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Research Article

Family Health Support Centers and care for people with disabilities and rehabilitation needs: data from the third PMAQ-AB cycle

Os núcleos de apoio à saúde da família e o cuidado às pessoas com deficiência e necessidades de reabilitação: dados do terceiro ciclo PMAQ-AB

Equipos de Apoyo a la Salud de la Familia y atención a personas con discapacidad y necesidades de rehabilitación: datos del 3er ciclo PMAQ-AB

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Abstract

Introduction: The Primary Health Care teams represent an opportunity to welcome and care for people with disabilities or with some kind of loss of functional capacity who reside in the territories covered by them. **Objective:** To describe the profile of the Family Health Support Centers according to care practices for people with disabilities and rehabilitation needs. **Methods:** This is a cross-sectional, descriptive study with secondary data from the third cycle of the National Program for Improving Primary Care Access and Quality, 2017, including 4,031 professionals from the country's Family Health Support Centers, 98.0% of these. **Results:** Only 5.0% of the teams reported not performing care actions for people with disabilities and rehabilitation needs, with worse results in relation to planning, execution, and evaluation of the tasks provided for the Family Health Support Centers. Adaptations of home conditions and functional approach were the most mentioned actions; and support to Primary Health Care teams in the early identification of disability, the least mentioned. **Conclusions:** The teams that reported providing some care for people with disabilities and rehabilitation needs have a better organized work, but challenges remain related to the management of teamwork, intersectoral organization, and the development of singular therapeutic projects.

Keywords: Primary health care; National health strategies; Disabled persons; Rehabilitation.

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Resumo

Introdução: As equipes da atenção básica à saúde representam uma oportunidade de acolhimento e cuidado às pessoas com deficiência (PcD) ou com algum tipo de perda de funcionalidade que residem nos territórios cobertos por elas. **Objetivo:** Descrever o perfil dos núcleos de apoio à saúde da família (Nasf) segundo práticas de cuidado a PcD e pessoas com necessidades de reabilitação. **Métodos:** Estudo transversal, descritivo, com dados secundários do terceiro ciclo do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica, 2017, incluindo 4.031 profissionais das equipes de Nasf do país, 98% delas. **Resultados:** Apenas 5% das equipes disseram não realizar ações de cuidado a PcD ou de reabilitação, com piores resultados em relação ao planejamento, à execução e à avaliação das atribuições previstas para o Nasf. Adaptações das condições do domicílio e abordagem funcional foram as práticas mais citadas, e o suporte às equipes da atenção básica à saúde na identificação precoce de deficiências, a menos citada. **Conclusões:** As equipes que apontaram cuidado a PcD/reabilitação têm o trabalho mais bem organizado, persistindo desafios relacionados à gestão do trabalho em equipe, à articulação intersetorial e à construção de projetos terapêuticos singulares.

Palavras-chave: Atenção primária à saúde; Estratégias de saúde nacionais; Pessoas com deficiência; Reabilitação.

Resumen

Introducción: Los equipos de Atención Primaria de Salud (APS) representan una oportunidad para acoger y atender a las personas con discapacidad (PcD) o con algún tipo de pérdida de funcionalidad que residen en los territorios que abarcan. **Objetivo:** Describir el perfil de los Equipos de Apoyo a la Salud de la Familia (NASF) según las prácticas de atención a las personas con discapacidad y las necesidades de rehabilitación. **Métodos:** Estudio descriptivo transversal, con datos secundarios del 3er ciclo del Programa Nacional de Mejoramiento del Acceso y Calidad de la Atención Primaria, 2017, incluyendo 4.031 profesionales de los equipos NASF del país, el 98,0% de estos. **Resultados:** Solo el 5,0% de los equipos relató no realizar acciones de atención a las personas con discapacidad o de rehabilitación, con peores resultados con relación a la planificación, ejecución y evaluación de las tareas previstas para la NASF. Las adaptaciones a las condiciones del hogar y el enfoque funcional fueron las prácticas más mencionadas y el apoyo a los equipos de APS en la identificación temprana de deficiencias fue la menos mencionada. **Conclusiones:** Los equipos que derivaron la atención a PcD/rehabilitación tienen trabajo mejor organizado, persistiendo desafíos relacionados con la gestión del trabajo en equipo, la coordinación intersectorial y la construcción de proyectos terapéuticos singulares.

Palabras clave: Atención primaria de salud; Estrategias de salud nacionales; Personas con discapacidad; Rehabilitación.

INTRODUCTION

The Primary Health Care (PHC) teams represent an opportunity to welcome and care for people with disabilities or with some kind of loss of functional capacity who reside in the territories covered by them.[1] The work of multidisciplinary teams in PHC takes place through the proposal of interdisciplinarity and is organized as reference teams of the Family Health Strategy (FHS) and matrix support, with the Family Health Support Centers (*Núcleos de Apoio à Saúde da Família* – NASF)[2] and, more recently, the multidisciplinary teams.[3]

Rehabilitation is part of the set of health actions provided for by PHC and is, therefore, the responsibility of all professionals included in this level of care.[4,5] These should develop actions such as: follow-up of newborns, early identification of disabilities, provision of support to families, creation of lines of care and implementation of clinical protocols; home care; amongothers.[6,7]

Furthermore, with regard to care for people with disabilities, the Care Network for People with Disabilities (*Rede de Cuidados à Pessoa com Deficiência* – RCPD) was established aiming at expanding access, qualifying health care, and promoting the connection of people with disabilities and their families to health centers in different territories, thus qualifying the care for this population.

The actions provided for PHC in the ordinance are: early diagnosis in prenatal care, following up high-risk children, health education, creation of lines of care to guide the care for people with disabilities, implementation of welcoming and risk classification strategies and vulnerability analysis for people with

disabilities, care and follow-up in home care; provision of support and guidance to families/companions and development of inclusion initiatives, also through the School Health Program.[8] However, challenges remain related to the lack of knowledge of professionals about the RCPD and the privilege of programmatic actions in PHC, with more specific initiatives aimed at people with disabilities, which often depend on interdisciplinary and intersectoral actions — which, in turn, are inefficiently developed.[9]

Specifically with regard to NASF teams, there is great potential for interdisciplinarity, as they are composed of many professionals, including social workers, physical education professionals, pharmacists, physiotherapists, speech therapists, nutritionists, psychologists, occupational therapists, physicians of various specialties, among others, considering the proposal of matrix support and expansion of the problem-solving capacity of PHC teams.[10]

The NASF teams were established in 2008 aimed at providing technical, pedagogical, and care support to the FHS teams. Its functions include participating in the territorialization process; updating the registration of families in information systems; carrying out healthcare actions according to the needs of the local population, including promotion, prevention, diagnosis, and rehabilitation initiatives; ensuring continuity of care and developing bonds; carrying out active search and notification of diseases and injuries of compulsory notification; participating in team meetings to discuss the planning and evaluation of actions, based on available data; among others.[11] In 2017, with the reformulation of the National Primary Care Policy (*Política Nacional de Atenção Básica* – PNAB), these teams were renamed as Expanded Family Health and Primary Care Centers (*Núcleos Ampliados de Saúde da Família e Atenção Básica* – NASF-AB).[5]

Although rehabilitation actions are provided for in PHC actions, it is crucial to expand them even further,[6] considering that multiprofessional teams can play an important role in this regard, as they include occupations related to rehabilitation, thus strengthening care practices for people with disabilities.[7] However, the operationalization of these practices has several challenges, from the lack of visibility of people with disabilities in the team's operating area, limited access and accessibility to family health units (FHU), precariousness of work, teams' lack of organization, imbalance between care and health promotion actions, to the lack of interdisciplinary and intersectoral organization.[12,13]

Other important challenges related to the actions and care practices provided for PHC teams, generally speaking, but which also refer to the actions of NASF and rehabilitation, are the evaluation and monitoring of the performed actions, providing reflection on the achieved results, the facilitators and challenges of the process, and the valorization of the work of the teams. From the perspective of evaluation, the National Program for Improving Primary Care Access and Quality (*Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica* – PMAQ-AB), established in 2011, aimed at the improvement of quality and the incentive to expand access to PHC, and represented one of the strategies used to ensure transparency and effectiveness of actions directed to PHC, in addition to presenting and assessing what has been done by multiprofessional teams.[14] However, the program was extinguished in 2019, being replaced by the *Previne Brasil* [Brazil Prevents] program.[15]

In the political and economic context of the Brazilian Unified Health System (SUS) and PHC, with the setbacks of PHC policies, more specifically between 2017 and 2020,[15] relativizing universal access, weakening financing and deconfiguring teams and work processes, disentangling the typology, and extinguishing new NASF-AB accreditations,[16] we emphasize the importance of giving visibility to the actions and results of the PHC teams' work, thus reinforcing the need to maintain a more comprehensive and problem-solving PHC model and overcoming the still hegemonic biomedical and care model.[17]

Within this context, in this study we aimed to describe the NASF profile according to care practices for people with disabilities and rehabilitation needs.

METHODS

This is a cross-sectional, exploratory and descriptive study based on secondary data from the second phase of the third cycle of the PMAQ-AB, an external evaluation whose collection was carried out in 2016-2017, covering a total of 5,324 municipalities (95%) and 4,031 NASF teams (98%). The PMAQ-AB microdata are publicly accessible and available on the portal of the Department of Primary Health Care, of the Brazilian Ministry of Health,[17] and were obtained through structured interviews carried out by trained interviewers, under the supervision of educational and/or research institutions. The collection was carried out using tablets, and the questionnaire was applied at the very FHU by the interviewers, with the participation of one or more NASF professionals appointed by the team members.[18]

The study population consisted of professionals from the 4,031 teams that agreed to participate in the evaluation, as per the indication of the municipal managers through the PMAQ-AB system. The external evaluation instrument had six modules: modules I and V, on the structure of the units in an observational way; modules II and VI, with interviews with professionals from the reference teams; module III, for interview with the user; and the module of interest of the present study, module IV, which concerned the interview with the NASF professional and verification of documents in the health unit. Module IV aimed to evaluate what the PMAQ-AB presents as the work process of the teams and the organization of care for users.

The evaluated axes included: identification of the health unit, NASF management at the municipal level, qualification of care in PHC, care for people with disabilities and those with rehabilitation needs. This module had multiple-choice questions for the answers. More than one NASF professional should be present to do the interview, as recommended. In questions on the verification/observation of documents, the interviewee should indicate in the said document the elements that served as a proof for the question (supporting documents).[18]

The variables of interest were related to the professional profile and the identification of care practices related to the attributions of the teams caring for people with disabilities, and were presented in the following components:

- IV.2: identification of the FHU (interviewed professional) and location;
- IV.3: axis 1, NASF management at the municipal level;
- IV.7: axis 5, qualification of care in PHC — NASF team work process; and
- IV.10: care for people with disabilities and rehabilitation needs.

Simple and relative frequencies were estimated and presented in tables, according to the NASF team's report of support to and development of rehabilitation strategies with the PHC teams, that is, according to the "yes" and "no" categories of variable IV.10.1 — general (Does NASF support and develop rehabilitation strategies with the PHC teams?). Absolute and relative frequencies of the variables of interest were presented according to the NASF teams that perform or do not perform actions for people with disabilities or rehabilitation needs. The variable *professionals interviewed*, in Table 1, does not total 100%, as the interviewees could concomitantly answer the same question by the team or because they could answer more than one option (category). In Tables 2, 3 and 4, the values total 100%. In Table 5, the same situation described in Table 1 is observed. All analyses were carried out in the SAS 9.4 statistical package.

Table 1. Profile of the teams and management of the Family Health Support Center according to the report of support to and development of rehabilitation strategies with the primary health care teams*.

Variables	Perform actions aimed at people with disabilities and rehabilitation needs (n=3,825)		Do not perform actions aimed at people with disabilities and rehabilitation needs (n=206)		Total (n=4,031)	
	n	%	n	%	n	%
* Professionals interviewed						
Physiotherapist	2,051	53.6	33	16.0	2,084	51.7
Psychologist	2,011	52.6	117	56.8	2,129	52.8
Nutritionist	2,001	52.3	93	45.1	2,094	51.9
Social worker	1,342	35.1	62	30.1	1,404	34.8
Physical education professional	994	26.0	53	25.7	1,047	26.0
Speech therapist	835	21.8	24	11.6	859	21.3
Pharmacist	474	12.4	25	12.1	499	12.4
Occupational therapist	234	6.1	6	2.9	240	5.9
Physician or others	197	5.1	13	8.6	214	5.3
Number of Family Health Strategy Teams supported						
One or two teams	754	19.7	83	40.3	837	20.8
Three to six teams	1,525	39.9	72	35.0	1,597	39.6
Seven to nine teams	1,061	27.7	35	17.0	1,096	27.2
Over nine teams	485	12.7	16	7.8	501	12.4
NASF's technical reference in municipal management						
Yes	3,585	93.7	170	82.5	3,755	93.2
No	240	6.3	36	17.5	276	6.8
Holds monthly meetings between the municipal technical reference and NASF (if yes in the previous question)						
Yes	3,421	90.4	139	81.8	3,560	94.8
No	164	9.6	31	18.2	195	5.2
There is a document supporting the monthly meetings (if yes in the previous question)						
Yes	3,126	87.2	109	64.1	3,235	86.1
No	295	12.8	30	35.9	325	13.8
Performs territory diagnosis to guide the formation of the NASF team						
Yes	2,645	69.1	81	39.3	2,726	67.6
No	793	20.7	93	45.1	886	22.0
Did not answer it	387	10.1	32	15.5	419	10.4

NASF: Family Health Support Center; *Percentages do not total 100% according to the recommendation that more than one professional from each NASF team answer the questions of the instrument.

RESULTS AND DISCUSSION

Participants of the third cycle

Most NASF covered three to six FHS teams (39.6%), had a technical reference in municipal management (93.2%), and held monthly meetings (94.8%), although only 67.6% carried out territory

diagnosis to guide the formation of NASF teams. When comparing the NASF in which actions for people with disabilities and rehabilitation needs were performed and those in which such actions were not performed, we observed that, among the latter, fewer FHS teams were covered, between one and two teams (40.3%), and they mentioned, more frequently, the lack of NASF's technical reference in municipal management (17.5%), in addition to the majority not performing territory diagnosis (45.1%) (Table 1).

According to the characteristics of the work and qualification of care, for the totality interviewed, most NASF professionals stated that they always planned actions with the PHC teams (63.5%), met to discuss the work process (97.5%), and had no locomotion problems in the territory (51.4%) (Table 2). We observed a higher proportion regarding the lack of planning of joint actions with PHC teams, or planning only a few times (32%), and not holding work process meetings (13.1%) between teams that did not carry out actions for people with disabilities/rehabilitation needs, when comparing them with the teams that performed these actions (Table 2).

Table 2. Characteristics of the work of the Family Health Support Center team and qualification of care according to the report of support to and development of rehabilitation strategies with the primary health care teams.

Variables	Perform actions aimed at people with disabilities and rehabilitation needs (n=3,825)		Do not perform actions aimed at people with disabilities and rehabilitation needs (n=206)		Total (n=4,031)	
	n	%	n	%	n	%
Plans joint actions with primary health care teams						
Always	2,486	65.0	74	35.9	2,560	63.5
Most of the time	1,061	27.7	66	32.0	1,127	27.9
Never or only a few times	278	7.3	66	32.0	344	8.5
There is a document supporting the joint organization of monthly actions between NASF and primary health care teams						
Yes	3,306	86.4	126	61.2	3,432	85.1
No	485	12.7	61	29.6	546	13.5
Does not carry out joint organization	34	0.9	19	9.2	53	1.3
Holds meetings on work process						
Yes	3,752	98.1	179	86.9	3,931	97.5
No	73	1.9	27	13.1	100	2.5
Has locomotion problems in the territory's NASF (great distances and lack of vehicles)						
Yes	1,850	48.4	110	53.4	1,960	48.6
No	1,975	51.6	96	46.6	2,071	51.4

NASF: Family Health Support Center.

Regarding the evaluation of the NASF teams, from the total of the teams, most carried out monitoring and analysis of work process indicators (80.5%) and self-assessment in the last year (90%), through the AMAQ (Self-assessment for the Improvement of Access and Quality of Primary Health Care [*Autoavaliação para melhoria do acesso e da qualidade da atenção básica*]) instrument (87.3%), defined access criteria, flows and attributions of each NASF professional (89.8%), registered actions in medical records shared with the PHC teams (89.1%), and carried out an analysis of the effectiveness of collective actions (94.2%). Nevertheless, we also observed teams that did not present documents supporting self-assessment (38.5%), monitoring and analysis of indicators (19.5%), and the definition of NASF attributions (21%) (Table 3).

Table 3. Assessment of the Family Health Support Center team according to the report of support to and development of rehabilitation strategies with the primary health care teams.

Variables	Perform actions aimed at people with disabilities and rehabilitation needs (n=3,825)		Do not perform actions aimed at people with disabilities and rehabilitation needs (n=206)		Total (n=4,031)	
	n	%	n	%	n	%
Monitoring and analysis of work process indicators						
Yes	3,136	82.0	109	52.9	3,245	80.5
No	689	18.0	97	47.1	786	19.5
There is a document supporting the monitoring/analysis of indicators (if yes in the previous question)						
Yes	2,449	78.1	65	59.6	2,514	77.5
No	687	21.9	44	40.4	731	22.5
What self-assessment instrument did you use in the previous year?						
AMAQ – NASF	3,376	88.3	144	69.9	3,520	87.3
Own instrument of municipality/team	62	1.6	2	1.0	64	1.6
Instrument developed by the state	10	0.3	0	0	10	0.2
Other assessment instruments	33	0.9	2	1.0	35	0.8
Did not perform the assessment	344	9.0	58	28.2	402	10.0
There is a document supporting the self-assessment (if the self-assessment is mentioned)						
Yes	2,154	61.9	77	52.0	2,231	61.5
No	124	38.1	8	48.0	132	38.5
Definition of access criteria, flows, attributions of each NASF professional						
Yes	3,482	91.0	139	67.5	3,621	89.8
No	343	9.0	67	32.5	410	10.2
There is a document supporting the definitions of NASF attributions (if yes in the previous question)						
Yes	2,784	80.0	75	54.0	2,859	79.0
No	698	20.0	64	46.0	762	21.0
Registration of NASF actions in medical records shared with primary health care teams						
Yes	3,448	90.1	145	70.4	3,593	89.1
No	377	9.9	61	29.6	438	10.9
Analysis of the effectiveness of collective actions carried out or supported by NASF						
Yes	3,651	95.5	148	71.8	3,799	94.2
No	174	4.5	58	28.2	232	5.8

NASF: Family Health Support Center; AMAQ: Self-assessment for the Improvement of Access and Quality of Primary Health Care.

When comparing the evaluation of the teams that carried out actions for people with disabilities/rehabilitation needs with those that did not, we noticed that the latter pointed more to the absence of monitoring and analysis of indicators (47.1%), self-assessment (28.2%), definition of access criteria, flows and attributions of professionals (32.5%), analysis of the effectiveness of collective actions (28.2%), in addition to the undernotification of actions in medical records (29.6%) and the lack of documents supporting the performance of these evaluations (40–48%) (Table 3).

Among the activities carried out by the NASF, the most carried out by all the teams were: health education initiatives (96.5%), shared consultations between NASF/FHS professionals (94.7%), body

practices/physical activity in the territory (93.7%), and operative therapeutic groups (92.3%). Among the least mentioned are: the Singular Therapeutic Project (*Projeto Terapêutico Singular* – PTS) (77.9%) and health surveillance (74.3%). For these activities, about 15% of the teams did not present supporting documents for the PTS; 15.3%, for shared consultations; and 7.9%, for operative groups. Among the teams that did not perform actions for people with disabilities/rehabilitation needs, they reported not carrying out these activities the most when compared to the other teams (Table 4).

Table 4. Activities carried out by the Family Health Support Center according to the report of support to and development of rehabilitation strategies with the primary health care teams.

Variables	Perform actions aimed at people with disabilities and rehabilitation needs (n=3,825)		Do not perform actions aimed at people with disabilities and rehabilitation needs (n=206)		Total (n=4,031)	
	n	%	n	%	n	%
Shared consultations between professionals of the NASF/Family Health Strategy						
Yes	3,653	95.5	166	80.6	3,819	94.7
No	172	4.5	40	19.4	212	5.3
There is a document supporting the shared consultations (if yes in the previous question)						
Yes	3,123	85.5	112	67.5	3,235	84.7
No	530	14.5	54	32.5	584	15.3
Therapeutic or operative groups						
Yes	3,559	93.0	163	79.1	3,722	92.3
No	266	7.0	43	20.9	309	7.7
There is a document supporting the operative groups (if yes in the previous question)						
Yes	3,296	92.6	134	82.2	3,430	92.1
No	263	7.4	29	17.8	292	7.9
Support to and development of body practices and physical activity in the territory						
Yes	3,627	94.8	149	72.3	3,776	93.7
No	198	5.2	57	27.7	255	6.3
Health surveillance actions						
Yes	2,898	75.8	99	48.1	2,997	74.3
No	927	24.2	107	51.9	1,034	25.7
Health education activities						
Yes	3,714	97.1	177	85.9	3,891	96.5
No	111	2.9	29	14.1	140	3.5
Shared development of PTS for complex cases						
Yes	3,052	79.8	88	42.7	3,140	77.9
No	773	20.2	118	57.3	891	22.1
There is a document supporting the development of PTS for complex cases (if yes in the previous question)						
Yes	2,603	85.3	65	73.9	2,668	85.0
No	449	14.7	23	26.1	472	15.0

NASF: Family Health Support Center; PTS: Singular Therapeutic Projects.

The actions performed by more than 90% of the teams that reported support to and development of rehabilitation strategies with the PHC teams are the guidance on adaptations of home conditions (95.8%) and functional approach, considering the diversity of people's needs (94.8%). Individual or collective care for musculoskeletal (88.9%) and neuromuscular (88.7%) disorders was also among the most frequently reported actions. Individual or collective care for urogynecological conditions was mentioned only by 54.9% of the teams, and 0.18% reported they did not perform any of the aforementioned actions (Table 5).

Table 5. Actions performed by Family Health Support Center teams who reported supporting and developing rehabilitation strategies with the primary health care teams.

Actions performed (carried out)*	n	%
Assessment and guidance on adaptations of home conditions	3,663	95.8
Functional approach according to people's needs	3,628	94.8
Individual or collective care for musculoskeletal disorders	3,399	88.9
Individual or collective care for neuromuscular disorders	3,393	88.7
Comprehensive approach to people with disabilities	3,376	88.3
Evaluation and referral for use of orthoses, prostheses, and auxiliary means of locomotion	3,320	86.8
Individual or collective care for rheumatic disorders	3,264	85.3
Disease prevention and health promotion groups in the care of people with rehabilitation needs	3,258	85.2
Promotion of the insertion of people with disabilities in sports, work, and leisure activities	3,201	83.7
Support to primary health care teams in the early identification of disabilities	3,126	81.7
Individual or collective care for urogynecological conditions	2,101	54.9
None of the above	7	0.18

*Percentage of teams that reported performing the described actions (frequency does not total 100% because the teams could mention carrying out more than one of the actions).

We observed that most of the implemented NASF teams adhered to the third PMAQ-AB cycle and performed some type of care aimed at people with disabilities or with rehabilitation needs. Psychologists, nutritionists, and physiotherapists were the most interviewed professionals, although among the teams that did not report actions for people with disabilities/rehabilitation needs, physiotherapists were not mentioned among the three professionals most interviewed. Physiotherapists, speech therapists, and occupational therapists are traditional rehabilitation occupations.[19,20] Therefore, interviews with their participation may have resulted in a broader understanding of the elements related to rehabilitation topics in PHC. Another hypothesis is that these occupations are more usual in NASF teams and, for this reason, they were also among the most interviewed.[21]

The teams that reported carrying out actions for people with disabilities/rehabilitation needs support a greater number of FHS teams, with the majority covering three to nine teams, a number that remains in accordance with what is provided for in the NASF guidelines.[10] It is noteworthy that 12% of them are still overburdened with the coverage of more than nine teams, with a greater disadvantage among teams that carried out actions for people with disabilities/rehabilitation needs. One possibility is that the modalities/type of these teams are different, NASF types 1 or 2,[8] and/or they are more complete in relation to the number and insertion of different occupations in health, but it is not possible to identify these aspects based on the PMAQ-AB data.

The teams that reported performing actions for people with disabilities/rehabilitation needs presented the NASF's technical reference in municipal management the most. In this regard, it is worth mentioning that the choice of team formation and where they are implemented is the responsibility of municipal managers, according to the needs of the territory. Hence the importance of dialogue between NASF and the management[12,22] and the monthly meetings between them. Moreover, the teams performed twice as much territory diagnosis for guiding the NASF formation when compared to the teams without actions for people with disabilities/rehabilitation needs.

Regarding the provided for actions and care practices, the planning of joint actions with other PHC teams and work process meetings, supported by documents, were also reported the most in the teams that performed actions for people with disabilities/rehabilitation needs. This was also observed for the evaluation of the teams, with monitoring and analysis of work process indicators, definition of access criteria, flows and attributions of professionals, registration of actions in medical records, and analysis of the effectiveness of collective actions.

According to these results, we observe greater fragility in the provided for actions and practices and in the qualification of care of the teams that did not perform actions aimed at people with disabilities/rehabilitation needs, highlighting the insufficiency in the joint work of PHC teams, such as, for example, incipience in matrix support,[23] which may be related to the way the work is organized, either due to lack of registration, or the number of FHS teams supported by them, or the Brazilian region in which they are inserted,[24] suggesting that these teams may have less interaction in the territory and less social participation as well.[10]

Self-assessment is part of a process of reorganization and expansion of the qualified provision of SUS services, both for PHC and management teams.[24] According to our results, we can perceive that the NASF teams carry out evaluation activities; but in this context, the teams that perform actions aimed at people with disabilities/rehabilitation needs reported carrying out the self-assessment the most, as well as evaluating and documenting the performed actions, when compared to those that did not carry out these activities, which can directly impact how these teams recognize and deliberate adversities, in addition to their potentialities, thus influencing the quality of the services provided by the team.[25]

As for supporting the actions through documents, the teams that performed rehabilitation actions presented the documentation in at least 78% of the questions, with lower frequencies for actions related to evaluation/self-assessment, which represents good reliability of the answers. The teams that reported not carrying out actions aimed at people with disabilities/rehabilitation needs performed worse in relation to supporting documents as a proof of actions, reinforcing the hypothesis of greater fragility in the organization of the work process. Documentation is considered to strengthen the evaluation of the actions carried out, avoiding inconsistencies, valuing the work of the teams, and enabling adjustments in future processes and planning, operation, and even increased funding for teams. Furthermore, the lack of documentation of actions may be related to the precariousness of work processes and the overburden of team professionals.

Among the activities carried out by the teams, our findings corroborate what is provided for in the NASF guidelines,[10] and all the aforementioned initiatives were carried out in greater proportion by the teams that performed actions for people with disabilities/rehabilitation needs, with major differences for actions on health surveillance and physical activity. It is also worth mentioning that, nonetheless, surveillance actions and the shared development of PTS were the least mentioned by both groups. Both health surveillance and the development of PTS are the responsibility of the PHC teams and are important to improve the quality of the performed actions, in addition to offering support and problem-solving capacity to the needs of the territory.[26,27]

Surveillance mainly works based on the premise of territorialization, assisting in the problems and health specificities of this population.[26] In turn, the PTS systematizes care by exploring singularity and guaranteeing the autonomy of the subject, and it must be developed in an interdisciplinary way, which tends to strengthen the joint work of the teams. Moreover, the development of PTS also requires the active participation of the user and is important for creating a team-subject-family bond, identifying vulnerability, continuity of care, and expansion of the clinical practice.[28] Health training in Brazil, which still tends to be based on a little interdisciplinary and more specialized model, hinders the process of formulating PTS.[27,29] Therefore, the nonperformance of these actions may indicate the fragility of the premises of territorialization and accountability of care, essential for the operationalization of PHC and tending to be more distant from the proposal of the expanded clinic.

Regarding the actions performed by the teams that mentioned initiatives for people with disabilities/rehabilitation needs, actions of home care, functional approach, and those aimed at musculoskeletal disorders prevailed. The most specific actions, such as a comprehensive approach to people with disabilities, attention to the use of orthoses, prostheses, and auxiliary means of locomotion, promotion of the insertion of people with disabilities in sports, work, and leisure activities, and early identification of disabilities, although reported, were not among the most frequent. The report of actions with a more care-related profile may indicate the vulnerability of people with disabilities who are unable to access the FHU, either due to the aspect of the territory or due to the lack of public policies that favor them, which may impair comprehensive care, affecting the users' quality of life.[10]

The PMAQ-AB has its assessment instrument based on the PNAB, only investigating the attributions regulated for NASF teams. On the one hand, there is no room for reporting unplanned, different, or innovative actions. On the other hand, there may be an embarrassment in the denial of actions that should have been taken. In addition, this is not a specific questionnaire for the purpose of the study, which may have negatively influenced the results related to actions for people with disabilities/rehabilitation needs. It should be noted that the PMAQ-AB is a voluntary adherence program of the PHC teams, representing an evaluation process, which can have a positive impact on the result.

It is worth mentioning that this is an unprecedented study. We investigated the characteristics of the profile of NASF teams and care practices for people with disabilities and rehabilitation needs and explored data on care actions offered by NASF teams, identifying potentialities and challenges, demonstrating the importance of these teams in supporting, expanding, and qualifying care in PHC, especially with regard to vulnerable populations such as people with disabilities. Furthermore, evaluation is one of the fundamental premises of PHC, making the work of the teams visible and, in turn, valuing this work and enabling the planning of more effective actions in PHC.

CONCLUSIONS

The teams that reported providing some type of care to people with disabilities/rehabilitation needs tend to have a better organized work, considering the actions provided for by the PNAB and the RCPD. The comparative purpose of the study contributes to a reflection on how the NASF teams have been organizing their actions and attributions, expanding the scope of performance of the PHC beyond the programmatic actions in the PHC. Nevertheless, challenges related to the structuring of the teams, the organization of interdisciplinary work, with reference teams, intersectoral network, and territories persist, which appears more expressively in the teams that reported not performing actions for people with disabilities/rehabilitation needs.

It is worth emphasizing that, although occupations — such as psychologists, physical education professionals, and nutritionists — are not traditionally associated with rehabilitation, they can offer significant contributions to the care of people with disabilities/rehabilitation needs, so much so that they are part of the multidisciplinary teams to support the FHS since the creation of NASF and remain in the current proposal of multidisciplinary teams, dated from 2023.

Therefore, we reinforce the importance of reestablishing policies to strengthen the matrix support teams to the FHS and the premises of PHC, especially in the context of change in government in 2023. The results allow us verifying that, after 15 years of its implementation, the multidisciplinary teams of matrix support to the FHS continue to fulfill their duties, qualifying and expanding the care capacity in PHC as provided for in the PNAB. Nonetheless, it is worth noting the presence of weaknesses related to care for people with disabilities and/or rehabilitation needs, with teams that still face difficulties in carrying out and organizing the planned actions, which eventually compromise the problem-solving capacity and quality of care attributed to these teams.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

AOCs: Conceptualization, Data curation, Methodology, Writing – original draft, Writing – review & editing. MMCA: Conceptualization, Data curation, Methodology, Supervision, Visualization, Writing – review & editing.

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