Multidisciplinary Home Care Team: history of the license in a Municipality of São Paulo

Equipe Multiprofissional de Atenção Domiciliar: histórico da habilitação em um Município de São Paulo

Equipo Multidisciplinario de Atención Domiciliaria: historia de su autorización en un Municipio de São Paulo

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RESUMO

Objetivo: analisar uma implantação de EMAD em um Município do Estado de São Paulo, Brasil. **Método:** estudo qualitativo de análise documental. Leitura flutuante foi mais efetiva pelo site do Ministério da Saúde com maior número de portarias encontradas, do que no site do Governo do Estado. **Resultados:** Em 2012 teve a mobilização de gestores para implantação de dois EMADs, com autorização cedida em 2013 para sua habilitação, no entanto apenas uma foi implantada. A partir de 2014 teve um crescimento gradual no atendimento domiciliar, de 124 para 759 pessoas em 2019. **Considerações Finais**: Nota-se boa articulação do gestor no Município estudado, com mais profissionais, equipamentos e estrutura para atender a todos com necessidades específicas em casa.

Descritores: Serviços de Assistência Domiciliar; Atenção Domiciliar; Equipe Multiprofissional de Atenção Domiciliar

ABSTRACT

Objective: to analyze an EMAD implementation in a Municipality in the State of São Paulo, Brazil. **Method:** Qualitative study of document analysis. Floating reading was more effective on the Ministry of Health website, with a greater number of ordinances found, than on the State Government website. **Results:** In 2012, managers were mobilized to implement two EMADs, with authorization granted in 2013 for their qualification, however only one was implemented. From 2014 onwards, there was a gradual increase in home care, from 124 to 759 people in 2019. **Final Considerations:** there was good articulation from the manager in the Municipality studied, with more professionals, equipment and structure to serve everyone with specific needs at home.

Descriptors: Home Care Services; Home Health Aides; Patient Care Team.

RESUMEN

Objetivo: analizar una implementación del EMAD en un Municipio del Estado de São Paulo, Brasil. **Método:** estudio cualitativo del análisis de documentos. La lectura flotante fue más efectiva en la página web del Ministerio de Salud, encontrándose un mayor número de ordenanzas, que en la página web del Gobierno del Estado. **Resultados:** En 2012, los directivos fueron movilizados para implementar dos EMAD, y en 2013 se les concedió autorización para su calificación, pero solo se implementó uno. A partir de 2014, hubo un aumento paulatino de la atención domiciliaria, de 124 a 759 personas en 2019. **Consideraciones Finales**: hubo buena articulación de la gestora en el Municipio estudiado, con más profesionales, equipamiento y estructura para atender a todas las personas con necesidades específicas en el hogar.

Descriptores: Servicios de Atención Domiciliaria; Atención Domiciliaria; Equipo Multidisciplinario de Atención Domiciliaria.

ORIGINAL

Introduction

It is a fact that Brazil, as well as the world, has experienced many changes in recent years that forced managers and governors to idealize transformations that could accompany this new scenario. Among the transformations, one of great importance was the reorganization of public health policies, including Home Care (HC).

HC is a form of health care, substituting or complementary to hospital care, which involves health promotion actions, prevention and treatment of diseases, as well as rehabilitation of individuals in the home environment, with a guarantee of continuity of care and integrated into health care networks. In this way, it enables dehospitalization for chronic, clinically stable patients who need to maintain a multidisciplinary follow-up. In order for this practice to occur with humanization, a good hospital discharge strategy is necessary.[1-3]

It is a public policy of the Unified Health System (SUS) and, therefore, must maintain universality, equity, comprehensiveness, resolvability and expansion of access. In this sense, the Home Care Service (SAD) must guarantee these concepts together with the reception and humanization of individuals with the indication of care in this environment, the home.[4]

On the other hand, there is an increase in Chronic Non-Communicable Diseases (NCDs), directly related to population aging, changes in habits and lifestyle, socioeconomic disparities and access to health services, requiring longer and more expensive health care. This phenomenon leads to an increase in the prevalence of coverage of the family health strategy and HC, contributing to the hospital discharge of these people who need continued care for long periods, reducing hospital costs and providing comfort.[5]

Hospital discharge can occur even when there is not a full recovery of nutritional status or full ability to eat normally orally and have adequate absorption of all nutrients. Thus, the possibility of the patient going home can promote a better quality of life for individuals with special dietary needs after hospital discharge. However, aspects that involve not only food, but also clinical, nutritional, social, cultural and affective particularities related to health status must be considered, for which the entire multidisciplinary health team is involved.[6]

It was in 1998, when it was considered that home hospitalization humanizes the care of people chronically dependent on the hospital and that adequate dehospitalization provides greater contact between the patient and the family, favoring their recovery and reducing the risk of hospital infections. Based on these premises, Ordinance No. 2,416 was published, which establishes requirements for hospital accreditation and criteria for home hospitalization in the SUS.[7]

The current scenario, with higher life expectancy and an increase in NCDs, led to the growth of HC and the Federal Government implemented the Better at Home Program (PMeC). This Program aims to expand the care provided to users at home. It is a service indicated for people who have temporary or permanent difficulty in leaving their residence to get to the health unit, being assisted by the SAD.[6,8]

The PMeC's SAD is also part of the Health Care Network (RAS) and should be integrated through the establishment of care flows, clinical protocols, and regulation mechanisms. It is a substitute or complementary service to

hospital and outpatient hospitalization, and is responsible for the management and operationalization of the Multidisciplinary Health Team (EMAD) and the Multidisciplinary Support Team (EMAP) to serve the entire population[6].

Each municipality interested in implementing a DSS needs to meet some criteria for this implementation, as stated in the ordinances referring to HC within the scope of the SUS. Among the criteria, it needs to have a population equal to or greater than 20,000 inhabitants by the Brazilian Institute of Geography and Statistics (IBGE), be covered by the Mobile Emergency Care Service (SAMU) and have a reference hospital in the municipality.[8-10]

It is also necessary for the manager to construct the situational diagnosis of the Municipality (sociodemographic data, description of existing health services and epidemiological profile of the population), detail the objectives of the project, the number of EMADs (type 1/type 2), or EMAPs that they intend to implement, implementation schedule, furniture, equipment, vehicles for the transportation of the teams and the model of medical records that will be used. The SAD must be registered with the National Registry of Health Establishments Service (SCNES)[9].

EMAD type 1 are those that make up the SAD in municipalities with more than 40 thousand inhabitants and less than 100 thousand inhabitants. It has a team composed of doctors, nurses with a minimum workload of 40 hours per week, physiotherapy or social worker with a minimum workload of 30 hours per week and nursing assistants or technicians with a minimum workload of 120 hours of work. EMAD type 2 can be requested by municipalities with a population of more than 20 thousand inhabitants and less than 40 thousand inhabitants.[9,10]

While EMAP is responsible for a population of 100,000 to 300,000 inhabitants, to support and complement home health actions for up to three EMADs, when requested by them, in the care of AD users. Its minimum composition must be three higher education professionals chosen from: social worker, physiotherapist, speech therapist, nutritionist, dentist, psychologist, pharmacist and occupational therapist. The sum of the weekly workload of the chosen components must accumulate at least 90 hours per week. The Municipality with a population equal to or greater than 100,000 inhabitants may constitute a second EMAD, and a new team for every 100,000 subsequently. For the municipality with more than 200 thousand inhabitants, it will be valid from 100 thousand to 80 thousand for each team.[10]

The financial support by the Ministry of Health (MS) for the Municipalities that have PMeC SAD and depend on minimum requirements and the amount varies according to the presence of EMAD type 1 (R$ 50,000.00/month per team), EMAD type 2 (R$ 34,000.00/month per team) and EMAP (R$ 6,000.00/month per team)[9].

The municipality of Itapecerica da Serra, with its almost 160 thousand inhabitants, is in the Southwest Zone of the Metropolitan Region of São Paulo, 36 km from the capital of São Paulo[11]. It had its origin in the sixteenth century, in a village founded by Jesuit priests, under the invocation of Our Lady of Pleasures. The origin of the name "Itapecerica" comes from the Tupi-Guarani language, which means "smooth stone", or "slippery stone" (ita = stone; pecerica = smooth, or slippery)[12].

According to the latest regional division made by the IBGE, it has an area of 150.742 km², an elevation of 920 m. The estimated population in 2022 was

158,522 inhabitants[10], which results in a demographic density of 1051.61 inhabitants/km². The population is equally distributed between the sexes (male and female) and life expectancy is 70.69 years[11].

Knowing the importance of SAD within the RAS for the Brazilian population and how the managers of each municipality should organize themselves in the health sector, we observed that there is no study with reports of the implementation of EMAD. Thus, some questions served as the basis for his idealization of this study: how did the managers of the Municipality adhere to the PMeC? What are the steps indicated by the Ministry of Health? Is it possible to obtain information on the deployment of an EMAD through existing public websites?

Therefore, this research, in an unprecedented way, aims to bring to the scientific community, to managers and health professionals, how the implementation of EMAD, an important health service, took place in a municipality in the State of São Paulo, as well as its evolution in the period.

Method

This article is part of the result of a study approved by the CEP of the School of Nursing of the University of São Paulo (EEUSP) under opinion number 5.421.545, CAAE: 42803321.0.0000.5392.

This is a qualitative study of document analysis (Flowchart 1). Documents from the websites of the Ministry of Health and the Health Secretaries of the State of São Paulo and the Municipality of Itapecerica da Serra were analyzed. According to BARDIN, document analysis can be defined as follows13,14: "an operation or a set of operations aimed at representing the content of a document in a form different from the original, in order to facilitate, at a later stage, their consultation and referral".

Document analysis focuses on documents that have not yet received an analytical treatment, they are primary sources of information[15].

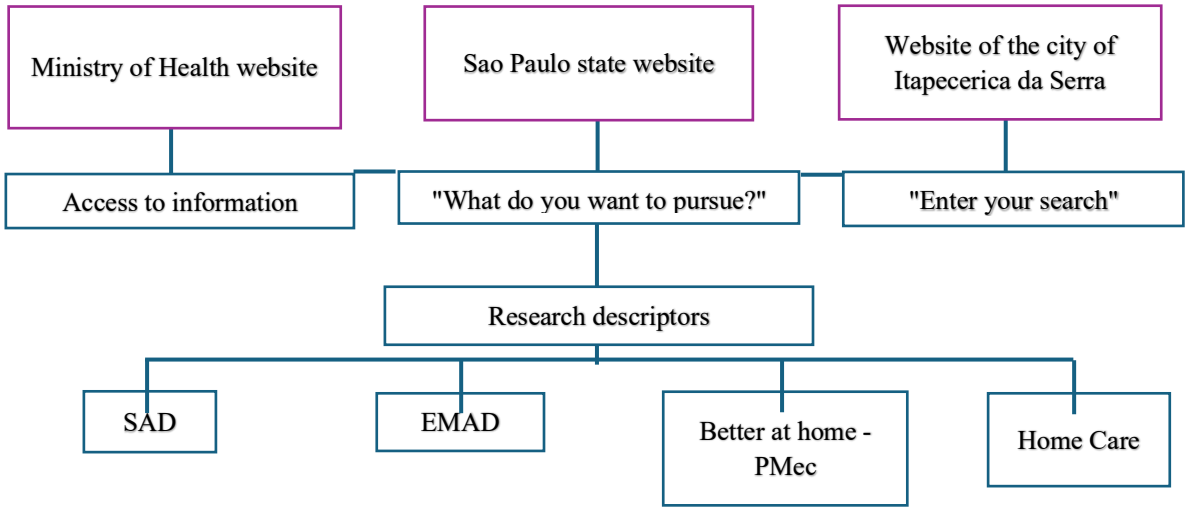
In this study, written documents (administrative publications, private documents, institutional records, among others) and non-iconographic documents (images, drawings and paintings) were used[15].

Carrying out documentary research has the advantage of analyzing a stable and adequate source of documents, such as institutional records, for example, which are those written by government institutions (bills, minutes of meetings of legislative houses, etc.)[15].

Ordinances, legislation, technical notes and normative acts were raised on the history and implementation of the SAD, the management and operationalization of EMAD in the municipality of Itapecerica da Serra.

The search for official documents took place during the period from July to September 2023. To maintain the methodological organization, the following steps were performed: (a) Floating search of the terms; (b) Selection of Units for the research; (c) Description of Units. The search terms used were "SAD", "EMAD", "Better at home - PMeC" and "Home Care". After the floating reading, the documents were separated by common subjects and at the end in ordinances that spoke to the focus of this research.

Flowchart 1 - Description of the method used for document analysis.



Results

- Floating Reading:

During the floating reading, we found a total of 10,694 documents on the MS website, the majority (66%) using the term PMeC (7,063 docs) followed by AD with 29% (3,152 docs), 3% (352 docs) by SAD and 2% EMAD (127 docs), as we can see in Flowchart 2. When using the name of the studied municipality (Itapecerica da Serra) in the filter, there was a reduction in the number of documents. On the Ministry of Health's website, it reduced to 176 documents. Also on the Ministry of Health website, 12 Ordinances were found, which, after reading and removing the duplicates, were reduced to five final ordinances (Flowchart 2). Of the five Ordinances, only two are related to "EMAD" associated with "Itapecerica da Serra", which are highlighted in Table 1. Ordinance 825/2016 informs that only one EMAD in this municipality was qualified and Consolidation Ordinance No. 5, of September 28, 2017, deals with a consolidated document of the rules on SUS health actions and services. In this document, the AD can be found in chapter 3, pages 140 to 149 and the name of the municipality is in one of the annexes as a municipality contemplated by stage number 11 of the program for qualification and structuring of work management and education in the SUS.

On the state government's website, where the municipality studied is located, the total number of documents found was lower, with 2,567 documents. Considering the descriptors used in this research, the highest number was observed by PMeC with 81% (2074 docs), followed by AD, EMAD and SAD with 15% (385 docs), 2.5% (62 docs) and 1.5% (46 docs) respectively. By adding the name of the Municipality "Itapecerica da Serra" to the filter, the number was reduced. A greater number of Ordinances was also observed (22), however, only one of these was repeated among the 12 found on the MS16 website. Among the 22 ordinances on the state government's website, none was related to the implementation of EMAD in the municipality studied.

Flowchart 2 - Description of the floating reading carried out using the websites of the Ministry of Health and the government of the State of São Paulo, São Paulo, 2023.

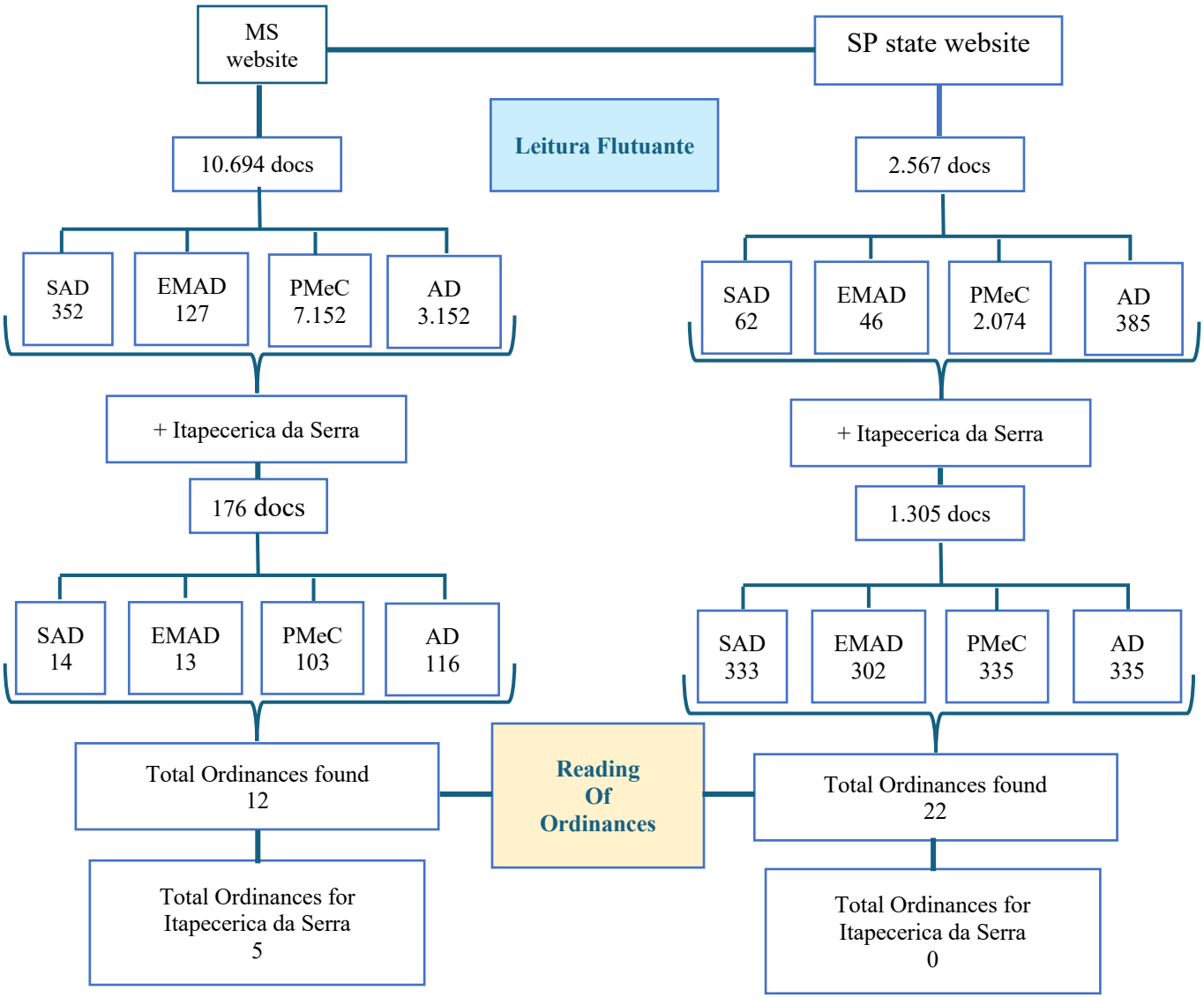


Chart 1 - Ordinances of the MS site related to Itapecerica da Serra.

Ordinances	Description of the Ordinances	Relationship with the Municipality of Itapecerica da Serra
Ordinance No. 825 of April 25, 2016[1]	It redefines Home Care within the scope of the Unified Health System (SUS) and updates the qualified teams.	The EMAD of the municipality of Itapecerica da Serra has an annual cost of 600,000 reais according to the latest update of the number of qualifications of EMAD and EMAPS teams throughout Brazil[1].
Consolidation Ordinance No. 5, of September 28, 2017[16].	Consolidation of the norms on the health actions and services of the Unified Health System.	The municipality of Itapecerica da Serra was included in stage 2 of the program for the qualification and structuring of work management and education in the SUS (ProgeSUS), which aims to develop joint actions between the federated entities with a view to the creation and/or strengthening and modernization of the work management and education sectors in the SUS. aiming at their effective qualification. At the time, the municipality had 147,540 inhabitants and 2,599 public jobs[16].
Ordinance No. 2,512, of September 28, 2017[17].	Enables States, Federal District and Municipalities to receive funding incentives for the structuring and implementation of food and nutrition actions by the State and Municipal Health Departments based on the National Food and Nutrition Policy, referring to the 2017 financial year.	The Municipality of Itapecerica da Serra receives a financial incentive for structuring and implementing food and nutrition actions in the amount of R$20,000.00[17].
MS Ordinance No. 874, of May 10, 201918.	Defines the municipalities and monthly values related to the certification of primary care teams and NASF participating in the 3rd Cycle of the National Program for Improving Access and Quality of Primary Care (PMAQ-AB).	The municipalities and maximum monthly amounts of the financial incentive related to the Primary Care Teams and the Expanded Family Health and Primary Care Centers (NASF-AB) certified in the 3rd cycle of the National Program for the Improvement of Access and Quality of Primary Care (PMAQ-AB) are defined, but Itapecerica da Serra was not contemplated[18].
Ordinance No. 894, of May 11, 2021[19].	Establishes, on an exceptional basis, federal financial incentives for funding within the scope of Primary Health Care, to be transferred, in a single installment, to municipalities and the Federal District, to face the Public Health Emergency of National Importance (ESPIN) resulting from Covid-19.	The municipality of Itapecerica da Serra received a financial incentive of R$141,394.65 in order to combat malnutrition during the covid-19 pandemic[19].

- EMAD Implementation in Itapecerica da Serra

After analyzing the documents, files of the professionals working in EMAD and unofficial reports related to the history of SAD qualification in the municipality studied, it was found that in 2012 the project called "Home Care Implementation Project and the Detailing of the Home Care Component of the Action Plan of the Emergency Care Network" was sent. for the Ministry of Health, requesting qualification for two EMADs and one EMAP, since the population by the IBGE (2010) was above 150 thousand inhabitants (152,614 inhabitants)[20].

The publication in the Official Gazette of the Union, Ordinance 1084 of June 2013, in which it enables health establishments contemplated with SAD, the Municipality of Itapecerica da Serra was authorized to qualify two EMADs and no EMAP, and it is necessary to insert the EMAD in the municipality's health SCNES. It was at the end of that same year that EMAD was inserted into the SCNES, thus allowing its official implementation to start the activities of the DSC. Subsequently, it was observed that only one type 1 EMAD was enabled, in the information of the Official Gazette of the Union, Ordinance 825 of April 2016, in addition to redefining the AD by SUS, updates the qualified teams and includes the municipality of Itapecerica da Serra receiving the amount of R$600,000.00 per year[1,21].

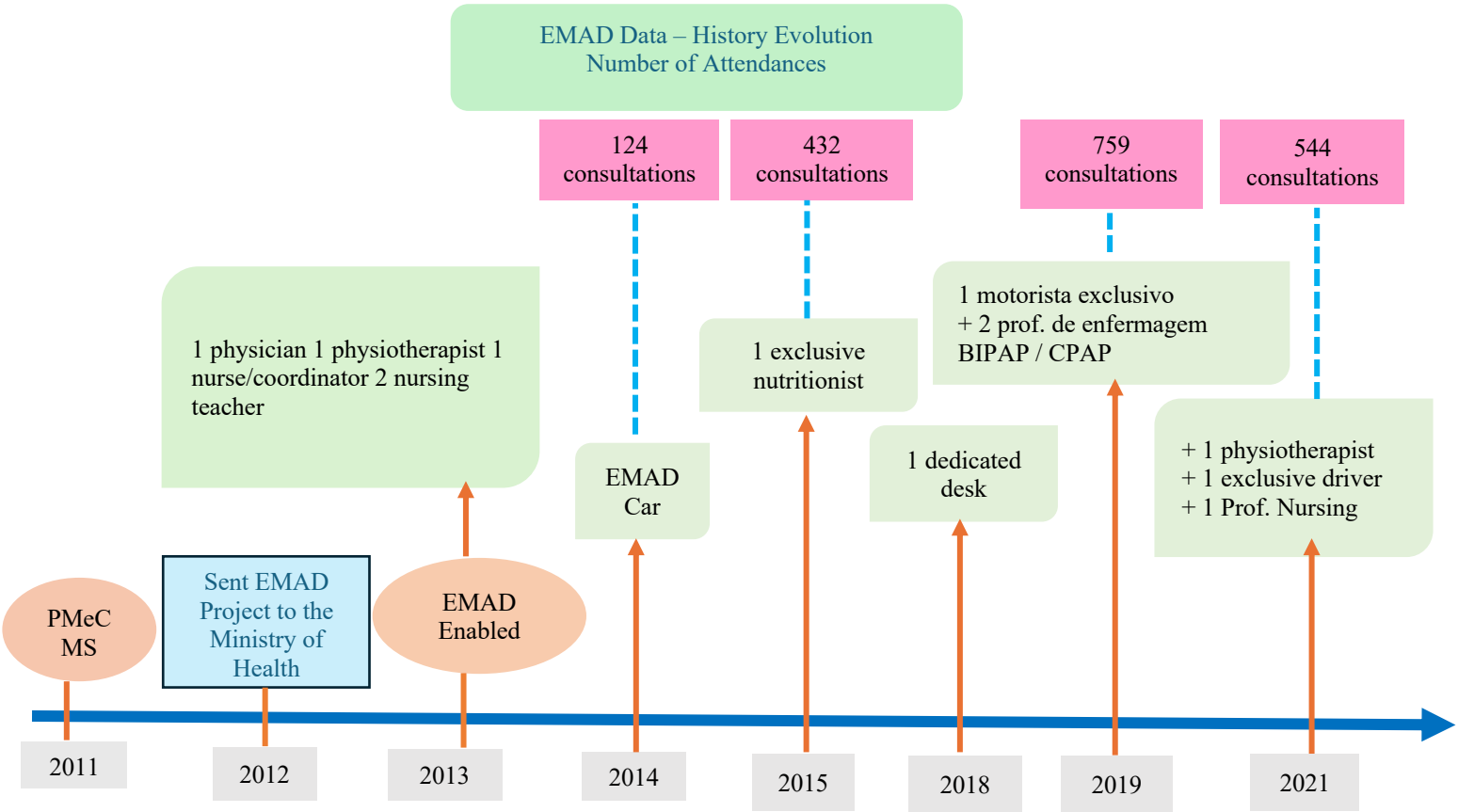
The Municipality started with evaluations and follow-up by EMAD in December 2013, as can be seen in Figure 1, and gradually increased its demand for both evaluations and people being monitored (Figure 2).

Initially, there was a lower number of evaluations and follow-up of people, in 2014 there were 35 new evaluations to the service throughout the year and 89 follow-ups by EMAD, with gradual growth, reaching 628 in 2019 (Figure 2). In 2022, a drop was observed that was related to the lower number of months analyzed in the survey, which was carried out until June 2022. In general, it was possible to observe that the growth in the number of individuals followed over the years had a behavior similar to the number of those evaluated, with different numerical proportions, which was related to the time in which each individual remained under the care of EMAD (Figure 2).

The professionals who started as members of EMAD were: a physician with a workload of 40 hours per week, a nurse with 40 hours per week, who was also the coordinator of EMAD, a physiotherapist with 30 hours per week and two nursing professionals with 40 hours per week. As the SAD was restructured and the growth in both evaluations and follow-ups, other requirements were introduced to assist the initial team in the care of SAD users (Figure 1). There was a need to have a nutrition professional to accompany and monitor people with Home Enteral Nutrition (NED), checking the increase in the EMAD team by this professional, offered by the municipal authority, exclusively as of January 2015 (Figure 1). In the first years, the visits were carried out by a car from the city hall and in 2014 there was the acquisition of an exclusive vehicle for the use of EMAD and currently has two exclusive drivers (Figure 1). To assist the health professionals working at EMAD, there was an increase in the team with an administrative professional (secretary) of 40 hours per week from 2018 and in the following years, a new increase in the health team, with more nursing and physiotherapy professionals (Figure 1).

An important aspect to highlight, among those who are monitored by EMAD, is the presence of many children and young adults who need to use equipment such as BIPAP (Bilevel Positive Airway Pressure) and CPAP (Continuous Positive Airway Pressure). Until 2018, these devices were supplied by the State, and as of 2019, after the municipality received a communication from the state secretariat, the supply of this equipment was the responsibility of the municipality (Figure 1).

Figure 1 – Timeline in the implementation of EMAD and evolution of the number of attendances in Itapecerica da Serra, São Paulo, 2023



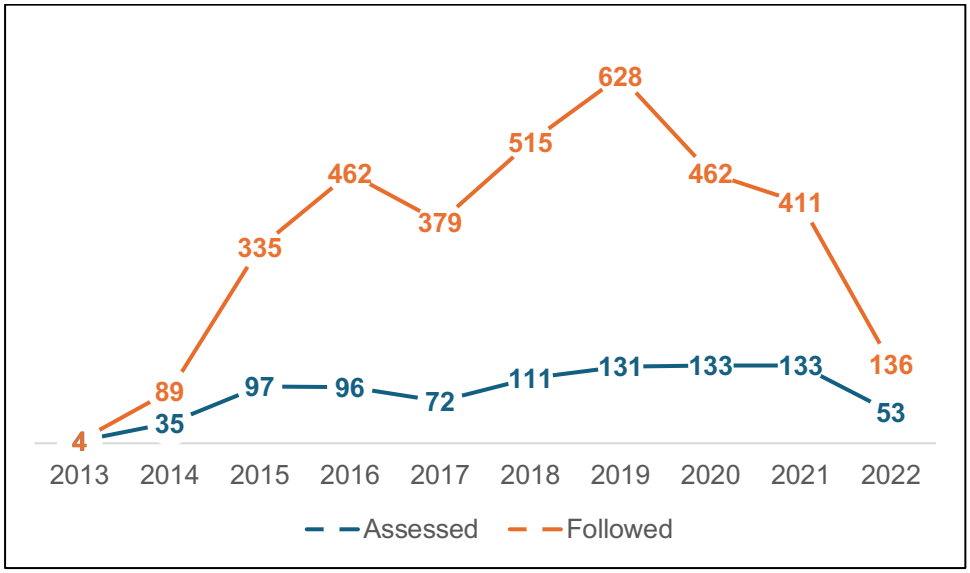


Figure 2- Number of patients evaluated and followed up by EMAD-1, 2014-2022, São Paulo, 2023

Discussion

The results of this study showed the difficulty in analyzing data by public websites. A reduction in the number of documents that were related to the proposed theme was observed, finding Ordinances that refer to the Municipality studied only through the MS website.

In a study that carried out document analysis on HC in the SUS, to identify care modalities and inequalities in use, there were also limitations related to the source of information and some underreporting. Nevertheless, as this is a broader analysis, they were able to find Ordinances and sufficient information to adequately describe their proposed objectives[22], unlike this study, which is related to the implementation of EMAD in a municipality.

Regardless of the difficulty of access to information, it was observed that there was coherence in following the guidelines given by the Ministry of Health as soon as they launched the PMeC, respecting its existing structure, its motivation and need, adhering appropriately to the implementation of EMAD in the municipality. Although the implementation was authorized for two EMAD units, only one was possible, following the norms of the Ministry of Health ordinance. Despite not having publications on the subject of EMAD implementation, studies on the success of adhering to the SAD through the PMeC were observed in the literature, as observed by Castro et al. (2018), in a study with 12 municipalities in Minas Gerais, showing a success in the organizational mode of AD4[9,21].

It should be noted that in the search on the website of the government of the State of São Paulo, no documents were found that evidenced the involvement of the State with the Municipality studied. The municipality studied, after learning about the publication of the national policy of HC with the launch of the PMeC, analyzed the local health profile with its services and structures already existing in the RAS and mobilized to implement an EMAD to serve its population. It is worth highlighting the protagonism of the Municipal manager who composed the organizational team for the idealization of the EMAD request studied[9].

Among the users served, many have NED and other nutrition care as care, which may be related to the increase in users being monitored over the years. Knowing that home nutritional care is the exclusive responsibility of the nutritionist[23], which includes home visits to identify diseases and deficiencies associated with nutrition, promoting adequate nutritional care as recommended by the Ministry of Health.

Looking at the timeline, it can be said that the composition of the team varied according to the need and its need, in the EMAD studied, in addition to the availability of an exclusive nutritionist from 2015, one more physiotherapist was included in 2021. According to the PMeC Ordinance, some professional categories are not part of EMAD, only EMAP, however, the municipality offered these "extra" professionals even though it only had one EMAD qualified, considering the demands pointed out by the population. This different composition also occurred in other municipalities[4].

The increase in professionals increased the cost for EMAD, in addition to other extra expenses such as the acquisition of its own vehicle, two drivers, an administrative vehicle and the supply of equipment such as BIPAP and CPAP. Analyzing these acquisitions with the transfer of the Ministry of Health to the program, it was possible to understand that the amount transferred does not cover all the fixed expenses of EMAD, that is, the Municipality contributed with the supply of more professionals and other demands of the Service and Team.

The high costs of health, including HC, were observed in the qualitative study that analyzed 12 municipalities in Minas Gerais, emphasizing that by far the amount of transfer by the Ministry of Health is below the total expenditure (vehicles, fuel, staff, etc.), and the role of municipal management is fundamental for the viability of the SAD, which we observed well in the municipality studied[4].

This costing situation shows that public health policies need adequate funding and should work in a tripartite manner, that is, have the participation of Federal, State and Municipal management, according to Ordinance GM/MS No. 3,005, of January 2, 2024[10]. In this Municipality, we found the Federal financial counterpart with funding from the PMeC for the Municipality, which was responsible for the qualification of EMAD, its structural organization, equipment and health professionals over the years, but it was difficult, due to the form of analysis adopted, to define the State's counterpart[24].

It is clear that there are numerous functions described in detail about the role of the State Health Secretariats in complementing the financial resources transferred by the Ministry of Health to EMADs[10]. Among them, we highlight, for example, resources for the training/training of professionals, acquisition of equipment relevant to care actions, and others[10]. However, it was difficult, due to the form of analysis adopted in this research, to define what was the State's counterpart[24].

Also in relation to the Municipality's counterpart, there was a readjustment of some existing projects with the UBS, improving the integrality between the PHC and specialized services of the Municipality. The projects provide diapers for those who need them, as well as materials and equipment for the use of enteral nutrition and dressings. With the completion of the supply of equipment used for AD users, those of greater complexity and need for hard technology such as BIPAP and CPAP, the Municipality organized itself to maintain this supply for all those who have this indication[10].

Commitment to health seems to be a priority in this municipality, which currently has the following health services: 12 Basic Health Units, a General Hospital of Itapecerica da Serra (HGIS) that is a reference for traumas due to its location (near BR 116 – Regis Bittencourt Highway), two Emergency Units, a Municipal Maternity Hospital, a medical specialties clinic with physiotherapy rehabilitation, an EMAD (where the study was carried out and by the number of inhabitants was classified as 1), a CAPs – for alcoholism, a Testing and Counseling Center – CTA (opened at the end of 2022) and a Women's Health Reference Center (opened in May 2023)[12].

Despite the difficulties faced by EMAD, considering the people benefited by HC in the Municipality, the assistance provided by the unit is evident, in view of the number of people with chronic diseases and the permanence for long periods at home, demanding care. These data validate the importance and necessity of HC and non-hospital, which can serve as a strategy for dehospitalization, rationalization of the use of hospital beds, cost reduction and organization of patient-centered care[22].

Many difficulties were encountered in the elaboration of this study, among them the lack of access to the historical record in the three spheres, Federal, State and Municipal. In spite of this, the report can show how the process of implementing the EMAD in a municipality occurred, which can support managers and professionals in the organization of their services.

Final Considerations

The request and implementation of EMAD in the Municipality of Itapecerica da Serra occurred at the beginning of the national creation of the program. The attendance to the number of people, throughout its existence, has shown growth that includes a greater number of EMAD and EMAP, to meet the demand of this population.

There was the organization and participation of the Municipality's managers over the years, enabling professionals in greater numbers than indicated by the PMeC, improvement in infrastructure and supply of high-tech equipment when indicated.

Despite the difficulties in finding data on official websites on the topic of "implementation of EMAD or EMAP", we hope that other researchers will want to share how it was their experience in the implementation of their services in AD to instigate municipalities that do not yet have DSS, to understand that it is possible and how much this complementary service can help to meet the needs of the population. especially those with few resources or lack of supplementary health.

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