REVISTA | MAGAZINE

IPH

INSTITUTO DE PESQUISAS HOSPITALARES ARQUITETO JARBAS KARMAN

PUBLICAÇÃO IPH + FBAH

FEDERAÇÃO BRASILEIRA DE ADMINISTRADORES HOSPITALARES

45 ANOS
1971
2016

FBAH

Gestão em Saúde

Eficiência, Inovação e Sustentabilidade

Anais do
39º Congresso
Brasileiro de Administração
Hospitalar e
Gestão em Saúde
e do
IX Congresso Latino Americano
de Administradores
de Saúde

REVISTA IPH - EDIÇÃO Nº 13 - JUNHO DE 2016

13

Revista IPH

Edição Nº13

Primeiro Semestre de 2016

ISSN 2358-3630 *digital*
ISSN 1519-14-51 *impresso*

Endereço para correspondência

IPH - Instituto de Pesquisas Hospitalares Arquiteto Jarbas Karman
Rua Ministro Gastão Mesquita, 354 – Perdizes
CEP.: 05012-010
São Paulo, SP

Tel. (11) 3868-4830

E-mail: *revista@iph.org.br*
Endereço eletrônico: *www.iph.org.br/revista*

Summary

ENGLISH VERSION

Editorial

The thirteenth issue of *IPH Magazine* brings a thorough panorama concerning the four days during which the *39th Brazilian Congress of Hospital Management and Health Management* and the *9th Latin American Congress of Health Managers* took place; carried out by the Federação Brasileira de Administradores Hospitalares – FBAH – and the Federaciòn Latinoamericana de Administradores de la Salud – FLAS.

Embracing the theme *Health Management: Efficiency, Innovation and Sustainability*, the discussions presented national and international experiences that shed some light on creative alternatives towards overcoming financial halts and towards improving the quality of services provided.

Within this issue you may also find the *Annals of the Summary* of the Congress, which is a collection of the summaries or articles from the lectures and panels presented at Expo Center Norte, São Paulo, SP, Brazil, between the 17th and the 20th of May, 2016. There are twenty-nine texts covering the six themes of the Congresses: financial management and costs; engineering, architecture and logistics; people management and leadership; health management; patient's quality of life and safety; and hospital hospitality. Under the name of the Congress, the reader may find its respective credits and articles.

We would like to thank the designer Carla Vendramini from Formo Arquitetura e Design, who has kindly provided us with the design for the cover of our current issue and the Federação Brasileira de Administradores Hospitalares – FBAH – for their everlasting partnership.

With this new issue of *IPH Magazine*, the Institute wishes to reiterate its commitment to broadcast and enrich the discussion concerning hospital management, as we keep on believing that knowledge is a powerful tool to overcome times of crises. Have a nice reading!

Health Management: Efficiency, Innovation and Sustainability

Health Management Focused on Efficiency, Innovation and Sustainability! This is the key theme from which the **FBAH** and the Federaciòn Latinoamericana de Administradores de La Salud - **FLAS**, teamed up with Hospitalar Feira + Fórum, organized the *39th Brazilian Congress of Hospital Management and Health Management* and the *9th Latin American Congress of Health Managers*.

Such a challenging theme that the **FBAH**, with its 45 years of experience, has put a lot of effort into bringing renown lecturers able to meet the attendees' expectations during the four-day event, in a unique moment, with people coming from all over Brazil and from neighboring countries, with viewpoints and realities that differ from ours, but with great experience in entities focused on public and private health and on mixed organizations.

The lecturers have shared their knowledge, discussed opinions and presented real cases concerning their field of work, envisioning the hoped innovation with necessary efficiency and sustainability!

The attendees, multitalented health professionals who are engaged in this triple foundation that was the 2016 Central Theme, have the great mission of spreading these ideas to allow that other professionals get the chance to absorb and enrich our knowledge!

The **FBAH** is proud to enable this encounter among their peers and to gather knowledge so we may achieve a fair Health System!

We candidly would like to thank the Developers, Sponsors, Supporters, Lecturers, Executive Committee, Scientific Commission, Attendees and the Commission of Operations for the friendship that allowed us to organize another grand event like this one together.

Finally, we are especially grateful to the Lecturers, who have authorized us to publish their work, and to ***IPH***, who has gently put it together in this rich publication: the *2016 FBAH Annals of Congress*!

The Congresses:

Costs and Financial Managment - 17 and 18 May
People Managment & Leadership - 17 and 18 May
Engineering, Architecture and Logistics - 17 and 18 May
Health Management - 19 and 20 May
Patient´s Quality and Safety - 19 and 20 May
Hospital Hotel - 19 and 20 May

CONGRESS PRESIDENT
Paulo Roberto Segatelli Camara

CONGRESS VICE-PRESIDENT
Oscar Ressia González

EXECUTIVE COMITTEE

Antônio José Rodrigues Pereira
Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo - HCFMUSP

Danilo Oliveira da Silva
Pró-Saúde - Associação Beneficente de Assistência Social e Hospitalar

Eliete Di Spirito
FBAH - Federação Brasileira de Administradores Hospitalares

Jairo Ferreira Campos
FBAH - Federação Brasileira de Administradores Hospitalares

Liliana Chiodo Cherfen
FBAH - Federação Brasileira de Administradores Hospitalares

Márcia Cristina Mariani
INDSH - Instituto Nacional de Desenvolvimento Social e Humano

Maria Alice Rocha
Hospital Beneficência Portuguesa

Oscar Ressia González
FLAS - Federación Latinoamericana de Administradores de la Salud

Paulo Roberto Segatelli Camara
FBAH - Federação Brasileira de Administradores Hospitalares

Salim Lamha Neto
MHA Engenharia

Sérgio Fernando Rodrigues Zanetta
Hospital Sírio-Libanês

Solange Amora Aliandro
FBAH - Federação Brasileira de Administradores Hospitalares

Valdesir Galvan
FBAH - Federação Brasileira de Administradores Hospitalares

Waldomiro Monforte Pazin
FBAH - Federação Brasileira de Administradores Hospitalares

Waleska Santos
Presidente da Hospitalar - Feira + Fórum

PROMOTERS

Hospital Beneficência Portuguesa de São Paulo

Hospital das Clínicas/Fundação Faculdade de Medicina

Sociedade Beneficente de Senhoras - Hospital Sírio Libanês

MHA Engenharia

Instituto Nacional de Desenvolvimento Social e Humano - INDSH

Pró Saúde - Associação Beneficente de Assistência Social e Hospitalar

Congress for Cost and Financial Management

Congress for Cost and Financial Management

Scientific Coordination

Marcus Henrique Wächter
FBAH - Federação Brasileira de Administradores Hospitalares
Pró-Saúde - Associação Beneficente de Assistência Social e Hospitalar

Vice coordinator

Walter Cintra Ferreira Júnior
FBAH - Federação Brasileira de Administradores Hospitalares
FGV - Fundação Getúlio Vargas
Hospital das Clínicas da Faculdade de Medicina da USP

Members

Adilson Bretherick
Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo - USP

Antônio Sérgio Vulpe Fausto
SINDAESP - Sindicato das Empresas de Administração no Estado de São Paulo

Carlos Alberto Marsal
Hospital Sírio-Libanês

Carlos Herculano Bressiani
Hospital Beneficência Portuguesa de São Paulo

Joan Castillejo
Gesaworld do Brasil

Jorge Elias Aoni
SINDAESP - Sindicato das Empresas de Administração no Estado de São Paulo

Sérgio Lopez Bento
Planisa - Planejamento e Organização de Instituições de Saúde

Congress for Cost and Financial Management

Hospitals, networks and sustainability

Osvaldo Artaza

Health systems are currently stressed by a number of factors related to environment changes occurred in recent decades, and it is known that much of the income and high hospital costs are due to a previous failure of health and social system. These considerations imply a profound change in the work of healthcare organizations that must modify themselves from being organizations dedicated to heal and rehabilitate the damage to organizations able to contribute to keep people healthy. PAHO is committed to contributing to the development of health systems based on Primary Health Care - PHC - and modeling from them Integrated Health Services Delivery Networks - IHSDN - in order to provide more accessible, equitable, efficient health services, with better technical quality and that meet the expectations of citizens.

Hospitals today	Hospitals network
Work in isolation, in a disintegrated way within the establishment (stagnant processes) and outpatient settings.	They are components of integrated health services that support the response capacity of primary care networks.
Privilege activities related to hospitalization.	Privilege outpatient care activities and procedures, thus avoiding unnecessary hospitalizations.
Organize their processes concerning the well-being of their staff, particularly the specialists who exercise power.	Organize their activities - processes - having as core axis the people.
High rates of adverse events and accidents concerning their staff.	They provide a safe environment for their users and employees, besides being friendly to the environment.
The hospital staff have high rates of poor physical and mental health. The context is stressful and overloading with insufficient protective factors.	They are concerned with their staff's health, wellness and competence development, because they are the hospital's main resource.
Tend to take on technologies under the pressure of the industry, without prior cost-effectiveness evaluations.	They use only cost-effective technology and are based on evidence-based medicine to modify and improve their skills.
Important quality losses and waste by inefficient and redundant use of resources.	They are efficient in using their resources and contain costs to contribute to equity.
Opaque management of resources and lack of evaluation of results and impacts.	Incorporate evaluation and accountability as part of a continuous improvement cycle.

Integrated Health Services will not be feasible unless hospitals understand that healthcare processes begin and finish outside its walls. It implies that protocols and clinical guidelines should be participatory co-constructions among different actors trough the network. This requires forming cross-professional teams of specialists, family physicians, among others actors, for the management of each integrated care process, not belonging to different levels but to a single organizational model sharing the patient as a unified path based on shared clinical practice guidelines.

In any case this involves the strengthening of coordination mechanisms between levels (ideally within transverse and integrated multidisciplinary teams). Both in terms of searched results and as standardization and normalization way of working (guidelines, standards, work methods, evaluation mechanisms, management control and learning). It will require to gradually go from process indicators (the most appreciated at hospitals) to result indicators (positive

change in the epidemiological pattern of the population). This requires a clear vision of population and territory from the network and hospital managements, working from the health plan of this population and territory as well changing the traditional ethical principle of doing good effectively (doing all possible for the sick) as it is usual at hospitals for equity (much more embedded in the PHC core). Doing everything possible for the sick person focusing on the individual can be the source for inequality for many others.

Along with healthcare integrations, it is required explicit definitions on bypass rules; information systems, management control and public income statement.

Allocation policies and incentives should encourage networking. For an example, economic resources for the purchase of intermediate products, such as imaging and biochemical examinations and buying the first consultation referral to specialists, may be in the budgets of the PHC in order to stimulate this resolution capability and instill in the hospital the idea of PHC as a client. In this same line of thought, established incentives for meeting goals should be shared by one and another level since to have access to them is required cooperative action of each other. For the latter, it will be important to establish incentives for integrated service delivery network planning. The latter because, currently, a central aspect hindering the integration of health services is due to the fact that health goals are not shared by different network nodes. Thus, the organization of integrated network hospitals should consider formal instances of planning and common goals with the other network nodes to assess their performance and efficiency according to coordination and cooperation with other network levels.

It will be difficult to talk about network without the network manager receives a capitation allocation corrected depending on the characteristics of the population and territory, so that it in turn makes contracts or distribution agreements between the network devices based on the definition that the network itself makes concerning the type of care activities of each establishment. Network through the institutions of government that should have - regardless of “ownership” of the various establishments - the ability to model the different nodes via the definition of service portfolios, decisions on network investments, capacity to mobilize human and technological resources from one to another level to integrated care and cost-effectiveness. Without this ability to generate a flexible adaptability to demand it is difficult to imagine an effective network management.

It is key that the network contracts with the establishments that comprise it are constructed “bottom - up” in order to engage clinical teams in compliance and that there are mechanisms for monitoring compliance and generate feedback. The contracts must be promises that are impeccably fulfilled, in order to strengthen confidence among the actors in a network. The budget should be strongly aligned with the strategy of the network and generate strong incentives to shift.

The objective of a funding aligned with an integration strategy is to drop limits and boundaries between PHC and hospital care, because these borders are often pretext to reinforce compartments and hinder continuity of care.

A key element to the aforementioned are the Tics, which have come to help with the ease of real-time communication between hospitals and the different network nodes.

The integration model should be a “business unit” to cross-cutting teams that are responsible for the integrated process (PHC - hospitals - tech Outpatient Centers etc.); which must be connected and complemented with long stay devices, partner health services, among others, all of which must not go outside the network.

It is the PHC - the needs of people - that must set - through government networks – the profile of each node so that the distinction between acute and long-stay hospitalization or home care are not mechanisms for “the hospital to take over patients’ problem” but a logical, cooperative, humane and cost-effective way to manage care, so that the users of the network are always in right time and place according to their needs and it is the rational modeling that makes their resource network.

The goal of having organized and managed network hospitals must be paid by different mechanisms. Corporate governance must be established in the network and not only on its nodes (and hence ability to plan, coordinate, evaluate and provide feedback), the management of clinical processes must be unified so that clinical hospital units should gradually give cross-step equipment, intermediate products must be of the network and not a particular node (business units should be network). Also support services, logistics, maintenance, among others, should aim to integrate into shared business units in order to generate economies of scale and enhance the identity of collaborative work. Having users in the center of the business, devices that support and diagnostic, therapeutic

or logistical support, having as clients nodes that give open or closed attention, informing the network manager, who has skills and capabilities to model the network and generate assignments and incentives aligned with this new organizational architecture.

All this will be possible in LAC whenever we have the capacity to broad national consensus in the field of health; flexibility to articulate establishments of different ownership and dependence; understanding that it is necessary to strengthen health institutions particularly in the ability to design, implement and regulate persistent public policies; leadership and expertise to support complex change processes; alignment between objectives, funding and implementation tools and, finally, ability to learn what works and generosity to share mistakes and best practices.

Cost Reduction through Process Review

José Geraldo B. Chaves Filho

The economic moment Brazil is currently experiencing, with inflation and high interest rates, as well as increased operating costs, has caused many companies to rethink their processes in order to reduce costs and maintain their competitiveness (BENEDICT, S.L.; 2016). This is precisely the topic discussed in this study.

Losses and waste can decisively affect the performance of your health institution. We believe that more can be done with it, so we use tools and knowledge that enable the analysis of processes and the systematic and sustainable disposal of waste, whether of time, capacity, quality or cost (CHAVES FILHO, 2010).

We present the information to management and reduction of hospital costs; the use of management tools for effective reduction of costs: eliminating rework, optimization flow, reduce inventory, among others; and process management tools and the involvement of the teams in the solution and process optimization.

We recommend the standardization of care, support and management processes, investing in the review, automation and optimization thereof, eliminating everything that does not add value to the patient; the total costs and results management, seeking to increase the organization competitiveness, through the generation and proper analysis of strategic management and business information and assistance.

Focusing the solution in process management using the methodology LURE, Profit + Return for Lean Healthcare, Business Process Management, outcome indicators and Kaizen events, we present a case to demonstrate the results that can be obtained.

The addressed topics are: how was reversed the result of a hospital for an average primary surplus of more than 1 mm / month in 2015; how was the 6% reduction in monthly costs; how was reduced by 53% (R$ 653,000) the value in stock of expensive medicine in the warehouse (~ 24% of total stock); how monthly occupancy was increased of the rooms of the Surgical Center by 12%; how the queue for EV AMB Chemotherapy was reduced from 12 to zero days, keeping the occupation of 63%; how the patient will schedule appointments for a date up to 40% closer; how it gained 30% in space and 95% in agility for archiving / search records; how was the reduction from 11 to 6 days in the general average delivery time of pathological examinations (RELATÓRIO ANUAL ACCG 2015).

In the specified case, 3 macro solutions have been suggested to improve the hospital: programming of care (PCP elective consultations and QT application); reset handling and transport (layout and service personnel); and organization and resources management (forms, equipment and inventories).

At the end of the process, there was uniform distribution of patients throughout the day, schedule service, organization and resource management, expansion of service capacity, less waiting time to meet the patient and greater success in prescriptions.

José Geraldo B. Chaves Filho is Master of Science in Production Engineering Department at USP and Production Engineer - Materials UFSCar. Researcher and visiting professor at the Faculty of Technology GAP (UNIGAP), the Institute Dotis / IBEMEC and the Institute Francisco Ludovico (IFL).

Integrating the Business Management Assistance to Management

Lilian Quintal Hoffmann

The high cost of health, the need for individualized treatment and the premise of making the experience less lingering and more pleasant to the patient as possible, the hospital environment becomes even more complex in relation to the data. The challenge of integrating the business management to the assistance management can be overcome by changing the posture of technology departments, effectively closing up the business and bringing solutions that add to the hospital management and patient care. Incorporate to the IT staff professionals from assistance (doctors, nurses, pharmacists), promote analysis and proper collection of data, with specialized professionals dedicated to this task and use benchmark to effectively meet the competitors and delimit targets are possible ways that support to overcome the proposed challenge.

International Experience on the Compensation Models

Joan Castillejo Peña

There are several compensation models existing at international level, however, the different existing compensation models stand out as main purposes to promote the efficient production of services by providers, minimizing administrative costs by donors / buyers of services.

Before defining what better model to be used, it is necessary to reflect on some important points on compensation models on how to use them.

The search for efficient services production by providers and the minimization of administrative costs is the starting point for consideration of the compensation models, then we should be confident that the service providers have economic, financial and administrative conditions to manage hospital costs, providing quality service to users.

Through information systems adapted to hospital reality all information is obtained and recorded enabling the funder/buyer to accomplish the budget forecast of the service provider in the allocation of financial resources. The funder cannot use an information system where the remuneration model cannot be controlled. This information system should support the budget forecast for strategic planning, where can be established what is expected for the year, both in terms of budget and in terms of hospital productivity. The budget planning and productivity is important for both the service provider as for the funder to purchase the services.

We can define the product/unit services purchase through structure, processes (intermediate products) and outcomes, where issues related to structure are directly related to certification and accreditation processes, we can mention for example, human resources, material resources, economic resources and the information system. Intermediate products refer to internal work processes and may be related to compensation for process systems, such as the amount of consultations and examinations, length of stay, surgery, among others. The results are related to the fulfillment of end-health goals, such as reducing the incidence of certain pathology, satisfaction index, adjusted life years for quality of life (Quality-adjusted life-year), conditions diagnosed (through DRG, PMC, ACG).

The actual cost of the hospital should be analyzed so that the funder/buyer get subsidies to define the most appropriate remuneration model and the amount to be paid to the service provider. In a brief analysis of the costs, we can say that when the paid prices are higher than the actual cost there is a tendency to induce unnecessary services and weakness of the viability of the health system and when the paid prices are lower than the actual cost there is a tendency to induce sub-benefits, discouraging offer from providers and encouraging unnecessary super-activity.

The most suitable is that the remuneration paid to the provider must be adjusted as close as possible to the actual costs of the hospital. Each compensation model has different specific incentives and risks, let's look at some examples of the different compensation models in the world:

- Compensation for history of service model
- Per capita remuneration model
- Adjusted per capita remuneration model
- Aggregate activity remuneration model
- Compensation for itemized activity/processes model
- Length of stay compensation model
- Intermediary products compensation

Financially, the compensation models are related to levels of aggregation of the budget, so in a brief analysis we can say that an important premise to be considered in relation to the risks is that the more added the compensation model of the budget, the greater the risk to the service provider and the less aggregate, the greater the risk for the funder/buyer.

Therefore, there is not a payment unit that can be valid whatever time, place and type of service; the choice of compensation model depends, among other things, of the funder objectives and also the development of appropriate information systems.

There are some desirable features in remuneration models that should be considered, such as: balance between performance and compensation, ease of understanding of the payment system, quality improvement of the promotion, adaptability to industry changes and incentives generation for desired capacity.

Citing international models used, the experience shows that:

- The per capita compensation adjusted by combined risk with compensation based on treated cases are the best alternative for compensation in cases of service integration between different levels of health care.
- The mixed remuneration, considering the structure and according to the complexity of cases treated, are the best alternative to pay hospitals. This remuneration is characterized by measuring the cases treated by applying DRGs, adapted to their own countries and modulated by comparison systems between hospitals (benchmarking).
- The per capita compensation adjusted by risks, which converges with the model using morbidity (ACG, DCG CRG) are the best alternative for the remuneration in primary care.
- The special mixed remuneration, are the best alternative to other areas or services, such as emergency, remote areas, special treatments etc.

In addition to all the aforementioned topics, we conclude that to introduce changes in hospital payment system, you must create a compensation model where the relationship between funder and provider must be based on mutual trust and agreeing on risk levels between them, where the remuneration model is based on legally and technically robust contracts supported by strong information systems that can be audited and verified by both parties. The model shall be in accordance with the strategic objectives of both the funder as the service provider to minimize the risks in incentives. We conclude that each country implements compensation models adapted to their reality, but with tools internationally validated.

The Future of Hospital System - The Sustainability Challenge of Small Hospitals

Paulo Carrara de Castro

In recent years, studies published in several journals deal with issues that, at present, may be strategic for the future of Brazilian public system: the demographic process in progress, the current epidemiological situation, the health care network built and the services it offers.

About the first, the 2010 census showed some results that indicate significant changes in demographic trends in Brazil. The crude birth rate has been falling sharply, reaching in 2013 an estimated 13.82 / 1000 inhabitants, a level deemed to European standard. An indicator very sensitive and important aspect of this is the fertility rate from 2000 to 2013 decreased by 31.4%, which now means around 1.64 children per woman in reproductive age. Other key information in this chapter refers to life expectancy at birth, which had 70.43 years in 2000 and in 2013, 74.23 years, an increase of 5.4%.

From an epidemiological point of view, it is increasingly evident that chronic diseases are in the leading causes of death. In the mid-60s of the twentieth century there was an inversion in the curve of the proportion of deaths due to specific causes, with cardiovascular disease taking the lead in place of infectious and parasitic diseases. In the 80s, cancer, respiratory diseases and external causes also exceed the proportion of deaths corresponding to infectious and parasitic diseases. Since then, this scenario is accentuated because, currently, diseases of the circulatory, respiratory, digestive and tumors, added to external causes account for more than 60% of deaths volume nearly 15 times greater than that posed by infectious and parasitic diseases. There has also been a sharp decline in the volume of admissions in the last 16 years, with a decrease of about 17% in the proportion of admissions, being 5.57% of the amount in 2012. This information deserves a deepening in its analysis as that numerous factors contribute to this decline, with yet another set of circumstances that determine the existence of waiting lists for surgery or other clinical requirements, setting up paradoxical frame.

On the other hand, when analyzing the hospitals built in the country, their occupation has a significant idle capacity that reaches almost half the hospital beds in the country. In some states the occupancy rate does not reach 45% of beds. This fact undoubtedly also forces to deepen the reasons underlying this scenario, but we can, with some confidence, discuss some aspects that have contributed and still contribute to this scenario. The fall in the birth rate, as well as improving nutritional conditions and technology for coping childhood diseases influenced the decrease in demand for admissions both in the field of obstetrics, pediatrics. Similarly, technical advances in surgery allowed a sharp contraction in the average time spent in a huge number of procedures in the area. Nevertheless, Brazilian hospitals in general still have the same traditional pattern of supplying services and their correspondence on beds in the basic specialties, which implies underutilization presented in the table mentioned in this article.

Porte	Nº Estab.	Total Leitos SUS	Méd. Perman.	Taxa Ocupação
Menos de 50	3296	85761	3,2	26,2
De 51 a 100	1020	72366	4,0	41,8
De 101 a 200	597	83751	6,5	64,1
Mais de 200	303	100761	7,9	70,5
Total	**5216**	**342639**	**5,6**	**51,8**

Hospital indicators by hospital size
Source: SIH-SUS

After analyzing this idleness from another angle, classifying hospitals by size, it is observed that the smaller hospitals, which make up most of the country units, have the lowest rates of occupation, as shown in Table 4. The occupancy rates increase to the extent that the hospital size also grows in size.

Also adds to this picture the financing condition for the services that are provided by the network, how they occur, the corresponding efficiency and quality.

This context necessarily requires a reflection on the role of hospitals in national set, defining new doctrinal basis for the provision of hospital services and the provision of health services in inpatient settings, and even resetting the vocation of hospitals for services to that better meet the health needs of the population.

Paulo Carrara de Castro

GRADUATION: Faculty of Medicine, University of Mogi das Cruzes, graduated in 1979. GRADUATE: Medical Residence in Public Health by the Public Health Department, Faculty of Medical Sciences of Santa Casa de São Paulo, completed in 1981.

Advances in Patient Safety: Indicators and Impact on Cost Assistance

Fernando Paragó

The presentation initially makes the consideration that, although the theme “Patient Safety” is very much in vogue today, it is present in the practice of care in health since ancient times. The Latin maxim primum non nocere, known as the principle of non-maleficence, attributed to Hippocrates, illustrates this fact. Then goes on to highlight a number of initiatives that can be identified as associated with concern for patient safety, since then, culminating in the framework of the modern process of study and development of safety in health care, published by the Institute of Medicine, the report To Err is Human, 1999. The advances of the last decade are addressed and their main steps are listed.

Indicators associated with Patient Safety, from national and international data are discussed, from literature review and reporting of key market institutions. Surveys on impact on costs of care are listed. The numbers of National Efforts To Make Safer Care, from the US Agency for Research and Quality in Health Care (AHRQ), from 2010 to 2014 are presented and is made a projection of values based on DATASUS.

Fernando Paragó

Graduate in Medicine at the Faculty of Medicine UFF - Niterói, 1993; Residency in General Surgery, Air Force Hospital Galeão, Rio de Janeiro - RJ; Specialist in General Surgery; Graduate Diploma in Health Quality and Patient Safety FIOCRUZ - RJ.

Prospects for Public Private Partnerships and the Partnership Arrangements with Health Social - Critical Analysis of the PPP Brazilian Experiences in Health

Maurício Portugal Ribeiro

The lecture will focus on private equity alternatives to the provision of health services in the public, focusing on the provision of such services through public-private partnerships under the Law 11.079 / 04.

Engineering, Architecture and Logistics Congress

Engineering, Architecture and Logistics Congress

Scientific Coordination

Antônio José Rodrigues Pereira
Hospital das Clínicas da Faculdade de Medicina da USP

Vice coordinator

Salim Lamha Neto
FBAH - Federação Brasileira de Administradores Hospitalares
MHA Engenharia

Members

Adhemar Dizioli Fernandes
ABDEH - Associação Brasileira para o Desenvolvimento do Edifício Hospitalar

Alexandre Henrique Hermini
UNICAMP - Universidade de Campinas

Antônio Carlos Cascão
Hospital Sírio-Libanês

Carla Vendramini
Formo Arquitetura e Design

Daisy Figueira
Hospital das Clínicas da Faculdade de Medicina da USP

João Fabio Bianchi Garcia Silva
Hospital Beneficência Portuguesa de São Paulo

Marco Antônio Bego
Hospital das Clínicas da Faculdade de Medicina da USP

Engineering, Architecture and Logistics Congress

Hospital logistics: Intelligence at Service for the Health Manager

Domingos Fonseca

According to the ANAHP (Brazilian National Association of Private Hospitals), for the first time in the last 10 years, the net revenue of the 22 largest private hospitals in Brazil has plummeted, among other factors, as a ripple effect from the reduction of plans of portfolio health and also the reduction of operators in the market. In the public system is no different, with the increasing scarcity of funds against the increased demand. In this scenario, there is no magic, but there are solutions to optimize existing resources to generate economic efficiency and more profitability.

This is the presentation of Domingos Fonseca, considering the application of customized hospital logistics and committed to results. With over 30 years of industry experience and accustomed to thinking cubically for better space management, materials, people and technology expert will present successful cases that show their solutions.

People Management & Leadership Congress

People Management & Leadership Congress

Scientific Coordination
Fabrício Rosso
Fator RH - Programas de Desenvolvimento

Vice coordinator
Claudio Collantonio
AACD - Associação de Assistência à Criança Deficiente

Members
Cláudia Aparecida Nogueira Palmuti
Fator RH - Programas de Desenvolvimento

Daniela Teles
Fator RH - Programas de Desenvolvimento

Eliete Di Spirito
FBAH - Federação Brasileira de Administradores Hospitalares

Elisabeth Alves
Fator RH - Programas de Desenvolvimento

Fábio Patrus Mundim Pena
Hospital Sírio-Libanês

José Luis de Lira
Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo - USP

Luiz Vieira de Carvalho
SPDM - Associação Paulista para o Desenvolvimento da Medicina
Complexo Hospitalar Prefeito Edivaldo Orsi

Maria Alice Rocha
Hospital Beneficência Portuguesa de São Paulo

Maria de Lourdes Neves Fonseca Azevedo da Costa
GRAACC - Grupo de Apoio ao Adolescente e a Criança com Câncer

Renato Donizeti de Oliveira
FBAH - Federação Brasileira de Administradores Hospitalares

People Management & Leadership Congress

Illusionist Performance: Transformation and Innovation in Tough Times

Lucca Viery

Creating a relax environment, effective ideas leads to productivity. Technical concepts of motivation and professional training are presented in the midst of a structured show of magic and humor.

Among the numbers of the magic show and the speech content, Lucca Viery practices intelligent humor. Jokes, stand-up comedy texts, gags and incidental humorous situations spice the content of the speech.

This format propitiates a productive interaction with the present public, increasing the assimilation of the content and the training results.

This activity is not limited to a mere motivational speech. It is a profound and detailed technical leadership training. Visions for results leadership, how to bring out the best performance in a once unengaged team, how to turn corporate results into personal goals for the ones being led and how to equate results and people, make this training an in-depth conceptual content.

Concepts list:

• Trends in business leadership results
• Leading to manage, organize and increase productivity
• Developing skills for excellence: tools for creating professional results
• Adapting our team to the era of constant change: not the most experienced ones survive today, but those who best adapt to novelty
• How to motivate the team constantly?
• Building teams of multi-function minded professionals: the commitment to the result above the “commitment to the function”
• Teamwork in practice: how to create and be part of an integrated and committed team
• The strength of the details: creating a commitment to daily quality
• How to win and keep customers through our attitudes
• Leading to equate Results X People: how to punish or reward
• How to accomplish personal and professional goals: Running Skills

Link: www.luccaviery.com.br

Lucca Viery, illusionist, advertiser and lecturer, specialized in connecting the business world to Magic and Humor! He specialized in linking the art of magic to business management issues.

Implementation Careers & Salaries: New Paradigms and Opportunities

Alessandra Itri de Menezes

We can define Career and Salary Plan - PCS - as the set of rules governing the people management structure of a company. The PCS aims basically to provide employees growth and professional development; balance the organizational climate; structure the management of people; clarify the company's criteria in relation to wages and their respective positions; set working hours, ordinary and special, overtime; bonuses and extra benefits.

The PCS is important to ensure internal and external balance of positions and salaries, i.e., according to the reality of the labor market, finding the best way to motivate and retain talent, and protect the company from possible labor liabilities generated by the internal imbalance of salaries, differences that can bring people management issues with requests for equal pay, for example.

When we consider the implementation of a Career and Salary Plan, first, we think on how laborious is its preparation, which involves market research on applied salaries, specifying all positions and respective activities of all company.

Then we imagine that all employees feel motivated and will engage increasingly in the common goal to develop and grow the corporate and personal point of view.

However, the day-to-day shows that, after the implementation of PCS, the motivation is compromised and the PCS is seen as a problem and not as a solution and means of motivating and retaining talent.

This can occur for several reasons, but the main reasons involve:

- Failure in internal communication of the company, generating lack of clarity of information on the activities that each employee should play in their respective position and function;
- The use of "false promotion", moving an employee from a function (activity performed effectively) to another, but keeping him in the same position (depending on the classification) and with the same salary;
- "Create" very divided positions, in which, inevitably, developers will end up performing the same tasks, although in different positions.

Legally, the aforementioned problems, will eventually generate labor claims seeking almost always pay gap equalization, change of role and accumulation of roles, precisely because of the "confusion and mix of activities" that ends up forming when the Career and Salary Plan is not sufficiently clear and properly applied.

Specifically, in the health area we will have a higher probability of labor demands in the administrative area of the hospital or institution, but also in respect to the supervisor and coordinator positions, in this case involving doctors, nurses and other employees.

Today, likewise, two issues that generate controversy on the PCS are the need of being or not compulsory the approval of the Career and Salary Plan by the Ministry of Labor and Employment and the mandatory use of electronic clock, after the enactment of Decree 1,510 of MTE.

So in addition to discuss and clarify the possible risks the company is exposed to when you deploy the Career and Salary Plan, we want to provide mechanisms and solutions to prevent possible labor actions and greater effectiveness and efficiency in the implementation of the Career and Salary Plan.

Alessandra Itri de Menezes

Bachelor of Laws from Universidade São Judas Tadeu in 1997. Postgraduate in Law Work Material and Labor Process by the School of Law - ESA. Master's Degree in Labor Law from PUC / SP. Assistant teaching of labor law courses at ESA-SP.

The Art of Leading Generations X, Y and Z - How to retain talent?

Sidnei Oliveira

We currently have five generations coexisting in the market. All seeking their own interests, but the differences that could be complementary end up becoming conflicts between generations. Young leaders are constantly challenged to access the knowledge and experience of traditional leaders and veterans who in turn need to reinvent themselves and train successors. The new realities have challenged today's leaders that envision dozens of possible scenarios for this and the coming years, but nothing seems to bring security. New generations bring part of the answers, but to access them leaders must reassess all "truths" we have learned in recent years.

With a hot market and increasing job opportunities and career, company, HR professionals and leaders can attract talent and transmit the culture and organizational environment with transparency in order to retain them. Learn also how to attract, retain and develop young professionals who come to companies, as well as lead and maximize the results of increasingly younger teams.

Sidnei Oliveira
Consultant, Author and Speaker, expert Generation Conflict, Generation Y and Z, Development of Young Potentials and Mentorship. Author of several books on leadership and best-selling series Generation Y.

Giving Back Over the Organizational Climate - Talent Retention Strategies

Gideon Oliveira Basilio and Eliane Basilio

Organizational climate are the aspects of the business environment that an institution has, being influenced by internal and external environment. The Climate, when diagnosed, reveals the degree of satisfaction of employees from a number of aspects perceived by them.

The research analysis derive from what was supplied by their expectations and their culture. This diagnosis is important, since it identifies which optimize practices or compromise the bottom line.

The Adventist Hospital Manaus (HAM) is certified by the National Hospital Accreditation Organization (ONA) on two levels: ONA I and II; member of the National Private Hospitals Agency (ANAHP). It is a charitable institution maintained on the ideals of the Seventh-day Adventist Church, which explains the understanding of "the love of God and neighbor, and the patient as the center of attention ..." as the description of its institutional values.

Thus, it is essential that the organizational climate is in accordance with the principles adopted by the sponsor. Thus, the Organizational Climate Diagnosis is considered as the technical, formal and scientific method that should guide the practices to be developed by HAM.

Therefore, with the support of an external consultant, a qualitative and quantitative research was carried out by sampling, considering two hierarchical levels: leaders and followers.

When qualitative, in interview and dynamic, it was considered the verbal sample exposure. When quantitative, we used a research tool in the form of an electronic questionnaire, answered by Likert scale, filled confidentially.

The research was based on analyzing various topics from four major groups, in which each represents a dimension of influence in the workplace, namely: Culture and Management (institutional policies, organization, customer focus, quality culture) leadership (leadership style, recognition, communication and feedback and autonomy & development), People Management (remuneration, improvement and enhancement & reward) and

Desktop (working conditions, interpersonal relationships and job content & sense of accomplishment).

With the diagnosis made, HAM Administration decided to develop the program HAMARH (Adventist Hospital Manaus Evaluate, Acknowledge and Humanize) to meet the main needs of employees from strategic policies that values the result obtained in Organizational Climate.

Through this program it was possible to identify the needs of employees and offer incentives and benefits, with these actions the average 2014 turnover rate was 2.75% to 1.94% in 2015, a reduction of 30%.

The HAMARH program has contributed significantly to the retention of talent, thus establishing the HAM essential practices to transform the institution in one of the best companies to work for.

Gideon Oliveira Basilio.
Manager and Pastor.
Acts as Manager for the Adventist Church of the 7th Day institutions for twenty-seven years, the last six as CEO of the Adventist Hospital in Manaus.

Eliane Selma Magalhães Basilio
Graduated in Psychology
She took over the management of people at the Adventist Hospital in Manaus 6 years ago.

Creative Practices to Innovation in HR

Luz Loo de Li

Human talent in health services provide a range of opportunities, creativity to lead the management of health institutions, to create a space of comfort, well-being, professional growth, personal, spiritual for internal users, who share many hours of day care of patients or in related processes that contribute to the health of people who come to health services, they are the pillars of our multidisciplinary teams in health, it is therefore for all, a commitment.

The development of technology, advances in general, begins with human talent in health, to achieve results we must have their active participation.

Humanization of health care is undoubtedly a priority in times like this when you feel dissatisfaction, especially from the human talent in health.

The management of institutions in many of them are almost always focused on the demands of external users, without sometimes giving due weight to the fact that we are people that serve people with soul, with spirituality, as human beings with our own world, not only health professionals or health workers with a mission, a purpose, a job to do; one has a life that sometimes is complex, perhaps co-workers do not know and in general cannot anyone know, and that every day is faced with challenges of caring for others, years of service that perhaps may not have been recognized .

Providing spaces to develop human resources in health, such as a cultural center where art, creativity, culture, multiculturalism, the practice of disciplines in which the holistically human being develops, the spirituality, the reflection and meditation is fostered, will undoubtedly generate satisfaction to those who have a beautiful job, caring for another human being.

Luz Loo de Li
Medical surgeon, specialist in Health Administration, Advisor to the Ministry of Health of Peru, former president of the Peruvian Federation of Health Administrators - FEPAS and International Coordinator of the Andean and Amazonian Federation of Hospitals and Health Services - Peru.

Health Management Congress

Health Management Congress

Scientific Coordination

Gonzalo Vecina Neto
Faculdade de Saúde Pública da Universidade de São Paulo - USP

Vice coordinator

Sérgio Fernando Rodrigues Zanetta
FBAH - Federação Brasileira de Administradores Hospitalares
Hospital Sírio-Libanês

Members

Carlos José Massarenti
FBAH - Federação Brasileira de Administradores Hospitalares

Eduardo Luiz de Brito Neves
MHA Engenharia

José Carlos de Souza Abrahão
ANS - Agência Nacional de Saúde Suplementar

Luiz Eduardo Loureiro Bettarello
Hospital Beneficência Portuguesa de São Paulo

Marisa Riscalla Madi
Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo - USP

Ronaldo Pasquarelli
FBAH - Federação Brasileira de Administradores Hospitalares
Hospital Ipiranga

Waldomiro José Pedroso Federighi
CRA/SP - Conselho Regional de Administração

Waldomiro Monforte Pazin
FBAH - Federação Brasileira de Administradores Hospitalares

Health Management Congress

Efficiency

Ana Luiza D'Ávilla Viana

In the 2010 WHO report, the issue of efficiency is treated as a priority to achieve universal coverage, as estimates show that 20-40% of all health expenditures are wasted due to inefficiency. Thus, all countries, regardless of their income level, can take steps to reduce inefficiency, which requires an initial assessment of the nature and causes of local inefficiencies. For WHO, efficiency is "a measure of the quality and/or quantity of the products obtained (i.e. products or health services) for a given level of inputs (i.e. costs). Cetin and Bahce (2016) published a study in which they evaluated the efficiency of health systems in OECD countries, using 7 input variables (number of physicians, number of nurses, number of beds, spending on health per capita, health expenditure in % of GDP, number of MRI devices, tobacco use rate) and 2 variable output (life expectancy at birth and infant mortality). The results showed that the efficiency varies widely across OECD countries and that the most efficient health systems are in Canada, the Czech Republic, Iceland, Ireland, Israel, Japan, Korea, Poland, Slovenia, Sweden and the United Kingdom. Other countries have health systems considered inefficient.

Ozcan and Khushalani (2016) published another study to examine changes in the efficiency of health systems in 34 OECD countries over the period of 2000-2012. Several of these countries (14) carried out reforms in their health systems in this period and the article provides a table where you can see the nature of reforms in each country. The study used a model that separates the health systems into two components: public health (collective actions) and medical care (individual). The results show that countries that have carried out reforms in their health systems had more efficiencies when compared to countries that did not. However, this efficiency gain was mainly due to the public health component. The authors recommend that further efficiency gains could be achieved by reducing the component input medical attention. In an article on the determinants of health system efficiency in Canada, Allin, Grignon and Wang (2015) concluded that the Canadian system has great inefficiencies (range 18-35%), which are the result of three sets of factors: factors related to the management (such as hospital readmissions), factors related to public health (such as smoking and obesity rates) and environmental factors (such as average income in the region). The OECD publication Health Statistics in 2014 - How does Brazil compare? Briefly, the data show that:

Health spending: health expenditure as % of GDP in Brazil is equal to the average of OECD countries (9.3%). However, in per capita terms, the annual cost is only 1/3 of the average of OECD countries (1109 USD in Brazil, against 3484 USD in the OECD).

Public vs private: public spending in Brazil is only 46% of the total, way below the average of OECD countries (72%). It is even lower than in the US (48%), Chile (49%) and Mexico (51%), the three OECD countries with the lowest share of public spending.

RH: Number of physicians per 1,000 citizens was 1.8 in Brazil (in 2010) against 3.2 in OECD (2012). The number of nurses per 1,000 inhabitants is even worse: 1.5 in Brazil (in 2010) against 8.8 in OECD (2012)

Hospital beds: Brazil had 2.3 beds per 1000 population in 2012, which is less than half the OECD countries' average for the same year (4.8)

Life expectancy at birth: although Brazil has increased the life expectancy in 19 years since 1960, reaching 73.7 years in 2012, is still 6.5 years below the OECD average (80.2 years)

Infant mortality: major improvement in the infant mortality rate in Brazil, which fell from 51.6 per 1,000 alive newborns in 1990 to 12.9 in 2012; even so, it is 3 times higher than the OECD average (4.0 per 1000 alive newborns)

Obesity (a risk factor for many diseases): grew in all countries, but the situation in Brazil (18% of the population) is worse than the average of OECD countries (15%).

Ana Luiza D`Ávila Viana is an economist. She began to study economics at FEA (Faculty of Economics, Management and Accounting) at the University of São Paulo in 1968 and graduated in 1974 at the Faculty of Economics and Political Sciences from Cândido Mendes University in Rio de Janeiro. She completed her master's degree in economics in 1981 and her doctorate in 1994, both at the Economics Institute of Unicamp (University of Campinas). She is a retired professor from USP, where she taught from 2002 to 2015 in the Department of Preventive Medicine, School of Medicine. She is a supervisor at the graduate program of this department (supervises currently seven doctoral theses).

Efficiency (2)

Geraldo Amaral Jr.

The Efficiency lecture aims to demonstrate how the best practices used in the industry can be translated and adapted to be used with excellent results in the hospital, in order to reduce waste and improve organizational and operational efficiency.

The presentation shows the evolution of quality improvement principles, since the beginning of the First Industrial Revolution to the recognition of the Toyota Production System as philosophy and practice used for waste reduction, efficiency improvement and organizational excellence.

The translation of this philosophy and practices into the hospital area and successful examples of organizations that benefit from this cultural change testify that the Lean Methodology can and should be used in health care to reduce waste, improve efficiency and keep on the serach for excellence.

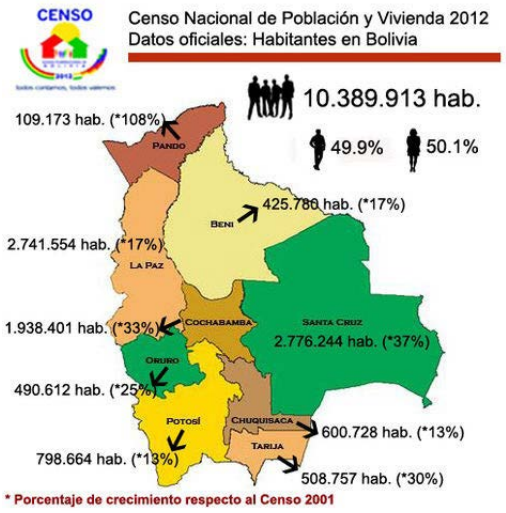
Geraldo Amaral Jr.
Professional with over 50 years of experience in Production Engineering, Maintenance, Total Quality Management, Human Resources, Quality Management, Strategic Planning and Process Excellence in national and multinational companies.

The process of change in Bolivia "Hospital Arco Iris" from Solid Hospital to Liquid Hospital

Ramiro Narváez Fernández

Bolivia, historically a laggard country, Bolivia, located in the center of South America, has 9 departments and 337 municipalities, an area of 1,098,581 km2 and a population estimated by the National Statistics Institute (INE) for 2013 of 389,913 inhabitants, 66% urban and 34% rural. Life expectancy at birth was 66.34 years, the population growth rate of 2.24% and the total fertility rate of 3.5 children, with significant urban-rural differences and the crude birth rate of 27, 1 born by 1000; with a social debt accumulated over many years,

which is facing new challenges, the so-called “process of change”, whose main attributes were the revaluation of the ancient culture and therefore the inclusion of areas forgotten in the national agenda, sustained economic growth and a better distribution of economic resources in the health field, health as a right contained in the new State constitution, the constitutionalizing informed consent, and a long way to have to move to the real transformation of health. Nevertheless they have laid the foundations for a real transformation, we are a different country, so should change the system, hospitals and health professionals in a changing world in permanent crisis; there arises the conceptual first need to dare to propose a different hospital model, which involves a change in the care model based on paradigm shifts in our country. We assume the challenge in the framework of a public-private partnership, out of our four walls, projecting the people and the place where they live and work (street communities); peripheral populations of the cities of La Paz and El Alto and rural populations of the Department of La Paz, coordinating health services networks, interconnecting supported by the ICT, Telemedicine, mobile phone, etc. Thus generating alliance agreements with different organizations, indigenous and native peoples and with the plural state.



From the perspective of the Meso and Micro management, focus management on patients, by providing our services and technology, relying on knowledge and permanent innovation, trying to change the “physical state of our hospital” and thus the rigid existing hospital structure in our country, solid, focused on doctors, health personnel and hospital centripetal way, a flexible model, patient-centered and needs, this hospital we call “hospital liquid “, i.e. this at the height of the times and the processes of transformation and change, which are merit of the group and its people. In a changing world, where people do not want to be second and therefore are more demanding, they are more informed and want to make decisions about their disease. The development of new technologies allows obtaining information and instant communication, i.e. we are living in times of change and some very profound changes.

This resembles the story of Hospital Arco Iris in the city of La Paz; Bolivia, who wanted to interpret the sentiment of the people and become fluent, plain and simple as the lowliest Bolivia, abandoned long protagonist of this new country we all want to win.

Ramiro Narváez Fernández

Pediatrician; Master in Hospital Management; Professor of Graduate University of San Andres (Guest); Director General Hospital Arco Iris; President of the Bolivian Association of Hospitals; President of the Bolivian Society of Telemedicine and Medical Informatics.

Patient's Quality and Safety Congress

Patient's Quality and Safety Congress

Scientific Coordination

Sandra Cristine da Silva
Hospital Sírio-Libanês

Vice coordinator

José Ribamar Branco
Hospital São Camilo

Members

Antônio Carlos Onofre de Lira
Hospital Sírio-Libanês

Allan Jacqueson Barbosa Lobo
Pró-Saúde - Associação Beneficente de Assistência Social e Hospitalar

Eduardo Silva de Oliveira
MHA Engenharia

Haino Burmester
CQH - Compromisso com a Qualidade Hospitalar

Jairo Ferreira Campos
FBAH - Federação Brasileira de Administradores Hospitalares

Laura Maria Cesar Schiesari
Hospital Sírio-Libanês

Liliana Chiodo Cherfen
FBAH - Federação Brasileira de Administradores Hospitalares

Solange Amora Aliandro
FBAH - Federação Brasileira de Administradores Hospitalares

Vera Lúcia Borrasca
Hospital Sírio-Libanês

Patient's Quality and Safety Congress

Impact of External Assessment on Brazil

Mara Marcia Machado

Since the 1970s, the concern with the use of the results of external evaluations for the improvement of organizational policies to quality and safety has generated numerous studies around the world. In Brazil, this debate seems to have not yet received proper attention. In Brazil, still prevails de idea that there is a simple linear relationship between evaluation and improvement of quality and safety in institutions. We are currently discussing the importance of external ratings for the transformation of quality and safety standards in Brazilian institutions.

This debate shall refer to an essential issue and that has generated a broad question about assessment practices adopted to date, as well as on how it is structured the evaluation function.

External evaluation is increasingly used worldwide to regulate and improve the health care providers, especially hospitals. The most common models are peer review - accreditation. Accreditation has been gradually adapting to meet the new demands of public accountability, clinical effectiveness and quality improvement and safety.

Mara M. Machado is CTO at IQG and Accreditation Canada in Brazil. Degree in nursing with a specialization in Public Health, MBA on Business Administration, postgraduate degree in Hospital Administration and Auditing Health, Institutional Member of ISQua by IQG.

Impact of External Assessment on Brazil (2)

Haino Bumester

The importance of using a systemic management model, integrated and coherent, from which as a result will come quality, patient safety, care humanization and other requirements for excellence. Disregarding the good management practices in general and focusing attention on particular demands, the focus shifts from major attention dispersing energies that could / should be focused on proper management. CQH, after 25 years of experience in health management area, advocates the adoption by health organizations in a systemic management model, coherent and integrated as the only way to face the challenges that these organizations have to face in the twenty-first century. Fads that have contributed in the nineteenth and twentieth centuries can no longer meet the challenges of larger organizations, more complex, sophisticated, with multiple specializations and interest groups. Access to information and social networks; knowledge dominated by the customers of these organizations demand faster, accurate and comprehensive answers that only a systemic, coherent and integrated organization can provide.

Haino Bumester
Medical and business administrator; for nearly 40 years engaged in the management of health services, particularly public and private hospitals. It is currently Coordinator of Human Resources of the State Health Secretariat of São Paulo.

Quality and Impact of Patient Safety in the Hospital Financial Result - Santa Casa de Misericordia de Maceió

Dácio Guimarães Borges
Luiz Cláudio Ramos de Albuquerque

Summary

This study points out some tools used in financial management processes of the Santa Casa de Misericordia de Maceió, in order to provide, with the results, some parameters that show the impact of Quality and Safety in the financial results of the said Hospital Organization. Among the found parameters are related: Surgical Safety Protocol, Pressure Ulcer Prevention Program, Aspiration Prevention Protocol ID Protocol and treatment of sepsis and severe sepsis prevention, VTE Prevention Protocol, all monitored with key indicators. The financial management of the hospital demarcates points assessment costs versus quality care using as parameters: evolution of stay, antibiotic consumption, standardization of surgical time, hospital admissions and average earnings per medical procedure and service, being practiced the integration of clinical staff financial results/assistance combined with monitoring the effectiveness rate of each tool.

Introduction

In the current economic panorama, it is necessary to review processes. Management for Quality focusing on patient safety enables hospital managers to base their decision-making process on reliable information. The Santa Casa de Misericordia de Maceió, accredited since 2009, has been implementing tools aimed at the effectiveness of its processes, with the integration of electronic systems to the deployment of managed care protocols. In this context, the values of information serve as support to patients, ensuring the sustainability of the organization, reducing mortality rate, higher bed occupancy and reduced fixed costs.

Methodology

This study reports an experience at the Santa Casa de Misericordia de Maceió in which management was result-driven and it was developed by the implementation and monitoring of quality management tools in their processes. In search of best practice focusing on results and allies patient safety, a few years ago, we used some methods of payment for performance to remunerate some clinical staff groups based on their care efficiency.

Final considerations

The management model was developed and it is evolving, it is grounded in the models of the National Accreditation Organization and the Canadian Accreditation model. Noteworthy are changes in restructuring, innovation in the pursuit of excellence through: systemic view of the organization of the institutional processes, the

establishment of care protocols, of the safety culture development and focus on results, aimed at high productivity and effectiveness.

Dácio Guimarães Borges
Currently holds the position of Administrative and Financial Director of the Santa Casa de Maceió, a company which has worked for 15 years in sectors related to financial activity/strategy, supporting decision making.

Quality and Safety Integration on Education Process

Sonia Regina Pereia
Rita Simone Lopes
Moreira, Fernanda Amaral R. Chaves

Ordinance MS / GM No. 529/2013 establishes a set of basic protocols defined by the WHO. Two issues prompted the WHO to elect these protocols: the small investment required for its implementation and the magnitude of the errors and adverse events resulting from the lack of them. Progress in health is accompanied by the rise of technology, requiring professionals working in this sector, the search for knowledge continued, so there is a balance between these in patient care.

The International WHO Patient Safety Rating aims to provide a comprehensive understanding of the field of patient safety. It aims to represent a cycle of learning and continuous improvement, enhancing the identification, prevention, detection and risk reduction; recovering the incident and resilience of the system. Learning and improving the quality should permeate the health system complexities that are connected with the various sources of information and the different fields of expertise among professionals, staff, patients and technology.

Many researchers have proposed that the strategies for patient safety should follow the models used in aviation and the nuclear power industry, believing that it will achieve the same success. However, the reality is probably more complex.

Patient safety promotion movement in health services begins to make sense when it is put into practice, i.e., it ceases to be a project or a regulation to meet the learning process steps of recommendations for managers, or to the databases of those responsible for risk management and is constituted as a change of culture that is based on the attention to the patient and his family.

Accepting the transition from craftsman mentality (my patient) by professionals in the same category is one of the barriers to be overcome by the team that provides services.

The creation of a secure system involves normalizing the activity of various professionals, so that the quality does not suffer inappropriate variations. To reach the next level of safety, health professionals must face a very difficult transition, leaving their status and self-image of being the artist who single-handedly is responsible for the outcome and, instead, adopt a position that values the equivalence between the different professionals who work in the health system. Creating a culture of safety drives professionals to be responsible for their actions through a proactive leadership, which enhances the understanding and explain the benefits, ensuring impartiality in the treatment of adverse events, without taking punishment measures against the occurrence of the same.

In a review and meta-analysis, researchers critically examined the literature to identify studies that pointed the importance of beliefs, attitudes and behaviors that are part of the safety culture in hospitals. Identified several properties, which organized in seven subcultures as described: Leadership, Teamwork, Communication, Learning from mistakes, Justice, Care patient-centered and evidence-based practice. The teaching of this content among all health professionals can be an essential key for everyone to be and feel responsible for the provision of safe care.

The inclusion of this content as required in the formation of multi-resident can promote the construction of critical professional and unison in this practice.

Sonia Regina Pereia
Residency General Coordinator in Health / Education Development Board Health / SESu / MEC, Assistant Professor / Department of Pediatric Nursing / Paulista School of Nursing / UNIFESP.

Management

Veruska Amorim Ramalheiro

The Regional Hospital of the Lower Amazon is in a very restricted area when it comes to geographical access and its population has many cultural characteristics. Implementing a health service of high efficiency based on assumptions of quality and safety of patient eventually becomes a challenge. The output for the Regional Lower Amazon Hospital found to be currently considered a center of reference and excellence in health management in their state and region was due to projects based on and written into the strategic institution planning with main focus on humanized care, implementation and support processes, people development and sustainability. The mix of these elements treated as strategic objectives and being monitored regularly resulted in an innovative and solid culture with very positive results for all patients, employees and the local community.

Within the strategic map of the Hospital, they defined specific goals that led to the establishment of targets concerning the execution of tasks, the projects were defined and all the planning took place. Currently, the Regional Hospital of the Lower Amazon can, through their innovation projects and sustainability, attain results that increase the efficiency with focus on safe care. Here are three projects with satisfactory results:

Composting and Vegetable Garden's HRBA (Sustainability): The Regional Hospital Lower Amazon (HRBA) implemented a pioneering environmental project in the region, in order to reuse the organic waste generated by the unit. Less than six months later, 25% of waste are no longer dumped in the municipal landfill to become fertilizer for the garden unit. Currently, they are growing sweet potato, caruru and macaxeira, as well as herbs such as lemongrass, fennel and mint. The Regional Hospital generates an average of four tons of organic waste. With the project of compost and garden, almost a ton is reused. To expand the planting area in the hospital, a donation campaign of seedlings and seeds will be held.

Putting yourself in patients' shoes (Customer/Humanization): The objective of the project is to improve the sensitivity of employees to provide humane care to users of the Unified Health System (SUS). For this, the receptionists and attendants were subjected to anxiety and stress, so they could feel and distress and suffering experienced daily by those who need care. After the first stage of implementation of the project, we could verify user satisfaction indicators with an increase in its results and positive projection. The program took place in three stages. The first was the choice of participants. They were told about the methodology of training and signed a term of participation, as well as guaranteed to keep secret among colleagues. In the second step, the simulations occurred in different areas of the hospital. The third stage in the auditorium of the unit. Workers told the experience to colleagues and scored what could be improved so that users feel more welcomed and receive a humanized care.

Risk Management (Patient Safety): The Regional Lower Amazon Hospital works with mapping and managing risks of all areas of the hospital, currently 55 areas are mapped by adding 134 risk managed with 1,326 control practices performed daily to minimize the likelihood of such risks. The HRBA is running its eleventh risk audit cycle occurring every six months through the internal auditing team. The compliance rate of risk management audit was an increase of 42%, this means that at the beginning of the risk management activities the Hospital had 65.5% practices

controls evaluated in full compliance, currently in its last cycle audit the hospital reached a rate of 93.21% in control practices implemented correctly, in short this means that the probability of occurrence of the mapped risks are much lower now than at the beginning of its activities; another positive impact application of this tool are the adverse event rates that decreased their recurrence through the proper management and execution of control practices, thus ensuring a safer service for users of the Hospital.

Veruska Amorim Ramalheiro
Business Administrator for the Esperança Institute of Higher Education, graduate degree in Hospital Administration by UNINTER, has extensive experience in managing production processes.

The Apthapi as Innovation Strategy in the Humanization of Healthcare Hospitality

Ramiro Narváez Fernández

The “Apthapi” is an Aymara term, it constitutes an ancestral heritage of the native peoples of western Bolivia, which means “pick of the crop” meaning “communal meal”; the concept is “TO SHARE” is a space of unity, reconciliation and reciprocity, it is a very important value that our hospital has adopted as a humanization strategy in an intercultural environment, meeting in the “taypi health” in Andean cosmogony, is the command center of a whole time-spatial, the meeting point of all parties, it is mediation, balance and convergence in the world of dualities; finally, it means convergence, complementarity and reciprocity, to resolve the contradictions, this is the hospital conceptually for us.

So it's not only building, technology, it is fundamentally "ajayu" soul, which is understood in the Andean world as the force that contains the feelings and reason, it is also treated as the center of a being who feels and thinks; it is the cosmic energy that generates and gives the movement of life. People are responsible for giving all this vitality; and therefore, by serving others, we share VALUES, PRINCIPLES, FEARS, UNCERTAINTIES, KNOWLEDGE, CULTURE AND VITAL HEALTH CONCEPT COMPREHENSIVE AND INCLUSIVE OF "SUMAQMAÑA". It is all about trying to recover our ancestral values, to serve and to the service of our patients, who come from different socioeconomic and cultural levels, and in some cases have not had the chance to grow up in a family, or have a house, as in the case of children living and working on the streets of the city of La Paz and El Alto, other indigenous peoples and peasants, historically excluded for various reasons, they have to come to our hospital for health reasons.

"Not only to try to heal, but mainly to take care and accompany" is our principle, by building trust and living the experience of our patients, we welcome, accompany and provide services, certificates and committed to quality, safety and our ancient culture and ancient. Respecting the values and dignity of patients, delivering the best we have, humanism and professionalism, teamwork, respecting rights and bioethical principles, and basically sharing "values".

Ramiro Narváez Fernández
Pediatrician; Master in Hospital Management; Professor of Graduate University of San Andres (Guest); Director General Hospital Arco Iris; President of the Bolivian Association of Hospitals; President of the Bolivian Society of Telemedicine and Medical Informatics.

The Experience of the State Hospital Sumaré / Unicamp in Management by Care

Maurício Wesley Perroud Júnior

The State Hospital Sumaré (HES), which opened in September/2000, is an institution that belongs to the State of São Paulo and is administered by the University of Campinas (Unicamp) through the Foundation for Development of Unicamp (Funcamp). The management contract between the State and the University establishes production and quality targets that are linked to the transfer of the budget defined in this contract. Due to this feature, the hospital sought to implement contemporary management models to ensure not only the fulfillment of these goals, but also to meet its mission which includes, among its main points, be recognized as a public institution of reference in quality management.

This continuous search for quality led to the adherence to the certification process of the National Accreditation Organization (ONA) in 2001. The following year, the hospital was certified as level 1 and reached the level of Accreditation with Excellence, maximum in only 5 years. All the ONA certification process was essential to establish the quality of management of foundations and training of institutional culture. The path to the methodology certification by the Canada Accreditation was a natural process, mainly due to the need for continuous efforts to improve processes that, in turn, stems from the efforts to implement the health care quality management.

The methodology certification by the Canada Accreditation was achieved in 2012. The process for implementation of this quality management model was essential for the consolidation of the care lines. The care line for management began incipient in 2007 through the implementation of the first institutional protocols. The guidelines established by the Canada Accreditation formatted the working model for the care lines and allowed the expansion and consolidation of its shares.

The hospital care lines were defined based on their epidemiological profile. Three lines have been set: mother and child, critically ill and surgical patients. For each row, a management group was formed, named 'team', which was formed by professionals from different areas of knowledge, health professionals or not, of various hierarchical levels. In each group it was possible to find doctors, nurses, administrators, engineers, physiotherapists, pharmacists, administrative assistants, among others. Each team was given the task of reviewing all flows and processes related to the care of patients seen in the type of care, and to propose and implement corrective actions to achieve optimal flows and processes. The activities were coordinated by a team leader and there was no hierarchical level within the group; Furthermore, the hierarchical relationships that existed off the team, did not apply in group activities (For an example, a medical coordinator did not have "more authority" than other team member).

This working model allowed faster identification and troubleshooting, basically because it led to the sharing of responsibilities and decentralization of decisions. Sharing responsibilities came with the multidisciplinary activities of assistance teams in assessing "problems" and in proposing "solutions" for a very simple motto: if you find a problem, it is yours. This approach stemmed decentralizing decisions. However, the latter depends on the institutional maturity, particularly concerning high-level management.

In addition to the process management related to the line, each team inherited the management of institutional protocols in their area and also had to develop new care protocols with the responsibility of promoting multidisciplinary actions.

What are the results? As an example, I cite some of which were obtained by the surgical patient team.

The initial evaluation of the flow of patients referred for elective surgery identified several points that could be improved, both in scheduling flow of new cases and returns. They also worked in management routines to reduce the waiting time for surgical procedure from the date of the first consultation (new case consultation). Corrective measures were implemented over 18 months and reached the following results: [1] the average time of the internal

queue for elective surgery has been reduced from 6 months to 2 months; [2] reduction in the number of return visits between the first consultation and surgery; in the end, it was possible to achieve the annual surgical target by reducing the number of appointments by 9,000.

The surgical team took over the management of the institutional protocol of hip fracture in the elderly and identified, based on the epidemiological profile, the need to prepare two more protocols: cholecystectomy and hernia repair. These three protocols were process indicators and results that have not changed for the actions that led to the results described in the preceding paragraph. These indicators were related to the time between admission and the procedure and the time between the rise in the operating room and hospital discharge. The discussion to find a solution to achieve the goals of these times led to the following “diagnostics”: [1] would only be possible to reach them by creating a routine for admitting the patient on the same day of surgery (secondary benefit: reducing the length of stay and increased availability of bed); [2] the outpatient surgery center, located on the ground floor, and three operating rooms, had idle time; [3] would be feasible, considering the building structure, to carry out a refurbishment of the central operating room, located on the first floor, to transfer the outpatient surgery for this sector and create an area for admission on the same day of patients who require hospitalization in the post operatively; [4] the previous item would allow to free the outpatient surgical center for a new assistance project.

These points were presented to the hospital superintendent who authorized the project. The reform of the surgical center lasted about 6 months, cost about R$ 90,000.00 and increased the number of rooms from 6 to 8. The outpatient surgeries were directed to this new structure and allowed to optimize the medical and nursing staff, as all operations were centralized in one location. There was no reduction of the surgical production, even during the refurbishment, and the monthly cost of the surgical areas was reduced by approximately R$ 45,000.00.

And what happened to the area of the former outpatient surgery center? After two years, it was renovated for the implementation of an ophthalmologic center with two offices and three operating rooms. This new unit will perform about 1,350 cataract surgeries and 140 vitrectomies, and other procedures (Such as, glaucoma, plastics) in the first year of operation, and the forecast is to double the number of procedures in the second year. That is, we have to create the ‘Ophthalmologic patient team’!

Maurício Wesley Perroud Júnior
PhD in Clinical Medicine - State University of Campinas School of Medical Sciences. Director of Assistance - State Hospital Sumaré - Unicamp. Assistant Physician of Pulmonology, School of Medical Sciences of Unicamp.

Hospital Hotel Congress

Hospital Hotel Congress

Scientific Coordination
Terezinha Covas Lisboa
FBAH - Federação Brasileira de Administradores Hospitalares
TLC Consultoria

Vice coordinator
Marcelo Boeger
FBAH - Federação Brasileira de Administradores Hospitalares
Hospitallidade Consultoria

Members
Luz Maria Loo Palomino de Li
Instituto Nacional de Enfermedades Neoplàsicas - Perú

Márcia Cristina Brandão da Silva
MHA Engenharia

Márcia Cristina Mariani
FBAH - Federação Brasileira de Administradores Hospitalares
INDSH - Instituto Nacional de Desenvolvimento Social e Humano

Marcio Gonçalves Moreira
FBAH - Federação Brasileira de Administradores Hospitalares

Maria Helena Peraccini
Brasanitas - Limpeza e Conservação/ Sociedade Brasileira de Hotelaria Hospitalar

Maria Lúcia Pontes Capelo Vides
Hospital Professor Edmundo Vasconcelos

Marina Muto
Hospital Sírio-Libanês

Paulo Roberto Mergulhão
FBAH - Federação Brasileira de Administradores Hospitalares

Walter Souza Pinto
GHS - Gerência Hospitalar em Saúde

Hospital Hotel Congress

Hospitality in Patient Perspective

Henrique Miller Balieiro

The management in healthcare has developed to respond and adjust numerous problems, among which we can highlight the rising costs, increasing access restrictions (private services) and decreased quality of services associated with increasing costs.

There is real need for professional policy of organizational development with adaptations to the requirements of a dynamic market that demands efficiency and effectiveness to customers increasingly knowledgeable about the market.

The alternatives to meet this market are in the reinvention and restructuring of strategic planning, human resources management programs, information improvement, quality programs.

Among the alternatives to improve the service, the perception of this improvement, attracting customers associated with their safety growing hotel management that is becoming an increasing share of the market as among the main customers of hospitals are patients and their companions.

In addition to the assumptions here already described as technology, resolving power and security you need an annual planning aligned with a budget with targets to be met, including the following areas: sales department (marketing and sales), governance, maintenance, administration, reception, recreation, food and drinks.

The concern of taking care of service, and not only of the patient, in its various stages may be the most noticeable characteristics of the patient and their carriers. Making it possible to get the loyalty of your customers and to attract new ones in the future.

Defining what is the value pack in your institution, which storable elements, catered meals, hygiene, non-stock elements and appreciate the cleanliness, comfort and safety are the watchwords in this new scenario.

Meeting the needs and desires that influence the expectations of patients and their companions, because they are the main drivers in search of services.

Increasing the market share of the hospital and creating in your hotel structure the concept of conflict (tradeoffs), i.e. being efficient and effective at times that are known to have waiting situations so the customer leave satisfied; for an example: check-out, bath time, room hygiene etc.

To conclude, the sale of the product diagnosis, treatment and prognosis for a good professional team of health is still and always will be the foundation of any institution of health, and this product must have to be rooted in patient safety.

The new niche market is the perception of the service. The quality, safety, technology has to be in line with a good perception, food, hygiene and also leisure during a hospital stay.

Investing in hospitality healthcare will encourage your patient to become a customer, as well as his accompanying clients, who will become your patient if they ever become a patient.

Henrique Miller Balieiro
Graduated in Medicine at the Valencia School of Medicine, Cardiologist by the Brazilian Society of Cardiology-SBC, Intensive by the Brazilian Intensive Medical Association - AMIB, Master and PhD in Cardiovascular Sciences at the Universidade Federal Fluminense-UFF.

Hospitality at the Service of Humanization

Marcelo Boeger

Hospitality is an attitude. When put in a larger sense, we can see the domestic, social and commercial matters.

In the first perspective, we have attitudes that spring from values that people have, and shape their way of acting. In this context, in the domestic sphere, particularly personal.

The second perspective is the relationship that people show to strangers. Here I would like to propose that we commonly call Humanization.

The third perspective, brings the idea of compensation as the reason for hospitality, based on service and criteria linked to the level of services.

> "The wider understanding of the hospitality suggests, first, that this is fundamentally the relationship built between host and guest. To be effective, you need to make guests feel that the host is being hospitable, by feelings of generosity, the desire to please and to see him, guest as an individual" (LASHLEY; MORRISON, 2004).

The hospitality attitudes in commercial business are characterized by being premeditated actions (trainable), linked to a number of elements, such as minimum service time parameters in each point of contact, team attitude by customers' wishes out of specification, team attitude of a complaint (within 24 hours), team attitude in the workplace, personal presentation requirements, among others in which processes with drawings and clear streams, team autonomy and clarity in the objectives of interface areas, results in huge efficiency for the customer: we announce that we are well prepared to serve them - even if to the client it feels something spontaneous – it was based on the desire of their managers – the staff has been trained extensively to achieve this level of quality.

Humanization actions occur, but via another path. How to enable a developer to be more human with his customers if it is not his natural reaction to this situation?

How to empower someone to love someone?

Obviously this happens via another path - that is via empathy and it is shown when we see actions that demonstrate that they care, that include someone - regardless of having to ask, train or stimulate. It is absolutely spontaneous. In this case, our leadership role is to raise awareness.

They should serve well, because they are paid to do so or because certain situations require greater relationship of the individual effort that is providing the service? And in health institutions, given the client's condition, virtually all situations require dealing with anxiety, fears, uncertainties, insecurities, and other very sensitive feelings.

Features are so intimate and genuine, a standard answer cannot have any legitimacy if these people are not, first, sensitized to the results of their work with respect to the direct and indirect benefits to be generated.

We need to make people aware of the reason they are acting in that activity and show them their importance in the customer service process. Otherwise, we are training them to be hypocrites. Of course they must meet well, but more than that, they should worry about the customer not only as a simple commercial exchange.

Humanization is moved by the offer; and hospitality, by demand. That is, it depends only on the employees' perception of the need to humanize. If they do not, there is not much the client can do to ask for it because, in most cases, he would not even know what to ask for or what could be done differently.

Godbout (2010) in his studies had already showed us that all hospitality attitude happens through an alternate equivalence, a requirement of reciprocity, in the case of commercial hospitality is based on compensation, but the social and domestic hospitality, only in love.

Marcelo Boeger
Holds a Master degree in Planning and Environmental and Cultural Management (2003), Master in Hospitality at Anhembi Morumbi University (2007). It is a partner and consultant at Hospitality Consulting. Coordinator and Professor of the Specialization Course in Albert Einstein Hospital Hospitality.

Hospitality and Humanization

Teresinha Covas Lisboa

The central theme of the lecture discusses a survey conducted at the end of the Post-Doctoral Program in Business Administration at Florida Christian University - FCU, in the United States, and presents a study on the skills required from managers of health organizations, in order to facilitate training and development of people in the care of patients with humanization.

The research demonstrates the entrepreneurial vision that strengthens the modern concept of leadership and management that seeks to provide conditions to integrate people and units.

As a result, the degree of motivation and commitment of employees makes a more agile and efficient organization.

The study analyzed the models of existing skills in customer service, researching the times when people are interacting with the hospital.

The research involves the following universe and sample:

a) Three hospitals located in São Paulo, where they interviewed three managers using skills such as working methods and observing the humanization as “mirror” for the establishment of a good humane care;

b) The manager of a US nursing home;

c) The management of a nursing home in the city of São Paulo;

d) The management of a Home Care company;

e) The Legal Counsel of the National Fund of Resources of the Ministry of Health of Uruguay;

f) A nurse manager of the National Fund for Resources of the Ministry of Health of Uruguay;

g) A patient (Nurse) with newly high in São Paulo

h) A consultant of Hospital Hospitality area.

The methodology used was exploratory and qualitative research, with collection of testimonials and it was concluded that the mission, vision and objectives of the institution need to be aligned with the skills required in the hiring of employees. Thus, the behavior change process becomes easier. The statement from the patient interviewed “Humanization is as important and necessary as the remedies and is only possible through these people, the set of all of them” brings us to the reflection that we need very little for decent and humane care.

The result of the research generated the book “Competências de gestores no processo de humanização em saúde”, published in 2015 by Editora Laços.

Teresinha Covas Lisboa

Doctorate in Business Administration from Mackenzie University, Master in Hospital Administration, Specialization in Didactics of Higher Education, Specialization in Hospital Administration.

Hospitals Infrastructure Trends aimed at Physical and Mental Comfort for Patients and Families

Luz Loo de Li

The challenges in recent years in relation to hospital infrastructure, immersed on the mandate of quality management of health services, seeking the satisfaction of internal users (multidisciplinary management team,

helpful, support and administrative staff) and external users (patients first, family and general users), with innovation areas, considering the environmental management, communications management, security in patient care, the demands of users in its passage through the health services are those hospitals high, medium, and low complexity or establishments of primary care, in integrated health services networks, with emphasis on the management of companionship, that gives comfort also to companions.

Undoubtedly, all under the umbrella of strengthening the management of the Humanization of care, of multiculturalism management, to offer integrative medicine to users, providing a service to the end, looking for comfort with a holistic approach, perceiving the person as a physical, mental, spiritual and energetic human being.

Health managers have the task of introducing new paradigms and being willing to accept the design for hospitals that focus on the welfare of consumers, because we are people who serve people.

Luz Loo de Li
Medical surgeon, specialist in Health Administration, Advisor to the Ministry of Health of Peru, former president of the Peruvian Federation of Health Administrators - FEPAS and International Coordinator of the Andean and Amazonian Federation of Hospitals and Health Services - Peru.

The Multidisciplinary Integration of Beds Management as a Way to Seek Effectiveness

Carolina Kitade Velloso

Currently, a major challenge for hospitals is to make their beds more efficient. Hospital administrators, based on the national scene and increased perspective on frequency and use of health services due to population aging and increasing complexity of patients due to chronic diseases, among others, are increasingly investing in the management of beds, they understood that it is not enough to create beds through the construction of buildings. Efforts are needed to optimize the existing beds, through the pursuit of excellence of hospital processes.

The performance of this team within hospitals is critical in the search for use of beds available at its maximum capacity, without representing risk to the patient or hospital, ensuring the financial health of the institution and the satisfaction of external and medical staff clients.

Thus, a study was conducted in order to understand all the processes that exert some influence on the management of beds and high patient flow, based on the results of Edmundo Vasconcelos Hospital Complex. We began the analysis by verifying all the problems faced by the bed management team, such as the waste of time in care and administrative processes, lack of communication between the teams, lack of choice to hospitalization, lack of beds for hospitalization of emergency patients, delay in hospitalization of elective surgical patients; afterwards, we reflected on how these issues had a negative relationship with the lack of efficiency of hospital beds.

All the results and times related to the flow of patient discharge were checked, detailed and measured thoroughly, in order to evaluated existing flaws and operational inefficiencies of processes, and then improvement actions were taken. We come to the conclusion that for the success of this work and improvement of hospital processes, acting in conjunction with the multidisciplinary teams is essential, because only in this way can we work together to find answers to the sustainability and effectiveness of the system, and so the hospital beds can be more efficient, meeting the need for the proposed service in the best possible way.

Carolina Kitade Velloso
Supervisory Hospital Complex Beds Management Edmundo Vasconcelos, graduated in Nursing from the United Metropolitan Colleges, postgraduate degree in Hospital Administration from Universidade Paulista. She worked for 13 years in inpatient units.

Spirituality in Hospital Focusing on Healthcare Hospitality

Luz Loo de Li

Spirituality moves people, integrates values, development, beliefs, has to do with religion, with faith, transcendence; and in health it becomes more important for the reason of being of the health professions, since it deals with people and manages human suffering; which it is why people come to seek care in health institutions by the altruistic work that develops among people who care for others.

Since 1948, WHO places that "health is a state of complete physical, mental, social harmony and environmental well-being and not merely the absence of disease or infirmity." (Preamble to the Constitution of WHO, 1948), this definition marks the challenge of looking beyond technical skills to provide care that would achieve health in people, considering that health is integral, and that in recent years there is a worldwide tendency to strengthen health management Humanization.

Spirituality is related to personal growth and development, positive mental health in which prevails hope, reflection, meditation, acceptance, ongoing struggle with energy and strength to overcome difficulties, to avoid being a victim and see interventions in a pessimistic manner, to learn that the human being is the one who motivates his health, that he is able to grow and develop with each experience and that diseases are often expressions of an imbalance in the soul, the feelings, the perception of feeling valued, loved, to assume responsibilities that go beyond the capabilities that one has.

In the management of hospital hospitality, one of the goals is to make the person feel a pleasant atmosphere, as if he were at home, with standards of multiculturalism, providing service to achieve customer satisfaction, considering the external user (patient, family) and internal user (multidisciplinary health team), spirituality, love, warmth in dealing contribute to the recovery of the person and his mental health.

Understanding who is in front of you is to be open, to understand the world view and to work together to get healthy, have balance... a challenge for managers in health, for professionals and health workers.

Make way for meditation spaces, to be in peace with oneself, feeling happy, management beliefs, quality of life, palliative care, management of good death, to fully see the person contributes to the health objectives for the person and the health team.

New paradigms and humility to continue learning, unlearning and relearning.

Luz Loo de Li

Medical surgeon, specialist in Health Administration, Advisor to the Ministry of Health of Peru, former president of the Peruvian Federation of Health Administrators - FEPAS and International Coordinator of the Andean and Amazonian Federation of Hospitals and Health Services - Peru.

IPH

INSTITUTO DE
PESQUISAS
HOSPITALARES
ARQUITETO
JARBAS KARMAN