



National Association of EMS Physicians Congressional Request for 2024

I. BACKGROUND.

The National Association of EMS Physicians (NAEMSP®) represents thousands of physician EMS medical directors and Chief Medical Officers who are committed to ensuring that the citizens in their communities have fair and equal access to needed emergency medical care. EMS is the practice of medicine in the out-of-hospital setting, overseen by EMS physician medical directors who ensure the quality of the care delivered by and credentialing of EMS professionals, and establish treatment protocols for the entirety of the care provided before and during transport. NAEMSP® is the lead organization that promotes and refines the standards for EMS medical care, research, education and training for our nation’s EMS leaders. EMS provides a critical component of the health care system, treating conditions that range from car accidents to drownings, heart attacks to pediatric asthma, by ground and by air as well as moving patients between facilities. EMS is much more than a ride to the hospital. It is a system of coordinated response and emergency medical care, involving multiple people and agencies.

II. KEY CHALLENGES AFFECTING EMS PATIENTS.

Inadequate Compensation for EMS Medical Directors and Professionals. Physician medical directors form the essential foundation of quality and excellence in EMS patient care as they directly or indirectly supervise all of EMS care for many cities and counties across the nation. However, in the current EMS system physician medical directors are not always compensated for this additional work unless operating in very specific circumstances or within certain facilities at the time of engagement. Further, EMS agencies continue to struggle to obtain sufficient funding to attract and retain EMS professionals to provide emergency medical care. It is essential for a high quality EMS system to have sufficient resources to attract and retain EMS medical directors and professionals.

Drug Shortages of Essential Emergency Medications and Whole Blood. Shortages of essential EMS medications (EEMs) continue to plague our ability to care for patients. EMS agencies are currently seeing severe restrictions in the availability of IV fluids (essentially sterile salt water), pain medications, anti-nausea medications, sedatives, and airway management medications. Drug shortages are a market failure, not because the cost of drugs is too high, but most often because the cost of generic sterile injectables is too low for manufacturers to be able to produce a stable, sufficient and redundant supply. A 2024 survey of physician medical directors of EMS agencies, undertaken by NAEMSP®, demonstrated serious and adverse impacts of drug shortages on EMS patients, including errors in drug administration and dosing, and high rates of unavailability of essential medications, many with no suitable substitute. The nature of EMS medical care is such that when drugs or specific concentrations of a drug go into shortage, medical directors must continually revise their protocols based on what drugs and concentrations they may be able to secure, and paramedics must quickly adjust to alternative medications or the same medication but in a different concentrations, greatly increasing the risk of medication errors in a fast-paced environment when minutes count for patients. EMS agencies also lack sufficient resources to offer whole blood on most ambulances due to the high cost and short shelf life, which the military has proven saves lives.

Wall Time. Within the larger “patient boarding” crisis at hospitals with overcrowded EDs across the nation, the impact is adversely impacting EMS agencies transporting patients to those EDs. Patients are too often left “along the wall” of the hospital waiting to receive emergency care, and EMS professionals are forced to stay with the

patient and continue to provide care, sometimes for hours at a time. Commonly referred to as “wall time”, EMS professionals face excessive delays when attempting to transfer the patient to the hospital’s care, a serious concern for patients needing timely treatment for critical care issues such as strokes, sepsis, heart attacks and other cardiological issues, and trauma, for whom the risk of death increases with treatment delay. Under federal law¹, hospitals are required to accept medical responsibility for patients who have come to the hospital via an ambulance, and provide an appropriate medical screening examination to that patient on a timely basis. Hospitals may not delay screening, treatment or transfer by relying upon EMS professionals to care for such patient “on the wall”. However, EMS professionals continue to involuntarily remain at hospital EDs for extended periods of time far beyond the fifteen-minute period during which a normal patient hand off should be completed.

III. WHEN MINUTES COUNT FOR EMS PATIENTS LEGISLATION.

NAEMSP supports the transformation of EMS and realignment of incentives to advance medical excellence in the provision of patient care to emergency medical patients in the out-of-hospital setting. As EMS has matured over the past half century, we’ve made much progress in our delivery of quality and safe medical care. New proposals initiated during the pandemic have introduced mechanisms to modernizes the current EMS system, utilizing treatment-in-place and other scenarios outside of the traditional treatment and transport to a hospital. NAEMSP supports modernizing the model of care to include treatment in place and transport to alternate destinations. However, these and any changes must be coupled with meaningful and measurable patient safeguards to ensure quality and safety of patient care and appropriate medical decision-making for patient treatment and disposition. Representatives Richard Hudson (R-NC) and Debbie Dingell (D-MI) are sponsoring legislation that would establish three critical building blocks to transforming the EMS System to ensure the highest quality out-of-hospital care for patients with emergency medical conditions. The legislation has three primary components:

- ***MedPAC Study on EMS Medical Director and Professional compensation.*** The bill would require MedPAC to conduct a study on the level and type of compensation to attract and retain physicians to oversee and direct the highest level of quality care on ambulances. Further, the study would evaluate the resources necessary for ambulance agencies to attract and retain EMS professionals who provide the actual care in ambulances. MedPAC would be utilizing the ambulance cost data that is now being reported, and provide context for not just the levels of compensation for EMS medical directors and professionals, but also what is needed to transform EMS treatment and transport as out-of-hospital care into a modern delivery system beyond transporting all patients to the hospital.
- ***CMMI Demonstration Program on EMS Drug Shortages and Whole Blood.*** The bill would require a demonstration program at CMMI to evaluate a separate payment for essential emergency medications in shortage to promote the availability of medications that are absolutely essential to the delivery of EMS care for patients when minutes count to survival and avoidance of disabling conditions. Many studies have shown that whole blood on ambulances saves lives, and the demonstration program would also evaluate separate payment for whole blood to incentivize its use on ambulances.
- ***Secretarial Guidance and Report on “Wall Time”.*** The bill would require the Secretary of HHS to reissue guidance to hospitals to address the wall time crisis and provide a report to the Congress on how to tackle the global issues plaguing hospitals and EMS systems of overcrowding and patient boarding.

Request: We respectfully request that you cosponsor the When Minutes Count for Ems Patients legislation being developed by Representatives Hudson and Dingell, to be introduced shortly.

¹ Emergency Medical Treatment and Active Labor Act (EMTALA), Section 1867 of the Social Security Act.