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It is better at home: characterization of home care services

Melhor em casa: caracterização dos serviços de atenção domiciliar

Es mejor en casa: caracterización de los servicios de atención domiciliaria

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ABSTRACT

Objective: to characterize the Home Care Services in operation in Paraíba. **Method:** this is a descriptive, exploratory, quantitative research. Data collection was conducted between March and June 2020 with professionals and coordinators of Home Care Services in 17 municipalities of Paraiba using Google Forms sent by email. Data were statistically analyzed using absolute and relative frequencies. The project was approved by the Research Ethics Committee. Results: 14 teams (61%) were active from Monday to Friday; 16 (69.6%) used transportation of care shared with other services; 11 teams (47.8%) did not use electronic patient records and, among those who did, they did so in the format interconnected to the Health Care Network or in communication only with the Home Care Service (34.8%; 17.4%). As for the Singular Therapeutic Project, 13 teams (56.5%) prepared it. The reference and counter-reference process occurred only at admission and discharge in 19 teams (82.6%). **Conclusions and implications for the practice**: it was evidenced the need for adjustments in the operation of the service and improvements in technological resources, communication and transportation to be implemented by public management for the qualification of home care.

Keywords: Home Care. Comprehensive Health Care. Health policies. Home Care Services. Unified Health System.

RESUMO

Objetivo: caracterizar os Serviços de Atenção Domiciliar em funcionamento na Paraíba. **Método:** trata-se de uma pesquisa descritiva, exploratória, de abordagem quantitativa. A coleta de dados foi realizada entre março e junho de 2020 com profissionais e coordenadores do Serviço de Atenção Domiciliar de 17 municípios paraibanos a partir da utilização de formulário no *Google Forms* enviado por correio eletrônico. Os dados foram analisados estatisticamente por meio de frequências absolutas e relativas. O projeto foi aprovado pelo Comitê de Ética em Pesquisa. **Resultados:** 14 equipes (61%) estavam em atividade de segunda a sexta-feira; 16 (69,6%) utilizavam o transporte assistencial compartilhado com outros serviços; 11 equipes (47,8%) não utilizavam prontuário eletrônico do paciente e, dentre as que utilizavam, o faziam no formato interligado à Rede de Atenção à Saúde ou em comunicação apenas com o Serviço de Atenção Domiciliar (34,8%; 17,4%). Quanto ao Projeto Terapêutico Singular, 13 equipes (56,5%) o elaboravam. O processo de referência e contrarreferência ocorria apenas na admissão e na alta em 19 equipes (82,6%). **Conclusões e implicações para a prática:** evidenciou-se a necessidade de adequações no funcionamento do serviço e de melhorias nos recursos tecnológicos, comunicação e transporte a serem implementadas pela gestão pública para a qualificação da assistência domiciliar.

Palavras-chave: Assistência Domiciliar. Assistência Integral à Saúde. Políticas de Saúde. Serviços de Assistência Domiciliar. Sistema Único de Saúde.

RESUMEN

Objetivo: caracterizar los Servicios de Atención Domiciliaria que operan en Paraíba. **Método**: se trata de una investigación exploratoria y descriptiva, con enfoque cuantitativo. La recogida de datos tuvo lugar entre marzo y junio de 2020 con profesionales y coordinadores del Servicio de Atención Domiciliaria de 17 municipios de Paraíba mediante un formulario en *Google Forms,* enviado por correo electrónico. Los datos se analizaron estadísticamente utilizando frecuencias absolutas y relativas. El proyecto fue aprobado por el Comité de Ética en Investigación. **Resultados:** 14 equipos (61%) estaban activos de lunes a viernes; 16 (69,6%) utilizaban transporte asistencial compartido con otros servicios; se encontró que 11 equipos (47,8%) no utilizaron la historia clínica electrónica de los pacientes; y entre los que la utilizaron, los hacían en el formato conectado a la Red de Atención Sanitaria o en comunicación solo con el Servicio de Atención Domiciliaria (34,8%; 17,4%). En cuanto al Proyecto Terapéutico Singular, 13 equipos (56,5%) lo prepararon. El proceso de derivación y contraderivación ocurrió solo en la admisión y en el alta en 19 equipos (82,6%). **Conclusiones e implicaciones para la práctica**: se evidenció la necesidad de ajustes en el funcionamiento del servicio, y de mejoras en los recursos tecnológicos, la comunicación y el transporte por parte de la administración pública para la cualificación de la atención domiciliaria.

Palabras clave: Atención Domiciliaria de Salud; Atención Integral de Salud; Política de Salud; Servicios de Atención de Salud a Domicilio; Sistema Único de Salud.

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INTRODUCTION

In the mid-1940s, in North America and Europe, as a result of the accelerated aging of the population, there was an expressive increase in Home Care Services (HCSs), with the goal of keeping elderly individuals assisted for the longest period of treatment and rehabilitation at home.[1] In Brazil, this growth happened, more vehemently, in the 1990's due to the increase in the prevalence of chronic and incapacitating diseases in the most varied age groups added to the increase in life expectancy.[2]

However, only in 2011, the HCS was made effective by the National Policy of Home Care (NPHC), integrating the Urgency and Emergency Network (UEN) by the "Better at Home Program".[2,3] This care modality acts in a complementary or substitutive way to the care implemented in hospital institutions. It presents itself as a potential strategy for reducing costs through de-hospitalization, reducing the risk of secondary infections and readmissions,[4] promotion of humanized care, as it is provided in the safety of the home and promotes the autonomy and confidence of the patient and the family, transforming the scenario from hospital hegemony to continuous health care at home.[5,6]

The planning of care offered by the HCS is organized according to the specific care needs of the user, periodicity of visits, intensity of multi-professional care, and use of equipment. It is classified as Home Care (HC) 1 when the demand for specialized care is less frequent, care that, therefore, must be offered by Primary Care (PC); in HC2 for users with chronic diseases that require intense and sequential care; and in HC3 for the population with conditions similar to those of HC2, but that require care of greater complexity and/or technological density, both under the responsibility of the HCS.[5]

Thus, for home care not to become a difficulty for the family and caregivers, in addition to the operationalization of assistance, the HCS, along with the Primary Health Care (PHC) network, acts in the training of these. Thus, it promotes health education for the caregiver, contributing to the empowerment of family members in home care.[3]

According to data from the Ministry of Health (MH), during the period from 2012 to 2016, a total of 4,008,612 outpatient procedures were performed at home throughout Brazil by HCS.[5] However, there are challenges for its operationalization; since the insertion of HCS in the health care field occurred only after the implementation of the Unified Health System (UHS). Therefore, it is observed that its offer still does not meet the demands of the country and of the children, since it presents gaps in the workforce and in the fulfillment of public policies.[7-9]

Despite being promising, studies have shown weaknesses in the HC, such as the lack of operationalization of health policies developed, limitations regarding the coordination of care, low articulation with the other points of the Health Care Network (HCN), as well as the vulnerability of the service to governmental and economic changes that are related to the weaknesses in the infrastructure.[8-10]

In this context and in a continental country like Brazil, with important variations in the form and coverage of care offered by UHS, it is necessary to know the demands and characterize the various HCSs distributed in the national territory. The characterization of these services allows the identification of the potentialities already implemented in certain municipalities, as well as highlights gaps and difficulties experienced by them. Only then is it possible to outline strategies to improve these services in Brazil. Therefore, the objective of this study was established: to characterize the Home Care Services in operation in the State of Paraíba.

METHOD

This is a descriptive, exploratory, quantitative research linked to a multicenter project entitled "Production of Care and Validation of a Flow Protocol for Home Care Services for Children with Special Health Needs", which is being developed in seven Brazilian states (Paraná, Rio Grande do Sul, Santa Catarina, São Paulo, Mato Grosso do Sul, Paraíba and Maranhão).

This article presents the data from the collection in the State of Paraíba. Data collection occurred in all 17 municipalities of Paraíba qualified to provide home care services until June 2019, according to information disclosed in Ordinances No. 825/2016 and No. 3438/2016 of the MH and explained in Chart 1. According to the number of accredited services, care is implemented from Multi-professional Home Care Teams (MHCT 1 and 2) and Support Teams (MHST), which are activated when the collaboration of more professionals in care actions is needed. Inclusion criteria were: being the HCS coordinator in each municipality or the MHCT health professional indicated by the coordinator to participate in the research. Professionals who were on vacation and/or sick leave during the collection period were excluded from the study. Free will was respected in the decision to participate or not in the research. However, there was no refusal. Among the municipalities listed, it was observed that 23 MHCT 1 and 2 were in operation. From these teams, a representative of each was invited to obtain quantitative data, totaling 23 professionals/coordinators. This contact was made by telephone from a list made available by the State Health Secretariat with the help of the respective Municipal Health Secretariats. Data were collected from November 2019 to February 2020 through a Google Forms form sent by e-mail, which was completed after agreement with the Free and Informed Consent Term. When necessary, telephone contact was made for clarification or complementation of information.

The data collection instrument was developed by the research team of the multicenter study, addressing the following aspects: professional identification; identification and operation of the service; assessment and eligibility of users to participate in the HCS; Single Therapeutic Project (STP); records in medical records and in the information system; health transport; medical care/telephone calls; reference and counter-reference (HCS, PHC, UEN); insertion of the MHST in the care; home visits; professional support for caregiver/family.

The data was analyzed using descriptive statistics and presented in absolute numbers and percentages. A matrix was drawn up in Microsoft Excel (2007) in which the collected information

Chart 1. Quantitative of Multi-professional Home Care and Support Teams enabled in 17 municipalities in the State of Paraíba by June 2019.

Location	Quantity of Accredited Services		
MUNICIPALITY	MHCT* 1	MHCT* 2	MHST**
Areia	0	1	1
Boqueirão/Cabaceiras/Caturité/São Domingos do Cariri	0	1	1
Caaporã	0	1	1
Cabedelo	1	0	1
Cajazeiras	1	0	1
Conceição/Serra Grande	0	1	1
Conde	0	1	1
Cuité	1	0	1
Guarabira	1	0	1
Itaporanga	0	1	1
João Pessoa	7	0	3
Monteiro	0	1	1
Pedras de Fogo	0	1	1
Piancó/Olho D'água	0	1	1
Pombal	0	1	1
Queimadas	1	0	1
Sousa	1	0	1

Source: prepared by the authors (2019) based on Ordinance MH No. 825/2016 and Ordinance MH No. 3,438/2016.
* Multidisciplinary Home Care Team; **Multidisciplinary Support Team.

Chart 2. Categorization of the participating professionals regarding the function performed in the Home Care Service and professional training. João Pessoa, PB, Brazil, 2020. (N= 23)

Function/Position	Participant's Profession	N=23	No of professionals	%
Coordinator	Physiotherapist	1	13	56.5
	Social Worker	2		
	Nurse	7		
	Nutritionist	2		
	Administrator	1		
HCS Professional*	Nurse	8	10	43.5
	Physician	1		
	Physiotherapist	1		

Source: elaborated by the authors/research data, 2020.
*Home Care Service.

was grouped and organized, and later processed by the software Statistical Package for Social Sciences (SPSS), version 21.0.

The project was approved by the Research Ethics Committee under Opinion No. 1,741,820 on July 31, 2019.

RESULTS

The health service of the State of Paraíba is directed by the Executive Management of Health Surveillance (EMHS), which contributes to improving the quality of life of the population of Paraíba through the coordination, management, monitoring and evaluation of the health situation, articulating itself as a set of actions aimed at controlling determinants, risks and damages to the population's health.[11]

The HCS in the State of Paraíba was enabled in 17 municipalities in 2019, totaling 23 HC teams between MHCT 1 and 2. It provides home care in the areas of Clinical Medicine, Physiotherapy, Nursing, Speech Therapy, Nutrition, Psychology, Pharmacology, and Social Work.[12]

Of the 23 participants, 13 worked as coordinators (56.5%) and ten worked as members of the multi-professional teams (43.5%). Regarding the coordinators' education, most of them were nurses (7), followed by social workers (2), nutritionists (2), physicians (1), physical therapists (1), and administrative professionals (1) (Chart 2).

Regarding the age of the population served by the HCS in the municipalities under study, it was found that in all teams (23 MHCT), care for the elderly and adults predominated, while in 16 of them (69.6%), there was also a demand for adolescent care, and in 13 (56.5%), care for children, as shown in Table 1.

The work process of the 23 HC teams working in the state of Paraíba was analyzed regarding the dynamics of operation and care, use of service equipment, and the action of the multi-professional team, as shown in Table 2.

As for operation, 61% of the teams are active from Monday to Friday and most of the HCS headquarters (73.9%) were attached to other health services. As for the home care model, 22 teams (95.7%) offered care only in the user's home.

Regarding the use of some equipment and tools of the work process, 12 (52.2%) teams have their own telephone, and the telephone answering service was available in 20 teams (87%) of the HCS. Regarding the Electronic Patient Record (EPR), 11 teams (47.8%) did not use it. Among the 12 teams that used the EPR, they used it in the format interconnected to the HCN or in communication only with the HCS (34.8%; 17.4%). Most services used, for assistance, transport shared with other services (69.6%).

As for the characteristics of the care provided to the population assisted by the HCS, the following stood out: professionals/services that elect users to the program; the guidance methods they use; the insertion of the MHCT in the assistance, the professional family support, the use of the STP and the reference and counter-reference network (Table 3).

Table 1. Identification of the population served by age group in the Home Care Service of the State of Paraíba. João Pessoa, PB, Brazil, 2020.

Variables	No. of MHCT	%
Quantitative of elderly	N=23	
1 to 10	4	17.4
11 to 30	9	39.2
31 to 50	8	34.8
51 to 60	1	4.3
>60	1	4.3
Quantitative of adults	N=23	
1 to 10	13	56.5
11 to 30	7	30.4
31 to 50	3	13.0
>50	0	0
Quantitative of adolescents	N=16	
1 to 10	15	93.7
11 to 30	1	6.3
>30	0	0
Quantitative of children	N=13	
1 to 10	13	100
>10	0	0

Source: elaborated by the authors/research data, 2020.

Table 2. Characterization of the work process of home care teams regarding the operation, use of equipment and professional action of Home Care Services in the State of Paraíba. João Pessoa, PB, Brazil, 2020.

Variables	No. of teams	%
Days of operation	N=23	
Monday to Friday	14	61.0
Monday to Saturday	1	4.3
Twice a week	1	4.3
Every day of the week	7	30.4
Business hours	N=23	
Two shifts during the week	15	65.2
At least two shifts during weekdays and one to two shifts the weekend	8	34.8
Headquarters	N=23	
Own	6	26.1
Attached to another service	17	73.9
Service Location	N=23	
In-home only	22	95.7
At headquarters and at home	1	4.3
Service's own phone number	N=23	
Yes	12	52.2
No	11	47.8
Telecare	N=23	
Yes	20	87.0
No	3	13.0
Electronic Patient Record	N=23	
Interconnected Electronic Health Record	8	34.8
Electronic medical record with communication only within the HCS*	4	17.4
Does not exist	11	47.8
Vehicle for transportation	N=23	
Own	1	4.3
Shared	16	69.6
Does not use one	6	26.1
MHCT professionals who do home visits**	N=23	
All professionals in the team	20	87.0
Some staff members	3	13.0
Frequency of Home Visits	N=23	
Weekly	10	43.5
Less than once a week	3	13.0
More than once a week	10	43.5

Source: prepared by the authors/research data, 2020.
*Home Care Service; **Multidisciplinary Home Care Team.

Table 3. Characteristics of the care provided by the Home Care Service teams in the State of Paraíba. João Pessoa, PB, Brazil, 2020.

Variables	No. of teams	%
Professionals who elect users for admission to the program	N=23	
All staff members	3	13.0
Only some professionals in the team	20	87.0
Services that refer to HCS	N=23	
Public and private services	8	34.8
Public services only	15	65.2
Methods of orientation about the care and operation of the program	N=23	
Verbal orientation	5	21.7
Verbal and written orientation	14	60.9
Verbal, written, and audio-visual orientation	4	17.4
Reference and Counter-Reference	N=23	
On admission and at discharge from the HCS	19	82.6
Continuously, more than once a month	4	17.4
Singular Therapeutic Project	N=23	
Yes	13	56.5
No	3	13.0
Occasionally	7	30.4
Insertion of MHST* in the service	N=23	
Upon request from MHCT**	20	87.0
Upon request from MHCT and of the caregiver	3	13.0
Professional support for caregiver/family	N=23	
There is no support	0	0
Supported by HCS***	5	21.7
There is support by the Health Care Network	18	78.3

Source: elaborated by the authors/research data, 2020.
*Multidisciplinary Support Team; **Multidisciplinary Home Care Team; ***Home Care Service.

Regarding the eligibility for admission to the HCS, it was predominantly performed by only some professionals of the service (87%; n=20). The referral of the user to the HCS teams occurred mostly exclusively by public services (65.2%; n=15) and the orientations about the functioning of the program, as well as the care to users, happened predominantly through verbal and written orientations (60.9%; n=14). The reference and counter-reference process was employed in the admission of the user and in the discharge from the HCS by most teams (82.6%).

Among the studied teams, 13 (56.5%) used the STP. In 20 teams (87%), the insertion of the MHCT in the assistance happened only after the evaluation of the MHCT. As for the professional support offered to the caregiver and the family, it was evidenced that this occurred mostly by other services of the HCN (78.3%; n=18) and five teams (21.7%) offered this support in the HCS.

DISCUSSION

The studied teams predominantly took care of the elderly and adults, but part of them also took care of children and teenagers. In this aspect, national and international studies corroborated the predominance of the elderly in the population served by HCS.[13,14]

Another study conducted in Brazil, which analyzed data from the Health Information System (HIS-UHS) regarding home care, revealed that the rate of home care admissions increases proportionally with age.[15] As for children and adolescents, who should also be assisted by HCS, despite being a minority population, studies have suggested that the low rates of home admissions may result from the lack of official data showing the public and private assistance.[16,17] Therefore, the need for home care in Brazil for this population may be underreported.[3]

Regarding the days and hours of operation of the HCS, according to the Ordinance of the MH No. 825/16, it should offer at least 12 hours a day, either on weekdays, weekends, and holidays, in order to ensure continuity of care, and on weekends and holidays, it is possible to organize the MHCT on call and special shifts for MHST. 3 However, in the state of Paraíba, it was observed that some HCS teams do not meet the minimum workload required, working only in some shifts, and also do not work on weekends, which reflects directly on the continuity of care. It happens that the demands of users who require this service are daily and, despite the support of the caregiver/family, it is essential to have the possibility of frequent support offered by the health team responsible for the care.[18]

As for the place of physical installation, it was noted that, predominantly, the headquarters of the HCS in the municipalities investigated were attached to other health services. However, studies have shown weaknesses regarding the articulation between these services, classifying them as fragmented systems,[18,19] as regulated in the ordinance, which guarantees that it is not mandatory for the HCS to have its own headquarters, but it may be attached to other services as long as it meets the foreseen requirements.[3]

Still, regardless of having their own headquarters and in convergence with the premises of this type of service, most teams offered care in the users' homes. This type of care is one of the main characteristics of the HCS; prioritizing health care provided at home, where there is an affective meaning for the user and the family, contributing to better coping and encouraging autonomy.[20,21]

Regarding the use of care tools used by the HCS, it was identified that telecare is offered by 20 teams, being an important strategy of care for the assisted population. An international study pointed out that this virtual attendance modality is effective in the rehabilitation process of children with disabilities because it allows the consolidation of a continuous and daily contact between professionals, parents and children.[22] However, only 12 of the investigated teams had their own telephone number, which may make it difficult and even impossible to provide effective telecare in these places or even expose the health professional, who makes his personal contact available for guidance and care outside working hours.

It was also identified in this study that most of the HCS teams in the state did not have their own transportation, doing it in a shared way and, therefore, were subject to face difficulties as a result of the unavailability of vehicles due to the demands of other services. It is common that users assisted by the HCS require care in other services of the HCN. Thus, the service must also provide transportation for users and teams, when necessary.

According to the regulatory norm, the effectiveness of this transport flow and the removal of the user must be a priority by the management, since the legislation ensures it from the insertion of the HCS in the HCN for both emergency and elective situations.[3] In addition, Ordinance MH No. 2,563/2017 guarantees funding for the use of Elective Health Transport intended for users in UHS, thus enabling the integrality of care from the displacement of users for health promotion and rehabilitation.[23]

Given this direction, there is a need for public health management to pay special attention to the provision and guarantee of health transportation. Besides being an imminent need of the user assisted by the HCS for treatment and rehabilitation at other points of the HCN, it is a right provided by law.

As for the practical aspects of the use of the service by the population, the process of admission to the HCS should be initiated by a referral from the attending physician of any health service. This referral must contain a detailed report that contributes to the assessment of the user's clinical picture by the HC. Similarly, the discharge is done through referral of the individual due to the less complex clinical picture, characterized as "Discharge to HC1" under the care of PHC.[1]

In this study, the admission of the population contemplated by the HCS is performed by care professionals of the service itself. This is in accordance with the MH Ordinance No. 825/2016, which ensures the admission as an assignment of the care team, requiring the agreement of the user and the family member or caregiver through the Term of Clarification and Responsibility.[3] For the effectiveness of admission to the HCS, it was observed that most teams only accept users referred by public health services. However, this conduct diverges from what is recommended by the NPCP to access the HCS, considering that referrals can come from services that make up the HCN linked to the UHS and also from private services, both by spontaneous demand and by active search.[24]

Therefore, it is emphasized that all the services of the HCN have to identify the user in need of receiving home care assistance in order to guarantee that this population has access to HCS.[25] Therefore, it was identified the need to expand the access to the studied HCS and to create new ones in order to meet the demands of users, especially children/adolescents followed by the different points of the HCN, including private health services, when necessary.

Among the teams investigated, in only three, all professionals of the HC team performed the assessment of the user's eligibility. It is noteworthy that the methods of guidance about the care and operation of the program occur in verbal and written form, reaffirming that all professionals of the HC teams are responsible for the guidance about the operation of the program, as well as the care of users, which should be arranged clearly and objectively, verbally and also in writing, facilitating the understanding of the competencies of the service, the care to be provided by the family and caregivers and the operation of the work process of these professionals.[3]

As for the frequency of follow-up of the user by MHCT professionals, most teams performed the Home Visit (HV) with adequate frequency, even though three teams in the state do not do it with the indicated regularity. It is inferred that this minority can compromise the continuity of home care and access to services for some users who are unable to travel to the health unit with the necessary regularity.

The performance of the HV, according to the National Primary Care Policy, is a responsibility of the DC.[24] The Portaria MH nº 825/2016 reinforces that the HV must be performed at least once a week by the MHCT and that its frequency is linked to the classification of the user's HC modality.[3] The study also highlights that the visits have a positive influence on the adherence to the health service and contribute to the construction of the bond between user/family-team, a primordial factor for the promotion of integral care by the HC.[26] In addition, the HV meets the technical and scientific knowledge needs that family members require for care at home.[27]

Another important factor in ensuring comprehensive care is the sharing of intra- and intersectoral information. In this sense, the use of the EPR and the actions of reference and counter-reference between the other services of the HCN are strategies that ensure the completeness of care.

The EPR stands out as an important tool for sharing information about the care provided to users among the teams that follow them and, therefore, effective for ensuring the completeness and continuity of care in different health care settings. It is an Information and Communication Technology with the objective of electronically recording the activities developed in the assistance,

as well as the user's information to be shared with the team and, broadly, with the HCN.[28]

However, half of the HC teams studied did not commonly use this tool. Studies have revealed that its non-use can result in potential implications in the assistance strategies promoted by other services of the HCN when the process of referral and counter-referral of the user is carried out. These implications include the difficulty in grouping information from different levels of care, as well as the integration of control measures adopted by the health services the user has already used.[29,30]

Regarding the reference and counter-reference processes between the HCS and PHC, it was evidenced that, in most teams, it occurred only upon admission and discharge, while in a minority, this process occurred continuously. Thus, it is evident the disparity of this reality when compared to what is provided by the Ordinance MH No. 825/2016. According to this regulatory standard, these processes should not occur only upon admission and discharge of users. The HCS has continuous insertion in the HCN in order to ensure the reference flow for emergency services and hospitals, as well as referrals, in elective and urgent situations, to specialties and complementary methods of diagnosis during the assistance provided to the user.[3] During the permanence of the user under HCS care, the reference and counter-reference process must happen in a continuous manner.[18,25]

Studies have shown the dissatisfaction of users and professionals regarding the fragility of the articulation of flows between the HCS and the HCN. These problems were related to the low accessibility to the referred services, as well as to the need of informal personal contacts to get care for the user, the lack of dialogue between professionals for a better articulation, the lack of knowledge of the professionals of the HCN about the assistance of the HCS, and even the opening hours of the services.[18,19]

These administrative flows and counter-flows are of fundamental importance in the HCS, considering that most users are referred to the HCS from tertiary care for continuity of treatment because they demand care that requires less technological and therapeutic resources when compared to hospitals.[3] However, these users are subject to disease aggravation, requiring, sporadically, redirection to tertiary care. Another circumstance is that, after the stabilization of the clinical picture of the user and with the proper training of the family caregiver, the patient is also discharged from the HCS with the transfer of care to PHC.[26,31]

Still with regard to ensuring completeness and continuity of care, another strategy that can be used to adjust care planning to the demands of the user/family is the STP.[3] Most teams in the state used this tool routinely or occasionally, and a small part did not use it. Therefore, it is evident that most users have a therapeutic approach focused on their needs, making the individual the main actor in the process of illness-rehabilitation, ensuring care based on uniqueness.[32]

This integral health care planning is based on the elaboration of therapeutic conducts that are adequate to the user's reality, meeting the objective and subjective demands, contributing to the development of the individual's autonomy, the appropriation of his/her care process and a better quality of care based on the integrality of the individual-family.[32,33]

In most of the teams investigated, the need for insertion of the MHST in the care was based exclusively on the clinical assessment of the user by the MHCT, while three teams (13%) also listed the request of the caregiver as a requirement for this insertion. Thus, the team can clinically evaluate the user's demand from the construction of the SPT and request the insertion of the MHST in care, offering multi-professional support to the family, which contributes to a better quality of care.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The variables used in this study allowed us to characterize the HCS in operation in the State of Paraíba. The services studied ensure the continuity of assistance to users, the availability of face-to-face home care and the articulation with other services of the HCN. The data presented in this study contribute to the development of improvements as to the need for technological resources, communication and transportation in order to produce a higher quality of care. The implementation of the STP and EPR in the municipalities of Paraiba can contribute to the qualification of care and public management. In addition, it is necessary to adjust the days and hours of operation of the service.

The importance of the actions already successfully developed by some HC teams, such as the HV, the use of the STP, and the telephone assistance.

It should be noted, however, that the results of this study do not answer or clarify, in full, the flows and functioning of the HCS in Brazil. It is noteworthy that similar studies have been developed in Paraná, Rio Grande do Sul, Santa Catarina, São Paulo, Mato Grosso do Sul, and Maranhão because they encompass multicenter research. It is suggested, recognizing its importance, the development of new studies on the subject with the expansion of the same to other Brazilian states, after the pandemic period, in order to support the improvement of the quality of HCS provided nationwide.

The limitation of the study was configured by the difficulty in contacting the participants for the presentation of the research as well as their availability to collaborate, because these health professionals were being recruited to face the first cases of COVID-19 in their municipalities, which prolonged the time of data collection.

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