

Original Article

# The interface of occupational therapists practices with regards primary health care attributes<sup>1</sup>

## *A interface das práticas de terapeutas ocupacionais com os atributos da atenção primária à saúde*

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### **Abstract**

**Introduction:** The specific dialogue of occupational therapy with Primary Health Care (APS) has weaknesses, which requires in-depth understanding.

**Objective:** To identify and analyze the practices of occupational therapists in APS and its interface with the essential and derived attributes of this level of care.

**Method:** Research of mixed methods (explanatory sequential) through three phases: *Phase 1* - a collection of quantitative and qualitative data by an Internet Surveys with 105 occupational therapists from APS; *Phase 2* - qualitative approach starting the Grounded Theory, through interviews and observations of the practice with 8 professionals from the first phase; *Phase 3* - Discussion and analyzing of results. **Results:** *Phase 1* - 93.3% of the participants were women, mostly from state capitals and metropolitan regions, and from the Extended Family Health and Primary Care Center (NASF-AB). Regarding the orientation of their practices by APS attributes, the following results were identified: first contact attention (92.3%), longitudinality (84.7%), completeness (95.2%), care coordination (83.8%), family orientation (90.4%), community orientation (76.1%) and cultural competence (60.9%). *Phase 2* - Eight NASF-AB occupational therapists from southeastern and northeastern capitals and metropolitan regions reported the work process in APS and their analysis indicated the following categories: practice characteristics and rationale, occupational therapy in clinical and pedagogical support, and challenges of

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practice. **Conclusion:** It was possible to verify that the occupational therapists' practices interface with the APS attributes, which indicates their relevance and insertion in this level of care.

**Keywords:** Primary Health Care, Occupational Therapy, Professional Practice, Unified Health System, Research/methods.

### ***Resumo***

**Introdução:** O diálogo específico da terapia ocupacional com a Atenção Primária à Saúde (APS) apresenta fragilidades, o que requer compreensão em profundidade.

**Objetivo:** Identificar e analisar as práticas de terapeutas ocupacionais na APS e sua interface com os atributos essenciais e derivados desse nível assistencial.

**Método:** Pesquisa de métodos mistos (sequencial explanatória) por meio de três fases: *Fase 1* – coleta de dados quantitativos e qualitativos por uma *Internet Surveys* com 105 terapeutas ocupacionais da APS; a *Fase 2* – abordagem qualitativa por meio da Teoria Fundamentada em Dados, por meio de entrevistas e observações da prática com oito profissionais, oriundas da primeira fase; *Fase 3* – discussão e análise dos resultados. **Resultados:** *Fase 1* – 93,3% das participantes foram mulheres, a maioria de capitais e regiões metropolitanas e do Núcleo Ampliado de Saúde da Família e Atenção Básica (NASF-AB). Quanto à orientação das suas práticas pelos atributos, foram identificados: atenção ao primeiro contato (92,3%), longitudinalidade (84,7%), integralidade (95,2%), coordenação do cuidado (83,8%), orientação familiar (90,4%), orientação comunitária (76,1%) e competência cultural (60,9%). *Fase 2* – oito terapeutas ocupacionais do NASF-AB, de capitais e regiões metropolitanas do sudeste e nordeste, informaram o processo de trabalho na APS e sua análise indicou as seguintes categorias: características e fundamentação da prática, terapia ocupacional no apoio clínico e pedagógico e desafios da prática. **Conclusão:** Foi possível constatar que as práticas de terapeutas ocupacionais fazem interface com os atributos da APS, o que indica sua pertinência e inserção nesse nível assistencial.

**Palavras-chave:** Atenção Primária à Saúde, Terapia Ocupacional, Prática Profissional, Sistema Único de Saúde, Pesquisa/métodos.

## **1 Introduction**

Since the late 1970s, occupational therapy in Brazil has developed practices in Primary Health Care (APS) (Silva, 2016). This level of assistance has been locally and globally identified as an emerging field of action for this professional area (Baissi & Maxta, 2013; Bolt et al., 2019; Donnelly et al., 2014). Occupational therapy is also expert to meet the needs of people, families, groups, and populations in APS close to the contexts of daily life, work, playing, learning and living (Jordan, 2019).

However, occupational therapy still has theoretical, conceptual, and practical weaknesses to be effectively inserted in APS, mainly due to the insufficiency of professional-specific dialogues with this area (Silva & Oliver, 2016).

APS is a health care level responsible for the preferential entrance into a health system with the following essential and derivatives attributes. The essential is the care of the first

contact, longitudinality, integrality, and coordination of care. The derivatives attributes are for family orientation, community orientation, and cultural competence (Starfield, 2002). These attributes are the guidelines for the qualification of different professional practices in APS (Lima et al., 2018).

The evaluation of these attributes has been used in research and as strategies to face the challenges and strengthen the APS, based on a comprehensive, universal perspective and change in the model of health care in the Unified Health System (SUS) (Facchini et al., 2018; Oliveira & Pereira, 2013).

Therefore, understanding how the different professional areas that work at this care level dialogue and/or guide their specific and shared practices to achieve the goals of these essential and derived attributes is strategic and enhances health care.

Thus, identifying and analyzing the practices of occupational therapists in APS and its interface with the essential and derivatives attributes of this care level can favor a broad and in-depth understanding of the development of the professional area.

## 2 Method

This study is showing part of the results of doctoral research entitled “**The practice of occupational therapists in APS in Brazil**”, and debates the results and discussion of the interface of the practice carried out by occupational therapists in APS with the attributes of this health care level (Silva, 2020).

We developed the research through a mixed-methods approach that is characterized by combining quantitative and qualitative study designs, or vice versa so that the complementarity of these methods builds comprehensive inferences about the object of study (Creswell & Clark, 2013; Paranhos et al., 2016).

Among the mixed method strategies, We adopted the **mixed method (explanatory sequential)** that is developed through an extensive data collection, in two different interactive phases: I - Quantitative: it begins with the collection and analysis of quantitative data; and, II - Qualitative: after the collection and analysis of qualitative data (Creswell & Clark, 2013). At the end of the process, the researcher interprets how the qualitative results enable to explain the initial quantitative results, which can add greater understanding to the object of the study (Creswell & Clark, 2013).

Thus, the **mixed methods approach (explanatory sequential)** had:

- ✓ **Phase 1**, mostly quantitative, including the collection of quantitative and qualitative data through Internet Surveys (Manfreda & Vehovar, 2008). For **Phase 2** of the research, we carried out the connection process - which means a mixed strategy in which the results of one element of the data shape the collection of data in the second element (Creswell & Clark, 2013). This mixed strategy *connected* the two phases of the research through the following procedures: an intentional selection of eight occupational therapists from 105 participants in **Phase 1**; the improvement of data collection instruments for **Phase 2**; the triangulation of qualitative data collected between **Phase 1 and Phase 2**;
- ✓ **Phase 2**, with only a qualitative approach, having the collection and analysis of qualitative data through a study of Data Grounded Theory (Charmaz, 2009);

- ✓ **Phase 3**, with the interpretation of the quantitative results based on the qualitative data, expanding the understanding of the research object (Creswell, 2011).

## **2.1 Phase 1**

### **2.1.1 Quantitative methodological approach (Internet Surveys)**

The Internet Surveys is when there are studies on the web through self-administered questionnaires, which the participants answer without the presence of the researcher, and the answers are automatically stored on a server (Manfreda & Vehovar, 2008).

Phase 1 of this research collected quantitative and qualitative data through Internet Surveys, based on an online questionnaire using Google Docs<sup>®</sup> (Google, 2005).

### **2.1.2 Participants**

In this phase, 105 occupational therapists worked in APS teams. This sample was calculated based on the total number of APS occupational therapists ( $n = 789$  professionals) who worked at this care level in 2016, according to the Department of Primary Care (DPC) of the Ministry of Health (Brasil, 2016).

We applied a 95% confidence interval and 80% power to the number of participants, which constitutes a minimum ideal sample number of 86 participants. At finish, 105 occupational therapists participate (Silva & Oliver, 2019).

The inclusion criteria for the sample were being an occupational therapist and working at APS for at least six months. The exclusion criteria were occupational therapists who did not work in the APS and who were away from work due to illness, maternity leave, or vacation and unable to access the internet to answer the online questionnaire.

### **2.1.3 Data collection instrument**

The researcher specifically developed the Questionnaire for Occupational Therapists in Primary Health Care (*QTO-APS* - self-administered and semi-structured) for this study (with experience of practice, teaching, and research in APS). After its construction, there was a validation process - the questionnaire was sent to 10 specialists (occupational therapists) in the area of public health and APS, who sent suggestions. They also applied the *QTO-APS* as a pilot with three occupational therapists at this care level, which attested to its applicability (Silva & Oliver, 2019).

The *QTO-APS* had 54 questions with answers recorded through numerical frequencies and descriptions of the participants on the sociodemographic and work context characterization; the identification of the practices performed based on a previously constructed list; the characterization of the theoretical orientation of practices; the identification of populations, needs, and demands assisted; the understanding of doubts, limits, challenges, and powers of practice; the assessment of occupational therapy research priorities in APS (Silva & Oliver, 2019).

For this article, we highlighted two dimensions of the instrument: the characteristics of the occupational therapist's practices and work context in APS, and the orientation of these occupational therapy practices by the essential and derived attributes of APS.

#### **2.1.4 Period and place of the research**

**Phase 1** was between November 2017 and February 2018, when we reached a higher number than the established sample calculation. We held the data collection in a virtual “online” environment.

#### **2.1.5 Procedures for data collection**

The QTO-APS was available in occupational therapy groups on social networks, professional e-mail addresses, and messaging applications on the world wide web.

Before accessing the questionnaire, we presented research information such as objectives, methodology, confidentiality, and the possibility of interrupting voluntary participation. After these clarifications, we asked the participant to download the Informed Consent Form (ICF) and press the button to choose whether or not to participate in the study. If the professionals did not accept it, they would see a thanks message. If the participants accept, they entered into the Google Docs® application (Google, 2005) to answer the questionnaire, and, when completing it, they could choose the option of receiving the data on their email address.

#### **2.1.6 Data analysis**

We tabulated the quantitative data using descriptive statistics and we organized the qualitative data for thematic analysis. For this article, we used data on the characteristics of APS practices and context (systematized in tables) and we grouped and systematized the data on the theoretical and technical orientation of occupational therapy practices in APS by the essential attributes and derivatives of APS in a chart.

### **2.2 Phase 2**

#### **2.2.1 Qualitative methodological approach (Data Grounded Theory)**

The Data Grounded Theory (DGT) was the qualitative approach chosen to compose the mixed methods that seek to explain and describe the process of common experience and gather knowledge based on the data constructed through its methods to formulate theories (Charmaz, 2009).

We adopted the DGT constructivist perspective and in this approach, the knowledge and the use of flexible guidelines for data collection are the results of a co-construction between the researcher and the participants (Charmaz, 2009).

In the constructivist perspective, there is an incentive to use multiple sources for the construction of data, with emphasis on intensive interviews and observations. Data collection and analysis are simultaneous and the coding process consists of three coding steps: initial; focused and theoretical. These steps are supported by diagrams and memos, which are the guidelines for the researcher throughout the survey (Charmaz, 2009).

### 2.2.2 Collection period, participants and instruments

Phase 2 took place from March 2018 to January 2019. From 105 occupational therapists of the APS who participated in Phase 1, the researcher contacted those who showed an interest in participating in Phase 2, intentionally choosing the occupational therapists who presented relevant criteria for understanding the object of the research in-depth and who had a profile similar to the results of the quantitative data of Phase 1.

The relevant criteria considered for the participation of occupational therapists were to work at NASF-AB, work in capitals and metropolitan regions in the southeast and northeast, and with a long time working in APS in these regions. These criteria were listed due to the greater number of APS occupational therapists being at NASF-AB; most participants work in capitals and metropolitan regions in the southeast and northeast; and have a longer period of experience due to the accumulation of practical experience by the professional.

Thus, eight women occupational therapists from NASF-AB, capitals, and metropolitan regions of the southeast and northeast participated in the study. There were eight interviews and two observations for data collection and ended after the theoretical sampling (Fontanella et al., 2008).

The instruments used were the **Observation Guide** - to record descriptive and reflective data on the actions of occupational therapists in APS; and the **Interview Guide** - to understand the practices and their characteristics, the demand, and the offer of occupational therapy services, according to the population's health needs. The researcher specifically made these guides for this study. Diagrams, field diaries, and memos were also used during data collection.

The instruments were subjected to a process of semantic and content validation through the analysis of ten occupational therapist research judges (masters and doctors) with expertise in the public health area and APS, and their application was carried out in a pilot with an occupational therapist of the APS.

We should highlight that the *connection* phase of the mixed methods research also contributed to the improvement of the collection instruments of Phase 2.

### 2.2.3 Data analysis

In the DGT, the collection and analysis are simultaneous and seek a consistent explanation of the phenomena and/or the construction of theories based on data (Charmaz, 2009). In this sense, we applied the three analysis techniques: **initial coding**: consisting of reading and rereading data and conceptualizing initial codes; **focused coding**: it broadened the understanding of the significant initial codes, exploring their aspects in new interviews, memos, and observations; **theoretical coding**: theoretical codes specify the relationships between categories. This coding stage seeks to find and deepen central categories (Charmaz, 2009; Tarozzi, 2011).

There was also a triangulation of data from these Phase 2 categories with qualitative data from Phase 1, giving greater consistency to the theoretical categories.

After the analysis, four theoretical categories were constructed that expressed the central category: ***Practices in construction: the work process of occupational therapists in APS***.

## **2.3 Phase 3**

### ***2.3.1 Mixed method analysis (joint interpretation of quantitative and qualitative results)***

We organized the analysis and discussion of the results by presenting the synthesis of the quantitative results of **Phase 1** (using graphs) and the synthesis of data from qualitative categories and subcategories of **Phase 2** that supported the understanding of the quantitative results.

### ***2.3.2 Results validation of the mixed methods research***

We carried out the following strategies to minimize the limitations and contribute to the validation of the results of this study (Creswell & Clark, 2013): a) validation of the collection instruments by specialists in the APS and Public Health area; b) a review by the research advisor during the three phases; c) statistical advice by a researcher experienced in quantitative association studies; d) a review of the first data collected from Phase 2 by a researcher specialized in Data Grounded Theory of the Graduate Program in Nursing at UFSCar.

### ***2.3.3 Ethical procedures***

The research follows the principles of Resolution 466/2012 (Brasil, 2012) and the Research Ethics Committee of the Federal University of São Carlos (CEP/UFSCar) approved it according to CAAE nº 68134317.0.0000.5504.

Before accepting to participate in the research, occupational therapists signed the Free and Informed Consent Form and were informed about the study methodology and the researcher's responsibility for the preservation of their identities, with the name of each occupational therapist maintained confidential and replaced by numeric codes.

## **3 Results**

### **3.1 Quantitative results – Phase 1**

#### ***3.1.1 Characterization of participants***

Based on the answers of the QTO-APS, we characterized the participants by gender, age group, postgraduate training, municipalities, and services in which they worked, length of experience, and knowledge about the development of APS in their municipalities (Table 1).

**Table 1.** Characteristics of the participants in Phase 1.

Characteristics	N	%
<b>Gender</b>		
Female	98	93.3
Male	7	6.7
<b>Age group (years old)</b>		
Up to 29 years old	31	29.5
30 to 39 years old	51	48.6
More than 40 years old	23	21.9
<b>Post-graduation in APS/Public Health/Collective Health</b>		
Yes	64	61
No	41	39
<b>Country Region</b>		
<u>Southeast</u>	58	55.3
<u>Northeast</u>	30	28.6
<u>South</u>	10	9.5
<u>North</u>	6	5.7
<u>Midwest</u>	1	0.9
<b>Size of the municipality where the professional works</b>		
≤50 thousand inhabitants	14	13.3
Between 50 and 100 thousand inhabitants	7	6.7
> 100,000 inhabitants	21	20
Capitals and metropolitan regions	63	60
<b>Time working in the APS</b>		
Up 3 years	52	49.5
Between 3 and 7 years	44	41.9
> 7 years	9	8.6
<b>Type of service</b>		
NASF-AB	74	70.5
UBS	14	13.3
Multi-professional Residence	7	6.7
Street Office	2	1.9
Home Care/Better at Home	2	1.9
Primary Prison Care	1	0.9
Others	5	4.8
<b>Hours working in APS</b>		
20 hours	41	39.1
30 hours	46	43.8
40 hours	6	5.7
60 hours	12	11.4



Table 1. Continued...

Characteristics	N	%
<b>Participation of APS services that OT works in the National Program to Improve Access and Quality of Primary Care (PMAQ-AB)*</b>		
Yes	82	78.1
No	12	11.4
I do not know	11	10.5
<b>Knowledge of OT about the percentage of current APS coverage in the municipality that works**</b>		
Yes	47	44.8
No	58	55.2

**Source:** The author. \*The Program to Improve Access and Quality (PMAQ) created in 2011 is a strategy that seeks to continuously assess the quality of APS; institutionalize specific financing to improve the care offered; assess the strengths and weaknesses of the care model; and subsidize policies aimed at improving APS (Facchini et al., 2018). Thus, the knowledge that most occupational therapists at this care level participate in a program that encourages the improvement of Brazilian APS is relevant. \*\*Knowing about the percentage of APS coverage enables to identify the scope of occupational therapists' practices among the population of a given municipality and can contribute to better professional engagement at this care level. Explanatory note: N – number of occupational therapists; APS – Primary Health Care; NASF-AB – Extended Nucleus of Family Health and Primary Care; UBS – Basic Health Unit.

### 3.1.2 Guidance of the occupational therapists' practices by APS attributes

In the QTO-APS, 105 participants answered the question “Do you guide your practices by the essential and derived attributes of APS?” The answers could be marked for each attribute, based on three options: yes, no and I don't know. Figure 1 shows the results of these answers.

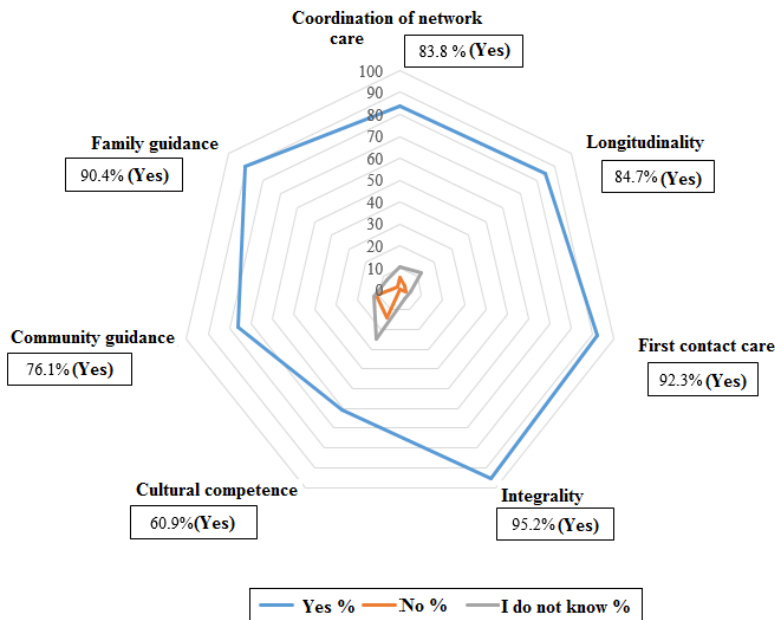


Figure 1. Guidance of the occupational therapists' practices by the attributes of the APS.

Source: The author.

### 3.1.3 Characteristics of the work context and practices of occupational therapists in APS

Knowing the characteristics of the work context and practices helps the understanding of the insertion of occupational therapy in APS. In this sense, Table 2 shows these characteristics.

**Table 2.** Characteristics of the work context and practices of occupational therapists in APS.

<b>I - How people, families, and communities have access to the practices of occupational therapists in APS</b>	<b>N</b>	<b>%</b>
Matrix Support - pedagogical [discussion of cases, specific topics for permanent education and coordination of network care]	85	81
Referrals	77	73.3
Active search based on epidemiological indicators	43	41
Direct access to care and monitoring	40	38.1
Others	8	7.6
<b>II - Characterization of the type of practice*</b>	<b>N</b>	<b>%</b>
Attention to users, family, and community [individual, family, groups, and articulation in the health and intersectoral network]	103	98.1
Service or team management	24	22.9
Teaching activities [preceptorship and/or tutoring for occupational and/or multi-professional therapy]	24	22.9
Others	10	9.5
<b>III – Do you recognize interprofessional work in planning and implementing practices in APS?</b>	<b>N</b>	<b>%</b>
Yes	95	90.5
No	10	9.5
<b>IV - Place of the practice of occupational therapists in APS</b>	<b>N</b>	<b>%</b>
UBS	96	91.4
People and/or family homes	89	84.8
Territory equipment [schools, daycare centers, community centers, shelters]	87	82.9
Public spaces [squares, parks, streets]	54	51.4
<b>V - Use of assessment instruments with people, families and the community that the occupational therapist assists or follows up in APS</b>	<b>N</b>	<b>%</b>
Use of instruments developed by the professional or the APS service	64	61
Use of specific and standardized assessment tools for occupational therapy	46	43.8
Does not use assessment tools	26	24.8
Others	6	5.7
<b>VI - Type of record/documentation of actions performed by occupational therapists in APS</b>	<b>N</b>	<b>%</b>
Paper record by E-SUS service	57	54.3
Medical records or multi/interprofessional records	56	53.3
Electronic service record by E-SUS	33	31.4

**Table 2.** Continued...

Medical records or exclusive occupational therapy records	16	15.2
Others	13	12.3
<b>VII - Specific demand, populations, health needs and/or problems assisted by occupational therapists in APS</b>	<b>N</b>	<b>%</b>
<b>Specific demand</b>		
People with an impairment and/or difficulty in participating and carrying out their daily activities/occupations	96	91.4
<b>Lifecycles</b>		
Prenatal, pregnant women and newborns care	62	59
Children and adolescents	92	87.6
Adults	91	86.7
Seniors	96	91.4
<b>Health and/or problem needs</b>		
People with chronic diseases	89	84.8
People in psychological distress	86	81.9
Bedridden people	85	81
Disabled people	82	78.1
People restricted to the home (not bedridden)	77	73.3
People in situations of social vulnerability	76	72.4
People with needs resulting from the abusive use of tobacco, alcohol and other drugs	65	61
Victims of violence	52	49.5
People with communicable diseases	47	44.8
Homeless people	24	22.9
People deprived of their liberty	3	2.9
<b>Others</b>	<b>6</b>	<b>5.7</b>

**Source.** The author. \*The publications by Silva & Oliver (2019) and Silva (2020) identified the diversity of practices and approaches performed by occupational therapists in APS. Explanatory note: N – number of occupational therapists; APS – Primary Health Care; UBS – Basic Health Unit; E-SUS – data computerization system of the Unified Health System.

## 3.2 Qualitative results – Phase 2

### 3.2.1 Characterization of participants

Eight participants were chosen and show in Table 3.

**Table 3.** Characterization of Phase 2 participants.

Participant	Region	Work Hours	Time working in APS	Type of Participation
Participant 1 [Salvador]	Northeast	20 hours	> 3 years ≤ 5 years	Interview ( <i>online</i> )
<b>Participant 2 [Recife]</b>		20 hours	> 3 years ≤ 5 years	<b>Interview (face-to-face) and Practice Observation</b>
Participant 3 [Metropolitan region - Recife]		20 hours	> 1 years ≤ 3 years	Interview (face-to-face)
Participant 4 [Maceió]		30 hours	> 3 years ≤ 5 years	Interview (face-to-face)
Participant 5 [São Paulo – South area]	Southeast	30 hours	> 5 years ≤ 7 years	Interview ( <i>online</i> )
Participant 6 [Rio de Janeiro]		30 hours	> 3 years ≤ 5 years	Interview ( <i>online</i> )
Participant 7 [Belo Horizonte]		40 hours	> 3 years ≤ 5 years	Interview ( <i>online</i> )
<b>Participant 8 [São Paulo – north area]</b>		20 hours	> 3 years ≤ 5 years	<b>Interview (face-to-face) and Practice Observation</b>

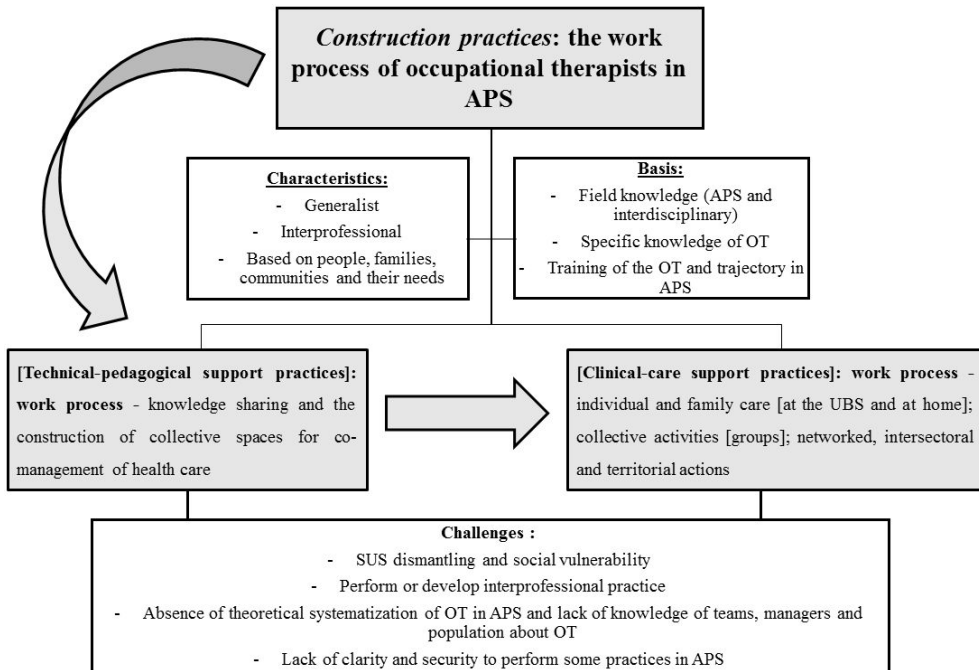
**Source:** The author. APS – Primary Health Care.

The data obtained through two practice observations and eight interviews with occupational therapists from NASF-AB in capitals and metropolitan regions in the northeast and southeast produced four theoretical categories:

- Category I - Practices of occupational therapists in technical and pedagogical support (work process - knowledge sharing and the construction of collective spaces);
- Category II - practices of occupational therapists in clinical-care support (work process - individual and family care [at the UBS and home], collective activities [groups], network, intersectoral and territorial actions);
- Category III: characteristics and basis for the practice of APS occupational therapists;
- Category IV: challenges for the practice of occupational therapists in APS.

The four theoretical categories have a central category: ***“Practices under construction: the work process of occupational therapists in APS”***.

Figure 2 shows this process by a diagram that is the result of the construction and analysis of the data via initial, focused, and theoretical coding, according to Charmaz's DGT (Charmaz, 2009), and the triangulation of qualitative data between Phases 1 and 2.



**Figure 2.** Work process of occupational therapists (OT) in APS. Source: The author. APS – Primary Health Care; UBS – Basic Health Unit; SUS - Unified Health System.

Figure 2 shows the central category of Phase 2. At first, it is worth noting that most professionals in the area who work at this care level are in NASF-AB. Occupational therapists have been included in NASF-AB since its creation in 2008; this service aimed at expanding the scope of the actions offered and support the Family Health Strategy (ESF) (Brasil, 2008). In this sense, we identified in this research that the **work process** is still under construction and is carried out, mainly, through matrix support via two strategies: clinical-assistance and technical-pedagogical.

The recent and poorly systematized character of the work of occupational therapists in APS, even though identified in this research as being carried out by different support strategies, still lives with different models of health care in services and practices, which may be: the model assistance-curativist, the sanitary, the matrix support and expanded clinic, among others (Arce & Teixeira, 2017; Nascimento et al., 2018), which gives the character under construction of the work process.

The work process of occupational therapists, with their **characteristics** and **basis** mainly begins after the contact with the ESF reference teams, in different collective co-management spaces, in **technical and pedagogical** support practices, through meeting modalities [NASF-AB and ESF team; NASF-AB team; NASF-AB team and health network, intersectoral and territorial], occupational therapists share knowledge and strategies such as case discussion; teamwork and networking; construction of therapeutic projects; permanent education; expanded clinic; organization of the work process; expansion of the number of shares offered by APS.

Based on these different collective spaces for the co-management of health care, cases, and strategies are shared between the ESF, the NASF-AB team, and the care network.

Thus, the population has access to different practices developed by occupational therapy at NASF-AB. These **clinical-assistance** support practices can be specific or shared, using a variety of care technologies through the following strategies: assistance, home visits, groups and network, intersectoral and territorial actions.

The set of **challenges** for the practice of occupational therapists in APS is linked to the **health area and the assistance level**, with emphasis on the processes of dismantling SUS, constituting interprofessional practice and social vulnerability and violence in the territories of APS services. Other challenges are present when considering the **core of occupational therapy** such as the absence of theoretical and practical systematization to act at this care level; the lack of knowledge of the teams, managers and the population about the area and the lack of clarity and security to carry out some practices contextualized in the APS scenario.

## 4 Discussion

The results showed that occupational therapists from APS identify that their practices are guided by the essential and derivate attributes of APS and that the characteristics of the context in which the process of practice takes place interfaces with these attributes and contributes to the strengthening of APS.

In the analysis of the results, the qualitative data of Phase 2 sought to explain the quantitative findings of Phase 1, which demonstrated the present interface between the essential and derivate attributes of APS and the occupational therapy practices at this care level. This interface is discussed in two topics: first, the essential attributes and then, the derivate attributes of APS.

### 4.1 I - The interface of the practices of occupational therapists in Primary Health Care with the *essential attributes* of APS

The **attribute of first contact care** means the access and the preferred entrance for the population to the health system, as well as a strategy to assess the importance of other professionals and specialized services for solving less frequent and/or high complexity health problems (Starfield, 2002; Lima et al., 2018). Occupational therapists from Phase 1 of this study stated that 92.3% of their practices are guided by the attribute of first-contact care. Although it has this prevalence, Table 2 identified that the population accesses the occupational therapist mainly after discussions of cases and referrals and to a lesser extent through active search or direct access to care.

In Phase 2, user access is performed mainly by the reference team of the Family Health Strategy (ESF), which suggests approximations with the findings of Phase 1. Thus, after the ESF team verified the need for a specific contribution from other professionals, it shares the case (s) and begins the first contact.

This first contact process is mainly understood in the technical-pedagogical support during collective spaces of co-management through different types of meeting, permanent education and shared practices, as shown in some examples:

*“The flow for the occupational therapy care is through the **case discussion** meeting with the Reference Team [Participant 3 - Metropolitan Region - Recife]”; -*

**[Observation of a case discussion]** - *the ESF refers: man, psychological distress, not medicated, 'eats garbage on the street' that in the case, the occupational therapist indicates that she will carry out a joint home visit [with the ACS] (Diary of Field - observation of practice - Southeast).*

NASF-AB does not necessarily work as the entrance to APS, that is, the user does not directly access the occupational therapist of this system, as initial contact is necessary, most of the time, with the reference team to report the user's need to later reach the professional. Due to the difficulty of understanding FHS teams about the role of occupational therapy, sometimes the population's access to practices in this category is lost (Onório et al., 2018).

However, the dynamics of the “open door” of APS allows people to access Basic Health Units (UBS) through spontaneous demand, in such a way that, during their stay at the UBS and in scheduled appointments, occupational therapy professionals perform welcoming, guidance and clarification on the flow of referrals, talk and resolve an emergency or occasional issues of users (Caldeira, 2009).

Although the process of the first contact of the population with occupational therapy professionals in APS is understood, it is still necessary to explore different aspects that would give greater consistency to the specific role of this area together with the attribute of the first contact, such as opening hours of the UBS; barriers to physical and attitudinal accessibility; reception models, risk classification and scheduling of consultations, and the excessive demands and queues for care at the APS (Lima et al., 2018).

The **longitudinality attribute** is mainly defined as care oriented to the person through a long-term personal relationship between health professionals and users in their health units (Starfield, 2002). As for this essential attribute, 84.7% of participants in Phase 1 stated that this attribute guides their practices. The relationships of users and occupational therapists in APS also take place in different locations: at the UBS, at home, in facilities in the territory and public spaces, which indicates the proximity of professionals to the territorial and community context, which, in theory, can favor longitudinality. This is seen in the following report from Phase 2 - *“I assess the needs of the users in [home visits and individual care at the UBS] and observe the functional issues, routine, social roles and the family context [Participant 7 - Belo Horizonte]”*.

In Phase 2 of the research, it was also possible to identify that occupational therapists offer care to different populations and seek to strengthen bonds, understanding and assessing people's needs, life history, doing, engagement in daily activities and their disruptions and impediments, as seen by the participant in the following report: *“Practical approach of OT in NASF-AB [in reception and evaluation] - it seeks to know the life story and do it [and also strengthen] bond and longitudinality [Participant 8 - São Paulo - northern zone]”*.

The groups carried out by occupational therapists can foster longitudinality by intervening to promote health and in specific populations (in different life cycles) in people with chronic problems and/or who require continuous monitoring and need care throughout people's lives (Caldeira, 2009). These characteristics can be seen in the group for people with diabetes and hypertension:

- “[HiperDia group results] *he is changing some life habits and improving self-care. Some examples of topics discussed by OT in this group were memory, attention/concentration, routine, and medication organization* [Participant 2 - Recife]”. Also, *different results are expected from occupational therapy groups, so that the main objectives are to promote “[...] social participation, the balance of people in daily activities, work, leisure.* [Participant 7 - Belo Horizonte]”.

The specific basis of the practice through the object of study of occupational therapy (activities/occupations and daily life) described in Phase 2 indicated a comprehensive understanding of the users and their needs, which can favor trust and bond since the practice it is not only based on diseases and their symptoms, as the expanded clinic guides, which is clear in the following speech: - “*We have the opportunity [at APS] to look at occupations, there in context, which expands the focus beyond the disease and symptom* [Participant 3 - Metropolitan Region - Recife]”. The understanding of activities and daily life can also be a therapeutic-occupational resource for APS care (Silva & Oliver, 2016).

This interface of the object of occupational therapy with the strengthening of the bond and the expanded clinic is significant since studies on longitudinality have turned to investigate the interpersonal bond between users and their source of attention (Oliveira & Pereira, 2013). The results of research on the National Program to Improve Access and Quality of Primary Care (PMAQ-AB) indicated that, in general, professional-patient relationships are unsatisfactory, especially for the continuity of the relationship, and are also shown inadequate in the quality of the professional-patient relationship (Lima et al., 2018), which indicates that occupational therapists can favor the achievement of longitudinality.

The **integrality attribute** expresses the scope of care, the recognition of the diversity of users' needs, and the offer of services and diversified actions so that APS resolution can be achieved (Lima et al., 2018; Starfield, 2002). Thus, it is not expected that any professional or service alone will meet all the needs of the population (Starfield, 2002), being the attribution of this care level, being responsible for the most common problems, as well as referrals to the specialized services of the network (Portela, 2017).

In Phase 1, 95.2% of the participants considered that integrality is an attribute that guides the practice in APS. This data is similar to the findings of qualitative research on the orientation of the training of occupational therapists for APS, which identified the integrality as a reference for professional education, even in undergraduate courses (Silva, 2016).

It was also identified that 78.1% of occupational therapists were part of the PMAQ-AB. The study by Lima et al. (2018) on the evaluation of the results of the PMAQ-AB identified that greater resolution in APS was also related to the increased support of NASF-AB and CAPS teams. The insertion of occupational therapists in NASF-AB teams, who participate in the PMAQ-AB, demonstrates that these professionals are also inserted in strategies that encourage the improvement of APS, which can, to some extent, strengthen access and comprehensive care. at this care level, although participation in PMAQ-AB does not guarantee the resoluteness of practices in APS.

Most of the participants (55.2%) in Phase 1 indicated that they were not aware of the percentage of APS coverage in the city where they work, which may mean a weakness



in the articulation of their activities in the interface with this integrality attribute since the professional does not know about the APS and, possibly, about the health care network and other social and territorial services.

Also, in Phase 1, in Table 2, **in item V** - on the use of instruments for assessing needs – they were mostly prepared by the professional or by the service, which hinders greater systematization for accountability for care.

Occupational therapy practices in APS are comprehensive and, in the populations assisted, 91.4% attend people with specific demands related to impairment and/or difficulty in participating and performing their daily activities/occupations. People from all stages of the life cycle and people with health needs and/or specific problems are also assisted such as people in psychological distress, with disabilities, with chronic diseases, in situations of social vulnerability, among others. This profile of the population is similar to the population found in a literature review on the practices of occupational therapists in APS (Cabral & Bregalda, 2017).

In Phase 2, occupational therapists perform practices of dimensions: **clinical-assistance**: individual and family care, home care, groups, care practices in the health network, intersectoral and territorial [specific or shared]; **technical-pedagogical**: participation in meetings, case discussions, expanded clinic, permanent education, teamwork and support to “*understand the demographic and epidemiological characteristics of the territory in which is the UBS supported by NASF-AB* [Participant 7 - Belo Horizon]”. These different practices demonstrate the scope of occupational therapy in APS and are presented as strategic to implementing comprehensive health care in SUS (Cecílio, 2001).

To understand how occupational therapy contributes to the effectiveness of integrality in APS, there is here an example of a home visit. The occupational therapist of the NASF-AB and an ACS carried out the visit of a 40-year-old woman who suffered a stroke one year ago (2018), who lives in a small two-room house with two children, unemployed and in a situation of social vulnerability, who lost her job after the stroke and is restricted to the home. The user has already performed specialized care in a rehabilitation center. However, she remains with sequelae in speech and motor skills in the right hemi-body, which gives her a unique experience of living her daily life. One of the objectives of the visit was to monitor the use of an alternative communication board. Here, there is a description of the approach:

*The **occupational therapist** sits in front of the user and starts the conversation by writing in a notebook. The user mentions little ability to write with her left hand, as she is right-handed and says she uses the communication board little because of her literacy difficulties. For this reason, the occupational therapist shows three-sentence schemes linked to daily life according to the user's desire: [1<sup>st</sup> - what did I do today? 2<sup>nd</sup> - what did I watch or want to watch? 3<sup>rd</sup> - what did I eat or want to eat today?]. The occupational therapist also reinforces the indication of a communication application suggested by the NASF-AB speech-language therapist. After some orientations, they agreed to use three different strategies [communication board, notebook through writing, and the use of a cell phone application]. (Field diary - observation of practice - Southeast).*

The home visit sought to favor comprehensive care for the development of a process of communication and perception of different needs and with the provision of compatible strategies.

The **attribute of care coordination** is defined as the possibility of working together in a network to solve complex and less frequent problems based on the availability of consistent information to ensure health care (Starfield, 2002; Lima et al., 2018). The results in Phase 1 indicate that this attribute guides the practice of 83.8% of occupational therapists.

The qualitative results of Phase 2 with the clinical-care dimension [in practices: network, intersectoral and territorial actions] demonstrate that this attribute has a relevant interface with occupational therapy. This professional area is generalist not only in the health area in which it articulates well with mental health and rehabilitation services but also with other areas, especially in education and social assistance, in which the occupational therapists are a potential facilitator and aggregator in the construction of care networks to the population (Avelar & Malfitano, 2018) and which encompasses different dimensions of everyday life in their practices (Galheigo et al., 2018).

The participants defined how they perform the role of the coordinators, based on the following reports:

- *“the role of NASF-AB and the occupational therapy is to connect the different points of the health care network [Participant 4 - Maceió]”; - “Individual care [mental health] - so when the patient comes with mental health, I first try to structure his routine, we make referrals to CAPS, or we do something [...] we work together with CAPS, with the family, the network I work in is very powerful. [Participant 5 - São Paulo - south area]”.*

However, there are several challenges to build care coordination, mainly linked to the insufficiency of the health system, and an installed network, considering the financing capacity to meet the needs of the population and social vulnerability, as seen in the challenges category results of Phase 2. These challenges are amplified when there is an absence or scarcity of information about users and their families, as identified in the study by Almeida et al. (2019) that when analyzing data on people with disabilities monitored in municipal health services within the scope of primary care and medium complexity, they identified that the lack of information compromises the knowledge of the needs of the population and the provision of comprehensive care.

The results of Phase 1 can show this difficulty [Table 2 - **in item VI** on the type of record of actions performed by occupational therapists in APS], which showed more than four possibilities of recording in different medical records (E-SUS; multi-professional medical record; electronic service record; an exclusive medical record of occupational therapists), and it can become an obstacle to the practice of occupational therapy, considering the importance of care coordination. Caldeira (2009) found a similar reality in the study by identified the non-systematic use of medical records to record visits by APS occupational therapists.

Another obstacle perceived during the observation of practices is the delay in carrying out consultations with specialists, which demands the need for specialized care for occupational therapy in APS, as shown in this description:

*Child, 1 year and 2 months old [...], accompanied in a Shantala group by the NASF-AB occupational therapist and speech-language therapist. These professionals suspect on sequels of Cerebral Palsy and delayed neuropsychomotor development, and in this sense, they referred the child to the Specialized Rehabilitation Center (SRC). However, due to the long waiting list and the child's age, the occupational therapist justifies weekly attendance with a focus on the child's global development and, therefore, guides the mother to stimulate development at home [Field diary - observation of practice - Southeast].*

This reality shows the historic fragility of the network and the constant lack of structure of the SUS, but it also means the population's access to occupational therapeutic care in APS for problems that previously were only cared for at a specialized level. This context indicates the need for studies on the profile of population groups to be attended by occupational therapists in APS since in the Brazilian context, it is still necessary to identify the real health needs and those most common to be handled by APS (Portela, 2017).

#### 4.2 II - The interface of the occupational therapists' practices in Primary Health Care with the derived attributes of APS

The **attribute of family guidance** is the knowledge that APS professionals have about the context of the families of the people assisted and how these professionals also consider family involvement during health care (Starfield, 2002; Prates et al., 2017).

In Phase 1, the result of the family orientation attribute was 90.4%. Table 2, **item II** identified that one of the types of practice that the professional performs is the care to users and families. In **item IV**, about the location of the practices, 84.8% of occupational therapists perform these actions at the home of people and/or families, which indicates approximation to the family context.

Phase 2 shows that one of the characteristics of the practices is to base their actions on people, families, communities, and their needs. During the observation of family visits and discussion of cases, the search for occupational therapists for information about the family context was noticed. To illustrate this characteristic, it is possible to visualize the interface with the family orientation attribute, from the following perspectives:

*“In the consultations, we also seek to carry out the **family** approach and not just the case [Participant 2 - Recife]”; - “[Speech by a professional from the NASF-AB team about the way that the OT of the NASF-AB provides guidance] – The management guidelines you give to the family make you feel very much like “Wow, you managed to make the child talk, she didn't even talk to me in the other consultation” [Participant 8 - São Paulo - north area]”.*

Family care is part of the repertoire of occupational therapy in APS, not only as a source of information to provide care but also as part of the centrality of care that professionals perform (Caldeira, 2009). Also, the link between occupational therapists and families can contribute to the longitudinal monitoring of complex cases especially for people with disabilities and social vulnerability through the following strategies: whenever possible, talk about the importance of care, offer schedule options, and make joint calls (Caldeira, 2009).

The results of Phase 2 show that home care by occupational therapists in APS seeks to understand the needs of users, family members, and the context, as seen in the reports: - *"I go to their homes to assess the context [...] [Participant 3 - Metropolitan Region - Recife]"*; - *"So I go to the house, do this assessment of the family member's demand and the elderly's demand, for example. [Participant 7 - Belo Horizonte]."* These interventions at home based on an approach centered on the family's health needs have shown significant results in promoting changes in self-care in everyday life (Baissi & Maxta, 2013).

The **community guidance attribute** seeks to maximize the health services so they can contribute to addressing social vulnerability and its repercussions on health and reducing inequities in populations (Starfield, 2002).

In Phase 1, 76.1% of the participants said that this attribute influences their practices in APS. **Item IV of Table 2** was described that in addition to carrying out practices in the UBS and their homes, 82.9% of occupational therapists perform practices in equipment in the territory and 51.4% in public spaces, which characterizes community capillarity of their practices in APS. Although the practices have some community capillarity, the fact that they are carried out in the territory does not necessarily mean that the interventions are facing social vulnerability and operating in the collective on the social determinations of the health-disease process, which adds to the limitations of the APS and the little theoretical and methodological accumulation of occupational therapy to guide their community practices at this assistance level.

Phase 2 shows a comprehensive understanding of the issues for the scope of clinical-assistance support practices, as highlighted by the participant: *"My analysis capacity is more systemic, which involves complexity in people's daily lives [Participant 8 - São Paulo - north area]"*. Daily life permeates the relationship of people in the micro and macro-social spheres (Galheigo, 2003), which can enable a greater interface between occupational therapy practices and the attribute of community orientation. However, for this to happen, it is necessary not to consider only the individual production of daily life, which could cause the construction of practices for dealing only with individual problems.

The practices performed in territorial services and public spaces were perceived less frequently in Phase 2, we observed two actions: an articulation of the occupational therapist for scheduling activities in a school in the territory through health promotion actions in adolescence; a group of women in a Social Assistance Reference Center (CRAS) with the theme "how is to be a woman?", to promote care for women that are not limited only to the health-disease process.

Thus, this evidence is added to the guidance for the community in the practices of APS occupational therapists aimed at people with disabilities to favor the understanding of social determinations of disabilities, the use of equipment in the territory, and

interventions aimed at recognizing and dealing with the community's perception of people with disabilities, among others (Caldeira, 2009).

Social inequalities produce adverse effects on health (Starfield, 2002), which makes the knowledge of the community context relevant to the planning of actions. Phase 1, Table 1, demonstrated that 60% of occupational therapists work in capitals and metropolitan regions. In Phase 2, there were different challenges for the development of practices in these contexts, such as the presence of social vulnerability and violence in the territories of the services, as shown by the participants: - “[The APS work context] *we have violence and vulnerability of the population* [Participant 8 - São Paulo - north area]”; - “*We have difficulty facing social issues [...] and the complexity of the health needs of the territory* [Participant 1 - Salvador]”.

To face this situation, it is necessary to seek the implementation of practices that strengthen the SUS and intersectoral actions (Akerman et al., 2014), as well as the construction of the expanded clinic that brings together elements of the organic dimensions, subjective and social in its practices (Cunha, 2010). For occupational therapy in APS, the community and territorial contexts must be used as an instrument to enhance health care, insertion, and social participation (Bianchi, 2018).

The **attribute of cultural competence** shows the process of adapting APS services to meet the cultural singularities of a community (Prates et al., 2017; Starfield, 2002). This attribute has also a strategic responsibility to qualify the actions (Damasceno & Silva, 2018).

Phase 1 of the survey showed that 60.9% of the participants identified this attribute as a guide for their practices, with the lowest score among all the attributes investigated. In this national survey, there are several socio-sanitary, ethnic, age, and epidemiological realities, with the need for sensitivity and concern for the interface of practices with this attribute.

The cultural specificities of the population must be considered by the management and the different APS professionals so that there is a great influence of socio-cultural and behavioral aspects on self-care, the possibilities of carrying out prevention, perception and coping with conditions risk and access and use of APS services (Damasceno & Silva, 2018).

Even though the interface with the attribute of cultural competence is challenging, occupational therapists participating in **Phase 2**, during meetings of the NASF-AB team and the NASF-AB and ESF team, *sought to problematize the social context of a UBS supported by the team, such as also to better understand the family and territorial context of the users through the ESF professionals, especially by the ACS*. These strategies are important for bringing occupational therapists closer to territorial reality. However, they are still insufficient to transform the care of the APS service in the direction of considering socio-cultural issues in the care provided by the entire team.

When the rationale for occupational therapists for APS practices was presented, **Phase 2** showed the influence of group approaches, community therapy, popular health education, and integrative and complementary practices, as well as the indication of propositions transformative theorists - critical occupational therapy, social occupational therapy, occupational justice, and occupational apartheid. The use of these approaches

and theories can contribute to the achievement of results that consider cultural competence in APS.

In this sense, two examples in Phase 2 indicated the proposition of practices that approach the attribute of cultural competence. In the **first example**, one school demands interventions with high school youth from a vulnerable territory who are having difficulties in identifying possibilities for their lives - based on the popular education approach: “[...] *The occupational therapist suggests that she will reflect together with the NASF-AB team on actions that promote the life project and job possibilities for young people* [...]” [Field diary, Observation, Northeast].

The **second example** is about the group of women victims of domestic and gender-based violence and in psychological distress and/or social vulnerability that is coordinated by the NASF-AB occupational therapist; this professional is also a reference in the team for referring women who are victims of violence and who experience suffering situations. According to the occupational therapist, what mainly influences this practice are gender studies and critical occupational therapy.

As seen in the examples, occupational therapists can promote interventions that come close to cultural competence, by directing their practices towards socio-cultural specificities of young people from the periphery and women victims of gender violence. Practices involving this attribute are few among the actions performed by occupational therapists in APS. The implementation of the attribute of cultural competence has been a challenge because the meanings of falling ill, the perception of the suffering and vulnerability of different population groups are often overlooked by APS workers (Damasceno & Silva, 2018).

## **5 Final Considerations**

The joint interpretation of the results of the mixed methods research in Phase 1 and 2 showed that the practices of occupational therapists’ interface with the essential and derivatives attributes of APS, which indicates the pertinence, justifies the insertion and attests how much the occupational therapy can carry out contextualized practices at this care level.

The characteristics of the object of the profession, such as its central emphasis on activities/occupations and daily life, are significant to reach APS attributes, especially because occupational therapists perform practices that based on its specificity, they seek the focus on the person, the family and the territorial and community context and not only on diseases and their symptoms or only on the individual.

Although the results demonstrated the interface, there is still a need for research that details and systematizes the specific collaboration for each of the attributes, whether essential or derived, through prospective studies that use APS instruments and also encourages the creation of instruments specific to the area to provide a clearer basis for the interface and the impact of the practices of occupational therapists for this care level.

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### **Author's Contributions**

Rodrigo Alves dos Santos Silva performed data collection, organization, and data analysis, and worked on the writing and review the text. Fátima Corrêa Oliver was responsible for guiding the research, reviewing the data analysis, writing, and reviewing the text. All authors approved the final version of the text.

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