CASE REPORT ARTICLE

THE PRACTICE OF COMPREHENSIVE CARE MANAGEMENT: EXPERIENCE REPORT

A PRÁTICA DA INTEGRALIDADE NA GESTÃO DO CUIDADO: RELATO DE EXPERIÊNCIA

LA PRÁCTICA DE LA INTEGRALIDAD EN LA GESTIÓN DEL CUIDADO: ESTUDIO DE CASO

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ABSTRACT

Objective: to present practices of care of a health service and to go through the changes, after interventions, from the knowledge acquired on the tools of the management of the clinic. Method: descriptive study, type of experience report, changes in the practices of a health service, after interventions, based on the knowledge acquired in the specialization performed at a Health Unit of the Municipality of João Pessoa (PB), Brazil. Results: the knowledge of the management tools of the clinic, the introduction of discussions in the team meetings and the implementation of permanent education, which favored a work process in which criticism helped transform and modify care production practices for the model Recommended by the Unified Health System. Conclusion: the course made possible a critical look at some health situations and promoted changes in health practices. Descriptors: Health Services; Unified Health System; Continuing Education.

RESUMO

Objetivo: apresentar práticas de cuidado de um serviço de saúde e transcorrer sobre as mudanças, após intervenções, a partir do conhecimento adquirido sobre as ferramentas de gestão da clínica. Método: estudo descritivo, tipo relato de experiência, das mudanças nas práticas de um serviço de saúde, após intervenções, a partir do conhecimento adquirido na Especialização realizada em uma Unidade de Saúde do Município de João Pessoa (PB), Brasil. Resultados: o conhecimento das ferramentas de gestão da clínica, pela introdução de discussões nas reuniões de equipe e da implementação da educação permanente, que favoreceram o processo de trabalho em que a crítica ajudou a transformar e modificar práticas de produção de cuidado para o modelo preconizado pelo Sistema Único de Saúde. Conclusão: o curso possibilitou um olhar crítico frente a algumas situações de saúde e fomentou mudanças das práticas de saúde. Descritores: Serviços de Saúde; Sistema Único de Saúde; Educação Permanente.

RESUMEN

Objetivo: presentar las prácticas de atención de un servicio de salud y transcurrir acerca de los cambios, después de las intervenciones de los conocimientos adquiridos sobre las herramientas de gestión clínica. Método: estudio descriptivo, de tipo estudio de caso, de los cambios en las prácticas de un servicio de salud, después de las intervenciones de los conocimientos adquiridos en la Especialización realizada en una Unidad de Salud en la ciudad de João Pessoa (PB), Brasil. Resultados: el conocimiento de las herramientas de gestión clínica, por la introducción de discusiones en las reuniones de equipo y de la implementación de la educación permanente, que favorecieron un proceso de trabajo en el cual la crítica ayudó a transformar y modificar las prácticas de producción de cuidado para el modelo preconizado por el Sistema Único de Salud. Conclusión: el curso permitió un ojo crítico frente a algunas situaciones de salud y fomentó cambios en las prácticas de salud. Descriptores: Servicios de Salud; Sistema Único de Salud; Educación Continua.

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The Family Health Strategy (FHS) presents itself as the central element of the Primary Care Policy. In this way, since its implementation, in 1994, several structural changes have taken place in the Unified Health System (UHS), provoking a reorganization of the UHS care model, aiming at improving the quality and access to Primary Care, approaching the Model of Health Promotion.

However, as the decentralization and the regionalization of health care and management, with increasing levels of universality, equity, integrality and social control, the social dimensions present in the practices of attention are still quite fragile. Therefore, a National Humanization Policy (NHP) for Health Care and Management was proposed.

The NHP constitutes a strategy for the qualification of integral care, with accountability and bond, for the valorization of workers and for the advancement of the democratization of management and participatory social control.\(^1\)

In this context, the UHS comes with the proposal to face this challenge, focusing health as a right of humanity in the service of the public health services users, through the integration of health systems and articulation of prevention, promotion, recovery and a comprehensive approach to individuals and families.

Based on the knowledge acquired, related to the devices of the Expanded Clinic, Emphasis was placed on integrality of care, on the reception and on the Unique Therapeutic Project (UTP), based on experience as managers of Family Health Unit and, difficulties in the practice of care management, when observed, especially, the NHP, where there was no elaboration of UTP for the users nor the host with risk classification and the integral care to the user, prevailing the fragmented care.

In this article, the practices of care of a health service will be presented, taking into account the changes in these practices, based on the interventions made, in view of the knowledge acquired about the tools of the NHP: integral care, reception and UTP, recording the processes experienced before and after the Clinic Management Course.

**OBJECTIVE**

- To present the care practices of a health service and to make changes after interventions, based on the knowledge acquired about the tools of the clinic management.

**METHOD**

Descriptive study, Related Experience type about health care practices with the respective analysis of the changes that occurred in these practices, based on the interventions made, in view of the knowledge acquired about the tools of the NHP: integral care, welcoming and UTP, recording processes experienced before and after the Clinical Management Course, which was developed by students of the Specialization in Clinical Management in the Health Regions of the Institute of Education and Research of the Sirio Libanés Hospital in 2013, conducted in an Integrated Family Health Unit with four teams in the municipality of João Pessoa-PB, Brazil.

From the knowledge acquired in the course, elements of the clinic management tools were gradually used in team meetings, which were introduced in the discussions with readings of protocols, basic care notebooks, and strategic planning was applied, which sought the reflection of work processes, so that the critique helped to transform and modify the practices of production of care for the model advocated by UHS.

**RESULTS**

Knowledge of the management tools of the clinic, through the introduction of discussions in team meetings and the implementation of permanent education, favored a work process in which the criticism helped to transform and modify the practices of production of care for the model recommended by the UHS.

This study, carried out at the São José Family Health Unit (FHU), after intervention in the work process of the team related to the integrality of care, brought advances with the implantation of the host and with sporadic discussions about some complex cases, as well as with readings of protocols, basic attention books, and the use of strategic planning, through the identification of critical nodes by teams, whether within the work process or in the reach of some indicator.

It is worth mentioning that this is an initial and continuous process, that, will gradually, be consolidated in a work process in which criticism will help transform and modify care production practices.

**DISCUSSION**

Integrity in care is defined as a UHS principle that, taking into account the biological, cultural and social dimensions of the user, guides health policies and actions
able to meet the demands and needs in accessing the service network. It is built on the praxis of the health teams and in the health services. It is configured in the service to the user in all its dimensions, be it biological, social and cultural of being care, being the consolidation of this principle the effective change of the practice of health care, since it will be abandoned the then centered medical model. However, to make this effective, it is necessary to know and practice some devices such as the extended clinic, the host and the UTP, at the moment of caring for the user.

Even with the understanding of the importance of care, based on integrality and the elements mentioned above, fragmented attention focused on the disease is still very much present, in the professional context. In this way, satisfactory answers are not obtained to the users’ needs. Therefore, a service focused on the humanization policy is necessary, where welcoming and qualified listening are paramount.

In this sense, it is essential to re-signify the concept of health and rethink the care practices, placing the user as the center of attention and perceiving the social context in which he lives, from the understanding of the need for care in a humanized way, which made him seek the health service. To do this, it is essential to use the available tools in order to offer care with quality and resolution.

According to Cecílio (2001), "The struggle for integrality as a principle of the Unified Health System (UHS) implies rethinking important aspects of the organization of the work process, management, planning and construction of new knowledge and health practices." With the progress achieved in cities such as Curitiba-PR, which has a strengthened primary health care, which orders and coordinates care throughout the network, it is believed that in the study unit it may also be possible to consolidate this principle for the advancement and improved access and quality of service to users. Integrality translates into the resolubility of the team and services, through ongoing discussions, team building, use of protocols and reorganization of services.

The FHS, composed of a multi-professional team, proposes to offer a health care focused on the integrality of the human being and considering the complexity of this individual, in the environment in which it is inserted. However, these concepts are not well consolidated in a part the work is still focused on medical knowledge, overwhelmed by a demand for consultations and triggering care aimed at curative treatment, with a poor focus on health promotion, although it has as a main axis. It is also noticed, that, some teams do not discuss the problems of their area of action in an integral way, do not plan the actions and more rarely evaluate them in the daily life of their practices.

In view of the above, the issue of integral care as practiced and perceived prior to the course was far from that recommended by the UHS, since it was understood that the implantation of the host in the FHU and the existing bond with the community were sufficient to conclude that the attention to health was fully realized. However, although completeness was distant in this FHU composed of four family health teams with approximately 60 professionals directly involved in the care, it was possible to qualify it, since the user who attended the FHU daily may have needs that went unnoticed, since full care is not offered. In this way, the reorganization of the work processes, the use of the tools of the extended clinic, the reception and the UTP, are important for the integrality of the care.

The use of a satisfactory empirical framework within the scope of other FHUs and the system of permanent education as a tool that the expanded clinic translates as an important ‘management strategy’, with great potential to provoke changes in the daily life of services, as well as in its micro-politics , very close to the concrete effects of health practices on the lives of users and as a process that occurs “at work, by work and for work”. Stimulated the team to consolidate the production of integral care.

The host is based on the principles of the UHS to serve all the people who seek the services, and seeks the reorganization of the work process, shifting the axis centered on the doctor to a multi-professional team, being able to produce qualified listening, accountability, bonding and resolubility.

In the host, qualified listening, for risk classification, is performed by professionals of a higher level. In the absence of these, the Community Health Agents accept the demand, according to the needs of the users. It is important to emphasize that the risk classification takes into account the physical and psychological aspects, in order to guarantee compliance with the UHS principles: Universality, Equity and Integrality, aiming at resolution in the service.

The reception and the classification of risk diverges from the one advocated by the NHP, the practice of comprehensive care...
since it occurs in a space common to the four teams, not guaranteeing the privacy for listening.

Another divergent point of the NHP is the non-use of protocols for the classification of risks. In this way, the listening diverges from one professional to another, where each classifies according to their conduct.

The risk classification organizes the waiting queue and proposes another order of attendance other than the order of arrival, it also presents other objectives, such as: guaranteeing the immediate care of the user with a high risk degree; inform the patient that there is no immediate risk; give better working conditions for professionals by discussing the ambience and implementation of horizontal care; increase user satisfaction and, above all, enable and instigate pacing and construction of internal and external customer service networks.2

With regard to reception, humanized care goes beyond listening, since it is also necessary to perceive the health needs, that are often, omitted by the users, and for this, it is important to create a favorable environment, both physical, and related.6

Based on the evidence and knowledge about welcoming acquired in the course, it is seen that the reception requires professionals to incorporate continuous discussions about their work process7 and also allows triggering reflections and changes in the organization of health services,8 where listening and the dialogue established with the host allows the construction of solidarity meetings, by opening possibilities for meeting the health needs of the people.9 Thus, the discussions with the team were strengthened in the sense of welcoming the users, observing their needs, using in listening all the possibilities of the clinic to solve the identified need.

During the team meetings, the need to build a protocol for risk classification was discussed, so that there were criteria, always with the support of Permanent Education, which fosters dialogic spaces and reflection on the care practices of FHU professionals, in an attempt to seek the implementation of UHS principles.

In the team meetings, the discussion about the need to implement the UTP was strengthened and some professionals (especially, physicians) were resistant, arguing that there was no time to elaborate the UTP, since “the demand for care did not allow this”, while others justified being more of an assignment. Finally, some pointed out that they did it, they just did not register it.

The practice of comprehensive care...

During several meetings, the team was able to continue a specific case, with difficulty in the participation and involvement of the medical professional. Teamwork modes directly interfere with the UTS's success possibilities. In view of the above, the resistance of some professionals who work in a fragmented way is one of the factors that interfere in the construction of UTP, and, what actually makes the implementation process more difficult, since they resist group work. In UTP, the most coherent form of teamwork would be the one in which the collective space of discussion seeks to articulate in the field (health, care, work, extended clinic, etc.) the different professional nuclei, with their knowledge and specific practices, different ways of seeing the problem in question, composing shared, but not necessarily unique, explanatory hypotheses, allowing the team in its relationship with the user(s), the composition of joint intervention strategies, with a greater chance of success and less possibility of damage. This would be the way in which a UTP coproduces. Still, according to some authors,10,11 the planning of actions allows the development and implementation of strategies to meet user needs, once organized and valued the knowledge of the different health professionals in the construction of this work process.

Thus, in the team meetings, the importance of the protected agenda was discussed, with all professionals, in order to discuss UTPs that require multi-professional intervention and articulation, such as the Family Health Support Center (FHSC) and other levels of care for the resolution of cases, giving quick and safe answers to the real needs of users. According to Brasil,12 in order to have the possibility of a team meeting and formulating a UTP, it will be necessary to create this possibility in their daily work, producing spaces in the agenda.

CONCLUSION

The experience gained in the Specialization Course in Clinical Management in the Health Regions was enriching both for professional growth and for the personnel, since it allowed the students involved, through the activities, an intense process of reflection. The methodology used was extremely relevant with regard to the teaching-learning process, since it facilitated the search for individual and collective knowledge.

The knowledge of the tools of Clinic Management such as the UTP, the extended clinic and the host, served to trigger changes...
in the process of caring for the team, so that it built autonomy and responsibility through strategic planning. During the meetings with health professionals, a critical analysis and transformation of the practices was carried out, with a broader look at the needs of the users, not only from a listening in the reception or during a consultation, but also from the perception of the context inserted to the territory and information systems. It is worth mentioning that, little by little, there was also a strengthening and strengthening of Permanent Education, fostering spaces and moments of reflection for professionals during the team meetings, so that they felt the need to transform their practices, centered on dialogue, participation and construction of knowledge focused on problem solving, committed to the construction of UHS, based on the changes developed and using the tools of clinical management.

The difficulty in implanting or implementing some devices and tools in the FHS, such as the UTP, is the lack of commitment and profile of the professionals to adhere to these, often because they do not wish to remain in Primary Health Care, in addition to difficulty in dealing with subjective issues in the process of caring for the user, lack of infrastructure in some FHUs, where there is no privacy during qualified listening at the reception, resistance to policies that involve health promotion and prevention, biomedical model and the disease-centered approach to an integral approach that recognizes stories and sensations in the experience of illness. In this way, it is important to provoke reflections with professionals to rethink their practices, aiming at a greater commitment to consolidate the UHS, implementing its principles and making them responsible for the care of the users in an integral way.

REFERENCES


