BASIC PRINCIPLES, DEFINITIONS AND CONCEPTS ON THE ORGANIZATION OF PUBLIC HEALTH PALLIATIVE CARE PROGRAMMES AND SERVICES

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I. - Introduction

This document aims to describe the key elements of a care model in palliative care and to provide basic definitions on palliative care services’ organization and provision. It is meant to be:

✓ simple
✓ understandable
✓ adaptable to different and changing situations.

II. - Principles

A Palliative Care Organisation must be based on the needs of patients and families. The model is built up in different levels, following the assessment of those needs.
III. - Palliative Care: basic, general and organizational definitions

Palliative care is the comprehensive care of patients with advanced or terminal diseases and their families. The aims of palliative care involve improving the quality of life of the patients and promoting adjustment to illness and loss. Such care is provided by a competent multidisciplinary team, either in general, conventional or specialist services.

The basic organisational definition of palliative care is the systematic approach to multidimensional needs assessment practised by a competent interdisciplinary team. Such team exercises a methodology of ethical decision-making by applying a systematic approach to needs assessment, such as the square of care + respect for the individual values and preferences + advanced care planning.

General measures in palliative care organisation (also known as basic level of palliative care) include the different actions undertaken by any conventional service (e.g. oncology, primary care, geriatrics, emergency services, nursing homes and others) to improve the quality care of advanced, incurable and terminal patients. Furthermore, training and accessibility are enhanced and team work and links with specialist palliative care services are promoted.

Transitional measures in palliative care organisation are models of care delivering that use human resources (frequently a specific one), such as a specialist nurse or a physician not fulfilling the criteria for a specialist team or service, but devoted to palliative care activities.

Palliative care specialist resources (called services in some countries) are the specific resources devoted to care of advanced and terminally ill patients and their families. They include a well trained multidisciplinary team, who follows adequate care processes and who are clearly identified by patients, families and other services. Moreover, such specialist resources hold an administrative identity. They also have a specific budget assigned and leadership. They include support teams, units, outpatient clinics, day care centres, comprehensive networks and hospices.

In a district or sector, palliative care organisation consists of diverse types of services (including acute hospitals, rehabilitation and long term facilities, support teams, nursing homes, home care teams, day care and respite care) either linked, coordinated or integrated together, which make use of several levels of case management and advanced care planning as pillars of care organization. Palliative care comprehensive networks (PCCN) can be defined as a unique reference team or service acting in all of the settings of a sector or district which makes uses of a methodology of case management.

Palliative Care Providers are the public, private, profit or non-profit organisations that make palliative care services available.

Palliative Care Programmes (PCP) are a group of combined measures developed to implement and improve palliative care in a demographic context (national, regional or district-based), oriented to all target populations. Palliative Care Programmes with a Public Health perspective have full coverage, equity, access and quality as its main goals in a specific sector or district.
IV. - Target patients for palliative care measures and services

IV.1. Characteristics of the terminal situation

IV.1.1. Criteria: Terminal situation can be defined by a combination of several parameters and factors, including:

1. Disease: A progressive, advanced and incurable illness, such as cancer, progressively degenerative conditions of the CNS, HIV/AIDS, dementia, multi-organs failure (including respiratory, cardiovascular, liver, renal impairments), presented either individually or associated within the many and simultaneous pathological states related to ageing.

2. Response to specific treatments: Low or no probability to respond to specific treatments.

3. Symptoms: Multiple (mean 8-10), severe, changing over time and of diverse nature according to disease.

4. Gradual impact on physical autonomy.

5. Emotional impact on patients, families and professionals.

6. Limited life expectancy or prognosis (mean between 3 – 12 months depending on the underlying disease).

7. Frequent ethical dilemmas (including issues related to nutrition, hydration, admission into, or discharge from, hospital).

Other relevant aspects are:

8. Evolution with frequent crisis of needs.

9. High level of needs of, and demands for care.

10. High tendency to use acute care and emergency resources, especially in the absence of palliative care services.

11. Complexity: difficult situations, either occasionally or permanently, are the main reasons for needing the intervention of specialists. The most frequent causes of complexity are young age, difficult or refractory symptoms, high emotional impact, lack of caring support, or weak coping strategies, either emotional or practical.
IV.2. Criteria and evolving patterns of consolidation

There are several criteria and models of evolving patterns of palliative care consolidation, described in the Gold Standards Framework (FIGURES 1 AND 2)

**FIGURE 1.** Adapted from ¹

**FIGURE 2.** Adapted from ¹

V. - The model of care and intervention

It must be based on the needs and demands of patients and families, carried out by a multidisciplinary team and systematically incorporated into any health care intervention (FIGURES 3 and 4).

V.1. Dimensions

FIGURE 3. - A model to guide patient and family care-Reproduced with permission from


V.2. Square of care / Model of care

![Process of care diagram](image)

**FIGURE 4.** - The Square of Care – Adapted from 3

V.3. Systematic and continued approach by dimensions

FIGURE 5 illustrates a recommended approach to guide patients’ assessment and decision making throughout the illness trajectory. The systematic application of an approach like this would guarantee to take into account all the most relevant aspects of care and would allow comparing the information gathered across services that routinely apply the same method.

![A model to guide hospice palliative care](image)

**FIGURE 5.**- A model to guide hospice palliative care - Reproduced with permission from
V.4. Integrated, flexible and shared care

Palliative care principles and practice must be applied whenever and wherever a patient and his/her family may need it (FIGURE 6). In general, specialist services tend to act according to the complexity of patients’ needs, adopting flexible, early, shared and cooperative models of intervention. The best indicators for evaluating this process are the length of intervention (from weeks to months) and the proportion of patients with shared care.

![Diagram](image)

**FIGURE 6.-** Health care interventions throughout the illness trajectory.
(A diagram suggested by the authors at the WHO Collaborating Centre for Public Health Palliative Care Programmes)

In a model based on patients needs and services complexity, patients will need different levels of interventions according to the progression of their condition and they should be able to have access to them on a flexible pattern (FIGURE 7).
FIGURE 7.- A guide to palliative care service development: a population based approach Adapted from⁴

Some myths and barriers must be reviewed and updated:

1. Limited Prognosis is not the main issue to define the need of specialist interventions and complexity and crisis of needs are the main reasons for specialist interventions
2. The indication of specific disease treatment must not be a barrier for specialist interventions
3. Shared and flexible care between conventional and specialist services are the most useful models of organisation. Such goal is reached by defining the responsibilities in the follow-up, by the continuing and emergency care and by defining the roles on case-management (See FIGURE 8)

VI. – Microorganisation: Multidisciplinary team

The basis of the organisation of specific resources consists of a multi- and interdisciplinary team approach. Team members should hold an advanced training level in palliative care, and should carry out a routine assessment of clinical, social, psychological and spiritual needs. Furthermore, treatment goals should be defined and the therapeutic plan should be elaborated. Review and monitoring of needs must always be conducted with respect to patients, families, and team values and preferences by holding clinical ethics as the main approach to decision-making.

We define a Basic specialist team as the team composed by, at least, one full time doctor and one nurse with support from a social worker, a psychologist and administrative aid. A Complete specialist team could be made of, at least, all those professionals mentioned previously fully devoted to palliative care and other health care professionals on an “as needed” basis.

Promoting team approach is a basic general measure to care for incurably ill patients in other conventional services, specifically in those services with a high prevalence of advanced and terminally diseased patients.
VII. - General measures in conventional palliative care services (Basic level of palliative care)

General measures are particularly important in services with a high prevalence of advanced and terminally ill patients and, in general, to enhance palliative care coverage and make it available to all patients’ needs in any setting, because of any disease, or at any disease phase.

A possible list of general measures may include:

1. Training in palliative care and ethics of health care professionals at any conventional service.
2. Protocols of action and clinical sessions on the basic management of symptoms and palliative care emergencies (including pain and other symptoms; last days; key communication skills).
3. Improving team approach.
4. Improving the patient’s accessibility and continuing care (both at home and in hospital).
5. Improving the family presence, accessibility and support (in hospitals).
6. Improving family care (at home).
7. Improving bereavement support.
8. Links with palliative care specialist services for managing and referring complex patients, enhancing specialist support and encouraging training.
9. Assessment tools and documentation.
10. Research.

General measures are crucial to guarantee coverage at any point within the health care system, although the care of highly complex, advanced or terminally ill patients requires the intervention of specialist teams.
VIII. - Specific Palliative Care Resources and Services: definitions, types, levels, and settings

VIII.1. Definitions and types

_Palliative care specialist resources (PCR)_ (specialist nurses or consultants, support teams, units, outpatients clinics and day hospitals, comprehensive networks or hospices) are the specific full time resources devoted to care of advanced and terminally ill patients and their families. They include a trained multidisciplinary team that acts with the adequate process of care and it is identified by patients and other services as a specialist palliative care resource, even though it may act mostly in another service.

_Palliative care specialist services (PCS)_ are made of either _one or a combination of specialist resources and are identified by patients and other services_ as a specialist service. Moreover, those services hold an independent head of service, an assigned budget and administrative identity.

_General measures (or basic level of palliative care)_ are the different initiatives taken by any conventional service such as oncology, primary care, geriatrics, emergency, nursing homes and others to improve the quality care of patients. General measures mainly include training, better accessibility, the promotion of team approach to care and links with specialist services.

VIII.2. Levels of complexity of resources

There are several levels of palliative care organisation defined in terms of their complexity. Such levels are more necessary in metropolitan areas, where there are great numbers of patients suffering from different disease types as well as a larger number of resources. In small areas, a basic or complete palliative care team can be the reference resource. Frequently, the implementation of palliative care moves gradually from the basic to the most complex levels (FIGURE 9).
VIII.3. Mixed or disease-specific

According to the type of patients they look after to, resources and services can be disease-specific or mixed.

In general, resources placed in the community and in small districts are more likely to be mixed; that is, they will care for patients suffering from a variety of illnesses, whereas in bigger areas the prevalence of specific disease patients is higher. Teams will tend, then, to care for more specific disease groups.

VIII.4. Settings of Palliative Care Services

As it is shown in FIGURE 10, palliative care resources can be placed in any setting within the health care system. In each of these settings, palliative care resources will care for different types of patients and their outputs will, then, be different. However, they will have in common the model and the process of care as well as the outcomes of the palliative care services.

FIGURE 9. - Increasing complexity in services’ organization and expertise.
(A diagram suggested by the authors at the WHO Collaborating Centre for Public Health Palliative Care Programmes)
FIGURE 10.- Different palliative care settings operating within the Health Care System. (A diagram suggested by the authors at the WHO Collaborating Centre for Public Health Palliative Care Programmes)

VIII.5. Demographic scenarios of Palliative Care Systems

In any country, there are demographic scenarios that can be identified as having similar inhabitants and geographical characteristics. They usually share similar models of organisation of the health care services. These models can also be used to plan and implement the palliative care services.

Examples of demographic scenarios include:

- Metropolitan areas with high population needs (millions, and more than 500,000 habitants in each sector) which have large reference hospitals
- Rural areas with < 50,000 habitants
- Urban areas with between 100,000 and 250,000 inhabitants
IX. - Specific Palliative Care Resources: structure

IX.1. Main components of the structure of palliative care resources

The main components of the structure of palliative care resources are:

IX.1.1 A Multidisciplinary team

- Basic: 1 doctor, 1 nurse, with the participation of a psychologist and social worker
- Complete: Basic + 2 more fulltime professionals
- Other professionals to involve in several degrees: physiotherapists, occupational therapists, chaplains, pharmacists, nutritionists and other professionals
- Links and advice from reference specialist services previously involved in the care of patients, such as Oncology, Internal Medicine, Geriatrics, Primary Care and others as well as other more complementary to palliative care such as the pain services
- Volunteers are also strongly recommended as components of the palliative care team and with links to society

IX.1.2 Advanced specialist training

It is a crucial element when dealing with complex situations.

IX.1.3 Transitional experiences

There are transitional situations where a specialist physician or a nurse may be the only available resource.

IX.1.4 Other components

Other components of the palliative care resource structure are documentation, recording and gathering of data material, phone access and an independent office.

Finally, palliative care services are recommended to be independent from other services and to directly depend on health care managers.
X. - Specific Palliative Care Resources and Services: care activities, processes, expected clinical outcomes and basic key indicators

X.1. Care activities (List of different possibilities)

- Home care visits
- Outpatient visits
- Day care
- Hospital visits in conventional services
- Hospital visits in specialist services
- Phone support
- Continued care and emergency care
- Case management
- Support to other professionals
- Evaluation
- Follow up
- Others

X.2. Processes (activities of a palliative care team or service)

- Care of patients (applying the square of care)
- Care of the family
- Bereavement
- Team activities
- Ethical decision-making
- Continued and urgent care
- Monitoring, documentation, evaluation of results
- Formal and cooperative links with other specialist services and with community services
- Education of patients and relatives
- Internal training of the team
- Training of other professionals
- Evaluation and quality improvement
- Research
- Volunteers
- Advocacy
- Other
X.3. Expected clinical and organisational outcomes (outputs to be considered for individual resources)

The main goal of palliative care is to reduce suffering and improving the experience of patients and families. The administration of palliative care produces several common results on the patients:

- Lessening the severity of symptoms
- Lessening the emotional impact of disease and favouring adjustment of patients and families
- Increasing satisfaction
- Decreasing the risk of complex grief
- Reduction of hospital stays, length of stay and of emergency visits (30-50%)
- Reduction of health care costs (50%)

X.4. Basic key indicators

The basic key indicators are the minimal structure and process requisites that any palliative care resource or service must accomplish to demonstrate good quality palliative care practice (FIGURE 11).

![Basic Key Indicators of PCSs](image)

**FIGURE 11.** Key quality indicators of palliative care services. Adapted from “Catalano-Balear” Society of Palliative Care (SCBCP) Standards and Spanish Society for Palliative Care (SECPAL) core indicators

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XI. - Transitional Palliative Care measures: Specialist Nurses and Consultants

A basic formula of specialist organisation is an individual specialist consultant or nurse, who operates within other resources and carries out some of the palliative care activities.

Good examples are the Macmillan Nurses in the UK, the hospital nurse specialist and the nurse community in India or Africa.

These resources can undertake activities, such as expert advice, clinics, or other activities operating within other services.

Transitional measures can be very appropriate and efficient in some demographic or geographic scenarios and settings (nurses in rural scarce areas or specialist nurses devoted to specific patients in hospitals), and/or also be the first step of implementation preceding the development of a specialist multidisciplinary service.

XII. - Palliative Care Support Teams: structure, process, levels of intervention, settings, expected outputs, limits

XII.1. Definition and structure

A Palliative Care Support Team (PCST) is a specialist palliative care resource made of a basic or complete team, mainly working in a consultative basis with other teams without allocated beds. They need a specific setting (e.g., an office) and to be identified by other services.

XII.2. Processes /activities

According to their setting and based on their capacity, PCSTs can offer inpatient consultations, outpatient's clinics and day care, home care visits, phone support, support to other services and various degrees of continued care.

According to their different characteristics, PCSTs can be:
✓ Disease-specific or mixed
✓ Comprehensive (covering all dimensions of patients’ and families’ needs)
✓ Predominantly devoted to symptom control (symptom control teams)
✓ Psychosocial teams, if devoted solely to the psychosocial aspects of care

XII.3. Settings
They can be based in hospitals (HSTs), the community (HCSTs), and/or within comprehensive networks. In the case of the community and comprehensive networks, it is strongly recommended to act in a defined district or sector in order to establish steady relationships with other services and to avoid time wasting.

In hospitals, PCSTs can be the most efficient way to start a palliative care service by means of gradually implementing other resources, such as outpatient clinics, day care centres, units and comprehensive palliative care services.

XII.4. Levels of intervention
FIGURE 12 shows the different levels at which a palliative care support team may get involved in the care of patients.

**Support teams: levels of intervention**

I. **Advice to other professionals (session or personal)**
II. **Evaluation and proposals (with no follow up)**
III. **Evaluation, shared follow up, intermittent interventions**
IV. **Evaluation, shared follow up, regular interventions**
V. **Evaluation, shared or not follow up, regular interventions, full responsibility for decision-making and administrative aspects**

**FIGURE 12.- Different levels of intervention of support palliative care teams**
(A diagram suggested by the authors at the WHO Collaborating Centre for Public Health Palliative Care Programmes)
XII.5. Expected outputs

Additional to standard outcomes of specialist services, PCSTs are extremely efficient because, though being very basic and small structures, they hold great influence on the care of patients and on the training and regular functioning of many professionals.

Factors that influence outputs are the setting, the type of patients, the relation with other services, the availability of other palliative care services in the district, and the level of intervention.

Home Care Support Teams can attend around 200-300 new patients / year with lengths of intervention of around 4-12 weeks, and 20-40 prevalent patients. They usually achieve excellent results by means of increasing the opportunity of dying at home and by reducing the use of beds and emergency services. Sectorised intervention limiting the time of travelling is crucial to achieve efficiency.

Hospital Support Teams can attend 200-300 new patients / year with lengths of intervention of 1-2 weeks (only inpatients care) to 6 months (outpatients’ clinics) and 20-40 prevalent patients.

XII.6. Limits

The restrictions of individual support teams are related to their limited structure (e.g. limitations to guarantee care on time and on call availability and workload), to their partial capacity to provide intensive or complex intervention when distressed patients are at home or have been admitted into non-specialist services, and to negotiate with other teams when the care is shared and decisions need to be taken.
XIII. - Palliative Care Units (PCUs): definition and structure, settings, process, expected outputs, limitations

XIII.1. Definitions, types, and structure
A Palliative Care Unit is an independent specialist resource of beds, exclusively devoted to the care of advanced and terminally ill patients. The structure must promote privacy and comfort for the patients, altogether with the presence of the family and the team.

According to their length of stay (and linked to the setting), PCUs can be acute units (less than 15 days of patients stay), mid-term units (15 to 25 days), or chronic palliative care units (>25 days) (see below for details). The number of beds ranges from 12 to 28 depending upon the usual organisation. The needs of staff and the costs to be assumed will vary according to different parameters.

XIII.2. Settings
PCUs can be placed in acute hospitals of any size or level, cancer institutes, mid-term resources (Socio-health), nursing homes or hospices. According to their placement, palliative care units will care for different types of patients (and their outputs will also differ): mixed populations in general hospitals, cancer patients in cancer centres, more geriatric patients in nursing homes.

XIII.3. Process
Added to the standards processes, admission, discharge, referral and access criteria are crucial.

XIII.4. Expected outputs
The main outputs to consider are the length of stay, the type of patients, the mean age, mortality, and the costs. The following table illustrates the way in which different palliative care resources can be defined according to some of their characteristics, their place within the health system and the population of patients being cared of.
<table>
<thead>
<tr>
<th></th>
<th>Length of stay in days</th>
<th>Characteristics</th>
<th>Type of patients</th>
<th>Age (mean)</th>
<th>Mortality rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Units</td>
<td>&lt; 15</td>
<td>Hospitals, University, Cancer institutes, Reference, High complexity</td>
<td>Depending on the setting being considered</td>
<td>55-65</td>
<td>50-60%</td>
</tr>
<tr>
<td>Mid term / sub-acute Units (*)</td>
<td>15-25</td>
<td>Post-acute, socio-health care centres (**)</td>
<td>More geriatric if are in mid-term hospitals or nursing Homes</td>
<td>70-80</td>
<td>70-80</td>
</tr>
<tr>
<td>Chronic Units</td>
<td>&gt; 25</td>
<td>Low complexity</td>
<td>Mostly low complexity and geriatric patients</td>
<td>&gt; 80</td>
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**TABLE 1**: Characteristics and outputs of PCUs (Adapted from Porta et al, 2008)<sup>6</sup>

(*) Subacute, mid term care or units: between acute and long term, usually devoted to rehabilitation and palliative care

(**): sociohealth centers: havng subacute, mid term, and long term facilities, especially for advanced-terminal, chronic and geriatric patients

XIII.5. Limitations

Isolated units with no other available and related resources, such as outpatient clinics, community or hospital support teams may have some difficulties in the preadmission process and during the discharge.

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XIV.- Palliative Care Outpatients Clinics (PCOPCs), Day Care Centres (or Hospitals) (PCDHs), and Palliative Care Bereavement Service or clinic: definitions, structure, settings, process, expected outputs, limitations

XIV.1. Definitions and structure

- A Palliative Care Outpatient’s Clinic is a specific resource taking care of outpatients. It includes clinical evaluation, follow up, phone support and other possible care and support activities. The most common strategy to routinely assess clinical outcomes is to evaluate at visit 1 and at pre-established follow up visits.

The structure can be very simple and the staff can include one specialist or a basic or complete team.

- A Palliative Care Day Centre or Hospital is a specific resource which practises day care which can include either:
  - Complex drug or medical interventions or procedures (ex: intravenous titration of opioids, catheters, thoracic drainage)
  - Complex multidisciplinary interventions (combining patients and family support, psychosocial care, etc)
  - Physiotherapy, occupational therapy, and/or group therapy
  - Social events

The structure requires one or various rooms with the necessary equipment for physiotherapy/occupational. The team needs to be adapted to the different aims and activities.

- Palliative Care Bereavement Service or clinic is a resource specifically devoted to look after bereaved relatives, especially if they suffer from complicated grief (10 to 20%).
XIV.2. Settings

Palliative Care Outpatients Clinics (PCOPCs) and/or Day Hospitals (PCDHs) can be placed in any setting of the health care system, but they are generally linked to services having several resources (Units, Support Teams or Hospices).

XIV.3. Process

The process starts generally with an evaluation visit and is followed (or not) by a follow-up process, either shared or not with other resources or services. Advanced care planning can include phone support and access, continued planning and emergency care and advice to other services and professionals.

Palliative Care Outpatients Clinics (PCOPCs) and/or Day Hospitals (PCDHs) are crucial, since they are the first resources of a more complex service to evaluate and take care of patients and families for a long term follow up.

XV. - Hospices: structure, process, expected outputs

Hospices are specific organisations fully dedicated to palliative care. They usually have a unit, outpatients care, home care and day care. In some countries, the term hospice is used for units (Italy), or for home care services (some areas of US). This is a model of care mainly extended in the UK, US and other Anglo-Saxon countries. On the other hand, such model is very unusual in other European countries.

XV.1. Structure

Hospices may either operate within or outside the health care system, since they are frequently financed by a foundation, a charitable entity or other type of non-profit organization. They usually represent an independent building that operates in a quiet and comfortable area of the city. The philosophy behind assuring these commodities is to provide the terminally ill patient with a peaceful environment in which to spend the last days of life. Hospices may also function in the community caring for very ill patients at home; this is an alternative model that exists in some European countries that differ from the traditional English model of hospice care.
XV.2. Process

Hospices are usually linked to the local hospital and community services and provide care during the patients’ last days of life (the most seriously ill patients). They also offer respite care for families and informal carers. Hospices concentrate bereavement care in the community as well as creative activities amongst group of patients.

XV.3. Outputs

Patients’ and families’ care satisfaction is amongst the most valued outcomes expected from hospice care. Quality of life (and death) and professional support of bereaved carers are the most frequently assessed outputs of hospices’ interventions.

XVI. - Palliative Care Comprehensive Networks (PCCN)

A Palliative Care Comprehensive Network (PCCN) is a system of care in which, for a defined demographic scenario (more likely, a district), there is a leading palliative care service. Such service has all the different resources needed and intervenes in all the settings with a methodology based in case-management. It requires leadership, a consensus of all the different providers, a unique information system and a financing model which stimulates the process.

In small districts (< 50), a basic multidisciplinary team disease-mixed can offer this approach, intervening in the district hospital, the sub-acute care resources, the nursing homes and the community.
XVII. - Palliative Care Reference Services (PCRS)

These are specialist services including several types of resources (always including, at least, an acute unit, an outpatient's clinic and a support team), based in acute university hospitals, generally in metropolitan areas (having links with a wide range of other palliative care specialist resources) and mainly devoted to care of complex patients, advanced education, training and research.

XVIII. - Palliative Care Plans or Programs: Definitions, Principles, Elements

XVIII.1. Definitions

A *Palliative Care Program (PCP)* is a group of combined measures to improve and develop palliative care in a demographic context (nation, region, district), oriented to all the target population.

A *Public Health Palliative Care Program (PHPCP)* is a Palliative Care program based on the principles and aims of a Public Health approach, which aims to guarantee coverage, equity and quality care in the provision of palliative care.

A *WHO Demonstration Project on Palliative Care implementation* is a pilot Public Health Palliative Care Program, defined and appointed by the WHO, with the commitment to generate experience and evidence, and disseminate its expertise amongst other settings.
XVIII.2. Principles and aims of PHPCP

**Principles**
- Measures in all places
- Sectorised
- Insertion in pre-existing services, including sociohealth
- Gradual implementation
- Public Planning and leadership
- Public funding

**FIGURE 13.- Principles of a Public Health Palliative Care Programme**
(A diagram suggested by the authors at the WHO Collaborating Centre for Public Health Palliative Care Programmes)

**Aims**
- Public coverage
- Equity and accessibility
- Quality (efficiency, efficacy, satisfaction)
- Reference (WHO)

**FIGURE 14.- Aims of a Public Health Palliative Care Programme**
(A diagram suggested by the authors at the WHO Collaborating Centre for Public Health Palliative Care Programmes)
XVIII.3. Elements of PCPHPs

**FIGURE 15-** Elements of a Public Health Palliative Care Programme  
(A diagram suggested by the authors at the WHO Collaborating Centre for Public Health Palliative Care Programmes)

XVIII.4. Foundational measures of PCPHPs

**FIGURE 16.-** Foundational measures of a Public Health Palliative Care Programme  
(A diagram suggested by the authors at the WHO Collaborating Centre for Public Health Palliative Care Programmes)
XVIII.5. Key indicators to assess PHPCPs

**FIGURE 17.** Key quality indicators of a Public Health Palliative Care Programme (A diagram suggested by the authors at the WHO Collaborating Centre for Public Health Palliative Care Programmes)
Bibliography

Recent bibliography from the authors:

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