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Research Article

PRIMARY CARE: PATIENTS WITH CHRONIC DISEASES

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ABSTRACT

The aim of this study was to create a project to be applied in the evaluation of the population that carries these chronic diseases in the municipality and to develop strategies for continuous care control according to individual needs, through risk stratification, formation of support groups, training of professionals and offer multidisciplinary attention. The intervention involves the patients enrolled in the Family Health Strategy unit and all the spontaneous patients attended by the UBS of Altamira do Paraná, with a chronic disease such as SAH and DM TYPE II. With all measures together we seek to increase the longevity of these patients, reducing comorbidities resulting from poor health control and improving quality of life. In addition, we can reduce the costs of hospitalizations, medications and procedures, and make patients who do not have the disease working on their prevention daily, avoiding an increase in the incidence of type II DM and SAH in our country.

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INTRODUCTION

Systemic arterial hypertension (SAH) is a multifactorial clinical condition characterized by elevated and sustained levels of arterial pressure. It is often associated with functional and / or structural changes in target organs and metabolic changes, with an increased risk of fatal and nonfatal cardiovascular events. SAH is a serious public health problem in Brazil and in the world. Its prevalence in Brazil varies between 22% and 44% for adults (32% on average), reaching more than 50% for individuals aged 60-69 years and 75% among individuals over 70 years of age (SBC, 2010). of being a direct cause of hypertensive cardiopathy, is a risk factor for diseases resulting from atherosclerosis and thrombosis, which are predominantly manifested by ischemic heart, cerebrovascular, peripheral vascular and renal disease. As a result of hypertensive and ischemic cardiopathy, it is also an etiologic factor of heart failure. Cognitive deficits, such as Alzheimer's disease and vascular dementia, also have SAH in earlier stages of life as a risk factor. In Brazil, the challenges of the control and prevention of hypertension and its complications are, above all, the Primary Care (AB) teams. The teams are multiprofessional, whose work process presupposes a link with the community and the clientele, taking into account the racial, cultural, religious diversity and social factors involved. In this context, the Ministry of Health advocates that changes in lifestyle, which are fundamental in the therapeutic process and in the prevention of hypertension, be worked out.

AB professionals are of primary importance in strategies for the prevention, diagnosis, monitoring and control of hypertension. They should also always focus on the fundamental principle of person-centered practice and, consequently, involve users and caregivers, at the individual and collective levels, in the definition and implementation of hypertension control strategies (Tavares *et al*, 2013). In this context, it is understood that in AB services one of the most common health problems that health teams face is hypertension and that there are difficulties in performing early diagnosis, treatment and control of levels pressure. The term "diabetes mellitus" (DM) refers to a metabolic disorder of heterogeneous etiology, characterized by hyperglycemia and metabolic disorders of carbohydrates, proteins and fats, resulting from defects in secretion and / or action of insulin (WHO, 1999). DM has been increasing its importance due to its increasing prevalence and is usually associated with dyslipidemia, arterial hypertension and endothelial dysfunction. It is a health problem considered to be a Primary Care Condition, that is, evidence shows that good management of this problem still in Primary Care avoids hospitalizations and deaths due to cardiovascular and cerebrovascular complications (Alfredique, 2009). Acute and chronic complications of diabetes cause high morbidity and mortality, leading to high costs for health systems. Department of Basic Attention considering that the proportion of diagnoses is lower than expected, that treatment is often inadequate and control of DM is low (Duncan, *et al*, 2013). DM and systemic arterial hypertension (SH) are responsible for the first cause of

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mortality and hospitalizations in the Unified Health System (SUS), and represent more than half of the primary diagnosis in people with chronic renal failure undergoing dialysis (Tavares, *et al*, 2013) . The results in the control of DM come from the sum of several factors and conditions that allow the follow-up of these patients, for whom the expected result beyond glycemic control is the development of self-care, which will contribute to the improvement of quality of life and decrease of morbimortality. The most important objectives of health actions in DM are to control glycemia and, in the long term, reduce morbimortality caused by this pathology. Therefore, making a systematized and permanent educational intervention with health professionals is a fundamental aspect to change current practices in relation to these health problems. The objective of this paper was to identify the situation of the population and to construct a project to evaluate the population with chronic disease and to elaborate strategies to control the morbidities.

METHODS

The intervention site is at the Primary Health Care Unit of the Altamira Family of Paraná. The unit has a reception, two medical offices, two dental office, a vaccine room, two administrative rooms, a dressing room, a room to perform preventive examination, a room to hold US, a kitchen, a pharmacy room, room for epidemiological agent, two rooms for nurses, a meeting room, a room for sterilization of instruments, two bathrooms. We have two PSF, one urban and one rural, both consisting of: one doctor each, one dentist, one nurse, one nursing assistant, one oral health assistant, community health agent (10 in rural PSF and 5 in PSF urban). We also have NASF support (a psychologist, a nutritionist, two physiotherapists, a physical activity teacher) and CRAS (psychologist and social worker). The intervention involves the patients enrolled in the Family Health Strategy unit and all the spontaneous patients attended by the UBS of Altamira, with a chronic disease such as SAH and DM TYPE II. It will take approximately 5 months to put this intervention into practice.

RESULTS AND DISCUSSION

According to data from the IBGE, currently Altamira do Paraná has an estimated population of 3,990 inhabitants, of which 1,833 people correspond to rural areas and the vast majority of the population is composed of elderly people, since the younger ones migrated to larger cities behind better employment conditions, studies. (IBGE, 2016). It has a social profile, with a high Poverty Index (45.83%), most of the population at risk participates in social income programs, where 163 families participate in Bolsa Familia. The health system is composed of a UBS where they have PSF Rural, Family Health Support Center and a Municipal Hospital. The consultations are performed only on demand, we have a register of consultations held at UBS, but the health team does not program the services according to the identified demand, we only prepare for greater attendance of certain pathologies related to the season, epidemic, and chronic diseases already known to the population. Most of the population has chronic diseases, the most common of which are: Systemic Arterial Hypertension (SAH) and Type II Diabetes Mellitus (DM), both with prevalence in May 2016 of 48 existing cases of SAH per 100 people and of 10 cases of DM for every 100 people, both data

refer to the rural area only. We present the five main causes of death in the year 2014: acute myocardial infarction, cerebral vascular accident, malignant neoplasms, pneumonia and external causes of accidental injuries. The five main causes of hospitalizations of the elderly are: Pneumonia, dehydration, urinary infection, hypertensive crisis and pain. The importance of the problem and the need to intervene would be due to the lack of follow-up for people with chronic diseases such as hypertension and DM very frequent in the UBS, and that is related to the great cause of morbidity and mortality, in the majority of the time, these patients only return to the clinic to request prescription drug withdrawals or because they do not present a clinical and laboratory control of their disease and the lack of knowledge in which stage they are, often already needing a more complex center for their treatment or follow-up.

To construct a protocol for attending to suspected cases of chronic diseases, within the UBS, so that nurses and technicians can take some action at the moment and do not let this patient be lost, since most of the time they do not return to the consultation Determine the severity of the disease each patient was classified into high, intermediate and low risk groups by means of BP measurements and HGT measurements performed by nursing auxiliaries, a clinical evaluation performed by physicians at the UBS and basic laboratory tests (blood glucose, lipid profile , creatinine, potassium, partial urine) ECG and fundoscopy. Develop ongoing care schedules according to individual needs. Stimulate Lifestyle Change (VME), informing each patient of the importance of this change and the relevance of their treatment to maintaining a healthy lifestyle. Cessation of smoking, decreased alcohol consumption, physical activity, healthy eating and weight loss, form support groups and provide multidisciplinary attention.

The Intervention Procedures will be: To guide and train the professionals of the health unit to better approach the cases of chronic diseases, to promote the promotion and prevention of health in the population. Encourage scheduled appointments to control your health. Training of nursing technicians and nurses, to identify the intermediate and high risk patient and to directly pass the consultation to the UBS doctor. To identify the cases of High and Intermediate risk, to evaluate the need for specialized care, to study the patient to determine if it presents any underlying disease, and to plan a curative, rehabilitative or palliative care with quarterly and semi-annual continuous care controls. In low-risk cases, provide preventive care and stimulate the annual health control of these patients, leaving the nurse in charge to schedule continuous care actions for this group. To form support groups, through quarterly meetings with different health professionals, for example: Psychologist to explain the importance of acceptance of the disease and its treatment, to guide about the SEM and to identify cases of anxiety and etc. Nutritionist to address the importance of healthy eating, control of carbohydrates and salt in the diet, to perform a clinical follow-up of these patients through anthropometric measurements and food re-education. Physical activity teacher, organizing walks with risk groups, seniors weekly, and encourage the population to practice physical activity. Inclusion of other professionals such as nurses, doctors, dentists, thus offering a multiprofessional attention to the sick population, trying to reduce as much as possible the

number of medicines of these patients. Justify together with the pharmacy the need for the availability of medications necessary to cover the treatment of all cases. Have a qualified biochemist and request a time availability in the laboratory for the examinations of the patients of continuous care. Monthly meetings with involved in multidisciplinary attention and thus, each professional inform their point of view, exchange information on different cases, often encountering the problem of non-control of the disease or non-adherence to treatment.

With the implementation of this work, we sought to raise the awareness of patients with chronic diseases such as DM type II and SAH in the city of Altamira do Paraná, the importance of care and control of their health, stimulating lifestyle modification, laboratory tests and treatment adherence.

Modifications in daily activities, food, sports and mental are expected of patients who attend frequent meetings, and establish links with both the health team and other patients. Expand the access of the sick population to the resources and services of the UBS of Altamira of Paraná through the risk stratification, once the patient is already stratified, to elaborate a continuum of care according to their needs, whether preventive, rehabilitative or curative. To promote collective activities and care in groups offering a multidisciplinary attention, to facilitate the patient's access to the routine exams for the control and availability of medicines, to offer the patients an integral attention (all the physiological systems as well as psychological aspects and family context and Social). Perform the scheduling of the times and schedules, indicate the recommendations on the number of consultations to be performed by each patient according to their risks and thus guide the appointment of consultations in the agenda of ongoing care and professionals involved. Stimulate the practice of programmable queries in order to reduce queries of spontaneous demand. Take advantage of the revenue renewal queries to include these patients within the care protocols. With all measures together we seek to increase the longevity of these patients, reducing morbidities resulting from poor health control and improving quality of life. In addition, we can reduce the costs of hospitalizations, medications and procedures, and make patients who do not have the disease working on their prevention daily, avoiding an increase in the incidence of type II DM and SAH in our country.

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