Attributes derived from primary care in assisting oncologic patients

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ABSTRACT

Objective: to evaluate the presence and extent of the Primary Health Care Derivatives Attributes in assisting oncologic patients, according to the perception of health professionals working in teams of the Family Health Strategy. Method: cross-sectional study, developed in Family Health Strategy units of the urban region. The city manager, nurses and doctors are part of the study. The data was collected through questionnaires, which evaluated the social-demographic conditions, and the Primary Care Assessment Tool, for the overall assessment of derived attributes of PHC. Data were presented in tables and discussed with literature. Results: the family orientation attribute obtained mean score of 8.74 ± 1.45, and, for community orientation, its average score was 5.81 ± 1.51. The overall score of the derived attributes was 7.28. Conclusion: health services, when directed and guided by the attributes of PHC, favor the planning and execution of assistance actions.Descriptors: Primary Health Care; Neoplasms; Family Health Strategy.

RESUMO

Objetivo: avaliar a presença e extensão dos Atributos Derivados da Atenção Primária à Saúde na assistência ao paciente oncológico, na percepção de profissionais de saúde atuantes em equipes, de Estratégia de Saúde da Família. Método: estudo transversal, desenvolvido em unidades de Estratégia de Saúde da Família da região urbana. Integra o estudo o gestor municipal, enfermeiros e médicos. A coleta de dados se deu por meio de questionários que avaliaram as condições sociodemográficas e o Primary Care Assessment Tool, na avaliação geral dos atributos derivados da APS. Os dados foram apresentados em tabelas e discutidos com a literatura. Resultados: o atributo orientação familiar obteve escore médio 8,74 ± 1,45, e, para a orientação comunitária, seu escore médio foi 5,81 ± 1,51. O escore geral dos atributos derivados foi 7,28. Conclusão: serviços de saúde, quando orientados e norteados pelos atributos da APS, favorecem o planejamento e execução de ações da assistência. Descritores: Atenção Primária à Saúde; Neoplasias; Estratégia de Saúde da Família.
INTRODUCTION

Neoplasms, which involve more than 100 diseases, are characterized by a worldwide public health problem; their high demand leads to higher hospital and ambulatory costs, sophisticated therapies and suitable technological innovation support. For health care, oncology is a challenge regarding the need for continuity of care in a network of articulated attention to account for the needs and demands of these patients.

Given the extent of cancer morbidity and mortality in Brazil, the Ministry of Health (MOH) created the National Policy of Oncology Care (PNAO - Política Nacional de Atenção Oncológica in Portuguese), aiming at qualification, specialization and ongoing education of health professionals, who play an important role in controlling cancer. This policy proposes actions focused on Promotion, Prevention, Diagnosis, Treatment, Rehabilitation and Palliative Care.

With the expansion of Chronic Noncommunicable Diseases (NCDs) and the Family Health Strategy (FHS) in Brazil, changes in the care system to public health have occurred, in order to expand the actions of disease prevention and health promotion, early diagnosis, and, thus, a timely treatment. Recognizing the user needs support in these processes denotes that the support network must be prepared to pay a planned and quality care, which increases the demands for health professionals working in Primary Health Care (PHC).

Activities that contribute to this process are the training of cities and states health teams, establishing actions of prevention, promotion and assistance. Defining indicators for monitoring methodologies appropriate to the local realities promote continuity of care and comprehensiveness in patient care.

The PHC is responsible for the ongoing care, coordination of care within the system, promotion of attention focused on the family, guidance and participation in community. Therefore, the structural axes or essential attributes of the PHC are defined, which constitute the attention to the first contact of the individual with the system, longitudinality, comprehensiveness and coordination of care; to qualify the PHC, there are derived attributes that are the family and community guidance, and cultural competence.

The FHS unit team is responsible for longitudinally monitoring users. Even when they need a specialized service or hospitalization, this team is responsible for coordinating the actions of various services, and these professionals should provide care and attention focused on the family and community. They are responsible for coordinating the various departments and health units that make up the networks, participating in the organization of flows and health needs of certain population.

A basic care service directed to the general population is a PHC provider when contemplating the essential attributes and derivatives, which increases its power of interacting with individuals and the community. The family-centered attention derived attribute recommends an evaluation of individual care and family background, their health care and threat conditions, with tools of family approach. And the community orientation derived attribute requires the recognition by the health service of the health needs of the community through epidemiological data and direct contact with the community, with joint service planning and evaluation. The bonding via transformers means of reality between professional, family and health service promotes safety and commitment to clinical, social and existential path.

There is need to investigate how the Brazilian healthcare services are informed about the essential and derived attributes from the perspective of users, health professionals and managers, in particular with regard to the care offered to oncologic patients, given the estimated incidence and prevalence. In this study, it was decided to show how the derived attributes are offered. So, the following guiding question is outlined: Is the service provided by doctors, nurses and health manager oriented according to the attributes derived to oncologic patients?, with the objective of:

Evaluating the presence and extent of Attributes Derived from Primary Health Care in the care of oncologic patients, according to the perception of health professionals working in teams of the Family Health Strategy.

METHOD

Cross-sectional study, which makes up the matrix project called << Evaluation of demands for care of oncologic patients in non-hospital treatment and the activities performed by teams of the Family Health Strategy (FHS) and attributes of the Primary Health Care >>.

It was developed in a city in the northwestern region of the State of Rio Grande do Sul (RS), Brazil, more specifically in
FHS of the urban region of the city. Inclusion criteria: being nurses or doctors working in the FHS units for over a year, being health manager in the city, having ascribed oncologic patients in the FHS.

The data was collected from July to August 2012. The mentioned city contained 14 FHS units, eight of which met our inclusion criteria. The data was collected by two questionnaires. The first one was developed by the researchers to obtain the sociodemographic conditions: age, sex, working time and function in the unit. The second one, self-administered, was the Primary Care Assessment Tool (PCATool), created and validated for use in children and adults in the United States of America\textsuperscript{11}, translated, adapted and evaluated for validity and reliability of PCATool-Brazil, users version for adults\textsuperscript{12} and professionals.\textsuperscript{13,14}

The PCATool originally features self-administered versions. It evaluates how health services are geared to the defining attributes of the PHC, from responses of health professionals and manager (Professional version) and users over 18 years old (Adult version); this study used the Professional version.

For this study, only derived attributes were evaluated, which include family and community orientation. Data were organized in Epi-Info\textsuperscript{8} 6.04, with independent double typing. After corrections of errors and inconsistencies, the statistical analysis was performed using the Statistical Package for the Social Sciences (SPSS)\textsuperscript{10} 18.0.

For analysis, all professionals had their scores of derived attributes calculated. The values of the questions in each derived attribute vary on a scale from one to four, and, for the final score of each attribute, the average of the answers to its questions is calculated. Next, the scores for the derived attributes of PHC were calculated. For evaluation of high and low score for PHC, values of scores ≥ 6.6 were used, which are defined as appropriate extension (satisfactory) of each attribute and equivalent to the value of three or higher on the Likert scale.\textsuperscript{15}

The research project was approved by the Research Ethics Committee (REC) of the Federal University of São Paulo, under the Opinion 47215, of June 29\textsuperscript{th}, 2012.

\textbf{RESULTS AND DISCUSSION}

This study was attended by 15 professionals: doctors, nurses and city health manager, workers from eight FHS teams, in the urban area of a city in northwestern Rio Grande do Sul, Brazil. 2012. These data are presented in Table 1.

<table>
<thead>
<tr>
<th>Social-demographic/labor characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>66.7</td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>33.3</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 40 Years</td>
<td>9</td>
<td>60</td>
</tr>
<tr>
<td>&gt; 40 Years</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td>Function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>7</td>
<td>46.7</td>
</tr>
<tr>
<td>Doctor</td>
<td>7</td>
<td>46.7</td>
</tr>
<tr>
<td>Health Manager</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Time in the Specialization</td>
<td></td>
<td></td>
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<tr>
<td>≤ 12 Months</td>
<td>4</td>
<td>26.7</td>
</tr>
<tr>
<td>13 - 24 Months</td>
<td>5</td>
<td>33.3</td>
</tr>
<tr>
<td>25 - 36 Months</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>37 - 72 Months</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Specialization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>93.3</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collective Health or Family Health Strategy</td>
<td>8</td>
<td>53.3</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td>Specialization in progress</td>
<td>1</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>100</td>
</tr>
</tbody>
</table>
In applying PCATool research tool, the "definitely yes" had the highest percentage of responses. As for the options "certainly no" and "probably not" were less answered about family orientation attribute. Regarding the planning of treatment, 40% of the professionals did that along with the patient.

In this study, 40% of professionals said they plan the therapy with the oncologic patients, as it should be discussed and rethought by professionals, because the patients must collectively discuss, with their reference team, available forms of treatment, being a strategy of greater understanding strategy on their own illness and the care they need.

The family guidance has to be performed by health professionals about the special characteristics of the patient’s disease and treatment that has to be followed. Accessible language should be used for the understanding of medications, as well as effects, duration of treatment, side effects, benefits of use, consequences in case of abandonment of the treatment and the patient’s opinion on the proposed therapy.16 Dialogue and interaction favor bonding, trust and improved family welfare, directing the care for the family.10

Proposing to meet the patients’ relatives to discuss and solve problems involved in the family context was a matter in which most professionals mentioned being available to do. Family history of diseases and investigation of risk factors (intrinsic and extrinsic), which may be determining the occurrence of the disease, are important factors to be addressed and discussed with the patients and their families. In this sense, the family participation in the determinations of care strategies is essential for the attention focus not to be fragmented and to abide the patients’ needs and their family group.17 The integration between family and health professionals in the care expands the relationship between the subjects, restoring the health care approach.

When asked about the health problems that occurred within the patients’ family, 93% of professionals say they ask, and 80% of them made themselves available to meet the family to discuss their health problems. The family guidance is related with the contact that health professionals have with the users and their family, an important relationship in the patients’ adherence to treatment. Involving them, along with their family, in the decisions of their therapy is fundamental for coping and the conduct to be followed.

Regarding the community guidance attribute, “probably yes” was answered in all questions, which shows that many professionals did not have bonds with their attended community; 93% said they performed home visiting. Home visits is an attribute provided by the FHS in order to assist in interventions from the direct observation of the community reality, which does not limit the user to search for the health service.16

Regarding the knowledge about the health problems of the community and families served by professionals, 26.7% said they knew, 66.7% said they probably knew the situation, and 6.7% were probably not aware.

As for the research conducted by the health team, 40% said they heard the community’s views on how to improve health services, 60% reported that the researches “are not” or “probably are not” conducted. Still, 40% said they didn’t do it and 33.3% probably did not conduct any research at the community to identify the main health problems faced by the population. Regarding the participation of users in the Local Health Council, 40% of professionals said that there was participation.

Regarding the opinions of the community and users to improve health services, 40% of the professionals said they listened to them. A study conducted with professionals, using the same collection instrument, showed that 34.5% of professionals requested users an assessment of the offered service. This assessment is essential for the care planning and decision making.16

In the overall assessment of the PHC derived attributes, the family guidance obtained satisfactory evaluation, averaging 8.74, higher than the cutoff point. The community guidance was considered unsatisfactory, with a final average of 5.81. The overall score of derived attributes was considered high, with an average of 7.28, as shown in Table 2.
In home attention, activities that include soft technologies, resulting in a humanistic and welcoming approach to health care, can be developed through practices involving effectiveness and trust between professionals, users, family and community. Family and community shall be fully understood in their social space, that is, their socioeconomic and cultural context should be considered, and knowing that interactions and conflicts that directly influence on the health of people occur in the family.

Besides home, the FHS team must seek and identify health problems of individuals throughout their area. People with low income, living in urban areas with housing and poor education conditions are more susceptible and vulnerable to illness. It is expected that the health professionals of the FHS units have understanding of aspects related to family dynamics, functioning, as well as social, cultural, demographic and epidemiological characteristics. This implies a different attitude based on respect, ethics and commitment to families. Yet the bond and trust positively act in building healthier environments in the family space.

The family record should support the monitoring of health care of the members. This should gather the information necessary to the ongoing monitoring provided to the family, considering the territory where they live and their living conditions. A study assessing the quality of the progress in medical records in primary care highlights the paucity of records on the conditions of family status.

The health team acts as knowing the needs of the population in their area, making interventions as only the technical knowledge and goal were enough for effectiveness of care. In this regard, it is stressed the importance of listening to people, because their problems or health needs should be considered from the social determinants.

A PHC, when structured, has organized service and recognized structural axes associated with the essential and derived attributes, focusing on the family. The family focus refers to the recognition of factors related to the disease and its treatment. It is also up to the professionals knowing and addressing social aspects and their risk factors, benefiting from communication and bonding between patients and their family.

In FHS, the family focus by health professionals should be fully carried out in their social space. The subject should be addressed in their socioeconomic and cultural context, recognized as a social subject and bearer of autonomy to discuss his/her health conditions. Thus, the knowledge that the FHS teams must have of their users, families and community is what provides qualified assistance, as well as targeted and guided by the attributes of PHC.

### CONCLUSION

The overall assessment of the services provided and guided by the PHC derived attributes in the view of doctors, nurses and health manager to cancer patients was satisfactory with regarding the family guidance and, in relation to community orientation, the appropriate minimum average was not obtained. The results show need for proposals to improve the Community orientation attribute related to care practices in the health care of cancer patients.

In assistance, there were weaknesses in derived attributes of PHC with oncologic patients, which highlight the need for strengthening the relationship between health workers and patients and their families. Still, the research results point to the need for further studies focused on the evaluation of PHC services with focus on the assistance to oncologic patients, caregivers and family.

### FINANCING

Universal Notice CNPQ 2014

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