HEALTH CLOSER TO YOU – ACCESS AND QUALITY
NATIONAL PROGRAM FOR ACCESS AND QUALITY
IMPROVEMENT IN PRIMARY CARE (PMAQ)

INSTRUCTIONAL MANUAL

Brasilia – DF
2012
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Series A. Standards and Technical Manuals

Brasilia – DF
2012
Abbreviation List

AB – Primary Care
ACS – Community Health Worker
AMAQ – Self-Assessment for Access and Quality Improvement in Primary Care
CIB – Bipartite Inter-management Commission
CIR – Regional Inter-management Commission
CIT – Tripartite Inter-management Commission
CMS – Municipal Health Council
CNES – National Registry for Health Establishments
Conasems – National Council of Municipal Health Secretaries
Conass – National Council of State Health Secretaries
DAB – Primary Care Department
EAB – Primary Care Team
ESB – Oral Health Team
ESF – Family Health Strategy
GM – Ministers Office
IBGE – Brazilian Institute for Geography and Statistics
MS – Health Ministry
PAB – Primary Care Salary Floor
PIB – Gross Domestic Product
PMAQ – National Program for Access and Quality Improvement in Primary Care
PNAB – Primary Care National Policy
RAS – Primary Care Network
SAS – Health Care Secretary
SF – Family Health
SGDAB – Program Management System of Primary Care Department
SIA – Ambulatory Information System
Siab – Primary Care Information System
Sisprenatal – Monitoring and Evaluation System for Prenatal and Puerperium
Sisvan – Food and Nutrition Surveillance System
Siscolo – Information System for Uterine Cervix Cancer
SUS – Unified Health System
TC – Declaration of Commitment
UBS – Basic Health Unit
UF – Federal Unit
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1 National Program for Access and Quality Improvement in Primary Care

One of the main current guidelines of the Health Ministry (MS) is to run public management based on induction, monitoring and assessment processes as well as measurable results, ensuring health care access and quality to the entire population. In this sense, many efforts have been made in order to adjust the strategies planned out in the Primary Care National Policy (PNAB) in order to recognize the quality of Primary Care (AB) services offered to the Brazilian society and stimulate access and quality expansion in various contexts existing in the country.

In recent years, with an estimated coverage of more than half of the Brazilian population through the Family Health Strategy (ESF) and a population coverage through other AB models that may vary between 20% and 40%¹, the issue with management quality and AB team practices has received greater importance on the agenda of the managers from the Unified Health System (SUS). Thus, the MS proposes several initiatives focused on qualifying AB such as the National Program for Access and Quality Improvement in Primary Care (PMAQ) which has been highlighted.

The PMAQ was established by Ordinance No. 1654 GM / MS, July 19, 2011, and was the result of an important negotiation and agreement process involving the three levels of SUS management that included several moments in which the MS and the municipal and state managers, represented by the National Council of Municipal Health Secretaries (Conasems) and National Council of State Health Secretaries (Conass), discussed and formulated solutions for designing a program that would permit access expansion and quality improvement of primary care in all of Brazil.

The program’s main objective is to induce the access expansion and quality improvement of primary care, with a guaranteed national quality standard, both regional and locally, in order to allow greater transparency and effectiveness of the government actions directed to Primary Health Care.

¹ Estimated value considering different calculation methods, based on the amount of Basic Health Units (UBS) that are organized through various primary care methods, which are different than the Family Health Strategy, and / or the number of professionals working in these UBS.
Among its specific goals, we can highlight:

I - Increase AB impact on the population’s health conditions and user satisfaction, through strategies for facilitating access and improving the quality of AB services and actions;

II - Provide standards for good practices and organization within the UBS that will guide AB quality improvement;

III – Promote UBS greater compliance with AB principles, increasing effectiveness in the health condition improvements, user satisfaction, health practice quality and the health system’s efficiency and effectiveness;

IV - Promote quality and innovation within the AB management, strengthening self-assessment processes, monitoring and evaluation, institutional support and continual education within the three government spheres;

V - Improving the quality for updating and use of information systems as an AB management tool;

VI - Institutionalize an evaluation culture of the AB in the SUS and management based on induction and monitoring of processes and results, and

VI – Stimulate AB focus on the user, promoting transparency of management processes, participation and social control and health responsibility of the health professionals and managers with the improvement of health conditions and user satisfaction.

The commitment for quality improvement should be constantly reinforced with the development and improvements of initiatives that are more appropriate due to the new challenges generated by reality, both because of the increasing complexity of the populations health needs, due to epidemiological and demographic transitions as well as the current sociopolitical context, with the populations increased expectations regarding the efficiency and quality of the SUS.
The PMAQ is inserted in a context where the federal government gradually develops and undertakes actions aimed towards improving the access and quality of the SUS. Among them, it is important to highlight the Assessment Program for SUS Qualification, which has the main objective of evaluating the results of the new health policy in all of its dimensions, especially for the AB component. It is a model for evaluating health system performance, at all the three government levels, which aims to measure the possible effects of the health policy in order to support decision making, ensure transparency of the management processes in the SUS and generate visibility to the results achieved, as well as strengthen social control and the health system’s focus on users.

**Amongst the challenges PMAQ intends to face for qualifying AB, the following are highlighted:**

I - Precarious physical infrastructure, with a significant portion of the UBS’s in inappropriate conditions;

II – Unwelcoming Environment of the UBS, providing users with an impression that the services offered are low quality and negatively targeted to the poor population;

III - Inadequate working conditions for professionals, compromising their intervention capacity and work satisfaction;

IV - The need for qualification of the work processes for the AB teams, characterized generally by their inability to take on acute health problems; insufficient integration of team members; and lack of work orienting based on priorities, goals and results, defined jointly by the staff, municipal management and community;

V – Team instability and high turnover levels within the team of professionals, compromising bonds, care continuity and team integration;

VI – Beginning of management processes focused on induction and quality monitoring;
VII - Overload of teams with too many people under their responsibility, compromising the coverage and quality of their actions;

VIII - Low integration of the AB teams with the diagnostic and therapeutic support network as well as with the rest of the Health Care Network (RAS);

IX - Low completeness and resolution of practices, with the persistence of the complaint-conduct model, prescriptive care, medical-centered-procedure, focused on the biomedical dimension of the health-disease-care process;

XI - Insufficient and inadequate financing of the AB, linked to team accreditation, regardless of the results and quality improvement.

Considering all of these challenges, as well as the progress achieved through the National Primary Care Policy in recent years, the Health Ministry, with the contribution and incorporating of the state and municipal managers perspective, structured the design of the National Program for Access and Quality Improvement in Primary Care through seven guidelines that govern its organization and development:

I – Have a comparison parameter between the primary care teams (EAB), considering the different health realities: an important element that must always be present in the process of evaluating health service quality is the presence of mechanisms that ensure the possibility for comparison between health services offered by the different primary care services, respecting the diversity of contexts.

II - Be incremental, envisioning a continual and progressive process for the improvement of standards and access and quality indicators that involves management, work processes and the results achieved by the primary health care teams: the choice of the standards and indicators for monitoring and evaluating actions developed by primary care teams considered, initially, a number of aspects that can be measured for all the teams, regardless of the context in which they are inserted. However we anticipate the need throughout the program’s development, to define new standards and indicators that permit
the continued accumulation and adequacy of the commitments contracted, being consistent with the regional and local specifications.

III - Be transparent in all of its stages, allowing continual monitoring of their actions and results, by society: the process for improving health policies presupposes the presence of mechanisms that favor permanent monitoring, by the whole society, of the actions taken by the health services, as well as the results they generate. In this sense, the performance of the municipal \(^2\) management and the EAB participants of the PMAQ may be accompanied by the States, municipalities and organized civil society, among others, through the Primary Care Department portal at the following electronic address www.saude.gov.br/ dab.

IV - Involve, mobilize and make the federal manager, state management, Federal District, municipal and local, teams and users responsible through a management culture change process and qualification of primary care: ever since participation and contracting in the PMAQ, managers and EAB shall be responsible for a series of actions that may qualify the management work process and workers in primary care. Users will also be involved in the program, as they may potentiate the changes through monitoring and discussion regarding the performance of teams and municipal management in locations such as the Local and Municipal Health Councils. Besides this, an important dimension that will be present in the assessment process of the EAB participating in the program will be the evaluation of user satisfaction.

V - Develop a negotiation and contracting culture involving the management of resources based on the commitments and results agreed upon and achieved: one of the main elements of the PMAQ is the establishment of mechanisms for financing AB by contractual commitments of the EAB, the municipal and state management and linking the resource transfers to team performance. The objective is recognizing the municipal management and AB workers efforts to develop actions that increase access and quality of the services offered to the population.

VI - Stimulate effective change in the care model, the development of workers and services focused on needs and user satisfaction: the entire PMAQ design considers the need

\(^2\) In this document, the Distrito Federal (Federal District) will be considered a municipality and the local health management of the Distrito Federal will be considered municipal management, as to avoid the Repetition of the DF specification throughout the entire content.
to recognize the quality of AB produced and offered to the population, in order to induce change in the work process and, consequently, the impact caused by this change on the users and workers. Based on the principles of primary care, the program seeks to encourage the change of the care model based on the understanding that the context conditions, as well as the role of different participants, may produce significant changes in how to care and manage care permitting the EAB qualification. Worker development is also an objective in the program. It seeks to mobilize them, offer strategies for permanent education and encourage the establishment and improvement of mechanisms that ensure rights, stable bonds and qualify work relations. At the same time, the PMAQ seeks to incorporate the user population’s perception, as well as invite them to participate, through creating environments for participation, agreement and assessment, which will guide the organization of care based on the concrete needs of the population.

VII - Have a voluntary characteristic for membership both in the primary care teams and within the municipal management, assuming that its success depends on the motivation and pro activity of the participants involved: participation in the PMAQ and incorporating processes aimed towards improving access and quality of the AB presupposes the main role of all participants involved in the program implementation process, and the voluntary characteristic for participation is associated with the idea that the strengthening and the introduction of practices related to increasing the quality of AB can only be performed in environments where workers and managers feel motivated and essential to its success.
2 Primary Health Care

Primary health care is characterized by a set of health actions, both individual and collectively, which includes the promotion, protection and restoration of health, with the goal of developing a comprehensive care that will impact the health situation and people autonomy as well as community health determinants and conditions. It is developed with the highest degree of decentralization and capillarity, close to people’s lives. It is operated through care and management practices, democratic and participatory, through teamwork, targeting populations in defined territories, and responsible for their health conditions, considering the dynamics in the territory were these populations live. Using complex and varied care technologies that should assist in the management of health needs and demands that are more frequent and relevant in their territory, observing the risk criteria, vulnerability and resilience and the ethical imperative which stated that all demands, health needs or suffering must be cared for.

It is the contact and preferential gateway for users in the health care network. It is guided by the principles and guidelines of the SUS and holds specific functions and characteristics. Primary care considers the individual as unique and singular taking into consideration their social cultural integration, seeking to provide comprehensive care through their health promotion, prevention, diagnosis, treatment, rehabilitation and harm or suffering reduction that may compromise their autonomy. The following principles and guidelines are highlighted:

I – Territorialization and health commitment

The territorialization process is a fundamental step in the appropriation / knowledge of the country by the primary care worker teams, where the mapping of the territory occurs from different maps (physical, socioeconomic, health, demographic, social network etc). Through territorialization, it is possible to recognize living conditions and the health situation of the population in one coverage area through a broadened perspective, as well as the collective risks and the territory potential. The dimensions of health commitment regards the responsibility that teams should take on in their performance territory (ascription), considering environmental, epidemiological, cultural and socioeconomic issues, contributing through health actions, as to reduce risks and vulnerabilities.
II – User ascription and bond

The user ascription is a process for linking people and / or groups and families to professionals / teams, as a reference for care. The bond, in turn, consists in building affection and trust relationships between the user and the health worker, permitting the deepening of the co-responsibility process for health, built over time, as well as being potentially therapeutic.

III - Accessibility, care and preferential gateway

The establishment of mechanisms that ensure accessibility and care presupposes an organization and functioning logic for the health service that is based on the principal that the health unit must receive and care for every person seeking its services, in a universal and non excluding manner. The health service should be organized in order to take on its main function which is caring, listening and offering positive responses, capable of solving health problems and / or minimizing harm and suffering, being responsible to offer answers even if they may need to be offered in another unit of the network. The proximity and the ability to provide care, bonds and commitment are fundamental to the effectiveness of primary care as a contact and preferential gateway in the care network.

IV – Longitudinal Care

The longitudinal aspect of care presupposes the continuity of the clinical relationship, building bonds and commitment between professionals and users over time and permanently, monitoring the effects of the health interventions and other elements in the lives of the users, adjusting conducts, when necessary, avoiding referral losses and reducing the risks of iatrogenesis resulting from the lack of knowledge regarding life stories.

V - Health Care Network (RAS) Ordination

Primary health care should be organized based on the RAS, due to its capillarity and work logic, and must have a key role in organizing the Network. For this, it is necessary to have adequate population coverage and high care capacity, with a high resolution degree. The RAS ordination also
implies that most of the care flows, care segments and therapeutic and diagnostic support offers are designed and implanted based on the health needs identified by the primary care services.

VI - Management of the comprehensive care network

The bond built by a solving, humanized and comprehensive primary care enables the gradual development of care management for the users by the teams, in the various scenarios and moments of care, even when the continuity of the care requires being relocated to other care units of the RAS, which is when the primary care coordination is decisive.

VII - Work in multi professional team

Given the diversity and complexity of situations dealt with by primary care, it is necessary to have / build analysis and intervention capacity amplified amidst the demands and needs for building comprehensive and effective care. This requires the presence of different professional backgrounds and a high degree of coordination between professionals so that not only are the actions shared, but there also occurs an interdisciplinary process in which, increasingly, the nucleus of specific professional expertise will enrich the common field of expertise, thus increasing the whole team’s care ability. This organization presupposes that the work process focused on professional procedures will become focused on the user, where care is the ethical and political imperative that organizes the technical scientific intervention.
3 Implementation Phases of the National Program for Access and Quality Improvement in Primary Care

The National Program for Access and Quality Improvement in Primary Care is organized into four phases that complement each other and form a continuous cycle of AB access and quality improvement, namely:

1 - Participation and contracting;
2 - Development;
3 - External Assessment;
4 – Contract renewal.

3.1 Participation and Contracting

The first phase of the PMAQ is the formal step of joining the program, through contracting commitments and indicators formalized through the primary care teams and municipal managers, and then with the Health Ministry, in a process that involves local, regional and state agreement and the participation of social control.

3.1.1 Participation and Permanency in the program

The Health Ministry, aiming towards qualifying all of the basic care within the country, through a three way agreement process, allows the Family Health teams to participate in the PMAQ, which is a priority strategy for expansion and strengthening AB in Brazil as well as the primary care teams organized differently, provided they fulfill the assumptions and requirements of the program.

Thus, all the primary care health workers\(^3\), including oral health, in different methods, may join the PMAQ provided that they are in accordance with the primary care principles\(^4\).

\(^3\) The details of the formalization process for participation in the program on the SGDAB are described in item 3.1.6 of this instructional document.

\(^4\) The parameter and equivalence criterias for the different primary care organization methods with the Family Health Strategy are detailed in item 3.1.4 of this instructional document.
Participation shall be voluntary presupposing an initial agreement process between primary care teams and municipal managers, which should precede the municipality’s formal participation process with the Health Ministry.

The PMAQ joining process will be permanent and there is no deadline for the EAB and municipal managers to enter the program, except for seven months before the municipal elections. Therefore, in years when municipal elections occur, the Program Management System of Primary Care Department (SGDAB) will be open for PMAQ participation up until the end of February. However, each municipality may only have new primary care team(s) joining the program once a year, with a minimum six month break between one joining process and another.

In this first year of program implementation, an exception to the rule will be made, as the registries will take place between the 1st of September and October 31, 2011, and new enrollments for 2012 will be suspended and opened again in 2013. Participation in the PMAQ will be done through the SGDAB, which will be available on the DAB website, at www.saude.gov.br/dab.

It is important to highlight that each municipality may include all or part of their teams in the program, within the limits for membership and contract signing described in section 3.1.5 of this informative.

Upon membership approval, performed by the Health Ministry, the municipality will monthly receive, through a fund to fund transfer, 20% of the full value of the Quality Component from the Variable Primary Care Salary Floor (PAB Variable), per participant primary care team considering the competence of the month in which the approval was issued.

The full value of the Quality Component of the Variable PAB is equal to $ 6,500.00 per primary care team, and may reach up to R$ 8,500.00 in cases where there is an Oral Health team linked to the EAB. Thus, each municipality will receive, by joining the program, R$ 1,300.00 per EAB an R$ 1,700.00 when there is an ESB linked to the EAB. After the program’s external assessment process, scheduled for phase 4, the amount transferred per EAB will be linked to their performance.

5 These values will be readjusted periodically by the Health Ministry, according to budget availability.
The Health Ministry will perform the approval for municipalities and EAB that join the program, on a monthly basis, publishing an official order that specifies the municipalities that are participating in the PMAQ, with the respective number of teams. To formalize the joining process for the program, the publishing date of the official order will be considered.

After the municipality’s participation approval, the manager should inform it to the Municipal Health Council (CMS)\(^6\), the Regional Inter-management Commission (CIR)\(^7\) and the Bipartite Inter-management Commission (CIB)\(^8\). It is important to remember that this step will not prevent the municipality’s participation approval for the PMAQ, nor the transfers of funds linked to the program. However, loading the electronic scanned documents that prove that the municipality has informed their participation to the collegiate mentioned is a condition for requesting the external evaluation process, to be held during the fourth PMAQ phase.

In regards to the conditions for remaining in the program, the municipalities will lose accreditation with the PMAQ and will no longer receive the financial incentives in situations where the municipal management does not formalize, via SGDAB, the request for external assessment within a maximum period of six months for the first cycle and 18 months for the next cycles of the program. In such cases, the municipalities will also be prevented from joining the program during a period of two years. This mechanism seeks to prevent participation that is not effectively committed to the full compliance of the program’s quality cycle.

**In turn, EAB permanence in the PMAQ is conditional to:**

1. The same requirements that govern the PAB variable payment provided in the current Primary Care National Policy\(^9\). Managers must register and regularly update information regarding

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\(^6\) In the Distrito Federal (Federal District), this communication should be performed with the Distrito Federal Health Council.

\(^7\) Or commission, council or analog committee, which is present in the State.

\(^8\) In the Distrito Federal, this communication should occur with the Management Collegiate of the DF Health State Secretary.

\(^9\) In cases were the primary care teams have organization methods that are different then the ESF, similar requirements will
all of the professionals in the primary care teams in the National Registry for Health Establishments (CNES), as well as comply with the working hours according to that which was informed;

II – Monthly updating of the Primary Care Information System (Siab) with data, including the new PMA2-Complementary report\textsuperscript{10}, by using the simultaneous transmitter\textsuperscript{11} through the municipality, in order to send the Siab database; the Food and Nutrition Surveillance System (Sisvan) and the Family Support Program Management Method\textsuperscript{12} (Bolsa-Família), thus allowing for the effective monitoring of the program’s formalized indicators;

III – Non worsening in more than one standard deviation for at least three months in the monitoring indicators score achieved and considered in the certification process;

IV - Non-verification by control agencies and the national audit system, that the certified conditions are no longer present, in which case, a process should be conducted under the provisions of the national audit system;

V - The guarantee, by managers and teams, of the visual identification established by the Health Ministry, containing information such as the service portfolio offered by the team, the working hours of the Basic Health Unit, the professionals’ name and scale, the phone numbers of the municipality ombudsman (if any) and the Health Ministry, as well as the web address which holds information regarding the results achieved by the team\textsuperscript{13}.

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\textsuperscript{10} The Primary Care Information System (Siab) is being modified with the inclusion of new fields referring to the services provided by the team professionals (doctor, nurse and dental surgeon), that will use a specific record (PMA2-Complementary) for production registry, as well as complementing the information in the family registry regarding the Family Support Program (Bolsa-Familia).

\textsuperscript{11} The new file format of the Siabmun requires separate information per team, when transferring to a national level (Data-sus), through a transmitter.

\textsuperscript{12} In the future, with the progressive improvement of the program monitoring process and the health information systems, permanency in the PMAQ will also be conditional to regular updating of the systems such as the Monitoring and Evaluation System for Prenatal and Puerperium (Sispendina), the Information System for Uterine Cervix Cancer (Sisco) and the Ambulatory Information System (SIA).

\textsuperscript{13} The Health Ministry will then publish the visual standards for team identification.
3.1.2 Commitments

The contract process provides for the following:

1 - The signing of a Commitment Term (TC) between the Primary care team (s) and the municipal management;

2 - Signing a TC between the municipal management and the Health Ministry in the participation process, which includes contract signing between management and its teams as a pre-stage; and

3 – Signing a TC and / or a resolution from the CIB providing commitments concluded between the municipal and State management for support and participation in the PMAQ.

Commitments made by the teams and three management entities:

i. Organize the team’s work process in accordance with the primary care principles provided in the National Program for Access and Quality Improvement in Primary Care and in the PNAB;

ii. Implement care procedures for the spontaneous demand in order to amplify, facilitate and qualify access;

iii. Update the Primary Care Information System (Siab) on a regular and consistent basis regardless of the team’s organization method;

iv. Schedule and implement activities, prioritizing the individuals, families and groups with higher risk and vulnerability levels;

v. Establish regular moments for discussing the team’s work process as well as building and monitoring singular therapeutic projects;

vi. Establish self-assessment processes as mechanisms that may trigger reflection regarding the organization of the team’s work, involving all the professionals in the team;
vii. Develop inter sector actions focused on health care and promotion;

d. Agree upon goals and commitments for the qualification of primary care with the municipal management.

II – Municipal Management Commitments:

i. Ensure the minimum composition of the primary care team(s) that participate(s) in the program, with their professionals duly registered in the National Registry for Health Establishments (CNES);

ii. Regularly and consistently update the Primary Care Information System (Siab) with information regarding the primary care team(s) that are participating in the program, allowing for its permanent monitoring;

iii. Ensure a minimum supply of health actions for the population covered by the primary health care team, according to the Primary Care National Policy (PNAB) and translated by the indicators and quality standards set by the program;

iv. Use the resources from the Quality Component of the Variable PAB for actions that promote qualifying primary care;

v. Structuring the Primary Care Coordination, providing and ensuring operating conditions for the management team responsible for the local implementation of the program;

vi. Establish self-assessment procedures for management and primary care team(s) that participate in the program;

vii. Define the Basic Health Units (UBS) performance territory and the population for each primary care team;

viii. Implement institutional and matrix support for the primary care team(s) in the municipality;
ix. Perform continual education actions with / for the primary care team (s);

x. Implement a regular monitoring and assessment process, for monitoring and disclosing results regarding the municipality’s primary care;

xi. Perform actions that improve working conditions of the primary care team (s);

xii. Support the establishment of collegiate management mechanisms in the Basic Health Units;

xiii. Request an external assessment, performed by the Health Ministry, of the primary care teams participating in the program, at the deadlines stipulated;

xiv. Support the external assessment process of the primary care teams participating in the program, providing accommodation and transport for the external evaluation team.

III – State Management Commitments:

i. Establish mechanisms for institutional support to the municipalities participating in the program, in order to enhance the primary care access and quality improvement processes;

ii. Implement a regular monitoring and evaluation process, for monitoring and disclosing the primary care results in the State;

iii. Provide continual education actions and other qualification strategies for management, care and care management;

iv. Agree upon, strategies and guidelines with the Bipartite Inter-management Commission for the implementation of the program in the state, according to its guidelines;

v. Stimulate and promote experience exchange between the various municipalities, in order to share knowledge and technologies aimed at improving the access and quality of primary care;
vi. Contribute with the national coordination of the external assessment process to which the teams participating in the program should be submitted to, through the Conass;

vii. Conduct studies on the technical and financial feasibility for the establishment or orientation of the co-financing state mechanisms for primary care, in convergence with the Primary Care National Policy.

IV – Health Ministry Commitments:

i. Ensure the effective program implementation at a national, state, Distrito Federal and municipal level;

ii. Regularly Transfer the resources from the Quality Component of the Variable PAB, according to the rules of the program;

iii. Perform an analysis regarding the fulfillment of the participation conditions and the municipality’s permanency in the program;

iv. Develop tools and promote institutional support processes in order to subsidize the implementation of the program;

v. Provide continual education actions and other qualification strategies for management, care and care management;

vi. Implement a regular monitoring and assessment process, for monitoring and disclosing the primary care results in the country;

vii. Perform assessments that guide the program’s improvement and expand its management capacity and suitability to the needs of those involved in its implementation;

viii. Finance and coordinate (in a tripartite manner) the external assessment process to which the teams participating in the program will be submitted to;
ix. Coordinate the Contract renewal process for the actions focused on improving the quality of primary care, individually with each primary care team participating in the program, according to their performance in the certification process.

### 3.1.3 Contracting Indicators

When joining the program, amongst the commitments contracted by the primary care teams and the municipal management, is a set of indicators that were elected from the possibility of accessing information that may have a minimum aggregation level with the EAB.

As the assessment unit of the PMAQ will be the primary care team, the choice of indicators was limited to those that can be monitored and assessed by the Primary Care Information System (Siab), since this is the only system available for updating and monitoring the teams on an individual basis. However, in 2012, the Health Ministry will begin the implementation of a new information system that will allow for the national registry of health information, linked to the use of National Health Card and capable of interoperability with the diverse systems used by the States and municipalities. The implementation of this system, linked to the computerization process of the care network, will increase the scope of information and indicators monitored.

The Siab choice is also justified due to the fact that the system allows for the updating of record data on the population assigned to each team (age, gender, epidemiology characteristics etc...), permitting the analysis of the sufficiency and appropriateness of the services offered for some specific population needs covered by the team assessed. To enable the use of the Siab for monitoring the PMAQ, a review of the system was performed, focused on monitoring the results per team, and inclusion of new fields and attributes related to the indicators elected for the contracting and monitoring of the program.

In line with the PMAQ guidelines, the monitoring process should be subject to continual improvement of both the performance parameters and indicators. Given the current limitations of the health information systems for a more effective monitoring of the coverage and expected...
results of the primary care teams, we have decided to start monitoring with the most solid available indicators. With the improved updating of the Siab, induced by the PMAQ monitoring process, we expect to establish a more consistent database, allowing for the inclusion of new indicators and making this stage of the performance assessment more wholesome.

**Amidst all of this, 47 indicators were selected, and subdivided into seven strategic areas classified according to the nature of their use:**

i. Performance indicators: linked to the external assessment process and will be used for EAB classification, according to their performance;

ii. Monitoring indicators: monitored regularly in order to complement information on the services provided and the results achieved by the team, without, however, influencing the scores awarded to the EAB in the external assessment process. In the next cycles of program implementation, these indicators may be incorporated to the set of performance indicators. Even if one theme only has monitoring indicators its qualification will be evaluated and induced by external assessment and verification during the certification process, thereby contributing so that important issues are not left out of the quality improvement process.

The selected indicators relate to some of the key strategic focuses in primary care (prenatal care, prevention of uterine cervix cancer, child health, systemic arterial hypertension and diabetes mellitus control, oral health, mental health and transmittable diseases) as well as strategic initiatives and programs from the Health Ministry (Stork network, rede cegonha, psychosocial care network, urgency and emergency network), striving for synergy between the PMAQ and the priorities agreed upon by the three government spheres. It is also worth noting that the indicators defined for contracting in the PMAQ are related to the indicators that were historically agreed upon by the Health Pact and with the indicators used for creating the National Health Indicator for the SUS Qualification Assessment Program.
Chart 1 – Summary of the selected indicators

<table>
<thead>
<tr>
<th>Strategic Area</th>
<th>Nature of the Use</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Performance</td>
<td>Monitoring</td>
</tr>
<tr>
<td>1. Woman’s Health</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>2. Child Health</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>3. Diabetes mellitus and systemic arterial hypertension control</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>4. Oral Health</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>5. General Production</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>6. Tuberculosis and leprosy</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>7. Mental Health</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
<td><strong>23</strong></td>
</tr>
</tbody>
</table>

Following are, the 47 selected indicators listed, according to the strategic care and the nature of its use. For greater knowledge regarding the PMAQ indicators, the technical data sheets for each indicator, with a breakdown of the calculation method and sources, as well as its use possibilities, parameters for result interpretation and potential improvement actions for each indicator are presented in an annex to this paper.

1. **Women’s health:**

   **Performance:**

   1.1 Proportion of pregnant women registered by the primary care team;
   1.2 Average amount of prenatal care per pregnant women registered;
   1.3 Proportion of pregnant women that began prenatal care in the first quarter;
   1.4 Proportion of pregnant women with up to date prenatal care;
   1.5 Proportion of pregnant women that are up to date with vaccinations;
   1.6 Ratio between uterus cervix cytopathologic exams at the age of 15 years or more.

   **Monitoring:**

   1.7 Proportion of pregnant women cared for through home visits.
2. Child health:

Performance:

2.1 Average of childcare medical visits;
2.2 Proportion of children under four months old with exclusive breastfeeding;
2.3 Proportion of children under one year old with vaccinations up to date;
2.4 Proportion of children under two years old that are weighed;
2.5 Average of medical visits for children under two years old;
2.6 Average of medical visits for children under five years old.

Monitoring:

2.7 Proportion of children with low birth weight;
2.8 Proportion of children under one year old cared for through home visits;
2.9 Coverage of children under five years old in the Food and Nutrition Surveillance System (Sisvan).

3. Diabetes mellitus and systemic arterial hypertension control:

Performance:

3.1 Proportion of diabetic patients registered;
3.2 Proportion of hypertensive patients registered;
3.3 Average of treatments per diabetic patient;
3.4 Average of medical visits per hypertensive patient.

Monitoring:

3.5 Proportion of diabetic patients followed up on through home visits;
3.6 Proportion of hypertensive patients followed up on through home visits.
4. Oral health:

**Performance:**

4.1 Average of the supervised tooth brushing collective action;
4.2 Coverage of the first programmatic dental appointment;
4.3 Coverage of the first appointment for pregnant women dental care;
4.4 Ratio between treatments completed and first programmatic dental appointments

**Monitoring:**

4.5 Average of dental prosthesis installations;
4.6 Average of dental emergency visits per inhabitant;
4.7 Incidence rates of oral mucosa alterations.

5. General Production:

**Performance:**

5.1 Average of medical visits per capita;
5.2 Proportion of medical visits for ongoing / planned care;
5.3 Proportion of medical visits for a scheduled demand;
5.4 Proportion of immediate medical visits.

**Monitoring:**

5.5 Proportion of medical emergency visits with observation;
5.6 Proportion of referrals for emergency and urgent care;
5.7 Proportion of referrals for specialized care;
5.8 Proportion of referrals for hospital stays;
5.9 Average of tests requested per primary medical visit;
5.10 Average of nurse care;

The Oral Health indicators contracted will only be applicable in situations where EAB participation is attached to an ESB.
5.11 Average of home visits performed by the community health worker (ACS) per registered family;
5.12 Proportion of health condition supervisions by the families benefiting from the Family Support Program (Bolsa Familia).

6. Tuberculosis and leprosy:

Monitoring:

6.1 Average medical visits for tuberculosis patients;
6.2 Average medical visits for leprosy patients.

7. Mental Health:

Monitoring:

7.1 Proportion of Mental Health medical visits, except for alcohol and drug users;
7.2 Proportion of medical visits for alcohol users;
7.3 Proportion of medical visits for drug users;
7.4 Alcoholism prevalence rate.

3.1.4 Criteria for Parameters and Equivalence of the Different Primary Care Organization methods with the Family Health Strategy

Since 1994 The Family Health Strategy has been the Brazilian option for expanding and strengthening primary care. Since then, a significant increase in its coverage has been noticed, as well as global access to services, supplies and public health efforts.

However, many municipalities, especially those located in the central-south region of the country, in the 1990s, already had important Primary Care Networks established, responsible for the care of a significant number of Brazilians. These services that exist in most of the country covering 20% to 40% of the population, depending on the criteria used, are organized in a larger or smaller level according to the AB principles. The fact is that, recognizing
that the ESF did not have a substitution characteristic in these locations, it is necessary for the services to be organized according to the principles of the Primary Care National Policy, qualifying the entire population’s health care.

It is important to state once again that, in order to qualify all of primary care in the country, the Health Ministry considers that for the PMAQ, the Family Health teams are a priority strategy for expanding and strengthening AB in Brazil, but recognizes the need to incorporate primary care teams that have different organization methods into the qualification processes, provided they fulfill the expectations and requirements of the program.

After extensive discussions and a tripartite agreement, the Health Ministry formulated minimum standards so that the EAB organized differently than the ESF may join the National Program for Access and Quality Improvement in Primary Care. The set of parameters built considers minimum core professionals that make up the team and workload.

As described in the PMAQ guidelines, all of the primary care teams participating in the program must organize themselves in order to guarantee the primary care principles, such as the definition of the performance territory of the UBS and the population assigned to the EAB.

In order to define parameters for the PMAQ, participation of the EAB organized differently than the ESF will be subject to registration at the CNES, classifying the graduated professionals according to the following workload ranges.

Chart 2 - Equivalence of the different primary care organization methods with the ESF according to the sum of the minimum workload for doctors and nurses

<table>
<thead>
<tr>
<th>Sum of minimum Medical work hours</th>
<th>Sum of minimum Nurse work hours</th>
<th>Equivalence with the ESF</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 hours</td>
<td>60 hours</td>
<td>1 SF team</td>
</tr>
<tr>
<td>100 hours</td>
<td>80 hours</td>
<td>2 SF teams</td>
</tr>
<tr>
<td>150 hours</td>
<td>120 hours</td>
<td>3 SF teams</td>
</tr>
</tbody>
</table>

A Basic Health Unit that has an amount of medical professionals with an added workload that goes over 150 hours and a nurse workload that goes over 120 hours may conform more
than one EAB. In a situation where the sum of the doctors workload in a UBS reaches 220 hours and the sum of the nurses workload reaches 180 hours, this unit may conform a EAB (150 hours medical hours and 120 nursing hours), which is equivalent to three SF teams, plus an EAB (70 medical hours and 60 nursing hours), which is equivalent to one SF team. Alternatively, this same unit may conform two EAB14, being that each one is equivalent to two SF teams.

Where there are oral health actions and EAB participation is linked to an ESB, the workload for the dental surgeon must be in accordance with the ranges described in the table below.

Chart 3 - Equivalence of the different primary care organization methods with the ESF, according to the sum of minimum work hours for dental surgeons.

<table>
<thead>
<tr>
<th>Sum of the minimum work hours for Dental Surgeons</th>
<th>Equivalence with the ESF</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 hours</td>
<td>1 SF team</td>
</tr>
<tr>
<td>80 hours</td>
<td>2 SF teams</td>
</tr>
<tr>
<td>120 hours</td>
<td>3 SF teams</td>
</tr>
</tbody>
</table>

The transfer value of the Quality Component of the Variable PAB per EAB that is organized differently than the ESF will follow the equivalence described in the charts above. In cases where the EAB is equivalent to three Family Health teams, the municipal manager will monthly receive the amount referring to three EAB of the Variable PAB Quality Component.

**In order to establish parameters, the EAB composition must also meet the following rules:**

I – The Medical professionals that will be considered for the makeup of the team are:
   i. Generalist;
   ii. Clinical;
   iii. Pediatrician;
   iv. Obstetrician-gynecologist.

II – The presence of a generalist or clinical doctor will be obligatory, and the sum of the workload for these professionals should be equal to or greater than that of other

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14 In this case, the distribution of medical and nurse workloads per EAB may be done through different methods. Sample: (a) two teams with 110 medical work hours and 90 nursing work hours; (b) a team with 100 medical work hours and 80 nursing work hours and another with 120 medical work hours and 100 nursing hours; etc.
medical professionals. For demographic reasons, the need for doctors caring for the adult population (generalist or clinical) is greater than that of doctors caring for children (pediatrician) and specific aspects related to women sexual and reproductive health (obstetrician-gynecologist);

III - The presence of an obstetrician-gynecologist is optional and when there are none on the team, all of the care actions for women’s health will be carried out by a generalist and / or clinical doctor and nurse, together;

IV - The generalist and clinical doctors as well as the pediatricians ,nurses and dental surgeons, should, individually, have a minimum workload equal to 20 weekly hours;

V - When the gynecologist-obstetricians professionals are present in the team, they should individually have a minimum workload of 10 weekly hours.

Each team may have different population ranges designated, and this should be associated with the workload of these professionals. The city manager must define the population under the responsibility of each team and based on this definition, the population must be registered ,and the Siab should begin to be regularly and consistently updated with the information necessary for monitoring actions performed.

As previously mentioned, the EAB must also register the designated population and update the Siab with this information as a condition for remaining in the PMAQ, considering that most of its indicators will be calculated based on the registry. However, for this type of AB, the registration data may be entered into a single micro-area and does not necessarily need to be linked to an ACS, but to any professional in the primary care team.

The same professional may be linked to two UBS and up to two different municipalities as long as their overall workload does not exceed the limits established by the sector regulation.
In regards to the population designated to each primary care team, for this program the Health Ministry will consider the designated population range related to the composition of the medical and nurse workload, as described in the following chart:

Chart 4 - Reference designated population ranges for the primary care organizational methods that differ from the ESF, according to the sum of the minimum workload for dental surgeons

<table>
<thead>
<tr>
<th>Sum of the minimum Medical workload</th>
<th>Sum of the minimum workload for Nurses</th>
<th>Reference designated population Ranges (Inhabitants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 hours</td>
<td>60 hours</td>
<td>Minimum 3.450</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maximum 7.000</td>
</tr>
<tr>
<td>100 hours</td>
<td>80 hours</td>
<td>Minimum 7.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maximum 10.000</td>
</tr>
<tr>
<td>150 hours</td>
<td>120 hours</td>
<td>Minimum 10.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maximum 15.000</td>
</tr>
</tbody>
</table>

3.1.5 Limits for Program Participation and Contract Signing\(^{15}\)

Due to the timeline for logistical, administrative and budget progress for the National Program for Access and Quality Improvement in Primary Care, in the first implementation year, limits per municipality for participation in 2011 (corresponding to the 2011-2012 period) will be defined establishing percentages of primary care teams that may participate in the program, considering the number of teams from the Family Health Strategy.

For the first six months, the total number of EAB that may join the PMAQ will be 17,664, and 14,590 for Oral Health. Since there is not precise information regarding the number of EAB that are organized differently than the ESF, the number of Family Health teams present in the municipality will be considered in order to define the participation limits per municipality.

Each municipality may have 50% of its Family Health teams join the program. Sample: a city with 24 SF teams and 5 EAB that are organized differently may have 50% of their SF teams join the program. In this case, the participation limit for this municipality shall be 12 of its 29 teams. When 50% results in a fraction number, the higher number will be considered.

\(^{15}\) Due to the Tripartite Inter-management Commission on August 25th, 2011, the rules that define the limit for primary care teams participating in the PMAQ initially have been changed.
In cases where the ESF coverage is equal to zero, the municipality may have one EAB participate and the municipalities with only one Family Health team may make this team participate.

3.1.6 Steps for Program Participation with the Program Management System of Primary Care Department (SGDAB)

PMAQ participation will be formalized by the Program Management System of Primary Care Department (SGDAB) and will follow the following steps:

i. The municipal manager must access the Primary Care Department website at www.saude.gov.br / dab, and enter into the Program Management System of Primary Care Department (SGDAB);

ii. In the SGDAB, he must select the National Program for Access and Quality Improvement in Primary Care;

iii. Next, he must register the user responsible for managing the program in the municipality, by selecting the correct State and municipality, amongst the options presented;

iv. The next step will be visualizing the set of indicators that will be contracted by the municipality. At this stage, at the discretion of the municipal manager, the goals for the set of indicators\(^\text{16}\) may be agreed upon;

v. Then the manager must allow the primary care team(s) in his municipality to begin the participation and contracting phase;

v. After the EAB permission, the manager should identify the main challenges for qualifying primary care in the municipality. This information will be critical to the organization and planning of the actions that will be undertaken by the state and federal managers, with the objective of supporting the primary care qualification process.

\(^{16}\) Agreeing on goals is not obligatory and should be performed in situations where the municipal manager sees the need and /or importance in previously defining the goals for part or all of the indicators. It is important to note that achieving or not the goals agreed upon will not be a criteria for team certification. As may be observed in item 3.3.2 of this Instructional Manual, the certification criteria will consider the team’s performance in regards to the rest of the category which is also considered in the external assessment.
II – Primary Care Team Participation and Contracting:

i. After the municipal manager’s expressions of interest and the permission for team participation and contracting, each EAB that is interested in participating in the program should access the DAB website, at www.saude.gov.br / dab, and access the Program Management System of Primary Care Department (SGDAB);

ii. In the SGDAB, the EAB shall select the National Program for Access and Quality Improvement in Primary Care;

iii. Then, the EAB must register the user responsible for the team by selecting the correct State, municipality and team, amongst the options presented\(^{17}\);

iv. After completing the registration, the EAB will view the set of formalized indicators. If defined by the municipal manager, at this stage, the teams should agree upon goals for the set of indicators\(^{18}\);

v. The next step will be pointing out, from the perspective of the EAB professionals, the main challenges for qualifying the services offered by the team. This information will be critical to the organization and planning of actions that will be undertaken by municipal, state and federal managers, in order to support the qualification process of primary care;

vi. Finally, the team should, in the SGDAB, generate the electronic file with the Commitment Term (TC), which is the formalization of its participation and contracting within the PMAQ, and forward the document, signed by the person responsible for the team, to the municipal manager\(^{19}\).

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\(^{17}\) It is also important to highlight that only the teams that are regularly registered in the CNES may be registered, contracted and participate.

\(^{18}\) Just as with the municipal management, Agreeing on goals is not obligatory and should be performed in situations where the municipal manager sees the need and /or importance in previously defining the goals for part or all of the indicators.

\(^{19}\) This Phase may also be done through the SGDAB, generating the electronic file with the TC signed by the person responsible for the team and digitalized in PDF format.
III – Participation and Contracting of the Municipal Manager:

i. As the EAB perform their registration and begin the participation process, the municipal manager will be able to visualize the information regarding which EAB has performed this step on the SGDAB screen;

ii. Once the deadline set by the municipal manager has been finalized for the participation and contract signing of the EAB in their municipality, he must list all of the teams that showed interest in participating in the program in order of priority, defining if there is a greater number of interested teams than that stipulated by the criteria for participation limits per municipality, defining the EAB that should be approved initially and those that will remain on standby for a possible future approval if the national participation is below the previously defined number;

iii. Then, the municipal manager must electronically generate the TC for EAB, signed and scanned in PDF format, at the “Load Commitment Term” option on the SGDAB. This electronic generation should be done on the specific field for each team\(^{20}\) and respect the EAB limits for those that may initially join the program;

iv. Finally, the manager should, in the SGDAB, generate the electronic file with the Municipal Commitment Term (TC), which is the formalization of his participation and contracting within the PMAQ, and generate the digital document, in PDF format, in the “load Commitment Term” signed by the Municipal Health Secretary, in the SGDAB.

After finalizing the municipality’s participation process, the Health Ministry (MS) will consider whether the electronic documentation is according to the rules defined and will then

\(^{20}\) The electronic document with the Commitment Term, signed and digitalized, from the team (s) may also be performed per team.
go on to approving the municipality and its respective teams. In cases where the documentation is considered invalid or inconsistent, the MS will contact the municipality and request them to adequatethe documentation.

**3.2 Development**

The second phase of the PMAQ consists in the development stage of the set of actions that will be undertaken by the primary care teams, by the state and municipal management and the Health Ministry in order to promote the management, care and care management changes that will improve the access and quality of primary care.

This phase is organized into four dimensions:

1 - Self-Assessment;
2 - Monitoring;
3 - Continual education, and
4 - Institutional support.

**3.2.1 Self-Assessment**

Self-assessment is the starting point for the development phase, since the processes focused on quality improvement must begin by the team’s identification and recognition, of the positive dimensions as well as their work problems, producing purposes that may potentially become facilitators mobilizing change initiatives and improvement.

Assessing may mean formulating opinions and issuing judgment value regarding a certain issue. And often, the assessment topic is associated to negative aspects such as punishment and elimination of those who did not achieve a certain result. The PMAQ seeks to contribute to overcoming these aspects and considers self-assessment a tool for stimulating the collective group to analyze their work process and think about ways to change it in order to overcome problems and achieve objectives agreed upon by the
same group. It is a process that aims to constantly guide decision making processes, establishing itself as a central action for improving the quality of health.

In the program, it is recommended that self-assessment is done through a tool made up of a set of quality standards, and a set of statements regarding the quality expected for the structure, the processes and results of the primary care actions, thus becoming a tool with educational potential and a problem-solving reflective characteristic, that enables building solutions based on the identification of problems.

Considering the complexity and inherent relativity in the quality concept, which varies according to the historical, political, economic, scientific and cultural context of society (UCHIMURA & Bosi, 2002), it is important that the self-assessment tool used takes into account the different points of view of those involved in healthcare - users, managers and professionals - understanding that all are jointly responsible for the qualification of SUS.

Self-assessment processes must not only be based on problem identification, but also through conducting interventions for overcoming them. It is not possible to intervene in all that seems necessary - considering time, resources, political issues etc. - It is vital that investment priorities are established, so that through identifying priorities, actions and strategies may be built with concrete initiatives for overcoming the problems identified. Thus, self-assessment processes committed to continual quality improvement may leverage the other processes in the development phase of the PMAQ, as it will, among other things, contribute to identifying the greatest needs for continual education and institutional support. In this sense, self-assessment should not be looked on with small importance, nor as a distressful moment that may result in punishments or workers loosing motivation.

At the same time, so that it may be considered a critical-reflexive action, it is important for the self-assessment to be performed between pairs, collectively, considering all of those involved in primary care in its various areas. Based on the result of the self-assessment, situations that need to be revised and / or modified will be identified.

Considering all of this, the DAB will provide a self-assessment tool - Self Assessment for Access and Quality Improvement of Primary Care (AMAQ) - built from reviewing and
adapting different tools used and validated nationally and internationally. It is important to note that the tools offered by the Health Ministry may be combined with others, and it is up to the municipal managers and primary care team(s) to define the instrument(s) or tool(s) that suit their need and reality.

Its development was guided from the principle that all primary care services may use it.

**The AMAQ tool was also built considering the following guidelines:**

I – To reflect the core objectives and guidelines of the National Program for Access and Quality Improvement in Primary Care;

II – Be capable of promoting reflections regarding responsibilities, both in regards to the organization method as well as with the working practices of those involved in the municipal management and primary care teams, in order to promote quality access to the services provided;

III - Encourage the effective change in the care model and strengthening the service focus towards users needs and satisfaction;

IV - Reflect quality standards that are incremental, where suitability of the situation analyzed is performed through a numeric scale, and

V – And permit the quantification of self-assessment responses so as to enable the establishment of overall quality scores.

Based on these elements, AMAQ was organized in dimensions and sub dimensions for a set of quality standards covering what is expected regarding quality in management and in direct health care in primary care. These quality standards are characterized by their scope, referring to a broad view of the system and the health actions and being capable to evidence changes - both advances and setbacks. However, it is important to highlight that AMAQ does not intend to exhaust the entire universe of primary care practices, however, it
consists of a certain set of actions that are considered strategic and potential for generating changes in the daily services.

In order to systemize the quality improvement actions, it is suggested that action plans be built, initially covering less complex problems that are under the responsibility of a specific person.

In order to contribute with the organization process for using the AMAQ, the primary care team may register the results of their self-assessments and action plans for dealing with the weaknesses identified, in the SGDAB. The goal of this strategy is to enable teams to monitor the implementation of the intervention plan, as well as the progressive analysis of the self-assessment results.

There is no defined frequency for performing self-assessments. However, between one and another there must be sufficient time to perform some actions towards quality improvement. Said differently, it is essential that the time interval between two self-assessments allows for the performance of part of the action plan so that when the self-assessment is repeated, the teams are already capable of identifying not only the obstacles, but also the results of their interventions.

Finally, it is important to recall that the performance of self-assessments from time to time, with the help of structured instruments, does not exclude the existence and importance of everyday “evaluation practices”, not always done consciously or in a planned out manner, which can also mobilize the workers towards the improvement of their practices.

3.2.2 Monitoring

In the development phase of the PMAQ, the monitoring of the contracted indicators is an essential element for the implementation of the program.
The monitoring of the indicators is focused on:

I - Guiding the process of negotiation and goal and commitment contracting between the EAB and the municipal manager, as well as between this and the other SUS managerial levels;

II - Subsidize the priorities and scheduling of actions to improve the quality of the AB, both for the participating teams as well as for the managers in the three government spheres;

III - Promote institutional learning by identifying and prioritizing challenges for improving the quality of AB, the acknowledgement of the achieved results and the effectiveness or improvement need of the intervention strategies;

IV - Promote the democratization and transparency of the AB management and strengthening of the users participation through advertising targets, quality standards and results, and

V - Strengthen the health responsibility and role of those involved, through revealing both the successes and weaknesses, and motivating the health teams and managers from AB to meet the challenges.

It is also important to note that in the course of improving the quality of AB, achieving good results in the quality indicators and standards entails the constant monitoring, for a priority diagnosis for continual education, institutional support and programming and contracting work process improvement actions.

Regarding the primary care teams work, the use of information is an essential element for care management, as the first step for the organization of a team’s work process should be the home registration and development of a situation analysis that will guide the team’s actions for dealing with health problems. This diagnosis should guide the planning and programming of actions agreed upon with the community, and the actions implemented by the team should be monitored and assessed systematically, aiming towards the continual improvement of work processes.
The municipal management and the EAB, with the goal of promoting the broadening of access and quality improvement, will promote the improvement of the indicators and the team’s performance in the primary care quality standards. They need to offer a set of actions that are compatible with the health needs of the population with satisfactory quality, reflecting the results of this effort in the indicators and quality standards that will be evaluated, as well as in terms of user satisfaction.

For the Health Ministry, the systematic monitoring of what has been achieved by the teams will allow for a review of the scope of the minimum results in the formalized indicators. Considering that the regular and consistent updating of the information systems is a general responsibility of all professionals and managers in the SUS and an important AB quality criteria, it is expected that the results in the indicators reflect to some extent the efforts of the health teams and management to improve AB quality, and there should be consistency between the team’s performance in the indicators and compliance of their actions with the quality standards associated to good primary care practices.

Moreover, as will be presented later, the team’s performance for all of the contracted indicators will make up one part of the external assessment for quality assurance of the AB teams. For each performance indicator, a score proportional to that achieved by the team, will be calculated, comparing the results obtained with the minimum standards and / or with averages for their municipality, State, region, Brazil and / or level of municipalities it belongs to, as defined in section 3.3.3, in the same period.

In regards to the local monitoring processes for AB, some assumptions may be useful to guide its design, implementation and improvement. Among them we may highlight:

I - Have a formative, educational and practice reorienting nature, with an approach in which information may produce change in the action. The monitoring process should not be understood as an end in itself or only as the fulfillment of a merely formal commitment, but as a mechanism that is capable of producing change, generating proposals for improving the quality of the actions and processes monitored, besides promoting institutional learning and accountability;
II - Subsidize the AB management, incorporating information regarding performance in the decisive processes and aligning the monitoring, planning, continual education and institutional support processes;

III - Avoid linking the monitoring processes to punitive consequences that reinforce resistance, resulting in misrepresentation or unnecessary tensions that hinder the appropriation of results and compromise the professional’s interest and motivation to adequately update the information systems;

IV – Acknowledge the success of the teams that have good performance, encouraging them in their search for better results;

V - Permit the identification of successful experiences and create opportunities for horizontal cooperation between the teams, promoting recognition between pairs and solidarity relations rather than competition for best results;

VI - Have mechanisms that ensure democratic participation of those involved, constituting a negotiation and agreement process between those sharing co responsibilities;

VII - Establish mechanisms for systematic disclosure of results regarding the AB monitoring process, focusing on the democratization and transparency of these processes, institutional learning, recognition of the results achieved and facing the challenges for improving AB quality.

3.2.3 Continual Education

The consolidation and improvement of primary care as an important aspect for reorienting the health care model in Brazil requires knowledge and continual education that are embodied in the actual practice of health services. Continual education must be constitutive, therefore, qualifying the care, management and popular participation practices.

The redirecting of the care model clearly establishes the need for permanent transformation of the services functioning and the team work processes, requiring from those
participating (workers, managers and users) greater analysis, intervention and autonomy capacity for the establishment of transformational practices, change management and closer links between conception and work performance.

In this sense, continual education, in addition to its obvious pedagogical dimension must also be seen as an important “management strategy”, with great potential for provoking changes in daily services, in its micro policy, which is very close to the actual effects of health practices in the lives of the users, and as a process that takes place “at work, for the work and benefiting work.”

Continual education must be based on a long educational process that includes the acquisition / update of knowledge and skills as well as learning from the problems and challenges faced in the work process, involving practices that may be defined by multiple factors (knowledge, values, power relations, planning and work organization, etc..) and consider the elements that make sense to those involved (meaningful learning).

Another important assumption of continual education is the ascending education planning / scheduling, which, through the collective analysis of work processes, identifies the critical obstacles (various kinds) to be faced in care and / or management, enabling the construction of contextualized strategies that promote dialogue between the general policies and the uniqueness of the places and people, encouraging innovative experiences in care and health service management.

Linking the processes of continual education to the strategy of institutional support can greatly enhance the development of management and care skills in primary care, as it increases the alternatives for dealing with the difficulties experienced by workers in their daily lives. Along the same lines, it is important to diversify the repertoire of actions incorporating assistive devices and horizontal cooperation such as exchanging experiences and discussing situations between workers, practice communities, study groups, matrix support moments, visits and systematic studies of innovative experiences etc.
Finally, recognizing the ascending character and initiative of continual education, it is important that each team, each health unit and each municipality demand, propose and develop continual education actions trying to match unique needs and possibilities with more general offers and processes of a policy proposed to all of the teams and the entire municipality. It is important to tune in and mediate the pre-formatted options for continual education (courses, for example) with the timing and context of the teams, so that they make more sense and therefore have higher use value and effectiveness.

Similarly, the state and federal governments support and articulation for municipalities is important, seeking to answer their needs and strengthen their initiatives. The reference is more related to support, cooperation, qualification and providing various initiatives for different contexts rather than the attempt to regulate, format and simplify the diversity of initiatives.

3.2.4 Institutional Support

Institutional support should be thought of as a management function that seeks to reformulate the traditional way of supervising health. Traditional supervision, generally, reduces role players to executors, prioritizes checking, prescription and the norm rather than the problematical exchange, relying more on discipline and framework than in freedom with commitments and in increasing another’s action capacity.

However, institutional support implies a specific way to manage collectives / teams, linked to rationales that are not restricted to instrumental reasoning. While supervision operates capturing live work, support seeks to empower it, obviously paying attention to its use direction. Institutional support seeks to assist teams with the task of putting their work and their practices into the analysis, on one hand, and the construction / testing of interventions on the other. Helping teams to explicit and deal with problems, discomforts and conflicts, as well as assisting in the construction and use of tools and technologies. Rather than denying or repressing, the institutional supporter recognizes the complexity of the work and takes the concrete problems, challenges and tensions of everyday life as raw working material, seeking, whenever necessary, to facilitate the transformation of paralyzing situations into productive situations.
Institutional health support must seek institutional democracy, the expansion of the level of personal autonomy, the defense of life and the principles and guidelines of the SUS. The revelation and analysis of problems and difficulties of the teams / collectives that are supported must be linked to an effort of empowering teams and their experiences, avoiding blaming, powerlessness and irresponsibility. Thus, the actual practice of support always requires a certain level of sensitivity, openness to be affected and at the same time, capacity to affect and mobilize.

Thus, institutional support can be done at the municipal, state and federal levels, and the development of institutional support actions must have a shared characteristic and must be built based on the realities and peculiarities of each area, as well as requiring planning, ongoing assessment and agendas for continual education for the development of the managerial, educational and matrix dimensions performed by the supporters. It is vital to have proper dimensioning of the number of teams per supporter, reinforcing the need for building a bond between them that can be increased through the construction of communication strategies and agendas for regular meetings.

The centrality of institutional support within the PMAQ is strongly associated with the idea that the efforts of management and health care performed by managers and workers in primary care teams in order to qualify what is offered to the population, should be incremented through the union of diverse experiences and knowledge in areas of widespread communication that may enhance the results produced by the work of these members. The supporter should help teams analyze their own work and produce alternatives for facing all the challenges.

PMAQ includes the following institutional support strategies: from the Health Ministry to the state coordination of primary care, Cosems and municipalities (eventually) ; from the state coordination of primary care to the management of primary care in the municipalities, and from the municipal management to the health teams.

In these dimensions, there are at least three spheres present, namely: (a) The inter federal relations (b) Concerning the design and coordination of primary care in other care units
in the network, as well as the care segments, and (c) that which refers to the work process of the teams and the micro policy of everyday life.

It is important to consider that despite the fact that the institutional support is the same for the three support dimensions described (Health Ministry, state coordinators and municipal management), there are certain characteristics that mark each one of them, so that the three spheres (inter federal relationships, network arrangements and daily work processes of the teams), although always present, will have different weights or emphasis, depending on the location of the supporter and of those supported. For example, when supporting health teams, plans two and three (in particular) tend to be more striking.

Below, are some examples of actions that can be carried out by supporters:

I - Discussion and set up of team agendas while devices organize and guide the everyday collective work regarding the needs and health priorities;

II - Supporting the implementation of caring for a spontaneous demand;

III - Support building natural therapeutic projects, from cases or situations that mobilize and challenge the team;

IV - Support the implementation of devices for qualifying clinical, care management and resource regulation of the network resources based on the UBS team;

V - Facilitating the organization of inter sector interventions;

VI - Analysis of indicators and health information;

VII - Facilitating local planning processes;

VIII - Mediating conflicts, seeking to help in the creation of joint projects between
workers, managers and users, without attempting to eliminate differences and tensions, but seeking to enrich the processes through uniting differences, the effort of listening/dialoguing, the conversion of paralyzing crises to productive crises and building united projects;

IX - Joining matrix support actions to the NASF and other network services. Although the examples mentioned give greater emphasis to institutional support for primary care teams, a lot of the information also applies to state and municipal management support.

3.3 External Assessment

The third phase of the National Program for Access and Quality Improvement in Primary Care is the external assessment, where a set of actions will be performed in order to ascertain the access and quality conditions of all the municipalities and primary care teams participating in the program. This phase is subdivided into two dimensions:

I – Performance certification of the primary care teams and municipal management participating in the PMAQ: assessment of the access and quality of the EAB participating in the PMAQ, by monitoring the formalized indicators and verifying a set of quality standards at the team’s performance locations;

II – Assessment of the access and quality of primary care that is not related to the certification process: consisting of an assessment process that includes the assessment of the local health care system by the teams of primary care and complementary processes for evaluating user satisfaction and service use.

The whole external assessment process in the PMAQ will be conducted by educational and/or research institutions hired by the Health Ministry to develop the field work, by applying different assessment tools.

3.3.1 Certification of the Primary Care Teams

The certification process for primary care teams should be understood as a moment of recognition for the efforts for improving the access and quality of AB developed by the
participating teams and the municipal manager. At the same time, the objective of the team’s certification process is not limited to the recognition of those who have high quality standards, but also those developing actions to strengthen management and work processes focused on improving quality.

Considering that the concept of quality varies according to the historical, political, economic and cultural context and knowledge accumulated on the topic, it is expected that the PMAQ be constantly improved, so as to include, progressively, the diversity of scenarios were it will be implanted; the need for adapting the criteria, parameters and assessment and management tools, focusing on the new demands and challenges of the Primary Care Policy as well as the historical moment of the SUS implementation, and the need for reviewing concepts, methodologies and tools based on institutional learning regarding the PMAQ implementation with the collaboration of those involved.

At each program cycle, new quality parameters can be defined, leading to advances in what is expected in terms of developing the management, team and scope of the population’s health results.

When joining the PMAQ, the deadline for the municipality to request the external assessment, through the Program Management System of Primary Care Department, will be two to six months, counted from the date of the ordinance publication approving the municipality and primary care team (s) participation in the program. For the year 2011-2012, we have an exceptional situation, due to the logistical, administrative and budget schedule for the program’s first implementation year, for all municipalities, the external assessment will take place six months after joining the program.

Starting from the second cycle of program implementation, the primary care team will be evaluated every 18 months.

Exceptionally, in the first implementation year of the PMAQ, the external assessment, for all the participant municipalities, will occur six months after joining the program, and the rule for requesting assessment between two and six months does not apply.
The request for external assessment shall be subject, to the above criteria for remaining in the program and for information, to the CIR, CIB and CMS, to updating the SGDAB, to a set of information regarding the EAB practices in situations where these practices have a higher degree of subjectivity and variability regarding how they may be developed. The system will enable each EAB to describe based on standard forms, how actions are developed such as health care and diagnosis. This information will be essential to guide the work of the external evaluator, who will verify if what was stated is equal to that observed at the teams work location.

It is worth noting that the external assessment will occur with all teams participating in the municipality. Therefore, in municipalities with more than one team participating in the program, it will not be possible to request the team’s external assessment at different moments.

Regarding the verification of quality standards at the team’s work location, the external assessment process will consist of the application of an instrument composed of a set of quality standards, aligned with the AMAQ standards, and their respective verification forms which represent or reflect the expected quality.

The external assessment instrument will be organized into four broad dimensions and 12 sub dimensions, which consist in the analysis guidelines of the quality standards.

Unlike the self-assessment (based solely on responses from those evaluated), the certification will be mainly based on evidence found through documents (summaries, reports, tools, charts, etc.), from direct observation and other verifiable sources. It is worth noting that the selection of elements that evidence compliance with the quality standards also considers local solutions and innovations that meet the objectives linked to the standards, especially those related to work processes, not limiting the creativity and pro-activity of the teams and municipal management.
<table>
<thead>
<tr>
<th>Analysis Unit</th>
<th>Dimension</th>
<th>Subdimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestão Management</td>
<td>Municipal Management</td>
<td>Implanting and implementing primary care in the municipality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organization and Integration of the health care network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participation, social control and user satisfaction</td>
</tr>
<tr>
<td></td>
<td>Primary Care Coordination</td>
<td>Institutional Support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Permanent Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitoring Management and evaluation– M&amp;A</td>
</tr>
<tr>
<td></td>
<td>Basic Health Unit</td>
<td>Infraestrutura e equipamentos</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inputs , immunobiologics and medication</td>
</tr>
<tr>
<td>Teams</td>
<td>Profile, work process and health care</td>
<td>Team Profile</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organization of the work process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comprehensive Health Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participation, social control and user satisfaction</td>
</tr>
</tbody>
</table>

3.3.2 Criteria for Primary Care Team Certification

The primary care teams will be certified, according to their performance, considering three dimensions:

I - Implementation of self assessment processes;

II - Verification of the performance achieved for the set of contracted indicators;

III - Verification of evidence for a set of quality standards.
In the certification process, the final score for each team will be composed of the following distribution.

**Chart 6 - Percentage of the final certification score, according to the dimension**

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Percent of the Final Certification Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I – Implementing self assessment processes</td>
<td>10%</td>
</tr>
<tr>
<td>II – Verifying the achieved performance for the set of contracted indicators</td>
<td>20%</td>
</tr>
<tr>
<td>III – Verifying evidence for a set of quality standards</td>
<td>70%</td>
</tr>
</tbody>
</table>

Based on the understanding that the implementation of self-assessment processes is of utmost importance to improving the quality of management and health care, 10% of the final certification score for the primary care team will be linked to self-assessment performance, regardless of the outcome.

From the results obtained for the set of formalized indicators, the EAB may receive up to 20% of the final certification process score, and according to its performance, regarding the set of quality standards observed at the teams work location, the teams may receive up to 70% of the final score.

Certification will be guided by criteria, which allows for comparability between each team’s performance, through verifying the performance averages, considering the three dimensions defined. But, considering the diversity of socioeconomic, epidemiological and demographic scenarios between the Brazilian municipalities, the differences of the participating municipalities and the specific responses demanded from the local health systems and the EAB will be considered in the evaluation. In this sense, for the classification of the team’s performance, each municipality will be distributed in different levels defined based on a fair criteria, and their team’s performance will be compared to the average and the standard deviation of all the teams participating in the same category.
From the external assessment, the primary care teams may be classified into four categories:

I - Unsatisfactory performance: when the result achieved is less than -1 (minus one) standard deviation of the average performance of the teams participating in their category;

II - Regular Performance: when the result achieved is less than the average and greater than or equal to -1 (minus one) standard deviation of the average performance of teams in their category;

III – Good performance: when the result achieved is greater than the average and less than or equal to +1 (plus one) standard deviation of the average performance of teams in their category, and

IV - great performance: when the result achieved is greater than +1 (plus 1) standard deviation of the average performance of teams in their category.

Starting from the second certification cycle, each team’s performance will be compared not only to other teams, but also regarding their development between one certification and another. This aspect will allow for the team’s analysis with itself over time, considering the progress of their performance in quality improvement efforts undertaken since joining the program.

Once the team is certified, the municipal manager will receive different amounts than that of the Quality Component Variable PAB, according to performance.

In cases where the team is classified as unsatisfactory in the certification process, the municipal manager will not get the incentive value related to that team and they, the local team and manager, will have to take on an adjustment term.

In situations where the team is classified as regular, the manager will continue receiving 20% of Quality Component Variable PAB (R $ 1,300.00), but the team will also have to sign an adjustment term for contract renewal.
After the certification process, the municipalities will receive the value related to the Quality Component Variable PAB, according to their team(s) development, retroactively, counting from the competence month of the request for external assessment.

When the team is classified as good, the value passed on will be 60% of the Quality Component Quality Variable PAB (R $ 3,900.00) and, when classified as excellent, the transfer will be 100% of the Quality Component (R $ 6,500.00).

3.3.3 Criteria for Categorizing the Municipalities for the Primary Care Team Certification Process

In order to ensure greater fairness in the comparison of EAB in the certification process, the municipalities will be divided into categories that consider social, economic and demographic aspects.

An index ranging from zero to ten was created, composed of five indicators:

1 - Gross domestic product (PIB) per capita;
2 - Percentage of the population with health insurance plans;
3 - Percentage of the population with the Bolsa Família (Family support) program;
4 - Percentage of the population in extreme poverty;
5 - Population density.

The PIB per capita used was from 2008, provided by the Brazilian Institute of Geography and Statistics (IBGE). Due to the large disparity between the lowest and highest value, a normalization technique was used to assign a zero through five score for half of the municipalities that receive the lowest PIB per capita. The other half received a score distributed from five to ten.

The data on population density was also provided by IBGE and just as with the PIB, this indicator showed considerable variability between the lowest and highest value. For this reason it was necessary to use the same normalization technique to assign the scores for that indicator.
Data regarding the population that has health plans, by municipality, is from 2009 and was provided by the National Health Agency. Each municipality received a zero to ten score, according to the percentage of people with health plans.

The percentage of the population in extreme poverty has been calculated by the IBGE, based on preliminary universe of the census 2010. Each municipality received a score from zero to ten, according to the percentage of people who are not in extreme poverty.

In turn, the percentage of the population receiving the Bolsa Familia (Family Support) was informed by the Ministry of Development and Fight against Hunger based on the year 2010. Each municipality received a zero to ten score, according to the percentage of people who do not receive the Bolsa Familia.

To make up the index, the five indicators were given different weights, and for each municipality the lowest score between the percentage of the population with the Bolsa Familia and the percentage of the population in extreme poverty, was considered.

Chart 7 - Weight of the indicators for the composition of the municipality category index

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross domestic Product per capita</td>
<td>2</td>
</tr>
<tr>
<td>Percent of the population that has a health plan</td>
<td>1</td>
</tr>
<tr>
<td>Percent of the population that participates in the</td>
<td>1</td>
</tr>
<tr>
<td>Bolsa Familia (Family Support) program</td>
<td></td>
</tr>
<tr>
<td>Percent of the population in extreme poverty</td>
<td>1</td>
</tr>
<tr>
<td>Demographic density</td>
<td>1</td>
</tr>
</tbody>
</table>

The municipalities were divided into six categories, according to their total scores and population size21:

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21 Information regarding each municipality’s category will be available on the DAB website.
Chart 8 – Category criteria for municipalities

<table>
<thead>
<tr>
<th>Category</th>
<th>Category Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Municipalities with scores lower than 4,82 and population up to 10 thousand inhabitants</td>
</tr>
<tr>
<td>2</td>
<td>Municipalities with scores lower than 4,82 and population up to 20 thousand inhabitants</td>
</tr>
<tr>
<td>3</td>
<td>Municipalities with score lower than 4,82 and population up to 50 thousand inhabitants</td>
</tr>
<tr>
<td>4</td>
<td>Municipalities with scores between 4,82 and 5,4 and population up to 100 thousand inhabitants; and municipalities with scores lower than 4,82 and population between 50 and 100 thousand inhabitants</td>
</tr>
<tr>
<td>5</td>
<td>Municipalities with scores between 5,4 and 5,85 and population up to 500 thousand inhabitants; and municipalities with scores lower than 5,4 and population between 100 and 500 thousand inhabitants</td>
</tr>
<tr>
<td>6</td>
<td>Municipalities with population levels over 500 thousand inhabitants or with scores equal or over 5,85</td>
</tr>
</tbody>
</table>

3.4 Contract Renewal

The fourth phase of the PMAQ includes the contract renewal process that must occur after the EAB certification. Based on the each team’s performance assessment, a new contracting process with commitments and indicators should be performed, completing the quality cycle expected by the program.

In this phase, agreements between teams and municipalities with new standards and quality indicators, encouraging the institutionalization of a systematic and cyclical process based on the results achieved by the PMAQ participants.

Based on the results achieved by the teams, it will be possible to identify tendencies that will guide the construction of new categories that take into account the reality of the regions, the location area of the UBS and other issues that will increase the possibility of comparisons that are fairer.
Team performance may also be compared not only to that of other teams but also with its progress, ensuring that the work undertaken by managers and workers may be considered in the certification process.
References


Colofão
Informações da Gráfica.