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Situational strategic planning drawn up in a family health unit: an experience report

ABSTRACT | This article aims to report the development of a Situational Strategic Planning (PES) carried out by resident professionals. This is an experience report where the meetings held for the preparation of the PES started on October 1, 2016 and took place until January 31, 2017. Data were collected from October to November 2016 in six moments , used as methodologies the strategies of conversation circles and dialogued exposition. The high rate of patients with arterial hypertension and diabetes mellitus was the result found, having as a discourse the guarantee of full monitoring of this aforementioned public and the low adherence to hypertension and diabetes mellitus consultations. For resident professionals, the performance of the PES was essential for professional training, since this work tool aroused a reflection on the forms of assistance provided by Primary Care professionals.
Keywords: Health planning; Basic Attention; Chronic diseases.

RESUMEN | Este artículo tiene como objetivo informar del desarrollo de una Planificación Estratégica Situacional (PES) realizada por profesionales residentes. Se trata de un relato de experiencia donde las reuniones realizadas para la elaboración del PES comenzaron el 1 de octubre de 2016 y se llevaron a cabo hasta el 31 de enero de 2017. Se recolectaron datos de octubre a noviembre de 2016 en seis momentos, se utilizaron como metodologías las estrategias de los círculos de conversación y exposición dialogada. La alta tasa de pacientes con hipertensión arterial y diabetes mellitus fue el resultado encontrado, teniendo como discurso la garantía de un seguimiento completo de este público mencionado y la baja adherencia a las consultas de hipertensión arterial y diabetes mellitus. Para los profesionales residentes, la actuación de los SPE fue fundamental para la formación profesional, ya que esta herramienta de trabajo suscitó una reflexión sobre las formas de atención que prestan los profesionales de Atención Primaria.
Palabras claves: Planificación de la salud; Atención básica; Enfermedades crónicas.

RESUMO | Este artigo tem como objetivo relatar a elaboração de um Planejamento Estratégico Situacional (PES) realizado por profissionais residentes. Trata-se de um relato de experiência onde os encontros realizados para a elaboração do PES iniciou no dia 1 de outubro de 2016 e se deu até 31 de janeiro de 2017. Os dados foram coletados nos meses de outubro a novembro de 2016 em seis momentos, utilizou como metodologias as estratégias de rodas de conversa e exposição dialogada. O alto índice de pacientes com hipertensão arterial e diabetes mellitus foi o resulto encontrado, tendo como discursão a garantia do acompanhamento integral deste público supracitado e a baixa adesão as consultas de hipertensão arterial e diabetes mellitus. Para os profissionais residentes a realização do PES foi essencial para formação profissional, visto que essa ferramenta de trabalho despertou uma reflexão sobre as formas de assistência prestada pelos profissionais da Atenção Básica.
Palavras-chaves: Planejamento em saúde; Atenção Básica; Doenças Crônicas.

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INTRODUCTION

Planning is defined as a situational strategy characterized as a flexible method, capable of quickly adapting to local needs through the definition of problems and determinations of their causality and consequence.[1]

The Situational Strategic Planning (SSP) model appears in the broader scope of economic and social planning and has been increasingly adapted and used in areas such as health and education. SSP is a problem planning method and deals mainly with poorly structured and complex problems, for which there is a normative solution or previously known as in the case of well-structured ones. [2]

The Health Indicator is a unit of measurement characterized as a measurement tool to manage, evaluate and plan actions, thus enabling changes in these actions and ensuring the improvement of a given variant. [3]

The indicators used in the Family Health Units translate quantitatively the problems found and alert the professional to the need to carry out specific planning to change this indicator. [4]

Systemic arterial hypertension (SAH) is a multifactorial clinical condition characterized by elevated and sustained levels of blood pressure - BP (BP ≥140 x 90mmHg). It is often associated with functional and / or structural changes in target organs (heart, brain, kidneys and blood vessels) and metabolic changes, with an increased risk of fatal and non-fatal cardiovascular events.[5]

Arterial hypertension, in addition to being a direct cause of hypertensive heart disease, is a risk factor for diseases resulting from atherosclerosis and

thrombosis, which are predominantly manifested by ischemic heart, cerebrovascular, peripheral and renal vascular disease.[5]

The term "Diabetes Mellitus" (DM) refers to a metabolic disorder of heterogeneous etiologies, characterized by hyperglycemia resulting from defects in secretion and/or the action of insulin. It is a public health problem characterized by being a condition sensitive to Primary Care, in this sense, studies show that an adequate monitoring at this level of health avoids hospitalizations and deaths due to cardiovascular and cerebrovascular complications.[6]

The interest in the theme arose from the moment that the construction of a SSP was triggered to the resident professionals, since in the moments of the elaboration and execution of this instrument, it was realized the importance of this tool to be used in the territory as a service potential for detecting and evaluating the main factors that affect a community's health-disease process.

This article is of great relevance, because with its result, it is intended to highlight the importance of the elaboration of a SSP in Primary Care with the perspective of awakening in all the actors that compose the family health team to carry out a critical analysis of the existing problems in the territory so that later they can draw up an action plan that aims to solve or minimize these health barriers existing within the community.

In this sense, the present article aims to report the elaboration of a Situational Strategic Planning carried out by professionals residing in a municipality in the interior of the state of Ceará.

METHOD

It is an experience report that sought to describe meetings for the preparation and execution of a Situational Strategic Planning. The experience report is considered a research instrument that allows the researcher to analyze certain actions that were experienced bringing with them the descriptions of the moments giving emphasis to the existing singularities of the moment, thus, describing the main characteristics that one wants to address during the development of the study. [7]

The municipality of Quixeramobim is located in the Mesoregion of the Sertões Cearenses. It is the second largest city in the central sertão, with an estimated resident population of 75.565 inhabitants. [8]

The scenario of the experience was in a Basic Health Unit in the urban area of the city of Quixeramobim composed of a multidisciplinary team with a doctor, two nursing technicians, a nurse, dentist and an oral health technician, attendant, community health agents and a resident NASF team from the School of Public Health of Ceará (a Physiotherapist, Psychologist, Nutritionist and Social Worker).

The PES elaboration and execution period started on October 1st, 2016 and lasted until January 31st, 2017. The meetings were held according to the existing demands during the execution and analysis of the SSP proposal, if used active methodologies within the proposal of the conversation circles.

Initially, the main proposal for holding the meetings was explained to the basic health unit team and that the participation of all professionals would be fundamental in this process, in addition it was agreed among them that the place would be in the health unit itself since all professionals have access and the closed day and time were at 9:00 am on Fridays, these criteria were established considering that at the end of the week the demand for the team decreases a little and thus having a greater availability of time to carry out the meetings.

The data were collected in the months between October and November 2016, the professionals who participated in the study during the six meetings: were composed by nurses (2 from the city and 2 residents), two nursing technicians, one doctor, NASF Residence (Physiotherapist and Psychologist), community health agents, field and core preceptorship and users and some sectors that make up the Health Care Networks.

During the execution of the six meetings so that the data were collected, the strategies of conversation circles and dialogued exposure were used as methodologies, where through the evaluation it was possible to define the target audience that was understood by the individuals with arterial hypertension and diabetes mellitus being in the age group of 25 to 90 years.

RESULTS AND DISCUSSION

In order for the Situational Strategic Planning (SSP) to be put into practice, it was necessary to know the Health Care Networks in the municipality of Quixeramobim, as well as the social devices operating within the community.

In this sense, the municipality's assistance network is organized through the services that comprise it, such as the Family Health Support Center (NASF), Quixeramobim Polyclinic, Clinical Analysis Laboratory, Quixeramobim Psychosocial Care Center (CAPS Geral II), Psychosocial Care Center Alcohol and other Drugs - Porch, Dr. Pontes Neto Regional Hospital (HRDPN), Nossa Senhora do Perpétuo Socorro Children's Hospital, Occupational Health Reference Center (CEREST), Quixeramobim Integrated Care Center (CAIQ), Pharmaceutical Assistance Coordination (CAF), Home Care Service (SAD), Control, Evaluation, Regulation and Audit Center (NUCARA), Dental Specialties Center (CEO) Regional, Municipal Health Secretariat (SMS), Epidemiological Surveillance, SAMU.

From this point on the analysis of

the health services offered by the municipality and the support services within the community that could be part of the elaboration and execution of the Situational Strategic Planning (SSP), the definition of the actors who participated in the planning occurred, where it was composed of nurses (2 from the municipality and 2 residents), two nursing technicians, one doctor, NASF Residency (Physiotherapist and Psychologist), community health agents, field and core preceptorship and users and some sectors that make up the Health Care Networks Health.

In the second step, a meeting was held with all the actors involved and the problems of the unit and the determinants of each one were listed, being defined to carry out strategic situational health planning for patients with hypertension and diabetes. The team noticed that many hypertensive and diabetic patients were not being followed up, they were looking for the unit only in order to renew the prescription or when they already had some complication.

The third step was a conversation circle with some users, in which the knowledge deficit was perceived with the clinical management of the mentioned chronic conditions, as well as the ways to prevent its complications. Next, the health situation problem was identified, "high rate of patients with arterial hypertension and Diabetes mellitus" and the health production problem "low adherence to hypertension and Diabetes mellitus consultations". This step was more critical to be carried out, as the members had a different look, being analyzed the graphics of the health situation room carried out in the territory, and thus the problem was discussed, and a consolidated check-list was built, containing the list of hypertensive and diabetic patients with their co-morbidities and which were delivered to each Community Health Agent (CHA), to carry out the identification of patients with this profile in the territory.

In this sense, the consolidated was composed as follows: user identification, date of birth, age, and any of the following health problems were present: hypertension, diabetes, obesity, smoking, sedentary, co-morbidities (stroke, nephropathy and retinopathy) and monitoring in a specialized unit.

In the fourth step, the Community Health Agents (CHA) from the home visits performed the active search of the patients based on filling out the worksheet. Concomitantly, the fifth step was carried out, where we held a meeting through a round of conversation with the municipal health management, in order to socialize the findings previously found during the construction of the Situational Strategic Planning (SSP), as well as the Coordinator of Permanent Education had a wide participation in this process.

In the sixth step, a meeting took place between residents and the family health team to build the action plan to face the identified problem. For construction, the Ministry of Health's hypertension and diabetes notebooks and the texts made available for the Planning module were used as guidelines. In the territory of the unit there is an elderly living center - CCI (centro de convivência do idoso) that operates on Tuesdays and Thursdays in the morning, with the purpose of entertainment and socialization for the elderly and since the beginning of the Residence has proved to be a great partner for development of actions.

Thus, the Elderly Living Center (CCI) was included in health education activities to approach the elderly population as one of the interventions, since it is the age group most affected by chronic diseases in the territory. With the plan, the team will have subsidies that will guide the next actions to provide care to patients, in order to maintain effective control of the aforementioned chronic conditions and avoid complications in advance.

In the action plan, the problems identified were the high rate of patients with arterial hypertension and diabetes mellitus, with the expected result of ensuring full monitoring of this target audience and low adherence to consultations for arterial hypertension and diabetes mellitus with the expected result that patients develop autonomy for self-care, highlighting in steps 1 and 2 the stages of the operationalization process for each problem mentioned.

However, during the implementation of the SSP it can be seen that it is a work tool that provides the actors involved with assessing and reorganizing the goals and results that could not be achieved, as this fact occurs

Chart 1: Operationalization of planning at the high rate of patients with arterial hypertension and diabetes mellitus. Quixeramobim, Ceará, Brazil, 2016.

AÇÃO	RECURSOS	RESPONSÁVEL	PERÍODO
Realizar o levantamento dos pacientes com HAS e DM e co-morbidades	Visitas ACS Check-list do Processo saúde-doença	Agentes comunitários de saúde	Outubro de 2016
Realizar estratificação de risco dos pacientes	Protocolo de estratificação de risco (nome do protocolo)	Médica, enfermeiras, cirurgião dentista e residentes	14 de novembro de 2016
Realizar busca ativa dos pacientes com HAS e DM associadas + co-morbidades	Visitas ACS Marcação de consultas	ACS Recepção	Cuidado continuado

Realizar acompanhamento dos pacientes	Visitas ACS Atendimento	Médica, enfermeiras, NASF e residência, ACS	Cuidado continuado
Oferecer exames e consultas especializadas, se necessário	Rede de referência e apoio diagnóstico	SMS	Cuidado continuado

Chart 2- Operationalization of planning at low adherence to consultations on hypertension and diabetes mellitus. Quixeramobim, Ceará, Brazil, 2016.

AÇÃO	RECURSOS	RESPONSÁVEL	PERÍODO
Realizar educação em saúde no CCI	Definir de acordo com atividade a ser realizada	Equipe saúde da família e residência	Mensal
Criar grupo de doenças crônicas na ADS	Definir de acordo com atividade a ser realizada	Equipe saúde da família, NASF e residência	Mensal
Realizar sala de espera	Definir de acordo com atividade a ser realizada	Equipe saúde da família, NASF e residência	De acordo com a demanda

because the territory is a living space and dynamic subject to changes and transformations with respect to the health process disease of the enrolled population.

Therefore, the SSP is a tool that makes it possible to identify the potentialities and difficulties of the local area where the health team works, where the situational approach guarantees the effective participation of all the actors involved in this process. [9]

It was necessary to point out that the monitoring of the implementation of the actions that were carried out will be constant, since it was agreed with the team of the health unit the continuation of the execution of the Situational Strategic Planning, as it is of paramount importance that the actors involved can evaluate and analyze whether or not the activities carried out so far have achieved the objectives set so that, based on this assumption, they can identify the essential changes to improve the quality of life of the population that make up the territory.

CONCLUSION

After listing the indicators that would be worked on in this Planning, it took several steps to arrive at the elaboration of an intervention plan. There were several actors involved because when it comes to health, most of the time we need to activate the network since there are several health determinants.

This activity was extremely important, as it triggered the importance of having a more acute look at the needs of the community in which we operate, and that it is essential to plan actions aimed at the real problems of the territory.

In this sense, to the resident professionals the stages experienced in the construction and deployment of the SSP were essential for professional training, since this work tool aroused in them a reflection on the forms of assistance provided by professionals in the Basic Health Unit, as the care and actions performed did not have continuous assistance.

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