

EVIDENCE-BASED PRACTICE IN THE CONTEXT OF THE FAMILY HEALTH SUPPORT CENTERS IN CHAPECÓ

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ABSTRACT: Objective: to analyze Evidence-Based Practice in the work of the professionals of the Family Health Support Center team. **Method:** descriptive study carried out in the municipality of Chapecó - Santa Catarina. The study population consisted of 28 professionals working in the centers in the year 2016. Data analysis was performed through descriptive statistics. **Results:** the professionals highlighted difficulties in converting knowledge needs into research questions, however, reported that they were able to collect scientific evidence and identify the main types and sources of information existing. Among the obstacles to the development of Evidence-Based Practice, they mentioned the high workload and lack of incentives from the managers. **Conclusion:** the professionals need to appropriate the elements of Evidence-Based Practice, helping the teams in the resolution of health problems.

KEYWORDS: Primary healthcare; Evidence-based clinical practice; Health personnel: Family health; Health services.

PRÁTICA BASEADA EM EVIDÊNCIA NO CONTEXTO DOS NÚCLEOS DE APOIO A SAÚDE DA FAMÍLIA EM CHAPECÓ

RESUMO: Objetivo: analisar a Prática Baseada em Evidência no trabalho dos profissionais da equipe do Núcleo de Apoio à Saúde da Família. **Método:** estudo descritivo realizado no município de Chapecó - Santa Catarina. A população do estudo foi composta de 28 profissionais que atuavam nos núcleos, no ano de 2016. A análise dos dados ocorreu por estatística descritiva. **Resultados:** os profissionais destacaram dificuldades em converter as necessidades de conhecimento em questão de pesquisa, mas se disseram aptos para levantar evidências científicas e identificar os principais tipos e fontes de informação existentes. Entre os obstáculos para o desenvolvimento da Prática Baseada em Evidência, mencionaram a alta carga de trabalho e a falta de incentivo dos gestores. **Conclusão:** os profissionais necessitam se apropriar dos elementos da Prática Baseada em Evidência, auxiliando as equipes na resolução dos problemas de saúde.

DESCRIPTORES: Atenção primária à saúde; Prática clínica baseada em evidências; Pessoal de saúde: Saúde da família; Serviços de saúde.

PRÁCTICA BASADA EN EVIDENCIA EN NÚCLEOS DE APOYO A SALUD DE LA FAMILIA EN CHAPECÓ

RESUMEN: Objetivo: analizar la Práctica Basada en Evidencia en el trabajo de profesionales del equipo del Núcleo de Apoyo a Salud de la Familia. **Método:** estudio descriptivo realizado en municipio de Chapecó - Santa Catarina. Población integrada por 28 profesionales actuantes en los núcleos, durante 2016. Datos analizados por estadística descriptiva. **Resultados:** los profesionales destacaron dificultades para convertir las necesidades de conocimiento que fueron objeto de la investigación, aunque afirmaron estar aptos para relevar evidencias científicas e identificar los principales tipos de fuentes de información existentes. Entre los obstáculos para el desarrollo de la Práctica Basada en la Evidencia, mencionaron la alta carga de trabajo y falta de estímulo de los gestores. **Conclusión:** los profesionales necesitan apropiarse de los elementos de la Práctica Basada en Evidencias, ayudando a los equipos en la resolución de los problemas de salud.

DESCRIPTORES: Atención Primaria de Salud; Práctica Clínica Basada en la Evidencia; Personal de Salud; Salud de la Familia; Servicios de Salud.

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● INTRODUCTION

Since the creation of the Brazilian Nation Health System (*Sistema Único de Saúde* - SUS), a new form of organization of the health services and practices, based on Primary Care (PC) has been designed⁽¹⁾. Primary Care is the gateway to the health system and represents the set of actions of promotion and protection of health, prevention of injuries, diagnosis, treatment, rehabilitation and maintenance of health in individual and collective contexts⁽²⁾.

In order to improve the quality and coverage of the Primary Care, the Family Health Support Center (*Núcleo de Apoio à Saúde da Família* - NASF) was created through Law No. 154 of January 24, 2008⁽³⁾. The work in the NASF contributes directly to the transfer of knowledge, skills and responsibilities, providing experience for all the professionals of the center. Basically, the NASF is a strategy to improve the efficiency and the problem solving of the teams when they act faced with the health problems of the population⁽⁴⁾.

The activities common to all the professionals involved in the center are developed jointly with the family health teams and are guided by the welcome process, humanization of health, intersectoriality, multiprofessional actions and shared responsibility⁽⁵⁾. The complexity of the actions carried out by the professionals who work in this scenario requires abilities of analysis, intervention and autonomy in order to establish transformative practices, manage changes and narrow the links between comprehension and performance of the work⁽²⁾.

Among the many characteristics and purposes of the NASF, the team formed by different professionals, the specialized support in the Primary Care, the support in foreseen and unforeseen situations, the actions shared with the Family Health Strategy (ESF) teams, helping the team to avoid referrals to other care points, increasing the capacity of the team in Primary Care, and helping to articulate with other care points in the network can be highlighted⁽⁴⁾.

The NASF should work in articulation with the FHS in order to strengthen teamwork, carry out specialized care for users and provide feedback, discussion and ongoing education⁽⁶⁾. For this, it is necessary for the professionals to use Evidence-Based Practice (EBP) as a strategy to increase the quality of their practices and the problem solving ability of the FHS.

Evidence-based practice has become a tool to qualify healthcare work, as well as presenting itself as a good strategy for clinical effectiveness and support for decision making, which the professional assumes in performing care⁽⁷⁾. This practice is based on the delimitation of a problem and on decision-making based on knowledge, previously published on the subject, added to the knowledge obtained in the practice⁽⁸⁾. For other authors, EBP is the integration of the best scientific evidence, clinical skill and patient preferences⁽⁹⁾. Furthermore, this practice is a field of permanent knowledge constantly in construction, for the analysis and greater comprehension of health phenomena⁽¹⁰⁾.

Therefore, EBP is an important tool for qualifying health care⁽¹¹⁾, as well as for bridging the dichotomy between research and care⁽¹²⁾. Nevertheless, there is a lack of studies on the use of EBP in the practice developed by the NASF team. The majority of the studies performed in Brazil, considering PBE, are about childhood and adolescence, Infectology, mental health and surgery, with prevention, treatment, rehabilitation, diagnosis and evaluation as the predominant focuses⁽¹¹⁾. Considering the above, the aim of this study was to analyze the EBP in the work of the NASF team professionals of the municipality of Chapecó - Santa Catarina (SC).

● METHODOLOGY

This was a quantitative, descriptive and cross-sectional study. The research scenario included all health units of the municipality of Chapecó - SC that had a NASF team working in the year 2016. According to the monitoring data of the Primary Care of the State Health Department, the municipality had five type I NASF, being denominated NASF West, NASF South, NASF East, NASF North and NASF Center⁽¹³⁾.

All the professionals belonging to the NASF were invited to participate in the research. According to information obtained from the Municipal Health Department in March 2016, NASF registered professionals were: two physiotherapists, five psychologists, five pharmacists, five nutritionists, five physical educators and six social workers, totaling 28 professionals⁽¹³⁾. Among all the NASF professionals, those who had been in the center for more than 6 months and who agreed to participate in the study were included. Two participants who were on maternity leave at the time of data collection, one who was not available to respond to the questionnaire after three contact attempts and three professionals who no longer worked in the NASF (dismissed during the period) were excluded, totaling a sample of 22 professionals.

Data collection took place between July and August 2016 and was performed through two instruments with objective questions: a version of the Evidence-Based Practice and Clinical Effectiveness Questionnaire (EBPQ) validated for Brazil⁽¹⁴⁾, composed of three parts related to the attitudes, knowledge and skills associated with EBP; and a Auxiliary Questions Script (AQS), developed by the researchers through previous studies.

The AQS contains 14 objective questions. In the first block, the questions are related to the characteristics of the participants, such as gender, age, graduation year, post-graduate degree or not and time spent in Primary Healthcare (PHC). The second block concerns the performance of research and access to resources in the work environment, such as the computer and the Internet. In the third block, the questions seek to identify the types of information sources and the frequency of EBP in the care practice. Finally, the last block relates to management, mastery of foreign languages and the teaching-service relationship.

Data analysis was performed by first inputting the variables into an Excel spreadsheet, which was later transferred to the Statistical Package for the Social Sciences (SPSS®) software, version 22.0. In this program, measures of position (mean, minimum and maximum) and of dispersion (standard deviation) were performed. The study was approved by the Research Ethics Committee of the Universidade Comunitária da Região de Chapecó, under authorization No. 1.573.371.

● RESULTS

The NASF professionals who participated in the study included a physiotherapist, four psychologists, four pharmacists, four nutritionists, five physical educators, and four social workers.

Of the total participants, 81.8% ($n=18$) were female, with a mean age of 31.3 years ($SD\pm 7.44$ years), minimum age of 23 and maximum of 56 years. The mean time since graduation was 8 years ($SD\pm 6.81$), median of 6 (3-33) and 90.9% ($n=20$) had postgraduate degrees, all of whom were postgraduate students in specializations. The mean time that the study professionals had worked in Primary Care was 3 years ($SD\pm 2.15$) and median of 4, with a minimum of 1 and a maximum of 8 years.

According to the NASF professionals, in their PHC practices, clinical experience was the main guide for their actions, with a mean of 5.59. The preference of the patient in decision-making was evidenced as the most tenuous component in the context of the EBP pillars, with a mean of 4.14 (Table 1).

Table 1 - Frequency that the NASF professionals considered elements of Evidence-Based Practice in Primary Healthcare. Chapecó, SC, Brazil, 2017

Variables*	Mean \pm SD	Median (min.; max.)
Their clinical experience	5.59 \pm 1.14	6 (3; 7)
The scientific evidence	5.23 \pm 1.23	5 (3; 7)
The preference of the patient	4.14 \pm 1.28	4 (1; 6)

*Answers presented on a Likert-type scale from 1 (never) to 7 (often).

SD = standard deviation; min. = minimum; max. = maximum.

Table 2 characterizes the knowledge and skills of the NASF professionals for the development of EBP on a Likert-type scale ranging from 1 to 7. Regarding the skills to review the practice and share ideas, a mean of 4.91 was observed. In relation to research skills, it was more difficult to translate knowledge needs into a research question, with a mean of 4.41. In terms of knowledge, the professionals presented a favorable mean for collecting evidence (4.64) and for identifying the main types and sources of information (5.18).

Table 2 - Presentation of the scale regarding knowledge and skills of the NASF professionals for EBP. Chapecó, SC, Brazil, 2017

Variables*	Mean \pm SD	Median (min.; max.)
Knowledge to:		
Identify the main types and sources of information existing	5.18 \pm 0.85	5.0 (4; 7)
Collect evidence	4.64 \pm 1.09	5.0 (3; 6)
Skills to:		
Review your own practice	5.36 \pm 0.95	5.5 (4; 7)
Share your ideas and knowledge with co-workers	5.23 \pm 1.27	5.5 (2; 7)
Disseminate new thinking about care among colleagues	5.09 \pm 1.34	5.5 (2; 7)
Identify gaps in the professional practice	5.00 \pm 1.02	5.0 (3; 7)
Apply knowledge to individual cases	5.41 \pm 1.14	5.5 (3; 7)
Use computer science	5.18 \pm 1.26	5.0 (3; 7)
Determine how clinically applicable the material is	5.18 \pm 1.01	5.0 (3; 7)
Monitor and review practices	4.73 \pm 1.12	5.0 (3; 7)
Perform research	4.91 \pm 1.07	5.0 (3; 7)
Determine how valid the material is	5.32 \pm 0.89	5.0 (3; 7)
Critically analyze evidence faced with previously established standards	4.91 \pm 1.07	5.0 (2; 6)
Convert knowledge needs into a research question	4.41 \pm 1.44	4.0 (2; 7)

*Responses presented on a Likert-type scale from 1 (bad) to 7 (very good). SD = standard deviation; min. = minimum; max. = maximum.

From the results of the AQS, it was verified that during the professional formation 90.9% ($n=20$) were taught how to search for scientific papers. However, only 77.3% ($n=17$) solved their doubts through scientific journals, 54.5% ($n=12$) through the Internet and 50% ($n=11$) through the *Telessaúde* system. In addition, it can be reiterated that the number of professionals of the NASF who used the Internet to solve doubts was low, considering that all had a computer with access to the network available in the health facility.

It was observed that only 3 (13.6%) professionals read and understood English “well”, while 4 (18.2%) read and 2 (9.1%) understood Spanish “well”.

Table 3 shows that the NASF professionals recognized scientific evidence as being fundamental to the exercise of their profession and that it could transform their practice. However, they demonstrated that the workload in PHC is an obstacle to staying current with all the latest scientific evidence (Table 3).

Table 3 - Description of the attitudes towards EBP of the NASF professionals. Chapecó, SC, Brazil, 2017

Variables*	Mean ± SD Median (min.; max.)	Variables*
My workload is too great for me to keep up to date with all the latest evidence.	□ □ □ ■ □ □ □ 4.14 ± 2.01 4 (1; 7)	New evidence is so important that I allocate time for this in my work schedule.
I feel uncomfortable when my practice is questioned.	□ □ □ □ □ ■ □ 5.64 ± 1.53 6 (1;7)	I openly welcome questions about my practice.
Evidence-based practices are a waste of time.	□ □ □ □ □ □ ■ 6.59 ± 0.85 7 (4;7)	Evidence-based practices are fundamental for the professional practice.
I keep using tried and tested methods instead of switching to something new.	□ □ □ □ ■ □ □ 5.59 ± 1.10 6 (4;7)	My practice has changed due to the evidence I have found.

*Responses presented on a Likert-type scale from 1 (bad) to 7 (very good). *SD* = standard deviation; min. = minimum; max. = maximum.

The NASF professionals, when questioned about the incentives of the managers regarding study time during the work day, presented a mean of 4.64 on the Likert-type scale from 1 to 7. It was also observed that 45.5% ($n=10$) had developed some research, with or without the team, in the previous 3 years. It was found that 4 (18.2%) of the NASF professionals had links (tutoring, direct or indirect supervision, among others) in their work environment with people from a university, 3 (13.6%) being academics.

● DISCUSSION

Although the NASF professionals participating in this study acknowledge the importance of performing EBP, it was still very much focused on the pillar of clinical experience and to a lesser extent on the pillars of scientific evidence and patient preference. A study carried out in São Paulo (SP) also showed that a significant number of health professionals considered the opinion of specialists to be the most important for decision-making⁽¹⁵⁾.

In addition to considering the knowledge of specialists, it is important for NASF professionals to amplify the use of EBP in the NASF, since when the team shares opinions and knowledge in an attempt to promote the care for the individual, as proposed by the Singular Therapeutic Project (*Projeto Terapêutico Singular* - PTS), this qualifies the project and the action proposals⁽⁵⁾. In addition, it is understood that a function of the NASF is to provide scientific evidence for dialogue with the FHS, since it acts in Primary Care as a source of ongoing education.

Listening to the patients and considering their opinions and beliefs is also part of the EBP process. Likewise, without the use of the best scientific evidence, care becomes obsolete, and the probability of errors in the conduct increases, since EBP has as its final objective the best outcome for the patient, with the resources available⁽¹⁶⁾.

As in previous studies, which claim that insufficient knowledge and skills are significant barriers to EBP⁽¹⁷⁾, the results of this study highlight that the NASF professionals had difficulties in converting their knowledge needs into a research question and, consequently, their decision-making was anchored in protocols provided by the Ministry of Health.

The fact that the professionals had the protocols as support is also due to the availability of these materials, from the Ministry of Health, to guide the NASF actions. This practice is measured by the Self-Assessment for Improving Access and Quality of Primary Care (*Autoavaliação para Melhoria do Acesso e da Qualidade da Atenção Básica - AMAQ - NASF*), which assesses whether the coordinators provide on-site and/or virtual mechanisms, such as practice communities, the *Telessaúde* system, discussion groups, an interactive virtual site or collaborative social network, seminars, exhibitions and workshops, among others, in order to promote the sharing of experiences and the exchange of knowledge⁽¹⁸⁾.

The *Telessaúde* system was used to solve doubts and resolve problems by half of the professionals studied in this research, with it being considered a strategy for the qualification of Primary Healthcare. Its actions are directed toward all the professionals working in PHC and toward the other professionals of the PHC Support Centers. Its aim is to qualify the work of the teams that work in the PHC axis and its activities are guided by the principles of the SUS, the PHC attributes and the best and most current scientific evidence available for the primary care practice⁽¹⁹⁾.

Although the protocols are validated instruments and their use is encouraged by the Ministry of Health, their performance is standardized, that is, they do not consider the epidemiological and cultural aspects of the different regions of Brazil. There is also no assurance that the contents of these protocols are based on the best scientific evidence. The protocols or guidelines are highly respected management tools, however, the analysis of their limits shows that they can promote alienation at work when they are used indiscriminately as standards, since the original perspective of their formulation is lost⁽²⁰⁾.

Professionals do not need to exclude the use of protocols from their practice, however, they must consider the location and context of the patient. Many health professionals today still present a positivist ideal, imposing a closed theoretical model, in which the service user does not actively participate in the process, as well as dissociating health and illness from the historical, social and cultural aspects and dimensions of the individuals⁽²¹⁾.

However, this does not mean that health professionals should set aside the theoretical models that guide them in their activities, rather that they need to communicate with others to understand the real needs of the individual. In addition, they must take into account that they are subjects of their own story, and therefore, exercise control over their lives, perceiving and acting according to experiences in the collective life⁽²¹⁾.

Another result of this study concerns the academic formation, demonstrating that, although the professionals highlighted that they were taught in their academic training how to search for scientific articles, the majority did not do this. This attitude of not searching for scientific productions is a limiting factor, both for the deprivation of the formation directed toward the EBP approach and for the lack of continuity of incentive for the research process after graduation. To form students with aspiration for research it is necessary to develop favorable conditions throughout the graduation period. In this sense, it is essential to encourage the academics and involve them in the research and extension activities of universities⁽²²⁾. In a similar study carried out with physiotherapists from the state of São Paulo, Brazil, which aimed to identify knowledge and skills related to EBP, the professionals acknowledged that the information acquired during graduation was insufficient for the implantation of EBP⁽¹⁵⁾.

In this study, the NASF professionals presented the high workload as a limiting factor for EBP. Another author affirmed that the NASF work overload, with an excess of users and tasks of the FHS with groups and generalist actions, is due to the low quality of some FHSs in filtering the users and/or to the few or nonexistent collective (generalist) actions⁽⁶⁾. Similar studies have affirmed that the lack of time is the most common personal barrier for health professionals to implant EBP^(15,17). Despite health professionals presenting positive attitudes regarding the need to base their work on and implement EBP, studies indicate that they do not feel empowered to make changes in their practice⁽²³⁻²⁴⁾.

Although the development of studies and of EBP is considered a fundamental activity for the practice of the NASF professionals investigated in this study, the integration of scientific evidence with the updating of the clinical practice appears to be a challenging process in the health services⁽²⁵⁾. Thus, it can be said that the attitudes of NASF professionals do not solely depend on their positions, since they are also regulated by the organization and policy of the health services. Nevertheless, the initiative to change this reality needs to be exercised by its participants, the NASF professionals. It is agreed that this transformation is not a simplistic one, since the aspects of the formation, organization of the services and incentives of the professional representation bodies need to be reviewed and improved.

The NASF must be more than a user of scientific evidence, it must also be a generator, in order to complement the actions of the FHS. Another author justified the articulation between the NASF and the FHS by pointing out that clinical and work actions should occur in a synergistic way, developing ongoing mutual education and providing permanent education to the FHS, with an increased ability for resolution, since the NASF is a strategy to improve the efficiency and health problem solving ability in Primary Care⁽⁶⁾. The work of the NASF contributes directly to the transfer of knowledge, skills and responsibilities, providing experience for all the professionals of the center⁽⁴⁾.

This study has the limitation of having been performed in a single municipality, however, it is considered a regional reference in health for the state of Santa Catarina. In spite of this, this study provides information that can support reflections regarding the Family Health Support Center in other regions and municipalities, as it identifies the knowledge and skills gaps of the professionals who work there in relation to the act of performing and using studies to support decision-making. The present study also stimulates the debate around the need to strengthen the process of professional formation with regards to Evidence-Based Practice.

● CONCLUSION

The NASF practitioners recognized that EBP is central to the practice of their profession, however, is now more focused on the clinical experiences of the professional and to a lesser extent on the pillars of scientific evidence.

The FHS team, due to its generalist function, needs specialized support to meet the demand. Thus, this specialized care is a function of the NASF and, therefore, it is necessary that there is a review of the work processes, since the workload cannot prevent the NASF from using EBP to carry out its function, which is to offer specialized support to the FHS team.

Further research is needed to understand and recognize possible barriers in order to consolidate EBP, since the development of this approach enables health services to assist people more efficiently and resolutely.

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