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ORIGINAL RESEARCH

Potential changes in health practices: the perception of workers of a Rehabilitation Network in (trans)formation

Potencial de mudança nas práticas de saúde: a percepção de trabalhadores de uma Rede de Reabilitação em (trans)formação.

Posibles cambios en las prácticas de salud: la percepción de los trabajadores de una Red de Rehabilitación en (trans)formación.

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ABSTRACT | The health of disabled people reached a priority in the Brazilian government's agenda resulting in the formulation of specific policies for these users in the Brazilian Unified Health System (SUS).The creation of a care network for disabled people and the use of the International Classification of Functioning, Disability and Health (ICF) are among the regulations recently published. This qualitative study examined a proposal for coordinated training between the Federal University of Minas Gerais and the Municipal Secretariat of Health, designed to assist the reorientation of Belo Horizonte's Rehabilitation Network based on the ICF model. The study aimed at understanding the perception of health professionals regarding their experiences in SUS scenarios in the light of the knowledge acquired about ICF, as a change in potential of the daily working practices and the construction of the Health Network. For such results, we used document analysis, non-participant observation and focus groups. Content analysis allowed identifying two main themes: harmony between work and professional development and power of the bio psychosocial model for the organization of rehabilitation. The results revealed a gap between academic professional development and the reality of work and, at the same time, a process of transformation in the way important constructs for the reorientation of rehabilitation are conceived, such as functionality, context and the relation between them. The current health care model still meets with non-conformities to the full coordination of care, however, motivation, knowledge of public policies and changes in the professional development of SUS can favor communication between agents and services, thus fostering networking.

Keywords | International Classification of Functioning, Disability and Health; Education, Continuing; Rehabilitation Centers; Integrality in Health.

RESUMO | A saúde da pessoa com deficiência alcançou prioridade na agenda do governo brasileiro, resultando na formulação de políticas específicas para esses usuários no Sistema Único de Saúde (SUS). A criação de uma rede de cuidados à pessoa com deficiência e o uso da Classificação Internacional de Funcionalidade, Incapacidade e Saúde (CIF) estão entre as normativas recentemente publicadas. Esta pesquisa qualitativa examinou uma proposta de capacitação articulada entre Universidade Federal de Minas Gerais e Secretaria Municipal de Saúde, concebida para auxiliar a reorientação da Rede de Reabilitação de Belo Horizonte a partir do modelo da CIF. Teve como objetivo conhecer a percepção de profissionais sobre suas experiências nos

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cenários do SUS à luz dos conhecimentos adquiridos sobre o modelo da CIF, e este como potencial de mudança das práticas cotidianas de trabalho e construção da Rede de Saúde. Utilizou-se análise documental, observação não participante e grupos focais. A análise de conteúdo permitiu identificar dois eixos temáticos: consonância entre trabalho e formação profissional e potência do modelo biopsicossocial para a organização da reabilitação. Os resultados revelaram distanciamento entre formação acadêmica e realidade de trabalho e, ao mesmo tempo, um processo de transformação da forma de conceber constructos importantes para a reorientação da reabilitação, como funcionalidade, contexto e a relação entre eles. O modelo assistencial vigente ainda encontra inconformidades para a coordenação integral do cuidado, mas motivação, conhecimento das políticas públicas e mudanças na formação de profissionais para o SUS podem facilitar a comunicação entre atores e serviços, favorecendo o trabalho em rede.

Descritores | Classificação Internacional de Funcionalidade, Incapacidade e Saúde; Educação Continuada; Centros de Reabilitação; Integralidade em Saúde.

RESUMEN | La salud de las personas con discapacidad fue prioridad en la agenda del gobierno brasileño resultando en la formulación de políticas específicas para estos usuarios del Sistema Único de Salud (SUS). La creación de una red de atención a personas con discapacidad y el uso de la Clasificación Internacional del Funcionamiento, de la Discapacidad y de la Salud (CIF) se encuentran entre las normativas recién publicadas. Este estudio cualitativo examinó una propuesta de formación coordinada entre la Universidade Federal de Minas Gerais y la Secretaria Municipal de Salud, diseñada para ayudar a la reorientación de la Red de Rehabilitación de Belo Horizonte, Brasil, partiendo del modelo CIF. El objetivo fue conocer la percepción de los profesionales de salud con respecto a sus experiencias en los escenarios del SUS, en vista de los conocimientos adquiridos acerca del CIF como un posible cambio de las prácticas de trabajo diarias y la construcción de la Red de Salud. Se utilizó el análisis de documentos, la observación no participante y grupos de enfoque. El análisis de contenido nos permitió identificar dos ejes temáticos: la armonía entre el trabajo y la formación profesional, y la potencia del modelo biopsicosocial para la organización de la rehabilitación. Los resultados revelaron una brecha entre la formación académica y la realidad del trabajo y un proceso de transformación en la manera de concebir constructos importantes para la reorientación de la rehabilitación, como la funcionalidad, el contexto y la relación entre los mismos. El modelo de atención actual sigue deficiente para la plena coordinación de la atención, sin embargo, la motivación, el conocimiento de las políticas públicas y los cambios en la formación de profesionales para el SUS pueden facilitar la comunicación entre los agentes y servicios, favoreciendo el trabajo en red.

Palabras clave | Clasificación International del Funcionamiento, de la Discapacidad y de la Salud; Educación Continua; Centros de Rehabilitación; Integralidad en Salud.

INTRODUCTION

The health of disabled people has reached priority in recent years, which resulted in policies aimed towards the construction of services consistent with the doctrines of the Brazilian Unified Health System (SUS). In 2012, Ordinance No. 793[1] was published to create the Care Network for People with Disabilities and Ordinance No. 835[2] to establish the funding rules to structure services and enable professionals. In the same year, Resolution No. 452[3] was published, instituting the use of the International Classification of Functioning, Disability and Health (ICF) in SUS. These standards certify initiatives that strengthen the principles of Universality and Integrality, extending the right to the care of disabled users, reorganizing this and proposing a biopsychosocial model to guide these changes.

Using this logic, the Rehabilitation Centers (CER) are spaces for articulation with other care points of the SUS[4]. This reorientation of practice needs to overcome organizational issues and reach professionals regarding collective conceptions of the health-sickness[5] process and of the concept of disability. It is on these respects that the ICF can uniquely contribute.

The theoretical model of ICF[6] conceives health and human functionality as the result of a complex and dynamic interaction involving the individual and the context, not restricting itself to biological questions. Individuals with the same clinical diagnosis can present different levels of functionality, while others with the same level of functionality, may not share the same diagnosis[7,8]. Therefore, there are many areas of life that influence functionality, which make the Network a promising alternative to the integrality of care.

To this end, the Ministry of Health's (MS) policy for the inclusion of disabled people, defines approaches ranging from prevention, to the protection of health and as well as rehabilitation[9]. Despite advances, assistance for rehabilitation in the country displays weakness, dislocation and a discontinuity of actions. Different conceptions of fundamental constructs that generate distinct and overlapping standards for the operation of the services are being adopted[10].

In 2009, the Municipal Secretariat of Health (SMSA) of Belo Horizonte (BH) began to integrate rehabilitation services[11], organizing information and qualifying employees[12]. Currently, it has 557 employees, organized in teams in the Family Health Support Nucleus (NASF) and CER. The network incorporates private services and the Odilon Behrens Municipal Hospital (HMOB). Although legally integrated, these services and their professionals have found difficulties in communication, which compromises the consolidation of the network.

Thus, at the initiative of the Coordination of Rehabilitation in partnership with the Center for study and Research on Disability and Work at the Federal University of Minas Gerais (NEPIT/UFMG), the training "reorientation of the assistive rehabilitation network model SUS-BH, based on ICF" was proposed[12]. Its preparation was anchored in the understanding that, for the reorientation of the care model, to contemplate Integrality, the fundamental concepts of alignment between rehabilitation professionals and the development of new skills would be essential. These skills stimulate new ways of conceiving human functionality, which could be implemented in daily services.

From this perspective, the objective of this study was to understand the perception of professionals regarding their experiences in the confines of SUS in light of knowledge acquired about the ICF model, and using this as a potential for changing of the daily work practices and of the construction of the Health Network.

METHODOLOGY

Study-unit demarcation

A qualitative approach case study was developed together with a group of health professionals that represented the workers of the BH Rehabilitation Network. These professionals had been through training with an objective to promote critical reflection of the assistive rehabilitation model, changing the focus of the disease care for care of functionality, seeking an integrality of care.

Training

The guiding axis of this training process, carried out from March to November 2012, was anchored in the premises that guide rehabilitation in the public network and the biopsychosocial model of ICF.

Sixty-one professionals (multipliers) of the various services that make up the network, indicated by the coordination of rehabilitation, participated in this study. The contents were discussed in eight face-to-face workshops, e-learning and consultation about the work environment, and have been replicated by the multipliers in their services to the professionals who participated in the workshops in person.

Sampling, data collection and treatment

Intentional sampling was carried out from the workers of the BH rehabilitation network's work environment, with 21 professional selected for this study. Many subjects participated, including professionals that did notparticipate in the workshops in person.

The data was collected from March 2012 to November 2013 using documentary research methods, non-participant observation and focus groups. The study included documentary reports, records of the workshops, working meetings and evaluation of activities, and assisted in the identification of policies/legislation regarding the adopted rehabilitation and assistance models.

Non-participant[13] observation was performed during the meetings and favored the researchers' approach to the learning context throughout the training process.

The three focus groups were conducted with seven, nine and five participants, respectively. Each group (with a duration of 2 hours) was formed of professionals of a CER, NASF and a member of the HMOB. The groups were coordinated by a sociologist, aided by three observers responsible for the reporting and monitoring of the equipment used for the data collection. The conduction of the focus groups came from these key items: 1) Reality of work and training; 2) Concepts

of the integrated network of assistance and the BH Rehabilitation Network; and 3) The potential use of ICF for the deployment of the biopsychosocial model in the municipality.

After transcription of the recordings, content analysis[14] was used to identify relevant categories.

Ethical considerations

The project was approved by the ethical committees at UFMG and SMSA/BH, under processes no. 399.328 and 408.479.

RESULTS AND DISCUSSION

Of the 21 professionals who made up the focus groups, 90.5% were female, aged between 29 and 54 years and had spent an average of six years working for SMSA. Most of these professionals had developed their work activities at NASF (57.1%) and CER (28.6%). The distribution by occupation was: ten physiotherapists, four speech therapists, four occupational therapists, one social worker, one psychologist and a pharmacist. The average time elapsed since the graduating was 14 years, and more than half (66.7%) reported having a post-graduate degree in Public Health.

Rehabilitation network: challenges in two themes

The content analysis identified two main themes, that are presented below. Identification of the narratives will be made by the specification of the focus group from which they were taken (FG1, FG2 or FG3).

Theme 1 – The line between work and professional training: the context of rehab

Situations that help to contextualize rehabilitation in Belo Horizonte were revealed, highlighting the strengths and highly challenging experiences. The discussions highlighted the potential and scope of work in the SUS, qualifying activities as being diverse, dynamic and creative.

NASF workers highlighted the characteristics of everyday activities that enable interdisciplinary work, home visits and individual and group care. Thus, the pleasure of creativity at work presents the possibility of performing tasks with freedom, without giving this up to fulfil commitments, innovating and transforming the "way to work". "I think it is sensational, this question of being dynamic, changing all the time, always being in a place doing something, meeting people" (FG3).

The organization of the work processes in primary care has integrality as a cornerstone, with a wide range of actions[15]. The pleasure gained from exchanging experiences generates constant learning and was widely valued, reaffirming the power of working in pairs and with other professionals, sharing difficulties and mutual help.

The workers of the CER, in turn, highlighted the autonomy in management and assistance, and also the fact that they are public servants:

> *I like to work in the public service because I think that it is very dynamic, gives me a lot of opportunity to do different things, to get out of the routine.* [...] *I worked for 30 years in one place and it is like if I have worked in various different places* (FG2).

Challenging aspects were identified in the workplace, such as lack of physical infrastructure, which represents a problem in personal comfort and a barrier for the implementation of activities. The physical structure, mainly in Basic Health Care units, is quite distinct, coexisting with spaces in adapted buildings and new constructions. Problems such as the lack of space to accommodate the rehabilitation team, for the greeting and attending to groups, and also the lack of transport for home visits: "Many times, I have a health center which has a huge demand and I can't make evaluations because there isn't a room [...] for more distant home visits, if I depend on the car, it's very complicated" (FG1).

The number of professionals in primary care grew with the Family Health Care Program (PSF), as did the number of NASF team. This has caused structural problems for the allocation of the professionals. The workers have shown that problems of this order contaminate daily work life, provoking conflict and dissatisfaction: "I think that these are things that come from policy, that is progress, but the material resources and the issues of physical space are not keeping up with the pace" (FG2).

The high turnover of professional teams was cited as being difficult due to undermining bonds, which might reflect negatively on actions in conjunction with the community and on teamwork. According to data from a national survey on insecurity and job quality in the PSF, 60% of physicians, for example, spend less than two years in their work position[16]. In addition, other

professionals who join in the public sector with service contracts, learn the entire work process, remain for short periods and are replaced by professionals with no experience in the SUS:

> *We have a big problem, that being issue of turnover in the network. You follow the process, create the link, a network and then the doctor, the nurse, and the whole Health Center changes and you have to start all over again. It's exhausting! I say again: This is what NASF is. This is how the matrix works, a person stays for two months and then leaves […], and then the process begins again* (FG3).

The discontinuity of management also generates dissatisfaction. It is challenging to develop actions that are presented as important and then suddenly change due to a change of manager, causing disruption to the service and that discredit the users:

> *Changing management changes everything, and we will have to do something else. A new project that they're going to throw at us will appear and we'll have to start working on something else. Then that feeling ... They start things at the city hall and there is no continuity* (FG3).

> *We're always changing the tire with the car moving* (FG2).

Although they pointed to many challenges and difficulties, the workers stressed the advances made in work processes since the creation of the NASF. This fact has allowed for greater coordination between the family health and rehabilitation teams, understanding the actions and the definition of roles, providing professionals with a sense of belonging, appreciation and recognition, both by the community and by the health care team:

> *The creation of the NASF was a breakthrough for rehabilitation, because it brought these professionals to primary care. We're not seen as a team from the outside, but as part of that team, as part of the user's care, as coordinators. I can see that the team has a better understanding that we're there as a partner and we seek to discuss the cases, to do, to plan, to create therapeutic plans for the patient* (FG2).

In BH, rehabilitation already structures itself in the network by combining the actions of its services in the various levels of care, having integrality as a goal. However, gaps were pointed out that have impacted the consolidation of the network, such as the fact that professionals are unfamiliar with the local health care system. These workers that have graduated, are supposedly able to meet a diversity of cases and can develop multidisciplinary activities within the public service. However, there were conceptual inaccuracies, simplification in the understanding of the organization of the work and limited knowledge about SUS , which make the professional understand the user's demands only in the context of their profession: "recognition of the policies takes a lot of personal effort. A newbie enters and is not ingrained with the depths of the policies… it's a repeat without reflection" (FG3).

According to Filho[17] new models of training that empower the subject beyond their technological skills are needed. Professionals need to have the opportunity to develop their creativity, autonomy and the skills that enable them to work in teams that are determined and engaged in the promotion of health care, since the current model decontextualizes epidemiological and demographic issues, it does not meet the needs of the people, or the work processes in health care[18]. With this in mind, new curricular structures for the grading of different health professions, multiprofessional residence under the SUS and post-graduate courses are being proposed, which may reflect positively on the problem[19].

The need for change in vocational training being noted, shows that services almost always need to adapt the workers to the logic of the organization of work and to make them aware about both institutional and local policies. In that sense, the importance and fragility of the training needed to join the public service in BH was highlighted. For some, the information they receive on the service ends up being the first approach with the public policies, programs and projects underway in the city:

> *When people come in and have the time to train, an awareness meeting, initial service training, things are placed, but that is not worked, often keep each take that stuff, read and search* (FG3).

Such training has been viewed positively by the professionals and represents an attempt to fill the gaps in training, by means of passing the learned knowledge to the municipality from the training institutions.

In this way, although motivated to work, structural and organizational problems hinder the operation of

the network. In addition, the training of rehabilitation professionals with insufficient skills to work in SUS seems to have an impact on communication in its widest sense.

Theme 2 – Potential of the biopsychosocial model for the organization of the network: enabling change

It has become a challenge for Brazilian cities to establish a list of priorities regarding basic needs in favor of work based in a health care network. In BH, rehabilitation services have been trying to overcome operational dilemmas in order to advance. Workers positively view the care network strategy finding it possible to identify a conceptual construction in relation to the theme:

> *The network is not an organization chart, it is a living organism, it depends on the people. The network is intersectoral to ensure the broad concept of health care. Its construction is a breakthrough. [...] making the network is a challenge* (FG2).

In the view of the participants, the rehabilitation care network, although fragile, already points toward a new way of performing actions in the provided services:

> *When faced with the practicalities, it will question the very model that we are creating and the policy that it has, we will be trying to build possibilities* (FG2).

> *And we in the service have arrived at a certain point and we continue to talk: this is as far as I will go. From here I have to communicate with other services, with other colleagues, this forces this movement* (FG1).

The training examined here created space for discussions that allowed the professionals to: review and rethink the rehabilitation center's location in terms of its organizational logic within the complexity of the SUS, the relationships established between themselves and with other health care teams and also the work processes and communication that occurs between professionals: "The network does not exist without meeting people; meeting people strengthens the network Are we moving forward to strengthen the network? Are we surely finding our place?" (FG2).

Understanding the actions that are performed in different health care teams and understanding the operation of each of the network's units and also understanding the way in which these are powerful and resolute for the mobilization of the user in terms of his/her requirements, were also objects of reflection in the focus groups:

> *The user is not found at only one point, understanding this is very important. There is a catchphrase among us "the user is lost in the network". One does not know how to receive, the other does not know how to refer* (FG2).

> *I find the network disconnected, but between CREAB and NASF contact after training has been greatly improved* (FG1).

Although the professionals feel more qualified after the training and it is possible to identify and list improvements, many of them still sum up their understanding of the network only with the possibility of referring users without taking responsibility for his/her own follow up:

> *There are still some holes to fill. Sometimes I see a patient arrive with a particular problem and nobody in the network is able to attend to them: they from one unit, to the next. I keep thinking: geez, what will happen with this patient? [...] The organization is just passing on cases, forwarding them elsewhere. The profile of the professionals is inadequate* (FG1).

These questions refer us back to vocational training, reinforcing the findings that, historically, the template that accompanies these professionals brings characteristics of model practices, such as: focus on disease; search for normality defined by parameters outside the subject; fragmented and individualized actions; little experience of teamwork and a restricted vision of the user in his/her role just of being a patient[19]. The focus groups showed that these premises still wield significant influence in the daily working processes and permeate the norms defined by the SMSA that bind the implementation of changes.

> *We still work with the diagnostic model. To refer the patient, I can't use the functionality model; I need to have a diagnosis. There must be a diagnosis, there are doctors!* [...] *The whole logic of the system is geared toward medical care, for a set number of queries, for the question of a cure* (FG1).

To provide a theoretical framework that seeks to fully identify and understand the individual

requirements, the ICF points towards the development of more comprehensive services that are necessarily interconnected, which makes communication an essential skill, with specific regard to the assistential model. So, the finding that ESF professionals and even users follow demanding traditional rehabilitation procedures is challenging: "The challenge is to share the vision of functionality with other professional, who are attached to the medical model" (FG1). If the actual assistential model still finds non-conformities for the full coordination of care and, consequently, inefficiency in the construction of health care networks for people with disabilities, what then would be the alternative[1,7]? Would the biopsychosocial be a good model be a strategy to operationalize the network[6,8,20]? Taking the assumptions of the conceptual model of the ICF requires profound changes in the work processes and also the commitment of professionals with the proposal:

> *Change is a constant awareness because people change, but changing the way we work is complicated* (FG2).

> *The professional profile is built. We need to be militants to that idea!* (FG1)

The effective application of the theoretical perspective of the ICF in rehabilitation services assumes that the instruments and tests employed by professionals are able to provide information about individual components of the model[8]. We would like to refer to one of the products of this training that fits in with the Rehabilitation Issues Survey Protocol (PLPR)[21], which will be used to systematize the collection of the user from any point in the network, and a notebook to aid the professionals[22]. PLPR supports the demand for a computerized protocol and is consistent with the ICF model, enabling the construction of a functional database, revealing the users demands and fostering communication and interaction between professionals, essential factors for work in networks[12,20]:

> *I believe that this is the tool (PLPR) that will operationalize the model* (FG2).

> *I believe that PLPR is a guide for this vision for those who cannot view the biopsychosocial being (FG1).*

The fact that the participants of the modules were indicated by the coordinators is a possible limitation of this study. These professionals may have brought a bias related to their greater experience in the service and in management positions, as well as their motivation for working within a network.

Reorientating the model of rehabilitation assistance in BH implies a new dynamic service in its levels of complexity within a network perspective, recovering the focus of its object of intervention, human functionality in a larger view and, therefore, contextualizes the users of the services and what is provided to them in view of the principle of integrality.

CONCLUSION

Rehabilitation anchored to the biopsychosocial model can represent a promising environment to establish new practices and technology combinations that incorporate the concepts of disability and the functional limitations of the context, which will promote better communication and network functionality.

In turn, the promised democratic rehabilitation network for a an expanding project that qualifies the integral health care demands, needs to rely on infrastructure and motivated professionals with adequate training, professionals that understand the policies governing their work so that they can truly rethink and change their ways of doing things.

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