Cogitare Enfermagem

EXPERIENCE REPORT

# COMPLEX CLINICAL HOSPITAL MODEL OF DISCHARGE MANAGEMENT: CONCEPTION AND IMPLEMENTATION

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**ABSTRACT**

Objective: to present the conception and implementation of the Discharge Management Model of the Clinics Hospital Complex of the Federal University of Paraná. Method: experience report occurred between 2017 and 2020, about the design and implementation of the Discharge Management model with support of the logic model. Results: continuity of care and case management are operationalized by a dedicated team of liaison nurses who manage and counter-reference care to primary care and other points in the health care network. Conclusion: discharge management has been consolidated as a managerial strategy that integrates the health care network, avoids discontinuities in care, promotes patient and family safety, and optimizes beds, and inserts complex patients into the primary care agenda. It contributes to the continuity of care and represents evidence of a new field of work for nurses.

**DESCRIPTORS**: Health Services Administration; Patient Discharge; Health Services; Continuity of Patient Care; Nursing.

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## INTRODUCTION

The population aging[1], the increase in deaths from Chronic Non-Communicable Diseases (NCDs)[2] and issues related to underfunding, in addition to technological advances in health care are conditions that pose challenges to the Brazilian Unified Health System (SUS). The demands related to the management of NCDs sometimes exceed the possibilities offered, leading to obstacles, discontinuities of care, and overloading of the health system[3-5].

Considering this context, common in the Brazilian reality and in international realities, political and management strategies are elaborated to balance the population's demand for health care and the offers provided by integrated systems or healthcare networks (HCN). In Brazil, guidelines[6-7] establish flows and services that aim to provide universality, integrality, and equity in health care to the population. Among these, the Internal Regulation Centers, which constitute the interface with the Regulation Centers of the different management spheres, should be highlighted, aiming at meeting the users' needs, including alternatives to hospital practices[7-8].

As part of the HCN body of the capital city of Paraná, the Clinics Hospital Complex of the Federal University of Paraná (CHC-UFPR) experiences this daily imbalance between offers and demands, thus challenging institutional management to promote systematic adjustments that contribute to the balance and continuity of care. In this context of self-regulation and seeking to meet the profile of clinical patients with multiple comorbidities and difficult management, the CHC-UFPR implemented in 2017 the CHC Discharge Management Model and, therefore, this article aims to present the design and implementation of the Discharge Management Model of the Clinics Hospital Complex of the Federal University of Paraná.

## METHOD

This is a professional experience report on the conception and implementation of the CHC (Clinic Hospital Complex) Model of Discharge Management, which occurred in the largest public teaching hospital in Paraná - Brazil, between the years 2017 and 2020. The design process involved technical visits, research developed on the subject and the use of methodological support.

The conception of the CHC Discharge Management Model was based on research developed in the institutional context[11-12] and on experiences in the international scenario, the product of a multicenter study between Portugal, Spain, and Canada[13-15], as well as specific national legislation[7]. This proposal allowed the construction of a hybrid model, designed based on successful experiences and needs of the service and the HCN.

The model was structured under the assumptions: exclusive team with emphasis on the liaison nurse (professional responsible for coordinating discharge regarding the transfer of information from the hospital to PHC(Primary Health Care), i.e., makes the link between patients, family, professionals and outpatient care)[11]; centralized in the Care Regulation Unit; early identification of patients according to the inclusion criteria established by the service team (patients with chronic diseases of difficult control; in palliative care; with need for continuity of care at home; using ventilatory support devices, food or other health devices; patients with important social frailties and de-hospitalization situations); institutionalization of counter-reference using digital resources such as electronic medical records and official communication by electronic mail; integration with the Municipal Health Secretariats and with the State Health Secretariat.

The implementation relied on the methodological support of the logic model (LM) for planning, pilot execution, and consolidation. The LM emerged in Germany as a methodological resource to systematize and guide project planning in a systematic and visual way[9]. The planning carried out with the schematic construction of the LM in health allows for a better understanding of the interventions through details involving actors, structure, resources, objectives, and evaluations with progressive monitoring of the interventions[10].

The study was approved by the Ethics Committee of the Clinics Hospital Complex of the Federal University of Paraná, as No. 3,409,894, June 2019.

## RESULTS

The timeline, presented in Figure 1, shows the main stages that will be detailed below. The implementation started with planning using the LM, highlighting: the definition of initial, intermediate, and final objectives of this phase; and the definition of human, physical resources, materials, and equipment needed to develop the activities. The institutions involved were an essential part, representing articulation and contractual agreements between CHC-UFPR and municipal and state managers.

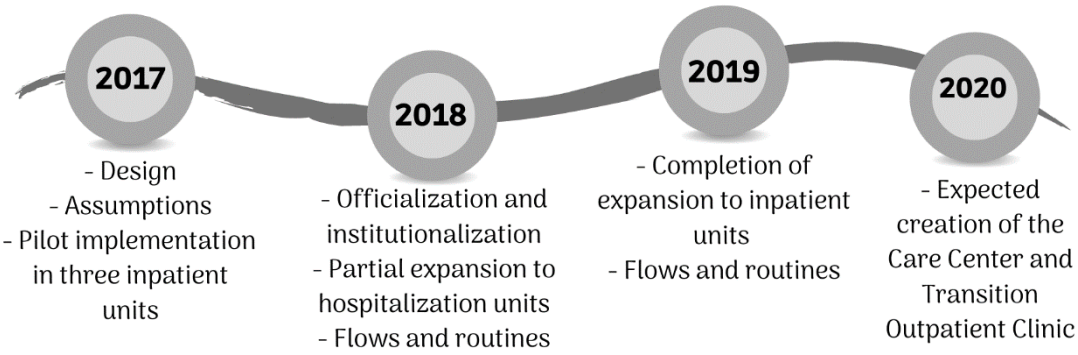


Figure 1 - Timeline of conception and implementation of the CHC Model - of Discharge Management. Curitiba, PR, Brazil, 2020

Source: Authors (2020).

General and specific activities were conceived by the coordinators and first professionals linked to the service and involved: theoretical deepening of the theme, construction of workflows and work algorithms; standard operating procedures, selection of patient inclusion criteria; establishment of mediation and communication with the HCN; and production of visual identity and dissemination material. The barriers and facilitators of the implementation process were identified in this phase, presented, respectively, as the numerical limitation of professionals exclusive to the service and the existence of an internal policy that supports the CHC model of discharge management.

After the planning phase, the execution of a pilot study was initiated in three inpatient units in the second half of 2017 with the selection of new team members, called liaison nurses. Professionals were identified and selected based on individual competencies through curriculum analysis, clinical experience, decision-making, knowledge of the HCN, communication skills, and empathy.

After a period of six months, the model was made official and institutionalized in a ceremony involving health managers from the institutional, municipal, state, and federal spheres, marking the beginning of a consolidation phase. Figure 2 represents the CHC Management Model.

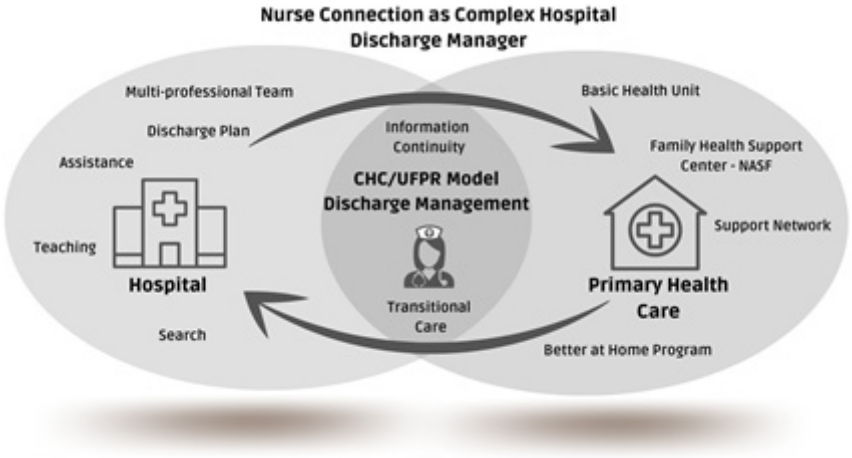


Figure 2- CHC Model - of Discharge Management. Curitiba, PR, Brazil, 2020

Source : Authors (2020).

For the expansion process in all hospital units, the service had five liaison nurses, and each one was responsible for approximately 100 beds. Strategies were used, such as: disclosure of the Discharge Management service attributions to the multi-professional team through clinical and administrative meetings; electronic, printed and digital newsletters; classes for resident professionals and integration events for new professionals; disclosure of indicators; and daily visits to the inpatient units for dissemination and identification of patients that met the criteria for discharge management.

Patient capture occurred based on requests from any member of the multi-professional team or active search through visits to the units. Figure 3 shows the flow of patient intake and discharge management.

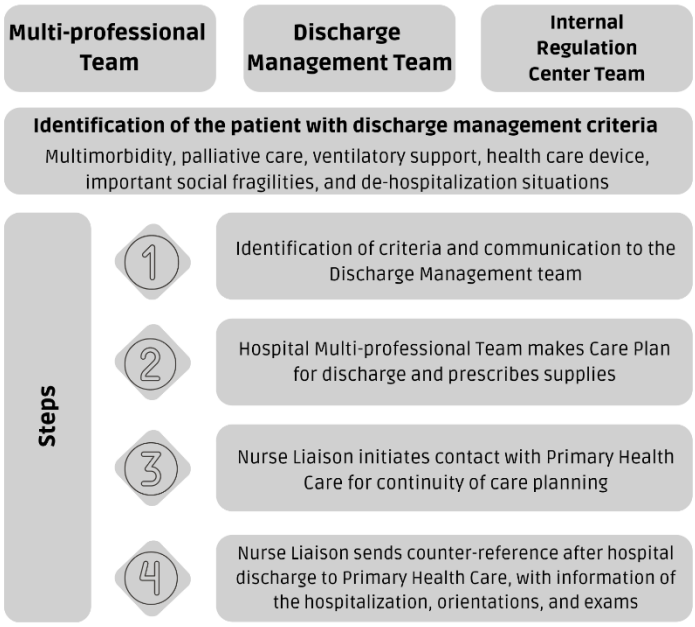


Figure 3 - Flow of capture and management of hospital discharge in the CHC-UFPR Discharge Management Model. Curitiba, PR, Brazil, 2020

Source: Authors (2020).

Based on the identification of criteria and selection of patients with potential benefit from discharge management, the liaison nurses initiate the articulation with the HCN points through e-mail messages, printed documents, and telephone calls. The early contact with the PHC team allows the planning and organization of the assistance for the continuity of care, including patients with home ventilatory support, rehabilitation, and home care service. The exchange of information occurs in electronic medical records and by e-mail, involving discharge summaries, care plans, prescriptions for supplies and exams performed during hospitalization.

A new expansion will include the management of outpatient discharges by creating outpatient support services with joint protocols between hospital and primary care. This project will strengthen the resoluteness for patients linked to the CHC-UFPR and those who need stabilization before being referred to the PHC.

Currently, the service is an internship field for resident nurses and receives professionals from other institutions to exchange experiences. Furthermore, research has been developed to create indicators that can measure the impact of the implementation of this model in terms of the reduction of hospitalization time, reduction of institutional costs, and impact on care.

## CONCLUSION

The implementation of the CHC Discharge Management Model in a public, tertiary and teaching hospital represented an innovation and a challenge. It proved to be effective in what was proposed and is consolidated as an administrative tool and as a counter-referral strategy for patients considered potential consumers of health services.

Avoiding discontinuities in relation to care, promoting safety for patients and families, optimizing hospitalization beds, and inserting complex patients in the PHC agenda are some of the contributions of the model that can serve as an example for other institutions and as evidence of a new field of work for nurses.

The expansion of this model is a consequence of its successful implementation and consolidation. The expansion of the model to outpatient clinics and the Transitional Care Center represents an investment in the management of chronic conditions, contributing to the effectiveness of continuity of care.

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