WORK PROCESS: PERCEPTION OF THE FAMILY HEALTH TEAM
PROCESSO DE TRABALHO: PERCEÇÃO DA EQUIPE DE SAÚDE DA FAMÍLIA
PROCESO DE TRABAJO: PERCEPCIÓN DEL EQUIPO DE SALUD FAMILIAR

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ABSTRACT

Objective: to describe the perception of a multiprofessional Family Health Strategy team about the organization of the work process in their unit. **Method:** this is a qualitative, descriptive study, developed in a health unit with 11 professionals, using the focus group technique, guided by the Self-Assessment for Improving Access and Quality of Primary Care in the dimension of work process organization. The data was submitted to the technique of Content Analysis. **Results:** it is pointed out that, in the data organization, two categories emerged: Organizational Aspects and Relational Aspects. Emphasize the importance of nurses for the coordination of actions and the need to encourage collaborative work for the integrality of actions. **Conclusion:** there is a need to establish, within the health team, routine reflection on the organization of work processes based on the attributes of primary health care, in addition to the practice of evaluation as a tool to improve the quality of care. **Descriptors:** Organization and Administration; Primary Health Care; Family Health; Patient Care Team; Basic Health Services; Health Services.

RESUMO

Objetivo: descrever a percepção de uma equipe multiprofissional da Estratégia Saúde da Família sobre a organização do processo de trabalho na sua unidade. **Método:** trata-se de estudo qualitativo, descritivo, desenvolvido numa unidade de saúde com 11 profissionais, utilizando a técnica de grupo focal, norteada pela Autoavaliação para Melhoria do Acesso e da Qualidade da Atenção Básica na dimensão de organização do processo de trabalho. Submeteu-se os dados à técnica de Análise de Conteúdo. **Resultados:** aponta-se que, na organização dos dados, emergiram duas categorias: Aspectos organizacionais e Aspectos relacionais. Enfatizam-se a importância do enfermeiro para a coordenação das ações e a necessidade de se fomentar o trabalho colaborativo para a integralidade das ações. **Conclusão:** constata-se a necessidade de se instituir, no âmbito da equipe de saúde, a reflexão rotineira sobre a organização dos processos de trabalho pautada nos atributos da atenção primária à saúde, além da prática de avaliação como ferramenta para melhorar a qualidade da atenção. **Descritores:** Organização e Administração; Atenção Primária à Saúde; Saúde da Família; Equipe de Assistência ao Paciente; Serviços Básicos de Saúde; Serviços de Saúde.

RESUMEN

Objetivo: describir la percepción de un equipo multiprofesional de Estrategia de Salud Familiar sobre la organización del proceso de trabajo en su unidad. **Método:** este es un estudio cualitativo, descriptivo, desarrollado en una unidad de salud con 11 profesionales, utilizando la técnica de grupo de enfoque, guiado por la Autoevaluación para mejorar el acceso y la calidad de la atención primaria en la dimensión de la organización del proceso de trabajo. Los datos fueron sometidos a la técnica de Análisis de Contenido. **Resultados:** se señala que, en la organización de datos, surgieron dos categorías: Aspectos organizacionales y Aspectos relacionales. Se enfatiza la importancia de las enfermeras para la coordinación de las acciones y la necesidad de fomentar el trabajo colaborativo para la integralidad de las acciones. **Conclusión:** es necesario establecer, dentro del equipo de salud, una reflexión rutinaria sobre la organización de los procesos de trabajo basados en los atributos de la atención primaria de salud, además de la práctica de la evaluación como una herramienta para mejorar la calidad de la atención. **Descritores:** Organización y Administración; Atención Primaria de Salud; Salud de la Familia; Grupo de Atención al Paciente; Servicios Básicos de Salud; Servicios de Salud.

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INTRODUCTION

Primary Health Care (PHC) is a reference in the world scenario to reduce health inequities, and is considered a fundamental strategy to increase the effectiveness and resoluteness of health services. It is known that the advance of PHC in recent years has evidenced this level of attention as one of the main entry doors of the Unified Health System (UHS).¹

In Brazil, the Family Health Strategy (FHS) has been the model of care adopted in PHC, whose pillars are integral health care, the attachment of multiprofessional teams to the population of a given territory, the door preferential entry into the system, in addition to the responsibility for coordinating health care networks,² therefore, is a strategy that has the power to reorient the care model.

In this context, it is evaluated that the organization of the work process in PHC is fundamental, including a set of coordinated actions whose knowledge and strategies employed by professionals become instruments to enable health care.³

It is noteworthy that the health work developed collectively, prerogative in the implementation of the FHS through the adoption of multidisciplinary teams, however, persists by a work permeated by fragmented actions. It is necessary a specific look at the organization of the work process, since the changes in the epidemiological profile, with the predominance of chronic diseases that require longitudinal follow-up, and the need for a comprehensive approach, require a proper approach to multiprofessional practice and teamwork.

It is understood, since professionals who work in health work are essential to enable new models of care,³ that the implementation of mechanisms that evaluate the conditions for the development of the work process is fundamental to understand health work.

Since 2004, the Ministry of Health has been developing actions to institutionalize evaluation within PHC, however, incorporating and expanding evaluation actions in management is a challenge. Since 2011, the implementation of systematic evaluation processes has been guided through the National Program for Access and Quality Improvement of Primary Care (PMAQ-AB), established through Ordinance GM/MS No. 1,654 of 2011, updated on 2015, by Ordinance No. 1.645, of the GM/MS. This program aims to improve the quality of health services through financial incentives to family health teams that agree on quality goals,⁴ including changes in the work process.

Thus, this research is justified by the relevance of professionals to the development of the health

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work process, knowledge of the specificities of sociodemographic and professional characteristics, reflections on the strengths and weaknesses of work that may contribute to the evaluation in the FHS as well as the possibility of using evaluation as a management tool.

OBJECTIVE

- To describe the perception of a multiprofessional Family Health Strategy team about the organization of the work process in their unit.

METHOD

This is a qualitative, descriptive research, developed in a municipality located in the southwest of the state of Mato Grosso that, in 2016, exponentially accelerated the process of expansion of primary care, reaching 100% coverage.

For the selection of the participating service, the mapping of the health units distributed in geographical regions in the municipality was performed. Subsequently, the following criteria were applied in relation to these units: being registered in PMAQ; have a complete multiprofessional team and be located at extremes of the city, with geographical limitations of access. Three units met the proposed criteria, having been visited for the presentation of the project and the invitation to participate in the research, and the team of one unit agreed to participate in the research.

It was observed that the participants were all professionals of the multidisciplinary team who agreed to participate (nurse, doctor, nursing technicians, receptionist, community health agents, dentist and oral hygiene technician), totaling 11 professionals.

An agenda with possible dates for meetings was created, with the participants' acceptance, which was made available to the team, which allowed the consensual choice of date, a strategy used to favor the participation of as many professionals as possible in order to capture the looks and observations of all actors involved in the work process.

Data was collected by the researchers in September 2016 using the focus group technique⁵, performed with the presence of a moderator and two observers.

The focus group was guided by a roadmap based on the Self-Assessment Tool for Improving Access and Quality of Primary Care (AMAQ), used by the Ministry of Health to evaluate the National Program for Improving Access and Quality of Primary Care (PMAQ).⁶

Although the instrument has different dimensions for this study, it was used the

dimension related to the Organization of the Work Process, which fits the objective of the study. The items of the instrument are evaluated by a rating scale, with a score of zero indicating non-compliance and a score of ten indicating total adequacy. In addition, the ranges between zero and ten are degrees of compliance/compliance of the analyzed situation in relation to the desired quality. It was described that the participants scored according to the value they considered appropriate to the reality experienced regarding each question of the instrument and, at each score, the justification of the assigned value was requested; then, we grouped with the pattern that the question indicated as an evaluation parameter.

The instrument was made available in hard copy to each participant and was also projected on a multimedia device. A banner with the scoring of the guiding questions was constructed to be consulted if necessary.

Note that the meeting was audio recorded and lasted for two hours and thirty minutes. The transcribed material was submitted in full to the exploratory reading for the appropriation of the totality of the content and, afterwards, the exhaustive reading was performed in order to grasp, in depth, the content of the material. In the analysis and interpretation, the thematic representational aspect of Bardin 7 was used, based on the pre-analysis, analysis and exploration phases. Two categories emerged from the empirical material: Organizational Aspects and Relational Aspects.

All ethical aspects in research were respected, in accordance with Resolution 466/12, with the appreciation and approval of the UNEMAT

- Successive area/territory redefinitions;
- High turnover of professionals;
- Limited team communication;
- Fragile articulation with counter-referral services;
- There is no evaluation of actions taken at the unit.

Figure 1 - Justifications cited by health professionals that interfere in the organization of the work process in family health units. Tangará da Serra (MT), Brazil, (2016).

From the systematization and content analysis of the focus group speeches, two empirical categories were evidenced: Organizational Aspects and Relational Aspects.

◆ **Organizational Aspects**

The organizational aspects category refers to the structuring of the work processes of the care team, including planning actions from the territory, the demands of users at the primary level of care, the integrated and horizontal actions with the care line services. , as well as its assessment of coordination in the care network.⁹

Territorialization, a factor closely linked to the organization of the work process in the FHS, was found to be weakened. It is found that the

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RESULTS

The most frequent characteristics of the participants' socioeconomic profile are: age over 40 years (33.3%); female gender (55.5%); white color (66.6%); married (55.5%); with children (55.5%); with employment in statutory regime (55.5%) and acting as community health agents (CHA) (55.5%). It is noteworthy that this multidisciplinary team had the participation of a doctor from the Mais Médicos Program (MMP).

The following characteristics of the professional profile were predominant: admission to the unit in 2015 (77.7%); with admission training received (77.75%); with regular satisfaction with the salary (66.6%); with a good degree of satisfaction with the employment relationship (77.7%) and also a good degree of satisfaction with the 40-hour weekly workload (88.8%). There was an adequate relationship between scheduled and spontaneous consultations (55.5%). Regarding previous professional experience (77.7%), professional qualification (88.8%) and achievement of goals (100%), participants never received any financial bonus.

It was found, considering the score issued in the self-assessment of professionals in the items related to the AMAQ Work Process Organization, that the dimension analyzed is unsatisfactory in relation to the desired quality. Justifications that are summarized in figure 1:

delimitation of space still undergoes constant changes, a noticeable situation in the statements.

We work with the defined micro areas, but the process of territorialization has undergone some changes, it is; some not, several. (CHA 4)

If you really had a specific territory, you would do it all, you would be 100%, because you know your population, work in it, change habits, lifestyle, help, care, continue, follow up all patients, whether they are sick or not. (Nurse)

The biggest problem is territorialization, it always changes and we need to re-register. (CHA 3)

It is observed that professionals express a significant need to review the referral and

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counter-referral system, as exemplified by the following statements.

[...]because we don't know when it was released, if it was released. The counter reference does not exist. (Nurse)

This specialized exam business, the patient goes and never comes back. There is no such sequence here. (Doctor)

We forward, but there is no answer. (Doctor)

[...] to go, there is no follow up. (Dentist)

It is understood that another highlight was the absence of an evaluative culture, as stated by professionals.

We do not monitor anything and do not evaluate. We did the HPV campaign, did we evaluate the results? No. They can evaluate there at City Hall, get our data and evaluate. We really don't do that. (CHA 3)

Not everyone sits down and does the planning and then evaluates. (Dentist)

It is evident from the statements that the team must be sensitized so that the evaluation of the results achieved can be used as one of the forces of reflection for the elaboration of the planning.

◆ Relational Aspects

This category refers to the integration of the health team in the logic of the work process organization, in their practices, the different spaces of internal communication that cohabit the functionality of services in PHC.

It is noted that staff turnover in health teams is an impediment to achieving longitudinality, as reported by participants.

For people to get a bond with the nurse, for women to come here and do a preventive or whatever action, it's about six months, eight months to get a bond. (ACS 2)

Then, when you get this bond, you end up changing the professional. (ACS 4)

There's the nurse question too. In a year or so, four nurses have passed. Hence, there is no way to start an action and end it. (Doctor)

We had a lot of problems because we had no stable nurse. In one year, we had many nurses. (Dentist)

It is evident that the meeting space refers to the act of transmitting operational information, which is held only when there is an orientation to be directed to the actions inherent to the professionals' functions.

There is a meeting, but we cannot give our opinion. The meeting is to talk: such a day, we will do such a thing, in such a place and at such a time. (CHA1)

When the meeting with the team is done, we do not discuss any cases [...]. (Doctor)

Meetings are held and come from top to bottom. And it's on average 40 minutes only. (CHA 4)

The speeches show that the meeting space refers to the act of transmitting operational

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information, which is performed only when there is an orientation to be directed to actions inherent to the professionals' functions.

DISCUSSION

It is noted as to the organizational aspects that the FHS health team operates in a territory, which adds spatial, epidemiological and contextual aspects, in addition to the quantitative aspect of users. The frequent redefinitions of territories, soil and process, indicate a possible rupture in the principles and attributes of PHC that may disorient the actions of bonding and longitudinality of care.

It is considered that the FHS health team operates in a territory considered a place of interaction between people and health services, characterized by a specific population, with defined health problems, with health conditions and determinants and that should be used for health planning guided by the context of life of the population in the territory.⁸

It is important for the work process of this team to understand in the territory analysis the degree of effectiveness, determined by the intervention capable of producing benefits to users and PHC, referring to the attention capable of preventing diseases or controlling acute episodes resulting of chronic conditions,⁹ and resoluteness, for the ability to solve health problems of individuals in situations of social and biological vulnerability guided by the attributes of access, longitudinality, comprehensiveness and coordination.¹⁰

The two concepts presented are articulated and added to the power of PHC communication with the health care networks as essential to favor the longitudinality of care.

At the national level, the FHS has been experiencing problems related to the physical structure of the services, the scarcity of resources and the insufficiency of professionals.¹¹ The findings of this research pointed to fragility in the articulation between the points of attention of the network, evidenced by the inadequate planning and definition of flows, as well as by the fragmentation of the reference and counter-referral system, which manifests itself in other different Brazilian regions.¹²

The referral and counter-referral system is considered important not only for operationalizing care, but also for providing the most appropriate care resource. In addition, considering the possibility of bonding, territory definition, referral team, proximity to PHC, the use of this system as a resource, also of communication, may qualify care. It is understood that the user can be referred to a specialized service, but still belongs to the territory, PHC remains the closest health service.

It is noteworthy that, after almost thirty years of UHS, specialized attention is a bottleneck

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driven by two extremes of organization of this system, the high cost and PHC13 that add to an emerging need for integration of health services and requires the effective existence of health care and requires the effective existence of the referral and counter-referral system, understood as a mechanism of mutual referral of users between the different levels of technological density of the services.¹⁴

It is understood that the organization of PHC communication with health care networks is essential to enhance the longitudinality of care and the model proposed in the FHS facilitates the monitoring of various moments of the life cycle of individuals, their families, the community itself and a relationship of mutuality in which this collective knows/recognizes the health team.

It appears that believing in the possibility of incorporating evaluation in health services stems from understanding the evaluation from the experience of the actor being evaluated, which contributes to the strategic dimension of management by directing possible information channels in the production of a systematic and systematized process in the light of the local reality, when approaching the decision field to the actors that compose the organization of health services.¹⁵

It is understood, thinking of the opportunity to reflect the evaluation guided by the principle of comprehensiveness, necessarily that will need to be presented to this team tools for work that strengthen the look for the interdisciplinarity that are oriented, by strengthening the actions of health services from the perspective of the work process evaluation, possibilities for continuous improvement, consolidating the integration among the team professionals.

Health assessment, in this field of looking at the work process, is recognized as an important management component that can contribute to decision making and direct interventions and practices within a political, economic, social, cultural and social context. professional.¹⁶

It is known that, in UHS, many nationwide information systems can promote health situation analysis and support better policy decisions, planning, administration, monitoring and evaluation.¹⁷

In this sense, there are, in theory, structural subsidies for the implementation of monitoring and evaluation that could be incorporated into the work process of the team in question.

Integrating with organizational aspects, those that relate to the relational dimension that encompass strategies to favor the continuity of health actions is the strengthening of bonding and accountability relationships between the teams and the assigned population,¹⁸ as inherent actions to the work process, a fact that, although it has a

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strong relational component, it is not disconnected from the organizational aspect of the territory. From the perspective of longitudinality, the model proposed in the FHS facilitates professionals to follow up various moments in the life cycle of individuals, their families, the community itself and, in a mutual relationship that this collective, knows/recognizes the health team

Therefore, it is important that the FHS coordinator reflects with the team professionals on the concept of health team, which can be related to the simple grouping of agents, characterizing a fragmented attention, or even the integration characterized by the articulation according to the proposal of the integrality of health.

It is important to understand the meaning of the weekly meeting for the participants, as this space can be an opportunity for continuous reflection of the work process, the achievement of the established goals, the collective construction of therapeutic projects and the discussion of the feasibility of execution, based on look from different professionals, and become, intuitively, a context of permanent education of the team.

It is argued that working collaboratively in teams committed to health care requires trained professionals, and this form of work should be part of the daily exercise in which agents operate the articulation of interventions and dialogic practice contributes to overcoming hierarchical and social relationships and awakens the potentialities of the actors, which often do not manifest themselves in the individual work routine, representing a possibility of opposition to professional overspecialization.¹⁹

Collaborative interprofessional practice is defined as a possibility for the organization of health care through patient-centered care, based on the interaction between two or more professionals.²⁰

Thus, it is considered that collaborative teamwork is fundamental for the quality of health care and for patient and professional satisfaction.²¹

Regarding the difficulties that permeate communication, one can point out the diversity in the training of professionals, which privileges scientific knowledge, as well as the social differences resulting from the wide range of social actors in health services; Thus, it is necessary to equip health workers, since graduation, with knowledge that provides the exercise of dialogic communicative practices.²²

It is pointed out that a strategy to improve communication is the periodic holding of team meetings to discuss objective and quantitative aspects of the work, as well as being an opportunity for professionals to exchange

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experiences and expectations, thus improving coexistence and the work process.²³

It is found that, for the World Health Organization,²⁴ the education and continuing education of health professionals is very important, since the health workforce is a pillar for the strengthening of health services²⁵ and the organization of the work process is essential for conducting safer practices and articulation of the multidisciplinary team.

The team emphasizes the importance of the presence of nurses, which is essential for action planning and team articulation, besides performing the role of coordinator of the FHS, however, due to the conditions found in the care model proposed in the municipal management, with temporary bond, there is greater turnover, a situation that disrupts the organization of the work process. Contract flexibility in the Brazilian labor market is known to have led to the hiring of staff with unsafe ties to the professional, thus aggravating the precariousness of health work, job instability and wage cuts.²⁶

It is understood that the establishment of professionals can assist in greater preventive actions, improving the use of health services by the population that respects the reach and limits of health teams, as well as reducing the proportion of hospitalizations, increasing the capacity professionals in properly assessing people's needs and favoring the integrality of care and the coordination of actions, that is, results in services with greater user satisfaction.²⁷

Even with a quantitative increase of professionals, it is necessary that health care management favors continuing education actions and conditions necessary to qualify care. Interdisciplinary healthcare teams' qualification strategies for care practice increase their chances of success if configured through effective communication between team members.

CONCLUSION

This study found the need to establish, within the health team, a routine reflection on the organization of the work process. It is evaluated that the use of process evaluation can help in the adoption of judicious and organized strategies that highlight the possibilities of facing the challenges presented in the researched unit.

The need for local management to participate in actions to qualify care, strengthen and redirect the organization of the work process was perceived, as a possibility to increase the performance of the unit manager, which has accumulated in the practice of nurses, the dual role of manager and assistant.

The need to support the coordination of primary care in the instrumental use of AMAQ and to encourage the use of evaluation as a resource

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to support planning meetings is inferred. It is considered important the reflection of these participants, which may have already signaled possible strategies for change, as well as a more concrete dialogue of their responsibilities in the organization of the work process. Given the scenario of few studies in this perspective, in the state of Mato Grosso, these data may direct subsidies for local planning and reflection on the need for studies in this area.

One limitation of this study is the on-site verification of only one unit, which may not reflect, even with defined selection criteria, the reality of the health service, considering local specificities. In this sense, it is necessary to carry out studies that measure, with greater precision, the quality predicted by the PMAQ in these units and a look at the use of national and regional parameters that evaluate the guidelines of the National Policy of Primary Care.

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