THE INTEGRATION OF CARE: DIFFICULTIES AND PERSPECTIVES

A INTEGRAÇÃO DO CUIDADO: DIFICULDADES E PERSPECTIVAS

LA INTEGRACIÓN DEL CUIDADO: DIFICULTADES Y PERSPECTIVAS

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ABSTRACT

Objective: to characterize the integration of care among the teams of Home Care Therapy in HIV / AIDS and the Family Health Strategy from the perspective of professionals, patients and caregivers. **Method:** this is a qualitative, descriptive study with 26 health professionals from the Home Care Therapy in HIV / AIDS (HCT) and Family Health Strategy (FHS) and eight patients / caregivers. We used structured interview scripts that were analyzed through the technique of Discourse Analysis, by Bardin, and presented in the form of categorization. **Results:** it is demonstrated that the teams do not develop integrated actions but believe in the improvement of the quality of care if the care were joint. It is observed that the lack of integration is also perceived by the patient and / or caregiver, contributing more and more to the distancing of primary care by people living with HIV / AIDS (PLHA). **Conclusion:** it was concluded that it is necessary to promote, with institutional support, the articulation of the teams for the achievement of integrality and, consequently, the reach of humanized and quality care. **Descriptors:** Primary health care; Home Care; Family Health Strategy; Patient Assistance Team; HIV-AIDS; Integrality.

RESUMO

Objetivo: caracterizar a integração do cuidado entre as equipes de Assistência Domiciliar Terapêutica em HIV/Aids e a Estratégia Saúde da Família na perspectiva de profissionais, pacientes e cuidadores. **Método:** trata-se de um estudo qualitativo, descritivo, com 26 profissionais de saúde das equipes de Assistência Domiciliar Terapêutica em HIV/Aids (ADT) e Estratégia Saúde da Família (ESF) e oito pacientes/cuidadores. Utilizaram-se roteiros de entrevistas estruturados que foram analisadas por meio da técnica Análise de Discurso, de Bardin, e apresentadas sob a forma de categorização. **Resultados:** demonstra-se que as equipes não desenvolvem ações integradas, mas acreditam na melhora da qualidade da assistência se os cuidados fossem conjuntos. Constata-se que a falta de integração também é percebida pelo paciente e/ou cuidador, contribuindo, cada vez mais, para o distanciamento da atenção primária pelas pessoas vivendo com HIV/Aids (PVHA). **Conclusão:** concluiu-se que é necessário promover, com apoio institucional, a articulação das equipes para a conquista da integralidade e, conseqüentemente, o alcance de uma assistência humanizada e com qualidade. **Descritores:** Atenção Primária à Saúde; Cuidados Domiciliares; Estratégia Saúde da Família; Equipe de Assistência ao Paciente; HIV-AIDS; Integralidade.

RESUMEN

Objetivo: caracterizar la integración del cuidado entre los equipos de Asistencia Domiciliar Terapéutica en VIH / SIDA y la Estrategia Salud de la Familia en la perspectiva de profesionales, pacientes y cuidadores. **Método:** se trata de un estudio cualitativo, descriptivo, con 26 profesionales de salud de los equipos de Asistencia Domiciliar Terapéutica en VIH / SIDA (ADT) y Estrategia Salud de la Familia (ESF) y ocho pacientes / cuidadores. Se utilizaron guiones de entrevistas estructuradas que fueron analizadas por medio de la técnica Análisis de Discurso, de Bardin, y presentadas en forma de categorización. **Resultados:** se demuestra que los equipos no desarrollan acciones integradas, pero creen en la mejora de la calidad de la asistencia si los cuidados fueran conjuntos. Se constata que la falta de integración también es percibida por el paciente y / o cuidador, contribuyendo, cada vez más, al distanciamiento de la atención primaria por las personas viviendo con VIH / SIDA (PVHA). **Conclusión:** se concluyó que es necesario promover, con apoyo institucional, la articulación de los equipos para la conquista de la integralidad y, conseqüentemente, el alcance de una asistencia humanizada y con calidad. **Descriptor:** Cuidados domiciliarios; Estrategia de Salud Familiar; Grupo de Atención al Paciente Exhaustividad; VIH-SIDA.

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INTRODUCTION

AIDS is revealed as a global, continuous and unstable reality, whose dynamicity of the epidemiological profile and the alarming rates of morbidity and mortality have made the epidemic a serious global public health problem and a challenge for the organization of health care.¹ It is set as a chronic, debilitating and contagious disease, which brought about the need to reformulate the structure of care, imposing that the health care of people living with HIV / AIDS (PLHA) be provided in an integral manner.²

Home Care Therapy in HIV / AIDS (HCT) was implanted in the country in 1995, reflecting concern about improved care and reduction of conventional hospitalizations.³ The team was set up in Campo Grande (MS) in 2001, being linked to the Center for Infectious Diseases (CID) of the Municipal Health Department.

Joint Ordinance No. 1 was established between the Health Care and Health Surveillance Secretariats in 2013, defining HCT as a multiprofessional home care, ranging from short-term care, similar to outpatient care, to the care directed to patients who need constant attention and specific care of low complexity, with characteristics of medium duration and elective programming.⁴

In the National Primary Care Policy (NCP), the family health was chosen as the priority strategy for the expansion and consolidation of basic care, and universality, equity and integrality were defined as principles and regionalization and hierarchization, territorialization, the population ascribed, person-centered care, resolution, longitudinality of care, network ordering and community participation as guidelines.⁵

The specialized services in the provision of care should be transcended to PLHA and the active participation of the FHS should be taken into account. It is essential, in the perspective of integrality, that the FHS, even in view of the need to refer users, maintains the articulation with the specialized services so that it participates in the monitoring of the user in the health care network (HCN) for the provision of an efficient and integrated care system.⁶

The concept of integrality refers to the integration of services through assistance networks, recognizing the interdependence of actors and organizations, in view of the fact that none of them has all the resources and skills necessary to solve the health problems of a population.⁷

It is important to characterize the integration between HCT and FHS teams to

fully assist patients under their care, demonstrating, in their care practices, the facilitating and hindering factors.

OBJECTIVE

- To characterize the integration of care among the teams of Home Care Therapy in HIV / AIDS and the Family Health Strategy from the perspective of professionals, patients and caregivers.

METHOD

This is a qualitative, descriptive study carried out in the city of Campo Grande (MS), from February to May 2017, with the research population being composed by the health professionals of the Domiciliary Therapeutic Assistance in HIV / AIDS (HCT) and the Family Health Strategy (FHS) and patients and / or caregivers in follow-up by both teams.

The following inclusion criteria were listed: top-level professionals working in HCT or FHS. We included, in relation to the professionals of the FHS, all those who had patients in their area of coverage, in attendance by HCT. Patients and / or caregivers in follow-up by HCT who were in the area covered by the FHS were contemplated.

Professionals who were on medical leave during the interview period were excluded from the survey, those with impairment in the ability to understand and verbalize, and participants who felt embarrassed.

As participants in the research, 26 professionals from the HCT and FHS teams were added, of which 22 from the FHS, four from the HCT and eight patients and / or caregivers. Data were collected at the Center for Infectious Diseases (CID), where the HCT team is linked, in the Basic Family Health Units and in the residence of the patients attended by both teams. The authors of this article prepared interview scripts, applied in a reserved way, preserving the confidentiality after obtaining the Free and Informed Consent Term of the participants. The semantic evaluation of the instruments was carried out by the health professionals of the municipal network, who had extensive knowledge of the dynamics of the participating teams.

Data was explored using Laurence Bardin's Discourse Analysis technique, which uses categorization.⁸ The participants were enumerated with codes that identified them as a professional, patient, and / or caregiver for the proper analysis. The ethics study was approved by the Ethics Committee in Research with Human Beings of the Federal University of Mato Grosso do Sul, through Opinion No. 1,803,079, dated November 1, 2016.

RESULTS

The results are described, by categorization, in two groups of interviewees:
Health professional

health professional and patients and / or caregivers.

Table 1. Social characterization of the professionals working in the FHS and HCT. Campo Grande (MS), Brazil, 2017

Variables	Nº	%
Profession		
Nurse	9	34
Doctor	8	31
Dentist	7	27
Social worker	1	4
Psychologist	1	4
Sex		
Female	19	73
Male	7	27
Age (Years)		
<31	4	15
31-40	13	50
41-50	5	20
51 or +	4	15
Bond		
Public servant	23	88
Employee	3	12
Time working in the team (years)		
0-5	17	65
6-10	5	20
11 or +	4	15
Specialization		
Yes	19	73
No	7	27
Participation in integrated care course		
No	22	85
Yes	4	15

It is shown, according to table 1, the characterization of the professionals of the HCT and FHS teams, in which nurses were the most professional category in the research, followed by doctors and dentists. It is pointed out that the female gender and the age group of 31 to 40 years were more prevalent among professionals.

It is observed that the predominant employment relationship was the bankrupt and that most of the professionals had little

time in the teams, showing the turnover. It was reported that the majority reported having a Lato sensu postgraduate course in several areas, with a predominance of family health (9/19). It is added that, when asked if they had participated in any course with the integrated care approach, 22 interviewees denied participation.

Table 2. Recognition of the performance of teams between FHS and HCT professionals. Campo Grande (MS), Brazil, 2017.

Categories	N	%
Knowledge by the FHS of patients with HIV / Aids with disabling sequelae		
Yes	13	59
No	9	41
Knowledge of the professionals by the work of the HCT/FHS teams		
Yes	13	50
No	10	38
Partially	3	12

Table 2 shows that among the professionals in the FHS, 59% were aware of patients with HIV / AIDS within their area of coverage with sequelae or limited mobility, in which six

were nurses, four were doctors and three, dentists.

It was noticed the predominance of the ignorance that one team had in relation to the work developed by the other. It is verified

that, among the professionals of the FHS, the majority affirmed that the information they had about the actions developed by the HCT

were those passed on by patients and / or caregivers.

Table 3. Care actions integrated by the professionals of the FHS and HCT teams. Campo Grande (MS), Brazil, 2017.

Categories	N	%
Development of integrated care actions		
No	24	92
Sometimes	2	8
Knowledge about the effect of integration between teams on improving the quality of care		
Yes	22	84
No	3	12
Do not know	1	4
Reasons for improving the quality of care when there is integration		
Information shared with the patient	12	-
Integrity of actions	12	-
Continuity and complementarity of health care	10	-
Geo-facilitated access	6	-
Increased adherence to treatment	1	-

It is evident that most of the respondents did not develop integrated care actions and, of the professionals who said they performed "sometimes", none specified when and how these actions were developed.

It was also asked if the integration between the teams would improve the quality of the assistance and why, with 84% believing in the improvement. It should be emphasized that the teams do not perform shared health actions, even acknowledging the importance they would have for the quality of patient care.

In the transcriptions of some of the professionals' speeches, it is possible to see the importance of team integration, according to the categorization.

- Information shared with the patient

There, the doctor here passed the medicine to him, when CID's team came to visit him, said that it was not to take. There we stayed in that doubt, but why? Then we asked his mother to request a "letter" from them to understand the reason they were suspending ... they said that these medications were already contemplated in the medications they carried. But, he needed the "people" to go after and everything. (FHS-N1)

It is pointed out that the information shared with the patient would avoid duplicity of conduct and embarrassment.

- Comprehensive care

I believe that the fragility one observes may be helping another team. Even in the matter of information gathering, of knowing how the patient is or is needing something, since the team that is there,

the family already trust and is already accustomed, the family has already opened and knows that it is "Seropositive". Sometimes it's easier for them to tell us than for us. This family does not comment on "seropositivity", nor for CHAs they comment. We know it has, though, we do not comment, we do not touch the subject. So, I believe, if the teams talked, it would be great to improve the quality of the assistance. (FHS-N5)

It should be emphasized that integrated care would improve the quality of care, since the patient would be assisted in full.

- Continuity and complementarity of health care

It would give us more ground for us to attend more safely and work together with the specialist [...] because they will know more about this patient. (FHS-M7)

It is evident in some interviews that the integration would stimulate the continuity and complementarity of the care provided to the patients served by the teams due to the acquisition of skills by the FHS professionals.

- Geo-facilitated access

To give better dental care to the patient in his / her area of coverage and not need to move so much. (FHS -O6)

It was pointed out that integration would facilitate access to FHS by patients followed by the specialty.

- Increased adherence to treatment

There are people who do not adhere to the treatment, do not understand the guidelines of the reference team (from there or here). Such integration would

help to make the patient better understand and adhere to treatment. (FHS-N10)

Table 4. Difficulty of HCT and FHS professionals in performing integrated care. Campo Grande (MS), Brazil, 2017.

Categories	N
Fragmentation of services	11
Work overload	9
Lack of schedule / work plan	8
Lack of initiative	7
Self-sufficiency of HCT	2
Professional training model	1

Table 4 shows that the majority of professionals believe that the fragmentation of the health network and the overload of work are obstacles to the implementation of integrated care actions. Considering the difficulties recorded, the transcriptions of some discourses by categories are presented.

- Fragmentation of services

It was not even thought of a way to integrate the entire public network. Each one has a project, but one distinct from the other. No one thinks of global and integrated monitoring. Everyone does with competence, but does not have communication between spheres. (FHS-D4)

- Work overload

I believe the overhead, both for us and for them. (FHS-N9)
In my case, I have to attend many patients and I do not have time to talk. (FHS-012)

- Lack of schedule / work plan

I think, in fact, it lacks a policy for this, a greater view of this integration. I think it gets very fragmented. Missing a target. (HCT-AS 1)

- Lack of initiative

I think it's the day to day, the work leaves us very focused. I never looked for them

and they never even looked for us. It may even be for lack of information. (FHS -03)

- Self-sufficiency of HCT

I do not think there would be a greater obstacle. Every time we need to resort to them, we had a good answer. The point, even, is that our team assumes that we need to solve the patient's problem and not be delegating or moving to the other to solve. So that's why we often do not turn up, we realize, we do not need to ask for help for them. (HCT-P2)

- Professional training model

In the network, as a whole, besides this formation rooted in the fact that the patient is seropositive and, therefore, should carry out the treatment here [...]. In a sense, it is rooted in the training of physicians and other professionals and in the patient himself, that the infectious physician is needed to be handling all patients with AIDS, which is not true. (HCT-D3)

Table 5. Prospects for care actions integrated by the professionals of the HCT and FHS teams. Campo Grande (MS), Brazil, 2017.

Categories	N
Meeting or meeting of teams	20
Counter-referencing	6
Unique therapeutic design (UTD)	6
Matriculation	5
Shared query	3
Integrated computer system	1

Table 5 shows the strategies suggested by professionals for performing integrated care, with the most cited action being the meeting.

Patients and / or caregivers

Seven patients/caregivers were interviewed by the FHS/HCT five caregivers due to the difficulty of verbalization and understanding of the patients. Most female (5/7) aged 30-60 years (4/7). It is worth

mentioning that one caregiver had two patients, so a total of eight patients were accompanied by the FHS/HCT teams with seven caregivers.

Different situations referred to by patients and / or caregivers when asked about the services they seek in the FHS, such as intercurrent, vaccination, medication, among others, are shown in the interviews. It

was emphasized, by the majority, that it is not necessary to seek the assistance of HCT, since they are always present in the residence.

It was also recorded that, of the seven patients and/or caregivers interviewed, four reported not receiving a home visit by the FHS members, a situation considered serious when the responsibility of the FHS is linked to its assigned area.

It is observed in most of the interviews that the perception of the patients/caregivers is that the two teams do not talk about the care given, as well as the lack of stimulation by the specialized team to seek care at the FHS. It is evidenced that, in general, patients and/or caregivers do not recognize the interest of the FHS professionals for the care actions developed by HCT.

DISCUSSION

Health professional

The results are mainly the presence of women and young adults (aged 20 to 39 years), similar to those found in other studies, where the analysis of the profile of the professionals of the family health teams points to a feminization of the workforce and reveals that more than a third of the doctors and nurses of the teams are young adults.⁹⁻¹⁰

It was observed that the predominance of nursing professionals is a positive aspect, since they had more knowledge of the patients participating in the research, as well as knew about the organization of the municipal health network. It is considered that nurses, as health professionals, have a role of acting in the implementation of public policies and in the assistance to the user.¹¹

The statutory employment relationship is presented as predominant, demonstrating a recurring concern of health managers regarding the replacement of outsourced staff. It is pointed out that, although the public tender is a reflection of the policy of "deprecarization of work" and facilitates the fixing of professionals, the action is not enough to keep the participants in their work positions, as observed by the participants' turnover.⁹

It is demonstrated, however, that there are no statistically significant associations between the time of performance of doctors and nurses in the FHS and the frequency of the planned activities. Thus, while it is expected that a greater amount of professional experience in the FHS will have an impact on the accomplishment of more group activities, community meetings and

home visits, it is not possible to realize this association, intending the discourses widely spoken.¹²

The difficulty of assuming, in practice, the incorporation of the attributes foreseen in the NCNP, such as the coordination of care by FHS, longitudinality, completeness, among others, even with a considerable number of professionals with postgraduate in health of the family. It is known that this incorporation depends on factors other than vocational training, but it is expected that the specialized or skilled professional will perform its role more effectively.

It is inferred that lack of qualification in integrated care is a problem to be faced, since qualified professionals working in PHC teams are essential for building access, resolubility, coordination and community-based and "empowering".¹³

Table 2 shows the fragmented behavior of HCT and FHS professionals, since patients and / or caregivers are, for the most part, exclusively assisted by the specialized team and that there is no sharing of care with FHS.

It is noted that the FHS has difficulty in assuming the role of coordinator of the most critical patient care in its area of coverage, facing the demands and the large number of users, as well as the lack of human and material resources, disregarding itself by the care when the patient is being followed by another program. It is observed that the specialized team presents difficulties to perform the *matriciamento* and to share the care, considering the history of implantation of the team in the centralized model and of the accompanying patients, who also demonstrate resistance in seeking care in basic care.

One of the main causes of poor quality of care is the fragmentation of care, caused by inefficient communication, associated with higher costs, duplication of diagnostic procedures, use of multiple medications and conflicting therapeutic plans, with negative effects more potent on chronic conditions.¹⁴

It is understood that the integration of basic care with medium and high complexity health services is a challenge. It is known that the integration between the services contributes to a better reception, bonding and resolubility by the basic attention, enabling an approximation and effective communication with the specialized service. It is argued that, in this way, the FHS teams will feel strengthened and can count on the support of the specialized teams whenever necessary.

It is responsible for the performance of the FHS as fundamental for the effectiveness of the integration of care, since the main characteristics are the possibility to establish a greater bond with the individuals / families, to assume the coordination of the care with the other levels and to follow all the the user's path in the network.¹⁵ In this way, it is verified that the basic care teams are the most apt to assume the function of coordinating the therapeutic path of the users in HCN.¹⁴

It can be seen in table 3 that the teams do not discuss or plan health actions together, which may be related to the difficulty of integration, as well as a historical context, since, since the implementation of HCT, there were no incentives or formal institutional mechanisms to integrate the specialized team and the health network, as well as to maintain the barrier created by PLHA more linked to specialized services, avoiding the constraint of exposing its diagnosis in other services.

There is unanimity among workers regarding the importance of interdisciplinarity for health work, but it seems to be difficult to define it. This aspect is understood as the referral of patients from one professional to another or as a team work. It is considered that the difficulty in conceptualizing the interdisciplinarity generates distortions in the practice of the activities.¹⁶

It is observed that professionals are aware of the importance of multiprofessional work, but it is still strongly organized in a biomedical model, resulting in the compartmentalization of care.¹⁷

It is evaluated that, in relation to the reasons listed on the improvement in the quality of the assistance when there is integration, the majority said that the information shared with the patient by the teams would allow to provide better quality care. The quality of patient safety assistance is associated and therefore information exchange, teamwork and communication are important to avoid errors.¹⁸

In the interviewees' discourse, it should be emphasized that integrated care would improve integrality, defined as the provision of a set of services that meet the needs of the population, from promotion, to palliative care, in addition to adequate recognition of problems biological, psychological and social factors that cause.¹⁹

It is presented that the continuity and complementarity of health care between the teams strengthen shared care and accountability to provide better quality care,

but the FHS team also voices the insecurity in meeting the PLHA.

In the speeches of FHS professionals, one can see the concern about acquiring the "ability" to be able to watch PLHA, while the care taken in its entirety by the specialized team reduces the workload and improves the resiliability in their area attached.

It is evident that, when the potential of teamwork is revealed, together and in an articulated way, health teams increase their capacity for care and problem solving, make health care devices more accessible, and share responsibility for improving the quality of health and life of a population.²⁰

It is explained that the ease of geographical access verbalized by the professionals is defined as the distance between the health service and the place of residence of the individual, considering the time and means used for their displacement, as well as the difficulty to obtain the care and treatment received. It is recommended, for the treatment of the diseases, whenever possible, that the patient should be treated close to his / her residence, in order to improve adherence to treatment.²¹

It is inferred that, if the patient accompanied by the HCT feels bound to the FHS, it will have the geographical access facilitated and also will be assisted in its attached area. It is necessary, for this connection to happen, that the patient feels welcomed and that the service has resolve.

The difficulties to perform the care actions integrated by professionals are identified, as shown in table 4, mainly pointing out the fragmentation and the work overload.

In the results of the Program for Improving Access and Quality of Primary Care (PMAQ-AB), it is evident that the contact between primary care professionals and specialists is an infrequent practice, demonstrating that there is a barrier to the coordination of care by the because of the low availability of shared electronic medical records and the weak reception of counter-referral, as affirmed in the speeches of the professionals of HCT and FHS.¹⁴

It is noticed that the realization of the integrated care is understood as an increase of the work overload for the teams. It creates the sensation of anguish in the teams, when trying to achieve a better reception through the viabilization of access, due to the strenuous workload and the emotional stress.¹³ It is considered therefore essential enough professionals to enable working

conditions that allow access and service in longitudinality.

There is a lack of a schedule or work plan and a lack of initiative or interest as difficulties to carry out shared actions. It is pointed out that it is not enough, just, that the members of the teams define the schedules and initiatives among themselves; it is necessary the involvement of those in charge of the teams. It is verified that multiple independent providers, without an articulating axis, can not clearly define their responsibilities.¹⁴ Thus, it is necessary for teams to develop integrated care, an articulator that assists in the conduct of actions, working the difficulties and potentialities.

It is understood that the institutional support provides the expansion of the capacity of analysis of the teams and seeks to include the employees in the work, facilitating the reflection on the difficulties of that environment.²²

Self-sufficiency is reflected by the specialized team through the lack of availability to perform and carry out the integrated care, not recognizing their role as nurse. It is emphasized that the specialized team assumes all the health care of the patient, causing him to have the perception that the follow-up of basic care is inferior or unnecessary. It is evaluated that, in relation to the FHS team, the feeling is not knowing the assistance provided, being oblivious to the follow-up performed by the HCT.

It is noticed that, in health, there was a growing division of labor that makes it difficult to integrate the care process and care for people, and that this structure creates extreme management difficulties, which is a structural obstacle to the adoption of the working method matrix support.²³

It is considered that the professional formation is a difficulty for the accomplishment of the integrated actions, since, in the academic formation and in the professional trajectory, activities are not developed that contemplate the integrated work. It is pointed out, as one of the main factors that hinder the practice of interdisciplinarity in the teams, the training of health professionals, which prioritizes technical knowledge.²⁴

In the context of the integration perspectives between the teams and considering the work practices, it was verified that the meeting was the most cited action by the professionals interviewed, according to table 5. It should be emphasized that

instruments such as meetings, phone calls or e-mails are actions to address some purpose, not an integration mechanism. They were presented, by professionals, as other mechanisms for integration, counterreference, the elaboration of a unique therapeutic design (UTD) and matriciamento.

It is observed that the counter-referral is still little performed, even though it is considered important and widely known by professionals in relation to the continuity / complementarity of the patient's care in HCN. It is understood that the counter-referral does not occur in the HCT that has a small number of users, and this situation is aggravated when it expands to a complex health network with many needs.

There are several reasons for not doing the counterreference, but if the actions are not coordinated, it will continue without execution. This condition is extended to the UTD and the matriciamento, since, in order to be carried out, they depend little on the physical structure, but rather on the institutional support and professionals aware of the need to implement the mechanisms for improving the quality of care.

It is suggested among professionals that one of the strategies for teams to develop integrated actions is the UTD, a potent tool to care for users of specialized mental health services, as well as a tool for organizing and sustaining the activities of the Nucleus Support to Family Health (NSFH) based on the concepts of co-responsibility and integrated care management.²⁵

It is explained that instituting this tool is a challenge, since there is still a process of changes of practices, in which there are advances and setbacks. It is understood that changing, replacing and re-creating practices requires overcoming, deconstructing the old and social participation.²⁶

Matrizing is a practice of cooperation between the FHS teams and their support references and also as a way of strengthening the work with primary health care in all its complexity.²⁷ It is necessary that the matriciamento is a collaborative work between the teams and that there is no privilege of a type of knowledge. In the case of the HCT and FHS teams, the decentralization of PLHA care and the strengthening of care in the territory should be.

Patients and Caregivers

It is observed, in relation to the users that were being monitored by the teams, how much the assistance is directed by the

specialized team. It should be emphasized that it is not a matter of discussing the quality of the care provided by the HCT team, as it is known that this small group of patients is benefited by quality monitoring.

The integration between the specialized team and the primary care is questioned, and the integration has a series of benefits to the patients that were widely discussed in this research. It is highlighted, as a reflection, the way in which the FHS acts as coordinator of care with this group of patients, considering that they are being assisted, in most cases, only by HCT. It is defined, as necessary, to reconstruct the assistance model for follow-up patients and the others, with the care profile, in the HCT team.

The negative perception of the integration between the teams by the patients and / or caregivers is evidenced, since there is a lack of dialogue about the care provided and there is no incentive for the HCT to seek care at the FHS. It is noticed that patients and / or caregivers do not recognize the interest of the FHS professionals for the care actions developed by HCT.

In relation to the integration of care between the specialized services and the FHS, 89.4% of the participants did not receive any stimulus, guidance or questioning about the assistance of the FHS; 35.5% admitted that the FHS was unaware of their HIV / AIDS diagnosis and 48.9% stated that even knowing the existence of the case, the FHS did not perform any treatment or follow-up treatment. It was also noted the scarcity in the search for primary care by the PLHA, since they do not recognize the FHS as a service area for individuals who already experience the disease.⁶

The constraint of the disclosure of seropositivity to the health professional is described as one of the difficulties experienced by PLHA in the search for health care, since it is an aggravation that still carries a social stigma.²⁸

It is observed that the lack of integration between the teams is felt by the patient, stimulating, more and more, the detachment of the PLHA from primary care. It is understood that this patient feels the need to remain "hidden" and finds, in this fragmented context of HCN, the favorable factors to move away from primary care.

Since 2014, the Ministry of Health has been reorganizing health care for PLHA through the implementation of HIV management in basic care and the beginning of the establishment of a matricial care model that is more

efficient and resolute.²⁹ It is demonstrated the need for decentralization of assistance to PLHA by the Ministry of Health in order to guarantee greater access to the health system.

It is considered, as a limiting factor of the study, the lack of participation of managers, as the inclusion of these actors as participants in the research would further expand the discussion about how management understands the importance of integrating care in the process of integrality.

CONCLUSION

It was observed that the integration of care between the FHS and HCT, from the perspective of the professionals, was characterized by the lack of knowledge that one team had in relation to the other, evidencing that care is provided in isolation by the teams. It is evaluated that professionals, even if they do not perform integrated care, believe in improving the quality of care, if there is integration.

The analysis of the integration of care from the perspective of patients and / or caregivers with a greater connection with HCT is characterized, since the FHS, for these patients, provides sporadic care. Patients and their caregivers are, for the most part, the advantage of distancing basic care and approaching the specialized team.

It is considered that, in the search for integrality, multiprofessional teams must mobilize or at least be concerned with integration into HCN, overcoming the isolation of different practices. Initiatives to stimulate integration should be idealized in order to increase the credibility of primary care professionals, overcome hierarchical relationships, and isolate primary and specialized care.

It is concluded that the work to be developed depends on a wide discussion with all those involved, in order to define the possibilities of changes in work processes, in order to strengthen the integrated actions. It is also pointed out that, in addition, managers should stimulate and support the integration spaces to effect the decentralization and consolidation of PLHA care in basic care, also guaranteeing the necessary physical conditions.

REFERENCES

1. Palácio MB, Figueiredo MAC, Souza LB. HIV/AIDS Care and Primary Health care: Possibilities of Assistance Integration. Psico [Internet]. 2012 July/Sept [cited 2018 July 15];43(3):360-7. Available from:

<http://revistaseletronicas.pucrs.br/ojs/index.php/revistapsico/article/view/9816/8237>

2. Sousa CSO, Silva AL. HIV/Aids care according to the perspective of healthcare providers. *Rev Esc Enferm USP*. 2013 Aug;47(4):907-14. Doi:

<http://dx.doi.org/10.1590/S0080-623420130000400019>.

3. Ministério da Saúde (BR), Secretaria de Vigilância em Saúde, Programa Nacional de DST e Aids. Rotinas de assistência domiciliar terapêutica (ADT) em HIV/Aids: manual: relatório de recomendações [Internet]. Brasília: Ministério da Saúde; 2007 [cited 2018 May 25]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/manual_rotinas_ADT_2007.pdf

4. Ministério da Saúde (BR), Secretaria de Vigilância em Saúde. Portaria conjunta nº 1, de 16 de janeiro de 2013. Altera na Tabela de Serviço Especializado no Sistema de Cadastro Nacional de Estabelecimentos de Saúde (SCNES), o Serviço 106 - Serviço de Atenção a DST/HIV/Aids, e institui o Regulamento de Serviços de Atenção às DST/HIV/Aids, que define suas modalidades, classificação, organização das estruturas e o funcionamento. [Internet]. Brasília: Ministério da Saúde; 2017 [cited 2018 June 15]. Available from: <http://www.aids.gov.br/pt-br/legislacao/portaria-conjunta-no-1-de-16-de-janeiro-de-2013>

5. Ministério da Saúde (BR), Gabinete do Ministro. Portaria de Consolidação nº 2, de 28 de setembro de 2017. Consolidação das normas sobre as políticas nacionais de saúde do Sistema Único de Saúde [Internet]. Brasília: Ministério da Saúde; 2017 [cited 2018 June 15]. Available from: <http://dab.saude.gov.br/portaldab/pnab.php>

6. Medeiros LB, Trigueiro DRSG, Silva DM, Nascimento JA, Monroe AA, Nogueira JA, et al. Integration of health services in the care of people living with aids: an approach using a decision tree. *Ciênc saúde coletiva*. 2016 Feb;21(2):543-52. Doi: <http://dx.doi.org/10.1590/1413-81232015212.06102015>.

7. Hartz ZMA, Contandriopoulos AP. Comprehensive health care and integrated health services: challenges for evaluating the implementation of a “system without walls”. *Cad Saúde Pública*. 2004;20(Suppl 2):S331-6. Doi: <http://dx.doi.org/10.1590/S0102-311X2004000800026>

8. Bardin L. A análise do discurso. In: Bardin L. *Análise de conteúdo*. Lisboa: Edições 70; 2000. p. 214-20.

9. Mendonça MHM, Martins MIC, Giovanella L, Escorel S. Challenges for human resources management from successful experiences of family health strategy expansion. *Ciênc saúde coletiva*. 2010 Aug;15(5):2355-65. Doi: <http://dx.doi.org/10.1590/S1413-81232010000500011>.

10. Lima EFA, Sousa AI, Primo CC, Leite FMC, Souza MHN, Maciel EEN. Social and professional profile of family healthcare team members. *Rev enferm UERJ*. 2016;24(1):e99405. Doi: <http://dx.doi.org/10.12957/reuerj.2016.9405>

11. Siqueira MCF, Nóbrega MML, Bittencourt GKGD, Silva AO, Nogueira JA. Term base for nursing practices with elderly women with HIV/AIDS. *Rev Gaúcha Enferm*. 2015 Mar;36(1):28-34. Doi: <http://dx.doi.org/10.1590/1983-1447.2015.01.46671>.

12. Santos AM, Giovanella L, Mendonça MHM, Andrade CLT, Martins MIC, Cunha MS. Healthcare practices of family health teams in four major cities. *Ciênc saúde coletiva*. 2012 Oct;17(10):2687-702. Doi: <http://dx.doi.org/10.1590/S1413-81232012001000018>.

13. Tesser CD, Norman AH. Rethinking the access to healthcare in the Family Health Strategy. *Saúde soc*. 2014 July/Sept;23(3):869-83. Doi: <http://dx.doi.org/10.1590/S0104-12902014000300011>

14. Almeida PF, Santos AM. Atenção Primária à Saúde: coordenadora do cuidado em redes regionalizadas? *Rev Saúde Pública*. 2016;50(80):1-13. Doi: [10.1590/S1518-8787.2016050006602](http://dx.doi.org/10.1590/S1518-8787.2016050006602)

15. Almeida PF, Giovanella L, Mendonça MHM, Escorel S. Challenges for healthcare coordination: strategies for integrating levels of care in large cities. *Cad Saúde Pública*. 2010 Feb;26(2):286-98. Doi: <http://dx.doi.org/10.1590/S0102-311X2010000200008>.

16. Costa R P. Interdisciplinarity and health staffs: conceptions. *Mental* [Internet]. 2007 June [cited 2018 July 15];5(8):107-24. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1679-44272007000100008.

17. Silva NEK, Oliveira LA, Figueiredo WS, Landroni MAS, Waldman CCS, Ayres JR. Limitations of multiprofessional work: a case study of STD/AIDS reference centers. *Rev Saúde Pública*. 2002 Aug;36(4 Suppl):108-16. Doi: <http://dx.doi.org/10.1590/S0034-89102002000500015>

18. Oliveira RM, Leitão IMTA, Silva LMS, Figueiredo SV, Sampaio RL, Gondim MM. Strategies for promoting patient safety: from the identification of the risks to the evidence-based practices. *Esc Anna Nery Rev Enferm*. 2014 Jan/Mar;18(1):122-9. Doi: <http://dx.doi.org/10.5935/1414-8145.20140018>.

19. Ministério da Saúde (BR), Conselho Nacional de Secretários de Saúde. A Atenção Primária e as Redes de Atenção à Saúde [Internet]. Brasília: Ministério da Saúde; 2015 [cited 2018 June 14]. Available from: <http://www.conass.org.br/biblioteca/atencao-primaria-e-as-redes-de-atencao-a-saude/>

20. Pereira R C, Rivera F J U, Artmann E. The multidisciplinary work in the Family health strategy: a study on ways of teams. *Interface comun saúde educ*. 2013 Apr/June;17(45):327-40. Doi: <http://dx.doi.org/10.1590/S1414-32832013005000006>.

21. Perrechi MCT, Ribeiro SA. Tuberculosis treatment: integration between hospitals and public health care clinics in the city of São Paulo, Brazil. *J Bras Pneumol*. 2009 Nov;35(11):1100-6. Doi: <http://dx.doi.org/10.1590/S1806-37132009001100007>.

22. Barros SCM, Dimenstein M. Institutional support as a reordering mechanism for the work processes in primary health care. *Estud pesqui psicol* [Internet]. 2010 Apr [cited 2018 July 15];10(1):48-66. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1808-42812010000100005

23. Campos GWS, Domitti AC. Matrix support and reference team: a methodology for interdisciplinary health work management. *Cad Saúde Pública*. 2007 Feb;23(2):399-407. Doi: <http://dx.doi.org/10.1590/S0102-311X2007000200016>.

24. Loch-Neckel G, Seemann G, Eidt HB, Rabuske MM, Crepaldi MA. Challenges to an interdisciplinary action in basic care: implications related to composition of family health teams. *Ciênc saúde coletiva*. 2009 Sept/Oct;14(1 Suppl):1463-72. Doi: <http://dx.doi.org/10.1590/S1413-81232009000800019>

25. Hori AA, Nascimento AF. The singular therapeutic project and mental health practices at family health support centers in Guarulhos in the state of São Paulo, Brazil. *Ciênc saúde coletiva*. 2014 Aug;19(8):3561-71. Doi: <http://dx.doi.org/10.1590/1413-81232014198.11412013>

26. Carvalho LGP, Moreira MDS, Rézio LA, Teixeira NZF. The construction of a Singular

Therapeutic Project with the user and the family: potentialities and limitations. *Mundo saúde* [Internet]. 2012 July/Sept [cited 2018 June 15];36(3):521-25. Available from: <http://pesquisa.bvsalud.org/enfermeria/resolve/en/int-4698>.

27. Medeiros RHA. Uma noção de matriciamento que merece ser resgatada para o encontro colaborativo entre equipes de saúde e serviços no SUS. *Physis*. 2015;25(4):1165-84. Available from: <http://dx.doi.org/10.1590/S0103-73312015000400007>.

28. Garbin CAS, Garbin AJI, Moimaz SAS, Carmo MP. Bioética e HIV/Aids: discriminação no atendimento aos portadores. *Rev Bioética*. 2009;17(3):511-22. Available from: http://revistabioetica.cfm.org.br/index.php/revista_bioetica/article/view/514/515

29. Ministério da Saúde (BR), Secretaria de Vigilância em Saúde. 5 passos para a implementação do Manejo da Infecção pelo HIV na Atenção Básica: Guia para Gestores [Internet]. Brasília: Ministério da Saúde; 2014 [cited 2018 Mar 25]. Available from: <http://www.aids.gov.br/pt-br/pub/2014/5-passos-para-implementacao-do-manejo-da-infeccao-pelo-hiv-na-atencao-basica>.

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