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# Home care as change of the technical-assistance model

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## ABSTRACT

**OBJECTIVE:** To analyze home care practices of outpatient and hospital services and their constitution as a substitute healthcare network.

**METHODOLOGICAL PROCEDURES:** A qualitative study was carried out using tracer methodology to analyze four outpatient home care services from the Municipal Health Department and one service from a philanthropic hospital in the municipality of Belo Horizonte, Southeastern Brazil, between 2005 and 2007. The following procedures were carried out: interviews with the home care services' managers and teams, analysis of documents and follow-up of cases, holding interviews with patients and caregivers. The analysis was guided by the analytical categories home care integration into the healthcare network and technical-assistance model.

**RESULTS:** Home care implementation was preceded by a political-institutional decision, both with a rationalizing orientation, intending to promote cost reduction, and also with the aim of carrying out the technical-assistance rearrangement of the healthcare networks. These two types of orientation were found to be in conflict, which implies difficulties for conciliating interests of the different players involved in the network, and also the creation of shared management spaces. It was possible to identify technological innovation and families' autonomy in the implementation of the healthcare projects. The teams proved to be cohesive, constructing, in the daily routine, new forms of integrating different perspectives so as to transform the healthcare practices. Challenges were observed in the proposal of integrating the different substitutive healthcare services, as the home care services' capacity to change the technical-assistance model is limited.

**CONCLUSIONS:** Home care has potential for constituting a substitutive network by producing new care modalities that cross the projects of users, family members, social network, and home care professionals. Home care as a substitute healthcare modality requires political, conceptual and operational sustainability, as well as recognition of the new arrangements and articulation of ongoing proposals.

**DESCRIPTORS:** Descriptors: Home Care Services. Models, Organizational. Qualitative Research.

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## INTRODUCTION

Governments, health system managers and financial capital (with insertion in the health system by means of securitization) approach expenses and risks control by means of rationalizing initiatives in work organization and focalization policies.<sup>1,6</sup> However, new needs deriving from population aging, demands for better quality of care and for integral and continuous care have strengthened anti-hegemonic practices and the formulation of new strategies and mechanisms for healthcare. Thus, it is possible to observe the emergence and amplification of non-traditional assistance spaces, such as *Estratégia Saúde da Família* (Family Health Strategy), therapeutic home care services targeted at HIV/AIDS patients, proposals for palliative home care, among others. Home care services emerged in the 1960s and have expanded in Brazil with more intensity from the 1990s onwards. Due to this, it is necessary to regulate their functioning and to design public policies so as to incorporate the offer of these services into the institutionalized practices of the National Health System (SUS).

There is scarcity of records and lack of systematization of home care public and private services, even when they occur through explicit institutional initiative (of municipal health systems, hospitals, private healthcare services, among others). Only the experiences that are considered to be successful or which have been functioning for longer periods of time are known.<sup>8</sup> Home care initiatives connected with hospitals are almost always oriented towards dehospitalization, cost reduction, risk prevention and assistance humanization, and are targeted at groups of users according to pathologies (home treatment of wounds, people affected by muscular dystrophy, HIV/AIDS patients). In the public network, home care proposals have been constructed as experiences guided by extension of coverage or by early dehospitalization. The debate and political investment in home care as an alternative to the work processes and in the way of producing care are still limited, characterizing the substitutive nature of the healthcare practices.<sup>9</sup> We call “substitutive” the healthcare possibilities that deinstitutionalize the hegemonic mode, creating new healthcare production practices.<sup>2</sup>

In the last years, home care has been present in the formulation of public health and social work policies, in management and in other practices concerning healthcare services. Legal mechanisms such as Directive

2416,<sup>a</sup> Law 10.424<sup>b</sup> and RDC 11 - issued by *Agência Nacional de Vigilância Sanitária*<sup>c</sup> (National Agency for Sanitary Surveillance) - represent marks in the discussions about public policies that focus on home care as a modality of offer in health assistance organization.

Although it is recognized that there has been an evolution in relation to the legislation that regulates home care as an assistance modality in Brazil, its proposition was not part of the original project of SUS, and it was incorporated into the system as complementary.<sup>10</sup>

Based on the literature and on the researchers' experience, the point of departure was the presupposition that there are many dimensions of home care and this type of assistance has assumed a great diversity of modelings and organizations. This ranges between home visits to chronic patients and the establishment of a medical-hospital apparatus of great complexity in the patient's home, like in home hospitalization.

The objective of the present study was to analyze home care practices of outpatient and hospital services and their constitution as a substitutive healthcare network.

## METHODOLOGICAL PROCEDURES

This study analyzed data from a broader research<sup>d</sup> conducted in different regions of Brazil from 2005 to 2007. Case studies were carried out based on an intentional sample that included experiences developed through the initiative of municipal and state health departments, involving hospitals (public and philanthropic) and specific home care services developed by the healthcare services network in the scope of SUS.

The field study was organized in three stages:

1. Mapping and selection of home care experiences in different municipalities of Brazil. The municipality of Belo Horizonte, southeastern Brazil, was selected because it meets the following criteria: existence of public home care services of several initiatives (direct federal, state or municipal public administration, as well as services offered by philanthropic institutions), connected with SUS in an outpatient or hospital character, and existence of political strategies for home care consolidation within the municipality's assistance

<sup>a</sup> Ministério da Saúde. Portaria nº 2.416, de 23 de março de 1998. Estabelece requisitos para credenciamento de hospitais e critérios para realização de Internação Domiciliar no SUS. *Diário Oficial Uniao*. 26 mar 1998;Seção 1:106.

<sup>b</sup> Brasil. Lei nº 10.424, de 15 de abril de 2002. Acrescenta capítulo e artigos à Lei 8080 de 19 de setembro de 1990, que dispõe sobre as condições de promoção, proteção e recuperação da saúde, a organização e funcionamento de serviços correspondentes e dá outras providências, regulamentando a assistência domiciliar no Sistema Único de Saúde. *Diário Oficial Uniao*. 16 abr 2002. Seção 1:1.

<sup>c</sup> Agência Nacional de Vigilância Sanitária. Resolução da Diretoria Colegiada - RDC nº11, de 26 de janeiro de 2006. Dispõe sobre o regulamento técnico de funcionamento de serviços que prestam atenção domiciliar. *Diário Oficial Uniao*. 30 jan 2006;Seção 1:78.

<sup>d</sup> Research developed by the Ministry of Health, called “Implantação de Atenção Domiciliar no Âmbito do SUS – Modelagem a partir das Experiências Correntes” (Home Care Implementation in the Scope of SUS - Modeling based on Current Experiences).

actions. Initially, all the public home care services were visited. The procedures used for data collection were documental analysis and interviews with services managers and key informants in the management scope. Subsequently, a database was built with information from all services referring to: management of services' resources (investment and defrayal of costs), teams composition (number of working hours, remuneration, type of contract) and assessment indicators. The teams were requested to identify significant cases, which were called tracers – cases that were representative of the service's profile, and which had caused discomfort or satisfaction. In Belo Horizonte, six tracer cases were thoroughly analyzed.

Tracers are an investigation strategy that is used both in quantitative studies (for example, biological markers, clinical markers) and in qualitative studies, in the social and political sciences and also in the areas of health and education.<sup>3,5,11,a</sup> Tracer cases can be prospectively designed or retrospectively identified (like markers used to analyze care processes, change processes or educational processes).

The analysis of tracers enables to examine *in situ* the ways in which complex work processes are concretized in practice, like those of health and education, which involve an important degree of autonomy on the part of the professionals. The concrete scene reveals values, concepts and technologies that are not necessarily captured in an interview (in general, when subjects talk about what it should be – and not about what it really is – or about how each one interprets the lived scene – without necessarily expressing the conflicts). Depending on the marker, different types of teams' action are observed, as well as different configurations of interaction among workers and between workers and users, different technological repertoires, different organizational arrangements. The character of marker or tracer of the case selected for study was determined by characteristics such as being a typical case, a successful situation (“good practice”), a situation of tension or of difficult resolution that marked the team's action.

The cases analysis involved analysis of medical records, interview with all the team members in the service and also with users and family members in the patient's home, during the case's follow-up with the team, enabling a self-analysis process of the home care team. Therefore, it enabled to assess the work and management process (construction of care, the team's dynamics, the used technologies, the relationship with user and caregiver, the relationship between home care and other healthcare services that are sometimes needed to provide adequate care, where it failed, why it was successful, what could have been done to avoid or

amplify this situation), allowing the capture, interpretation and in-depth study of the object of investigation *in loco*. The tracer case enabled the contact with professionals of the home care teams and the monitoring of the team “in action” at the patient's home, through direct observation.

2. Analysis of experiences and identification of contributions to the making of policies. The experiences were analyzed taking as variables: arrangement and composition of the team; articulation of home care with the local healthcare system; caregiver's characteristics; the conformation of the care act (definition of care plan, protocols, technological incorporation, eligibility and discharge criteria); economic rationality (origin and management of resources, home care assessment tools).

In the study, the variables “articulation of home care with the local healthcare system” and “conformation of the care act” were analyzed, based on the two phases of the investigation.

3. Production of indicators for the formulation of a policy, presenting modalities of home care offer and organization, regulation and financing, besides the analysis of services' costs, which was conducted in the national scope.

## ANALYSIS OF RESULTS

### Phase 1: Cartography of the home care services in Belo Horizonte

Three nuclei of home care services were identified, organized according to different institutional initiatives in the municipality, namely: *Programas de Atenção Domiciliar* (PAD – Home Care Programs) or *Programas de Internação Domiciliar* (PID – Home Hospitalization Programs) in municipal, state, federal and philanthropic institutions.

PAD connected with the Municipal Health Department: it is constituted of seven services, one located in the Municipal Hospital - PAD Hospital Odilon Behrens (it has been in operation since 2000 and the majority of patients it assists have skin lesions deriving from long periods of hospitalization) and six services connected with emergency units: PAD Esmeralda, PAD Ametista, PAD Topázio, PAD Barreiro, PAD Pampulha and PAD Diamante (the first five have been located in the municipality's emergency medical services since 2002, in the logic of distribution by districts of the municipality. They assist patients with acute conditions and prevalent profile of infections (urinary, respiratory and skin infections) whose hospitalization is indicated, but it can be avoided by means of more intensive home care

<sup>a</sup> Ham C, Parker H, Singh D, Wade E. Getting the basics right: final report on the care closer to home: making the shift programme. Coventry: NHS Institute for Innovation/Birmingham: Improvement and Health Services Management Centre; 2007.

**Table.** Home care services selected for in-depth analysis in the municipality of Belo Horizonte, Southeastern Brazil, 2007.

Variable	PAD HOB	PAD connected with emergency unit	PIDNEO Hospital Sofia Feldman
Articulation with the healthcare system		Services located in the UPA and connected with the Urgency Management of SMS.	Special program of the hospital's Neonatology Unit.
Institutional insertion	Hospital's special program.	Insertion in the program occurs through indication by the UPAs doctor and clinical evaluation conducted by the PAD's doctor of the UPAs patients with issued AIH, which can be cancelled. Admission also occurs through ESF's request for acutized chronic cases. In the case of PAD Diamante, which exclusively assists HIV/AIDS patients, the demand is generally made by the doctor responsible for the hospitalized patient and for the SAE, to avoid hospitalization, even in the UPAs.	
Assistance flow	The assistant doctor contacts PAD's social service, which makes an assessment to check the eligibility criteria. Then, the social service contacts PAD's team, the team makes another assessment and defines referral to home care.		The patient's admission to the Program is evaluated during his/her stay in the intermediate care unit, after hospitalization in an ICU.
Urgency assistance/ interurrences and diagnostic and therapeutic support	For patient's removal in case of interurrences and in hospital's procedures, HOB's transport service is used. On weekends and during the nights, removal is performed by SAMU.	Necessary tests are performed in the UPAs with material collected at the patient's home or by means of patient's removal in the Program's vehicle. Assistance is supported through a partnership with HOB for SADI and when there is the need of specialists' intervention.	The hospital guarantees the necessary backup to PID's patients in terms of SADI, with material collection at their homes, for which the program's vehicle is used. On weekends and holidays, caregivers and families are instructed to call the Support Team if necessary. If the Support Team cannot provide urgent assistance, the family is instructed to look for the Urgency Unit in the respective catchment area or to call SAMU.
Relationship to the local healthcare units	The Primary Healthcare Unit is informed by PAD about the patient's admission. The answer concerning patients' follow-up by PAD has been diverse, according to characteristics of the functioning of the ESF.	Articulation with ESF is diversified, with some teams adhering and others, not. The difficulties are related to transport, equipment (medicines and materials) and professionals for the continuity of care in ESF.	There are problems in the relationship to Belo Horizonte's healthcare network, mainly the primary network. The team takes the initiative in making a direct and systematic articulation with ESF of the patient's catchment area, through the social worker, so as to ensure treatment's continuity after discharge.
Conformation of the care act			
Program's objective	Dehospitalization.	Pre-hospitalization. In the case of PAD Diamante, dehospitalization and pre-hospitalization.	Dehospitalization.
To be continued			

Table continuation

Variable	PAD HOB	PAD connected with emergency unit	PIDNEO Hospital Sofia Feldman
Conformation of the care act			
Definition of the care plan	<p>Outlined mainly by the nurse, but also by the assistant doctor before dehospitalization.</p>	<p>Outlined by the team, that defines the number of visits to be implemented.</p>	<p>Outlined by the team, that defines the number of visits to be implemented.</p>
Team work	<p>The first visit to the patient's home is performed by the doctor or nurse and the subsequent visits, by the nursing assistant. Visits of the other professionals occur according to the needs identified by the basic team. The team functions as a collegiate which every 15 days discusses all the cases, defining priorities according to complexity.</p>	<p>The subjects mention that there is articulation between the team's members who evaluate the cases and establish the care plan. The systematized care plan is followed for the cases that have greater degree of dependence; the others are discussed by the team and flows are defined. In the case of PAD Diamante, care is organized in programmed visits, with up to 3 weekly medical consultations. If more consultations are necessary, hospitalization is indicated due to the program's technical limit.</p>	<p>Care is programmed and monitored by the entire team, with a good relationship. Experiences were developed with technologies indispensable to the routine development of the activities, such as the program's "Bag", containing a set of materials, medicines, and equipments that the team takes to the patient's home in the visits.</p>
Continuity of care	<p>Continuity through the primary network is negatively affected due to lack of professionals in some units; insufficient vehicles for home visits; low qualification of some professionals.</p>	<p>After discharge, the patient is referred to specialized services (in the case of PAD Diamante) and/or to the Family Health Program; if the patient's clinical conditions worsen, the patient is hospitalized.</p>	<p>In the case of premature babies, the hospital provides outpatient follow-up during one year after discharge, but mothers are also instructed to search for assistance in the primary healthcare network.</p>
Caregiver's role	<p>The caregiver does not have to be a professional of the health area. The person who will be responsible for the patient, providing him with care, is elected caregiver: this person can be a family member (the highest incidence), a neighbor or a religious individual. The developed activities are: bath, medication, feeding, recreation, and also curative activities. In general, there is a diversity of caregivers. The great majority adheres to patient's care, but in some cases there is resistance against this care, and it is necessary to search for alternatives with other substitute caregivers.</p>	<p>The criterion of eligibility of the caregiver only applies in the case of patient's dependence. In the other cases, the patient's degree of autonomy is taken into account in the execution of self-composed of family members, with no specific qualification. Their activities are: bath, feeding, medicine supplied on time. The caregivers' qualification is performed during the assistance of the PAD team. In the majority of the cases, there is adherence on the part of the family to patient care.</p>	<p>The caregiver is, almost exclusively, the mother, but there may also be secondary caregivers, like the grandmother. The activities developed by the caregivers concern the basic care provided for the newborn, like breastfeeding, change of diapers, bath. Premature newborns generally use as medicines vitamin supplements and the mother is instructed on how to offer the medicines during hospitalization. In the moment of the newborn's admission to the Program, the team reiterates the instructions and discusses with the mother the care plan, explaining how to offer the medicines, care with sun bath and diet.</p>

AIH: Autorização para Internação Hospitalar (Authorization for Hospital Booking); ESF: Estratégia Saúde da Família (Family Health Strategy); HOB: Hospital Odilon Behrens; PAD: Programa de atenção domiciliar (Home Care Program); PID: Programas de Internação Domiciliar (Home Hospitalization Programs); SADT: Serviço de apoio diagnóstico e terapêutico (Diagnostic and Therapeutic Support Service); SAE: serviço de atenção especializada (Specialized Care Service); SAMU: Serviço de Atendimento Móvel de Urgência (Mobile Emergency Care Service); SMS: Secretaria Municipal de Saúde (Municipal Health Department); UPA: Unidade de Pronto Atendimento (Emergency Unit).

compared to the classic follow-up of primary care. PAD Diamante follows the structure of the other municipal PAD with exclusive assistance to HIV/AIDS patients).

2. Programs connected with the state's hospital network (FHEMIG Network) with four PAD in different hospitals: PAD Hospital João XXIII (in operation since 1999, targeted at the dehospitalization of patients staying in the hospital for very long periods, especially those with lower spine injuries); PAD Centro Geral de Pediatria (CGP - General Pediatrics Center) (constituted of two teams: Home CGP and VentilLar. The first has been in operation since 2000 and acts in the dehospitalization of children coming from intensive care with neurological problems, chronic pneumopathies, swallowing disorders, among others. The second team, created in 2002, assists children with progressive muscular dystrophy who need permanent ventilator monitoring and invasive mechanical ventilation); PAD Hospital Eduardo de Menezes (Therapeutic PAD that has been assisting HIV/AIDS patients since 1995. In the logic of shared management, there is regionalization of assistances in the municipality with PAD Diamante, of the Municipal Health Department); PAD Hospital Júlia Kubitschek (exclusively destined for adult patients with Muscular Dystrophy; in operation since 2002).

3. Programs connected with other public/philanthropic hospitals: PIDNEO Hospital Sofia Feldman (in operation since 2005 with the purpose of dehospitalization of stable newborns that are in the hospital's kangaroo care unit to gain weight; jaundiced newborns who need phototherapy, without risk of exchange transfusion); PID Hospital das Clínicas (in operation since 1999, at the moment with the action of two teams. The first assists adult patients mainly with severe neurological disorders: sequelae of cerebrovascular accident, dementia of several etiologies, as well as patients with immobility and its consequences and neoplasias that require palliative care. The second team assists children with prevalent profile of malformations and cerebral palsy).

The services analyzed in detail in phase 1 of the study (PAD Hospital Odilon Beherens, PAD connected with the emergency units of the Municipal Health Department and PIDNeo Hospital Sofia Feldman) are described in the Table.

Home care in the hospital units of SUS in Belo Horizonte is regulated by Directive SMSA/SUS-BH no. 03/2001, which establishes the criteria so that the public hospitals of the municipality can implement their programs. Remuneration should be calculated via the table of the Outpatient Clinic Information System.<sup>a,b</sup>

However, this financing mechanism was not effective in the municipality's units, and the financing was made with resources from the budget of the health departments and hospitals, except for PAD Diamante and PAD Hospital Eduardo de Menezes, which receive specific payment through the National DST/AIDS Program.

In all services there were difficulties to collect data on investment, defrayal and financing of the programs, because the finance operations (purchase of material and equipment, hiring of personnel, building maintenance, among others) were carried out by central structures of the municipal health department, of the municipal government, of the state department - directly or by means of foundations -, being out of the scope of the programs' coordination.

## Phase 2: Analysis of the tracer cases

In the fieldwork, six tracer cases were analyzed, selected in the following services: two cases in PAD HOB, one case in PAD Topázio, one case in PAD Diamante and two cases in PIDNEO Hospital Sofia Feldman.

The selection of experiences was guided by the criteria of feasibility (availability of resources for the implementation of the proposals; availability of technology and of materials belonging to the home care program and administrative structure that enables the insertion of researchers for team analysis in the visits); diversified users' profile with varied cases per age group and clinical condition; and ongoing case.

Typical cases, successful cases (good practices) and tension cases were included, namely:

**Typical case:** it was indicated by the team of PIDNEO Hospital Sofia Feldman: the follow-up of a child who was born prematurely at 34 weeks, referred to the program after 15 days of hospitalization. The case represents the predominant characteristic of the assisted patients (newborns admitted to gain weight) who evolve satisfactorily in the program, contributing to the program's positive statistics. In the case's follow-up it was possible to notice what the team calls "indicators that the Program's formal assessment does not show": the family's receptiveness, expectations and the stories that are told in the patient's home.

**Successful cases** ("good practices"): two successful cases were indicated, one by the team of PAD HOB and the other by the team of PIDNEO Hospital Sofia Feldman. In case A, the team of PAD HOB reported the follow-up of a patient admitted to PAD after four days of hospitalization due to surgical debridement of necrotizing fasciitis. The patient remained in the

<sup>a</sup> Secretaria Municipal de Saúde. Diretrizes para a atenção domiciliar no município. Belo Horizonte; 2003.

<sup>b</sup> Belo Horizonte. Portaria SMSA/SUS-BH nº 03/2001, de 3 de abril de 2001. Normatiza a atenção domiciliar terapêutica nas unidades hospitalares do SUS em Belo Horizonte. *Diário Oficial Município*. 2001;7(1351). [cited 2009 Dec 3]. Available from: <http://portal6.pbh.gov.br/dom/iniciaEdicao.do?method=DetalheArtigo&pk=884874>

Program for 35 days. In this period the team requested an evaluation provided by a specialist who indicated a new surgery, but the patient defined the care project and chose not to undergo it. The good practice results from the team's implication in care production, as they considered the user as the definer of the therapeutic project. With an ethical-political positioning, the team was capable of considering the demands and needs of the user, who assumed centrality in care production. In case B, the team of PIDNEO indicated the follow-up of a low weight newborn; the child of adolescent parents who had difficulties in accepting the pregnancy. The child remained in the Program for 24 days, a period in which the team enabled the parents' responsabilization for the care of the newborn. Responsibilization was constructed based on the autonomy that care supplied at home provides, a situation reported by the parents as "difficult to be constructed" due to the hospital's rigid rules and hours.

**Tension cases:** three cases were indicated because the teams considered them as being of difficult resolution or as having impacted the team in view of the challenges to action. The team of PAD HOB indicated the follow-up of a child with Edwards Syndrome, included in the program after six months of hospitalization. The child was followed up by PAD during three months until she was hospitalized again and died. The case can be characterized as palliative care due to the poor prognosis and, thus, the family was prepared for the child's death. However, the challenge posed to the team did not refer to the end of the child's life, but to the mobilization of technologies that the team did not know how to use at that moment to deal with the disturbed family relations and financial difficulty. In palliative care, the team reported that the intensity of the bonds created by the provided care demanded of the team a new work dynamic, not always with established working hours, to meet the family's demand. The second tension case was indicated by the team of PAD Diamante: the follow-up of a care-dependent patient whose caregiver (defined as such due to lack of another option) neglected to provide care. The case revealed the need to discuss the relations that are established within home care, among them the definition of the caregivers and the daily working routine in the patient's home. At the same time, it also revealed the need to build a social network to support home care. The third tension case was indicated by the team of PAD Ametista: the follow-up of a 56-year-old male patient admitted to the Program by the criterion of multiple demands (suffering from gout, alcoholic, hypertensive, frequently attending the urgency service). The team considered it was an emblematic case due to the patient's low adherence to the Program's orientations and prescriptions. The case revealed the limit for the team's action in complex situations.

The tracer cases allowed the identification of analyzers or analytical categories, defined as a set of elements that reveal the aspects that constitute the situations, allowing to establish the relations between what was proposed in the policy and in the programming and what was executed. In addition, the analyzers enabled to understand the multiplicity and complexity of relations that are established between the subjects that participate in home care in the analyzed situations.

In this sense, we would like to emphasize that the cases were able to mobilize in the teams the use of soft technologies and the need to search for articulation with other networks apart from that of the healthcare services. The teams revealed that home care puts them in contact with aspects which, despite being asked during the hospital or outpatient assistance (housing conditions, family relations, among others), are not the direct object of their work. Thus, at the patient's home, solidarity and invention begin to compose the team's tool box,<sup>2</sup> configuring a movement of incorporation of new technologies into healthcare actions.

## DISCUSSION

As for the variable "articulation of home care with the local healthcare system", the implementation of home care in Belo Horizonte, in its diverse modalities and modelings, was preceded by a political-institutional decision so as to assume it as a technical-assistance health organization strategy in the municipality, aiming at promoting, simultaneously, dehospitalization (better use of the existing beds and cost reduction) and care humanization. This can be observed in the interviews with the municipal manager, in the documental analysis, in the direct observation (for example, through the meeting during which all the home care experiences were presented) and by means of the investment in the articulation of the home care teams with other levels of the healthcare system.

The articulation between the different home care services in the municipality of Belo Horizonte has been discussed, and there has been a proposal for the design of a Municipal Home Care Guideline. The initiative was of the Municipal Health Department, through Home Care Coordination, which has promoted debates and seminars with the presence of all the Home Care services, both municipal ones and those developed by other institutions. Therefore, these services constitute a network of care, with potential to contribute to the continuity and integrality of assistance.

In the First Meeting of the Home Care Programs of SUS-BH,<sup>a</sup> the general characteristics and the mode of functioning of each one of the programs operating in the municipality were presented. The discussion

<sup>a</sup> Meeting organized by the Home Care Coordination of the Municipal Health Department in December 2006.

also includes the movement of integration between the home care services and the family health teams and the distribution of the Programs' responsibilities concerning the meeting of the municipality's demands, respecting the logic of regionalization and assistance according to specialties.

The regulation proposal, through Directive SMSA/SUS-BH no. 03/2001,<sup>a</sup> represents a strategy to organize the practices in the field and translates a political definition for it. The findings also revealed that the coordinator of the municipal programs has a special interest in integrating all the existing services in a perspective of a problem-solving network, according to the guidelines of SUS and to the role expected for the municipal manager. This process is constructed with difficulties, mainly concerning admission mechanisms, continuity after discharge from home care (in which disputes and tensions among teams from different health equipments are revealed) and financing of the proposals.

The two lines that mobilized the political-institutional decision in relation to home care – the rationalizing one (home care as a way of diminishing costs by means of the reduction in or substitution of hospitalization) and the one that intends to promote the technical-assistance reorganization with valorization of the substitutive care network (home care as a more humanized and contextualized alternative according to the needs of users and their families) – are not exclusive, as both are present, expressed in the guidelines for programs' organization and in the practices instituted by the teams.

These two lines affect in a different way the PAD professionals and municipal managers. To the professionals participating in the study, the potentiality of home care in the production of new modes of care and the establishment of new relations in the institutional environment are more relevant; to the managers, however, although they also recognize these aspects, the logic of dehospitalization constitutes the main motivation to the implementation of home care.

The logic of dehospitalization is expressed in the mechanisms of access to PAD, which, in all the experiences of Belo Horizonte, have, as point-of-departure, the search for dehospitalization and, in the case of the PAD located in the emergency units, pre-hospitalization. This condition concentrates the decisions on the professionals of the hospital environment and of the outpatient units. No other mechanisms of access to home care are identified, being restricted to the demand of hospitals and emergency units.

It is believed that the user's admission to home care could also occur through the demand of the family health teams, considering that it is also possible to identify, in this scope, situations that require greater intensity of care, but without the need of hospitalization. Thus, one of the points of debate in services articulation has been the construction of assistance flows in three possibilities of home care organization, concerning the entrance doors: demand coming from the family health team; demand coming from the hospital; and demand coming from the emergency units.<sup>b,c</sup> This opening would create an opportunity for home care to be effectively guided by users' needs, configuring itself as an alternative for certain types of clinical situation, constituting a truly substitutive modality.

The PAD distribution by districts reveals the intention to assume territoriality as the organizing principle, which has enabled advances and different degrees of articulation with the family health teams. The reach of the articulation, in terms of continuity and attribution of responsibility for care to the Family Health Program, during or after discharge from home care, occurs according to the characteristics of the work of some teams in their catchment area, focusing on the demand for each case. It is not a systematic modality of a care network.

This difficulty is revealed in all the studied services, and it is a concern for the professionals of the home care teams, who understand that the difficulty in articulation derives from the family health teams' impossibility to absorb one more demand, in view of the intense rhythm of work in primary care.

The difficulty in establishing home care as a station of the healthcare network may be related to the "place" this modality occupies in the services. In the configurations analyzed in Belo Horizonte, the conception that prevails is the one of home care as a special program in the institutions, of small proportions and, due to this, with little capacity to absorb the entire demand and to have an impact on the assistance model.

In the fulfillment of the home care proposals, it can be noted that diverse projects are in dispute (projects from institutions, professionals, users, families). In the analysis of the experiences in the field of Belo Horizonte, this condition becomes evident in the dispute concerning the different ways of organizing the home care services, like, for example, the organization, by pathology, of the hospital services in dehospitalization and the organization of PAD in the emergency units in pre-hospitalization.

<sup>a</sup> Belo Horizonte. Portaria SMSA/SUS-BH nº 03/2001, de 3 de abril de 2001. Normatiza a atenção domiciliar terapêutica nas unidades hospitalares do SUS em Belo Horizonte. *Diário Oficial Município*. 2001;7(1351). [cited 2009 Dec 3]. Available from: <http://portal6.pbh.gov.br/dom/iniciaEdicao.do?method=DetalheArtigo&pk=884874>

<sup>b</sup> Secretaria Municipal de Saúde (Belo Horizonte). Atenção básica de saúde em Belo Horizonte: recomendações para a organização local. Belo Horizonte; 2006.

<sup>c</sup> Secretaria Municipal de Saúde. Diretrizes para a atenção domiciliar no município. Belo Horizonte; 2003.



The existence of diverse services organized with distinct logics, according to the institution that originates the initiative, reveals the challenge of a shared management, capable of integrating the different services in the construction of a care network, taking into account territoriality and the construction of the logic of substitutability, as they are practices that aim at other types of objects and ways of providing care.

This complexity strengthens the importance of the manager in resources operation, such as the capacity for making policies, for inducing the incorporation of new technologies and for enabling technological innovations in health production.

However, as observed by Merhy,<sup>7</sup> if managers fail to produce an impact on the ways in which agreements are constructed between managers, workers and users in the daily routine of the services, the care models will not be transformed. Furthermore, it is possible to state that this is the reality of the home care programs analyzed in the field of Belo Horizonte, with practices and experiences of integral care, teams formation and positive results in new arrangements in healthcare production. Nevertheless, this has been a production on the part of the teams, subject to the vicissitudes of daily routine, but there is not an intention on the part of the manager concerning its establishment and expansion. This is revealed especially by the fact that almost all the experiences function as special services in the institutions, occurring in parallel with the other actions and isolated from the rest of the services network, from the point of view of exchanges and articulation of care.

Therefore, when we analyze the home care experiences on the field, we identify that there are many players and projects in dispute and, even with all the government's capacity, expressed in the definition of home care as institutional policy, the tensions that constitute the action in the field of health have surpassed the potentialities of the ongoing innovative practices.

Even with no specific investment made by the proposing institutions in relation to the production of new modes of care and recognizing the disputes in the daily working routine in home care, it was possible to identify, in the experiences analyzed by means of the tracer cases, technological innovation (mainly in the field of soft technologies) and the fact that the caregiver may assume the role of definer of user-centered relations. The care provided at the individuals' home offers them more freedom of creation and conduction of their activities, like definition of times for baths, feeding and medicines (according to certain side effects), routine of change of diapers, position changing in bed and mobilization according to the caregivers' availability and the home's dynamic. Thus, patients can have a direct relationship with the professionals (without intermediaries), building stronger bonds. It is observed that the families have autonomy to implement the care projects.

Many teams have a new work dynamics, are cohesive and share knowledge. There is mutual respect and the teams construct forms to view the specificities of each professional as essential for quality care in the working routine. A health production model centered on procedures and organized according to the medical-hegemonic logic has started to be replaced by work modeled by the recognition of the practice of other health professionals. In the experiences, disputes between nuclei and fields of professional knowledge were not observed, as there is joint construction and proactivity of all the professionals according to users' needs. As this is an arrangement produced by the teams, without the manager's specific support, it is evident the need to have a qualified professional whose profile is adequate for the multiprofessional and interdisciplinary work of home care. Thus, due to the strength of the worker-caregiver-user encounter and due to the ethical-political project that guides the work of many of the teams, home care is a potency that can transform the healthcare practices.

In spite of this, it was possible to notice that, even in the patient's home, doctors and nurses continue to be as strategic and nuclear (in the definition of the therapeutic plan - as they are the ones who prescribe the care to be provided -, and in the hierarchization and classification of care's complexity) as they are in other modalities of health assistance.

The innovative potential of home care is related to the teams' greater permeability to the different aspects experienced by users and their families and also concerns the production of amplified care that is not restricted to the biological aspects of the illness. Therefore, technological innovations of care are developed, together with greater possibilities for team work, which articulates and shares different types of knowledge and professional practices in the therapeutic projects, with amplification of autonomy (of users or caregivers).

The experiences show that it is possible to create a new care environment, crossed by values and beliefs from the daily routine of the patient's home. This environment configures new manners of production of therapeutic projects, in which the projects of users, family members, the social network, and home care professionals coexist and intersect each other.

## CONCLUSIONS

Changing the care model is a complex process, as it is conditioned to the incorporation of alterations into the health work process regarding its purposes, objects, means, and mainly, alterations to the relations between professionals and services users. The change in the technical-assistance model is only truly effective when the centrality of the user in care production is assumed, as users express their needs and occupy the place of

subject in the construction of therapeutic projects. The “macro”-systemic initiatives related to the formulation and implementation of policies give objective conditions to changes in the “micro” level. However, changes just occur through the incorporation of soft technologies into work processes, indispensable to advance in the replacement of the biomedical paradigm.<sup>7</sup>

The implementation of home care as an innovative strategy requires reflection on health and life conceptions that support the organization of practices in the

patient’s home. It is necessary to take into account elements such as integrity of care, economic-financial rationality, the subjects of care and articulation with the other healthcare services. The definition of the political organization of home care becomes fundamental, as well as the attributions of teams and families, and the construction of new relations, more articulated and cooperative, between the different types of health equipment. In this new scenario, family and user recover centrality in care production, which used to be restricted to the health professionals’ practices.

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