ACCESS VERSUS CARE CONTINUITY IN HEALTH NETWORK SERVICES: EXPERIENCING POSSIBILITIES AND CONTRADICTIONS

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ABSTRACT

Objective: to understand the meaning of access to health services with a view to care continuity in the care network for users and professionals.
Method: qualitative research, which used the methodological steps of Grounded Theory, carried out from November 2015 to April 2017. The theoretical sampling was obtained with 33 participants from a hospital institution and a Family Health Strategy unit. The participants were organized into three sample groups according to circular and continuous orientation of data collection and Grounded Theory analysis. The analysis was conducted according to the guidelines of the methodological framework which was composed of the open, axial and integrative coding phases.
Results: four central concepts emerged from the data that demonstrate how participants experience access with a view to care continuity. These range from the first contact with the health network, through limitations and alternatives found to achieve perspectives to the care continuity in health actions and services.
Conclusion: possibilities and contradictions were identified in the experience of care, with regard to access to health services and actions for the continuity of care, understanding them as feasible in health services, but divergent from the ideal advocated by the literature on the theme, as well as by the norms and prerogatives in force in the Unified Health System.

DESCRIPTORS: Continuity of patient care. Comprehensive health care. Data-based theory. Symbolic interactionism. Nursing care.

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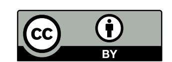

ACESSO VERSUS CONTINUIDADE DO CUIDADO NOS SERVIÇOS DA REDE DE SAÚDE: VIVENCIANDO POSSIBILIDADES E CONTRADIÇÕES

RESUMO

Objetivo: compreender o significado do acesso aos serviços de saúde com vistas à continuidade do cuidado na rede de atenção para usuários e profissionais.
Método: pesquisa qualitativa, que utilizou os passos metodológicos da Teoria Fundamentada nos Dados, realizada no período de novembro de 2015 a abril de 2017. Obteve-se a amostragem teórica com 33 participantes provenientes de uma instituição hospitalar e uma unidade Estratégia Saúde da Família. Os participantes foram organizados em três grupos amostrais conforme orientação circular e contínua da coleta e análise dos dados em Teoria Fundamentada nos Dados. A análise foi conduzida segundo as orientações do referencial metodológico utilizado, composto pelas fases de codificação aberta, axial e integrativa.
Resultados: emergiram, dos dados, quatro conceitos centrais que demonstram como os participantes vivenciam o acesso com vistas à continuidade do cuidado. Estes vão desde o primeiro contato com a rede de saúde, passando por limitações e alternativas encontradas para alcançar perspectivas à continuidade do cuidado nas ações e serviços de saúde.
Conclusão: identificaram-se possibilidades e contradições na vivência do cuidado, no que concerne ao acesso aos serviços e ações em saúde para a continuidade do cuidado, compreendendo-as como exequíveis nos serviços de saúde, porém, divergentes do ideal preconizado pela literatura acerca da temática, bem como pelas normativas e prerrogativas vigentes no Sistema Único de Saúde.

DESCRITORES: Continuidade da assistência ao paciente. Assistência integral à saúde. Teoria fundamentada nos dados. Interacionismo simbólico. Cuidados de enfermagem.

ACCESO VERSUS CONTINUIDAD DE LA ATENCIÓN EN LOS SERVICIOS DE LA RED DE SALUD: EXPERIMENTANDO POSIBILIDADES Y CONTRADICCIONES

RESUMEN

Objetivo: comprender el significado del acceso a los servicios de salud con vistas a la atención continua en la red asistencial para usuarios y profesionales.
Método: investigación cualitativa, que utilizó los pasos metodológicos de la Teoría Fundamentada en datos, realizada de noviembre de 2015 a abril de 2017. La muestra teórica se obtuvo con 33 participantes de un hospital y una unidad de Estrategia de Salud de la Familia. Los participantes se organizaron en tres grupos de muestra de acuerdo con una guía circular y continua para la recopilación y el análisis de datos en Grounded Theory. El análisis se realizó de acuerdo con los lineamientos del marco metodológico utilizado, compuesto por las fases de codificación abierta, axial e integrativa.
Resultados: de los datos surgieron cuatro conceptos centrales que demuestran cómo los participantes experimentan el acceso con vistas a la continuidad de la atención. Estos van desde el primer contacto con la red de salud, pasando por las limitaciones y alternativas encontradas para lograr perspectivas de continuidad asistencial en acciones y servicios de salud.
Conclusión: se identificaron posibilidades y contradicciones en la experiencia de la atención, en cuanto al acceso a los servicios de salud y acciones para la continuidad de la atención, entendiéndose como factibles en los servicios de salud, sin embargo, divergiendo del ideal recomendado por la literatura sobre el tema, así como las normas y prerrogativas vigentes en el Sistema Único de Salud.

DESCRIPTORES: Continuidad de la atención al paciente. Atención integral de salud. Teoría fundamentada en datos. Interaccionismo simbólico. Cuidado de enfermería.

INTRODUCTION

Care continuity (CC) is an expression that is related to the quality of care received over time. Thus, the health characteristics that the user needs as or the health services of primary care and/or in one-off episodes, such as a hospitalization.[1]

Thus, this concept, essential for clinically qualified and safe care, should permeate health practices in all points of the system. The better the performance, or the higher the degree of care connectivity, the better the quality of care, the health outcomes for the user and the cost-effectiveness benefits for the population and for the health system in general.[2]

As it is a complex term, with different definitions in the scientific literature, CC has been described as a concept that involves the perspective of both professionals and users. However, these individuals tend to value different aspects of the theme.[3] For professionals, the most relevant questions concern the management of information for care, as well as the structure and work process, interactions and professional connections for care and the development of an effective shared care plan.[4–5] Users often focus their concerns on issues involving access to services and the support offered.[3]

It is believed that the discussions about CC should also include the aspects that evolve the resolution of health problems in a timely manner for the user.[3] Thus, it is necessary to consider the issues related to access to health services, not only as a gateway or as the first contact with health care, but mainly, how this access allows those who use and need care services and actions to resolve their demands.

It is possible to find other studies in the literature that highlight the difficulties regarding access to health actions and services and, thus, negatively effecting CC. These difficulties encompass a very broad universe, ranging from geographical issues to the insufficient supply of services affected by organizational, economic, social, cultural, religious, epidemiological and communication aspects between teams of the same or different services.[6–7]

In view of the above, this article includes access to CC, both as one that ensures the first contact to care in a health service, as well as a guarantee of the provision of the necessary care, coherent and timely to the health demand presented. Thus, it was decided to use the term 'access to care' to refer to its approach more broadly.

Considering the importance of the theme to CC, this article aimed to understand the meaning of access to health services regarding care continuity in the care network for users and health professionals.

METHOD

This is a qualitative interpretative study based on the steps of the Grounded Theory (GT), for data collection and analysis,[8] resulting from the elaboration of a doctoral thesis that sought to understand the experience of care by users and professionals in the health care network from the perspective of continuity.

This study was carried out in a university hospital in a Family Health Strategy (ESF) unit of the municipal health care network, both located in the city of Curitiba/Paraná.

It was determined, respecting the methodological precepts of GT were respected, the sampling by theoretical saturation of the data and sensitivity of the researcher, totaling 33 participants, 22 health professionals of different categories, six network users and five family members. Subsequently, the participants were divided into three groups, the first being intentionally composed of 13 hospital care professionals; the second, by nine primary care professionals and the third, with five family members and six users. The third group was composed of family members and users due to the limitations of the disease, which often incapacitated them from answering the interview questions.

The inclusion criteria for professionals were: being a health professional in the SUS-Curitiba network; included in hospital and primary care institutions with characteristics of care for users with chronic health conditions and linked to the local network. The inclusion criteria for users and family members were: SUS-Curitiba network users; belonging to hospital and primary care; with chronic health conditions and who were linked to the local network.

Data were collected through audio-recorded interviews, with the help of a semi-structured questionnaire, from November 2015 to April 2017. The questions that guide the interviews focused on the experience of care by professionals, users and family members from the perspective of care continuity throughout their journey through the health network. Each interview was transcribed and analyzed in full, totaling an average duration of 60 to 90 minutes each.

Open, axial and integrative coding were used as an analysis technique, as proposed by the methodological framework, in addition to the theoretical support of Symbolic Interactionism.[8] After data analysis, three themes emerged: access to health care and services; information and communication of information; relationships and interrelationships between professionals and users for care from the perspective of continuity. However, in this article, only the first theme was studied.

RESULTS

From the data analysis, a total of 5,823 codes emerged, divided into 416 components, 38 premises and 11 concepts. From the intersection of the data between the three sample groups,3,265 codes, 186 components and 12 premises corresponded to the four concepts presented (Chart 1).

The development and interrelationship of the concepts that explain the participants' experience about access in relation to CC occurred through the analytical tool[8] called "Paradigm", which determines the conditions, actions-interactions and consequences of phenomena. It is noteworthy that the relationships between conditions, subsequent action-interaction and consequences rarely follow a linear path, being demonstrated, in this way, in Chart 1 as a didactic form of presentation of the results.

Chart 1 – Theoretical code, concepts and premises.

Theoretical Code	Concepts	Premises
Experiencing possibilities and contradictions in the context of access to care of network services	Initiating approach to care.	• Ensuring initial access to the service. • The limitations of care continuity at the primary level are addressed. • Feelings emerge from the limitations experienced.
	Using other health care points.	• Reporting the motivations to access the other services of the network. • Encountering barriers to access to specialized/hospital care services. • Recognizing the influence of the physical and organizational structure of the services to ensure access to other points of attention.
	Using different care access flows.	• Prioritizing emergency situations. • Seeking access to care through emergency and emergency services. • Using their own support to achieve care.
	Finding the perspectives for the follow-up of care to the user on the network.	• Continuing care in specialized/hospital care services. • Linking the user in Primary Health Care (PHC) as a guarantee of access to health materials and devices. • Identifying the PHC service as a gateway to other health system configurations.

Living possibilities and contradictions in the context of access to care by network services

The context of care in the care network is characterized by possibilities and contradictions, in the relationship of demand and supply, in which access to primary care services is real. However, the probability of guaranteeing resolutive care, for which care was sought, is not always concrete in this first contact, and it is necessary to resort to other points of care in the networking order to reach it. Seeking care at different points of care does not mean having immediate responses to health problems, since admission to these services is marked by obstacles that make it difficult for it to occur at the opportune time.

These interactions lead to a perspective that care in the network, although delayed by the difficulty of access, is more likely to be resolved in the scope of care of services with greater technological complexities, such as specialized/hospital care. Thus, care occurs until the “final solution” of health problems, that is, the first access to care follow-up in situations of post-specialized consultation or post-hospitalization. There are situations in which home care services are used, however, the connection continues to be as an outpatient. In these circumstances, PHC is identified mainly as responsible for the supply of health materials and devices and, rarely, as a follow-up point of counterflow care.

Thus, with regard to the follow-up of counterflow care, it is emphasized that this is possible to the user, in some way, within the network, however, it differs from the recommended ideal (Figure 1).

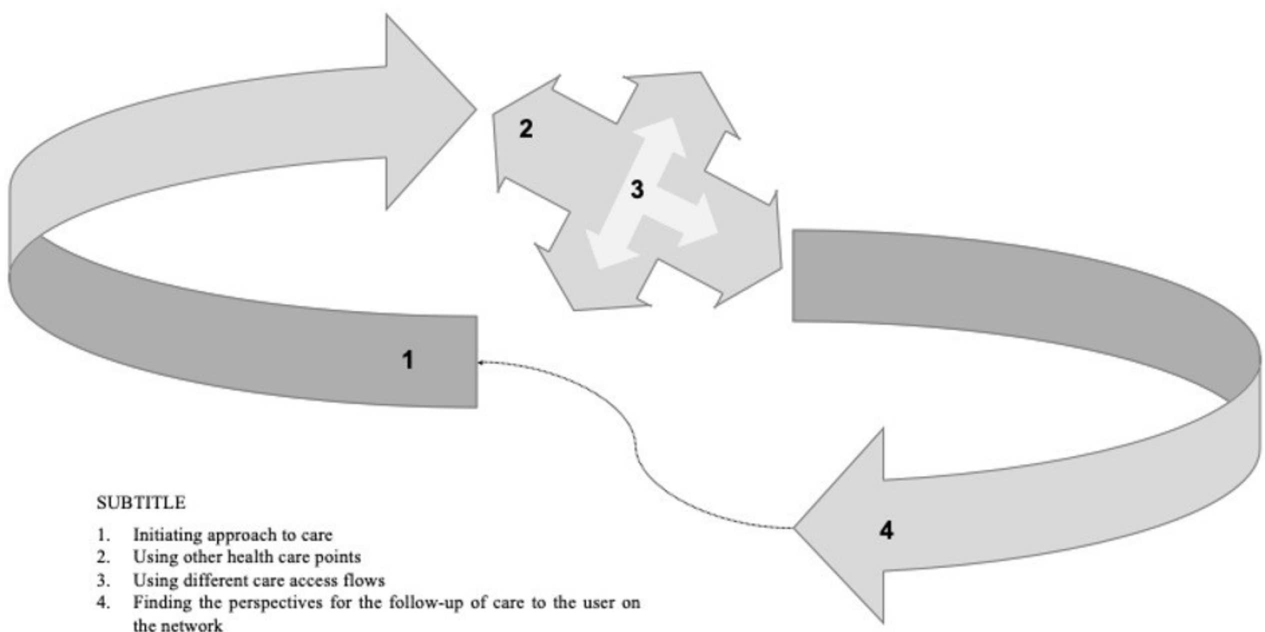

Figure 1 – Living possibilities and contradictions in the context of care access for network services.

Figure 1 demonstrates how this experience is given significance by the participants in relation to CC. In summary, the diagram seeks to represent the search for a continuous ‘link’ for care in the network, however, it presents constant interruptions and fragmentations that hinder this result. The

starting point, shown by the number 1, in the image, represents the beginning of access to network services and concerns primary care units. At that moment, there is a guarantee of access to health services, but not necessarily to the care actions that users need to solve their health problems.

Thus, it is necessary to resort to the other points of care in the network (2) and use different access flows (3) to reach/guarantee the resolutive access to care. It is emphasized that these actions are common to all research participants, professionals and users. To the former because they seek to guarantee access to care in a resolutive way to the user in various ways and strategies, and the latter goes through the different points of the network in which he believes in solving his health problem. Thus, care understood as continuous is that which is achieved in the spaces where the "solution" of the health problem occurred. The care continuity in the counter-reference, on the other hand, is meant in a way that differs from the ideal recommended by the literature and related regulations. However, it cannot be said that it is totally nonexistent or insufficient, since there are prospects for its follow-up in the health network (4).

Therefore, it is justified that the structure and process for 'access to care' in the care network are, at the same time, possible and contradictory, with regard to the conditions, actions-interactions and consequences to CC. The processes that underlie how these concepts occur are presented in more detail below.

Concept: initiating approach to care

The approach to the health care network is represented by the certainty of initial access to services, but little significant in ensuring access to resolutive care. This fact is justified by the difficulties found within PHC in ensuring care for the health demands that motivated the care. These are recognized as limitations regarding the use of system resources, resulting in low professional autonomy to solve health problems without having to access other points in the care network.

The formation of the system with these characteristics causes limiting feelings to participants who wish to conduct care, but face obstacles that hinder this sequence. The experience of these interactions gives PHC low problem-solving capacity for health needs.

Concept: using other points of health care

The search for the services of the other points of health care occurs due to the need to ensure the flow of care in a resolutive manner. It is motivated in two different situations: in the first, it refers to limitations on autonomy to conduct care; the second concerns the restriction of the professional's scientific and technical knowledge to solve existing health problems, considering that the user's health demands exceed their know-how, that is, their skills have already been mobilized.

However, the relationship between the need for health and the guarantee of access to services with more advanced technological densities differs from the ideal, resulting in delays in the follow-up care, with possible consequences for the user. Despite this, it seeks to understand the limitations of access, recognizing the influences that the physical and organizational structure of the services has on the care and regulation of vacancies. These conditions and interactions imply the meaning that care from specialized/hospital care services, although difficult to reach, is the most likely means of solving health problems, regardless of the outcomes of this care for the user.

Concept: using different flows of access to care

The difficulties experienced related to the guarantee of access to resolutive care, cause professionals and users to seek alternatives to cope, being asked to prioritize care for more critical situations. However, this alternative does not always ensure care in the necessary time.

These conditions and interactions motivate the search, usually mistaken, for care in emergency services, as well as the motivation for seeking resources from the private sector as a means of guaranteeing the resolution for the necessary care.

Concept: finding perspectives for the follow-up user care in the network

Naturally, there is a difficulty in recognizing PHC as responsible for coordinating care in the health care network. This meaning is partly due to the limitations experienced in the flow of care, but mainly from the experience of gaps in the integration of care with this level of care in the counterflow.

These, in turn, result from the symbolization of specialized/hospital care services as places where care occurs from "beginning to end". Primary care is generally recognized in the counterflow as a place to guarantee access to materials and devices for the performance of care by the user and family and not by health professionals in this scope of care. These conditions and interactions contribute to the characterization of PHC as a gateway to other points of care in the network.

DISCUSSION

According to the participants' experience, CC in the health services of the local care network is possible, however, there are weaknesses already perceived in the first contact with the services, having a direct relationship with the aspects related to access. However, the difficulties presented are not related to the guarantee of initial access to care, but rather to the resolutive and timely access to the care necessary to the existing health demand.

It is believed that the CC, experienced over time by people who seek health services, should be considered, from the first contact with the establishments, permeating all the path that the user will need, until their return to health monitoring.[9]

It is worth noting that CC manifests itself differently among health system services[10]. In PHC, it is considered an essential element for care,[2,11] since this point of the network is considered responsible for the centrality of communication and coordination of care.[12] In this context, it refers to a continuous care relationship and strongly involves the issues of bonding and trust between user and professional.[2]

In the hospital environment, CC takes a subsidiary place and gives rise to concepts that involve the degree of consistency and coordination between different specialties and professional categories. However, its quality and effectiveness are also related to the ability to communicate with PHC,[1] since it is in this space that the user will continue their health monitoring upon discharge. Therefore, the ability to communicate in both directions is considered: reference and counter-reference.

Specifically with regard to access, CC and health services, the PHC context represents the place where users have their first contact with care and, conceptually, should be responsible for its coordination and continuity over time.[12–14]

However, although it is considered responsible for non-specialized outpatient care, with a resolution capacity of up to 85% of the community's demands,[12,15] difficulties in fulfilling this role are demonstrated.[6,16] These refer to the organizational and bureaucratic aspects related to the availability of fundamental exams and services, which limit their power to give effective and timely answers to users.[17–18] Thus, the access guaranteed by the first contact in PHC is not synonymous with guaranteeing resolutive care to the needs presented, which can be evidenced in the results of this research.

Other studies reiterate weaknesses in CC with regard to the availability of resources and network bureaucracies. These, instead of facilitating the work process, often hinder the effectiveness of actions.[19–20] Thus, access to care becomes compromised, since it becomes necessary to resort to other flows as an alternative to ensure effective and timely responses to existing health demands.

A study conducted in 2017 in the State of São Paulo found results similar to this research. In the study in question, the authors analyzed, from the perspective of managers and users, the coordination of care by PHC, and the difficulty of this point of care, both in constituting the main gateway to the system and in offering a problem-control health care was evident. As a justification for the users' experience, the managers reproduced arguments provided for in the national guidelines for the organization and bureaucracy of network flows.[18]

However, although it is considered as responsible for a non-specialized outpatient care, with a resolution capacity of up to 85% of the community's demands,[12,15] difficulties in fulfilling this role are presented.[6,16] However, the fundamental conceptions of this point of care should be considered as responsible for offering low technological density care.[15] Thus, it is emphasized that not all health demands, identified as unresolved, are, in fact, sensitive to primary care.

A study that evaluated the relationship of access and resolution in child health care in PHC observed that the majority of prioritized care for medical consultations occurred in acute situations of disease,[21] corroborating this research, which showed that the dimensioning of vacancies for medical consultation was also performed under the criterion of prioritization for acute cases.

With this, the predominance of the search for services centered on curative actions is perceived, both by users and professionals. It is noteworthy that, in general, the low resolutive power of PHC contributes to the insufficient recognition of this point in the network as a source of trust for care continuity,[22] including prevention and health promotion actions. These situations contribute to congestion from other points of the network, such as emergency services, specialized outpatient and hospital care, restricting access for users who need these services.[17,23]

Authors[24] investigated the access and quality of health services in 100 cities distributed in 23 states of the five geopolitical regions of Brazil and found that the lack of access to services was more prevalent in hospital establishments, followed by emergency care services and home care.

These findings converge and differ, in part, with the experience of the participants of this study. They converge on difficulties in accessing hospital services, but differ on access to emergency facilities. These were identified as a form of deviation from the first contact in the network, as an alternative for access to faster and solutions to health care network users.

Another finding in the research conducted, which was not reported in the research,[24] refers to the limitations of access to specialized outpatient care, which is considered one of the bottlenecks of the SUS,[16–17] since its greater fragility is related to the hegemony of the curative health model, the low resolution of PHC and the dimensioning and organization of the provision of services.[24]

Conceptually, the use of services of greater technological complexity should meet the logic of providing support for situations of greater clinical severity and/or diagnostic difficulty and, therefore, assist PHC in promoting more effective care, with specialized actions to those who need them.[16,25] However, in this study, it was possible to identify that the demand for access to these services did not always follow this logic, being referred to by primary care professionals as necessary to act in situations in which they were scientifically capable of solving, but without autonomy to use therapeutic resources and diagnostic support.

A counterpoint should be made about the difficulties of access to specialized care, drawing attention to the insufficient practices of health care in chronic conditions in which meetings with PHC professionals are usually punctual and cases of acute disease.[6,13,26] Frequent meetings with the same

health team over time are considered valuable for care continuity, since they can strengthen the bond of trust between professional and users, with consequent mutual cooperation for care.[5,27–28]

These meetings, described in the literature as relational continuity, are considered one of the central characteristics of PHC.[27–28] They favor the development of interpersonal relationships, improve treatment adherence, promote improved preventive care, contribute to the reduction of hospital admission rates and the need to use emergency services, and improve the results in the safety of user care.[28–29]

In this research, this type of continuity was not identified with regard to PHC, leaving this relationship of trust with a professional or identified team restricted to specialized/hospital care services. Thus, for the participants, care is "continued" in these establishments from the moment of access to the resolution of their problems.

Equally, PHC has not shown any initiative, in its actions, to favor the construction of a unique and connected therapeutic project with the other services of the network, since they are not responsible for user care, when identifying that they are being cared for by a reference service.[19]

In this sense, efforts must be made to assume its role in the Health Care Network (HCN) and, thus, contribute to reducing demands on other health care points.[13,17,19,23] It is highlighted that such efforts are also related to government actions that aim to increase PHC's resoluteness power,[2,6,15] investing in training for these services and professionals in order to optimize care and referral flows.

Finally, it is emphasized that the research presented some limitations related to the participants and the study site. Regarding the participants, it is first highlighted that it did not involve managers. With this, the experience of care from the perspective of continuity presents the gap of those who organize and operationalize the flows in the network.

Despite the location of the study, specifically related to access to the health network for CC, the selected PHC service had a different characteristic in which care was prioritized according to the demand of the disease's aggravation, thus emphasizing the experience of the limiting conditions of access to resolutive care in the network flow.

Such limitations do not invalidate the results found, since this is the reality of the experience of this group of participants who sought to demonstrate as proposed by the methodological framework used.

CONCLUSION

Access to health services is directly related to care continuity issues. However, it does not only concern the guarantee of service in a given service, but also the resolution of the actions for the demands presented.

In this respect, they also influence issues related to physical infrastructure and human resources, autonomy in the use of network resources by services, technical-scientific knowledge, the responsibility of health professionals, the ability to communicate and understand relevant information in health and the correct use of health care points by the users.

In general, the literature already discusses the strengthening of PHC and the investment in the professional training in this field, the specific training for the performance in primary care, as well as the greater power of autonomy for the resolution of health problems in these spaces. This research shows, in addition to these aspects already discussed in the current literature, the sensitization of health professionals of the network as a whole to the discussions about the concept and importance of care continuity in the three spheres: users, professionals and the health system.

Thus, the health agents themselves will be able to interact symbolically with each other and with the users of the system and, thus, incorporate the culture of care continuity in addition to curative

actions, but also as a desirable practice for adequate prevention and health promotion. This is an important step to combat the so-called 'crisis' of access to care in health services and contribute to the effectiveness of care continuity in the health network.

REFERENCES

1. Gulliford M, Naithani S, Morgan M. What is Continuity of care? J Health Serv Res Policy [Internet]. 2006 [cited 2017 Jul 26];11(4):248-50. Available from: https://doi.org/10.1258/135581906778476490
2. Palmer W, Hemmings N, Rosen R, Keeble E, Williams S, Imison C. Improving access and continuity in general practice: Practical and policy lessons. Report Nuffield Trust [Internet]. 2018 [cited 2019 June 6]; Available from: https://www.nuffieldtrust.org.uk/files/2018-11/improving-access-and-continuity-in-general-practice-summary-final.pdf
3. Weaver N, Coffey M, Hewitt J. Concepts, models and measurement of continuity of care in mental health services: A systematic appraisal of the literature. J Psychiatr Ment Health Nurs [Internet] .2017 [cited 2016 Aug 04];24(6):431-50. Available from m: http://dx.doi.org/10.1111/jpm.12387
4. Reid RJ, Haggerty J, Mckendry R. Defusing the confusion: concepts and measures of continuity of health care. Canadian Health Services Research Foundation. [Internet]. 2002 [cited 2016 Aug 02]. Available from: http://www.cfhi-fcass.ca/Migrated/PDF/ResearchReports/CommissionedResearch/cr_contcare_e.pdf
5. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. BMJ [Internet]. 2003 [cited 2017 Apr 21];327:1219-21. Available from: https://doi.org/10.1136/bmj.327.7425.1219
6. Paula CC de, Silva CB da, Nazário EG, Ferreira T, Schimith MD, Padoin SM de M. Fatores que interfere in the longitudinality attribute of primary health care: integrative review. Rev Eletr Enf [Internet]. 2015 [cited 2019 Jun 5];17(4):3639. Available from: https://www.fen.ufg.br/revista/v17/n4/pdf/v17n4a20.pdf
7. Gibson O, Lisy K, Davy C, Aromataris E, Kite E, Lockwood C, et al. Enablers and barriers to the implementation of primary health care interventions for Indigenous people with chronic diseases: a systematic review. Implement Sci [Internet]. 2015 [cited 2017 May 18];10:71. Available from: https://doi.org/10.1186/s13012-015-0261-x
8. Corbin JM, Strauss A. Basics of qualitive research: Techniques and Procedures for Developing Grounded Theory. 4th ed. Thousand Oaks, CA (US): SAGE; 2015.
9. Zanello E, Calugi S, Rucci P, Pieri G, Vandini S, Faldella G, et al. Continuity of care in children with special healthcare needs: a qualitative study of family's perspectives. Ital J Pediatr [Internet]. 2015 [cited 2016 Aug 06];41:7. Available from: https://doi.org/10.1186/s13052-015-0114-x
10. WHO. Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services [Internet]. 2018 [cited 2019 June 07]. Available from: https://apps.who.int/iris/bitstream/handle/10665/274628/9789241514033-eng.pdf?ua=1
11. Irwin KA, Agius M. How does continuity of care affect quality of care in primary healthcare? Psychiatria Danubina [Internet]. 2017 [cited 2017 June 07];29(Suppl 3):452-6. Available from: https://pdfs.semanticscholar.org/f1ca/7ed394a9645b8bf180209660a7a9522fec20.pdf
12. Oliveira AFF, Araújo FLSM, Garcia PT. Health care networks: emergency care network within the scope of the Unified Health System. [cited 2019 June 07] São Luis, MA (BR): EDUFMA; 2018. Available from: http://www.unasus.ufma.br/site/files/livros_isbn/isbn_redes05.pdf

13. Duarte ED, Silva KL, Tavares TS, Nishimoto CLJ, Silva PM, de Sena RR. Care of children with a chronic condition in primary care: challenges to the healthcare model. Texto Contexto Enferm [Internet]. 2015 [cited 2016 Feb 19];24(4):1009-17. Available from: https://doi.org/10.1590/0104-0707201500003040014

14. Ye T, Sun X, Tang W, Miao Y, Zhang Y, Zhang L. Effect of continuity of care on health-related quality of life in adult patients with hypertension: a cohort study in china. BMC Health Serv Res [Internet]. 2016 [cited 2016 Sept 16];16(1):674. Available from: https://doi.org/10.1186/s12913-016-1673-2

15. Gonçalves MR, Umpierre RN, D'Avila OP, Heinzelmann R, Trevisan L, Harzheim E, eds. Challenges of Primary Health Care in Brazil. [cited 2019 June 01]; Porto Alegre, RS (BR): UFRGS; 2017.

16. Tesser CD, Poli Neto P. Specialized outpatient care in the Unified Health System: to overcome a void. Science Collective Health [Internet]. 2017 [cited 2017 Nov 04];22(3):941-51. Available from: https://doi.org/10.1590/1413-81232017223.18842016

17. Belluci JA Junior, Matsuda LM, Marcon SS. Analysis of the emergency hospital patient flow: a case study. Rev Eletr Enf [Internet]. 2015 [cited 2019 June 8];17(1):108-16. Available from: https://doi.org/10.5216/ree.v17i1.23823

18. Bousquat A, Giovanella L, Campos EMS, Almeida PF, Martins CL, Mota PHDS, et al. Primary health care and the coordination of care in health regions: managers' and users' perspective. Ciênc Saúde Coletiva [Internet]. 2017 [cited 2017 Oct 18];22(4):1141-54. Available from: https://doi.org/10.1590/1413-81232017224.28632016

19. Nóbrega VM, Silva MEA, Fernandes LTB, Viera CS, Reichert APS, Collet N. Chronic disease in childhood and adolescence: continuity of care in the Health Care Network. Rev Esc Enferm USP [Internet]. 2017 [cited 2017 Nov 5];51:e03226. Available from: https://doi.org/10.1590/s1980-220x2016042503226

20. Pires MRGM, Gottems LBD, Vasconcelos JE Filho, Silva KL, Gamarski R. Sistema de informação para a gestão do cuidado no rede de atenção domiciliar (si gescad): subsidy to coordination and continuity of care in the sus. Science and Public Health [Internet]. 2015 [cited 2019 June 5];20(6):1805-14. Available from: https://www.scielosp.org/pdf/csc/2015.v20n6/1805-1814/pt

21. Finkler AL, Viera CS, Tacla MTGM, Toso BRGO. Access and difficulty in the resolution of child care in primary health care. Acta Paul Enferm [Internet]. 2014 [cited 2016 Sept 30];2(6):548-53. Available from: https://doi.org/10.1590/1982-0194201400089

22. Neves ET, da Silveira A, Arrué AM, Pieszak GM, Zamberlan KC, dos Santos RP. Childcare network with special health needs. Text Context Enferm [Internet]. 2015 [cited 2016 Jul 05];24(2):399-406. Available from: https://doi.org/10.1590/0104-07072015003010013

23. Vasconcelos MIO, Xavier ALC, Nascimento MN do, Cavalcante YA, Rocha SP, Gomes JS da. Evaluation of the problem-solving capacity and effectiveness of primary health care: integrative literature review. Sanare, Sobral [Internet]. 2018 [cited 2019 June 5];17(1):65-73. Available from: https://sanare.emnuvens.com.br/sanare/article/download/1232/663

24. Santiago AD, Tomasi E, Thumé E, da Silveira DS, Siqueira FCV, Piccini RX, et al. Lack of access and continuity of adult health care: a national population-based survey. Rev Saúde Pública [Internet]. 2015 [cited 2017 Oct 12];49(31)1:15. Available from: https://doi.org/10.1590/S0034-8910.2015049005503

25. Ministry of Health (BR). Federal University of Rio Grande do Sul (UFRGS). Referral protocols from Primary Care to Specialized Care. Endocrinology and Nephrology. Brasilia, DF (BR): Ministry of Health, 2015.

26. Coelho APC, Larocca LM, Chaves MMN, Felix JVC, Bernardino E, Alessi SM. Tuberculosis care management: integrating a teaching hospital to primary health care. Text Context Enferm. [Internet]. 2016 [cited 2017 Sept 19];25(2):e0970015. Available from: https://doi.org/10.1590/0104-07072016000970015

27. Mendes FRP, Gemito MLGP, Caldeira EC do, Serra IC da, Casas-Novas MV. Continuity of care from the perspective of users. Ciênc Saúde Coletiva [Internet]. 2017 [cited 2019 June 09];22(3):841-853. Available from: https://doi.org/10.1590/1413-81232017223.26292015

28. Paula CC, Silva CB, Nazário EG, Ferreira T, Schimith MD, Padoin SMM. Factors that interfere in the longitudinality attribute of primary health care: integrative review. Rev Eletr Enf [Internet]. 2015 [cited 2016 Dec 04];17(4):1-11. Available from: https://doi.org/10.5216/ree.v17i4.31084

29. Mendes FRP, Gemito MLGP, Caldeira EC, Serra IC, Casas-Novas MV. Continuity of care from the perspective of users. Ciênc Saúde Coletiva [Internet]. 2017 [cited 2017 Oct 13];22(3):841-53. Available from: https://doi.org/10.1590/1413-81232017223.26292015

NOTES

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CONTRIBUTION OF AUTHORITY

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CONFLICT OF INTEREST

There's no conflict of interest.

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