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RESEARCH

POTENTIALS AND LIMITS IN HOME CARE SHARED BETWEEN TEAMS: A QUALITATIVE STUDY

POTENCIALIDADES E LIMITES NO CUIDADO DOMICILIAR COMPARTILHADO ENTRE EQUIPES: UM ESTUDO QUALITATIVO

POTENCIALIDADES Y LÍMITES EN LA ATENCIÓN DOMICILIARIA COMPARTIDA ENTRE EQUIPOS: UN ESTUDIO CUALITATIVO

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ABSTRACT

Objective: to apprehend how professionals working in Primary Health Care (PHC) and Home Care Service (HCS) perceive the potentialities and limitations of shared care. **Method: d**escriptive exploratory study, with a qualitative approach, based on the theoretical assumptions of the Health Care Network (HCN), carried out with 10 healthcare professionals working in one of the capitals of a state in Brazil. Data were collected in October 2019 through a single focus group session, at which time, based on the construction of the SWOT matrix (Strengths, Weaknesses, Opportunities, and Threats), strengths, weaknesses, opportunities, and threats that permeate shared care in home care. Data were submitted to content analysis, thematic modality. **Results:** as potentials, the following were highlighted: the care actions carried out jointly by the different professionals of the teams; conducting objective and targeted meetings; the division of responsibilities and the definition of roles; and the flows that can improve communication between teams and enhance the practice of shared care in home care. As limitations, the following stand out: insufficient knowledge of the eligibility criteria for home care; the deficiency of material resources and information technology; and gaps in professional training. **Conclusion:** the results can contribute to the qualification of care among the different services that make up the Health Care Network, especially by identifying elements related to the work process itself that influence shared care.

Palavras-chave: Home Care Services; Primary Health Care; Family Health; Delivery of Health Care; Continuity of Patient Care.

RESUMO

Objetivo: *apreender como os profissionais atuantes na Atenção Primária à Saúde (APS) e no Serviço de Atenção Domiciliar (SAD) percebem as potencialidades e as limitações para o cuidado compartilhado.* ***Método***: *estudo descritivo exploratório, de abordagem qualitativa, fundamentado nos pressupostos teóricos da Rede de Atenção à Saúde (RAS), realizado com 10 profissionais de saúde atuantes em uma capital brasileira. Os dados foram coletados em outubro de 2019 mediante a realização de uma única sessão de grupo focal, ocasião em que foram discutidas, a partir da construção da matriz SWOT (Strenghts, Weaknesses, Opportunities, and Threats), as forças, as fraquezas, as oportunidades e as ameaças que permeiam o cuidado compartilhado na atenção domiciliar. Os dados foram submetidos à análise de conteúdo, modalidade temática.* ***Resultados***: *como potencialidades, foram destacadas: as ações de cuidado realizadas em conjunto pelos diferentes profissionais das equipes; a realização de reuniões objetivas e direcionadas; a divisão de responsabilidades e a definição de papéis; e os fluxos que podem melhorar a comunicação entre as equipes e potencializar a prática do cuidado compartilhado na atenção domiciliar. Como limitações, destacam-se: o conhecimento insuficiente dos critérios de elegibilidade para a atenção domiciliar; a deficiência de recursos materiais e de tecnologia da informação; e lacunas na formação profissional.* ***Conclusão***: *os resultados podem contribuir para qualificação da assistência entre os diferentes serviços que compõem a Rede de Atenção à Saúde, especialmente pela identificação dos elementos relacionados ao próprio processo de trabalho que influenciam no cuidado compartilhado.*

Palavras-chave: *Serviços de Assistência Domiciliar; Atenção Primária à Saúde; Saúde da Família; Atenção à Saúde; Continuidade da Assistência ao Paciente.*

RESUMEN

Objetivo: *apreciar como los profesionales activos en la Atención Primaria a la Salud y el Servicio de Atención Domiciliaria perciben las potencialidades y limitaciones para el cuidado compartido.* ***Método:*** *estudio descriptivo exploratorio, de abordaje cualitativo, fundamentado en los presupuestos teóricos de la Red de Atención a la Salud, realizado con 10 profesionales de la salud activos en una capital brasileña. Los datos se recogieron en octubre de 2019 mediante la realización de una única sesión de grupo focal, en la que se discutieron las fortalezas, debilidades, oportunidades y amenazas que permean el cuidado compartido en la atención domiciliaria a partir de la construcción de la matriz* SWOT *(Strenghts, Weaknesses, Opportunities, e Threats). Los datos se sometieron a un análisis de contenido, modalidad temática.* ***Resultados:*** *como potencialidades se destacaron las acciones asistenciales realizadas de forma conjunta entre los diferentes profesionales de los equipos, la celebración de reuniones objetivas y focalizadas, el*

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reparto de responsabilidades y la definición de roles y flujos que pueden mejorar la comunicación entre los equipos y potenciar la práctica de los cuidados compartidos en la atención domiciliaria. Como limitaciones destacaron el insuficiente conocimiento de los criterios de elegibilidad para la atención domiciliaria y la falta de recursos materiales y de tecnología de la información, así como las lagunas en la formación profesional. ***Conclusión:*** *los resultados pueden contribuir a la cualificación de la asistencia, entre los diferentes servicios que componen la Red de Atención a la Salud, especialmente mediante la identificación de los elementos relacionados con el proceso de trabajo que influyen en el cuidado compartido.*

Palabras clave: *Servicios de Atención de Salud a Domicilio; Atención Primaria de Salud; Salud de la Familia; Atención a la Salud; Continuidad de la Atención al Paciente.*

INTRODUCTION

Home Care (HC) conveys changes in the healthcare system by enabling care to be offered in a unique way than what is done in hospitals, outpatient clinics and other points of the Health Care Network (HCN). This is due to the fact that it provides continuity of care and comprehensive care, which is not only directed to the individual, but also to his/her family.[1]

The increased prevalence of chronic health conditions, HC emerges as a strategy to manage the new demands and needs of the population.2 In addition, this care modality cooperates to rationalize expenses by shortening or replacing hospitalization, as well as highlighting the importance of a unique care centered on the health needs of those assisted and their families.[1]

In this sense, users, caregivers, and healthcare professionals participating in a study carried out in Ceará, Brazil, pointed out the advantages of HC. For example, the elderly mentioned improvements in their health conditions as a result of frequent monitoring and evaluation by professionals and the possibility of discussing about various problems experienced at home. Caregivers highlighted the ease of access to medications for continuous use and the scheduling of appointments and exams. Professionals, in turn, highlighted the availability of enteral diet, devices, materials, opportunity for psychosocial care, guidance, health education groups and elaboration of the unique therapeutic project (UTP).[3]

Nevertheless, a study carried out in Canada pointed out that, despite the high levels of user satisfaction with HC, it is still underestimated and insufficiently supported.[4] The adequate supply of material resources, for example, is one of the management challenges in HC; however, the sufficiency of these resources is not enough for the appropriate performance of care in the home context. For HC to happen with quality, it is necessary that managers take ownership of the strategic planning, enable permanent education for the teams and have human and material resources available.[5]

Health care systems experience continuous pressure to meet the growing demand for care in a context of limited financial resources — not to mention that, sometimes, patients and caregivers do not recognize the strategies used by healthcare teams, such as support actions and support for families. These aspects point to the need to implement strategies that contribute to enhance, on a daily basis, the effectiveness and efficiency of services.[6]

Thus, as much as HC proves to be important and necessary, there are still weaknesses that permeate it and that need to be overcome. Research that explores its limitations — but, in particular, its potential — is needed. The importance of these studies is, above all, with regard to the sharing of care as a strategy able of integrating, organizing, and optimizing the actions of the different healthcare teams that work in this care modality, in order to expand the perspectives of use and its resolution.

The sharing of care between the Home Care Service (HCS) teams and the Primary Health Care (PHC) teams, represented by the Family Health Strategy (FHS) and the Expanded Nucleus of Family Health and Primary Care teams (NASF-AB, *Núcleo Ampliado de Saúde da Família e Atenção Básica*), it is necessary, since the HCS team aims to support the care actions carried out by the PHC.[7] This support is aimed at those patients who, after hospital discharge, need follow-up frequently due to clinical complexity and dependence on technologies, such as tracheostomy, stoma, among others. This continuity of assistance is provided by the PHC team, given the greater proximity to the households.

The articulations between the different points of the HCN are essential for the user to have access to services with equity. However, sharing health care and achieving good results is just one of the challenges faced by the HCN, such as insufficient services and human resources, deficits in flows for continuity of care and weaknesses in care coordination.[8]

Given the above, the question is: how is sharing home care perceived by healthcare professionals who work in this scenario? With the goal to respond to this question, this research aimed to apprehend how professionals working in Primary Health Care and in the Home Care Service perceive the potentials and limitations of shared care.

METHOD

Descriptive-exploratory study, with a qualitative approach, which used the theoretical assumptions of the HCN as a conceptual basis, whose purpose is to offer health care in a continuous and shared way between the different points of care, with Primary Care being the care coordinator.[9] As a reference to guide data collection, the assumptions of strategic planning were adopted, through the construction of the SWOT matrix (Strengths, Weaknesses, Opportunities, and Threats).[10] The study is part of a matrix survey carried out in the capital of one of the states in the Midwest region of Brazil. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines conducted the reporting of results.

The city under study is divided into seven healthcare regions and, at the time the research was carried out, it had 68 Basic Health Units (BHU) — of which 52 were Family Health Units (FHU) —, 143 teams from the Family Health Strategy Family (FHS) and 12 NASF-AB teams. It also had four Regional Health Centers (RHC), six Emergency Care Units (UPA, *Unidade de Pronto Atendimento*), and three HCS teams. Study participants are part of the Primary Care and HCS services in the same healthcare region.

It is important to clarify that, in this city, one of the HCS teams is related to the Municipal Health Department; the other two, to a large hospital. The two teams related to the hospital follow the guidelines set out in the ordinance but use their own and independent criteria for defining the patients to be followed-up at home.

In the matrix research, individual interviews were carried out with 17 technical and higher-educated professionals working in two FHU, a team from NASF-AB and a team from HCS, all making part of the same healthcare region of the municipality. At that time, participants were consulted about their interest in participating in a focus group (FG) session in the second stage of the study.

The only inclusion criterion established was having participated in the first stage. Thus, a total of 14 professionals were contacted by telephone to check availability and scheduling the FG, since three professionals had already reported their lack of interest. In turn, professionals who were on sick leave (one) or vacation (three) were not included, resulting in 10 participants.

Data were collected in October 2019 by conducting a single focus group (FG) session on the premises of the FHU, on a convenient day and time for most potential participants. The session lasted 2 hours and 30 minutes and was conducted by a nurse (Master's student in Nursing) with the support of two nurses, who acted as observers, and a Nursing student, who acted as rapporteur. All of them were previously trained in research group meetings. Only the moderator had already had contact with the participants, as she had conducted individual interviews in the first phase of the study; she was also the one who made the telephone contacts to schedule the FG.

During the FG, as a strategy to trigger the discussion, the participants were invited to reflect on the fundamental elements of the SWOT matrix, specifically the strengths, weaknesses, opportunities, and threats that permeate shared care in home care. To do so, initially, an explanation was given about the meanings of the terms used in the SWOT matrix. Then, to promote the exchange of knowledge, encourage effective participation and discussion, the participants were divided into pairs and instructed to record the components of the matrix referring to home care on four cards.

It is noteworthy that, before the beginning, it was reiterated to the participants that there was no right or wrong, and that the record should correspond to the way they perceive the daily care provided by the services. To address this record, four guiding questions were used, in order to meet the aspects of the SWOT matrix: 1) What factors facilitate the development of home care shared between teams? (Strength — internal environment); 2) What factors hinder the development of home care shared between teams? (Weakness — internal environment); 3) What factors can you not control and that hinder or hamper the home care shared between the teams? (Threat — external environment); 4) What factors encourage shared home care between teams? (Opportunity — external environment).

Three minutes were allocated for the pairs to discuss and record their responses on the corresponding cards. Subsequently, one minute was available for a representative of each pair to fix the cards on the matrix panel and explain the answer. It should be noted that, during the construction of the SWOT matrix, the participants themselves allocated the cards within the tool, with no interference from the researchers.

To record the participants' statements and later transcribe the data, two recorders and a cell phone operating in offline mode were used, in order to avoid a possible interruption. In the transcripts, no verb tense or grammatical errors were corrected. Perceptions and observations regarding the professionals' verbal and bodily expressions during the session were recorded by the observers and by the reporter as a strategy to complement the transcripts and enable a greater understanding of the context and the theme researched. In order to detail the aspects listed with the focus group discussions and construction of the matrix, the empirical material was submitted to content

analysis, thematic modality, according to the three proposed stages (pre-analysis, material exploration, treatment and interpretation of the results obtained).11 Initially, 13 core meanings emerged: 1 – sharing of care between the different teams working in PHC; 2 – expansion of services; 3 – decrease in the occupation of hospital beds; 4 – resources to speed communication up between members of the different teams that carry out the HC; 5 – objective and directed team meetings; 6 – division of responsibilities, roles and flows between teams; 7 – communication failure; 8 – lack of knowledge about HC; 9 – lack of construction of a singular therapeutic project among the teams; 10 – unavailability of a vehicle to carry out the HC; 11 – lack of details about the patient's clinical case; 12 – lack of advanced technology; 13 – lack of recognition of the importance of HC.

Subsequently, through a full reading process, with identification of common and specific aspects, in addition to reflection guided by the assumptions of the HCN, there was a deepening and connection between the different nuclei of meaning.11 This process originated the category: "Potentials and limitations for carrying out shared home care".

In order to guarantee the secrecy and anonymity of the participants, the abbreviation GF was used to designate "focus group", followed by the indicative number of the sequence of the participants' statements, such as GF01, and so on. The study was approved by the Research Ethics Committee of the signatory institution (Opinion Report No. 3,226,138). Before the start of the FG session, to facilitate communication between peers, participants received a badge with the name and institution to which they belonged, and all signed the Free and Informed Consent Form (ICF). It is noteworthy that a brief presentation of the results of the study was carried out at a service meeting of the institutions involved.

RESULTS

The 10 FG participants were aged between 26 and 55 years (mean 34.4 years), working in the teams between 6 and 180 months (mean 42.6 months). Five participants were men and five were women. The group of participants had two community healthcare agents, two doctors (one from HCS and another from FHU), two physiotherapists (one from HCS and another from NASF-AB), a nurse (HCS), a Nursing technician (HCS), a physical educator and an occupational therapist (both from NASF-AB). Six of them worked 40 hours a week, and two had specialization in family health/public health.

The terms referring to HC for each item in the SWOT matrix are shown in Table 1.

The verbal manifestations during the presentation/explanation of the terms used in each item gave rise to the category "Potentials and limitations for carrying out shared home care", which consists of two subcategories that will be described below.

Potentials in carrying out shared home care

Among the potential strategies for shared care, the participants highlighted the actions carried out jointly between the professionals of the two services and the increase in the number of teams and FHUs.

> *We were successful once by being able to make a home visit together with the NASF nutritionist. The work of professionals from the HCS, "NASF", and BHU professionals is necessary. We already managed it together with the community health agent. This contact is very important to build the UTP, to set goals and achieve goals together (GF10);*

> *The expansion of the "NASF" and the FHS was important. It promoted the expansion of management in terms of team*

Table 1 - SWOT matrix of home care in the view of health professionals. Campo Grande, MS, Brazil, 2019

Strength (internal environment) – Knowledge of the patient's case; Communication between teams; Unity between teams, patients, caregivers; Access to home service; Staff meeting; Multidisciplinary and Resoluteness
Weaknesses (internal environment) – Lack of communication between teams; Lack of a unified medical record; Disunity between teams; Lack of integration between teams; Lack of automation of the Health Care Network
Opportunity (external environment) – Improving knowledge and education about home care; Multidisciplinary team; Communication; Expansion of services; Expansion of teams and territory coverage; Training for professionals with seminars, forum; Undergraduate training provided by universities
Threats (external environment) – Management interference; Judicialization; Bureaucracies; Policy; Lack of autonomy in management; Lack of structure; Exchange management; Lack of security; Media influence; Lack of unified medical record for access to all points of the Health Care Network

training, expansion of the FHS's territory, the possibility of a broader, more comprehensive service (GF06);

The entry of a physician into the "NASF" was important; in order to offer these specialties to more people, today nine "NASF" teams can count on Gynecologist and Pediatrician care (GF01).

They also pointed out that meetings between the different teams, carried out in an objective and directed way, as well as collective discussions at an opportune moment, favor HC.

Reunião de equipe, por exemplo entre o NASF e as equipes das unidades de saúde. Entende-se como reunião de equipe o que dá, e quando dá, não precisa ter aquele dia específico e não só quando está todo mundo. Quando é possível também (GF01);

Com todo mundo reunido, alguém vai ter uma resposta mais concreta para cada caso, alguém sabe que aquele paciente existe, que está precisando daquela atenção (GF05).

In addition, they listed strategies that, although not used, could be adopted to favor the work process, such as a shared agenda and definition of flows.

It would be very good if there was a way to know the agenda, the day of the visit, the team to talk together in the patient's house. This would avoid a bit of cross-information. It could have a better overall view of the patient; the care would be adequate as well as the work tools (GF07);

If there was a better connection, if the HCS sent us from the BHU: "one day the HCS will be there, about that time, in that moment". This would create an alliance, so the patient will receive care from the team, they will be there interconnected with each other (GF05);

From the moment the HCS takes over the patient, he/she is not under our care only, but the under the care of the unit. Therefore, we must have joint attention and dedication (GF03);

[...] create an opinion report system, "the HCS has five days to respond an opinion report sent to them", it is a faster communication system, it would be very effective for us (GF09);

I imagine that a proper flow even improves the productivity of the professionals' work, it becomes more productive and more resolving [...] (GF08).

Imagino que um bom fluxo melhora até a produtividade do trabalho dos profissionais, fica mais produtivo e mais resolutivo [...] (GF08).

Limitations in carrying out shared home care

Among the limitations for shared home care, aspects related to communication between teams and effectiveness of referral and counter-referral were highlighted.

There was a patient I assisted, I never had any contact [with the HCS team], about what they [the HCS] are doing, I never had feedback, there is no communication between the teams (GF04);

If this engagement could be a slightly better between HCS, "NASF" and the unit itself, I think it would make care easier. The secretary of social assistance also [...] (GF07);

There are some cases in which the hospital announces that the patient is going to be discharged, but most of the time, we will have access to the patient three, four months later. Ideally, he/she should leave the hospital with the evaluation of HCS or "NASF" or USF professionals, but there is no discharge letter or guidance (GF09);

The caregivers don't even know the names of the professionals [...] you ask them, they don't know: "Oh, a lot of people came here, I think it's a nurse" (GF04).

However, participants highlighted that the use of some tools can facilitate and speed up the organization of teams.

The use of instruments, e.g., the "Informe-SUS", Whatsapp [...] already happens informally and facilitates, it is a means that we use to pass on an important or urgent information, a facilitator for our work process (GF06);

We [municipality] do not have a counter-referral system [...] the faster we forward and resolve that initial request, the faster the patient returns to his/her work matter, goes back to work, or even returns to his/her activity at home [...] (GF09). laboral, volta a trabalhar ou até volta a sua atividade dentro do domicílio [...] (GF09).

As well as HCS's participation in PHC meetings and the use of instruments such as the ecomap.

> *It is important to have the HCS participate [in the meetings] to work on techniques, case evolution (GF02);*

> *To work with the ecomap to identify who the support network is. This directs and qualifies the level and intensity of the necessary bond between the team and the family [...] (GF08).*

However, they mentioned that insufficient knowledge about the eligibility criteria for HC — including by professionals who work in the different HCN devices — and the unavailability of a vehicle for transporting professionals limit shared care

> *They think HCS is an exclusive physiotherapy service. This is not only for the hospitalization unit, but also for the management. It started wrong [in the municipality], just to absorb this demand for physiotherapy and avoid judicialization [...] (GF10);*

> *What makes shared care difficult is transportation. When we [HCS] can arrange to go to a visit, the "NASF" cannot go that day, or only one professional can go [...] (GF10);*

> *The "NASF" has difficulties, as it has already happened, the car is scheduled for tomorrow, the day has come, and the vehicle broke down and they were left with no car (GF03).*

Still as limitations, the difficulty for the joint construction of a UTP was pointed out, considered an important tool for improving care in the home context.

> *Until today we [HCS] have not been able to sit down together with the "NASF" team and do a UTP together. We do it ourselves, one copy is inside the physical record at our base, and another is in the patient's home record where everyone can access it (GF10).*

There was also mention of the absence of a detailed description of the clinical cases of patients referred to HC.

> *We already had situations where there was no description of the patient's case, or what was written was not compatible with the patient's case (GF09).*

Another fact pointed out was the technological deficiency and the lack of a unified medical record system within the network.

> *The instruments themselves should make it easier for those who are going to provide care. For example: the professional accessed the medical record and there was "patient confined to bed, HCS care". There should be at least some small screen already indicating it, and it's easy to do that, the IT people do it incredibly quickly. "Is it HCS"? Then, let's take a closer look at this patient's history, see how he/she is being treated. It costs nothing to have a link to facilitate service and care, but this technology is not available. Even the professional looking for the patient's history in both systems takes time and becomes complicated (GF07);*

> *Make a checklist of what you have and point it there [in the system]. If the patient is being followed up at HCS, at Psychosocial Care Centers ["CAPS"]. That would make it easier too. We use a very archaic system, you have to pick up a phone to dial "I referred a patient to the "CAPS", is he going there? Because he shows up every day here at the unit asking for a prescription" (GF01).*

Finally, it was highlighted that the education and training of healthcare professionals for shared care are fragile.

> *In the College I graduated, I never had anything along with a healthcare center, my concept of multidisciplinary work was vivid at the university clinic comprised by a physio, speech therapist [...] you know that dream clinic, nobody ever said: "you are here learning, but this is not how you are going to work, you are going to work like this". "SUS"? I had nothing about "SUS", just a training somehow, you know [...] (GF01).*

DISCUSSION

Shared care between the HPC and HCS teams enables a different look at the different health practices, providing comprehensive care to the patient and increasing the resolution of HCN actions — which, in theory, should be coordinated by the HPC. Thus, it is considered that the possibility of discussing aspects related to this practice using the SWOT matrix as a guide enabled the participants to identify the common factors between the teams, which enhance and limit the effectiveness of shared home care.

The use of the SWOT matrix as a support tool for data collection helps to understand the situations that interfere in the work process of the teams, cooperating for the establishment of intervention goals that favor the quality of the services offered.[10] In the researched context, the results reiterate the importance of home care provided by professionals belonging to different teams being unique in each case. This is because this care modality allows the organization of joint actions between the PHC and HCS

teams, based on the identification, in loco, of the needs of patients and their families.[1]

Furthermore, the results of this study reiterate the importance of coverage by healthcare teams within the scope of PHC, as these services provide opportunities for continuity of care within the HCN in the home environment. Thus, in Brazil, the expansion of home care — offered by the PHC and HCS teams — contributes to the improvement of health care as it provides more timely access for the population.[12] This, in turn, can contribute to the reduction of hospitalizations for chronic conditions that are sensitive to this level of care, which is beneficial for the healthcare system, but, above all, for patients and their families.

The results showed that the lack of local organization between the HCN services, such as the definition of roles and competencies of PHC and HCS professionals, weakens the shared care between the teams of these services. In this sense, the participants pointed out the need for integration between health professionals who perform HC. This integration, as pointed out in a study carried out in Florianópolis, Santa Catarina, Brazil, can be encouraged by joint meetings between the different teams, with a view to planning and organizing healthcare actions.[13] In light of this result, it becomes relevant to rethink health care teaching practices, so that, during the training process, future professionals are made aware of and know the different configurations of collaborative/shared work and the strategies to implement them in their care practice.

The existence of a shared agenda between the different teams was pointed out as a possibility for organizing the work process and planning shared care actions. It should be noted that the closer professionals from different services are to each other and the more available for exchange and dialogue, the greater the probability of identifying which actions in the field each one of them responds to. Likewise, it will be easier to recognize your inherent skills, which are decisive for the production of care.[14]

The results of this study also allow us to assume that the elaboration of a care plan involving the patient and his/her family can contribute to improved outcomes of shared home care. It is noteworthy that carrying out periodic visits is a strategy to enhance the offer of HC consistent with the unique needs of individuals and their families, which, in turn, favors the recovery and maintenance of health.[15]

Through home monitoring, professionals are able to observe how care is performed by the family/caregiver on a daily basis, monitor the evolution of the condition, identify new health demands/needs and guide the practices necessary to meet them. In addition, they can identify and provide, within the network, the professional support that the family needs.[16] In this sense, the need for, during professional training, to explore the basic precepts that should guide the home visit, from its planning to its execution, registration, and evaluation. This action/activity needs to be systematized and valued by the healthcare team to such an extent that it is possible to distinguish that not every attendance of healthcare team members at home can be considered a home visit.

However, to ensure referral/counter-referral, reduce weaknesses in communication between professionals and optimize the work of the PHC and HCS teams, the participants pointed out the importance of pre-established flows within the HCN, which would enable improvement in coordination and longitudinality of care. These notes corroborate the difficulties found in another study regarding the coordination of care, especially the difficulties related to the low integration between the services of the HCN.[17]

The division of responsibilities is essential for comprehensive and continuous assistance within the PHC,[18] even when the user is being monitored by the HCS, especially when care is transferred to HC1. The results of the study, therefore, reiterated that the field of relationships encourages shared home care, with the potential to meet the attribute of comprehensiveness and equity[9]

It is also noteworthy that the deficiency of pre-established flows also limits shared care. To overcome these barriers, the participants highlighted the role of communication between the different points of the HCN as a strategy to improve care. In this context, effective communication involves assertive behaviors to transmit, receive and interpret information with clarity and mutual respect among professionals. Furthermore, when communication is well established, there are benefits for the quality of services provided and patient safety.[13]

In view of this, the participants also pointed out the importance of carrying out training that could favor this skill among the teams, as well as practical simulations and the use of specific instruments and/or registration in medical records containing a minimum and previously established set of information about the patient. From the perspective of the participants, these measures would overcome the fragility in communication and encourage the education process in the daily lives of professionals working in HC. It is also noteworthy that, according to the study participants and our beliefs, for shared home care to happen, it is important that there is effective

communication between the teams that perform this service.

Another strategy mentioned by the participants and that can be used to enhance actions towards shared home care between the PHC and HCS concerns the creation of a communication channel to strengthen the bonds of professionals working in the various points of the HCN. This communication channel — like WhatsApp groups — can contribute to understanding the role and work process of the teams that carry out HC.[1]

Thus, communication between professionals and linking users with the different points of the HCN favor comprehensive care in the production of care.[14] In the meantime, to improve and facilitate communication between teams and favor shared home care, participants suggested using the WhatsApp® application. It is noteworthy that, although the use of this resource is not official, it is part of the daily lives of professionals. Thus, formalizing its use for communication between professionals would facilitate this process, in addition to contributing to the sharing of information and, therefore, to the quality of care offered.

The participants also highlighted the use of the ecomap as a relevant resource, as it favors the construction of critical thinking and the elaboration of a care plan according to the reality experienced by the individual/family. It favors the identification of possible social, cultural, and economic resources that can be used by the person assisted.[19]

With regard to limitations, the participants pointed out that, although the eligibility criteria for HC are well defined in ordinances, the lack of knowledge of these criteria by many professionals working in the HCN weakens shared home care. According to the participants, managers and coordinators sometimes make exceptions for inclusion, depending on the fragility of the local network. However, in order to strengthen HC as a contributing tool to the consolidation of the SUS and a strategy to reduce the occupancy rates of hospital beds, it is necessary to structure a resolving network.[20]

The Unique Therapeutic Project (UTP), in turn, was identified as a tool with potential to promote shared home care. However, the participants reported difficulties in maintaining a routine and periodicity in their elaboration and revision. These weaknesses reinforce that the excessive demand from users can be related to the lack of use of an instrument to plan health care in PHC, such as the UTP,3 which, associated with bureaucratic activities, constitute harmful factors for shared care.

Although it may be a barrier related to the place of study and not the governance of the participants, they pointed out as important the fragility for shared care and the limitation in the availability of transport for HCS professionals — and, in some cases, also for PHC — for home care. This fragility can impact the quality and resolution of care offered to patients at home.[15] In the context of the FHS, proximity to the home represents a facilitator of access to healthcare services. This is because, on the one hand, users usually do not need to travel far or use means of transport to obtain health care; on the other hand, professionals access the population more easily.

However, HCS teams do not have the same facility and require the means to carry out their actions. Thus, considering that the performance of the HCS teams does not replace (but complements) the performance of the PHC teams, a review study of the legislation on public policies related to the organization of HC in the SUS pointed to the need to restructure the care network and the regular offer of transport for professionals. It also stated that the availability of time for FHS and NASF-AB professionals to care for patients at home at the necessary frequency is characterized as one of the difficulties experienced by the PHC teams. Thus, it is necessary that the professionals of the different services under study follow the criteria defined in ordinances for the eligibility and prioritization of users to be monitored in the HC.

Another difficulty pointed out concerns failures in the referral of patients eligible for HCS. The participants highlighted the importance of the detailed description of each case referred to the service, which can minimize unnecessary referrals of conditions with possibilities of management and resolution by the PHC. A study carried out in the state of Santa Catarina, Brazil, focusing on the use of teleconsulting articulated to the regulation centers, suggests the use of logistics for patient referrals within the HCN, considering the risk of individuals, schedules, and examinations of healthcare services.[22]

It should be noted that the discussion of cases that are of common care between the teams could be favored by support systems and logistics that make up the operational structure of the HCS. This is because, in order to make HC feasible, there must be management with strategic planning, logistics, use of technologies and computerization in healthcare to assess the biopsychosocial needs of the patient, in addition to qualified professionals for this care modality.[10] Therefore, this limitation of shared care could be circumvented by the existence of electronic medical records interconnected and used by the PHC, HCS teams and other sites of the HCN. This resource would facilitate the registration and exchange of information necessary for referral and counter-referral, as

well as longitudinality and comprehensiveness in patient care in HC.[16]

Thus, the survey restated that actions for shared home care between the PHC and HCS must be based on the needs of patients and goals for self-care. It also corroborated that the elaboration of the care plan and definition of the role of each team in the care is important to improve the quality of care for people with chronic conditions. For that, it is necessary that the professionals of these two services are aligned in the perspective of a joint work, because when the professionals support each other and recognize the importance of each category and the competence of each service, the care flows and enables the achievement of the work goals in health.[23]

In addition, this research identified that it is important to implement, even in the field of professional training, actions that promote the experience and knowledge about shared home care. This can be operationalized with the practical development of care plans that encourage integration between family health teams, NASF-AB, HCS teams, in addition to other services, such as "CAPS", specialized outpatient clinics and hospitals.1 In this way, it reinforces the importance of teaching institutions (public and private) to enhance the development of pedagogical activities related to collaborative work. This should be done in order to instigate reflection on the importance and practicality of sharing care, making students aware that this care requires planning, integration, and joint organization of actions between the various HCN services.[8]

As pointed out in an integrative review,15 this research highlighted the importance of implementing permanent education actions and computerized systems to horizontally manage the teams' work processes and signal risks. This would enable a comprehensive view of the user, planning, coordination, and evaluation of the actions carried out in the HC, longitudinality of care and articulation with the other points of the HCN.

In this sense, it appears that interprofessional collaboration has the potential to contribute to the restructuring of the healthcare model in Brazil,[24] since this practice increases the resolution and quality of health care, especially in the context of HC. This care model requires the implementation of care practices that prioritize the real needs of patients and their families, and for its effectiveness, it is necessary to strengthen interprofessional education in the training of professionals.[8]

However, a study that compared attitudes related to inter-professional collaboration self-reported by different PHC teams with the observed reality of their work processes, noting differences between what was said and what was experienced in relation to inter-professionality in the work routine of the services studied. That is, the work processes observed showed few situations of inter-professional practices.[25]

This reality is not very different from what was found in the present study, with the exception that the participants demonstrated, in their statements, that they value and recognize the benefits of shared work, both for the quality of care provided and for the organization of the work process. However, they do not put it into practice due to structural difficulties of the services involved.

As possible limitations of this research, we highlight the non-inclusion of professionals belonging to all teams in the municipality that work in the HCS. However, the group discussion strategy used allowed professionals from different services to share and discuss their perceptions about the limitations and potentialities of assistance in the home context. This provides subsidies for better coping with the fragmentation of care actions, not only for the study participants, but for all professionals who work in this type of care.

FINAL CONSIDERATIONS

The results of this study showed that, in the perception of professionals working in the FHS, NASF-AB and HCS, sharing home care is a strategy that enhances HC by allowing the establishment of goals that favor the assisted person and his/her family.

The technique used in data collection made it possible for professionals from different teams to meet and stimulated a joint discussion about their care practices and the necessary changes for their improvement. As strategies favorable to the sharing of care, planning and carrying out joint actions and meetings between the teams, expanding the number of teams and health units, the shared work schedule, and the definition of flows within the HCN were identified. In turn, they pointed out as obstacles to its effectiveness the deficiency of transport and communication between teams of the different services, the fragility in the training of professionals, their insufficient knowledge about the eligibility criteria for HC and the lack of joint planning of the caution.

They emphasized that communication between the different teams that make up the Health Care Network, with exchange of information and discussions about the users' clinical data, would make it possible to go beyond discharge notes, contributing to meeting the specificities of each case.

These results can support reflection on HC in order to improve its potential and minimize weaknesses, as well as contribute to the qualification of care among the different services that make up the HCN, especially by identifying elements related to the work process itself that influence the shared care.

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