INTEGRALITY OF SURGICAL PATIENT CARE: ARTICULATION BETWEEN HOSPITALS AND PRIMARY CARE

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The health care model before the Unified Health System (*Sistema Único de Saúde* – SUS) was predominantly individual, biomedical, and disease-centered. The health care approach to the patient was performed in a compartmentalized and timely manner, focused on the biological body and the resolution of the signs and symptoms presented. The hospital institution, as the maximum representative of this model, had a prominent place, both in terms of valuing its service offer and of the hierarchical level it occupied among health facilities, portraying a hierarchical and fragmented system[1].

After health reform, the understanding that health is not just the absence of disease culminated in the creation of SUS, which adopted a model of comprehensive care in which the individual is seen as an indivisible whole, and the process of illness as a result, not only of anatomical and physiological dysfunctions, but also determined by social and environmental conditions, and affected by support networks[1].

In this sense, health promotion, protection and recovery actions must also form an indivisible whole and cannot be compartmentalized, just as service providers, with their varying degrees of complexity, must be configured into a system capable of providing integral care to the patient[1,2].

Hence, it is necessary to ensure the continuity of care, through an adequate transition process between the points of attention of the health care networks, polyarchic organizations with common goals that guide service offerings and are coordinated by primary care[2].

As the demographic profile changes and chronic conditions increase, the health system is challenged to structure itself to provide ongoing care and health monitoring in an integrated and cooperative service model that entirely and continuously meets the health needs of the population[2].

The patient who undergoes a surgical intervention, after hospital discharge, needs a transition process between the hospital environment and the risk-free home environment that ensures continuity of care and preparation of both environment and family. This continuity is paramount to prevent complications and readmissions, to reduce health expenses and to promote the quality of life of both patient and family. Depending on the patient's degree of complexity, this transition can be a complicated process that requires proper communication, knowledge and skills by the professionals[3].

In the literature, strategies for comprehensive care and ensuring continuity of care in this transition process have been reported. As an example, we have the experience of the Catalan health system in Spain with Enlace hospital nurses, whose job is to verify the need for continuity of care after discharge, through consultation with the multiprofessional team and active search in the institution's information system of hospitalized patients. Nurses are aware of the resources needed to carry out this continuity and make contact with professionals in the patient's area of origin (primary care, health centers, hospitals and/or households) by telephone, e-mail or by shared computer systems services, ensuring a visit to the patient by the nurse or primary care physician within 48 hours of discharge[4].

In Brazil, a similar model to the Spanish one is developed in a region of the city of São Paulo, where there is the case manager figure, which articulates the hospital service with the Basic Health Units (*Unidades Básicas de Saúde* – UBS) and the home care service. The case manager, who may be a nurse or social worker, identifies patients with complex chronic conditions at hospital discharge, a group that often includes surgical patients, and that redirects them to the referral UBS for follow-up. If necessary, they make the assessment for admission to the home care service immediately after discharge[5].

Another initiative found in the literature is a communication system based on an internet platform, developed as a social network adapted for the use of health professionals,

which allows the sharing of information, documents and treatment plans between the hospital and the UBS, promoting the exchange of information and dialogues about the condition and treatment of patients during and after hospitalizations and readmissions[6].

Regarding the poorly integrated and articulated structure of our current health system, it needs to be further integrated, just as we are doing here in this editorial. Other actions include utilizing the tools of collaborative, patient-centered interprofessional care and promoting integration across disciplines from training with curricula that do not compartmentalize the patient into systems, specialty professionals and services on specialized care islands.

Understanding the completeness and continuity of care as protective and health-promoting factors for patients is as fundamental to better treatment outcomes as following discharge and nursing care

Fernanda Amendola

Nurse, PhD in Sciences by Universidade de São Paulo (USP). Professor of undegraduate and postgraduate courses at the Faculdade Israelita de Ciências da Saúde Albert Einstein (FICSAE), São Paulo, Brazil.

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