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Research Article

Function and performance of the home care service from the perspective of primary health care professionals

Função e atuação do serviço de atendimento domiciliar na perspectiva de profissionais da Atenção Primária à Saúde

Función y desempeño del Servicio de atención domiciliaria desde la perspectiva de los profesionales de Atención Primaria de Salud

Ana Cláudia Búrigo Lima[1], Diego Floriano de Souza[2], Fabiane Ferraz[3], Amanda Castro[3], Jacks Soratto[3]

[1]Municipal Department of Health of Içara – Içara (SC), Brazil.
[2]Municipal Department of Health of Rincão – Rincão (SC), Brazil.
[3]Universidade do Extremo Sul Catarinense – Criciúma (SC), Brazil.

Abstract

Introduction: The Home Care Service (HCS) is a complementary service to the care provided in basic and basic care and aims to intensify the integrality of training, as it plays an important role in the prevention of new care in the form of complementary and substitutive care. **Objective:** To identify how the HCS work process occurs from the perspective of primary health care professionals in a municipality in the extreme south of Santa Catarina. **Methods:** This is a qualitative research, of the descriptive-exploratory type, carried out with 14 professionals who work before the implementation of HCS and continue to work in Family Health teams in the municipality. The analysis process emerged through the content analysis technique, with the help of Atlas.ti qualitative data analysis software. **Results:** HCS's role is restricted to providing care at home; carrying out multi-professional work; bedridden patients as the focus of care; reference team to provide care. In relation to the role of the HCS, the Family Health teams are associated with support; in helping to carry out comprehensive care; encouraging no hospitalization; improvement in quality of life; and access to health services. **Conclusions:** HCS's performance represents a service closer to the bedridden population, performed by a multiprofessional reference team. And its function linked the improvement of care and guarantee of the right to health.

Keywords: Home nursing; Home care services; Primary health care; Public health.

Corresponding author:
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Resumo

Introdução: O Serviço de Atenção Domiciliar (SAD) é um serviço complementar aos cuidados realizados na atenção básica e urgência e visa fortalecer a integralidade da atenção à saúde, pois assume papel importante na formação de novas estratégias de cuidado na modalidade de atenção complementar e substitutiva. **Objetivo:** Caracterizar a função e atuação do SAD na perspectiva dos profissionais da Atenção Primária à Saúde (APS) em um município do extremo sul catarinense. **Método:** Trata-se de uma pesquisa de abordagem qualitativa, do tipo descritivo-exploratório, realizada com 14 profissionais que atuaram antes da implantação do SAD e continuam trabalhando em equipes de Saúde da Família do município de Araranguá/SC. O processo de análise ocorreu pela técnica de análise de conteúdo, com auxílio do *software* para análise de dados qualitativos Atlas.ti. **Resultados:** A atuação do SAD restringe-se à prestação do cuidado no domicílio; à realização de trabalho multiprofissional; a pacientes acamados como foco da assistência; à equipe de referência para prestação do cuidado. Com relação à função do SAD, ela associa-se ao apoio às equipes de Saúde da Família; ao auxílio para a efetivação da integralidade do cuidado; ao incentivo à desospitalização; à melhoria na qualidade de vida; e à ampliação do acesso ao serviço de saúde. **Conclusão:** A atuação do SAD representa um serviço mais próximo da população acamada e é realizado por equipe de referência multiprofissional. Sua função vincula-se à melhoria da assistência e à ampliação da garantia do direito à saúde.

Palavras-chave: Assistência domiciliar; Serviços de assistência domiciliar; Atenção primária à saúde; Saúde pública.

Resumen

Introducción: El Servicio de Atención Domiciliaria (SAC) es un servicio complementario a la atención prestada en la atención básica y básica y tiene como objetivo intensificar la integralidad de la formación, ya que juega un papel importante en la prevención de nuevos cuidados en forma de complementos y sustitutivos. cuidado. **Objetivo:** Analizar cómo ocurre el proceso de trabajo del SAC en la perspectiva de los profesionales de la atención primaria de salud en un municipio del extremo sur de Santa Catarina. **Métodos:** Se trata de una investigación cualitativa, de tipo descriptiva-exploratoria, realizada con 14 profesionales que actúan antes de la implantación del SAC y continúan actuando en los equipos de Salud de la Familia del municipio. El proceso de análisis surgió a través de la técnica de análisis de contenido, con la ayuda del software de análisis de datos cualitativos Atlas.ti. **Resultados:** El papel de SAC se restringe a brindar atención en el hogar; realización de trabajos multiprofesionales; pacientes encamados como foco de atención; equipo de referencia para brindar atención. En relación al papel de la SAC, los equipos de Salud de la Familia están asociados al apoyo; en ayudar a llevar a cabo una atención integral; alentar la no hospitalización; mejora en la calidad de vida; y el acceso a los servicios de salud. **Conclusiones:** La actuación de SAC representa un servicio más cercano a la población encamada, realizado por un equipo de referencia multiprofesional. Y su función vinculada a la mejora de la atención y garantía del derecho a la salud.

Palabras clave: Atención domiciliaria de salud; Servicios de atención de salud a domicilio; Atención primaria de salud; Salud pública.

INTRODUCTION

Brazil is experiencing rapid growth in the number of elderly people,[1] advancing even further in changing its demographic profile[2] — a situation that, over the next few years, will lead the country to have the sixth largest population of people over 60 years old on the planet.[1]

Thus, home care assumes an important role regarding the formation of new care strategies. For the Ministry of Health, home care should be understood as a form of health care, offered in the patient's home and characterized by a set of health promotion, disease prevention and treatment and rehabilitation actions with a guarantee of continuity of care and integrated with the Health Care Network (RAS).[3,4]

Home Care Service (HCS) is a complementary service to primary care and the emergency network, which materializes through multidisciplinary home care teams and multidisciplinary support teams. As one of the points of the RAS, its effectiveness requires greater articulation with hospital services, the Basic Health Units (UBS), among other sectors and services linked to the process of care and dehospitalization of the population.[5]

In this sense, for the development of home care, it is necessary to dialogue and strengthen or institute intersectoral movements for the constitution of the team and the development of the work with different services, for example, with the social assistance service at home. Still, the difficulty

of working in an interprofessional way, generated both by conflicts between different professional practices and by the lack of qualified professionals for the management of care, interferes with the implementation of the service.[3,5]

Given this scenario, even after the creation of various legislation related to home care in the Unified Health System (SUS), the present study aimed to characterize the role and performance of the HCS from the perspective of primary health care professionals in a municipality in the extreme south of Santa Catarina.

METHODS

This was a qualitative, descriptive-exploratory study approved by the Research Ethics Committee under Approval No. 3.481.531.

This study was carried out in eight UBS with family health teams (FHt) in the municipality of Araranguá (SC), which has a well-structured RAS in services, being the referral municipality in the health region of the extreme south of Santa Catarina.

Fourteen health professionals participated in the study (Chart 1); they were selected taking into account the precepts of qualitative research, namely: *"[...] types of people who best increase the researcher's understanding of the phenomenon*".[6] The inclusion criteria were health professionals who worked before the implementation of the HCS, in 2012, and continued to work in the FHt during the study period.

Chart 1. Profile of study participants.

Code name	Professional	Work in FHt (years)	Highest education
P1	Nursing	16	Post-Graduation
P2	Nursing	8.5	Post-Graduation
P3	Nursing	13	Post-Graduation
P4	Dentistry	7	Graduation
P5	Nursing technician	16	Technical
P6	Medicine	11	Post-Graduation
P7	Oral health technician	8	Technical
P8	Nursing technician	18	Technical
P9	Nursing technician	12	Technical
P10	Dentistry	9	Post-Graduation
P11	Dentistry	7	Graduation
P12	Nursing	14	Master's
P13	Nursing	16	Post-Graduation
P14	Nursing technician	18.5	Technical

FHt: family health team. Graduation: bachelor. Post-Graduation: doctorate.

Data were collected in November and December 2019, using a semi-structured interview consisting of two blocks with nine open questions about the investigative object and five closed questions related to the profile of the participants. In the fieldwork, the interviews were recorded in digital format and lasted an average of 30 minutes. All interviews were transcribed in full.

Data treatment was conducted through thematic content analysis,[7] according to Soratto et al.,[8] with the help of the Atlas.ti software, and structured in three stages: pre-analysis, which began with the exhaustive reading of all the material collected; exploration of the material, with the creation of codes and groups of codes based on the selection of citation excerpts; and treatment of results and inference relating codes, citations with findings in the literature.

The discussion of the data was based on the theoretical precepts of health work. To ensure ethical aspects, participants are identified in the results by the letter P followed by a number.

RESULTS AND DISCUSSION

The results of this study on the analysis of the HCS work process generated 221 excerpts from selected statements and 11 codes linked to two categories, namely HCS performance and HCS function (Table 1).

Table 1. Quote excerpts according to categories and codes related to the analysis of the work process of the Home Care Service in Araranguá (SC), 2019.

Categories/Codes	n	%
Performance of Home Care Service (n=130–58.8%)		
Provision of care at home	61	46.9
Carrying out multidisciplinary work	26	20.0
Bedridden patients as focus of care	24	18.5
Referral team for care delivery	19	14.6
Function of the Home Care Service (n=91–41,2%)		
Support for FHt	40	44.0
Assistance for the effectiveness of comprehensive care	20	22.0
Contribution to dehospitalization	14	15.4
Improvement of quality of life	11	12.1
Expanding access to health services	6	6.6

FHt: family health team.

Performance of Home Care Service

The participants associated the performance of the HCS with the semantic meaning of the name of the service itself and understanding how to perform care at home: "*[...] provide home care for the patient because this patient cannot move to the unit, bedridden patient who has difficulty moving around*" (P3). *"[...] Home care helps to take care of the patient who would be in the hospital occupying a bed, the HCS is able to provide this care at home*" (P7).

Still, data analysis allowed us to determine that the understanding of the participants about the performance of the HCS is structured based on the performance of actions, including support for the family, delivery of inputs and equipment and performance of procedures. They considered the HCS a referral team for users who need more effective home care, with greater dependence on specialized technical follow-up.

The purposes of HCS expressed by the participants are in line with what is found in the literature,[9] in which home care programs are oriented towards dehospitalization, cost reduction, risk prevention and humanization of care. Also, the Ministry of Health describes home care as a "complementary care modality, characterized by a set of health promotion actions, prevention and treatment of diseases and rehabilitation provided at home, with a guarantee of continuity of care and integrated with health care networks".[5] In this way, the relationships established at home tend to humanize care, making the user more a subject of the process and less an object of intervention.[3]

The participants also highlighted that **HCS's work takes place in a multidisciplinary** way, enhancing care actions and improving the quality of life of users and their families. However, even with this perception, some testimonies still reinforced the presence of the physician as the professional who provides greater security in patient care, as we can observe in the following report:

> "*[...] HCS works with a team of several professionals, this is very important for the family and patient in need. Since there is a multidisciplinary team, they guide the family more. The doctor is needed, when the doctor is there, the family is much safer*" (P14).

The multidisciplinary composition of the HCS team, in addition to promoting a better quality of life for the users served, also presents care measures aimed at family members and caregivers. The bond built between them and the HCS team directly impacts the quality of care provided to users.

Still, regarding HCS's performance, it was pointed out that its composition followed the requirements of the Ministry of Health for multidisciplinary configuration in the teams. This is because, according to a specific ordinance,[5] the teams may be composed of doctors, nurses, nursing technicians, physiotherapists, social workers, speech therapists, nutritionists, dentists, psychologists, pharmacists and occupational therapists.

As for the performance of multidisciplinary health teams, they must act based on collaborative practices, planning and articulating actions that meet the needs of users and the community, according to the logic of integrality. Such practices must have communication and cooperation as their main bets, based on dialogue, through a conversation network between the professionals of the multidisciplinary team, thus allowing professionals to recognize the work of the others and share goals and interests in common, to build even more integrated care plans.[10]

Thus, the work of multidisciplinary teams aims to ensure and intensify the construction of comprehensive care, through the organization of collective and multidisciplinary professional work, the work process and public health policy; this, with a system of cooperation between subjects, which aims to overcome the reductionist view that health care can be provided through a professional.[11]

The reports also show that the HCS's performance is more focused on bedridden users, at home and with chronic diseases, who demand comprehensive care, as we can see in this report: "*[...] They are patients, in this case bedridden, who need a 24-hour caregiver, who is sometimes a family member*" (P2). *"[...] They are bedridden with tracheostomy, some dressing, especially those who have tracheostomy, colostomy bag, serum, medication*" (P8).

With regard to the profile of users seen by HCS, the reports also indicate that its performance follows the recommendations of the Ministry of Health, being directed primarily to bedridden users, at home and with chronic diseases, which demand comprehensive care.

The study by Feuerwerker and Merhy[12] describes the profile of users in home care as those in situations of chronic restriction to bed, or continuous use of medication, or equipment such as oxygen concentrators,

probes and catheters, users in palliative care, in closing of wounds and recovery, chronically bedridden, users with AIDS, and monitoring the development of premature babies, among others. Thus, there is a consonance between the profile of users cared for by HCS in the view of FHt professionals with what is established in the literature.

The results show that, for primary health care professionals, the HCS team assumes the role of a **referral team** in the care of certain therapeutic demands. This is demonstrated by the following report: "*[...] HCS for us is a referral for bedridden patients, patients who need greater attention, patients who have wounds that do not heal*" (P13).

> "*[...] If you use a probe and there is something else, we forward it to the HCS. If you have a stroke and need physiotherapy, everything is referred to the HCS, some dressings that are too big they use the plates they have available, we also refer them to HCS*" (P7).

In view of the participants' reports, it can be seen that the HCS team is understood as a referra; team after hospital discharge. In many cases, users who are bedridden, who have chronic wounds or stroke sequelae already leave the hospital with a referral to be cared for by the HCS team.

The referral team corresponds to a new form of organization that aims to reinforce multidisciplinary action, seeking to unify work processes.[13]

In this way, the referral team is structured on the basis of a group of professionals considered essential for meeting the health demands of each area of knowledge. These professionals are co-responsible for the management and users of health care, to develop viable therapeutic plans with agreed interventions, according to the reality of each user/community.

One of the tools used to put these proposals into effect is the term management responsibility, which refers to the task of handling care in a longitudinal and horizontal manner.[13] The referral team is responsible for creating and offering devices that can facilitate the creation of bonds between professionals and users, through the establishment of effective communication, the exchange of knowledge, affection and co-responsibility between different players.[14]

When this process occurs vertically, with division of functions and little dialogue, there is a reduction of the object of work, allowing what is called "denying responsibility".[14]

In Brazil, the FHt is a structural axis in care in the health-disease process of the assisted population.[15] The UBS with FHt is an innovative proposal, established with a project that stimulated the SUS that sought to reform the work processes and interpersonal relationships between professionals and users, establishing itself as a referral in care focused on the reality of the families served.[15]

Therefore, when observing the statements of the FHt professionals about the performance of the HCS professionals as a referral team, it can be inferred that the service can contribute to a certain lack of responsibility of the FHt in the care of bedridden users, when taking on activities that are also with the competence of the FHt. Therefore, it is important to standardize care flows and processes so that the competencies of each RAS device are established.

Function of Home Care Service

The participants stated that the function of HCS is to support the FHt, as we can see in the following reports: "*[...] The patients who they see would be our patients, but we have a great demand for patients in*

the unit, and they would be patients that we would have to go to every day and it would take a lot of time" (P7). "*[...] A very important aid for the nurses, for the unit's staff. A very important help, because when we have someone bedridden we have millions of doubts. We don't prepare for that, but they are prepared*"(P9).

The excerpts indicate how much the FHt is not prepared to deal with the most complex cases, either due to lack of professional training or due to lack of inputs, time, etc. However, it is known that the HCS is a device that integrates the RAS,[16] which in turn is a tool to improve the political-institutional role of SUS, aimed at guaranteeing the individual the measures and services they need. With RAS, it is possible to provide continuous care to a given population at the right time and place, with adequate cost and quality.[17]

Home care encompasses practices aimed at humanizing care and reducing complications.[16] In this sense, the HCS is characterized as an integral part of the RAS,[3] as well as the FHt.[4]

The establishment of the RAS is based on the integration of health services and the interdependence of different players and organizations, understanding that no service has all the necessary resources and skills to resolve the health demands of the population in its various life cycles.[16]

In this way, the interaction between HCS and the FHt is a decisive factor to guarantee users the most resolute and quality care. It is observed, from the perspective of the FHt professionals, that there is integration between these two points of the RAS, with mutual support.

HCS is also understood as a very important tool for **comprehensive health care**, as we can see in the following reports:

> "[...] *Because HCS provides comprehensive treatment" (P6).*
> "[...] *They have a car to go when the patient needs it, for us it is more difficult because we don't have a car available here*" (P7).
> "*[...] Sometimes we have our patient who needs a speech therapist, and with us it takes a little longer and physiotherapy takes a little longer, not there. Their recovery is better and any time the patient needs them they are available, the doctor goes along, the nurse, a whole team goes*" (P1).

Another important aspect of HCS's performance is in the logic of its assistance, in the search for comprehensive care, as it tries to reconcile the use of soft, soft hard and hard technologies in the care of the user and family.

In addition, HCS is also understood as a very important tool for comprehensive health care, which is characterized in the actions of each professional on the team, in their live work in action and in the use of technologies in the health care process.[18]

The expression "integrality" has been used to designate one of the principles of the SUS, understood as the ideal that is expected to be achieved in health practices and in the planning of a care model, expressing one of the banners of the health movement.[16,19]

In this sense, completeness is seen as the search for a comprehensive, expanded view, which aims to understand holistically what can favor health, considering the needs of users in different life cycles. This vision of comprehensive health requires longitudinal and horizontal follow-up to establish the link and meet the individual and collective needs. Thus, it goes far beyond just verifying health-disease demands.[16]

In addition to promoting integrality, for some participants, another function of the HCS is the **dehospitalization** movement:

> [...] *An assistance even at the hospital level, because the focus of the HCS is to dehospitalize that patient who needs hospital assistance, but who does not necessarily need to be inside the hospital so that he can be rehabilitated. The main focus is dehospitalization* (P12).

HCS's focus is on the dehospitalization of users, but not only; it also acts to prevent hospitalization. In critical situations, with demands for complex professional assistance, the HCS acts by reducing the length of hospital stay, thus also avoiding further complications related to this hospitalization and acting directly on the quality of life of users cared for by the team.[5]

Corroborating the statements of FHt professionals, Brito et al.[16] state that one of the main objectives of home care is dehospitalization. This process is related to the humanization of care, to provide the subject with faster rehabilitation at home.

Hospital discharge is associated with the rationalization of hospital beds, since, considering the high costs of health care, it has become a worldwide trend to prioritize hospital beds for acute or decompensated illnesses.[20] Thus, one of the central pillars of home care is to accelerate the hospital discharge process with continued care at home.[20]

Thus, the home came to be understood as a space for health care, allowing rationalization of the use of hospital beds and costs, in addition to establishing a practice centered on the individual. With the dehospitalization process, the objective is to humanize service and care, ensure minimal care and supplies, reduce hospitalizations and prevent readmissions, increase the availability of hospital beds and reduce costs.[21]

Another aspect pointed out by the participants is **improvement in the quality of life**, also reinforcing the comprehensive health care of the service users, as can be seen in the excerpt: "[...] *And the patient has a better quality of life. That's what the team is for*" (P14).

> "[...] *Usually, when a patient is probed, we end up not being able to provide the necessary support and the tendency was to get worse and worse, and with the HCS team, this aspect improved a lot, very much, walking and leading a normal life and if it weren't for this team, I think that we wouldn't make it*" (P13).

Participants emphasize that the function of the HCS is directly linked to improving the quality of life, as it speeds up service to users, especially in the aspect of recovery from stroke injuries and sequelae, traffic accidents and disabilities.

Thanks to new psychosocial approaches, concern with issues related to quality of life has intensified, valuing aspects that go beyond symptom control, reducing morbidity and mortality and increasing life expectancy.[22]

The concept of quality of life is comprehensive and complex and does not only represent health, but involves different approaches, such as economic, psychological, biomedical and general or holistic.[22]

Quality of life can be understood as offering the subject the minimum of conditions so that he can develop the maximum of his abilities and potential. This term encompasses many meanings, which reflect individual and collective knowledge, experiences and values in different places and times, thus representing a sociocultural construction.

HCS is understood as a device **to improve access** to health goods and services, especially for users who find it difficult to travel and/or have special health conditions that require more professional attention. This is what we can observe in the report: "*[...] The HCS came with the proposal to act on the demand that we have from these patients who have more difficulty accessing the unit*" (P1).

Thus, from the perspective of the FHt professionals, it is possible to verify that the HCS provided the improvement of access to health services, facilitating it mainly for users with mobility difficulties and health conditions that would not allow their displacement to the UBS.

According to Travassos e Martins,[23] the use of health services symbolizes the essence of how health systems work, which results from direct contact (medical consultations, hospitalizations) or indirect contact (performing preventive and diagnostic tests). According to the authors, access is a complex and variable concept. In general, it would be the act of entering and being admitted to the service, but it can also indicate the degree of ease with which the individual obtains care.

Access to health services can be influenced by different determinants, such as: demographic, geographic, socioeconomic and cultural characteristics, and availability and amount of resources, among others.[23,24]

CONCLUSION

HCS's performance is linked to providing care at home, carried out by a multidisciplinary referral team for the provision of care, with special emphasis on bedridden patients.

With regard to the role of HCS, it is connected to supporting the FHt, expanding access, helping with the dehospitalization process, improving quality of life and promoting comprehensive care.

The HCS is one of the devices of the RAS that makes it possible to expand the guarantee of the right to health and collaborates to reduce the workload of the FHt by assuming some actions or procedures that converge with those performed by professionals who work in the UBS.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

ACBL: Project administration, Writing – original draft, Writing – review & editing, Investigation, Methodology, Validation, Visualization. DFS: Writing – review & editing, Research, Methodology, Validation, Visualization. FF: Writing – review & editing, Research, Methodology, Validation, Visualization, Supervision. AC: Writing – review & editing, Research, Methodology, Validation, Visualization. JS: Project administration, Writing – original draft, Writing – review & editing, Investigation, Methodology, Validation, Visualization, Software, Supervision.

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