Original Article

Home care organization with the Better at Home Program

Organização da atenção domiciliar com o Programa Melhor em Casa

Organización de la atención a domicilio con el Programa Mejor en Casa

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ABSTRACT

Objective: To understand the home health care organization modes in the context of health care delivered by municipalities that have joined a Program entitled Better at Home.

Methods: A multicenter qualitative study. Data collection performed in 12 municipalities, from February 2014 to July 2015, through semi-structured interviews with 12 Home Care Services coordinators and six managers. Content analysis was used as a method of data handling.

Results: Two categories of analysis emerged: Supply management regulated by political and administrative demands, previous experiences and local health profile and organization Modes mediated by users' needs.

Conclusion: It is concluded that the significant progress observed in home care organization modes stems from the integration of management and care aspects. It is highlighted that this substitutive care modality may enhance the effectiveness of services, reducing fragmentation and solvability of health needs.

Keywords: Health services management. Home care services. Home care.

RESUMO

Objetivo: Compreender os modos de organização da Atenção Domiciliar no contexto da atenção à saúde ofertada por municípios que aderiram ao Programa Melhor em Casa, no Estado de Minas Gerais.

Métodos: Estudo multicêntrico com abordagem qualitativa. Dados coletados em 12 municípios mineiros, entre fevereiro de 2014 e julho de 2015, por meio de entrevistas semiestruturadas, com 12 coordenadores de Serviços de Atenção Domiciliar e seis gestores. Utilizou-se a Análise de Conteúdo como método de tratamento dos dados.

Resultados: Obtiveram-se duas categorias de análise: Organização da oferta regulada por demandas político-administrativas, experiências prévias e perfil de saúde local e Modos de organização mediados pelas necessidades dos usuários.

Conclusão: Depreende-se que o sucesso notado nos modos de organização da Atenção Domiciliar decorre da integração entre elementos da gestão e assistenciais. Reforça-se que esta modalidade assistencial substitutiva apresenta potencial para a efetividade dos serviços, redução da fragmentação e resolubilidade das necessidades de saúde.

Palavras-chave: Administração de serviços de saúde. Serviços de assistência domiciliar. Assistência domiciliar.

RESUMEN

Objetivo: Comprender las maneras de organización de la atención domiciliaria en el contexto de la atención a la salud ofrecida por municipios que adherirán al Programa Mejor en Casa.

Métodos: Estudio metacéntrico con abordaje cualitativa. Datos colectados en 12 municipios, entre febrero de 2014 y julio de 2015, por medio de entrevistas semiestructuradas, con 12 coordinadores de servicios de atención domiciliaria y seis administradores. Se utilizó el Analice de Contenido como método de tratamiento de los datos.

Resultados: Se obtuvieron dos categorías de analice: Organización de la oferta regulada por demandas político-administrativas, experiencias previas y perfil de salud local y Maneras de organización mediadas por las necesidades de los usuarios.

Conclusión: Se deprende que el suceso notado en las maneras de organización de la atención domiciliaria se sigue a la integración entre elementos de la administración y asistenciales. Se refuerza que esta modalidad asistencial substitutiva presenta potencial para la efectividad de los servicios, reducción de la fragmentación y resolución de las necesidades de salud.

Palabras-Clave: Administración de los servicios de salud. Servicios de atención de salud a domicilio. Atención domiciliaria de salud.

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INTRODUCTION

The organization of the Home Care (HC) offer in Brazil has undergone transformations in recent years. These changes had as an important milestone the guidelines proposed by the National Home Care Policy (NHCP)[1]. HC is included in the Health Care Network (HCN) of the Unified Health System (SUS), assuming the principles and guidelines of this system, provided by law, highlighting the universality, equity, completeness, resolubility, and broadening of access, associated with the reception and humanization, that must be observed in the organization of Homecare Services (HCS)[2].

The implementation of the HCS is a challenge for the HCS managers and coordinators as well as for professionals, who invest in identifying and analyzing the health conditions that subsidize and qualify the decisions and the actions of management or assistance, so that they are resolute. Challenge, due to the need to keep management's actions integrated with care, given the complexity of the care to be offered by the HC, with the displacement of the care setting to the home, previously focused on health institutions legitimized by the State.

The process of organizing a HCS includes the identification of the offer flow of the existing services in the HCN; from the inclusion request and the admission of the user through the eligibility criteria, followed by the care planning, which has been made possible by the evaluation of the degree of complexity, definitions about the modality, resources and technologies of the care demanded, including the periodicity of the home care. This process generates the need for elaborating budgets, costing sheets, definition of professionals with adequate training, practice of home care and the monitoring of the user from the admission to the discharge, with the requirement of formal records, including the use of Information System[1,3].

It is understood that there are two aspects that mobilize managers in the political-institutional decision to implement the HC after the creation of the Better at Home Program (BHP) in the country in 2011. The first is that this modality of attention is understood as an abbreviation or substitution of the hospitalization, aiming, therefore, at reducing costs. Another, as an alternative to the reorganization of the techno-care model, making this type of service a space to manage new ways of caring. These, complementary to each other, are considered central in the agency of managers and professionals who stand at the forefront of the organization process of HCS[3].

Thus, it is believed that discussing the forms of planning, understanding the interfaces that permeate the HC organization in its macro and micro-structural aspects, considering the existing relationships and others that are established from the implementation of the service, becomes fundamental for the expected effectiveness of the actions that it offers[4].

Minas Gerais is one of the Brazilian states located in the southeastern region of the country, and in July of 2016, 26 of its 853 municipalities registered multiprofessional home care teams (MHCT) according to the modality proposed by the BHP, being 51 of type 1; Six of type 2, and 24 multiprofessional support teams (MHCT). Together, according to the current form of the HC financing in the country, an annual cost of R$ 1,761,048,000.00 (one billion, seven hundred and sixty-one million, forty-eight thousand reais)[5].

In addition to the punctuated aspects, and considering the territorial extension of the state, the assistance diversity that is conjugated under the aegis of the same guidelines and norms of the SUS becomes relevant to understand the modes of organization of the HCS, from the point of view of the coordinators and municipal managers who have made efforts in order to implement these services.

In this way, the research presented here has as object the organization of HC in Minas Gerais, according to the modality proposed by the National Policy of Home Care, since its creation in 2011, with the launch of the BHP. The question arose: how did the managers of the municipalities that joined the MHCT and the coordinators of the HCSs devised conceive the organization of the provision of these services in the care setting in which they are inserted? The aim of this study was to understand the organization of home care in the context of public healthcare provided by the municipalities that joined the Better at Home Program in the state of Minas Gerais.

METHODS

This article results from a qualitative, descriptive and exploratory study based on the methodological framework of the Marxist dialectic discussed by Minayo[6], in which the data were collected through a visit to Minas Gerais' municipalities, which met the National Policy for Home Care, instituted by the Ministerial Decree No. 2,029/2011[7].

It presents the findings of the analysis stage of the supply, extracted from the multicentric research "Home Care in Health: effects and movements in the supply and demand in SUS in the State of MG" developed between 2013 and 2015 by research groups from six Universities in the State of Minas Gerais.

Thirty municipalities that met the national regulations were identified. Subsequently, contacts were established with the Health Secretaries of these municipalities, forma-

lizing the request for an authorization to carry out the research. Nineteen municipalities that offer Home Care Services linked to the Better at Home Program accepted participating in the study. The data collection occurred between February of 2014 and July of 2015.

For the analysis of the supply stage, 12 municipalities were constituted as scenario. At this stage, we sought to analyze the organizational and logistic characteristics of the existing services. The interview was guided by a semi-structured script as an instrument for data collection with municipal managers and or HCS coordinators of the scenarios municipalities. The script contained open questions that dealt with: the linkage of the Home Care Services, both institutional and in the Healthcare Network; the number; the composition and profile of qualified teams; the mode of the care provided; the profile of the users served; the protocols used by the service; the routing flows and the relationship with the other network services.

Eighteen interviews were conducted, 12 with HCS coordinators and six with municipal managers, with an average duration of 43 minutes, totaling 15 hours, 48 minutes and 15 seconds of recording at this stage of the research. For the coding of the interviews, the letter M was used to define the municipalities (for example, M1) and the letter G for the interviews with managers and coordinators (for example, G1), respectively.

The interviews were transcribed in their entirety by the researchers and, later, the material was submitted to content thematic analysis. The data was ordered with emphasis on the discovery of sense nuclei, evidenced from the themes that composed the communication, linked to the context of the enunciation, whose presence or frequency has significance for the analytical objective of this stage of the research through pre-analysis, material exploration, treatment of the results obtained, inference and interpretation[8].

The participants were informed about the objectives and purposes of the study and signed the Free and Informed Consent Term, obeying the ethical precepts of the Brazilian legislation. The project was approved by the Research Ethics Committee of the Federal University of Minas Gerais, under the Opinion No. 938.240 and CAE 07698212.7.0000.5149.

RESULTS AND DISCUSSION

From the analysis process undertaken, the following thematic nuclei were extracted: "Supply management regulated by political and administrative demands, previous experiences and local health profile" and "Modes of organization mediated by users' needs", which will be discussed below.

Supply management regulated by political and administrative demands, previous experiences and local health profile

Through data analysis, the emergence of a way of organizing the HC supply consistent with the demands of management has been identified, given the existing structures, the health specificities of the municipalities, consonant with the different motivations for adherence and implementation of the BHP. Initially, those who immediately adhered to the policy emphasized the need to invest in the implementation of HCS, based on the technical and political specificities of the local networks, considering the existing services prior to the publication of the Administrative Rule No. 2,029/2011[6].

> *The inpatient program had been in existence for 14 years, now turning 15, and we are currently in this phase of HCS implementation, according to Better at Home; with the Ordinance approved since October of 2013 (M7G2).*

In addition, new services were introduced, resulting from the movement of professionals who, when they became aware of the publication of the National Policy on Home Care and the launching of the BHP, invested in sensitizing the manager, based on the local health profile, counting on the services structure already existing in the HCN.

> *So we started working with Better at Home, after all this journey I told you about: meetings with the Basic Attention, meetings with the management, meetings with the PSF, meetings with the Nasf team [...].We started in 2012, so, in 2012, we already started with the process of capturing a patient, to see what the demand is, case discussion. And from there, we started to create our own thing (M11G1).*

In the HCS implementation processes, the role of the coordinator and the municipal manager for the organizational aspects, the operation of the Program, the flow pacing and the definition of protocols was fundamental. However, it is known that the dynamics of these services enables a mobilization of technological arrangements in the daily work process in health, giving potential to the creation of new forms of care in the home environment[3,6].

Progressively created services have shown a peculiar organization way when they enter HCN. A first aspect refers to the training of the professionals who integrated the teams, which brought previous experiences to their work processes, considering the place where they have previously worked, being it in public or private health services.

Some professionals who joined the teams come from Primary Care services and others from Hospital Care or Emergency Care, highlighting the need to promote specific training for the HC work. The training was shown as a relevant aspect for the organization of the service, given the importance of investment in professionals with the skills required by the assistance offered at home.

> *The nursing assistants, we, as it was of medium and high complexity, we trained with them in the emergency care, in the laboratories, because we need the collection, right? So they were trained in this way, the physiotherapists in courses, the nursing in specific courses for the dressings, wounds, each one did training and qualifications in their areas, and then all went to home service training in others, another state (M19G1).*

The accomplishment of technical visits with the permanence and observation by the professionals of the work dynamics in HCS already established was reported as a management strategy for the initial qualification. In addition, the managers and coordinators stressed the need to evaluate the profile of the professional when selecting them to work in the HC.

The work moves to the context of private life, outside the aegis of health institutions, requiring complex changes, with detachment of the traditional practices, which, in other assistance realities, are spread as certain, as well as the development of new skills[9]. Understanding the user's individualities, intra-family relationships, and promoting strategies to enhance the construction of home care knowledge are some examples of these skills[10-11]. It is also necessary to consider the profile of the professional to deal with the singularity and the subjectivity that surrounds the process of caring at home, since the professionals and the patient will find the family[2,11].

The experience of transition from the care provided in the hospital environment to the one that is offered at the patient's home, implies intense emotions, sometimes negative, to the caregivers, family and to the user himself. In this context, the possibility of physical and emotional overload of the family caregiver is highlighted. With this, the development and strengthening of effective communication among those involved with care; the education of the caregivers and family members, the support of the HC service in the health needs of the users and the identification of support networks are fundamental strategies to minimize the burden of this transfer[2,12].

> *We say it is not enough just being good, right? You have to have the profile of putting this [technique] together with the home Care, right? That is to sit anywhere [...] to enter the house, right? That is having to sometimes accept the coffee they offer you [laughs] (M1G1).*

In the home care, emerges the complexity of social, clinical and epidemiological problems. And, in this way, the professionals who work in the HC, when they change the *locus* of care, of the healthcare institution to the home, they need to modify the logic of care, because the conception of care will take into account the reality found[3,13-14].

Another aspect identified is that the managers and coordinators interviewed recognize the need for dialogue with all the points of the HCN, in which communication must be continuous, aiming at the resolubility in meeting the users' demands, in addition to enabling comprehensive care and ensuring the continuity of care at home. It is established, initially, a relation with the existing devices in the HCN, citing, for example, the model of admission and registration of HC; the flow for readmission and the eligibility criteria, which follow the BHP definitions.

> *[...]We have observed that there is a difficulty for HCS [...] to really interface with the other Services, and when you read the Ordinance, you see that it is a new point on the Network, right? We are there in the emergency, but it has to communicate with the whole network.. [...] The hospital transfers the patient's care to the HCS [...] and, like the hospital, the patient will be discharged to some place and it is for Primary Care. I do not know why [...] the Basic Care has had an enormous difficulty absorbing this patient (M3G1).*

Through the need to guide decisions, domains and competencies of the HCS, in the hierarchical list of services offered, the managers do so from the administrative demands. One of them is the definition of the HCS location point in the HCN and the ideal flow for users of this service in the Network.

> *Then all the flows were built, debated. We made the interfaces, so we held meetings with the basic attention and the HCS team along with basic attention [...]. Then we made the interface with the hospital and the emergency department of the municipality, which is the polyclinic (M11G2).*

It should be highlighted that in some municipalities, the organization of the BHP team is based within the Emergency Care Unit, which makes it possible to articulate the HCS with this HCN point, facilitating the decision-making regarding the care with the user and contributing to the process of deinstitutionalization. It also strengthens the

normative aspect of the HC as a component of the Emergency Care Network[1]. In this scenario, the HCS promotes the necessary articulation within the HCN, acting as a substitute modality, seeking to ensure the continuity of care, which was initiated, preventing the hospitalization[14].

In primary healthcare (PHC), the Family Health Strategy (FHS) is seen as an ordinator of the HCN and coordinator of care, with territoriality as its organizational principle. The type of HC offered by the PHC and the one that is offered by the HCS differ among themselves not only by the work process of the teams, but also by the frequency and technological density of the care[3,13-14].

The interlocution between the professionals who work in HC with those of other HCN care points is fundamental to consolidate the doctrinal principles of the SUS[14]. The accomplishment of meetings between the teams of other services was a strategy pointed out by the interviewees for the establishment of the flow of the user and improvement in the interlocution with the other points of attention in the HCN.

> *So, with a lot of talk, with a lot of team meetings, we've evolved. All the flows were built, debated, we made the interfaces, then. We think in the transition, the evolution of the home care service, because, in our view, not only in my own as a manager of the service, it is the view of the management, and, especially, of the team, we think of evolving, right? (M11G1).*

As a result, the flows are defined, from the point of view of the management, according to the demands, thinking of a better itinerary, nonetheless, taking into consideration the health needs and trajectories of the users in search of care. The implementation of the HC with this look encompasses the efforts of SUS, with the aim of reducing the fragmentation of actions by strengthening the policies in search of equity and integrality[13].

Among the factors that induce changes in the organization of the healthcare in SUS, there is an increase in expenditures, the need to revise investments in the health sector, evidencing the proposition that the HCN assumes the HC in a more systemic way[9].

It is identified, through the reports, that the HC organization was influenced by high costs and healthcare, requiring a new financing model. The managers mention that, in addition to the financial resources from the Federal Government subsidy for the BHP membership, there was a compromise in the municipality, which would be jointly responsible for complementing and ensuring the operation of the BHP in line with local demands.

> *And the transfer of the Ministry of Health is one hundred and fifty-six thousand reais per month for the cost of the Team. So, [...] our two major contracts are the [...] municipal treasury that assumes: [...] the leasing of vehicles and the hiring of personnel [...]. The contracts of equipment and several others of costing even of the equipment, of the infrastructure and fuel, are with the resources of the Better at Home. But, well, it is far from being enough to cost (M8G2).*

The role of the municipal management for the viability of the HCS is highlighted, since managers report as insufficient the value transferred by the Federal Government, for the expected functioning of this modality of care. It has been described that the programmed values are still not sufficient for the costing of the actions and services offered, being necessary studies and revisions, since the model of financing operated in the HC precedes the launching of the BHP[13,15].

In order to make the offer of the service viable, coordinators and managers use the existing HCN resources and equipment as strategies for the HCS user access technologies of different costs, ranging from laboratory or imaging tests to readmissions. Thus, it is avoided to generate its own revenue, due to the budget allocation model practiced in the municipalities and in the state for this type of care.

> *We made a compromise with the lab, okay? With patients who are from the Better at Home. When the doctor or nurse asks for some tests, even the nutritionist, we send them to the laboratory together with the collection [...], we collect them and send them to the laboratory, the municipal laboratory here of M11. And they, in 24 hours, respond to people, that is, there is agility in the response of this service (M11G1).*

The internal agreements between the services that integrate the HCN contribute to the efficiency of the care, satisfaction of the users, and effectiveness of the service. The study participants also report investments for the adequacy of care according to the conditions of the infrastructure and logistics for the implementation of home hospitalization.

> *If we see that there is a lot of patients already, and that the car is not supporting it, we will stop here, now. We start hospitalization next week, when we discharge some of them (M1G1).*

The organization of the service offer, regarding the entry of new users, depends on the feasibility for home care and the car becomes an essential technology for working at the HC. In order to promote better coordination of the

service, it is essential to identify the instruments, the number of patients attended/day, as well as the routes to be covered, as they are relevant requirements both in the arrangements and in the formal planning of the assistance that will be carried out with the users registered in the HCS.

Although the political-administrative demands have primarily guided the option of the managers to implement the BHP, other motivations have been identified, highlighting health needs, signaling to a way of organization that combines management and assistance.

Modes of organization mediated by users' needs

The analysis of the data identifies the existence of an evaluation process that allowed a revision of the internal logic of the attendants by the managers, seeking a resolute praxis in the modes of organization of the services based on the needs of the user.

> *[...]We, today, in the service of the Better At Home, we can offer what the patient needs, what he needs. Of course, a survey was made, that we understand that the hospitalization at home, we want to offer to patient as if it were the hospital. So what is the hospital offering? A hospital bed, a serum support, depending on an infusion pump, an oximeter, those necessary supplies (M11G1).*

It is understood that they are concerned and committed to the structuring and planning of protocols that favor the standardization of administrative and assistantial care as well as the systematization of the service, with attitudes of flexibility mediated by the singularities of the users/family. In order to make a decision about the logistics of the supplies, the managers use the expense information, comparing it with the standardized lists of materials, inserting or excluding items according to the reality of the cases[2-3,9,11,15].

In addition to equipment, users sometimes need consumer supplies, which are provided to caregivers in order to enable care.

> *The patient today is captured, we take responsibility for all the necessary input; if they have ten wounds, that need so many supplies, so many packages of gauze, our team, we have a spreadsheet [...] signed by the family, that they are receiving it, so every month our team goes there and pick up the signature that they are receiving that material for the care (M11G1).*

It is known that, in order to perform the HCS, it is necessary that the residences have a structure with the permanent and consumption materials that make it possible to recover and/or stabilize the health situation of the HCS. In this sense, it is necessary to develop an individualized care plan that describes all the basic and advanced needs of these individuals[9-13].

In order to provide the required inputs, managers and coordinators consider the appointment of the professional, guided by the users' assistance needs and the dismissal. They are also based on worksheets created by the services themselves, in order to obtain a better arrangement of the materials offered.

> *A flow of dismissing the coverage that, because they are too expensive [...], we end up trying to surround this, right? The person who indicates the coverage has to be the specialist nurse in coverage, right? The one that knows how to indicate (M3G1).*

Providing the service with equipment, medication or materials indicated/prescribed by specialists in care plans that are guided by needs confers resolubility in the assistance and efficiency in the use of financial resources. The qualification and specialization of the professionals who work in the HC have been demanded in the care of the users of this service, given the complexity of their demands of care at home, which make it a complex patient[2,9,11,14,16-17]. It requires change in care practice and this "means transcending into a new space and developing new skills, stripping away from entrenched and widespread traditions and constraints over the decades"[16].

The allocation of professionals has been a concern for the management of human resources in several home care services[2-3,16]. Decisions related to the number, specialization of professionals and their destination to different locations are influenced by the demands of users and families and by local strategic planning[18].

> *The team here is composed of the doctor, who has the workload of 40 hours, by two nurses, 20 hours each, because it would have to be 40 hours that the service requests. So we chose to have two nurses of 20, three nursing technicians, two being on call and one daily [...]. And Emad also has a physical therapist that's 30 hours. And in the Emad, the MHCT is also composed by the speech therapist 30 hours, one more, nutritionist 30 hours and another physiotherapist. Because here in YYY in the county, the greater demand is for physical therapy [...] (M19G1).*

It is understood that the composition of the team varies according to the specificities of each municipality and this flexibility facilitates the process of organization and resolubility.

M19G1's report emphasizes that physiotherapy represents the greatest demand of this municipality, choosing to include this professional category in both EMAD and MHCTA as lack of some professional categories in home care, associated or not with the lack of certain services, as a barrier to the access of HC users to complementary services.[4,11,19].

However, the existence of hiring by different legal regimes, such as temporary contracts or the allocation of professionals already in the network, is identified. It is known that this aspect, in addition to compromising the organization of the work, affects the solidification of the public health system[20]. In HC, the commitment is potentiated, because the significant turnover of workers and the admission of professionals without the profile to act in the HC put at risk the quality of the care to the users, by breaking the bond, continuity and making the definition of inter professional care plans unfeasible.

> *Some, others are not. But those who are not admitted by contests, are by selective processes, or contract by referral, because when we make a contract by referral, we ask for the opening of the selection process, next year, it seems that there will be a big contest in the city hall, right, it is planned. (M8G2)*

In addition to the previously highlighted aspects, different types of records, including user data, also characterize the organization mode. It was identified by the interviews that these are done in their own forms, created from models used in hospitals, showing a creation movement, with new knowledge both for the definition of protocols and for the creation of HC's own organizational processes[9,11].

> *[...]Since we had few patients, we started to build a structure to function in full [...] for when we had the patients, so today we have hospitalization records, (...) registration form, referral form, every protocol of this type. (M4G1)*

The clinical evolution of the care with the users is carried out in handwritten medical records and in the services researched, at the time of the data collection, experiences with computerized medical records were not identified. In some services, the registration of the service to the users is seen as a way to compute the productivity of the procedures performed during home visits.

> *The report provided is one that exists in all municipalities, it is the register of outpatient health actions that are the HCN and we do it and the municipality is now entering a different moment that is the E-SUS. We are having a change from this HCN to the citizen's electronic medical record, the PEC, among other things, the use of tablets and send them, the production at the moment, to the Ministry of Health, but the main form of registration and reporting are the HCNs. (M15 G1)*

The register of the information and data resulting from the production of home care by the HCS are of vital importance both for the organization of the offer of this SUS service and for the State's evaluation in its role of planner and public policy maker. They also make it possible to carry out research that contributes to the advancement of the management, assistance and training of health professionals with a profile for work in the HC.

FINAL CONSIDERATIONS

The findings indicated the existence of modes of organization of services regulated by political-administrative demands, experiences accumulated by the HCS offer and local health profile, and also mediated by the users' care needs.

The contribution of these findings to the field of Nursing is emphasized, which includes a large number of professionals who make up the EMAD and MHCT. In particular, they contribute to those who work in the HCS management, in different realities, by pointing them to factors that must be considered, such as the influence of training models and work processes on previous experiences on the organization of this care modality.

It was concluded that a positive point for the success of the HC care modality is the integration between management and care elements in organizational modes. The National Home Care Policy was valued as a substitutive care modality, with potential for service effectiveness, reduced fragmentation and resolubility of the health needs.

The research stage presented in this article did not include an investigation with professionals of the teams, users and caregivers and was carried out in a period that coincided with the implementation of the services according to the proposal of the BHP in the State of Minas Gerais. These can be considered as gaps, showing the importance of new research in the field of Nursing and Health capable of elucidating the organization of the HC services from the point of view of team professionals, including the effectiveness of the established care model.

REFERENCES

1. Ministério da Saúde (BR), Organização Pan-Americana da Saúde. Atenção domiciliar no SUS: resultados do laboratório de inovação em atenção domiciliar. Brasília (DF): Ministério da Saúde;2014.

2. Braga PP, Sena RR, Seixas CT, Castro EAB, Andrade MA, Silva YC. Oferta e demanda na atenção domiciliar em saúde. Cienc Saude Coletiva. 2016 [cited 2016 Jul 10];21(3):903-12. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232016000300903&script=sci_abstract&tlng=pt.
3. Silvia KL, Sena RR, Seixas CT, Feuerwerker CM, Merhy E. Atenção domiciliar como mudança do modelo tecnoassistencial. Rev Saude Publica. 2010 [cited 2016 Aug 20];44(1):166-76. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102010000100018.
4. Furukawa PO, Cunha ICKO. Perfil e competências de gerentes de enfermagem de hospitais acreditados. Rev Lat-Am Enfermagem. 2011 [cited 2016 Oct 23]:19(1):106-14. Available from: http://www.scielo.br/scielo.php?pid=S0104-11692011000100015&script=sci_arttext&tlng=pt.
5. Ministério da Saúde (BR). Portaria n° 825, de 25 de abril de 2016: redefine a Atenção Domiciliar no âmbito do Sistema Único de Saúde (SUS) e atualiza as equipes habilitadas. Diário Oficial da União [da] República Federativa do Brasil. 2016 abr 26;153(78 Seção 1):33-8.
6. Minayo MCS. Desafio do conhecimento: pesquisa qualitativa em saúde. 14. ed. São Paulo: Hucitec; 2014.
7. Ministério da Saúde (BR). Portaria n° 2.029, de 24 de agosto de 2011. Institui a Atenção no âmbito do Sistema Único de Saúde (SUS). *Diário Oficial da União* [da] República Federativa do Brasil. 2011ago 25;148(164 Seção 1):91-2.
8. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
9. Brito MJM, Andrade AM, Caçador BS, Freitas LFC, Penna CMM. Atenção domiciliar na estruturação da rede de atenção à saúde: trilhando os caminhos da integralidade. Esc. Anna Nery. 2013 [cited 2016 Sep 15];17(4):603-10. Available from: http://www.scielo.br/scielo.php?pid=S1414-81452013000400603&script=sci_abstract&tlng=pt.
10. Giesbrecht MD, Crooks, VA; Stajduhar , KI. Examining the language–place–
11. healthcare intersection in the context of Canadian homecare nursing. Nurs Inquiry. 2014 [cited 2017 Jun 20]; 21: 79-90. Available from: http://onlinelibrary.wiley.com/doi/10.1111/nin.12010/epdf?r3_referer=wol&tracking_action=preview_click&show_checkout=1&purchase_referrer=onlinelibrary.wiley.com&purchase_site_license=LICENSE_DENIED.
12. Pires MRGM, Duarte EC, Gottems LBD, Figueiredo NVF, Spagnol CA. Fatores associados a atenção domiciliaria: subsídios a gestão do cuidado no âmbito do SUS. RevEscEnfermUSP. 2013 [cited 2016 Jul 18];47(3):648-56. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342013000300648.
13. Rojas, MA, Garcia-Vivar, C. The transition of palliative care from the hospital to the home: a narrative review of experiences of patients and family caretakers. Invest Educ Enferm. 2015 [cited 2017 Jun 21];33(3):482-491. Available from: http://aprendeenlinea.udea.edu.co/revistas/index.php/iee/article/view/24457/19992.
14. Oliveira Neto AV, Dias MB. Atenção Domiciliar no Sistema Único de Saúde (SUS): o que representou o Programa Melhor em Casa? Divulg Saúde Debate. 2014 [cited 2016 Sep 15];51:58-71. Available from: http://cebes.org.br/site/wp-content/uploads/2014/12/Divulgacao-51.pdf.
15. Andrade AM, Brito MJM, Silva KL, Montenegro LC, Caçador BS, Freitas LFC. Organization of the Health System from the perspective of home care professionals. Rev Gaucha Enferm. 2013 [cited 2016 Jul 26];34(2):111-7. Available from: http://www.scielo.br/pdf/rgenf/v34n2/en_v34n2a14.pdf.
16. Ministério da Saúde (BR), Departamento de Atenção Básica. Manual de monitoramento e avaliação: Programa Melhor em Casa. Brasília (DF); 2014.
17. Frank TC, Pelloso SM. The perception of professionals regarding planned home birth. Rev Gaucha Enferm. 2013 [cited 2016 Jul 25];34(1):22-9. Available from: http://www.scielo.br/pdf/rgenf/v34n1/en_03.pdf.
18. Manning, E, Gagnon, M. The complex patient: a concept clarification. Nurs Health Sci. 2017 [cited 2017 Jun 21];19(1):13-21. Available from: http://onlinelibrary.wiley.com/doi/10.1111/nhs.12320/epdf.
19. Gutiérrez EV,VidalCJ. (2013). Home health care logistics management problems: a critical review of models and methods. Rev Fac Ingen Universidad de Antioquia. 2013 [cited 2017 Jun 22];(68):160-75. Available from: http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0120-62302013000300016&lng=en&tlng=en.
20. Fazaeli AA, Hadian M, Rezapour A. Assessing the distribution of household financial contributionto health system: a case study of Iran. Glob J Health Sci. 2016 [cited 2016 Jul 20];8(10):233-40.Disponível em: http://www.ccsenet.org/journal/index.php/gjhs/article/view/55911/30824.
21. Frutuoso MFP, Mendes R, Rosa KRM, Silva CRC. Gestão local de saúde em território de vulnerabilidade: motivações e racionalidades. Saúde Debate. 2015 [cited 2016 Sep 27];39(105):337-49**.** Available from: http://www.scielo.br/readcube/epdf.php?doi=10.1590/0103-11042015050002003&pid=S0103-11042015000200337&pdf_path=sdeb/v39n105/0103-1104-sdeb-39-105-00337.pdf&lang=pt.

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