REME • Rev Min Enferm. 2018;22:e-1137
DOI: 10.5935/1415-2762.20180066

RESEARCH

PRIMARY HEALTH CARE: THE COORDINATOR OF THE CARE INTEGRATION IN THE EMERGENCY AND URGENCY NETWORK

ATENÇÃO PRIMÁRIA À SAÚDE: ORDENADORA DA INTEGRAÇÃO ASSISTENCIAL NA REDE DE URGÊNCIA E EMERGÊNCIA

ATENCIÓN PRIMARIA DE SALUD: ORDENADORA DE LA INTEGRACIÓN ASISTENCIAL EN LA RED DE URGENCIAS Y EMERGENCIAS

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Submitted on: 2018/01/10 Approved on: 2018/08/14

ABSTRACT

Primary health care (PHC) is considered the main gateway to the health care network; however, there are difficulties to achieve it as such. Therefore, the objective of this study is to analyze the integration between the health unit and the emergency care unit (ECU – "*Unidade de Pronto-atendimento*", in Portuguese), with the PHC as an Emergency and Urgency Network (EUN) coordinator. It is qualitative, descriptive and exploratory research. During the data collection, 49 interviews were conducted with physicians, nurses and health managers between February and June 2015 in a capital city in the southern region of Brazil. From the data processing to the textual analysis performed by the IRAMUTEQ software, four classes emerged: formal and informal communication in the health organization; population access to health services; integration between HU and ECU; HU and ECU roles in the health care network. The research showed that the care integration between PHC and ECU is fragile and disjointed with the other services that make up the health care network, boosted by the lack of definition of the attributions of each EUN component by system managers and healthcare professionals, as well as the overlapping of roles between the HU and ECU.

Keywords: Systems Integration; Primary Health Care; Health Services Accessibility.

RESUMO

A atenção primária à saúde (APS) é considerada a principal porta de entrada na rede assistencial à saúde, no entanto, apresentam-se dificuldades para efetivá-la como tal. Portanto, o objetivo do artigo é analisar a integração entre unidade de saúde (US) e unidade de pronto-atendimento (UPA), tendo a APS como ordenadora da rede de urgência e emergência (RUE). Trata-se de pesquisa qualitativa, descritiva e exploratória. Na coleta de dados foram realizadas 49 entrevistas com médicos, enfermeiros e gestores de saúde, entre fevereiro e junho de 2015, em uma capital da região Sul do Brasil. Do processamento dos dados para a análise textual realizado pelo software IRAMUTEQ resultaram quatro classes: comunicação formal e informal na organização de saúde; acesso da população aos serviços de saúde; integração entre a US e a UPA; funções da US e da UPA na rede de atenção à saúde. A pesquisa revelou que a integração do cuidado entre a APS e a UPA mostra-se frágil e desarticulada com os outros serviços que compõem a rede assistencial à saúde, potencializado pela indefinição das atribuições de cada componente da RUE pelos gestores do sistema e profissionais assistenciais e a sobreposição de funções entre a US e a UPA.

Palavras-chave: *Integração de Sistemas; Atenção Primária à Saúde; Acesso aos Serviços de Saúde.*

How to cite this article:
Ros C, Peres AM, Bernardino E, Lowen IMV, Poli Neto P, Moura MEB. Primary health care: the coordinator of the care integration in the emergency and urgency network. REME – Rev Min Enferm. 2018[cited _____ ___ ___];22:e-1137. Available from: _____ DOI: 10.5935/1415-2762.20180066

RESUMEN

La atención primaria de salud (APS) está considerada como la puerta de entrada a la red de asistencia de salud. Sin embargo, hay dificultades para hacerla realmente efectiva. El objeto del presente artículo es analizar la integración entre la unidad de salud (US) y la unidad de urgencias y emergencias (UPA) ya que la APS es la ordenadora de la Red de Urgencias y Emergencias (RUE). Se trata de una investigación cualitativa exploratoria descriptiva. Para la recogida de datos se realizaron 49 entrevistas a médicos, enfermeros y gestores de salud entre febrero y junio de 2015, en una capital del sur de Brasil. Del procesamiento de datos para el análisis de texto, realizado por el software IRAMUTEQ, resultaron cuatro clases: comunicación formal e informal en la organización de salud; acceso de la población a los servicios de salud; integración entre la US y la UPA ; funciones de la UPA en la red asistencial de salud. La investigación reveló que la integración de los cuidados entre la APS y la UPA es frágil y desarticulada con los demás servicios que componen la red asistencial de salud, agravada por la falta de definición de las atribuciones de cada componente de la RUE, por los gestores del sistema y profesionales asistenciales y por la superposición de funciones entra la US y la UPA.

***Palabras clave**: Integración de Sistemas; Atención Primaria de Salud; Accesibilidad a los Servicios de Salud.*

INTRODUCTION

Health systems have the responsibility to ensure universal access to health care and to meet the needs of the population. These are expressed in the different health situations that require care and an inclusive and resolute service organization, with integration between the care points of the health system.[1]

Primary health care (PHC) is considered the point of communication of the health care network (HCN) and has the role of coordinating the care provision.[2] In systems with barriers to access to services, there is evidence of the loss of continuity of care and the lack of coherence between the services provided and the health needs.[3] Therefore, the way to organize the health systems can only be effective if it is people-centered.[4]

The PHC, which is the coordinator of care, organizes and rationalizes the use of all the basic and specialized resources directed to the promotion, maintenance and improvement of health.[5] In line with the theoretical framework proposed by Barbara Starfield, this study assumes that the difficulties begin with the PHC focused primarily on programmatic care, to the detriment of the reception and care of people affected by low-complexity acute conditions that generate referrals to emergency care units (ECU), which, in turn, carry out symptomatic treatments, with serious damage to a comprehensive care.[6]

The Brazilian emergency and urgency services are very crowded, with demands that mix, in the same environment, people in situations of real urgency and emergency and others of low complexity, which has interfered in the work process of the teams and in the quality of care provided.[7]

When considering the fragmentation of care, the difficulty of making PHC as the preferred gateway and the integration of the services, it is necessary to use strategies that contribute to the reorganization of services, in the expansion of access and comprehensive care, which is also proposed by a study carried out in Canada, integrating specialized units with teaching hospitals.[8] In this sense, the aim of this research was to analyze the integration between the health unit (HU) and the ECU, with the primary care as the emergency and urgency network (EUN).

METHODS

It is qualitative, descriptive and exploratory research. The researched South-Brazilian municipality is organized in 10 health districts (HD), with a total of nine ECU and 110 HU, of which 66 have family health teams and 44 are HU without the *Estratégia Saúde da Família* (ESF) implemented. The criterion for choosing one of the HD was to perform the highest number of visits per day in its ECU, in comparison to the other ECUs in the municipality.

As inclusion criteria of the participants, a physician, a nurse and a local manager who worked in the ECU were chosen, the same numbers and professional categories that worked in the 18 HUs of the HD, besides three managers of the central level of the MHD and a district manager related to the PHC or EUN. Physicians, nurses and managers were excluded from their activities due to vacation, premium leave or health treatment during the data collection period.

The data collection was carried out from February to June 2015. Of the 58 professionals surveyed, 49 were available and accepted to participate in the research through an interview. Of these, 12 were physicians and 16 were nurses working in the ECU or in the HU, 17 were local level managers, three from the central level of the Municipal Health Department (MHD) and one from the HD.

The interviews were guided by a semi-structured script and carried out in a reserved place and defined by the participants during their working hours, by prior telephone scheduling. All of them were informed that it was a research, its objectives and the procedure of data collection, and they were included after signing the free and informed consent term.

The 49 interviews had the average duration of 15 minutes, recorded with an application of the cellphone and transcribed by the researchers. Participants were characterized regarding their gender, age, professional training, time in the profession and permanence in the current position. The questions asked in the survey were: what are the responsibilities of ECU and HU? What characteristics distinguish the ECU from the HU? From your perception, how does the integration of the ECU with the

HU occur? Indicate the facilities and difficulties. What are the reasons for the user to seek care in the HU or in the ECU? The field notes made by the researchers subsidized the discussion. Of the participants, 21 (42.8%) were managers, three from the central level, one from the district and 17 local managers from the HU and ECU, in addition to 16 (32.6%) nurses and 12 (24.4%) physicians, healthcare professionals from the HU and ECU.

The data processing was performed by the software *Interface de R pourles Analyses Multidimensionnelles de Textes et de Questionnaires* (IRAMUTEQ) developed in France by Ratinaud in 2009. Its use in Brazil started in 2013, predominantly in social representations, however, several researchers from other areas have been using this tool.[9-11] IRAMUTEQ provides five different statistical analyzes of texts, of which the Hierarchical Descending Classification (HDC) was used. Each interview is considered an Initial Context Unit (ICU) and its set is called *corpus*, which was prepared from two variables coded according to the number of the participant and the professional category, nurse or manager.[12]

The classes are represented through a dendogram that allows their visualization, percentage of the Elementary Context Unit (ECU) of each class and the connections between them. Each ECU, also called a text segment, has around three lines and its set in each class represents a topic to be analyzed. It is considered that the total use of the ECUs should be at least 70% from the most frequent words and with a value of χ^2 equal to or greater than 3.84. The higher the value of χ^2, the greater its association with the class.[12,13]

The textual analysis deals with the verbal analysis transcribed and can come from texts, interviews and documents, among others.[14] In this research, the textual analysis was performed by the researchers after the data processing and from the assumption that the PHC is the care coordinator.[5]

The research was submitted to the Research Ethics Committee of a public university and to the Research Ethics Committee of the municipality, in accordance with the Resolution No. 466 of December 2012 of the National Commission for Ethics in Research of the National Health Council and approved under CAE number 33867114.0.0000.0102 and the substantiated opinion of the co-participating institution under No. 848.555.

RESULTS

Of the 49 interviewees, six were males and 43 females, with a mean age of 42 years old, mean training time of 16 years, mean time in care provision of 9.6 years and mean time in management of four years. Most of them took *stricto* and/or *latosensu* postgraduate courses in different areas of knowledge; only one of them attended the first specialization and another had not attended it.

In the data processing through the software, 84.69% of the textual material was used, which resulted in 979 ECUs. The four classes, according to Figure 1, presented aspects related to integration, communication and access to services, called: class 1 – formal and informal communication in the health organization; class 2 – population access to health services; class 3 – integration between HU and ECU; class 4 - HU and ECU roles in the health care network.

Class 1 – formal and informal communication in the health organization – presented the forms of communication established between health professionals and managers and between them and users, according to the following reports:

> *Because when you refer a user, you can hardly make telephone contact with the person on call. I have already had the opportunity to call the service and I got transferred several times, the call broke several times and I could not talk to the person on call, until I found out that it was a colleague who works with me elsewhere and call his private telephone, only then I was able to refer the patient [...]* (Doc. 5).

Class 2 – population access to health services – brought results on the access of people to health care in the HU and in the ECU, based on statements related to the organization of the service, the work process, the link and on issues understood as cultural.

> *Geography makes it easier for him to come to ECU [...], for the user, the complaint is that often the attendance at the HU will take long [...]* (Man. 19).

> *They do not want to wait all day at the ECU to be attended, they prefer to come here, to the HU [...]* (Doc. 9).

Class 3 – perception on the integration between HU and ECU – the integration between HU and ECU was approached from the perspective of the participants, according to the following statements:

> *I think the integration between the ECU and the HU is very bad, of course the users arrive there at the ECU and there are some that did not need to be there, but they are and that suffocates the ECU [...]* (Doc. 4).

> *[...] when having the three equipment, we will have serious difficulties of dialogue due to the characteristics of the ECU and of the professionals that work there, by the way the ECU was implanted; to have it dialogue well, both with the hospital and with the PHC, it has a birth defect [...]* (Man. 17).

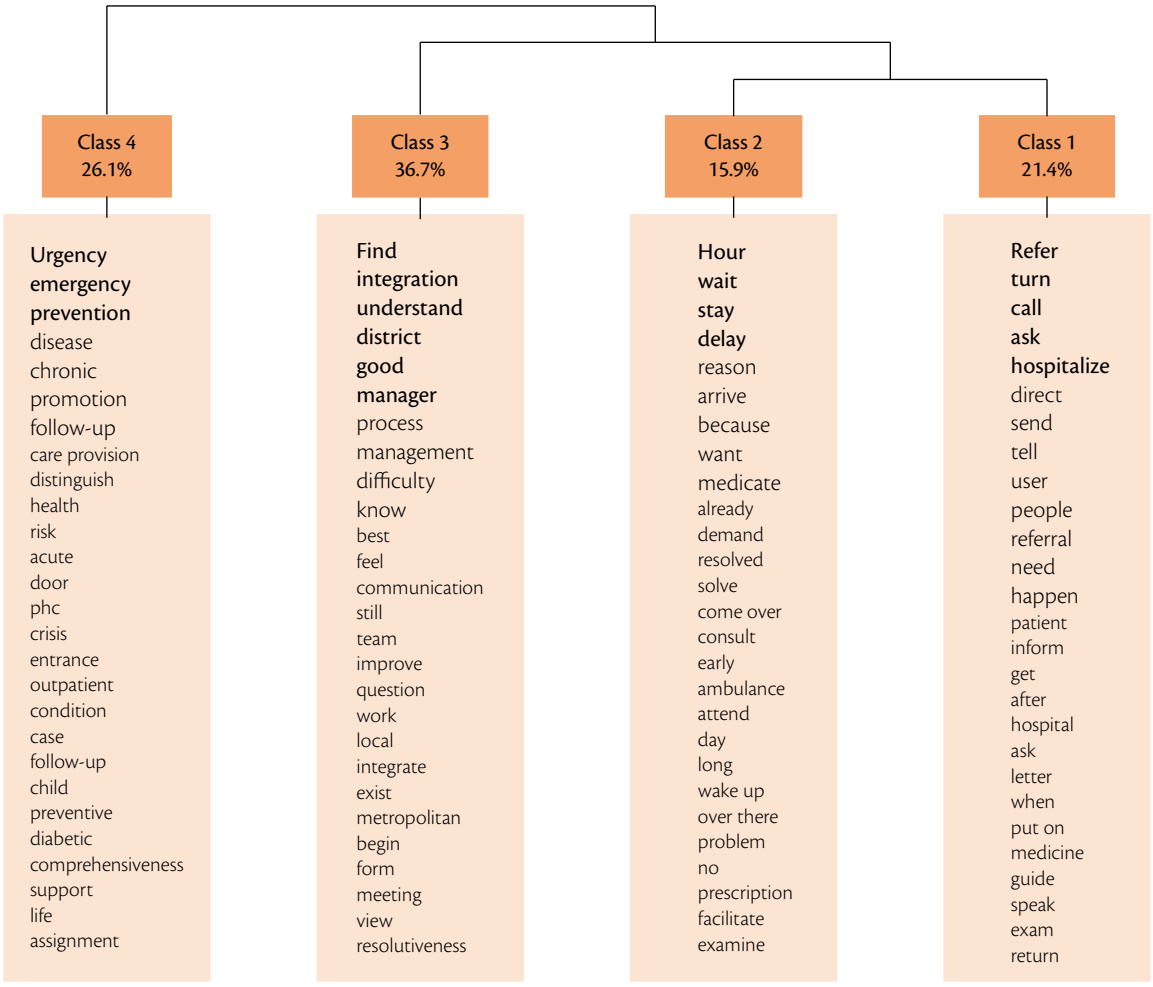

Figure 1 - Class Dendogram - The relationship between the EUN and the PHU having the latter as care coordinator.
Source: primary data collected from the research.

Class 4 – HU and ECU roles in the health care network – presented results on the understanding of the professionals and managers on the roles of the HU and ECU, considering the implementation of the services, the organization and the complexity of both.

> *The ECU responds to the urgencies, the acute and not the chronic diseases, and the HU must respond to the chronic part, to meet the chronic demand of the day to day that are not the urgencies and emergencies [...]* (Nur. 4).

DISCUSSION

The majority of the participants have a *latosensu* training and preparation for activities linked to the Unified Health System (*SUS – "Sistema Único de Saúde"*, in Portuguese), which are data similar to the study developed in another institution with PHC in the Northeast region of Brazil.[15] The experience time of the professionals in the care provision, more than 11 years in most of the cases, suggests more professional experience and bond with the population served.

The forms of informal communication are the telephone contacts that are usually based on friendship, without register in the medical record. This communication, known as "corridor network", is understood as the core of informal communication. Generally, it is agile and facilitates the information and it is difficult to interrupt it, because there is no accountability for the information transmitted.[16]

The formal communication is affirmed from the existence of an electronic medical record and the letter, which would be the referral guide and counter-referral. The use of online interactive systems, networked systems and integrated systems, despite presenting flaws, allows professionals to share files and information, making communication efficient, using technologies such as social networks, text messaging, e-mail and intranet.[16,17]

The electronic medical record is a tool used to improve integration, having as main advantages the quick access to the health history, improved time management, planning and qual-

ity of care. However, there is still resistance from health professionals regarding the use of new technologies, which is due, in most cases, to a lack of computer skills.[18] The research participants highlighted the electronic medical record as positive in relation to the integration and continuity of care. On the other hand, lack of registration is recognized as a great difficulty, both in terms of the resistance of the professional who makes incomplete, simplified and the non-registration.

The challenges and importance of the registers in the electronic medical record, referral and counter-referral guide as practical communication forms are highlighted, avoiding comings and goings of the users, but mainly in the perspective of advances in the continuity of care.[19,20]

Access consists of not restricting people's access to health services and the facility to obtain care whenever they need and in the most comfortable way.[21] The ECU has easy access, extended hours, favorable geographical location and serves all the people who seek the service.[22]

The HU has limited days and hours of operation, its population is defined by the territory, it has difficulty scheduling of appointments and, by organizing its work process, it often fails to attend people on the same day or at most the next day. These are evaluation criteria considered relevant to a quality PHC.[23,24]

For professionals, the difficulty of expanding the access is related to excess demand, the way the work process is organized and the lack of professionals in the HU, which shows difficulties in combining the team's ability to offer appointments to users' demands on a daily basis.[25] It is recommended that to improve the access and meet the users' needs, BU nurses, physicians, and other professionals should have open schedules throughout the work shift.[24]

The perception that the choice of place of care is related to culture and lack of understanding about the organization of the system refers to the speech in this research about the organization of the PHC to the other, as if the interviewee were not a user of the health system. Therefore, there is a mismatch between the legal norm and the discourse of SUS professionals, managers and intellectuals.[26]

The findings regarding the integration between the HU and the ECU show an initial difficulty of the ECU, which competes with the hospital emergency and with the PHC. It is still a great challenge to integrate the various levels of care and support systems and logistics to support the flow of communication, as highlighted in an integrative review, which identified these and other weaknesses found in PHC as coordinator of HCN.[23]

The failures in communication between professionals of different hierarchical positions are due to the amount of levels in which the information is filtered, the space distance and the presence of subgroups that affect the messages to be transmitted and the way they are perceived.[16]

A study on accessibility and demand in a ECU indicates that people learn to use the health services from their needs, and their choices are guided by their experiences,[24] which contrasts the statements about the lack of understanding of the population regarding the organization of the system.

Most of the professionals and managers have clarity regarding the identification of the ECU assignments. Regarding the attributions of the PHC, they identify that its main role is to carry out actions of health promotion, prevention of illness and chronic conditions.

In general, the PHC in Brazil persists with the vertical vision of programs and protocols, which has repercussions on a rigid and fragmented model of SAR, with an emphasis on the preventive vision and scarce development of clinical actions. This way of organizing the PHC, selective and in priority groups, makes the symptomatic people, in most cases mild, to look for the ECU.[25]

There was a contradiction between the overlapping of ECU and HU roles regarding the different ways of organizing the access in the PHC and at the ECU It was also identified the existence of a service gap in the speeches of professionals and managers, when manifesting, on the one hand, that the PHC should not address acute situations, but focus on actions to promote and prevent diseases; and on the other hand, that it would not be the role of ECU to attend acute low-risk situations. Although there is concern about these cases, with the discontinuity of care and the fragility of integration between these points of HCN, there is no organization of the work process that contemplates this need of the user and the services.

CONCLUSIONS

In the search for an understanding of the relationship established between the health unit and the emergency care unit, aspects related to communication, population access to health services, work process and the understanding of the roles of each equipment in the health care network were found.

The data show that the integration between the PHC and the ECU is fragile, fragmented and disjointed with other services that make up the HCN. It is evident the lack of definition of the roles of each equipment, of the managers themselves, as well as the healthcare professionals who expressed that the care provided to users in acute low risk situations is not attributed to the PHC or to the ECU.

The research provided a more critical insight about how the health system is organized. One limitation was the adjustment of the time of data collection to the availability of the professionals; however, they were willing to contribute to the research.

It is recommended to improve the integration tools already being used in the municipal network, such as the electronic medical record, as well as to promote innovative actions

that enhance the communication and integration between professionals and health services.

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