CoDAS
ISSN 2317-1782 (Online version)

Original Article
Artigo Original

Maria Gabriella Pacheco da Silva[1]
Vanessa de Lima Silva[2]
Cynthia Maria Barboza do Nascimento[2]
Mirella Bezerra Rodrigues Vilela[2]
Maria Luiza Lopes Timóteo de Lima[2]

Access to speech-language pathology therapy and continuity of assistance in Primary Health Care for victims of motorcycle accidents

Acesso à reabilitação fonoaudiológica e a continuidade do cuidado pela Atenção Primária em Saúde para vítimas de acidente de motocicleta

Keywords

Speech, Language and Hearing Sciences
Primary Health Care
Rehabilitation
Accidents
Motorcycles

ABSTRACT

Purpose: To verify the access to speech-language pathology (SLP) therapy and continuity of assistance in Primary Health Care (PHC) for victims of motorcycle accidents. **Methods:** A quantitative and qualitative study was conducted at a large hospital in the city of Recife, Pernanbuco state, Brazil. Among the 99 victims recruited between June and July 2014, 30 had SLP complaints as a result of the accidents. After hospital discharge, all victims were contacted for investigation of the SLP rehabilitation process. Absolute and relative frequencies were used for the analysis in PHC, and data were displayed in tables for the therapy cases. **Results:** Among the 30 individuals who reported having alterations of the stomatognathic system, eight were undergoing rehabilitation and 18 reported residing in an area covered by the Family Health Strategy (primary care modality). Seeking and obtaining continuity of treatment (medication and bandaging) in primary care were frequent; in contrast, home visits were less frequent. The main obstacles to access SLP therapy were distance to the service and waiting time to begin treatment. **Conclusion:** This study identified obstacles that hamper access to SLP therapy in PHC, such as the low frequency of home visits, contributing to the fragmentation of continuous and complete care for victims.

Descritores

Fonoaudiologia
Atenção Primária à Saúde
Reabilitação
Acidentes
Motocicletas

RESUMO

Objetivo: Verificar o acesso à reabilitação fonoaudiológica e a continuidade do cuidado pela Atenção Primária à Saúde em vítimas de acidente de motocicleta. **Método:** Trata-se de estudo realizado em um hospital de grande porte localizado em Recife-Pernambuco, recrutado entre o período de junho e julho de 2014. Após a alta hospitalar todos foram contatados para investigação do processo de reabilitação fonoaudiológica. Para o estudo na Atenção Primária à Saúde, foram utilizadas medidas de frequência absoluta e relativa. Já os casos em reabilitação foram descritos através de quadros. **Resultados:** Foi verificado que 99 indivíduos foram vítimas de acidentes por motocicletas no período estudado. Desses, 30 entrevistados referiram ter essas queixas de alteração no sistema estomatognático, dos quais 8 estavam em reabilitação e 18 referiram residir em área adstrita a Unidade de Saúde da Família. Os principais obstáculos para o acesso à fonoterapia apontados foram a distância aos serviços de Fonoaudiologia e o tempo de espera para início do tratamento. Um dos aspectos relacionados à continuidade do cuidado pela Atenção Primária à Saúde, como a busca e obtenção de insumos, foi visto como frequente. Ao contrário da visita domiciliar, menos frequente. **Conclusão:** Foram identificados obstáculos que dificultaram o acesso à fonoterapia, assim como fragilidades nos cuidados dispensados pela Atenção Primária, como a visita domiciliar, contribuindo para a fragmentação do cuidado contínuo e integral às vítimas.

Correspondence address:
Maria Gabriella Pacheco da Silva
Departamento de Fonoaudiologia, Universidade Federal de Pernambuco – UFPE
Av. Prof. Moraes Rego, 1235, Cidade Unversitária, Recife (PE), CEP: 50670-901.
E-mail: gabriellafono@gmail.com

Received: June 22, 2018.

Accepted: May 07, 2019.

Study conducted at the Departamento de Fonoaudiologia, Universidade Federal de Pernambuco – UFPE - Recife (PE), Brasil.

[1] Universidade São Miguel - Recife (PE), Brasil.

[2] Departamento de Fonoaudiologia, Universidade Federal de Pernambuco – UFPE - Recife (PE), Brasil.

Financial support: nothing to declare.

Conflict of interests: nothing to declare.

INTRODUCTION

In Brazil, 10.08% of all hospitalizations in 2016 were due to external causes. Among these cases, 15.8% were traffic accidents. Specifically regarding motorcycle accidents, the risk of hospitalization due to this cause increased 262.1% between 2008 and 2016, going from 2.08 to 5.02 hospitalizations per 10 thousand inhabitants[1].

Injuries resulting from motorcycle accidents are generally more serious and the victims often require specialized care. Koizumi[2] reports that victims of motorcycle accidents are discharged from hospital before complete recovery. Indeed, the risk of sequelae is one of the striking aspects of this experience, as the consequences of such accidents can affect social interactions and the capacity for work.

The Brazilian National Policy for Reducing Morbidity-Mortality Due to Accidents and Violence (instituted through ordinance number 737/2001)[3] guides actions in the health field. One of the guidelines of this policy is the structuring and consolidation of care directed at recovery and rehabilitation. To expand the offer of healthcare services to victims with sequelae, the Health Ministry instituted the Care Network for Individuals with Disability in 2012. For such, the public healthcare system must offer a network of integrated, effective rehabilitation services on different levels of care for patients who need this type of service[4,5]. Access to speech-language therapy for victims of motorcycle accidents could minimize the sequelae resulting from such accidents that affect quality of life.

For the present study, we considered the concept employed by Donabedian[6] as reference, in which the term "accessibility" is used to indicate the degree of ease with which individuals obtain health care, focusing on the quality of what is accessible. Two dimensions in continuous interaction were investigated: socio-organization accessibility, which involves all aspects of the functioning of services, such as the times the service is offered and the waiting time to begin treatment, and geographic accessibility, which regards the spatial distribution of resources, the existence of transportation and the location of the services[6].

To ensure care and orientate victims in the service network, the primary care system plays an important role as care coordinator and organizer of access to all healthcare services. With the creation of the Family Health Support Centers (FHSC) in 2008, speech therapy and other care categories were included in primary care[7]. Thus, the public healthcare system offers speech therapists who guide and coordinate this form of care for accident victims in the network, ensuring the rehabilitation of human communication disorders on the primary care level.

With the advent of the FHSC, speech therapists contribute to primary care, helping to reorganize primary care services and diminish wait lines at specialized services, thereby assuring access to and the coordination of care regarding needs related to human communication[8].

Therefore, the aim of the present study was to verify the access to speech-language therapy and continuity of assistance in Primary Health Care (PHC) for victims of motorcycle accidents.

METHODS

An observational, cross-sectional study was conducted in three phases: 1) recruitment of victims of motorcycle accidents in the hospital setting; 2) home survey after discharge of cases of alterations of the stomatognathic system; and 3) cases undergoing continued treatment at primary care services. In the first phase, the study population was composed of all victims of motorcycle accidents treated at Restauração Hospital between June and July 2014, which totaled 99 cases. In the second phase, victims with alterations of the stomatognathic system resulting from the motorcycle accident were included, totaling 30 cases. In the third phase, all cases registered with primary care units were included, totaling 18 individuals, eight of whom were undergoing speech-language rehabilitation.

In the hospital setting (first phase), a total of 99 victims of motorcycle accidents were in the oral-maxillofacial, neurosurgery and trauma infirmaries between June and July 2014. This study was conducted at a large public hospital in the city of Recife, Brazil, which is considered a reference center in neurosurgery.

After a period of one to three months (time predicted for discharge from hospital), all participants in the first phase were contacted by telephone to answer a short questionnaire on alterations of the stomatognathic system. The interviews were conducted by one of the researchers using the first two parts of the Speech Therapy Questionnaire for Patients with Facial Trauma[9], which was answered either by the participant recruited for the sample or a caregiver, if the case so required.

The Speech Therapy Questionnaire for Patients with Facial Trauma[9] addresses aspects of human communication that may be altered due to trauma to the head and neck region. The questionnaire is composed of two parts: 1) patient history, addressing the main myofunctional complaints in this region of the body, such as the loss or reduction of facial mobility, changes in occlusion, limited jaw movements, difficulty chewing, changes in food consistency, changes in speech, difficulty swallowing and choking; the second part addresses morphological and functional aspects of the stomatognathic system.

The third phase involved 18 individuals with speech complaints sent for treatment in primary care, to whom a 10-item questionnaire was administered. The questionnaire was designed by the researcher and based on a questionnaire created by Almeida and Macinko[10]: need for medication/bandages; if affirmative, sought Family Health Unit (FHU)?; obtained help from FHU?; received a home visit from a health professional from the FHU after the accident?; if affirmative, how frequent were the visits?;

received general health counseling from the FHU?; had help from the FHU regarding the new living condition?; staff at the FHU aware of the patient's need for rehabilitation?; received care from physician, nurse or FHSC team? The response options were "never", "sometimes" and "always".

Although 30 individuals had complaints of alterations of the stomatognathic system, only eight were undergoing speech therapy. For these cases, we analyzed information regarding access to speech therapy services.

Absolute and relative frequencies were determined for the analysis of the quantitative data. Median values were calculated and the results were plotted on a graph to facilitate the visualization of the answers with the greatest occurrence.

Categories were established in four domains to evaluate access to speech therapy services: 1) availability – existence or not of healthcare services in appropriate location and at the time it is needed; 2) affordability – relation between the cost of using healthcare services and payment capacity of the individuals; 3) information – the notion of empowering patients to make well-informed decisions regarding the use of healthcare services; and 4) acceptability – the nature of the services offered and how such services are perceived by individuals and communities[11].

All participants received clarifications regarding the objectives of the study and signed a statement of informed consent. This study received approval from the local human research ethics committee (certificate number: 504.301/12).

RESULTS

Ninety-nine individuals were selected in the first phase of the study, 90 of whom were male. Mean age was 32.4 years. Among the 99 interviewees, 30 reported speech complaints, 28 of whom were male (mean age: 32.5 years) and 60% (18 individuals) resided in areas of coverage of FHUs. Hospital stay ranged from four to 200 days.

Among the 18 victims of motorcycle accidents sent for the continuity of treatment in the primary care setting, 96.6% required some type of medication or bandaging after discharge from hospital. Among these individuals, 83.3% sought care at an FHU and 80% of these individuals obtained the care they sought. Home visits were conducted in 44.4% of cases, with monthly frequency in 50% of these cases. Care was offered by a physical, nurse or FHSC team in 77.7% of cases (Figure 1).

Orientations regard general health care and help from the FHU regarding the new living condition were frequent (66.6% and 61%, respectively). Knowledge regarding the need for speech-language rehabilitation was restricted to those patients already undergoing speech therapy (33.3%) (Figure 1). The male sex predominated among these cases (5/8 cases); age ranged from 21 to 54 years and six were in treatment at an FHU (Chart 1).

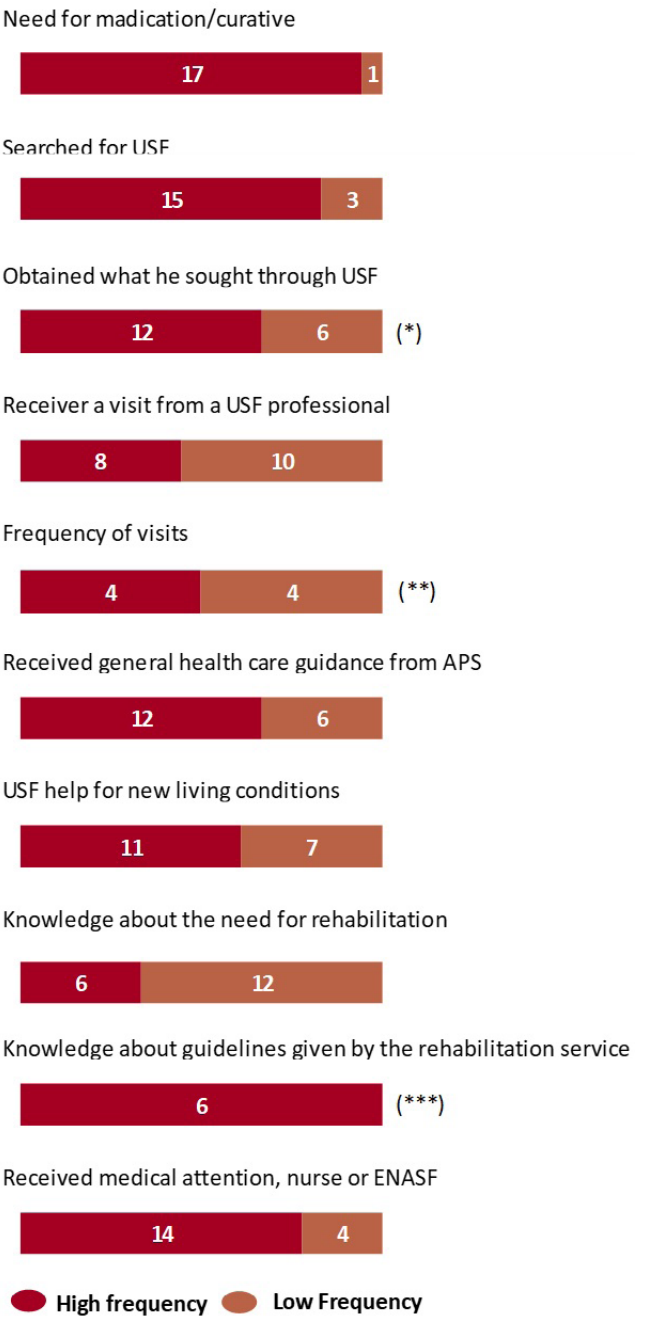

Figure 1. Scale quantifying attributions of primary care regarding continuity of treatment

Regarding accessibility, the waiting time for the onset of therapy ranged from two weeks to three months. The most common complaints were a change in pronunciation (eight cases) as well as facial pain and limited jaw movements (six cases). Six individuals underwent speech therapy at public healthcare services. The main obstacles mentioned regarding access to rehabilitation were the distance to the speech therapy services, which were generally located in neighboring cities, and the waiting time to begin treatment. Among the eight cases studied, only one individual had returned to labor activities (Chart 2).

Chart 1. Description of cases enrolled in speech-language rehabilitation services following motorcycle accidents related to patient and accident, Recife, 2014

Case	Age	Sex	Municipality of residence	Injuries resulting from motorcycle accident	Hospital stay (days)	Registered with FHU
1	54	Male	Jurema-PE	Severe head trauma; multiple facial fractures; lower limb fracture	84	Yes
2	32	Male	Saloá-PE	Severe head trauma; multiple facial fractures; upper limb fracture	200	Yes
3	25	Male	Recife-PE	Mild head trauma; facial fracture	47	Yes
4	21	Male	Olinda-PE	LeFort I and II facial trauma; tooth loss	21	No
5	34	Male	Belo Jardim	Mild head trauma; facial facture; extensive tongue laceration	33	Yes
6	21	Female	Goiana-PE	Severe head trauma; facial fracture; dental trauma	45	No
7	24	Male	Goiana-PE	LeFort I facial trauma; nasoorbitoethmoidal fracture; dental trauma.	4	Yes
8	23	Female	Recife-PE	Mild head trauma; complex fracture of middle third of face; amputation of lower limb	30	Yes

Chart 2. Description of cases enrolled in speech-language rehabilitation services following motorcycle accidents related to sequelae and access to rehabilitation, Recife, 2014

Case	Stomatognathic complaints	Waiting time to begin treatment	Speech-language rehabilitation service	Reported difficulty regarding access to speech therapy	Return to labor activities
1	Facial pain; Change in food consistency; Difficulty chewing and swallowing; Choking on liquids; Altered speech	2 weeks	Polyclinic of public healthcare system in municipality of residence	Distance to rehabilitation service	No
2	Diminished facial mobility; Change in food consistency; Difficulty chewing and swallowing; Choking on liquids; Altered speech.	2 weeks	FHSC team	Difficulty obtaining speech therapy	No
3	Limited jaw movements; Facial swelling; Change in occlusion and food consistency; Difficulty chewing; Change in food consistency; Difficulty chewing and swallowing; Choking on liquids; Altered speech.	3 months	Teaching clinic of institution of higher education	Not being orientated on where to seek speech therapy by public healthcare system	No
4	Facial pain; Limited jaw movements; Diminished facial mobility; Change in occlusion; Change in food consistency; Difficulty chewing and swallowing; Choking on liquids; Altered speech.	2 months	Private service in neighboring municipality	Not being orientated on where to seek speech therapy by public healthcare system	No
5	Facial pain; Limited jaw movements; Diminished facial mobility; Change in occlusion; Change in food consistency; Difficulty chewing; Altered speech.	1 month	Public rehabilitation service in other municipality	Distance and transportation to service	No
6	Facial pain; Limited jaw movements; Diminished facial mobility; Change in occlusion; Change in food consistency; Difficulty chewing and swallowing; Altered speech.	3 weeks	Private service in municipality of residence	Absence of public service in municipality of residence	No
7	Facial pain; Limited jaw movements; Change in occlusion; Change in food consistency; Difficulty chewing; Altered speech.	40 days	Public rehabilitation service in other municipality	Distance to rehabilitation service	Yes
8	Facial pain; Limited jaw movements; Change in occlusion; Change in food consistency; Difficulty chewing; Altered speech.	2 months	Public rehabilitation service	Waiting time	No

DISCUSSION

Among the 99 victims of motorcycle accidents who participated in the present study, 90 were male and mean age was 32.4 years. Calil et al.[8] and Oliveira & Sousa[9] also found that the male population was more affected by this type of traffic accident and that the mean age of the victims was 32.7 years.

The group studied was composed predominantly of male young adults distributed among different municipalities. These results are in agreement with data reported in previous studies[12,13]. Records from the Mortality Information System reveal that 83% of deaths resulting from motorcycle accidents in 2014 involved the male population[14].

Among the cases in the present study, those with the longest hospital stay were individuals with traumatic brain injuries (200, 84, 47 and 45 days) (Chart 1). This type of injury is considered the most serious. Indeed, any injury to the head, such as facial trauma, requires greater care, leading to a longer hospital stay[15].

The speech-language complaints in the group studied were altered pronunciation, facial pain and limited jaw movement[16] (Chart 2). Injuries involving the jaw are particularly important, as this structure contributes to speech, chewing efficiency, swallowing and the shape of the lower portion of the face[16]. Limited jaw movements, swelling, mandibular deformity and abnormal mobility are common symptoms in trauma affecting the mandible[7]. Indeed, facial trauma is generally more complex and more difficult to manage, as this type of injury often causes wounds with a complicated healing process and sequelae[17]. Moreover, head trauma and particularly facial trauma have repercussions that can affect one's emotional wellbeing and orofacial functions and can lead to permanent deformity that exerts a negative esthetic impact[16].

Regarding the continuity of care, reciprocity was found for 18 interviewees among those who sought and obtained materials (medications and bandages) from an FHU; among the 15 who sought an FHU, 12 achieved what they needed (Figure 1). These results reveal the recognition of the attributions of Family Health teams as a regular source of care, demonstrating that the FHU is a habitual care reference for the majority of health needs. Cunha & Giovanella[18] state that this identification on the part of the population is dependent on the offer and availability of this source, which, in qualitative and quantitative terms, should be aligned with the health needs of the population.

One problem identified at the FHUs was the low frequency of home visits in the group studied. Routine home visits should occur at least once a month per family and should be more frequent when necessary, as in cases of victims of motorcycle accidents, depending on the situation of each particular case[19]. Home visits constitute a valuable tool favoring the continuity of care by enabling permanent health education and strengthening the care network[20]. In the present study, home visits occurred due to knowledge on the part of the primary care service regarding the needs for speech therapy, as only those individuals with speech-language complaints included in a rehabilitation services had their needs recognized. However, among the eight individuals in rehabilitation, the six registered with primary care services also had their symptoms detected by Family Health teams, which reiterates the role of primary care in the coordination and continuity of care (Figure 1).

One of the attributes of healthcare continuity by primary care services is the trust established between the patient and health team. Cunha & Giovanelli[18] describe such ties as possibilities of creating more integral care. According to Caprara & Rodrigues[21], a good relationship between the health team and patient involves trust, communication, the consideration of the problems reported by the patient and biopsychosocial aspects. When this occurs, there is continuous adherence to general health counseling as well as knowledge on the part of the health team regarding the new living condition following the accident.

In the present study, health advice, the assistance from the FHU regarding the new living condition and awareness of the orientations of the speech therapy services were considered frequent (six cases), which demonstrates the importance of primary care in ensuring the continuity of information, making it the central axis of the health network due to its proximity to individuals and their daily lives[4]. Besides basic health actions, primary care provides a link to other healthcare services, thereby ensuring continuous care. In this context, FHSC teams play an important role in shared actions as well as the co-management and co-responsibility of treatment offered in primary care. Through their technological tools, FHSCs expand knowledge in primary care, operating in a cooperative, interdependent manner with primary health teams, enhancing the problem-solving capacity and guiding patients within the healthcare network[22].

Regarding access to services of speech-language rehabilitation, the waiting time for the onset of treatment ranged from one week to three months. Remoaldo & Costa[23] consider a waiting time for specialized treatment up to 30 days to be reasonable. The increase in this time constitutes a barrier to access to rehabilitation services (Chart 2).

Among the indicators the Donabedian[6] suggests for the evaluation of "ideal access", availability regards receiving care at the time the patient requires it. This concept also encompasses the scope, quality and quantity of the services offered. When these aspects are insufficient, rehabilitation services become overwhelmed and waiting lists are formed, which exert a direct influence on access to care, making the waiting time a measurable variable that affects a patient's entrance into the healthcare system. It should be pointed out, however, that availability alone does not ensure effective access or the problem-solving capacity of the system[6].

In the present study, three of the eight patients who underwent speech-language rehabilitation were unable to do so in the public healthcare system, turning either to the private sector or a teaching school in speech therapy at a higher education institution (Chart 2). The search for free rehabilitation was inviable for individuals who lived in municipalities distant from the treatment centers of the public healthcare system, as speech-language impairment may coexist with motor impairment. Indeed, motor impairment is a common consequence of motorcycle accidents. The ideal situation would be the offer of services at nearby locations or even at the same healthcare unit, favoring access to different health services. This constitutes another aspect of availability,

namely, the geographic relation between healthcare services and the individuals that need these services[11]. In four of the cases, the patients needed to travel to neighboring municipalities to obtain care. These individuals reported the distance to the therapy services as an obstacle to access. In the state of Pernambuco, speech therapists are concentrated in the metropolitan region of the state capital. Currently, there are 511 speech therapists in the state distributed among the 185 municipalities, 39% of whom work in the capital, Recife[24]. Sanchez & Ciconelli[11] discuss this as the most tangible aspect of availability, reflecting the organization and effectiveness of public health policies in terms of access (Chart 2).

Affordability[11] was pointed out as a hindrance to speech therapy, as rehabilitation generates costs. This aspect encompasses indirect costs related to transportation to the healthcare services and the loss of productivity stemming from the accident. In the present study, only one of the individuals returned to work (Chart 2). Soberg et al.[16] states that individuals who return to work after an accident tend to have a better physical and psychological status.

With regards to information, the failure in the offer of speech therapy services was evident, leading to the "loss" of individuals from the network. When patients are not equipped with sufficient information to make use of the healthcare system, they use the system in a manner that is inadequate to their needs (Chart 2). Sanchez & Ciconelli[11] recognize this aspect as a gap between the opportunity for use and the actual use of services.

Access to and the continuity of care are concepts that involve a relation of interdependence. Care continuity requires access to services and the absence of barriers at the time the patient enters the system. Barriers to access to healthcare services compromise the efficient passage of patients through the network of services, which constitutes a considerable challenge in terms of ensuring the maintenance of integral care and the harmonious efforts of all sectors of the system toward a single goal: quality health care[25].

The present study has limitations that should be considered. The fragmented design, with the investigation of different aspects at different periods of time, does not enable the establishment of temporal relations among the variables analyzed. Memory bias is another factor to consider, as alterations in the stomatognathic system and related issues were investigated by telephone (self-reports) at a time distant from the occurrence of the accident. However, the data were collected by trained interviewers using standardized instruments, which ensures the quality of the information presented.

CONCLUSION

Knowledge regarding factors that affect access to speech-language rehabilitation among victims of motorcycle accidents assists in understanding barriers to obtaining care for needs related to human communication health. The distance to the services and waiting time were considered the main obstacles to access to speech therapy. These findings are explained by poor distribution of speech therapists throughout the state, who are mainly concentrated in the capital city. Such factors may affect the rehabilitation and prognosis of the victims and point to determinants of inequality in the offer of speech therapy services.

Care continuity was frequent in terms of the offer of medication and bandages at primary care services. In contrast, home visits, which constitute a differential attribute of primary care compared to other levels of health care, were infrequent, which can exert a negative impact on the ties between patients and the public healthcare system

Finally, the impact of treatment for the population registered at primary care services was evident in the assurance of treatment continuity, as six of the eight patients in rehabilitation resided in an area of coverage of the Family Health Strategy.

REFERENCES

REFERENCES

1. Brasil. Ministério da Saúde. Sistema de Informação sobre Mortalidade – SIM. Brasília: Datasus; 2017. [citado em 2017 Fev 1]. Disponível em: http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sim/cnv/ext10uf.def
2. Koizumi MS. Natureza das lesões nas vítimas de acidentes de motocicleta [tese]. Ribeirão Preto: Escola de Enfermagem, Universidade de São Paulo; 1990.
3. Brasil. Portaria MS/GM nº 737 de 16 de maio 2001. Institui a Política Nacional de Redução da Morbimortalidade por Acidentes e Violências. Diário Oficial da União; Brasília; 16 maio 2001.
4. Brasil. Portaria Nº 793, de 24 de Abril de 2012. Rede de Cuidados à Pessoa com Deficiência no âmbito do Sistema Único de Saúde. Diário Oficial da União; Brasília; 24 abril 2012.
5. Minayo MCS, Deslandes SF. Análise da implantação da rede de atenção às vítimas de acidentes e violências segundo diretrizes da Política Nacional de Redução da Morbimortalidade sobre Violência e Saúde. Ciênc Saúde Coletiva. 2009;14(5):1641-9. http://dx.doi.org/10.1590/S1413-81232009000500002. PMid:19851573.
6. Donabedian A. Los espacios de la salud: aspectos fundamentales de la organización de la atención médica. México: Editora Biblioteca de la Salud; 1988.
7. Brasil. Ministério da Saúde. Cadernos de atenção básica: diretrizes do NASF. Brasília: Secretaria de Atenção à Saúde; Departamento de Atenção Básica; 2009.
8. Lima TFP, Acioli RM. A inserção da Fonoaudiologia na Atenção Primária do Sistema Único de Saúde. In: Silva VL, Lima MLLT, Lima TFP, Advíncula KP, editores. A prática fonoaudiológica na atenção primária à saúde. São José dos Campos: Pulso Editorial; 2013. p. 25-42.
9. Bianchini EMG, Mangili LD, Marzotto SR, Nazário D. Pacientes acometidos por trauma de face: caracterização, aplicabilidade e resultados do tratamento fonoaudiológico específico. Rev CEFAC. 2004;6(4):388-95.
10. Almeida C, Macinko J. Validação de uma metodologia de avaliação rápida das características organizacionais e do desempenho dos serviços de atenção básica do Sistema Único de Saúde (SUS) em nível local. Brasília: Organização Pan-Americana da Saúde; 2006.
11. Sanchez RM, Ciconelli RM. Conceitos de acesso à Saúde. Ver Panam Salud Publica. 2012;31(3):260-8. http://dx.doi.org/10.1590/S1020-49892012000300012.
12. Zwicker D, Picariello G. Discharge planning for the older adult. EUA: National Guideline Clearinghouse; 2003.
13. Rodrigues NB, Gimenes CM, Lopes CM, Rodrigues JMS. Mortes, lesões e padrão das vítimas em acidentes de trânsito com ciclomotores no município de Sorocaba, São Paulo, Brasil. Rev Fac Cienc Med. 2010;12(3):21-5.
14. Brasil. Ministério da Saúde. Sistema de Informação sobre Mortalidade – SIM. Brasília: Datasus; 2017 [2017 fev 01]. Disponível em: <http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sim/cnv/ext10uf.def

15. Calil AM, Sallum EA, Domingues CA, Nogueira S. Mapeamento das lesões em vítimas de acidentes de trânsito: revisão sistemática da literatura. Rev Lat Am Enfermagem. 2009;17(1):120-5. PMid:19377817.

16. Soberg HL, Roise O, Bautz-Holter E, Finset A. Returning to work after severe multiple injuries multidimensional factoring and the trajectory from injury to work at 5 years. J Trauma. 2011;71(2):425-34. http://dx.doi.org/10.1097/TA.0b013e3181eff54f. PMid:21045746.

17. Duarte ML, Costa VHF, Mota LS. Avaliação da trajetória, no SUS, de pacientes atendidos na clínica cirúrgica de um serviço de emergência a partir de seus diagnósticos histopatológicos. Rev Brasileira de Medicina da Família e Comunidade. 2008;4(15):157-64. http://dx.doi.org/10.5712/rbmfc4(15)167.

18. Cunha EM, Giovanella L. Longitudinalidade/continuidade do cuidado: identificando dimensões e variáveis para a avaliação da Atenção Primária no contexto do sistema público de saúde brasileiro. Ciênc Saúde Coletiva. 2011;16(Suppl 1):1029-42. http://dx.doi.org/10.1590/S1413-81232011000700036. PMid:21503452.

19. Azeredo CM, Cotta RM, Schott M, Maia TM, Marques ES. Avaliação das condições de habitação e saneamento:a importância da visita domiciliar no contexto do Programa de Saúde da Família. Ciênc Saúde Coletiva. 2007;12(3):743-53. http://dx.doi.org/10.1590/S1413-81232007000300025. PMid:17680132.

20. Santos JS, Borges ACL, Alves VS. Visita domiciliária na atenção a usuários de álcool e outras drogas no município de Santo Antônio de Jesus-BA. Extramuros. 2014;2(2):27-35.

21. Caprara A, Rodrigues J. A relação assimétrica médico-paciente: repensando o vínculo terapêutico. Cien Saude Colet. 2004;9(1):139-46. http://dx.doi.org/10.1590/S1413-81232004000100014.

22. Mendes VLF. (a) Fonoaudiologia, atenção básica e saúde da família. In: Fernandes FDM, Mendes BCA, Navas ALPGP, organizadores. Tratado de Fonoaudiologia. 2. ed: São Paulo: Roca; 2009. p. 612-8.

23. Remoaldo PC, Costa ME. Equidade no acesso aos cuidados de saúde - Resultados de dois inquéritos realizados à população. In: Colóquio Internacional de Saúde - Saúde e Discriminação Social; 2002 Fev 22-23; Braga. Actas. Braga: Instituto de Ciências da Saúde; Universidade do Minho; 2002. p. 71-90.

24. Brasil. Cadastro Nacional dos Estabelecimentos de Saúde – CNES. Brasília: Datasus; 2017. [citado em 2016 Out 1]. Disponível em: http://tabnet.datasus.gov.br/cgi/tabcgi.exe?cnes/cnv/prid02pe.def

25. Travassos C. Fórum: equidade no acesso aos serviços de saúde. Cad Saude Publica. 2008;24(5):1159-61. http://dx.doi.org/10.1590/S0102-311X2008000500023. PMid:18461245.

Author contributions

MGPS: Data collection and analysis and production of manuscript; VLS: Orientation, production and revision of manuscript and coordination of study; CMBN: Orientation, production and revision of manuscript; MBRV: Orientation, production and revision of manuscript; MLLTL: Orientation, production and revision of manuscript and coordination of study.