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Performance of the expanded Family Health Centers in evaluating the PMAQ-AB*

Desempenho dos núcleos ampliados de saúde da família na avaliação do PMAQ-AB

Desempeño de los núcleos ampliados de salud de la familia en la evaluación del PMAQ-AB

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ABSTRACT

Objective: To analyze the performance of the Expanded Family Health Centers in the state of São Paulo in the Work Process Organization dimension in evaluating the *PMAQ-AB*, according to the Paulista Social Responsibility Index. **Method:** A cross-sectional, descriptive, exploratory study with a quantitative approach based on data from the 2nd cycle of the National Program for Improving Access and Quality in Primary Care (*PMAQ-AB*). There were 149 teams from 47 municipalities distributed in five groups analyzed by simple frequency, according to the Paulista Social Responsibility Index. **Results:** The teams from group four (municipalities of low wealth and intermediate social indicators) achieved satisfactory and very satisfactory performance (90.9%). The teams from the group two municipalities (high wealth index and unsatisfactory social indicators) had worse performance; the teams from the municipality of São Paulo obtained the highest percentage of satisfactory and very satisfactory performance (95.8%). **Conclusion:** The teams from the municipality of São Paulo (high wealth index and unsatisfactory social indicators) and the teams from the municipalities of group four (low wealth and intermediate social indicators) were those that achieved better performance.

DESCRIPTORS

Primary Care Nursing; Health Planning; Patient Care Team; Health Evaluation; Quality of Health Care.

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INTRODUCTION

The Family Health Support Center (*NASF – Núcleo de Apoio à Saúde da Família)* was created to expand the actions, resolution and comprehensiveness of the care actions provided in Primary Healthcare[1]. After reviewing the guidelines of the National Primary Care Policy, it was renamed the Expanded Family Health Center and Primary Care (*Núcleo Ampliado de Saúde da Família e Atenção Básica – NASF-AB*)[2]. The *NASF-AB* is composed of a multiprofessional team consisting of different professional categories in the health area according to the need of the supported region, which is integrated into the daily work of the Basic Health Units (BHU) through a horizontal and interdisciplinary relationship, with a view toward "longitudinal care and provision of direct services to the population"[2]. "The strategies and work organization forms are not fully instituted and systematized, but after an assessment of the day-to-day functioning of the NASF-AB units that are already operating in the country, this experience can be improved"[3].

The NASF-AB Work Process Organization (WPO) can take on a number of conformations, depending on the diversity of professionals that make up the multiprofessional team, which enables an integration of knowledge between the support teams and the Family Health Strategy (FHS)[4]. The planning should occur in two different moments: in the first, the actions of the NASF-AB team should be planned; in the second, actions aimed at supporting the reference teams and the care offered to the population in the meeting spaces with the Family Health Teams (FHT)[5-6].

In these co-management spaces, the cases are discussed, objectives are defined, the priority criteria are established, longitudinal follow-up of the shared cases is performed, criteria for assessing the work process and resolving conflicts are defined, among other actions[1].

These moments enable better knowledge of cases identified as priority by the NASF-AB, and qualify the referrals through matrix support so that actual references and counter-references to other health units occur, as well as to extend the longitudinal follow-up in the healthcare network[7].

From the perspective of matrix support, Work Process Organization seeks to overcome and transform the hegemonic logic of healthcare through daily changes in power relations, which are hierarchized and impact health service management[8].

In order to analyze the management, organization and healthcare offered by the NASF-AB, the Ministry of Health evaluated these teams through the National Program for Improving Access and Quality in Primary Care (*PMAQ-AB – Programa Nacional de Melhoria do Acesso e da Qualidade na Atenção Básica*)[9]. The 1st evaluation cycle was carried out from 2011 to 2012; the 2nd cycle from 2013 to 2014; and the 3rd cycle was currently ongoing in the state of São Paulo (2017 to 2018) at the time of this report. Thus, the performance of the NASF-AB teams evaluated in the 2nd cycle is examined according to the social development of the municipalities. Thus, this study aims to analyze the performance of the Expanded Family Health Center teams of the state of São Paulo in the Work Process Organization dimension in evaluating the PMAQ-AB, according to the Paulista Social Responsibility Index.

METHOD

Study design

This is a cross-sectional, exploratory and analytical study of a descriptive nature with a quantitative approach, based on secondary data from the 2nd cycle of the External Evaluation of the *PMAQ-AB* (2013 to 2014), which refers to the external evaluation of Module IV, an interview with *NASF-AB* professional.

Data collection

Data were provided by the Primary Care Department of the Ministry of Health (*DAB/MS*) in Excel spreadsheet format (Microsoft Corporation, United States). Data were analyzed and interpreted by simple frequency in order to understand the obtained information, relating it to the questions which incited the investigation.

For this study, the WPO dimension was composed of five sub-dimensions and 76 quality questions/standards, elaborated based on the PMAQAB/NASF-AB notebook. The sub-dimensions analyzed were: 1) Action planning (23 questions/standards); 2) Organization of the schedule (12 questions/standards); 3) Organization of matrix support to teams (23 questions/standards); 4) Demand and shared care management (8 questions/standards); and 5) Activity log (10 questions/standards). A score was given for each sub-dimension, generating the score and performance of the teams.

Data analysis and processing

The teams were classified on the basis of a Likert scale after analyzing the quality standards in each sub-dimension by a numerical variation from 0 to 100: Very Unsatisfactory (VU) – 0 to 19.99, Unsatisfactory (U) – 20 to 39.99, Average (A) – 40 to 59.99, Satisfactory (S) – 60 to 79.99, and Very Satisfactory (VS) – 80 to 100. Performance is the sum of the team's score on the five sub-dimensions which form the Work Process Organization dimension.

For the performance analysis, the teams were grouped according to the Paulista Index of Social Responsibility (*IPRS – Índice Paulista de Responsabilidade Social*), created by *SEADE* Foundation to subsidize formulating and evaluating public policies at the municipal level. This index preserves the three HDI dimensions – income, education, longevity – and incorporates methodological changes which enables capturing changes in the living conditions of municipalities in a short period of time. The indicators that compose this index were combined, generating five groups[10].

The 149 NASF-AB teams that participated in the 2nd cycle of the PMAQ-AB were distributed across all five groupings according to the IPRS. There were 25 NASF-AB teams from 11 municipalities in the IPRS group 1 (high wealth and good social indicators); 21 NASF-AB teams from 9 municipalities in IPRS 2 (high wealth and unsatisfactory social indicators); 16 NASF-AB teams from 12 municipalities in IPRS 3 (low wealth and good social indicators); 11 NASF-AB teams from 10 municipalities in IPRS 4 (low wealth and intermediate social indicators); and finally 4 NASF-AB teams from 4 municipalities in IPRS 5 (low wealth and unsatisfactory social indicators). Data from the NASF-AB teams in the city of São Paulo were analyzed separately from the data from teams of other municipalities grouped according to IPRS 2 (high wealth and unsatisfactory social indicators), and constituted 72 NASF teams.

Ethical aspects

The study was approved by the Research Ethics Committee of the Nursing School of the Universidade de São Paulo under opinion no. 1.667.301/2016. The study met the requirements of Resolution No. 466/12 of the National Health Council and is exempt from having to apply a Free and Informed Consent Form because it uses secondary databases.

RESULTS

One hundred fifty-one (151) NASF-AB teams in the state of São Paulo participated in the 2nd cycle of the PMAQ-AB. Data from two teams were not included in this study because of inconsistencies, so that the study sample was formed by 149 NASF-AB teams from the state of São Paulo – 47 municipalities that joined the program, representing 7.0% of the total of 645 municipalities that make up the state (Table 1).

Table 1 – Distribution of NASF-AB teams participating in the PMAQ-AB according to the IPRS, RRAS* and Administrative Region – São Paulo, SP, Brazil, 2018.

MUNICIPALITY	NASF	IPRS	RHCN	ADMINISTRATIVE/METROPOLITAN REGION
Altinópolis	1	3	13	Ribeirão Preto AR
Amparo	2	1	15	Campinas AR
Andradina	1	3	12	Araçatuba AR
Araçatuba	4	1	12	Araçatuba AR
Araraquara	1	1	13	Central AR
Birigui	2	3	12	Araçatuba AR
Botucatu	1	2	9	Sorocaba AR
Bragança Paulista	2	4	16	Campinas AR
Caçapava	1	2	17	São Paulo MR
Cachoeira Paulista	1	4	17	São Paulo MR
Cafelândia	1	5	9	Bauru AR
Capão Bonito	1	4	8	Itapeva AR
Cordeirópolis	1	1	14	Campinas AR
Cubatão	1	2	7	Baixada Santista AR
Descalvado	1	2	13	Central AR
Embu das Artes	1	2	4	São Paulo MR
Guaíra	1	2	13	Barretos AR
Guapiaçu	1	3	12	São José do Rio Preto AR
Guarulhos	6	2	2	São Paulo MR
Itapetininga	1	3	8	Sorocaba AR
Itapeva	1	4	8	Itapeva AR
Itatiba	2	1	16	Campinas AR
Ituverava	1	4	13	Franca AR
Jacareí	1	1	17	Vale do Paraíba e Lit. Norte MR
Jales	1	3	12	São José do Rio Preto AR
Junqueirópolis	1	4	11	Presidente Prudente AR
Marília	3	3	10	Marília AR
Mauá	7	2	1	São Paulo MR
Monte Mor	1	1	15	Campinas AR

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MUNICIPALITY	NASF	IPRS	RHCN	ADMINISTRATIVE/METROPOLITAN REGION
Osvaldo Cruz	1	3	10	Presidente Prudente AR
Penápolis	1	5	12	Araçatuba AR
Peruíbe	1	5	7	Baixada Santista AR
Piraju	1	3	9	Itapeva AR
Praia Grande	2	2	7	Baixada Santista AR
Presidente Prudente	1	4	11	Presidente Prudente AR
Registro	1	5	7	Registro AR
Santa Fé do Sul	1	3	12	São José do Rio Preto AR
São Bernardo do Campo	10	1	1	São Paulo MR
São Caetano do Sul	2	1	1	São Paulo MR
São Carlos	1	1	13	Central AR
São João da Boa Vista	1	3	15	Campinas AR
São Paulo	74	2	6	São Paulo MR
Sud Mennucci	1	3	12	Araçatuba AR
Tupã	1	4	10	Marília AR
Tupi Paulista	1	4	11	Presidente Prudente AR
Urânia	1	4	12	São José do Rio Preto AR
Votuporanga	1	3	12	São José do Rio Preto AR

*RHCN – Regional Healthcare Networks.

The results (Table 2) show that 90.9% of the NASF-AB teams of municipalities grouped according to the IPRS 4 (municipalities with low wealth and intermediate social indicators) achieved satisfactory and very satisfactory performance. The NASF-AB teams from the city of São Paulo (IPRS 2) obtained the highest percentage of satisfactory and very satisfactory performance (95.8%).

Table 2 – Results of the 149 NASF-AB teams according to the Work Process Organization (WPO) performance classification, grouped according to the IPRS – São Paulo, SP, Brazil, 2018.

Performance Classification	Groupings											
	IPRS 1		IPRS 2		IPRS 2 SP		IPRS 3		IPRS 4		IPRS 5	
	WPO	%	WPO	%	WPO	%	WPO	%	WPO	%	WPO	%
Very Unsatisfactory	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Unsatisfactory	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	25.0
Average	5	20.0	7	33.3	3	4.2	4	25.0	1	9.1	0	0.0
Satisfactory	10	40.0	8	38.1	24	33.3	7	43.7	7	63.6	2	50.0
Very Satisfactory	10	40.0	6	28.6	45	62.5	5	31.3	3	27.3	1	25.0
Satisfactory and Very Satisfactory performance sum	-	80.0	-	66.6	-	95.8	-	75.0	-	90.9	-	75.0

Only one NASF-AB team in a municipality (25.0%) according to IPRS 5 achieved unsatisfactory performance. Twenty NASF-AB teams (13.4%) achieved average performance in 16 different municipalities: five teams (20.0%) from four municipalities (36.4%), according to IPRS 1; seven teams (33.3%) from five municipalities, (55.5%), according to IPRS 2; three teams (4.2%) from the city of São Paulo; four teams (25.0%) from four municipalities (33.3%), according to IPRS 3; one team (9.1%) of one municipality (10.0%) according to IPRS 5.

Data analysis in the action planning subdimension reveals that teams with average performance were harmed because they did not receive manager/coordinator health information such as epidemiological data, main health problems in the territory, main demands of FH teams and the demand profile served by NASF-AB.

The results show that 68 NASF-AB teams (45.6%) from the 149 participants answered that they did not monitor the support requests of FH teams (ET.IV.10.1/1).

Sixteen (80.0%) of the 20 NASF-AB teams with average performance answered that they did not follow the indicators and health information in conjunction with the Primary Healthcare teams, and 17 (85.0%) answered that they did not carry out the follow-up regarding their work process.

The analysis of the data in the organizational sub-dimension of the matrix support shows that the majority (136 teams, 91.3%) answered that they dedicate a weekly or biweekly time to an internal meeting (IV.9.1). Only 13 teams (8.7%) answered that they did not reserve any agenda period for the meeting, corresponding to 11 municipalities (23.4%) that participated in the 2nd cycle of the PMAQ-AB/NASF-AB. These municipalities belonged to different groups according to the IPRS: one municipality of IPRS 1, five municipalities of IPRS 2, one municipality of IPRS 3, two municipalities of IPRS 4 and two municipalities of IPRS 5.

These results show that the municipalities that least reserve space for work process organization of the NASF-AB teams were IPRS 5 (50.0%) and IPRS 2 (44.4%).

Of the 149 NASF-AB teams that participated in the external evaluation, 144 (97.0%) held a meeting with the Family Health Teams with defined intervals. The five teams that had no defined periodicity to carry out activities/meetings with the Family Health Teams belonged to four municipalities: two from the IPRS 2, one from IPRS 3, and one from IPRS 4. These municipalities correspond to almost 10% (8.6%) of the total number of participating municipalities and 22.2% of the municipalities grouped in IPRS 2.

DISCUSSION

The NASF-AB work process organization encompasses co-management and matrix support, constituting indispensable tools for the work carried out by the multiprofessional team. Data analysis shows that more than 90% of the NASF-AB teams had a weekly or biweekly time for internal meetings. This space is used for meetings between professionals of the NASF-AB team, with the aim to plan the actions to be carried out and to organize the work process.

Co-management can assist in prioritizing cases that need specialized backup in Primary Healthcare, as well as organizing schedules and other types of activities. It reinforces the importance of meeting spaces for planning actions, to collectively identify priority needs, discuss complex cases, survey the need for articulation with the other departments/units in the territory and to accomplish internal matrix support[11]. In addition, actions such as intermediation of cases for the referral network, matrix support, elaboration with a greater number of employees for constructing Singular Therapeutic Projects and to evaluate the discussed cases also occur in the meeting spaces[3].

The results show that the municipalities that had the least reserved space (meeting) to organize the work process of the NASF-AB teams were IPRS 5 (50.0%) and IPRS 2 (44.4%). These data are confirmed by a study carried out in the state of São Paulo, which showed that the poorest municipalities with fewer services and opportunities are the ones which least carry out planning actions in Primary Healthcare[12].

Coordinating the work process is the first aspect of participatory management and serves to democratize power relations, politicize management, negotiate and transform practices[13]. The second facet occurs through co-managing care shared with the Family Health Teams, with the planning, organization and co-responsibility of care. This moment occurs in meetings between the NASF-AB and FH teams.

In the present study, this co-management of care was identified in more than 90.0% of the NASF-AB teams with the FHT in the shared meeting with intervals defined between the two teams; a result similar to that found in a study carried out in the city of São Paulo[11], in which the NASF-AB teams allocated most of their workload to meetings with the referenced FH teams.

In contrast to this finding, a study carried out with six NASF-AB teams from a large municipality in the Northeast identified that the current arrangement of these teams has not enabled planning and health management[14].

In addition, joint meetings do not occur due to conflicts[14], the absence of physicians and nurses[15] and the resistance of the Family Health Teams to the new work management model[16]. Other obstacles identified are the incompatibility of agendas, the lack of personal skills of NASF-AB professionals such as empathy, assertiveness and organization, difficulty in dealing with conflicts and power relations among team members, which interfere in performing the meetings and compromise implementing matrix support[16].

These difficulties are present where there is a tendency "for the transfer of care between the teams, to the detriment of the shared work"[6].

Professionals do not have the habit of talking among themselves, perhaps between services, to collectively construct therapeutic projects, according to the NASF-AB guidelines[8], so investing in the relationship between the NASF-AB team and the FHT is extremely important to enable dialogue, re-evaluation and reprogramming[1], with a view to quality, resolution, and comprehensive care of users monitored in the various territories and other points of the health care network. However, this does not always happen easily due to the lack of appropriation of this space by the teams, disorganization of their agendas, lack of discussion of cases, lack of organizational arrangement and outpatient focus, all to the detriment of matrix support[15].

The underutilization of matrix support in the technical-pedagogical perspective[11] and the lack of openness for knowledge exchange make it impossible to co-manage care[17]. Most cases are not discussed with the frequency and depth they should be, and are often "passed on" to the NASF-AB without the necessary co-responsibility of Family Health Teams in longitudinal follow-up[15,18].

Co-management flexibility between the NASF-AB team and the FHT should be discussed and planned

together. It can range from "a greater dedication to matrix activities in the form of a meeting to discuss cases"[4], to the construction of a singular therapeutic project[4,11], and to individual and shared care[17]. This possibility varies according to the health and care profile of each municipality[4]. However, matrix support must continue to be the main strategy for the work process organization and the co-responsibility of care, as it provides a dialogical relationship between professionals.

There are a number of ways to provide matrix support, such as meetings between the NASF-AB team and the FHT, technical and general meetings at the Basic Health Unit, shared consultations, educational and/or therapeutic groups, home visits and intersectoral actions, among others.

The interdisciplinary actions are present in a small part of the FHT agenda, since the individual care practices dominate the performance of the professionals of these teams[8].

The potential for matrix support is evidenced by the diversity of knowledge that comes from the different professional categories that make up the NASF-AB, which is reflected in the discussion and deepening of cases and in the accumulation of knowledge, providing clinical autonomy and care quality in the periodicity and systematic implementation of meetings, in the shared construction of the Singular Therapeutic Project and in the articulation with the Healthcare Network[11].

Therefore, knowing the obstacles in conducting internal planning meetings (NASF-AB), shared planning (NASF-AB/FHT), organizing the agenda, organizing matrix support, managing demand, shared care actions, and registration of the activities performed by the NASF-AB can enhance matrix support practice across the diverse contexts. In addition, such knowledge can improve the work organization among the teams by increasing the dialogue for the consensual agreement based on the need of each team, and also to increase the knowledge of the singularity of the subjects and the territory.

Therefore, strengthening the NASF-AB work process with the FHT is extremely important, and can be done through strategies which can improve the relationship between the teams. These strategies should be built locally with the participation of professionals and management support and from the perspective of continuing health education. The guarantee of permanent spaces for dialogue, listening and collective knowledge construction can enhance the interpersonal and communication skills of professionals, as well as collaborative and interdisciplinary practices, strengthening relationships and integration to solidify teamwork. In some contexts, the presence of an institutional supporter is effective in stimulating transformations in work processes, aiming at a grouping of solidarity which seeks to overcome the challenges and achieve better shared care practices[19], despite differences in work organization between the two teams[11]. These differences occur due to several issues, for example, the productivity that is required in the FHT. Productivity, or attending a certain number of patients from an individualized and purely care perspective, makes the goal an obstacle in the work of the teams. The solution to this issue is not in the scope of the teams, but in the macro management – Municipal Health Secretariats.

The result of this study shows that most of the NASF-AB teams have organized the work process together with the Family Health Teams, as another study had identified[6]. This partnership helps to expand the work developed by the supported teams, and therefore they do not limit the actions developed by the FHT. This organization of the work process evidences the presence of organizational support, indispensable to minimize the conflicts and differences existing in the work dynamics of the teams, and also avoids fragmenting the actions, thus constituting a strategy that can be used to improve the relationship between the teams. Other joint actions may also reduce the barriers in the relationship between the NASF-AB and FH teams, such as shared individual care, shared home care, and shared collective activities[4].

A study carried out with the data of the 2nd cycle of the PMAQ-AB identified that the agreement between the teams is a device that facilitates communication and access of the FH teams to the NASF-AB teams, as well as organization of the intra- and inter-team work process to be another device in seeking resolution by the NASF-AB team in shared cases[6].

Contrary to these data, one study argues that the NASF-AB teams in São Paulo act as a pre-regulatory device between the FHT and the various units in the territory that reduce the capacity of healthcare management performed by these teams[20]. This idea contradicts all the organizational guidelines about the work process of the NASF-AB, based on the co-responsibility of care with the FHT in the technical-pedagogical and clinical-care support[1-2,4-5].

As a co-management device of care, the NASF-AB teams potentiate producing changes in Primary Care through the incorporation of new practices in the daily lives of the services by sharing and providing support to health practices[21].

The results show that the monitoring actions and data analysis related to the work process are not part of the reality of the NASF-AB teams, and generally are not incorporated in the daily lives of health professionals as a whole, which reinforces the importance of evaluation processes such as the PMAQ-AB, which stimulates organization and reflection on the practice. However, it is important to highlight that these actions are excellent tools for managing and organizing the work process, since they facilitate decision-making by providing reliable and necessary information for the changes[22].

CONCLUSION

The data analysis revealed that the NASF-AB teams in the city of São Paulo and the municipalities of IPRS 4 (low wealth and intermediate social indicators) performed better in work process organization.

It is considered that the organization of the NASF-AB team work process depends on planning actions, organizing the individual agenda, organizing the matrix support to the supported teams, shared care management and registering all the activities developed by the NASF-AB team. In order

to plan the actions, it is fundamental to reserve schedules for meetings in the NASF-AB and FH team agendas in order to organize the work.

Data monitoring and analysis are indispensable tools for the Work Process Organization, since they help in managing and planning actions, but they have been little used by the NASF-AB teams.

The NASF-AB teams of the IPRS 2 municipalities (high wealth and unsatisfactory social indicators) and those of the IRPS 5 (low wealth and unsatisfactory social indicators) were the teams which least organized the work process.

Municipal managers should appropriate the PMAQ-AB/NASF-AB results, as well as the results of this and other studies. In doing so, they will be able to support the work organization of multiprofessional support teams in Primary Healthcare.

This study contributes to understanding the Work Process Organization developed by the NASF-AB. However, it has limitations because the analysis is based on secondary data. The results of this research can help other researchers in preparing studies on the work of NASF-AB in the three spheres of government.

RESUMO

Objetivo: Analisar o resultado do desempenho dos Núcleos Ampliados de Saúde da Família do estado de São Paulo, na dimensão Organização do Processo de Trabalho, na Avaliação do PMAQ-AB, segundo o Índice Paulista de Responsabilidade Social. **Método:** Estudo transversal, descritivo, exploratório, com abordagem quantitativa, baseado nos dados do 2º ciclo do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica. Foram analisadas por frequência simples 149 equipes, de 47 municípios, distribuídas em cinco agrupamentos, de acordo com o Índice Paulista de Responsabilidade Social. **Resultados:** As equipes do agrupamento quatro (municípios com baixa riqueza e indicadores sociais intermediários) alcançaram desempenho satisfatório e muito satisfatório (90,9%). As equipes dos municípios do agrupamento dois (alto índice de riqueza e indicadores sociais insatisfatórios) tiveram pior desempenho; as equipes do município de São Paulo obtiveram o maior percentual de desempenho satisfatório e muito satisfatório (95,8%). **Conclusão:** As equipes do município de São Paulo (alto índice de riqueza e indicadores sociais insatisfatórios) e as equipes dos municípios do agrupamento quatro (baixa riqueza e indicadores sociais intermediários) foram as que alcançaram melhor desempenho.

DESCRITORES

Enfermagem de Atenção Primária; Planejamento em Saúde; Equipe de Assistência ao Paciente; Avaliação em Saúde; Qualidade da Assistência à Saúde.

RESUMEN

Objetivo: Analizar el resultado del desempeño de los Núcleos Ampliados de Salud de la Familia del Estado de São Paulo, en la dimensión Organización del Proceso de Trabajo, en la Evaluación del PMAQ-AB, según el Índice Paulista de Responsabilidad Social. **Método:** Estudio transversal, descriptivo, exploratorio, con abordaje cuantitativo, basado en los datos del 2º ciclo del Programa Nacional de Mejoría del Acceso y la Calidad de la Atención Básica. Fueron analizadas por frecuencia simple 149 equipos, de 47 municipios, distribuidas en cinco agrupaciones, según el Índice Paulista de Responsabilidad Social. **Resultados:** Los equipos de la agrupación cuatro (municipios con baja riqueza e indicadores sociales intermedios) alcanzaron desempeño satisfactorio y muy satisfactorio (90,9%). Los equipos de los municipios de la agrupación dos (alto índice de riqueza e indicadores sociales insatisfactorios) tuvieron peor desempeño; los equipos del municipio de São Paulo obtuvieron el mayor porcentual de desempeño satisfactorio y muy satisfactorio (95,8%). **Conclusión:** Los equipos del municipio de São Paulo (alto índice de riqueza e indicadores sociales insatisfactorios) y los equipos de los municipios de la agrupación cuatro (baja riqueza e indicadores sociales intermedios) fueron las que alcanzaron mejor desempeño.

DESCRIPTORES

Enfermería de Atención Primaria; Planificación en Salud; Grupo de Atención al Paciente; Evaluación en Salud; Calidad de la Atención de Salud.

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