HOSPITAL MANAGER MANUAL

VOLUME 3

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VOLUME 3

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HOSPITAL MANAGER MANUAL

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Brasília
Federação Brasileira de Hospitais – FBH
2021

Printing: 2.000 copies

Information and elaboration:
Brazilian Hospital Federation - FBH
SRTVS Qd. 701 – Conjunto E, n. 130 – 5º andar
Edifício Palácio do Rádio I, Torre III
Brasília/DF
ZIP CODE 70.340-901

Graphic Design and Layout: Viva Comunicação Group
Textual Review: Amanda Vasconcelos
Bibliographic standardization and catalog: Thaís Marques CRB/1-1922 Produced in Brazil

International Cataloging Data in Publication – CIP

P936m

Prestes, Andréa.
Manual do gestor hospitalar / Organizadores: Andréa Prestes, José Antônio Ferreira Cirino, Rosana de Sousa Oliveira Barbosa; Viviã de Sousa. – Brasília: Federação Brasileira de Hospitais, 2021 .
167 p. : fots. ; 21 x 29,7 cm (v. 2)

ISBN 978-65-88821-00-8
Inclui referências bibliográficas.

1. Saúde, Brasil. 2. Manual, Saúde. 3. Hospital, Gestão. 4. Gestão hospitalar, Brasil. 5. Gestor hospitalar. 6. Setor de saúde, qualificação. 7. Gestão, qualificação. I. José Antônio Ferreira Cirino. II. Viviã de Sousa. III. Rosana de Sousa Oliveira Barbosa. VI. Título.

CDD – 658

ASSOCIATIONS

AHCES – Association of Hospitals, Clinics, and Health Service Providers of Espírito Santo

AHCSEP – Association of Hospitals and Health Homes of the State of Pará

AHEAL – Association of Hospitals of the State of Alagoas

AHECE – Association of Hospitals of the State of Ceará

AHEG – Association of Hospitals of the State of Goiás

AHERJ – Association of Hospitals of the State of Rio de Janeiro

AHESC – Association of Hospitals of the State of Santa Catarina

AHESP – Association of Hospitals of the State of São Paulo

AHMG – Association of Hospitals of Minas Gerais

AHOPAR – Paraná State Hospitals Association

AHORN – Association of Hospitals of the State of Rio Grande do Norte

AHRGS – Association of Hospitals and Health Establishments of Rio Grande do Sul

AHSEB – Association of Hospitals and Health Services of the State of Bahia

ANH – Northeastern Hospitals Association

APH – Paraiba Hospitals Association

SUMMARY

SUMMARY

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Ronald Lavater

- Ronald Lavater is Executive Director of the International Hospital Federation, with 25 years of leadership experience in public, investor-owned, and public healthcare companies in the US and international markets.
- Before joining IHF, he served as CEO of Well Street Urgent Care based in Atlanta, Georgia. From 2014 to 2016, he was the CEO of Al Noor Hospitals Group, Plc. He also worked for six years for John's Hopkins Medicine International, serving first as CEO of Corniche Hospital in Abu Dhabi for five years and then as a senior executive representing many of the company's interests in the Middle East. Ronald began his healthcare career in 1993 as a senior management analyst for the insurance company Blue Cross and Blue Shield. After a few years, he was recruited by the Hospital Corporation of America, where he held various leadership positions in US hospitals, including CEO and COO. He also served as the Non-Executive Director of Optegra Eye Health Care.
- Ronald holds a bachelor's degree in political science from the University of Florida and a master's degree in public administration from Florida State University. He is a fellow of the American College of Healthcare Executives (ACHE) and previously completed a two-year term as president of the ACHE Middle East and North Africa group.

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PRESIDENT

WORD FROM THE PRESIDENT

Adelvânio Francisco Morato

President of FBH

WORD FROM THE PRESIDENT

We ended 2021 with the publication of this great work which, like the two previous editions, consolidates the commitment of the Brazilian Hospital Federation (FBH) to effectively contribute to the development of the sector and the improvement of care provided to the Brazilian population.

All this effort is the result of the work that started a little over three years ago when we outlined the ambitious goal of carrying out a broad qualification process, which would allow us to bring knowledge and practical solutions to the management of the most distant hospitals in this country. The goal was to overcome the heterogeneous scenario with which the Brazilian hospital network is configured, and offer these managers, who face the most diverse difficulties, greater training support so that they could improve the management of the establishments they manage.

Today, as the "Scenario of Hospitals in Brazil 2020" points out, approximately 70% of all establishments in the country are made up of small and medium-sized hospitals, that is, with up to 100 beds. Seven out of 10 hospitals are located outside major urban centers. Many of these hospitals, depending on the municipality where they are located, are the only medium and high complexity care option for the entire population of the region.

We realized that providing these hospital managers with information and knowledge that would help them in their daily activities would be the best way to contribute to this much-needed transformation process.

The first two editions of the Hospital Manager's Manual were very well accepted and evaluated by professionals working in the area. The success of the publications led us to translate the editions into English and, thus, present them, too, to institutional leaders around the world, during the congresses held by the International Hospital Federation (IHF).

The publication of this third edition of the Hospital Manager's Manual crowns the continuous effort of the Brazilian Hospital Federation (FBH) to contribute to the qualification of managers and decision makers, who are at the forefront of the most diverse and essential health services offered to the population. It also reinforces, it is important to highlight, FBH's tireless performance in the search for solutions to the main problems that affect the sector as a whole.

Over the past two years, we have been challenged by one of the greatest health crises that humanity is aware of. The human capacity to adapt, to reinvent itself and seek to overcome were our main weapons to win this war against an unknown enemy. This resilience, so characteristic of those who work in an area that deals with people's pain, anxieties and hopes daily, proved to be even stronger, making it clear how much it is necessary, much more than technology, to have highly skilled professionals and trained and prepared technicians to deal with any type of adversity.

For FBH, the promotion of professional qualification has been the main development vector for the Brazilian hospital sector. This position is also reflected in the leading role of the entity, which, over the last decade, has stood out in the dissemination of knowledge to professionals working in the sector on different fronts.

Working for the improvement of the Brazilian hospital network has always been an imperative mission for FBH and we believe that this work makes another great contribution to the preparation and qualification of our managers. On behalf of all our associates and the entire body of professionals who provide hospital care, I want to thank the participation of each employee, who made it possible to make this construction a piece of knowledge and an update tool for this class of professionals, so essential to the health sector's evolution.

PREFACE

Ronald Lavater

Chief Executive Office (CEO)
International Hospital
Federation (IHF)

PREFACE

This third edition of the *Hospital Manager's Manual* is a clear demonstration of the commitment of the Brazilian Hospitals Federation (FBH) towards knowledge exchange, the sharing of strategic content and the development of critical thinking as vectors to improve the provision of healthcare.

As part of this approach, the FBH became a member of the International Hospital Federation (IHF) in 2018. The FBH's active and valued contribution to the IHF includes leadership in its governance. Dr Adelvânio Morato, President of the FBH, was elected to serve on the IHF Governing Council in November 2020. In fact, the IHF has a long history of collaboration with Brazilian hospitals and healthcare. Rio de Janeiro was chosen as the host city of the World Hospital Congress in 2009.

The IHF is the non-governmental organization (NGO) that has been the voice of international healthcare for more than 90 years, promoting excellent management standards among hospitals and health service organizations. The IHF has representation from over 125 different organizations, and, through them, is connected to over 20,000 hospitals and healthcare organizations across the globe.

The IHF is a place for global knowledge exchange and collaboration. Whether acting bilaterally or as part of large networks in the international Geneva ecosystem, the IHF works in partnership with other stakeholders to ensure its members' voice is heard by the international healthcare community.

The IHF's vision is a world of healthy communities served by well-managed hospitals and health services where all individuals reach their highest potential for health. Excellence in leadership is the thread connecting all of its activities and services.

The world has faced significant challenges in the past two years due to the COVID-19 pandemic, much of the burden being faced by hospitals and healthcare workers. These difficulties at local and regional level became a shared experience across the world. In tackling this collective crisis, international collaboration and the sharing of good leadership practices has been crucial to shape the response.

Hospitals have innovated and transformed their service delivery at rapid speed. Changes that were slowly evolving were suddenly required at the forefront of care, such as telemedicine. As the world moves on to the recovery and rebuilding of a post-pandemic landscape, it is the role of hospital leaders to take forward the lessons and become increasingly agile. The IHF's members have sharpened their focus on preparing for future needs of the healthcare sector.

Supporting the needs of its members, the IHF's core activities focus on thematic areas to deliver valuable services around the most important issues facing hospitals right now. The current special interest groups (SIGs) managed by the IHF are centred around telehealth, big data and leadership for sustainability. These are key areas that hospital leaders around the world will need to engage with to deliver the services to meet the needs of their communities.

The FBH recognizes the importance of these initiatives, indeed telehealth forms the basis for Chapter 3 of this Manual, with digital leadership covered in Chapter 7. This connectivity between national and international knowledge exchange and capacity building is the vital pathway towards hospital leaders taking local actions to build a responsive workforce and a sustainable future in the healthcare sector.

Whilst sustainability is not covered in this edition of the *Manual*, the IHF is taking steps to deliver valuable resources for its members on addressing climate change. Healthcare leaders and patients share the goal to make reducing climate impact a priority. However, this is a long-term challenge for the healthcare sector that will likely require multi-year commitments and the transformation of almost every aspect of how hospitals operate.

In 2022, the IHF will launch the Geneva Centre of Healthcare Leadership for Sustainability. The Centre's global reach and impact will build awareness and promote action among healthcare leaders and provide capacity building to anchor leadership for sustainability into the healthcare sector for the long-term. The IHF looks forward to engaging with the FBH at the Centre.

The FBH plays an active role in the IHF's annual flagship event, the World Hospital Congress, which brings together leaders and decision-makers of hospitals, health services and healthcare organizations from across the globe. In 2021, the Brazilian delegation to the 44th Congress in Barcelona was led by Dr Adelvânio Morato. He was accompanied by the Secretary General of FBH, Luiz Aramicy Bezerra Pinto, and the superintendent of the institution, Luiz Fernando Silva. As well as performing his duties on the IHF Governing Council, Dr Morato and the Brazilian delegates participated in the Congress' sessions and networking events around the theme "People on board: Transforming healthcare by blending agility, responsiveness, and resilience".

The programme for the 45th World Hospital Congress in Dubai (9–11 November 2022) will be designed around the theme "Global learnings; Local actions: Sustainable healthcare". The IHF looks forward to welcoming the FBH delegation to this event and to embarking on many impactful future collaborations together.

On behalf of the IHF, I would like to congratulate the FBH on the publication of this third edition of the *Hospital Manager's Manual*, a commendable initiative to share expertise, promote excellence, and enable the improvement of service delivery to patients and users of hospitals across Brazil. This publication captures the spirit of the IHF's vision and will be a valuable resource for the hospital sector in Brazil.

Ronald Lavater
Chief Executive Officer
International Hospital Federation

INTRODUCTION

INTRODUCTION

Dr. Paulo Borem

Senior Director of IHI

TRANSFORMING HEALTH CARE BY/FOR PEOPLE

The Institute for Healthcare Improvement (IHI) contributes with the Hospital Manager's Manual – volume 3 of the Brazilian Hospital Federation (FBH) structuring the presentation of this important work for the health sector with the triple objective of IHI, with a focus on improving hospital management.

The chapters that make up this compendium are fundamental to help in the search for people-centered health, improving the health of the population and individuals, reducing waste and per capita cost, and improving the care experience, for those who care and for those who are cared for, main focuses of the triple objective.

IHI is a leading innovator in healthcare improvement worldwide, independent and non-profit. Headquartered in Boston, Massachusetts, with a team of 220 people around the world, the institute mobilizes teams, organizations and nations to imagine and achieve a better future of health and health care.

The values of IHI are love, trust, fairness and courage. Our mission is to improve health and healthcare around the world. Our vision is for everyone to have the best health care possible.

With the publication of *Errar é Humano* and Crossing the Abyss of Quality, a better definition of "quality" became imperative. The Institute of Medicine then defined the 6 dimensions of quality: timely, equitable, efficient, effective, people-centered and safe care. Nolan, John Whittington and Don Berwick in 2006 went one step further and introduced the Triple Purpose concept to the healthcare system. And what is the Triple Objective after all? The Triple Objective in a way proposes a redesign of the health system. It serves as a compass. It is expected that health organizations can improve these 3 dimensions simultaneously.

Figure 1 – Triple IHI Objective

Source: Institute for Healthcare Improvement (IHI)

One of the main ways to achieve major advances in quality and patient safety is through "collaborative learning" using an innovative model that IHI created in 1995 called "Collaboration for Great Breakthroughs" or simply "Collaborative". The collaborative is a very effective/efficient method to achieve the triple IHI objective.

The driving vision behind Collaboratives is this: there is solid science in which costs and outcomes of current healthcare practices can be improved, but much of that science is not being used in daily work. There is a gap between what we know and what we do.

It consists of a variable-term learning system (12 to 36 months), which brings together a large number of teams from organizations to seek improvements in a focused thematic area.

In Brazil, IHI has partnered with several public and private sector organizations for the development of Collaboratives.

Collaborative Theme	Environment	Duration	Result
Sepsis mortality reduction	12 emergency rooms including 10 public hospitals	24 months	54% reduction
PAV, ITU-AC and IPCSL reduction	12 emergency rooms including 10 public hospitals	36 months	71% reduction
PAV, ITU-AC and IPCSL reduction	114 SUS ICUs	36 months	54% reduction
Increased percentage of vaginal births as a positive and safe experience - Appropriate Childbirth I	28 public and private hospitals	24 months	Increase from 22% to ≈ 40% vaginal births
Increased percentage of vaginal births as a positive and safe experience - Appropriate Childbirth II	150 public and private hospitals	24 months	Increase from 30% to ≈ 40% pregnant women classified as Robson 1-4

Collaborative Theme	Environment	Duration	Result
Improving maternal and child care Adequate Delivery III	30 dyads (operator-hospital) private sector	12 months	still in progress
Reduction of in-hospital maternal mortality	19 public hospitals	24 months	Reduction of 36% in-hospital mortality from all causes, 70% hemorrhage mortality and 74% sepsis
Work with Joy	17 public hospitals	12 months	still in progress > 200 changes implemented
Quality improvement in Primary Health Care in the private sector	20 dyads (APS unit + operator)	36 months	Started in late 2021. Still in progress
Early identification and treatment of maternal and partner syphilis	9 SUS primary care units	12 months	still in progress

Table 1. Collaboratives completed and in progress in Brazil

Source: Institute for Healthcare Improvement (IHI)

The "Collaborative" was conceived in late 1994, when one of IHI's founders, Paul Batalden, MD, sketched the model on a napkin at an IHI Group Practices Improvement Network meeting and turned it over to the IHI CEO, Don Berwick, MD. Batalden and Berwick sought ways to accelerate improvement in health care using more practical educational approaches compared to traditional methods (classroom and theoretical training) by providing a framework for learning the improvement model and theory of change (the topic of Collaborative) – theory in Learning Sessions (LS) and practice – Periods of Action (PA) (periods of action interspersed with theoretical sessions when organizations would make real changes at the system level that would lead to dramatic improvements in care (tests of small-scale changes using PDSA)

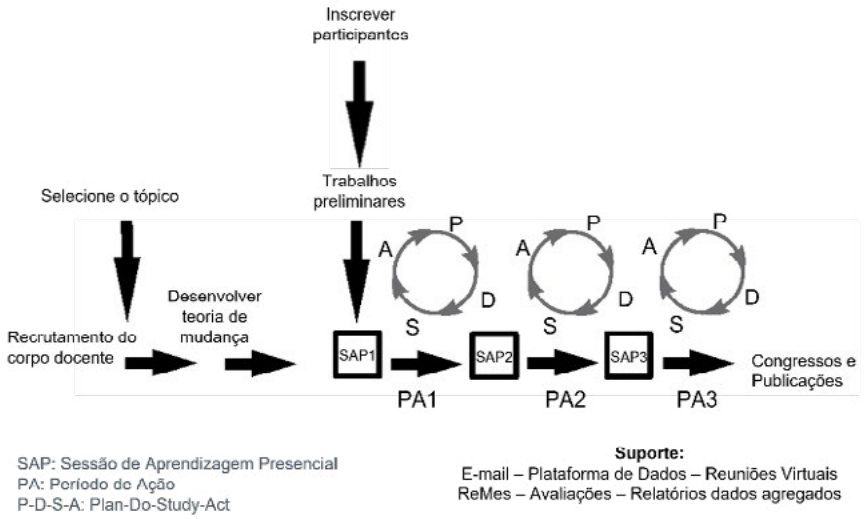

Figure 2. Innovative series model (Collaborative)

Source: Institute for Healthcare Improvement (IHI)

Topic Selection: area or problem of health care that is ripe for improvement, there is solid knowledge and there is a gap between evidence and practice. Always include the equity theme.

Faculty Recruitment: physicians/nurses and other health professionals who have demonstrated innovative performance in their own practice. An Improvement Specialist teaches and trains teams on improvement methods and how to apply them in designated locations.

Registration of Participating Organizations and Teams: We always recommend that the application process be voluntary and that there is a strong will from leaders in the organization to improve.

Learning Sessions – typically three: Learning Sessions bring together multidisciplinary teams from each organization and specialized faculty to exchange ideas, gain knowledge about the topic and about the improvement model II.

Periods of action (PAs): During the PAs between the learning sessions, teams test and implement changes and collect data to measure the impact of changes and receive feedback from faculty.

The Improvement Model: To apply changes to selected locations, participants learn the Improvement Model. This model was developed by Associates in Process Improvement (The Improvement Guide, Jossey-Bass, 1996) – Improvement Model.

Figure 3. The Improvement Model

Source: Associates in Process Improvement (The Improvement Guide, Jossey-Bass, 1996

The Improvement Model requires Collaborative teams to ask and answer three questions:

- *What are we trying to accomplish?* (Objective): Here, participants determine what specific outcomes they are trying to change with their work.
- *How will we know if a change is an improvement?* (Indicators): Here, participants identify appropriate metrics to track their success.

» *What changes can we make that will result in improvements?* (Changes): Here, teams identify the key changes they will actually test.

Based on this elucidation of the IHI Triple Objective, the Collaboratives' execution structure and the improvement model, we hope that the hospitals that make up the FBH and other health units can be inspired to seek safe, timely, efficient care, effective and equitable, a theme that is also discussed in the chapters of the Hospital Manager's Manual.

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Chapter 1
CLINICAL GOVERNANCE

Tania M. G. Pedrosa and Renato C. Couto

CLINICAL GOVERNANCE

Tania M. G. Pedrosa and Renato C. Couto

Goals

- Present clinical governance for delivering value in healthcare;
- Support the concepts and operationalization of clinical governance;
- Integrate the discussion of clinical governance with corporate governance.

What is clinical governance?

The term "clinical governance" was introduced by the British government through its National Health System, the NHS, in the late 1990s. The word governance was imported from the corporate world, which defined corporate governance as a system by which companies protected shareholder investments and minimized the risk of fraud and malpractice.[1]

The NHS was formed in 1948 and for most of its first 40 years it worked with an implicit notion of quality based on the philosophy that providing well-trained staff, good facilities and equipment were synonymous with high standards.[2,3]

In 1997, clinical governance was first mentioned in the NHS Health Whitepaper as a strategy to modernize and improve the quality of the system, following a series of serious failures in performing pediatric cardiac surgery at a Bristol hospital, which determined the death of dozens of children (30 to 35 patients) between the years 1980-1990 and permanent severe sequelae in many others.[4]

These events became public and caused intense national commotion, leading to a significant mobilization of the population, which started to demand more transparency and government intervention to guarantee security in assistance.

The final report made it clear that the failures at the Bristol hospital were a consequence "[that] not only [...] the NHS did not have a system to monitor quality or reliable data, but also that there was no agreement on what constituted the quality".[5] The faults were not just the surgeons. The

[1] MCSHERRY, R.; PEARCE, P.; TINGLE, J. **Clinical governance**: a guide to implementation for healthcare professionals. 2nd ed. Chichester: Wiley-Blackwell, 2007.

[2] *Ibidem*.

[3] HONE, T. The future of universal health systems: how Brazil's Unified Health System can learn from the UK's National Health Service (NHS)? *In*: BARROS, F. P. C. (Coord.). **CONASS Debate**: *o futuro dos sistemas universais de saúde*. Brasília: CONASS, 2018.

[4] SMITH, R. One Bristol, but there could have been many. **BMJ**, v. 28, n. 323, p. 179-180, 2001.

[5] *Ibidem*.

analysis of 80 cases, carried out by the investigators, showed inadequacies at all points, from referral to diagnosis, surgery, to intensive care.[6]

At the height of the 1990s, the NHS was seen by UK society as "bureaucratic and financialist", guided by financial and production goals, with the resulting deterioration in the quality of healthcare provision.[7]

The concept of clinical governance came to be enshrined in the 1998 government document "A first class service: quality in the new NHS", being defined as:

> A framework within which NHS organizations are responsible for continuously improving the quality of their services, as well as safeguarding high quality standards, by creating an environment in which clinical excellence will develop.[8]

This was the NHS's innovative way of rethinking healthcare organizations and the participation of their professionals in the management of the healthcare system.

Concept of Clinical Governance and its Pillars

Within the scope of the new models of healthcare organization, clinical governance is the process through which healthcare organizations are responsible for the continuous improvement of the quality of their services and for ensuring high standards of care, creating an environment that encourages the excellence of care.[9]

It is a robust structure of process interactions that emphasizes the importance of adopting a culture of sharing responsibilities across the health care network to sustain and improve the quality of services and care outcomes. It is to instill trust in both the population and health professionals, delivering a safe care environment.[10]

The key components of clinical governance are described in Figure 1.

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[6] *Ibidem*.

[7] UNITED KINGDOM. Department of Health. **Learning from Bristol**: The Department Health's response to the report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. London: Secretary of State of Health, 2002. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/273320/5363.pdf. Access in: November 15. 2021.

[8] UNITED KINGDOM. Department of Health. A first class service: quality in the new NHS. **National Archives**, 1st July 1998. Available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20110322225724/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006902. Access in: November 15. 2021.

[9] SCALLY, G.; DONALDSON, L. J. The NHS's 50 anniversary. Clinical governance and the drive for quality improvement in the new NHS in England. **BMJ**, v. 4, n. 317, p. 61-65, 1998.

[10] McSherry, Pearce e Tingle (2007).

Figure 1 – Key components of clinical governance

Source: prepared by the IAG Saúde Group based on McSherry, Pearce and Tingle (2007).

In the figure, the term "accountability" appears. There is no single term in Portuguese that defines the word accountability, and it is necessary to work with a composite form. The meaning of the concept involves responsibility (objective and subjective), control, transparency, accountability, justifications for actions that were or have not been taken, awards and/or punishment.[11]

For clinical governance to function effectively, the key components must be clear and operational. Clinical quality and continuous improvement in the healthcare chain will only be achieved in a culture and environment that supports, values and develops the human capital. Likewise, each healthcare professional must continually develop their skills and standards by strengthening roles and responsibilities within the system.[12]

In 2010, the Portuguese Association of General Practitioners (APMCG) held a workshop on the theme "Clinical and Health Governance", during which an octagon-shaped diagram was drawn up that further details the key components of governance clinic (figure 2):[13]

[11] PINHO, J. A. G.; SACRAMENTO, A. R. S. Accountability: *já podemos traduzi-la para o português?* ***Revista de Administração Pública***, v. 43, n. 6, p. 1343-1368, 2009. Available at: https://doi.org/10.1590/S0034-76122009000600006. Access in: November 14. 2021.

[12] McSherry, Pearce e Tingle (2007); Scally e Donaldson (1998).

[13] PORTUGAL. *Ministério da Saúde. Governação clínica e de saúde em cuidados de saúde primários: o que é? Para que serve? Como fazer? Lisboa: Ministério da Saúde, 2011*. Available at: https://livrozilla.com/doc/1050419/governa%C3%A7%C3%A3o-cl%C3%ADnica-e-de-sa%C3%BAde-em-cuidados-de-sa%C3%BAde. Access in: November 14. 2021.

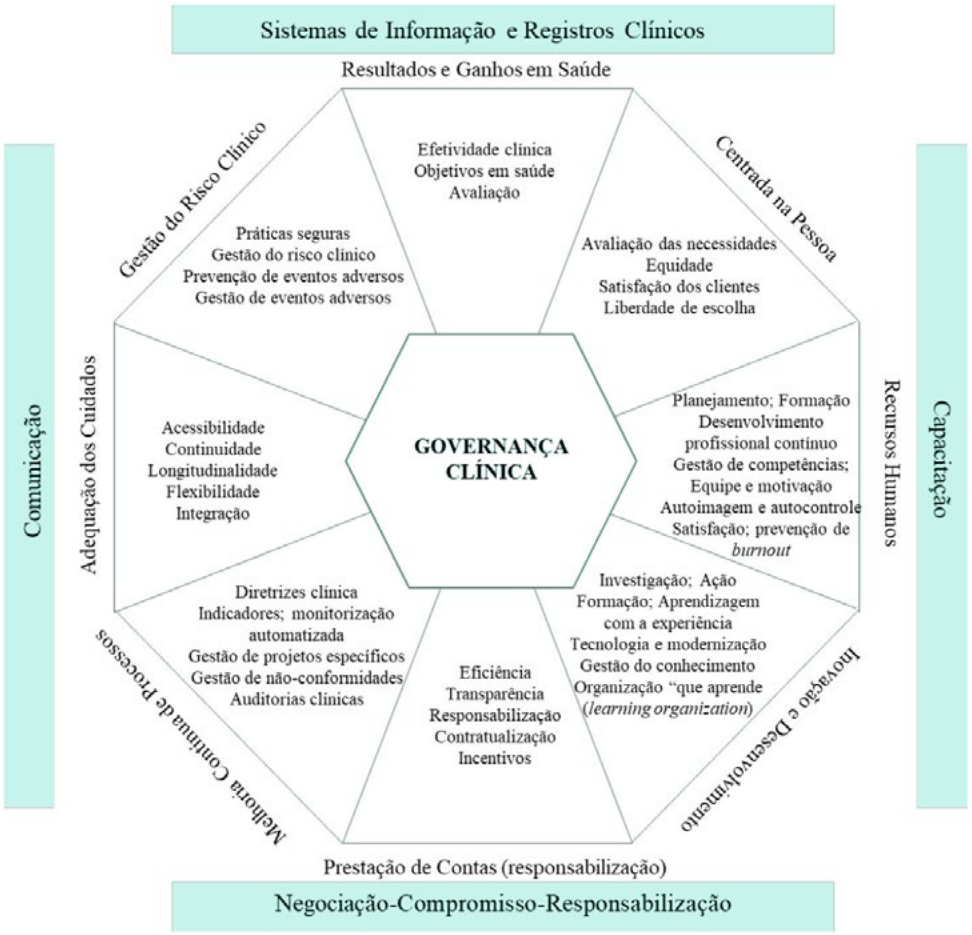

Figure 2 – Diagram of the key components of clinical governance

Source: prepared by the IAG Health Group based on APMCG (2010).

There are several "structures" or "pillars" of clinical governance, but they all focus ultimately on providing safe, effective, and person-centered care for **each** patient, **at all times**.:[14]

1. Health outcomes and gains (clinical effectiveness and other health determinants);
2. Patient centrality (system organized based on the patients' needs);
3. Human resource management (continuous professional development and engagement);
4. Innovation and development ("learning organization");
5. Transparency with accountability;
6. Continuous improvement (strongly supported by clinical audits and monitoring);
7. Adequacy of care (access; integrated and continuous care);
8. Clinical risk management (safe practices).

[14] MACFARLANE, A. J. R. What is clinical governance? **BJA Educ**., v. 19, n. 6, p. 174-175, 2019.

For healthcare professionals, clinical governance is an approach aimed at delivering value, based on the principles of ownership, teamwork, leadership, communication and systemic awareness:[15]

- **Ownership**: it refers to the active participation of health professionals in the design and execution of care. As such, healthcare professionals share the responsibility for quality improvement. The appropriation and solution of problems by health professionals requires a work environment that allows creativity and freedom to express opinions;
- **Teamwork**: refers to collaboration between health professionals. Contributes to high quality patient care through mutual learning and increasing knowledge and skills in a team;
- **Leadership**: to support teamwork and create a supportive work environment, leadership is essential;
- **Communication**: Quality improves when leaders encourage communication about quality health care outcomes. Communicating information about the patient clearly and completely to everyone involved in the provision of services is essential, for example, during the transition of care. Furthermore, effective communication contributes to a collective vision shared by all members of the organization. Communication is essential for establishing the correct diagnosis and involving patients in developing a treatment plan that meets their needs;
- **Systemic awareness**: guilt-free sharing of unfavorable experiences (when something goes wrong or nearly wrong: nearly missed, incidents with or without harm) helps healthcare professionals learn from mistakes and become more aware. This awareness is also known as systems awareness: it means recognizing that health processes are interrelated and the process in which one is working can contribute to errors in others due to the lack of alignment between them. This awareness leads to a reassessment of processes with risk reduction.

We can identify the similarity of purpose between the pillars of clinical governance and the principles of the US Institute of Medicine (IOM, now called the National Academy of Medicine) for a quality healthcare system. IOM Principles:[16]

- Safety: prevent assistance, which is intended to help patients, from causing harm;
- Efficiency: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those who will not benefit;
- Patient centrality: clinical decisions must respect and be guided by the patient's preferences, needs and values;
- Access: reduction of waits and delays, sometimes harmful, for both those who receive and those who provide the care;
- Efficiency: rational use of resources, avoiding waste of equipment, materials, ideas and energy;
- Equitable: the quality of care cannot vary with the patient's personal characteristics, such as gender, ethnicity, religion, socioeconomic level, marital status, etc.

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[15] VEENSTRA, G. L. *et al*. Rethinking clinical governance: healthcare professionals' views: a Delphi study. **BMJ Open,** n. 7, 2017.

[16] IOM – INSTITUTE OF MEDICINE. **Crossing the quality chasm**: a new health system for the 21st Century. Washington: The National Academies Press, 2001. Available at: https://iom.nationalacademies.org/~/media/Files/Report20Files/2001/Crossíng-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf. Access in: May 1st. 2016.

The conditions to achieve this quality healthcare system are:[17]

- Patient care must be continuous, and, for this, there must be an integration of processes and information;
- Assistance must be personalized, meeting the patient's needs and values;
- The patient must make the decisions about his treatment. Opportunities and information for free choice must be given;
- Knowledge must be shared and information must flow freely. Patients must have unrestricted access to their own medical information and scientific knowledge. Doctors and patients must share information and communicate effectively;
- Care decisions must be based on scientific evidence. Patients should receive treatment based on the best scientific knowledge available. Assistance must not vary from doctor to doctor or place to place;
- Security is a system priority. Patients must be protected from the preventable adverse events of care by systems designed for this purpose;
- Transparency: patients and families must have available information that allows them to freely and consciously choose the health plan, hospital and treatment. Information should include care performance with a focus on safety, available treatments based on scientific evidence and user satisfaction with the services provided;
- Anticipating patient needs rather than simply responding to requests;
- Reduce wasted resources and time for patients;
- Care coordination must be achieved through active cooperation (integration of processes and information) between physicians and institutions.

Clinical governance, clinical management and clinical practice: are there differences?

Gomes et al. (2015) brought to light the difficulties of standardizing concepts in an interesting study that sought to explore polysemy – that is, the multiplicity of meanings of a word or phrase – within the context of clinical governance.

They concluded that the variation in meanings is related to the way in which the authors of the studies reviewed express or unfold the structuring conceptual components that are widely accepted as clinical governance.[18] In this way, let's adopt the meaning given by Brennan and Flynn.[19]

- **Clinical governance:** structures, systems and standards that apply to create a culture of governance to direct and control clinical activities. Accountability is part of a subset of

[17] COUTO, R. C. *et al*. Proposing national priorities. *In*: *ANUÁRIO DA SEGURANÇA ASSISTENCIAL HOSPITALAR NO BRASIL*, 2., 2018, Belo Horizonte. **Anais** [...]. Belo Horizonte: IESS, 2018. Available at: https://iess.org.br/cms/rep/Anuario2018.pdf. Access in: December 11. 2021.

[18] Gomes et al. (2015).

[19] Brennan and Flynn (2013).

clinical governance and involves monitoring and oversight of activities, including regulation, auditing, assurance and compliance by managers (such as boards of directors, senior management), regulators (such as governments and professional bodies), internal and external auditors;

» **Clinical management:** processes and procedures conducted by managers, including clinical staff resources, to provide safe, high-quality, efficient and systematic clinical care;

» **Clinical practice:** medical procedures performed with high quality, generating safe care in accordance with clinical policies and standards and serving the interests of patients.

Figure 3 illustrates the interrelationship of these concepts:

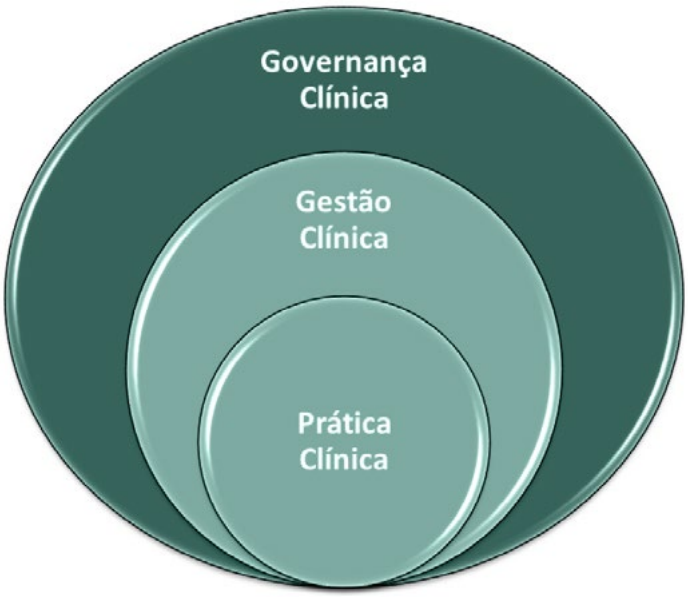

Figure 3 – Clinical governance, clinical management and clinical practice

Source: prepared by the IAG Saúde Group based on Brennan and Flynn (2013).

But what are the steps to implement clinical governance?

The provision of health care is an extremely complex, multidimensional and multimodal process, with rapidly changing guidelines and technologies, as well as the expectations and needs of patients and society.

It is always worth mentioning the example of the Covid-19 pandemic. The unprecedented challenges presented by the first wave of the coronavirus found global health communities unprepared. This lack of preparation revealed very deep fractures between the reality of health systems and the needs of the population and health professionals.[20]

[20] FAVI, E. *et al*. Salus Populi Suprema Lex: considerations on the Initial Response of the United Kingdom to the SARS-CoV-2 Pandemic. **Front Public Health**, n. 9, 2021.

Health service organizations, such as hospitals, are embedded in intricate networks of different types of services at the primary, secondary and tertiary care levels. Patients move between these services and levels, with safety and quality risks at every point on this journey.

Although the safety and quality of healthcare provided to each patient is highly dependent on the skills and performance of each physician, ensuring a system that delivers value in healthcare is recognized as an individual and collective role and responsibility of all links: patients, health professionals, managers and directors of organizations providing health services, funders, government agencies and their health departments.[21]

Delivering value in healthcare depends on effective governance processes and the establishment of systems involving many stakeholders across different healthcare delivery organizations and across the healthcare system.

The most common barriers to the implementation of clinical governance are associated with culture, management, leadership, communication, education and training, knowledge and support by stakeholders.[22] And strategies must be developed to overcome them.

Integration with corporate governance

it is critical for success that clinical governance is an intrinsic dimension of organizational governance.

Clinical governance should be a component of the corporate governance of healthcare organizations. It ensures that everyone – from front-line physicians to senior management and members of government agencies and boards of directors – is accountable to patients and the community for ensuring the provision of safe, effective, integrated, timely and high quality health services.

This integration ensures better management of installed capacity and continuous improvement of care quality, with a horizontal model focused on quality and patients, with a high degree of participation of professionals in strategic and operational decisions, and with public demonstration of the results obtained (figure 4):[23]

[21] AUSTRALIA. Australian Commission on Safety and Quality in Health Care. Clinical Governance. **National Model Clinical Governance Framework**, 2021. Available at: https://www.safetyandquality.gov.au/topic/national-model-clinical-governance-framework. Access in: November 20. 2021.

[22] Brennan and Flynn (2013).

[23] Rodrigues and Felício (2017).

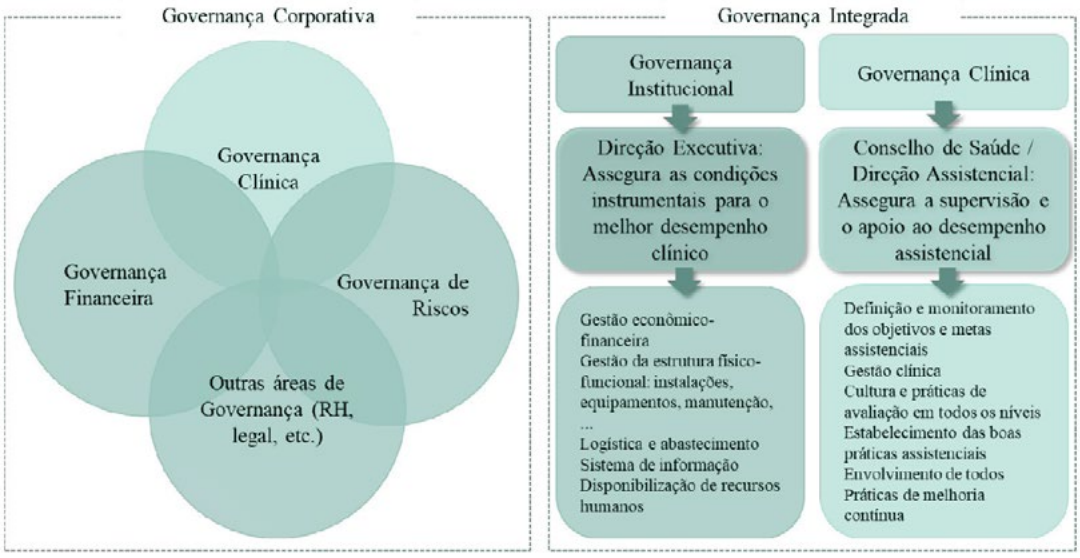

Figure 4 – Clinical governance as an integrated component of corporate governance

Source: prepared by the IAG Saúde Group based on Rodrigues and Felício (2017).

Corporate governance is the responsibility of the top management of organizations, their boards of directors and members of government bodies. It encompasses the establishment of systems and processes that shape, sustain and oversee the management of a business. It has the inalienable role of disseminating, throughout the organization, that the promotion of best care practices constitutes one of the main, if not the main, motors for economic efficiency, through the increase of clinical effectiveness.[24]

From vision to reality: fundamentals for implementing clinical governance

Implementing clinical governance includes new approaches to leadership, strategic healthcare planning, patient engagement, information and analytics, staff management, and process management. There is no single way to develop each of these areas, but certain basic organizational attributes are essential for a successful implementation.[25] The following points are our adaptation of the study by Halligan and Donaldson.[26]

» **Effective leadership:** a well-led organization effectively communicates the vision, values, and methods of clinical governance to everyone in the organization. This communication gives the team a common, consistent purpose and clear expectations. Good leadership encourages teamwork, creates an open and inquisitive culture, and ensures that both the behavior and the daily exercise of clinical governance remain an integral part of every clinical service;

[24] Rodrigues and Felício (2017).

[25] HALLIGAN, A.; DONALDSON, L. Implementing clinical governance: turning vision into reality. **BMJ**, v. 322, n. 7299, p. 1413-1417, 2001.

[26] *Ibidem.*

- **Strategic planning in health:** clinical governance cannot be implemented based on intuitive decision-making. Organizations need to build their health strategic planning to explicitly and clearly direct their goals to all care teams. Planning should be based on an objective assessment of patient needs and the degree of value delivered. This assessment includes analysis of clinical risk, regulatory requirements, staff competences, training needs, and analysis of current performance against similar services and best practices. Diagnose and scale care waste and its causes, identifying the main opportunities to generate high value for the patient and the consequent organizational sustainability (new/improvement of care and economic models). It is also important to ensure that key support structures (such as information technology, education and training, research and development) meet strategic health objectives. The construction of the planning must have the contribution of everyone in the organization, generated not only at the top management level, but also in individual teams at other assistance operational levels;
- **Be truly patient-centered:** organizations should make clear how patient reports are used to assess and improve the quality of services. Engaging patients in their care, empowering them with information and encouraging their contributions to service planning positively influences the development of clinical governance. Patient contributions affect not only responsiveness and service performance, but also the process by which quality improvement initiatives are identified and prioritized. All actions must be patient-centered and organized to meet their needs and provide safe and effective care;
- **Information, analysis, insights:** a healthcare organization that establishes a culture of clinical governance must develop excellence in the selection, management and effective use of information and data to support decision-making and process improvement. For information and data to be useful, it must be valid, up-to-date, and presented in a way that facilitates situational diagnosis. Qualified data, which highlights differences in output, flaws in standards, comparisons with other services and time trends, are essential. This information is vital in letting everyone know how they are doing and showing where there is room to improve. Sharing information to improve quality: regular meeting of multidisciplinary teams; agreed and shared service protocols; mechanism for implementing recommendations and guidelines; mechanisms for reviewing and dealing with clinical incidents and complaints; sharing and reviewing clinical results to enable practice modification across the service; benchmarking with other services and best care practices based on medical science;
- **Ordinary people doing extraordinary things:** people must be able to make the best possible contribution, individually and collectively, to improving health care. Ideally, the organization should allow and encourage employees to develop and use their full potential in line with the organization's goals. One step towards that goal is education and training to support the implementation of the clinical governance culture so that knowledge, skills and attitudes are reinforced in the workforce. At the most basic level, it means ensuring that staff feel valued, that they participate in policy discussions on the development of clinical governance, and that management is seen as trying to resolve their problems and concerns, and that they listen to their ideas for improvement and innovation. It is also necessary to provide appropriate technical support, such as access to the best valid evidence to support clinical decisions. Finally, creating a blame-free culture that encourages open analysis of error and failure is a fundamental characteristic of services dedicated to quality improvement and learning;

» **Adequacy of process organization**: It is always important to see how processes in healthcare delivery can be better planned. An organization working to implement clinical governance must: establish how healthcare processes are designed to meet patient, quality, and operational requirements (including best practice requirements); establish how care chain processes are coordinated and monitored to ensure timely and trouble-free delivery, and enhanced for better performance. Process monitoring includes clinical audits, specific project management and non-compliance management. The goal is to manage clinical risk by strengthening safe practices and preventing undesirable events associated with care.

Outcome of clinical governance: measurement and accountability

The ability to measure the quality of services is essential for the successful implementation of a culture that supports clinical governance.

Measures should include indicators of effectiveness and efficiency that demonstrate the degree of value delivered to patients and the sustainability of the organization.

The results must be disclosed to generate transparency and a healthy environment in search of continuous improvement. And, finally, an entire contracting/remuneration model that supports and encourages organizational improvement cycles in delivering value to the patient and society, recognizing good practices in the provision of quality, safe and timely care.

Operationalization of clinical governance

the essence of clinical governance lies in a cycle of interrelated steps:[27]

1. Strategic planning in health:
   a. Characterize problems and/or situations that you want to modify or maintain;
   b. Define results to achieve.
2. Deployment of strategic goals into actions (*plan, do, check, act* – PDCA):
   a. Define ways and means (strategies, interventions, activities...);
   b. Execute;
   c. monitor and control;
   d. Evaluate the results and act correctly.

This way of operating can also be expressed in another quality and risk management tool – the 5W1H (Table 1):[28]

[27] Rodrigues and Felício (2017).

[28] Portugal (2011).

What?	Set of relationships and responsibilities established to ensure care results with high value delivery for the patient
Why?	Because there are specific problems and specific health needs that require adequate responses to achieve the following goals: - Effectiveness: health gains; - Efficiency: achieving these "gains" at the lowest possible cost, without waste or unnecessary expenses; - Equity: reducing unacceptable health inequalities; - Quality: continuous improvement; - Motivation and satisfaction of professionals; - Empowerment and autonomy of patients; - Patient satisfaction.
Who?	Mobilizing and involving everyone
When?	Every day, throughout the year, for multi-year cycles
How?	- Definindo os processos essenciais (assistenciais e de intervenção em saúde); - Identificando prioridades para intervenções específicas; - Defining goals and targets to be achieved; - Establishing good individual and team practices (including guidelines for their flexibility and adaptation on a case-by-case basis); - Monitoring performance through selected indicators; - Introducing corrective actions when necessary; - Defining and executing specific projects (limited in time and with well-defined objectives or "end product"); - Developing teamwork and relying on it; - Studying and applying principles and strategies that encourage the motivation, involvement and responsibility of all professionals, with an emphasis on continuous professional development; - Using standardized methods and techniques, such as: audits, quality cycles, clinical risk management, patient and professional safety, process innovation, among others; - Applying an assessment culture and practices at all levels.
Where?	At all levels of the health organization, individually and collectively

Table 1 - How to operationalize clinical governance using the 5W1H tool

Source: prepared by the IAG Saúde Group based in Portugal (2011).

What are the desired results with the implementation of clinical governance?

essentially, the results to be achieved are:[29]

- Health level: improve people's health level and self-perception of their health status;
- Health determinants: reduce or control factors that can determine the occurrence of illness, accidents or death;
- Acute illnesses: help resolve and/or reduce acute episodes of illness and consequent suffering;
- Preventable diseases: reduce the occurrence of preventable diseases in a given period;
- Chronic diseases: reduce or control the occurrence of suffering, consequences, disease complications;
- Preventable premature deaths: reduce the number of preventable premature deaths (with available means);
- Quality of life: increasing levels of functionality and health-related quality of life;
- Quality life expectancy: increasing the number of years lived with quality.

Clinical governance and value-based health: how do they complete?

Following its historical landmarks, it is possible to affirm that clinical governance emerged as a necessary tool for the "full affirmation and implementation of the knowledge generated and accumulated by health professionals and their organizations".[30]

The challenge for the sustainability of current healthcare systems is to identify critical elements for their governance, in order to promote the transformation from a traditional organization to a learning organization in highly complex healthcare services that ensure value to all stakeholders.[31]

Learning is structured from the qualification of the care process, which encompasses the stages of access, permanence and continuity of treatment, evolving from information to knowledge (figure 5):[32]

[29] Portugal (2011).

[30] Rodrigues and Felício (2017); Portugal (2011).

[31] GONÇALO, C. R.; BORGES, M. L. Knowledge-Intensive Health Organizations: a study in the context of high-complexity services. **Saúde Soc**., São Paulo, v. 19, n. 2, p. 449-461, 2010.

[32] Ibidem.

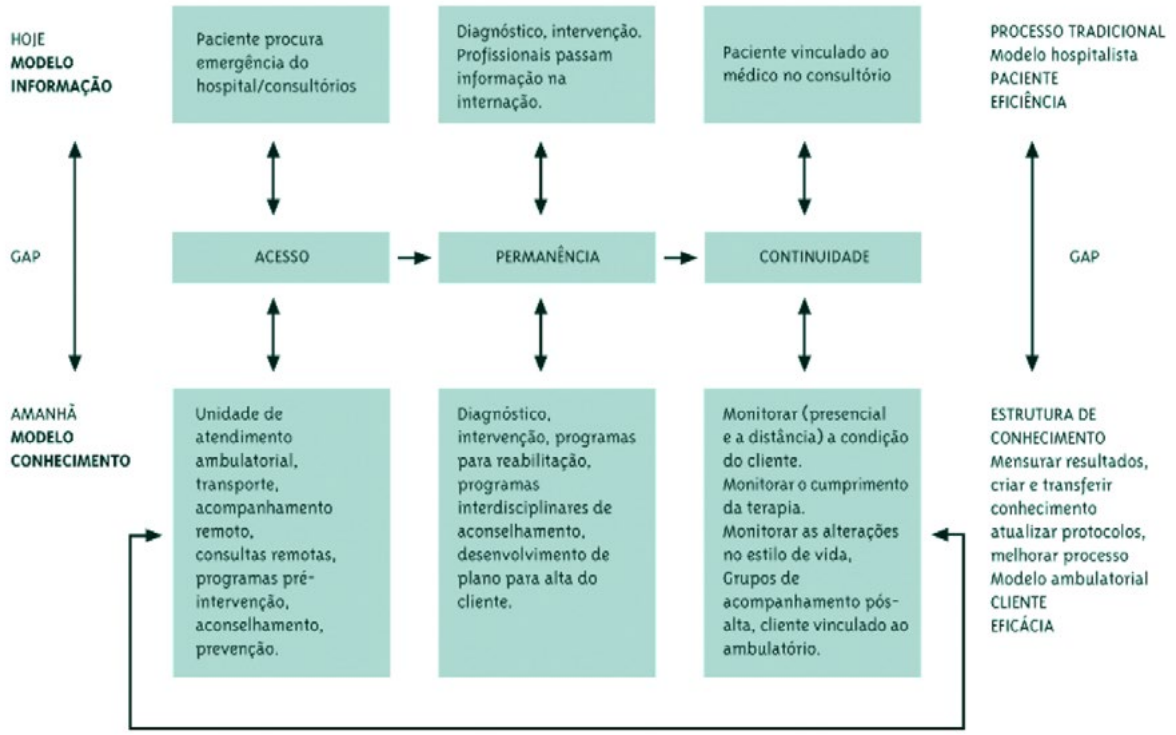

Figure 5 – Knowledge intensive healthcare organizations

Source: Gonçalo and Borges (2010).

It was with the systematic practice of clinical audit that the increase in clinical effectiveness, risk management, training, innovation and transparency was promoted through the dissemination of the results achieved.[33] It is "the simultaneous convergence of these vectors that makes clinical governance a transforming reality".[34]

A healthcare system that creates value for all links is one that puts patients at its center, improves the outcomes that matter to patients, and optimizes costs to achieve those outcomes.This requires **technical expertise** to design and implement the necessary actions, **leadership committed to change,** and **cooperation and transparency** between different organizations working together to improve patient outcomes.[35]

Value is the relationship between the achieved health outcomes that are important to the patient and the costs of achieving this result.[36]

A healthcare system that applies clinical governance establishes the culture, conditions and favorable environment for delivering value. Clinical governance paves the way for achieving high levels of value (box 2).

[33] McSherry, Pearce and Tingle (2007); Rodrigues andFelício (2017).

[34] Rodrigues and Felício (*op. cit.*).

[35] NEJM CATALYST. What is value-based healthcare? **NEJM Catalyst**, January 1st, 2017. (Brief article). Available at: https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558. Access in: July 21. 2021.

[36] Porter and Teisberg (2006).

Pillars of Clinical Governance	Value Based Health Care (VBHC*)
Health results and gains Patient centrality Adequacy of care Clinical risk management Human resource Management	Health outcomes that matter to the patient
Innovation and development Transparency with accountability	Sustainability

Table 2 – Clinical governance as an instrument for delivering value in health

Source: prepared by the IAG Health Group.

Note: * *Value-based healthcare*.

The contribution of the Valor Saúde by DGR brasil® platform to clinical governance

There are several functionalities of the Valor Saúde DRG Brasil® platform, which transform data into information for decision-making based on the diagnosis of opportunities to reduce waste in the healthcare system. Reducing waste equals delivering more value to the patient on their journey through the healthcare system.

The company believes that the organization of the care model must be strengthened by the remuneration model that encourages the virtuous cycle of value in health, resulting in the reduction of care waste (figure 6):

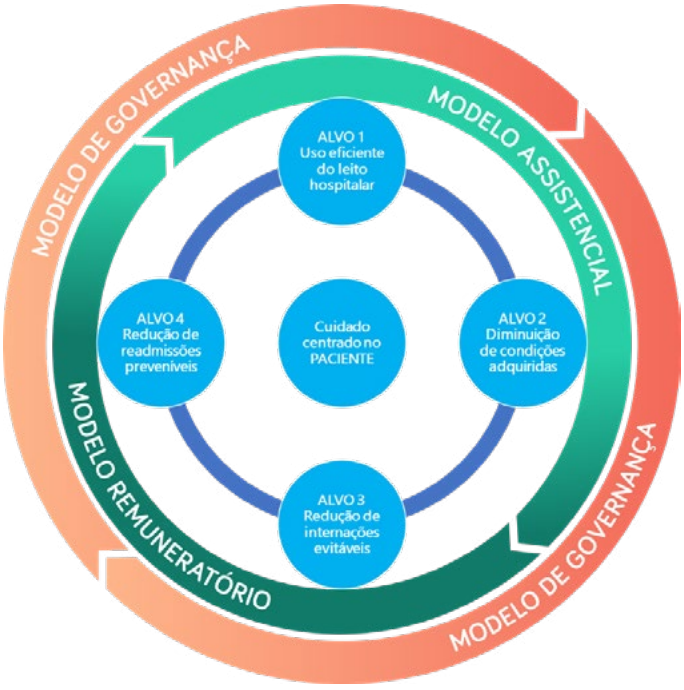

Figure 6 – The virtuous cycle of reducing healthcare waste through delivering value in healthcare – Valor Saúde Brasil platform by DRG Brasil®

Source: prepared by the IAG Health Group.

The Valor Saúde DRG Brasil® platform, through its analytical structure, predictive outcome models and data exposure, supports compliance with the pillars of clinical governance (Table 3):

Pillars of Clinical Governance	DRG Brasil® Valor Health Platform
Health results and gains	IVSB*
Patient centrality	lines of care Bedside application for the prevention of healthcare risks with the participation of the patient and family in the management of their care
Adequacy of care	The four assistance targets**
Clinical risk management	Adjustment for care complexity in severity levels Bedside application for the prevention of care risks with predictive models by artificial intelligence
Innovation and development	Bedside application for the prevention of healthcare risks
Human resource Management	value calculator PDCA for continuous improvement
Transparency with accountability	IVSB*

Table 3 – DRG Brasil® Valor Saúde Platform supporting clinical governance

Source: prepared by the IAG Health Group.

Notes: * Brazilian Health Value Index (in Portuguese, *Índice de Valor da Saúde Brasileira - IVSB*)

****** Efficiency in the use of the hospital bed; increase care security; reduce avoidable readmissions; reduce preventable admissions (ICSAP).

Final guidelines for clinical hospital governance in brasil

The patient and the results of the health system must be at the center of the relationship between providers and the funding source and occur in a transparent, non-punitive manner, based on the improvement of health system processes with sharing of economic gains. For Couto and Pedrosa, you should:[37]

- Qualify the health records of the contracted hospital network;
- Share the collection and use of DRG information between operator, hospitals and physicians;
- Increase the competence of professionals dedicated to coding health data;

[37] COUTO, R. C.; PEDROSA, T. M. G. Guidelines for a value-based healthcare system. **Valor em Saúde Brasil**, [*s.d.*]. Available at: https://www.drgbrasil.com.br/materiais/. Access in: September 26. 2020.

- Have validations for cost and health information;
- Standardize economic information.

Changing the care model based on the DRG:

- Develop a safe dehospitalization care process for patients with pathologies sensitive to primary care and for patients at high risk of readmission;
- Develop a process for the integration of primary and home care to the hospital;
- Develop the care qualification process of the hospital network with a focus on care safety.

Changing the remuneration model of health services:

- Primary attention:
  Pay for better access and resolution.
- Hospital network:
  - Pay for qualification:
    - Qualification of network structure and processes;
    - Patient safety;
    - Quality records;
    - Information and improvement of care results.
      - Pay for reduced length of stay;
      - Pay for safe post-discharge care;
      - Pay for resoluteness in the emergency;
      - Pay for DRG consumption patterns.
- Align the remuneration of the clinical staff to the model established for the provider network, ensuring cooperation and alignment with the expected results.

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Chapter 2
TELEMEDICINE

Dr. Chao Lung Wen

TELEMEDICINE

Goals

- Know the history of Telemedicine and the highlights of the decade of Government Academic Telemedicine
- Knowing what Telemedicine is and its legal ethical aspects
- Learn Telemedicine's areas of activity and the modalities of teleassistance services
- Know the system for carrying out the Teleservice
- Know the fundamental topics for training in Telemedicine

The context of Telemedicine

There is no consensus on when Telemedicine (TM) began, as it depends on the reference used to cite it as the first experience in distance medicine. Some exemplify that the first use of TM occurred in the Middle Ages, in Europe, during the plagues that devastated the continent. Due to the high risk of contamination, a doctor isolated himself on the opposite bank of the river that bathed his village and, from there, communicated verbally with a "community agent" in loco, who helped the population. The agent described the symptoms and course of the disease to the doctor and received guidance from him on the course of action to be taken. Others prefer to consider that the first example was the invention of the stethoscope by the French physician René Laënnec, in 1816, who used a rolled-up paper tube to channel the sound coming from a patient's chest to her ear, considered as the first example of physical distance between the doctor and the patient's body, since the practice at the time was auscultation with direct contact with the patient's body. Others cite that it was in the mid-19th century with the invention of the telegraph and telegraphy, through the use of the same, among others, to transmit the report of radiography exams between different places.

It was between the late 1950s and early 1960s that scientists and engineers from the National Aeronautics and Space Administration of the United States of America (NASA) began monitoring the blood pressure, temperature, respiratory and heart rate of astronauts by doctors located at the base. Emergency diagnostics and treatment capabilities have been enhanced, resulting in a complete healthcare system. Videoconferencing technology was developed, having had a great boost in the 1960s with the advent of space flights, which provided the first medical applications with the use of video, through NASA experiments. In 1969, Mankind arrived on the Moon. TM helped ensure the health of astronauts in orbit by sending their physiological signals – electrocardiograms, blood pressure, temperature, respiratory rate – to the Earth's space centers, thousands of thousands of miles away, where they could be monitored by NASA doctors. The spaceflight program spurred the development of sophisticated biomedical telemetry, remote sensing and space communications technologies.

The first complete and interactive system was installed in Boston in 1967. This closed television system was used to assess the health of travelers who were at the medical station at Logan International Airport, for primary and emergency care services, performed by physicians who stayed at Massachusetts General Hospital.

Until the period before 1990, there is no record of the existence of entities or publications specifically dedicated to telemedicine. It was from 1993 onwards, with the creation of the "American Telemedicine Association (ATA)", based in Washington, DC, that there were changes, as it became responsible for the publication "Telemedicine Journal and e-Health" and promotes events on telemedicine and holds annual congress. In England, telemedicine was driven by the "Royal Society of Medicine", which sponsored the "Journal of Telemedicine and Telecare", whose first copy was published in 1995.

In Brazil, in November 1997, the first discipline of Telemedicine in Brazil was created in the Department of Pathology of the Faculty of Medicine, by the then head professor of the department, György Miklós Böhm. In 1998, courses for Graduate and Undergraduate began. In November 2002, in the same year as the publication of the first resolution on Telemedicine of the CFM (Aug/2002), and following in the footsteps of the ATA, the Brazilian Council of Telemedicine and Telehealth (CBTms) was created, led by Prof. Dr. György Miklós Böhm and Prof. Dr. Chao Lung Wen, which aimed to consolidate Telemedicine and Telehealth in the country, by encouraging Academic Telemedicine, involving the participation of researchers, academic groups, representatives of governmental entities and bodies, and the promotion of national and international events. In 2003, the first CBTms congress was held, and in 2005 the 2nd CBTms Congress and the 10th ISfTH International Congress were held. In 2016, CBTms changed its name to its current name, ABTms (Brazilian Association of Telemedicine and Telehealth).

Another important action was when the Ministry of Science and Technology and Innovation, in 2005, launched the public notice "*Programa Institutos do Milênio*", which means Millennium Institutes Program in english through CNPq. This public notice encouraged interested parties to prepare and submit research proposals in a network to be financed by the Ministry. The goal was to promote quality research that could be competitive and integrated into the international scenario. One of the areas induced in this public notice was Telemedicine (MTC, 2005). Among the winning projects was the Digital Medical Station, from the Faculty of Medicine of the University of São Paulo, which involved nine university institutions and sought to expand and establish the foundations for telemedicine in the country and was the basis for the formulation of the Telematics Project in Support to Primary Care in Brazil, organized by DEGES/SGTES (Department of Education Management, Department of Labor Management and Health Education) and which in the future became the *Programa Nacional Telessaúde Brasil Redes*. The initial design of the Ministry of Health project took place from December 2005 to November 2006. Nine university institutions were invited to form Scientific Technical Centers and implement 900 service points in primary care. Four were institutions that participated in the Millennium Telemedicine Project (USP, UFMG, UEA, and HC-PA/UFRGS), approved by the Millennium Institutes call for proposes.

Recognizing the need to focus on Telemedicine, RNP developed the Telemedicine University Network (in Portuguese, *Rede Universitária de Telemedicina - RUTE*) project in the first half of 2006. The MCTI, with the support of the Brazilian Association of University Hospitals (Abrahue), created *RUTE* to

promote and integrate the isolated activities that were taking place in the country. *RUTE*, coordinated by Eng. Luiz Ary Messina, established itself as a supporter of the improvement of Telemedicine projects in progress, and also provided the creation of new inter-institutional works. The first Telemedicine Centers implemented by the network were those in São Paulo (SP), Florianópolis (SC), Manaus (AM), Rio de Janeiro (RJ), and Recife (PE). Over time, *RUTE* and the MS Telematics project cooperated and became complementary projects.

Telemedicine in practice

The incorporation of TM in the health care chain is a natural process that will occur in an increasingly accelerated way resulting from the adoption of the use of digital resources in the daily life of society. The ability of TM to improve quality, equity and accessibility is indisputable when correctly implemented. It is essential to highlight that there is no competition between medicine and TM. What exists is the possibility of expanding medical and health care with the inclusion of interactive and communication digital technologies (assistance teletechnologies) in the patient care chain.

From the perspective of health for the third decade of the 21st century, it can be said that we are at an opportune moment to idealize, organize, measure, and implement new sets of services that can have scalable growth, with quality and add value to the population. The consolidation and expansion of TM will make it possible to improve the health service chain with the provision of services, which range from self-care education, guidance and prevention for the population (eCare), monitoring of chronic situations and professional multi-care at home. The advances of the Internet of Things (IoT), the Internet of Medical Things (IoMT), and the emergence of increasingly fast smartphones with the ability to perform multiprocessing, cloud data sharing, integration with multiple devices, the hyperconnectivity provided by 5G, improved cloud processing, organizing data lakes and embedding Artificial Intelligence (AI) will change personal health monitoring scenarios.

Instead of the centralization of care processes based exclusively on physical hospitals, we will move towards distributed health, in which people's homes will be the points for continuous care, such as greater humanization and reduction of the risks of contagion of diseases in hospital environments. Home care (telehomecare or telemulticare) will be enhanced by electronic devices that will help with self-care, such as digital thermometers and sphygmomanometers, devices for oropharyngeal and otoscopy exams, digital oximeter, doppler monitor, glucometers, devices for monitoring anticoagulation, digital scales with bioimpedance, among others. In this scenario, Hospitals could organize their telehomecare sectors as an integral part of expanded home care, becoming hubs for home telemonitoring, avoiding the risk of unnecessary readmissions, or continuous monitoring of chronic patients, when necessary.

Wearables with biological signal monitoring capabilities (biosensors and diagnostic devices using biomarkers) will change the way personal health care is provided. The diffusion of electronic home devices with AI (smart speakers, with capabilities for video calls or even assistive robots) will make Smart Homes and Residences with continuous health services by teletechnologies common. This scenario will open perspectives for the provision of telemonitoring and teleorientation services

supported by devices and will be the basis for the organization of the new health ecosystem for Society 5.0 (a term created in Japan, in 2016, to consider the new social organization after the fourth Industrial Revolution).

The increase in life expectancy and the average age in the world, with a consequent increase in the elderly population, changes in habits that lead to an increase in people with overweight/obesity, chronic and degenerative diseases, metabolic diseases, physical disability, neoplastic diseases, the risk of pandemics due to the increase in globalization and due to the increase in the number of trips and displacements, and among other characteristics has been modifying the profile of diseases and showing that in addition to the exclusive treatment of diseases, it will be necessary to create new strategies with a multiprofessional approach, organization of health care axes to solve problems and minimize the risk of resurgence or re-aggravation of diseases, especially chronic diseases, and the maintenance of health status through the incorporation of new habits. We can designate it as the Telemedicine application in Biopsychosocial Care when we implement a set of actions that promote quality of life.

TM has the potential to add new health solutions and many of the face-to-face procedures and routines could be replaced by care mediated by technologies. It does not necessarily have to be complete on its own and can be part of hybrid care. If the doctor does not feel safe to take action after a remote evaluation, he should call the patient for a complimentary face-to-face examination.

In Brazil, TM is understood as "the practice of medicine mediated by technologies for assistance, research, prevention of diseases and injuries and health promotion", according to article 3 of Federal Law 13.989/20. In the letter of the Federal Council of Medicine nº 1.756/2020 - Cojur, of March 19, 2020, three procedures that can be performed by the doctor through TM are recognized: Teleorientation, Telemonitoring and Teleinterconsultation. TM is considered an ethical practice and can be performed in Brazil within the limits of the CFM Resolution, the CFM Official Letter, the Ministerial Ordinance (467/2020), Law 13.989/2020 and with the possibility of carrying out an electronic prescription for medicines authorized by ANVISA.

The Municipal Telemedicine Law of São Paulo (17.718 of Nov 23, 2021), includes, in addition to the previous aspects, Education as an integral part of the scope of Telemedicine activities, including a more complete definition with the following text: "Telemedicine is considered, among others, the practice of medicine with the secure transmission of audiovisual content and data by secure digital technologies, for assistance (monitoring, diagnosis, treatment and epidemiological surveillance), prevention of diseases and injuries, promotion of health, education and health research".

Contrary to what most professionals and people suppose, TM is not a tool. It is a medical method for performing medical services mediated by technologies. This definition is well established in paragraph 1 of article 37 of the Code of Medical Ethics (CFM), article 3 of Law 13.989/2020, and in article 3 of Municipal Law of São Paulo 17.718/Nov-21. Therefore, for its adoption, it is necessary to have a series of care concerning the use of safe technological resources, ethical norms, legal rules, guidelines of good practices and previous professional training.

Metrics and tools

Telemedicine is defined as "the practice of medicine mediated by technologies for assistance, research, prevention of diseases and injuries and health promotion", according to article 3 of Federal Law 13.989/20, it is considered as a professional exercise equivalent to the face-to-face medical act (Article 5) as well as their remuneration. This position is reinforced by ANS/2020 Technical Notes 6 and 7, which indicate that there is no need to create a new payment code for remuneration for service provided by Telehealth.

TM is considered an ethical practice and can be performed in Brazil within the limits of what is determined by CFM Resolution 1.643/2002, CFM Official Letter 1.756, Ministerial Ordinance 467, and Law 13.989/2020 and with the possibility of carrying out an electronic prescription for medicines authorized by ANVISA. CFM resolution 2.227/18 specified eight modalities: (1) Teleconsultation; (2) Teleinterconsultation; (3) Telediagnosis; (4) Telesurgery; (5) Medical Teletriage; (6) Telemonitoring/ Telesurveillance; (7) Teleorientation and (8) Teleconsulting.

Medical Teleservices cannot be understood as compared to video calls. The doctor performs a formal professional exercise, with anamnesis, physical examination of observation, general assessment of the patient's behavioral aspects such as breathing pattern, movement, posture, inspection when necessary (in case of skin changes, lesions, tumors, etc.), supervised patient self-palpation and self-maneuvering. As a complement to the non-face-to-face service, the physical examination can be complemented by data obtained from devices such as a digital thermometer, sphygmomanometer, glucometer, scale, digital oximeter, among others. Considering these aspects, it can be said that it is not possible to carry out quality teleservice using simple telephones or exchange of messages and audios by WhatsApp. In addition to being limited, tools are vulnerable to scams.

Even with the authorized TM, we have to be careful about the choice of digital communication resources. This highlight is important, as the punitive process with fines under the General Data Protection Law (in Portuguese, *Lei Geral de Proteção de Dados - LGPD*) began on August 1st, 2021. To have some technical criteria while there is still no *LGPD* technical criteria, the HIPPA (Health Insurance Portability and Accountability Act) guidelines can be used when choosing digital tools. The Health Provider Portability and Accountability Act (HIPAA) fostered the emergence of guidelines created in the US in 1996 that contain safety rules and standards that, when applied, serve to safeguard and protect sensitive health information (ePHI: Protected Health Information). These security rules apply to any person or system that has access to confidential patient data. The four main areas defined to protect sensitive health data are technical, physical, administrative, and behavioral safeguards. The HIPPA rules were expanded in 2009 with the Health Information Technology for Economic and Clinical Health Act (HITECH) and are spread worldwide and adopted by major technology companies.

It is recommended that teleservices be carried out from specific platforms that ensure data confidentiality, including enabling the issuance of official medical documents, such as medication prescriptions, certificates, and exam requests, which are validated electronically through a digital signature, such as the platform launched by CFM, CFF and ITI (*Instituto Nacional de TI*).

As TM is a method, the consultations must follow a minimum system so that it can be registered and characterized as a medical act. It can be based on 5 pillars:

1. Apply a Term of Agreement and Authorization considering that the services provided by Telemedicine are a type of contract and that the patient and/or guardian must read, understand and agree, in writing, to be eligible for Teleservice. To make the process more agile, it is possible to release the Term of Agreement and Authorization to the patients, after the due signature, it becomes eligible for this type of service. This can be done digitally, or when the patient has some face-to-face care.
2. To obtain greater efficiency, patients can fill out a simplified form of reasons for requesting consultation (when they are patients not previously scheduled or with new complications), with at least four aspects such as: reason and duration of the complaint about requesting a consultation, if sought any previous assistance for the current complaint, if he/she has tests related to the complaint and in which location he/she is located and for how long at the time of the request.
3. Conducting the structured interview by video call after previous analysis of the simplified form of a request for care sent by the patient divided into anamnesis, physical examination and recording of data obtained by devices.
4. Closing of the structured interview, with registration in the medical record, the definition of medical conduct, prescription of medication and/or request for exams.
5. Submission of a Telecare Summary to be sent to patients with information on the date, duration, CRM of the assistant physician, the platform used, the reason for telecare and medical conduct.

Issuance of a medical prescription, certificate, and request for exams

Remote revenue issuance will be valid by electronic means when an electronic signature is used through certificates and keys issued by the Brazilian Public Key Infrastructure (ICP-Brasil), generating an electronically signed document with all the security guarantees of ICP-Brasil - authenticity, integrity, confidentiality, and non-repudiation.

An example is the ITI platform, launched jointly by CFM and CFF, in April/2020 (https://prescricaoeletronica.cfm.org.br/), which has models of Medical Certificate, Simple Prescription, Special Control Prescription, Antimicrobial Prescription, Medical Report and Test Request. The digital medical prescription must be issued by the doctor who performed the teleservice.

By legal determination, the issuance of Special Control Prescriptions and prescriptions for antimicrobial drugs with a digital signature under the terms of MPV 2.200-2/2001 can be accepted, provided that the pharmacy or drugstore has the resource to consult the original electronic document, which is presumably valid by legislative imposition.

The digital prescription does not apply, for the time being, to controlled drugs, such as the Prescription Notification A (NRA), Special Prescription Notification for Thalidomide, Prescription Notification B, and B2 and Special Prescription Notification for Systemic Retinoids.

Caution: the digital prescription, with a digital certificate, is not a scanned prescription. Digital receipts and certificates have legal value, notarial effect and function as a signature with notarization, as any change in these electronic documents is accused and prevents their validation. The scanned prescription is just a "printed photographed" prescription. A digital document is entirely electronic.

One of the planned service modalities is Medical Teleinterconsultation and it can use a wide variety of diagnostic support devices, connectable to smartphones for physical examination purposes: (1) Portable ultrasound that communicates over WiFi, with or without Artificial Intelligence; (2) ECG equipment; (3) Lens adapters for Dermatoscopy with external ocular photography that allow recording of dermatological lesions and/or evaluation of external ophthalmological alterations; (4) Ophthalmoscopes; (5) Otoscope and adapters for rigid or flexible endoscopes that allow accurate ear canal and ENT examinations; (6) Colposcope; (7) Spirometer; (8) Digital Stethoscope; (9) Oximeter; (10) Pro-thrombin timer; etc.

Among the obstacles to the expansion and consolidation of Telemedicine in Brazil is the adoption of training strategies since graduation. Since the publication of the 2002 resolution by the CFM, less than 1% of the faculties have Telemedicine disciplines for undergraduate courses, and training courses for medical residency or graduate studies are lacking. This same situation occurs in all health professions. Thus, it is urgent to implement a Telemedicine course in at least 50% of the Medical schools in the next 5 years, offer courses for training in Medical Residency and Multiprofessional Residency, courses of rapid diffusion for the team involved. This training is defined as mandatory in the Municipal Telemedicine Law of São Paulo (17.718/2021).

Programmatic topics for training in care telemedicine:

1. Ethics, responsibility, and digital behavior.
2. Regulation: laws, ordinances, resolutions and technical standards.
3. Term of Agreement and Authorization x TCLE.
4. Digital Security and criteria for choosing platforms (HIPAA, LGPD).
5. Service modalities in telemedicine.
6. Pillars for teleservice.
7. Digital media training in teleservice.
8. Telepropedeutics and non-face-to-face physical examination.
9. Device-supported physical examination.
10. Medical act x territorialization and its ethical aspects
11. Professional remuneration.

Synthesis

Telemedicine is a promising method for improving the health system. Although for a short period it can still generate resistance (implicit or explicit) due to lack of knowledge and fear, adoption is irreversible in Brazil and around the world.

In the context of accelerated changes, care must be taken not to generate excessive and unrealistic expectations and/or excitement. It is necessary to focus on Responsible Telemedicine based on four main pillars:

1. Ethical-technical legal aspects, institutional compliance rules, Agreement and Authorization Agreement for patients and Good Practice Guidelines;
2. Management and planning of integrated care logistics, implementation of the technical audit of services quality and definition of sustainability and professional remuneration;
3. Continuing training of human resources, institutional communication, organization of a multi-professional approach, dissemination of information to the general population, etc.; and
4. Secure digital technology infrastructure, data interoperability and technological innovations/ renovations.

To organize a Connected Medicine or Connected Health service, one must take into account the potential for generating direct benefits and differential advantages when integrating care teletechnologies in the care chain. They are: improving the efficiency of the chain (Integrated Health Care), reducing waste (duplication or tripling of exams, delays, unnecessary displacements and overloading of health structures), optimization of services and regulation with periodic technical audits (control of quality), expansion of access to users and structuring of network work.

When we see Medicine not only as services for the treatment of diseases but as a chained set of actions that range from health promotion and disease prevention, recovery of people in disease conditions to social reintegration, we then offer Telemedicine s ervices. that integrate the different levels of health services (Integrated Care). This strategy will be fundamental for the reality 2025 and 2030, represented by the Society 5.0 with the aging of the world and Brazilian population, which will create a series of challenges such as an increase in chronic diseases, cancer, physical and cognitive dependence, among others.

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Chapter 3
PERSON-CENTERED CARE

Gilvane Lolato and Péricles Góes da Cruz

PERSON-CENTERED CARE

Goals

- Understand person-centered care and its concepts AND understand its practical application;
- Demonstrate person-centered care focusing on welcoming, a unique therapeutic project and discharge plan;
- Emphasize the importance of valuing health professionals and monitoring the effectiveness of humanized care;
- Present the alignment of actions at the strategic level and the unfolding of concepts at the tactical and operational levels.

Understanding Person-Centered Care

To start our conversation about person-centered care, let's first talk about the trajectory that involves the patient and which can also be called the line of care. The line of care is expressed by the care flow and involves all processes that deliver some input or service so that care is provided consistently and safely. The line of care, that is, this care trajectory through which the patient goes through, needs to be continuous and integral. And comprehensive care is the result of multidisciplinary and aligned work at all times.

Talking about the patient's trajectory is to imagine the itinerary that the patient can follow within a health organization and that represents the care continuity composed of promotion, prevention, treatment and rehabilitation actions. Lines of care are systematically developed recommendations with the aim of providing appropriate health care in relation to a given condition or pathology. These are recommendations that regulate the entire process of the condition or pathology throughout its natural history and across all points of Health Care.

In turn, care centered on the person, and in this case, the patient, is all the attention given during this trajectory, so that in addition to safe care, there is empathy and what really matters to the patient.

Person-centered care consists of involving the patient, their families and caregivers in day-to-day decisions, so care becomes profiled and personalized, bringing to the center what really matters to the patient. It is about looking and listening to the needs, values and preferences of patients, access to care, physical comfort, without pain, continuous and integrated care, relief from fears and anxiety, information, education and emotional assistance. The Health Foundation has identified four principles linked to person-centered care:[38]

[38] "Measuring what really matters". Collins A. Health Foundation, Available at: www.health.org.uk/publications/measuring-what-really-matters

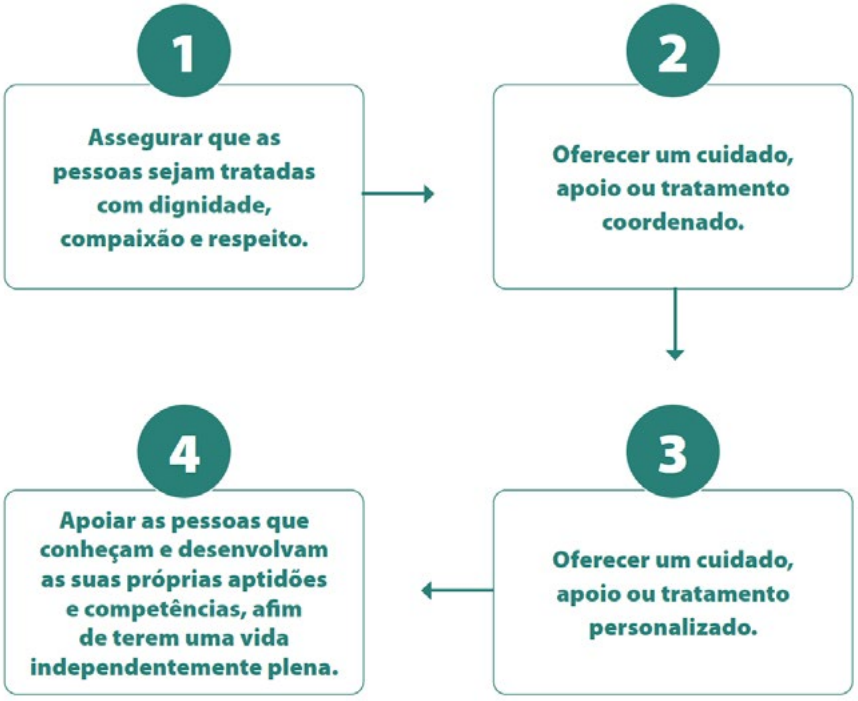

Table 1 - Principles related to person-centered care

Source: Health Foundation

For the application of person-centered care, some points are relevant. One of them, it is important to discuss the issue involving not only patients but also professionals. The attention, care and preparation of professionals is a critical success factor. Another relevant point is to understand the patient's experience and co-production.

The patient's experience can be given from a client's own account of his journey within a healthcare organization. This report ends up being a key result for the service of the multidisciplinary team and provides for the improvement of the quality of the processes. Therefore, it is composed of all interactions interpreted and experienced by the patient in their care trajectory. The patient experience has some dimensions, such as the attention of the multidisciplinary team, support processes such as cleaning, hospitality, linen, nutrition, among others. Dignified and respectful treatment, patient outcomes, pain control, physical comfort, family involvement, discharge, among others.

Co-production, on the other hand, consists of understanding the relationship between patients and health professionals, the contribution of patients to the provision of services, as well as listening to patients to redesign processes and identify improvements. It is important to capture the patient's experience, understand and improve the experience and also measure the improvements implemented from processes connected to people.

For a consistent capture of the patient experience, we may institute councils or committees with the involvement of users, their families and friends. We can also opt for structured interviews, invite patients for moments of reflection and redesign of processes and also invite some people to be hidden patients in some processes, among many other initiatives that are valid.

The opportunities for improvement that we can identify and implement from these sources are numerous, but it is worth attention. Involving the patient in these initiatives requires maturity, preparation and the organization's understanding of the necessary infrastructure. It is important to be transparent, convey professionalism, empathy and reliability in the health system.

Putting person-centered care into practice

The interaction between the processes in a health organization must be structured in order to ensure that the flows between the various services work in a harmonious way, ensuring access to patients. We must identify ways to integrate this practice into the daily life of the patient's trajectory, that is, ensure that all decision-making is based on and focused on person-centered care. The patient is always the center of care, but without forgetting to also take care of those who care, which are health professionals. Actions, behaviors, and attitudes need to make sense and bring reflection so that the team does not fall into a routine and can perform tasks with a focus centered on the people involved.

Empathy needs to be part of the patient's trajectory. Think about "what matters to the patient", what we should know about patients who are not in the medical record if there is something that concerns them, or what a successful procedure or examination means for the patient. Looking with the eyes of patients and professionals, listening with the eyes of patients and professionals, not patient care, but care for patients and their families.

Some initiatives can be adopted to strengthen person-centered care, such as:

- Eliminating visiting hours, thus allowing greater flexibility for family members to visit patients, taking into account their work schedules and allowing them to be in moments of greater dedication.
- Allow the family to observe procedures, as far as possible, in order to have greater knowledge to share decisions.
- Allow patients to share and write in medical records, to report their experiences, their concerns.
- Include patients in multidisciplinary visits, even with well-established and clear rules, but allowing for their concerns to be expressed.
- Invite patients to form improvement project teams where they can talk about their perceptions within the organization.
- Establish partnerships to design self-care mechanisms, listening to patients and implementing actions that will make all the difference.
- Actively involve patients in shared decisions, whenever possible through effective communication channels.
- Knowing the patient's life, having empathy, putting yourself in their shoes, diving into their history and understanding what really matters to the patient and their families.

The translation of the text originally written by the Health Foundation and translated by PROQUALIS[39] highlights some actions such as:

> Carry out care planning together with professionals, identifying what is important for the person and what is the best treatment. Collect the experiences of professionals and patients to redesign processes and promote improvements. Healthcare professionals say their name and professional category when introducing themselves to patients.Care in partnership between professionals and patients, organization of resources effectively, patients participate in decisions about their treatment, tables so that patients can report what really matters to them, among other important and impacting actions.

We emphasize mainly the planning of care with the involvement of professionals. Empowering the team in care planning taking into account the multidisciplinary team is crucial and a critical success factor, as they will feel part of the planning and not just something that someone demands and does not listen to their concerns.

Welcoming is also part of person-centered care. When performed with empathy at the front door and throughout the care trajectory, it surprises patients. And speaking of the patient's trajectory, the singular therapeutic project unfolded in daily goals with the participation of the multidisciplinary team, brings positive results, mainly when there is the involvement and effective commitment of the patients, their families and caregivers in the decision making, when the information and concerns are shared by all. And, as a consequence, the discharge plan built since hospitalization, which provides a profiled care, considering the individual characteristics of patients, as well as family and society conditions that can impact the outcome and continuity of care.

In addition, valuing health professionals is very important for all these actions to take place in organizations effectively. We can cite as examples:

- The daily recognition of good practices;
- Greetings in the face of simple actions and initiatives;
- Appreciation for new ideas, regardless of their complexity;
- Listening to the employee's concerns, even though at times it is not possible to propose improvements;
- Among others.

Accreditation and Patient-Centered Care

The Brazilian Accreditation System considers that health organizations are complex systems, in which the structures need to be dimensioned and designed to meet the existing profile and

[39] Simplifying person-centered care. What everyone should know about person-centered care. Quick guide. Proqualis | Institute of Scientific and Technological Communication in Health - Fiocruz, 2016

demand, organize and understand the interdependencies of the internal processes that compose it, to achieve their results and at the same time excellence over time.

The health assessment in the SBA methodology verifies the components of structure, process and result and the causal relationship between them, in which the structure supports the execution of processes, and the processes are executed to generate results. In other words, the evaluation is transversal and uses a systemic approach that allows analyzing the work processes and the relationships with the results.

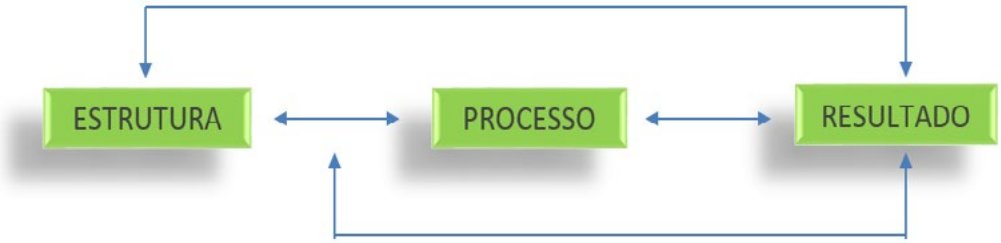

FIGURE 1: Structure, Process and Results and the transversal and systemic evaluation logic.

The understanding of the concept of quality in health in the Brazilian Accreditation System is multidimensional, that is, the Dimensions of Quality guide the evaluation of the performance of health organizations against the defined standards and requirements.

And to consolidate the Conceptual Model of the methodology of the Brazilian Accreditation System, a set of Fundamentals of Health Management is structured, which characterize the methodology and support the evaluation of practices and performance factors, expressed through the standards and requirements of the Manual of Health Service Providers.

FIGURE 2: Conceptual Model - Manual for Organizations Providing Health Services version 2022

The Quality Dimensions[40] guide the assessment of organizational performance along with the defined requirements, that is, it is through the Quality Dimensions that the organization's practices are evaluated in relation to the requirements presented. All dimensions are considered in the assessment for accreditation, as they guide the assessment by requirements.

- Safety prevents injuries to patients by the care that is intended to help them;
- Effectiveness provides services based on science to those who can have an improvement in their clinical condition and avoiding the underutilization of this service or the provision of care to those who would not benefit.;
- Opportune aims to optimize processes and times, for operational excellence in the value chain;
- The efficiency that offers assistance to patients/clients in a rational way, avoiding waste and excesses, whether in the use of equipment, exams, beds, procedures, supplies, ideas, energy and human resources;
- Equity that provides equitable care to the people served, considering the diversity of patients;
- Finally, the dimension of Patient-Centered quality is highlighted, which contextualizes person-centered care as part of the methodology. This perspective provides care that respects and responds to individual patient/client preferences, needs, and values and ensures that patient/client values guide all clinical decisions.

The methodology, in turn, brings some important points through its requirements to enhance person-centered care, such as: involving patients and their families in self-care, taking into account the individual characteristics of patients/clients and companions, respecting their cultural traditions, beliefs, diversities, personal values and privacy for care planning. Stimulating the participation of the patient and family in the redesign of the processes, promoting improvements based on the patient's experience.

What results can we expect?

Among the main results, we can expect a better experience for patients and their families, greater satisfaction, safer care, maturity of the organization and its professionals, change in organizational culture, accountability on the part of the team, continuous learning and greater support for patients, family members and health professionals regardless of category.

Monitoring the effectiveness of humanized care, as well as the alignment of actions at a strategic level and the unfolding of concepts at the tactical and operational levels are issues of high impact for organizations.

The health system is a service co-created by all stakeholders, including professionals, patients, their families and caregivers. This construction provides us with accountability for patient safety. This path tends to improve the health system and invites us to consider new formats for preparing health

[40] Crossing the quality chasm : a new health system for the 21st century / Committee on Quality Health Care in America, Institute of Medicine.p.; cm.Includes bibliographical references and index. ISBN 0-309-07280-8

professionals and socializing with patients, as well as new looks at organizational structures, delivery of health services and new metrics to measure success.

Another result that we can expect is to understand and measure what happens to patients during the trajectory of care delivery. This can be considered the first step in the search for improvements in health services. In this scenario, the safety culture is highlighted, as it reflects the commitment of the organization's professionals to the continuous promotion of a safe therapeutic environment and influences safe behaviors and results, both for health professionals and patients.

Get to work!

Organizational culture change consists of changing attitudes and behaviors based on the organization's values, beliefs and purpose. It is an action that positively contaminates all those involved, all stakeholders from professionals, patients, family members, suppliers, providers, agreements, and other interested parties. Person-centered care does not mean increasing the time taken to provide care or procedures, but a change in mentality that brings patients as partners in the care itself. Simple actions such as introducing patients by name and professional category can make a big difference. We need to disseminate and spread the concept, establish actions and initiatives that are effective and collect the results for later feedback to those involved.

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Chapter 4
MULTIDISCIPLINARY TEAM MANAGEMENT

Audrey Rippel

MULTIDISCIPLINARY TEAM MANAGEMENT

Goals

- To describe the concepts of multidisciplinary team in hospital organizations to present the typology and components of the multidisciplinary team in hospital organizations;
- To present reference bases for the structuring of multidisciplinary teams in hospital organizations;
- To describe the strategies for managing the multidisciplinary team in hospital organizations;
- To discuss the benefits offered to patients assisted by a multidisciplinary team in hospital organizations;
- To discuss the impact of the multidisciplinary team on the results of hospital organizations;

Definition, contexts and challenges in the management of the multidisciplinary team in hospital organizations

Hospital models in our country derive from institutions of benevolence and charity structured by religious and other representatives of society. Since their beginnings, they have been structured through the training models of health professionals, which have evolved in specialization, complexity and resolution over time, and due to the constitution of the scientific model

For VECINA and MALIK (2018), hospital organizations are one of the most complex organizations within health systems, due to the coexistence of numerous simultaneous care and administrative processes, a great diversity of production lines and a fragmentation of care decision processes with the presence of a multidisciplinary team with a high degree of individual autonomy.

From the constitution of the Unified Health System, through the Federal Constitution of 1988, one of the novelties brought by it was the assumption that the service should be carried out by a multiprofessional health team. According to SILVA et al (2013), these teams must be understood horizontally, breaking with a vertical system of relationships, centered on a single professional, focused on individualized care and the cure of diseases.

However, the entire process of specialization in the health area, as mentioned by PEDUZZI (2001), tends to vertically deepen knowledge and intervention in individualized aspects of health needs, without simultaneously contemplating the articulation of actions and knowledge of the members of the health team.

Multiprofessional team can be defined as the involvement of several professionals, with different training and specialties, directed as a team to diagnose health needs, care planning

and attention to patients/clients (SILVA et al 2013). And in hospital organizations, it is made up of all professionals who provide assistance to patients, such as nurses, physiotherapists, doctors, pharmacists, nutritionists, social workers, psychologists, speech therapists, dentists, occupational and biomedical therapists, in addition to technical professionals specialized in the various areas of health knowledge. The diversity and number of professionals that make up the multidisciplinary team provide an idea of the challenge of teamwork among them.

PEDUZZI (2001, 2005) conceptualizes multiprofessional 'teamwork' as a modality of collective work that is built through the reciprocal, two-way relationship between the multiple technical interventions and the interaction of professionals from different areas, configuring, through the communication, articulation of actions and cooperation. It also establishes a typology of teamwork, shown in Figure 1, which does not configure a static model, but a dynamic one, between work and interaction that prevails at a given moment in the continuous movement of the team: team integration and team grouping.

Figure 1- Typology of teamwork prepared by PEDUZZI (2001)

In the first type, there is the articulation of actions and the interaction of agents; in the second, there is a juxtaposition of actions and the mere grouping of professionals. The tendency towards one of these types of teams can be analyzed by the following criteria: quality of communication between team members, specificities of specialized jobs, questioning the unequal social valuation of different jobs, flexibility in the division of labor, professional autonomy of an interdependent and construction of a common assistance project PEDUZZI (2001, 2005).

SILVA et al (2013), argues that the terms multidisciplinarity, pluridisciplinarity, interdisciplinarity and transdisciplinarity constitute different forms of interaction of professionals in a multiprofessional work, and describe these particularities:

Terms	Definition
Multidisciplinary	It is defined as a simple juxtaposition, in a given work, of the resources of several disciplines, without necessarily implying teamwork.
Pluridisciplinarity	It is determined as a juxtaposition of different disciplines located at the same hierarchical level and grouped in such a way as to make the existing relationships between them appear as a single-level and multi-objective system with cooperation but without coordination.
Interdisciplinary	It is characterized "by the intensity of exchanges between specialists and by the degree of real integration of the disciplines, within a specific research project". Such interaction becomes important, as it favors collaboration between different areas of knowledge around a case.
Transdisciplinarity	It is constituted by the formation of a broader network of meanings about collective work in health, assuming the possibility of not having a single logic of knowledge.

Table 1 - Terms used to describe teamwork developed by – adapted from SILVA et al (2013).

For CAMELO (2011), the hospital is a complex environment, a stage where professionals from various specialties and different backgrounds work and where there is a large volume of activities, which must operate in harmony. What they have in common is that they work in perfect harmony to achieve the recommended results. The professionals and processes developed within the organization must interact in perfect harmony, otherwise, the final objective, which is quality care for patients/clients, will be harmed.

The National Hospital Care Policy (in Portuguese, *Política Nacional de Atenção Hospitalar - PNHOSP*) within the scope of the SUS, established by Consolidation Ordinance No. 2 from July 28, 2017, brings in its article 12 § 2nd:

> The multidisciplinary reference teams will be the core structure of the hospital's health services and will be formed by professionals from different areas and knowledge, who will share information and decisions horizontally, establishing themselves as a reference for users and family members.

The hospital care model must include a set of care devices that ensure access, quality of care and patient safety (MS 2017).

The construction of a clinical management model, in which the therapeutic planning articulated between the multiprofessional team, to meet the health needs of patients/clients and directing common goals to be achieved by the multiprofessional team, should be used as a model and strategy for the management and model of hospital care.

Reflections on the practice of multidisciplinary team management in hospital organizations

Favoring interaction between members of the multidisciplinary team to achieve common care results is a major challenge for the practice of management in hospital organizations.

Taking as a reference the concepts of Structure, Process, and Results proposed by DONABEDIAN (1966), we suggest a reflection on the practical aspects of managing multidisciplinary teams.

The issues related to the structuring of multidisciplinary teams correspond to the strategies and guidelines to adequately dimension, in number and profiles or types of professionals, the team members. The basis for defining the dimensioning and profiles of professionals must be considered from the analysis of the epidemiological profile and demand of the hospital organization, as well as taking into account the current legislation.

The organization of organizational processes contemplates the definition of the strategic processes of a hospital organization, whether these are aligned with the organizational identity and institutional strategic planning, as well as the consensus of the interaction between them. It is important that there is a clear definition of the activities that will be performed within each care process, to define the roles and responsibilities of each member of the multidisciplinary team.

As an example we can think of the surgical process in a hospital organization, among the activities of this process are admitting patients in the preoperative period, verifying all items related to the preparation and safety of the patient, performing the surgery with safety and quality, recovering the patient from anesthesia so that they can be referred to a place where they will have the post-operative. Each role, responsibility and goal of the members of the multidisciplinary team (surgeons, anesthesiologists, nurses, nursing technicians, pharmacists, among others) must be clear.

The process management model favors the direction and communication of the members of the multiprofessional team, as it defines their responsibilities and contributions to the achievement of a common care objective.

In addition, the common results, achieved from the collective effort, that is, the integration of the multiprofessional team, need to be agreed upon. The care results, or even those of production, monitored as process indicators are the result of the effort of a multidisciplinary team when we approach care processes. Transferring the same concept at a systemic level in an organization, the results of a hospital organization are also the results of the efforts of a team, and more specifically, the organizational care results are the result of the collective work of the multiprofessional team.

Structure	Process	Result
Adequate sizing of the team (quantity and technical quality)	Definition of the roles and responsibilities of the members of the multidisciplinary team - based on the organization of activities	Definition of common results - Impact of the performance of the multiprofessional team on patients, populations

Table 2 - Management of multidisciplinary teams: structure, process and results - prepared by the author of the chapter

In addition to the use of the concepts of Structure, Process, and Results proposed by DONABEDIAN (1966), there are clinical management strategies and models that are important tools for directing the multidisciplinary team.One of the most widespread models worldwide is that of Clinical Governance, developed by the National Department of Health Service - NHS (VECINA AND MALIK 2018), in which 7 pillars are proposed as a model for clinical management, as shown in Figure 2 below:

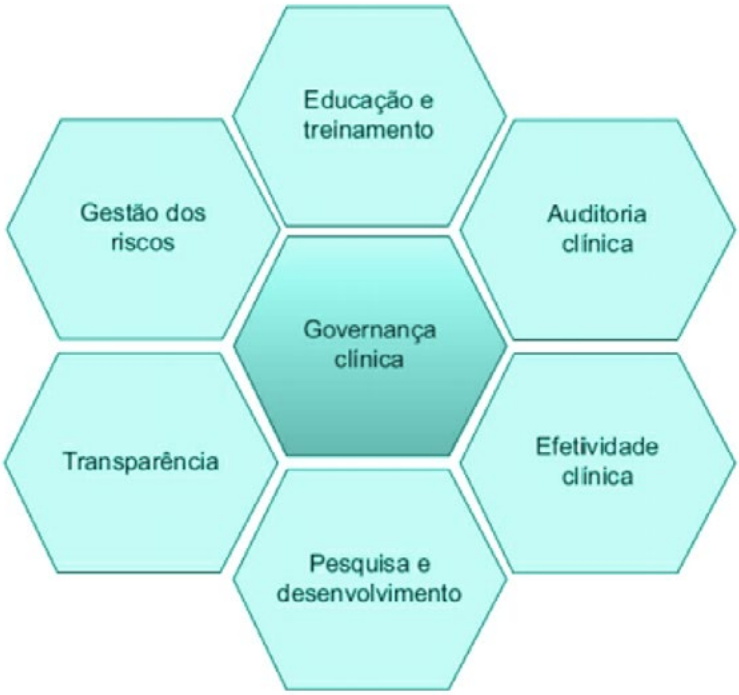

Figure 2 Clinical governance: six pillars of actions.

Source: Department of Health. The new NHS: modern, dependable, 1998. Source: Vecina Neto, Gonzalo; Malik, Ana Maria.Health Management (p. 218). Guanabara Koogan. Kindle edition.

This model proposes that the pillars be used as resources to favor the interaction between the components of the multiprofessional team, in addition, they propose that feedback on the team's performance be offered, through clinical audit and communication strategies based on a relationship of transparency.

According to VECINA and MALIK (2018), the evolution of clinical governance is intended to consolidate, codify and universalize policy approaches capable of creating organizations in which the ultimate responsibility for governance rests with the organization's executives with this vision of quality of care.

Each organization must work, in addition to its responsibility for the outcomes, with the construction of pacts and agreements between the various corporations of health professionals that make up the hospital, duly communicated to the entire organization, aiming at adequate patient care.

Tools of multidisciplinary team management practice in hospital organizations

As discussed above, there are clinical management models to be used, and similar aspects are the use of evidence-based health to build protocols as a tool for directing and demonstrating care effectiveness.

The choice of protocols must be based on the care profile of patients/clients and the organization's demand, as well as risk and sustainability situations must be considered for their definition and monitoring in the panel of strategic indicators of a hospital organization.

There are many references to monitor the performance of the assistance of multiprofessional teams, we list some of them below:

Indicator name:	Deaths in stroke patients Measurement of the case fatality rate of patients admitted to the health care institution with stroke. Target population: Patients admitted to the emergency unit with suspected stroke and who have confirmed the diagnosis.
Data to be collected	Total patients admitted with a diagnosis of stroke who died x 100 Total exits of patients admitted with a diagnosis of stroke Stratify the formula data into: Patients with ischemic stroke (AVCi) and transient ischemic attack (AIT); Patients with hemorrhagic stroke(AVCh).
Recommended data closing frequency:	Monthly
Recommendations for target setting and direction (inversely or directly proportional):	**AVCi and AIT:** ≤ 10% **AVCh:** ≤ 25%
Possible participants in the critical analysis of this data:	Multidisciplinary team: nurses, physiotherapists, doctors, pharmacists, nutritionists, social workers, psychologists, speech therapists, dentists, occupational therapists

Table 3 - Parameterization of the indicator Deaths in patients with stroke SOURCE: ANS 2020 - Consortium of Hospital Quality Indicators

Indicator name:	Proportion of patients with ACS who were readmitted within 30 days Measurement of the percentage of patients admitted with a diagnosis of acute coronary syndrome (ACS) who were readmitted within 30 days of hospital discharge. Target population: Patients admitted to the emergency unit with suspected ACS and who have confirmed the diagnosis.
Data to be collected	Total patients who were readmitted within 30 days of hospital discharge and who were admitted in the period of interest x 100 Total patients admitted for ACS with hospital admission in the period of interest

Recommended data closing frequency:	Monthly
Recommendations for target setting and direction (inversely or directly proportional):	≤ 14%
Possible participants in the critical analysis of this data:	Multidisciplinary team: nurses, physiotherapists, doctors, pharmacists, nutritionists, social workers, psychologists, speech therapists, dentists, occupational therapists

Table 4 - For the proportion of patients with ACS who were readmitted within 30 days SOURCE: ANS 2020 - Hospital Quality Indicators Consortium

In addition to monitoring the performance of the multidisciplinary team through the results of care protocols, there are other tools used for team management, which facilitate communication and interaction between members of the interdisciplinary team, one of these tools is Safety Huddle.

The Safety Huddle is a quick meeting between members of the interdisciplinary team and representatives of hospital management, in which the objective is to know all the processes in order to identify strengths and weaknesses in each institutionalized protocol, anticipate possible failures, identifying them even before happen, put them up for debate with the multidisciplinary teams and then invest in improvement actions. Originally, the Safety Huddle was published in 2018 (BRASS et al, 2018) and implemented at a California Community Hospital, the goal was to be recognized as a highly trusted organization, improving communication between different departments, solving operational issues, focusing on safety and quality metrics, reporting unusual occurrences, and connecting leaders across the institution board. Tools such as Safety Huddle only work with mastery if there is high adhesion of the professionals involved in the processes.

The Safety Huddle meeting should have a daily schedule, with a maximum time of 15 to 20 minutes and guided by a script. See the table below:

Safety Huddle	
Frequency	Daily
Duration	15 – 20 minutes Exemple:8:15 to 8:30 am
Script	Previously defined Exemple: Current status of the unit/process Expected discharges (care units) Intercurrences in the last 24 hours (Adverse events) Concerns for the next 24 hours Team related issues Compliments Complaints Suggestions Something to celebrate?

Safety Huddle	
Participants	Process leaders, leaders or representatives of multidisciplinary teams, representatives of senior management.
Notes	All relevant notes must be noted. Example: on flipchart, whiteboard or in case of virtual huddle on slides or other tool.
Feedback	Diary about the notes and resolutions of the previous huddle (meeting).

Table 5 – Safety Huddle – prepared by the author of the chapter

The experience of Hairmyres University Hospital in Scotland was presented by the IHI (Institute for Healthcare Improvement, 2018). The group meets voluntarily every day at 8:15 am, the hospital has about 500 beds. The results of this experience were an improvement in the hospital's workflow, standardization of mortality rates, reduction in the number of surprise events, proximity between clinical and technical teams (such as, for example, members of the IT areas who also participate in the meetings to hear complaints from users of the systems), improving team engagement and improving corporate culture.

Key points for managing multidisciplinary teams

The professionals and processes developed within the organization must interact in perfect harmony, otherwise, the final goal, which is quality care for patients/clients, will be harmed. In this sense, the construction of a clinical management model, in which the therapeutic planning articulated between the multiprofessional team, to meet the health needs of patients/clients and directing common goals to be achieved by the multiprofessional team, must be used as a model and strategy for the management and model of hospital care.

There are several recommended models of clinic management, and they can be adapted to be used according to the profile of hospital organizations. To this end, protocols can be used as a tool to direct and demonstrate the effectiveness of care and to monitor the performance of multidisciplinary teams.

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Chapter 5
PROCESS MANAGEMENT

J. Antônio Cirino

PROCESS MANAGEMENT

Goals

- To understand process management as an essential methodology for the management of health services, focusing on the standardization of activities;
- To contribute with a view to the contractualization of processes and the relationship between customers and internal suppliers, for the continuous improvement of the inputs and outputs of the processes;
- To present the main steps for the practice of process management in health;

Standardize to run safely

In all areas it is crucial to manage processes, but in health this is mandatory, aiming at greater safety in the procedures undertaken, contributing to the avoidance of harm to patients, family members, professionals and society.

Process management is, then, a hospital management methodology for delivering value to internal and external customers/users.

> Process management is defended as the most suitable for achieving operational excellence, as the unit is focused on: a) know your processes – map them, in order to know which ones exist and how they work; b) manage – contract them so that their interconnections and necessary agreements can be understood; c) improve – constantly analyze them, through possible breaches of contract and evidenced opportunities for advancement, enabling the continuous improvement of these processes.[1]

Management by processes needs to be cyclical, as it allows us to have knowledge about the practices and activities, the contractualization of these with other suppliers and internal customers, and most importantly: provide improvements based on possible ruptures in these process interaction agreements.

[1] PRESTES, A; CIRINO, JAF. introduction: Excellence in the management of projects, people, and processes in the hospital environment. In: PRESTES, A; CIRINO, JAF; OLIVEIRA, R; SOUSA, V. **Hospital Manager's Manual**. Brasília: Brazilian Hospital Federation, 2019, p. 29.

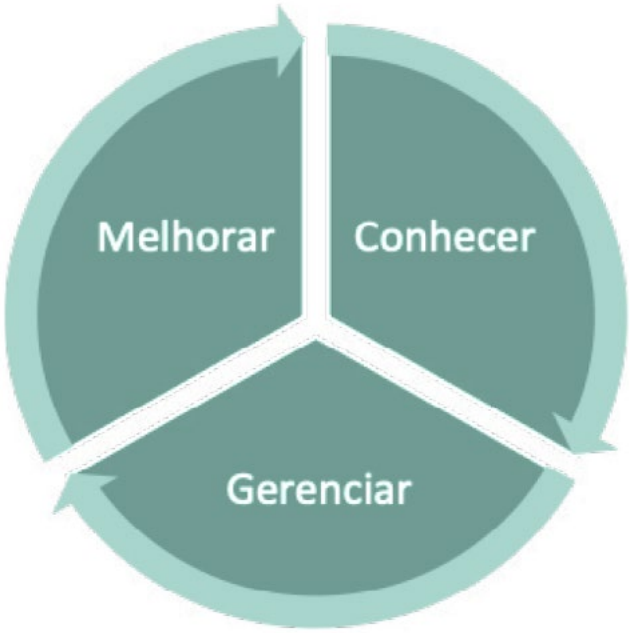

Figure 1 – Process management focuses

Source: prepared by the author of the chapter

All this needs to be connected to the hospital's corporate governance model, based primarily on its management system, with a clear and defined Value Chain (we'll discuss it below), connected to the Strategic Planning and still aligned with institutional policies. This well-structured ecosystem provides greater security and standardization for the work of health professionals.

Hospitals have macro-processes in their structure, which can be understood as interconnected processes and which have a similarity of focus for delivering a result to the patient, such as an intensive care macro-process or critical patient care. A process is a "structured set of sequential activities that have a logical relationship with each other in order to meet and, preferably, overcome the needs and expectations of external and internal customers [...]".[2] In the care example we gave for critically ill patients, we may have mapped the care of the Intensive Care Unit – ICU as processes, as well as other processes that contribute to this care, such as renal replacement therapy or other diagnostic services, to illustrate.

Each of these processes has activities with tasks, which are the smallest particles in the process. We can start mapping and understanding the macro-processes and go down, cadenced, or even start with a task and understand until reaching the macro-processes, depending on the methodology that the institution will apply.

These processes can be categorized into a framework commonly used in healthcare organizations:

[2] OLIVEIRA, D. P. R. Administração de processos: conceitos – metodologia – práticas. São Paulo: Atlas, 2019, p. 9.

- Finalistic/assistance processes: processes that directly generate value for the patient/client should be allocated in this category, as well as other services that are offered by the health unit to society, for example: hospitalization, emergency, outpatient clinic, etc.;
- Management/administrative processes: the processes that contribute to the administrative management of this hospital complex are allocated in this category, for example: communication, quality, finance, billing, etc.;
- Support processes: the processes that support the hospital routine and deliver inputs/services for assistance to take place are organized in this category, for example: cleaning, clothing processing, warehouse, sterilized material center, etc.

This categorization becomes important for the organization of themes and the adoption of specific measures for each type of process, aiming at adequate and effective management in the hospital's daily routine.

Process management in hospitals

For a step-by-step understanding of the implementation of process management in hospitals, we recommend a flow that can be adapted to the reality and interest of each organization, with the possibility of application on a small scale to rotate improvement cycles or in the entirety of the unit, depending on the intention for the moment.

Figure 2 – Process management stages

Source: prepared by the author of the chapter

Responsible structure assignment

As in any activity, it is crucial that the top management of the health unit evaluate the best structure to be responsible for implementing process management, aiming to provide autonomy for the fulfillment of the next steps.

Among the most common structures, we have hospitals in Brazil that work with a specific area of processes, or as one of the responsibilities of the quality sector, or even a commission with this focus or in a broader scope of continuous improvement, for example.

The benefit of being a sector is that we have people dedicated to these activities, and in the commission, this work would be shared with professionals who work in other roles. The benefit of the commission is the multidisciplinary perspective, due to the participation of people from different areas, and in the sector, we have less diversity of perspectives.

The fact is, regardless of the structure, it is recommended that for the effectiveness of management by processes, there is a clear definition of roles, the attributions of all those involved, as well as the creation of mechanisms, which we will strengthen in this text, for the follow-up of results.

Process Management Planning

While the responsible structure is orchestrated, it becomes feasible to undertake planning for the implementation of management by processes. Some issues are crucial for the reflection of this team with the top management:

- What methodology will be used by the health unit? Will we start with one method and then move forward with another to complement it?
- How do we intend to train professionals and other stakeholders involved in process management? What formats, schedules and contents need to be marked out?
- What is our Value Chain? What nomenclature will we use to typify the grouping of macro-processes? What visual format will we adopt for the theme dissemination?
- What criteria will be used to prioritize the processes that we must map, contract and manage? What schedule will be applied?
- How are we going to map the processes? What is the flow to be used for greater effectiveness and standardization of maps?
- What is the contractual format between suppliers and internal customers? What are the priority products/inputs for this description? How will we conclude the agreement?
- Are we going to adopt a communication plan to inform the mapped and contracted processes? What is the frequency and how will we update possible changes in the processes and contracts signed?
- Based on the processes initially, mapped, what is the documental structure that we will use to standardize the activities and process interactions in the hospital?

- In order to verify the results of this process, how are we going to base the construction of indicators for monitoring?
- How are we going to connect process management with risk management to prevent possible failures in standardized activities?
- What mechanisms will we adopt to monitor contracts, indicators and failures?
- Shall we structure an internal audit for processes? What is the periodicity?
- How will the information obtained from monitoring processes and auditing create opportunities for improvement cycles?
- What is the standard frequency for reviewing processes and the entire structure based on this management for continuous monitoring?

These are the main questions that should be planned at this stage, in order to understand what we will achieve with process management in the health unit. Knowing this entire path will provide greater security and clarity to the drivers of this implementation and to the managers and professionals participating in the activity.

Definition of methodology

The definition of the methodology will dictate the next steps and will permeate each of the training, sensitization and structuring of management by processes. There is no right and wrong in this case, but what is applicable to the hospital in which you work and the moment of management maturity. That's why we recommend the search for methodologies used by units similar to your profile, as well as those that present the results that are desired in the strategic planning vision.

One of the most used and which is the basis for the start of many units is SIPOC (suppliers, inputs, process, outputs and customers)

This methodology for mapping processes is simple and helps managers and professionals to have a clear and defined direction on their main activities and with whom they relate, from the perspective of suppliers and internal customers.

Another methodology, used in units with process management with a more advanced maturity, is BPM - Business process management, which provides, in addition to mapping, the modeling of best practices and desired results for these activities, following some steps such as: analyzing, mapping, implementing, managing, optimizing and planning in a cyclical way for the continuous improvement of processes

In addition, during the management of already structured processes, other tools and techniques are common for the day to day of the organization, such as the Lean Six Sigma methodology package, the PDSA improvement cycles (plan, do, study, act), and 5S (*seiri*/utilization, *seiton*/organization, *seiso*/cleaning, *seiketsu*/standardization, and *shitsuke*/self-discipline) with a focus on improving the physical environment and work climate for the execution of processes.

Team training

Based on the decision of which methodology will be used for the management of processes in the health unit, it is important to train professionals to deal with the conceptual, technical and practical aspects of this choice.

It is recommended that, at first, a current diagnosis of the leaders can be carried out, consulting previous experiences that could help in this implementation and, even, inviting them to contribute to the training of other colleagues. This situational analysis will allow us to verify at what level we are in order to plan the depth of training.

This is not an exclusive capability for the tactical level, leaders in a strategic position also need to be enlightened for this process approach, with a focus on conducting their deliberations from this perspective.

Regardless of the current state of knowledge on the topic of the leaders of this hospital, the entire operational team will need to be trained to know how to manage the topic on a daily basis, aligning concepts and nomenclatures that were pacified in the institution for the administration of activities. Therefore, for units that will start implementing process management, it is recommended:

- Initial training of Senior Management with a focus on strategic management of processes;
- Development of leaders at a tactical level for the deployment of the management methodology by processes;
- Sensitization and guidance of all professionals working in the unit for knowledge about the terms, importance, and benefits of standardization of activities and how they can contribute to this result.

After this primary training, the theme of management by processes is inserted in the introductory training of the health unit, to welcome the incoming professionals with awareness on the topic. In addition, it is suggested to add the topic as part of the training matrix for all positions, each with the required level of depth. In this way, the standardized management of activities becomes a continuous agenda in the formation of the health team.

Structuring the Value Chain

Following the training of professionals, we can start structuring the Value Chain, engaging them to contribute with the essential look to answer: how do we generate value for the hospital's stakeholders? "These value chains are combinations of the different elements that add value to customers represented by suppliers, distributors, and consumers."[3]

[3] OLIVEIRA, 2019, p. 46.

Based on this premise, it becomes feasible to list the unit's macro-processes, bringing together the processes by the affinity of thematic and results from management, providing an amalgamating view of the care, administrative and support structures of this organization.

With some variations in nomenclature and in the profile of each hospital, this is usually the most common composition of the Value Chain in the country. When carrying out this activity, each process must be able to know its participation in the macro-processes and how they help to deliver value to the patient/client.

Figure 3 – Traditional Value Chain Model

Source: prepared by the author of the chapter based on the most common uses

From a visual point of view, the graphic scheme is usually structured from left to right, with connection to the organizational identity elements of the hospital's strategic planning, such as the mission, vision, values , and purpose.

Prioritization of processes

Despite the team's desire to map all processes and manage them immediately, this is a medium and long-term construction, since initially, we will need to choose which ones are critical and should be prioritized, including aiming to improve management flows when establishing pilots and promoting improvements in scale. Therefore, we can initially prioritize some processes for management, considering that by improving these, a cascading effect is carried out for all structures that may be connected in this supplier and internal customer relationship.

For this analysis, we can use a GUT matrix (Gravity, Urgency, and Tendency) to understand which of the processes present in the macro processes will be listed in the first step. Another possibility is to apply some questions that lead to reflection on the impact of these activities for the hospital, taking into account whether: the result of this process impacts the patient/client; contributes to the sustainability of the organization; provides increased security and compliance; better work environment and climate; among other essential points.

From this, the processes that will be contemplated in the first moment of the mapping of the processes are chosen, which will come in the sequence and those that will be in the third stage, for example. Dividing everyone into timelines shared with teams to ensure participation and understanding of those involved.

Process mapping

Upon reaching the stage of mapping the processes, through the methodology defined above, it is suggested to structure dynamics that can clarify the discussion about the activities carried out, including:

- Suppliers: who delivers something for this process;
- Inputs: what arrives in this process for its operation;
- Process: what are the main steps of this process that demonstrate its beginning, middle and end;
- Outputs/products: what are the results of this processing performed;
- Customers: who receives these products/services for the continuity of the process cycle in the hospital.

For this data collection, some dynamics are possible, such as conducting interviews with professionals working in the process; brainstorming with the group to refine the reflections; schedule benchmarking at other hospitals to see how we can model the process; and observation, evaluating how it is carried out in practice.

With this information, the standardized map is formalized by the health unit, presenting it in an understandable way for the different hierarchical levels and formations working in this organization. A good process map is one that both those working in this activity can explain, like any other hospital professional. Therefore, training in the methods adopted contributes to the effectiveness of process management.

Contracting of processes

Mapping makes the most sense for everyone when we associate process interaction contracts. A process is better understood when we visualize that it is always connected with another process, in this infinite wheel of providing and being a customer at different times and situations, providing

clarity that we only generate value for patients/customers when we assume this role of continuous improvement, to serve better internally, improving external service.

In this sense, the contractualization intends to establish for each of the inputs/products that were defined in the mapping phase how they will be delivered, considering:

- Scope: characterization of the input/output, its aspects and requirements to be fulfilled;
- Deadline: at what time/periodicity this input/product needs to be delivered;
- Format: in which support/structure/methodology the input/product should be supplied/received;

When detailing the quality requirements of this supplier and internal customer relationship, there is a perception of the integration and interaction between the processes, demonstrating that in order to reach the hospital's strategic goals, to deliver value to the patient/customer, we need to do it together.

Many health facilities contract their relationships more generally, not necessarily with a formal contract, such as the Service Level Agreement (SLA) structure that can be adopted. The contract "[...] aims to describe and define what the client area needs from the supplier areas to execute its process".[4]

In this context, it is suggested that even if the processes are well standardized in their own documentation, such as SOP (standard operating procedure) and others, for example, process interaction contracts are still essential as a way of monitoring possible disconnections between mapped activities. In the process monitoring topic, we will talk about this.

As a dynamic, it is possible to contract the processes and carry out a symbolic formal moment of signing these contracts, making suppliers and customers responsible for the continuous improvement of the service provided by the hospital.

Process communication

Now that we have a structured Value Chain, priority processes mapped, and their contractual relationships, establish a plan for communicating this information to the hospital's stakeholders. Everyone needs to know and act guided by this process management system.

As previously recommended, we can carry out training moments that will strengthen awareness of the use of tools and methodology, an action that must be complemented with continuous communication reinforcements on: the importance of process management; where to find the process mappings; how to read maps; the benefits of contracting processes; among other topics that can guide the themes of this plan.

[4] AFONSO, TC. Connecting and managing the processes. In: CIRINO, JAF; PRESTES, A; LOLATO, G. **Strategies for Accreditation of Health Services**. Curitiba: Appris, 2021, p. 80.

Standardization of processes

The mapping and contracting of processes are not the only standardization necessary to make the hospital even safer. It is essential to establish the document management of the health unit, based on common categories in Brazil, such as manuals, standard operating procedures (SOP), routines, work instructions, forms, policies and others.

In this sense, the hospital can list which categories will be used, define a formatting and content model and guide the teams for their use. The focus is on the traceability of information and the security of everyone involved in these processes.

With the process map in hand, when viewing each of the deliveries and stages of the process, we verify the possibilities of activities that must be standardized in specific documents. As an example, we can think of the process of an intensive care unit (ICU), which in addition to the supplier and client relationship contract with several other hospital processes, will also need to describe the main procedures such as patient care practices, administrative routines area, digital or physical forms to show the assistance/administrative tasks carried out, etc.

Structuring metrics

The structuring of process indicators, by the name itself, is linked to process management. When mapping the activities of a process, we can also perform the parameterization of possible metrics that contribute to the monitoring of results.

In this way, results management and analysis of process performance are intrinsically connected with process management, providing hospitals with the opportunity to have their data and information in dialogue with the process management structure, generating improvements in the provision of services. And not only formulating indicators but also monitoring them to promote the desired positive changes, a subject that we continue in the process monitoring stage.

Risk identification

Another important connection with process management is risk management. Mapping the activities of a process, we can clarify which are the possible failures and how we can prevent them, making them even safer in the health unit. When carrying out risk management connected to processes, there is greater potential for effectiveness. We recommend checking chapter 4 of the Hospital Manager's Manual - volume 2 in which we delve deeper into the implementation of Risk Management.

Process monitoring

With the management structure by processes in progress, the health unit institutes frequent monitoring of the main sources of information for the improvement of activities: the result of

the indicators; the occurrence of failures; the breach of interaction contracts. In addition to other possibilities, such as the internal audit mentioned below.

From the point of view of indicators, for the proper management of processes, we can structure a critical analysis of periodic results, providing opportunities for the discussion of the data collected, of how these indicators demonstrate the interrelationships of the processes and the actions that must be carried out collectively for improvement of the care provided.

The occurrence of failures also needs to be monitored, either through a specific risk audit or by other sources of improvement such as the Ombudsman, Notification of adverse events, mandatory Commissions, and others that demonstrate the ruptures of processes and at which points we can improve the mapped activities. The most important thing here is to provide feedback: errors in surgical procedures, for example, should provoke a review of the process map.

As for the interaction contracts, we can offer the health unit a structured reporting channel or methodology regarding possible breaches in the signed agreements. The idea here is to monitor non-conformities resulting from the relationship between suppliers and customers to avoid failures that impact the safety of those involved, as well as guarantee the sustainability of the institution. Structuring monthly indicators for monitoring these contractual breaches and instituting a flow of analysis and treatment of these breaches will also impact the look of revisiting the process on an ongoing basis.

At a strategic level, these three pieces of information (indicators, risks and breaches of contract) need to be continuously monitored by top management, using dashboards that bring this context together for decision-making regarding the hospital's Value Chain.

Internal process audit

As a complement to other internal audits and assessments that may be being carried out at the hospital, it is suggested to periodically carry out an internal audit of processes, with a focus on evaluating a) the compliance of the mapped processes; b) compliance with standardized services; as well as c) the procedural interrelationship between supplier and client in the health unit.

As this is an internal audit, we recommend training the organization's professionals to carry out this assessment, using the items mentioned above (a, b, c) as a checklist, organized into points where it is possible to attribute compliance (C) or non-compliance (NC) with the appropriate observations and recommendations for analysis of the audited process in order to improve activities.

Improvement cycles

As a result of the monitoring of processes and the internal audit, we will establish continuous improvement cycles, which can be undertaken in PDSA format (plan, do, study and act), to perceive the points of improvement and leverage these actions, but we can also act in a proactive way when there is the possibility of implementing technologies and/or innovation in the process.

At this stage, the most important thing is to provide clarity to all those involved about the tool that will be used, the way in which we should highlight the improvements made, and the place for this registration and monitoring in a unified way, resulting in clear dashboards and reports for top management.

Continuous review and monitoring

Even if there has been no failure, non-compliance with contractual clauses, or even if the result is always within or above expectations, it will not go unchecked. At least in an annual cycle, all processes need to be reviewed and validated again, so that the look for improvement is always attentive.

In other words, in addition to the revisions and improvements provided by the results in indicators, by possible adverse events, breaches of contract and others, it is good practice to establish a calendar for collective review of the entire process narrated here. Therefore, we restarted the continuous cycle of management by processes by providing a new look at what had already been structured before.

Metrics and tools

In order to contribute to process management in the hospital where it operates, we present below some structures that can be applied.

Title of process				
Suppliers	**Inputs**	**Process**	**Outputs**	**Customers**
Processes that provide for that process	Inputs needed for this process	Main steps of this process and/ or flowchart	Products that are offered by this process	Processes that receive these products
Indicators:	List of indicators that are monitored			
Risks:	List of risks that are managed			
Documents:	List of documents that support the activities			

Figure 4 – Integrated process mapping template

Source: prepared by the author of the chapter

Process Interaction Agreement	
Code:	Create a coding system to monitor breaches of contract and number the clauses
Supplier:	Process that is offering this product/service
Product/output:	Product/service name
Quality requirements:	Detailing what the service is, how it is offered, at what time, in what quality and what information is essential
Client:	Process that will receive the product/service

Figure 5 – Process interaction contract template

Source: prepared by the author of the chapter

Improve healthcare processes

Management by processes, as discussed in this chapter, has the main purpose of improving the services provided in the hospital, both for the internal and external public, generating more and more value for patients/customers.

For this to be possible, it is necessary that the processes are connected with risk management, with the management of results, with the sources of improvement and have a cohesive document system for their standardization. We need to view management by processes as one of the modules for corporate governance and the pursuit of excellence in services, which is even more effective when the organization also implements the other themes, which are integral parts of this management.

Either with the use of indicators to measure the results and critically analyze the necessary improvements; the identification of failures to avoid risks and create barriers in the stages of the process; the structuring of guidance through clear and understandable documents for the health team; as well as the use of the different sources of improvement (Ombudsman, adverse events, breaches of contract and many others) to perceive the bottlenecks still present in this flow mapped for its improvement.

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Chapter 6
DIGITAL LEADERSHIP IN HEALTH

Thiago I. Constancio, Ivana Siqueira and Francisco Balestrin

DIGITAL LEADERSHIP IN HEALTH

Goals

- Introduce the discussion on the potent combination between protagonism and the influence of managers and leaders;
- Support this relationship with the organizations' digital assets;
- Present (iii) people development as a strategy to quickly achieve the desired efficiency, sustainability and economic impact in healthcare organizations, in the context of transformation and improvement.

Digital leadership: a new challenge

The world has been undergoing important transformations in depth and speed in terms of technology. When we talk specifically about the digital component, people and organizations have been concerned about how to participate in what is happening, not letting this "digital wave" pass without really enjoying its main benefits.

A survey[1] by CBEXs - Brazilian College of Health Executives with 1532 Brazilian health executives from the public and private sectors reveals that 74,22% of respondents say that the digital transformation in the organizations in which they work was accelerated due to the pandemic.

Similarly, another survey[2] also with executives in the current context of the pandemic shows us where the new hires and employability are in this period and it was identified that the areas of health, technology and digital education are identified as the most demanded.

This involves sub-areas such as the health and safety workforce, automation and artificial intelligence, digital customer experience, digital education and agile methods of communication and work.

There was, therefore, according to the same survey, an acceleration of investments for the purpose of digitizing the interaction and collaboration between workers and for the adoption of automation and artificial intelligence.

And, in that context, who will organize and orchestrate all these sudden changes? Who will lead and orchestrate this new scenario in which the technological and digital component gains even greater relevance?

Sensitized by the impact and growing opportunity that digital transformation brings to the management of activities and development of people in the health sector, as well as the wide gap in

[1] Atlas CBEXs - Brazilian Health Leadership Profile Survey, 2021.

[2] McKinsey Global Business Executives Survey, July, 2020.

digital skills and competencies of leaders in the new scenario, we propose a concise and introductory discussion on the theme Digital Leadership in Health and its potential.

The subject arouses interest, curiosity and even strangeness for many in health, a sector that by its nature has the challenge of dealing with lives, historically behaves more conservatively when it comes to technological incorporation, compared to other areas such as industry and services.

It is also up to us to alert to the need to guide the advances and transformations by diligence and support in scientific evidence, expanding the possibilities of benefits and mitigating the risks to the lives of people and organizations.

In this sense, education must be man's great motivation for his development and, thus, the leader is an educator in the essence of his role and the evolution of his team in different aspects is a primordial condition for us to be able to improve and appropriate the context. The evolution that we mention, when directed by a real leader, becomes transformative not only for people but for the environment as a whole. We understand, therefore, that the ethical, timely and rational use of technological assets favors the face of this challenge, offering modern and agile tools and a lot of specialized knowledge, thus bringing the idea of digital leadership.

In the health sector, the potential digital leader leads and develops people, whether in care or in corporate strategy, acting directly or indirectly for the professional maturation of employees and the organization. This role has a relevant impact on the results of its institutions, delivering greater value from the rational and efficient use of digital technologies.

The concept of Digital Leadership in Health or Healthcare E-leadership in this chapter covers the idea of leadership and the influence of the leader in the strategic use of the organization's digital assets to achieve business objectives, with emphasis on the processes of people development, management, technology and corporate education. For this, digital leadership is challenged to develop new skills and competencies that allow it to react quickly to changes imposed by the external environment, as well as to new customer needs in today's world, making assertive decisions with confidence and knowledge.

Digital assets are understood as any digital component of an organization that generates value for customers and employees and also profitability for shareholders, such as, for example, its relationship strategy, content, data and information generation, services and products from or through the digital technologies. Nurturing and properly managing these assets expands the points of contact between the organization, employees, and customers to consolidate the brand and it goes beyond the geographic reach and variety of service and product offerings, which can now be digital in part or in whole.

In this sense, it becomes mandatory for the leader to lead people (or himself to transit) through the language of the world of information and communication technology, the internet, innovations, applications and startups, understanding and knowing how to extract and apply the best use of these technological tools in the institution's daily life, aiming at improving performance and productivity, assertiveness in decisions and strategic alignment of daily activities with business goals.

Effective digital leadership, therefore, has the ability to lead and direct heterogeneous, multiprofessional, multigenerational, and questioning teams to obsolete practices until reaching the desired transition, which will lead your organization to differentiate itself in the market, as well as to obtain and maintain important competitive advantages in today's world, based on the construction of a relevant digital culture, with greater efficiency in work and communication leading to the development of employees' digital skills and, consequently, to the expansion of the organization's digital capacity. We will see more about these topics below.

Digital Capacity

Digital Capacity can be defined as the organization's ability to use digital tools and assets in order to renew and transform its business model, either with applications in the management model or with applications to improve the experience and customer relationship desired.

The relevance of the digital world today has really taken on unprecedented proportions, which puts in a prominent position the health professionals and organizations that have developed digital capabilities to lead the necessary transformations, such as the expansion of access to health services, efficiency in people development processes and data intelligence for better decision making.

Additionally, the turbulent moment in which we are inserted, due to the repercussions of Covid-19 on society as a whole, has led us to abruptly migrate to the digital world of relationships, communications and education. Numerous events, training, classes and face-to-face corporate meetings were suspended due to the pandemic and found the virtual route as the only possible alternative.

Discussion of Dynamic Capabilities[3] becomes central in this context: in the struggle for survival, organizations are impelled to adapt, change, (re)build and (re)configure their competencies to deal with rapid changes in the external environment. In particular, digital capabilities stand as organizational assets on the rise, enabling the construction of viable alternatives and paths in this moment of uncertainty and rapid change.

Contemporary organizations have undergone an important change in their operational and strategic models in response to environmental dynamism and, specifically, due to digital innovations that are presented to the market with increasing variety and speed. It is possible to notice that organizations have increasingly digitized their operations and processes in search of better performance and results, a process considered irreversible by experts and which has been called "digital transformation".

More specifically, digital transformation can also be defined as "the use of new digital technologies such as mobile technologies, artificial intelligence, cloud, blockchain and Internet of Things (IoT) to enable major improvements in business, to extend and improve the customer

[3] The Dynamic Capabilities approach proposes to analyze and explain how the continuous development of organizational resources and capabilities can be related to organizational performance. They can be grouped into Mobilizing Capacity, Adaptive Capacity, Digital Capacity, Replication Capacity, Absorptive Capacity, Innovative Capacity, Programmatic Capacity and Political Capacity. (CONSTANCIO, 2019).

experience, simplify operations or create new business models. Warner and Wäger's Notes (2019)[4] reveal that digital transformation is a continuous process of using new digital technologies in organizational daily life, which recognizes agility as the central mechanism for strategic renewal:

a. of the business model
b. of the collaborative approach and, finally,
c. of an organization's culture.

All these dynamics seem to have important implications for the organization, in the sense of aligning business strategies and digital or technology strategies, in order to merge them in the form of a digital strategy. On the other hand, the increasingly intense environmental dynamism also makes it difficult for organizations to fully articulate their digital strategies. The dynamism and complexity of the business and technology environment suggest that digital strategy must be emergent, interactive and influenced by the development and evolution of organizational capabilities (YEOW, 2017; GALLIERS, 2011)[5].

In the same direction, Kohli and Melville (2018)[6] believe that organizations are under increasing pressure to apply digital technologies in order to renew and transform their business models, but at the same time, they are not ready to respond to digital trends, with an asynchrony between these market demands and organizational capabilities to respond accordingly.

For these latter authors, digital innovation involves:

1. initiation activities (triggers, identification of opportunities, decision-making);
2. development (design, develop, adopt);
3. implementation (installation, maintenance, training, incentives) and
4. exploration (maximize returns, leverage existing systems/data for new purposes.

In this way, the digital component of the dynamic capabilities of a contemporary organization seems to play a relevant role when thinking about the rapid transformations of business models and also when we take into account the pressures arising from the external environment, so that organizations remain sustainable and viable.

Along these lines, at the end of 2018, the consultancy McKinsey & Company published a survey called "Digital Maturity Index: Brazil" in which it evaluated digital transformation processes in 124 companies from eight segments. An interesting result was found: organizations that are more digitally mature have results, in terms of EBITDA growth rate (Earnings before Interest, Taxes, Depreciation, and Amortization), 3 times higher than the other companies surveyed.

Then, in 2019, Google launched a "digital maturity index" to understand how the level of maturity of Brazilian internet users is, considering that the economic impact of these changes both at an individual and organizational level is quite important. The study found a positive correlation between income and the digital skills index. At the limit, all skills combined can have an impact of up to +R$380 on a worker's monthly income, equivalent to almost 40% of the minimum wage.

[4] Warner e Wäger (2019)

[5] YEOW, 2017; GALLIERS, 2011

[6] Kohli and Melville (2018)

Bringing this issue to the world of health, the NHS (National Health System - British National Health Service) we admire and follow a lot in Brazil, made a publication calling attention to the need to prepare the workforce to "deliver the future digital health." Topol (2019) lists some areas of more immediate attention and investments such as genomics, digital medicine, robotics and artificial intelligence. The leader's first step, therefore, is to know and understand the benefits of these technologies for health.

However, even with the increasing incorporation of new technologies, sectors such as health and education[7] expanded their relevance in relation to other sectors in terms of employability, pointing to a trend of not replacing labor, but of coexistence between strictly human, relational and technological activities.

The representativeness of the health sector in the Brazilian GDP, which has been relevant in recent years, is vigorous and active considering new contracts in progress. According to Anahp - National Association of Private Hospitals, there was a positive balance of about 147.000 jobs in the sector in 2020.

Giving even greater criticality to these findings, when it comes to the adoption and use of digital communication, information and remote assistance technologies, there is evidence and a common sense that there was an accelerated dynamism by the global health crisis from 2020 onwards. A clear example of this effect was that 85% of consultations carried out by an important American healthcare[8] operator were carried out by video in 2020. In the previous year, the percentage was 15%.

In other words, an inflection point in organizations, a concern for this future is already in place. In this way, how do leaders and organizations reach the digital maturity that is so much discussed and presented as a pressing need?

Practical questions for the digital leader

The world changed. The way of thinking, learning and developing people and activities, too. In this context, leaders from all over the planet are striving to adapt in order to facilitate the transmission of priority information in a timely manner to health professionals, while the drastic change in routine, the exponential increase in the production and availability of information and the social distancing have considerably altered practices that have been considered "standards".

In this context of change, a survey of more than a thousand CEOs from 131 countries, from different sectors of the industry and from companies of different sizes, already pointed out since 2016 that **90%** of them already believed that their businesses would suffer disruption or be reinvented by digital models, and **70%** believed they did not have the right skills, leadership or operating structure to adapt to the changes. A challenging situation for both executives and organizations, which is present and legitimate to this day.

[7] CNBC / McKinsey&Company / IPUMS USA, 2017.

[8] Kaiser Permanent, 2021.

In Brazil, we follow the same inevitable trend, with an important movement of consolidation, mergers and acquisitions, and expansion of this digital segment, including education and health companies going public on the stock exchange (national and American) for greater visibility and raising the necessary resources for their audacious projects. Healthcare organizations that seek care and operational excellence, specifically, also direct their efforts and investments to enhance and expand corporate learning processes, efficiency and continuous improvement.

The development of the organization's digital maturity, based on the digital capabilities of its leaders and employees, becomes, therefore, a key point in this change trajectory, having as main vehicles the digital education strategy and the dissemination of targeted and large-scale information and knowledge to achieve results.

In this way, the biggest challenge proposed is to insert the leaders of health organizations in the new digital context, through the development of transformative skills and competencies in technology, education and leadership, in the direction of digital dexterity. Therefore, they will be able to lead and foster continuous, autonomous, and peer learning, integrating digital with face-to-face and encouraging the efficient use of technology.

We point out below what is expected of digital leadership in terms of characteristics, skills and competencies in this context:

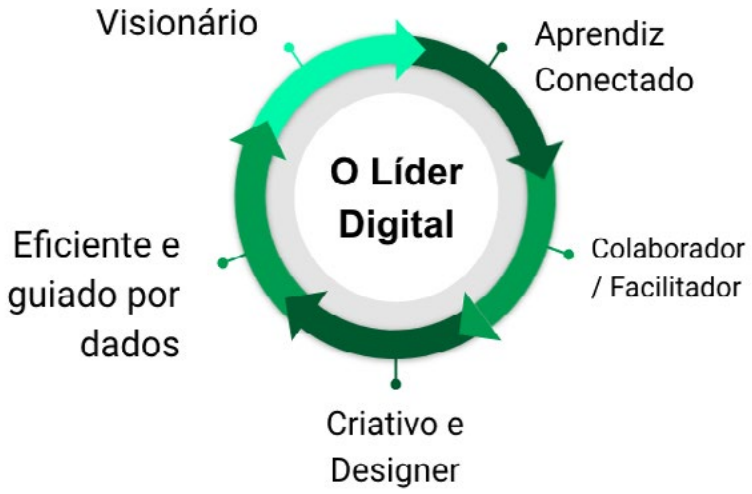

Figure 1: The Digital Leader

Source: Authors of the chapter

- **Visionary:** The Digital Leader, based on a well-defined and diligent purpose, has the ability to foresee evolving scenarios, see new business possibilities, and list solutions to complex problems with the digital and exponential way of thinking. In addition, it empowers its team members to experiment and innovate in a safe and humane environment, where the error is considered a learning path.
- **Connected Apprentice:** Digital leaders are thirsty to learn and relearn what brings results and impacts people's lives in this digital scenario. He invests his time in connecting with mentors, innovative communities and is an active user of digital tools that allow him to

develop the necessary dexterity.

- **Collaborator and Facilitator:** To horizontalize the relationship from the understanding that knowledge and information are distributed throughout the organization, needing to orchestrate and facilitate so that they are structured in a common direction. The digital leader invests his time in activation and collaboration between himself and his followers, in a less hierarchical way.
- **Creative and designer:** Digital leaders realize that they can design and create new projects never before imagined, due to the limitations of the analog and face-to-face world. They invest their time thinking and designing the delivery of a possible future in the digital age.
- **Efficient and data-driven:** Understanding that in the digital age, efficiency goes hand in hand with the use of data is the first step.The Digital Leader bases its operations on data and facts generated by the structuring of its operation. However, at no time does he leave aside human experience and intuition.

We can identify, therefore, that we are talking about finding and defining purpose for professional performance and the potential to transform the way of thinking and acting, in a moment of collapse and crisis in which the relevance of the digital moment becomes enormous, impacts our lives and thus, we propose to inspire and enable leaders to make even more difference at this moment, considering that digital leaders are, first and foremost, leaders who already influence, participate and lead people.

As we mentioned earlier, we have many questions to address when we talk about digital health leadership and its impacts on organizations. For example, which business areas will be most affected by the world and digital practices. Who will actually lead and take advantage of the opportunities that will come with this transformation? The idea when studying and discussing digital leadership is to activate and enable people based on shared reflection and experience.

Where does digital impact?

Currently, of the 20 largest companies in the world in terms of market value, 60% are technology companies operating in various sectors[9]. This indicates a very important movement happening around the digital age and the dimensions that are affected by the changes, that is, we have to pay attention to the impact that technology has had in important areas for health, as we can see in the figure below[10].

[9] Source: Interbrand - Best Global Brands, 2020.

[10] Source: Adapted from Rogers, D. Digital Transformation: Rethinking Your Business for the Digital Age, 2017.

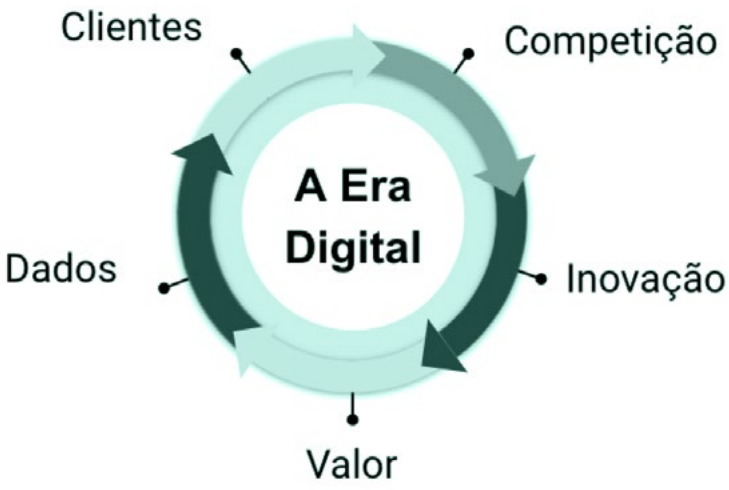

Figure 2: The five domains of Digital Transformation

Source: David Rogers. 2017.

- **Clients:** In the digital age, it is customer networks that drive change, not mass markets anymore. Clients dynamically connect and interact, changing relationships with each other and with companies: they discover, evaluate, comment, use products and services using digital tools.
- **Competition:** Competition and cooperation are no longer binary opposites. The digital platform model is creating fluid industry boundaries where companies from other industries are starting to challenge and enter previously protected markets. The digital age allows the creation and capture of value from models that facilitate interactions involving other customers and companies. We can mention the entry of companies from the telecommunication sector in health, providing connection and open paths for the practice of telemedicine.
- **Data:** The way companies generate, store and process information is different in the digital age. Big data tools provide conditions for companies to forecast and anticipate unwanted scenarios and patterns. Improvement and value creation can be leveraged in the business from data, now seen as strategic assets and the vital force of organizations.
- **Innovation:** Digital impacts how new ideas are developed, then validated into minimal-viability prototypes and released to the market. Fast and less expensive experimentation, based on continuous learning, allows innovation to be seen in a lighter and more attractive way.
- **Value:** In the digital world, the value delivered to the customer is changeable, constantly impacted, being disrupted by the new dynamic business models offered by competitors. Adapting after the change has taken place may be too late.

Transformations in the digital age

The transformations arising from the "world" or the "digital age" are a reality and, as we have seen, advance in the health segment, generating impact and profound changes, which prove to be significant for the lives of people and organizations.

It seems to us, therefore, that it is no longer a matter of choosing to participate or not in this transition, but rather a duty of leaders to enter the new scenario as protagonists so that in a diligent and influential way, they make sure that we are collectively adopting practices and tools more beneficial, prudent and safer than ever before.

The view of leaders on the health system and its dynamics need to change, we need to consider that the digital economy has a different behavior, exponential in its risks and benefits and manifesting itself much faster than we can achieve in our usual and linear way of reflecting and considering the facts.

Issues such as data security and privacy, digital education and artificial intelligence[11] are critics and also the tip of an iceberg that is still unknown and that deserves attention from leaders, organizations and governments. Various initiatives have been emerging across the country, leading to the belief that the employability and opportunities scenario is making sense for many Brazilians when it comes to bringing efficiency, sustainability and economic impact through technologies and data science to the digital health sector.[12].

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[12] Constancio e Valério Netto, Desafios da formação em IA para promover soluções na área de saúde, 2021.

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Chapter 7
COMPETENCY MANAGEMENT

Milton Marinho Nogueira Júnior

COMPETENCY MANAGEMENT

Goals

- Present the general elements that conceptualize, standardize and dynamize the view on competency management in organizational environments and, in particular in this writing, competency management in the hospital context;
- Recognize the organizational scenario that supports competencies based on elements of strategic planning and their consequences, favoring management focused on the identity of each hospital organization;
- Analyze the contemporary elements about the "integral individual", allowing a holistic and contributory vision in attending to individual, group and organizational results, which I am used to calling and proposing as assertiveness to effective and, above all, sustainable results;
- Build with the reader of our content a proposal of indicators to analyze, strengthen and develop employees in general competencies of a company and individual in results, while analyzing the relationships and ambiences in summative and exchanged professional actions.

Historical Paths and Organizational Contexts for Understanding the Concept of Competencies

Inevitably, professional actions and, because of them, labor relations are intensely mobilized in favor of assertiveness, work responses in line with the expectations of companies, managers of organizational areas and the professional himself, which allows us to translate these concepts for the technical orders of performance through knowledge, skills and attitudes.

When adopting a look directed at these levels of performance, a qualified and total analysis of professional deliveries is assumed, which we can call capabilities, but which, because they are innate or potentially learned, offer a more dynamic perspective, designating them Skills. Such competencies are of great and qualified effect when we are faced with the ever-desiring and, currently, increasingly imperative need to manage human resources in hospital organizations, extracting from this management one of the elements of the management of organizational resources, resignifying the concept of management not only of results, but vigorously and definitively, of people management for the generation and management of organizational results.

From this perspective, it is absolutely necessary and enlightening that we offer the basic elements for this construction, originating from the socio-historical and evolutionary context of the term competences.

According to Isambert-Jamati[1], In the Middle Ages, the term "competence" was always closely associated with legal studies, referring to the ability attributed to someone or an organization to judge a certain matter, which is largely associated with the etymology of the word (from the Latin *competentia*, to win, achieve, claim in court). Not infrequently, nowadays, we are faced with dialogues and legal treaties that deal with the idea that a legal professional is or is not competent for such a rite analysis, a legal instance presents itself competent or not competent for procedural analysis.

From the point of view of modern and, specifically, scientific administration treated by Frederick Taylor, the concept of operational efficiency and effectiveness was born through studies of organizational productivity. According to Motta[2], the interest in rationalization and ideal work systems, based on the scientific study of professional action, allowed a first essay on behaviors and technical skills for work practices, even if this was not the author's initial goal.

Motivational, reflective and absolutely modern scholar on our topic, McClelland[3] brought to behavioral profiles an analysis beyond intelligence tests, enabling us to understand that skills at work are not exclusively cognitive, which allows me to suppose that this study anchors and boosts the competencies currently established as multiple, both in the intelligence spectrum and in other social, intrapersonal and organizational skills.

Thus, from McClelland's humanist studies and also from the School of Human Relations, there is a greater involvement with the competencies that deal with and translate behaviors and productivity as a broader concept, not only dedicated to a task or professional practice, since leadership, power relations, communication processes, motivation and the employee's perception of the environment in which he works are clear marks and characteristics of a positive, productive or unproductive, productivist response, not only due to the skills and abilities trained or developed, but especially for the whole context that involves work itself and work relationships.

In this recent way, and also in the light of Zarifian's studies[4], Dutra[5] and Rabaglio[6], management by competencies is established as a mechanism that favors the achievement of individual, sectoral and organizational goals, stimulating the look at the "integral individual" in great association with organizational culture, once it strengthens and reorganizes the concept of healthy, holistic and sustainable productivity to results, not only acting under the micro organizational elements of a professional practice, but above all and definitely in support of strategies that involve efficiency, effectiveness and economy.

According to Nogueira Junior,

> When determining a "competent" individual, it is necessary that a repertoire of previous knowledge (theories, techniques, postulates, formulations,

[1] ISAMBERT-JAMATI. The Appeal to the Notion of Competence in the Journal L'Orientation Scolaire et Profissionelle.In: F. Ropé & L. Tanguy (org.) **Knowledge and Skills: The Use of Such Notions at School and Business**. Campinas: Papirus, 1997.

[2] MOTTA, F. **Teoria das Organizações: evolução e crítica**. São Paulo: Editora Pioneira, 2001.

[3] MCCLELLAND, D. **Testing for competence rather than for "intelligence".** US: American Psychologist, 1973.

[4] ZARIFIAN, P. **Objetic Compétence**. Paris: Liaisons, 1999.

[5] DUTRA, J. **Competencies: concepts and tools for people management in the modern company**. São Paulo: Atlas, 2010.

[6] RABAGLIO, M. **Gare by Competencies: a tool for attracting and attracting human talents**. Rio de Janeiro: Qualitymark, 2015.

> concepts) be established. In addition, competencies draw on predisposing skills or abilities, innate or learned by the individual. However, they need to be put into practice, granting attitudes such as the combination of knowledge and skills.
>
> However, factors extrinsic to the subject need to be incorporated into this analysis - especially in such diverse organizational contexts. - what makes the individual/group/organizational values, the history of the organization and its members and the situations in this context oxygenate and sediment the atmosphere of full competence. [7]

It is therefore quite opportune that our chapter emphasizes, from now on and definitely, the desire to promote a contributory analysis to the reader and to the hospital organizational environment in which it operates, finding in the C.H.A.V.E.S. (Concept based on Nogueira Junior, M. which stands for *conhecimento, habilidades, atitudes, valores, entornos* and *situações*) of competencies the intended success and now reflected, treating the keys as Knowledge (I know!), Skills (I know how to do it!) and Attitudes (I know how to make it happen!), but also respecting the organizational environment and its Values (beliefs, culture, organizational strategy), based on Environments and Situations that legitimize this view of real, authorized and, above all, managed competences.

Thus, the determination of integral competencies (individual, relational, organizational) disseminates what we intend to address below, strengthening the recognition of such competencies so that hospital organizations can design and find the virtues of this analysis of competencies in all human resources subsystems, from the recruitment, selection and onboarding process of employees (dissemination, choice of candidates approved by technical and behavioral criteria and integration of professionals into the company's culture), also passing through the organizational training and development subsystem (technical training for the position and individual development for relationships and for life), systematic evaluation and performance management (analysis of integral performances, systems for verifying objective and subjective results of employees in hospital organizations), management of remuneration and visualization of meritocratic practices based on the analysis of competencies and results, ensuring effective management by Skills.

"Skills": A Classifying, Contributive and Assertive Understanding of Health Organizations

The previously mentioned concept of competency management directs the understanding that work organizations and, in this particular, hospital and health organizations, establish techniques and understandings about the individual at work, through a variety and versatility of knowledge, skills and attitudes, which we intend to classify below, stimulating understanding and favoring people management practices through competences, both in the face of modernities and innovations to which individuals, companies and societies have been invited to rethink.

[7] NOGUEIRA JUNIOR, M. *Resolução de Conflitos: CHAVES e elementos contributivos a uma soft skill de mediação*. In: BRESSAN, C., RIBEIRO, M, & ROMA, A (orgs.). ***Liderança com Base nas Soft Skills***. São Paulo: Editora Leader, 2019.

Such classification, according to Resende, "aims to favor a more organized and didactic assimilation of the subject, given the plurality of definitions and applications, and the fact that it is a subject that is developing very quickly". [8] This author assumes the idea that the classification and understanding of organizational and individual competencies should not be understood only by those who work in the management of people in health organizations, but directly by the entire company, all management and every employee that intends to be part of desirable and, assertively, sustainable results.

In general terms, we currently practice (emphasize: modernity without fad!) theoretical, technical, and practical concepts that ensure what we have strengthened a lot here, namely the analysis and management of the individual by competencies, so that performances are measured and passed on developments, now nominally from 4 (four) observable spectra, namely:

Core Competencies / essential company skills

Treated as essential competencies and the identity of a health unit, the definition of core competencies takes a look at the strategy, mission, vision and organizational values, impacting organizational actions and strategy with the Company's professional teams. We understand that the construction, dissemination and amplification of these competencies determine the identity of the hospital entity, not allowing further negotiations and deviations from the route regarding the desires and the direction of the organization, guiding the actions of the business and, why not, testing the convergence of the values of the professionals included in it.

According to Prahalad and Hamel, the core competencies are presented as "a set of skills and characteristics that contribute to the value perceived by the customer, something competitively unique or exclusive".They also emphasize that the company's core competencies serve as "a collective learning of the organization, a unique set of capabilities that allows the company to create great products" [9].

Based on this understanding, in the hospital and health organizations that we have worked with, attended and produced knowledge, we often observe essential competencies such as agility, integrity, quality of care, attention and customer service, "customer" focus, hospital safety, transparency, management for results, technological innovation, management by processes as imposing and structuring brands of the "health business", which directs sustainable actions and results guided by a strategy and, especially, by an organizational identity.

CONTRIBUTING ELEMENTS TO THE CREATION OF CORE COMPETENCIES IN HEALTH ORGANIZATIONS:

A. **Classification**: Core Competencies;
B. **Meaning**: Essential competencies, identity, "reason for being" of the organization;
C. **Localization**: Organizational Strategic Planning, Mission, Vision, Values, Value Proposition of the Organization, Passive Transformative Purpose of the Hospital Organization;

[8] RESENDE, E. ***O Livro das Competências.*** Rio de Janeiro, Ed. Qualitymark (2010).

[9] PRAHALAD, C. & HAMEL, G. **The Core Competence of the Corporation**. Harward Business Review 68 (3), 79-92 (1990).

D. **Who it is for:** all employees of the Hospital;

E. **Applicability in Management by Competencies in People Management:**

f. recruitment, selection and onboarding: publicizing vacancies in the market with express evidence of the company's culture, analysis of the employee's adherence profile to organizational values [match analysis], integration of the employee into the company's culture since admission, with regular follow-ups;

g. training, development and learning ecosystems: constant updating of knowledge and employee development in compliance with the organizational structure and strategy, favoring dynamic, cyclical and continuous learning about values and the practice of values in the organization;

h. performance and potential management: systematic analysis of employee engagement with organizational values and mission, with an effect on their development, alignment of values and organizational retention, in addition to continuous feedback practices on competency performance;

i. compensation management: adoption of direct or indirect (financial or non-financial) meritocratic practices to recognize employees who stand out for their commitment to the organizational vision and values;

j. mediations: practices of understanding, communication and constant dissemination of planning and the institutional mission, reordering routes and qualifying the experience of organizational identity with employees.

Hard skills / technical skills

Previously presented as a Taylorist perspective of understanding the best and "scientific" ways of working, the professional study of positions has always given ample scope and vision to technical competencies, since they are directly observable, trainable and, usually, relate to the knowledge required for the exercise of the position, both in its cognitive aspects and in the increasingly necessary and inseparable technological aspects.

According to Ibrahim, Boerhannoeddin and Bakare[10], hard skills are easier to quantify and observe, as they meet an objective and "visual" pattern of responses (know/don't know).

In hospital and health organizations, given the complexities and scientific aspects offered, technical competencies are commonly linked to training, the knowledge required for the technical exercise of positions, additional technical training for continuous improvement of work processes, compliance with national/regional regulations, in addition to technical and procedural compliance established by health accreditation bodies.

CONTRIBUTING ELEMENTS TO THE CREATION OF HARD SKILLS IN HEALTH ORGANIZATIONS:

A. **Classification**: Hard Skills;

B. **Meaning**: Technical skills, knowledge required for the exercise of the position;

C. **Localization**:Job description, manuals of standards and work instructions, operational

[10] IBRAHIM, R., BOERHANNOEDDIN, A. & BAKARE, K. The Effect of soft skills and training methodology on Employee performance. In: **European Journal of Training and Development**, v. 41, n. 4, p- 388-406, 2017.

procedures, Brazilian Classification of Occupations (In Portuguese, *Classificação Brasileira de Ocupações - CBO*);

D. **Who it is for**: each position in the organization has specific technical skills;

E. **Applicability in Management by Competencies in People Management:**

f. recruitment, selection and onboarding: evidence of technical, instructional and technological knowledge to enter the position and the institution;

g. training, development and learning ecosystems: constant updating of technical and technological knowledge, with support for employee development in compliance with formal and assertive job requirements;

h. performance and potential management: systematic analysis of the employee's knowledge of the objective exercise of work tasks, in addition to continuous feedback practices on performance in the competence;

i. compensation management: adoption of direct or indirect meritocratic practices (financial or non-financial) to recognize employees who stand out for their commitment to the knowledge and techniques used in a job;

j. mediations: feedback of training programs in the company based on the results of the employees in the objective-formal and technical aspects of the tasks.

Soft skills / behavioral skills

widely studied and applied in contemporary organizations, soft skills, also known as behavioral/attitudinal/relational/distinctive skills, refer to the psychological and attitudinal responses of employees to work, relationships and organization, which requires an effort of constant adaptability of such competencies, given the daily invitation to changes in the company, economy, society and the world.

Treated as transversal, behavioral competencies are linked to character traits, attitudes and behaviors. From Robles[11], "It is the intangible, non-technical and specific valences of the personality that determine the strengths of an individual".

This same transversal concept points to the fact that we are facing a set of competencies that reveals the motivational energy directed to work (for example, innovation, initiative, adaptability, resilience, flexibility, planning, organization, creative thinking, risk taking, agility), but also strongly linked to the relational elements that are integrated and have repercussions on the professional responses and attitudes of an employee, since no work practice is assumed that is not interdependent (e.g. leadership, assertive guidance, delegation, communication, people management, teamwork, interpersonal relationships, empathy, facilitation, etc.).

Indeed, it is worth noting that soft skills also authorize the definition of positively unexpected and distinctive behaviors, generating an association of desirable and detachable attitudes that are not necessarily necessary for a job, but if conquered and presented, they have an exponential

[11] ROBLES, M. Executive Perceptions of the Top 10 Soft Skills Needed in Today´s Workplace. In: **Business Communication Quarterly**, 75 (4), 453-465, 2012.

and outstanding improvement in performance (for example, knowledge of the hospital business, integrated vision of work and practices, systemic/holistic vision, vision for results).

Therefore, given its potential and developmental strength, Marras[12] proposes that the valorization of behavioral competencies makes it possible to deliver a work that is better than expected, valuing new postures and, therefore, effectively more productive results and professional relationships.

CONTRIBUTING ELEMENTS TO THE CREATION OF SOFT SKILLS IN HEALTH ORGANIZATIONS:

A. **Classification**: Soft Skills;
B. **Meaning**: Behavioral, attitudinal, relational and distinctive competencies;
C. **Localization**: Job description, professional file, manuals of norms and work instructions, Brazilian Classification of Occupations (In Portuguese, *Classificação Brasileira de Ocupações - CBO*);
D. **Who it is for:** ideally, each hierarchical family of the organization has specific behavioral competencies, given the structural nature of each position and the behavioral elements linked to each hierarchy of positions (assistants, technicians, managers, superintendents, directors, c-levels);
E. **Applicability in Management by Competencies in People Management:**
    a. recruitment, selection and onboarding: behavioral psychological assessment for entry into the position and the organization;
    b. training, development and learning ecosystems: constant updating of intra and interpersonal development practices, with support for employee development in compliance with the subjective requirements of the position;
    c. performance and potential management: systematic analysis of the employee's knowledge regarding the performance of work tasks and potential growth in the company, in addition to continuous feedback practices on performance in the competence;
    d. compensation management: adoption of direct or indirect meritocratic practices (financial or non-financial) to recognize employees who stand out for their behavior and attitudes at work, favoring growth in position, salaries, and careers;
    e. mediations: feedback of training programs in the company based on the results of employees in the subjective aspects of actions and professional relationships.

Result skills

regarding strategic management in hospital organizations, we would also like to propose a particularly contributory look at the direct results of the work and, above all, a focus on the dynamics and understanding of the objective results of each position and work in companies.

Thus, a set of skills relatively new to management by skills, but increasingly trending in hospital organizations concerns performance indicators, creating and solidifying a management culture for results based on measurable, objective goals and metrics that are associated with the

[12] MARRAS, J. **Human Resources Management: from operational to strategic.** São Paulo: Editora Saraiva, 2016.

behaviors and techniques previously described so that we can find effectiveness in results, touching and integrating sustainability by objective and subjective criteria.

Divided into key performance indicators (KPI's) and objective and key results (OKR's), the concepts of competencies and performance measured by metrics favor key results which, in effect, enhances and also boosts competency-based management since they contribute decisively to the establishment of effective results and, as much as that, to be generated and managed to consolidate results to the work sectors of hospital institutions and, vigorously, to the goals of the organization as a whole.

I must assume, especially, that in most Brazilian companies this concept is not reserved for competency management studies, but as a mix of daring and desire for effectiveness in results, I propose that all organizations determine and design their key indicators (for this reason, the use of the term "key", integrating and making the confluence between the assertive so that the behaviors and the techniques are, therefore, delivered and associated with the results).

In other words, our proposal is that competency management is always integrated into the culture of results, which is not established as an objective and tangible way of studying and understanding organizational behaviors and results, but mainly to meet a link that makes the convergence in the individual and relational analysis of the works in clear, contributory and effective language in numerical results, palpable and, above all, understood in a systemic way. To Chiavenato[13] ,the use of measurements and indicators privileges all important aspects of business management, facilitating the link with strategic planning and its consequences for the business, which also stimulates and feeds the behaviors necessary to achieve success.

Sull and Houlder[14] determine that, periodically, companies must measure not only the results, but also check for discrepancies between what we do and the way we actually do it, as sometimes objective results may not be adjusted to actual values and potential commitments of business.

Through these prisms and analyses, competency management becomes integrated, strategic and exemplified in key performance indicators (KPIs), whether procedural, demographic or financial, at the same time that we can also structure and design goals and metrics of achievement projected into the future, a continuum of performance with a view to what must be achieved.

Our proposal, in short, is that each hospital organization defines its key indicators of current and prospective performance, as this decision of financial indicators (profit making and cost avoidance, usually translated into profitability, billing, EBITDA, analysis of expenses), procedural (quality in the delivery of work and compliance with work procedures and processes, measured by effectiveness and compliance indexes, gloss index , etc.) and demographics (population dynamics, measured by internal and external satisfaction, turnover rates, absenteeism, churn rate, organizational climate) to sectors, departments and hierarchies serves as a great and decisive fusion point between organizational behaviors, attitudes, techniques and strategies that, according to Doerr[15], helps ensure companies focus efforts on the same important issues across the enterprise.

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13 CHIAVENATO, I. **How to Transform HR (from an expense center to a profit center).** São Paulo: Makron Books, 2000.

14 SULL. N. & HOULDER, D. **Do Your Commitments Match Your Convictions?**. Harvard Business Review, v. 83, p. 72-80, 2005.

15 DOERR, J. ***Avalie o que Importa*. Rio de Janeiro: Ed. Alta Books, 2019.**

Thus, the synergy between competencies, behaviors and organizational strategy is solidified, with a view to improvement, development, the uncertain, but potentially drawable, obstinate and desirable future.

ELEMENTS CONTRIBUTING TO THE CREATION OF RESULT SKILLS IN HEALTH ORGANIZATIONS:

A. **Classification**: Result Skills;
B. **Meaning**: Key Performance Indicators (past results analyzed in the present) and Objective Results Indicators (results prospected for the future);
C. **Localization**: Company Goals Book, Area Indicators;
D. **Who is it for**: individuals, areas, and departments and management for Results teams;
E. **Applicability in Management by Competencies:**
    a. Creation and definition of personal, sectoral and organizational goals with a focus on behavioral strategy for the entry into the position and organization;
    b. training, development and learning ecosystems: design of learning processes that direct and determine a culture of results through technical and practical behaviors;
    c. performance and potential management: systematic analysis of the employee's objective results in the performance of work tasks and the commitment to shared delivery of results, in addition to continuous feedback practices on performance in the competence;
    d. compensation management: adoption of direct (commissions, bonuses, awards, participation) or indirect (benefits) meritocratic practices to achieve goals;
    e. mediations: feedback of the training programs in the company from the objective results of the collaborators in the subjective aspects of the actions and professional relationships.

In short, like this: The "Integral" Individual Delivers!

My convictions and my writing are now given over to your reading and, mainly (in the field of my desire), to your reflections so that, in the hospital organization to which you are a part, the collaborators are perceived in all direct, transversal, technical and, for these reasons, sustainable to effective results.

I cannot fail to always emphasize that this dynamic of effective management by competencies is not a step dedicated and oriented only to the areas of people management, but bluntly and tendentially, to every professional who finds in their leadership, team management, and performance practices organizational structure, the identity of the transformation and the "suitability" of the complied deliveries and, usually, agreed between companies and employees. Therefore, a paradigm is broken! Managing people, generating insights, managing competencies is not a designation of an area, but especially a constant, lasting action and achievement, and, above all, self-contributory and to which one lives and is expected to be effective.

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CHAPTER 8
DATA PROTECTION

Lidia Hatsumi Yoshikawa

DATA PROTECTION

Goals:

Know the existing legislation in the country on the protection of personal data.

Acquire knowledge about the requirements of the General Data Protection Regulation (In Portuguese, *Lei Geral da Proteção de Dados - LGPD*) for the collection and processing of personal data.

Apply the *LGPD* in everyday work so as not to engage in practices considered illegal by our Courts.

The protection of personal data in Brazil

BACKGROUND: DATA PROTECTION

The Institute for the Protection of Personal Data has in its DNA the European regulatory frameworks and the decisions of the Courts of the United States[1]. It follows from the American Supreme Court the guarantee "The right to be alone" or the right to be left alone.

In Brazil, the Federal Constitution of 1988 spelled intimacy, private life, honor and people's image as inviolable. This constitutional guarantee founded the treatment provided by other legal instruments to these individual rights, as occurred in the reform of the Civil Code of 2002[2], that in its art. 21 guaranteed the inviolability of private life.

[1] Mendes, Laura Schertel - Danilo Doneda - Ingo Wolfgang Sarlet - Otavio Luiz Rodrigues Jr, in *Tratado de Proteção de Dados Pessoais*, page 5.

[2] Art. 21. The private life of the natural person is inviolable, and the judge, at the request of the interested party, will adopt the necessary measures to prevent or stop an act contrary to this norm.

Also noteworthy are the legal provisions of the Consumer Protection Code[3], Positive Registration Law (Law No. 12.414, of 2001)[4], Law on Access to Information (Law No. 12.527, of 2011) and the Civil Rights Framework for the Internet (Law No. 12.965, of 2014).

Finally, as a concession, Law No. 13.709, of August 14, 2018, was approved, providing for the protection of personal data in Brazil.

LEI GERAL DE PROTEÇÃO DE DADOS (LGPD)

LAW No. 13.709, OF AUGUST 14, 2018

The interactions that take place in the virtual universe know no boundaries. There is an exchange of information involving personal identification data and images that can expose them without the consent of their holders.

At the same time, the growth in consumption via e-commerce that has occurred in the last decade has made companies seek to adapt to consumer demands regarding the protection of their personal data.

In order to be integrated into the international commercial market, companies need to demonstrate that they comply with data protection regulations.

In Brazil, the issue of data protection is associated with incipient discussions that took place from 2004 onwards, within the scope of the Southern Common Market (Mercosul), trade and investment integration of which Brazil is a member.

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[3] Art. 43. The consumer, without prejudice to the provisions of art. 86, will have access to existing information in files, records and personal and consumer data filed on him, as well as on their respective sources.
§ 1st Consumer records and data must be objective, clear, truthful and in easy-to-understand language, and must not contain negative information referring to a period of more than five years.
§ 2nd The opening of registration, form and personal and consumption data must be communicated in writing to the consumer, when not requested by him.
§ 3rd The consumer, whenever he finds inaccuracy in his data and records, may demand its immediate correction, and the archivist must, within five working days, communicate the change to any recipients of the incorrect information.
§ 4th Databases and registries related to consumers, credit protection services and the like are considered public entities.
§ 5th Once the statute of limitations regarding the collection of consumer debts has been completed, the respective Credit Protection Systems will not provide any information that may prevent or hinder new access to credit with suppliers.
§ 6th All information referred to in the caput of this article must be made available in accessible formats, including for people with disabilities, upon consumer request.

[4] Art. 3rd The databases may contain information on the performance of the registrant, for the formation of the credit history, under the conditions established in this Law.
§ 1st For the formation of the database, only objective, clear, true and easy to understand information that is necessary to assess the economic situation of the registrant may be stored.
§ 2nd For the purposes of the provisions of § 1, the following are considered information:
I - objective: those descriptive of the facts and that do not involve value judgments;
II - clear: those that make it possible for the registrant to understand immediately, regardless of referring to annexes, formulas, acronyms, symbols, technical terms or specific nomenclature;
III -true: those exact, complete and subject to proof under the terms of this Law; and
IV - easy to understand: those in common sense that ensure the registrant has full knowledge of the content, meaning and scope of the data recorded on him.
§ 3rd It is forbidden annotations of:
I - excessive information, thus considered to be those that are not linked to the consumer credit risk analysis; and
II - sensitive information, thus considered to be relevant to social and ethnic origin, health, genetic information, sexual orientation and political, religious and philosophical beliefs.

Recently, by the way, it is worth noting that Mercosul Decision No. 15, of 2020, approved the Mercosul Electronic Commerce Agreement, containing a specific clause on the protection of personal data, in the following terms:

"Article 6: Online consumer protection

1. The Parties recognize the benefits of protecting the personal information of e-commerce users and its contribution to improving consumer confidence in e-commerce.
2. The Parties shall adopt or maintain laws, regulations and administrative measures for the protection of the personal information of users involved in electronic commerce. For such purposes. They will take into account existing international standards in this area, as provided for in Article 2.5 (f).
3. Each Party shall endeavor to ensure that its legal framework for the protection of the personal data of e-commerce users is applied in a non-discriminatory manner.
4. Each Party will publish information about the protection of the personal information it provides to e-commerce users, including how to:

a. individuals can exercise their rights of access, rectification and suppression;

b. companies can comply with any legal requirement;

5. The Parties shall exchange information and experiences on their legislation for the protection of personal information.
6. The Parties will encourage the use of security mechanisms for users' personal information, and their dissociation or anonymization, if such data are provided to third parties, in accordance with applicable legislation.
7. **The Parties undertake to apply an adequate level of protection to personal data received from another Party by means of a general rule or specific autonomous regulation or by mutual, general, or specific agreements or in broader international frameworks, allowing for the private sector the implementation of contracts or self-regulation.**
8. The Parties will arbitrate the necessary means to establish common measures for the protection of personal data and their free circulation within MERCOSUL.

The legal framework for data protection in Brazil was inspired by the European Union's General Data Protection Regulation (GDPR) of 2016, which came into force in May 2018. With the approval of the *LGPD*, Brazil joins other 140 countries that have regulations on personal data protection.

LGPD - Law No. 13.709, of August 14, 2018 - treats the protection of personal data as a true legal institute. It applies to any natural or legal person under public or private law that treats personal data as an activity or with the aim of offering or providing goods or services, in the national territory.

The *LGPD* does not apply to the processing of personal data (i) carried out by a natural person exclusively for private and non-economic purposes (ii) carried out exclusively for journalistic and artistic or academic purposes (iii) carried out for the exclusive purposes of public security, national defense, State security or investigation and prosecution of criminal offenses (iv) coming from outside the national territory and which are not the object of communication, shared use of data with Brazilian processing agents or object of international data transfer with another country other than

the country of origin, provided that the country of origin provides a degree of adequate personal data protection.

The *LGPD* provides for the principles and requirements applicable to data processing and the rights of holders of personal data. It defines sensitive personal data - including health data - and sets limits to its treatment. It imposes rules for the processing of personal data of children and adolescents and for the termination of data processing.

This legal diploma contains provisions specifically applicable to the processing of data carried out by the public authority. It also provides for rules to be observed in the international transfer of data.

The *LGPD* defines the agents for processing personal data and the liability hypotheses of each one. It encourages the adoption of security measures and good practices and governance in the treatment of data by establishing specific rules in this regard.

Finally, the *LGPD* provides for inspection rules and applicable sanctions in case of infractions that may be committed and creates the National Data Protection Authority (ANPD) as an organ of the direct administration of the Presidency of the Republic and responsible for overseeing and monitoring compliance with the *LGPD*.

The *LGPD*, despite being young, received two amendments. The first through Law 13.853, of July 8, 2019, with the main objective of creating the ANPD. The second, through Law 14.010, of June 10, 2020, postponed the validity of the sanctions to August 1, 2021.

There are currently 113 bills pending in the Chamber of Deputies and one in the Federal Senate to amend the *LGPD*.

National data protection authority (*Autoridade Nacional de Proteção de Dados - ANPD*)

The *ANPD* was created by Law No. 13.853, of July 8, 2019, as a body linked to the Presidency of the Republic, with technical and decision-making autonomy, but without its own framework of positions and functions.

The executive body of the *ANPD* is the Board of Directors, made up of the Chief Executive Officer and four other directors.

Among the *ANPD's* competencies, those of a preventive and educational nature deserve to be highlighted, such as promoting the population's knowledge of the norms and public policies on the protection of personal data and security measures and encouraging the adoption of standards of services and products that facilitate the exercise of control of personal data by their holders.

Brazil still walks slowly in terms of good data protection practices. There is no data protection culture in the country. Most national companies are small and medium-sized, a reality that takes time to invest in security systems and train human resources involved in collecting and processing personal data.

The *ANPD* is empowered to edit regulations and procedures on the protection of personal data and privacy, to inspect and apply sanctions, exclusively, in case of processing of data in violation of the *LGPD*, through an administrative process that ensures the adversary system, ample defense and the right to resort.

Although the *ANPD* was instituted in 2019, it was only structured in August 2020, with the edition of Decree No. 10,474, of August 26, 2020. This time-lapse between the approval of the *LGPD* and the creation of the *ANPD* led to a mismatch in the regulatory agenda of this Authority.

Currently, the *ANPD* has been producing, in partnership with the Information and Coordination Center of Ponto BR – NIC.BR, booklets on internet security. Edited the Information Security Guide for Small Handling Agents and the guide on How to Protect Your Personal Data, the latter in conjunction with the National Consumer Secretariat. Regulated the process of inspection and application of sanctions to data processing agents, natural or legal persons, of public or private law.

Recently, the *ANPD* signed a Memorandum of Understanding with the Spanish Data Protection Agency aimed at technical cooperation to exchange knowledge and experiences and identify best practices in the field of personal data protection.

In 2021, the *ANPD* joined the Ibero-American Data Protection Network.

Aspects of *LGPD* aimed at the hospital sector

As stated, the protection of personal data as a legal institute was consolidated in Brazil with the approval of *LGPD* – Law No. 13,709, of August 14, 2018, although the theme has permeated our legal system associated with the rights to privacy, of the consumer and as a guarantee of individual freedoms.

The guarantee of these rights is contemplated in the Federal Constitution, in the Civil Code, in the Consumer Defense Code, in the Law on access to information, in the Civil Rights Framework for the Internet, and in other scattered laws, as indicated elsewhere.

The treatment of health data, defined in the *LGPD* as sensitive data, is regulated, in part, by the rules of the Federal Council of Medicine, among which Resolution No. 1.331/1989 (revoked by Resolution No. 1.331/1989 (revoked by Resolution No. 1.821/2007), which provides for general rules on medical records and Resolution No. 2.217/2018, which provides for the Code of Medical Ethics.

The *LGPD* imposes obligations common to all legal entities that process data in Brazil, namely, the need to respond to requests from the data subject free of charge and within the deadlines provided for in regulation, maintenance of the record of personal data processing operations, the preparation of an impact report on the protection of personal data, the processing of data in accordance with the legislation, the indication of the person in charge of the processing of personal data, the rules on data portability of the holders, the guarantee of security, good practices and governance of personal data.

There is no doubt about the scope of the *LGPD* to hospitals and health service providers, but there are many challenges to be faced for its regulation, especially for small and medium-sized ones, which do not have surplus financial resources for investments, even more in the context of the Covid-19 pandemic.

Seeking to adapt the *LGPD* to the reality of small and medium-sized hospitals implies making alternatives available to comply with legal requirements. In this sense, perhaps some issues may receive different treatment for small hospitals, such as the waiver of the indication of a data manager or the performance of this task in a collegiate way, the setting of broader deadlines, the non-compulsory elaboration of an impact report to the personal data protection.

Another issue is the possibility of self-regulation or co-regulation by small hospitals or the hospital sector, based on art. 50 of the *LGPD*, which is a way of producing normative acts with the participation of the ANPD, the body legally responsible for the regulation of the *LGPD* and which, in this case, acts as an approval body. At this point, we note that Bill No. 6.212, of 2019, authored by Senator Antônio Anastasia, which provides for co-regulation, is pending in the Federal Senate.

The entry into force of the *LGPD* sanctions

The *LGPD* provides that the provisions on sanctions have been in force since August 1, 2021. Considering that the *LGPD* itself came into force in the second half of September 2020, it is correct to say that individuals or legal entities that process data personnel had just under a year to adapt to the new legal obligations.

Although it is possible to argue that the *LGPD* was approved in 2018 and, therefore, since then its provisions have been widely known, the fact is that the vast majority of entities representing the business sector, including small and medium-sized hospitals, clinics, and laboratories, are not fully prepared to experience any inspection action by the *ANPD*, especially in the face of the Covid-19 pandemic that continues to put the health sector under pressure.

Therefore, the initiative of the *ANPD*, which submitted the proposed Inspection Resolution to public consultation, must be commemorated. This proposal aimed to regulate the procedure to be adopted for the inspection and application of sanctions and its content demonstrates that the *ANPD* is in line with the best practices of responsive action.

Some points addressed in the proposal discussed deserve to be highlighted, namely, the special attention given to the monitoring, guidance and preventive action procedures, which precede the beginning of the repressive process by the *ANPD*.

The monitoring procedure provided for in the proposal implies the collection of information necessary for the *ANPD* to be aware of the regulated environment and the demands of data subjects, processing agents and those interested in the protection of personal data.

It is also worth mentioning the guiding assumptions of the *ANPD*'s inspection activity indicated in the proposal discussed, such as responsive action, with the adoption of measures proportional to

the identified risk and the attitude of those administered, encouraging the promotion of a culture of protection of personal data and the provision of mechanisms of transparency, feedback and self-regulation. Self-regulation is an important measure for the health sector as a form of self-protection and legal certainty.

The proposal submitted for public consultation also indicated guidance measures, including recommending compliance with codes of conduct and good practices established by certification bodies or another responsible entity. The data processing agents or their representative associations may, by the proposal, suggest the adoption of these guidance measures, under evaluation by the *ANPD*.

Finally, we highlight the so-called Compliance Plan provided for in the proposed Resolution, as a preventive measure that can be adopted by the *ANPD*. This instrument will contain, at least, the object, the deadlines, the actions foreseen for the reversal of the identified situation, the monitoring criteria and the trajectory of reaching the expected results. In addition to this instrument, the proposal provided for the term of conduct adjustment, as one of the possible conducts after the sanctioning process is instituted.

Regulation of the supervision process and the sanction administrative process within the scope of the national data protection authority

After carrying out the public consultation informed in the previous item, the *ANPD*, in the use of its legal competence, edited the Inspection Regulation that provides for the inspection process, through Resolution CD/ANPD No. 1, of October 28, 2021.

This Regulation defines that inspection includes monitoring, guidance and preventive action activities and aims to guide, prevent and repress violations of the *LGPD*.

This infra-legal diploma establishes the limits of the *ANPD*'s performance by providing for the duties of agents who are subject to its supervision, such as providing a copy of documents, access to physical facilities, submission to audits carried out or determined by the *ANPD*.

Regulates the administrative process by setting deadlines and other procedural rules. It also provides for the inspection process and deals with the so-called responsive action, comprising monitoring, guidance, prevention and, finally, repression activities. It establishes the means of inspection, which may occur by letter or through the *ANPD*'s provocation.

The Inspection Regulation provides for the premises of its inspection performance, such as encouraging the promotion of a culture of personal data protection and the adoption of measures proportional to the identified risk and the attitude of the personal data processing agents, as was provided for in the initial proposal submitted for public consultation.

However, according to our understanding, even if the *ANPD* has amended the text of the approved Inspection Regulation - considering the text of the initial proposal that was submitted to

public consultation - because it withdrew the forecast for the edition of new acts necessary for its repressive action, thus reducing legal uncertainty, there are still some points to be improved.

This is because, regarding sanctions, the *LGPD* determines that the *ANPD* must publish the methodologies that will guide the calculation of the base value of the fine. The value of the fines established in the *LGPD* varies from 2% (two percent) of the agent's billing to R$50.000.000,00 (fifty million reais).[5] The other sanctions provided for are considered from mild to very serious, such as suspension of data processing activity.

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[5] Art. 52. Data processing agents, due to violations committed to the rules provided for in this Law, are subject to the following administrative sanctions applicable by the national authority: (Validity)
I - warning, indicating a deadline for the adoption of corrective measures;
II - simple fine, of up to 2% (two percent) of the revenue of the legal entity governed by private law, group or conglomerate in Brazil in its last fiscal year, excluding taxes, limited in total to R$50.000.000,00 (fifty million reais) for infringement;
III - daily fine, observing the total limit referred to in item II;
IV - publication of the infraction after its occurrence has been duly investigated and confirmed;
V - blocking of the personal data to which the infraction refers until its regularization;
VI - deletion of the personal data to which the infringement refers;
VII - (VETOED);
VIII - (VETOED);
IX - (VETOED).
X - (VETOED); (Included by Law No. 13.853 of 2019) (Promulgation vetoed parts)
XI - (VETOED); (Included by Law No. 13.853 of 2019) (Promulgation vetoed parts)
XII - (VETOED). (Included by Law No. 13.853 of 2019) (Promulgation vetoed parts)
X - partial suspension of the operation of the database to which the infraction refers for a maximum period of 6 (six) months, extendable for an equal period, until the processing activity is regularized by the controller; (Included by Law No. 13.853 of 2019)
XI - suspension of the exercise of the activity of processing personal data to which the infraction refers for a maximum period of 6 (six) months, extendable for an equal period; (Included by Law No. 13.853 of 2019)
XII - partial or total ban on the exercise of activities related to data processing. (Included by Law No. 13.853 of 2019)
§ 1 Sanctions will be applied after an administrative procedure that allows the opportunity for a full defense, gradually, isolated or cumulatively, according to the peculiarities of the specific case and considering the following parameters and criteria:
I - the seriousness and nature of the infringements and personal rights affected;
II - the good faith of the offender;
III - the advantage obtained or intended by the violator;
IV - the economic condition of the offender;
V - recidivism;
VI - the degree of damage;
VII - the offender's cooperation;
VIII - the repeated and demonstrated adoption of internal mechanisms and procedures capable of minimizing the damage, aimed at the safe and adequate treatment of data, in line with the provisions of item II of § 2 of art. 48 of this Law;
IX - the adoption of a policy of good practices and governance;
X - the prompt adoption of corrective measures; and
XI - the proportionality between the seriousness of the fault and the intensity of the sanction.
§ 2 The provisions of this article do not replace the application of administrative, civil or criminal sanctions defined in specific legislation.
§ 2 The provisions of this article do not replace the application of administrative, civil or criminal sanctions defined in Law No. 8.078, of September 11, 1990, and in specific legislation. (Wording provided by Law No. 13.853, of 2019) Validity
§ 3 The provisions of items I, IV, V, VI, VII, VIII and IX of the caput of this article may be applied to public entities and bodies, without prejudice to the provisions of the Law No. 8.112, of December 11, 1990 (Statute of the Federal Public Servant), in Law No. 8.429, of June 2, 1992 (Administrative Improbity Law), and in Law No. 12.527, of November 18, 2011 (Access to Information Law).
§ 3The provisions of items I, IV, V, VI, X, XI and XII of the caput of this article may be applied to public entities and bodies, without prejudice to the provisions of Law No. 8,112, of December 11, 1990, in Law No. 8.429, of June 2, 1992, and in Law No. 12.527, of November 18, 2011. (Wording provided by Law No. 13.853, of 2019).
§ 4 In calculating the amount of the fine referred to in item II of the caput of this article, the national authority may consider the total revenue of the company or group of companies, when it does not have the amount of revenue in the branch of business activity in which the infraction occurred, defined by the national authority, or when the value is presented incompletely or is not demonstrated unequivocally and reputably.
§ 5 The proceeds from the collection of fines imposed by the ANPD, whether or not registered in active debt, will be allocated to the Fund for the Defense of Diffuse Rights referred to in art. 13 of Law No. 7.347, of July 24, 1985, and Law No. 9.008, of March 21, 1995. (Included by Law No. 13.853 of 2019)
§ 6 (VETOED). (Included by Law No. 13.853 of 2019) (Promulgation vetoed parts)
§ 6 The sanctions provided for in items X, XI and XII of the caput of this article will be applied: (Included by Law No. 13.853 of 2019)
I - only after at least 1 (one) of the sanctions dealt with in items II, III, IV, V and VI of the caput of this article have already been imposed for the same specific case; and (Included by Law No. 13.853 of 2019)
II - in the case of controllers submitted to other bodies and entities with sanctioning powers, after hearing these bodies. (Included by Law No. 13.853 of 2019)
§ 7 Individual leaks or unauthorized access referred to in the caput of art. 46 of this Law may be the object of direct conciliation between controller and holder and, if there is no agreement, the controller will be subject to the application of the penalties mentioned in this article. (Included by Law No. 13.853 of 2019) Validity

In view of this broad provision for the application of sanctions provided for in the *LGPD*, in order for it to be implemented, the Inspection Regulation must indicate the conduct considered contrary to the *LGPD* and the respective sanctions that may be applied to those who practice them, as well as the methodology adopted for the application of fines. Without these provisions, the Inspection Regulation lacks the legal certainty required for its execution by the data processing agents, so that its compliance remains impaired.

Without the provision of normative hypotheses (conducts), the subsumption of the facts to the norm will not be possible, and, therefore, the Inspection Regulation will be subject to numerous questions when the *ANPD*'s repressive assessment is carried out in the face of the legal uncertainty that arises from it.

It should be noted that the health sector has suffered from the leakage of data from its users, both on the public and private networks.

The protection of personal data in the courts

the national Judiciary, through its Courts, has been basing the application of the *LGPD* in decisions that recognize the right to the protection of personal data as a fundamental right of the human person, but maintains in these decisions, the memory of the Consumer Defense Code, of 1990, essential diploma in force in our legal system, for the accountability of inappropriate practices in the use of personal data.

In the health area, the judged cases are mostly related to the leakage of sensitive personal data, which is conceptualized in the *LGPD*. Judicial decisions are unanimous in guaranteeing the right to non-disclosure of personal data reported in medical or hospital services, but they differ in terms of the recognition of rights in the criminal or civil sphere regarding the granting of compensation claims for material or moral damages.

It is worth transcribing some excerpts from recent decisions of the Courts for a better understanding of the position of the national Justice on the matter:

"CIVIL APPEALS. MORAL DAMAGES. MATERIALS DAMAGE. MEDICAL RECORD DISCLOSURE. HIV.

The author's medical data is made available to the public on the city's website by simply entering his CPF and date of birth, information that is easily accessible. The absence of an access password makes the information, in practice, public. The leakage of the applicant's medical record (pages 31/35), when indicating that he was HIV positive, created an embarrassing and degrading situation in the work environment.

Strict civil liability requires only the occurrence of the damage, the existence of a causal link between the conduct and this damage, and the absence of excluding blame on the part of the victim. (art. 37, § 6º CF).

The secrecy of personal data is gaining more and more sensitive contours, being an increasingly regulated matter in the legislative field. Any leaks of private data are evident facts that generate damage, whether of a moral or material nature, and the legislator tends to protect them, especially when they relate to personality rights.

Art. 5, X, Federal Constitution, art. 42 of Law No. 13.709/2018 (*LGPD*) and art. 4 of Law 13.787/2018.

Moral damages configured. Increased indemnity amount.

Material damage not configured. Absence of proof of a causal link between the exposure of medical data and the effective dismissal of the author. Adjusted attorney fees. Author's appeal partially provided. Defendant's appeal was dismissed.

(...) In turn, with the advent of the digital age, the issue of secrecy of personal data gains more and more sensitive contours, being an increasingly regulated matter in the legislative field, in addition to already contemplated by art. 10, item X of the Federal Constitution. **Any leaks of private data are evident facts that generate damage, whether of a moral or material nature, and the legislator tends to seek the protection of sensitive information, especially when it concerns the personality rights of individuals.** In this sense, Article 42 of Law No. 13.709/2018 (General for Data Protection) brought a direct prescription on liability for improper disclosure of data, i*n litteris*:

Art. 42. The controller or operator who, due to the exercise of personal data processing activity, causes property, moral, individual, or collective damage to others, in violation of the personal data protection legislation, is obliged to repair it."

Civil Appeal No. 1016844-03.2020.8.26.0068 Appellant/Appellee: E. T. da S. Appellee/ Appellant: M. de B. District: Barueri Vote No. 14.884.

"Habeas Corpus. Claim aimed at closing the criminal action under the thesis that the evidence that served as the basis for its filing was obtained in violation of the duty of professional secrecy. Viability.

- In this case, **the hospital that treated the patient informed the police that she showed signs of having an abortion, a communication from which all the other evidence that served as the basis for bringing the criminal action originated.**

- An apparent conflict between, on the one hand, the constitutional principles of intimacy and privacy and, on the other hand, the duty of professional secrecy and the general principles of protection of public security and access to information. A solution that challenges the application, in each specific case, of criteria of reasonableness and proportionality, without losing sight of the fact that, despite the understanding that there are no rights and obligations of an absolute nature, breach of the duty of professional secrecy is only justified by exceptional means, that is, in the face of a situation of great upheaval or social commotion, otherwise the right to intimacy and privacy will have to be honored. For this reason, it cannot be accepted as a premise for all cases that any crime is a just cause capable of denying the individual's constitutional guarantees.

- In case, it is inferred that the patient, before seeking medical help, bled a lot, was between life and death. In such a way that, if there was any legitimate interest of the collectivity, it could only be that it be saved, not subjected to criminal prosecution.

- In conclusion, there is no reason to justify the breach of the duty of professional secrecy. A breach that, as the core of the police investigation, the investigation that served as the basis for the filing of the criminal action, contaminated all the other evidence produced in the records, especially the oral evidence and the remittance of the patient's medical file to the police authority that requested it by trade.

- Order granted to stop the criminal activity.

(.....) 2. The theme touches on the apparent conflict between, on the one hand, the constitutional principles of intimacy and private life and, on the other, the duty of secrecy and the general principles of protection of public security and access to information. Therefore, it is urgent to bring to light the relevant regulation.

Federal Constitution. Art. 5, X - the intimacy, private life, honor, and image of people are inviolable, ensuring the right to compensation for material or moral damage resulting from their violation;

XIV - access to information is ensured to all and source secrecy is protected, when necessary for professional practice;

In the Penal Code, the crimes of violation of professional secrecy and failure to communicate a disease whose notification is mandatory are worthy of mention.

Violation of professional secrecy- Art. 154 - Exposing someone, without just cause, a secret, of which he is aware because of his function, ministry, trade or profession, and whose disclosure may cause harm to others: Penalty - detention, from three months to one year, or a fine of one thousand ten *contos de réis*.

Sole paragraph - It only proceeds through representation.

Failure to notify disease - Art. 269 - Failure by the doctor to report to the public authority a disease whose notification is compulsory: Penalty - detention, from six months to two years, and a fine.

The topic did not escape, in the specific scope of medicine, the Code of Medical Ethics (Resolution CFM nº 2217/2018):

Chapter I - **FUNDAMENTAL PRINCIPLES XI -** Physicians will maintain confidentiality regarding the information they know of in the performance of their duties, except for cases provided for by law.

Chapter IX - **PROFESSIONAL CONFIDENTIALITY The doctor is forbidden**: Art. 73. Reveal a fact that he knows of under the exercise of his profession, **except for just reason**, legal duty, or written consent of the patient.

Single paragraph. This ban remains:

a. even if the fact is public knowledge or the patient has died;
b. when giving his testimony as a witness (in this case, the doctor will appear before the authority and declare his impediment);
c. **in the investigation of a suspected crime, the doctor will not be able to reveal a secret that could expose the patient to criminal proceedings.**

Immediately, it seems clear that the specific rules of the medical profession, except for the exceptional hypothesis of "fair reason", require the professional to respect the confidentiality of the patient's information that he obtains in the exercise of his profession.

To enrich the debate, here is what Resolution 1.605/2000 of the Federal Council of Medicine provides:

> Art. 1 The physician cannot, without the patient's consent, reveal the contents of the medical record or medical record.
>
> Art. 2 In the cases of art. 269 of the Penal Code, where the communication of disease is compulsory, the physician's duty is restricted exclusively to communicating this fact to the competent authority, and the remittance of the patient's medical record is prohibited.
>
> **Art. 3 In the investigation of the possibility of committing a crime, the doctor is prevented from revealing a secret that could expose the patient to criminal prosecution.**

Although it is not a guarantee, professional secrecy has characteristics that make it almost absolute.

Even if submitted to a criminal investigation, it is worth mentioning that the doctor will remain covered by professional secrecy, having no duty to collaborate with the authorities. To reinforce this position, the Code of Civil Procedure excludes the obligation of the health professional, when he is a party or witness, to testify about the facts subject to professional secrecy.

> Art. 388. The party is not obliged to testify about facts: I - criminals or crooks that are imputed to him; II - in respect of which, by state or profession, he must keep secrecy;
>
> Art. 448. The witness is not obliged to testify about facts: I - that cause serious damage to him, as well as to his spouse or partner and his blood relatives or similar, in a direct or collateral line, up to the third degree; II - in respect of which, by state or profession, must be kept confidential.

The Criminal Procedure Code, also except for an exceptional case, transforms professional secrecy into a true witness impediment:

Art. 207. People who, because of function, ministry, trade or profession, must keep a secret are prohibited from testifying, unless, allowed by the interested party, they wish to give their testimony.

As a last resort, it could be questioned whether the new General Data Protection Regulation (*LGPD*) has brought any regulation that is of interest to the present case. Indeed, the legal diploma provides that data relating to the health or life of the individual constitute sensitive personal data:

> Art. 5 For this Law, it is considered:

I - personal data: information related to an identified or identifiable natural person; II - sensitive personal data: personal data about racial or ethnic origin, religious conviction, political opinion, affiliation to a union or organization of a religious, philosophical, or political nature, data referring to health or sexual life, genetic or biometric data, when linked to a natural person;

Therefore, the *LGPD* has a list of hypotheses that allow the legitimate processing of sensitive data. Among these hypotheses, the following stand out:

> Art. 11. The processing of sensitive personal data can only occur in the following cases:
>
> I - when the owner or his legal guardian consents, specifically and prominently, for specific purposes;
>
> II - without providing the consent of the holder, in cases where it is essential to:
>
> a) compliance with a legal or regulatory obligation by the controller;
>
> (...)
>
> e) protection of the life or physical safety of the holder or a third party;
>
> (...)
>
> f) protection of health, exclusively, in a procedure performed by health professionals, health services, or health authority;

It is inferred that none of the listed hypotheses allows the health professional to share data regarding the clinical status without the patient's consent. It should be noted that the *LGPD* excludes from its scope of application the processing of personal data carried out for public security and investigation and prosecution of criminal offenses. For this reason, Bills aimed at creating a "Criminal *LGPD*" are being processed in Congress and may imply that, soon, there will be news, or greater conflicts, on the subject. Here is one more provision of the current regulation:

> Art. 4 This Law does not apply to the processing of personal data:
>
> III - carried out for the exclusive purposes of:
>
> a) public security;

b) national defense;

c) State security; or

d) investigation and prosecution of criminal offenses; (...)" HABEAS CORPUS CRIMINAL No. 2161941-27.2020.8.26.0000 PLAINTIFF: D.P. DO E. DE S.P. PATIENT: R. A. G. DISTRICT: LINS VOTE No. 22286

Considerations

The virtual life that involves the transfer of personal data has increasingly aroused awareness of the importance of guaranteeing the right to its protection, especially as a requirement of its holders.

Data processing agents, natural and legal persons, companies, and service providers are being required to comply with data protection rules to integrate national and international markets.

The protection of personal data, which has the status of a fundamental right in Brazil, is being consolidated as a legal institute with the participation of the *ANPD* and the economic, social and governmental sectors. It is a path of no return.

Synthesis

The protection of personal data in the world has as a regulatory framework the one adopted in Europe and the decisions of the US courts.

The legal framework for data protection in Brazil (Law nº 13.709, of 2018-*LGPD*) was inspired by the General Data Protection Regulation (GDPR) of the European Union, of 2016, which came into force in May 2018.

The *ANPD* was created by Law No. 13.853, of July 8, 2019, as a body linked to the Presidency of the Republic, with competence to edit regulations and procedures on the protection of personal data and privacy, inspect and apply sanctions, exclusively, in case of processing of data in non-compliance with the *LGPD*.

Personal health data is considered sensitive and is partially regulated by the rules of the Federal Council of Medicine, among which Resolution No. 1.331/1989 (revoked by Resolution No. 1,638/2002, in turn, revoked by Resolution No. 1.821/ 2007), which provides for general rules on medical records and Resolution No. 2.217/2018, which provides for the Code of Medical Ethics.

The *LGPD* imposes common obligations on all legal entities that process data in Brazil, including hospitals and service providers, namely, the need to respond to requests from the data subject free of charge and within the deadlines provided for by regulation, maintenance of the registration of personal data processing operations, the preparation of an impact report on the protection of personal data, the processing of data by the legislation, the indication of the person in

charge of the processing of personal data, the rules on data portability of the holders, the guarantee of security, best practices and governance of personal data.

The Inspection Regulation approved by the *ANPD* is subject to improvement to rule out future questions about its execution.

The confidentiality of personal data is the rule. Any leaks of private data are facts that generate damage, whether of a moral or material nature and the legislator tends to protect them, especially when they concern personality rights.

The sharing by the health professional of data regarding the clinical status without the patient's consent, even if they represent evidence of the practice of a crime, may not be considered sufficient just cause to exempt him from liability.

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CHAPTER 9
CONTRACT MANAGEMENT

Mariana Forbeck Cunha

CONTRACT MANAGEMENT

Goals

- Understand the importance of strategic contract management for hospitals.
- Define the main risks involved in a contract.
- Detail tools and models for controlling and mitigating risks in contracts.
- Discuss the contract management model from the preliminary definitions to its closure.
- Demonstrate the importance of performing Due Diligence and Compliance in the contract management process.

Introduction

The reality of a hospital establishment involves not only the provision of medical services, but a whole range of ancillary services that are fundamental for achieving the ultimate objective of the activity. Among these services are those related to the acquisition of materials, supply of items, purchase of equipment, maintenance and contracting of third-party service providers.

These relationships require the formalization of an instrument that stipulates the obligations between the parties, values and deadlines regarding the services and, of course, goals and indicators, in order to guarantee transparency in business relationships.

Due to the large amount of negotiations, the management of contracts has shown itself, more and more, of fundamental importance within the hospital establishments, since it ensures the mitigation of problems and prevents conflicts, in addition to removing labor, fiscal, civil cases and even strengthening processes regarding anti-corruption rules.

However, the management of contracts does not entail the mere formalization of contractual terms with third parties[1] and archiving the protocols: management is more than that. It requires organization and direction of activities, teamwork, coordination, planning, monitoring and evaluation of indicators, issues duly analyzed in this text.

Thus, it is of fundamental importance, in order to give greater legal certainty to contractual relationships, an efficient contract management, which starts from the delimitation of the internal responsibility, goes through the necessary due diligence in the contracting, and extends until the end of the relationship.

In this chapter we present the outline of a contract management process, which will facilitate the control of business relationships and mitigate labor, civil and fiscal risks.

[1] In the present text, the term 'third parties' should be generically understood as suppliers, distributors, service providers, commercial representatives, consultancies, dispatchers and all those who have business and contractual relationships with the health establishment.

What is Contract Management

The hospital activity demands not only the provision of services related to health, but several others already mentioned. For all existing relationships between the entity and third parties, it is extremely important to describe the obligations defined between the parties, through the elaboration of an instrument for this purpose: the contract.

Such an instrument is defined as a "bilateral legal act, dependent on at least two declarations of will, whose objective is the creation, alteration or even extinction of rights and duties of patrimonial content"[2].

Thus, any and all negotiations carried out when formalized through a contract can guarantee more security and effectiveness, avoiding future problems regarding the points being negotiated.

However, simply writing contracts is not enough if they are not properly managed within the organization. The organization of activities from the drafting of the contract to its termination is essential to avoid any risks during the contractual relationship and to facilitate the manager's daily life.

In this way, the management of the contract in the health establishment, considering the aforementioned concepts involves, among other activities, (i) assessment of the need for the contract; (ii) planning regarding the contracts to be made; (iii) organization of contracts; and (iv) monitoring of signed contracts until their termination.

A good management of signed contracts prevents demands and conflicts with suppliers and third parties, in addition to facilitating the resolution of internal demands and conflicts that may arise, avoiding undue losses or at least reducing them.

Labor risks can also be avoided or reduced as a result of contracts with bad service providers that do not remove the employment relationship; civil risks due to abusive clauses or conditions other than those discussed between the parties that were provided for in an unreviewed contract and even tax risks, when there are no express delimitations about the collection of taxes and tax liabilities.

Contract management can be performed according to the principles of the so-called Contract Lifecycle Management (CLM), which has as models the Project Management Book of Knowledge (PMBOK), Contract Management Body of Knowledge (CMBOK) and Contract Management Maturity Model (CMMM).[3]

Such contract management models bring approaches that basically involve the stages in the context of the life cycle of contracts, such as pre-contracting, contracting, pre-execution, execution and closing, with each model having its peculiarities.

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[2] TARTUCE, Flávio. **Direito Civil**, v. 3: *Teoria geral dos contratos e contratos em espécie*. 13 ed., rev., currently. and ampl. Rio de Janeiro: Forense, 2018, p. 01.

[3] SILVA, Raquel Ximenes. **Contract lifecycle management in a large company**: a model from an adaptive planning perspective. 2015. 105f. Masters dissertation. Pontifícia Universidade Católica do Rio de Janeiro, Rio de Janeiro, 2015.

In this chapter we address this within the context of the Contract Lifecycle model, involving the phases around definition, pre-contracting, contracting, pre-execution, execution and closing. The implementation of a process regarding the management of contracts is, therefore, fundamental for health activity.

Contract Management Process

As seen above, contract management has numerous benefits, mitigating labor and tax risks, stipulating penalties, thus reducing non-compliance with deadlines and undue charges, facilitating the daily life of managers.

The implementation of a contract management process entails, initially, the analysis of the main business characteristics of the company, delimitation of the existing difficulties regarding contracts and negotiations, as well as the reflection on the need to centralize this management in a single sector or distribute responsibilities.

The centralization of the process will demand greater control since a single sector will be responsible for the implementation of all stages of the process, and the administration of all signed contracts.

On the other hand, shared management, also called participatory management, involves hiring by one area, and management by the others, stimulating synergy, internal negotiation, specific knowledge of demands and the market, in addition to the exchange of knowledge and commitment between all those involved.[4]

It is suggested that this management be shared between sectors, with a centralization regarding validation, registration and archiving, but also maintaining daily control with the person responsible for negotiation.

It is important to define, from now on, what will be the attributions of each of the actors within the process, especially those most involved in contracting such as the Acquisitions/Purchasing Sector, Financial Department, Board of Directors/Superintendence, Legal Department, among others.

The search for partners within the institution and the adhesion of employees to the contract management program is crucial for the successful implementation of the process.

The flow will begin with the delimitation of its main objective, which may involve the organization of existing contracts and the creation of flows regarding new contracts; the centralization of the elaboration of contract management in a given sector; mitigation of labor risks in service contracts; the reduction of the payment of fines for non-compliance; improvements in contracting suppliers, etc.

[4] SILVA, Raquel Ximenes. **Contract lifecycle management in a large company:** A model from an adaptive planning perspective. 2015. 105f. Masters dissertation. Pontifícia Universidade Católica do Rio de Janeiro, Rio de Janeiro, 2015.

This definition will be made after an internal analysis of the main difficulties encountered by the company regarding its business relationships, and how such difficulties can be minimized or eliminated.

Regarding the importance of this analysis of the reality of the establishment, it is worth mentioning that:

> One of the most relevant aspects before starting the development of the methodology is the need to know and analyze the structural situation of the hospital. It is essential to know and analyze the general context of the institution and its surroundings, in order to identify its complexity, planning methodology and processes, among other aspects, to understand it and facilitate the determination of mechanisms for risk analysis.[5]

As an example we can mention the difficulty regarding the archiving of contracts, lack of centralization of the file, and problems with lost documents. The solution, in this case, may be the centralization of the file and archiving control, and even the signing of contracts only in digital mode.

After mature discussions about the objective, which are the main problems arising from relationships with third partie, and the definition of those responsible for contracts and negotiations, the process will begin to be outlined.

The steps involved in implementing this flow are:

1. Definitions and Pre-Hiring;
2. Hiring;
3. Pre-execution;
4. Execution;
5. Termination.

Each stage will be analyzed separately below, with an understanding of the main focuses of attention in each of them.

Step 01: Definitions and Pre-Hiring

The first stage of the process involves the analysis of the need for the contract as an instrument for formalizing the relationship between the establishment and its external partners.

It is at this first moment that the internal demands will be mapped, and the support network created within the hospital itself, with the involvement of all sectors.

The definition of which is the internal activities that demand contracts and the delimitation of values for negotiation are fundamental. This is because it is up to the hospital manager to define

5 MALAGÓN-LONDOÑO, Gustavo; LAVERDE, Gabriel Pontón; LONDOÑO, Jairo Reynales (null). **Hospital management for effective administration**. 4. Rio de Janeiro: Guanabara Koogan, 2018, p. 366.

which commercial relationships will be the object of the contract, through the definition of values for free negotiations.

It should be noted that there is no obligation to formalize a contract. The execution of a legal business, by itself, without the formalization of a contract, already has legal guarantees and is effective.

However, the contract is the instrument through which the parties describe and delimit their obligations, responsibilities, deadlines and measures in case of non-compliance, bringing more transparency to the business relationship.

Thus, it is common for values of authority to be defined that do not require the writing of a formal contract or the recognition that, in certain cases, the contract will not be necessary.

It is a matter of mere liberality of the establishment that, after defining what works or not within its structure, will create an internal policy on these issues, assuming the risks of not formalizing a contract

Such risks, as already mentioned, involve possible problems regarding meeting deadlines and even financial losses. It should be noted that the absence of a contract does not mean the absence of legal protection, but only the application of the generic protection provided for by law, especially in articles 104 and following of the Civil Code that provide for legal transactions.

The wording of a contract will always bring the "rules of the game" clearly laid out to the parties, not giving rise, on several occasions, to the Judiciary Power in order to resolve any pending issues.

Having defined, then, the scope of negotiation without the need to write a contract, the main businesses that, on the contrary, demand contracts must be defined, as well as the main contract modalities to be used, such as service contracts of general services, provision of medical services, supply, purchase and sale, maintenance, etc.

Finally, having defined the contracts, the sectors involved, and the partners in the process, the discussions of the second stage begin, about the elaboration of the contracts themselves.

Step 02: Hiring

The elaboration of a contract involves, initially, the choice of the contractor. Research on the reputation and reliability of the provider is no longer a mere formality, but essential for the success of the contract.

Therefore, performing due diligence and compliance assessment should be the first steps when choosing a third party, even before the negotiation between the parties.

That's because a good price is useless, if the company's reputation is of those who do not deliver the items on time, it has several legal problems, in addition to protests.

The term compliance can be defined as "acting in accordance with legal, moral, ethical and conduct rules in the face of situations experienced by us, commercially, professionally and personally speaking"[6].

The formalization of compliance programs in the health environment is already a reality, but even if the establishment does not have an established program, nothing prevents such principles and rules from being applied in terms of contracts.

And within this concept of acting in accordance with legal, moral and ethical rules, nothing is more correct than looking for suppliers that act in this way. In addition, hiring a supplier that has a good reputation in the market removes (or at least reduces) the eventual non-compliance risks.

It is therefore necessary to carry out the so-called due diligence, which can be defined as

> (...) a mechanism for legal entities to identify the business partners with which they relate or intend to relate, including verification of their image and reputation in the market in which they operate and possible involvement in cases of corruption, fraud and other relevant illicit acts.[7]

Companies in the healthcare sector should reduce risk by following basic due diligence guidelines to confirm the real existence of a supplier or track legal, regulatory and reputational issues, for example, will help you make decisions, protecting the business[8].

This analysis regarding third parties must involve mapping information and risk classification regarding the hiring of that professional, especially regarding the following items:

> (i) What is the "type" of the third party (agent, consultant, forwarding agent, etc.) and if the service to be provided is adequate considering their technical capabilities and specialization;
>
> (ii) What is the third party's industry;
>
> (iii) How is your image and reputation in the market;
>
> (iv) Which companies make up the corporate group of which the third party is a part, including the identification of the final beneficiary;
>
> (v) What is the value of the contract and whether it is consistent with market practice, with the service to be provided and with the third party's level of expertise;
>
> (vi) Verification if there is supporting documentation related to the provision of services/products provided;[9]

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[6] TEIXEIRA, Josenir *in* PRESTES, Andréa. **Hospital Manager's Manual**. V. 2 Brasília: Brazilian Hospital Federation, 2020. p. 60

[7] CARVALHO, André Castro (coord.) *et al*. **Compliance manual**. 3. Rio de Janeiro: Forense, 2021. p. 123.

[8] COTTER, Phil. **In times of a pandemic, do not neglect due diligence**. Available at: http://br.perspectives.refinitiv.com/risk-management-and-compliance/em-tempos-de-pandemia-nao-descuide-da-due-diligence/ Access in November 22. 2021.

[9] Idem, p. 126.

In addition to the above, it is important to carry out a search for the existence of lawsuits, complaints, investigations, in addition to requesting clearance certificates that demonstrate that the company does not have repeated lawsuits due to contractual breaches.

Carrying out due diligence not only removes bad service providers and third parties, but also those involved in corruption practices and investigations.

Fundamental examples of due diligence in the health area involve the investigation of third-party medical professionals to be hired: in being the professional establishment responsible for the acts of its agents[10], the choice of physician must always take into account the analysis of his previous life in the Regional Council of Medicine of the state, the existence or not of ethical processes due to medical malpractice, negligence and imprudence.

That is why due diligence is more than a mere search: it involves effective research and investigation of any and all third parties to be hired, further reducing the risks of non-compliance, civil and even criminal damages.

After carrying out the due diligence, upon requesting certificates on behalf of the third party (class councils, judicial distributors, notary offices, serasa, etc.), and verifying the suitability of the provider, the commercial issues will be defined and formalized between the parties .

It is at this point that the terms, amounts, quantity, payment method, fines in case of non-compliance, termination and obligations of the parties are discussed by the internal manager of the contract with the third party.

It is important that at this stage the service level agreements or, as widely known, the SLA (Service Level Agreement) are also defined. The contract itself may include in its terms the parameters expected regarding the services to be provided, how to adjust these levels, even without the need for a new contract, and even awards or discounts/disallowances in case of variations from the established pre-paid level[11].

Subsequently, once the commercial issues are defined, the contract must be prepared, or revised, by the Legal Department, bringing all the provisions that guarantee compliance with the defined within the deadline and for the values agreed in the contractual instrument.

The correct wording of the contract may eliminate possible labor risks, bringing provisions that show the inexistence of alterity, subordination, personality and habituality[12], characteristics of the employment relationship, in particular in contracts relating to the provision of services.

Legal validation is, therefore, essential to translate, in legal terms, the commercial conditions and the defined SLA's, stipulating the obligations between the contracting parties and penalties in case of non-compliance.

[10] This provision is set out in Art. 927 of the Civil Code: "Art. 927. Anyone who, by unlawful act (arts. 186 and 187), causes damage to another, is obliged to repair it. Single paragraph. There will be an obligation to repair the damage, regardless of fault, in the cases specified by law, or when the activity normally carried out by the author of the damage implies, by its nature, a risk to the rights of others".

[11] SALU, 2021, p. 110.

[12] These characteristics are provided for in the *CLT* in its articles 2, 3 and 4

Validation should not be carried out only by the Legal Department: all sectors involved in the negotiation must analyze and assess whether, effectively, the legal terms about it are consistent with the reality of the contract.

This is because a contract that provides for all possibilities is useless if it is not applicable to that legal relationship itself. It will be up to each health unit to define which internal managers should validate the signed contracts: if only the immediate manager and the Legal Department or if there is a need, for example, for approval by the Board of Directors.

After the validation of all those involved, including after discussing any doubts with the contractor and collecting the signatures of those involved, the contract must be registered, and the third stage of the process takes place.

Step 03: Pre-Execution

Once all the signatures of those involved are collected, and the process regarding the draft is finalized, the contract registration will be carried out. The suggestion is that the chosen platform can be accessed by all those involved in the execution of the contract: immediate manager, financial, purchasing, legal, warehouse.

An example of the importance of access for all those involved can be seen when formalizing a drug supply contract.

It is important that the purchasing department can access the draft in order to verify delivery times; the warehouse must have access to check the delivered stock; the pharmacy is responsible for analyzing its direct stock and making any complaints about the product; the legal department must be informed in the event of non-compliance; the financier will access the instrument to check payment terms and amounts, and so on.

Standardization, the availability of the collection of contracts in digital form, the correct registration of information, and the physical (or digital) archiving of the draft should also be the object of the process as they facilitate day-to-day management.

It is also at this stage that the most critical control points to be monitored are prepared, the ways of processing information are identified, the necessary access is granted, and those responsible are communicated about the formalization. [13]

Step 04: Execution

The execution of the contract involves activities related to the management of the duly contracted between the parties. The contract administration activities seek to ensure the performance

[13] SILVA, Raquel Ximenes. **Contract life cycle management in a large company:** a model from an adaptive planning perspective. 2015. 105f. Masters dissertation. Pontifícia Universidade Católica do Rio de Janeiro, Rio de Janeiro, 2015.

of the contract, and its successful conclusion, through the formalization of amendments that are necessary, forwarding of problems, payments, conferences, among others.[14]

Here, the management of the contract will be the responsibility of the person responsible internally defined between the parties for the conference regarding the fulfillment of the contractual provisions.

It is at this stage that the established SLA's will be monitored, in order to verify compliance or not with the contractual provisions. Any changes to the contract may be formalized at this stage, so that the draft is adequate to the reality of the business relationship, as well as notifications regarding non-compliance.

Step 05: Termination

Finally, the last step involves formalizing the closure of activities carried out under the signed contract. Issues such as checking work completion, documentation and financial resolutions involve implementing checklists.

In addition to practical questions about the service provided, the legal instrument competent to terminate that relationship must also be formalized, whether it be a dissolution, a notice of termination or a term of termination.

Once the contract has been concluded, and the competent document to formalize the end of the contractual relationship has been signed, the establishment may create, if it so wishes, a database regarding the experiences learned during the contracting process.

Based on this analysis, new contracts can be adapted and improved, with the redefinition of SLA's, deadlines and values, bringing lessons for future contracts.

Conclusion

Contract management for hospitals involves creating a process that handles all stages related to contracting, from the initial phase to its closure.

Such steps must be the object of the creation of effective Contract Management, which will involve: (i) definitions and pre-hiring; (ii) hiring; (iii) pre-execution; (iv) execution, and (v) termination.

Even more important than the definition of stages and delimitation of responsibilities is the understanding that contract management will help to mitigate risks related to non-compliance, financial losses, tax and labor problems, and even the violation of anti-corruption rules.

[14] Idem.

To this end, the engagement of senior management and all sectors is essential, ensuring that good hires are carried out, ensuring that the service is performed as defined and expected.

Mitigating risks, establishing flows, a nd d efining ru les ab out co ntracts, me an no t on ly reducing costs but also encouraging good practices and rewarding appropriate conduct, bringing positive impacts to the image and reputation of the health establishment, as well as better conditions for the development of the final activity of a hospital.

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CONSIDERATIONS

J. Antônio Cirino

THE STRATEGY CONNECTED TO PEOPLE AND PROCESSES

As discussed during the third volume of the Hospital Manager's Manual of the Brazilian Hospital Federation - FBH, health care must be maintained with strong foundations in the organizational strategy for an adequate connection to the management of people and processes inherent to hospitals.

IHI's triple objective for improving hospital management provided an essential look at achieving health focused on people, bringing the opportunity to improve the health of the population and optimize processes to reduce costs for everyone involved in the value chain.

About Clinical Governance, the concept and theoretical framework, its main pillars, and how they unfold in effective care management were discussed; clinical auditing as one of the tools for continuous improvement, and also the implementation format of the Clinical Governance model, with the definition of attributions and responsibilities; facilitators, barriers and challenges for this realization and monitoring and monitoring tools.

The chapter on Telemedicine supports the relevant concepts and regulations, bringing the benefits and challenges of the topic in hospitals of different sizes, as well as the steps to structure a telemedicine service, how to prepare and train the team on tools and techniques to assist the telemedicine process.

Next, there was an approach to Person-Centered Care, as essential for the humanization of care and the enhancement of professionals. In addition to explaining examples for reception, the unique therapeutic project and the discharge plan. Actions focused on the active participation of family and friends and the strengthening of practices for the alignment of actions at the strategic level and the deployment of concepts at the tactical and operational levels.

To support these excellent practices, the Multidisciplinary Team Management chapter focused on the best practices for this management in hospital organizations, guidance on the benefits offered to patients assisted by a multidisciplinary team and how this team impacts the hospital's results, enabling ways to measure these results.

In the chapter on Management by Processes, the core strategy of establishing the hospital's value chain was explained, with process mapping methodologies and how to establish process interaction contracts, the performance of process audits, monitoring of breaches of contract, indicators and their critical analysis and risk management, how to provide continuous improvement of processes.

Considering the scenario focused on innovation and technology, the Digital Leadership chapter brought important aspects regarding the future of healthcare management and what it means to be a digital leader. The need for corporate education in hospitals to generate value with

digital technologies and also statistical data regarding the essential turning point for a new moment in health management in Brazil.

As for Competence Management, this chapter brought the vision of strategic people management, with its concepts, methods and techniques for competency management, how to identify competencies and their ramifications and the definition of the profile of positions based on competencies, making it possible to integrate the subject with subsystems and behaviors.

In the Data Protection chapter, the purpose was to guide the security of information in hospitals, based on the legislation and its application to health to comply with the GDPR - General Data Protection Regulation. The importance of raising awareness and training stakeholders on data protection to support this culture in the country.

Finally, regarding Contract Management, aspects of outsourcing and the management of these agreements were addressed. The control and risk mitigation tools in service contracts, such as the Service Level Agreement (SLA), the methodologies for monitoring contracts and the risks inherent in contracting, as well as the methods for evaluating proposals and the decision process and the application of Compliance in Contract Management.

All of these chapters strongly help to sustain excellent practices in hospitals in Brazil and the world and can greatly contribute to the promotion of strategic actions based on people as essential for the transformation of health processes.

FBH AND THE FEDERATE

FBH

A HISTORY OF STRUGGLES FOR IMPROVEMENT IN THE COUNTRY'S HEALTH SECTOR

The Brazilian Hospital Federation (FBH) is a non-profit association that, for over 50 years, represents the Brazilian hospital sector. Full member of the Health Chamber of the National Supplementary Health Agency (ANS), A constant presence with the National Health Surveillance Agency (Anvisa) and the Ministry of Health (MS), FBH participates in the main decisions of the sector, fighting for better working conditions for the companies it represents and for the quality of services provided by the private health network.

Currently, one of the main focuses of the Federation is the fight to mitigate the financial crisis that affects a significant portion of private hospitals affiliated with the Unified Health System (SUS), including charitable institutions and specialized clinics, such as nephrology. The table of SUS procedures remained without any readjustment from 1994 to 1999, which resulted in a marked lag that was never corrected. FBH proposes to strengthen the entity's institutional position in the face of negotiations of the private health network with the public power and health plan operators, to promote a plan for recovery by updating the amounts paid to the units associated with the SUS and the supplementary system.

Another great banner of struggle of the Federation is the reduction of the tax burden in the Health Sector, considered by tax studies one of the highest in the Brazilian economy, with double taxation levied on some taxes.

The tax burden imposed on the sector is the subject of constant debate by FBH with the public authorities and the National Congress. The FBH proposes the exemption of some taxes that affect the revenue to reduce the charges, thus improving the negotiation of the adjustment of SUS tables and health plans.

HISTORIC

A trajectory of struggles

FBH, one of the largest representatives of the country's private health network, has helped to write the history of Brazilian public assistance over the last 50 years.

The Federation and its state associations act in the defense of clinics, hospitals, and outpatient clinics, representing today more than 4 thousand units responsible for 62% of SUS care and 100% of the supplementary system, meeting the care needs of the population in locations where there are no public hospitals.

Growth and modernization

In this trajectory, FBH has turned adversities into achievements and nowadays is guided by the permanent goal of qualifying public assistance, always based on ethics, justice, and the idea that health is a right for everyone.

Quality first

The National Accreditation Organization (ONA), established by the FBH's initiative, sponsorship, and incentive, is the first national entity to create a quality program, attest credibility, and encourage the improvement of institutions that offer health services throughout the country, by accreditation programs, which permanently evaluate the quality of health services in the country. This was another important step in the history of FBH.

The creation of courses for the qualification of professionals from private institutions, using the structures of its affiliates, is a constant investment by FBH, with the permanent purpose of qualifying the Brazilian hospital sector.

Association of Hospitals of the State of Alagoas

The Association of Hospitals of the State of Alagoas (AHEAL) was founded on May 31st, 1974 in a memorable meeting held at the headquarters of the Society of Medicine of Alagoas in the city of Maceió, capital of the Alagoas state.

The AHEAL was formed to bring together the hospitals of Alagoas state, to promote and improve the cultural and scientific medicine focusing on the country's development and effective social welfare factor of our community

It is up to the entity to represent the hospitals associated with the FBH, support the legitimate interests of its affiliates, as well as to organize congresses, courses, seminars, and conferences, effectively providing the continuity of its guiding principles for the full development of hospitals in Alagoas.

Currently, AHEAL consists of 16 associated hospitals, totaling over 1.847 beds.

The Association remains vigilant and attentive to the health policy in the country, in line with the actions promoted by FBH, to promote the constant updating of its members, paying attention to the technical-scientific advances in medicine and the quality of health services

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Association of Hospitals and Health Services of the State of Bahia

The Association of Hospitals and Health Services of the State of Bahia (AHSEB) is a non-profit or economic civil association, founded on October 20th, 1965. Today, in the state, there are 635 hospitals and 14.186 beds.

Since its inception almost 50 years ago, AHSEB has been committed to permanently contributing to the orientation of associates with a view to the quality of the health sector in Bahia state; to appear as a procedural substitute in the defense of the interests of its members in the judicial or administrative sphere; represent associates before authorities, professional associations, public or private institutions, and the general public, in defense of their interests, rights, and reputation.

The purpose of the Association is to approximate hospitals, clinics, and other establishments in the area, stimulating the exchange of information, making AHSEB a reference for the Health Sector, in the search for solving problems involving private health areas in the state. Through partnerships with important and reputable entities - Salvador University (Unifa-cs), Federal University of Bahia (UFBA), Northern University of Paraná (Unopar), and Brazilian Micro and Small Business Support Service (Sebrae) -, AHSEB achieves excellence in continuing education

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Association of Hospitals of the State of Ceará

Association of Hospitals of the State of Ceará (AHECE) was created in 1967, a non-profit organization that seeks to defend the interests of its members (hospitals and clinics) and also those who provide services to SUS, as well as the supplementary health chain (operators, insurers, cooperatives, and self-management tellers).

The Ceará state has 277 hospitals and 8.816 beds. The entity also acts with the Executive, Legislative, and Judiciary powers, promoting congresses and courses aiming at the constant improvement of the political-administrative management of its associates.

The Association currently operates in its headquarters acquired in August 2007, with the Covenant Department covering hospitals and imaging clinics and the Legal Department.

It is worth being associated because only then the benefits derived from the entity's work in defense of the Health Sector will be achieved

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Association of Hospitals, Clinics, and Health Service Providers of Espírito Santo

The Association of Hospitals, Clinics, and Health Service Providers of Espírito Santo (AHCES) together with the Union of Health Services Establishments of the State of Espírito Santo (SINDHES), are the only legal representatives of the economic category in the Espírito Santo area, bringing together over 3.000 companies in the state. The Association is responsible for defending the collective or individual rights and interests of the category, including legal, technical, and administrative matters.

The Association's history began on December 10th, 1970, in Vitória-ES, with an assembly between representatives of hospitals, clinics, nursing homes, and laboratories of the philanthropic and private networks installed in the state. At the time, the first board of directors of AHCES was elected, chaired by Dr. Herwan Wanderley.

From the beginning, there was the participation and support of companies from all over the state, which saw the Association as a democratic and important space for negotiations and discussions of the sector. Since then, AHCES's trajectory has been marked by the defense of the collective interests of affiliated health institutions, allied to modernization, resoluteness, and quality in the provision of services to the Espírito Santo population.

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Association of Hospitals of the State of Goiás

Associative representation entity, the Association of Hospitals of the State of Goiás (AHEG) was founded on August 6th, 1968, being formed to define and orient hospital policies and standards of its members, aiming at quality, rationalization, improvement in care, and treatment, the establishment of rules for interpersonal and interdepartmental relationships in hospitals, and the maintenance of technical-operational and market research bodies. The Association represents the sector in a state that includes 435 hospitals and 11.394 hospital beds.

AHEG also aims to maintain cultural activities, such as directed events, study exchange, publications, courses, training, and representation of its members before the public authorities, class entities, and the general public, always subordinated to their interests, their defense, and their rights.

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Association of Hospitals of Minas Gerais

Due to the need for leadership in the medical and hospital area, the Association of Hospitals of Minas Gerais (AHMG) was founded on December 9th, 1956.

Due to Belo Horizonte's growth and the increasing arrival of illnesses from the interior of the state, the supply of hospital beds in the capital no longer supported the demand. These facts, added to the nationalization of care services, motivated the emergence of new hospital organizations. Today the state has 677 hospitals and 32.015 beds.

To represent them there was the Hospitals' Union. However, due to the strictness of the specific legislation, the union could not act with the desired freedom with the Social Security entities. Because of this, it was unanimous to welcome the founding of AHMG.

Structured on the principles of medical ethics, AHMG was a department of the Medical Association of Minas Gerais but soon became autonomous, given the need for broad autonomy and independence of action.

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Association of Hospitals and Health Homes of the State of Pará

The Association of Hospitals and Health Homes of the State of Pará (AHCSEP) was founded on January 27th, 1977 to do effective work for the hospital and nursing home classes. There are 239 hospitals with 8.443 beds throughout the state.

The first board had Fernando Guimarães as president, Carlos Costa de Oliveira as vice president, Joaquim Alcides Queiroz as 1st secretary, Sérgio Vasconcelos Paiva as 2nd Secretary, Fernando Jordão de Souza as 1st Treasurer and Victor Moutinho da Conceição as 2nd Treasurer. On February 16th, 2001, AHCSEP was merged into the Union of Health Services Establishments of the State of Pará (Sindesspa).

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Paraiba Hospitals Association

Founded on July 26th, 1968, its vision is to act with excellence in health care, promoting the search for the improvement of services offered by associated institutions to provide society with access to quality, humanized, and high resolution medicine

Through the work done by APH, the associates are represented by public agencies and agreements for any and every negotiation of institutional nature. The state has 153 hospitals and 3.143 hospital beds, and the Association is working to continuously strengthen the sector.

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Paraná State Hospitals Association

The Association was born under the necessity of strengthening the political actions and technological updating and knowledge, complementing the attributions of the Union of Hospitals (Sindipar) and, later, of the Federation of Hospitals and Health Services Establishments of the State of Paraná (FEHOSPAR). The state has 502 hospitals and 20.181 beds. The Association also represents the promotion of exchanges between members to share experiences and knowledge, aiming at improving the standard of the service and reducing operating costs.

In 2016, AHOPAR celebrated its 43rd anniversary. The story began to be constructed in March 1973, when 16 representatives of Curitiba's main hospital institutions met in consecutive assemblies to form a non-profit organization that, as FBH's arm, could give more political voice in the defense of the interests of the private hospital sector, complementing the actions inherent to the union of the category, the Sindipar. AHOPAR's trajectory presents great achievements that deserve to celebrate by its leaders and associates.

In the early 1990s, the Association engaged in major national and state movements. It participated in the Parliamentary Health Front creation, the enhancement of public and supplementary health services, and the reduction of taxes, including the Municipal Services Tax (ISS) and the URV lawsuit, which represents an important financial recovery to the network affiliated with the SUS. AHOPAR supported the Paranaense Institute of Hospital Accreditation (IPASS) creation and placed great emphasis on knowledge dissemination through courses, congresses, and meetings.

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Northeastern Hospitals Association

Northeastern Hospitals Association (ANH) was founded on July 13th, 1967, and works with associates to defend the interests of the sector, promoting scientific administration through courses, seminars, and congresses to develop and improve hospital management. Strives for improvement in the conditions of hospital, medical and outpatient services. The state nowadays has 20.181 hospital beds and 250 hospitals.

It was designed by psychiatrist Luiz Inacio de Andrade Lima and founded in Recife with the partnership of Professor Waldemir Miranda and physicians Avelar de Castro Loureiro, Savio Vieira, João Marques de Sá and Tomé Dias.

The paths taken by the Association have always been of many struggles in defense of hospitals, especially those located in the inner cities that constantly faced the most diverse demands made by the State Health Department and the Municipal Health Secretariats.

Pernambuco state representative, which has one of the largest health centers in the country, ANH has the role of defending the interests of these establishments and strengthening regional leadership. A region that has more than 400 hospitals and 8.000 beds and generates more than 107.000 jobs, Pernambuco is one of the most sought locations for health care, due to its technology, adequate infrastructure, and advanced health facilities.

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Association of Hospitals of the State of Rio de Janeiro

Rio de Janeiro State Hospitals Association (AHERJ) is a private, non-profit civil society whose purpose is to gather, coordinate and defend the interests and objectives of health care units, whether hospitals, nursing homes, clinics, sanatoriums, and other outpatient units, as well as complementary services for diagnostic and treatment, private or public, established in Rio de Janeiro state. The state has 504 hospitals and 21.091 beds.

In 1969, the Duque de Caxias Care Hospital (NADUC) was created, and formed by a group of hospitals in that municipality. In 1971 NADUC was transformed into AHERJ. In 1972, November, the definitive Board of Directors formed by the founders of AHERJ was formed. In 1975, with the merger of Rio de Janeiro state with Guanabara state, by FBH's decision, AHERJ was officially recognized as the only representative resulting from the union of the two states.

In 2002, AHERJ, through the Niterói and São Gonçalo Regional, played a key role in rescuing the Niterói and São Gonçalo Hospital, Clinic, and Health Care Union, promoting legal, economic, and communication advice. AHERJ reformed its bylaws in 2015 to form a new board of directors, with an executive vice president and the Ophthalmology Department.

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Association of Hospitals of the State of Rio Grande do Norte

The Association of Hospitals of the State of Rio Grande do Norte (AHORN) was founded in 1973 to represent the state hospital sector, which has 2.336 beds and 107 hospitals. The paths taken by the Association in its trajectory of representativeness and struggles in defense of hospitals were marked by struggles and achievements

Presidents' succession line: Paulo Santiago Henriques Bittencourt was the first AHORN president, re-elected for five consecutive terms, from 1973 to 1983. Founding member participated in the bylaws drafting committee and had a vote of honor proposed at the General Assembly; Severino Lopes da Silva, AHORN's second president re-elected for five consecutive terms from 1983 to 1993; Ricardo Bittencourt, AHORN's third president, reelected for five consecutive terms from 1993 to 2003; Carlos Alexandre A. Garcia, AHORN fourth president, elected in 2003 and who served until 2005; Elson Sousa Miranda, AHORN fifth president, elected in 2005 and serving in office until 2008. The Association experienced a retirement moment, returning to its activities in 2013, with Élson Sousa Miranda serving as president for 13 years.

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Association of Hospitals and Health Establishments of Rio Grande do Sul

The night of January 23rd, 1969 was a milestone for the health of the state. At a meeting at Hospital Moinhos de Vento, representatives of 14 institutions in Porto Alegre, Canoas, Caxias do Sul and Bento Gonçalves founded two entities that have since been indispensable in defending the interests of the category. The state today has 341 hospitals and 25.001 beds.

In almost five decades there were numerous advances and achievements, achieved with much commitment and unity of the entities of the state.

During the 1970s, the Association emphatically claimed policies favorable to the hospital network with national authorities and leaders, with presidents Geisel, Médici, and Figueiredo. In the second run, chaired by Lauro Schuck, the Association moved to a second headquarters, located in a gallery (called Champs Élysees) in the Moinhos de Vento neighborhood

AHRGS is currently developing a new communications and action plan to strengthen its membership base and offer more services to its maintainers

Affiliated to the FBH since its foundation, came from AHRGS the former president of the FBH, the physician Angel Antonio Gomez Del Arroyo, and the also physician and former vice president for various managements, Lauro Schuck.

AHRGS presidents were the hospital administrator Hélio Henriques (1969-1971), the physician Lauro Schuck (1971-1981), the physician Vicente Passos Maia Filho (1981-1982), the accountant Ilso Menegás (1982-1987, 1995-1998, and 2005-2010), the physician Paulo Schuller Maciel (1987-1989 and 1998-2005) and the physician Claudio Allgayer (1989-1995 and 2010-present).

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Association of Hospitals of the State of Santa Catarina

The Association was founded on August 31st, 1963, with the mission of representing the interests of the Santa Catarina hospital network. The state has 254 hospitals and 11.879 beds.

In January 1975 the headquarters of the entity was acquired, being expanded in 1983, with the acquisition of new adjoining rooms, giving conditions for the accomplishment of its activities. Since 1980, AHESC has decentralized its activities by creating seven regional centers, which were renamed Regional Hospital Administrative Council (CARH), and in 2009, as a result of strategic planning, were renamed AHESC Regional, divided into the following regions: Greater Florianópolis Regional, North and Northeast Regional, South Regional, Mountain Regional, Midwest Regional, Western Regional, and Valleys Regional.

The entity's objectives are: to define and guide the hospital policy in the state; promote the development of hospital care; establish operating rules aimed at the integration of medical services; represent associates and defend their interests, rights, and reputations; promote the development of scientific administration through courses and seminars in the various areas of interest of the hospital class; disclose and enforce the Code of Ethics of the Hospital Administrator and other professionals associated.

In August 1995, the entity had an important reinforcement in carrying out the activities inherent to health. The Federation of Hospitals and Health Services Establishments of the State of Santa Catarina (FEHOESC) creation only added to AHESC's efforts, consolidating the partnership in May 1996, with the union of the two entities in the same work environment, at the AHESC office.

In 2010, AHESC and FEHOESC joined forces and acquired a new, broader, and more adequate headquarters to develop activities and better serve their associates. AHESC currently represents 105 associated hospitals, totaling over 8.365 beds

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Association of Hospitals of the State of São Paulo

On June 7th, 1965, the Hospitals Association was created to provide services to the Social Security, presided at the time by Livio Amato. Two years after its founding, on August 7th, 1967, the entity was renamed the São Paulo State Hospitals Association and its president was Pierpaolo Gerbini.

The state today has 1.059 hospitals and 66.479 hospital beds. AHESP has the great mission of representing the largest health center in the country and acting to defend the interests of the hospital sector. It works to establish policies in the hospital management area, encouraging the adoption of good practices, aimed at quality care, patient safety, and preserving the sustainability of the sector. Facilitates and assists the relationship of hospitals with the market and the regulatory body. Represents its members before the public and private institutions. It promotes studies, research, and events to improve the technical and administrative staff of members, as well as exchanges between members and institutions in the area of health care. Defends the common legal and economic interests of its members

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ISBN: 978-65-88821-00-8