



**TESTIMONY BEFORE THE
HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH**

"Strengthening Our National Trauma System"

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Introduction:

Good morning Chairman Pitts, Ranking Member Green and distinguished members of the Subcommittee. My name is Brent Myers and I served as the Director and EMS Medical Director for the Wake County Emergency Medical Service for over a decade.

I want to commend you for holding this hearing on Strengthening Our National Trauma System. The National Academy of Medicine's report is extremely important in jumpstarting a new conversation about how to achieve zero preventable deaths. Part of achieving zero preventable deaths includes ensuring emergency medical services practitioners (EMS) who treat and transport seriously injured patients are able to immediately administer life-saving medications.

I am pleased to be here on behalf of the National Association of EMS Physicians to express our strong support for the Protecting Patient Access to Emergency Medications Act of 2016, H.R. 4365. On behalf of our ~1500 members, the majority of whom are EMS physicians, we wish to thank Representative Hudson for his tremendous leadership, and the support from Representative Butterfield, Doctors Heck and Ruiz, as well as the other 113 cosponsors of this vital legislation.

Our goal in securing enactment of H.R. 4365 is to preserve our model of care that for 40 years has delivered timely and efficient life-saving treatment to millions of patients. The legislation addresses several critical issues: 1) it will statutorily preserve our ability to utilize standing orders, otherwise known as EMS protocols, to govern the administration of life-saving medicines; 2) it

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will provide a clear framework to enable DEA to oversee EMS in a consistent manner across the nation and clarify the rules for us to follow in a uniform manner to prevent diversion.

Background on Unique Nature of EMS Model of Care Delivery:

Modern emergency medical services systems (EMS) systems are designed to bring sophisticated emergency medical care to the patient's side. While our EMS systems do not routinely utilize physicians to deliver care, the public expects to receive equivalent care provided by EMS personnel. As such, EMS systems require knowledgeable physician participation and supervision at every level.

The National Association of EMS Physicians is made up of physicians and other EMS professionals partnering to foster excellence in EMS Medicine. The majority of our members are physicians who serve as medical directors for EMS agencies, some of whom are board certified in EMS Medicine. Many of our members are emergency physicians, while some others are board certified in family practice or internal medicine.

The model of delivery in emergency medical services is unique – EMS practitioners, such as paramedics and EMTs, work under the license of a physician medical director who supervises all the care provided by these practitioners in the field according to protocols or “standing orders.” Such standing orders govern the type of care and treatment provided by practitioners in the field to patients with emergency medical conditions, including the administration of medicines and controlled substances.

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Medical care and the administration of medicines provided to patients in a facility is different. In a hospital inpatient unit, a doctor will prescribe a specific order or medicine for a specific patient that is carried out by a nurse. In the field, that isn't possible – EMS practitioners arrive at the scene to provide care and transport to a patient with an emergency medical condition. Our practitioners must quickly assess the patient's condition, often with limited information, and provide immediate treatment and medicines, sometimes not even knowing the name of the patient. The physician medical director creates standing orders in advance to direct the best treatment for specific emergency medical conditions such as trauma or seizure. The EMS practitioner utilizes these orders to provide the treatment and medicines needed by the patient at the scene. For the vast majority of patients, this gives the paramedics the ability to immediately treat the patient and administer medications without additional consultation. These standing orders only apply for treatment provided by practitioners in the course of EMS evaluation and transport and no medications are prescribed or dispensed for use later. In special circumstances, the paramedics will call their medical directors or emergency physicians at the hospital to address patient treatment issues that are not contemplated in the proscribed standing orders. In general, these calls are reserved for unique situations that fall outside of protocol or high risk but not time-sensitive situations like a patient refusal of transport.

Preserve Use of Standing Orders:

The Drug Enforcement Administration has informed us that they believe the Controlled Substances Act prohibits the use of standing orders that enable EMS practitioners to administer controlled substances such as pain and anti-seizure medicines to patients in need in the field.

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The DEA further indicated that they are preparing to promulgate regulation that would prohibit the use of standing orders. This would be catastrophic for our most seriously ill and injured patients.

Prohibiting the use of standing orders would endanger the lives of thousands of patients across the nation. For many of these patients, the delay caused by calling for permission to give a medication that the practitioner already knows is required would lead to worsening patient outcomes. Additionally, communication systems are far from perfect and a significant number of scene providers may be unable to reach a physician. This would certainly have a disproportionate negative effect on patients in rural or frontier environments.

We utilize controlled substances for a variety of emergency medical conditions. For example, we administer morphine or fentanyl to patients with major traumatic injuries to calm their bodies and minds, and to prevent further tissue or organ damage. We know that administration of pain management in the field produces better patient outcomes and certainly a better patient experience. Most importantly, failure to manage pain in a severely injured patient can result in death or serious disability. We also administer benzodiazepines to seizing patients – failure to administer such medicine as soon as possible after the onset of the seizure can have catastrophic results also including death or permanent brain injury. Additionally, these medications are important to the safety of our practitioners and other public safety partners such as police officers. Controlled substance are often used to calm patients who may be at increased risk of violence because of drug use or severe mental illness. Use of these medications results in decreased risk to both the provider and the patient. In most instances there isn't time for the

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paramedics to call a physician to secure permission to administer such life-saving drugs. Additionally, there simply aren't enough physicians to take these calls if it became mandatory to speak to a physician for every administration of a controlled substance, nor can they undertake 25 million ambulance calls themselves.

To ensure our ability to continue providing immediate and life-saving care, it is imperative that the Congress amend the Controlled Substances Act to preserve our ability to utilize standing orders as provided for in H.R. 4365. And, it is essential that the Congress enact this vital legislation now, before a regulation is promulgated that would endanger patients.

Improve Clarity of Rules and Consistency in DEA Enforcement to Prevent Diversion:

We strongly support appropriate oversight of EMS by the DEA, including through the promulgation of a regulation specific to EMS. The existing regulations are applicable to non-mobile environments and so don't meaningfully fit with our mobile health care delivery environment. We believe that updating the Controlled Substances Act, as addressed by H.R. 4365, will provide a clear framework and necessary roadmap to enable the DEA to better tailor its oversight to our mobile environment. Ultimately, we believe this will result in better and more consistent management of controlled substances and reduced opportunity for diversion throughout the industry.

One key area in need of clarification is registration with the DEA. In other health care settings, it is the entity that registers with the DEA, such as hospitals. Right now, for most non-hospital based EMS agencies, the medical director is using his or her DEA registration number as a

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physician on behalf of all the patients served by the EMS agency. This has led to confusion and inconsistent enforcement across the nation, and even among neighboring jurisdictions in how DEA offices interpret and enforce existing rules. For example, several medical directors have been required to register a “distributor” for the purpose of receiving and moving drugs from one location to another. Other medical directors have been required by their local DEA office to receive controlled substances at their home residences as the registrant physician. We even have situations where the same medical director with an EMS agency serving multiple DEA office jurisdictions must utilize differing protocols and procedures due to inconsistent guidance from those DEA offices. In some instances, DEA offices have required the agency medical director to obtain a new DEA number for each station in the EMS system. As a result, some EMS physicians have more than 30 DEA registration numbers.

We believe, and the American Ambulance Association agrees, that the EMS agency should most appropriately be the registrant. This will enable the EMS agency to be responsible for all administrative aspects of receipt, movement and control of the drugs. And it will enable physician medical directors to be responsible for all medical aspects of administering controlled substances to patients in need. These clear lines of delineation provided for in H.R. 4365 will enable consistent interpretation and enforcement across the nation so that we can treat patients in need and minimize diversion to the greatest extent possible.

Conclusion:

Mr. Chairman and Ranking Member Green, we greatly appreciate the Subcommittee holding this hearing on this vital issue of improving our nation’s trauma system and this crucial legislation to

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protect patient's access to life-saving medications. The EMS community is united in preserving our model of care delivery for the patients we serve and creating a meaningful framework for clear guidelines and consistent enforcement to prevent diversion. We urge your expeditious passage through the Subcommittee and Committee of H.R. 4365 to enable us to continue saving lives every day.

Thank you for the opportunity to testify before you today and for your consideration of this essential legislation.