Health conditions and care needs for elderly people assisted at their homes in a program of the supplemental health system

Condições de saúde e necessidades de cuidado de idosos assistidos no domicílio em programa do sistema de saúde suplementar

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RESUMO

Objetivo: identificar as condições de saúde e as necessidades de cuidados aos idosos assistidos pelo sistema de saúde suplementar no âmbito domiciliar de Florianópolis, Santa Catarina. Método: Estudo quantitativo, realizado no domicílio de 92 idosos atendidos pelo programa de atendimento domiciliar de uma instituição de saúde suplementar. Para a coleta de dados utilizou-se instrumento estruturado para caracterizar os idosos e suas necessidades de cuidado, sendo também aplicada a escala de Medida de Independência Funcional e o Mini Exame do Estado Mental. Resultados: A média de idade dos sujeitos foi de 83,2 anos, sendo que 67,5% pertenciam ao grupo dos idosos longevos. Metade da população encontrava-se acamada, sendo corroborado pela avaliação da capacidade funcional na qual 32% dos idosos apresentavam dependência total e avaliação cognitiva onde 54% de idosos estavam com perda de cognição severa. Conclusão: Os programas de assistência domiciliar visam à permanência dos idosos no domicílio, entretanto, as características de saúde encontradas na população exigem uma rede de suporte e apoio fortalecida.

Descritores: Assistência domiciliar; Saúde do Idoso; Envelhecimento

ABSTRACT

Objective: to identify the health conditions and care needs of the elderly population assisted by the supplementary health system in the home context of Florianópolis, Santa Catarina. Method: This is a quantitative study carried out in the home of 92 elderly people assisted by the home care program of a supplementary health institution. For the collection of data, a structured instrument was used to characterize the elderly people and their care needs, and the Functional Independence Measure and the Mini-Mental State Examination scale was also applied. Results: The mean age of the participants was 83.2 years old, and 67.5% belonged to the group of elderly people. Half of the population was bedridden, corroborated by the functional capacity assessment in which 32% of the elderly participants had total dependence and cognitive evaluation, and 54% of them had a loss of severe cognition. Conclusion: The home care programs aim at the stay of the elderly person in the home, however, the health characteristics found in the population demand a network of support and support strengthened.

Keywords: Home care; Health of the Elderly Person; Aging

INTRODUCTION

The aging process has brought the possibility of people living with more quality of life discovering and enjoying new ways of living aging. On the other hand, the length of stay with chronic diseases is prolonged and the risk of developing more damages in this population increases.

Chronic diseases are the main causes of morbidity and disability in the elderly population, and in this age group, it is usually associated with the presence of more than one pathology, polypharmaceuticals of continuous use, periodic examinations and constant care.[1] The presence of chronic diseases may interfere in the ability to perform daily activities, thus, the functional evaluation and monitoring of this population is fundamental.[2]

The limitations become more evident with the elderly population, or in this stage of life, since they tend to present greater difficulties to perform daily activities, with loss of autonomy and independence, usually associated with the chronic conditions that gradually lead them to greater fragmentation.[3]

These aspects are evidenced in a study[4] that evaluates the prevalence and factors associated with functional dependence of elderly people living in small municipalities, also showing a strong relationship between dependence and chronic diseases. In this sense, the condition of functional dependence requires differentiated care for the family and health services, since access to the care dependency condition may decrease or have less suffering, sadness, and isolation. Thus, the care for the elderly requires their own structure, based on the characteristics of this population. Currently, the care for the elderly is fragmented through numerous specialists, information not shared among professionals, generating the use of poly-drugs, numerous examinations and procedures.[5]

Aging, chronic diseases, falls and functional incapacity may lead to the need for periodic care at home, requiring assistance to perform the basic activities of daily living (BADL), and may be related to loss of physical autonomy, psychic or intellectual.[6]

In the current public policy scenario, the care of elderly people at home is important through home care, supported by the family. In Brazil, these policies have gained strength since the 1990s, through regularization of the functioning of home care services within the scope of the Unified Health System (SUS).[7]

Some advances have already occurred in the perspective of home care. Administrative Rule Number 963, dated May 27, 2013 redefines home care within the scope of the SUS, understood as "a new modality of health care, substitute or complementary to existing ones, characterized by a set of actions to promote health, prevention and treatment of diseases and rehabilitation provided at home, with guarantee of continuity of care and integrated into health care networks."[8]

Regarding the supplementary health, private health insurances are also faced with the aging of its users. It is known that 12.5% of 50 million beneficiary links to private health care insurances in Brazil are from people 60 years old or older and 60% are women and 17% are over 80 years old or more.[9]

A new model of health care for the elderly person proposed by the National Agency of Supplementary Health (ANS) provides for the definition of a hierarchical structure of care, which contemplates actions from the healthy and active elderly person to the elderly person in the final phase of his life, including home care in this area.[2] Access to home care for additional health was expanded, since it is part of the list of procedures required by the ANS, provoking a trend towards early de-hospitalization and valuing the interpersonal and professional relationships that can be developed at home, besides to the possibility of comprehensive care for the elderly within their home.[10-11]

This trend shows a new perspective on care for the elderly person at home. However, in the national context, little is known about how we can understand such a phenomenon to adapt the care in this context, which tends to expand continuously. Similarly, supplementary health actions need to be developed to meet the care needs of a portion of the aging population, with particular characteristics, especially when treated at home. Currently, the predictors of the use of supplementary home care services are poorly studied.

From the gerontology and geriatrics and management supplementary health point of view with, it is important to have information on the type of care needed, the reasons for the need for care and the quality of life among the elderly population living in their own homes, to support their independence and maximize their quality of life. Thus, a study was carried out to identify the health conditions and care needs of the elderly person assisted by the supplementary health care system at their home context in Florianópolis, Santa Catarina.

METHOD

This is a quantitative cross-sectional and exploratory study carried out in the home of the elderly person assisted by the home care program of a supplementary health institution located in the city of Florianópolis, Santa Catarina. The service is provided through multi-professional team performing therapeutic, preventive, palliative and rehabilitation care for adults and children.

During the period of data collection, the population assisted monthly by the service was approximately 190

patients, of whom about 140 were in the age group above 60 years old. From them, a final sample of 92 elderly people that participated in this research was obtained, and the data was collected between July and September of 2013, through home visits. It was decided to work with the entire population of the sample because as the *n* was small (140), it was not recommended to perform a sample calculation. Then, the approach was carried out with the whole population and 92 elderly people accepted to participate.

Older people who had been in the program for more than seven days were included in the study. Previously a telephone contact was made, in which the researcher identified and explained the general objective of the study and made the invitation to participate. A home visit was scheduled at a date and time established by the person when he showed interest. All were invited to participate in the research, explaining the objectives of the study and requested that, once informed about it, they sign the informed consent form (ICF). The ICF was signed by the elderly participant when he has his cognition preserved, or else, by the responsible family member.

To characterize the elderly person, an instrument was used with variables that allowed the identification of gender, age, school level, previous pathologies, medications in use, marital status, family home arrangement and presence of caregiver (family or occupational), time of participation in the program household and type of care that he demanded.

The Functional Independence Measure (FIM) scale was used to measure the degree of third-party care that the person demands to perform motor and cognitive tasks, and the Mini-Mental State Examination (MMSE) test was used to assess mental cognition.

The data collected were entered into a database using the Excel program and analyzed through the Sestatnet program of the Federal University of Santa Catarina (UFSC).[12] Statistical tests were used to identify the association (Student t, Sperman, ANOVA, Chi-Square and Fisher's exact test) for significance level adopted of 5%, the value of p≤0.05. In the descriptive analysis of the data for the categorical variables, simple and percentage frequencies were used.

The research project was submitted to the Research Ethics Committee of the Federal University of Santa Catarina and was approved by Opinion 343,656 of 08/12/2013. All the interviewees signed the Free and Informed Consent Form, respecting all the ethical precepts determined by Resolution 466/12 of the National Health Council.

RESULTS

Sixty-two of the 92 participants in the study (67.5%)

belonged to the group of elderly people older than 80 years old. A total of 12 (13%) elderly people were between 60 and 69 years old, 18 (19.6%) were between 70 and 79 years old, 33 (35.9%) were between 80 and 89 years old and 29 (31.5%) elderly individuals were older than 90 years old.

Table 1 shows the data that characterize the elderly person in the variables: age, marital status, school level, home arrangement and length of service in the home care program, according to gender.

The mean age of the 92 participants was 83.2 years old, the median was 85.5 and the standard deviation was 10.3. Comparing the age between male and female, Student's t-test indicated that the differences were not statistically significant (p = 0.07). The age of the elderly men varied between 61 and 97 and the elderly between 60 and 103 years old. In the distribution by gender, the percentage of women is higher than the elderly men in all age groups.

As for the marital status, widows predominate among women, while most of the married were men. The school level showed higher percentages in the first and second complete grades. Regarding the time of service in the program, elderly people who participated for more than six months (27.2%) predominated, with a proportion of 22.8% for those who were more than three years old.

In the family organization, most of the elderly participants lived with a member of their family, representing a total of 72 (79.3%), while 20 (21.7%) lived with employees and/or non-family caregivers. In this way, it stands out that none of the elderly participants live alone. Relating this information to the high level of dependence found in this population, the need for care in the home environment may require the existence of other people living with the elderly person.

Systemic Arterial Hypertension (76.1%), Diabetes Mellitus (35.9%), Alzheimer's disease (34.8%), Cerebral Vascular Stroke (33.7%) and Cardiac Diseases (32.6%) were the most identified in the study population. The presence of several pathologies may require the use of many drugs, either by the proposed therapeutic regimen or in an empirical way. The most commonly used drugs were antihypertensives (69.9%), antiplatelet (46.7%), gastric protectors (39.1%), anxiolytics (32.6%), neuroprotectors (27.2%), , antidiabetics (26.1%) and diuretics (23.9%).

Evaluating the number of diseases and medications used by the elderly participants, 52.2% had 1 to 3 pathologies and 47.8% used 4 to 6 medications.

Table 2 shows the distribution of care needs according to gender. Regarding the generally reported care needs, there were 46 (50%) elderly participants in bedridden condition, 54 (58.6%) were showered with a chair, 66

TABLE 1 – Characterization of the elderly person assisted in the home care program. Florianópolis, SC, Brazil. 2013.

Variables	Female (n=56) n (%)		Male (n=36) n (%)	
Age				
60-69	5 (8.9)		7 (19.4)	
70-79	12 (21.4)		6 (16.7)	
80-89	19 (33.9)		14 (38.9)	
More than 90	20 (35.7)		9 (25)	
Marital status				
Single	3 (5.4)		1 (2.8)	
Separated	1 (1.8)		2 (5.6)	
Married	10 (17.9)		25 (69.4)	
Stable union	0 (0)		1 (2.8)	
Widow	42 (75)		7 (19.4)	
School level				
Incomplete Elementary school	7 (12.5)		2 (5.6)	
Complete Elementary school	23 (41.1)		6 (16.7)	
Incomplete High school	1 (1.8)		0 (0)	
Complete High school	21 (37.5)		15 (41.7)	
Incomplete Higher Education	0 (0)		2 (5.6)	
Complete Higher Education	4 (7.1)		6 (16.7)	
Post-graduation	0 (0)		5 (13.9)	
Family organization				
Husband	1 (1.8)		3 (8.3)	
Husband and children	7 (12.5)		17 (47.2)	
Husband, children and grandchildren	0 (0)		4 (11.1)	
Children	10 (17.9)		0 (0)	
Children, daughters in law and/or sons in law	8 (14.3)		3 (8.3)	
Grandchildren	1 (1.8)		0 (0)	
Children and grandchildren	7 (12.5)		3 (8.3)	
Caregivers and employees	17 (30.4)		2 (5.6)	
Other Family members	2 (3.6)		1 (2.8)	
Family members and caregiver	3 (5.4)		3 (8.3)	
Service time				
Up to 2 months	1 (1.8)		3 (8.3)	
From 2 to 6 months	2 (3.6)		6 (16.7)	
From 6 to 12 months	16 (28.6)		9 (25)	
From 1 to 2 years	12 (21.4)		6 (16.7)	
From 2 to 3 years	11 (19.6)		5 (13.9)	
Mora than 3 years	14 (25)		7 (19.4)	

Source: from this research

(71.7%) needed diaphragms, 59 (64.1%) fed orally with assistance and 29 (31.5%) had gastrostomy for feeding and medication. All the care reported requiring great help from others, in many cases with total dependence.

Table 3 shows the care needs distributed by the age group, showing that the elderly with 80 years or more concentrate the greatest needs.

When observed the care needs distributed by age group, the 80 years old or more elderly people had the greatest needs. In the analysis of the relationship between the care and gender variables, the Student's t-test was used, and no statistical significance was found (p = 0.33) between the two variables.

The functional capacity (FC) was evaluated through the Functional Independence Measure (FIM) scale, which aims to quantitatively assess the burden of care required by a person to perform motor and cognitive tasks of daily living. The following characteristics were found in the study: 16 (17%) independent elderly participants, 15 (16%) with modified care of up to 25%, 32 (35%) with modified care of up to 50% and 29 (32%) with total dependency. Analyzing the variables total FIM value and age, through the ANOVA test, no significance was identified between both, where p-value = 0.172.

The MEEM instrument was used to evaluate mental cognition, covering domains of temporal orientation, spatial orientation, immediate memory, recall memory, calculation, language - naming, repetition, comprehension, writing and drawing copy. There were 50 (54%) of the elderly with loss of severe cognition and 21 (22%) with normal cognition. In the analysis between FC and mental cognition, the Chi-square test was used, and there was a strong association between the variables (p = 0.000001).

In this study, 56 elderly people with severe cognitive impairment were highly dependent. In the cognitive alteration associated with functional dependence, the

TABLE 2 – Care needs of the elderly person assisted in the home care program, by gender. Forianópolis, SC, Brazil. 2013.

Care needs according to gender

Care Needs	Female	n	%	Male	n	%
Company	54		96.4	31		86.1
Walking help	17		30.4	12		33.3
Beddriden	32		57.1	14		38.9
Wheelchair user	1		1.8	5		13.9
Decubitation change	36		64.3	20		55.6
Armchair position	41		73.2	24		66.7
Bones Massage	38		67.9	21		58.3
Airway aspiration	7		12.5	4		11.1
Shower bath	8		14.3	7		19.4
Shower bath with a chair	36		64.3	18		50
Bed bath	12		21.4	7		19.4
Bathroom help	17		30.4	17		47.2
Diaper change	41		73.2	25		69.4
Curative	16		28.6	12		33.3
Oral feeding	37		66.1	22		61.1
Gastrostomy	19		33.9	10		27.8
Oxygen	3		5.4	5		13.9
Nebulization	9		16.1	10		27.8
Oral medication	34		60.7	22		61.1
Intravenous medication	1		1.8	0		0
Subcutaneous medication	5		8.9	5		13.9
GTT medication	19		33.9	9		25

TABLE 3 – Care needs of the elderly person assisted in the home care program, by age group. Florianópolis, SC, Brazil. 2013.

Age group

Care needs	60-69 years old %	70-79 years old %	80-89 years old %	90 years old or more %
Company	10.6	18.8	37.6	32.9
Walking help	6.9	6.9	48.3	37.9
Bedridden	10.9	21.7	34.8	32.6
Wheelchair user	33.3	50	16.7	0
Decubitus change	8.9	19.6	35.7	35.7
Armchair position	7.7	18.5	35.4	38.5
Bones Massage	8.5	20.3	37.3	33.9
Airway aspiration	27.3	36.4	9.1	27.3
Shower bath	6.7	13.3	46.7	33.3
Shower bath with a chair	13	22.2	35.2	29.6
Bed bath	10.5	10.5	36.8	42.1
Bathroom help	14.7	11.8	41.2	32.4
Diaper change	9.1	21.2	34.9	34.9
Curative	7.1	17.9	42.9	3.1
Oral feeding	10.2	20.3	40	30.5
Gastrostomy	10.3	17.2	37.9	34.5
Oxygen	37.5	12.5	0	50
Nebulization	15.8	5.3	31.6	47.4
Oral medication	12.5	19.6	35.7	32.1
Intravenous medication	0	5.6	0	0
Subcutaneous medication	20	10	30	40
Gastronomy medication	10.7	17.9	35.7	35.7

elderly person requires more care, since he needs help to perform basic motor activities and activities that require reasoning and decision making.

DISCUSSION

The predominance of the elderly participants over 80 years old corroborates the population projections[3], which indicate an increase in the population of the elderly people. In Brazil, data from the Brazilian Institute of Geography and Statistics (IBGE) show that this portion of the elderly population may increase from 19 million in 2060.

Also, the process of feminization of aging that has been evident in the last decades stands out. The estimate for 2060 is that the number of men is 33 million while the women should reach 40.6 million, representing a fall in the gender ratio of 79 men for every 100 women among the elderly population.[13]

The results of the study show that a percentage of women is higher than men in all age groups, represented by 60.9% of the participants. These findings corroborate with a study[14] carried out with elderly people who need home care. The research showed a greater number of elderly women dependent, as well as the need of health professionals, especially the nurse, to plan interventions aimed at training family members in the care of this population.

In the studied population, multi-morbidity was also evident, where 52.2% had 1 to 3 pathologies. In a study about the hospitalization of the elderly and associations, multi-morbidity and the presence of health insurance were related to the increase in hospital admission when compared to primary care patients, who presented more morbidities and disabilities, emphasizing that supplementary health patients have more access to health services.[15]

The comorbidities that affect the elderly people are present over the years, and may negatively affect their quality of life. Such conditions may still be related to some complications, such as cardiovascular, encephalic, coronary, renal and peripheral vascular, among others.[16] Regarding the association between comorbidities and the risk of death and re-hospitalization, the multi-morbidities were related to mortality rates after hospitalization.[17]

Due to the physiological changes that occur with increasing age, along with the high use of medications, the elderly people are more likely to present some adverse reaction or drug interaction, in addition to some drugs that are considered inappropriate for them.[18] In the study, all the elderly patients used continuous medication, with 47.8% using 4 to 6 medications per day.

Alzheimer's patients in the study were 34.8% of the elderly population. There was a high level of complete dependence or modified dependence in up to 50%, according to the FIM evaluation. In a study on the correlation between the Alzheimer's stage and the elderly FC, the functional independence was compromised as the stage of dementia progressed, and the elderly person with advanced dementia showed complete dependence.[19]

Regarding the care needs mentioned, 50% of the sample is represented by bedridden elderly people, demonstrated a high degree of dependence. Most of the bedridden patients are at high levels of physical or mental weakness or both.

The performance of BADL, such as hygiene, food, and transfer, among others, become unviable for patients under these conditions, making them necessarily dependent on other people. The other care needs with greater predominance require great help to perform them, such as shower with a chair, diaper change, oral feeding with assistance and gastrostomy for feeding and medication.

In Brazil, IBGE data show that 6.8% of the elderly population presents functional limitations to perform their daily activities, being more evident in people over 75 years old. Of them, 84% reported needing some form of help in carrying out daily activities. When investigated the type of care they receive, 78.8% stated that care was performed by relatives and 17.8% received care by contracted professionals.[3]

In this study, when the relationship between FC and age was evaluated, no statistical significance was found between them. This result is different from another study in which older adults presented a higher prevalence of functional disability.[20] Other socio-demographic determinants are associated with a decrease in FC, such as female gender, advanced age group, living alone or being widowed, low school level or illiteracy, and the presence of chronic diseases.[11,20]

Also, a study on the association of socio-demographic characteristics and FC of elderly people, the age variable presented significance only when related to total FIM. Elderly people from rural areas, with low socioeconomic status, were more likely to develop functional disabilities than those from the urban environment, with better income and access to information. The income variable showed a significant association with the total FIM variable, demonstrating that access to information and health services contribute to maintaining FC.[21]

Other studies on the prevalence and factors associated with the functional dependence of the elderly population, regarding aspects related to health and functionality, showed in the elderly a high degree of independence for the BADL to perform instrumental activities of daily living (IADL).[22,23] Such divergences can be explained by the characteristic of the population, while in this study

only the elderly participants belonging to the home care program were considered.

This study found that 56 elderly participants presented severe cognitive impairment accompanied by high dependence. The present results affirm the importance of policies aimed at improving the mobility, social environment, mental condition, and physical condition of the elderly population. In the cognitive alteration associated with functional dependence, the elderly person requires more care, since he need help to perform basic motor activities and activities that require reasoning and decision making.

The findings of this study have important clinical implications for the care of the elderly population. In many cases, they are on the threshold of being cared for at home and need to be cared for in a hospital setting, often leading to a rapid worsening of their clinical condition. This suggests that care support for these families should be structured in such a way as to make possible quality home care with the commitment of a team capable of solving the demands from the imbalances inherent in the health condition presented by the elderly in their homes.

The home care programs aim at the stay of the elderly person in his home. However, the health characteristics found in the population require a network of support and support strengthened to meet this reality. Also, the survey of care needs should be part of an individual and unique evaluation for each elderly person, starting from the home reality where he is inserted, seeking the most coherent adaptation for each condition.

The understanding of the determinants of the use of home care services may allow the development of interventions that may modify the determinant and the use of home care services.

FINAL CONSIDERATIONS

The reality of the elderly participants in the program showed that the demand for home care is high. Half the population was bedridden, depending on the help of other people to perform basic survival activities. This is corroborated by the FIM evaluation, where 32% of the elderly population had total dependence and MMSE assessment, in which 54% of the elderly population had a severe cognitive loss, repercussions on their health conditions and need care at home.

Thus, the importance of cognitive and functional assessment to adjust the planning of actions that favor the promotion of health and the maintenance of the elderly's FC are highlighted, providing support and training the caregivers for a qualified follow-up.

In many circumstances, the home does not have the structure so the need for care is more adequately addressed, hindering to provide help and creating disruption to the family network, which needs to be adapted and restricted so the elderly person receives care at home.

The home care modality concentrates the elderly with complex clinical cases with the possibility of a rapid deterioration of their condition suggesting that care support for these families should be structured in such a way as to enable quality home care with a committed staff to solve the requirements from the imbalances inherent to the health condition presented by the elderly person and identified in this study.

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