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Health care networking in cases of high complexity and high vulnerability: the experience of a Health Center

O trabalho em rede nos casos de alta complexidade e de alta vulnerabilidade: a experiência de uma UBS

El trabajo en redes en los casos de alta complejidad y alta vulnerabilidad: la experiencia de una Unidad Básica de Salud

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Abstract

This study aims to present and analyze the health care network formation processes around cases of high complexity and high vulnerability served by the Family Health Strategy at UBS, in the region

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of Brasilândia, in São Paulo, Brazil. Such processes have been developed from writing workshops conducted by PUC-SP Pro-Health in partnership with Health Supervision Technical FÓ/Brasilândia SMS/SP. The workshops were formed as a way to mobilize the narrative of experiences and reflection about the professional practices. The work was started from three index cases treated at UBS, which required a configuration of extended care networks that extended beyond the multidisciplinary care of the Unit and the support of NASF. Reflections were woven around the different health care models, of the possibility of resolving such cases and the responsibility of the actors involved in the care. It was concluded that the network formation approximates professionals of the territory, explores the assistance capability and makes it possible a more integrated approach, providing a more humanized care.

Keywords: Family Health Strategy; Primary Health Care; Health Centers, Health Vulnerability.

Resumo

Este estudo tem como objetivo apresentar e analisar os processos de formação de redes de atenção à saúde em torno de casos complexos e em contextos de alta vulnerabilidade, atendidos pela Estratégia Saúde da Família na UBS, na região da Brasilândia, São Paulo. Tais processos foram desenvolvidos a partir de oficinas de escrita realizadas pelo Pró-Saúde-PUCSP em parceria com a Supervisão Técnica de Saúde da Freguesia do Ó/Brasilândia da Secretaria Municipal de Saúde de São Paulo. As oficinas se constituíram como forma de mobilizar o relato de experiências e a reflexão sobre a prática profissional. Partiu-se de três casos índices atendidos na Unidade Básica de Saúde que demandaram uma configuração de redes ampliadas de cuidado que se estenderam para além do atendimento multiprofissional da Unidade e do apoio do Núcleo de Apoio à Saúde da Família (NASF). Foram tecidas reflexões em torno dos diferentes modelos de assistência em saúde, da resolubilidade de tais casos e a da corresponsabilidade dos atores envolvidos no cuidado. Concluiu-se que a formação de rede aproxima os profissionais do território, explora a potencialidade de assistência e possibilita uma abordagem mais integrada, proporcionando um atendimento mais humanizado.

Palavras-chave: Estratégia Saúde da Família; Atenção Primária à Saúde; Centros de Saúde, Vulnerabilidade em Saúde.

Resumen

Este estudio tiene como objetivo presentar y analizar los procesos de formación de la red de atención de salud en torno de casos complejos y en contextos de alta vulnerabilidad, atendidos por la Estrategia Salud de la Familiar en la Unidad Básica de Salud (UBS), en la región de Brasilândia, en Sao Paulo, Brasil. Tales procesos se han desarrollado a partir de talleres de escritura realizadas por Pro-Salud-PUC-SP en colaboración con la Supervisión Técnica de Salud de la "Freguesia do Ó"/ Brasilândia Secretaria Municipal de São Paulo. Los talleres se formaron como una forma de movilizar la narración de experiencias y la reflexión sobre las prácticas profesionales. El trabajo se inició a partir de tres casos índice tratados en la UBS, que requerían una configuración de redes ampliadas de atención que se extendieron más allá de la atención multidisciplinaria de la Unidad y del apoyo del Núcleo de Apoyo a la Salud (NASF). Reflexiones fueron tejidas en torno a los diferentes modelos de atención de la salud, a la posibilidad de resolver este tipo de casos y a la corresponsabilidad de los actores implicados en la atención. Se concluyó que la formación de la red aproxima a los profesionales del territorio, explora la capacidad de asistencia y hace posible un enfoque más integrado, proporcionando una atención más humanizada.

Palabras claves: Estrategia de Salud Familiar; Atención Primaria de Salud; Centros de Salud, Vulnerabilidad en Salud.

Introduction

The reflections presented in this text were triggered by means of writing workshops in a UBS, which were promoted by the Pro-Health/PUC-SP, the National Program for Reorientation of Professional Training, in the Ministry of Health, that is a result of the partnership of PUC-SP with the Health Technical Supervision of Fó-Brasilândia, in the Sanitary District of the Northern Health Coordination / São Paulo Health Municipal Department[1]. The starting point in its development was the initial assumption of Pro-Health that the professionals of such services would be a reference for operations involving the handling or producing technical-operative procedures. In addition, they also would be partners of teachers and students in the production of theoretical references/knowledge of health-related training. The workshops were composed of spaces for reflection and knowledge production from questioning and recording of experiences in the work processes of professionals in this health unit, thus configuring a way of approaching between the university and the health care services.

Six meetings with professionals were conducted as a systematization strategy and experience record of workers of the health care network of the FÓ/Brasilândia. These meetings were performed with professionals in the Unit Family Health Strategy (FHS) and the Family Health Strategy Support Centers (NASF) of reference of three UBSs. The workshops were supported by two instructors, who had to promote and facilitate the discussion and the production of texts that should express the knowledge generated in the daily practice of the health care service. The way of working, which was named as Writing Workshop, favored the creation of a space in which workers were encouraged to recall significant experiences in their trajectories in that UBS and that would reflect the building process a joint work to the Healthcare Model of Comprehensive Health Care of the Brazilian Unified Health System. In the first meeting, the group was able to list and produce collective reflections on the most challenging experiences faced by the teams. The professionals involved were able to establish some routes, in order to analyze the way in which they produce the work on networks and their impacts on the health care of the cases discussed. After this initial warming up moment, the group was instructed to indicate a central topic that could guide the collective production of a text about their practices. The chosen topic was

"The creation of networks in cases of high vulnerability and complexity," and, in subsequent meetings, teams were able to focus on complex cases to remove some common guiding working principles and unfolding reflections on obstacles and challenges. The team members were responsible for metabolizing actual experiences, in order to build a collective speech on the way of providing it and its practices, and then share them with the field of health knowledge production. In this process, instructors audio recorded the discussions of the meetings, making transcripts that guided the writing of the participants, and also acted as organizers of the various "comings and goings" of the text, which, even after the completion of the workshops, was being built and revised by all authors.

Family Health Strategy: Implications on the ways of providing care

The health care model has been changing over the years. Principles intended to ensure the universality, comprehensiveness and equity in health care were introduced with the implementation of the SUS in 1990. As a consequence of the PACS (Health Community Agents Program), which was created in the early 1990s[2], the so-called Family Health Program (FHP)[3], which was designed in 1994, represented a further step in ensuring integral care, by redirecting the health care of users in the context of their territory of life, listening to their concerns and needs, incorporating actions in the fields of prevention, promotion, recovery and rehabilitation of diseases and health problems. Since 2006, it was recognized as the

Family Health Strategy, in an attempt to emphasize its strategic and central role in the health policy at the expense of a specific and restricted program, as it work in the perspective of overcoming the curativist and hospital-centered health care model, which focuses only on the specialist consultation[2].

Such work assumptions have been promoting important changes in Primary Care (PC), redirecting the health care model in Basic Health Units (UBSs). This new health care organization provides greater contact of the healthcare system with people's lives, and also facilitates the recognition of the territory and of the existing health

demands in a collectivity, that is, in the community itself. In addition, it also promotes the formation of connections between health care professionals and the population assisted, and it creates possibilities of other actions to promote the health of the population.

In the context of the incorporation of the FHS, the position of the Community Health Agent (CHA) takes a central responsibility, as their presence goes beyond the physical space reserved in the health care service, towards the approach of the existential contexts of users. In addition to being a integral part of the territory, who knows the reality experienced by the population, these professionals enrich the level of health information of the community assigned, by leaving their health care equipment and visiting the user, and getting closer to their way of life.

If the health care model was previously organized according to a hospital environment or consulting rooms, based on specific knowledge, reflected in the experts (unique professionals, physicians, psychologists, nurses), the innovation of the ESF aims to broaden the perspectives and to overcome the knowledge fragmentation. The work conducted alone based on different areas of knowledge, the clinic based on disease, the "treat 'em and street 'em" paradigm, the logic of the segmentation generating the practice of referral to various professionals are remains of a health care model that does not address the complexity of the subjects and communities.

With the implementation of the FHS, it was possible to provide a closer approach of health professionals to different records of the experience of the subject in all its multiplicity, producing a field favorable to the completion of the integrality of health care. Specifics health care as a unique response, as well as their protocol and bureaucratized practices, were rejected in the search for other ways to understand the health-disease processes. New horizons are revealed when facing the singularity of the subject, listening to their stories of how they experience the illness, and inserted in the context of their life story.

As part of a strengthening process in the FHS, the Family Health Strategy Support Centers (NASF) was created in 2008, which incorporated the group of primary health care professionals[4]. NASF was created aiming to improve and horizontalize the discussion and coordination between the different areas of knowledge, proposing a practice to reorganize primary health care. In addition, it aims to contribute to the expansion of the range of actions in more complex situations, aiming at more effective strategies on the health-disease process.

However, the composition of this health care model is not provided in advance; it is something that has been built according to certain movements and to the extent that certain demands are being produced. The configuration of a health care network is permeated with comings and goings and requires many moments of discussion and reflection, which may generate controversy and different forms of conflict. Therefore, it is a work that requires openness to the unpredictable, since it is composed and built in procedural actions of events.

Presenting the high vulnerability and complexity cases of the UBS

In the procedure care routine to the population, many paths are traveled. In the experience of the UBS, which is located in the sanitary district of Brasilândia, the high vulnerability and complexity cases are presented as a daily challenge for the local health care network. The unit serves a population of more than 6,400 families, totaling about 24,000 inhabitants. It is one of the poorest areas of the city with one of the highest rates of social vulnerability (group 6 in the São Paulo Social Vulnerability Index, which indicates a "very high vulnerability"), in addition to the low socioeconomic status, a very young population (about one-third are between 0 to 19 years old; and one-third are between 20 to 39 years), with high rates of school dropout[5].

The families are composed of a young head of household, low income, low level of education, a significant number of small children, a significant number of pregnant adolescents, and an insufficient family support. All this, coupled with the increased exposure to urban violence, as a population subject to risk, not only from the point of view of the difficulty of leaving the zone of poverty, but also brings complications to the health care and to the maintenance of health status.

The complex cases of people who live in high vulnerability conditions and are covered by the UBS involve situations such as: mistreating person with physical disabilities, socioeconomic difficulties, family relationship issues, use of psychoactive substances, teenage pregnancy, lack of accessibility to patients with severe physical- motor skill limi-

tations, young people facing difficulties to attend school, insufficient hygiene, housing in precarious condition. The reality of these users raises recurring demands to UBS, placing several questions: how to take care of the health of a person when their reality is shrouded in other social dimensions that directly impact in their processes of illness? How to act in public health in a high vulnerability and violent territory?

Given the complexity of each case in the UBS, healthcare professionals are mobilized to expand their professional practices in addition to their training and individualized interventions. In these cases, in addition to the need of subsidies in other areas of knowledge, and of other professionals, the operation of extended networks, which are composed of other services in the health area and even from other public sectors, is also required.

Thus, the present work addressed the experience of the FHS in this UBS and the issues arising from the daily practice of production of health care networks. This study was prepared in order to contemplate the purpose of this communication from the study of three cases of high complexity and vulnerability involving not only the health of UBS, as well as other levels of health care, and other public sectors.

Discussion on the challenges in the creation of health care networks for complex cases and high vulnerability situations

In the daily work of the UBS, the high vulnerability cases are those that require the expansion of health care devices, space for case discussion, requiring the movement of their demands among the teams and also among other services.

The identification of these cases is possible, first of all, by bringing the ACSs with families to their territory of reference. Then the situations faced and/or requested are shared and discussed in the Family Health team. In this process, the idea is to include the users, their families and other people in the community who can help in the development of health care strategies and support actions to be conducted. Finally, a PTS (Singular Therapeutic Project) is prepared, which may comprise the NASF and other services (the health care network and other sectors, such as Social Assistance, Education, Housing, etc.), as needed.

In this way, it is possible to highlight at least five levels of network articulation: 1) among professionals of an extended team (SF/NASF Team); 2) between distinct teams of the same service; 3) between different health care services (primary care and secondary and tertiary health care levels); 4) between services and equipment of other policies (Social Assistance, Education, Housing, the Tutelary Council, the Public Prosecutor, etc.); 5) among health care teams, the family and the community. The following will briefly present the three emblematic cases, given the complexity of their demands and the multiple ramifications that the monitoring provided, and the way that they articulated the networks and the challenges faced by the SF/NASF teams.

The first case is of a young patient who lived alone and who remained hospitalized for many months; he was paraplegic, bedridden with pressure ulcers and recurrent infections. It was necessary to search for an extended health care network involving his family and neighbors for the daily care: bathing, changing clothes, eating; the CRAS/CREAS, in search of the INSS Benefit and DPVAT rights; hospital reference for the clinical care; and, especially, the layout of the UBS/NASF for daily care of dressings that lasted about an hour, including Saturday, Sunday and holidays, as well as for the emotional support to patients and their families. This patient died, causing a strong emotion in people involved.

The second case concerns a large family with histories of mental illness, use of psychoactive substances, teenage pregnancy, children and young people not attending school, poor housing and sanitation. In this case, the network was set aiming to join forces with the CRAS/CREAS, Tutelary Council, CAPS Adolescents, CAPS Alcohol and Drug Use, in addition to a school in the region. All this intersectional approach aimed at attempting to cooperate in a possible reorganization of the family, in which human rights could be preserved and put into practice by the institutions responsible and by the family itself. Currently, the proposals combined, even with the family group, are underway, some with greater success, others in the reconstruction phase and with new settlements.

The third case concerns a man with cognitive, physical and motor impairment who lives literally on the floor of the house of his relatives. He lives naked, and he eats and drinks in bowls placed on

the floor. In addition, he also crawls around. Metaphorically, it is a familiar shadow that haunts the SF/NASF teams. On the construction of the Singular Therapeutic Project (PTS), a partnership with the religious institution attended by the family was established by the CRAS/CREAS and CAPS Adults. The process of producing several health care actions for this patient was long, hard, involved many discussions, agreements, and a change in the family understanding regarding the disabled person. At the time, he lives with more dignity in his family group.

In general, to meet the complexity of the situations present in these cases, the strategy was to extend the micro-network (understood as a primary care and family network) for a territorial macro-network extending support for the interventions that were needed. In this process, different questions underlie the formation of care network, concerning the following aspects:

a) Different health care models

One of the dimensions concerning the formation of health care networks relates to the notions of health, which are often antagonistic and confrontational, that underpin the practice of different actors who compose the work process. From the 1980s, the WHO incorporates the design of health care promotion, which does not restrict the notion of health to the absence of a disease, aiming to provide action on the living conditions of the population, in intersectoral actions necessarily. Since 2006, the Ministry of Health incorporates this principle in the Brazilian National Policy for Health Promotion[6], strengthening the principles of SUS that had already predicted a conception of health, covering the multiple dimensions of life, such as social, economic, political, and cultural dimensions.

The operation experience of providing health care in the territory demonstrates that it is not possible to ignore the fact that health is involved with various sectors of life, implying a connection with other services. Thus, the interaction of SUS with other social policies is indispensable when operating with a view to prevention and health promotion, and not just aiming to treat the disease.

Despite the changes that have occurred in recent decades, which redirected health policies from an integral vision of the subject, and conceptions focused in the physician are still present and restrict the individual to their biological dimension.

The complexity of the reality faced in the cases doesn't fit the reductionist model focused in the physician, being almost an obligation to expand the health care on the health-disease process. The advances achieved in the field of several academic fields combined with the technological progress, promoted, at the same time, an increasing specificity, but it also requires the approximation and combination of different areas of knowledge. The journey from the action centered in one area of knowledge to the intersectoriality goal, needs to transpose the field from unity to the multiplicity.

To this end, one of the possibilities would be to recognize not only the limits of each knowledge, but also to be opened to the mutual influence of several specific knowledge, and go beyond, establishing new relationships inserted in a more integrated device, thus seeking to mitigate any hard boundaries between disciplines, when faced with such vulnerability and complexity.

In discussions and reflections arising from the experience from the cases brought to the team, it was possible to realize that different conceptions about health and care coexist among the different actors in the network, and they are updated in the process of establishing health care networks. Thus, this is the challenge of building a health care network that exceeds the technical models that is able to meet the health needs of an individual or population instigated to access other dimensions, in search of a process of change.

b) The problem-solving capacity issue

The problem-solving capacity, one of the principles of SUS, consists in the efficiency and quality of health care, for a continuous assistance according to the demands of the population, in its different levels of complexity. Thus, the problem-solving capacity aims to focus the evaluations of the actions from the concrete health care demands of users to the capacity of the health care system to provide the appropriate care, including the access to the system.

However, when we discuss about extremely complex cases, the problem-solving capacity, as a parameter to measure the success of health care actions, opens several questions: how to overcome the action focused on results, the expectation of a

prompt response to the problem presented? Would it be possible to have a single answer set in a cause-effect relationship in high vulnerability cases? To take care of these cases is not as easy as performing a surgical procedure to excise a problem. So, how to take care of the subject's illness who is inserted in his own and so complex reality?

In the first case, for example, the chronicity of the condition experienced by the subject put into question the possibilities of "problem-solving capacity" for the event. In the situation where the user was on the verge of death, the following question was given: what is the responsibility of the health care network in a situation in which its actions could not avoid the imminent death of the user?

As an answer, the professionals found important parameters by which they can guide the actions, based on promoting the quality of life and dignity in death. Thus, throughout this process, a movement of solidarity was created among the professionals who began to understand the essential role of monitoring the hard process experienced by the user and in investing in dignity as possible. Thus, the problem-solving capacity needs an elaboration of a broad and strategic PTS to health care that must be appropriate to the real needs of the population.

c) The co-responsibility principle

Another dimension that proved to be of extreme importance in the formation of networks is the co-responsibility principle as a guide to the actions and to the engagement of each professional and service in the composition of the health care network. In this comprehensive model - in which the various services and institutions interact, agree, and act sharing responsibility - the commitment to process the work must necessarily be part of actions in each case, promoting the mental health of all involved, as well as the confrontation of differences, the restrictions imposed by the other (family or service) and the ability of each one to deal with the unexpected.

When processing actions with the intersectoral health care network being established, it is possible to assess the complementarity, the interdependence and the synergism of actions, as well as the willingness to share goals, decisions and the responsibility, the need to improve interpersonal relationships and enhance communication between those involved, thus clearly setting out the goals and interventions.

There is a great challenge in defining goals for the team(s) in the formation of the intersectoral health care network, since it is almost inevitable to generate dissatisfaction, find crystallized positions, labeling and deteriorating interpersonal relationships and creating mechanisms to blame people in order to be able to overcome the frustrations of the "alleged failures".

The formation of bonds and the agreement of commitments shall establish a co- responsibility among the professionals involved and the community, allowing new interventions in the territory. The co-responsibility implies in establishing the Territorial Health Project (THP) aimed to care for and manage relief from suffering, in addition to improve and prolong life, avoid or reduce damage, promote the construction of autonomy, improve living conditions and prevent the abandonment and the isolation of the subject.

Given this way of providing health care in the territory, it is understood that the prospect that the health of a person or a territory involves several sectors should not be ignored, thus implying in associations with other services that relate to other important aspects of life.

Final Considerations

The health care model of a centralized health classified by levels of complexity no longer matches the reality experienced by health care professionals in Primary Care. The demand of the problems presented by the population needs a health care management with greater organization of actions. It seems important to provide more physical, technological and human resources that can contemplate the vulnerability and complexity issues of the processes of illness.

The trajectory to create a friendly health care system with problem-solving capacity does not rule out the need for consultation with medical experts, as well as the consultations with other health professionals, diagnostic and therapeutic procedures and hospitalizations. However, the construction of interpersonal and interdisciplinary relationships needs to be optimized.

Similarly, the responsibility for health care is not a task for a single sector. The co- responsibility involves not only the SF/NASF teams, the

involvement of families and community, but also the possibility of sharing the health care with the various health care services and other public sectors. Creating the conditions for the co- responsibility implies that the professionals involved can take ownership of their responsibilities, that they can reflect on their ability to solve problems, and also that they may be open to new possibilities for partnerships, understand and respect each of the levels of health care.

Therefore, providing health care for this population implies a permanent link between different teams, services and sectors, even more when we recognize that the complexity of the health care demands is closely related to the different dimensions of the life context of the user. Thus, it is important to increase the interaction between institutions and the different health care services, strengthening the partnership with other public services and consolidating the intersectorality in health care. All this is being built and, at the same time, being permanently provided by the protagonists of health care.

References

1. SUPERVISÃO DE SAÚDE FÓ BRASILANDIA. PUC-SP Pró-Saúde. [Acesso em: 26 de jul. de 2016]. Disponível em: <http://www.pucsp.br/prosaude/downloads/territorio/Tecnica_saude.pdf.

2. Brasil. Ministério da Saúde. Secretaria Executiva Programa Agentes Comunitários da Saúde. Brasília Ministério da Saúde, 2001.

3. Rosa WAG, Labate RC. Programa Saúde da Família: a construção de um novo modelo de assistência. Rev Latino-am Enfermagem 2005 novembro-dezembro 13(6):1027-34. Disponível em: http://www.scielo.br/pdf/rlae/v13n6/v13n6a16.pdf. Acesso em: 12 ago. 2016.

4. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Diretrizes do NASF. Brasília: Ministério da Saúde, 2009. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/caderno_atencao_basica_diretrizes_nasf.pdf. Acesso em: 18 ago. 2016.

5. SÃO PAULO. Secretaria de Planejamento Regional do Estado de São Paulo. Fundação Sistema Estadual de Análise de Dados. Índice Paulista de Vulnerabilidade Social. São Paulo, 2013. (Disponível em: http://indices-ilp.al.sp.gov.br/view/pdf/ipvs/metodologia.pdf) Acesso em: 05 jul. 2016.

6. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde. Política Nacional de Promoção da Saúde. Brasília: Ministério da Saúde, 2006.