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RESEARCH | PESQUISA

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Work process for coordination of care in the Family Health Strategy

Processo de trabalho para coordenação do cuidado na Estratégia de Saúde da Família

Proceso de trabajo para la coordinación de la atención en la Estrategia de Salud de la Familia

Átila Chagas de Araújo[1,2]
Luiza Jane Eyre de Souza Vieira[2]
Antonio Rodrigues Ferreira Júnior[3,4]
Antonio Germane Alves Pinto[5]
Kerma Márcia de Freitas[2,6]
Camila Lima Ribeiro[2,7]

1. Universidade de Fortaleza, Instituto de Educação Superior Raimundo Sá. Fortaleza, CE, Brasil.

2. Universidade de Fortaleza, Programa de Pós-Graduação em Saúde Coletiva. Fortaleza, CE, Brasil.

3. Universidade Estadual do Ceará, Programa de Pós-Graduação em Saúde Coletiva. Fortaleza, CE, Brasil.

4. Universidade Estadual de Campinas, Programa de Pós-Graduação em Saúde Coletiva. Campinas, SP, Brasil.

5. Universidade Regional do Cariri, Programa de Pós-Graduação em Saúde da Família. Crato, CE, Brasil.

6. Centro Universitário Vale do Salgado, Departamento de Enfermagem. Icó, CE, Brasil.

7. Universidade Federal do Ceará, Maternidade Escola Assis Chateaubriand. Fortaleza, CE, Brasil.

Corresponding author:
Camila Lima Ribeiro.
Email: camila_lima_ribeiro@hotmail.com

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Abstract

Objective: To understand the work process of Family Health Strategy teams in the coordination of care, highlighting factors involved in this coordination. **Method:** Qualitative study based on the attributes of care coordination, carried out with 18 care and management professionals between January and March 2020. **Results:** Three final themes emerged: "Care plan"; "Standardization of practices"; and "Dialogical communication at different levels of care". The pattern of responses points to the fragmentation of care and weakens coordination mechanisms. The exposure of restrictive factors related to the meso- and macro-organizational levels of the municipal health system reverberates in the ability of teams to coordinate care. **Conclusion and implications for practice:** The coordination of care faces obstacles related to the work process of teams and structural issues in the organization of the health network. The contributions go beyond care and management, reaching education, research, and extension in professional training. Permanent education enables reorientations to guarantee the flow of users in the care network and provide comprehensive care to the population.

Keywords: Delivery of Health Care; Primary Health Care; Family Health Strategy; Health Management; Unified Health System.

Resumo

Objetivo: Compreender o processo de trabalho de equipes da Estratégia Saúde da Família na coordenação do cuidado, ressaltando fatores intervenientes a essa coordenação. **Método**: Pesquisa com abordagem qualitativa, ancorada nos atributos da coordenação do cuidado, realizada com 18 profissionais da atenção e gestão, entre janeiro e março de 2020. **Resultados**: Emergiram três temas finais: "Plano de cuidados", "Alinhamento de condutas" e "Comunicação dialógica nos distintos níveis de atenção". O padrão de respostas aponta a fragmentação da assistência e fragiliza os mecanismos de coordenação. A exposição de fatores restritivos relativos ao nível meso e macro organizacional do sistema municipal de saúde reverbera na capacidade das equipes de coordenar o cuidado ao usuário. **Conclusão e implicações para a prática**: A coordenação do cuidado enfrenta obstáculos relacionados ao processo de trabalho das equipes e questões estruturais na organização da rede de saúde. As contribuições transpõem a atenção e gestão, alcançam o ensino, pesquisa e extensão na formação profissional. A educação permanente possibilita reorientações para garantir o fluxo dos usuários na rede de atenção e propiciar atenção integral à população.

Palavras-chaves: Atenção à Saúde; Atenção Primária à Saúde; Estratégia de Saúde da Família; Gestão em Saúde; Sistema Único de Saúde.

Resumen

Objetivo: Comprender el proceso de trabajo de los equipos de la Estrategia de Salud de la Familia en la coordinación de la atención, destacando los factores involucrados en esa coordinación. **Método:** Investigación con abordaje cualitativo, anclada en los atributos de la coordinación de la atención, realizada con 18 profesionales asistenciales y gestores, entre enero y marzo de 2020. **Resultados:** Surgieron tres temas finales: "Plan de cuidados"; "Alineación de conductas"; y "Comunicación dialógica en los diferentes niveles de atención". El patrón de respuestas apunta a la fragmentación de la asistencia y debilita los mecanismos de coordinación. La exposición de factores restrictivos relacionados con el nivel meso y macro organizacional del sistema de salud municipal repercute en la capacidad de los equipos para coordinar la atención al usuario. **Conclusión e implicaciones para la práctica:** La coordinación del cuidado enfrenta obstáculos relacionados con el proceso de trabajo de los equipos y cuestiones estructurales en la organización de la red de salud. Los aportes van más allá de la atención y la gestión, alcanzan la docencia, la investigación y la extensión en la formación profesional. La educación permanente posibilita reorientaciones para garantizar el flujo de usuarios en la red de atención y brindar atención integral a la población.

Palabras-clave: Atención a la Salud; Atención Primaria de Salud; Estrategia de Salud de la Familia; Manejo de la Salud; Sistema único de Salud.

INTRODUCTION

Family Health Strategy (*Estratégia Saúde da Família* - ESF) is known for actions that improve Brazilian health by expanding, qualifying, and consolidating the attributes of Primary Health Care (PHC). Advocated as the preferential access to the Brazilian Unified Health System (*Sistema Único de Saúde* – SUS)[1,2] due to its dissemination in different territories, with its dynamics and vulnerabilities,[3] this care model has shown to be powerful for welcoming the users' needs and enhancing health indicators.[4]

Enhancing the work process as a powerful tool to implement patient-centered care practices[4,5] comprises the construction of interdisciplinary, shared care, which formulates and reformulates a unique therapeutic project integrated to family context and patient social support, extrapolating the organicist view of the individual clinic.[6]

Thus, when carrying out activities, it is necessary to perform a diagnostic assessment of patients, identifying their needs and care demands, detecting populations which are more vulnerable to fragmented care and determining likely challenges to care management.[7,8]

The importance of standardized practices, clinical protocols, and evidence-based directives is inherent to clinics providing anticipatory care[9,10] and widely acknowledged. These measures are intended to standardize work processes, identify, and stratify risks, help understand the most used services, and assess performance, improving the flow of PHC patients requiring secondary or tertiary care.[11-13]

Outside Brazil, studies have identified planning gaps across care levels, contributing to duplicated diagnostic tests, the misuse of reference services, and discontinued care, which compromises care quality.[14,15] Studies also mention that the necessary elements of individual health planning depends on a connection among these services through information exchange and unified care plans, synchronized with care interfaces.[16]

The analysis of this work process reveals a complex reality regarding structure and processes that enable planning, organizing, and carrying out standardized practices in coherence with the foundations of SUS.[8] Moreover, it is of utmost importance to think about the structural challenges which for three decades have remained unsolved in health services, overcoming barriers to provide universal access to health.[17]

A complex scenario surrounds PHC: social inequality, increased hospitalizations due to primary care sensitive conditions as per an organized and resolutive PHC, exacerbation of chronic conditions, lack of promotion of training as well as recognition and implementation of plans for professional positions and salaries, scarcity of resources to implement innovative technologies to develop clinical practices, and underfunding. These factors compromise the role of PHC in organizing and coordinating care.

However, the work process of ESF must include elements of such coordination. The literature emphasizes the planning of singular care,[10,18] standardization of practices,[9,10] reference and counter-reference,[9,19] dialogue among care sites including professionals of different care levels and, within the levels, a dialogue with patients and their relatives,[20,21] and, finally, patient monitoring.[9,20,22] Following this rationale, this study poses the question of how ESF professionals in a small municipality in the Brazilian Northeast carry out the care process, considering that ESF promotes care coordination in the Healthcare Network (HCN).

Out of the elements provided by the literature, this study focuses on (1) care plan, (2) standardization of practices and (3) dialogue among the different health levels. Thus, this study aims at understanding the work process of ESF teams in the coordination of care, emphasizing its intervening factors.

METHOD

This is a qualitative study conducted in eight primary healthcare services of the municipal health network of Picos, in the state of Piauí, Brazil, from January to March 2020. Eight nurses, eight physicians, and two representatives of the ESF management took part of this study.

The study site was chosen since the municipality of Picos is part of Piauí state's Valley of the River Guaribas Development Region, whose organization reports to the governmental planning unit to improve sustainability, mitigate social inequity, and provide quality of life to its citizens. This organization aims at democratizing and regionalizing programmatic and budget activities.[23]

The inclusion criteria were participating in an ESF or health management team and carrying out professional activities in that municipality or team for at least six months. Professionals who had been away from work activities in the data collection period for reasons such as vacations and leave, among other reasons, were excluded.

For data production, a semi-structured interview was conducted. It comprised twenty-nine open questions on the guiding elements of care coordination: individual care planning, standardization of practices, and dialogue among care sites.

The participants were identified and indicated through the snowball technique, following their contact network,[24] based on work experience and their acceptance of study participation. The inclusion criteria were employed with the organization of an interview schedule, with a favorable day and hour being suggested by each participant. The data were collected in this study's health services in a private room, following the professionals' suggestions. The interviews were recorded upon participant consent and had a mean duration of 25 minutes.

After an integral transcription of the interviews, a floating reading and rereading of each one was performed, followed by the organization of the empirical material. Subsequently, content analysis in the thematic modality was carried out, following the steps of identification, coding, and interpretation, extracting core meaning. These were then regrouped in a search for more comprehensive, well-defined themes for the identification of the professionals' roles in the work process of the ESF teams in the development of care coordination. For a representation of the interviewees' utterances, the first letter of their professional category followed by the number of the interview was employed.

This study was developed as proposed in the Resolution n. 466/2012,[25] by the Brazilian National Health Council and its complements, which describe the ethical and moral standards of research involving human beings, guaranteeing the participants' rights and the obligations of the research towards the scientific community. This study was approved by the Research Ethics Committee of Universidade de Fortaleza in opinion n. 3.773.604, dated December 16, 2019.

RESULTS

Eight nurses, eight physicians, and two representatives of the ESF management took part in this study. They had been carrying out professional activities in the municipality or the team for at least six months. The nurses were all female, with a mean age between 30 and 40 years old and with a specialization in family health. In relation to the physicians, three were male and five were female, with a mean age between 28 and 35 years. Three of them were members of the *Mais Médicos* program (*Programa Mais Médicos para o Brasil* – PMMB) and the others were specialists in general practice, gynecology, and cardiology. The technical and institutional support professionals were a nutritionist, MSc in Collective Health, 33 years old, and a MSc in Nursing and Nursing graduate, female, 35 years old.

The data analysis led to three thematic categories: (1) care plan; (2) standardization of practices; (3) communication among care sites.

Care plan

In the reports by team members, particularly physicians, the statement that there is no team planning to discuss and build a shared individual therapeutic plan was recurrent. The most striking reports indicated that the participants' decisions on institutional practices are due to work routine situations, which manifests in instantaneous and direct unplanned practices. The following statements demonstrate such description:

> (...) *building an individual therapeutic plan is not part of our routine... We discuss cases, but don't build plans with all the information, no; only unofficially.* (E1).
>
> *It's direct. Sometimes we come here, enter the room, you see?... It's direct... Sometimes I leave and go there to talk to her about the patient.* (M7).

All the study participants declared that the teams have administrative planning meetings to organize work schedules for the week or month, normally coordinated by the team's nurse. In these meetings, the professionals use the opportunity to discuss occasional cases of patients; however, this is not a specific meeting to design a singular therapeutic plan:

> *We have monthly meetings to discuss the plans for the station and the calendar, we don't meet to discuss about one patient only.* (M5).
>
> *They meet to organize the month's schedule... What they are taking up, whether they will perform some community health promotion activity, this kind of issue* (...) (G2).

There is a remarkable unanimity among the participants in reporting that the participation of physicians in these organizational meetings is minimal. To E7, the absence of any team professional in the meetings – even if the agenda for some meetings is more directed at administrative discussions and challenges of the work process in the Basic Health Unit – shows a fragmented team performance, impacting the quality of therapeutic decisions. The following statements convey this comprehension:

> (...) *so we feel this difficulty in our practice due to some professionals, such as the doctors, who rarely participate. I believe that nursing is more open to this issue of making singular therapeutic projects* (E6).
>
> (...) *when some professionals don't participate in the meetings, in the discussions, don't help with planning, this shows a broken team performance, which may have repercussions for the quality of decisions during practice.* (E7).

When referring to the scheduling of basic consultations in the health unit, a consensus among the professionals and managers of the ESF is observed. They report that the nurses' schedules have fixed days every week for types of health program, i.e., there is a schedule for prenatal consultations, providing care to diabetic and hypertensive patients, to groups of children to receive follow-up, among others.

On the other hand, the strategy of having a fixed schedule for pre-established programs does not apply to medical professionals, whose demand is spontaneous, with a mean quantity of twenty pre-defined slots per shift, reserving three slots for possible urgencies or emergencies, as pointed out in the following statements:

> (...) *there's a schedule with the day of each program, but if a different patient shows up I won't ask the patient to go home. Monday: prenatal; Tuesday: spontaneous; Wednesday: childcare; Thursday: prevention; and Friday: morning – hypertension and diabetes program; afternoon – home visit.* (E3).
>
> *The schedules are, well, actually, we have no specific day for children, pregnant women... They manage to do that in nursing; there's the prenatal day, the childcare day, but we work here with spontaneous demand*. (M3).

The participants have also pointed out asymmetries between the work process of medical professionals in teams with members of PMMB and those teams with physicians who are not in the program.

The report of E1 reveals the importance of physicians in PMMB, considering that this professional has a workload of 40 hours per week, facilitating the access to patients and problem-solving in the Basic Health Unit. M4 adds that PMMB professionals take the Family Health Specialization course, offered by the Brazilian Ministry of Health, with much rigor, and this amplifies their knowledge of medical action in primary health care.

> *Since the doctor is in the Mais Médicos program, he provides care every day in the mornings and afternoons, then it's easier for us to solve everyday issues* (E1).
>
> (...) *the Mais Médicos program, it's supposed to make us specialists; we are forced to specialize in family health and this makes us learn more... They want us to be residents in the program...* (M4).

The management of quotas by the regulation central is not explicitly based on epidemiological criteria of needs and risk stratification and are not discussed and shared with the ESF professionals. This lack of organization interferes with the plans for the teams' work process, since the professionals cannot predict how many patients they will be able to refer the following month. This manifests as follows:

> (...) *perhaps if they had a meeting with us to understand what we really need every month or plan this with us, define a flow, then maybe there could be an improvement, I don't know.* (M6).
>
> (...) *because generally the number of slots is reserved to an Agreed and Integrated Programming* [Programação Pactuada e Integrada – PPI] *in which each city gets an amount every month depending on the number of citizens... And you can't assess the needs of each team, because they need too much.* (G2).

Standardization of practices

Throughout the interviews, it was noticeable that the ESF professionals had no defined criteria or instruments to stratify risks and vulnerabilities and thus to safely define the flows and priority patients for the PHC practices and referral in the reference services:

> (...) *no protocols here, the only protocol we see is that of the Brazilian Society for each specialty, you see? But a protocol established by the city, as far as I know, there is no such thing.* (M1).
>
> *No, referral is based on your need, which we see during the consultation. No. But this is about us doctors; protocols are an issue for the management team, you know?* (M7).

The teams' professionals keep a register on the protocol of pregnancy risk classification, mostly carried out by the teams' nurses. They report that there is no dispute regarding the protocol and that they consider it applicable. The participants provided the following descriptions:

> *This one on pregnancy is really helpful when referring pregnant women. I believe this is not questioned. But it should be available for other services and specialties.* (E3).
>
> (...) *here we have directives on high-risk pregnancy, we have it here, you see? Under 15 and over 35 years old. Then, here, low-income patients, we assess them for risk classification and refer them to the integrated women's health clinic* [*Clínica Integrada de Saúde da Mulher* – CLISAM]. (M2).

Specific protocols for nursing professionals required by the professional association were noted; these are admittedly outdated and their use was not mentioned by any of the teams. It was also observed that all recognize the Brazilian Ministry of Health's protocols and admit their importance; however, they do not have a copy of them in the BHU. The manager admits that there are no clinical protocols and flows, but does not present a plan to implement them.

> *There is a protocol in the health office which guides us to make appropriate referrals. This was a demand by the Regional Nursing Council. There are the Ministry of Health protocols, but ideally there should be a municipal plan matching our reality.* (E1).
>
> *We don't really have our own protocol to guide referral. It's a flaw.* (G2).

The professionals' utterances show that there is no standardization of therapeutic practices, since the municipal health network has no flowchart to guide referral practices to the target services and specialties. This lack of flow standardization has been making professionals, particularly physicians, uncertain in decision-making. M6 suggests that these disharmonious practices increase the possibilities of malpractice, as made evident by the following statements:

> (...) *the care flowcharts are quite inductive; even laypeople can more or less understand how the sequence works, when they go, they can tell where we are taking them, ok, but we don't have it here.* (M5).
>
> *Sometimes we feel very insecure, a certain uncertainty, because there is not a standardized flow and we might make the wrong referral, there might be two different practices, I don't know, there is no standard.* (M6).

Dialogue among care points

Recurrently there is lack of communication or discussion of cases among the professionals of the HCN to intermediate

and enable the flow of information about users among the ESF teams and between these and the secondary and tertiary levels. These observations are supported by the following statements:

> *No, because we have no access to that. We never got in contact with any of the specialists. We also never had information from specialized care, they never looked for us*. (E1).
>
> *There is no case discussion here. At most the nurse comes to talk to me if she has some question.* (M6).

Throughout the interviews, it shows that all information on any practice of the specialized care is known through patients themselves, because there is no dialogue among the professionals of different care points. M2 considers that information from patients is slightly distorted and incomplete.

> (...) *they* [patients] *don't know how to say anything! So, we are in the dark. They've been to the specialist, but I don't know what the specialist's care plan is, I don't know if they prescribed any medication, because the patients won't bring the prescription. Most can't even read. So, if they don't bring the prescription, the information is inaccurate, partial, distorted.* (M2).

The explanations presented to describe the communication problems are related to the absence of a standardized flowchart for each specialty, non-adherence and lack of professional dedication, high demand, and mainly to the lack of an information system integrating different points of care, which, according to M3, would be the solution. The perceptions about "communication problems" are presented in the following utterances:

> *I think this is only going to be solved when we really have an information system within the network connecting its points, primary care and specialized care, where we could access information digitally and in a timely manner, and there is no such thing currently.* (M3).
>
> *Actually, I think that commitment is what is missing, for them to dedicate somehow, but there is also the hurry, the number of people, and all that, because the patient demand is also high.* (M5).

The management understands that there are flaws in this approximation among care levels, confessing the lack of a process flow to facilitate standardized communication; however, it does not provide at any moment a proposal of organizational institutionalization to foster communication among professionals and services in different care points of the network.

> *There is no such communication, actually; it's a flaw and it must be worked out. When there is, it's because these professionals know each other and can exchange information through calls or WhatsApp messages.* (G1).

DISCUSSION

Changes in the conditions of life and health of the population required changes in health system architectures and services to improve efficiency and reduce the fragmentation of healthcare. In this context, ESF is expected to organize healthcare, becoming a driving force in communication within an integrated HCN. Being the center of communication implies playing the essential roles of resolution, systematization of flows, and responsibility for patients.[12,16]

To this end, a study[26] asserts the need for employing mechanisms to strengthen PHC, ensuring its capacity in coordinating and organizing the health system, responding to the population's health demands, and contributing to the reorientation of the healthcare model under discussion. Consequently, ESF has been pointed out[21] as having this property, due to its potential and for being based on the guiding principles for the development of health practices, being emphasized as the main element of the political agenda for the organization of resolutive primary healthcare services and actions in Brazil.

Although care coordination has been an increasingly frequent object of evaluative research, both international and Brazilian studies show the persistence of a series of obstacles to its operation.[16,22,27,28]

The three dimensions analyzed in this article point out limitations that compromise the coordination of care by the ESF in the municipality under study.[9,10,18-20,22] These studies reaffirm that coordination by the PHC depends on qualified care planning, a standardization of practices, and dialogue among the different care points throughout the patient's journey in the network.

In the case studied in this research, ESF as the organizing element in PHC faces a series of response patterns that reveal the fragmentation of care and fragilize the mechanisms of coordination, in addition to exposing the restrictive factors related to the meso- and macro-organizational levels of the municipal health system. These interfere considerably in the team's capacity of coordinating patient care.

The difficulties pointed out in care planning make evident the need for implementing care practices based on shared responsibility both among professionals and between professionals and patients, as well as establishing criteria for risk stratification, aiming at guaranteeing more rational exam, procedure, and referral requests, avoiding thus the duplication of means and responsibility conflicts among the services which comprise the care network.

The organizational production[8] of care in health services is marked by a technical and social division of labor, which points out new elements and becomes central for work process organization. To this end, the team needs a procedural organization

of work to favor the interaction among the several professionals involved in care.

Thus, teamwork among the different care providers in PHC is indispensable. The specific competences of each professional do not cover the complexity of healthcare, and it is important to articulate and bring comprehensiveness to limited competences in search for the required actions in care coordination. To enable so, the discussion of cases is fundamental for shared care, since not all cases require individual consultation with a specialist.[29]

This study shows that physicians and nurses are unaware of the existence of care guidelines and municipal standardized clinical protocols. This result points out a faulty planning in standardizing adequate practices that facilitate patient referral, revealing also the need for permanent education actions for ESF professionals. Managers are responsible for implementing and training their professionals to provide care in accordance with the directives and principles of SUS.

Researchers in this area understand that clinical directives (guidelines and clinical protocols) are important for care coordination, since they reorganize healthcare and, consequently, work processes, comprising a matrix of knowledge, procedures, services, and flows, integrating promotion, prevention, and care actions. Thus, they articulate care, avoiding fragmentation and promoting comprehensiveness, favoring the coordination of care in all its dimensions.[30,31]

To achieve comprehensiveness and an effective coordination of care, it is necessary to face organizational and care challenges in the health systems. In the studied case, among the most mentioned challenges, the following are emphasized: access difficulties, fragmented offering of health actions and services, and absence of communication among care points, adding to the human resource gap between PHS and specialized care.[20]

The findings of this study indicate that improvements in patient health will hardly ever be provided by a fragmented, reactive, episodic work process mostly targeted at fighting acute conditions. This did not work in other countries and is not working in Brazil.[19]

The coherence between work process, health indications, and the foundations of SUS should be reestablished. It is important to advance the implementation and monitoring of the HCN, strengthening a polycentric logic to balance integrated and resolutive health systems. This logic is guided by effectivity, efficiency, safety, quality, and equity, which are indispensable for improving the health conditions of the Brazilian population.[32,33]

The regulation processes for specialized care traditionally coordinated by the health office in a centralized way, associated to the lack of a technological system integrated into a network, were pointed out by the participants of this study as one of the biggest bottlenecks precluding communication among the professionals of several care levels, corroborating a continuity of inefficient care and making PHS uncapable of coordinating care.

Differently from fragmented systems, integrated systems are organized through a continuous care network, providing uninterrupted care, which can take responsibility for a defined population. Thus, the first presupposition is that coordination of care is a characteristic of PHC with integrated systems. This practice was considered by other studies as innovative and as having the potential to monitor actions and referrals, so as to provide in a single database data referring to the whole care pathway.[11,30,34]

To play its role in care coordination, the system must be organized in an integrated manner, which implies that PHC must be the center of communication and, in turn, implies a robust and strong PHC in accordance with the previously described attributes, reverberating into qualified ESF teams who are apt to perform coordination of care in the territories.

This logic considers it indispensable that not only informatized registers be implemented, but also telecommunication technologies to reduce barriers and tighten relations between the ESF professionals and the municipality's secondary and tertiary care professionals. Thus, the articulation of PHC in health systems is fundamental for care coordination.

The divergencies between managers and professionals in the different aspects of the team's work process point out the opportunity of institutionalization of regular service assessment and monitoring, aiming at guaranteeing a better coherence between activity planning and execution, particularly those essential for performing the function of care coordination by the FHC teams.

However, the studied municipality needs managers and care professionals to meet their responsibilities, since, in spite of established agreements, these still have not modified the bureaucratic and programmatic view of work process in relation to the social and health reality of the territories.

In the perception of professionals and managers, despite limitations, ESF seems to pose good resolution prospects, which reaffirms the need for investments to make it stronger. This is why studies[20,29] place strengthening PHC among the most effective strategies to improve the coordination and efficiency of health services. Robust primary care is capable of solving most of the health problems in a timely manner, with a broadened access and ensuring longitudinal care.

One limitation of this study is its focus on the professional dimension. However, disagreements among professionals of the same team and between teams and management show an urgent need for reapproximating professionals and managers through discussions and assessment and monitoring strategies for PHC services in a regular and participatory manner.

Despite these spatial and geographical limitations, this study has shown crucial and recurring challenges that underly the work process of family health teams in the conduction and reorientation of the PHS to be effectively consolidated as the entrance to the HCN, presenting itself as robust, resolutive, qualified, related to the territories, and as having teams with qualifications regarding competence, skills, and attitudinal procedures that reflect epistemic and operational principles of SUS, one of the biggest healthcare policies to claim universality.

FINAL REMARKS AND IMPLICATIONS FOR THE PRACTICE

The results of this work show that coordination of care is under construction and faces obstacles related to the work process of the teams and structural issues in the organization of the municipal health network. Care plan, standardization of practices, and dialogue between the care points are emphasized as points for improvement.

Improving the knowledge of the effectivity of care coordination strategies requires research also assessing the perspective of users regarding the extent to which care meets their healthcare expectations. This is a limitation of this study which may guide a deeper perspective on these questions in further similar studies.

The implications for the practice are beyond contributions to health care and management, also reaching education, research, and extension for the formation of professionals in different health areas. Permanent education in these spaces of health production enables the care model to redefine goals, with practices guaranteeing patient flow, mitigating the fragmentation of care, and providing comprehensive care to the population.

AUTHOR'S CONTRIBUTIONS

Design of study. Átila Chagas de Araújo. Luiza Jane Eyre de Souza Vieira.

Data collection. Átila Chagas de Araújo.

Data analysis. Átila Chagas de Araújo. Luiza Jane Eyre de Souza Vieira. Antonio Rodrigues Ferreira Júnior. Antonio Germane Alves Pinto. Kerma Márcia de Freitas. Camila Lima Ribeiro.

Interpretation of results. Átila Chagas de Araújo. Luiza Jane Eyre de Souza Vieira. Antonio Rodrigues Ferreira Júnior. Antonio Germane Alves Pinto. Kerma Márcia de Freitas. Camila Lima Ribeiro.

Writing and critical review of the manuscript. Átila Chagas de Araújo. Luiza Jane Eyre de Souza Vieira. Antonio Rodrigues Ferreira Júnior. Antonio Germane Alves Pinto. Kerma Márcia de Freitas. Camila Lima Ribeiro.

Approval of the final version of the article. Átila Chagas de Araújo. Luiza Jane Eyre de Souza Vieira. Antonio Rodrigues Ferreira Júnior. Antonio Germane Alves Pinto. Kerma Márcia de Freitas. Camila Lima Ribeiro.

Responsibility for all aspects of content and integrity of the published article. Átila Chagas de Araújo. Luiza Jane Eyre de Souza Vieira. Antonio Rodrigues Ferreira Júnior. Antonio Germane Alves Pinto. Kerma Márcia de Freitas. Camila Lima Ribeiro.

ASSOCIATED EDITOR

Beatriz Rosana Gonçalves de Oliveira Toso

SCIENTIFIC EDITOR

Ivone Evangelista Cabral

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