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ARQUIVOS DO MUDI

ARTIGO ORIGINAL

Analysis of Multidisciplinary Teams in the *Melhor em Casa* Program in the Various Regions of Brazil

Análise das Equipes Multiprofissionais no Programa Melhor em Casa nas Diversas Regiões do Brasil

Análisis de los equipos multidisciplinarios del Programa *Melhor em Casa* en las distintas regiones de Brasil

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ABSTRACT. Objective: this study aimed to analyze the operationalization and outcomes of the Melhor em Casa program in Brazil**. Methods**: a retrospective and ecological study was conducted, analyzing health data from 2011 to 2021, extracted from LocalizaSUS. The research included annual program records from all five Brazilian regions, evaluating the distribution of the Multiprofessional Home Care Teams (EMAD1, EMAD2) and the Support Team (EMAP). Descriptive statistical analysis was performed using Microsoft Excel®. **Results:** the results indicated that the Southeast region leads in EMAD1 and EMAP averages, while the Northeast region stands out in EMAD2. The highest variability was also observed in the Southeast, suggesting differences in service organization and availability. **Conclusion:** the regional disparities identified in the study highlight challenges in the equitable distribution of home care services, which may be related to the unequal allocation of resources, regional peculiarities, and socioeconomic inequalities.
Descriptors: Unified Health System; Home Care Services; Home Care**.**

RESUMO. Objetivo: este estudo teve o objetivo de analisar a operacionalização e os resultados do programa Melhor em Casa no Brasil. **Métodos:** foi conduzido um estudo retrospectivo e ecológico, com análise de dados de saúde de 2011 a 2021, extraídos do LocalizaSUS. A pesquisa incluiu registros anuais do programa em todas as cinco regiões brasileiras, avaliando a distribuição das Equipes Multiprofissionais de Atenção Domiciliar (EMAD1, EMAD2) e de Apoio (EMAP). A análise estatística descritiva foi realizada utilizando o software Microsoft Excel®. **Resultados:** os resultados indicaram que a região Sudeste lidera em médias de EMAD1 e EMAP, enquanto a região Nordeste se destaca em EMAD2. As maiores variabilidades também foram observadas no Sudeste, sugerindo diferenças na organização e disponibilidade dos serviços. **Conclusão:** as disparidades regionais evidenciadas no estudo apontam para desafios na distribuição equitativa dos serviços de assistência domiciliar, que podem estar relacionados à alocação desigual de recursos, peculiaridades regionais e desigualdades socioeconômicas.
Descritores: Sistema Único de Saúde; Serviços de assistência domiciliar; Assistência domiciliar.

RESUMEN. Objetivo: este estudio tuvo como objetivo analizar la operacionalización y los resultados del programa Melhor em Casa en Brasil. **Métodos:** se realizó un estudio retrospectivo y ecológico, con análisis de datos de salud desde 2011 hasta 2021, extraídos de LocalizaSUS. La investigación incluyó registros anuales del programa en las cinco regiones de Brasil, evaluando la distribución de los Equipos Multiprofesionales de Atención Domiciliaria (EMAD1, EMAD2) y de Apoyo (EMAP). Se realizó un análisis estadístico descriptivo utilizando el software Microsoft Excel®. **Resultados**: los resultados indicaron que la región Sudeste lidera en promedios de EMAD1 y EMAP, mientras que la región Nordeste se destaca en EMAD2. Las mayores variabilidades también se observaron en el Sudeste, lo que sugiere diferencias en la organización y disponibilidad de los servicios. **Conclusión:** El estudio evidencia disparidades regionales en la distribución de servicios de atención domiciliaria, relacionadas con la asignación desigual de recursos y desigualdades socioeconómicas.
Descriptores: Sistema Único de Salud; Servicios de asistencia domiciliaria; Atención domiciliaria.

INTRODUCTION

With the global population aging and the consequent prevalence of chronic diseases, healthcare systems have been challenged to develop effective and sustainable care models. In response to this need, the Brazilian Ministry of Health has implemented the Melhor em Casa Program, which represents an innovative response to the challenges brought by global population aging and the increasing prevalence of chronic diseases. This program, launched on November 8, 2011, was created to expand home care services within the Unified Health System (SUS)[1].

This trajectory has been shaped through various significant moments, evidenced by specific ordinances focusing on comprehensive patient care, prioritizing home care. This includes the revision of home care through Ordinance No. 963 of May 27, 2013, within the SUS, and the creation of Ordinance No. 1,208 of June 18, 2013, which then integrates the Melhor em Casa Program with the SOS Emergências Program. Additionally, Ordinance No. 825 of April 25, 2016, replaces Ordinance No. 63/GM/MS of 2013, reformulating home care to adapt to changes in the federal management of the program, including the funding of teams. This ordinance updates Home Care within SUS and improves team training[2-4].

For this latest ordinance, it is essential to characterize home care as a type of healthcare that is part of the Health Care Network (RAS), including disease prevention and treatment, rehabilitation, palliative care, and health promotion, all performed at the patient's home. Meanwhile, the home care service (SAD) is complementary to primary care and emergency services, which can replace or supplement hospital admission. The SAD manages and operates the Multiprofessional Home Care Teams (EMAD) and Support Multiprofessional Teams (EMAP), aiming to reduce the need for hospital care, shorten hospitalization times for these patients, make healthcare more humane, increase patient autonomy, deinstitutionalize care, and optimize the financial and structural resources of the RAS[4].

The mentioned services operate with diverse professional teams, each playing a specific role in patient care. First, the Family Health/Primary Care team focuses on patients in stable conditions. This team conducts monthly home visits, ensuring the maintenance of well-being and regular patient monitoring. Next, we have the EMADs, which are designated for patients with more chronic conditions, requiring more intensive and personalized care. These teams provide a broader spectrum of care, ensuring that each patient's needs are met effectively. Working alongside the EMADs are the EMAPs, which provide additional and specialized support. This support is essential for managing more complex cases, where the demand for care is continuous and requires more rigorous monitoring and follow-up. The combination of these teams forms an integrated care network, enabling more

efficient and humanized treatment, adapted to the varying needs of patients at different stages of their health conditions[1,4].

The composition of the EMAD varies according to the municipality's population size. In municipalities with more than 40,000 inhabitants, EMAD Type 1 comprises doctors, nurses, physiotherapists or social workers, and nursing assistants or technicians. The minimum required weekly workload is 40 hours for doctors and nurses, 30 hours for physiotherapists or social workers, and 120 hours for nursing assistants or technicians[4].

For municipalities with a population between 20,000 and 39,999 inhabitants, EMAD Type 2 requires a doctor with a minimum workload of 20 hours, a nurse with at least 30 hours, a physiotherapist or social worker with at least 30 hours, and nursing assistants or technicians with a total of 120 weekly hours. Additionally, the EMAP supports the EMADs and primary care teams, including Family Health Teams and Family Health Support Centers. The EMAP consists of at least three higher-education professionals, selected from various specialties, with a combined workload of at least 90 weekly hours. It is important to note that this assistance must be shared with the patient's family or designated caregiver[1].

Additionally, the Melhor em Casa program has emphasized the qualification and expansion of Home Care within SUS, including efforts to standardize information and key indicators for this healthcare service modality. The implementation of this program exemplifies how the Brazilian healthcare system is adapting to meet the needs of an aging population by prioritizing care models that are both effective and sustainable[1].

Among the essential care needs, it is important to highlight that hospital healthcare services must be efficient and carefully managed to avoid overloading the system, especially during financial constraints. This program allows patients who have received hospital care and are in a condition to continue their recovery at home to be transferred to a familiar environment. This strategy contributes to reducing hospitalization costs, presenting home care as an innovative approach aimed at deinstitutionalization and humanization of care, allowing treatment to be provided in the comfort of the patient's home. Therefore, it can be inferred that the implementation of this service represents a significant advantage for patients and their families, fostering an atmosphere of emotional and affective support[5,6].

This review aims to analyze the operationalization and outcomes of the Melhor em Casa program in Brazil, focusing on the quality of care, patient and family satisfaction, and challenges healthcare professionals face in home care. Based on a rigorous analysis of descriptive, exploratory, and analytical studies, this study will compare home care teams across different Brazilian regions

involved in the Melhor em Casa Program, thereby contributing to improving public policies and clinical practices associated with home care in Brazil.

METHODS

This is a retrospective ecological study based on health data. Data collection occurred in 2023, with information extracted from the LocalizaSUS portal through the online Melhor em Casa dashboard.

The target population for this study includes all records from the Melhor em Casa program between 2011 and 2021. The analyzed variables comprise the annual "Melhor em Casa records," considering the Multiprofessional Home Care Teams 1 and 2 (EMAD1 and EMAD2) and the EMAP within Brazil's five regions: South, Southeast, North, Northeast, and Central-West.

The inclusion criteria established were all records available in the LocalizaSUS panel, data provided by the Ministry of Health. The data were organized and processed using the R software, which was employed to perform descriptive statistical analysis.

This research was conducted using publicly accessible secondary epidemiological data, freely available on LocalizaSUS, allowing analysis and evaluation of the Melhor em Casa program records across the national territory. Therefore, it is exempt from assessment by the Research Ethics Committee, as stated in Resolution No. 510/2016 of the National Health Council.

A descriptive analysis of the dataset was conducted. Initially, the mean and standard deviation of the variables EMAD1, EMAD2, and EMAP by region were calculated. Subsequently, bar charts were created for these variables by region, as they are discrete quantitative variables, representing the count of EMAD1, EMAD2, and EMAP.

RESULTS

Table 1 shows that, on average, the Southeast region presents the highest level of EMAD1, whereas the North region has the lowest average level of the EMAD1 variable. The Southeast region also exhibits the highest standard deviations, indicating more significant variability around the mean associated with this region.

Table 1. Means and standard deviations of the EMAD1 variable by region.

Regions	EMAD1	
	Mean	Standard deviation
South	28.00	10.53
Southeast	96.50	84.48
North	10.71	13.11
Northeast	24.00	17.27
Central-West	16.75	11.32

Unlike EMAD1, it is observed that, on average, the Northeast region presents the highest level of EMAD2 (Table 2). However, the Southeast region shows the highest standard deviation, indicating more significant variability around the mean associated with this region.

Table 2. Means and standard deviations of the EMAD2 variable by region.

Regions	EMAD2	
	Mean	Standard deviation
South	6.00	2.65
Southeast	11.00	11.01
North	1.29	3.40
Northeast	14.00	10.51
Central-West	5.75	8.26

Like the EMAD1 variable, the EMAP variable presents the highest average level in the Southeast region. The lowest level is associated with the North region (Table 3). Regarding the standard deviation, there is also more significant variability around the mean in the Southeast region.

Table 3. Means and standard deviations of the EMAP variable by region.

Regions	EMAP	
	Mean	Standard deviation
South	11.00	3.46
Southeast	51.75	38.32
North	7.28	12.80
Northeast	27.00	18.03
Central-West	15.00	16.15

The figure 1 shows that the Southeast region has the highest frequency of EMAD1, while the Central-West region has the lowest. For EMAD2, the Northeast region exhibits the highest frequency, whereas the North region has the lowest. Lastly, the Northeast region has the highest frequency for EMAP, while the South region has the lowest.

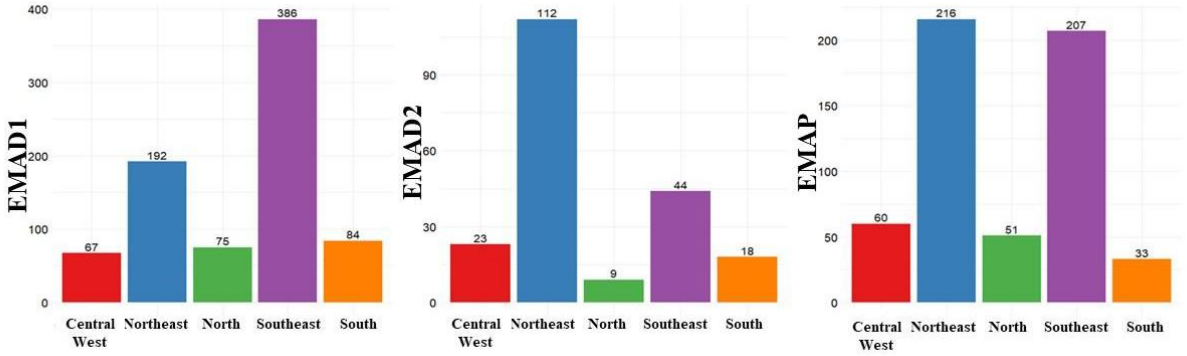

Figure 1. Bar chart of the EMAD1, EMAD2 and EMAP variable by region.

DISCUSSION

The findings of this study indicate a heterogeneous distribution of home care teams (EMAD1, EMAD2, and EMAP) across different regions of Brazil. It was observed that the Southeast region had the highest average levels of EMAD1 and EMAP, along with the highest standard deviations, suggesting more significant variability in the distribution of these teams within the region itself. In contrast, the North region recorded the lowest average levels of these variables, which may indicate lower coverage of this service. Regarding EMAD2, the highest average was found in the Northeast region, while the highest standard deviation remained in the Southeast, highlighting variations within that locality. Regarding team frequency, the highest presence of EMAD1 was observed in the Southeast, while the Central-West region had the lowest frequency. For EMAD2 and EMAP, the highest concentration was identified in the Northeast, with the lowest values observed in the North and South regions, respectively.

The Melhor em Casa Program represents a fundamental strategy to expand access to home care in Brazil. It supports patients with difficulty traveling to healthcare facilities due to medical conditions, advanced age, or other limitations. Additionally, this care model has proven to efficiently reduce costs associated with prolonged hospitalizations, promoting more humanized and effective healthcare[5]. However, the distribution of program teams is not homogeneous across the national territory, reflecting structural and regional inequalities that affect access to this type of service.

The results of this study revealed that the EMAD1 is more prevalent in the Southeast region, while the EMAD2 and EMAP are more concentrated in the Northeast region. This pattern may be explained by the broader distribution of outpatient home care services in these regions, allowing for a wider reach across states. These findings align with research by Rajão and Martins[7], which identified that the Northeast and Southeast regions led in home hospitalizations, as more than half of

healthcare procedures were performed and distributed in these areas. Similarly, Silva et al.[8] found that the Southeast region stood out in providing home care throughout Brazil, reinforcing the centralization of investments and healthcare infrastructure in this locality.

On the other hand, it was observed that the North region had the lowest levels of EMAD1 and EMAD2, while the South region had the lowest score for EMAP. These results may be associated with socioeconomic and structural factors limiting home care services expansion in these areas. According to Procópio et al.[9], the organization of healthcare services often considers the characteristics of the population served and their living context, which can result in significant regional variations in resource allocation. Additionally, disparities in team distribution may be attributed to differences in access to medical equipment and technology, availability of qualified professionals, transportation infrastructure, and public health investments[7,10].

The analysis of results highlights that, despite advances in strengthening home care policies, significant challenges remain in ensuring equitable distribution of services across Brazil. Although strategies have been implemented to expand and improve home care, such as funding and coverage expansion negotiations, regional inequalities remain an obstacle to implementing the Melhor em Casa Program[9(9)]. Therefore, it is essential to formulate public policies prioritizing historically underserved regions, promoting more significant equity in this type of care.

This study presents some limitations that should be considered. Firstly, it is based on secondary data analysis, which may limit the level of detail in some aspects, such as the quality of services provided and user experience. Furthermore, heterogeneity in data collection and recording across different regions may influence the accuracy of the analyses. Another limitation is the absence of variables that could deepen the understanding of the factors determining inequality in team distribution, such as socioeconomic and infrastructure indicators. Future studies may address these issues with more comprehensive qualitative and quantitative methodologies, allowing for a more detailed evaluation of home care's impact on the Brazilian population's health.

CONCLUSION

It is concluded that significant geographical disparities in access to home care across all regions of Brazil may be linked to the uneven distribution of services, regional particularities, persistent socioeconomic inequalities, and insufficient public investment. These factors highlight the need to improve the Melhor em Casa Program through a comprehensive approach that includes strengthening as a public policy, structural investments, continuous training of managers and healthcare professionals, and practical strategies to promote equitable access to services.

The SUS plays a crucial role in reducing these inequalities; however, structural and operational challenges still persist. Therefore, continuous monitoring of health indicators and implementing targeted measures for the most vulnerable regions is essential to optimize the coverage and quality of home care in the country, ensuring a fairer and more efficient healthcare system.

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