




EVALUATION OF THE COORDINATION OF CARE BY USERS OF PRIMARY HEALTH CARE SERVICES

AVALIAÇÃO DA COORDENAÇÃO DA ATENÇÃO POR USUÁRIOS DOS SERVIÇOS DE ATENÇÃO PRIMÁRIA À SAÚDE

EVALUACIÓN DE LA COORDINACIÓN DE LA ATENCIÓN SANITARIA POR USUARIOS DE LOS SERVICIOS DE ATENCIÓN PRIMARIA DE SALUD

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ABSTRACT

Introduction: the coordination of care is shown as a strategic point of interventions in primary health care (PHC). **Objective:** to evaluate the quality of PHC services in a regional health coordination through users in the dimension of coordination of care. **Method:** analytical, cross-sectional study, in which 1,071 adult users from 32 municipalities that make up two health regions were interviewed. The primary care assessment tool (Primary Care Assessment Tool) Brazil was used in the adult version, and Pearson and Kruskal-Wallis chi-square tests were performed. **Results:** there was a high score in the dimension "integration of care" in the basic health unit (BHU) (6.66), Family Health Strategy (FHS) (6.34) and integrated BHU (6.87) and high score in the dimension "information systems" at BHU (7.22), FHS (7.09) and integrated BHU (7.27), with no significant differences in the assessment between the different models of care. The dimension of coordination of care, in the present study, was well evaluated, obtaining a high score in the different models of care. In addition, the study indicated that there was no statistical difference between them in PHC, as assessed by users. **Conclusion:** the study contributes so that PHC can be rethought in relation to the model that is being implemented in units with FHS, whose results need to be reflected by municipal and regional health managers.

Keywords: Primary Health Care; Health Management; Outcome and Process Assessment (Health Care); Community Health Nursing.

RESUMO

Introdução: a coordenação da atenção mostra-se como um ponto estratégico de intervenções na atenção primária à saúde (APS). **Objetivo:** avaliar a qualidade dos serviços de APS em uma coordenadoria regional de saúde por meio dos usuários na dimensão da coordenação da atenção. **Método:** estudo analítico, do tipo transversal, no qual foram entrevistados 1.071 usuários adultos de 32 municípios que compõem duas regiões de saúde. Foi utilizado o instrumento de avaliação da atenção primária (Primary Care Assessment Tool) Brasil na versão adulto, e realizados os testes qui-quadrado de Pearson e Kruskal-Wallis. **Resultados:** verificou-se alto escore na dimensão "integração de cuidados" na unidade básica de saúde (UBS) (6,66), Estratégia de Saúde da Família (ESF) (6,34) e UBS mista (6,87) e alto escore na dimensão "sistemas de informação" na UBS (7,22), ESF (7,09) e UBS mista (7,27), não havendo diferenças significativas na avaliação entre os diferentes modelos de atenção. A dimensão da coordenação da atenção, no presente estudo, foi bem avaliada, obtendo alto escore nos diferentes modelos de atenção. Além disso, o estudo indicou não haver diferença estatística entre esses na APS, conforme avaliação dos usuários. **Conclusão:** o estudo contribui para que possa ser repensada a APS em relação ao modelo que está sendo implementado nas unidades com ESF, cujos resultados precisam ser refletidos pelos gestores municipais e regionais de saúde.

Palavras-chave: Atenção Primária à Saúde; Gestão em Saúde; Avaliação de Processos e Resultados (Cuidados de Saúde); Enfermagem em Saúde Comunitária.

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RESUMEN

Introducción: la coordinación de la atención sanitaria es un punto estratégico de intervención en la atención primaria de salud (APS). **Objetivo:** evaluar la calidad de los servicios de APS en un coordinador regional de salud a través de los usuarios en la dimensión coordinación de la atención. **Método:** estudio analítico transversal en el que se entrevistó a 1.071 usuarios adultos de 32 municipios que conforman dos regiones de salud. Se utilizó la herramienta de evaluación de la atención primaria (Primary Care Assessment Tool) Brasil en la versión para adultos y se realizaron las pruebas chi-cuadrado de Pearson y Kruskal-Wallis. **Resultados:** hubo puntuación alta en la dimensión "integración de la atención" en la unidad básica de salud (UBS) (6.66), la Estrategia de salud familiar (ESF) (6.34) y UBS mixta (6.87) y puntaje alto en la dimensión "sistemas de información" en UBS (7.22), ESF (7.09) y UBS mixta (7.27), sin diferencias significativas en la evaluación entre los diferentes modelos de atención. En el presente estudio la dimensión coordinación de la atención fue bien evaluada, obteniendo puntuación alta en los diferentes modelos de atención. Además, el estudio indicó que, según la evaluación de los usuarios, no había diferencia estadística entre ellos en la APS. **Conclusión:** el estudio contribuye a repensar el modelo que se está implementando en la APS en las unidades con ESF y sus resultados deben ser considerados por los administradores municipales y regionales de salud.

Palabras clave: Atención Primaria de Salud; Gestión en Salud; Evaluación de Procesos y Resultados (Atención de Salud); Enfermería en Salud Comunitaria.

INTRODUCTION

Health assessment is related to quality control, since, when assessing, the services offered are continuously monitored, in order to identify and correct weaknesses found early, providing the improvement and development of the services evaluated. Evaluation is understood as a formal intervention that requires resources and actors committed to improving decisions.¹

In the same way, the evaluation of health programs and services aims to improve their execution, as far as it increases their effectiveness and efficiency by providing useful information for a better distribution of infrastructure and available resources. Added to the assistance in conducting the cycle of planning, development, implementation and operationalization of future programs.^{1,2}

The coordination of care is shown to be a strategic point of intervention. It is understood as a set of actions aimed at the continuity of care, with the perspective of the articulation of health services, in order to compose a synchronized intervention and with the common objective of integrating and rationalizing the system and the use of information about individual and collective care, over time and in different spaces, subsidizing decisions and planning.^{2,3}

The search for a new care model centered on Primary Health Care (PHC) stems from a historical social moment,

in which the technician, hospital-centered model no longer meets the emergence of changes in the modern world and, consequently, the health needs of users. In this sense, the Family Health Strategy (FHS) presents itself as a model of care for health services, with the family at the center of attention, incorporating a new look in the intervention process and seeking to implement preventive actions.⁴

PHC is the first level of assistance in the system and its essential attributes are the individual's first contact with the health system, continuity and integrality of care and coordination of care within the system. In addition to three other derived attributes: family and community orientation and cultural competence.² Based on this, there is a friendly, resolute PHC perspective that advances in the management and coordination of user care in the health care network (HCN).⁴

In this context, the coordination of care has the capacity to guarantee continuity of care in the different points of the HCN and its essence is the availability of information about previous problems and services and the recognition of these to meet current needs. Without coordination, longitudinality would decrease its potential, integrality would be compromised and the attribution of first contact would have an essentially administrative connotation.^{2,5}

The evaluation must be implemented in a transversal way in the health actions in the PHC, being understood as a management and care process developed by the multiprofessional team, in a shared way, whose objective is to improve and adapt directions and conduct. Evaluation has a management and support tool for the consolidation of the Unified Health System (*Sistema Único de Saúde, SUS*), as it strengthens or develops the technical qualification of managers, health workers and users in the adoption of monitoring and evaluation actions relevant to planning and management, in addition to subsidize the formulation of policies and assist in the decision-making and training process of the actors involved.³

Thus, the research was conducted with the following question: "how is the degree of coordination of care in the PHC network evaluated by users in a regional health coordinator in *Rio Grande do Sul*?" Therefore, it aimed to assess the quality of services of primary health care in a regional health coordination through users in the dimension of coordination of care.

METHODS

This is an analytical, cross-sectional study with a quantitative approach carried out in PHC in the municipalities of the 4th Regional Health Coordinator (RHC) of *Rio Grande do Sul* (4^a CRS/RS). The aforementioned coordination has

two health regions called *Verdes Campos*, composed of 21 municipalities, and *Entre Rios*, composed of 11 municipalities. The PHC model in these regions has a conventional basic health unit (BHU), FHS and integrated BHU.

PHC is organized based on two models of care, BHU with or without Community Health Agents (CHA) and the FHS. Both are fixed structures located close to the user's home, in geographically delimited areas. Although the BHU are a reference for an enrolled population of 15 to 20 thousand inhabitants, they are not as close as the FHS units, which cover smaller population contingents.⁶ There is also the integrated BHU, where health services can be observed with the performance of an FHS team and a team of the conventional model or specialist professionals, configuring an integrated care model.

Research subjects were adults aged 18 years or older, whose access to the health service was not the first. The sampling was probabilistic, not random and for convenience, with the sample delimited by a sample calculation based on an estimate of the population average, considering the following parameters for the sampling of adult users: population estimate for the year 2014 equal to 559,498 and adults of 406,741 with normal distribution 1.96, $p=0.5$, $e=0.3$ and $\alpha=0.05$.

The sample of adult users consisted of 1,071 users. Of these, 76.94% belong to the *Verdes Campos* region and 23.06% to the *Entre Rios* region. Regarding the type of unit in which the research took place, 42.11% of respondents accessed conventional BHU, 42.02% Family Health Strategies and 15.87% basic integrated health units.

For data collection, the Epi-Info[®] 7.0 program was used on tablets with typing on the interface of the sociodemographic questionnaire (age, education, marital status, race, private health plan, means of transport used, number of children, employment, income and others) and the PCATool-Brazil instrument, in the adult version, with the saving feature after being completely filled out.

The PCATool-Brazil adult version was validated in Brazil according to the model presented by the Ministry of Health and measures the presence and extent of the four essential attributes and the three attributes derived from PHC. It is noteworthy that the present study analyzes the dimension of coordination of care (integration of care and information system), which is composed of 12 items in the adult version, divided into integration of care and information systems.⁷

The data collection period was from February to August 2015. As adult users, who met the inclusion criteria, accessed health services, an invitation was made to participate in the study.

The responses were of the Likert type, with an interval of one to four. The possible answers for each of the items were:

“certainly yes” (value=4), “probably yes” (value=3), “probably not” (value=2), “certainly not” (value =1) and “I don't know/don't remember” (value=9). After consolidating the data related to the attention coordination attribute, the values were transformed into a continuous scale, varying between zero and 10, using the following formula: $Ep = [(score\ obtained - 1) \times 10] / 3$. $Ep \geq 6.6$ were defined as high and equivalent to the value three or more (≥ 3) on the Likert scale, while $Ep \leq 6.6$ was considered low.⁸

Pearson's chi-square test was performed to assess the associations between the attention coordination attribute and the users' characteristics. The tests assumed a 5% significance level and a 95% confidence interval. The statistical package used was the Statistical Package for the Social Science (SPSS), version 19. To calculate the evaluation with the types of units (conventional, FHS, integrated) the Kruskal-Wallis test was used with a significance of 5%. The present study followed the ethical principles contained in Resolution Nr. 466/2012 and was approved by the Research Ethics Committee of the *Universidade Federal de Santa Maria, Santa Maria-RS*, under CAEE Opinion Report Nr. 34137314.4.0000.5346, and had the support of the *Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPQ)* Public Notice Nr. 014/2014.⁹

RESULTS

The analysis of the research data was made from the perspective of the health care model that composes the 4th RHC/RS. One thousand and seventy-one interviews were carried out with adult users from the 32 municipalities in the 4th RHC/RS. The sociodemographic characteristics of these users are shown in Table 1.

It was found that there is an association between the conventional BHU, FHS and integrated BHU care models in the health regions of *Verdes Campos* and *Entre Rios*. The same is true for age, training, race, transportation, employment and income. As for sex, marital status, health plan and number of children, the variables are independent, that is, distinct, in relation to the type of unit.

In the attribute of coordination of care, integration of care and information system, the analysis showed that there is no significant difference between BHU, FHS and integrated BHU in the evaluation of users. In the consultation with a specialist, 44.78% of the BHU users have already received assistance in a specialized service, 49.11% of the FHS and 52.94% of the integrated BHU. In addition, when assessing the average of the coordination scores that is composed of the integration of care and information system, considering the maximum and minimum limits, the score was high in the different service models (Table 2).

Table 1 - Sociodemographic profile of users of primary health care at the 4th Regional Health Coordination of Rio Grande do Sul, Santa Maria, Rio Grande do Sul, Brazil. 2015 (n=1071)

Characterization	Conventional		FHS		Integrated		p-value*
	N	%	N	%	N	%	
Region							
Verdes Campos	412	91.35	269	59.78	143	84.12	<0.0001
Entre Rios	39	8.65	181	40.22	27	15.88	
Gender							
Male	102	22.62	111	24.67	42	24.71	0.7366
Female	349	77.38	339	75.33	128	75.29	
Age range⁺							
18-38	234	52.23	189	42.19	63	37.72	0.0034
39-59	156	34.82	175	39.06	72	43.11	
60-91	58	12.95	84	18.75	32	19.16	
Education⁺							
Elementary School	207	46.10	265	59.15	116	68.24	<0.0001
High school	183	40.76	139	31.03	47	27.65	
Higher Education	52	11.58	22	4.91	4	2.35	
Other	1	0.22	5	1.12	1	0.59	
Not literate	6	1.34	17	3.79	2	1.18	
Marital Situation⁺							
Single	111	24.78	107	23.78	42	24.85	0.4421
Married	175	39.06	197	43.78	77	45.56	
Other	162	36.16	146	32.44	50	29.59	
Race⁺							
White	330	73.66	290	64.44	123	72.78	0.0320
Black	77	17.19	209	46.22	33	19.53	
Other	41	9.15	51	11.33	13	7.69	
Private health plan⁺							
Yes	119	26.56	124	27.56	34	20.12	0.1587
No	329	73.44	326	72.44	135	79.88	
Transportation⁺							
By foot	229	51.23	331	73.56	76	44.71	<0.0001
Ride	12	2.68	8	1.78	9	5.29	
Collective/school transportation	71	15.88	23	5.11	27	15.88	
Own transportation	135	30.20	88	19.56	58	34.12	
Nr. of children⁺							
None	69	15.4	68	15.11	22	12.94	0.8213
One	113	25.22	114	25.33	47	27.65	
Two	118	26.34	120	26.67	51	30.00	
Three	87	19.42	74	16.44	28	16.47	
Four	36	8.04	39	8.67	9	5.29	
Five or more	25	5.58	34	7.56	13	7.65	

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Table 1 - Sociodemographic profile of users of primary health care at the 4th Regional Health Coordination of Rio Grande do Sul. Santa Maria. Rio Grande do Sul, Brazil. 2015 (n=1071)

Characterization	Conventional		FHS		Integrated		p-value*
	N	%	N	%	N	%	
Work[†]							
Yes	144	32.14	117	26.12	28	16.77	0.0006
No	304	67.86	331	73.88	139	83.23	
Income[†]							
Up to 1 minimum wage	137	30.51	169	37.72	59	34.71	0.0096
2 wages	185	41.20	193	43.08	77	45.29	
3 wages	85	18.93	50	11.16	28	16.47	
4 wages	24	5.35	21	4.69	1	0.59	
5 wages or more	18	4.01	15	3.35	5	2.94	

Source: research data, 2015.

*Person's chi-square test.

†Variables that did not reach 100%; variable age and employment = 8 losses; variable Race, education, marital status, income, health insurance and transportation = 4 losses; variable number of children = 3 losses.

Table 2 - Scores of indicators and composite indexes of coordination of care - integration of care and information systems, according to adult users in the 4th Regional Health Coordination of Rio Grande do Sul. Santa Maria. Rio Grande do Sul, Brazil. 2015 (n=1071)

Indicator	Average Scores (IC 95%)			p-value*
	Conventional BHU (n)	FSH BHU (n)	Integrated BHU (n)	
Care integration				
Consultation with specialist	0.55 (0.504 -0.596) 451 202 (44.78%)	0.50 (0.454-0.546) 450 221 (49.11%)	0.48 (0.401-0.555) 170 90 (52.94%)	0.1763
Did the service suggest consulting the specialist?	3.64 (3.51-3.76) 202	3.43 (3.27-3.58) 221	3.47 (3.23-3.70) 90	0.1113
Is the service aware of the consultation with the specialist?	3.67 (3.55-3.78) 202	3.55 (3.41-3.68) 220	3.63 (3.44-3.81) 90	0.7219
Did the service discuss the different services where it could be served?	2.15 (1.95- 2.34) 202	2.15 (1.96-2.33) 219	2.22 (1.92-2.51) 90	0.9002
Did someone from the service help you make an appointment?	2.92 (2.72- 31.1) 202	2.75 (2.56-2.93) 222	3.11 (2.83-3.38) 90	0.1106
Did the service write any information to the specialist?	3.30 (3.13-3.46) 201	3.23 (3.06-3.39) 221	3.28 (3.03-3.52) 90	0.9259
Does the service know the results of this consultation with the specialist?	3.01 (2.82-3.19) 202	2.84 (2.65-3.02) 221	3.11 (2.85-3.36) 90	0.2595
Did someone from the service talk about what happened at the appointment?	2.74 (2.54-2.93) 202	2.65 (2.46-2.83) 221	2.93 (2.64-3.21) 90	0.2230
Did anyone from the service seem interested in the quality of the specialist's care?	2.53 (2.34-2.71) 202	2.56 (2.37-2.74) 220	2.7 (2.41-2.98) 91	0.5920
Partial score	6.66 (6.28-7.03)	6.34 (5.94-6.73)	6.87 (6.30-7.43)	0.3921
Information systems				
Do you have a health record when you go to the service?	3.08 (2.96-3.19) 448	2.97 (2.84-3.09) 449	3 (2.81-3.18) 169	0.4051

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Table 2 - Scores of indicators and composite indexes of coordination of care - integration of care and information systems, according to adult users in the 4th Regional Health Coordination of Rio Grande do Sul, Santa Maria, Rio Grande do Sul, Brazil, 2015 (n=1071)

Indicator	Average Scores (IC 95%)			p-value*
	Conventional BHU (n)	FSH BHU (n)	Integrated BHU (n)	
Information systems				
Is the medical record available at the consultation?	3.80 (3.73-3.86) 443	3.77 (3.7-3.83) 443	3.77 (3.67-3.86) 168	0.3846
Could you read the medical record?	2.58 (2.49-2.66) 443	2.62 (2.53-2.70) 443	2.76 (2.61-2.90) 167	0.0967
Partial score	7.22 (7.02-7.41)	7.09 (6.88-7.29)	7.26 (6.94-7.57)	0.7536

Source: research data, 2015.

* Person's chi-square test.

**Kruskal-Wallis test.

DISCUSSION

The predominance of females in the profile of users, regardless of the type of unit, is in line with findings evidenced in studies carried out in *Espírito Santo* and *Porto Alegre-RS*.^{10,11} This refers to a social situation in which women assume a main role in the family in relation to health care, accessing health services more frequently, compared to men. Historically, in the view of common sense, the man is seen as a strong being, who hardly gets sick, with the female predominance looking for health services.¹² On the other hand, the data may reveal that the predominant demand for women in the services may be associated with the programs offered by the service, since in Brazil, historically, health policies have emphasized actions aimed at the maternal and child extent.

The study showed the predominance of married people in the three types of health units, which is in line with a research that obtained 59.1% of married women.¹⁰ This data is similar to that of another study, which found a predominance of females (89%) in family income, with the interval between one and two minimum wages being the most prominent.⁵

Data from the *Instituto Brasileiro de Geografia e Estatística* (IBGE) revealed that in 2013, 27.9% of the Brazilian population had at least one private health plan.¹³ When assessing adherence to the private health plan, the study showed that 25.86% of adult users have a private plan. This shows that 73.76% of adult users are assisted exclusively by SUS, highlighting the role and importance that this system plays in guaranteeing access and comprehensive care in health services in Brazil.

The 2013 IBGE National Health Survey supplementary health survey revealed that, in Brazil, 77.8% of resident people, when they needed health care, used to look for the same place, doctor or health service. PHC was the place most declared as sought (47.9%), followed by private practices (20.6%) and the

hospital outpatient clinic (11.3%). This level of care was usually sought mainly by people belonging to classes whose monthly income per capita was low, and as income increased, the proportion of people who sought PHC decreased. In contrast, visits to private practices showed a positive association with income.¹³

Most survey users have one or more children. A study found that women with low education and low income tend to get married or associate with partners earlier, start sexual life and have earlier births, with a greater number of children.¹⁴ Thus, it contributes to the increase in the number of births, without, however, affecting the dizzying drop in absolute birth numbers.

In the present study, the coordination of care did not obtain a statistical difference in PHC between the models of care observed, under the evaluation of users. This result was also demonstrated in a study that compared the performance of the essential attributes of PHC based on the perception of users attended at BHU and FHS in a large city in Brazil, not identifying differences in the evaluation of conventional BHU and FHS regarding the studied attribute.¹⁵

The coordination of care in this study obtained a value considered to be high in the different models of care, a reality found in other studies in which coordination obtained a value close to the ideal.^{15,16} In another study, the coordination and integration of care obtained a low evaluation.¹⁷ Already in an investigation that also analyzed the coordination of care integration, similarity was found in user satisfaction, in which most units obtained a high PHC score.⁵

The indicator "proportion of users referred to specialists" had no significant difference between the different types of units, a result similar to that found in other studies.¹⁸ Users positively evaluated questions regarding referrals, such as the

service's suggestion for the consultation with specialist and the knowledge of the PHC service on consultations with the specialized service. The assessment, however, was not positive in terms of PHC discussing with the user the different services to which he could be referred for the resolution of his health demand. In another study, the same variable showed a statistically significant difference between the BHU and the FHS, in which the highest average was found in the FHS, indicating that these professionals give more options for patient care locations.¹⁷

Users interviewed from conventional BHU and integrated BHU positively evaluated the help in scheduling consultations with specialists, considering the values referring to the upper limit of the Likert scale. In the FHS BHU, this item was poorly evaluated. The questions referring to the reference and counter-reference, such as: writing useful information to the specialist, monitoring the result of this consultation, in all types of study units were well evaluated, corroborating with data found in the literature.⁵ Different result from another study whose reference and counter-reference showed low average in both models and did not report a statistically significant difference between the models studied.¹⁷

In this study, the question regarding the service talking to the user about what happened during the consultation with the specialist had a low evaluation in the conventional BHU and FHS, but the integrated BHU, considering the upper limit of the Likert scale, was well evaluated. Users' analysis of the service's interest in the quality of care provided by the specialist was considered low in the three models of care.

Information sharing is a requirement when it comes to coordination of care, since it reduces unnecessary repetition and provides health professionals with access to service records from other providers and activates their involvement and integration.¹⁸ In addition, the absence of the counter-referral strategy is a factor that contributes to the failure of the coordination of care, since users return to the service without knowing what has been done at other levels of care. Likewise, the PHC reference team is left without information if the treatment was carried out and/or completed.⁵

The user, in seeking to meet the needs, tends to seek other doors of entry into the HCN, either with the explicit knowledge of the teams working in PHC, through transfers, either through direct access or self-referral.² The coordination of care plays an organizing role of assistance among the different professionals, services and levels of assistance necessary for recovery, maintenance and health promotion.

Some factors have an impact on the coordination of care in PHC. Among them, we highlight the increase in the role of general practitioners, related to management and accountability for the user's therapeutic path, throughout the

care network; better PHC resolution capacity, based on the allocation of resources and the expansion of services offered; and well-established reference and counter-reference along the therapeutic path.¹⁸

Thus, health services must be guided by the principles of the HCN. These are polyarchic organizations of health service sets, linked together by a single mission, by common objectives and by a cooperative and interdependent action, which allow to offer continuous and integral care to a determined population coordinated by PHC.³

In the coordination of care, the medical record constitutes an essential document for the development of coordination, the main record of the pertinent information of the user and the care provided and guarantees communication between the health team, aiming at comprehensive care.¹⁹ The study revealed good evaluation by users in relation to their records and existence of medical records in consultations and medical services, data confirmed by another survey, in which the availability of family medical records during consultations was perceived as positive by users.⁵

Users' permission to read or examine their medical records in this study was low. These data are opposed to those of another study, which obtained a positive evaluation.⁹ The research made it possible to assess that in the dimension of coordination there are no significant differences in the evaluation by models of care in PHC. This result shows that in the 32 municipalities studied, which comprise two health regions, the FHS does not appear as a model of care that differs from the others, not presenting itself as a potential for changing the model of care.

This goes against what was expected at the time of the implementation of the FHS, which arose in response to the crisis of the hegemonic medical-clinical model, proposing a real change in the way of thinking and carrying out health actions. This is because the predominant care model in the country does not yet contemplate the principles of SUS, prioritizing care that is sometimes individualized, based on healing and medicalization, with low resolution and low social impact.

CONCLUSIONS

The dimension of the coordination of care, in the present study, was well evaluated, obtaining a high score in the different models of care. In addition, the study indicated that there was no statistical difference between them in PHC, as assessed by users. The results presented have important implications for the model of services evaluated and for public health care policies and reinforce the development of evaluative studies to improve the quality of PHC and the coordination of care.

As a limitation, the quantitative design does not make it possible to verify the experience of users in PHC services regarding the coordination of care. It is emphasized the need to continue the study, with a qualitative approach, so that this experience can be contemplated, in order to strengthen PHC as the preferred port in the health system. The study contributes to the rethinking of PHC coordination in municipalities with characteristics similar to the scenario studied with regard to the model being implemented in units with FHS, whose results need to be reflected by managers and professionals of the regional health network, with the participation of the community to ensure that the fragmentation of care is overcome.

REFERENCES

1. Donabedian A. The quality of medical care. *Science*. 1978[cited 2019 Jan 17];200(4344):856-64. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/417400>
2. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: Unesco; 2002[cited 2019 Jan 17]. Available from: <https://www.nescon.medicina.ufmg.br/biblioteca/imagem/0253.pdf>
3. Sarti TD. A atenção primária coordenada as redes de atenção à saúde: a realidade dos grandes municípios. *Rev Bras Med Fam Comun*. 2017[cited 2019 Jan 17];12:(39)1-4. Available from: <http://docs.bvsalud.org/biblioref/2018/02/877125/1549-9035-2-pb.pdf>
4. Ministério da Saúde (BR). Secretaria de Atenção à Saúde, Implantação das Redes de Atenção à Saúde e outras estratégias da SAS/Ministério da Saúde. Secretaria de Atenção à Saúde. Brasília: Ministério da Saúde; 2014.
5. Carneiro MSM, Melo DMS, Gomes JM, Pinto FJM, Silva MGC. Assessment of the coordination attribute in Primary Health Care: application of the PCATool to professionals and users. *Saúde Debate*. 2014[cited 2019 Jan 17];38:279-95. Available from: <http://www.scielo.br/pdf/sdeb/v38nspe/0103-1104-sdeb-38-spe-0279.pdf>
6. Pinto LF, Giovannella L. Do Programa à Estratégia Saúde da Família: expansão do acesso e redução das internações por condições sensíveis à atenção básica (ICSAB). *Ciênc Saúde Colet*. 2018[cited 2019 May 21];23(6):1903-13. Available from: <https://www.scielosp.org/pdf/csc/2018.v23n6/1903-1914/pt>
7. Ministério da Saúde (BR). Secretaria de Atenção em Saúde. Departamento de Atenção Básica. Manual do Instrumento de Avaliação da Atenção Primária à Saúde: Primary Care Assessment Tool PCATool-Brasil. Brasília: Ministério da Saúde; 2010.
8. Harzheim E, Oliveira MMC, Agostinho MR, Hauser L, Stein AT, Gonçalves MR, et al. [Validation of the Primary Care Assessment Tool: PCATool-Brazil for adults]. *Rev Bras Med Fam Comun*. 2013[cited 2019 June 06];8(29):274-84. Available from: <https://www.rbmf.org.br/rbmf/article/view/829/588>
9. Ministério da Saúde (BR). Conselho Nacional de Saúde. Resolução nº466. Regulamenta pesquisas envolvendo seres humanos. Brasília: Ministério da Saúde; 2012.
10. Lima EFA, Sousa AI, Primo CC, Leite FMC, Lima RCD, Maciel ELN. An assessment of primary care attributes from the perspective of female healthcare users. *Rev Latino-Am Enferm*. 2015[cited 2019 May 17];23(3):553-9. Available from: <http://www.scielo.br/pdf/rlae/v23n3/0104-1169-rlae-0496-2587.pdf>
11. Gonçalves MR, Hauser L, Prestes IV, Schimidt MI, Duncan BB, Harzheim E. Primary health care quality and hospitalizations for ambulatory care sensitive conditions in the public health system in Porto Alegre, Brazil. *Fam Pract*. 2016[cited 2019 Feb 10];33(3):238-42. Available from: <https://www.ncbi.nlm.nih.gov/pubmed/26124441>
12. Levorato CD, Mello LM, Silva AS, Nunes AA. Fatores associados à procura por serviços de saúde numa perspectiva relacional de gênero. *Ciênc Saúde Colet*. 2014[cited 2019 Jan 17];19(04):1263-74 Available from: <https://doi.org/10.1590/1413-81232014194.01242013>
13. Instituto Brasileiro de Geografia e Estatística. Pesquisa Nacional de Saúde: percepção do estado de saúde, estilos de vida e doenças crônicas. Rio de Janeiro: Ministério do Planejamento, Orçamento e Gestão; 2016.
14. Freitas DMO, Branco NVC, Luna FMS, Bubol GA, Moreira SC, Lima KF, et al. [Teen pregnancy: social context, related issues and preventive approach]. *Rev Enferm Atenção Saúde*. 2017[cited 2019 Jan 17];6:952-61. Available from: <https://www.acervosaude.com.br/doc/REAS64.pdf>
15. Martins JS, Abreu SCC, Quevedo MP, Bourget MMM. Comparative Study between Health Care Units with and without Family Health Strategy using PCATool. *Rev Bras Med Fam Comunidade*. 2016[cited 2019 Jan 17];11(38):1-13. Available from: <https://www.rbmf.org.br/rbmf/article/viewFile/1252/823>
16. Vidal TB, Tesser CD, Harzheim E, Fontanive PVN. Avaliação do desempenho da atenção primária à saúde em Florianópolis, Santa Catarina, 2012: estudo transversal de base populacional. *Epidemiol Serv Saúde*. 2018[cited 2019 Jan 17];27(4):e2017504. Available from: <http://www.scielo.br/pdf/ress/v27n4/2237-9622-ress-27-04-e2017504.pdf>
17. Martins JS, Abreu SCC, Quevedo MP, Bourget MMM. Estudo comparativo entre Unidades de Saúde com e sem Estratégia Saúde da Família por meio do PCATool. *Rev Bras Med Fam Comun*. 2016[cited 2019 Jan 17];11(38):1-13. Available from: <https://www.rbmf.org.br/rbmf/article/download/1252/823>
18. Aleluia IRS, Medina MG, Aleida PF, Vilasbôas ALQ. Care coordination in primary health care: an evaluative study in a municipality in the Northeast of Brazil. *Ciênc Saúde Colet*. 2017[cited 2019 Jan 17];22(6):1845-56. Available from: http://www.scielo.br/pdf/csc/v22n6/en_1413-8123-csc-22-06-1845.pdf
19. Ferreira TLS, Souza AMG, Medeiros JSS, Andrade FB. Evaluation of the attribute coordination of care in childcare services in Primary Health Care. *Rev Ciênc Plural*. 2017[cited 2019 Jan 17];3(1):98-107. Available from: <https://periodicos.ufrn.br/rcp/article/view/12325/8591>