The role of Family Health Support Center in assistance coordination of Primary Health Care: limits and possibilities

O papel do Núcleo de Apoio à Saúde da Família na coordenação assistencial da Atenção Básica: limites e possibilidades

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ABSTRACT The aim of this study was to analyze how the Family Health Support Center has contributed to Family Health Teams in the fulfillment of its assistance coordination function. A qualitative case study was performed in the city of Camaragibe, State of Pernambuco. Data collection was held from January 2015 to May 2015 by means of focal groups, document analysis, and participatory observation. Results demonstrate that the Family Health Support Center, which acts following the logic of matrix support, is able to collaborate for the reinforcement of the Primary Health assistance coordination function.

KEYWORDS Primary Health Care. Access to health services. Comprehensive health care.

RESUMO *O objetivo deste estudo foi o de analisar como o Núcleo de Apoio à Saúde da Família tem colaborado com as Equipes de Saúde da Família na sua função de coordenação assistencial. Realizou-se um estudo qualitativo do tipo estudo de caso no município de Camaragibe, Pernambuco. A coleta de dados cobriu o período de janeiro a maio de 2015 e aplicou grupos focais, análise documental e observação participante. Os resultados evidenciam que o Núcleo de Apoio à Saúde da Família, atuando segundo a lógica do apoio matricial, pode colaborar com o fortalecimento da função de coordenação assistencial da Atenção Básica.*

PALAVRAS-CHAVE *Atenção Primária à Saúde. Acesso aos serviços de saúde. Assistência integral à saúde.*

Introduction

In order to guarantee full access to health care, one of the most currently discussed strategies is the organization of Health Care Networks (RAS), whose main guideline is the integration between care levels and the strengthening of Primary Care (PC) to exercise the coordination function of care (GIOVANELLA ET AL., 2009). The success of RAS depends on the effectiveness of PC in three fundamental roles: resolvability, accountability and coordination (MENDES, 2011).

In 2006, the Brazilian Ministry of Health defined family health as the main strategy for reorganizing the health system with the perspective of implementing a more comprehensive primary care model (SISSON ET AL., 2011). More recently, the National Policy of Primary Care (PNAB) has broadened the scope and understanding of PC, in accord with the international discourse, by defining the Family Health Teams (EqSF) as a preferred point of contact for a network of resolutive services and universal access. It was also established that PC should coordinate RAS and implement integrality in the various dimensions (BRASIL, 2017).

Assistance coordination is an important attribute to change the model of health production and, in this article, is understood as an agreement of all the services that compose the care network, regardless of the place where it is offered, so that these services harmonize for a common purpose. In this perspective, care coordination focuses on the interaction between health service providers (TERRAZA-NÚÑES; VARGAS; VÁSQUEZ, 2006).

The assistance coordination has three dimensions: information, clinical and administrative management. Information coordination includes the transfer and use of knowledge about the clinical history and biopsychosocial aspects of the patient among the different levels of attention that he uses (BÉLTRAN, 2006). The coordination of the clinical management is the guarantee

of care in a sequential and complementary way by the different services that make up the levels of attention (VARGAS ET AL., 2011) and is characterized by the subdimensions coherence of attention, accessibility between levels and adequate follow-up of the patient. And administrative coordination includes the mechanisms to guarantee patient access along the care line according to their needs (VARGAS ET AL., 2015). It has the subdimensions existence of mechanisms for administrative coordination; administrative reference of the patient to the appropriate unit; and prior programming of care in the transition between levels.

Several strategies have been implemented in Brazil with a view to strengthening the case-resolving capacity of the PC and its role of coordination of the attention networks. However, some studies have revealed that the Family Health Strategy has not yet been able to materialize as a service of first quality and resolute contact. The access to specialized services continues to be very difficult, despite the several implanted referral and counter-referral mechanisms and outpatient regulatory centers that aim to organize care flow in several municipalities (CECÍLIO ET AL., 2012; SOUSA ET AL., 2014).

Moreover, the inexistence of effective mechanisms for health care integration and the persistence of a process-centered work process organization model that generates an excess of administrative and assistance demands for EqSFs makes it difficult to carry out care coordination actions (CECÍLIO ET AL., 2012; SOUSA ET AL., 2014).

One of the initiatives implemented in Brazil with a view to strengthening the case-resolving capacity of PC and its role of coordination of care networks was the implementation in 2008 of the Family Health Support Centers (Nasf) (ALMEIDA; FAUSTO; GIOVANELLA, 2011; BRASIL, 2014).

Nasfs consist of professionals from different specialties who should work, in the perspective of matrix support, together with

the EqSF to strengthen them through the expansion of their clinic and their scope of assistance actions, as well as support them in the exercise of assistance coordination. According to the Ministry of Health, this mode of action would enable a more comprehensive and resolutive assistance arrangement, still within the scope of PC (BRASIL, 2014).

The performance format of Nasf gives it a greater possibility of 'transit' between different teams and services, which allows it to have greater power to interact with the various points of the network of attention (BRASIL, 2014). When this action is organized with the purpose of favoring communication and exchange between these teams and services, Nasf can play an important role in strengthening the interchangeable coordination – between the teams that operate in PC – and inter-levels – between PC and other services of health or organs of other sectors.

The empirical observation of the potentialities of Nasf and the relative scarcity of studies on the results of the performance of these matrix teams were the motivations for this study, which aimed to analyze the role of Nasf in strengthening the coordination of care of family health teams.

Methodological pathway

The case study in Camaragibe (PE) was chosen as one of the pioneers in the implementation of Nasf, in 2008.

The municipality is administratively organized in four sanitary regions, called Health Territories (HT), and maintains in operation 42 EqSF and four Nasf, which are responsible for the PC of almost 95% of its population. To collect the data, the HT3 was chosen because it was one of the first territories to have a Nasf implanted and, also, because it presented a lower turnover in the composition of the team.

Data were collected from january to May 2015 through participant observation, documentary analysis and three Focus Groups (FG) performed with the HT3 Nasf team. They also participated in an EqSF, indicated by the coordination of PC as one of the teams with better organization of the work process, and the team of a specialized service, the Municipal Rehabilitation Center (MRC), which attends patients referenced by Nasf.

In the FG of the EqSF, eight professionals participated, among CHA, nurse, physician and nursing technician. From Nasf, five workers participated, including physiotherapist, phonoaudiologist, nutritionist, psychiatrist and psychologist. And from the Rehabilitation Center, there were physiotherapists, occupational therapists, social workers, psychologists and phonoaudiologists, making a total of eleven participants. All the participants signed the Free, Prior and Informed Consent (FPIC).

The focus groups were previously scheduled and carried out at a time and place most convenient for each team. Each one lasted on average 90 minutes and was coordinated by two collaborators of the research, one in the function of mediation of the discussions and another in the observation of the behavior of the participants. During the focus groups, a script was used with the following guiding questions: (i) has Nasf's actions provoked a change in the number and profile of referrals for Specialized Care (SC)? (ii) Does Nasf support the articulation between EqSF and specialized services? (iii) Does Nasf support queue management in specialized services? (iv) Does the user attended in specialized services maintain a bond with EqSF? E (v) Do reference services inform EqSF or Nasf about the discharge or abandonment of the users' treatment?

Participant observation was carried out at meetings between the EqSF and Nasf; among the four Nasf teams in the municipality; and between Nasf and Rehabilitation Center. In these meetings, the most relevant aspects about the routine of the activities of

the teams, the themes and guidelines discussed at the meetings and the interaction among the professionals were observed and recorded in a research diary.

After transcription of the focus groups, the thematic analysis was performed, where the content was organized and structured following a sequence proposed by Minayo (2001), of pre-analysis, material exploration and treatment of results. This author considers that a thematic analysis consists in discovering the nuclei of meaning that make up a communication whose presence or frequency means something to the analytical objective intended (MINAYO, 2001).

In the documentary analysis, the municipal protocol of practices and actions of the Nasf and the minutes of meeting between the EqSF and Nasf were included.

The Research Ethics Committee of the Aggeu Magalhães Research Center approved the research, of the Oswaldo Cruz Institute Foundation (Fiocruz), through CAAE 37036814.9.0000.5190 and opinion nº 915.211, dated december 2014.

Results and discussion

In the development of the research, it was possible to participate in some Nasf actions, especially meetings, which produced important observations and records in our field

diary. The observation and analysis of this daily work revealed some peculiar characteristics of the work process of the Nasf team that are fundamental to understand 'what' the actions of this team can produce in the care network of the studied territory and 'how' it happens.

The gear of everyday life: brief description of the Nasf work process

In the municipality studied, the Nasf team organized its work process based on the Matrix Support guideline, where a multi-professional team of specialists offer clinical and pedagogical support to a set of reference teams that are responsible for the care of a particular population (BRASIL, 2014). In this case, the Nasf team was formed by six professionals from the areas of psychiatry, psychology, nutrition, phonoaudiology and physiotherapy, who support ten EqSFs of the HT3. Each the professionals face 40 weekly working hours, except physiotherapists, who face 20 weekly working hours each.

Since the beginning of the implementation of the Nasf, the management of the municipality together with the professionals established that the Nasf work process would be developed from four basic activities: specific and shared services; home visits; educational groups and team meeting (CAMARAGIBE, 2013).

Chart 1. Set of activities that make up the work process of Nasf in the municipality of Camaragibe (PE)

Activity	Objective	Target audience	Periodicity
Meeting between EqSF and Nasf	Discuss and analyze the cases of individuals and families who are accompanied at the Family Health Unit (FHU) and who require intervention from the EqSF and Nasf team or need to be referenced to the specialized network. At these meetings, unique therapeutic projects, collective action planning and discussion of clinical issues are built according to the need of the EqSF.	EqSF and Nasf team and, eventually, trainees and residents, territory manager and other professionals working in the network of health services, education and social assistance.	Monthly.

Chart 1. (cont.)

Technical meetings between Nasf teams	Promote integration between the Nasf teams and their coordination, giving priority to dialogue, exchange of experiences and reflection on the organization and development of the work process in the territory with the EqSF, as well as the construction of ways to evaluate and monitor actions.	All the professionals that make up the Nasf teams, the territory managers and Nasf Coordination.	Monthly.
Meetings for articulation of the service network	Strengthen the communication between the services with the aim of aligning the care to the user in an organized way within the care network. At these meetings, there are discussions about the flow of care, discussion of the more complex cases identified by the EqSF and the Nasf team or by reference services.	Professionals who make up Nasf teams and representatives of the other services of the health network and assistance of the municipality, i.e. Psychosocial Care Center, Municipal Rehabilitation Center, Social Assistance Reference Center, etc.	Monthly.
Attendance at FHU	Provide individual or shared care for evaluation, educational guidance and therapy. This care cannot be characterized as outpatient. Cases that require systematic care should be referenced for specialized services.	Users needing individualized or shared care, identified from the meetings of the team.	Monthly, and may vary according to the demand of each EqSF.
Home visit	Individual and/or shared visit for evaluation, educational and therapeutic guidance to the family and/or caregiver. Cases that require systematic care should be referenced for specialized services.	Users in need of socioeconomic evaluation or assistance, identified from the meetings of the team, who are bedridden or unable to travel to the FHU.	Variable. According to the demand of each EqSF.
Health and/or Therapeutic Education Groups	Perform collective activities with educational or therapeutic focus. These activities can be performed with programmatic groups of EqSF (Hiperdia, pregnant, adolescents, etc.) or groups created from the epidemiological profile of the territory (postural education, community therapy, benzodiazepine dependents, nutritional disorders, etc.). These groups can be held at the headquarters of the FHU or social facilities.	Population attached to EqSF.	Variable. According to the demand of each EqSF.

Source: Constructed by the authors based on the Protocol of Guidelines and Practices of the Family Health Support Center (CAMARAGIBE, 2013).

Each one of these activities should be developed according to the need and availability of the teams' agenda, except for meetings that are mandatory. This determination was the result of the agreement of the professionals of Nasf with the management of the municipality because they believed that the meetings of teams were a priority to structure actions of the Nasf and promote the meetings necessary to create a bond between the teams and the (re)cognition of their daily field needs.

Based on the theoretical benchmark adopted on assistance coordination and the systematization of the data of the focus groups and the field diary, three thematic categories and four subcategories were identified, according to *chart 2.*

Chart 2. Categories and subcategories of analysis

Categories	Subcategories	
Coordination of information	Transfer of the information	- Formal mechanisms
		- Informal mechanisms
	Use of the information	
Coordination of clinical managemen	Coherence of attention	- Clinical objectives and shared treatments
		- Clinical adequacy of patient transfer
	Adequate patient follow-up	- Access monitoring
		- Fragility in the existence of responsible for clinical follow-up
		- Assistance support from PC until the establishment of access to the SC
		- Assistance support from PC until the establishment of access to the SC
Administrative Coordination		

Source: Own elaboration.

Of the three dimensions that make up the concept of care coordination, evidences were found showing the support role of the Nasf in the exercise of coordination of information and clinical management by the EqSF. It is worth noting that this evidence is limited to the PC's relationship with some of the specialized services, such as the Municipal Rehabilitation Center (MRC) and the Psychosocial Care Centers (CAPs), which are subdivided into care modalities: child, other drugs.

This specificity of the experience studied was reported by the professionals of Nasf because of the greater openness of the Caps and the MRC to build actions in a shared way and by the initiative of coordinating these services in stimulating meetings between the teams. The other specialized municipal services, consisting predominantly of medical specialties, have their access organized from a tagging center and a system of monthly quotas that define how many patients can be referenced for some specialized consultations and complementary examinations, according to the diary of field.

Franco (2006) argues that for the performance of networked services and teams, it is necessary to strengthen the mechanisms that favor meetings, communication and the creation of a bond between workers as much as the implementation of services and logistics systems. In this sense, the meetings between the EqSF and Nasf are fundamental for the permanent education and for the construction of joint intervention plans between Nasf and the related teams. This type of meeting is also called 'matrix support' in some places, because it allows the exchange of knowledge and the broadening of the view of all those involved on health problems and the possibilities of intervention (BRASIL, 2014). To be more effective, it should have regular frequency and count on the active participation of the professionals of the Nasf and EqSF. When this happens, it is one of the actions that most impact healthcare coordination.

The possible assistance coordination: potential and limits of the experience analyzed

The World Health Organization (WHO), in its proposal for the reorganization of health systems, presents PC as the originator, coordinator or manager of health care because of

the central position it should assume in the operationalization of care networks (WHO, 2008). Some brazilian authors are quite critical of this conception and argue that, despite all the efforts already made, there is a great distance between the ideality of the health care models in force and the concrete social practices performed by users and health professionals in the production spaces of care. They exemplify the fact that PC has never fully achieved its role as the main gateway to the set of health services (CECÍLIO *ET AL.*, 2012).

Considering the PC limits for the full exercise of the coordination function, another group of authors formulated a concept that includes the coordination of care as an organizational attribute of the health services, that is, of the system as a whole, exercising the PC important role in the guarantee of this attribute, but not exclusive (ALMEIDA *ET AL.*, 2010; MAGALHÃES JUNIOR; PINTO, 2014). This understanding seems quite adequate to explain the results found in this study, where it was possible to identify evidence that the PC can exercise coordination of attention, when supported by other teams that also act at this same level of attention and operate with work process where there is greater possibility integration with other levels of care.

COORDINATION OF THE INFORMATION

For PC to coordinate care it is fundamental that there is an exchange of information between services/professionals (CHUERI, 2013). Several studies point out that the conditions and the possibility of information management are important issues for the organization and management of care, in this sense, the computerization of medical records has been pointed out as a powerful mechanism to enable the exchange of care information (ALMEIDA *ET AL.*, 2010).

The results of the evaluation carried out by the Program for the Improvement of Access and Quality of Primary Care (PMAQ) in 2012 reveal that only 14% of the PC teams use an electronic medical record (MAGALHÃES JUNIOR; PINTO, 2014). Despite this low computerization, there may be multiple forms of dialogue between professionals from different services that allow some level of coordination of care (MAGALHÃES JUNIOR; PINTO, 2014).

The results of this study demonstrate that the teams use some mechanisms to transfer the intra-level information of the Family Health and Nasf and of the inter-levels of PC and SC.

Chart 3. Discursive evidence on coordination of information

Dimension: Coordination of Information		
	Result found	**Evidence**
Transfer of intra-level information	Formal mechanism: Team meeting and registration in the family medical record	*Communication on clinical cases is basically done through meetings.* (Prof.3_Nasf). *Here with Nasf, along with us discussing the case, the integration is much more interesting.* (Medical.1_FH).
		Professionals of Nasf record the guidelines, prescriptions and referrals made during the visits and home visits, in the family medical record in the field diary.
	Informal mechanism: telephone and messages	*[...] we communicate through WhatsApp, over the phone. [...] there is no bureaucracy to speak on the day of the case discussion.* (Prof.1_Nasf).
		When we come to the service, for an attendance... We interact a lot, the communication is ample. (Prof.3_Nasf).

Chart 3. (cont.)

Transfer of inter-level information	Formal mechanism: referral form to the specialist and meeting for network articulation	*The network articulation meeting serves to establish the triage and risk criteria that we use in the queue to be able to organize the queue.* (Prof.1_Nasf). *Patients are referenced from basic care with that specialist referral form; when they are discharged, we do the counter-referrals. So we say what the treatment was for the post, how that patient evolved and how it should continue [..]. I always say, 'Look, now you're going to get this paper here and you're going to give it to that physical therapist there from the Nasf who is accompanying you'.* (Prof.1_NR).
	Informal mechanism: telephone and messages	*When I call to articulate, to speed up the process of the patient.* (Prof.1_Nasf).
Use of Information	The shared information about the social conditions in which the patients live and their clinical history are considered in the construction of the therapeutic behaviors of all the teams.	*This information about the patient is handled in the meetings to bring the feedbacks.* (Prof.4_Nasf). The social information given, mainly, by the health agents and the clinical behaviors are considered by the Nasf and Family Health professionals in the therapeutic conduction of the patients. In meetings with specialized services, the more complex cases are also discussed and the specificities of the patients are considered in the therapeutic decisions, it is recorded in the field diary.

Source: Own elaboration.

The performance of Nasf with the EqSF in the daily confrontation of the demands and needs of the territory can provide possibilities of interaction and exchange of information that surpasses the formal strategies of integration between teams.

The meeting between the EqSF and Nasf for case discussion is cited as a formal and well-consolidated mechanism that contributes directly to the coordination of the information. In addition to this monthly meeting, these teams use the same medical record to register all actions developed with the patient, constituting, thus, another formal mechanism for the transfer of unmanageable information, according to the field diary. Professionals also report the freedom of communication they have and how they use other means to exchange information, such as telephone, electronic messages and short dialogs between clinical activities.

Meetings of network articulation with the specialized services teams of the Rehabilitation Center and Caps help in the interpersonal knowledge of the professionals of the different teams and are used to discuss queue management, priority and discharge criteria, among others. This kind of coordination mechanism that favors the personal contact of professionals seems to be more effective in improving integration among professionals of different levels of attention, creating spaces for communication and favoring the exchange of information and the adjustment and sharing of therapeutic strategies (HENAO *ET AL.*, 2009).

An important observation is that the meetings between PC teams were much more consolidated than the networking meetings. The first activity has a fixed schedule agreed with all EqSF supported by Nasf. Because the meeting with the specialized services have a schedule that was more subject to variation and mandatory, not all Nasf professionals participated periodically according to the field diary.

Although these results are limited to the areas of rehabilitation and mental health, they represent important evidence that it is possible to exercise care coordination.

Particularly in the national context where the results of the PMAQ have shown that only 15% of the PC teams maintain frequent contact with other health services to exchange information related to care. Of the mechanisms used to facilitate the exchange of information, the reference and counter-reference instruments and case discussion were the most cited (MAGALHÃES JUNIOR; PINTO, 2014).

With the intention of ensuring good coordination and, consequently, sharing information and projects, matrix support stands out as one of the innovations implemented to reduce distancing and bring PC specialists and professionals closer together, as well as to allow discussion about the difficulties encountered by the EqSF in its own field of action (ALMEIDA *ET AL.,* 2013).

The integration of the PC service network to other levels of care is an important condition to counteract a selective conception of the primary level, understood as a restricted package of low quality services directed at the poor (WHO, 2008).

Building a service network is one of the essential strategies in the work logic of Nasf teams; for this reason, the creation of internal and external discussion spaces is so important. In these actions, Nasf must overcome the fragmented logic of health for the construction of networks of care and care in a manner that is co-responsible with the EqSF and other equipment and services present in the territory, such as health, education, sport, culture, etc. (BRASIL, 2014).

Initiatives that favor personal knowledge and exchange of experiences between PC and SC professionals have been considered more successful in strengthening integration between levels and creating a culture of collaboration (ALMEIDA *ET AL.,* 2013).

MANAGEMENT COORDINATION OF THE CLINIC

The coordination of clinical management is defined based on the access to the necessary assistance with a guarantee of coherence of the objectives of care and the adequate follow-up of the patient between the different levels of care. The implementation of care protocols, reference and counter-referral guides, shared clinical meetings and follow-up consultations are examples of strategies to strengthen clinical management in the health care network (VARGAS *ET AL.,* 2011).

In Brazil, in general, the results of the PMAQ evidenced that there is a great deal of deficiency in the clinical management of patients who need continued care. Although this question is the subject of constant interventions by health managers, whether in training processes or in the formulation of protocols, what is perceived is an important gap between what is advocated and the reality of health services (MAGALHÃES JUNIOR; PINTO, 2014).

In this study, it was found that the performance of the Nasf with the EqSF has collaborated in strengthening the clinical management coordination of users referenced to SC, especially in rehabilitation and mental health. The existence of a protocol of the Nasf, the different modalities of meetings between teams and the monitoring of the access of the patients that the teams of the PC perform are some of the mechanisms used in the studied experiment and that give the clinical management of the care.

Chart 4. Discursive evidence on the coordination of clinical management from the coherence of care

Dimension: Clinical Management Coordination		
	Result found	**Evidence**
Coherence of Attention	Existence of clinical objectives and shared intra and inter levels treatments	In the meetings between teams, the more complex cases of the Unique Therapeutic Projects (UTP) are constructed. In addition, each professional share the information about the consultations he has done individually and asks how the follow-up of these patients by the EqSF and the Community Health Agents (CHA) is going. In some of these meetings, Caps AD (Alcohol and Drugs) and disorder professionals also participate and build UTP along with Family Health and Nasf, both during discharge moments of some Caps patients and in division of activities when the patient is in semi-intensive care. It is recorded in the field diary.
		We hold a meeting here once a month, where all cases are brought and discussed together with the Nasf. Then, we will address each case: if you need an appointment, a visit, a referral. (Nurse.1_FH).
		In network articulation meetings also happen case discussions and agreements are made on the timing of the discharge of the specialized care, agreeing on what is necessary and possible to do in PC. It is recorded in the field diary.
	Clinical adequacy of patient transfer	*Sometimes, I'm not sure where he's going to and Nasf helps me to understand. Sometimes, what I thought that belonged to a certain professional, I discover that it is not, that he must go to another professional, and that serves as knowledge even for a next patient, a next appointment that I do.* (Medical.1_FH).
		In the Nasf implantation process, a workshop was carried out between Nasf and specialized services to define the profiles of patients that should be sent to each service, as well as the demands Nasf could help resolve in PC. This workshop product has already been discussed and adjusted a few times in networking meetings. (Prof.2_Nasf).
		Some cases presented by EqSF in team meetings are attended by the professionals of Nasf to make a more specialized listening or evaluation and help about the decision by referral to SC. This action helped to better judge who and when must be referred. (Prof.5_Nasf).

Source: Own elaboration.

Intra and inter-level team meetings, in addition to the use of shared records, such as a single medical record and convoying forms, help to increase the coherence of care. These interdisciplinary meetings often facilitate discussion of cases, shared planning of actions and evaluation of the conduct of therapeutic projects for a particular user or family.

Although they do not count on vertical information systems – such as electronic medical records – that allow access and discharge of all patients referred to the SC, EqSF professionals reported how the performance of the Nasf helps to monitor the access of the patients in SC in rehabilitation and mental health, according to field diary.

Chart 5. Discursive evidences on the coordination of clinical management from the adequate follow-up of the patient

Dimension: Clinical Management Coordination		
	Result found	**Evidence**
Adequate patient follow-u	Access monitoring	*When the Nasf meeting happens, there is that exchange of how that patient was, how he was referred, where he went, what happened to him. (CHA.3_FH). If he did not have access, we put the case in the discussion and the whole team interacts and sees the best way. (Prof.4_Nasf).*
	Fragility in the existence of responsible for clinical follow-up	The responsibility of tracking patient follow-up is usually left to the CHA because they visit the patient, or the Nasf, because they attend meetings with the SC and monitor the access of the patient. But this does not happen evenly with all EqSF. In units where the work process seems to be less organized or the CHA are not as collaborative, the follow-up of the patient is impaired is recorded in the field diary.
	Support assistance from PC until access to the SC	*Even if the access takes time, she does not release the patient. It's taking a while, but send he back to me, let me see him again, let's see how we can do it, let's try another way... you understand, so this way we don't stop helping, don't stop there. Done, I've referred him and it's over. (Nurse.1_FH).*
		In order to avoid the worsening of the sequel, the patient is being treated in PC, by the Family Health or Nasf, until he gets access to the specialized service it is recorded in the field diary.
	Continuity of bond with PC	*It does not mean that he becomes a reference; this patient continues to be monitored. So, he really is accompanied by the referral service, but it does not mean it's not our responsibility anymore. At any moment we know that we can also be driven to help with this care. (Prof.3_Nasf).*

Source: Own elaboration.

An important fragility is the fact that there is no definition of a professional directly responsible for the clinical follow-up of users referenced for SC. Generally, this role is performed in a little structured by the CHA that has a greater link with users and monitors if the patient has already accessed another level of care, is improving, etc. In practice, it is the CHA that acts as a 'care coordinator'.

In the experience analyzed, one does not work with the concept of Reference Technician (RT), as in other Nasf's experiments and, more often, in mental health. The RT is a possibility of care arrangement where each professional approach in a special way a certain number of patients and starts to monitor their therapeutic projects, assuming the responsibility for the monitoring of each one of its stages and articulating the discussions for adjustments whenever necessary (FURTADO; MIRANDA, 2006). This type of organization could give more solidity to the clinical follow-up of referenced patients and strengthen, more specifically, the coordination of clinical management.

An aspect that stands out is the level of interaction between the EqSF and Nasf, since it allows the formation of a strong bond between professionals and a better knowledge of the territory. Teams even get to the point of being able to think together support strategies, including care, to meet the care needs of users who are referenced, but are slow to access specialized services. During the collection of data, it was possible to follow several discussions of patient cases that had already been referenced for the rehabilitation nucleus, but which, given the difficulty of access, which could take up to six months, were still attended by the professionals of Nasf to alleviate suffering and prevent the progression of functional losses, according to field diary.

These organizational (re)arrangements about the offer of Nasf both in educational and care support seem to contribute to the expansion of PC's scope and resolution. However, it is very important to emphasize that the professionals of Nasf cannot replace the role of specialized services and that their performance with EqSF should be supported by SC and highly complex, so that these Nasf teams are a Health Care Network, as recommended by the National Policy of Primary Care (BRASIL, 2017).

ADMINISTRATIVE COORDINATION

Considering the most used mechanisms for administrative coordination (VARGAS *ET AL.,* 2015), the municipality counts on a center to schedule specialized medical appointments and exams, but with action limited to medical specialties. Sometimes, the professionals of Nasf need to refer patients to medical specialties – such as neurology or endocrinology, for example – and the waiting time is too long. In addition, they do not receive information on how the treatment performed in these specialized services, as per the field diary. The family health team also reports the same problem

> *We do not have the counter-reference, usually, of another professional, nor in writing we have. If I send to a specialist, I do not have an answer, how is the treatment going to be?* (Physician_FH).

When discussing access to SC, professionals still complain of organizational barriers that put patients on waiting lists for too long.

Except for the existence of the municipal protocol of activities of Nasf and the criteria defined for referencing patients to specialized services, which had the active participation of professionals in its construction and revision, no evidence of Nasf's collaboration in administrative coordination was identified.

Final considerations

The normative framework presents the Nasf as a proposal whose main objective is to strengthen primary health care in its role of ordering the health care model and coordinating care in the Health Care Network. But this is a proposal in full process of construction and has operated with very diverse forms of organization.

In each territory where Nasf is deployed, the challenge is to adapt the normative guidelines to its political context, the specifics of its service network and the possibilities existing in each territory. Hence the importance of studies like this, because, when analyzing concrete experiences experienced in the daily life of the SUS, they can help to understand how Nasf teams have acted, their results and the organizational aspects that influence certain models of performance.

In this study, it was evidenced how Nasf can and has contributed with the objective of strengthening the PC in its important role of assistance coordination, especially in the dimensions of information coordination and clinical management. The organization of the work process based on matrix support provides concrete conditions for integration between teams in PC and at different levels of care. The way of organizing the work process, with prioritization of meetings between teams for case discussion, shared planning and construction and evaluation of therapeutic projects, has been one of the most relevant mechanisms in the transfer of information and coordination of clinical management still within the scope of PC. In addition, the register in single medical record by the various professionals also collaborates a lot to share information and avoid superposition of therapeutic conducts.

In the coordination of the inter-level access, the meetings between Nasf teams and professionals of specialized services were also evidenced as important mechanism of integration between professionals

and information sharing. The approach of the professionals enables the sharing of therapeutic strategies, the review of behaviors and the management of the waiting list, shortening, in many cases, the waiting time for access in another level of care. In addition to the use of informal mechanisms such as telephone and messages, referral forms and their adequate registration were also cited as mechanisms for information transfer and clinical management by the professionals of Nasf and specialized services.

These results indicate ways of possibilities for the exercise of assistance coordination by PC. But they also reveal some limits, since the use of these mechanisms only happened through the Nasf and the interface with specialized services in the area of rehabilitation and mental health. Some obstacles seem to be generating or aggravating these limits, such as the absence of meetings between the teams of PC and other specialized services, the inexistence of electronic medical records and the misuse of referral forms that can help in the transfer of information. The center to schedule appointments is an administrative coordination mechanism, although, according to reports, it has little impact on guaranteeing access in the transition of care levels.

Therefore, the advances identified are directly related to support Nasf gives to the EqSF and its performance model inspired by matrix support. This leads one to deduce that without the support of the matrix teams the results found would not be possible.

This study can contribute to the construction of more integrated and necessary models of care, especially when it comes to people who need continuous care, such as rehabilitation, mental health and other chronic conditions. However, a greater number of studies with different methodological strategies are still necessary to evaluate in depth the results of the performance of the Nasf in the articulation of care networks and in the strengthening of the coordination of these networks from PC.

Collaborators

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