


## PERCEPTIONS OF THE APPLICATION OF THE MODEL OF CARE FOR CHRONIC CONDITIONS IN PARANÁ, BRAZIL

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### ABSTRACT

The current health care model for users with chronic conditions in the Unified Health System needs to be transformed. In Paraná, there are strategies for continuing education and co-financing of services focused on the Care Model for Chronic Conditions. This is a descriptive and exploratory study, with a qualitative approach, which analyzed the perceptions of Primary Health Care and Specialized Outpatient Care professionals about the implementation of the Care Model for Chronic Conditions. 4 focus groups were held, with the participation of 37 professionals, the discussions permeated the work processes from the perspective of thematic analysis. In the statements, elements such as the risk stratification of the health condition, the organization of care and the approximation of the teams were identified. The elaboration of the care plan is incipient due to the lack of understanding of professionals and users about the tool. In health units, access occurs in the logic of acute care, and care is shared through regulation centers. Permanent education strategies, structured public policies and specific funding are drivers for the consolidation of the Model.

**Keywords:** Care Models, Chronic Condition, Primary Health Care, Outpatient Care.

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## INTRODUCTION

In recent decades, there have been important variations in the morbidity and mortality patterns of the population worldwide, due to demographic and epidemiological transitions, with a decrease in the prevalence of infectious diseases and a higher prevalence of Chronic Non-Communicable Diseases (NCDs). There are different models of health care for acute and chronic conditions in public and private health systems around the world<sup>2,3</sup>. In order to offer effective and effective care to the population, it is necessary to organize the supply of health services to meet the demand for care for both acute and chronic conditions, balancing the intensity of the care offered, according to the needs of the population and the territory of sanitary responsibility.

NCDs include diseases of the circulatory system (CAD), neoplasms, chronic respiratory diseases (CKD) and diabetes mellitus, and constitute the main cause of death in the world. In Brazil, in 2019, 738,371 deaths due to NCDs were registered, and 41.8% of these deaths occurred prematurely, between 30 and 69 years of age, representing a mortality rate of 275.5 deaths per 100 thousand inhabitants.

Considering the assumptions of the Unified Health System (SUS) and the challenge of a universal health system in a continental country such as Brazil, with inequalities in the supply and access to health services in the different health regions, it is urgent to change the health care model<sup>2,4</sup>. Currently, the current model is still predominantly organized to care for acute conditions and acute events, and it is necessary to move towards a system that is proactive, integrated, continuous and focused on the promotion and maintenance of the person's health.

In 2011, a Brazilian sanitarian proposed a model of care that considered the peculiarities of the health conditions of the Brazilian population, the Chronic Conditions Care Model (MACC)<sup>2</sup>. This model is based on the models of the Social Determination of Health, on the elements of the Chronic Care Model (CCM), and on the proposal of the Kaiser Permanente Risk Pyramid.

In Paraná, since 2014, the MACC has been recommended for the care of users in the Lines of Care established in the state. The lines of care seek to describe the user's itinerary in the Health Care Network (HCN), in order to improve the problem-solving capacity of care, based on the risk stratification of the population, which directs the intensity of care and priority location for adequate care in the HCN. Systemic Arterial Hypertension (SAH) and Diabetes Mellitus (DM) represent chronic conditions that impact the quality of life

of a large part of the population of Paraná, generating disabilities and lost years of life, which requires public health efforts at the municipal, state and federal levels to ensure the care of the affected population.

Within the scope of the state management of the SUS in Paraná, strategies are developed to drive the change in the current care model for the care of people with chronic conditions, focusing on the permanent education of health professionals in Primary Health Care (PHC) and Specialized Outpatient Care (AAE), and on the co-financing of specialized outpatient clinics that serve the Lines of Care of SAH and DM, that in order to be entitled to the financial resources made available, they need to organize the service with a focus on the implementation of the MACC.

In this context, it is relevant to incorporate scientific evidence into clinical practice, in an attempt to reduce the gap between scientific investigation and professional practice, with the integration of knowledge and routine practice of health services to promote the quality and effectiveness of health care. Therefore, analyzing the implementation of public policies in the context of the SUS is essential to evaluate the performance of interventions at all levels of management, contributing with reflections applied to practice.

Thus, considering the need to identify the impact of the strategies implemented in Paraná, to change the care model offered to the population living with chronic conditions, this research aims to analyze the perceptions of PHC and AAE health professionals about the implementation of the MACC.

## **METHODS**

This is a descriptive and exploratory study, with a qualitative approach. Four (4) face-to-face focus groups were held, mediated by a semi-structured script, conducted by 2 researchers, where we sought to collect information on how the implementation of the MACC is delivered to the target population, in this case users with SAH and DM, from the perspective of PHC and SEA professionals.

The groups were carried out between April and July 2023, in two PHC Units and two AAE services managed by Intermunicipal Health Consortia, in the municipalities of Apucarana, Piraquara and São José dos Pinhais, in the state of Paraná. These health establishments were included in the research because they are located in two different health macro-regions of Paraná, being in the northern macro-region the municipality of Apucarana, and in the eastern macro-region the municipalities of São José dos Pinhais and

Piraquara. In addition, the health services that provided care to users of the SAH and DM Care Lines at the time of data collection were selected.

The type of sampling used was by convenience, and the participants were middle and higher level health professionals from PHC Units and AAE services, with a minimum time of 06 months of experience in the service. The focus groups were carried out in the workplaces of the health professionals, who agreed to participate in the study, after signing the ICF, which ensures the confidentiality and confidentiality of the data. Nurses, physicians, nursing technicians, dentists, community health agents, nutritionists, psychologists, physiotherapists, pharmacists and social workers who worked at the research sites participated, according to the composition of the PHC and AAE teams, the study scenarios. There was no refusal on the part of the professionals to participate in the research.

The semi-structured script used in the focus group discussions was composed of six (6) subjective questions, which allowed the participants to express perceptions about the interaction between health professionals from the same service and with other points of the RAS, the facilities and weaknesses found to perform care according to the MACC, and what is the professionals' perception of the user's participation in their own care.

During the execution of each group, the audio discussions were recorded through a voice recorder and video capture by the Zoom videoconferencing® platform. The audios were transcribed and the product of the transcriptions were transformed into text files and reviewed through the text editor software. The transcriptions were analyzed through thematic analysis, from the perspective of Minayo, Deslandes, Gomes.

This article emerged from the results achieved in the research entitled "Implementation of the Care Model for Chronic Conditions in Primary Health Care and Specialized Outpatient Care from the perspective of health professionals", approved by the Research Ethics Committee of the Federal University of Paraná under CAAE No. 64814622.1.0000.0102. All ethical aspects provided for in Resolutions No. 466/2012 and No. 510/2016 were observed.

## **RESULTS AND DISCUSSION**

Thirty-seven (37) health professionals participated, nineteen (19) of them from PHC (51.3%), and eighteen (18) from AAE (48.7%). Each focus group lasted an average of 54 minutes, totaling 3 hours and 37 minutes of discussion on the theme. Of the total number of

study participants, thirty-four (34) had higher education in the health area, and three (3) participants had completed high school. Regarding the gender of the participants, in PHC, fourteen (14) health professionals were female and five (5) were male. In the AAE, thirteen (13) female professionals and five (5) male professionals. The average time to finish the participants' academic training was 5 to 10 years.

After a thorough transcription and rereading of the focus group products, vertical data analysis took place, which consists of evaluating the individual speech of each participant. Next, the horizontal analysis of the material was carried out, through the identification of common elements in the speeches of different participants. From this, it was possible to identify a main theme, related to the work processes in PHC and SEA with a focus on MACC. From this central theme, 3 nuclei of meaning emerged: 1) Access and organization of care; 2) Care plan and the performance of the multiprofessional team; 3) Permanent education focused on work processes in PHC and AAE.

## **ACCESS AND ORGANIZATION OF CARE IN PHC AND AAE**

Users' access to health services is a topic widely discussed in the literature, considering the peculiarities of universal health systems and the variety of forms of access that a system can provide<sup>15</sup>. It is related to the way users enter health services, as well as their continuity of care within the system. In Brazil, considering the assumptions of the SUS, PHC is the main gateway for users to enter the system, being responsible for coordinating care and ordering users in the RAS<sup>16,17</sup>.

According to Brasil<sup>16</sup> (2017), ensuring the user's first contact with the system is an essential attribute for PHC, as a source of care for each new problem or new episode of the same health problem, with the exception of emergencies and urgencies, when the population and the team identify PHC as the first resource to be sought when there is a need or health problem.

Thus, the presence of spontaneous demand, which is about users who seek the service on demand, in case of need, and the act of welcoming it, when they seek this level of care, is part of the work routine of PHC teams. User embracement is recommended by the National Humanization Policy<sup>18</sup> (2013) as an alternative to meet the needs presented by the user, to reorganize the team's work process and overcome the biomedical health model, removing the focus on care from the medical professional alone, for the involvement of the PHC team in this welcoming process<sup>19</sup>.

One of the greatest challenges of PHC is to organize the forms of access, balancing the needs arising from acute and chronic conditions<sup>19</sup>. In the PHC focus groups, in the statements of the study participants, it is evident that the search for care occurs predominantly by spontaneous demand, in the search for welcoming, and that the programming of care for chronic conditions is focused on the agenda of the medical professional, for specific groups:

We can make more appointments for the doctor [...] because only the nurse can do the reception [...] there is a movement that we are not able to solve, you know? there are people with sore throats, there are people with chronic low back pain, there are decompensated people [...] we spend most of the time in the shelter [...] (P13. PHC, Nurse)  
[...] we try to separate a space in the agenda specifically for chronic, hypertensive and diabetic patients, it turns out that it is much more than [...] it ends up that in the middle of the pregnant women's consultation, there are hypertensive and diabetic patients (P15. APS, medical)

In Brazil, it is common in PHC to have a future thematic scheduling model, as an organization of its care flow, for access by specific groups, such as: pregnant women, children, the elderly, hypertensive and diabetic, excluding a large part of the population in its territory that does not fit into a group, and when they actually need care, they end up facing difficulty in access<sup>16, 20</sup>. It is important to highlight that appointments with later dates favor absenteeism and hinder care, restricting access to those who really need it.

It is recommended that the PHC team organize its agenda in order to contemplate the diversity of the health needs of its population. It is necessary to guarantee access in cases of urgency, non-urgent spontaneous demand and continued/scheduled care for chronic conditions<sup>16</sup>. The PHC service portfolio is broad, and the offers of consultations, exams and procedures need to be scheduled with a certain periodicity, according to the risk stratification and the individual needs of each user.

The participants' statements corroborate the identification of absence or fragile scheduling of the agendas for the care of users with chronic conditions, and especially with SAH and DM. Reactive and episodic care is identified in the statements, predominantly focused on acute conditions and exacerbation of chronic conditions:

Diabetics are very common to come, right? to manage the reception [...] We have agendas, right? We have the days that make appointments for patients to come with scheduled appointments, but they also come to the reception [...] (P13. PHC, Nurse)

[...] But I try to talk a lot with patients when they come uncompensated in the reception [...] (P14. APS, medical)



[...] Even in the reception, when the chronics pass the reception, we already see in the medical record if there are recent exams, if there are not, we already request it and then it is already scheduled [...] (P17. PHC, Nurse)

Mendes (2019) argues that one of the major problems of contemporary health care systems is to respond to non-acute chronic conditions through the acute conditions care model. A care model focused predominantly on spontaneous demand and reception of acute cases and exacerbation of chronic conditions is not effective for stabilizing health conditions, and especially chronic conditions. The organization of care predominantly centered on unscheduled care is a sign of the fragility of care for chronic conditions.

The MACC recommends risk stratification of users with chronic conditions in PHC, based on guidelines, guidelines and clinical protocols, based on the best scientific evidence. Risk stratification is fundamental because it allows the identification of people and groups with similar health needs that must be served by specific technologies and resources, enabling PHC to organize the care of users in the territory, with a view to promoting adequate access, through the programming of appropriate care for each case, with regular and predictable intervals, in addition to being a beacon for the user's sharing to other points of care in the RAS, in a timely manner.

The execution of risk stratification of chronic conditions in PHC was identified in the statements of PHC participants. It is noteworthy that the professionals understand that risk stratification helps in the monitoring of these users within the scope of PHC, and it is necessary that it be carried out and reviewed at each service, as evidenced in the following statements. Another important detail is that it was identified that the act of stratifying was not centralized in the figure of the PHC medical professional only, and the nurse also performs:

[...] even in the reception [...] when the chronic patients pass the reception, we already see in the medical record if there are recent exams, if there are not, we already request and stratify them too [...] and already ask to schedule the appointment to follow up [...] (P17. PHC, Nurse)

[...] we work with risk stratification [...] we record the stratification of patients in our spreadsheets [...] the professionals who do the stratification are the professionals at a higher level, who are the doctors and nurses who end up doing it [...] (P13. PHC, Nurse)

In the AAE, for the care of users with chronic conditions, access to the outpatient clinic depends on the identification of users eligible by PHC, based on risk stratification, and considering its essential attribute of coordination of user care in the RAS17. This means

that the outpatient clinic's agenda expresses the work of PHC in identifying the population with chronic conditions, who knows who and how many people should be shared with the specialized team<sup>3,17</sup>. In the following statement, it is identified that for the sharing of care with the outpatient clinic, the risk stratification of the chronic condition is performed and informed:

[...] I usually make written referrals, right? Guiding, talking about something that takes, why I am forwarding, along with the risk stratification [...] (P11. APS, medical)

In the AAE services, the participants described that access to the outpatient clinics is somehow regulated by the user's municipality of origin. The difficulty reported in relation to this flow is related to the fact that the people responsible for scheduling are from the administrative area, and do not understand the criteria established through the guidelines and clinical guidelines, which are expressed in the risk stratification of the referrals made, as reported below:

[...] For them to have access to the outpatient clinic, they are scheduled by the municipality, right? [...] who manages the queue [...] most are administrative people in the scheduling part [...] the doctor can even make a referral [...] but the scheduler does not have this notion of what is stratified, what the patient's demand is [...] he will schedule where he thinks it is convenient (P2. AAE, nurse)

[...] Schedulers [from the municipalities] don't know what the criteria are, depending on what is placed in the referral there and if there is no stratification, just because there is the word diabetes in the middle of the referral is diabetes network, you know? (P5. AAE, Physician)

The existence of another stage of verification of the sharing of care between PHC and AAE, such as that carried out by existing regulation systems in the SUS, removes from PHC the coordination of care for the users under its responsibility, considering that risk stratification already represents the criterion for regulating access to specialized care<sup>17</sup>. Therefore, it is suggested that the professionals of the PHC teams themselves directly schedule users with stratified chronic conditions, according to the criteria for care in the outpatient clinic<sup>3,4,17</sup>. Such autonomy enables PHC to be in fact the organizer and coordinator of user care in the HCN, contributes to the reduction of waiting time by providing timely scheduling, strengthens the ties between PHC and SEA professionals for the sharing and transition of care, and strengthens the co-responsibility of PHC for the integrality of care<sup>3, 16,17</sup>.



A qualitative study carried out in the city of Rio de Janeiro, between 2019 and 2020, evaluated the decentralization of outpatient regulation to PHC, through interviews with managers and health professionals, complemented by analysis of municipal documents. Advances were identified in the interaction between the requester (PHC) and the regulator, the partial expansion of the capacity to coordinate PHC care. However, the proposal increased the competition for vacancies and inequities of access between Health Units, and exposed the fragile interface between PHC and specialized care. The study concluded that the decentralization of regulation is promising, but requires attention to the work processes in PHC and SEA, in addition to the synergy between centralized regulatory processes.

For Mendes (2018), PHC and SEA should function as a single clinical microsystem, even if operating separately in different units. This conception, by being based on the concept of network, breaks the principle of hierarchy so present in the theoretical, legal and operational documents of the SUS. In the logic of the clinical microsystem, PHC and AAE are organized to meet the same purpose, with the structuring of common processes, with the center of this microsystem being the users, with health professionals who meet and know each other, with well-designed work patterns and processes, which complement each other to provide shared care.

The participants described how the care of users with chronic conditions in the outpatient clinic is organized, with details regarding the flow since the user's arrival at the service, aspects related to multiprofessional action, and how the care is concluded both for new users shared by PHC and for users who return for sequential care:

[...] When they arrive at the outpatient clinic, they are welcomed, triaged, and after that they do a whole cycle of care [...] So everyone is passed on the same day by the team (P2. AAE, nurse)

[...] Most people come from far away, because in their municipality there is no such service [...] So, one day that she would spend to make an appointment with the doctor, that he would refer another day to go to the nutri, to refer the next day to the pharmacist, he already goes through everyone [...] (P6. AAE, nutritionist)

For the organization of care in outpatient clinics according to the MACC, it is recommended that care occurs in the logic of Continuous Care<sup>24</sup>. It is a care technology developed for the management of people with chronic, non-acute, more complex conditions, who benefit from varied professional approaches<sup>3,25</sup>. Consultations by different professionals occur individually, sequenced, in the same work shift and are terminated after the case is discussed and the care plan is prepared<sup>24,25</sup>.

Regarding the dynamics of care provided by the multidisciplinary team during the continuous care cycle, in the following statement, the participant emphasized that users with SAH and DM are cared for by all members of the multidisciplinary team (nurse, physician, nutritionist, pharmacist and psychologist) every time they return to the outpatient clinic:

[...] they [nursing technicians] make this distribution to ensure that patients go through all professionals [...] So all [users] are passed on the same day by the team [...] Always! It always goes through everyone [...] Unless he doesn't want to, it's very difficult [...] (P2. AAE, nurse).

It should be noted that the cycles of continuous care in the AAE can be differentiated into cycles of complete care, for users in the first visit to the outpatient clinic or in subsequent visits, according to the care plan elaborated; or partial, in the case of subsequent care, considering the recommendations made by the team in their last care plan<sup>24</sup>. This means that in the user's first visit to the outpatient clinic, he or she will be evaluated by all the professionals who make up the specialized team, and the returns should consider the user's needs, expressed in the individual care plan, completed by these professionals in the first evaluation<sup>4</sup>.

There are no impediments for the user to be seen again by the entire team on the return visit, as long as this care adds value to the care of this user<sup>24,25</sup>, which was not evident in the statement evidenced above. The participant also refers to the support point in the continuous care cycle of the outpatient clinic:

[...] And at the end, there is the support point [...] where he checks this entire cycle to see if he has gone through all these professionals (P2. AAE, nurse).

The support point is a health professional in the outpatient clinic responsible for managing the user's care during their stay in the service<sup>25</sup>. He acts and intervenes so that the user is at the center of care, must have technical knowledge about the functioning of PHC and AAE, the care plan and the clinical guidelines adopted by the service, to propose interventions with the team whenever necessary<sup>24,25</sup>.

## **CARE PLAN AND PERFORMANCE OF THE MULTIPROFESSIONAL TEAM IN PHC AND AAE**

The care plan is an important tool to promote the management of the health condition of all users in the PHC territory, and especially users with chronic conditions<sup>3</sup>. It is

recommended that it be prepared by the PHC team together with each user, with the definition of goals to be met over certain periods, with the proactive participation of users in their care<sup>25</sup>.

In the need for PHC to share user care with other points of care in the HCN, the care plan is essential because it is an instrument completed by the PHC multiprofessional team that demonstrates all the management already performed by the team, as well as the way in which the user participates in their own care<sup>2,3</sup>. For this reason, it is desirable that it be assumed as the main instrument of communication between the teams, being initially prepared by the PHC team, reviewed and complemented by the SEA team and monitored by both teams, always centered on the needs and expectations of the main person interested in care: the user<sup>24</sup>.

According to the reports, in relation to the elaboration and use of the care plan, it was identified that this tool is used, but in an incipient way by the PHC and AAE teams, as shown in the following reports:

He doesn't come back [with a care plan], if he comes back [...] he comes back with the prescription changed like this, he took out the Losartan and entered, I don't know, Amlodipine, let's suppose [...] (P2. PHC, Nurse)

[...] Some units write [in the care plan] there are some that are very cute, they do everything right, but some don't even look [...] (P16. AAE, nutritionist)

The function of the shared care plan is to ensure that PHC and SEA professionals are pursuing the same goals, and not just a mere filling in of information about individual conducts of professional categories. The actions foreseen in the care plan need to add value to the care of the user, who is the main protagonist of this process, as well as contribute to PHC exercising its role of care coordination.

The participants comment on how the process of sharing the care plan between PHC and SEA occurs, and it is evident that the initial elaboration of the tool does not occur by PHC, but by the SEA team, which delivers a copy of the care plan to the user and forwards the same document to the PHC team, thus disqualifying the main purpose of the tool, which is the communication and integration between the teams and conducts carried out by the two teams, with different levels of care:

[...] We structured the care plan through Google Drive [...] then the municipalities have access [...] if the municipality has seen the care plan, if it hasn't seen it [...] we can do this through technology, but it is still very difficult [...] (P7. AAE, Physician)

They send the care plan to us [...] and deliver a copy to the patient, right? [...] it comes in the unit's email, I download the care plan and in our electronic medical record you can attach the PDFs [...] then I attach it (P13. PHC, Nurse)

The establishment of goals with the user, and the monitoring of the actions foreseen in the care plan by the PHC and AAE teams are essential to ensure that the user achieves the stability of his health condition<sup>25</sup>. Therefore, it is essential that the user understands the importance of the instrument developed by the two teams that accompany him, as well as what his participation will be in his own care process<sup>26</sup>.

The participants recorded in their statements the difficulties in understanding the users' understanding of the care plan prepared by the team during the continuous care cycle, highlighting barriers such as low education and lack of understanding of the proposal for using the tool, as observed in the following statements:

[...] We have already made attempts to make the care plan printed and deliver it to the patient, but it did not work [...] the process is lost [...] most of our patients are illiterate. So we delivered, they were like, "Oh, what do I do with this here?" I arrived at the unit "ah, they gave me this, but I don't know what it is". I came back to the appointment, "was I supposed to bring this here?", so it wasn't working [...] (P17. AAE, psychologist)

[...] The feeling I have is that less than 10% of patients read the care plan [...] If you ask the patient at the return appointment "did you bring the exams?", they deliver the care plan and say: this is what you asked for" [laughs] (P5. AAE, Medical)

The difficulties that users have in understanding, evaluating and applying health care guidelines are related to the level of health literacy<sup>27</sup>. Studies have shown that individuals with low socioeconomic conditions, lower educational level and lower self-perception of social status have limitations in understanding written materials and the guidance spoken by health professionals<sup>28</sup>.

A cross-sectional study<sup>29</sup> conducted in 2017 in the municipality of Picos, in the state of Piauí, assessed the level of health literacy of 357 adults with and without Systemic Arterial Hypertension, through the application of the Brazilian version of the Test of Functional Literacy in Adults, in individual interviews. Inadequate literacy was observed in more than 70% of the hypertensive patients investigated. The finding reinforced the need to improve the self-care skills of this group, especially in those with older age and fewer years of schooling.

In contrast to the user's limitations, health professionals often use incomprehensible words, speak quickly and do not provide sufficient information about their health status, in

addition to not making sure that the individual understood their health problem<sup>30</sup>. As important as the health literacy competence of the users, are the vocabulary and communication skills of the professionals, especially when promoting effective communication through simple language<sup>31</sup>.

The follow-up of chronic conditions in PHC and AAE, especially SAH and DM, represents a significant challenge for the health system, requiring approaches that go beyond the traditional model centered on isolated specialties<sup>32</sup>. For this reason, the performance of the multidisciplinary team, in an interdisciplinary way, can substantially increase the adherence of users to the therapeutic goals established collaboratively in the care plan<sup>33</sup>. The integration of teams from different levels of care emerges as a promising strategy, bringing together professionals from different areas to provide comprehensive and personalized care<sup>34</sup>.

In this sense, the participants discussed the potential of the multiprofessional team's performance in the care of users with SAH and DM, both in PHC and in AAE:

[...] Another potential that I also see is the multiprofessional team [...] so we have the privilege of having a multiprofessional team every day in the unit, right? [...](P1. APS, occupational therapist)

[...] I, particularly, also see this issue of the development of the work from the moment we had other professionals within the area [...] this helped a lot in this issue of care for hypertensive patients, diabetics and other issues as well, right? Because there are several professionals in physical education, psychologist [...] (P8. PHC, community health agent)

In the AAE service, it is highlighted that the presence of the multiprofessional team is not common at this level of care for individuals with SAH and DM, and that even for SUS users, the multidisciplinary and not just focal care modality is a differentiated practice:

[...] They go through a multi-team, which is also not common in many places... And what already scares them is this business of the multi-team But when they enter the first service, they are well attended, that they are well received, that they observe that we are there to guide and help... already change [...] (P1. AAE, nurse).

[...] Because we serve in a multidisciplinary way, right? So, every patient who comes to us in the first appointment is received by the whole team, right? [...] (P15. AAE, endocrinologist)

The presence of a multidisciplinary team within PHC has been in place since 2008, when the Family Health Support Centers (Nasf) were established, through a normative act and funding from the Ministry of Health. In the AAE, historically, the services were organized for care in focal specialties, in a fragmented way and without communication with

PHC, and without standardization by the Ministry of Health of the organization and model of care for this point of care.

In 2023, the National Policy for Specialized Care was instituted within the scope of the SUS, representing an important normative act that corroborates the change in the care model, especially in the organization of care through multiprofessional teams, which work in an interdisciplinary way, to ensure access, welcome, offer quality care, and provide support, through matrix support to other teams and services of the RAS.

### **CONTINUING EDUCATION FOCUSED ON THE WORK PROCESSES OF PHC AND AAE**

Considering the complexity of the work processes in PHC, the multidisciplinary team is required to have an expanded knowledge of different health conditions, to provide comprehensive care to the user and ensure the problem-solving capacity of this point of care<sup>38</sup>. For this reason, investing in the permanent education of teams is an important step towards the integrality of care and work in RAS<sup>39</sup>. In the MACC proposal, SEA services play an important role as PHC matrixers, through active learning based on practice, strengthening ties between the teams of these two points of care<sup>40</sup>. From the participants' speeches, permanent education actions emerged through training and meetings between the teams of the care levels:

[...] because in addition to these trainings, there are some videos too, both the [cardiologist] and the [endocrinologist] made some very didactic videos explaining how to stratify and all municipalities have access, so if doubts arise they look there [...] (P17. AAE, psychologist)

[...] Only when the [outpatient clinic] opened [...] When it opened, they came here to the municipality and presented all the lines, right? From pediatrics, the elderly [...] When it opened, after that it never [...] Then we went there too, we went to meet the professionals, all the professionals at the higher level at the time [...] but there was never this movement again (P13. PHC, Nurse)

Providing integrated actions and practices on a continuous basis between PHC and AAE favors the strengthening of bonds, considering that the daily routine of health work constitutes an intense relationship of knowledge exchange and cooperation among professionals<sup>38</sup>. Through these actions, the aim is to incorporate different tools in the management of health care, which depends directly on professionals who understand a new way of thinking and offering care to chronic health conditions, uniting theory and practice, to achieve the expected changes in the organization of services and, consequently, in the model of care offered to this population<sup>41</sup>.



## FINAL CONSIDERATIONS

The study made it possible to highlight the perceptions of health professionals from PHC and AAE services about the work processes implemented to care for SUS users with chronic conditions, especially with SAH and DM. From the perspective of these professionals, issues related to the participation and accountability of the user in their own care emerged in the discussions, and that the population served still has little understanding of the MACC proposal, to the detriment of the fragmented and biomedical model that prevails in the care of chronic conditions in public and private health services.

In the statements of the study participants, important elements related to the MACC were identified, such as the approximation of the PHC and AAE teams, the risk stratification of the population with chronic conditions identified in the PHC territory, and the organization of care in a multidisciplinary and interdisciplinary way, especially in the AAE. However, there are still barriers to the consolidation of this model, such as the organization of the PHC agenda without care programming, focused on medical conduct, and the presence of intermediaries between the relationship between PHC and AAE, such as municipal regulation, making it difficult for these levels of care to act as a single clinical microsystem.

Permanent health education strategies focused on changing the current care model for chronic conditions, as well as structured public policies and directing funding, are potentiators for changing care practices, and need to be effectively established in the SUS, followed and monitored permanently, regardless of government programs and political movements, in order to actually achieve the desired change in the care model.

Evaluating the changes in the model of care offered to chronic conditions in Brazil, and especially in Paraná, is a challenge, because the transformation of this scenario involves basic professional training in the health area, which is still fragmented, centered on the figure of the medical professional and on the model of care for acute conditions and the exacerbation of chronic conditions, as situations related to the management of services and the organization of work processes.

Of the limitations observed, it is noted that the study covered the universe of two (2) AAE services that receive co-financing from the state of Paraná to organize the care of users with SAH and DM according to the MACC, out of a total of twenty-two (22) existing in Paraná in the same condition. In addition, the technical teams of the PHC and AAE services participated, and it was not possible to understand the perception of managers and users about the implementation of the care model.

It is important that new studies in this perspective be carried out, to identify the impacts and effectiveness of permanent education strategies and public financing policies focused on the MACC.

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