

Dehospitalization of Elderly People in Situations of Social Vulnerability: The Experience of Belo Horizonte

Desospitalização de Idosos em Situação de Vulnerabilidade Social: A Experiência de Belo Horizonte

Deshospitalización de Personas Mayores en Situación de Vulnerabilidad Social: La Experiencia de Belo Horizonte

RESUMO

O presente relato descreve a experiência inovadora da Secretaria Municipal de Saúde de Belo Horizonte na desospitalização de idosos em situação de vulnerabilidade social. Por meio da atuação de uma enfermeira referência técnica nos hospitais da Rede SUS-BH, foram articuladas ações intersectoriais entre saúde e assistência social para viabilizar a alta segura de pacientes sem suporte familiar. O estudo apresenta o caso de um idoso que permaneceu internado por dois anos após alta clínica, destacando a metodologia de avaliação integral e plano de ações que incluíram transporte para hemodiálise e admissão em Instituição de Longa Permanência (ILPI). A experiência demonstrou que, embora complexo, o processo de desospitalização é viável quando há integração efetiva das redes de cuidado. A iniciativa contribui para a qualificação da atenção, a liberação de leitos e a garantia do direito à vida digna, rompendo com o paradigma do isolamento social imposto a idosos vulneráveis.

DESCRIPTORIOS: Desospitalização; Vulnerabilidade Social; Regulação

SUMMARY

This report describes the innovative experience of the Municipal Health Department of Belo Horizonte in the discharge of socially vulnerable elderly patients. Through the work of a nurse acting as a technical reference in hospitals of the SUS-BH network, intersectoral actions between health and social care were coordinated to enable safe discharge for patients without family support. The case of an elderly man hospitalized for two years after clinical discharge is presented, highlighting a methodology based on comprehensive assessment and an action plan that included dialysis transportation and admission to a Long-Term Care Institution (LTCI). The experience showed that, although complex, hospital discharge is feasible when care networks are effectively integrated. The initiative contributes to improving care quality, freeing up hospital beds, and ensuring the right to a dignified life, challenging the paradigm of social isolation often imposed on vulnerable elderly individuals.

DESCRIPTORS: Deinstitutionalization; Social Vulnerability; Regulation

RESUMEN

Este informe describe la experiencia innovadora de la Secretaría Municipal de Salud de Belo Horizonte en la desinstitucionalización de personas mayores en situación de vulnerabilidad social. A través del trabajo de una enfermera como referencia técnica en los hospitales de la red SUS-BH, se articularon acciones intersectoriales entre salud y asistencia social para posibilitar un alta segura a pacientes sin apoyo familiar. Se presenta el caso de un adulto mayor que permaneció hospitalizado durante dos años tras el alta clínica, destacando una metodología basada en evaluación integral y un plan de acción que incluyó transporte para hemodiálisis e ingreso en una Institución de Larga Permanencia (ILPI). La experiencia demostró que, aunque complejo, el proceso de alta hospitalaria es viable cuando hay integración efectiva de las redes de atención. La iniciativa contribuye a mejorar la calidad del cuidado, liberar camas hospitalarias y garantizar el derecho a una vida digna, enfrentando el aislamiento social impuesto a los mayores vulnerables.

DESCRIPTORIOS: Deshospitalización; Vulnerabilidad Social; Regulación

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INTRODUCTION

Long hospital stays are evident when patients' stays exceed thirty days. This situation, when related to social issues, primarily affects public institutions. Immediate consequences for public health include, in addition to the high cost to the Unified Health System, increased pressure on tertiary care and difficulty in managing queues at regulatory centers.

As individual issues, the losses are related to the loss of functional capacity of elderly people and people with disabilities, risks of falls, infections related to care, mental suffering, risk of iatrogenesis, among others¹. Long-term hospitalization associated with social conditions is a complex and multifactorial problem, which is associated with the epidemiological transition, which causes profound changes in health and disease patterns, with social determinants, in addition to the refusal of discharge by families. 2

In Brazil, inequality in income distribution, low levels of education, housing conditions and a precarious living environment have a negative impact on people's quality of life and health. 3 Given this challenging context, innovative strategies are needed to ensure the safe and humane discharge of these individuals to inclusive housing or Long-Term Care Facilities (LTCF).

This study aims to report on the experience of Belo Horizonte, which, through the Directorate of Regulation of Medium and High Complexity (DMAC - Diretoria de Regulação de Média e Alta Complexidade), organized a unique work methodology involving the technical reference team in hospitals that are part of the SUS-BH Network.

As an innovative strategy of the Belo Horizonte Municipal Health Department, a nurse works in hospitals as a technical resource to support and train teams in managing cases of patients who remain hospitalized

even after discharge due to multiple vulnerabilities. The nurse monitors all patients, participates in bed assignments, case discussions, and hounding sessions with providers' care teams, as well as facilitating coordination with the municipal social service network.

METHOD

This is an experience report using a descriptive qualitative approach. The study describes a snapshot of the life trajectory of a 61-year-old man who was hospitalized for the management of diabetes complications and had no income or living family. The patient remained in the hospital for two years after discharge, between 2021 and 2023, with a total hospital stay of 738 days, due to a lack of family support and social vulnerability.

Data collection was conducted through medical record review, observation, and the author's participation in the interventions. The process began with a comprehensive assess-

ment of the patient, identifying their health needs, functional limitations, and social context.

Based on this understanding of the current situation, an action plan was developed that included: Health Network Coordination: Involvement of various services, such as healthcare to ensure continuous monitoring, the Health Department to facilitate access to hemodialysis beds, and organization of transportation to hemodialysis sessions to minimize mobility difficulties. Integration with the social assistance network through a survey of available resources in the community and coordination with social services to facilitate the transfer of the patient to a Long-Term Care Facility (LTCF), such as: analysis of the necessary conditions for admission to the LTCF, provision of documentation, and updating of vaccination records.

RESULTS/DISCUSSION

During the period analyzed, 102 patients undergoing dehospitalization processes in the city of Belo Horizonte were monitored, seven of whom were successfully transferred to long-term care facilities. It is important to emphasize, however, that this is a highly complex process, mainly due to the scarcity of beds in long-term care facilities and the extremely restrictive admission criteria established for these patients.

Replicating this methodology in other contexts can serve as a model for the continuous improvement of health care, especially for vulnerable populations. Characterizing the observed variables, it is noteworthy that the insufficiency or absence of family support proved to be an important determinant of discharge for elderly individuals. In cases where patients are dependent for activities of daily living, dehospitalization becomes more difficult for both the family unit and the long-term care facility.

Social issues occupy an important space in hospital care, as institutions play a role that goes beyond clinical care when it is necessary to intervene in the patient's life, such as contacting family, locating a relative to take responsibility for the patient, arranging new documentation, and providing benefits. This is called working with and planning for discharge.

The development of this work front highlighted that the process of dehospitalizing elderly people and people with disabilities between the ages of 18 and 59 is complex and multifaceted, but possible through the coordination of an intersectoral network. Given this context, it is essential that health and social assistance policies have available resources to develop more comprehensive public policies, as the increasing presence of elderly people in fragile families or in situations of great social vulnerability is a reality.

The dehospitalization of underserved individuals faces specific challenges, such as unequal access to healthcare. In many regions, especially the most vulnerable, the lack of adequate infrastructure and home health services hinders the safe discharge of patients. The Unified Health System (SUS) has made efforts to expand these services, but there are still many gaps that need to be addressed to ensure that dehospitalization is a viable option for everyone^{4,5}.

It is also important to emphasize that care for vulnerable elderly individuals or people with disabilities cannot be segmented and must be considered from a holistic perspective, grounded in intersectoral collaboration. The experience in Belo Horizonte demonstrates that it is possible to break with old paradigms in which society often imposes isolation on elderly individuals or people with disabilities in the name of protection and care, relegating them to the sidelines and excluding them from social

interaction. There is life after social dehospitalization.

The safe and humane dehospitalization of this population opens a new window of opportunity for continuity of life, countering the social stigma of finitude and isolation. The experience proves successful not only due to the dehospitalization but also due to the quality of care provided to this patient profile.

Despite structural limitations, it is understood that the role of technical references in hospitals is a fundamental element for improving care quality, as it contributes to the systematization of care, the standardization of administrative and care procedures, and the optimization of hospital bed management flows. This practice strengthens comprehensive care and favors the rational use of available resources, consolidating advances in the dehospitalization process within the Unified Health System.

The results of this experience report demonstrate the effectiveness of the methodology implemented by the Directorate of Regulation of Medium and High Complexity (DMAC - Diretoria de Regulação de Média e Alta Complexidade) of the Belo Horizonte Municipal Health Department. The coordination of work between hospitals, healthcare networks, and social assistance, coordinated and mediated by the regulatory directorate, can positively transform the dehospitalization processes of socially vulnerable patients.

CONCLUSION

The experience in Belo Horizonte highlights that dehospitalizing elderly and people with disabilities in socially vulnerable situations is a complex but feasible challenge when there is effective coordination between the health and social assistance sectors. The work of the technical reference team in hospitals within the SUS-BH

Network demonstrates that careful discharge planning, combined with comprehensive patient assessment and strengthening the intersectoral network, can transform situations marked by exclusion. This practice not only enables the safe discharge

of patients from the hospital environment but also contributes to the humanization of care and social reintegration.

The case presented reinforces the importance of structured public policies and adequate resources to guar-

antee the right to a dignified life, especially given the growth of social inequalities and an aging population. Replicating this strategy can serve as a model for other locations, promoting concrete advances in the health care of vulnerable populations.

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