NATIONAL PALLIATIVE AND HOSPICE CARE PROGRAM

MANUAL of OPERATIONS, PROCEDURES, and STANDARDS

Department of Health

Published by

National Palliative and Hospice Care Program
Disease Prevention and Control Bureau
Department of Health
San Lazaro Compound, Rizal Avenue,
Sta. Cruz, Manila 1003, Philippines

An electronic copy of this publication can be downloaded at http://www.doh.gov.ph

Suggested Citation:
Department of Health. (2021). *Manual of Operations, Procedures and Standards National Palliative and Hospice Care Program*. Manila, Philippines: Department of Health.

FIRST EDITION

Manual *of* Operations, Procedures, and Standards *for* National Palliative and Hospice Care Program

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Foreword

Congratulations to the industrious and dedicated people behind this Manual of Operations, Procedures and Standards (MOPS) together with the Training Modules for the National Palliative and Hospice Care Program. The development of MOPS and training modules is indeed a game-changer in our health care system as we finally integrate palliative care at all levels of care from the hospital to the homes of our patients.

According to the Astana Declaration, primary health care is the cornerstone of a sustainable health system for Universal Health Care (UHC) and health-related Sustainable Development Goals (SDGs). We envision our primary health care and health services to be high-quality, and equitably provided by health professionals who are well-trained, and committed. Promotive, preventive, curative, rehabilitative services and PALLIATIVE CARE must be accessible to all.

In light of the implementation of the National Integrated Cancer Control Act (NICCA), the Universal Health Care Act (UHC), and the Department of Health - Administrative Order No. 2015-0052: National Policy on Palliative and Hospice Care in the Philippines we are on the right track towards ensuring holistic health care, including quality palliative care, is accessible for all Filipinos in various health care settings.

As health care providers, we ought *to cure sometimes, relieve often, and comfort always.* Indeed the implementation of palliative care across the country will require the work of many stakeholders, individuals and organizations namely the DOH, PhilHealth, Food and Drugs Administration (FDA), public and private hospitals, LGUs, community workers, specialists, general practitioners and family physicians, public health officials, allied health professionals, social workers and even colleagues in cultural, religious-spiritual, legal and ethical sectors.

Let us all work together in preserving human dignity and improving quality of life in the last remaining days of a patient's life.

Congratulations and *mabuhay!*

FRANCISCO T. DUQUE III, MD, MSc
Secretary of Health

Preface

The Philippine Healthcare System has come a long way through the years. Life expectancy has increased further with improvements in health and social services.

In 2014, the World Health Assembly approved the resolution strengthening palliative care as a core component of comprehensive care throughout the life course. This endorses the need to improve access to palliative care as a core component of the healthcare system emphasizing that it is an ethical responsibility and duty to alleviate pain and suffering, whether physical, psychosocial or spiritual, irrespective of whether the disease or condition can be cured.

In 2019, the Philippine government passed the National Integrated Cancer Control Act (NICCA) and the Universal Health Care (UHC) Law. These laws serve as basis for providing palliative and hospice care services to all Filipinos. Historically, palliative care programs served only to the health needs of cancer patients. To date, palliative and hospice care services expand its scope covering chronically ill, with life-limiting or life-threatening conditions.

The Department of Health in partnership with Jose B. Lingad Memorial General Hospital (JBLMGH) led the development of the Manual of Operations, Procedures and Standards for National Palliative and Hospice Care Program. The manual intends to guide the program managers and health practitioners in implementing palliative and hospice care programs in all settings, level 1 to level 3/Apex and sub-specialty hospitals, public and private institutions/workplaces, community or professional practice.

May you find this manual helpful and appreciate the value of an Integrated Palliative Care Network (IPCN) to facilitate an effective program implementation of palliative and hospice care provision throughout the country.

Agnes B. Bausa-Claudio, MD, MPH, DFM, FPSHPM
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Abbreviations

DOH	Department of Health
HCPN	Health Care Provider Network
MOPS	Manual of Operations, Procedures and Standards
NICCA	National Integrated Cancer Control Act
PCS	Philippine Cancer Society
PSHPM	Philippine Society of Hospice and Palliative Medicine
TAG	Technical Advisory Group
TWG	Technical Working Group
UHC	Universal Health Care
CAPC	Center to Advance Palliative Care
MHO	Municipal Health Officer
CHO	City Health Officer
BHW	Barangay Health Worker

Palliative and Hospice Care

SECTION I

Section I. Palliative and Hospice Care

A. Introduction

What is palliative care and hospice care? Who needs palliative and hospice care?

Palliative care is a **fundamental human right** (World Palliative Care Alliance Declaration, 2009) and an essential component of comprehensive and integrated care for persons with serious, chronic, complex, and life-limiting or life-threatening health problems. Palliative Care should be practiced not only by palliative care specialists but also by healthcare workers and social care providers of different specialties or disciplines. Moreover, it should be provided in any health care setting, including patients' homes and dedicated facilities.

Palliative care refers to a systematic, organized, multidisciplinary approach of care to patients, across all ages, with any chronic life-limiting or life-threatening illness. It aims to improve the quality of life of the patient and their families through a holistic, age appropriate, gender responsive, culturally sensitive and rights-based approach. It is care directed to the anticipation, prevention, and relief of suffering through early identification, impeccable assessment, treatment and management of pain and other problems involving the physical, emotional, social, and spiritual needs of the patient and is started as soon as the diagnosis of a life-threatening disease is made. It promotes dignity, quality of life, and adjustment to progressive illnesses, using the best available evidence.

Hospice care is a component of palliative care which deals with persons who are not expected to survive for more than six months. It is provided by skilled health care workers and volunteers. For dying patients, peace, comfort, and dignity are the main goals which are attained by providing holistic support which includes medical, psychological, and spiritual support. Anticipatory guidance and bereavement support for up to two years are rendered as part of the hospice care services for the surviving family members.

All people, irrespective of diagnosis, income, age and sociocultural background should have access to a nationally determined set of basic health services, including palliative care. Financial and social protection systems need to take into account the human right to palliative care for poor and marginalized population groups. It is a person-centered accompaniment of patients and their families throughout the illness, including at the end of life that optimizes quality of life, promotes personal growth and well-being, and maximizes dignity.

People who need palliative care include those with the following:

- Chronic, progressive, far advanced conditions which are life-limiting or life-threatening conditions (e.g. cancer, organ failure, stroke, dementia, etc.)
- Multidimensional needs (physical, emotional, social, spiritual, existential, etc.)
- Complex palliative care interventions such as opioid titration for intractable pain and other symptom management
- Life-limiting or life-threatening condition of a family member with dysfunctional family dynamics and with difficult decision-making or ethical/psychosocial issues
- Complicated grief and bereavement
- Any life-limiting or life-threatening conditions with a poor prognosis

Features of the Palliative Care Approach

- The care paradigm includes all dimensions of care - physical, psychological, emotional, social and spiritual
- Applicable to all patients, across all ages with life-limiting or life-threatening illnesses
- Caters to all stages of the disease trajectory
- Can be rendered across all settings in the society - hospitals, home, community, workplace, and other long-term/nursing facilities or institutions
- Employs multidisciplinary / interdisciplinary / transdisciplinary team approach to care (inclusive of medical practitioners and allied health professionals like nurses, nurse aides, social workers, caregivers, spiritual providers, as well as patients and their families)
- Promotes quality of life through impeccable assessment and treatment of distressing symptoms
- May provide a cost-effective approach to care specifically to low income and low middle-income countries
- Promotes compassionate communities to enhance public health awareness about living in the face of dying and maximizing individual and community assets to promote individual and community growth

B. National Situation and Policy related to Palliative and Hospice Care in the Philippines

History of Palliative and Hospice Care in the Philippines

Organizations

Throughout the history of palliative and hospice care in the Philippines, there had been notable organizations that were instrumental in its promotion. The first organization is the Pain Society of the Philippines which is one of the first societies to promote pain management and access to essential pain medications including opioids which are an integral part of palliative and hospice care. The society started in 1987 through the leadership of Dr. Cenon Cruz and it brought about the multidisciplinary approach to pain management in the country. Through the efforts of the Pain Society, the Department of Health (DOH) had authorized the distribution of morphine for cancer pain management to DOH accredited hospitals in 1989. During the Opioid policy development workshop in 2008, Secretary Dayrit announced a budget of PhP10 Million for the provision of opioids for cancer patients. The society, in 2015 during the 6th Association of South-East Asian Pain Societies Congress, also lent its support on the 2010 Declaration of Montreal which urgently called for the improvement in access and availability of essential pain medications.

Another organization that helped in the promotion of palliative and hospice care in the early years is the Philippine Cancer Society (PCS). In 1991, then PCS President and former DSWD Secretary Mita Pardo de Tavera with Dr. Catherine L. Krings as Program Director, created the first dedicated Hospice Home Care Program (originally named PCS Patient Outreach Services) in the Philippines to alleviate the suffering of cancer patients. In 1995, the society published the first Hospice Home Care Manual (Caring at Home – Hospice Care) for caregivers in collaboration with DOH (authored by Drs Catherine L. Krings, Corazon A. Ngelangel, and Marilou G. Munson) and organized the first National Hospice Convention, with key speaker Dr. Josefina B. Magno (a Filipina, who established some of the 1st hospice programs in the United States (U.S.) and helped bring the hospice concept to the mainstream). In 2003, PCS initiated the formation of the National

Hospice and Palliative Care Council of the Philippines or more commonly known as the Hospice Philippines. PCS has continued to promote palliative and hospice care, participating in DOH technical working groups for policy development and partnering with organizations to create palliative and hospice care programs.

The National Hospice and Palliative Care Council of the Philippines (Hospice Philippines) was formed on September 9, 2003, with the vision of being committed to ensuring the best quality of life for terminally ill patients and those afflicted with life-threatening illnesses and their families and its mission to promote networking and cooperative linkages with local and international agencies through advocacy, education, and training, standardization of care and services and research and registry. It has been active in organizing the training for health professionals and volunteers in palliative and hospice care. In 2007, they hosted while PCS sponsored the 7th Asia Pacific Hospice Conference (APHC) which was held in the Philippines.

In 2012, the Philippine Society of Hospice and Palliative Medicine (PSHPM) was established and was recognized in 2015 as a sub-specialty society under the Philippine Academy of Family Physicians. The aim is to promote high quality palliative care through fostering high-quality hospice and palliative care education, research, policy, and evidence-based practice. In 2018, the society initiated the Specialty Examination for the Board Certification of Palliative Medicine Specialists.

Initiatives

- ***Hospital Based Programs***

  In the mid to late 90's, Dr. Josefina Magno had been instrumental in promoting hospice and palliative care. She helped start Hospital-based Hospice Programs in different hospitals such as in Makati Medical Center and University of Santo Tomas in 1994 and 1997 respectively. In 1989, palliative care was integrated into the Family Health Care Program of the Department of Family and Community Medicine in University of the Philippines-Philippine General Hospital which also developed a 3 bed palliative care unit in 1997. Other hospitals also began setting up their own hospice care programs such as Philippine Children's Center in 1994, Southern Philippines Medical Center in 2011, Davao Region Medical Center in 2014, and Jose B. Lingad Memorial General Hospital in 2015 to name a few.

- ***Community Based Programs including Non-Government Organizations, Foundations, and Private Institutions***

  Starting in the 90s, several disease specific programs had been developed to cater to the community or special population groups to provide home care that incorporates the model of palliative and hospice care.

  The following is the list of such programs:

  - Hospice Home Care Program by Philippine Cancer Society (1991) - home visits for cancer patients in Metro Manila
  - Kythe Foundation in East Avenue Medical Center (1992) - Child Life Program and care for children
  - Madre de Amor Hospice in Laguna (1994) - home visit and care of cancer patients, psychosocial and volunteer program
  - Ayala Alabang Hospice in Muntinlupa (1994) - church-based home care
  - Canossian Sisters of Charity in Bukidnon and Cagayan de Oro

- Starship Program in San Lazaro Medical Center (2001) - program for rabies patients
- PALCARE Volunteer Group (2002) -volunteer group for hospice and palliative care in PGH, established in 2002 and became the first palliative care volunteer group affiliated with an academic medical center to gain recognition from DOH and PCS
- Center for Health Improvement and Life Improvement Development (2004) - temporary shelter for children with cancer
- Palcare Hospice Foundation, Inc. (2008) - first community based home care serving in the Province of Bulacan linking both the LGU and the provincial hospital (Bulacan Medical Center)
- Ruth Foundation for Palliative and Hospice Care (2012) - community-based service for homebound elderly and patients with life-limiting or life-threatening illness and palliative and hospice care education for nurses, volunteers and other community-based health professionals
- ActivCare Home Health Solutions, Inc. (2016) - private company that provides coordinated palliative and hospice care services for continuity of care transitioning from hospital to home care by a palliative care team- palliative care specialists, palliative trained nurses/caregivers and other specialists who work together to provide pain and symptom control, end-of-life care at home thru its Interdisciplinary and Transdisciplinary Team Approach bringing together a group of healthcare professionals with appropriate skills to develop best care plan for the patient in collaboration with patient's family

- ***Training***

Training of healthcare professionals in palliative and hospice care started in 1994 by the Philippine Cancer Society in association with Dr. Josefina Magno. Starting 2012, the National Hospice and Palliative Care Council of the Philippines has started to conduct its own training of health care workers.

Regarding formal training of physicians through residency and fellowship, it has started in 1989 wherein concepts of hospice and palliative care was integrated into the Family Health Care Program (FHCP) of the Department of Family and Community Medicine (DFCM) of the University of the Philippines - Philippine General Hospital (UP-PGH). Later the hospital created the first Hospice and Palliative Medicine Fellowship program in the country in 2002 headed by Dr. Catherine Krings followed by other training hospitals like the Southern Philippines Medical Center (SPMC) in 2012, Jose B. Lingad Memorial General Hospital (JBLMGH) and Far Eastern University-Nicanor Reyes Memorial Foundation (FEU-NRMF) in 2018.

The Philippine Society of Hospice and Palliative Medicine (PSHPM) was established in 2012 and was recognized as a Sub-Specialty Society in 2015 under the Philippine Academy of Family Physicians (PAFP) and started the Specialty Examination for the Board Certification of Palliative Care Specialists in 2018.

The Ruth Foundation for Palliative and Hospice Care (TRF) has organized an annual End-of-Life Nursing Education Consortium (ELNEC) Core training since 2012 for health care professionals engaged in palliative and hospice care. In addition, the first ELNEC-Pediatric Palliative Care course in the Philippines also happened in 2016.

ActivCare Home Health Solutions, Inc. an institution accredited by Professional Regulation Commission (PRC) in 2017 to provide Continuing Professional Development (CPD), education and skills training in palliative and end-of-life care for nurses, caregivers and allied health professionals directly involved in the care of patients at home. It provides hand-on training for doctors as well post palliative care training.

- ***Legislative and DOH Actions***

The national movement to promote palliative and hospice care started in the early 2000. Through the efforts of the president of the National Hospice and Palliative Care Council of the Philippines (NHPCCP) Atty. Asuncion B. Kalalo, President Gloria Arroyo declared through Presidential Proclamation No. 1110 in 2005 the 1st week of October of each year as the "National Hospice and Palliative Care Week".

In 2012, Palcare Hospice Foundation organized the First Regional Conference in Palliative and Hospice Care (Region 3) which was held at the Bulacan Capitol Gymnasium where the Department of Health, Hospice Philippines, Philippine Cancer Society, Pain Society of the Philippines and several politicians and leaders of medical societies came in attendance to support the movement. As a result Congresswoman Linabelle Villarica of the 4th district of Bulacan in July 2013 filed a bill in the 16th Congress House Bill 49 entitled "Hospice and Palliative Care Act: Integrating Palliative and Hospice Care into the Philippine Health Care System. The bill passed the lower house in January 2015.

A 2015 Quality of Death Index Study ranking the end-of-life care across 80 countries had listed the Philippines as one of the worst places to die, 3rd next to Iraq and Bangladesh. This prompted action from the Department of Health and issued an Administrative Order 2015-0052, also known as the "National Policy for Palliative and Hospice Care in the Philippines". It was signed and circulated on December 21, 2015, with the objective to set the overall policy directions and identify the roles and functions of DOH, its offices, and partner agencies in the provision of palliative and hospice care in hospitals, health facilities, communities, and home-based levels.

Interest in palliative and hospice care had increased in both the lower house and the Senate as evidenced by various house and Senate bills. In 2019, two landmark bills were enacted. The first of which is the R.A. 11215 otherwise known as the National Integrated Cancer Control Act (NICCA) and the R.A. 11223 otherwise known as the Universal Health Care Act (UHC) in which palliative care is included as one of the primary services that is needed to be provided at all levels of care.

- ***Pediatric Palliative Care***

Pediatric palliative care in the Philippines started with the ChildLife Program Services. It was established in 1992 which started in East Avenue Medical Center through the founding of the Kythe group. It was initially intended to provide psychosocial support for children with cancer at the hospital. Yet as interest grew, it became registered as a non-stock, non-profit organization in 1994 and in 1998 incorporated the ChildLife Program which became accessible in eight Philippine tertiary government hospitals.

Another program catering to palliative and hospice care needs of children was established in 2003 called Center for Health Improvement and Life Improvement Development

(Childhaus) in Quezon city which is a halfway house for children with cancer as they seek treatment in Metro Manila.

Another initiative that helps promote palliative and hospice care for children is the arugaproject.com which was initiated in 2018. The ARUGA project was implemented to develop e-learning platform accessible online for pediatric palliative care. It provides training with certification for Healthcare providers (physician, nurses) and volunteers.

- ***Local/Provincial Initiatives***

  The following is a list of some initiatives in palliative and hospice care in different locales
  - Laguna - Madre de Amor Hospice Foundation since 1994, provides palliative and hospice care service covering 23 out of 30 municipalities and cities in Laguna
  - Bulacan - In 2011 Palliative and Hospice Care Unit was established in Bulacan Medical Center the provincial hospital of Bulacan in coordination with Palcare Hospice Foundation followed by the First Regional Conference in Palliative and Hospice Care in 2012; In 2019 the first to have local city ordinance for the Integration of Palliative and Hospice Care in the City of Malolos with a yearly allocated budget
  - Davao - Southern Philippines Medical Center (SPMC) started fellowship program in 2012 and Davao Regional Medical Center (DRMC) Palliative and Hospice Program in 2014
  - Pampanga - Capacity Building and Integrated Palliative Care Network (IPCN) referral system through the efforts of Jose B. Lingad Memorial General Hospital (JBLMGH), DOH Regional Office (Region 3), and Local government Units (LGU) in 2018
  - There are also palliative and hospice care providers and specialists involved in initiating and strengthening the health system integration of the discipline in the following cities and provinces – different cities in Metro Manila, Ilocos Region (ITRMC), Cebu, Iloilo, Leyte, Zambales, Cagayan De Oro
    (see list of hospice and palliative specialists at https://www.pshpm.org/fellows)

Current Challenges

Health inequalities still abound which contribute to the current challenges in delivering quality health care including palliative and hospice care especially in geographically isolated and disadvantaged areas (GIDA). The following are some examples of these inequalities:

- Unfavorable political, administrative and economic environment leading to catastrophic cancer treatment costs and high out-of-pocket expenses for the patients
- Armed conflict leads to inaccessibility of health services in some areas
- A limited number of government subsidies or programs for individuals accessing palliative care
- High incidence of preventable cancer and other preventable chronic noncommunicable diseases in geographically isolated and disadvantaged areas
- Shortage of essential medicines and devices in health facilities
- Lack of adequate physical structure in health units
- The severe shortage of specialized palliative care professionals and an inability to maintain a pool of trained and available health care workers and volunteers in palliative and hospice care

- Uncoordinated research efforts regarding palliative and hospice care in cancer and other life-limiting and life-threatening diseases

Fragmented efforts among the stakeholders in the implementation of palliative and hospice care services also is a barrier in achieving a holistic system of service delivery across all levels of care setting. Some examples are the following:

- There is lack of physical structure for palliative care services in local health units, and in some areas, palliation outside tertiary hospitals are very inconsistent or non-existent
- Irregular home visits by providers of palliative care services
- Limited or no palliative and hospice care services in hospitals and community centers
- Lack of an electronic medical record system for proper and timely documentation in local, regional, and national levels
- Registries and population databases are mostly limited to cancer only
- Unawareness of some healthcare administrators regarding palliative care
- Mismanagement of resources especially in our devolved healthcare system

The low awareness or even lack of awareness of healthcare professionals about the need for palliative and hospice care not only in cancer but especially in chronic, non-cancer diseases also is a challenge presently faced by the program. Some identified reasons are the following:

- Limited knowledge and low interest in palliative and hospice care of health care providers
- Lack of understanding of the implementation of palliative care services
- Lack of understanding of individual roles in the interdisciplinary and transdisciplinary healthcare team for palliative and hospice care
- Lack of integration into the school curriculum especially in nursing schools and medical schools of palliative and hospice care concepts
- The low number of physicians with S2 license that is essential to prescribe essential regulated drugs for palliative and hospice care especially during end of life

Impaired health and medication literacy among patients may result in some resistance to, or be unaware of the need for, early treatment and palliation. This also plays a factor in the low demand and utilization of palliative and hospice care services in the country. Some of the reasons for this include the following:

- Lack of knowledge among patients about the timing to seek palliative care services
- Lack of awareness about the need for palliative care among patients who are terminally ill with communicable and/or chronic lifestyle diseases

Major Global and International Commitments

Table 1. Major International Commitments of the Philippines

Date	Commitment	Declarations about Palliative Care
2009	International Association for Hospice and Palliative Care - World Palliative Care Alliance	• Develop strategies to recognize palliative care and pain treatment as fundamental human rights • Advocate and create policies to increase resources for palliative care and improve access and availability of opioids and other medicines • Advocate for academic institutions and teaching hospitals to ensure palliative and hospice care positions and resources
2014	World Health Assembly Resolution 67.19 - Strengthening of Palliative Care as comprehensive care throughout the life course	Advocates the creation of policies for the: • Integration of palliative care services into the structure and financing of national health care systems at all levels of care • Expanding human resource on palliative care through education and training • Ensuring availability of essential medicine particularly opioid analgesics • Researching palliative care needs and identifying standards and models of services that work
2017	70th World Health Assembly: Cancer Prevention and Control in the context of an integrated approach	Urges member states to: • develop and implement evidence-based protocols for palliative care for cancer patients • provide pain relief and palliative care as a component of comprehensive care throughout the life course • promote early detection of patient's palliative care needs and access to services • foster partnerships between government, civil society, health-related NGOs, and patient organizations to support palliative care
2018	Astana Declaration on Primary Health Care	• Identified palliative care as one of the services that must be accessible to all • Member government is committed to aiming to meet all of the people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care
2019	Political Declaration for the UN High-Level Meeting on Universal Health Coverage (UHC)	• Recognize that UHC implies that all people have access, without discrimination to nationally determined sets of the needed promotive, preventive, curative, rehabilitative, and palliative essential health services • Scale-up efforts to respond to the needs of the rapidly aging population, especially the need for promotive, preventative, curative, rehabilitative, and palliative care

Legal Commitments

Our Constitution guarantees the right of the people to quality health care, as such the Department of Health (DOH) recognizes the need to integrate palliative and hospice care into our health care delivery system to provide holistic health care. The inclusion of palliative and hospice care in the hospitals or health facilities and in the community and home-based levels addresses the goals of Universal Health Care or *Kalusugan Pangkalahatan*. With this, the National Policy on Palliative and Hospice Care in the Philippines known as DOH AO 2015-0052 was issued. This Order is aimed to set overall policy directions and identify the roles and functions of DOH, its offices and partner agencies in the provision of palliative and hospice care in hospitals, health facilities, communities and home-based levels.

The establishment of an integrated palliative and hospice care in the Philippines is still a work in progress. To date, there are provisions of palliative and hospice care services available in many parts of the country and efforts to begin the integration into the formal health care system are still underway. Palliative and hospice care has been included in many major health policy documents including:

- Republic Act
  - RA No. 11215 National Integrated Cancer Control Act (2019)
  - RA No. 11223 Universal Health Care Act (2019)
- Administrative Order
  - AO No. 2011-0004 Guideline for Distribution and Monitoring of Morphine Sulfate
  - AO No. 2015-0052 National Policy on Palliative and Hospice Care in the Philippines
  - AO No. 2016-0001 Revised Policy on Philippine Cancer Prevention and Control
  - AO No. 2020-0003 Integrated People-Centered Health Services in All Health Facilities
  - AO No. 2020-0007 Patient Safety in Health Facilities
- DOH Memorandum Circular and Department Order
  - DOH MC 2019-0011 supporting the RA 11223 Instituting UHC for All Filipinos, Prescribing Reforms in the Health Care System and Appropriating Funds
  - DOH Memorandum Circular No. 2019-0036 on the Implementing Rules and Regulations of Republic Act No. 11215 also known as the National Integrated Cancer Control Act
  - DOH HFDB Department Order No. 2021-0001 on Designation of Selected DOH Hospitals as Specialty Centers where palliative care is among the common services required in the frameworks of designated selected hospitals
- PhilHealth Circular
  - PhilHealth Circular 2019-0009 regarding premium contribution schedule in the NHIP pursuant to RA 11223 UHC Act
- The Philippine National Objectives for Health 2017-2022, where access to essential quality health products and services shall be ensured at appropriate levels of care including palliative care in the comprehensive essential health service package and specialized health services for all life stages

In addition, as mandated in the Local Health Code, local government units can come up with their own local programs on palliative and hospice care. One example is the City of Malolos where an ordinance was passed in 2019 to provide for the mechanism and integration of Palliative and Hospice care in the treatment of life-threatening illness in the city (City Ordinance No. 17-2019). Also, there were other efforts from the provinces of Pampanga, Samar, Leyte, Davao, and some cities in the NCR like Pasig, Makati, Muntinlupa which started their own pilot projects for palliative care in their respective areas.

National Framework

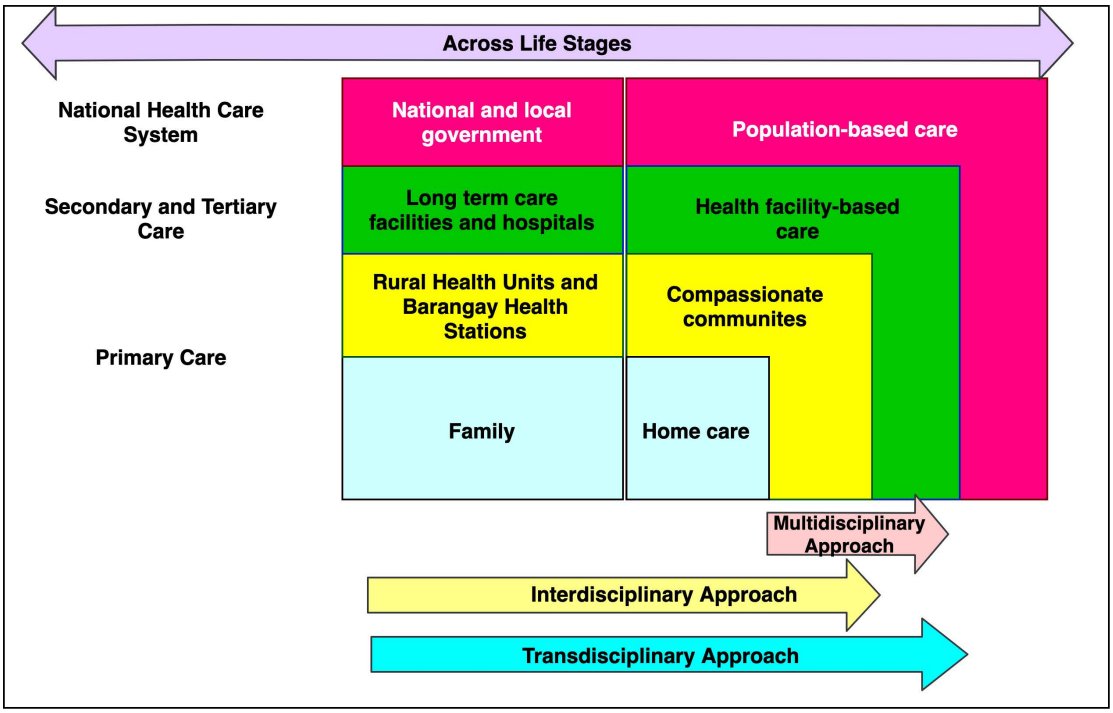


Figure 1. Integration of Palliative and Hospice Care National Framework

This figure shows the framework by which palliative and hospice shall be integrated into our health system, where community and hospital shall both be part of a healthcare provider network (HCPN). This network encompasses all levels of care so that any palliative or hospice patient needing the service can enter the system ideally with a seamless experience of care management and referral through the proper channels, may it be from the home, compassionate communities, private or public sector, the hospital and encompassing even the workplace or other free-standing hospice facility. This can be done through building commitments and cooperation from the different stakeholders especially through the leadership of the DOH and the different local government units as well as partnering with PhilHealth to ensure better financial health coverage to include palliative and hospice services. Also making sure that there is an interoperable system for the Palliative Care registry is vital for making this network a successful integration to achieve universal health care (UHC).

C. Objectives and Scope of the Manual

The manual is developed to assist the national and LGU health program implementers towards achieving the goal of integrating palliative and hospice care into the Philippine Health Care Delivery System. It is in line with the National Integrated Cancer Control Act (NICCA) and Universal Health Care Act (UHC) since it shall describe palliative health care programs across all levels of care settings. Also, it can be used to guide local stakeholders in driving into operation the National Policy on Palliative and Hospice Care in the Philippines.

This manual specifically aims to:

1. Provide guidance/standards in the implementation of Palliative and Hospice Care at the DOH Central Office, Regional Offices, DOH Retained Hospitals, Local Government Units, including Partners and Stakeholders

2. Capacitate the Regional Offices, DOH hospitals, and other partners and stakeholders in the provision of Palliative and Hospice Care through guidance in the conduct of training
3. Strengthen collaboration with stakeholders in the provision of palliative and hospice care to patients with life-limiting and/or life-threatening illnesses
4. Improve the quality of life for people of any age and at any stage with life-limiting and/or life-threatening illnesses

D. Target Users

The manual is written for all healthcare professionals and carers involved in the provision of palliative and hospice care across all levels of care setting from the home, communities, including the workplace, to the hospitals and special populations so they can strengthen local systems and resources for an integrated and seamless transition and navigation of the palliative and hospice patients and their families.

E. Approaches

- **Multidisciplinary team approach** - A multidisciplinary team is composed of members from more than one discipline so that the team can offer a greater breadth of services to patients. Appropriate experts from different aspects of a patient's care independently and interact formally. Professionals provide separate evaluations and assessments, set their own discipline-specific goals for the patient and implement individual intervention plans. The team members may communicate with each other on a less frequent and less formal basis than with other models.

- **Interdisciplinary team approach** - An interdisciplinary team is a group of persons who are trained in the use of different tools and concepts, among whom there is an organized division of labor around a common problem with each member using his own tools, with continuous intercommunication and re-examination of postulates in terms of limitations provided by the work of the other members and often with group responsibilities for the final product. The team requires interaction among members for the assessment and development of intervention plan / best method for service delivery.

- **Transdisciplinary team approach** - The transdisciplinary team approach is based on the premise that one person can perform several professional roles by providing services to the patient under the supervision of individuals from the other disciplines involved. This approach represents the concept of the multi-skilled health practitioner that requires team members showing respect for each other and a willingness to share professional expertise in order to promote alignment of strategies, coordinated approach to service delivery and collaboration between team members. They cross professional discipline boundaries to achieve service integration by consulting with one another.

Stakeholders in Palliative and Hospice Care in the Philippines

SECTION II

Section II. Stakeholders in Palliative and Hospice Care in the Philippines

A. Roles and Responsibilities of DOH and Stakeholders

Government Agencies

Department of Health (DOH)

- **Strategic and Technical Advisory Group on Palliative Care (STAG-PC)**
  - Formulate and create a policy for regional/local government and community palliative care provision and services
  - Create policies and guidelines for the availability and accessibility of opioids particularly morphine (oral and intravenous forms) and sedatives commonly used in palliative care and hospice care in the community and home care setting.
  - Provide permits for Palliative Care Providers which are defined as specially-trained teams of doctors, nurses and specialists which provide palliative and hospice care. In particular, permits for Physicians and/or Nurses to transport dangerous drug preparation such as opioids in their task to manage patients at home
  - Recognizes and certifies palliative care providers
- **Health Facilities and Services Regulatory Bureau (HFSRB)**
  - Shall set standards for the licensing and regulation of palliative care facilities which are hospitals and health facilities that provide palliative care services such as in patient, in-house, out-patient or home care
- **DPCB-Cancer Control Division and Center for Health Developments**
  - Provide technical support to hospitals and LGUs to help them in the creation of their palliative care programs
  - Monitor and evaluate of the implementation of the program
  - Submit reports to NEDA and DBM

Department of Budget and Management (DBM)

- Ensures that the LGUs and Government hospitals shall be allocated with the necessary budget in order for them to get the necessary resources for them to establish palliative care health services

Dangerous Drugs Board (DDB)

- Formulate policies and guidelines on the procurement and distribution, transporting, storing, prescribing, dispensing, and disposing of dangerous drug preparations to be used for palliative and hospice care services

Philippine Drug Enforcement Agency (PDEA)

- Ensures the proper implementation of the policies and guidelines issued by the Dangerous Drug Board

Food and Drug Administration (FDA)

- Shall ensure the availability and accessibility of quality, safe and effective palliative care medicines
- Shall closely coordinate with DDB and PDEA to further validate the category of palliative care medicines/drugs as dangerous drugs

National Economic and Development Authority (NEDA)

- Oversight for plans, policies, programs for health and all other sectors, including monitoring and evaluation

PhilHealth

- Formulate and create packages to pay for palliative and hospice care services
- The main source of payment for palliative care services

National Council on Disability Affairs (NCDA)

- Ensures that palliative and hospice care services are incorporated in policies for disabilities

Department of Labor and Employment (DOLE) / Civil Service Commission (CSC)

- Creates palliative and hospice care policies in the workplace

Technical Education and Skills Development Authority (TESDA)

- Training and skills development; Has a role in standardization, registration of caregiving programs, assessment and certification, as well as the conduct of monitoring and continuous evaluation

Professional Regulatory Commission (PRC)

- Ensures that all health professionals has a minimum

Commission of Higher Education (CHED)

- Includes palliative and hospice care in the curriculum of health professionals e.g., for nursing, PT, clinical pharmacists

Professional Societies

Philippine Society of Hospice and Palliative Medicine (PSHPM)

- Regulates training for advanced palliative medicine specialists

Association of Philippine Medical Colleges (APMC)

- Advocate the inclusion of palliative and hospice care into the curriculum for medicine

Nursing and Allied Health Associations

- Promote and strengthen palliative and hospice care principles, knowledge, and skills in the education and training of nurses and other allied health care professionals

Local Government Unit (LGU)

- Create mandate/policy/ordinances in the provinces/cities/municipalities for the advancement of palliative and hospice care programs
- Coordinate and provide the needed Human Resource or manpower
- Provide the logistical needs and budget for the program

Expanded Local Health Board

- shall serve as an advisory committee to the local health system and propose to the *Sanggunian* the necessary policies and budget needed for the program. It is headed by the local chief executive and includes government and non-government stakeholders

Non-Government and Advocacy Groups

National Hospice and Palliative Care Council of the Philippines (aka Hospice Philippines)

- the national umbrella body of palliative and hospice care providers responsible for capacity building and advocacy for palliative and hospice care

Other stakeholders (Non-government organizations, professional groups, other national agencies/organizations, academe)

- Have the responsibility to adopt, assist, and support the implementation of the palliative and hospice care program to their respective institutions and network

Health Care Providers in Different Settings

Level 2 and Level 3 private and public hospitals

- Ensure provision of palliative care to patients presenting with complex problems
- Provide training for palliative and hospice care to doctors, and other allied medical professionals
- Coordinate / ensure proper endorsement of discharged palliative or hospice patients back to the community through the City Health Unit or Rural Health Unit which shall then ensure proper registry to the network and endorse the palliative patient and family to assigned local community health workers who shall do a follow-up at home
- Develop processes to ensure data privacy

Level 1 private and public hospitals

- Provision of basic to intermediate palliative care services
- All palliative care providers share responsibility for communication and information transfer
- Ensure a smooth referral system, transfer of medical information, and endorsements between the different health professionals responsible for patient palliative or hospice care to and from the hospital
- Develop processes to ensure data privacy

Employers/Companies

- Companies and employers should have policies and programs in place for providing basic palliative care services to their employees and may partner with institutions or facilities for proper referral
- Company clinic doctors and nurses must have a basic to intermediate training in palliative and hospice care

Rural Health Unit/City Health Unit

- The local health unit is the focal point of the palliative and hospice care initiatives in the community which include integration of palliative and hospice care to the current population-based and patient based health programs and home-based palliative and hospice care.
- Develop processes to ensure data privacy

Private sector

- Defined as NGOs, private institutions with palliative care service, private facilities and service provider
- Private palliative care providers have the responsibility to follow DOH rules, regulation and guidance in rendering palliative and hospice care services
- Individual healthcare providers minister at the minimum basic to intermediate palliative and hospice care services.

Social Welfare Services

- Help navigate palliative patients in accessing support at different levels of care
- Provide social support and psychosocial counseling when necessary
- Provide careful support and negotiation about sensitive personal situations
- Use relevant legislation to protect the rights and dignity of people who are deemed to lack the capacity to make decisions for themselves and ensure that these decisions are made in their best interests

Physicians

- **Clinicians (Hospital setting and community setting)**
  - Provides basic to specialized palliative care services
  - Advocates for holistic care for the health and well-being of a patient
  - Collaborate with other professionals regarding patient's plan of care
- **Managerial (Provincial Health Officer/Municipal Health Officer/City Health Officer)**
  - Oversees palliative and hospice care services in their respective local government unit
  - Provide logistical support to community health workers and community-based palliative and hospice care program
  - In charge of LGU's health care system and ensures the referral system between the different levels of care

Nurses in Hospitals

- Advocate for the health and well-being of a patient such as ensuring the provision of holistic care that includes psycho-spiritual aspect for the patient and the relatives
- Communicate with a hospital chaplain or the relative's religious officers
- Educate relatives on the current situation
- Collaborate with the multidisciplinary team regarding a plan of care

Child Life Specialist

- Health professionals with child development background trained to implement child life services.

Rural Health Nurse / Public Health Nurse

- Supervises the rural health midwives that are in charge of delivering palliative health services at the barangay level
- Act as liaison between patient and family, other health professions, and between different healthcare services
- Develop a tailored plan of care to the patient and family
- Properly record and document interventions and coordination done

Rural Health Midwives

- Coordinates and supervises the BHWs in ones assigned barangay cluster and reports to the MHO/CHO
- Have supervisory, coordination, and teaching roles in palliative and hospice care
- Conduct home visits and assessment of the medical condition and distressing problems of palliative and hospice care patients
- Have their catchment area which consists of one or more barangays depending on the size of the municipality/city and the number of midwives. The midwives run the different health programs in the barangays and they supervise the BHWs.

Barangay Health Workers (BHW)

- Identify households with patients in need of Hospice or Palliative care services using eligibility criteria provided using a checklist.
- Refer confirmed patients to the rural health nurse/midwives for a home visit and assessment of medical condition including distressing problems
- Regularly visit a patient /family in need of emotional and psychosocial support and update status to the rural health midwives
- Involves in the coordination with the midwives, supervision, and monitoring of home care including patient's care by volunteers
- Ensure documentation of home care
- Assists the midwives and helps in going house to house to check on the patient and their families

Home Palliative Care Nurse (PCN)

- Provides basic to intermediate home-based palliative and hospice care services

Palliative Health Aide (PHA)

- TESDA trained caregivers certified to provide basic palliative and hospice care in the home/community-based or hospital/facility based setting
- TESDA trained caregivers with NC II Certificates and should have undergone Basic Training Course in Palliative and Hospice Care

Pharmacists

- Checks and monitors the availability of dangerous drug preparations and other medications, the adverse drug events and drug interactions; dispenses them in all health facilities for patients use or consumption; and maintains documents, records and prescriptions for reporting, and monitoring and evaluation.

Volunteers

- Provides at least Basic Palliative Care Services
- Regularly visit a patient/family in need of emotional and psychosocial support and update status to the rural health midwives
- Involves in the coordination with the midwives, supervision, and monitoring of home care including patient's care
- Ensure documentation of home care patients/families
- Assists the midwives during their Home Care Visits

Families and Family Caregivers

- The patient's family should be actively involved and empowered in informed and shared decision making
- Family or designated/authorized representative should be always updated and informed about the patient's medical condition
- Continuous communication is essential for families to function and cope; with capacity to share feelings and eventually engage in collaborative decision-making in the care of the patient
- Family members are involved in the care of the patient at home hence can be an important source of information for the palliative team to better understand the palliative need of the patient and gives feedback to the palliative healthcare services the patient receives
- As much as possible the family should be trained with the best practices on palliative care and hospice care at home
- Discusses with the health care provider to come up with a clear plan of care
- As the disease progresses, the family members and pertinent caregivers will have an increasing important role to play particularly in decisions about goals of care and treatment preferences, provision of emotional support for the illness, advocacy for appropriate treatment for the patient, acts as trusted confidantes about healthcare issues and surrogate decision-makers
- If designated as Surrogate Decision Maker, documents the preferred advance medical directives from before the start of service to have a clear plan of care

B. Palliative and Hospice Care National Registry

To date, the development of a country-wide registry for palliative and hospice care in the Philippines is still in its early stage. Records of palliative cases are mostly available only in facilities with palliative providers and specialists. This is a gap that needs to be addressed to further strengthen the palliative and hospice care program in the Philippines.

According to the DOH AO 2015-0052, the Knowledge Management and Information Technology Service (KMITS) shall lead in the development and maintenance of the palliative and hospice care registry including the software for monitoring. This shall be integrated from all existing programs such as HIV and AIDS, TB, Philippine Cancer Registry, Integrated Chronic NCD System, etc. to make a National Registry for Palliative and Hospice Care in cooperation with Hospice Philippines, PhilHealth, Philippine Society of Hospice and Palliative Medicine, and other various stakeholders both in the public and private sectors. Submission of palliative care data for both private and public institutions shall be mandatory and shall be linked to PhilHealth's e-claims.

The Rural Health Unit/City Health Unit shall have access to the National Registry for Palliative and Hospice Care in order to get the data of the palliative and hospice care patients in their respective municipalities and cities. The RHUs/CHUs shall validate the data and shall create a patient target list per barangay which the RHU/CHU shall be tasked to provide community-based palliative and hospice care.

Palliative and Hospice Care Policies, Standards, and Practices

SECTION III

Section III. Palliative and Hospice Care Policies, Standards, and Practices

A. Levels of Palliative and Hospice Care

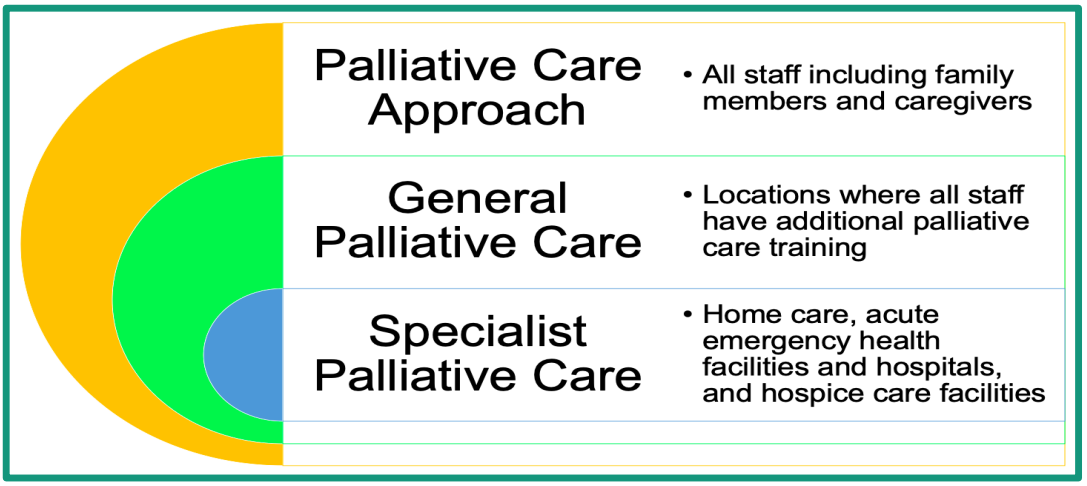


Figure 2. Levels of Palliative Care

- **Palliative Care Approach** - Palliative care principles should be practiced by all health care professionals, volunteers and family members. It aims to promote both physical and social well-being.

- **General Palliative Care** - At this level, a proportion of patients and families shall benefit from the expertise of health care professionals who, although not engaged full time in palliative care, have had some additional training and experience in palliative care.

- **Specialist Palliative Care** - Specialist palliative care refers to the specialized practice of palliative medicine as their core and which services are provided by an interdisciplinary/transdisciplinary team, under the direction of a consultant physician with fellowship training in palliative medicine.

General Standards

1. Palliative Care Models

A coordinated multi-/inter-/transdisciplinary care system where the palliative care needs of patients and their families, inclusive of all people living with serious illness, regardless of setting, diagnosis, age or prognosis, are identified and met at all levels that is beneficial at any stage of a serious illness. The health care system should have trained personnel who are capable of anticipating, preventing and managing physical, psychological, social and spiritual pain and/or suffering to ensure and optimize quality of life. Distance communication should be instituted at the national or regional level through palliative

centers (or other tertiary/specialty care centers) to support those providing palliative care to patients in lower resource areas.

2. **Timing**

Palliative care needs should be addressed for all patients with serious life-limiting or life-threatening illness at presentation using appropriate screening, especially when disease-modifying interventions are not available.

3. **Nurse Role in Pain Management**

The nurse should participate in ensuring care coordination and meeting patient and family needs. Nurses should be trained to assess patients' palliative care needs, including pain control assessment and evaluation, make recommendations, and communicate needs to adequately trained medical staff or physicians.

4. **Spiritual Care**

Spiritual care provided by appropriately trained providers should be available in all settings, whether locally or by referral. In addition to providing direct patient care, spiritual care providers may advise and support the care team to support the patients and their families. Nurses or counselors may be trained to assess the spiritual needs of patients and their families. Providers should be observant of and sensitive to the religious norms of patients and their families.

5. **Social Work/Counseling**

The psychosocial needs of patients and their families should be addressed in all settings and across the healthcare continuum. This role can be addressed by social workers, mental health professionals, or community health workers with training in the needs of palliative care patients and the special approaches required in this population. The role of the social worker/counselor becomes more critical in patients with advanced illness or when curative therapies are not an option, as is often the case in limited-resource settings. Collaboration with counselors/social workers can assist with communication between patients and clinicians, when available.

6. **Pain Management and other Symptom Control**

Health care systems should safely provide necessary pain management including opioid medications and other non-pharmacologic interventions and ensure that the supply is readily and continually available for dispensing by trained professionals and accessible to patients to meet their needs, following the principles of balance through regulations, policy, and existing recommendations. Health care systems should strive to offer all pain control interventions on the WHO Essential Medicines List.

7. **Telemedicine**

Telemedicine or teleconsultation is an innovative way to facilitate direct, patient-centered communication between patients and proxies, primary care physicians, and specialist palliative care teams. This is specifically useful in situations where face-to-face conferences are unavailable, limited, prohibited, or geographically not possible. The telemedicine practice guidelines that have been released through a joint circular from the DOH and UP Manila (JMC 2020-0001) shall be adopted in ensuring the provision of setting up a good quality of care in telemedicine services for palliative and hospice patients that empowers the patients, their families, and the health care team. (see Annex XII for Guidelines and Telemedicine Consultation Process Flow)

8. Health Education and Promotion Services

It is important for all stakeholders to have the same basic knowledge about palliative and hospice care so as to start at the same page. This includes government officials, politicians, palliative and hospice organizations, people's organizations, patient's families and volunteers.

Service Level Allocation

Figure 3. Service Level Allocation for palliative and hospice care services across different levels of care

This shows that palliative and hospice services should be integrated across all levels of care (the home, the communities, and the health facilities and hospitals). At home, patients should be able to receive hospice and home palliative care, end of life and bereavement care, nutrition services and occupational health and support services. At the community level, in addition, diagnostics such as basic laboratory services, ER transport, outpatient, pharmacy services to provide access to medicines in levels of care setting, support services, telemedicine, stand-alone palliative care and long-term care facilities should be included. Finally, for the level of specialized care which could be found in hospitals, it should include acute emergency, inpatient, critical care, radiologic and respite care. Patients could freely transfer from one level to another. For a more detailed table of service level allocation see Annex I.

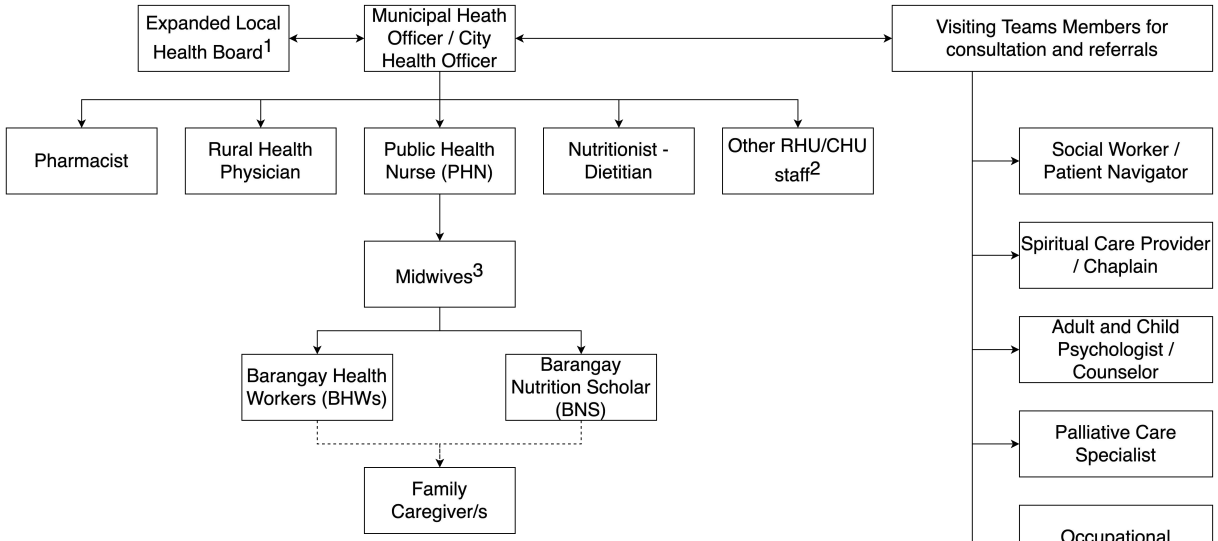
B. Palliative and Hospice Care in the Community

This subsection includes key areas of palliative and hospice care in the community which is in the local health unit, in the workplace and in school. The local health unit is the focal point of the palliative and hospice care initiatives in the community which include integration of palliative

and hospice care to the current population-based and patient based health programs and home-based palliative and hospice care. Workplaces and schools would need to coordinate with the local health unit for their palliative and hospice care programs to ensure continuity of palliative and hospice care services.

1. Palliative and Hospice Care in the Local Health Unit

Organization



1 The Expanded Local Health Board is composed of the Local Chief Executive, the Municipal/City Health Officer, Development Management Office (DO), Barangay Health Worker (President), District Hospital Chief, SB on Health, Barangay Captains, MSWD, DepEd, and civil society organizations

2 Other staff include Sanitary Inspector, Public Health Dentist, Medical Technologist

3 Each Midwife will be assigned at least one barangay that will be her catchment area in which he/she will oversee the health programs in the barangay with the help of BHWs and BNS

Figure 4. Organizational Structure for Palliative and Hospice Care in the Community

This figure shows the organizational structure of palliative and hospice care in the community. The local government unit is responsible for ensuring the provision of their constituents' palliative and hospice care needs which include the creation of the necessary policies to promote awareness of palliative and hospice care to the community, assure access to hospice and palliative care services with the help of the different stakeholders. In this regard the expanded local health board shall be key.

Expanded Local Health Board

- which include the Municipal Health Officer/ City Health Officer, Sangguniang Bayan on Health, other stakeholders and with the Local Chief Executive at its helm, shall serve as a steering committee and shall ensure that the palliative care is integrated into the Local Health System by:
  - Formulating and implementing policies that integrate evidence-based palliative care in the provision of primary care, community and home-based care
  - Ensuring the availability of and access to essential medicines for the management of symptoms, including pain and psychological distress, particularly controlled

medication such as opioid analgesics for relief of pain and respiratory distress, while minimizing opportunities for their diversion and abuse
- Ensuring patients' and their families' access to medical, psychosocial, and spiritual support
- Ensuring that necessary policies and resources are available to educate health workers, barangay health workers, and primary caregivers on palliative care and to advocate palliative care in the community

The RHU/CHU staff led by the MHO/CHO shall be responsible for the provision of palliative and hospice care in the community. This includes the creation of a palliative and hospice care program to increase awareness, recruit and train volunteers, provide palliative and hospice care outpatient services, home care services, and referral of patients to appropriate institutions based on their need. The MHO/CHO Is also in charge of coordinating with visiting specialists for consultation and referral.

Scope of Service

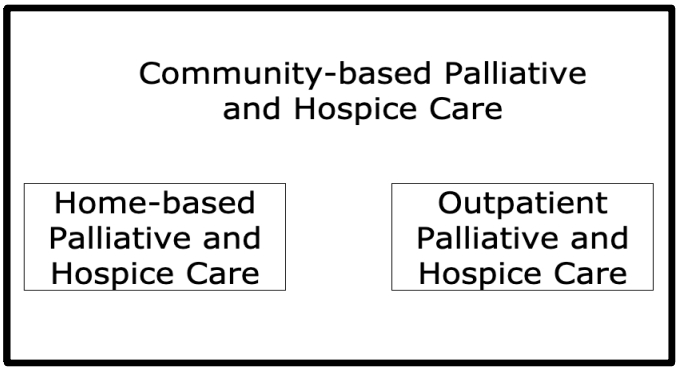


Figure 5. Community-Based Palliative and Hospice Care

Community-Based Palliative and Hospice Care

Definition of Community-Based Palliative and Hospice Care

Community-based palliative care services are those offered in the community such as Barangay Health Centers/ Rural Health Unit/ City Health Unit or that are run with community participation. Community participation is the involvement of people in a community to solve their own problems. This includes community involvement in the needs assessment, planning, implementation, resource mobilization, day-to-day management and evaluation of the program.

Community-based palliative care services are typically provided by both health-care professionals and community health workers/volunteers. At a minimum, doctors and nurses are needed. They work at the RHU/CHU and support the barangay health workers and additional volunteers who visit patients and families at home. Health-care

professionals based at a RHU/CHU also can visit patients at home when needed and keep in touch with patients and family members via mobile telephones. The team may include other voluntary allied health professionals if available. Barangay Health Workers or volunteers, supported by health-care professionals, shall provide the basic home care.

Integrating Palliative and Hospice Care into a Community

- **Conduct sensitization and advocacy to build support**
  - Community
    The first step is to hold an awareness meeting/discussion for people who are likely to be interested in helping. All the groups/organizations involved in social / healthcare activities in the region should be invited.
      - The meeting should ideally be convened by a "neutral" local body to ensure participation from different interest groups and organizations
      - Program facilitators should appeal to as broad an audience as possible
      - Concern should be expressed about incurably ill patients in the region, and ways to help them should be discussed
      - Persons willing to spend a short time each week to assist such patients should be registered as volunteers
  - Health workers
    Sensitization of existing staff: The medical and moral reasons for palliative care should be introduced to the community health unit staff and make clear that palliative care services shall not overburden them
  - Governing bodies
    Seek the support of the Expanded Local Health Board and the *Sangguniang Bayan/Panlalawigan*. Advocacy can focus on the savings resulting from investment in palliative care services, by reducing hospital admissions and length of stay
- **Establishing the systems**
  - Policies
    - With the support of the expanded local health board, policies to support the palliative and hospice care program.
  - Health Information System
    - Development of database systems for palliative and hospice care
    - Create a database of patients that need palliative and hospice care such as senior citizens, cancer patients, patients with chronic diseases, pain patients and patients with disabilities per barangay.
    - Use of electronic medical record
  - Financing
    - Ensure that palliative and hospice care program and procurement of essential medicine are included in the local investment plan and the annual operation plan
    - Ensure that families and individuals have PhilHealth membership
  - Access to medicine
    - Ensure the procurement, storage and distribution of palliative and hospice care medication especially the opioids and other essential regulated medications

- Creation of Necessary Forms
  - Palliative Care Assessment Form
  - Referral Form
  - Target Client List (patients assessed/counselled/referred/ treated on)
  - Master list (list of the patient needing palliative care services)
  - Consolidated accomplishment report form (to have data to be reported by the health center staff based on the target client list)
- Referral system
  - Create Memoranda of Agreements between the RHU/CHU other primary care facility, Level 1 and 2, Level 3 and apex referral hospital, other palliative and hospice care providers and specialists for sharing of information, consultation and referrals.
  - Establish a transportation system for patients to be referred for further management and transportation back to their respective homes.
  - Establish a system for telemedicine or distance communication for possible referral and consultation of patients to specialists should be in place

- **Training**

Palliative care training is a prerequisite for the accreditation of the health care providers.

- Current health workers

  Training should be provided first to the medical doctor(s) and nurses at the RHU/CHU
  - They should receive at least 40 hours of combined theoretical and practical training in palliative care (intermediate training at the minimum)
  - Once trained, the medical staff can participate in the training of nurses and Barangay Health Workers or volunteers
  - Midwives (at least one per barangay) should also undergo the minimum basic training curriculum for palliative care and go through the 40 hours of combined theoretical and practical training in palliative care
- Volunteers

  Existing barangay health workers already trained in some home-care services should receive basic palliative care training capable of recognizing uncontrolled physical or psychological distress or significant social distress and reporting these to a supervisor at the community health unit

  For new volunteers, basic palliative care training and a curriculum for a 16-hour basic volunteer training course (basic nursing care, communication skills, and emotional support) should be done
  - Using a standardized form/template, the trained barangay health workers and volunteers should document the problems of incurably ill patients in their neighborhood

        - It is important to have weekly review meetings per barangay with midwives to discuss solutions to the problems documented
        - A social support program should be started with the volunteers to supply food to starving families, educational support to patients' children, emotional support to patients and families, and to meet other needs
        - The barangay health station shall serve as the information contact point
- **Establishing Palliative and Hospice Care Services**
    - Outpatient Clinic

      At a minimum, the community health unit should provide out-patient palliative care and hospice care services.
    - Patient Navigator

      The RHU/CHU shall serve as patient navigators, referring patients to the next level of care when needed and to social services and financial assistance
    - Home Care

      RHU/CHU supports home care by supervising barangay health workers or volunteers, by sending nursing and/or medical staff to visit patients at home as needed, or by keeping in touch with patients or families by telemedicine consultation (like the use of mobile phone)
    - Palliative and Hospice Care should be included into the Public Health Programs
        - NCDs
        - Disease prevention
        - Nutrition
        - Immunization
        - Maternal and Child Health
        - Senior Citizens
        - Rehabilitation
        - Medicine Access, free medicines
    - Death Certification

      Death at home - Usually requires barangay certificate, medical certificate from MHO and submission to Local Civil Registrar
- **Establishing regular review and evaluation**
- **Continue with sensitization and training of volunteers**

Human Resource

As part of the new paradigm which includes palliative and hospice care as part of routine practice of health care, palliative and hospice care shall be incorporated to the skillset of the existing LGU health care workers. Table 2 shows the recommended staffing requirement. Depending on the local government unit's setting, partnership with existing palliative care foundations/programs could be established to augment the LGU staff.

Table 2. Staffing for Clinical Service in the Municipality or City

	Role	Skills Required	Position	Availability	Service
Municipal/City Health Officer	Team manager	Minimum of basic and intermediate training in palliative and hospice care Communication skills including children and families Understanding childhood development and rights Provide medical support and supervision for nurses, midwives and BHWs, home care visits and outpatient care and due referral to HPCN hospitals when necessary	Regular	Full-time	Out-patient / Home care
Rural/City Health Physician	Team member	Minimum of basic and intermediate training in palliative and hospice care Communication skills including children and families Understanding childhood development and rights Provide medical support and supervision for nurses, midwives and BHWs, home care visits and outpatient care and due referral to HPCN hospitals when necessary	Regular	Full-time	Out-patient / Home care
Public Health Nurse	Team member	Minimum of basic and intermediate training in palliative and hospice care Communication skills including children and families Understanding childhood development and rights Initiate and provide nurse-led home care and care at primary health care centers	Regular	Full-time	Out-patient / Home care
Pharmacists	Team member	Basic to Intermediate training in palliative and hospice care Stores and dispenses palliative and hospice care medication including opioids	Regular	Full-time	Out-patient
Nutritionist - Dietitian	Team Member	Basic to Intermediate training in palliative and hospice care Communication skills including children and families Understanding childhood development and rights Nutrition needs in the adult and pediatric age group	Regular	Full-time	Out-patient / Homecare (oversees BNS)
Barangay Nutrition Scholar	Team member	Basic to Intermediate training in palliative and hospice care Communication skills including children and families Understanding childhood development and rights Nutrition needs in the adult and pediatric age group	Regular	Full-time	Home care

Rural Health Midwives	Team member / Coordinator	Basic to Intermediate training in adult and pediatric palliative and hospice care Communication skills including children and families Understanding childhood development and rights Coordinate and provide patient home care and appropriate reporting to a higher level when needed	Regular	Full-time	Home care (oversees BHWs)
Barangay Health Workers	Team member	Basic training in palliative and hospice care focusing on capability to recognize palliative needs and when to refer Recommended to have Caregivers training through TESDA Communication skills including children and families Understanding childhood development and rights Contribute to patient home care by offering emotional support, basic nursing tasks, help with mobility, reporting of uncontrolled distress to appropriate higher level	Regular	Full-time / Part-time	Home care
Social Worker	Team member	Basic to Intermediate training in palliative and hospice care	Regular / Visiting	Full-time / part-time	Referral as needed
Spiritual Care Provider	Team member	Basic to Intermediate training in palliative and hospice care Provision of spiritual support when needed	Visiting	Part-time	Referral as needed
Occupational Therapist / Physical Therapist / Speech, play music therapist	Team member	Basic to intermediate training for special needs in palliative and hospice care Provision of support therapies when appropriate	Visiting	Part-time	Referral as needed
Psychologist	Team member	Trained with basic to intermediate knowledge and skills to handle special psychosocial needs in palliative and hospice care Provide additional psychosocial support when necessary	Visiting	Part-time	Referral as needed
Palliative Care Specialist	Team member	Advanced training in palliative and hospice care Provide additional training, support, and guidance in doing palliative services in the community/home Can accept and coordinate referrals for possible admission when higher levels of care are needed	Visiting	Part-time	Referral as needed

Outpatient Palliative and Hospice Care

Palliative and hospice care should be incorporated in the usual outpatient consultation that is being done in the Rural Health Unit/City Health Unit. Each institution will need to develop their own algorithm/process flow in accordance to their setting.

Human Resource

Outpatient palliative and hospice care team with a minimum of intermediate training on palliative and hospice care, with the core team composed of a doctor and a nurse. Additional members of the team depending on needs may include nutritionist-dietician, pharmacists, social workers, spiritual care providers, palliative care specialists and other allied professionals.

Medicine and Equipment

The Out-patient clinic of the RHU/CHU should have a PDEA S-3 License, non-movable or immovable cabinet provided with double lock and with properly and correctly labeled medicines. Expired drugs or medicines shall follow the proper disposal policies or procedures imposed by the DENR. Dangerous drug preparations must be disposed of in accordance with the Regulations issued by the Dangerous Drugs Board. The RHU/CHU must have access to immediate release (IR) oral and injectable morphine to address the pain needs of palliative and hospice care patients. List of Essential medicines and equipment can be seen at Annex X and XI.

Processes

Outpatient profile

- The organization identifies the types of outpatients receiving complex care and/or with complex diagnoses who required an outpatient profile
- The necessary information to be included in the outpatient profile is identified by clinicians who treat those patient
- The organization uses a process that shall ensure the outpatient profile is easy to retrieve and review
- The process is evaluated to see if it meets the needs of the clinicians and improves the quality and safety of outpatient clinic visits.

Outpatient consultation

- Palliative and hospice care needs should be evaluated in the routine outpatient consultation.
- Checklist could be produced to facilitate the assessment.
- If there is a need for specialist care the patient should be guided and referred to the necessary specialist

Transportation

- The process for referring patients includes an assessment of transportation needs for patients who may require assistance.
- The transportation provided or arranged is appropriate to the needs and condition of the patient.

- Transport vehicles owned by the hospital meet relevant laws and regulations related to their operation, condition, and maintenance.
- Transportation services, including contracted services, meet the hospital's requirements for quality and safe transport.
- Staff responsible for monitoring the patient or providing other patient care during transport have the qualifications required for the type of patient being transferred
- All vehicles used for transportation contracted or hospital-owned, comply with the infection control program, and have appropriate medical equipment, supplies, and medications to meet the needs of the patient being transported.
- There is a process in place to monitor the quality and safety of transportation provided or arranged by the hospital, including a complaint process.

Palliative and Hospice Care in the Home

What is Home-based Palliative and Hospice Care?

Palliative care services can be offered in different settings, one of which is in the comfort of the patient's home. Home-based palliative care provides care to people with chronic, progressive, life-limiting or life-threatening health problems such as cancer, advanced cardiac, liver, renal and respiratory diseases, HIV/AIDS, and chronic neurological disorders, in the comfort of their home. It is best delivered by a multidisciplinary team trained in palliative care, including doctors, nurses, community health workers, and volunteers.

There are a number of advantages to home-based palliative care in many situations. For instance, many patients feel more comfortable in their home than in a health-care setting. A home-based service means that family members are integrated into the process, which in turn means that the patient has easy access to care. A home-based approach provides advice and support to family members to help them as caregivers, and the home-care team is able to facilitate referral to additional services.

On the one hand, home-based care helps the patient and family maintain privacy and confidentiality, but on the other hand, it helps to increase community awareness of palliative care. Local resources and support networks can be mobilized, and training can be provided by community health workers to others in the local area.

Requirements:

- Well-functioning system and workflow
- Important to have referral pathways in place to ensure a seamless transition for patients and their families
- Best delivered by a multidisciplinary team trained in palliative care (doctors, nurses, midwives, BHW, and volunteers)
- The family caregiver should take care of the patient as far as possible (for disabled patients, those near the end of life)
- The home environment must be safe for the home care team to visit

- A safe and accessible place for the team/nurse to store the medicines and equipment
- Transport system to enable the nurses/team to visit patients and their homes.
- Team members need mobile phones so that they can be in contact with patients and families round-the-clock
- Patients and their caregivers should be able to contact the home-care team outside of their visits through the use of teleconsultation/telemedicine options
- Referral to social health services to ensure care matches with patient's needs.

Facilities

The following can be done to prepare the home for palliative and hospice care.

- Remove obstacles and hazards.
    - Home environment should be free from obstructions and should be organized in a way that allows equipment, caregivers, and the patient to move freely in the living space.
- Find suitable place for a bed
    - The bed should be placed in an area that is safe and accessible, while allowing the patient to be comfortable.
    - If a patient is having difficulty getting in and out of a regular bed, a hospital bed can provide a safer and easier way for a patient to receive care. A hospital bed is roughly the size of a twin bed, with a moveable foot and head that can be elevated and lowered. The bed is normally wheeled and contains convertible bed rails for patient safety.
- Prepare the bathroom
    - Non-slip bath mats can help prevent slipping, as can grab bars or handrails
    - Raised toilet seats and shower chairs can keep the bathroom safe and accessible to the patient
- Organize a care folder
    - The folder should include details of all medical records, medications, doctors, and emergency contacts.
- Keep the comfort items
    - The main focus of hospice and palliative care is comfort, so when setting up the home for hospice and palliative care, keep any special or meaningful items such as favorite blanked or chair

Human Resource

Home care team with basic to intermediate training on palliative and hospice care, composed of a doctor, nurse, nutritionist-dietician, midwife, BHW, BNS and volunteers. Also depending on the need, patients could be referred to social workers, spiritual care providers, palliative care specialists and other allied professionals.

Medicine and Equipment

The RHU and CHU should ensure that the family has access to essential palliative and hospice care medicine and the RHU/CHU staff can provide emergency medicines during home visits of health care workers with the supervision of an S-2 licensed doctor.

Processes

Each institution will need to develop their own algorithm/process flow in accordance to their setting.

Community Palliative Care Service (Home visit)

- Good collaboration must exist between the palliative care service in the hospital and the community-based palliative care service in order to ensure continuity of palliative and hospice care services
- The community care team is composed of a medical officer, a nurse, midwife (serving as coordinator) and BHWs. They would be in close coordination with a medical specialist preferably a family medicine specialist or an experienced palliative care practitioner
- The role of the community team is to review patients as and when necessary in their homes, so as to provide continuity of care after discharge from the hospital
- Minor procedures may also be performed at home as long as consent is given. (Please see below)
- The community palliative team should meet regularly to discuss all cases on their list of patients to ensure all issues are covered
- A contact number after office hours should be available for patients requiring assistance at home and the trained community nurses/palliative home care nurses should have an on-call roster in order to answer calls to the contact number. The palliative trained medical officer on call should be available to assist the community nurse/palliative home care nurses in handling after office hours problems

Palliative Care Procedures in the Home

- In providing home care for terminally ill patients, doctors can undertake procedures to augment comfort and avoid the necessity for hospitalization
- **Subcutaneous drug administration** - when a patient cannot swallow oral medications and the rectal route is not appropriate for the administration of necessary drugs, trained family carers/caregivers can administer drugs via an intravenous cannula held in place with strapping and equipped with a plastic cap with a sterile membrane (Hep-lock) supervised by a licensed and trained palliative care provider. Examples of common palliative medicines given subcutaneously are Morphine, Oxycodone, Fentanyl, Metoclopramide, Dexamethasone, Hyoscine N-Butyl Bromide, Midazolam, Diphenhydramine HCl, Furosemide and Haloperidol
- **Subcutaneous hydration** - when oral intake becomes difficult and thirst is a problem, the provision of fluids by another route may be appropriate particularly if the cause of the inability to drink is temporary, or if it is not clear that the patient is in the very terminal phase, subcutaneous infusion by gravity is a convenient way to achieve steady and regular administration of drugs and fluids in a very terminally-ill patient provided that the procedure is administered by a certified palliative care provider or specialist
- **Use of a syringe driver** - battery-powered syringe driver is a more controlled way of delivering drugs subcutaneously, and is more appropriate where hydration is not an issue; the drawback is the units are quite expensive and are not necessarily superior to intermittent injections or gravity infusion

2. Palliative and Hospice Care in the Workplace

Workplace is defined by the Department of Labor and Employment as the office, premises or work site, where the workers are habitually employed and shall include the office or place where the workers, who have no fixed or definite work site, regularly report for assignment in the course of their employment.

The Department of Labor and Employment had created a manual on the Occupational Safety and Health Standards (OSH) that was amended last 1989 which provided a guide for employers to ensure the health and safety of their employees. Republic Act No. 11058 which was passed last 2018 aims to strengthen the compliance of these standards and provide penalties for their violations. The following section aims to include the palliative and hospice care to the current OSH standards.

Organization

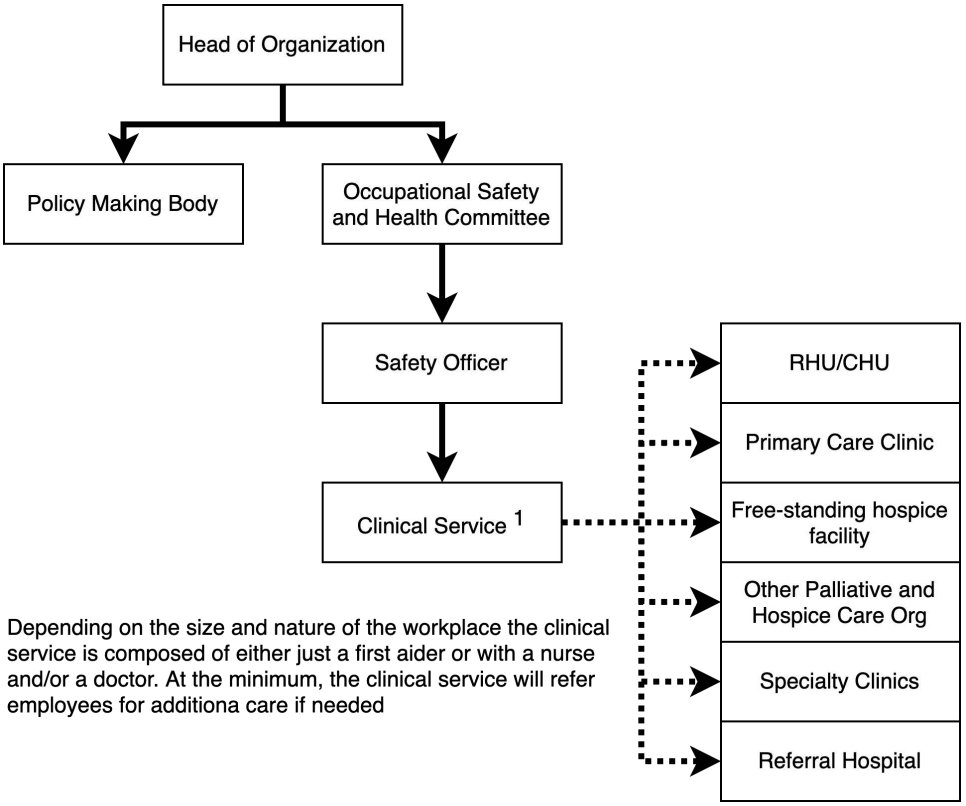


Figure 6. Organizational structure for palliative and hospice care in the workplace. It involves key figures within the organization and connections to and from the Rural Health Unit (RHU) or City Health Unit (CHU) where the workplace is located and other referral hospital or health service providers

Employer (Head of Organization)

- Oversees all efforts of the organization in promoting palliative and hospice care in the workplace
- Ensures that enough resources are provided for the palliative and hospice care initiatives

Policy Making Body

- Reviews and creates policies or guidance documents for palliative care, dying, death, and loss

Occupational Safety and Health Committee

- Ensures that Palliative and Hospice Care be included in the organization's OSH program

Safety Officer

- Oversees the overall implementation of the OSH program
- Must have basic knowledge on palliative care
- Oversees the clinical service
- Organizes advocacy campaigns and training to promote palliative and hospice care

Clinical Service (Doctor, Nurse, First Aider)

- At the minimum, navigates the palliative and hospice care delivery system and refers employees for additional care if needed
- If the workplace has a nurse or a doctor
    - Provides outpatient care service for employees
    - Holds the clinical information of employees
    - Provides yearly report to the human resource manager regarding the employees that receive palliative care and employees that are the primary caregiver and needs additional support

Scope of Service

At a minimum, the company clinic should have doctors, nurses or first aiders capable of providing a basic palliative care approach in the workplace. They need to follow guidelines on when to refer employees for further intervention. They shall work as additional resources and support for employees (as a patient and/or family member) in need of palliative care service. The palliative care programs should provide detailed information about palliative care in the workplace, counseling and bereavement support services. The company palliative programs can be initiated by the employer with support from palliative care professionals for any information or therapeutic interventions.

a. Clinical Service

- The organization should ensure that the palliative and hospice care needs of its employees are made available. Depending on the size and capacity of the organization, it could provide Out-patient primary palliative care, In-house or through a partnership with a primary care facility.

Table 3. Staffing for Clinical Service in the Workplace depending on the size of workplace

Staff	Role	Requirements	Position	Availability
Doctor	Team manager / member	Basic training in palliative and hospice care Capable of Mental Health and Psychological Support (MHPSS) service including psychological first aid S2 license	Regular staff	Full-time or Part-time (in-house for workplaces with low occupational health risk and with at least 200 workers or for workplaces with medium to high occupational health risk and with at least 100 workers otherwise through a partnership with a primary care facility)
Nurse	Team member	Basic training in palliative and hospice care Capable of Mental Health and Psychological Support (MHPSS) service including psychological first aid	Regular staff	Full-time or Part-time (in-house for workplaces with low occupational health risk and with at least 100 workers or for workplaces with medium to high occupational health risk and with at least 51 workers otherwise through partnership with a primary care facility)
Palliative Care Advocate (Staff / First Aider)	Team member	Orientation* in palliative and hospice care especially recognizing uncontrolled physical or psychological distress or significant social distress, first aid	Regular staff	Full-time (In-house for all)

* companies can partner with LGU / private training to give orientation to palliative care

Medication and Equipment:

- The outpatient service both in-house or a partner primary care facility should have adequate amounts of essential medicines in stock and complete essential equipment. Please see Annex X and XI A.
- Policies should be implemented in conformity with the proper storage system, recording, reporting, labeling, inventory, prescribing, dispensing and disposal of drugs. See Annex XI B & C

Sample Out-Patient Consultation Process Flow

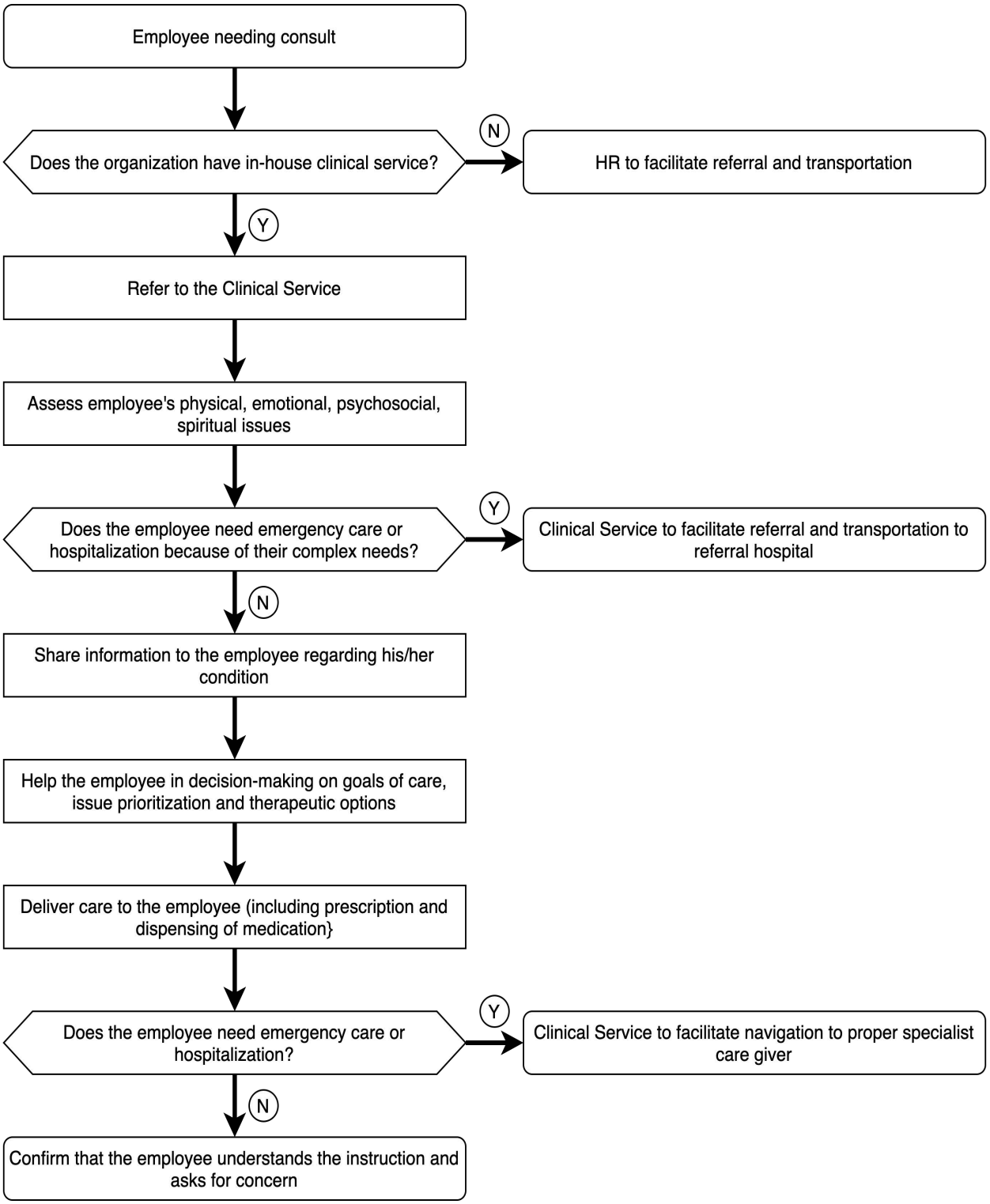


Figure 7. Sample Outpatient Consultation Flowchart for the Employee in the Workplace

Information management: The company clinic both in-house or outsourced must ensure proper data management by filing patient information in electronic medical records and securing them as mandated under the data privacy act. Company clinics should have a policy to ensure that they have access to needed medicine and facilitate referral to a palliative care center for appropriate care of a specialist.

b. Advocacy

- Advocating for palliative and hospice care in the workplace shall be included in the Occupational Safety and Health (OSH) program of the organization and the OSH committee shall be responsible in its implementation. This could include an orientation on palliative care, talks on serious illness, end-of-life care and bereavement, and setting up support groups.

c. Policies to Promote Palliative Care in the Workplace

- The policy-making body of the organization should ensure that policies of the organization promote the welfare of employees receiving palliative care as well as employees that are the primary caregiver for patients with a terminal illness.

  This may include the following:

  - Creating a support group or referring to a support group for employees that are palliative and hospice care patients or primary caregivers of patients
  - Social safety nets such as paid leaves for palliative care patients and caregivers
  - Could also provide monetary assistance for employees who have a family member that is a palliative or hospice care patient in order for them to pay for home caregivers
  - Possible different or flexible working arrangements. A work from home is an example of a flexible working arrangement

Accreditation and Monitoring

The company/workplace clinic must be part of a healthcare provider network in which the design follows the DOH AO No. 2020-019 and are subject to monitoring and evaluation. Regular reporting and evaluation of palliative care services should be done annually.

3. Palliative and Hospice Care in the Schools

Palliative and hospice care shall be advocated in schools. This shall be done through creating awareness for primary, secondary and collegiate students, training guidance counselors on principles of palliative and hospice care, creating support groups for students who are palliative and hospice care patients, have family members that are patients or currently grieving.

The Department of Education and the Commission on Higher Education shall help schools in all levels to create policies to promote palliative and hospice care such as student leaves for those that need to take care of family members in hospice care.

C. Palliative and Hospice Care in the Hospital

This subsection includes key principles and guidance for palliative and hospice care in the hospital setting including Level 1, 2, 3 and Apex hospitals. Hospitals play a significant role in identifying, caring and supporting patients in need of palliative care. Transitioning and coordinating these patients as well as facilitating their care to and from the community is important in strengthening and implementing the integration of palliative and hospice care in the Philippine healthcare system.

Hospital-Based Palliative and Hospice Care

The universal health care law had indicated that every Filipino shall be granted access to palliative care. With this all hospitals must have a palliative and hospice care service. It improves patient outcomes. The on-site availability of different specialties and ancillary procedures makes the care more comprehensive and makes it easier to facilitate discussion of the patient's condition including values, diagnosis, prognosis, and agreement about the goals of care.

A hospital-based palliative and hospice care service generally reduces a patient's length of stay in hospital and enables a smooth transition to care in the community. It also reduces the use of non-beneficial or harmful treatments near the end of life. Apart from the benefits for specific patients, it also allows the positive impact of palliative care to all hospital staff, helping health workers in other disciplines learn about palliative and hospice care and promoting its further use.

Organization

Organizational Structure for Level 1 and Level 2 Hospital

- The Hospital Palliative and Hospice Care Team in Level 1 (non-departmentalized) and Level 2 (departmentalized) Hospitals shall be under the responsibility of the medical service.
- The head of the palliative care service should be ideally a palliative medicine doctor with advanced or specialist training. In the absence of such, intermediate training in palliative and hospice care is the minimum requirement for all doctors and nurses who shall be part of the palliative and hospice care team.
- Other recommended members of the team include staff from allied medical services like pharmacists, nutritionists, psychologists, social workers and spiritual care providers.

Organizational Structure for Level 3 and Apex End-Referral Hospital

- The Palliative and Hospice Care Team in Level 3 and Apex End-Referral Hospitals shall be under the hospital director and the palliative care unit shall be administratively managed by the head or medical chief of medical personnel staff. It should be headed by a trained Palliative and Hospice Care specialist.
- The head of the palliative care team shall be responsible for clinical management of patients, and supervision of medical officers, procurement of equipment and

consumables, development of clinical care pathways and protocols to cater to local needs and continuing medical education program.

- The assigning of human resources for the provision of palliative and hospice care service shall be under the decision of the hospital director. Nursing service staff dedicated specifically to the palliative care unit should have advanced training in palliative and hospice nursing care (both adult and pediatric).
- Inter-/Transdisciplinary care for patients needing palliative and hospice care is necessary to provide a holistic team approach. The involvement of other subspecialties, allied medical, and ancillary professionals with enough palliative basic to intermediate knowledge is required of the team members.

Scope of Service

The scope of service of the palliative and hospice care team in the hospital covers both cancer and non-cancer patients with progressive life-threatening conditions including:

- Medical management of chronic cancer pain and other distressing physical symptoms related to advanced cancer
    - Including metastatic or locally advanced incurable cancer
    - Difficult to control physical or psychological symptoms (e.g. moderate to severe symptom intensity for more than 24-48 hours) like pain or dyspnea
- Medical management of pain and other distressing physical symptoms related to progressive life-threatening non-cancerous illnesses including:
    - End-stage cardiac disease with refractory symptoms
    - End-stage liver disease with refractory symptoms
    - End-stage pulmonary disease with refractory symptoms/Severe chronic airway limitation with deteriorating respiratory function and poor candidate for ventilatory support
    - End-stage renal disease where dialysis support is not feasible or is withdrawn
    - Progressive neurodegenerative disorders (i.e. Motor Neuron Disease, Multiple Sclerosis
    - Life-threatening pediatric conditions including life-threatening congenital disorders
    - HIV / AIDS not responding to anti-retroviral therapy or rapidly deteriorating due to overwhelming disease-related complications (infections or malignancy).
    - XDR-TB / MDR – TB not responding to therapy or rapidly deteriorating due to disease complications
    - Frailty in the elderly with multiple progressive comorbidities in collaboration with a geriatrician
- Provision of psychosocial, emotional, and spiritual supportive care to patients and families facing life-threatening illness
- Provision of terminal care for patients at the end of life
- Provision of respite care for patients and families
- Provision of a holistic management plan to optimize the quality of life throughout the course of patients' illness and to apply a multidisciplinary approach to care

- Provision of consultative advice and assistance to other medical colleagues regarding palliative management of patients with life-threatening situations under their care
- The service should collaborate with oncology and interventional radiology service when required for the treatment of cancer pain and other distressing physical symptoms
- The service should coordinate and provide community palliative and hospice care support where possible
- The service should play a role in the teaching and promotion of palliative and hospice care

Core Functions and Operation

Main components of Palliative and Hospice Care Services in the Hospital

- **In-patient palliative and Hospice Care Unit**
  - It has dedicated palliative care beds (which can be reprofiled from existing beds) with staff trained in palliative and hospice care present 24 hours a day.
  - The unit enables more consistent care to be provided and also makes it easier to monitor quality of life and to create a more accommodating environment for family members.
  - An in-patient palliative care unit may also serve as a demonstration unit and training hub for the rest of the hospital.

- **Palliative and hospice care consultation service for hospital in-patients**
  - It offers consultations to inpatients of other departments of the hospital.
  - The service can be a simple add-on to an outpatient clinic using the same staff.
  - The consultation service has the potential to build the capacity of other staff in pain management, palliative, and hospice care.

- **Outpatient palliative and hospice care clinic**
  - It can offer low-cost care to a large number of mobile or ambulatory palliative patients and, when coupled with an inpatient consultation service, is the best model if resources and start-up funding are limited
  - Care can be provided by a nurse, social worker, or doctor (or ideally a team including all three). Psychologists and spiritual care providers, nutritionists, and physical therapists also perform important roles in some settings.
  - Patients may be referred to the clinic for pain management, symptom control, nursing needs, or psychosocial support.

- **Ambulatory Care and/or Daycare service**
  - It can be added to an outpatient clinic or inpatient consultation service in order to offer stabilization of symptoms, respite for caregivers, and counseling of both patient and family.
  - The service can also deal with longer procedures, such as draining of ascitic fluid and wound care, as well as injections and education of family caregivers.

- Daycare can also play an important social role (e.g. providing food and companionship) or rehabilitative function (e.g. physiotherapy or occupational therapy).

- **Palliative care Outreach/Home-Care Service**
  - It is a mobile service of the hospital that brings care to patients who are not able to travel to seek treatment.
  - This kind of service requires little infrastructure and places minimal demands on the hospital.
  - Care can be delivered by the staff of the palliative care outpatient clinic and one of the important features of the outreach service is that it harnesses the strengths of family caregivers.

- **Teleconsultation / Telemedicine service**
  - It can be added to an outpatient clinic or inpatient consultation service to allow palliative or hospice consultations via phone call, chat, short messaging service, or audio- or video-conferencing especially for situations that limit doing face-to-face meetings (i.e. geographic distance, or in a pandemic situation)
  - It can allow physician issuance of electronic clinical abstracts, referrals, prescriptions within a telemedicine consultation (see Annex XII)

Persons / Staff Requirements

Table 4. Recommended Minimum Staffing for Palliative and Hospice Care Team in Level 1 and 2 Hospitals

	Role	Skills Required	Position	Availability	# per team
Doctor	Team manager / member	Minimum of basic and intermediate training in palliative and hospice care Communication skills with adults, children and families Understanding childhood development and rights Nutrition	Regular staff	Full-time or Part-time	1
Nurse	Team member / Coordinator	Minimum of basic and intermediate training in palliative and hospice care Communication skills with adults, children and families Understanding childhood development and rights Nutrition	Regular staff	Full-time	1
Nursing Aides / Caregivers	Team member	Basic to Intermediate training in palliative care Communication skills with adults, and or children and families Understanding childhood development and rights	Regular staff	Full-time	2-3
Social Worker / Care Navigator / Spiritual Care Provider / Child Life Specialist	Team member for psychosocial care, with access to social security funds/grants, where available	Basic to intermediate training in palliative care Communication skills with adults, and children and families Understanding childhood development and rights shall work as a care navigator	Regular staff	Full-time / part-time	1

Table 5. Recommended Minimum Staffing for Palliative and Hospice Care Team in Level 3 and Apex / End-Referral Hospitals

	Role	Skills Required	Position	Availability	# / team
Palliative Care Doctor / Physician (Adult)	Team manager / Team member	Advanced training in adult palliative and hospice care	Regular staff	Full-time	>2
Palliative Care Doctor (Pediatric)	Team manager / Team member	Advanced training in pediatric palliative and hospice care	Regular staff	Full-time	1
Palliative Care Nurse (Adult)	Team member	Advanced training in adult palliative and hospice nursing care	Regular staff	Full-time	>1
Palliative Care Nurse (Pediatric)	Team member	Advanced training in pediatric palliative and hospice nursing care	Regular staff	Full-time	1
Nursing Aides and Palliative Health Aides/Caregivers	Team member	Basic to Intermediate training in palliative and hospice care to assist staff nurses in clinical work	Regular staff	Full-time	≥2
Pharmacist	Team member	Intermediate training in palliative and hospice care	Regular staff	Full-time	1
Nutritionist Dietitian	Team member	Trained with intermediate knowledge and skills for special needs in palliative and hospice care	Regular staff	Full-time	1
Psychologist (Child and Adult) / Child Life Specialist	Team member	Trained with intermediate to advanced knowledge and skills for special needs in palliative and hospice care	Regular staff / Visiting	Full-time	1
Rehabilitation Specialist (PT/OT/Play therapist)	Team member	Trained with intermediate knowledge and skills for special needs in palliative and hospice care	Regular staff / Visiting	Full-time / part-time	1
Care Navigator or Social Worker	Team member	Trained with intermediate knowledge and skills for special needs in palliative and hospice care	Regular staff	Full-time	1
Spiritual Care Provider	Team member	Trained with intermediate knowledge and skills for special needs in palliative and hospice care	Regular staff	Full-time	1
Other Subspecialties like Oncology / Anesthesiology / Surgery / Gynecology / IM / Pediatrics / Psychiatry / Physician Nutrition Specialist / Nutrition Support Physician (adult or pediatric)	Team member	Trained with intermediate knowledge and skills for special needs in palliative and hospice care Provide interdisciplinary support in the care of the palliative/ hospice patient as applicable based on their specialty	Regular staff / visiting	Full-time / part-time	Depends on need and availability

Capacity building of Human Resource for Palliative and Hospice Care

All medical officers, nurses, and staff newly assigned to a palliative care unit or service should undergo a period of basic training in palliative care and skills training in order to enable them to understand the philosophy of care and management of patients in the palliative care setting.

- In units where there is a consultant palliative medicine physician, medical officers new to palliative medicine should undergo intermediate level / in-house training and a period of supervised "tagging" before they can independently be placed on call and the specialist in charge should determine the readiness of the medical officer to handle on-call duties
- If there is no experienced consultant available, training can be obtained through clinical attachments in centers such as in UP-Philippine General Hospital, Southern Philippines Medical Center, Jose B. Lingad Memorial Regional Medical Center among others where trained consultants in palliative medicine are available. Observership and short courses run by private palliative organizations (like in Medical City and ActivCare Home Health Solutions) and NGOs such as The Ruth Foundation, Kythe Foundation, Madre de Amor Hospice Foundation, Palcare Hospice Foundation and other palliative care organizations are also available where expert speakers are employed to provide a good resource for training of medical officers.
- Nurses new to the concept of palliative care should also undergo a period of in-house training and supervision to introduce them to the field
- Formal training in the form of an advanced diploma in palliative care nursing may be available in the near future and all services should look towards encouraging such formal training among staff who are interested
- Clinical attachments and short courses in palliative care are also helpful to provide informal training by centers where more expertise is available

- Continuing medical and nursing education sessions for both doctors and nurses should be conducted and contributions by all doctors and nurses are compulsory with activities including journal club discussions, case presentations, academic meetings, workshops, and CME talks by accredited CPD providers and the pharmaceutical industry
- Other regular and visiting staff in the interdisciplinary palliative and hospice care team should have at least a basic to intermediate level of training in palliative and hospice care and have a good grasp of the discipline to be able to support the team in caring for the patients and their families holistically
- Areas of basic knowledge for managing palliative care services include the following:
  - Introduction and General Principles of Palliative Care
  - The Palliative Care Approach
  - Communication skills in Palliative Care
  - Hospice Care
  - Grief and Bereavement
- Areas of Intermediate Training for palliative care services include the following:
  - Palliative and Hospice Care Introduction
  - Pain Management in Palliative and Hospice Care
  - Symptom Management

- The Art of Listening and Effective Communication
- Cultural and Spiritual Care
- Ethical Considerations in End-of-Life Care
- Loss, Grief and Bereavement Care
- Final Hours Management
- Pediatric Palliative and Hospice Care
- Nutrition and Physical Medicine in Palliative Care
- Special Topics like Palliative Care for Vulnerable Groups / Special Populations / Situations, Palliative Care and Telemedicine
- Teaching Primary Palliative Care to Community Health Workers

Equipment and Palliative Care Unit

- All equipment and stock of disposables are the responsibility of the palliative care unit nurse who may delegate the duties of keeping track of palliative care equipment in the ward
- Equipment belonging to the palliative care service may be lent to patients who are discharged home and require specialized equipment to ensure the continuity of care and comfort. In such circumstances, the palliative care service should have its own local policy regarding how this should be done to ensure safe return of equipment. Please see Annex XI for a list of equipment.
- The palliative care unit can be a dedicated room or ward with complete staff, devices, vital signs monitoring equipment and other necessary materials specific to the care of palliative and hospice care patients which may include hospital bed, blood pressure apparatus, oxygen source, pulse oximeter, commode, IV stand, infusion pumps, Patient Controlled Analgesia (PCA) machine and others deemed necessary to maintain patient's comfort and quality of life
- In line with the DOH Department Order 2021-0001, specialty centers, like renal care centers, lung care centers, orthopedic centers, physical and rehabilitation medicine centers, brain and spine care centers, geriatric centers, eye care centers, dermatology centers, cancer centers, and mental health facilities, shall have palliative and hospice care in their framework of services

4. Hospital Services

Hospitals are expected to ensure palliative and hospice care services are provided by a core team composed of a doctor, nurse, nurse aide and social worker all trained in palliative and hospice care. All persons / staff engaged in the service should be able to effectively provide all 8 domains of palliative care service namely:

1. **Structure and processes of care** - palliative care principles are delivered as part of an interdisciplinary team, with professional qualifications, education, training, and support needed to deliver optimal patient-centered and family-focused care with emphasis on coordination of care to ensure sustainability especially when transitioning to and from the hospital back to the community

2. **Physical aspect of care** - focusing on relieving symptoms and maintaining functional status and quality of life; emphasizing on symptom management including pharmacological, non-pharmacological, interventional, behavioral, and complementary treatments
3. **Psychological and psychiatric aspects of care** - by conducting comprehensive developmentally and culturally sensitive mental status screening and facilitating mental health assessment and treatment and effectively communicating the implications of psychological and psychiatric aspects of care to the patients and family
4. **Social aspects of care** - social determinants of health influences care outcomes, the interdisciplinary team must partner with the patient and family to identify strengths and needs to address environmental and social factors that affect the patient making social workers essential players in the interdisciplinary team
5. **Spiritual, religious and existential aspects of care** - spirituality is a fundamental aspect of palliative care expressed through beliefs, values, traditions, and practices and the interdisciplinary team respects all spiritual beliefs, practices and recognizes the dynamism in which persons seek meaning, purpose, and experience relationships; also respects the autonomy of patients and families even when they decline to talk about their belief or refuse to accept support
6. **Cultural aspects of care** - care plans must incorporate culturally sensitive resources and strategies with respectful knowledge and support for grieving practices and the interdisciplinary team members continuously increase their awareness of own biases and perceptions to be more culturally sensitive to patient belief, values and traditions
7. **Care of the patient nearing end of life** - with particular emphasis to care on the days leading up to and just after the death of a patient, involving a comprehensive assessment and management of physical, social, spiritual, psychological, and cultural aspects of care near death; providing appropriate education to patient, family and other people involved in this equally important time of the patient's life, where an interdisciplinary model of hospice care is recognized to be the best care support to optimize outcomes
8. **Ethical and legal aspects of care** - applying the principles of ethics to the care of patients with serious life-limiting or life-threatening illness, including honoring preferences, and decisions made by surrogates that represents the best interest of the patients; important to have familiarity with local laws needed in relating to advance care planning, decision-making with regards to life-sustaining treatments, and evolving treatments with legal ramifications like the use of medical marijuana

In-patient Service and Palliative Care Unit Admission

- New admissions should be seen by the specialist in charge within 24 hours of admission.
- The individuals responsible for the coordination of the patient's care is identified in the patient's medical record and available through all phases of inpatient care.
- Nursing staff should work on a shift basis and the number of beds available in the ward depends on the number of staff nurses available.
- Nurses are required to be familiar in intermediate/advanced palliative care nursing skills including appropriate use of analgesics and the use of simple devices such as subcutaneous line, infusion pumps, syringe drivers, or if available Patient Controlled Analgesia (PCA).

- Observation of vital signs and symptoms should be done according to assessment, evaluation and recommendation of the palliative care specialist/palliative care provider for symptoms that may need attending to.
- Patients requiring in-patient service admission during office hours may be admitted directly to the palliative care ward after being reviewed as a "walk-in-review", from the outpatient clinic, from the ER, or as a scheduled admission from the community after review by the community palliative care service.
- After office hours, patients known to the palliative care unit should be admitted to the unit through the ER unless stated otherwise in the local hospital policy. In such situations, the medical officer on call should be informed and appropriate management and investigations should be organized in the ER before admission to the ward.
- Patients who are admitted after office hours and are in severe distress or acutely/rapidly deteriorating should be seen by the duty palliative care physician or by the medical officer on call and be referred to palliative care specialist if necessary.
- Patients who are not known to the palliative care team and are referred by ER after office hours should NOT be admitted to the palliative care unit directly if there is no available duty palliative care specialist and/or physician provider. This is to prevent misunderstandings among the family and caregivers who may not be familiar with the role of the palliative care unit or may not be adequately informed regarding the patient's condition and prognosis. They should therefore be admitted to the primary team in charge of the patient's prior care after advice on symptom management given by the medical officer on call. The patient should then be seen the following morning by the medical officer or specialist on call and may be transferred to the palliative care unit if deemed appropriate after adequate counseling and discussion with the family on the prognosis and advanced care plan for the patient in the palliative care unit.
- The family and caregivers of all patients admitted to the palliative care unit should be made aware of the role of the palliative care unit and the status of the patient's disease as well as the intent of treatment. They should be aware that in palliative care patients, resuscitation is often inappropriate and futile if the deterioration is due to their primary disease. All discussions with the family regarding advanced care plans and resuscitation should be well documented.

Consultative Service / Referrals

- All referrals must be made by the primary team with a proper referral letter summarizing patients' history and problems.
- Referrals are seen during office hours (Monday to Friday 8 am-5 pm, and on Saturday Sunday or holiday from 8 am-12noon), and new cases are seen within 24 hours of referral. Patients with severe distressing symptoms should be seen immediately.
- New referrals which are categorized as non-emergency medical/psychosocial should be reviewed by a specialist palliative medicine physician at least once within the week of referral.
- Patients under the care of the consultative team may require review by the medical officer on call over weekends and public holidays if deemed necessary.
- Large units may employ the services of a nurse coordinator who shall follow up on all new referrals and look into all palliative care nursing issues with relation to the patient.

Education of staff in other wards with regards to pain management techniques and monitoring is also the role of the palliative/hospice nurse coordinator.

- If no further active management is planned by the referring team and the patient's care is primarily palliative, the patient may then be taken over to the palliative care unit for further care if agreed upon by the family.
- Good collaboration between the consultative team and the primary team should exist throughout the care of the patient and active discussions regarding the best management options for the patient should be facilitated to encourage holistic multidisciplinary care
- Patients who are discharged from the primary team ward may either be followed up by community care teams or be given a follow-up appointment in the palliative care outpatient clinic. Discharge medication and planning should be organized by the primary team.
- If patients previously seen by the palliative care consultative team come into the emergency department, the patient should not be automatically transferred under the care of the palliative care team unless the patient or the next of kin has expressed that their reason for admission is to utilize the hospice services of the hospital and opt for comfort measures during the terminal phase or end of life stage of the patient. If otherwise, the primary team should still be informed. If the reason for the emergency department visit is related to previous intervention by the primary team such as post-op sepsis, neutropenic sepsis, deconditioning post-procedure, etc. then the patient should be admitted under the primary team. The palliative care consultative team shall still make themselves available for assistance in managing symptoms in such cases.

Outpatient clinic

- The outpatient palliative care clinic is for follow up of patients who are still fairly ambulatory and have a good performance status.
- The clinic should be at fixed times. However, if patients have urgent problems, walk-in reviews are acceptable. The respective palliative care service should develop its own local policy regarding "walk-in-reviews" as to how and where this should be conducted and what patients should expect in order to be reviewed when necessary.
- Clinic reviews should be conducted by the specialists and medical officers of the palliative care unit and consultative team. If there is a community team available, they should also assist in clinic reviews.
- Medications should be provided in sufficient amounts until the next clinic review.
- Patients who are becoming too ill to attend regular clinic appointments should then continue to follow up by means of telemedicine (teleconsultation and e-prescription) or community care. Medications may be continued through E-Prescription, by the community team or may be obtained from the clinic by proxy whatever is applicable to the patient/family.

Community Palliative Care Service (Home Care)

- At present, the majority of community palliative care services are run by Private Organizations or a Non-Governmental Organizations (NGOs) - hospice organizations, and eventually, the rural health units shall be the main providers and coordinators of community health care services, hence where such community-based palliative care services are available, this component of care may not be duplicated by the hospital.

- Equipment belonging to the community palliative care service may be lent to patients being managed at home that require specialized care to ensure the continuity of care and comfort. The community palliative care service should have its own policy regarding on rentals whether a cash deposit is required to ensure safe return of equipment. Please see Annex XI for list of equipment.
- Good collaboration must exist between the palliative care service in the hospital and the community-based palliative care service of private organizations, NGO's, the RHUs and CHUs in order to ensure continuity of care
- A specialist, or a palliative care provider should be in close coordination with the community palliative care team of the RHUs/CHUs.
- The lead specialist or palliative care provider should meet regularly with the entire palliative care department to discuss all cases on their list of patients to ensure all issues are covered
- A contact number after office hours should be available for patients requiring assistance at home and the community nurses should have an on-call roster in order to answer calls to the contact number. The medical officer/trained palliative care provider on call should be available to assist the community nurse in handling after office hours problems

Continuity of Care

- The leaders of departments and services should design and implement processes that support continuity of and coordination of care including at least
    - Emergency services and inpatient admission
    - Diagnostic services and treatment services
    - Surgical and nonsurgical treatment services
    - Outpatient care programs; and
    - Other organizations and other care settings.
- Continuity and coordination of care processes are supported by the use of tools, such as care plans or guidelines, and must be evident throughout all phases of patient care
- There has to be a process for transferring the responsibility for coordination of care from one individual to another individual; The process identifies how these individuals assume the transferred responsibility and document their participation or coverage
- Patients and families are educated about:
    - the safe and effective use of all medications, potential side effects of medications, and prevention of potential interactions with over-the-counter medications and/or food
    - the safe and effective use of medical equipment
    - proper diet and nutrition
    - pain management
    - different routes of medications
    - rehabilitation techniques
    - proper waste disposal management (proper handling, segregation, collection, treatment and disposal of wastes like infectious body fluids or objects, hazardous and sharp objects) according to local sanitary regulations

Administrative and Support process

Patient and Family Oriented Medical Record

- The patient's medical records are a primary source of information on the care process and the patient's progress and thus is an essential communication tool. For this information to be useful and to support the continuity of the patient's care, it needs to be available during inpatient care, outpatient visits, and at other times as needed and kept up to date. Medical, nursing, and other patient care notes are available to all the patient's health care practitioners who need them for the care of the patient
- The patient's medical record or a summary of patient care information is transferred with the patient to another service or unit in the hospital. The summary contains the following:
    - Reason for admission
    - Significant findings
    - Any diagnosis made
    - Prognosis
    - Goals of care
    - Any procedures performed, medications administered, and other treatments provided
    - The patient's condition at transfer

Discharge summary

- The discharge summary contains the following:
    - Reason(s) for admission, diagnosis, and comorbidities
    - Significant physical and other findings
    - Diagnostic and therapeutic procedures performed.
    - Significant medications, including all discharge medications
    - The patient's condition/status at the time of discharge.
    - Goals of care, advance care planning documents including advance directives in the hospital if available
    - Home care instructions and special procedures at home
    - Follow-up instructions and contact numbers
- A discharge summary is placed in the inpatient's medical record
- It is prepared by the Attending/Primary Care Physician or Physician involved in the care of the patient
- A copy of the discharge summary is provided to the practitioner responsible for the patient's continuing follow-up care
- A copy of the discharge summary is provided to the patient in cases in which information regarding the practitioner for the patient's continuing or follow-up care is unknown
- A copy of the completed discharge summary is placed in the patient's medical record in a time frame identified by the hospital

Out-Patient Profile

- The hospital identifies the types of outpatients receiving complex care and/or with complex diagnoses who required an out-patient profile
- The necessary information to be included in the out-patient profile is identified by clinicians who treat those patients

- The hospital uses a process that shall endure the out-patient profile is easy to retrieve and review
- The process is evaluated to see if it meets the needs of the clinicians and improves the quality and safety of out-patient clinic visits

Transportation

- The process for referring and/or discharging patients includes an assessment of transportation needs for patients who may require assistance
- The transportation provided or arranged has to be appropriate to the needs and condition of the patient
- Transport vehicles owned by the hospital should meet relevant laws and regulations related to their operation, condition, and maintenance
- Transportation services, including contracted services, should meet the hospital's requirements for quality and safe transport
- Staff responsible for monitoring the patient or providing other patient care during transport should have the qualifications required for the type of patient being transferred
- All vehicles used for transportation contracted or hospital-owned, should comply with the infection control program, and have appropriate medical equipment, supplies, and medications to meet the needs of the patient being transported
- There has to be a process in place to monitor the quality and safety of transportation provided or arranged by the hospital, including a complaint process
- Ensures that guidelines for delivery of dangerous drug preparations from the health facility to the patient through a service provider must be strictly implemented pursuant to Section 6 paragraph 20 of Board Regulation No. 1, Series of 2014.

Documentation

- Record keeping of all opioid drugs used by the department should be kept for a period of two years and the prescription for dangerous drugs must be kept for a period of One year by the pharmacist, nursing staff, and doctors
- Department meetings are to be held as required with all members of staff and should be documented by an appointed department secretary
- Funding palliative and hospice care services should be under the hospital director budget plan and reimbursements claims from PhilHealth in the future

Process Flow

Each hospital institution shall develop their own algorithm/process flow in accordance to their setting.

<u>Criteria for admission to a Palliative Care Unit may include:</u>

- Patients who are known to the palliative care service presenting with any of the following:
  - with acute deterioration of symptoms or condition requiring stabilization
  - who are dying and the family request for terminal care in the hospital
  - who require minor procedures such as a pleural tap or peritoneal tap

    - who require respite care due to social issues
    - who are in acute psychosocial crisis and require a safe place to work out issues
  - Patients seen by consultative teams and felt appropriate for transfer to the palliative care unit after approval of the specialist in charge

Discharging of Patients

- Patients are discharged based on their health status and needs for continuing care
- Readiness for discharge is determined by the use of relevant criteria or indications that ensure patient safety
- There is a process for patients being permitted to leave the hospital during the planned course of treatment on an approved pass for a defined period of time
- All patients should have appropriate discharge planning before discharge from the ward. A referral to an appropriate community care team should be made and follow up updates in the clinic arranged.
- The discharge planning process includes the need for both support services and continuing medical services
- Patients who are terminally ill and dying and request to be discharged should still be provided all medication deemed essential. If medication required include parenteral drugs, then an appropriate amount should be provided in the form of ampules or pre-filled syringes and the patient's carers should be advised on how they are to be administered. The respective palliative care service should develop a local policy as to how much medication can be supplied at one time and if further medication is required. An appropriate system should be in place to enable the family/carers to obtain such medication.
- For patients who are going home taking large amounts of opioid analgesia, discharge instructions and Special prescription form for Dangerous Drugs (yellow prescription) should be provided to explain the need for this medication which comes under the Dangerous Drugs Act.
- The complete discharge summary is prepared for all inpatients
- Referrals outside the hospital can be addressed to specific individuals and agencies in the patient's home community whenever possible
- Referrals are made for support services (such as spiritual, psychosocial, financial support)
- Follow-up instructions are provided in a language the patient understands
- Follow-up instructions are provided in writing, verbally and/or in another form the patient understands
- The instructions include any return for follow-up care
- The instructions include when to obtain urgent care

Home Against Medical Advice

- Admitted patients who are still receiving disease modifying interventions and decide to discontinue any further management in the Hospital Setting should be informed of the risks and consequences of such a decision.
- The patient should be discharged according to the hospital discharge process

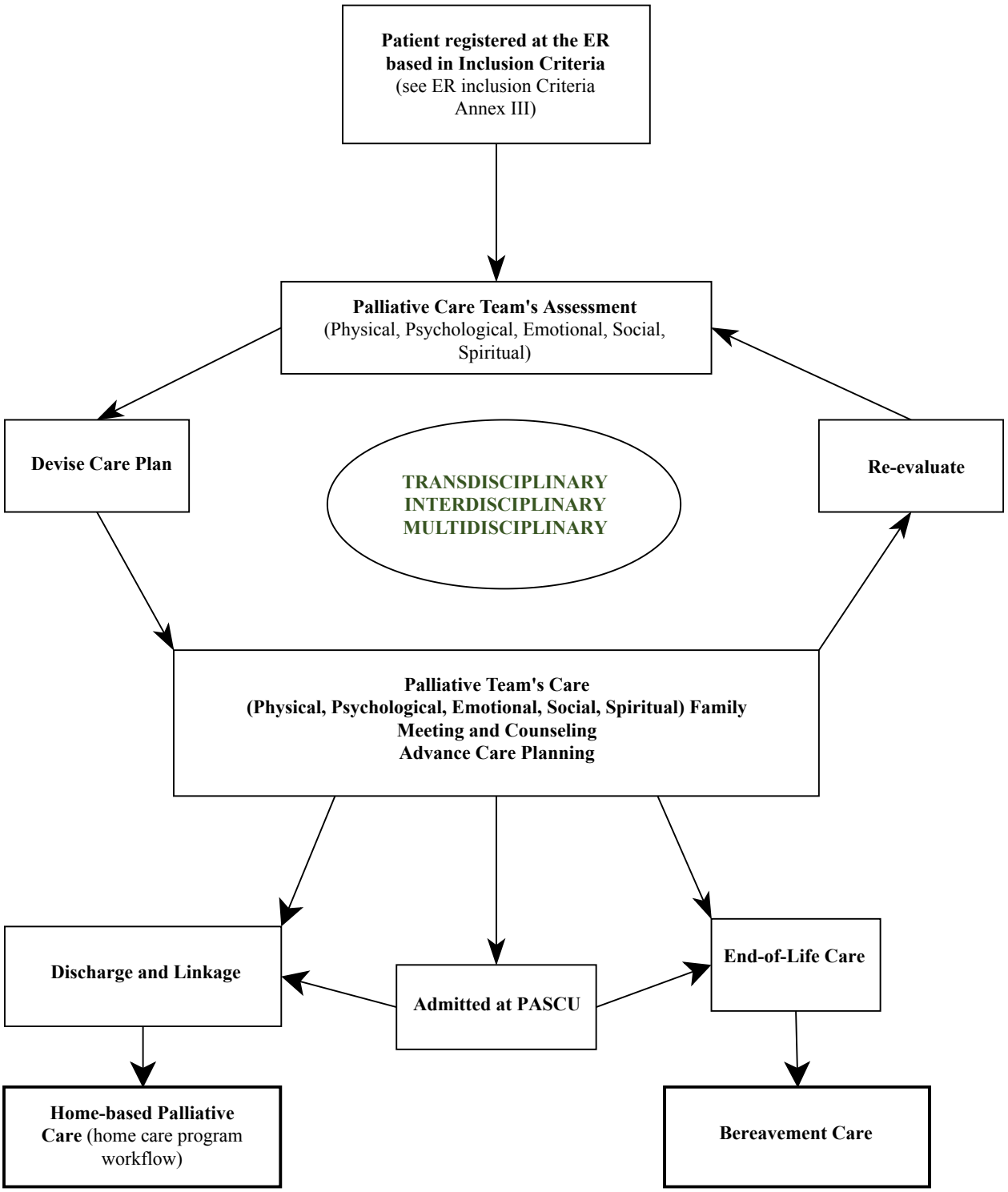
- If the physician of a patient leaving against medical advice is known and has not been involved in the process, the physician is notified
- The hospital has a process to try to identify the reasons for patients leaving against medical advice
- The process is consistent with applicable laws and regulations, including requirements for reporting cases of infectious disease and cases in which patients may be a threat to themselves or others

Transfer of patients

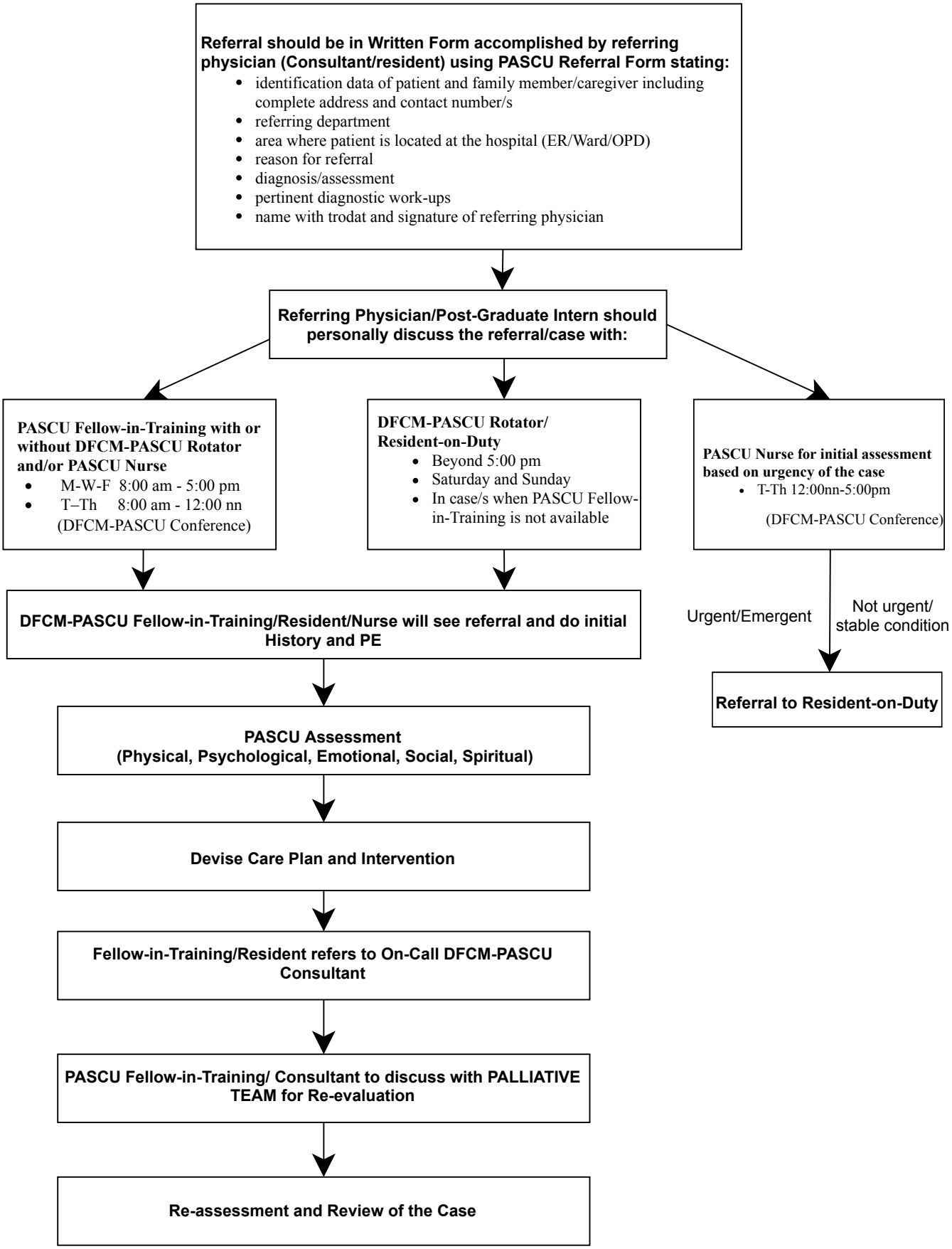
- Transfers of patients are based on criteria developed by the hospital to address patients' needs for continuing care
- The referring hospital determines that the receiving organization can meet the needs of the patient to be transferred
- Formal or informal arrangements are in place with receiving organizations when patients are frequently transferred to the same organizations
- The hospital develops a transfer process that addresses how and when responsibility for continuing care is moved to another practitioner or setting
- The transfer process identifies who is responsible for monitoring the patient during transfer and the staff qualifications required for the type of patient being transferred
- The transfer process identifies the medications, supplies, and medical equipment required during transport
- The transfer process addresses a follow-up mechanism that provides information about the patient's condition upon arrival to the receiving organization
- The transfer process addresses the situations in which transfer is not possible
- There is a process to evaluate the quality and safety of the transfer process
- The receiving organization is given a written summary of the patient's clinical condition, the interventions provided by the referring hospital and goals of care and directives.
- The transfer process is documented in the patient's medical record

Sample Palliative Services Workflow and Forms from Jose B. Lingad Memorial General Hospital

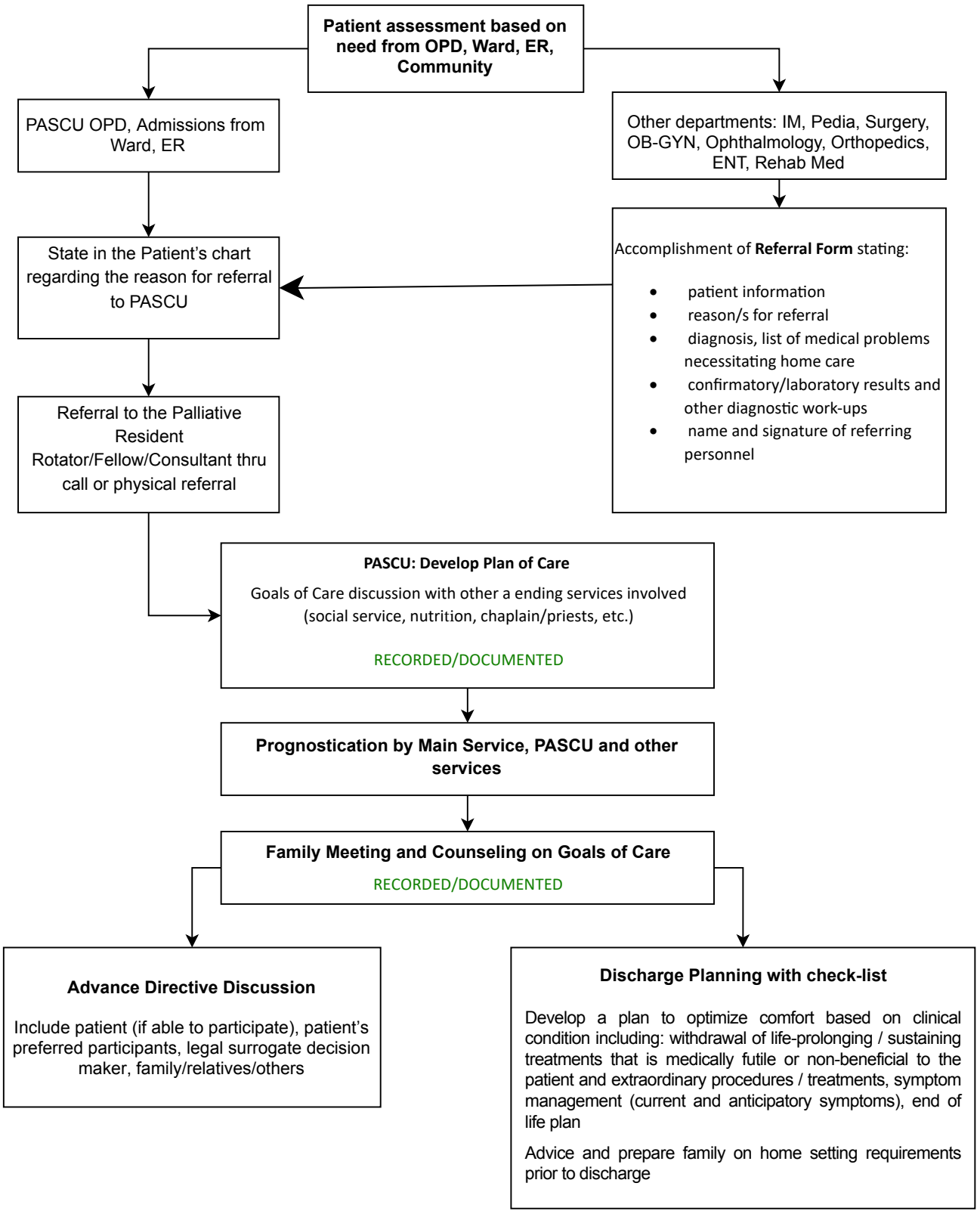
Palliative and Supportive Care Unit (PASCU) Workflow at the ER

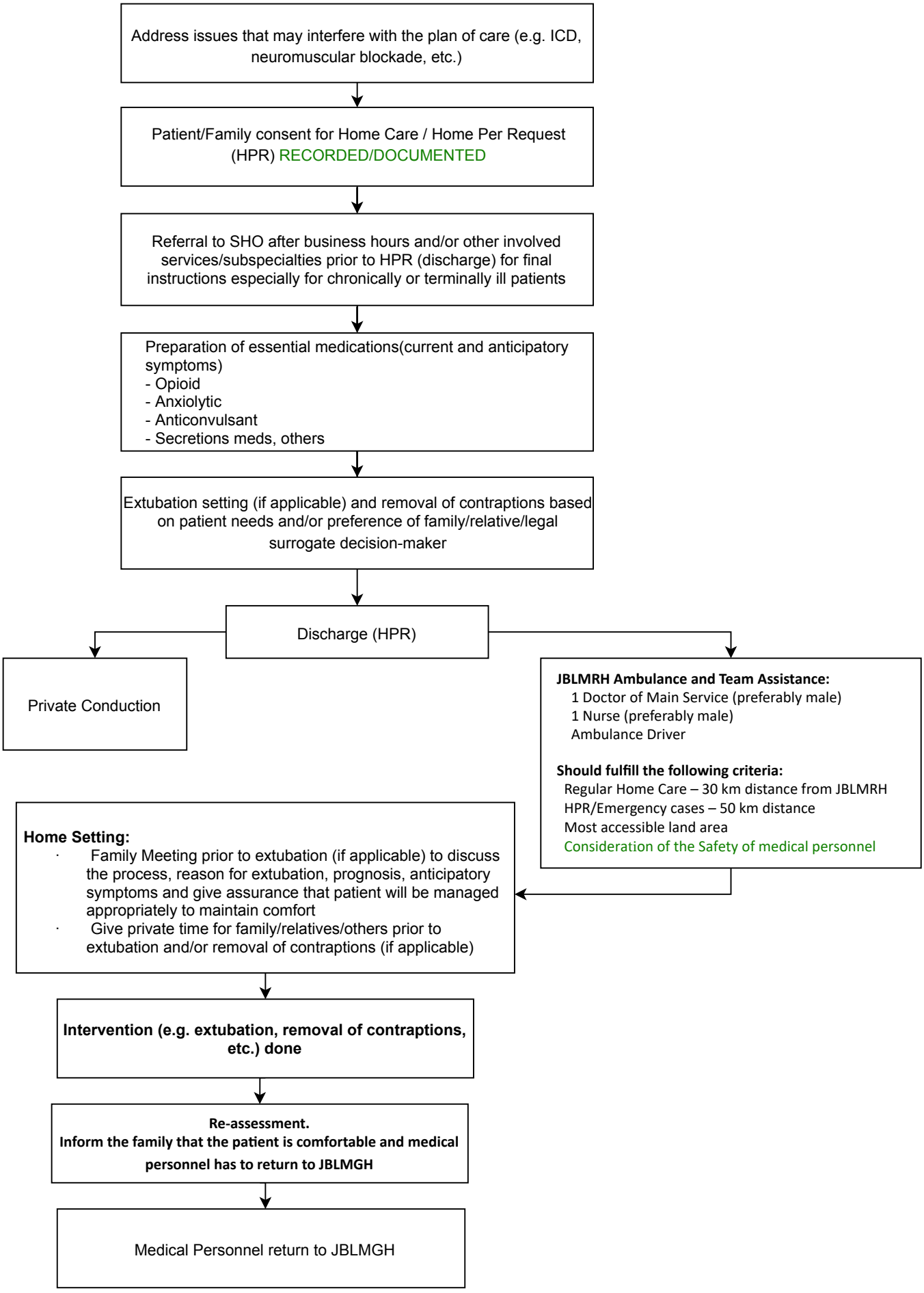


Sample of Palliative and Supportive Care Unit (PASCU) Referral Workflow at ER/WARD/OPD (from JBLMGH)



Palliative and Supportive Care Unit (PASCU) Home Care Program (from JBLMGH)




Address issues that may interfere with the plan of care (e.g. ICD, neuromuscular blockade, etc.)
Patient/Family consent for Home Care / Home Per Request (HPR) RECORDED/DOCUMENTED
Referral to SHO after business hours and/or other involved services/subspecialties prior to HPR (discharge) for final instructions especially for chronically or terminally ill patients
Preparation of essential medications(current and anticipatory symptoms)
- Opioid
- Anxiolytic
- Anticonvulsant
- Secretions meds, others
Extubation setting (if applicable) and removal of contraptions based on patient needs and/or preference of family/relative/legal surrogate decision-maker
Discharge (HPR)
Private Conduction
JBLMRH Ambulance and Team Assistance:
1 Doctor of Main Service (preferably male)
1 Nurse (preferably male)
Ambulance Driver
Should fulfill the following criteria:
Regular Home Care – 30 km distance from JBLMRH
HPR/Emergency cases – 50 km distance
Most accessible land area
Consideration of the Safety of medical personnel
Home Setting:
· Family Meeting prior to extubation (if applicable) to discuss the process, reason for extubation, prognosis, anticipatory symptoms and give assurance that patient will be managed appropriately to maintain comfort
· Give private time for family/relatives/others prior to extubation and/or removal of contraptions (if applicable)
Intervention (e.g. extubation, removal of contraptions, etc.) done
Re-assessment.
Inform the family that the patient is comfortable and medical personnel has to return to JBLMGH
Medical Personnel return to JBLMGH

Withholding and Withdrawing of Life-Sustaining Measures

- "*Withholding*" being defined as the decision not to start or increase a life-sustaining intervention, and "*Withdrawal"* as the decision to actively stop a life-sustaining intervention presently being given.
- The hospital should make arrangements and protocols for patients not benefiting from life-sustaining measures
- Coming from the principle of beneficence and nonmaleficence, the health care providers are obligated to carefully weigh the burdens and risks associated with any treatment. When treatment becomes unacceptably burdensome to the patient, no longer beneficial to the patient, or is inconsistent with the patient's known wishes or goals of care, it should be discontinued.
- There should be regular evaluation of these processes as well as the discussion of ethical issues, and emotional burden for the patients, the family, and the healthcare team.

Allowing Natural Death

- This process of allowing natural death is meant to ensure that only comfort measures are provided to the dying patient. In doing so, physicians and other medical professionals would be acknowledging that the person is dying and that everything that is being done for the patient — including the withdrawal of nutrition and hydration — shall allow the dying process to occur as comfortably as possible.
- In the face of a terminal illness, palliative care does not prolong the dying process, neither does it hasten or postpone death. Allowing the natural course of the disease and providing comfort and quality of remaining life is the main goal of care and at the same time supporting the patient and the family facing such difficult times.
- This decision is an active, positive position representing the hope that dying shall occur peacefully and naturally as possible, surrounded by loved ones. It does not indicate a withdrawal of care, although it may include withholding or discontinuing resuscitation, artificial feedings, fluids, and other measures that would prolong a natural death. In addition to agreed interventions, the person shall continue to receive:
    - prompt assessment and management of pain and other distressing symptoms
    - other comfort measures including emotional, cultural and spiritual support
    - privacy and respect for the dignity and humanity of the person and their family
    - management of hydration and nutrition needs as appropriate
    - oral and body hygiene

D. Palliative and Hospice Care in Special Situation and Special Populations

1. Special Situations

Emergency Situation, Pandemic, Natural Disasters, Man Made Disasters such as Armed Conflicts

General Principles

People affected by different types of emergencies or crises, such as earthquakes, major storms, hemorrhagic fever epidemics or political violence, may suffer in different ways and require care of different kinds. Yet several principles apply to palliative care in any humanitarian emergency or crisis.

1. The most fundamental goal not only of palliative care, but also of medicine itself is to relieve human suffering. Saving lives is a crucial way to achieve this goal but not the only way.
2. Humanitarian responses to emergencies and crises should include palliative care and symptom control. Responses that do not include palliative care are medically deficient and ethically indefensible.
3. In humanitarian emergencies and crises, the statements that palliative care "regards dying as a normal process" and never intends to "postpone death", as in the 2002 WHO definition, require additional clarification. In this setting, any clinician, including those trained in palliative care, should make every effort to save the life of any patient who may potentially recover. The only exception should be patients with a pre-existing chronic life-threatening condition who had decided and left clear instructions to forego life-sustaining treatment.
4. Palliative care never intentionally hastens death, but provides whatever treatment is necessary to achieve an adequate level of comfort for the patient in the context of the patient's values. In keeping with the ethical principle of double effect, there may be rare cases of severe, refractory symptoms in a patient with a terminal illness or mortal injury when the intention of assuring comfort may result in unintentional but foreseeable hastening of death.
5. Palliative care and life-saving treatment should not be regarded as distinct. Palliative care and symptom control should be integrated as much as possible with life-saving treatment for patients with acute life-threatening conditions or triaged.
6. Palliative care should commence immediately, as needed, for patients with non-life-threatening conditions (triaged yellow) whose injury- or disease-specific treatment may be delayed.
7. Palliative care must be provided for all patients deemed expectant (triaged blue) and should commence immediately.

Types of Suffering of People Affected by Sudden-onset natural or manmade disaster

- Physical Suffering
  - Symptoms due to acute injury or illness
  - Symptoms due to injury-related complications and subacute or chronic illnesses
- Psychological Suffering
  - Acute effects - acute anxiety, acute depressed mood, acute grief
  - Chronic effects - post traumatic stress disorder (PTSD), chronic anxiety disorder, chronic depression, complicated grief, survivor's guilt, substance use disorders
- Social Suffering
  - Loss of access to shelter, clothing, food, sanitation, protection from violence, school (for children), extreme vulnerability (including frail older people, unaccompanied children, people with mental or physical disabilities, people living in extreme poverty)
- Spiritual Suffering
  - Loss of meaning and value
  - Existential Issues

a. Preparedness

Preparedness includes developing a plan to address how the managers shall provide the needs of the patients during the disaster. It includes a thorough hazard identification and hazard mitigation activities.

The preparedness phase involves the capacitating the system in order to handle the possible needs of people during disasters. This includes ensuring availability and accessibility of essential palliative care medicine drugs such as morphine, training of health care providers in order for them to address the palliative care needs of patients. This phase also includes planning for surge capacity which should include considerations that in addition to patients affected by the disaster, pandemic or emergency, there are other patients who need palliative care e.g. the bedridden, elderly, cancer patients, chronic kidney patients, etc.

b. Response and recovery

Recommended Acute Palliative Care Response

- Develop protocols for a minimum standard of symptom assessment and treatment, and for care of expectant patients.
- Train health care providers in the protocols for the physical and psychological symptom assessment and treatment
- Ensure availability and accessibility of the following medicines
  - Oral and injectable morphine
  - Oral fluoxetine
  - Injectable midazolam, diazepam
  - Oral and injectable haloperidol
- Partner with local community and spiritual leaders for advice on cultural values and beliefs relevant to mental illness

- Include mental health care providers to give culturally and linguistically appropriate care
- Organize support groups for patients and survivors who may wish to share experiences and challenges
- Ensure access to shelter, appropriate clothing, food, sanitation school
- Arrange protection from physical or psychological abuse
- Seek partnerships with local spiritual counselors willing to visit patients and family members on request
- Setup provisions for self-care and debriefing for health care workers which includes palliative providers.
- Include provisions for self-care and debriefing for health care workers which includes palliative providers.

In the standard triage categorization, it makes no mention of palliative care or symptom relief and suggests that category 4 or expectant patients require even less attention than those with minor health conditions. A medically and ethically categorization is described below

Table 6. Recommended triage categorization in humanitarian emergencies and crises

Category	Color code	Description
Immediate	Red	Survival possible with immediate treatment Palliative care should be integrated with life-sustaining treatment as much as possible
Expectant	Blue	Survival not possible given the care that is available Palliative care is required
	Yellow	Not in immediate danger of death, but treatment needed soon Palliative care and/or symptom relief may nevertheless be needed immediately
Minimal	Green	Shall need medical care at some point, after patients with more critical conditions have been treated Symptom relief may be needed

Lifted from *WHO 2018 Guide: Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises*

During a state of public health emergency like in a pandemic, the pandemic task force shall assess patients and make due referral to the palliative care team for those identified with poor prognosis.

Referrals may be made through accomplishing the referral form. Afterwards, the palliative team shall assess the patient and/or family's values and goals through face-to-face or virtual conference. After longevity and quality of life is fully explained and understood by the patient/family, discuss advanced care planning and advanced directives. If there are no objections regarding end-of-life care, securing a signed do not intubate/resuscitate form or allow a natural death consent form is important. If with objection, refer back to primary service and record the referral.

Communication / goal setting / advanced care planning is essential and must be standardized throughout the health system. Especially when limited resources are at play and the healthcare system is overburdened by severity of the pandemic, effective prioritization and triaging of patient cohorts is essential. Incorporation of palliative care early on in the care of these patients afflicted by the pandemic take for example COVID-19, can help decrease the burden and fill the gaps in caring for people with life-limiting and life-threatening diseases where life-supporting or heroic measures shall no longer be beneficial.

The Department of Health shall adopt the Palliative Care Guidelines for COVID-19 which was developed by Philippine Society of Hospice and Palliative Medicine (PSHPM) and Hospice Philippines through the support of The Ruth Foundation, and Philippine Society of Public Health Physicians (PSPHP) to provide recommendations for palliative care for all patients, and help healthcare providers to include palliative care services in different care settings (communities and hospitals) during the COVID-19 pandemic (refer to Annex XIII for the link to the Palliative guidance document). In addition, there are also several international guidelines that can be accessed online to further supplement these documents for patient management *(see https://www.capc.org/covid-19/ for COVID-19 Response Resources toolkit and the ebook on Palliative Care Guidelines for COVID-19 Pandemic by PallicovidKerala)*.

2. Special Populations

Military, Persons Deprived of Liberty, PWDs, LGBTQ, and persons with MDR-TB / HIV-AIDS / Rabies

Possible Palliative and Hospice Care Issues in the Military

- Post-Traumatic Stress Disorder
- Chronic Pain
- Depression
- Traumatic Grief/Survivor Guilt
- Substance Abuse/Addiction Recovery (Alcoholism included)
- Service-Related Diseases
- Traumatic Brain Injuries
- Spiritual Uncertainty

Possible Palliative and Hospice Care Issues in Person Deprived of Liberty

- Psychological issues related to persons deprived of liberty's death and dying
- End of life care decision making - possible lack of autonomy and individualized decision-making ability for medical care and treatment for incarcerated individuals
- The need for end-of-life care for persons deprived of liberty
- Possibility of compassionate release law, policies and practices
- Feasibility of prison hospice program
- Barriers to treatment
    - Mistrust between staff and persons deprived of liberty
    - Potential misuse of pain medications

- Safety concerns
- Negative public attitudes toward compassionate end of life care for the persons deprived of liberty
- Bureaucracy and prison restrictions

Possible Palliative and Hospice Care Issues in Patients with Disabilities

- Lack of awareness/understanding for palliative care
- Communication issues (care providers and people with disabilities)
- Service provider assumptions about the competence of people with disabilities
- Diagnostic 'overshadowing' - attributing the symptom of a disease to the disability
- Distrust of health services
- Inadequate support for carers and families
- Lack of integration between health, disability and aged care sectors
- In community living settings, lack of organizational support for dying in place of choice.

Possible Palliative and Hospice Care in LGBT patients

- Provider communication
- Patient perceptions of safety and acceptance
- Assessing and respecting patient's definition of family (Chosen family, Family of Origin)
- Assumptions of spirituality

The minimum staffing requirement for a palliative and hospice care service delivery for the special populations should include doctors and nurses with special training on special needs and rights of the vulnerable groups, be able to provide support as well as knowledge on safety, rehabilitation and occupational medicine. Also it can be recommended to include a nutritionist, physical therapist, Rehabilitation Specialist, Social Worker and Psychologist in the team for a multidisciplinary/interdisciplinary approach of taking care of the special population. A spiritual care provider or counselor may also be part of the team, as usually many of these special populations are served by faith-based organizations. Also the safety of the service facility from accidents/fall/armed conflict especially for very weak, frail, or debilitated patients must be ensured.

The current programs for HIV and MDR-TB already included offering palliative and hospice care services to these patients and their families whenever possible. Aside from providing medication access to antiretrovirals and anti-TB medications, the staff of these facilities should have training on palliative and hospice care and be able to provide to some extent palliation of symptoms, counselling, psychosocial support, advanced care planning and in some instances, end-of-life care and bereavement support to severe terminal patients and their families. (see Annex for Palliative Care for TB Patients)

In the future, in line with the UHC, each DOH program especially for those vulnerable and special populations, should create provisions for access to palliative and hospice care services to ensure a holistic approach to primary care and universal health care coverage.

Referral System

SECTION IV

Section IV. Referral System

A. General Principles

- Ensures that on transfer between health care settings, there is timely and thorough communication of the patient's goals, preferences, values and clinical information so that continuity of care and seamless follow-up are assured
    - Can also provide access to palliative and hospice care that is responsive to the patient and family 24 hours a day, seven days a week

- Care plan is integrated across the person's experience to ensure smooth transitions within and between services

- Effective communication systems to support integrated care, including processes for communicating information about the care plan, goals of care, prognosis and death of the person should always be present since there are policies and procedures in place that support and promote continuity of care across settings and throughout the course of the person's illness
    - Specialist palliative care services' admission criteria are clear, applied consistently, and communicated to the local health and wider community, and result in equitable access to services based on clinical need
    - Referrals from the specialist palliative care service are made to appropriate specialists or services that are able to meet the identified physical, social and spiritual needs of the person, their family and carers (for example acute pain services, mental health services, bereavement counsellors)
    - Discharging a person from a specialist palliative care service should allow adequate time for services to be put in place prior to discharge, and include a formal handover to ensure continuity of care and minimize risk
    - Plans should be discussed with the person, their family and carers to ensure that their needs and preferences are accommodated, and that they understand that the person may enter the service again if and when their needs change
    - Assist local community-based service providers to build their capability to help people to be cared for in their home, where this aligns with the person's preferences.
    - Policies for prioritizing and responding to referrals in a timely manner should be documented and audited regularly to identify improvement opportunities

B. Governance and Stakeholders: Province and City Level Networks

With the Universal Health Care Law in place, Local Government Units (LGU) are enjoined to establish a Healthcare Provider Network (HPCN) wherein the roles of different health facilities in the network are defined. The DOH has identified coordination as a critical key component to ensure organized and streamlined health services of facilities within the network.

1. Each city-wide or province-wide HCPN shall establish a health facility coordinating center that includes palliative and hospice care coordination under the management of LGU composite teams, headed by a designated referral and liaison coordinator

2. Each city-wide or province-wide HCPN shall establish pre-hospital care services which includes hotlines which shall facilitate the pick-up and/or transfer of patients to appropriate facilities, provide medical transport services for palliative/hospice patients, ensure availability of trained human resource to provide pre-hospital care, and follow the standardized referral protocol as described in DOH AO 2020-0019

3. LGU shall encourage primary health care provider, home-based and community-based palliative and hospice care providers, palliative referral hospitals, other Level 2 and Level 3 hospitals with Palliative and Hospice Care Units to formalize their partnership and coordination with existing primary care facilities in their locality through Memorandum of Agreements

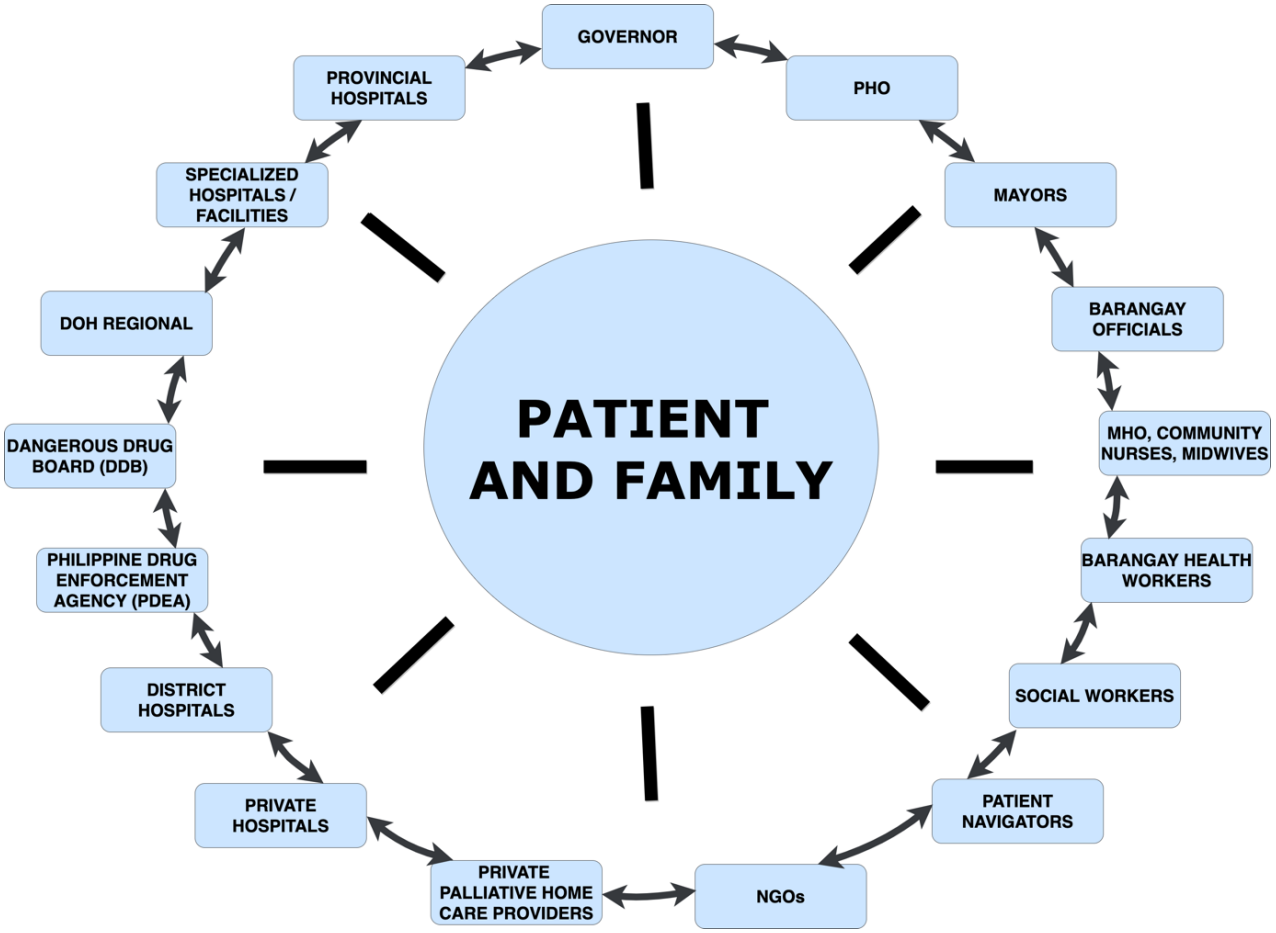


Figure 8. Integrated Palliative Care Network and Referral System

In accordance with the UHC, this figure shows an integrated palliative care network and referral system where all sectors are involved from the community up to the regional office of the Department of Health with the active participation of DDB, PDEA, LGU and private sector. (adapted from Pampanga pilot project courtesy of Dr Agnes Bausa-Claudio

C. Overview of the Referral Network

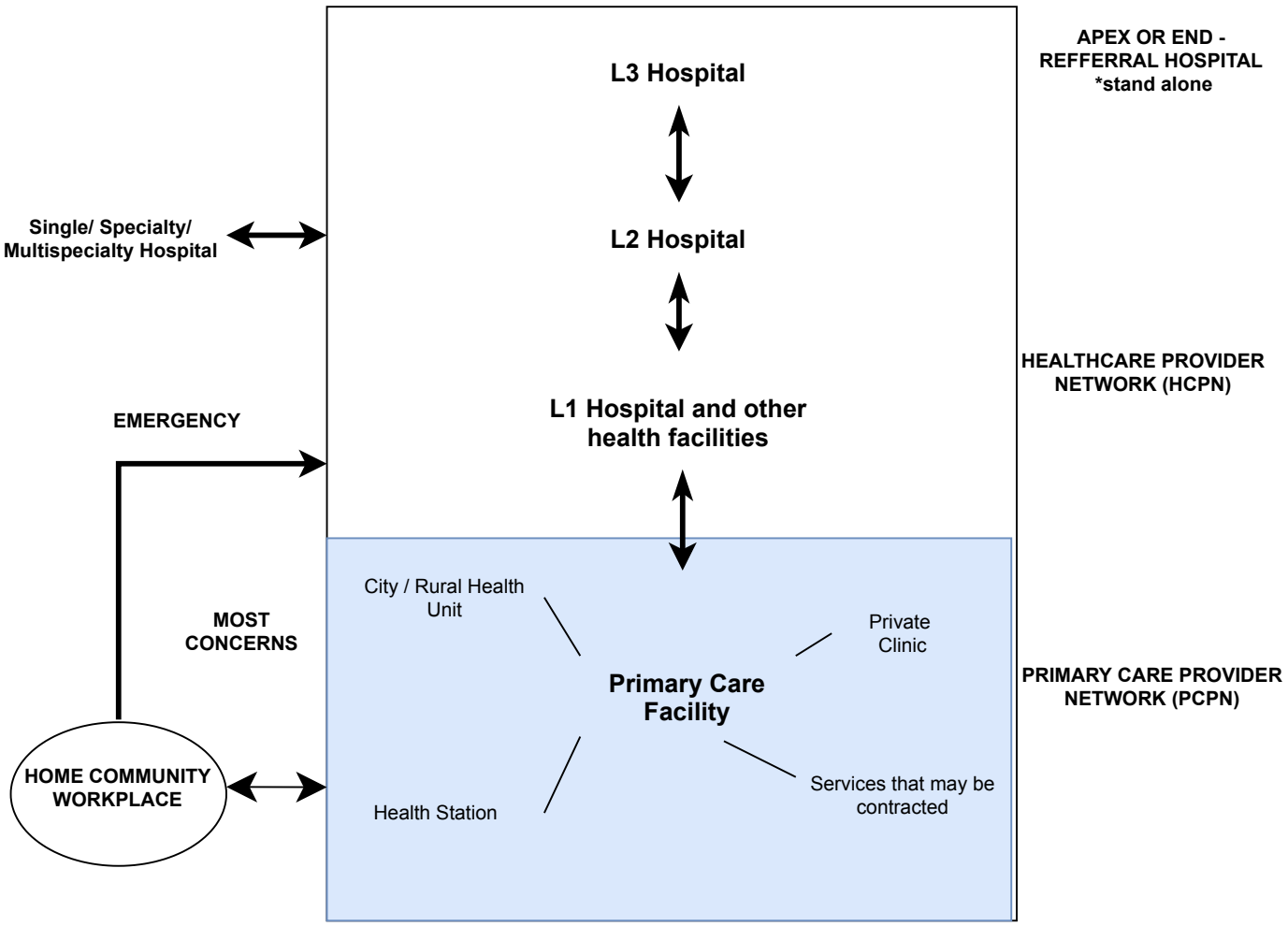


Figure 9. Patient Flow in the HCPN and referral pathway (based from DOH AO 2020-0019)

This figure shows an interplay between primary care provider network, healthcare provider network and apex/stand-alone end-referral facilities. Most palliative concerns fall under the services of primary care providers. This also recognizes that there should be a referral process from PCPN to higher facilities depending on the need of the patient and family for more specialized palliative and hospice care interventions. In addition, a step-down mechanism must also be in place for those patients coming from specialty/end-referral facilities being discharged back to their homes and communities where proper endorsement of care should ensue.

D. Referral Criteria for Palliative and Hospice Care

Considerations when to refer to the specialist palliative and hospice care team

Presence of a potentially life-limiting or life-threatening condition such as but not limited to:
• Metastatic or locally advanced incurable cancer
• Difficult to control physical or psychological symptoms like pain or dyspnea (moderate to severe symptom intensity for more than 24-48 hours)
• Elderly patient, cognitively impaired, with or without fracture
• Chronic home oxygen use
• Out of hospital cardiac arrest, anoxic encephalopathy
• Multiple recent prior hospitalization with same symptoms or problems
• Patients with advanced directives, living wills, do not resuscitate and/or comfort care orders
• Disease and/or treatment-related feeding problems that may lead to malnutrition-related morbidity and mortality
• Patient previously enrolled in a home care program
• Patient / caregiver / family / physician desires palliative and hospice care but has not yet been referred
• Consideration of ICU admission and/or mechanical ventilation in a patient with cancer with one or more comorbidities/chronic diseases and poor functional status at baseline
• Disagreements or uncertainty among patient, family, and/or staff concerning
  ○ Major medical treatment decisions
  ○ Resuscitation preferences
  ○ Use of non-oral feeding or hydration

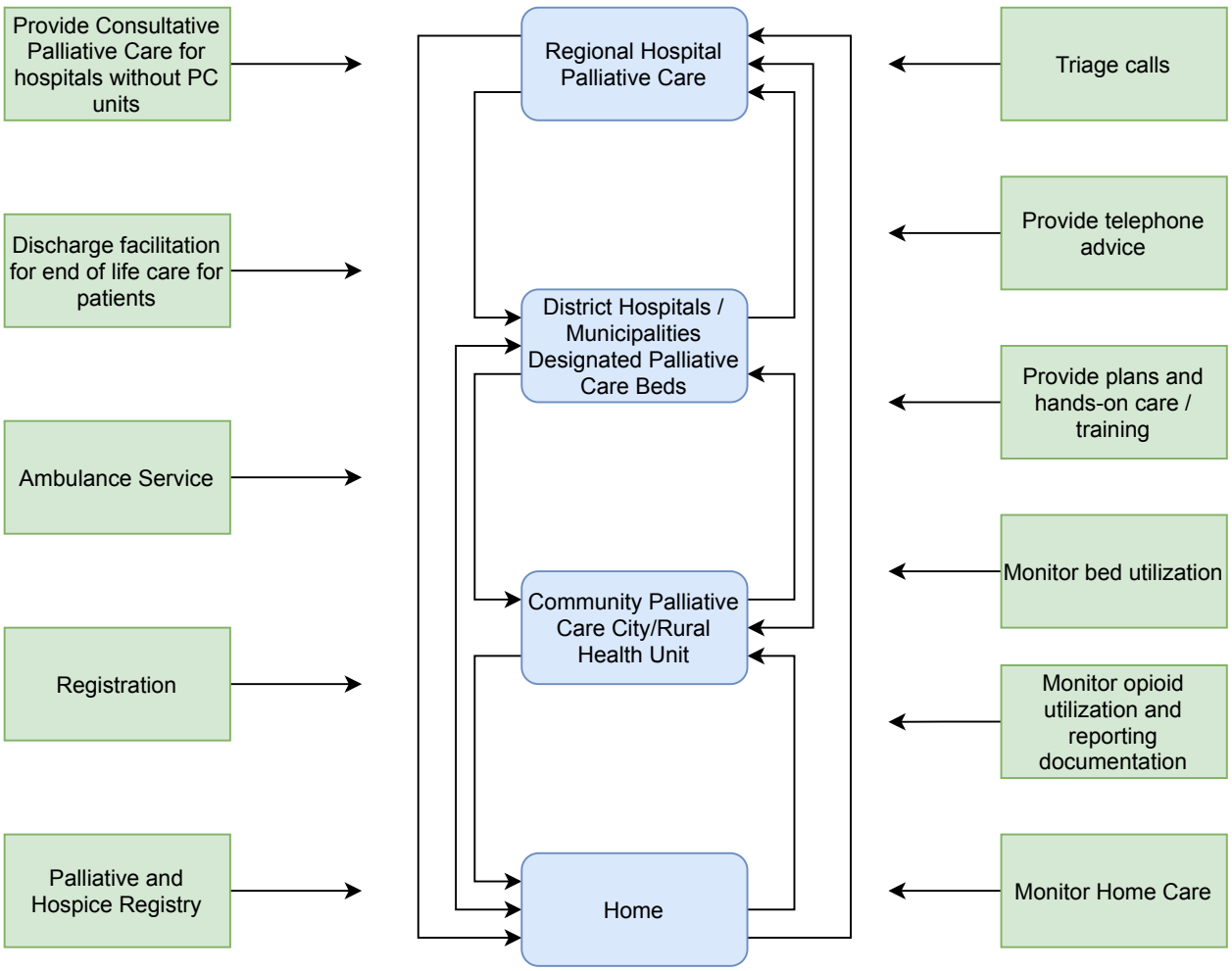


Figure 10. Workflow for the palliative care referral network
(*Adapted from Jose B. Lingad Memorial General Hospital (JBLMGH) Capacity Building Pilot Project: Integrated Networking and Referral System for Palliative and Hospice Care A Pilot Project for Palliative Care as part of UHC in the Province of Pampanga (2017)*

E. Processes

Referring Patients to Palliative and Hospice Care

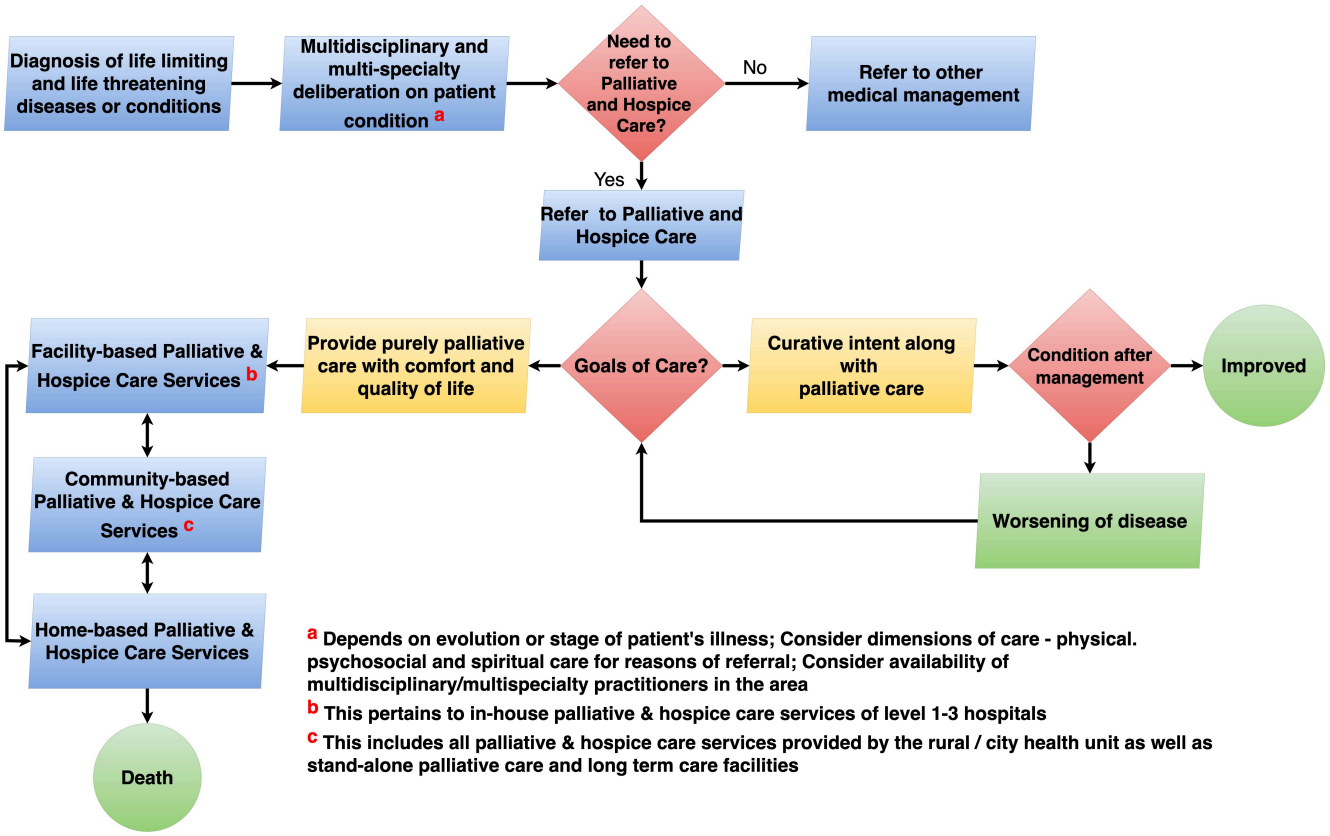


Figure 11. Patient Referral to Palliative and Hospice Care

The process of referral usually depends on the current process being followed per institution with some using referral letters with complete details and reasons for referring usually for non-urgent occasions, while in some instances like for emergency referrals, a need to personally endorse the case via face-to-face endorsement or phone call may be much more appropriate. More commonly, palliative and hospice care referrals are received on a non-urgent basis, usually during office hours. The times when palliative and hospice care are urgently needed include circumstances where the patient is in the end-of-life at the ER and there are difficulties in patient and family decisions of care where the medical team and families are not in congruence and no goals are set, also in occasions where acute palliative interventions are needed like in palliative sedation in a dying rabid patient, etc.

Referral Process Algorithm

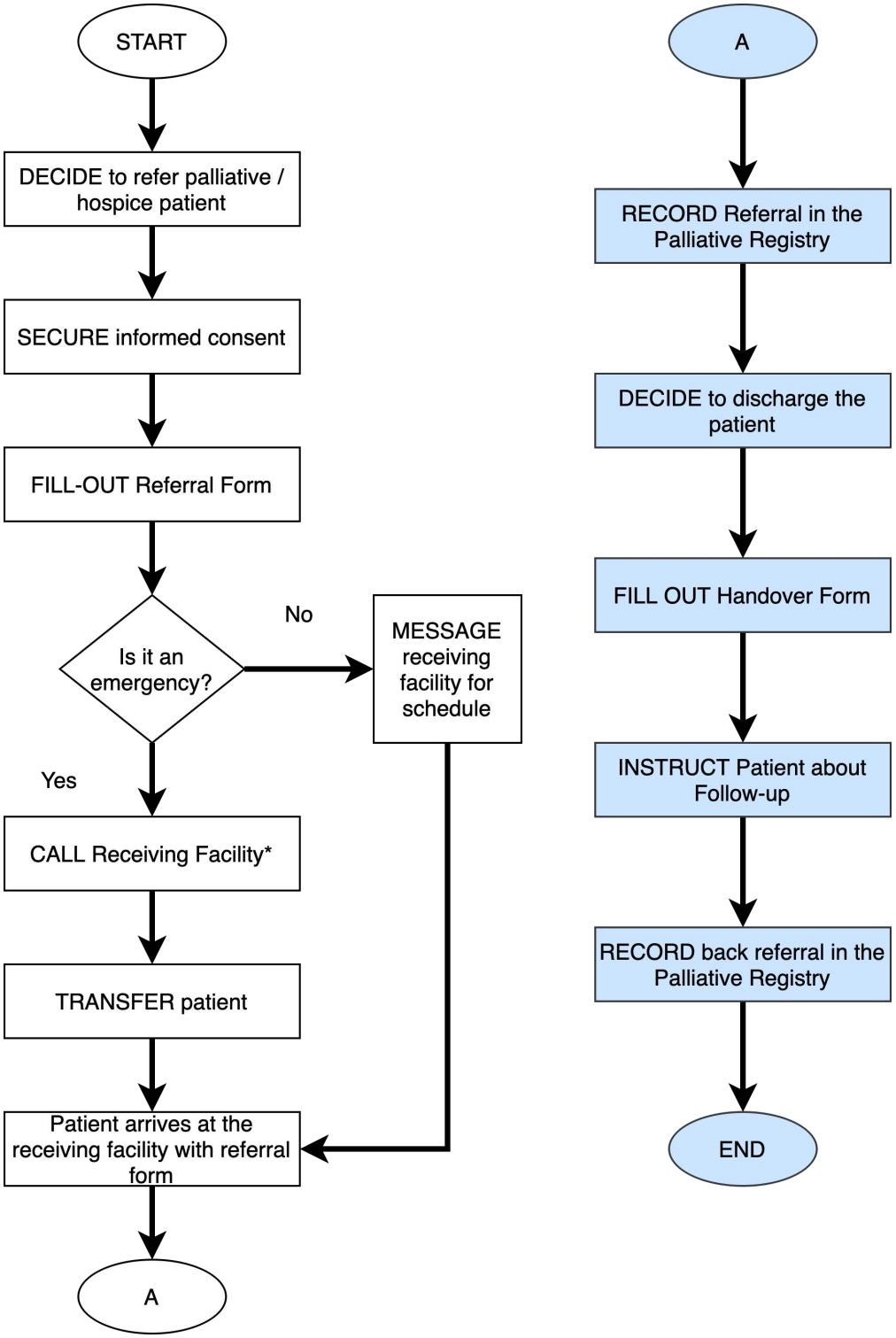


Figure 12. Interfacility Referral Algorithm for Palliative Care patients
White boxes - by initiating facility; Blue boxes - by Receiving facility
**Steps may happen simultaneously (i.e. call is being made during transfer of patient)*
(adapted from DOH from AO 2020-0019)

Information Needed During Referral

Referral of palliative patients must include key information that shall help in the proper endorsement of care and that goals of the referral are met and properly understood by both the referring and receiving parties. Some of the recommended referral methods - SBAR, IPASStheBATON, and 5Ds of Discharge, can be utilized. (Source: from AO 2020-007, AO 2020-019)

Tools for Referral

Use of standardized methods, forms or tools to facilitate consistent and complete handovers and referral of patient care (SBAR, IPASStheBATON) (from AO 2020-007, AO 2020-019)

Standard Communication Protocols for Emergency and Non-Emergency Cases via Phone

Table 7. Tools for Referral - SBAR - a form of standardized technique to facilitate communication during transitions of care

Situation	What is the situation? ● Identifying self, the unit, and the patient (by using two patient identifiers - name and birthdate) I am (name), (position) of (initiating facility) I am calling about an emergency referral Who am I talking with? [Wait for Response 1] ● Briefly state the problem: complaint, onset, severity Patient is a (age), (sex), with chief complaint/problem: (state problem) Present working impression is: (Working Impression) Reason for referral is: (state reason) Current vital signs are: (BP, HR, RR, O2 Sats, Temp)
Background	Provide background information relevant to the situation (name of patient, diagnosis, medication list, allergies, vital signs, other clinical information)
Assessment	What is your assessment of the situation? ● I think the problem/concern is: (describe) ● State issues for the referral
Recommendation	What is your recommendation of the situation (i.e. patient to be seen now, to be admitted, referred, or an order to be changed) ● We would like to transfer the patient immediately, are you ok with the plan? ● Is there anything I need to do in the meantime? [Wait for Response 2]
Response	
1	Name of Receiver and position
2	Yes, please transfer to our facility immediately No, our facility's capacity is full. Please transfer to (specify another facility) Other instructions: (e.g. give medicines on the way)

Table 8. Tools for Referral - IPASStheBATON - an effective tool of a hand-off checklist of critical information

I	**I**ntroduction of self and role
P	**P**atient - name, identifiers, age, gender, location
A	**A**ssessment - presenting chief complaint, vital signs, symptoms, diagnosis
S	**S**ituation - current status or circumstance, level of uncertainty, recent changes, code status
S	**S**afety Concerns - critical lab values / reports, socio-economic factors, allergies and alerts (falls, isolation, etc.)
[THE]	
B	**B**ackground - comorbidities, previous episodes, current medications, family history
A	**A**ctions - what actions were taken or required?
T	**T**iming - level of urgency and explicit timing and prioritization of actions
O	**O**wnership - who is responsible (nurse / doctor / team)? Include patient/family responsibilities
N	**N**ext - what shall happen next? Anticipated changes? What is the plan?

Effectively discharge patients using the standardized format "5 Ds of Discharge"

Table 9. 5 Ds of Discharge - for effective discharge and successful continuity of care

Diagnosis	Does the patient understand his or her diagnosis and why he or she was in the hospital/clinic/facility or receiving care from a doctor?
Drugs	Does the patient/family know each medication the patient must take, the reason for the medication, when to take the medication, and how to administer it? Resources to obtain the medication?
Diet	Does the patient/family know and understand any dietary provisions or restrictions? Does the patient need a nutrition consult?
Doctor follow-up	When should the patient see the doctor next? How and when to make necessary appointments and appropriate transportation?
Directions	Are there directions necessary to increase the patient's and family's ability to achieve optimal health / quality of life? Does the patient/family understand when urgent care should be obtained?

Sample of the Uniform Referral Form

HCPN LOGO NAME OF HEALTH CARE PROVIDER NETWORK
REFERRAL FORM

Name of Initiating Facility _____ Contact Number _____
Address _____

Date of Referral _____ Time Called* _____
Name of Receiving Facility _____ Receiving Personnel _____
Address _____ Response _____

Referral Category □ Emergency □ Outpatient
Working Impression _____

Reason for Referral
□ Consultation _____
□ Diagnostics _____
□ Treatment/ Procedure _____
□ Others _____

Name of Patient _____ Identity Number _____
Age _____ Sex □ Male □ Female
Address _____
Chief complaint _____
Clinical History _____
_____
_____
Findings _____
Vital Signs BP ___ HR ___ RR ___ O2Sat ___ Temp ___ Weight ___ Height ___
(attach laboratory results) _____
_____
Treatment Given _____
(attach treatment cards) _____

_____ _____
Print Name and Signature of Health Professional Date and Time

Return Slip

Action Point: Received
Referred

Access to Medicine

SECTION V

Section V. Access to Medicine

A. Basic Principles

The provision of information and tools to governments and procurement officers are key steps to ensure access to essential medications for palliative and hospice patients. Access to essential palliative medicines is an important part of the right to health. Simply put, access to medicines implies that patients have the right medicines of the right quality, at the right price and at the right place.

Safety, Quality and Efficacy

Safety and quality of medicines are ensured through different mechanisms. The Food and Drug Administration as a regulatory agency is mandated to ensure the safety, efficacy or quality of health products as defined by RA 97111. The FDA produces and regularly updates the Philippine National Formulary (PNF) that includes a list of all medicines that government hospitals and health facilities can purchase. The PNF serves as the national reference for quality and rational selection of the medicines that are vital in achieving best health outcomes.

Cost-Effectiveness

Under the Universal Health Care Act Section 34, Health Technology Assessment (HTA) process shall be institutionalized as a fair and transparent priority setting mechanism for the development of policies and programs, regulation and the determination of a range of entitlements such as drugs, medicines, pharmaceutical products and other devices, procedures, and services that is recommended to the DOH and PhilHealth, as well as recommend the development of any benefit package. HTA aims to ensure that health products, services and programs are cost-effective and can produce the best health outcomes.

B. What Medicines should be made available?

The essential medicines concept was developed by the WHO that gives a list of minimum medications for a basic health care system that should include the most efficacious, safe, and cost-effective drugs for priority conditions that shall cater to the needs of the population. These medications should always be available, affordable and used adequately. This Essential Medicines List is included in the MOPS to guide government agencies in what medicines should be made available at different levels of care. (See Annex X)

Procurement

In the 2017 DOH AO Guidelines on Pain Management Using Opioids for Palliative and Hospice Care; General Guidelines C, it was stated that Designated Regional / Provincial / Municipal Centers for Palliative and Hospice shall create an Opioids (and Regulated Medications) Board tasked to ensure legal and regulatory systems, wider access and

availability of opioids and other regulated medication for palliative and hospice care use while maintaining measures for preventing diversion and misuse.

Specifically, the Regional / Provincial / Municipal Centers OPIOIDS (and Regulated Medications) BOARD shall comply with the reportorial requirement of the National Advisory Board on the use of Opioids for Palliative and Hospice Care (NABOPHC) (DOH AO No. 2017- Guidelines on Pain Management Using Opioids for Palliative and Hospice Care; Specific Guidelines C.3.e)

In addition, Government and private hospice care providers and NGO's shall be authorized to purchase through a Local Order Permit (LOP), transport and dispense opioids and other regulated medications for home-based hospice patients under their care following a standard system of prescribing, handling and reporting. (DOH AO No. 2017- Guidelines on Pain Management Using Opioids for Palliative and Hospice Care; Specific Guidelines D.1)

All health facilities (government hospitals, NGO, RHU, private institution catering to palliative and hospice patients) access sites shall be required to become palliative medicines access sites.

Sale and Supply

No entity shall engage in a conduct that constitutes the sale, supply, or dispensation of any dangerous drug, in any dosage form, unless a holder of a valid S-3 or S-4 license, or any of the following:

1. a pharmacist employed by a licensed entity, who sells, supplies, or dispenses to another entity with a valid S-2 prescription; or
2. a nurse or pharmacy assistant under the immediate supervision of a pharmacist;
3. be on a Special Prescription Form for Dangerous Drugs, unless in emergency cases in which case the prescribing medical practitioner shall, within three (3) days from the issuance of an ordinary personalized prescription, inform the DOH Dangerous Drugs Abuse Prevention and Treatment Program (DDAPTP) of the same in writing;
4. be signed and dated by the prescribing practitioner on the date of issue;
5. contain only one dangerous drug;
6. be issued in triplicate copies with specific direction of use.

Satellite Pharmacies

Satellite pharmacies are allowed to maintain stocks of dangerous drugs under the following circumstances.

1. The central pharmacy is an S-3 Licensee
2. The inventory of its stocks shall be recorded and reported similar to floor stocks
3. Floor stocks shall only be replenished using stocks from the central pharmacy

Supply Chain Management

Effective medicines supply systems are integral in ensuring a strong health care system. Using the medicines management cycle of WHO can help build an effective

management of medicines supply from selection, quantification and forecasting, procurement, storage, and distribution.

Access to medicines that is reliable can occur with rational selection, affordable prices, reliable health and supply systems, and sustainable financing. Integrating supply management to the health system development is important where an efficient mix of public-private partnerships can be developed. Detailing on proper warehousing, handling, transportation, inventory management, procurement with critical reordering points, identifying officers in charge with appropriate training for each task in maintaining medicine quality in distribution channels are all essential to ultimately ensure sustainable access to essential palliative care drugs.

Prescription

A medical practitioner carrying out a treatment option of a patient who has pain from cancer, intractable pain, pain as a result of terminal illness, or any ailment requiring a dangerous drugs or its preparation, shall ensure that such patient's medical history has been obtained and a physical examination has been conducted, including an assessment of physical and psychological function, underlying or coexisting diseases or conditions, any history of drug abuse, and the nature, frequency, and severity of any pain. The practitioner shall document the diagnosis and the medical need for the prescription in the patient's medical record**.** The medical record must reflect the following:

1. a recognized medical indication for the use of the dangerous drugs
2. the generic and brand name of the dangerous drugs
3. the dosage, strength, and quantity of the dangerous drugs
4. specific instructions to the patient about frequency of use; and
5. patient response to the treatment

An S-2 Licensee shall only prescribe dangerous drugs, using a Special Prescription Form, that are commensurate to the therapeutic needs or requirements of the patient which they had personally and physically examined, assessed and diagnosed.

Where there is a need for a longer duration of the therapy, the S-2 licensee may prescribe dangerous drugs for a maximum of 30-day supply per prescription.

In case of epilepsy, dystonia and other conditions such as generalized anxiety disorder and chronic insomnia that require long term and continued care, the S-2 licensee may prescribe dangerous drugs for a period not exceeding 90 days. In such cases, the diagnosis of the patient must be indicated on the prescription.

The S-2 licensee involved in palliative and hospice care shall indicate a specific length of therapy or number of doses in the individual patient's order, which shall not exceed 30-day supply.

In cases of emergency

In emergency cases, as defined and described in the Regulation, the issuance of dangerous drugs using ordinary prescription forms may be allowed only for initial dosing or initial treatment to promptly address the emergency.

Provided, upon the alleviation of the symptoms or severe pain of the patient, the S-2 Licensee shall promptly cause, within twenty-four to 72 hours, the issuance of a prescription using the Special Prescription Form indicating therein the particulars of the dangerous drugs prescribed and administered to the patient during an emergency case.

Provided, further, that the ordinary prescription earlier issued shall be consolidated with the Special Prescription Form and shall form part of the report for submission to the PDEA.

Provided, finally, that the pharmacists who dispense dangerous drugs during emergency cases shall indicate in the registered record book the reason or emergency that warranted the dispensing of such substance under such circumstances.

Acquisition of Special prescription forms

An S-2 licensee may acquire at most ten (10) booklets of special prescription forms at a time from any government hospitals or DOH-designated official distribution sites. An S-2 licensee may only possess a maximum of 5 booklets at a single time. Special Prescription Forms are non-transferrable and S-2 licensees are accountable. These shall be for the exclusive use of the S-2 licensee, which shall be valid for the duration of the S-2 license and shall be used consecutively according to its serial number.

All unused Special Prescription Forms for dangerous drugs shall be immediately surrendered to any government hospitals or DOH official distribution sites and may be used by other medical practitioners under any of the following circumstances, provided such transfer is officially documented:

1. departure for any place outside the Philippines, if the period of stay therein is more than six months
2. cessation of, or retirement from, practice
3. non-renewal of PDEA S-2 license
4. death – the surrender of the special prescription forms for dangerous drugs may be done by the nearest kin of the deceased practitioner to whom such forms were issued
5. in any case, the DOH or its authorized representatives shall issue an acknowledgment receipt for the surrendered special prescription forms for dangerous drugs
6. the licensed practitioner shall keep the used prescription booklets in a separate file in such a manner as to be readily accessible for inspection by PDEA, for a period of one (1) year

Electronic Prescription

Relative to the prescribing and dispensing of dangerous drug preparations, the Board shall establish an electronic prescription system to support and prevent shortage on the printing and distributing of the SPFDD. The system shall control and closely monitor the medical practitioners and pharmacists responsible for the prescribing and dispensing of dangerous drug preparations.

Dispensing

For floor stocks, the required Special prescription form may also be dispensed within emergency cases through the use of a PDEA prescribed Requisition Sheet and Controlled Drug Administration Sheet (CDAS) in hospital settings.

High strength opiates/narcotic drugs which apply to any intravenous admixture to be used in Patient Controlled Anesthesia (PCA), must only be ordered when required to meet an individual patient's needs. When ordering high strength opiates/narcotic drugs, the order shall be accompanied by a Special Prescription Form for Dangerous Drug for out-patient or CDAS for in-patient, and Medication order.

C. Administration of Dangerous Drugs

In homes where the patient is under palliative and hospice care, the administration of dangerous drugs may be designated to a well-trained health care practitioner, trained relatives or helper or a community health care organization under the supervision of the physician with a valid S-2 License who prescribed the dangerous drugs.

A record of administration of dangerous drugs shall be maintained and to be submitted every quarter to the PDEA-CS or appropriate PDEA regional office.

Emergency bags for medical practitioners engage in palliative and hospice care

Medical practitioners who are S-2 licensees may possess or carry drugs for home care patients not exceeding the following quantities:

1. Morphine Sulfate (short acting), 10mg/tab - 10 tablets
2. Morphine 10mg/ml amp - 5 ampules
3. Morphine 16mg/ml amp - 3 ampules
4. Oxycodone 10mg/ml amp - 3 ampules
5. Fentanyl 100mcg/2ml amp - 3 ampules
6. Fentanyl 100mcg/tab (sublingual) – 3 tablets
7. Midazolam tab 15mg/tab - 3 tablets
8. Midazolam amp 5mg/ml - 3 ampules
9. Diazepam 10mg/tab - 3 tablets
10. Diazepam 10mg/2ml - 3 ampules
11. Clonazepam 2mg/tab – 3 tablets
12. Naloxone 0.4mg/ml - 2 ampules

D. Registries

All registered, licensed, accredited, or authorized entities shall maintain registers pursuant to Republic Act No. 9165, as amended by Republic Act No. 10640, section 40. In addition thereto, the said entities shall, likewise, comply with the following:

1. A person who makes an entry in a register shall only be the authorized person of the company and must register online through the Regulatory Control Monitoring Information System.
2. Any person required by this Section to keep a register shall, subject to any written direction to the person by PDEA, retain possession of the register and commercial documents relating to entries therein for two (2) years after the date of the last entry in the register. A prescription that has been duly filled shall be retained by the pharmacist for a period of one (1) year from the date of sale of such drug. The used prescription booklet of the prescribing physician shall be retained for one (year) from date of full consumption. Such records shall be subject to review by the PDEA.
3. Any person required under Subsection (1) to keep and maintain a register in relation to any dangerous drug shall record the transaction within one hundred twenty (120) hours of any import, export, manufacture, supply, acquisition or disposal.
4. Any time supplies are wasted, including spillage, this must be documented in the register. The entry is to be verified by a witness who shall countersign his/her name in the remark's column of the register.
5. Organizational members of Philippine Society of Hospice and Palliative Medicine and Hospice Philippines Inc. and other organizations shall comply with the reportorial requirements.

E. Disposal of Dangerous Drug Preparations

1. All licensed entities except in a hospital/clinic setting that has an inventory of controlled drug preparations for disposal shall secure an approved local order permit from the PDEA Compliance Service and notify the PDEA Laboratory Service or PDEA Regional Office in writing and surrender the item. Upon acknowledgement of the receipt thereof, a copy shall be submitted to Compliance Service for reference and notation in the Dangerous Drugs Register.
2. In cases where the disposal of a dangerous drug shall be through a destruction facility, the facility shall be DENR-registered and compliant with the prescribed manner of disposal. It shall notify the PDEA Laboratory Service in which case a PDEA Laboratory personnel shall witness the actual destruction. A copy of the destruction report shall be submitted to Compliance Service for notation in the register. The licensed operator shall bear the cost of disposal.
3. In hospital settings, individual doses of dangerous drugs which are prepared but not administered; syringe contents of partly used ampules; residual unused content of dangerous drugs in ampoules and vials, unused portion and volumes of infusions; and unopened or out of date products shall be disposed immediately in conformity with existing regulations. Such disposal shall be witnessed by a nurse and a pharmacist. It must be documented in an appropriate form provided by the medical institution.

4. Medication returns for unused stock of dangerous drugs shall be in accordance with existing laws and regulations. Provided, that patient safety shall at all times be of paramount consideration.
5. The pharmacist shall be responsible for the quality of medications that has to be dispensed. If the quality and integrity of the medications to be returned are questionable, this should not be accepted for the purpose of dispensing it to another patient.
6. The hospital and community pharmacy shall notify the PDEA of all expired dangerous drugs and preparations in its possession and surrender them to the PDEA Laboratory Service or PDEA Regional Office which shall witness the destruction by authorized methods. The cost of destruction shall be borne by the licensed supplier or operator.
7. Documentation of the transfer of items for return, surrender or destruction shall be through a permit system and shall indicate the drug name, dosage form, strength, quantity, and date of transfer, names and signatures of persons making the turn-over and the person receiving, including two witnesses.
8. Accidental breakage of dangerous drugs must be reported to the pharmacist with accompanying duly notarized Incident Report.

Improving access to essential palliative medicine is a responsibility of legislators, the national government, down to the community health unit team.

See Annex X for the Recommended Model List of Essential Medicines for Palliative Care and the Recommended Model List of Essential Medicines for Palliative Care for Children

Ensuring sustainable medicine access in health facilities

1. Palliative and hospice care medicines should be part of the PNF and the MOPS
2. Develop general clinical pathways for Palliative and hospice care and define the specific medicines to the specific diseases in palliative care
3. Ensure LGU hospital pharmacies are S3 licensed
4. The medication should be accessible up to primary care level and not just in bigger hospitals or private institutions
5. Annual Operational Planning of government hospitals and health facilities should include a budget for palliative and hospice care
6. Create a timely and efficient procurement process
7. Create regulations in the proper storage and dissemination of palliative and hospice medication and use of e-prescription

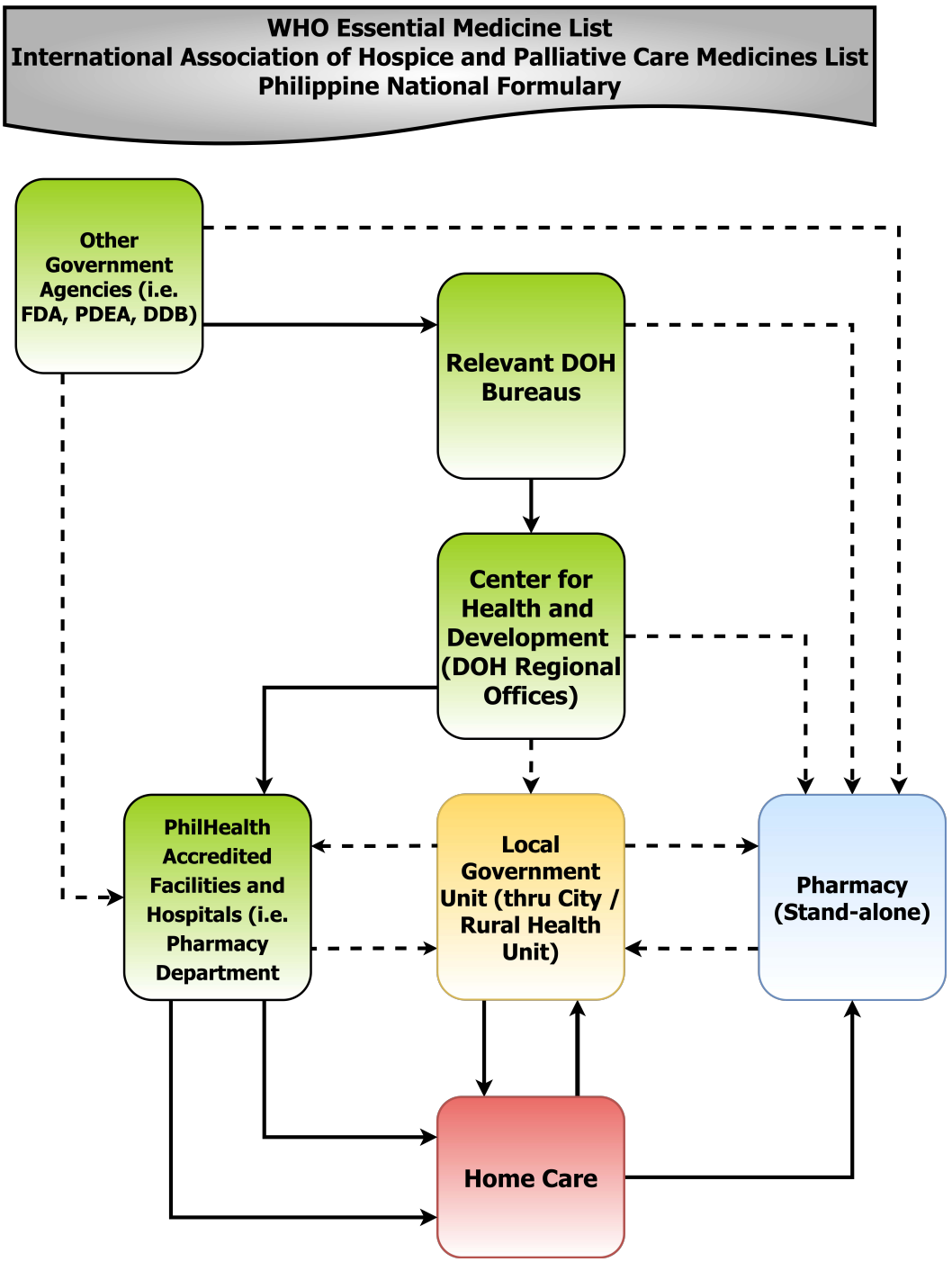


Figure 13. Flow for Palliative and Hospice Access to Medicine - this figure shows the flow of medicines and where the drugs can be accessed. The government plays a key role in ensuring sustainable access to medicines. The regulatory bodies involved in the planning and ensuring safe and cost-effective access to palliative medicines (as recommended in the WHO EML, IAHPC Medicines list, and PNF) include Relevant DOH Bureaus, Pharmaceutical Division, as well as other government agencies (including FDA, DDB, PDEA, etc.). These medicines shall be coordinated through the different DOH regional offices and be passed to hospital pharmacies, the rural/city health units, stand-alone pharmacies, and to the patient's home. Those medicines not covered by PhilHealth shall be covered by the palliative care medicines access program through the DOH CHD and Regional Offices.

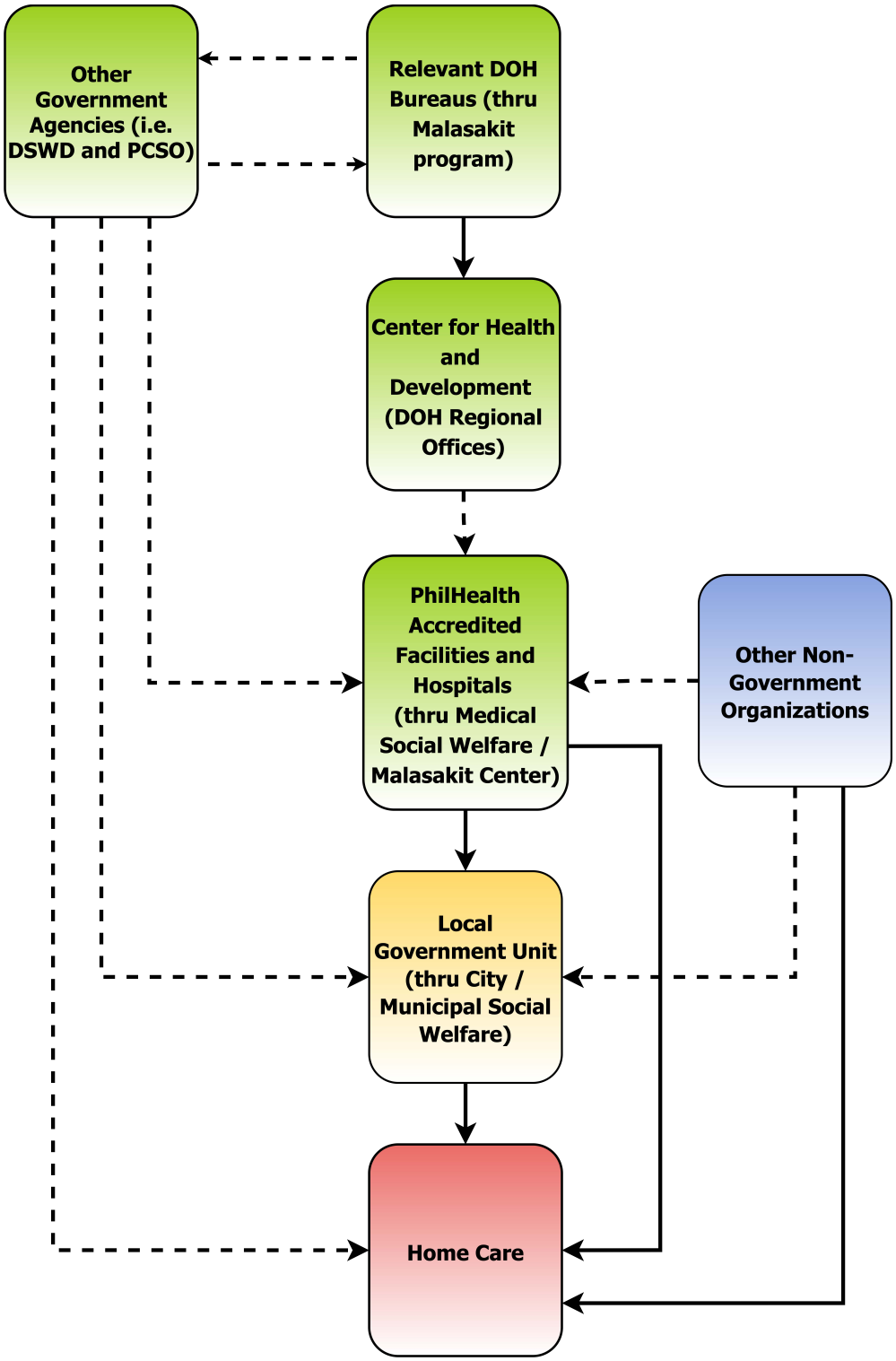


Figure 14. Access to other support services - spiritual, psychosocial, financial (NGOs) - this figure shows the flow of stakeholders involved in ensuring effective access to other support services for palliative and hospice care such as spiritual, psychosocial, and financial support (like *Malasakit* center) through social workers, NGOs, PCSO, LGU, and other agencies involved in supporting the multiple aspects of healthcare. In addition, establishing a working National Palliative Care Registry is important to make this system efficient and coordinated.

Financing and Governance

SECTION VI

Section VI. Financing and Governance

As part of this mandate, the government should ensure that these services are adequately funded and should be paid in such a way to not overburden the people.

A. Elements for the funding and reimbursement of healthcare

To guide the creation of the financing model, Deber et. al (2008) had identified the following elements:

Need, demand and utilization relationship

This provides the context which palliative care should be provided. In the Philippines, the Universal Health Care Law indicates that palliative and hospice care should be a part of the health services that must be provided to the Filipinos. With this palliative care services must be made accessible early on in the disease progression and this includes:

- Malasakit Center Act (RA 11463) - This law established the creation of Malasakit Centers in all DOH hospitals that shall serve as a one stop shop for medical and financial assistance.
- Universal Health Care Act (RA 11223) - The law included palliative health services as one of the services that all Filipinos should have access to.
- National Integrated Cancer Control Act (RA 11215) - The law included responsive palliative care as one of the services of an integrated cancer control act. It also stipulates the expansion of PhilHealth benefits to include this service and that DOH should ensure sufficient, available and affordable supply of palliative and pain management medication.
- Sin Tax Reform Law (RA 10351) - The law restructured the tax on alcohol and tobacco products to curb their consumption and to funneling the revenues to health programs.
- Expanded Senior Citizens Act (RA 9994) - One of the aims of the law is to provide a comprehensive health care and rehabilitation system for disabled senior citizens to foster their capacity to attain a more meaningful and productive ageing.
- Magna Carta for Disabled Persons (RA 7277) - This law mandates that disabled persons have access to an affordable, integrated and comprehensive health service that encompass prevention of disability, recognition and early diagnosis of disability and early rehabilitation of the disabled.
- Rare Disease act (RA 10747) - States that the state shall institutionalize a system that is comprehensive, integrative and sustainable to promote the right of persons suffering from rare diseases to survival and full and healthy development.
- Mental Health act (RA 11036) - One of the aims of the law is to establish a comprehensive national mental health care system responsive to the psychiatric, neurologic and Psychosocial needs of the Filipino people.

Also, to promote access to palliative and hospice care in the rural and far-flung areas as well as to decongest the hospitals, financing should give importance to the community-based and home-based palliative and hospice care. The following services needs to be paid:

- Home visits and other services which include expenses incurred by the family, BHWs and RHU staff in the provision of the service, telemedicine to specialist/palliative care providers, and transportation services
- Palliative and hospice care outpatient consult
- Support services (psychosocial, spiritual)
- End of life care and bereavement
- Inpatient palliative and hospice care service
- Interdisciplinary services
- Incentives for employees in the workplace who are in need of palliative and hospice care or who is the primary caregiver of patients in need of palliative and hospice care
- Incentives for RHU/CHU (performance based) to provide and promote palliative and hospice care

The nature of funding flows

1. **Financing** - Involves individuals or organizations that are paying the health service. The following are those involved in financing palliative and hospice care in the country.

PhilHealth

- PhilHealth is the social health insurance of the country and based on the UHC law should be the primary payer of the health services.
- PhilHealth coverage is attained through the pooling of premiums and use of Sin Taxes cover premiums of the poor
- PhilHealth has role to regularly review coverage and enhance it based on what is cost effective
- PhilHealth shall provide additional benefits to pay for the palliative and hospice care services of patients.

Malasakit Center

- As per (RA 11463) *Malasakit* centers also play a role in ensuring availability and access to medicines for palliative and hospice care. They provide a one-stop shop for the provision of financial assistance to patients. The direction of this shall be towards making the centers available in the LGU especially in their government hospitals and establishing a clear coordination and networking through MOA with the province wide HCPN.

DOH-Hospitals

- The DOH-Hospitals have an annual budget that they use to fund the services that they are providing to indigents. The DOH shall fund the resources needed to provide palliative and hospice care which include the provision of essential palliative and hospice care medicine.

Local Government Unit - Internal Revenue Allotment

- The internal revenue allotment is the local government unit's share of revenues from the Philippine National Government. The LGU has the responsibility to use a portion

of this financial resource to fund health services in their locality. The LGUs shall fund their local palliative and hospice care program.

Private Health Insurance

- Privately owned organizations collect premiums from individuals and in return the organization shall pay a part of the cost of healthcare service that individuals shall need. Private Health Insurance should provide palliative and hospice care packages.

Civic Societies and Non-Government Organizations

- These societies and NGOs provide programs that directly or indirectly fund the palliative care services of the patients.

Out of Pocket

- This is when patients or the family pay for themselves the cost of services. Through the UHC law, this method of financing is aimed to be reduced.

2. **Delivery** - These are the service providers. These includes options from public sector, not-for-profit firms with paid workers, not-for-profit volunteers, for profit small business, for profit investor owned, or individuals and their families

   Service providers for palliative and hospice care and must be payed are the following:
   - PhilHealth Accredited Private and Public Hospital Facilities
   - PhilHealth Accredited Private and Public Primary Care Providers
   - Private, Public or NGO based Community Palliative and Hospice Care Provider (which includes the BHWs and other volunteers)
   - Interdisciplinary teams officially registered in the hospital
   - Stand-alone Hospice and Palliative care provider
   - Home Palliative and Hospice Care Providers

3. **Allocation** - Groups or individuals that determine what and where to allocate the resources. This is the link between financing and delivery and recognizes variation in the incentives inherent in various arrangements

   Department of Health
   - To ensure the adequate provision of palliative and hospice care, DOH should allocate resources on the following:
     - Procurement and distribution of essential palliative and hospice care medication
     - Promotion of Palliative and Hospice Care Services
     - Capital outlay, Human Resource, Training, Medicine and Equipment for public palliative and hospice care providers.
     - Provide technical assistance to LGUs and their palliative and hospice care programs.

Local Government Units

- To ensure the adequate provision of palliative and hospice care, LGUs should allocate resources on the following:
    - Enrollment of indigent constituents to PhilHealth
    - Programs that promote the availment of Palliative and Hospice Care Services
    - Capital outlay, Human Resource, Training, Medicine and Equipment for public palliative and hospice care providers.
    - Ensuring payments from PhilHealth shall be reallocated in the health service provision.

Health care institutions

- Shall allocate necessary funds for the provision of palliative and hospice care services and programs and they should invest in ways to improve the patient accessibility to such services.

Employers

- Employers shall allocate funds to promote palliative and hospice care in the workplace, to refer employees needing palliative and hospice care and to provide benefits to employees that are palliative and hospice care patients or who are a caregiver of a family member in need of palliative and hospice care.

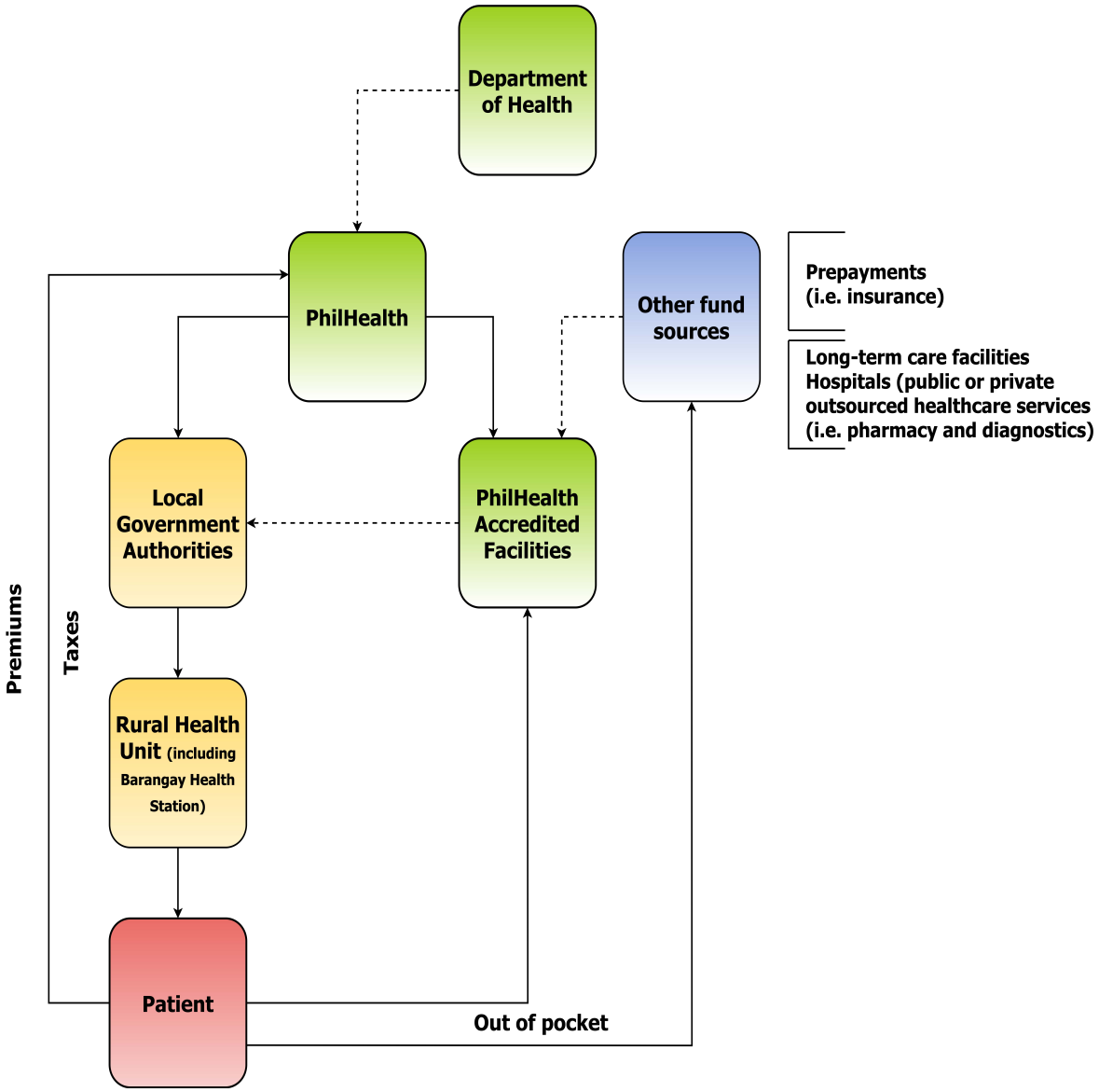


Figure 15. Financing Model for Palliative and Hospice Care - Financing and Governance policies greatly influence the development and provision of palliative and hospice care services. There are several elements that influence models of funding and reimbursement of healthcare. The flow of funding can come from mixed sources, the majority should be covered by PhilHealth under the mandate of DOH in congruence with the UHC through payment of premiums by employees. In addition, funding for palliative and hospice care services may also come from allocated budgets by local government authorities for healthcare/primary care, taxes, while others can be out of the pocket of the patient/families. There are also other fund sources in the form of prepayments (like insurance) or from outsourced healthcare services.

Potential basis for payment on which resources can flow to those delivering care (like contracts, payment per bed day and per head / capitation)

PhilHealth has the responsibility in creating the PhilHealth packages to pay the different health care providers of the different services that they provide for a variety of patients.

B. Creation and Integration of the PhilHealth package

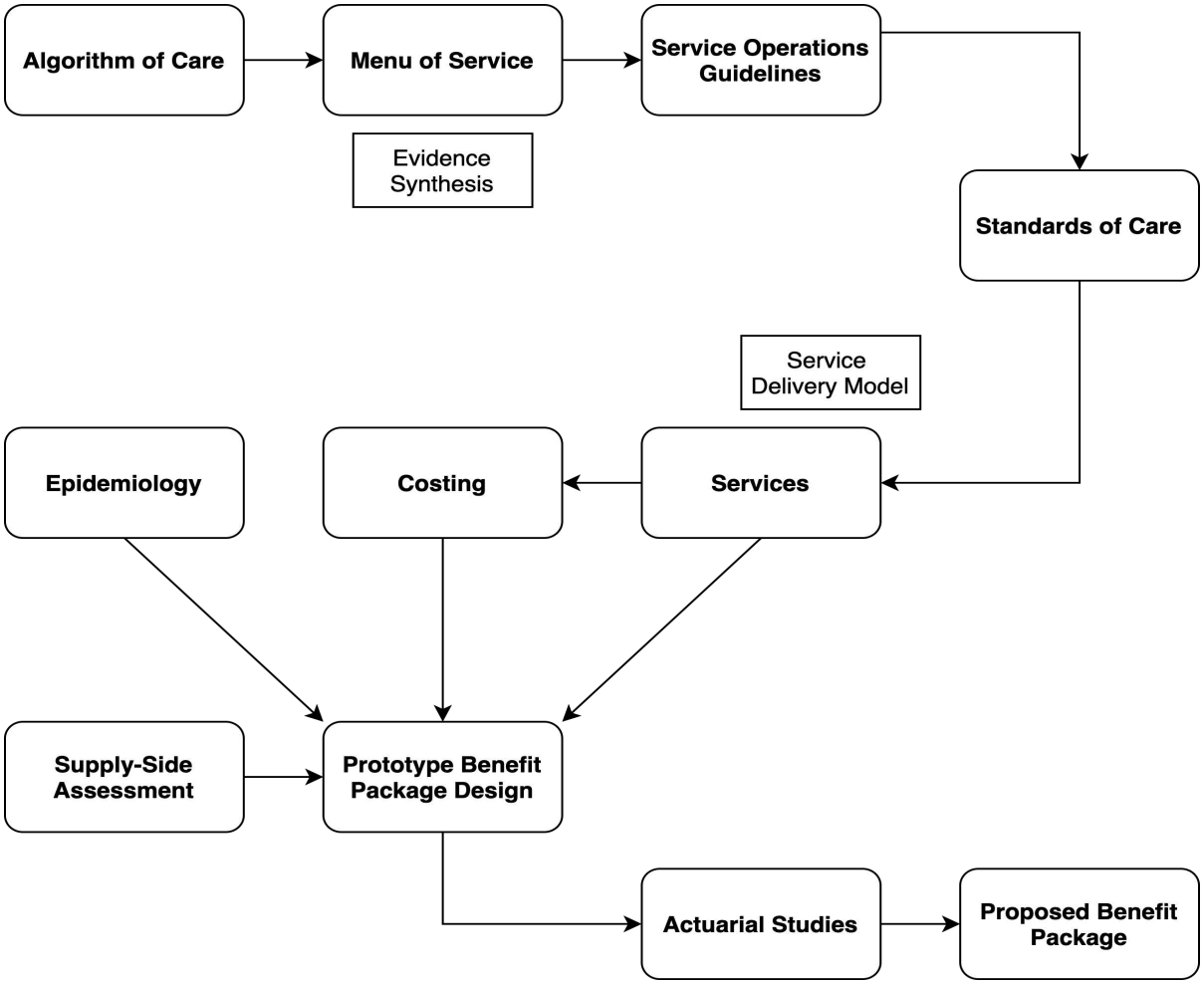


Figure 16. Process flow for the creation and integration of the PhilHealth Package.
(Source: Bundoc JR, Geroy LSA, Jiao PM, Mauricio MU, et al (2018). Technical Assistance for the Development of PhilHealth Z-Benefits for Rehabilitation of Adult Disabilities. Final Technical Report. Physicians for Peace Philippines (PFPP), Philippine Health Insurance Corporation (PhilHealth) and Philippine Council for Health Research and Development (PCHRD). [Unpublished])

There is a need for research and evidence on financing palliative and hospice care programs to ensure sustainability.

Studies on costing analysis, cost of care (hospital versus home), data from existing programs, services, institutions, data collection, epidemiologic studies especially on financial sustainability and development of benefits (PhilHealth) are necessary. Currently there are limited small-scale local cost-analysis studies available for palliative and hospice care. The program requires evidence, and has a process to be done e.g. HTA; epidemiology/ population studies; costing studies; defining services, interventions and amenities; benefits design, defining cost-analysis of hospital care versus primary care and home care. Cost-analysis is necessary to provide evidence of cost-effectiveness of home care and out-patient care for palliative and hospice patients. One example for a Health Technology Assessment question – "What is the impact of palliative care versus rehabilitation?".

It is imperative that the roles of networks and the home/ family are defined and the pathways of different types of conditions for palliative care are well understood. Services specific to palliative and hospice care may be challenging to delineate since it encompasses a huge spectrum of conditions from womb to tomb and is found more effective when integrated in each program as well as using an interdisciplinary approach to planning care. Financing and Quality of Life Studies are also important in developing clinical pathways, HTA, knowing what to prioritize in terms of population coverage, service coverage etc. is crucial in designing PhilHealth benefits for Palliative and Hospice Care Services Packages like in financing of Home care. This shall be possible by means of effective collaboration between DOH, PhilHealth, and all involved Stakeholders. Population based interventions shall be covered by DOH; PhilHealth shall cover individual-based interventions.

In line with this gap, and the transition towards Universal Health Care Coverage (UHC), it is recommended that PhilHealth shall identify palliative and hospice care services and integrate it in already existing benefit packages for funding like in the primary care services, *konsulta* package or case rates for inpatients.

C. Desirable features of a funding model for palliative care

The desirable features of a funding model for palliative care should be acceptable and effective delivery of aid to those that need it including:

- support for the goal of getting appropriately early access to palliative care (not just at end of life)
- support for an appropriate mix of services with palliative and curative intent
- support for services in the most appropriate location
- avoiding financial hardship to service users and families
- providing stable and predictable funding that allows services to be planned and developed in a coherent way
- support services with clear entitlements and that are easy to understand and navigate, and which avoid unnecessary administration and transaction cost

D. Ensuring financial sustainability for health care services

- Aim of UHC is financial risk protection. This is achieved through pooling where the rich, the young and healthy can contribute to the poor, the old and the ill.
- PhilHealth is the country's social health insurance system aiming to pool earmarked resources for healthcare. PhilHealth funds come from payments through employment, while a proportion of the Sin Taxes pays for premiums for the poor
- Local governments and employers must ensure that all their constituents and staff are PhilHealth members
- Hospitals, Local governments and workplaces must ensure that palliative care is integrated into their institutions and programs. This is done through having an institutional, organizational or local government policy to include palliative care in health programs and services. The MOPS provides guidance on what services and activities should be provided by workplaces, local governments through CHUs/RHUs and hospitals.
- Once palliative care is institutionalized through a policy, Annual Operational Plans must include essential services and medicines as prescribed in this MOPS.

Education, Certification, Information and Research

SECTION VII

Section VII. Education, Certification, Information and Research

A. Governance of Education and Certification

- The DOH, CHED, TESDA, PRC shall be responsible in developing and planning for the expansion of existing and new allied and health related degree and training programs to include palliative and hospice care education based on the health needs of the population.
- The DOH Health Human Resource Development Bureau (HHRDB) is responsible for providing technical assistance in the development of learning interventions for health professionals involved in palliative and hospice care and facilitating integration of palliative and hospice care in the academic curriculum of health professionals.
- The Professional Regulation Commission (PRC) through the health regulatory boards is responsible to ensure that health professionals comply with the requirements for the training and practice of palliative and hospice care based on the standards. It shall review and update if necessary, the accreditation standards and admission policies or requirements for medical residency, and sub-specialty training and specialization tracks for allied health professionals to support competencies in palliative and hospice care.
- The Commission on Higher Education (CHED) in coordination with duly registered medical and allied professional societies shall include palliative and hospice care in the collegiate and graduate health curricula and develop new programs to supply health care provider networks with practice-ready health and allied health care professionals and health care workers equipped with knowledge and skills in basic palliative and hospice care.
- The Technical Education and Skills Development Authority (TESDA) has the role of setting standard, assessment and certification as well as conducting monitoring and evaluation of caregiving training programs to include basic palliative and hospice care skills and approaches.
- The role of the National Hospice and Palliative Care Council of the Philippines or Hospice Philippines and the Philippine Society of Hospice and Palliative Medicine are important key leaders in promoting and advocating quality education, training, certification and research for palliative and hospice care providers in the country.

Training per service level is important as the approach in Palliative Care is mostly holistic and inter/multidisciplinary, transdisciplinary. It must be inclusive (even lay persons, child life coordinators and specialists services from all hospital levels). A committee should be established from key agencies, DOH, Hospice Philippines, PSHPM, NGOs, public and private agencies, and other stakeholders engaged in advancing palliative and hospice care in the Philippines. This shall be a collaborative effort geared towards programs and projects on training for how to set-up programs/teams and individual training skills for palliative and hospice care.

B. Training Requirement per Healthcare Provider per Level of Care Setting

The following are the required palliative care training of health workers per level of care setting. The training is a prerequisite for the accreditation of the healthcare providers.

Table 10. Training Requirement per health care provider per level of care setting (Service Level Allocation)

Levels of Care	Primary Care Provider	Training Required
Workplace	Doctor	Basic
	Nurse	Basic
	Human Resource Manager	Basic
Community	Doctor, Clinical Officer, Assistant Doctor/Rural Health Physician	Intermediate
	Nurse	Intermediate
	Midwife	Basic to Intermediate
	BHWs	Basic Recommended to have Caregivers training under TESDA with at least 3-6 hours of training in recognizing uncontrolled physical or psychological distress or significant social distress
	New volunteers (NGO)	Basic 16 hours (Basic curriculum on nursing care, communication skills, and emotional support)
Hospital (Level 1 and 2)	Doctor, Nurse	Intermediate to Advanced
	Nursing Aide, Spiritual Care Provider	Basic
	Social Worker, Pharmacist, Counsellor or Psychologist, Nutritionist Dietitian, Child Life Specialist	Basic to Intermediate
Hospital (Level 3 and Apex/ End-referral) *Palliative Care Unit	Doctor (Pedia/Adult Palliative)	Advanced (for MDs)
	Nurse (Pedia/Adult Palliative)	Intermediate to Advanced (for Nurses)
	Nutritionist Dietitian, Psychologist (adult/child), Child Life Specialist	Intermediate to Advanced
	Nursing Aide and Caregivers	Basic to Intermediate
	Pharmacist, Rehab specialist (PT/OT/Play therapist), Care Navigator or Social Worker, Spiritual Care Provider, Other subspecialties	Intermediate

C. Training Programs

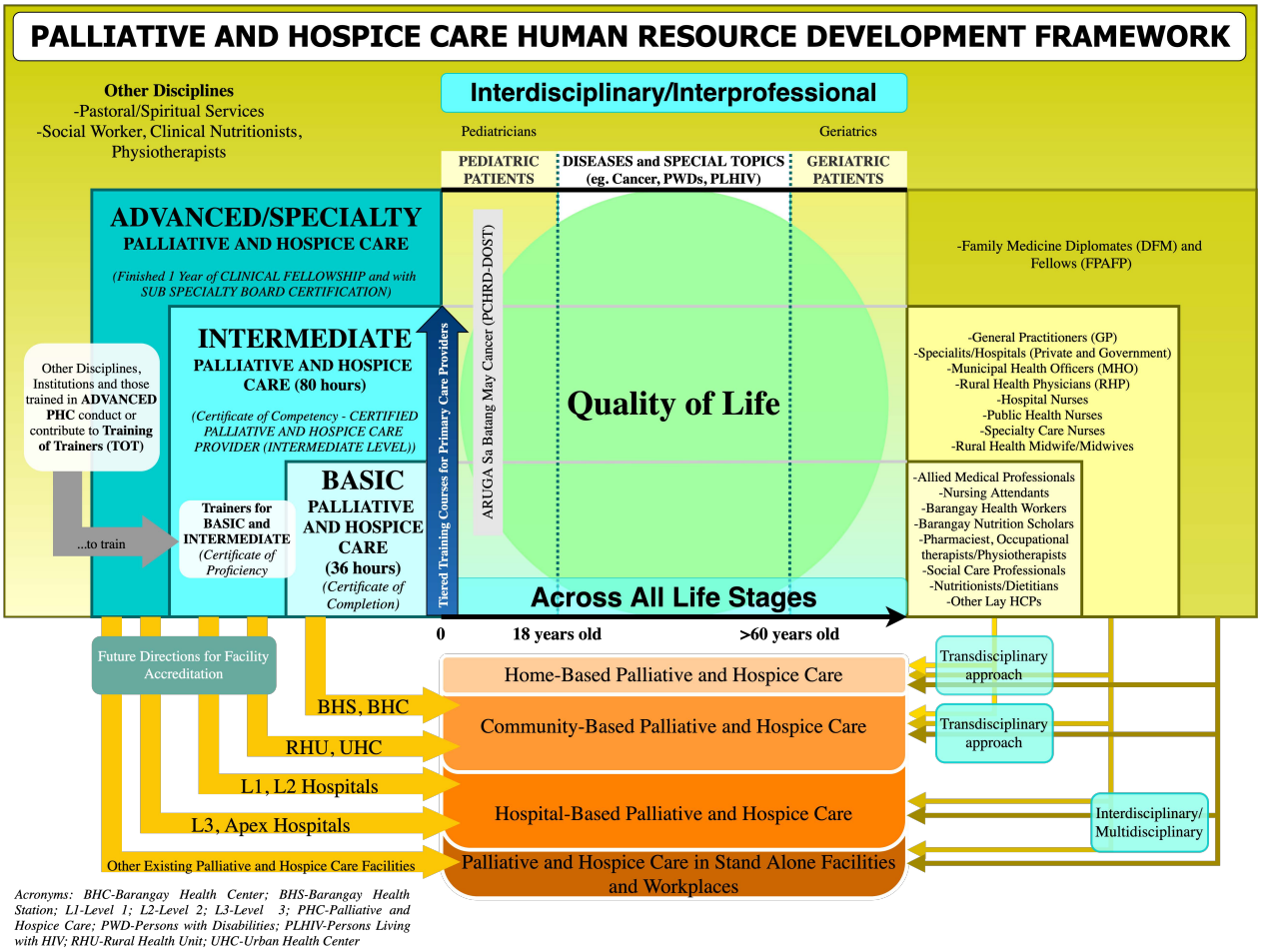


Figure 17. Drafted Palliative and Hospice Care Human Resource Development Framework

This shows that palliative and hospice care training must be aligned and appropriate to each setting, from basic, intermediate to advanced training and that it should be made available to all healthcare providers and all persons involved in providing palliative and hospice care services.

Basic Training

- Module 1 Introduction and General Principles of Palliative Care
- Module 2 The Palliative Care Approach
- Module 3 Communication
- Module 4 Hospice Care
- Module 5 Grief and Bereavement

Intermediate training

- Module 1 Palliative and Hospice Care: An Introduction
- Module 2 Pain Management in Palliative and Hospice Care
- Module 3 Symptom Management
- Module 4 The Art of Listening and Effective Communication
- Module 5 Cultural and Spiritual Care
- Module 6 Ethical Considerations in End-of-Life Care
- Module 7 Loss, Grief and Bereavement Care
- Module 8 Final Hours Management
- Module 9 Pediatric Palliative Care
- Module 10 Nutrition and Physical Medicine in Palliative Care
- Module 11 Special Topics
- Module 12 Teaching Primary Palliative Care to Community Health Workers

Some of the other critical considerations that need to be planned in the future to help ensure that healthcare workers are equipped to handle palliative cases and provide good service delivery include the following: palliative and hospice care nursing practice, clinical pharmacy, clinical nutrition, social work, technical skills development of BHWs and volunteers, caregivers, and lay persons.

D. Palliative and Hospice Care Providers

Medical doctors and other health professionals may be considered palliative or hospice care practitioners when they fulfill all of the following requirements:

- Completed the DOH basic and intermediate training for palliative and hospice care
- Certifying institution of training must be recognized by the DOH, or Philippine Professional Regulation Commission, or local or international professional societies or other reputable international organizations specializing in palliative and hospice care
- Must be a member of a recognized Professional Society

E. Palliative and Hospice Care Specialists

Medical doctors and other health professionals may be considered palliative and hospice care specialists when they fulfill all of the following requirements:

- Board-certified specialist (locally or internationally-trained) with at least a minimum of 1 year face-to-face advanced training or postgraduate studies in palliative and hospice care with research studies and passed the required subspecialty board examination
- Certifying institution of advanced or specialty training must be recognized by the Philippine Professional Regulation Commission, or local or international professional societies or other reputable international organizations specializing in palliative and hospice care
- With at least 1 year of professional experience in palliative and hospice care (in either clinical or public health setting)
- Must be a member of Hospice Philippines or Philippine Society of Hospice and Palliative Medicine (PSHPM)

Advanced specialty training for medical doctors

The Philippine Society of Hospice and Palliative Medicine (PSHPM) is currently a member organization under the Philippine Academy of Family Physicians (PAFP), whose members are specialists in Palliative Medicine, focusing on training of medical doctors and research in palliative and hospice medicine, also extending beyond through service and advocacy. Currently there are only a few training institutions in the country recognized by PSHPM for advanced palliative medicine specialization for Family Medicine diplomates who want to further train in the field of palliative and hospice care. Those in other fields may opt to further train abroad but eventually as the program establishes its integration, more training for specialized palliative medicine shall hopefully ensue locally.

In addition, it is encouraged to develop local innovative training programs (like a practice-based palliative medicine fellowship or distance learning education) in the future since it is very much relevant especially during times of limited travel and health crisis, to ensure continuous training and learning for doctors engaged in palliative and hospice care.

Advanced specialty training for registered nurses

Palliative care nursing involves the assessment, diagnosis, and treatment of human responses to actual or potentially life-limiting or life-threatening illness and necessitates a dynamic, caring relationship with the patient and family to reduce suffering. The following are special skills needed for advanced specialty in palliative care nursing:

- Communication - Palliative care nurses must have the ability to explain complex information as patients are often seeking clarity on disease progression, medications, and plan of care. They need to be able to explain this information for both the patient and family.
- Compassion - Compassion for self can help to prevent burnout, while compassion for patients and families helps to establish a supportive, trusting relationship as symptoms change or worsen or death approaches.

The following are the advanced knowledge needed for a specialist palliative care nurse:

- Expert knowledge in palliative care
    - Pathophysiology of diseases
    - Advanced pain and symptom assessment and management,
    - Counseling
    - Communication skills
    - Advanced care planning
- Advanced knowledge about caring for individuals with serious, life-threatening illness, as well as those who are imminently dying.

As of this time, there is still no advanced palliative specialty training for nurses established in the country. However, MA in Nursing (specializing in Adult Health Nursing/Medical Surgical Nursing/Community Health Nursing/Gerontology Nursing) are available. There are also certification and advance training provided by Nursing Specialty Groups. Career progression and specialization for nursing in Palliative and Hospice Care have been created by the Philippine Regulatory Board of Nursing (PRBON) with the Palliative and End-of-Life Care Association of the Philippines (PEOLCAP). (Annex XXIII)

F. Training of Trainers, Recognition and Certification of Trainers

Continuity and standardization of the basic and intermediate training for health care providers can be ensured by conducting a training of trainers with proper recognition and certification process for participants.

G. Other trainings

There are also other training available like Aruga sa Batang may Cancer, End-of-Life Nursing Education Consortium (ELNEC) which can be accessed for further training on pediatric palliative care and palliative nursing care in addition to some Masters degrees for nurses being offered locally.

Incorporation to the Syllabus of all Health workers

Palliative care must be included in the undergraduate course of the health workers.

- The curriculum must include the following core competencies:
  - Basics of palliative care
    - Definition and principles of palliative care
    - Models of palliative care
    - Integration of Palliative Care in the Health Continuum
  - Identification and control of symptoms
    - Pain
    - Respiratory symptoms
    - Gastrointestinal symptoms
    - Insomnia
    - Delirium
  - End-of-life care
    - Palliative sedation
    - End-of-life care
  - Basic Nutrition for the Vulnerable age group
  - Ethical and legal issues
  - Psychosocial and spiritual issues
    - Emotional issues
    - Grief and bereavement
    - Spirituality
    - Caregiver and family
    - Communication and therapeutic relationship
  - Teamwork
  - Self-awareness and self-care in caring for terminally ill patients
    (Prastana, et. al. 2016; EFPPEC, 2018)

H. Foundation Course in Palliative Care

- Introduction to Palliative Care
    - Background, Definition, Philosophy and Essential Principles of Palliative Care
    -
- Pain
    - Pathophysiology of Pain
    - Management of Pain
- Communication Skills
    - Definition and Components of Communication
    - Role of Communication Skills in Palliative Care
    -
    - Characteristics of a Good Speaker and a Good Listener
    - Active listening
    - Steps in Breaking Bad News
    - Barriers to Effective Communication
- Wound Management
    - Pressure Sore
    - Fungating wound
- Symptom Management
    - Nausea and Vomiting
    - Constipation
    - Bowel Obstruction

    - Ostomy care
    - Breathlessness
    - Cough
- Psychosocial Spirituality Issues
    - Psychosocial assessment
    - Spiritual assessment
    - Psychosocial and Spiritual interventions
- Emergencies in Palliative Care
- Palliative Procedures:
    - Subcutaneous infusion and Hypodermoclysis
    - Lymphedema and Decongestive Therapy Practical Session
- End of Life Care and Medical Ethics

I. Research

- This shall involve collaboration among the PCHRD, PNHRS, NUHRA, in including palliative and hospice care among the research agenda setting
- DOH provides recommendations for research, where palliative and hospice care studies need to be included
- Role of hospital and training institutions in research is equally important in generating relevant local studies appropriate to the Philippine setting
- See Annex XXIII for some of the recommended Research agenda in palliative and hospice care

J. Information System

- National database for palliative care (DOH KMITS), information on stakeholders and health providers
- DICT Law (2015) includes provisions to build better health information system as part of national strategy to improve ICT
- Database should be created at local levels, LGUs and barangays
    - Hospitals use iHOMIS
    - Health Facilities iClinicSys
    - Hospitals and health facilities are required to have EMR so they can apply for and file PhilHealth claims
- Other existing information systems provided by private sector providers, mainly used by public and private sectors
- Information system requires planning, investment and regular upgrading

Regulation, Accreditation, Monitoring of Palliative and Hospice Care Facilities

SECTION VIII

Section VIII. Regulation, Accreditation, Monitoring of Palliative and Hospice Care Facilities

A. Accreditation Criteria

Hospitals, private hospice institutions, medical practitioners, health workers, and social workers for palliative and hospice care shall be accredited by the Department of Health (DOH). The DOH, in partnership with the National Hospice and Palliative Care Council of the Philippines (Hospice Philippines, Inc.) shall formulate the rules and guidelines for accreditation to ensure a standard qualification of palliative care services.

An accredited health care institution (public or private) must ensure efficient quality of palliative and hospice care services and at the same time follow the rules, policies, laws, and procedures by DOH and PhilHealth in order to maintain continuous participation in the Universal Health Coverage Act and National Health Insurance Program.

The Health Care Institution or HCI (RHU, Workplace, Community-based, Home-base, Hospital-base, or Stand Alone) shall submit all the requirements for continuous participation on time, register to PhilHealth as an employer and ensure that employees and affiliated health care workers are active members of PhilHealth, must have an established system for credentialing affiliated health care professionals.

B. Regulation of Health Facilities

The regulation of the health facilities is under the purview of the Health Facilities and Services Regulatory Bureau (HFSRB) and the DOH Center for Health Development - Regulation Licensing and Enforcement Division (DOH CHD-RLEDs) which provides the license to operate to health facilities in accordance to the DOH AO 2021-0019 and other relevant issuances.

Role of HFSRB:

- Shall set standards for the regulation of hospitals and health facilities at different levels. These standards shall be guided by the different palliative and hospice care services that should be made available at different levels as defined in this MOPS.
- Shall create/modify inspection and monitoring tools from time to time.
- Shall disseminate regulatory policies and standards and updated forms for information and guidelines to the DOH CHD-RLEDs.
- Shall provide consultation and technical assistance to regulatory officers from DOH CHD-RLEDs and stakeholders in the regulation of hospitals and other health facilities.
- Shall conduct unannounced monitoring visits to hospitals and other health facilities to check for continuous compliance to the standards and requirements, as oversight and monitoring functions.
- Shall monitor and evaluate annually the DOH CHD-RLED's performance in the regulation of hospitals and other delegated health facilities and services.

Role of DOH CHD-RLED

- Shall implement and uphold the standards and requirements set forth in the Assessment Tool for Licensing a Hospital, their ancillary and/or add-on facilities and services and other relevant policies issued by HFSRB
- Shall ensure timely submission of accurate and relevant statistical data on hospitals and other delegated health facilities and services, as required or as needed

C. Regulation of Health Workers

The first level regulatory body for health practitioners such as doctors, nurses, pharmacists, nutritionist dietitians, social workers and other allied medical professionals is the Professional Regulatory Commission. Their role in the promulgation of palliative and hospice care in the Philippines is to ensure that all health professionals have at least a certification for basic training.

Each of the health professionals and health workers shall have their own certifying body. Nursing Aide (NC II) and Caregivers shall be certified after undergoing DOH basic training for palliative and hospice care and doctors shall be certified by the DOH after undergoing DOH basic and intermediate training for palliative and hospice care. Certifying body of each of the other health professions shall still need to be identified.

Health providers in the Palliative Care team shall be required by PhilHealth to submit basic documents on certification. As a grandfather clause, for health professionals who had undergone palliative and hospice care training in the past 3 years prior to the publication of this MOPS need only to take an intermediate training.

All individuals engaged in the practice of palliative and hospice care should be a member of the National Hospice and Palliative Care Council of the Philippines, Inc. (Hospice Philippines, Inc.) and the said institution in partnership with DOH shall be part of the main accrediting body.

D. Regulation of Medicines

Regulatory agencies

The regulation of medicines is the responsibility of three national agencies. The Food and Drug Administration is mandated to ensure the safety, efficacy and quality of health products which includes and medicines. The Dangerous Drugs Board is mandated to create policies for the procurement, distribution and disposal of dangerous drugs. These policies are being enforced by the Philippine Drug Enforcement Agency.

Scheduling of Medicines

Scheduling is a national classification system that controls how medicines are made available to the public.

Table 11. Philippine Schedule of Drugs

Philippine Schedule	Generic Names
Philippine Schedule I has no currently accepted medical use in treatment in the Philippines; has lack of accepted safety for use of the drug under medical supervision	
Philippine Schedule II may have currently accepted medical use treatment in the Philippines; has high potential for abuse that may lead to severe psychological or physical dependence	Fentanyl, Morphine, Oxycodone, Pethidine, Methylphenidate, Remifentanil
Philippine Schedule III has a currently accepted medical use in treatment in the Philippines; has a potential for abuse less than the drug in schedules I and II that may lead to moderate or low physical dependence or high psychological dependence	Buprenorphine, Phenobarbital
Philippine Schedule IV has a currently accepted medical use in treatment in the Philippines; has a low potential for abuse less than the drug in schedule III that may lead to limited physical dependence or psychological dependence	Alprazolam, Bromazepam, Clonazepam, Clorazepate, Diazepam, Midazolam, Phenobarbital, Phentermine, Zolpidem
Philippine Schedule V has a currently accepted medical use in treatment in the Philippines; has potential for abuse that may lead to from low to high psychological or physical dependence. Dangerous Drugs in the Philippines only.	Ephedrine, Ketamine, Nalbuphine

Prescription, Distribution and Disposal of Dangerous Drugs

In the Philippines the law that oversees the dangerous drugs is the Republic Act No. 9165, "An Act Instituting the Comprehensive Dangerous Drugs Act of 2002". In it the dangerous drug board was delegated as the policy-making and strategy-formulating body in the control of dangerous drugs.

Currently, to prescribe dangerous drugs, there is a need to have an S2 license and for a pharmacy to dispense dangerous drugs, they need an S3 license.

E. Possible Sources of Information for Monitoring and Evaluation

- Regular review of the patient's chart
- Weekly case management meeting
- Virtual management - Viber groups/SMS
- Weekly, Monthly, Quarterly, and Yearly Census
- Quality of care is assessed by review and audit on basis of patient-reported outcomes

F. Monitoring and Evaluation for the National Palliative and Hospice Care Program

Table 12. Sample indicators for assessing enhanced access to palliative care in PHC

Category	Indicator
Policy	Existence of a current national palliative care policy that requires access for all to palliative care and to pain control with opioid pain medicines (yes/no)
	Existence of a current national palliative care strategic plan to create access for all within a specified time period to palliative care and to pain control with opioid pain medicines (yes/no)
	Existence of current national policies or strategic plans that promote access to palliative care and to opioid analgesia on the following topics: primary health care (yes/no) cancer (yes/no) noncommunicable diseases (yes/no) older persons (yes/no) pediatrics (yes/no) HIV/AIDS (yes/no) drug-resistant tuberculosis (yes/no)
	Essential Package of Palliative Care for Primary Health Care included in universal health coverage (yes/no)
	Laws and regulations in place for safe and effective opioid prescribing in line with international drug conventions at the district level? (yes/no) At the community level? (yes/no)
Education	Proportion of medical schools that include palliative care education in undergraduate curricula (ratio of medical schools with palliative care at the undergraduate level to total medical schools)
	Proportion of nursing schools that include palliative care education in undergraduate curricula (ratio of nursing schools with palliative care at the undergraduate level to total nursing schools)
	Proportion of medical technical schools (for training clinical officers, assistant doctors, nurse practitioners, pharmacists, nutritionist dietitians and other allied medical professionals) that include palliative care education in undergraduate curricula (ratio of medical technical schools with palliative care to total medical technical schools)
	Number of specialized palliative care educational programs for different health professionals accredited by the national competent authority
Service Provision	Palliative care included in the list of services provided at the primary care level (yes/no)
	Proportion of communities that provide palliative care services (ratio of the number of communities that provide palliative care services to the total number of communities)
	Number of palliative care services per million inhabitants
	Number of physicians working in palliative care per million inhabitants
Medicines	Consumption of strong opioids per cancer death (milligrams of oral morphine equivalents per patient who dies from cancer)

	Consumption of strong opioids per capita (milligrams of oral morphine equivalents per year / total number of inhabitants
	All WHO essential medicines for palliative care included on the national list of essential medicines (yes/no)
	Proportion of districts where oral morphine is in stock and available in at least one pharmacy (ratio of districts with oral morphine in stock and available to the total number of districts)
	Number of pharmaceutical establishments that dispense strong opioids per million inhabitants
Outcomes	Percentage of patients with access to palliative care at the time of death
	Number of patients receiving palliative care per 100 000 inhabitants

Sources: Adapted from ACLP 2013, WHO 2016 (3), Knaul et al. 2017 (1).

Monitoring and Evaluation for Palliative and Hospice Care Program in the Provinces

Table 13. Sample indicators for assessing palliative and hospice care in the provincial level

Category	Indicator
	Percentage of people who receive care in their last 30 days of life: home care services, health care provider home visits, hospice care **Denominator:** Number of people who died and were in the community in the last 30 days of their life (exclusions: people who spent their last month in hospital, long-term care/complex continuing care or an inpatient rehabilitation facility **Numerator:** Number of people in the denominator who in their last 30 days of life received any home care, palliative home care and physician home visit
	Percentage of people who had one or more unplanned emergency department visits in their last 30 days of life **Denominator:** Number of people in the province who died in each year of interest (exclusions: people who spent their last month in hospital, complex continuing care, or an inpatient rehabilitation facility) **Numerator:** Number of people who had at least one unplanned emergency department visit in their last 30 days of life (exclusions: planned emergency department visits)
	Percentage of people who died in hospital, long-term care and the community **Denominator:** Number of people in the province who died in each year **Numerator:** Number of people who died in each of the following settings: ● hospital (in-patient care, emergency department, complex continuing care, or inpatient rehabilitation facility) ● Long-term care homes ● The community (home, hospice residence, retirement home, or assisted-living home)

Health Quality Ontario (2018)

Monitoring and Evaluation for Palliative and Hospice Care Program in the Hospitals

- All palliative care services should keep up-to-date records of their activities and patient statistics as well as perform regular auditing of services
- Auditing of services shall be determined by the head of the individual palliative care service and should observe issues of efficiency, effectiveness, patient safety and patient satisfaction of services
- Key Performance Indicators and other QA Indicators for palliative care services which shall serve to monitor the performance of the palliative care service in the hospital

Table 14. Sample indicators for assessing palliative and hospice care program in the hospitals and palliative/hospice care facility

Category	Indicator
Process	Percentage of health professionals (nurses, doctors, clinical officers) trained and providing palliative care services
	Number and percentage of palliative care sites with minimum staff norms (1 trained nurse and 1 trained clinician)
	Number of drug day availability
	Total number of patients receiving palliative and hospice care services
	Number of referrals to other facilities and services relative to palliative care
	Number of referrals received by the facility from other facilities or services relative to palliative care
	Number of received transfers of service to palliative care unit
	Number of sent transfers of service by palliative care unit
	Number of patients discharged and sent home for home care
	Number of patients who opted for Home per Request
Output	The proportion of patients seen at home
	Percentage of patients seen as inpatients in the palliative care unit
Impact	Quality of palliative and hospice care services
	Cost/financial impact of palliative and hospice care (out-of-pocket, PhilHealth, insurance)
Medication	Consumption of strong opioids per cancer death (mg per number of deaths)
	Consumption of strong opioids per non-cancer death (mg per number of deaths)

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Annex I. Service Level Allocation

Focus Area	Home Care	RHU/CHU	Workplace / School	L1 Hospital	L2 Hospital	L3 Hospital	Apex Hospital
APPROACH	PC Approach	PC Approach	PC Approach	Specialist Support for General Palliative Care	Specialist Support for General Palliative Care	Specialist PC	Specialist PC
TEAM- WORK							
***Multidisciplinary:** draws on knowledge from different disciplines but stays within their boundaries (Choi and Anita, 2006)							
****Interdisciplinary:** analyzes, synthesizes and harmonizes links between disciplines into a coordinated and coherent whole (Choi and Anita, 2006)							
*****Transdisciplinary:** Integrates the natural, social and health sciences in humanities context, and transcends their traditional boundaries (Choi and Anita, 2006)							
SERVICES							
Telemedicine consultation							
Home Care							
Community-Based							
Outpatient Care		Primary Care				Specialist Care	Specialist Care
Acute Care							
In-patient Care							
Intensive Care							
Palliative Care Unit						Consulta-tive Service (if w/o PCU)	
Palliative Care for Children							
Referral	Refer to RHU or other levels	Navigator of the System	Refer to Primary Care	Refer to either RHU or L3	Refer to either RHU or L3	Refer back to primary care/ L1-2 Hospital	Refer back to primary care/ L1-2 Hospital

Focus Area	Home Care	RHU/CHU	Workplace / School	L1 Hospital	L2 Hospital	L3 Hospital	Apex Hospital
ASSESSMENT							
Physical Exam							
Laboratory		Level 1 Lab		Level 2-3 lab	Level 2-3 lab	Level 3 lab w/ histopath	Level 3 lab w/ histopath
Imaging (X-ray,CT, MRI, etc)		Xray		Level 1-2 imaging	Level 1-2 imaging	Level 3 imaging	Level 3 imaging
Patient/Family assessment form							
Social worker assessment form							
Spiritual Care Assessment Form							
OTHER SERVICES							
Individual Counseling							
Family Counseling							
Spiritual Care Counseling							
Survivorship Programs							
Support Groups							
Advanced Care Planning							
Patient and Family Education							
Respite Care for Patients and Family							
Grief and Bereavement Support							
Care for Carers			leave benefits				
Physical Therapy and Rehab		Currently lacking					
Nutritional Support		(more of BHNS)					
FINANCIAL SOURCES		Municipal LGU Special Health Fund		Special Health Fund HMOs OOP	Special Health Fund HMOs OOP	Direct Contracting (Apex Hospital) Special Health Fund HMOs OOP	Direct Contracting (Apex Hospital) Special Health Fund HMOs OOP

Focus Area	Home Care	RHU/CHU	Workplace / School	L1 Hospital	L2 Hospital	L3 Hospital	Apex Hospital
Committee							
Palliative and Hospice Care Committee							
Ethics Committee							
Hospital Palliative Care Support Team							
Home Care Palliative Care							
Palliative Care Unit Team							
Inpatient Hospice Care Team							
HUMAN RESOURCE	**TRAINING**						
Caregivers/Family	Basic	Basic					
Volunteer	Basic	Basic					
BHW	Basic-Intermediate	Basic-Intermediate					
Midwives		Basic-Intermediate					
Social Worker		(MSWD) Basic		Orientation palliative special needs	Orientation palliative special needs		
PT/OT							
Nutritionist Dietitian							
Palliative Nursing Aid				Basic	Basic		
Psychologist/ Counselor							
Psychiatrist/ Psychologist							
Child Psychiatrist							
Chaplain		(Religious Leaders)					
Teacher							
Nurse				Intermediate-Advanced	Intermediate-Advanced	Palliative Specialist	Palliative Specialist
Doctor				Intermediate-Advanced	Intermediate-Advanced	Palliative Specialist	Palliative Specialist
Pediatrician				Intermediate (children)	Intermediate (children)	Palliative Specialist	Palliative Specialist
Other Specialist							

Focus Area	Home Care	RHU/CHU	Workplace / School	L1 Hospital	L2 Hospital	L3 Hospital	Apex Hospital
MEDICINES and SUPPLY							
Oral pain and opioid meds							
Oral and topical antibiotics							
IV antimicrobials							
IV drips of pain meds and sedatives							
Oxygen therapy							
Palliative Care Chemo/ Radiotherapy							
Specialized Nutrition Support (ONS, EN, PN)							

Palliative Care Approaches of Intervention

	Multidisciplinary*	**Interdisciplinary****	**Transdisciplinary*****
Assessment	Separate assessment by team members	Separate assessments by team members	Team members and family conduct a comprehensive developmental assessment together
Family Participation	Family meets the individual team members	Family meets with the team or team representative	Family members are full, active, and participating members of the team
Service Plan Development	Team develop separate plans for their discipline	Team members share their separate pans with one another	Team members and the parents develop a service plan based upon family priorities, needs, and resources
Service Plan Responsibility	Team members are responsible for implementing their section of the plan	Team members are responsible for sharing information as well as for implementing their section of the plan	Team members are responsible and accountable for how the primary service provider implements the plan
Service Plan Implementation	Team members implement the part of the service plan related to their discipline	Team members implement their section of the plan and incorporate other sections where possible	A primary service provider is assigned to implement the plan with the family
Lines of Communication	Informal lines	Periodic case-specific team meetings	Regular team meeting where continuous transfer of information, knowledge, and skills are shared among team members
Guiding Philosophy	Team members recognize the importance of contributions from other disciplines	Team members are willing and able to develop, share, and be responsible for providing services that are a part of the total service plan	Team members make a commitment to teach, learn, and work together across discipline boundaries to implement unified service plan
Staff Development	Independent and within their discipline	Independent within as well as outside of their discipline	An integral component of team meetings for learning across disciplines and team building

Source: Adapted from *Woodruff, G. & Hanson, C. (1987). Project KAt,778 Warren Street, Brighton, MA 02135. Funded by the U.S. Department of Education, Special Education Programs, Handicapped Children's Early Education Program.*

Annex II. Core Competencies in Palliative Care (from CAPC)

General Medicine Has broad understanding of and experience in the care of serious or life-threatening diseases/ conditions, including course of illness, prognostic factors, common complications/syndromes and symptoms. In particular: cancer, chronic lung / heart / kidney / liver / endocrine / rheumatologic / vascular / infectious diseases; progressive neurological disorders; and serious trauma.
Pain and Symptom Management Appropriately manages pain and other distressing physical symptoms of disease, illness or treatment in a timely manner and achieves outcomes and side effects acceptable to the patient / family. Management may include referral to appropriate specialists and/or acceptance and support of the patient's decision to include complementary therapies in treatment.
Emotional Supports patient and family expression of emotional needs. Listens actively, supports as appropriate, and refers to support groups, other patients and families with similar conditions, and/or professionals with expertise in this area. May use open-ended questions such as "How are you doing? How are things going in your life? What, if anything, are you feeling anxious about?"
Psychosocial Provides an environment to support patient and family expression of psychosocial needs. Listens actively, supports as appropriate, and refers to support groups, other patients and families with similar conditions, and/or professionals with expertise in this area. Integrates this area with each interaction. May use open-ended questions such as "How are you doing? How are things going in your life? How have things changed for you in your life? How are your spirits? How are you feeling inside yourself?"
Spiritual/Cultural Manages interactions to support patient and family expression of spiritual needs, strengths and cultural practices. Creates an environment that allows integration of dialogue about spiritual issues within care experience. Refers to spiritual care staff and community resources as congruent with patient/family values. Communicates cultural care preferences of patients/families to others. May use questions such as "What is the meaning of this illness to you and for your life? What lessons would you want to share? How has your sense of time changed? What strength have you called upon as you go through this illness? Are there specific religious or family traditions you would like us to consider?"
Relationship: Family and Community Addresses desires and needs for support from family and friends. Determines if there has been a change in family communication. Facilitates family communication of specific issues by structure of interactions. Provides anticipatory guidance for family members as they focus on their relationships. This may include reconciliation of relationships. Provides helpful tools and/or resources for assistance with family communication. May use questions such as "How have things been within your family? Are there things you would like to say to your family or things you would like them to know? Friend? Colleague? How much change has occurred with your social relationships outside the family?
Honoring Patient Care Wishes Understands and communicates patient and family wishes prior to crises or impending death. Honors wishes as care goals change. Carries out interventions that make a difference for patient comfort and/or recovery. Supports patient and family when
Dying and Death

Identifies those who are approaching last days of life. Communicates honestly to patients / family about approaching death and helps make the most of the last days. Determines patient/family wishes regarding place of death and seeks to have death occur where desired. Assists family to give patient permission to die, to say good-bye and to bring reconciliation to family relationships.
After Death Prepares family for events that occur immediately following death, e.g., selecting funeral homes and making funeral arrangements; notifying agencies, and attorneys who handle estate; addressing financial issues; canceling appointments; etc. (This could be presented to the family in a brochure or packet of information.)
Bereavement Manages interactions with the bereaved that support communication of clinical concerns and questions as appropriate. Actively initiates referrals for support during bereavement.
Relationship Establishes rapport with patients and family. Is viewed as "present, really listening, caring and trustworthy." Initiates contact with bereaved family as appropriate to the relationship (e.g., call and/or send a card or letter to the family expressing condolences).
Communication Is available physically and mentally for patient and family communication. Delivers difficult information in an honest, clear manner. Maintains hope by focusing on palliative care when cure or life prolongation is no longer possible. Focuses on helping patients/family live in a way meaningful to them.
Teaching Assesses patient and family knowledge and questions. Refers to appropriate resources for additional information and support. Provides anticipatory guidance and reading materials about illness, treatments, possible outcomes and health system issues.
Team Collaboration Provides care with a team approach that includes patient and family as integral and essential members of the care team. Recognizes the value of all team members in caring for seriously ill patients and their families.

Annex III. Referral Criteria for Health Services in Palliative and Hospice Care (based from CAPC)

General Referral Criteria

Presence of a serious illness and one or more of the following:

- New diagnosis of life-limiting illness for symptom control, patient/family support
- Declining ability to complete activities of daily living
- Weight loss
- Progressive metastatic cancer
- Admission from long-term care facility
- Two or more hospitalizations for the same illness within three months
- Difficult-to-control physical or emotional symptoms
- Patient, family or physician uncertainty regarding prognosis
- Patient, family or physician uncertainty regarding appropriateness of treatment options
- Patient or family requests for futile care
- DNR order uncertainty or conflicts
- Uncertainty or conflicts regarding the use of nonoral feeding/hydration in cognitively
- impaired, seriously ill or dying patients
- Limited social support in setting of a serious illness (e.g., no family support system,
- lives alone, homeless, chronic mental illness)
- Patient, family or physician request for information regarding hospice appropriateness
- Patient or family psychological or spiritual distress

Intensive Care Unit Criteria

- Admission from a nursing home in the setting of one or more chronic life-limiting
- conditions (e.g., advanced dementia)
- Two or more ICU admissions within the same hospitalization
- Prolonged or failed attempt to wean from ventilator
- Multiorgan failure
- Consideration of ventilator withdrawal with expected death
- Metastatic cancer
- Anoxic encephalopathy
- Consideration of patient transfer to a long-term ventilator facility
- Family distress impairing surrogate decision making
- Coma or PVS lasting more than two weeks

Cancer Criteria

- Metastatic or locally advanced cancer progressing despite systemic treatments
- Karnofsky < 50 or ECOG > 3
- Brain metastases, spinal cord compression or neoplastic meningitis
- Malignant hypercalcemia
- Progressive pleural/peritoneal or pericardial effusions

Neurological Criteria

- Folstein Mini Mental Score < 20
- Feeding tube being considered for any neurological condition
- Status epilepticus > 24 hours
- ALS or other neuromuscular disease considering mechanical ventilation
- Any recurrent brain neoplasm
- Parkinson's disease with poor functional status or dementia
- Advanced Alzheimer's or other dementia with poor functional status and one or more hospitalizations for infection in the last six months
- Coma or PVS lasting more than two weeks

Referral Criteria for Hospital-based Services in Palliative and Hospice Care (based from Jose B. Lingad Memorial General Hospital PASCU)

INCLUSION CRITERIA (EMERGENCY ROOM)

A potentially life-limiting or life-threatening condition and;

- Metastatic or locally advanced incurable cancer
- Difficult to control physical or psychological symptoms (e.g. moderate-to-severe symptom intensity for more than 24-48 hours)-for example, pain, dyspnea, etc.
- Elderly patient, cognitively impaired, with or without acute hip fracture.
- Chronic home oxygen use
- Out-of-hospital cardiac arrest; Anoxic encephalopathy provided that there are no heroic measures
- Multiple recent prior hospitalization with same symptoms/problems
- Patient with Advance Directives, Living wills, DNR and/or Comfort Care (CC) orders
- Patient previously enrolled in a home care program
- Patient/caregiver/physician desires hospice and palliative care but has not been referred
- Consideration of ICU admission and or mechanical ventilation in a patient with cancer with one or more chronic diseases and poor functional status at baseline
- Aim is comfort and quality of life and no aggressive/heroic measures

INCLUSION CRITERIA (IN-PATIENT)

A potentially life-limiting or life-threatening condition and;

- Metastatic or locally advanced incurable cancer
- Difficult-to-control physical or psychological symptoms-for example, pain, dyspnea, etc.
- ICU length of stay >6 days
- Disagreements or uncertainty among the patient, staff, and/or family concerning:
    - Major medical treatment decisions
    - Resuscitation preferences
    - Use of non-oral feeding or hydration
- More than one admission for same condition within several months
- Prolonged or difficult ventilator withdrawal; considering extubation
- Multi-organ failure provided that there is no heroic measures
- Consideration of ventilator withdrawal with expected death
- Anoxic encephalopathy provided that there is no heroic measures
- Patient/family/surrogate emotional, spiritual, or relational distress
- Patient/family/surrogate request for palliative care/hospice home care services

Home per request (HPR)

- PASCU strongly advises early referral of patients to palliative care at least 5 days prior to HPR to give time for plan of care/Discharge Planning (if feasible)
  Except:
    - Acute cases (e.g. CVA, Trauma, etc.)

PASCU Co-Management instead of Transfer of Service

- Patients on Mechanical Ventilation
- Patients needing ICU care
- The patient and/or the family chose aggressive management (medical/surgical) despite the diagnosis and prognosis; for Psychosocial support and counseling
- If a patient was referred late and the prognosis is less than 24 hours, PASCU shall instead co-manage the care of the said patient. Ideally should be referred earlier as stated above.
- Patient on chemotherapy/radiation
- Patients with consent to life sustaining treatments such as CPR, use of mechanical ventilation, vasopressors etc.

PASCU referring to other Departments for co-management

- The PASCU doctor (consultant/resident) deemed it necessary for the care of the patient
    - seeking opinion for palliative chemotherapy
    - IDS referral, CKD patients needing Nephrology consult/opinion
    - patients with obstructive uropathy needing nephrostomy tube
    - infected wounds needing surgical debridement
    - patients with malignant ascites/pleural effusion needing pig-tail insertion
    - patients needing PEG tube, Jejunostomy tube for nutrition/drainage

Transfer of Service to PASCU

- If with advance stage with poor prognosis and have signed the advance directive not to use extra-ordinary/life sustaining measures such as CPR, intubation, defibrillation and inotropes

Transfer of Service to other Departments

- Advance Directives with YES to intubation, CPR, mechanical ventilator, defibrillation

Referral for Symptom Management

- Pain Management of advanced illnesses
- Management of non-pain symptoms such as dyspnea, nausea, vomiting, anorexia-cachexia of malignancy, complications of cancer
- Terminal care
- Respite care
- Home care
- Psychosocial support
- Counselling
- Palliative Emergencies: SVC, Hypercalcemia, non-surgical bleeding, wound care, etc.

Annex IV. Patient / Family Meeting Record Form

Patient/Family Meeting Record

Date: _____ Care Conference Coordinator: _____
Patient: _____
Conference Date, Time, and Location: _____
Diagnosis:
_____

Purpose of meeting:
_____
_____

Participants in meeting and relationships:
_____
_____

How are the patient's wishes known?

- Patient cognitive/verbal
- Patient's previous request
- Advance Health Care Directive
- Other:

If the patient is a child (8–18), requires child's assent and parent/legal proxy consent.
Who is the decision maker for the patient?

- Patient
- Proxy (specify):
- Parents (if child is under 18)
- Other:

Issues to be addressed (consider patient update, current problems/stressors, needs and goals of patient/family, desired outcome of conference, accommodating going outside):
_____
_____
_____
_____

Discussion/Outcomes/Follow-up:
_____
_____
_____
_____

Communication to other health professionals involved in patient care:
_____
_____
_____
_____

Chart updated to reflect care plan:

Date: _____ Initials: _____

Tentative date for next Patient/Family Meeting: _____

Annex V. Nutrition Screening Forms

There are several tools that could be used for nutrition screening

Name Author, year, country	Patient Population	Nutrition screening parameters	Criteria for risk of malnutrition	When/ by whom
Malnutrition Screening Tool (MST) Ferguson et al. (1999) Australia	Acute adults: inpatients & outpatients including elderly Residential aged care facilities	Recent weight loss Recent poor intake	Score 0-1 for recent intake Score 0-4 for recent weight loss Total score: ≥2 = at risk of malnutrition	Within 24 hours of admission and weekly during admission Medical, nursing, dietetic, admin staff, family, friends, patients themselves
Mini Nutritional Assessment – Short Form (MNA-SF) Rubenstein et al. (2001) United States	Elderly May be best used in community, sub-acute or residential aged care settings, rather than acute care[2]	Recent intake Recent weight loss Mobility Recent acute disease or psychological stress Neuropsychological problems BMI	Score 0-3 for each parameter Total score: < 11 = at risk, continue with MNA	On admission and regularly Not stated gender
Malnutrition Universal Screening Tool (MUST) Malnutrition Advisory Group, BAPEN (2003) UK	Adults – acute and community	BMI Weight loss (%) Acute disease effect score	Score 0 – 3 for each parameter. Total score: >2 = high risk 1 = medium risk 0 = low risk	Initial assessment and repeat regularly All staff able to use
Nutrition Risk Screening (NRS-2002) Kondrup et al. (2003) Denmark	Acute adult	Recent weight loss (%) Recent poor intake (%) BMI Severity of disease Elderly	Score 0-3 for each parameter Total score: > 3 = start nutritional support	At admission and regularly during admission Medical and nursing staff

Annex VI. Social Worker Assessment Form

Patient's Name: _____ DOB: _____
Age: _____ Gender: ____ Case Number #: _____
Address: _____ Phone: _____
Primary caregiver: _____ Phone: _____
Address: _____
Diagnosis: _____ Onset: _____
_____

MD(s): _____

Prognosis: _____

Current goal of care: ☐ Curative ☐ Rehabilitation ☐ Life-prolonging ☐ Comfort

Mental status: ☐ Alert ☐ Oriented ☐ Lethargic ☐ Unresponsive / Coma

Coping status: Coping well Coping with some difficulty Significant coping difficulty

Comments: _____

Emotional status: ☐ Anxious ☐ Agitated ☐ Depressed
☐ Tearful ☐ Shock ☐ Anger
Comments: _____

Learning needs: ☐ Cultural ☐ Religious ☐ Motivational
☐ Physical ☐ Cognitive ☐ Language
Comments: _____

Home situation: _____

Support systems: ☐ Good ☐ Fair ☐ Poor
Comments: _____

Financial status: ☐ Adequate ☐ Marginal ☐ Crisis
Comments: _____

Advance directives: ☐ Living will ☐ Power of Attorney ☐ Other: _____
Health care surrogate (name): _____
Contact info: _____

Patient's wishes related to goals and location of care (if applicable):
_____
_____
_____

Patient's/family goals and expectations for this hospitalization:
_____
_____
_____

Preferences regarding death (place, family presence, rituals):
_____
_____

Summary Assessment: _____
_____
_____

Referrals/Needs:

- ☐ Hospice
- ☐ Nursing home/intermediate care facilities
- ☐ Home health care
- ☐ Outpatient palliative care
- ☐ Durable medical equipment services
- ☐ Rehabilitation services
- ☐ Counseling services
- ☐ Transportation
- ☐ Rehabilitation
- ☐ Medication assistance
- ☐ Counseling
- ☐ Education
- ☐ Other

Palliative Care Social Worker: _____
Contact #: _____

Annex VII. Spiritual Care Assessment Form

Spiritual Care Assessment

Faith Group: _____ Particular Affiliation: _____
Pastor: _____ Phone: _____
Patient/family _____ gives consent to contact Pastor: ☐ Yes ☐ No

Areas to address
1. What is the patient's/family's source of strength?

2. What relationships have been significant in the past and at this time?

3. What group or organization has been important for providing strength?

4. What network shall be available at home?

5. What are the spiritual needs at this time and how can the chaplain be of help?

Theological issues
1. Image of God: _____

2. Relationship with God: _____

3. Important spiritual
resources: ☐ Prayer ☐ Scripture ☐ Sacraments ☐ Worship ☐ Other:

Spiritual issues to address (use back of form if necessary):

Proposed spiritual component of Care Plan (use back of form if necessary):

Chaplain's signature _____ Date _____

FICA Spiritual History Tool - a clinically validated tool that can be used by health care professionals in taking spiritual history and assessment

FICA Tool	
F: Faith, Belief, Meaning	"Do you consider yourself spiritual? or "Is spirituality something important to you?" "Do you have spiritual beliefs that help you cope with stress, difficult times, or what you are going through right now?" *(Contextualize questions to reason for visit if it is not the routine history.)* "What gives your life meaning?" *(The question of meaning should be asked regardless of whether the patient answered "yes" or "no" about spirituality. Sometimes patients respond to the meaning question with answers involving family, career, or nature.)*
I: Importance and Influence	"What importance does spirituality have in your life?" *(For people not identifying with spiritual ask about the importance of their sources of meaning)* "Has your spirituality *(or sources of meaning)* influenced how you take care of yourself, particularly regarding your health?" "Does your spirituality affect your healthcare decision making? *(Answers to these questions may provide insight regarding treatment plans, advance directives, etc.)*
C: Community	"Are you part of a spiritual community?" "Is your community of support to you and how?" For people who don't identify with a community consider asking: "Is there a group of people you really love or who are important to you?" *(Communities such as churches, temples, mosques, family, groups of like-minded friends, or yoga or similar groups can serve as strong support systems for some patients.)*
A: Address/Action in Care	"How would you like your health care provider to use this information about your spirituality as they care for you?" or "How would you like me, as your healthcare provider, to address spiritual issues in your healthcare?" *(With newer models, including the diagnosis of spiritual distress, "A" also refers to the "Assessment and Plan" for patient spiritual distress, needs and or resources within a treatment or care plan.)*

Source: *Puchalski, C. 1996, updated 2020. The ©FICA Spiritual History Tool. A Guide for Spiritual Assessment in Clinical Settings. The George Washington Institute for Spirituality and Health. Accessed last May 2021. https://smhs.gwu.edu/spirituality-health/sites/spirituality-health/files/FICA-Tool-PDF-ADA.pdf*

HOPE Questions for Spiritual Assessment

Category	**Sample Questions**
H: source of hope	We have been discussing your support systems, I was wondering, what is there in your life that gives you internal support? What are your sources of hope, strength, comfort and peace? What do you hold on to during difficult times? What sustains you and keeps you going? For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs, is this true for you? If the answer is "Yes", go on to O and P questions If the answer is "No", consider asking: Was it ever? If the answer is "Yes" ask: What changed?
O: organized religion	Do you consider yourself part of an organized religion? How important is this to you? What aspects of your religion are helpful and not so helpful to you? Are you part of a religious or spiritual community? Does it help you? How?
P: personal spirituality and practices	Do you have personal spiritual beliefs that are independent of organized religion? What are they? Do you believe in God? What kind of relationship do you have with God? What aspects of your spirituality or spiritual practices do you find most helpful to you personally? (e.g. prayer, meditation, reading scripture, attending religious services, listening to music, hiking, communing with nature)
E: effects on medical care and end-of-life issues	Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relationship with God?) As a doctor, is there anything that I can do to help you access the resources that usually help you? Are you worried about any conflicts between your beliefs and your medical situation/care/decisions? Would it be helpful for you to speak to a clinical chaplain/community spiritual leader? Are there any specific practices or restrictions I should know about in providing your medical care? (e.g. dietary restrictions, use of blood products)
If the patient is dying How do your beliefs affect the kind of medical care you would like me to provide over the next few days/weeks/months	

Source from Anandarajah G, Hight E. Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. Am Fam Physician. *2001;63(1):87*

The Open Invite Mnemonic

Category	Sample Questions
Open (i.e., open the door to conversation)	May I ask your faith background? Do you have a spiritual or faith preference? What helps you through hard times?
Invite (i.e., invite the patient to discuss spiritual needs)	Do you feel that your spiritual health is affecting your physical health? Does your spirituality impact the health decisions you make? Is there a way in which you would like for me to account for your spirituality in your health care? Is there a way in which I or another member of the medical team can provide you with support? Are there resources in your faith community that you would like for me to help mobilize on your behalf?

Annex VIII. End-of-Life Care Checklist

☐ Family spokesperson notified of change in patient's condition:
Name: _____
Address: _____
Phone: _____
Relationship to patient: _____
Y N
__ __ Appropriate care plans initiated
__ __ Resuscitation status clarified
__ __ Bereavement protocol initiated
__ __ Patient relations notified
__ __ Quiet room obtained
__ __ Hospitality basket requested
__ __ Literature given
__ __ State donor network notified
__ __ Chaplaincy notified __ Defers services (indicate time to reassess) ____
__ __ Social services notified __ Defers services (indicate time to reassess) ___

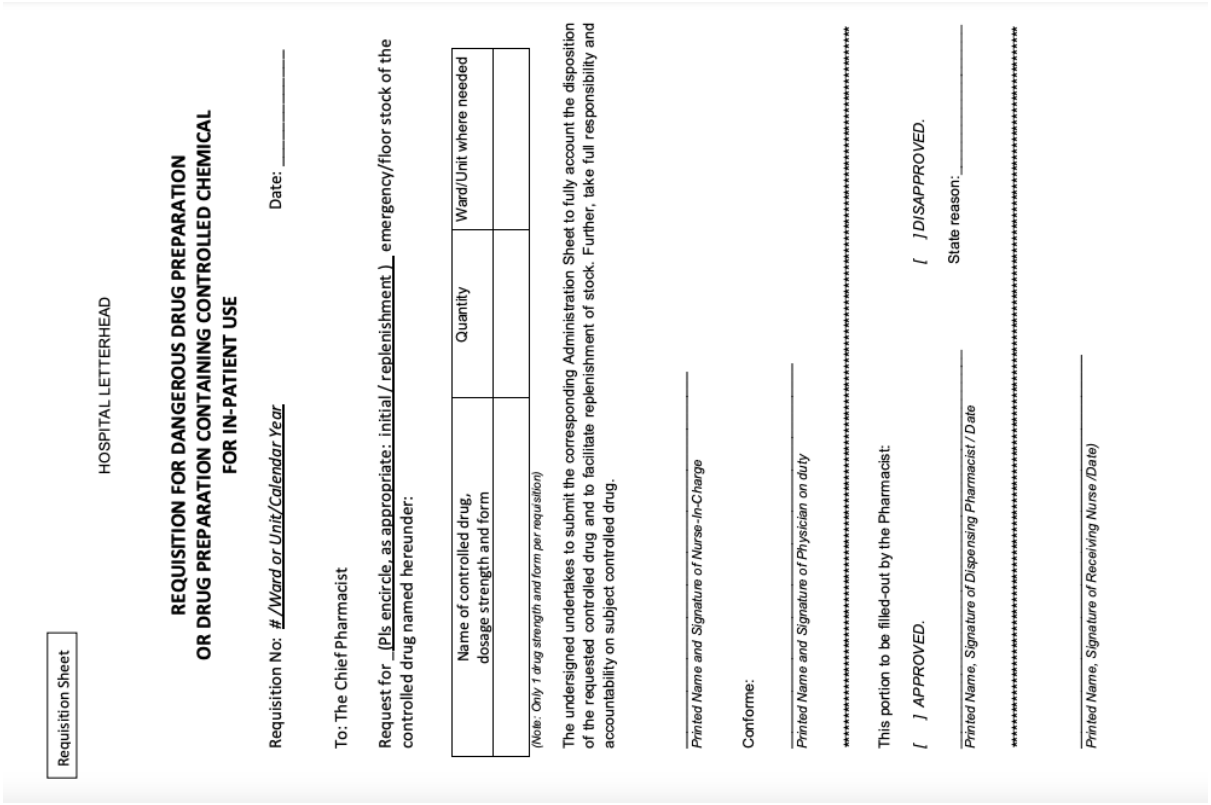
Time-of-Death Checklist:
Y N
__ __ Medical examiner notified __ Not applicable
__ __ Medical records notified
__ __ Death notice form completed by MD __ Not applicable
__ __ Postmortem care completed
__ __ Sympathy card initiated

Other:
_____
_____
Disposition of belongings:
__ To family
__ To morgue/funeral home with body
__ To security
__ To police
__ No belongings

List items sent:
_____

Initials: _____ Signature: _____ Date: _____ Time:_____

Annex IX. Dangerous Drugs Order Form



Requisition Sheet

HOSPITAL LETTERHEAD

REQUISITION FOR DANGEROUS DRUG PREPARATION OR DRUG PREPARATION CONTAINING CONTROLLED CHEMICAL FOR IN-PATIENT USE

Requisition No: *# /Ward or Unit/Calendar Year* Date: _____

To: The Chief Pharmacist

Request for _(Pls encircle, as appropriate: initial / replenishment)_ emergency/floor stock of the controlled drug named hereunder:

Name of controlled drug, dosage strength and form	Quantity	Ward/Unit where needed

(Note: Only 1 drug strength and form per requisition)

The undersigned undertakes to submit the corresponding Administration Sheet to fully account the disposition of the requested controlled drug and to facilitate replenishment of stock. Further, take full responsibility and accountability on subject controlled drug.

_____
Printed Name and Signature of Nurse-In-Charge

Conforme:

_____
Printed Name and Signature of Physician on duty

****

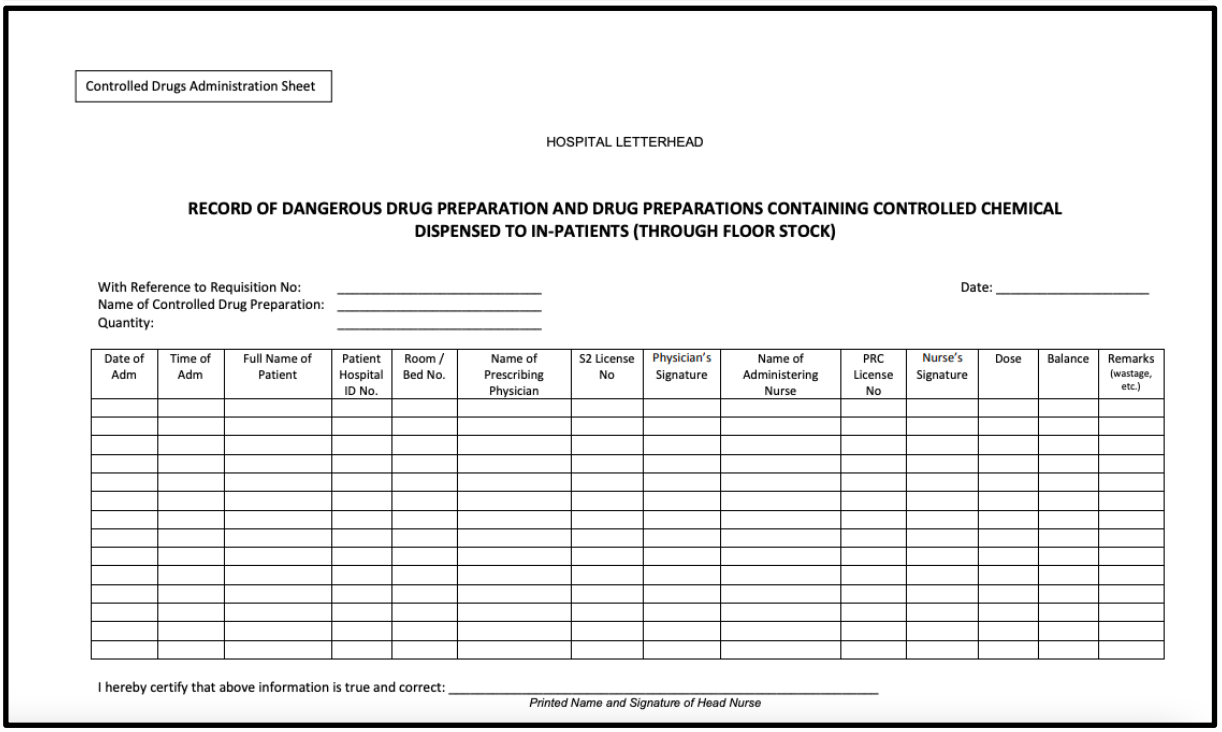
This portion to be filled-out by the Pharmacist:

[ ] *APPROVED.* [ ] *DISAPPROVED.*

_____ State reason: _____
Printed Name, Signature of Dispensing Pharmacist / Date

****

_____
Printed Name, Signature of Receiving Nurse /Date)



Controlled Drugs Administration Sheet

HOSPITAL LETTERHEAD

RECORD OF DANGEROUS DRUG PREPARATION AND DRUG PREPARATIONS CONTAINING CONTROLLED CHEMICAL DISPENSED TO IN-PATIENTS (THROUGH FLOOR STOCK)

With Reference to Requisition No: _____
Name of Controlled Drug Preparation: _____
Quantity: _____

Date: _____

Date of Adm	Time of Adm	Full Name of Patient	Patient Hospital ID No.	Room / Bed No.	Name of Prescribing Physician	S2 License No	Physician's Signature	Name of Administering Nurse	PRC License No	Nurse's Signature	Dose	Balance	Remarks (wastage, etc.)

I hereby certify that above information is true and correct: _____
Printed Name and Signature of Head Nurse

https://www.ddb.gov.ph/images/Board_Regulation/2014/BD.REG1/Annex_H_-_Requisition_sheet.pdf

Annex X. Essential Palliative and Hospice Care Medicines List

*availability of these medicines may vary locally

A. Adult

IAHPC LIST OF ESSENTIAL MEDICINES FOR PALLIATIVE CARE ©				
Medication	**Formulation**	**IAHPC Indication for PC**	**PNF 8th edition**	**WHO Essential Medicines Model List** **Section, subsection and Indication**
*Amitriptyline**	50-150 mg tablets	Depression Neuropathic pain	Not included	24.2.1 - Depressive disorders
Bisacodyl	5mg Tablets 10 mg rectal suppositories	Constipation	Included	Not included
Carbamazepine**	100- 200 mg tablet (200mg tablet (B); 200mg and 400mg MR tablet; 100mg/5ml syrup, 120ml)	Neuropathic pain	Included	5 - Anticonvulsants/ antiepileptics 24.2.2 - Bipolar disorders
Citalopram *(or any other equivalent generic SSRI except peroxetine and fuvoxamine)*	20 mg tablets 10 mg/5ml oral solution 20-40 mg injectable	Depression	Not included	Not included
Dexamethasone	0.5-4 mg tablets 4 mg/ml injectable	Anorexia Nausea Neuropathic pain Vomiting	Included	3 - Antiallergics and anaphylaxis 8.3 - Hormones and antihormones
Diazepam **(A1)**	5 mg/ml injectable	Anxiety	Included	1.3 - Preoperative sedation short term procedures 5 - Anticonvulsants/ antiepileptics 24.3 - Generalized anxiety, sleep disorders

Diclofenac	25-50 mg tablets	Pain - mild to moderate	Included	Not included
	50 and 75 mg/3ml injectable			
Diphenhydramine	25 mg tablets	Nausea	Included	Not included
	50 mg/ml injectable	Vomiting		
Fentanyl **(A1)**	Fentanyl injectible: 100mcg/2ml ampule, 500mcg.10ml ampule Transdermal Patch: 12.5 mcg.hr, 25mcg/hr, 50mcg/hr Sublingual tablet: 100mcg/tablet, 200mcg/tablet, 300mcg/tablet, 400mcg/tabletIV	Pain - moderate to severe	Included	Not included
Gabapentin	100mg/tablet, 300mg/tablet, 600mg/tablet	Neuropathic pain	Included	Not included
Haloperidol	0.5 - 5 mg tablets	Delirium	Included	24.1- Psychotic disorders
	0.5 - 5 mg/ml injectable	Vomiting		
		Terminal restlessness		
Hyoscine butylbromide	Injectible: 10mg/ml Tablet: 10mg/tablet Hyoscine-N-butylbromide 10mg + Paracetamol 500 mg tablet	Nausea	Included	Not included
		Terminal respiratory congestion		
		Visceral pain		

		Vomiting		
Ibuprofen	200 mg tablets	Pain - mild to moderate	Included	2.1 - Non opioids and NSAIMs
	400 mg tablets			
Levomepromazine	5 - 50 mg tablets	Delirium	Not included	Not included
	25 mg/ml injectable	Terminal restlessness		
Loperamide	2 mg tablets	Diarrhea	Included	Not included
Lorazepam***	0.5-2 mg tablets	Anxiety	Not included	Not included
	2 mg/ml liquid/drops	Insomnia		
	2-4mg/ml injectable			
Megestrol Acetate	160 mg tablets	Anorexia	Included	Not included
	40 mg/ml solution			
Metoclopramide	10 mg tablets	Nausea	Included	17.2 Antiemetics
	5mg/ml injectable	Vomiting		
Midazolam **(A1)**	Injectable: 5mg/ml, 5mg/5ml, 15mg/3ml Tablet: 15mg/tablet	Anxiety	Included	Not included
		Terminal restlessness		
Mineral oil enema			Not included	Not included
Mirtazapine (*or any other generic dual action NassA or SNRI*)	15-30 mg tablets	Depression	Not included	Not included
	7.5-15 injectables			
Morphine **(A1)**	Injectible: 10mg/ml,16mg/ml ampules Immediate release tablet: 10mg/tablet, 30mg/tablet Prolonged release tablet:	Dyspnea	Included	2.2 Opioid analgesics
		Pain - moderate to severe		

	10mg/tablet, 30mg/tablet, 60mg/tablet			
Octreotide	100mg/ml injectable	Diarrhea Vomiting	Included	Not included
Oral rehydration salts		Diarrhea	Included	17.5.1 Oral rehydration
Oxycodone **(A1)**	Oxycodone prolonged release tablets: 10mg, 20 mg and 40 mg Oxycodone plus Naloxone prolonged release tablets: in 5mg/2.5mg, 10 mg/5 mg, 20 mg/10 mg, 40 mg/20 mg Oxycodone syrup: 5 mg/5ml	Pain - moderate to severe	Included	Not included
Paracetamol (Acetaminophen)	chewable tablet at 120 mg/tablet, syrup 120 mg/5ml, 250 mg/tablet, 500 mg/tablet, injectable: 300 mg/2 ml ampule Infusion: 500 mg/50 ml, 1 gram/100 ml Rectal Suppository: 125mg and 250mg	Pain - mild to moderate	Included	2.1 - Non opioids and NSAIDs
Prednisolone (*as an alternative to Dexamethasone)*	15mg/5ml syrup 5mg tablet	Anorexia	Included	3 - Antiallergics and anaphylaxis 8.3 - Hormones and antihormones 21.2 Anti-inflammatory agents
Pregabalin	50 mg, 75 mg and 150 mg capsules	Neuropathic pain	Not included	Not included
Senna	8.77mg Ca sennosides equivalent to 187mg/tab, 17.54mg Ca sennosides	Constipation	Included	17.4 Laxatives

	equivalent to 374mg/tab			
Tramadol	Tramadol immediate release 50 mg/capsule Tramadol dispersible tablet 50 mg/tablet Tramadol prolonged release 100 mg/tablet Injectable: 50mg/ml and 100mg/2ml	Pain - mild to moderate	Included	Not included
Tramadol + Paracetamol	37.5 mg/325 mg tablet, 18.75 mg/162.5mg tab	Pain-mild to moderate	Not Included	Not Included
Zolpidem (still patented) **(A1)**	10mg tablets **(x)**	Insomnia	Included	Not included

Complementary: Require special training and/or delivery method
* Side-effects limit dose
**Alternatives to amitriptyline and tricyclic antidepressants (should have at least one drug other than dexamethasone)
*** For short term use in insomnia
(A1) - Dangerous Drug Preparations to be prescribed and dispensed through the **DOH Official Prescription Form (Yellow Rx)**. Only one (1) dangerous drug preparation shall be prescribed in one single prescription form. Partial filling allowed. **Strictly no Refill**
(x) - To be prescribed using **Personalized Prescription** issued by the prescribing physician with the **S2 license # indicated** therein. Only one (1) drug preparation shall be prescribed in one single prescription form. Partial filling allowed. **Strictly no Refill**
Notes:
Non-Benzodiazepines should be used in the elderly
Non-Steroidal Anti-Inflammatory Medicines (NSAIMs) should be used for brief periods of time
NO GOVERNMENT SHOULD APPROVE MODIFIED RELEASE MORPHINE, FENTANYL OR OXYCODONE WITHOUT ALSO GUARANTEEING WIDELY AVAILABLE NORMAL RELEASE ORAL MORPHINE.

B. Children

Non-opioids and non-steroidal anti-inflammatory drugs (NSAIDs)	
ibuprofen [a]	Oral liquid: 200 mg/5 mL Tablet: 200 mg; 400 mg; 600 mg [a]Not in children less than 3 months
paracetamol*	chewable tablet at 120 mg/tablet, syrup 120 mg/5ml, 250 mg/tablet, 500 mg/tablet, injectable: 300 mg/2 ml ampule Infusion: 500 mg/50 ml, 1 gram/100 ml Rectal Suppository: 125mg and 250mg *Not recommended for anti-inflammatory due to lack of proven benefit to that effect
Opioid analgesics	
morphine*	Injectable in 10 mg/ml, 16 mg/ml ampules Immediate release tablet 10 mg/tablet, 30 mg/tablet Prolonged release tablet 10 mg/tablet, 30 mg/tablet, 60 mg/tablet
Medicines for other common symptoms in palliative care	
amitriptyline	Tablet: 10 mg; 25 mg; 75 mg
cyclizine	Injection: 50 mg/ mL Tablet: 50 mg
dexamethasone	Injection: 4 mg/ mL in 1mL ampoule (as disodium phosphate salt) Oral liquid: 2 mg/5 mL Tablet: 2 mg; 4 mg
diazepam	Injection: 5 mg/ mL Oral liquid: 2 mg/5 mL Rectal solution: 2.5 mg; 5 mg; 10 mg Tablet: 5 mg; 10 mg
docusate sodium	Capsule: 100 mg Oral liquid: 50 mg/5 mL
fluoxetine [a]	Solid oral dosage form: 20 mg (as hydrochloride) [a] >8 years
hyoscine hydrobromide	Injection: 400 micrograms/mL; 600 micrograms/mL Transdermal patches: 1 mg/72 hours
lactulose	Oral liquid: 3.1–3.7 g/5 mL
midazolam	Injectable: 5 mg/ml, 5 mg/5 ml, 15 mg/3 ml Tablet 15 mg/tablet
ondansetron [a]	Injection: 2 mg base/mL in 2mL ampoule (as hydrochloride) Oral liquid: 4 mg base/5 mL Solid oral dosage form: Eq 4 mg base; Eq 8 mg base [a]>1 month
senna	Oral liquid: 7.5 mg/5 mL

Source: WHO Model List of Essential Medicines for Children, 5th List. Geneva: World Health Organization

C. Dangerous Drugs Preparation

Medicine	**Formulation**
Diazepam	5 mg/ml injectable; Oral liquid: 2 mg/5 mL; Tablet: 5 mg; 10 mg
Fentanyl	Fentanyl injectable: 100 mcg/2ml, 500 mcg/10ml transdermal patch: 12 (or 12.5) mcg/hr, 25 mcg/hr, 50 mcg/hr Sublingual tablet: 100 mcg/tablet, 200 mcg/tablet, 300 mcg/tablet, 400 mcg/tablet
Midazolam	Injectable: 5 mg/ml, 5 mg/5 ml, 15 mg/3 ml Tablet 15 mg/tablet
Morphine	Injectable in 10 mg/ml, 16 mg/ml ampules Immediate release tablet 10 mg/tablet, 30 mg/tablet Prolonged release tablet 10 mg/tablet, 30 mg/tablet, 60 mg/tablet
Oxycodone	Oxycodone prolonged release tablets: 10mg, 20 mg and 40 mg Oxycodone plus Naloxone prolonged release tablets: in 5mg/2.5mg, 10 mg/5 mg, 20 mg/10 mg, 40 mg/20 mg Oxycodone immediate release capsule: 5 mg, 10 mg Oxycodone liquid/syrup: 5 mg/5ml

Annex XI. Essential Equipment List in Palliative and Hospice Care

List of Equipment in Palliative Care							
Equipment	**Home**	**OPC**	**PCU**	**Equipment**	**Home**	**OPC**	**PCU**
Medical Equipment							
Ampule opener	■	■	■	Manual defibrillator (ambu bag)			■
Bedpans	■		■	Nebulizer + Nebulizing kit (pedia and adult)	*	■	■
Beds for patient and attendant	■		■	Oxygen regulator/ gauge	*	■	■
Bedside cabinet			■	Oxygen stand	*	■	■
BP apparatus	■			Oxygen tank	*	■	■
BP apparatus with wheel		■	■	Oxygen tank carrier	*	■	■
Cabinet	■	■		PCA machine			■
Cardiac table			■	Pulse oximeter	■	■	■
Chart cart			■	Stethoscope	■	■	■
Cotton Jar		■	■	Stethoscope (pedia and adult)		■	■
Drape			■	Stretcher			■
Drip stands			■	Suction machine	*		■
Drop light		■	■	Syringe	■	■	■
ECG machine			■	Syringe pump			■
Emergency cart			■	Treatment cart			■
Glucometer	■	■	■	Urinals			■
Infusion pump			■	Weighing scale		■	■
Laryngoscope set		■	■	Wheelchair		■	■

*if necessary, nebulizer, oxygen support and suction machine should be available at home

List of Equipment in Palliative Care							
Equipment	**Home**	**OPC**	**PCU**	**Equipment**	**Home**	**OPC**	**PCU**
Non-Medical							
Aircon			■	**Transportation**	■	■	■
Ceiling fan/ Stand fan	■	■	■	**Paper**	■	■	■
Chair		■	■	**Pencil**	■	■	■
Computer printer		■	■	**Sharpener**	■	■	■
Computer set		■	■	**Steel tray**			■
Dining set			■	**Tables**		■	■
Emergency light		■	■	**Wall clock**		■	■
Filing cabinet		■	■	**Wall fan**			■
Fire extinguisher		■	■	**Wrench**			■
Mobile telephone	■	■	■				

A. Sample basic equipment and medicines for a palliative care home-care kit

<table>
<tr><th colspan="2">Basic medical equipment and supplies</th></tr>
<tr><td>Equipment</td><td>Supplies</td></tr>
<tr><td>• Stethoscope
• Blood pressure apparatus
• Torch
• Thermometer
• Tongue depressors
• Forceps
• Pulse Oximeter</td><td rowspan="2">• Dressing supplies
• Cotton
• Scissors
• Gauze pieces
• Gauze bandages
• Dressing trays
• Gloves
• Micropore tape
• Transfusion supplies
• IV sets
• Intracath and butterfly needles
• Syringes and needles
• Tubes and bags
• Suction catheters
• Urinary catheters
• Condom catheters
• Urine bags
• Feeding tubes</td></tr>
<tr><td>Supportive equipment</td></tr>
<tr><td>• Backrests
• Air mattresses
• Water mattresses
• Suction machines
• Nebulization kits (pedia/adult)
• Wheelchairs
• Walking frames
• Bath chairs
• Bed pans/commodes
• Oxygen tank/oxygen concentrator as necessary</td><td></td></tr>
<tr><th colspan="2">Medicines</th></tr>
<tr><td>Pain control
• Paracetamol
• Ibuprofen
• Diclofenac
• Tramadol
• Morphine and other opioids
• Gabapentin</td><td>Antibiotics and antifungals
• Ciprofloxacin
• Metronidazole
• Amoxicillin
• Fluconazole</td></tr>
<tr><td>Respiratory Symptoms</td><td>Hemostatic Medications</td></tr>
<tr><td>• Anti-asthmatics/COPD Preparations</td><td>• Tranexamic Acid, Midazolam</td></tr>
<tr><td>Gastrointestinal symptom control</td><td>Psychological symptom management</td></tr>
<tr><td rowspan="2">• Metoclopramide
• Domperidone
• Dexamethasone
• Bisacodyl
• Loperamide
• Oral rehydration salts
• Ranitidine
• Hyoscine-N-Butyl Bromide</td><td>• Diazepam
• Haloperidol
• Amitriptyline</td></tr>
<tr><td>Nutritional supplements
• High protein and calories food supplements
• Iron, vitamin and mineral supplements</td></tr>
<tr><td>Wound management</td><td>Other miscellaneous</td></tr>
<tr><td>• Povidine-iodine lotion and ointment
• Metronidazole jelly
• Hydrogen peroxide</td><td>· Lidocaine jelly
· Cough preparations</td></tr>
</table>

Source: Indian Association of Palliative Care, CanSupport. Guidelines for home based palliative care services. New Delhi: CanSupport; 2007.

B. CONTROLLED DRUG INVENTORY SHEET FOR HOME CARE **MR#: ___________**

PATIENT NAME: ____ AGE: ___________ GENDER: ____BIRTHDAY: ______________
PT. ADDRESS: ____
PT.DIAGNOSIS: ____ ATTENDING PHYSICIAN: ____

DATE	Prescribing MD	RX	QTY	MEDICINES Generic / Brand	STOCK DOSE	LOT#	EXP. DATE	QTY ON HAND	QTY USED	QTY LOST	QTY DAMAGE	QTY LEFT	PCN/PHA ON DUTY	SIGNATURE
		NO:												
		PRC LIC:												
		S2:												
		NO:												
		PRC LIC:												
		S2:												
		NO:												
		PRC LIC:												
		S2:												
		NO:												
		PRC LIC:												
		S2:												
		NO:												
		PRC LIC:												
		S2:												

D.C.- discontinue	ac – before meal	p.c. – after meal	b.i.d – 2x a day	s.c. /s.q.–Subcutaneously	c - with
OH- on Hold	a.d. – right ear	o.d. – right eye	t.i.d – 3x a day	IV – Intravenous	gtts. - drops
C- Completed	a.s. – left ear	o.l./o.s – left eye	q.i.d – 4x a day	IM – Intramuscular	ugtts. - microdrops
R – pt. Refused	p.o. – by mouth	o.u. – both eyes	SL,sl–Sublingual	p.r.n. – as needed	MSO4- Morphine Sulfate
mg. – Milligram	mcg –Microgram	syr. – syrup	tsp.-teaspoonful	tbsp.- tablespoonful	cc or ml- milliliter

D. CONTROLLED DRUG ADMINISTRATION SHEET FOR HOME CARE

MR #:
PATIENT NAME: _____ AGE: _____ GENDER: _____ BIRTHDAY: _____
PT. ADDRESS: _____
PT. DIAGNOSIS: : _____
ATTENDING PHYSICIAN: _____

MEDICATION: dose, route, and frequency	**DATE:** **TIME TO BE GIVEN**							

Annex XII. Telemedicine Guidelines and Consultation Process Flow

A. DOH and UPM Joint MC 2020-0001

Telemedicine Guidelines and Process Flow

A. Recommended physical and technical requirements

1. Recommended minimum technology requirements:
    a. Stable internet connection
    b. Communication device with or without video capabilities: landline, mobile phone with or without camera, tablet, laptop or desktop computer (i.e., consider use of dual monitors and high-definition webcam positioned at eye level)
    c. Noise-cancelling headphones
    d. Speakers and microphones
    e. Secure, privacy-enhancing and non-public-facing videoconferencing or communication software; and or video-conferencing facility integrated with an electronic medical record system, if available
2. In setting up a telemedicine workstation, the healthcare provider is recommended to observe the following measures:
    a. Ensure room is quiet, interruption-free, secure, and private with adequate lighting
    b. Wear headphones for better audio, if available
    c. Test every speaker and microphone before every visit
    d. Learn about the platform or software that shall be used for the telemedicine consultation and always test ahead of visit, download, or install any update needed
    e. Check internet speed
    f. Turn off other web applications and notifications
    g. Angle the screen so no one can walk by and see the consultation
    h. Wear same level of professional attire as in face-to-face consultation
    i. Avoid visual distractions such as busy patterned shirts, messy desks, food and drinks, photos and posters on background wall
    j. No virtual background
3. In choosing the right telemedicine platform, consider the following:
    a. The platform is supportable across all devices (e.g. laptop/desktop computer or tablet, etc.), and possibly, can be integrated to a new EMR system, or interoperable with an existing EMR system
    b. The quality of service with the use of the platform is equal or better than face-to-face consultation
    c. The platform allows for remote patient monitoring, and clinical validation
    d. The bedside manners are properly observed and addressed when using the platform
    e. The platform is as easy as possible for patients to access and use, and for the physician to manipulate its features and present oneself appropriately to the patient
    f. The platform is secure, privacy-enhancing and non-public facing

B. Webside manners during a telemedicine consultation

1. Greeting
    a. Introduce self and your role. Ask patient to introduce himself/herself and family members or other companions in the room, if assisted
    b. Confirm with patient that s/he can see and hear you clearly
    c. Acknowledge the use of the new technology. Normalize any discomfort with the use of the platform
    d. Demonstrate confidence in the technology and reason for use. Include instructions on what to do in case of disconnection
2. Maintaining etiquette
    a. Be aware of one's actions since these shall be magnified on camera. Sit fully upright
    b. Do not fidget, scratch, play with your hair, or touch your face
    c. Disable picture-in-picture function

d. Look directly at the camera. This can be perceived by the patient as making eye
e. contact
f. Position video window of patient's image at the top of your screen below the webcam
g. Explain and narrate all your actions

3. Empathy and Communication
   a. Speak slowly and clearly. Pause longer between statements to allow for transmission delay
   b. Type into the chat window to reiterate instructions or next steps
   c. Check in frequently to elicit reactions and confirm understanding
   d. Use non-verbal cues even on virtual visits: Smile often, use a warm tone of voice
   e. Increase the frequency of empathetic statements to show that you are listening
   f. Inform the patient when occupied such as when writing notes or looking at radiologic images or laboratory results
   g. Summarize and clarify questions in case of delay or signal interference
   h. In case of disconnection during video consultations, inform the patient how to continue the consultation

C. Activities within a consultation as applied to telemedicine

1. Proper informed consent must be established with all the necessary information regarding the features of telemedicine consultation fully discussed with the patient/family including but not limited to:
   a. How telemedicine works, including the services to be provided, expected benefits, and billing and insurance, if any, within the telemedicine consultation
   b. Limitations of telemedicine, including risk of technology failures, and service limitations
   c. Manner of processing of health information, including submission to public health authorities such as DOH for health policy and planning purposes
   d. Privacy and security measures and concerns
   e. Protocol on referral or care coordination
   f. Documentation of the patient consent
2. General recommendations for conducting virtual physical exam are as follows:
   a. Take a thorough medical history.
   b. Have a keen eye for observing the patient's condition
   c. Consider what can be examined while going through the Review of Systems
   d. Partner with the patient or his/her companion to gain valuable clinical insight
      i. Using a home monitor, request patients or relatives to take vital signs
      ii. Request a family member or relative to conduct palpation maneuvers or assist in physical examination while giving instructions
   e. Take advantage of available technology
      i. Sharing photos or videos that are difficult to visualize on webcam
3. All physicians shall issue electronic prescription in accordance with FDA Circular No. 2020-007 and any subsequent FDA guidelines, and pursuant to RA 2382
4. General documentation requirements are as follows
   a. All telemedicine consultations should have proper documentation, which includes, but not limited to, the following:
      i. Patient and provide location
      ii. Family members or other companions present during the telemedicine consultation
      iii. Patient consent
      iv. Referring physician, if applicable
      v. Telemedicine platform or videoconference or communication software used
      vi. Patient's feedback about the telemedicine consultation
   b. All health care providers whose services are sought through telemedicine shall keep records of all electronic clinical abstracts/consultation summaries, prescriptions and/or referral forms issued

D. Telemedicine Consultation Process Flow

1. Before Telemedicine Consultation
    a. Prepare technical set up of the telemedicine workstation
    b. Determine if the patient is suitable for a certain telemedicine service. Normalize any discomfort with the telemedicine platform, if any
    c. Prepare the patient's previous medical records, if applicable
    d. Ensure that both signal/audio/video are clear on both the patient's and provider's side Give introductions. Family members or other companion present should also be introduced
    e. Set expectations and secure consent
2. During Telemedicine Consultation
    a. Determine mutually agreeable agenda items
    b. Explain to the patient how you shall get the information you need for diagnosis and plan of management
    c. Conduct your history taking and virtual physical examination
    d. Obtain patient feedback
3. After Telemedicine Consultation
    a. Summarize key points and ask for clarifications. Have the patient repeat back what they understood
    b. Explain plan for laboratories and ancillaries
    c. Explain ePrescription instructions
    d. Arrange for a face-to-face follow-up consultation, or give instructions to go to the nearest health facility in case of worsening symptoms or emergencies post telemedicine consultation
    e. Ask if the patient was comfortable with the telemedicine set-up
    f. Give a clear sign to the patient that the consultation is coming to an end, thank the patient
    g. Complete the documentation
    h. Email the patient a password-protected file of a summary on what was discussed during the telemedicine consultation. A password-protected prescription can also be included, if applicable

B. E-prescription of Dangerous Drugs

The Dangerous Drug Board had created a guideline for the use of electronic prescription for dangerous drugs during the duration of the COVID-19 pandemic. These the Dangerous Drug Board might continue or improve the guidelines in order to be used post pandemic. The following is the guideline.

SUBJECT: AMENDMENT OF ADVISORY DATED 18 MARCH 2020 WITH SUBJECT, "USE OF ELECTRONIC PRESCRIPTION FOR DANGEROUS DRUGS DURING THE DURATION OF THE STATE OF CALAMITY PURSUANT TO PROCLAMATION NO. 929 OF THE OFFICE OF THE PRESIDENT"

The title of the Advisory dated 18 March 2020 is hereby amended and shall read as follows:

"Use of Electronic Prescription for Dangerous Drugs During the Duration of the State of Public Health Emergency Throughout the Philippines Pursuant to Proclamation No. 922 of the Office of the President."

The set of guidelines set forth in the Advisory is also hereby amended and shall read as follows:

a. For the duration of the State of Public Health Emergency Throughout the Philippines pursuant to Proclamation No. 922 issued by the Office of the President, an electronic prescription for dangerous drugs, or the photo of the (i) Special Prescription Form for Dangerous Drugs or (ii) ordinary prescription form stored in a cellular phone or any electronic gadget, may be used by the patient or his/her authorized representative and presented to a drugstore or pharmacy for proper dispensing of the required medication.

b. The prescribing physician shall provide the following information in the electronic prescription:

1. Full name, business address, and contact details of the prescribing physician;
2. The current S-2 license number;
3. Complete name and address and age of the patient;
4. Date of prescription;
5. Generic and brand name of the medicine containing dangerous drugs to be supplied, the dosage strength and form and the total number of dosage units or quantity needed in words and its numerical equivalent;
6. Direction of use; and
7. Original signature of the prescribing physician.

There shall be an inscription of "no refill" in the electronic prescription.

c. Section 31 (6)(d) of Regulation No. 1, Series of 2014 issued by the Board provides that in extraordinary circumstances, the prescribing physician may issue multi-month prescriptions, not exceeding thirty (30) days' supply per prescription or a total of ninety (90) days' supply for medicines containing dangerous drugs in Schedule IV of the 1971 UN Convention, all dated on the day of issue and with written instructions on the second prescription of when to obtain the medicine. In such cases, the prescribing physician shall indicate on the face of the prescription, the number of prescriptions issued to the patient (i.e. one of 3 Rx, two of 3 Rx and three of 3 Rx).

In cases where the prescribing physician has issued a prescription for thirty (30) days' supply and the condition of the patient requires more dose medication than originally assessed, he/she may issue a supplemental prescription within the thirty-day period reckoned from the date when the original prescription was made.

The use of electronic prescriptions shall be allowed in both cases.

d. The prescribing physician shall keep records of all electronic prescriptions issued and report the same to the Compliance Service of the Philippine Drug Enforcement Agency within fifteen (15) days after the lifting of the State of Public Health Emergency throughout the Philippines. The same rule applies to licensed drug stores or pharmacies dispensing medicines containing dangerous drugs as prescribed by the electronic prescription. As such, drugstores or pharmacies shall secure copies of the electronic prescriptions, or photos thereof, which shall serve as supporting records to their report.

e. An individual duly authorized by the patient may purchase the medicines in behalf of the latter, provided that a written or electronic authorization, identification card of the authorized individual, and the electronic prescription are presented to authorized personnel of the drugstore or pharmacy.

f. The Advisory shall cover the entire country for the duration of the State of Public Health Emergency.

Section 40(b) of Republic Act No. 9165 of the Comprehensive Dangerous Drugs Act expressly provides that no prescription once served by the drugstore or pharmacy shall be reused nor any prescription once issued be refilled.

Presidential Proclamation No. 922 provides that the State of Public Health Emergency shall remain in force and effect until lifted or withdrawn by the President.

C. Telehealth and Palliative Care (CAPC)

Using telehealth offers many benefits to palliative care teams and their patients and families. There are 3 main "use cases" for telehealth: Provider-initiated visits; patient or caregiver call response; and provider-to-provider communications. This guide consolidates best practices on technology set-up, visit etiquette, and documentation/billing

	Provider-initiated Visits	Patient/Caregiver Response	Provider-to-Provider Communications
Set-up and Process Basics	Invest in a high-quality webcam and microphone. Patients must be able to clearly hear you	Palliative care programs should have a 24/7 number to respond to patient calls. The call center should have procedures for routing the call to the appropriate clinician	Team members may collaborate on visits via telehealth
	Telehealth Platform during the COVID Emergency: CMS is authorizing the use of telephones with audio and visual capabilities, with HIPAA enforcement and penalties waived. Platforms can include: FaceTime, Skype, Updox, Zoom for Healthcare, Doxy.me, Google G Suite Hangouts. Advice is to use the platform that shall be easiest for the patient/family, such as one that is already included in their smartphone.		
	Designate staff to help patients/families set up the platform, give consent, and prepare ahead of the first visit	Patients or caregivers are encouraged to call with questions, concerns, as well as to report urgent issues/change of condition	Palliative care clinicians can consult with treating colleagues via telehealth
	Prepare patients/families - make sure they have a place in the home ready, are comfortable communicating via the platform, have their questions answered, etc.	Clinicians can respond to patient/caregiver needs via telephone or can initiate a telehealth visit if they need to see the patient	Home health providers can also collaborate with the palliative care team via telehealth
	Train all members of the care team in how to use the technology, follow required etiquette, and document	Systems should be in place to notify the clinician when the patients are ready to see them; many technologies provide a virtual waiting room, but a phone call or text shall work too	Communication protocols should be established within the team and with collaborating home health agencies and other collaborators
	Ensure all staff can assist with technology questions and glitches during the actual visit. Provide a checklist to test capabilities	Designated staff (or the responding clinician) should be ready to help patient/family get on the platform	Team members, treating clinicians, and/or home-based staff should contact the program for help with issues and decision-making
	Schedule the visit, and send reminders with detailed instructions on how to access, and whom to call if there's a problem	Clinician should instruct where to place the device's camera to see the area of concern, such as a wound, when warranted	Tele-consult services, such as Project Echo, may work with palliative care teams to extend consultation capabilities into smaller hospitals or rural areas
	Check with your malpractice insurance carrier to make sure that services provided via telehealth are covered		

	Provider-to-Patient Communications	Provider-to-Provider Communications
Virtual Visit Etiquette	Start the visit by confirming the screen is set up correctly and the patient/family can see and hear. Then make a clear transition to the start of the clinical visit - "how are you doing?"	The palliative care team may need to triage provider consultations based on urgency
	Let patient/family know that it is ok to interrupt if they need to pause or make adjustments during the visit	Use the technology to provide immediate help for home visits
	Confirm that you shall call them in the event that sound, or video is lost during the visit	When feasible, include a supervisor or experienced staff person on new staff visits with patients/families to model communications and provide feedback after the visit
	If responding from home, clinician should find a quiet location with a neutral background	
	Always dress appropriately, and wear plain clothes (patterns can create nausea/discomfort)	
	Be mindful of the background- make sure to keep it as neutral as possible, and make sure to have good lighting	
	Speak slowly and clearly, and check every so often to ensure that you are being heard	
	Remember to look at the camera on your own device (not at the screen that has the patient's video). Match your 'head size' to theirs by positioning your distance to the camera	
	Call wrap-up: Let patient/family know when 5-10 minutes left and ask if there's anything they want to make sure to cover	
	End the visit by summarizing what you heard, what the plan is, reviewing prescription refill needs and how they shall be provided	
Documentation / Billing	Document and bill as you would face-to-face visits (who was present, what was discussed, what amount of time).	
	Document patient consent to the use of telehealth (verbal is allowed; for example: "discussed with patient risks and benefits of telehealth and patient consented to receipt of such telehealth")	
	Typical copayments apply. (During the COVID emergency, Medicare is allowing practices to reduce or waive co-pays, but they shall not cover the difference)	

Annex XIII. Algorithm for COVID-19 patient triage and referral for resource limited settings during community transmission

Link to the Documents for Palliative Care of Patients including those with Life-Threatening Illness

- Please see bit.ly/PalliativeCareGuidelines
- Please see PSMID Unified COVID-19 Algorithms (documents are periodically updated based on the current situation and latest recommendations of the HPAAC)

Annex XIV. Palliative Care in Other DOH Programs

Palliative and Hospice Care must be integrated in the Manual of Procedures or Clinical Practice Guidelines of the different DOH programs. The following are the programs that incorporated palliative and hospice care.

1. National Tuberculosis Control Program
    - In the 6th edition of the National Tuberculosis Control Program Manual of Procedures, it was indicated that palliative care should be offered to TB patients who cannot be cured or refused treatment. The link to the document is as follows: http://www.ntp.doh.gov.ph/downloads/publications/guidelines/NTP_MOP_6th_Edition .pdf

Annex XV. Sample forms for Palliative and Hospice Care

Sample of Palliative and Supportive Care Unit (PASCU) Advanced Directives Form (Allow a Natural Death Form, JBLMGH)

JOSE B. LINGAD MEMORIAL REGIONAL HOSPITAL
Dolores, City of San Fernando Pampanga
Telephone No. (045) 961-3544

ADVANCE DIRECTIVES FORM
(ALLOW A NATURAL DEATH)

PATIENT'S NAME (Last, First, Middle)			MEDICAL RECORD NO.	AGE	SEX
ADDRESS	DATE OF BIRTH (mm/dd/yyyy)	CIVIL STATUS	TELEPHONE NO.	DATE (mm/dd/yyyy)	TIME (AM/PM)

Diagnosis and prognosis explained by attending doctor? Yes ☐ No ☐

PATIENT'S/RELATIVE'S DECLARATION

Please indicate your preference and affix your signature
In case of cardiopulmonary (CP) arrest, Call the Code Team? Yes ☐ No ☐

Treatment:

	YES	SIGNATURE	NO	SIGNATURE
Intubation/ Resuscitation/CPR	☐	_____	☐	_____
Defibrillation	☐	_____	☐	_____
Mechanical Ventilation	☐	_____	☐	_____
Inotropes	☐	_____	☐	_____
Medicines for pain & comfort	☐	_____	☐	_____

Other instructions/Specific orders:

_____
_____
_____
_____

Do you have a particular person to decide for you in case you are unable to decide regarding your health care?
YES ☐ NO ☐

If yes, please indicate Name _____ Relationship _____

I have discussed the above request with my Attending Physician _____ M.D. and I understand and consent to the withholding/withdrawing of aggressive and heroic intervention and to allow the natural course of the disease and peaceful death.

_____ Signature over Printed Name of Patient/Representative
_____ Relationship to Patient
_____ Date and Time

_____ Signature over Printed Name of Attending Physician
_____ Signature over Printed Name of Witness
_____ Date and Time

JBL-FAM-FM-15

Sample Advanced Health Care Directives Form for Patients with End-stage or Terminal Diseases from Southern Philippines Medical Center (SPMC) in English and Bisaya Versions

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J.P. Laurel Ave., 8000, Davao City, Philippines
Tel. No. (082) 2272731 loc. 4607/4608

SPMC-F-MRI-21N(A)

ADVANCE HEALTH CARE DIRECTIVE FORM FOR PATIENTS WITH END-STAGE OR TERMINAL DISEASES

Be it known that _____(Complete name of the index patient) is suffering from a terminal or end-stage disease which there is no reasonable expectation of a full recovery resulting in permanent coma and vegetative state or death regardless of the use of aggressive medical interventions for the purpose of sustaining life or the discontinuation of such.

The poor prognosis and dismal clinical outcomes have been thoroughly discussed with the patient and family after due consultation with Dr. _____.
(Complete name of physician)

This form outlines the treatment preferences and decisions of _____
(Complete name of the index patient) as outlined below.

Complete name of the person making the advanced health care directive form.

_____

Date: _____ (mm/dd/yy)

Please tick:

Sex: [ ] Male [ ] Female Civil Status: _____

Date of Birth _____

Age (years): _____

Address: _____

_____

Mobile Number: _____

Landline Number: _____

Diagnosis: _____

I am exercising my right to make my own health care decisions. I understand that I am currently suffering from an end-stage or a terminal disease for which there is no reasonable expectation for a full recovery or cure. This disease will ultimately result to death or if not, permanent coma or unconsciousness and vegetative state regardless of whether or not medical treatment is given.

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SPMC-F-MRI-21N(A)

As such, I have made the following health care decisions:

1) Optimization of palliative care measures to make me as comfortable as possible. Comfort measures may come in any of the following interventions:
   a) Pain and symptom control using conventional analgesics or regulated drugs.
   b) Sedation either as add on medication or as primary drug intervention to provide immediate relief regardless of the predominating physically distressing symptom (e.g., breathlessness, agitated delirium)
   c) Any comfort measures as advised by the doctor

2) Absolutely no extraordinary measures or life sustaining interventions to be given.

3) In the face of imminent death, all life-sustaining interventions should be withheld or withdrawn.

4) I choose to receive only hospice care when I am imminently dying. It is essential to keep me as comfortable as possible.

5) I am willing to donate my organs if I will be diagnosed as brain dead, but the informed consent for organ donation should be documented in a different form. My signature or thumbmark below indicates that I am WILLING TO DONATE my organs.

Complete Name	Signature/thumbmark	Date (mm/dd/yy)	Time

6) I am not willing to donate my organs if I will be diagnosed as brain dead. My signature or thumbmark below is evidence of my REFUSAL TO DONATE my organs.

Complete Name	Signature/thumbmark	Date (mm/dd/yy)	Time

7) I wish to add the following instructions, preferences, decisions and goals for my family and all the health care staff attending to my needs:

_____

_____

_____

_____

_____

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8) If the patient is too sick to make health care decisions (e.g., loss of mental capacity regardless of cause), the following person/s and next of kin can make decisions on the patient's behalf:

Complete Name of the legally acceptable representative	Relationship to the patient
Complete Name of the legally acceptable representative	Relationship to the patient
Complete Name of the legally acceptable representative	Relationship to the patient

I have fully disclosed and carefully discussed all the components of the advanced care planning process with the index patient, relatives, caregivers and other medical specialists. All questions and concerns of the index patient have been addressed comprehensively.

Complete Name of the physician getting the consent/Signature	Date (mm/dd/yy)	Time

The following witnesses signed this advanced health care directive form:

Complete Name of the first witness	Signature	Date (mm/dd/yy)	Time
Complete Name of the second witness	Signature	Date (mm/dd/yy)	Time

Note: A second copy of this form should be given to the patient if he/she will be terminally discharged or transferred to another hospital or facility.

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SPMC-F-MRI-21N(B)

ADVANCE HEALTH CARE DIRECTIVE FORM FOR PATIENTS WITH END-STAGE OR TERMINAL DISEASES (BISAYA)

Nahibal-an nga si _____ (kompleto nga ngalan sa indibidwal nga pasyente) nag-antos gikan sa usa ka "terminal" o "end-stage" nga sakit nga wala nay mapaabot nga usa ka hingpit nga pagkaayo. Kini moresulta sa pagka "koma" ug "pagkagulay" o kamatayon sa pasyente bisan pa sa paggamit sa agresibong medikal nga mga "interbensyon" sa katuyoan sa pagpatunhay sa kinabuhi o paghunong sa ingon.

Ang dili maayo nga "*prognosis*" ug dili maayo nga klinikal nga mga resulta an gihisgutan sa hingpit uban sa pasyente ug pamilya niini human sa konsultasyon ni Dr. _____ (kompleto nga pangalan sa doktor).

Kini nga porma naglatid sa mga pagtambal nga gitugotan ug subay sa desisyon ni _____ (kompleto nga pangalan sa indibidwal nga pasyente) nga gilatid sa ubos.

Kompletong pangalan sa naghimo sa porma isip pasiuna ng direktiba sa pag-atiman sa panglawas sa pasyente:

_____

Petsa: _____ (bulan/adlaw/tuig)

Palihug sa pag tsek:
Babae/Lalaki: [ ] Lalaki [ ] Babae Estado Sibil: _____

Petsang Natawhan: _____

Edad: _____

Pinuy-anan: _____

Numero sa Cellphone: _____

Numero sa Telepono: _____

Dayagnosis: _____

Akong gihimo ang akong katungod sa pagdesisyon mahitungod sa pag-atiman sa akong kaugalingong panglawas. Akong nasabtan nga ako nag-antos sa usa ka "end-stage" o usa ka sakit nga walay posibleng mapaabut nga hingpit nga pagkaayo o pag-ayo. Kini nga sakit sa

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katapusan moresulta sa kamatayon o kung dili, permanente nga koma o pagkawala sa panimuot ug "pagkagulay" nga estado bisan pa man mapadayon o dili ang pagtambal.

Tungod niini, gihimo nako ang mosunod nga mga desisyon sa pag-atiman sa panglawas:

1) Pag-hingpit nga pag-amping aron mapalig-on kutob sa akong mahimo. Ang mga lakang sa paghupay mahimong kining mosunod:

a) Pagdumala sa sakit ug simtomas gamit ang "conventional analgesics" o mga "regulated drugs".

b) Paghatag og pangpakalma alang sa pagdugang sa tambal o paghatag sa pangunang tambal alang sa hinanaling kahupayan bisan pa naay nagpatigbabaw nga sintomas nga hinungdan sa pagpasakit sa lawas (e.g., pagginhawa, pagkalibang nga katahap)

c) Bisa'y unsang mga lakang sa kahupayan nga gitambag sa doktor

2) Wala nay laing talagsaon nga mga lakang o ang pagpatunhay sa kinabuhi ang ihatag.

3) Tungo sa nagkaduol nga kamatayon, ang tanan nga pagpatunhay sa kinabuhi kinahanglan ihikaw o dili ipadayon.

4) Akong gipili nga modawat lamang og pangpahupay nga tungod sa akong pag-atiman nga kamatayon. Importante nga hatagan ako komportable kahimtang kutob sa mahimo.

5) Uyon ko nga idonar ang akong "bato," "kasingkasing," "lapay," "mata," o "bukog", apan kung ako mamatay ang pag-uyon alang sa donasyon sa organ kinahanglan nga madokumentado sa laing paagi. Ang akong pirma o thumbmark sa ubos nagpakita nga AKO UYON SA PAGDONOR GIBUHATAN sa akong mga "organ."

Kumletong Pangalan	Pirma/thumbmark	Petsa (bulan/adlaw/tuig)	Oras

6) Dili ko uyon nga mo-donar sa bisan unsang bahin sa akong lawas kung patay na ang akong utok. Ang akong pirma o thumbmark sa ubos mao ang ebidensya sa akong PAGDUMILI SA PAG DONAR sa bisan unsang bahin sa akong lawas.

Kumletong Pangalan	Pirma/thumbmark	Petsa (bulan/adlaw/tuig)	Oras

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7) Gusto nakong idugang ang mosunod nga mga instruksyon, mga kagustuhan, mga desisyon ug mga tumong alang sa akong pamilya ug tanan nga kawani sa pag-atiman sa panglawas nga nag-atiman sa akong mga panginahanglan:

_____

_____

_____

_____

_____

_____

8) Kung ang pasyente dili na makahatag og desisyon tungod sa iyang sakit (samasa sa pagkawala sa kapasidad sa paghuna-huna), ang pamilya o pinakaduol nga paryente. Mahimong modesisyon alang sa pasyente:

Kumpleto nga Ngalan sa Legal nga Representante	Relasyon ngadto sa pasyente
Kumpleto nga Ngalan sa Legal nga Representante	Relasyon ngadto sa pasyente
Kumpleto nga Ngalan sa Legal nga Representante	Relasyon ngadto sa pasyente

Ako ng gibutyag ug gipaklaro ang tanang proseso bahin sa pag-atiman ngadto sa pasyente, mga paryente sa pasyente, tig-atiman sa pasyente ug sa uban pang mga medikal nga mga espesyalista. Ang tanan nga mga pangutana ug mga gikabalak-an sa pasyente hingpit nga gipaklaro og iyang nasabtan.

Kumpletong Pangalan sa Duktor nga mikuha sa pagtugot/Pirma	Petsa (bulan/adlaw/tuig)	Oras

Ang mga mosunod nga mga saksi mipirma niining advanced nga porma sa direktiba sa panglawas:

Kumpletong Pangalan sa Unang Testigo	Pirma	Petsa(bulan/adlaw/tuig)
Kumpletong Pangalan sa Ikaduhang Testigo	Pirma	Petsa(bulan/adlaw/tuig)

Note: Ang ikaduha nga kopya niini nga porma kinahanglan ihatag sa pasyente kon siya mopauli na gumikan sa tambag sa medikal o mobalhin ngadto sa laing hospital o pasilidad.

Sample of Informed Refusal Form and Discharge Against Medical Advice Form from Jose B. Lingad Memorial General Hospital (JBLMGH)

JOSE B. LINGAD MEMORIAL GENERAL HOSPITAL
Dolores, City of San Fernando, Pampanga
Telephone No. (045) 409-6688

REFUSAL OF TREATMENT / RELEASE FORM

PAGTANGGI O HINDI PAGSANG-AYON SA GAMUTANG PAMAMARAANG MEDIKAL

Ako ay si _____, _____ taong gulang ay hindi sumasang-ayon na sumailalim sa gamutan o proseso ng _____.
Paraang medikal

Ano man ang panganib na maaaring idulot ng hindi ko pagsang-ayon ay lubos na naipaliwanag sa akin ni _____ at ang aking pagsalungat ay maaaring hadlang sa aking pag-asang gumaling at magdulot ng panganib sa aking buhay.

Inaalis ko sa ospital ng JOSE B. LINGAD MEMORIAL GENERAL HOSPITAL sampu ng kanyang mga empleyado, nars at doctor na kaakibat ng aking pagiging pasyente ang ano mang pananagutan dahil sa kanilang paggalang at pagsunod sa aking kahilingan.

_____ _____
Lagda ng saksi / Kamag-anak Lagda ng pasyente o legal na bantay

_____
Petsa at oras

JBL-NUR-FM-60
Rev. 03-12/04/19

JOSE B. LINGAD MEMORIAL GENERAL HOSPITAL
Dolores, City of San Fernando, Pampanga
Telephone No. (045) 409-6688

PAG-UWI NG PASYENTE NA WALANG PAHINTULOT ANG DOKTOR AT PAGAMUTAN
(Discharge Against Medical Advice)

Ako si _____ nasa wastong gulang at pag-iisip ay mapitagan kong hinihiling at kusang-loob na ilabas sa pagamutang _____
Pangalan ng Ospital

Ang aking pasyente na si _____ na aking _____.
Pangalan Kaugnayan

Tumututol ako sa anumang gamutan na gagawin sa aking pasyente, bagamat ako'y pinayuhan sa maaaring idulot ng aking pagpapasya.

Kaugnay nito lubos kong nauunawaan ang mga pamantayang umiiral at handa kaming balikatin ang anumang pananagutan na di masasangkot ang _____ at ang kanilang mga kawani.
Pangalan ng Ospital

Ako ay lumalagda bilang katunayan sa ngalan ng aking pasyente ngayong ika- _____ araw ng _____ taong _____.

_____
Buong pangalan ng pasyent at lagda

_____
Buong pangalan ng Nars at lagda
(Witness)

_____
Buong pangalan ng kinatawan ng
Pasyente at Lagda

JBL-NUR-FM-60
Rev. 03-12/04/19

Sample Informed Refusal Form from Southern Philippines Medical Center (SPMC) in English and Bisaya Version

Republic of the Philippines
DEPARTMENT OF HEALTH
Center for Health Development – Southern Mindanao
SOUTHERN PHILIPPINES MEDICAL CENTER
Davao City

SPMC-F-MRI-21M(A)

INFORMED REFUSAL FORM

Name of Patient: _____ **Ward/Bed No.** _____
Diagnosis: _____
Attending Physician: _____

I was advised to undergo the following procedures or treatments which is/are necessary for my health condition.

Advanced Cardiac Life Support for life threatening events	Imaging studies	Laboratory Examinations	Treatments

My attending physician has satisfactorily explained the benefits and risks of the above test/s, treatment/s, procedure/s. I am exercising my right to make my own health care decisions.

- **I decided NOT to accept or permit the test(s), treatment(s), or procedure(s) listed above.**
- I understand that my failure to follow my physician's advice and recommendation/s may seriously affect my health.
- I understand that my decisions may lead to an increased risk of developing medical or surgical complications, and even death.
- I am personally accountable for the risks and consequences of my refusal, and release my attending physician and his/her health care staff, my next of kin or any legally acceptable representative, and health administrators of any form of liability for any injury or discomfort that I may sustain as a result of refusal to receive above recommendations.
- I had the opportunity to ask my attending physician questions about the proposed recommendation/s, and had these answered to my satisfaction.

Complete Name of the patient	Signature/Thumbmark	Date (mm/dd/yy)	Time
Complete Name of the legally acceptable representative		Relationship to the patient	
Complete Name of the physician getting the consent/Signature		Date (mm/dd/yy)	Time
Complete Name of the witness/Signature/Thumbmark		Date (mm/dd/yy)	Time

Note: A second copy of this form should be given to the patient if he/she will go home against medical advice or opt to transfer to another health care facility.

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Sample Informed Refusal Form from Southern Philippines Medical Center (SPMC) in English and Bisaya Version

Republic of the Philippines
DEPARTMENT OF HEALTH
Center for Health Development – Southern Mindanao
SOUTHERN PHILIPPINES MEDICAL CENTER
Davao City

SPMC-F-MRI-21M(B)

PORMA SA GIPAHIBALO NGA PAGDUMILI/PAGBALIBAD

Ngalan sa Pasyente: _____ Ward/Bed No. _____
Dayagnosis: _____
Duktor nga Nag-atiman: _____

Gitambagan ko nga mopailalom sa mosunod nga mga pamaagi o mga pagtambal nga gikinahanglan alang sa akong kondisyon sa panglawas.

Advanced Cardiac Life Support alang sa mga panghitabo nga naghulga sa kinabuhi	Imaging studies sama sa X-ray, CT Scan, MRI ug uban pa	Mga eksaminasyon o laboratoryo	Mga Pagtambal

Ang doktor nga nag atiman kanako adunay katagbawan nga nagpatin-aw sa mga benepisyo ug mga risgo sa ibabaw nga mga pagsulay, mga pagtambal, ug mga pamaagi. Gihimo nako ang akong katungod sa paghimo sa akong kaugalingon nga mga desisyon sa pag-atiman sa panglawas.

- Mihukom o nagdesisyon ako nga dili dawaton o tugotan ang (mga) test, (mga) pagtambal, o (mga) pamaagi nga gilista sa ibabaw.
- Akong nasabtan nga ang akong kapakyas sa pagsunod sa tambag ug rekomendasyon sa akong doktor mahimong makaapekto sa akong panglawas.
- Nasabtan nako nga ang akong mga desisyon mahimong mosangpot sa dugang risgo sa pagpalambo sa mga komplikasyon sa medikal o operasyon, ug bisan sa kamatayon.
- Ako manubag sa mga kapeligrohan ug mga sangputanan sa akong pagdumili, ug buhian ang akong nag-atiman nga doktor ug ang iyang mga kawani sa pag-atiman sa panglawas, ang akong sunod nga miyembre sa pamilya o bisan kinsa nga legal na pareyente, ug mga administrador sa mga tulobagon sa bisan unsa nga kadaot sa panglawas aron mapalig-on ko isip resulta sa pagdumili nga makadawat sa mga rekomendasyon sa ibabaw.
- Ako adunay oportunidad sa pagpangutana sa akong (mga) doktor bahin sa gisugyot nga mga rekomendasyon, ug kini natubag sa akong katagbawan.

Kumpletong ngalan sa pasyente/ Pirma o thumbmark Petsa Oras

Kumpletong ngalan ug pirma sa legal nga representante/ Relasyon ngadto sa pasyente Petsa

Kumpletong ngalan sa duktor nga mikuha sa pagtugot/ Pirma Petsa Oras

Kumpletong ngalan sa testigo/ Pirma Petsa Oras

Ang ikaduha nga kopya niini nga porma kinahanglan ihatag sa pasyente kon siya mopauli gikan sa tambag sa medikal o mopili sa pagbalhin ngadto sa laing pasilidad sa pag-atiman sa panglawas.

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Annex XV. Training Materials and Online Resources (Virtual Access to Palliative Care)

Clinical management in palliative care

WHO guidelines on the pharmacological treatment of persisting pain in children with medical illnesses, WHO Geneva 2012 (available in English and Spanish):
http://www.who.int/medicines/areas/quality_safety/guide_perspainchild/en/

Palliative care: Symptom management and end-of-life care guidelines. Integrated management of Adult/Adolescent Illness (2004) (available in English and French):
http://www.who.int/hiv/pub/imai/primary_palliative/en/

Clinical Protocol: Palliative care for people living with HIV/AIDS. WHO Regional Office for Europe (available in English and Russian):
http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/publications/pre-2009/hivaidstreatment-and-care2.-clinical-protocols-for-the-european-region/protocol-3.-palliative-care-for-peopleliving-with-hivaids

Policy and program design

Cancer control: Palliative care. WHO guide for effective programs (2007) (available in English and Spanish):
http://www.who.int/cancer/publications/cancer_control_palliative/en/

Palliative care for older people: better practices. WHO Regional Office for Europe (2011) (Available in English, Russian and Spanish):
http://www.euro.who.int/en/health-topics/noncommunicable-diseases/cancer/publications/2011/palliative-care-for-older-people-better-practices

Palliative care: the solid facts. WHO Regional Office for Europe (2004) (Available in English, Russian and Spanish):
http://www.euro.who.int/en/health-topics/noncommunicable-diseases/cancer/publications/pre-2009/palliative-care.-the-solid-facts

Uganda advancing the integration of palliative care in the National Health System (2013)
http://www.who.int/evidence/sure/PCBFullReportSept2013.pdf

Monitoring palliative care

Palliative care for noncommunicable diseases: a global snapshot in 2015 (2016) (available in Arabic, Chinese, English, French, Russian and Spanish):
http://www.who.int/ncds/management/palliative-care/palliative-care-NCDs/en/

Global atlas on palliative care at the end of life (2014)
http://www.who.int/cancer/publications/palliative-care-atlas/en/

NCD toolkit: Indicator 20 - Access to Palliative Care
http://www.who.int/nmh/ncd-tools/indicator20/en/

Advocacy and communications

WHO fact sheet on palliative care (available in Chinese, English, French, Russian and Spanish):
http://www.who.int/mediacentre/factsheets/fs402/en/

Infographic on palliative care (available in Arabic, Chinese, English, French, Russian, Portuguese and Spanish): http://www.who.int/ncds/management/palliative-care/pc-infographics/en/

Other Links
World Health Organization
Palliative Care Programme http://www.who.int/palliativecare/en/

Guidelines on persisting pain in children
http://www.who.int/medicines/areas/quality_safety/guide_perspainchild/en/

Planning and implementing palliative care services: a guide for programme managers
http://www.who.int/ncds/management/palliative-care/palliative_care_services/en/

Global atlas of palliative care at the end of life
http://www.who.int/ncds/management/palliative-care/palliative-care-atlas/en/

World Hospice Palliative Care Alliance
http://www.thewhpca.org/

Pain and Policy Studies Group
http://www.painpolicy.wisc.edu/

International Association for Hospice and Palliative Care (IAHPC)
https://hospicecare.com/home/

International Children's Palliative Care Network
http://www.icpcn.org/

Asia Pacific Hospice Palliative Care Network
http://aphn.org/

European Association for Palliative Care
http://www.eapcnet.eu/

European Association for Palliative Care (EAPC) Primary Care Reference Group
http://www.eapcnet.eu/Themes/ProjectsTaskForces/EAPCReferenceGroups/PrimaryCare.aspx

World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA)
http://www.globalfamilydoctor.com/

VitalTalk COVID ready communication guides https://www.vitaltalk.org/guides/covid-19-communication-skills/

Center to Advance Palliative Care
https://www.capc.org/toolkits/

Annex XVI. List of Palliative and Hospice Care Groups in the Philippines

List of Palliative and Hospice Care Groups in the Philippines	
ActivCare Home Health Solutions, Inc.	Manila Doctors Hospital
AKBAY Inc	National Children's Hospital
Alay Kapwa Kilusang Pangkalusugan (AKAP)	Manila Medical Center (Previously Medical Center Manila)
Amang Rodriguez Memorial Medical Center	National Hospice & Palliative Care Council of the Philippines OR Hospice Philippines
Asian Hospital and Medical Centre	National Kidney & Transplant Institute (NKTI)
Ayala Alabang Hospice Care Foundation	Nightingale Nursing Services Inc.
Bigkis ng Tayabas Inc.	Ospital ng Makati
Cagayan Valley Medical Center (DOH retained hospital)	Pain Management Center, St Luke's Medical Center
Cancer Center Palliative Care Service-The Medical City Cancer Center	PALCARE Hospice Foundation, Inc.
Cancer Council Phils., Inc.	Palliative Care Family Support Services (PCFSS)
Canossa Hospice Care Program	Patmos Retreat House
Cardinal Santos Medical Center (CSMC)	Perpetual Succor Hospital
Carewell Community Foundation, Inc.	Philippine Cancer Society Inc
Cebu Cancer Institute	Philippine Children's Medical Center
Central Luzon Pain Management & Hospice Care Center	Philippine General Hospital - Supportive Hospice and Palliative Medicine Section
Chong Hua Hospital Mandaue	Provincial Health Office (PHO) Zambales
Cradle of Hope	Quirino Memorial Medical Center
Damayang Filipino	RAFI-Eduardo J. Aboitiz Cancer Center
Davao Regional Medical Center	Ramon Magsaysay Memorial Hospital
Dr. Jose N. Rodriguez Memorial Hospital and Sanitarium	Rizal Medical Center
Dr. Paulino J. Garcia Memorial Research and Medical Center	San Jose Marello Hospice and Palliative Care
De La Salle Hospice Care Program	San Pedro Hospital Cancer Care Center
East Avenue Medical Center	Servants of Jesus the Healer Hospice & Pain Clinic

Eastern Visayas Regional Medical Center	Siliman University Medical Center
FEU-NRMF Supportive & Palliative Care Services	Sinag Kalinga Foundation Inc
Francis Regis Clet House & Pain Clinic	Southern Philippines Medical Center
Home Care Nurses Alliance of the Phils (HCNAP)	Springfield Medical Foundation, Inc.
Home Health Care, Inc.	St. Jude Hospital & Medical Center Manila
Ilocos Training and Regional Medical Center	St. Paul's Hospital Iloilo, Section of Hospice and Palliative Care
Iloilo Mission Hospital Pain & Palliative Care Clinic	Starfish Palliative Care Program
Isabela United Doctors Medical Center	The Medical City (TMC)
Jose B. Lingad Memorial Regional Hospital	The Ruth Foundation for Palliative and Hospice Care
Jose R. Reyes Memorial Medical Center	University of Santo Tomas Hospital Hospice
Kythe Foundation, Inc.	Vicente Sotto Memorial Medical Center
Lung Center of the Philippines	Vineyard Medical Foundation
Madre de Amor Hospice Foundation Inc	Western Visayas Medical Center
Makati Medical Center (Integrative Palliative and Home Care Unit)	Wingless Angels of Lucena Hospice

Annex XVII. Application Steps for S2 and S3 License

PDEA is the one responsible for providing the steps needed to get an S2 license for practitioners and S3 license for retailers. Latest updates could be viewed in the following webpages.

for S2 license: https://pdea.gov.ph/compliance-service/cs-advisory

for S3 license: https://pdea.gov.ph/images/ComplianceService/2019/CS-citizens-charter---S-License-March-2019.pdf

Annex XVIII. Proposed data sets for the National Palliative and Hospice Care Registry

The following is based on the Danish National Patient Registry

Data Type	Description
Administrative data	
PhilHealth number	A 12-digit number as reflected in the PhilHealth Number Card/ Identification Card/ Member Data Record
Full Name: • **Surname** • **First name (and Suffix)** • **Middle name**	The name of the patient as it appears in their birth certificate
Birth date	Birthdate as it appears in their birth certificate. mm/dd/yyyy
Residence	Barangay, Municipality, and Province of Residence
Health facility	Health facility that have contact with the patient
Patient contact	Home care, Inpatient, outpatient (ambulatory), or emergency department contacts
Admission type	NA, acute or non-acute
Referred from/referred to	General practitioner, outpatient (ambulatory) clinic, other hospital departments, foreign hospital, no referral (eg, acute admission via ambulance), or death (only applies to "referred to" if death is declared during admission)
Referral period	Period from referral date to start date for patient contact
Waiting time	Period from referral date to start date for treatment
Contact reason	Reason for the health facility contact: diagnosis, accident, act of violence, suicide attempt, late complications, unknown (eg, unconscious patient), or other (rarely used)
Accident	Accident description, when an accident is the contact reason
Time specifications	Date and time of home visit start and finish, Date and time of inpatient admission/discharge, start/end date for outpatient treatment, date of arrival to/discharge from emergency department, and date of referral (if relevant)
Other administrative data	Home visit or out-of-home visit (eg, drop-in center or prison service) Treatment status of cancers covered by national treatment guaranties: referred, examined, or under treatment

Diagnoses	
Primary diagnosis	Main reason for patient contact. When a patient is being examined and a diagnosis is not yet confirmed, a tentative "obs pro" (observation for) diagnosis may be used (the ICD-10 "Z-codes")
Secondary diagnosis	Optional diagnoses supplementing the primary diagnosis by, eg, describing the underlying chronic disease that is related to the current patient contact
Referral diagnosis	Diagnosis given by referring unit as the reason for referral
Temporary diagnoses	Diagnoses used only for ongoing non-psychiatric outpatient contacts and never for completed contacts or for psychiatric contacts
Complications	Procedure-related complications, eg, perioperative bleeding or postoperative infections
Supplementary codes	Up to 50 codes supplementing the primary diagnosis, typically tentative diagnosis (eg, adding meningitis examination to the primary diagnosis disease of the central nervous system), drug abuse (eg, adding heroin to acute opioid intoxication), drug side effects (eg, adding acetylsalicylic acid to peptic ulcer disease), or cancer stage (eg, adding TNM stage to primary tumor diagnosis)
Treatments	
Surgery	For example, surgery on the thyroid gland, lung, or coronary arteries
Other treatments	Patient care: eg, dress a wound with sterile bandage or supra pubic catheter change Invasive procedures: eg, implantation of pacemaker/cardioverter-defibrillator or radiofrequency ablation Mechanical ventilation: invasive or noninvasive Cancer/immune-modulating treatments: antibody or immune-modulating therapy, radiation therapy, stem cell or bone marrow transplantation, cytostatic treatment, and biological therapies Other medical treatment: eg, fibrinolysis or initiation of parturition with prostaglandin Telemedicine: eg, patient counseling by phone, email, or video Systemic psychotherapy: individual, couple, or family Physiotherapy or occupational therapy Other treatment examples: dialysis, medical abortion, electroconvulsive therapy, total parenteral nutrition, and acupuncture
Anesthesia and intensive care	For example, during intensive care

Examinations	
Radiological procedures	For example, angiography, computed tomography, magnetic resonance imaging, X-ray, and ultrasound scan
Other examinations	For example, planning rehabilitation, distortion product otoacoustic emission, and cardiotocography For example, psychological evaluation, semi structured diagnostic interview, writing medical certificate, providing preoperative antibiotic prophylaxis, and procedure cancellation due to nonappearance of the patient

Annex XIX. Recommended contents on Palliative Care for Undergraduate Courses

Palliative care must be included in the undergraduate course of the health workers.
The curriculum must include the following core competencies:

Definition and principles of palliative care
- Definition and principles of palliative care
- Models of palliative care

Identification and control of symptoms
- Pain
- Respiratory symptoms
- Gastrointestinal symptoms
- Insomnia
- Delirium

End-of-life care
- Palliative sedation
- End-of-life care

Basic Nutrition for the Vulnerable age group
Ethical and legal issues
Psychosocial and spiritual issues
- Emotional issues
- Grief and bereavement
- Spirituality
- Caregiver and family
- Communication and therapeutic relationship

Teamwork
Self-awareness and self-care in caring for terminally ill patients
(Prastana, et. al. 2016; EFPPEC, 2018)

Annex XX. Strategic Plan 2021-2030

Department of Health
National Palliative and Hospice Care Program
Strategic Plan 2021-2030

15 December 2020

BACKGROUND

Palliative care refers to a systematic, organized, multidisciplinary approach of care to patients, across all ages, with any chronic life-limiting or life-threatening illness. It aims to improve the quality of life of the patient and their families through a holistic, age appropriate, gender responsive, culturally sensitive and rights-based approach. It is care directed to the anticipation, prevention, and relief of suffering through early identification, impeccable assessment, and treatment of pain and other problems involving the physical, intellectual, emotional, social, and spiritual needs of the patient. It promotes dignity, quality of life, and adjustment to progressive illnesses, using the best available evidence.

Hospice Care is a component of palliative care that deals with the end-of-life care (usually to patients with about 6 months or less to live) by skilled health care providers and volunteers. The goal of care is to help people who are dying to have peace, comfort, and dignity by providing holistic support (providing medical, psychological and spiritual support). Hospice programs also provide support services for a patient's family usually in the end-of-life, anticipatory grief, and even up to 1-2 years of bereavement.

All people, irrespective of income, disease type, or age, should have access to a nationally determined set of basic health services, including palliative care. Financial and social protection systems need to take into account the human right to palliative care for poor and marginalized population groups. It is a person-centered accompaniment of patients and their families throughout the illness, including at the end of life that optimizes quality of life, promotes human development and well-being, and maximizes dignity.

Palliative care is a **fundamental human right** (World Palliative Care Alliance Declaration, 2009) and an essential component of comprehensive and integrated care for persons with serious chronic, complex, and life-limiting or life-threatening health problems. Palliative Care should be practiced by health and social care providers of many disciplines, as well as palliative care specialists, and should be provided in any health care setting, including patients' homes.
People who need palliative care are those with the following:

- Chronic, progressive, far advanced conditions which are limiting or life-threatening conditions (e.g. cancer, organ failure, stroke, etc.);
- Multidimensional needs (physical, emotional, spiritual, etc.);
- Complex palliative care interventions such as opioid titration for intractable pain and other symptom management, difficult decision-making with dysfunctional family dynamics brought about by the life-threatening condition of a family member, complicated grief, and bereavement in the family, etc.; and
- life-limiting or life-threatening conditions whose prognosis is limited.

Our Constitution guarantees the right of the people to quality health care, as such the Department of Health (DOH) recognizes the need to integrate palliative and hospice care into our health care delivery system to provide holistic health care. The inclusion of palliative and hospice care in the hospitals or health facilities and in the community and home-based levels addresses the goals of Universal Health Care or Kalusugan Pangkalahatan. With this, a DOH administrative order in 2015 was mandated and is known as the National Policy on Palliative and Hospice Care in the Philippines, DOH AO 2015-0052. This order is aimed to set overall policy directions and identify the roles and functions of DOH, its offices, and partner agencies in the provision of palliative and hospice care in hospitals, health facilities, communities, and home-based levels.

The establishment of integrated palliative and hospice care in the Philippines is still a work in progress. To date, there are provisions of palliative and hospice care services available in many parts of the country, and efforts to begin the integration into the formal health care system are still underway.

Palliative and hospice care been included in many major health policy documents including:

- Republic Acts
  - RA 11215 National Integrated Cancer Control Act (2019);
  - RA 11223 Universal Health Care/UHC Act (2019);
- DOH Administrative Orders and Programs
  - AO 2011-0004 Guideline for distribution and monitoring of Morphine sulfate
  - AO 2015-0052 National Policy on Palliative and Hospice Care in the Philippines
  - AO 2016-0001 Policy on Cancer Prevention and Control
  - AO 2020-0003 Integrated People-Centered Health Services in All Health Facilities
  - AO 2020-0007 Patient Safety in Health Facilities
  - DOH MC 2019-0011 supporting the RA 11223 Instituting UHC for All Filipinos, Prescribing Reforms in the Health Care System and Appropriating Funds
  - DOH MC 2019-0036 IRR of RA 11215
  - The National Tuberculosis Control Program (NTCP Manual of Procedures 6th ed 2020)
- PhilHealth Circular
  - PhilHealth Circular 2019-0009 of the PHIC regarding Premium contribution schedule in the NHIP pursuant to RA 11223 UHC Act

The Philippine National Objectives for Health 2017-2020, where access to essential quality health products and services shall be ensured at appropriate levels of care including palliative care in the comprehensive essential health service package and specialized health services for all life stages

In addition, as mandated in the Local Health Code, local government units can come up with their own local programs on palliative and hospice care. One example is the City of Malolos LGU where an ordinance was passed in 2019 to provide for the mechanism and integration of Palliative care in the treatment of life-threatening illness in the city (City Ordinance No. 17-2019). Also, there were other efforts from the provinces of Pampanga, Samar, Leyte, Davao, and some cities in the NCR like Pasig, Makati, Muntinlupa which started their own pilot projects for palliative care in their respective areas.

Recent strategic directions and priorities in public health are set in the Philippine Health Agenda 2016-2022 (DOH, 2016) and the FOURmula One Plus for Health (DOH, 2017). These directions provide the context when the Palliative and Hospice Care Program Strategic Plan and its supporting guidance documents were developed.

Three Guarantees of the Philippine Health Agenda 2016-2022

1. **Health services for both the well and the sick**: To cover for all life stages & triple burden of diseases - includes palliative and hospice care
2. **Functional Network of Health Facilities**: Includes services delivered by networks that are fully functional, compliant with clinical practice guidelines, available 24/7, practicing gatekeeping, located close to the people and enhanced by telemedicine
3. **Universal Health Care**: Financial Freedom when Accessing Services

The Strategic Pillars of the Philippine Health Agenda 2016-2022 (DOH, 2016)

- A - Advance quality, health promotion and primary care
- C - Cover all Filipinos against health-related financial risk
- H - Harness the power of strategic HRH development
- I - Invest in eHealth and data for decision-making

- E - Enforce standards, accountability and transparency
- V - Value all clients and patients, especially the poor, marginalized and vulnerable
- E - Elicit multi-sectoral and multi-stakeholder support for health

FOURmula One Plus (2017-2022)

- Vision: The DOH envisions Filipinos as among the healthiest people in Southeast Asia by 2022, and in Asia by 2040.
- Mission: The DOH shall lead the country in the development of a productive, resilient, equitable and people-centered health system.
- Core Values: The DOH shall embody at all times integrity, excellence and compassion in carrying out its tasks and responsibilities.
- Goals: The F1+ for Heath aims to ensure better health outcomes, a more responsive health system and a more equitable health care financing.
- Strategic Pillars: The DOH shall organize health sector initiatives into four (4) pillars, namely: Financing, Service Delivery, Regulation, Governance, plus a cross-cutting initiative on Performance Accountability.

HOW THE STRATEGIC PLAN WAS DEVELOPED

The Strategic Plan was developed through a process that included: Literature review as part of the development of the Manual of Operations and Standards and the Training Packages (May to July 2020); Gathering of inputs from meetings and consultations (June to September 2020); Framework analysis and development of draft by the Project Team (October to November 2020); and Review of draft by members of the Technical Working Groups (TWG) for MOPS, TWG for Training Manuals, the Pilot Training Pool and health system, program development and planning experts (December 2020 to January 2021). Inputs were integrated towards a second draft that was reviewed during a second public consultation in February 2021. The Strategic Plan was finalized and approved in March 2021 along with other palliative and hospice care program documents that included the Manuals of Operations and Standards, Training Packages and the Research Agenda.

PURPOSE OF THE DOCUMENT

This document aims to guide national, regional, provincial, city and local planners, managers and partners in the planning, implementation and M&E of palliative and hospice care activities. It describes Strategic Directions aligned with UHC and the FOURmula One Plus for Health. Intended users include DOH central and regional officials, PHOs, CHOs, MHOs, public health and LGU planners, managers and implementers, including officials of partners, NGOs, academic institutions, research agencies, private hospitals, international partners and other entities that govern and manage health care systems and institutions in the Philippines.

GOALS AND TARGETS

- By 2030, the Philippines shall have a responsive, quality, accessible and equitable palliative and hospice care program that is recognized internationally (systems goal).
- By 2030, the palliative care program and services has been established in 20 hospitals and 20 provinces (health sector goal).
- By 2030, 200 patients have been provided access to quality palliative and hospice care services every year in each tertiary and secondary hospital (QOL target). [Hospital refers to those listed in the DOH program providing services as defined.]
- By 2030, OOP for palliative care has been reduced to 20% (financial protection).

STRATEGIC AREAS

Requesting Project Team to Prepare a Figure that would illustrate how the Strategic Areas shall strengthen health access and services, towards improved health outcomes and goals.

SA 1: Governance and Policy

Objective: To strengthen leadership and management capacities, coordination and support mechanisms necessary to ensure functional, people-centered and participatory health services for palliative care.

This Strategic Area is anchored on F1+ Strategic Pillar 4 Governance that aims to strengthen leadership and management capacity, organizational development and policy development.

Actions	Agency	Timeline	Budget
1. Establish DOH governance through approved Palliative Care Program with Coordinator, Staff and Annual Budget (through a Policy/ Department Memorandum)	DOH	2021	
2. Strengthen role of Hospice Philippines	Hospice Philippines	2021 onwards	
3. Identify reference hospitals in Luzon (1), Visayas (1) and Mindanao (1) to implement services, gather experts, conduct research and initiate trainings	DOH	2021	P15 million per year
4. Organize regular program updates with key government agencies and stakeholders (e.g. regular Palliative Care Council Meetings)	DOH	2022	P2 million per year
5. Identify and capacitate Regional and Provincial Coordinators for Palliative and Hospice Care	DOH, Hospice Philippines	2022	P1 million per year
6. Establish 20 compassionate communities (primary care) programs under LGUs in Luzon, Visayas and Mindanao, with local policy, coordinator, Annual Operational Plan, medicines access, services and partnerships	DOH, LGUs, Hospice Philippines	2023	P2 million
7. Establish palliative care program and services in 20 hospitals and 20 province	DOH, LGUs, Hospice Philippines	2030	P2 million per year

SA 2: Communication and Advocacy

Objective: To promote the development of palliative and hospice care services among health and local officials and health service providers and increase awareness and utilization among the general population.

Palliative and Hospice Care is a new program that should be integrated well into the health system. Much of the inputs during meetings and consultation reflect the importance of communication and advocacy for palliative and hospice care. This Strategic Area is anchored on the Philippine Health Agenda Strategy A to achieve quality, health promotion and primary care.

Actions	Agency	Timeline	Budget
1. Promote PhilHealth registration and unique number for all Filipinos	LGUs	2021 onwards	
2. Organize LGU-based advocacy activities and events to promote palliative care and compassionate communities	LGUs	2022 onwards	P10 million
3. Organize National Conference on Palliative and Hospice Care starting in 2023 and then annually	DOH	2023 onwards	P3 million per year

SA 3: Sustainable Services and Access to Medicines ensuring Financial Protection

Objective: To ensure accessibility of essential palliative and hospice care services at appropriate levels of care, while ensuring sustainability, efficiency and equitable use of health resources.

This Strategic Area is anchored on F1+ Strategic Pillar 1 (Financing), SP 2 (Service Delivery) and SP 4.3 (Governance in Procurement and Supply chain management). SP 2 Service Delivery is further described into:

- SP 2.1 Increase access to quality essential health products and services
- SP 2.2 Equitable access to quality health facilities
- SP 2.4 Engage SDNs to deliver comprehensive package of health services

SP 4.3 of F1+ aims to improve processes for procurement and supply chain management to ensure availability and quality of health commodities. It includes activities e.g. planning, forecasting, coordination, procurement and logistics management strengthening. The Manual of Operations and Standards for Palliative and Hospice Care has been developed to guide all activities and delivery of services at different levels.

Actions	Agency	Timeline	Budget
1. Approval, dissemination and implementation of MOPS in UHC Integration Sites	DOH	2021	P1.5 million
2. Develop 10 service networks linking hospitals and communities in Luzon, Visayas and Mindanao	DOH, Hospitals, LGUs	2022-2024	P15 million
3. Establish palliative care services in 30 public hospitals with hospital policy, services, home care, access to medicines, multidisciplinary staff and annual operational plans	Hospitals	2022-2025	P10 million
4. Develop CPG and home protocol development for common conditions	DOH	2022	P2 million
5. Ensure inclusion of Essential Medicines (MOPS) in the PNF	DOH	2023	P2 million
6. Medicines Access Program for Palliative and Hospice Care	DOH	2022 onwards	P15 million
7. Research to enhance access to medicines: HTA for essential medicines not yet in the PNF; HTA for other common medicines; research on the use of restricted drugs; costing review and analysis for medicines,	DOH, PCHRD and Research Partners, PSHPM, Hospice	2023 onwards	P10 million

services (inpatient, outpatient and home care) and program implementation	Philippines, Hospitals, Funders		

SA 4: Equitable Distribution of Human Resources for Health in Palliative Care

Objective: To ensure equitable distribution of human resources for health through mapping, alignment of strategies, training and supportive working environment in all areas of the country.

SA 4 is anchored on F1+ SP 2.3 that aims to Ensure Equitable distribution of Human resources for health (HRH). The DOH, in partnership with Jose B Lingad Memorial General Hospital (JBLMGH), Hospice Philippines, Philippine Society of Hospice and Palliative Medicine (PSHPM) and partners, has developed the Basic and Intermediate Training packages that would form the basic requirements for health workers and professionals in the delivery care especially in communities, cities, rural health units, district hospitals and provincial hospitals.

Actions	Agency	Timeline	Budget
1. Partnership with professional societies and associations who are part of the multidisciplinary team	Hospitals	2021 onwards	
2. Organize and implement training programs in the next three years targeting the following participants: all 17 regions, 20 DOH hospitals, 30 LGU hospitals, 30 private hospitals, 20 workplaces, 20 PHOs, 30 CHOs, 100 RHUs and 500 barangays	DOH, CHDs, Training Institutions/ organizations	2021 onwards	P10 million per year
3. Build a pool of 100 trainers and experts all over the country with certification by DOH and Hospice Philippines to support rolling out of the program in public hospitals, private hospitals, LGUs and communities	DOH, Hospice Philippines, PSHPM	2021-2022	P5 million
4. Continue to conduct other special training e.g. pediatric palliative care, pain, care for cancer patients, ELNEC, etc.	Hospice Philippines, PSHPM, Hospitals, Training Institutions/ organizations	2021 onwards	
5. Integration of palliative care in the training program of physicians, nurses and allied professionals	Hospice Philippines, PSHPM, DOH, CHED	2022	

SA 5: Information and Evidence Support

Objective: To ensure reliable information and use of evidence that shall support policy development, decision-making and program planning and implementation.

SA 5 is anchored on F1+ SP 4.1 that ensures generation and use of evidence in health policy development, decision making and program planning and implementation. Research, M&E and electronic health information are included in this area.

Actions	Agency	Timeline	Budget
1. Develop, test and enhance M&E framework and indicators for the program	DOH	2022	
2. Database of Health Service Providers, Hospitals and Facilities, Public and Private, and with Health Facility Codes	DOH, Hospice Philippines	2022	
3. Development of EMR in health facilities	Hospitals		
4. Development of National Palliative Care Registry (possibly City-, Province- on Region-Based following design of UHC)	DOH, LGUs, Hospice Philippines	2022 2022 onwards	P10 million P10 million
5. Develop protocols and implement telemedicine for palliative care in health			
6. Conduct of other essential research in palliative and hospice care areas e.g. pediatric, nutrition, special populations, rehabilitation, cancer care, nursing care, social science, economic (e.g. financial protection) and new technologies.	Hospitals, LGUs DOH, PCHRD, PSHPM, Hospice Philippines, Funders, Hospitals, Experts	2021-2022 2021 onwards	P10 million P20 million

LIST OF CONTRIBUTORS AND REVIEWERS

Technical Advisory Group
Technical Working Group for MOPS and Training Manuals
DOH Offices
Training Network
Project Team

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Annex XXI. Research Agenda

Department of Health
National Palliative and Hospice Care Program
Research Agenda 2021-2023

15 December 2020

BACKGROUND

Palliative care refers to a systematic, organized, multidisciplinary approach of care to patients, across all ages, with any chronic life-limiting or life-threatening illness. It aims to improve the quality of life of the patient and their families through a holistic, age appropriate, gender responsive, culturally sensitive and rights-based approach. It is care directed to the anticipation, prevention, and relief of suffering through early identification, impeccable assessment, and treatment of pain and other problems involving the physical, intellectual, emotional, social, and spiritual needs of the patient. It promotes dignity, quality of life, and adjustment to progressive illnesses, using the best available evidence.

Hospice Care is a component of palliative care that deals with the end-of-life care (usually to patients with about 6 months or less to live) by skilled health care providers and volunteers. The goal of care is to help people who are dying to have peace, comfort, and dignity by providing holistic support (providing medical, psychological and spiritual support). Hospice programs also provide support services for a patient's family usually in the end-of-life, anticipatory grief, and even up to 1-2 years of bereavement.

All people, irrespective of income, disease type, or age, should have access to a nationally determined set of basic health services, including palliative care. Financial and social protection systems need to take into account the human right to palliative care for poor and marginalized population groups. It is a person-centered accompaniment of patients and their families throughout the illness, including at the end of life that optimizes quality of life, promotes human development and well-being, and maximizes dignity.

Palliative care is a **fundamental human right** (World Palliative Care Alliance Declaration, 2009) and an essential component of comprehensive and integrated care for persons with serious chronic, complex, and life-limiting or life-threatening health problems. Palliative Care should be practiced by health and social care providers of many disciplines, as well as palliative care specialists, and should be provided in any health care setting, including patients' homes.

People who need palliative care are those with the following:

- Chronic, progressive, far advanced conditions which are limiting or life-threatening conditions (e.g. cancer, organ failure, stroke, etc.);
- Multidimensional needs (physical, emotional, spiritual, etc.);
- Complex palliative care interventions such as opioid titration for intractable pain and other symptom management, difficult decision-making with dysfunctional family dynamics brought about by the life-threatening condition of a family member, complicated grief, and bereavement in the family, etc.; and
- life-limiting or life-threatening conditions whose prognosis is limited.

Our Constitution guarantees the right of the people to quality health care, as such the Department of Health (DOH) recognizes the need to integrate palliative and hospice care into our health care delivery system to provide holistic health care. The inclusion of palliative and hospice care in the hospitals or health facilities and in the community and home-based levels addresses the goals of Universal Health Care or Kalusugan Pangkalahatan. With this, a DOH administrative order in 2015 was mandated and is known as the National

Policy on Palliative and Hospice Care in the Philippines, DOH AO 2015-0052. This order is aimed to set overall policy directions and identify the roles and functions of DOH, its offices, and partner agencies in the provision of palliative and hospice care in hospitals, health facilities, communities, and home-based levels.

The establishment of integrated palliative and hospice care in the Philippines is still a work in progress. To date, there are provisions of palliative and hospice care services available in many parts of the country, and efforts to begin the integration into the formal health care system are still underway.

This context is an opportunity for the Philippines to initiate and build its capacity for palliative and hospice care research. It is important to document experiences and best that can be shared with other countries.

HOW THE RESEARCH AGENDA WAS DEVELOPED

The Research Agenda was developed through a process that included: Literature review as part of the development of the Manual of Operations and Standards and the Training Packages (May to July 2020); Gathering of inputs from meetings and consultations (June to September 2020); Framework analysis and development of draft by the Project Team (October to November 2020); and Review of draft by members of the Technical Working Groups (TWG) for MOPS, TWG for Training Manuals, the Pilot Training Pool and health system, program development and planning experts (December 2020 to January 2021). In all these meetings, policy, programmatic, clinical and operational questions were collected and analyzed into themes.

A draft of the Research Agenda was prepared with research questions/ objectives added to provide more definition to topics and themes. This draft was reviewed during a second public consultation in February 2021. The Research Agenda was finalized and approved in March 2021 along with other palliative and hospice care program documents that included the Strategic Plan, Manuals of Operations and Standards and Training Packages.

PURPOSE OF THE RESEARCH AGENDA

This document aims to synthesize all potential policy, programmatic, clinical and operational questions that shall require research and technical assistance. Intended users of the research agenda include PCHRD, hospitals, researchers, academe, DOH central and regional officials, partners, NGOs, international partners, private sector, investors and other stakeholders. The agenda can guide planning for annual research funding allocation. This is the first time that different research themes, questions and topics are collected in one document. Its duration covers only until 2023 in time for new management. Review of research implementation and identification of new questions and research priorities should be done in 2022.

RESEARCH TOPICS

Theme 1: Improving Access to Palliative Care Services
This covers topics related to access including medicines, costs and basic epidemiologic studies.

Research Topics	Research Questions/ Objectives	Timeline and Expertise Needs	Budget
Develop CPG and home protocol development for common conditions	● What are common conditions requiring palliative and hospice care in the Philippines? ● How can these conditions be managed at home?	2021-2023	

HTA for essential medicines not yet in the PNF	• Which essential medicines for palliative and hospice care are not yet in the PNF? • What is the cost-effectiveness of these medicines? • Can the Philippines afford to pay for these medicines? • What are equity, ethical and social issues related to the access of these medicines?	2022	
HTA for other common medicines	• Which other important medicines for palliative and hospice care are used in the Philippines? • Should these be included in the PNF? • What is the cost-effectiveness of these medicines? • Can the Philippines afford to pay for these medicines? • What are equity, ethical and social issues related to the access of these medicines?	2023	
Research on the use of restricted drugs	• What important medicines have restricted access? • Is the evidence robust for these to be used? • What is the policy context for access in the Philippines? • What is the experience in other countries? • How can policies be adjusted to improve access?	2023	
Costing review and analysis for medicines; services (inpatient, outpatient and home care)	• How much do services and medicines cost at different levels? • How much is covered by PhilHealth and DOH? How much is covered from Out-of-pocket?	2022	
Costing review and analysis for program implementation	• What is the cost of programs and services for palliative and hospice care in government hospitals? • What is the cost of programs and services for palliative and hospice care in private hospitals? • What is the cost of programs and services for palliative and hospice care in communities?	2023	
Epidemiology Studies for Development of PhilHealth Benefits	• What are common conditions requiring palliative and hospice care? • What is the proportion of the population that requires these services?	2022	
Actuarial studies	• How sustainable are essential services/ packages based on current population needs?	2023	

Theme 2: Improving Standards and Quality of Care

These studies include topics on palliative care services and how these can be improved at different levels. It covers clinical as well as operational questions.

Research Topics	Research Questions/ Objectives	Timeline and Expertise Needs	Budget
Conduct of other essential research in palliative and hospice care areas: ● Pediatric population ● Palliative nutrition ● Special populations ● Rehabilitation ● Cancer care ● Nursing care ● Home care ● Chronic care ● Palliative emergencies ● Social science ● Economic (e.g. financial protection) ● New technologies	[Identify research questions]	2022-2023	
Operational studies	[Identify research questions]		

Theme 3: Enhancing Demand and Environmental Context

These are demand- and market- side studies that are essential to better implement palliative care programs through the support of families, communities, health care provider networks, enterprises/ workplaces and local governments.

Research Topics	Research Questions/ Objectives	Timeline and Expertise Needs	Budget
[Identify research topics]	[Identify research questions]	2022-2023	

Annex XXII. Career Progression and Specialization for Nursing

source from joint collaboration of DOH, Hospice Philippines, Professional Regulation Commission and Palliative and End-of-Life Care Association of the Philippines, Inc. (PEOLCAP)

Specific Descriptors of Practitioners in Palliative Nursing

PARAMETERS	PHILIPPINE QUALIFICATIONS FRAMEWORK (PQF)		
	LEVEL 6	**LEVEL 7**	**LEVEL 8**
I. Field of study	Nursing	Nursing	Nursing
Academic Requirements and Professional Qualifications	Graduate of a BSN program from a recognized institution.	Graduate of a Master's Degree in Nursing from a recognized academic institution preferably with a major in FHN Family Health Nursing	Graduate of Doctoral Degree in Nursing or related field (earned through formal education)
	Completed certifications in Palliative and Hospice Nursing Practice accredited by PRBON. Specialization program must include a formal didactic instruction and clinical experience approved by PRBON. • Introduction to Palliative Care Nursing • Communication in Palliative Care • Pain Management in Palliative Care • Symptom Management in Palliative Care • Loss, Grief and Bereavement • Final Hours of Life • Preparing for a Good Death • Caring for the Imminently Dying Patient	Completed Post Graduate course • Discuss the multiple roles of the advanced practice nurse (APN), in providing or advocating for quality palliative care for patients with serious illness and their families. • Apply communication skills essential for the role of the advanced practice • Facilitate advance care planning conversations • Prepare for and lead family meetings centered on serious illness conversations while honoring and respecting unique cultural norms • Integrate critical components of an advanced pain assessment: history, physical examination, and diagnostic testing, into clinical practice. • Apply the biopsychosocial/ spiritual model of pain assessment and management to selected common symptoms associated with serious illness. • Prescribe pharmacological and non-pharmacological interventions for management of selected common symptoms in serious illness. • Discuss the role of the APN I in preparing the patient and family for death. • Integrate the essential elements of compassionate and	• Advanced practicum I and II care of adolescents, adult and aged • Communication and counselling Organization and management • Physical assessment • Apply the three essential elements of advanced practice nursing leadership in improving palliative care for all patients with serious illness across the life-span and in all settings. • Integrate transformational leadership concepts into primary palliative care APN practice in various domains of care. • Analyze patient, family, community and/or system challenges and opportunities as an APN leader in serious illness care. • Discuss the importance of resiliency in care of patients with serious illness and their families.

II. Work setting	Service Institutions: •Hospital *Home Care •Community *Nursing homes •Primary Care Facilities (Rural Health Unit/Barangay Health Station) *Academic Institution	Service Institutions: •Hospital •Home care •Community *Nursing homes *Other palliative and hospice care related agency or institution	Service Institutions: •Hospital *Home care •Community *Nursing homes •Primary Care Facilities (Rural Health Unit/Barangay Health Station) *Academic Institution
III. Professional Practice	All Settings	Specialized unit/setting Supervisory/management in specialized unit/setting	Institutional, national, global
A. Tracks	Certified Nurse Specialist in Palliative and Hospice Care (PHC)	Advanced Practice Nurse (APN) I in Palliative and Hospice Care (PHC)	Advanced Practice Nurse (APN) II in Palliative and Hospice Care (PHC)
B. Minimum work of experience required	Upon PRC licensure as bedside care nurse for at least one (1) year to provide professional nursing services to individual diagnosed with or at risk of having life limiting disease	PQF Level 6 + Minimum of Three (3) continuous years of professional years of professional practice in any field of palliative nursing (setting may be service / training/ research or education) in a supervisory or managerial position or MAN Major in Family Health Nursing/CHED requirements	PQF Level 7 + least 5 years in an administrative position in any field of palliative (setting may be research, service/training or or DNP/ CHED requirements.
1. Clinical Hours Required	Completion of BSN/RN and/or Required PRBON-accredited Palliative and Hospice Nursing Certification	Based on MAN/CHED requirements and/or 4,160 clinical hours (2 years) and completed Post-Graduate Course for Palliative and End Of Life Care	Based on DNP/CHED requirements and/or 10,400 clinical hours (5 years) and completed Post-Graduate
	Provides professional nursing service (safe administration of medications, to at least 10 patients/ individuals for one (1) year diagnosed with or at risk of having serious illness and their families per shift schedule 12 hours).	*To be translated from competencies to clinical practice hours in palliative hospice nursing.	*To be translated from competencies to clinical practice hours in palliative hospice nursing.
2. Personal and Professional Development	•PRC required CPD units •Training courses provided by PEOLCAP •Maintains membership in accredited professional organization •Maintains membership in PEOLCAP	•PRC required CPD units •Training courses provided by PEOLCAP •Maintains membership in accredited professional organization •Maintains membership in PEOLCAP	•PRC required CPD units •Training courses provided by PEOLCAP •Maintains membership in accredited professional organization •Maintains membership in PEOLCAP
	Completes at least 20 Continuing Professional Development (CPD) units every year.	Assumes responsibility for personal and professional development in Palliative Hospice nursing, including self – care, leadership and lifelong learning.	Implements/ monitors educational programs, based on assessed needs of staff to improve Palliative Hospice nursing practice and patient outcomes.

	Maintains active membership with at least one (1) accredited professional organization (Philippine Nurses Association), Hospice Philippines and accredited specialty group/ association (Palliative and End of Life Care Association of the Philippines)	Utilizes interventions, pain and symptoms management and monitoring parameters based on selected therapy associated with clinical procedures, serious illness emergencies and those related to life limiting disease	Develops palliative hospice – related policies, procedures, standards, and guidelines based on available evidence
		Serves as an officer in professional nursing organizations or as a head / member of any of the committees. A resource person/speaker/trainer	Mentors nurses to critique and apply evidence to palliative hospice nursing practice.
			Acts as a role model to palliative hospice nurse practitioners in leadership, advocacy and political skills
3. Nursing Practice Standards for Palliative and Hospice Care based on PQF Domains and Descriptors	•Have broad and coherent knowledge and skills in Palliative and Hospice nursing •Have comprehensive understanding of the principles of palliative and hospice nursing practice •Applies concepts from evidence-based researches in terminally and chronically ill patient care •Sensitive to ethical and legal issues in palliative and hospice nursing •Seeks opportunities for life-long learning and self-development, education, and leadership and governance	•Have advanced knowledge and skills in palliative and hospice nursing or multidisciplinary field of study for professional practice •Applies advanced principles of palliative and hospice nursing practice •Demonstrates core competencies in the care through developmental lifespan, seriously ill; focuses on quality of life •Capable of legal and ethical-decision making in the workplace •Applies leadership and management principles in a specialized or multi-disciplinary professional work •Guides and educates nurses in the field of practice •Conducts and utilizes evidence-based researches in practice •Seeks opportunities for life-long learning and self-development, education, and leadership and governance	•Have highly-advanced systematic knowledge in expert level and specialized, complex skills in palliative and hospice care •Conducts, utilizes, and disseminates complex and multidisciplinary researches in palliative and hospice care for advancement of practice •Demonstrates expert-level competencies in in the care through developmental lifespan, seriously ill; focuses on quality of life •Displays expert level legal and ethical-decision making skills in the workplace •Mentors nurses in the field of palliative and hospice nursing •Demonstrates expertise, innovation and leadership in palliative and hospice nursing practice; advocates independent practice •Seeks opportunities for life-long learning and self-development, education, and leadership and governance
4. Population Foci and Client Level (Recipient of Care)	*HIV AIDS patients *Cancer patients *Motor neuron disease /SCI *End stage respiratory diseases (COPD/TB) *End stage cardiac diseases (CHF) *End stage renal disease (CKD 5) *Dementia and Alzheimer's *End stage liver disease (liver cirrhosis)	*HIV AIDS patients *Cancer patients *Motor neuron disease / SCI *End stage respiratory diseases (COPD/ TB) *End stage cardiac diseases (CHF) *End stage renal disease (CKD 5) *Dementia and Alzheimer's *End stage liver disease (liver cirrhosis	*HIV AIDS patients *Cancer patients *Motor neuron disease /SCI *End stage respiratory diseases (COPD/TB) *End stage cardiac diseases (CHF) *End stage renal disease (CKD 5) *Dementia and Alzheimer's *End stage liver disease (liver cirrhosis
5. APN Track	Certified Nurse Specialist in Palliative and Hospice Care (PHC)	Advanced Practice Nurse (APN) I Palliative and Hospice Care (PHC)	Advanced Practice Nurse (APN) II Palliative and Hospice Care (PHC)
6. Complex Multi-disciplinary Field	Work in a multidisciplinary team focusing on patient with life limiting illness.	Collaborative practice with other health professionals in palliative and hospice care facility and/or independent nursing practice such as nurse – led clinic or nurse visit	Collaborative practice with other health professionals in palliative and hospice care health facility and/or independent nursing practice such as nurse – led clinic or nurse visit

7. Creative Work/ Innovation/ Social Responsibility	Participates to at least one (1) in a palliative hospice initiative such as; • Participates in Palliative Hospice awareness programs/projects and socio – civic activities outside of professional work/ practice • Helps Palliative Hospice patients gain access to needed material resources through appropriate linkages/ referral networks; Phil health, Philippine Charity Sweepstakes Office, referral to Social Services, etc. • Malasakit program • Bereavement care • Relevant community outreach programs	Contributes to the Palliative Hospice knowledge base of healthcare community through activities such as; • Community outreach, involvement in professional organizations presentations • Leads in mission work on Palliative Hospice prevention campaigns among individuals diagnosed with or at –risk of having serious illness, their families and the community. • Malasakit program • Bereavement care • Relevant community outreach programs	Designs community – based programs for Palliative Hospice prevention needs in National and International level. • Implements creative and innovative patient care programs that address patient needs across the full continuum of Palliative Hospice care. • Malasakit program • Bereavement care • Relevant community outreach programs
8. Research	Participates at least one (1) in data collection for palliative and hospice care health researches, such as, but not limited to the following research areas: * Pediatrics * Elderly care * Seriously ill patient * Chronic diseases patient care * Cancer •Best Practices in Palliative and Hospice Nursing Care • Participates in at least one (1) service institutions – based studies in palliative hospice nursing and related fields • Participates in –at least one (1) service institutions based, Quality Improvement Program for Palliative Hospice nursing and related fields	Conducts, publishes, and presents at least one (1) palliative and hospice researches, such as, but not limited to the following research areas: *Pediatrics •Elderly care *Seriously ill patient *Chronic diseases patient care *Cancer •Best Practices in Palliative and Hospice Nursing Care • Has completed at least one (1) research in the field of Palliative Hospice nursing and related fields • Conducts critical appraisal of a research report related to Palliative Hospice nursing and related fields • Conducts systematic review of literature on palliative hospice nursing and related fields • Has presented peer reviewed research study through poster/ oral venue, locally or internationally. • Participates in Evidence based practice (EBP) activities.	Responsible for translational research and dissemination of research results, such as, but not limited to the following research areas: *Pediatrics •Elderly care *Seriously ill patient *Chronic diseases patient care *Cancer •Best Practices in Palliative and Hospice Nursing Care • Completes a collaborative research in Palliative Hospice nursing and related fields every 3 years • Has published at least one (1) research in a peer -reviewed journal, locally or internationally • Initiates EBP in the unit and in the institution. • Implements processes to sustain evidence – based changes in Palliative Hospice nursing practice, palliative hospice programs of care and clinical innovation. • Applies research findings/ results and other evidence for other professionals to improve the care of patients with a past, current or potential diagnosis of life limiting diseases.
9. Leadership and Governance Roles and Responsibilities	Palliative Care Nurse Staff Nurse Charge Nurse	Nurse Case Manager/Head Nurse Clinical Nurse Specialist, Supervising Nurse, Chief Nurse/Head of Nursing Service	Director of Nursing, Chief Nurse, Chief Executive Officer

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Acknowledgements

LGU/City Health Office Marikina
LGU/City Health Office Malolos, Bulacan
LGU/City Health Office City of San Fernando, Pampanga
Amang Rodriguez Memorial Medical Center
Diosdado P. Macapagal Memorial Medical Center
Far Eastern University – Dr. Nicanor Reyes Medical Foundation
Jose B. Lingad Memorial General Hospital
Lung Center of the Philippines Palliative Care Program
Manila Doctors Hospital
National Children's Hospital
Philippine Children's Medical Center
Quirino Memorial Medical Center
Region 2 Trauma and Medical Center
Rizal Medical Center
Southern Philippines Medical Center
St Luke's Medical Center QC Pain Management Center
The Medical City
Tondo Medical Center
University of the Philippines - Philippine General Hospital
Philippine Cancer Society, Inc.
Philippine Society of Hospice and Palliative Medicine
Pain Society of the Philippines
Hospice Philippines
The Ruth Foundation
ActivCare Home Health Solutions, Inc.
PalCare Hospice Foundation, Inc.
Madre De Amor Hospice Foundation, Inc.
Kythe Foundation Inc.
Dr. Madonna Baccoro
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