FAMILY HEALTH SUPPORT CENTER: BOOKLET N.39
NÚCLEO DE APOIO À SAÚDE DA FAMÍLIA: CADERNO Nº 39
NÚCLEO DE APOYO A LA SALUD DE LA FAMILIA: CADERNO N. 39

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It is reported that the basic care book n. 39: Family Health Support Unit - volume 1: Tools for management and daily work concerns the Family Health Support Centers (FHSC) in the municipalities of Brazil, aiming to increase the effectiveness of the resolution and the quality of Primary Care. It is added that this belongs to the standards and technical manuals, is a publication of the Ministry of Health, the Secretariat of Health Care and Department of Programmatic Actions. It is detailed that this is the first edition of basic care book n. 39, published in 2014, with 118 pages and 50 thousand copies.

It is accessible through electronic means (http://bvsmis.saude.gov.br/bvs/publicacoes/nucleo_apoio_saude_familia_cab39.pdf) and available to professionals and all interested parties. The book is divided into five chapters \ parts and their respective subdivisions: part I - *Primary care and the family health support centers*; part II - *Putting the FHSC into operation*; part III - *Implementing matrix support: some tools FHSC can use*; part IV - *FHSC in the networks: integration between health care network services and intersectoral articulation*; part V - *The use of the information to qualify FHSC's actions*.

Chapter One is directed - *Primary care and the family health support centers* to the routine instruments for administration in the Family Health Support Center and the structure of the Family, and the authors describe these actions in a fragmented way, guiding the professionals. This part is subdivided into the following titles: *But what is FHSC then? What guidelines guide this work?*; *What is the purpose of all this ?*; *What activities can FHSC develop to achieve these goals?*

It is important to emphasize the first sub-item, *The Health Care Network (HCN) reconciled by Primary Care (PC)*, which it tends to be

deliberative and egalitarian so that, in line with actions aimed at the preferential open door space, it can contribute harmoniously to the needs in which people and social groups are most vulnerable. It is described, by the authors, that the Family Health Strategy (FHS) had great repercussion, being recognized even by the Pan American Health Organization (PAHO), however, it brought some difficulties with regard to Primary Care and the model of the care offered through the actions of care and management, establishing resolute behaviors to cover other points of HCN, creating, thus, a model with actions and committed teams.

It is exposed, however, that the health care needs of the population are constant, and public policies need to be organized to respond positively. It is understood, in relation to the other sub-item - *But what is FHSC then?*, by the authors, FHSC as a multi-professional team of different health areas, which supports the professionals of the family health and Primary Care teams, composed of professionals who have undergraduate health and postgraduate studies in Public or Collective Health.

It is mentioned, in another sub-item - *What guidelines guide this work?*, by the authors, that the FHSC is guided by the guidelines of Primary Care, giving support to the teams, focusing on integrality, based on territoriality and sanitary responsibility, teamwork, integrality and autonomy of individuals and groups. It is reported, in subitem - *What is the purpose of all this?*, by the authors, that the main objective is to expand and improve the answers to the quality of care in Primary Care, organizing services, intervening in the support of care, expanding actions and articulating professionals.

Finally, in the last sub-item of this chapter, is it questioned what activities the FHSC can develop

to achieve these goals? It is important, according to the authors, to consider the epidemiological reality of the territory, allowing the FHSC to act in any moments of people's lives, and it is important to recognize that FHSC has two target audiences, the family health care teams and individual users in each reality of life, being the teams composed by multi-professionalism, but also by the singularity of each professional, where each one must contribute in specific thematic areas, needing to plan and balance work dynamically.

It should be noted in the second chapter, entitled *Putting the FHSC into operation*, the implementation of the FHSC will be done when the municipality presents a project that considers the analysis of the territory and the identified needs from the perception of the Primary Care (PC) teams. It is essential that the professionals who will be inserted in each FHSC make a reading of the reality of the place of the territory, taking into account the epidemiological and social situation, the support needs presented by the PC teams, the characteristics of the loco-regional attention network and the demands and health needs of users.

Atribui-se, para essa construção, o número de equipes de AB no município por meio do gestor, a disposição das equipes na RAS e o número de Nasfs a serem implementados. Dever-se-á, na definição do número de equipes que serão vinculadas a cada Nasf, ser garantida uma organização que contemple: o menor número possível de equipes de AB vinculadas por Nasf; a proximidade geográfica entre as equipes vinculadas, identificada por meio de mapeamento do território e a integração entre as necessidades de saúde da população e os recursos do território.

For this construction, the number of PC teams in the municipality is attributed to the manager, the layout of the teams in the HCN and the number of NFHSC to be implemented. In determining the number of teams that will be linked to each FHSC, an organization should be guaranteed that includes: the smallest number of PC teams linked by FHSC; the geographical proximity between the linked teams, identified by means of mapping the territory and the integration between the health needs of the population and the resources of the territory.

It is explained that, with the new insertion of the professionals, they will seek to face a set of new challenges before their knowledge, therefore, they will receive the maturity after the challenges to work in the logic of the matrix support. It is necessary that there is a development of agreement, renegotiation and communication with the teams of PC so that there is the possibility of support among the teams, bringing the link as a way of contributing to the improvement of most health problems in Primary Care, along with other services offered and of the management, criteria

and flows, when necessary, favoring a direction in the actions to be developed in the matrix support.

It is known that some actions are fundamental for the elaboration of the integrated work from the perspective of mutual accountability among the professionals involved, as well as the recognition of the territory and the HCN by the FHSC to the agreement with the related teams. The recognition of the territory by the FHSC team can be initiated based on the information already raised in the mapping by the municipal management during the construction of the project that was implemented.

The PC teams are considered as reference for the care of a certain population in a defined territory under their sanitary responsibility. They should therefore be accessible to spontaneously respond to and respond to this population in a longitudinal manner through advocacy, prevention, treatment, rehabilitation and harm reduction, and to coordinate their health care network. It is emphasized that FHSC's mission, in turn, is to support the work of these teams in HCN, broadening the scope, scope and quality of actions in Primary Care, and contribute to the increase of their capacity of care.

It is noted that the action of the FHSC is different from the outpatient model focused on scheduling specific queries offered by professionals according to their specialty; on the other hand, one of the possibilities of intervention of these professionals is to articulate the technical-pedagogical dimension, seeking the improvement of skills and permanent education to guide the professionals of the teams on how to do.

The third chapter is entitled - *Implementing matrix support: some tools FHSC can use*. It is divided into eight topics: *Working with groups; Technical fundamentals that facilitate the structuring and organization of group work; Unique Therapeutic Project (UTP); Genogram; Ecomap; Shared home care; Shared individual attendance and Specific individual attendance*.

There is matrix support as a strategy to improve health where several teams can pool resources with therapeutic-pedagogical interventions, thus broadening the services offered. Nasf is the function of entering Primary Care, both with actions and with professionals, participating in discussions, interventions, unique therapeutic project, as well as other services.

It is shown, in the first topic - *Working with groups*, the importance of this resource, where groups can be identified as: open reception groups; thematic groups related to certain pathologies (hypertension, obesity, diabetes); thematic workshops (income generation, crafts); medication groups; therapeutic groups and others. Psychic support and interaction between those involved is favored. In a kind of collective consultation, health education is carried out and,

considering that general hospitals and outpatient clinics do not address these issues, Primary Care needs to highlight these problems, giving continuity to and valuing group spaces.

These techniques generate significant changes in the lives of users, and the strength of bonding, receiving, listening and support make these moments important, promoting and preventing illness. Among the activities, community therapy is developed, an approach that exists throughout the country where people can share their pain and suffering, being a therapeutic area of specific mental disorders where any member can lead and follow up the therapy. It is added that another point is the living groups where the groups of the third age are inserted, differentiating themselves from the other groups, because in these, there can be celebrations, moments of socialization inside and outside the unit, always in the community, manual work, since they have a particular action of social reintegration of the patients. It is recalled that there is a group of women, carried out in the units of Primary Care as support and support that strengthen self-esteem, the bond with the team, with open themes and without defined themes where issues such as violence, gender discrimination and other themes chosen.

It is possible to emphasize, as group work methodologies, also, some groups such as the motivational one, being it dynamic, reflexive, democratic and with autonomy, where they are defined as the activities will be; therapeutic groups, where experiences are shared, favoring self-knowledge, and motivational groups that offer help for a change in a particular area of the user, such as behavior, for example. The second topic is the technical foundations that facilitate the structuring and organization of group work, showing at the beginning the basic structure of a group meeting, which has three phases: presentation, development and closure.

Strategies are used to ensure everyone's resourcefulness and there is a concern for feedback and final considerations from all involved at the end of the meeting. It becomes clear that every meeting needs a contract to be a success and one of the rules of the guidelines is secrecy. The dynamics of the group should be consolidated, providing reflections in a light manner. It is believed that in the meetings, communication is extremely important, as well as non-verbal communication that occurs, and the moderator / facilitator's expertise is needed, as well as the planning of activities with group discussions, and this topic shows a step by step so that a wheel has a positive balance.

It is approached, in the third topic, the *Unique Therapeutic Project (UTP)*, which is a set of observed individual behaviors that can be worked on and supported by the FHSC team. It is a variation of the clinical case discussion used in

specific cases, and is an intervention device that generates challenges due to its methodology, which offers team discussion and sharing. Four stages should be followed for its construction: diagnosis and analysis; definition of actions and goals; division of responsibilities and reassessment. It is necessary, for the resolution, of support of the team, because to build a UTP is a shared process and, therefore, it is important the participation of the user in its definition, as well as of the family and the professionals.

It is discussed in the fourth topic about the *Genogram*, whose function is to organize the family data quickly and dynamically, identifying the problems and improvements in each family through symbols. It is clarified that each familiar characteristic has a certain symbol, which should be used, such as: sex; pre-existing disease; marriage; children; divorce; death; on gestations; family relationships and other characteristics that are important to the unit.

The fifth topic is *Ecomap*, which is an instrument for family assessment where there is an association between the genogram for both diagnostic and health planning purposes, and the ecomap represents the interactions of the family with people, institutions or groups at any given time. A constant updating is needed according to the modifications of the families, and the areas represented in the ecomap are: health services; community groups such as churches, schools and education services; significant personal relationships and work.

There is talk, in the sixth topic, about *Shared home care*, which requires a series of skills such as: posture; ethic; listening to the family; the presence of the community health agent is paramount, helping the health team to have free transit in the community and among its members. It is revealed that it is an activity that involves family, different professionals and groups like FHSC and professionals of the FHS. The seventh topic refers to *Shared Individual Care*, considered the most frequent modality in the FHSC, which strengthens the bond between the family health team and the FHSC support team, facilitates communication, allows the supporter a contact with the patient's reality and gives the team opportunities for discussion before and after care.

It is explained that the eighth and last topic of this chapter is the *Specific Individual Service*, where the need of the territory of the user and the family implies the frequency of the specific services, and there are places where the network, for services, is smaller than the flow which needs it, and greater investments are needed in health services. It is necessary that the team understands the real needs of the community and is able to intervene, solve problems and prevent injuries.

It is reproduced in the fourth chapter entitled *The FHSC in the Networks: Integration between*

Services of the Health Care Network and Intersectorial Articulation, that the Health Care Networks (HCN) are organizational arrangements, of various demographic densities, that seek to guarantee the integrality of care, and can generate political and administrative consequences. It became, by the way, fundamental for link building, diversified demand, epidemiological transcription and coping with the fragmentation of the health system.

It can be implemented, considering the integrality as a doctrinal principle of the Unified Health System (UHS), through an integral view of the patient linked to the ideas of prevention and health promotion, building a link between professionals and users. They can also act by providing actions and services at different levels of complexity of the system, without interruption and through thematic networks that bring lines of care together with the HCN on specific issues and groups such as the Stork Network.

It is added, with respect to PC, that it is the communication center of HCN, coordinator of the care and ordering of the actions and services that are available on the network and, along with it, the Family Health Support Center (FHSC), which is a multi-professional team that is complementary to the PC teams. It is sought that this team is an organic member of the PC, guaranteeing longitudinality of the care and favoring the organization of care flows that facilitate the coordination and the provision of direct services to the population.

In this proposal, we catalyze the establishment among professionals / teams of different services, networks and assistance flows in the territory of action. Added to this is the matrix support, which discusses cases and elaborates the construction of the singular therapeutic project (UTP), becoming individual and shared care. It is, therefore, based on the articulation with specialized teams, PC a place with integrated care practices and qualified question, regulating access with professional decision, and its resolution is fundamental in the coordination of care. Should the FHSC seek a shared care, avoiding professional care of a specific place (example: FHSC or ambulatory).

It is necessary that the teams of FHSC and PC jointly discuss the most important cases, aiming at integrative activities to explain the importance of each professional in solving a case. In addition, the FHSC can qualify the referrals by means of a regulatory function following only the necessary cases.

It is sought to evaluate, based on intersectoral articulation, the living conditions of users, the environment and how it affects health, developing integrative actions and avoiding social exclusion. This articulation is one of those used in PC, since it involves several sectors and other policies, such as security and education, aiming at promotion

and prevention in the search for integrality. It is hoped that FHSC is the ideal partner of the PC teams to develop this articulation by having better knowledge about the networks of performance.

In this sense, it is also described in this chapter, by the authors, on the Street Doctor Teams (SDT), which come with the responsibility of articulating and paying full attention to the health of street people, in a fixed or mobile, seeking to broaden access through a proactive approach. FHSC can leave the SDT more resolute with the integration of the teams, the discussion of UTP and intersectorial articulation.

It is mentioned by the authors, another service offered, which are the Health Academies, with the aim of promoting health, favorable lifestyles and self-care. These poles are called these spaces and their use is enhanced by the actions of the health professionals of the PC, and the use by FHSC extends PC's collective intervention. Specialized mental health teams should work to promote articulation between local health units and mental health services. It should also be pointed out that these services are open doors for spontaneous care and demand and, soon afterwards, are referred to the best treatment.

Another service is, *the Health in School Program (HSP)*, which comes as an intersectoral policy to realize integral attention of promotion, prevention, diagnosis and training where the teams work together with the parents and teachers according to the age. It is pointed out, for the HSP organization, that there are listening groups about the problems that are formed by professionals from the PC and the school to discuss about such problems.

This is the last topic of the chapter described *Home Care Service - HCS (Best at Home Program)*, which is a home care that seeks a coordination of the care of users in home care in their territory. It is also emphasized the importance of FHSC in the rehabilitation of bedridden / domiciled users, as they present difficulties to perform daily activities, as well as in the discussion of cases and construction of UTP.

It is exposed, in the fifth chapter - *The Use of Information for the Qualification of FHSC Actions* by means of other subtopics such as: *Monitoring and evaluation: Conceptual aspects; How to evaluate the set of FHSC activities; Sentinel events and tracers; Self-assessment to improve access and quality of Primary Care; Logical model or theoretical model (program design); How to evaluate the effectiveness of FHSC actions; The registration and use of information by the FHSC teams and the Health Information System for Primary Care (Sisab).*

Evaluation and monitoring have been increasingly considered as positive processes for improving the quality of health services. By incorporating evaluation and monitoring as

systemic practices, useful information can be provided to assist in the definition of intervention strategies, decision-making and professional organization of work.

It is emphasized that monitoring and evaluation as practices may or may not be based on well-defined standards, criteria and instruments (good standing, capacity for analysis, sensitivity and attention are elements that can also allow assessments without awareness or need to name whether what is being done is evaluation or not).

It should be noted that there is some information that can support the choice of monitoring priorities, among which we can mention: health situation of the population assigned to the reference PC teams; results of pacts carried out at the municipal, state and / or national levels; markers for monitoring the work of the Primary Care team (s) (eg the degree of autonomy to manage certain conditions or tools); markers for the monitoring of FHSC actions in the territory, such as the priority actions for the beginning of FHSC activities. It is possible to evaluate the actions developed by FHSC in its clinical-assistance or technical-pedagogical dimensions, resulting in the definition on what should be considered adequate for its practice.

For this, parametric parameter demarcation is necessary to evaluate if the expected results are being achieved. It is important to note that, in the evaluation process, it is important for FHSC managers, coordinators and professionals to discuss / define criteria or guidance instruments for evaluation and to elaborate intervention instruments (plan, matrix or something along these lines) in a way integrated with planning of actions. Another element in the evaluation process, which is the result of previous evaluations, is a rich object of analysis so that the team can monitor the execution of the intervention plan, as well as analyze the progress made, so that a situation or problem is not representative from the point of view of the territory in question but influences the results observed in monitoring and evaluation, as in the case of sentinel events and tracer or marker cases. These techniques become appropriate when dealing with daily situations in the health services, that is, for the moments when there is no need for extensive diagnoses, but rather an instrument that points the way and helps to monitor and feedback health practices.

In order to improve the access and quality of Primary Care, a self-assessment is made to induce the implementation of self-assessment processes for the teams. This instrument establishes quality standards in compliance with current technical and scientific standards and documents, expressing the desired results.

It is suggested, through this tool, the use of a method for the construction of a matrix of interventions in which a plan of action will be drawn up containing: identification of strategies to reach the goals / targets; activities to be developed; resources; expected results; deadlines and mechanisms and indicators to assess the achievement of results. It is mentioned later by the author on the logical model, which is a scheme that shows the theory of a program or intervention by demonstrating the causal relationship between the activities advocated and the effects expected to reach the objectives previously agreed upon.

The models should be presented in a visually clear way, allowing the understanding of the relationships between the interventions and the expected effects to be achieved, presenting in the form of a figure, table, flow chart or map the sequence of steps or relationships that lead expected effects. It is possible to visualize, through this instrument, the design of the program's operation and its main components, allowing the systematic checking of the organization of the program to achieve the expected results.

The effectiveness of FHSC's actions is evaluated by observing the results achieved in relation to the defined objectives of an action or program implemented. It is therefore important for teams and managers to be clear about these results and expected objectives, to define and prioritize mechanisms for recording priority actions and activities.

It is supported by the adequate registration of the actions developed by FHSC professionals, in the e-UHS PC or other information systems available, in the continuity of care to individuals, enabling the sharing of the conduct between professionals and allowing the constant improvement of the process of work and services offered through the monitoring and evaluation of the data collected.

It is critical, for this to happen, that municipal management and PC teams, with the support of the Nasfs, develop strategies for expanding the information culture in order to create meaning for teams on how important proper registration and stimulating the use of available information. The Health Information System for Primary Care (HISPC) is used to restructure the current information system (Siab), presenting a modern technological platform composed of two software systems, namely: e-UHS PC, with Electronic Citizens Health Records (ECHR), and e-UHS PC, with Simplified Data Collection (SDC).

It is demonstrated, with e-UHS PC / HISPC, that Nasf professionals now have a national information system to use with other Primary Care teams. In the e-UHS PC with SDC, by the Nasf, three of the seven available data sheets can be used: individual answer sheet, procedure form and

collective activity form. There will be professionals, in the e-UHS PC with ECHR, access to different modules with their respective functionalities, which are: *Appointments*, having access to the list of attendance of citizens, adding individuals to the list, performing initial listening and the appointment; *Citizen*, with consultations of the registers, register of new citizen and edition of register data; *Schedule*, with making appointments and printing of the daily schedule of the professional; *Reports*, with generation of reports; *SDC*, with the visualization and typing of the files of the system with simplified data collection, including the collective activity files and of procedures, that are not contained in the ECHR.

It is recommended that this literature, which has a great relevance for the academic growth of students and health professionals, acting in a multiprofessional way, since it is able to describe, in an exceptional way, a primordial content related to collective health, addressing a theme of extreme relevance for the development of health care professionals' research and practice.

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