Emergency Medical Services
Palliative & End of Life Care
Assess, Treat and Refer Program

Program Overview, Expansion to Phase II and Initial Findings
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There are no relationships that pose a conflict of interest to declare AND this program has been developed without support from commercial entities.
The Opportunity

• Most Canadians prefer to be at home when receiving palliative and end of life care

• Most Canadians prefer to die out of hospital (home or in other facility), most still currently die in hospital

• Complex care issues leave community clinicians and paramedics no option but to transport patients to hospital
The Opportunity

Recommendation from the Health Quality Council of Alberta (2012):

“Strive to support palliative patients who have a sudden, unexpected symptom crisis so these patients have options for immediate care at home that can obviate the need to go to an emergency department and support the patient and family’s decision to remain at home”

www.hqca.ca, February 2012 Executive Summary, p. 15
Palliative Assess, Treat and Refer Goals

• Provide urgent care and treatment in the home
• Enhance patient and family satisfaction
• Encourage interdisciplinary collaboration
• Reduce potentially avoidable transports to ED and acute care usage
• Determine frequent causes and outcomes when palliative individuals or families require EMS services
Simply a process to facilitate collaboration between EMS and community resources to facilitate treatment in place and appropriate follow up.
Recognition/Inclusion Criteria

• Adult patient presenting with symptom crisis (increasing pain, dyspnea, delirium, nausea and vomiting)

• Overall care currently focused on comfort and symptom management

• Unable to manage with current care plan/resources, could be managed at home if additional urgent medications/supports provided
Three Routes of Activation

• **Clinician On Scene Initiation** – clinician in the home calls for EMS assistance (since April 2015)

• **Remote Clinician Initiation** – clinician aware of crisis, calls for EMS assistance on behalf of patient/family (added October 2016)

• **EMS Initiation** – EMS identifies opportunity for treatment in place from 911 event (added October 2016)
Clinician Activation

• Clinician activates program through 911
  – Use of script for correct event coding – tracking and program evaluation
  – “Urgent” rather than “emergent” response (non lights and sirens)
  – No allied resources (police, fire)
• Collaboration in the home or via phone

EMS Activation

• EMS connects with primary/palliative clinician
• Clinician provides additional patient history/information to assist in development of care plan
• Clinician advises if family/palliative physician available for consult
Collaborative Care Model

- Collaborative decision making between EMS, clinician, on call physician, patient and family
- Align care with patient’s wishes, Goals of Care, and preferred location when possible
- Transport may still be most appropriate decision based on resources available
Roles/Responsibilities

**Paramedic**
- Liaise with clinician and on call physician to build tailored treatment plan
- Administer treatment in collaboration with clinician (in the home or via phone) and patient/family

**Clinician**
- Ensures patient’s family and/or palliative physician made aware of event
- Arranges additional on-going resources (oxygen, equipment, medications, etc.) through standard procedures
Key Features

- Provincial rollout (urban and rural areas)
- Uses existing continuing care and EMS resources (transport capable)
- Uses primary and advanced care paramedics
- Uses current EMS formulary and equipment
- Flexible model, integrated into current processes based on regional resources
Phased Development/Implementation

Phase 1 – (2014/16)
- Launched April 1, 2015
- Clinician activates by phoning 911 and requesting PEOLC EMS support
- Clinician & EMS collaboration on scene
- Tailored treatment plan in conjunction with online medical consultation

Phase 2 – (2015/17)
- Launched October 1, 2016
- Building from Phase 1, EMS crews identify PEOLC patients and contacts community supports to maintain the patient in the community setting
- Remote access by clinician enroute to scene
- Follow up process if clinician cannot attend scene
- Additional PEOLC education for paramedics (LEAP Paramedic blended online/face to face course)

Phase 3 – (2016/18)
- Expansion to pediatric population
- Continued education for paramedics (LEAP)
- Evaluation and sustainability planning
- Investigate:
  - Non lights and sirens response to calls from patients/families
  - Opportunity to leave medications on scene
  - Development of palliative care symptom management guidelines
Program Evaluation/Key Findings

• Robust program evaluation including:
  – Collection/analysis of event data (patient demographics, treatments administered, time on task, location of death, goals of care, etc.)
  – Experience surveys (email) with paramedics, clinicians and physicians involved in events
  – Experience surveys (phone) with family members

• Midway Phase II Results (October 1, 2016 – March 31, 2017)
Provincial Activity To Date

• 160 events under Phase I (April 2016 – October 2016)
• ~ 500 events in the last year (since Phase II launch – October 2016)
• 221 events in first six months, additional ~275 in last six months
• Activations in all zones, urban and rural
Most patients (90%) were treated at home and not transported to hospital.

62% of the events occurred through remote activation (clinician not on scene) or EMS identification of appropriate patients when they arrive in the home (which are new routes of activation in Phase II).
Since the launch of Phase II, **program activations have significantly increased across the province**.

There were 221 events in the first 6 months of Phase II. This is a **56% increase** from the number of events since Phase I.

*Phase I data has been adjusted to reflect the new data collection methodology introduced in Phase II.*
### Top Three Primary Complaints

1. Pain (39%)
2. Dyspnea (21%)
3. General malaise/weakness (11%)

### Top Three Medications Given

1. Morphine (30%)
2. Normal Saline (12%)
3. Oxygen (10%)
Overall, clinicians, EMS staff, and physicians believed that the program benefits patients and family members. In Phase I, the majority of clinicians and EMS staff felt that the ATR program benefitted patients and families. This trend continued in Phase II with the addition of physician data.

*Please note that there is no Phase I data for physicians.*
Phase II Midway Recommendations

• Encourage clinicians to activate program on behalf of the patient/family
• Increase communication/awareness of program with physicians, EMS, patients, and families
• Communicate successes (reduced time on task) to help with culture shift/program acceptance with EMS staff
• Provide education in palliative care, grief and bereavement for EMS
Richard’s Story

Family Experience Video

(https://www.youtube.com/watch?v=zNMpJuKCyZs)
For more information, email: EMS.Palliative@ahs.ca

Program Website:
http://www.albertahealthservices.ca/info/Page14899.aspx