

# Implementation of a Municipal Palliative Care Network

## Implantação de uma Rede Municipal de Atenção em Cuidados Paliativos

### *Implementación de una Red Municipal de Cuidados Paliativos*

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## Abstract

**Problem:** Palliative Care (PC) is a comprehensive healthcare approach provided by a multidisciplinary team to individuals dealing with serious, life-threatening illnesses that no longer respond to curative treatments or who present complex symptoms that compromise their quality of life as well as that of their families. **Methods:** This study described the experience of implementing a Municipal Palliative Care Program in a large city, organized as a Palliative Care Health Care Network (*Rede de Atenção em Saúde – RAS*). It outlines the planning process involved in establishing it as a public health policy, along with the actions taken and the results achieved. **Results:** The actions adopted to organize the access to and the provision of PC included: 1) Performing a situational diagnosis and identifying the demand for PC support in the municipality and the way healthcare network was organized; 2) Promoting the training of healthcare professionals in PC; 3) Strengthening Primary Health Care (PHC) to guide PC in the health care network; 4) Promoting integration among public healthcare services that offered PC; 5) Carry out actions to raise community awareness and establish specific public policies for the development of PC. The strategy involved creating a municipal health program with a management working group comprising representatives from services at all levels of care, which already serve patients in need of PC. **Conclusions:** It is concluded that Permanent Health Education is an essential strategy for the integration and consolidation of the Municipal Palliative Care Network. This strategy is based on the need to improve PC support, focusing on the program's guidelines and objectives: to provide quality palliative care and comfort to individuals and families facing life-threatening illnesses, and to support physical, spiritual, social, family, and emotional suffering.

**Keywords:** Palliative care; Delivery of health care; Continuing education; Health policy.

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## Resumo

**Problema:** Os Cuidados Paliativos (CP) são uma modalidade de assistência integral em saúde ofertada por uma equipe multiprofissional para a pessoa que lida com uma doença grave, ameaçadora da vida e que não responde ao tratamento modificador ou que apresenta sintomas complexos que comprometem a sua qualidade de vida e a da sua família. **Métodos:** Este estudo descreve a experiência de implantação de um Programa Municipal de Cuidados Paliativos em um município de grande porte, organizado como uma Rede de Atenção em Saúde (RAS) em CP, e apresenta as etapas realizadas para seu planejamento como política pública em saúde, as ações e os resultados alcançados. **Resultados:** As ações que foram aplicadas para organizar o acesso e a oferta de CP incluíram: 1) Realizar diagnóstico situacional, da demanda do suporte em CP no município e da forma de organização do trabalho em saúde na RAS; 2) Promover a capacitação de profissionais de saúde em CP; 3) Fortalecer a Atenção Primária à Saúde (APS) para a orientação dos CP na rede de saúde; 4) Promover a integração entre serviços públicos de saúde que ofereciam CP; 5) Realizar ações para sensibilizar a comunidade em geral e estabelecer políticas públicas específicas para o desenvolvimento dos CP. Adotou-se a estratégia de criar um programa municipal de saúde com um grupo gestor de trabalho, com participação de serviços de todos os níveis de atenção, os quais já atendem pacientes com necessidade de receber CP. **Conclusão:** Conclui-se que a Educação Permanente em Saúde é uma estratégia essencial para a integração e consolidação da Rede Municipal de Atenção em CP, com base nas necessidades de aperfeiçoamento do suporte em CP, focando nas diretrizes e nos objetivos do programa: oferecer cuidados paliativos de qualidade e conforto a pessoas e famílias que enfrentam doenças ameaçadoras da continuidade da vida, com suporte aos sofrimentos físicos, espirituais, sociais, familiares e emocionais.

**Palavras-chave:** Cuidados paliativos; Atenção à saúde; Educação continuada; Políticas de saúde.

## Resumen

**Problema:** Los Cuidados Paliativos (CP) son una modalidad de atención en salud ofrecida por un equipo multidisciplinario a personas que enfrentan enfermedades graves, que amenazan la vida y no responden a tratamientos modificadores de la enfermedad, o presentan síntomas complejos que comprometen su calidad de vida, así como a sus familias. **Método:** Este estudio describe la experiencia de implementación de un Programa Municipal de CP en un municipio grande, organizado como Red de Atención a la Salud (RAS), presenta los pasos dados para su planificación como política de salud pública, las acciones y resultados alcanzados. **Resultados:** Las acciones que se aplicaron para organizar el acceso y oferta de CP incluyeron: 1) Realizar un diagnóstico situacional y de demanda de CP en el municipio y la forma en que se organiza el trabajo en la RAS; 2) Promover la formación de profesionales de salud en CP; 3) Fortalecimiento de la Atención Primaria de Salud (APS) para orientar los CP en la red de salud; 4) Promover integración entre servicios de salud pública que ofrecen CP; 5) Realizar acciones de sensibilización de la comunidad en general y establecer políticas públicas específicas para el desarrollo de los CP. La estrategia fue adoptada para crear un programa municipal de salud, con un grupo de gestión de trabajo con la participación de servicios de todos los niveles de atención, que ya atienden pacientes que necesitan recibir CP. **Conclusión:** Se concluye que la Educación Permanente en Salud es una estrategia esencial para integración y consolidación de la Red Municipal de Atención de CP, basada en las necesidades de mejorar el soporte de CP, centrándose en directrices y objetivos del programa: ofrecer CP de calidad y confort a personas y familias que enfrentan enfermedades que amenazan la continuidad de la vida, con apoyo al sufrimiento físico, espiritual, social, familiar y emocional.

**Palabras clave:** Cuidados paliativos; Atención a la salud; Educación continua; Política de salud.

## INTRODUCTION

Palliative care (PC) is a critical component of comprehensive healthcare, delivered through an active support approach for individuals facing serious, life-threatening illnesses that are unresponsive to disease-modifying treatments, or conditions involving complex symptoms or suffering that impair quality of life. It addresses physical, social, spiritual, and emotional needs and is provided by a multidisciplinary team. Access to PC remains uneven across countries, with an estimated 78% of adults requiring such care residing in low- and middle-income nations.<sup>1,2</sup> The World Health Organization (WHO) recommends integrating PC into health systems with universal coverage and highlights the role of Primary Care in facilitating population-wide access to these services.<sup>3</sup>

The adoption of specific public policies for the inclusion of palliative care is essential for integrating this practice into the planning and implementation of public health initiatives within a given region. Such policies reflect the social and political commitment to be articulated through governance and public planning; they establish the legal framework for operational processes, regulate the practice, and

promote related initiatives. Additionally, they safeguard the right to access and deliver palliative care services and support.<sup>1</sup>

In Brazil, Resolution No. 41 of the Tripartite Intermanagerial Commission (*Comissão Intergestores Tripartite* – CIT) was approved in 2018, establishing guidelines for the organization of PC within the Brazilian Unified Health System (*Sistema Único de Saúde* – SUS).<sup>4</sup> Additionally, some states have enacted legislation to promote the inclusion of PC in public health initiatives.<sup>5,6</sup> According to the *Global Atlas of Palliative Care*, Brazil has made progress in this area in recent years, with an increase in the number of services offering PC; however, these services are not yet fully integrated into the health system and remain inaccessible to a significant portion of the population.<sup>2</sup> On May 7, 2024, the Ministry of Health published Ordinance GM/MS No. 3.681/2024, which amended Consolidation Ordinance GM/MS No. 2/2017 and established the National Palliative Care Policy (*Política Nacional de Cuidados Paliativos* – PNCP).<sup>7</sup> Further efforts are needed to examine how PC can be implemented within SUS-affiliated services, to integrate it into the broader healthcare network, particularly within Primary Care, and to develop operational guidelines and disseminate experiences that support the widespread implementation of this policy across the health system.

This study aimed to describe the implementation of a Municipal Palliative Care Program in a large municipality, structured as a Health Care Network (*Rede de Atenção em Saúde* – RAS) for Palliative Care and grounded in public policy. It also seeks to present the actions undertaken, the results achieved, and to discuss the possibilities for integrating palliative care within the context of SUS.

Brazil is undergoing an epidemiological transition characterized by a rise in mortality from non-communicable chronic diseases (NCDs), driven by population aging and lifestyle factors. Nevertheless, some regions continue to exhibit a high proportion of deaths from acute conditions and external causes. Projections indicate that the proportion of aged individuals will increase from 9.2% (2018) to 25.5% by 2060, with a higher concentration in the southern regions of the country. This demographic shift is expected to significantly increase the demand for continuous health care across the lifespan.<sup>8</sup>

There is a growing demand for PC, particularly in low- and middle-income countries.<sup>1,2</sup> However, an assessment of access to and quality of end-of-life care across 81 countries ranked Brazil 79<sup>th</sup>, revealing a critical deficiency in the provision of PC and end-of-life services. These findings are supported by the *Quality of Death Index*, developed by the Economist Intelligence Unit and published by the Lien Foundation, which offers a global comparative analysis of end-of-life care quality.<sup>9</sup> In the 2015 report, which evaluated five national indicators — such as availability of PC services, public policies, human resources, and access to opioids — Brazil ranked 42<sup>nd</sup> out of 80 countries. While still unsatisfactory, this ranking was based on objective criteria reflecting the structural characteristics of national health systems. In the most recent edition, published in 2022, a revised methodology was applied, relying on input from national experts. The assessment considered indicators in five categories: the general and palliative care environment, human resources, accessibility, quality of care, and community engagement. This new approach resulted in Brazil falling to 79<sup>th</sup> out of 81 countries, emphasizing the importance of understanding the methodology and composition of the indicators, as these significantly influence interpretation of the results. These findings underscore the persistent and substantial barriers to the inclusion of and access to PC services, particularly within the public healthcare sector.

Within SUS, RAS serve as the primary framework for organizing services and care flows. Their objective is to promote equitable healthcare and ensure the integration of health systems and services, grounded in health technology assessment and evidence-based practices, including citizen empowerment.

In this organizational model, Primary Health Care (PHC) is responsible for coordinating care. For users requiring PC, PHC can facilitate biopsychosocial support, aligned with the individual's and family's life context, and ensure access to interprofessional care.<sup>10</sup>

However, guidelines for the implementation of PC as a public policy remain underdeveloped, particularly with regard to defining its practices and structuring access and service delivery within RAS. Additionally, studies and literature exploring the integration of this approach within SUS are limited, hindering its broader establishment. In this context, the present experience report outlines the steps involved in developing a municipal palliative care program in a large municipality, focusing on the implementation of a PC network across multiple levels of care, with PHC serving as the central coordinating element.

## METHODS

The integrated PC development model adopted by the WHO includes the following essential components for implementation:

1. Health policies related to PC;
2. Involvement of individuals and communities in this context;
3. Research in the area;
4. Access to and use of essential medications;
5. Education and training in the area; and
6. Provision of integrated palliative care services in the health system.<sup>1</sup>

Based on this framework, interventions were conducted across various development areas to implement and organize RAS in PC as a public policy in a large municipality in the interior of Paraná, which already had a history of related initiatives.<sup>11</sup>

This report describes the development of RAS as a PC program, established by municipal law,<sup>12</sup> and implemented in the city of Londrina (Paraná) between 2021 and 2024.

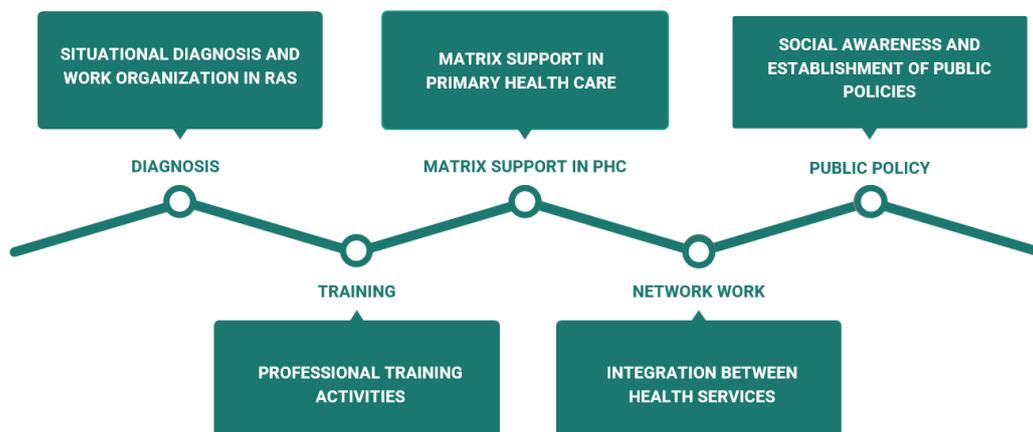
Actions were undertaken to organize the provision of PC, including:

1. Conducting a situational diagnosis of the demand for PC support in the municipality and the organization of work within RAS;
2. Promoting the training of health professionals in palliative care PC;
3. Strengthening PHC to guide PC within RAS;
4. Promoting the integration between health services that provide care for patients requiring PC;
5. Raising awareness in the community and establish specific public policies for the development of PC.

## RESULTS

The experience was structured into the following phases (Figure 1):

1. Situational diagnosis and work organization in RAS;
2. Professional training activities;
3. Matrix support in PHC;
4. Integration between health services; and
5. Social awareness and establishment of public policies.



Source: Prepared by the authors, 2024.

**Figure 1.** Moments of implementation of the Municipal Palliative Care Program of Londrina (PR), Brazil.

These phases are presented separately for descriptive purposes; however, in practice, they occurred concurrently, allowing the actions to mutually reinforce each other and contribute to the achievement of the results.

### Situational diagnosis and work organization in the Health Care Network

As preliminary steps in conducting the situational assessment, professionals and services interested in promoting and developing PC within the municipality were identified. Initial individual contacts were made with these stakeholders, leading to the formation of a voluntary and informal group of representatives tasked with presenting the context, fundamentals, and needs of PC support within the health network to municipal health managers. This process involved meetings and awareness-raising activities with coordinators of Basic Health Units (*Unidades Básicas de Saúde – UBS*) and services affiliated with municipal administration. Additionally, the Directorate of Work Management and Health Education of the Municipal Health Authority conducted an online survey of health workers with PC training (ranging from basic to postgraduate levels). Fewer than ten professionals with any such training were identified among approximately 3,000 workers, underscoring the need for increased awareness and comprehensive training for personnel across the health network.

It was observed that, beyond the limited number of professionals trained in palliative care, significant misconceptions regarding its concepts, principles, and indications persisted. This finding aligns with results from previous studies.<sup>13</sup> In Primary Care, some palliative actions were already in place, including support for Family Practice residency projects available at certain UBSs. Regarding hospitals, five institutions affiliated with SUS were identified as providing some level of PC service or support. Among these, only one oncology center offered a higher level of complexity in PC, including outpatient clinics, inpatient hospitalization, and specialized home care. The remaining hospitals provided either consultative teams or intermediate-level inpatient care, primarily limited to patients with advanced functional impairment and those in the terminal stages of life.

The municipality already had a Home Care Service (*Serviço de Atenção Domiciliar – SAD*) with some professionals trained in this area; however, there was no dedicated team specifically assigned to individuals eligible for palliative care. Additionally, healthcare professionals demonstrated limited awareness of the capabilities of other teams, poor communication, and, consequently, discontinuity in care during

patient transitions between different healthcare services. Recognizing the need for integrated work within the healthcare network, efforts were made to raise awareness and engage stakeholders involved in the intervention project to strategically organize actions. These stakeholders included representatives from municipal administration, professionals from primary and multidisciplinary care teams, the Family Practice Residency Program (*Residência de Medicina de Família e Comunidade – RMFC*), SAD, hospital services, and emergency services. Moreover, an intersectoral and interprofessional working group was established to develop and plan the Municipal Palliative Care Program.

## Professional training activities

The demand for a specialized approach, as required in palliative care, necessitates training professionals to enhance their capacity and qualifications in this field.<sup>13,14</sup> Those involved in end-of-life care must integrate technical expertise with an understanding of the realities and needs of individuals and families during this period of heightened physical and emotional vulnerability associated with death and dying. Addressing these challenges requires skills in managing complex human relationships, which are often insufficiently addressed in professional education.<sup>15</sup>

In the initial phase, training was conducted with an experimental group of professionals from Family Health Strategy (FHS) teams. This training included sessions presenting theoretical content on PC and clinical case discussions utilizing the Extension for Community Healthcare Outcomes (ECHO) methodology, in collaboration with a PC reference service. This approach facilitates direct access for PHC professionals to specialists, enabling learning activities and case discussions within a practical, real-world context.<sup>16</sup>

In a subsequent phase, basic technical training courses in PC were offered, involving professionals from primary care teams, hospital services, home care, emergency and urgent care, and long-term care facilities affiliated with public administration. Complementing these educational efforts, multidisciplinary residency programs in Family Health and Family Practice participated in practical and supportive professional development activities.

The educational activities aimed to integrate theoretical knowledge with practical reflections by the teams to advance understanding of PC, acknowledging that the needs of patients eligible for PC are already present across healthcare services at varying levels of complexity. Emphasis was placed on uniting professionals from diverse disciplines and healthcare settings to provide comprehensive, longitudinal, and coordinated care within the healthcare network.<sup>17</sup> The municipal administration supported these initiatives by providing professional education departments for logistical organization, access to a virtual platform for online modules, and certification for participants.

The basic training course included 555 participants from various professional categories, such as nurses, nursing technicians, physicians, nutritionists, physical therapists, social workers, physical education professionals, community health workers, and administrative staff. Among the 315 respondents to an evaluation questionnaire, 59.4% rated the practical applicability of the knowledge as 5 out of 5, 28.9% rated it 4 out of 5, and 10.7% rated it 3 out of 5.

## Matrix Support in Primary Health Care

To identify eligible patients, FHS teams were encouraged to use the Supportive and Palliative Care Indicators Tool (SPICT-BR) in its Brazilian Portuguese version, combined with a functional assessment using

the Palliative Performance Scale (PPS). For care planning, the Multidimensional Assessment Diagram (MAD) was employed to facilitate comprehensive care across the multiple dimensions integral to the PC approach.

Following the basic training course, a matrix-based approach was implemented with PHC family health teams in small groups across 54 primary care units, involving over 300 participants. A regular meeting schedule was established to discuss cases within PHC. At each meeting, the team, comprising a physician, nurse, nursing assistant, and community health worker, presented a case from their area in which specific assessment tools (SPICT and PPS) were applied. MAD was developed collaboratively by all attendees, alongside discussions of relevant topics such as symptom management with an emphasis on pain, caregiver support, respect for individual sacredness, spirituality, nutrition and hydration at the end of life, and other issues pertinent to each case. The process also underscored the importance of each professional reflecting on their own experiences and reframing their approach to deliver comprehensive, individualized care.

Among other tools, an electronic communication group was established to support PC matrix activities within PHC, facilitating communication, experience sharing, information dissemination, and resolution of team inquiries. Additionally, a dedicated email address was created to receive counter-referrals of patients eligible for palliative care, initially targeting those treated at secondary hospitals within the municipality. Data monitored between October 2022 and March 2023 showed that 103 patients were referred for continued care by UBS teams.

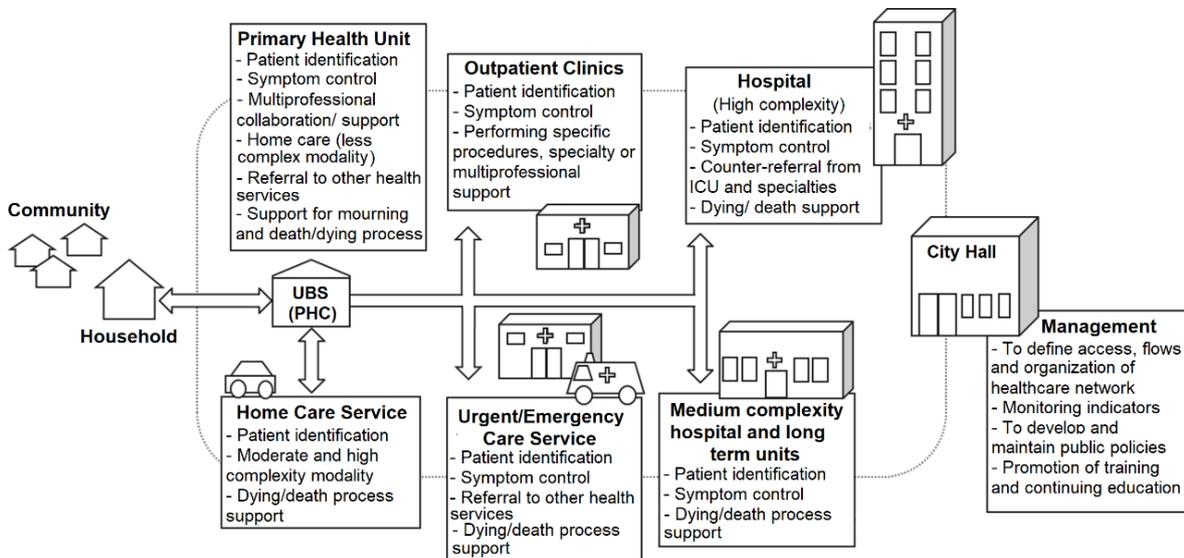
A multidisciplinary approach is considered essential for the development of PC. Thematic workshops were conducted with FHS, multidisciplinary, and oral health teams to collaboratively develop individualized care plans, enhance knowledge, integrate support services, and address challenges faced by various professional categories. Discussions with pharmacists focused on challenges related to incorporating medications for symptom control, expanding access to opioids, and equitable management of resources within the units. For nutritionists, the protocol for providing diets to patients eligible for palliative care was reviewed. Psychologists engaged in organizing matrix support for grief counseling, communicating difficult news, and family outreach.<sup>17</sup>

## Integration between health services

To organize the integration among different health services, define work processes, and establish referral and counter-referral flows, a Working Group (WG) for the Municipal PC Program was established. This group included representatives from various health services and all levels of care (PHC, medium- and high-complexity hospitals, emergency and urgent care services, the home care service, and health system management), as illustrated in Figure 2.

For municipal management services, workshops and meetings were conducted with teams to provide guidance on the fundamental concepts of PC, deepen theoretical understanding, and review case studies, symptom management, and end-of-life care. These activities involved SAD (including three multidisciplinary teams) as well as emergency and urgent care services (117 professionals, including physicians, nurses, nursing technicians, ambulance drivers, and social workers), representing two municipal Emergency Care Units (*Unidades de Pronto Atendimento – UPAs*), Adult and Pediatric Emergency Care, along with the Regulation Center and Mobile Emergency Care Service (*Serviço de Atendimento Móvel de Urgência – SAMU*) teams.

Instruments and informational materials were also standardized to guide the flow of patients receiving care from services offering the PC approach. The objective was to establish clear referral and counter-referral processes between points within the network, thereby improving communication and ensuring continuity of care.



Source: Prepared by the authors, 2024.

**Figure 2.** Flow and service model of a Palliative Care Network.

Initially, three public general hospitals (two medium-complexity and one high-complexity) were incorporated into the municipal program, each designating beds exclusively for patients requiring PC.<sup>18</sup> Due to internal service demand, priority was given to patients who met at least two positive criteria on SPICT and had a PPS score of 40 or lower. An identification card was also developed and distributed to PC teams. In cases of clinical complications, the card guides SAMU in directing the patient to the same hospital, aiming to ensure continuity of care, maintain a therapeutic relationship with the care team, provide ongoing family support, and streamline service flow. These hospitals carry out discharge counter-referrals to SAD or UBS using a referral letter and a designated email address. The UBS within the corresponding coverage area is also notified to evaluate the need for grief support.

The municipality also had an oncology reference service, which included an exclusive inpatient unit specialized in PC, as well as dedicated outpatient and home care services for cancer patients.

In the context of public policy for PC, PHC must assume a central role as the coordinator of care, given its capacity to understand the life context of patients and their families, provide longitudinal follow-up, and enable early identification of the need for PC. An analysis of patients referred from hospitals to UBSs revealed that 99% were already being monitored and known by ESF teams. The majority of these individuals were frail older patients over the age of 70 with advanced chronic diseases.

However, further progress is needed in integrating and preparing health services to provide palliative care within specialty outpatient clinics (e.g., cardiology, pulmonology, nephrology, neurology, geriatrics, etc.) as well as in Long-Term Care Facilities for the Elderly (*Instituições de Longa Permanência de Idosos – ILPI*). These services frequently care for individuals with palliative needs and must be equipped to identify such needs and provide appropriate support within their respective areas of expertise.

## Social awareness and establishment of public policies

Community awareness campaigns were carried out to inform the public about palliative care and promote social engagement. These initiatives included the development of an explanatory brochure for the general population and the participation of municipal employees in radio, television, and online broadcasts.

Events were organized to promote awareness of palliative care, including activities in observance of World Palliative Care Day, celebrated annually on the second Saturday of October, and scientific events (symposia, lectures, etc.) held in collaboration with partner institutions. Social organizations operating in the health and social care sectors were also identified, enabling the coordination of donations or loans of essential equipment for home care (hospital beds with mattresses, wheeled shower chairs, IV poles, step stools, meal support tables, and air mattresses) for patients receiving palliative care and experiencing social vulnerability. Such support contributes to improving the quality of life for patients and their families by promoting comfort and dignity.

In collaboration with public administration, efforts were made to draft a municipal bill to support the practice and formally establish the Municipal PC Program.<sup>12</sup> The development of lasting public policies requires the creation of regulatory and legal frameworks to guide both planning and implementation. Specific municipal legislation secures the right to access palliative care within municipal health services across all levels of care and defines the parameters for its implementation.

In Brazil, a significant legal milestone was Resolution No. 41 of 2018 of CIT, which established guidelines for the organization of palliative care within SUS.<sup>4</sup> In the state of Paraná, State Law No. 20.091, of 2019, set forth the principles and foundations of PC at the state level.<sup>5</sup> At the federal level, legislative proposals are also under consideration. In 2024, the Ministry of Health instituted PNCP, responding to demands presented by representative entities during the 2023 Health Conferences.<sup>7</sup>

PNCP aims to integrate and expand access to PC within SUS, with an emphasis on primary care, matrix support, and coordination of services within the Health Care Network. Accordingly, it is expected that this experience report may serve as a reference for organizing this network in the context of Brazilian municipalities. The policy also provides for financial support from municipal and state entities for the registration of Palliative Care Matrix Teams and Assistance Teams (*Equipes Matriciais* and *Equipes Assistenciais de Cuidados Paliativos* – EMCP and EACP, respectively), which must include, at a minimum, professionals from medicine, social work, psychology, nursing, and nursing technicians.<sup>7</sup>

The creation of a Municipal Palliative Care Program, aimed at preventing and relieving physical, psychological, social, and spiritual suffering, seeks to organize access to and the provision of PC within the healthcare network. The proposed municipal bill aimed to ensure the delivery of palliative care; progressively expand access and investment in material and human resources; guarantee the quality of care through the monitoring of quality and performance indicators; and promote the training of professionals through continuing education. The bill was presented by the municipal executive branch and approved by the City Council on April 17, 2023, as established by Law No. 13.567, which created the Municipal Palliative Care Program.<sup>12</sup>

Future plans include the development of a Municipal Palliative Care Guideline and the establishment of Clinical Protocols for Symptom Management in Emergency Services, particularly to streamline and expand access to analgesic medications, such as opioids, and to ensure appropriate support during the dying process across all levels of care. Additionally, research will be conducted to identify barriers and potential outcomes, and efforts will be made to integrate this local initiative with PNCP to enhance its scope and continuity.

Many challenges remain in fully integrating PC into the healthcare network, including the need for specific funding, expanding timely access to pain medication, developing multidisciplinary teams, and incorporating the PC approach into the training of healthcare professionals. It is essential to advance and sustain agile, safe, and patient- and family-centered referral flows between healthcare services. Research is also necessary to support PC practices within SUS, including incorporating the topic into university

curricula to raise awareness, train the academic community, and subsequently disseminate knowledge to the broader public.

Continuing Health Education is a key strategy for the integration and consolidation of the Palliative Care Network within the municipality. It is guided by the need to improve services and is aligned with the program's objectives and principles: to provide care and comfort to individuals and families facing life-threatening illnesses through a multidisciplinary team, offering support for physical, spiritual, social, familial, and emotional suffering.

This report aimed to contribute to this context by describing the feasibility of implementing PC within RAS, considering the structure and organization of SUS in a large municipality with comprehensive health management. The adopted strategy involved creating a municipal health program, supported by a management working group composed of services across all levels of care that already serve patients in need of PC. With the establishment of PNCP, it is expected that this initiative will be strengthened through the allocation of funding for the formation of dedicated PC teams, as well as increased awareness among public officials and the population regarding the program's maintenance and the expansion of access to quality PC within SUS.

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## CONFLICT OF INTERESTS

Nothing to declare.

## AUTHORS' CONTRIBUTIONS

BZ: Project administration, Formal analysis, Conceptualization, Data curation, Writing – original draft, Investigation, Methodology. FCIM: Project administration, Formal analysis, Conceptualization, Data curation, Writing – original draft, Investigation, Methodology. VCSA: Project administration, Formal analysis, Conceptualization, Data curation, Writing – original draft, Investigation, Methodology. MGC: Formal analysis, Project administration, Conceptualization, Data curation, Writing – original draft, Investigation, Methodology. FFCS: Formal analysis, Writing – review & editing, Methodology, Supervision, Visualization. RM: Formal analysis, Writing – review & editing, Methodology, Supervision, Visualization. RAM: Formal analysis, Writing – review & editing, Methodology, Supervision, Visualization.

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