# EMS Integration with Special Medical Needs

*A look into the success of collaboration, legislation, education and solutions created and adopted in Missouri*

## Frequently Asked Questions and Misconceptions

*NOTES: Acronyms used: SMN -Special Medical Needs; RD-Rare Diagnoses*

1. EMS already know about life threats
    a. While EMS is adept at addressing the most common threats, the subset of patients with SMN or RD likely have unique emergency needs that are not well known or commonly addressed in the standard curriculum or protocols.
2. Just contact Medical Control
    a. When responding to time critical conditions, each additional step and level of complexity can increase the time to definitive care. Even minor delays in treatment can cause increased morbidity and mortality.
3. Our protocols are state of the art and evidence based.
    a. These solutions generate a framework that empowers medical providers to enact changes at the speed of medicine and addresses both current and future needs.
    b. Generates a standardized approach to education and training for the patients within their community and a basis for treatment of other SMN care.
4. Physicians should practice medicine not legislators – or – we don't need another law.
    a. This model enables your state legislators to help support and protect physicians in leading the direction of care for the SMN patient population
5. Are you asking us to carry all these medications?
    a. Ambulance space is limited
    b. Allowing for the use of the patient's home meds &/or medical equipment reduces the burden on ambulance services and reduces the potential waste of unused products
    c. Increases the likelihood of sister services being able to provide appropriate medical treatment
    d. Having orders from the patient's specialty team with the medications provides for proper individualized dosing
6. If it's not in our formulary, we can't touch it.
    a. Every medication cannot be addressed in every formulary. Medications for the special needs patient are rare and not commonly needed so this solution allows for a standard approach to treatments for the SMN patient and the necessary guidelines
    b. Creating treatment plans provides the instructions for appropriate dosing, contra-indications and side affects
7. Do you realize how much education this will require?
    a. In this solution, the education can be focused on a standardized approach and process instead of disease specific education alone increasing the knowledge while decreasing the overall educational burden
8. I don't think we have to worry about this. How many people does this actually affect, anyway?
    a. This systematic approach covers the overall larger group of SMN patients while allowing individual agencies to focus on more common presentations. Across the US, based on the data to date, we have over 26 million Americans with diseases requiring specialized medical care
9. What kind of stress is this additional responsibility going to put on our providers?
    a. This approach should reduce the stress on providers when treating patients with SMN requiring an immediate response by creating a response framework to use in cases of unfamiliar and uncommon disease presentations

10. Why can't the local ED just handle the situation
    a. Prehospital providers are the first link in the chain of survival associated with time critical patient management
    b. Even delays from short transport or patient handoff can lead to the increase in morbidity and mortality.
    c. Hospitals and EDs have their own medical formularies which are also limited for specialized medications. Tertiary Care Centers are likely the only locations that regularly stock these types of specialized resources
11. How can we be sure we are providing appropriate care in such a system?
    a. Approaching this from a systemic perspective and including quality improvement and patient safety focus we increase the likelihood of discovering rare unintended consequences and adverse outcomes so we may improve our treatments. The increased statistical power from individual agencies working together allows us to recognize and intervene on more rare adverse effects
12. Our protocols are to stabilize and quickly transport to the nearest Specialty Center for them to treat. Why doesn't that work?
    a. Implementation of this collaborative solution can reduce the financial and resource burden on the patient, agency and the community
13. What if the medication wasn't stored properly and is ineffective?
    a. Medications function may be reduced by improper storage but typically retains enough functionality which is better than delayed administration
    b. This system encourages the participation of the patient families, pharmacies and drug manufacturers to improve the process and decrease the likelihood of medication mishandling.
14. How easy is it to cause undue harm to the patient by using their home meds or supplies?
    a. In these circumstances it is more likely to cause harm through inaction rather than implementation of best efforts. The medical team who creates the evidence based guidelines can focus on those areas of emergency needs, and weight the risk benefits of each protocol to maximize patient safety
    b. This system encourages a Just Culture model for assessment of individual providers' management of patients and identifying areas of system improvement
15. Why doesn't the patient or family member just provide treatment?
    a. Although patients and families regularly provide their own care and do in emergency situations, EMS needs to be available and able when the trained person can't help or isn't available

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