Better at Home Program: Challenges and Perspectives in Home Care - Literature Review

Programa Melhor em Casa: Desafios e Perspectivas na Atenção Domiciliar - Revisão de Literatura

Programa Mejor en Casa: Desafíos y Perspectivas en la Atención Domiciliaria - Revisión de Literatura

RESUMO

Objetivos: Sintetizar desafios e perspectivas do Projeto Melhor em Casa descritos na literatura, destacando achados por eixos temáticos e recomendações para gestão e prática. **Métodos:** Revisão de literatura (2015–30/10/2025) nas bases LILACS, SciELO e PubMed. Incluíram-se estudos originais (qualitativos, quantitativos ou mistos), relatos/avaliações de serviço e revisões pertinentes. Excluíram-se editoriais, cartas, protocolos, resumos de congresso. O processo, gerido no StArt, identificou 178 registros; após triagem, 16 compuseram a amostra (13 em português e 3 em inglês). **Resultados:** A redução de internações, alta satisfação de usuários e maior eficiência do programa, embora persistam fragilidades operacionais e de padronização, foram identificados como resultados do Programa Melhor em Casa. **Conclusões:** A literatura sustenta o programa como estratégia promissora para qualificar a Rede de Atenção à Saúde, desde que apoiada por arranjos organizacionais, como investimentos em coordenação, suporte ao cuidador e maior informação clínica.

DESCRITORES: Programas Nacionais de Saúde; Serviços de Assistência Domiciliar; Sistema único de saúde; Qualidade de Vida; Continuidade da Assistência ao Paciente.

ABSTRACT

Objectives: To synthesize the challenges and perspectives of the Better at Home Program described in the literature, highlighting findings by thematic axes and recommendations for management and practice. **Methods:** Literature review (2015–October 30, 2025) in the LILACS, SciELO, and PubMed databases. Original studies (qualitative, quantitative, or mixed methods), service reports/evaluations, and relevant reviews were included. Editorials, letters, protocols, and conference abstracts were excluded. The process, managed in StArt, identified 178 records; after screening, 16 studies (13 in Portuguese and 3 in English) comprised the final sample. **Results:** The reduction in hospitalizations, high user satisfaction, and greater program efficiency were identified as outcomes of the Better at Home Program, although operational and standardization weaknesses persist. **Conclusions:** The literature supports the program as a promising strategy to strengthen the Health Care Network, provided it is supported by robust organizational arrangements, such as investments in care coordination, caregiver support, and improved clinical information.

DESCRIPTORS: National Health Programs; Home Care Services; Unified Health System; Quality of Life; Continuity of Patient Care.

RESUMEN

Objetivos: Sintetizar los desafíos y perspectivas del Proyecto Melhor em Casa descritos en la literatura, destacando los hallazgos según ejes temáticos y las recomendaciones para la gestión y la práctica. **Métodos:** Revisión de la literatura (2015–30/10/2025) en las bases LILACS, SciELO y PubMed. Se incluyeron estudios originales (cualitativos, cuantitativos o mixtos), informes/evaluaciones de servicios y revisiones pertinentes. Se excluyeron editoriales, cartas, protocolos y resúmenes de congresos. El proceso, gestionado en StArt, identificó 178 registros; tras la selección, 16 conformaron la muestra (13 en portugués y 3 en inglés). **Resultados:** La reducción de hospitalizaciones, la alta satisfacción de los usuarios y la mayor eficiencia del programa, aunque persisten debilidades operativas y de estandarización, fueron identificadas como resultados del Programa Melhor em Casa. **Conclusiones:** La literatura respalda el programa como una estrategia prometedora para cualificar la Red de Atención a la Salud, siempre que cuente con arreglos organizacionales sólidos, como inversiones en coordinación, apoyo al cuidador y mayor disponibilidad de información clínica.

DESCRIPTORES: Programas Nacionales de Salud; Servicios de Atención de Salud a Domicilio; Sistema Único de Salud; Calidad de Vida; Continuidad de la Atención al Paciente.

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INTRODUCTION

Home care is an essential strategy for ensuring continuity of care and improving the Health Care Network (RAS) in the face of an aging population and an increase in chronic conditions. In Brazil, the Better at Home Program (PMeC), established in the Unified Health System (SUS) since 2011 and operated by Primary Health Care (PHC), organizes multidisciplinary teams to provide home care for people with dependency, rehabilitation needs, technological support, or palliative care [1].

National and international literature indicates clinical, psychosocial, and economic benefits of this modality—improved comfort and bonds, reduced barriers to access, and fewer avoidable hospitalizations [2,1]. At the same time, recurring implementation challenges are pointed out: incomplete clinical records and insufficient standardization of home nutritional therapy, with the use of homemade formulas and diagnostic failures [3]; high incidence of falls, related to the fragility of users, the home environment, and

caregiver overload [4]; and limitations in human and financial resources and integration between levels of care [5]. These gaps justify a critical and updated synthesis of the program's performance and operational issues.

Given this, the question arises: what are the main challenges and perspectives of the PMeC in SUS home care over the last ten years? The objective of this study is to analyze, in recent literature, the challenges and perspectives of the PMeC in SUS home care, considering care and economic outcomes, user profiles, and operational, financial, and technical bottlenecks [6,7].

METHOD

A literature review was conducted on the challenges and prospects of the PMeC in SUS home care from January 1, 2015, to October 30, 2025. Searches were conducted in the LILACS, SciELO, and PubMed databases, in Portuguese and English, using the de-

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scriptors "Melhor em casa" (Better at home), "SUS" (SUS), and "Atenção domiciliar" (Home care), combined by Boolean operators and adapted to the syntax of each database. In addition, snowballing was applied to the reference lists of the included studies to capture works not retrieved in the primary search.

The references (.RIS and .BIB formats) were imported into StArt, organizing the process into three phases: planning (question, descriptors, and criteria); execution (search, automatic deduplication with manual review and screening); and summarization (extraction and synthesis). The inclusion/exclusion criteria were parameterized in StArt and applied in

two stages: (I) screening of titles and abstracts; (II) full-text reading by two independent reviewers with consensus for disagreements. StArt kept a log of decisions, generating the extraction matrix (title, authors, year, design, setting, population/sample, main results), used in the narrative synthesis and simplified PRISMA.

Inclusion criteria:

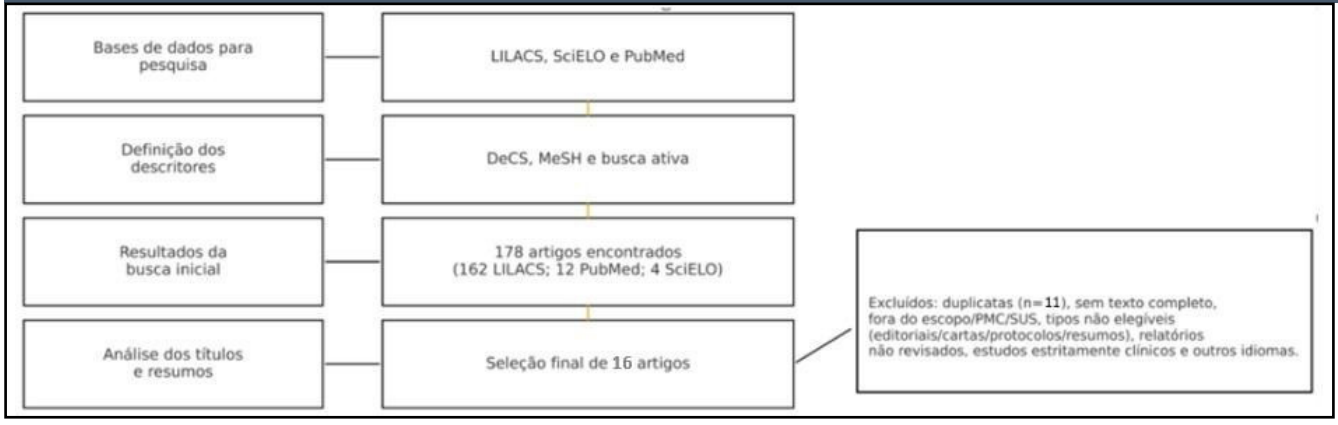
- Publications with full text between 2015 and 2025;
- Studies on PMeC and/or home care in the SUS that describe challenges and/or perspectives;
- Original research (qualitative, quantitative, or mixed) and service reports/evaluations;
- Studies in Portuguese and English.

Exclusion criteria:

- Publications outside the context of the SUS;
- Studies on AD without mention of PMeC;
- Editorials, letters, comments, protocols, and conference abstracts;
- Technical reports and documents not peer-reviewed (except when published as an article);
- Clinical studies without interface with AD organization/management;
- Other languages;
- Duplicates.

Of the 178 records identified, 11 were removed (duplicates), resulting in 167 records. After applying the eligibility criteria in two stages (title/abstract and full text), 151 were excluded and 16 articles comprised the final synthesis. The selection stages are shown in Figure 1.

Figure 1 - Selection of articles for analysis



Data extraction was performed based on a complete reading, consolidated in a matrix in StArt (title, authors, year, design, setting, population/sample, main results). Among the studies included, 13 are in Portuguese and 3 in English. Given the heterogeneity of the designs and the absence of a basis for combinable quantitative synthesis, a thematic narrative synthesis was performed to guide the results.

RESULTS

Sixteen studies (2019–2025) were included, covering various PMeC scenarios in the SUS, with observational (cross-sectional/case series), qualitative, case study, and ecological/evaluative designs (1–16).

AD/PMeC organization and access/flow

Organizational heterogeneity was observed, with a predominance of operation on weekdays, restricted use of electronic medical records, and Singular Therapeutic Project (PTS) not always systematized; referral/counter-referral concentrated on admission/discharge with gaps in follow-up[8]. PHC managers reported low agenda prioritization, training difficulties, and the absence of specific policies for dependent elderly people. Family overload and fragmentation of care were also observed [9].

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Clinical/epidemiological profile and management

In home palliative care (Joinville–SC), neoplasms ~94%, death at home ~76%, opioids ~87% (morphine), and palliative sedation ~25% (midazolam) indicate high demand for symptom control at home [3]. Pediatrics in home mechanical ventilation showed high complexity and technological dependence, with a central caregiver [10]. In the nutrition of palliative patients, there was a predominance of low weight/malnutrition and the use of hyperprotein formulas [5]; in children and adolescents, nutritional care and specific needs were mapped [11]. Expanded studies outlined the clinical-epidemiological profile of public AD users [12], with reports of multidisciplinary practice that reinforce integration between areas (medicine, nursing, nutrition) [2].

Dehospitalization and end of life

Organized services showed higher rates of death at home, lower hospitalization, and fewer visits to the emergency room at the end of life [13]; the patient-caregiver-professional triad emerged as the axis of safety and shared decision-making [4]. The case of the PMeC in Acreúna–GO illustrates functional recovery with tracheostomy removal and resumption of oral feeding after integrated care[7]. A national survey recorded high satisfaction among users/caregivers, associated with perceived quality, shorter waiting times, and clarity of guidance[14].

Installed capacity and regional variation

The national analysis described the distribution and inequalities of Multidisciplinary Home Care Teams (EMAD) and Multidisciplinary Support Teams (EMAP), with implications for resource allocation, equity, and intensity of care [15].

Economic impact/resource use

There are signs of a reduction in hospital expenses associated with the PMeC, depending on the structure, logistics, and quality of care [6].

Caregivers and transitions

Overburdening and depressive symptoms in caregivers of older adults are common, reinforcing the need for psychosocial support and training[2]. Challenges in coordination/communication persist, especially in the hospital-home transition and in the organization of support services [16].

DISCUSSION

The PMeC/AD aligns preferences (staying at home) and rationalizes resources, but its effectiveness depends on implementation in the territory. The heterogeneity of processes (PTS, medical records, flows) indicates a gap between guidelines and practice, scheduling bottlenecks, provision/training of human resources, and support for families explain the fragmentation [8,9]. The low capillarization of continuing education suggests mainly operational problems—supervision and in-service learning—rather than normative ones [1].

Clinically, AD deals with high complexity: pain and palliative sedation protocols; home technologies in pediatrics; risk-based nutritional plans—requiring clinical governance and process/outcome indicators for safety and quality [3,5,10-12]. At the end of life, when flows and support work, AD makes the home the preferred setting; the patient-caregiver-professional triad supports safety and shared decision-making [4,13].

Installed capacity (EMAD/EMAP) is uneven, with a risk of inequality; expansion should follow need/risk, with monitoring [15]. There are signs of a reduction in hospital expenses, conditional on structure, logistics, and quality [6]. Users/caregivers report a good experience, even coexisting with caregiver overload and psychological distress [2,14,16].

Implications: standardize a "minimum common" organizational standard (integrated medical records, useful PTS, transition flows); implement clinical protocols (pain, sedation, nutrition) with ongoing education and supervision; plan for equity (EMAD/EMAP sizing by risk/need); monitor value with clinical, experience, and resource use indicators [1,3-6,8-11,13-16].

Limitations: observational/qualitative studies with potential bias and heterogeneity that prevent quantitative synthesis predominate; review in three databases (PT/EN) may have missed articles, mitigated by reference checking and deduplication. Multicenter and implementation evaluations are needed to consolidate protocols and best practices [1,3,4,6,15].

CONCLUSION

This study indicates that Home Care in the SUS, structured by the PMeC, can offer person-centered care, aligned with the desire to remain at home and the more rational use of resources. Performance depends less on new guidelines and more on execution: medical records that support clinical practice, operational PTS, clear flows in the hospital-home transition, and continuous training of teams. Regional asymmetries persist, requiring planning by need/risk and support for caregivers, which is decisive for the sustainability of care. In summary, the advancement of the PMeC requires standardizing a "minimum common" organizational and clinical level, strengthening continuing education, and monitoring indicators of quality, experience, and resource use, reducing inequalities and sustaining favorable results in the territory.

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