Revista Portuguesa de Diabetes. 2025; 20 (1): 34-42

The Role of Home Hospitalization: A Perspective on Diabetes Care

O Papel da Hospitalização Domiciliária: Uma Perspetiva sobre os Cuidados na Diabetes

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Abstract

Introduction: With the extension of average life expectancy and the consequent increase in the elderly population, health systems need to be adapted to face the increase in chronic pathologies and their exacerbations. Type 2 diabetes is considered one of the most prevalent chronic diseases and is a focus of great concern for national and international health policies.
Objectives: Demonstrate the role of Home Hospitalization in the integrated care process for diabetes in Portugal and to present guidelines for the provision of care to patients/families/caregivers with type 2 diabetes.
Methodology: Opinion article produced after analysis of scientific evidence and national and international clinical guidelines.
Results: In Portugal, with the integration of various levels of care, through the creation of Local Health Units, Home Hospitalization establishes value-based home care, reduces the risk of hospital infections and physical and cognitive decline, promotes early recovery of patients and empowers the patient and family to manage the disease(s). With the advantage of practice in family environment and contributing to the sustainability of the National Health System.
Conclusion: It is important to define and implement the entire care process in the National Health System, and the role of each actors in the care of people with diabetes is clarified. Home Care Hospitalization is at the same time, an integrated stage of care between the hospital and the health center and a safe, effective and sustainable approach. In this sense, the best institutional protocols with clear procedures should be designed, which produce effective gains for people and result in the reduction of diabetes complications and the consequent avoidable hospitalizations.

Keywords: hospital at home; type 2 diabetes *mellitus*; health care professionals

Resumo

Introdução: Com o prolongar da esperança média de vida e consequente aumento da população idosa, surge a necessidade de adaptações nos sistemas de saúde, para fazer face ao acréscimo de patologias crónicas e às suas agudizações. A diabetes tipo 2 é considerada uma das doenças crónicas mais prevalentes da atualidade e foco de grande preocupação por parte das políticas de saúde nacionais e internacionais.
Objetivos: Demonstrar qual o papel da Hospitalização Domiciliária no processo assistencial integrado da diabetes em Portugal e apresentar linhas orientadoras para a prestação de cuidados à pessoa/família/cuidador com diabetes tipo 2.
Metodologia: Artigo de opinião produzido após análise de evidência científica e orientações clínicas nacionais e internacionais.
Resultados: Em Portugal, com a integração dos vários níveis de cuidados, pela criação de Unidades Locais de Saúde, a Hospitalização Domiciliária estabelece cuidados domiciliários baseados em valores, reduz o risco de infeções hospitalares e declínio físico e cognitivo, promove a recuperação precoce dos pacientes e capacita a pessoa e família para gerir a(s) doença(s). Com a vantagem de fazê-lo no seu ambiente familiar e contribuindo para a sustentabilidade SNS.
Conclusões: É importante definir e implementar todo o seu processo assistencial no sistema nacional de saúde, de forma que se esclareça o papel de cada um dos atores nos cuidados à pessoa com diabetes. A prática de cuidados em Hospitalização Domiciliária constitui-se ao mesmo tempo, um palco integrado de cuidados entre o hospital e o centro de saúde e uma abordagem segura, eficaz e sustentável. Neste sentido, devem ser concebidos os melhores protocolos institucionais com procedimentos claros, que produzam ganhos efetivos para as pessoas e resultem na redução das complicações da diabetes e nos consequentes internamentos evitáveis.

Palavras-chave: hospitalização domiciliária; diabetes *mellitus* tipo 2; profissionais de saúde

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Recebido/Received: 27/04/2024; Aceite/Accepted: 19/02/2025.

Revista Portuguesa de Diabetes. 2025; 20 (1): 34-42

> INTRODUCTION

The current and demanding social context and the complexity of health needs pose enormous challenges to health policies. In Portugal, it is argued that the integration of care is a means to improve their quality, and it is hoped that it will promote accessibility and citizen satisfaction and consequent health gains.

The National Health Service (NHS), founded in 1979, is made up of public organizations that provide promotion, prevention and treatment care, and is divided into:

- Primary Health Care (PHC) – the first level of contact with the person/family/community, constituting the central element of the NHS and assuming an integrated perspective of articulation with the other levels of care. They play a key role in health promotion, disease prevention, direct provision of care with continuity and community approach. Provide healthcare only when the medical condition does not require specialized care;
- Hospital Health Care (HC) – is a second level of care that is more specialized in technical means, providing care in different areas, through clinical referral or urgent or emergency cases;
- Integrated Long-Term Health Care (ILHC) – these are services that correspond to rehabilitation or long-term care. They focus on sequential, health and/or social support interventions, which aim to enhance the autonomy and functionality of the person in a situation of dependency, through their rehabilitation, readaptation and family and social reintegration. [1]

Since its formation, the NHS has undergone several reforms, with the concept of local health systems [2] emerging as a set of health centers, hospitals and other services, in a given geographical area of a health region, which are responsible for ensuring health promotion, continuity of care provision and rationalization of the use of existing resources. This model was eventually transformed[3] and the current Local Health Units (LHUs) were implemented, where the same level of responsibility for the health of the community, the same level of articulation with the management bodies of the LHUs and the same level of prioritization and appreciation of its activities is intended. [3]

The creation of LHUs has promoted greater integration between different levels of care, facilitating the implementation and expansion of models such as home hospitalization. [3]

The first Home Hospitalization Units (HHUs) emerged in the 1940s in the United States as an alternative to conventional hospitalization of acute patients. [4] That´s a type of healthcare that provides patients with healthcare at home comparable to what they would receive in a hospital, either by continuing the treatment started in a conventional hospital or by initially receiving the patient from Primary Care, Residences, Consultations or Emergency Services (home care for initiation or avoidance of admission). [5]

There´s been identified some home care programs in the World: "Melhor em Casa", from the Brazilian public healthcare system, "Hospital in the Home", from the Queensland State's, New South Wales, and Victoria's Department of Health, in Australia; "Hospital at Home" from the Scotland's National Health Service; "Hospitalización a Domicilio" from Spain's Sociedad Española del Hospitalizacióna Domicilio; "Hospitalisation à Domicile" from the French Fédération Nationale des Établissements d' Hospitalisation à Domicile and models proposed by the North American marke. [6]

In Portugal, due to the implementation of Standard 020/2018, HHU emerged as a model of hospital care practiced at the patient's home, during a transitional period, as an alternative to conventional hospitalization. [7] They aim to provide patient-centered care with a cost-effective benefit, the basic principle of which is the treatment of patients with acute illness due to a chronic condition who require hospital care but who are able to be treated at home, such as type 2 diabetes (T2D), as it enables continuous, personalized and patient-centered monitoring, promoting better adherence to treatment and preventing complications. [4,5,6,7]

According to the standard, home hospitalization is defined as an alternative to conventional hospital admission, providing continuous and coordinated care to patients who, requiring hospital admission, meet a set of clinical, social and geographic criteria that allow hospitalization at home. [4,5,6,7] This model differs from the health and social support responses at home already implemented in the SNS, as it focuses on the acute phase of the disease and/or the worsening of the chronic disease. [7]

The standard specifies that HHUs are responsible for ensuring patient care 24 hours a day, every day of the year, providing and managing acute and chronic therapy, in addition to other clinical consumables necessary for the patient's care plan. [7]

The implementation of home hospitalization was reinforced by Order No. 9323-A/2018, of October 3, 2018, which determined that all SNS hospital entities that received funding for the establishment of UHDs should

begin their respective care activities by March 31, 2019. This order also established that the Regional Health Administrations should present a plan to expand UHDs in the remaining hospital entities. of the SNS, to run until June 30, 2019. [7]

Nowadays, with the LHUs structure, home hospitalization benefits from a more effective articulation between hospital care and primary care, allowing a smoother transition for patients between hospital and home. This integration facilitates continuity of care, improves communication between multidisciplinary teams and ensures closer monitoring of patients in their family environment. [4,5,6,7] Furthermore, the implementation of Home Hospitalization Units (HHUs) within LHUs has been a priority, with several LHS establishing their own UHDs to meet the needs of the local population. [7] For example, the Matosinhos Local Health Unit, Norte Alentejano Local Health Unit, Médio Tejo Local Health or Leziría Local Health are among the institutions that have implemented UHDs to provide hospital care at home.

The creation of LHUs in Portugal has facilitated the expansion and consolidation of home hospitalization, promoting an integrated and patient-centered approach, which improves the integration and efficiency of healthcare and user satisfaction. [7]

Furthermore, the integrated management of T2D is also encouraged, promoting prevention, early diagnosis and appropriate treatment. Some ULS have invested in the creation of specialized structures to monitor patients with T2D and are aligned with the National T2D Program.

With the creation of an Integrated Care Process in Diabetes (ICPDD), [10] the person, their needs and expectations, are the center of the system. It is a tool that allows you to analyze the different components that intervene in the provision of health care and organize the different workflows, integrating up-to-date knowledge, standardizing actions and emphasizing results. A set of sequential activities aimed at the clinical monitoring of patients with diabetes were thus defined in this document, ensuring the co-responsibility of all health professionals and the continuity of care between all levels: PHC, HC, and ILHC. [10]

However, 10 years after the construction of this document, deep changes have occurred through the stage of caring for T2D. Society is witnessing a digital revolution, flanked by an urgency in the reform of health systems due to the pressure of demographic evolution and therapeutic innovation, which have brought new challenges that need to be addressed. The reform in PHC, imprinted by community-based care in family teams and clinical governance models, artificial inteligence, scientific innovation in the approach to the treatment of T2D, introduction of new drugs, and the priority on the prevention of cardiovascular mortality, are examples of major transformations. For all these reasons, it is essential to integrate new actors and new care guidelines into this plan.

> METHODS

This opinion article was produced after consulting recent evidence resulting from documentary research on the plataforms Ebsco and Pubmed (2020 – 2025) using the mesh terms: "home care services" (title/abstract) OR "hospital at home" (title/abstract) AND "diabetes mellitus" (title/abstract) with inclusion criteria encompassing documents related to home care services/ home hospitalization, official policies, program evaluations, and relevant academic literature with people with diabetes mellitus. [9] Documents with unclear sources or unidentified authors were excluded, and only official documents and peer-reviewed literature were included in the analysis. Our comprehensive review included government documents (statutes, regulations, and official reports), academic sources (peer-reviewed journals and professional publications), gray literature (policy reports and program evaluations), and internal documents from the Expert Group on Health for Portugal Government. Six articles were selected.

Beyond this aspect, and an extensive search was carried out on the website of the Spanish Society of Home Hospitalization, one of the largest European societies of Home Hospitalization, with Spain being one of the countries with the greatest implementation of this treatment modality and were select three articles.

To systematically evaluate this treatment modality and propose future directions, we employed SWOT analysis as our primary analytical framework. [10] A SWOT analysis is a tool to help organizations identify problems and formulate basic strategies. [10] On its own, a SWOT analysis is simply a list of problems but it can be a useful tool for systematic strategy formulation if it is followed by a plan for future actions. [10]

The SWOT analysis was conducted through a systematic four-phase process (Table 1), following all the evidence and government documents. First, we identify the internal environment – health professionals and people with DM. Second, the external environment that´s all the policy documents, demographic trends, healthcare statistics, telehealth, artificial intelligence. Finally, we developed a SWOT matrix by cross-linking strengths, weaknesses, opportunities, and threats to derive strategic alternatives. [10]

> NATIONAL HEALTH SYSTEM RESTRUCTURATION AND DIABETES CARE

In the context of the increase in the prevalence of chronic diseases, T2D, according to the Portuguese Diabetes Society, [8] has a strong impact on hospital admissions and increased health expenditure. It is associated with (...) rapid cultural and social changes, an ageing population, increasing urbanisation, dietary changes, reduced physical activity and unhealthy lifestyles, as well as other behavioural patterns. [8] Such factors place T2D currently as one of the most serious public health problems, and it is expected to be one of the main causes of morbidity and total or partial disability during the twenty-first century. [8]
At the PHC level, T2D surveillance appointments are carried out by the family team, with a minimum periodicity every six months, depending on the risk, where the focus of care is the management of the therapeutic regimen and self-surveillance. [8] It aims to ensure adequate patient monitoring, based on compliance with the guidelines and standards of the Portuguese Public Health Authorities (PPHA). [11] This moment can be carried out in an outpatient clinic or at the person´s home and prioritizes the involvement of the family and social network in the care provided.
As for hospital level care, they occur after a first contact and request from other services, based on a institutional protocols/PPHA standards. This appointment intend to optimize the control of the disease (internal medicine/endocrinology); control associated comorbilities and also the chronic complications installed (with the support of other clinical specialties).
The LHUs in Portugal are integrated structures that combine primary, hospital and continued healthcare, aiming for a more coordinated and efficient approach to the provision of healthcare. This integration facilitates continuity of care and improves communication between multidisciplinary teams, ensuring closer monitoring of patients. [2] The implementation of LHUs has had a positive impact on the care provided to diabetic patients. Studies indicate that, after the creation of LHUs, there was a decrease in the volume of hospitalizations due to diabetes, as well as a reduction in the risk of lower limb amputations in diabetic patients. [12,13,14,15] According to a study on hospital admissions for T2D in mainland Portugal, T2D has a high prevalence in the Portuguese context having significant influence on hospital admission and complication rates in patients admitted to Portuguese NHS hospitals present extremely high values, when compared to the context international. [12]
Therefore, the authors suggest the need to introduce admission criteria based on severity and models for better T2D management. [12] Highlighting the need for changes in the processes of caring for these patients, supporting and contributing to introducing new intervention strategies for better care for people with this disease. [12]
ULS and Home Hospitalization emerge as facilitators of this process. According to Vitorino, evaluated the impact of implementing LHUs on the care provided to diabetic patients. [16] The number of hospitalizations per capita after the creation of the LHUs decreased, particularly in diabetic patients and diabetic patients with major amputation of the lower limb. [16] The risk of lower limb amputation due to T2D after the creation of the LHUs decreased in most of them. [16]
With this health system restructuration, the different levels of care should optimize this integration and clearly define their papers in the T2D treatment and prevention. Thus, the creation of Integrated Clinical Pathways for T2D, such as the LHU in Coimbra, allows each user to have a personalized journey, updated in real time, identifying signs of worsening and stratifying patients according to their risk or severity, knowing exactly who needs care, what care and in what context.
In Portugal, the integration of all level of health within a unified system has proven effective in optimizing resources and ensuring continuity of care, with the creation of LHUs. [3] National and local governments should develop strategies for community. [10] That´s a oppurtunity for integrated a multidisciplinary team work, in line Australia's multidisciplinary approach through Aged Care Assessment Teams (ACAT) witch integrate visiting nurses, physiotherapists, and dieticians to deliver tailored interventions in the community. [10]
In addition to primary and secondary care, home hospitalization can be defined as part of this path as a model aimed at providing care at home for exacerbations of T2D in complex patients, whose biological, psychological and social conditions allow it. [16] When admitted to HD directly at home, without going through the Emergency Service, at the request of Primary Health Care, external consultation or transferred from other hospitals to the area of residence. [12,13,14,15]

> DIABETES HOME CARE

As previously mentioned, home hospitalization innovates above all in the organization and form of providing access to care, continuous and coordinated assistance. The HHUs, [7] is based on a model of care provision during the acute phase of the disease, following an episode of hospitalization, admission to the emergency de-

partment, follow-up consultations, and there may also be direct referral from PHC or ILHC. The reference criteria are: clinical stability; the transient clinical situation; comorbidities controllable at home, in addition to the social criteria and the geographical criteria.

Home care increases the patient and family satisfaction, safe care, education of patients, families, and healthcare teams, reduction in re-admissions, medication management, communication, coordination, and cooperation of healthcare team, patients, and families, and preferences and inclinations of patients and families. [10]

A recent meta-analysis suggests that patients with chronic conditions who presented to the emergency department and were treated at home had a reduced risk of hospital read-mission and long-term care admission compared to those who received conventional hospital treatment. [17] Conversely, findings from the meta-analysis revealed that HHUs increased the time to readmission, reduced index costs, and improved health-related quality of life among patients requiring hospital-level care for heart failure. However, larger randomized control trials were needed to confirm the effect of home care on readmissions, mortality, and long-term costs. [18]

According to Lee et al., with applied a home care pilot program to people with T2D, that was clinically effective in improving glycemic control and may provide an efficient care option for people with T2D, they hope positive outcomes are expected to expand the program to include more patients. [19] On other hand, Heidapour *et al*., showed improvement in glycated haemoglobin (HbA1c) and high-density lipoprotein (HDL-c) levels with home care programs in patients with diabetes who underwent general surgeries. [20]

If we look at the most recent scientific evidence [12-22] in the area of diabetes, studies emerge on HHUs programs applied mainly to the young population and those with type 1 diabetes. In-hospital home care appears to be an acceptable transition for newly diagnosed children. Multidisciplinary support tailored social care, and access to social benefits can improve disease acceptance rates, especially among low-income households. [11] The acute treatment of a wide range of chronic diseases (obstructive pulmonary disease, chronic heart failure, cellulitis/erysipelas, community- or hospital-acquired infections, infections by multidrug-resistant microorganisms) in a safe and cost-effective manner is also well established in the literature. [8]

In the future, the application of new available technologies will expand the opportunity for treatment and follow-up of patients at home, as an extension of the care provided by the HUUs. Telemonitoring tends to be a new future in home care, bringing the patient numerous advantages, namely better results in the control of chronic pathologies, such as T2D, and better quality of life, leading to a reduction in hospital admissions, length of hospital stays, and number of visits to the emergency department. [10] Sertbas *et al*., reveals that digital health interventions can contribute to strengthening health systems by quickly making reliable and upgraded information available. [21]

Table 1 helps assess factors that contribute to relative advantages and disadvantages of HHUs in T2D care, based on SWOT analysis.

According to SWOT analysis, one of the major strengths was the cost savings associated with home care, along with increased patient and family satisfaction, and a re-

Table I - HHU: SWOT analysis. [10]

STRENGTHS [12-22]	WEAKNESSES [7,14]
• Reduction: nosocomial infections, falls, pressure ulcers, confusional syndrome, decline in functional status, malnutrition, duration of hospitalization, readmission and mortality rate in patients with T2D • Improves: patients sleep quality and satisfaction due to the greater comfort provided; • Ensure continuity of care in acute complications	• Implementation of home care teams with their own training and skills, which develop their practices based on the best evidence, guiding standards and institutional protocols/ procedures; • Care in metabolic disorders, control the glycemic profile and comorbilities; • Change professionals resistance; • Promote health literacy in people with conscious in their therapeutic plan;
OPPORTUNITIES	**THREATS**
• New health local systems: integrated care Multidisciplinary teamwork • Quick advance of telemedicine and telenursing/digital revolution/ artificial inteligence – new tools • lower costs – patients with T2D had a higher number of hospitalization days.	• Reconstruction of integrated care processe, care continuity and coordination between the different levels of care is a complex process in institutions -need profissionals and time • No common records/clinical files and unprepared the moment of discharged -Improve clinical files; • Reduced scientific evidence/ similar reference models in T2D • Requires inicial financial injetion

duction in re-admissions. Some threats like sociopolitical and infrastructural contexts often do not align with the operational needs of home care service organizations, presenting challenges to healthcare equity. [10]
Reconstructing a integrated care processes requires coordination between the different levels of care. It´s a complex process and should be describing in a new Integrated Care Plan in T2D, resumed by Integrated Clinical Pathways for T2D, in which HHUs should be actors.

> INTEGRATED CARE PLAN IN DIABETES – THE ROLE OF HOME HOSPITALIZATION

In the care of the person and family with T2D, the HHUs services may direct its intervention in the resolution, control and prevention of the exacerbations of the disease, at several levels: stabilization of the acute complication and control of the disease; preventive education; continuity of care. Adapting the T2D ICPD, built in 2013 to HHUs, [8] it is considered essential to:

A. Provide direct care for metabolic disorders, control the glycemic profile and comorbilities associated with T2D. At home, it is possible to perform various complementary diagnostic tests and therapeutic procedures, such as blood and urine tests, electrocardiogram, ultrasound, intravenous administration of medicines for exclusive hospital use, oxygen therapy, non-invasive ventilation, wound care, among others;
B. Ensure continuity of care in acute complications under the terms defined by the PPHA Guidelines. In the event that it is necessary to carry out an examination or procedure that cannot be performed at home or a consultation by other professionals, which involves a face-to-face evaluation, the patient is transported to the referral hospital unit. In particular, with regard to complications of diabetic retinopathy, diabetic nephropathy and diabetic foot, HHU health professionals should pay special attention;
C. Multidisciplinary teamwork, with resources for several professionals in the clinical and social areas;
D. Register in a single, shared and individualized clinical file, all interventions performed;
E. Carefully prepare the moment of discharged, to promote excellence in the integration of care:
   - Other teams: the discharged report should include the activities carried out during hospitalization, the diagnoses and clinical decisions, as well as the therapeutic and care plan. In a discharged note from the multidisciplinary team, there is information about the educational activity carried out and the monitoring plan and the recommended care for the level of care for which it is intended. In the event that it is appropriate to integrate the patient with T2D into an integrated care, it should be signalled as soon as this need is identified, under the terms provided for in the legislation in force.
   - Family/caregivers: patients hospitalized in HHUs, and their caregivers, have direct telephone contact with the health team that is available 24 hours a day to answer in case of doubt or any complication. Whenever necessary, the health team goes to the home, and if the exacerbation requires a higher level of vigilance, the patient can be transported back to the referral hospital unit. At the time of discharged, they receive all verbal and written information related to the various focus of therapeutic education, prioritizing the control of exacerbations.

The diagram of Figure 1 summarizes the above proposal for the integration of care in the T2D care process, introducing the reform that occurred in health services and the research carried out on the relevance of the HHU context.

> DISCUSSION/CONCLUSION

After the analysis, it was possible to stablish relationships with previous evidence/guidelines, identifying recurring themes, pointing out new perspectives and consolidating the area of knowledge. [9,10]
The findings suggest that this model of hospital care provides a personalized approach adapted to the individual reality of each patient in their usual environment. One of the solutions for dealing with the growing demand for hospital beds and reducing the duration of hospitalization and its costs is home hospitalization. [14]
From the perspective of the sustainability of the NHS, home hospitalization reduces the costs and complications inherent to conventional hospitalization and can be a solution to the problem of overcrowding, with evident clinical advantages.
It is considered that the current and future sustainability of the Portuguese NHS cannot be limited to its financial dimension. It is essential to build new investment horizons in it, not as a mere expense for the country, but as a way to obtain quality results and gains in health for the population. That is a golden opportunity in health promotion and the decentralization of hospital care to care in the community and at home. [13]
To improve the process we need to implement home care teams with their own training and skills, which develop their practices based on the best evidence, guiding standards and institutional protocols/ procedures. Each

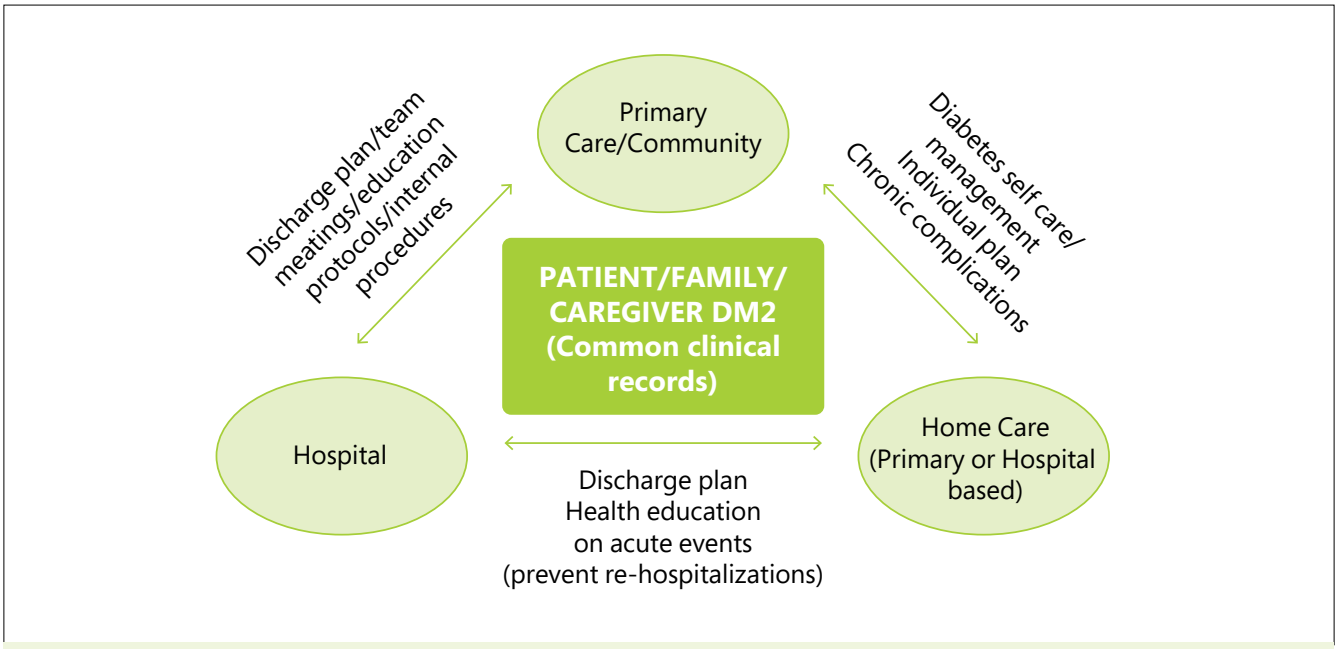

Figure 1 - Person/family/caregiver approach in the integrated care process for type II diabetes.

borough should aim to incorporate visiting all multidisciplinary health professionals, by building on the experience of seasoned health professionals, such teams could provide high-quality, coordinated care at the community level. [10]

Home Hospitalization mostly handles patients with chronic conditions in acute phase. It is an important context to develop health education and promotion processes of health literacy and essential that the documentation that regulates the operation of Home Hospitalization has support for interventions for promotion of literacy and health education. It is important promote health literacy in people with conscious in their therapeutic plan, in this case in T2D. [22]

It´s necessary planning regular visits and personalized treatment with keeping in mind the benefit to risk ratios in diabetic patients is an inevitable part of home health care, [21] require qualify and motivates health professionals to give holistic home care.

The existence of a support network in PHC for the follow-up of people with T2D is the strong point highlighted in the care of acute complications. The goal was to improve cooperation between the hospital and the community, design a transitional care team using digital tools, common registry support and an emphasis on the role of family members in managing the disease. It is essential promote health literacy with conscious decision-making by the person in their therapeutic plan.

To facilitate the future researches we recommend to improve clinical files, there´s no common records and that difficults the discharged process. As said above, there´s a reduced scientific evidence and similar reference models in T2D which need to improved.

After this research the next step should be the right review of diabetes care process, implementing care continuity and coordination between the different levels, recognized as essential elements to ensure the best, timely and effective health results. This should be supported on local health organizational change with involvement of all health professionals.

The need for scientific studies in this area emerges, given the scarce bibliography found in databases, which is a limitation of this research. It is recognized that one of the challenges of the future is the implementation of home care teams, HC or PHC, which work in an effective articulation with a view to effective gains for the community, result in a reduction in T2D complications and consequent avoidable hospitalizations.

In conclusion, the care provided to patients with T2D must be beyond the hospital walls, focusing care on the patient in a perspective of proximity, moving the hospital to their home instead of the hospital going to the hospital, promoting comfort and greater quality of life. <

Conflicts of Interests and Sponsorships/*Conflitos de Interesses e Patrocínios:*
The authors declare no conflicts of interests or sponsorship./ *Os autores declaram a inexistência de conflitos de interesses e de patrocínios.*

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