ORIGINAL ARTICLE

JNUOL
Journal of Nursing UFPE Online

Profile and clinical conditions of patients in the “Better at Home” program

Perfil e condições clínicas de pacientes atendidos no programa “Melhor em Casa”

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Scientific Editor:
Tatiane Gomes Guedes
Managing Editor:
Maria Wanderleya de Lavor
Coriolano Marinus

Submitted: 05/16/2023
Accepted: 09/17/2024
Published: 11/09/2024

ABSTRACT

Objective: to analyze the profile and clinical conditions of patients treated in the 'Better at Home' program after hospital discharge. **Method**: cross-sectional-analytical study based on data from patients referred to home care. The variables studied were: gender, age, previous diseases, health status at hospital discharge. Bivariate and multiple analyses were performed to verify associations between health conditions and patient profile, with a significance level of $p < 0.05$. **Results**: the profile of 254 patients was mostly men (56.3%), elderly (57.9%), people with diseases prior to hospitalization (80.3%), bedridden (90.6%) and in need of tubes (74.4%). Men were younger ($p = 0.030$) and more frequent to use tubes ($p < 0.05$). The bedridden had a higher prevalence of tube use, tracheostomy, ostomy, and the presence of pressure injuries ($p < 0.05$). **Conclusion**: a higher frequency of men, the elderly, individuals with pre-existing diseases at the time of hospitalization, bedridden and tube users was identified. The bedridden condition was associated with the use of a tube, tracheostomy, ostomy and the presence of a lesion, male gender was associated with the tube. Non-elderly patients had a higher frequency of tracheostomized and ostomy conditions.

Descrpitores: Home Patients; Home Care; Primary Health Care; Comprehensive Health Care; Public Health.

RESUMO

Objetivo: analisar o perfil e as condições clínicas de pacientes atendidos no programa ‘Melhor em Casa’ após a alta hospitalar. **Método:** estudo transversal-analítico a partir dos dados de pacientes referenciados para a atenção domiciliar. As variáveis estudadas foram: sexo, idade, doenças prévias, condição de saúde na alta hospitalar. Análises bivariadas e múltiplas foram realizadas para verificar associações entre condições de saúde e perfil dos pacientes, com nível de significância $p < 0,05$. **Resultados:** o perfil de 254 pacientes foi majoritariamente de homens (56,3%), idosos (57,9%), pessoas com doenças prévias à internação hospitalar (80,3%), na condição de acamados (90,6%) e com a necessidade de sondas (74,4%). Os homens apresentaram menor idade ($p = 0,030$) e maior frequência para o uso de sondas ($p < 0,05$). Os acamados apresentaram maior prevalência para o uso de sonda, traqueostomia, ostomia e presença de lesão por pressão ($p < 0,05$). **Conclusão:** identificou-se maior frequência de homens, idosos, indivíduos com doenças pré-existentes à internação hospitalar, acamados e usuários de sondas. A condição de acamado foi associada ao uso de sonda, traqueostomia, ostomia e presença de lesão, sexo masculino associou-se a sonda. Os pacientes não idosos apresentaram maior frequência para as condições de traqueostomizado e ostomia.

Descriptores: Pacientes Domiciliares; Assistência Domiciliar; Atenção Primária à Saúde; Assistência Integral à Saúde; Saúde Pública.

HOW TO CITE THIS ARTICLE:

Pinho S, da Silva Junior RF, Pereira VG, de Pinho L, da Silva CV, Caldeira AP, et al. Profile and clinical conditions of patients in the “Better at Home” program. J. Nurs. UFPE on line. 2024;18:e258610 DOI: https://doi.org/10.5205/1981-8963.2024.258610

INTRODUCTION

Home Care (HC) is one of the responsibilities of Primary Health Care (PHC), especially the Family Health Strategy (FHS) team.[1] However, for home care to be effective, it is necessary to clearly define the criteria for patient admission to avoid unnecessary time consumption and the abandonment of more complex health situations.[2]

HC is strengthened by linking the health sectors and seeking ways to advance comprehensive health care. It is based on in-depth knowledge of the health service user, with their real needs, routines, culture, and family context.[3] HC was supported by the National Home Care Policy (NHCP), established in Brazil in 2011. In 2016, Ordinance No. 825/2016 redefined HC within the Unified Health System (UHS) scope and updated the qualified teams.[4]

The NHCP integrates public health, hospital PHC. The NHCP promotes greater interaction between clinical and administrative actions based on the implementation of relational, educational, and technical measures, including the '*Melhor em Casa*' (Better at Home) program.[3] This program was created to improve and expand care within the UHS for patients who can receive assistance at home with their families, so as to humanize care.[1] Therefore, the home environment provides a new space for health care, which goes beyond technical and hospital actions.[5]

Other purposes of HC are to reduce the length of time patients stay in hospital, to ensure better use of hospital beds, to reduce the risk of infection[1] and costs, and to organize care centered on the health service user. These purposes are consistent with Brazil's demographic and epidemiological characteristics in the sense of continuous care for multiple chronic diseases.[6]

Discussing the profile of patients cared for in-home care will help with care planning and the implementation of better healthcare interventions. However, there is a lack of publications on this subject[7,8] of dehospitalization. In this study, we hypothesized that different health conditions, such as the use of tubes, tracheostomies, ostomies, and Pressure Injuries (PI), are associated with different demographic and clinical profiles.

OBJECTIVE

This study aimed to analyze the profile and clinical conditions of patients cared for in the 'Better at Home' program after being discharged from the hospital.

METHOD

This is a cross-sectional, analytical study, which complied with the guidelines recommended by The Strengthening the Reporting of Observational Studies in

Epidemiology (STROBE).[9] Data was analyzed from the health records of patients who were discharged from the hospital and received into the ‘Better at Home’ program in the public health services network of a municipality located in the north of Minas Gerais, Brazil. The data refers to patients cared for in the ‘Better at Home’ program between 2016 and 2019 in a municipality with a population of around 400,000 inhabitants and four ‘Better at Home’ teams in place.

Data was collected during the first and second semesters of 2020. The following variables were analyzed: sex (male, female), age, limited mobility (bedridden, wheelchair users, difficulty walking), existence of diseases before hospital admission (yes, no), need to use tubes (yes, no), tracheostomized (yes, no), ostomies (yes, no) and PIs (yes, no). The variables age and limited mobility were dichotomized into elderly aged 60 or over (yes, no) and 'bedridden' (yes, no).

The data was described in absolute values and percentages. The means (standard deviations - SD) of the ages and respective 95% Confidence Intervals (95%CI), medians, minimums, and maximums were calculated. Age medians were analyzed according to gender and clinical profile variables using the Mann-Whitney test due to the non-normality of the data using the Kolmogorov-Smirnov test ($p < 0.05$).

Bivariate and multiple analyses were carried out using Poisson regression, with robust variance, and crude and adjusted Prevalence Ratios (PR) were estimated, with the respective 95% confidence intervals (95%CI). The dependent variables were the patients' clinical conditions at the time of hospital discharge: use of tube, tracheostomy, ostomy, and Pressure Injury (PI). The independent variables were sex, elderly ≥ 60 years, bedridden, and presence of previous illnesses. The statistical treatment considered a significance level of $p < 0.05$ and was processed using IBM® SPSS® software, version 22.0.

The research was approved by the Research Ethics Committee, duly accredited by the National Research Ethics Commission (CONEP) which granted a consubstantiated opinion integrated into the Brazil platform under No. 3.582.723, thus guaranteeing the anonymity and confidentiality of the data extracted from the medical records.

RESULTS

In four years, 254 patients who had been discharged from the hospital were treated at home in the UHS network under the 'Better at Home' program. The demographic profile of the patients showed that the majority were male (56.3%) and aged 60 or over (57.9%). Age ranged from 1 to 105 years, with a mean of 58.84 (±25.1) and a median of 63.5 years. Concerning the clinical profile, 80.3% of the patients had pre-existing illnesses when they

were admitted to hospital. At discharge, there were limitations in terms of mobility, with 90.6% of patients being bedridden, 6.3% being wheelchair users, and 3.2% having difficulty walking. Table 1 shows that the majority of patients went to the HC service with the need to use tubes (74.4%).

Table 1. Clinical conditions of patients received by the 'Better at Home' program after hospital discharge. Northern Minas Gerais, Brazil. 2016 to 2019. Montes Claros (MG), Brazil, 2020.

Clinical conditions	Yes	
	N	%
Use of tubes	189	74.4
Tracheostomized	89	35.0
Ostomies	97	38.2
PI	101	39.8

When the age of patients was analyzed according to gender, it was found that men had a lower median age (62 years) when compared to women (p = 0.030). The age of patients with tracheostomies and ostomies was lower compared to those without these conditions (p < 0.05). No statistical difference was found between the ages of patients for the use of tubes and PIs, nor limited mobility. People with pre-existing illnesses at the time of hospital admission were older than those without previous illnesses (Table 2).

Table 2. Age of patients according to sex and clinical condition, Northern Minas Gerais, Brazil, 2016 to 2019. Montes Claros (MG), Brazil, 2020.

Variables		Age of patients					
		Mean 95%CI*	SD	Median	Minimum	Maximum	p**
Sex	Female	62.80 58.24-67.37	24.266	66.0	1	105	0.030
	Male	55.74 51.49-59.99	25.525	62.0	2	102	
Use of tubes	Yes	57.07 53.25-60.89	26.261	62.0	1	102	0.166
	No	63.98 59.19-68.78	19.339	66.0	9	105	
Tracheostomy	Yes	49 .69 43.98-55.40	27.104	57.0	1	92	<0.001

	No	63.78 60.32-67.25	22.543	67.0	2	105	
Ostomy	Yes	51.59 46.14-57.04	27.051	57.0	1	102	0.001
	No	63.32 59.73-66.92	22.782	67.0	2	105	
PI	Yes	63.19 59.17-67.20	20.335	64.0	14	105	0.170
	No	55.97 51.58-60.37	27.501	63.0	1	100	
Difficulty walking	Bedridden	58.67 55.33-62.01	25.678	64.0	1	105	0.805
	Wheelchair user/difficulty walking	60.50 52.43-68.57	19.120	58.0	26	98	
Pre-existing illnesses	Yes	61.74 58.26-65.22	25.210	66.0	1	105	<0.001
	No	47.02 41.03-53.01	21.074	43.5	2	88	

*95%CI - 95% Confidence Interval.

**p-value for comparing medians using the Mann-Whitney test.

***SD – Standard Deviation.

Among those with a record of pre-existing illnesses, 53.4% were men, although there was no significant difference when compared to women (p = 0.063); also, for bedridden patients, the highest frequency (57.4%) was for men, p = 0.277. The use of a tube in men was 11% higher than in women (PR = 1.11) and 35% higher among those discharged from the hospital as bedridden (PR = 1.35), with statistical significance. Among tracheostomized patients, the highest prevalence was for patients aged under 60 (PR = 1.14) and among bedridden patients (PR = 1.16), with statistical significance (p < 0.05). Although men had a higher prevalence of tracheostomy records in the bivariate analysis, the gender variable did not remain associated with the multiple analyses (Table 3).

Table 3. Bivariate and multiple analysis (Poisson Regression) for variables associated with the use of tubes and tracheostomies in patients receiving HC. Northern Minas Gerais, Brazil. 2016 to 2019. Montes Claros (MG), Brazil, 2020.

Variables	**Use of tube**					
	Yes	**No**	**Bivariate**		**Multiple**	
	N(%)	**N(%)**	**PR(95%CI)***	**p**	**PR(95%CI)***	**p**

Sex						
Female	73(65.8)	38(34.2)	1	0.005	1	0.010
Male	116(81.1)	27(18.9)	1.13(1,04-1,23)		1.11(1.03-1.21)	
Elderly (≥60 years)						
Yes	105(71.4)	42(28.6)	1	0.195	-	-
No	84(78.5)	23(21.5)	1.05(0.97-1.15)			
Bedridden						
Yes	8(33.3)	16(66.7)	1	<0.001	1	<0.00
No	181(78.7)	49(21.3)	1.37(1.22-1.54)		1.35(1.20-1.52)	1
Pre-existing illnesses						
Yes	151(74.0)	53(26.0)	1	0.771	-	-
No	38(76.0)	12(24.0)	1.02(0.91-1.13)			

	Tracheostomized					
Variables	**Yes**	**No**	**Bivariate**		**Multiple**	
	n(%)	**n(%)**	**PR(95%CI)***	**P**	**PR(95%CI)***	**p**
Sex						
Female	31(27.9)	80(72.1)	1	0.033	-	-
Male	58(40.6)	85(59.4)	1.08(1.01-1.16)			
Elderly (≥60 years)						
Yes	39(26.5)	108(73.5)	1	0.001	1	0.001
No	50(46.7)	57(53.3)	1.14(1.05-1.22)		1.14(1.05-1.22)	
Bedridden						
Yes	3(12.5)	21(87.5)	1	0.001	1	<0.001
No	86(37.4)	144(62.6)	1.15(1.06-1.25)		1.16(1.08-1.27)	
Pre-existing illnesses						
Yes	68(33.3)	136(66.7)	1	0.270	-	-
No	21(42.0)	29(58.0)	1.05(0.96-1.16)			

* PR - Prevalence Ratio; 95%CI - 95% Confidence Interval.

Ostomy was associated with age, with a higher prevalence among non-elderly patients (PR = 1.10) and among those who were bedridden at hospital discharge (PR = 1.14), with $p < 0.05$. For PIs, bedridden patients had a 22% higher prevalence when compared to wheelchair users or individuals with difficulty walking, as shown in Table 4.

Table 4. Bivariate and multiple analysis (Poisson regression) for variables associated with ostomy and PI in patients receiving HC. Northern Minas Gerais, Brazil. 2016 to 2019. Montes Claros (MG), Brazil, 2020.

	Ostomy			
Yes	**No**	**Bivariate**	**Multiple**	

Variables	N(%)	N(%)	PR(95%CI)*	P	PR(95%CI)*	p
Sex						
Female	37(33.3)	74(66.7)	1	0.156	-	-
Male	60(42.0)	83(58.0)	1.06(0.98-1.14)			
Elderly (≥60 years)	47(32.0)	100(68.0)	1	0.018	1	0.011
Yes	50(46.7)	57(53.3)	1.10(1.02-1.18)		1.10(1.02-1.19)	
No						
Bedridden						
Yes	5(20.8)	19(79.2)	1	0.025	1	0.014
No	92(40.0)	138(60.0)	1.12(1.01-1.23)		1.14(1.03-1.25)	
Pre-existing illnesses	77(37.7)	127(62.3)	1	0.771	-	-
Yes	20(40.0)	30(60.0)	1.01			
No						

Variables	PI					
	Yes	No	Bivariate		Multiple	
	N(%)	N(%)	PR(95%CI)*	P	PR(95%CI)*	p
Sex						
Female	43(38.7)	68(61.3)	1	0.768	-	-
Male	58(40.6)	85(59.4)	1.01(0.94-1.09)			
Elderly (≥60 years)	64(43.5)	83(56.5)	1	0.145	-	-
Yes	37(34.6)	70(65.4)	0.94(0.88-1.02)			
No						
Bedridden						
Yes	2(8.3)	22(91.7)	1	<0.001	1	<0.001
No	99(43.0)	131(57.0)	1.22(1.14-1.32)		1.22(1.14-1.30)	
Pre-existing illnesses	84(41.2)	120(58.8)	1	0.335	-	-
Yes	17(34.0)	33(66.0)	0.96(0.88-1.05)			
No						

* PR - Prevalence Ratio; 95%CI - 95% Confidence Interval.

DISCUSSION

This study described the demographic and clinical profile of 254 patients referred for home care under the 'Better at Home' program in the UHS, in a municipality located in the north of Minas Gerais, Brazil, after discharge from the hospital. The hypothesis proposed in this investigation was also confirmed: different health conditions (use of tubes, tracheostomy, ostomy, and PI) were associated with different demographic and clinical profiles.

The profile of the patients was mostly made up of men, the elderly, people with illnesses before hospitalization, bedridden, and requiring the use of tubes. The

predominance of the elderly age group among patients who used the home care service has also been observed in other studies.[7, 10-13] Although two of them refer to the period before the implementation of the 'Better at Home' program, it is noteworthy that the studies were conducted in locations where actions similar to this program were already being provided.[10,11]

It should be noted that in addition to the need for continuous care related to the aging of the population, other conditions are susceptible to long-term care, such as premature babies, sequelae and chronic diseases, degenerative diseases, palliative care, life support, and rehabilitation[14], which explains the wide variation in the age of the patients investigated in this study, from one to 105 years.

Women had a higher median age when compared to men, but both groups were above the age of 60 years old. The higher frequency of elderly people may be related to the increase in life expectancy and the prevalence of chronic diseases in this age group, conditions which make people more likely to need home care[11]. As for the higher percentage of men among those studied, there are divergent results in other studies[7,10,12], with a predominance of women.

The majority of patients were bedridden, a result that is in line with another study of 131 patients treated by a public home care program.[7] Lack of mobility is a criterion for patients to be treated by the 'Better at Home' program.[13] Being bedridden was associated with the use of a tube, tracheostomy, ostomy, and PI, conditions that further weaken patients who are unable to move.

Another trend observed in the study was the use of a tube for the majority of patients, regardless of age, but with a higher percentage and statistical association among men and bedridden patients. Concerning feeding, the study by Souza, Neuman et al.[15] showed that the majority of patients use an oral tube (64%). In public services, the frequency of use of a nasal tube (NET) or nasogastric tube (NGT) is higher than that of gastrostomy, which is more expensive for the UHS and is a more difficult surgical procedure to perform.

As presented in this study, there is some variation in the clinical profile of patients admitted to 'Better at Home.' As for the patient's eligibility profile for HC, the Ministry of Health establishes that it is for those with clinical stability and when home care is considered an opportune offer for treatment. It can be for palliation, rehabilitation, or disease prevention, taking into account the autonomy of the patient, family members, and caregivers.[4] In situations where no 'Better at Home' team exists in municipalities that don't have the population size to have an HC service or even those that haven't yet defined the implementation of this service, primary care teams can become referrals for all HC users.[16]

Also, according to the results of this study, tracheostomy and ostomy were more prevalent among non-elderly patients and bedridden patients. However, these morbidities may be conditions that imply that the patient falls into the 'HC2' or 'HC3' modalities, which are prerequisites for admission to 'Better at Home.'[1] Multiple comorbidities represent common characteristics in the profile of patients admitted to HC services.[17-19] The results of this study showed that patients had multiple follow-up needs, with health conditions that meet the eligibility criteria for 'Better at Home'.

The degree of dependence on 'Better at Home' varies according to the complexity of the patient's health condition. The greater the degree of complexity, the greater the degree of dependency. Another study, with a home care plan for 2,934 patients, found that 53% of high-complexity patients were totally dependent[18], confirmed by this study, with more than 90.0% of patients being bedridden.

There are many criteria for a patient to be assisted by 'Better at Home'. In addition to mobility problems, as mentioned above, other conditions can be highlighted: wounds, use of antibiotics for respiratory difficulties, and use of ventilatory support.[13] In this study, patients had pre-existing illnesses before hospitalization, which suggests fragility in their health condition.

The most frequent problems in patients receiving HC are pneumonia, diabetes, tuberculosis, and visceral leishmaniasis[11], neurological problems, tumors[10,15], bone and cardiorespiratory problems[9]; as well as vascular diseases[7] and PI/ulcers.[7,20] Many of these diseases are more prevalent among the elderly, in line with the demographic profile found in the patients who requested the 'Better at Home' service.

The actions carried out at home aimed to fulfill basic human needs, providing comfort, and contentment and restoring the balance of psychological, biological, and physiological functions. These are essential needs for sustaining life, common to all people[14] who needed continuity of care after hospital discharge.

As for access to HC services, understanding this is a process that goes beyond the number of existing services and the different levels of accessibility in the care network. It includes the quality of care provided through humanized care[21] and articulated communication between the different points of care in the UHS, which is a foundation for transversality.[22]

This acknowledges the importance of home care and, at the same time, the need for this service within the UHS. However, following the progressive increase in the population of the municipality analyzed, as well as its surroundings, which has the hospital where the study was carried out as a reference for various specialties, it is understood that it is

necessary to expand not only the 'Better at Home' teams themselves, but to maximize their technical possibilities.

The study also showed a higher frequency of patients with PIs among those who were bedridden, in agreement with another study.[23] Even for patients without PI, it should be emphasized that being bedridden puts them at greater risk of developing these injuries[12] when they are cared for at home.

HC is a proven safe and effective option for patients with chronic or acute illnesses.[24] Among other benefits, it is clear that it reduces the incidence of nosocomial infections, allows specific treatments for certain illnesses, and, finally, makes hospital beds available for patients who need more complex treatments.[11] A significant proportion of elderly patients admitted to hospitals could benefit from bed replacement services at home, as demonstrated in a study conducted in an Australian referral center hospital.[25]

It is becoming increasingly important in different social and health organizations to expand HC services as a viable and promising alternative. From this perspective, a meta-analysis concluded that home-based intervention based on health education and care support for patients with heart failure reduced readmission rates and increased patient survival.[26]

HC should enable people to experience a new type of health care that brings together knowledge and technology. It is based on the real situation of each person according to their needs and provides personalized, more humane care and faster recovery.[10, 27] When the prognosis is very unfavorable, dehospitalization should also be considered as a possibility of ending life in the family environment through palliative care.[28] A study that assessed the preference of patients diagnosed with cancer as to the place of death found a higher frequency of opinions for death at home.[29]

The benefits of this system are not only directed at the patient but at all the spheres that permeate it, including the allocation of public health resources. This justifies improving and expanding HC services based on the demographic and clinical profile of users of this type of health care.

One of the limitations of this study is the fact that there is still no standardized, technologically efficient system between hospitals and PHC that can serve as a basis for substantiated data to better investigate patient flows, referrals, and counter-referrals between the different levels of care in the UHS. The data was collected from a hospital's medical records, following a survey of patients admitted to 'Better at Home,' so there is a possibility of information bias as this is secondary data.

CONCLUSION

The profile and clinical conditions of patients discharged from the hospital for home care under the 'Better at Home' program in the UHS showed a higher frequency of men, elderly people, individuals with pre-existing diseases, bedridden people, and people using tubes. The condition of being bedridden was associated with the use of a tube, tracheostomy, ostomy, and the presence of a PI, placing them in a situation of greater frailty. Men were younger and had a higher frequency of needing tubes. Non-elderly patients had a higher frequency of tracheostomy and ostomy conditions.

Delimiting and analyzing the clinical conditions of patients at hospital discharge can support the planning and implementation of appropriate interventions. It should be emphasized that the aging process of the population is a factor that encourages the health system to pay attention to new models of health care, such as home care, although these new medical strategies are relevant to effective changes in health practices, regardless of age group.

CONTRIBUTIONS

All the authors contributed equally to the conception of the article, data collection, analysis, and discussion, as well as to writing and critically reviewing the content, making intellectual contributions, and approving the final version of the study.

CONFLICTS OF INTERESTS

Nothing to report.

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