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ORIGINAL ARTICLE

# COMPREHENSIVE CARE NETWORK FOR OLDER ADULTS: THE EXPERIENCE OF NURSE-MANAGERS IN PRIMARY CARE

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**ABSTRACT**

Objective: to understand the conception of the comprehensive care network for older adults according to the experiences of nurse-managers working in Primary Health Care services. Methods: a qualitative research study conducted in 2019 in a number of host municipalities from five health regions of the state of São Paulo, Brazil. The interviews were audio-recorded, transcribed and analyzed according to the Grounded Theory, with theoretical saturation from the fifth interview. Results: three sub-processes emerged, namely: recognizing potential for the constitution of a comprehensive care network for older adults in the context of the public health system; getting discouraged for not visualizing the Care Network for Older Adults, given the organizational and cultural challenges to strengthen Primary Health Care; and discouragement to mobilize towards the constitution of the comprehensive care network for older adults. Final Considerations: this study contributes for the teams working in the Primary Health Care services to reassess their health practices, seeking to advance in the constitution of the comprehensive care network for older adults.

**DESCRIPTORS:** Older Adult: Comprehensive Health Care; Primary Health Care; Nurses; Administration of Health Services.

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## INTRODUCTION

Population aging is a global phenomenon. In Brazil, there are repercussions on the public policies and on their implementation in the services provided in the territory, with the Unified Health System (Sistema Único de Saúde, SUS) standing out, which must provide qualified care to meet the demands arising from the increase in non-communicable chronic diseases and to control infectious diseases, which persist across the country, also reaching older adults[1-2].

In view of this, the Ministry of Health updates policies[3-4] in order to address the demands of the aged population, policies aimed at establishing and disseminating guidelines for the health services, especially Primary Health Care (PHC), for greater resoluteness in advancing comprehensive care for older adults.

The PHC services have been organized through the Family Health Strategy (FHS), a priority model for PHC expansion and consolidation in the country[8]. The team consists of a family doctor, a nurse, nursing technicians and a Community Health Agent (CHA), with its management most frequently in charge of the professional nurse[9].

The Health Care Networks (HCNs) were established in 2010 and they are understood as organizational arrangements to guarantee comprehensive care, by different services[5], aiming to overcome the fragmented health system. Strategic guidelines were proposed in 2014 for their implementation, among them the constitution of the comprehensive health care network for older adults to guarantee active aging[6], with emphasis on the PHC services as organizers of this network[7].

Even in the face of the acknowledged PHC expansion, a number of national studies conclude that there is disarticulation in the health services and absence of a care network for older adults[2,10-12]. There seems to be a gap between the needs imposed by population aging and the response capacity of the health services in Brazil, mainly PHC[11], with insufficient discussions about the new demands, such as heterogeneity and longevity[13].

The question is as follows: Which is the conception regarding the comprehensive care network for older adults of nurse-managers working in PHC, responsible for the implementation of the Ministry of Health's guidelines and protocols? The objective of the study was to understand the conception of the comprehensive care network for older adults, abstracted in a theoretical model, and based on the experiences of nurse-managers working in PHC services.

## METHOD

A qualitative and comprehensive research study carried out according to the Consolidated Criteria for Reporting Qualitative Research (COREQ)[14], using the Grounded Theory[15] and Symbolic Interactionism[16] as its methodological and theoretical frameworks, respectively. In addition, it was based on the main policies, laws and ministerial recommendations aimed at older adults and health services, considering the National Health Policy for Older Adults[3] and the basic care booklet called "Aging and Health for Older Adults"[4], to deepen understanding of the comprehensive health care network for older adults, based on the experiences of nurse-managers working in PHC services.

The requirements considered for participation in the study were being a PHC nurse and service manager from the host municipalities of five health regions in the state of São Paulo (Bauru, Jaú, Lins, Avaré and Botucatu), Brazil; they were defined intentionally, according to the following inclusion criteria: being an FHS unit, and the manager having

been in the position for at least two years and being available for an interview. Those managers who had held the position for less than two years were excluded from the study, as well as those distanced from work during the period or who were not available to schedule an interview. Choice of these towns was due to the previously conducted research study, and the indications regarding managers and services were defined by the Municipal Health Secretariat of each municipality.

A scheduled non-directive interview was carried out in 2019 and it took place in the PHC premises where each manager worked. The interviews were audio-recorded and lasted from 30 to 50 minutes. A semi-structured script was used, with questions for the characterization of the actors and the following guiding question: Tell me about your experience as a manager for the organization and implementation of actions targeted at older adults in this PHC service."

Collection took place individually from September to October 2019 in the very premises of the services. After transcribing the interviews, the entire audio-recorded content was deleted, and their reports were presented through alphanumeric codes (E1, E2, E3, E4 and E5), with "E" representing "Interviewee" ("Entrevistado" in Portuguese). In addition, field observations and notes were made, which were judged pertinent to comprise the analysis.

Adopting the qualitative research guidelines and the methodological framework used (Grounded Theory), the stages of data collection and analysis took place concomitantly until reaching theoretical saturation from the analysis of the fifth interview (E5); and the resulting model was validated and compared with the unprocessed data, which proved to be able to explain the conception of the comprehensive care network for older adults based on the experiences of nurse-managers working in PHC services.

The interviews were manually transcribed and analyzed by the researchers without using any software program, and were later validated in accordance with the stages set forth in the Grounded Theory (GT)[15] methodological framework, namely: microanalysis, open coding, axial coding and selective coding.

The study was approved by the Research Ethics Committee under opinion No. 3,490,251.

## RESULTS

Five actors participated, all women, aged between 37 and 46 years old, PHC managers for more than two years, nurses, three of them with a specialization in Family Health and one with a stricto sensu graduate degree (PhD in Nursing).

The categories identified and the theoretical relationships established enabled the development of the analytical and explanatory process through three sub-processes that comprise the experience, namely: (A) recognizing potential for the constitution of a comprehensive care network for older adults in the context of the public health system; (B) getting discouraged for not visualizing the Care Network for Older Adults, given the organizational and cultural challenges to strengthen Primary Health Care; and (C) discouragement to mobilize towards the constitution of the comprehensive care network for older adults.

The central category (Theoretical Model) was unveiled from the realignment of the sub-processes: "Getting discouraged to build an idealized comprehensive care network for older adults for not visualizing it in the face of organizational and cultural challenges to strengthen PHC" (Figure 1).

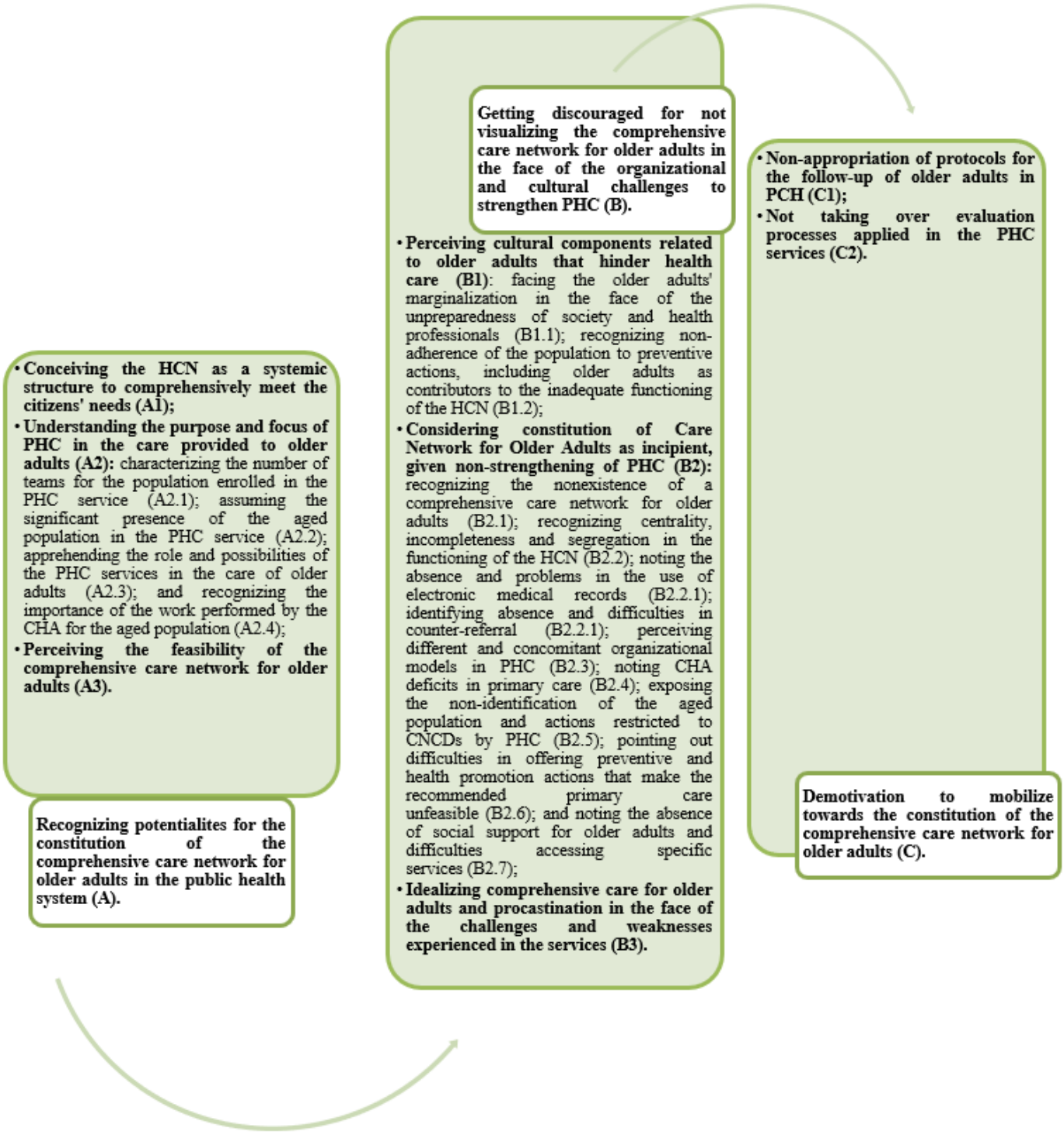


Figure 1 - Central category (Theoretical Model): Getting discouraged to build an idealized comprehensive care network for older adults for not visualizing it in the face of organizational and cultural challenges to strengthen PHC Botucatu, SP, Brazil, 2020. Source: The authors (2020).

The central category represents the entire process. Asserting and reinforcing the nonexistence of a comprehensive care network for older adults from the context of the PHC services, the actors recognize that there is potential for its constitution, arranged in the public policies, and specific actions developed by the services, although cluttered by countless problems and challenges that extrapolate the control possibility by these professionals, noticed in the unfoldings of the three sub-processes.

Recognizing potential for the constitution of the comprehensive care network for older adults in the context of the public health system (A), consisting of categories and

subcategories, stems from the actors' understanding of the HCN concept and how it should work as recommended, in the provision of comprehensive care made possible by different services, such as PHC, the gateway to and organizer of health care.

Category (A1) – Conceiving HCN as a systemic structure to fully meet the citizens' needs – represents the actors' findings regarding the HCN on the composition of the health services in the three spheres (primary, secondary and tertiary care levels) and other areas.

The actors also understand that the HCN must work in an intersectoral, non-hierarchical way, aiming to meet the totality of the individuals' needs, regardless of age group and gender, whether internally or externally to the municipality; having an electronic Health Service Supply Regulation Center (Central de Regulação de Oferta de Serviços de Saúde, CROSS) system, responsible for signaling the availability of beds and outpatient specialties in the health system, reflecting an integration device, as reported by E4:

*[...] I see the network as a job in which one service supports the other [...]. Primary, secondary and tertiary care and the other services, which are intersectoral (E4).*

It is with the deepening of the reflections about the HCN that category (A2) emerges: Understanding the purpose and focus of PHC in the care provided to older adults. In this category, the actors recognize PHC as the gateway to the public health system due to the greater proximity and knowledge of the population's demands, characterizing the PHC service: number of teams and enrolled population (A2.1).

In which the PHC services must develop actions focused on prevention and health promotion for older adults, present in expressive numbers in the territories, assuming the significant presence of the aged population in the PHC service (A2.2) and apprehending the role and the possibilities of the PHC services in the care of older adults (A2.3).

*[...] It's ant work, but we're improving day after day. [...]. Then as Primary Care, I think that we should work a lot with promotion and prevention, and our role is fundamental [...] (E2).*

However, this represents a slow process to be constituted despite the legitimate advances in this care level, which are possible with the collaboration of different actors, such as the CHAs (Community Health Agents), who qualify the work of the teams from the Family Health Units (FHUs), recognizing the importance of the work performed by the CHA for the aged population (A2.4).

*[...] The community agent brings in the older adults' problem, then I dial and get into contact [...] (E3).*

In view of having verified the significant presence of older adults and the fundamental role of the PHC services, the category called "Perceiving the feasibility of the comprehensive care network for older adults (A3)" emerges, which recognizes the need to organize the comprehensive care network for older adults, so that it works in an integrated way, considering the biopsychosocial needs of this population segment. Collaboration from the services, professionals and the older adults' family members is fundamental, as there are successful experiences waiting the path to constitute this network.

*[...] So, when there is a problem with a given older adult, the network is tied between the Specialized Reference Center for Social Assistance (CREAS), the CRAS, the health service and the family [...] (E2).*

Paradoxically, the actors verify the nonexistence of this network, constituting the second sub-process of the experience of nurse-managers working in PHC services, (B) Getting discouraged for not visualizing the Care Network for Older Adults, given the organizational and cultural challenges to strengthen Primary Health Care, comprised by categories, subcategories and elements, as a reaction to the discredit and disincentives to face confrontations at work.

Perceiving cultural components related to the older adults that hinder health care (B1), they identify that society itself does not have a conception about the need to respect and support older adults, whether in senescence or senility, being extended to the health professionals, facing older adults' marginalization in the face of the unpreparedness of society and health professionals (B1.1).

Subsequently, in relation to the very generation of older adults, who resist participating in prevention and promotion actions, perhaps influenced by the disease-centered health model, recognizing the population's non-adherence to preventive actions, including the older adults, as a contributor to the inadequate functioning of the HCN (B1.2).

*[...] As a nurse and daughter of an aged woman with Alzheimer, I can say that I was unprepared [...] (E1).*

*[...] The HCN works in stages because, unfortunately, when you tell the older adults that they have to take preventive measures, not all of them accept it [...] (E2).*

In addition to the problems identified above regarding the unpreparedness of society and professionals, the everyday experience of the actors in the PHC services is added, and they consider the care network for older adults incipient in the face of the non-strengthening of PHC (B2).

In this way, nonexistence of a functioning comprehensive care network for older adults is verified, integrated with different services to cover health and social needs, and qualified to promote holistic care for older adults in the reality of the municipalities, because what does exist is insufficient, inadequate and lacks criteria, recognizing the nonexistence of a comprehensive care network for older adults (B2.1).

*[...] Specifically, there's no such thing as a care network for older adults, what we have is somehow general [...] (E3).*

Pointing out the weaknesses in the articulated functioning of the HCN and, consequently, of the comprehensive care network for older adults, recognizing centrality, incompleteness and segregation in the functioning of the HCN (B2.2), providing centralized, incomplete care, as it lacks specialists and exams available for the population's health needs, and unjust, with programs and actions only for a few segments.

In addition to this, the HCN works in a disarticulated manner due to the absence of electronic tools for quick and effective communication, noting the absence and problems in the use of electronic medical records (B2.2.1) and identifying absence and difficulties in counter-referral (B2.2.2).

*[...] There is the women's network, but there are no networks targeted at older adults, or to adolescents in any case [...] (E1).*

*[...] The system we use today, e-SUS, is not the same that the tertiary level uses, here [...] (E4).*

Related to the difficulties in the communication of these services across the care levels, the actors also identify the different types of primary care services in these municipalities from São Paulo, perceiving different and concomitant organizational models in PHC (B2.3); they have different structures and work processes, emphasizing the CHA's presence in the Family Health units and absence in the traditional Basic Health Unit.

*[...] Family health is a little different from the traditional model (BHU), because we have the possibility of making home visits through the community agent, who is the person that makes this connection [...] (E4).*

However, even recognizing the importance of the CHAs in the Family Health unit, these professionals are not always in sufficient numbers to cover the population enrolled

in the territory, with a discrepancy in the number of CHAs, verifying insufficiency of CHAs in primary care (B2.4).

*[...] This area here would need 14 community agents, we have seven [....] (E4).*

Coupled to these problems are those specifically related to the PHC services. The actors believe that care for older adults is still driven by CNCDs and by the HiperDia program, with lack of knowledge about the aged population enrolled in the territory, exposing the non-identification of the aged population and actions restricted to CNCDs by PHC (B2.5), thus reducing old age to diseases.

*[...] Then older adults are centralized within the HiperDia program [...]. Where are the healthy older adults? Mental health? [...] (E1).*

It simultaneously verified that factors such as high spontaneous demand in primary care, restrictions on the request of specific services and lack of a multiprofessional team to support these services make it impossible to organize and offer actions for this purpose, indicating difficulties in offering preventive and health promotion actions, which make the recommended operation of primary care unfeasible (B2.6).

*[...] Next door there is a handicraft group for women [...], but I can't leave here and go there, because I'm swallowed up by the service, by the demand [...] (E4).*

The actors recognize that there are aggravating factors regarding social vulnerability and the violation of the rights of the older adults who are in the territory of the PHC service, characterized by deficient social support and by family disarrangements, mainly in more distant locations.

In addition to the absence or minimal supply of services that meet social and care demands for these older adults, such as public or philanthropic Day Centers and Long-Term Institutions for Older Adults, evidencing the absence of social support for aged individuals and difficulties accessing specific services (B2.7).

*[...] We have some difficulties when a place is needed for the older adults to spend the day. The services we have are all overcrowded [...] (E4).*

Faced with this scenario, the actors idealize actions for older adults that can be implemented by the PHC services, aiming to advance in comprehensive care that includes preventive and health promotion practices, idealizing comprehensive care for older adults based on the challenges experienced in the services (B3), but which currently does not occur or only occurs occasionally.

*[...] Doing some recreational activity for the older adults, such as painting, crochet [...], for those who stay locked up in their houses all day [...]. So that they don't see the health center only as a place that fills prescriptions [...] (E1).*

The actors visualize comprehensive care for older adults, but they remain inert and indifferent, which discourages them from mobilizing towards the constitution of the comprehensive care network for older adults (C), resulting from the nurses' reaction when interacting with everyday signs of PHC weakening and, consequently, distancing them from what they idealize for the organization of this network.

As a coping mechanism, they adopt an attitude of indifference to strategies used by the Ministry of Health to induce them to reorganize health care for older adults in these services, either through guidelines or laws, refusing protocols for the follow-up of older adults in PHC (C1).

They also do not evaluate the results of evaluation processes, in which these services have participated in recent years, and they do not adopting evaluation processes applied in the PHC services (C2), showing that these tools are not being incorporated into the

planning of the services or into qualified decision-making.

*[...] The municipality's protocol is for hypertensives and diabetics, most of them are older adults [...]. I think that there should be protocols to develop other actions [...] (E4).*

*[...] Before the National Program for Improving Access and Quality in Primary Care (PMAQ) came, we filled out that questionnaire, but I don't remember and don't know what happened after that [...] (E1).*

## DISCUSSION

The study allowed apprehending the interactional movement of nurses, managers of primary care services, on the reality of the comprehensive care network for older adults in the context of different municipalities from the state of São Paulo. The guidelines on the HCN and PHC were verified and recognized as adequate; however, they point to non-implementation for comprehensive care for older adults, showing a stoppage and lack of motivation towards its constitution.

According to the Symbolic Interactionism assumptions, it is possible to understand that, although they recognize that the public policies are adequate, the actors still do not implement them in the face of countless problems. Considering that this theoretical framework assumes that people devise elements for themselves and are able to use their reasoning to interpret and adapt based on the circumstances, in a flexible manner, so that they come to define a given situation[16].

The actors acknowledge the indispensable role of PHC in the performance of actions focused on older adults' health prevention and promotion. In fact, the principles from the Alma Ata Conference emphasize the importance of identifying health needs in the territories with participation of the populations, with greater accountability of PHC[17], especially when focused on older adults[4].

The actors highlight the importance of the role of the CHA as an enhancer for practices aimed at older adults, which is fundamental to bring the PHC team closer to this population segment in the territory; this professional can become a catalyst for diverse information in the community to expand social support, being able to optimize practices for holistic and quality care[18].

However, paradoxically, in the routine of the services the actors identify non-implementation of the HCN and PHC principles and the nonexistence of a comprehensive care network for older adults, due to a set of weaknesses and challenges of the structure and work process, in addition to the older adults' behavior.

In this sense, the social role of older adults in Brazil is permeated by stigmas that influence the health care provided, as they historically occupy a marginalized place, marked by the look of the need for care reinforced by the hegemonic biomedical model (disease-centered) prevailing in the services provided in the country[19].

Such fact seems to be related to the actors' testimonies about the older adults not adhering to the health prevention and promotion activities. It is emphasized that the individual must have self-knowledge and discern the importance of these actions, as well as have access so that there is effective adherence to both drug and non-drug treatments; in addition to considering the schooling level, individual preferences, and the relationships between professionals and clients[20-21].

The actors point to the high demand in the PHC services and to the lack of human resources, such as CHAs and collaborators, for the non-organization of actions for older

adults, especially preventive and health promotion actions. A number of Brazilian studies corroborate the situation of high spontaneous demand in the context of these services, challenging reorientation of the SUS care model[22-23].

It is necessary to strike a balance between the provision of care and health prevention and promotion actions offered by the PHC services[24], especially in the care of older adults. In this study, the actors recognize disregarding the peculiarities of the older adults in the territory, without expansions beyond the HiperDia program, the system for registration and monitoring of people with systemic arterial hypertension and diabetes mellitus, with expressiveness of older adults, carried out with dispensation of medications, minimally, overlooking health promotion and prevention[25].

Added to this is the lack of knowledge of the recommendations for the organization of these services for the care of older adults, highlighting the lack of gerontological knowledge by the PHC team of professionals[10].

The actors also showed non-appropriation of the services' evaluation processes. Evaluation and monitoring strategies are now recognized as essential tools to assess effectiveness of the health system, with different instruments available, such as PMAQ-AB and QualiAB (Questionnaire for the Assessment and Monitoring of Primary Care Services), which propose, among its indicators, those inherent to the care to be provided to older adults[2].

The main limitation of this study is the choice of PHC services, which were directed by the municipal health secretariats, where one of the services was characterized as a traditional basic health unit.

## FINAL CONSIDERATIONS

The abstraction of the experiences of nurse-managers working in PHC services, through the theoretical model that emerged, in the light of Symbolic Interactionism and the laws and recommendations in force on the theme, implies countless challenges that must be overcome to achieve comprehensive care for older adults, signaling the synergistic contribution of the various services existing in the health network with strengthening of primary care and intersectoriality, to build and advance in the comprehensive care network for older adults.

The current study supports federal, state and municipal administrations to advance in updates and implementation of practices aimed at older adults, as well as it contributes to the team of Primary Health Care services to reassess their practices, in order to contemplate the heterogeneous demands and advance in the constitution of the comprehensive care network for older adults.

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