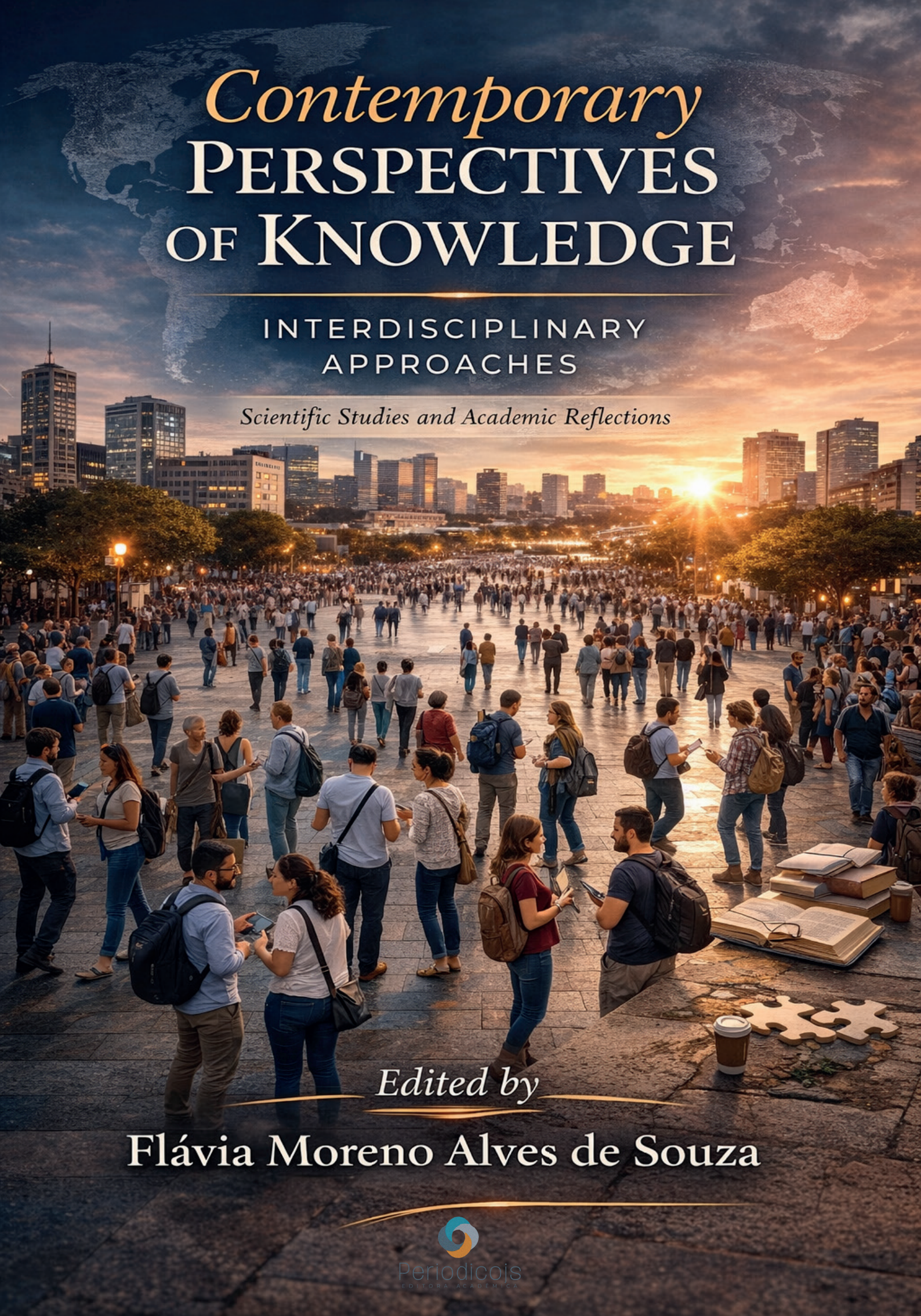




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Chapter 30

**INTEGRATED HEALTH MANAGEMENT:
FROM SCIENTIFIC REVIEW TO HOSPITAL
PRACTICE IN THE CAREER OF LUPÉRCIO
DE CASTRO PEDRA**



INTEGRATED HEALTH MANAGEMENT: FROM SCIENTIFIC REVIEW TO HOSPITAL PRACTICE IN THE CAREER OF LUPÉRCIO DE CASTRO PEDRA

Lupércio de Castro Pedra¹

Abstract: This technical report systematizes the author's technical and scientific output in the field of integrated health management. It brings together an integrative literature review on the financial sustainability of rural and community hospitals; a technical analysis of regulatory compliance, value-based payment, the workforce, continuous improvement, and management training in U.S. healthcare organizations; and a documented record of nine years of professional experience in operational hospital management in Brazil. The method combines an integrative synthesis of scientific studies and technical literature published between 2021 and 2026 with a documentary reconstruction of hospital management cases, supported by the author's professional record, a formal accountant's statement, and letters from professional colleagues. The operational results show a substantial cost reduction in a medical gas supply contract, a significant increase in contract value with Brazil's public health system, more than 35,000 hemodialysis treatments delivered without interruption during a critical period of the pandemic, and the turnaround of a healthcare facility from an operating deficit to an operating surplus. From a theoretical standpoint, both works converge on the same central argument: the sustainability of healthcare organizations depends on the deliberate integration of governance, revenue cycle management or regulatory compliance, the workforce, continuous improvement, and leadership — not on isolated interventions targeting revenue or costs. The author's professional career offers practical evidence consistent with this theoretical model, which has yet to be formally tested empirically on a larger sample of healthcare organizations.

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Keywords: Integrated health management. Hospital financial sustainability. Regulatory compliance. Value-based payment. Healthcare leadership.

Introduction

The sustainability of healthcare organizations is currently one of the most pressing issues in health management, in high-income countries and emerging economies alike. In Brazil, rural and community hospitals — particularly *Santas Casas* (charitable Catholic hospitals) and other nonprofit institutions — face chronic financial fragility associated with low patient volume, an unfavorable payer mix, and underfunding of the Unified Health System (*Sistema Único de Saúde*, SUS). In the United States, hospitals and other healthcare organizations operate in one of the most complex regulatory and payment environments in the world, where compliance with the requirements of the Centers for Medicare & Medicaid Services coexists with the ongoing transition from volume-based to value-based reimbursement models.

The purpose of this technical report is to systematize and analyze the technical and scientific output of the author, Lupércio de Castro Pedra, on these two settings, and to connect it to his nine-year professional career in operational hospital management, carried out at a state-run urgent and emergency care hospital, within a network managed by a social health organization (*organização social de saúde*), at a municipal hospital under court-ordered receivership, and at a hemodialysis clinic belonging to a multinational network. The author holds a Bachelor's degree in Business Administration from the Federal University of Juiz de Fora and an MBA in Financial Management, Controllershship and Auditing from Fundação Getulio Vargas, and is licensed by the Regional Board of Administration of Minas Gerais. To date, his technical and scientific output comprises a scientific article on the financial sustainability of rural and community hospitals and a book chapter on the integration of regulatory compliance, value-based payment, the workforce, continuous improvement, and management training



in U.S. healthcare organizations, both published in 2026, in addition to news articles documenting his professional work during the COVID-19 pandemic.

This report is organized into six sections, plus acknowledgments and references: Section 2 describes the technical subject of this report; Section 3 details the procedures and methodology used in the underlying scientific work and in the reconstruction of the author's professional career; Section 4 presents the results obtained, both bibliographic and operational; Section 5 analyzes and discusses the convergence between the theoretical model proposed by the author and the practical record of his work, while also addressing the limits of that convergence; and Section 6 presents the conclusions and recommendations arising from this synthesis.

Technical Description

The author's own scientific work

The first technical subject of this report is the article Strengthening the Financial Sustainability of Rural and Community Hospitals Through Integrated Health Management: An Integrative Literature Review (PEDRA, 2026a). It is an integrative review that systematizes the Brazilian and international scientific literature published between 2021 and 2026 on hospital financial sustainability, linking it to four related pillars: institutional governance, revenue cycle management, leadership, and operational efficiency. As the author's own theoretical contribution, the work proposes an integrated health management model that connects these five thematic pillars, explicitly classified as an interpretive proposal that has not yet been directly tested empirically.

The second technical subject is the chapter Integrating CMS Compliance, Operational Excellence, and Workforce Development in U.S. Healthcare Organizations (PEDRA, 2026b), which examines five dimensions of management in U.S. healthcare organizations: the regulatory architecture for compliance with the Centers for Medicare & Medicaid Services; value-based payment programs; the structural healthcare workforce crisis; continuous improvement methodologies and high-reliability



organizations; and competency models for management training — the latter discussed critically, including evidence of a null finding on the effect of professional credentials on hospital performance. Following the same methodological approach as the earlier article, the chapter proposes a second integrative model, which the author likewise explicitly classifies as a theoretical construct pending empirical validation.

From theoretical model to a hospital management method documented in practice

In addition to this body of published work, the subject of this report includes the systematization of an operational hospital management method, which the author himself named AEGIS, reconstructed from the documentary record of his professional career between 2013 and 2022. This period includes the administrative coordination of twelve healthcare facilities within a social health organization network (six urgent care centers, or UPAs, and six hospitals and maternity hospitals); the administration of Rocha Faria State Hospital, handling roughly 10,000 urgent and emergency visits per month; serving as chief executive of Hospital São José in Nova Serrana, Minas Gerais, while it was under court-ordered receivership; and the operational management of the DaVita Kidney Care hemodialysis unit in Juiz de Fora during the COVID-19 pandemic.

As systematized in a professional methodology dossier prepared by the author in September 2026, the method is organized into five pillars whose English initials form the name AEGIS: an integrated diagnosis of cash flow, contracts, supplies, staff, and patient care workload (Integrated Diagnosis); distinguishing necessary clinical costs from waste, idle capacity, or contracts misaligned with actual use (Economic Discrimination); carrying out changes together with the teams that run day-to-day patient care, with course corrections whenever practice revealed a flaw in planning (Sequential Execution); putting governance instruments in place — responsibilities, records, and indicators capable of flagging deviations before they turn into a crisis (Governance Instruments); and treating continuity of patient care as a non-negotiable constraint on every administrative decision



(Assistance Continuity). This is the author’s own terminology for a consistently applied professional practice, not a methodology with independent external validation — a distinction made explicit in the dossier that documents it.

Understood in this way, the technical subject of this report is not a stand-alone proposal, but rather the convergence of two theoretical models published by the author — one on hospital financial sustainability and the other on regulatory-operational integration in U.S. healthcare — with the AEGIS operational method, documented through nine years of hospital management practice in Brazil.

Procedures and Methodology

Integrative literature review (scientific article)

The integrative review underlying the first technical subject (PEDRA, 2026a) followed search, screening, and synthesis steps inspired by the PRISMA statement. The term “systematic review” was deliberately avoided in favor of “integrative review,” since the work does not fully meet the methodological requirements of a systematic review in the strict sense. The databases searched were PubMed/MEDLINE, Scopus, Web of Science, PLoS, Frontiers, ScienceDirect, and Semantic Scholar for the international literature, and SciELO, BVS/LILACS, Dialnet, and Brazilian institutional journals for the Brazilian literature, supplemented by institutional gray literature. Sixteen structured searches were run using descriptors in Portuguese and English, without formal Boolean operators in the native interfaces of the proprietary databases. A total of 78 unique records were screened, 38 full texts were assessed, and 32 studies and documents were included in the final synthesis, which were subjected to a simplified methodological quality appraisal inspired by the AMSTAR-2 and MMAT tools. Screening and full-text assessment were conducted by a single author, supported by AI-assisted search and organization tools, without independent dual screening or a pre-registered protocol.



Technical and conceptual synthesis (book chapter)

The analysis underlying the second technical subject (PEDRA, 2026b) consisted of a technical and conceptual synthesis of U.S. regulatory, institutional, and academic literature published between 2021 and 2026 on five dimensions of health management, deliberately taking a critical stance: rather than descriptively reproducing the institutional narrative of regulators and value-based payment programs, the work incorporates counterpoints documented in the academic literature — such as the disproportionately higher penalties imposed on safety-net hospitals by the readmissions reduction program, and the absence of a statistically significant effect of educational credentials and professional association membership on hospital performance, as identified in a study published in the journal *Healthcare*. For illustrative purposes, the chapter also presents a hypothetical composite scenario, explicitly identified as not corresponding to any real organization, intended solely for teaching purposes.

Documentary reconstruction of the author's professional career

In addition, the reconstruction of the AEGIS operational method drew on four types of sources, systematized by the author in a professional methodology dossier dated September 2026: (i) the author's professional résumé, which records dates, employers, patient volumes, and contract values; (ii) a statement of business ownership issued by accountant Lucélia Lopes Inocencio, registered with the Regional Accounting Board of Minas Gerais (CRC-MG) under No. 079083/O-0, certifying that the author was the owner of the sole proprietorship Domínio Controladoria e Gestão Financeira, Brazilian corporate taxpayer ID (CNPJ) 21.339.630/0001-65, from October 27, 2014, to November 24, 2021; (iii) letters of professional observation signed by Rodrigo A. Farinazzo, Project Manager at Rede D'Or, on July 10, 2026, and by Vinícius Queiroz, director of Queiroz e Vilaça Gestão de Negócios, on July 14, 2026, both professional colleagues who worked alongside the author



on hospital projects; and (iv) press reports documenting the court-ordered receivership at Hospital São José, published by O Popular NS on April 20, 2018, and by G1 Centro-Oeste on June 20, 2018. The dossier that systematizes the method explicitly distinguishes, in a dedicated section, what it considers documented fact in these four sources from what remains an expression of interest by third parties — a methodological distinction that this technical report adopts in full.

This technical and scientific report does not incorporate, as results obtained, any financial projections from a business plan associated with a commercial application of the AEGIS method in the United States, since these are planning estimates for a pre-operational venture rather than results obtained or empirically tested; where relevant, this application is mentioned in Section 6 solely as a prospective development.

Stated methodological limitations

In keeping with the methodological caution adopted by the author in both underlying works, this technical report acknowledges significant limitations: neither work constitutes a systematic review in the strict methodological sense, given the absence of a pre-registered protocol, independent dual screening, and formal risk-of-bias assessment; the literature search was conducted using a general academic search engine rather than Boolean strings run directly in each database's native interface; and the reconstruction of the operational method relies on a self-reported professional record, corroborated by only two third-party letters and one accountant's statement, rather than by an independent, systematic assessment of institutional performance. The theoretical models proposed in both works are, as the author explicitly states, interpretive constructs and not conclusions drawn directly from studies that have empirically tested the integration of the proposed pillars.



Results

Results of the review on hospital financial sustainability

The synthesis of 32 studies and documents revealed a cyclical, cumulative pattern of financial vulnerability among small hospitals, in which governance deficiencies, the lack of structured revenue cycle management, leadership gaps, and low operational efficiency reinforce one another, increasing the risk of closure or service discontinuation (BELLARD et al., 2026; BALAKRISHNAN et al., 2025). A Kaiser Family Foundation survey showed that, in U.S. states that had not adopted Medicaid expansion, about half of rural hospitals reported negative operating margins in 2023 (KAISER FAMILY FOUNDATION, 2025). In Brazil, chronic underfunding of the Unified Health System and reliance on extraordinary transfers worsen this situation for *Santas Casas* and nonprofit hospitals, even after the enactment of Law No. 14,820/2024, which established periodic, annual review of reimbursement rates for these services (AGÊNCIA SENADO, 2025; BRASIL, 2024).

Among the five pillars analyzed, revenue cycle management emerged as the operational lever most directly convertible into short- and medium-term financial results, with preliminary evidence of 15% to 30% improvements in accounts receivable indicators associated with process automation (PETROV; KHUNTIA, 2025). Operational efficiency, measured predominantly through Data Envelopment Analysis, proved methodologically heterogeneous, with no consensus on optimal measurement parameters (ZUBIR et al., 2024), while hospital governance was found to lack conceptual standardization (JALILVAND; RAEISI; SHAARBAFCHIZADEH, 2024). Finally, a significant asymmetry was identified among the bodies of literature reviewed: the financial sustainability pillar is dominated by U.S. studies, whereas the leadership pillar is dominated by lower-impact Brazilian literature — a limitation discussed in Section 5.



Results of the analysis on regulatory compliance, value-based payment, and the workforce

The analysis of the U.S. regulatory architecture found that hospital compliance with the Centers for Medicare & Medicaid Services is organized around the Conditions of Participation set forth in Title 42 of the Code of Federal Regulations and the seven-element compliance program established by the Office of Inspector General's General Compliance Program Guidance, published in November 2023. The review of value-based payment programs revealed a patchwork of mechanisms with different units of analysis and levels of financial risk — from the Hospital Value-Based Purchasing Program to the Medicare Shared Savings Program — marked in 2026 by significant regulatory instability: the announced end of the ACO REACH model at the close of 2026, to be replaced beginning in 2027 by the Long-term Enhanced ACO Design model, and sharp controversy over the Medicare Advantage star rating system, whose national average score fell from 3.92 to 3.65 stars in the initial October 2025 release, leading to litigation and a recalculation by the regulator itself.

The analysis also identified important critical counterpoints: safety-net hospitals were penalized under the Hospital Readmissions Reduction Program at a systematically higher rate than other hospitals between 2009 and 2016 — 72% versus 59% of cases — raising questions about whether the program's risk adjustment adequately accounts for socioeconomic factors (BANERJEE et al., 2022); and the Medicare Payment Advisory Commission estimates that, in 2026, payments to Medicare Advantage plans will exceed the corresponding costs under traditional Medicare by approximately \$76 billion.

Regarding the workforce, the American Hospital Association's 2026 Health Care Workforce Scan projected that the ratio of healthcare workers per older adult will fall from 4 to 2.9 over the next five years, with a shortfall of more than 78,000 registered nurses by the end of 2025 and a shortage of up to 85,000 physicians by 2036. Regarding continuous improvement, Lean and Six Sigma showed a positive impact in more than 88% of the surgical studies analyzed, subject to the risk of publication bias, and senior management support proved to be a central determinant of the relationship between



these methodologies and continuous quality improvement (AHMED et al., 2023). Finally, regarding management training, a study published in the journal *Healthcare* reported a significant null finding: no statistically significant effect of either health administration program accreditation or membership in a professional executive association was found on the cost, quality, and access outcomes of Texas hospitals — a finding that qualifies, without invalidating, the proposed integration of the five dimensions analyzed in the chapter.

Operational results documented in the author's professional career

The operational results documented in the author's professional career, summarized in Table 1, illustrate the practical — albeit uncontrolled — application of the integrated management principles discussed in Sections 4.1 and 4.2. At Rocha Faria State Hospital and the twelve facilities of the HMTJ social health organization network, which he coordinated from 2014 to 2018, the author held administrative command over support services and medical supply traceability under a patient care workload of roughly 10,000 urgent and emergency visits per month. At Hospital São José in Nova Serrana — a facility he took over under court-ordered receivership in 2018, burdened with R\$21 million in debt accumulated by prior administrations from unpaid payroll taxes and employment-related contributions — renegotiating contracts and putting idle capacity to use cut the price of medical gases from R\$25.00 to under R\$4.00 per cubic meter (savings of roughly R\$40,000 per month) and raised the monthly contract value with the Unified Health System from R\$480,624.94 to R\$680,000.00, without interrupting the region's only urgent and emergency care service. At the DaVita Kidney Care hemodialysis unit in Juiz de Fora, from April 2021 to June 2022, more than 35,000 treatments were delivered without interruption over thirteen months of the pandemic, with a team of about 100 professionals, no shortages of personal protective equipment, an investment of approximately R\$15 million to implement online hemodiafiltration, a turnaround in operating results from near-zero or deficit levels to a consistent surplus, and an annual employee climate survey with



no serious fluctuations throughout the pandemic.

Table 1 — Summary of operational results documented in the author's professional career

Institution	Period	Role	Documented result
Rocha Faria State Hospital and HMTJ social health organization network (12 facilities)	2014–2018	Administrative Manager; Operations Manager	Roughly 10,000 urgent and emergency visits per month under his coordination; supply traceability across 12 facilities
Hospital São José (Nova Serrana, MG)	2018	Chief Executive Officer under court-ordered receivership (facility taken over with R\$21 million in debt)	Medical gases: from R\$25.00 to < R\$4.00/m ³ (≈ R\$40,000/month in savings); SUS contract: from R\$480,624.94 to R\$680,000.00/month
DaVita Kidney Care (Juiz de Fora, MG)	Apr. 2021–Jun. 2022	Operations Manager	More than 35,000 treatments without interruption; about 100 professionals; ≈ R\$15 million invested in HDF; results turned around from deficit to surplus
Domínio Controladoria e Gestão Financeira (sole proprietorship)	Oct. 2014–Nov. 2021	Owner	7 years of activity certified by accountant's statement (CRC-MG 079083/O-0)

Source: prepared by the author based on his professional résumé, the accountant's statement by Lucélia Lopes Inocencio (CRC-MG 079083/O-0), and letters from Rodrigo A. Farinazzo (Rede D'Or, Jul. 10, 2026) and Vinícius Queiroz (Queiroz e Vilaça, Jul. 14, 2026).

These results are reported as recorded in the author's professional résumé and are corroborated — with respect to integrated diagnosis, execution alongside the teams, and maintaining continuity of patient care — by the letters from Farinazzo (2026) and Queiroz (2026), as well as, regarding the author's ownership of his sole proprietorship during that period, by the statement from accountant Lucélia Lopes Inocencio.

Technical and scientific dissemination

With respect to technical and scientific dissemination, the article on hospital financial



sustainability and the chapter on regulatory compliance, value-based payment, and the workforce were formally published in 2026, as evidenced by a proof of publication containing their respective electronic records. In addition, two journalistic profiles of the author's professional career were published between August and September 2026 in five news outlets — A Gazeta Popular, Folha Fluminense, Gazeta Fluminense, O Estado do Rio, and Tribuna da Tarde — focusing on the supply management, multidisciplinary coordination, and operational resilience he demonstrated during the COVID-19 pandemic at the hemodialysis unit in Juiz de Fora.

Analysis and Discussion

Convergence between the theoretical model and the practical record

Reading the results presented in Section 4 together reveals significant convergence between the theoretical models proposed by the author in his two underlying works and the pattern observed in his own professional career. The integrated health management model proposed in the article on rural hospitals (PEDRA, 2026a) treats governance, revenue cycle management, leadership, and operational efficiency as inseparable pillars of financial sustainability; the AEGIS method documented at Hospital São José and DaVita Kidney Care illustrates this same logic in practice — in both cases, an integrated diagnosis of contracts, costs, and patient care workload preceded decisions that combined contract renegotiation, the use of idle capacity, and maintaining continuity of care as a non-negotiable constraint. Similarly, the integrative model proposed in the chapter on U.S. healthcare organizations (PEDRA, 2026b) positions the workforce as the shared execution resource linking regulatory compliance and value-based performance, and management training as a cross-cutting enabler that is not sufficient on its own — a proposition consistent with the finding, in the author's documented career, that carrying out changes together with operational teams, and not merely the formal authority of an executive position, was noted by professional observers as a distinguishing feature of his work.

It is necessary, however, to define precisely the nature of this convergence. Just as the



author cautions in both underlying works that the theoretical models proposed there are interpretive constructs rather than conclusions drawn directly from studies that empirically tested the integration of the proposed pillars, the same caution must be applied to the relationship between this academic output and the professional career described in this report: the cases documented at Hospital São José, the HMTJ social health organization network, and DaVita Kidney Care constitute convergent and illustrative evidence, not a controlled test of the proposed theoretical model. None of these cases was conducted as a study with a comparison group, and attributing the operational results solely to the author's work — rather than to other contributing factors, such as conditions in the supply market, decisions by other managers involved, or changes in patient demand — cannot be established with the degree of certainty that would characterize an academically controlled case study.

Asymmetries and limits of the evidence

The two underlying works reveal a significant asymmetry in the bodies of literature they draw on: the hospital financial sustainability pillar is dominated by U.S. studies and reports, whereas the healthcare leadership pillar is dominated by Brazilian literature of lower impact and reach. This same asymmetry is, in a sense, mirrored in the author's own career, which combines a Brazilian academic background, predominantly Brazilian professional experience, and technical and scientific output that, in one of the two works, focuses on U.S. regulatory and academic literature — a position that may favor a comparative reading of the two contexts, but that also reproduces, at the individual level, the same coverage limitation identified in the literature review: additional searches of proprietary databases using formal Boolean strategies could uncover international studies on leadership in rural hospitals that were not captured by the search process documented here.

As for the reconstruction of the author's professional career, it must be acknowledged that the available documentary base — a professional résumé, one accountant's statement, and two letters from professional colleagues — is substantially narrower than the bibliographic base supporting the



two scientific works. This asymmetry in methodological robustness between the published work and the reconstruction of professional practice is a limitation that should be taken into account when reading this report: the convergence noted in Section 5.1 strengthens the plausibility of the proposed theoretical model, but it does not replace the formal empirical validation that both underlying works acknowledge as necessary.

Transferability across care settings

A recurring argument in the press coverage of the author's career is that principles observed in a specialized care setting — such as a hemodialysis clinic — are transferable to larger general hospitals, since the difference between the two settings would be primarily one of scale rather than of management principle. This claim, while consistent with the logic of the two underlying works on integrating governance, the workforce, and operational efficiency, likewise lacks direct comparative testing across care settings of different sizes and complexity. The author's own documentary record does, however, offer a meaningful indication in this direction: the same sequence of integrated diagnosis, identification of waste, execution with teams, establishment of governance, and continuity of care was applied over nine years in four distinct settings — a large urgent and emergency care hospital, a twelve-facility network, a municipal hospital under court-ordered receivership, and a multinational hemodialysis clinic — which constitutes preliminary, albeit uncontrolled, evidence of transferability across care settings of different kinds.

Conclusions and Recommendations

This technical report has systematized the technical and scientific output of Lupércio de Castro Pedra in integrated health management and connected it to his documented nine-year career in operational hospital management. The two underlying works converge on the same central argument,



which the author explicitly classifies as a theoretical proposal rather than an empirically established conclusion: the sustainability of healthcare organizations — whether Brazilian rural hospitals facing chronic underfunding or U.S. healthcare organizations operating in a complex regulatory and payment environment — depends on the deliberate integration of governance, revenue cycle management or regulatory compliance, the workforce, continuous improvement, and leadership.

The author's documented professional career, summarized in Section 4.3, offers practical evidence consistent with this theoretical model, although it does not, in and of itself, constitute an empirical test of it. As a technical contribution, this report recommends: (a) that the integrated management model proposed by the author be subjected to prospective empirical testing, simultaneously measuring indicators of governance, revenue cycle management, the workforce, continuous improvement, and leadership in a larger sample of Brazilian rural and community hospitals; (b) that the reconstruction of the AEGIS operational method be the subject of an academically conducted case study, triangulated with sources beyond those currently available; (c) that the author's technical and scientific work on leadership in rural hospitals be expanded through a formal systematic review with a pre-registered protocol and independent dual screening, given the gap identified in the high-impact international literature on the topic; (d) that the technical, scientific, and journalistic dissemination begun in 2026 be maintained and expanded, given the public interest demonstrated by the press coverage already documented; and (e) that, should it begin commercial operations, any application of the AEGIS method through a consulting venture in the United States be accompanied, from its first year of operation, by real and auditable performance indicators, so as to allow future comparison between planning projections and actual results.

In conclusion, integrated health management constitutes — both in the literature reviewed and in the practical record systematized in this report — a necessary, though not in itself sufficient, condition for the sustainability of healthcare organizations operating under financial and regulatory pressure.



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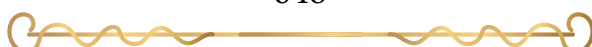
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