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Home care for older adults: characterization of care in Primary Health Care

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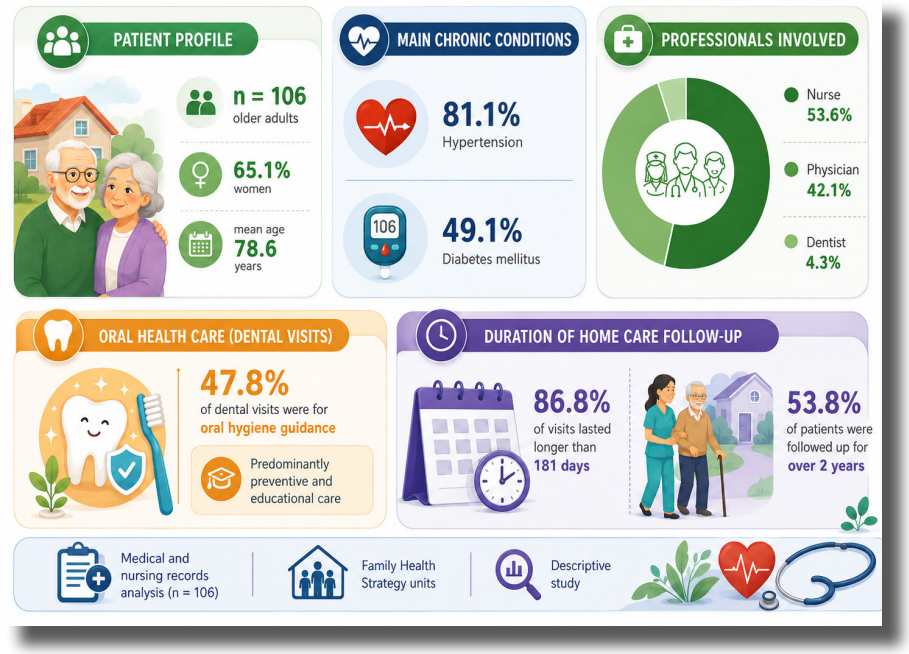
Graphical Abstract



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Highlights

- *Predominance of female older adults in advanced age groups among users followed by home care.*
- *High burden of chronic conditions, with emphasis on cardiovascular and metabolic diseases, requiring continuous follow-up.*
- *Care concentrated primarily in nursing and medicine, reflecting the complexity and longitudinality of care.*
- *Dental practice more punctual and predominantly preventive, focused on oral hygiene education and guidance.*

Abstract

Brazil faces rapid demographic transition, with an increase in the elderly population and life expectancy. Alongside this, nutritional and epidemiological transitions occur, which are correlated with poor diet and the prevalence of chronic diseases, especially in older adults. This transition – marked by population aging – underscores the need for primary care for these individuals. In this context, home care (HC) is defined as a set of actions and services aimed at health promotion, providing users with continuous access to health care, especially the most vulnerable, such as older adults. Although HC represents a significant strategy for a humanized approach, the establishment of bonds, and access to services, there remains a scarcity of scientific evidence on care provided to the elderly population requiring home care. This study aimed to characterize home care provided to older adults in a medium-sized municipality in the interior of São Paulo, describing the sociodemographic profile of this population, the prevalence and types of morbidities, the main procedures performed within the scope of home care, the professional category responsible for care, and the duration of follow-up. A data survey was conducted from 2022 to 2024, using the medical records of older adults (n=106) attended by HC in primary health care across 8 Family Health Strategy units. Data analysis was performed using descriptive statistics. Regarding the sociodemographic profile, the mean age of older adults was 78.6 years, with a prevalence of female individuals (63.9%). Regarding the most frequent morbidity, arterial hypertension affected the largest number of patients, reaching 81.1%. In terms of care delivery, nurses predominated with 53.6% of total visits. Among medical visits, the most prevalent procedures were the general health examination (35.3%) and blood pressure measurement (28.1%). Among dental visits, the most performed procedure was oral hygiene guidance, reaching 47.8% of visits. It is concluded that home care for older adults is marked by female predominance and chronic diseases such as hypertension and diabetes. Nurses and physicians were the primary professionals responsible for care, while dental practice was punctual and preventive. The long duration of follow-up reflects the complexity of the conditions treated.

Keywords: Home Care. Older Adults. Family Health. Non-Communicable Diseases. Primary Health Care.

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INTRODUCTION

Globally, the trend of population aging is on the rise. According to the World Health Organization, it is estimated that the proportion of the population aged over 60 years will increase from 12% to 22% between 2015 and 2050[1]. This phenomenon is accompanied by interlinked demographic, epidemiological, and nutritional transitions: the demographic transition refers to the change in the population profile, marked by declining birth and mortality rates and the consequent increase in the proportion of older adults; the epidemiological transition corresponds to the replacement of infectious and parasitic diseases – previously predominant – by chronic non-communicable diseases (NCDs) as the main causes of illness and death; and the nutritional transition refers to changes in the population's dietary patterns, with a reduction in the consumption of fresh foods and an increase in ultra-processed food intake, which contributes to the worsening of NCD burden[2]. NCDs comprise a set of multifactorial, clinically prolonged conditions with long latency periods and generally non-infectious origins[3], and should not be understood as an inevitable consequence of aging, but rather as potentially preventable and manageable conditions through continuous and qualified care.

The feminization of old age is also observed, characterized by women's greater longevity relative to men and the consequent higher proportion of elderly women in the population, especially in more advanced age groups. This phenomenon tends to also be reflected in the profile of users followed by home care services, historically composed, in their majority, of women[4,5,6]. With the aging of the population, there is a growing demand for care support for dependent older adults, directed at the general public[7]. The increase in life expectancy and the increase in older adults with chronic diseases highlight the need for long-term care, becoming one of the main challenges for health systems in many countries[8].

Long-term care corresponds to the set of actions directed at people who, due to chronic disease, functional disability, or dependency, require continuous support for the performance of basic and instrumental activities of daily living, involving both formal health services and care provided by family members and caregivers. Recognizing this complexity, Brazil enacted, through Law No. 15,069 of December 23, 2024, the National Care Policy, which has as its priority target population, among other groups, older adults who require assistance, support, or aid for the performance of basic and instrumental activities of daily living, recognizing care as a right and a responsibility shared among the State, families, the private sector, and civil society[9]. A comprehensive strategy for long-term care for older adults must be developed, considering models that offer continuous support to users with diverse care needs[9,10]. Recognizing the importance of family care, it is crucial to expand support to caregivers, covering instrumental, emotional, and financial aspects.

When it comes to home care for older adults, current research has focused on meeting needs but has placed less emphasis on care quality[11,12]. The quality of care provided by caregivers is crucial to ensuring the well-being of older adults and the quality of their daily lives. Studies also indicate that the quality of care provided to older adults is directly related to the professional satisfaction of caregivers[13].

Home care (HC), according to the World Health Organization, encompasses the set of health and social support services provided to patients in their own homes, with the objective of restoring, maintaining, or promoting maximum comfort, function, and health, including care aimed at the process of dignified death, being able to prevent, postpone, or replace temporary or long-stay institutional care[14]. HC is distinguished from home visits: while the latter represents a punctual action of contact with the user at home, HC presupposes an articulated and continuous set of care actions, with a defined therapeutic plan and longitudinal follow-up[15]. Within the scope of the Unified Health System, HC is operationalized both by the Family Health Strategy teams, at the level of Primary Health Care, and by the Melhor em Casa Program – a Ministry of Health initiative that organizes Multiprofessional Home Care and Support Teams directed at users with bed or home restriction, in clinical or temporary or permanent vulnerability conditions[16]. It is an important working tool used by the Family Health Strategy Team, which allows the establishment of bonds with users, knowledge of the community's reality, and understanding of the dynamics of family relationships, with the development of health promotion, disease prevention, and health surveillance activities, with family follow-up according to needs defined by the team[17,18].

However, serious gaps persist in the provision of

care services, including medical care, rehabilitation training, and other services beyond basic care for daily living[19]. Family members often lack professional nursing knowledge and care tools, in addition to lacking the conditions to provide emergency medical treatment to the dependent older adult[20].

It is envisioned that, by noting the importance of home care directed at the elderly population, there is the necessary opening for improvement targeting the specificities of each patient – such as their morbidity, home location, and socioeconomic condition – and associating them with the most suitable treatment. Home care therefore guides the prevalence of visits to older adults in a way that preserves patient comfort while still delivering treatment for their condition, enabling the elderly population to achieve greater life expectancy.

Health services oriented by population needs tend to be more effective, as they favor the harmonization of objective and subjective dimensions of care, valued by both professionals and users. In this sense, it becomes essential to rethink the concept of health needs and the way they guide the work process, adopting a broader understanding of desires, expectations, and demands related to services. The balance between supply, demand, and needs therefore constitutes a central premise for reorganizing this triad and qualifying the care provided.

In this context, the present study aims to characterize home care provided to older adults in a medium-sized municipality in the interior of São Paulo, describing the sociodemographic profile of this population, the prevalence and types of morbidities, the main procedures performed within the scope of home care, the professional category responsible for care, and the duration of home care follow-up.

METHODOLOGY

This was an observational, descriptive, retrospective study with a quantitative approach, based on documentary analysis of clinical records, conducted in a medium-sized municipality in the interior of the state of São Paulo, Brazil, part of the Metropolitan Region of Campinas and located northwest of the state capital, approximately eighty kilometers away. Clinical records in electronic format of older adults requiring home care by Family Health Strategy health professionals were used as the data source, providing information on sociodemographic profile, health history, treatments performed, and specific needs.

To enable the research, formal authorization was requested from the Administrative Coordinator of the Family Health Strategy Units in the municipality to access and use the data. Records were included for individuals aged 60 years or older followed between January 2022 and December 2024, a period selected intentionally as it corresponds to the implementation of a new computerized medical record system in the municipality, which ensured greater standardization, organization, and ease of access to information.

Records predating 2022 were not migrated to the new platform, making their inclusion unfeasible; for this reason, analysis was restricted to data available in the updated system, ensuring greater uniformity, precision, and reliability. After institutional authorization, the researcher contacted the nurses responsible for the units to schedule visits, present the study, and operationalize data collection.

Medical records were obtained by direct download from the municipal computerized system, in Portable Document Format (PDF), and the information was organized in a specific and secure database, with restricted access to the responsible researcher, ensuring confidentiality and secrecy. Variables were collected regarding sex, age, socioeconomic and educational conditions, marital status, home location, type and prevalence of morbidities, professional category responsible for home care, type of care provided, frequency of visits conducted, and caregiver need.

Data were analyzed at two levels to avoid ambiguity regarding the unit of analysis: (i) by older adult/medical record (n = 106), for sociodemographic and morbidity variables; and (ii) by visit performed, for variables related to professional category, procedures performed, and duration of follow-up, since each older adult could have undergone multiple visits throughout the study period. Statistical analysis was descriptive, with calculation of absolute (n) and relative (%) frequencies for categorical variables and measures of central tendency and dispersion for quantitative variables.

The study was approved by the Human Research Ethics Committee of the responsible institution (CAAE: 69122923.6.0000.5416).

RESULTS

Data from 106 medical records of older adults requiring home care were analyzed. The mean age of participants was 78.6 years. A higher frequency of female patients was observed (n = 69), representing 63.9%, while male patients (n = 37) accounted for 34,9%.

General health conditions

These data refer to the total of 106 older adults/medical records analyzed, each individual potentially presenting more than one morbidity. The general health conditions of older adults receiving home care were analyzed from medical record data. More than one morbidity was present, with arterial hypertension standing out with a prevalence of 81.1%, followed by diabetes *mellitus* (49.1%), reduced mobility (19.8%), limb pain and urinary tract disorders (17.9% each), hypothyroidism (11.3%), heart failure (9.4%), Alzheimer's disease (7.5%), fractures (7.5%), chronic obstructive pulmonary disease (5.7%), and Parkinson's disease (2.8%).

Professional category and practice in home care

Figure 1 presents the distribution of home care visits by professional category.

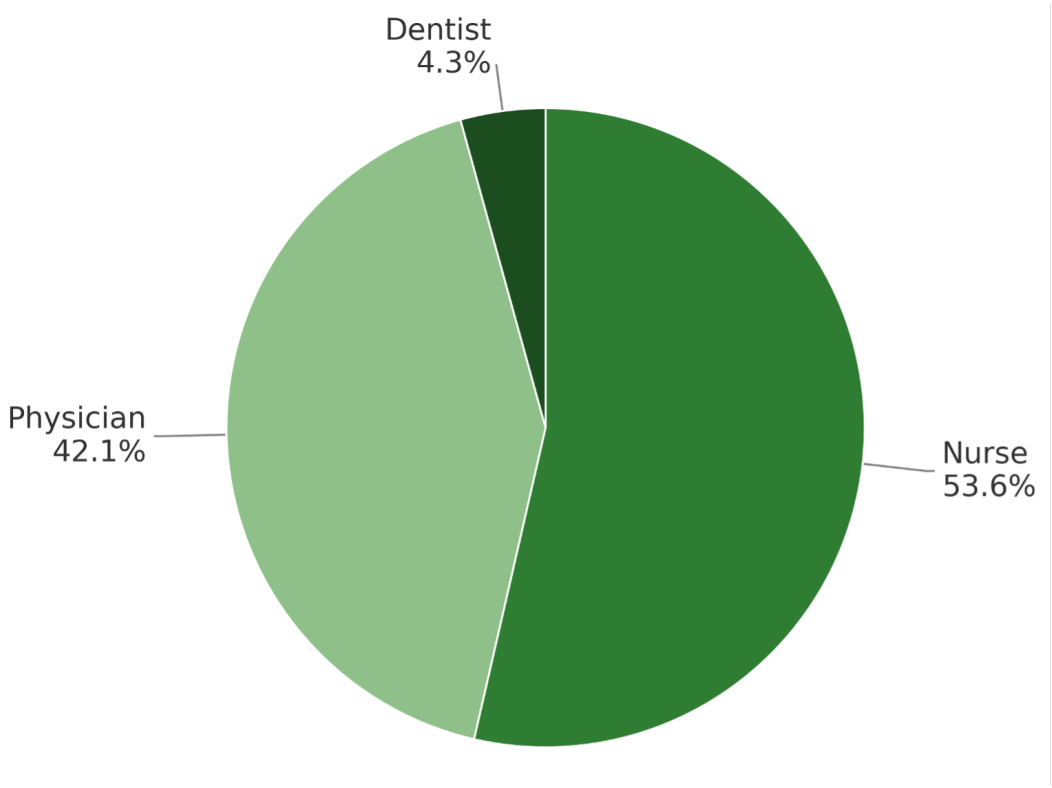

Figure 1 - Distribution of home care visits according to professional category in the municipality of Itatiba – São Paulo, 2024.

The data show that nurses were responsible for the largest portion of home care visits, totaling 792 (53.6%) records, which evidences their central role, reflecting the continuous nature of home care, primarily in the follow-up of chronic conditions, wound care, guidance, and patient reception.

Physicians, totaling 622 (42.1%) visits, also played an expressive role, reinforcing their importance in the diagnosis, prescription, and clinical follow-up of patients requiring more in-depth assessment. Nevertheless, their frequency was lower than that of nurses, which is common in Family Health Strategy teams,

where nurses maintain more intensive care practice.

Finally, dental surgeons performed 64 (4.3%) visits, a number significantly lower than that of other professional categories. This points to a still limited participation of dentistry in home care, which may be related to structural, logistical, and training barriers, or to the absence of well-defined protocols for home dental care.

Table 1 presents the procedures performed by physicians during home visits as recorded in medical records; the data refer to the total of 622 medical visits, and not to the number of older adults.

Table 1 - Distribution of procedures performed by physicians in home care visits, according to absolute frequency (n) and percentage (%), in the municipality of Itatiba – São Paulo, 2025.

Procedure	n	%
General health examination	479	77.0
Blood pressure measurement	62	10.0
Collection of material for laboratory examination	18	2.8
Intramuscular medication administration	13	2.1
Complex wound care	11	1.8
Simple wound care	10	1.6
Repeat prescription issuance	9	1.5
Urinary catheterization	8	1.3
Capillary blood glucose measurement	6	0.9
Laser therapy	3	0.5
Assessment of respiratory function and mechanics	3	0.5
Total	**622**	**100**

The data above affirm that the most frequent procedures in home care visits by physicians were the general health examination and blood pressure measurement, at 77.0% and 10.0%, respectively, demonstrating the possible prevalence of arterial hypertension as a chronic disease condition among patients.

In descending order, the collection of material for laboratory examination accounted for 2.8% of procedures, while intramuscular medication administration accounted for 2.1%. A similar number of complex wound care (1.8%) and simple wound care (1.6%) procedures was also obtained.

Repeat prescription issuance (1.5%) indicates the need for continuous medication use, which may be related to chronic diseases arising from the epidemiological transition.

Urinary catheterization (1.3%) and capillary blood glucose measurement (0.9%) are procedures for urinary tract disorders and diabetes *mellitus*, respectively, whose frequency is justified by the presence of older adults registered with such diseases.

Finally, laser therapy (0.5%) and assessment of respiratory function and mechanics (0.5%) appear at lower frequency.

Table 2 presents the distribution of the duration, in days, of home care follow-up provided by the Family Health Strategy team (physicians and nurses) to all 106 older adults – not the number of visits or procedures performed.

Table 2 - Distribution of care duration (days) in home care visits by physicians and nurses, according to absolute frequency (n) and percentage (%), in the municipality of Itatiba – São Paulo, 2025.

Care duration period	Frequency	%
Up to 7 days	3	2.8
8 to 30 days	2	1.9
31 to 180 days	9	8.5
181 to 365 days	11	10.4
More than 366 to 730 days (1 to 2 years)	24	22.6
More than 730 days (> 2 years)	57	53.8
Total	**106**	**100.00**

From the analysis of care duration (days) in home visits by physicians and nurses, it is evident that few visits had a duration of less than 180 days, accounting for 2.8% up to 7 days, 1.9% from 8 to 30 days, and 8.5% from 31 to 180 days, totaling 13.2%. Meanwhile, visits lasting more than 181 days – 10.4% from 181 to 365 days, 22.6% from 366 to 730 days (1 to 2 years), and 53.8% more than 730 days (over 2 years) – resulted in a total of 86.8%. This demonstrates that medical and nursing care required more time to carry out treatments for older adults – generally over 2 years in this study – evidencing the possible complexity and chronicity of the health conditions of the older adults served.

Of the total of 106 older adults followed, 55 (51.9%) received dental care performed by dental surgeons, totaling 90 procedures; the data in Table 3 therefore refer to the number of procedures (n = 90), and not the number of individuals served.

Table 3 presents the number of procedures performed by dental surgeons, according to the notes in medical records.

Table 3 - Distribution of dental procedures performed in home care visits, according to absolute frequency (n) and percentage (%), in the municipality of Itatiba – São Paulo, 2025.

Procedure	n	%
Oral hygiene guidance	43	47.9
Preventive oral cancer examination	24	26.8
Dental prescription	4	4.4
Impression for prosthesis fabrication	3	3.3
Tooth extraction	3	3.3
Reception with risk classification	2	2.2
Emergency care	2	2.2
Restorations	2	2.2
Provisional sealing of dental cavity	2	2.2
Blood pressure measurement	1	1.1
Pulp access	1	1.1
Occlusal adjustment	1	1.1
Prosthesis repair	1	1.1
Prophylaxis – plaque removal	1	1.1
Total	**90**	**100.00**

Among the procedures, oral hygiene guidance was the most frequent, with 43 occurrences (47.9%), reinforcing the preventive profile of home dental care. Next, oral cancer prevention guidance and examination stand out with 24 cases (26.8%), representing an important early screening measure in oral health. These two preventive actions account for 74.7% of the procedures performed, evidencing the predominance of educational and oral health surveillance practices carried out by dentists in this study.

Other more complex procedures appear with lower frequency and should, for the most part, be performed at the dental office in the Health Unit – including rehabilitative procedures such as impressions for prosthesis fabrication, and surgical procedures such as extractions, pulp access, occlusal adjustment, prosthesis repair, and prophylaxis with plaque removal – reflecting technical limitations in the home care context.

Table 4 presents the distribution of the duration of home dental visits, referring to the 55 older adults who received this type of care.

Analysis of the duration of home dental visits demonstrates that the overwhelming majority of interventions occurred within "up to 7 days", corresponding to 70.9% of the total care provided. This data suggests that, in most cases, dental care is punctual, focused on immediate actions.

The remaining duration periods present lower frequency: 9.0% extended to 31 to 180 days and 5.5% lasted between 8 to 30 days, followed by smaller percentages for the remaining periods. These data may suggest that a small group of older adults required some medium-term follow-up.

Finally, the short duration of long-term home dental care (over one year, reaching up to two years of care), evidenced in this study, may prompt the fundamental reflection on the need to assess the conditions of functional dependency or chronic diseases that preclude home dental care for older adults.

Table 4 - Distribution of care duration (days) in home dental care visits by dental surgeons, according to absolute frequency (n) and percentage (%), in the municipality of Itatiba – São Paulo, 2025.

Care duration period	Frequency	%
Up to 7 days	39	70.9
8 to 30 days	3	5.5
31 to 180 days	5	9.0
181 to 365 days	2	3.6
More than 366 to 730 days (1 to 2 years)	3	5.5
More than 730 days (> 2 years)	3	5.5
Total	**55**	**100.00**

DISCUSSION

The sociodemographic data from medical records revealed a predominance of female older adults (63.9%), with a mean age of 78.6 years, which is consistent with the literature. Rivas *et al.*[4] in an integrative review identified that home care users are predominantly women, with low educational attainment and a mean age of 82.76 years. Similarly, Johann *et al.*[5] also observed a significant prevalence of women assisted by home care teams, with Brazilian studies pointing to expressive female percentages ranging between 53% and 72%[6]. This finding is consistent with the feminization of old age described in the Introduction, since women's greater longevity tends to translate into greater demand for long-term care in this elderly population segment.

The general health conditions, as recorded in the analyzed medical records, evidence the high prevalence of chronic non-communicable diseases (NCDs) among the patients served, with emphasis on arterial hypertension (81.1%) and diabetes *mellitus* (49.1%). These conditions can lead to functional disabilities and demand continuous follow-up in the home care context[21], corroborating findings by Ramos *et al.*[22], who identified arterial hypertension and diabetes *mellitus* among the most prevalent morbidities in older adults linked to home care in southern Brazil. The high occurrence of these NCDs can be understood in light of the epidemiological and nutritional transition described in the Introduction; studies indicate that high consumption of ultra-processed foods is associated with greater risk of frailty, dyslipidemias, and arterial hypertension in older adults[2], which reinforces the importance of strategies to promote adequate and healthy eating in this group, even though the present investigation did not directly assess participants' dietary habits.

The performance of health professionals in home care is predominantly marked by the presence of nursing, which accounts for 53.6% of recorded visits. This expressive participation is consistent with the literature, which recognizes the nurse as the central agent in home care, responsible for actions ranging from basic hygiene care to technical procedures such as medication administration[23]. Andrade *et al.*[24] highlight that this professional assumes a fundamental role in care delivery, articulating clinical, educational, and family support actions at home.

In the Family Health Strategy (FHS), nurses also stand out for developing diverse activities aimed at care for older adults, including nursing consultations, risk factor identification, blood pressure measurement, and guidance on lifestyle habits and therapeutic adherence, especially in the management of chronic diseases such as arterial hypertension[25]. Such actions reinforce their relevance in health promotion and complication prevention, contributing to stimulating the functional autonomy of older adults.

Regarding physicians, the results found in this study corroborate the literature evidencing the relevance of these professionals in Primary Health Care, especially in the context of home care, exercising attributions that go beyond the traditional clinical consultation. In Brazil, physicians are estimated to perform an average of 3.74 home visits per week, representing approximately 10% of their weekly workload[26]. During these visits, whether previously scheduled in the context of home hospitalization or arising from intercurrences, the physician performs central functions such as formulating

diagnoses, prescribing medications, organizing the multidisciplinary therapeutic plan, classifying care complexity, and requesting hospitalizations. Furthermore, their practice includes health promotion and patient and family education actions, strengthening the integrality of care[26].

Still regarding the performance of health professionals in home care, it was observed that visits by dental surgeons corresponded to the lowest frequency among the professionals investigated in this study (4.3%). This low frequency can be attributed to various factors, such as the absence of adequate portable equipment for clinical practice outside the dental office, the lack of standardized clinical-care protocols, and limited specific training of professionals for home care contexts[27,28]. These findings reinforce the trend observed in this study, indicating the need to expand academic training and institutional strategies that enable the effective performance of dental surgeons in home care, ensuring comprehensive and continuous care also in the domain of oral health[29].

Regarding dental procedures performed at home, a predominance of educational and preventive actions was observed, with oral hygiene guidance (47.8%) and the preventive examination for early detection of oral cancer (26.8%) standing out. These findings are consistent with data from the literature reporting that the majority of home dental activities are focused on oral health promotion and prevention, reinforcing the strategic role of the dental surgeon in home care[30]. Given the predominance of oral hygiene guidance among dental procedures and the high prevalence of functional dependency among the older adults followed, the importance of strategies aimed at training family and formal caregivers to perform basic oral hygiene care in the home routine is reinforced – including guidance on brushing, flossing, and denture cleaning – in order to extend the preventive reach of dental practice beyond the punctual visits performed by the dental surgeon.

The results of the present study reveal that 86.8% of home care visits performed by physicians and nurses lasted more than 181 days, with more than half (53.8%) exceeding two years of continuous follow-up. This data evidences that the majority of interventions directed at the elderly population require prolonged care, possibly due to the high clinical complexity and chronicity of health conditions. These findings are consistent with the study by Genaro *et al.*[10], which identified that 64.9% of participants had been linked to home care for more than one year, reinforcing the need for longitudinal and comprehensive follow-up in the context of home care for older adults.

CONCLUSION

The present study characterized home care provided to older adults in the analyzed municipality, evidencing a predominantly female and advanced-age profile, with a high prevalence of chronic non-communicable diseases such as arterial hypertension and diabetes *mellitus*. Nursing was the professional category with the greatest participation in care, followed by physicians, while the practice of dental surgeons was limited and concentrated in preventive and educational actions, especially oral hygiene guidance. The prolonged duration of most care episodes reflects the complexity and chronicity of the health conditions of this population, reinforcing the need for longitudinal, comprehensive, and interprofessional follow-up in the scope of home care.

CRediT author statement

Conceptualization: Aurelio, TG; Genaro, LE; Valsecki Júnior, A; Rosell, FL. Methodology: Aurelio, TG; Genaro, LE; Valsecki Júnior, A; Rosell, FL. Validation: Genaro, LE; Rosell, FL. Statistical Analysis: Genaro, LE; Valsecki Júnior, A. Formal Analysis: Genaro, LE; Valsecki Júnior, A. Investigation: Aurelio, TG; Genaro, LE. Resources: Rosell, FL; Valsecki Júnior, A; Genaro, LE. Writing - Original Draft: Aurelio, TG; Genaro, LE. Writing - Review & Editing: Rosell, FL; Valsecki Júnior, A; Genaro, LE. Visualization: Rosell, FL. Project Administration and Supervision: Rosell, FL.

All authors have read and agreed to the published version of the manuscript.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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