

Review

Clinical and epidemiological profile of patients from the home care program of Federal District Brazil

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The hegemonic presence of chronic conditions in the world in recent decades has pushed health systems to reorganization, aimed at viability and economic sustainability with ‘user-centered’ and integrated actions, and also using the logic model of health care networks. One of the alternatives to meet this need relates to home care, which intends to assist bedridden chronic patients at home as a substitute and/or complementary to hospital care. This study aim to describe the socio-demographic and clinical profile of the population assisted by the home care program of Federal District, bearing in mind how recent is the model of home care in Brazil, and the fact that studies in this area are scarce. The study is a cross-sectional descriptive study, based on data collection from medical records of all the 857 patients enrolled in the home care program of Federal District between January, 2012 and August, 2013. The study variables were the socio-demographic characteristics (place of residence, age and gender) and clinical-epidemiological characteristics (primary diagnosis, care modality, length of stay and clinical evolution). The general profile of patients assisted in the service was characterized by the predominance of older people - over 60 years (62.66%), females (55.78%), with cardiovascular diseases (26.37%), in low-complexity care (61.49%), remaining in the program between 1 and 2 years (46.09%) and remaining active in the service registration (21.82%). The analysis of this profile identified that the home care program (Programa de Internação Domiciliar, PID) of Federal District has assisted patients with predominant low complexity profile, which is the responsibility of the Primary Health Care, thus distorting its potential for dehospitalization of medium-complexity chronic patients, which is its public target.

Key words: Home care services, epidemiologic study characteristics as topic, delivery of health care, homebound persons, home care services, hospital-based.

INTRODUCTION

Chronic non-communicable diseases (NCDs), represented By cardiovascular diseases, chronic respiratory diseases,

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diabetes, cancer and others, including kidney diseases have become the main priority in the health area worldwide and specifically in Brazil, accounting for 72% of deaths in 2007 and predominantly affecting the poor population. Parallel to the decrease in mortality rates from chronic cardiovascular and respiratory diseases, probably due to the successful implementation of health policies that led to the smoking reduction and the expanded access to primary healthcare, there has been an increase in the prevalence of diabetes, hypertension and obesity, associated with unfavorable changes in diet and physical activity (Schmidt et al., 2011).

In 2002, the world health organization (WHO) launched the project innovative care for chronic conditions, defining the term 'chronic conditions' as those covering the health problems that persist across time, and require ongoing management over a period of several years or decades. From this perspective, 'chronic conditions' cover an extremely broad category of diseases that apparently would have no relation among each other. However, although communicable diseases (example, HIV/AIDS) and non-communicable diseases (example, cardiovascular diseases, cancer and diabetes), physical and structural impairments (example, amputations, joint disorders) and long-term mental disorders seem different, they are included in the category of chronic conditions. The reasons for the differentiated definition of 'chronic conditions' are the similar characteristics of these conditions, namely: they are increasing in the world and no country is immune to their impact; they represent a serious challenge for the current health systems in regards to efficiency, effectiveness and ability to organize strategies that meet the upcoming demands; they cause serious economic and social consequences in all regions and threaten the healthcare resources in each country (WHO, 2002). The increase in chronic conditions reflects demographic, epidemiological and socio-cultural changes, which are sensitive to the behavior of the economy and the design of public policies. Although, they are present worldwide, these changes have peculiarities relating to their characteristics and intensity in the different countries, such as Brazil (Seixas et al., 2013)

Taking into consideration demographic aspects, it should be noted that the Brazilian population is aging at a very fast pace compared to most of the countries considered developed. Especially, when observing the population distribution expected for the elderly group (60 years or older), representing 11% in 2013 and 11.7% in 2015, which corresponds to an increase of 1,863,567 elderly in this two-year period (IBGE, 2014). In addition to the aging of population, other demographic components contribute to the increase in chronic conditions, such as the falling total fertility rate, increasing proportion of women who did not have live births, and life expectancy at birth on the rise (Portaria no 963, 2013). In relation to the disease burden, a unique epidemiological transition of developing countries must be put into context, inclusive in Brazil, recently defined as a triple burden of diseases. This in-

volves at the same time, an incomplete schedule of infections, malnutrition and reproductive health problems, in addition to the strong relative prevalence of chronic diseases, and their risk factors, as well as the growth of violence and external causes (Frenk, 2006). The social response to the growing demand for care for chronic conditions refers specifically to the need for reorganizing the health care systems. This restructuring should comprise the economic viability and sustainability of the system, the greater wellbeing of users and their families, and the reduction of health inequalities, which can be done with user-centered actions that are also designed and integrated in the logic model of the health care network (Silva et al., 2010).

In this scenario, the home care (HC) is a very consistent alternative, given the current epidemiological trends, the issue of health economics and the need to change the current techno-assistance model, which is hospital-centered. It has characteristics of low rationality and efficiency in certain medical conditions, as with chronic patients, who may be in home care when they are no longer of high complexity but of high dependence. Thus, HC is the care modality that can meet this demand due to the provision of assistance to patients in their home, creating family conditions for the continuity of care, without losing its quality and effectiveness and meeting the aspirations of patients, their families, health workers and services (Shepperd et al., 2009; Golden et al., 2013; Ornstein et al., 2013).

Brief history of home care in Brazil and in the unified health system (SUS – Sistema Único de Saúde)

The first domiciliary activities in Brazil were carried out in the twentieth century, more precisely in 1919, with the creation of the service of visiting nurses in Rio de Janeiro (Duarte and Diogo, 2000) and the urgent home care service (SAMDU) in 1949, originally related to the ministry of labor and social security. As a planned activity, it was set up by the public sector, with the implementation of the home care service of the public servant hospital of the state of São Paulo (Hospital do Servidor Público do Estado de São Paulo) (HSPE) in 1967. Following a global trend, home care spread as an organized service in the form of home care, focused on private companies in big cities, with a significant increase in the mid-90s, through public and private hospitals, governments, medical associations, health insurance companies, group practices, among other companies (Rehem and Trad, 2005).

Home care in the Sistema Único de Saúde (SUS) began with the implementation of the program of health community agents (PACS – Programa de Agentes Comunitários de Saúde) in the early 90s, a strategy currently understood as a transition to the then family healthcare program (PSF - Programa de Saúde da Família), currently the family health strategy (ESF -

Estratégia de Saúde da Família), which is now accountable for the family group healthcare in defined territories by providing bonding and home care. Subsequently, in 2002, Law No. 10,424, approved by the Ministry of Health, added to the Organic Health Law – No. 8,080 of September, 19, 1990 – Medical Care at Home. Home care legislation in Brazil evolved in 2011, with the establishment of the National Policy for Home Care through the publication of norms that were recently amended by the Ordinance no. 963 of 27 May, 2013. This policy reaffirms the HC in the SUS as a technological incorporation of substitute character or complementary to low and medium-complexity hospital interventions, in care services initiated in the Emergency Department, and Primary Care (Portaria no 963, 2013). This ministerial decree defines three types of HC according to the complexity and characteristics of patients' condition, the frequency of home visits, and the healthcare team responsible for this service:

HC1: Home care type 1 – aimed at users with checked/under control (low complexity) health problems, with physical difficulty or impossibility of locomotion to a health facility, with less need for health resources and within the capacity of care of Basic Health Units (*UBS – Unidade Básica de Saúde*). Also, receiving regular home visits at least once a month, this service is responsibility of primary care teams, including the Family Health Strategy (Portaria no 963, 2013).

HC2: Home Care type 2 – characterized by patients requiring procedures of medium complexity, such as the following: complex dressings, adaptation to use of tracheostomy device, probes and ostomy; rehabilitation of people with permanent or temporary disabilities, who require continuous care, palliative care and need intravenous, subcutaneous or muscular medication for a pre-set time and in clinical stability.

HC3: Home Care type 3 – patients with HC2 profile, and making use of noninvasive ventilatory support, peritoneal dialysis and / or paracentesis (Portaria no 963, 2013).

The HC2 and HC3 patients have the minimum necessity of a weekly appointment, and are the target audience of home care services of the SUS, which is called Home Care Program (PID - Programa de Internação Domiciliar) in Federal District (DF).

Highly complex medical care at home is intended for patients requiring invasive mechanical ventilation, through ongoing monitoring; intensive nursing care and supplementary propaedeutics; and use of complex medication with potentially serious side effects or hardly manageable, which service is outsourced by the State Department of Health of the Federal District (SSH-FD).

HC in federal district

PID in DF began in 1994, with gradual implementation of the current 15 Regional Centers for Home Care (NRAD -

Núcleos Regionais de Atenção Domiciliar), located in the respective General Health Coordination (CGS – Coordenações Gerais de Saúde) of the State Secretariat of Health of Federal District (SSH-FD), covering 57.16% of the population. The DF is a typical unit of the federation because it is indivisible and not municipalized, as established by the Brazilian Federal Constitution, even though it shares many of the problems afflicting other Brazilian regions. It comprises a territory of 5,787.8 square kilometers, equivalent to 0.06% of Brazil's surface, the Federal District itself, there are no headquarters, as it is indistinguishable from the federal capital, Brasília, ranked as the fourth most populated city in Brazil, with a population of 2.570.160 inhabitants (Instituto Brasileiro de Geografia e Estatística, 2014). In order to facilitate administration, the territory of DF was divided into 31 administrative regions (*RAs – Regiões Administrativas*) established by district laws, approved and published in the period between 1964 and 2012. The current organization of the Health System in DF was established in the Master Plan of Regionalization (RDP - Plano Diretor de Regionalização, DF-2007). In a general way, it defines seven health regions (RS – Região de Saúde) and 15 General Health Coordination, which are the Regional Centers for Home Care, located in Regional Hospitals or Basic Health Units, and coordinated by an instance in Central Administration denominated Management of Home Care. As the HC model is recent in Brazil, and the literature on this subject is fragmented and lacks international comparative studies (Genet et al., 2011), this study is aimed at describing the socio-demographic and clinical profile of the population covered by the home care program.

METHODOLOGY

This is a cross-sectional descriptive study, based on data collected from medical records of the 857 patients enrolled in the PID, belonging to the coverage area of 15 NRAD, from January, 2012 to August, 2013. A health services team was responsible for completing the forms, after discussion and establishment of a standard for information collection. Data from new admissions occurring in this period were not included, and no patient record was excluded. The study variables were the socio-demographic characteristics (place of residence, age and gender) and clinical-epidemiological characteristics (primary diagnosis, use of long-term oxygen therapy (LTOT) at home, care modality, length of stay and clinical evolution). The variables of age group and length of stay were measured in years. The information collected in excel spreadsheets were transferred to a database built in the STATA version 12, and subjected to descriptive analysis of frequency of events. The project was approved by the committee of ethics and human research of the Foundation of Teaching and Research in Health Sciences (FEPECS/SSH-FD) under protocol number 392/08.

RESULTS

The general profile of patients in the home care program was predominantly of older people, with cardiovascular

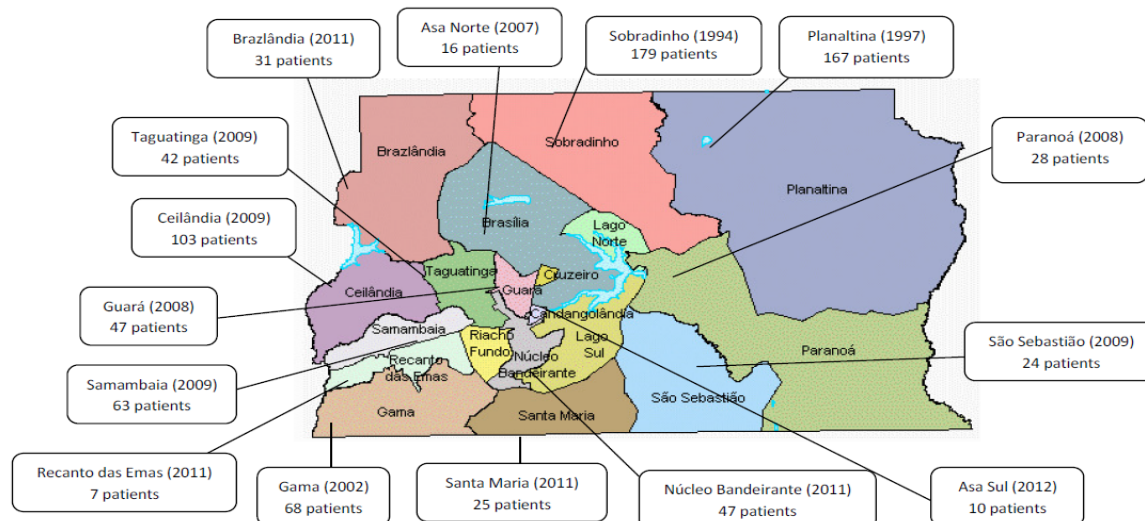


Figure 1. Map of the health care regions of the Federal District and regional centers for home care (NRAD - Núcleos Regionais de Atenção Domiciliar), according to implementation year and number of patients served. Brasília - DF, 2014.

Table 1. Distribution of patients by age group and gender (Brasília - DF, 2013).

Age group/gender	Female		Male		Total	
	N	%	N	%	N	%
Younger than 1 year	1	0.11	1	0.11	2	0.22
1 to 59	127	14.88	178	20.86	305	35.74
60 to 89	297	34.81	183	21.45	480	56.26
Older than 90	48	5.62	18	2.11	66	7.73
Total	473	55.42	380	44.53	853	100

Source: SSH-FD.

disease, in low-complexity care, with between one and two years of average length of stay in the service. The places of residence of patients served by the PID (Figure 1) were, in decreasing order: Sobradinho - 179 (20.89%); Planaltina - 167 (19.49%); Ceilândia - 103 (12.02%); Gama - 68 (7.93%) and Samambaia - 63 (7.35), summing to the total of 580 patients (67.68%). Table 1 shows age and gender. It was found that 546 (63.99%) of the patients treated in the PID during the study period were elderly (people above 60 years), with 66 (7.73%) users aged over 90 years, six of which were centenarians (0.7%). In relation to gender, 473 (55.42%) users were female and 380 (44.53%) were male. In the frequency distribution of the diseases group (Table 2), diseases of the circulatory system were predominant with 247 cases (29.02%), followed by diseases of the respiratory tract with 226 cases (26.55%), and 187 cases of diseases of the nervous system (21.97%). In fourth place was the presence of two conditions, with neoplasms and injuries, poisoning and certain other consequences of external causes with 49 patients each (5.75%).

This distribution was according to the international classification of diseases 10th revision (ICD-10), given that patients represented mainly by the elderly, had more than one disease being treated. The use of LTOT at home in the population of the study was 31.54%, corresponding to 269 patients (Table 3). In relation to care modality, Table 3 shows the prevalence of low complexity patients (61.70%), characterizing the profile HC1. Patients in healthcare scenarios classified as HC2 and HC3 represented 31.49% of the served population. Table 3 also shows the time of permanence in the PID, and the majority of patients (46.63%) who participated in the program for 1 to 2 years, followed by patients participating for 3 to 4 years. Regarding the clinical evolution variable, Table 3 shows that 426 (49.94%) patients remained active in the program, 187 (21.93%) died, 106 (12.43%) were discharged after recovery, 20 (2.34%) due to worsening, and 114 (13.3%) for other reasons such as change of address, unidentifiable caregiver, non-adherence to treatment and institutionalization. Totals for each variable may differ due

Table 2. Distribution by disease group (ICD-10) (Brasília - DF, 2013).

Group of disease (ICD-10)	N	%
Certain conditions originating in the perinatal period	3	0.35
Certain infectious and parasitic diseases	6	0.7
External causes of morbidity and mortality	1	0.11
Diseases of the skin and subcutaneous tissue	5	0.58
Diseases of the circulatory system	247	29.02
Diseases of the digestive system	1	0.11
Diseases of the genitourinary system	5	0.58
Diseases of the respiratory system	226	26.55
Diseases of the ear and mastoid apophysis	1	0.11
Diseases of the blood and blood-forming organs and certain immune disorders	4	0.47
Diseases of the nervous system	187	21.97
Diseases of the musculoskeletal system and connective tissue	10	1.17
Endocrine, nutritional and metabolic diseases	17	1.99
Factors influencing health status and contact with health services	1	0.11
Injury, poisoning and certain other consequences of external causes	49	5.75
Congenital malformations, deformations and chromosomal abnormalities	13	1.52
Neoplasms (tumors)	49	5.75
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	8	0.94
Mental and behavioral disorders	18	2.11
Total	851	100

Source: SSH-FD.

to missing data.

DISCUSSION

Figure 1 shows the comparison between health regions of Federal District and regional centers for home care according to implementation year and number of served patients, by drawing a parallel between the largest number of assisted patients and the antiquity of service implementation in the DF. It is possible to note a larger number of patients registered in the administrative regions of Sobradinho (1994), Planaltina (1997) and Gama (2002), who were the first nuclei to be implemented, hence the oldest, and in the most populated administrative regions of Ceilândia (414.531 inhabitants) and Samambaia (205.516 inhabitants), despite these being newer sites, implemented in 2009.

The age and gender distribution of assisted patients (Table 2) showed similar profiles to the population of most of the studied services, either national, with the family health strategy and the home care teams (Martos and Sanches, 2009; Marques and Freitas, 2009; Marin et al., 2010; Del Duca et al., 2012), or international (Genet et al., 2011; Llobet et al., 2011; Jones et al., 2012), which is in agreement with data from the Brazilian Institute of Geography and Statistics (IBGE - Instituto Brasileiro de Geografia e Estatística) (IBGE, 2014). It states the age of 80 years or older with the highest growth rates among the

elderly, higher incidence of chronic diseases, poorer functional capacity, lesser autonomy, requiring more attention from the family and society, and greater predominance of women. However, this profile differs from that found in two studies (Maroldi et al., 2012; Gaspar et al., 2007), that added other analysis parameters to draw the demographic profile of their patients. The first study, carried out in a home care service of a hospital in the state of São Paulo (Maroldi et al., 2012), shows that 57.2% were men, aged 65 years on average, among which 10.7% were between 16 and 40 years, 28.6% between 40 and 60 years, and 60.7% between 60 and 96 years. The authors disagree with the information that most patients assisted by home care services are elderly women and with high mortality of men, without incorporating studies of the potential determinant of gender in the relation between health status and living arrangements, characterized by gender inequalities in face of socioeconomic and structural conditions, for instance, domestic conditions and family income.

In the study of Gaspar et al. (2007), the social exclusion index was used to understand how social and health inequalities are expressed in the disease profile of people with functional losses and dependence, assisted at home by the ESF in São Paulo. Overall, there was a predominance of older women with mild disability, requiring less complex care, which is assisted by the primary health care (APS). However, in districts with

Table 3. Distribution by use of home oxygen, care modality, length of stay and clinical evolution (Brasília - DF, 2013).

Clinical-epidemiological variables	N	%
Use of home oxygen		
No	58	68.4
	4	6
Yes	26	31.5
	9	4
Care modality		
HC1	52	61.7
	7	0
HC2	26	31.4
	9	9
HC3	58	6.79
Length of stay		
Less than 11 months	11	12.9
	0	8
1 to 2 years	39	46.6
	5	3
3 to 4 years	19	23.2
	7	5
5 to 9 years	11	14.0
	9	4
More than 10 years	26	3.06
Clinical evolution		
Active	42	49.9
	6	4
Death	18	21.9
	7	3
Improvement	10	12.4
	6	3
Change of address	36	4.22
Worsening	20	2.34
Others	78	9.14

Source: SSH-FD.

greater social exclusion was identified a higher proportion of men under 60 years and children with severe disabilities in need of increased complexity care, compared to districts with less exclusion.

The difference between these studies are probably related to the design and the different sample characteristics described in them; thus, it is important to recognize the value of these points of view that could not be addressed in our study. A description of this nature should be interesting, especially when considering that people are aging heterogeneously, depending on their social class, religion, ethnicity or gender, among other parameters. As well as with limited access to public

facilities in general, especially health facilities, either because of lack of opportunity and possibility to seek care in other services, by difficult mobility, or by the insufficient offer of health services capable of accommodating this population profile (Gaspar et al., 2007).

When comparing the frequency of groups of diseases of patients in the PID (Table 2) with the other services (Marin et al., 2010; Martos and Sanches, 2009; Jones et al., 2012), it was found that in general, the NCDs were the most frequent, as: cardiovascular diseases and those of the nervous and digestive system; cancer, neurodegenerative disorders, endocrine disorders, and chronic obstructive pulmonary diseases. In the home care program at a university hospital in Minas Gerais (Martelli et al., 2011) the most frequent diseases were pneumonia (16.1%), diabetes mellitus (6.6%), tuberculosis and visceral leishmaniasis (5.1% each). Such results show some difference in the primary diagnoses of patients, compare to the aforementioned services. This may reflect conditions related to the epidemiological profile typical of each region and the care modality of service, probably pre hospital, due to the low complexity, the frequency of acute diseases, and the control programs of the primary health care itself. Patients who made use of LTOT at home (Table 3) accounted for 31.5% (269) of the total PID patients, with the chronic obstructive pulmonary disease (COPD) (45% of the Respiratory Diseases Group) as the most frequent disease associated to this therapy.

Data on the prevalence of COPD in Latin America are scarce. In Brazil specifically, such data are related to the epidemiological population-based study of the Latin American Project for the Investigation of Pulmonary Obstruction (PLATINO) in five major cities in Latin America, among which São Paulo/São Paulo from 2002, through follow-up of patients participating in the survey during nine years (Menezes, 2006). This project recorded the prevalence of 15.8% of COPD in adults aged 40 years or more in the metropolitan region of São Paulo using spirometry as the gold standard for diagnosing COPD. Similarly to what was found in other Latin American cities, most people in the sample had no previous medical diagnosis. In addition to common risk factors for COPD, are tuberculosis and indoor air pollution.

The main factor related to under diagnosis was the low use of spirometry as a diagnostic tool. The error or absence of a diagnosis makes the occurrence of effective interventions unlikely. Moreover, 83.3% of individuals diagnosed with COPD in São Paulo received no pharmacological treatment, 47.3% were not advised to stop smoking and 72.4% did not take the flu shot (Moreira et al., 2014). These findings show COPD is an underdiagnosed and undertreated disease, which may have serious consequences for patients, such as increased morbidity and mortality, and result in a

considerable economic impact on the healthcare system.

Just as in the PID, the eligibility criteria for admission to service have been established in several European countries and regions (Genet et al., 2011). However, even with the target audience of program defined as medium complexity, HC2/HC3, in Table 3, calls the attention of the fact that the majority of patients assisted by the PID are of low complexity (HC1), a service profile that should be monitored by primary health care teams. Although, the primary health care in Brazil is considered the main strategy to modify the model of health care in the SUS, the service infrastructure (human resources, materials and equipment) is still precarious, and consequently, incapable of meeting all kinds of patients requiring care, including HC1 patients, assisted by the PID.

There is abundant and consistent evidence to prove the effectiveness and efficiency of the beneficial impact of primary health care on the health of the population, not limited only to various aspects of health but extending to most of the death causes and injuries, and to reducing inequalities in health for the majority of population subgroups (Starfield et al., 2005). There are six mechanisms, which alone or jointly have this impact, two of which stand out due to the direct relationship with HC: early monitoring of health problems before they become serious enough to require hospitalization or emergency services, and the role of PHC in reducing unnecessary and untimely referrals for specialized care. Such mechanisms would expressively act in hospitalizations for conditions sensitive to primary care, which represent health conditions that may have the risk of unnecessary hospitalization diminished by effective actions of PHC, and that have also been used as indicators of access and quality of PHC (Alfradique et al., 2009). This circumstance probably has limited new admissions resultant of pent-up demand of dehospitalization (HC2 and HC3 profiles), due to the difficulty faced by the NRAD with discharging less complex patients for PHC. This fact seems to reflect either the lack or deficiency of articulation between services, as the need for amplification and better problem-solving of PHC, especially in caring for injuries and chronic diseases of long duration, in rehabilitation, and other conditions.

Despite the advances of recent years, with the implementation of new teams and qualification of professionals, among others, the NRAD have not yet been able to ensure comprehensiveness and continuity of care, which is observed in European services of home care (Genet et al., 2011). Designed on the logic of dehospitalization, most of the NRAD are physically located in regional hospitals. However, there is a disagreement whether the 'place' taken by this modality in the service limits its ability to absorb other demands, reducing its potential to impact on the care model (Seixas et al., 2013), because there are NRAD working inside basic health units too. More important than the 'place' is

the lack of political and institutional decision to assume the HC as an important strategy for the technic-assistential organization in the health of DF. It should provide the necessary logistics for the teams' work, and a broad discussion from the primary attention to the more complex levels of care in order to include the integration movement of services and agreement of responsibilities, through flows, protocols, management of chronic cases, among others.

The results regarding the time of permanence in the PID shown in Table 3 are similar to those of the Center for Interdisciplinary Home Care of São Paulo (NADI - Núcleo de Assistência Domiciliar Interdisciplinar de São Paulo) (Martos and Sanches, 2009), in which the average time of patients in the program was 495 days (1.35 years); 58% spent less than one year, and 42% more than one year. And also similar to another service of HC (Benassi et al., 2012), where it was found that the majority (27.42%) of patients in treatment have been hospitalized for 3 years, a fact explained by the large number of chronic diseases affecting the users of this type of service, who demand prolonged follow-up by a multidisciplinary team.

There are even services where it appears that the average time found confirms the characterization of a transient service (Marin et al., 2010), in which the average time of hospitalization was 35 days; and another (Martelli et al., 2011), where the most frequent average length of stay was 16 to 30 days (41.6%). Such services probably attend in the pre-hospitalization modality, acting as both the entrance and way out of emergency rooms, assisting in acute illnesses at home, and preventing hospitalizations. The fact that there were 26 patients (3%) being monitored by the department for over 10 years is noteworthy, and leads to a reflection about the extension of life with dependence: people are living longer, even sick, which allows reaffirming HC as a reversal strategy for the hospital-centered care, enabling the construction of a resized, valued and widely used approach to home care.

The results of the clinical evolution found in other services do not have any correlation with the results of Distrito Federal (Table 3) or among each other, although, despite in principle, carrying out the same type of assistance. Thus in a study of Martelli et al. (2011), 59% of patients were discharged with improvement, 28% died, 7% had unaltered clinical picture and 6% were referred to other institutions. In another study conducted by Martos and Sanches (2009), among the total of 861 patients, 600 (69%) died, 103 (12%) were discharged and 155(18%) were still being visited by the team. Also, in another study conducted by Marin et al. (2010), 12% of patients remained in treatment (the rest was discharged), among which 54% died, 23% were interrupted for ambulatory care, 5% were institutionalized and 6% were interrupted due to non-adherence of the caregiver.

From this study, it is possible to infer conclusions on

the diversity of models and organizations that home care has been taking in Brazil and other countries (Genet et al., 2011), sometimes characterized by high rates of cure and clinical improvement, which is assumed to be of low-complexity patients. And at other times by high mortality rates, which could be related to patients of more complex care due to the more aggressive characteristics of diseases that affected this study population. Among the limitations of the study, is the fact that it is of cross-sectional and descriptive type, with the quality control of collected information. The presented data also may not represent the size of all problems, and not all information contained in the records was complete (under 1% loss).

CONCLUSION

The profile of patients treated at the Home Care Program of Distrito Federal was evidenced by patients aged between 70 to 79 years, of female gender, with circulatory system diseases, in low-complexity care, between 1 and 2 years of length of stay in service, coming from the Administrative Region of Sobradinho, which is the oldest service and therefore, the most experienced and known by patients and their families. The analysis of this profile showed that the PID is not exercising its potential for dehospitalizing chronic patients of medium complexity (HC2/HC3), because the program is assisting mostly patients of HC1 profile (low complexity), from responsibility of the PHC. Thus, there is an urgent need for better coordination between services, in addition to amplification and greater effectiveness of PHC, especially in caring for injuries and chronic diseases of long duration and the rehabilitation of these patients.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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