



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

CHALLENGES OF HOMECARE FROM THE PERSPECTIVE OF COST REDUCTION/EXPENDITURE OPTIMIZATION

DESAFIOS DA ATENÇÃO DOMICILIAR SOB A PERSPECTIVA DA REDUÇÃO DE CUSTOS/RACIONALIZAÇÃO DE GASTOS

RETOS DE LA ATENCIÓN DOMICILIARIA BAJO LA PERSPECTIVA DE LA REDUCCIÓN DE COSTES/RACIONALIZACIÓN DE GASTOS

Kênia Lara Silva¹, Roseni Rosângela de Sena², Laura Camargo Macruz Feuerwerker³, Paloma Morais Silva⁴, Ana Carolina Silva Martins⁵

ABSTRACT

Objective: to analyze homecare services from the perspective of costs. **Method:** this study has a qualitative approach and it was conducted in 13 homecare services. Interviews were held with managers from these services and some cases were followed up. Data were treated by means of thematic content analysis. The study was approved by the Research Ethics Committee of the Federal University of Minas Gerais (UFMG), under the opinion ETIC 0555/07. **Results:** cost reduction occurs mainly through the transfer of costs and responsibilities of operators of private health insurance plans to the family and the public health care system. In public services, optimization also occurs by transfer of costs to the families. **Conclusion:** homecare requires a regulation that increases its innovative potential for producing care and, at the same time, protects users and their rights. **Descriptors:** Homecare Services; Homecare; Cost.

RESUMO

Objetivo: analisar os serviços de atenção domiciliar em saúde sob a perspectiva de custos. **Método:** trata-se de estudo com abordagem qualitativa realizado em 13 serviços de atenção domiciliar. Foram realizadas entrevistas com gestores desses serviços e acompanhamento de casos. Os dados foram tratados por meio da análise de conteúdo temática. O estudo foi aprovado pelo Comitê de Ética em Pesquisa da Universidade Federal de Minas Gerais (UFMG), sob o parecer ETIC n. 0555/07. **Resultados:** a redução de custos ocorre principalmente por meio da transferência de custos e responsabilidades de operadoras de planos privados para a família e para o sistema público de saúde. Nos serviços públicos, a racionalização também se dá por transferência de gastos para as famílias. **Conclusão:** a atenção domiciliar requer regulamentação que amplifique seu potencial inovador na produção do cuidado e, ao mesmo tempo, proteja os usuários e seus direitos. **Descritores:** Serviços de Atenção Domiciliar; Assistência Domiciliar; Custo.

RESUMEN

Objetivo: analizar los servicios de atención domiciliaria en salud bajo la perspectiva de costes. **Método:** esto es un estudio con abordaje cualitativo realizado en 13 servicios de atención domiciliaria. Se llevaron a cabo entrevistas con gestores de esos servicios y seguimiento de casos. Los datos fueron tratados por medio del análisis de contenido temático. El estudio fue aprobado por el Comité de Ética en Investigación de la Universidad Federal de Minas Gerais (UFMG), bajo la opinión ETIC 0555/07. **Resultados:** la reducción de costes se produce principalmente a través de la transferencia de costes y responsabilidades de operadoras de planes privados para la familia y para el sistema público de salud. En los servicios públicos, la racionalización también se produce por transferencia de gastos para las familias. **Conclusión:** la atención domiciliaria requiere regulación que amplifique su potencial innovador en la producción de la atención y, al mismo tiempo, proteja a los usuarios y sus derechos. **Descriptores:** Servicios de Atención Domiciliaria; Atención Domiciliaria; Coste.

¹Nurse. Ph.D in Nursing. Professor at the School of Nursing of the Federal University of Minas Gerais (UFMG). Belo Horizonte (MG), Brazil. Email: kenialara17@yahoo.com.br; ²Nurse. Ph.D in Nursing. Emeritus Professor from the School of Nursing of UFMG. Belo Horizonte (MG), Brazil. Email: rosenisena@uol.com.br; ³Physician. Senior Lecturer in Public Health. Professor at the School of Public Health of the University of São Paulo (USP). São Paulo (SP), Brazil. Email: laura.macruz@usp.br; ⁴Nurse. MS student at UFMG. Member of the Center for the Study and Research on Nursing Teaching and Practice (Nupepe). Belo Horizonte (MG), Brazil. Email: palomamoraismail.com; ⁵Nurse. Member of Nupepe. Belo Horizonte (MG), Brazil. Email: anacarolinasilvamartins@yahoo.com.br.

INTRODUCTION

The use of home as a place for health care has expanded globally in recent decades. This trend observed in many countries around the world was motivated by the need to optimize the use of hospital beds, reduce the costs of care and establish a rationale based on humanization, in an attempt to overcome the crisis of the hospital care model.^{1,2}

In Brazil, the systematized experiences of homecare services have been intensified since 1990, with a rapid growth.³ This is in line with the international movements in search of alternatives is aimed at expenditure optimization.¹ This motivation is deeply implied in the expansion of home services both in the private and the public sectors. The reduction of costs observed by means of homecare is justified by the decreased average length of stay in inpatient institutions, reduced number of readmissions, increased patient adherence under homecare¹, as a result of having greater involvement and individuation on the part of the family and health team regarding situations experienced and ways of coping with them.

Transferring user assistance from the hospital to home has also implied transferring to the family the responsibility for the various material costs derived from treatment at home.⁴ Moreover, it demands emotional abilities from family members to actively participate in the work process that characterizes homecare.⁵

Homecare is among the modalities of care with potential to contribute to construct arrangements to organize care aimed at comprehensiveness.^{2,6} Health care at home developed by a multidisciplinary team and by informal caregivers, such as relative, friend, community member, may represent, on the one hand, an effort to construct new arrangements of care that favor a comprehensive and equitable approach, on a shared basis between team, caregivers, and users, providing users and caregivers with quality of life and autonomy.⁶

At the same time, homecare favors reducing operational costs of services, in that it provides faster recovery, fewer infectious complications, etc., but mainly because along with the patient many costs are also transferred, either direct, such as costs with materials and medicines, or indirect, derived from workload and life opportunities lost by the caregiver and family when taking homecare.^{2,6} Given the above, this study

aimed to analyze homecare services, from the perspective of costs.

METHOD

This research has a qualitative approach and it was conducted by means of a case study for apprehending the reality of homecare. The study setting consisted of institutions providing homecare in the capital city, Belo Horizonte, and in the towns of Contagem and Betim, in the state of Minas Gerais, Brazil.

In the first phase of the study, we performed a mapping of institutions that offer homecare (HC) in the 3 municipalities. We identified 52 institutions, out of which 41 answered to the structured questionnaire that aimed at their general characterization. From this set, 13 institutions were included in the second phase of the study, for in-depth analysis, as they met the following criteria: services with care organization defined by systematically delimited territorial coverage, services whose existence is over 2 years, and services that operated with a multidisciplinary team.

In these 13 institutions, 5 operators of private health insurance plans (services HC4, HC7, HC11, HC12, and HC13) and 8 public institutions (services HC1, HC2, HC3, HC5, HC6, HC8, HC9, and HC10), interviews were held, guided by a semi-structured script, with managers and/or coordinators of homecare services. At the time of interview, we asked for the indication of a case to be monitored at home, something which allowed the capture, interpretation, and deepening of the research object *in loco*. Subsequently, we analyzed the cases indicated, where interviews were held and we observed the caregivers, family members, and patients. Data were treated by thematic content analysis.

This study was approved by the Research Ethics Committee of the Federal University of Minas Gerais (UFMG), under the opinion ETIC 0555/07, in accordance with Resolution 196/96, from the National Health Council (CNS), which regulates research involving human subjects.

RESULTS

Data analysis allowed us to identify 2 thematic categories that reveal 2 relevant aspects regarding the analysis of cost reduction enabled by homecare, namely, optimization of costs and transfer of costs and responsibilities.

Data analysis allowed us to understand that there is a major economic and financial component in the decision to adopt homecare

as a modality for organizing care, both in the public and the private sectors.

In health insurance, in many cases, a population that overuses services is identified, perhaps because it fails to achieve the desired well-being through the usual (medical) monitoring available. This situation is evidenced by the frequent use of the emergency room or by readmissions. For the operators, these situations imply expenses regarded as excessive. Different modalities of homecare are, then, proposed as alternatives to the “management of rather complex cases”, which require the interference of a multidisciplinary team and/or a closer monitoring.

As I was a hospital manager and also a manager of a large operator of health insurance plans, I see that the costs were concentrated on patients, on the same patients, chronic patients, patients with an already defined prognosis, patients periodically readmitted with difficulty to maintain her/his clinical status at home, then, as a management tool, we have created this service, at the time it did not exist here, we have created this service with the intent to maintain these patients at home, improving quality of life, reducing costs for the operator. (HC7 service manager)

[...] The cost for the operator [with homecare] is three times lesser than with hospitalization, you know, because there are no hospital daily rates, we pay the technician and this also generates a cost, but this way it is much lower. Generally, for the family, it is much better having the patient at home. No mentioning the risks, etc. (HC12 service manager)

In the Unified Health System (SUS) cost studies were not shown. The issue of expenditure optimization is rather aimed at a more efficient use of current resources. Thus, it was more frequent to argue for the opportunity to adopt homecare due to the need for increasing the turnover of the current hospital beds (by means of early hospital discharge) or reserving hospital beds for cases where there is clinical instability (avoiding certain admissions). In some cases, homecare is organically linked to the emergency room services, and this is regarded as a station within the urgency/emergency network.

In the public and private sectors, the optimization component of health care supply is also associated with the possibility of improving the quality of life of users and relatives of users who require constant care.

The study allowed us to identify some mechanisms to reduce costs/expenses implicit

in the adoption of homecare. A first component of cost reduction is related to the shortening of hospital stay for completion of the needed procedures by family caregivers backed by professionals (e.g. completion of intravenous antibiotic therapy, wound dressings, etc.). Similarly, there are resource savings by avoiding lengthy hospital stays and complications that may arise from them, such as cross infections.

A second component has to do with the positive effects of a closer care and rather aimed at user's needs, which result in decreased readmission rates.

Another component of cost reduction observed in health insurance is associated with the outsourcing of homecare services through contracts aimed at a high productivity of each team, which also enable transferring the costs of labor liabilities and the management of conflicts to contracted third parties.

The relationship with a health care provider is a relationship of service provision, indeed. There already exists a contract, or what has to be done, and they fulfill this contractual relationship and send the management report. There are no regular meetings to discuss clinics nor discussion of cases, with the provider, no, this is a case management relationship. (HC4 service manager)

The most important component of cost reduction, however, is based on the transfer of costs and responsibilities to families. They directly take responsibility for providing care for most of the day (either directly or through the hiring of caregivers). In addition, in health insurance, families also become responsible for the procurement of medicines, supplies, and equipment needed for the care procedures concerned. Within SUS, usually homecare services or other units of the system are directly responsible for providing this material. But, even this way, sometimes the burden of procurement of certain supplies falls on the family.

For these children undergoing ventilation, we need 2 caregivers, because only 1 person will not be able to do everything... this person is trained, we dehospitalize people, take her/him home, the team, in the first weeks, visits her/him on a more frequent basis and gradually these visits become less frequent... and the family itself continues to care. (HC2 service coordinator)

Usually, when support is greater, then, the nurse goes, performs a general assessment, he puts as many gauzes, as many solutions as needed, he comes to us, we assess what is up to us and what is not: disposable diaper is up to the family, bed, chair, this is

up to the family, you know, oral medicines are up to the family, and so on, we separate everything. (HC12 service manager)

Another mechanism for reducing costs within health insurance is transferring costs and responsibilities to SUS. That is why, whenever “needed”, users are encouraged to seek help and support in SUS services. They are even told to “fight for their rights in court”, if they cannot afford everything they need and if private services will not guarantee these resources for them. This alternative is usual for acquiring oxygen concentrators and high-cost medicines:

What happens, when the patient needs oxygen, the operator does not provide oxygen, but we indicate the way to get it through... through SUS. Thus, there already exists a protocol, a form. We refer. “Ah, but she/he has to leave the hospital now”, then, we will deliver oxygen, you go there at the time to deliver the protocol, we provide the oxygen... (HC4 service manager)

Diapers, shampoo, cream, these things are user’s task. In turn, medicine and material for procedure are operator’s task. But, then, we refer to the public network. (HC11 service manager)

Both within SUS and in private health insurance, families take expenses with diapers, water, light, and food implied in homecare.

She (the caregiver) informs that she had to sell the patient’s goods to buy the drugs that are not standardized in Brazil. She also speaks of the cost of electricity due to the oxygen concentrator [...] she reports that, out of the goods, only the house where they live remains. (Field diary, case HC4)

I am coping with a difficult situation here, right? Because his feeding, 130 reais [...] There are drugs. They are very expensive. And there is also a vitamin to be included into the diet, which costs 70 reais [...] I am spending on average 2,000 reais. (Female caregiver in case HC7)

In certain situations, family’s difficulties to paying for all needed expenses calls into question the maintenance of homecare as an alternative to produce care.

Patient’s husband provides the household with all food and support, but today he does not even talk to the patient. She is retired and purchases foods such as fruits and other more specific ones regarding her feeding. (Field diary, case HC11)

Besides transferring of expenses, it became evident in the services under study the transfer of responsibility for care activities at home to user’s family – an assumption of homecare.

When doing the wound dressing, the nurse explains in detail to the caregivers the way

how they must proceed in the subsequent exchanges [...]. She also checks caregivers’ evolution. (Field diary, case HC4)

The mother is well advised with regard to care for her son; when asked what she needed to provide it, she exemplified with aspiration, by describing all the material she needs. (Field diary, case HC2)

This is a big problem, because there are patients who will need 24-hour nursing care, because if he is taking an antibiotic agent every 6 hours, if he is under assisted respiration, if the family really has no structure, as we do not have much access to caregivers [...] there is also no consensus of operators to take this task, which is something really up to the family, you know, this is not up to the operator... (HC7 service manager)

In the analysis of cases also become apparent the tensions faced by caregivers during the homecare process.

The family has shown the ability to care for the ill patient, but the mother has psychological and emotional signs and symptoms of illness related to the fact of experiencing her son’s suffering. (Field diary, case HC5)

Patient’s daughter and primary caregiver reported that she feels overwhelmed with the tasks arising from the presence of her father at home. She reported that, besides taking care of household chores, she still needs to help the nursing technician to care for the patient. (Field diary, case HC7)

We also found concern with caregiver’s guidance and monitoring, besides the recognition of the importance of a social support network to minimize the workload:

Look, our teams are very careful with the caregiver, one of our concerns is that the caregiver does not get tired, does not get burned out, does not get broken. So, our big concern today is that the caregiver is an individual who will be able to care for that person. We also have a role of teaching the caregiver, providing the caregiver with support. And our relationship with caregivers is good, in general it is good, we had no struggle, also, with the caregiver, sometimes we have to take a stronger role, the caregiver who does not provide care in a rather correct way. (HC5 service manager)

DISCUSSION

Expenditure optimization/cost reduction is an important aspect in the adoption of homecare as an alternative health care. In itself, this is not a problem, since the best use of scarce resources has been a goal pursued by the management of public and private services. The problem are the ways how this reduction has been produced, among others, especially in health insurance, by transferring expenses for families and/or transferring

spending from the private system to the public system.⁷

It became apparent that some mechanisms are used to reduce costs, through the use of homecare as a way to produce care, such as the abbreviation of homecare. Dehospitalization has been a motivational factor for implementing homecare to reduce the costs arising from unnecessary hospitalization, and there is, thus, an economic and financial perspective of hospital bed optimization through homecare⁸, since, when transferring a hospitalized patient to home, beds become available for clients who require a better quality of supplies, procedures, and services.⁹

Another way of optimizing expenditure is by outsourcing homecare services. Outsourcing has become, especially in the last 20 years, an alternative that aims to increase productivity and efficiency in the production of services, by transferring the costs of labor liabilities and the management of conflicts for contracted third parties.¹⁰ In the health sector, almost always, outsourcing is recognized as an issue that implies the management of services, particularly in relation to the results, given the heterogeneity of production processes in the sector, the diversity and non-homogeneity of products, in addition to assigning values to goods that represent social processes marked by subjectivity.¹¹

There are difficulties to manage the technical and ethical quality of professional work due to the proliferation of atomized cores of command and decision; decreased participation and loss of workers' interest in the mission of health services; disengagement with the continuity and comprehensiveness of care, dehumanization of users care. This stems from the lack of criteria and the disordered way how the outsourcing of health services has been done.¹⁰ Thus, although outsourcing represents a way to optimize resources, we put into question its role in the cost/benefit ratio for health care models, since optimization strategies, particularly targeting the clientele for preferred providers and service outsourcing, seems to negatively influence on the quality of care at home. Therefore, users point out problems and criticize the care received from operators of private health insurance plans.¹²

In the case of families, especially within health insurance, there is no negotiation, since homecare is offered as a benefit and the operators have full autonomy to set conditions for this offer. Thus, families take supplies, medicines of habitual use, consumables,

increased spending on electricity, water, and support structure, such as laundry and diet¹³, plus costs (direct or indirect) with the caregiver in complex care situations and highly dependent patients.²

In the case of the public system, it absorbs spending on expensive medicines and equipment, confirming the rationale established in other homecare services.⁷ We highlight the existence of a utilitarian view of the public health system on the part of private services. This relationship provides the private homecare services with lower costs, since the costs with materials and medicines are transferred to the public system. As a result of the attitude of some private services to advise users to seek support in SUS services we observe, from the end of the 1990s, an exponential growth in the number of judicial warrants on health seeking mainly to ensure people access to medicines, as well as to diagnostic and therapeutic procedures.¹⁴

The costs for the family have a different impact, considering the various levels of purchasing power, there is greater impact on low income families.¹³ Something that may put into question the continuity of care at home. Studies show that it is difficult for the caregiver to combine homecare to a paid occupation, temporary or permanent work abandonment often occurs, and even the refusal of a job.¹⁵⁻¹⁷

It was also possible to verify that the cost of care goes beyond the financial domain, since home caregivers, by taking this task, give up various other aspects of their lives¹³, among them: pleasure, wishes, and individual dreams. This finding points out the need to strengthen support networks that help caregivers in coping with difficult situations that are posed by care at home. Moreover, we can glimpse the need to train health professionals for homecare with an expanded conception of health, enabling the transformation of the way to provide users and family members with care¹⁸, making it dialogic, humanized, and able to meet these individuals' care needs.

CONCLUSION

Despite the numerous positive aspects provided by homecare that were identified by various studies, the findings related to transferring of expenditures both to families and SUS constitute a matter of concern.

The regulation is a key point in this situation. Both to protect the rights and interests of families directly involved and to protect the rights of all citizens, since, once again, SUS has been responsible to bear the

costs and liabilities that might be taken by the operators of private health insurance plans regarding their beneficiaries.

In all cases – in the public and private domains – the issue of care for caregivers also emerges with strength, because it proves to be essential to avoid carelessness.

REFERENCES

1. Silva KL, Sena RR, Seixas CT, Feuerwerker LCM, Merhy EE. Atenção domiciliar como mudança do modelo tecnoassistencial. *Rev Saúde Pública* [serial on the internet]. 2010 [cited 2013 Apr 1];44(1):165-75. Available from: http://www.scielo.br/scielo.php?pid=S0034-89102010000100018&script=sci_abstract&tlng=pt.
2. Feuerwerker LM, Merhy EE. A contribuição da atenção domiciliar para a configuração de redes substitutivas de saúde: desinstitucionalização e transformação de práticas. *Rev Panam Salud Pública* [serial on the internet]. 2008 [cited 2013 Apr 1];3(24):180-8. Available from: http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S1020-49892008000900004&lng=pt&nrm=iso&tlng=pt.
3. Serafim AP, Ribeiro RAB. Internação domiciliar no SUS: breve histórico e desafios sobre sua implementação no Distrito Federal. *Comun Ciênc Saúde* [serial on the internet]. 2011 [cited 2013 Apr 1];22(2):163-8. Available from: http://www.dominioprovisorio.net.br/pesquisa/revista/2011Vol%2022_2_8_Internacao.pdf.
4. Silva KL, Sena RR, Silva PM, Souza CG, Braga PP. Supplementary home health care services and the inclusion of nursing in Belo Horizonte/Minas Gerais (Brazil). *Acta Paul Enferm* [serial on the internet]. 2012 [cited 2013 Apr 1];25(3):408-14. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-21002012000300014&lng=en&nrm=iso&tlng=en.
5. Rodriguez A, King N. The lived experience of parenting a child with a life-limiting condition: a focus on the mental health realm. *Palliat Support Care* [serial on the internet]. 2009 Apr [cited 2013 Apr 1];7(1):7-12. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/19619370>.
6. Mesquita SRAM, Anselmi ML, Santos CB, Hayashida M. Programa interdisciplinar de internação domiciliar de Marília-SP: custos de recursos materiais consumidos. *Rev Latino-Am Enferm* [serial on the internet]. 2005 [cited 2013 Apr 1];13(4):551-61. Available from: <http://www.scielo.br/pdf/rlae/v13n4/v13n4a14.pdf>.
7. Franco TB, Merhy EE. Atenção domiciliar na saúde suplementar: dispositivo da reestruturação produtiva. *Ciênc Saúde Coletiva* [serial on the internet]. 2008 [cited 2013 Apr 1];13(5):1511-20. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232008000500016&script=sci_abstract&tlng=pt.
8. Andrade AM, Brito MJM, Silva KL, Von Randow RM, Montenegro LC. Singularidades do trabalho na atenção domiciliar: imprimindo uma nova lógica em saúde. *Rev Pesqui Cuid Fundam* [serial on the internet]. 2013 [cited 2013 Apr 1];5(1):3383-93. Available from: <http://pesquisa.bvs.br/brasil/resource/pt/bd-e-24227>.
9. Cunha MAO, Moraes HMM. A assistência domiciliar privada em saúde e suas estratégias (aparentes e ocultas). *Ciênc Saúde Coletiva* [serial on the internet]. 2007 [cited 2013 Apr 1];12(6):1651-60. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232007000600026.
10. Girardi SN, Carvalho CL, Girardi Junior JB. Formas institucionais da terceirização de serviços em hospitais da região sudeste: estudo exploratório. *Espaç Saúde* [serial on the internet]. 2000 [cited 2013 Apr 1];12(6):2(1):[about 7 p.]. Available from: <https://www.nescon.medicina.ufmg.br/biblioteca/imagem/2451.pdf>.
11. Cherchiglia ML. Terceirização do trabalho nos serviços de saúde: alguns aspectos conceituais, legais e pragmáticos. In: Santana JP, Castro JL, organizers. *Capacitação em desenvolvimento de recursos humanos de saúde*. Natal: Ed. UFRN; 1999. p. 361-85.
12. Meneses CS, Cecilio LCO, Andreazza R, Araújo EC, Cuginotti AP, Reis AAC. Os usuários e a transição tecnológica no setor de saúde suplementar: estudo de caso de uma operadora de plano de saúde. *Ciênc Saúde Coletiva* [serial on the internet]. 2013 [cited 2013 Feb 1];18(1):57-66. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232013000100007&script=sci_arttext.
13. Faller JW, Barreto MS, Ganassin GS, Marcon SS. Sobrecarga e mudanças no cotidiano de cuidadores familiares de paciente com doença crônica. *Ciênc Cuid Saúde* [serial on the internet]. 2012 [cited 2013 Feb 1];11(1):181-9. Available from: <http://periodicos.uem.br/ojs/index.php/CienCuidSaude/article/view/18876>.
14. Baptista TWF, Machado CV, Lima LD. Responsabilidade do Estado e direito à saúde

no Brasil: um balanço da atuação dos poderes. Ciênc Saúde Coletiva [serial on the internet]. 2009 [cited 2013 Feb 1];14(3):829-39. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232009000300018&script=sci_arttext.

15. Moraes HCC, Soares AMG, Oliveira ARS, Carvalho CML, Silva MJ, Araujo TL. Sobrecarga e modificações de vida na perspectiva dos cuidadores de pacientes com acidente vascular cerebral. Rev Latino-Am Enferm [serial on the internet]. 2012 [cited 2012 Apr 1];20(5):944-53. Available from: http://www.scielo.br/scielo.php?pid=S0104-11692012000500017&script=sci_arttext&lng=pt.

16. Toly VB, Musil CM, Carl JC. A longitudinal study of families with technology-dependent children. Res Nurs Health [serial on the internet]. 2012 [cited 2012 Apr 1];35(1):40-54. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/22161731>.

17. Hewetson R, Singh S. The lived experience of mothers of children with chronic feeding and/or swallowing difficulties. Dysphagia [serial on the internet]. 2009 Sep [cited 2012 Apr 1];24(3):322-32. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/19259730>.

18. Santos RS, Oliveira JMM, Fernandes FM, Farias PHS, Araújo AM, Menezes RMP. A assistência domiciliar ao idoso na perspectiva dos enfermeiros. Rev Enferm UFPE On Line [serial on the internet]. 2013 Mar [cited 2013 Apr 20];7(1):697-705. Available from: <http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/3655>.

Submission: 2013/04/30

Accepted: 2014/04/15

Publishing: 2014/06/01

Corresponding Address

Kênia Lara Silva
Rua Furtado Nunes, 131 / Ap. 101
Bairro Padre Eustáquio
CEP 30730-090 – Belo Horizonte (MG), Brazil