

# Research Implementation Plan Brazil

*What are the factors to be considered and negotiated for successful referral from primary to secondary care and back in Brazil?*

## **Abbreviations**

ESF	Family Health Strategy
RAS	Network Care Health (Redes de Atenção à Saúde)
SUS	Brazilian Health System

## **Background and significance**

With the implementation of Brazilian Health System (SUS), institutionalized in Brazil by Laws 8080/90 and 8142/90, the development of primary health care (PHC) began to generate better health outcomes for Brazilian citizens. This level of care, recommended since the International Conference on Primary Health Care Alta-Ata,<sup>1</sup> as a driver of a broader view on health surveillance, population nutritional conditions and prevention, already a look beyond the individual, that is, for the family, environment and community.

The political agenda for strengthening PHC through the Family Health Strategy (ESF)<sup>2</sup> gradually consolidated in the country, and in 2006 became one of the priority dimensions of the Pact for Life. The ESF consolidation strengthened the Brazilian PHC, making it possible to extend coverage, provide integral care and develop health promotion. ESF became the main entrance of the SUS user, coordinating care and organising the Network Care Health (RAS, in Portuguese: Redes de Atenção à Saúde).

However, this broad mosaic of possibilities, which made it possible to expand health coverage in the Brazil, especially among the most vulnerable, left some gaps, especially in the communication between the primary and secondary levels of care, jeopardising WONCA core competencies such as primary care management (including care coordination, the so-called centrality of care carried out in the RAS) and the comprehensive approach.

Thus, considering these central aspects, we must investigate what factors should be considered - and negotiated - for effective referral between primary and secondary care in Brazil.

## **Specific Aims**

- 1) To identify factors that influence referral between primary and secondary care in Brazilian context.
- 2) To test and develop strategies to improve communication between primary and secondary care within the main systems of referral in Brazil

## **Objectives**

- To evaluate characteristics of the PHC task force that influence the attribute "care coordination" in the population of Brazilian physicians and nurses working in the PHC and also in secondary care.
- To explore and better detail the barriers and potentialities involved in referral between primary and secondary care.

- To construct and develop strategies to cope with the communication gap between primary and secondary care from tracer conditions (like depression, diabetes type 2 or cervical cancer but to be defined) (e.g., patient accompanied by different physicians and without medication conciliation; patients with multiple requests for the same laboratory or images studies by different physicians, disruption of the longitudinal care of the family doctor with his patient after referral, queuing and delay of care in specialised care).

### **Study design**

Five health regions will be studied (or ten, depending on financing, preferential), representing the five Brazilian regions, according to the Brazilian Institute of Geography and Statistics:

- Midwest: Distrito Federal and Anápolis
- Southeast: Rio de Janeiro and Ribeirão Preto
- Northeast: Feira de Santana and Teresina
- South: Porto Alegre and Florianópolis
- North: to be determined

### ***Rationale***

Brazil is a continental country with extremely diverse regions (population, socioeconomics, politics and culture). The Brazilian Health System (SUS) was developed based on local policies; it is necessary to research the local influence in the referral process between primary and secondary care. The workplace of researchers will be considered.

### ***Targeted population***

- Family Physicians or General Practitioners (GP) and Nurse Practitioners (NP).
- Workers of primary health care (In Brazil, not all workers of PHC are specialised).
- Workers of Hospitals and Secondary Care Centers
- Municipal managers of selected regions (health secretaries and PHC coordinators, Secondary care coordinators and care regulation coordinators).

### ***Methodology***

**PHASE 1:** Application of online national questionnaire developed (or a questionnaire validated; Primary Care Assessment Tool is indicated) to evaluate the attribute "care coordination" and variables that may influence this variable. Semi-structured interviews (online mode is possible) with primary health care professionals, managers and professionals of medium complexity services of 10 cities in five regions of Brazil will be held to: 1) define how Health Systems are organized in each of them, and; 2) the main barriers and facilitators allowing comparison between these different system when it comes to successful referral of the conditions studied.

**PHASE 2:** Case studies in each of the selected regions will be selected to deepen the analysis of **successful referral from primary to secondary care and back in each area**, detecting which mechanisms have been established to improve the GAP of communication between PHC and secondary care, so that barriers and best practices already existing can be better understand. The conditions have been selected to be studied of a list and are conditions that depend mainly on PHC for a good standard of care, but where coordination of care by PHC and good quality of communication are essential for the good resolution of more severe cases. These conditions will involve

different RAS (like as Psychosocial Network, Chronic Conditions and Women's Health) in SUS allowing an opportunity to study the problems from a more complete perspective (e.g., patient accompanied by different physicians and without medication conciliation; patients with repeated requests for the same laboratory or repeated imaging exams by different physicians; disruption of the patient longitudinal care with the family physician/GP after referral; queuing and delay of care in specialized care).

**PHASE 3:** After the eight cities in four regions have been compared, the most frequent barriers and the best practices in each of them and in the national system will be identified, providing a framework that can be used to improve communication and integration between these two levels in each studied case.

The next and final phase will be directed to motivate the development of successful strategies to improve PHC coordination and communication between primary and secondary care.

Participatory methodology will be used in the construction of intervention plans in each region, according to the selected marking condition. Assessment of indicators of structure, process and results

**Considerations:**

- It should be emphasised that according to the marked condition, patients or communication flows will be evaluated from the point of view of integral care. collaborative/shared.<sup>3</sup> Care is a form of integration and communication.
- In phase two it will be used various methodologies for its implementation (therapeutic itinerary, questionnaires for the target population, focus groups).

**Potential research team and partners**

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## Overview work plan

	1 quarter	2 quarter	3 quarter	4 quarter
Year 1				
First researchers' meeting				
Data collection (online national questionnaire & semi-structured interviews)				
Phase 1 Data analysis				
Year 2				
Second researcher's meeting				
Case studies by region – data collection				
Case studies by region – data analyses				
Year 3				
Third researchers' meeting				
Communication strategies development				
Communication strategies implementation				
Final report – paper writing				

### Barriers to implementation

- Difficulty of understanding GP and NP about their role as care coordinators;
- Difficulty of understanding as physicians about their role as a support network for PHC and the role of GP and NP as care coordinators.
- Reference to incomplete and non-standardized information (reference and counter-reference).
- Absence of integrated electronic medical record.
- Almost complete absence of mechanisms of counter-referencing and the need for qualitative improvement of it in places where it already exists.
- Still deficient monitoring of GP and NP on their patients in other levels of attention (mainly in secondary care).
- Different health policies adopted by municipalities with regard to integration between PHC and secondary care.
- Poor structuring and regionalisation of the service network.
- National and local policies that influence behaviour of GPs and nurses

### Dissemination of results

Plans for dissemination of the results to policymakers and communities, as well as next steps

- Publication of partial and final project reports
- Seminars in the regions involved in the project (with professions, managers and researchers).
- Publication of articles in specialised journals.
- Realisation of forums in Family Medicine and PHC congresses.
- Realisation of forums with municipal managers of selected regions (health secretaries and PHC coordinators, Secondary care coordinators and care regulation coordinators).
- Disseminate widely to people working on the ground.

## References

1. World Health Organization. Declaration of Alma-Ata. International Conference on Primary Health Care. Alma-Ata, USSR: WHO, 1978.
2. Trevisol DJ, Traebert J, Schuelter-Trevisol F. Brazil's Family Health Strategy. *N Engl J Med* 2015;373(13):1277. doi: <https://dx.doi.org/10.1056/NEJMc1509056>
3. Ivbijaro GO, Enum Y, Khan AA, et al. Collaborative care: models for treatment of patients with complex medical-psychiatric conditions. *Curr Psychiatry Rep* 2014;16(11):506. doi: <https://dx.doi.org/10.1007/s11920-014-0506-4>