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Assessment of Experiences and Needs in the Implementation of the Pilot for the Deployment of Territorial Teams: Health Model based on Primary Care in Bogotá (Colombia), 2021

Valoración de experiencias y necesidades en la implementación de la prueba piloto de despliegue de los equipos territoriales: modelo de salud basado en atención primaria en Bogotá (Colombia), 2021

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ABSTRACT

The current administration of Bogotá (Colombia) seeks to adjust the city's health model, base it on primary care, and offer quality health care. Hence, the District Health Secretariat has carried out, for three months, a pilot test of interdisciplinary territorial teams that provide resolute home care in the most vulnerable areas of the city to adjust before its deployment throughout the city. The objective of the accompaniment was, among others, to investigate the experiences and perspectives of the actors involved in the planning and execution of this pilot to recognize learning and generate recommendations for adjusting the operation of the equipment. Through a mixed analysis, the information collected through focal groups and in-depth interviews with the participants of the exercise was analyzed, who highlighted the importance of the phases before implementation, covering an adequate induction and training of professionals in the field; prior dissemination of the intervention; community involvement during the planning, implementation and monitoring process; the prior assurance of the inputs and knowledge required for care, and the adaptation of the proposed strategies to the territorial context. It is important to point out that this type of health program must have an iterative development process, which requires constant evaluation in the different stages of planning and implementation that lead to improvements in the processes.

Keywords

primary health care; community medicine; health care models.

RESUMEN

La actual administración distrital de Bogotá (Colombia) busca ajustar el modelo de salud de la ciudad, para basarlo en la atención primaria y ofrecer calidad de cuidado en salud. De ahí que la Secretaría Distrital de Salud haya realizado, durante tres meses, una prueba piloto de equipos territoriales interdisciplinarios que brindan atención resolutiva domiciliaria en las zonas más vulnerables de la ciudad, para hacerle ajustes antes de su despliegue en toda la ciudad. El objetivo del acompañamiento fue, entre otros, indagar las experiencias y perspectivas de los actores involucrados en la planeación y ejecución de esta, con el fin de reconocer aprendizajes y generar recomendaciones para el ajuste de la operación de los equipos. Mediante un análisis mixto, se analizó la información recolectada por medio de grupos focales y entrevistas a profundidad a los participantes del ejercicio, quienes resaltaron la importancia de las fases previas a la implementación, abarcando una adecuada inducción y capacitación de los profesionales en campo; la difusión previa de la intervención; la vinculación de la comunidad durante el proceso de planeación, implementación y monitorización; el aseguramiento previo de los insumos y conocimientos requeridos para la atención, y la adaptación de las estrategias propuestas al contexto territorial. Es importante señalar que este tipo de programas en salud deben tener un proceso de desarrollo iterativo, lo que requiere una constante evaluación en las diferentes etapas de planeación e implementación que lleven a mejoras en los procesos.

Palabras clave

atención primaria de salud; medicina comunitaria; modelos de atención en salud.

Introduction

Latin America is one of the regions with the greatest inequalities in the world, due to health disparities as well as its socioeconomic and cultural characteristics (1), which are intensified by factors such as violence and migratory dynamics. Colombia is no exception, and its capital, Bogota, is the center of arrival for a large number of displaced persons due to the internal conflict in the country or adverse situations in other countries—mainly the case of Venezuelans in recent years (2,3). Furthermore, the city has a high burden of disease due to chronic non-communicable diseases such as neoplastic, cardiovascular, and musculoskeletal diseases. In addition, despite efforts, there are still reported cases of child malnutrition and perinatal conditions that mainly affect the most vulnerable population, including gender, age, and disability factors (3).

In the District Development Plan (2020-2024) of the current administration of Bogota, Goal 16 was incorporated, which seeks to adjust the health model of the city to base it on Primary Health Care (PHC) and positively influence the socio-environmental determinants of health (4-7). The adjustment, or Territorial Health Model (THM), incorporates a population-based differential approach based on citizen culture, gender, participation, and resolution, which includes the rural population and the population with disabilities. The THM proposed to have an operational component of attention, territorial equipment (TE), composed of a base equipment

(BE) and a complementary equipment (CE), to directly reach the homes of the families in the areas targeted mainly by multidimensional poverty index.

The objective of the TEs is to bring healthcare to the homes using a BE, composed of a general practitioner, a nursing assistant, and an environmental or public health technician who carries a kit with biomedical elements. In its initial visit, the BE characterizes the social and environmental conditions of each home, analyzes the affiliation status to the General Social Security Health System, and consults the health situation of the individuals present in the home, regardless of their insurance, age, and family relationship, among others. If necessary, the BE refers individuals to a specialist and can prescribe drugs and order paraclinical tests for those who are affiliated with Capital Salud EPS-S.

Subsequently, a CE, which includes nursing, psychology, nutrition, and oral hygiene professionals, analyzes the information collected in the BE visit and classifies the family according to a series of priorities: 1) high, those households with a priority population without control or requiring complementary psychology or nutrition diagnoses; 2) medium, those families with a priority population without health alerts; or 3) low, otherwise. After the referred diagnoses, the BE and the CE meet in a Family Care Committee, in which recommendations are made to improve or maintain family health. With these self-care suggestions, the CE visits the homes again to present them and, with the family's consent, agree on a Family Care Plan which will be the basis for the follow-up that will be done by telephone with each household.

Although TE management focuses on assisting families during home visits, it is not limited to home visits but encompasses the knowledge management that is carried out with the information collected. For this reason, the actions of the TEs also contemplate approaches to the community and the transfer of information and articulation with other intra- and intersectoral actors.

To field test the deployment of the aforementioned TEs after implementation throughout the city, a pilot project was conducted for three months within the framework of an agreement between the District Health Secretariat and the State Social Enterprise Southwestern Integrated Health Services Subnetwork (Empresa Social del Estado Subred Integrada de Servicios de Salud Sur Occidente [SISSSO]). The purpose of this project was to operate fifty TEs in twelve neighborhoods in the four localities of influence of this subnetwork (Bosa, Fontibón, Kennedy, and Puente Aranda), prioritized due to their high poverty, morbidity, and mortality rates and high demand for healthcare services.

In the context of this pilot test, an equipment from the Pontificia Universidad Javeriana was in charge of accompanying and monitoring the implementation of this test and generating adjustments based on the findings obtained to seek better results and impact before the deployment of TE in other targeted areas of the city. The objective of this study was to inquire about the experiences and perspectives of each of those involved in the planning and execution of the SLM pilot test, to recognize lessons learned, and to make useful recommendations for the implementation process throughout the city.

Methodology

Study design

A descriptive-qualitative exploratory study was conducted between February and March 2021 (8-10). This study was approved by the Research and Institutional Ethics Committee of the Hospital Universitario San Ignacio and the Pontificia Universidad Javeriana, as per the act FM-CIE-1145-20 of November 20, 2020.

Participants and study description

The information about the experiences expressed by those individuals involved in the design and

implementation of the pilot test of the TEs in the framework of the THM was collected through focal groups (FG) and semi-structured interviews (SSI).

Eighteen FGs with different profiles (BEs, CEs, and other stakeholders) participated in the design and implementation of the pilot test in the four locations described (Table 1). The FG participants were selected by SISSSO from those who had been involved in the pilot for at least two weeks. It is important to mention that beneficiary families were not included in this exercise.

Table 1. Distribution of focal groups and interviews

Table 1
Distribution of focal groups and interviews

Focal groups				
Equipment	**Profession or occupation**	**Number of groups**	**Participants per group**	**Number of participants**
Base equipment	Physician	2	6	12
	Nursing Assistant	2	7 group 1 6 group 2	13
	Public health/environmental technician	2	8 group 1 6 group 2	14
Complementary equipment	Nursing	2	5	10
	Psychology	2	5	10
	Nutrition	1	3	3
	Oral Hygiene	1	5	5
Logistical support	Social work	1	4	4
	Territorial leaders	2	4	4
Data management	Systems Engineer	1	4	1
	Systems/administrative technician			2
	Typist			1
District Health Secretariat	THM Lawyer	1	2	1
	THM Relationship Referent			1
SISSSO	Model referent	1	2	2
	Director of risk management			
Total semi-structured interviews	**Focal groups**	**18**	**Participants**	**83**

Equipment	**Profession or occupation**	**Number of interviews**	**Participants per interview**	**Number of participants**
Community	Community representatives (one per locality)	8	1	4
SISSSO	SISSSO Manager	1	1	1
	SISSSO Assistant manager	1	1	1
	Geographer	1	1	1
District Health Secretariat	THM Manager	1	1	1
	THM Geographer	1	1	1
	THM training referent	1	1	1
Total	**Interviews**	**14**	**Participants**	**10**

THM: Model of Primary Territorial Health Care; SISSSO: Integrated Health Services Sub-Network Southwest SSI.

Fourteen SSIs were carried out: 8 to community representatives, previously identified by the SISSSO, to evaluate, at two different times, the change in their perspectives during the implementation of the pilot test, and six to specific profiles of the SISSSO and the District Health Secretariat, who formed part of the design and implementation of the pilot test, to learn about the experience from the perspectives of management, administration, and direction. The details of the FGs and SSI developed are presented in Table 1.

The topics to be addressed in the FGs and SSIs were established based on THM approaches and reviewed iteratively between the District Health Secretariat and researchers from the Pontificia Universidad Javeriana. The categories underlying the SSI and the FG were: the territorial component of THM (planning, dissemination, implementation, and family care plans), capacities and needs (inductions, resources and physical spaces, and time resources), relationships with others, objectives, and attributes of THM (PHC, socio-environmental determinants of health, territorial, differential, and gender approaches, participatory, and resolutive). After establishing the categories, a pilot of the FGs was carried out with the researchers.

Data collection and analysis

During the FGs and SSIs, conducted by a psychologist-anthropologist and a physician and with an average duration of 60 minutes, the participants' experiences during the performance of their role, their perceptions during the

implementation of the pilot test, and aspects and opportunities for improvement for the field operation of the TEs for each of the above-mentioned categories were discussed. The interactions were carried out with the prior verbal and informed consent of the participants.

The FGs and SSIs were recorded and transcribed, anonymized, and then the transcripts were reviewed for accuracy. Finally, deductive and inductive content analysis (11,12), according to the process described by Elo and Kyngäs (13), was used to explore the experiences and opinions of the participants. NVivo 12 (14) was used for coding and analysis.

Results

The main findings identified by category in the FGs and SSIs conducted on the different individuals involved in the implementation of the TE pilot test in the THM adjustment framework are presented below.

Territorial Component of the Territorial Health Model

The pilot test went through the planning, dissemination, and implementation stages. First, the entities in charge of planning the operation, in this case, the District Health Secretariat and SISSSO, emphasize interdisciplinarity and teamwork. In addition, this process was supported by the lessons learned from projects implemented by previous administrations, consistent with the objective of "building on what has been built."

The participants suggested the need for a more explicit general operational document than the one used in the pilot test, in which the functions and activities of each professional profile are established, as well as the processes to be developed. One of the territorial leaders of the TEs gave an account of this in the following intervention:

> Although prior work was done to analyze the operational needs, the participants describe that additional preparation time is needed between the signing of the agreement and the start of fieldwork by the TEs. This time would be used for the approval and allocation of resources, the definition of administrative roles, the purchase of equipment (biomedical, biosafety, technological, and communications equipment, transportation, etc.), the setting up of sites, the hiring and induction of personnel, and the socialization of the THM with the professionals of the subnetwork.

Regarding diffusion, the participants stressed the importance of a territorial reconnaissance process before the start of the fieldwork to identify the particularities of each neighborhood and its options for the diffusion of local information, for example, through community representatives. These people should be, from the beginning, central figures in the development of the project. In addition, the scope of the TEs and the THM must be shared with the community from this first approach.

The participants also considered that the diffusion of the PHC-based model is fundamental, being part of the district's political agenda to ensure that its existence, objectives, and methodology are promoted on a large scale, either through mass media or within the health centers and hospitals of the different localities. The city's health system and other district entities must be aware of and support the project.

During the implementation of the pilot test, the professionals recognized great strengths, such as the capacity of the TEs to bring health to the most vulnerable populations in Bogota. They believe that it will have a positive impact on people's well-being and quality of life. They value the effort to understand the context in which individual, family, and neighborhood dynamics develop, as they can guide the approach of medical, environmental, and social intervention. They agree that one of the most relevant elements was to count on interdisciplinary teams made up of professionals and technicians from the health and social disciplines. They emphasized the willingness to serve and the commitment of those involved in the THM.

As an opportunity for improvement, they mentioned that more importance and speed should be given to the processes of communication and follow-up of obligatory notification events (for example, cases of child malnutrition, violence, or mental health).

Concerning the dynamics of the care committees for the elaboration of health recommendations, the need was identified to standardize the activities and responsibilities carried out in these boards since it was observed that different processes were being carried out in each locality.

Therefore, this space should function as a place for interdisciplinary dialogue and discussion in which professionals provide their points of view on the situation of each family and generate practical, contextualized, and specific recommendations for each household.

In addition, regarding the process of delivering the recommendations to the families already visited, the participants suggested that, for families classified as low priority, the recommendations should be socialized at the characterization meeting. With them, it would not be necessary to take the case to the Care Committee or to resubmit the Family Care Plan. Furthermore, they suggested using graphic resources with health promotion and prevention information according to the life cycle to make the recommendations clearer for the families. They mentioned that low-priority families do not show as much interest and even feel uncomfortable receiving "always the same recommendations." In addition, they considered that such deliveries take a lot of time, which could be used for other purposes.

Regarding the delivery of family care recommendations, it is essential to ensure that professionals have sufficient time and resources to perform this process. Each family must be given individualized care, respecting the confidentiality of the individuals as patients. Finally, regarding the care recommendations, their format and the language used must be friendly and understandable. It is suggested that field or concept tests be conducted using cognitive interviews with people being attended to evaluate the aforementioned aspects.

Capabilities and needs

In analyzing this category, we identified three subcategories: (i) inductions, (ii) physical resources and spaces, and (iii) time resources. In the pilot test, all those involved attended an induction on THM and TE management. However, the participants stressed the importance of clear and standardized inductions with practical exercises that exemplify field activities and provide information on data collection tools.

In addition, they expressed the need to receive periodic training and updates on topics related to the provision of health services. The topics proposed included technical aspects such as the use of tools for data collection, updating clinical practices, knowledge of governmental and non-governmental programs to guide families, etc.

The second subcategory identified referred to the physical resources and spaces required by the TE members. Five groups of essential elements were identified: (i) biosecurity, (ii) biomedical, (iii) technology and connectivity, (iv) location in the territory, transportation, and headquarters, and (v) items of furniture. Although it was expected that during the pilot test the professionals would have most of these implements, due to administrative difficulties they were not always available, were insufficient, or arrived in the last three weeks of the fieldwork. For this reason, the participants consider it pertinent to have these elements in sufficient quantity and quality before starting the implementation. It was identified that participants perceived a direct relationship between having the necessary resources and their job satisfaction, the quality of the data collected, the team's ability to solve problems, and the receptiveness of the families attended.

Data collection formats or instruments were a very relevant issue in all the FGs and SSIs. In the pilot test, data were collected in a Microsoft Excel format with several open fields

that did not contemplate the hierarchy between questions. One file was filled out per family, and then the information was compiled and validated manually. The participants in the FGs and SSIs point out that innovative and appropriate technological aids should be used for the collection, storage, and organization of large amounts of information. In addition, specific training should be provided on the use of the tools and the application and interpretation of the questions and response possibilities, since this is the only way to provide quality data. Finally, they consider that it is important to provide feedback on these formats to improve them based on field experience.

The last subcategory identified refers to what is necessary for the development of the activities of the different TE profiles. Concerning this, two themes were emphasized: the first is to strengthen the planning of the activities of each role, taking into account the objective of their work and the context of the community in which they will participate; the second is regarding the measurement of results. All participants considered that it is better to evaluate productivity per individual and not per family, without neglecting the health approach per family nucleus and its quality.

Relations

The relationships between the professionals who participated in the design and implementation of the TEs were examined. In general, it was observed that for most of them, it was essential to have clarity about their duties, capacity for action, and those of each profile. Knowing who to turn to at different times and having clarity about the activities of the members generates a sense of well-being among the collaborators, improves communication between individuals, and increases their job satisfaction. Conversely, the lack of this knowledge can affect the functioning of ETs, as reflected in one of the comments of a physician who expected his social worker colleague to assume responsibilities other than those indicated in her contract:

> The management of the social work role is not clear. For example, you need them to make an affiliation and they say they cannot... You say to the social workers: "Come on, this person has been asking for an appointment for so many days," but they answer that it is not their job to make these procedures; then, as a physician, you look bad. (FG, physician).

When speaking about relations with external entities, all members considered it essential to manage inter-institutional links, programs, or projects that could solve the needs identified by the BE in the population of the intervened neighborhoods. Some of the entities mentioned by the participants were: private benefit plan administrators, other district secretariats (the Secretariat of Social Integration, the Secretariat of Women, the Secretariat of Habitat and Environment, the Secretariat of Security, and the Secretariat of Government), and sub-secretariats of the District Secretariat of Health, the Special Administrative Unit of Public Services, and other home care programs of each subnetwork.

They considered that managing and strengthening the links between entities would increase and reinforce the model's resolving power, which would lead to a real impact on the socio-environmental determinants of health and the quality of life of the inhabitants of Bogotá.

Model objectives and attributes

The TEs are based on the PHC, seeking to have an individual and community impact on morbidity and mortality indicators, in addition to the socio-environmental determinants of health, as well as to respond to the THM approaches (e.g., territorial, population, differential, gender, participatory, and resolutive). For this reason, all participants were asked about how the latter were implemented in daily practice.

The people approached mentioned, as a circular relationship, the incidence of socio-environmental determinants of health in the morbidity and mortality of the communities. The importance of this topic for the community representatives in each locality is noteworthy.

All of them consider that this issue should be an integral part of the management of the TEs to canalize the environmental needs to the institutions responsible for providing an appropriate solution.

Considering that Bogota has great ethnic and racial diversity, the presence of foreigners, various religious beliefs, and diverse gender identities and sexual orientations, it was opportune for the participants to discuss the approaches and attributes of the model. People highlighted the importance of identifying, recognizing, and integrating the particular and differentiating needs of each community and territory, as well as their priority groups for health interventions.

This means that, even when some TE deployment procedures are standardized, they must be flexible enough to address each collective, bearing in mind their particular and differential characteristics, and seeking real acceptance by the population.

Related to the previous points, the importance of participation, constant feedback, and openness to change was highlighted. This appreciation is an invitation to count on the perspective of the community and of the actors involved in the provision of the service in the territory (medical professionals, nurses, psychologists, etc.). For the latter, opening these spaces for participation would have two important effects: (i) to help in the joint construction and continuous improvement of the THM's TE processes; and (ii) to generate a sense of belonging and responsibility in all areas, promoting adoption and loyalty to the model.

Lastly, regarding the resolutive intention of the THM, the participants emphasized the importance of providing solutions to the individual and community needs encountered and not limiting themselves to characterization. They consider that to ensure resolutive capacity, it is crucial to achieve integration with other governmental and non-governmental sectors, as well as the sustainability of the services provided.

Discussion

Based on the lessons collected in the FGs and SSIs, and taking into account the findings and reflections of similar international research (5-8), a three-stage plan is proposed to undertake similar health models: planning, implementation, and monitoring. For organizational reasons, the stages are presented consecutively; however, it should be kept in mind that since this is a complex intervention with multiple interacting components, they should not be developed linearly. On the contrary, there must be constant and iterative feedback for the continuous improvement of the process (15).

Planning

The first stage comprises the actions before the first contact with the community and the development of inter-institutional work. In principle, a leadership team is established in charge of agreeing on the respective responsibilities, commitments, and goals for the implementation of the respective model. The participants highlighted the need to prioritize inter-institutional relationship processes, within and outside the health sector, to increase decision-making power and provide solutions to the needs in terms of health and socio-environmental determinants. Other authors also emphasize the importance of creating a network of organizational leaders at all levels as a mechanism to implement high-quality health models (16).

One way to encourage the participation of all sectors involved is the creation of a directory of available services and resources so that professionals in the territory can adequately guide citizens. This is in agreement with Mosquera et al. (17), who used comprehensive care routes as a mechanism to improve access to health services in a community in Bogotá (Colombia). In this case, there was inter-institutional work to identify and link the entities that respond to the social needs of the locality, in addition to providing information to individuals

about their rights and mechanisms to guarantee them. Improving access to healthcare services is strongly recommended to ensure greater adherence of the community to primary care practices as well as channeling specialized care, pointing out a proportional relationship between the willingness and speed of the professional to refer patients when necessary and the users' satisfaction (18).

Taking into account the structure proposed for the TEs and the conclusions of various studies showing the effectiveness of PHC (19-21), it is recommended that, during this phase, the human team that will provide services to the communities be formed and its functions clearly established. It also highlights the importance of guaranteeing at all times the biomedical, biosecurity, communication, and technology resources to fulfill their functions with efficiency and quality, as well as the creation of an explicit operational document where the standardized functions of all the individuals participating in the implementation are established.

In a review of facilitating aspects and barriers to the implementation of a PHC program focused on dementia, Chaw et al. (22) found in nine of ten studies that professionals considered access to clear and standardized training an essential facilitator. This was also found in the present study: all participants emphasized the need for an induction and training process that includes historical, political, social, and theoretical context on which the model is based; their objectives, scope, and approaches; the functions and activities of each actor; as well as the tools they have to carry them out; and other useful topics in the daily development of health care.

In addition to the theoretical component, it is favorable to do practical exercises on the activities to be carried out in the field. It is considered essential to work on the soft skills of the professionals to strengthen bonds and harmonious work, in addition to generating spaces for communication among them. It has been shown that this improves the relationships between teams as well as the efficiency of the model. This aspect becomes especially important when the healthcare teams meet subjects with a higher level of comorbidities or more social difficulties (23).

During the planning phase, it is also suggested to establish productivity and efficiency goals for the deployment of care groups. However, it is important to take into account the characteristics of the territory and population density, among other factors that facilitate or hinder the achievement of these goals. Excessive goals that are not in line with the context may reduce effectiveness and timely access to healthcare (13).

Finally, it is proposed to develop a solid and orderly information system with technological tools. This could increase the quality of the information and the effectiveness of the teams by reducing the time required to collect information and review and debug databases. Ideally, this type of technology should be linked to a health alert system that identifies the cases that should be treated as a priority or urgently channeled Implementation (24).

Implementation

The second stage of the project begins after the first contact with the territory by the professionals who will implement the model. To begin with, it is important to conduct a diffusion process. The participants of the focal groups mentioned that it was fundamental to make the project known in the communities, using communication strategies that take into account the dynamics and characteristics of the territory. This requires the capacity for adaptation by professionals in the field. Craig et al. (15) insisted that complex health interventions be more flexible to adapt to local dynamics rather than being standardized processes to be replicated on a large scale.

For example, the crisis caused by the SARS-CoV-2 infection generated the need to reorganize the healthcare systems since the increase in demand for professionals in healthcare institutions reduced the availability of workers to carry out fieldwork, such as those performed by

ETs. Likewise, the concern of the professionals for having personal protection elements increased as they were more exposed, given the characteristics of their work (25,26), a fact that is reflected in the reports of the participants in this project, who pointed out the pandemic as a major limitation during the development of the THM pilot test.

On the other hand, once the activities of characterization, identification of needs, referral to health services, and recommendations for promotion and prevention are initiated, they should be based on high-quality scientific evidence, either the country's guidelines or international recommendations for healthcare promotion and prevention in PHC. Accordingly, the World Health Organization considers PHC as one of the cornerstones of universal health coverage and as an approach to health and well-being focused on the needs and circumstances of individuals, families, and communities, with the advantage that PHC assesses life-cycle illnesses (23).

Bodenheimer et al. (16) show the importance of generating patients' commitment to their own health. This is reflected in the Care Plan agreed upon in the management of TEs. The participants considered this to be a very helpful strategy for each family nucleus to become involved with the self-management of their health and take an active role. It is recommended that this document be prepared, delivered, and explained to family members without violating their privacy. In addition, it should use simple language and be adapted to the needs and capabilities of each family as well as to their sociocultural context.

Monitoring

The third stage involves a process of evaluation and constant improvement of the processes. To this end, basic information must be available to compare progress and impacts over time, so it is usually suggested to build a set of indexes and indicators to facilitate the monitoring and evaluation of crucial aspects. In this sense, it is necessary to identify to what extent the achievements obtained in healthcare management are attributable to the proposed model.

On the other hand, it is suggested to periodically open spaces for dialogue and feedback with the different actors of the model to evidence their degree of satisfaction and hear suggestions. In the case of the TEs, by listening to the opinions of the participants in the focal groups, opportunities for improvement and recommendations for the project were identified.

Complementarily, and to give greater relevance to the territorial and participatory attributes of TEs, people considered that interaction with the community should be increased, including it in construction spaces, differentiating needs by territory, and managing local connections. Giraldo and Vélez (24) agree that one of the great challenges for Latin American healthcare systems that are in the process of implementing PHC-based models is the limited community participation, which is why they highlight its strengthening as a priority.

Finally, monitoring implies flexibility to adapt to and overcome difficulties that arise not only in the development and fulfillment of the activities of each model but also in the availability of the information necessary for follow-up and evaluation (26).

Conclusion

Increasingly, PHC has greater relevance in the healthcare of populations and is one of the proposals to reduce the gaps in access to health services. The pilot implementation test of the BEs in the Colombian capital revealed opportunities for improvement and identified the relevance of including the community in the deployment of the district THM, ensuring the required inputs and knowledge beforehand, and adapting the proposed strategies to the context and needs of each community, among other aspects. The above is essential to achieving greater acceptance of the management of the teams by the community so that the healthcare of the most vulnerable people in the city is more effective and

progress is made in the achievements outlined in the District Development Plan in this area.

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Conflict of interests

The authors declare that we do not have any conflict of interest related to this publication.

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