





## ORIGINAL ARTICLE

# Practice of street clinic teams and recording of actions in the e-SUS Primary Care

*Prática de equipes de consultórios na rua e registro das ações no e-SUS Atenção Primária*

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## ABSTRACT

**Objective:** To describe the perceptions of Street Clinic teams about their practice and the use of the e-SUS Primary Health Care strategy to record their care. **Method:** Descriptive-exploratory study with a qualitative approach. Twenty professionals from three Street Clinics from the state of Goiás, Brazil. Self-administered questionnaires with a professional profile and focus groups were used, whose data were submitted to content analysis. **Results:** Two categories of analysis were identified: “Aspects that influence the work process of the Street Clinic teams” and “Records in the e-SUS Primary Health Care strategy by the Street Clinic”. **Final considerations:** The need for investment to overcome the challenges of qualified care for the homeless population was evidenced, for the effectiveness of records, considering their specificities and needs.

**Descriptors:** Homeless Persons; Vulnerability; Information Systems; Delivery of Health Care; Health Services.

## RESUMO

**Objetivo:** Descrever as percepções das equipes de Consultório na Rua sobre sua prática e a utilização da estratégia e-SUS Atenção Primária à Saúde para registro do seu atendimento. **Método:** Estudo descritivo-exploratório de abordagem qualitativa. Participaram 20 profissionais de três Consultórios na Rua do Estado de Goiás, Brasil. Foram utilizados questionários autoaplicáveis de perfil profissiográfico e grupos focais, cujos dados emergentes foram submetidos à análise de conteúdo. **Resultados:** Foram identificadas duas categorias de análise: “Aspectos que influenciam o processo de trabalho das equipes dos Consultórios na Rua” e “Registros na estratégia e-SUS Atenção Primária à Saúde pelo Consultório na Rua”. **Considerações finais:** Evidenciou-se a necessidade de investir para superar os desafios para o cuidado qualificado à população em situação de rua, para a efetividade dos registros considerando suas especificidades e necessidades.

**Descritores:** Pessoas em Situação de Rua; Vulnerabilidade; Sistemas de Informação; Atenção à Saúde; Serviços de Saúde.

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## INTRODUCTION

The number of homeless people has increased, especially in the large urban centers of Brazil and the world. This social reality is impacted by the dynamics of the urban space, generating conflicts, precarious living conditions<sup>(1)</sup> and a situation of invisibility and social inequality<sup>(2-3)</sup>.

According to the Ministry of Citizenship<sup>(4)</sup>, of the people assisted at the Specialized Reference Centers for Homeless Population (Pop Centers) in 2018, 49% were drug users, 29% were migrants and 6% had some diagnosed psychological distress.

The Homeless Population (HP) has different ways of life and relationships with and on the street. This plurality imposes challenges to guarantee citizenship and decent conditions for survival<sup>(5)</sup> for this contingent. Among the main problems of the HP, the difficulties of access to work, healthcare and education network stand out. In addition to the constant exposure to violence, which requires inter and transdisciplinary actions focused on the group, considering the specificities of the diversity of these people.

The different territories have diverse social, economic, political and cultural characteristics, which need to be considered in their singularities for the development of more problem-solving activities<sup>(6)</sup>. Such context is reflected in the life and health of the HP. This makes the practice of care challenging, considering the need to reflect on the social issue that explains the inequalities and care particularities aimed at this public<sup>(2-3)</sup>.

In Brazil, Primary Health Care (PHC) has the challenge of promoting the realization of rights and health care in a process of construction and implementation of Psychosocial Care Networks (Portuguese acronym: RAPS) to expand care in the territory. In this context, the Street Clinic (Portuguese acronym: CnaR) teams develop actions aimed at the HP. They seek to offer comprehensive care, through welcoming and listening, in a humanized and qualified healthcare to increase the user's autonomy<sup>(1,7)</sup>.

The actions developed by the CnaR teams focused on the HP are recorded through the e-SUS Primary Health Care strategy (Portuguese acronym: e-SUS APS). Which aims to reorganize health information systems to enable improvements in the quality of care for the individual, family and community. This strategy seeks to implement software systems to capture citizens' health data, namely: Simplified Data Collection (SDC) and Citizen's Electronic Health Record (CEHR)<sup>(8)</sup>. The CEHR modality demands material resources such as internet connection and computers for health teams. The SDC modality is recommended for services that do not have an internet connection or that have a reduced number of computers for professionals<sup>(8)</sup>.

The e-SUS APS strategy presents possibilities for advances with the use of information and is in line with the more general proposal for restructuring the Health

Information Systems of the Ministry of Health. Therefore, understanding that the qualification of information management is essential to increase the quality of service to the population. However, there are challenges to be overcome, such as: the lack of recognition that the data recorded in the e-SUS provide tools for local planning and care management, precariousness in the computerization of health units, resistance to the use of technology and lack of technological skills among health professionals<sup>(9-10)</sup>.

The e-SUS APS strategy is an essential tool in the work processes of health professionals in the care and management scope of services. However, for a satisfactory operation of this tool, it is necessary that the multidisciplinary teams know its features for an effective record of health data<sup>(11)</sup>. Thus, the objective of this study is to describe the perceptions of CnaR teams about their practice and the use of the e-SUS APS strategy to record care.

## METHOD

This is a descriptive-exploratory study with a qualitative approach<sup>(12)</sup>, in which twenty professionals from three Street Clinics from the state of Goiás, authorized by the Ministry of Health (MS), participated. All those who were working in the CnaR teams for a minimum of three months were included, and those who were on official leave at the time of data collection were excluded.

Among the professionals, there were 6 male and 14 female, aged between 25 and 68 years. Regarding education, 70% declared having a higher education and two professionals completed a *lato sensu* specialization course in the area of Primary Health Care. Regarding the profession, psychologists, nurses, doctors, social workers, administrative assistants, drivers and social educators participated. Most were social educators.

Data collection took place in 2016, using a self-administered questionnaire with a professional profile and focus groups were held with each CnaR team. A nurse specialist in coordinating groups led the focus groups, through the following guiding questions about the perceptions of the CnaR teams about their practice with the e-SUS APS strategy: What is the meaning of the e-SUS Primary Health Care strategy in your practice at CnaR? and What care actions are registered in the e-SUS Primary Health Care?

The focus groups took place in seven meetings at the teams' workplaces, lasting two hours each, and were recorded through photos and notes in a field diary and audio recording. At the end of each meeting, the data collected were transcribed and pre-analyzed to be validated in subsequent meetings by the professionals and a team of researchers. All data collection meetings were preceded by planning meetings and discussion of the content obtained in the data collection process.

The analytical process followed the three stages of content analysis, proposed by Bardin<sup>(13)</sup>:

1. pre-analysis, in which the floating reading is performed;
2. exploration of the material, in which operations of codification and categorization of the information are carried out; and
3. the interpretation and presentation of the results. ATLAS.ti Qualitative Data Analysis software version 6.2 was used as an auxiliary tool in data analysis.

This study followed the ethical-legal principles of research carried out with human beings, as highlighted by Resolution no. 466/12 of the National Health Council<sup>(14)</sup>. The Ethics Committee of the Federal University of Goiás, CAAE 51841815.8.0000.5083, with a favorable opinion (protocol No. 1,437,925), approved it. All participants signed the Free and Informed Consent Form (FICF).

## RESULTS

The analysis of the results showed two categories on the perceptions of the CnaR teams about their practice and the e-SUS APS strategy: “Aspects that influence the work process of the Street Clinic teams” and “Records in the e-SUS Primary Health Care strategy by the Street Clinic”.

### Aspects that influence the work process of the Street Clinic teams

Regarding care practices, professionals expressed the condition of establishing a bond with users and the activities carried out by them in the daily routine of the CnaR:

*Care actions, that is, dressing, injection, oral medication that we do a lot on the street, due to alcoholism, blood pressure measurement, medical care. The doctor provides care and referral. (P3).*

Another report reinforces:

*Directly, due to the type of demand we have, it is difficult to provide assistance and create a bond. (P10).*

The CnaR teams emphasized the difficulty of integration with the other services that make up the Health Care Network (Portuguese acronym: RAS) and highlighted the difficulty of communication between the health services. Limitations influenced by the lack of investments in information technologies, which directly or indirectly make the accessibility and comprehensiveness of health care aimed at the HP unfeasible. As they report:

*We do not have access to healthcare. Even here at the Emergency Care Unit, we have to wait from 5 to 8 pm for the service. (P4).*

Another participant describes:

*There is a classic case of how difficult it is to communicate services. We see that the patient who is treated at the CAPS AD [Portuguese acronym for Psychosocial Care Center — Alcohol and Other Drugs] in two, three days because ‘they didn’t let us sleep, you know...’. Then, they apply pressure, and the doctor discharges this patient without referral, [...] the patient with severe neuropathy and could barely walk, at the beginning of abstinence, 4 days of abstinence and they wanted to discharge him/her. They wanted the clinic team to take him/her to a relative’s home. (P18).*

The CnaR teams reported the invisibility and lack of recognition of the work carried out, with evidence of the lack of knowledge of the records of actions carried out by the CnaR teams in relation to the RAS and the PHC itself. CnaR teams do not feel like PHC teams, even when located in the same Basic Health Unit (Portuguese acronym: UBS).

*The CnaR is an anonymous, almost invisible work. (P15).*

Another participant highlights the commitment and importance of management participation:

*The fact that the management did not attend [the Seminar], scared me, I expected them to be interested, even because there were people from other places, even a matter of appearance: we are together. We are so unimportant that we don’t even need anyone to go there, pay attention, we’re abandoned, we’re an unwanted adopted child. (P7).*

### Records in the e-SUS Primary Health Care strategy by the Street Clinic

The professionals pointed out the importance of a SDC form of the e-SUS APS strategy specific to the HP. They believe that the form is standardized for all PHC services and does not include the specifics of this public, which can be illustrated by the statements:

*In this form, there is a field aimed at the homeless population, we do not know whether to fill it in completely or skip some items and go straight to this field. (P11).*

Another participant considers:

*So, because the CnaR is part of Primary Care, you would have to think of a different form due to the type of care, due to the demand that the CnaR has. (P13).*

*We are lost, because our reality is different and, in my understanding, the e-SUS is aimed at a fixed unit or, in the case, those who work with the HP would have time to accompany the person in a fixed place. (P4).*

The condition of the HP seems to be invisible, even in the registration forms of actions, which do not include the work processes of the CnaR team:

*The form is more focused on Primary Care, which was thought of at the beginning, the standard. So, for the reality of homeless people, it is complicated. (P2).*

*Because you understand that the e-SUS is planned, and if you compare the Street Clinic with the standard Primary Care teams, we are tiny. (P10).*

The CnaR teams also emphasized material resource limitations in relation to other health services. This makes it difficult to perform records in the workplace through portable computers with effective time optimization in system power:

*[...] We hear that there is not even the possibility of exchanging equipment for better ones, so you can't think higher. I've already heard that other Street Clinics take tablets to the street and feed the system there, after, they fill in the data online, which goes to the system. (P6).*

## DISCUSSION

The relationship of trust and bonding are fundamental strategies for the work process of CnaR teams. In which the construction of the ambience is carried out from the temporality of the street and the HP and by identifying and respecting the individual's singularity<sup>(15)</sup>. A study carried out in the central region of Brazil revealed that the dialogue between professionals and the HP is an important relational care technology that facilitates the reception, approximation and demystification of prejudices and stereotypes<sup>(16)</sup>.

In the process of welcoming the HP, Duarte<sup>(15)</sup> reports on the "welcoming persistence", in which the health professional insists on the construction of this bond even if it is not successful several times. Considering that users feel suspicious most of the time and may be under the influence of psychoactive drugs, it is necessary for the professional to be attentive and sensitive to these peculiarities.

Several strategies can be used to build bonds with the HP, such as music, paintings, drawings, capoeira, percussion

instruments workshops, among others<sup>(10)</sup>. However, the CnaR teams report that generating this bond is difficult due to the social invisibility of the HP<sup>(5-6)</sup>.

The care practices reported by the CnaR teams in this work dialogue with those from other contexts<sup>(6,17)</sup>. Such as measuring vital signs, drug therapy, wound treatment with dressings, prenatal consultations, care for infectious diseases, referral to other care specialties, among other activities. The care actions practiced by the CnaR range from clinical issues to the delivery of groceries<sup>(17)</sup>.

The care offered by CnaR teams can also include activities such as immunization actions, assistance to women through pap smears and pregnancy tests, screening and diagnosis of infectious diseases (tuberculosis, hepatitis, HIV and syphilis), in addition to health education and construction of a unique therapeutic project<sup>(18)</sup>.

The scenario of obstacles in the assistance process for the HP is not an isolated fact. In several regions of Brazil, there is resistance to the appreciation of the HP as a group subject to rights, revealing the need to break paradigms to promote progress and extinguish setbacks in relation to the HP<sup>(5)</sup>.

Data from the national survey on this population reveal that the weaknesses of the HP care network are important obstacles to care. Among these weaknesses are the small number of specific health units, difficulty in making connections with other services, limitations of the physical structure and material resources of these institutions, etc.<sup>(15)</sup>. From this perspective, considering the precariousness of services in relation to the HP, making referrals is seen as important to meet their health needs<sup>(16)</sup>.

The testimonies of the teams show that the HP suffers from stigmatization and exclusion even from the health institutions that provide care to this public through the CnaR. This demonstrates a precariousness of the RAS, which generates losses for the provision of comprehensive care. It is noteworthy that the effective articulation with other health services for networking is characterized as the main obstacle faced by the CnaR, because the HP needs care that goes beyond the biological character. In addition, for intersectoral work to be established satisfactorily, it is important to know the spaces that make up the territory so that the CnaR teams have greater possibilities to meet the demands of the HP<sup>(5-6,19)</sup>.

The consequences of this fragility of the RAS are reflected in the care provided by the multidisciplinary teams to the HP. They make it difficult to meet the health needs of this population, demanding training for a more humane and comprehensive approach<sup>(17,20)</sup>. When there is dialogue between the various services that make up the RAS, there is greater fluidity and problem-solving capacity. Strategies such as visiting other institutions that provide care to the HP have proved to be a powerful tool for integration among professionals. This allows to know the actions that are being

carried out and the sharing of restrictive and driving factors for the assistance of this group<sup>(18)</sup>.

The social prejudice suffered by the HP is one of the factors that generates the invisibility of this group in society. This fact can be reflected in the treatment with the health teams that provide care to the HP, which makes health professionals often provide rigid care and makes it difficult for these people to access the health system. Thus, health professionals should welcome these individuals to alleviate this situation<sup>(10,15)</sup>.

Despite the work developed in the CnaR not being appreciated and recognized externally by society as reported in this research, the literature reveals that professionals who work directly with the HP have a personal gratification. Which is based on their daily practice that recognizes and respects the subjectivity of the people assisted<sup>(10)</sup>.

This process of exclusion suffered by the CnaR, including PHC services such as UBS, also reflects on the HP's adherence to the health service, which brings harm, including in the management of work processes<sup>(6)</sup>. However, the positioning and self-recognition of CnaR teams as PHC services is an essential factor for full assistance that addresses all the needs of the HP<sup>(18)</sup>.

The CnaR teams surveyed showed difficulties in offering care to the HP in places other than the street, including the reference UBS. One of the teams has an administrative headquarters at the UBS and the others have their own headquarters, but with an administrative nature. In this way, none of the teams occupies a physical space to perform HP care.

The Ministry of Health<sup>(21)</sup> recommends that the CnaR has its headquarters in the UBS, in addition to the mobile structure to act on the streets, for activities in partnership with the other health services that make up the RAS. It is expected that the CnaR offers comprehensive assistance to the HP, although they are classified as services linked to PHC, they must interact with other health devices belonging to the RAPS.

Research carried out throughout the Brazilian territory identified that only 6% of health services have integration between health and information technology teams. This makes it difficult to develop a system that meets the specificities of the Brazilian Internet Steering Committee<sup>(22)</sup> aiming to improve the e-SUS APS strategy according to the reality of each population profile<sup>(9)</sup>.

Although the CnaR is linked to the HP, the complexity of the HP goes beyond the current care model provided by the FHS teams. A scope review that aimed to map the productions related to the work of the CnaR professionals in the scope of PHC in Brazil in the national scientific literature, revealed that there is a need to carry out further studies to elucidate the practice of the teams that provide assistance to the HP<sup>(23)</sup>.

Many care actions are carried out on the street, which is the care space, in order not to miss the opportunity to provide it. However, the lack of technological conditions and systematization of work processes causes many actions to be underreported, even if professionals recognize the importance of recording care in medical records and in the e-SUS APS strategy, they do not do so routinely.

There are situations in which the CnaR team performs the user registration in a preliminary way, during the initial approach. Thus, with the establishment of the bond, as more information is generated, the record is completed, supporting the planning of the team<sup>(18)</sup>. The teams recognize that the care provided by the CnaR must be recorded in the e-SUS APS strategy and in the medical record, but they admit that they do not perform it on a daily basis in a systematic way. The operationalization of electronic records is important because it materializes the complexity of the care implemented and can influence the monitoring the health situation of the individual, family and community<sup>(24)</sup>. Electronic records are important because they facilitate access to information about the assistance provided, in addition to giving visibility to CnaR actions and subsidizing the management of assistance aimed at the HP<sup>(25)</sup>.

To achieve the potential of the e-SUS APS strategy in the context of the HP, it is necessary to overcome the idea that there are limitations regarding the adequacy of the Simplified Data Collection form. In addition, it must be understood that the objective of the current information system is to reach the Citizen's Electronic Health Record, in which it will be possible to meet the particularities of care for the HP.

When the CnaR's professional practices are recorded, the process of evaluating the activities performed becomes more consistent and assertive. This enables the planning of future actions and the need for changes in the practices carried out so far to provide the most resolute care for the HP<sup>(5,20)</sup>.

Another restrictive factor to the realization of records in the workplace is the limitation of material resources such as portable computers, which could optimize the system's supply with information of users and services. The limitation of investments in the CnaR teams is in line with the professionals' report regarding the invisibility and lack of recognition of the work carried out in relation to the RAS and the HP itself.

Lima and Seidl<sup>(16)</sup> also point out that the scarcity of material resources, such as the lack of basic elements, including uniforms for workers and harm reduction kits, impairs the assistance provided by the CnaR teams. An investigation carried out in a CnaR in southern Brazil identified difficulties in providing the service, revealing the poor condition of the computers available at the health service and the lack of portable devices, which are barriers to the realization of records<sup>(5)</sup>. This corroborates the findings of the present study.

## FINAL CONSIDERATIONS

The main difficulties perceived by the CnaR professionals were the lack of establishing a bond with the users, the team's difficulty in communicating with the other RAS services, the invisibility of the teams and lack of recognition of the work carried out. They consider the participation of managers to be important in supporting work actions and training the teams.

The disarticulation of the RAS permeates the stigmatization and exclusion of the HP and the precariousness of the network, with consequent damages to holistic care.

Regarding the e-SUS APS strategy, the perception is that the data collected through the forms do not contemplate the reality of the CnaR teams. In addition, the lack of material resources makes it impossible to carry out records during the service.

Despite these difficulties, it is noteworthy that the e-SUS APS strategy is an important tool to qualify care, point out the demands and specificities, evaluate the strategies adopted and carry out more assertive planning in the care offered to homeless people. In addition, this tool has the potential to support the management of care and the work processes of the CnaR teams.

There is a lot to be invested to overcome the challenges faced in the practice of CnaR teams and to achieve the effectiveness of records. Thus, giving voice and visibility to the CnaR teams and the population in situations of vulnerability, providing qualified care to the HP.

The study has its limitations, as each territory of action is unique and the characteristics of the teams are diverse, the impossibility of generalizing the results is considered a limitation of the study. For aspects related to work processes with the e-SUS Primary Health Care strategy to be better explored, it is necessary to develop studies in other contexts.

## REFERENCES

- Rosa AS, Santana CLA. Consultório na Rua como boa prática em Saúde Coletiva. *Rev Bras Enferm* [Internet]. 2018 [cited 2022 Mar. 02];71(supl.1):501-2. Available from: <https://doi.org/10.1590/0034-7167-201871sup102>.
- Sousa AP, Macedo JP. População em situação de rua: Expressão (im)pertinente da “questão social”. *Psic Teor e Pesq* [Internet]. 2019 [cited 2022 Mar. 02];35(e35510):01-11. Available from: <https://doi.org/10.1590/0102.3772e35510>.
- Mendes KT, Ronzani TM, Paiva FS. População em situação de rua, vulnerabilidades e drogas: uma revisão sistemática. *Psicol Soc* [Internet]. 2019 [cited 2022 Mar. 02];31(esp):e169056. Available from: <https://doi.org/10.1590/1807-0310/2019v31169056>.
- Ministério da Cidadania (BR). Secretaria de Avaliação e Gestão da Informação. Departamento de Monitoramento. População em situação de rua no Brasil: o que os dados revelam? [Internet]. Brasília (BR): Ministério da Cidadania; 2019 [cited 2022 Mar. 02]. Available from: [https://aplicacoes.mds.gov.br/sagirmsp/ferramentas/docs/Monitoramento\\_SAGI\\_Populacao\\_situacao\\_rua.pdf](https://aplicacoes.mds.gov.br/sagirmsp/ferramentas/docs/Monitoramento_SAGI_Populacao_situacao_rua.pdf).
- Kami MTM, Larocca LM, Chaves MMN, Piosiadlo LCM, Albuquerque GS. Saberes ideológicos e instrumentais no processo de trabalho no Consultório na Rua. *Rev Esc Enferm USP*. [Internet]. 2016 [cited 2022 Mar. 02];50(3):442-9. Available from: <https://doi.org/10.1590/S0080-623420160000400010>.
- Ferreira CPS, Rozendo CA, Melo GB. Consultório na Rua em uma capital do Nordeste brasileiro: o olhar de pessoas em situação de vulnerabilidade social. *Cad Saúde Pública* [Internet]. 2016 [cited 2022 Mar. 02];32(8): e00070515. Available from: <https://doi.org/10.1590/0102-311X00070515>.
- Curvo DR, Matos ACV, Sousa WL, Paz ACA. Integralidade e clínica ampliada na promoção do direito à saúde das pessoas em situação de rua. *Cadernos Brasileiros de Saúde Mental* [Internet]. 2018 [cited 2022 Mar. 02];10(25):58-82. Available from: <http://orcid.org/0000-0003-2380-4581>.
- Ministério da Saúde (BR). Secretaria de Atenção Primária à Saúde. Estratégia e-SUS Atenção Primária: em busca de um SUS eletrônico [Internet]. Brasília (BR): Ministério da Saúde; 2021 [cited 2022 Mar. 02]. Available from: <https://sisaps.saude.gov.br/esus/>.
- Oliveira AEC, Lima IMB, Nascimento JA, Coelho HFC, Santos SR. Implantação do e-SUS AB no Distrito Sanitário IV de João Pessoa (PB): relato de experiência. *Saúde Debate* [Internet]. 2016 [cited 2022 Mar. 02];40(109):212-8. Available from: <https://doi.org/10.1590/0103-1104201610917>.
- Silva TIM, Cavalcante RB, Santos RC, Gontijo TL, Guimarães EAA, Oliveira VC. Difusão da inovação e-SUS Atenção Básica em Equipes de Saúde da Família. *Rev Bras Enferm* [Internet]. 2018 [cited 2022 Mar. 02];71(6):3121-8. Available from: <https://doi.org/10.1590/0034-7167-2018-0053>.
- Zacharias FCM, Schönholzer TE, Oliveira VC, Gaete RAC, Perez G, Fabriz LA, et al. e-SUS Atenção Primária: atributos determinantes para adoção e uso de uma inovação tecnológica. *Cad Saúde Pública* [Internet]. 2021 [cited 2022 Mar. 02];37(6):e00219520. Available from: <https://doi.org/10.1590/0102-311X00219520>.
- Polit DF, Beck CT. Fundamentos de pesquisa em enfermagem: avaliação de evidências para a prática da enfermagem. 9ª ed. Porto Alegre: Artmed; 2019.

13. Bardin L. Análise de conteúdo. Augusto Pinheiro e Luís A. Reto, tradução. Lisboa: Edições 70; 2018. p. 181.
14. Ministério da Saúde (BR). Conselho Nacional de Saúde. Resolução nº 466 de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos [Internet]. Brasília (BR): Ministério da Saúde; 2012 [cited 2022 Mar. 02]. Available from: <https://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf>.
15. Duarte AHC. O Acolhimento em saúde no espaço da rua: estratégias de cuidado do Consultório na Rua. Textos Contextos (Porto Alegre) [Internet]. 2019 [cited 2022 Mar. 02];18(2):e34306. Available from: <https://doi.org/10.15448/1677-9509.2019.2.34306>.
16. Lima HS, Seidl EMF. Consultório na rua: atenção a pessoas em uso de substâncias psicoativas. *Psicol Estud* [Internet]. 2015 [cited 2022 Mar. 02];20(1):57-69. Available from: <https://doi.org/10.4025/psicoestud.v20i1.24697>.
17. Timóteo AVG, Silva JVS, Gomes LKG, Alves ASS, Barbosa VMS, Brandão TM. Caracterização do trabalho e ações desenvolvidas pelas equipes do Consultório na Rua de Maceió-AL. *Enferm Foco* [Internet]. 2020 [cited 2022 Mar. 02];11(1):126-30. Available from: <https://doi.org/10.21675/2357-707X.2020.v11.n1.2757>.
18. Engstrom EM, Teixeira MB. Equipe “Consultório na Rua” de Manguinhos, Rio de Janeiro, Brasil: práticas de cuidado e promoção da saúde em um território vulnerável. *Ciênc Saúde Colet* [Internet]. 2016 [cited 2022 Mar. 02];21(6):1839-48. Available from: <https://doi.org/10.1590/1413-81232015216.0782016>.
19. Silva N, Sousa JM, Nunes FC, Farinha MG, Bezerra ALQ. Desafios na operacionalização dos Projetos Terapêuticos Singulares nos Centros de Atenção Psicossocial. *Psicol Estud* [Internet]. 2020 [cited 2022 Mar. 02];25(esp.):e49996. Available from: <https://doi.org/10.4025/psicoestud.v25i0.49996>.
20. Antunes CMC, Rosa AS, Brêtas ACP. Da doença estigmatizante à resignificação de viver em situação de rua. *Rev Eletr Enferm* [Internet]. 2016 [cited 2022 Mar. 02];18:e1150. Available from: <https://doi.org/10.5216/ree.v18.33141>.
21. Ministério da Saúde (BR). Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). [Internet]. Brasília (BR): Ministério da Saúde; 2017 [cited 2022 Mar. 02]. Available from: [https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436\\_22\\_09\\_2017.html](https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html).
22. Núcleo de Informação e Coordenação do Ponto B. Centro Regional de Estudos para o Desenvolvimento da Sociedade da Informação – Cetic.br. Pesquisa sobre o uso das tecnologias de informação e comunicação nos estabelecimentos de saúde brasileiros – TIC Saúde 2015 [Internet]. São Paulo: Comitê Gestor da Internet no Brasil; 2016 [cited 2022 Mar. 02]. Available from: <https://www.cetic.br/media/docs/publicacoes/2/tic-saude-2015-livro-eletronico.pdf>.
23. Alves NR, Fernandes SET, Alves ASS, Tigre HWA, Santos CEB, Lima JLR, et al. Atuação dos profissionais do consultório na rua no âmbito da Atenção Primária à Saúde do Brasil: uma revisão de escopo. *Research, Society and Development* [Internet]. 2021 [cited 2022 Mar. 02];10(4):e59410414470. Available from: <http://dx.doi.org/10.33448/rsd-v10i4.14470>.
24. Costa C, Linch GFC. A implementação dos registros eletrônicos relacionados ao processo de enfermagem: revisão integrativa. *Rev Fun Care Online* [Internet]. 2020 [cited 2022 Mar. 02];12:12-9. Available from: <https://doi.org/10.9789/2175-5361.rpcfo.v12.6648>.
25. Gava M, Ferreira LS, Palhares D, Mota ELA. Incorporação da tecnologia da informação na Atenção Básica do SUS no Nordeste do Brasil: expectativas e experiências. *Ciênc Saúde Colet* [Internet]. 2016 [cited 2022 Mar. 02];21(3):891-902. Available from: <https://doi.org/10.1590/1413-81232015213.01062015>.

