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The Better at Home Program in Teresina: an analysis of the agreement between practice and regulations in home care.

The Melhor em Casa Program in Teresina: an analysis of the agreement between practice and regulations in home care

Kézia Magna Martins Costa
Federal University of Piauí
keziacosta@ufpi.edu.br

Iracilda Alves Braga,
Federal University of Piauí
iracildabraga@ufpi.edu.br

Summary

The expansion of home care within the Brazilian Unified Health System (SUS) has been presented as a strategy to improve the quality of care and reduce hospital demand; however, questions persist regarding the adequacy between the normative design of public policies and their implementation in the territories.
In this context, the present study aimed to evaluate the agreement between the regulations of the Better at Home Program and the configuration of the Home Care Service teams in the municipality of Teresina, Piauí. This is an evaluative, documentary and quantitative research, based on implementation evaluation, using secondary data from DATASUS, the National Registry of Health Establishments and population estimates from IBGE, for the period from 2014 to 2024. The analysis considered the proportion between the number of teams implemented and the population contingent, as well as the professional composition and workload of the EMAD and EMAP teams in relation to the current normative parameters. The results indicate that, although the teams meet the minimum requirements for composition and workload established in the ministerial ordinances, the expansion of the program in the municipality occurred slowly and did not keep pace with population growth, which highlights a deficit in healthcare coverage.

It is concluded that formal regulatory compliance does not, in itself, guarantee sufficient institutional capacity to meet local demands, indicating the need for a more in-depth evaluation of...
Implementation of home-based care in large urban settings.
Keywords: evaluation. Better at Home Program. Home care.

Abstract

The expansion of home care within the Brazilian Unified Health System (SUS) has been presented as a strategy to improve care and reduce hospital demand; However, questions persist regarding the adequacy between the normative design of public policies and their implementation in the territories.
In this context, the present study aimed to evaluate the agreement between the Better in Home Program regulations and the configuration of the Home Care Service teams in the municipality of Teresina, Piauí. This is an evaluative, documentary, and quantitative study, based on implementation evaluation, using secondary data from DATASUS, the National Registry of Health Establishments, and population estimates from IBGE, for the period from 2014 to 2024. The analysis considered the ratio of implemented teams to the population contingent, as well as the professional composition and workload of the EMAD and EMAP teams relative to the current normative parameters. The results indicate that although the teams meet the minimum composition and workload requirements established in ministerial regulations, the program's expansion in the municipality progressed slowly and did not keep pace with population growth, highlighting a deficit in healthcare coverage. It is concluded that formal regulatory compliance alone does not guarantee sufficient institutional capacity to meet local demands, indicating the need for further evaluation of the implementation of home-based care in large urban contexts.

Keywords: assessment. Better in Home Program. Homecare.

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1. Introduction

In Brazil, home-based care has become a relevant strategy within the Unified Health System (SUS), especially given the need to reorganize the...
healthcare services, due to the reduction in hospital admissions, due to resource costs.
human, financial and material needs, and the expansion of continuity of healthcare. In this
In this context, the Better at Home Program is configured as a strategy within the scope of policies.
public services, focused on providing multidisciplinary care at home, linked to the Care Networks.
Health-related and guided by federal regulations.

Based on this, the present article consists of an evaluation of the Better at Home Program.
in Teresina, Piauí. The purpose of the study is to evaluate the PMeC's compliance with the regulations that
they govern. To that end, a survey of academic and scientific publications was conducted in databases.
of selected data and data collection from national health information databases.

The guiding question of the study is: the quantity and composition of the care teams.
Home care providers that operate the Better at Home Program in Teresina/PI are in accordance with the
What are the program's regulations? The relevance of this study is based on the need to understand...
To what extent does the local implementation of the program meet the institutional requirements set out in
federal regulations, especially in a municipality with a large population and significant importance.
regional healthcare services.

The overall objective of this study is to evaluate the agreement between the regulations that
They regulate the Better at Home Program and the configuration of the Care Service teams.
Home care in the municipality of Teresina, Piauí, considering the proportion of teams deployed, its
professional composition and working hours in relation to the parameters established by
current ministerial decrees.

Regarding the specific objectives, these correspond to identifying the quantity of
multidisciplinary home care teams (EMAD) and support teams (EMAP) deployed in
In the municipality of Teresina, from 2014 to 2024, verify the adequacy between the number of teams.
implemented and the population size of the municipality, according to the normative criteria of
The Better at Home Program and, finally, an analysis of the professional composition of the EMAD and EMAP teams.
Based on data recorded in the National Registry of Health Establishments (CNES); Examine
the weekly workload of the professionals who are part of the teams, comparing it with the requirements
minimum requirements defined in the regulations for Home Care Services.

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2. Theoretical Framework / Results

Based on observation of the public policy cycle, the intended evaluation is associated to the implementation stage, which, according to Jannuzzi (2011, p. 262), refers to the stage in which the public policy begins to be implemented and the allocated resources begin to translate into "Actions capable of acting and changing a certain reality." By definition, the evaluation of implementation or objective process evaluation:

> [...] to assess whether the policy is implemented according to its design, identifying whether the links between inputs, processes and outputs are consistent with expectations or whether they can be improved (BRAZIL, 2018, p. 157).

In this context, based on the approach of Figueiredo and Figueiredo (1986, pp. 110-111), the The evaluation is based on measuring effectiveness: "whether the program is being (or was) implemented effectively." in accordance with the guidelines designed for its implementation and whether its product will achieve (or has achieved) the "Desired goals." Specifically, the aim is to observe whether the teams in the Care Service are achieving their goals. Home-based programs, through the Better at Home Program in Teresina/PI, were implemented in accordance with in accordance with the provisions of Ordinances No. 825, of April 25, 2016, and No. GM/MS No. 3,005, of January 2, 2024, regarding the composition and proportion in relation to the municipality's population.

This objective can be related to instrumental motivation and the criterion of functional effectiveness. outlined by Figueiredo and Figueiredo, as the study aims to "assess whether the means and methodology of The implementation of the program is being carried out in accordance with the previously established strategies. defined" (FIGUEIREDO AND FIGUEIREDO, 1986, p. 112). Thus, the aim is to verify if the quantity of teams deployed between 2014, the year the first team began its activities, and 2024, The year this study began corresponded to the population size of the municipality of Teresina/PI.

According to Ordinance No. 983, of May 27, 2013, home care is "characterized by a set of actions for health promotion, disease prevention and treatment, and rehabilitation. Services provided at home, with guaranteed continuity of care and integrated into healthcare networks. health" (BRAZIL, 2013). Therefore, it is possible to infer that home care encompasses conception of a cross-cutting service integrated into the Health Care Networks (RAS), which offers Actions to care for the health and well-being of users who need more accessible resources. to daily life, allowing care to be provided in the home environment, which promotes Maintaining ties with the socio-familial network promotes greater humanization of care.

According to Procópio et al. (2019, p. 593), the growth of this mode of healthcare is a way to "meet the need for economic viability and sustainability of systems of health, as well as the search for a care proposal that promotes greater well-being for users and to their families, reducing health inequities." Even with the establishment of objectives

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While efforts aimed at improving comprehensive healthcare cannot overlook the challenge of implementation and maintenance of home care as a component of public health, because "[...] its supply remains insufficient to meet the country's needs, and it is vulnerable to changes in government and economic priorities" (PROCÓPIO, 2019, p. 593).

To operationalize home care, the Home Care Service (SAD) acts as a "substitute or complementary to hospital admission or outpatient care, responsible for management and operation of Multidisciplinary Home Care Teams (EMAD) and Multiprofessional Support Teams (EMAP)" (BRAZIL, 2013). The objectives of SADs are:

> Reduction in demand for hospital care; reduction in the length of stay for hospitalized users; humanization of health care, with increased user autonomy; deinstitutionalization and optimization of the financial and structural resources of the RAS (BRAZIL, 2024).

It is important to mention that the implementation of the SAD was planned through integration between the Ministry of Health, State Health Departments, Municipal Health Departments and the Federal District. Responsibilities are described in Ordinance GM/MS No. 3,005, of January 2nd. of 2024, which presents crucial points for the implementation of home care. Among them, it is worth mentioning... to highlight the guarantee of the composition of the SAD/PMeC assistance team, as a responsibility at the municipal level; the qualification of the teams at the state level; and the transfer of the incentive. financial support to municipalities, in order to enable the contribution to SAD/PMeC (BRAZIL, 2024).

As a strategy to boost the Home Care Service, the Ministry of Health implemented the Program Better at Home. According to the Ministry of Health, the target audience for the program consists of "People of all ages and with different health problems can receive this care in "Home, including those who need frequent, daily, and specialized care to treat various conditions" (MINISTRY OF HEALTH, 2024). Adherence to the program occurs in a way... tripartite, agreed upon between the three levels of government and, at the federal level, the intermediary is the Ministry of Health (Brazil, 2024).

This integration also includes the evaluation and monitoring of SAD/PMeC, having as a reference the indicators proposed in the 'Monitoring and Evaluation Manual: Program'. Better at Home' (BRAZIL, 2024). User information necessary for monitoring. and evaluation of the PMeC are recorded in the e-SUS Home Care module, connected to e-SUS. Primary Care. The objective of this system is to "improve the quality of information recording, enabling its "It allows for faster implementation with less data loss, as well as assisting in the management and regulation of care and integration with other services in the healthcare network" (MINISTRY OF HEALTH, 2016).

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The minimum team composition is defined in the legal framework governing their operation.
from SAD/PMeC:

> Article 17. The EMAD (Home Care Team) shall have the following minimum composition: I - EMAD Type 1: a) medical professional(s) with a total weekly workload (CHS) of at least 40 (forty) hours of work per team; b) nursing professional(s) with a total CHS of at least 40 (forty) hours of work per team; c) physiotherapist(s) or social worker(s) with a total CHS of at least 30 (thirty) hours of work per team; d) auxiliary or technical nursing professionals, with a total CHS of at least 120 (one hundred and twenty) hours of work per team; Article 18. The EMAP (Home Care Team) shall have a minimum composition of 3 (three) professionals with higher education, chosen from the occupations listed below, whose total CHS of its members shall be at least 90 (ninety) hours of work: I - social worker; II - physiotherapist; III - speech therapist; IV - nutritionist; V - dentist; VI - psychologist; VII - pharmacist; or VIII - occupational therapist. Sole paragraph. No professional comprising the EMAP may have a workload of less than 20 (twenty) hours (BRAZIL, 2016).

In Teresina, the SAD/PMeC teams are in compliance with the minimum composition.
established in the ordinance. Multiprofessional care enables comprehensive health care for users.
and enables differentiated, yet coordinated, actions to meet their demands, contributing
also for the observance of their unique characteristics.

It should be emphasized that, in order to accurately state that home care provided by
The work done by EMADs and EMAP in Teresina is falling short of what was planned; it is essential to carry out a...
A study that gathers other data, especially local data and data with restricted access to managers and professionals. Without
After a thorough investigation of this data, the assertion is that the records published in the systems of
Open access disagrees with the SAD/PMeC regulations.

2. Material and Method

In order to highlight the importance of studying the Better at Home Program, it was
A literature review was conducted between November and December 2024, using the following databases.
Data sources: Brazilian Digital Library of Theses and Dissertations (BDTD), Virtual Health Library
(BVS) and Catalog of Theses and Dissertations of the Coordination for the Improvement of Higher Education Personnel
Superior (CAPES).

The survey prioritized studies that focus on the evaluation of
The functioning, implementation, or results of home care within the SUS (Brazilian Public Health System). In each database
The descriptors used were "evaluation" and "better at home," in quotation marks. It was observed...
The following elements: type of production, broad area of knowledge, theme, and general objective.

In the BDTD (https://bdtd.ibict.br/vufind/), the search returned 40 results and, after reading
After a floating study to identify the chosen elements, 15 studies remained. In the BVS
(https://brasil.bvs.br/), on the theses and dissertations page, after searching with the descriptors, it was
The complete library collection was chosen, which generated 20 results; after reading, 8 remained.

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productions. Finally, in the CAPES catalog (https://catalogodeteses.capes.gov.br/catalogo-(theses/#!/), the search returned 20 results and, after searching for those that emphasize evaluation, Four studies remained. After characterizing the 27 studies, eight productions were selected that... They emphasized the evaluation of the sociopolitical factors of the Better at Home Program.

It has been observed that studies on PMeC have gained traction in various areas of... knowledge. Furthermore, it was considered important to analyze the composition of the teams, as this factor It also directly impacts agreement with what is being done, with the objectives of SAD/PMeC, related and discussed in the next section.

In order to achieve the proposed objectives, data obtained from the Department of Informatics of the Unified Health System (DATASUS), relating to the health teams of Piauí, were analyzed. Specifically, EMAD Types I and II and EMAP. –, crossed with the number of inhabitants of Municipality of Teresina/PI, obtained from the Brazilian Institute of Geography and Statistics (IBGE). Furthermore, consultations were carried out in the National Registry of Health Establishments (CNES). to analyze information about the teams at the reference establishments.

3. Results and Discussion

3.1 The Better at Home Program as an Object of Study in the Selected Productions

Of the 27 selected works, 24 studies (89%) were developed in the broad area. of Health Sciences, 2 (7%) in Applied Social Sciences and 1 (4%) in Human Sciences, as This can be seen in Table 1.

Table 1. Broad area of knowledge / number of selected works. Absolute value: abs.

Broad area of knowledge	Abs	%
Primary section title	24	89
Secondary section title	5	7
Quaternary section title	1	4
TOTAL	27	100

Source: Prepared by the author based on data from selected databases.

Observing Table 1, it can be inferred that the concentration of studies in the Health Sciences This reveals opportunities for integrated and multidimensional approaches to the program. Furthermore, the Table 2 presents the topics covered: service, program or policy evaluation (30%), aspect clinical (22%), professional work (15%), caregiver (11%), user perception (11%), production scientific (7%) and health education (4%).

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Table 2. Topics covered. Absolute value: abs.

Themes	Abs	%
Evaluation of a service, program, or policy.	8	30
Clinical aspect		22
Professional work		15
Caregiver		11
User perception		11
Scientific production		7
Health education		4
TOTAL	6	100

4 3 3 2 1 27 Source: Prepared by the author based on data from selected databases.

The fact that the largest number of studies are on the evaluation of home care, whether they are Regarding the service, program, or policy, it demonstrates that there is a focus on evaluative actions. and analytical, such as impact measurement, validation of practices, and also management practices.

It became relevant to characterize, albeit briefly, the eight studies that evaluated the home care in Brazil, and thus make it worthwhile to study the composition of AD teams in Teresina/PI. There is no intention here to exhaust the investigations on this aspect. but rather to contribute to filling a knowledge gap and encouraging further studies.

Oliveira Neto's dissertation (2016, p. 21) analyzed the implementation of PMeC in municipalities. Brazilians and sought to "understand it from the perspective of municipal health managers." Among the Among the variables analyzed, the author examined the type and quantity of EMADs and EMAPs by region, state, and... The municipality's "competence in implementing the teams" was assessed according to the CNES (National Registry of Health Establishments), and, regarding the municipalities, the Human Development Index (HDI) and the coverage of the Health Strategy were observed. Family Health Strategy (ESF) and the population size of municipalities in specific ranges (OLIVEIRA NETO, 2016, p. 53).

In order to evaluate home care on a specific territorial basis, Almeida (2019) The objective was to analyze the SAD/PMeC, focusing on pediatric care in Sobral, Ceará. The data The data were collected through questionnaires and interviews with professionals (manager, healthcare professionals working in home care, and caregivers). It is interesting to mention that Almeida analyzed the composition of the teams, comparing it with what is established in Ordinance No. 825. Related to this study, Nascimento et al. (2022, p. 2) presented an “evaluation of the structure-process-outcome triad defined in Donabedian's theoretical-methodological framework”, considering “only the data and the "analyses relating to the process dimension".

Silva (2022) sought to “evaluate the National Home Care Policy with regard to time Average length of stay per patient/day in the emergency and urgent care network in Pernambuco between 2013 and 2016”. Using the “econometric method of synthetic control, developed by Abadie and Gardeazabal through the construction of a counterfactual” (SILVA, 2022, p. 33), the author analyzed

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Factors such as the home care services enabled and implemented in Pernambuco, the potential of the program to alleviate the overload on emergency and urgent care facilities, the coverage population size, the origin of the users, among other factors.

Furthermore, Rodrigues (2013) evaluated the PMeC referenced to the Monsenhor Walfredo Hospital. Gurgel (Natal/RN), with the aim of "understanding how the actions implemented by the hospital "They effectively promote the benefits of SAD/PMeC" (RODRIGUES, 2013, p. 18). According to The author's research focused on "a formative or process evaluation of the public policy of home care and... "It prioritizes the aspect of effectiveness" (RODRIGUES, 2013, p. 80) and, to develop it, carried out an analysis. from health data and interviews with coordinators, sub-coordinators and professionals from EMAD, from EMAP and the bed management unit of the hospital complex.

Databases, such as the Hospital Information System of the Unified Health System. (SIH/SUS) are significant sources for knowledge building. Related to this fact, Bogado (2022) conducted a quantitative study on the aforementioned database, delimiting the period from 2008 to 2019, with the objective of "analyzing home hospitalizations within the SUS (Brazilian Public Health System) during this period and correlating them- along with the cost of hospitalization, clinical and epidemiological variables" (BOGADO, 2022).

Using the same system – SIH/SUS –, Nishimura, Carrara and Freitas (2019, p. 3) They developed their research with the goal of "verifying if the Better at Home program succeeds." "Reduce spending on hospitalizations." Using a regression discontinuity design, the The authors used the following covariates or control variables: "age and expenses related to patients in the unit." "intensive care."

Finally, we present the article by Pozzoli (2013, 157), which discussed the legal nature of primary and home care services, analyzed "the proposal of the Better at Home Project of The Ministry of Health, as a model for Brazilian home care, reflected on how these... Services can promote the mental health of the elderly and their caregivers." The author's discussion addresses the National Primary Care Policy, National Health Policy for the Elderly, Health Program of Family – currently, the Family Health Strategy –, the Community Health Agents Program and the Family Health Support Centers and achieves the implementation of the Better at Home Program in Brazil.

3.2 The Better at Home Program as an Object of Study in the Selected Productions

Based on the 2022 Census from the Brazilian Institute of Geography and Statistics (IBGE), the The resident population of Teresina/PI was 866,300 people, with an estimated population for 2024 of 902,644 people (IBGE, 2022). According to the 2010 Census, the municipality's population was 814,439.

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people (IBGE, 2010), with an estimated 840,600 for 2014 (IBGE, 2014). These references serve as a basis for discussing the implementation of home care teams according to the contingent population of the municipality.

According to Ordinance GM/MS No. 3,005, of January 2, 2024:

> 1. Municipalities with a population exceeding 200,000 (two hundred thousand) inhabitants may request an increase in the number of additional EMAD teams, modifying the ratio from one for every 100,000 (one hundred thousand) inhabitants to one for every 80,000 (eighty thousand) inhabitants, provided that all teams already in operation have achieved the following indicators in the 12 (twelve) months prior to the request:
>
> I - Average number of patients per EMAD type I greater than or equal to 50 (fifty);
> II - Monthly increase in SAD greater than or equal to 25% (twenty-five percent);
> III - Hospital origin greater than or equal to 70% (seventy percent); and
> IV - Registration of teams in the CNES and feeding of data into SISAB, without suspension in the previous 12 (twelve) months.
>
> § 2 The proportion referred to in § 1 may be reduced again, upon request, to one for every 64,000 (sixty-four thousand) eligible individuals, if the indicators listed in the paragraphs of § 1 are previously met by all active teams, after one year from the approval of the first increase in teams.
>
> § 3 In municipalities with a population size that allows for the implementation of more than one EMAD, the organization of the SAD/PMeC is permitted to structure it through differentiated arrangements composed of specialized EMADs, responsible for the care of patients with specific characteristics, such as pediatric care, orthopedic care, palliative care, mechanical ventilation, among others, according to the care needs of the territory (BRAZIL, 2024).

According to the data collected in the DATASUS tabulator, the first Team The multidisciplinary home care program implemented in Teresina refers to the year 2014. The team It was activated, with the Teresina Emergency Unit Prof. Zenon as the reference facility. Rocha - HUT (CNES: 5828856), under the name HUT EMAD and with the National Team Identifier (INE) No. 0001551809.

In news released by the Municipal Health Foundation (FMS/TERESINA), the EMAD of HUT had an average of 60 patients treated at home (FMS, 2021). This fact may have This has driven the deployment of an additional EMAD and the first EMAP in the capital, which, However, this only occurred in 2024. The teams mentioned are linked to the Getúlio Vargas Hospital. (CNES: 2726971), with the names EMAD HGV (INE: 0002494132) and EMAP HGV (INE: 0002494140).

The period between the activation of the first EMAD and the activation of the additional EMAD and EMAP, When related to the population of Teresina, it raises concerns regarding... compromising the efficiency of the municipal health system and the possibility of exacerbating social inequalities, especially with regard to home care.

Given that the present study aims to evaluate the adequacy of what is being done to which is foreseen in the legal framework of the program, it becomes important to “simulate the suitability between the proposed means and ends, taking into account the organizational and social conditions in which the program is implemented.

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being implemented" (FIGUEIREDO AND FIGUEIREDO, 1986, p. 112). For this purpose, it will be
The ideal number of SAD/PMeC teams in Teresina was calculated using population figures.
estimated for 2014 and 2024, based on a population of 80,000, as established in
first paragraph of Article 559 of Ordinance GM/MS No. 3,005.

Calculating the estimated population for 2014 (840,600 people) and dividing by 80,000, we obtain-
I understand that the ideal number of teams, following this logic, is 10.51 teams. This means that with
With only one team, the ratio of deployed teams to the ideal number is 9.52%. There are,
Thus, there is a large gap between the number of teams deployed and the number needed to meet the demand.
appropriately the population considered.

Regarding the population estimate for 2024, 902,644 people, if the same calculation is done.
With a quantity of 80,000, we obtain the number of 11,283.05 teams. Therefore, we obtain...
The proportion of approximately 26.5% of the deployed teams in relation to the ideal number. The deficit
The ratio between the number of teams and the number of inhabitants can generate negative repercussions in
health coverage for the population using the program, as well as the burden on the workers who...
They provide home care services.

However, this calculation does not highlight other nuances of team qualification.
SAD/PMeC in the municipality, such as the average number of patients per type I EMAD being greater than or equal
to 50 and the monthly discharge rate from SAD being greater than or equal to 25%. It is also necessary
to assess the hospital origin of the users, which must be greater than or equal to 70%, as well as the registration.
of the teams in the CNES and the feeding of the Health Information System for Primary Care
(SISAB), and teams cannot be suspended for 12 months (BRAZIL, 2024). Furthermore, another
The point to be evaluated is that the regulation leaves it "optional for the organization of the SAD/PMeC to start from
differentiated arrangements composed by specialized EMAD" (BRAZIL, 2024).

Another important element is the composition of the teams. Produced based on the information
From the National Registry of Health Establishments, tables 3, 4, and 5 present the organization of
home care teams in relation to the occupations performed and their working hours, elements
highlighted in the SAD/PMeC regulations:

Table 3. HUT EMAD Team (INE: 0001551809). Workload: CH.

	Hospital CH	Outpatient CH	Other CH
General Practitioner 1	0 40 0		
General Practitioner 2	20	40	0
Nurse 1	10	40	0
Nurse 2	10	20	0
Physiotherapist	10	30	0
Nursing Technician 1	10	30	0
Nursing Technician 2	10	30	0

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Nursing	30	30	0
Technician 3 Nursing	Not informed	Not informed	Not informed
Technician 4			

Source: National Registry of Health Establishments, July 2025.

Table 4. EMAD HGV Team (INE 0002494132). Workload: CH.

Hospital Care	Occupations	Outpatient Care	Other
General Practitioner	1	0	40 0
Intensive care physician	1	20	40 0
Nurse	1	10	40 0
Nurse	2	10	20 0
Physiotherapist	10	30	0
Social worker	10	30	0
Technician	10	30	0
nursing	1		

Source: National Registry of Health Establishments, July 2025.

Table 5. EMAP HGV Team (INE 0002494140). Workload: CH.

Hospital Care	Occupations	Outpatient Care	Other
Nutritionist	30	0	0
Clinical psychologist	30	0	0
General Speech Therapist	40	0	0

Source: National Registry of Health Establishments, July 2025.

The minimum team composition is defined in the legal framework governing their operation. from SAD/PMeC:

> Article 17. The EMAD (Home Care Team) shall have the following minimum composition: I - EMAD Type 1: a) medical professional(s) with a total weekly workload (CHS) of at least 40 (forty) hours of work per team; b) nursing professional(s) with a total CHS of at least 40 (forty) hours of work per team; c) physiotherapist(s) or social worker(s) with a total CHS of at least 30 (thirty) hours of work per team; d) auxiliary or technical nursing professionals, with a total CHS of at least 120 (one hundred and twenty) hours of work per team; Article 18. The EMAP (Home Care Team) shall have a minimum composition of 3 (three) professionals with higher education, chosen from the occupations listed below, whose total CHS of its members shall be at least 90 (ninety) hours of work: I - social worker; II - physiotherapist; III - speech therapist; IV - nutritionist; V - dentist; VI - psychologist; VII - pharmacist; or VIII - occupational therapist. Sole paragraph. No professional comprising the EMAP may have a workload of less than 20 (twenty) hours (BRAZIL, 2016).

In Teresina, the SAD/PMeC teams analyzed show agreement with the minimum composition and with the workload parameters established in the regulations that They regulate the program, indicating formal compliance with the professional structure required for the How the service works.

The presence of different professional categories in the EMAD and EMAP teams promotes Multiprofessional and interdisciplinary action is an essential factor for the effective implementation of home care as a comprehensive care strategy within the Unified Health System (SUS).

This configuration enables the development of coordinated care actions, aimed not only at treatment of clinical conditions, but also to the promotion of user autonomy and continuity.

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of care and consideration of the specific social and family circumstances present in the home environment.

However, the observed compliance with the normative criteria does not, in itself, allow... only, to affirm that the home care provided fully achieves the objectives foreseen in the design. from the Better at Home Program. The analysis of work hours and professional composition reveals Structural adequacy, but it does not consider dimensions related to the dynamics of the work process. to the territorial distribution of demand, the intensity of monitoring carried out, or the conditions concrete details of how the activities will be carried out by the teams.

In this sense, to more accurately assess the service's care capacity and its... Given the impacts on coverage and quality of care, the incorporation of data becomes necessary. local and institutional spaces with restricted access, especially those linked to municipal management, to care monitoring and the organization of user flow. Thus, in light of the information available in public systems, it can be concluded that there is a formal correspondence between the composition of teams and current regulations, even though analytical limitations remain regarding the verification of Practical effectiveness of home care in the municipality.

Final Considerations

The work consisted of evaluating the functional effectiveness of the Better at Home Program in The municipality of Teresina/PI aimed to verify the PMeC's compliance with regulations. that govern it. The implementation periods of the EMAD and EMAP teams were analyzed in municipality, as well as the composition of these teams and the conformity of working hours. professionals with the program's regulations. To that end, an indicator was developed to measure the "Ideal number of SAD/PMeC teams in Teresina."

Prior to that, a literature review was conducted in the Brazilian Digital Library of Theses and Dissertations (BDTD), in the Virtual Health Library (BVS) and in the Theses and Dissertations Catalog from the Coordination for the Improvement of Higher Education Personnel (CAPES), prioritizing studies that focus on evaluating some aspect of the program. Twenty-seven studies were selected and The areas of knowledge and topics covered were analyzed. In addition, 8 studies were analyzed. which focused on the sociopolitical factors of the program.

Regarding the intended evaluation, it is stated that it revealed that the expansion of the Better Program The implementation of housing in Teresina, between 2014 and 2024, was slow and did not keep pace with growth. population. In 2021, the average number of patients treated by EMAD HUT was already 60, exceeding The minimum requirement was 50 per team. Even so, the expansion only occurred three years later. suggesting a disconnect between local needs and political and administrative responses. Such

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This could compromise the efficiency of the municipal health system and exacerbate social inequalities.

especially in the context of home care.

Therefore, as a recommendation based on evaluation, it is suggested to develop studies.

evaluative tools with restricted and local access data, to assess whether the number of SAD/PMeC teams

In Teresina, it is capable of providing comprehensive care to users and their needs. Furthermore, with the

In order to understand the agreements established between professionals, teams, and management, it is recommended...

investigate local records to verify the consistency between regulations and practice, which

It enables the full continuity of home care.

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