Integration with Primary Health Care: Experience of a Referral Unit in Palliative Oncology Care

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Integração com a Atenção Primária à Saúde: Experiência de uma Unidade de Referência em Cuidados Paliativos Oncológicos

Integración con Atención Primaria de Salud: Experiencia de una Unidad de Derivación en Atención Oncológica Paliativa

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INTRODUCTION

The principles of the National Health System (SUS) are based in the universality, equity, and integrality, targeted to the participation of the individuals, regionalization and hierarchy and decentralization. It attempts to ensure the population the access to health across all levels of attention[1]. The "*Hospital do Câncer IV (HC IV)*" Palliative Care Unit of the National Cancer Institute José Alencar Gomes da Silva (INCA), provides care to patients with advanced cancer without possibility of disease modifying treatment referred from other INCA units. HC IV/INCA's mission is to "promote and provide high quality palliative oncologic care with technical and humanitarian proficiency"[2]. Following this logic, it endeavors to minimize the human suffering of physical, psychic, social and spiritual nature, and improve the quality of life[3].

In this INCA unit, the patient can be followed up at the outpatient service or homecare, depending on its functionality and other clinical criteria evaluated by the team. In addition to the patients living in the city of Rio de Janeiro, HC IV/INCA provides care to patients referred by other municipalities of the State of Rio de Janeiro (RJ) and other states.

Physical, social, economic, geographic, and urban factors can hamper the process of locomotion from the patient's house to the hospital. They provoke concrete impacts to follow up and care for these patients, as many are unable to keep the regularity of the visits, compromising the continuity of the treatment.

The inter-disciplinary team of the HC IV/INCA outpatient unit created a modality called "Remote Outpatient" as a proposal to solve the difficulties. It is a feasible alternative to ensure the quality of the technical-professional care to patients and their families based in the principles of Palliative Care[3]. It was structured and began in 2017 with the objective of ensuring the continuity of the palliative care to the patient in its household environment, minimizing the transportation through an integrated action with Primary Health Care (PHC). PHC's professionals provide in-person consultation and HC IV/INCA professionals guide and conduct the caring plan.

The patients with low functionality (evaluated under specific criteria such as the Karnofsky Performance Status – KPS)[4] for whom the in-person consultation causes discomfort or suffering were included. These patients do not meet the criteria for homecare: living in until 60 km from HV IV/INCA and residing in areas not characterized as under urban conflict.

The objective of the article is to describe how the HC IV/INCA's modality Remote Outpatient was structured and systematized after three years of actual consultation.

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DEVELOPMENT

Structuring of the remote outpatient

The plan to begin the activities of the Remote Outpatient was based in the following lines:

1. Identification of the eligible patient:

The first step is to identify the patient who meets the eligibility criteria for the Remote Outpatient and any professional of the HC IV/INCA care team can perform this assignment. The eligibility criteria are:

- Be partially or fully dependent (KPS 50% or lower) with family/caretaker as reference.
- Living in an area not covered by HC IV/INCA home care: out of reach (currently 60 km) or in conflict areas where safe access is not warranted.
- Household under PHC coverage.

While identifying the patient with profile to be included in this modality, he/she and/or relative are provided clarifications about how it functions and if agreed, the inclusion is completed.

2. Contact with PHC:

Contact the PHC responsible for the area where the patient lives and ask to be included in the modality of remote care through the existing platforms as e-mail, texting, land line or mobile call. The coordination or technical care team of the health unit explains the procedures.

3. Documentation:

After the telephone contact and upon approval by the PHC, the family member receives the social referral in writing to forward the patient to the health unit where it lives, formalizing the integrated consultation. The patient receives a complete clinical report issued by the doctor of HC IV/INCA outpatient unit, containing all the necessary information for the PHC team to proceed with the in-person consultation. Other healthcare professionals may also issue reports if needed. A specific form is handed over to the patient, called Remote Outpatient Follow-up Report (Figure 1) with fields to register the relative and the PHC professional. The form should be delivered to the HC IV/INCA outpatient team in the next visit when the relative/caretaker acts on its behalf.

The PHC is in charge of regular home visits with physician and nurse, preferentially biweekly at the most because of the condition of fragility; this visit should occur prior to the subsequent visit to HC IV/INCA for the team to receive the Remote Outpatient Follow Up Report with information about the clinical evolution of the patient. Home visit is meant to evaluate the patient in-person by the healthcare professional of its neighborhood and make technical and accurate information to reach the HC IV/INCA professional in order to support the conducts and avoid the patient to leave its house.

The patient's relative with the Remote Outpatient Follow Up Report should go to HV IV/INCA outpatient unit at the day of the subsequent visit, when the attending physician will issue a new report with orientations about the new conducts taken and/or responses to the request of intervention by the PHC professional. Through the entire process of follow-up, reports will be exchanged in order to ensure the continuity of the safe care to the patient in his home.

Experience of the remote outpatient

Since its beginning from 2017 until 2020, 208 patients were followed up at the Remote Outpatient: 202 from 50 municipalities of the State of Rio de Janeiro and six from other States, four from Minas Gerais, one from Piauí and one from Sergipe. Some Secondary Health Care units and hospitals have also conducted these consultations, considering that the focus of this modality of care is its connection with the PHC. The 208 patients were referred to 174 health units, being 109 to Family Health Care, 46 to Health Units, eight to the Program Better at Home, seven to the Outpatient Service, two to the Older Adults Homecare Program (PADI) and two to hospitals.

The adherence of these units was very important to materialize the integrated care. In addition, it favored the use of the resources of the health network to the same patient through an integrated proposal of care.

The patients cared by this modality are spread in several Regions, so, the numbers per area are not quite expressive, but their relevance is revealed in the total, showing the importance of this care: 202 patients of 49 municipalities of the State of Rio de Janeiro. Figure 2 shows the distribution per municipality.

Figure 3 shows the survival curve of the patients cared by Remot Outpatient between September 2017 and October 2020 (184 patients), being the initial moment the first visit. 56 patients died in the first month after the referral and 18 were alive when this study was being made.

The conclusion of the subjective evaluation of the team revealed positive results, with satisfactory care offered to the patients with no locomotion to HC IV/INCA for elective visits while increasing the safety of the outpatient staff without in-person consultation, except the cases where the patient, relatives or healthcare team deem necessary.

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REMOTE OUTPATIENT FOLLOW-UP REPORT

Name of the patient:_____
Register: _____ Age: _____
Neighborhood _____ Municipality: _____
Health Basic Unit: _____Tel.: _____

Rescue if in pain			
date	hour	date	hour

Edmonton Scale (fill one day before the visit)											
	Pain	Tiredness	Nausea	Sadness	Anxiety	Somnolence	Loss of appetite	Not well-being	Shortness of breath	Others
10										
9										
8										
7										
6										
5										
4										
3										
2										
1										
0										

Bleeding	Urine	Stoools
( ) Yes ( ) No	( ) No alteration ( ) With alteration	( ) Regular ( ) Constipation ( ) Diarrhea

Odor	Wound
( ) Yes ( ) No	( ) Yes ( ) No

COMMENTS OF FAMILY MEMBER: _____

EVOLUTION BY THE HEALTH PROFESSIONAL: _____

_____
Signature and stamp of the professional

Date: ___/___/____

Figure 1. Remote Outpatient Follow up Report

CONCLUSION

With the creation of this modality, a network was established to broaden the scope of the care offered by the specialized unit, integrating the Quaternary Attention to the PHC, promoting not only the possibility of technical-professional care to the part of the population, but also the consolidation of the integration to the Health Attention Net, one of the great challenges of the Brazilian health policy.

CONTRIBUTIONS

All the authors contributed substantially for the study conception/design, collection, analysis and/or interpretation of the data, wording, critical review and approved the final version to be published.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

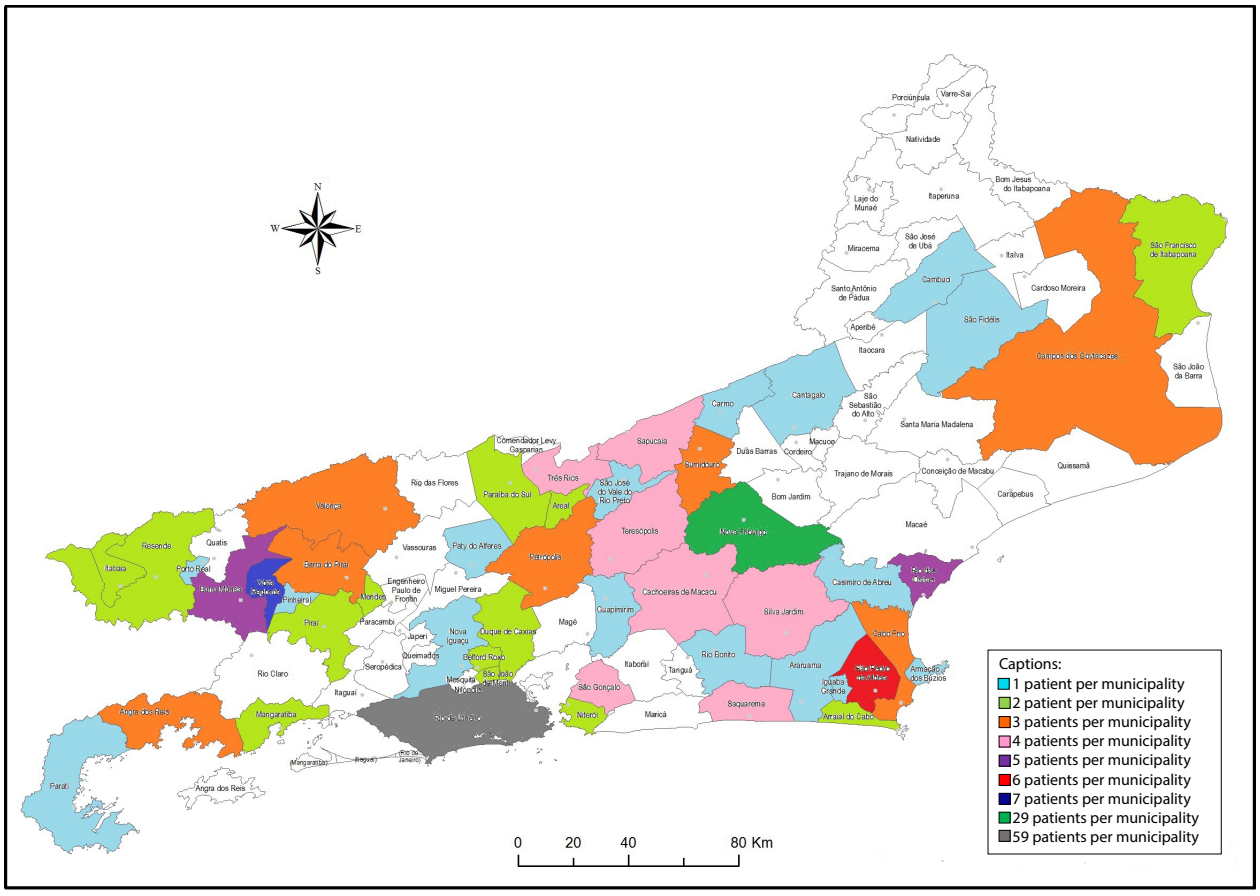

Figure 2. Distribution of the patients of the HC IV/INCA Remote Outpatient Unit between September 2017 and October 2020 in the municipalities of the State of Rio de Janeiro

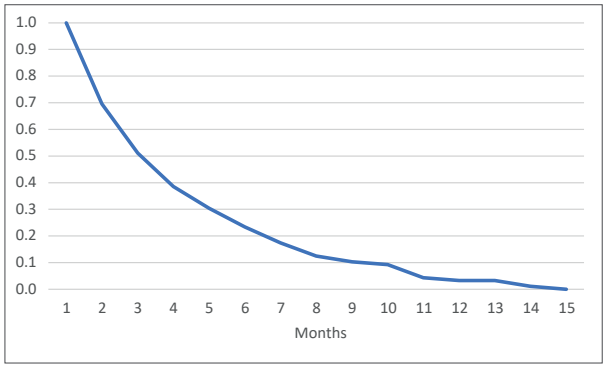

Figure 3. Survival curve of patients in the municipality of Rio de Janeiro after enrollment in Remote Outpatient (n=184))

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None.

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