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Approaches to family risk classification with community health agents

Abordagem da classificação de risco familiar com agentes comunitários de saúde

Abordaje de la clasificación de riesgo familiar con agentes comunitarios de salud

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The objective of this study was to describe the experience of a training course for community health agents (ACS) about the categorization of Family Risk. This is an experience report of undergrads from the Nursing Graduation course, as they implemented an intervention project during their supervised Collective Health internship together with a Family Health team in the city of Uberaba-MG. The intervention was carried out in May 2016, through three meetings. The course used a dialogical and participative methodology, in which an expository method opened to dialogue was used, opening space for discussions, reflections about problems and experiences, based on previous knowledge and professional practice experienced by the agents during their domiciliary visits. Family risk categorization broadens the vision of health professionals and aids in the resolution of problems related to the assistance to the user. With that, it collaborates for the discovery of vulnerabilities, allowing for the health professional to frequently monitor the cases that need it the most.
Descritores: Atenção primária à saúde; Saúde da família; Visita domiciliar; Fatores de risco.

O objetivo deste estudo é descrever a experiência numa capacitação para Agentes Comunitários de Saúde (ACS) sobre a Classificação do Risco Familiar. Trata-se de um relato de experiência de acadêmicas do curso de Graduação em Enfermagem ao implementar um projeto de intervenção durante o estágio supervisionado em Saúde Coletiva junto a uma equipe de Saúde da Família do município de Uberaba-MG. A intervenção foi realizada no mês de maio de 2016, por meio de três encontros. A capacitação pautou-se na metodologia participativa dialógica, em que foram utilizadas exposições dialogadas, discussões, problematizações e vivências, baseadas nos conhecimentos prévios e na prática profissional vivenciados pelos ACS durante a realização das visitas domiciliares. A classificação de risco familiar amplia a visão dos profissionais de saúde e auxilia na resolução dos problemas relacionados à assistência ao usuário. Com isso, colabora para os achados de vulnerabilidades, permitindo que o profissional de saúde acompanhe com frequência os casos de maior necessidade.
Descritores: Atenção primária à saúde; Saúde da família; Visita domiciliar; Fatores de risco.

El objetivo de este estudio es describir la experiencia en el entrenamiento para Agentes Comunitarios de Salud (ACS) sobre la Clasificación del Riesgo Familiar. Este es un relato de experiencia de estudiantes del curso de Graduación en Enfermería al implementar un proyecto de intervención en la práctica supervisada en Salud Colectiva con un equipo de Salud de la Familia de la ciudad de Uberaba-MG, Brasil. La intervención ocurrió en mayo de 2016, a través de tres reuniones. En la actividad se usó la metodología participativa dialógica, en la que se utilizaron exposiciones dialogadas, debates, problematizaciones y experiencias, basadas en conocimientos previos y en la práctica profesional vivenciados por los ACS durante la realización de las visitas domiciliarias. La clasificación de riesgo familiar amplía la visión de profesionales de la salud y asiste en la resolución de problemas relacionados con la asistencia al usuario. Con ello, colabora a los resultados de las vulnerabilidades, lo que permite que el profesional de salud haga el monitoreo de los casos de mayor necesidad.
Descriptores: Atención primaria de salud; Salud de la familia; Visita domiciliaria; Factores de riesgo.

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INTRODUCTION

Primary Health Care (PHC), proposed in the Alma-Ata conference, is worldly understood as a strategy to organize health services capable of effecting the universalization of health access, through the offering of a continuous assistance process, supported by prevention, promotion, healing and rehabilitation, and has been built as part of a course towards social and economic development, aimed at intersectorality as a strategy for confronting social health determinants[1,2]. Its field of action takes place in the first level of assistance and aims to guarantee continuous and quality assistance, to value the integrality and longitudinal offering of health care, not merely focusing on medical assistance[3].

In our country, the Family Health Strategy (ESF) is the national PHC model, defined by the National Policy of Primary Care. It puts into effect the principles and directives of the Unified Health System (SUS)[3]. Initially created as the Family Health Program (PSF), its creation took place six years after SUS was implemented, as a strategy to re-orientate and organize the Network of Health Attention (RAS), which is related to the PHC services, associating principles such as territorializing, longitudinallity, intersectoriality, political and administrative decentralization, the establishment of hierarchies for attention levels and social control, promoting a type of assistance targeted at the needs of individuals and aimed at leaving behind the biomedical model of health care[2].

The ESF teams must be constituted by, at least, one physician, one nurse, nursing technicians or auxiliaries, and Community Health Agents (ACS). The ACS acts within this context, as a member of the health team, and is responsible for a micro-area inside the territory within the scope of the service, developing actions that seek to integrate the health team and the population, and being responsible for: registering everyone in their micro-area and maintaining such records up to date; developing health promotion activities, to prevent diseases and grievances, and health surveillance ones, through domiciliary visits and individual and collective educational actions in residencies and in the community, among others[4]. They should be professionals selected from the very community which is under the scope of the service, to work together with its population. Each agent must be responsible, on average, for 400 to 750 people[4].

Their work takes place, mostly, out of the physical environment of the health unit, and they work as intermediaries between the users and the health services. This connection is made in many ways, and the Domiciliary Visit (DV) is the most important within the scope of the actions developed by the health agents[5].

DVs stand out as work strategies capable of allowing for the professional to enter into the family environment of the users, as to allow for a better understanding of the relationships that exist within that environment, knowing the realities of the lives of these individuals and for the creation of bonds between health worker and individuals, to promote the autonomy of each patient and family in the management of their own care, through the establishment of goals to be negotiated between the parts[6-8].

Considering the important role of this strategy in the context of the ESF work, effective VD planning becomes essential, and the Evaluation of Family Risk is an effective tool to direct the actions to the families with the most needs[9]. Such a tool emerges as a proposition that allows one to distinguish the families that belong to the same area, as to identify risk factors that would justify the prioritization of certain treatments[10,11].

Thus, for such a methodology to be used to support the definition of strategies to track vulnerable families, it becomes necessary for the entire health team to be trained for its use, especially the ACSs, the professionals most responsible for this mediation between the health services and the health team. Therefore, the objective of this work is describing the experience in the conduction of a training course for ACSs, on the classification of family risk.

METHOD

This is an experience report, emerging from activities developed by the undergrads enrolled in the discipline "Monitored Internship in Collective Health", from the 9th semester of the Nursing graduation course of the Federal University of the Triângulo Mineiro - UFTM (Uberaba/MG), whose syllabus includes the integration of the professor in the context of administrative and assistance tasks in the field of primary care, in Primary Health Care Units which have ESFs or RASs in the city of Uberaba/MG. It should be highlighted that one of the requirements for the conclusion of the discipline is the elaboration of an intervention project in the health team of choice of the students.

As soon as the students start their internship activities, they are asked to provide a situational diagnostic of the health unit, considering the need to recognize its physical and administrative structure, in addition to the attended community and its vulnerabilities. The use of the situational and administrative diagnosis is a broad process that makes it so the service is socially compromised and has credibility, it being an essential instrument for a better organization and growth of the team[12,13]. Through this strategy, priority actions can be defined according to the reality of the institution, its users and the territory within its scope[14].

During the elaboration of the situational diagnostic, the students collected data based on reports from the workers of the unit, the users, and a mapping of the processes that take place there. After this information was collected, the needs of the unit were discussed with the nurse of the team, and it was found that the health agents had great difficulties in planning their DVs, considering the low number of professionals and the high demand for their services, and also that only one of the agents in the team had undergone a training course for the classification of family risk. Therefore, the group of undergrads, under the guidance of the teacher who was responsible for the discipline and of a student from the MS in Health Care, and together with the nurse who was the preceptor for RAS, decided to develop, as their intervention, a training course for the agents, since the team showed the need to understand and classify better the risk of the families being monitored, as to better update the situational map of the area.

The intervention took place in May, 2016, in three stages: the first meeting rose awareness about the subject and discussed the methodology; in the second, a theoretical expositional course was conducted, using as a support the distribution of material with information on the content to be discussed, the step-by-step classification of family risk and the conduction o collective exercise based in clinical cases; in the last meeting, a risk classification of at least one family was conducted together with each agent, considering the families these agents were monitoring.

The training used the participative and dialogic methodology propose by Paulo Freire, aiming to lead to autonomy during the pedagogical process of teaching through students, valuing their individual cultural aspects and previous empirical knowledge[15].

Dialogic expositions, discussions, problematizations and experiences were used to reach the goals of the course, always taking into consideration the previous knowledge and professional practice of the agents during the conduction of their DVs. In addition, an internship student from the Nutrition course gave support to the actions, as she also accompanied the activities and routine of the team.

These encounters took place in the meeting room of the health unit, in the same days and times of the routine meetings of the team, counting on the participation of all professionals (Nurse, ACSs, Physician, Dentist and students from the Multiprofessional Health Residency who care for patients in the same unit).

The behavior of the participants and the conducted discussions were recorded in a field journey during the conduction of meetings, as well as in the minute of the team, where all permanent education activities and meetings are noted down.

As this is an experience report, the Free and Informed Consent Form was not

necessary. The administrative manager of the health unit was asked for authorization before the intervention was conducted. All agents received explanations on the objectives of the intervention and the possibility of publication of the results, and that they would not be identified, nor would it be any information that could identify the participants. The terms of understanding and assent for the publication were collected from all participants. Additionally, no data that would allow for the identification of the health unit or its professionals will be divulged, in respect to the directives of Resolution 466/2012[16] of the National Research Ethics Council (CONEP).

RESULTS

All ACSs in the team participated in the training course, the Nursing professionals (Nurse and Nursing technician), the physician and oral health professionals (dentist and oral health technician), to a total of 09 professionals.

To better present and discuss the results, three categories were created, according to the conducted activities: 1. the Importance of the Categorization of Family Risk Levels; 2. the role of the health unit/professionals considering the vulnerabilities; and 3. the identification of family risk by all health agents and the proposal of solutions.

To do so, an instrument from the State Health Secretariat of Minas Gerais was used (SES/MG).

DISCUSSION

The instrument used belongs to the recommendations given in the training course for the Implementation of the Master Plan of Primary Health Care of the State of Minas Gerais, together with the Public Health School of the State of Minas Gerais[17]. It classifies the families according to socioeconomic aspects and priority chronic conditions/pathologies in the family, using the following criteria to classify them:

1. Socioeconomic factors:

a) Literacy of the head of the household: the family whose household head is illiterate (cannot read or write simple notes) is considered to be under risk;

b) Family Income: the family in extreme poverty (monthly income of up to R$60,00 - approximately US$20,00, if there are children or not) is deemed to be under risk;

c) Water provisions: the family whose house has no adequate water supplies is considered under risk, i.e., those who are not under the scope of any water supply network and have to drink water from wells, cisterns, springs or others. Table 1 presents how scores are calculated.

Table 1. Scores for each risk factor according to documents from SES/MG[17].

No risk factors	0
Presence of one risk factor	1
Presence of two risk factors	2
Presence of three risk factors	3

2. Presence of priority conditions or pathologies - the family which has one or more of its members in one of the following conditions or pathologies, per life cycle, is considered to be under risk:

a) Children with Group II risk situations: low weight at birth, prematurity, severe malnourishment; neonatal triage positive for hypothyroidism, phenylketonuria, sickle-cell anemia or cystic fibrosis; vertical transmission diseases: toxoplasmosis, syphilis, AIDS; important complications in the neonatal period, notified during hospital discharge; inadequate growth/development; unfavorable evolution of any disease.

b) High Risk Teenagers: sexually transmitted diseases or hosts of the HIV/AIDS; early unplanned parenthood; eating disorders; bulimia and anorexia; use/abuse of licit and illicit substances (tobacco and alcohol being highlighted); victims of sexual exploration or those who underwent sexual abuse; depression framework; mental disorders and/or risk of suicide; frequent escapes from home or homelessness.

c) Adults under High or Very High Cardiovascular risk. Group of high risk: Arterial Hypertension (AH) levels 1 or 2, with three more other risk factors; or those with AH level 3, with no other risk factors; very high-risk group: people with AH level 3, with

one or more other risk factors; or those with AH with manifest renal or cardiovascular diseases.

d) Adults with Risk of Diabetes: non-insulin users, with hypertension; insulin users.

e) Adults with High Risk for Tuberculosis: users with prior cases or clinical evidence indicating acute or chronic hepatopathy; people with AIDS or positive HIV diagnoses; prior cases or clinical evidence of nephropathies; suspected multi-resistant tuberculosis; extra-pulmonary tuberculosis (especially meningitis tuberculosis); patients being treated again due to abandonment, relapse or failure.

f) Adults with High Risk for Hansen's disease: repetitive reactional outbreak; report of adverse medication effects; presence of sequelae on the eyes, nose, feet and hands.

g) Adults with High Mental Health Risks: users with severe and persistent mental conditions; damaging use of alcohol and other drugs; people coming from mental health services.

h) High Risk Pregnancies: dependency on licit and illicit drugs; anterior perinatal death; repeated abortions; sterility/infertility; uterine growth deviation, number of fetuses and volume of amniotic fluid; premature labor and prolonged pregnancy; preeclampsia and eclampsia; gestational diabetes; premature membrane rupture; gestational hemorrhages; isoimmunization; fetal death; arterial hypertension; cardiopathy; pneumopathies; nephropathies; endocrinopathies; hemopathy; epilepsy; infectious diseases; autoimmune diseases; gynecopathies.

i) High Risk/Frail Elders: 80 year-old or older elders; 60 year-old or older elders with the following conditions: more than 5 diagnosed pathologies; polypharmacy (more than 5 drugs/day); partial or total immobility; urinary or fecal incontinence; postural instability (repeated falls); cognitive disabilities (cognitive decline, demential syndrome, depression, delirium); elders with frequent hospitalizations or in the period immediately after discharge; elders who are not independent in daily life activities - DLA; family insufficiency; elders who live alone or are institutionalized.

j) Other conditions or pathologies the health team considers to be priorities. Table 2 shows how these types of risk are scored.

Table 2. Scores for each risk factor according to documents from SES/MG[17].

No component has any conditions or pathologies.	0
Only one component has a pathology or condition.	1
Two or more components have one pathology or condition.	2
One or more components have two or more concomitant conditions or pathologies.	3

To categorize risk, it is necessary to consult information in the family register form (FORM A - SIAB) and identify the socioeconomic factors and pathologies/conditions there are within a given family, calculating the score of each criterion and crossing the two categories and final score, according to Image 1, which will then lead to the final score, shown in Image 2.

FINAL SCORE FOR CATEGORIZATION OF RISK LEVELS		SOCIO-ECONOMIC CRITERIA			
		No risk factors	One risk factor	Two risk factors	Three risk factors
	P	0	1	2	3
CLINICAL CRITERIA: No component has any conditions or pathologies.	0	0	1	2	3
CLINICAL CRITERIA: Only one component has a pathology or condition.	1	1	2	3	4
CLINICAL CRITERIA: Two or more components have one pathology or condition.	2	2	3	4	5
CLINICAL CRITERIA: One or more components have two or more concomitant conditions or pathologies.	3	3	4	5	6

Image 1. Categorization of scores according to "Socioeconomic Criteria" and "Clinical Criteria".
Source: Public Health School of the State of Minas Gerais. Implantation of the Master Plan of Primary Health Care: Health Care Networks. Belo Horizonte; 2008.

TOTAL SCORE	RISK LEVEL
0	No risk
1	Low risk
2 - 3	Medium risk
≥ 4	High risk

Image 2. Categorization score according to risk level.
Source: Public Health School of the State of Minas Gerais. Implantation of the Master Plan of Primary Health Care: Health Care Networks. Belo Horizonte; 2008.

During the training course, the participants sat in circles so there could be visual contact between them and the coordinators. After these workshops were conducted, verbal reports from the health agents indicated that this methodology allowed for a better interaction between course coordinators and participants and among the participants themselves, which contributed for the discussions to be directed toward situations that took place in their work reality.

Considering how important is the Categorization of Family Risk Levels for the work of ESF, it can be understood that this tool aids in the actions of health promotion and disease prevention, in addition to helping in the recognition of the vulnerabilities of the

family and proposing solutions for the problem faced confronted by the users, allowing for an effective way to organize and prioritize the visits conducted by the agents[18].

The agents indicated, in the discussions conducted during the encounters, the importance of understanding and interpreting information from the family risk categorization in their work context, as a mechanism to find resources and give support to the users they attend, in addition to being a tool to improve, optimize and organize their work routine, considering that the families from each risk group will be assigned a color, making it possible to visualize them in a map of the area for better visualization and follow up, according to their risk level. However, the participants highlighted some problems within the categorization which prejudice the understanding of the families' situation, mainly: incomplete information, address changes without previously informing the health agents, users who resist using the public services, and the small number of agents for a broad area.

The categorization of family risk aims to show the adequate way to deal with these users to the health agents and the health team. For the unit/service it is important for the professionals to know the characteristics of the area they cover, as to make it easier to monitor and offer adequate care for each family, since the objective is to contribute for the planning and guiding of health policies directed to give support to the most susceptible areas[9].

There are numerous difficulties pointed out by the health agents in their daily work, which may contribute for them to feel professionally discouraged regarding their professional expectations and the actions that they developed in practice. A study showed that health agents have an excessive workload, due to the distortions that come from a lack of clarity concerning their attributions, to a point that they are often saw as solely responsible for putting into effect the principles and directives of SUS when it comes to PHC[19]. Due to this context, they present stress symptoms more frequently than other members of the team, as they deal directly with a family environment and are responsible for establishing a bond between user and heath service without being properly trained to do so[20].

With consideration to the role of the health unit/professionals regarding vulnerabilities, health agents have reported that it is important for the users to feel welcomed by the health service and the health unit professionals, considering the principles and directives prescribed by the National Humanization Policy. In addition, they recognize their potential to identify the risks and vulnerabilities of the population, and how important it is to present and discuss that with their team, so that everyone has the opportunity to give their opinions and discuss the best way to approach the case.

In the report of the agents, it is clear how lacking the actions of the professionals in the health unit are when it comes to problem-solving and giving support to the actions of the health agents. Stand out some cases of poor service and deficit in the offering of services and available professionals, due to the high demand[19]. These situations can undermine the credibility of the work of health agents, when one considers that, when the user, due to the encouragement and referral of the agent, seeks health services and is unable to access them, be it due to space constraints, poor service or absence of a professional, this user loses his trust in the whole team[20].

The satisfaction of users with the work of the agents is frequent during the DVs and it becomes realized through a correct family diagnostic conducted by this professional, since the ESF team will get to know the real health needs of the family and that will allow for a greater satisfaction of the users with the work of the agents and the health services offered by the ESF[20].

The most common risks identified in the training of the agents were: low family income considering the number of members in the family, and the presence of pathologies such as Arterial Hypertension and Diabetes Mellitus.

No scientific reports on the use of the tool of Family Risk Classification were found

or used in the intervention, although some were found to use the Family Categorization Scale of Coelho and Savassi[21]. This scale is very similar to the one used in this intervention project, and categorizes the families according to the information available in the Form of family records (Form A).

In recent study, conducted in a Family Health Unit (USF) in the city of Londrina (Paraná), 889 family register forms of registered users were analyzed, and 11.2% of families showed some type of risk, especially biological factors, AH and diabetes, and social ones, such as a higher number of family members than rooms in the house they live in and unemployment[18].

Another study evaluated 927 families registered in an USF from the city of Porto Alegre (Rio Grande do Sul state) and found that 31.5% of them had at least one type of family risk, the most common ones being low basic sanitation conditions, Arterial Hypertension, diabetes and drug addiction[9].

The solution proposed to most problems identified, including the most frequent ones, was that during domiciliary visits the agents guide the users regarding prevention and adequate control of the pathologies they have. Guidance, connected to the transmission of knowledge, is pointed out by the health agents as one of the most common activities in the scope of their work, and it is a factor that generates satisfaction for these professionals, as it offers them autonomy and the feeling of contributing for the well-being and health improvement of the population.

In the view of the users, since this information exchange is not mediated by an interposing hierarchy, which happens when the professional caring for them has higher education, as physicians and nurses, their acceptance and adherence is much higher. That also contributes for the formation of trust and tighter bonds, which is essential for the work of the agents[21].

CONCLUSION

Educational activities are important, as they promote the renewal of professional practices and the generation of knowledge, allowing for its exchange among the speakers and listeners. It is an essential activity in the work routine of the professional nurse, as part of their attributes is the training of the individuals, the encouragement and promotion of self-care, in addition to the guidance and training of the health agents.

Though verbal expositions and the use of support material such as booklets, posters with self-explanatory images and demonstrations of how to conduct the classification of family risk, important information were transmitted to the agents, to empower them regarding the self-management of their work routine, based on the actual vulnerabilities of the population they care for.

Family risk categorization broadens the vision of health professionals and aids in the resolution of problems related to the assistance to the user. With that, it collaborates for the discovery of vulnerabilities, allowing for the health professional to frequently monitor the cases that need it the most.

Risk areas are categorized by the health agents, thus creating groups of attention aimed at that family, leading to a reunion of all professionals in the unit to lessen or solve the problem. Therefore, health agents have an essential role in the exchange of information between users and health service, through the bond they develop with the families during interviews, which favor adhesion to the guidance and treatments prescribed by the PHC professionals.

It was found that the group that participated accepted the proposal, since the health agents participated in the proposed activities through experience reports and the clarification of doubts. In addition, a bond was created between the coordinators and the health professionals, which made it easier for the exchange of knowledge and improved the working process during the internship.

To the students involved, the intervention project brought cultural,

educational and scientific improvements, leading to the exchange of knowledge among listeners and among themselves, while also bringing benefits to the health service. An opportunity that became clear was the encouraging for the insertion of this type of activity during the undergraduate course, not only during the internships, which take place in the last year of graduation. They may contribute to a more precocious approximation between academic and health services of PHC from the RAS.

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CONTRIBUTIONS
Adrieli Oliveira Raminelli and Cíntia Cristina Andrade participated in the conception and writing of the article**. Luan Augusto Alves Garcia** took part in the writing and critical review of the article. **Fabiana Fernandes Silva de Paula and Álvaro da Silva Santos** contributed in the critical review of the article.

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