Analysis of an instrument for primary health care monitoring

Análise de um instrumento para monitoramento da atenção básica em saúde

Análisis de un instrumento para monitoreo de la atención básica de la salud

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Abstract

Objective: To analyze an instrument for monitoring primary care.

Methods: Qualitative, descriptive, and analytic research that consisted in the application of the instrument in 442 Basic Health Units - *PCC* from São Paulo city with the participation of local managers in its elaboration; the instrument is composed of 47 aspects that contemplated indicators of Structure, Process, and Result and we organized them in six thematic blocks: I - welcoming technical reception – WTR (reception); II - nursing work; III - medical work; IV - assistance organization and team integration; V - vaccination and program coverage; VI - management and participation. For the statistical analysis, we utilized the SPSS 25.0 program.

Results: The average and median scores obtained by the 414 evaluated Primary Care Centers (total of 470 possible points) were 356 and 380, respectively. Through the multivariate modeling, nine aspects of Structure and Processes stood out, when analyzed concerning the aspects of the Result, presenting statistical association ($p<0.05$): WTR carried out in every period of Primary Care Centers; specific training for the care in WTR; nurse clinical performance; systematized medical rearguard for WTR; complete oral health team; reserved time for team meeting; group appointment carried out systematically; health promotion actions; adequate physical accommodations.

Conclusion: The instrument presented the capacity to capture different stages of the organization and the results of the participant units of this study, and, besides a global evaluation, it revealed critical questions of the services related to the intended changes. As an evaluative tool for the services, it may contribute to the monitoring and the support to the everyday techno-management decision making.

Resumo

Objetivo: Analisar um instrumento para o monitoramento da atenção básica.

Métodos: Pesquisa quantitativa, descritiva e analítica, consistiu na aplicação do instrumento em 442 Unidades Básicas de Saúde - UBS do município de São Paulo, contando com a participação de gestores locais na sua elaboração; o instrumento foi composto por 47 quesitos que contemplaram indicadores de Estrutura, Processo e Resultado e foram organizados em seis blocos temáticos: I - recepção técnica acolhedora – RTA (acolhimento); II - trabalho da enfermagem; III - trabalho médico; IV - organização assistencial e integração da equipe; V - cobertura vacinal e de programas; VI- gestão e participação. Para análise estatística utilizou-se o programa SPSS 25.0.

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Resultados: A média e a mediana de pontuação obtidas pelas 414 UBS avaliadas (total de 470 pontos possíveis) foram 356 e 380, respectivamente. Por meio de modelagem multivariada, nove quesitos de Estrutura e Processo se destacaram, quando analisados em relação aos quesitos de Resultado, apresentando associação estatística (p<0,05): RTA realizada em todos períodos da UBS; treinamento específico para atendimento na RTA; atuação clínica do enfermeiro; retaguarda médica sistematizada para RTA; equipe de saúde bucal completa; horário reservado para reunião da equipe; atendimento em grupo realizado sistematicamente; ações de promoção à saúde; acomodações físicas adequadas.

Conclusão: o instrumento apresentou capacidade para captar diferentes estágios da organização e de resultados das unidades participantes do estudo e, além de uma avaliação global, revelou questões críticas dos serviços relacionadas às mudanças pretendidas. Como ferramenta avaliativa para os serviços pode contribuir no monitoramento e no apoio à tomada de decisões tecno-gerenciais cotidianas.

Resumen

Objetivo: Analizar un instrumento para el monitoreo de la atención básica.

Métodos: Estudio cuantitativo, descriptivo y analítico, que consistió en la aplicación de un instrumento en 442 Unidades Básicas de Salud (UBS) del municipio de São Paulo y contó con la participación de administradores locales para su elaboración. El instrumento estuvo compuesto por 47 ítems que contemplaron indicadores de Estructura, Proceso y Resultado, y fueron organizados en seis bloques temáticos: I – recepción técnica acogedora RTA (acogida); II – trabajo de enfermería; III – trabajo médico; IV – organización asistencial e integración del equipo; V – cobertura de vacunación y programas; VI – gestión y participación. Para el análisis estadístico se utilizó el programa SPSS 25.0.

Resultados: El promedio de puntuación obtenido por las 414 UBS evaluadas fue 356 y la mediana de 380 (total de 470 puntos posibles). Por medio de la modelación multivariada, se destacaron nueve ítems de Estructura y Proceso, al ser analizados con relación a los ítems de Resultado, y presentaron asociación estadística (p<0,05): RTA realizada en todos los períodos de la UBS, capacitación específica para atención en la RTA, actuación clínica del enfermero, retaguardia médica sistematizada para RTA, equipo de salud bucal completa, horario reservado para reunión del equipo, asistencia en grupo realizada sistemáticamente, acciones de promoción de la salud, instalaciones físicas adecuadas.

Conclusión: El instrumento presentó capacidad para captar diferentes niveles de la organización y de resultados de las unidades participantes en el estudio y, además de una evaluación global, reveló cuestiones críticas de los servicios relacionadas con los cambios pretendidos. Como herramienta evaluadora de los servicios, puede contribuir para monitorear y respaldar la toma de decisiones tecno-administrativas cotidianas.

Introduction

Since the creation of the Unified Health System (*SUS*) in 1988, the discussion about the redefinition of the assistance model has prioritized the primary health care (PHC) theme as a strategic question. The SUS' principles, especially the integrity of the actions, as of the qualifiers of nascent social law, propel the expression of the intended transformations and substantiate the social alliances so that the outreach and the coverage of public policies will not reduce to the minimum.[1,2]

There was, in this period, expressive expansion of access to public health services. However, there remain insufficiencies still not overcome for a wide and integral offer among them we highlight the inability of the response of the primary health care to a nonscheduled demand necessary to guarantee the adequate access and care and for its consolidation as a preferential door of the health system.[3-5]

Such a situation induced the creation of new intermediate health services modalities among the Primary Care Centers (PCC) and first-aids, as the Emergency Care Unit – ECU[6], especially those classified in simple modalities of service and the Medical Care Ambulatory unit (MCA), in the city of São Paulo.[7] The MCA, with its limited resolutions and partial opening hours, at the same time that it broke the integrality and the continuity of the care induced by the primary care it weakened the role of Medical centers in the system, reorienting them to the minimum qualification, programmatically closed.[7]

The health management in São Paulo, initiated in 2013, developed the organization of the integral Primary Care Centers as one of the proposals of change, aiming to amplify the access with quality and defining it as a welcoming PCC and open to the health problems and the diversity of use conditions. It established the description without prohibition, incorporating and registering students and workers also by place of activity; established integration of the pragmatic activity with the nonscheduled service in order to break the fragmentation between PCC and MCA; it valued the promotion of health with the community. A renewed PCC to solve the majority of problems and in conditions to coordinate the continuity of the care with other network attention points.[8]

With these intentions of change, it became fundamental and necessary the development of

evaluative processes. The primary care process of evaluation in the scope of the SUS has been developed by management pacts between the State and Municipal Secretaries of Health and the Health Ministry. The Guidelines, Objectives, Goals, and Indicators were defined in a tripartite way, and a system for the data inclusion was provided - SISPACTO.[9-11] Subsequently, the PHC Access and Quality-Improvement Program (PMAQ) additionally proposed a set of strategies of qualification, predicting an increase of federal incentive resources for the participant municipalities that achieved improvement according to the national pre-established standard.[12]

Alongside these federal initiatives, the institutionalization policies of the primary care evaluation have been valued, understood as strategies to incorporate daily by the managers and professionals[13-15] overcoming the conception of legal reporting to funding institutions. Hartz[16] emphasizes the differences between evaluation and monitoring, affirming that the monitoring would focus on generating information of easy appropriation and utility for the daily life of managers, aiming to support the decision-making. The monitoring is articulated; however, it is not associated with the evaluation functions of health policies and programs.

With the changes that have occurred in the primary network of São Paulo, we emphasize, therefore, the necessity of support instruments to the monitoring that organize the information and that could contribute to the capacity of local management. This article analyzes the adequacy of a PHC monitoring instrument of the proposal actions.

Methods

This study is part of the Research Project – Análise do perfil da força de trabalho e da política nacional de gestão da educação na saúde com relação ao seu estágio de implementação na rede de serviços de saúde, sob a gestão da Secretaria Municipal de Saúde de São Paulo (Haddad AE, coordinator. CNPq Process nº 401449/2013-0. Call MCTI/CNPq/MS – SCTIE – Decit nº 08/2013). The present article addresses the relating component to the knowledge of the situation of the municipal primary care network. For that purpose, we utilized an evaluative instrument of the *PCC* contemplating the indicators Structure, Process, and Result,[17] with a special emphasis on the actions related to the structuring of the intended changes for the qualifications of the integrality of the care.

In 2014, the service network under the administration of the municipality of São Paulo had 442 PCC, 80 Centers for Psycho-social Attention (CAPS), 30 Specialty Outpatient Clinics, 120 AMA, 25 first-aid posts, 18 Municipal Hospitals (1720 neds). For the application of the evaluative instrument, the present study considered the totality of the PCC in the municipality.

Type of study – The initial project, constituted by three components, was a descriptive research of the case study type with a quanti-qualitative approach. The component, object of this article, is quantitative research that involves the application of an instrument developed in previous research (*Análise de um indicador de monitoramento dos serviços de atenção básica de saúde em diferentes modelos assistenciais. Cornetta VK, coordenador. Process CNPq nº 401449/2013-0. CallMCT/CNPq/MS/DAB/SAS nº 049/2005*) after its adaptation and reformulation.

The process for the adaptation and reformulation of this instrument followed the subsequent steps, aiming to assist the new objectives of this present study: a) presentation of the instrument objectives from the previous research for technicians of central level, regional coordinators, and municipal technical supervisions (health district); b) identification of the key-points of the current intended changes in the basic network, aspects discussion and incorporation of the presented suggestions; c) holding the pilot in two units from each of the 25 existing technical health supervisions; d) adjustments and final definition of the instrument that now is constituted by 76 aspects; e) application of the instrument in the 442 existing PCC in the city, in May 2014, after the training and standardization of the service of the questions. The research team and the Primary Care Coordination from SMS-São

Paulo conducted such activity, integrating into this process around 120 professionals involved in primary care; the PCC teams answered the questionnaire through an electronic device – FORMSUS, with the monitoring of the technical health supervisors.

For this article, we considered 47 objective aspects from the adapted and reformulated instrument, so-called "Organizational guidelines of the Primary Care from São Paulo: instruments and indicators of monitoring and evaluation," to allow the quantitative analysis of the consistency of the delimited instrument. From the total 442 PCC, we received 414 (94%) questionnaires under analysis conditions. We organized the 47 aspects, independently if they evaluate the Structure (5 aspects), Process (29 aspects), or Result (13 aspects), in six thematic blocks (dimensions) to facilitate the local discussions and the answers: I - Welcoming Technical Reception – WTR (RTA) (reception); II - Nursing Work; III - Medical Work; IV - Assistance Organization and team integration; V - Vaccination and program coverage; VI - Management and participation. The questions could obtain a score of 0, 5, or 10, in which for some that did not accommodate intermediate situations, the score could be only 0 or 10. The highest score possible for each PCC was 470 points (10 x 47). In the statistical analysis of the data concerning the PCC. We consolidated it in an Excel spreadsheet (Office ®), and we analyzed them with the SPSS 25.0.

We compared the aspects classified as Structure and Process with each other and concerning the Result aspects. For such purpose, we recode in a categorized way as No (0 to 5) and Yes (10) the score of the questionnaire aspects referring to the Structure and Process (n=34). We transformed in centesimal scale (0 to 100 variation) the aspects of Result (13). We tested the transformed Result variable in two conditions of categories of the other as well as its normality. After verifying the normal distribution, we presented them in the medium±deviation-standard and compared them through the t-Student test. This procedure allowed us to identify the statistical significance of the Structure and Process aspects regarding the Result; we included in the multivariate model those with p-value < 0.10 that presented p < 0.05.

The project was approved by the Research Ethics Committee (nº 803775) from the Odontology College from USP and by the Health Secretariat from the city of São Paulo (CAAE: 32909014.8.3001.5505).

Results

The average and the median of points obtained by the 414 PCC evaluated (in a total of 470 possible points) were 356 and 380, respectively (minimum 155; maximum 455). The amplitude of the values was 310 points. We verified 110 PCC (27%) in the first quartile, 95 PCC (23%) in the second, 89 (21%) in the third, and 120 (29%) in the fourth quartile. In Table 1, we presented the 47 aspects individually and grouped them by thematic blocks. The number of answers for each query varied between 358 (68.5%) and 414 (100.0%). Regarding the score obtained, according to blocks, we observe that Block II - Nursing work - was the one who had the higher score and, as well as the Block VI - Management and participation, presented a higher average of the overall of the aspects.

Amplifying the analysis, we sought to compare the behavior of each aspects classified as Structure and Process, categorized as Yes (present) or No/Parcial (absent or partially present) against the summation (in centesimal scale) of those classified as Result. We confirmed that the Result's score was higher in the occurrence of Yes regarding the No/Partial of the aspects Structure and Process, with statistical significance for 29 of them from the total of 34 (Table 2).

Continuing, we developed a multivariate analysis of the Structure and Process aspects defined as independent variables and the sum of the obtained values of the Result aspects – dependent variable. From the 34 aspects (p<0.05) 9 (nine) remained in the model, which may be considered significant predictors of the Result aspects values. Being them: 4 – WTR works during all the periods of PCC (B=8.22; IC:3.04-13.40; p=0.002); 7 – Presence

Table 1. Type of aspect, number of responding *PCC*, points obtained, and its percentage regarding the maximum possible punctuation of each aspect

Ord.	Evaluated aspect	Type*	Nº of answers	Points obtained	%
I. Reception (Welcoming Technical Reception - WTR) – Total			2854	21505	75.4
1	WTR is in an exclusive place and the service is individualized	P	412	2480	60.2
2	Vacancy occupation one day after the WTR evaluation	P	412	3555	86.3
3	Scheduling after the evaluation of WTR	P	411	3450	83.9
4	WTR works during all the periods of *PCC*	P	410	3670	89.5
5	Waiting time for WTR < 40 minutes	R	386	2850	73.8
6	Presence of records of appointments in the WTR (reason and decision)	P	410	3255	79.4
7	Presence of specific training for the service in the WTR	P	413	2245	54.4
II. Nursing work – Total			1656	15290	92.3
8	Systematic presence of nurse in the unit	E	414	3930	94.9
9	The nurse carries out the appointment systematically	P	414	3680	88.9
10	The nurse appointment relies on formal protocols	P	414	4040	97.6
11	Active nursing in the WTR	P	414	3640	87.9
III. Medical work – Total			2825	21665	76.7
12	Medical presence in the *PCC* (10 = all the periods; 5 = 8 or 9 periods)	E	413	3335	80.8
13	Waiting time - child ≥ 2 years old (10: ≤ 30 days; 5: >30 ≤45; 0: >45)	R	413	3360	81.4
14	Follows the child care schedule < 2 years old	R	381	3245	85.2
15	Waiting time - adult appointment - (10: ≤30 days; 5: >30 ≤45; 0: >45)	R	413	2015	48.8
16	Waiting time - woman appointment (10: ≤30 days; 5: >30 ≤45; 0: >45)	R	412	2685	65.2
17	Waiting time - pregnant woman appointment (10: ≤30 days; 5: >30 ≤45; 0: >45)	R	381	3695	97.0
18	Presence of medical rearguard to support WTR	P	412	3330	80.8
IV. Assistance organization and team integration – Total			6106	47295	77.5
19	Assistance activities planned in multi-professional meetings	P	414	3550	85.7
20	Systematic multi-professional meetings for discussion of cases	P	414	3440	83.1
21	Scheduling is continuous without periodic closing	P	414	3840	92.8
22	Scheduling is carried out during all working day	P	414	3975	96.0
23	Agenda with reservation of vacancies for the demand of the day	P	414	3070	74.2
24	Papanicolaou integrated to the appointment (without separate scheduling)	P	406	3240	79.8
25	Papanicolaou with open routine (without pre-scheduling)	P	407	2930	72.0
26	RN with increase in maternity with scheduled appointment in *PCC*	P	408	3720	91.2
27	Complete oral health team **	E	406	2285	56.3
28	Complete mental health team***	E	407	1075	26.4
29	Group appointment carried out systematically	P	407	3440	84.5
30	Hold regular visits to defaulting	P	408	2300	56.4
31	Reference system with formal systematic	P	375	3490	93.1
32	Regular health promotion actions – community	P	406	3645	89.8
33	Regular health promotion actions – intersectoral	P	406	3295	81.2
V. Vaccination and program coverage – Total			2576	18655	72.4
34	Penta Vaccination coverage: *10:* ≥90%; *5:* <90% and ≥80%	R	369	2805	76.0
35	Triple Viral Coverage: 10: ≥90%; 5: <90% and ≥80%	R	371	2865	77.2
36	Papanicolaou rate: *10:* ≥20%; *5:* <20% and ≥15%	R	366	2685	73.4
37	Pregnant coverage: *10:* ≥70%; *5:* <70% and ≥50%	R	374	3190	85.3
38	Live births with 7 or + consultations: *10:* ≥50%; *5:* <50% and ≥30%	R	358	3025	84.5
39	Hypertensive coverage: *10:* ≥30%; *5:* <30% and ≥20%	R	369	2015	54.6
40	Diabetic coverage: *10:* ≥20%; *5:* <20% and ≥15%	R	369	2070	56.1
VI. Management and participation – Total			2726	22800	83.6
41	Accommodation: no lines, with water dispenser, good cleaning	E	389	3130	80.5
42	Presence preventive maintenance of equipments	P	389	2470	63.5
43	Public identification of the team: uniform, badge	P	390	2820	72.3
44	Respect to the user: no grid at the reception, no threatening poster	P	390	3810	97.7
45	Handbooks are separated in advance to the treatment	P	390	3620	92.8
46	Team meeting scheduled in advance	P	389	3350	86.1
47	Presence of Local Council or other mechanisms of participation	P	389	3600	92.5
All Questions – Total			18743	147210	78.5

* Type: E = Structure; P = Process; R = Result; ** Complete oral health team = 1 dental surgeon,1 oral health technician, and e 1 oral health assistant; *** Complete mental health team = 1 psychiatrist, 1 psychologist e 1 occupational therapist

Table 2. Score average of the Result aspects (n=13) according to the answer (Yes or No) attributed to the Structure and Process aspects (n=34)

Structure and process aspect	Average of the values of the result aspects		p-value*
	No or Parcial (0 ou 5)	Yes (10)	
WTR is in an exclusive place and the service is individualized	68.3±19.4	78.4±15.6	< 0.001
Vacancy occupation one day after the WTR evaluation	58.8±18.0	78.5±15.5	< 0.001
Scheduling after the evaluation of WTR	57.0±18.9	77.5±15.8	< 0.001
WTR works during all the periods of *PCC*	53.6±19.2	77.7±15.4	< 0.001
Presence of records of appointments in the WTR (reason and decision)	65.4±19.6	77.9±16.0	< 0.001
Presence of specific training for the service in the WTR	67.9±19,2	82.1±12.5	< 0.001
Systematic presence of nurse in the unit	57.8±19.9	76.1±16.9	< 0.001
The nurse carries out the appointment systematically	56.3±18.4	78.4±15.1	< 0.001
The nurse appointment relies on formal protocols	60.3±15.3	74.9±17.8	0.021
Active nursing in the WTR	58.2±21.7	77.5±15.4	< 0.001
Medical presence in the *PCC* (10 = all the periods; 5 = 8 or 9 periods)	68.8±18.9	77.5±16.6	< 0.001
Presence of medical rearguard to support WTR	61.6±17.4	80.2±14.8	< 0.001
Assistance activities planned in multi-professional meetings	57.0±17.5	77.3±16.3	< 0.001
Systematic multi-professional meetings for discussion of cases	56.8±18.8	77.8±15.7	< 0.001
Scheduling is continuous without periodic closing	61.3±19.1	76.2±17.0	< 0.001
Scheduling is carried out during all working day	62.8±17.1	75.4±17.6	0.022
Agenda with reservation of vacancies for the demand of the day	62.7±17.0	78.5±16.4	< 0.001
Papanicolaou integrated to the appointment (without separate scheduling)	68.7±20.4	75.9±16.9	0.005
Papanicolaou with open routine (without pre-scheduling)	62.9±19.1	78.7±15.5	< 0.001
RN with increase in maternity with scheduled appointment in *PCC*	64.4±20.5	76.0±17.0	< 0.001
Complete oral health team **	71.9±17.8	82.0±16.0	< 0.001
Complete mental health team***	74.7±17.7	73.5±19.1	0.724
Group appointment carried out systematically	61.9±18.5	78.4±15.8	< 0.001
Hold regular visits to defaulting	69.5±18.8	82.7±12.5	< 0.001
Reference system with formal systematic	63.6±22.6	75.4±17.2	0.003
Regular health promotion actions – community	55.9±17.5	77.4±16.1	< 0.001
Regular health promotion actions – intersectoral	66.1±17.8	77.7±16.8	< 0.001
Accommodation: no lines, with water dispenser, good cleaning	70.7±17.9	77.3±17.4	0.001
Presence of preventive maintenance of equipments	73.2±18.2	75.5±17.7	0.274
Public identification of the team: uniform, badge	60.4±19.5	79.5±14.4	< 0.001
Respect to the user: no grid at the reception, no threatening poster	67.8±17.9	74.8±17.9	0.347
Handbooks are separated in advance to the treatment	72.5±20.8	74.8±17.6	0.570
Team meeting scheduled in advance	56.1±16.1	77.4±16.4	< 0.001
Presence of Local Council or other mechanisms of participation	71.8±18.5	74.9±17.8	.429

*Significance level of the t-Student test

of specific training for the service in the WTR (B=4.62; IC=1.29-7.95; p=0.007); 18 – Presence of medical rearguard to support WTR (B=9.94; IC:6.42-13.46; p=0,000); 27 – Complete oral health team (B=66.38; IC:3,05-9.71; p=0.000); 29 – Group appointment carried out systematically (B=5.18; IC:1,16-9.20;p=0.012); 32 – Regular health promotion actions – community (B=7.12; IC:1.90-12.34; p=0.008); 41 – Accommodation: no lines, with water dispenser, good cleaning (B=4.51;IC:1.54-7.48; p=0.003); e, 46 – Team meeting scheduled in advance (B=6.02; IC:1.01-11.03; p=0.019).

Discussion

No set of qualifying aspects can be understood as absolute. It is another instrument that can be improved and suitable to the current moment and the established objectives. The selection of aspects and indicators for the evaluation process or monitoring always involves value judgment e world views.[18,19] In this case, through the coverage and extension of everyone's right to health, reflected on the organizational options of basic health units, we pursued analyzing the possibilities of a methodological alternative of monitoring the primary care network. This paper aimed to contribute to the evaluative initiatives, a topic of permanent debate, in front of the process of changes in the policies and health actions of our country, well establishing the necessity of new tools, aiming to confirm the agility and higher possibility of directing actions, in real-time.[20-22]

The application of this instrument, considering its operational simplicity, could occur regularly, highlighting, especially, its utilization as a pedagogical tool for the discussion of the unit team and them with the participant population of the established regular forums. The inclusion of the health team in the process of evaluation and monitoring, adopted in this methodological proposal, has been considered essential, aiming for its legitimacy and sustainability. [13,14,22]

The use of Donabedian referential - structure, process, and result[17] and the necessary adapta-

tions, aiming to respond to the new conformation to the services, notably to the primary health care networks, has been one of the adopted ways[21] and formed an important component of this study. Among the aspects of the questionnaire classified as Result, some are known indexes and widely utilized in other situations such as SISPACTO[11] and other evaluation processes.[23,24] The participant team of this research defined that the chosen items should express the main ambitions of change of the primary care network. Thus, besides the classical aspects of assistance coverage values, we included the variables related to waiting time for the appointment in the WTR and the child, adult, women, and pregnant medical appointments. These result from the degree of adequacy of the Structure and Process components, being, in addition, a qualification much valorized by the population.[4,5,22]

The general score obtained by the 414 PCC, resulting from the summary of the 47 aspects, presented a large evaluative amplitude, allowing to delimit different stages and organizational situations of the PCC included in the study. The higher score obtained indicated qualities to be maintained and ways for achieving improvement in their work processes. The lower score allowed us to identify the most critical units, which contributed to the definition of priorities by the managers.

Concerning the thematic blocks, there was also a variation among them, allowing us to identify those that presented greater difficulties for the process of the intended change. The Blocks II – Medical Work and V – Vaccination and program coverage that concentrates the aspects of structure and process also presented inferior scores in the overall average. Thus, the set of aspects of Result could critically mirror the structural condition and the work processes. However, there is a need for caution on its interpretation because the aspects of Result, in the majority of the time, need time to register the impact of improvement in the service operation.

The Block I - WTR, specifically, is situated as a critical point of the performance aiming at the improvement of the access and the intended integrality to the primary care network. Such findings are highly pertinent and plausible, according to the knowledge already established.[4,5,22-24] The WTR, as a way to qualify the access substituting the traditional administrative reception (the counter), has been considered as a possibility to better understand, contributing to the continuity of the care and, for that reason, integrating different instruments of evaluation of the primary care.[25,26]

In the multivariate analysis, it remained in the model, with statistical significance, aspects of Structure and Process also related to the organization of the access to the user with the formalization and the capacitance of the welcoming service, considered a considerable challenge in the primary care, and with the structural potential of the unit[27]: 4 – WTR works during all the periods of PCC, 7 – Presence of specific training for the service in the WTR and 18 – Presence of medical rearguard to support WTR. Among them, we highlight that aspects number 4 and 18 were the ones that had the highest values of predictive power in the model.

Still, regarding the multivariate analysis, aspects 9 – The nurse carries out the appointment systematically, and 46 – Team meetings scheduled in advance refer to the organization and valorization of teamwork. Aspects 29 – Group appointment carried out systematically and 32 – Regular health promotion actions in the community highlight the health unit work in the health promotion and preventive activities accomplishment. Regarding these four aspects, we highlight the role of the nurse, especially in the assistance and care provided to the user and in the welcoming. Studies that approach these questions indicate the relevance of this professional work in the clinic, managerial educational practice, as well as the conflicts that still pervade this performance and its challenges to be overcome. [28-30] Aspect 27 – Complete oral health team valorizes the oral health as an important component for the integrality of the PCC activities; finally, the aspect 41 – Accommodation: no lines, with water dispenser, good cleaning suggests basic questions of humanization to the services for the qualification and improvement of results of the PCC.

We verified that in almost the totality of the aspects, the average of the Result's values was higher,

with statistical significance, when the aspects of the Structure and Process were categorized in the form "Yes." This finding reinforces the internal consistency of the questionnaire, showing these aspects as possible predictors of better-intended results. They portrayed the lived moment by the network and the objectives of the changing process defined by the managers following the participative processes of listening to the users.

Hence, as qualifying of Structure and Process, the evaluated and identified aspects with significant statistical association with the higher score values of aspects of the Result expressed coherence and cohesion with the nature of the proposed construct, according to the founding principles of the changing process under development.

Regarding the validity of the instrument, this was the original question handled in the genesis of its elaboration with the definition of the construct to be addressed compatibility and comprehensively, according to the process of discussion of the interested, besides supporting the scientific development of previous works for the monitoring of primary care network.[3,14,15,23]

To define qualifying aspects is a way that aims to approximate the comprehension of the operation of the whole. However, it can not be understood as objectives of action or management, in which the hierarchical levels with lower power would be obligated to centralize it in their mission because they feel vulnerable to external charging, which, in the majority of the time, has no real operational sense.[31] There is always a tendency to transform an indicator into a goal, and, consequently, it ends up reducing to a volume controller of acts without producing changes in the performance of the service. In the view of monitoring, indicators are instruments that help to observe a characteristic or a set, always limited, of characteristics and allow immediate corrective action. They approximate us to the comprehension of the whole of a complex system based on the decomposition of its parts, judging them according to values of the projected duty for social practice. Hence, they allow closer monitoring of the actions and activities, also collaborating with subsidies to the planning and management.[23]

Conclusion

The findings of the study reinforce the favorable hypotheses to the instrument elaborated in a participative way, based on the established construct and priorities. Structured in 47 aspects and easily applicable, the instrument presented the capability to capture different stages of the organization and the results of the participative units of this study, and besides the global evaluation, it revealed those critical questions of the service related to the intended changes. It constitutes an evaluative tool for the services, allowing it to contribute to the monitoring and substantiate everyday techno-management decision-making, aiming for the improvement of the expected performance for the basic health units.

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Collaborations

Puccini PT, Haddad AE, Souza FIS, Gonçalves RC, Ribeiro CLM and Puccini RF collaborated with the conception of the study, analysis and data interpretation, writing of the article, relevant critical revision of the intellectual content and approval for the final version to be published.

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