Emergency Medical Services Palliative and End of Life Care
Assess, Treat and Refer (EMS PEOLC ATR) Program
Alberta Health Services

THE INNOVATION

Most Canadians prefer to be at home when receiving palliative and end of life care; however, complex issues often leave community clinicians (such as home care professionals) and paramedics with no option but to transport patients to hospital during unexpected symptom crisis.

The EMS PEOLC ATR program aims to support patients and families who would prefer to receive urgent care at home. In this unique program, paramedics work collaboratively with the patient’s primary/palliative care team during symptom crisis to manage and support the patient to remain within their preferred location of care.

Objectives:
- Provide urgent care and treatment in the home
- Enhance patient and family satisfaction
- Encourage interdisciplinary collaboration
- Reduce potentially avoidable transports to hospital
- Determine frequent causes and outcomes when palliative individuals or families require EMS services

IMPACT AND RESULTS (PHASE 1)

Most Patients Treated at Home
There were a total of 112 ATR events and 98 unique patients (April 1, 2015 – April 1, 2016). The majority of patients were not transported (89%, n=100).

The top three primary complaints of patients were:
1. Pain (29%) 2. Dyspnea (26%) 3. Altered level of consciousness (12%)

The main agents and medications administered were:
1. Morphine (22%) 2. Normal saline (12%) 3. Oxygen (11%) 4. Midazolam (10%)

Preferred Location of Care
The majority of family members who were surveyed said that the patient received treatment in their preferred location of care during the ATR event.

EMS Time Savings
Despite longer time on scene for ATR events, the overall time on task for EMS staff was lower for ATR events compared to provincial EMS events where transport occurred.

High Satisfaction
Clinicians and EMS staff were satisfied with their collaboration
Family members, clinicians, and EMS staff were satisfied with the ATR event

IMPROVING PATIENT SATISFACTION

“...I still remember when they came through the door . . . the amount of compassion, and they seemed so completely understanding about where I was. It made the difference between him dying in hospital and dying at home . . .

You’ll get, as I did, an amazing sense of comfort to know they are really fighting for you, to make your wish come true, to keep you at home.”
~ family member ~

KEY FEATURES
- Symptom management in home; no transport required
- No new resources added (uses EMS resources in community and current EMS formulary)
- EMS responds non-lights and sirens (as preferred by PEOLC population)
- Rolled out provincially (rural and urban settings)
- Consult model with an online physician (patient’s palliative or family physician as available or EMS consultation physician) to build a tailored symptom management plan
- Palliative specialist advice available when needed
- Follow up care coordinated by clinician

IMPACT STORY

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SPREAD
- Provincial program developed and scaled from programs in Edmonton and Calgary
- Initially activated by clinician in the home (Phase I), has since expanded to include 911 calls from patients and families (Phase II)
- Significant increase in program use in rural areas
- Expansion to pediatrics (Phase III)
- Interest from other provinces
- Similar innovation concurrently demonstrated in Nova Scotia & Prince Edward Island

CHALLENGES
- Paramedic comfort with treat and refer
- Concerns with EMS unit availability

LESSONS LEARNED & CULTURE SHIFT

Challenges
- Paramedic comfort with treat and refer
- Concerns with EMS unit availability

Key Successes
- Increased interdisciplinary collaboration
- Improved process for continuity of care and enhanced communication between EMS and community palliative care providers