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Care Management in the Family Health Support Core: Technologies Operated in the Professional Dimension

ORIGINAL

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Abstract

Introduction: The Centre for Health Support Family - NASF has a innovative character with potential to concretize change in the organization of services and in care practices, supporting and expanding the solvability of the actions of the teams of the Family Health Strategy - FHS. To this end, it must operationalize technologies, arrangements and care management devices.

Objective: To describe the care management technologies, particularly in the professional dimension, operated by the teams of the Support Centre for Family Health, in its dialogue with the Health Strategy.

Methods: Case study with a qualitative approach, with the 12 professionals from a NASF team of Maracanaú, Ceará, Brazil. Focal group was performed. The empirical material was analysed based on the content analysis.

Results: There is evidence of a proposal for production of integral care based on the use of technologies as host, bond, autonomy and accountability. The user approach is based on the principles of the extended clinic. However, there are difficulties related to the regulation of access, the construction of bonds, the construction of therapeutic projects and intersectional articulation.

Conclusions: It appears necessary to overcome the challenges, strengthen mechanisms for coordination and for negotiation of la-

bour, as well as rethinking the NASF linking logic to a seemingly high number of FHS teams complicates the organization of work processes, building of agendas, weakens the bonds with the users and even the solvency.

Keywords
Primary Health Care; Health Management; Caution; Support Nucleus for Family Health.

Introduction

The process of building the Unified Health System - SUS promoted changes in the health care model in Brazil, resulting from a proposal for organization and functioning, guided by principles such as universality, equity and integrality, with a view to conferring materiality on the right to health established in the Carta Magna of 1988. For this purpose, the Primary Health Care - PHC was established as structuring of the health system, prioritizing its reorganization through the implementation of proposals such as the Family Health Strategy (FHS).

Facing the expansion and the results achieved by the FHS, it is recognized its consolidation as a model of attention and its strategic character as a reorganization of the PHC. However, when considering the changes in the morbidity and mortality profile of the Brazilian population, as well as the complexity of the health-disease process, there are challenges related to the capacity to offer care and the resolubility, compromising the integrality of health care. Thus, in order to support the work of the FHS teams and expand the scope of actions, increasing the resolution of PHC, the Family Health Support Centre - NASF was implemented [1].

The NASF, implemented in 2008, has as main objective to support the actions developed by the HSF, in addition to expanding the scope of these actions, according to territorialisation and regionalization. It should contribute, therefore, to the qualification of actions and strengthening PHC in the coordination of the care network, reducing the referrals to other levels of care, with greater length and integration of professionals in care [2, 3].

It is understood that the NASF's work proposal constitutes innovation, breaking the fragmented logic of care, proposing sharing of actions and integration between teams, having matrix support and co-management as management arrangements for the organization of the work process. The teams are composed of different professional categories, among them pharmacists, psychologists, physiotherapists, occupational therapists, social workers and physical educators, among others. Three to 15 FHS teams link each NASF team, depending on its modality. His work should focus on actions in the following strategic areas: Physical Activity and Body Practices; Integrative and Complementary Practices; Rehabilitation/Integral Health of the Elderly; Food and Nutrition; Mental health; Social service; Child and Adolescent and Youth Health; Women's Health and Pharmaceutical Assistance [2].

Considering the role of the NASF in the production of care, its innovative character, capable of promoting changes in the logic of work organization and services, therefore, in the model of health care, believes that they must have arrangements and devices that allow the management of care and work in an articulated manner with the FHS, in order to materialize the attributes of PHC, par-

ticularly the coordination of care, longitudinality and completeness.

According, health care management can be understood as provision of health technologies, according to the unique needs of each person in different moments of life, in order to achieve their well being, security and autonomy to continue with a productive and happy life. It comprises six dimensions: individual (capacity that each one has to take care of their own health), family (are inserted here the relatives and friends in the support), professional (here is the technical preparation and the ethics of the professional, as well as the construction of this bond with the user), organizational (this dimension is focused on the technical division of work performed by professionals and managers), systemic (work with networks of health care that is carried out by managers), and corporate (the state and the society as protagonists of social policies) [4].

Based on these considerations, we highlight an issue that we consider central to the research: how does NASF care management fit into its articulation with the Family Health Team? Thus, the objective of this study was to describe the care management technologies, particularly in the professional dimension, operated by the teams of the Family Health Support Unit, in their interlocution with the Family Health Strategy.

Methods

It is study that assumes the general design of single case study, a qualitative approach. Partial data from the research on care management in the NASF in its dimensions, arrangements and devices for completeness and humanization in the production of care, approved by the Research Ethics Committee of the State University of Ceará - UECE, under Opinion No. 1,876,254. The ethical principles of human research have been respected. All the participants expressed their acquiescence in participating in the study by signing the Informed Consent Term-TCLE [5].

The research scenario is the municipality and industrial pole Maracanaú, Ceará, Brazil, located 22km from the capital, which has the second largest Gross Domestic Product - GDP of the state, with a population of approximately 209,057 inhabitants in the health sector, the municipality it is organized into six Surveillance Areas Health - AVISA, where they operate the following teams APS: 56 FHS, two indigenous health, 34 oral health and six NASF [6].

When demarcating the case to be studied, it was considered the complete team, with a greater number of professionals, to develop precepts alongside multiprofessional residency in Family Health and linkage to the largest number of ESF. Thus, the AVISA NASF team 2 was chosen, whose professionals were considered key informants in the composition of the qualitative sample of this study, comprising 12 participants, among them: two nutritionists, three social workers, three physiotherapists, one veterinarian, one psychologist, an occupational therapist and a pharmacist.

The data were captured by means of a focal group, performed in a single moment, lasting approximately 90 minutes. This was guided by a road map with issues related to NASF care management and the work process. The statements were recorded and transcribed in full, in order to ensure the reliability of the information.

Data were organized and interpreted based on content analysis, thematic modality, as proposed by Minayo, a critical-reflexive perspective [7].

Results and Discussion

The research findings were systematized in thematic axes, with emphasis on the professional dimension of health care management, namely: Relational Technologies in NASF Care Management/ Production and Technologies for Comprehensive Care Organization. In this sense, we analyse the technologies operated in the daily work of the NASF teams, in their articulation with the FHS, consi-

dering the integrality and humanization in health practices.

Relational Technologies in NASF Care Management/Production

The professionals point out, at the discursive level, the operation of different technologies in the processes of management and/or production of care, which are limited in the scope of the relationships, called light technologies, among which is located the reception, qualified listening and co-responsibility.

It is noted that the work process of the teams is organized based on the reception of the users' demands, as represented in the following speech.

> *Thus, we try to welcome this user. [...] the corridor talks, the reception, we created a group with conversations, a mural where we put the information, this work allows me to do that, this communication.*
>
> P8.

The findings indicate that the reception can happen individually, as well as in group activities, situations may favour access to information about the organization and operation of the service, as well as conducting referrals. It is organized, therefore, in a user-centred way, which implies a reorganization of the work process, shifting its central axis from the physician to a multiprofessional team, that is, the host team, which is in charge of listening to the user, compromising themselves with their health problem [8].

In these terms, the NASF sets up innovative health equipment with the potential to bring about changes in health practices. In this sense, the host is an institutional device that facilitates the communication and management processes of user-centred care. Therefore, it is necessary to ensure spaces for meetings and dialogue between those involved in health production [9].

At the heart of the discussion about reception, professionals indicate the existence of conflicts and tensions related to access, resulting from the confrontation between the NASF guidelines that establish their support role with the FHS teams and the daily practice in which they face spontaneous demand of users in the search for care.

> *Well, the NASF is not, or should not be, the gateway to the health unit.*
>
> P2.

> *User input comes from spontaneous demand. Then we publicize the groups, then I welcome.*
>
> P4.

It is recognized that the NASF is not the gateway to the health system. Therefore, its actions must be integrated into the FHS teams, prioritizing the identified demands and agreed between the two teams [10].

On the other hand, it is necessary to recognize that the construction of access flows is a social production, resulting not only from institutional guidelines, but also from the search for users for resolvability in the search for care. In these terms, the access regulation, understood as the availability of a care alternative more adequate to the needs of the user, is not always ruled by governmental instrumental rationality. Settle is therefore logic informal setting, when users launch direct access strategies for professional and/or services, escaping regular appointments or referral mechanisms/referrals between different health services [11].

In this way, professionals seek to overcome tensions and different ways of acting through the operationalization of the reception, in which attentive listening, respectful dialogue and mediation of the limits established by the modes of service organization, assumed as the driving axis of the needs of the user, from the perspective of the responsibility for the health problem, as it enters the NASF.

It is evident that in the process of producing care, especially through the execution of group activities, there is a link between professionals and users.

> *I believe that this bond is more built in groups. [...] Individual care users only return three months. I think the strongest bond is with the population that is involved in the groups.*
>
> P5.

> *There I began to make guidance, to teach that person to take care. [...] we create a very big bond with that user and sometimes even an extra office, they come to ask a question with us, so we have this very strong bond.*
>
> P4.

Thus, it seems pertinent to consider that the building of bonds is mediated by the care practices developed by the NASF team, although the frequency of meetings between professional-users is a relevant determinant. Workers develop care modes of production, which are in line with the proposition advocatez, saying that the generation of professional-user relationship should result in strengthening of trust and accountability with user demands.

Thus, the link can be a device for the development of user autonomy and co-responsibility. In this sense, the agency exchanges knowledge between the technical and the popular, the scientific and the empirical, the objective and the subjective, converging to perform therapeutic acts consistent with the health needs of users. Thus, the link is constituted device for management/production of health care, with potential to contribute to overcome the fragmentation of care and reorient the work process, a comprehensiveness construction logic [12, 13, 14].

The NASF professionals, however, point out aspects related to the organization of the service that undermine the establishment of the bond, as they lead to discontinuity of care processes.

> *I was used to working with that user every day. But here it was difficult because there are many teams and there is still a change of teams.*
>
> P4.

The speech signals that the configuration and number of FHS teams linked to the NASF makes it difficult to link with users in the territory, since the demand is high, in addition to the agendas being weekly with the FHS teams. In addition, there is the turnover of the professionals, due to the precariousness of the employment bonds.

Is defended the idea that the greater the conviviality of the teams in the territory, with users and families, the greater the possibility of joint action, and to develop longitudinally care, a construction perspective of comprehensiveness. Thus, it is recognized that high staff turnover within the PHC and particularly the NASF is not decisive consolidation of these services, considering the principles and guidelines [15, 16, 17].

Nevertheless, NASF professionals point out that the practice of welcoming, building links and accountability is made possible by qualified listening in the professional-user encounter.

> *In care, the issue of qualified listening is important. This is does create the link.*
>
> P8.

In the relationship between professionals and users, it is evident the operationalization of qualified hearing as a device in the production of care. It is recognized that the professional, to perform the ability to listen in health practices, can develop the user the feeling that he is important and that there concern with his health, resulting in increased confidence in the relationship [18].

In this sense, it is understood that qualified listening is a tool for the humanization of care, insofar as it enables the expression and appreciation of subjectivities in health, forging new ways of producing

care. On the other hand, you can set as a powerful care management device to institutionalize reorganization processes of healthcare work, providing greater resoluteness to NASF, in order to consolidate its innovative character in the reorganization of APS in its articulation with the care networks, through shared work and in multiprofessional teams with a view to the integrality and humanization of health care [19].

Potentials and Challenges in the management of integral care

In the professional dimension, when considering the integral approach to NASF users, the potentialities and challenges that permeate the work process of the team emerge.

Within the scope of potentialities, it is observed that the team seeks to produce integral care based on the premises of the expanded clinic. In order to do so, they signal to take as object of care the subject in its multiple dimensions, considering its historical, economic, political and socio-cultural context, respecting its singularity, as expressed in the following statements.

> *Which goes according to the enlarged clinic. Indeed, several looks, different knowledge that are articulating, in this management of care.*
>
> P6.

> *This look not only for disease, but for the patient as a whole, that look, the work that he is inserted, see him as a whole, not only focused on the disease.*
>
> P7.

The speeches signal relevant reflections about the complexity of integral care, in which the approach should not reduce the subject to illness or suffering, but rather value their knowledge and their way of life, since, considering their multiple dimensions and needs [20].

According to the interviewees' statements, the production of care takes place through the performance of the different professionals, as well as the articulation of different knowledge, which signifies the implementation of the extended clinic, as guideline that guides the work in NASF.

It is understood that the expanded clinic is a guideline whose operability produces integral care and humanization in health practices, one acts based on the following axes: extended understanding of the health-disease process - through the articulation of different knowledge in the integral approach of subjects, considering their subjectivity and ways of the life; the shared construction of diagnoses and therapeutics - recognizing the complexity of the health-disease process implies the sharing of diagnoses and actions among professionals, from the perspective of teamwork, in the logic of interdisciplinary; expansion of the work object - moves from the disease to the people; and the transformation of work processes - by incorporating arrangements and systems enabling transversal and horizontal communication between the teams [21].

In these terms, the expanded clinic enhances the interaction between two subjects, the articulation, interaction and dialogue of different knowledge to better understand the health-disease process, as well as the inclusion of users in the decisions and elaboration of their therapeutic projects. Thus, it stands out from the interface between clinical and policy, since the meeting takes place between modes of subjectivity forged in the collective, in the social sphere [22].

The modes of production of integral care, according to the NASF professionals, are guided by the construction of the Unique Therapeutic Project - UTP, in articulation with the FHS teams, in monthly meetings, in which the cases are discussed in a user-centred logic.

However, it can be seen that the effective inclusion of the user in decision-making processes still represents a challenge in NASF practice, since professionals discuss the case and elaborate UTP without the presence of the user.

Then once a month the entire FHS and NASF is requested to attend the meeting. So, in this monthly meeting, we try to discuss and do the UTP, since the whole team is present.
P6.

The Unique Therapeutic Project, when formulated and implemented in accordance with the actual health needs of the individual and with the participation of the same and the family becomes a management device capable of causing processes of reflection/action on workers opening up possibilities for them to rethink their work processes and practices.

On the other hand, there are signs that the UTP, during its practical exercise, with the user, has fostered the construction of autonomy and co-responsibility, in the perspective that users should be encouraged to develop self-care practices [23].

The main thing is to allow the user to be co-responsible for himself [...] this notion that I am responsible for myself, for the body, for my health.
P7.

It is emphasized the importance of building autonomy for users. The authors affirm that the greater or lesser adherence to the therapeutic plan is focused on the way this care is managed, that is, the authors bet on the co-responsibility of care and on the empowerment of the subject as a way to guarantee their quality of life. In this way, the autonomy of users in their treatment increases when the team provides an environment of dialogue and shared actions, so the team understands better the way the individual interacts with the world, it is necessary for professionals to understand, as Cecílio tells us, the *how to walk the life* way of each user, as well as devices that provides for the care of itself [24, 25].

Faced with such articulation, it is possible to direct a user of spontaneous care, according to their need, to collective activities in the community, that is, professionals, horizontally, have the freedom to create new ways to care according to risks and health needs of individuals. However, what we perceive in the units' daily lives are vertical activities, translated into programs, which often fail to work the health needs of the community, failing to provide adequate responses to the construction of targeted care.

Another challenge that stands in the work of the NASF is the demand for individual service, resulting mainly from spontaneous demand, which creates queues and hampers the execution of collective actions.

End up getting a bit tied to the issue of work because of waiting queues because they perform clinical care. Avoiding this queue, avoiding this outpatient clinic, I do not know how I can say it.
P6.

Demand is very, very, very great, only we have to direct, what really needs to be seen individually, and what we can direct to the groups.
P2.

It can be noticed that the construction of agendas in the NASF is also centred in the capacity of the professionals offering, with a reduced capacity to balance the spontaneous demand relationship and agreed demand with the FHS teams. Therefore, working with groups and collectives has become an alternative to increase the capacity to respond to individual problems. In this sense, is identified a mismatch between what is proposed in the guidelines for the NASF's work and the daily practice of the team, since this mode of operation decharacterizes the support function and weakens the shared management of the work process in its articulation with the FHS.

In this sense, the challenge is to organize agendas that, despite waiting lines, prioritize the agreed

demand between NASF and FHS, so as not to assume the role of other levels of attention, since the absence of supply of specialized services can induce an erroneous operation of the NASF, which tends to take the responsibility to respond to the demands of the population [26, 27].

The team points out that it is difficult to articulate the different policies implemented in the territory, which expresses a reduced capacity to effect intersectoriality and, ultimately, completeness.

> *They work in boxes, they do not work together, health is health, assistance is assistance, they do not align the thought of working together. We go to the networks, but we do not have a return, there is no reference / counter-reference.*
>
> P2.

> *Meetings with case studies with CRAS, CREAS, the Guardianship Council, to see intersectoriality, these meetings would be important for NASF to work together with other policies.*
>
> P9.

It is recognized that the production of integral care requires intersectional articulation, that is, the involvement committed to solving problems faced by the population. In these terms, strategies, such as meetings and joint case studies, are pointed out by agencies that execute assistance and social protection policies.

In this sense claims that the need for intersectional work sets up a reality of health teams face the complexity of the health-disease process in its multiple determinations, which entails the user 's search for answers to their demands Extrapolate the sphere of specific competence of the health sector, involving dimensions linked to social problems [28].

Conclusions

Exploring how NASF care management is delivered, particularly in its professional dimension, has highlighted the technologies used in the production of care, as well as highlighting potentialities and challenges in its work in articulation with the FHS.

In this sense, it was observed that the NASF professionals use a set of light technologies to work the care management, because they are limited to the relational dimension, that converge to the construction of integrality and humanization in health care, among them the reception, bond, construction of autonomy and co-responsibility of care.

It is noteworthy that the acceptance of users arriving at the service is permeated by contradictions and conflicts, given the expressiveness of spontaneous demand, generating barriers to access, inasmuch as professionals, in implementing the NASF guidelines, do not recognize it as a gateway to entrance of the health system. Thus, there is evidence of disarticulation and weaknesses in the agreement between the NASF and HSF teams, as well as the formation of informal mechanisms of regulatory access flows. In these terms, it is necessary for professionals to mediate between the bureaucratic logic that governs access to the NASF, imposed by the service organization's own guidelines, and the expansion of access, considering the health needs of the population, through the effective practices.

In the perspective of an integral approach to the user, the team seeks to develop an expanded clinic, the main tool being the elaboration of UTP, as potentialities of the care management process, although with difficulties of effective inclusion of users in the decisions related to their therapeutic plan.

However, the expanded clinic and UTP allow a greater understanding of the health-disease process, considering the needs and subjectivities of each user. On the other hand, it requires articulation

of knowledge and practices with a view to greater resolubility in health care.

In the care management processes, aspects that make it difficult to build links between the team and the users, such as the logic of NASF and HSF linkage, and the turnover of professionals, due to the precariousness of labour relations, are identified. In addition, there are challenges to be overcome, such as the non-inclusion of users in the definition of UTP the intersectional disarticulation and the high spontaneous demand for individual care.

Finally, it is important to emphasize that it is necessary to strengthen the mechanisms for articulating and agreeing on work, as well as rethinking the logic of linking the NASF to a seemingly high number of UTP teams makes it difficult to organize work processes, weakens the bonds with the users and even the resolubility.

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