

Evaluation of the clinical-care resolution capacity of multiprofessional teams in a municipality in the Northeast Region of Brazil

Avaliação da resolutividade clínico-assistencial de equipes multiprofissionais em um município do nordeste brasileiro

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DOI: 10.1590/2358-2898202514599411

ABSTRACT This article aims to evaluate the clinical-care resolution capacity of multiprofessional teams in a municipality in the Northeast Region of Brazil. The concept of resolution capacity relates to the positive impact on users' quality of life and considers functionality and contextual factors in their development. It is quantitative research with an evaluative and longitudinal approach. There was a follow-up of users assisted in a priority way, with shared follow-up among professionals from multidisciplinary teams and the Family Health Strategy (ESF). The clinical evolution of the users was performed using the Evaluation and Monitoring Form of the Clinical-Care Resolution Capacity of the Family Health Support Center (RCaNASF). The results are presented in two sections: the first one discusses the profile of the research subjects, considering their sociodemographic and clinical aspects, essential elements for understanding the healthcare work of multiprofessional teams; and the second discusses the resolution capacity of these teams in promoting the quality of life of users in primary health care. The conclusion suggests using RCaNASF to monitor the cases discussed between multidisciplinary and Family Health teams, enriching the workflow and health evaluation practices.

KEYWORDS Primary Health Care. Outcome and process assessment, health care. Patient care team. Family health. Unified Health System.

RESUMO Este artigo teve como objetivo avaliar a resolutividade clínico-assistencial das equipes multiprofissionais de um município do nordeste brasileiro. O conceito de resolutividade utilizado se relaciona com o impacto positivo na qualidade de vida dos usuários e considera a funcionalidade e os fatores contextuais no seu desenvolvimento. É uma pesquisa do tipo quantitativa, com abordagem avaliativa e longitudinal. Houve seguimento de usuários assistidos de forma prioritária, com acompanhamento compartilhado entre profissionais das equipes multiprofissionais e da Estratégia Saúde da Família. A evolução clínica dos usuários foi realizada pelo Formulário para Avaliação e Monitoramento da Resolutividade Clínico-assistencial do Núcleo de Apoio à Saúde da Família (RCaNASF). Os resultados estão apresentados em duas seções: a primeira discute o perfil dos sujeitos da pesquisa, considerando seus aspectos sociodemográficos e clínicos, elementos importantes para o entendimento do trabalho em saúde das equipes multiprofissionais; e a segunda discute a resolutividade dessas equipes na produção da qualidade de vida dos usuários na atenção primária à saúde. Conclui-se sugerindo a utilização do RCaNASF para o acompanhamento dos casos compartilhados entre as equipes multiprofissionais e de Saúde da Família, enriquecendo o processo de trabalho e a prática da avaliação em saúde.

PALAVRAS-CHAVE Atenção Primária à Saúde. Avaliação de processos e resultados em cuidados de saúde. Equipe multiprofissional. Saúde da família. Sistema Único de Saúde.

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Introduction

In 2008, the Brazilian Ministry of Health (MS) created the Family Health Support Center (NASF) to enhance the effectiveness and comprehensiveness of Primary Health Care (PHC) in Brazil. Implemented through the creation of multiprofessional teams, the NASF has been set up in various municipalities across the country, undergoing multiple changes over time: in 2017 its name was changed¹, to Expanded Family Health Center (NASF-AB); in 2019 it faced the threat of extinction due to a new PHC funding model that withdrew specific resources for its maintenance²; and in 2023, the Ministry resumed efforts to strengthen an expanded PHC, issuing an ordinance³ to reinstate funding for multidisciplinary teams to provide collaborative and complementary healthcare with primary care of NASF teams, now known as Multiprofessional teams (eMulti).

It is noteworthy that in some municipalities, the NASF teams were maintained with municipal funding, adopting the new eMulti designation in 2023. Although the ordinances that created these teams (NASF and eMulti) share many similarities, some significant changes were introduced with Ordinance No. 635 of May 23, 2023³. These include the expansion of professional categories eligible to be part of the teams, the return of more robust funding, the definition of other types of work teams, and the inclusion of new activities. Each of these changes may influence the groups' workflow and should be closely monitored and studied in greater depth to support improvements in the teams' workflow to strengthen interprofessional collaboration, comprehensiveness, and effectiveness of care in PHC.

Bispo Júnior and Almeida⁴ point out that eMulti offers a wide range of activities, including individual and group healthcare, home assistance, shared consultations, case discussions, therapeutic projects, collective

activities, matrix support, territorial interventions, remote healthcare, and intersectoral practices. When well-organized and effectively delivered, these activities have the potential to significantly enhance the problem-solving capacity of Primary Health Care (APS), as required by the regulations.

Since the creation of the Unified Health System (SUS), Brazil has undergone various reforms and policy shifts, with legal changes and new deliberations, intending to transform PHC through the Brazilian Family Health Strategy (ESF). The Family Health Support Center Team (EqNASF) consisted of the inclusion of new professional categories in PHC, to support the Family Health Teams (EqSF) in attempting to achieve comprehensive and effective healthcare for users, ultimately enhancing the quality of care in PHC⁵.

The concept of comprehensiveness considers that health-related actions should be implemented at both individual and collective levels, addressing the determining and conditioning factors of health. This includes integrating health promotion, prevention, and recovery activities through an interdisciplinary approach that incorporates the broader concept of health into practice⁶ and encourages public participation.

The theoretical-methodological framework of the interprofessional work process of the former EqNASF and the current eMulti uses matrix support as its central axis subdivided into technical-pedagogical and clinical-assistance support. From this perspective, specialized backup is requested to improve the quality of care for more complex clinical cases, which the EqSF could not resolve alone or would find very difficult to do so⁷. This theoretical framework of matrix support remains the basis for current eMulti.

The interprofessional work proposed to guide the work of these teams is positioned as strategic for confronting the traditional biomedical, curative, and highly fragmented healthcare model. By creating a 'caring collective', this approach enables support, sharing,

and transformation of actions, carried out in a multi-professional way, seeking to meet the real needs of users and increase the effectiveness of care⁸.

Throughout the existence of the NASF many studies have been conducted to understand the work process of these teams. These studies have highlighted the complexity of their knowledge and actions, as well as the need to evaluate their outcomes from a perspective that recognizes not only the absence of disease but also the quality of life of users.

Thus, this study uses the concept of resolution capacity as the positive impact on users' quality of life (QoL), focusing on addressing their health needs. It emphasizes the importance of comprehensiveness in healthcare practices, encompassing everything from health promotion and maintenance to rehabilitation, with the aim of a satisfactory response, which includes relieving or minimizing suffering⁹.

It is worth emphasizing the importance of evaluating the results of actions to help managers and teams in planning, monitoring, and guiding healthcare practices. Therefore, the use and improvement of evaluation tools in the workplace should be encouraged, enabling the institutionalization of healthcare evaluation, which is often neglected in services¹⁰.

This study aimed to evaluate the clinical-care resolution capacity of eMulti in a municipality in the Northeastern region of Brazil.

Material and methods

This is an evaluative, quantitative, longitudinal study with an analysis of effects, conducted in a municipality in the metropolitan region of Recife, Pernambuco (PE), in the Northeast region of Brazil, from January to October 2019¹¹.

This research followed a series of studies. The first one, conducted by Nascimento¹², investigated the organization of the NASF work process in three municipalities in

Pernambuco. Subsequently, Sousa¹³ focused on professionals' perceptions of comprehensiveness, the expansion of resolution capacity, and the development of healthcare coordination in PHC. The third study was a thesis that developed and validated the content of a measuring instrument for evaluating and monitoring clinical-assistance care resolution¹⁴, the Evaluation and Monitoring Form of Clinical-Care Resolution Capacity of the Family Health Support Center (RCaNASF).

The sample was comprised of: a) professionals working in the eMulti teams (at the time of research, referred to as EqNASF) in the studied municipality, which covers seven health regions; all professionals in the teams with public employment ties through a competitive examination; those actively working during the data collection; and also those who participated in the matrix-based workshop to apply the data collection instrument. Users registered in the Family Health Units (USF) were also included; considered to be a priority for follow-up by eMulti teams and required care from at least two professionals from these teams and one from the EqSF¹⁴, regardless of whether they were part of a Singular Therapeutic Project.

Professionals who had been away from service for more than three months or those who could not submit the completed evaluation instrument by the end of the collection period were excluded, as were users who gave up participating in the study, without harming their clinical care.

Initially, the eMulti teams were made aware of the research by a video invitation and a summary of the project highlighting the importance of evaluating and monitoring the results of the actions. Afterward, the teams were trained on the new instrument through workshops held in each health region's territory¹¹.

A field diary was also used. This instrument allows for immersion in recording everyday experiences and situations with critical observation, enabling evaluations

and transformations¹⁵. The facilitating and hindering aspects of the interprofessional work process were documented and presented in four categories: the relationship between professionals; transportation; materials/physical structures; and training/qualification for working in the EqNASF¹¹.

The associated EqSFs identified the health needs of people considered priority cases for follow-up by the EqNASF. Based on this screening, data collection was initiated. To facilitate the completion of the RCaNASF form, tutorial videos were produced and made available to the participating teams¹¹.

To understand the profile of the participating professionals, a semi-structured questionnaire was created and applied individually. This questionnaire gathered information on their gender, length of service in the studied municipality, professional category, and postgraduate education in Public Health or other specializations. Additionally, data on the individuals monitored by the EqNASF teams were collected using the RCaNASF to identify details such as gender, age, education level, diagnosed diseases or health conditions, medication use, and clinical progress over time¹⁴.

In this form, three clinical evaluations are recorded longitudinally with a minimum interval of one month between each evaluation, which can be monthly, bimonthly, or quarterly, depending on the user's needs. The instrument is divided into two sections: functionality and contextual factors. For the functionality assessment, any impairments or difficulties observed during the evaluations should be rated as mild, moderate, severe, or very severe/total, based on the perspective of the healthcare professionals and the user, family member, or caregiver¹⁴.

In the functionality section, Part 1, there are two components: 'Body Functions and Structures' (FE) and 'Activities and Participation' (AP). The measurement of functionality is based on the International Classification of Functioning, Disability, and

Health (ICF). FE refers to physiological functions and anatomical parts of the body, while AP relates to the performance of tasks and the individual's involvement in life situations. In the contextual factors section, Part 2, there is the 'Social, Family, and Individual Aspects' (SFI) component. This refers to the physical and social environment in which the individual lives and interacts with others and the individual's details such as age, emotional state, etc., which can positively or negatively impact their health condition¹⁴.

Comparing data from the first and last evaluations allows for an inference about the resolution capacity of NASF's actions in improving the quality of life of users¹⁴. Although the second evaluation is not used for the comparative calculation, this measure is important for monitoring the data as it may reveal whether the proposed intervention needs any modification or adjustment and whether any external factor positively or negatively affects the health-disease process of the evaluated person¹¹.

The software used for data processing was Excel® 2010 and the Statistical Package for Social Sciences for Windows® (SPSS), version 20¹⁶. In all statistical calculations, a 95% confidence level was used. To infer the clinical-assistance resolution of the studied teams, a comparison between the 1st and 3rd evaluations was conducted in the FE, AP, and SFI components of RCaNASF, from the perspective of the healthcare professionals and the user, family member, or caregiver. The paired t-test¹⁶ and the Wilcoxon Signed Ranks test were used in the comparative analysis¹⁷.

The project that originated the study was approved by the Research Ethics Committee of the Oswaldo Cruz Foundation (FIOCRUZ Pernambuco), in compliance with the ethical principles of the National Health Council¹⁸. It is registered on Plataforma Brasil under the Certificate of Presentation for Ethical Consideration (CAAE) No. 53408516.1.0000.5190, Opinion No. 3.143.672¹¹. All participants were informed of the study's

objectives and signed the Free and Informed Consent Form.

Results and discussion

Between caregivers and healthcare: clinical-care profile of research subjects

According to the inclusion criteria, 51 potentially eligible users were selected for the study. However, during the data collection period, there was a sample loss of 20.0% (10.2): three declined to participate, four passed away before completing the data collection period, and three did not complete the last assessment. Consequently, the final sample consisted of 41 individuals monitored by EqNASF professionals and assessed using the RCaNASF instrument at three different moments¹¹, totaling 123 clinical evaluations. As *table 1* shows, 53.6% (22) of those assessed were female, 46.4% (19) were elderly, and 51.0% (21) had not completed elementary school.

These findings revealed a slight predominance of females receiving care by the EqNASF, which aligns with the percentage of women living in the studied municipality¹⁹. Similar trends have been observed in other studies on the work processes of EqNASF in the municipalities of Recife and Camaragibe, both in Pernambuco, with a predominance of women receiving care^{13,14,20}. Understanding the health-related profile of users is essential as it facilitates the planning of healthcare practices for the population's needs. This approach helps reduce costs while maintaining service quality, enabling timely and effective interventions in managing health risk conditions²¹.

Another significant finding was the number of older individuals receiving healthcare from the teams, accounting for nearly half of the sample. This aligns with the results of a previous study¹⁴ conducted in Recife.

These findings highlight the impact of the demographic transition on primary health care which faces increasing demands due to an aging population. The current scenario exposes an epidemiological profile that challenges the Brazilian health and social security systems, demanding effective responses to morbidity and mortality rates. It underscores the need for continuous, comprehensive, and multidisciplinary healthcare for older people²².

The analysis of users' educational backgrounds revealed that most had not completed elementary school. A study²³ using data from the 2019 National Health Survey found that Non-communicable Chronic Diseases (NCDs) are more prevalent among individuals with lower education levels, particularly those who are illiterate or have not completed elementary school. Supporting these findings, Delpino et al.²⁴ concluded that the occurrence of multiple chronic diseases (multimorbidity) was concentrated among individuals with lower educational attainment. Therefore, in clinical practice, a multi-causal view of the health-disease process should be taken, emphasizing its social determinants.

Table 1 also shows that 49.0% (20) of the participants had Systemic Arterial Hypertension (SAH), 32.0% (13) had mental health disorders, 29.3% (12) had Diabetes Mellitus (DM), and 27.0% (11) had experienced at least one episode of Cerebrovascular Accident (CVA). Regarding pharmacological treatment, 54.0% (22) used between one and four medications.

Hypertension (SAH) was the most common condition in the studied sample. Brandão and Nogueira²⁵ highlighted that this disease is the result of multiple factors; in Brazil, it affects approximately 36 million adults, that is, 32.5% of the population. It is more prevalent among men and accounts for 50% of deaths caused by cardiovascular diseases.

In this municipality, the second most common health issue among those monitored by EqNASF was mental health disorders, including depression, anxiety, alcoholism,

and schizophrenia. There is a complex and high demand for mental healthcare within the Family Health Strategy (ESF) to address issues such as family conflicts, neglect or lack of care for children, school-related problems, substance abuse, and eating disorders²⁶.

Diabetes Mellitus (DM) was also a prevalent condition among participants in this study. A study of individuals with diabetes followed by the ESF revealed that their quality of life was impaired due to the complications of DM²⁷. As a chronic and systemic disease, it is recommended that users actively participate in the treatment process to prevent or delay the onset of potential complications such as neuropathies, retinopathies, amputations, and others. This involves sharing goals and treatment plans with healthcare professionals, focusing on maintaining or improving the quality of life of these individuals²⁸.

Finally, the fourth most common issue requiring attention from the EqNASF teams was the sequelae following strokes (CVA), observed in 27.0% (11) of the individuals. Among them,

81.0% had hypertension (SAH), suggesting a strong link between these conditions. To effectively address hypertension and reduce related cardiovascular problems, such as stroke, it is crucial to invest in expanding the coverage of the Family Health Strategy (ESF) and improving the quality of care in PHC²⁵. This should be done through comprehensive, longitudinal healthcare for individuals, with monitoring of health actions and the interprofessional work of these teams.

As observed, Non-communicable Chronic Diseases (NCDs) were the most prevalent conditions among the population monitored by the EqNASF professionals. This may explain the high percentage of individuals on continuous medication – 78% of the sample. Successful healthcare strategies for NCDs point towards approaches focused on care, health education, and health promotion activities. These strategies should consider local culture, encourage behavior change, and support the adoption of healthy habits that integrate therapeutic measures and the health-disease process²⁹.

Table 1. Profile of users receiving shared care by EqNASF professionals, January to October 2019, Brazil

Variables	% (n)
Sex	
Female	53.6 (22)
Male	46.4 (19)
Age group	
0 to 11 years old (child)	2.4 (1)
12 to 18 years old (adolescent)	2.4 (1)
19 to 21 years old (young adult)	0.0 (0)
22 to 45 years old (adult)	24.4 (10)
46 to 59 years old (middle-aged)	24.4 (10)
≥ 60 years old (elderly)	46.4 (19)
Education Level (from 10 years old)	
No education	7.3 (3)
Incomplete elementary school	51.0 (21)
Complete elementary school	7.3 (3)
Incomplete high school	5.0 (2)
Complete high school	12.0 (5)

Table 1. Profile of users receiving shared care by EqNASF professionals, January to October 2019, Brazil

Variables	% (n)
Incomplete higher education	2.4 (1)
Not informed	15.0 (6)
Illness/health condition*	
Cerebrovascular accident	27.0 (11)
Amputation due to diabetes mellitus	5.0 (2)
Diabetes Mellitus	29.3 (12)
Rheumatic diseases	7.3 (3)
Systemic arterial hypertension	49.0 (20)
Traumatic injury	17.1 (7)
Obesity	15.0 (6)
Other neurological conditions	19.5 (8)
Mental health	32.0 (13)
Other conditions	19.5 (8)
Medication	
None	10.0 (4)
1 to 4	54.0 (22)
5 or more	24.0 (10)
Not informed	12.0 (5)

Source: Own elaboration.

*Each user may have more than one disease/health condition.

In 2019, the studied municipality had eight EqNASF teams, totaling 44 professionals. The smallest group consisted of four specialists, while the largest had seven. All specialists were invited to participate in this study; however, two groups did not meet the eligibility criteria. Therefore, six EqNASF groups participated in the investigation, totaling 28 specialists, including four social workers, four physiotherapists, three speech therapists, four nutritionists, four physical education professionals, three psychologists, and six occupational therapists. Of these, 93.0% (26) were female, with an average age of 34 years. Additionally, 29.0% (eight) had specialization in public health and related fields, 29.0% (eight) held a master's degree, and another 29.0% (eight) were specialists in specific clinical areas.

In the field diary, all professionals reported on the facilitating and hindering

aspects of the work process of the EqNASF teams¹¹. As for the facilitating ones, 93.0% (26) stated that there was a good relationship among team members, and 71.4% (20) mentioned that their training and qualifications were important for their professional performance.

As the hindering aspect, the material/physical infrastructures were considered precarious by 100.0% (28) of the professionals. Transportation was also considered poor by 71.4% (20) of the respondents, meaning that there was a lack of availability to carry out their work. This contrasts with another study that analyzed data from the evaluation of the Primary Care Access and Quality Improvement Program (PMAQ-AB), which indicated that vehicles were always or often available for such functions³⁰.

This contradiction indicated that there are several realities in the country when it

comes to the eMulti workflows. Fischborn and Cadoná³¹ pointed out that one cannot relativize or overlook the work conditions in the context of social and political relations so that there is autonomy for healthcare professionals.

Table 2 shows the professionals involved in the shared care of studied cases. In the EqNASF teams, occupational therapists worked in 76.0% (31) of the cases, and physiotherapists in 41.5% (17) of them. Among the EqSF professionals who shared care with specialists, nurses were the second most involved professional category, participating in 63.4% (26) of the cases.

The high demand for clinical follow-ups involving occupational therapists in this

study reflects several observations recorded in the field diary. The process of applying the RCaNASF instrument was facilitated by the daily work practice of this professional category in conducting a comprehensive assessment of the individual observing various components: mental, sensory, auditory, motor, social, and environmental, transiting through various areas of activity such as education, work, and health. This could indicate the need to strengthen the ongoing training of these teams with a focus on expanded clinical practices aiming at implementing increasingly comprehensive and collaborative healthcare practices.

Table 2. Professionals involved in the shared care of the studied cases, January to October 2019, Brazil

Variables	% (n)
EqNASF professionals involved*	
Social worker	24.4 (10)
Physiotherapist	41.5 (17)
Speech therapist	22.0 (9)
Nutritionist	27.0 (11)
Occupational therapist	76.0 (31)
Physical education professional	22.0 (9)
Psychologist	15.0 (6)
EqSF professionals involved*	
Dentist	15.0 (6)
Nurse	63.4 (26)
Doctor	44.0 (18)

Source: Own elaboration.

EqNASF = Family Health Support Center Teams; EqSF = Family Health Teams.

*More than one professional must be involved in the care of each individual.

Researchers³² observed a critical issue in the effective implementation of shared interprofessional healthcare related to team management. The authors highlighted the presence of power dynamics that influence managerial issues, team composition, and schedule planning. Therefore, a significant

effort is needed to organize the work process of EqNASF teams, as well as to remain open to changes, acting collaboratively with EqSF teams and other services in the healthcare network to achieve higher-quality care.

An article by Tavares³³ points out that EqNASF workers who were satisfied with

the communication and the clear definition of responsibilities among team members were more likely to rate their work positively.

Mazza et al.³⁴ highlight issues linked to the influence of macro- and micropolitical aspects on work organization, professional practice, and the integration of work between professionals in the matrix and reference teams. Collaboration demands a paradigm shift, replacing healthcare models that favor asymmetrical power relations and fragmented practices.

The resolution capacity of multi-professional teams and the production of quality of life for users under their care

This article aimed to evaluate specific aspects of clinical-care actions, one of the dimensions of matrix support within the workflows of healthcare teams. This methodological choice uses the RCaNASF instrument, which focuses on this dimension but prioritizes a comprehensive and collaborative approach by professionals, valuing the life and illness processes and the user's perspective. The RCaNASF was applied in situations where more than one profession had to work together, i.e. where the individual's health condition required interprofessional monitoring.

Table 3 presents the progression of cases monitored by the studied EqNASF teams. A positive progression indicates perceived improvements in the user's clinical and/or social condition over the three evaluations. On the other hand, maintenance reflects no change from the initial status, while negative progression suggests a decline or a perceived worsening. Discrepancies in some values between users and/or caregivers and healthcare professionals may be related to differences in their expectations of change.

In Part 1 of the RCaNASF, a positive progression was observed when comparing data from the first and last evaluations, especially in the FE component, both in the perception of professionals, in 80.4% (33) of cases, and

in that of users, in 73.0% (30) of cases. This finding aligns with a doctoral thesis¹⁴, whose pilot study used the RCaNASF. In the AP component, this improvement was noted in 70.8% (29) of cases according to professionals, and in 58.5% (24) according to users.

The data produced in this study show that, in Part 2 of the RCaNASF, within the SFI component, there was a positive shift in aspects identified as hindrances to health conditions in the monitored clinical cases. This improvement was observed both in the perception of professionals, in 65.8% (27) of cases, and in that of users, in 58.5% (24) of the cases. A positive progression was also noted in aspects already considered facilitators, in 22.0% (9) and 14.6% (6) of cases, while maintenance was observed in 65.8% (27) and 70.8% (29) of cases, in the perception of professionals and users, respectively (table 3).

Facilitating or hindering factors are elements that can either support or undermine the functional performance or quality of life of the evaluated user¹⁴. Therefore, a significant portion of the issues that were hindering patients' lives showed improvement, while those that were already facilitating their condition remained stable, with some even showing further improvement.

Considering the concept of resolution capacity used in this study and adding the percentages of clinical progression – whether positive or stable – in both parts and across each component of the RCaNASF, the results show achievement rates of 85.4% or higher in meeting the intended objectives. This suggests a potential positive impact on the health-related quality of life of the individuals¹¹.

In each of the three components, there was a small percentage of negative evolution, less than 17.1% of cases. This finding reflects the medical conditions of the individuals monitored in this study, as exacerbations can occur in non-communicable chronic diseases (NCDs). In the case of hypertension (SAH), risk factors such as diabetes, obesity, dyslipidemia, sedentary behavior, smoking, and excessive alcohol consumption can worsen this condition²⁵.

Table 3. Evolution of cases monitored by EqNASF, by RCaNASF component, according to the perception of professionals and users, January to October 2019, Brazil

RCaNASF	Component	Evolution (1st and 3rd assessment)	% (n)
Part 1	FE – Professional	Positive	80.4 (33)
		Maintained	9.8 (4)
		Negative	9.8 (4)
	FE – User	Positive	73.0 (30)
		Maintained	22.0 (9)
		Negative	5.0 (2)
	AP – Professional	Positive	70.8 (29)
		Maintained	14.6 (6)
		Negative	14.6 (6)
	AP – User	Positive	58.5 (24)
		Maintained	24.4 (10)
		Negative	17.1 (7)
Part 2	SFI (+) – Professional	Positive	22.0 (9)
		Maintained	65.8 (27)
		Negative	12.2 (5)
	SFI (+) – User	Positive	14.6 (6)
		Maintained	70.8 (29)
		Negative	14.6 (6)
	SFI (–) – Professional	Positive	65.8 (27)
		Maintained	22.0 (9)
		Negative	12.2 (5)
	SFI (–) – User	Positive	58.5 (24)
		Maintained	29.3 (12)
		Negative	12.2 (5)

Source: Own elaboration.

EqNASF = Family Health Support Center Teams; RCaNASF = Evaluation and Monitoring Form of the Clinical-Care Resolution capacity of the Family Health Support Center; FE = Body Functions and Structures; AP = Activities and Participation; SFI = Social, Family and Individual Aspects; (+) = Facilitators; (–) = Hinderers.

When analyzing *table 4* and considering the concept of resolution capacity adopted in this study, a positive evolution is observed in the monitored cases. This is because the sum of the percentages for maintenance and improvement in the evaluated conditions, in each component, and for each EqNASF team, was equal to or greater than 60.0%¹¹.

These data are in line with a doctoral thesis¹³, in which the EqNASF's resolution capacity reached 60.0% in the psychology category, and percentages above 70.0% for other

professional categories, showing an increase in PHC actions.

The negative evolution, represented by 40.0% in the AP – User component for Team 2 (*table 4*), was identified through database analysis. This result was due to two clinical cases: one in the field of mental health, involving difficulties in interaction and interpersonal relationships, along with worsening restrictions on community and social life. The other case involved sequelae from a traumatic injury with multiple pre-existing impairments that

led to social isolation and limitations in the individuals' leisure activities¹¹.

Another relevant observation is the negative evolution (33.3%) identified in two cases in Team 6, in the components AP – Professional, SFI (–) – Professional and User. The individuals being monitored faced multiple conditions: one with a degenerative disease and mental health disorders, and the other had rheumatic diseases, a disability, and mental health issues. These conditions indicate the need for prolonged follow-up to maximize the positive impact on their lives¹¹. This point is relevant as it underscores the limitations of NASF's multidisciplinary team (eMulti)

and emphasizes the need for network-based interventions, integrating various PHC and specialized services. Additionally, it reinforces the importance of developing intersectoral actions to address the social determinants of health that directly affect the effectiveness of PHC care.

When analyzing resolution capacity based on the EqNASF teams' profile, it is noted that Team 5 showed no negative evolution (*table 4*). A review of the database reveals that all professional categories were actively engaged in the cases and that this team's members are trained in clinical areas, public health, and mental health¹¹.

Table 4. Evolution of cases monitored by EqNASF, according to the perception of professionals and users, by RCaNASF components, January to October 2019, Brazil

RCaNASF	Component	Evolution	EqNASF						Total
			EqNASF 1	EqNASF 2 (n = 5)	EqNASF 3 (n = 5)	EqNASF 4 (n = 10)	EqNASF 5 (n = 6)	EqNASF 6 (n = 6)	
(n = 9)	FE – Profissional	Positive	77.8%	40.0%	80.0%	90.0%	100.0%	83.3%	80.4%
		Maintained	11.1%	40.0%	0.0%	10.0%	0.0%	0.0%	9.8%
		Negative	11.1%	20.0%	20.0%	0.0%	0.0%	16.7%	9.8%
(n = 5)	FE – User	Positive	71.4%	20.0%	80.0%	90.0%	100.0%	66.6%	72.2%
		Maintained	28.6%	60.0%	20.0%	10.0%	0.0%	16.7%	22.2%
		Negative	0.0%	20.0%	0.0%	0.0%	0.0%	16.7%	5.6%
(n = 5)	AP – Profissional	Positive	66.7%	40.0%	80.0%	80.0%	100.0%	50.0%	70.8%
		Maintained	33.3%	40.0%	0.0%	0.0%	0.0%	16.7%	14.6%
		Negative	0.0%	20.0%	20.0%	20.0%	0.0%	33.3%	14.6%
(n = 10)	AP – User	Positive	28.6%	0.0%	75.0%	77.8%	100.0%	60.0%	58.3%
		Maintained	71.4%	60.0%	0.0%	0.0%	0.0%	20.0%	25.0%
		Negative	0.0%	40.0%	25.0%	22.2%	0.0%	20.0%	16.7%
(n = 6)	SFI (+) – Profissional	Positive	12.5%	60.0%	25.0%	10.0%	50.0%	0.0%	23.1%
		Maintained	87.5%	20.0%	50.0%	80.0%	50.0%	83.3%	66.7%
		Negative	0.0%	20.0%	25.0%	10.0%	0.0%	16.7%	10.2%
	SFI (+) – User	Positive	100.0%	0.0%	75.0%	14.3%	0.0%	0.0%	15.0%
		Maintained	0.0%	100.0%	0.0%	85.7%	100.0%	100.0%	70.0%
		Negative	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	15.0%
	SFI (–) – Profissional	Positive	50.0%	60.0%	100.0%	70.0%	100.0%	33.4%	65.8%
		Maintained	37.5%	20.0%	0.0%	20.0%	0.0%	33.3%	21.0%
		Negative	12.5%	20.0%	0.0%	10.0%	0.0%	33.3%	13.2%
	SFI (–) – User	Positive	40.0%	33.3%	75.0%	77.8%	66.7%	33.4%	59.3%
		Maintained	60.0%	66.7%	0.0%	11.1%	33.3%	33.3%	29.6%
		Negative	0.0%	0.0%	25.0%	11.1%	0.0%	33.3%	11.1%

Source: Own elaboration.

EqNASF = Family Health Support Center Teams; RCaNASF = Evaluation and Monitoring Form of the Clinical-Care Resolution Capacity of the Family Health Support Center; FE = Functions and structures of the body; AP = Activities and participation; SFI = Social, family and individual aspects; (+) = Facilitators; (–) = Hinders; n = number of clinical cases monitored per team.

From the sum of the scores obtained in the 1st and 3rd evaluations, the average for each component of the RCaNASF was calculated, along with the p-value, resulting in what is shown in *table 5*. The higher the average, the greater the number of subcategories scored or qualified in each component¹⁴. The subcategories are evaluation elements that reveal impairment, difficulties, facilitators, and obstacles that interfere with the individual's functionality.

Table 5 confirms that Part 1 of the instrument, covering the FE and AP components, and Part 2, focusing on the SFI (-) component, were the most evaluated – representing identified impairments and difficulties, as well as recognized barriers, respectively. When comparing the means of the 1st and 3rd

evaluations, there was a statistically significant difference (p-value < 0.05), except for the SFI (+) component, a qualified facilitator, which obtained a p-value > 0.05 in both the professionals' and users' perceptions, supporting findings from a previous study¹⁴. Upon analyzing the means of the 1st and 3rd evaluations in this component, the values remained the same, suggesting that the facilitating aspects in individuals' lives stayed consistent, which, in a way, is positive for resolution capacity and the quality of lives¹¹.

Only one study¹⁴ is available to compare the quantitative data from this research with other studies using the same instrument, RCaNASF, emphasizing the need to expand the longitudinal evaluation of eMulti results to gather more robust evidence.

Table 5. Mean and standard deviation of scores obtained in the 1st and 3rd evaluations, by RCaNASF component, according to the perception of EqNASF professionals and users, January to October 2019, Brazil

RCaNASF	Component	Evaluations		p-Value*
		First	Third	
		Mean (DP)	Mean (DP)	
Part 1	FE – Profissional	2.4 (0.7)	1.7 (0.8)	< 0.001
	FE – User	2.7 (0.8)	1.7 (0.9)	< 0.001
	AP – Profissional	2.6 (0.8)	2.0 (1.1)	< 0.001
	AP – User	2.9 (0.9)	2.2 (1.3)	0.001
Part 2	SFI (+) – Profissionais	1.9 (0.7)	1.9 (0.6)	0.277
	SFI (+) – Users	1.7 (0.6)	1.7 (0.6)	0.481
	SFI (-) – Profissionais	2.6 (0.8)	2.1 (1.0)	0.001
	SFI (-) – Users	2.7 (1.0)	2.0 (1.3)	0.007

Source: Own elaboration.

RCaNASF = Evaluating and Monitoring Form the Clinical-Assistance Resolution Capacity of the Family Health Support Center; EqNASF = Family Health Support Center Teams; FE = Body functions and structures; AP = Activities and participation; SFI = Social, family, and individual aspects; (+) = Facilitators; (-) = Hinders; SD = standard deviation; p-value = statistical significance (< 0.05).

*paired t-test.

The RCaNASF can improve case discussions between EqNASF and EqSF by promoting comprehensive care for individuals. It involves identifying aspects of functionality and the

life contexts, documenting difficulties and impairments mentioned by users, and incorporating evaluations from healthcare professionals assisting them. This process enables

the mobilization of necessary resources for a more coherent intervention¹¹.

The instrument provides a comprehensive view of the user, including their concerns and health conditions, as well as the factors that facilitate or hinder their functional performance and quality of life¹⁴, while also tracking their progress over time. This can lead to the shared definition of goals and plans to specifically address current clinical and care processes¹¹.

Based on the collected information and continuous monitoring, managers and professionals can use the data to demonstrate the impact of the collaborative efforts between EqNASF and EqSF, and at the same time shedding light on the complexity of the health and disease conditions involved in their work.

In principle, the matrix support provided by EqNASF leads to improvements in the resolution capacity and comprehensiveness of PHC. However, gaps in monitoring may result in a lack of awareness of the factors influencing the effectiveness of these actions and the overall quality of healthcare³⁰.

Final considerations

The findings reinforce that EqNASF's interprofessional approach is a crucial strategy for enhancing the resolution capacity of PHC. An analysis of the RCaNASF data showed a positive and statistically significant difference in most evaluated components, indicating clinical improvement in individuals monitored by EqNASF, with a minimum resolution rate of 83.3%.

The users monitored in this study were primarily older individuals, women, and individuals with chronic conditions such as hypertension (SAH) and diabetes (DM), along with a high prevalence of mental health-related issues. As for the professionals in EqNASF, all categories were represented, with occupational therapists and physiotherapists playing a prominent role in most clinical follow-up requests, followed by nutritionists and social workers. It is important to note that the cases

studied reflect the health needs of the population in the areas covered by EqSF, with support from EqNASF.

In the evaluation conducted by EqNASF, both the maintenance and positive progress in resolution rates reached a minimum of 60% for each component of the RCaNASF instrument. Notably, some EqNASF teams reported no cases of clinical deterioration, while others observed negative progress percentages ranging from 10% to 40%. This suggests that the outcomes of EqNASF's clinical-care actions reflect a positive contribution by healthcare professionals in their respective fields, leading to improved resolution rates and a better quality of life for users being monitored.

The study recommends adopting RCaNASF for the matrix support in shared cases between EqNASF and EqSF, strengthening healthcare evaluation practices and enriching the overall work process. The systematic integration of this new tool into EqNASF's interprofessional care routine took place throughout the research, facilitated by matrix support workshops and discussions during the follow-up of the evaluated individuals.

Considering these perspectives, and the absence of comparative data from longitudinal studies that show quantitative results regarding EqNASF's resolution capacity rates, it is evident that expanding the documentation and evaluation of the work done by these teams is essential. Moreover, it is important to examine various contexts to strengthen the objectives outlined in the guidelines, to ensure quality and comprehensiveness in primary health care through the development of integrated actions that guarantee the effectiveness of healthcare practices.

Collaborators

Damascena CG (0000-0002-5993-6933)* and Santos RC (0000-0002-4973-123X)* contributed to all stages of the manuscript. Cabral DL

(0000-0002-6570-9710)* contributed to the critical review of the manuscript. Albuquerque PC (0000-0001-8283-5041)* contributed to the conception, methodology, and conclusions of

the manuscript. Sousa FOS (0000-0002-4482-3151)* contributed to the critical review and final approval of the manuscript. ■

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Received on 11/03/2024

Approved on 01/20/2025

Conflict of interest: Non-existent

Financial support: National Council for Scientific and Technological Development (CNPq)

Editor in charge: Maria Lucia Frizon Rizzotto