Bocconi

COMMUNITY HOSPITALS IN ITALY: recent developments and future strategies

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CERGAS
Centro di Ricerche sulla Gestione dell'Assistenza Sanitaria e Sociale

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Agenda

1. National Recovery and Resilience Plan
2. Mission 6 – Healthcare & Community Hospitals standards
3. Community Hospitals in Italy: a national mapping
4. A regional case: evidence from Emilia-Romagna
5. Key messages and conclusion

After COVID-19… huge investment plan: Next Gen EU Fund

€194.4 billions for the Italian economy

Total Grants Allocated
€71 780 Million

Total Loans Allocated
€122 602 Million

RRP Allocation as Share of GDP
9.32 %

Recent updates to the NRRP

- 2024-05-14 — Council of the European Union approves the assessment of the modified recovery and resilience plan of Italy
- 2024-04-26 — Commission endorses Italy's modified recovery and resilience plan
- 2024-03-04 — Italy submits a modified recovery and resilience plan
- 2024-01-25 — European Commission disburses €551.2 million in REPowerEU pre-financing to Italy
- 2023-12-29 — Italy submits a payment request of €10.6 billion

The National Recovery and Resilience Plan: Six Missions (+1)

The NRRP defines **6 priority MISSIONS,** articulated in a coherent package of **structural reforms and investments** for the **period 2021-2026,** to overcome the **economic and social impact of the Covid-19 pandemic**, acting on the country's structural nodes and successfully facing the environmental, technological and social challenges of our time

DIGITALIZATION & INNOVATION

Promote and support the **digital transformation** of the country and the innovation of the production system and invest in two key sectors for Italy: tourism and culture

INSTRUCTION AND RESEARCH

Strengthening the **education system, digital and STEM skills**, research and technology transfer

TRANSITION GREEN

Improve the sustainability and resilience of the economic system by ensuring a **fair and inclusive transition**

INCLUSION AND COHESION

Facilitate **participation in the labour market**, including through training, and strengthen active labour market policies; promote social inclusion

INFRASTRUCTURE FOR SUSTAINABLE MOBILITY

Rational development of a sustainable **modern transport infrastructure** extended to all areas of the country

HEALTH AND RESILIENCE

Strengthen **prevention and health services** on the ground, modernize and **digitize** the health system and ensure equity of access to care

Added in June 2024, after energy crisis

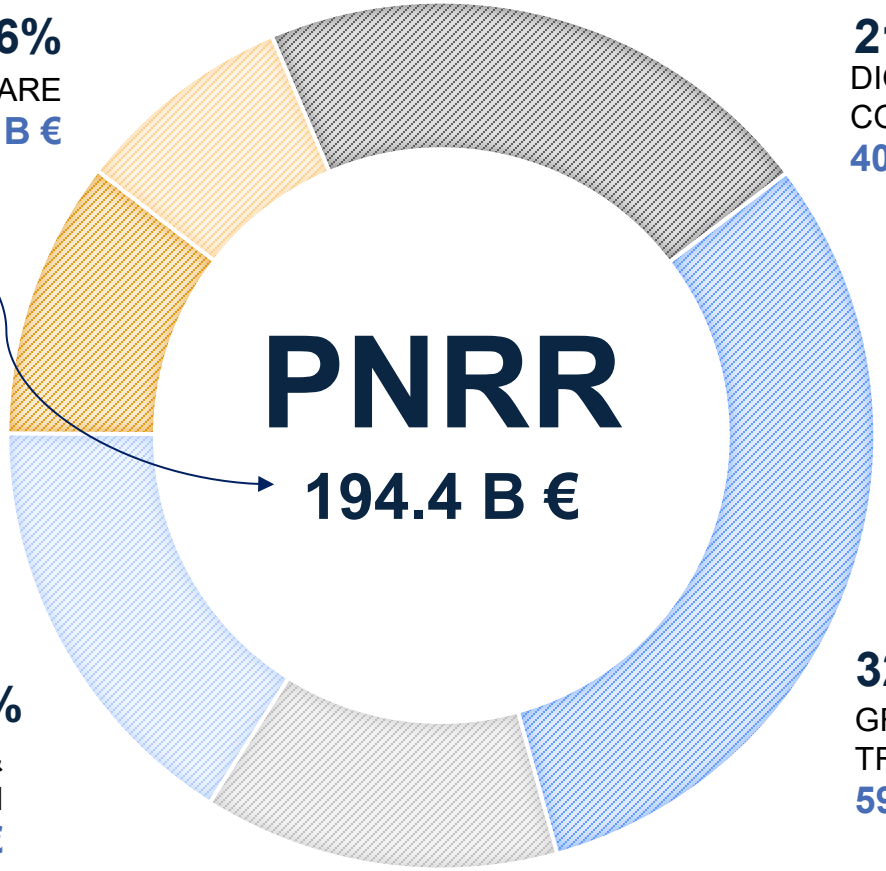
REPOWER-UE

tBoost Italy's **green and digital transition**, and span sectors such as **renewable energy, green supply chains and railways**

The National Recovery and Resilience Plan: Resources

The Plan mobilizes **over 235 billion €, including:**

- **€ 195,5** billion coming from **EU Next Generation**
- **Complementary National Fund** for a total amount of € 30.6 billion
- €13 billion from the **React EU Fund**



8,16%
HEALTHCARE
15,63 B €

21,04%
DIGITALIZATION, INNOVATION, COMPETITIVENESS AND CULTURE
40,29 B €

10,37%
INCLUSION & COHESION
19,85 B €

16,13%
EDUCATION & RESEARCH
30,88 B €

32,05%
GREEN REVOLUTION AND ECOLOGICAL TRANSITION
59,46 B €

13,26%
INFRASTRUCTURES FOR SUSTAINABLE MOBILITY
25,40 B €

Mission #6 - Healthcare

+€15.6 billion for renovating the NHS

1. Component

Innovation, research and digitalization of healthcare	8,63 €B
Technological and digital updating	***7,36 €B***
a) Modernization of the technological and digital hospital park	4,05 €B
b) Towards a safe and sustainable hospital	1,64 €B
c) Strengthening the technological infrastructure and tools for data collection, processing, analysis and simulation	1,67 €B
Training, scientific research and technology transfer	***1,26 €B***
a) Biomedical research improvement	0,52 €B
b) Enhancement of digital, managerial and professional skills of personnel	0,74 €B

2. Component

Proximity assistance and telemedicine	7,00 €B
Local health services, facilities and standards for assistance on the territory	***7,00 €B***
a) Community Houses	2,00 €B
b) Homes as the first place of care, home care and telemedicine	4,00 €B
c) Development of intermediate care	1,00 €B

- *In addition to the €15.63, the Supplementary Fund resources for health amounting to €2.9 B are allocated as follows:*
- *Towards safe and sustainable hospital (1,450 €B)*
- *Health, environment, biodiversity and climate (0.5 €B)*
- *Research initiatives for technologies and innovative pathways in the health and care sector (0.5 €B)*
- *Innovative health ecosystem (0,437 €B)*
-

SSN digitization, training and research: 8,63 €B + Proximity assistance and telemedicine: 7 €B + Complementary Fund: 2,9 €B = Total Healthcare Mission: 18,53 €B

The Healthcare Mission is composed by **two main components**:

1. **Innovation, research and digitalization,** that aims at disseminating **telemedicine tools and activities**, strengthening the healthcare system's information and **digital tools**, the modernization of equipment and hospitals
2. **Proximity assistance and telemedicine**, that aims strengthening prevention and **local assistance** with a view to increasing integration among hospital, local healthcare and social services

Mission #6 – Community Hospitals

2. Component

Proximity assistance and telemedicine	7,00 €B
Local health services, facilities and standards for assistance on the territory	***7,00 €B***
a) Community Houses	2,00 €B
b) Homes as the first place of care, home care and telemedicine	4,00 €B
c) Development of intermediate care	1,00 €B

- In the area of **proximity assistance and telemedicine**, there is a specific intervention dedicated to the development of intermediate care structures as **Community Hospitals** (CHs)

- In the **national legislation**, **CHs** are identified as health facility
  - that pertains to the **territorial assistance…**
  - …and performs an **intermediate function between home and hospitalization**
  - …with the aim of **avoiding improper hospital admissions** and **favoring protected discharges**,
  - …to improve **clinical stabilization, functional recovery** and **autonomy** in a closer setting to the home

Community Hospitals were introduced in the Italian Healthcare system **since 2015** (DM 70/2015), **but only recently** the national legislation adopted and defined **clinical and organizational standards** to qualify these structures (Intesa Stato-Regioni 2020, DM 77/2022)

Community Hospitals: organizational, clinical and structural standards

DM77/2022

Beds

- 1 Community Hospital with 20 beds per 100,000 inhabitants
- 0.2 beds per 1,000 inhabitants to be implemented progressively according to regional planning
- …meaning:

307 new Community Hospital in Italy to be activated by the end of 2026

Clincal Staff

Staff standards for 1 Community Hospital with 20 beds:

- **7-9 nurses** (including 1 Nursing Coordinator)
- **4-6 Social and Health Workers**
- 1-2 units of other **health personnel with rehabilitation functions**
- a **doctor** for 4.5 hours a day 6 days a week

Structural standards

- CHs can be **physically placed in different "locations"**…
- CHs can have its own stand-alone structure, be placed in a Community House, in multifunctional health facilities, in residential social and health facilities…
- …or be located in a hospital, but it is attributable to the services included in the district territorial assistance

Community Hospitals: what target of patients?

Four main categories of **eligible patients**:

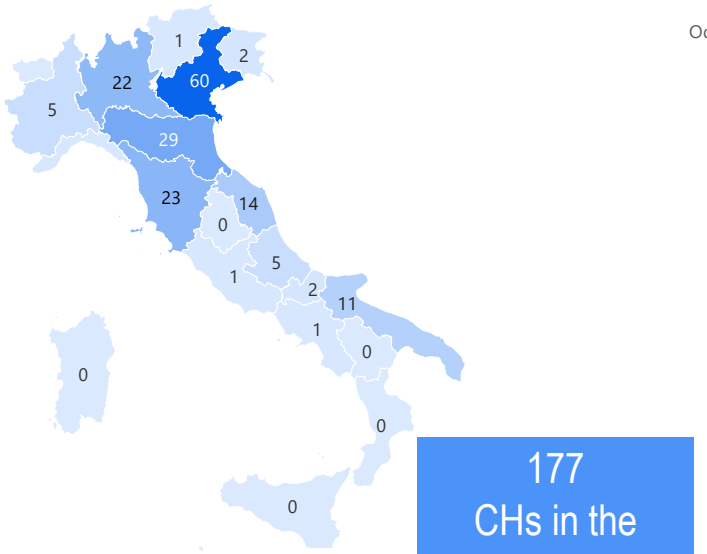
a) **fragile and / or chronic patients**, coming from home, due to the presence of exacerbation of a **pre-existing clinical condition**, in which hospitalization is inappropriate;

b) patients, mainly suffering from **multimorbidity**, coming from a hospital, acute or rehabilitative structure, clinically dismissible for the conclusion of the hospital diagnostic therapeutic path, but with conditions **requiring continuous nursing assistance**;

c) patients who need **assistance in the administration of drugs or in the management of devices**, who need support, education and training of the patient and caregiver before returning home;

d) patients who need **rehabilitation and re-educational support**, which can consist of:
   - evaluations aimed at proposing strategies useful for maintaining residual functions and capacities (e.g. proposals for the supply of aids);
   - support and therapeutic education to the patient with motor, cognitive and functional disabilities;
   - physiotherapy interventions in the context of Paths / Protocols already activated in the department of origin and aimed at returning home

Evidences from our mapping of Community Hospitals in Italy (1/2)

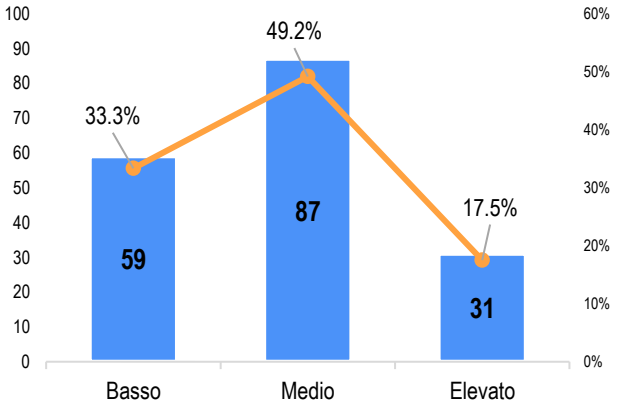


177
CHs in the database

Geographic area	% CHs on total
North	67,8%
Centre	21,5%
South	10,7%

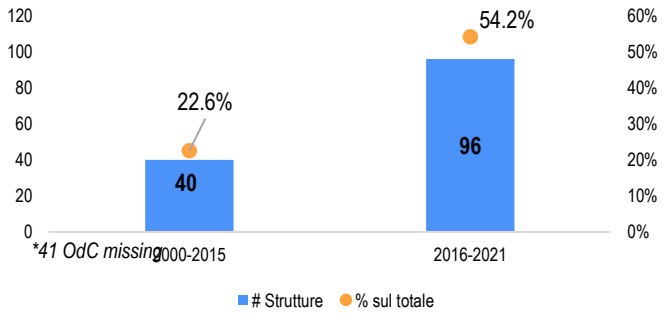
Veneto ed Emilia-Romagna count for 50% of total CHs

Location of CHs according to the degree of urbanization of the Municipalities, # and % of the total



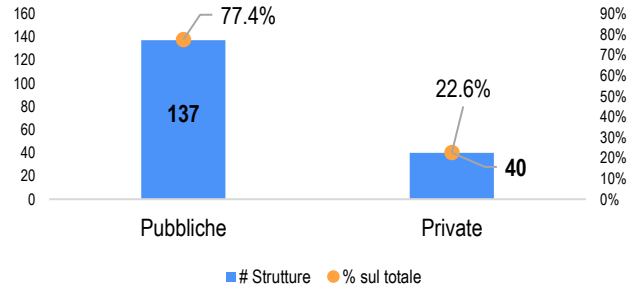
*Classificazione Eurostat

Years of establishment

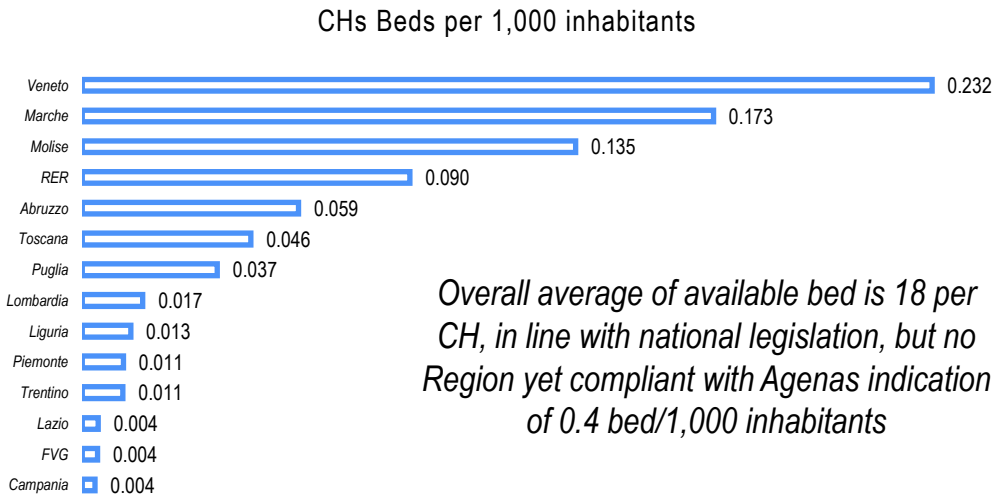


*41 OdC missing

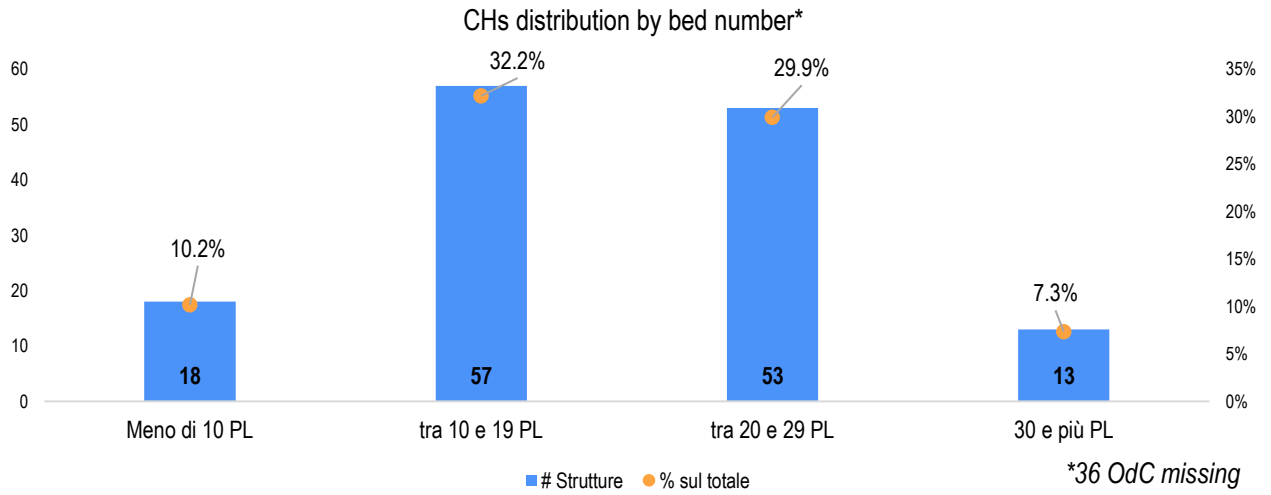
Legal entity (public/private)



Evidences from our mapping of Community Hospitals in Italy (2/2)



Overall average of available bed is 18 per CH, in line with national legislation, but no Region yet compliant with Agenas indication of 0.4 bed/1,000 inhabitants



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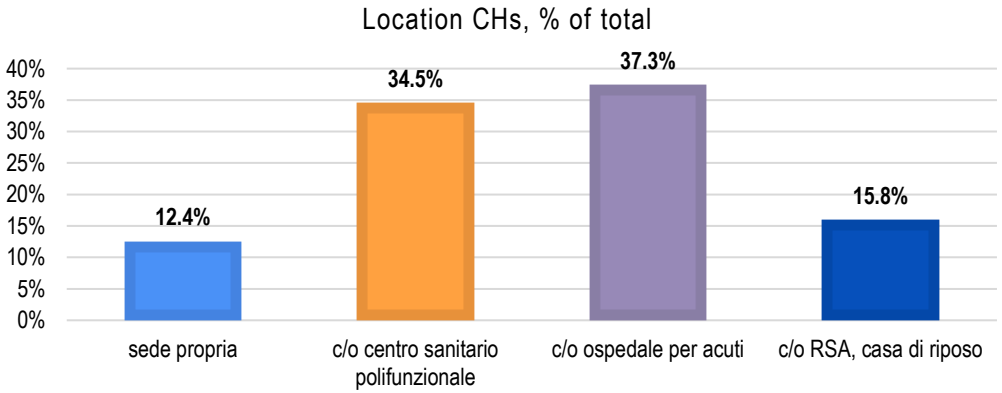

40 CHs (23% of the total) contiguous to **Hospice** or with beds dedicated to **terminal patients**

44 CHs (25% of the total) converted to **Covid hospital,** dedicating totally or partially beds to **Covid patients** in the post-acute phase

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Evidence from our last study: CHs in Emilia-Romagna

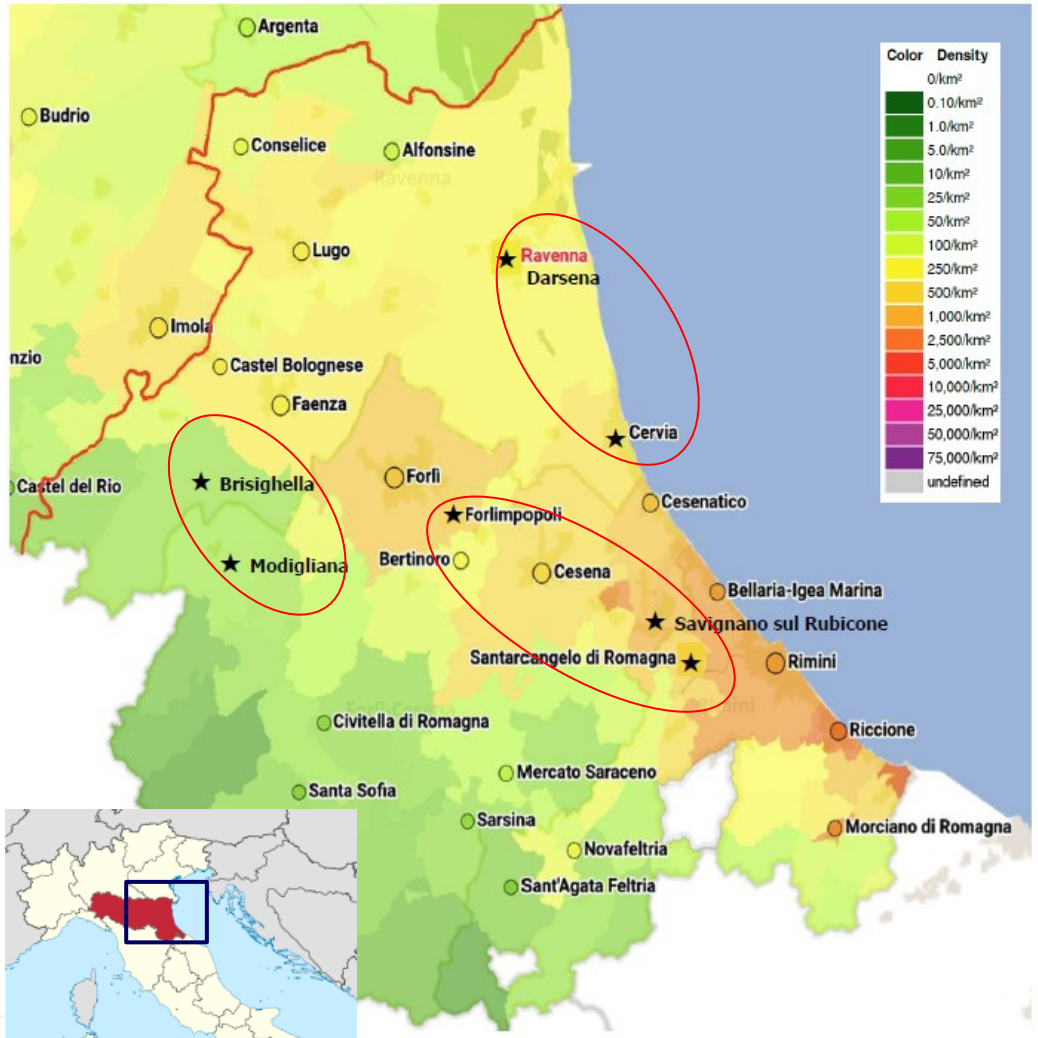
Aim: describing the contextual and organizational factors underlying the **interconnection between integrated care and CHs**

Theoretical background: Structural contingency theory (SCT): Organizational effectiveness depends upon how well an organization's model relates to its **context**, it depends on the ***contingencies*** the organization is facing *(Donaldson,1987 & 2001)*

Unit of analysis: 7 Community Hospitals in RER

	Context	Structure	Activity
Variables	• Demographic & territorial data of local context of CHs (e.g. pop density, %65y, Municipality frailty index) • Historical development of CHs	• Personnel (number and professional type) • Beds • Responsibilities for CHs management	• Number and reason for hospitalization • Number and modalities of discharge • Avg and max. length of stay • Barthel index • Re-admission rate after 30 days • Bed occupancy index

Three main territorial areas



Municipalities in which CHs are located	Pop at January 1st 2024	Pop density (inhab. per km²)	% over 65 pop	Aging index (over65/under 14)	Inland areas classification (2020)	Municipality Frailty Index** (2019)
Brisighella	7,713	37	29.1%	276.1	C	6
Modigliana	4,290	43	30.4%	275.4	D	5
Cervia	28,824	350	25.7%	248.9	C	3
Ravenna (Darsena area)	156,345	239	25.8%	223.4	A	1
Forlimpopoli	13,105	534	25.2%	193.8	C	2
Santarcangelo di Romagna	22,254	492	23.7%	188.5	C	2
Savignano sul Rubicone	17,954	768	21.7%	156.9	C	3

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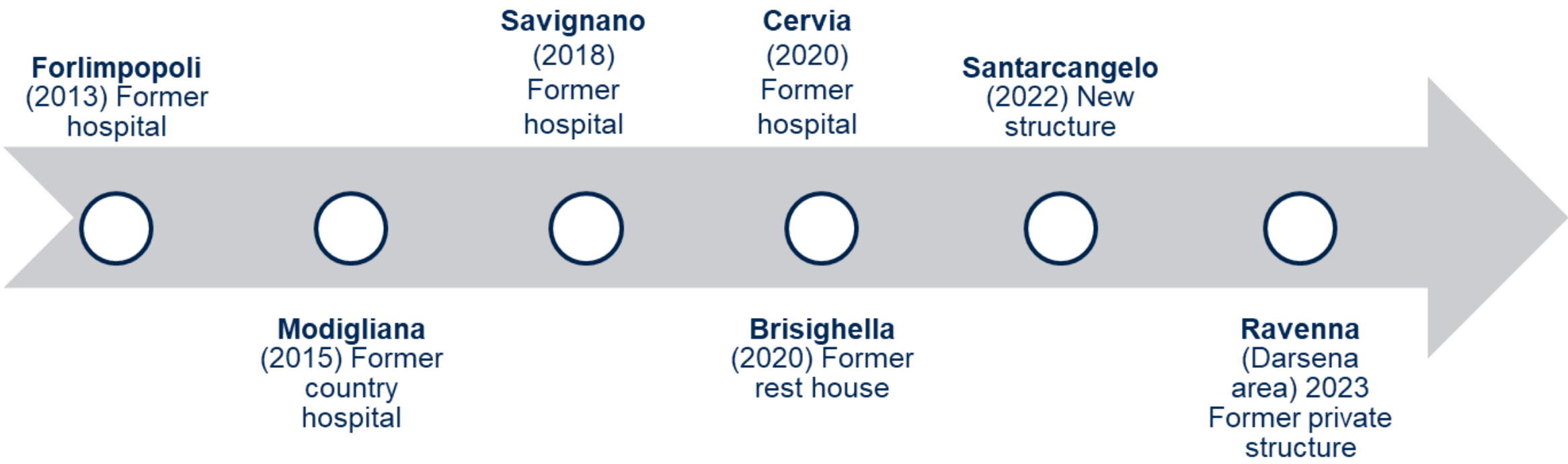
Year of foundation of the 7 Community Hospitals: different years, different stories

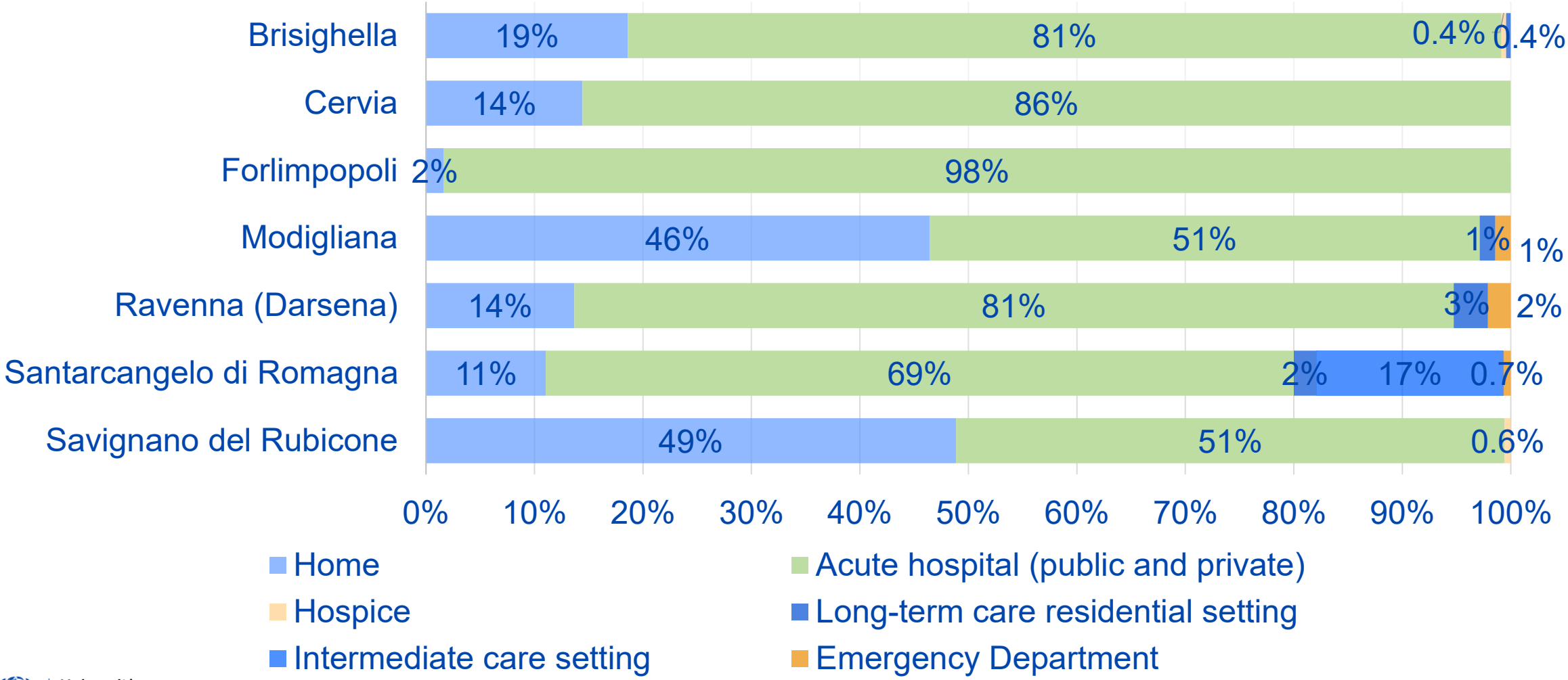


Community hospitals: professional roles & staff

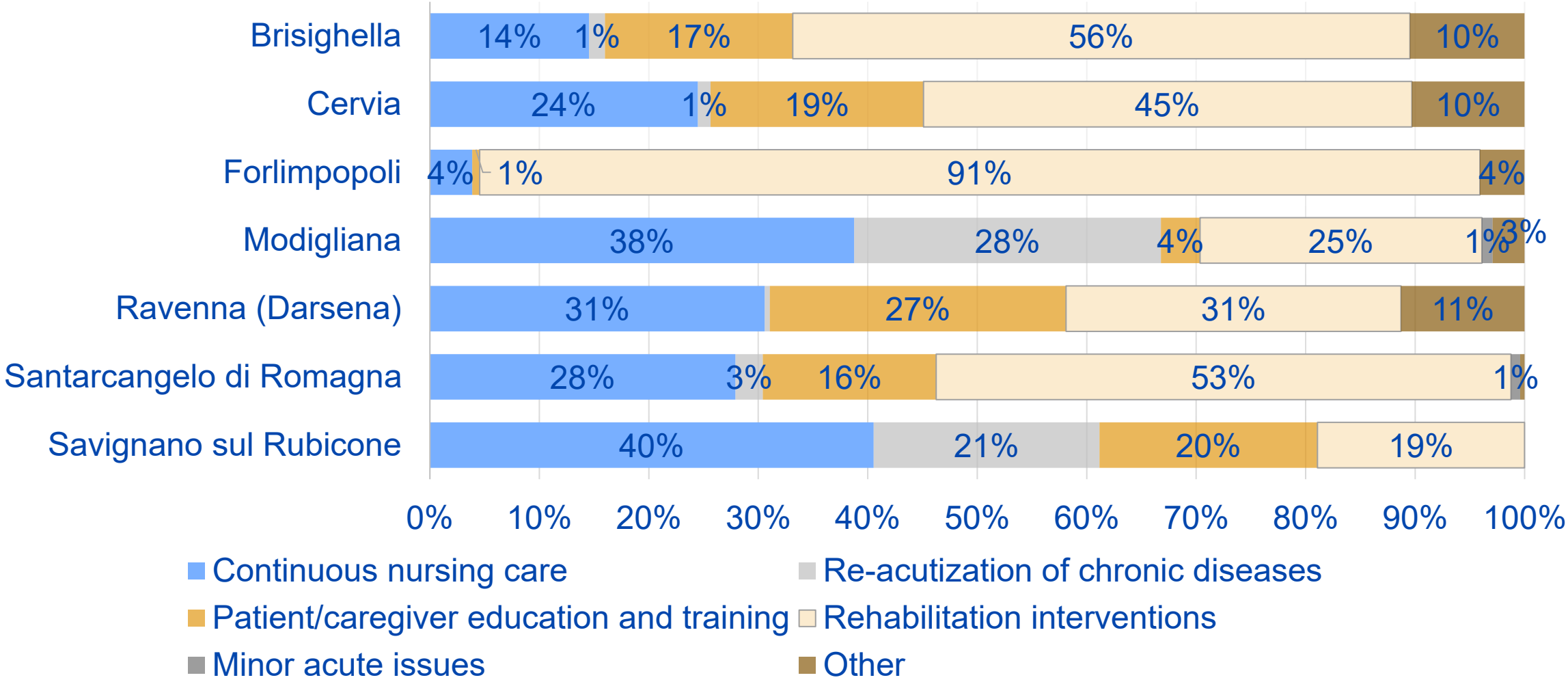
CHs (Data 2023)	Beds (min 20-max 40)	Nurses (of which 1 case manager)	Social workers	GPs	Out-of-hours doctors	Physiatrists/ physiotherapists
Brisighella	18	7	9	3	3	1
Modigliana				3	2	2
Cervia					1	3
Ravenna (Darsena area)					2	2
Forlimpopoli					0	6
Santarcangelo d Romagna					1	7
Savignano sul Rubicone					1	2

"Not all nurses can work here: you have a lot of responsibilities, and you need strong motivation for taking care of the patients in an holistic way. Who work here appreciates that, compared to acute hospitals, here you can see the patient along the care path, from the beginning to the end, even after discharge. And the goals of the care path (i.e. functional autonomy) are proper of the nursing profession." (NSS3)

Where CHs' patients come from: mostly acute hospitals, with the exception of only 2 Community Hospitals, more oriented to local territory



Reasons for admission in CHs: rehabilitation and continuous nursing assistance as primary causes, but high variability across structures



Activity indicators of CHs: high variability, possible correlation between ALS and rate of re-admission

CHs (data 2023)	N. of discharges	Average age of patients	Avg. length of stay (days)	Max. length of stays (days)	Discharges over 6 weeks (% on total discharges)	Rate of re-admission within 30 days (%)	Barthel avg. value at admission (a)	Barthel avg. value at discharge (b)	Barthel avg. delta value (b-a)	Discharges for death cause (% on total discharges)
Brisighella	231	81.0	22	151	6.5	8.3	41.5	56.8	+15.3	2.6
Modigliana	140	80.5	26	110	15.0	5.5	28.0	53.9	+25.9	7.1
Cervia	277	76.3	25	164	14.1	6.0	40.6	56.9	+16.3	0.4
Ravenna (Darsena)	190	76.1	24	126	9.5	5.1	46.6	65.9	+19.3	0.0
Forlimpopoli	426	82.1	17	69	1.4	9.1	12.3	47.8	+35.5	0.7
Santarcangelo di Romagna	145	79.6	28	118	15.9	5.7	42.8	67.3	+24.5	1.4
Savignano sul Rubicone	176	81.0	17	49	0.6	9.0	32.2	49.5	+17.3	5.1

Key messages and conclusions

— The CH as an intermediate «bridge» between hospital and territory, presents **strong elements of innovation**, especially on the **organizational-managerial level**, and represents an **interesting vehicle for strengthening territorial assistance**

— However, if not correctly addressed in its **function and mission**, the CH can run **two main risks**:

- become a small **"retirement home",** with high hospitalization stay, in the case of **elderly patients, not self-sufficient** or without support caregivers (higher risk where social-care is modest)
- **"re-hospitalize",** becoming a **micro-hospital for acute** and changing its mission from medium-low intensity care to high, with **risks of inappropriateness** due to inadequate equipment for acute care

— ...so several elements for the **future agenda**:

- determine where to place **new facilities** or which **existing structures** to convert: **feasibility studies** are necessary to understand if the CHs have sufficient catchment area and are able to attract the necessary staff
- identify the **type of doctors most suitable** for CHs management (not necessarily GPs)
- identify the **clinical competences** (also on a social side) necessary for the CHs, and enhance the role of nurses and other social and health professionals

- ensure an adequate investment in **information systems**, to track therapeutic and assistance paths and measure **patient outcomes**, according to a multidimensional approach

➢ **Implications**: implementation is not a mechanical step of the policy cycle and requires important adjustments to the planning phase according to environmental and organizational factors.

Thank you for the attention!

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