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

**Terri Woytkiw, RN, MN, CHPCN (c) GNC (c)**
Manger, Specialty Programs, North Zone, Seniors Health
Alberta Health Services
(780) 967-6231
Terri.Woytkiw@ahs.ca

*No conflicts to disclose*
The Opportunity

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

• 86% of Canadians prefer to die out of hospital (home or in other facility), 70% 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
Assess, Treat and Refer

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
• Patient may be managed at home if additional urgent medications/supports provided
Three Routes of Activation

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

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

3. **EMS Initiation** – EMS identifies opportunity for treatment in place from 911 event (added October 2016)
Program Activation

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/faceto-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

• Phase I Results March 31, 2015 through September 30, 2016
Common Complaints/Interventions

• Dyspnea – oxygen, bronchodilators and/or opioids/sedation (morphine, midazolam)
• Pain – morphine, fentanyl
• Delirium – fluids and/or haloperidol, midazolam
• Nausea/vomiting – ondansetron, metoclopramide
Common Complaints/Interventions

The top three primary complaints (Phase 1):
1. Pain (29%)  
2. Dyspnea (27%)  
3. Altered level of consciousness (10%)

Main agents and medications administered:
1. Morphine (25%)  
2. Normal saline (11%)  
3. Midazolam (10%)  
4. Ondansetron (9%)

Most Patients Treated at Home

88% of patients were successfully treated in place

(n=165 Phase I one – March 2015 through September 2016)
Despite longer time on scene, the overall time on task for EMS staff was lower when compared to all of the EMS events where transport occurred.
Honoring Preferred Location of Care

The majority of family members who were surveyed said that the patient received treatment in their preferred location of care.
Clinicians and EMS staff were satisfied with their collaboration.

Family members, clinicians, and EMS staff were satisfied with the ATR event.
Phase II Initial Findings

- Large increase in program usage with new routes of access
- 50% of events clinician activated (in the home or remote), 50% EMS identification of patients
- Time on task for EMS remains shorter than provincial average (transported events)
- Complaints and treatments remain consistent with Phase I
Richard’s Story
For More Information

Contact the presenter or email
EMS.Palliative@ahs.ca

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