

Organizational accessibility: Barriers to continuity of care in primary health care

Rev. Enferm. UFSM - REUFMS
Santa Maria, RS, v. 9, e17, p. 1-17, 2019
DOI: 10.5902/2179769228053
ISSN 2179-7692

Acessibilidade organizacional: barreiras na continuidade do cuidado na atenção primária à saúde

Accesibilidad organizacional: barreras en la continuidad del cuidado en una atención primaria a la salud

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Abstract: Objective to analyze accessibility to a Family Health Center. **Method:** qualitative research in the form of case study, carried out in a Family Health Center from a township in the State of Rio Grande do Sul, from February to July 2012. **Results:** the team does not take responsibility for the users' reception, which interferes in accessibility; miscommunication between staff and users, and the fact that professionals do not welcome the users undermines the staff's ability to solve the users' needs; it was identified that absenteeism was related to a lack of listening and to the absence of personalized care; professionals do not commit to handling the cases. However, lines of care are being created. **Conclusions:** it is necessary to qualify the reception and service offer, to strengthen the internal organization of the Unit and to invest in the communication between staff and users and with other units, establishing care flows and articulated networks.

KEYWORDS: Continuity of patient care; Unified Health System; Health assistance; Primary health care

Resumo: Objetivo: analisar a acessibilidade organizacional de uma Unidade de Saúde da Família. **Método:** pesquisa qualitativa na modalidade de estudo de caso, realizada em uma Unidade de Saúde da Família de um

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município do Rio Grande do Sul, no período de fevereiro a julho de 2012. **Resultados:** a equipe não se responsabiliza pela recepção dos usuários, interferindo na acessibilidade; as falhas de comunicação entre equipe e usuários, com ausência de acolhimento, prejudicam a resolutividade das necessidades dos usuários; identificou-se que o absenteísmo está relacionado à falta de escuta e singularização; os trabalhadores não se comprometem com a condução de casos. Contudo, linhas de cuidado estão em construção. **Conclusões:** é necessário qualificar a recepção e a oferta de serviços, fortalecer a organização interna da Unidade e investir na comunicação entre equipe e usuários e com outros pontos de atenção, estabelecendo fluxos assistenciais e redes articuladas.

DESCRITORES: Continuidade da assistência ao paciente; Sistema Único de Saúde; Assistência à saúde; Atenção primária à saúde

Resumen: Objetivo: analizar la accesibilidad organizacional de una Unidad de Salud de la Familia. **Método:** investigación cualitativa, en la modalidad estudio de casos, realizada en una Unidad de Salud de la Familia, en un municipio de Rio Grande do Sul, en el período de febrero a julio de 2012. **Resultados:** el equipo no se responsabiliza por la recepción de los usuarios, lo que interfiere en la accesibilidad; hay fallas de comunicación entre el equipo y los usuarios y ausencia de recepción, lo que perjudica la resolución de las necesidades de los usuarios; se identificó que el ausentismo está relacionado con la falta de atención y personalización; el equipo no se compromete con el manejo de los casos. Sin embargo, se están elaborando líneas de atención. **Conclusiones:** es necesario calificar la recepción y la prestación de servicios, fortalecer la organización interna de la Unidad e invertir en la comunicación entre el equipo y los usuarios y con otros puntos de atención, estableciendo flujos asistenciales y redes articuladas.

DESCRIPTORES: Continuidad de la atención al paciente; Sistema único de Salud; Prestación de atención a la salud; Atención primaria de la salud

Introduction

The object of study in this article refers to organizational accessibility to Primary Health Care (APS). “Accessibility makes it possible for people to reach services, that is, this is an aspect of the structure of a health system or unit and this aspect is necessary to provide attention in the first contact and continuity of care”.^{1:225}

In Brazil, the Unified Health System (SUS) establishes hospital care to people through promotion and recovery of health and prevention of diseases as one of its goals, in the form of Health Care Networks (RAS). RAS are proposed by Integrated Health Systems worldwide. They are defined as “organizational arrangements of health actions and services, of different technological densities that, integrated by technical, logistical and management support systems, try to assure integrality of care”. They aim to integrate health actions and services in a

“continuous, integral, quality, responsible and humanized” method, as well as improving SUS performance in terms of access, equity, effectiveness and efficiency.^{2,4}

APS as the preferred gateway has attributions such as the monitoring and organization of the services and user referral flows, in the different units of the RASs. In order to do so, it is responsibility of the APS to take care of the users in the other units of the RAS, based on a horizontal, continuous and integrated relationship, intended to create strategies for shared planning and management of integral care, in which access needs to be in the right place and at the right time, with equity.³

In this sense, access to health services represents a necessary condition for continuity of care, and presupposes the possibility to care for individuals, over time, in all of their needs. For this, professionals need to be prepared for the primary care work, so that it is possible to offer quality and continuous access to services and integral care.⁴

The obstacles to universal access to health have been identified in research with several groups. For managers and health professionals these obstacles are: expansion and strengthening of APS; lack of identification of key needs; poor material, human and technological resources; services with poor infrastructure; low resolution and absence of intersectoral public policies in APS.⁵ On the other hand, the study showed that, among the dimensions most valued by users in APS, we find access and availability of the health service; organization of the work process; relationship with health professionals; continuity of health care; bond between professionals and users and coordination of care.⁶

Thus, this research is justified as it sheds light on the organization of work, from the perspective and experience of health professionals and users of a Family Health Center (USF), regarding the dimension of accessibility, with the following research question: how does a USF's organizational accessibility interfere with the continuity of care in the RAS? The objective was to analyze the organizational accessibility of a Family Health Center.

Method

It was a qualitative research in the form of a case study,⁷ in which the following essential components were considered: study questions; proposals; unit of analysis; coherence that articulates data to the proposals and criteria for data interpretation. The unit of analysis,⁷ or “case”, is related to the research question, a USF.

The study scenario is a township located in Rio Grande do Sul and is considered medium-sized. It has 31 Basic Health Units, specialized services, a general hospital, an Emergency Care Unit, a Mobile Emergency Care Service and a university hospital.

The Family Health Strategy (ESF) proposal was implemented in 2003, with 16 teams. Minimal teams work in the USF, with five of these units having dental teams. The unit of analysis is a USF with two basic teams and a dental team. To keep the anonymity of the researched team, the research site was not revealed, but it establishes the spatial boundary of the case.⁷

The time limit for data collection was from February to July 2012. Data collection followed the essential principles of using multiple sources of evidence: creation of a database and maintenance of a connection between the evidence.⁷

The study participants were health professionals and users of the USF. Interviews were conducted with professionals and users, and the documents were monitored and investigated.

Inclusion criterion for professionals was to be an active employee of the USF during the period of data collection and, for users, being referred to another unit in the RAS. The interviewees were two nurses (enf1, enf2), two nurse assistants, one physician, one dentist, one dental assistant, one general service assistant, the USF’s coordinator, four community health agents (ACS) and six users, totaling 19 interviews.

It was a participant, unstructured and direct type observation,⁸ in alternating days and shifts, totaling 76 hours and 25 minutes. The field diary was prepared with a meticulous, detailed and

dense description of the object of study, which assisted in the analysis, since it is a rich source of information, and it is not possible to use other techniques of data collection.⁹

To increase the reliability of the observed data and to avoid research bias,⁷ research was conducted with two assistant observers who took turns following the observations. The field diaries were prepared by the researcher and the assistants and they were later confronted and discussed to guarantee greater trustworthiness to the observation. The documentation analyzed consisted of notebooks and reports of the team, management reports of the Local Health Office (SMS), schedules of referrals and official letters received.

Preparation of the *corpus* of the research was defined as an analytical strategy. Research data was revisited until it enabled the identification of important markers to guide the analysis and avoid a *priori* interpretations.⁷

Ethical issues were ensured and considered, according to Resolution No. 196/96, which was in force at the time of the research. The project was approved under protocol No. 1939/11 on December 9, 2011. Participation in the research was based on the participants' consent, signed through the Free and Informed Consent. Participants were kept anonymous by using the initial letters of the functions performed by the professionals, followed by a numerical representation.

Results

For their presentation, results were divided into subtitles. Thus, they are arranged as: organization of the reception in the USF; miscommunication between staff and users; absenteeism; and involvement of USF's professionals in the continuity of care.

Among the aspects of accessibility found, the *organization of the reception of users in the USF* was an obstacle to the continuity of care and access to the RAS. Users were welcomed in the USF by two employees who were not supposed to do this job, as they were hired for general services. In their absence, nurses, ACS and nurse technicians took over this function. The process

of scheduling referrals to the services available in the RAS was centralized in the receptionist. The team was not responsible for this process.

A woman approaches Enf1 behind the counter with a referral to an ophthalmologist. Enf1 writes the information required on the back. The woman asks: "where should I go? To the medical office? I want to switch doctors." RN 1: I don't know about that, you need to talk to the receptionist. [...] the woman keeps the referral and comes back here on Monday to talk to her (the receptionist) to see if it is possible. Woman: and I wanted to know about my granddaughter's referral, it's been a long time since and they have not scheduled it yet, she has to almost put her face against the notebook so she can read (gesture). Enf1: check with her too. (Field diary, 4/19/12)

In the afternoon shift, the employee left with this responsibility was the cleaner, who had taken over by the receptionist's decision, without training or concern of the staff.

[...] I am there, not that I like it, because it's not my job. My job is to clean here, but I do it so that the service is not delayed, a patient may need something and no one will be there to help them. (Interview with the cleaner)

Users lose their referrals or do not receive the correct information about the medical appointments in the other units of the RAS.

(Staff meeting) ACS4: [...] I advise people, someone said that customer service did not close at noon. The person came and they asked: who told you that? There is some misinformation. Coordinator: I think we have to say the same things. (Field diary, 2/29/2012)

Communication between staff and users was listed as an obstacle to accessibility. Miscommunication made the user go back and forth. The team did not know RAS's flows and justified the divergence in the information provided to the population due to recent changes in the service flow.

(Staff meeting) [...] ACS3: not one or two people complained to me, but several, but I did not know either. They tried to schedule an exam at the Office (SMS) but proof of residence was required. Several people at the meeting said they did not know either. [...] ACS4 talks about her father who had been referred to hematology and was informed by the USF that he

should go to the Local Health Office but, in fact, it was in the Hospital. Enf1 says that this was recently changed and that they did not know[...]. Enf1 also says that there is a lack of communication between services. (Field diary, 5/30/2012)

Miscommunication was related to the so-called 'excessive demand' in the USF. The team acknowledged that they were working as Urgent Care and not as USF, generating obstacles for users in accessibility, such as the size of the queue waiting for consultation early in the morning.

Miscommunication between staff and users was also related to the fact that the team was not organized to receive users, and the nurses' justification was that they needed doctors to legitimize the practice. In addition, and also inherent to accessibility, there were restrictions on the number of medical appointments (only 15 per shift) and the time the user should arrive at the USF to ensure care.

(Staff meeting) Enf1: this morning happened again, it is not the first time, today there was a child with a sore throat who went to [name of the hospital], where they said that it was not characterized as Urgent Care, then the child came here at 10 a.m. and there were not any doctors anymore. We need to inform people not to go to the [hospital]. (Field diary, 5/2/2012)

The absence of the doctor at 10 a.m. in a USF interfered with the use of the health service, as it was an unsuccessful experience for the users. In addition to the users going back and forth, the difficulty in approaching the staff and the professionals' inability to receive the patients, users did not have their problem solved and did not return to the USF.

The high rate of *absenteeism* in medical appointments and examinations referred to specialties in other units of the RAS were a barrier to continuity of care in this USF. The reason for this was related to lack of listening and absence of personalized care, as well as to the delay in scheduling the medical appointment.

At the counter, a woman speaks to the receptionist: and my examination with the rheumatologist? Have you scheduled it yet? [...] Receptionist: but this goes to the Office (SMS) only once a month. Woman: I know, but it's been months since I've been waiting. The receptionist takes the envelope

for follow-up to the rheumatologist and does not find the woman's request. The receptionist finds the request in the folder labeled as "lost" and says: it's here, it was scheduled for May 14, I called and nobody answered, I'll put it back for another attempt. Woman: take my other son's phone, he answers. (Field diary, 6/19/2012)

The receptionist reported that many people were informed about scheduled appointments and did not seek referral. Others, she could not inform. In the folder named "lost" there were several of these referrals, some without any notes.

Researcher: there are some that possibly have been received and not scheduled. The receptionist shrugs her shoulders and does not show any interest. The researcher counts the number of "lost" requests. Receptionist: you see, these people are impossible, then they show up here to complain about the delay in the appointment, but look how many of them don't go to the appointments, most were informed, these are recent requests. Researcher: not all are recent and not all have been informed. (Field diary, 6/19/2012)

In this case, absenteeism was related to how the receptionist related to the users. In this observation, blame for absences from medical appointments and examinations was transferred to them. Some actions of the reception showed disrespect to the user and lack of personalized care of each case.

[...] The receptionist receives a referral from a man, and says that she will call when it is scheduled. The man says she needs to call after 4 p.m. Receptionist: Okay. The researcher reminds the receptionist that the USF closes at 4 p.m. Man: So call me about noon. Receptionist: okay? The man leaves and she says: I couldn't care less about what time there are people at home; I call them, if they answer the phone, ok, if they don't, too bad for them. She puts the form inside the envelope, without writing anything down. (Field diary, 4/27/2012)

Lack of personalized care and people being unable to choose resulted in difficulty to access the RAS. The reception at a USF that wants to ensure the shortest time of access to another service needs to be supervised by the team at the risk of not achieving its goals.

It was also possible to identify lack of involvement of the employees at the USF to continuity of care. Thus, the first element was the way the nurses prioritized the use of family medical records.

(Staff meeting) Enf2 says that patients are coming up with no prescription and no medical record, which makes it difficult for the doctor to prescribe. She asks the ACS to inform the patients to bring the last prescription or the number of the medical record. Enf1: a patient arrived with a Blood Pressure of 160/100 mmHg and didn't know which medication he took, didn't know the number of the medical record, didn't know anything; it's hard to work like this. The researcher suggests to return the Excel worksheet with the registration [...]. ACS1 says she does not believe colleagues do not inform patients. [...] Enf2 says that it is not only to inform but rather to raise awareness. (Field diary, 5/23/2012)

Lack of prioritization to update the register of the population covered by the center affected organizational accessibility, which interfered with continuity of care. The team did not share the responsibility for continuity of care, nor was willing to think of alternatives so that the work process could help updating the users' files.

Continuity of care was also adversely affected by the lack of involvement of the nurses, felt by the ACS. When asked about the insertion of the USF in the RAS, ACS1 mentioned situations in which there was no reception and co-responsibility of the team for the cases.

[...] do you know those fishing nets? When a big fish passes, what happens? A hole (laughs), that is how I see it, because cases are not solved. [...] only gets to the first little netting of the net. You visit the patients and then they need something else, and the case does not continue [...] but if the net was well tied, it works [...] If I had a profile nurse, if I had a profile technician, a profile doctor, that part of the network would work [...] Then you ask me: has this already happened? Yes, yes, there was a net [...] there was resolution; people enjoyed working in a case, because it was resolved in time not to burst into the high complexity [hospital]. The prevention, guidance and information you do, but that part does not work, it really doesn't. (Interview with ACS1)

The symbology “hole in the fishing net” used to describe the RAS that was experienced by the ACS revealed the lack of cases being solved. The ACS often expose the cases to the team and do not realize the implication necessary for their resolution.

However, during the collection period, the construction of care lines was observed, based on the role of the Integrated Multi-professional Residency of the Public Health System (RMPISPS).

Enf1 says that the nurse from the surgical clinic of the Hospital (project transfer of care by the multi-professional residence) called and passed the case of a woman who was referred by the USF and underwent a hallux amputation, requesting home care. (Field diary, 5/16/2012)

[...] now that the hospital is calling to schedule childcare and postnatal appointments. The pregnant women go there, in the Obstetric Center, they deliver there and go to the maternity hospital, and from there they call to schedule the follow-up. Researcher: schedule with you before they are discharged? RN 2: yes, before discharge [...] this was not happening, I think the Residence is the one doing it. (Interview with Enf2)

Movements like this reinforce that accessibility in the USF and continuity of care are possible and linked to the relationships established within the service and with other units in the RAS. The RMPISPS stands out as the protagonist in the creation of SUS.

Discussion

Organizational accessibility may happen at the entrance or inside the USF.¹⁰ At the entrance of the USF studied, there was absence of standardization in care, and solitary and non-interactive behaviors among employees that generated difficulty in accessibility for users. This function should be a constant concern of teams and management, as the question of “how” the population was being received at the service doors was able to determine the trust and accessibility levels to the other units of the RAS.

The results corroborate with the research carried out in the townships of the northern region of the State of São Paulo. In the study, fragility was identified in the APS position, both as a regular point of care and as a preferential entrance door in the RAS.³

In this sense, it is necessary to emphasize the need for health services, especially in the APS, to adhere to the model focused on the people's needs, since there is evidence that it is more effective and efficient. Strengthening the APS is one of the flags of the World Health Organization (WHO), which since the mid-twentieth century proposes to achieve the goal of health for all.¹¹

Inside the USF, users did not receive personalized care regarding their needs, and the referral forms were lost, which caused delay in scheduling and in the appointments, and increase in the waiting time. The receipt of the demand was centralized in employees who were not supposed to do this job; the team did not take responsibility for these assignments and there were miscommunications about the services and their functions, due to the lack of knowledge of the RAS' flows. All these aspects were considered barriers to accessibility.¹⁰

This research was supported by a study in which informants from the multi-professional team identified as main barriers to universal access to health, among others, lack of recognition of priority demands and low resolution in health actions. However, unlike this research, nursing was highlighted with an in-depth look regarding its performance, contributing to equity in coverage and universal access.⁵

It was verified that the notes in the medical records were not prioritized and that responsibility was passed on to the ACS and to the population. This created barriers related to organizational accessibility, understood as "obstacles that originate in the organization of health care resources".^{10:7}

A research also revealed that the socio-organizational dimension is still a barrier to access the APS in the State of Pernambuco, and that care and coordination of care were present indicators

of the APS and relevant for accessibility.¹² Another study identified that the prevalence of a regular source of services was low, both in users affiliated to the Basic Health Unit and the ESF, indicating that this implied the straightening of the link and provided follow-up of the patients.¹³

It is important for the APS and the RAS that the population is covered, that is, linked to a service, since one of the pillars of the integrated health model is the population basis. Knowledge of the user population is a key element in eliminating the organization of services based on offers, which is characteristic of fragmented systems.¹⁴

Therefore, the necessary involvement of USF's employees to ensure continuity of care is highlighted. They are expected to make the connection with the other units of the RAS, paying particular attention to each case and enabling its resolution.

The care lines implemented by the RMPISPS represent micro-political alternatives in the creation of the RAS in the SUS. This practice stands out because there is not just one way to social transformation, because it coexists with a society that is authoritarian and libertarian at the same time. Thus, since there are several forms of oppression and domination, there are also several forms of resistance and protagonist agents.¹⁵

Postponement to solve the health problems brought by the ACS also revealed the simplification of the complexity of the cases from the perspective of the team, interfering in continuity of the care and in access to the health service. When the team did not try to solve the problem, the case was referred to the service of high technological density.

It was noted that it was necessary for the team to develop a collaborative work and that, for collaborative care to happen, social and professional ability of care managers was essential.¹⁶

The team asked the ACS to advise users not to seek Urgent Care for the treatment of injuries that could be treated in the USF. Thus, the basic question seems to be the creation of a bond as a device that enables adherence to treatment and/or continuity of treatment, avoiding unnecessary appointments and hospitalizations.¹⁷

Users' preference for a place that would immediately solve their problems, such as Urgent Care, may be related to the lack of organization of the team to meet users' spontaneous demand. Therefore, it was not characterized as a gateway, nor did it enable continuity of care, corroborating with another study.¹³

The barriers in accessibility made it possible to state that neither the principles of universality nor the integrality of the SUS were ensured. In this context, humanization was also compromised, since normative and bureaucratic actions were not sufficient to guarantee care practices and welcoming processes that attempted improvements in accessibility to health services.¹⁸⁻¹⁹

To act in the complexity presented here, it is necessary to escape from the trap of justifying what exists and betting on the recovery of hope. Hope lies in the "possibility of creating fields of social experimentation where it is possible to locally resist the evidence of inevitability by successfully promoting alternatives that seem utopian at all times and places".^{20:36}

A possible limitation of this study was the methodological option as the case study was performed in only one USF, revealing specific aspects of its organization. However, it was possible to understand the phenomenon of organizational accessibility in this space, enabling the generalization in the theoretical perspective, as evidenced in the comparison with other studies.

Conclusions

This research identified the way users were welcomed, relating organizational accessibility and their movement in the RAS. The daily life of the USF studied presented important organizational barriers to accessibility, which would need to be addressed. Restructuring the care model depends on this, making it effective and efficient. The reception of the service is essential in a health service, because it is from there that the connection of the user with what is offered inside and outside the unit, in the RAS, happens. When this is not valued and there is a divergence

of information, the reception of users can become fragile, without responsibility and prioritization by spontaneous demand.

The users' real obstacles in the search for continuous and integral care in the SUS need to be addressed; otherwise, continuity of care will be jeopardized. It is necessary to expand and qualify the service offer, to strengthen the internal organization of the USF, in order to consolidate the ESF as a regular source of care. It is also recommended to invest in communication with other care units of the SUS, establishing care flows and enabling the construction of an articulated RAS.

References

1. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília (DF): UNESCO, Ministério da Saúde; 2002.
2. Brazil. Ministry of Health. Portaria n. 4.279, de 30 de dezembro de 2010. Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde (SUS). Diário Oficial da União, Brasília; 2010 dez 30. Seção 1, p. 89.
3. Bousquat A, Giovanella L, Campos EMS, Almeida PF, Martins CL, Mota PHS et al. Atenção primária à saúde e coordenação do cuidado nas regiões de saúde: perspectiva de gestores e usuários. Ciênc Saúde Colet [Internet]. 2017 [acesso em 2018 dez 18];22(4):1141-54. Disponível em: <http://www.scielo.br/pdf/csc/v22n4/1413-8123-csc-22-04-1141.pdf> doi: 10.1590/1413-81232017224.28632016
4. Figueira MCS, Silva WP, Silva EM. Integrative literature review: access to primary healthcare services. Rev Bras Enferm [Internet]. 2018 [acesso em 2018, dez 18];71(3):1178-88. Disponível em: <http://www.scielo.br/pdf/reben/v71n3/0034-7167-reben-71-03-1178.pdf> doi: 10.1590/0034-7167-2017-0441
5. França VH, Modena CM, Confalonieri UEC. Visão multiprofissional sobre as principais barreiras na cobertura e no acesso universal à saúde em territórios de extrema pobreza: contribuições da enfermagem. Rev Latinoam Enferm [Internet]. 2016 [acesso em 2018 dez 11];24:e2795. Disponível em: http://www.scielo.br/pdf/rlae/v24/pt_0104-1169-rlae-24-02795.pdf doi:10.1590/1518-8345.1042.2688
6. Moraes VD, Campos CEA, Brandão AL. Estudo sobre dimensões da avaliação da Estratégia Saúde da Família pela perspectiva do usuário. Physis (Rio J) [Internet]. 2014 [acesso em 2018 dez 11];24(1):127-46.

Disponível em: <http://www.scielo.br/pdf/physis/v24n1/0103-7331-physis-24-01-00127.pdf> doi: 10.1590/S0103-73312014000100008

7. Yin RK. Estudo de caso: planejamento e métodos. 4ª ed. Porto Alegre: Bookman; 2010.
8. Polit DF, Beck CT. Fundamentos de pesquisa em enfermagem: avaliação de evidências para a prática da enfermagem. 9ª ed. Porto Alegre: Artmed; 2018.
9. Tonin L, Lacerda MR, Favero L, Nascimento JD, Zagonel IPS. Diário de campo na pesquisa qualitativa de enfermagem. In: Lacerda MR, Ribeiro RP, Costenaro RGS, organizadores. Metodologia da pesquisa para a enfermagem e saúde: da teoria à prática. v. 2. Porto Alegre: Moriá; 2018. p. 373-98.
10. Fekete MC. Estudo da acessibilidade na avaliação dos serviços de saúde. In: Santana JP, Santos I, Fekete MC, Galvão EA, Mandelli MJ, Penna MLF, et al., organizadores. Desenvolvimento gerencial de Unidades Básicas do Sistema Único de Saúde (SUS). Brasília (DF): Organização Pan-Americana da Saúde; 1997. p. 177-84.
11. Organización Mundial de la Salud (OMS). Más sano, más justo, más seguro: la travesía de la salud mundial 2007–2017. Ginebra: Organización Mundial de la Salud; 2017.
12. Albuquerque MSV, Lyra TM, Farias SF, Mendes MFM, Martelli PJJ. Acessibilidade aos serviços de saúde: uma análise a partir da Atenção Básica em Pernambuco. Saúde Debate [Internet]. 2014 [acesso em 2015 nov 12];38(esp):182-94. Disponível em: <http://www.scielo.br/pdf/sdeb/v38nspe/0103-1104-sdeb-38-spe-0182.pdf> doi: 10.5935/0103-1104.2014S014
13. Lima-Costa MF, Turci MA, Macinko J. Estratégia Saúde da Família em comparação a outras fontes de atenção: indicadores de uso e qualidade dos serviços de saúde em Belo Horizonte, Minas Gerais, Brasil. Cad Saúde Pública [Internet]. 2013 [acesso em 2015 nov 21];29(7):1370-80. Disponível em: <http://www.scielo.br/pdf/csp/v29n7/11.pdf> doi: 10.1590/S0102-311X2013000700011
14. Brazil. Conselho Nacional de Secretários de Saúde. A Atenção Primária e as Redes de Atenção à Saúde/Conselho Nacional de Secretários de Saúde. Brasília (DF): CONASS; 2015. 127 p.
15. Santos BS. Para um novo senso comum: a ciência, o direito e a política na transição paradigmática. 7ª ed. São Paulo: Cortez; 2009.
16. Overbeck G, Davidsen AS, Kousgaard MB. Enablers and barriers to implementing collaborative care for anxiety and depression: a systematic qualitative review. Implement Sci [Internet]. 2016 [acesso em 2018 dez 11];11:165. Disponível em: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5192575/pdf/13012_2016_Article_519.pdf doi: 10.1186/s13012-016-0519-y
17. Barbosa MIS, Bosi MLM. Vínculo: um conceito problemático no campo da Saúde Coletiva. Physis (Rio J) [Internet]. 2017 [acesso em 2018 dez 18];27(4):1003-22. Disponível em:

<http://www.scielo.br/pdf/physis/v27n4/0103-7331-physis-27-04-01003.pdf> doi: 10.1590/s0103-73312017000400008

18. Brazil. Ministry of Health. Departamento de Atenção Básica. Acolhimento à demanda espontânea. Brasília (DF): Ministério da Saúde; 2013.
19. Ribeiro JP, Mamed SN, Souza MR, Souza MM, Rosso CFW. Acessibilidade aos serviços de saúde na Atenção Básica do Estado de Goiás. Rev Eletrônica Enferm [Internet]. 2015 [acesso em 2016 set 04];17(3):1-11. Disponível em: <https://www.fen.ufg.br/revista/v17/n3/pdf/v17n3a04.pdf> doi:10.5216/ree.v17i3.29436
20. Santos BS. Para um novo senso comum: a ciência, o direito e a política na transição paradigmática. 7ª ed. São Paulo: Cortez; 2009.

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How to cite this article

Schimith MD, Budó MLD, Weiller TH, Prestes LA, Wilhelm LA, Alberti GF. Organizational accessibility: Barriers to continuity of care in primary health care. Rev. Enferm. UFSM. 2019 [Accessed on: June 15th, 2019];vol ex:p1-p17. DOI:<https://doi.org/10.5902/2179769228053>