Review Article

Factors interfering with the attribute longitudinality in the primary health care: an integrative review

Fatores que interferem no atributo longitudinalidade da atenção primária à saúde: revisão integrativa

Cristiane Cardoso de Paula[1], Clarissa Bohrer da Silva[2], Elisa Gomes Nazário[3], Tamiris Ferreira[4], Maria Denise Schimith[5], Stela Maris de Mello Padoin[6]

[1] Nurse, Ph.D in Nursing. Adjunct Professor of the Nursing Department at Universidade Federal de Santa Maria (UFSM). Santa Maria, RS, Brazil. E-mail: cris_depaula1@hotmail.com.
[2] Nurse, Master in Nursing. Student of the Nursing Graduate Program, Doctoral level, at Universidade Federal do Rio Grande do Sul. Porto Alegre, RS, Brazil. E-mail: clabohrer@gmail.com.
[3] Student of the Nursing Undergraduate course at UFSM. Santa Maria, RS, Brazil. E-mail: nazario.elisa@gmail.com.
[4] Student of the Nursing Undergraduate course at UFSM. Santa Maria, RS, Brazil. E-mail: tamirisf26@hotmail.com.
[5] Nurse, Ph.D in Nursing. Adjunct Professor of the Nursing Department at UFSM. Santa Maria, RS, Brazil. E-mail: ma.denise2011@gmail.com.
[6] Nurse, Ph.D in Nursing. Associate Professor of the Nursing Department at UFSM. Santa Maria, RS, Brazil. E-mail: stelamaris_padoin@hotmail.com.

ABSTRACT

Our objective was to assess the evidence available in the literature about factors interfering with the primary health care attribute longitudinality. This is an integrative review, developed in May of 2014, on the following electronic databases: LILACS, PubMed and Scopus. We used the descriptors “primary health care” and “continuity of patient care”. In total, 16 articles were fully assessed. We organized the data in accordance with care aspects longitudinality (structure and performance) and we divided the identified factors in accordance with the attribute interference (favoring or disfavoring). The evidence offer aids to compose a global panorama of interfering factors on longitudinality, reinforcing the value of its interpersonal relationships and minimizing gaps in the organization of health services. The prevalence of descriptive studies suggests the need to strengthen the construction of knowledge with studies of higher evidence level.

Descriptors: Primary Health Care; Continuity of Patient Care; Nursing.

RESUMO

Objetivou-se avaliar as evidências disponíveis na literatura acerca dos fatores que interferem no atributo longitudinalidade da Atenção Primária à Saúde. Trata-se de uma revisão integrativa, desenvolvida em maio de 2014, nas bases de dados eletrônicas: LILACS, PubMed e Scopus. Utilizaram-se os descritores "atenção primária à saúde" *and* “continuidade da assistência ao paciente”. Totalizaram 16 artigos analisados na íntegra. Os dados foram organizados segundo os aspectos da atenção do atributo longitudinalidade (estrutura e desempenho) e os fatores identificados foram divididos segundo a interferência no atributo (favorecendo ou desfavorecendo). As evidências oferecem subsídios para a composição de um panorama mundial dos fatores que interferem na prática do atributo longitudinalidade, reforçando a valorização das relações interpessoais e a minimização das lacunas na organização dos serviços de saúde. A prevalência de estudos descritivos sugere a necessidade de fortalecer a construção do conhecimento com estudos de maior nível de evidência.

Descritores: Atenção Primária à Saúde; Continuidade da Assistência ao Paciente; Enfermagem.

INTRODUCTION

The Primary Health Care (PHC) is the service with less technological density offering a preferential entrance in the health system, addressing common problems from the community, offering prevention actions, cure and rehabilitation to maximize health and well-being[1]. Organized systems from an resolute PHC present lower incidence rates for diseases, hospitalization and mortality for preventable causes, lower costs and more equity of health services[1-3].

There are different ways to organize and operate the assistencial system. However, global results from PHC actions and services not always are satisfactory[2-4]. Strengthen of health promotion actions in PHC are an important strategy to follow and intensify provided care. It allows identification of local priorities and its scope context, as well as the actions developed for the improvement of quality of life[5].

Thus, it is possible to verify the quality of attention to the population through the empirical identification of PHC attributes[6]. Attributes constitute a group of PHC structuring elements classified in accordance with the structure's characteristics (environment and equipment conditions in which services are provided) and process/performance (quality of services provided individually or in groups by health professionals, refers to professional qualification, organization and coordination of the team work process) [1].

The PHC guiding attributes are called essential attributes (first contact access, longitudinality, comprehensive care and coordination of care) and derivatives, which increase the interaction power with individuals and the community (family orientation, community orientation and cultural competency)[1]. These can be separately assessed, although they are inter-related on the assistencial practice.

Among these products, longitudinality is conceptualized as the existence of one source of attention and its regular use, being the PHC being capable to identify the elective population, as well as the individuals that should receive attention in the service. Besides, the connection should promote interpersonal ties that reflect mutual cooperation between users and health professionals[1].

In the national and international literature, the word "longitudinality" is not usual, the term "continuity of care" have been used with a similar meaning, not having uniformity in what it is referred to the characteristics between the patient-professional relationship, which can restrict the attribute meaning[7]. For Starfield[1], the continuity would be related to the sequence of events among consultations without caring to where and for what reasons it occurred, and without establishing a personal relationship throughout time. These literature disagreements allow adoption of dimensions in accordance with the organizational principals from the public health system, once it is in consonance with the author's assumptions who discuss the theme[7].

Longitudinality benefits on PHC are related to favoring: accompaniment of users, follow up and effectiveness of treatment, assessment of health needs, comprehension regarding the referral process, reduction of hospital admissions, and the satisfaction and trust from users. It also contributes for the implementation of health promotion actions and prevention of diseases[1].

In this aspect, presenting the longitudinality relationship with the attention positive results, the recognition of this attribute as PHC central characteristic is opportune and should be desired and assessed[7]. Longitudinality assessment involves measurement of its structural aspects (the identification of the habitual source of attention by people and the identification from the elective population by the physician or team), and some performance aspects (adequate use of the attention source and the strength of interpersonal relationships), allowing to implement structural and process improvements to qualify the attention; aiming health promotion and reduction of referrals to specialists[1].

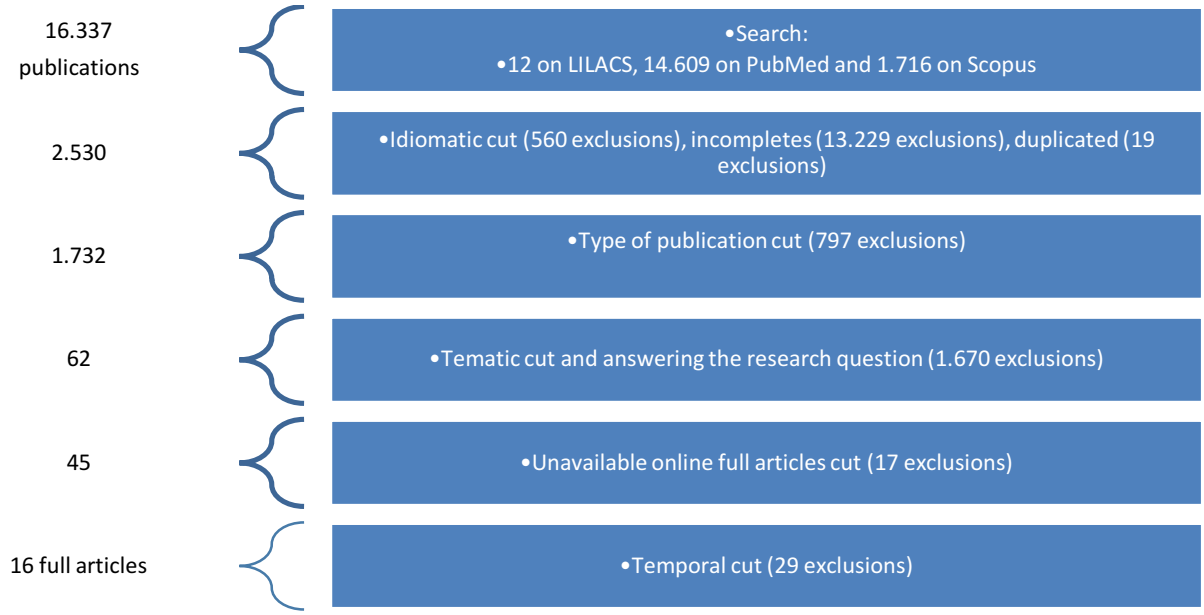
Facing the lack of studies directly addressing longitudinality, especially in Brazil[7], the search for subsidizes to promote this attribute importance in the PHC, and the recognition of interfering factors, the present study is justified; with the objective to provide elements to rethink and improve health practices. In this perspective, **we aimed to** assess the evidence available in the literature about factors interfering with the primary health care attribute longitudinality.

METHODS

An integrative literature review[8] aimed to synthesize results from studies in a systematic manner using the research question: what are the factors favoring or disfavoring longitudinality in the primary health care service? We developed the search on the Biblioteca Virtual de Saúde (BVS), on the electronic database Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS), Public MEDLINE (PubMed) and SciVerse Scopus (Scopus). We used the descriptors/MeSH Terms "primary health care" and "continuity of patient care". We justify the term of the last descriptor because the longitudinality is not a Health Science Descriptor (DECS), however, its description englobes health assistance continuously offered since the initial contact, following the patient during all attention phases.

The search on the literature was conducted in May of 2014. The inclusion criteria were articles of studies about the theme; fully available online and free; published in Portuguese, English or Spanish. The exclusion criteria were articles without an abstract in the database or incomplete. We used filter tools available on PubMed and Scopus. We identified 16,337 publications. Facing the analytical practicability of the study, we considered only studies published on the past five years (2009 to 2013). The selection of studies was conducted by reading of titles and abstracts that were submitted to inclusion criteria, totalizing 16 full articles (Figure 1).

Figure 1: Selection of studies fluxogram, in accordance with the pre-established criteria, on LILACS, PubMed and Scopus databases, 2014.



Two researchers read the articles and filled the instrument independently, to minimize possible selection bias from studies. For possible disagreements, a third researcher was consulted (study supervisor).

After reading the selected studies, a data extraction file was completed, with the following items: study identification, origin (place where data collection was developed), field of knowledge, year of publication, objective and study design (we adopted the concepts

used by the own authors), level of evidence and main results (considering favoring or disfavoring factors to longitudinality)[9].

Data analysis of extracted data was descriptive, allowing the assessment of the quality of evidence through the seven levels described by Melnyk and Fineout-Overholt[10] and providing syntheses and comparisons from included studies for readers, emphasizing differences and similarities[11].

The political organization of health services from the studies was not assessed in this review. Thus, the study selection was done considering those that presented the PHC services as data collection setting, being: community health centers, general practice, primary care services, basic health units ("*unidades básicas de saúde –UBS*") or family health ("*saúde da família"*).

We organized the evidence following attention aspects form longitudinality attributes (structure and performance). This division is merely didactic to present our results, and some factors can be in both aspects.

Regarding ethical aspects, we respected ideas, concepts, and definitions used by primary authors, which were reliably presented as well as described and cited.

RESULTS

The characteristics of the 16 analyzed articles are presented on Table 1.

We developed a synthesis for each study answering the research question (Chart 1).

The factors interfering on longitudinality at PCH services are presented on Chart 2.

Table 1: Characteristics of analyzed articles. LILACS/PubMed/Scopus, 2014.

	N	%
Origin		
Denmark	1	6
Spain	1	6
Brazil	1	6
Netherlands	1	6
USA	2	13
Australia	3	19
England	3	19
Canada	4	25
Knowledge field		
Nursing	1	6
Multi-professional	5	31
Medicine	10	63
Year of publication		
2009	3	19
2010	3	19
2011	1	6
2012	8	50
2013	1	6
Total:	16	100

Chart 1: Integrative Review *Corpus*. LILACS, PubMed and Scopus, 2014.

Reference	Objectives	Methods	Results		Level of evidence
			Favoring factors	Disfavoring factors	
Lester H, Khan N, Jones P, Marshall M, Fowler D, Amos T, et al[12]	To explore the user's perspectives of early intervention services and primary health care, in depth and over time.	Qualitative study P = 21 youngers with a first psychosis episode	Easy access to primary care Professional easy to talk and trust The same physician knew them for a long time (sometimes before the disease).		6
Baratieri T, Mandu EN, Marcon SS[13]	To describe the nurses' perceptions about the assistencial practice with the longitudinality perspective.	Qualitative study P = 20 nurses from the Family Health Program	Access Bond, being strengthen by constant contact Depends on team work Home visit Chronic disease situation		6
Wong ST, Regan S[14]	To analyze how primary health care provides services and its accessibility increase.	Qualitative study P= 50 people living in rural communities	Access to services for continuing care. Has a continuous relationship with the professional, in order to "feel comfortable" to receive care and trust the recommendations. To build a positive and respectful relationship between patient and professional. Management of chronic conditions.	Workload of professionals	
Kristjansson E, Hogg W, Dahrouge S, Tuna M, Mayo-Bruinsma L, Gebremichael G[15]	To analyze the practice, the provider and preceptors of patients of care continuity in a large sample of primary health care practices in Ontario, Canada.	Cross-sectional study P=363 professionals and 5296 patients	Older patients or patients with chronic diseases.	Difficulty to access services. Increase of professionals (more rotation, less bond). Not being seen by your regular doctor. Users who worked full time were more educated	6
Berkelmans PG, Berendsen AJ, Verhaak PF, Van der Meer K[16]	To comprehend elderly preferences in relation to non-medical attributes of primary health care.	Qualitative study P = 13 seniors (65-91 years)	Accessible by phone. Safety when speaking to your own doctor or professional. User treated with respect, the doctor listens and gives them enough time and personal attention. Home visits. Professional has enough time to rest. The front desk and the nurse know them. To listen to a familiar voice or see a familiar face in the practice makes them comfortable. Doctor's knowledge about diseases, patient (body and mind), to make the correct diagnose and to refer them to specialists.	Long waiting time for a consultation	6

Reference	Objectives	Methods	Results		Level of evidence
			Favoring factors	Disfavoring factors	
McDonald J, Jayasuriya R, Harris MF[17]	To explore the power dynamics and trust influence in the collaboration between health professionals involved in diabetes management and its impact on patient's experiences.	Qualitative case study P= 45 health service providers of nineteen organizations and 8 patients from two services	Direct communication, normally by telephone. Trust between the professional and the patient is developed over time with good communication.		6
Delva D, Kerr J, Schultz K[18]	To comprehend, exploring the family doctor's perspectives, how the conception of care continuity can influence their attention.	Qualitative study P=37 family doctors	Satisfaction and trust to know about patients and family members. Relationships needs time to develop. A relationship can be quickly built.	The doctor have to care for a patient that he does not like.	6
Riggs E, Davis E, Gibbs L, Block K, Szwarc J, Casey S, et al[19]	To explore experiences of using maternal-infant health services, from the family perspective of refugees funds and service providers.	Qualitative study P=87 family members	Home visits Fundamental relationship to build service' trust and permanent engagement.		6
Reilly S, Planner C, Hann M, Reeves D, Nazareth I, Lester H[20]	To describe and analyze patient's characteristics and service use.	Cohort study P= 1.150 primary care patients		Service size, that is, the number of registered patients User having a job	4
Hudson SV, Miller SM, Hemler J, Ferrante JM, Lyle J, Oeffinger KC, Dipaola RS[21]	To identify the preferences from a population characterized by challenges from health problems related to their previous cancer treatment and who might have many years of care accompaniment	Qualitative care P= 42 cancer survivor patients	Familiarity, continuity and history Professionals responsible for small health care problems providing supplementary assistance.	Doubts about when to call your primary care or specialist doctor.	6
Schultz K, Delva D, Kerr J[22]	To explore continuity conceptions of care between family doctors in traditional practices.	Qualitative study P= 37 family doctors	Familiarity or a profound comprehension of the patient. Trust relationship and awareness of patient's fears allowed doctors to use the relationship as therapy and lead to adherence through treatment suggestions. Management of chronic diseases.	Loss of objectivity when facing a strong connection with patients. Patients disliked by doctors, who makes them feel uncomfortable, and they have to assist them anyways.	6
Frederiksen HB, Kragstrup J, Dehlholm-Lambertsen G[23]	To explore the creation of satisfaction or dissatisfaction of the interpersonal relationship with professionals in a broad way; to investigate how this is related with care continuity.	Qualitative study P= 22 interviews with patients from two practices	Satisfaction with the interpersonal relationship with the doctor who presented interest and respect. Chronic diseases.	Negative experiences as when the professional humiliated, ignored, insulted, or mocked.	6
Bonney A, Phillipson L, Jones SC, Iverson D[24]	To investigate attitudes of older patients reluctant to general clinic	Qualitative study P=38 patients 60 years or older from three practices	High levels of trust in their habitual doctors and interpersonal communication. Chronic conditions.		6

Reference	Objectives	Methods	Results		Level of evidence
			Favoring factors	Disfavoring factors	
Hernández MBA, Lorenzo IV, Pérez IS, Martínez DH, De Lassaletta JC, López JRL, Mercadé MF, Figuera LC, Navarrete MLV[25]	To analyze the perception of users of assistencial continuity, as well as its experienced elements of (dis) continuity in health services from Catalonia.	Cross-sectional study P= 200 users	Trust in doctors accompanying, considered an adequate communication with professionals and would recommend it for friends and family members. Professional team stability Duration of the relationship with the doctor.	Moderate waiting time to consult with the doctor.	6
Aboulghate A, Abel G, Elliott MN, Parker RA, Campbell J, Lyratzopoulos G, et al[26]	To determine the frequency that patients express preference to see a determined doctor and the measure of this attended request.	Quantitative documented study P=data from 2009/2010 of 2.169.718 individuals	Chronic disease or psychological/emotional condition Senior women (age 74-85 years)		6
Wolinsky FD, Bentler SE, Liu L, Geweke JF, Cook EA, Obrizan M, et al[27]	To examine if older adults who had care continuity with a primary care doctor presented lower mortality.	Cross-sectional study P= 5457 participants 70 years old or more	Lower subjective life expectancy; Those with health self-perception regular or bad; Difficulty to walk; Psychological conditions; Higher levels of depressive symptoms; With arthritis, cancer, diabetes, pulmonary disease, heart diseases, hypertension, stroke; Admitted on the year before the reference; Who completed high school;		6

Label: P = research participants

Chart 2: Description of the aspects and its definitions and the factors interfering with longitudinality in the PHC, 2014.

Attention aspects	Definition	Factors	
Structural	Identification of the common attention source by people and the identification of the elective population by the doctor or group	Favor	Access[12-17]
			Service organization[16]
			Time to develop the relationship[16-18]
			Development of home visits[13,16,19]
		Disfavor	Work load[14-16,20]
			Conflict of when to access the PHC or specialty service[21]
Performance	Adequate use of the attention source and the strength of interpersonal relationships	Favor	Aspects of interpersonal relationship[12-14,16-19,21-25]
			The user presented chronic diseases or psychological/emotional conditions[13-15,22-24,26-27]
			Sociodemographic characteristics of users[15,20,26-27]
			Co-responsibility[21]
			Relationship duration[12,18]
		Disfavor	Long wait times, to cancel consultations and lack of available providers[16,25]
			Doctor's lack of knowledge about diseases[16]
			Bad experiences[18,22-23]

DISCUSSION

Attention aspects referring to structure

Longitudinality is favored by **accessibility,** considering that users value easy access to primary care[12-13]. The closest the use is from the PHC service, the easiest and immediate this assistance will be, showing the importance of adequate geographical position of the unit in the enrolled area[13-15].Thus, the implementation of the Health Family Program (PSF)[13] was a favoring factor to longitudinality. Regarding access by telephone, this practice could improve standard of care and reduce the waiting time for consultations, allowing to maintain interpersonal relationship[16-17].

Regarding the effectiveness of contact with the professional when needing medical help, it is highlighted that users felt safe and capable to talk to their own doctor[16]. The service functioning in weekends makes patients to not consult with their usual doctor, and vacations and holidays are considered barriers to longitudinality[15].

The **organization** of PHC services can influence longitudinality. A study shows the importance of the receptionist and health professionals knowing the users, as a familiar voice and face makes them feel comfortable and help users to consult with the same professional[16].

It was evident that having **time do develop the relationship** favors longitudinality, that is fundamental to establish trust[17-18]. Users consider time and interest dedicated to them by care providers as the proof of their singularity, influencing their attitude and attending their expectations[16]. Being the time reduced to listen the user, to visit and to have contact with the professional considered barriers[16].

The **home visits** was seen as important for a continuous compromise with the service[19] demonstrated as main strategy used to know and follow the family[13]. However, users believe the doctor's time to be precious and it should be reserved for those in need[16].

The **work load** disfavor longitudinality, being associated with the number of registered users in the service and to the professionals acting in it[15,20]. Considering this, lack of resting time for the professional[16] compromising the quality of attention. Besides, it can restrict the variety of attended users. On the same way, attention in rural communities can be irregular, impeding to keep a continuous relationship[14].

The **conflict of when to access the PHC or the specialty** disfavor longitudinality once users have doubts about the professional responsible for their care[21].

Aspects of health attention referring to performance

The **aspects of interpersonal relationships** favors longitudinality by propitiating bond[13], familiarity[21-22], user's comprehension[22], trust[12,14,16-19,22-25] and safety[16,23], respect[14,16-17,23], welcoming from professionals[17], communication[17,21,24-25] and user's and professional's satisfaction[18,23]. When there are strengthening of this relationship there is higher permanent engagement in the service aiming health promotion[19].

The user **with chronic diseases or psychological/emotional conditions** was presented as favoring longitudinality, as this user configures a vulnerable group requiring priorities in health attention[13]. In this group, there are those with less subjective life expectancy, with self-perceived health as regular or bad, with chronic problems[14-15,22-24,26-27], complex or psychological conditions[26-27], as well as those who were admitted or with a serious health event[27].

Some **sociodemographic characteristics of users** were associated to higher longitudinality. This association was more common among women[26], seniors or retired[15,26], educated[15,27] and among those unemployed[15,20]. It is inferred that these populations have a need and availability for the regular health service use, allowing the constitution of more consistent interpersonal bonds.

The **co-responsibility** between professional and user allows more longitudinality at the measure that it promotes safety, coordination of care and referral to other professionals when needed[21]. For this, the professional knowledge about the user is essential, and the identification of the professional as the main responsible care provider aiming to contribute for long-term attention.

The **duration of the relationship with the health professional** favors longitudinality, as when there is a relationship of years[12,18], covering changes of the life's cycle, crises and episodes of chronic and acute diseases, it encourages the individualized attention.

However, **long periods of time, the cancelling of consultations and the lack of available providers** disfavor attention longitudinality to users. The time at the waiting room causes dissatisfaction of users, who mentions the importance of comfort in this room[16]. This waiting time to consult a doctor indicates the importance to manage longitudinality[25], as when the user does not feel satisfied with the service that he/she uses, it harms the bond and the regular use of this service.

Users report **lack of knowledge of doctors about diseases** as a barrier for longitudinality. The knowledge of users, of diseases and treatments, as well as the correct diagnostic interfere on the user's trust on the professional[16].

Bad experiences present other disadvantages interfering on longitudinality. The loss of objectivity as result of a strong relationship with users worry professionals, they fear the possible negative effects, as the fail in diagnosis that this relation can cause in the health assistance of people[22]. Adding to this, the doctor judgement about the users causing a treatment in a humiliating way as to compromise the provided care[18,22-23].

CONCLUSIONS

The evidence available in scientific papers about factors interfering with the attribute longitudinality in the PHC showed that these could be favorable or unfavorable. Those favorable to longitudinality were related to the time to develop interpersonal relationships, the service organization, accessibility, characteristics of users and to have chronic diseases. This evidence sustains the value of these relationships, in a way to secure an effective interaction aiming the quality of health attention. The unfavorable ones were associated to the gaps in the organization and the management of health services, as the work volume, the lack of professionals, bad experiences, and the lack of user's knowledge, which can cause unpleasant experiences, negatively influencing the PHC assistance.

To maximize the favoring factors, investment in permanent education is needed, aiming the composition of an integrated and collaborative team that cares for the quality of attention to users and for the connection of those to the service. On the side of strategies that minimize what disfavor, through the PHC reorganization surpassing the curative model, hiring professionals through public tender, permanent education promotion of team work, the investment in material and human resources, that allows access, the offer and the communication between the services and users in a resolute way.

The evidence offer aids to compose a global panorama of factors interfering in the practice of the longitudinality attribute in the PHC. The prevalence of descriptive studies suggests the need to strengthen the construction of knowledge with studies of higher level of evidence. Beyond that, there were limitations in the cut established by the used search strategy.

Thus, it is necessary to rethink care actions developed in the PHC and this attribute should be recognized as central characteristic. It is opportune and desired the implementation of assessment practices and monitoring this and other attributes. In this sense, the nurse, as well as the doctor who works in the PHC should be co-responsible by the identification of the elective population and to position as mediator of interpersonal relations. Thus, it will be possible that each time, bonds, and cooperation will be reinforced involving users, professionals and the service.

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