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REVIEW

Impact of matrix and institutional support on the work processes of health teams: an integrative review

Impacto do apoio matricial e institucional nos processos de trabalho de equipes de saúde: revisão integrativa

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ABSTRACT

Objective: to analyze studies on matrix and institutional support (AM and AI), seeking to discover potentialities and obstacles in the work processes of health teams. **Data source:** bibliographic search of articles written between 2005 and 2016, the keywords "matrix support" OR "institutional support", with 188 articles found. After reading the titles and abstracts, 36 articles remained, read in full and 15 were selected for the sample. **Results:** the barriers refer to the fragmentation of care reflected in the absence of comprehensive care for users, difficulties in understanding the role of the supporter and work overload and low qualification of the team as factors that discourage professionals for the development of bf. The potentials refer to the encouragement for permanent education in health and the support as spaces for reflection on practices. **Conclusion:** the supports are now understood as effective tools by health teams and managers.

RESUMO

Objetivo: analisar estudos sobre Apoio Matricial e Institucional (AM e AI), buscando conhecer potencialidades e entraves nos processos de trabalho de equipes de saúde. **Fontes dos dados:** realizada pesquisa bibliográfica de artigos escritos entre 2005 e 2016, as palavras-chaves "matrix support" OR "institutional support", sendo encontrados 188 artigos. Após leitura dos títulos e resumos, restaram 36 artigos, lidos integralmente e selecionando-se 15 para a amostra. **Síntese dos dados:** os entraves referem-se à fragmentação do cuidado refletida na ausência da integralidade da atenção aos usuários, dificuldades em entender o papel do apoiador e sobrecarga de trabalho e baixa qualificação da equipe como fatores que desmotivam os profissionais para o desenvolvimento do AM. As potencialidades referem-se ao estímulo para a Educação Permanente em Saúde e os apoios como espaços de reflexão sobre práticas. **Conclusão:** os apoios passam a ser entendidos como ferramentas eficazes pelas equipes de saúde e pelos gestores.

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Introduction

The conception of Matrix Support (AM) and Institutional Support (AI) comes from the Paideia methodology (Método da Roda), established by Gastão Wagner de Sousa Campos and collaborators, in 1999. Widely used in health policies and practices in Brazil, it seeks democratic management in institutions, promoting collectivity, the articulation of knowledge for the production of goods or services and the organization of the teams' work processes. For this, it advocates the reform of health organizations in search of co-management, and sharing of knowledge, aiming at the construction of horizontal relationships in the health service.[27]

Support is based on comprehensive health care and the matrix teams, together with the health service teams, seek to understand the subjectivity and life history of each person, seeking to meet their needs and outline the best therapeutic practice to be used, having the participation of the subject or family. Multiprofessional work, welcoming and respect for human beings and their suffering are present in the process, to offer better health care.[32]

To qualify the support to the Primary Health Care (ABS) teams, the Ministry of Health created, in 2008, the Family Health Support Centers (NASF). Each NASF is linked to a variable number of family health teams or ABS, ranging from one to nine teams.5 In 2011, in the continuity of health care qualification, the Family Health Programs (PSF), which started in 1995, became Family Health Strategies (ESF), increasing their importance in the Unified Health System (SUS), since it is no longer a program. In the same year, there is the emergence of the Support Centers for Primary Care (NAAB), established in RS, as a specific support strategy for mental health care in municipalities with up to 16,000 inhabitants. Therefore, both NASF and NAAB follow the theoretical-methodological principles of AM and AI. Thus, these come to meet the reference teams to outline objectives and goals, conduct their work and management processes, being able to improve their attention to the subjects, aiming at the integrality and equity of the services offered.[5,32]

At the international level, there is talk of interprofessional work bringing the terms shared work and collaborative care. Oliveira and Campos (2015) argue that only in Brazil were found studies that use the Paideia method and AM as a basis for the NASF.[27] Therefore, it is clear that the way in which health is organized within the

scope of public policies in Brazil makes AM and AI become important strategies to support management and care in ABS. Given the above, the present study aims, through an Integrative Review (IR), to investigate the impact of AM and AI on the work processes of health teams.

The IR proposes to bring together different studies on a theme and synthesize the published productions on AM and AI. It consists of a broad review method, consisting of theoretical and empirical studies, with different approaches.[30]

Methods

The literature search was carried out by searching for articles available in the PubMed database. The choice of this one is because it is a reference for the search for national and international scientific articles in the health area. To search for articles, those containing the descriptors "matrix support" OR "institutional support" in the title were filtered. Free full-text texts published between 2005 and 2016 were included, totaling 199 works. Of these, theses, dissertations and informative materials were excluded, totaling 188 articles.

The sample selection was performed by 5 researchers and based on two criteria: reading the titles and abstracts of the articles and, later, critical reading of the articles selected in the previous step. Articles that were repeated or that did not meet these criteria were excluded. Only those publications whose data refer to the objectives of this study remained in the final sample.

The pre-selection took place by reading the titles and abstracts of the 188 articles, of which 152 were excluded, as they did not specifically refer to AM and AI. In the end, 36 articles were included, which were read in full, and critically, totaling 15 articles consistent with the objectives of the study.

The final sample was systematized in Table 1, which displays the following information: title, year, study location, study method, journal/journal of publication and authors.

Next, the content analysis by categorization proposed by Bardin (2011) was developed. Subsequently, in the phase of interpretation of the results, the potentialities and obstacles of AM and AI were analyzed in the light of different authors.[2]

The obstacles are presented in three nuclei of meanings: Health care model: questioning the fragmentation of care; Challenges to the supporters' work process; and Daily work in health. Potentialities, on the other hand, comprise five nuclei of meanings: Permanent Education in Health (EPS); Changes in work processes and the team's view of health conditions; Team meetings; Changes in the management of work processes; and Team's perception of Matrix Support.

Results

When analyzing the studies included in this integrative review, six were developed in the state of São Paulo, where the Paideia method was created; in sequence, three studies were developed in the Brazilian Northeast, the region with the highest concentration of NASF teams, which, predominantly, act as supporters of the ESF teams. The oldest study included in the analysis is from 2009, which discussed the performance of teams in the mental health care network. The last study analyzed was published in 2016, which describes the impact of the actions of the team of supporters in Primary Health Care (PHC).

The categories regarding the potential and obstacles of AM and AI mentioned above are described below. It should be noted that the potential and obstacles were observed in the 15 articles analyzed, which means that an article may have been cited in more than one category.

Potential of matrix and institutional support in the work processes of health teams

Permanent Education in Health

Six articles were selected that highlighted EPS as a potentiality of AM. The articles in this category describe the importance of AM performed by NASF or CAPS professionals with ABS teams. In this way, the knowledge of the FHS teams about mental health care was expanded, breaking with prejudices and taboos.

Changes in work processes and the team's view of health conditions

This category consists of nine articles that describe the changes in work processes and the team's view of the population's health conditions as the potential of BF.[3,14,16,21,31] The articles describe that BF produced greater co-responsibility in the cases, making the teams work together, especially about the relationship between the ABS teams and specialized care.

Team meetings

This category consists of six articles that describe the impact of AM and AI on teamwork. It is identified that from the supporters' actions, the matrixed teams started to prioritize team meetings, in addition to instituting spaces for reflection on practices and discussion of cases, bringing together areas of knowledge.[3,8,10,14,26,33]

Table 1. Information about the publications analyzed

Study Code	Title/year	Study setting	Method	Journal	Authors
A1	Accessibility and resolution of mental health care: the experience of matrix support (2013)	Sobral and Fortaleza – CE	Qualitative	Ciência e Saúde Coletiva	Quinderé et al.
A2	Democratic management and institutional support practices in Primary Health Care in the Federal District, Brazil (2016)	Federal District	Qualitative	Cad. Saúde Pública	Cardoso; Oliveira and Furlan
A3	Institutional support as a pillar in the co-management of primary health care: the experience of the Program TEIAS - School manguinhos in Rio de Janeiro, Brazil (2014)	Manguinhos – RJ	Experience report	Ciência e Saúde Coletiva	Casanova, Teixeira and Montenegro
A4	Matrix support and reference team: a methodology for the management of interdisciplinary work in health (2007)	Campinas – SP	Literature review	Cad. Saúde Pública	Campos and Domitti
A5	Work of the matrix supporter: difficulties in the scope of primary health care (2014)	João Pessoa- PB	Qualitative	Revista Gaúcha de Enfermagem	Romera et al.
A6	Matrix support: a device for solving clinical cases of mental health in Primary Health Care (2013)	Fortaleza – CE	Qualitative	Revista Brasileira de Enfermagem	Jorge, Sousa and Franco
A7	Mental health in the Family Health Strategy: evaluation of matrix support (2010)	Porto Alegre – RS	Qualitative	Revista Brasileira de Enfermagem	Mielke e Olchowsky
A8	Mental health in primary health care: an evaluative study in a large Brazilian city (2011)	Campinas – SP	Qualitative	Ciência e Saúde Coletiva	Campos et al.
A9	Mental health in primary health care in Campinas, Sao Paulo: a network or a tangle? (2009)	Campinas –SP	Qualitative	Ciência e Saúde Coletiva	Figueiredo and Campos
A10	The insertion of the nutritionist in Primary Care: a proposal for the matrix support of nutritional care (2015)	Campinas - SP	Quantitative	Ciência e Saúde Coletiva	Borelli et al.
A11	The perspective of primary health care professionals on matrix support in mental health (2015)	Porto Alegre - RS	Qualitative	Ciência e Saúde Coletiva	Hirdes
A12	Evaluation of innovative strategies in the organization of Primary Health Care (2012)	Campinas - SP	Qualitative	Revista Saúde Pública	Onocko-Campos et al.
A13	Institutional and matrix support and its relationship with care in primary care (2015)	Minas Gerais Brazil	Quantitative	Revista Saúde Pública	Santos et al.
A14	Matrix support in SUS Campinas: analysis of the consolidation of interprofessional practice in the health network (2016)	Campinas - SP	Quantitative	Ciência e Saúde Coletiva	Castro, Oliveira and Campos
A15	Matrix support strategy: the experience of two teams from the Family Health Support Center (NASF) in the city of São Paulo, Brazil (2015)	Sao Paulo - SP	Qualitative	Ciência e Saúde Coletiva	Barros et al.

Source: by the authors.

Changes in the management of work processes

The four articles that made up this category highlighted the potential of co-management in the production of autonomy and reflection on work processes and their impact on management. In this sense, spaces that prioritize dialogue, teamwork and comprehensive care as a guiding axis of health care result in the approximation between professionals and social control.[7,10,11]

Team's perception of matrix support

The last category addresses the teams' perception of AM. The analysis of the four articles clearly showed that AM is established in services that provide care to people with psychological distress. Initiatives of supporters working in other services were also identified, such as CAPS Alcohol and Drugs, the Casa do Idoso and the Municipal Pharmacy, promoting the exchange of knowledge and the expansion of understanding about health work. Thus, support teams that are composed of different health professionals have privileged conditions to provide spaces for reflection on practices, covering discussions according to the needs of the territories.[13,20]

Obstacles of matrix and institutional support in the work processes of health teams

Health care model: problematizing the fragmentation of care

The category consists of eight articles. It was possible to identify that most of the articles deal with the relationship established between specialized services and APS, concerning the difficulty of establishing care networks for people with psychological distress.[3,8,9,11,20,21,26,31]

Challenges to the work process of supporters

The category consists of ten articles and deals with the challenges of supporters and AM as work in action. Most of the articles describe the difficulty for teams to understand what AM is and what the role of the supporter is. In addition, they address the difficulties of the supporter in assuming responsibilities in carrying out the BF, such as identifying the different profiles of the teams and organization and time management.[3,7,11,14,16,20,21,26,31,33]

Daily work in health

This category consists of ten articles that address workers' perceptions of their work process. The difficulties of teamwork, the absence of self-management, the lack of communication and the decision-making centered on the physician stand out. Workers report that the low qualification of the teams, added to the excess work overload, results in traditional clinical approaches and a lack of recognition from users.[3,7-11,14,21,26,33]

Discussion

Potential of matrix and institutional support in the work processes of health teams

Among the potential of AM and AI, it is understood that EPS is one of the most important. There are many expectations placed on the NASF, among them is the increase in the resolution of APS linked to the idea of the potential of interdisciplinary work of NASF professionals and family health teams, as well as easier access to health services by the reorganization of demand and reduced demand for secondary and tertiary care services as a gateway to the health system.[34]

The *in-loco* training carried out by supporters and some agreed actions, such as workshops on specific themes, individual consultations, case assessment and home visits, were essential for expanding the knowledge of ABS professionals about some specificities of the service.[3,16,26] In this way, the assumptions described in the 2004 National Policy on Permanent Education in Health, which emphasize learning at work, where learning and teaching are incorporated into the daily life of organizations and work, are contemplated in AM meetings. Given the above, professionals realized that EPS is linked to AM, enabling the improvement of care for users.[24]

Specifically, the training on mental health that took place through the AM, but was carried out by professionals working at the CAPS, qualified the care provided to users, so that all professionals reported feeling more appropriate to assess, identify, intervene and welcome users with disabilities. mental disorders, which before, often went unnoticed, due to the lack of knowledge and preparation of the team.[16,21,33]

Another aspect enhanced by the AM refers that the possibility of thinking and discussing the daily work reflecting on the organization of work and the circulation of information between the health services, facilitating the performance of mental health actions in the territory and contemplating health promotion actions. In this sense, the AM is seen as a potentiator of new care strategies, such as the development of educational therapeutic groups and workshops with specific themes.[3,16,26]

Creating spaces for workers to observe and discuss their care practices encourages (re)thinking and modification, which are rooted in health systems. EPS spaces are important tools for the qualification of work due to the possibility of sharing ideas and voices that build and deconstruct stabilized concepts, evidencing a collaborative and collective construction. The authors highlight the suggestion of collectively discussing the work processes of health services, to carry out humanized care and carry out teamwork, which is one of the desired changes in the health care model.[12]

Gomes et al.[19] emphasize that EPS spaces enable the emergence of the health teams' needs through discussion and collective sharing of perceptions about cases, as well as evidence of individual commitment to solving problems related to the health care of patients. users. From this space for debate, the overcoming of discussions predominantly on operational issues was observed, emerging space for dialogue and exchange of relevant information about the cases and the specificities of the performance of each professional.

In addition, the AM guaranteed spaces for reflection and evaluation of the actions developed, enabling the approach to problems from new perspectives and the construction of new work logic among professionals. Thus, unnecessary referrals were avoided, making it possible to work on the bond between users and the team, favoring the user's autonomy and quality of life.[3,9,21]

Another aspect highlighted the perception of the teams about the AM to help in the sharing of responsibilities and their commitment to the implementation and application of AM actions. This methodology can be expressed as a link between the team and the user, as it strengthens their reception and that of their families in the care network. Thus, the AM is understood as a powerful space, which promotes the encounter with the other and with the field of mental health, allowing issues not previously perceived by the ESF professionals.[13,16,21,31]

Similar to the findings of this integrative review, Machado and Camatta[22] pointed out as positive aspects the collective construction of knowledge, better communication between workers and greater diffusion of BF as an articulator of interprofessional relations between specialized services and APS. The AM favors the reorganization of health workers and the implementation of co-management in the daily life of services through the implementation of permanent spaces to rethink the work process and enable the transformation of practices[13], positively impacting the health conditions of users.

The team meetings were also potentialities brought by the analyzed articles. Regarding the AI, the impacts of the developed actions referred specifically to the constitution of an organizational chart to identify the difficulties regarding the actions developed by the teams, listing the competencies of each actor involved in the processes and in the organization of monthly meetings, which allowed the analysis of the work process. Likewise,

AM also impacted the organization to team meetings. This space started to be prioritized by the teams to discuss intervention plans, with the integration of Community Health Agents, including the organization of teams by area of activity for the discussion of cases. Thus, team meetings enable the development of activities and collective agreements.[3,8,13]

The studies also highlight a result the possibility of problematizing the actions of the team, planning ways to face the challenges presented in the management of care in the ABS and identifying the need to articulate with the social and health services of the territory to develop actions and strategies with views of intersectionality.[33]

Another important category related to the potential of AI changes in the management of work processes. The final result of AI is horizontal, autonomous management and greater accountability of workers. Therefore, it is important to highlight that the institutional supporter is configured as a subject, who is not exempt from feelings such as fear, doubts, or anguish, but who helps in the organization of services and in the creation of a space where there is interprofessional integration.[7,10, 11]

Maerchner[23] highlights that the organization of work processes, the exchange of experience through the interaction of subjects, and decision-making in a consensual and group way, as well as the planning and fulfillment of tasks, actively collaborate with the autonomy of those involved in the processes of the job. The author complements AI as a transformer of practices and provides opportunities for other areas and sectors to participate in the construction of the work. The importance of clear management participation versus supporter participation is raised, so that there is no decentralization of decisions, avoiding intra-team fragmentation and disagreements.

The team's perception of AM is also one of the potentialities observed. The homogeneity among NASF workers concerning the conceptual understanding of the support proposal, its importance and the mission to implement it, was provided by the exchange of experiences and theoretical-practical knowledge, aiming at expanding the possibilities of understanding and acting in cases. Thus, matrix support would imply the democratization of knowledge, discussion, reflection and agreement on responsibilities for the continuity of actions.[3] The importance of investing in the bond between supporters and the reference team is highlighted, as the team's constancy becomes fundamental for the analysis of the impacts of the actions developed.[10]

Obstacles of matrix and institutional support in the work processes of health teams

The health care model was one of the obstacles found in the analyzed articles. Talking about a health care model is talking about the articulation of different levels of complexity, its organization to meet the different types of health care demands and the articulation of the network is offering the answer to the user, promoting communication within the team and between professionals and user, providing coherent effective and resolute health care.[28]

Mental health care has been the focus of discussion and problematization in the field of health. Thus, when the teams' difficulty in proposing actions and defining care networks is identified in the articles, it is not surprising. The teams and professionals, when reporting their difficulties regarding mental health, show their weaknesses in the problematization of their practices and also, perhaps, the fragility of training.[31]

One of the articles reports that there is a rush of professionals concerning referrals from health centers to Psychosocial Care Centers (CAPS), since, in most cases, ABS workers feel insecure in following up on mental health cases. Difficulties that have direct repercussions on accessibility, that is, on the relationship between the supply of services and the impact of the population's capacity to use them, which are often irregular and make it impossible to resolve assistance in meeting the population's health needs.[31]

Integrality is one of the main guidelines of the SUS and is based on understanding the subject and his/her health demand. This is given by the reception and bond made between professional and user. It consists of the horizontalization of care, and articulation between the professionals of the units to identify situations of health risk and promote collective activities in the health territory consistent with the demand.[29]

In this sense, thinking about health assessment and teamwork, when we analyze the articles that report experiences of support - whether matrix or institutional - they point to the need for discussion of cases, but care actions are fragmented, according to the specialties of professionals.[3,8,20,26]

Gomes and collaborators[19], when problematizing the work, understand that the actions of the teams must occur in a synchronized way, “like an orchestra composed of several melodies, each one with its responsibilities weaving the care network”, so that, in this way, they can be Strategies were formulated that allow dealing with the peculiarities of the health demands that arise, taking care not to fall into the fragmentation of care, directing the demands to the specialties.

Thus, when we problematize the health care model, which is expressed in fragmented care and the difficulty of team and network work, we inevitably refer to health training. Although the National Curriculum Guidelines for Health Courses indicate the training of competent professionals for interprofessional work, the performance of comprehensive care actions and (intersectoral) networking, a large number of health workers are still perceived - and the articles /research evidence these difficulties and weaknesses - failing to operate with the principles and guidelines of the SUS.

There are many challenges during the supporters' work process. ABS workers' lack of knowledge about AM reflects the difficulty or lack of commitment of the teams in understanding the role of the supporter.

Supporters play the role of expanding people's ability to deal with power, with the circulation of affections and knowledge, while at the same time they are working and fulfilling tasks. For the supporter to be able to carry out their functions, it is important that collective spaces exist or that these spaces are created or reformulated with their support.[10]

We understand the supporting role in the insertion of the work context of the teams, helping in the analysis of the management and the organization of their work process, in the construction of collective spaces beyond the teams, "transversalizing" other actors in the health area and different sectors and disseminating the ability to build social groups in the community.[23]

With the supporter's work, a new process of resistance begins, with the active construction of new institutions, new paradigms in health, new sociability and new relationships based on democracy. The idea of support is, as we understand it, inextricably linked to the idea of co-management of these relationships: co-management of power relationships, health work and even co-management of self-government.[1]

Some authors, when studying the work process of the AI team, draw attention to both the existence of supporters with intense workloads and the precariousness of employment relationships, noting that, in some situations, supporters are unable to fulfill the agenda with the teams due to the great demands of the state secretariats and the federal government. Likewise, research shows that in recent years there has been a certain “political disinvestment in support, as a working methodology”. This situation, in the authors' view, makes it difficult for institutional supporters to do, in the sense that they cannot develop their work, according to the methodological proposal.[4,15,25]

The daily work in health is also shown to be an obstacle for AI and AM. The analyzed works highlight that the implementation of AM in Health Units is hampered by the lack of intersectoral and interprofessional work. The little variety of specialists, as well as the resistance of professionals in reorganizing agendas for the full participation of the team in the meetings, demonstrate that support is not a priority for the teams.[7,14]

Another point highlighted is the complexity of the health territory, which impacts work processes due to the accelerated demographic transition and the marked presence of drug trafficking and violence in several municipalities in our country. Failures in the management of work processes and the lack of reflection on it, as well as the lack of intra-team communication and the unavailability of professionals, make work and the practices of joint actions difficult, resulting in practices centered on the biomedical model of care in health.[3,10,11,18,26,35]

Simões and Freitas[35], in a study carried out with a family health team involving a case in a situation of social vulnerability, reported that the teams, despite the difficulties, understand that the work must be done, even though improvisation in the work processes is the main key to accessing this population. The teams perceive a vicious cycle in which poor living conditions lead the new generations to find a way to drugs. Added to this, the teams blame the population for the environment and reality they live in: lack of education and hygiene, littering and lack of interest. In line with this, the article by Casanova and Teixeira[11] shows that the health territory is an influencer of work processes.

Frutuoso et al.[18] carried out a study with four managers and three professionals from a city in the interior of São Paulo on the management and production of health in vulnerable territories and observed that most families living in this reality are needy and demand more attention, then any and every action performed generates a great effect. Managers mention that the demands for punctual and emergency results make it difficult to carry out planned actions, affecting the primary level of health care.

From the worker's point of view, the obstacles to the implementation of AM, identified in the articles, refer to the team's lack of motivation arising from the lack of recognition in their work and the overload generated by the care practice centered on the complaint. In addition to these factors, the view of the disease as a focus of treatment, a culture of assistance, lack of prevention and health promotion actions and the encouragement of drug treatment without full monitoring of the user stand out.[8,9,21]

The study carried out by Campos and Malik[6] with 242 ESF doctors showed that the dissatisfaction of doctors in these teams is triggered mainly by the presence of stress, a precarious physical environment and lack of training. Satisfaction is due to factors such as skills, confidence in the work and the team, quality of service and care, adherence and unit and team meetings. Physicians' satisfaction varies according to their turnover in the ESF.

Alves Filho and Borges[17] highlighted that the work motivation of health professionals at Basic Health Units in Natal, RN, results from the interaction between individual and environmental aspects and the effort or pressure to which a worker is submitted to perform his tasks. From the analyses, it was observed that 52.8% of the professionals are motivated at a higher moderate level. In the lower moderate motivational force, 36.2% of professionals are found. In the degree of a lot of demotivation or a lot of motivation, there are few people (11%). Also in this study, there is a comparison that demonstrates that over 13 years (2001-2014) the expectations of health professionals remain quantitatively similar, despite the factors being different.

In the measures of motivational strength, differences were noted: the number of professionals in the “positive motivational strength” index decreased, and in the “negative motivational strength” index, it increased, that is, professionals felt less motivated over time. These data can be related to the findings in the articles of this integrative review, in which workers' lack of motivation is shown to be an obstacle to the implementation of AM.

Wisniewski, Silva et al[36] carried out a study with 64 nurses and 148 nursing technicians from three hospitals named philanthropic, private and public. From questionnaires, it was observed that gender, training time, sector and work shift, number and type of employment relationship, team size, sector accommodation, safety to perform work, occupational medicine, job satisfaction, task distribution, stimulus given by the work environment (hospital) and appreciation of work by the immediate superior are significant factors in the evaluation of satisfaction and dissatisfaction at work. These observations indicate, similarly to the results of the analyzed articles, that both sociodemographic and professional characteristics, constitutive elements of working conditions, as well as relationships at work, are all factors that determine satisfaction in the work environment.

Given the above, it is clear that the professionals of the team report difficulties in understanding the role of the supporter in the development of activities with the teams. Added to this scenario is the absence of political investment for the development of support actions, impacting the identification of the different profiles that make up a team.

Still, concerning obstacles, the analysis showed that the motivation of workers is composed of individual and environmental elements. These difficulties stem from the lack of self-management and intra-team communication. The centralization of actions in the figure of the medical professional, as well as the work overload and the low qualification of the team, are factors that directly impact the motivation of professionals.

The complexity involved in working in the health area must be highlighted. The relationships between the population's lack of self-care about their health and care for the health environment, also considering the demographic transition, stress the qualification of the team for the care, which in practice can generate demotivation for workers.

In this context, for the changes to be implemented in fact, it is necessary to prioritize the meetings between the health team, so that there is the development of activities and collective agreements and intersectoral actions, through the identification of the priority health needs of users and the consequent planning of care actions. These changes in the team imply work relationships, providing horizontal, autonomous management and greater responsibility on the part of the workers.

Ultimately, from the supporters' point of view, it is noteworthy that the articles point to the need to provide spaces for reflection on practices, and that support teams must be interprofessional, covering discussions according to the needs of the territories. Thus, the exchange of experiences and knowledge aims to expand the possibilities of understanding and acting in cases.

Conclusion

This study aimed to gather publications that cover AM and AI, in search of results that highlight the potential and obstacles to the implementation of these devices in the work processes of health teams, especially concerning AB.

The obstacles identified in the analyzed productions refer to the permanence of the fragmentation of care that reflects the absence of comprehensive care for users. These difficulties are mainly expressed in mental health care, when the insecurity of health professionals regarding the development of care was identified, resulting in the non-sharing of care strategies among professionals.

Even with the obstacles found in the use of AM and AI, the described potentialities overlapped, since as support is being applied, they are understood as effective tools by health teams and managers.

Conflict of interests

The authors declare that there is no potential conflict of interest.

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