Emergency Medical Services Palliative and End of Life Care
Assess, Treat and Refer (EMS PEOLC ATR) Program – Phase 2 and Next Steps

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Palliative and End of Life Care

BACKGROUND/OBJECTIVES

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 in the community. 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.

The program is being developed and implemented using a phased approach. Phase 1 launched April 1, 2015 across the province.

PROGRAM OVERVIEW – PHASE 2

Initiation

EMS Initiation
EMS assesses PEOLC patient with symptom crisis and identifies opportunity to treat in place.

Collaborative Practice
- EMS must attempt to connect with patient's care team
- Clinician may be able to come to provide follow up care and support
- Multiple parties may be connected to one another through dispatch
-EMS consults OLMC if collaborative practice attempt is unsuccessful

Clinician: Remote
Clinician receives notice of PEOLC patient with symptom crisis and anticipates the need for EMS support. Clinician proceeds to scene to support ATR as available.

Clinician: On Scene
Clinician on scene assesses PEOLC patient with symptom crisis and determines the need for EMS support. Clinician remains on scene.

Clinician calls 911 and requests EMS PEOLC ATR program using a special dispatch script.

Dispatch activates EMS PEOLC ATR program
- The most appropriate unit (BLS or ALS) is sent to the event
- EMS resources is dispatched with no lights and sirens and no allied resources (police, fire, etc.)
- Crew alerted that the event is for PEOLC ATR while enroute and are provided with clinician name and contact information

Assess

Develop Care Plan
- Care plan is created in line with patient/family's wishes and/or Goals of Care designation.
- Clinician (if available) initiates arrangements for additional on-going resources and follow up as required.
- EMS OLMC encouraged to engage palliative physician on call or community paramedics if appropriate

Treat

Initiate Patient Treatment
- Care is provided within scope of practice and local protocols
- In consultation with the patient, family, clinician and physician, EMS supports non-transport decision if requested or provides transport to acute care or hospice setting if desired

Refer

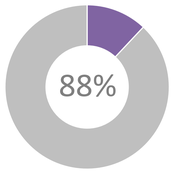
Event Closure and Referral
- EMS completes patient care record and ensures patient/family understands they can call care team or 911 again if needed
- Clinician arranges additional on-going resources and follow up as required

KEY FEATURES

- Symptom management provided in the community; no transport required
- Clinicians are able to access EMS PEOLC ATR remotely, or while on scene with the patient
- EMS PEOLC ATR is available to all current EMS frontline staff and uses EMS formulary - Rolled out provincially (rural and urban settings)
- EMS responds non-lights and sirens (as preferred by PEOLC population)
- 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
- Follow up care coordinated by clinician

PHASE 2 RESULTS

There were a total of **466** EMS PEOLC ATR events in the first year of Phase II (October 1, 2016 to September 30, 2017). The program served 389 unique patients. Most patients had one EMS PEOLC ATR event, although 16% had two or more events. Two-thirds of events occurred in homecare settings and **76%** involved continuing care clinicians.



88% of events resulted in treatment in place. And 94% of patients were treated in their preferred location(including transports that are due to patient preference). Most transports were due to patient or family preference (43% of transports).

Pain (35%) and dyspnea (21%) were the main symptoms addressed during EMS PEOLC ATR events.

Intravenous and intramuscular initiation and medication administration were the most common interventions.

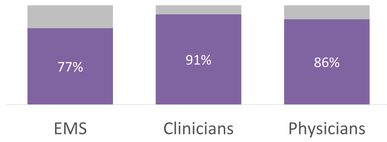
50% of EMS PEOLC ATR patients died at home. In contrast, in 2014 it was estimated that only 14% of PEOLC patients died at home.

Overall, patients and family members were satisfied with their EMS PEOLC ATR experience. They noted that the healthcare practitioners collaboration and communication were key to making the event go well.

"We do not need to be afraid or worried because [the patient] was in capable hands and with knowledgeable people. So that made us feel a lot better" ~Family member

Program training was developed and available in multiple formats. Most paramedics completed an online e-learning module, while most clinicians participated in training face to face or via videoconference. EMS staff said they wanted more training on palliative and end of life care, as well as grief counselling training.

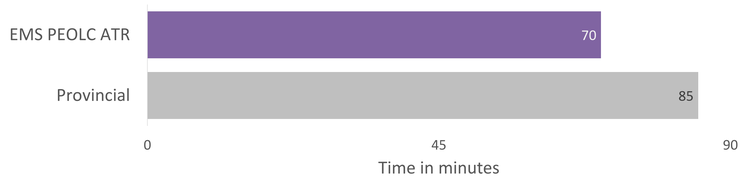
Overall, health care providers were satisfied with their EMS PEOLC ATR event experience.



Some EMS staff felt like the EMS PEOLC ATR events were increasing their workload; however, the program was not increasing EMS staff's time on task.

EMS PEOLC ATR non-transported events took ***less*** EMS time on task than transported events. Furthermore, EMS PEOLC ATR transported events took less EMS time on task than the 2016/17 provincial average EMS time on task for transported events.

Average EMS time on task for non-transported events in Alberta comparted to EMS PEOLC ATR events



The evaluation concluded that the EMS PEOLC ATR program is providing patient-centred care while reducing unnecessary ED visits without increasing EMS staff time on task.

NEXT STEPS

Phase 2 – (2015/17)
- Launched October 1, 2016
- Building from Phase I, EMS crews will now also identify PEOLC patients and phone community supports to maintain the patient in the community setting
- Remote access by clinician enroute to scene
- Follow up process if clinician cannot attend to scene
- EMS Medical Control Protocols January 2018, Inclusion of PEOLC Protocol

Phase 3 – (2018/19)
- Inclusion of the Pediatric population
- Building from Phase II, exploring patients and families activating through 911 requesting EMS PEOLC ATR for palliative emergency support
- Expand treatment modalities