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RESEARCH

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CLINICAL ASPECTS OF PATIENTS IN HOME TREATMENT FOR THE BEST AT HOME AND DE-HOSPITALIZATION

*Aspectos clínicos de pacientes em tratamento domiciliar pelo melhor em casa e desospitalização**Aspectos clínicos de los pacientes en tratamiento domiciliario para el mejor domicilio y deshospitalización***Sirlaine de Pinho**¹ **Rene Ferreira da Silva Junior**² **Cristiane Vieira da Silva**³ **Lucineia de Pinho**⁴ **Rosângela Ramos Veloso e Silva**⁵ **Simone de Melo Costa**⁶ 

ABSTRACT

Objective: to analyze data on the dehospitalization of patients with continuation at home by the Better at Home Program. **Method:** analytical cross-sectional study, conducted with data from the profile of patients reason for: hospitalization, pre-existing diseases, admission clinic, days of hospitalization and period between medical discharge, hospital discharge and admission. **Results:** among the 254 patients, 57.9% were elderly and 56.3% were men, hospitalized due to stroke (26.4%), pneumonia (14.2%) and traumatic brain injury (11.0%). The diagnosis of hypertension was recorded for 32.8%, admission to neurology for 49.6% and 52.8% remained hospitalized for 15 days or more. Hospital discharge occurred on average 3.45 hours after medical discharge and admission to the program occurred on average after 11.93 days from hospitalization. **Conclusion:** there is a need for better articulation between health care levels to ensure faster hospital admission and discharge.

DESCRIPTORS: Length of stay; Home nursing; Primary health care; Continuity of patient care.

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RESUMO

Objetivo: analisar dados sobre a desospitalização de pacientes com prosseguimento no domicílio pelo Programa Melhor em Casa. **Método:** estudo transversal analítico, conduzido com dados do perfil de pacientes: motivo da internação, doenças pré-existentes, clínica de entrada, dias de internação e período entre alta médica, alta hospitalar e admissão. **Resultados:** entre os 254 pacientes, 57,9% eram idosos e 56,3% homens, internados por acidente vascular cerebral (26,4%), pneumonia (14,2%) e por traumatismo cranioencefálico (11,0%). O diagnóstico de hipertensão foi registrado para 32,8%, internação na neurologia para 49,6% e 52,8% permaneceram internados por 15 dias ou mais. A alta hospitalar ocorreu em média após 3,45 horas da alta médica e a admissão no programa ocorreu em média após 11,93 dias da desospitalização. **Conclusão:** há necessidade de melhor articulação entre os níveis de atenção à saúde para garantir uma admissão mais ágil e desocupação hospitalar.

DESCRIPTORIOS: Tempo de internação; Assistência domiciliar; Atenção primária à saúde; Continuidade da assistência ao paciente.

RESUMEN

Objetivos: analizar datos sobre la deshospitalización de pacientes con continuación en el domicilio por el Programa Mejor en Casa. **Método:** estudio transversal analítico, realizado con datos del perfil de los pacientes: motivo de hospitalización, enfermedades preexistentes, clínica de ingreso, días de hospitalización y período entre alta médica, alta hospitalaria e ingreso. **Resultados:** entre los 254 pacientes, 57,9% eran ancianos y 56,3% hombres, hospitalizados por accidente cerebrovascular (26,4%), neumonía (14,2%) y traumatismo craneoencefálico (11,0%). El diagnóstico de hipertensión se registró para el 32,8%, ingreso a neurología para el 49,6% y el 52,8% permaneció hospitalizado por 15 días o más. El alta hospitalaria ocurrió en promedio 3,45 horas después del alta médica y el ingreso al programa ocurrió en promedio después de 11,93 días desde la hospitalización. **Conclusión:** existe la necesidad de una mejor articulación entre los niveles de atención de salud para garantizar un ingreso y egreso hospitalario más rápido.

DESCRIPTORIOS: Duración de la estancia; asistencia domiciliar; Primeros auxilios; Continuidad de la atención al paciente.

INTRODUCTION

Faced with Brazil's demographic and epidemiological transition, there is an emerging need to adapt the paradigm of care in the health sector, with the implementation of Home Care (HC).¹⁻² Although it is within the scope of other services, a large part of HC in the SUS is carried out in Primary Health Care (PHC) in the Health Care Network (HCN). PHC is shown to be a strategy for organizing and reorganizing health systems, and is fundamental for ensuring longitudinal and comprehensive care for patients with chronic diseases and conditions in its catchment area, when HC is shown to be the most appropriate care modality.¹

With the need to look for alternative methods to optimize health spending and universalize public health, dehospitalization is a tool that plays an important role.³⁻⁵ However, the dehospitalization model poses challenges in its process, which includes applying the eligibility criteria for inclusion/exclusion of the patient in the service⁶ and challenges in the performance of care, such as: construction of a care plan and professional qualification to provide comprehensive care, within the context of the patient's home and life, in a team effort. The country's regional inequalities must also be taken into account, requiring attention within the Unified Health System (SUS) network to ensure access and continuity of care.⁷

The guidelines for Home Care through the Ministry of Health's Programa Melhor em Casa (PMC) replace or complement hospital care.⁸ Thus, HC emerged as an important de-

mand for the SUS⁷ and was consolidated by the PMC. In order to make the PMC effective, research into de-hospitalization is important, considering the need to offer comprehensive care, with continuity of care and strengthening of HC.⁹

Studies on de-hospitalization are scarce and it is important to investigate the clinical aspects of patients discharged from hospital and admitted to the PMC. This data can contribute to planning and coordination between the hospital and the Melhor em Casa services, with Primary Health Care assuming its role as the system's coordinator. The aim of this study was to analyze data on the dehospitalization of patients who were continued at home by the Better at Home Program.

METHOD

This is an integrative literature review that consists of presentinThis is an analytical cross-sectional study conducted with data collected from the health records of patients discharged from hospital and referred for home care by the PMC team in the SUS network in Montes Claros, in the northern region of the state of Minas Gerais, Brazil. The data investigated refers to the period from January 2016 to December 2019.

The PMC offers assistance, monitoring, guidance and training for family members and caregivers. The PMC team in the study setting is made up of a nurse coordinator and care teams, called the Equipe Multidisciplinar de Atenção Domiciliar (EMAD). Each EMAD is made up of a nurse, a physiotherapist, a doctor and four nursing technicians.

It also has two support teams called the Equipe Multidisciplinar de Apoio (EMAP), EMAP 1: made up of a speech therapist, psychologist and nutritionist and EMAP 2: made up of a physiotherapist, social worker and psychologist. The municipality analyzed has a population of 400,000 inhabitants, so it has 4 EMAD teams.

The variables analyzed were: life cycle (children up to the age of 11; adolescents aged 12 to 17; adults aged 18 to 59 and the elderly aged 60 or over); gender (female/male); reason for hospital admission (stroke; traumatic brain injury (TBI); pneumonia; amputation; amputation of a child in a hospital; pneumonia; hospitalization due to limb amputation; tumor resection; bone fracture, except skull fracture, and other reasons); pre-existing diseases (systemic arterial hypertension; diabetes mellitus, cancer - all with answer options: yes, no); area of hospitalization/medical specialty; number of diseases pre-existing hospitalization; days of hospitalization; time between medical discharge and hospital discharge and; time between medical discharge/hospital discharge and admission to Melhor em Casa. Regarding the medical specialty of hospitalization, the answers were categorized into two categories (Neurology and Non-neurology).

The data was presented in absolute values and percentages. For the numerical data, the means, 95% confidence intervals (95% CI) and standard deviations, medians, maximum values and 25th and 75th percentiles were calculated. The medians were analyzed according to gender, age group (up to 59 years, 60 years or older), hospitalization in neurology (yes, no), reason for hospitalization due to stroke (yes, no), hospitalization due to TBI (yes, no) and hospitalization due to pneumonia (yes, no). The Mann-Whitney test was used, after verifying the non-normality of the data using the Kolmogorov-Smirnov test ($p < 0.05$). The significance level was $p < 0.05$ and the statistical treatment was processed using IBM® SPSS® software, version 22.0.

The research project was approved by the Research Ethics Committee with substantiated opinion no. 3.582.723, guaranteeing the anonymity and confidentiality of the data analyzed.

RESULTS

Data was analyzed on 254 patients who continued treatment at home after their health condition stabilized in hospital. Adolescents made up the smallest proportion of patients (1.6%) and the elderly the majority (57.9%). The majority (56.3%) of patients were male (Table 1).

The reasons for hospitalization are shown in Table 2, with emphasis on stroke (26.4%) and pneumonia (14.2%).

The average number of pre-existing illnesses at the time of hospitalization was equivalent to 1.36 (± 1.07) illnesses per person, with 49.2% having one illness, 19.7% two illnesses, 9.1% three, 2.8% four, 1.2% five and 0.4% six illnesses. Pre-existing diseases included hypertension (32.8%), diabetes mellitus (11.8%), followed by cancer (17.8%).

Patients were cared for in hospital in different medical specialties, as shown in Table 3, especially neurology (49.6%).

Table 1 - Demographic characteristics of patients admitted to Melhor em Casa, in the public health system, after hospital discharge. Montes Claros, MG, Brazil, 2016-2019

Life cycle	n	%
Children - 0 to 11 years	19	7,5
Teenagers - 12 to 17 years old	4	1,6
Adults - 18 to 59 years	84	33,1
Elderly - 60 and over	147	57,9
Gender	n	%
Female	111	43,7
Male	143	56,3

Source: authors, 2019.

Table 2 - Reason for hospitalization of patients admitted by the Melhor em Casa program, in the public health system, after hospital discharge. Montes Claros, MG, Brazil, 2016-2019

Reason for hospitalization	n	%
Cerebral vascular accident - CVA	67	26,4
Traumatic brain injury - TBI	28	11,0
Pneumonia	36	14,2
Limb amputation	4	1,6
Tumor resection	16	6,3
Bone fracture (except cranial)	9	3,5
Other reasons	94	37,0

Source: authors, 2019.

Table 3 - Area of hospitalization of patients taken on by the Melhor em Casa program, in the public health system. Montes Claros, MG, Brazil, 2016-2019

Medical specialty	n	%
Head/neck	2	0,8
Cardiology/cardiovascular	6	2,4
General surgery	10	3,9
Medical clinic	58	22,8
Neurology	126	49,6
Oncology	18	7,1
Orthopedics	15	5,9
Pediatrics	11	4,3
Plastic	2	0,8
Urology	2	0,8
Vascular	4	1,6

Source: authors, 2019.

Table 4 - Description and comparison of the time taken between medical and hospital discharge according to the demographic and clinical profile of patients admitted to the Better at Home program. Montes Claros, MG, Brazil, 2016-2019

Time between medical and hospital discharge in minutes					
Variables	Mean (95% CI)	Median	25%	75%	p*
Gender					
Female	204,43 (126,01-282,85)	120,0	64,0	201,0	0,115
Male	210,58 (171,68-249,49)	144,0	78,0	251,0	
Age group					
Up to 59 years old	192,32 (150,57-234,07)	137,0	82,0	216,0	0,685
60 and over	219,16 (155,76-282,57)	130,5	64,0	225,3	
Specialty hospitalization					
Neurology	223,72 (173,64-273,81)	135,0	80,0	229,0	0,244
Other	195,79 (135,0-256,58)	131,0	62,0	225,0	
Stroke hospitalization**					
Yes	237,73 (168,00-306,66)	139,5	77,0	261,3	0,366
No	197,28 (147,88-246,68)	132,5	72,8	221,3	
Hospitalization for TBI**					
Yes	259,50 (153,14-365,86)	166,0	121,0	308,3	0,041
No	201,42 (157,64-245,20)	127,5	66,5	219,5	
Hospitalization for Pneumonia					
Yes	113,86 (82,82-144,90)	98,0	40,0	144,0	0,012
No	223,04 (176,50-269,57)	141,0	77,0	232,0	

*p value of non-parametric Mann-Whitney U test; **TBI = Traumatic Brain Injury.
Source: authors, 2019

Table 5 - Description and comparison between medical discharge and admission to the Better at Home program according to patients' demographic and clinical profile. Montes Claros, MG, Brazil, 2016-2019

Time between medical discharge and admission to Melhor em Casa in days					
Variables	Mean (95% CI)	Median	25%	75%	p*
Gender					
Female	13,70 (10,95-16,46)	8,0	21	21,0	0,052
Male	10,55 (8,19-12,92)	6,0		14,0	
Age group					
Up to 59 years old	10,62 (7,83-13,40)	6,0	12	14,0	0,087
60 and over	12,88 (10,52-15,24)	7,0		21,0	
Specialty hospitalization					
Neurology	12,19 (9,49-14,90)	8,0	22	16,0	0,501
Other	11,73 (9,31-14,15)	6,0		18,0	
Stroke hospitalization**					
Yes	12,16 (8,3-16,03)	8,0	22	16,0	0,870
No	11,84 (9,82-13,87)	7,0		18,0	
Hospitalization for TBI**					
Yes	9,71 (3,00-16,43)	7,0	12	12,0	0,172
No	12,20 (10,35-14,06)	7,0		18,5	
Hospitalization for Pneumonia					
Yes	8,19 (3,91-12,48)	4,5	12	9,5	0,021
No	12,55 (10,58-14,51)	8,0		18,0	

*p value of non-parametric Mann-Whitney U test; **TBI = Traumatic Brain Injury.
Source: authors, 2019.

A hospitalization period of 15 days or more was identified for 52.8% of patients, with the average being 30 days and the longest being 1,482 days. Patients were discharged from hospital an average of 3.45 hours after discharge.

Patients admitted for TBI had a longer time between medical and hospital discharge (median = 166 minutes) when compared to those admitted for other reasons ($p = 0.041$); those admitted for pneumonia had a shorter time ($p = 0.012$). No difference was observed for patients admitted for stroke and neurology, between sex and age group (Table 4).

The waiting time for admission to Melhor em Casa after hospital discharge was seven days or more for 52.4% of patients, with a mean (standard deviation) of 11.93 (± 14.52) days and the longest period of 97 days.

Admission to Melhor em Casa after discharge had a lower median number of days for those who had been admitted for pneumonia, $p = 0.021$ (Table 5).

DISCUSSION

This study can contribute to the articulation of the SUS care network by analyzing clinical aspects related to patients taken on by the PMC for continuity of home care within the SUS. We highlight the higher frequency of patients hospitalized in the neurology area, due to strokes, in the elderly age group and people with a diagnosis of hypertension, prior to hospitalization, the majority were hospitalized for more than two weeks, and the longest time between hospital discharge and medical discharge was for patients hospitalized for TBI. Admission to Melhor em Casa took place, on average, 12 days after hospital discharge.

This study revealed a predominance of elderly patients admitted to the PMC. Among the elderly, there is a high percentage of people with functional impairment, a condition associated with morbidities in functional systems such as cognition, mood/behavior, communication and mobility.

The health of the elderly is closely related to functionality, which involves the potential for self-care.¹²

The structure of the Elderly Health Care Network is based on a clear definition of the health of the elderly. Diseases in this age group are more common, but not always related to functional dependence.¹³ On the other hand, this age group can be described as robust, i.e. with low clinical-functional vulnerability, active engagement and no disabilities.¹⁴ However, considering the greater chance of clinical-functional vulnerability among the elderly, aged 60 and over, it is important to try to reduce it through the intervention of matrix support to train professionals from the Family Health Strategy (FHS) to care for those who are not yet frail.¹⁵

Among the reasons for hospitalization, stroke, pneumonia and TBI stood out. Patients had pre-existing illnesses at the time of hospitalization, most frequently chronic non-communicable diseases such as hypertension, diabetes mellitus and cancer. These chronic diseases in themselves often generate conditions that favor the need for continuous care and home care, and they can also be coadjuvants in worsening the general clinical state of health, which would explain, in part, the length of stay of 15 or more days for most patients.

Each patient's situation must be considered, in a personalized and inclusive way, taking into account their singularities.¹⁰ In this discussion, multiprofessional tools such as the Braden, Barthel, Coelho and Savassi Family Vulnerability Scales, the Karnofsky Performance Scale and the Morse Scale, among others¹, help to assess the complexity of the patient as a biopsychosocial individual in order to offer optimized care¹⁶ to those with more than one disease and different needs, as the study found, with up to six diseases being recorded for the same patient.

The occurrence of multiple health needs is consistent with increased financial costs and time spent on care. Similarly, the patient's inability or difficulty in performing simple tasks (such as bathing) to more complex activities (such as managing their own medication and financial resources) often leads to the need for care for the caregiver as well.¹⁷ The condition of multiple comorbidities prioritizes eligibility for AD.

Almost half of the patients referred to the PMC were admitted to the medical specialty of neurology. Discharge from hospital occurred on average almost four hours after medical discharge. Another study analyzed the reasons for delayed hospital discharge and found that the high percentage of delays was mainly due to process-related factors, such as lack of discharge planning or out-of-hospital support scheduling. Delays in hospital discharge are worrying, given the scarcity of beds and the lengthy wait for hospitalization.^{XX}¹⁸

Possible reasons for the delay in discharging patients from hospital include: the lack of suitable equipment to continue caring for the patient at home and the family's refusal to accept discharge, due to the patient's multiple needs, which require monitoring by a multidisciplinary team. These reasons are also based on the lack of admission to the PMC immediately

after hospital discharge. A study carried out in a North American hospital found that communication failures during the hospital discharge process can lead to adverse events, as well as dissatisfaction and delays in hospital discharge.¹⁹

Hospital stays are caused by extrinsic factors or factors that are not only associated with the patient's comorbidity, as is the case with medical discharge. Thus, the patient is discharged by medical judgment, based on hospital history and the development of improvement. The PMC proposal establishes that the planned discharge strategy should be a reinforced practice among the professionals who make up the hospital team. This practice is one of the tools necessary for de-hospitalization. It is necessary for professionals to set aside space to discuss cases that can be transferred to AD, in order to promote longitudinal care at home.¹⁹

Patients cannot be compulsorily transferred from hospital to home, as this would violate the principles of humanization and go against the constitutional principles of the SUS. The main factor for a patient to be discharged from hospital and taken on by the PMC is to meet the inclusion criteria adopted for this program, based on clinical and administrative aspects.¹¹ In this study, patients were admitted to the PMC, on average, almost two weeks after being discharged from hospital. At this point, it could be argued that the system may also be overcrowded, given that at the time of the study the municipality had four PMC teams for around 400,000 inhabitants. However, this parameter is in line with the criteria defined by the Ministry of Health for adherence to *Melhor em Casa*, i.e. one team for every 100,000 inhabitants, which may suggest a new organizational evaluation of the programme as a public health policy.

The results of this study refer to patients admitted to the PMC after being discharged from hospital. It should be noted that in addition to the hospital network, patients can be referred from primary care and urgent and emergency services. This referral requires the use of a counter-referral scheme or instrument with a detailed report, which should contain relevant data to assess the user's clinical condition.²⁰

Still from the perspective of the delay in admitting patients to the PMC after hospital discharge, the literature discusses weaknesses in the program. Resources are still scarce to meet the demands of patient care, and the lack of communication is also discussed as a weakness, affected by failures in the interpersonal relationship between staff, patient and family. In some cases, for example, family members feel frustrated when the patient is discharged from hospital before being cured, since they relate discharge to cure.

A poor home structure or lack of sanitation also hampers the development of AD, since patients opt for SUS care, in many cases due to the scarcity of their own resources. Therefore, the lack of adequate physical space can also be an obstacle. Patients often need spaces that are accessible and adapted to their needs. The lack of financial resources becomes a problem for various reasons, but above all because

patients need materials and medicines, which are not always easily accessible or even free.

It should be assessed on a case-by-case basis, according to the specific situation, identifying the singularities and needs of the patients, as well as taking into account their abilities and PMC conditions¹¹. In a country with intense social inequality, it is suggested that the team discuss and evaluate the possibility of flexibility in the eligibility criteria for HC, as long as it does not compromise the quality of the service to be provided.

Another aspect to be considered is the process of migrating care. It should be integrated as a two-way cycle, i.e. at the same time as de-hospitalization occurs, hospitalization can take place. The motivation is to reduce hospital congestion and provide a new logic of care, with a focus on providing patients and families with a more favorable and humane psychosocial environment, promoting health and preventing illness.

The system must be integrated because, in the event of discharge from the PMC, patients in stable or improving condition should be referred to PHC and those with complications should be referred to hospital.²⁰ Insufficient coordination between the services that make up the HCN does not enable continuity of care at home, nor does it enable comprehensive care. Coordination must also involve the points of care and family members. It is recommended that mechanisms and strategies be created to make these links possible, helping family caregivers to feel more secure in providing care at home.⁹ Better coordination between the different levels of care could also help to reduce the length of admission to the PMC after hospital discharge.

Other support strategies that can be included in the routine and practices of professionals to improve coordination between the levels of care in the HCN, with PHC as the center of communication and the organizer of care, are local diagnosis of the population and identification of the demand for home and hospitalized patients, planning and organization of the team to provide home care, agenda management, organization of support materials such as specific supplies and vehicles, continuing education on clinical assessment tools and care protocols, assessment and adaptation of the residence, singular therapeutic project, recording instruments, among others.¹ The limitations of this study include the analysis of data extracted from medical records, which could lead to possible information bias due to flaws in the records.

CONCLUSION

Patients with continuity of home care after hospital discharge were characterized mostly as elderly, admitted to neurology, diagnosed with hypertension prior to hospitalization, admitted due to stroke and for 15 days or more, discharged within almost four hours of discharge and admitted to the Better Home Program 12 days after discharge. Patients with

different ages, morbidities and comorbidities were admitted to the Better at Home Program.

The period between hospital discharge and admission to Melhor em Casa suggests a need to improve communication/articulation between the different levels of health care in the SUS service network, in order to guarantee faster admission to the HC. This could also help to reduce the time between medical discharge and hospital discharge, by ensuring that patients and their families have continuity of care at home.

The health system must be prepared to meet the multiple needs of patients in an integrated way within the health care network. From this perspective, the data from this study can support planning in health services, enabling a better flow between hospital and primary health care.

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