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Articles

Interprofessional Collaborative Practices in Collective Spaces of Family Health Units

Práticas colaborativas interprofissionais em espaços coletivos de unidades de Saúde da Família (abstract: p. 18)

Prácticas colaborativas interprofesionales en espacios colectivos de unidades de Salud de la Familia (resumen: p. 18)

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The way Family Health teams work can encourage sharing between different fields of knowledge and the development of interprofessional collaborative practices. The objective was to understand how interprofessional collaborative practices are built in the work process in Family Health units. Exploratory, descriptive research, with quantitative and qualitative approaches, carried out with Family Health teams from 26 municipalities in the countryside of the state of São Paulo, using secondary data and semi-structured interviews. From the analysis, two thematic categories emerged: the development of interprofessional work and aspects related to the team. The construction of interprofessional collaborative practices permeates collective spaces in moments of professional integration. However, there are weaknesses arising from the fragmentation of professional practices and the lack of user-centeredness.

Keywords: Interprofessional relations. Interdisciplinary placement. Patient-centered care. Primary health care.

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Introduction

Health care practices are stressed by the constant transformations of population profiles that directly impact people's quality of life, leading to great challenges to be overcome by the Brazilian National Health System (SUS)[1]. In this scenario, we have the Family Health Strategy (FHS) as a priority model for the expansion and strengthening of Primary Health Care (PHC) in the country[2]. It is committed to developing actions to promote health, prevention, recovery, rehabilitation of diseases and injuries, comprehensive health care for assisted families, through a multidisciplinary team totally focused on the user[2].

However, user-centered care is a challenge, requiring intense exchange of knowledge and effective communication between those involved[3]. This practice aims to promote essential intersubjective interactions to ensure that power and responsibilities are shared[4].

At times, professionals' activities are directed to their specialties, but often, when alone in their practice, they cannot solve the different issues required by the population, because the result of comprehensive care is the product of personal and professional relationships focused on rescuing the meaning of collaboration in interprofessional work[3].

According to this view, interprofessional education (IPE) and collaborative practice (CP) emerge as important strategies. IPE allows professionals from different areas to learn from and with each other, about each other and themselves, to collaborate effectively[5]. Collaborative practice occurs when professionals from different areas provide services based on integrality in healthcare, involving patients and their families[5], and is based on the pillars of sharing, partnership, interdependence of actions, and horizontal power relations, permeated by respect and trust[6].

To make this practice more present in health services, there must be opportunities for integration, with shared decisions. The environment (facilities and infrastructure) and the work process have important roles, as they can provide moments of dialogue and shared activities, in addition to challenging professionals to leave isolation in their practice[7].

Thus, the work process of the teams of Family Health Units and the way they develop joint activities is questioned if they have moments that favor information sharing among workers from different fields of knowledge, which enables the development of interprofessional collaborative practices.

The purpose of this study is to understand how interprofessional collaborative practices are built in the work process in Family Health units.

Materials and methods

This is an exploratory, descriptive investigation, of quantitative and qualitative approaches, conducted with Family Health teams from the 26 municipalities of

the Regional Health Department - DRS XIII, in the countryside of the state of São Paulo.

Secondary data on the results of the evaluation of the 3rd cycle of Brazil's National Program for Improving Primary Care Access and Quality (PMAQ) implemented between 2015 and 2016 were obtained from the Ministry of Health's public access platforms.

In May and April 2021, data were collected on the characterization of the collective spaces of the health units in module II, consisting of three groups: "Team Meeting", "Planning", and "Support". The database contained information from only 21 of the 26 municipalities. Data were entered into an Excel spreadsheet and submitted to descriptive statistical analysis.

In the qualitative approach, the semi-structured interview technique was used and was carried out by the main author of the study. The most reputable health units in the PMAQ assessment of each municipality were invited to participate in this study. Of the twenty-six municipalities in the DRS XIII, five did not score in the PMAQ assessment and were not included. To select the worker to be interviewed, we asked the unit coordinator to suggest the most appropriate member for the team's activities. The workers were invited through telephone calls, when the interviews were scheduled, and they agreed to send the terms of free and informed consent via email. During this process, we lost four participants: two people refused to participate and two were not found after five contact attempts.

The interviews were carried out online, between April and July 2021, on the Google Meet platform, by a single researcher who knew semi-structured interview techniques and had professional experience in the Family Health strategy. The interviewer had no conflict of interest with the participants of the study. The interviews lasted approximately thirty minutes, with the support of a semi-structured script consisting of two parts: in the first one, the participants were characterized and in the second, they were invited to talk about the topic of the study. The script was previously applied in pilot interviews with two nurses from Family Health Units of one of the municipalities, for possible improvement, and the content was not included in the analyses. All interviews were recorded and transcribed, and the data were submitted for content analysis[8], in the light of the theoretical foundation of the work and interprofessional collaboration.

The research was approved by the CEP, with opinion No. 4.574.817 and CAAE No. 41142820.0.0000.539.

Results

Seventeen interviews were conducted with 14 nurses, 2 community health agents, and 1 physician, aged between 25 and 62 years. All participants had previous experiences in the FHS before joining the team they belonged to at the time of the interviews. The time working in the team ranged from 6 months to 13 years.

The PMAQ data related to the characterization of collective spaces existing in the organization of the work process of the teams of the 21 municipalities of

DRS XIII in the countryside of the state of São Paulo show that 19 (90.5%) hold team meetings regularly. Fourteen (66.7%) hold weekly meetings, 4 (19.0%) hold biweekly or monthly meetings, and 3 (14.3%) have undefined periodicity or do not hold them at all. Action planning is carried out in 19 (90.5%) municipalities, by all teams, with varying frequencies: weekly, biweekly, monthly, and annually. Two municipalities reported that they do not have such action.

The indicators show that 20 municipalities receive institutional support, and only 3 have a Family Health Support Center (NASF). There was no information on how frequent this support was offered to the teams.

Dialogue with professionals

From the analysis of the interviews, two thematic categories emerged: the development of interprofessional work and aspects related to the team.

First category – Development of interprofessional work

This category consists of the subcategories: interprofessional work from the perspective of the participants, facilitators for the development of interprofessional work, the various collective spaces, and the time that the team works together.

Interprofessional work from the perspective of the participants

Several concepts of interprofessional work existed among the participants, and the interviewees considered it to be part of interprofessional work.

> I think it is because it is the moment that we can discuss everyone's opinion, of all professionals, to know how far we can go and what is the best method for us to achieve our goal, which is better patient care. (E 10)

Although some interviewees consider their work as interprofessional, there is fragmentation, without integration of knowledge:

> I think it is in these moments that we add the technical knowledge of each of these professions. So, in a group, for example, we agree that the nurse will be in charge of feet exams, the doctor will explain the exams, the community agents will deliver the pamphlet on the disease information; then, each one with their technical knowledge contributes to that care. (E 7)

Facilitators for the development of interprofessional work

The testimonials demonstrate subjective and objective elements that facilitate interaction between team members. Regarding the subjective elements, unity among team members, willingness to work, and respect stand out:

> To me, the team must be united. I think that's the point! We must be united in the first place, otherwise, the work will never get done properly. (E 8)

Some objective elements were identified as facilitators of interprofessional collaborative work. Team meeting is fundamental so that it is possible to develop interprofessionalism and activity planning.

> I arrived at the unit and this meeting would never happen; it took us about three years to arrange it, and this was a huge facilitator. So, having this moment once a month and stop the unit operation was a powerhouse; it is very important for us to have this multiprofessionality. (E 7)

To make the meetings possible, the participants pointed out that it was important to schedule them beforehand and block the agendas for this activity.

Their reports demonstrate that the meetings are important to make team integration effective, as they discuss internal issues and ways for its members to act together, aiming at the development of interprofessional collaborative practices.

> In these meetings, we discuss both family cases and the work process, as well as some stuff related to daily routine. (E 7)

The various collective spaces

Participants mentioned different collective spaces in which team members interact with each other and also with other relevant actors to perform user, family, and community care actions.

The meetings were referred to as collective spaces where we work with FHU supporters, matrix support, and interactions with different managers and coordinators of the municipality, promoting intersectorality.

> We had a network meeting, in which we also met with the coordinators of the entire municipality, the school, the CRAS (Social Assistance Reference Center), the social worker, psychotherapists, and all the principals of the schools (basic education) in the city. (E 14)

Shared consultations were considered as collective spaces where care is provided by professionals from different areas.

> I have a shared consultation with the doctor; she stays inside the room with me. The dentist also usually present. (E 2)

Health promotion and disease prevention activities are developed by the teams with hypertensive, diabetic, pregnant, and postpartum women patients.

> We had a group of hypertensive patients; we organized meetings with the nurse, the dentist, the physical therapists; then, the entire multidisciplinary team had these meetings with the groups of hypertensive patients, and pregnant and postpartum women. (E 13)

However, in most cases, the groups were coordinated by a single professional during the meeting, even when there was more than one professional responsible for the group. Thus, this development was fragmented, with a clear division of tasks between the different professionals. This did not mean that the work was being developed interprofessionally.

In addition to the FHU, there are collective spaces with great potential for the development of collaboration, such as home visits (HV) and the School Health Program (SHP).

> Sometimes the team comes together to perform collective activities and more specifically, home visits. (E 7)

In the case of SHP, the intersectoral action between the areas of health and education involves the activities planned in the team meetings, based on the demands of the school management, with high potential for the development of network collaboration:

We go to school, ask what the principal and teachers want at that moment, the topics they want at that moment. Then we give the lecture, we guide them. (E 2)

Time that the team works together

The turnover of professionals, especially physicians, was pointed out as an aspect that influences the work of the team and can weaken the development of interprofessional work.

> There is a considerable turnover of doctors who arrive through the program Mais Médicos. Since I've been here, it's already the third different doctor. (E 3)

Some interviewees reported that the team has been working together for a long time, favoring greater bonding, trust, and, consequently, better results and collaboration among its members:

> As we are a team that has been here for a long time, this creates a very strong bond and this interprofessional work helps, because if I have any question, my colleague may help; thus, we work better. We can have better results, with everyone helping each other. (E 12)

Second category - Aspects related to the team

This category includes the subcategories communication and articulation, encouragement, and unity to carry out interprofessional collaborative practice, support for teams, knowledge of the role of team members and the distance we are from user-centered practice.

Communication and articulation

Professionals report using various communication strategies among team members, either through user medical records or by using digital technologies such as message exchange software:

> About three years ago, we installed [...] an internal chat, which is specific to the unit; it is not open to anyone who logs into the chat. Through computers, we distribute the name of the place where it is located, and thus we organize and also communicate through this chat. (E 7)

To meet the new and complex health needs of the population, health professionals must articulate themselves in the practice of care, as reported by the participant:

> [The meeting] is when we can discuss everyone's opinion, of all professionals, to know how far we can go and what is the best method, and it involves everyone, because the patient leaves the reception to the doctor's office. So, it is time for us to achieve our goal, which is to deliver better patient care. (E 11)

On the other hand, one of the interviewees reports the difficulty of articulation, especially in times of team meeting:

> Team meetings are very difficult for us to achieve here, because it seems that it is a rocket science". We don't even feel like arranging them. (E 3)

Other difficulties mentioned were the lack of human resources and the professionals that have different working hours.

Encouragement and unity to carry out interprofessional collaborative practice

Stimulation and unity were observed as fundamental factors for the interdependence of actions and the achievement of better results in people's health care. Teamwork, which is based on interprofessional collaborative practice, has motivated and qualified professionals; its members feel recognized and perceive their contributions as relevant in the work process, generating a better climate within the team.

> If I say, 'come on, guys!', the others are always agreeing, participating, giving ideas. I have a team that participates a lot. (E 2)

On the other hand, there are also situations in which professionals feel discouraged, which hinders collaboration. Even without explaining the reasons for the lack of stimulus, the fact stood out in the analysis as relevant for understanding the team's work process.

> I think the team feels discouraged; from the beginning, I have been searching for ways to try to stimulate them, to make them move forward. (E 3)

Team support

The figure of a supporter also contributes to the development of interprofessional collaboration. Respondents mentioned that different actors are supporters who contribute to facilitating dialogues and exchanges of practices and knowledge.

One of these actors is the university that, when present in the FHS units, enables scientific knowledge dissemination and meets the training needs of the teams:

> We had a lot of help from the university staff; they set up the projects and we participated together. (E 13)

The support received from NASF was also mentioned. Their cooperation with the FHS teams favors team resolution and matrix support**.**

> The speech therapy team and the psychotherapist are from NASF, (and work together) with the physical education teacher. They also participate in meetings and learn about the cases so that when there is a home visit, they make a diet plan or monitor the family's mental health. They follow up with us and give feedback in the meetings. (E 2)

Other sectors of the health area appear to support the teams. Most interviewees reported the importance of relying on mental health support from professionals at the Psychosocial Care Center (CAPS), mainly to discuss cases of users or situations that are happening in PHC:

> The CAPS team comes to discuss with us any specific case that the team chooses. (E 7)

The work with professionals from the Specialized Reference Center for Social Assistance (CREAS) and the Reference Center for Social Assistance (CRAs) in activities such as home visits with the FHS teams was also mentioned:

> I have an excellent relationship with the social assistance team, with the CRAS, which also has a social worker, who comes by and pays visits. (E 17)

The institutional support of management, which was also mentioned, assists in conducting work in PHC, enables the qualification of teams, and favors more effective and satisfactory collaborative work in health:

> We have great support from the DRS (Regional Health Department) organizer. Whenever I contact her, I receive help. I think that DRS is a very great support for the Family Health strategy. (E 14)

The community leaders were mentioned as supporters of the FHS teams:

> We have community representatives – I don't know if that's what they call them – who are community leaders who always bring the demands to us. (E 13)

Knowledge about the role of team members

The knowledge of the team professionals about the role of each one is a challenge for achieving interprofessional collaboration. The excerpt below shows that everyone is important, and actions are interdependent:

> I always say this in meetings: everyone is important here, from the doctor to the cleaner, because there is no health without cleaning, just as we depend on a doctor. The agents are also very important because, in addition to home visits, they help us in the routine within the unit. (E 9)

The distance we are from user-centered practice

This subcategory highlights the place of the user, the family and the community in the work process of the teams, given the importance of their central position in the production of care.

The needs and vulnerabilities of the users motivated the actions of the teams in search of the best form of care:

> We discussed everyone's vulnerability, how we will be able to help multiprofessionally. (E 6)

The Singular Therapeutic Project (STP) used in PHC is an example of user-centered care practice for the construction of the care plan, in which the participation of the team professionals, the user, and their family is recommended:

> There are the visit cases that we and the community agents bring, we check which are priority cases and sit down to define the unique therapeutic project. (E 6)

However, the interviewee does not explain how the team includes the user and their family in decisions about care and if the user was empowered to manage their health situation.

In one of the reports, it is noteworthy that the team has difficulties in providing care because of the patient:

> The difficulty is the patient because, sometimes, they do not accept the visit, do not accept being cared for, do not accept that we gave them an opinion; sometimes, the patient is living in a way that is not good for them, but they do not accept it. (E 4)

Given the fragments, the team's understanding of what would be the place that the user occupies in the interaction to produce care is questioned.

Discussion

The results shown allow us to understand that the construction of interprofessional collaborative practices in the FHS teams permeates the collective spaces within the organization of work.

The PMAQ indicators analyzed show that valuing the collective dimension through the inclusion of process indicators related to practices that the team is expected to perform together, somehow, ended up encouraging the teams to value the collective workspaces. However, the PMAQ has been discontinued, and there is no other program or instrument with the same purpose. The qualitative data obtained in the interviews complement the effort to understand the process of building interprofessional collaborative practices.

Team meetings – one of these indicators – are held in most municipalities, a positive sign towards interprofessional work. These can be tools to organize planning, disseminate information, outline guidelines, and make decisions[9]. However, performing them less frequently may not favor interactions between team members to build bonds of trust and integration relevant to interprofessional collaboration[6,10]. Likewise, action planning is also carried out in most municipalities. However, having teams that do not plan their actions shows a lack of opportunities to establish interprofessional collaborative practices[6].

To ensure this integration, team meetings are confirmed as devices with great potential. In these meetings, professionals exchange information, discuss the work process, make decisions, that is, they are articulated around multiprofessional actions of the work dynamics[9,10]. As the last indicator, there is the support to the team, which, according to the National Humanization Policy[11], is an intervention device that suggests necessary changes and "how to do something". It articulates workers and services to enable critical analysis of the work process, the interaction between subjects, knowledge sharing, and the transformation of health practices[12] and, in this process, stimulates interprofessional collaborative work.

The results of this study show the relevance of supporting the teams to have meetings with the presence of the user and their families and produce a new way of providing health care, by listening to the user, exchanging knowledge, evaluating the relevance of the care interventions designed by the team in dialogue with the expectations and possibilities of the user and family[9].

In this context, we can observe interviewees who defined interprofessional work – which coincides with the definitions found in the national and international literature – as a modality of collective work, of communicative action[6], in which the development of a cohesive practice between professionals from different areas occurs. At the same time, testimonies show that, although there are collective activities in the daily lives of the teams, the actions are developed in a fragmented way, because of the biomedical model rooted in the practices[13]. Thus, although the actions are developed by recognizing the health needs of the users that are interpreted by the professionals, in their action, a hegemonic working style still echoes.

Characteristics in the dynamics of the teams that indicate the potential to promote integration and, consequently, the implementation of collaborative

practices are observed. Bond strengthening between professionals, exemplified by the recognition of team unity and cohesion, in addition to willingness to work, which are identified as interactional determinants of collaboration[14], emerge as relevant aspects. These determinants are intrinsically linked to interpersonal relationships in the work process, including respect, trust, and willingness to collaborate[14].

In the context of interactional determinants, communication plays a crucial role in interprofessional work, being considered one of the pillars of collaboration[15]. Communication effectiveness is manifested when team members are open to dialogue, favoring dialogue and active listening to different opinions. This approach is essential for conflict resolution, joint planning, and knowledge exchange among professionals[3]. However, teams reproduce the relations of society, that is, they reproduce the division of social classes, and it is not always possible to establish more horizontal relations. In general, what is established prevails, which is expressed by the physician and higher education professionals, and, in the interaction, the voice of Community Health Agents is little heard[16].

Thus, professionals must prioritize dialogue and interact in search of team cohesion, aiming at the most appropriate interventions for the health-disease-care process of users[7]. A practice highlighted by the interviewees is the exclusive dedication to the meeting, with time slots established for it. This is not always possible, although the National Policy of Primary Care[2] includes the guarantee of space for qualification of the multidisciplinary team, meetings, and health education in a perspective of horizontal cooperation. In addition, some teams have difficulties in making the professionals attend meetings, as there are different understandings about the importance of meetings in the work process of an FHS.

Beyond the walls of health facilities, there is significant potential for the development of collaborative practices. Home visits and the School Health Program were mentioned by the interviewees. Home visits provide a space for interprofessional dialogue, promoting the exchange of knowledge and experiences[17]. This type of network collaboration, whether with the community or with other sectors such as education, highlights the search for alternatives that promote comprehensive and more resolute care, fostering intersectoral work and user participation[17].

The time that the team spends working together proved to be a factor that impacts the development of interprofessional work. In the literature, for a more comprehensive understanding of interprofessional work, four domains were established: 1- relational, 2- procedural, 3- organizational, and 4-contextual domains[18]. Working time shared by the same team is categorized as a procedural domain and contemplates how space and time influence the accomplishment of the work.

In the second category of this study, we have aspects related to the team, which impact the development of interprofessional collaborative practices. In the interviews, we observed that the teams use technologies in their work process to establish communication channels. Digital or physical medical records allow professionals to access information about the care being provided to the user. Other communication channels mentioned were an internal chat on the computers of the

health unit and the use of instant messaging applications via mobile phones. The use of these technologies can help the work routine and serve as an indirect instrument of information exchange among professionals[17]. Thus, there is more agility in disseminating information, but this can also affect face-to-face communication among team members, impairing direct communication, which enables the exchange of knowledge and keeps professionals apart[17].

Another aspect related to the team, mentioned by the interviewees and that is relevant to the development of interprofessional collaborative practices was the support to the team. It enables the articulation of the service with different actors, generating a critical analysis of the work process[19]. In addition to the interaction between the subjects, there is the socialization of knowledge, the qualification of actions, the transformation of practices aiming at the feasibility of the objectives agreed upon, and the improvement in the quality and resolvability of the services provided[19]. This definition is in line with the statements of the interviewees that mentioned the role played by universities in supporting PHC teams.

The social assistance service was also mentioned as an important supporter of the teams that, in an articulated way, seek the socialization of knowledge, in a collaborative and intersectoral way. The interviews show that support and matrix support usually happen through team discussion or in situations in which mental health professionals provide feedback and discuss the cases referred by the reference team. A similar practice was reported in a study carried out in João Pessoa-PB[20], regarding the matrix support carried out by the specialized service in PHC, which promoted a less fragmented form of work, providing better meetings and experiences[20].

Another modality to be considered is the matrix support carried out by the NASF. Created in 2008 focusing on qualifying and making the performance of primary care more resolute, it has a multidisciplinary team[11]. Only three municipalities reported having NASF teams, which may be related to the current PHC policy that no longer funds this modality[12]. Without an inducing policy, this important strategy to support the teams is emptied or does not even exist. In addition, the financing mode l – Previne Brasil – leads the teams to focus on the number of registered users and the production of a group of indicators considered for financing, which limits the actions of PHC[13] and restricts strategies to organize the teamwork process that favor the establishment of interprofessional collaboration.

As important as the figure of the external supporter, the appreciation of the professionals of the team itself is also of great importance for the development and implementation of interprofessional collaborative practices. This recognition occurs when professionals can understand the role of each one within the team and, thus, can communicate respectfully and integrate different knowledge and skills in the services provided[21]. In the interviewees' reports, it was possible to identify that the recognition of the professions also enabled the perception of a certain degree of autonomy and the interdependence between them.

However, the distance from user-centered practice calls our attention and instigates reflection. Having the user as a care partner is one of the competencies to develop interprofessional collaborative practices[4,15,21,22], so that professionals

integrate their knowledge with that of the user, the family, and the community, seeking to build care actions, sharing decisions with autonomy and empowerment of the population[22]. The interviewees expressed situations that, in theory, approach this practice, focusing on the health needs and vulnerabilities referred to in the elaboration of the PTS, for example. However, the reports do not explain how the interaction with users takes place, and the perception of distance intensifies in view of the report that holds the user responsible for the team's difficulty in providing care. An important gap is evidenced for the effectiveness of interprofessional collaborative practices, the effective and active presence of the user in the decisions, and production of their care together with the team.

Final considerations

The results of this study can contribute to strengthening interprofessional work and collaborative practices, enabling quality health care for the population, as it was possible to understand that the construction of interprofessional collaborative practices permeates the collective spaces of Family Health Units when professionals meet and collaborate with each other. In these moments, collaborative practices and interprofessional work are characterized by actions developed by different professionals with different levels of integration.

The study has limitations regarding the number of teams interviewed. Although the ones with the best scores in the PMAQ assessment participated, they do not represent the totality of teams in the region studied. In addition, some professionals immersed in technical and individual practice, either by training or practical performance, have difficulties discussing the topics.

Although there are several moments with great potential for the development of interprofessional collaborative practices, one weakness within the process is that their practices are also highlighted by the fragmentation of health care and the non-inclusion of the user in decision-making about their own care. In this sense, we can highlight the importance of NASF, the matrix and institutional support and management, at all levels, to encourage and support the teams, to overcome the hegemonic way of working and, thus, open themselves to more effectively experiment with interprofessional collaborative practices centered on the user, the family, and the community.

Team meetings emerge as strategies to overcome these weaknesses, as a space that can bring together all professionals and provide their integration, in a democratic way, as well as permanent education, which is also extremely relevant to training professionals in this logic of collaborative care centered on users and helps break with practices based on the fragmentation of the biomedical model.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

The authors have no conflict of interest to declare.

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O modo de trabalhar das equipes de Saúde da Família pode favorecer o compartilhamento entre diferentes campos de saberes e o desenvolvimento de práticas colaborativas interprofissionais. Objetivou-se compreender como se dá a construção de práticas colaborativas interprofissionais no processo de trabalho em unidades de Saúde da Família (USF). Investigação exploratória, descritiva, com abordagens quantitativa e qualitativa, realizada com equipes de Saúde da Família de 26 municípios do interior paulista, utilizando dados secundários e entrevistas semiestruturadas. Da análise, emergiram duas categorias temáticas: o desenvolvimento do trabalho interprofissional e aspectos relacionados com a equipe. A construção das práticas colaborativas interprofissionais perpassa os espaços coletivos em momentos de integração dos profissionais. Porém, existem fragilidades decorrentes da fragmentação das práticas profissionais e da não centralidade no usuário.

Palavras-chave: Relações interprofissionais. Práticas interdisciplinares. Assistência centrada no paciente. Atenção primária à saúde.

El modo de trabajar de los equipos de Salud de la Familia puede favorecer la compartición entre diferentes campos de saberes y el desarrollo de prácticas colaborativas interprofesionales. El objetivo fue comprender cómo se realiza la construcción de prácticas colaborativas interprofesionales en el proceso de trabajo en unidades de Salud de la Familia. Una investigación exploratoria, descriptiva, con abordajes cuantitativo y cualitativo, realizada con equipos de Salud de la Familia de 26 municipios del interior del Estado de São Paulo, utilizando datos secundarios y entrevistas semiestructuradas. Del análisis surgieron dos categorías temáticas: el desarrollo del trabajo interprofesional y aspectos relacionados con el equipo. La construcción de las prácticas colaborativas interprofesionales atraviesa los espacios colectivos, en momentos de integración de los profesionales. No obstante, hay fragilidades provenientes de la fragmentación de las prácticas profesionales y de la no centralidad en el usuario.

Palabras clave: Relaciones interprofesionales. Prácticas interdisciplinarias. Asistencia centrada en el paciente. Atención primaria de la salud.