

CHALLENGES OF REFERRAL AND COUNTER-REFERRAL IN HEALTH CARE IN THE WORKERS' PERSPECTIVE*

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ABSTRACT: This study's objective was to identify the challenges of Primary and Tertiary Healthcare in the health services of a municipality in the South of Brazil. It is a descriptive-exploratory study, with a qualitative approach, undertaken with the multi-professional team. The data were collected between July and August 2014, using semistructured interviews. The results were organized in two thematic categories: Difficulty in articulation in the health services and the solitary work. The lack of communication between the services' workers, lack of knowledge regarding the services in the network, lack of continuing education, the absence of feedback from the services and the lack of responsabilization of the professionals involved in the care were highlighted, which weakens the processes of referral and counter referral.

DESCRIPTORS: Health services; Comprehensive health care; Reference and appointments; Patient care team.

DESAFIOS DA REFERÊNCIA E CONTRARREFERÊNCIA NA ATENÇÃO EM SAÚDE NA PERSPECTIVA DOS TRABALHADORES

RESUMO: O objetivo deste estudo foi identificar os desafios da Atenção Primária à Saúde e Terciária nos serviços de saúde de um município do sul do Brasil. Estudo descritivo-exploratório, de abordagem qualitativa, realizado com equipe multiprofissional. Os dados foram coletados entre julho e agosto de 2014, utilizando-se a entrevista semiestruturada. Os resultados foram organizados em duas categorias temáticas: Dificuldade de articulação nos serviços de saúde e o trabalho solitário. A falta de comunicação entre os trabalhadores dos serviços, o desconhecimento sobre os serviços da rede, a carência de educação permanente, a ausência de retorno dos serviços e a falta de responsabilização dos profissionais envolvidos no cuidado foram destaque, o que fragiliza os processos de referência e contrarreferência.

DESCRIPTORIOS: Serviços de saúde; Assistência integral à saúde; Referência e consulta; Equipe de assistência ao paciente.

DESAÍOS DE LA REFERENCIA Y CONTRARREFERENCIA EN LA ATENCIÓN EN SALUD EN LA PERSPECTIVA DE LOS TRABAJADORES

RESUMEN: El objetivo del estudio fue identificar los desafíos de la Atención Primaria a la Salud y Terciaria en los servicios de salud de un municipio del sur de Brasil. Estudio descriptivo exploratorio, de abordaje cualitativo, realizado con equipo multiprofesional. Los datos fueron obtenidos entre julio y agosto de 2014, utilizándose la entrevista semiestructurada. Los resultados fueron organizados en dos categorías temáticas: Dificultad de articulación en los servicios de salud y el trabajo solo. La falta de comunicación entre los trabajadores de los servicios, el desconocimiento acerca de los servicios de la red, la carencia de educación permanente, la ausencia de retorno de los servicios y la falta de responsabilización de los profesionales involucrados en el cuidado fueron destaque, lo que debilita los procesos de referencia y contrarreferencia.

DESCRIPTORIOS: Servicios de salud; Asistencia integral a la salud; Referencia y consulta; Equipo de asistencia al paciente.

*Article taken from the Specialization dissertation titled: "The process of referral and counter referral of service users with vascular alterations from a hospital institution to the healthcare network". Federal University of Santa Maria, 2014.

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Received: 02/10/2015

Finalized: 20/01/2016

● INTRODUCTION

The epidemiological and demographic transitions, allied with the intense process of globalization, urbanization and unhealthy living habits, trigger demands to be faced by the health services - the Chronic Non-Communicable Diseases (CNCDs)⁽¹⁾. Data from the World Health Organization estimates approximately 38 million deaths per year from these health problems, with higher rates in developing countries. In Brazil, this number corresponds to 72% of causes of death⁽²⁾.

In the light of this, the Brazilian CNCD Strategic Action Plan 2011 – 2022 was launched, with the objectives of developing and implementing effective and integrated public policies, so as to prevent and control these comorbidities and their risk factors⁽³⁾. To this one may add the creation of Ministerial Ordinance N. 483, which redefines the Health Care Network for People with Chronic Diseases in the ambit of the Unified Health System (SUS) and establishes directives for the organization of its lines of care⁽⁴⁾.

The chronic diseases and the CNCDs require joint actions from Primary, Secondary and Tertiary Health Care, with the objective of treating the service user in this journey in the Health Care Network (RAS, in Portuguese) such that the comprehensiveness of the care may be achieved.

The RAS are polyarchic organizations of sets of interlinked health services which offer continuous, comprehensive and humanized care to a specified population, being coordinated by the Primary Health Care (PHC) Service⁽⁵⁻⁶⁾, in articulation with Secondary and Tertiary Care. The points of Tertiary Care are technologically denser in comparison with those of Secondary Care; however, there is no relationship of subordination between them, as all are equally important for the achieving of the RAS's objectives⁽⁵⁾.

For the effectiveness of the work in the RAS, it is necessary for the workers to take responsibility for the continuity of the care to the service user, and for the work processes – that is, the way that each professional works – to be organized. The work process is the key to the issue, as it is through this that one promotes the care for the service users⁽⁷⁾. For this, it is necessary that these services of the different levels of care (PHC, secondary and tertiary) should be interlinked, causing them to put into effect the processes of referral and counter-referral.

Studies have been undertaken with the PHC⁽⁸⁾ and secondary care⁽⁹⁾. However, studies have not been identified on the articulation of the PHC and Tertiary Care, which would assist in the analysis of the processes of referral and counter referral between the health professionals. It is based on this perspective that the question is raised: What are the challenges identified by the health workers of the PHC and Tertiary care for the effectiveness of the processes of referral and counter referral? This article aims to identify the challenges between Primary Health Care and Tertiary Health Care in the health services of a municipality in the south of Brazil. Studies such as that proposed demonstrate the need for greater integration of the services and the establishment of formal flows of referral of the service users⁽¹⁰⁾, allowing the health professional to direct her actions.

● METHOD

This is a descriptive-exploratory study with a qualitative approach. This type of research is characterized by working with the universe of meanings, motives, beliefs and attitudes. This method is made up of an explanation⁽¹¹⁾ of what the subjects say and express⁽¹¹⁾.

It was undertaken in July – August 2014 in a university hospital and in the RAS of a municipality in the south of Brazil, whose estimated population in 2014 was 275,000 people, and which has 68 SUS health establishments.

The University Hospital is characterized as a teaching hospital, which attends only service users of the SUS and which is a center of excellence in the provision of care for more than 42 municipalities. In relation to the municipality's RAS, this has 13 Health Stations or Primary Care Centers* (UBS), 14 Family Health Strategy (ESF) units, three Emergency Departments (PA) and five District Units.

Firstly, the municipality's RAS was investigated through the Annual Health Plan (2013/2016). Following that, the service users hospitalized in the University Hospital's surgical inpatient unit with vascular alterations, and the workers who provided care, were identified. This identification took place weekly through the records of attendance in the service users' medical records, and in the occurrence of the recording of more than one worker from each professional nucleus, lots were drawn. It is emphasized that the surgical unit has two bed spaces for service users with vascular alterations. In the referral for discharge from hospital, the UBS/ESF to which the service user belonged was identified, and telephone contact was made with the objective of arranging a time for the identification of the workers who worked in that department.

A total of eight workers from primary care (basic) and tertiary (hospital) participated, from different professional nuclei: two physiotherapists, two physicians, and four nursing workers (two nursing technicians and two nurses). The inclusion criteria for the workers who provided care in the hospital were to work in the unit where the service user with vascular alteration was hospitalized, and to have provided care to the same during the period of hospitalization. For the nucleus of medicine, it was established that in the hospital care it would be the prescribing physician (the vascular surgery resident, this being a University Hospital), as it was he who undertook the daily assessment of the service user. For the primary care professionals, those professionals who worked in the unit to which the service user had been counter-referred were included. Those workers who were on leave of any kind were excluded. A time period of two months was established for data collection.

The data collection technique was the semistructured interview, held individually, in accordance with the participant's availability and in the areas where he or she worked. It was guided by a script directed towards the type of interview selected, in which the topics encompassed the range of the information expected, functioning as reminders which allow flexibility in the conversations and the inclusion of new issues and questions raised by the interlocutor as being of his or her structure of relevance. These were analyzed according to the stages of pre-analysis, exploration of the material, treatment of the results obtained, and interpretation(11). The interviews had a mean duration of 30 minutes, and were recorded following the participants' authorization. They were transcribed in full.

This study complied with the rules established under Resolution N. 466(12), with the study objectives and Terms of Free and Informed Consent (TFIC) being presented to the participants. The participants from primary care were identified with letters of the alphabet followed by random numbers (a5, b3, c1....) and, for those from tertiary care, followed by random Roman numerals (aII, bIV, cVI...). All participants read and signed the TFIC and retained one copy for themselves.

The study was approved by the Research Ethics Committee, under CAAE N. 32533014.0.0000.5346, on 15th July 2014.

● RESULTS

The participants from primary care had a mean age of 32.5 years old, and those from tertiary care, 43.25 years old.

Based on the analysis of the interviews, the following categories were constructed: Difficulty of articulation and The solitary work.

Difficulty of articulation in the health services

The PHC workers mentioned difficulties in the health services such as the lack of articulation and communication between the services, and the workers' lack of knowledge regarding the functioning of the RAS, as evidenced in the accounts below:

*These units are only for preventive care, such as gynaecological or dental consultations or vaccinations. Emergency treatment is undertaken in dedicated emergency units. Translator's note.

[...] We have points of care, it is necessary to interlink these points to form the network, some things work, but this is not institutionalized, you depend much more on the professional who is there[...] I think that what is missing is for the services to reunite, to get to know each other, to converse among themselves in order to form this network, it has to be formalized [...] to be instituted longitudinally, for all the services of the network to be able to have these times for conversing, and to have this concern about counter-referring/referring, because it is very important [...].(a5)

[...] I think that nothing works, that there is not enough management, that what is missing is somebody to organize things and train the staff themselves [...] The training would be fundamental, because I can't see this happening, you go to primary care and nobody knows anything, you passed the examination for the job there, and don't know anything, how it works, you discover it from a conversation here, a conversation there, but I think that training should be done for the person's own understanding [...] I think that nothing works, that there is a shortage of management, a lack of guidance, a lack of training. (b8)

In the field of hospital practice, the workers also mentioned lack of knowledge, and a certain fragmentation of knowledges, in which each professional seeks to meet the service user's needs in an isolated way, due to the inexistence of communication:

[...] What I see as the difficulty is that sometimes they change and don't tell us[...] We don't have clear information, it is when there is a change of routine, simply the routine changes, and we don't find out. (cX)

[...]I don't normally guide the patients [...] we give them medical guidance and, when the patient has doubts, we always refer to them via the Health Department, or, if it is another municipality close by, we refer them to primary care, sometimes we refer them by referral and counter-referral, referral to other specialities, in accordance with the access of the SUS network, which is not very easy [...].(all)

[...] There is a lack of communication [...] and the physicians, also, sometimes do not discuss things with us [...] We do not have this communication, this relationship [...].(bIV)

In the light of the difficulties, the workers from primary care and hospital care demonstrated inertia, failing to find a solution for the problem:

[...] Does this network exist or not? It exists! It is just that it is not functional [...] I'm not sure what is missing for it to function, but one thing is that it must function, because otherwise the entire SUS, and the precepts, and basic principles, do not make sense, the service's history of comprehensiveness does not make sense [...] because I am locked in primary care, and there I am able to refer the patient to another level, it is just that, when he returned, he returns without anything, as if he had never been out of primary care[...] I feel really isolated in primary care, I don't have contact, I'm isolated, I don't have contact with anybody from the other levels... If it works, it would be great!(c3)

[...] It is impossible for a professional to make it work if he doesn't even know how it works, or who supports him, nothing [...] it also depends on the professional, each person is different, sometimes it doesn't work, I think that it is the part of organizing that is missing, organizing a little, because that way each one does their own work, in their own corner, and it ends up [...] that I do my part [...] I care for my patient's shoulder and then send him there, and from then on it is his problem, and I don't even know how he is [...] and this way, it is another job to get any information [...] Once I needed information from the hospital, about one of my patients, and I telephoned there, and couldn't achieve anything [...] So, this interaction is lacking [...] I don't even know what the path to choose is (laughs) [...] Someone needs to create (laughs) a system for integration (laughs), with open doors, I have no idea how to do that, not even how to get started [...].(b8)

It is in this context that the multi-professional work is put into effect, which has as its aim to articulate the different knowledges in order to seek comprehensive treatment for people, causing the work not to be solitary.

The solitary work

In this category, the primary care workers discussed that in order to make the system of referral and counter-referral effective, it is necessary to work together:

[...]No we don't get any feedback about the patient [...] Sometimes we find out if the patient hasn't brought it to us(referring to the counter-referral document), I try to have, more or less, the control of what we send, then, if the patient doesn't bring it, I ask the community health worker to go to the patient's house, only that this is a problem, because most of the services do not provide in writing what was done [...].(a5)

[...]the referral document is generally when you're going to refer a patient for secondary care, generally tertiary, so you send, write – more or less – the patient's history, what needs to be evaluated, and what is correct would be to return that document with the response, let us say, from that specialist, so that you can know what happened, and provide treatment in conjunction with that speciality [...] I have never received anything, since I've been here, nothing, zero, zip [...] I only meet difficulties, [...] we refer them first, because we don't receive information back, and secondly, because it is very difficult for you to achieve an appointment [...].(c3)

In the hospital care, the challenges are similar, with emphasis on the responsibility of all the professionals involved in the care. In this way, the length of hospitalization and its costs can be reduced, and it is possible to decentralize the care. This is evidenced in the following accounts:

[...] It is the responsibility of all the professionals, but these referrals and counter-referrals generally end up falling upon the shoulders more of one than of another. I understand that it ends up falling much more on the shoulders of the nursing staff, and to a certain extent on the doctors, it is very rare for a professional who is in the other point to get back to us, contact us, we often find out what is going on through the patient [...]there is no point in me sending a patient off with all the documentation ready and everything, but who needs care, and if he doesn't receive this care needed, all our work ends up having been wasted, and in our professional experience this has happened many, many times, so you end up becoming extremely annoyed and demotivated [...].(all)

[...] There are some failures, as this hospital is a referral hospital, for example, the population has grown, but the hospital has not, so there aren't the bed spaces for taking people in for inpatient treatment, there aren't any rooms for undertaking surgery, often the patient is a patient who does not need to come to the tertiary hospital, but ends up coming, we take time to attend to those who need it, but the problem that could be resolved in primary care is not resolved there, and comes here. However, the proposal for the system is to function properly, this needs to be improved slightly, you have, for example, to increase this hospital's structure, it was built 40 years ago, and still has the same structure [...] The system only functions if everybody works together, otherwise, at some point, there is an obstacle [...].(cX)

● DISCUSSION

The RAS is the integration of the entire health system, the articulation between the health services being important if the workers are to establish communications and exchanges so as to create a bond with the service user, such that this may be attended in the RAS for the continuity of her care. This “journeying through the network”, with a view to attending their needs and/or requirements, may be termed ‘shared care’^(5,13).

The data extracted from the interviews show that lack of communication, associated with the workers’ lack of knowledge regarding the functioning of the services, are factors which may compromise the articulation in the health services, and, consequently, in the RAS. One study demonstrated the need to guide the service user, from the point of the system gateway until the end of their life; and that the services should be integrated at all their levels of care⁽¹⁴⁾.

In another study, on the analysis of the journey traveled by the SUS user, from the level of lowest technological density through to that of highest density, authors describe that the principal difficulties found by the individuals are the comprehensiveness and continuity of the care, the structuring of the RAS, with strengthening of the integration between the workers being necessary so as to agree on the health care flows in the network⁽¹⁵⁾, a fact which is consonant with this study.

One of the negative points for Comprehensive Care is the fragmentation of the RAS, and, as a result of this, primary care is unable to exercise its principal function, which is to be the center of

communication, that is, that responsible for coordinating the care⁽¹⁶⁾. In order for the care flows to exist and to be effective and resolute, it is essential to form Lines of Care, with the flows being agreed upon among the managers with a view to facilitating the user's access to her needs. They reveal the paths which must be guaranteed to the service user, and define the actions which must be undertaken in the points of care of different technological densities⁽⁵⁾.

Based on this, one can observe from the participants' accounts that the RAS continues to present weaknesses in the municipality investigated. In spite of some workers understanding how it functions, the lack of preparation and lack of information regarding how to work in a network are evident; this may indicate the limitations of the management and organization of the set of healthcare services, and cause dispendency and demotivation in the workers. One study concluded that, in order to qualify PHC, the following are necessary: trained professionals, the qualification of the provision of services, the monitoring of results, and the valorization of the health professionals involved⁽⁸⁾.

It is necessary to investigate the processes of referral and counter-referral, one of the management tools that the SUS brings for its consolidation. These processes constitute part of the competence of each component of the RAS (primary care, specialized care)⁽⁴⁾, and present how the way of organization of the services - configured in networks and supported by criteria, flows and mechanisms of agreement on functioning in order to assure comprehensive care to the service users - occurs.

In understanding the network, one must ensure links in different intra-health team dimensions, inter-teams/services, between workers and managers, and between service users and services/teams⁽¹⁷⁾. Based on the analysis of the interviews, one can perceive the fragmentation between the services, characterizing the work as solitary, without the sharing of the care of the service user in the RAS. This fragmentation of the care is manifested, particularly, in the weakness of the articulation between points of the system's management, as well as the lack of articulation between the health services, and also as lack of articulation between the clinical practices undertaken by different workers from one or more services, geared towards a single individual or group of individuals⁽¹⁾.

As an example, in a service with higher technological density, one must plan discharge from hospital since the day of the service user's hospitalization. This could contribute to reducing re-hospitalizations and, in particular, to giving continuity to the care. As a result, it is understood that in order to qualify the processes of referral and counter-referral, it is necessary to invest in the multi-professional care, in particular at the time of discharge from hospital, which will trigger an integrated, resolute and humanized action for the continuity of the health care.

Research undertaken in a secondary care service emphasizes that creating flows and counter flows facilitates the service user's movement through the network, which, in its turn, facilitates access to, and the continuity of, the care. It concluded that extending the services, the access to consultations and specialized procedures, and the articulation of the services of the points of the network, are important aspects of the comprehensiveness of the care⁽⁹⁾. In relation to this, the author emphasizes that the meaning of referral and counter-referral, no matter how it may be considered a change in the system, continues to be hampered, particularly regarding its effectiveness and functionality⁽¹⁸⁾.

In view of this, it is necessary to refer to the humanization of the care, which relates to an ethical-aesthetic-political bet. The biggest challenge posed to the National Humanization Policy (PNH) is articulating the RAS in a shared way, which ensures the service users' access with quality and resolute capacity, as the services must serve as spaces for sociability with periods of continuing education⁽¹⁶⁾. It is important to invest in continuing education on the part of the services' managers, with a view to improving the quality of the care provided, meeting that stipulated by the PNH.

The hospital work requires changes in the process of professional work, placing emphasis on the articulation and communication between teams and the multi-professional work⁽¹⁹⁾, continuing education, and the application of public policies. In all the services, furthermore, it is necessary to form a network of articulated services so as to guarantee resolution of the population's health problems, with work processes that viabilize the practice of comprehensive care⁽²⁰⁾.

In order to achieve the comprehensiveness of the care, it is necessary to have a network of articulated services, which will contribute in the resolving of the population's health problems, in a

perspective directed towards the practice of Comprehensive Care and work processes which viabilize this proposal⁽²⁰⁾. It is important to think comprehensively about the service user, which requires workers who are involved and motivated, and requires a change of attitude in order to function in a systematized way and as a multi-professional team.

As a consequence, it is necessary to implement the processes of referral and counter referral, so as to improve the attendance to the service users. Encouragement to continuing education may be one of the strategies for better communication between the services and resolutive capacity of the healthcare, which would contribute to reducing the waiting lists, in the levels with greater technological density, and re-hospitalizations.

● FINAL CONSIDERATIONS

It was evidenced in this study that the challenges identified by the health workers from primary and tertiary care in the health services are related to the lack of communication between the workers of the services, to lack of knowledge regarding the services of the RAS, and to the lack of continuing education. Often, the work is characterized as solitary, due to the absence of feedback from the services to which the service user was referred, and to the lack of responsabilization of the professionals involved in the care, which compromises the effectiveness of the processes of referral and counter-referral.

These processes meet resistance and difficulties for their implementation and formalization, with it being necessary to raise people's awareness/provide training regarding the Health Care Network, with views to offering the service user comprehensive care. It is in this context that multi-professional and interdisciplinary work, and the need to work in networks, are inserted.

As limitations of this study, emphasis is placed on the time criteria for data collection, as the hospitalized service user, due to the canceling/rearranging of operations, remained there for a period of time greater than that foreseen, which did not allow counter-referral. It is emphasized that the production of data arising from the interviews met the objectives proposed, and that, as a result of this, further participants were not included.

Also as limitations, there is the fact that this study was undertaken with a local sample, in a single context, the analyses therefore possibly being limited, as they represent the perceptions of a particular group, it not being possible to make generalizations from the results.

Nevertheless, the data indicate the need for further investigations, such as investigating the service users' perception regarding the RAS of the municipality studied, which would broaden the discussions on the weaknesses/strengths of the services, and allow the planning of actions.

This study contributes to the planning of actions referent to the RAS, and advances the production of knowledge in the specific ambit of primary and tertiary care, in which there is a lack of investigations. The need for continuing education is suggested, with a view to qualifying the healthcare services of the municipality investigated, strengthening the referral and counter-referral and offering the service user comprehensive care.

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