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ORIGINAL ARTICLE

PERCEPTION OF USERS AND CAREGIVERS ABOUT MANAGEMENT OF CHRONIC PATIENTS IN SUPPLEMENTARY HEALTH INSURANCE

Patrícia Chatalov Ferreira*
Sonia Silva Marcon**
Vanessa Carla Batista***
Iven Giovanna Trindade Lino****
Rubia Mariana de Souza Santos*****
Ricardo de Souza Campos Seguraço******
Eleandro do Prado*******

ABSTRACT

Objective: to clarify the perception of beneficiaries of a health insurance company and their caregivers regarding the Chronic Patients Management program. **Methods:** descriptive study with a qualitative approach. Data were collected in May and June 2019 through semi-structured interviews with nine beneficiaries participating in the Chronic Patient Management program and seven caregivers. The data assessment was realized through a thematic content analysis. **Results:** from the interviews analysis, two categories emerged: Support network through the management of the chronic condition and Limitations experienced. In the first category, it was found that the management of the chronic condition by a case manager is seen by the participants and caregivers, as a refuge and support during the illness, contributing to the reduction of costs and burdens for both groups. The second category showed that the limitations were due to administrative barriers inherent to health services and the lack of knowledge when performing case management. **Final considerations:** with this strategy, there was a burden reduction both on patients and caregivers. However, such results could be enhanced with the consolidation and improvement of the healthcare team, carrying out case discussions and elaborating care plans, mainly by implementing home visits in the program.

Keywords: Supplementary health. Chronic disease. Health promotion. Disease prevention.

INTRODUCTION

Chronic non-communicable diseases (NCD) are the world's main cause of death, especially in less developed countries, as for example, Brazil. In this country, NCD are responsible for 72% of mortality, mainly among the most vulnerable groups of the poor population, due to a greater exposure to risk factors(1).

NCD are among the main causes of hospital admissions, burdening the country's economy. In most cases, these episodes are related to low adherence or failure to correctly follow drug therapies, and the low scope of activities directed to health promotion(2).

Due to its significant prevalence and greater impact on low- and middle-income countries, the most viable solution for these nations was to invest in the prevention and appropriate treatment for these diseases, in order to avoid complications and worsening cases(3). As estimated, these initiatives could protect approximately eight million lives by 2030 and save an average of US $ 350 billion(3).

In this sense, some epidemiological control studies have pointed to a 20% reduction in mortality rates due to NCD in the last decade, besides the stability in the hospitalization rates for these diseases. It is believed that such rates were reached due to the control of smoking and a greater primary healthcare access(4). Thus, recognizing the importance of prevention and health promotion actions against NCD, the Ministry of Health instituted several strategies within the scope of primary care in order to ensure holistic assistance and education in continuous health, in addition to theoretically subsidizing professionals to improve the processes aimed at this situation(5).

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*Nurse. Master student in Nursing at the State University of Maringá.Maringá, Paraná, Brazil. E-mail: pattychatalovf@gmail.com. ORCID: https://orcid.org/0000-0001-9409-5888.
**Nurse. PhD Professor of the Nursing Course at theState University of Maringá. Maringá, Paraná, Brazil. E-mail: soniasilva.marcon@gmail.com. ORCID: https://orcid.org/0000-0002-6607-362X.
***Nurse. Master in Nursing. PhD student in Nursing at the State University of Maringá.Maringá, Paraná, Brazil. Orcid: https://orcid.org/0000-0002-3267-3969.
****Nurse. Master in Nursing. PhD student in Nursing at the State University of Maringá. Maringá, Paraná, Brazil. Orcid: https://orcid.org/0000-0003-0631-9971.
*****Nurse. Master student in Nursing at the State University of Maringá. Maringá, Paraná, Brazil. E-mail: rubia_mariana@hotmail.com. Orcid: https://orcid.org/0000-0001-8599-3272.
******Nurse. Master student in Nursing at the State University of Maringá. Maringá, Paraná, Brazil. E-mail: r.mgapr@gmail.com. Orcid: https://orcid.org/0000-0002-1075-1962.
*******Nurse. Master in Nursing. PhD student in Nursing at the State University of Maringá. Professor of the Nursing Course at theFaculty ofGuairacá, FAG. Guarapuava, Paraná, Brazil. Orcid: https://orcid.org/0000-0003-2403-5462.

Likewise, the private sector, through the National Agency of Supplemental Health (NASH), also sought to invest in a new model of health care, implementing similar strategies(6,7) aiming to offer comprehensive assistance, continuing education and costs reduction(7,8).

In order to these objectives, the Chronic Patients Management program (CPM) is one of the strategies suggested by the Agency, enabling the health operators to implement, inspect and evaluate the results(7). This management must be performed by a multidisciplinary team with the objective of giving a continuous and complete support to patients and their caregivers(7,8).

Supervision and assistance to beneficiaries are carried out through systematic screening, with the updating and monitoring of the clinical condition. This makes possible to identify risk factors (smoking, physical inactivity and bad eating habits) and treatment complications(7,8). Patients and their caregivers receive information about the diagnosis, treatment and strategies to cope with the disease(7).

This study explores a low researched topic in health policies, *i.e.*, the private healthcare sector. Despite the little information on the subject, this sector is responsible for assisting a significant portion of the Brazilian population(7,9). Therefore, this research aims to elucidate the perception of users and their caregivers regarding the CPM program offered by a health insurance company.

METHOD

This was a descriptive research with a qualitative approach, conducted in a health insurance company located in the municipality of Maringá, state of Paraná, which has been operating in the market for 29 years and has 30.000 beneficiaries.

The preventive medicine sector coordinated by a social worker is responsible for health promotion and prevention actions. The CPM group within this sector is composed of a multiprofessional team (social worker, licensed nurses, nursing technicians, general physician and cardiologist) which monitors 450 chronic beneficiaries.

Inclusion in the CPM program occurs after a qualified interview conducted by the licensed nurse when the beneficiary is linked to the plan. The presence of a chronic condition is signaled to the auditing physician, who stratifies it according to the complexity of the condition and sends it to the Preventive Medicine sector, which starts monitoring the clinical condition and managing consultations.

For the participants selection, a list of participants from the CPM program was made available by the Preventive Medicine sector, then each name was numbered. The individuals to be interviewed were determined by means of an electronic draw. In cases where the selected person did not meet the eligibility criteria or refused to participate in the survey, the next person on the list was automatically approached, repeating this operation up to three times. After all these precepts, the meetings were scheduled according to the interviewee's availability, with an average duration of 20 to 70 minutes.

Data were collected from May to June 2019 through semi-structured interviews with beneficiaries and their caregivers. The interviews were audio-recorded after authorization and performed at the participants' homes. The inclusion criteria established for the beneficiaries were: being registered in the CPM program for more than six months, residing in Maringá, being aware and oriented. For caregivers it was defined: to be caring for at least 6 months and to be the main caregiver. New participants were included until new data ceased to emerge and the study objectives were achieved.

A script consisting of two parts was used during the interviews, the first containing questions related to socioeconomic and occupational characteristics, and the second comprising the guiding question “What does the CPM program represent to you?” and some auxiliary questions when necessary, such as: "Which professional do you have the most contact with?" and “Do you have any suggestions for the program? Which are they?”.

Regarding the interview’s analysis, they were fully transcribed, preferably on the same day they were conducted and, subsequently, the three stages of content analysis with a thematic modality were followed: pre-analysis, analytical description and inferential interpretation(10).

In the pre-analysis, the organization of the collected material and the accomplishment of the overview happened, formulating thus, the research objectives, the hypotheses and the corpus of the investigation. In the analytical description, the corpus was subjected to an in-depth study, performing the codification, classification and categorization of the speeches. In order to perform the inferential interpretation, the selection of significant categories along with the inferences and the opinion of other authors were chosen.

The study was developed in line with the recommendations in Resolution 466/2012 of the National Health Council and the project was approved by the Standing Committee on Ethics in Research with Human Beings of the Maringá State University (Opinion nº 3.268.487). The participants signed the Informed Consent Form and, to preserve their anonymity they are identified with the letters P and C respectively for patients and caregivers, followed by a number indicating the order of the interview (P1 or C1) and a second number indicating the interviewee's age (P1, 62).

RESULTS

Nine beneficiaries (three of whom had no caregivers) and seven caregivers were interviewed. It is noteworthy that, in the case of the beneficiary with cognitive impairment and dyslalia (due to a stroke sequelae), only her caregiver was interviewed.

Of the nine beneficiaries under study, all were over 60 years old, four were retired, there was just one male participant and eight had a maximum of eight years of study. Six of them receive up to two minimum wages and three between two and five minimum wages. The period of follow-up by the Preventive Medicine sector ranged from eight months to 18 years. Regarding health data, six entered the group due to cancer diagnosis, two due to cardiovascular diseases and one due to obesity. All had other comorbidities correlated with the main condition, such as: hypertension, diabetes mellitus, obesity and hypothyroidism.

As for the seven caregivers, six were female, three were under 60 years old, three are already retired, two had completed higher education and the others had less than eight years of study. Regarding marital status, five were single and two were married. Related to the bond with the patient, all had some family bond, two of whom were spouses, one was a brother and four were children.

The exploration and analysis of the interviewees' statements resulted in two categories: Support network through the management of chronicity and Experienced limitations.

SUPPORT NETWORK THROUGH THE MANAGEMENT OF CHRONICITY

Patients acknowledge the help they receive from the CPM program and point out that the greatest benefit resulting from this participation is the agility in clarifying doubts and resolving scheduling requests (consultations and exams).

> [...] If I didn't have her {Social Worker}, I wouldn't be alive. (P3, 63)
>
> [...] it helps me a lot, she {Social Worker} helps me a lot. (P5, 65)
>
> [...] Wow, I think it's wonderful. (P6, 72)
>
> [...] Yes ... like this ... by helping in speeding up consultations ... sometimes, there is a long time until the appointment date ... then I ask to anticipate it. So it fits ... you know? (P8, 71)

Nevertheless, caregivers are more emphatic and specific about chronicity management. Besides the benefits of facilitating and speeding up appointments, they also point out that, through the group's actions, they have become empowered in the face of new responsibilities.

> I feel more confident to take care of my mother, [...] So, they were like a light. They gave me a light in each step of the treatment, a guide [...]. (C6, 54)
>
> The girls help us well, they facilitate some guide because we have some difficulty. Now I returned to work, but, for example, until a few days ago I was right at home with my mother. Then, there was nobody to stay with her, so I got a leave from work and stayed right next to her. Then, getting out of home and leaving her alone to get a medical appointment, looking for an exam. It's very difficult, you see? [...] (C7, 42)
>
> [...]Oh for me it was very good because it is a lot, yeah ..., they answer ..., like this ... very, very fast ... they don't lose sight of us, they're ready to answer. It helps a lot, they collaborate a lot for us, they're the ones who save us. At times, we got lost, especially at the beginning, so if it weren't for the social worker and the program, we ... we would have to depend on auditing, we would have to wait. (C1,62)

Patients and caregivers reported the CPM program support occurs under many circumstances and this makes possible for them to feel safe, as they know that in cases of incidents, whether during trips or during treatments, assistance is immediate.

> [...] I went to the beach once and I had water allergy [...] It opened everywhere, blisters on my legs, then I took a picture and sent it to the social worker. But... man, i got in trouble, because the doctor, the cardiologist saw, she showed him [...] (P3, 63)

> [...] And every time she got sick, she was doing radiotherapy, right? And she had those weaknesses [...] Then it was just, I didn't even have to call. [...] Then I sent a WhatsApp, and through WhatsApp she already booked. And she was always asking how she was doing.. (C6, 54)

> [...] The girls, they acted so calm like this: I sent a message "look, she is complaining ... about pain", then they already provided, they setted up everything and said ... go that day or come here at the ambulatory. I like their service, it's very chill. (C7, 42)

The monitoring of the patients and the orientations are carried out, most of the times, via cell phone, both by calls and by instant messages. This form of communication favors bonding and agility in the execution of actions. And this diligence is perceived by the interviewees as a form of prevention.

> That's a preventive action, right? I think it is! The team's agility towards us ... that's preventive work... Diseases are very dynamic, there isn't time for you to think in the future, you just have time to think about tomorrow [...] Agility! That's very important when getting sick [...]. (P1, 63)

> My mother ... she started going to the nutritionist to lose some weight [...] but then ... as soon as she started doing the treatment we realized that the nutritionist didn't treat her to lose weight but to give her the right nutrition because she was very weak [...] I realized that all this attention and care, really worked as a prevention measure, the attention to my mother's health, helped her to cure [...]So, I think ... I could even give a name for this group: life... (C6, 54)

P1 correlates the benefit of agility as a means of prevention, since, when appointments are anticipated, they prevent the worsening of the condition. C7 also identified the preventive actions of the program, when she referred the patient to the nutritionist as soon as she started chemotherapy. This alleviated the side effects of the therapy and helped maintain the patient's immune status. In the same report, she also showed gratitude to the CPM program, because the actions aimed to prevent diseases, contributed to the cure and quality of life of her loved one.

Regarding the continuity of care, the participants reported the CPM program seeks to schedule appointments with the same medical professional. For this reason, the team requests that patients and caregivers inform when they need care.

> It's just that many times our mother is sick, we take her right there, to get some medical attention, but she (social worker) will know it because that information appears on her computer. Then she (social worker) calls us asking… she (social worker) wants to know exactly, why our mom was admitted. She wants to know...why we didn't call her? (C3, 68)

> You can go to another hospital. But, when arriving there ... they're not always the same people, so you have to give all that information and so. That's why it's easier this way, because they already have such information. So, you already know what it's about, how is it, what's happening. So, that’s why it’s good. (C4, 59)

Systematic monitoring allows the direction of the actions and the conducts to be taken and, users show confidence in following them. Reports show that most guidelines are provided by the social worker and the licensed nurse. Caregivers, in particular, showed appreciation for the guidance from health professionals, especially from licensed nurses.

> [...] the nurse guided me, “look, the bandage goes like this” when it comes to moving it, you should turn it, you turn it like this. This way it doesn't hurt... so I think it's pretty cool. (C7, 42)

> Sometimes when mom doesn't feel good, I call her (nurse), then I check my mom's blood pressure. So if it's something like that, she (nurse) says I should take mom to the hospital [...] I call her (nurse), you know, I tell her: 'look, my mom feels like this', then she (nurse) says, ok, you'll do it like this [...] (C4, 59)

> [...] And sometimes, too, the medication is not doing well, so she (nurse) guides. So, it has been good in that sense. (C8, 68)

> [...]Because look, I have high blood pressure problems, but sometimes my blood pressure is low. I feel bad here. The nurse called and said: 'the time is coming for you to visit your cardiologist!', 'I see it ...' Then she (nurse) turned the computer on, because the social worker left it up to them. 'I don't see P3 coming' 'Did you call P3 to remind her?' Because I tend to forget. I go to the doctor, I lose even my referrals. I lose them, there is no one who helps me, I end up losing them. (P3, 63).

In the reports, it is possible to perceive the scope of the actions carried out by nursing professionals, which encompasses from orientations regarding the positioning change, bandage management and medication information to the active search for those who are absent in consultations. The knowledge expressed by the nursing professional impressed one interviewee:

> [...] It surprised us, because we had that opinion that the nurse only had those arrangements there to make

> bandages, right? But she was unaware of medication reactions and she demonstrated all that knowledge, you know? [...] Because it was like that, she went there and followed the dressing, she looked at my mom and then she spoke how she was, if mom was healing what should she use and what shouldn't, you know? And then I even commented to my mother ... wow how this girl knows, right? She is surprising us [...] (C6, 54)

The knowledge demonstrated by the nursing professional gives credibility to patients and caregivers, providing the necessary confidence and support when doubts and fears arise.

EXPERIENCED LIMITATIONS

In this category, the impasses that interfere and limit the achievement of more satisfactory results and suggestions for program improvement are described.

One aspect that drew attention was the lack of knowledge on the part of beneficiaries and caregivers about the composition of the CPM program and its functions:

> I don't know, because ... I never participated like that ... in this group. What does it look like? (P2, 60)

> It's not a group, it's just the two of them [...]. (P7, 72)

> [...] they should ... the program should call us and say: 'look, it's like this, this way, this way and that way. You have to report. You should talk to us the right way, ok?'. We entered the program and went on, we change one thing for other, the same (the beneficiary) he said ... that the person did something he should not have done. [...] It should be more clarified ... what is the purpose of the program. (C1, 62)

In the reports, one of the participants also pointed out the need to be informed when they are inserted in the CPM program and to be clarified about the objectives, duties and responsibilities, in order to avoid mistakes.

When aiming for improvements to their loved ones, the caregivers expressed their eagerness for home visits, either to improve the assistance performed or to provide emotional support.

> Look, I think that ... it should have psychological support, a psychologist, to talk to us from time to time ... to help us, because... being a caregiver means also being part of the problem... sometimes, we get... a little crazy, a little! [...]". (C1, 62)

> If we would receive home care only. [...]So, the thing that would improve the program would be home care [...] (C4, 59).

The reports show the need for emotional support for the patient as well as for the caregiver. This support may come from just being heard by the nurse or social worker, consultation with a psychologist, or through home visits by a health professional.

> I don't know, if only they had someone who made more constant visits, right? Once a month, because ... I don't know, the reality that I'm living there ... is ... the complaint is to be alone, nobody visits us [...] For the person being visited, in this case my mother, it makes a difference, she feels important, it encourages her. (C7, 42)

Despite the team's efforts to align the appointments with the same professional, including directing the patient's treatment to the hospital where the physician works, there are situations in which this does not occur, triggering dissatisfaction.

In the next reports, the participants reaffirm that the continuity of care should be implemented by the same professionals, because according to them, this continuity favors the bond, increases the resolution and quality of the service offered.

> [...] I think so, just like when consulting the cardiologist ... there are two of them, nowadays P8 consults one, right? Then, the medication, or something else isn't working ... and she needs to go back there, then the cardiologist she consulted isn't there, now there is another one. Then you've to get there ... and repeat all over again [...] If it's the same doctor I think that creates more like ... a bond, right? [...]. (C8, 68)

> [...] I think that... I do like to participate with them there. It's only they change a lot, I mean the staff. You get attached to a girl there, who works with her (patient). Suddenly it doesn't work, the nurses ... they leave ... [...]. (P3, 63)

> Ah... if I do the treatment with a physician at the hospital. I think I would have to do the treatment every time at the same place where the physician works. (P2, 60)

The reports in this category show that although the continuity of assistance by the same professional is one of the benefits of participating in the CPM program, there are flaws in this process. This causes stress, due to the need to repeat information about the diagnosis, besides expenses with exams and unnecessary consultations to elucidate a condition already diagnosed and even undergoing treatment.

DISCUSSION

One of the strategies to face the high demand for interventions, such as hospitalizations, relapses and urgent and emergency consultations by beneficiaries in chronic conditions, has been the implementation of sectors that promote prevention and health promotion actions (7,11,12), as in the case of preventive medicine. Therefore, as part of this sector, the CPM program assumes the purpose of monitoring in a methodical and articulated manner all the care that its beneficiaries with a chronic condition demand, in order to avoid complications and unnecessary costs with exams and several consultations (7,8,11).

However, the testimonies reveal that the professionals of the CPM program are performing Case Management (CM) unintentionally, which justifies the fact that some participants are unaware of such a program as a group. Internationally, it has been pointed out that CM is an effective strategy for coordinating care in chronic conditions and to mitigate hospitalizations for patients with some chronicity(13-15).

Although CM is a strategy used internationally and already suggested for implementation in Brazil(5,16), it continues to be little explored by Brazilian health services. CM consists of the fact that an individual takes care of the patient's care management, articulating all the assistance and health services the patient will use, promoting the safety of both the beneficiary and the family, offering resolutive and quality care, besides optimizing the expenses caused by chronicity(17).

According to the study's participants, it is clear that the professionals who took over CM were the social worker and nursing professionals. They were identified as facilitators and coordinators of care during the illness phase. The leadership assumed by these professionals in the CM is a characteristic commonly found in other countries(14,15,17). This probably occurs because these professionals in their practice prioritize the biopsychosocial view, which in turn facilitates the creation of a bond, the identification and resolution of the problems that may arise in that period.

It was also found that caregivers develop a greater bond with nurses and, patients refer more to the social worker. This differentiation occurs because caregivers need to anchor their daily actions in knowledge and care practice, and to achieving this goal they need to be systematized. Patients, on the other hand, need the support of a social worker to resolve psychosocial problems. Therefore, the actions of these professionals are interdependent and, when necessary, redirect between themselves and other professionals(17).

Thus, the testimonies of some caregivers revealed resignation, represented, for example, when referring to the abandonment of work and the difficulties in the administration of new responsibilities, besides the emergence of some impasses when assuming this new caregiver function (18,19). In this way, the CPM program or the CM is recognized by the participants, users and caregivers, as a facilitator in solving problems that arise in the phase of changes, helping to reduce the burden through the provision of care guidelines(19) (bed bath, dressings, administration of diets and medications), in scheduling and articulating consultations and exams, in guiding the best way forward or simply serving as a refuge in times of insecurity.

It is worth noting that, in this company, the Case Managers, through monitoring and constant contact with the participants, keep themselves updated about the clinical condition with a holistic and preventive view regarding the possibility of complications(17). The beneficiaries and informal caregivers do not have this view, so the role of the case manager becomes essential to keep the chronic condition under control and, consequently, it will promote a better quality of life for the affected and their caregivers(17,19).

Other particularities of the CM, such as the provision of counseling, guidance and monitoring through phone calls and instant messages (14,17) were also mentioned. Thus, technological advances and the use of instant messaging applications have increased the accessibility and the bond between caregivers and case managers(14). They allow, despite the distance, immediate assistance capable of alleviating the distress until the difficulty that arises is totally resolved. However, it must be mentioned that text messages are not intended to replace face-to-face interactions, providing case managers with an additional form of communication with patients, favoring support and counseling about care, besides stimulating self-care(20).

Following this thinking, some caregivers reported that the guidance provided during home visits is more enriching and beneficial, and consequently, helps to reduce the burden. Home visits allows to know the family context and to propose more effective care and guidance (6,21). Moreover, when entering into the patient's home reality, it is possible to make eye contact and even identify other problems hidden in the distance service. Some Brazilian health operators are adopting Family and Community Medicine (22). This type of model may help in the deficit of home visits in the private sector.

It was also found in the statements that, the sudden change of priorities, the overload of tasks and when faced with finitude, people with chronic conditions get emotionally destabilized(18) especially, the loved one who takes care. In order to go through these obstacles, they require support and protection (19). Thus, despite the study's participants recognized as support the guidelines provided by the case managers, they demonstrated the need for psychological monitoring.

Nevertheless, the assistance of these managers must transcend the obvious, and it becomes necessary to identify the subjects' burden, exposing and clarifying the benefits and the reasons for imposing the monitoring of another professional, such as the psychologist. It is believed that the burden on patients and caregivers will be reduced if the case manager intensifies and articulates multidisciplinary assistance with greater precision(15).

Discussion of cases by a multidisciplinary team and the development of a systematic care plan for each beneficiary may expand the benefits of the CPM program(13-15). Furthermore, they promote promotion and prevention actions, complying with the basic objectives of the program, in fact, they encourage self-supported care in the face of health conditions, a relevant point for the management of chronicity(16,17).

Due to the constant monitoring and attention, plus the feeling of agility and priority shown in the appointment schedules, the subjects enjoy uniqueness, and they feel important and privileged to participate in the CPM program. The management of chronic patients or case management leads to subject satisfaction, as already identified in another study(15).

Despite the satisfaction, among the reported deficits and suggestions, there is the lack of knowledge of the interviewees about the objective, rules and functions of the program. In this sense, they pointed out that it is essential to be informed as soon as they join the CPM program about the criteria used to be included in it, its purpose and how it will be monitored, the duties and responsibilities of the participants and other pertinent information. The availability of this information from the beginning will avoid mistakes and, consequently, user dissatisfaction.

Another limitation evidenced in the interviews was the discontinuity of care. A study that analyzed 1.013 e-mails sent to the NASH Relationship Center from beneficiaries in the southeastern region of Brazil found that, cost reduction strategies have impacted the quality, comprehensiveness and continuity of care(23). The limitation of care continuity may present itself in different ways, with the non-release of a request/guide, in the precariousness of the providers network, or even when faced with the imposition of reports, supporting documents, inconsistent or mistaken information, inefficient communication channels and a restricted access to data(23).

However, failures in the process of articulating assistance, reported by the interviewees, are tangible when considering the administrative barriers that rule health services, especially in the case of health operators that have a limited service network.

Another aspect to be considered is, professionals were not trained to become case managers and, therefore, perform certain actions institutionally. Unlike Brazil, in the United States does not yet exist standardized practices for CM. Through non-profit organizations, it has been developed a standard of practice for CM (17), supporting the progress of the profession in that country. Without the standardization of these professional activities, the effectiveness of management ends up being affected and questioned, taking into account that CM will depend primarily on personal and professional experiences of the subjects who assume this role, thus obtaining different results.

The limitation of this study resides in the fact that it was carried out within the scope of only one health care provider, which may have assumed unique characteristics in relation to the management of chronicity.

CONCLUSION

This research found that the Chronic Patients Management, or Case Management, constitutes an important support network for beneficiaries with chronic conditions, as well as for caregivers. However, such benefits can be enhanced through improvements in processes, consolidation and improvement of the healthcare team and home visits.

It is worrying that, if these individuals happen to no longer participate in health plans, and consequently, they no longer have guidance, they will become helpless and lost. Thus, it becomes necessary for the professional healthcare team to work more on the autonomy of these patients so they can acquire the knowledge of their current health situation and learn the importance of adhering to the treatment and performing self-care on an ongoing basis.

It is hoped this research will assist in the reformulation of some management programs, besides exposing the benefits caused by CM, which, although being a recent strategy in Brazil, has already achieved vast results internationally. Finally, it is emphasized the need for more studies that elucidate strategies for promotion and prevention in supplementary health and, mainly, about CM in Brazil.

PERCEPÇÃO DE USUÁRIOS E CUIDADORES SOBRE A GESTÃO DE DOENTES CRÔNICOS NA SAÚDE SUPLEMENTAR

RESUMO

Objetivo: elucidar a percepção dos beneficiários de uma Operadora de Saúde e seus cuidadores a respeito do programa de Gestão de Doentes Crônicos. **Método:** estudo descritivo de abordagem qualitativa. Os dados foram coletados em maio e junho de 2019 por meio de entrevista semiestruturada com nove beneficiários participantes doprograma de Gestão de Doentes Crônicos e sete cuidadores. A apreciação dos dados sucedeu por análise de conteúdo modalidade temática.**Resultado:** da análise das entrevistas emergiram duas categorias: Rede de apoio mediante o gerenciamento da condição crônica e Limitações experienciadas. Na primeira categoria, constatou-se que o Gerenciamento da condição crônica por um Gestor de caso é visto pelos participantes e cuidadores como refúgio e amparo durante o adoecimento e, dessa forma, contribui na diminuição dos encargos e sobrecarga para ambos os grupos. Já na segunda categoria, depreende-se que as limitações decorreram por entraves administrativos inerentes dos serviços de saúde e pelo desconhecimento de estarem realizando a Gestão de Caso. **Considerações Finais:** Com essa estratégia houve a diminuição da sobrecarga do paciente e do cuidador, contudo tais resultados poderão ser potencializados com a solidificação e aperfeiçoamento da equipe, realização de discussões de casos, elaboração de planos de cuidados e, principalmente, ao se implantarem visitas domiciliares no programa.

Palavras-chave: Saúde Suplementar. Doença Crônica. Promoção da Saúde. Prevenção de Doenças.

PERCEPCIÓN DE USUARIOS Y CUIDADORES SOBRE LA GESTIÓN DE ENFERMOS CRÓNICOS EN LA SALUD SUPLEMENTARIA

RESUMEN

Objetivo: dilucidar la percepción de los beneficiarios de una Operadora de Saludy sus cuidadores a respecto del programa de Gestión de Enfermos Crónicos. **Método:** estudio descriptivo de abordaje cualitativo. Los datos fueron recolectados en mayo y junio de 2019 por medio de entrevista semiestructurada con nueve beneficiarios participantes del programa de Gestión de Enfermos Crónicos y siete cuidadores. Los datos fueron evaluados por medio del análisis de contenido modalidad temática. **Resultado:** del análisis de las entrevistas surgieron dos categorías: Red de apoyo mediante la gestión de la condición crónica y Limitaciones experienciales. En la primera categoría, se constató que la Gestión de la condición crónica por un Gestor de caso es percibido por los participantes y cuidadores como refugio y amparo durante el enfermarse y, así, contribuye en la disminución de los encargos y de la sobrecarga para ambos los grupos. Ya en la segunda categoría, se verificó que las limitaciones provienende impedimentos administrativos inherentes de los servicios de saludy por el desconocimiento de estar siendo realizada la Gestión de Caso. **Consideraciones Finales:** conesta estrategia hubo la disminución de la sobrecarga del paciente y del cuidador, pero tales resultados podrán ser potenciados con la solidificacióny el perfeccionamiento del equipo, realización de discusiones de casos, elaboración de planificaciones de cuidados y, principalmente, alimplantar visitas domiciliarias en el programa.

Palabras clave: Salud suplementaria. Enfermedad crónica. Promoción de la salud. Prevención de enfermedades.

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Corresponding author: Patrícia Chatalov Ferreira. Rua Osvaldo Cruz, 324, apto 05. Maringá, Paraná, Brasil. (44) 99717-6616 / pattychatalovf@gmail.com.

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