Rosana Teresa Onocko-Campos[I]

Gastão Wagner de Sousa Campos[I]

Ana Luiza Ferrer[II]

Carlos Roberto Silveira Corrêa[I]

Paulo Roberto de Madureira[I]

Carlos Alberto Pegolo da Gama[II,III]

Deivisson Vianna Dantas[I]

Roberta Nascimento[I]

Evaluation of innovative strategies in the organization of Primary Health Care

ABSTRACT

OBJECTIVE: To compare the performance of Primary Care Units according to the implementation of new arrangements and strategies in primary care and mental health.

METHODOLOGICAL PROCEDURES: Evaluative research with triangulation of methods and theoretical framework of critical hermeneutics, carried out at six Primary Care Units of the two most populous health districts of the city of Campinas (Southeastern Brazil) in 2007. The Primary Care Units were analyzed according to clinical resolution, articulation between the primary care and mental health networks and implementation of health promotion strategies. Two groups were defined by cluster analysis: one with higher and another one with lower degree of implementation of the actions. The groups were compared based on the improvement in clinical follow-up, given by the occurrence of cerebral vascular accident; evaluation of dispensation of psychiatric medicines; focal groups with workers, users and community health agents; and interviews with users and relatives. Inclusive and participatory research strategies were employed.

ANALYSIS OF RESULTS: There were no pure models, but a mosaic of organizational proposals. Positive advances were identified in the group with higher implementation of innovative strategies in relation to better integration of the community agents in the Units' teams; to the workers' and agents' perception of improvement in the assistance; and to the facility for referrals and assistance of mental health cases. The difficulties identified in both groups were: communication among the levels of care and within the teams, in the implementation of matrix support, and incipient health promotion actions.

CONCLUSIONS: The development and implementation of mechanisms to fix professionals in Primary Care in large cities are necessary. The community health agents are fundamental to perform the territorial work proposed by the Family Health Strategy, using mechanisms to integrate the community health agents into the healthcare teams in order to counterbalance the tendency to isolation. The researched arrangements proved to be potent to produce this integration.

DESCRIPTORS: Primary Health Care, organization & administration. Organizational Innovation. Program Evaluation. Local Strategies. National Strategies. Unified Health System. Matrix support.

INTRODUCTION

The strategy of Primary Health Care as public policy has been discussed and implemented in European countries since the middle of the 20th century. The Alma-Ata Conference, held in 1978, established the consensus that Primary Care would be the fundamental strategy and the entrance door to the health system,

[I] Universidade Estadual de Campinas (Unicamp). Campinas, SP, Brasil

[II] Programa de Pós-Graduação em Saúde Coletiva. Unicamp. Campinas, SP, Brasil

[III] Universidade do Vale do Sapucaí. Pouso Alegre, MG, Brasil

Correspondence:
Rosana Teresa Onocko-Campos
Departamento de Saúde Coletiva
FCM - UNICAMP
Universidade Estadual de Campinas
Caixa Postal 6111
Cidade Universitária Zeferino Vaz
Barão Geraldo
13081-970 Campinas, SP, Brasil
E-mail: rosanaoc@mpc.com.br

Received: 7/27/2010
Approved: 8/18/2011

Article available from: www.scielo.br/rsp

with capacity to solve 80% of the health problems of the population.[21] Strategies that strengthen the capacity of primary care and that emphasize health promotion tend to improve the health status and reduce costs.[13]

The *Sistema Único de Saúde* (SUS – National Health System) in Brazil is affiliated to this tradition. The health network of the city of Campinas (Southeastern Brazil) has 61 *Unidades Básicas de Saúde* (UBS – Primary Care Units), approximately one for every 20,000 inhabitants, organized based on an amplified model of *Estratégia de Saúde da Família* (ESF – Family Health Strategy). Besides the professional categories included in the ministerial program, specialists were introduced (pediatrician, gynecologist and dentist), as well as organizational innovations, aiming to modify the traditional doctor-centered model.

The municipality has one mental health team for every 30,000 inhabitants, present in 30 UBS to support the family health teams in the assistance provided for mental patients. Among the implemented innovations, we highlight: team meeting and fixed spaces for regular discussions, presence of a mental health team at the UBS, existence of matrix support, construction of a Singular Therapeutic Project for cases of high clinical risk and social vulnerability, health education and health promotion groups, existence of collegiate management and community's participation in the management.

The present study aimed to compare the performance of Primary Care Units according to the implementation of new primary care and mental health arrangements and strategies.

METHODOLOGICAL PROCEDURES

Evaluative,[4] participatory[6] and predominantly qualitative study,[4] guided by Gadamerian hermeneutics[7] and using methods triangulation.[14]

The evaluation occurred by means of three axes: improvement in the clinical follow-up through the evaluation of the frequency of cerebrovascular accidents (CVA); articulation between the Primary Care and Mental Health networks; and effective implementation of health promotion strategies.

Six UBS of the two most populous health districts of Campinas, 2007, were analyzed, with poor socioeconomic indexes and high social vulnerability rate (IBGE,[a] 2000 demographic census). UBS with similar structural characteristics and production data were included to avoid disparate dimensions concerning installed resources and catchment area.

To identify homogeneity in the implementation of the arrangements and strategies in the UBS, a scale was created to evaluate: the implementation of PSF (*Programa de Saúde da Família* – Family Health Program) teams with enrolment of users; existence, frequency and dynamics of the team meeting; development of therapeutic projects and collective discussion of clinical cases; regular presence (monthly, fortnightly or weekly) of matrix support in mental health with the functions of joint discussion of clinical cases, joint assistance of cases and theoretical-conceptual qualification of the team; existence and frequency of intersector activities and group activities at the unit aiming at prevention and health promotion. The arbitrary values increased the higher the frequency and the number of attributes declared by the UBS to each variable. The scale was previously validated in two UBS that did not participate in the study, using group consensus as response to avoid biases of individual opinions. It was administered during a team meeting by two independent researchers and calibrated.

The cluster analysis technique[5] with the S-Plus 4.0 software was utilized to group the UBS that had more points in common among the mapped variables. The result of the clusters highlighted two groups due to similarities among the variables: group I (two UBS with higher degree of implementation of innovative arrangements and strategies – teams organized according to the PSF model, regular weekly meetings to develop therapeutic projects and discuss clinical cases, presence of mental health support at least once every fifteen days and joint assistance and discussion of cases); and group II (four UBS with lower degree of implementation – without the presence or with low frequency of these variables, monthly support of mental health, and only qualification support, with no discussion of clinical cases nor joint assistance, among others).

Focal groups (FG) were conducted with workers, users and community health agents (CHA) of each group. The separation between workers and CHA was based on homogeneity criteria in the composition of the groups[8] and on the experience of a previous research, in which differences in level of schooling produced institutional situations of use of power that were reflected on the group context.[16] Nine FG were conducted: three of grouping I (workers, CHA and users) and six of grouping II (two of workers, two of users and two of CHA). Having known or having worked at the unit for more than six months and being interested in participating in the study were criteria of inclusion in the FG. Specific criteria: for users, being an adult and having used the UBS at least three times in the previous semester. Six hypertensive individuals and six users of the metal health services

[a] Instituto Brasileiro de Geografia e Estatística. Estimativas de população: estimativas para 1° de julho de 2006. Rio de Janeiro; 2006 [cited 2011 Sep 14]. Available from: http://www.ibge.gov.br/home/estatistica/populacao/estimativa2006/estimativa.shtm

were invited. Among the workers (except CHA), the following professionals were invited: two doctors, two nurses, four psychologists or occupational therapists, and four professionals with secondary education.

Of the total of individuals who were invited to each group, there was an average of ten people in the groups of workers (including groups of CHA) and six in the groups of users. The FG were audio-recorded and fully transcribed.

The transcriptions were transformed into narratives, as proposed by Ricoeur[17] and Onocko Campos & Furtado.[15] The different voices (workers, users and CHA) were analyzed within each group and were compared (e.g., users with users) in the two groups to identify differences. The contents were analyzed repeated times by researchers, performing the hermeneutic interpretive spiral. The aim was not the objectivation of hard evidences, but the discovery of values and explanations that the actors attributed to their practices.

The variables were: assistance provided for patients with CVA; care provided for patients with mental suffering and their families; and development of health promotion strategies.

A one-year quantitative, descriptive, cross-sectional and documental study was carried out to map the occurrences of CVA (International Classification of Diseases, 10th Revision I.64) in the city's three public reference hospitals. The medical records of the patients of each one of the six Units were analyzed and the coordinators of these UBS were interviewed, to access the professionals' understanding of the clinic developed in CVA cases.

The following aspects were analyzed: the logic of the referral of mental health cases; the pattern of psychotropics consumption; the patients' knowledge of the psychiatric medication; the relatives' view about the mental illness and its treatment; and the teams' evaluation of the matrix support.[3] The dispensation of psychiatric medication was surveyed for eight months through the computerized database of the drugstores of the UBS of the municipal government. Every time a medication is effectively delivered to a user, the prescriber is registered, along with the patient and the amount and type of medication that was delivered. The frequency with which the patient took away the medication was estimated, independently of the place.

Twenty-nine semi-structured interviews were conducted in home visits with mental health users and relatives from the UBS with experience in referral to specialized services, like the *Centros de Atenção Psicossocial* (Caps – Psychosocial Care Centers), independently of the outcome.

To evaluate the implementation of health promotion strategies, users' involvement in preventive and health promotion projects and programs was assessed, as well as the type and number of group activities that were carried out, the involvement of the CHA and of the team in meeting demands of the territory and developing intersector activities.

The research was approved by the Research Ethics Committee of the School of Medical Sciences of Universidade de Campinas (on 9/25/2007, register no. 562/2007).

RESULTS AND DISCUSSION

Improvement in the clinical follow-up

We identified 133 CVA cases: 96 in the South District and 37 in the Southwest one. In 38% of the hospital records there was no indication of the place for follow-up after discharge, 39% had no indication of discharge and 23% were referred to UBS or specialized centers. Of the 34 patients belonging to the six analyzed UBS, 25 belonged to group II and nine to group I, but with no statistical significance.

Studies point to better results in the reduction of morbidity and mortality caused by cardiovascular diseases when some strategies are adopted, like the handling of high-risk cases by nurses,[1] and joint planning between patients and primary care professionals of singularized and multifaceted strategies. Components with proven effectiveness were context analysis, professional support, clear and simple recommendations based on robust evidences, good communication, use of well-established networks to exchange information with specialists,[23] programs with joint and practical activities, and small groups.[19]

The absence of statistical significance may derive from the size of the sample and represent a limitation of the study. Of the 34 patients belonging to the UBS, 18 had their medical records found – another limitation of the study and of the health services; 13 had registers before the CVA, without significant differences between the two groups. In group II, three hypertensive patients had abandoned the service – or were not able to have access to it – in the two years before the CVA and another two had abandoned follow-up at the UBS in the previous year. The period of two years before the occurrence was used, since it could be the period of adjustment in medication, reorientation of habits and diet, insertion in conviviality spaces and possible prevention of the CVA. Another limitation of the research was the choice of a single indicator as clinical parameter.

The evaluation of admissions due to CVA performed by public hospitals in the period allows getting close to

the expected prevalence. However, the loss of medical records, and the lack of correct referral and counter--referral suggest inadequate articulation of primary care with the reference hospitals and low accountability for the follow-up of patients with arterial hypertension, which raises doubts about their effectiveness. There were no significant differences regarding the type of outcome (CVA) between the two groups, despite the fact that group I presented more inclusive practices and practices of clinic amplification.

According to the qualitative analysis of the FG narratives, the workers of the UBS from group I stated that the clinic begins at reception and/or welcoming. The interventions were discussed and planned in the team meetings. They worked with risk prioritization, groups of chronic users and conducted supervised treatments. The CHA felt integrated into the team and participated in the discussions of the cases.

Group I users praised the home visits and the follow--up of hypertensive and diabetic individuals, but they complained about the difficulty in scheduling consultations with specialists. They knew about the existence of groups of hypertensive individuals and recognized their help in the treatment, although they are little advertised and despite the lack of formal referral by doctors. They believed that participation in the groups produced better assistance on the part of the team. According to them, test results were slow and there were losses; however, they were told by telephone when there were alterations in the tests results.

Group II users reported that access was regulated by the reception in some UBS and, in others, it was necessary to take a slip of paper early in the morning with a number marking the patients' order of arrival. They said there were doctors with whom it was possible to talk and others who gave them prescriptions without conversation. They strengthened the importance and the need to be heard as "persons". In spite of the mentioned difficulties, their narratives showed excessive understanding and they even blamed themselves for the services' failures. This posture may represent a limiting factor for the assertion of rights.

Group II workers believed that they practiced good amplified clinic and did not show self-criticism regarding the aspects pointed by users. The CHA believed that they were responsible for the true amplified clinic and stated that the other workers did not get involved with users intensely. Between the CHA and the other workers, there seemed to be a large distance and the lack of recognition for the work of the CHA.

Group I presented greater integration in the work team, including the CHA. Those belonging to group I recognized beneficial aspects as part of the treatment offered by the health teams and mentioned what needed to be improved. In group II, what predominated was the report of difficult access, little hearing and, in spite of this, a kind of users' self-blame for the pointed failures, as if they were responsible, and not the teams. The literature lacks data that approach the impressions and feelings of teams and users considering different operating arrangements and strategies. Studies of the Brazilian case may point to questions for other emerging countries, in which the degree of citizen claim does not seem to be as developed as in rich countries.

Articulation between the primary care and mental health networks

Users and relatives from both groups emphasized the importance of the mental health professionals' hearing during the treatment, but they complained about their high turnover, which produces discontinuity in the treatment. This seems to be a difficulty of the health system itself.

Group I workers had more elaborated criteria regarding the profile of the patient who should be referred. They knew more about the different levels of the health care network and mentioned that they could communicate more easily with spheres like the Caps.

Better integration was observed between group I CHA and mental health teams, with joint discussions of cases and pacts of offers to include users in the service and follow them up in the territory. This seems to reflect greater integration of the team in a general way, including the CHA and the mental health team as components of a single and cohesive group. Strategies of democratic management and of clinic amplification may have favored this union. In group II, the logic of transfer of accountability for the case, and not of co-accountability, remained.

The differentiated implementation of matrix support in group I, with regular meetings, participation of the entire team, and proposition of joint assistance between Caps and UBS professionals, seems to have effectively produced greater co-accountability for the cases. This is reflected on the knowledge that the teams had of who was being assisted in the Caps, on the evaluation that the dialog with other services was possible and that they had adequate specialized backup.

In group II, matrix support happened in a precarious way with some professional categories, being limited to case discussion and referrals. The feeling of loneliness, impotence and unpreparedness to deal with the complexity of mental health is common. This ranges from difficulties in understanding the proposal to the lack of profile of the professional in charge of matrix support, not to mention the management's failures in the organization of the meetings. The correct implementation of matrix support has potential for being explored

in the Brazilian context so as mental health assistance is truly included in primary care. This problem has been faced as a dilemma by other health systems, like the Chilean[18] and the Australian[10] ones. It was found that 8% to 10% of the UBS users took anti-depressants and 7.5% used benzodiazepines without distinction between the two UBS groups being studied – data that are similar to those of the international literature.[22] Long periods of use were reported, with sparse reevaluations and lack of alternative therapeutic offers. The absence of continuing clinical follow-up and the lack of periodic evaluations of patients who use psychotropics tend to create the practice of repetition of prescriptions, criticized by users.

The workers mentioned feelings of impotence concerning social vulnerability and stated that they provide "palliative treatment", which can produce the medicalization of the social dimension. This practice was questioned and criticized by the group I workers, but without practical consequences, as they stated that they could not see alternatives to the users' many social and personal problems, except for use of medicines. The unpreparedness of the professionals working in primary care may be one of the reasons for the difficulty in strengthening and promoting mental health, similarly to what happens with Chilean primary care psychologists. [18] According to a Mexican study for the treatment of depression, interventions made by family doctors working in primary care can be effective when they receive a brief training. [11]

Users showed they had little information to decide on the use of medication. Paradoxically, they said they assume control of the treatment, altering doses and interrupting treatments without professional backup. In addition, the teams had difficulty in establishing dialogs that enabled the transmission of specialized knowledge in an accessible way to the public. In a qualitative study carried out in Chester and Manchester, feelings of impotence were identified among people with chronic health problems, and the sensation of being "lost" in the health system was identified among those with mild/moderate mental health problems, the most responsive system to intensification cases or more serious cases.[2]

Mental health users said they utilize medicines without knowing the duration and the reason for the treatment. They searched for information about their treatments in drug labels and on the Internet because they did not feel supported by their doctors. Although the treatment in the UBS seemed to be centered on the prescription of psychotropic drugs, users recognized the existence of other types of treatments, like psychological assistance, the Caps and/or Conviviality Center. They said they help more than the medicine itself and complained about the high turnover of these professionals in the SUS.

Among relatives of patients with serious and persistent mental disorders, the treatment was perceived as long, tiresome and extremely difficult in the two groups. The relatives felt relieved with the link with Caps, because they knew who they should look for in emergency situations, and this could be performed through a simple telephone call. Caps seems to have a better welcoming and, possibly, a higher degree of accountability than primary care with this population.

Implementation of health promotion strategy

There were no significant differences between the amount of group activities, users' involvement and coverage of the territory's demands between groups, but important differences were observed between the opinions of workers, CHA and users of the services.

To the workers, their work was not recognized. They brought to light its complexity, highlighting that they were dealing with other problems in addition to health, such as: education, housing, unemployment, drug addiction, among others. They complained about the disease as the main focus of their work, with priority being given to serious cases, and about the high demand. Health care was considered a factor that impeded the performance of prevention and promotion activities.

The partnerships between the UBS and other network services were recognized as important, mainly in cases of high social vulnerability; even with investments in these partnerships, intersector activities are far from being achieved. The use of schools, churches, and neighborhood associations was justified by the lack of physical space at the Unit rather than by integration with the territory. According to the workers, the community has difficulties in adhering to the community spaces and to the proposed groups due to the culture of assistencialism to which they are used, which may suggest a frozen and prejudiced representation of the population under their care.

The CHA considered themselves closer to the population than the other workers. This was something expected, because they necessarily live in the community that is located in the catchment area of the UBS. They also mentioned that there is a large social separation between those who live in the territory and the other professionals, which may reflect the social split that exists in the Brazilian society.

Workers, CHA and users recognized the existence of group work devices, like workshops, therapeutic groups and community activities. The groups developed outside the UBS were under the responsibility of the CHA. This may contribute to the CHA's sensation of distance from the team and may negatively affect the primary care practice by isolating the CHA's knowledge of the assisted clientele. The group I CHA, on the other

hand, felt integrated into the team and stated that their contributions were taken into account in the conduction of the cases.

The participatory arrangements that we evaluated (case discussion, development of therapeutic projects, regular team meeting and others) seem to have effect on the integration of the CHA into the health teams. It was not possible to prove their clinical efficacy due to the limitations.

The short time of practice of strategies like Collegiate Management and matrix support may have contributed to the few differences that were found between the two groups. The turnover of professionals in the UBS and of health care models at each municipal election negatively affects the continuity of the proposals. However, these factors were not explored in this study.

Despite the choice of the ESF, the Brazilian health system does not provide the municipal governments with clear outlines about strategies for the coordination of cases, longitudinal follow-up and system regulation, as is the consensus in other worldwide universal systems.[9,12,20] It is necessary to invest in innovative strategies so that fragmented services operate in a coordinated and comprehensive way and play the role of prevention in the community.

Users from both groups highlighted the importance of implementing strategies that qualify the assistance, like knowing the professionals, criticized the doctors' turnover and mentioned their dissatisfaction with the lines. The workers also recognized this need when they questioned themselves about the inadequacy of the instituted culture, called "exchange of prescriptions". This modality of care seems to have begun to ensure treatment continuity. However, it is considered bad by the professionals and by the mental health users. There is a positive correlation between the group with greater implementation of innovative arrangements and strategies and the perception of improvement in the assistance mentioned by users and workers, including CHA.

In conclusion, we presented suggestions to strengthen the formulation of public policies in the Primary Care of the large Brazilian cities. The development and the implementation of mechanisms to maintain the professionals in Primary Care in large cities are necessary. The CHA are indispensable to perform the territorial work proposed by the ESF, and the goal of CHA that is present in the ministerial directive should be met, using mechanisms to integrate them into the health teams in order to counterbalance the tendency to isolation. The researched arrangements proved to be potent to produce this integration.

It is also necessary to promote the organization of mental health care in the UBS, implementing risk assessments and opportune intervention devices in view of the high prevalence of these disorders. This would avoid reducing treatments to the continued use of medication. Matrix support is capable of promoting the integration of the mental health team into the PSF team, helping to articulate the health services network when it is adequately implemented.

REFERENCES

1. Berra K. Does nurse case management improve implementation of guidelines for cardiovascular disease risk reduction? *J Cardiovasc Nurs*. 2011;26(2):145-67. DOI:10.1097/JCN.0b013e3181ec1337
2. Campbell SM, Gately C, Gask L. Identifying the patient perspective of the quality of mental healthcare for common chronic problems: a qualitative study. *Chronic Illn*. 2007;3(1):46-65. DOI:10.1177/1742395307079193
3. Campos GWS. Equipes de referência e apoio especializado matricial: um ensaio sobre a reorganização do trabalho em saúde. *Cienc Saude Coletiva*. 1999;4(2):393-403. DOI:10.1590/S1413-81231999000200013
4. Denzin NK, Lincoln YS, editors. Handbook of qualitative research. Thousand Oaks: Sage; 1994.
5. Everitt B. Cluster analysis. London; Heinemann Educational for the Social Science research Council; 1974. (Reviews of Current Research, 11).
6. Furtado JP, Campos RO. Participação, produção de conhecimento e pesquisa avaliativa: a inserção de diferentes atores em uma investigação em saúde mental. *Cad Saude Publi*ca. 2008;24(11):2671- 80. DOI:10.1590/S0102-311X2008001100022
7. Gadamer H-G. Verdade e método: traços fundamentais de uma hermenêutica filosófica. Petrópolis: Vozes; 1997.
8. Gondim SMG. Grupos focais como técnica de investigação qualitativa: desafios metodológicos. *Paideia (Ribeirao Preto)*. 2002;12(24):149-61. DOI:10.1590/S0103-863X2002000300004
9. Grant CC, Forrest CB, Starfield B. Primary care and health reform in New Zealand. *N Z Med J*. 1997;110(1037):35-9.
10. Johnson C. Managing mental health issues in general practice. *Aust Fam Physician*. 2007;36(4):202-5.
11. Lara-Munoz MD, Robles-Garcia R, Orozco R, Real T, Chisholm D, Medina-Mora ME. Estudio de costo-efectividad del tratamiento de la depresión en México. *Salud Ment*. 2010;33(4):301-8.
12. Larizgoitia I, Starfield B. Reform of primary health care: the case of Spain. *Health Policy*. 1997;41(2):121-37.
13. Milstein B, Homer J, Hirsch G. Analyzing national health reform strategies with a dynamic simulation model. *Am J Public Health*. 2010;100(5):811-9. DOI:10.2105/AJPH.2009.174490
14. Minayo MCS, Assis SG, Ramos de Souza E. Avaliação por triangulação de métodos: abordagem de programas sociais. Rio de Janeiro: Editora Fiocruz; 2005.
15. Onocko-Campos R, Furtado JP. Narrativas: utilização na pesquisa qualitativa em saúde. *Rev Saude Publica*. 2008;42(6):1090-6. DOI:10.1590/S0034-89102008005000052
16. Onocko-Campos R, Baccari IP. A intersubjetividade no cuidado à Saúde Mental: narrativas de técnicos e auxiliares de enfermagem de um Centro de Atenção Psicossocial. *Cienc Saude Coletiva*. 2011;16(4):2051-8. DOI:10.1590/S1413-81232011000400004
17. Ricoeur P. Interpretação e ideologias. 4. ed. Rio de Janeiro: Francisco Alves: 1990.
18. Scharager Goldenberg J, Molina Aguayo ML. El trabajo de los psicólogos en los centros de atención primaria del sistema público de salud en Chile. *Rev Panam Salud Publica*. 2007;22(3):149-59. DOI:10.1590/S1020-49892007000800001
19. Sjöström M, Karlsson AB, Kaati G, Yngve A, Green LW, Bygren LO. A four week residential program for primary health care patients to control obesity and related heart risk factors: effective application of principles of learning and lifestyle change. *Eur J Clin Nutr*. 1999;53 Suppl 2:S72-7.
20. Starfield B. Atenção Primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília (DF): UNESCO/ Ministério da Saúde; 2002.
21. Starfield B. Reinventing primary care: lessons from Canada for the United States. *Health Aff (Millwood)*. 2010;29(5):1030-6. DOI:10.1377/hlthaff.2010.0002
22. Vedia Urgell C, Bonet Monne S, Forcada Vega C, Parellada Esquius N. Estudios de utilización de psicofármacos en atención primaria. *Aten Primaria*. 2005;36(5):239-45.
23. Wright J, Harrison S, McGeorge M, Patterson C, Russell I, Russell D, et al. Improving the management and referral of patients with transient ischaemic attacks: a change strategy for a health community. *Qual Saf Health Care*. 2006;15(1):9-12. DOI:10.1136/qshc.2005.014704

Research financed by the Research Program into Public Policies of *Sistema Único de Saúde,* agreement *Fundação de Amparo à Pesquisa do Estado de São Paulo/Conselho Nacional de Desenvolvimento Científico e Tecnológico/SUS* (Process no. 61411-4).
The authors declare no conflicts of interest.