Hospital territorial integration in the National Recovery and Resilience Plan era: if not now, when?

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Abstract

Integrating hospital and territorial services is essential, particularly for elderly patients, as they are at risk of yearly hospitalizations for multimorbidity, frailty, and complex diagnostic procedures. The emergency room organization aims to focus mainly on acute time-dependent diseases and cannot meet the needs of older patients. The authors present the preliminary results of an integration protocol between the hospital's services and those of the territorial elderly home care unit in Avellino, Italy.

Introduction

The growing requirements of healthcare and the growing impact of chronic diseases and multimorbidity associated with limited human and financial resources available for the health state service have pushed many nations to change the way they provide care with the following aims: facing the fragmentation of health services and the passage to integration, and connecting and coordinating the providers of services along a continuum of care that puts the patient at the center of health services.[1]

For these reasons, in Europe, many projects for healthy aging refer to service integration, such as that of Action Group B3 (*Replicating and tutoring integrated care for chronic diseases*).[2] The partners in this action group aimed to reduce the unnecessary hospitalization of older people with chronic conditions. They worked towards integrated care services that are more closely oriented to the needs of patients and are multidisciplinary, well-coordinated, accessible, and anchored in community and home care settings. Such models improve coordination between health services and social care levels throughout the health promotion and care chain. They harmonize and coordinate the management, organization, and delivery of services to ensure quality and efficient solutions that respond to the patients' needs. The major integration possible is between home care and hospital services in a continuum of care. The necessity of emergency room access should be reserved only for critical care conditions.

The Protocol

The protocol has been agreed upon between San Giuseppe Moscati Hospital and the Local Health Authority in Avellino (Italy), specifically between the hospital geriatric ward and the older patients care unit on the territory.[2] The protocol is divided into two parts. The first one refers to patients discharged from the hospital who necessitate home care. For these patients, a comprehensive geriatric scale establishes an individual plan. In this first part, the hospital's nurse case manager communicates with the home care nurse. A nurse discharge letter is provided. A commune platter is available for the hospital physicians to register the older patients, who are divided by the intensity of care. The second part of the protocol is a preferential *iter*, without emergency room access, for older patients who are in charge of home care and necessitate hospital admission for a new acute phase of chronic disease, complex diagnostic exams, and invasive procedures (paracentesis, thoracentesis, peripherally inserted central catheter) (Figures 1 and 2).[3]

Results

In one month, June 2023, ten patients were discharged to an elderly home care unit with a comprehensive geriatric scale, in agreement with family members and the family doctor. Eight elderly patients were in charge of nutrition and health services and were

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checked through telemedicine monitoring. However, the interesting data refers to elderly patients admitted to the ward according to protocol without access to the emergency room.

Table 1 shows the patients' clinical characteristics. The first patient (the oldest one), with abdominal pain, was visited by different physicians with different specialties and admitted to the geriatric ward with a diagnosis of gastric cancer. He was discharged with indications for the home geriatric unit and oncological territorial pathway.

Table 1. Patients in the protocol in June 2023.

Patients	Discharged to home care unit from hospital (n. 10)	From territory to geriatric ward without accessing to emergency room (n. 6)
Female/male	6/4	4/2
Age	84±6	81±4
Chronic respiratory failure	6	2
Anemia	1	2
Percutaneous endoscopic gastrostomy		1
Pneumonia		1
Dementia after acute stressor diseases	2	

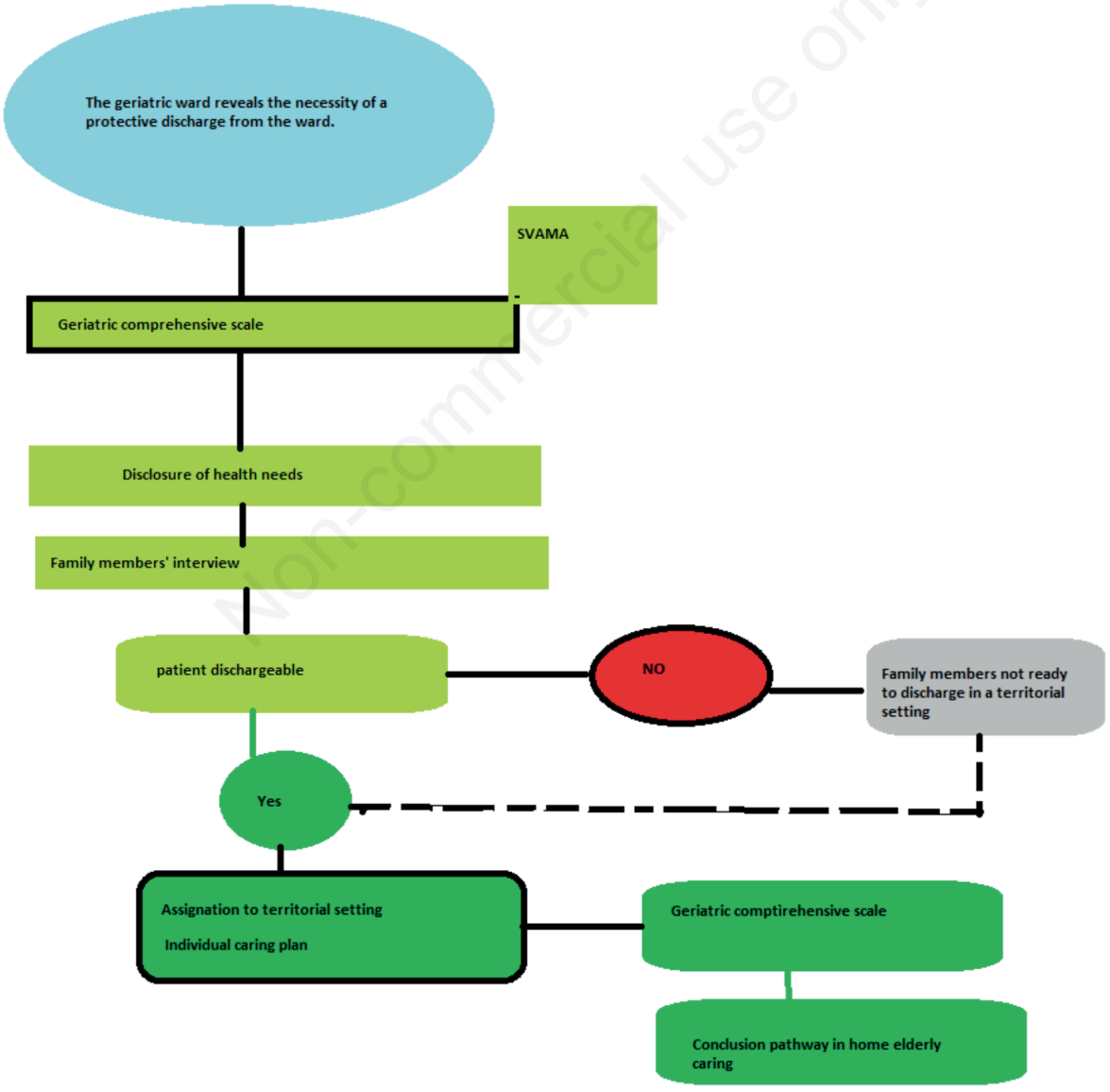

Figure 1. From the ward to the elderly home care unit. SVAMA, multidimensional assessment of adults and the elderly.

A patient affected by chronic respiratory failure was treated with home oxygen therapy and was overseen by the home care unit. After evidence of the increased need for oxygen, the family doctor requested an admission without accessing the emergency room according to protocol. During hospitalization, a diagnosis of community-acquired pneumonia was made. The treatment with non-invasive ventilation for some days was necessary, and after ten days, the patient was discharged.

A female patient was discharged a month earlier from another hospital with a diagnosis of heart failure and anemia due to digestive loss. During that admission, she refused an endoscopy. She was followed by physicians from the home care unit who requested an admission according to protocol to study anemia. After many home transfusions, exams were done for hematological anemia. She was discharged after five days. She continued the follow-up in the hematological ward.

A female patient with an advanced stage of Alzheimer's disease had difficulty swallowing, and the family doctor required admission for a percutaneous endoscopic gastrostomy. After the dysphagia protocol evaluation, the nutrition specialist prescribed oral nutrition integration and follow-up in their unit.

Six elderly patients were directly admitted to the geriatric ward in the first month after the protocol began. We reported only four cases because the other patients had an anamnestic disease that may have allowed us to identify them.

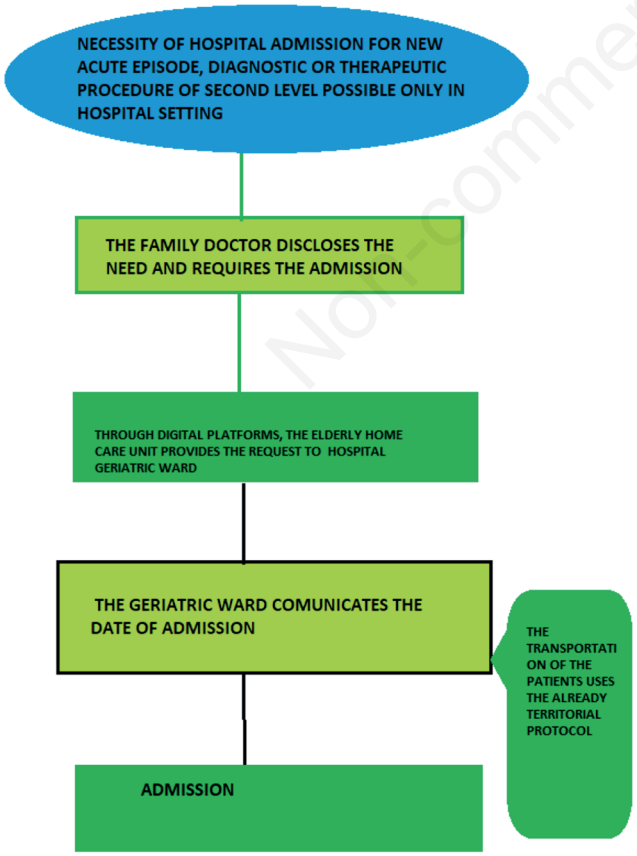

Figure 2. From the territorial unit to the hospital.

Discussion

In a few days, after several meetings, San Giuseppe Moscati Hospital in Avellino and the Local Health Authority elaborated a protocol for hospital territorial integration. The actual relationship between hospitals and territory in some Italian regions is well known to all of us. Some personal reflections and suggestions, especially for our scientific society, the *Società Italiana di Geriatria Ospedale e Territorio*, are topical. An old patient may be admitted to the hospital many times in a year, every time with a stopover in the emergency room and a waiting time before the ward admission of 3-5 days, with many care difficulties. Generally, an emergency room setting is for acute disease patients or patients that must be inserted into time-dependent networks, such as stroke or coronary artery disease. For this kind of patient, the waiting time is short. For an elderly patient who stays longer in the emergency room, the impact on the emergency organization is strong. It is necessary to plan meals, administration of drugs, and personal hygiene in an often overcrowded environment.

Furthermore, an older patient arrives at the hospital after a visit to different physicians (general practitioners, outpatient specialists, geriatricians of integrated home care, often dementia diagnosis and treatment centers, emergency physicians, hospital and territorial nurses, and different ward physicians), without considering the role of the patient's caregiver in the guardianship of the benefits of Law 104,[4] and the fund assistance. The caregiver sometimes acts as a true integrator between all the professional figures. The evidence showed that a good organization reduces mortality and improves outcomes.[5]

The protocol, made at no cost, is that the old patient is notified to a home care service through direct contact with the service and is provided with a physician and nurse hospital discharge letter and a comprehensive geriatric assessment. Communication is crucial between physicians and services, as is the empowerment of family members. The territorial case manager works in collaboration with the general practitioner. If the home care patients must return to the hospital for a new clinical stabilization, invasive diagnostic, or therapeutic procedure, they may be admitted directly to the ward without going through the emergency room on a bed reserved for home care service. The beds are reserved only for the patients in charge of home care management.

Integration still has a long way to go and requires many efforts. Some essential issues are still to be evaluated. Many professional figures have different contracts with the national health system (for example, outpatient specialists and general practitioners). A solid functional integration may resolve this limit. The functional integration between hospitals and territorial figures should positively affect the health system. Indeed, if, in the future, hospital physicians follow the home care patients and territorial physicians work in the hospital ward, everything will be fine. This professional exchange could be productive for elderly patients in terms of healthcare continuity.

The Italian National Recovery and Resilience Plan suggests increasing the percentage of elderly home care patients until 2026, reaching 10%. It is an ambitious but necessary purpose. It is unthinkable to have a great number of elderly patients with many chronic diseases and disabilities in nursing homes. Many people with disabilities end up in nursing homes because of inadequate services or housing.[6]

It would have been appropriate for the National Recovery and Resilience Plan to consider a family member health fund related to Law 104,[4] which reaches about 10 billion euros and would require, as in many European countries, its destination to services and

continuity. Providing integration between these funds and health services is vital. Another need is to equate the work and economic conditions between territorial and hospital nurses and health care assistants. This action will improve professional care work. The National Recovery and Resilience Plan positively differentiates residential interventions from basic hospital and territorial services and could solve many of these difficulties because it provides adequate funds. So, if not now, when?

Conclusions

Integration is a very difficult pathway that needs the efforts of all actors involved, especially those of senior scientific societies that can now influence geriatric cultural change. This protocol showed that if the territory is constructive in caring for elderly patients, the hospital setting is also productive. On the other hand, a hospital setting that communicates with the territory can make it more efficacious. Although the road is still long, a good health organization with more coordination and less fragmentation may help resolve the dire emergency room crisis.

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