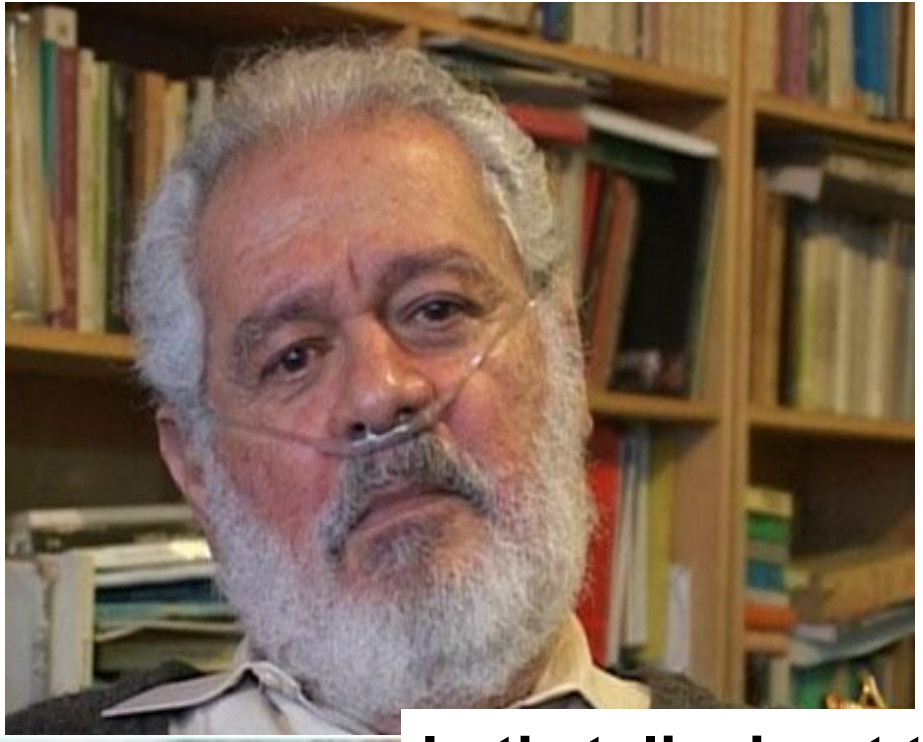
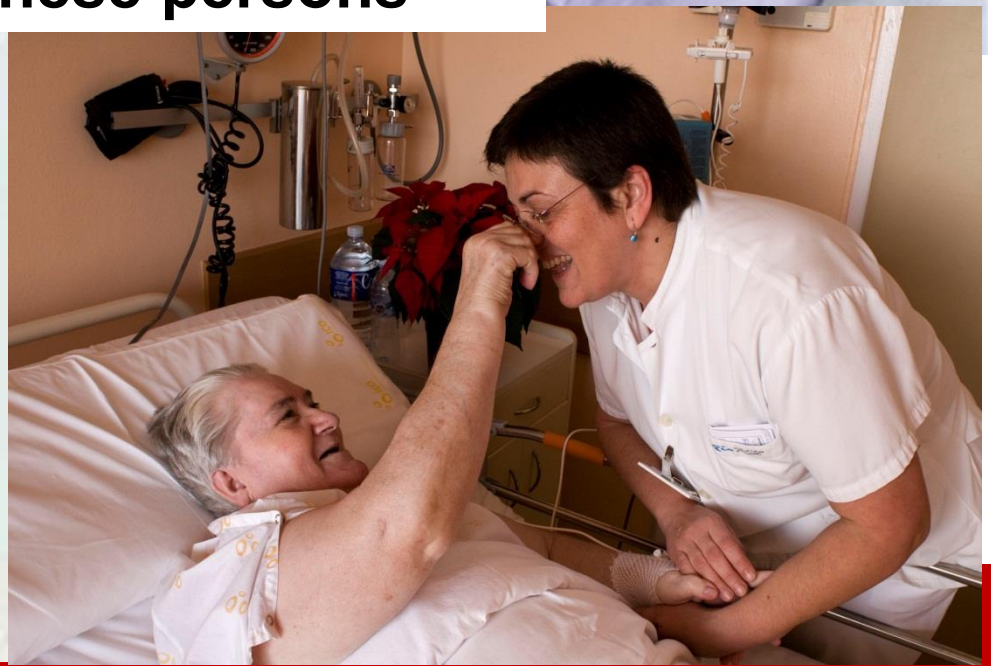


Let’s talk about these persons



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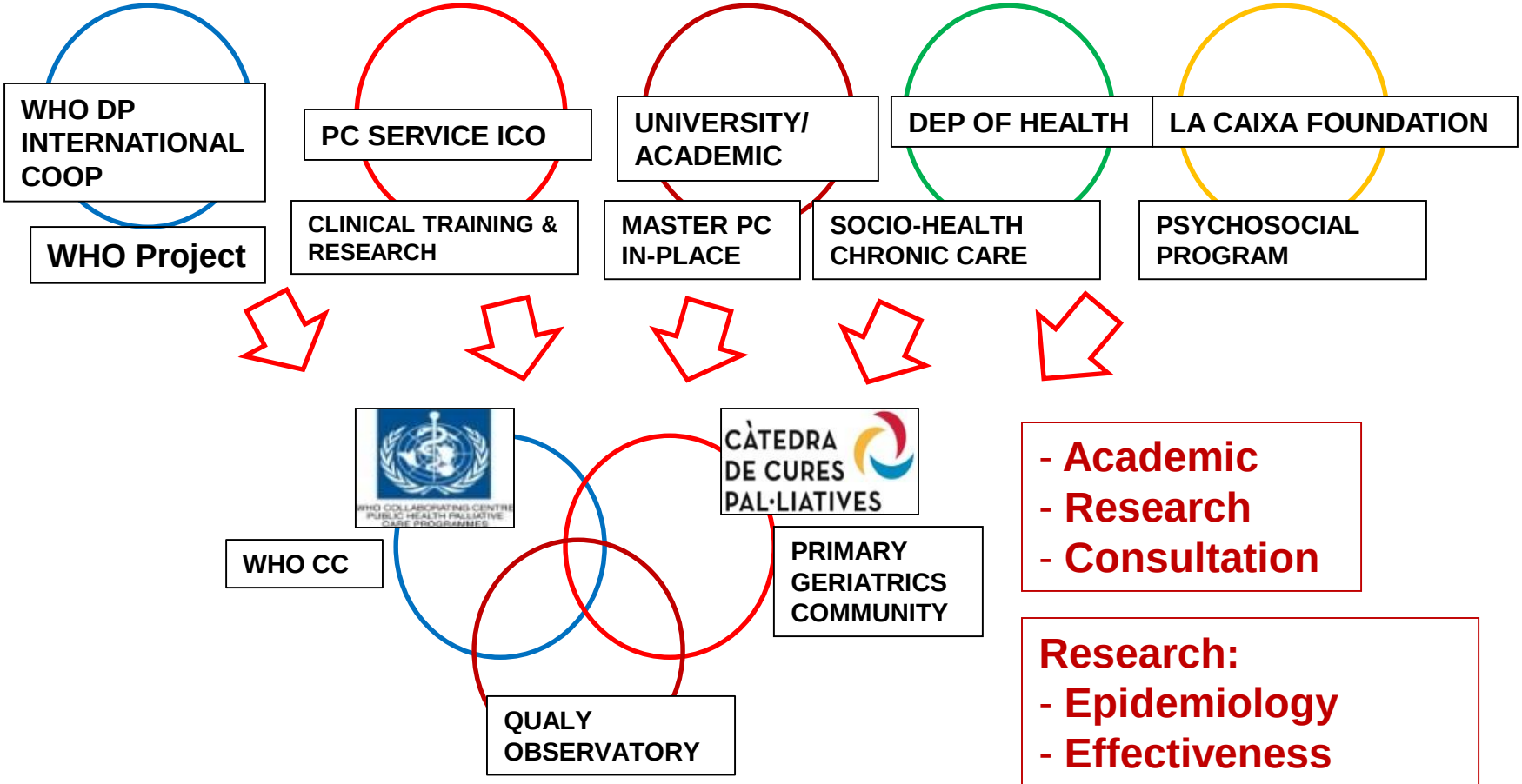
Chairperson

- **Standing advisory committee for the prevention and care of people with chronic conditions. Department of Health. Government of Catalonia.**

Former Medical Officer for Palliative and Longterm care. WHO HQ. Geneva


WHO DP INTERNATIONAL COOP
WHO Project
PC SERVICE ICO
CLINICAL TRAINING & RESEARCH
UNIVERSITY/ ACADEMIC
MASTER PC IN-PLACE
DEP OF HEALTH
SOCIO-HEALTH CHRONIC CARE
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WHO CC
CÀTEDRA DE CURES PAL·LIATIVES
PRIMARY GERIATRICS COMMUNITY
QUALY OBSERVATORY
- Academic
- Research
- Consultation
Research:
- Epidemiology
- Effectiveness
- Services/program's

Challenges of Public Health Palliative Care

- How to extend palliative care
  - All patients: Targets?
  - All chronic conditions
  - All dimensions: multidimensional
  - Timely: 1st transition
  - All health and social settings
  - All countries
- Rol of specialized services?
- Society involvement
- Sustainability
- Accountability

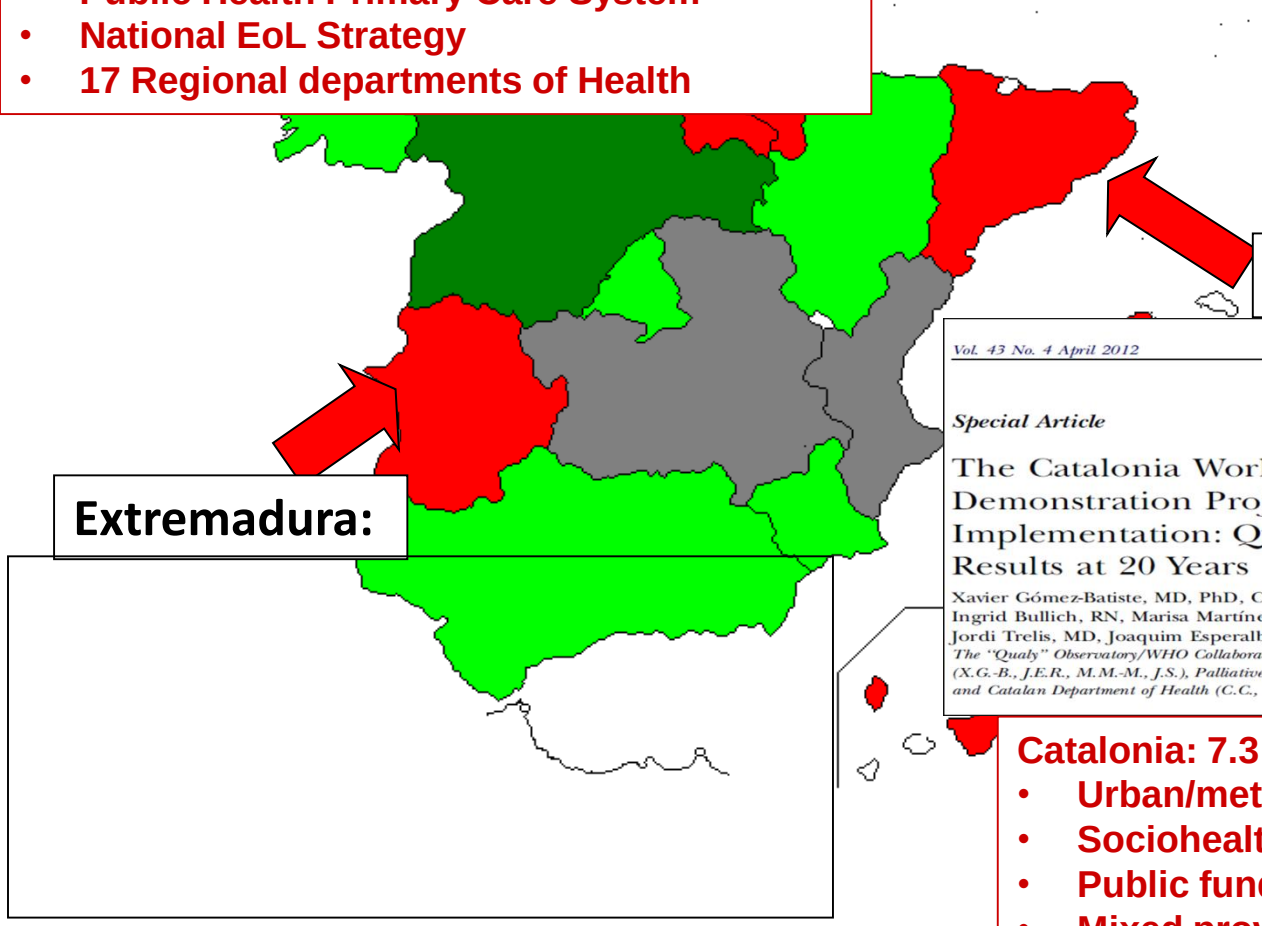
	FROM	Change TO
Concepts	Terminal disease	Advanced progressive chronic disease
	Death weeks or months	Limited life prognosis
	Cancer	All chronic progressive diseases and conditions
	Disease	Condition (multi-pathology, frailty, y, .)
	Mo	
Model of care and organisation	Dic	, shared, combined care
	Sp	ID palliative treatment needed
	Pr	as criteria
	Lat	fication in all settings
	Rig	ervention
	Pa	/ Advance care planning
	Re	of crisis / Case management
	Fragmented care	Integrated care
Perspective for planning	Palliative care services	+ Palliative care approach everywhere
	Specialist services	+ Actions in all settings
	Institutional approach	+ Community approach
	Services' approach	Population & District
	Individual service	District approach

From
Cancer to all conditions
Terminal to advanced
Specialist to all Services
Services to population

Conceptual transitions in Palliative Care XXIc
XGB et al, BMJ SPC 2012

Spain:

- **Universal Health Care Coverage**
- **Free Access**
- **Public Health Primary Care System**
- **National EoL Strategy**
- **17 Regional departments of Health**



Catalonia

Extremadura:

Vol. 43 No. 4 April 2012 Journal of Pain and Symptom Management 783

Special Article

The Catalonia World Health Organization Demonstration Project for Palliative Care Implementation: Quantitative and Qualitative Results at 20 Years

Xavier Gómez-Batiste, MD, PhD, Carmen Caja, RN, Jose Espinosa, MD, Ingrid Bullich, RN, Marisa Martínez-Muñoz, RN, Josep Porta-Sales, MD, PhD, Jordi Trelis, MD, Joaquim Esperalba, MD, MBA, and Jan Stjernsward, MD, PhD

The "Qualy" Observatory/WHO Collaborating Center for Palliative Care Public Health Programs (X.G.-B., J.E.R., M.M.-M., J.S.), Palliative Care Service (J.P.-S., J.T.), Catalan Institute of Oncology; and Catalan Department of Health (C.C., I.B., J.E.), Government of Catalonia, Barcelona, Spain

Catalonia: 7.3 milion

- **Urban/metropolitan/rural**
- **Sociohealth system**
- **Public funding**
- **Mixed provision**

Extremadura:

- **1 milion**
- **Public Provision**
- **Rural**
- **Sparsely populated**

Existing Palliative Care has shown effectiveness and efficiency

- Improves symptoms
- Reduces suffering
- Reduces complex bereavement
- Increases satisfaction
- Reduces suffering

- Added values:
- Comprehensive
- Patients and families
- Essential needs
- Interdiscilpinary
- Dignity
- Ethics
- Humanism

- Reduce use of hospital beds
- Reduce admissions and length of stay in hospital
- Reduce emergencies
- Cost of Palliative care beds 50% of conventional
- Increases home care
- Cost of health care 70% in the last 6 months
- Cost of hospitals is 70% of the cost of End of life care

Special Article

The Catalonia WHO Demonstration Project of Palliative Care: Results at 25 Years (1990–2015)

Xavier Gómez-Batiste, MD, PhD, Carles Blay, MD, MSc, Marisa Martínez-Muñoz, RN, PhD, Cristina Lasmarías, RN, BA, MSc, Laura Vila, RN, MSc, José Espinosa, MD, MSc, Xavier Costa, MD, Pau Sánchez-Ferrin, MD, Ingrid Bullich, RN, MSc, Carles Constante, MD, and Ed Kelley, PhD

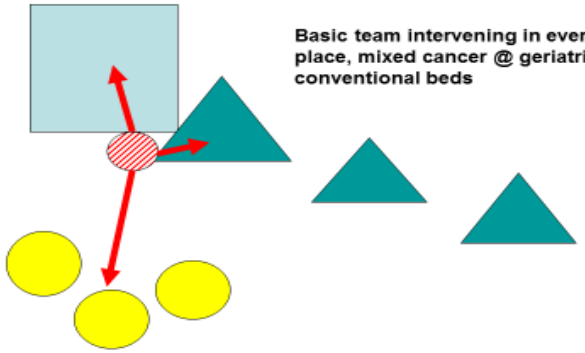
Catalonia 2014

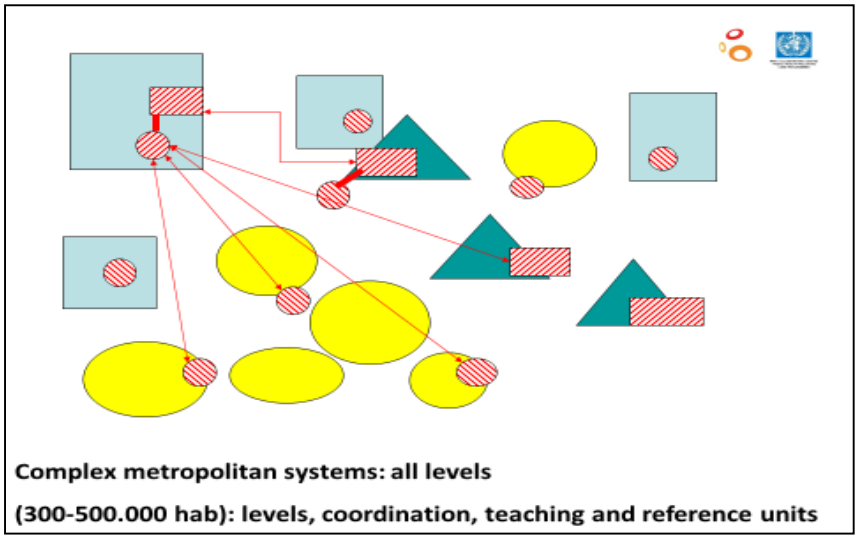
- Coverage (geographic): 95%
- Coverage cancer: 73%
- Coverage non cancer: 40-56% (*)
- Proportion cancer/noncancer : 50%
- Nº Dispositives: 236
- Beds/milion: 101.6
- Full time doctors: 220 (30 / milion)

(*) McNamara, 2006

	Type of service	*2010*	*2015*
Specialized care services	Home Care Support Teams (HCSTs)(*) (**)	72	73
	Hospital Support or Consultation Teams (HST)	49	49
	Specific Support Teams to Nursing homes (STNH)	-	20
	Psychosocial Support Teams (PSSTs)	6	9
	Palliative Care Units (PCU)in Intermediate Care Centers (***)	28 PCU 383 Beds	28 PCU 383 Beds
	Palliative Care Units in Nursing Homes	27 319 beds	27 358 beds
	Palliative Care Units in acute hospital	5 PCU 40 Beds	5 PCU 40 Beds
	PC Outpatient Clinics	50	50
	Private services	2	3
Other specific structures (academic or managerial)	Teams at the Dept. of Health	1	1
	Education and training units	1 (ICO)(****)	1 (ICO)
	Clinical research team	1 (ICO)	1 (ICO)
	Chairs of Palliative Care	0	2 (University of Vic and International University of Catalonia)
	Observatory/WHOCC	1 (ICO)	1 (ICO)
Total	Specialized services (care + other)	239 + 4 = 243	264 + 6 = 270 (+ 27)

Comprehensive system in small districts (20-50.000 hab)

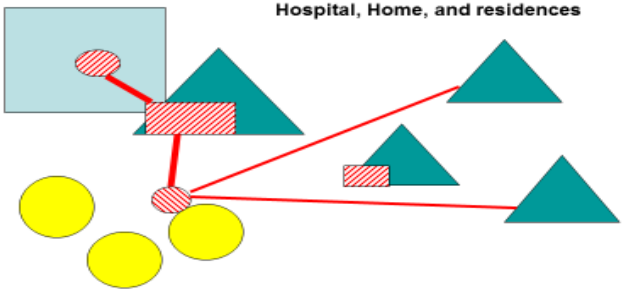




Complex metropolitan systems: all levels

(300-500.000 hab): levels, coordination, teaching and reference units

Comprehensive district system
(16 sectors of 100-150.000 hab): integrated



District organizational models

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DOI: 10.1089/jpm.2010.0059

Quality Improvement in Palliative Care Services and Networks: Preliminary Results of a Benchmarking Process in Catalonia, Spain

Xavier Gómez-Batiste, M.D., Ph.D.[1] Carmen Caja, R.N.,[2] Jose Espinosa, M.D.,[1] Ingrid Bullich, R.N.,[2] Josep Porta-Sales, M.D., Ph.D.,[3] Carme Sala, M.D.,[4] Esther Limón, M.D., Ph.D.,[5] Jordi Trelis, M.D.,[6] Antonio Pascual, M.D., Ph.D.,[7] M. Luisa Puente, M.D.,[8] on behalf of the Working Group of the Standing Advisory Committee for Palliative Care

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Special Article

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Xavier Gómez-Batiste, MD, PhD, Carmen Caja, RN, Jose Espinosa, MD,

- Quantitative / 5 years (Gómez-Batiste X et al, JPSM)
- External evaluation of indicators (Suñol et al, 2008)
- SWOT nominal group of health-care professionals (Gomez-Batiste X et al, 2007)
- Focal group of relatives (Brugulat et al, 2008)
- Benchmark process (2008) (Gomez-Batiste et al, 2010)
- Efficiency (Serra-Prat et al 2002 & Gomez-Batiste et al 2006)
- Cost / savings (Paz-Ruiz, Gomez-Batiste et al 2009)
- Effectiveness (Gomez-Batiste et al, J Pain Symptom Manage 2010)
- Satisfaction of patients and their relatives (Survey CatSalut, 2008)

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Weak Points

- Low coverage noncancer, inequity variability, sectors and services (specific and conventional)
- Difficulties in access and continuing care (7/24)
- Late intervention
- Evaluation
- Psychosocial, espiritual, bereavement
- Volonteers
- Professionals: low income, support, and academic recognition
- Financing model and complexity
- Research and evidence

X. Gomez-Batiste

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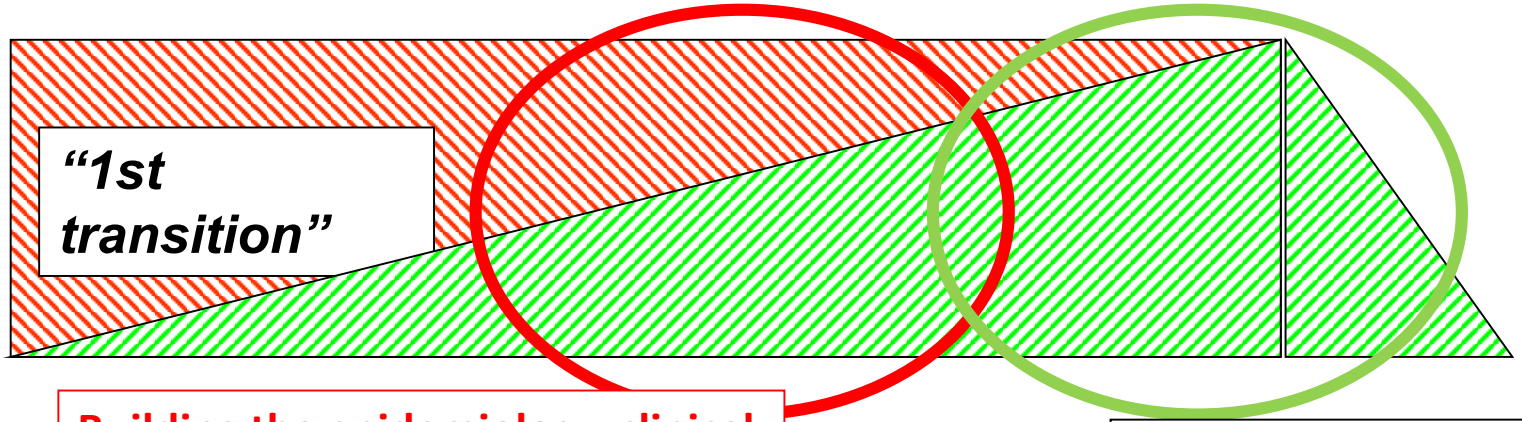
New perspectives, new challenges:

- Palliative approach / chronic care
- Care of essential needs: Psychosocial spiritual care
- Community involvement

New concepts

Palliative approach and care in the evolution of patients with advanced chronic conditions



Building the epidemiology, clinical care, ethics and organization for the 1st transition

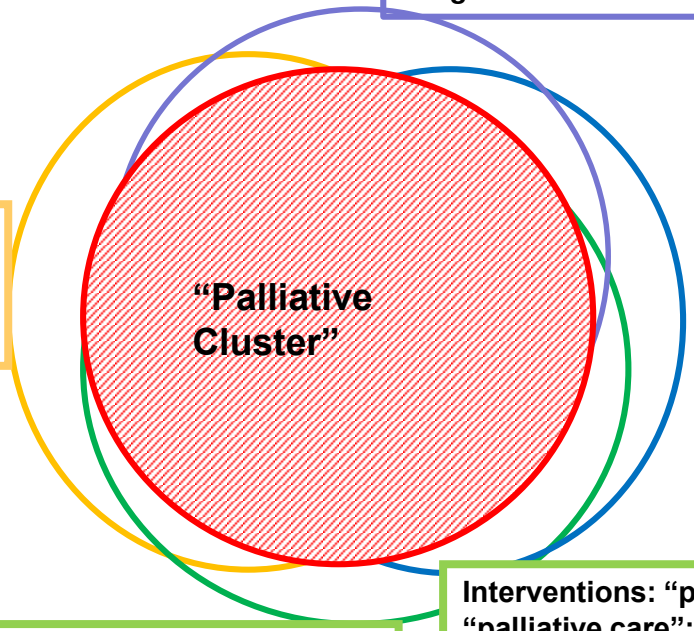
"Classical" Palliative care

- [illegible]
- [illegible]
- [illegible] homes
- Frailty, multimorbidity, organ failures, dementia, cancer
- Prognostic: limited life prognosis (median survival around 2 years)
- Progressive impairment and loss
- Complex clinical decission-making combining curative/palliative
- More focus on
  - Advance care planning
  - Essential needs (spirituality, dignity, relations, hope, autonomy)
  - Psychosocial aspects (emotional, loss, family)
  - Bereavement
- Organizational: all services involved

Components to define target patients

Chronic, serious, life-threatening, illness or condition, mostly:
- Advanced
- Progressive
- Frequent crisis of needs
- High need and demand

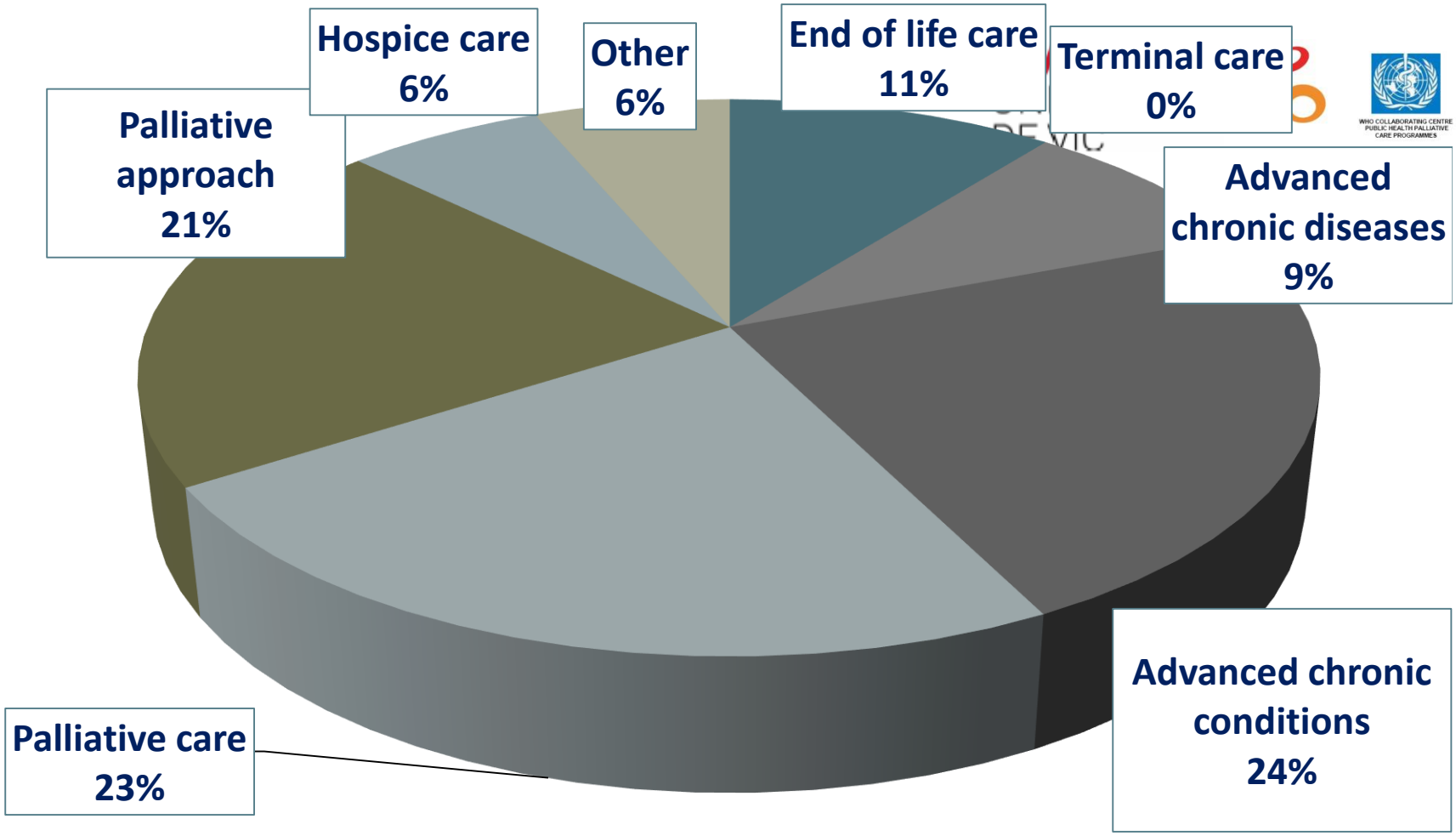
Life prognosis:
- Limited
- Years, months, weeks



Palliative needs of patient and family:
- Basic or complex
- Multidimensional
-Suffering
- Essential

(Disease – specific interventions have mostly a progressively limited impact in modifying the course of disease, prognosis, and quality of life)

Interventions: "palliative approach" or "palliative care": basic or complex
-Assessment
- Symptom control
- Emocional support
- Care of essential needs
- Ethical dilemmas
- Advance care Planning
- Case management, integrated and continuing care



Taxonomy: change of names and concepts

"Comprehensive, person-centred and integrated palliative approach and care for persons with complex advanced chronic conditions in all settings"

How many people needs palliative care?

Estimations: based in mortality

75% of people are dying caused by chronic conditions after years of suffering

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Identification and palliative care approach of patients with advanced chronic diseases and limited life prognosis in health care services: the NECPAL/MACA Project in Catalonia

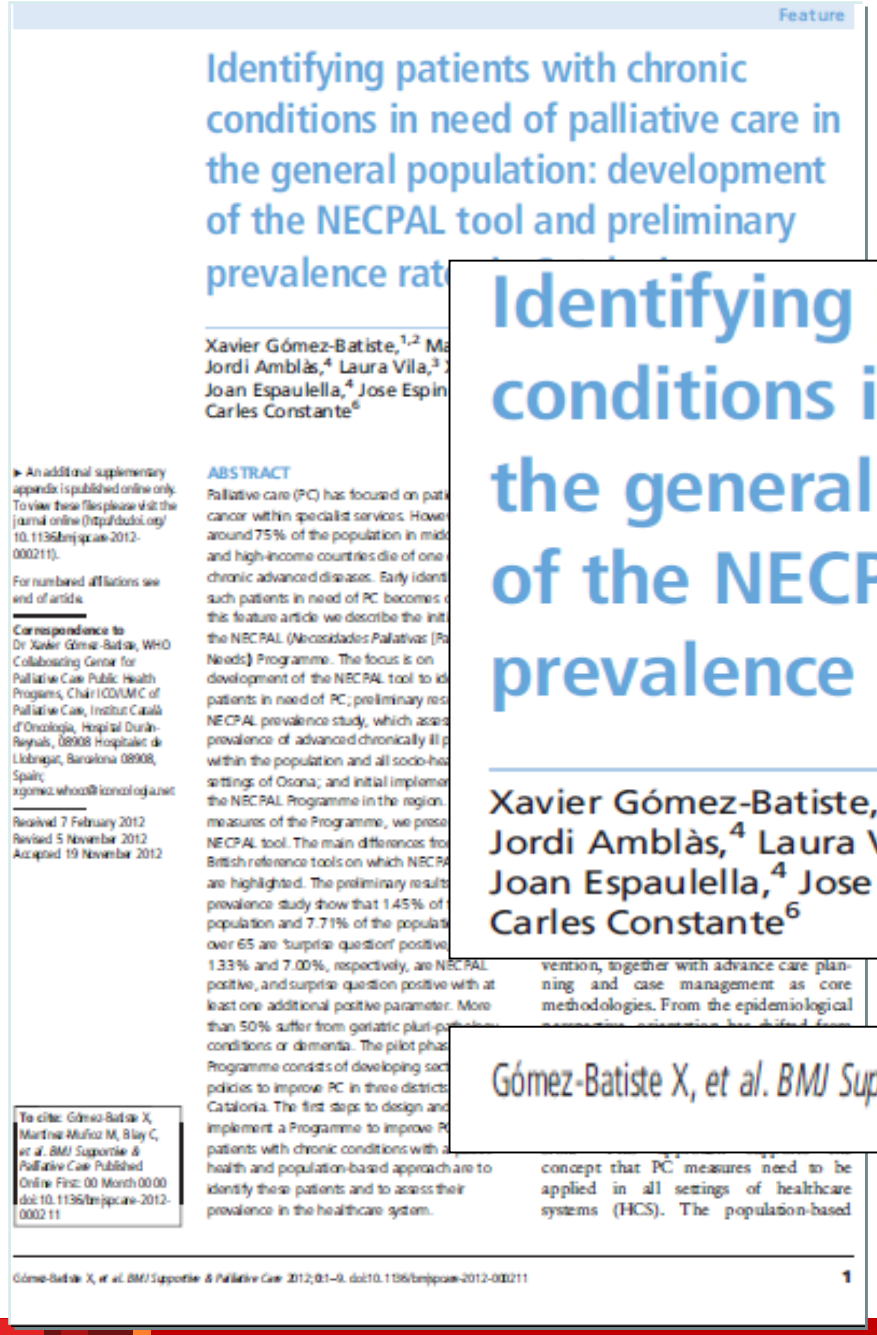
The 'Qualy' Observatory

WHO Collaborating Centre for Public Health Palliative Care Programmes

Chair of Palliative Care. University of Vic

&

Catalan Department of Health



Feature

Identifying patients with chronic conditions in need of palliative care in the general population: development of the NECPAL tool and preliminary prevalence rat

Xavier Gómez-Batiste,[1,2] Ma
Jordi Amblàs,[4] Laura Vila,[3]
Joan Espaulella,[4] Jose Espin
Carles Constante[6]

ABSTRACT

Palliative care (PC) has focused on pati
cancer within specialist services. Howe
around 75% of the population in mid
and high-income countries die of one
chronic advanced diseases. Early identi
such patients in need of PC becomes
this feature article we describe the init
the NECPAL (Necesidades Paliativas (Pa
Needs) Programme. The focus is on
development of the NECPAL tool to id
patients in need of PC; preliminary res
NECPAL prevalence study, which asses
prevalence of advanced chronically ill p
within the population and all socio-he
settings of Osona; and initial implemen
the NECPAL Programme in the region.
measures of the Programme, we prese
NECPAL tool. The main differences fro
British reference tools on which NECPA
are highlighted. The preliminary result
prevalence study show that 1.45% of
population and 7.71% of the populati
over 65 are 'surprise question' positive
1.33% and 7.00%, respectively, are NECPAL
positive, and surprise question positive with at
least one additional positive parameter. More
than 50% suffer from geriatric pluri-pathology
conditions or dementia. The pilot phas
Programme consists of developing sect
policies to improve PC in three districts
Catalonia. The first steps to design and
implement a Programme to improve PC
patients with chronic conditions with a
health and population-based approach are to
identify these patients and to assess their
prevalence in the healthcare system.

vention, together with advance care planning and case management as core methodologies. From the epidemiological

concept that PC measures need to be applied in all settings of healthcare systems (HCS). The population-based

► An additional supplementary appendix is published online only. To view these files please visit the journal online (http://dx.doi.org/10.1136/bmjspcare-2012-000211).

For numbered affiliations see end of article.

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Gómez-Batiste X, *et al*. *BMJ Supportive & Palliative Care* 2012;0:1–9. doi:10.1136/bmjspcare-2012-000211 1

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Identifying patients with chronic conditions in need of palliative care in the general population: development of the NECPAL tool and preliminary prevalence rates in Catalonia

Xavier Gómez-Batiste,[1,2] Marisa Martínez-Muñoz,[1,2] Carles Blay,[2,3] Jordi Amblàs,[4] Laura Vila,[3] Xavier Costa,[3] Alicia Villanueva,[5] Joan Espaulella,[4] Jose Espinosa,[1] Montserrat Figuerola,[1] Carles Constante[6]

Gómez-Batiste X, *et al*. *BMJ Supportive & Palliative Care* 2012;0:1–9. doi:10.1136/bmjspcare-2012-000211

NECPAL CCOMS-ICO 3.0 2016©

PATIENT: ..... HC: .....

DATE: ...../...../..... SERVICE: .....

RESPONSIBLE(S): .....

Surprise Question (to/among professionals)	Would you be surprised if this patient dies within the next year?		☐ Yes ☑ No (-) (+)
"Demand" or "Need"	- Demand: Have the patient, the family or the team requested in implicit or explicit manner, palliative care or limitation of therapeutic effort?		☐ Yes ☑ No
	- Need: identified by healthcare professionals from the team		☐ Yes ☑ No
General Clinical Indicators: in the last 6 months - Severe, sustained, progressive, not related with recent concurrent process - Combine severity WITH progression	- Nutritional Decline	• Weight loss > 10%	☐ Yes ☑ No
	- Functional Decline	• Karnofsky or Barthel score > 30% • ADLs >2	☐ Yes ☑ No
	- Cognitive Decline	• Loss ≥ 5 minimental or ≥ 3 Pfeiffer	☐ Yes ☑ No
Severe Dependence	- Karnofsky <50 or Barthel <20		☐ Yes ☑ No
Geriatric Syndromes	- Falls - Pressure Ulcers - Dysphagia - Delirium - Recurrent infections	• Clinical data anamnesis ≥ 2 recurrent or persistent	☐ Yes ☑ No
Persistent symptoms	Pain, weakness, anorexia, dyspnoea, digestive...	• ≥ 2 symptoms (ESAS) persistents or refractory	☐ Yes ☑ No
Psychosocial aspects	Distress and/or Severe adaptive disorder	• Detection of severe emotional distress > 9	☐ Yes ☑ No
	Severe Social Vulnerability	• Social and family assessment	☐ Yes ☑ No
Multi morbidity	>2 advanced chronic diseases or conditions (from the list of specific indicators)		☐ Yes ☑ No
Use of resources	Evaluate Demand/intensity of interventions	• > 2 urgent or not planned admittances in last 6 months • Increase Demand/intensity of interventions (homecare, nurse interventions, etc)	☐ Yes ☑ No
Specific indicators	Cancer, COPD, CHD, Liver, Renal, CVA, Dementia, Neurodegenerative diseases, AIDS, other advanced	• To be developed as annexes • Criteria of severity and progression	☐ Yes ☑ No

Classification:		
Surprise Question (PS)	SQ + (I would not be surprised)	√
	SQ - (I would be surprised)	
NECPAL Parameters	NECPAL + (de 1+ a 13+)	
	NECPAL - (No parameters)	√

Codification and Registry

Propose codification as Patient with Advanced Chronic Conditions (PCC)

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The NECPAL-ICO-CCOMS © Tool

How many people needs palliative care: based in prevalence

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WHO COLLABORATING CENTRE PUBLIC HEALTH PALLIATIVE CARE PROGRAMMES

Original Article

PALLIATIVE MEDICINE

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SAGE

Prevalence and characteristics of patients with advanced chronic conditions in need of palliative care in the general population: A cross-sectional study

Xavier Gómez-Batiste[1,2], Marisa Martínez-Muñoz[1,2], Carles Blay[2,3], Jordi Amblàs[4], Laura Vila[5], Xavier Costa[5], Joan Espaulella[4], Jose Espinosa[1,2], Carles Constante[6] and Geoffrey K Mitchell[7]

Abstract

Background: Of deaths in high-income countries, 75% are caused by progressive advanced chronic conditions. Palliative care needs to be extended from terminal cancer to these patients. However, direct measurement of the prevalence of people in need of palliative care in the population has not been attempted.

Aim: Determine, by direct measurement, the prevalence of people in need of palliative care among advanced chronically ill patients in a whole geographic population.

Design: Cross-sectional, population-based study. Main outcome measure: prevalence of advanced chronically ill patients in need of palliative care according to the NECPAL CCOMS-ICO© tool. NECPAL+ patients were considered as in need of palliative care.

Setting/participants: County of Osona, Catalonia, Spain (156,807 inhabitants, 21.4% > 65 years). Three randomly selected primary care centres (51,595 inhabitants, 32.9% of County's population) and one district general hospital, one social-health centre and four nursing homes serving the patients. Subjects were all patients attending participating settings between November 2010 and October 2011.

Results: A total of 785 patients (1.5% of study population) were NECPAL+: mean age = 81.4 years; 61.4% female. Main disease/condition: 31.3% advanced frailty, 23.4% dementia, 12.9% cancer (ratio of cancer/non-cancer = 1/7), 66.8% living at home and 19.7% in nursing home; only 15.5% previously identified as requiring palliative care; general clinical indicators of severity and progression present in 94% of cases.

Conclusions: Direct measurement of prevalence of palliative care needs on a population basis is feasible. Early identification and prevalence determination of these patients is likely to be the cornerstone of palliative care public health policies.

Populational Prevalence approach

- Population: 1-1.5%
- General Practitioner: 20-25
- District General Hospital : 38%
- University Hospital: 39%
- Internal Medicine: 47%
- ICU HUB: 30%
- Nursing homes: 40-70%

Prevalence x settings

	Cancer	Organ failure	Dementia	Advanced frailty	P- value
Age Mean (SD)	73.3 (13.9)	76.0 (14.0)	85.5 (6.5)	87.0 (6.8)	<0.001
Male N (%)	58 (57.43)	138 (54.12)	37 (19.89)	84 (29.47)	< 0.001
Female N (%)	43 (42.57)	117 (45.88)	149 (80.11)	201 (70.53)	

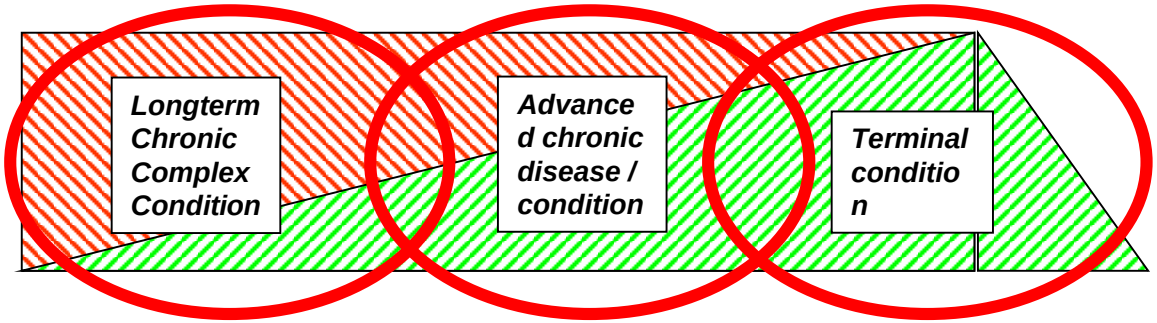
TABLE 3. Characteristics of SC+ patients by disease / condition

Male 75y
cancer & organ failures

Females > 85y
Severe frailty, multimorbidity & dementia

Who need palliative care in the general population?
Total prevalence: 1-1.5%

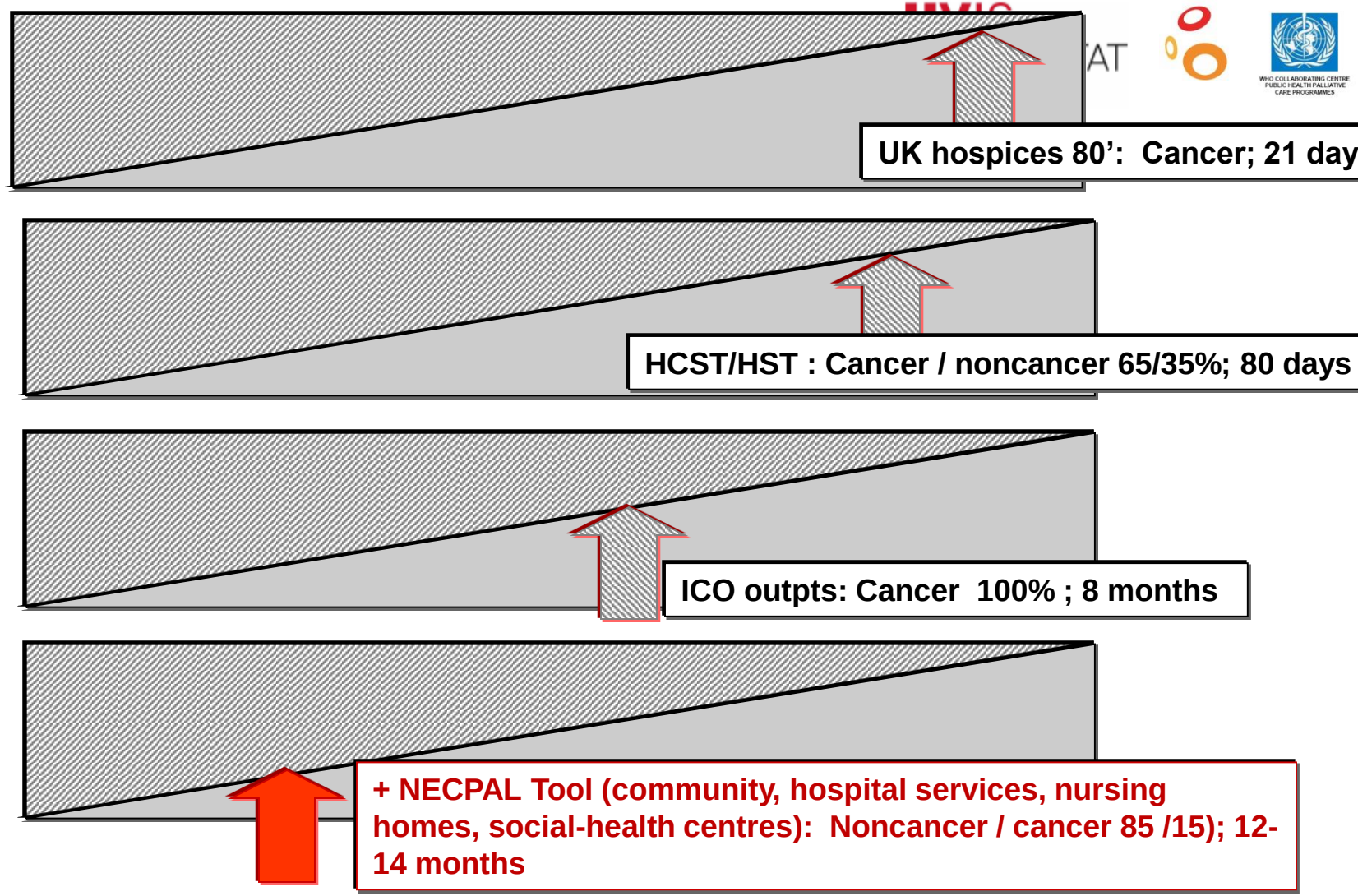
Adapting the clinical , ethical & organizational perspectives of palliative approach & palliative care to the evolution of persons with advanced chronic conditions



Time line: -------- 2-5 years ---------- 2 years ---------- 6 months

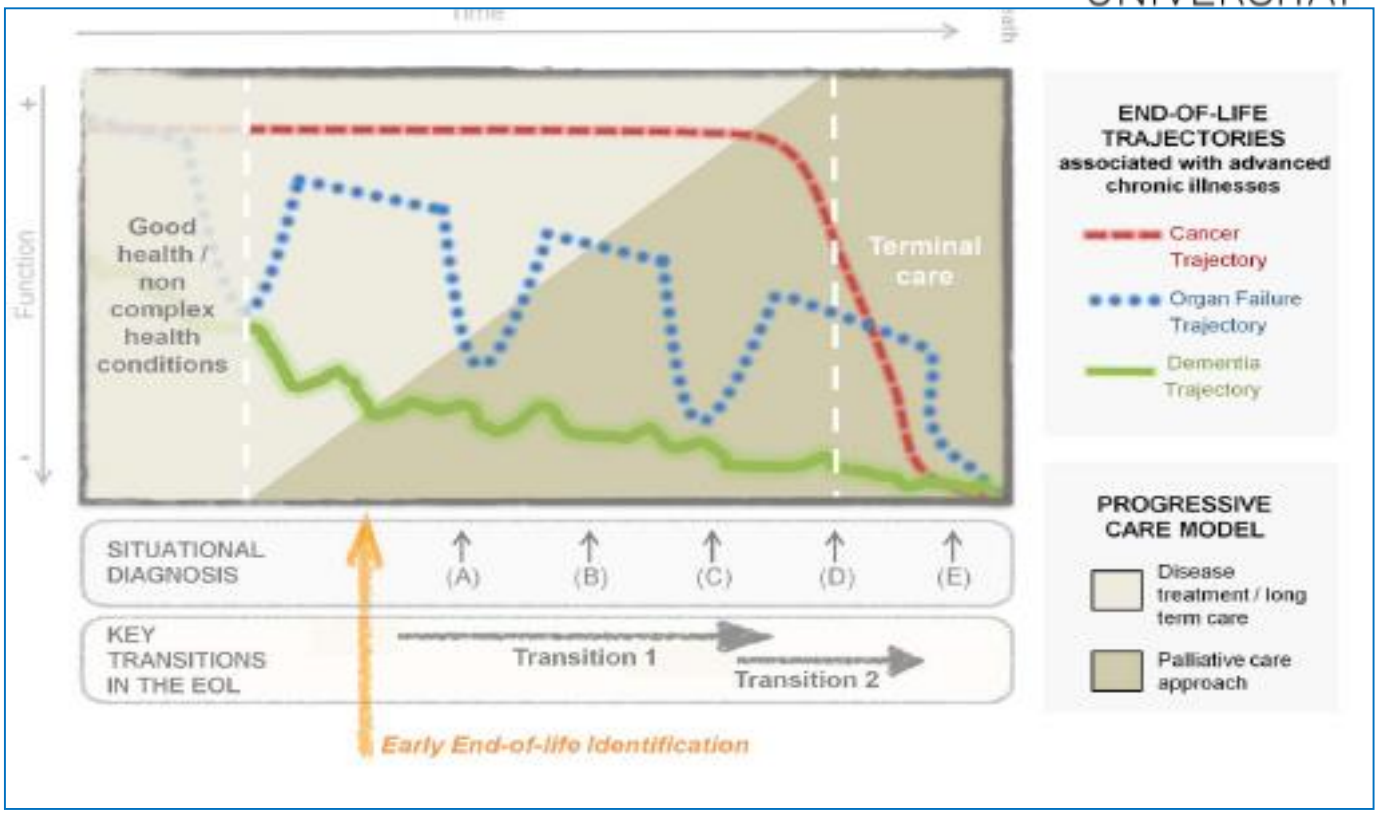
"Complex Chronic condition"	*"Advanced chronic condition"*	*"End of life or terminal"*
- Disease-centered - Survival, sec/tert prevention - Build confidence - Shared Decission - Common language - Advance directives - Disease / Care management - RHB - Primary & secondary specialist care	- Condition & QoL - Multidimensional assessment - Gradual palliative care approach - Gradual essential needs - RHB - Case management & Integrated care - Primary care & secondary & occasional palliative care	- QoL - Review & Adjust - Nutrition/hydration - Bereavement - Primary & palliative care (if needed) shared care

- **5.0 % Complex chronic patients**
- **1.5% Advanced chronic patients**



Earlier detection, proportion cancer /noncancer; time of intervention/survival and place & type of service of Patients with Palliative Care Needs

HCST: Home Care Support Team; HST: Hospital Support Team; ICO Outpts: Palliative Care Outpatient Clinic at the Catalan Institute of Oncology; + NECPAL Tool: patients identified by the NECPAL tool



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BMJ Open

Identifying patients with advanced chronic conditions for a progressive palliative care approach: a cross-sectional study of prognostic indicators related to end-of-life trajectories

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Special Article

Comprehensive and Integrated Palliative Care for People With Advanced Chronic Conditions: An Update From Several European Initiatives and Recommendations for Policy

Xavier Gómez-Batiste, MD, PhD, Scott A. Murray, MD, Keri Thomas, OBE, MBBS, MRCGP, DRCOG, MSC, Carles Blay, MD, MSc, Kirsty Boyd, MD, PhD, Sebastien Moine, MD, MSc, Maxime Gignon, MD, PhD, Bart Van den Eynden, MD, PhD, Bert Leysen, MD, PhD, Johan Wens, MD, PhD, Yvonne Engels, PhD, Marianne Dees, MD, PhD, and Massimo Costantini, MD

Improving Patient's procedures

Main issues:

1.Multidimensional assessment

2.Review disease and treatment

3.Advance care planning

4.Case managementt

1. Identify, codify, register
2. Assess needs of patient and careers
3. Identify values, goals and preferences (ACP)
4. Review diseases and conditions
5. Review pharmacologic treatment
6. Identify careers
7. Build up a Therapeutic plan
8. Design a responsable, continuing and emergency care (Case Management)
9. Coordinate with other services: rols

Improving palliative care approach in all Health and Social services

1. Identify and register patients in need of palliative care approach
2. Training, policies and protocols of professionals in most prevalent situations
3. Multidisciplinary team approach
4. Identify primary career and family needs and choices
5. Improve accesibility, home care, intensity of care, etc
6. Case management, preventive approach, continuing care, coordination and integrated policies, district approach

District Palliative Care Planning

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Specialist Services

Context / Needs:

- Demography
- Resources
- Type patients
- cancer, geriatrics, aids, other
- Complexity
- Mortality / Prevalence
- Qualitative assessment (SWOT)

Direct coverage for complex

Joint policies & shared & integrated care

- Estratification, identification and registry
- Criteria intervention
- Continuing / emergency care / Coordination
- Information system
- Training / incentives

Good care for noncomplex

+ General Measures

in conventional services

+ Evaluation & Quality improvement

+ Leadership

How to planify Palliative Care Public Health Programs

- Establish a formal national or regional policy with participation of patients and all stakeholders (professionals, managers, policymakers, funders)
- Determine (or estimate) the populational and setting-specific mortality and prevalence and needs assessment
- Elaborate, agreeand validate an adapted tool for the identification
- Establish protocols to identify this patients in services
- Establish protocols to assure good comprehensive person-centered care for the identifed patients
- Identify the specific training needs, train professionals and insert palliative care training in all settings
- Promote organisational changes in primary care, Palliative Care Specialised, Conventional services and integrated care across all settings in districts
- Identify and address the specific ethical challenges
- Insert palliative approach in all policies for chronic conditions (cancer, geriatrics, dementia, other,...)
- Establish and monitorise indicators and standards of care and implementation plans and generate research evidence

10 actions for establishing a national/regional policy for comprehensive and integrated palliative approach X Gómez-Batiste, S Murray, S Connor, 2017

Ethical approach: Benefits & risks

- Starting Systematic process: Needs assessment, Advance Care Planning, Review of Condition and treatment, Family involvement, Case management, Continuing care, etc
- Patient's involvement/ACP
- Starting palliative perspective
- Adequation vs limitation of resources
- Increasing home care

- Estigma
- Abandonment
- Dichotomic perspective
- Reducing curative opportunities
- Impact on patients and families
- Misuse to reduce cost

X Gómez-Batiste et al, J of Palliat Care 2016, in press

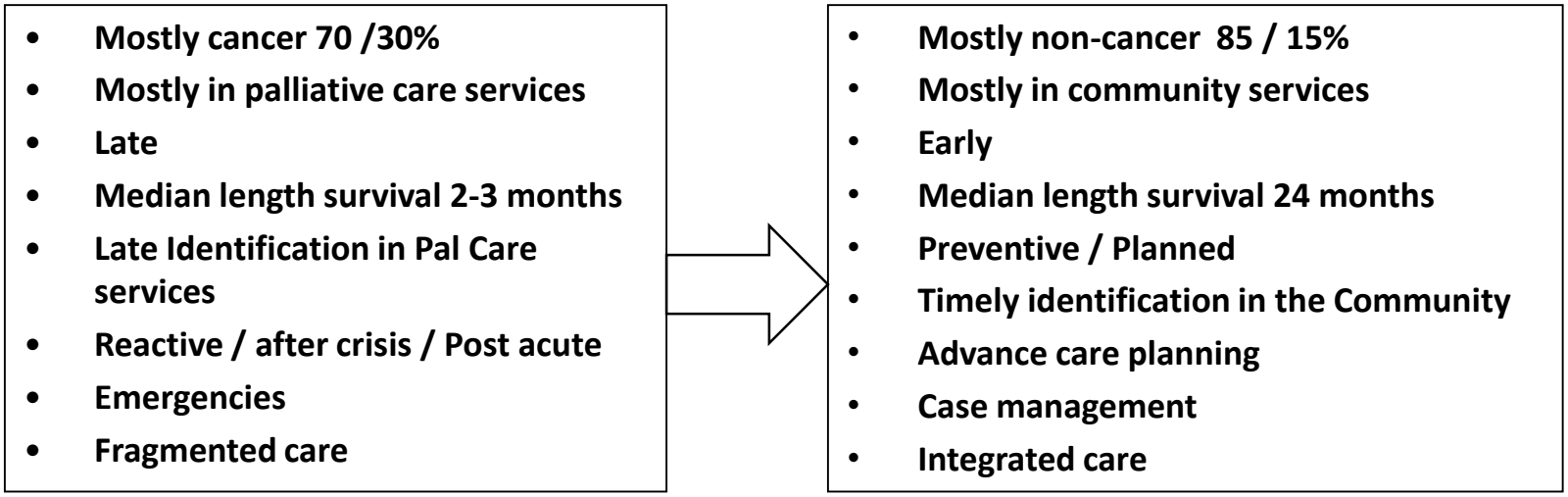

FIGURE 4: Models of palliative interventions in chronic advanced palliative care

Adapting palliative care services

- From passive, late, one-directional dychotomic intervention based in prognosis
- to timely, flexible, cooperative, shared, based in complexity
- From cancer to all
- Training:
- Clinical
- Ethical
- Organizational / managerial
- From service to population
- From own to all services' approach
- Resistances and barriers

Change of perspective!!!!

Adapting palliative care national / regional programs

- **New epidemiology: from mortality to prevalence**
- **New perspective: from services to population**
- **New organization:**
- **integrated care, networks, sectors**
- **All services**

Change of perspective!!!!

New opportunity to reform

From WHO Resolution to Revolution

X. Gomez-Batiste

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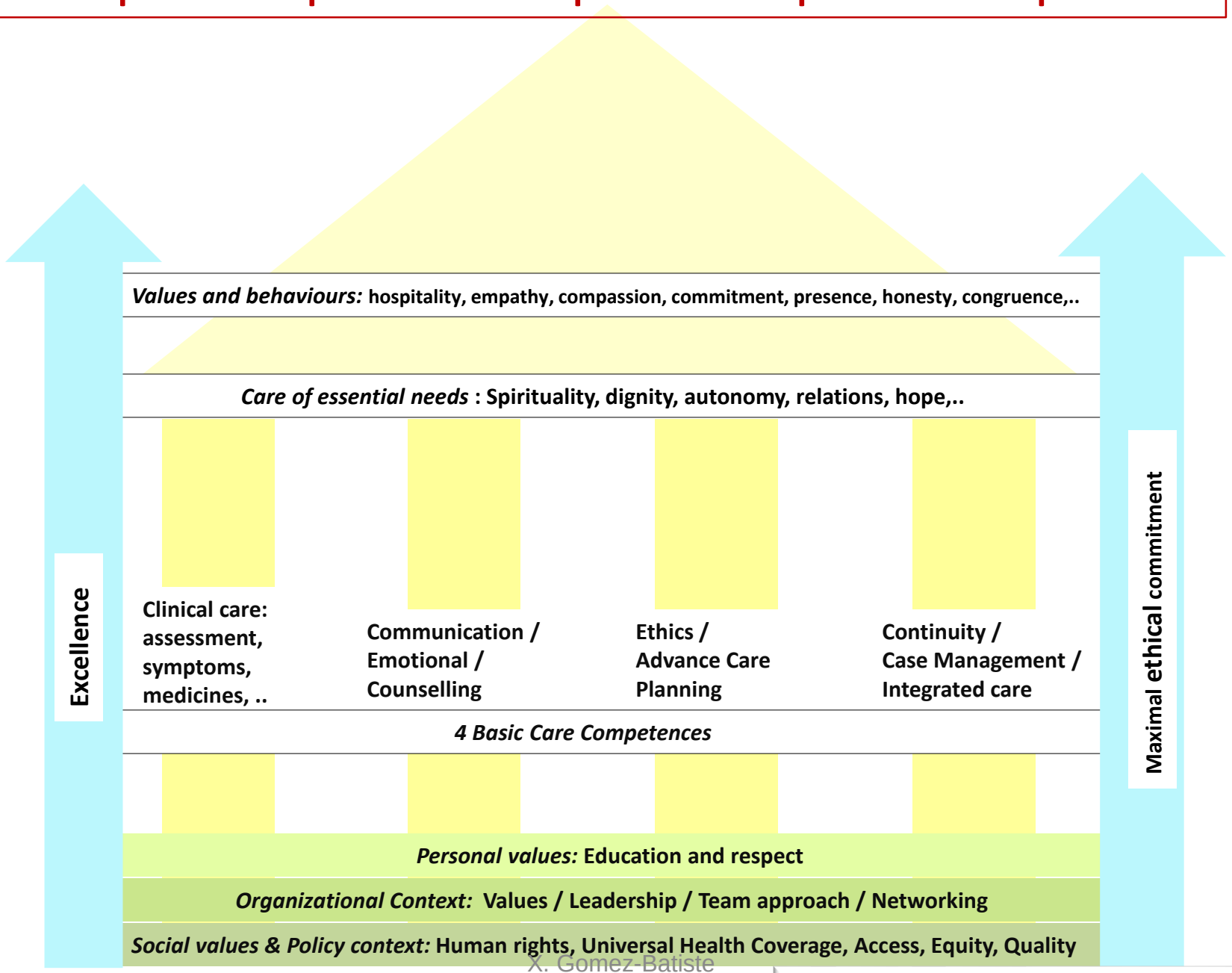
New perspectives, new challenges:

- **Care of essential needs**

Model of personal & profesional competencies for palliative care provision



X. Gomez-Batiste

Maté-Méndez J, et al. J Palliat Care 2013; 29(4): 237-243

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New perspectives, new challenges:

- **Psychosocial spiritual care**

Program for the comprehensive psychosocial and spiritual care of patients with advanced conditions and their families

La Caixa Foundation & WHOCC Barcelona

Palliative and Supportive Care (2011), **9**, 239–249.
© Cambridge University Press, 2011 1478-9515/11 $20.00
doi:10.1017/S1478951511000198

ORIGINAL ARTICLES

The "*La Caixa*" Foundation and WHO Collaborating Center Spanish National Program for enhancing psychosocial and spiritual palliative care for patients with advanced diseases, and their families: Preliminary findings

XAVIER GÓMEZ-BATISTE, M.D., PH.D.,[1] MONTSE BUISAN, B.SC. (PSYC.),[2] M. PAU GONZÁLEZ, B.SC. (PSYC.),[1] DAVID VELASCO, B.SC.,[1] VERÓNICA DE PASCUAL, L.L.B.,[2] JOSE ESPIÑOSA, M.D.,[1] ANNA NOVELLAS, B.A.(SOCIOL.),[1] MARISA MARTÍNEZ-MUÑOZ, R.N.,[1] MARC SIMÓN, M.B.A.,[2] CANDELA CALLÉ, M.D.,[3] JAUME LANASPA, M.B.A.,[2] AND WILLIAM BREITBART, M.D.

Obra Social
Fundación "la Caixa"

How we do it, and with whom

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Structure

42 Psychosocial Care Teams (EAPS) distributed around the 17 autonomous communities.

200 multidisciplinary professionals (psychologists, social workers and nurses)

511 volunteers

Sphere of action

126 hospitals

109 home care teams/ hospitals

Map showing third sector partner organisations

Concept of Psychosocial support teams giving support to existing services

Care delivery details: more than **40,000 patients** and more than **65,000 relatives**

	2009	2010	2011	2012	2013	TOTAL
Patients	6.957	8.385	10.203	**12.422**	**6.070**	**44.037**
Family Members	11.011	13.885	15.738	**17.468**	**7.784**	**65.886**

>200.000 persons careed

8.5 milion Euros / year

Interaction Chronic & Palliative Care

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CURRENT OPINION

Identifying needs and improving palliative care of chronically ill patients: a community-oriented, population-based, public-health approach

Xavier Gómez-Batiste[a,b], *Marisa Martínez-Muñoz*[a,b], *Carles Blay*[b,c], *Jose Espinosa*[a,b], *Joan C. Contel*[c], *and Albert Ledesma*[c]

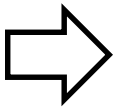
Purpose of review
We describe conceptual innovations in palliative care epidemiology and the methods to identify patients in need of palliative care, in all settings.
In middle–high-income countries, more than 75% of the population will die from chronic progressive diseases. Around 1.2–1.4% of such populations suffer from chronic advanced conditions, with limited life expectancy. Clinical status deteriorates progressively with frequent crises of needs, high social impact, and high use of costly healthcare resources.

Recent findings
The innovative concept of patients with advanced chronic diseases and limited life prognosis has been addressed recently, and several methods to identify them have been developed.

Summary
The challenges are to promote early and shared interventions, extended to all patients in need, in all settings of the social care and healthcare systems; to design and develop Palliative Care Programmes with a Public Health perspective. The first action is to identify, using the appropriate tools early in the clinical evolution of the disease, all patients in need of palliative care in all settings of care, especially in primary care services, nursing homes, and healthcare services responsible for care provision for these patients; to promote appropriate care in patients with advanced diseases with prognosis of poor survival.

Keywords
advanced chronic patients, chronic care, planning, policy, stratification

- Mostly cancer 70 /30%
- Mostly in palliative care services
- Late
- Median length survival 2-3 months
- Identification in Pal Care services
- Reactive / after crisis
- Post acute
- Emergencies
- Fragmented care

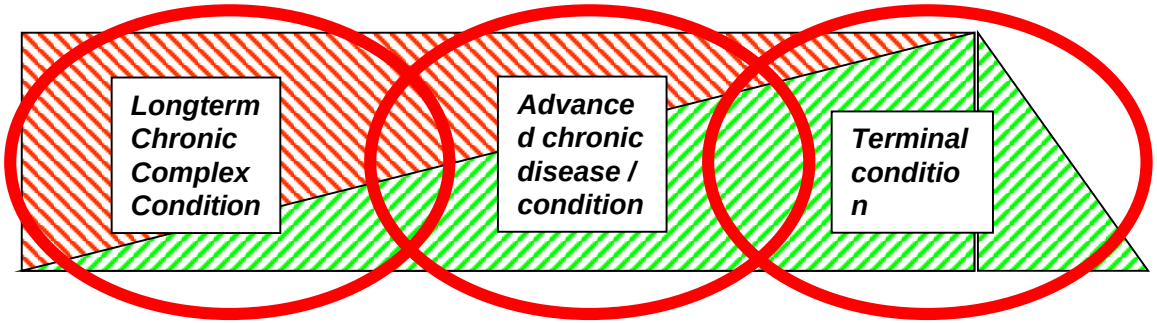


- Mostly non-cancer 85 / 15%
- Identification mostly community services
- Early
- Median length survival 24 months
- Preventive / Programmed
- Advance care planning
- Case management
- Integrated care

Models of palliative interventions in chronic care: from late, institutional, reactive and fragmented to early, community, preventive and integrated

XGB et al, 2012

Adapting the clinical , ethical & organizational perspectives of palliative approach & palliative care to the evolution of persons with advanced chronic conditions



Time line: -------- 2-5 years ---------- 2 years ---------- 6 months

"Complex Chronic condition"	*"Advanced chronic condition"*	*"End of life or terminal"*
- Disease-centered - Survival, sec/tert prevention - Build confidence - Shared Decission-making - Common language - Advance directives - Disease / Care management - RHB - Primary & secondary specialist care	- Condition & QoL - Multidimensional assessment - Advance Care Planning - Values & Preferences &Scenarios - Crisis prevention - Gradual palliative care approach - Gradual essential needs - RHB - Case management & Integrated care - Primary care & secondary & occasional palliative care	- QoL - Review & Adjust frequently - Essential needs - Sedation - Elarging / shortening life - Nutrition/hydration - Bereavement - Primary & palliative care (if needed) shared care

Pal.liative care approach: the “soul” of Chronic Care Programmes

Involving Society:

Compassive communities projects

Obra Social "la Caixa"

VIC, CIUTAT CUIDADORA

Vic, 15 de febrer de 2017

Ajuntament de Vic

Vic, ciutat a la mesura humana

CÀTEDRA DE CURES PAL·LIATIVES

X. Gomez-Batiste

Viure amb sentit, dignitat i suport al final de la vida

Reflexió, debat i accions compartides
Vic, gener- juny 2017

Conferències
Formacions
Tallers
Taules rodones

www.vicciutatcuidadora.cat
ciutat.cuidadora@gmail.com

Vic Ciutat Cuidadora

Vic, ciutat a la mesura humana

CONTEXT I CONCEPTES

Al nostre país, es calcula que l'1,5% de les persones pateixen malalties cròniques avançades que causen el 75% de les morts. Aquestes situacions generen, d'una banda, necessitats físiques, psicològiques, espirituals i socials, causen patiment en pacients i famílies i, de l'altra, provoquen una gran necessitat i demanda d'atenció, especialment quan es combinen malalties avançades i necessitats de caràcter social, com la solitud o la pobresa.
Davant de situacions de gran vulnerabilitat, hi ha experiències que han donat bons resultats amb un bon suport social. Tanmateix, cal promoure actituds i comportaments socials de suport, solidaritat i compassió envers persones en situacions d'extrema vulnerabilitat.

OBJECTIUS DEL PROGRAMA

Millorar les actituds socials i culturals envers una malaltia avançada i el final de la vida.
Promoure el suport social i la qualitat de vida a les persones que ho pateixen.

Organitza

CÀTEDRA DE CURES PAL·LIATIVES
CESS CENTRE D'ESTUDIS SANITARIS I SOCIALS UVIC-UCC
ICO Institut Català d'Oncologia
Ajuntament de Vic

Amb el suport de

Obra Social "la Caixa"

VISIÓ I VALORS

Convertir Vic en una ciutat referent d'atenció a les persones amb major vulnerabilitat. Promoure i compartir l'humanisme, la solidaritat, la compassió i la participació social.

CARACTERÍSTIQUES DEL PROJECTE

Es tracta d'un projecte social liderat per organitzacions locals.

FASES

Inicialment, es pretén fomentar la participació ciutadana, millorar el traspàs d'informació entre les organitzacions locals, promoure l'educació i formació de voluntaris; a mig termini, millorar l'atenció integral i integrada de persones en situació de malaltia avançada i amb necessitats socials.

ACTIVITATS

Es duran a terme activitats culturals, socials i formatives amb la participació de les organitzacions socials.

Entitats participants

ADFO
AFMADO
Amics de la Gent Gran
Ashes
Associació del Casal de la Rambla
Associació de Vídues de Vic i Comarca
Associació El Tupí
Associació Sant Tomàs
Associacions de veïns: d'Horta Vermella, del Barri Vic Nord, del Barri del Remei, de la Guixa, de l'Estadi-Plaça Moragas
Aula d'Extensió Universitària de Gent Gran d'Osona
Banc del Temps
Càritas Arxiprestal de Vic
Casal de Gent Gran de Vic Mossèn Josep Guiteras
Col·legi Escorial
Creu Roja
Entitats Religioses
Fundació Antiga Caixa Manlleu
Fundació Mil·lenari
Fundació Projecte i Vida
INS Jaume Callís de Vic
INS Vic
Osona Contra el Càncer
Unitat de Medicina Integrativa – Bayés Integral

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Programa*

*Programa preliminar

	Dia, lloc i hora	Activitats formatives	Títol	Ponents i entitats col·laboradores
GENER	**Dilluns, 30.01.2017** De 18 a 19.30 h UVIC Sala Mercè Torrents	Conferència	**Com atenem en equip persones amb malalties avançades**	• Cristina Lasmarias (infermera) • Anna Albó (metgessa) • Olga Bosch (psicòloga) • Carme Guinovart (treb. social)
FEBRER	**Divendres, 03.02.2017** de 18 a 21 h **Dissabte, 04.02.2017** de 10 a 13 h UVIC Aula F101	Curs formatiu	**Curs bàsic d'acompanyament al final de la vida**	• Creu Roja • Amics de la Gent Gran
	Dimecres, 15.02.2017 18 h L'Atlàntida, Sala Ramon Montanyà	Conferència	**El projecte de Vic, Ciutat Cuidadora**	• Xavier Gómez-Batiste (director de la càtedra de Cures Pal·liatives de la UVIC) • Sílvia Mateu (coordinadora del Departament de Benestar i Família i Salut Pública de l'Ajuntament de Vic)
	Dilluns, 27.02.2017 De 18 a 19.30 h UVIC Sala Mercè Torrents	Conferència	**Com afrontar el dol**	• Alba Payàs (experta en atenció al dol)
MARC	**Divendres, 03.03.2017** De 18 a 21 h **Dissabte, 04.03.2017** De 10 a 13 h UVIC Aula F101	Curs formatiu	**Curs bàsic d'atenció al dol**	• Creu Roja • Amics de la Gent Gran
	Dilluns, 27.03.2017 De 18 a 19.30 h UVIC Sala Mercè Torrents	Conferència	**Com afrontar l'envelliment i la proximitat de la mort**	• Ramon Bayés (catedràtic emèrit de Psicologia de la UAB)
	Dimarts, 28.03.2017 **Dimecres, 29.03.2017** De 18 a 21.00 h UVIC Aula F101	Curs formatiu	**Curs bàsic d'acompanyament al final de la vida**	• Creu Roja • Amics de la Gent Gran
ABRIL	**Dilluns, 24.04.2017** De 18 a 19.30 h Auditori Fundació Antiga Caixa Manlleu Rambla Hospital, 11, Vic	Conferència	**Atenció religiosa al final de la vida**	• Francesc Torradeflot (secretari de l'Associació Unesco per al diàleg Interreligiós)
	Dimarts, 25.04.2017 **Dimecres, 26.04.2017** De 18 a 21 h UVIC Aula F 101	Curs formatiu	**Curs bàsic d'atenció al dol**	• Creu Roja • Amics de la Gent Gran
MAIG	**Dissabte, 06.05.2017** Tarda Rambla del Passeig, Vic	Mostra	**Participació a la 14ª Mostra d'Entitats i Músiques de Vic**	
	Dilluns, 08.05.2017 **Dilluns, 15.05.2017** **Dilluns, 22.05.2017** De 17.30 h a 19.30 h UVIC Sala Mercè Torrents	Conferència-Taller	**Cinema i atenció al final de vida**	Dilluns, 08.05.2017 • Julio Gómez (metge de l'Hospital Sant Joan de Déu de Santurce)
	Divendres 26.05.2017 De 18 a 21 h **Dissabte 27.05.2017** De 10 a 13 h UVIC Aula F 101	Curs formatiu	**Curs bàsic d'acompanyament al final de la vida**	• Creu Roja • Amics de la Gent Gran
	Dilluns, 29.05.2017 De 18 a 19.30 h UVIC Sala Mercè Torrents	Taula Rodona	**Les paraules de suport: cures, compassió, empatia...**	
JUNY	**Divendres, 16.06.2017 i** De 18 a 21 h **Dissabte, 17.06.2017** De 10 a 13 h UVIC Aula F 101	Curs formatiu	**Curs bàsic d'atenció al dol**	• Creu Roja • Amics de la Gent Gran
	Dilluns, 26.06.2017 De 18 a 19.30 h UVIC Sala Mercè Torrents	Taula Rodona	**Com integrem la mort en la vida**	• Càritas Arxiprestal • Unitat de Medicina Integrativa – Bayés Integral

Actes gratuïts, adreçats a totes les persones

Cal inscriure's per participar en els cursos formatius: 660 246 966 (de 9 a 17 h)

SERVICE DELIVERY
& SAFETY

WHO INITIATIVE FOR PALLIATIVE CARE: STRATEGY AND ACTION PLAN

World Health Organization

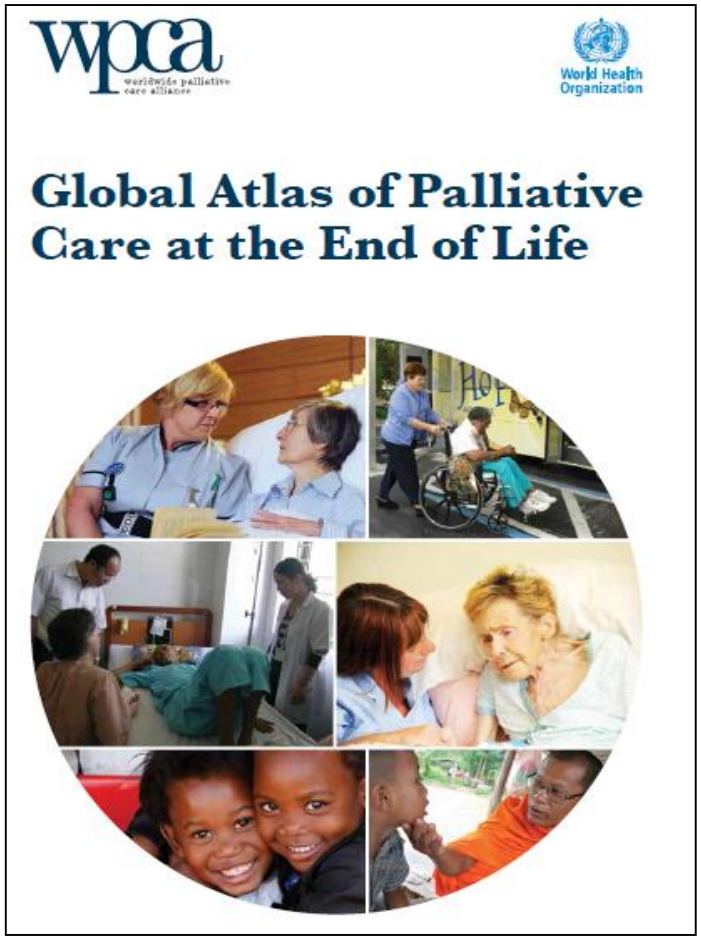
WHA Resolution 67.19: SCOPE & MODEL ISSUES

(1) to develop, strengthen and implement, where appropriate, palliative care policies to support the comprehensive strengthening of health systems to *integrate evidence-based, cost-effective and equitable palliative care services in the continuum of care, across all levels, with emphasis on primary care, community and home-based care, and universal coverage schemes*;

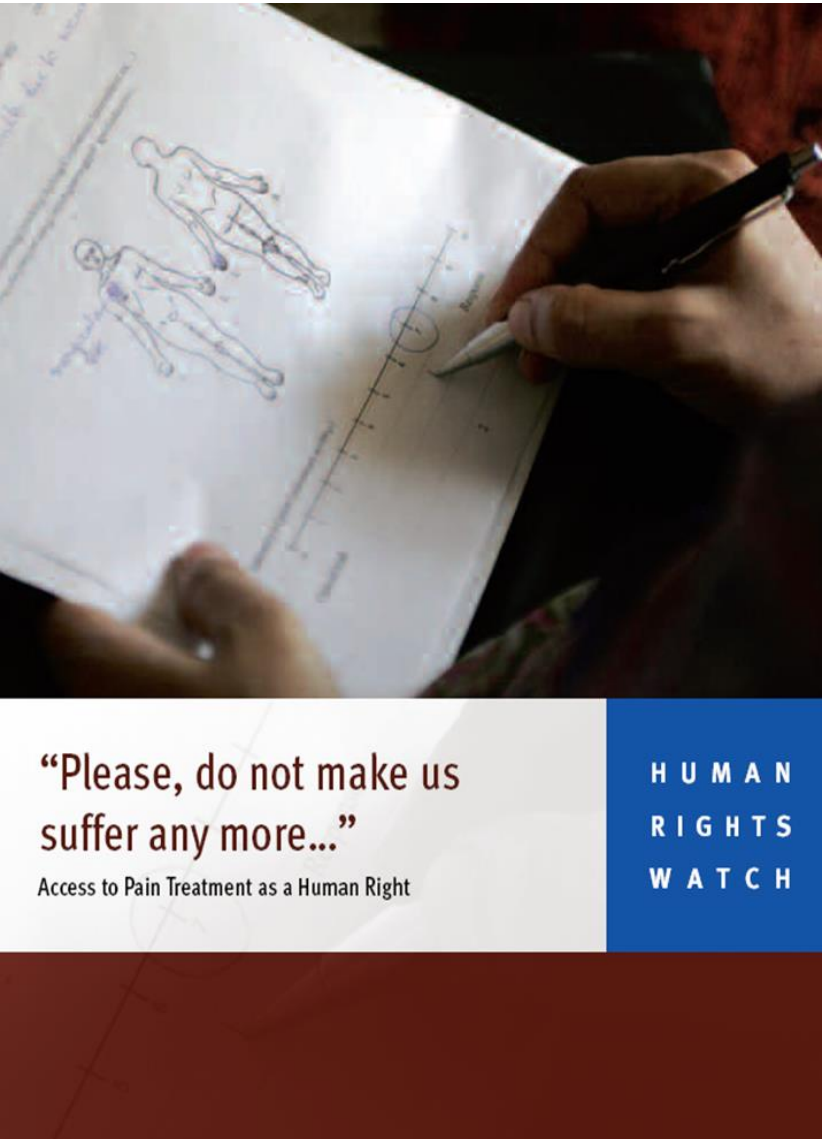
(3) to develop and strengthen, where appropriate, evidence-based guidelines *on the integration of palliative care into national health systems, across disease groups and levels of care, that adequately address ethical issues related to the provision of comprehensive palliative, such as equitable access, person-centred and respectful care, and community involvement, and to inform education in pain and symptom management and psychosocial support*

WHO proposal
for
Palliative care & approach

All patients
All conditions
All time
All needs
All professionals
All settings
All countries



Needs assessment and Context analysis: The Global Atlas



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Palliative care: basic human right indicator of degree of respect for human dignity All countries

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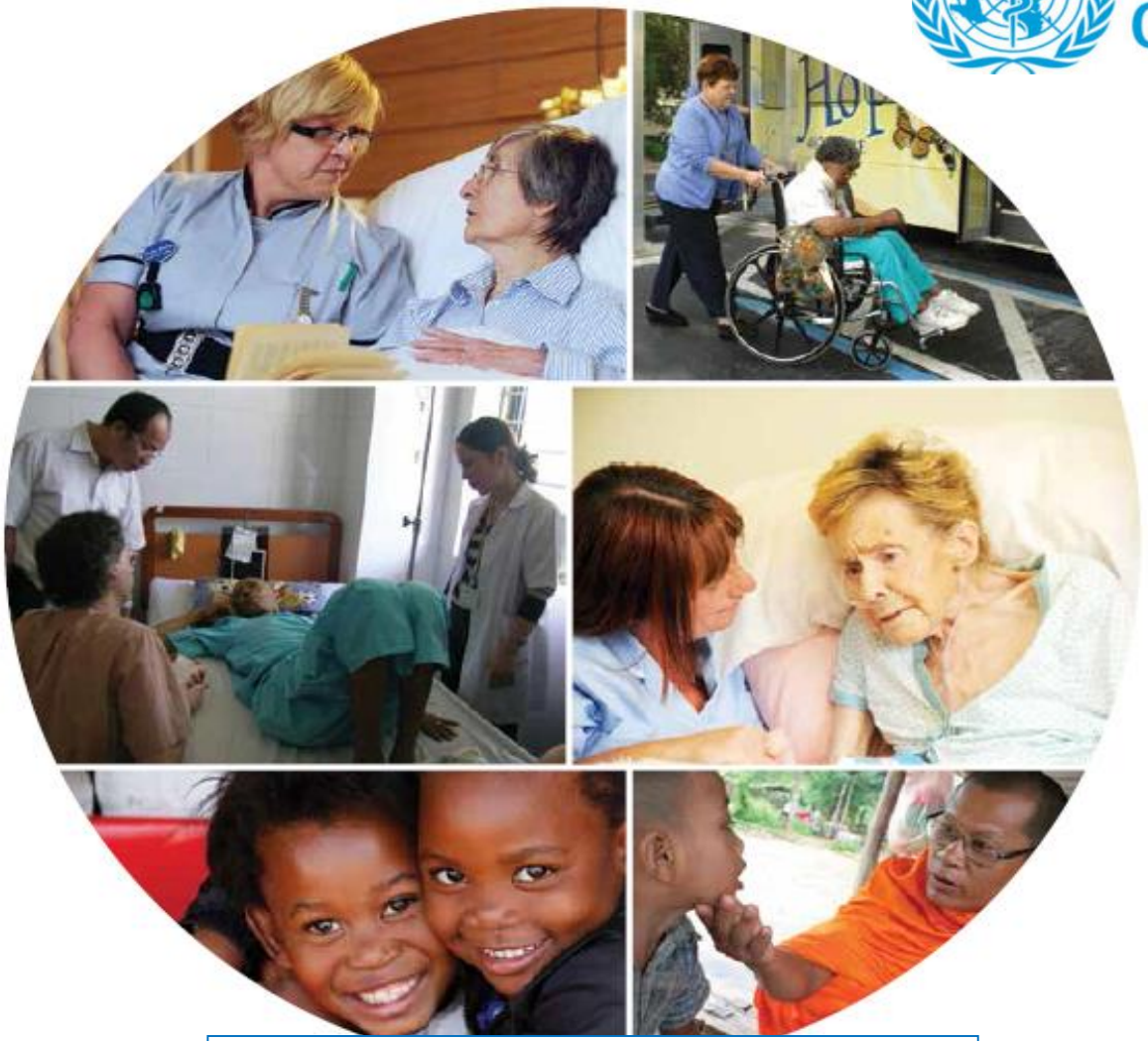
Palliative care: the soul of the health care system:

"Comprehensive and integrated care for people with advanced chronic conditions and their families"

World Health Organization



You all matter for WHO