

**PERCEPTIONS AND
EXPERIENCES OF
HOME CARE SERVICES:
ELIGIBILITY CRITERIA,
ADMISSION AND
DISMISSAL OF USERS**

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Abstract: Goal: to describe the perceptions and experiences of Home Care Services regarding the eligibility criteria, admission and dismissal of users. **Methods:** qualitative study, with 17 managers and health professionals from Home Care Services linked to state hospitals in Ceará. Data were obtained through semi-structured interviews with the interviewees, in addition to systematic observation and document analysis, and the transcribed information was subjected to thematic-categorical content analysis. **Results:** from the analysis of the participants' discourse, the following categories and subcategories emerged: Perception of home care; Admission process and eligibility criteria; Disconnection of the patient from the Home Care Services. **Conclusion:** From the perceptions and experiences of the managers and health professionals of the Home Care Services, it is emphasized that each of the services has its individualized implementation according to the care profile of the hospital unit to which it is linked, and with the composition of the multidisciplinary team according to the extension of service. The points of similarity in the implementation of the evaluated services are the eligibility criteria and the difficulty of disconnecting the patient from the service. **Keywords:** Home Assistance Services; Home Assistance; Hospital Home Care Services; Public Health Policies; Health Services Research.

INTRODUCTION

The practice of home care has accompanied the evolution of scientific knowledge, available technologies and socioeconomic changes in different countries. The industrialization process combined with scientific discoveries had direct repercussions on the place and the way of providing care to sick individuals, highlighting hospitals as places of high technological density and preferred choice for

curative care. However, the growing cost of medical practices, the change in the profile of morbidity and mortality and population aging have rescued and valued the home space as a therapeutic environment, in a perspective of humanization of health practices⁽¹⁻³⁾.

On the international scene, combined with population aging, and the increase in the chronicity of diseases, the spread of home care in several countries follows, in parallel, the interests of health systems, in the process of dehospitalization, in the turnover of hospital beds, in the reduction hospital costs and individualized and patient-centered care⁽⁴⁻⁶⁾.

In Brazil, the first home care systems were: the Emergency Home Medical Care Service, organized for policyholders and beneficiaries of institutes and retirement and pension funds, linked to the Ministry of Labor, Industry and Commerce; and the home care service created at the State Public Servant Hospital of São Paulo in 1967, with the main objective of reducing the number of occupied beds, and therefore, a restricted type of home care was implemented, encompassing care of low clinical complexity⁽⁷⁻¹⁰⁾.

As of 2006, home care gained new impetus with the advent of the Family Health Strategy, as the primary care strategy, which proposed care centered on the family and on the territory, based on disease prevention, promotion and health care, aiming at the production of new modes of care, the Family Health Team proposes the home visit as a central instrument in the work process of the teams, guaranteeing interaction between the team and the user, knowledge about the environment in which it is inserted, and providing assistance based on comprehensiveness⁽¹¹⁻¹²⁾.

The process of implementing home care in the Unified Health System in Brazil is anchored in several norms for this modality over the last 30 years. In total, there are 19 ordinances dealing with the organization and

implementation of services related to AD: the first deliberated in 1998 and the most recent in 2016. In 1998, in an attempt to organize the provision of AD services, Ordinance Number 2,416, established requirements for accreditation of hospitals and criteria for carrying out home care in the SUS. From then on, the configuration of AD in the SUS gradually took place through the formulation of subsequent and complementary ordinances.

Another milestone in the construction of HC in Brazil was the launch of the Better at Home Program, by the federal government, which incorporated HC into the SUS as one of the components of the Urgencies and Emergencies Care Networks (RUE) and, from this perspective, according to the proposition of Ordinance Number 1,600, of July 2011, must be included in the Health Care Networks (RAS). It reestablished norms for registering SADs and their respective teams, named as follows: Multidisciplinary Home Care Teams (EMAD) and Multidisciplinary Support Teams (EMAP). It also established qualification criteria for health establishments, such as a SAD, to which the EMAD and EMAP would be linked. Then, in 2013, Ordinance Number 963 again redefined AD within the scope of the SUS; gaining a new version in 2016, from Ordinance Number 825 which, in addition to redefining AD within the SUS, boosted the qualification of SADs.

Besides, through the last described ordinances, some criteria were established for users to have access to this type of service, which includes: the eligibility criteria of the clinical condition, the admission and discharge criteria of the service, in order to define the patient's profile and the team that will provide assistance. And when carrying out the search for scientific production on the subject of Home Care, one can verify the rich production, both international and national, in what concerns the theme of home caregivers,

training and coping with professional activities that are performed in the home environment and the particularity of this care at home, guaranteeing the individuality of care.

However, the diversity of functioning of each Home Care Service was evidenced, which made it difficult to determine the criteria for inclusion and discharge of users, and hence the guiding question of this study arose: How do managers and health professionals perceive these criteria for inclusion and discharge of users in Home Care Services?

Seeking to continue and contribute to this discussion in the Brazilian context, in the development of this study, it was aimed to address Home Care inserted in the care model, given the need to respond to new demands in health and the structuring, organization and coordination of care, in particular in home care services linked to state hospitals in the State of Ceará. Therefore, this study aimed to describe the perceptions and experiences of Home Care Services regarding the eligibility criteria, admission and dismissal of users.

METHODS

The qualitative study, following a content analysis approach as a theoretical-methodological framework, since it is a technique with the aim of objectively producing inferences from a text to its social context, and was developed in accordance with the criteria recommended by Consolidated Criteria for Reporting Qualitative Studies (COREQ) for qualitative research.

It was carried out with 17 managers and health professionals from home care services linked to state hospitals located in the city of Fortaleza. The choice of this scenario was the possibility of a plurality of services, covering all age groups of users and the breadth of territory reach of this type of assistance, allowing for diversity in the characterization of services

The inclusion criteria adopted were: being a health professional or a program manager and working at the service for at least six months. On the other hand, the exclusion criteria adopted were: professionals and managers who were away from work during the data collection period, or who were not available to carry out the interview at the moment offered to the researchers due to the dynamics of the assistance activities.

Data collection was carried out by one of the authors from May to July 2018, using a semi-structured interview with the participants, in depth, and guided by the following questions: how would you describe the admission process? What are your perceptions regarding the eligibility criteria used to outline the user's profile? Tell me how you experience the user's disconnection process from the home care service. In addition to these questions, the script also included some variables of the professionals, namely: profession, employment relationship, length of experience.

The recruitment of participants began with prior telephone contact with the manager of each service in order to schedule the face-to-face meeting and visit to the service. On the scheduled day, this visit to get to know the service and interview with the manager was carried out, which helped the researcher to access the health professionals of the services, in addition to providing opportunities for document analysis and systematic observation of the work routine.

When approaching the research object, the researchers showed that the team of health professionals that contemplated each service was very numerous, and it would not be possible to cover all professionals, determining that an interview must be carried out with the service manager and two professionals of each service, which would be delegated by the management of the service. And on the

day scheduled for the interviews with each service, it was also evident the difficulty in the availability of professionals due to the routine of their care activities and workloads.

To carry out the individual interviews in an environment chosen by the participants and with guaranteed privacy. All interviews took place at the workplace, before or after the work shift, and lasted an average of 60 minutes, being recorded in audio files, with their subsequent transcription, without the use of any software.

In the researcher's visit to the Home Care services, through the systematic observation technique, the script was followed with the following points: service infrastructure, composition of the multidisciplinary team and work dynamics. During the observation, the researcher wrote notes of the points of the script in the field diary and contested her observations with the research participants.

As an analysis technique, thematic content analysis was adopted, involving the steps of: pre-analysis, for the systematization of the ideas that emerged from the interviews, followed by floating reading; exploration and organization of the material, for the definition of recording units; and coding, when the meaning units were identified and grouped into larger sets.

The results were organized into major themes that emerged from the subjects' narratives: 1-Perceptions about home care; 2-Admission process and eligibility criteria; 3-Disconnection of the patient from the Home Care Service.

This study was approved by the Ethics Committee and Research with Human Beings by opinion n° 3.520.872/2019 and Certificate of Presentation of Ethical Appreciation 17995019.7.0000.5054, according to the norms of Resolution n° 466/2012 of the National Health Council of the Ministry of Health.

RESULTS

This research consisted of the following participants: in total, there were 17 interviewees, 2 of whom were exclusively managers of managerial activities, 6 managers who carried out care activities, and 9 health professionals. As for the professional category, 7 nurses, 5 doctors, 2 physiotherapists, 2 social workers and a psychologist participated.

By time of academic training, 8 professionals had 1 to 5 years of graduation, 5 had more than 10 years of training, and 4 had more than 20 years of training.

As for the time working in home care services, it was observed that 3 were in the services for over 10 years, 7 were between 5 years and 10 years, 7 were less than 5 years in the services. The age group of the participants in this study comprised 20-30 years old, there were 3 professionals; 31-40 years comprised 8 professionals; 41-50 years comprised 4; and between 51-70 years were with 2 professionals.

Among the interviewees, a mixed composition was observed regarding the employment relationship regime, as there were 5 outsourced/cooperated workers, 5 under the Consolidation of Labor Laws regime, and 7 public servants.

PERCEPTIONS ABOUT HOME CARE

During the study, through the systematic dynamic observation of the Home Care Services and through the evidence of the interviewees' perceptions, it can be seen that the main objectives they wanted to achieve with the implementation of home care were the rotation of beds, dehospitalization with the continuity of home care, cost reduction, individuality and humanization of care. Reports follow: *We aim to dehospitalize to vacate hospital beds, and at home, the cost is much lower and it is more humanized. (E12). The objective of unburdening beds, rotating and*

optimizing hospital beds, so that was the speech. (...) with the intention of clearing this volume of patients in the corridors, they sent them with a certain frequency (E16)

In the organization of home care, the actors also signaled bad grandeur, the particularity of such assistance, and the contribution to the excellence and improvement of their professional activities: (...) *I like this service closer to the population, because it is a new experience, where every day you have a new knowledge of the patient and a new demand, not being that routine of always being the same thing (...). (E1). Home care has its particularities, its difficulties and its enchantments. I exercise my function with great mastery, and I try to provide my support, affection and attention, because in this case, it is not just the patient who is sick, the family also becomes sick, due to the compromised health of a loved one, the exaggerated concerns that home care has and the responsibility that each decision involves. (E2).*

According to the managers' speeches, the allocation of professionals has been a concern for the management of human resources in the evaluated services, and decisions regarding the number, specializations are influenced by the strategic planning of each hospital, in which the service is inserted. This has repercussions on the dynamics of activities, care, and the demands of users and families are sometimes not considered, as can be seen from the following recording units: *HToday, I am unable to carry out more detailed care, as I only have a multidisciplinary team, where professionals are assigned a shift to the Home Care Service, which compromises the efficiency of care. Every team is not exclusive to the Home Care Service (E3). The team is not complete yet, we miss professionals such as psychologists, occupational therapists, and speech therapists (E16). We do not provide a social worker (E13).*

According to the report of interviewee 11, it can be seen that the professionals' lack of employment makes it difficult for them to remain in the services, resulting in greater turnover and breaking one of the basic principles of home care, which is the bond of trust, of respect and even affection between the team and user/family, in addition to breaking the care plan carried out by the previous professional: *Lack of professional appreciation, which results in higher turnover, compromising follow-up. We also have the difficulty of finding professionals who have the profile for home care, because the same amount they earn working at the hospital, they earn working at home, and that is why many prefer to stay in the hospital.*(E11).

ADMISSION PROCESS AND ELIGIBILITY CRITERIA

The process of admitting patients to the Home Care Services, observed on the days of the interviews, is an individualized process for each service, however with some points and criteria common to all, described below.

In the speech of interviewee 5, the beginning of the admission process takes place as follows: patients are referred by the hospital care team, which perceives the presence of needs requiring the continuity of some care at home. *A report is prepared by this team, including the patient's clinical condition and all home care needs, for evaluation by the SAD assistance team.*

In view of the analysis of the speeches regarding the initial evaluation for inclusion of patients in the SAD, the medical, nursing and social service evaluation were very highlighted: (...) and when we received the inclusion request, we arranged a visit to the bed, which most of the time is initiated by the nurse, but they will also visit the doctor and the social worker. The nurse evaluates the profile, following the dependencies (...) (E5).

When we receive it, we carry out the previous assessment in bed, talk to the family, go to the home, carried out by nursing and social service. (E14). When he arrives here, the nurse speeds things up within her knowledge spectrum, she articulates the rest of the team that needs to evaluate this patient and everyone focuses on the referral and we carry out the visit to the patient. As a social worker, I carry out the visit at the patient's bed, which allows me to translate to the patient and family what the program is, in basic and general terms, as the functioning of the program is gradually and systematically learned by them, and they will have the perception of what the program is. (E16).

In this initial assessment, some criteria are relevant for the admission to have a positive outcome with the dehospitalization of the patient to his home. They are the so-called eligibility criteria, the dependency factors that the patient has regarding care at home, in addition to socioeconomic, territorial and family conditions in which the individual is inserted. However, some of them are common in several experiences, despite the heterogeneity and local singularities. This is described in the following speech: The inclusion criteria are: residing in Fortaleza, having a caregiver, bedridden patient, without the possibility of locomotion for outpatient care, having family and socioeconomic conditions, having safe access to home care, because in the face of urban violence we need to establish this, present clinical stability, without the need for intravenous medication and need care that require team supervision, such as dressings, enteral diet, rehabilitation, oxygen support and mechanical ventilation ostomy care, treatment palliative care (E6).

Faced with any adversities to these conditions, the patient is unable to be discharged from hospital to home in monitoring programs: The only impossibility

of the patient not going home assisted by SAD, and the case that the patient has no condition of electricity, lack of sanitation, with precariousness of the home environment, and in cases where the patient does not have a companion to be the main care, type he lives alone and family is not responsible for his care. Another criterion for home care by SAD is that the patient must live in Fortaleza, we do not serve metropolitan areas (I1). What impacts most on the dehospitalization of the patient is the financial condition, that they have no way to support themselves, unfortunately the patient does not leave the hospital. The SAD offers supplies and equipment, but house, food and other costs are the responsibility of the family (E5)

DISCONNECTION OF THE PATIENT FROM THE HOME CARE SERVICES

After understanding how the implementation of home care is currently designed, a point that deserves to be highlighted is the disconnection of patients from the aforementioned programs. It was observed that the user population of these programs includes patients with chronic degenerative diseases, with a conservative prognosis, without possibilities for rehabilitation, or partial rehabilitation, with dependence on care and support of essential equipment for life, and hence arises the concern about how to Is it possible to disconnect these patients from the program that helps in their survival?

And this concern was answered by noting that the services have very low dismissal rates, due to the dependence of patients, the lack of structure of Primary Care that absorbs the contingent of patients dependent on this assistance. This confirms that the rotation of vacancies in the services does not exist and that the permanence of these patients in the programs is until its finitude. In view of all

this, it is worth emphasizing the insecurity of the family in the face of the disconnection, generating conflicts.

Many were the statements that portrayed the difficulty of disconnection: The forms of disconnection are through improved discharge, death and transfer to the Basic Health Units. However we are not managing to transfer to the Primary Health Care Units,... because we have patients with a discharge profile, a profile for follow-up by Primary Health Care, so we can't discharge this patient because we know that this patient will be left alone, without assistance... These transfers have been the cause of great conflicts, where the Basic Health Units claim not to have the structure to admit the patients, and still have a position against our discharge, urging the family to sue the program, if they are discharged (E3). As for discharge, we have a big problem to give this discharge, because today we have no family health strategy, ne? There are few units that provide services in the territorialisation. The ideal thing would be for us (SAD) to stabilize the patient and return to primary care for follow-up. However, that's not what happens. In short, our discharge is due to an improved discharge, after rehabilitation; due to expected death. And then we stay with the patient, because we don't have an escape valve for these patients (E5). However, we have the difficulty of giving continuity through primary care, we improved communication, but it is still very difficult because they are out of control, where primary care does not exist (E6).

Another possibility of disconnection is hospital readmission, because in the event of a clinical complication, where there is the need for hospitalization, most services do not have back-up beds in the hospitals where they are located, and so the patient is advised to call the mobile urgency and emergency services, to be taken to the emergency services of the

network, and may have the possibility of hospitalization in the most diverse hospitals that include the hospital network. In the case of interurrences at home, we advise them to contact SAMU, and enter the emergency room here or in other hospitals, and the family contacts us. When they are discharged from another hospital, the doctor sends the family a report informing the current clinical picture. And we re-include them at the patient's home (E13). In this, they may lose contact with the service of origin, although there are situations in which the program itself monitors the patient's condition with the family and after hospital discharge resumes home monitoring by the Home Care Service of origin. As the following account: So, it can happen that the patient is admitted to another hospital, ending the follow-up by our Home Care Program. If the other hospital does not forward, or signal our program, we end up losing the link with the patient (E1).

DISCUSSION

The benefits of this study are evident, since the findings reflect the complexity of the care process at home that goes beyond the care itself, reinforcing the need for strengthening, financing and breadth of this type of assistance. Still, the results established here reinforce the importance of determining the eligibility criteria and strengthening the health care network in which home care is inserted. It is considered important to report that a single meeting or interview may not have been enough to capture the senses and meanings attributed by the participants, which could characterize a limitation.

Home care has important peculiarities, as it will be carried out in the context of the individual's private life, and with the presence of intrafamily relationships, where it requires complex changes, with detachment from traditional practices and the development

of new skills, requiring a professional who knows how to deal with the uniqueness and subjectivity that surrounds the process of caring at home(2,13).

The multidisciplinary of the care team in home care, aims to provide that various professionals, with their areas of knowledge and different proposals for work and action, can act together, without establishing a hierarchy, boosting the development, dissemination and production of diversity in the health care.(9,14).

Home services need to have a cohesive team and that the bonds of action with the family are preserved, assimilar data were found in the study carried out that the professionals working in the AD studied, the existence of hiring by different legal regimes was identified, such as temporary contracts or the allocation of public tendered professionals already existing in the network, compromising the organization of work, affecting the solidification of the public health system. As for the significant turnover of workers, they put the quality of care for users at risk, by breaking ties, continuity and the impracticability of interprofessional care plans⁽¹⁷⁾.

Studies complement the analysis carried out by describing the inclusion and eligibility criteria in the SAD. Eligibility criteria cover both clinical and administrative aspects. Clinical aspects relate to the patient's condition, care procedures and frequency of visits. Administrative aspects refer to the operational and legal conditions for patient care to be carried out, which includes residing in the municipality and having a home environment that is minimally adequate and safe to receive the patient. Inclusion criteria in HC are related to administrative aspects, having a home with physical infrastructure compatible with performing HC (water, electricity, communication sources, vehicle access, windows and minimum size for a bed

and equipment) ^(15, 17,19,20).

The studies point out that access to home care must start from the three possibilities of organization, facing the following entry points: demand arising from the Family Health team; demand from the hospital institution and demand from emergency care units. This opening would create an opportunity for home care to be effectively guided by the needs of users, becoming an alternative of choice for certain types of clinical situation, constituting an effectively substitutive modality^(12,20).

In addition to dependence on care, another point that prevents patients from being disconnected from services is the deliberation of important inputs for home care and that, due to the financial conditions of the patient and family, in most cases being compromised by the course of the disease, resort to judicialization of health to maintain both home care and the continuity of receipt of inputs. Another fact that maintains this link between patients and services is the issue of caregivers' dependence on the need to monitor the care provided, avoiding harm to the patient due to the care provided⁽²⁰⁾.

In this context, it is up to the Home Care Services to start strengthening the autonomy of the caregiver, as well as the development of palliative care at home. For greater control of risks in the home environment, control measures are adopted when selecting the patient who will be surrounded by palliative care in the home care modality, mainly evaluating the family environment in the predisposition to support the demands. As for the team of professionals, technical capacity and skill in transmitting knowledge and essential information to the family group are recommended, strengthening palliative care, and the perception of the end of the path with quality^(16,19).

CONCLUSION

The study made it possible to describe the perception of the main actors in the implementation of home care services, which are managers and health professionals, emphasizing the admission and removal of patients from the service, as well as the composition of the multidisciplinary team of each unit and the frequency of home visits. Each of the services has its individual implementation according to the care profile of the hospital unit to which it is linked, and with the composition of the multidisciplinary team according to the scope of care. The points of similarity in the implementation of the evaluated services are the eligibility criteria and the difficulty of disconnecting the patient from the service.

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