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NASF's tools and practices in health of physical therapists

As ferramentas do NASF nas práticas em saúde de fisioterapeutas

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Abstract

Introduction: With the creation of the Support Center for Family Health (NASF) and the high insertion of physiotherapists in this, it is necessary to have a better knowledge on this category's current work. **Objective**: To analyze the process of work of physiotherapists at NASF and their education, and the technological tools usage. **Methods**: Transversal study, descriptive, analytic, enforced by online semi-structured questionnaires to NASF's physiotherapists in Mato Grosso do Sul. The results were analyzed through descriptive statistics and chi-square test (significant level of 5%). **Results**: 37 physiotherapists (21 cities) participated. Among them, 27% Family-Health/Primary-Health-Care post graduates, and 51.4% in other clinical areas. Most (91,9%) did not receive enough capacitation when joining NASF, and 94.6% consider that did not have enough knowledge to do their activities. The articulation NASF and Family-Health-Strategy team is considered unsatisfactory to 51.3%. Individual rehabilitation is the most carried activity on a daily basis (59.5%), and NASF's tools are used by less than half, except the Amplified Clinic, which is used by 54,1% of physiotherapists. There was a significant association between capacitation to NASF's work and the tools usage of Singular-Therapeutic Project, Territorial Health Project and Support Pact. There was no association between the tools usage and the specialization in Family Health. **Conclusion**: The assistive and rehabilitator model has been the conductor of physiotherapists' actions. NASF's tools are little used. These results are

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explained due to the limited knowledge about NASF's attributions, resulting from the small capacitation offer to these activities and the traditional rehabilitator education.

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

Resumo

Introdução: *Com a criação do Núcleo de Apoio à Saúde da Família (NASF) e a alta inserção de fisioterapeutas neste serviço, faz-se necessário conhecer melhor o trabalho da categoria neste cenário.* ***Objetivo****: Analisar o processo de trabalho dos fisioterapeutas nos NASF, a utilização de ferramentas-tecnológicas e a formação destes para o trabalho.* ***Métodos****: Estudo transversal, descritivo-analítico, por meio de questionário on-line semiestruturado aplicado com fisioterapeutas dos NASF de Mato-Grosso do Sul. Os resultados foram analisados através de estatística descritiva e teste qui-quadrado (p<0,05).* ***Resultados****: Participaram 37 fisioterapeutas de 21 municípios. Destes, 27% possuem especialização em Saúde da Família (SF)/Atenção-Primária à Saúde e 51,4% em outras áreas clínicas. A maioria (91,9%) não recebeu capacitação ao ingressar no NASF, e 94.6% não possuíam conhecimento suficiente para realizar suas atividades. A articulação NASF e equipe de Estratégia de Saúde da Família é considerada insatisfatória para 51,3%. A reabilitação individual é a atividade mais realizada diariamente (59,5%), e as ferramentas do NASF são utilizadas por menos da metade, exceto a Clínica Ampliada, realizada por 54,1%. Houve associação significativa entre a capacitação para o trabalho no NASF e a utilização das ferramentas Projeto-Terapêutico-Singular, Projeto Saúde no Território e Pactuação de Apoio. Não houve associação entre a utilização das ferramentas e a especialização em SF.* ***Conclusão****: O modelo assistencial-reabilitador tem sido o condutor das ações dos fisioterapeutas, e as ferramentas do NASF são pouco utilizadas. Estes resultados podem ser explicados pelo limitado conhecimento sobre as atribuições do NASF, resultante da pouca oferta de capacitação e da formação tradicional.*

Palavras-chave*: Fisioterapia. Atenção Primária à Saúde. Saúde da Família.*

Introduction

In Brazil, in recent years, we have observed the implementation of new juridical and legal arrangements, managerial and organizational, theoretical and technical-assistance arrangements in the field of public health policies in order to overcome the challenges to the implementation of the Unified Health System (SUS) and qualify the actions in the health industrial facilities (1).

In this context, in 2008, it was instituted the Support Center for Family Health (NASF) with the aim of expanding the scope, the resolution, the territoriality, and the regionalization of the actions of the Family Health Strategy (ESF). The NASF are not constitute as system gateway or how specialized care services. They are multidisciplinary teams that have the role to share knowledge, support the health practices of ESF teams and develop health actions among the population in the territories under the responsibility of the Family Health Teams (1, 2).

Thus, NASF's working process has very particular characteristics and should develop itself into a logical counter-hegemonic health work (3). It requires the joint effort, integrated and intersectoral (4, 5), with the basic principles of integrity, knowledge of the territory, teamwork, humanization, popular and permanent health education, interdisciplinarity (2), the participation of users, incorporating the expanded concept of health assumed by SUS (4). It also foresees the shared responsibility between the ESF's and NASF's team, expanding the practice of referrals to a longitudinal follow-up process of the ESF's team's responsibility, prioritizing shared and interdisciplinary care, with knowledge exchange, training and mutual responsibility between all the professionals involved (2).

Given the challenges involved in NASF working process, specific tools guide and should be inserted in the practices and daily life of NASF teams: the Amplified Clinic, the Matrix Support, the Support Pact, the Singular Therapeutic Project (PTS) and the Territorial Health Project (PST) (2).

Although the order of NASF lists the specifications of the powers of the teams and tools to be used, ignorance and lack of skills are impediments to the

work of professionals in the ESF and NASF (4, 6). Conducted studies at the NASF workers in the country show that the professionals of speech therapy (7, 8), occupational therapy (7, 9), psychology (10), nutrition and pharmacy (7) tend to have as priority practices individual rehabilitation action, creating a dichotomy between "support" and "answer" within NASF actions.

Despite the relevance of the mentioned studies, we see still a gap in relation to investigations into the use of all NASF's tools in the work processes of the teams, as well as state or nationwide studies, because so far these limit themselves to analyse isolated teams, or limited to a single region or city.

Considering that the physical therapist is the professional category with greater quantitative representation in teams across the country, according to data from the National Health Facilities (CNES), studies to identify the working process of these professionals in NASF's teams and the use of tools proposed by this policy are central to the planning of actions that contribute to the consolidation of NASF in the country and consequently to expand the resoluteness of the ESF's actions.

Given these projections, this study aims to analyse the working process of physical therapists in NASF from all over the state of Mato Grosso do Sul (MS) in order to identify the use of NASF's tools in daily work, the most performed activities by these professionals, in addition to aspects related to the training of the Physical Therapist for this function.

Methods

This is a study of transversal lining, descriptive and analytic, which has professional physical therapists as the referent population. They act in NASF units of the state of Mato Grosso do Sul, in the period from November 2012 to August 2013.

Initially, it was asked to the Department of Primary Care information on NASF implanted in the state: cities with NASF, which professional categories that made up the teams and the number of professionals by category. Next, the researchers got in touch with the Health Departments of the State and cities with NASF containing physiotherapists in teams, presented the research proposal and requested a list of therapists and their e-mail contacts and telephone numbers. With the relation in hand, physical therapists from each NASF were invited by telephone to participate in the study. After initial contact, e-mail messages were sent containing the presentation of the study and the links to access the consent form and the survey instrument (online questionnaire). The professional, upon insertion of the Social Security Number, accessed the Instrument of Consent, and the questionnaire was released to be answered by those who pointed out the "read and agree" option. This study followed the ethical aspects of Resolution 466/2012 of the National Health Council and was approved by the Research Ethics Committee, approval nº 132 434/2012. The questionnaires whose respondents operations had less than three months in NASF were excluded.

The instrument used for data collection consists of online questionnaire, semi-structured and self-administered, with objective questions that encompassed various aspects of characterization of the professional and his/her performance in NASF. The questions were related to age, gender, training, qualification for work in NASF and about the work process and the use of tools established by the Ministry of Health to work in NASF (2).

Data analysis was done through descriptive statistics, and the association between the variables specialization / training and the use of various NASF's tools was performed using the chi-square test. It was used the "software" SPSS, version 17.0, with a significance level of 5% (11).

Results

In Mato Grosso do Sul, at the time of data collection, there were 39 cities with implanted NASF and from these 33 reported that the physical therapist was among the professionals who made up the teams. At least one physical therapist of each city were invited to participate in the study, and the final sample consisted of 37 physical therapists from 21 cities in the state.

The characterization of the respondents is shown in Table 1.

Table 1 - Percentage and number related to the characterization of NASF's physical therapists of the state of Mato Grosso do Sul, in 2013 (n = 37)

Variable	% (n)
Age*	32.43 ± 6.73
Gender	
Female	83.8 (31)
Male	16.2 (6)
Training	
Specialization	64.9 (24)
College degree	24.3 (9)
Master's degree	10.8 (4)
Field of specialization	
Primary Health Care (APS)/Family Health	27.0 (10)
Clinical physical therapy specialties	51.4 (19)
No specialization	21.6 (8)
Employment status	
Approved applicants	56.8 (21)
Nominated	43.2 (16)
Received training immediately after joining in NASF	
Yes	8.1 (3)
No	91.9 (34)
Received training throughout the operations in NASF	
Yes	32.4 (12)
No	67.6 (25)
When joined the team, one had extensive and sufficient knowledge to carry out the activities of NASF	
Yes	5.4 (2)
No	94.6 (35)
Currently, how would you rate your knowledge related to your duties and the functioning of NASF and the Family Health Strategy	
Not enough	2.7 (1)
Barely enough	54.1 (20)
Enough	40.5 (15)
Completely enough	2.7 (1)

Note: *Data are presented as average ± standard deviation or relative frequency (absolute frequency).

With regard to post-graduate (Table 1), 27% (n = 10) have specialization in Primary Health Care and/or Family Health and 5.4% in health management (n = 2). However, most respondents reported a postgraduate degree in physical therapy specialties or related to clinical areas, such as trauma-orthopedic and musculoskeletal (n = 9), acupuncture and oriental therapies (n = 6), respiratory and in-hospital therapy (n = 5), manual therapy and osteopathy (n = 4), neurology (n = 2), workers health (n = 2), aesthetic therapy (n = 1), exercise physiology (n = 1) and hydrotherapy (n = 1).

Results related to the articulation between the NASF's team and ESF's teams, and specifically on the joint assessment of the area's situation, development of the work process and goals between NASF's and ESF's staff, managers and social control are shown in Table 2.

Table 2 - Variables related to the work process of NASF's physical therapists of Mato Grosso do Sul, 2013 (n = 37)

Variable	% (n)
There is joint assessment of the area's situation between NASF/ESF	
Yes	35.1 (13)
No	62.2 (23)
No information	2.7 (1)
There is joint assessment of the area's situation between NASF/Managers	
Yes	43.2 (16)
No	56.8 (21)
There is joint assessment of the area's situation between NASF/Boards	
Yes	29.7 (11)
No	70.3 (26)
Is there articulation between NASF and ESF?	
Yes	81.1 (30)
No	18.9 (7)
Is the articulation satisfactory?	
Yes	43.2 (16)
No	51.3 (19)

Note: The data are presented as relative frequency (absolute frequency).

Regarding the frequency of activities carried out in the work of NASF, about 90% of physical therapists reported that individualized treatment is the most frequently performed activity (daily or 2 - 4 times/week), followed by health promotion activities and prevention, and group activities. Health Education was the least frequently performed activity among the respondents (Table 3).

Table 3 - Type and frequency of activities carried out by physical therapists from NASF of Mato Grosso do Sul, in 2013 (n = 37)

Activity	Frequency of use			
	Daily	2-4 times/ week	Fortnightly or monthly	Less than once/ month
Treatment and individual rehabilitation	59.5 (22)	29.7 (11)	5.4 (2)	5.4 (2)
Health promotion and prevention	21.6 (8)	35.1 (13)	21.6 (8)	21.6 (8)
Therapeutic group activities	16.2 (6)	45.9 (17)	18.9 (7)	18.9 (7)
Education in Health	10.8 (4)	13.5 (5)	51.4 (19)	24.3 (9)

Note: The data are presented as relative frequency (absolute frequency).

When asked specifically about the use of NASF's inherent tools in daily work, the Amplified Clinic was said to be the most performed and Support Pact the least (Table 4).

Table 4 - Use of tools inherent to NASF carried out by physical therapists from NASF of Mato Grosso do Sul, in 2013 (n = 37)

Tool	% (n)
Amplified Clinic is performed	
Yes	54.1 (20)
No	45.9 (17)
Matrix Support is performed	
Yes	45.9 (17)
No	54.1 (20)
Singular Therapeutic Project is performed	
Yes	37.8 (14)
No	62.2 (23)
Territorial Health Project is performed	
Yes	37.8 (13)
No	62.2 (23)
Support Pact is performed	
Yes	24.3 (9)
No	75.7 (28)

Note: The data are presented as relative frequency (absolute frequency).

Although a significant number of physical therapists report that does not use NASF's tools, we identified statistically significant association between respondents who received some kind of work training in NASF and the use of tools Singular Therapeutic Project (PTS), Territorial Health Project (PST) and Support Pact. There was no significant association between the use of NASF's tools regarding the post-graduate courses in family health or public health (Table 5).

Table 5 - Association between training/specialization, with the use of NASF's tools for physical therapists in Mato Grosso do Sul, in 2013 (n = 37)

Tool	Training	
	Yes	No
Amplified Clinic (p = 0.173)		
Yes	69.2 (9)	45.8 (11)
No	30.8 (4)	54.2 (13)
PTS (p = 0.004)*		
Yes	69.2 (9)	20.8 (5)
No	30.8 (4)	79.2 (19)
PST (p = 0.029)*		
Yes	61.5 (8)	25.0 (6)
No	38.5 (5)	75.0 (18)
Matrix Support (p = 0.161)		
Yes	61.5 (8)	37.5 (9)
No	38.5 (5)	62.5 (15)
Support Pact (p = 0.002)*		
Yes	53.8 (7)	8.3 (2)
No	46.2 (6)	91.7 (22)
Tool	**Specialization**	
	Yes	**No**
Amplified Clinic (p = 0.659)		
Yes	60.0 (6)	51.9 (14)
No	40.0 (4)	48.1 (13)
PTS (p = 0.869)		
Yes	40,0 (4)	37,0 (10)
No	60,0 (6)	63,0 (17)
PST (p = 0,173)		
Yes	20,0 (2)	44,4 (12)
No	80,0 (8)	55,6 (15)
Matrix Support (p = 0.659)		
Yes	40.0 (4)	48.1 (13)
No	60.0 (6)	51.9 (14)
Support Pact (p = 0.624)		
Yes	30.0 (3)	22.2 (6)
No	70.0 (7)	77.8 (21)

Note: The data are presented as relative frequency (absolute frequency). *P value in the chi-square test ($p < 0.05$).

Discussion

This study aimed the analysis of the working process of physiotherapists of NASF of Mato Grosso do Sul, in particular concerning the use of tools established by the Ministry of Health as a structural guideline of work in the Cores. This is an unpublished study, statewide, whose centrality is in the knowledge of reality as a guide for improvements in quality of care, involving a relatively new public policy, where currently the physical therapist is what is implied in most number across the country.

The results show a worrying fact, a significant percentage of respondents does not use the technological tools of NASF on a daily basis of work and personal recovery is the most frequently used activity by such professionals. Another important finding is the fact that almost all physiotherapists indicated that when they start their activities in NASF, knowledge about the duties and specifics of the job was not enough, and that did not receive any initial training for the job. Only a third of respondents received some kind of qualification after their inclusion in NASF, and more than half also believes that knowledge to act in this role is rather enough.

The results for the insufficient knowledge of NASF's assignments and little professional qualification for this work may explain the limited daily use of technological tools, identified in NASF in the studied cities. Since its origin, physical therapy was aimed almost exclusively to control damage from diseases that compromise functional health (12). Faced with the reality of the reorientation of the assistance model, it is necessary that the physical therapist develop skills that qualify him to work in NASF, where they are needed spaces for dialogue, work organization, cooperation and articulation (5, 13).

The use of NASF tools are involved with the assistance model guided by APS, the principles of universality, accessibility, continuity of care, comprehensive health care, accountability, humanization, equity and social participation (14). Traditionally, the physical therapist has his training and performance characterized by rehabilitation actions in the field of secondary and tertiary health care (13), distanced from the APS. Not only in Brazil but worldwide it is identified that there is disinterest of physical therapists in relation to professional practices in the APS (15), and due to this reality, the World Confederation for Physical Therapy (WCPT) focuses on the need for stronger guidance and focused physical therapy in APS, emphasizing health promotion and disease prevention. This topic has been widely discussed in other countries, such as Spain (16), Australia (17) and New Zealand (18).

Specifically regarding NASF, insufficient knowledge about the tasks and specifics of the job also occurs in other realities, whose weaknesses regarding its operation and understanding reverberate dislocation in the working process by the ESF (19, 20) and highlight the lack of professional preparation arising from the lack of training and practice of permanent education (1, 7 - 10, 21).

With regard to the relationship between ESF and NASF, approximately half of the respondents does not consider satisfactory, and shares of joint evaluation of territory with ESF, managers and councils are poorly made. This reality may be due to barriers that professionals are to take responsibility in co-management, permitted by NASF, out of a vertical power logic (22), as well as the fact that the knowledge generated by the traditional physical therapist training are insufficient to the multidisciplinary and interdisciplinary approach (19) to the situational diagnosis and risk and to performance at the community level in order to encourage the community on issues related to their health (5, 12), and provide the user autonomy and citizenship.

In addition, little articulation between NASF's and ESF's teams is possibly by the lack of working together and the unawareness of NASF must be an SF team supporter and not exclusive assistance reference (1, 19 - 21). The articulation between NASF and ESF can be achieved through frequent meetings, especially the responsibilities and duties of each professional, so they can be triggered shared actions (5, 23). When NASF's and ESF's teams do not work together, discussion spaces get empty, merely informative, compromise the practice and the effectiveness of the Matrix Support, the proposal and the debate concerning PTS, PST and the practice of Permanent Training.

Another important result was the appointment of individual rehabilitation as the practice most often performed by the large majority of physical therapists. Although the NASF's Guidelines establish the Rehabilitation as a strategic area also that spells out that personal recovery should occur only in extremely necessary cases, not being a priority practice (2). The results show that physical therapy actions within NASF reproduce the rehabilitation and individualized model, historically performed by the physical therapists in other levels of care.

The practice of rehabilitation in NASF, with individual visits as the most developed practices in daily work, was identified in studies with professionals of speech (7, 8), occupational therapy (7, 9), psychology (10), nutrition and pharmacy (7). Possibly this is a reality present in teams of NASF, which involves practices focused on hegemonic logic-centered procedure and distant from the expanded vision of health (1, 20). It is worth noting that studies show the implementation of other activities, especially actions with population groups such as hypertensive and elderly people, however, these practices are not reported as the most performed by the teams. The lack of action to disseminate successful experiences of NASF, whose work processes are guided in the use of tools, coupled with the high demand of users who require individual assistance in SUS, complicate and push the work of professionals who make up the teams NASF (9).

This result can be explained by two overlapping situations: 1) the high demand for rehabilitation services not supplied by the level of secondary care; 2) lack of knowledge about the duties of NASF, arising from the characteristics of training of the physical therapist and the lack of qualification when the professional is included in the service.

Regarding the demand for rehabilitation services, there are a lot of users without access, either for lack of vacancies, or lack of medical transportation providing displacement of individuals with disabilities to services. In this situation, NASF's physiotherapists take the attention of users, who require individualized attention to rehabilitation actions (24). Thus, the care of users who should have access to Rehabilitation Centres of Expertise can hamper NASF's physical therapist to perform actions relating to its tasks in APS (5, 12, 19, 25).

In addition to the problems resulting from lack of access to rehabilitation services in secondary care, are the obstacles imposed by the training of health professionals. Despite the changes in the country's health model, with reorientation by the principles of APS, physical therapy has not yet widely incorporated training for preventive actions and health promotion (12, 13), nor aspects related to practices guided by the principles of APS. In college courses, the inclusion of subjects focused on this level of attention occurred only in the last decade, and postponed the profile focused on the biomedical model of health (12, 26). The National Curriculum Guidelines state that all levels of care should be included graduation (27), however, it still prevails technicalities training focused on illness and rehabilitation (12, 25). Therefore, many of the professionals who currently work in NASF possibly have had in their education the necessary basis for a broad understanding of public health policies and the performance profile for the APS. Specifically, in relation to NASF, it is a recent policy, which proposes a particular work process, within which many professionals are still unaware of their role (9, 20).

Also in relation to training for work in NASF, although almost 80% of the studied professionals are postgraduates, specialties regarding postgraduate areas informed by the physical therapists are observed: most have training in clinical areas of physical therapy, which rehabilitating practices are central. Although approximately 30% of professionals have taken specialized courses in Health (SF) or APS, there was no association between this training and increased use of NASF's tools.

Through these results it is indicated that if the post-graduate courses in family health/APS have contemplated the specifics of the work process proposed for the NASF and its role as supporter of the ESF. This is an essential approach, since the articulation between ESF and NASF is still unsatisfactory (9, 19, 21), and is essential for NASF to effectively act integrated to the teams of ESF and increase the effectiveness of APS.

While the specializations in SF and APS do not interfere with the increased use of NASF's tools in the cities studied, there was a significant association between the achievement of specific training courses for work in NASF and increased use of PTS tools, PST and the Support Pact. Therefore, it can be said that the training regarding the professional's needs provides knowledge mobilization to impact the realization of practical guidelines guided by such policy. Considering that more than half of respondents rate their knowledge as rather enough, in the case of the role and assignments of NASF, qualifying initiatives are important.

Given the above, it is necessary to reframe the practices of health professionals inserted in NASF, the assisted population and care networks, incorporating technologies and tools that enable the break with the logic of fragmented attention and focused on the disease that still exists in training processes and in the current healthcare model (6).

It is in this perspective that the Permanent Education (EP) takes on outstanding importance,

since it is one of the strategies of action listed by NASF guidelines, and constitutes an important proposal focused on the implementation of new practices in workers' daily life and health services. There is evidence that the EP actions are effective for changes in health, and should be common practice in areas where it produces health (28, 29, 30).

We have the understanding that the analysis of a single professional category may allow a fragmented view of the working process of NASF. However, we can infer that by identifying individual practices of a single professional category, where workers mention insufficient articulation with the ESF, management and advice, and that the qualification procedures were limited, perhaps that's the same reality of the entire team, as already evidenced in the literature for studies on NASF work process of other professional groups in different regions of the country (9, 10, 20).

We can not avoid to also reflect on the adopted method. The population survey consists of a consolidated scientific method, with respondents' assurance of anonymity and allowing data collection of representative population groups of a community. The choice of such a method is given for allowing involvement in the research of all cities of the State. However, the results are due to professional reports and have not been confirmed by observation in the field, to check how the working process in such spaces really is. For deepening the subject, it is recommended to carry out studies observing the daily life of NASF's teams, interviews with the ESF's teams, managers and users.

In the cities we studied, it was found that physical therapists barely utilize NASF's tools. And the practice of individual rehabilitation as more frequent activity demonstrates the reproduction of the assistencial model of common spaces in rehabilitation of secondary and tertiary care. This reality is possibly associated with lack of professional qualification to work in NASF, whether in undergraduate, graduate or in-service training. Gaps in training limit professional work according to the guidelines established for the work in NASF.

Conclusion

The assistential models are established in everyday services, and are affected by a number of factors emerging from a social-economic-cultural-historical context. By the reflections so far put on the process of working with physical therapists, it is concluded that NASF in the form that is implanted in Mato Grosso do Sul, still finds limits to achieve the goals proposed by the Ministry of Health, even with all the advances. Curriculum changes and effective actions of EP are strategies that can change this situation and optimize the resoluteness of the work of NASF's teams. It is necessary to create discussion spaces where the main obstacles that hinder the implementation of this new work process model are raised, as well as for planning and evaluating actions along with workers, managers and users.

We cannot idealize, in a reductionist way, that the implementation alone of NASF's teams ensure that the guidelines set by this policy are met and that, consequently, it extends the resoluteness of the actions of ESF and the changes in the assistencial model proposed by SUS. This shift demands transformation of working processes, management and training.

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