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# The work of Family Health Support Group Physical Therapists in elderly care

# O trabalho de fisioterapeutas de Núcleos de Apoio à Saúde da Família na assistência ao idoso

# El trabajo de fisioterapeutas de Núcleos de Apoyo a la Salud de la Familia en la asistencia al anciano

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This study aims at investigating the work process of physical therapists from the NASF of a sanitary region of the city of Belo Horizonte. It is a descriptive and quantitative study, using data from a self-applied questionnaire that was answered by 10 professionals from September to October, 2015. Results indicated that most actions were in accordance to the directives regarding elderly health care, although there were some actions that did not comply with NASF directives, which reiterates the need to adjust the way in which the actions of the NASF are carried out, as it is being created. Carrying out actions that contribute to diminish the disabilities, the physical therapist acts with the multiprofessional team and contributes for the assistance of the elder in the primary health care.
**Descriptors:** Primary health care, Family health; Comprehensive health care; Physical therapists.

Este estudo tem como objetivo investigar o processo de trabalho de fisioterapeutas do NASF de uma regional de saúde da cidade de Belo Horizonte. Trata-se de estudo descritivo, quantitativo, com dados de um questionário autoaplicado, respondido por 10 profissionais entre setembro e outubro de 2015. Os resultados demonstraram conformidade da maior parte das ações com as diretrizes relativas à atenção ao idoso e algumas inconformidades em relação às diretrizes do NASF, o que reforça a necessidade de ajustes na forma de atuação dos NASF, ainda em construção. Com ações que contribuem para redução de incapacidades, o fisioterapeuta atuando junto à equipe multiprofissional contribui para a assistência ao idoso na atenção primária.
**Descritores:** Atenção primária à saúde; Saúde da família; Assistência integral à saúde; Fisioterapeutas.

Este estudio tiene como objetivo investigar el proceso de trabajo de fisioterapeutas del NASF de una regional de salud de la ciudad de Belo Horizonte. Se trata de un estudio descriptivo, cuantitativo, con datos de un cuestionario autoaplicado, respondido por 10 profesionales entre septiembre a octubre de 2015. Los resultados demostraron conformidad de la mayor parte de las acciones con las directrices relativas a la atención al anciano y algunas inconformidades en relación a las directrices del NASF, lo que refuerza la necesidad de ajustes en la forma de actuación de los NASF, aún en construcción. Con acciones que contribuyen a la reducción de incapacidades, el fisioterapeuta actuando junto al equipo multiprofesional contribuye a la asistencia al anciano en la atención primaria.
**Descriptores:** Atención primaria de salud; Salud de la família; Atención integral de salud; Fisioterapeutas.

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## INTRODUCTION

From an epidemiological perspective, populational aging is followed by the relative increase in the number of chronic diseases and health conditions, as well as that of associated disabilities[1]. Therefore, public policies targeted at the elderly population and to the new health profile of the country become necessary.

Brazil has been developing public policies for this age group. In 2006, the National Health Policy for the Elderly Person (PNSPI)[2] was approved. Its aim is to "recover maintain and promote the autonomy and independence of elderly individuals, using collective and individual measures in all levels of care".

In the context of the Unified Health System (SUS), the need to broaden the scope of the actions of the Family Health Strategy (ESF) led to the creation, in 2008, of the Family Health Support Groups (NASF). The NASF are multiprofessional teams, made up of professionals from different areas of knowledge, who must act together with the Family Health Teams, in the logic of a matrix structure support network[3,4].

In accordance to the health model targeted at health networks, with the basic attention as a coordinator of care, the ESF must represent, for the elders, their main link to the health system[5]. Considering that public policies for the elderly population consider maintaining/recovering the functionality of the elder to be the focus of integral care, all actions of health promotion, assistance and rehabilitation, must consider this as their main goal[2,6].

Therefore, the ESF professionals must have the specific competencies to guarantee the execution of the activities that are considered the most important for the health of the elderly person[2,6]. Since the NASF is a part of primary care, one of its missions is to offer support to the ESF to offer integral care to the elderly, according to the same directives.

### The National Health Policy for the Elderly Person

The PNSPI was the result of a need to improve the practices in order to achieve the integral health of the elder population at SUS. Its understanding of the health of the elderly is based on the paradigm of functionality, assuming that the loss of functional capabilities is the main problem that can affect the elery[2].

Some of the directives of this policy are: promotion of active and healthy aging; integral attention, encouragement to inter-sectoral actions, aiming at offering integral care; providing resources to guarantee the quality of attention; strengthening social control; offering permanent education and training for health professionals at SUS; divulging the PNSPI for SUS health professionals, managers and users[2].

### The NASF

The actions of the NASF are based on the directives that relate to basic health care, and are conducted according to a methodology called matrix support, in which reference professionals and specialists horizontally share knowledge and are in connection to one another, as a way to generate knowledge and possibilities of action, which decreases the fragmentation of care[4,7].

The actions of the NASF professionals must address health promotion, rehabilitation and prevention, favoring the offer of care for the population in all stages of life and improving the ESF. Shared attention and intervention for the users and their families must be prioritized and articulated with the ESF. The most common types of assistance are the domiciliary visit, the individual care, and the operative groups. An important activity prescribed by the definition of the working process at NASF is the singular therapeutic project (PTS).

### The physical therapy professional at NASF

The intersection of the physical therapist in NASF is the first formal situation in which physical therapy is close to the first level of attention. [8] Since its origins, physical therapy has had an essentially curative and rehabilitating character.

Actions on the field in the areas of promotion and prevention have not been taking place for long[8-10]. In this new field, it is essential to

break the isolation and the individualism of physical therapy rehabilitation practice, in order to create a new logic for actions within a multi-professional and inter-disciplinary team, as to guarantee the offering of integral assistance[9].

Whatever the level of attention, the physical therapist presents the functionality as an emphasis to their therapeutic objectives, aiming to promote as well as possible the return of an individual to society.

From this perspective, the importance of the physical therapist for the integral attention of the elder within the ESF is evident, since the focus of their actions is in accordance to the directives of the policies of attention to the health of the elder, which are directed at dealing with incapacities[10].

Therefore, this study aims at investigating the work process of physical therapists from the NASF of a sanitary region of the city of Belo Horizonte.

## METHOD

This is an observational and descriptive study, with a sample made up of 10 physical therapists that made up the total of NASF teams of a sanitary region of Belo Horizonte, MG, from September to October 2015.

The professionals were invited to participate in the study in person, when they were informed of the objectives and procedures of the research. According to the convenience of the professional, a visit was scheduled to their workplace, so that the procedures of the research could be explained, and the Free and Informed Consent Form read.

A semi-structured and self-applicable questionnaire was adapted to investigate issues regarding the actions of physical therapists[11]. The instrument was made up of 89 questions, addressing the following dimensions: general identification, physical structure and resources, organization of the matrix support to the ESF, specific demands of the elderly population, permanent education, final product of the assistance and professional satisfaction. Most questions were closed, with answers that could go from 0 to 10, with simple or multiple answers (in the latter, more than one option could be selected).

Central tendency, dispersion and frequency measures were used in data analysis, and data was processed in the Microsoft Excel Software (2010). The study was approved by the Research Ethics Committee at UFMG, under register CEP 982.331.

## RESULTS

The results will be presented in items using four of the seven dimensions of the questionnaire, which are: 1) Profile of the participants; 2) Physical structure and material resources; 3) Predicted activities and matrix support; and 4) Specific demands of the elderly population and the management of said demand.

### Profile of the participants

All 10 professionals invited to participate in the study answered the questionnaire. Nine professionals (90%) were female and one (10%) was male, and their mean age was 39 years of age. Five (50%) were married, four (40%) single and one (10%) divorced.

All professionals in the NASF work 20 hours a week and 80% of them have another job. They have been working at the NASF for a period that varied from 2 years and 11 months to 8 years. Eight professionals (80%) have been there for 6 years or longer. The NASF teams in which the interviewees work offer support to Family Health Teams from different Health Units. Five professionals (50%) offer support to three Health Centers and five (50%) to two. Regarding the number of teams they give support to, four (40%) stated to offer support to 8 teams, one (10%) to 9, two (20%) to 11, and two (20%) to 12.

All participants completed their education in institutions at Belo Horizonte - MG, having spent from 4 to 25 years in their educational process. 90% of them finished their education 9 years ago or more. Seven professionals (70%) have some type of post-graduation, though none in the field of aging or targeted at primary health care.

### Physical structure and material resources

Regarding the spaces used to care for the elders (individual or collective) the most frequent were offices shared with NASF professionals, followed by Meeting Rooms/Groups and Spaces within the facility. Regarding whether the spaces were adequate to care for the population and to the development of these activities (in a scale from 0 to 10, varying from very bad to excellent), the mean score was 5.3 and 5.2, respectively. Regarding the material and other resources needed to care for individuals and groups, all professionals answered that there was not enough.

Concerning the availability of transportation to conduct domiciliary visits, 100% of professionals answered positively, but this availability attends only partially to the demands of the service.

### Predicted activities and matrix support

The results regarding the scheduled activities and the way in which professionals make their schedules available for the teams that have them as a reference are described in tables 1 and 2, respectively. It was found that the activities are very similar between the different NASF teams, which is not the case when it comes to the way in which these schedules are made available for the ESF team.

Considering the existence of protocols and well-defined fluxes of both referrals to the NASF and the planning of actions carried out together by the NASF and the ESF, most professionals answered both questions negatively (60% for the first and 100% for the second).

**Table 1.** Scheduled activities, according to physical therapists of a Health Regional. Belo Horizonte, 2015.

| Activities | %* |
|---|---|
| Individual consultations specific for evaluation | 100.0 |
| Individual care specific for treatment | 100.0 |
| Shared attention | 90.0 |
| Therapeutic groups and/or health education groups | 90.0 |
| Domiciliary visits | 100.0 |
| Matrix reunions with the health family teams | 100.0 |
| Actions shared with other instances, such as social assistance or community. | 60.0 |

* The same participant could give different answers to the question.

**Table 2.** Way in which the schedules were made available for the health teams, according to physical therapists of a Regional Health Unit. Belo Horizonte, 2015.

| Way in which schedule was made available | %* |
|---|---|
| Verbally, during the meetings with the ESF | 40.0 |
| In written form, during the meetings with the ESF | 10.0 |
| The scheduled is affixed to a visible place in the reference unit(s) | 60.0 |
| The schedule is not made available to the ESF | 30.0 |

* The same participant could give different answers to the question.

Regarding the meetings with the ESF, not all professionals stated that they take place monthly. The perception of the quality of the matrix relations conducted in the meetings (in a scale from 0 to 10, from very bad to excellent) had a mean of 5.3. The main negative factors that influenced the quality of the matrix relations that have been pointed out were: lack of knowledge about ESF on the proposal of matrix relations, lack of knowledge of the actions and forms of action of the NASF by the ESF, lack of interest and adherence to the matrix meetings from the ESF.

Among the main positive factors noticed about the matrix relations are: "broader perspectives", "possibility for sharing and multiplying knowledge among professionals", "training", "better information for referred cases", "increased number of solved cases" and "better referral of the user within the network". Regarding the elaboration of the PTS, most professionals (60%) state that they do not elaborate any.

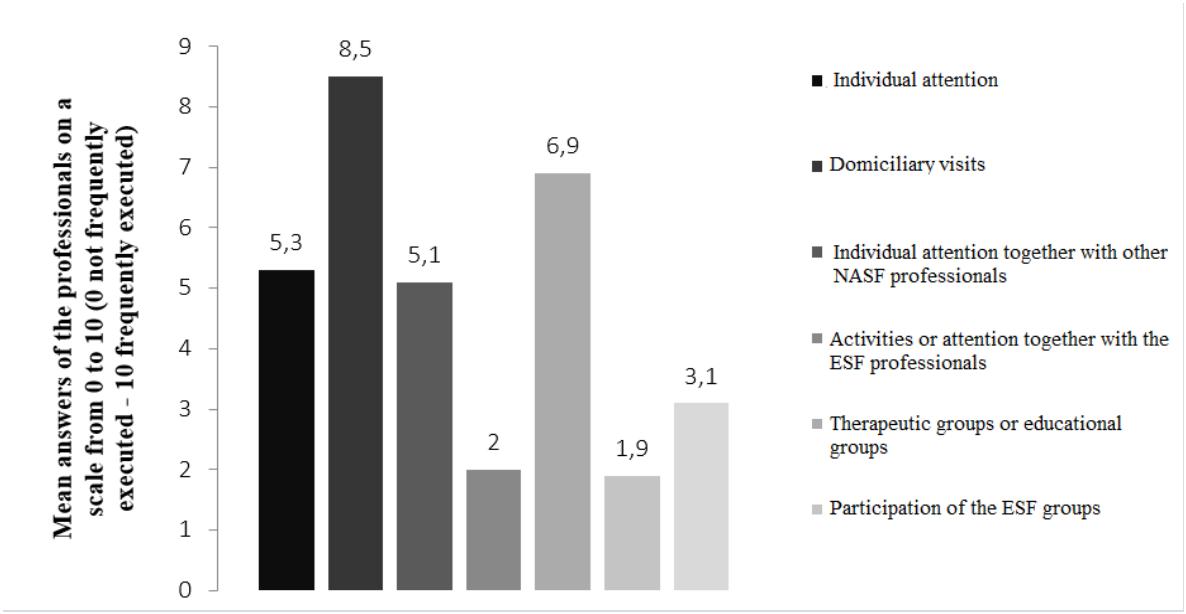
Specific demands of the elderly population and its management

Regarding the approximate number of referrals of people above 60 years of age, two (20%) did not know how many there were, one (10%) answered that there were seven, and the others (70%) said they were 15 or more. Among the 8 participants that answered, the average number of referrals was 16.63.

The main motivation for the referral of users older than 60 to the NASF by the ESF is their clinical condition/diagnosis, according to 70% of professionals. Other reasons are complaints of the user or of the family and the functional situation of the user.

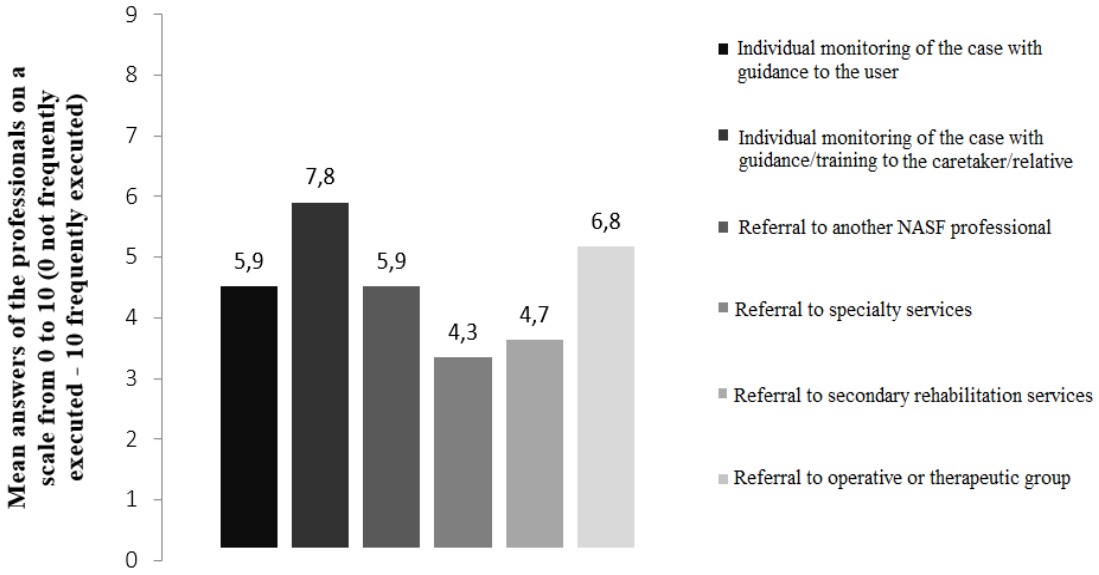
Regarding the types of attention, the physical therapists offer specifically for the elderly, the domiciliary visits and the operative groups were the most common (Chart 1).

**Chart 1.** Activities conducted for the elder population referred to the service, according to physical therapists of a Regional Health Unit. Belo Horizonte, 2015.




The frequent conduct with these users was: individual monitoring with guidance/training of the caregiver/relative, followed by referral to groups, as Chart 2 indicates.

**Chart 2.** Conduct in cases being addressed, according to physical therapists of a Regional Health Unit. Belo Horizonte, 2015.




From actions of health promotion, health problem prevention, and rehabilitation, the preventive ones were the most commonly mentioned (83%).

The average perception of professionals regarding the efficacy of their actions for the maintenance/promotion/recovery of the functionality of the elder (in a scale from 0 to 10, from very bad to excellent) was 6.44.

Regarding the use of the CIF model as a guide in the assistance to elderly users, only 40% of them used said model, despite the fact that 70% stated to have received specific training on the subject. Regarding permanent education, in the last year, only one professional (10%) received specific training on themes related to aging.

Considering the fact that the system conforms to the RAS, five (50%) participants stated that they do have frequent contact with institutions from other levels of attention, and the same number of professionals declared that they do not articulate actions with other instances, apart from those in the health field.

## DISCUSSION

The NASF directives prescribes that its professionals should partner with the professionals from the ESF, sharing their health practices in the territory under their responsibility[4]. A study, describing the work methodology of matrix support and reference teams, [7]emphasized the need for a reorganization of the health systems so that these specialized back-end professionals do not work fragmentedly, with mechanisms such as the reference and counter-reference, but horizontally, in the shared construction of clinical and sanitary directives.

To do so, the reference teams must work dialogically, being responsible for the maintenance of a longitudinal relational coordination with the users and the support teams, which are responsible to contribute with interventions or specialized knowledge.[7]

Since it is a support center, the actions of the NASF are dependent to those of the ESF and cannot be disassociated from them[12]. Therefore, the lack of articulation between these two teams was found in this study due to the low index of realization of shared tasks. The participation in their specific groups and the collaborative elaboration of singular therapeutic projects go against this basic directive.

Another study[11] about the index of results from the NASFs in Belo Horizonte have also observed the difficulties of their professionals when conducting actions in partnership with the ESFs. The contact between references and support

professionals must be direct and periodical, always generating the construction of integrated therapeutic projects[7].

It was found that, despite the fact that meetings take place frequently, participants find that the matrix relations in the cases are of low quality. This low quality is mainly attributed to the fact that the ESFs would not know the proposal of matrix support and the actions of the NASF, while also being uninterested on the matrix reunions and, as well, lacking relevant information about the users to aid in the conduction of cases.

This is, possibly, a consequence of the persistent difficulties in dealing with the new ways to organize the work and with technological tools, such as the matrix support and the singular therapeutic project[11]. Other studies about the NASF support these findings[12-16], which in turn highlight the need of changing the way in which professionals involved in this care process act.

Another possible reason is the low participation of some professional categories from the ESF in the meetings and the high turnover of professionals, especially physicians, that takes place[11].

In addition, the professionals report that there are no well-defined protocols that plan the actions carried out together and the referrals to the NASF, which could make more difficult this essential communication.

These findings show the need for adjustments relating to the working process of the NASF, according to the directives of the Ministry of Health, which is still difficult, due to the need to change the logic of the actions[4]. The educational profile of most professionals is seen as an obstacle in the path of the implantation of NASF, since the teamwork is not present in the graduation syllabus of any subject[15]. Therefore, a critical review of the educational process of the health professionals that favor the creation of opportunities for continuous, integrated and inter-sectoral actions is necessary, considering the proposal made by the NASF of inter-disciplinary work[13,15-17].

The activities reported by the participants seem to contemplate most actions described by the National Policy of Primary Care (PNAB)[3]. Similar to what happens in relation to the activities specifically targeted at the elder population, the assistance is adequate to the heterogeneity of this population, attending to the directives of the policies that focus on it.

The PNSPI[2] values a welcoming and attention that is efficient in solving the problems, in actions that include health promotion, prevention and treatment, prioritizing group activities that encourage conviviality and social participation. Therefore, the predominance of domiciliary visits, followed by collective activities, is coherent with these policies as well as with NASF directives.

However, if, on one hand, prescribed actions are being carried out, on the other, there are more individual than group attention sessions, contradicting the principles of matrix support for the prioritization of collective and/or shared activities when compared to the direct and individualized attention, which should take place only in extremely necessary situations.[7]

Clearly, the methods used in this study for analysis do not allow one to make assertions about the differences in the frequency with which each type of attention is offered. Nonetheless, it is clear that, in the eyes of the professionals, only a few shared activities are conducted and shared with the ESFs. Similar results were found in another work[11], highlighting individual and specific training, despite the diversity of actions conducted by the NASF professionals. This type of attention increases the chance of fragmenting the care[4,7]. This reiterates how difficult it is to effectively use matrix support, as well as using tools such as the PTS[11].

Other factors that make the process more difficult, such as lack of material resources to conduct the activities (whether these are individual or collective), the inadequate physical spaces for the activities that are offered to the elderly population and the insufficient availability of transportations to care for the demands of visitors, certainly negatively influence in the conduction of shared activities. Considering that, the shortcomings of the primary units is pointed

out by the Ministry of Health as one of the challenges for the change of ESF practices throughout Brazil[11].

The predominance of referrals for groups and monitoring with guidance as opposed to referrals to secondary health rehabilitation specialties is according to the PNAB and the PNSPI, according to which users should preferably be attended in primary care[2,3], and, also, that 80% of health problems should be solved in this level of attention[18].

Still, an important factor to be considered is that the NASF never should replace the role of other levels of attention[13,14]. That is because the insufficiency of the specialized services may lead the NASF to work incorrectly, but it is not its function to cater for the demand of individualized attention that is not absorbed by the adequate levels[11,13,14]. Specially in the case of rehabilitation, which also represents a diminished secondary access, it is relevant to ponder about the issue, since the attention to this demand on the primary care may suffocate attempts to develop other activities[9].

Additionally, it is important for the rehabilitation actions executed in basic care not to be mistaken by those conducted in other levels of attention. To fulfill its important role in the context of the RAS, the NASF should contribute with the ESF to make it easier for users to have access to the network in a coherent and resolutive way, aiding in the coordination of cases that are referred to other services[3].

Considering that, the fact that only 50% of the participants are frequently in contact with other levels of attention is not in accordance with this primary care and PNSPI directive, which predicts an integral attention integrated to the health of the elder in all levels of attention, including the hospital network and other specialties[2]. Similarly, the poor inter-sectoral articulation brought forth by the professionals in the study is also not in accordance to the PNSPI when it comes to the NASF directives, which encourage inter-sectoral and integrative actions with other social policies, such as education, sport, culture, work, leisure, and others[2,4].

Regarding the efficiency of the actions of the physical therapists at NASF to maintain/recover the functionality of the elders, it was found that, according to the perception of professionals, it is around 64%. Despite the fact that no studies with similar data were found for comparisons to be made, considering the estimates according to which 80% of health problems can be solved in primary care[18], this can be considered as a reasonable average. However, considering that the health paradigm for the elder is based on their autonomy and independence[2], it would be important for this data to be discussed by other studies.

The perception of a balanced distribution between actions of promotion, health problem prevention and rehabilitation by physical therapists, seem to indicate that they are capable of acting in many different ways to cater to the different demands they receive. The predominance of actions to prevent health problems is adequate to the level of attention they are in, and it can be inferred that the professionals are not being asked to conduct rehabilitation actions adequate to other levels of attention. In addition to that, many actions to prevent health problems are adequate to the population being attended, since this group is known to present a high number of chronic diseases that can affect functionality.

Still from the perspective of functionality, most referrals made by the ESF are carried out according to the clinical diagnostic and not to the functional diagnostic. Due to the complexity inherent to the health of elderly persons, the attention model focused on the disease is not effective, and it is necessary to have a global and multidimensional approach, which takes into account the high interaction between physical, psychological and social factors that must be addressed by a multiprofessional team[2].

Considering that, the World Health Organization, when classifying Capacity, Incapacity and Functionality (CIF), considers functionality as a dynamic interaction between health conditions and contextual factors. Therefore, it is a biopsychosocial

model of attention, as prescribed for elder health care and takes into account many useful concepts for the methodological proposal of using inter- and trans-disciplinarity in matrix support[2,18,19]. Its use in the SUS was determined in 2012 by the National Council of Health. However, it was found that only a small part of participants uses it in their daily practices, although most professionals are trained to do so.

It can also be noted that, although some actions are not in accordance to the guidelines, the group of this study, in general, showed knowledge of the directives of NASF, and apparently aims to adapt their actions to the proposed methodology, despite of having to face some challenges.

The fact that these are experienced professionals in the NASF (with a mean of 6.2 years working there) may be a facilitator. It must be reiterated, however, that from the point of view of integral health care to the elder, the improvement in the articulation with the ESF and with the network of services is necessary. In addition, the biopsychosocial attention model must be used to qualify the dialogue between professionals and decisions in the attention[19].

## CONCLUSION

After comparing the working process of the physical therapists with the directives of the Ministry of Health (both regarding the work directives of the NASF and in relation to the guidelines of the policies that deal with elderly care), it was found that, in general, the professionals are acting in accordance to the directives relative to elder care, which leads to believe that with their varied actions, contributing to the diminution of incapacities, the physical therapists, acting together with the multi-professional team, contribute effectively for the elderly attention in the primary health care.

When considering the guidelines from the NASF, it was observed that they do not follow some of them, which seems to justify the need to adjust the structures of this service as to be in accordance to the policy, which is also true for the professional education of these workers. Shared discussions, reflections and activities that can escape from a traditional and fragmented logic of attention are needed to address the health of the users, as prescribed by the public policies, aiming to adjust the actions of these centers, which are still being constructed.

The limitations of this study were the small sample and its descriptive character. However, it presents, produces knowledge and offers recognition to a reality which needs to be the target of more studies, especially when it comes to physical therapy studies on the care offered to the elders by the NASF.

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**CONTRIBUTIONS**
**Ana Luíza Moreira Pauferro e Fabiane Ribeiro Ferreira** participated in the conception, design, analysis and interpretation of data, writing and critical review. **Paula Maria Machado Arantes** acted from data analysis and interpretation, writing and critical review. **Rosana Ferreira Sampaio e Júlia Baldoni** contributed by writing and critical review.

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