
 - Presented current map of counties with OB service, presented NRP guidelines and differences between NRP current and state EMS guidelines, discussed access to NRP course, discussed population of neonates that are below EZIO weight parameters, presented UVC kit price of ~\$20/kit, need for biannual training on skill, for paramedic and above, for licensure for all providers, not just those on ambulances,
 - Ask: UVC added to state protocol, NRP training for all EMS providers in state, added to equipment list, added to training list for UVC skill,
 - Lemley discussed funding granted for providers \$55 exam fee, target of NRP to counties without OB services, state provides eBook, some coalitions have funded, some schools adding pre-grad NRP requirement, currently required for air providers,
 - Discussion of NRP vs STABLE courses
 - Discussion of required vs recommended, currently no alphabet classes required to renew license,
 - Discussed adding the skill of UVC first with appropriate training and skill evaluation to maintain proof of proficiency,
 - Moved discussion to consider UVC as an approved clinical practice that service can choose to add to their toolbox,
 - Approved clinical practice to be crafted by Dr Holley and brought back at next CIC meeting.
 - Dr. Holley asked for protocol review of current NRP guidelines, will be given to him by NRP subject matter experts, Lemley will discuss this more with Dr. Holley before next meeting.
 - **Motion** by Revelle/Cox to make UVC an approved clinical practice, medic only, part of required training for this practice is NRP, Q6mo comps added, addition of UVC equipment, skill may be checked off by a NRP instructor or Medical Director or his designee, passed without opposition.
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- 4. Hamilton Vents
 - Presentation by Grant Reatherford, Williamson Health EMS
 - Presentation on use of vent (i.e. Hamilton) for use as NiCPAP/biPAP by non CCP, non-vent medic and that all medics can use this equipment to provide said care/treatment. Currently need older machine or disposable device to provide this with bi-annual refresher training.
 - Also ask for hi flow nasal cannula use.

- State position says no rule saying you “can’t” use nasal cannula and does not say you “can’t” use a vent to provide this
 - Will move to clarify that we can currently do this as the device provides this per currently approved clinical practices, passed, Revelle/wood, no dissent.
- 5. UVC Access for EMS
 - Covered in above discussion.
- 6. Pulse Ox
 - EMR and above to be able to use SpO2 device,
 - Approved practice provided as copy by Dr Holly
 - Motion Cox/Revelle to move new clinical practice document forward to EMS Board, passed, no opposition.
- 7. Additional Practice areas
 - Ask: is to look at what potential areas EMS is migrating to, such as mobile int healthcare, community medic,
 - Drew Hooker presented- ask for a working group to look at current scope state, compare to other states, and look at future options and have group standing to look at currency and future,
 - Motion by Owens to create “Innovation workgroup”., Volunteers: Lemley, Chris Cox, Revelle, Derington, Fox, Bratton, Spratlin,; at first meeting nominate a chair,
 - first meeting organization assigned to Jon Wood
 - Group – touch base with ambulance workgroup on telemedicine was requested by Holley.
- 8. FDA Nasal Epi
 - Presented by Jason Fox, two documents provided; asked how nasal falls in current scope and law as example of “assist with EpiPen”, should it be stand-alone skill for providers?
 - Ask by fox: add as to be allowed as assist skill (EMR & EMT as in auto injector) for providers and/or stand-alone skill for providers (AEMT, EMTP,)
 - Skill vs decision making/assessment based on S/S, IPS discussed.
 - Holley stated that if it is FDA EMS approved, then state is good with it, may need to add who can “administer” and who can “assist”?
 - May just need state protocol addendum and amend current clinical practice for IN to include epi.
 - Motion by Revelle, Wood, to revise current state protocol and any associated clinical practice document to reflect commercial IN Epi devices that are FDA approved for allergic reaction is an approved med admin route. Passed no opposition
- 9. Telemedicine in EMS
 - Also being worked by Ambulance service committee who created a workgroup.
 - Ask: set minimum standard guideline for all EMS looking to venture into telemedicine, definition of telemedicine as it relates to EMS providers/services/functioning in state to carry out medical direction, build minimum requirement to keep patients/providers safe and a baseline of this functional area,
 - Ambulance workgroup will send asks to CIC Innovation workgroup which in turn will recommend if surge to own standing workgroup is needed. Workgroup will recommend members to overlap into ambulance group.

- 10. Scope of Practice
 - IV hydration, new areas/clinics, mass gathering/event medicine venues, etc. is example.
 - Discussed foundational info but no other action at this time.
 - Some examples are “can a hydration clinic hire an AEMT who can start IV’s?” currently yes, stay within scope and clinic assumes 100% liability of such.
 - Currently no oversight of that at such clinics and businesses
 - Event medicine may also be an arena of this to discuss as well.
 - No motions or immediate action today
- 11. Hamilton Co EMS Whole Blood
 - Dr. Buchheit advised Starting in Hamilton in conjunction with hospital and blood assurance.
 - PM is transfusing, not initiation, CCP is initiate.
 - Currently 2 pilot programs doing it on ground, needs to be pilot program,
 - Potential Action: enter into pilot program vs review clinical practices to remove need to be in pilot.
 - Motion 1: Discussion led to motion to alter clinical practice to “administer & initiate”, motion Buchheit/Derrington, no opposed, forward to EMS board
 - Motion 2: Revelle/Wood: to add Hamilton co EMS to blood pilot program Revelle/Wood, passed, none opposed.
 - Action: Motion 1 to board and then Motion 2 if needed.
- 12. Ambulance equipment List
 - Tabled from last meeting.
 - Issue 1: Thorocostomy procedure equipment
 - Minimum requirement for this procedure equipment: no making it a minimum item, if service wants to provide procedure, they need to have appropriate equipment to do so per their protocol.
 - Issue 2: Scoop stretcher being accepted alternative for one of the two LSB’s required, discussion on differing designs of items deemed a scoop stretcher,
 - Action: motion to not recommend any changes and not allow substitution of 1 of 2 required LBS by a scoop stretcher, Derrington/Revelle, passed, no opposition
 - Issue 3: Approval of BVM sizes where ask is be able to use a smaller BVM size on adult,; discussion by Holley shows data does not support smaller size BVM use makes difference in adult population as no data to support lowering minimum size of adult BVM,
 - Action: motion for no change to BVM equipment list/recommendation by Derrington/Revelle, passed not opposed
 - Lemley- discussed the lack of presence of uncuffed tubes on equipment list in peds/neo arena, discussed cuff & uncuffed tube and lack of uncuffed in equip list as currently written. 2.5/3.0/3.5 could use uncuffed; can also use LMA down to 1400grams, we can recommend all 3.0 & smaller tubes can be cuffed or uncuffed discussion.
 - Action: Recommend ETT size 3.0 and below can be cuffed or uncuffed, Lemley/Cox, passed no dissent
 - Reminder All equip changes must go to Sept board meetings.

- 13. Board Items
 - Obvious Death
 - Pt assessment on pt death
 - Action: current protocols and board policy adequately address this issue
- 14. Compact Guidelines
 - Non action.
- 15. Old Business
 - none
- 16. New Business
 - Lemley – asked to add a neonate epi dose as length based does not go below 3kg, current standards may not fit to length base in its current state, Holley discussed can this be addressed in protocols.
 - Lemley- also brought up volume for peds of 10ml/kg vs 20ml/kg in neonates; will also discuss with Medical Director Holley for future review.
 - Request for AEMT to administer cyanokits
 - For rural fire depts,
 - Moton for push to innovation work group below by Revelle/cox, passed no opposition.
 - Action: pushed to workgroup
 - Holley
 - Presented draft of the approved clinical practice document on non-formulary medication transport and list
 - Addresses management of ongoing infusion of vasoactive and cardiovascular medications as well as other area specific meds used during patient transfer from facility to facility.
 - Will IV pump be required to be sent on some by hospital? Medic knowledge of said pump will need to be established locally at service.
 - Action: sample document by Dr. Holley to be edited, moved to approve by Revelle/Fox, passed unopposed
 - Bratton- discussed awareness that LP15 in AED mode is not approved for use in kids < 8yoa per user manual on LP15, also in some populations not recommended A-P pad placement, no action at this time needed by this committee.
 - Derrington – discussed former discussion on finger thoracostomy, we will need presentation on ask for procedure at future board meeting that has quorum and it added as an agenda item.
- Adjourn Cox/Lemley @ 13:45