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The AcolheSUS Project in Primary Health Care in Brazil's Federal District

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Abstract *The recent change in model of primary health care introduced for the Family Health Strategy, to one centred on the user and territorialisation, provided the ideal opportunity to implement the* AcolheSUS *Project in a Basic Health Unit (UBS) of the Central Region of Brasília, in Brazil's Federal District. The UBS team conducted a situational diagnosis of the unit and situational strategic planning with a view to reorganising the service to address the problems identified, focusing on the work processes. With introduction of* AcolheSUS*, the number of individual user registrations performed by the teams increased from 135 to 3525, the number of nursing visits increased by 193.7% and the number of procedures performed by nurses increased by 121.2%. During changeover to the new care model, 71% of residents in the catchment area attended the basic health unit; after introduction of* AcolheSUS*, the percentage reached 90.5%. The monthly average of users received and classified was 1099.8. The joint construction of solid protocols and adjustments to work processes contributed to improving service delivery and afforded users greater access to the health care unit.*

Key words *Reception, Health management, Strategic planning, Primary health care, Family health strategy*

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Introduction

Primary health care (PHC) is widely acknowledged to be the backbone of health systems. In 1994 Starfield[1], revisiting findings from 1992, stressed the importance of the four pillars of PHC: it should comprise first contact care, continuity of care, comprehensive care and coordination of care. Robust PHC is associated with the absence of barriers to user access to PHC facilities[2].

The Federal District health department (*Secretaria de Estado de Saúde*, SES/DF) began to introduce structural changes in the model of health care under Administrative Order No. 77, published on 14 February 2017, which established a new primary healthcare policy for the Federal District, given that the previous policy was restrictive and offered an inadequate package of primary health care services. In that changeover, it was indispensable to resort to existing devices that would make it possible to listen with quality to health personnel's and users' input in order to construct the process of change collectively.

The devices identified as able to catalyse the process of change belonged to the Ministry of Health's humanised care and management policy (*Política Nacional de Humanização da Atenção e da Gestão*, PNH). The PNH invests in improving the quality of care practices in health care networks as a strategy for moving away from the hospital-centred model of care and management towards another model that prioritises the production of health and fosters health care networks centred on user care[3].

The overall coordinating body of the national humanized care policy set up the *AcolheSUS* project to raise the quality of care practices, initially at gateways to the public national health system (SUS) and in recognition of the challenges and potentials that the Reception guidelines offered for bringing about the changes desired by users. *AcolheSUS* aims to introduce and implement the Reception guidelines focusing on care management and guaranteed user access to quality care that solves their health problems. It specified four dimensions to guide planning of the measures that will steer investments, both in care organisation and work management, and in the institutional relations necessary for its successful implementation. The dimensions that frame planning of the *AcolheSUS* project's activities are care management and organisation, reception with classification and assessment of risks and vulnerabilities, ambience and continued professional development[4].

The care management and organization dimension calls for a critical analysis and valuation of care practices, making it possible to construct interventions in the light of co-management[4].

The Ambience dimension encourages collegiate intervention in physical spaces to reshape the production of health care and open up new possibilities of being together, predicated on the development of co-managed projects with the participation of users, health workers and managers[4].

Professional capacity building, the dimension that traverses the whole process, includes the active intervention-training methodology, comprising a technical-conceptual approach, dialogue-based exposition and between-session activities[4].

The project was made available to all the states and the Federal District, where 15 hospitals, two maternity facilities, one psychosocial care centre, one emergency care facility and one basic care unit (*Unidade Básica de Saúde*, UBS) were selected.

In the Federal District, the strategy was to implement the project in PHC in order to address the frequent complaints of barriers to access. The Ministry of Health, through a technical consultancy, actively supported the whole introduction process in order to re-signify how the service and its organizational bases were understood[5].

The support is a method of intervention that expresses a manner of doing things in collective settings, where a method of doing management on the co-management concept is applied[6,7]. Specifically, these collective spaces were the groups that make up the state management and the health service management, which are responsible for implementing the project and, within the *AcolheSUS* project, are denominated State Executive Groups and Local Executive Groups, respectively.

In the territories, the project was operationalised by workshops within the health services, deploying co-management, in order to conduct the intervention process in action, taking as its point of departure a guided visit to construct a situational diagnosis. The problems identified during the visit were posted on a visual panel in order to re-signify the processes and assess the need for changes in order to improve the quality of care and management.

The *AcolheSUS* project endeavours to problematise access to services and care from the health personnel's point of view, in dialogue with users, and serves to trigger possible processes of change.

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The intervention

After discussions in meetings of the health region's collegiate body, it was decided to apply the *AcolheSUS* project, for which a basic health unit (UBS) in the central region of Brasília was selected as the pilot unit. The UBS was in the process of implementing *Converte*, a model instituted by administrative order of the Federal District health department (SES/DF) in 2017, which altered the PHC previously provided by gynaecologists, general practitioners and paediatricians to comprehensive care to be given by Family Health Strategy teams.

At first, after the proposed change was presented, the UBS restricted care to residents of its catchment area who could show a document, such as an electricity or telephone bill, giving rise to a considerable increase in the number of complaints to the institutional ombudsman, as well as inconvenience to the population previously served by the UBS.

The conversion process at the UBS began in July 2017 by specifying the catchment area and organising to modify work processes. That included organising matrix support among doctors of the various specialities allocated to the UBS and capacity building by means of a theory course for doctors and nurses.

In late August 2017, after the on-site capacity building for doctors and nurses, the UBS introduced the new reception procedures and risk classification for all users attending the UBS. The frame of reference for reception was given by Ministry of Health pamphlet No. 28. One immediate effect seen was an increase in the number of appointments and in procedures, especially nursing care procedures, performed. User access was also seen to expand and complaints received, to decrease.

In October 2017 the first national workshop of the *AcolheSUS* project was held for the purpose of providing representatives of the states, the Federal District and health facilities with instruments with which to build quality in management and care practices, underscoring the need for there to be executive groups to implement the project and agree on agendas for the intervention.

Right after the national workshop, meetings were held with the steering groups to discover and problematize the health region's epidemiological profile and care network. In November 2017, the *AcolheSUS* project was formally inaugurated at the UBS. The first process of the intervention was a guided visit by the members of the executive groups to draw up a situational diagnosis, analysing internal and external work processes, prioritising the problems identified and preparing strategic planning.

Methodology applied at the UBS

This descriptive study examines implementation of the *AcolheSUS* project at a basic health unit in the central health region of Brasília, from November 2017 to March 2018, which used participatory methods of data production, intervention, monitoring and evaluation.

A situational diagnosis was performed and situational strategic planning drawn up specifying activities, actors, objectives and timeframes.

The situational strategic planning comprises a strategic component, which addresses feasibility and the obstacles to be surmounted, and a tactical-operational component[8].

Situational planning is a calculation that makes it possible to govern in situations of conflict and shared power, and builds on the assumption that it is impossible to predict the future, but that possibilities can be forecast so as to project actions and make them timely and effective[9].

Situational diagnosis of the UBS

The technical visit by representatives of the local executive group identified the following problems, which were categorised within the dimensions proposed by the *AcolheSUS* project (ambience, reception, care management and organisation and continuing professional development), as follows:

Lack of organisation of user care flow at the UBS: lack of personnel to orient users on arrival at the UBS, particularly from 7 to 8 a.m.; lack of specified user flow and poor optimisation of human resources.

Lack of organisation for receiving and meeting scheduled demand and spontaneous demand: all appointments are scheduled for the same time, 8 a.m. or 1 p.m. No process is specified for scheduling return appointments.

Reception of spontaneous demand is offered in a single room, leading to queues and disregarding priorities, but prioritising by order of arrival.

Difficulty in managing workers' schedules in line with PHC guidelines (home visit, team meeting, UBS management collegiate, comprehensive care, equity).

Home visits are not made, because the care schedule is full and consequently it is difficult to

register users, even in what are considered vulnerable areas.

There are difficulties in registering the catchment area population: the single reception room is overloaded.

Dental and nutrition teams are not included in the process of changeover to the Family Health Strategy.

Rearguard weakness identified when referral to another level of care is needed, especially to emergency hospital services.

Situtional strategic planning

After the SB's problems had been identified, the situational strategic planning was drawn up. For each problem identified, objectives were set, activities planned to attain them, and the actors responsible and execution timeframes specified (Chart 1).

After the planning was prepared, data available for the period prior to project startup (April-September 2017) were evaluated and monitoring began (October 2017 to March 2018) of the number of appointments, number of patients processed through reception and classified, number of procedures performed, as well as the number of individuals registered by the teams.

Results of the intervention

In October 2017, the unit held only 135 individual user records filed by the teams. In March 2018, after implementation of the *AcolheSUS* project guidelines, it held 3525 records. That was a consequence of the introduction of a specific time of day for home visits and individual registration by each team. That practice enabled the teams to assimilate the territory culturally, epidemiologically and environmentally. Moreover, the teams were motivated by each new discovery, which worked in favour of project progress.

Reception with user risk classification, which was absent in the months prior to the project, averaged 1099.8 in subsequent months, as shown in Graph 1. Training was given in the reception and risk classification protocol proposed by the Ministry of Health, patients classified by the colour green, i.e., those with acute disorders but no imminent risk of their condition's worsening, could be treated by the nurse in the course of the day[10]. Also, that fact fostered greater contact between the team and the population of the catchment area, thus contributing to closer bonding and improved access to the UBS.

Implementation of reception and risk classification caused the number of procedures and nursing appointments at the UBS to increase by 121.2% and 193.7%, respectively, as can be seen in Graph 2. The team was empowered by the pre-established protocols, capacity-building and matrix support, which offered nurses greater autonomy. They became leading agents of care at the UBS, specifically in child care, antenatal care and monitoring of patients with chronic diseases, such as hypertension and diabetes mellitus.

Management of the UBS changed in July 2017 and the information received at the time was that a minority of the catchment area population were SUS users and frequented the unit (not consolidated). In October 2017, the percentage of patients treated at the unit who lived in the catchment area was 71% (930 of 1328) and, in March 2018, reached 90.5% (2738 of 3026). Note that this information is declared by users themselves. According to reports from the resident population, under the former model, queues of patients from various different regions would form in the early hours of the morning, overwhelming the unit's care capacity and hindering access.

Discussion

Reorganisation of the SUS in the Federal District in early 2017 centred on strengthening primary care so as to enable PHC to fulfil its role as the care coordinating function in the health system. Ease of access and timely access are features of a PHC system that effectively solves user problems[2].

The problems detected by situational diagnosis at the UBS of the central region of Brasília – in the light of Franco et al.[11], who pointed to primary care access barriers as a major hindrance to PHC's becoming established as the coordinating function of the SUS health care network – revealed reasons in PHC for why, at the start of the project, the hospital-centred model has maintained its hegemony in Brazil's capital city.

As regards social and health indicators, the UBS studied here belongs to a highly urbanised Health Region where levels of schooling and income are also high in a large part of the resident population. CODEPLAN[12] reports that the Asa Norte area returned a Gini coefficient of 0.437, with per capita income of R$ 5,476.87 and mean monthly family income of R$ 12,428.50. Accordingly, this population was not believed to be primarily SUS users. However, with the UBS's changeover in work methods and improved ac-

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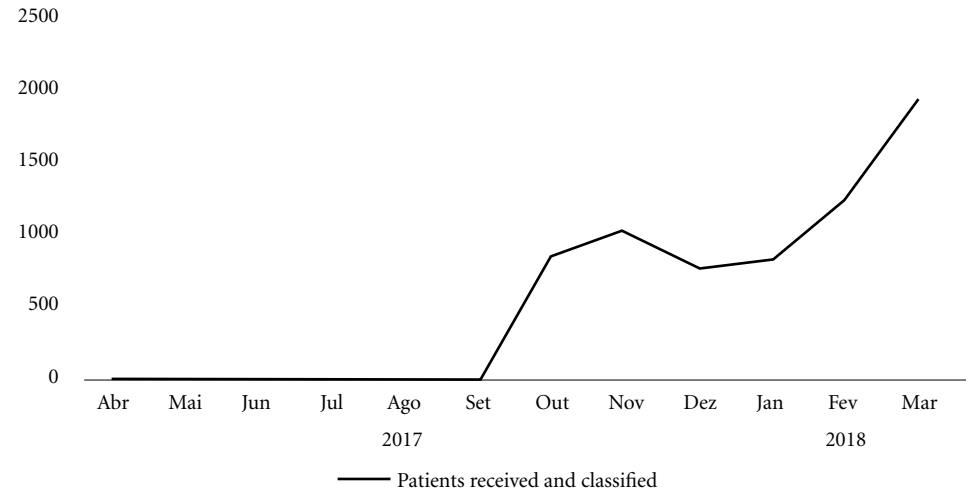
Chart 1. Situational strategic planning at UBS 2 in the Asa Norte, Federal District, 2018.

Objectives	Activities	Deadline	Responsibility of
Dimension: care management and organisation			
Organise health professionals' work schedule in compliance with PHC guidelines	Organisation of teams' schedules to assure home visits, team meetings, and doctors and nurses present every day at the UBS	Nov/2017	UBS management
	Organisation of team nursing technicians' shifts in vaccination rooms	Nov/2017	UBS management
	Organisation of representatives for the collegiate management group comprising team coordinators and representatives of the professions at the UBS	Nov/2017	UBS management
	Introduction of the oral health team and nutritionist into the new model of care	Jan/2018	UBS management and Local Executive Group
	Introduction and discussion of the schedule of PHC services with all workers at the UBS	Nov/2017	UBS management
Organise HT, DM, CD and antenatal patients for monitoring by the team	Preparation of spreadsheets for monitoring of appointments and routine examinations	Feb/2018	UBS management / Team coordinators
Use Ministry of Health PHC booklets (CAB MS) for consultation	Record MoH PHC booklets on all teams' computers	Nov/2017	UBS management
Monitor patient no-shows	Organise no-shows by noting on schedules	Feb/2018	Team coordinators
Dimension: Reception			
Care that solves user problems	Organise appointments by block of hours	Dec/2017	UBS management
	Set up reception and pre-care room for each team	Dec/2017	UBS management
	Reorganise specialised care appointment-setting flow	Nov/2017	UBS management
	Organise waiting list for pre-care and appointment scheduling	Nov/2017	UBS management
	Use risk classification in MoH CAB No. 28	Nov/2017	UBS management
Rearrange teams' areas	Reorganise the teams' coverage areas	Nov/2017	UBS collegiate body
Dimension: Ambience			
Receive users arriving at the UBS in such a way as to solve their problems	UBS reception balcony always open during working hours	Nov/2017	UBS management
Evaluate user satisfaction	Conduct user satisfaction survey	Dec/2017	UBS management and Local Executive Group

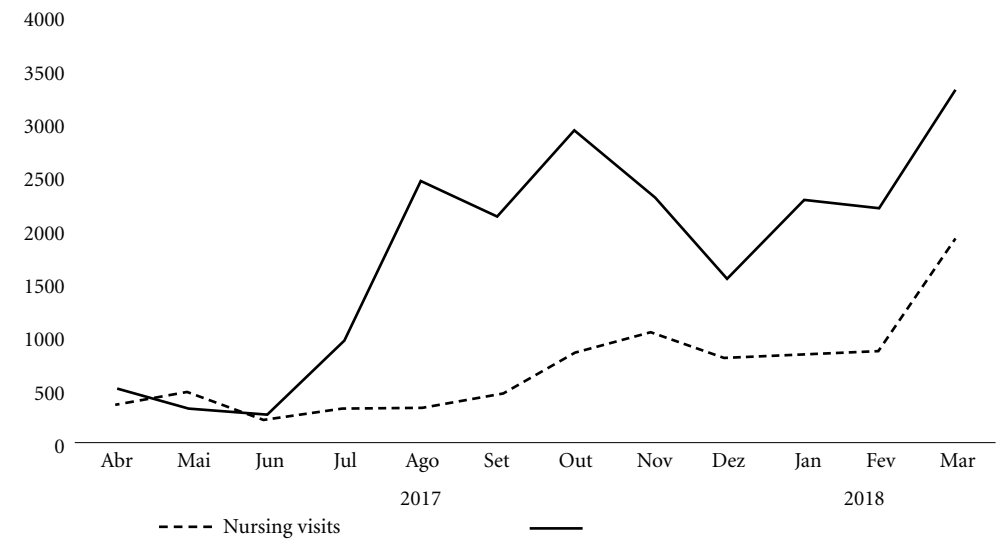
cess, the catchment area population began to attend the UBS as its health service of first choice. This shows that the SUS does not serve only populations with high social vulnerability.

Territorialisation, a technical concept that refers to the specification of territories in order to define health responsibilities, is another factor that facilitates user access to primary care[13]. This territorialisation was made possible by the change in model of care applied by the UBS, which enabled actions to be taken on a family-, community- and environment-based approach. As a result, the health service acknowledges and enhances the local people's culture and bonds with the territory[14].

Reception is a tool framed by the principles of the SUS to provide care to all those who attend health services, assuring universal access,



Graph 1. Number of patients received and classified at UBS 2, Asa Norte, Federal District, April-December 2017, January-March 2018.



Graph 2. Number of nursing procedures and appointments, at UBS 2, Asa Norte, Federal District, April-December 2017, January-March 2018.

shifting the centre of gravity from the medical professional to a multi-professional team and designed to produce informed listening, bonding and problem solving. Reception should extend to work process management, because it will only be possible if management is participatory, based on democratic principles and on interaction among the team[15]. Implementation of the guidelines for reception at the UBS was fundamental for spontaneous contact to occur directly with the health care team; it called for a professional practice involving a substantial degree of

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communication, interpretation, negotiation and shared responsibilities, and able to encourage bonding, calm anxieties and seek contextualised solutions to problems[16].

Reception with risk classification is a device that constitutes one of the potentially decisive interventions, always assuming that the care provided is effective. Increased use of that device, with the assistance of pre-established protocols, guides the response by level of complexity rather than by order of arrival, analysing and ordering demand by need and, in that all users are attended to, distancing itself from the traditional concept of screening and its exclusionary practices[13]. Accordingly, applying such protocols helps to break down user access barriers, which were visible in the former model of care in place at the UBS, in which a limited number of appointments were distributed among users by order of arrival, with no quality listening, thus jeopardising the safety of both patients and health personnel.

Individual registration is also of the utmost importance to the Family Health Strategy and, in most cases, is the population's first contact with their respective health care team and perhaps the first factor in their bonding with the UBS. It offers the opportunity to identify the population's chronic diseases and biological and cultural characteristics. This puts family health teams in a position to act preventively on the chronic conditions that constitute the main causes of, for instance, avoidable hospital admissions[17,18]. Accordingly, setting aside a time exclusively for individual registration has made it possible to increase the number and learn more about the UBS's catchment territory.

Similarly to the Tesser and Norman[17] study, the data in this report show that, in the PHC model prior to the conversion process, the nurses' role was given no prominence at the UBS. Nursing now plays a fundamental role in PHC, represented by comprehensive health care, which is one of the guiding principles underlying the SUS[19]. Even now, however, one of the major challenges facing nurses is the struggle for nursing care to be afforded due recognition and value in PHC in the Federal District.

There is a real need for care production by nurses to be made effective. This leading role was not acknowledged in the UBS studied here, where nursing played a lesser role in comprehensive health care for users. Implementation of the *AcolheSUS* project and the changeover to the new model of care increased the number of users attended to, and procedures performed, by nursing. The same was not true of numbers of users attended to and procedures performed by doctors which, in spite of the change in the public served, held stable in the subsequent months.

The rate of referrals from the UBS to other levels of care was 8% in March, thus representing a resolution rate in excess of 85%, as recommended by the present model of PHC applied by the SES/DF.

Conclusion

The *AcolheSUS* project is designed to improve the quality of access and health care practices by introducing and implementing the reception guidelines set out in Brazil's national humanisation policy (PNH) in health services. It has contributed important methodological tools and matrix support to steer the process of change to a model resting on the family health strategy at a basic health care unit (UBS). What then became fundamental to the UBS's functioning was, on the lines of situational strategic planning, to construct a model with an operating logic framed by participatory management.

Participatory modelling contributed to the plan's being assimilated and applied by all team members. However, knowledge of modelling techniques is needed in order to construct the strategic planning, as well as during the identification and analysis of problems in the course of the situational diagnosis. In addition/Besides that, there are no restrictions on its application.

The recent changeover of PHC model to the Family Health Strategy focusing on user centrality and territorialisation, corroborated by participatory management and the introduction of intervention tools of the *AcolheSUS* project, will in the long term be able to revert the harm done by the previous model, providing safe, appropriate care offered in a timely manner to SUS users by the SES-DF, with increased accessibility and resolution rates at the UBS.

In all, this study showed that appropriately capacitated local management, allied to scientific methods and using innovative ideas, is able to change local realities at basic health units and to reduce barriers to accessing PHC.

Collaborations

JM Cardoso, MB Botelho Alves and MIG Borges worked on the conception of the introduction, interpretation and final writing of the article and the approval of the version for submission to the publication. AP Paula worked on designing, designing, analyzing and interpreting data, writing the final article and approving the version for submission to publication. ACT Martins worked on designing, designing, collecting and organizing data, analyzing and interpreting data, writing the initial and final article, and approving the version for submission to publication.

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