

Advanced Access in a Family Health Unit in the countryside of the State of São Paulo: an experience report

Acesso Avançado em uma Unidade de Saúde da Família do interior do estado de São Paulo: um relato de experiência

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ABSTRACT Advanced Access (AA) is an agenda organization method in Primary Health Care (PHC) units that preaches the saying ‘Do today’s work today!’. It actively seeks to reduce the repressed demand for care, reduce absenteeism and increase access to users of the Brazilian Unified Health System (SUS). The objective of this study is to report the implementation of AA in a Family Health Unit (FHU). Interviews were conducted with FHU professionals about AA and, in a preliminary way, data from Primary Health Care Information System (Siab), E-SUS and physical agendas were used, for numerical comparison of some parameters between before and after AA implementation.

KEYWORDS Health services accessibility. Primary Health Care. Family Health Strategy.

RESUMO O Acesso Avançado (AA) é um formato de organização de agenda em unidades de saúde na Atenção Primária à Saúde que prega a máxima ‘Faça hoje o trabalho de hoje!’. Ele busca ativamente reduzir a demanda reprimida de atendimentos, reduzir o absenteísmo e ampliar o acesso aos usuários do Sistema Único de Saúde (SUS). O objetivo deste trabalho foi relatar aspectos da implementação do AA em uma Unidade de Saúde da Família (USF). Foram realizadas entrevistas com os profissionais da USF acerca do AA e, de forma preliminar, foram utilizados os dados do Sistema de Informação de Atenção Básica (Siab), do E-SUS e das agendas físicas, para comparação numérica de alguns parâmetros entre antes e depois da implantação e implementação do AA.

PALAVRAS-CHAVE Acesso aos serviços de saúde. Atenção Primária à Saúde. Estratégia Saúde da Família.

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Introduction

One of the central issues in Primary Health Care (PHC) is access to care. Quality access is one of the main aspects of public health policies. The challenge of searching for universal, longitudinal and comprehensive care is a central point of the National Primary Healthcare Policy¹ (PNAB).

One of the current ways of providing access in PHC is through the Advanced Access (AA) model, also known as open access or same-day appointment. This model allows patients to seek primary health care – with their reference professionals – at the time of their need or choice.

Traditional scheduling models do organize, by and large, appointments for future dates, often, resulting in delays in care provisioning. Therefore, it tends to favor the increase of absenteeism and compromise the longitudinality (by not assuring patient the care with his/her reference professional).

Starfield², in an essential attribute of PHC named ‘First contact access’, has differentiated the terms access and accessibility, often considered synonyms. Accessibility represents the provision of health services to the population and their ability to reach them, while access denotes no restriction on access to health services, rather than their freedom to do so. Although any health service can present varying degrees of accessibility and access, it is in the PHC that the main entry door of patients to the Unified Health System (SUS) is found.

It is worth noting that, unfortunately, the proportion of individuals seen by a Family Health Strategy (FHS) team, many times, exceeds the maximum number recommended by the last PNAB, which is 3,500 people. The extrapolation of this limit also reduces accessibility and imposes barriers to better health care and follow-up.

Considering this context, organizational models should be researched and tested for broadening access and accessibility. The AA model is already implemented in several

Brazilian cities and has been shown as a viable scheduling option in the PHC.

Advanced Access

AA is a scheduling organization method, firstly described by Murray and Tantau³ in 2000, which allows patients to seek and receive health care from their reference professional, at the most opportune time, usually on the same day. The AA has a golden rule: ‘Do today’s work today!’ This rule allows the approach of chronic conditions, acute events, administrative demands, preventive measures and coordination of patient care, all following the same appointment method, without fragmentation. The agenda is not divided by periods reserved for predominant groups, such as hypertensive, diabetic or smokers. The schedule remains open, and its timetables are filled daily, according to demand.

AA also dissociates from the concept of dividing the agenda between routine and emergency demand. Services and work processes are carried out on the same day, regardless of their nature, except for some cases in which they are scheduled for the near future, in general, because of a choice made shared between patient and health professional.

Each service organizes its own ‘tolerance limit’ for these future schedulings. In the Family Health Unit (FHU) of the present study, this time is 48 hours. Thus, when seeking care, the patient will be cared for on the same day (and may choose to wait at home and return at the time of consultation) or within 48 hours. Flexibility, however, is sovereign, and the patient can be scheduled for any later time if he/she wishes – and if his/her clinical condition allows.

In addition, the FHU team of this research chose to preserve some scheduling types for more extended periods, called ‘protected agenda’: prenatal consultation, puerperium, childcare and psychiatry (it is carried out at mental health matrix support FHU). Thus, an

AA model was organized in which approximately 90% of the agenda was open and in which 10% fit in the criteria of the so-called 'protected agenda'.

In 2014, the Municipal Health Secretariat of Curitiba published a booklet, entitled 'New possibilities for organizing Access and Agenda in Primary Health Care'⁴, guiding the steps for the implementation and deployment of AA. This booklet has been extensively studied by the FHU team in the AA implementation process and is a recommended source for further study.

Therefore, the main objective of this article is to report aspects of before and after the implantation and implementation of AA in a FHU.

Material and methods

Place and Team: Ribeirão Preto is the host city of the metropolitan region of Ribeirão Preto, in the countryside of the state of São Paulo, with approximately 700 thousand people, 40 Basic Health Units and 12 FHU. The FHS model began to be implemented in the municipality in the year 2000⁵.

The FHU of the study covers the area of the western health district of Ribeirão Preto. As stated in the Primary Care Information System⁶ (Siab), it had in its territory a total of 2,417 individuals registered in the year 2017. It is a FHU with predominantly young population and high social vulnerability, of which the majority depends on SUS for their health needs. It is a unit linked to the Medical School of Ribeirão Preto of the University of São Paulo (FMRP-USP), receiving, therefore, undergraduate students (medicine, nursing, dentistry, pharmacy, nutrition, among others) and family and community medical residents.

In 2017, it had an FHS team, consisting of a Family and Community Doctor (MFC) (who supervised two first-year residents and two second-year residents), a nurse, three nursing assistants, and five Community Health Workers (CHW).

In the resident supervision model adopted at the FHU where the study took place, all cases assisted by MFC residents were discussed with the MFC supervisor (and, if necessary, also examined by that supervisor, along with the resident). In this way, this supervisor evaluated, in some way, all the services carried out by the residents.

Data collection

A resident of the second year of MFC of the Hospital das Clínicas of the Medical School of Ribeirão Preto accessed the electronic system of the city of Ribeirão Preto (Hygia system) and the physical agendas of FHU's doctors in order to collect the data.

The data were collected in the months of May 2015 and May 2017.

- 2015: the month of May 2015 had 21 days of regular work, totaling 42 periods (morning and evening). Of these, 38 periods had two doctors (one MFC resident and MFC preceptor) in health care, and four periods with only one doctor (MFC preceptor), resulting in a total of 80 care periods. The schedullings were evaluated from 05/02/2015 to 05/08/2015 and from 05/29/2015 to 05/31/2015;
- 2017: The month of May 2017 comprised 23 regular working days, totaling 46 periods. All of these periods had two doctors (one resident of MFC and the MFC preceptor) in health care, generating 92 care periods. The schedullings were evaluated from 05/05/2017 to 05/08/2017 and from 05/26/2017 to 05/29/2017.

For the analysis of time, the period between the day the patient sought the FHU for care and his/her effective day was used.

The time clippings chosen were the May 2015 and May 2017 periods, which have contemplated an exact month of regular work on the traditional agenda's model (2015) and the AA's model (2017).

The selected periods represent similar times in relation to the seasonality of medical care and do not have a significant difference in the number of people in the territory (in 2015, the territory of the FHU had 2,262 individuals; and in 2017, had 2,417).

All medical schedules, all missed medical consultations and all referrals from May 2015 to May 2017 were analyzed.

To obtain the time between the day of the search for the service and the day of the care, initially, 100 medical appointments were selected from each collection period. Of the 100 appointments of 2017, four were considered inadequate to the analysis because they represent home visits. In the same way, two home visits of 2015 were withdrawn from the sum.

Analyzed criteria

In order to evaluate the implantation and implementation of the AA, four categories were used that are consistent with the reality of the FHU in question and which, in the international literature^{3,4,7}, are the most used for this purpose. They are:

Category I – Percentage of absences (absenteeism), that is, percentage of appointments

scheduled in the period evaluated in which patients did not appear, regardless of the reason.

Category II – Total number of medical appointments, that is, absolute number of visits carried out by medical professionals during the period evaluated, without discretion of the nature and length of the care.

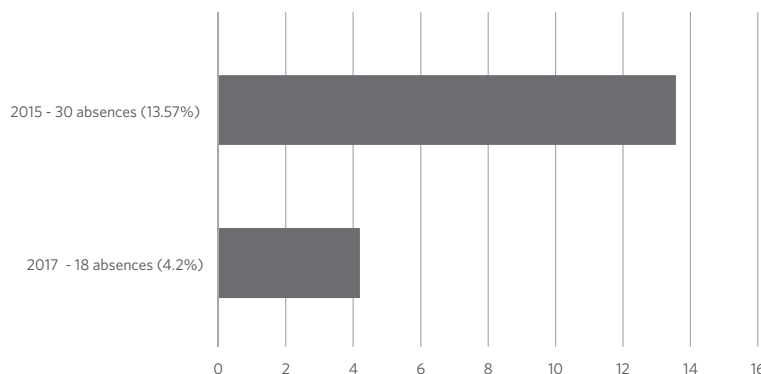
Category III – Total number of referrals, or rather, absolute number of patients cared for by a medical professional in the evaluated period who were referred for complementary imaging tests or for secondary or tertiary care¹.

Category IV – Time between the day the patient searches for the FHU for care and the effective day of the care, that is, the arithmetic mean of the sum of the time in days between the day of the patient's search for care at the FHU and the day that he/she is effectively assisted.

Results

Category I: it was observed, in May 2015, a total of 30 absences, corresponding to 13.57% of absenteeism. In May 2017, there were 18 absences, which corresponded to 4.20% of absenteeism.

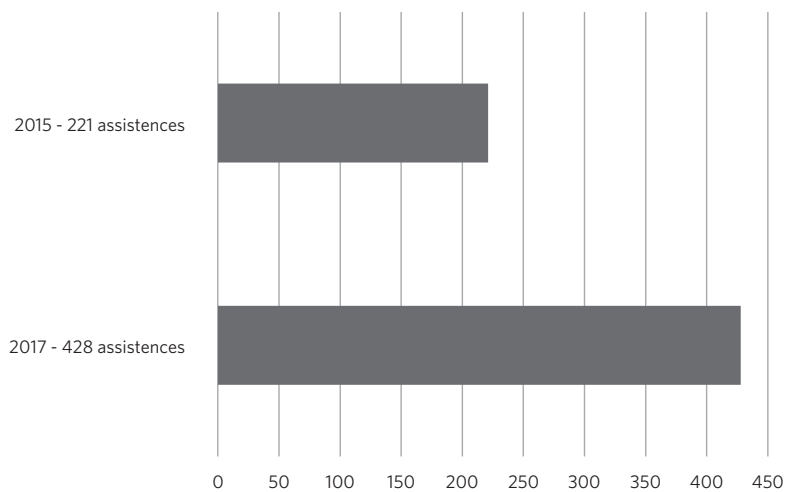
Graph 1. Absenteeism



Source: Own elaboration.

Category II: it was perceived, in May 2015, a total of 221 medical assistences. In May 2017, 428 medical assistences were made.

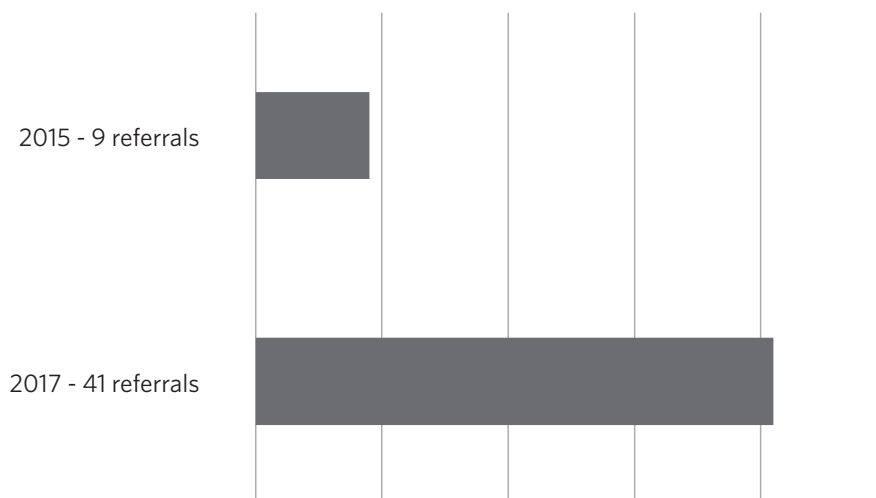
Graph 2. Number of medical assistences



Source: Own elaboration.

Category III: year 2015, 9 referrals; year 2017, 41 referrals.

Graph 3. Number of referrals

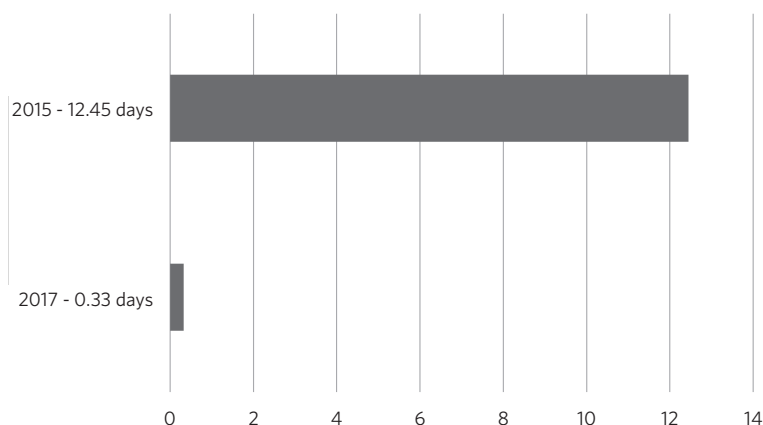


Source: Own elaboration.

Category IV: Category IV: in May 2015, there were 1.221 waiting days for the accomplishment of 98 medical assistance, with an average of 12.45 days of waiting for medical assistance.

In May 2017, there were 33 waiting days for 98 medical assistance, resulting in an average of 0.33 waiting days for medical assistance.

Graph 4. Waiting time until medical assistance



Source: Own elaboration.

Discussion

It is pertinent to evaluate the effect of AA on absenteeism and on the time until assistance. These two parameters are the most commonly reported in the literature⁷⁻¹⁹ on the subject, investigated extensively since the development of AA. In fact, supporters of AA's implementation emphasize such parameters as the major qualities of the model, which is, often, sought as an alternative when one, or both of them, present difficulties. The results found are in accordance with most of the results of the reviewed literature⁷⁻¹⁹, with a significant decrease in absenteeism and waiting time. The staff, especially the unit's reception staff, felt that shortening the waiting time made the daily workflow easier. The entire team considered that the reduction of absenteeism was beneficial to the longitudinality of the care expected in the FHS.

The total number of medical appointments

is described^{9,10} as a form of indirect measurement of the increase of access, since its increase reflects a greater number of medical appointments and, consequently, a greater offer to the population. It's questionable^{9,10}, however, whether this offer is not given at the expense of a shorter assistance time, which could affect the quality of health care and longitudinality. It was expected, with the implementation of the AA, a greater effectiveness of the consultations, reflecting the dynamics of the method, without compromising and, even, aiming to improve the quality of health care. In a review with the FHU team where the report was made, it was unanimous that the implantation and implementation of the AA improved the effectiveness of the work in the unit, expanding the vacancy offer and ensuring greater accessibility to the population.

Finally, studies have not being found that could measure the quantity or quality of referrals made before and after the implementation

of AA in Brazil. It is believed that this parameter is also an indirect measure of the increase of access, because independent of the quality of the service provided in the PHC, it often works as an entry door to secondary and/or tertiary care. The greater number of referrals has led to the inference that more patients are reaching the level of care they need. The medical and nursing teams, directly involved in the management of referrals, considered that the FHU population had their health needs better served after AA.

This report has some limitations. A process of work organization and access as far-reaching as AA requires prolonged observation of its post-implementation effects. An observation made over a longer period and appropriate statistical analysis would be fundamental to evaluate the sustainability of the AA's effect.

In addition, longer observation would bring greater comparison effects between the two methods. It would allow, for example, to accompany seasonal effects and other intercurrents that affect models.

It is worth considering that the present report occurred in an area whose population profile accepted the implementation of a method such as AA, perhaps because it lacked more supply and flexibility in the scheduling. Probably, the move to AA in a community where the traditional scheduling model is working well is wrong. In addition, during the implementation process, the need to involve the entire FHS team was identified. Without all the health care professionals involved, most likely the new model would not have worked properly.

Conclusions

Until the conclusion of this report, no publication was found evaluating the implementation of AA in a FHU in the state of São Paulo, nor in a FHU where a Medical Residency program in MFC operates. These data make this article an original report and can help those who wish to implant and implement AA (especially in a health care unit with MFC residents).

The results of the implantation and implementation were important, with, perhaps, the most interesting being the decrease in the average waiting time between the patient's search for the health unit and his/her effective consultation. There was also a reduction in absenteeism, datum consistent with the literature¹⁴. The referral and medical assistance numbers increased numerically.

Collaborators

Pires Filho LAS (0000-0001-5637-5221)* contributed to the design, planning, collection and interpretation of data; critical review of content; and approval of the final version of the manuscript. Azevedo-Marques JM (0000-0002-3100-3883)* contributed to the planning and approval of the final version of the manuscript. Duarte NSM (0000-0002-1586-4069)* contributed to the design of the manuscript. Moscovici L (0000-0003-4842-5422)* contributed to the design, planning, interpretation of data; critical review of content; and approval of the final version of the manuscript. ■

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