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Physical therapists role in Family Health Support Center

Atuação do fisioterapeuta no Núcleo de Apoio à Saúde da Família

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Abstract

Introduction: The creation of Family Health Support Centers (FHSC) configured advances in health care policy, however, it must recognize challenges of structural and logistical conditions for physiotherapist's role in Primary Care (PC). **Objective**: The study aimed to describe the physiotherapist's role in the context of the Family Health Support Centers. **Methods**: It was held a quantitative survey with a cross-sectional census of Physiotherapists working in FHSC in the city of Salvador, Bahia. The instrument was a questionnaire designed by the researchers, and was based, prior readings related to the theme of work. **Results**: There was the presence of the physiotherapist in all teams FHSC, with a predominance of type I and FHSC recent effective linkages work. Difficulties were presented that permeates from accountability among workers, managers and users of services, the operational issues such as lack of resources, transport and dismantling of the health care system in which led most of the limitations of working in FHSC. Regarding the physiotherapist's work demands in FHSC, presented greater representation for situations with neurological patients and related activities gerontology. **Conclusions**: Despite the challenges, the enlargement perspective of care services Primary Care to the physiotherapist is promising, in the proposed within the proposed comprehensive care to prevention and primary care users care, and that reflects, a step further decentralization of physiotherapy in the levels of health care.

Keywords: Physical Therapist. Family Health. Primary Health Care.

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Resumo

Introdução: *A criação dos Núcleos de Apoio à Saúde da Família (NASF) configurou avanços na política de atenção à saúde, entretanto, é necessário reconhecer desafios das condições estruturais e logística para atuação do fisioterapeuta na Atenção Básica (AB).* ***Objetivo****: Descrever o contexto da atuação do Fisioterapeuta no Núcleo de Apoio à Saúde da Família.* ***Métodos****: Foi realizada uma pesquisa quantitativa do tipo transversal com um censo dos Fisioterapeutas que trabalham no NASF, na cidade de Salvador, Bahia. O instrumento utilizado foi um questionário construído pelas pesquisadoras, e teve como base, leituras prévias relacionadas ao tema do trabalho.* ***Resultados****: Verificou-se a presença do profissional fisioterapeuta em todas as equipes do NASF, com predomínio do NASF tipo I e vínculos efetivos recentes de trabalho. Foram apresentadas dificuldades que perpassam desde a corresposabilização entre os trabalhadores, gestores e usuários dos serviços, às questões operacionais como falta de recursos, transporte e desarticulação da rede de saúde no qual lideraram a maior parte sobre as limitações do trabalho no NASF. Em relação às demandas de trabalho do Fisioterapeuta no NASF, apresentou maior representatividade para as situações com pacientes neurológicos e atividades relativas a gerontologia.* ***Conclusão****: Apesar dos desafios, a perspectiva de ampliação dos serviços de Atenção Básica para o fisioterapeuta é promissora, dentro da proposta de atenção integral para a prevenção e cuidado dos usuários da atenção básica, e que reflete, um passo frente a descentralização da fisioterapia nos níveis de atenção à saúde.*

Palavras-chave: *Fisioterapeuta. Saúde da Família. Atenção Básica.*

Introduction

Expanding access, improving quality and resolution of actions in Primary Care (PC) (1) are some of main challenges of the Unified Health System (SUS). Therefore, the Family Health Support Center (FHSC) was created in 2008 to support and strengthen the Family Health Team (FHT), in order to expand the scope, coverage and resolution of Primary Care (2).

The FHSC team is made up of professionals with different skills of knowledge, and it is composed by municipal managers following the criteria of priorities and local needs (2). It can be arranged in 3 categories, FHSC 1 is featured by 5 to 9 FHT linkage, the FHSC 2 has 3 to 4 FHT and the FHSC 3 is responsible for 1 to 2 FHT (1). Since its implementation, the FHSC has been modified and restructured according to the characteristics and needs of each regions (3). The proposed work involves recognizing FHSC to the demanded situations of FHT, by sharing management and coordination of care (4).

Despite FHSC proposal is subsidized in comprehensive health care, some challenges are found for its effectiveness. The activities developed by this core are commonly associated with changes in professional work processes which are linked mostly to a clinical assistance concept of "doing health". They require adaptation for these professionals who have not been trained in matrix support structure of health services (1). Thus, the inclusion of health professionals should create integrated performance possibilities, it has to focus in users and give co-responsible actions in health care (5), to succeed in the proposal.

Thereby, new forms of organization and production of health care are included to professionals who enter the FHSC. Since the dimension of care, also to accomplish the technical and pedagogical actions with the reference teams (FHT) (4). The Therapeutic Singular Project in community is one of the possibilities of actions, and it becomes important because it represents articulated therapeutic approaches, in individual or collective levels, specially when it aims to solve the complex situations (4).

Thus, it is expected that the work of physical therapists with the FHSC promotes improvement in health practices, a higher quality of population (5) care which are not limited only on quantitative assistance represented by number of attendances and following-up families. The new forms of actions in health technologies require professionals involved to develop new ways of working in accordance with the Health Ministry guidelines (4).

The inclusion of physical therapy in FHSC sets up an improvement and expansion on its occupation areas, in which historically curated and rehabilitated

individuals who had already affected by some kinds of disorder. Currently, physical therapy practice cover actions including the population´s quality of life (6 - 9). Consequently, it is reducing the demand of treatment in levels of greater complexity of health care (9).

Prevention and assistance to the community are highlighting in physical therapists assignments (10) in which the health prevention should be presented at all stages: in the diagnosis, treatment, disease recurrence and palliative care (10). It is added innovation and inclusion necessary to the principles of the current health model by the participating in Primary Health Policy. The physical therapy professional training requires, in contrast, to reorient in order to Brazilian health population priority needs (9).

Considering the regional differences to implement the FHSC work process, it is essential to recognize the challenges related to structural conditions and logistics for the labor of the Physical Therapists in Primary Care. Therefore, the aim of this research was to describe the context of the acting of the Physical therapists of the Family Health Support Center (FHSC).

Methods

The research adopted a cross-sectional design quantitative study in the city of Salvador, Bahia, Brazil, from May 2014. A census of physical therapists was done with whom worked at the Family Health Support Centers (FHSC). The Primary Care of the county is organized into 12 Health Districts (HD), which are smaller management units of the Municipal Department of Health, and the survey period, the city of Salvador had 8 FHSC teams distributed in 6 HD.

First a survey was conducted along with Municipal Department of Health to analyze which FHSC had physical therapists, and which health districts that they were allocated. Among these teams were involved 20 physical therapists. The study included participants who signed the Written Informed Consent Form (WICF) and excluded those who were on vacation, sick leave, maternity or do not accept the WICF.

The questionnaire was given to the participants in hand by the researcher at her workplace. For those professionals who were not found at the place of the research it was sent the online questionnaire to the e-mail given by the local Health Department. Professionals had a maximum of seven days to complete the questionnaire and return it to the researcher, as well as to return the online questionnaire to the survey e-mail. All participants full filled in the estimated time. The instrument was made by the researchers, and it was based by prior readings related to the subject of the work (2, 3, 4, 9). The questionnaire presented direct questions and it was prepared by blocks covering the following variables: 1) sociodemographic; 2) employment feature; 3) Physical therapists actions at FHSC; 4) ratio of FHSC and FHT and 5) job satisfaction at FHSC and violence acts and victimization. The variables used for the study were categorized into: gender (male, female), age (27 - 30 years, 31 years or more), education (higher level, expertise in the area, another specialization, master´s degree, Ph.D.). FHSC type (type I, type II), number of FHT by FHSC (3-5, 6-9, 10 or more), working time in FHSC (less than 1 year, 1 year or more), qualification/training indicated by the work institution (yes, no), employment relationship (public applying, outsourcing or Contract — Consolidation of Labor Laws), public clinic of physical therapy in territories (yes, no), counter-reference at health units (yes, no), job satisfaction (yes, no), satisfaction with payment (yes, no). And the variables of the categories of: limitation for performing the work (resources/materials, transportation, network disconnection, physical structure, management support, FHT participation, community involvement), distribution of activities (personal care, home visits, therapeutic singular project, therapeutic project in the territory, groups with the community), distribution of work demands (neurological, elderly, hypertension, diabetes, women's health, obesity, occupational health, child and teenager health), are presented by graphics. The variables used in graphic were multi-choice answers. The answers of the scale model, the values of 0-4 were considered negative and answers 5-10 were considered affirmative.

The results were described in absolute and relative frequencies and presented through tables and elaborate graphics with Microsoft Office Excel 2010.

The study procedures were approved by the Research Ethics Committee on Human Beings of Medicine School of Bahia of Federal University of Bahia (UFBA) in the report nº 617.453.

Results

The FHSC eight teams that provide service to the city of Salvador, (Bahia), all have physiotherapist.

A total of 20 Physical therapists work in the Family Health Support Center (FHSC) 18 participated (90.91%) of the survey and the vast majority were female (94.44%). The age of participants ranged from 27 to 41, concentrated in the range of 31 or more (55.56%), the average age of physical therapists was 31.61 years old. As for the level of training, most participants had expertise in the area (55.56%) (Table 1).

In the study there was a higher frequency of physical therapists inserted in FHSC type I (83.33%) with links of 6 to 9 FHT (88.89%). It was observed recent time of working in FHSC, 90% worked with time less than 1 year, with an average time of 10.5 months among the respondents. The effective job predominated among respondents physical therapists (88.89%). During this period, 50% of respondents reported had a job training.

Table 1 - Socio-demographic characteristics of Physical Therapists inserted in Family Health Support Center in the city of Salvador - Bahia, 2014

Variables	Frequency	
	n	%
Gender		
Female	17	94.44
Male	1	5.56
Age		
27-30	8	44.44
31 or more	10	55.56
Average	31.61	
Educational level		
Specialization in the area	10	55.56
Other specialization	6	33.33
Master degree	2	11.11

Ninety-four point forty-four percent (94.44%) reported to not have public physical therapy clinics in the territories that FHSC covers. It was also evaluated that 93.75% of physical therapists reported that when the refer patients to specialist services there is no counter-reference at units. On job satisfaction, most physical therapists reported being satisfied with the work (88.89%), and with rate of payment (72.22%) (Table 2).

Table 2 - Characteristics of the work in the Family Health Support Centers in the city of Salvador - Bahia, 2014

Variables	Frequency	
	n	%
Type of FHSC		
Type I	15	83.33
Type II	3	16.67
Number of FHT by FHSC		
3-5	1	5.56
6-9	16	88.89
10 or more	1	5.56
Time of working in FHSC		
Less than 1 year	16	90.00
1 year or more	2	10.00
avarage	10.5	
Trainning employment		
Yes	9	50.00
No	9	50.00
Employment relationship		
Public applying	16	88.89
Outsourcing and contract	2	11.11
Public clinics pf Physical therapy in territories		
Yes	1	5.56
No	17	94.44
Counter-reference in units		
Yes	1	6.25
No	15	93.75
Satisfacion with work		
Yes	16	88.89
No	2	11.11
Satisfaction with payment		
Yes	13	72.22
No	5	27.78

The limitations to work performance in FHSC were described in Figure 1. Higher frequencies were observed in the absence of resources / materials, transportation and network disarticulation (94%). Followed by difficulties with physical structure to work (58%), management support (52%), low participation of the FHT in the development of work in FHSC (41%) and low community participation in FHSC activities (35%).

At Figure 2 presents the activities carried out more frequently by physical therapists working in FHSC, 94% does home visits and activities in groups with the community.

Physical therapist labor demands in FHSC 100% was reported for demands of situations with neurological patients. Another significant demand were activities for the elderly (83%) (Figure 3).

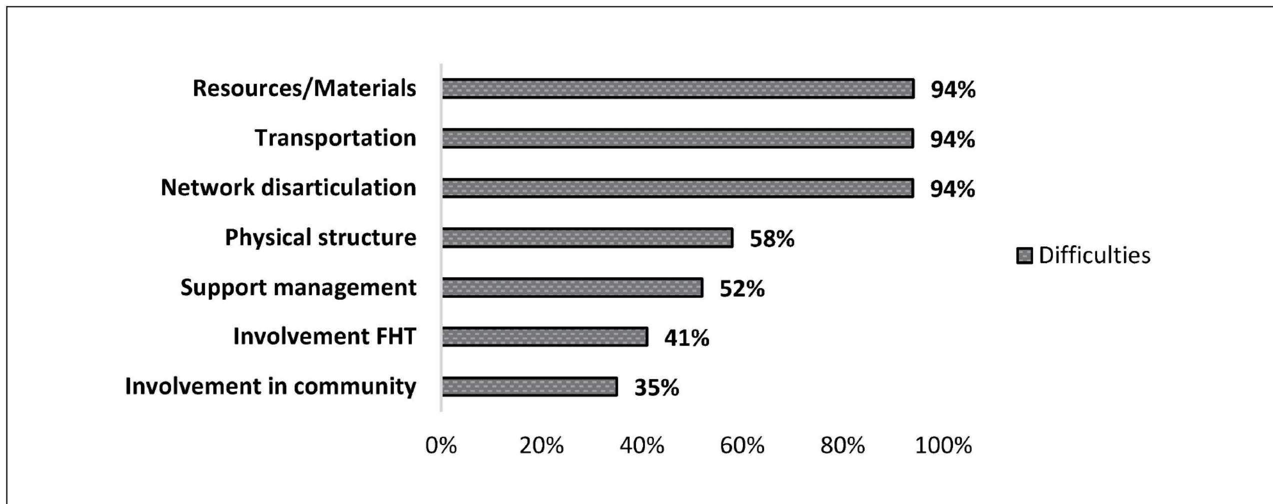

Figure 1 - Limitation to perform the work referred by physical therapists inserted to the Family Health Support Center in the city of Salvador/Ba, 2014

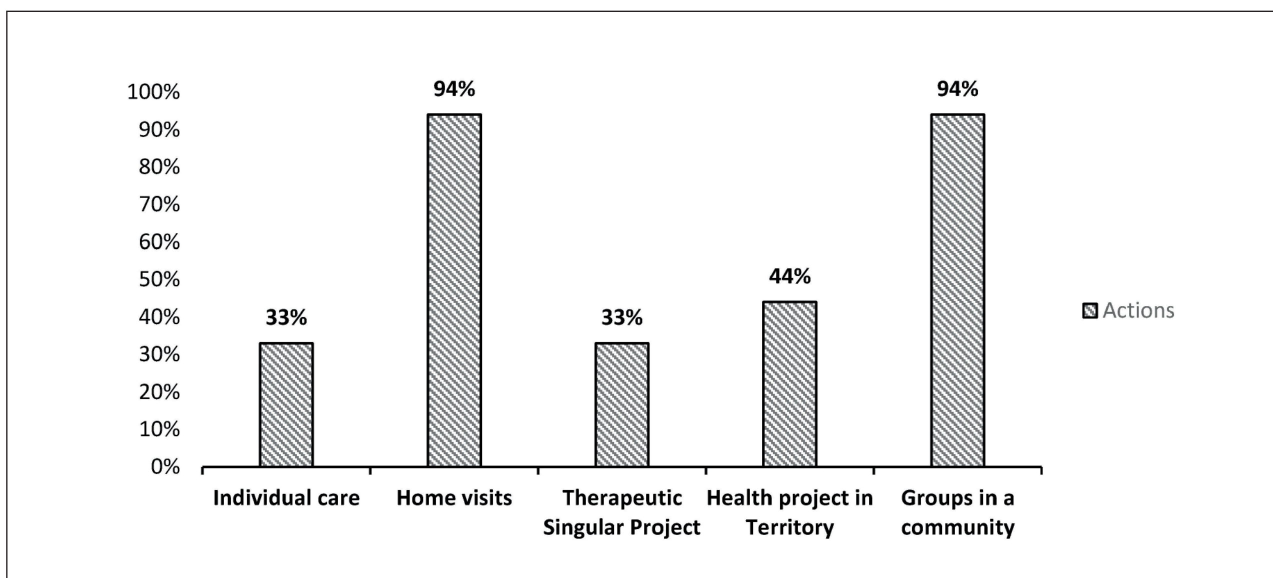

Figure 2 - Distribution of activities performed by physical therapists in Family Health Support Center in the city of Salvador/Ba 2014

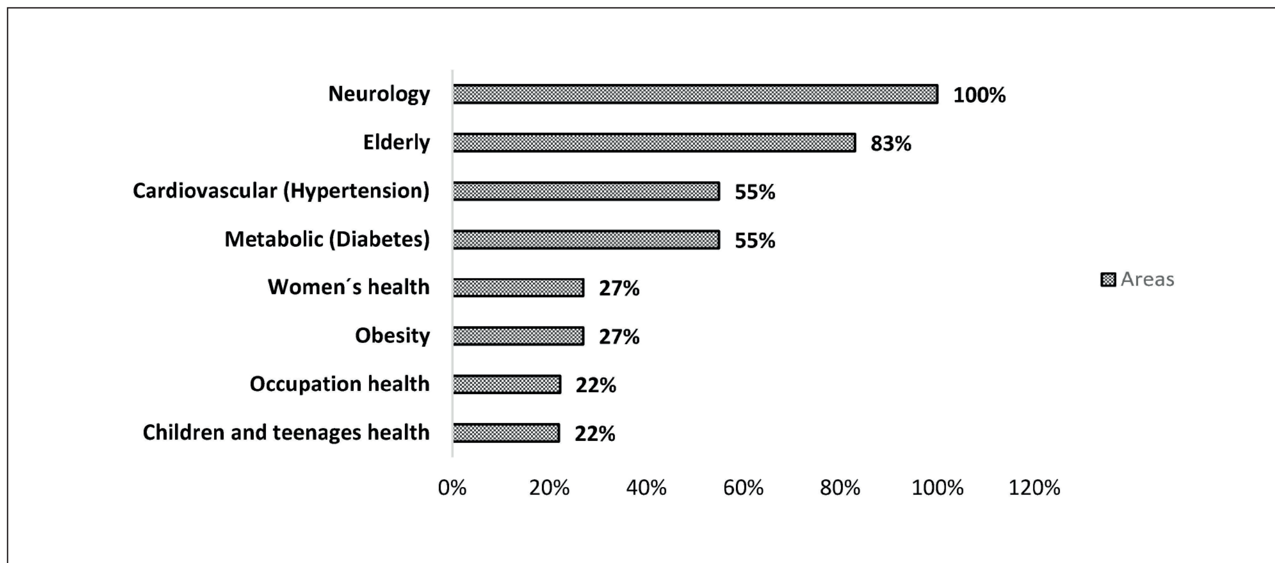

Figure 3 - Distribution of labor demands for physical therapists from Family Health Support Center in the city of Salvador/Ba, 2014

Discussion

The profile of physical therapists into the Family Health Support Center (FHSC) in the city of Salvador, Bahia was arranged by female workers, young people, with expertise in public health. It is possible to notice the interest of physical therapist at the field of public health. However, there is still needed to increase positions in the public health system and a more inclusive policy in order to cover professionals in services (11).

It was found that the majority of physical therapists working in FHSC type I had link between six to nine Family Health Teams (FHT), which are in line with the amount of FHT by FHSC recommended by the Ministry of Health (12). Although the amount of FHSC for FHT is appropriate to ordinance, it is necessary to consider the professionals dynamics in FHSC. Some limits are faced by physical therapists for maintenance work logistics, including differences in workload between the participants, the planning and shared care, the therapeutic projects and the distancing of the territories attached. So, the workload can be an obstacle in the integration of these professionals in primary care. The challenge of organizing the flow of activities and the time taken to meet the demands becomes a crucial fact for the effective monitoring of FHT users (6).

It was created the FHSC operational guidelines in Salvador, to ensure the longitudinal follow-up staff responsibility of the Primary Care/FHT (13) since 2008. Despite the time less than 1 year of work presented by most therapists, the effective workers set to be an improvement to the work of SUS as the result of strengthening and consolidation of public health policies. In this perspective, the physical therapist's inclusion in the primary care services still reflects a continuous process (14). However, the historically rehabilitative physical therapy profession went from 2009 to be recognized in the field of collective health (15). In addition, it is strengthening the restructuring the sense of responsibility in the health care process and in the Brazilian health care model.

When it comes to prevention in healthy people and education activities in health (16), the presence of the physical therapist in the activities of primary care is still unknown in the community. The empowerment and autonomy of individuals are valued for their health and the community. Despite ongoing debates this practice is still a challenge, as a paradigm of care is made gradually, understanding the cultural and social pillars. Consequently, in changing people´s lifestyles.

The FHSC is not a service that requires its own physical space to share the Primary Health Units and the attached territory to development the work (1). The interdisciplinary activities of FHSC team incorporate a new approach, as going to other social spaces such as schools, churches, bars, by decentralizing the attention of Primary Health Units and making interventions to various public community to promote

local health. Though, not always the territory can be enough for specific actions (3). This new view makes an assistance rearrangement in the field of primary care, it is needed practices centered on the user, a new bond between services and local needs by incorporating the community.

For the fulfillment of FHSC guidelines, expanding the training of health professionals, on special for the physical therapist, involving subject focused on collective activities and trans disciplinary health becomes a necessity (1). The FHSC acts as a production unit that experiences working methods established, by encouraging cooperative teamwork and exchanging of knowledge (17). Besides that, the working process of FHSC teams is not uniform and depends on the various contexts in which they are implemented (3).

Half of the physical therapists said they conducted training as assessing the training offered by the institution. The training and regular meetings with coordination are important in order to discuss specific critical points, meet the demands and organize service (7). Besides, it is essential to dialogue between management and the teams because of the complex health networks services (17). In this sense, the Primary Health National Policy (18) also recognizes the character and up initiative of each team for FHSC proposes and develop continuing education activities. Thus, continuing education is essential to the work interface, which, qualifying and reorganize professional work processes also dialogue with the territorial organization (19) by approaching the full care to the user and needs of the population.

It was possible to notice the coverage of physical therapy services, commonly identified in poor areas (20), the population characteristics that squatters these areas are difficulty to access the specialized health care (9 - 21). The limitation network services in many of health care levels are an obstacle to solve problems in primary care (22). Thus, there are obstacles to the role of the physical therapist in FHSC, and essential changes occur both in the organization of services and in the behaviour of health professionals conducts (5). In this context, it is necessary to invest in health care, without excluding the FHSC contribution to community health (1). Although constitute as support/specialized rear in their own primary care, the FHSC cannot be configured as an outpatient specialties or hospital service (1). It is important to establish community coverage with all health care levels.

The discontinuity in the planning of the health care network flow shows that there is still no organization that facilitates the achievement of users to other levels of care (23). The FHSC teams are facing a great demand to due to flaws in the network. Some programs help the search for equity of access to health actions and services in all the featured levels of care: the agreed and Integrated Health Assistance (24) and the Health Pact (25) are objectives of ensuring compliance and effectiveness in all levels of complexity of the system.

Resources and materials were also presented as some of the difficulties in carrying out the work, and they reported to use their personal materials and resources in services (22). This fact differs from the National Primary Care Policy (18) on the proposal that the Municipal Health Department is responsible for resources required for the development of minimum activities described in the scope of FHSC actions. Accessing and Quality Improvement Program, Ministry of Health strategy strengthens the quality of primary care services (PC), by providing infrastructure and modernization of information systems. So FHSC teams can participate in this process to improve its work (26).

Even though the goal of FHSC to support the FHT (2). There are FHS professionals resistance on doing interdisciplinary activities (3 - 22). Part of this resistance is related to the idea of FHSC, which develops a logic against hegemonic work in health (3). It is difficult by the FHT to prioritize preventive actions. However, there still exists individual focus on the FHSC (27). Another significant difficulties are the restricted quantitative view of care. While it is expected to carry out about 400 monthly visits by the FHT physicians; the FHSC prioritizes collective qualitative actions (22).

The inclusion of new professionals in PC through FHSC expanded the possibilities of promotion of health and care to population (5). In parallel, new forms of work organization in FHS reflect difficulties in the execution of technological tools such as Therapeutic Singular Project (TSP), essential to FHSC. Through discussion in team enables meet the most complex health conditions, covering also family participation and social network these subjects (28).

A few of physical therapists referred perform the Therapeutic Singular Project (TSP) at work. Thus, the TSP is still a recent strategy as a form of work organization and need to be fixed (21). Attention

should be paid to improve communication between staff; the construction of multidisciplinary spaces and focused on academic education to practice integral approach (27).

The service shared can be considered one of the most frequent interventions in the work routine of a professional FHSC (1). However, home visits represented the most frequent activity carried out by physical therapists. The needs of the territory, user or family and the city's network can influence the frequency individual specific assistance (1). Health professionals are on situation of vulnerability, with a great demand for attendance (3), and it can be difficult to the FHSC of professionals expand their possibilities of action beyond the specific actions of its core knows (1). The existence of the Home Care Service (HCS), it is essential to this partnership in the construction of therapeutic projects on their complexity (1).

Then it was appointed the achievement with group activities, whose practices bring several positive features, and essential tool for the work of the FHSC. Collective work should not be thought only as a way to meet the demand, but having characteristics that promote socialization, psychological support, exchange of experiences and knowledge and making collective projects (1).

The main demand raises the assistance of physiotherapists (100%) were cases with neurological patients. According to the Ministry of Health, about 85% of patients with stroke accident and 40% of victims of heart attack have hypertension (29). This scenario points to support the Registration and Monitoring of Hypertensive Diabetics System, which are treated in outpatient facilities of the Unified Health System (30), which reflects through this given weakness in the chain of prevention for chronic diseases, as well the adapting the proposal of primary care.

The majority of FHSC physical therapist said about job satisfaction, it was a positive trait, as the rate of payment. The question of job satisfaction is mentioned as a factor that contributes to the quality of working life in FHSC and it is emphasized the importance of identifying with the work even with the existent difficulties (3).

Conclusion

The participation of the physical therapist in FHSC is an improvement for the profession entering in primary health care and a step forward the decentralization of physical therapy in health care levels. The presence of this professional in all teams of FHSC contributed to the new health format access of the population to recognize the profession in primary care.

The study showed positive characteristics as the effective linkage, high level of education, physical therapist job satisfaction and numbers of FHT by FHSC team meeting the criteria of Ordinance n.154/08. However, it was found some limits on therapeutic effective actions and monitoring. The challenges cut across from the professional training with the involvement of multi and interdisciplinary work that involves the entire health care process, to the co responsability among workers, managers and users of services, but also in operational issues, which led to most of the limitations of working in FHSC, by differing from the National Primary Care Policy and as Accessing and Quality Improvement Program that tends to overcome these gaps.

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