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MYOCARDIAL REVASCULARIZATION: PATIENT REFERRAL AND COUNTER-REFERRAL IN A HOSPITAL INSTITUTION

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ABSTRACT

Objective: to understand the referral and counter-referral process experienced by the patient with coronary artery disease undergoing surgery for myocardium revascularization.

Methods: qualitative research, anchored on the Grounded Theory. The research scenario was a public hospital institution, reference in cardiovascular care in the State of Santa Catarina, (Brazil). The data collection took place between March 2013 and June 2014, through a semi-structured interview involving 21 participants, distributed in three sample groups (patients, health professionals and management professionals).

Results: the process of referral and counter-referral points to the phenomenon "High complexity emerging as a reference for the person submitted to myocardial revascularization in view of the Primary Health Care fragility in the follow-up and articulation with other care levels in the *Sistema* Único *de Saúde* (Unified Health System)", supported by five categories.

Conclusion: in order to this referralto occur, there is a need to consolidate the patient's relationship with the coronary disease with the primary health care, since they face difficulties in monitoring their condition in the public network. In the counter-referral, the disarticulation between the health care services was evidenced, which affects the care regarding the person submitted to myocardial revascularization in the maintenance of their quality of life.

DESCRIPTORS: Nursing. Myocardial revascularization. Integrality in health. Referral and consultation. Hospital.

REVASCULARIZAÇÃO MIOCÁRDICA: REFERÊNCIA E CONTRARREFERÊNCIA DO PACIENTE EM UMA INSTITUIÇÃO HOSPITALAR

RESUMO

Objetivo: compreender o processo de referência e contrarreferência vivenciado pelo paciente com coronariopatia submetido à cirurgia de revascularização do miocárdio.

Métodos: pesquisa qualitativa, ancorada na Teoria Fundamentada nos Dados. O cenário da pesquisa foi uma instituição hospitalar pública, referência em atendimento cardiovascular no Estado de Santa Catarina (Brasil). A coleta de dados ocorreu entre março de 2013 a junho de 2014, por meio de entrevista semiestruturada envolvendo 21 participantes, distribuídos em três grupos amostrais (pacientes, profissionais de saúde e profissionais gestores).

Resultados: o processo de referência e contrarreferência aponta o fenômeno "Emergindo a alta complexidade como referência para a pessoa submetida à revascularização miocárdica diante da fragilidade da Atenção Primária à Saúde no acompanhamento e articulação com os demais níveis de atenção no Sistema Único de Saúde", sustentado por cinco categorias.

Conclusão: para que a referência aconteça há necessidade de consolidar o vínculo do paciente com coronariopatia com a atenção primária à saúde, uma vez que este encontra dificuldades no acompanhamento da sua condição na rede pública. Na contrarreferência evidenciou-se a desarticulação entre os serviços de atenção à saúde, a qual afeta o cuidado à pessoa submetida à revascularização miocárdica na manutenção da sua qualidade de vida.

DESCRITORES: Enfermagem. Revascularização miocárdica. Integralidade em saúde. Encaminhamento e consulta. Hospital.

REVASCULARIZACIÓN MIOCÁRDICA: REFERENCIA Y CONTRARREFERENCIA DEL PACIENTE EN UNA INSTITUCIÓN HOSPITALARIA

RESUMEN

Objetivo: comprender el proceso de referencia y contrarreferencia vivido por el paciente con coronariopatía sometido a la cirugía de revascularización del miocardio.

Método: investigación cualitativa, anclada en la Teoría Fundamentada en los Datos. El escenario de la investigación fue una institución hospitalaria pública, referencia en atención cardiovascular en el Estado de Santa Catarina, Brazil. La recolección de datos se realizó entre marzo de 2013 a junio de 2014, por medio de entrevista semiestructurada con 21 participantes, distribuidos en tres grupos muestrales (pacientes, profesionales de salud y profesionales gestores).

Resultados: el proceso de referencia y contrarreferencia apunta el fenómeno "emergiendo la alta complejidad como referencia para la persona sometida a la revascularización miocárdica en vista la fragilidad de la Atención Primaria a la Salud en el sequimiento y articulación con los demás niveles de atención en el Sistema Único de Salud", sostenido por cinco categorías.

Conclusión: para que la referencia suceda es necesario consolidar el vínculo del paciente con coronariopatía con la atención primaria a la salud, ya que éste encuentra dificultades en el seguimiento de su condición en la red pública. En la contrarreferencia se evidenció la desarticulación entre los servicios de atención a la salud, la cual afecta el cuidado a la persona sometida a la revascularización miocárdica en el mantenimiento de su calidad de vida.

DESCRIPTORES: Enfermeria. Revascularización miocárdica. Integralidad en salud. Derivación y consulta. Hospital.

INTRODUCTION

Cardiovascular diseases are the main cause of death in Brazil and in the world. They were responsible for 33% of deaths in 2011 in most countries of the Organization for Economic Co-operation and Development (OECD)[1]. In Brazil, there has been a reduction in the mortality rate due to cardiovascular diseases in the last decades, especially in the southern and southeastern regions of the country, over the age range of 60 years old.[2] In addition to investments in promotion and prevention actions of diseases articulated with advances in the treatment of ischemic heart diseases; the myocardium revascularization surgery (MRS)and the coronary angioplasty are the approaches with important collaboration for this fact.[1]

The MRS, indicated as treatment of severe and extensive coronary obstructions, is funded by the Brazilian public health system. However, for its real effectiveness, there are several obstacles that show deficiencies in the referraland counter-referral process of the user in the *Sistema* Único *de Saúde* (SUS – Unified Health System),[3] as well as the limited number of beds in the country, when compared to the reality of OECD countries.[1]

In order to overcome the fragmentation and disarticulation between the services, the Health Care Networks, made up of oligarchical organizations of health service groups, linked by common goals and by interdependent and cooperative actions, aim to ensure equitable access and qualified care.[4]

Regulated in three dimensions, the SUS regulation is guided by the integration of the Health Systems Regulation, Health Care Regulation and Regulation of Access to Care,[5] to which the internal organizational flows of institutions are submitted. In the case of hospital institutions, this process is done through care lines, characterized as a strategy to enable the integrality of care facing the aggravations or other specific conditions, as well as by the Internal Regulation Nucleus, which establishes articulation with Centers of Regulation to inform and make available information on the care profile of the institution and seek support in other services for treatment and diagnosis of patients already hospitalized.[6]

However, even with the development of public policies to adapt the provision of care services to the users' demands, in an orderly, timely and rational manner, fundamentally based on the principles of universality and equity,[7] the process of referral and counter-referral is still in deployment and points to the need for improvement.[8-9]

In particular, in the cardiovascular care line, it is considered fragile the regulation of access to care for patients with coronary diseases and submitted to MRS among the health services from the perspective of patients, professionals and managers who work in Primary Health Care (PHC),[10] considering the waiting time for performing the surgical procedure as well as the absence of a formal counter-referral. Considering this scenario, we ask ourselves: how does thereferral and counter-referral process of the patient with coronary artery disease submitted to MRS with an emphasis on the hospital context occur? In that sense, theobjective of this study is to understand the referral and counter-referral process experienced by patients with coronary artery disease submitted to MRS with emphasis in the hospital context.

METHOD

This is a qualitative research guided by the Grounded Theory, for its potential to provide a better understanding of the phenomenon and to be an important guide for action.[11] The research scenario was a public hospital institution, reference in cardiovascular care in the State of Santa Catarina, located in the south of Brazil. The data collection took place between March 2013 and June 2014, through a semi-structured interview, conducted by theoretical sampling, that is, directed to the search for good informants to obtain a deeper understanding of the cases analyzed, favoring the development of concepts.[11]

For the participants' selection, the inclusion criteria were: to be a patient and/or health professional who lived and/or acted in some stage of the referral and counter-referral process to/from MRS. The first sample consisted of seven patients hospitalized at the reference hospital, one woman and six men. The semi-structure interview was conducted by two researchers without previous link with the institution, containing the following guiding question: how do you experience the referraland counter-referral process after being diagnosed with coronary artery disease and after having undergone MRS?

From the data analysis of this first sample group, it was hypothesized that it depends on the professionals who provide care to these patients in the high complexity and the responsibility for the referral to other health services after discharge, in order to continue the health follow-up. Thus, the second sample consisted of nine health professionals (five nurses, one social worker, two physicians, and one physical educator) who developed activities directly related to the patients submitted to MRS in the data collection scenario. The question was: how do you experience the process of referral and counter-referral of the patient with coronary heart disease with indication/submitted to MRS from admission to discharge?

The data then indicated that the health managers are responsible for decisions on this process. Therefore, the third sample group was composed of five health professionals linked to the management group of the State Health Department. The size of the sample was determined by theoretical saturation, in the occurrence of data repetition, absence of new findings relevant to the categories already constituted, and their consolidation in their properties and dimensions,[11] totaling, thus, 21 interviews. The interviews were individual, recorded in a digital device, with an average duration of 40 minutes, and later transcribed in full. The data collection and analysis occurred simultaneously and guided by the comparative analysis, following the coding steps proposed by the Grounded Theory, which are: open, axial and selective coding.

The open coding was the first step in the analysis, consisting of separating and conceptualizing the data obtained, analyzed line by line, and each interviewee's speech transformed into a code. The code groupings formed the subcategories, identified according to what they were dealing with. The next step of the analysis was the axial coding, in which the data were again grouped, forming categories. The selective coding was the search and development of the central phenomenon or category, supported by associations emerging between the categories oriented by the paradigmatic model, formed by the components: context, causal and intervenient conditions, strategies and consequences.[11] The NVIVO® software was used to sort and organize the data in the coding process.

The study followed the recommendations of Resolution 466/12 of the National Health Council and received a favorable opinion from the Research Ethics Committee of the Federal University of Santa Catarina under Protocol 120.184, from 10/08/2012 and CAAE: 03616612.6.0000.0121. The consent of the participants was obtained through the signing of the Free and Informed Consent Term. To preserve the participants' anonymity, their names were replaced by the letter "E" followed by the interview order number (E1, E2, E3, ..., E21).

RESULTS

From the analysis of the referral and counter-referral process of the coronary disease patient submitted to MRS, from one of the cardiovascular reference institutions for the State of Santa Catarina, five categories emerged, each of them being responsible for sustaining one of the five components of the paradigm model, interdependent and dynamically related, which originated the phenomenon: High complexity emerging as a reference for the person submitted to myocardial revascularization considering the fragility of the primary health care in the follow-up and articulation with the other care levels in the SUS.

Causal conditions

The category "Identifying the symptoms of the cardiovascular disease as generators of the process" represents how the patient enters the health system

until admission to the hospital. In their testimonies, some patients reported delay in seeking adequate care for not identifying the signs and symptoms of the disease, which were commonly attenuated with self-medication, as the speech illustrates: *what I could take, I would take, I would force. I tried to relieve pain with painkillers* [...], *but it didn't help. I was still in pain.*[...] (E4).

The search for health care only occurred when the symptoms worsened, compromising daily activities. Soon, some went to the Basic Health Unit, some of them sought care at the Emergency Care Unit and most of them went to the Hospital Emergency Room.In the Basic Health Unit, when assessed by a health professional, these patients were instructed to look for the Emergency Care Unit or the hospital emergency room. For those who sought the Emergency Care Unit, the clinical condition was stabilized to be followed by the referral or removal by the urgent mobile service to the hospital unit.

Patients reported that they were not routinely consulted in order to prevent or detect early coronary disease. The demand for care was in the acute condition of acute myocardial infarction, with the hospital being the first choice of most of the participants. According to the patients, the direct access to the hospital emergency room was due to the fact that they consider this option safer and more resolute in the health care network, since they can perform tests and get a faster assessment from health professionals when compared to other services.

Context

The category "Describing the complex context of the referral of the patient with coronary artery disease and the counter-referralof this patient already submitted to MRS" presents the context in which the phenomenon develops and evidences the hospital as a reference center for the state of Santa Catarina, in high complexity, for the patient with coronary artery disease, as well as for cardiac rehabilitation of patients submitted to MRS. The study hospital depends on exclusively public financial resources for the provision and operation of its services, as well as for the acquisition, maintenance or expansion of physical and human resources, physical structure, among others. In this study, the physical structure is considered insufficient to meet the demand and the needs of patients referred to it for surgical treatment of coronary artery disease, as observed in the patient's speech: *the problem is the small structure, in addition to waiting for care and surgery.* [...](E5).

Due to delays in the provision of services (consultations with clinicians, specialists and/or examinations) in the public network, patients seek care in the private network for access to consultations with specialists and for examinations. In addition, this delay justifies the patients' demand for hospital emergency rooms, a condition that reveals the commitment of the referral process. For its turn, the counter-referral of the patient who underwent MRS for a less complex service is avoided by the health team of the reference hospital because, according to the deponents, they are areas of health care that are not prepared with sufficient and qualified human resources , as well as with the technological resources needed to serve this specific clientele.

Intermediary conditions

The category "Difficulties for the referral and counter-referral process to occur in the health of the coronary and revascularized patients" reports the difficulties related to the primary and specialized health care perceived by the participants, namely: reduced number of medical consultations in basic and specialized care; work overload and lack of specialized knowledge of the PHC professional, which compromise the diagnostic and care capacity of the coronary and revascularized patient; low resolution of the problems regarding the patients' health in basic and specialized health care; services at the Basic Health Unit at times and days of the week that do not include the clientele with formal employment relationship. These conditions are possible causes of service overload in Emergency Care Units and hospital emergency rooms.

Also, according to the testimonies, the difficulty for primary and specialized health care to be successful in the patient referral process for early treatment of coronary disease in the hospital, during the first signs and symptoms, is the delay of this patient being attended due to the lack of beds for hospitalization and surgical treatment, as observed in speech: *the problem is the physical structure[...]. The impediment is in the number of post-operative beds.* (E12).

As the professionals pointed out, the counter-referral of the patient from the hospital unit to other services does not occur, mainly due to the lack of specialists and the preparation of general practitioners to deal with complex cases, such as the condition of revascularized patients. For those reasons, there is disarticulation between the health care services in the counter-referral process of the revascularized patient.

Strategies

The strategies for reaching the phenomenon are represented by the category "Aiming at organization strategies of patients flow for MRS and indicating the Systematization of the Nursing Care as a tool for counter-referral". This system describes the System of Regulation (SISREG) as a national, free, computerized system that integrates and manages the entire regulatory complex from PHC to high complexity. Even if it is in the process of implementation and even if it presents problems inherent to any starting process, the SISREG seeks to organize and systematize the priority criteria for protocol-based exams, consultations and hospitalizations and *in loco* training for professionals, with the support of regulatory professionals at the central level of the state sphere. In that sense, the SISREG can benefit the health care network, ordering the flow of patients in a humanized way, considering their clinical priorities, and allowing more efficient use of hospital beds and services, as illustrated by this speech: *as soon as there is an intensive care unit, the bed is delivered to this regulation. The postoperative, specifically, should not even enter this hall of beds because it is already little for our clientele*[...] *we already have a large flow in the surgical center of patients waiting inside the institutions themselves* (E9).

The study points to the systematization of the nursing care as a tool to favor and improve the internal flow of the patient in the hospital context, as well as the importance of nurses in the orientation process for discharge, as illustrated in the speeches: *in fact, the patient is from distant municipalities* [...] *and the nursing records are key to his care here* [...] *and he himself wants to continue being treated in his city* [...] (E14). *As a management action, I would still like to develop a project here in the hospital as a discharge room, where you will have a nurse only to ensure the patient is well-oriented and knows to which service he is going to and he can see his plan of care* (E8). Thus, participants indicated the need for systematization as an opportunity to enhance nursing care in the various health services, as well as give visibility to the profession.

Consequences

The component called consequences is represented by the category "The outpatient and cardiac rehabilitation services being the reference in health for the follow-up and rehabilitation of the revascularizedpatien".

Due to the incipient structure of the primary and specialized health care in the municipalities of Greater Florianópolis and Santa Catarina state for the follow-up and rehabilitation of patients submitted to MRS, professionals and patients pointed out the outpatient clinic and the cardiac rehabilitation hospital service for specialized follow-up and cardiac rehabilitation of the revascularized patient, as the speeches illustrate: *the revascularized patient is very specific... If there is any suspicion of decompensation, it is difficult for the clinician to handle it at the primary network. There are certain medications that the cardiologist, especially from our outpatient clinic, who knows how long he will use* (E11). [The professionals]*said: 'If you feel anything there*[home]*come over right away*[to the hospital], *show it to the doctor and get checked on arrival.* [...] *'And, for the routine appointment, I have the referral to schedule it in the ambulatory.'* (E2).

The rehabilitation service has its own space, with equipment and rehabilitation professionals, being used by patients who have the physical, mental and transportation conditions to enjoy it. The outpatient clinic serves patients from Greater Florianópolis and other cities in the state of Santa Catarina.

Some participants pointed out that the counter-referral involves the whole process of discharge guidelines. Still, they recognized that it is at the moment of discharge that the professionals transmit the greater volume of information and, at that moment, the patient, anxious for the discharge, little assimilates from the offered guidelines, as the speech illustrates: *after the surgery, before going home, was when they* [professionals] *talked me through what I could eat, what I can and what I can't do. It's a lot, isn't it?* (E3). Thus, professionals indicated that discharge guidelines should be performed daily during the post-surgical recovery, aiming to gradually consolidate information for self-care in the postoperative period and later in the community.

Also, in the testimonies, the lack of counter-referral among the health care services was pointed out, according to a professional's desire: *the doctor is expected to write a counter-referral letter so that the local unit doctor knows what is happening to his patient. Otherwise, the patient disappears and appears five years later with a scar on his chest.* [...] *How will the clinician suddenly handle a flu? How to think about rehabilitation if there is nothing structured?* (E21) The individual returns home without the knowledge of the PHC professionals regarding their condition and the particularities related to the process of surgical recovery and cardiac rehabilitation.

DISCUSSION

The referral process of the patient undergoing MRS is initiated by the search for care after the identification of an acute cardiac event. The study to compare the prognosis and waiting time for specialized intervention reveals that the recognition of signs and symptoms of acute myocardial infarction by the patient was a determining factor for the demand for specialized care.[12] In qualitative research with women who suffered acute myocardial infarction, they showed little clarity in accurately assessing their cardiovascular risk, poor preventive health behaviors, and delayed in seeking care based on the symptoms.[13] Threefactors were elaborated by patientsas a proper behavior toreducethedelayin searching for health care after the onset of symptoms: identifying the symptomsas having origin from theheart, having anaction planreadyin case of an emergency, and being withsomeone ormaking contact with otherpeople.[14]

Although the PHC is understood as the gateway to the health care network, it should guide users to other system services (medium complexity and hospitals) through the referral mechanism, which should bring them back to the PHC through the counter-referral, it is the responsibility of municipal managers to improve the access conditions of users to basic care and their regulation and to adequate the provision of services to ensure coverage of specialized medical consultations and procedures.[15] These actions may reduce the service overload of Emergency Care Units and hospital emergency rooms.

In this study, the majority of the patients sought the hospital emergency service in the perception of the disease symptoms to have access to exams and the resolution of their problem by hospitalization, if necessary. According to what is observed in this study, the demand of the population is greater by the urgency and emergency services, to the detriment of PHC. Therefore, the former become the preferred gateway to health care for users of the health network services.[15] In part, this mismatch with public policies occurs due to the needs presented by users of health services in this study and the provision of services of different levels of technological density in the health care network, particularly specialized care and diagnostic technology. Such condition is an obstacle to users and a challenge to the managers to face and advance through what is necessary to broaden the access, organization and regulation of the services in the network.[16-17]

Offering specialists and qualifying primary care professionals is a challenge for human resources in the health system to meet the demand of people affected by a coronary disease and revascularized patients in referral and counter-referral. However, it is complex to manage this challenge.[18]

Hospital admissions in high hospital complexity, such as cardiovascular surgery, as well as complementary beds (intensive care unit) should be guided by the clinics according to the distribution of beds in the National Register of Health Establishments.[19] However, in the reality of the study, the coronary intensive care unit beds, for the most part, are managed by the hospital institution itself.

This condition limits the access of users coming from other institutions and makes the waiting process for the cardiovascular surgery very long, even of the patients already hospitalized in the emergency, mainly due to the insufficient supply of beds for hospitalization in the coronary unit, the unavailability of surgical rooms and anesthetists.[20-21] Consequently, too much waiting for surgery is responsible for exacerbation of anxiety and worsening of the health condition of some patients,[21] culminating in the occurrence of serious complications or the death of patients while awaiting surgery.

A specific strategy for hospital clinical management guided by the Kanban system, consisting of a computerized list with all the beds, patients from the hospitalization unit and average length of stay, in a rear unit in Porto Alegre (Brazil), revealed improvements in the care processes articulated to the greater supply of beds to users.[22]

However, despite the good results in the hospital indicators after the implantation of aInternal Nucleus of Regulation of Beds at a reference institution in São Paulo (Brazil), there is a need to expand regulatory actions considering the dense network of SUS services.[23]

For the external flow, SISREG was mentioned as a computerized management tool in implementation. Managers of the regulatory complex seek to guarantee equal care provision to all, while assessing the need to increase the offer of quotas or reallocation of resources according to the access indicators.[9] Although managers linked to the Internal Nucleus of Regulation of Beds and SISREG are the ones who order the referraland counter-referralprocess, it depends on the professionals involved in the direct care to work, considering the need to update the system,[24] with clear and detailed clinical data to enable decision-making. Thus, in the process of seeking and waiting for care, especially when they are already hospital-

ized and experiencing the waiting for the MRS, patients recognize as an advantage to be able to discuss their heart problems with the health team as a means to reduce fear and anxiety.[25] It should be emphasized that the coordination of the hospital admission units is performed by nurses, who must understand the strategies used by the patients to manage their emotions during the period prior to the myocardial revascularization surgery, as well as throughout the surgical process.[8]

In this sense, nurses are summoned by the participants to document their guidelines, especially those regarding the discharge, aimed at bridging the hospital and the PHC by systematization of the nursing care and the "discharge room". The "discharge room" proposal corroborates a study that emphasizes the continuity of treatment after discharge; reduction of recurrence of hospitalizations, resolution of referrals; and co-responsibility of the user and his/her relatives in the treatment process.[26] In a recent review on the planning of hospital discharge as a nursing care, it is highlighted the importance of development and execution of a hospital discharge plan carried out by a nurse, taking advantage of the hospitalization time as an opportunity to implement health education. Guided by the systematization of the nursing care, whose guidelines for referral to other services in the Care Network would be applied interventions allowing the continuity of care through the standardization of the professional language with the adoption of the taxonomy *Nursing Diagnoses*: Definitions & Classification (NANDA-I) or theInternational Classification for Nursing Practice (CIPE®).[27]

The professionals of this study point out obstacles to counter-referring patients to the PHC and report a structure favorable to the continuity of the follow-up in the outpatient and cardiac rehabilitation with a link between patients and professionals and support for the post-discharge phase. Despite this, it should be emphasized that, in order to promote health, treatment of diseases and rehabilitation, the treatment of a person with coronary artery disease and submitted to MRS requires the integration of all the services in the health care network, articulated by the referral and counter-referral process, to ensure comprehensive and continuous care.[10] However, as in this study, counter-referral is a condition that is not or little verified in other Brazilian realities and in the American countries, as recommended by the World Health Organization, despite its need for continuity of care and health control.[28]

It is noted that the definition of guidelines and clinical protocols for flows and counter-flows of care and mapping of the health services network, by health professionals and managers, can establish the basis for the referral system[17,28] and also of counter-referral to the users of the health services and to the professionals who work in these services.

In order to be effective and applicable, it is required that the articulation of these protocols to processes that increase the teams' clinical capacity, practices that strengthen micro-regulation in basic care, and provide communication between basic units, regulatory centers and specialized services. In the referral process in cardiology, it is highlight the incorporation of telehealth tools articulated to the clinical decisions and access regulation, either for the patient with need of referral for emergency, for a diagnostic investigation or for the specialty.[17]

Thus, it is envisaged that the transition between health care services, which means from the hospital unit to the PHC, should be monitored in order to be effective in practice. Nurses can enhance this counter-referral process, considering that in the PHC a favorable effect of nurse-centered health centers on all-cause mortality and infarction was evidenced, with increased adherence to medications in patients with cardiovascular disease and adherence to treatment.[29] Also, in a systematic review of nursing interventions for the secondary prevention of cardiovascular events, there was a beneficial impact in patients with coronary artery disease or heart failure.[30]

An expanded hospital continuity of the care program for primary health care strengthened the partnerships among patients, physicians, nurses, and other hospital and PHC health professionals. As a result, it was possible to verify improvement of self-efficacy and return to work or previous level of activity of the patients without causing aggravation or significant changes in their clinical situation.[31] There is a need to overcome the system fragmentation, difficulties in accessing the health services, reduce hospital readmissions, and improve the cardiac function and quality of life for people undergoing MRS, among others.

Although this study emphasized the hospital context and administrative sectors at the state level, the non-collection with the PHC was a limitation. However, it was possible to obtain, as a guide to the professional practice, that the professionals of the different services need to be sensitive to the receipt and monitoring of people who have been or will be

submitted to the MRS in order to guarantee a safe and quality care.

CONCLUSION

The process of referral and counter-referral points to the phenomenon High complexity emerging as a reference for the person submitted to the MRS in the face of the fragility of the PHC in the follow-up and articulation with the other care levels in SUS. There is evidence of the need to consolidate the link between the patient with heart disease and the PHC, once he or she encounters difficulties in monitoring their condition in the public network, interfering with their referral to other services, according to their health needs, and making the entrance door into the health system a high complexity.

However, it is in the counter-referral process that the problem of the disarticulation between the services in the Health Care Network becomes more evident, which affects the care of the person submitted to the MRS in the maintenance of their quality of life. Although in this context, even with SISREG's performance, it is observed the need to structure and strengthen the referral so that the counter-referral can take place, an important space for the nurses' work is shown through the consolidation of internal and external flows with systematization of the nursing care's care and the discharge guidelines.

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