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Case study

Integral care for socially vulnerable elderly families: a family-centered approach in primary health care

Cuidado integral à família idosa em vulnerabilidade social: aplicação da abordagem familiar na atenção primária à saúde

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Abstract

Objective: to describe the application of family assessment tools in an elderly family in a situation of social vulnerability followed by a Family Health team. **Materials and Methods:** this is a qualitative case study conducted in a Family Health Strategy unit in Montes Claros (MG), Brazil, during the second half of 2025. Data were collected through home visits, using the following tools: genogram, ecomap, family life cycle, FIRO, and P.R.A.C.T.I.C.E., in addition to the Clinical-Functional Vulnerability Index (IVCF-20) and the Mini-Mental State Examination. **Results:** a family comprising older adults with chronic diseases and functional limitations, as well as a member with a mental disorder, was identified. The family exhibited mutual dependence and a fragile support network, in addition to other relevant aspects concerning family relationships, available resources, and strategies employed in everyday life. **Conclusion:** the tools enabled a broader understanding of family dynamics and supported comprehensive interventions, highlighting the importance of multiprofessional and intersectoral actions.
Keywords: Family health. Aged. Health vulnerability. Primary health care. Family relations.

Resumo

Objetivo: descrever a aplicação de ferramentas de abordagem familiar em uma família idosa em situação de vulnerabilidade social acompanhada por uma equipe de Saúde da Família. **Materiais e Métodos:** estudo qualitativo do tipo estudo de caso, realizado em uma Estratégia de Saúde da Família de Montes Claros (MG), no segundo semestre de 2025. A coleta de dados ocorreu por meio de atendimentos domiciliares, com aplicação das ferramentas genograma, ecomapa, ciclo de vida familiar, FIRO e P.R.A.C.T.I.C.E., além do IVCF-20 e Mini Exame do Estado Mental. **Resultados:** identificou-se uma família composta por pessoas idosas com doenças crônicas e limitações funcionais, além de um membro com transtorno mental, apresentando dependência mútua e fragilidade na rede de apoio, além de outros aspectos de suma importância acerca do relacionamento familiar, seus recursos e estratégias utilizadas no cotidiano. **Conclusão:** as ferramentas permitiram compreensão ampliada da dinâmica familiar e subsidiaram intervenções integrais, evidenciando a importância da atuação multiprofissional e intersetorial.
Palavras-chave: Saúde da família. Idoso. Vulnerabilidade social. Atenção primária à saúde. Relações familiares.

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Introduction

The Unified Health System (UHS) is founded on principles and guidelines aimed at guaranteeing universal and equitable access to the goods and services necessary for the promotion, protection, and restoration of health. To this end, it is structured as a regionalized and hierarchical network, with the objective of ensuring comprehensive health care for the population[1].

The Family Health Team (FHT) plays a fundamental role in identifying health needs within the local area, as such conditions can restrict access to available resources and increase the risk of illness. Given the complexity of health problems and demands, the use of family-oriented approach tools is essential; these tools support the development of intervention plans centered on individual, family, and social dynamics, particularly for highly vulnerable groups[2].

Among the population groups requiring greater attention, the elderly stand out—especially those affected by frailty syndrome, which is characterized by intensified physical and functional limitations associated with aging and, consequently, the need for continuous care provided by family members or caregivers[3].

In this context, various tools have been employed in the family-oriented approach, such as the genogram, ecomap, family life cycle, Fundamental Interpersonal Relations Orientation (FIRO), the P.R.A.C.T.I.C.E. model (Presenting Problem; Roles and Structure; Affect; Communication; Time in Life; Illness in Family; Coping with Stress; Ecology), and the family conference. These instruments allow for a broader understanding of family relationships, interactions, and dynamics, facilitating the identification of existing needs and the design of interventions suited to the issues identified[4,5].

Thus, this study aims to describe the application of family assessment tools with an elderly family facing social vulnerability, residing within the catchment area of a Family Health team in the municipality of Montes Claros, in the state of Minas Gerais (MG).

Materials and Methods

This is a qualitative case study conducted within a Family Health Strategy (FHS) unit in the city of Montes Claros, MG, during the second half of 2025. The family was selected based on the index patient, an elderly head of the household responsible for managing the lives of his sister (who is in the same life stage) and his son, who has schizophrenia. Data collection took place in November and December through the application of family assessment tools, such as the Genogram, Ecomap, Family Life Cycle, FIRO, and P.R.A.C.T.I.C.E., during ten home visits carried out by the team's nurse, psychologist, dentist, and physician to observe the family's behavior and organization.

The Clinical-Functional Vulnerability Index-20 (IVCF-20) is calculated using a 20-item

questionnaire covering various dimensions of elderly health, such as age, self-perceived health, functional capacity, cognition, mood, mobility, communication, and the presence of comorbidities. Each item carries a specific score assigned based on the identified level of impairment, and the sum of these points yields the instrument's final score. Based on this score, the elderly individual is classified as being at low, moderate, or high risk of clinical-functional vulnerability, which guides the planning of interventions and healthcare delivery[7].

Another tool employed was the Mini-Mental State Examination (MMSE), a brief assessment of the elderly individual that is effective for cognitive screening. It comprises 10 questions regarding orientation to time and language, while also allowing for the observation of the participant's visual-constructive ability and, notably, their attention and recall of recent and remote memories[8].

Ethical care

This study was submitted to the Research Ethics Committee of the State University of Montes Claros (Unimontes) and approved on November 11, 2025 (Opinion N. 7,968,891). Prior to the study's commencement, the family was consulted regarding their interest in participating via the Informed Consent Form, which was signed by a family member over the age of 18, in accordance with Resolution N. 466/12. The names used in this study are fictitious.

Results

Family Characterization

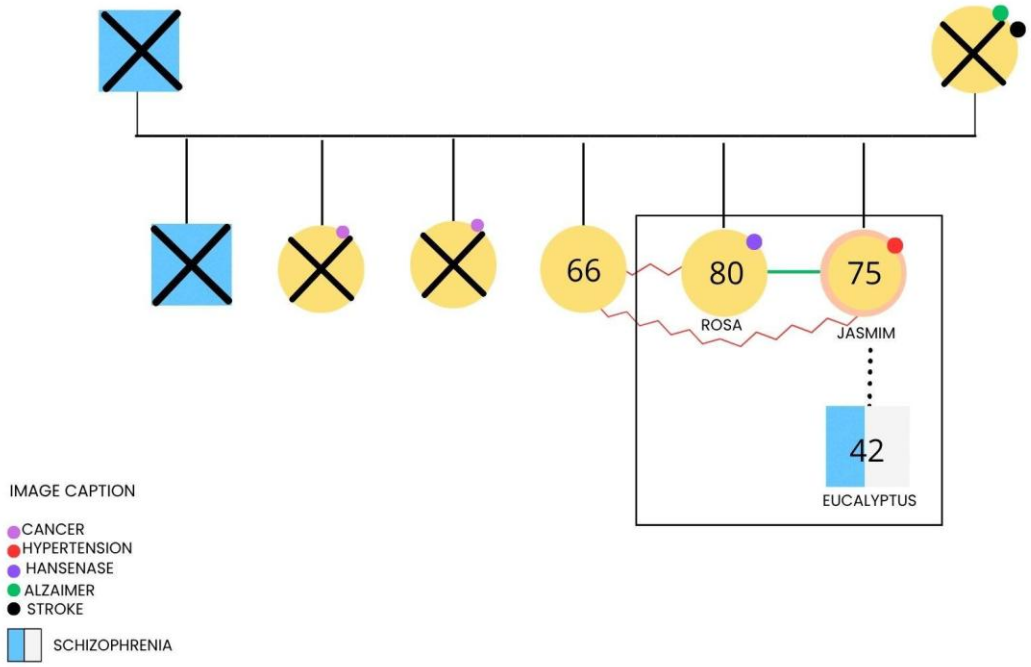
The index patient, Jasmim (75 years old), lives with her sister and son in a masonry house provided by the *Minha Casa Minha Vida* program for vulnerable families. Jasmim has systemic arterial hypertension and currently presents with malunion of a fracture in her left upper limb, resulting from a fall from a standing position. At the time of the injury, she refused surgery because there was no one available to take over the care of her sister and son, for whom she is the primary caregiver.

Her sister, Rosa (80 years old), has experienced significant hearing loss since childhood and is currently undergoing treatment for leprosy. Jasmim’s son, Eucalipto, is adopted; he was taken in at three months of age by Jasmim and Rosa’s mother due to his biological parents' mental illness. He is currently 42 years old and has been diagnosed with schizophrenia, with difficulties adhering to pharmacological and clinical treatment. Given the complexity of the case, family-centered approach tools were applied.

Genogram

The genogram (Figure 1) was structured across three generations, highlighting a family context characterized by the presence of chronic diseases, mental disorders, and functional limitations distributed throughout the generations.

Figure 1. Genogram of the studied family.

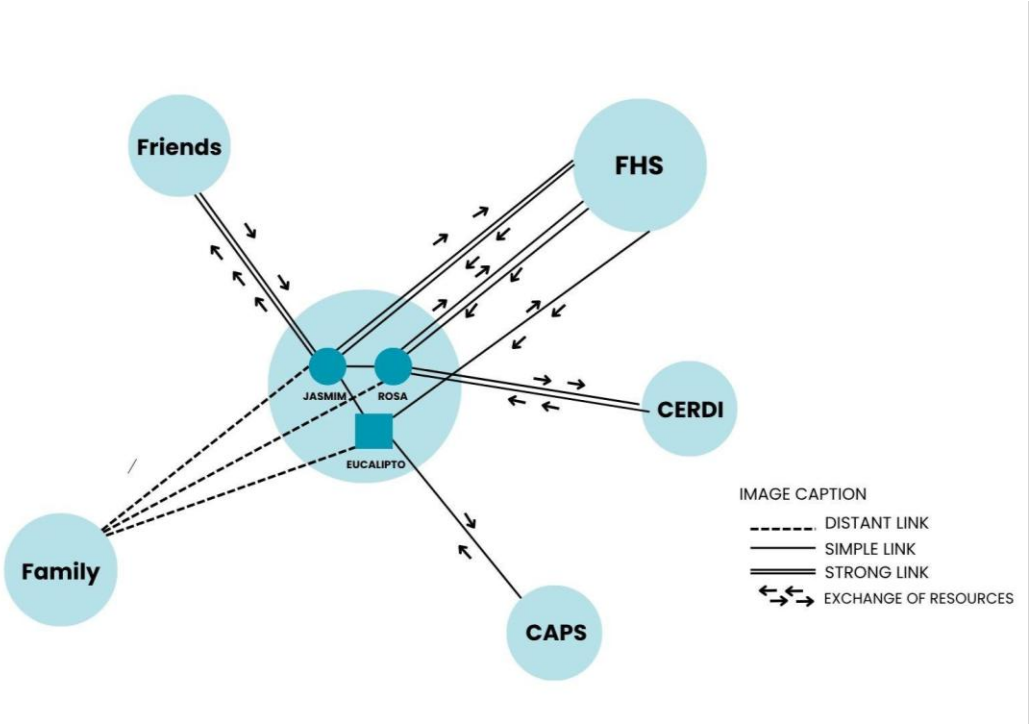


The matriarch passed away at age 80 due to a stroke and Alzheimer's disease, while the patriarch died at age 50 following complications from an inadequately attended fall. The couple had six children, two of whom, both daughters, have died: one from cervical cancer and the other from renal neoplasia. The family unit under study consists of sisters Rosa (80) and Jasmim (75), both of whom have clinical comorbidities that compromise their autonomy and functional capacity. Jasmim's son, Eucalipto (42), has a diagnosis that impacts his psychosocial adaptation and limits his ability to fully perform social and family roles. Despite these limitations, Eucalipto partially takes on the role of liaison with health services, particularly given Jasmim's reduced mobility, demonstrating a reorganization of family roles in the face of illness. Thus, the family system is characterized by limited internal resources to cope with caregiving demands, mutual dependency among members, and a fragile support network; this scenario requires continuous monitoring by Primary Health Care (PHC), focusing on comprehensive care and support for family dynamics.

Ecomap

Based on the graphic representation of the ecomap (Figure 2), it is possible to analyze current social relationships and understand some of the family's key needs. The dotted line connecting Jasmim, Rosa, and Eucalipto to the rest of the family indicates weak ties with the extended family; consequently, their social interactions and support network are largely limited to the elderly women and friends who, lacking resources, are seeking ways to sustain themselves.

Figure 2. Ecomap of the studied family.



The other relationships indicated in the ecomap—characterized by lines and arrows representing mutual connections—reveal the predominance of public health network services as fundamental and essential for all members.

Family life cycle

The family in this study is in the Late Stage (Final Family/Old Age), a phase characterized by the aging of its members and the need for increased healthcare. They struggle to manage the routines associated with this stage; tasks requiring physical capability become increasingly difficult to perform. Furthermore, the intellectual limitations of the sisters—Rosa and Jasmim—and the son, Eucalipto, hinder the management of family finances, resulting in a lack of basic necessities such as food.

F.I.R.O.

Family relationships can be categorized into three dimensions (Chart 1): inclusion, control, and intimacy, that is, the family can be studied in terms of its relationships regarding power, communication, and affection.

Chart 1. Data from the application of the FIRO tool to the study family.

Inclusion	Structure	The family establishes organizational norms and routines based on the directives of Jasmim, the family leader. Household tasks, such as cleaning, meal preparation, and caregiving, are carried out by Rosa with Eucalipto's assistance, while Jasmim handles shopping and financial matters. Currently, the medication and clinical support routine is organized by the health unit through home visits by the team's professionals.
	Union	Within the Union, family life is affectionate and takes into account the needs of each member. There are also strong bonds that intensify during times of greatest difficulty.
	Sharing mode	Regarding sharing, it is worth emphasizing once again that, despite physical and intellectual limitations, the members openly discuss their situations in order to seek solutions to everyday challenges.
Control		The family hierarchy centers on Jasmim, who took charge of decision-making and caregiving following Eucalipto's mental health decline and Rosa's hearing impairment. Individual needs are reported to the family leader so that solutions can be found and appropriate courses of action determined. The family income, derived from benefits granted to each member due to their respective health conditions, is managed collectively by Jasmim.
Intimacy		Regarding the topic of intimacy, a collaborative and dependent stance of Eucalipto and Rosa toward Jasmim was observed, as well as attitudes of care and collective concern among the members.

P.R.A.C.T.I.C.E.

Chart 2 presents the application of the P.R.A.T.I.C.E. tool, which comprises an analysis of social, affective, and stress-inducing roles, as well as problems, illnesses, the environment, and other factors.

Chart 2. Data from the application of the P.R.A.C.T.I.C.E. tool with the study family.

P.R.A.C.T.I.C.E.
P – *Problems* (Problem presented): Social and health vulnerability; it is observed that none of the family members are in a position to manage their own lives and fully meet their needs, most notably Jasmim, who suffers from arterial hypertension and has reduced mobility.
R – *Roles*: Jasmim is responsible for caring for her sister Rosa and her son Eucalipto, as well as for household chores whenever possible. Eucalipto, in turn, handles communication between the elderly women and the Family Health Strategy team (eSF), given Jasmim's limited mobility.

A – *Affect*: There are differences between Eucalyptus and Jasmine. Furthermore, Rose is often overlooked due to hearing impairment and the resulting difficulty in comprehension.
C – *Communication*: Communication is negatively affected by Rosa's hearing loss and Eucalipto's mental health struggles.
T – *Time in the Life Cycle*: The family is in the late stage of the life cycle, marked by the onset of old age and its associated physical, psychological, and social transformations, centered on the pursuit of autonomy, health, and quality of life.
I – *Illness* (past and present conditions): Jasmim has hypertension and experiences leprosy reactions; she has been under treatment for over two years. Rosa has a hearing impairment and has been undergoing treatment for leprosy for 22 months. Eucalipto has been diagnosed with schizophrenia.
C – *Coping with Stress*: The family finds it difficult to cope with stress as it adapts to the life cycle associated with aging and existing vulnerabilities.
E – *Ecology* (Ecology, environment): The resources are primarily health services, as well as friends in the neighborhood.

Complementary instruments

In this study, the application of the IVCF-20 made it possible to identify varying risk levels among the patients evaluated. Patient Rosa scored 10, classifying her as being at moderate risk for clinical-functional vulnerability; this indicates a need for increased attention and monitoring to prevent potential declines in her functional capacity. Conversely, patient Jasmim scored 15, classifying her as being at high risk for clinical-functional vulnerability; this highlights greater impairment and the need for more intensive interventions. These findings underscore the importance of using the IVCF-20 as a screening tool to guide individualized management and interventions in clinical practice.

The MMSE was administered only to Jasmim, as it was not possible to evaluate Rosa due to her difficulties in hearing and comprehending instructions. The results revealed a low level of formal education, with a score of 11 points, associated with difficulties regarding temporal orientation.

Following the application of family assessment tools, the need for a multidisciplinary intervention became evident, as the care provided to the index patient required expansion to ensure the protection of her physical, mental, and social health, particularly given her reduced functional capacity.

Family conference

It is evident that the social vulnerability experienced by the family extends beyond the scope of the health sector, requiring broader and more complex interventions. The family faces significant challenges regarding its organization and functioning, primarily due to the health conditions of Rosa and Jasmim and Eucalipto's psychiatric condition, which profoundly affect daily family life, causing suffering, instability, and strained relationships. Consequently, a meeting was held, facilitated by the Family Health Strategy (FHS) psychologist, nurse, and dentist, and attended by Jasmim and Rosa.

Regarding mental health care, guidance was provided on the possibility of referring Eucalipto to the Psychosocial Care Center (CAPS - *Centro de Atenção Psicossocial* in Portuguese) during crises, and the importance of adhering to psychiatric treatment was emphasized. Concerning the elderly women's quality of life, strategies for improving sleep, including the proper use of medication, were discussed, alongside the strengthening of religious and community ties to prevent social isolation. The provision of team-based home care was also highlighted, aiming to prevent psychological and emotional deterioration while promoting autonomy and cognitive stimulation. Finally, guidance was offered on organizing the household routine to avoid overburdening the family with daily tasks.

The team contacted the Specialized Reference Center for Social Assistance (CREAS) and the Elderly Affairs Coordination Office to expand social support and protection for the family. The family continues to receive follow-up care from CREAS as of the conclusion of this work. Additionally, the multidisciplinary team carried out the following interventions (Chart 3).

Chart 3. Interventions performed by professional category with the family studied.

Professional	**Interventions**
Nurse	● Multidimensional assessment of the elderly person; ● Medication administration; ● Wound dressing; ● Guidance on fall prevention, nutrition, and hygiene; ● Liaison with the Department for the Elderly and the Specialized Social Assistance Reference Center (CREAS).
Dental Surgeon	● Instructions for denture cleaning; ● Oral hygiene guidance; ● Preventive measures; ● Medication administration; ● Referral to the Dental Specialty Center (CEO) as needed.

Psychologist	● Multidimensional assessment of the elderly person; ● Administration of mental status examination; ● Assessment of symptoms of anxiety, depression, and psychological distress; ● Screening for risk of social isolation, neglect, or violence; ● Coordination with CAPS; ● Coordination with the healthcare network.
Doctor	● Medication management and optimization for respective comorbidities, with supervised prescriptions and dosages; ● Ordering of tests based on the needs and routine of each family member; ● Referral to specialized care when specialist evaluations and management are required—such as orthopedics, psychiatry, dermatology, and physical therapy; ● Routine physical examination during home visits; ● Guidance on nutrition, hygiene, wound care, and proper medication storage.

Discussion

The family genogram is a graphic representation that organizes family data and tracks relational dynamics during the assessment process, assisting Primary Health Care (PHC) in understanding the health, social, and emotional status of the family members under study[6]. Thus, this instrument revealed the presence of vulnerability factors, such as chronic diseases, mental disorders, and fragile family ties. Such conditions negatively affect the family dynamic as a whole[2]. These findings supported the identification of the family's main needs, facilitating the planning of comprehensive interventions tailored to those needs and aimed at strengthening care.

These results align with the literature[6], which identifies the genogram as a tool capable of broadening the understanding of family relationships and identifying risk and protective factors, thereby supporting the development of broader interventions centered on family history.

The ecomap is a procedure that enables a broader understanding of the family context by representing its support network and interactions with the external environment. It is a method that links living conditions to the family's environment, highlighting ties among members and resources offered by the community, while also identifying and assessing available support and how it is utilized[9]. Healthcare, as a resource, plays a primary role in identifying needs and vulnerabilities, as well as in building the bonds that ensure the work's effectiveness[10]. Knowledge of family history and the current social context, gained through the genogram and ecomap, revealed living conditions, available community resources, and how the family uses them, supporting the identification of key needs and the planning of comprehensive interventions.

The Family Life Cycle allows the analysis of the family's trajectory and organization as it evolves over time. It aids in identifying situations that may foster difficulties in family functioning, taking into account changes in the roles and responsibilities assumed by members at each stage of family development. In this context, the FIRO seeks to assess family members' feelings and their

experiences within daily relationships. It is used to understand changes in the family life cycle and to evaluate marital or family shifts, severe pathologies, and cases involving terminally ill patients. It offers significant insight into the late stage of the family life cycle, which characterizes the patients studied here. As for the PRACTICE tool, it is used to assess the internal functioning of families. It facilitates data collection and the understanding of problems, whether clinical, behavioral, or relational, while also aiding in assessment and the development of management plans with the family. It is indicated for more complex situations and should be administered during family meetings involving health professionals. The IVCF-20 and MMSE tools are designed to assess the clinical-functional vulnerability and cognitive performance of the elderly. Both have contributed substantially to identifying existing needs: the IVCF-20 analyzes the degree of vulnerability, supporting the planning of care interventions, while the MMSE enables the screening for cognitive changes that could compromise an individual's autonomy and functionality. Although they do not provide a comprehensive assessment of mental status, their use helps identify relevant aspects of the elderly person's mental health, providing information that guides the health team's decision-making and contributes to the development of care strategies better suited to the identified needs.

Therefore, it reflects on the implementation of public policies aimed at the elderly population entails understanding care as a holistic practice, one that considers the individual in their entirety and across multiple dimensions, while respecting and addressing their needs through the interactions among users, health professionals, and institutions[12].

As established by the Statute of the Elderly (Law N. 10.741/2003)[13], the family, the community, and society are responsible for ensuring the rights of the elderly, including the rights to life, health, dignity, respect, and family life. Consequently, these factors highlight the urgent need for intersectoral support. Experiences involving internal conflicts and limitations in coping with daily demands compromise the capacity for care and the promotion of well-being among family members. In this sense, coordinated action between the health and social assistance networks is essential; this requires continuous, planned interventions aimed at strengthening bonds, promoting autonomy, and reducing social risks.

The family conference is a therapeutic tool, a structured dialogue involving the patient, family, and care team, designed to discuss all findings from the study with the family[5]. This method facilitated the collaborative development of care strategies, strengthened bonds among those involved, and contributed to support centered on the family's needs. The results align with evidence identifying the family conference[14] as a strategy capable of integrating team actions, strengthening interdisciplinary work, fostering family members' accountability for their respective roles, and consolidating a

collaborative, comprehensive understanding of the problems and household dynamics, in accordance with UHS principles[1].

This study presents certain limitations that should be considered when interpreting the results. As this is a case study conducted with a single family in a situation of social vulnerability, the findings cannot be generalized to other contexts. Furthermore, the information obtained reflects a specific family dynamic that may change over time. It should also be noted that the application of family assessment tools relies on the participation and perceptions of family members, and the evaluation may be influenced by subjective responses and contextual factors.

Conclusion

Conducting this study proved significant, as it demonstrated that working with families relies on understanding and analyzing their structures, thereby enabling the creation of strategies tailored to each family unit through the use of appropriate tools. Applying these tools within a family-centered approach allows for a deeper understanding of the family as a whole and its operational dynamics. In this context, improvements are observed in the members' quality of life and health, alongside strengthened family bonds and clearer role definitions, all of which contribute to balanced relationships. Furthermore, the use of these tools fosters a bond between the primary care professional and the family. By offering attentive care and skilled listening, the professional gains greater acceptance to conduct assessments and interventions, promoting satisfaction among both the population served and the team involved in the process.

Authors' contributions

The authors' contributions are structured according to the (CRediT) taxonomy described below:

Research conception and design: Ellen Caroline Gonçalves de Sá; Isabela Evangelista Da Silva. Analysis, interpretation of data, and drafting of the manuscript: Ellen Caroline Gonçalves de Sá, Isabela Evangelista da Silva, Mariana Mendes Silveira Dias, Vinícius Braga Rodrigue Ellen Caroline Gonçalves de Sá; Isabela Evangelista Da Silva; Mariana Mendes Silveira Dias; Vinícius Braga Rodrigues. Resource management: Ellen Caroline Gonçalves de Sá, Isabela Evangelista da Silva, Mariana Mendes Silveira Dias, Vinícius Braga Rodrigues, Sara Antunes Rocha. Critical revision of the manuscript regarding intellectual content and final presentation: Sara Antunes Rocha. The authors approved the final version of the manuscript and accepted responsibility for all aspects of the work, including ensuring its accuracy and integrity.

Competing interests

None.

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