


OLDER ADULTS LINKED TO HOME CARE PROVIDED BY PRIMARY HEALTH CARE: CHARACTERIZATION, MORBIDITIES, AND ACCESS TO THE SERVICES

Gilmara Ramos¹ Mariane Lurdes Predebon² Fernanda Laís Fengler Dal Pizzol³ Juana Vieira Soares⁴ Lisiane Manganelli Girardi Paskulin⁵ Idiane Rosset⁵ 

ABSTRACT

Objective: to analyze older adults receiving Home Care provided by Primary Health Care regarding the sociodemographic variables, morbidities, and access to the health services, according to gender and to age group.

Method: an analytical and cross-sectional study with 124 older adults on Type 1 Home Care, conducted between 2018 and 2019 through home visits. A questionnaire on socioeconomic data, morbidities, and access to the services was applied. The Student's t, Mann-Whitney's, chi-square, and Fisher's exact tests were used.

Results: the mean age was 82.8 years old and there was predominance of the female gender. Most of the longer-lived older adults had from zero to four years of study and were widowed. Among the comorbidities, hypertension prevailed and arthrosis presented a significant association with the female gender ($p=0.004$). In relation to access to the health services, the women received less frequent home visits ($p=0.033$).

Conclusion: these data will be able to support the implementation of interventions, in addition to identify possible improvements in the care modality.

DESCRIPTORS: Older Adult; Primary Health Care; Nursing; Home Care; Access to the Health Services.

PERSONAS DE EDAD AVANZADA VINCULADAS A LA ATENCIÓN DOMICILIARIA PROVISTA POR LA ATENCIÓN PRIMARIA DE LA SALUD: CARACTERIZACIÓN, MORBILIDADES Y ACCESO A LOS SERVICIOS DE SALUD

RESUMEN:

Objetivo: analizar a las personas de edad avanzada que reciben Atención Domiciliaria provista por la Atención Primaria en relación con las variables sociodemográficas, las morbilidades y el acceso a los servicios de salud, por sexo y grupo etario. **Método:** estudio transversal y analítico con 124 personas de edad avanzada atendidos por la Atención Domiciliaria Tipo 1, realizado entre 2018 y 2019 a través de visitas domiciliarias. Se aplicó un cuestionario sobre datos socioeconómicos, morbilidades y acceso a los servicios de salud. Se utilizaron las pruebas t-Student, Mann-Whitney, chi-cuadrado y exacta de Fisher. **Resultados:** la media de edad fue de 82,8 años y hubo predominio del sexo femenino. La mayoría de las personas de edad más avanzada estudió entre cero y cuatro años y eran viudos/viudas. Entre las morbilidades, prevaleció la hipertensión y la artrosis presentó una asociación significativa con el sexo femenino ($p=0,004$). En relación con el acceso a los servicios de salud, las mujeres recibieron visitas domiciliarias con menor frecuencia ($p=0,033$). **Conclusión:** estos datos podrán sustentar la implementación de intervenciones, además de identificar posibles mejoras en esta modalidad de atención.

DESCRIPTORES: Persona de edad avanzada; Atención Primaria de la Salud; Enfermería; Asistencia Domiciliaria; Acceso a los Servicios de Salud.

¹Hospital Moinhos de Vento. Porto Alegre, RS, Brasil.

²Unimed. Porto Alegre, RS, Brasil.

³University of Alberta. Edmonton, AB, Canada.

⁴Grupo Hospitalar Conceição. Porto Alegre, RS, Brasil.

⁵Universidade Federal do Rio Grande do Sul. Porto Alegre, RS, Brasil.

INTRODUCTION

Population aging has been happening quickly due to the reduction in the fertility and mortality rates. Globally, it is estimated that the number of older adults (aged 60 years old or more) will be 1.4 billion in 2030⁽¹⁾. In Brazil, projections point out that the number of older adults in 2030 shall reach the level of 41.5 million individuals⁽²⁾.

In view of these particularities, challenges emerge for the health services, which are still unprepared to serve these new health demands⁽³⁾. In this context, Home Care (HC) has great relevance, and it may be a strategy to welcome and expand access to the health services by older adults, considering the health conditions and the context in which they are inserted⁽⁴⁾.

HC is organized in three modalities: Type 1 (HC1), Type 2 (HC2) and Type 3 (HC3)⁽⁵⁾. HC1 is less published when compared to HC2 and HC3, which are part of “*Melhor em Casa*” (“Better at Home”). However, HC1 has great care potential in face of population aging and the increased number of chronic diseases that often result in limitations and difficulties to access the health services⁽³⁾. Among its functions, there are actions related to the prevention and treatment of diseases, rehabilitation, maintenance of the functional capacity, as well as palliating and promoting health, thus ensuring care continuity⁽⁵⁾.

Although most of the studies found in the literature that characterize older adults refer to community-dwelling aged people in general⁽⁶⁻⁷⁾, it is known that health care actions must be planned in accordance with the population to be benefited, so as to propose specific interventions, promoting comprehensive assistance and facilitating access to health services by these individuals. Even though HC1 is not only directed to older adults, it is observed that, in the practice, most of the users are over 60 years old, especially in places with older population⁽⁸⁾.

The aged population that receives HC1 has been little studied, especially by comparing gender and age groups. In this perspective, the objective of this study was to analyze the older adults receiving HC1 provided by the PHC of a Health District regarding the sociodemographic variables, morbidities, and access to the health services, according to gender and to age group.

METHOD

This is an analytical and cross-sectional study, conducted with older adults linked to HC1 of a Health District (HD) in the municipality of Porto Alegre/Brazil. The Center HD is composed by three health units: Santa Cecília, Modelo and Santa Marta and, among the HDs, it has the highest proportion of older adults registered in the municipality⁽⁹⁾.

The data of this study come from a larger study entitled: “*Frailty, family functioning, and access of older adults linked to Home Care provided by Primary Health Care*”. Data collection took place between October 2018 and April 2019. There were 227 users registered in HC1 of the Center HD, but only 124 individuals met the inclusion criteria and participated in the study.

The identification of the users was based on lists provided by the health services. Older adults aged 60 years old or over linked to HC1 of this HD were included in this study, while those who were not found after three telephone call attempts in different shifts and days or after a Home Visit (HV) attempt were excluded, as well as those without the ability

of oral or written communication, with previous medical diagnosis of advanced dementia according to their caregiver/family member or team professional, and institutionalized older adults.

The researchers were trained for data collection, and the information was gathered in the participants' homes. The Mini Mental State Examination (MMSE) was applied to know if the older adults were in proper conditions to answer the instruments by themselves.

The MMSE seeks to assess the level of mental cognition of the individuals through a set of questions and tasks. The version used was that adapted for Brazil⁽¹⁰⁾. A study conducted with older adults assisted in PHC to assess the MMSE reliability presented a Cronbach's alpha of 0.80⁽¹¹⁾. The following cutoff points were used: 13 for illiterate individuals, 18 for low and medium schooling, and 26 for high schooling level⁽¹⁰⁾. In the cases in which the scores were lower or equal to 12, the caregiver/family member accompanying the older adult was invited to help in the answers to the instruments applied, in order to guarantee the veracity of the data informed.

A questionnaire prepared by the researchers was applied, with the following information: identification data, follow-up time by HC, age, gender, schooling, marital status, family income, number of people living in the house, morbidities (self-referred), access to the health service (if there is any health plan, what form of assistance is used, and frequency with which they receive HVs). In the questions related to family income and form of assistance used (exclusive HV, transportation to the service, calls to the health service and to the professional), the older adult could choose more than one option.

The quantitative variables were described by using mean and standard deviation, or median and interquartile range. The categorical variables were described by means of absolute and relative frequencies. The Student's t test was used to compare means and, in case of asymmetry, the Mann-Whitney's test was employed. In the comparisons of proportions, the chi-square or Fisher's exact tests were applied. The significance level adopted was 5%, and the analyses were carried out in the Statistical Package for the Social Sciences® program, version 21.0.

The study was approved by the Research Ethics Committee of the Hospital de Clínicas de Porto Alegre (No. 2,740,678) and by the Ethics Committee of the Municipal Health Secretariat of Porto Alegre (No. 2,900,696).

RESULTS

The mean age of the sample was 82.8 (± 9.2) years old. Of the 124 older adults, 94 (75.8%) were female, 99 (79.8%) retired, and 104 (83.9%) did not live alone. In addition to that, they presented a mean of three morbidities, 63 (50.8%) did not present cognitive deficit, 77 (62%) had a caregiver, 62 (50%) were visited at least once a month, 66 (53.2%) did not have any health plan, and 90 (72.6%) received HVs exclusively.

Table 1 shows the associations of the variables studied according to the age groups of 60-84 years old (n=69) and of 85+ years old (n=55). Schooling level and marital status were statistically associated with age groups. Most of the longer-lived older adults had studied from zero to four years, were retired, widowed, and had a health plan. In addition to that, 44 (80%) longer-lived older adults were not able to travel to the health service to receive assistance and, therefore, they received assistance exclusively at their homes.

Table 1 - Associations of the sociodemographic variables, number of morbidities, cognitive deficit, and access to the health services according to age group. Porto Alegre, RS, Brazil, 2019 (continues)

Variables	60 – 84 years old (n=69)	85+ years old (n=55)	p
Gender – n (%)			0,236
Female	49 (71)	45 (81,8)	
Schooling level – n (%)			0,026
0 – 4 years	24 (34,8)	32 (58,2)	
5 – 8 years	23 (33,3)	14 (25,5)	
> 8 years	22 (31,9)	9 (16,4)	
Family income* – n (%)			0,402
Up to 2 MWs	26 (37,7)	17 (30,9)	
3-5 MWs	33 (47,8)	25 (45,5)	
> 5 MWs	10 (14,5)	13 (23,6)	
Source of per capita income* – n (%)			
Retirement	52 (75,4)	47 (85,5)	0,243
Pension for partner's death	17 (24,6)	19 (34,5)	0,313
Family help	13 (18,8)	14 (25,5)	0,504
Lives alone – n (%)			0,244
Yes	14 (20,3)	6 (10,9)	
Marital status – n (%)			0,002
Married/With partner	24 (34,8)	9 (16,4)	
Single	14 (20,3)	9 (16,4)	
Divorced/Separated	8 (11,6)	1 (1,8)	
Widowed	23 (33,3)	36 (65,5)	
Number of morbidities – Median (P25-P75)	3 (2-4)	3 (2-4)	0,773
Cognitive deficit – n (%)			0,574
Yes	36 (52,2)	25 (45,5)	
Follow-up time in HC – n (%)			0,798
<1 year	12 (17,4)	8 (14,5)	
1 to 3 years	26 (37,7)	18 (32,7)	
> 3 to 5 years	17 (24,6)	14 (25,5)	
> 5 years	14 (20,3)	15 (27,3)	
Presence of caregiver – n (%)			0,212
Yes	39 (56,5)	38 (69,1)	
Frequency of HVs – n (%)			0,158
< 1 a month	9 (13)	14 (25,5)	
1 or more a month	35 (50,7)	27 (49,1)	
When requested	25 (36,2)	14 (25,5)	
Health plan – n (%)			0,315

Yes	29 (42)	29 (52,7)	
Form of care – n (%)			
Exclusive HV	46 (66,7)	44 (80)	0,147
Transportation to the service	23 (33,3)	11 (20)	0,147
Call to the health service	35 (50,7)	32 (58,2)	0,518
Call to the professional	26 (37,7)	18 (32,7)	0,701

*Calculated based on the current Minimum Wage (MW) (R\$ 954.00).

Source: The authors (2019)

In Table 2, it is possible to observe the associations of the variables studied according to gender. The source of income, pension for partner's death ($p=0.016$), marital status ($p<0.001$), number of morbidities ($p=0.048$), frequency of HVs ($p=0.033$), and call to the health service ($p=0.016$) variables showed a statistical relation with gender.

Table 2 - Associations of the sociodemographic variables, number of morbidities, cognitive deficit and access to the health services according to gender. Porto Alegre, RS, Brazil, 2019 (continues)

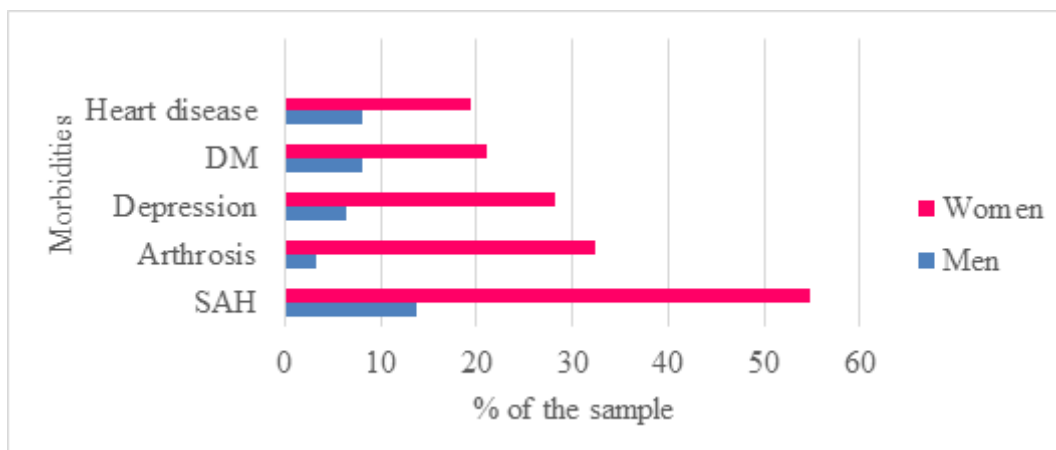
Variables	Male (n=30)	Female (n=94)	p
Age group – n (%)			0,236
60 - 84	20 (66,7)	49 (52,1)	
85+	10 (33,3)	45 (47,9)	
Schooling level – n (%)			0,155
0 – 4 years	9 (30)	47 (50)	
5 – 8 years	11 (36,7)	26 (27,7)	
> 8 years	10 (33,3)	21 (22,3)	
Per capita family income* – n (%)			0,1
Up to 2 MWs	8 (26,7)	35 (37,2)	
3-5 MWs	19 (63,3)	39 (41,5)	
> 5 MWs	3 (10)	20 (21,3)	
Source of income – n (%)			
Retirement	25 (83,3)	74 (78,7)	0,774
Pension for partner's death	3 (10)	33 (35,1)	0,016
Family help	5 (16,7)	22 (23,4)	0,6
Lives alone – n (%)			1
Yes	5 (16,7)	15 (16,0)	
Marital status – n (%)			<0,001
Married/With partner	18 (60)	15 (16)	
Single	7 (23,3)	16 (17)	

Divorced/Separated	0 (0)	9 (9,6)	
Widowed	5 (16,7)	54 (57,4)	
Number of morbidities – Median (P25-P75)	2 (2-3)	3 (2 -4)	0,048
Cognitive deficit – n (%)			0,914
Yes	14 (46,7)	47 (50)	
Follow-up time in HC – n (%)			0,103
< 1 year	1 (3,3)	19 (20,2)	
1 to 3 years	11 (36,7)	33 (35,1)	
> 3 to 5 years	11 (36,7)	20 (21,3)	
> 5 years	7 (23,3)	22 (23,4)	
Presence of caregiver – n (%)			0,074
With caregiver	14 (46,7)	63 (67)	
Frequency of HVs – n (%)			0,033
< 1 a month	1 (3,3)	22 (23,4)	
1 or more a month	16 (53,3)	46 (48,9)	
When requested	13 (43,3)	26 (27,7)	
Health plan – n (%)			0,823
Yes	13 (43,3)	45 (47,9)	
Form of care – n (%)			
Exclusive HV	21 (70)	69 (73,4)	0,897
Transportation to the service	9 (30)	25 (26,6)	0,897
Call to the health service	10 (33,3)	57 (60,6)	0,016
Call to the professional	8 (26,7)	36 (38,3)	0,347

*Calculated based on the current Minimum Wage (MW) (R\$ 954.00).

Source: The authors (2019)

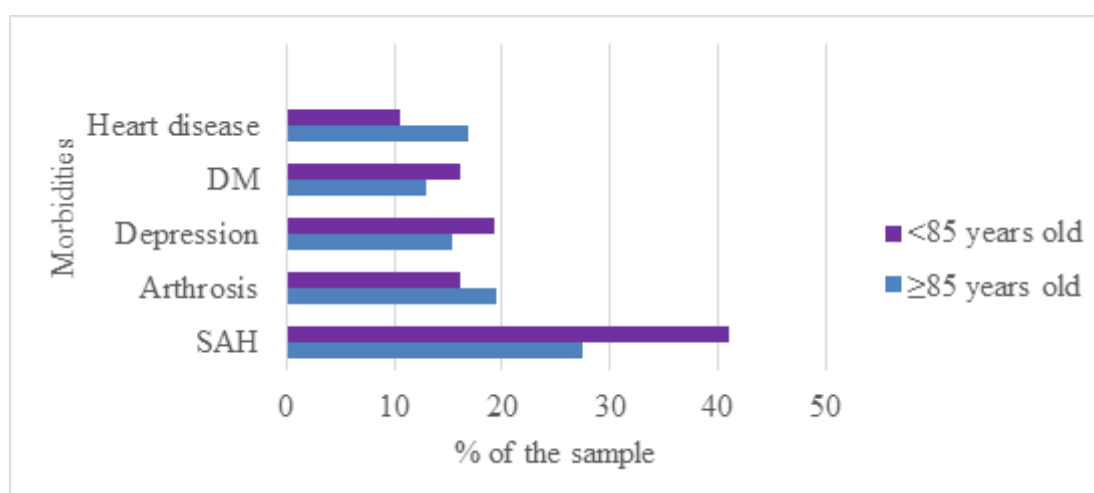
Graph 1 shows the five most prevalent morbidities in the population under study, according to gender. Among the self-reported morbidities, Systemic Arterial Hypertension (SAH) presented the highest prevalence, followed by arthrosis and by depression. It was observed that all the diseases illustrated were more prevalent in the female gender. The only morbidity that presented a statistically significant difference with gender was arthrosis ($p=0.004$), being mostly reported by women.



Graph 1 – Distribution of the five most prevalent morbidities in the sample, according to gender. Porto Alegre, RS, Brazil, 2019

Source: The authors (2019)

Graph 2 presents the most prevalent morbidities according to the age groups of younger and older aged individuals. None of the morbidities presented a statistically significant association when associated to age group. However, arthrosis presented a borderline value ($p=0.09$), so that a higher number of longer-lived older adults reported having arthrosis.



Graph 2 – Distribution of the five most prevalent morbidities in the sample, according to the age groups. Porto Alegre, RS, Brazil, 2019

Source: The authors (2019)

Higher prevalence of the following morbidities can be observed among the younger group: 28 (41.1%) older adults reported SAH; 13 (19.3%), depression; and 11 (16.1%), Diabetes Mellitus (DM). On the other hand, in the group of longer-lived older adults, 11 (19.4%) reported having arthrosis and nine (16.9%), heart disease.

DISCUSSION

The mean age of the sample was similar to that of other studies, both national and international, with older adults receiving home care⁽¹²⁻¹³⁾. However, national studies with community-dwelling older adults in general have a lower mean age than the one presented^(6,14). It is highlighted that the sample of this study has specific characteristics, such as the fact of receiving HVs, which are frequently requested by longer-lived older adults.

Regarding gender, there was prevalence of women, consistent with the literature data, related to the phenomenon of feminization of old age^(6,14-15). And regarding source of income, more than half of the sample were retired. This data matches that presented by the National Household Sample Survey (*Pesquisa Nacional por Amostra de Domicílios*, PNAD), pointing out that 76.6% of the individuals aged over 60 years old are retirees and/or pensioners⁽¹⁶⁾. Family help was not so expressive in this sample, which can be related to the fact that most of the participants had a household income from three to five minimum wages.

More than half of the participants of this study did not live alone, had a caregiver, and presented a mean of three morbidities. Therefore, the need for help and care of most of these older adults is clear. It is known that there are social, cultural, and clinical factors related to the demand of having a caregiver and, above all, not allowing an older adult to live alone⁽¹⁷⁾. In this way, the need is verified for home support by family members related to the difficulty of older adults in performing activities of daily living⁽¹⁷⁾.

The presence of caregivers proves to be essential for older adults who have cognitive deficit and consequently require help for a better performance of daily activities⁽¹⁸⁾. In addition to that, the caregiver can stimulate the older adult to practice intellectual activities, favor a safe environment, and strengthen the link with the health team⁽¹⁹⁾. In this study, a considerable percentage of the sample presented cognitive deficit, which can be related to the presence of caregivers, to the fact of not living alone, and to the percentage of longer-lived older adults, as it is known that the older the person, the higher the probability of presenting cognitive deficit⁽²⁰⁾.

The largest percentage of older adults received exclusive HVs as form of care, and half of them were visited at least once a month, emphasizing that this population requires more care by health services, families, and caregivers. There is an increase in the demand of older adults who seek health services in PHC⁽⁴⁾, which can impact on the fact that a good part of the sample is not monthly followed-up at their homes and a percentage ends up traveling to the health service. In addition, it must be considered that the HD population concerned is numerous and has a high proportion of older adults, which can impact on the assistance provided by the health services, considering the high population demand.

More than half of the sample reported not having a health plan, similar to what is presented by the PNAD⁽¹⁶⁾, which pointed out that more than 60% of the population does not have a health plan. Having a health plan unburdens the public health services, especially in relation to older adults, the age group that most uses the Brazilian complementary health assistance services⁽²¹⁾. It is also worth highlighting that the health plan of most of the older adults participating in this study was only for transportation, possibly due to the difficulty of traveling to a health service.

In relation to the schooling level, there was similitude with the findings of a national study conducted with 986 community-dwelling older adults⁽¹⁵⁾. Schooling level plays an important role in the person's health condition, which is essential for information to be understood and assimilated⁽⁶⁾. At the homes, health care professionals can have a holistic perspective of care and instruct the older adults through educational actions, so that they can understand their health status.

Being a longer-lived older adult was associated with a lower schooling level, which can be justified by the difficulty in accessing education in the past⁽²²⁾. In addition to that, women also presented a lower schooling level and, as they represented the largest proportion of the sample, such relation can also be attributed to low schooling.

Most of the longer-lived older adults were retirees and widows/widowers, which can be justified by the natural aging process, reflected in distancing from work activities and loss of partners over the years. In addition, a significant percentage of this group received exclusive HVs, confirming a national study which asserts that longer-lived older adults are more prone to having diseases resulting from aging, requiring more care actions⁽²³⁾. This dependence relationship is intensified over the years in which the older adults need help to perform their activities⁽¹⁷⁾. Normally, the caregiver is a family member – informal caregiver – who also needs a careful perspective, as they often quit their activities to devote to the older adult^(17,24).

The statistically significant association of the female gender with the source of income of the pension for partner's death type may have occurred because most of the sample was composed of women. Unlike the women, most of the men were married, similarly to a study conducted in Campinas/Brazil⁽¹⁵⁾. It is noted that there is a tendency for men finding a new partner after widowhood, unlike women, who tend to remain alone⁽²⁵⁾.

The female gender was associated with a higher number of morbidities. A study shows that women have higher life expectancy and, therefore, end up living with higher chances of multimorbidities⁽²⁶⁾. Arthrosis was the only morbidity that presented statistical significance when associated with the female gender, which can be justified by the pronounced bone loss after menopause, related to the hormone levels⁽²⁷⁾.

In addition to that, it was noted that a higher percentage of women received visits with less frequency when compared to men, and that they contacted the health service through telephone calls more frequently. Such results can be partially explained by the fact that most of the women have a caregiver, and also because they manage to solve some issues of less complexity by telephone, requiring fewer HVs. Women seek assistance in the health services more frequently and are more cautious when it comes to self-care. The use of telephone contacts for easy-resolution problems shows itself as a safe and low-cost alternative that can positively impact on the older adults' access to the health services.

In this study, the most prevalent morbidity was SAH, in consonance with data from the literature^(7,23). With aging, the onset of morbidities due to the continuous exposure to risk factors that trigger them is more frequent, and this scenario impacts on the provision of PHC services⁽⁷⁾. One of the priorities of the professionals who perform HVs is to prevent health problems, as they possess a wide range of diverse information regarding the context in which the older adult is inserted, therefore being able to adjust the guidelines to that specific reality.

The multiple morbidities presented by the older adults impact on the health services and end up increasing the number of hospitalizations and deaths⁽²³⁾. With that, the importance of PHC in the prevention of diseases related to morbidities becomes evident, especially in HC1, which is mostly composed of older adults who do not travel to the health service and need assessment and guidelines at their homes. The cross-sectional design and the characteristics of the sample, pertaining to only one HD of a municipality, can be pointed out as limiting factors of this study.

CONCLUSION

In the sample there was predominance of the female gender, retired individuals,

who did not live alone, had a caregiver, received exclusive HVs, had studied from zero to four years, and did not have any health plan. Among the longer-lived individuals, there was predominance of lower schooling level, retired individuals, widowed, and receiving exclusive HVs. The female gender presented a statistically significant association with the source of income of the pension for partner's death type and higher number of morbidities, especially arthrosis. When compared to the men, women received less frequent HVs and contacted the health service by telephone more. The most prevalent morbidity in the sample was SAH.

These data may be useful to subsidize other research studies focused on this specific population, for possible interventions in the prevention of health problems, aiming to improve the access to health services by older adults linked to HC1, causing a positive impact on these individuals, families, and society. Finally, it is noted that the HV has a considerable importance when it comes to an aging population with limitations.

REFERENCES

1. United Nations, Department of Economic and Social Affairs, Population Division. World Population Prospects: The 2017 Revision, Key Findings and Advance Tables [Internet]. Nova Iorque: United Nations; 2017 [accessed 17 jun 2020]. Available from: <https://www.un.org/development/desa/publications/world-population-prospects-the-2017-revision.html>.
2. Instituto Brasileiro de Geografia e Estatística (IBGE). Estimativas populacionais enviadas para o TCU, estratificadas por idade e sexo [Internet]. 2011-2012 [accessed 06 nov 2019]. Available from: <http://tabnet.datasus.gov.br/cgi/defthtm.exe?ibge/cnv/popuf.def>.
3. Medeiros KKAS, Pinto Junior EP, Bousquat A, Medina MG. O desafio da integralidade no cuidado ao idoso, no âmbito da Atenção Primária à Saúde. Saúde debate [Internet]. 2017 [accessed 16 maio 2020]; 41(spe3). Available from: <https://doi.org/10.1590/0103-11042017s322>.
4. Lubenow JAM, Barrêto AJR, Nogueira J de A, Silva AO. Access for the elderly to Primary Health Care services: an integrative review. Int Arch Med [Internet]. 2016 [accessed 16 maio 2020]; 9(46). Available from: <http://dx.doi.org/10.3823/1917>.
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 [Internet]. Brasília: Ministério da Saúde; 2016 [accessed 17 jun 2020]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2016/prt0825_25_04_2016.html.
6. Medeiros KKAS, Coura AS, Pinto Júnior EP, França ISX de, Bousquat A. The profile of the elderly in Primary Health Care in a Brazilian medium-sized city. Rev Kairos [Internet]. 2018 [accessed 17 jun 2020]; 21(2). Available from: <http://ken.pucsp.br/kairos/article/view/41072>.
7. Augusti ACV, Falsarella GR, Coimbra AMV. Analysis of frailty syndrome in primary care - cross sectional study. Rev Bras Med Fam Comunidade [Internet]. 2017 [accessed 16 maio 2020]; 12(39). Available from: [http://dx.doi.org/10.5712/rbmf12\(39\)1353](http://dx.doi.org/10.5712/rbmf12(39)1353).
8. Ministério da Saúde (BR). Atenção domiciliar no SUS: resultados do laboratório de inovação em atenção domiciliar [Internet]. Brasília: Ministério da Saúde; 2014 [accessed 17 jun 2020]. Available from: <https://iris.paho.org/handle/10665.2/7677>.
9. Prefeitura Municipal de Porto Alegre. Dados demográficos IBGE 2010 [Internet]. 2019 [accessed 09 ago 2019]. Available from: http://www2.portoalegre.rs.gov.br/sms/default.php?p_secao=918.
10. Bertolucci PHF, Brucki SMD, Campacci SR, Juliano Y. The Mini-Mental State Examination in an outpatient population: influence of literacy. Arq Neuro-psiquiatr. [Internet]. 1994 [accessed 16 maio 2020];

52(1). Available from: <http://dx.doi.org/10.1590/S0004-282X1994000100001>.

11. Santos C da S, Cerchiari EAN, Alvarenga MRM, Faccenda O, Oliveira MA de C. Avaliação da confiabilidade do mini-exame do estado mental em idosos e associações com variáveis sociodemográficas. *Cogitare enferm* [Internet]. 2010 [accessed 16 maio 2020]; 15(3). Available from: <http://dx.doi.org/10.5380/ce.v15i3.18879>.
12. Paskulin LMG, Bierhals CCBK, Santos NO dos, Day CB, Machado D de O, Morais EP de, et al. Depressive symptoms of the elderly people and caregiver's burden in Home Care. *Invest. Educ. Enferm* [Internet]. 2017 [accessed 16 maio 2020]; 35(2). Available from: <http://doi.org/10.17533/udea.iee.v35n2a10>.
13. Kleisiaris CF, Papathanasiou IV, Tsaras K, Androulakis E, Kourkouta L, Fradelos E, et al. Factors affecting the health status of elderly people receiving home care. *Arch. Hell. Med.* [Internet]. 2019 [accessed 09 ago 2019]; 36(2). Available from: <http://www.mednet.gr/archives/2019-2/pdf/237.pdf>.
14. Campos ACV, Rezende GP de, Ferreira EF e, Vargas AMD, Gonçalves LHT. Family functioning of Brazilian elderly people living in community. *Acta Paul Enferm* [Internet]. 2017 [accessed 17 jun 2020]; 30(4). Available from: <http://dx.doi.org/10.1590/1982-0194201700053>.
15. Sousa NF da S, Lima MG, Cesar CLG, Barros MB de A. Envelhecimento ativo: prevalência e diferenças de gênero e idade em estudo de base populacional. *Cad. Saúde Pública* [Internet]. 2018 [accessed 16 maio 2020]; 34(11). Available from: <https://doi.org/10.1590/0102-311x00173317>.
16. Instituto Brasileiro de Geografia e Estatística (IBGE). Síntese de indicadores sociais: uma análise das condições de vida da população brasileira: 2016 [Internet]. Rio de Janeiro: IBGE; 2016. [accessed 09 ago 2019]. Available from: <https://biblioteca.ibge.gov.br/visualizacao/livros/liv98965.pdf>.
17. Lima-Costa MF, Peixoto SV, Malta DC, Szwarcwald CL, Mambrini JV de M. Cuidado informal e remunerado aos idosos no Brasil (Pesquisa Nacional de Saúde, 2013). *Rev. Saúde Pública* [Internet]. 2017 [accessed 16 maio 2020]; 51(Suppl1). Available from: <http://dx.doi.org/10.1590/s1518-8787.2017051000013>.
18. Miranda AC de C, Sérgio SR, Fonseca GNS, Coelho SMC, Rodrigues JS, Cardoso CL, et al. Avaliação da presença de cuidador familiar de idosos com déficits cognitivo e funcional residentes em Belo Horizonte-MG. *Rev. bras. geriatr. gerontol* [Internet]. 2015 [accessed 16 maio 2020]; 18(1). Available from: <http://dx.doi.org/10.1590/1809-9823.2015.13173>.
19. Bezerra PK, Rodrigues KA, Felix KD, Sotero R da C, Ferreira AP. Déficit cognitivo: proposição de cartilha para atenção ao idoso. *RBPeCS* [Internet]. 2016 [accessed 16 maio 2020]; 3(1). Available from: <http://revistas.icesp.br/index.php/RBPeCS/article/view/65#:~:text=Objetivo%3A%20elabora%C3%A7%C3%A3o%20de%20uma%20cartilha,ao%20idoso%20com%20d%C3%A9ficit%20cognitivo.&text=Espera%2Dse%20com%20isso%20incentivar,aos%20idosos%20com%20d%C3%A9ficit%20cognitivo>.
20. Silva HS da, Duarte YA de O, Andrade FB de, Cerqueira AT de AR, Santos JLF, Lebrão ML. Correlates of above-average cognitive performance among older adults: the SABE study. *Cad. Saúde Pública* [Internet]. 2014 [accessed 16 maio 2020]; 30(9). Available from: <http://dx.doi.org/10.1590/0102-311X00131913>.
21. Oliveira M, Veras R, Cordeiro H. A Saúde Suplementar e o envelhecimento após 19 anos de regulação: onde estamos? *Rev. Bras. Geriatr. Gerontol* [Internet]. 2017 [accessed 16 maio 2020]; 20(5). Available from: <http://dx.doi.org/10.1590/1981-22562017020.170132>.
22. Santos-Orlandi AA dos, Brito TRP de, Ottaviani AC, Rossetti ES, Zazzetta MS, Gratão ACM et al. Perfil de idosos que cuidam de outros idosos em contexto de alta vulnerabilidade social. *Esc. Anna Nery* [Internet]. 2017 [accessed 17 jun 2020]; 21(1). Available from: https://www.scielo.br/scielo.php?pid=S1414-81452017000100213&script=sci_abstract&tlng=pt.
23. Santos VP, Lima WR, Rosa RS, Barros IM da C, Boery RNS de O, Ciosak SI. Perfil de saúde de idosos muito velhos em vulnerabilidade social na comunidade. *Rev Cuid* [Internet]. 2018 [accessed 16 maio

2020]; 9(3). Available from: <http://dx.doi.org/10.15649/cuidarte.v9i3.542>.

24. Bierhals CCBK, Santos NO dos, Fengler FL, Raubustt KD, Forbes DA, Paskulin LMG. Needs of family caregivers in home care for older adults. Rev. Latino-Am. Enfermagem [Internet]. 2017 [accessed 16 maio 2020]; 25. Available from: <http://dx.doi.org/10.1590/1518-8345.1511.2870>.

25. Pochintesta PA. The transition to widowhood in aging. A study of cases in Argentina, J Aging Innov [Internet]. 2016 [accessed 10 nov 2019]; 5(2). Available from: http://journalofagingandinnovation.org/wp-content/uploads/1-Agosto_2016.pdf.

26. Ribeiro PCC, Banhato EFC, Guedes DV. Perfil clínico e uso de serviços de saúde em idosos. Revista HUPE [Internet] 2018 [accessed 16 maio 2020]; 17(2). Available from: <https://doi.org/10.12957/rhupe.2018.40808>.

27. Lupsa BC, Insogna K. Bone health and osteoporosis. Endocrinol Metab Clin North Am [Internet] 2015 [accessed 16 maio 2020]; 44(3). Available from: <http://dx.doi.org/10.1016/j.ecl.2015.05.002>.

HOW TO REFERENCE THIS ARTICLE:

Ramos G, Predebon ML, Dal Pizzol FLF, Soares JV, Paskulin LMG, Rosset I. Older adults linked to home care provided by primary health care: characterization, morbidities, and access to the services. *Cogitare enferm.* [Internet]. 2021 [accessed "insert day, month and year"]; 26. Available from: <http://dx.doi.org/10.5380/ce.v26i0.73818>.

*Article extracted from the master's thesis entitled: "Frailty, family functioning, and access of older adults linked to Home Care provided by Primary Health Care". Universidade Federal do Rio Grande do Sul, 2019.

Received: 17/05/2020

Approved: 06/09/2020

Associate editor: Juliana Balbinot Reis Girondi

Corresponding author:

Gilmara Ramos

Universidade Federal do Rio Grande do Sul – Porto Alegre, RS, Brasil

E-mail: enfagilmara@gmail.com

Role of Authors:

Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - GR, MLP, IR

Drafting the work or revising it critically for important intellectual content - GR, MLP, FLFDP, JVS, LMGP, IR

Final approval of the version to be published - GR, MLP, FLFDP, IR

Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - GR, IR



Copyright © 2021 This is an open access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original article is properly cited.