Cogitare Enfermagem

ORIGINAL ARTICLE

AGED PEOPLE'S PERCEPTION ABOUT THE TRANSITIONAL CARE PROVIDED BY A MULTIPROFESSIONAL HOME-BASED ASSISTANCE TEAM*

HIGHLIGHTS

1. Home-based care enabled aged people's safety.
2. Articulation of the health services in the population aging setting.
3. Aged people benefit from home-based care.
4. Home-based care provided functional maintenance and recovery.

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ABSTRACT

Objective: to understand the aged people's perception about the care provided by a Multiprofessional Home-based Assistance Team in the city of São Paulo - Brazil. **Method:** a qualitative study using oral life stories. The data were collected between August 2020 and October 2021 by means of semi-structured interviews. The sample consisted of nine aged women assisted by the Multidisciplinary Home-based Assistance Team. The data were treated according to oral life stories, presented in the form of narratives and categorized. **Results:** seven thematic categories emerged from the narratives. The participants' perception of the health care provided by the team was positive and necessary, mainly because it favored access to the resources provided by the Unified Health System. **Conclusion:** the importance of home-based care for care continuity for aged people is highlighted. The study reinforced the need to include the finitude process in the planning of care actions in health services.

DESCRIPTORS: Older Adults' Health; Comprehensive Health Care; Health Services for Aged People; Health Care Quality; Qualitative Research.

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INTRODUCTION

Facing inequalities, mainly in old age, makes it fundamental to better understand the dynamics of the Brazilian population aging process; as well as the social determinants, as the greater the vulnerability in adulthood, the worse the living conditions in old age[1-2].

In this direction, it is indispensable to develop and implement public policies with an emphasis on healthy and active aging, as this contributes to reducing inequities, inequalities and social exclusion in the Brazilian population aging process.

In this logic, transitional care between services emerges as a relevant alternative in coping with lack of access and discontinuity of care. These factors multidimensionally affect people's living conditions, as they lead to an increase in social and economic inequalities by interfering with income, social and family dynamics, health and well-being of the aged population[1,3].

Transitional care for aged people is the health care modality that contributes to quality and safety in the line of care. Certainly, by ensuring access and care continuity, it promotes safe transfers between different care modalities, as well as resoluteness and effectiveness of the care provided.

In transitional care, the home visits made by health professionals were classified as alternatives for reducing the hospitalization rates. Thus, in Brazil, the "Better at Home Program" ("*Programa Melhor em Casa*") stands out, a home-based care modality established by Ordinance No. 2,029 of August 24th, 2011, updated by Ordinance No. 963 of May 27th, 2013[4-5].

This program is operated by Multiprofessional Home-based Assistance Teams (*Equipes Multiprofissionais de Atenção Domiciliar*, EMADs) or by Multiprofessional Support Teams (*Equipes Multiprofissionais de Apoio*, EMAPs), differentiated by workload and profile of health professionals, namely[4]: EMAD types 1 and 2 and EMAP. Physicians, nurses and gerontologists are not mentioned in the EMAP support team guideline. The Weekly Working Hours (WWH) vary according to the number of team members, the total hours must be at least 90 hours of work per team, and the professionals cannot present WWH of less than 20 hours[4].

EMAD and EMAP enable transitional care with articulation and integration with the Health Care Network. Through actions in the territory, the hospitalization demand and/or time decreased, which favored a reduction of expenses with hospitalizations in the Unified Health System (*Sistema Único de Saúde*, SUS)[5].

The study showed that the Better at Home Program reduced hospitalization costs by approximately 4.7% in 2011, 5.8% in 2012 and 10.2% in 2013. When directing the results to the aged population, verified a 9.6% reduction in expenses to the SUS is verified, proving to be an efficient public policy[5].

In view of what has been mentioned, it is worth inferring that transitional care has been contributing to access to services in the care process for aged people. Thus, the current study aimed at understanding the aged people's perception about the care provided by a Multiprofessional Home-based Assistance Team in the city of São Paulo - Brazil.

METHOD

A qualitative study using the oral life story approach. This approach contributed to identifying gaps related to health care for aged people, given its broad, complex and

heterogeneous nature[6].

Data collection took place with aged users of the service offered by EMAD, located in the West area of São Paulo (SP), which assisted a total of 804 users in the period from 2015 to 2020. Of the total number of visits, 93% were aged individuals, presenting high demand even though it is not a specific service for this population group[7].

For constitution of the sample, the users selected were those aged at least 60 years old, with due ability to communicate verbally and without advanced dementia. This information was verified from a list given to the researcher by the team. The list presented users' data according to the selection criteria, describing the following: name, date of birth, telephone contact of the main responsible person, date when the service by EMAD was initiated, medical record number, diseases and current health situation.

Subsequently, a researcher read the medical records and asked the professionals to indicate which users were more available to participate in the study. This indication considered the EMAD professionals' experience and bond. Based on this information, telephone contacts were made for a first approach. In this way, the researcher was able to introduce herself and explain the research objectives.

After the clarifications and the participants' acceptance, appointments were scheduled for the personal presentation of the researcher and the home-based interview. The interviews took place from August 2020 to October 2021, being recorded with the interviewees' consent using a digital recorder and lasting from 60 to 180 minutes.

The following guiding questions were used to carry out the interviews: 1) Tell me how you feel in relation to your health; 2) How did you start to be assisted by the Multidisciplinary Home-based Assistance Team (EMAD)?; 3) Tell me about the service you have been receiving through EMAD; and 4) Do you have support from any person or institution?

Data collection only took place at times when the EMAD users showed confidence in receiving the researcher in their homes, as well as after due approval by the competent bodies and SMS-SP flexibility in relation to the social isolation resulting from the COVID-19 pandemic.

The stories told by the participants were transformed into written narratives. This process was a careful and complex stage, carried out through transcription, textualization and transcreation. These stages made it possible to transform orality into written content, thus enabling the narrated reality to freeze in time[8].

The transcription stage considered transformation of the oral content into text. Subsequently, the textualization stage was carried out for the identification of repetitions, chronological organization of the testimonies and exclusion of textual elements and language vices. In the transcreation stage, elements not present in the statements were incorporated to recreate the context of the interviews and present the meanings perceived during data collection to the reader[8].

After finishing the narratives, the participants were again contacted to check them, a process which, given the COVID-19 pandemic, was carefully carried out by telephone. Some participants requested small adjustments, which were promptly accepted[8].

Subsequently, categorization of the data expressed in the narratives constituted convergence of the aged people's perceptions about the singularities of their life paths[9-10].

The categorization process enabled an in-depth contact with the content of the narratives through a horizontal, cross-sectional and exhaustive reading, treating the data in all their aspects, grouping and classifying them in a way that would allow for their interpretation and articulation[8-10]. To preserve secrecy, the aged individuals were identified with bird code names.

Analysis of the material followed the exhaustiveness and representativeness rules, by identifying essential characteristics in relation to the theme under study, homogeneity, pertinence and exclusivity, through data sorting and classification and exhaustive reading of the narratives[9].

The study was approved by the Ethics Committees with opinion No. 3,803,296, respecting the legal procedures established by these bodies.

RESULTS

The research context made it possible to understand the everyday life and work processes of the EMAD in question. The complex situations in the home environment that they encounter, whether due to the users' clinical conditions or to their socioeconomic situation, led to consequences that affected the entire care management process.

The study participants were nine aged individuals who lived in the West area of the city of São Paulo, with a mean age of 74.5 years old and a minimum of 63 and a maximum of 93. All study participants presented multiple morbidities and reduced functional capacity.

Reduced functional capacity included factors that resulted in difficulty commuting to and from the health services, which led to a frequent need for home-based care and continuous health monitoring. When considering income, the participants earned nearly one minimum wage and stated that they did not have the economic conditions to fully supply the treatment, as the necessary inputs for this were not always made available by the Unified Health System, requiring the support of family members.

The participants showed satisfaction in verbally sharing their memories. It was possible to identify seven categories, namely:

1) The health care network and the importance of its articulation for care continuity: this category explained the importance of articulating the health services in the population aging setting.

I've always had the best impression of the Unified Health System, although most people don't share this. My partner registered to be able to pick up the diapers at the Basic Health Unit and that's when they talked about the EMAD program. And so, wonderful doctors and nurses started to come here [...] [Blue Swallow]

With the care I received at home and with the medications I used, I can say that I have improved a lot. I started to be assisted by the EMAD after the hospitalization, through the Basic Health Unit. There they told me that there was this team that offers home-based care. My sister and I went to the BHU, I was in a critical condition, when I got there I was assisted by the social worker and the doctor [...] [Ruby Hummingbird]

2) Recognition of the EMAD as a basic home-based service for aged people: it presents the aged people's perception about home-based care, an assistance modality that favored access to the Health Care Network, care integrality and humanization of health care.

The EMAD is a service that is within the BHU, the inputs are collected at the BHU and I have to periodically do the control there. The EMAD doesn't come here every week, it comes when I ask, it comes twice a month. My daughter sends messages via the Internet to the doctor. [Tsuru]

The EMAD people help a lot… They even got a wheelchair, a bath chair and I'm registered to receive diapers. It's great to have their support. When something's wrong, we ask for guidance. They advise us, come here, look, twice a week. They measure pressure and temperature. So, it's very good, because I measure my pressure at home, but we're not

sure if it's right. We feel safer with them coming here and, when I need it, they also provide an ambulance to get to the chemotherapy. [Laughing Falcon]

3) Informal support network in the process of assisting dependent aged people: the data showed that the informal support network is present in aged people's everyday life, consisting of voluntary relationships, mainly through the support of women - daughters, wives or sisters.

[…] I only have support from my daughter, she does everything! Anything I need, that I'm not feeling well, she cooks, helps with bathing, buys medications... [Field Canary]

Support, it's a word that means shelter, aid and help... In addition to the EMAD, my sister helps me, she's the person I can always count on in my family. I think I don't give much work, but she always helped me a lot. Today I can take a shower by myself, put on clothes… For now, it still works, but I know that if I need anything I can count on my sister. [Toucan]

My children got married very young, they work but earn very little and are almost unable to support themselves... They help me when they can, today my daughter is my right hand, because if it weren't for her... because with these diseases, I'm alive by a miracle. [Orange Thrush]

4) Senility and financial precariousness as obstacles to aged people's autonomy: it presents the obstacles to aged people's autonomy unveiled by the participants, which interfere in a cross-sectional way with physical, mental and social health.

I wish I could do something, but I can't because I don't move, I lie in bed. I want to get up, I pay attention because that part doesn't move (pointing to the hip). So, that's what I do in physiotherapy. I sit down with this foot that doesn't move. Sitting down, I can't do almost anything during the day. I'd like to wash dishes to distract myself, but I can't because the faucet is high and I can't get up. [Field Canary]

The benefit for aged people might be improved, so that they could at least eat better. I say this for myself, due to my age, to my health, I need to have a fruit and a vegetable every week… What did the government do? They took away bus tickets from retirees. That was to make a strike, because that was not supposed to happen. Older adults' salary is miserable… With my salary, I spend more than half on rent, I even borrowed money from the bank so I could take the medication. There are medications that the health center does not have and the government does not help. When I get paid, I don't even have 200 reais. Some of the medications I use are not available in the SUS. The health center doesn't have the medication I use for blood pressure, the one I use for depression is always out of stock... And I suffer with all this, because there are families who can't even help and the older ones need so much... [Orange Thrush]

5) Spirituality as a strategy to cope with adversities in old age, a resource used to cope with the suffering and uncertainties related to illness and the future.

[…] *Nobody knows what it will be like from now on. I'm not afraid, because I trust in God! So, it'll be what God wants […] Let's see if it works from now on. I hope everything works out and I get well, healthy and then go on with my life… Godspeed!* [Laughing Falcon]

Jesus Christ is coming back and I'm so happy about it! Then it's just that, that we do bad to ourselves! Even you, do you have a bible? So, try to read, pray, wherever you are, you don't even need to kneel down, just look with your mind, talking to Jesus…. [Field Canary]

I have so much faith! I'm a Catholic and Messianic. I was only able to get through all of this because I had so many people praying for me. I learned that religion is the thing that we feel good about. I asked God for strength to be able to eat, I had the intuition to eat beans and porridge for breakfast. [Orange Thrush]

6) Finitude and losses experienced in old age: it presented aged people's anticipated mourning in the face of losses that occurred in old age.

I turned 63, I know I'm at an age where things will get harder. The doctor told me that I have to be patient, because my stroke was something very aggressive… I said: Doctor, for four years now I have heard people say the word patience to me at least four times a day. What I really wanted was to be able to have my life back, but I know I won't have it... [Blue Swallow]

I feel that my future is short… I'm already very old… I'm 81 and I want to be healthy until the end. Being healthy until the end and living a few more years... I don't like doing almost anything anymore. Everything's always the same, at home everything's always the same [...] [Toucan]

As some people say, I wait for death. I don't have any plans anymore, not even a plan to earn money and I've always been like that… I'd like to do something for myself, earn a little money for myself. I had a knitting machine, which was a factory for me. I used to sell, you know? I really liked it, but over time I couldn't use the machine anymore, so I decided to sell it to someone else, but I liked it, it was a good job, because I earned my money and worked at home. [Field Canary]

7) The COVID-19 pandemic: impact, restlessness and perspectives: it presented the feelings experienced during this period, such as fear and restlessness. In addition to that, the participants explained the comprehension difficulty arising from the different information presented by the media and the spread of fake news.

Now this pandemic came along and the two of us always home. I'm not enjoying this pandemic, but I also don't know what's going on that much... People say that it's nothing like that, that it doesn't exist, that not so many people are dying... We don't know the truth, there's a lot of different information. Here in my house no one had COVID, thank God! [Toucan]

DISCUSSION

The Health Care Network articulation presented an overview that encompassed the SUS guidelines and comprehensive care for the aged population. However, the narratives highlighted public health care as divine providence and not as a constitutional right.

The study showed that the population does not understand public services as a right; the Unified Health System is oftentimes seen as a social stigma, understood as a philanthropic act. In this way, it is understood as a place for people who do not earn enough money to pay for a private health service[11].

These data led to a reflection on the need to better understand the Unified Health System as a right. In fact, so that the population can use it, demand it and evaluate it without prejudice or stigma; thus ratifying that social control is a way to encourage improvements in the services and prevent degradation of the health system. On the other hand, recognition of the EMAD as a basic home-based service for aged people emphasized the users' perception about the existence of a service integrated with the Health Care Network.

The demand for home-based care is growing in the health system context given the aging of the Brazilian population, as older adults with chronic conditions and functional dependence tend to require this care modality more[12]. According to a systematic review study, some indicators of the need for home-based care included the following: functional dependence for the Activities of Daily Living, cognitive decline, reduced mobility, chronic diseases and advanced age[12].

The assistance offered by the EMAD favored an intermediation between the needs presented by aged people and care continuity. In this way, it contributed to access in the health scope, a multidimensional concept that encompasses the necessary care and the quality of life of aged people[1,13].

The participants valued the medical consultations offered at their homes, as well as the rehabilitation services provided by the physiotherapy and speech therapy services. The narratives also highlighted the relevance of Nursing care, attributed to the collection of test results, dressings and vaccines carried out in the comfort of their homes.

When compared to usual hospital assistance, home-based care reduced health expenses by preventing hospitalizations and frequent use of specialized health care. This care modality also stimulated physical activity in the users, contributing to better evolutions in their health conditions[14].

Home-based care, such as the one provided by the EMAD, enabled aged people's safety by reducing the hospitalization risk, in addition to collaborating with its users staying at their homes for as long as possible.

In the home environment, the narratives emphasized the importance of the informal support network in the process of assisting dependent aged people. The participants in this study asserted that the actions by this support network were centered on help with self-care, such as bathing, changing clothes and eating.

These data are in line with the findings of a cross-sectional study carried out with 348 community-dwelling aged individuals from the municipality of Várzea Grande, Mato Grosso, in which care for older adults is centered on the family, primarily provided by daughters or daughters-in-law, then by sons or sons-in-law and, finally, by spouses[15]. On the other hand, the increasing inclusion of women in the labor market indicates the difficulty of the female figure as the only person responsible for the care of dependent aged people[16-17].

Another difficulty highlighted corresponded to the social problems that are making it difficult for new generations to provide for their own needs, hindering their practice as informal caregivers and making aged people feel like a burden for society[16-17]. Another important aspect is the decrease in the informal family support networks, resulting from the reduction in family arrangements, referring to the need to value community support.

The literature highlighted that the support offered by aged people's social networks may be the only alternative for survival; thus representing the bridge for referral to a formal service, signaling repressed demands of the territory to the professionals[17].

Given this scenario, it is noted that the demands of the dependent aged population require constant assistance. However, the EMAD guidelines do not cover daily assistance to its users, requiring the presence of a caregiver. The service enables home-based care, provides guidance to family members and caregivers and cooperates with users' access to the Health Care Network, among other actions[5].

In this research, the participants associated old age, above all, with the onset of diseases, which incapacitate them for the Activities of Daily Living. A number of studies assert that the complexity of health problems causes mortality and dependence in older adults[3,18-19].

Dependence adds demands on home-based services and long-term care. This asserts the need to implement effective actions that allow maximizing functionality for as long as possible[3,18-19].

In the social sphere, poverty and inequality in old age persist over time, when health problems are accentuated. A study carried out in Mexico showed that, due to the increase in informal jobs, low income and lack of social security benefits, the sons' and daughters' ability to financially help their family members is decreasing[20].

This support is vital and influences aged people's total income in Mexico, making it impossible for them to access health services and treatments and meeting basic subsistence needs[20]. In this sense, people with a low socioeconomic status who do not have the financial support of family members may have a more disabling old age, seriously affecting the possibility of healthy aging. On the other hand, the narratives highlighted that spirituality and religiousness presented positive outcomes for coping with stressful events in old age, acting as a motivational basis to search for meanings and understanding of the episodes experienced.

Spirituality stimulated self-care, socialization and resilience to face challenges from old age to death, conferring meaning to life itself, in addition to promoting health and well-being[21-22]. It should be noted that, when not met, spiritual needs can lead to worse quality of life and less satisfaction with health care. Thus, it is relevant to consider spirituality in the care plans structured by formal services[23].

The data also shed light on finitude, marked by a decrease in functional and cognitive capacity. The narratives also mentioned changes in experienced social roles, such as death of loved ones and other biopsychosocial factors, which resulted in feelings and reactions underwent in the mourning process.

Losses in old age and the perception of one's own finitude were defined in the literature as symbolic death; the reactions presented can negatively influence health and physical capacity; a sensation of diminished physical and mental functionality; a feeling of low quality in interpersonal relationships; a reduction of material goods and purchasing power; a decrease in autonomy; a feeling of uselessness: and lack of well-being[1,24-26].

Finally, aged people mentioned the impact, concerns and perspectives in the face of the COVID-19 pandemic, as it affected older adults' mental health through feelings such as fear, loneliness, anxiety and sadness[27-28].

Social isolation was one of the strategies used to contain spread of the pandemic, such as closures or operating restrictions on businesses and workplaces. Although necessary, such strategies led to a reduction in household incomes.

For many people, the decrease in family income determined non-compliance with social isolation, a result of the stress caused by financial precariousness and lack of future prospects in relation to work[29].

Furthermore, the COVID-19 pandemic highlighted the need to implement effective strategies for comprehensive care for vulnerable aged people, whether they are residents of long-term care facilities for older adults or those living on the streets; thus validating the urgency of comprehensive care for aged people with a humanitarian, universal and equitable approach[30].

It is noted that the results should be interpreted considering the study limitations, even considering the potentialities of the findings presented. Specifically, the experiences of dependent aged people who were assisted by the EMAD at the collection moment were explored. Therefore, they may not reflect the reality of independent users who do not need home-based care.

FINAL CONSIDERATIONS

This research allowed understanding the service offered by the EMAD that provided functional capacity maintenance and/or recovery in aged people. Additionally, it strengthened both care continuity and the bond between users and professionals, reducing the number of hospitalizations and visits to urgency services. This care modality

favored integration with the community/Health Care Network, contributing to the aged population's access to the necessary services in a timely manner.

Furthermore, this research ratified that the actions by the health professionals who work with the aged population should focus on well-being and on integration of the Health Care Network. In this perspective, older adults should be the center of the care network and all existing resources in the community.

For Nursing, Geriatrics and Gerontology, the study reinforced the need to include the finitude process in the planning of care actions in health services, referring to the importance of developing research studies that contribute to the training of professionals on this theme.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Melleiro MM**; Drafting the work or revising it critically for important intellectual content - **Quintans JR, Melleiro MM**; 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 - **Quintans JR, Melleiro MM**. All authors approved the final version of the text.

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