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Original Article

# Challenges on network care considering the perceptions of preceptors of a Pet-Network regarding people with disabilities and at-risk infants: access, comprehensiveness and communication

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**Abstract:** Introduction: Health Care Networks (HCN) are seen as a possibility for articulating and coordinating actions, health services and is a priority in the health system. One strategy to assure their improvement is the Tutorial Education Program (PET-Redes) in the health area. Within this context, it is important to understand the challenges and strengths for the effectiveness of HCN to the network care. Objective: To identify and analyze the perceptions of professionals who are preceptors of PET-Networks (Stork/at-risk infants Network and Disabled People Network) about the configuration of the network care and the challenges of professional actions related to it. Method: Qualitative study conducted through two focus groups with professionals that are preceptors of the PET-Networks. Thematic analysis was used for data analysis. Results: Both networks presented the following categories related to the network care configuration: access, comprehensive health care and communication. For this care network configuration, some challenges mentioned include geographical and architectural barriers, lack of social support, lack of transportation, failure on care flow and discontinuities in the communicative process. To deal with these challenges, the following strategies were mentioned: implementation of electronic medical records and formulation of specific forums for debate and articulation of actions, among others. It is important to notice that these categories are intertwined and that more challenges than strategies to overcome them were pointed out by the participants. Conclusion: There are several challenges for effective HCN from different levels and the construction of strategies needs to be convened among all persons involved in the HCN.

**Keywords:** *Primary Health Care, Health Service Accessibility, Comprehensive Health Care, Communication.*

## Desafios do cuidado em rede na percepção de preceptores de um Pet Redes em relação à pessoa com deficiência e bebês de risco: acesso, integralidade e comunicação

**Resumo:** Introdução: As Redes de Atenção à Saúde (RAS) configuram-se como possibilidade de articular e coordenar ações e serviços, sendo hoje prioridade na organização do sistema de saúde. Considerando a necessidade de seu aprimoramento, o Programa de Educação pelo Trabalho (PET) na saúde é desenvolvido como uma estratégia para tal. Nesse contexto é preciso compreender os desafios e potências para a efetivação da RAS na produção do cuidado em rede. Objetivo: Identificar e analisar as percepções de profissionais preceptores de um PET Redes (Rede Cegonha/Bebês de risco e Rede Cuidado da Pessoa com Deficiência) sobre como se conforma a atenção em rede e sobre possíveis desafios das ações profissionais nessa configuração. Método: Estudo qualitativo, realizado por meio de dois grupos focais com profissionais preceptores de um PET Redes. Resultados: Em ambas as Redes o

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acesso, o atendimento integral e a comunicação apareceram como categorias da configuração do trabalho em rede. Alguns dos desafios mencionados envolvem: barreiras geográficas e arquitetônicas, falta de apoio social e transporte para deslocamento aos serviços, falhas de fluxos e descontinuidades nos processos comunicativos. Para lidar com esses desafios, foram mencionadas como estratégias: uso de prontuário eletrônico e constituição e participação em fóruns específicos de discussão e articulação de ações, entre outros. Destaca-se que as categorias estão articuladas e que os participantes apontaram mais desafios do que estratégias para superá-los. Conclusão: Os desafios para efetivação das RAS colocam-se em diferentes níveis e a construção de estratégias necessita ser pactuada entre os atores sociais envolvidos.

**Palavras-chave:** *Atenção Primária à Saúde, Acesso aos Serviços de Saúde, Assistência Integral à Saúde, Comunicação.*

## 1 Introduction

The health systems in the world have traditionally been guided to answer to acute conditions (PAN...; WORLD…, 2007; WORLD..., 2008; MENDES, 2011; SILVA, 2011), while the main health demands today are related to the care of the chronic ones. These conditions must be addressed by the establishment of Health Care Networks (HCN) (MENDES, 2011), which has been identified as a privileged strategy to overcome the fragmentation of healthcare and management (BRASIL, 2010).

HCN is defined as organizational arrangements of actions and health services, of different technological densities. As health care centers, they must be integrated with technical, logistical and management support systems, seeking to guarantee continuous and comprehensive assistance to a defined population (BRASIL, 2010; MENDES, 2011). In this sense, the Health Care Networks are oriented to respond to the challenge, faced by the Unified Health System (SUS) since its inception, of promoting better integration between health services and actions. The Primary Health Care (PHC) is an essential point of attention for HCN due to its responsibility to recognize and respond to most of the health needs of its population and to coordinate its healthcare in other care centers and in the territory (MENDES, 2011; STARFIELD, 2002).

The HCN implementation was the main guideline of the Secretary of Health Care (SHC) for the period 2011 to 2014, when there was given priority to the constitution and implementation of five thematic networks, among them the Stork Network -SN (*Rede Cegonha-RC*) (BRASIL, 2011) and the Network of Care for People with Disabilities (NCPD) (BRASIL, 2012, 2014). The SN aims to ensure the right to reproductive planning and humanized attention to pregnancy, childbirth and the puerperium to women and children, as well the right to safe birth and to healthy growth and development (BRASIL, 2011). The NCPD aims to broaden access and qualify care for people with disabilities (PD), promoting their bonding and their families to the points of attention and ensure the articulation and integration of the points of attention, qualifying care through the reception and classification of risk (BRASIL, 2012, 2014).

Despite the potential on the work within the HCN, many factors have hampered its management, such as the diversity of actors involved and the organization of PHC services, the scarcity of secondary and tertiary care services and the difficulties of controlling and coordinating interdependencies (MENDES, 2010). Considering this scenario, it was sought to understand on Health Care Networks (PET Redes USP Capital) through a Program of Education by Work (PET) in health, how does the network attention configures in the territory of Technical Supervision of Butantã (STS-BT) and which are the possible challenges of professional actions in this configuration, seeking to contribute to the implementation and qualification of SN and NCPD. It is worth mentioning that PET Networks is a program designed and promoted by the Ministry of Health to develop and improve HCNs at the national level. To achieve this purpose, PET Networks promotes the teaching-service-community integration, the qualification of professionals to work in accordance with SUS principles, the training of professionals focused on the comprehensive attention to the population health and inter-professional work and fosters research on the subject through learning and mentoring groups (BRASIL, 2013).

Seeking to contextualize the scenario in which the work was carried out, it is important to note that the mentioned PET Networks was developed between 2013 and 2015 in the STS-BT territory to specifically qualify SN and NCPD in STS-BT, being a partnership between the University of São Paulo and Butantã health services. The PET/SN and PET/NCPD tutorial groups developed a number of actions, including the collection of information on CPDs and at-risk infants in the region, follow-up, and participation in inter-professional and intersectoral actions aimed at these populations.

It is worth mentioning that SN was chosen because, despite the existence of a set of services for monitoring and coping with risk situations and a committee recognized by its technical competence to monitor babies at risk, the articulation between services in the region is still fragile. Thus, the option to approach the baby at risk was based on the territorial health diagnosis, in which, although the infant mortality coefficient in Butantã decreased (10.3 to 7.6), it is known that the conditions of babies at risk may also contribute to the composition of this coefficient. In this context, managers in the region verified the need to actively seek out the babies at risk in the region and to determine the care flows and to know possible nodes of the Stork Network, advocating to monitor the development of the baby from 0 to 24 months. In this way, they suggested that PET-Networks should prioritize this population in detriment of pregnant women. Despite the importance of the problem and the existence of services, the NCPD do not fully address the demands of this population. There is a lack of specific information on care for the group, great heterogeneity of the technical competencies of the professionals, lack of infrastructure and attention guidelines, insufficient articulation between health services, transportation and social assistance (SÃO PAULO, 2013b). Since 2015, the NCPD has been accompanied in the region by a specific commission.

This study is inscribed in this context, which aimed to identify and analyze the perceptions of preceptors about the conformation of the network attention and the challenges and potencies for the effective implementation of HCN in the production of network care from the development of a PET Networks.

## 2 Method

This study was part of a more comprehensive research project called "Basic Care as a provider of Stork Care and Care for the Disabled", promoted by FAPESP, which also composed the USP Capital Networks PET Program, supported by the Ministry of Health through the granting for tutors, preceptors, and undergraduate students. It was developed in the Regional Coordination of Central-West Health (CRS-CO), Technical Supervision of Health/Butantã (STS / BT), of the Municipal Health Secretary of São Paulo, through a partnership between researchers from the University of São Paulo), professionals from the services of the region and students. The Ethics Committee of the Municipal Health Secretariat of São Paulo and the Ethics Committee of the Medical School of the University of São Paulo approved it. The participating services of PET Networks were chosen in agreement with the Regional Coordination of Western Center Health - CRSCO and STS/BT for their articulation with the PHC and by already developing teaching activities and performing actions related to SN and/or NCPD. The preceptors of both Networks were indicated by the services/managers of each unit for their experience and connection to the activities related to the Networks, being 6 preceptors for SN and 6 for the NCPD, totaling 12 professionals.

This article presents and discusses the results referring to one of these stages of the research, characterized as qualitative, exploratory and descriptive. Two focal groups were conducted, one for each care network. The invited participants were the preceptors of the services that composed the SN and NCPD, because of their previous linkage. Thus, four SN professionals and six NCPD professionals participated in the study. Regarding their distribution by services: three were NASF representatives, one from BHU with FHS, two from hospitals, one from CECCO, one from specialty outpatient and two supervisors from the networks.

The focus group method was chosen because it is configured as a research tool that facilitates the understanding of less visible processes and it allows group highlighting unexplored aspects of a specific issue. It also allows access to meanings and conceptualizations of the participants on the topic under discussion and favors the exploration of their perspectives on issues without previous reflection (BARBOUR, 2009).

The focus groups occurred at the end of the PET Networks process, as it was understood that these would be configured as a potential space for dialogue between professionals from different services. The groups were performed in two sessions for each of the care networks. Five professionals participated in the NCPD and six in the second session. In the SN, there were four professionals participating in the first session and one professional in the second session. This variation of presence can be explained by unforeseen experiences by the participants. It should be noted that, considering the low adherence in the second session of the focal group of SN, only the results presented in the first session for this care network were considered.

The two sessions of the two focus groups of each of the networks were conducted separately in July

2015 at the Department of Physical Therapy, Speech and Hearing Therapy and Occupational Therapy at USP/SP and the duration of each session was two hours. The focus groups of the two networks were conducted by a principal moderator with experience in conducting focus groups and not involved with the PET Networks, and by assistant moderators (an occupational therapist and a technical training fellow, both participants of the PET Networks, but not in the focus group network). By understanding the research process and the proposal of the PET Networks, the assistant moderators assisted the main moderator with information to better lead the group.

For the development of the focal groups of the two networks, the same script was used to understand, considering the conformation of the SN and NCPD in the STS/BT, what actions and strategies the participants would propose to enhance the networks in which they are involved. The sessions of each of the focus groups were initiated by a triggering question favoring the discussion on the specific topic of research. The triggering question for the first session of the focus group of the two networks was: “What actions are currently carried out in your service to work in a network of care for children up to two years old and/or adolescents and/or adults and/or elderly people with disabilities in STS Butantã?” In the case of the second session of the NCPD group, the triggering question was: “Do you identify an emblematic case involving a child and/or adolescent and/or elderly assisted in the STS/BT service that mobilized networking health care?”

All the participants signed a free and informed consent form and the sessions were recorded and transcribed. The identification of professionals and their interventions were performed alphanumerically (P1: professional 1) and by the network participating through letters representing them (SN and NCPD).

Preanalysis, material exploration, data processing and thematic analysis were performed according to the steps described by Minayo (2007). It is considered that the thematic analysis allowed appropriate qualitative treatment to the data collected in the focal group sessions of both networks. The thematic analysis enabled to identify the following categories: access, comprehensive health care, and communication. These categories are related to the conformation of networking and from these categories the challenges and potentials of networking are pointed out by the study participants. In view of the interweaving between the three thematic categories, it was chosen to present the results of these categories together, only by differentiating the results of each of the networks.

## 3 Results

### 3.1 Stork Network/Infants at risk: access, comprehensive care, and communication

First, the professionals pointed out the existence of a difference in the access and the monitoring of the baby and the pregnant woman at risk between the constituted services such as the Basic Health Units (BHU) and those of the Family Health Strategy (FHU). They identify that this difference lies especially in the possibility of FHU teams carrying out an active surveillance, while in the traditional units access, monitoring and care management depend on the families, leading to the absence of the activities organized by the service.

Regarding the difficulties in the construction of an comprehensive care work, the professionals pointed out that there is a disarticulation between the services of the territory, leading to isolation of actions and making networking difficult. The professionals also considered that, even if the services maintain contact, there are conflicts in the understanding of what would be the health need of the patient and the possible referrals for the attendance of their needs, hindering to create a network between services:

> *P1SN:* [...] *who monitors,* [...] *the support network, is the BHU. And not always these two services dialogue* (hospital and BHU). *And when they talk, they spark. Because* [...] *several times some teams* (FHU) *came back from meeting* [...] *and they say ... people do not understand what this family is, this support network. We want to do this, but they do not want to release the baby* [...]. *I think that knowing each other's practice, talking about it, and maybe trusting the work of both parties.*

The difficulty in establishing a network between services is also present in the different perceptions about the condition of “baby at risk”. They argued that different criteria are used by the equipment to characterize this population:

> *P1SN:* [...] *each one will understand a situation of the baby at risk in a different way ... the technical supervision of health considers baby at risk below 2.5 kg, mother under 16 years old, with Apgar below 5 in the first minute* [...]. *The FHU, each from its territory reality, considers its gestation risk, the baby at risk by these criteria and by some*

> *others: vulnerability, nuclear family network, family support network, socioeconomic status* [...].

According to the participants, the difference in understanding of what a baby at risk would directly influence networking. When a service forwards a baby who is considered to be at risk for follow-up in another who does not have the same understanding, this baby may not be considered at risk or receive priority care.

The professionals also pointed out that there are important problems in the communication level:

> *P1SN:* [...] *what I identify as the main node. The services do not talk about it.*

They reflected on several reasons for the lack of communication and considered that one of the reasons would be the different conceptions among the services of the network on criteria to consider a baby as being at risk. They also reported the excess of demands on services, hindering to attend meetings with professionals in other health facilities, favoring isolation in the service.

Another issue pointed out was the flows established between services often highly dependent and focused on certain professionals:

> *P1SN:* [...] *it depends on the goodwill of the professional who is leading the case in sending orders individually to the other, which sometimes is even in personal email.*

In this sense, when a professional of reference to a certain process or management of care, for some reason, stops working in the service, this is interrupted:

> *P1SN: When the services do communicate, they focus on the figure of a professional* [...] *and this is very bad, because if the professional leaves, you lose the bond, the access to that team, the information.*
>
> *P3SN: If the person goes on vacation or retires, you lose her information.*

The participants pointed out that many times the patient arrives for care without the history and health complaints identified in the other services of the network. The difficulty of communication ends up slowing down the identification of the patient's demands and needs, influencing the provision of care. They cited, for example, the hospital staff's delay in identifying the history of alcohol and drug use in pregnant women at risk, previously assisted by the BHU, who previously knows this information:

> *P3SN: This pregnant woman history is sometimes never enough for us. It took us a long time to find out that she is a pregnant woman at risk* [...] *and many times BHU already knew and they could have sent it to us.*

Also, the difficulties in communication regarding previously agreed flows between services were mentioned:

> *P1SN: Is there an official flow? Theoretically, it has, but I do not know what happens that people do not follow it* [...] *they do not use the reference and counter reference* [...] *they have to follow that flow, regardless of people.*

They also stated that professionals often send the form to the services, but with little or no information about the patient and their family, not allowing to know the history and the needs of the patient:

> *P1SN: People put: 'to BHUS'. But, 'to BHUS' do what?* [...] *What is the history of this family?*

Due to the fact that these issues are identified as problematic in the patients´ care process, the professionals pointed out the higher quality of the referrals made through the transfer of relevant information about the patients and the possible advantages of official flows to ensure the participation of all services:

> *P3SN: A few years ago, I had a report* [...] *and it was very productive because the patient arrived and we already knew how to handle the case ... we managed to work very quickly.*

However, they argued that even with such actions, it is not guaranteed that the history of a patient is accessed by the services and pointed the electronic medical record as a possibility to favor communication:

> *P4SN:* [...] *in the medical record, everyone will have access to information.*

Concerning the challenges of this proposal, it was mentioned that the electronic medical record may not assist in the communication of information with the hospital since it is expected that such equipment would not have access to it. In this sense, they discussed sending information by electronic mail, agreeing that this should be done institutionally and not by the private addresses of professionals. They emphasized that this measure would require the services creating a flow for the arrival of information, with actions that guarantee the information was accessible to the professionals of that equipment.

Another issue related to communication is the difficulty of sending information from some hospital services to STS/BT, especially regarding the birth of at-risk babies. Professionals reported that when this official communication flow from the hospital to the STS/BT is not followed, it is not possible that this signals to BHU that there is a new baby at risk in that territory. In this sense, the search for care in the territory after hospital discharge is only under the responsibility of the family, who do not necessarily attend the service. They argued that this rupture prevents the follow-up of this baby in the health services network.

The computerization of the system and/or other communication mechanisms would allow the signaling, for the territory, that the baby is at risk, which would favor their identification and consequently the scheduling of their consultation, especially in traditional BHUs. They suggest the creation of some flag code that could be included in the codes generated by the system, for example, putting the word risk next to the baby's name:

> *P4SN:* [...] *we have to look for alternatives in the SIGA*[1][...] *maybe creating a code after the baby's name.*

They also suggested a flow created within the BHU that would separate all records of at-risk infants to easily verify the scheduling of their consultation. They also stressed that this signaling would boost the active search in the territory when the baby does not attend the consultation:

> *P4SN:* [...] *signals that it is at risk and the BHU is organized in a way that, for example, it separates the medical records of babies at risk* [...] *because when they have a consultation and did not come, they have to do an active search.*

They also reflected on the need to institutionalize discussion spaces to facilitate communication between the services and, even so, identified that only such spaces may not be sufficient for communication between services:

> *P1WN:* [...] *meeting places?* [...] *but they would have to follow an official flow. Because you also stay in the meetings, you stay focused on the people who go to these meetings.*

### 3.2 Care Network of the Person with Disabilities: access, comprehensive care, and communication

Considering the PHC as a gateway to the health system, it was argued that access to CPD may be hampered by a social representation of the role of the PHC and its different forms of organization in management models such as traditional BHU and those with FHU:

> *P4NCPD: In a traditional BHU* [...] *many people do not come to the service because neither the family understands that service as care for the CPD or the unit itself does not understand that there is space to take care of that person* [...] *you have a model* (FHU) *that does the active search, this does not guarantee access, but the fact that you look at the territory* [...] *makes all the difference.*

There were also difficulties in accessing the area, especially for people with reduced mobility. Participants identified accessibility problems in housing, on the streets, in services, and in public transportation.

Also, the professionals report that the difficulty in access is related to the restricted eligibility criteria for the usufruct of both adapted transportation service and health and rehabilitation services:

> *P6NCPD: And the wheelchair users? Besides having this difficulty, he needs ATENDE*[2][...]. *How will he be led to his unit?* [...] *there is a whole bureaucracy* [...] *he has to be in treatment* [to be entitled to ATENDE].
>
> *P5NCPD:* [...] *patient soon after a stroke ... mobilizing the teams* [...] *after a time that it becomes chronic* [...] *does not enter the protocol.*

Also, professionals argue that access to the service also depends on the existence of a social support network, composed of family, neighbors and community services:

> *P4NCPD:* [...] *because even if you get the services on the network, you will not be able to access* [...].
>
> *I think you have to mobilize even a support network* [...] *There is a local net there that you can articulate, or it's the family, a neighbor.*

Regarding the proposals to deal with the difficulties of transportation and movement of people with reduced mobility throughout the territory, the optimization of the use of the ATENDE service, neighborhood campaigns, such as "neighbor's ride" and negotiations with the government were mentioned. In these negotiations, they suggest, for example, that a van could circulate among health services to facilitate access.

On the comprehensive care, the importance of understanding the complexity of the needs of the CPD is discussed to think about the therapeutic project of the subject and his family:

> *P1NCPD:* [...] *thinking about CPD is not from the pathology, but from its condition, from its necessity ... to take care of the minimum conditions of life ... a rehabilitation action thinking about the CPD in the territory, In its more global condition of life.*

In the elaboration of the network therapeutic project, it is also necessary to understand the subject and his family as protagonists of the whole intervention process:

> *P4NCPD:* [...] *it is a challenge as you project the needs of the other into the project, centered on the desire of the other* [...], *but also considering the needs that we see at risk* […]. *A therapeutic project that considers* [...] *what we think is a clinical priority, with what he and the mother define as a priority.*

The professionals also stressed the importance of building a work with the articulation of different professionals and services in order to meet the real needs of the subject in each moment of his life. They emphasized the relevance of the longitudinal responsibility on the follow-up of the patient of the network to favor the comprehensive care.

They also pointed out that information and service flows are not clear to professionals and patients because, according to them, there is difficulty in understanding the correct paths for access to different services.

In situations of social vulnerability most experienced by CPDs, professionals report that established flows tend to be less efficient and point out strategies to facilitate access:

> *P3NCPD:* [the CPDs do not access the flows] *as much as we would like, so that's where we are in charge of our visits, the home visits, for us to reach this person.*

Also, the expansion of the offer of services and activities beyond the point of attention and according to the needs of the CPD were discussed. Therefore, the knowledge of the proposals made by the different professionals and services of the network can facilitate the routing and access of the patient, according to their multiple needs. In this proposal, the groups and actions already available in the services would be offered to all the CPDs that they need and not only to those of the area of coverage of the service.

The professionals also are identified as articulators of the care network, but they point to the difficulty in the development of the actions in the territory by the reduction of the number of professionals in the services. Another problem is the ruptures and challenges identified in the communication process. In this regard, they mention the difficulty of understanding the role of each service in the composition of the network, and that the network is often woven between specific professionals and not through official flows established between the different services.

It was mentioned that the fragile understanding about the role of professionals in the different services that make up the network of care of people with disabilities is an element that hinders communication. They pointed out that it would be important to have guidelines for the work of professionals at different levels of care and to broaden their understanding of the different professional roles:

> *P2NCPD: You can only know this role if you know* [...] *what conception you have in the municipality of what is expected of these professionals.*

Professionals also point out that in the PHC there are more consolidated protocols and flows in some lines and networks of care and for the assistance to the populations traditionally assisted at the local level. However, in the rehabilitation area of the CPD there is a need to build and agree on paths and flows that often depend on the profile and availability of the professional responsible for a particular service:

> *P2NCPD:* [...] *the network* [...] *that people do on a daily basis ... is a network that is not established* [...]. *It depends on this very personal articulation, which depends on availability, willingness to do so* [...]. *Sometimes the person has the will but has no agenda, and flexibility of managements to release professionals to discuss cases.*

However, the communication between professionals was also understood as potent for the responsibility for the care of the patient, especially from the primary care service, as the computer of the care network:

> *P4NCPD: Communication is an effort* [...] *that goes much further from PHC, where those who first arrive, who are closest to the case* [...]. *So, we have this role of: 'let's call!'*

They also pointed out the possibilities of establishing protocols and flows for the improvement of communication. However, they argue that such protocols should be flexible, considering the complexity of networking and patient needs, which are often not covered by predefined care flows.

Also, according to the participants' perception, there is a certain difficulty among network professionals in referring patients to other services not part of the direct referral network, which professionals have termed as "attachment to their patients":

> *P2NCPD: People hold on '*[...] *is my patient, I have to do everything here in my unit'* [...]. *But this attachment we have to the patient has to be deconstructed. How do you get the patients to circulate inside the network as well?*

One of the strategies to overcome the challenges was the existence of a discussion forum, enabling dialogue between the network services, promoting articulated work among professionals and services, collective discussion of health situations and rehabilitation of the population, and monitoring of patients in the various points of the care network.

In these spaces, several strategies of care, demand organization, and network assistance flows are discussed, as well as being a space that seeks to promote permanent training mechanisms for professionals. However, professionals recognize that there are many challenges to establishing more effective institutional communication:

> *P4NCPD:* [...] *forum is an important step* [...]. *We know each other, dialogue, make several agreements, but I think this thing had to be beyond us* [...] *how can we do to what we agree on at the forum* [...] *be part of the units flows.*

It was pointed out that the construction of networking also depends on institutional agreements between services and their management and between different departments related to the issues of the CPD.

> *P4NCPD: How do we get out of the personal sphere to* [...] *empower the service. I think that managers are of fundamental importance* [...] *because our governability is restricted.*

In this sense, the social participation of professionals and CPDs in political spaces was discussed as a fundamental means to give visibility to the needs of the population and to demand actions necessary to promote the improvement of the quality of care. Political participation is a challenge for all, something that is still in the process of being built:

> *P1NCPD:* [...] *we have to occupy more spaces also political, we and the CPDs in the territory ... we will create spaces for meetings between the CPDs* [...]. *That maybe is the way to understand what you want from them.*

# 4 Discussion

## 4.1 Access, comprehensiveness and communication in the care processes

Considering both networks in relation to the health system, it was pointed out as challenges to the production of care and networking: the geographical characteristics and territory architecture, lack of social support for displacement to the health services, the organizational and eligibility differences in services that constitute traditional BHU and those that rely on the FHS and the restricted criteria to use adapted transportation and to access health services.

The main issue of access identified by the participants is mobility, in particular for the NCPD. This problem precedes even arrive at the service and involves adaptation of the territory and housing, social support, availability of adapted transportation, among other necessities. The professionals have indicated local actions to address these difficulties, such as encouraging or building social support networks or encouraging local transportation alternatives. It is worth mentioning that the theme of architectural accessibility of the territory has been debated by many authors (SANTARPIO et al., 2015), highlighting the challenges of access to health services (KASSOUF, 2005; SOUZA; ROCHA, 2010; CASTRO et al., 2011; AMARAL et al., 2012). It should also be noted that legislation on the subject has not yet succeeded in ensuring the mobility of a large part of the population with limited mobility, especially in the peripheral regions of the municipalities.

Also regarding the access, the results showed difficulties related to different understandings about rehabilitation assistance to at-risk babies and CPD. Regarding CDPs in particular, the still present culture that can only be met in rehabilitation services was also considered as an access barrier. Thus, for CPDs to have the first contact with PHC services, it is necessary, first of all, to overcome the idea, both of the community and of professionals, that CPDs must be attended exclusively in specialized rehabilitation services. Some authors discuss the need to change this view (ALMEIDA, 1997; SOUZA; ROCHA, 2010).

For Starfield (2002), access/accessibility involves organizing the PHC service to meet the people who seek it and how the patient perceives that access. In any case, the PHC was considered a gateway that facilitates access to the SUS, mainly through the models of care that have FHS, enabling to carry out home visits and active search of the people in the service coverage areas. Specifically, on the issue of eligibility, it is worth noting that the patient follow-up protocols are defined, in large part, by clinical criteria related to acute illness, determined from pathologies and initial stages of the installation of pain and disability processes. Often, in this dynamic, processes and their protocols may restrict the care of subjects who do not meet the criteria.

Mendes (2010) points out the need to review the models focused exclusively on acute conditions, emphasizing the relevance of the range of interventions from the level of prevention in health directed to the general population to those aimed at patients with very complex chronic conditions that demand the case management. Marsiglia (2012) states that the main aspects that concern accessibility would be the adaptability of the service to the differentiated needs of the patients, the concern with the establishment of equity and the routines and protocols concerned with inclusion.

In this sense, it would be interesting that the set of care needs of the subjects be evaluated and debated in the services for the constitution of an effective network, with the service provision organized and the resources available to the care that considers the different situations and conditions of pregnant women, at-risk babies and CPD inhabitants of the territory, from the perspective of comprehensive care.

Understanding as a principle of the SUS and orientation of the World Health Organization, comprehensiveness considers the relevance of services suited to the singular demands of the subject (WORLD..., 2008). It also implies the articulation of actions between services and programs and the patient´s understanding of the complexity of their real needs (MATTOS, 2001; STARFIELD, 2002).

The understanding of life situations of the subjects includes their health needs and also situations of vulnerability, social and support networks, socioeconomic condition, among other elements. It was pointed out, for example, that the needs of CPDs should be understood beyond pathology and networking should aim to increase the autonomy and social participation of CPDs from the elaboration of the therapeutic project, in which the professional understands the subject and his family as protagonists of the whole process of intervention and are responsible for his care. Many authors argue that the needs of the CPD are related to the maintenance of life and access to rights, being very present the experience of social exclusion processes (PIMENTEL et al., 2011; SOUZA; GOMES; AOKI, 2012; AOKI; OLIVER, 2013; SOUZA; PIMENTEL, 2012). In this line, Othero (2010) states that the needs identified by the CPDs include specific aspects of healthcare, but also encompass other dimensions such as access, rights, work, and leisure, indicating the importance of comprehensiveness and cross-sectoral actions.

Also, the results show the existence of problems in the care flows between network services, which are often not precise - in particular, in the articulation between PHC and hospital care - and tend to be focused on certain professionals, leading to interruption of care. It is also worth noting that the issues of access and comprehensiveness are interrelated because if eligibility criteria and understanding of needs are restricted or confused by the interruption of flow, not only access to the service is limited, but the comprehensiveness of actions between services does not occur. Finally, they indicated the reduction and lack of professionals to meet the needs of the patients of the networks and the low knowledge of these professionals to offer actions and resources of the different services as a problem.

The investment in the hiring of human resources and training to work in the SUS, in the ambit of the PHC and in teamwork, has been pointed out as one of the great challenges to work in networks of attention (GONÇALVES et al., 2014; SHIMIZU, 2013). It is also important to note that, although not mentioned by professionals, care lines are network care protocols that seek to delineate some flows. These are proposals that seek to facilitate communication among teams and services, programs, actions and standardize certain resources, in response to the most relevant epidemiological needs, as well as coordinate the assistance longitudinally and connect roles and tasks of the different points of attention and professionals. The Care Lines presuppose a global response of the professionals involved in care, overcoming the fragmented responses (BRASIL, 2010). It is worth emphasizing that this need for more integrated responses was identified by the professionals participating in the study.

As strategies, participants addressed the possibility of accessing STS to deal with cases considered more complex. Also, they affirmed the need to offer services from a flow in the wider territory. In this sense, a patient monitoring group carried out at a particular point of care could be accessed, for example, by any CPDs in the area of technical supervision, if necessary.

For the effectiveness of the coordination of the fundamental care, the communication between the professionals, managers, and patients of the service is necessary. The communication concerns the exchange of information and the sharing of opinions and points of view, as well as the establishment of relationships of trust, possible to establish a link between those involved and the establishment of reference professionals and lines of care for patients.

In this sense, the effectiveness of communication requires a commitment of professionals with health practices. For Feuerwerker (2005), health workers have been guided by norms and standards of action that order their work in the SUS with few opportunities for direct participation in the formulation of policies and practices, producing a mismatch between identified health needs and the actions advocated by health policy, which are still focused on biomedical procedures. Moreover, health services are based on people, workers, and patients, who have beliefs and values about health work and how it should be performed. Therefore, they are actors with intentionality, they build bonds and such bonds build the network (FEUERWERKER, 2005). It is precisely in this aspect that it is fundamental to understand how the interpersonal communication in the care network is given.

Also, Lima and Rivera (2009), Pitta and Rivera (2006) and Silva and Rocha (2014) discuss the need to build new health communication models that promote more democratic, synergistic and supportive relationships among the different actors, composing the healthcare networks. The communicative action is an example of the alternatives to think about more democratic forms of communication:

> [...] based on the search for understanding (acting communicative), based on the ability of participants in the interaction to produce a reasoned consensus on the claim of validity that can be criticized which will motivate their actions and promote emancipation in the face of political domination and liberation of man for critical reflection. Such a perspective does not eliminate or even attempt to eliminate conflict. It seeks a solution through a dialogical interaction based on arguments (LIMA; RIVERA, 2009, p. 334).

As a result of this study, the participants pointed out that there are flaws and discontinuities in the communicative processes that compromise the networking, with the reproduction of a fragmented system of healthcare and rehabilitation, composed of isolated services, which present difficulties to provide continuous assistance to the CPD, pregnant women, at-risk babies and other populations. SN professionals have identified important failures in communication between services, in which the logistics system - which for Mendes (2011) is one of the components of the care networks - functions irregularly. This component should be supported by information technologies, with the organization of flows and counter flows of information and people in the different points of the care network, a system consisting of a patient identification card, electronic medical records, regulated access systems along with other health services and health transportation system, which would promote an effective reference and counter-referrence system.

The results also point out that participants understand that the PHC service should be the communication center of the networks, which would coordinate the flows and counter flows of the health system as a whole. They also dealt with the challenges faced in the day-to-day work of local PHC services that hamper communicative processes and networking, such as work overload and managerial problems. It is understood that the difficulty of treating PHC as an integrating center of the health care network generates, among other problems, the precarious hiring of health professionals, the reduced supply of inputs, the presence of ineffective management, among other problematized issues also by the study participants (MENDES, 2011).

As a strategy to overcome a set of challenges, the implantation of the electronic medical record was indicated by professionals of the SN as a possibility of integrating the information about the patients between the different services and improvement in the quality of the assistance. In this way, the history of interventions performed in the PHC could be accessed by hospital professionals and vice versa, with possible articulation between services of other levels of care as well. For Mendes (2011), the integration of the information system promotes access to a reliable patient history, which can produce better results in the clinical management performed by different professionals in different services.

In the absence of electronic medical records, SN professionals see the exchange of information between points of care through electronic mail as an alternative in which priority is given to direct contact with the reference professional, which has required the creation of institutional flows for sending and receiving information, since often the dismissal of a professional institutionally disrupts the actions. Similarly, professionals from the NCPD also discussed the importance of overcoming the construction of a network of care based mainly on professionals and interpersonal relationships and the need to involve units and managers in the discussion on better management of communication.

Regarding the organization of healthcare, there was a need for clearer and more flexible flows and protocols, discussed and agreed between professionals and services so they could be adapted to situations of greater complexity or to those not possible to maintain a route predefined by the health system. Once again, there is the articulation between the themes of access, comprehensiveness, and communication. For Pitta and Rivera (2006), such as protocols and care flows, although they are very important to organize the course of the subjects in the network and the quality of health care these communicative products must be instituted together with creative processes and strategies, based on minimum consensus, which is often conditioned by uncertainty given the complexity of health needs.

Thus, the challenge to integrate different professionals, services, managers, and patients requires communicative actions, which for Lima and Rivera (2009) only occur because of interpersonal relationships, interdependent relationships between care center in the daily practice of services. In this sense, it is observed that the inter-professional relationships were explored as a power, in particular in the CNPD, with the reflection about strategies that evidence communicative actions in the direction of the responsibility for the care.

Professionals of SN identified the lack of dialogue between services and professionals as a critical node of the network, suggesting the promotion of institutionalized "meeting spaces" that guarantee the participation of the workers. The professionals of the NCPD have identified the Rehabilitation Forum and other thematic meetings as a priority space for networking, but they share the concern about the scope and institutionality of the discussions that took place in this conversation space.

Therefore, it is clear the need to create mechanisms to improve the management of the network and its communicative processes, which could have impacts on the expansion of comprehensive actions and the guarantee of access to health care networks. These are three interlinked themes, indicating, on one hand, the complexity of network practices and, on the other hand, the need for creative and integrated actions to deal with the challenges to guarantee the right to care.

## 5 Conclusion

The implementation of HCNs and the discussion around them is still recent in the national territory, with ongoing experiences that seek to break with the fragmented model of care and offer a more effective response to the construction of access and comprehensive care, mainly to chronic health conditions. Although these proposals in the SN and NCPD seek to direct efforts for care network to these populations, it is observed the existence of important gaps between the recommended one and the daily reality of the work processes in the services, as described for the region in this study.

These issues point to the importance of the continuity of policies that induce the reorientation of the training of health professionals, such as PET. In this scenario, PET Networks enabled the reflection among the preceptors on the health care practices in the network and ways to qualify them. It is noteworthy that the study limited the perception of PET preceptors and could be extended to other professionals in care networks, obtaining a view of workers in general.

In the process of reflection on the subject, the emphasis was placed on the challenges for the construction of networking in the scope of access, comprehensive care and improvement of communication between professionals and services that make up the SN and NCPD. Professionals pointed out to address the lack of access of CPD and babies at risk to the network of care, the expansion of the Family Health Strategy to the other basic health units of the territory, the improvement of the mobility of families in the territory, pointing alternative forms of transportation offered by the public power and social support network. They also pointed out the need to create alternatives in rehabilitation for the care of chronic cases, often not eligible for specialized services and the organization of the assistance of CPDs and at risk babies from their needs and not just pre-established criteria and flows. It is identified the relevance of these being thought from the complexity of the life situations, considering that the service offer can occur from a flow in the extended and articulated territory.

Regarding the effectiveness of communication, professionals positively validated strategies that exploit and enhance inter-professional relationships (communication through e-mails, social networks, meetings between services), but with greater institutional support towards accountability for care. It was also pointed out the need to establish and strengthen flows and definitions of institutionalized care lines that are more flexible between the different services. This could be with guidance from STS and agreed in meetings between professionals in a discussion Forum, a strategy cited as a way to improve communication between professionals and service managers.

In this context, it is necessary to be clear that the complexity of the production of the care to the different needs of the subjects in a certain territory will always have new challenges. In this sense, the study pointed out the sensitivity of professionals to reflect on the difficulties faced in daily work and the possibilities for overcoming them. It is up to the governance of the care network, as presented by Mendes (2011), to provide an organizational arrangement that creates a mission and a vision in organizations, to manage all components, in this case also SN and CNPD. Thus, what seems to be fundamental to affirm is that even recognizing the importance of agreed actions and protocols for the management of care pathways to guarantee access and comprehensive care, the indispensable horizon in health practices is the production of processes of emancipation and expansion of social participation, guaranteeing, above all, the right to health.

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## Author’s Contributions

Marta Aoki and Marina Picazzio Perez Batista: text design, collection, treatment, and analysis of information, the organization of sources, writing and final revision of the text. Fátima Corrêa Oliver, Maria Helena Morgani de Almeida, and Daniela Molini-Avejonas: guidance and final revision of the text. All authors approved the final version of the text.

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[1] The SIGA (Integrated Management and Health Assistance System) manages the flows and services offered by the health care network (SÃO PAULO, 2013a).

[2] It is a door-to-door transportation mode, designed for people with physical disabilities with a high degree of severity and dependence, free of charge to its users, offered by the city of São Paulo.