

Challenges and Potentialities of the Chronic Care Model

Desafios e Potencialidades do Modelo de Atenção às Condições Crônicas

Desafíos y Potencialidades del Modelo de Atención a las Condiciones Crónicas

RESUMO

Objetivo: Revisar a literatura sobre os desafios e potencialidades na implementação de modelos de atenção às condições crônicas na Atenção Primária à Saúde no Brasil. **Método:** Revisão integrativa de estudos publicados nos últimos quinze anos, envolvendo populações adultas e idosas, em português, inglês ou espanhol. Foram consultadas bases de dados internacionais e documentos oficiais de organizações de saúde. A qualidade metodológica foi avaliada por instrumento específico de análise crítica. **Resultados:** Identificaram-se como principais desafios a ausência de planejamento integrado, a limitação de recursos financeiros, as falhas de comunicação entre diferentes níveis de atenção, o baixo engajamento comunitário e a capacitação insuficiente dos profissionais. Entre as potencialidades, destacam-se a centralidade do cuidado na pessoa, a possibilidade de integração multiprofissional e a promoção da autonomia dos pacientes. **Conclusão:** O fortalecimento da Atenção Primária, com modelos que assegurem continuidade do cuidado, participação ativa dos usuários e apoio ao autocuidado, é essencial para reduzir a fragmentação do sistema de saúde.

DESCRIPTORES: Doença crônica; Doenças não transmissíveis; Modelos de assistência à saúde; Atenção à saúde.

ABSTRACT

Objective: To review the literature on challenges and potentialities in the implementation of care models for chronic conditions in Primary Health Care in Brazil. **Method:** Integrative review of studies published in the last fifteen years, focused on adult and older populations, in Portuguese, English, or Spanish. International databases and official health organization documents were consulted. Methodological quality was assessed using a critical appraisal tool. **Result:** The main challenges identified were the lack of integrated planning, limited financial resources, communication failures between levels of care, low community engagement, and insufficient professional training. Potentialities included person-centered care, multiprofessional integration, and patient empowerment. **Conclusion:** Strengthening Primary Health Care with models that ensure care continuity, active patient participation, and support for self-care is essential to reduce the fragmentation of the health system.

DESCRIPTORS: Chronic disease; Noncommunicable diseases; Health care models; Health care.

RESUMEN

Objetivo: Revisar la literatura sobre los desafíos y potencialidades en la implementación de modelos de atención a condiciones crónicas en la Atención Primaria de Salud en Brasil. **Método:** Revisión integradora de estudios publicados en los últimos quince años, centrados en poblaciones adultas y mayores, en portugués, inglés o español. Se consultaron bases de datos internacionales y documentos oficiales de organizaciones de salud. La calidad metodológica fue evaluada mediante herramienta de análisis crítico. **Resultado:** Los principales desafíos identificados fueron la falta de planificación integrada, los recursos financieros limitados, las fallas de comunicación entre los niveles de atención, el bajo compromiso comunitario y la capacitación insuficiente de los profesionales. Entre las potencialidades se destacaron el cuidado centrado en la persona, la integración multiprofesional y el fortalecimiento de la autonomía del paciente. **Conclusión:** El fortalecimiento de la Atención Primaria, mediante modelos que aseguren continuidad del cuidado, participación activa de los usuarios y apoyo al autocuidado, es fundamental para reducir la fragmentación del sistema de salud.

DESCRIPTORES: Enfermedad crónica; Enfermedades no transmisibles; Modelos de atención a la salud; Atención a la salud.

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**Melissa Galvão de Andrade**

Specialist in Family and Community Medicine. Master's student in Anthropology at the Federal University of Pernambuco (UFPE). Residency in Family and Community Medicine at the University of Pernambuco (UPE). Bachelor's degree in Medicine from the Federal University of Pernambuco (UFPE). ORCID: <https://orcid.org/0009-0009-3056-0379>

INTRODUCTION

Chronic conditions represent one of the greatest challenges to global public health, accounting for a large proportion of premature deaths, loss of quality of life, and high economic costs. In Brazil, cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases account for the highest morbidity and mortality rates, in a scenario aggravated by an aging population and the triple burden of disease, which also includes infectious diseases and external causes⁽¹⁾. The mortality rate from chronic noncommunicable diseases in the country, in people aged 30 years or older, is about 600 per 100,000 inhabitants, which is higher than that observed in countries such as Canada and the United Kingdom⁽²⁾.

The traditional care model, based on acute episodes of disease and etio-pathogenic classifications, is insufficient to deal with the complexity of these conditions. In this context, the proposal for "Health Conditions" has emerged, which encompasses not only chronic diseases but also persistent infectious conditions and situations related to the maternal-child cycle⁽³⁾. This perspective underpins the Chronic Conditions Care Model (MACC), which seeks to overcome the fragmentation of care through an integrated, continuous, and per-

son-centered approach⁽⁴⁾. Primary Health Care (PHC) is identified as the coordinator of this process, due to its ability to articulate different levels of care and strengthen links between services, patients, and the community⁽³⁾.

Strengthening Primary Health Care and adopting innovative models of chronic care is crucial not only for improving patients' quality of life but also for the sustainability of the health system. However, gaps related to integrated planning, professional training, and intersectoral coordination persist, compromising the effectiveness of these proposals⁽⁵⁾. Given this scenario, this study aims to review the literature on the challenges and potentialities in implementing models of care for chronic conditions in Primary Health Care in Brazil.

METHOD

This study consists of an integrative literature review, an approach chosen because it allows the combination of data from theoretical and empirical studies, thus offering a broader and deeper understanding of the topic of interest. To conduct the study, we followed the steps recommended in the literature with adaptations⁽⁶⁾:

Formulation of the guiding question: The first step consisted of a clear and specific definition of the

topic of interest, followed by the formulation of the guiding question that guides the entire review. The research question established was: *"What are the challenges and potentialities in the implementation of models of care for patients with chronic conditions in Primary Health Care in Brazil?"*

Establishment of Criteria for Inclusion and Exclusion of Studies: Clear criteria were defined for the inclusion and exclusion of studies to be analyzed. The inclusion criteria were: articles published in the last 15 years, available in Portuguese, English, or Spanish, focusing on adult and elderly populations, as well as original works that report implementation experiences in Brazil. The exclusion criteria included: duplicate studies, those that did not meet the objective of the integrative review, studies outside the context of PHC, and texts that were not freely available in their entirety.

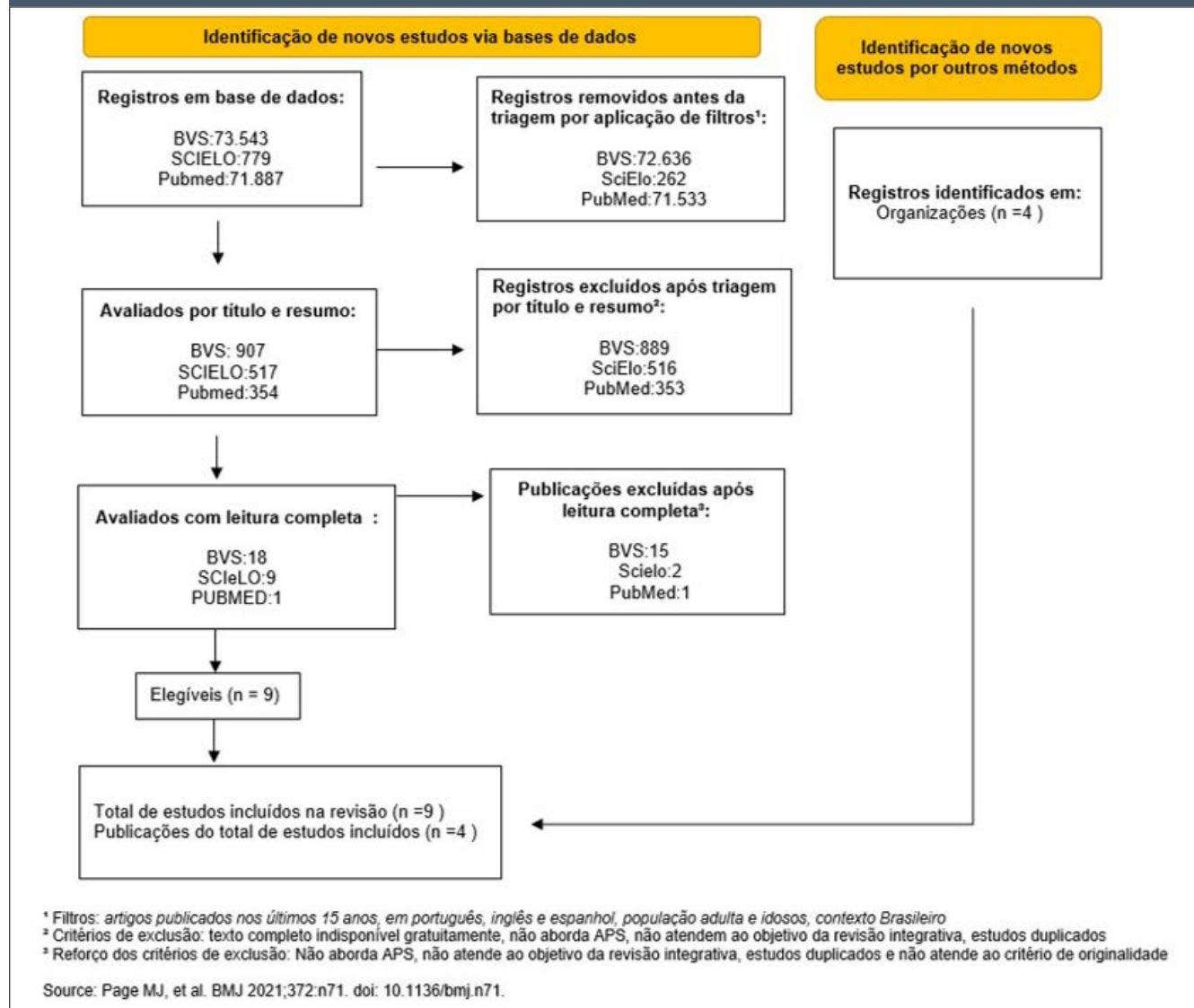
Literature Search: The search for studies was conducted in documents from the World Health Organization (WHO), the Pan American Health Organization (PAHO), the Brazilian Government, and electronic databases, including PubMed, SciELO, and BVS. Descriptors and their combinations in Portuguese and English were used, such as: ((chronic disease) OR (noncommunicable disease) OR (doença crônica) OR (doenças não

transmissíveis)) AND ((healthcare models) OR (delivery of health care) OR (modelos de assistência à saúde)

OR (atenção à saúde)). “AND (Brazil[Affiliation])” was used in PubMed due to the absence of a specific filter.

The detailed steps of the study selection process are illustrated in the flowchart in Figure 1.

Figure 1 - Flowchart of the article selection process



Critical Appraisal of Included Studies: Eligible studies were critically appraised for methodological rigor and relevance of results. For this purpose, evaluation criteria based on the Critical Appraisal Skill Programme (CASP)⁽⁷⁾ were applied. An instrument adapted from CASP was used, which included 10 items to be scored, including: 1) objective;

2) appropriateness of the method; 3) presentation of theoretical and methodological procedures; 4) sample selection criteria; 5) sample details; 6) relationship between researchers and participants (randomization/blinding); 7) respect for ethical aspects; 8) rigor in data analysis; 9) adequacy in the discussion of results; and 10) contributions and limitations of

the research. Finally, the studies were classified as level A (score between 6 and 10), indicating good methodological quality and reduced bias, or level B (up to 5 points), suggesting satisfactory methodological quality but with an increased risk of bias.

Interpretation of Results and Knowledge Synthesis: After the initial selection, 13 articles were in-

cluded, all classified as level A in methodological quality, according to the adapted CASP instrument. The challenges and potentialities identified

in each study were grouped according to their similarities, facilitating the evaluation of the most recurrent topics. Based on this, a table

was created that gathers important information for comparison with the existing literature on the subject:

Table 1 – Analysis of publications

Title	Location and Year	Challenges	Potentialities
Evaluation of the implementation of the Health Care Network for people with chronic noncommunicable diseases in a health district in the municipality of Recife – Pernambuco. (8)	PE, 2015	Fragmentation of services Deficiencies in the support structure Inadequate coordination between levels of care Problems in diagnosis and follow-up	Existence of specific coordination Coherent municipal plans Manager involvement Interdependence between network components
Evaluation of the implementation of the Leprosy Control Program in Camaragibe, Pernambuco. (9)	PE, 2017	Fragmentation of actions Insufficient infrastructure Lack of training Difficulty in monitoring Lack of social mobilization	Presence of coordinators and technical teams Availability of medicines Functional information system and equipment Action Plans Under Development
Challenges and lessons from a primary care intervention in a Brazilian municipality. (10)	MG, 2019	Weaknesses in the organization of diagnostic tests Limited use of electronic information systems Mixed health system Training and engagement of health professionals	Universal coverage of the ESF Strengthening the role of community health workers Coordination between levels of care Effective local management
The challenges of municipal planning from the perspective of nurse managers. (11)	RS, 2020	Difficulties in structuring the care network Insufficient training of professionals Limited integration between levels of care Resistance to change	Support for self-care Longitudinal and comprehensive care Community involvement Development of clinical protocols
Consolidating the Chronic Conditions Care Network: the experience of the Hiperdia Network in Minas Gerais. (12)	MG, 2011	Fragmentation of the care model Insufficient access to specialized services Adaptation of the Health System Professional Training: Resistance to Change:	Improvement in Quality of Care Reduction of costs related to hospitalizations and complications Multidisciplinary and scheduled care Professional and user satisfaction Prevention of serious complications
Challenges in implementing the chronic care model from the perspective of managers in the state of Paraná. (13)	PR, 2021	Lack of integration with hospital care Resistance to change in the work process Insufficient Training and Continuing Education Lack of Consistent Political and Financial Support	Continuing education as a tool for transformation Leadership of managers Improvement in the quality of care in the lines of attention Adoption of new care profiles
Comparative study of innovations in chronic conditions in primary care in Porto Alegre, RS, Brazil, and Ferrara, Italy. (14)	RS, 2020	Resistance to innovative practices Fragmented work culture Inadequate Professional Training Fragmented and Productivity-Oriented Management:	Continuing Education in Health Focus on Self-Care and Health Promotion Multidisciplinary Care Model
Institutionalization of chronic condition care practices and care management in primary care. (15)	RS, 2021	Resistance to Change Lack of Collective Engagement Work Overload Management Focused on Quantitative Results Lack of Dialogue and Support for Professionals	Continuing education and collective reflection Innovative Care Group Multidisciplinary and Sequential Care Professional Autonomy
Laboratory for Innovations in Chronic Condition Care in Primary Health Care: implementation of the Chronic Condition Care Model at the Alvorada Primary Health Care Center in Curitiba, Paraná. (16)	PR, 2013	Adaptation of the Model to the Reality of the SUS Risk Stratification and Clinical Management Information and Monitoring Systems Resistance to New Care Technologies	Support for Self-Care Shared Care Training and Continuing Education Support from Partner Institutions

Care pathways: high blood pressure and diabetes. (17)	SP, 2010	Fragmentation of Care Lack of Training and Continuing Education Insufficient Integration with Community Resources Difficulties in Stratification and Follow-up of Patients	Integrated Management Model Support for Self-Care Health Education and Therapeutic Groups Use of assessment tools (ACIC)
Perception of innovations in the care of chronic diseases/conditions: an evaluative study in Curitiba. (18)	PR, 2014	Fragmentation of care Lack of Training and Continuing Education Insufficient Integration with Community Resources Difficulties in Stratification and Follow-up of Patients Resistance to Paradigm Shift Professional Training Infrastructure and Resources Integration between Community and Services	Supported Self-Care Shared Care Monitoring and Evaluation Capacity Patient satisfaction
QualiDia Project: health education for self-care and continuous evaluation of the quality of diabetes care in Brazil. (19)	PE, SC, ES, RJ, 2012	Lack of Integration and Continuity of Care: Training of Health Professionals Monitoring and Evaluation of Care: Limited Resources	Strengthening Self-Care Shared Care Model Use of monitoring tools (ACIC) Successful experiences and technical cooperation
Healthcare Network for Diabetes Mellitus Patients: an analysis of its implementation in the SUS in Recife (PE). (20)	PE, 2015	Partial Implementation of the Care Network Lack of Risk Stratification Deficiencies in Counter-referral Problems in the Logistics System Insufficient Training and Qualification	Political Support for Network Implementation Structuring of lines of care Strengthening primary care Existence of support systems

RESULTS

In the 13 articles analyzed, the main challenges identified were: fragmentation of the health system and lack of coordination between levels of care^(8,9,11,13,17,19), insufficient infrastructure and resources^(8,10,11,18,20), training and continuing education for professionals^(9,10,12,17), resistance to cultural change^(12,14,15), inadequate individual and collective monitoring and management^(8,16,19), and limited community integration^(9,17,18).

The main potentialities highlighted were: specific coordination and management for chronic diseases with the involvement of managers and technical support in various regions^(8,9,10,13,20), integrated planning and strengthening of Primary Care, favoring the creation of care flows and integration of the health network^(8,20). Monitoring and evaluation tools were also mentioned, such as the use of ACIC and PACIC^(9,18,19), continuing education and training of health professionals^(13,14,16), support for self-care and patient involve-

ment^(11,14,19), and multidisciplinary care^(12,14,16).

DISCUSSION

Challenges and Limitations

The fragmentation of health services in Brazil compromises coordination between different levels of care, from PHC to specialized care, hindering the control of chronic diseases and continuity of care^(8,11,13). The WHO report highlights that "current health systems are not designed to address chronic problems, compromising the coordination and continuity of care"⁽²¹⁾. This problem is especially relevant in the Brazilian context, where integration between PHC and specialized care faces significant barriers.

The lack of effective communication and integrated protocols, coupled with the coexistence of public and private systems, weakens public control^(8,9,10). According to a study by Health Quality Ontario, the lack of protocols and poor communication between different levels of care negatively affect

the management of chronic diseases. The study suggests that the implementation of integrated protocols can improve care and reduce fragmentation⁽²²⁾. The Institute for Health Policy Studies points out that "the coexistence of public and private health systems in Brazil weakens public control and creates inequalities in access to specialized care"⁽²³⁾, impacting the control of chronic conditions and limiting the effectiveness of the SUS.

Limited access to specialized care, coupled with the inefficiency of the counter-referral process, aggravates the situation^(12,20), reinforcing the need for improvements in the Unified Health System (SUS)^(11,19). The epidemiological bulletin notes that bottlenecks in access to specialized services and failures in the counter-referral process hinder the adequate monitoring of patients with chronic diseases⁽²⁴⁾, pointing to the urgent need for a more integrated and efficient system.

The resistance of professionals and managers to the integrated and multi-professional care model, still focused

on episodic care, is another challenge, perpetuating fragmented practices^(12,13,14). According to the IEPS Panorama (2021), the lack of integration between different levels of care is one of the biggest challenges in implementing care guidelines for chronic non-communicable diseases (CNCDs). In addition, the lack of adequate training for multidisciplinary teams hinders the adoption of a more integrated and continuous care model⁽²³⁾.

The traditional training of health professionals, focused on the biomedical model, restricts the use of interdisciplinary approaches and tools such as clinical management and risk stratification^(9,10,16). The study by Karine Cavalcante da Costa (2015) on the ACIC instrument in the Family Health Strategy shows that many professionals face difficulties in applying essential concepts to the care of chronic conditions. This limitation reflects training centered on the biomedical model, hindering the adoption of interdisciplinary practices⁽²⁵⁾. The WHO report (2005) reinforces the need for intersectoral policies and continuous training to overcome these restrictions and enable a patient-centered approach⁽²⁰⁾.

The lack of adequate ongoing diagnosis, as in the case of diabetics with poor glycemic control, reflects the ineffectiveness of managing these conditions^(8,20). The document "Living Well with Chronic Illness" emphasizes that the lack of adequate diagnosis can lead to preventable complications in conditions such as diabetes, increasing morbidity. The implementation of robust chronic disease management programs is essential to improve health outcomes⁽²⁶⁾.

Management based on productivity indicators, lack of adequate planning, and exclusion of professionals in the development of new management models reinforce the fragmentation of care, particularly harming chronic patients^(14,15). The National Academy of Sciences analysis in "Living Well

with Chronic Illness" describes how management focused on immediate productivity prioritizes short-term results, neglecting preventive and integrated actions. This exacerbates fragmentation and ineffective management of chronic conditions⁽²⁶⁾.

The lack of human, material, and infrastructure resources, such as rooms and diagnostic kits, also exacerbates the situation, mainly affecting the preventive management of conditions such as diabetes and hypertension^(8,11,18). The IEPS Panorama highlights that the lack of trained personnel and the absence of specialized training are challenges in the management of Chronic Noncommunicable Diseases (CNCDs) in PHC in Brazil. The WHO also points out that inadequate infrastructure hinders the effective monitoring and prevention of chronic diseases, resulting in avoidable complications⁽²¹⁾.

These structural problems point to the need for greater investment and improvements in the use of information systems and ongoing government support^(13,19). The WHO document on "Innovative Care for Chronic Conditions" states that the lack of integrated information systems hinders the continuous monitoring of patients with chronic diseases, and investments in technology are essential to reduce fragmentation and ensure quality care⁽²¹⁾.

Potentialities

The commitment of managers is essential to the success of the Health Care Network (RAS) in the management of chronic diseases. In Recife, specific coordination for this population has facilitated policy planning and protocol implementation^(8,9). Mendes (2012) points out that, in contexts with a high prevalence of chronic diseases, such as Brazil, the effectiveness of networks depends on efficient coordination and structured policies that ensure integrated and

continuous care for patients with these conditions⁽¹⁾.

The technical and administrative support provided by state and municipal managers strengthens the control and continuity of care^(8,13). Primary care plays a central role in the RAS, as it ensures the comprehensiveness and longitudinality of the system^(8,20). Mendes (2011) reinforces that, without the integration of primary care, it is difficult to maintain the continuity and comprehensiveness of care, which are essential elements for the effective management of chronic conditions⁽³⁾.

Tools such as Sinan, ACIC, and PACIC are crucial for monitoring the quality of care and facilitating the integration of health teams^(9,18). PAHO (2015) points out that the Chronic Care Model aims to incorporate clinical information systems for monitoring and evaluation, which are essential for improving the quality of services. These tools provide accurate data that allow for adjustments to care protocols and promote more effective integration among multidisciplinary teams⁽⁴⁾.

Continuing Health Education (CHE) has transformed healthcare practices in cities such as Porto Alegre, promoting a more integrated approach^(13,14). The implementation of CHE surpasses traditional methods of education, as it is integrated with continuous professional development. This model values practice and facilitates behavioral and professional changes, resulting in better quality of care⁽³⁾.

Support for self-care has also shown positive results in the management of chronic conditions, increasing patient autonomy^(11,18,19). According to a PAHO document (2015), self-care is vital because it "encourages patients to actively participate in their care," a crucial aspect for improving their quality of life and self-management capacity⁽⁴⁾.

Programs such as Rede Hiperdia Minas, which use protocols and risk stratification, and the Shared Care

(CUCO) model have been effective in coordinating and providing comprehensive care for chronic diseases^(12,14,16). Mendes argues that the implementation of standardized protocols and risk stratification are essential to address the fragmentation of the system and optimize comprehensive care, highlighting the need for coordination between different levels of care^(1,3).

CONCLUSION

The implementation of models of care for patients with chronic conditions in PHC faces significant challenges, such as fragmentation of services, insufficient resources, lack of integration between levels of care, and

resistance to the adoption of innovative practices. However, strengthening PHC as the coordinator of care, adopting integrated patient-centered models, and using monitoring and continuous training tools are examples of potentialities that can transform the management of these conditions.

Despite these possibilities, the Brazilian health system remains structured in a predominantly episodic and reactive manner, inadequate to address the complexity of chronic conditions, which require continuous and integrated approaches. Structural barriers, such as insufficient resources and planning failures, are compounded by cultural limitations, such as the resistance of professionals and managers to paradigm shifts. Traditional training,

centered on the biomedical model, also restricts the use of interdisciplinary strategies and the focus on patient empowerment.

Transforming this scenario requires restructuring that prioritizes strengthening PHC, with consistent investment in public policies, increased resources, continuing education for professionals, and community integration. Only with robust and coordinated PHC will it be possible to reduce fragmentation of care, promote continuity, and ensure the system's responsiveness to the real needs of the population, enabling sustainable advances in the management of chronic conditions and public health in Brazil.

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