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PERCEPTIONS ABOUT HEALTH CARE FOR OLDER ADULTS IN THE REDE BEM CUIDAR: QUALITATIVE STUDY*

PERCEPÇÕES ACERCA DA ATENÇÃO À SAÚDE DA PESSOA IDOSA NA REDE BEM CUIDAR: ESTUDO QUALITATIVO

PERCEPCIONES ACERCA DE LA ATENCIÓN A LA SALUD DE LA PERSONA MAYOR EN LA REDE BEM CUIDAR: ESTUDIO CUALITATIVO

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RESUMO

Objetivo: Compreender a implementação da Rede Bem Cuidar – Rio Grande do Sul, na perspectiva de gestores e profissionais da atenção primária à saúde. **Método:** Estudo qualitativo realizado com gestores e profissionais vinculados ao referido programa. A coleta de dados ocorreu por meio de entrevistas semiestruturadas, conduzidas com base em um roteiro elaborado pelos pesquisadores e fundamentado no Instrumento de Avaliação da Coordenação das Redes de Atenção à Saúde pela Atenção Primária à Saúde. Os dados foram analisados por meio de análise temática. **Resultados:** Observou-se convergência na compreensão de profissionais e gestores acerca do programa, embora tenham emergido diferentes percepções e experiências relacionadas à sua implementação. Os achados evidenciam avanços e desafios no processo de implantação da iniciativa. De modo geral, os participantes relataram mudanças significativas na atenção à saúde da pessoa idosa, impulsionadas pelas metas estabelecidas pelo programa e pela disponibilização de recursos financeiros. **Conclusão:** A Rede Bem Cuidar apresenta potencial para promover mudanças relevantes na atenção à saúde da pessoa idosa. Entretanto, ainda existem desafios a serem superados para a consolidação de sua implementação e para a qualificação das ações assistenciais voltadas a essa população.

Descritores: Serviços de Saúde para Idosos; Política de Saúde; Atenção Primária à Saúde; Saúde do Idoso.

ABSTRACT

Objective: To understand the implementation of the *Rede Bem Cuidar* – Rio Grande do Sul from the perspective of managers and professionals working in primary health care. **Method:** Qualitative study conducted with managers and professionals linked to the program. Data collection was carried out through semi-structured interviews, conducted based on a script developed by the researchers and grounded in the Instrument for Assessing the Coordination of Health Care Networks by Primary Health Care. Data were analyzed using thematic analysis. **Results:** Convergence was observed in the understanding of professionals and managers regarding the program, although different perceptions and experiences related to its implementation emerged. The findings highlight both advances and challenges in the process of implementing the initiative. Overall, participants reported significant changes in health care for older adults, driven by the targets established by the program and by the availability of financial resources. **Conclusion:** The *Rede Bem Cuidar* has the potential to promote relevant changes in health care for older adults. However, challenges remain to be overcome to consolidate its implementation and to improve the quality-of-care actions directed toward this population.

Descriptors: Health Services for the Aged; Health Policy; Primary Health Care; Health of Older People.

RESUMEN

Objetivo: Comprender la implementación de la *Rede Bem Cuidar* - Río Grande do Sul desde la perspectiva de gestores y profesionales de la atención primaria a la salud. **Método:** Estudio cualitativo realizado con gestores y profesionales vinculados al referido programa. La recolección de datos se llevó a cabo mediante entrevistas semiestructuradas, conducidas con base en un guion elaborado por los investigadores y fundamentado en el Instrumento de Evaluación de la Coordinación de las Redes de Atención a la Salud por la Atención Primaria a la Salud. Los datos fueron analizados mediante análisis temático. **Resultados:** Se observó convergencia en la comprensión de profesionales y gestores acerca del programa, aunque emergieron diferentes percepciones y experiencias relacionadas con su implementación. Los hallazgos evidencian avances y desafíos en el proceso de implantación de la iniciativa. En general, los participantes informaron cambios significativos en la atención a la salud de la persona mayor, impulsados por las metas establecidas por el programa y por la disponibilidad de recursos financieros. **Conclusión:** La *Rede Bem Cuidar* presenta potencial para promover cambios relevantes en la atención a la salud de la persona mayor. Sin embargo, aún existen desafíos por superar para la consolidación de su implementación y para la cualificación de las acciones asistenciales dirigidas a esta población.

Descriptores: Servicios de Salud para los Ancianos; Política de Salud; Atención Primaria a la Salud; Salud del Anciano.

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What is already known:

- Population aging is associated with biological, social, and functional changes that require specific approaches in health care.
- Primary health care constitutes the main entry point to the health system and should include strategies aimed at health promotion.
- Rede Bem Cuidar – Rio Grande do Sul (RS) is a program developed with the objective of expanding and improving care for older adults.

What this article adds:

- The challenges identified in the study may support the implementation of measures aimed at strengthening the Rede Bem Cuidar RS.
- The resources provided by the program contributed positively to improving health care for older adults.
- The program promoted significant changes in health care for older adults within the scope of primary health care.

INTRODUCTION

Demographic transition has resulted in an increase in the proportion of older adults in the population, making population aging a global phenomenon that has intensified in recent decades and reflects significant social transformations[1]. This scenario imposes important challenges on health systems, which increasingly require care models capable of promoting autonomy and preserving the functional capacity of older adults[2].

Aging involves progressive and irreversible changes that are not always pathological but may contribute to increased vulnerability and to the decline of health status[3]. Due to the growing number of older adults and the complexity of their health needs, it becomes necessary to adopt approaches that integrate disease prevention and health promotion actions[4].

Primary health care (PHC) plays a central role in care for older adults, as it must consider the individuality of the person and the social determinants that influence their health and disease processes[5]. With the aim of promoting healthy aging and responding to the demands of this population, the *Rede Bem Cuidar RS* (RBC-RS; RS Well Care Network, in free translation for English) was created, a program developed by the State Health Secretariat of Rio Grande do Sul (SES-RS) to expand and improve health care for older adults[6].

RBC-RS seeks to articulate health services and promote effective and humanized care that respects the particularities of older adults and contributes to improving their quality of life[6]. The actions developed aim to improve work processes and the health care provided to the population. The implementation of the program aims to offer services that are more responsive to the demands of this population, with greater problem-solving capacity, strengthening of social participation, expansion and improvement of access to health services as well as the adoption of continuous health education strategies[6].

For the program implementation to be effective, it is essential that the adopted work processes are capable of ensuring the quality of services and health care[7]. The role of PHC professionals stands out in reassessing the needs of the assigned territory, using knowledge, skills, and competencies to develop strategies aimed at demands related to the health and disease processes of older adults. This work should prioritize a holistic and patient-centered approach[8,9].

Given the need to evaluate the implementation of the program and considering the role of health workers in this process, this study aimed to understand the implementation of RBC-RS from the perspective of PHC managers and professionals.

METHOD

This is a qualitative analytical study grounded in public policies for health care for the older adult population. To ensure methodological clarity and reporting quality, the recommendations of the Checklist Consolidated Criteria for Reporting Qualitative Research[10] were followed.

The study was conducted in the 20th Health Region, located in the state of Rio Grande do Sul, Brazil. This region comprises 26 cities, most of which have populations equal to or fewer than 5,000 inhabitants.

Managers and professionals linked to RBC-RS participated in the study. All cities that make up the 20th Health Region joined the program. Regarding managers, according to SES-RS guidelines, they should not be part of the minimum PHC team. The participating professionals were those working in the family health teams that joined RBC-RS.

To include cities in the study, the criterion established was that they should have a manager and professionals working since the moment of the program's creation and implementation. After applying this criterion, of the 26 cities in the region, 12 met the requirements and were included in the study. In each selected city, one manager and one professional linked to RBC-RS participated, totaling 24 participants. Selection of professionals was performed by drawing lots.

Data collection took place between April and June 2024 through individual, in-person interviews scheduled in advance and conducted by the principal researcher, a master's-level graduate student. An interview guide divided into two stages was used. The first stage included the characterization of participants, including age, sex, role, marital status, education, time since graduation, and length of work in the Family Health Strategy (FHS). The second stage included open-ended questions related to the study objective, adapted from the Instrument for Assessing the Coordination of Health Care Networks by Primary Health Care.

The interviews were recorded, with an average duration of 26 minutes, and were later transcribed in full, totaling 249 pages of textual material. Data analysis followed the assumptions of thematic analysis proposed by Minayo[11], structured in three phases. In the first phase, called pre-analysis, initial contact with the documents was established in order to organize and prepare the material and to conduct a floating reading. In the second phase, the software NVivo, version 15, a tool to support qualitative analysis, was used for material exploration and coding, with identification of meaning units, contextual elements, and thematic categories. In the third phase, the results were processed with identification of emerging categories, followed by interpretation and discussion of the findings in light of the scientific literature

and policies for health care for the older adult population.

The study followed the ethical principles of research involving human beings, as established by Resolutions No. 466/2012[12] and No. 510/2016[13]. The research was approved by the human research ethics committee under opinion No. 6,612,856. To ensure participant anonymity, the letters G and P followed by numerals (G1, G2, G3… and P1, P2, P3…) were used, corresponding respectively to the managers and professionals participating in the study.

RESULTS

Among the participating managers, all were female, with a mean age of 39 years. Regarding marital status, six were married, four were single, and two were in a stable union. Regarding their professional roles, five worked as nurses, two as health secretaries, one as a health coordinator, one as a basic health unit coordinator, one as a PHC coordinator, one psychologist, and one social worker. The predominant level of education was postgraduate training, reported by seven participants, while five had only undergraduate degrees. On average, the participants had 13 years of professional training and 12 years of experience working in the health unit. All reported having completed continuing education or professional development courses after graduation.

Among the 12 professionals interviewed, nine were female and three were male, with a mean age of 38 years. Regarding marital status, six were single, five were married, and one was in a consensual union. In terms of professional background, four were nurses, three physicians, three dentists, one psychologist, and one nutritionist. Regarding education, two had completed postgraduate studies at the master's level, seven had specialization degrees, and three had only undergraduate degrees. All reported having completed continuing education or professional development courses after graduation. The average time since professional training was 13 years, while the average length of work in the health unit was 9 years.

Data analysis allowed the identification of two thematic categories: understandings about RBC-RS: modifications in health care for older adults; and challenges for the implementation of RBC-RS in the PHC context.

Understandings about the RBC-RS program: modifications in health care for older adults

Understanding the functioning and objectives of RBC-RS proved to be a relevant element in the practice of health services, as it enables professionals and managers to understand its purposes and targets. The excerpts from participants' statements showed that both professionals and managers demonstrated knowledge about the program, highlighting, in daily practice, the central focus on the health of older adults.

> *I understood that these were actions that we had to plan, based on understanding the reality of our population and paying attention to the older population.* (G12)

> *My perception of the Rede Bem Cuidar is that it is something centered on older adults. It is based on a whole structure and differentiated care for older adults.* (G3)

> *Rede Bem Cuidar is a state health policy aimed at some groups, for example, older adults, pregnant women, and other specific groups, intended to improve both equipment and infrastructure.* (P10)

Participants reported that, before the implementation of the program, care for older adults in PHC was mainly centered on spontaneous demand and immunizations. With the implementation of the actions recommended by RBC-RS, care began to include multidimensional assessment, allowing a more targeted and assertive approach by considering the singularities associated with senescence and the implications of the aging process across biopsychosocial dimensions.

> *For us, care for older adults meant vaccination, influenza campaigns, and consultations. It was when multidimensional assessment began that we started to understand other things, and we began working more closely with older adults themselves.* (G1)

> *There was nothing specifically directed toward older adults. When we started to develop some strategies for older adult care, we realized how many older adults we had, what the at-risk population was, and who our most vulnerable older adults were. The team itself began to organize and look at things in a different way, both regarding this population that needs care and how we would provide that care.* (P4)

> *The multidimensional assessment of older adults was important for us to understand the profile of this population and to be closer to them. The assessment was already there, we could use it, it was a tool that everyone could use, but we did not use it or prioritize it in our schedule before, and now we do. That made us look at older adults differently in general.* (G8)

This expanded assessment positively affected the clinical decision-making process and enabled more accurate diagnoses, allowing the early identification of changes related to the health-disease process. One professional reported that through the multidimensional assessment it was possible to identify a case of bowel cancer early, which allowed timely intervention and patient rehabilitation.

> *The program target will take me to that house where I normally would not go. I diagnosed bowel cancer in a patient who never came to the unit. "Oh, but she's fine," but I still had to go there, weigh her, and see her. We went there and she was not well. I asked, "Have you had a colonoscopy as a routine test?" "Oh, I haven't had one in a long time, actually I've never had one." The result showed bowel cancer. She received care and today she is well. But that only happened because we made an early diagnosis, due to a (Program) target, which was weighing. When you have a pre-established target and a trained professional working toward it, you are able to make differential diagnoses.* (P7)

The incorporation of multidimensional assessment into health care for older adults, together with other principles of RBC-RS, also enabled the implementation of singular therapeutic projects (STPs). These projects guide interventions centered on the individual, considering the specific

characteristics of the older adult and their sociocultural context.

> *Because we have more time, we can identify which patients attend more frequently, and within that we can also develop a singular therapeutic project. It was something that was implemented and worked well*. (G8)

> *We maintained the multidimensional assessments and home visits. We also developed STPs with the team. We used them a lot, it was very good, and I think it is still being maintained. It came from there and is still ongoing.* (G11)

> *When we think about developing an STP, we need to look carefully at who we are going to assist. When we need to organize it, we realize how complex it is and how much intervention is possible in a given situation.* (P4)

In addition to the activities developed within the health unit, care for older adults began to include complementary actions aimed at maintaining functional capacity. Among these activities, the provision of free Pilates classes for older adults stood out, made possible through the financial resources provided by RBC-RS.

> *We started offering Pilates for them, from age 55 onward, motivated by the Rede Bem Cuidar and the funding that came with it. A Pilates studio was set up here and a physical therapist was hired to work exclusively with this population.* (G1)

The implementation of RBC-RS also promoted changes in work processes, as evidenced in the statements of both professionals and managers. There was an expansion of active search actions for users with chronic diseases in the assigned territory, especially through home visits as well as greater attention to the need for consultations in health services. These actions began to be carried out by the team in a multiprofessional manner.

> *We are always improving care, looking for patients with diabetes and hypertension, checking on their medication, and seeing whether they are really following treatment properly. This was already somewhat part of our practice, the whole team does this. Through home visits, with the help of community health workers, we try to follow these patients closely.* (G12)

> *There are many home visits every day. We provide good care. It is not like someone requests a home visit today because the patient is unwell or bedridden and we postpone it until the next shift or the next day. No. We go during the same shift when the request is made.* (G2)

> *We schedule appointments, the community health worker identifies the demands and what people need most, and brings that information to us. Then we either conduct a home visit or schedule a consultation here at the BHU.* (P12)

Additionally, participants reported the creation or strengthening of health groups for older adults, conducted by multiprofessional teams and focused on themes related to the health of this population. Initiatives such as health fairs were also mentioned, which expand spaces for care and help increase the visibility of actions directed toward older adult health.

> *We organized large events, you know? And everyone participated. We had an older adult group, and during that period all professionals took part and helped.* (G11)

> *Older adults were always attended, but not in the way they are now. There were no specific groups for older adults like there are today. There was only regular care at the unit. Now we have these groups focused on older adults. For example, every month we have a meeting with them. It is meant to include all older adults, but around 40 to 50 attend each meeting. In each meeting, a different professional leads the activities. It is a type of attention that did not exist before.* (G5)

> *We were able to become closer to older adults. With the multidimensional assessments we had more contact with them. We organized older adult health fairs and conducted home visits. We were able to organize things better.* (G11)

Another aspect highlighted was the strengthening of the bond between older adults and health service professionals as a result of the actions developed within RBC-RS. This bond was perceived as an important element for the humanization and improvement of care, allowing older adults to receive comprehensive care rather than care focused exclusively on their comorbidities.

> *Since I have been in the municipality for a long time, I noticed that in the past there were isolated actions, not so focused or with clear objectives. Today I see this work as more organized, more systematic, with important guarantees and rights.* (P1)

> *The most interesting thing is truly seeing the older adult as a whole. Before that we did not have that perspective. After this training, you look at gait, you look at the skin, you look at the whole person, including the home environment. It is about the integrality of the human being.* (G3)

> *With Rede Bem Cuidar, I believe there has been greater closeness with older adults. We began actively seeking them out to bring them into contact with us. What I noticed most in comparison with before is this greater closeness between the team and the older adults we serve.* (P3)

In addition to the direct impacts on care, RBC-RS also promoted training activities for health professionals, with the aim of improving care for the demands of the older adult population in health services.

> *There was one (course) that I really liked, the polypharmacy course, it was very good. It addressed medication interactions and these issues. I found it extremely useful.* (G2)

Overall, both managers and professionals reported positive changes resulting from the implementation of RBC-RS, highlighting the availability of financial resources, improvements in infrastructure, and the incorporation of a new perspective on care for older adults within the FHS.

> *I think the network only adds value, because besides funding and infrastructure, it improves the care provided to a population. So I think it is very worthwhile.* (P10)

> *I think it is a program that, if everyone commits to it, was a good decision by the government to implement. I think it was very good. I do not know what the level of adherence is among municipalities across the state, but it is a good initiative. It has already made a difference, even if not 100%, but in relation to older adult care it is already much better than it used to be.* (G6)

> *I think it improved things overall because we worked through the previous cycles [...]. It made us develop a different perspective focused on older adults in the various stages that were carried out. I definitely think it improved.* (G8)

Challenges for the implementation of RBC-RS in the context of primary health care

Professionals and managers reported that the implementation of RBC-RS was initially marked by some resistance to adopting the new strategies proposed by the program, especially regarding the standardization of multidimensional assessment and the need to achieve the indicators established to meet the program targets.

> *So we tried things starting with the multidimensional assessment, things that had not been done before. We started adopting them. Of course, we encountered some resistance. I think that with anything new there will always be some resistance. But I think we are managing to progress.* (P8)

> *Today everyone knows about Rede Bem Cuidar, what is done and what is not done, but at the beginning I felt some resistance from the team. "But why these targets? Why do we have to do this?" That generates questioning, because sometimes people think, why add more tasks? So in the beginning it was more difficult, but now it has become more accessible.* (G9)

The difficulties related to achieving these targets were mainly attributed to insufficient moments for dialogue and exchange between management and professionals as well as to the lack of adequate clarification about the new indicators used to guide care for older adults. This communication gap contributed to difficulties in understanding the targets and organizing the actions required to achieve them.

> *Very little discussion, almost none, actually zero. The health secretariat's attention to the program with us is zero. They never called us to sit down, talk about anything, ask for suggestions for different types of care or work, or give greater attention to any specific area.* (G5)

> *Indeed, the targets were a problem for us because until we understood how everything worked, we had considerable difficulty. That is why we did not achieve the targets at first.* (G6)

> *I noticed the difficulty in achieving these targets because of the challenge of organizing meetings with the team. So I think there is a lack of organization, perhaps even on my part as the RBC manager.* (G7)

Another challenge mentioned was the need to reconcile the activities of the FHS with the actions proposed by RBC-RS. According to participants, a large part of the workday is devoted to attending spontaneous demand and previously scheduled consultations, which limits the time available for other activities linked to the program. In addition, the reduced number of professionals in the services was mentioned as a factor that hinders the expansion and consolidation of the proposed actions.

> *If we had more time to dedicate to certain projects, it would help. But we have daily patient demand that is not scheduled, scheduled appointments, the projects, and also home visits. Sometimes something unexpected happens during the day that you also have to handle, so it can become complicated.* (P6)

> *Indeed, programs keep increasing while the number of staff remains the same and the workload is the same, so you really cannot keep up with everything.* (G10)

> *I think it would work better with a smaller team. Because here the demand is very high and we have to cover the entire municipality.* (G3)

Participants also reported difficulty incorporating moments of continuing health education into the work routine. This limitation may affect care practices, since professional updating and training directly influence the quality of the actions developed in the care of older adults.

> *I can say that time is always lacking. I think that if we had more time to read and dedicate ourselves to all those PDFs included in the courses, and complete them more calmly, the practical actions would be much more efficient.* (G12)

Similarly, in addition to time limitations, another difficulty identified, intrinsically related to continuing education, was participation in courses and training activities offered. Two main factors were mentioned: the predominance of online training modalities and the lack of interest among some professionals in participating in continuing education courses.

> *My main difficulty was getting the team to complete the courses, because I had to follow up every week. Eventually people managed to do them, they followed the links and set aside some time. I kept monitoring and helping them access the materials, especially the CHWs; we helped them access the courses.* (G11)

> *We had to require the team to complete the training course. If you do not require everyone to obtain the certificate, you cannot get people to study. So it was one of the battles we had. It was not 100% at first, but we eventually required 100% participation. Because*

it does not help if only one person knows; everyone has to know. Everyone needs to understand the population we are serving. (P4)

I particularly liked it because the team had to mobilize themselves through conversation, dialogue, data collection, and participation in the training courses. We realized that the team had considerable difficulty stopping their routine to complete a course, especially because participation was mandatory for everyone. (G11)

The health context during the period of implementation of RBC-RS actions also represented a challenge for health services. This period was marked by epidemics that required rapid reorganization of the health units and adaptation of teams to new protocols and care flows. This situation caused temporary disruption in services and led to the prioritization of contingency actions over other activities, including those related to the program.

I think things are a bit turbulent. For example, now everything is happening at once, there is dengue... many things happening at the same time. When we came out of COVID, we thought: now we will organize things and schedule activities. But then we had staff issues. For a long time we had only two nurses. (G2)

Unfortunately, we are not managing to maintain things the same way. At the beginning we were able to, but because of the dengue outbreak, which is not only here in Rio Grande do Sul but everywhere, since the beginning of the year a large part of the time only the physician was working. I took some days of vacation, then my colleague went on sick leave and later on vacation. (P2)

It is good care, but since our population increased a lot and we came out of a pandemic and then faced dengue, I think we would need more time to work more on this. But I believe we are trying to do the best we can. We always have someone on sick leave or another type of leave, so we are often short one staff member, which overloads the others. Still, we try to do the best possible work. (P8)

Finally, participants emphasized that the activities currently developed within RBC-RS represent only a starting point. According to their reports, there is still a need to expand and diversify strategies aimed at caring for older adults in order to promote actions that go beyond monthly meetings and enable more comprehensive and continuous care for this population.

We would need to develop more activities within the program. That is what I feel is missing here in our municipality. We could develop more activities and more situations that involve older adults. We work with them, provide care, and hold meetings, there is a meeting with them every month, but we could involve them more. More activities, more opportunities for them to make better use of this stage of their lives. (G5)

DISCUSSION

Care for older adults within the context of FHS showed changes after the implementation of RBC-RS. Among the modifications identified, professionals highlighted a shift in the central focus of care, which had previously been mainly directed toward meeting spontaneous demand and immunizations. A study[14] conducted with the objective of understanding care provided in PHC from the perspective of older adults showed that care often focuses on the control and monitoring of specific clinical conditions, without adequately considering the particularities and limitations resulting from the aging process.

In this context, the expanded assessment recommended by RBC-RS represents a relevant strategy because, in addition to clinical diagnosis, it incorporates physical, psychological, and social dimensions that influence the health and quality of life of older adults[14-16]. From this approach, it becomes possible to support the development of STPs, which aim to provide comprehensive and personalized care by considering the specific characteristics of each individual, including social, economic, family, cultural, and psychological aspects[17,18].

The collective development of the STP, based on dialogue among professionals from different fields, constitutes an effective strategy for a holistic approach to the specific needs of older adults[18]. A study conducted in the United States highlights that the individualization of care for patients with complex needs is associated with reduced costs, lower resource utilization, and the provision of safer and higher-quality care[19].

The strengthening of health groups was also mentioned as an important strategy for socialization and interaction among older adults, in addition to encouraging the exchange of knowledge and experiences. The implementation of collective activities has shown significant benefits for this population, as it favors the development of social support networks and strengthens interpersonal bonds, which are fundamental elements for promoting active and healthy aging[20,21]. Furthermore, a study[22] emphasizes that social interaction is an essential component of the mental and emotional health of older adults, contributing to disease prevention and the adoption of healthy lifestyles.

The perception that it is still necessary to expand actions directed toward older adults indicates that the activities currently developed for this population remain limited. Therefore, it is essential to broaden the strategies directed toward this group, moving beyond care models centered on traditional practices. Some authors highlight the advantages of closer follow-up and strengthened interaction between health professionals and older adults, emphasizing that strengthening this bond contributes to improving the quality of care, increasing trust, and facilitating communication between professionals and patients, factors that are essential for therapeutic success and user satisfaction[23,24].

Complementary activities implemented, such as the provision of Pilates classes, were also identified as important for improving quality of life and maintaining the functional capacity of older adults. These findings are supported by studies indicating that physical practices and physical activity encourage healthy lifestyles, help control comorbidities, and promote greater participation of older adults in the care

of their own health[25]. In addition, a prospective observational study[26] conducted to evaluate the feasibility and appropriateness of a Pilates program for older adults showed that most participants considered the practice appropriate and associated their participation with improvements in overall health.

The low participation and limited engagement of some professionals in the training activities offered by RBC-RS were associated with difficulties in reorganizing the work routine to complete continuing education and training courses. This aspect may be related to a lack of understanding about the importance of these activities for improving care and the quality of health services. The mobilization and engagement of health teams depend on interconnected processes that involve effective communication, continuous training, and collaborative environments. Evidence from the literature indicates that these practices contribute to increased team efficiency and improved health outcomes for patients and communities[27].

The set of actions developed by RBC-RS, together with the adoption of a more humanized approach to care for older adults, contributed to strengthening the bond between health professionals and users. A study[28] highlights that strengthening this bond makes it possible to understand the health-disease process more comprehensively, facilitating care and making assistance more effective.

Among the challenges identified by participants, the difficulty of reconciling spontaneous demand and other service responsibilities with the activities proposed by RBC-RS stood out. This situation is directly related to insufficient human resources and represents a significant barrier to the effectiveness of PHC, as it contributes to work overload and makes it difficult to adequately address the needs of the population[29,30]. Among the strategies that may be adopted to address this challenge is the implementation of policies aimed at redefining the roles, responsibilities, and scope of practice of health professionals as well as optimizing functions within multiprofessional teams[31].

In addition, epidemics that occurred during the period of program implementation, such as the dengue epidemic, also diverted the focus of actions directed toward the health of older adults. A study[32] shows that the emergence of epidemics significantly affects the organization and routine of health teams. Similarly, the resumption of care activities in PHC after the COVID-19 pandemic still presents important challenges, reflecting structural and operational changes that occurred during the health crisis[33].

Another challenge reported by professionals relates to completing the indicators required to achieve the program targets. This aspect was associated with weaknesses in communication between management and health services. The absence of clear and transparent communication can reduce trust between professionals and managers, creating less collaborative work environments and lower team engagement. In health organizations, where effective communication is essential, these limitations may directly affect the quality of services provided[34].

As a limitation of this study, its cross-sectional design should be highlighted, as it allows the analysis of participants' perceptions at a specific moment in time. Considering the complexity and constant changes in health work and in care for older adults within RBC-RS, these perceptions may vary over time. In addition, the predominance of small municipalities among the study participants should be considered, which may influence how program strategies are implemented and limit the generalization of the results to larger municipalities with different organizational realities in health services.

FINAL CONSIDERATIONS

The implementation of RBC-RS generated positive impacts on health services, particularly regarding care for older adults. The implementation of the program was associated with changes in the organization of care and with the availability of financial resources that contributed to strengthening the FHS teams.

The results revealed a diversity of perceptions and experiences among managers and professionals, indicating that the program has the potential to improve and expand health care for older adults. Among the main challenges identified are the lack of available time for professionals and work overload in health services.

Despite these difficulties, a good understanding of the objectives and targets of the program was observed among managers and professionals, along with positive evaluations related to the financial resources provided by RBC-RS.

The transformation of care practices in primary health care is a complex process that requires significant changes in the way care for older adults is organized. In this regard, improving care practices requires joint efforts involving training and awareness among teams as well as the creation of work environments that favor collaboration and effective communication between professionals and management.

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CONFLICT OF INTERESTS

The authors declare that there is no conflict of interests.

REFERENCES

1. Instituto Brasileiro de Geografia e Estatística. Censo Demográfico 2022 [Internet]. Rio de Janeiro: IBGE; 2021 [cited 2023 Aug 28]. Available from: https://www.ibge.gov.br/estatisticas/sociais/populacao/22827-censo-demografico-2022.html.
2. Ferreira PM, Dias JPB, Barbosa M, Martins T, Pereira RPG, Nascimento MC, et al. Influence of self-care on the quality of life of elderly people with chronic non-communicable diseases: a systematic review. Healthcare (Basel). 2026;14(3):308. https://doi.org/10.3390/healthcare14030308. PMID: 41682158.
3. Petermann XB, Oliveira J da L, Kocourek S. Frailty in elderly people in primary health care in Brazil: an

integrative review. SaudColetiv (Barueri). 2025;15 (93):14656-69. https://doi.org/10.36489/saudecoletiva.2025v15i93p14656-14669.

4. Lago JN, Lima AS, Santos AC, Carvalho ECL das D, Fernandes LR, Camboim BBP, et al. Os cuidados preventivos e promocionais para um envelhecimento saudável. Acervo Saúde. 2025;25:e18950. https://doi.org/10.25248/reas.e18950.2025.
5. Walker F, Lima JB de S, Heidemann ITSB, Celich KLS, Schleicher ML, Pilger KC de P, et al. Elderly care in primary health care: nurses' perceptions. Enferm Foco 2024;15:e-202464. https://doi.org/10.21675/2357-707x.2024.v15.e-202464.
6. Rio Grande do Sul (Estado), Secretaria Estadual de Saúde. Conheça a Rede Bem Cuidar RS [Internet]. Porto Alegre: Secretaria Estadual da Saúde; 2021 [cited 2023 Aug 28]. Available from: https://saude.rs.gov.br/rbcrs.
7. Ramos M, Brandão AL, Graever L, Campos CEA. Melhoria contínua da qualidade. Rev Bras Med Fam Comunidade. 2021;16(43):2736. https://doi.org/10.5712/rbmfc16(43)2736.
8. Rio Grande do Sul (State), Secretaria Estadual de Saúde. Manual de orientação novas adesões Rede Bem Cuidar RS. Porto Alegre: Rio Grande do Sul; 2023 [cited 2023 Aug 28]. Available from: https://saude.rs.gov.br/upload/arquivos/202308/22085649-manual-novas-novas-adesoes-rbc.pdf.
9. Ndateba I, Havaei F, Haase KR, Hogg W, Martin-Misener R, Wong ST. Association between team functioning and self-efficacy and quality of life for primary care patients in British Columbia, Nova Scotia, and Ontario. Prim Health Care Res Dev. 2026; 27:e20. https://doi.org/10.1017/S1463423626100887. PMID: 41676855.
10. Souza VR dos S, Marziale MHP, Silva GTR, Nascimento PL. Translation and validation into Brazilian Portuguese and assessment of the COREQ checklist. Acta Paul Enferm. 2021;34:eAPE02631. https://doi.org/10.37689/acta-ape/2021ao02631.
11. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14. ed. São Paulo: Hucitec; 2014.
12. Ministério da Saúde (BR), Conselho Nacional de Saúde. Resolução n. 466, de 12 de dezembro de 2012. Aprovar as seguintes diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos [Internet]. Brasília: Ministério da Saúde; 2012 [cited 2023 Aug 28]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html.
13. Ministério da Saúde (BR), Conselho Nacional de Saúde. Resolução n. 510, de 7 de abril de 2016. dispõe sobre as normas aplicáveis a pesquisas em Ciências Humanas e Sociais cujos procedimentos metodológicos envolvam a utilização de dados diretamente obtidos com os participantes ou de informações identificáveis ou que possam acarretar riscos maiores do que os existentes na vida cotidiana, na forma definida nesta Resolução [Internet]. Brasília: Ministério da Saúde; 2016 [cited 2023 Aug 28]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2016/res0510_07_04_2016.html.
14. Silva JDP da, Vendramini ACMG, Mufato LF, Oliveira D do C, Pinheiro TF, Santana AZR. Percepções de idosos sobre a assistência à saúde na estratégia saúde da família. Estud. interdiscip. envelhec. 2023;28:e114467. https://doi.org/10.22456/2316-2171.114467.
15. Gelsleuchter JC, Hammerschmidt KS de A, Girondi JBR, Locks MOH, Brehmer LC de F, Carvalho AA de. Uso da avaliação multidimensional em idosos com Diabetes mellitus na Atenção Primária à Saúde: um estudo piloto. Vittalle. 2020;32(3):119-27. https://doi.org/10.14295/vittalle.v32i3.11879.
16. Faria A, Martins MMFP da S, Aguilera JAL, Ribeiro OMPL, Silva JMAV, Fonseca EF, et al. Factors related to multidimensional fragility in elderly people. Rev. baiana enferm. 2022;36:e46531. https://doi.org/10.18471/rbe.v36.46531.
17. Marques ALN, Camargo FC, Duarte JMG, Lima AAP, Martins FTM, Guimarães HPN, et al. Family approach and individualized therapeutic projects in Family Health Strategy: a case study with elderly patients. REFACS. 2019;7(1):72. https://doi.org/10.18554/refacs.v7i1.2997.
18. Silva ES da, Souza CL de, Matos R da S, Magalhães DL, Prates JL, Souza A de O, et al. Atuação do agente comunitário na promoção da saúde na atenção básica: revisão integrativa da literatura. Braz. J. Hea. Rev. 2020;3(5):14878-93. https://doi.org/10.34119/bjhrv3n5-279.
19. Reese V, Psaila J, Schwartz M, Owens S, Miller R, Martinez-Baladejo M, et al. High utilizer care plan project: a network initiative to decrease inappropriate resource utilization among high-risk patients. Cureus. 2026;18(1):e100999. https://doi.org/10.7759/cureus.100999. PMID: 41658830.
20. Lima CAB de, Souza FOS. Atuação do núcleo ampliado de saúde da família e atenção básica na implementação de atividades coletivas no município de Bezerros-PE. In: Pereira VS, Silva BN da, organizadores. Saúde Pública: princípios e práticas [Internet]. Fortaleza: Editora IME; 2022 [cited 2023 Aug 28]. p. 271-83. Available from: https://www.editoraintegrar.com.br/wp-content/uploads/2024/07/Livro-saude-publica-principios-e-praticas.pdf.
21. Andrade AFSM de, Fonseca RG, Teles W de S, Silva MC da, Barros ÂMMS, Torres RC, et al. Atuação do enfermeiro no cuidado humanizado ao idoso na Atenção Primária. Res Soc Dev. 2021;10(12):e391101220283. https://doi.org/10.33448/rsd-v10i12.20283.
22. Minaré NF, Cardoso CL. Grupo comunitário de saúde mental: relações estabelecidas por participantes regulares de longo prazo. Vínculo. 2021;18(1):388-406. https://doi.org/10.32467/issn.19982-1492v18nesp.p388-406.
23. Melo RCCP de, Costa PJ, Henriques LVL, Tanaka LH, Queirós PJP, Araújo JP. Humanitude in the humanization of elderly care: experience reports in a health service. Rev Bras Enferm. 2019;72(3):825-29. https://doi.org/10.1590/0034-7167-2017-0363. PMID: 31269152.
24. Ferreira MCN, Cardoso R da SS, Silva SMM da, Depianti JRB. Grupo de convivência para idosos na atenção primária à saúde: relato de experiência. Rev. Enferm. Atual In Derme. [Internet]. 2023 [cited 2023 Aug 28];97(esp):e023135. Available from:

https://www.revistaenfermagematual.com.br/index.php/revista/article/view/1838.
25. Sousa BRB, Ferreira E do NS, Oliveira ACE, Sá LR, Silva PVC, Amaral IN, et al. Práticas integrativas e complementares na promoção da qualidade de vida para a pessoa idosa. Acervo Saúde. 2024;24(8):e16938. https://doi.org/10.25248/reas.e16938.2024.
26. Gonzales L, Ngo K, Kraus P, Zander Y, Hatch MN. Feasibility of a mat-based Pilates program for community dwelling seniors to improve balance and core strength. PM R. 2025;17(8):905-16. https://doi.org/10.1002/pmrj.13358. PMID: 40156452.
27. Gleriano JS, Fabro GCR, Tomaz WB, Forster AC, Chaves LDP. Family health team work management. Esc. Anna Nery. 2021;25(1):e20200093. https://doi.org/10.1590/2177-9465-ean-2020-0093.
28. Freitas FG, Viana ML, Medeiros AM de B, Oliveira RC. Relação médico-paciente: a importância de um atendimento humanizado. Braz. J. Hea. Rev. 2022;5(6):25301-10. https://doi.org/10.34119/bjhrv5n6-268.
29. Braghetto GT, Sousa LA, Beretta D, Vendramini SHF. Dificuldades e facilidades do enfermeiro da Saúde da Família no processo de trabalho. Cad. saúde colet. 2019;27(4):420-6. https://doi.org/10.1590/1414-462x201900040100.
30. Soratto J, Pires DEP de, Trindade LL, Oliveira JSA de, Forte ECN, Melo TP de. Job dissatisfaction among health professionals working in the family health strategy. Texto Contexto Enferm, 2017; 26(3): e2500016. https://doi.org/10.1590/0104-07072017002500016.
31. Gupta A, Ogundele OJ, Rabet R, Artyukh I, Trindade T, Cheng D, et al. Understanding the role and organization of health workers delivering non-communicable disease management in primary care in low- and middle-income countries: a scoping review. BMC Prim Care. 2025;26(1):365. https://doi.org/10.1186/s12875-025-03033-3. PMID: 41249909.
32. Beltrame AM, David ACV, Botelho ALSN, Corrêa BLP, Braga JR, Cipriano TSP. Saúde Bucal antes e durante a pandemia do COVID-19 na atenção primária do município de Ipatinga em Minas Gerais. Res Soc Dev. 2022;11(14):e260111435974. https://doi.org/10.33448/rsd-v11i14.35974.
33. Cirino FMSB, Aragão JB, Meyer G, Campos DS, Gryschek AL de FPL, Nichiata LYI. Desafios da atenção primária no contexto da COVID-19. Rev Bras Med Fam Comunidade. 2021;16(43):2665. https://doi.org/10.5712/rbmfc16(43)2665.
34. Prado-Roman C, Diez-Martin F, Blanco-Gonzalez A. The effect of communication on the legitimacy and performance of organizations. Rev. Bras. Gest. Neg. 2020;22(3):565-81. https://doi.org/10.7819/rbgn.v22i3.4071.

AUTHOR CONTRIBUTIONS
Study conception: Savariz ARM, Leite MT. Data collection: Savariz ARM, Leite MT. Data analysis: Savariz ARM, Leite MT, Fontana DGR, Carli P, Soder RM, Moura L. Data interpretation: Savariz ARM, Leite MT, Fontana DGR, Carli P, Soder RM, Moura L. All authors are responsible for the textual writing and critical revision of the intellectual content, for the final published version, and for all ethical, legal, and scientific aspects related to the accuracy and integrity of the study.

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