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RESEARCH | PESQUISA

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Contributions from continuous education to family health extended centers

Contribuições da educação permanente aos núcleos ampliados de saúde da família

Contribuciones de la educación permanente en los centros de salud familiar extendidos

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ABSTRACT

Objective: To analyze and understand how continuous education inserts itself into the Family Health Extended Centers. **Method**: Quanti-quanlitative research. Developed on the quantitative stage with 359 professionals from nine macro regions of Santa Catarina answered a Survey; on the qualitative one, five teams participated in focal groups. The quantitative data were analyzed with the *Statistical Package for the Social Sciences*, and the qualitative ones, with the support of the *Atlas.ti 8.0*. **Results:** The professionals are women, graduate students and who act in the Centers for more than three years. About 50% received specialized qualification and, of them, 46,1% by means of the Telehealth. Typical actions of matrix support were highlighted as frequent activities on the two stages of the study. The groups revealed that the Health Ministry and the State are supporters of the qualifications; however, it lacks managerial support. **Conclusion and Implications for practice:** Educational actions occur during the practices. The professionals demonstrate initiative to strengthen themselves in qualification terms, either through postgraduate studies or search for other devices, highlighting the Telehealth and integration with Universities. Spaces for dialogue between professionals and management support are important strategies for continuous education.

Keywords: Primary health care; Family health; Professional practice; Continuous education; Professional training.

RESUMO

Objetivo: Analisar como a educação permanente insere-se nas ações dos Núcleos Ampliados de Saúde da Família. **Método:** Pesquisa quanti-qualitativa. Na etapa quantitativa, 359 profissionais de nove macrorregiões de Santa Catarina responderam um *Survey*; na qualitativa, cinco equipes desses Núcleos participaram de grupos focais. Os dados quantitativos foram analisados com *Statistical Package for the Social Sciences* e os qualitativos, com auxílio do *Atlas.ti 8.0*. **Resultados**: As profissionais são, majoritariamente, mulheres, pós-graduadas e que atuam nos Núcleos há mais de três anos. Aproximadamente 50% recebeu qualificação específica e, destas, 46,1% via Telessaúde. Ações típicas de apoio matricial destacaram-se como atividades frequentes nas duas etapas do estudo. Os grupos revelaram que o Ministério da Saúde e o Estado são apoiadores das qualificações; entretanto, falta apoio dos gestores. **Conclusão e Implicações para a prática:** Ações educativas ocorrem durante as práticas. Os profissionais demonstram iniciativa para se fortalecerem em termos formativos, seja por meio da pós-graduação ou busca de outros dispositivos, com destaque para o Telessaúde e a integração com Universidades. Os espaços de diálogo entre os profissionais e o apoio da gestão são importantes estratégias para a educação permanente.

Palavras-chave: Atenção primária à saúde; Saúde da família; Prática profissional; Educação permanente; Capacitação profissional.

RESUMEN

Objetivo: Analizar cómo la educación permanente se inserta en los Centros de Salud Familiar Extendidos. **Método:** Investigación cuanticualitativa. En la fase cuantitativa, 359 profesionales de nueve macrorregiones de Santa Catarina respondieron una encuesta; En términos cualitativos, cinco equipos de estos Centros de Salud participaron en grupos focales. Los datos cuantitativos se analizaron con el paquete estadístico para las Ciencias Sociales y los cualitativos, con la ayuda de Atlas.ti 8.0. **Resultados:** Las profesionales son, en su mayoría, mujeres, con títulos de postgrado, que trabajan en los Centros de Salud Familiar hace más de tres años. Cerca de 50% recibió cualificación específica y de este porcentaje, el 46,1% lo hizo a través de *Telessaúde*. Las acciones típicas de soporte matricial se destacaron como actividades frecuentes en ambas etapas del estudio. Los grupos revelaron que el Ministerio de Salud y el Estado son partidarios de las cualificaciones; Sin embargo, falta el apoyo por parte de los gerentes. **Conclusión y Implicaciones para la práctica:** Las acciones educativas ocurren durante las prácticas. Los profesionales muestran iniciativa para fortalecerse en términos de capacitación, ya sea a través de estudios de posgrado o mediante la búsqueda de otros dispositivos, entre los cuales, se destaca la telesalud y la integración con las universidades. El diálogo entre los profesionales y el apoyo de la administración son estrategias importantes para el aprendizaje permanente.

Palabras clave: Atención primaria de salud; Salud familiar; Práctica profesional; Educación permanente; Capacitación profesional.

INTRODUCTION

In many countries that adopt universal health systems, Primary Health Care (PHC) is the foundation of the system, enabling access to users and being directly related to the success of these systems.[1] In Brazil, after 30 years of the Brazilian Public Health System (*Sistema Único de Saúde,* SUS), it is recognized that for its advances it is necessary to act in a network, articulating different levels of care as strategic points of attention to the health of individuals and communities. PHC is considered one of these points and the network's originator and, to fulfill these functions, must fulfill essential attributes: To be a gateway and first contact, to provide integral, longitudinal action and to coordinate the action of other services.[2]

The Family Health Strategy (FHS) is the primary reorientation model of the PHC, where care is provided through teams composed of generalist professionals (physician, nursing and community health agents). Each team (FHS) is responsible for a specific territory, as recommended by the National Primary Care Policy (NPCP).[3] PHC should develop actions aimed at disease prevention, health promotion, protection and recovery.[2] This demands that health services fulfill the attribute of access with high resolution (for most health problems of the population), within a continuity of care by the same team, for a long period of time (longitudinality).

If it is not possible to solve the problems of the linked population, the professionals of PHC, responsible for coordinating care, trigger specialized care, referring users to other points of the Health Care Network, aiming at achieving the integrality. In Brazil, when they need this specialized support or in case of questions from the FHS, they can access the Family Health Extended Centers - FHEC, created with the objective of expanding the actions and the solvability of the FHS and providing matrix support to the FHS, in order to contribute to the resolution of cases and expand the resoluteness of health care at this level of care.[4]

The matrix support methodology promotes the activation of spaces of communication and joint deliberation, knowledge sharing and organization of flows in the network. It can be developed on two interfaces: Technical-pedagogical support, which aims to promote continuous education movements for FHS professionals; and clinical-care support, in which FHEC professionals, upon specific demand, perform individual or collective clinical care.[3,4] Inspired by the Paideia Method[5] (methodology for reformulation of traditional management mechanisms focusing on the formation of people and democratization of relations), matrix support can be conceived as a strategy of continuous education and co-management of care work that values the broader conception of the health-disease process, interdisciplinarity and the joint construction of therapeutic projects.[5,6]

FHEC studies[7,8] treat it as a transformative device of the work process in PHC, being able to mobilize and impact hegemonic practices immersed in scenarios of devaluation of public services, in addition to the precariousness of working conditions. However, these surveys point to difficulties for FHEC professionals to perform their duties, resulting from the disjointed vocational training of SUS demands. There are few theoretical productions that analyze the work process of FHEC, following its actions and impact on health or at least on care practices.

Although SUS is the largest employer in the health sector in Brazil, the processes of training personnel to work in health remain directed to market demands. The training institutions present proposals that strengthen the incorporation of high complexity technological education at high costs, highlighting the specialties. Contrary to this model, the reorientation of training foresees reflections on the need for collaborative practices and interprofessional education, whose concept is linked to teamwork and negotiation of decision-making processes, with respect to the uniqueness of the nuclei of knowledge and professional practices.[9,10]

Considering these challenges, the performance of FHEC professionals deserves special attention, given the need for changes in education, in compliance with the National Policy for Continuous Education in Health.[11] The assumptions of Continuous Health Education (CHE) imply the articulation of knowledge production and care delivery, through meaningful learning, with a view to the needs of the population and the operationalization of SUS.[12] In addition to formal processes, these are collective and procedural movements of knowledge exchange that develop the power of knowledge built in/by the work. They occur in the concrete encounters and interactions between the subjects, preferably with pedagogical applicability in the professional and personal territory in which life happens.[11-13]

Given the above, the present study aimed to analyze how the continuous education is part of the actions of the Family Health Extended Centers.

METHOD

A quantitative-qualitative research, where the conceptual frameworks and analysis criteria were the Paideia Method for collective co-management[5] and theoretical contributions for continuous education.[11,12] The study was conducted in the state of Santa Catarina (SC), covering municipalities of the nine health macro regions, by researchers from five universities in southern Brazil, with the participation of the State Health Department (*Secretaria de Estado da Saúde*, SES) and support from the Support Foundation for Research and Innovation of the State.

For the quantitative stage, a descriptive exploratory cross-sectional study was developed, covering 149 (53.8%) municipalities among the 277 that had FHEC implemented during the data collection period, with a total of 1,312 professionals. Sample size calculation considered the significance level being equal to 4.5% ($p < 0.05$), and the confidence interval being equal to or greater than 95%, defining the need for 358 participants.

The collection of quantitative data took place by e-mail and with the help of the SES. A survey type questionnaire prepared by the researchers was sent, presenting the study and the Free and Informed Consent Form (FICF). Upon acceptance of the FICF, a link gave access to the instrument to all FHEC professionals in the State. To rake part in the study it was necessary to be formally working at the FHEC. Professionals who were away

for any reason during the data collection period were excluded. In total, 359 professionals, who work at FHEC in all nine state macro regions of the state, returned to the study. These data were collected between May and June 2017.

The survey consisted of 19 questions, with subdivisions, some closed of the *Likert* type and some open, including sociodemographic and socio-occupational data, questions about the work process and demands for the daily performance of the teams. The instrument obtained a high coefficient of *alpha* of *Cronbach* (α=0.819) and underwent an instrument test with a team of professionals from FHEC Paraná (peer review) to assess consistency and language. In order to analyze data related to continuous education in the daily lives of professionals working at FHEC, the following variables were selected: Age; gender; scholarship; professional category; working time at the FHEC; qualification to work at the FHEC; origin of the qualification; frequency of attendance at team meetings; frequency with which they conduct case studies/discussions.

In addition, the frequency of matrix support was calculated, from a score. Among the survey questions, 14 involved the frequency of accomplishing matrix support, considering an arsenal of actions that contemplate this method, such as: technical assistance and CHE support activities, search and analysis of data in the territory, case discussions with FHS, shared consultations and collective activities/groups. This arrangement allowed a score to be made, in which the most frequent option received five points and the least frequent one point. Thus, the total score could range from 14 to 70 points.

The analytical procedure of quantitative data was performed using descriptive statistics. Data were encoded and entered in the program *Excel,* being tabulated and analyzed using the *Statistical Package for the Social Sciences* (SPSS), version 21.0 program. Variables of this nature were described by measures of central tendency and dispersion: mean, standard deviation, median and observed minimum and maximum value, confidence interval estimate for the population mean based on the number of valid responses. Categorical variables were described by absolute frequencies, proportions, significance level of 0.05 ($p<0.05$), and significant association by testing the residuals adjusted to 5% significance. The outcome variable was continuous education, which was associated with the matrix support frequency score and the variables "acting exclusively in FHEC" and "body that promoted the qualification".

In the qualitative stage, five focus groups were performed,[14] in which FHEC teams took part, involving 43 professionals from five municipalities, belonging to four of the nine Macro regions of the state. At this research stage, the participants were selected for convenience, due to the displacement limitations of the researchers.

The five focus groups lasted an average of two hours, led by an interviewer, a rapporteur (making notes on the profile and sequence of speakers) and supporters (circling the room with the recorders). The interviews were fully recorded and transcribed. To conduct the groups we used a script with seven questions, among which two were related to the study: "Talk about how the FHEC work process takes place," and "Do you feel prepared/qualified for FHEC's work demands?" Data collection was terminated according to the theoretical saturation achieved when homogeneity and repetition in the interviewees' statements were obtained. This phase of the study took place between September and November 2017. Participants' identities were preserved by coding (letter N followed by the sequential focus group number).

The analysis of data from focus groups occurred concurrently with the production of data. Thematic analysis was used, following the moments of pre-analysis, material exploration and data processing.[15] The conceptual framework that guides the organization of FHEC was used as a conceptual framework, with emphasis on the Paideia Method and the theoretical contributions that support CHE. Complementarily, the findings were entered into *Atlas.ti Qualitative Data Analysis & Research Software*, version 8.0. From these *documents* it was possible to select significant sections (material exploration) based on the study objectives, associating them with identifying *codes*, which originated two *code groups (data treatment):* 1) Ministry of Health as a supporter; 2) Dialogic spaces as a CHE strategy.

The Figure 1 allows the visualization of data that emerged from focus groups associated with the identifying *codes*.

The research was submitted and approved by the Human Research Ethics Committee of the University that proposed the study under opinion No. 1,812,835/2016, and respects all ethical precepts and current Brazilian legislative guidelines, and data collection begins only after presentation of the study and acceptance of participants, by signing the FICF.

RESULTS

A total of 359 professionals who worked in 149 of the 295 municipalities of the state took part in the quantitative phase, and of these, 277 had FHEC implemented at the time of data collection. Therefore, the answers totaled 53.8% of the municipalities with implemented FHEC.

The survey revealed that most are women (n=315/88%), the prevalent age range among respondents for both genders was 30 to 39 years old (n=173/50.4%), with a mean of 33.6 years old, standard deviation of 7.6 years old, minimum age of 22 years old and maximum of 59 years old. The *latu sensu* postgraduate degree (n=256/71.5%) was the prevalent level of education and the Doctorate (n=1/0.6%) was the maximum degree. The performance at FHEC between three and four years (n=165/46.1%) stood out, followed by one to two years (n=122/34.1%), and less than one year (n=71/19.8%).

Among the professions recommended by the Ministry of Health (MoH) for the composition of FHEC, 11 stood out, the most frequent being the psychologist (n=96/27%), the physiotherapist (n=65/18.3%) and the nutritionist (n=63/17.7%), and the least frequent were the veterinarian (n=1/0.3%), the occupational therapist (n=2/0.6%) and the sanitarist (n=3/0.8%).

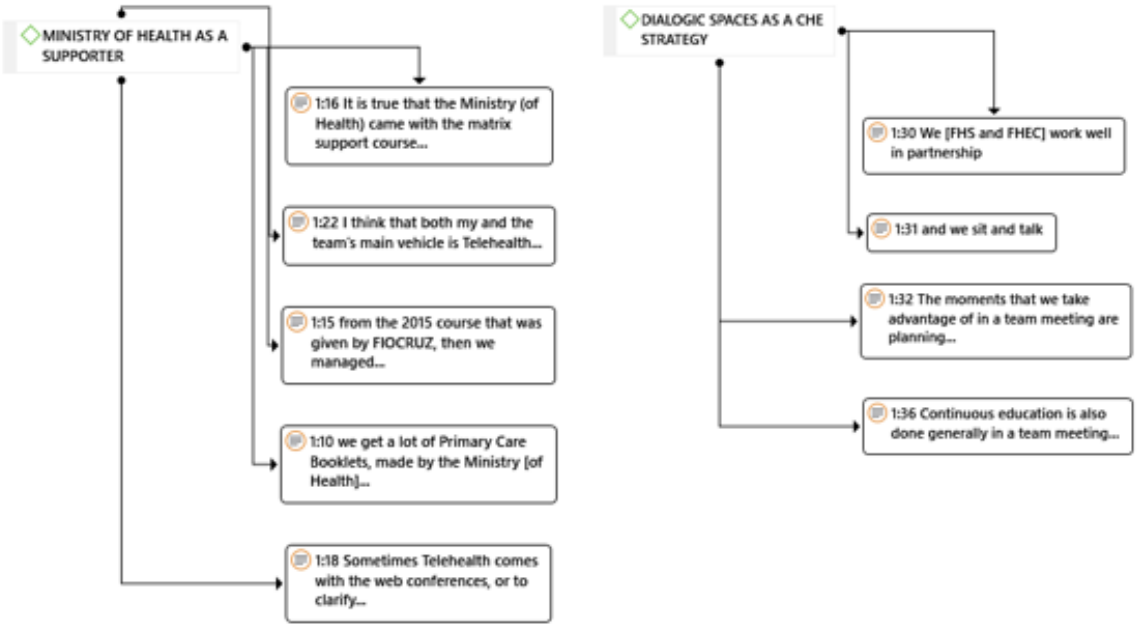

Figure 1 – Data obtained from focus groups with professionals working at FHEC in SC, Brazil, 2017.
Source: Elaborated by the authors with the aid of the *software* Atlas.ti (2018).

The professionals were asked if they received qualifications in order to develop their activities and most of them indicated negatively (Table 1). Among those who received this, the highlight was the MoH, via Telehealth.

The focal groups revealed that, despite the qualifications favoring the performance of FHEC, especially through the access of Telehealth, there are weaknesses, among which, especially, the lack of support from the municipal manager for CHE:

> *Today this is what we have, Telehealth. I don't know if all colleagues use the tool, but when I have doubts, we talk to each other, search the internet or use Telehealth [...] a pharmacist course came out, but we have to run after it, to form a group of 40 pharmacists to be able to win this course and we suffer for the management to support us and let us do it (N1).*

> *[...] we have been looking for alternatives that are offered by the state, sometimes some distance learning, postgraduate [...] (N2).*

> *From the moment we enter the network and receive the registration, and we may be registering; the main vehicle of mine and the team is the Telehealth [...] (N3).*

The study allowed us to identify the performance of technical assistance and CHE support activities developed by the FHEC for the FHS. The frequency of these actions performed "daily" or "up to three times a week" reached 17.4% (n=62), rising to 44.1% (n=157) for the response "up to twice a month".

The dialog spaces, such as team meetings and case studies/discussions emerged as CHE strategies among FHEC professionals and with the FHS, as follows (frequency is described in Table 2):

Table 1 – Qualification and its origin for the performance in the FHEC in a southern state. Brazil, 2017.

Variables	n (%)
Qualification to work at the FHEC	
Yes	178 (49.9)
No	**179 (50.1)**
Total	357 (99.4)
Origin of the qualification	
Universities	46 (25.6)
State (SUS/RET-SUS and SES Technical School Network Schools)	45 (25.1)
Municipality	47 (26.1)
Telehealth	**83 (46.1)**
Total	**178 (100)**

Source: Elaborated by the authors, 2018.

[...] We [CHE and FHEC] work well in partnership [...] sit and talk, sometimes it's more mental health, sometimes it's more of the psychologist's, it's a social situation, it's medicine, we are looking for [...] (N4).

[...] Continuous education, we, usually do, in team meeting [...] Case discussion is at the team meeting, sometimes outside, corridor conversations, but almost always at the meeting, solicitation of support also occurs at the meeting, but cases with higher priority occur in other spaces (N5).

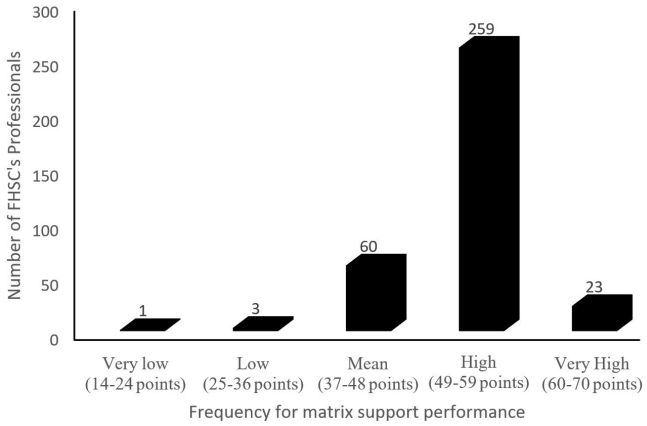

Figure 2 – Sample distribution regarding frequency of matrix support in a southern state. Brazil, 2017.
Source: Elaborated by the authors, 2018

It is noteworthy that the *codes groups* assisted in the analysis that the continuous education is part of the actions of the Centers in two ways, basically: through qualification initiatives offered by the MoH and through opportunities that present themselves as dialogical spaces (such as team meetings, for example).

The matrix support frequency score obtained a mean value of 52.7 points (± 5.6) ranging from 17 to 68 points, demonstrating a mean closer to the upper limit (ranging from 14 to 70 points). Figure 2 shows matriculation as a high-frequency activity and the following statement demonstrates how continuous education contributes to this function:

[...] we didn't work with matrix support at the beginning of the FHEC, then we studied, improved and did some courses, most FHEC professionals took courses, and the agent was adapting and following the logic of matrix support [...] (N2).

It was observed that professionals who work exclusively in FHEC have a higher average for attainment of matrix support and those who had qualifications promoted by the Universities also develop more matrix support (Table 3), regardless of the origin of the qualification (data shown in Table 1).

DISCUSSION

The technical approach, centered on the biomedical paradigm of undergraduate courses and on the lack of continuous education in services, makes it difficult for professionals to understand the complexity of individuals' constitutive and subjective dimensions

Table 2 – Conducting team meetings and case studies/discussions according to time worked at FHEC in a southern state, Brazil, 2018.

Variables	<1 year	1 – 2 years	3 – 4 years	P
	n (%)	n (%)	n (%)	
Team meetings				0.022
Weekly	43 (60.6) *	42 (34.7)	70 (42.7)	
Every 2 weeks	7 (9.9)	21 (17.4)	28 (17.1)	
Monthly	15 (21.1)	48 (39.7) *	44 (26.8)	
Rarely	5 (7.0)	9 (7.4)	17 (10.4)	
Never	1 (1.4)	1 (0.8)	5 (3.0)	
Case Studies/Discussions				0.004
Daily	15 (21.4) *	5 (4.1)	16 (9.7)	
Up to 3 times a week	26 (37.1)	34 (28.1)	51 (30.9)	
Up to twice a month	18 (25.7)	64 (52.9) *	70 (42.4)	
Rarely	9 (12.9)	16 (13.2)	25 (15.2)	
Never	2 (2.9)	2 (1.7)	3 (1.8)	

* Statistically significant association by the residuals test adjusted to 5% significance
Source: Elaborated by the authors, 2018

Table 3 – Significant associations with matrix support achievement score in a southern state. Brazil, 2018.

Variables	Matrix support score	P
	Mean ± SD	
At the Department of Health you work exclusively at FHEC		<0.001
Yes	54.2 ± 4.6	
No	50.8 ± 6.1	
Qualification promoted at FHEC by which body?		0.024
Universities	54.1 ± 3.4	
Marital	53.5 ± 4.4	
Municipality	53.3 ± 4.9	
Telehealth	52.7 ± 4.5	

Source: Elaborated by the authors, 2018

of health care.[16] These barriers, converging with research,[17,18] were noticeable in the statistics and the professionals' statements, when analyzing the performance of the FHEC in the investigated context. One adds the uniqueness of the work process of the teams of these Centers and the relative inconsistency of the ministerial guidelines in guiding them. They are located between PHC and Secondary Care (SC), are not directly accessible to users, are coordinated by PHC (as every SC should be), and are formed by non-generalist professionals, but induced not to act as a specialized reference - by normative belong to PHC and identify with it as to the common discursive prioritization of prevention/promotion.[6]

According to ministerial guidelines, the work of FHEC should prioritize: a) shared clinical actions for an interdisciplinary intervention, with emphasis on case study and discussion; b) FHEC professional's specific knowledge core interventions with users and/or families, based on an *a priori* negotiation with FHS professionals responsible for the case, so that individualized care occurs only in necessary situations; and c) shared actions in the territories, developed in articulation with the FHS and, preferably, with intersectoral approaches.[4] To make this work process effective, tools such as matrix support, the expanded clinic, the unique therapeutic project, the health project in the territory and the support agreement are used.

Although in the state at issue, most FHEC professionals are trained at the postgraduate level, in order to equip themselves for such assignments, they seek support in CHE offerings, considering the scope of actions that can be embraced by such a concept. CHE assumptions are guided by the pursuit of meaningful learning, which demands the involvement of all involved through issues that are dear to them in the work process. Such movements imply the re-signification of everyday life, making it provocative of learning. This demands reflexive, critical and purposeful actions and generates practices that value the emancipation of the subjects and their protagonism.[12]

In this sense, Telehealth, as an Information and Communication Technology (ICT), has been a resource widely accessed by FHEC professionals, as well as other ministerial devices proposed by the state. Consistent with other research studies, the data reveal the importance of in-service learning through distance communication.[19] The foundation for the structuring and provision of services by the Telehealth is the articulation and intersectoral work that involves teaching and service, supported by the CHE fundamentals to respond to the real needs of supported professionals and to strengthen PHC and the SUS.[20]

Team meetings are configured as a space for dialogue among FHEC professionals, and of these with the FHS. These are pedagogical moments, case discussion and information exchange, converging with the CHE. This dialogical organizational arrangement is expressed through collaborative interactions between professionals who are resolving issues related to management and care in their daily lives. In line with such a proposition, the Paideia Method corroborates the libertarian traditions of education and politics by suggesting that "in the wheel" problems are solved and that one generally does not get out of the wheel (of co-management) as it entered.[21] In this sense, training the professionals demands technical, ethical-political and relational competences, plus the sensitivity to think about life issues as well. The continuous formation of subjects under tension of different forces, with different durations, in constant movement and with possibility of transformation is proposed.[5,15] The Paideia Method aligns the theoretical and practical constructs for the fields of Collective Health, clinic, politics, administration, psychoanalysis, institutional analysis and pedagogy.[22] With such contours, the proposed matrix support of FHEC makes it possible to "place [...] knowledge and competence (field and core, as appropriate) at the service of the users (selected or referenced) and the FHS, to empower it, increase its resolve and provide Continuous Health Education (CHE)".[23:7]

At the core of this proposal, the support is born together with institutional experiences aimed at transforming daily life, based on the distribution of power, in order to overcome hierarchical models. More recently, discussions about interprofessionality also refer to work aimed at strengthening health systems, reducing suffering at work, through a participatory and, above all, collaborative organization between professionals with different nuclei of knowledge, which means the problematization of power relations, turning moments of conflict into pedagogical strategies, confrontation of ideas and negotiation.[24]

A study conducted with managers of Brazilian health institutions points to the prevalence of a culture in which there are no criteria to manage and that management is learned in practice.[25] As an alternative, support is proposed as a democratization device, based on the participation of managers, workers and users, so

that the management functions are exercised among subjects, with different levels of knowledge and power, who know how to cope with affections through covenants, alterity, and conflict mediation.[12,26] The research shows that matrix support is part of the teams' daily life, especially when there are CHE movements that contribute to its realization. Although few studies corroborate this finding, recent research on matrix support supports this activity as strengthening a broader look at the community rather than the logic of meeting the demand alone.[27]

Continuous education emerges in the context of FHEC as part of the daily routine of its work process and, thus, favoring the interprofessional dimension inherent to the performance of the teams. This perspective shares goals, develops team identity[28] and seeks comprehensive care, considering the complex and dynamic nature of the health needs of communities as co-producers of health. Consistent with recent research in the area, the study reveals that the success of FHEC depends on the relationship established between its members and the FHS professionals and that there are elements that may imply in such relationships, such as training and professional experience, and dynamics in the work.[29,30] No studies were found or we hypothesized fasts that justify the difference between genders and its relation with accomplishing the matrix support. Its relationship with the exclusive activity at the FHEC can be interpreted, perhaps as a greater professionalism and mastery of the work process by those who are full time dedicated to FHEC.

The support of Universities for CHE called attention, which demonstrates the possibility of understanding continuous education from the perspective of teaching-service integration. This rapprochement between the academic world and the world of work can be a strategy for changing pre-established relationships, triggering action-reflection-action movements.[31] Other studies encourage the expansion of spaces for dialogue between the University, services, community leaders, bringing together the different actors, from different backgrounds and their points of view, towards the reorganization of health care.[12,32]

As a limitation of this research, we highlight the difficulty for bringing together professionals from all regions of the state, as well as analyzing the different social contexts in which the teams work. This aspect points to the need for research that explores the theme, in order to contemplate other aspects not addressed.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

Educational actions that approach CHE, aimed at FHEC professionals and those in support for the FH teams occur during the matrix support practices reported by most research participants and contribute for the FHEC teams to perform their activities. This seems to be significant when analyzing the matrix support achievement score. The professionals demonstrate an initiative to strengthen themselves in terms of training, either through postgraduate studies or search for other CHE devices, highlighting Telehealth and integration with Universities, reinforcing their potential in the workplace. However, longitudinal studies could better explore such associations and may better understand aspects that may influence teaching-service integration.

The qualification of FHEC professionals for the performance of their practices remains a problem. In this sense, management support for access to different educational possibilities is fundamental as a transforming device of their work, in order to enhance the SUS service network.

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AUTHORS' CONTRIBUTIONS

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