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IMPLEMENTATION OF CARE COORDINATION BY NURSING IN DIGITAL PRIMARY CARE: AN EXPERIENCE REPORT

Thamires de Campos Santana
Nurse specialist in Health Services Management and Health Quality Management. Alice Saúde
São Paulo - SP

Mayara Mancini
Nurse specialist in Administration in the Management of Clinics, Hospitals and Health Industries. Alice Saúde
São Paulo - SP

Juliana Barony da Silva
Nurse with a master's degree in Health Care and Nursing. Alice Saúde
São Paulo - SP

Camila Kaory Kawagoe
Nurse specialist in Audit and Adult and Elderly Health. Alice Saúde
São Paulo - SP

Melissa Almeida Santos
Nurse specialist in Cardiovascular Health. Alice Saúde
São Paulo - SP

Aline Adryane Morishigue Bássiga da Cruz
Nurse specialist in Family Health and Health Services Management. Alice Saúde
São Paulo - SP

Mario Ferretti Filho
Doctor in Orthopedics. Alice Saúde
São Paulo - SP

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Abstract: Care coordination is a fundamental strategy in healthcare, characterized by the organization between healthcare professionals and levels of care with a focus on individual care. This study is a qualitative and descriptive experience report, from August 2021 to June 2022, which encompasses the activities of a care coordination team made up of nurses at a healthtech in São Paulo. Founded in 2019, healthtec prioritizes digital health care and individual autonomy. Its model emphasizes care coordination, especially in primary care and monitoring of chronic non-communicable conditions. The nursing team plays a central role in this coordination, integrating with other teams and using data analysis to improve the quality and efficiency of care. The approach includes educational actions and an active search to increase adherence to care and sustainability of the health system. Analysis demonstrates that effective care coordination increases patient engagement, improving healthcare access and experience.
Keywords: Care coordination; Nurse; Primary Health Care

INTRODUCTION

Care coordination can be characterized as the organization and synchronized articulation between different professionals and levels of health care to care for the individual. It is one of the main strategies for identifying and monitoring people with chronic or high-risk conditions in the Unified Health System (SUS), as it integrates the health needs of the population and aims to ensure continuity of care[1].

In the context of Primary Health Care (PHC), care coordination helps the user navigate the system and integrates different flows in different health spheres; important element in guaranteeing access, equity and quality of services[2].

Studies show that monitoring target populations combined with care coordination has become an important preventive instrument when we talk about chronic non-communicable diseases (NCDs), as care coordination at different levels of health care carried out by nurses, doctors and the participation of the multidisciplinary team allows for better management of chronic diseases, improves the user experience, reduces the number of hospital readmissions and general healthcare costs[2,3].

The importance of qualified health professionals in monitoring and directing patients in the health system is crucial to ensure effective care coordination. Furthermore, it is essential that the healthcare system integrates and develops appropriate technologies for this purpose. These technologies must be focused on efficient communication, accurate records in medical records and use of institutional protocols, as they are tools that facilitate the care coordination process and contribute to improving the quality of health care.

The effective combination of care coordination, technology and institutional protocols is essential to increase quality and patient satisfaction, in addition to promoting the sustainability of the health system.[2,5].

OBJECTIVE

Report the implementation of care coordination in population management, by the nursing team in a health operator with a new model focused on technology and primary care.

METHOD

This is a qualitative and descriptive study of the experience report type.

The data refers to activities that took place between August 2021 and June 2022 and refers to the experiences of the care coordination team made up of nurses from a healthtech

that offers a private health plan in the city of São Paulo.

EXPERIENCE REPORT

Healthtec was founded in 2019 with the purpose of providing health care digitally, with an emphasis on primary health care, and also promoting the individual's autonomy in their self-care.

The model presented here was developed in 2019 by an emerging healthcare operator, which calls itself a healthtech, due to its emphasis on applying innovative technological solutions and advanced data analysis to improve the quality, efficiency and personalization of healthcare.

This experience report aims to describe the implementation and relevance of the care coordination team made up of nurses, with a main focus on primary health care and the monitoring of chronic non-communicable diseases, such as diabetes mellitus and obesity, in addition to providing support to pregnant women during prenatal care.

At healthtec, care coordination was implemented through the integration of the care team, made up of medical and nursing professionals, with two other teams made up of nurses. One of these teams is dedicated to tertiary care, focusing on monitoring hospitalizations and elective surgeries. The other team is responsible for population management, focusing on quality assurance through institutional protocols and lines of care for chronic non-communicable diseases, known as the population monitoring team.

The monitoring team works by analyzing the monitoring of the target population, with the aim of identifying opportunities for improvement in the care provided, to build and guarantee the execution of an action plan for interventions that promote not only greater coordination of care, but also corroborate for adherence to best health practices and contribute to a more cost-effective system.

Due to the predominance of a young population, with an average age of 32 years, monitoring initially focused mainly on pregnant women and individuals with obesity and diabetes mellitus.

When monitoring pregnant women, monitoring begins as soon as the pregnancy is confirmed. All pregnant women receive monitoring and guidance from the nurse responsible for coordinating care, regardless of the level of risk of the pregnancy. During this process, exams are requested, adherence to consultations is assessed, support is provided for birth planning and support and guidance is offered in situations of miscarriage or pregnancy loss.

In relation to chronic conditions, monitoring occurs with all members, regardless of whether they are newly or pre-diagnosed. This monitoring consists of requesting and evaluating exams, verifying the need for physical exams (foot assessment, weight measurement and blood pressure measurement), referral for consultations and health guidance. For compensated members, this monitoring is carried out every 10 months; while for those with the decompensated condition, contact varies from monthly to quarterly. In addition, an active search is carried out for members who did not adhere to the proposed action plan.

Regarding the follow-ups carried out, from August 2021 to June 2022, 103 pregnant women were monitored, of which 33% had high-risk pregnancies. And of the individuals with chronic conditions, a total of 45 people with diabetes mellitus and 1500 with obesity were monitored. On average, over 163 days, 55% of diabetic patients showed a reduction in glycated hemoglobin, indicating an improvement in disease severity. Initially, 45% of these patients were classified as severe cases, and this proportion decreased to 23%.

With regard to individuals with obesity, 38% showed a reduction in body weight, and 13% managed to reduce their degree of obesity.

Currently, in addition to monitoring pregnant women, diabetic and obese patients, the monitoring team also monitors adult patients with hypertension, heart disease, cerebrovascular disease, chronic obstructive pulmonary disease, severe inflammatory diseases and degenerative diseases. In the pediatric population, all patients aged between 0 and 11 months are monitored, as well as children diagnosed with asthma, recurrent wheezing and autism.

In addition to the diagnosed patients mentioned above, those who frequently use health services, both in primary and tertiary care, are also monitored. This helps to identify specific target groups and better target these individuals, intervening in health education and treatment, as well as promoting the sustainability of the healthcare system.

It becomes clear that active search and educational actions aimed at the population are strategies that also make up care coordination, aiming for greater user autonomy in care and increased bonding and rapprochement between the health team and users who are less compliant with care.

CONCLUSION

Analysis indicates that effective care coordination increases patient engagement and improves healthcare access and experience. These findings suggest a review of nurses' education to emphasize its importance in coordinating care, highlighting their technical skills and management capacity. However, it is crucial to recognize that, as a case report, this study has inherent limitations to its generalizability.

Studies with more robust methodological designs are needed to validate the effectiveness of care coordination on a broader scale, thus ensuring the applicability and replicability of results in different contexts and populations.

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