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# Reorganization of the outpatient reference service for chronic conditions during the COVID-19 pandemic

## *Reorganização do serviço ambulatorial de referência para condições crônicas durante a pandemia da COVID-19*

## *Reorganización del servicio de referencia ambulatoria para condiciones crónicas durante la pandemia de COVID-19*

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## Abstract

**Objective:** To report the experience of the specialized care health team in reorganizing the work process for the continuity of care for people with complex chronic conditions during the COVID-19 pandemic. **Methods:** Experience report lived in an outpatient clinic in Paraná State between March and July 2020. The outpatient service in question adopts the Chronic Conditions Care Model for pregnant women, children, elderly people, people with hypertension, diabetes mellitus, and mental disorders, stratified as complex conditions. **Results:** The advance of the pandemic in Brazil implied the need to plan the reorganization of specialized ambulatory care, defining face-to-face care activities in the service, itinerant activities in municipalities, and the use of remote care technologies and matrix support. **Conclusion and Implications for practice:** Rigorous compliance with health recommendations allowed the reorganization of work processes in the service with modifications that allowed continuity of care for people with complex chronic conditions. The planning and development of the modifications in the service were fundamental to maintain the follow-up and monitoring of the health of people with complex chronic conditions amid the pandemic, minimizing decompensations and, consequently, reducing the need for these people to use health services.

**Keywords:** Outpatient Care; COVID-19; Chronic Disease; Nursing; Coronavirus Infections.

## Resumo

**Objetivo:** Relatar a experiência da equipe de saúde da atenção especializada na reorganização do processo de trabalho para a continuidade do cuidado às pessoas com condições crônicas complexas durante a pandemia da covid-19. **Métodos:** Relato de experiência vivenciada em ambulatório do Estado do Paraná entre março e julho de 2020. O serviço ambulatorial em questão adota o Modelo de Atenção às Condições Crônicas para o atendimento de gestantes, crianças, idosos, pessoas com hipertensão arterial, diabetes mellitus e transtornos mentais, estratificadas como condições complexas. **Resultados:** O avanço da pandemia no Brasil implicou a necessidade de planejar a reorganização da atenção ambulatorial especializada, definindo atividades assistenciais presenciais no serviço, atividades itinerantes nos municípios e uso de tecnologias remotas para assistência e matriciamento. **Conclusão e Implicações para a prática:** O rigor no cumprimento das recomendações sanitárias possibilitou a reorganização dos processos de trabalho no serviço, com modificações que permitiram a continuidade do cuidado de pessoas com condições crônicas complexas. O planejamento e o desenvolvimento das modificações no serviço foram fundamentais para manter o acompanhamento e o monitoramento da saúde das pessoas com condições crônicas complexas em meio a pandemia, minimizando as descompensações e, consequentemente, diminuindo a necessidade de essas pessoas utilizarem os serviços de saúde.

**Palavras-chave:** Assistência Ambulatorial; Covid-19; Doença Crônica; Enfermagem; Infecções por Coronavírus.

## Resumen

**Objetivo:** Exponer la experiencia del equipo de atención a la salud especializada, en la reorganización del proceso de trabajo para la continuidad de la atención a personas con enfermedades crónicas complejas durante la pandemia de COVID-19. **Métodos:** Informe de experiencia en un centro ambulatorio del estado brasileño de Paraná entre marzo y julio de 2020. El servicio adopta el Modelo de Atención a Condiciones Crónicas para el atendimiento de: gestantes, niños, ancianos, personas con hipertensión arterial, diabetes mellitus y trastornos mentales, estratificado como condiciones complejas. **Resultados:** El avance de la pandemia en Brasil implicó en la necesidad de planificar la reorganización de la atención ambulatoria especializada, al definir acciones de actividades asistenciales presenciales en el servicio, actividades itinerantes en los municipios y el uso de tecnologías remotas para la asistencia y apoyo matricial. **Conclusión e implicaciones para la práctica:** El rigor en el cumplimiento de las recomendaciones sanitarias permitió la reorganización de los procesos de trabajo en el servicio, con cambios que permitieron la continuidad del cuidado de las personas con condiciones crónicas complejas. La planificación y el desarrollo de los cambios en el servicio fueron fundamentales para mantener el acompañamiento y la vigilancia de la salud de personas con condiciones crónicas complejas en medio a la pandemia, minimizando las descompensaciones y, consecuentemente, disminuyendo la necesidad de que estas personas utilicen los servicios de salud.

**Palabras clave:** Atención Ambulatoria; COVID-19; Enfermedad Crónica; Enfermería; Infecciones por Coronavirus.

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## INTRODUCTION

COVID-19 is a disease caused by the SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), which poses numerous public health threats worldwide. On March 11, 2020, the World Health Organization declared it a pandemic status, and it has been regarded as one of the greatest health challenges of this century.[1] Coronavirus infections are caused by the transmission of the virus by respiratory droplets or contact, requiring special care regarding respiratory etiquette, hand washing with soap and water, and reducing the number of people on public roads to prevent spreading the disease.[2]

Brazil is the third country with more cases of COVID-19 in the world and the second in the number of deaths: by the end of the 25th epidemiological week of 2021, there were 18,386,894 infected people and 512,735 deaths in the country. Paraná State stands out in this statistic as it has the second-highest death rate in Brazil at 13.7 deaths/100,000 inhabitants.[3]

Faced with this scenario, health services needed to reorganize themselves to serve people with chronic diseases and health conditions that require continuous monitoring. Professionals from the Mobile Emergency Care Service (SAMU) of a capital city in southern Brazil revealed changes in the care flows and work routines and new needs for biological precautions and emotional support for the professionals involved.[4] In the context of chronic conditions, health professionals have a crucial role in maintaining people's motivation to adhere to drug treatment and behavioral changes, such as diet and physical exercise.[5]

In this health context, the specialized outpatient care (SOC), which integrates the secondary level of the Unified Health System (SUS) and systematizes its care to the specificities of the Model of Attention to Chronic Conditions (MACC),[6] needed to be readjusted to maintain the monitoring of people with complex chronic conditions during the pandemic. The MACC became a reference by the Ministry of Health to develop the Health Care Networks (RAS) that provide care to people in chronic conditions.[6]

According to the MACC, the competencies of the SOC are to provide back-up care and educational support to the primary health care (PHC) team.[6] The care actions are provided to people stratified with complex chronic conditions, and the matrix support occurs through technical-pedagogical consultancies. Hence, the mutual knowledge of both teams is essential for different knowledge to be added to the joint work. Because people with chronic conditions are considered a risk group for COVID-19,[1] the SOC must adjust its schedule, routines, protocols, and physical spaces to provide safe care to this audience; telemedicine tools such as video calls and phone calls have also been used.[7]

Given this context, this report sought to describe the specialized health team's changes in its work process to continue providing care to people with complex chronic conditions and maintain educational support through matrix support to PHC health teams according to the MACC. Therefore, this study aimed to report the experience of the specialized health care team in reorganizing the work process for the continuity of care for people with complex chronic conditions during the COVID-19 pandemic.

## METHODOLOGY

This is an experience report on the performance of a SOC health team in reorganizing work processes during the COVID-19 pandemic. The experience report was conceived as a qualitative study that values the descriptive, interpretive, and comprehensive explanation of phenomena while delegating to the researcher the challenge of articulating theoretical knowledge with the interpretations of the reported episodes.[8]

To understand the phenomena, the observation technique with moderate participation was adopted, which allowed the researcher to insert herself into the observed context and interact with the participants; hence, it was possible to grasp the meaning of being in such a situation.[9] Moderate observations occurred in individual consultations and the administrative routines of all SOC professionals to identify the changes in the organizational structure of the SOC and the functioning of the care services provided to people with chronic conditions during the COVID-19 pandemic. In addition to observations, five moments of discussions were scheduled with administrative and nursing personnel to update them on information regarding the reorganization of the service; these moments occurred by telephone call.

The processes described herein occurred from March to July 2020 in the SOC located in a municipality in north-central Paraná State. The SOC in question is a reference for specialized care of the SUS for the 17 municipalities belonging to the 16th Regional Health Office, which corresponds to almost 393,000 people.[10] The service has implemented the MACC since 2016 to assist people in chronic situations and stratified by the PHC according to the priority RAS: pregnant women, children, elderly people, hypertension, diabetes mellitus, and mental health. For the care, the service has a multi-professional team composed of 23 people from the following professional categories: social worker, nurse, physiotherapist, speech therapist, doctors with specialties in cardiology, endocrinology, geriatrics, obstetrics, pediatrics, and psychiatry, nutritionist, psychologist, and pedagogue.

In the pre-pandemic period, the RAS care was provided in person and individually, from Monday to Friday, in the morning and afternoon shifts. The multi-professional team was organized through continuous care to provide sequential care to people with complex chronic conditions who came to the SOC. The RAS for the elderly was the only one that did not provide care at the SOC's headquarters and was organized in a way that the multi-professional team traveled to the municipalities to provide care to people *in locu*.

In addition to the care services, the service performs matrix support actions as support for care management and continuing education for PHC professionals. Hence, the work processes that needed to be adjusted during the pandemic involved care and matrix aspects and were developed face-to-face, itinerantly, or remotely.

This report results from a postgraduate student's insertion into the SOC service. In the months preceding the pandemic, the insertion occurred face-to-face, and as COVID-19

advanced, the follow-up was performed remotely. This is the scenario of the Master's dissertation research approved by the Committee for Project Evaluation and the Committee for Ethics in Research with Humans (Opinion No. 4.032.609; CAAE: 27998719.8.0000.0104) and in accordance with Resolutions nos. 466/2012 and 510/2016 of the National Health Council on research with human beings.

## RESULTS

In order to better present the reorganization of the work process in the SOC with the COVID-19 pandemic, the results of this study were grouped into three categories: 1) planning for the reorganization of SOC; 2) face-to-face care activities in SOC and itinerant care activities in the municipalities; and 3) use of remote technologies for care and matrix support.

### Planning for the reorganization of specialized care

On March 23, 2020, in-person care at the SOC was suspended for two weeks with the recommendation that the team remain in their respective homes. As of April 6, 2020, the multi-professional team returned to the SOC to plan, together with the management, alternatives to minimize the impact of the suspension/decrease of services provided to people with chronic conditions who were in periodic follow-up at the service.

The following care strategies were defined: face-to-face appointments in the SOC, itinerant face-to-face appointments in the municipalities, and remote technologies for assistance and matrix support to the PHC teams. Given the need to serve the elderly population, which is the most vulnerable to COVID-19, the services that the SOC team performed itinerantly in the municipalities were extended to all the RAS. In addition, some municipal health vehicles could not take people over 60 years old, pregnant women, and children, which, for the RAS, directly affected the number of people served in the service.

Furthermore, the team has reorganized itself to maintain the matrix support for PHC remotely through phone calls, video calls, text messages, and e-mails.

### In-person assistance activities in specialized care

The resumption of in-person services implied structural reorganization to receive people safely. The service distributed alcohol swabs with 70% alcohol at strategic points, demarcated the distance of 1.5 meters between people, and prohibited the use of air conditioning, prioritizing the maintenance of open windows to favor airflow.

Properly trained and dressed nursing technicians were assigned to perform individual screenings of everyone at the entrance preceding access to the service facilities. The professionals inquired about their medical history regarding flu symptoms, contact with people with the flu, and checked their temperature.

The suspected cases of COVID-19 were redirected to the PHC of origin according to health recommendations. Even before people entered the service, identifying suspected cases were a key routine to prevent the spread of the virus in the waiting room and protect other people in the service and the health team. Nonetheless, it is noteworthy that no suspected cases were identified in the SOC, reinforcing the qualification of the previous triage performed by the PHC since appointments were only made for people with no suspicion of COVID-19.

The scheduling of face-to-face appointments was done at spaced intervals to avoid crowding in the waiting rooms. The PHC requested these appointments for cases in which a worsening in the clinical profile of the person with a chronic condition was recognized. Once the PHC requested the appointment, the multi-professional team of the SOC was responsible for regulating the schedules and confirming the face-to-face appointment, forwarding the information to the PHC (e.g., date and time scheduled). Altogether, the number of people attended in person by the RAS was reduced by 60%, from roughly 300 to 180 people per week. The use of cloth or surgical masks was required for everyone; for the multi-professional team, surgical masks, gloves, glasses or face shields, and apron were required.

Each service generated a multi-professional care plan as proposed by MACC. Health pacts, clinical goals, and drug prescriptions continued to be shared with the PHC team remotely, as was done in the pre-pandemic period.

### Itinerant assistance in the municipalities

The itinerant visits in the municipalities started to be performed by all the RAS and took place at the Basic Health Unit (UBS) headquarters. Previously, the UBS nurse contacted the nurses responsible for each RAS in the SOC, sending the risk stratifications of people with unstable chronic conditions. Each document was analyzed, the stratification was checked, and the appointment was scheduled. This scheduling occurred in agreement with the PHC, which was also responsible for notifying the people who would be seen and planning an appropriate place for these consultations.

The multi-professional SOC team went to the UBS on the scheduled date, which was already prepared to receive it. Each professional stayed in an office to provide continuous care, with individualized and sequenced care, as occurred in the SOC. The UBS professionals also came to accompany the specialized team's care in the format of shared care linked to the matrix support actions. In this reorganization, both the care activities and the educational support could be carried out concomitantly.

Before the consultations, people were evaluated to screen for respiratory problems, which was carried out by nursing professionals from the UBS. The people with scheduled care needed to wear cloth or surgical masks and the multi-professional team used surgical masks, gloves, glasses or face shields, and an apron. After the meetings, the product was a care plan prepared according to the MACC and already delivered to the person, besides being shared with the PHC.

In the period covered by the study, 22 itinerant activities were carried out in PHUs located in 11 municipalities, in which the entire multi-professional team participated and whose professionals were organized in rotation systems.

### Use of remote technologies for assistance and matrix support

Because they are part of risk groups, many people have been unable to return to face-to-face consultations at the beginning of the pandemic. Thus, the RAS of hypertension, diabetes mellitus, pregnant women, children, and the elderly were widely affected since, because of their health conditions, they were considered at risk for possible complications of COVID-19. Therefore, alternatives for non-face-to-face care and monitoring mediated using virtual or remote communication technologies were implemented into the service, and telephone calls were the resources most used by the service.

The multi-professional team divided itself into groups that performed remote consultations with people with chronic conditions and contacted the PHC teams for matrix support to perform the remote activities. There was no fixed division to execute these tasks, and a rotation among all professionals was performed with a previous schedule.

Regarding remote consultations, the professionals asked questions about self-care practices, such as using continuous medications, diet, physical activities at home, and guidance on recognizing early signs and symptoms of COVID-19. People were also asked about mental health during the pandemic, and all professional care had to be adapted to the pandemic scenario. Health professionals presented options for home exercises, especially for the frail elderly, where mobility needed to be encouraged daily. Nonetheless, one of the people's main complaints was the mental suffering caused by the restrictions and social isolation measures recommended by the WHO during the COVID-19 pandemic. Thus, more emotional support was offered when people reported suffering, with qualified listening, allowing them to verbalize their anguish and distress. People with signs and symptoms that indicated greater fragility were directed to the service's psychologist.

Regarding PHC support, the technical-pedagogical support of matrix support performed according to the MACC, was maintained; however, this support was given at a distance. The PHC support worked as a "second opinion" from specialists for the most challenging PHC management cases.[6] In addition, the moments of conversation between the SOC and PHC teams served to discuss clinical cases, adherence to care plans, reformulation of plans to meet people's needs, and monitoring people with stabilized chronic conditions and unstable conditions. Everything was done to set new goals or schedule care for difficult to manage patients.

In order to maintain the remote activities, all appointments were recorded in the patient's medical record, and the support activities for PHC were recorded in a specific document used by the team. The approximate number of remote consultations performed by the RAS reached approximately 150 people per week.

## DISCUSSION

According to MACC,[6] people with chronic conditions receive care based on three pillars: 1) risk stratification, which is performed according to the guidelines, whose low, moderate, and high-risk stratus guarantee access to the necessary service; 2) self-care supported by health professionals with actions directed to people's protagonism to learn to take care of themselves; and 3) care plan, with health goals for the person to achieve the stabilization of their conditions; such plans are elaborated by multi-professional teams and agreed with the people assisted.

The advance of the COVID-19 pandemic in Brazil produced repercussions on health services, making it necessary for them to reorganize themselves to preserve the health of the people they served. Additionally, people with chronic conditions would not be left unattended by professionals because these conditions, even if stabilized, demand continuous care and monitoring.

As the SOC is responsible for assisting people with complex chronic conditions,[6] it was necessary to quickly restructure its services to offer continuity of care to the assisted people and, consequently, avoid overloading the tertiary sector, which was already affected by the pandemic.

Thus, it was established that the SOC would maintain its activities but reorganize its work processes according to the degree of stability of the population, which varied from stabilized chronic conditions to persistent instability with the presence of influenza syndrome. After identifying the degrees of stability,[11] people with unstable chronic conditions received individualized care by SOC professionals either remotely or in-person; people with stabilized conditions maintained the follow-up in PHC under the supervision of SOC.[11]

For people with unstable conditions, the care provided in the specialized service followed current protocols that, in addition to standard precautions, called for the implementation of contact precautions, droplet precautions, and aerosol precautions.[12] The data showed that the service maintained the actions for the continuity of care, with longitudinal monitoring of people with complex chronic conditions according to their risk stratum, clinical stability, self-care capacity, and professional support to face the pandemic. This support occurred mainly through remotely monitoring the care plan with the help of the PHC and according to normative guidelines.

In this pandemic moment, the importance of the multi-professional health team stands out, and it has reorganized its care practices to provide satisfactory outcomes to the people assisted.[7] As a highlight of this reorganization, remote consultations made by phone calls predominated. Older and less educated people had difficulties using other tools for remote care.[13]

The appointments, even if remote, were a means of motivating adherence to drug therapy and behavioral changes necessary to treat the chronic condition.[5] In addition to assistance, the service maintained the activities of matrix support to guide the cases that

remained under PHC monitoring. The remote work was organized to support PHC as technical-pedagogical basis in guiding cases that would remain under PHC monitoring.[14] Joint discussion of cases, construction of the care plan, and "second opinion" of specialists were actions performed remotely,[11] contributing to the maintenance of continuity of care according to the MACC.

Considering that the primary purpose during this pandemic is to prioritize the reduction of health risks, in addition to providing satisfactory outcomes for people with complex chronic conditions, reports like this one are necessary to provide information, share strategies, and describe reorganizations of work processes during the pandemic period, which can assist other health services.

## CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

This report presented the healthcare team's experience from specialized care in reorganizing the work process to provide continuity of care for people with complex chronic conditions during the COVID-19 pandemic. The results showed that nobody with suspected COVID-19 symptoms was scheduled for the SOC, and the appointments respected the schedule spacing; protective measures were implemented for the team and the people cared for, demonstrating rigorous compliance with health recommendations.

Integrating the multi-professional team to develop this study was fundamental because the team participated in the decisions with the SOC management personnel. In addition, they had the autonomy to organize and restructure the face-to-face care in the SOC (itinerant in the municipalities or remote), emphasizing the activities of matrix support for PHC. This report demonstrated, therefore, that the modifications that occurred in the work process of the SOC during the pandemic allowed the continuity of care for people with complex chronic conditions.

The limitations of the study include the lack of research on the reorganization of outpatient care for people in chronic situations, which made it impossible to have a broader discussion. It is also relevant to point out the limitations imposed by the pandemic itself, which had repercussions on the suspension of the researcher's permanence in the service and making it necessary to resort to video conferencing or video calls so that the research could be finished without hampering the quality of the final product.

Lastly, this report presents contributions and implications for the practice, planning, and development of modifications in outpatient services that use the MACC as a model of care. Even amid the pandemic, these services needed to maintain the follow-up and monitoring of people's health with complex chronic conditions, minimizing decompensation and, consequently, reducing the need for these people to use health services.

## AUTHOR'S CONTRIBUTIONS

Experience report design. Francielle Renata Danielli Martins Marques. Maria Aparecida Salci. Ligia Carreira.

Information gathering. Francielle Renata Danielli Martins Marques.

Analysis of the experience. Francielle Renata Danielli Martins Marques. Lilian Ferreira Domingues.

Interpretation. Francielle Renata Danielli Martins Marques. Lilian Ferreira Domingues. Maria Aparecida Salci.

Writing and critical revision of the manuscript. Francielle Renata Danielli Martins Marques. Lilian Ferreira Domingues. Lígia Carreira. Maria Aparecida Salci.

Approval of the final version of the article. Francielle Renata Danielli Martins Marques. Lilian Ferreira Domingues. Lígia Carreira. Maria Aparecida Salci.

Responsibility for all aspects of the content and integrity of the published article. Francielle Renata Danielli Martins Marques. Lilian Ferreira Domingues. Lígia Carreira. Maria Aparecida Salci.

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