Management of interprofessional work in the singular therapeutic project: proposal for a work process model

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ABSTRACT

Objective: propose a model for organizing the activities of a Singular Therapeutic Project (STP) in the context of Family Health Strategy (FHS), contemplating interprofessional collaboration. **Method:** It is qualitative research. The action-research strategy was used, involving a multidisciplinary health team and interprofessional collaboration actions, in order to improve the practice. Action research was chosen because it is suitable for studies in social settings, in different contexts. The researchers and the team agreed the discussion of the STP would take place in large meetings to encourage discussion, reflection and proposals for actions to be taken for the case. Fieldwork involved approximately 20 meetings with the team that generated subsequent reflective moments of the research. This dynamic favored the proposal of the model. The stages of the research work were: problem recognition, planning, implementation and evaluation. **Result:** In the collective work meetings, some flaws in the STP process were noticed, such as: a lack of clarity of objectives; few interprofessional collaborative actions directed and planned along with the patient and family and low resolution. Thus, a four-step model was proposed: staff meeting, assignment of STP cases, executing the STP, and closing the STP. These steps range from case selection to completion of the STP, or definition of a new care approach by the team. **Conclusion:** The proposed model is a theoretical contribution and needs further empirical studies in order to validate its application within the FHS. The lack of pre and postgraduate training in interprofessional education of the participants was identified as a limiting factor for the care management for the STP. However, the model is justified as it helps to build interprofessional actions, recommended by the Unified Health System (UHS) and international health agencies (WHO and PAHO).

Keywords: Singular therapeutic project, Work process model, Interprofessional collaboration, Family health strategy, Action research.

INTRODUCTION

With the Unified Health System (UHS), the Brazilian Government sought to guarantee health, in the broadest sense, as a duty of the State and, for this purpose, proposed a set of social and economic policies[1].

Since its implementation in 1990, UHS has chosen policies and actions encouraging the qualification of professionals and physical structures to "overcome the difficulties imposed by the need to make health care more effective, efficient and equitable"[2], in the health network. In 1994, the Family Health Program was created, today called the Family Health Strategy (FHS), its attributes derive from Primary Health Care (PHC) and include multidisciplinary teams in a context of community-oriented work processes and their social determinants for health.

The evolution of the work of the Family Health Teams (FHT) showed the need to add other health professionals, in addition to doctors and nurses, to the service. In response to this demand, the Ministry of Health created the Family Health Support Nucleus (FHSN)[3], an assistance modality that enabled differentiated care from PHC, with the inclusion of other categories in the work process, such as physiotherapists, speech therapists, nutritionists, occupational therapists, among others.

FHSN was considered a fruitful space for the development of the interprofessional education of the FHT in the PHC, highlighting the leading role of the professional staff for the interaction and

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integration of the practices, constituting a work process of interprofessional collaboration[2,3].

Interprofessional collaboration comprises a work in which health professionals from different areas assume responsibilities, act with interdependence, are aware of their functions and have objective guidelines for providing integrated care[4,5].

All things considered, in order to facilitate the work process of interprofessional collaboration, the Singular Therapeutic Project (STP) presents itself as an "instrument for organizing health care built between the team and the user, considering the singularities of the subject and the complexity of each case"[6], integrating varied knowledge and visions of the different members of a health team.

STP is understood as "a set of proposed therapeutic approaches articulated for an individual, a family or a group that results from the collective discussion of an interdisciplinary team with matrix support, if necessary"[7].

The STP consists of four instances:

1) Diagnosis and analysis: it considers the physical, psychological and social aspects of the case, for a diagnosis contemplating the risks and vulnerability of the user.
2) Definition of actions and goals: it presents short, medium and long-term proposals that will be negotiated with the people/family/caregiver, preferably by the professional in the team with the best bond with him. According to Ditterich, Gabardo and Moysés[8], the team perceives "key moments" (changes in the life cycle, the emergence of diseases, among others) to choose the STP approach for the family.
3) Division of responsibilities and tasks for team members, in addition to a reference professional to ensure continuity of care and definition of who will coordinate case management[6].
4) Reassessment: it discusses the evolution and need for reformulations in the project.

It can be seen in the STP approach a challenge to innovate the care process, in which it is necessary to intensify professional interaction, to better qualify health care, reduce conflicts and expand interprofessional collaboration, as well as to improve the quality of care management, in terms of equity, efficiency and effectiveness[2,5,9].

A study carried out on the use of STP in mental health care in Brazil showed that there is an inconsistency between what the Ministry of Health recommends for the elaboration of the STP and what is verified in practice, especially with regard to: participation and co-responsibility between the team and the people in the construction of the STP; the definition of goals; the division of responsibilities in the teams involved; the difficulty of articulating professionals from different areas of knowledge for patient care; and the sharing and discussion of information about the cases[10,11].

Despite the fact that the STP is a tool for improving the effectiveness of therapeutic actions, its implementation represents a challenge, since elements such as communication in teamwork and joint construction of approaches to clinical cases are necessary, which challenges the traditional organization of the process of health work, as it presupposes the need for greater articulation between professionals, the use of meetings as a systematic collective space for meeting, reflection and discussion[3,7].

In this context, the following research question arose: how can the STP be incorporated into the routine of the FHT, favoring interprofessional collaboration?

It is, therefore, a matter of considering aspects relevant to the planning and organization of the work process within the scope of the FHT, in the sense of establishing a work routine oriented towards the use of STP and the establishment of an internal organizational environment that favors interprofessional collaboration[2].

To answer this question, it was elaborated this action research to propose a model for the organization of STP activities in the context of the FHS, facilitating interprofessional collaboration.

MATERIALS AND METHODS

The work has been developed in a professional training service for health, integrated into the health network of a large city in the state of São Paulo through an agreement with a state university. The service has an FHT, according to the norms of the National Primary Care Policy[12], to provide health care to the population in a reference area. Once it is a school service, the team develops preceptorship in the training of health professionals, covering family

medicine residents, multiprofessional residents and undergraduate teaching. In this context, the university develops, in partnership, the activities of the teaching programs with the team and promotes research focused on health care through professors and researchers linked to these services.

Services include assistance to patients with multiple health needs and a high rate of aging, such as patients in palliative care and patients with chronic non-communicable diseases. Moreover, the service is organized to deal with acute illnesses and monitor the development of children and adolescents, women and adults.

The presence of vulnerable patients due to age and the commitment of complications resulting from chronic non-communicable diseases demands a differentiated approach from health professionals and caregivers, focused on the interprofessional education of the team among themselves and between them and caregivers[13].

Given this context of the presence of cases, designated here as complex cases, which are not simple, an action-research strategy was run. It is, therefore, qualitative research that allows intervention. This strategy makes it possible to explore a way of organizing the team's work in an interprofessional collaboration environment, having the STP as the core element of patient and family care, in order to fulfill the attributes of follow-up, coordination and family orientation of the PHC as the organizer of care of the family in the Health Care Network (HCN)[3,6,14,15].

In action research, a collective situation or problem is approached, involving participants in a collaborative way[16]. It is an ongoing, systematic and empirically based attempt to improve practice in the health service[16,17].

Because it is a continuous research strategy, enabling frequent improvements in the studied situations; proactive; participatory, involving professionals from different areas; documented; allowing the recording of the learning obtained; and interventionist[17,18], proved to be adequate in order to answer the proposed research question.

Based on Tripp's reasoning[17], which establishes a protocol for the application of action research, the researchers and the FHT agreed that the STP discussions would be held in team meetings, guaranteeing, in addition to the participation of all the team, the time needed for discussions and proposals for actions, aiming at comprehensive health care[19]. The research steps were:

1) Recognition of the problem:
- Situation: There was not a broad understanding of the extent and usefulness of the STP for improving patient and family care. It was observed the potential for intervention[19].
- Participants: all the members of the multiprofessional team, plus the family medicine residents and multiprofessional residency, in addition to the researchers/ professors associated with the service.
- Current practices: individual appointment, collective appointment in the community and continuing education activities. These practices are recommended for the FHS. The STP was included in the activities but without a follow-up routine. The cases were selected after team meetings and discussed monthly.
- Intention: STP has the potential to be a practice that encompasses the attributes of PHC[14,20], and to be a core element of interprofessional collaboration in PHC[19]. In addition, it requires an integrated approach centered on the patient and his family, which contributes to professional training to adapt to the needs of strengthening the UHS[13].

2) Planning
- Submission and approval of the action-research proposal to the unit's team for intervention by the researchers, focusing on the STP.

3) Implementation
- The interprofessional learning process took place in the follow-up of complex health care, which favored interaction and the exchange of knowledge between professionals and students to improve their skills[3,19]. Based on a case of a patient under palliative care, requiring clinical care, guidance to the family, support to the main caregiver and articulation with other services in the UHS support network (Reference Center for Social Assistance, laboratories, Home Care Service) and private providers. It is worth emphasizing that both the case and the family were addressed considering social, community and cultural aspects, which make

up the attributes of PHC[14,21], characterizing the articulation of intersectoral aspects in an expanded Health Care Network[15]. This research stage was carried out from 11/2017 to 10/2019, which resulted in approximately 20 meetings with the team and subsequent reflective moments by the researchers. The STP on the agenda was proposed by the FHT, researchers and residents.

- Data collection methods were observation, record of team meetings, in which the studied case was discussed, and reports of the STP work.

4) Evaluation

- After the team meetings, the researchers met together to analyze and reflect on the collected data. In these meetings, an attempt was made to build a shared vision of the problems faced by the FHT for the effective conduction of the STP. This vision evolved as the interaction between the researchers and the FHT deepened, and considerations were made in the sense that the team reflected on possible referrals for actions that were more adequate to the health needs of the family and patient, as well as improving the process of STP itself and promoting interprofessional collaboration[2,5,8,10].
- From the shared vision of the problem, the researchers elaborated a first version of a work model proposal with a view to promoting interprofessional collaboration in the context of the STP. This model was presented to the FHT for discussion and evaluation. Based on the questions and suggestions made by the team, the proposed model was adjusted to be implemented[13,17].

It should be highlighted that this work approaches the model until its implementation phase. The application of the model will be the object of other studies to be carried out in the future. However, it is intended that the FHT will have, with the implementation of this model, a work process that makes it possible to propose innovative and integrative approaches, from the selection of cases for the STP to the definition of actions by the team, as well as the control tools with a specific tool for planning, recording and monitoring actions.

RESULT: AN ORGANIZATIONAL MODEL FOR USING STP AIMING FOR INTERPROFESSIONAL COLLABORATION IN THE FHS

From the monitoring of the meetings, the following conceptual and operational problems were raised:

a) Limitation of the adequate understanding of the concept of STP;
b) Failure to effectively apply the STP: no prior planning or adequate communication with the family was identified in approaching the patient's care plan. This raised questions from the patient's relatives about the care process;
c) The coordination of the work by the multidisciplinary team was not carried out satisfactorily, resulting in an accumulation of actions that overloaded the caregivers and the patient himself;
d) Although it is multidisciplinary, it was perceived that the collaborative skills of the team were insufficient for the purposes of interprofessional learning.

Added to this, several questions were raised in the STP evaluation meetings with regard to its resolution:

a) The decision to carry out the STP was taken only by the FHT, that is, the construction was not joint with the family. As a result, certain team actions were not understood by the family;
b) Lack of clarity regarding the PHC coordination aspects involved in the care process, both by the FHT and also by other providers of the Health Care Network[15] and family members and caregivers;
c) The interprofessional collaboration learning process was incipient and, therefore, the multidisciplinary team did not have the skills and abilities to promote interprofessional collaborative actions; and,
d) Lack of definition of an STP coordinator for the case.

Considering the reports of the meetings with the FHT in the realization of the STP, in which the difficulties raised above were all analyzed, a model was created to carry out the activities of the STP

within the FHS oriented towards the realization of interprofessional collaboration (Figure 1). This model has four steps, which range from choosing the case to finalizing the STP or defining a new approach for care by the team: staff meeting, assignment of STP cases, executing the STP, and closing the STP.

In sequence, each element of the proposed model will be discussed individually.

- **Staff meeting**

Within the scope of the FHS, the work process includes the monthly team meeting, with the purpose of understanding each case in the context of the family and community. Thus, encompassing not only clinical aspects but also socioeconomic and cultural aspects, making it the family case itself[10,21,22]. The team uses "setting", or the discussion of cases, to implement a different way of planning and sharing the clinic and the therapeutic process.

It is at this team meeting that the assessment of the case should begin to define the need to develop the STP or not. As the case is chosen for the STP, the study of the situation in its complexity begins. At this point, the use of specific tools is recommended, such as those with a family approach, such as the genogram, ecomap and checklist[8]. It is fundamental to be clear about the priorities of the case to be considered, both by the team members and the patient/family[21,22,23].

In this step, a management tool is used for the follow-up, control and programming of future actions, namely the STP Case Record. This instrument contains the echogram, genogram, patient and family record information, health problems, the clinical discussion of the STP by the team, the actions scheduled and to be carried out, the care plan updated at each meeting and the deadlines for future actions until the solution of the case, it will be used throughout the process and must be completed during the team's discussion of the case.

- **Assignment of cases**

This stage begins with the formation of professional teams to conduct each case, considering the intentionality of the result according to social, demographic and clinical factors of the patient and/or family[10]. These teams must be multidisciplinary and adequate to the needs of patients and/or families assisted in the STP[24,25]. To qualify the care, it is desirable that the professions involved "learn together in the workplace, in a planned way and with goals"[13]. The intention is that the context favors interprofessional learning since the work environment can offer participants "knowledge, ideas and support to make changes towards the growing interprofessional work"[3,7,13,19].

The second step is to choose a coordinator, preferably the reference professional, for each case. The coordinator's assignments should facilitate interprofessional work, conflict regulation, the connection between patient and/or family and the team, follow-up and evaluation of a health care plan,

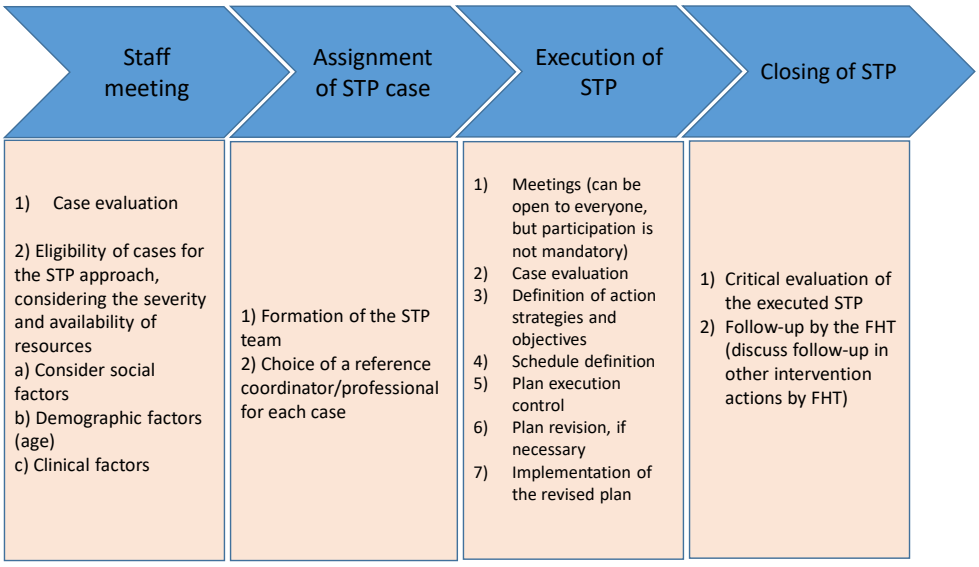

Figure 1. Model for applying the STP in the context of the FHS
Source: The authors

and preparation of reports[2]. Reports are prepared using data from the STP Case Record management tool, which must be filled by the coordinator.

It is important for the coordinator to exercise collaborative leadership, one of the domains of interprofessional work[13]. Such leadership, to be developed in interprofessional practice, takes place through the sharing of decisions and implies that each member is responsible for their actions, involving professionals as well as patients and their families[25,26].

Steps 1 and 2 of the model are important to ensure the cohesion of the team and the purposes of the STP, avoiding fragmented and disconnected actions by the participants. The elaboration of these steps rationalizes the use of organizational resources such as people, financial resources, time required, in addition to ensuring the team's commitment to the goals described in the work plan in the STP Case Record. Thus, these steps aim to mitigate the practical problems diagnosed by Baptista et al.[11], in addition to creating a favorable work environment to promote continuous interprofessional learning[13].

- **Execution of STP**

The main objective of this step is the elaboration of an action strategy defining the objectives of the STP for each case. This plan must be a collective construction done by a multidisciplinary team. Here, the importance of the coordinator for the development of interprofessional collaboration[5,13] is highlighted in the sense of providing effectiveness, equity, integrality in patient and family care.

In addition to drawing up the action strategy and objectives, other activities in this stage include:

- Hold a meeting - it is proposed to hold monthly meetings. However, the frequency will be defined by the team considering the complexity and schedule of the actions to be developed.
- Case evaluation: diagnosis of the family's health situation;
- Designate those responsible for each activity
- Establish an activity schedule
- Establish evaluation criteria
- Monitor the execution of the plan
- Redefinition of objectives and schedule of the plan, if necessary.

The execution step constitutes, therefore, the core of the care action, with regard to comprehensiveness, continuity, coordination and family guidance, which make up the PHC[27]. In addition, care practices must value the participation of families and caregivers, with whom objectives, actions and goals for the STP[10] must be agreed. The action plan includes articulation with other points of care in the health network, both public and private, as well as intersectoral services (social assistance, education, among others).

Orientation towards the result of care, through STP and group work, constitutes the method for developing skills and abilities for professional and interprofessional learning. Oliveira[10] recognized the potential of the therapeutic project as a new instrument and/or technology for the operationalization of new conceptions of the health-disease process and that facilitates the incorporation of knowledge from different areas in facing the challenges of care and management in the daily life of the UHS.

Since the FHS is one of the gateways to the health care network (HCN), the STP can be the practice that seeks innovation in care to avoid intense medicalization activities to face problems generated by the demographic and epidemiological transition, which patients and families are subject due to the effects of the social determinants of health, such as the vulnerability of age, gender, position in the labor market, etc. In addition, the STP can favor the humanization of care, as advocated by the institutions to which the UHS is linked - PAHO and WHO[22, 28].

In this step, the STP Case Record instrument is used again to record and evaluate the activities carried out, as well as to plan future activities. In Figure 2, the flowchart presents the work process, as well as the activities to be developed in step 3.

- **Closing of STP**

At this step, the STP team should reflect on and consolidate the patient care process. A brief report is suggested, indicating the evolution of the case. This document must be linked to the patient's and family's medical records. This step is also important so that the main lessons learned about the STP dynamics and those related to interprofessional collaboration can be recorded and shared with the FHT to be used in the PHC care process (follow-up)[19]. This can bring improvements to the quality of care in terms of effectiveness, efficiency and acceptability[9]. In addition, it can contribute to improving the professional and interprofessional training of doctors and nurses, residents, technicians and community

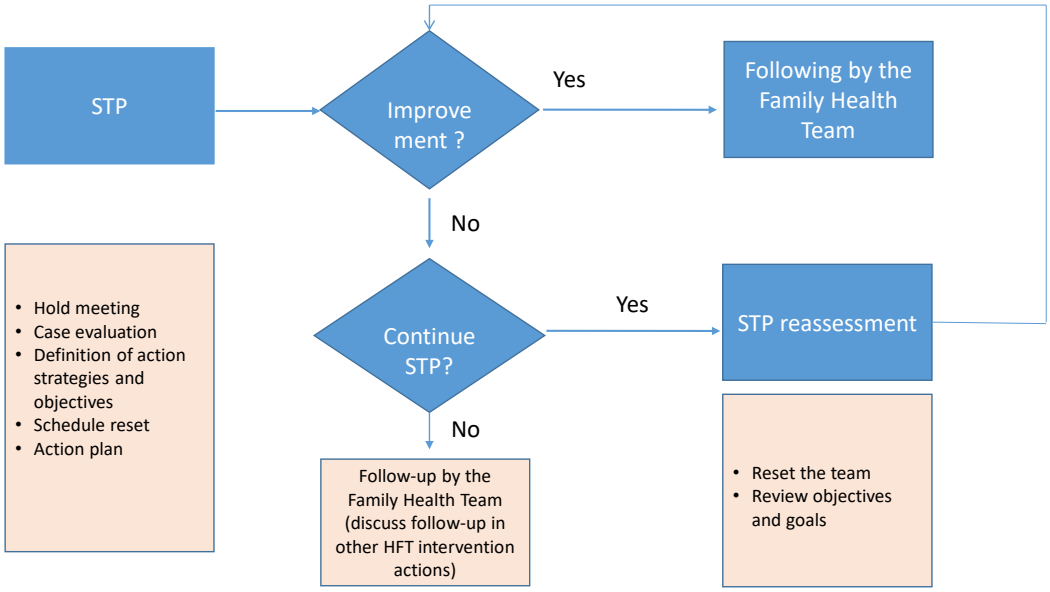

Figure 2. Flowchart of the STP Execution step
Source: The authors

agents who make up the health service[27], in addition to undergraduates from various courses in the health area who have this service as a scenario of practices.

CONCLUSION

The proposed model can materialize an innovative and suitable work organization process for learning interprofessional collaboration, as it facilitates the articulation of competencies (knowledge, skill and attitude) of different professionals.

In addition, with the objective of providing some actions for the specific and transitory health needs of patients and families, the FHT analyzes and identifies opportune moments to act and overcome access difficulties, in addition to integrating actions in the health network (counter-referral system). Thus, the model contributes to mitigating the problems arising from the duplication of actions, reducing possible errors due to the lack of communication between professionals and between them and the patient/family/caregivers, making the line of care action clearer to the patient/family for their safety.

With regard to training for interprofessional work, the model creates opportunities to develop knowledge and skills for collaborative practice focused on the patient/family, which may constitute an active and progressive learning method for interprofessional work.

The proposed model is a theoretical contribution that requires empirical studies to validate its application in the scope of PHC. In addition, depending on the specificities of each location, it must adjust to the social needs of the teams and the population. However, it is justified insofar as it helps build interprofessional actions recommended by health reference organizations such as WHO and PAHO.

It is also expected that the model facilitates the production of knowledge and the exchange of specific knowledge of professionals for interprofessional, innovative collaboration appropriate for the intervention, with the involvement of the patient, caregiver/family to reach a more adequate or comfortable care level for the patient and his family in relation to the health problem.

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