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Planning and support in the work process of PHC teams in the Northeast: analysis of the PMAQ-AB (3rd cycle)

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Abstract *This paper aims to describe the indicators related to planning and support in the work process reported by the Family Health Teams, from the 3rd cycle of the National Program for Improving Access and Quality of Primary Care (PMAQ-AB) in the Brazilian Northeast. This cross-sectional study employed secondary data from the external evaluation of the 3rd cycle of the PMAQ-AB. Sixteen indicators were used to ascertain the teams' work process actions, and 14,489 family health teams that adhered to the program were evaluated. Among the indicators assessed, we found that the teams held a meeting and planned actions and self-evaluated, monitored, and analyzed health indicators to reorganize the work process, highlighting the determining and conditioning factors. Health surveillance and the Extended Family Health Center (NASF) stand out in the indicators of institutional support and multidisciplinary support for solving complex cases. We identified improvements in the work process of the teams in the Northeast region, but the reality of fragmented and vertical work still requires a change to promote an outlook of shared teamwork, directly influencing the work process.*

Key words *Primary Health Care, Family Health Strategy, Health Assessment*

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Introduction

Primary Health Care (PHC) is the alternative to solve the health system's current challenges in a sustainable way. It is crucial to achieve the global goals shared in universal health coverage and the health-related Sustainable Development Goals (SDGs) due to its ability to achieve universal coverage, favoring intersectoral actions and equity to ensure a healthy life and promote well-being at all ages, according to the Astana Declaration[1].

In this context, the consolidation of PHC in recent decades is one of the most relevant advances in the Brazilian Unified Health System (SUS) as a public policy and universal health system. Such emergence is anchored mainly in the implementation of the Family Health Strategy (ESF) and with the institutionalization of the evaluation of PHC by the Ministry of Health. Such initiatives have led to an increased offering of broad-spectrum actions and services and contributed to critical positive effects on the health of the population, marking one of the most significant innovations in PHC since the Declaration of Alma-Ata and the creation of the SUS[2].

In this context, the National Primary Care Policy (PNAB) states that planning is an indispensable management tool used by the teams that support the organization of the diverse and complex PHC work processes. By proposing future action, planning expresses disputed purposes and interests, creativity, participation, and independence, and change is acceptable[3,4].

It also highlights the importance of planning actions based on the situational diagnosis of the operational territory of the Family Health Team (EqSF) and carrying out work with a defined territory to maintain ties with the community, based on existential realities, with joint multidisciplinary teamwork for better results in the self-assessment process[5,6].

In the team's self-assessment, PHC quality can be measured by the consensus of the team's professionals potentially qualified to assess the reality of the work process in their context. Such analysis can also facilitate decision-making and organization of care practices, contributing to the strengthening of the ESF through support and planning[6].

In 2011, the National Program for the Improvement of Access and Quality of Primary Care (PMAQ-AB) was implemented in Brazil by the Ministry of Health. This is a model for evaluating the performance of health systems, which aims to measure the potential effects of the health policy to subsidize decision-making based on planning and institutional support for actions, ensuring the transparency of SUS management processes and giving visibility to the results achieved, strengthening social control and focusing on users[7].

The PMAQ-AB aims to expand people's access to services, improving working conditions and, mainly, care quality. In this context, one of the aspects evaluated by the program is the work process of the AB teams[8].

Considering the breadth of the PMAQ-AB proposal, the inclusion of evaluative practices by primary care teams in the country is still incipient. There is also a lack of more comprehensive studies revealing the reality of the work process, varying according to the peculiarities of each municipality, state, or region, which must be considered in the evaluation process. Thus, considering data from the Northeast region regarding planning and support reported by family health professionals becomes relevant to understand which actions are most implemented or require improvement in the work process.

In this sense, this study aims to describe the indicators related to planning and support in the work process reported by EqSF professionals, based on data from the 3rd cycle of the PMAQ-AB in the Northeast of Brazil.

Methods

This is a cross-sectional study with secondary, multicenter data collected on primary care teams working in municipalities in the Northeast of Brazil and adhering to the 3rd cycle of the PMAQ-AB (2017). A total of 14,489 primary care teams from the Northeast region were considered for this study, corresponding to 37.28% of the total teams evaluated in the country and 99.94% of the Northeast teams.

The study was conducted considering the Northeast region of the country, covering the entire macroregional territory composed of nine states: Alagoas, Bahia, Ceará, Maranhão, Paraíba, Pernambuco, Piauí, Rio Grande do Norte, and Sergipe. This is the third-largest regional compound in the country, occupying 18.2% of its total area[9].

The data of this study were retrieved from the certification stage, which includes the external evaluation phase when a group of properly trained interviewers applied evaluation instruments to verify the standards of access and PHC

Ciência & Saúde Coletiva, 26(5):1749-1755, 2021

quality achieved by the municipalities, conducted by education or research institutions hired by the Ministry of Health. Therefore, the instrument was applied at the PHC unit (UBS) by the interviewer and an ESF professional designated by the team members to answer the questions. The collected data were then transferred to the national Ministry of Health database. Data referring to the context variable listed above were taken from the PHC Department of the Ministry of Health website based on the results of the External Assessment of the 3rd Cycle of the PMAQ-AB.

The external evaluation was developed in six modules. In this study, the data derive from module II – interview with the professional of the PHC team and verification of documents in the UBS, specifically retrieved from the questions related to the work process actions, such as team planning and institutional support, team access to NASF, articulation between ESF and NASF, and matrix support for PHC teams. The questionnaire included sixteen questions related to team meeting and frequency; action planning; consideration of results achieved in previous PMAQ-AB cycles in the work process organization; conducting a self-assessment process; information on health situations of the population made available by management to assist the team in analyzing the situation; planning and organizing the NASF action schedule in conjunction with the team; receiving permanent institutional support from a team or person from the Municipal Health Secretariat to discuss the work process or assist in the problems detected; evaluating the joint work of the institutional supporter with the team; ascertaining whether the team receives support from other professionals in complex cases and which professionals perform multidisciplinary matrix support; revealing in which situation the team feels the need for support from the NASF and what request modes are available; verifying that requests are answered timely; investigating the defined and agreed criteria between teams and NASF to call for action in unforeseen situations and whether support occurs in these cases.

A descriptive analysis was employed to present the data, considering the absolute and relative frequency and 95% confidence interval (95%CI). The analyses were performed using the Stata® v.13.0 statistical program.

The research is nested in the research project entitled "Evaluation of Primary Care in Brazil: integrated multicenter studies on access, quality, and user satisfaction", approved by the Research Ethics Committee of the Federal University of Rio Grande do Sul.

Results

The Ministry of Health currently accredits 16,497 EqSF teams in the Northeast region of the country, of which 14,489 were certified in the 3rd cycle of the PMAQ-AB, with 97.89% of the municipalities in the Northeast participating in the program.

Considering the total sample of the Northeast region, the actions of EqSF geared to planning with more significant proportions were team meeting (95.2%), frequency of monthly meeting (42.2%), monitoring and analysis of indicators and health information (87.6%), performing a self-assessment process (87.2%), and organizing the schedule and planning NASF actions in conjunction with the teams (68.3%) (Table 1).

We observed that 91.2% (95% CI: 90.7-91.6) of the teams reported receiving permanent municipal management support. The data show that 93.9% (95% CI: 93.5-94.3) of the EqSFs receive support from other professionals to solve complex cases. The main multidisciplinary matrix support actions are health surveillance (83.2%) and NASF (80.3%) (Table 2).

Discussion

The results of this study showed that most teams carry out activities for planning actions and meeting monthly. A study analyzing the teamwork process at the national and state level also found that most EqSF carry out these activities, emphasizing the attribution of professionals for discussing and planning actions based on local realities as per PNAB[10] guidance.

Studies highlight that the Northeast region had expanded PHC services through the ESF, emphasizing regions less favored by the public and private care offering, with improved regional distribution of medium and high-complexity services. Social determinants, democratic progress, and sustainable development are inextricably linked in the broader health context because a change in one domain affects others. Thus, integrated health, social, and economic actions are required to plan and support the teamwork process to reduce social and health inequalities[11,12].

Planning and management support are essential milestones in the organization of health ser-

Table 1. Description of the EqSF related to the planning indicators in the Northeast region, with data from the PMAQ-AB, 2017.

Planning indicators	Northeast Region	
	Nº	% (95%CI)
Performs team meetings	13,799	95.2 (94.9-95.6)
Meeting periodicity		
Weekly	3.379	23.3 (22.6-24.0)
Fortnightly	3.797	26.2 (25.5-26.9)
Monthly	6.120	42.2 (41.4-43.0)
No periodicity	503	3.50 (3.20-3.80)
The team carries out activity for planning actions	13,600	93.9 (93.5-94.2)
The team monitors and analyzes health information indicators	12,694	87.6 (87.0-88.1)
Results achieved in previous PMAQ-AB cycles were considered in the work process organization	10,006	69.0 (68.3-69.8)
In the last year, the team carried out some self-assessment process	12,641	87.2 (86.7-87.7)
Management provides information to assist in the analysis of the population's health situation	13,072	90.2 (89.7-90.7)
The planning and organization of the NASF action schedule is carried out jointly with the teams	9,902	68.3 (67.9-69.0)

Source: Data prepared by the authors from the final results of the 3rd cycle of the PMAQ/MS, 2017.

Table 2. Description of the amount of EqSF related to the indicators of access, institutional support, and NASF support in the Northeast region, with data from PMAQ-AB, 2017.

Access, Institutional Support and NASF Support Indicators	Northeast Region	
	Nº	% (95%CI)
EqSF receives permanent institutional support to discuss the work process and problem-solving	13,212	91.2 (90.7-91.6)
EqSF conducts an evaluation together with the institutional supporter for the qualification of the work process	6,830	47.1 (46.3-47.9)
The team receives support from other professionals to assist or support in the resolution of complex cases	13,609	93.9 (93.5-94.3)
Professionals performing multidisciplinary support		
NASF	11.643	80.3 (79.7-81.0)
CAPS	10,036	69.2 (68.5-70.0)
Health surveillance	12,050	83.2 (82.5-83.8)
Network specialists	11,414	78.8 (78.1-79.4)
Hospitals	11,111	76.7 (76.0-77.4)
Health Gym Hub	5,504	38.0 (37.2-38.8)
Specialized centers (rehabilitation, older adults, obesity, and others)	8,041	55.5 (54.7-56.3)
Ways of triggering NASF support by EqSF		
Written recommendations	9,880	68.2 (67.4-68.9)
Case discussion	9,329	64.4 (63.6-65.2)
Shared appointments	8,889	61.3 (60.5-62.1)
Scheduling appointments directly on the NASF professional's agenda	9,237	63.7 (63.0-64.5)
E-mail and telephone contact	8,874	61.2 (60.4-62.0)
NASF responds to the team's support requests promptly	7,052	48.7 (47.8-49.5)
There are criteria and ways defined and agreed upon between the team and the NASF to activate support in unforeseen situations	10,536	72.7 (72.0-73.4)
NASF support is received in unforeseen situations	11,355	78.4 (77.7-79.0)

Source: Data prepared by the authors from the final results of the 3rd cycle of the PMAQ/MS, 2017.

Ciência & Saúde Coletiva, 26(5):1749-1755, 2021

vices. However, it is necessary to be aware of and know local realities and particularities, respecting cultural, geographic, and social aspects, focusing on service quality. Knowing these aspects, the planning will lead the process of reorientation of actions and services and, together with institutional support, will demystify the external evaluation as being of a punitive nature, bringing positive effects to correct the directions and adaptations of the health actions in the work process[13].

Concerning the monitoring and analysis of health indicators and information, it is noteworthy that most teams carry out this monitoring. A study carried out in two states in the Northeast of the country found that most teams claimed to adopt this activity, with a high percentage of use in organizing the PHC work process[14].

Also, almost all of the teams stated that they perform a self-assessment to reorganize their work processes, detecting and recognizing their strengths and weaknesses. In this sense, a study carried out in the municipalities of Espírito Santo identified that teams mostly use self-assessment to improve PHC access and quality (AMAQ) as a management tool for reorganizing their work. Another study carried out in Paraíba showed that professionals recognize the self-assessment process as an opportunity to identify weaknesses in the teamwork processes[15,16].

The results of this work allow us to affirm that the relationship between planning and organizing the action schedule with the NASF is carried out jointly, highlighting the weaknesses regarding interprofessional collaboration between EqSFs and NASF professionals since there are still visions of individualized work with little integration in all variables of the studied context[17].

Studies claim that strengthening the understanding of team planning is essential for comprehensive care and the performance of actions that effectively meet the health needs of people and groups, raising the scope of resolving the work process[18,19].

Most teams declared receiving permanent management support to discuss the work process. EqSF work evaluation, together with the institutional supporter, was not considerable in the study. A survey that used data from Brazilian regions achieved better results concerning receiving institutional support and worse regarding the supporter's contribution to working together to qualify the work process and address problems. PNAB clarifies that institutional support for teams in the implementation, monitoring, and qualification of PHC is a municipal competence, besides expanding and implementing the work process[3,16].

Regarding matrix support, most teams receive support from other professionals in resolving complex cases, mainly from health surveillance and the NASF with no defined periodicity. A study that analyzed the PHC situation through municipalities with different population sizes points out that, in municipalities of small population size, the offering of PHC services is limited and not very effective compared to EqSFs in more favorable municipal contexts receiving support from other professionals[20].

However, this study showed that 93.9% of the teams reported receiving support to solve complex cases in the work process organization. These data deserve attention since the work process organization through matrix support must be thought in order to expand the scope of EqSF action, bringing an interdisciplinary team and increasing the potential for care comprehensiveness and resolution, either as a reference or incorporating them into the teams, establishing a horizontal and dialogical relationship among professionals. To this end, it is necessary to build several cross-sectional perspectives and sort this relationship between the reference team, support, and specialists based on dialogical procedures[21].

The data showed that the NASF has a vital role in planning and developing integrated actions with the EqSFs, and organizing its agenda in a defined and agreed manner for unforeseen situations, giving support in these cases[17].

It is worth noting that, although the analysis of this study was carried out in the Northeast region, its inferences can identify in some contexts the needs and most fragile elements in specified care regarding the PHC teams' work process, which can be applied in other parts of the country.

To the best of our knowledge, in the use of the PMAQ-AB assessed indicators, this is the first study conducted with data from the 3rd cycle, including data on the PHC teams' work process based on team planning actions and institutional support, team access to the NASF, articulation between ESF and NASF and multidisciplinary matrix support for PHC teams in the Northeast region.

Conclusion

Finally, given the lack of quantitative studies assessing the ESF work process actions in the

Northeast, the results shown here can be very valuable to managers, professionals, and academics who are somehow related to PHC. The EqSFs have planned and organized their work process with self-assessment, monitoring, and analysis of health information indicators, showing promising results in management and multidisciplinary matrix support actions.

The study provided a good representation of its results, some strengths and weaknesses of the work process of the EqSFs working in the Northeast region, requiring efforts to change the fragmented and vertical reality, promoting a work outlook signaling better results in the evaluative process of the PMAQ-AB, since PHC does not exist without a teamwork process and a collective subject of shared responsibility in deliberation and planning for the organization of adequate health services for the population.

Collaborators

GT Silva, FO Carvalho, APGF Vieira-Meyer, GMS Gomes, LMMR Bezerra, RV Camelo, VC Barbosa Filho equally participated in the conception, design, analysis, data interpretation, writing of the paper or its critical review, and approval of the version to be published.

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