

HOME CARE SERVICES: ELIGIBILITY, INCLUSION, EXCLUSION AND DISCHARGE CRITERIA

Serviços de atenção domiciliar: critérios de elegibilidade, inclusão, exclusão e alta

Servicios de atención domiciliar: criterios de elegibilidad, inclusión, exclusión y alta

Original Article

ABSTRACT

Objective: To describe the aspects involving eligibility, inclusion, exclusion and discharge in home care from the perspective of home care managers and coordinators. **Methods:** This is qualitative descriptive exploratory study. Interviews were conducted with five managers and 17 coordinators from 16 municipalities of Minas Gerais between January and September 2015. **Results:** Respondents reported following the criteria proposed in the national guidelines of the home care service, but with some exceptions. With regard to eligibility, most managers reported that patients undergo clinical evaluation performed by the physician who determines whether or not the patient is eligible for home care. Inclusion criteria refer to the assessment of the patient's conditions, the identification of the caregiver, social and environmental issues, team access and adaptation of the home to the patient's needs. Exclusion criteria point to the structural conditions of the home, the lack of caregiver and safety for professionals. The discharge is referenced by clinical stability criteria and the end of treatment. **Conclusion:** Although home care services criteria are set by the Ministry of Health, managers and coordinators make exceptions to the inclusion and discharge criteria considering: the fragility of the network regarding discharge and referral to another point of care and the patient's reality. Home care should be performed when the clinical and administrative conditions of the user are just right, considering the eligibility, inclusion, exclusion and discharge criteria.

Descriptors: Home Care; Home Care Services; Regional Health Planning.

RESUMO

Objetivo: Descrever os aspectos que envolvem a elegibilidade, inclusão, exclusão e alta na atenção domiciliar na perspectiva de gestores e coordenadores de atenção domiciliar. **Métodos:** Trata-se de estudo descritivo-exploratório de abordagem qualitativa. Foram realizadas entrevistas com cinco gestores e 17 coordenadores de 16 municípios de Minas Gerais entre janeiro e setembro de 2015. **Resultados:** Os entrevistados afirmaram seguir critérios propostos nas diretrizes nacionais do serviço de atenção domiciliar, com algumas exceções. No que diz respeito à elegibilidade, a maioria dos gestores informa que os pacientes passam por avaliação clínica realizada pelo médico que define se o paciente segue para a atenção domiciliar ou não. Os critérios de inclusão referem-se à avaliação das condições do paciente, a identificação do cuidador; a questão socioambiental, o acesso da equipe e adaptação da residência às necessidades do paciente. Como critérios de exclusão, apontam as condições estruturais do domicílio, a ausência de cuidador e de segurança para os profissionais. A alta é referenciada por critérios de estabilidade clínica e o fim do tratamento. **Conclusão:** Embora os critérios dos serviços de assistência domiciliar estejam definidos pelo Ministério da Saúde, os gestores e coordenadores abrem exceções na inclusão e alta considerando: a fragilidade da rede para alta e encaminhamento para outro ponto de atenção e a realidade do paciente. A atenção domiciliar deve ser realizada quando as condições clínicas e administrativas do usuário permitam, considerando os critérios de elegibilidade, inclusão, exclusão e alta.

Descritores: Assistência Domiciliar; Serviços de Assistência Domiciliar; Regionalização.

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RESUMEN

Objetivo: Describir los aspectos que involucran la elegibilidad, la inclusión, la exclusión y la alta de la atención domiciliaria desde la perspectiva de los gestores y coordinadores de la atención domiciliaria. **Métodos:** Se trata de un estudio descriptivo-exploratorio de abordaje cualitativo. Fueron realizadas entrevistas con cinco gestores y 17 coordinadores de 16 municipios de Minas Gerais entre enero y septiembre de 2015. **Resultados:** Los entrevistados afirmaron que con algunas excepciones seguían los criterios propuestos en las directrices nacionales del servicio de atención domiciliaria. Respecto a la elegibilidad, la mayoría de los gestores relata que los pacientes pasan por una evaluación clínica realizada por el médico el cual define si el paciente sigue para la atención domiciliaria o no. Los criterios de inclusión se refieren a la evaluación de las condiciones del paciente, la identificación del cuidador, la cuestión socioambiental, el acceso del equipo y la adaptación de la vivienda a las necesidades del paciente. Los criterios de exclusión fueron las condiciones estructurales del domicilio, la ausencia del cuidador y de seguridad para los profesionales. La alta es referenciada por criterios de estabilidad clínica y el fin del tratamiento. **Conclusión:** Aunque los criterios de los servicios de atención domiciliaria son definidos por el Ministerio de la Salud, los gestores y coordinadores permiten excepciones para la inclusión y la alta por considerar: la fragilidad de la red para la alta y el encaminamiento para otro sitio de atención y la realidad del paciente. La atención domiciliaria debe ser realizada cuando las condiciones clínicas y administrativas del usuario permitan, considerando los criterios de elegibilidad, inclusión, exclusión y alta.

Descriptor: Atención Domiciliaria de Salud; Servicios de Atención de Salud a Domicilio; Regionalización.

INTRODUCTION

Brazil is going through several changes, among which stands the epidemiological and demographic transition. These changes, linked to the increase in the population aging, with the sharp decline in fertility and reduction in mortality, provokes changes in the patterns of death, morbidity and disability associated with biological, economic, environmental, scientific and cultural features^(1,2).

As a result of this transition until the 30s of this century, there will be predominance of elderly relative to the number of children, besides a considerable decrease in working-age population⁽³⁾. That increase means prompts the demand for health services, more frequent hospitalizations and longer bed occupancy time considering the characteristics of the age group. To manage to cope with these changes, new healthcare strategies and mechanisms are needed, in addition to the construction of appropriate public policies

for health care and comprehensive interventions that become disengaged only from hospital care and anti-hegemonic practices⁽⁴⁾.

Home care thus takes place as one of care alternatives, with initial motivation to decongest hospitals and provide for the construction of a new logic of care, focusing on more favorable psychosocial environment for patients and families with health promotion and prevention, and humanization of care⁽⁵⁾. Service organization focused at the household is not a new practice. It emerged in the United States in 1947, in Brazil in 1949, and has been expanding worldwide⁽⁶⁾.

Because of the relevance of this care modality, the Ministry of Health has established, in the Brazilian Unified Health Service (*Serviço Único de Saúde - SUS*), the Home Care as a set of activities provided in the home, through Ordinance MS no. 2529 of October 19, 2006⁽⁷⁾. In 2011, the Home Care Program (*Programa de Atenção Domiciliar - PAD*), also known as *Melhor em Casa* (meaning Better at home), was launched by MS Ordinance No. 2029, which settled standards for qualification and registration in the Home Care Service - HCS (*Serviço de Atenção Domiciliar - SAD*)⁽⁸⁾. This program has been modified and is now governed by Ordinance MS no. 963 of May 27, 2013⁽⁹⁾.

The program is structured with multidisciplinary team focused on caring for the patient in its entirety at the highest and best level of response. The team is divided into multi-professional home care team (EMAD) and multi-professional support team (EMAP)⁽¹⁰⁾. As for the organization of the home service to the users, three types of home care (HC1, HC2 and HC3) are established, according to the complexity and frequency of the demanded home visits⁽¹⁰⁾.

In home care, health promotion becomes a favorable strategy to deal with the many health-related difficulties that affect the populations. Involving health workers, managers and users in the search for better health, as well as knowing the determinants of the context in which it intends to intervene is of utmost importance⁽¹¹⁾. Besides involving the practice of economic, social and health policies, home care aims at reducing the individuals' risk of becoming ill, promotes the surveillance and planning of health programs, and the implementation of preventive activities. It encompasses from health promotion to the recovery of individuals affected by a disease, who are in their own homes⁽¹²⁾.

For inclusion and permanence of the user in the HC program, some criteria must be met, namely: eligibility, inclusion, exclusion and discharge criteria. All criteria are based and applied considering the MS Ordinance No. 963/2013, which defines the profile of the patient to be

served⁽⁹⁾. Given the above, a question is raised: how are these criteria incorporated by the home care teams?

In this sense, the purpose of this article is to analyze the aspects involving eligibility, inclusion, exclusion and discharge in home care, from the perspective of health managers and home care coordinators.

METHODS

This is qualitative study with descriptive, exploratory approach. The methodological path undertaken in this study established as its scenario the Home Care Services (HCS) of Minas Gerais state, which amounted 20,000 or more inhabitants, in compliance with Ordinance MS no. 963/2013. To identify these services, a survey was conducted in the Health Facilities National Register (*Cadastro Nacional de Estabelecimentos de Saúde - CNES*) in 2015, leading to the identification of 25 HCS in the state of Minas Gerais. Interviews were carried out in 16 municipalities.

A total of 22 interviews were conducted with five health managers of the municipalities and 17 coordinators, professionals accounting for the HCS coordination. Each participant was given a code, consisting of letter M and the number of the municipality, while letter G was given to managers and coordinators, with their respective identification number.

The interviews took place in the workplace and these professionals were guided by semi-structured script, with questions for the manager or coordinator about their position, function and time in position. For the knowledge of home care services, they were asked which eligibility, inclusion, exclusion and discharge criteria the municipalities adopt in the Home Care Service. The interviews were recorded and then transcribed to facilitate analysis of information.

Complementarily, the *Melhor em Casa* Brochure, Volume 1, which discusses the criteria of the home care program (PAD) was submitted to analysis. The *Melhor em Casa* Brochures are manuals with guidance on the program organization, operation, structuring and composition.

In possession of the material, content analysis was conducted⁽¹³⁾. The empirical material underwent a floating reading, and the recording units and units of meaning were highlighted. The collected data was analyzed into categories grouped by analogy. In this path, by using content analysis, two categories have emerged, the first addressing the Eligibility and Inclusion Criteria and the second one regarding the Exclusion and Discharge Criteria.

This study was approved by the Research Ethics Committee of the Federal University of Minas Gerais, under opinion no. 129725, provided that it meets all ethical requirements for scientific research with humans, such as

voluntary participation, the privacy of participants and confidentiality of information.

RESULTS AND DISCUSSION

Interviews were conducted with five managers and 17 coordinators in 16 municipalities of Minas Gerais between January and September 2015. Of the 17 HCS coordinators interviewed, 12 have been in the coordinator position since the creation of the *Melhor em Casa* program. Four coordinators are males and 13 are females, and these are their academic backgrounds: 10 nurses, three social workers and two physiotherapists. As for the managers, three are females and two are males, and they are graduates of medicine, dentistry, nursing and accountancy.

Eligibility and Inclusion Criteria

Floating reading of the empirical material was conducted, highlighting the recording units and units of meaning. The collected data was grouped into categories by analogy for analysis. By applying content analysis, two categories emerged: the first, related to the Eligibility and Inclusion Criteria; and the second one, on the Exclusion and Discharge Criteria.

According to the normative documents of the *Melhor em Casa* program, “the eligibility criteria and conditions are the set of elements and information that allow evaluating the inclusion of patients in the home care service”⁽⁸⁾. The eligibility criteria include clinical and administrative features. The clinical aspects are related to the patient’s medical status, the care procedures and frequency of visits. Administrative aspects relate to the operational and legal conditions for patient care to be performed, which includes living in the municipality and having minimally adequate and safe home environment to receive the patient. The referral of the patient may come from agreement and referral on the part of the physician assistant, whether in the Primary Care, Urgency and Emergency Care or Hospital. This referral requires a protocol or counter-referral form, with a thorough report containing relevant data to evaluate the user’s clinical status. It is also mandatory for the users to have a caregiver whenever they present functional dependence⁽⁸⁾.

Considering these provisions by the program, the reports of the participants have pointed the same aspects that are marked in the policy concerning the clinical and administrative aspects used to determine the program eligibility:

“Our eligibility criteria, we always request a medical report with the patient’s medical history... and indicating the reason for the home care and multidisciplinary

monitoring and, in this report, we ask for the primary and secondary ICD, which is indeed a requirement made by the Ministry of Health, that we entry into the RAS afterwards.” (M14P2)

“[...] socioenvironment of the patient has to bring conditions for these, for these patients to go home. Therefore, it needs to be an area that does not pose risks to the team... an area free from drug trafficking, without violent individuals in the house, where we can provide in-home care... an area that does not put the patient's health at risk. So, a house that is falling apart, where he is unable to live in, no hygiene contents inside that house.” (M16G1)

“So, living here, or remaining here, somewhere, until it is done, along the treatment. In case there is no care autonomy, he has no condition to learn, this patient, he has to have a responsible caregiver, who is willing to learn, to be trained.” (M15G1)

The determinant for eligibility of the patient, as for the clinical criteria, refers to the patient's condition, which leads to the classification as HC1, HC2 or HC3. The HC1 mode includes patients with controlled/counterbalanced health problems, which allow for longer intervals between visits, do not require more complex procedures and techniques, and do not demand frequent medical care. Therefore, home care for these patients is under responsibility of the teams of the Family Health Strategy. For the patient to be included in the HCS, they need to fit into the HC2 or HC3 level, which includes the inability to travel to a health care facility and the need for care provided by the health team at least once a week⁽⁸⁾.

Considering the patient's clinical profile, Ordinance MS no. 963/2013 emphasizes the inclusion of demands for more complex procedures that are feasible to perform at home, such as complex dressings and abscess drainage, frequent need for low-complexity laboratory tests, and dependence on frequent monitoring of vital signs. In addition to monitoring of low weight, nutritional care and medication, are also included the patients who need oxygen therapy equipment or procedures and noninvasive ventilatory support, Continuous Positive Airway Pressure (CPAP), Bilevel Positive Airway Pressure (BiPAP), oxygen concentrator, peritoneal dialysis, and paracentesis⁽¹⁰⁾. To this end, the caregiver should receive training for adaptation to handling the devices, probes and ostomy, vacuum products, the postoperative and rehabilitation periods. This service is made appropriate for the patients until they present conditions to attend rehabilitation services.

According to the coordinators who participated in the study, evaluation and classification of users are performed as recommended by the manual of the HC (or *Melhor em Casa*) Program:

“... it already comes with a direction... in that sense, the assessment is made according to this scale of low, medium and high complexity, and we do not enroll low-complexity patients, which would be in the HC1 mode, a profile for health care units; unlike the medium and high complexity in this evaluation.” (M7G2)

“We divide the patients into HC1, HC2, HC3 [...]. The patient HC1 is the one who has difficulty going to the health unit, or outpatient clinic. But they need medical assistance, or nursing, or nutrition service... to pick up a prescription, to be able to pick up some devices, so they do not get worse and need hospitalization. This patient ... theoretically, they are monitored by... by HCS, initially, and then they are referred to primary care. The patient HC2, HC3 is that patient who is already more complex.” (M16G1)

“That's it... and the patient who really needs it, within those criteria HC1, HC2 and HC3. So, the patient, he must first be eligible within these criteria, have a caregiver, have a place to go... it doesn't have to be his own house, it can be a relative's home and... and that the team manages to perform care in that house.” (M16G1)

Health managers and home care coordinators stressed the clinical criteria as points for the eligibility of patients in the HCS, as in the following reports:

“[...] having life support device, pressure ulcers grade 2 or above, using probe, for probe adaptation [...], also for probe withdrawal, we make this transition.” (M4G1)

“The patient who needs dressings that are not infected, antibiotic therapy once a day or every 12 hours, physiotherapy sessions, nutritional counseling, social care assistance, pharmacotherapeutic monitoring.” (M15G1)

“HC2 is the patient who is already more complex. That is, they need intravenous antibiotics, for a certain period, they need an anticoagulant medication, and ... they have some bed sore, some ulcer, right? That is... someone who needs professional monitoring... patient who has ostomy, or tracheostomy, or gastrostomy, and the family still cannot handle these ostomies, then he is admitted to the program. And the patient HC3, a more complex patient, those under 24-hour invasive mechanical ventilation... and the patient in palliative care, which we discharge [...] monitor until death at home.” (M16G1)

It is noteworthy that the services and programs that offer home care adopt different criteria, mainly based on the clinical condition, age, or life cycle in which the patients are. This aspect determines the position that home care will occupy within the health care network⁽¹⁴⁾.

Priority in HC becomes even more relevant when there are several comorbidities⁽¹⁵⁾. Having more than one

condition or health problem matches with an increase in financial expenses, in time dedicated to care and the very production of care. Similarly, inabilities or difficulties in performing from simple tasks, such as bathing, to more complex activities, such as administering their own medication and their own financial resources alone, tend to result in the need for a caregiver, a problem that is one of the major causes for applications for inclusion in Home Care Services⁽¹⁶⁾.

In this sense, even understanding the importance of home care as a form of access to those patients who are most dependent of care, workers are, currently, unable to extend this work to all⁽¹⁷⁾. Thus, they stress the importance of criteria for inclusion of new patients in the program as a way to meet the principle of equity, offering greater attention to the most needy.

As for the administrative eligibility of the patient in HC, it is emphasized that the presence of the caregiver represents the more complex and important point. The caregiver is responsible for performing all the basic actions for maintenance of the patient's life, such as dressing, changing positions, diet preparation and administration, and support in the daily living activities^(18,19). The presence of the caregiver, from the moment the team evaluates the patient's administrative eligibility in the home care, and during his/her permanence from the established activities, has its importance highlighted:

"If one meets those criteria and has a caregiver, then he comes home [...]. But the really hard point is the caregiver." (M3G1)

"First thing: identified caregiver. Patients need to have someone to help us take care of them. The team is not 24 hours inside the patient's home. Therefore, bathing, feeding, sleeping with the patient is somebody's responsibility. This caregiver can be a caregiver... a relative, who we will train, who doesn't need to know anything, we'll do it with the person inside the hospital. A caregiver who is paid by the family." (M16G1)

The results indicate the centrality of care in defining the criteria for inclusion in home care. The HCS team, thus, plays an important role in the relationship with the caregiver, helping them, qualifying them to assistance procedures, answering questions and providing psychological support⁽²⁰⁾. It is essential that HC professionals establish a trusting relationship with the family, through maintaining the agreements, sympathizing with the situation of the patient and the caregiver and, whenever necessary, reviewing the plan of care⁽²¹⁾.

Inclusion criteria for HC are related to administrative aspects, owning a home with physical infrastructure compatible with the implementation of HC (water,

electricity, communication sources, access to vehicles, windows, and minimum size for a bed and equipment). All possibilities should be considered in relation to the needs and uniqueness of each case⁽⁸⁾, indicating the flexibility for inclusion that should be discussed and evaluated by the team, despite being based on the protocols and documents that govern the eligibility criteria for HC. In this way, each municipality manages to follow what is determined by the rules, but has power to suit them to its reality.

Nevertheless, it is present in the reports of the coordinators the reinforcement of the regulatory aspect, by following the aspects set out in the resolutions of the program nationwide. However, some special situations must be thoroughly evaluated by the team members jointly, with room for exceptions:

"We take into account the program's premises, determined by the program. But every rule [...] has an exception, that's what I told you." (M18P1)

The results indicate that the teams work with adaptations according to the reality and needs of the patient and still consider the shortcomings of the network to determine inclusion in AD.

"It has its exception [...]. There are some patients, which we know they belong to the primary care, which could be in primary care. But, for some detail, we end up bringing them in." (M18P1)

It becomes crucial to consider all the possibilities regarding the needs of the population served, considering the situation of each patient individually and in an inclusive manner, taking into account their singularities, besides the HCS conditions and ability to assist them in a comprehensive way⁽¹⁰⁾.

This strategy of getting organized to serve some patients who do not match the exact proposed profile is intended to use *transprofessional* tools that enable access to assistance with equity, by recognizing the complexity of the patient as a biopsychosocial being, and leads to the accomplishment of care optimization⁽²²⁾. For care to be effective, it is necessary that the HC team has an extensive clinical experience and practice directed at the human being and their subjectivity.

However, managers and coordinators make it clear that the inclusion criterion is fundamental to contribute in shaping the profile of the patients to be served in public policy. This prevents conflicts with other services and defines which service is best for each patient assessed.

Prior to the admission of users of home care services, each case undergoes an assessment, usually made jointly by nurse and social worker. The evaluation involves

understanding the case itself, the structure of the home and the family dynamics, and also enables the verification of the layout and the feasibility of performing in-home assistance⁽²³⁾.

According to the guidelines of the home care program, there are four ways to include users: 1) active search for inclusion, in hospitals; 2) search on the electronic database for patients with long permanence in inpatient units or high demand for emergency services; 3) indication by the assistance staff in hospital units or the primary care teams; and 4) spontaneous demand in acute situations, via phone call to the health services⁽¹⁴⁾.

The findings of the study confirm that the teams adopt these strategies:

“It’s in the household, we go to the patient’s household and conduct that first assessment, to know whether they really fit into the program or not. If they fit, we admit them, and other professionals begin to assist them; if not, we issue the counter-referral to who sent them to us.” (M9P1)

“So, before this patient is discharged from the polyclinic, our social worker, our physiotherapist, our nurse, she goes to the residence and conducts a structural household assessment” (M11G1)

“So we do a bed-to-bed investigation in the county hospital, weekly, every Tuesday, Wednesday and Thursday, our team is in there, discussing the cases, trying to capture the patients. We’ve been trying to make these bed-to-bed investigations within the clinical hospital. We still don’t have a deinstitutionalization team, but, always, whenever we identify [...] we walk in the hospital to be able to try to terminate some hospitalization and the team of the Melhor em Casa program in the municipality also always tries to capture the patients inside the integrated care units, right? [...] and... it is reference for hospitalization in the municipality.” (M16G1)

It is important to stress that the inclusion and eligibility criteria are often confused and, in the reports made by managers and coordinators, they become mixed when assessing the patient for the beginning of service in the program. Some inclusion criteria also leave room for different interpretations and are not fully clear and defined as to the actual feature the patient must present:

“The inclusion criteria, when we talk about inclusion, they end up resembling the eligibility criteria. Then, the patient, besides everything I’ve said about eligibility, being stable, residing here, [...] whether they can manage self-care or have a caregiver. There are situations in which it’s even easier for me to mention what leads to exclusion for us to figure it because the exclusion criteria are in a much smaller number. Then we already have an

idea that everything else we will be able to accept. [...] The program runs 12 hours a day, from 07:00 am to 19:00 pm. So we can not cope with any antibiotic therapy, whose posology is every 6 hours, every 8 hours.” (M15G1)

Discharge and exclusion criteria

According to the regulations of the *Melhor em Casa* program, the discharge from home care refers to the termination of the services due to the improvement of clinical conditions and or clinical stability; to worsening in the conditions that justifies hospitalization; change in the coverage area; the request for termination made by the patient and/or family, or death. The patients excluded from the HCS are those who violate the assistance agreements between the team and patients or caregivers. Being ensured to these users the continuity of assistance in other service of the health care network⁽¹⁰⁾.

Compliance with the discharge criteria defined by the normative documents of the HC policy appears in the statements of managers and coordinators:

“Stability discharge is... patient who no longer needs mechanical ventilation or oxygen therapy, patient who changes, right? Goes to another city, and we can no longer follow them up. Cases like these, patients who really get better.” (M16G1)

“So, having confirmed that they are free from the microorganism, the infection is not present anymore, then this patient has everything to be discharged.” (M15G1)

“Administrative discharge, when you, after the third visit, the patient is not found at home, change of address.” (M7G2)

“Discharge criterion is indeed that clinical stability, which we see that the primary care can manage it, because, when it cannot, the patient is elderly, the caregiver is elderly, and the family won’t cope with that, I usually do not recommend discharging the patient.” (M4G1)

Respondents have also reported that, when patients are discharged from the program, a counter-referral to another service in the network must be provided. The participants point the responsibility for the continuation of the patient’s treatment:

“Having stabilized, the family is already oriented, the patient is stable, we counter-refer to the primary care, and then the primary receives this patient; in case of an escalation into an acute condition, they refer back again.” (M19G1)

It is necessary to shape the network in a resolute form for the population’s demands, considering the points of attention and support and logistics systems⁽²⁴⁾. In cases of clinical stability or improvement, the patient should be

referred to primary care, whereas those whose condition has worsened should be referred to hospital or emergency care unit⁽⁸⁾.

The results evidence the participants' concerns about the uncertainty regarding the continuity of care elsewhere in the network, which "pushes" the teams to postpone the discharge of the patient.

"...primary care will handle it, because, when it can not, the patient is elderly, the caregiver is elderly, and the family won't cope with that, I usually do not recommend discharging the patient, despite everyone's complaints, like 'oh, you're protecting patients'. Sometimes I am, because I find it the worst thing for you, to see that you've approved the discharge of someone who wanted to live, but died because of irresponsibility. I'm not sure whether it's irresponsibility or negligence, right? So when I see that there's no other way, we face the discussion and everything else, and I say 'no way, they have to remain', even if it's one visit a month." (M4G1)

"[...] we begin to take our team off the field or to try to discharge [...], we only go every 15 days, try to see whether they build autonomy to call if something happens, then we see that some don't mind; that we have to go back there once a week because, as we get there, the caregiver says the patient went to the hospital because he felt something, but why didn't they call us, they know he's with us, then we begin to need to step back, to recede." (M1P1)

Among the points listed in the interviews with regard to exclusion, the caregiver was the most evidenced reason, either when care occurs inappropriately or when family members are not available or are unprepared for these responsibilities. Therefore, it is necessary to continually assess the patient's condition in HC and, should there be anything that compromises the care for the patient, that should be discussed between the HCS team and the family, which then might lead to discharge and/or referral to another point on the network. When such situation is detected prior to the patient's inclusion in the HCS, it becomes an administrative criterion for exclusion.

"And, for exclusion, in addition to these, we have the patient who does not reside here, who has no caregiver, who lives alone but has no self-care ability. [...] these are exclusion criteria; unfortunately, the patient can not enter the service." (M15G1)

"... The big problem today is not the household, it's the social issue, because we see too precarious houses, but with perfect care, you know? Because, soap and water, most of them have... as for the rest, we find a way, don't we? Even power... today we have the ministerial ordinance that provides for electricity bill discount for patients who use equipment that demand energy... thus, we can handle all the adjustments but, when it comes to

obliging a person to shelter [a patient], that is the big problem." (M3G1)

The presence of the caregiver becomes important, whether it be a relative, a neighbor, a volunteer friend or a hired caregiver. A part of the care that would, institutionally, be delivered by the health team becomes provided by the caregiver or the family. This way, one can understand the condition "not having a caregiver" as exclusion criteria⁽²³⁾. These caregivers can suffer from wear in the bonds, which interferences with the provision of care. Moreover, caregivers have other activities in addition to the care, which can lead to overload and affect the relationship with the patient and the rest of the family^(25,26).

The HC seeks to engage, as object of analysis and improvement, the work of the entire assistance team and of family members who are also responsible for patient care. It must be performed considering the ethical and legal principles of the professions, protecting the intimacy and privacy of the patient in order to shield them from inappropriate actions by the caregiver, suggesting ethically acceptable alternatives. The HC depends on the participation of all in a cooperative process, in which the goal should be the care for the patient in their demands and needs, regardless of the classification of care⁽²⁷⁾.

One can point as limitation of this study the presence, in the results, of some restrictions related to the context in which the study was conducted. The results presented give rise to new questions that can be answered through further research in this or other scenarios, which could enable comparison in the national and international context.

FINAL CONSIDERATIONS

Home care should be conducted when the user's clinical and administrative conditions allow it, considering the eligibility, inclusion, exclusion and discharge criteria.

The presence of the caregiver is evidenced as a major determinant for the patient's eligibility and exclusion, because they represent the key player for continuity of in-home care, in addition to acting as a link between the patient and the team.

Although the HCS criteria have been already defined by the Ministry of Health, it was observed that managers and coordinators make exceptions on the inclusion and discharge, considering the fragility of the network regarding discharge and referral to other care service and the patient's clinical or administrative reality.

Given the findings, it is clear that only through a well-structured and solving health network it will be possible to strengthen Home Care as an important strategy for SUS consolidation.

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