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The Organization of Secondary Outpatient Care at SHS-DF

Bruno de Almeida Pessanha Guedes (https://orcid.org/0000-0001-5412-3581) [1]
Fabiana Loureiro Binda do Vale (https://orcid.org/0000-0002-8170-803X) [2]
Rodrigo Wilson de Souza (https://orcid.org/0000-0002-6123-6485) [3]
Maria Katallini Alves Costa (https://orcid.org/0000-0003-0039-8058) [4]
Sandro Rodrigues Batista (https://orcid.org/0000-0001-7356-522X) [5]

Abstract *Secondary Outpatient Care (SOC) is a subject seldom studied in the literature, but of great importance for the strengthening of Primary Health Care (PHC) and the structuring of the Health Care Network. After the increase of PHC coverage following the Family Health Strategy (FHS) model, through the "CONVERTE APS" project, the State Health Secretariat of the Federal District (SHS-DF) identified the need to organize this level of care throughout the Federal District. SHS-DF has, as its Health Care Planning basis, the knowledge experienced in one of its regions, in addition to the theoretical framework produced and systematized by the National Council of Health Secretariats (CONASS) in recent years, as well as successful experiences in other regions of Brazil and countries with public health systems. The strategies to be used include the following: diagnosis and organization of facility structures, creation of a regional managerial level for Secondary Care, personnel sizing, development of the legal framework for level of care regulation, creation of technical milestones, regulation of medical and non-medical consultations in health regions and matrix support as an education strategy, but also of connection between levels of care.*

Key words *Secondary attention, Outpatient care, Specialized outpatient care*

[1] Diretoria de Atenção Secundária e Integração de Serviços, Subsecretaria de Atenção Integral à Saúde, Secretaria de Estado da Saúde do Distrito Federal. STN, Asa Norte. 70086-900 Brasília DF Brasil. brunopguedes@yahoo.com.br
[2] Secretaria Adjunta de Assistência, Secretaria de Estado da Saúde do Distrito Federal. Brasília DF Brasil.
[3] Núcleo Telessaúde do Distrito Federal. Brasília DF Brasil.
[4] Subsecretaria de Planejamento em Saúde. Brasília DF Brasil.
[5] Faculdade de Medicina, Universidade Federal de Goiás. Goiânia GO Brasil.

Introduction

Secondary Health Care (SHC) is a subject rarely explored in scientific literature on public health and, in recent years, the interest on this level of care has increased, mainly when discussing the organization of health systems from the perspective of the Health Care Network, developing from a fragmented system to integrated work processes aiming at greater efficiency[1].

However, the term originated almost 100 years ago, appearing for the first time in the Dawson Report (England, 1920)[2], which presents the terms primary and secondary care as the levels of care within a health system, necessary to systematically provide the health services that should be available to the population of a specific area. In order to create a network of services, Dawson considered important for professionals from different services to not be isolated, but rather build an "intellectual and close"relationship in order to act towards their own formation and the efficiency of the health units.

Overall, some equivalence can be established between specialized outpatient care and SHC; however, it has been observed that actions within the secondary care scope are often incorporated into hospital services, requiring caution in establishing this association as equivalent[3]. In this sense, it is understood that the secondary actions would involve a broader set of procedures, including or not outpatient activities.

In the Federal District (FD), during the process of health care system reformation, the need to strengthen Primary Health Care (PHC) has been debated[4-6]. Although there are no specific studies on SHC in the FD, it is believed that due to the low coverage and difficulty experienced by users when accessing PHC[7], one should consider the hypothesis that it is necessary to change the culture of the population, which is accustomed to a fragmented health system, based on services provided by focal specialists. In this context, it is considered that the term "specialized" means the hierarchization of knowledge, generating a common sense that it is related to something better, or even that it is associated with technological exams.

It is also understood, in this context, the need for "ambulatorization of care", defined by Lopes[8] as the change in the paradigm of providing a certain type of medical or surgical care, moving from a treatment regimen that is mainly hospital-based to a preferentially ambulatory-based treatment.

When debating about the SHC scope, one should consider the definition created by Rocha[9], which assumes that Specialized Outpatient Care should also be co-responsible for the users, fulfilling the objective of guaranteeing care and advisory support to caregiver processes, based on a more frequent key connection with Basic Care, while associated with Hospital Care and Urgency-Emergency Care.

Therefore, in the Federal District (FD), it was decided to define its levels of management and organization of services based on PHC, Secondary Outpatient Care (SOC) and Hospital Care (HC), defining SOC as set of actions and specialized services at the outpatient level, with intermediate technological density, between primary and tertiary care, which includes specialized services for diagnostic and therapeutic support. While being an assistance and consulting reference for PHC[10].

Methodology

This is a descriptive, experience report study, showing the development of the Secondary Outpatient Care in the Federal District.

The pre-structuring scenario of SOC

The FD has specific organizational characteristics in relation to its territory and it is not different regarding the health sector. It is a single state and municipality, which makes the State Health Secretariat (SHS-DF) responsible for the management of Primary Health Care, as well as the medium and high-complexity care, in addition to health surveillance actions throughout its territory. The territory is divided into seven Health Regions, each with its own management structure with some autonomy, intensified by the process of regionalization started in 2015. However, there is no financial autonomy[11] (Figure 1).

In spite of previous attempts to organize the PHC in the FHS model, a deconfiguration of the care network has occurred in recent years, characterized by an excessive number of professionals in more central and wealthy areas, with a fragmented network and many points of care that were practically not in contact with each other, according to the diagnosis of the Working Group created to discuss the SOC within the SHS-DF structure[12]. At the PHC, there was a mix of traditional model consisting of basic specialties coexisting with the FHS teams. It is believed that

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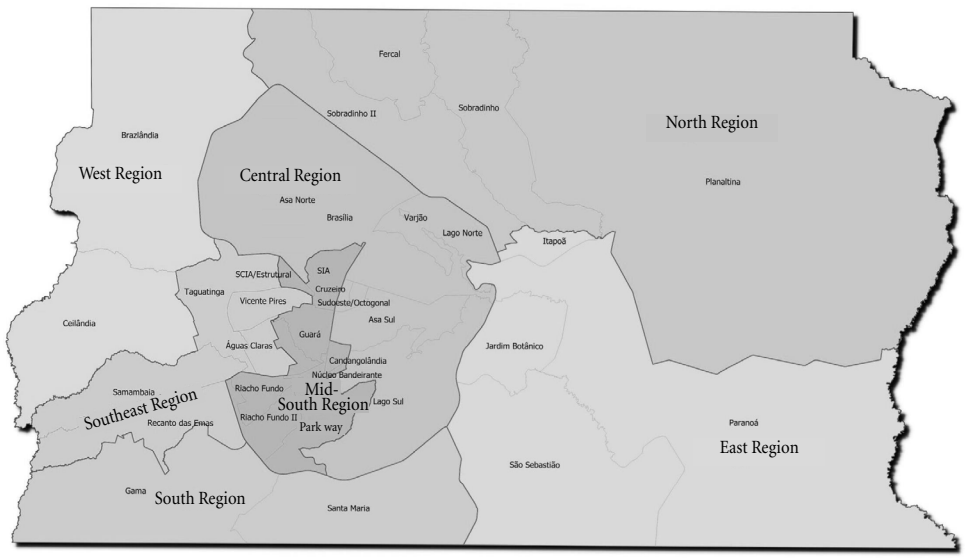

Figure 1. Graphical representation of the Federal District, health regions and administrative regions, FD, 2018.

due to bonuses and other issues, there was an accumulation of focal specialists (infectologists, cardiologists, etc.) in primary health care facilities, comprising health centers, basic health units, family clinics, etc.

The crucial step in the Network organization was the implementation of the "CONVERTE-APS" project, which established that the FHS would be the care model, in addition to standardizing that all PHC facilities would be called "Basic Health Units" (BHU). It provided the opportunity for professionals who worked in these facilities to choose to change their specialty of origin to Family Doctor, after undergoing a training course and an evaluation at the end of it[4,5].

Together with the development of the "CONVERTE-APS" project, some issues arose, which had to be considered: a) four units with no adherence of their teams, in areas of low vulnerability and close to other health facilities; b) doctors who had not adhered to the program, many with work restrictions that prevented them from working in urgency and emergency units; c) the need for a level of care that would provide assistance back-up for the PHC; d) the need to maintain the training and the matrix support of these new specialists who would work in the PHC as family doctors; e) the existence of a fragmented outpatient network, mainly in hospital environments that operated without regulated access, without prioritizing the users' needs, with endless and poorly categorized waiting lines; f) the lack of diagnosis of the outpatient network, with services that often comprised the needs of the professionals, instead of the needs of the population; g) absence of a clear flow of referral and appointments, causing duplicated waiting lines and a culture of users' "pilgrimage" in search of specialized consultations; h) existence of specific reference centers that had their own strong management structure, creating small "realms" that did not communicate with the network.

There were also positive initiatives within the Health Regions, such as matrix support strategies with successful results and the Health Care Planning (HCP), which was an inspiring experience for the entire project of Secondary Outpatient Care organization in the Federal District.

Health care planning: the experience of the Eastern Health Region

With the Health Regionalization process in the Federal District and greater independence of the Health Regions, the National Council of Health Secretaries (CONASS) supported the Eastern Health Region regarding the HCP proposal. The project had the differential characteristic of being initiated both in the PHC, with the purpose of promoting the change in the organi-

zation of the work processes of the FHS, offering more resolutive capacity, as well as in the secondary outpatient care[13].

With the organization of the work processes related to the HCP, the Eastern Region felt the urgent need to organize the other levels of care. Among the demands that naturally appeared were the organization of the secondary outpatient level, the regulation of appointments and also the hospital organization to receive the referral and counter-referral cases of care sent by the primary care.

The process in the SOC started with the presentation of the proposal to the specialties (endocrinology and cardiology) that accepted to comprise the line of care of chronic non-communicable conditions (diabetes and hypertension). The focal specialists would go through planning workshops together with PHC professionals. Subsequently, they would start being tutored by the CONASS consultants, initiating the dialogue between PHC and specialized care.

With the publication of the technical note "Management of Systemic Arterial Hypertension and Diabetes Mellitus in Primary Health Care"[14] issued by the technical areas of SHS-DF, the process of patient risk stratification in PHC in the line of care is started, classified as low, moderate, high and very high risk by the FHS teams. According to this logic, patients of low and moderate risk should be followed by the FHS. High and very high-risk patients are referred to the specialty outpatient clinic to be followed by the multiprofessional team according to the SHS-DF protocol, even though the link with the PHC was maintained.

The secondary care ambulatory was designed for multiprofessional care, based on the Chronic Condition Care Model (CCCM) proposed by Mendes[15]. In this model, the users are scheduled to be seen at the service, where they will go through the embracement and care, according to the users' identified needs. There is no need for setting up an exclusive schedule of professionals as seen in the traditional model, a health technology that uses individual and sequential care by professionals of a multidisciplinary team coordinated by a support point, aiming at meeting the integral care programming for each user, culminating in the creation of a user care plan, which shared with the PHC and aims at the user's clinical stabilization.

Another issue is that care is not limited to individualized medical consultation, but also includes group activities, as well as health promotion and prevention actions, optimizing the time of users and professionals in the service, in addition to improving user adherence to the proposed care. Moreover, all users will receive a therapeutic plan created by the entire team, which is referred to the user's reference team, with the necessary follow-up recommendations, and encouraging the link with the PHC. The multiprofessional team currently consists of physicians (endocrinologist, cardiologist, ophthalmologist), nurses, nurse technicians, nutritionist, psychologist, physical therapist, social worker and clinical pharmacist. There is also support from the hospital dental team.

The participation of the PHC and SOC teams in the meetings promoted by CONASS and also the development of the care plan in the SOC work process naturally increased the relationship and connection between these teams. In this process, the alignment between the teams becomes evident and the exchange of knowledge was a step taken towards the development of what would later be a milestone within the Eastern Health Region and in the Federal District. The specialists' perception that the teams had difficulty managing low and medium-risk patients was confirmed during some mentoring meetings promoted by CONASS. From that point on, it was decided to perform the matrix support with the PHC teams, to manage the patients that should be in PHC and those who were counter-referred by Specialized Ambulatory Care (SAC), increasing the PHC problem-solving potential and ensuring better control of these chronic diseases.

Currently, the matrix support naturally occurs in the region, and it is highlighted as successful according to the CONASS team, respecting the demands of each team and using an adaptive methodology. The process takes place in meetings where practical guidelines are provided, for instance, to help users deal with aspiration and insulin application procedures. Also, whenever necessary, consultations are shared, and cases are discussed. The SOC and PHC teams have social networking groups to solve doubts before making the referrals. In these groups, they provide guidance on necessary tests if there is a need for referral to the outpatient clinic, and whether a referral is really necessary. Another tool used by the teams was the implementation of group shared care– the multiprofessional and interdisciplinary collective care for users who, preferentially, have chronic health conditions and similar risk stratification.

As a practical example of the impact of matrix support, in the past, several procedures were

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canceled by the dental team due to hypertension peaks, but after it was implemented with the family health team, there was a decrease in 95% of the cancelled appointments. It is interesting to illustrate this modification using the words of cardiologist at the outpatient clinic: "In the past I used to complain about my colleague (MFC) who made wrong referrals to me, I did not even need to be inside the outpatient clinic. Today I feel responsible for the incorrect referral and that has led me to question at what point I made a mistake in my matrix support".

Currently, what seemed impossible became a routine in the professionals' work processes in the region. The qualification of care is undoubtedly the greatest victory of this project according to the managers of the region, "it is the guarantee of access to those who, in fact, need it. It reduces the '*Velcro* effect', which specialists tend to replicate because they think that primary care cannot manage this patient. The emphasis here is the user of the Unified Health System (SUS, *Sistema Único de Saúde*), based on the identification of the health needs of the population of a given region and their registration and, additionally, the monitoring of this population".

A secondary effect of the formal integration of services has been the reduction of hospitalization in these groups of chronic noncommunicable diseases followed at the abovementioned services, where many of these groups also show high social vulnerability. It is still necessary to confirm, with the follow-up of the work processes and the continuity of care, the reduction in the number of cases treated in the emergency room[16-18].

Experience of the SOC implementation in the FD

With the experience achieved with HCP, the managers of the Eastern Health Region took to the Adjunct Care Secretariat the proposal to create an intermediate level of care between PHC and HC that could be organized in order to meet the needs of PHC.

Therefore, a new function was created in the Central Administration (ADMC) of the SHS-DF, represented by the Outpatient Services Management, with the objective of recovering Secondary Outpatient Care models and to delineate, together with the other actors involved, a model proposal to meet the needs of the new PHC conformation.

At first, the managers face the reality of the fragmentation of services in the network, absence of diagnosis and information on productivity and human resources of the existing services. Moreover, there is a lack of integration between the regions and between levels of care in the same region, the lack of protocol standardization with referral criteria, resulting in endless waiting lines for focal care, with users being treated on a "first-come, first-served" basis, and not according to their needs. There were also medical-centered services and ghettos of excellence that provided quality care to those who had the opportunity to enter through innumerable access routes, not being available in a transparent and egalitarian way. Within this scenario, a plan, and subsequently, a strategic project were developed, for the organization of outpatient care in the FD, consisting mainly of the axes shown in Chart 1.

Diagnosis and organization of the physical structure for the SOC

In order to better understand the FD secondary care network and plan the SOC structuring, a fieldwork was carried out to catalog the structures/facilities that had the potential for this level of care, in addition to mapping the work processes that existed there.

Initially, four PHC facilities were made available, which did not undergo the conversion process. After the inspection, it was verified that the assessed physical structures with potential for outpatient care installation required minor adaptations, and the creation of polyclinics was planned. Among these structures, one of them stood out for its external and internal physical space, with an area for performing physical activities that was already built. This facility was then transformed into a Specialized Rehabilitation

Chart 1. Axes of the Strategic Project for the organization of the SOC in the SHS-DF, 2018.

- Diagnosis and Organization of physical structures (definition of SOC services).
- Creation of regional manager level of Secondary Care.
- Sizing of personnel
- Development of the legal framework to regulate the level of care
- Creation of technical frameworks.
- Regulation of medical and non-medical consultations in the health regions.
- Establishment of matrix support strategies in the health regions.

Center– SRC II. There was also a polyclinic that operated in the traditional fragmented model. Subsequently, four other structures for the installation of polyclinics were identified, and another one for the implementation of a Diabetes, Obesity and Hypertension Reference Center.

The Outpatient Model of Planification was located in a region that did not have an extra hospital structure for its operation. However, with adjustments of the physical space in the hospital ambulatory, its operation became feasible, demonstrating that its success was based on the change of the work processes and not on its location. Therefore, it was decided to re-evaluate all hospital outpatient structures.

Table 1 summarizes the set of facilities that would comprise the secondary outpatient care network.

Table 1. Set of facilities proposed for secondary outpatient care network, SHS-DF, 2018.

Health Facility	Quantity
Out-of-hospital Polyclinic	08
In-Hospital Polyclinic	10
Day Hospital	01
Specialized Rehabilitation Center (CER)	01
Center for Dental Specialties - CEO (out-of-hospital)	03
Center for Dental Specialties - CEO (in-hospital)	10
Psychosocial Care Center	18
Referral Center	03
Regional Laboratory (out-of-hospital)	02
Radiological Center	01

Results and discussion

Creation of a Secondary Care Regional Manager Level

History

In 2015, the SHS-DF was administratively structured in Central Administration (ADMC), Health Region Superintendences (SRS) and District Reference Units (URD). This structure consolidated the change from the centralized management model to the regionalized model, with the perspective of budget-financial decentralization, according to Decrees n. 36918, of November 26, 2015[19], n. 37057, of January 14, 2016[20], and n. 37515, of July 26, 2016[21]. The ADMC became responsible for the standardization, planning, control and evaluation of the SUS/FD Service Network management and the SRS and URD for the planning, monitoring and evaluation of the performance of services at the regional level.

The organizational modeling of the SRS was carried out by levels of care and process management. As a consequence, at that time, the administrative structure of the SRS was changed and consisted of a Board of Directors and Care Directors: Primary Care Board of Directors (DIRAPS) and Hospital Board of Directors (DH).

The SOC was structured according to the need for the organization of outpatient services. These services were partially linked to the SRS or DH. They did not have an administrative organization standard, as some had an official structure, but the vast majority did not. Thus, in November 2017, workshops were carried out to restructure the positions in order to create a Regional Secondary Care Board of Directors (DIRASE).

The workshops took place in each SRS with the participation of the superintendent and its directive body. The proposed structure was modeled using:

- One DIRASE per health region linked to the superintendence;
- A Planning, Monitoring and Evaluation Management, with two centers: one for collection and analysis of SUS data and another for Cost Management, linked to DIRASE, following the same structure pattern of other Care Board of Directors;
- Secondary Care Service Management (GSAS), linked to DIRASE, and quantified according to outpatient services in each region;
- Alteration of the administrative association of CAPS, UPAS and other specialized outpatient services already existing in the administrative structure, to DIRASE.

The standardization of the administrative structure of the health regions establishes and specifies all functional activities and limits of responsibilities of the organic units, in addition of balancing these activities, while considering the systemic organizational process, in which several sectors interact, aiming at achieving coherence and effectiveness of the whole. Therefore, the standardization aimed at allowing and enhancing the governability and performance of managers and employees, and to facilitate the performance of actions, management and exchange of experiences between managers.

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A training course was also held for future managers of this level of care, including topics such as care model and HCN, planning, financing and budget, among others. Currently, there are collegiate spaces among the DIRASES of each SRS to monitor and exchange information about the model implementation process.

Sizing of personnel

During the conversion process, there was a number of doctors and nurses who did not adhere to the change, being available for relocation to other levels of care. Subsequently, with the development of the regulation of the Family Health Support Nucleus – Basic Care (NASF-AB) in the Federal District, there were also other health professions available for the other levels of care, albeit at a smaller number.

Among doctors, most of the available human resources consisted of specialists in Pediatrics, Gynecology and Obstetrics and Internal Medicine. Considering the new model of care, it was defined that the scope of these professionals' work in SHC should focus on activities of the focal specialty or in specific areas of action of proposed lines of care. For this purpose, the technical areas of ADMC started working to define the technical milestones related to these professionals' scope of work. Then, a tool was developed to create a talent database, which consisted of identifying among the professionals the existence of a subspecialty, as well as areas of work or specific training of interest for the organization of the Polyclinics.

In this stage, professionals from the hospital outpatient clinics, hitherto administratively linked to the DH and working in specialties of interest for the structure of the secondary care services, were identified. Then a process of negotiation and persuasion of these professionals was carried out to convince them to work in extra-hospital or in-hospital polyclinics with a connection to the new secondary administrative structure.

Finally, with the diagnosis of the specialties' distribution in the regions and the creation of the parameterization manual of its workforce, it was possible to proceed with new appointments of professionals aiming at the organization of these services, based on the needs identified in each health region. Thus, the logic of care changes due to individual interests to a logic of organization of services according to the needs.

Development of the legal milestone to regulate the level of care

The publication of Decree n. 38982, of April 10, 2018[22], was a milestone to formalize the SHC, as, in addition to creating the new administrative structure, as previously stated, it officially established the creation of this level of care. However, the organization of new services and the proposed change in work processes generated the demand, mainly by regional managers, for standardization of criteria for service operations, allocation of medical specialties between DH and DIRASE and the officialization of the polyclinics and their functions.

Based on the Planification experiences, theoretical publications and experiences seen in the CONASS publications, with emphasis on the CONASS *DEBATE* –Innovation in Specialized Outpatient Care, in addition to the experiences that were already occurring in the model implementation in each health region, the SHS-DF issued SHS Ordinance N. 773, dated of July 19, 2018[10], which established guidelines and norms for the organization of Secondary Outpatient Care.

Among other things, the Ordinance provides conceptual definitions of the SOC, Matrix Support and Service Portfolios. Also emphasized are the guidelines and principles for the organization of this level of care, such as: sufficiency; complementarity; territoriality, the regulated access; the coordination by PHC and its multiprofessional characteristic. The scope of action of the SOC is outlined. It establishes the lines of care for Children and Adolescents, Women, People with Chronic Noncommunicable Diseases and Oral Health as mandatory in each region, as well as stimulates the lines of Health Care for People with Infectious Diseases (STIs/AIDS and tropical diseases), for Care of the Elderly and the Integrative Health Practices aimed at People in Situation of Violence as preferential ones.

Regarding the functioning of the units, the parameterization of the schedules and the definition of the appointments are defined, establishing that all the specialized care appointments will be regulated, prioritizing the use of the regulation system by the PHC, with no estimate of appointments for specialized care at spontaneous demand.

The successful experiences of Matrix Support and the importance of the SOC as a reference consultant are taken into account, also making the SOC responsible for improving the quality

of the follow-up of the less complicated cases by the FHS teams. Thus, in order to guarantee actions with this purpose, it was established that the SOC Units should function as a health education space for PHC professionals, recommending that between 10% and 20% of the total available workload in each specialty be dedicated to Matrix Support actions, according to the needs identified in the territory.

Lastly, the Health Council of the Federal District supported and recognized the importance of the SHC organization, and approved Resolution n. 505, of October 9, 2018 (DODF, 10/15/2018)[23], which establishes, among other items, that Secondary Outpatient Care is a strategy to strengthen Primary Health Care, based on the territorialization and care lines, according to the principles of decentralization and regionalization of SUS.

Creation of technical milestone

In order to organize the workflows, the technical areas of SHS-DF worked on referral protocols, delineating the criteria that define the user's permanence in PHC, and when they need to be referred to the specialties. This action also standardizes regulation in all health regions, which previously used assorted protocols produced by other institutions. The protocols were constructed in groups, involving all areas of action in the lines of care, including the evaluation and validation by technical teams of the SHS-DF Primary Care Coordination.

In order to facilitate the handling of the protocols, the SHS-DF Secondary Care Department issued these protocols as Technical Notes (TN), distributed to all FHS teams and SOC professionals, in addition to being permanently available on an electronic site. The compliance with the referral criteria is monitored by the regional regulating agents, and it is also the SOC professionals' responsibility to assess the quality of the referrals, producing reports that can diagnose the most sensitive points of the teams, allowing the Matrix Support planning actions, which should be individualized accordingly to the needs of each team.

Among the TN, four specialties benefited from the introduction of Telehealth, which joined other actions in improving the characterization of waiting lines and increasing resolutive capacity in PHC.

Regulation of medical and non-medical consultations in SRS

The restructuring of the public health system of the Federal District based on the PHC and FHS models, brings, as a challenge, the organization of a support network to allow the first level of care to be as resolutive as possible. Scientific evidence shows that a strong PHC depends on a strong basis, with the same sturdiness, so that the people's health care can be as skilled as possible[24]. Therefore, specialized outpatient and hospital levels are developed and restructured. Nevertheless, a new challenge arises for the management of this system: the need to promote the integration between these levels. As a consequence, it was necessary to organize a procedure to receive the requests from the PHC teams and that would contribute to the strengthening of the PHC gatekeeper role, leading to an equitable, transparent and safe access to specialized and hospital care. For this purpose, the Regulatory Complex in Health of the Federal District (CRDF) and its Regulatory Centers (CR) were structured to implement a regulatory access process based on the development of scenarios of health service provision and the regionalization model of the FD. Then, the following services were configured: Panorama 1 services (scenario in which the health regions are self-sufficient to provide services); Panorama *2* services (scenario in which the services need to be agreed between the health regions) and Panorama 3 services (scenario with strategic and scarce services, available to the entire FD population and under direct regulation of the CRDF).

The CRDF is, therefore, responsible for applying the Care Access Regulation together with its operational units. Medical regulation is configured as a sanitary authority, and promotes access based on protocols, risk classification and other prioritization criteria defined and agreed upon between the managers involved in the process to allow the most adequate care alternative to be provided according to the needs of the citizen.

Responsible for the regulation of patients' access to specialized consultations, exams, and other outpatient procedures, the Outpatient Regulation Center (CERA), subordinated to the Board of Directors of Outpatient and Hospital Care Regulation (DIRAAH) is one of the eight CR that comprise the CRDF. Outpatient regulation follows the Regulation Scenario or Regulation Model, adopted by SHS-DF and its CRDF, which consists of the subdivision of specialized and hospital care services according to regional

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distribution, resulting in the formation of supply settings of these services.

The implantation of the Telehealth Center in the Federal District

Innovative processes of management aid, such as the Telehealth, play an important role in the reorganization process of PHC, SHC and access regulation in the FD, since these processes become regulation practices and permanent education actions, being capable of integrating the regionalized levels of care and make the health professionals responsible for the user's care management.

In this context, the *Regula Mais Brasil* project is a partnership between the Ministry of Health and Hospital Sírio-Libanês through the SUS Institutional Support and Development Program (Proaudi-SUS) to promote regulatory and permanent education actions in PHC and SHC of four Brazilian capitals and the Federal District, based on the technical-scientific experience of Telehealth of the state of Rio Grande do Sul. Moreover, the *Regula Mais Brasil* project aims to implement the Telehealth in the FD.

The project started in late 2017 when CRDF professionals participated in the training of the *Regula Mais Brasil* project with the objective of identifying potentialities and weaknesses in the implementation of the FD Telehealth. In the first half of 2018, a sample study was carried out based on the waiting lines for specialized consultations, and four medical specialties (cardiology, endocrinology, neurology and pneumology) were identified to comprise the scope of the project.

In this context, DF Telehealth is in its implementation phase, and the main advances to date are:

- Teleregulation of the cardiology and endocrinology specialties of the southwest region. The regulatory actions are performed in the SISREG by the teleconsulting doctors of the *Regula Mais Brasil* project; thus, the referral criteria are evaluated according to the TN and the requests have three possible outcomes; approved, canceled and returned. The 'returned' status is provided with guidelines for the family doctor and community with the purpose of qualifying the referral information referencing the TN. If the requesting doctor wishes to discuss the case, a teleconsultation can be carried out.

- Engagement contact and/or Teleconsultation: at the first moment, the contacts are active, justifying the necessity of the first engagement contact to be carried out by the teleconsultant doctors to the family doctors and community. Hence, the field team makes the previous contact with the BHU managers to schedule a time for the teleconsultants to contact the BHU doctor to present the project, establish a connection and, if the family doctor and community intends to discuss cases of referrals that were returned via SISREG, a teleconsultation is performed.

- Fieldwork: it consists of collective actions such as team meetings, workshops, telephone contacts and technical visits to the BHU for the engagement of health professionals in the *Regula Mais Brasil* project.

Conclusion

In spite of the scarce publications on the SOC, from the moment when the Health Reform in the FD started with the Primary Health Care, the necessity to organize the other structural levels became imperative. For that purpose, asystematic and careful implementation of a public policy was started, based on all diagnoses carried out in the SHS-DF Network. Important results were obtained, both for the system organization and to meet the health needs of the population, which had been enduring endless waiting lines for an indefinite period of time. We still have a long way to go so that the changes can indeed be perceived by the population. However, small advances, such as transparent and organized procedures and consultations, and better use of the available hours of focal specialists can already be seen.

Collaborations

BAP Guedes, FLB Vale, SR Batista and RW Souza worked on the article design, on data research and organization, on the final writing of the manuscript, on the critical revision and the approval of the version for submission to publication. MKA Costa worked on research and writing of the manuscript.

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