The health and community care centre in the territorial health system

Francesca Giofrè, Sapienza Università di Roma, Dipartimento ITACA, Facoltà di Architettura Valle Giulia


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1. Premise

The research carried out by the ITACA Department of the Sapienza University of Rome involved the participation of an interdisciplinary group of experts, architects, programmers, planners and health workers who discussed the theme of the definition of a new experimental socio-health structure and its relationship with the network of services in the territory, a structure known as “Health and community care centre”. The necessity to study this theme stems from the need that has been uncovered in Italy for base structures where social and health activities are united physically to guarantee the participation and security of the communities that have been affected by the social processes of territorial readjustment. The experiment in health and community care centre projects not only satisfies this need, but represents an important moment in the re-planning of the network of services in the territory.

Assuming the health and community care centre is conceived as:
- a strategic point of the Health District (DS) established to deal with the most evident critical points in the relationship between the National Health Service (SSN) and the citizen, as well as guaranteeing Essential Levels of Assistance (LEA);
- a structure with a strong socio-health character and a hinge between the acute hospital and socio-health services of a territorial character that, therefore, has to be suitably planned on the basis of local socio-health and epidemiological developments;
the research studied in detail not only its strategic role and its relations with other elements of the care network, but also the typologies and characteristics of the services that should be provided.

In this way, a model of reference was arrived at that, as such, has necessarily to be contextualised in diverse settings.

The interdisciplinary research group initially met with the different professions involved in order to define the strategic contents of the Health and community care centre, the workers involved, the connections with other health and socio-health structures, before moving on to define the typologies and characteristics of the services that should be provided.

2. Health and community care centre: strategic role and relationships with other elements of the network

- The health and community care centre puts itself forward as a single seat for the surgeries of GPs and paediatric GPs as well as a point of reference and coordination for all the health and socio-health activities to be developed in the territory, concretely carrying out the National Agreement with solutions that raise the professional quality and reliability of primary care. The health and community care centre has to guarantee a 24-hour medical presence, including GPs and first aid.

With regard to the above, it is possible, however, that some GPs for objective and/or subjective reasons will not be able or willing to transfer their offices to this single location, but even when this happens the health and community care centre will form, in any case, the point of reference and coordination for all the common health and socio-health activities to be developed in the territory.

- The health and community care centre is in any case the place to bring together again the various territorial activities.

- The health and community care centre is the shared seat of continuous care, of outpatient specialists, nurses, therapists and social services that provides operational integration at the one time and in a single location. It is the place to establish systematic collaborative relationships with the referring hospitals whether on the basis of protocols that were agreed at the time of discharge or with the use of IT systems for the transmission of reports and the activation of real-time consultations (telemedicine).

- The health and community care centre is the seat for the exchange of information between GPs and the first-aid doctors through the elaboration of the data contained in the electronic medical report. The

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availability of epidemiological data allows the health and community care centre to become the common seat for staff refresher courses and professional training.

- If equipped, as we'll see, with an A&E, the health and community care centre represents a valid filter on the way to hospital.
- The health and community care centre may also find its appropriate site through the re-use of former hospital buildings.

The health and community care centre, therefore, concretely forms the principle-method of territorial planning because it unifies and integrates what had been dispersed and separate and because it enables a knowing participation on the part of the citizens in health projects. The health and community care centre in the end is not self-governing and self-sufficient but it is a structure that is closely linked to the health district to which it brings a knowledge base, proposals and with which it achieves its objectives coherently.

Thus, as was written in the document “A New Deal In Health – the Government programme for the promotion of and equality in health provision for citizens”, appearance by the former Health Minister Livia Turco before the Commission for Social Affairs – Rome June 27th 2006, following the publication of the research, “The health and community care centre could become the multipurpose multifunctional structure that proves capable of materially running the totality of primary care and guaranteeing continuity in treatment with the hospital and along with prevention activities.” ... “carrying out primary, secondary and tertiary prevention, health education and correct practices in the self-management of chronic diseases; it activates home-based care with strong multidisciplinary integration and, finally, it formalises the participation of citizens”. ... “In the health and community care centre, therefore, all basic diagnostic-instrumental controls have to be available 7 days a week for at least 12 hours a day. The health and community care centre has to implement the IT management of all health data and has to activate teleconsultation and telemedical procedures that will permit a level-2 specialist diagnosis.”

3. Health and community care centre: typologies and characteristics of the services that should be provided. The research defined and analysed the fundamental or invariable functions of the health and community care centre, articulating them in four sectors:
- Health Services (SS)
- Socio-Health Services (SSS)
- Social Services and Activities (SAS)
- Other Services (SAl).

In its most complex form, a health and community care centre will provide all the services in these four groups.

The following functional areas are present in the Health Services sector:

**HEALTH SERVICES_SS**
- Territorial Point of 1st Intervention _SS_PPI
- First Aid Station _SS_GM
- Radiology and Ultrasound _SS_RAD_ECO
- Specialist Outpatient Clinics _SS_AM_SP
- General Practice Surgeries _SS_AM_MMG
- Paediatric General Practice Surgeries _SS_AM_PLS
- First Sampling Point and Point of Care _SS_PPP_POC
- Day Hospital _SS_DH
- Community Hospital _SS_OdiC

A Unit of Geriatric Evaluation (U.V.G.) is also foreseen in the Health Services sector that represents the nucleus for the coordination of services aimed at the elderly. This function employs, in an organised and planned way, the outpatient areas, taking advantage of a series of professions that are mostly already present in the structure.

**SOCIO-HEALTH SERVICES_SSS**
- Family Planning Clinic _SSS_CF
- Rehabilitation Area _SSS_RIAB
- Psychiatric Area _SSS_PSIC
Each area/service relating to the three sectors has been set up following the different indications of national and regional law, contextualised in respect of the specific function of the health and community care centre. Each area/service was analysed through homogenous readings that lead to the following indications (fig.1-3):
- description of services and their typology
- layout of spaces/areas and rooms and their dimensions
- equipment
- personnel
- organisation chart for single functional areas.

From the analyses carried out on the reference model in dimensional terms, the percentage of surface usage was calculated for each of the four sectors, from which can be understood the characterisation of the health and community care centre: health services take up 54.8%, socio-health services 35.7%, social services and activities 4.3% and other services 5.2% (fig.4).

With the aim of providing guidance for planners on the correct aggregation of spaces, a matrix of spatial and functional relationships has been provided with the indication of the services available within the health and community care centre.

By spatial relationship, we mean the physical nearness that two services or activities need to have. The criterion of nearness in the relationship also considers the sharing of support or plant services. In particular, the services that operate continuously are characterised by a higher spatial relationship (distribution of meals, security, night heating, etc.).

By functional relationship, we mean rather the necessary functional connection between the two services and therefore the necessity, or opportunity, that both should find themselves in the same building and sharing the same timetables even if, for various reasons, they needn’t be adjacent. It may be, for example, that service “x” is felt to have a strong functional relationship with the RSA, but not a spatial relationship, so that so long as they were in the same building it might not be relevant that they be on the same floor or adjacent to each other.

The matrix is compiled in the following phases:
- A doctor and an architect from the research group compiled the matrix together attributing a grade to each parameter: High (3), Medium (2), Low (1).
- The empty matrix was compiled by a certain number of experts, by 9 “experts” (1 social work manager, 1 GP, 2 territorial nursing managers, 1 administrator, 1 district medical manager, 1 medical manager from the community hospital, 2 medical experts in health planning).
- The average of the evaluations was examined and it showed the following aberrations compared to the preliminary classification:
  - Spatial relationship: 80 agreements (76.2%), 24 disagreements of one level (22.9%), 1 disagreement of two levels (0.9%).
  - Functional relationship: 68 agreements (64.8%), 33 disagreements of one level (31.4%), 4 disagreements of two levels (3.8%).
- This result was discussed with some of the experts and 10 changes were made to spatial relationships and 15 to functional relationships. On the basis of these results, the definitive matrix was drawn up (fig.5 e 5 bis).

Another aspect that was evaluated is that of the distribution of health activities and the presence of personnel during the course of the day for the two sectors of health services and socio-health services (fig.6).

Finally, as mentioned at the start, the research was conducted on a hypothetical model of a health and community care centre containing all the above-mentioned services. The model as a model has to be contextualised, and different hypotheses were elaborated from here that consider the necessity or otherwise of the presence of certain services (fig.7).
4. Two case studies: the preliminary project for the reconversion of the Palombara Sabina Hospital (Lazio) into a health and community care centre and the feasibility study for the creation of a system of socio-health structures at Anticoli Corrado (Lazio).

On the basis of the study that was carried out, the 2007 Budget set aside 10 million euros for trials of the health and community care centre care model. In Italy, a number of trials are underway. Those discussed below refer to two very different scenarios:

a) the first is the restructuring of the Palombara Sabina Hospital site in the Lazio Region, belonging to the AUSL RMG.

b) the second is a feasibility study for the building of a private socio-health complex at Anticoli Corrado, again in Lazio, in the Province of Rome, which is to include a health and community care centre.

a) The preliminary project for the reconversion of the Palombara Sabina Hospital, unlike analogous situations, presented substantial difficulties because of the shape of the structure with its highly articulated geometry(fig.8).

The project had two aims:

1. that of preparing the complex plan for the health and community care centre through the redevelopment of the entire hospital building, bearing in mind the restrictions offered by the structure itself, without altering any disposition of volumes;
2. that of satisfying the immediate need of the purchasers, the Health Authority, to render one of the blocks that make up the complex, the block identified with the letter d, currently contracted out, independent in terms of its construction and functional organisation with regard to the whole plan. This would allow the authority to anticipate, from the point of view of the future creation of the health and community care centre, the planning actions that render the intervention "unitary".

Of the principal planning choices, with the identification of the services and of the layout that underpins the whole development of the preliminary plan as described, a number of principal data emerge.

- The hospice, that will be on a single level (ground floor, block c) for a total of 553 square metres; it is planned to house 10 bed places distributed in 6 single rooms (circa 26 square metres per room), each with a disabled toilet, and 2 double rooms (circa 26 square metres per room), each with the same toilet provision; the hospice will be equipped with a series of support services in line with current law (day room, charge nurse, etc).
- Long-term rehabilitation will be on two levels (first and second floor, block b) for a total 1,479 square metres; it is planned to house 32 bed places in 8 double rooms per floor (about 30 square metres) with disabled toilets; long-term rehabilitation will be equipped with a series of support services in line with current law (day room, charge nurse, outpatients, etc).
- The Assisted Health Residence will be on two floors (third and fourth floors, block B) for a total of 1,301 square metres; it is planned to house 32 bed places in 8 double rooms per floor (about 30 square metres) with disabled toilets; the RSA will be equipped with a series of support services in line with current law (day room, charge nurse, outpatients, etc), as well as the area dedicated to the Geriatric Evaluation Unit.
- The Community Hospital will be on one level (fifth floor, block b) for a total of 718 square metres; it is planned to house 16 bed places in 8 double rooms per floor (about 30 square metres) with disabled toilets; the Community Hospital will be equipped with a series of support services in line with current law (day room, charge nurse, outpatients, meeting rooms, etc.).

Given the character of the health and community care centre in the Palombara Sabina Hospital, spaces have also been planned for hydrotherapy, as well as physiotherapy for internal and external patients.

Services are located in line with what the study identified as characteristic of the health and community care centre, bearing in mind the requirements of spatial proximity of certain functions that in the specific case have to be read both for floors and blocks (fig.9).

b. Feasibility study for the creation of a private complex of socio-health structures at Anticoli Corrado, Province of Rome.
The feasibility study is centred on the analysis of a complex system of socio-health services aimed at the elderly. The proposed system, on the basis of an evaluation of the potential demand, regards the offer of physical structures, both of a residential and service character, some prevalently of a social nature, others primarily of a health nature.

The identified functions that have to be located, including those referring to the health and community care centre, in the privately owned area are as follows (fig.10):

- 1 Assisted Health Residence (RSA), with provision for 40 bed places;
- 1 service kitchen for all the planned functions;
- Decentralised Elderly Dialysis Unit (UDDA) with 3 technical bed places, located in the RSA;
- 1 long-term medical ward, with a post-acute rehabilitation centre adjoining and linked to the RSA, with 20 bed places;
- 1 protected residence area (RP) in a residential regime with 6 + 6 bed places;
- 1 area with night-time and holiday first-aid station, A&E point, instrumental diagnostic area, 2 general medicine outpatient clinics, 3 specialist outpatient clinics

and furthermore 2 nuclei dedicated to other types of activity linked to the nuclei defined above:

- 1 holiday home with 40 bed places;
- 1 multifunctional area with gym, swimming pool and restaurant/bar;
- 1 Alzheimer’s centre with 20 bed places;
- Support services (guards and parking).

What's on offer is complex and substantial both from the point of view of investment and from the point of view of organisation and management, and given the freedom of choice in locating the above-mentioned functions, in the two available lots, alternative hypotheses have been elaborated, whose costs have been evaluated in relation to the different phases of construction and on which have been subject to a cost-benefit analysis.

There are other experiments being carried out in Italy, many of which are linked to the redevelopment of small disused hospital structures. The two case studies are testimony to the fact that the health and community care centre should not be considered as a single model, but the services provided will vary in relation to the frame of reference, though its principal characteristic has to remain that of a structure with a strong socio-health character that forms a hinge between the acute hospital and health and social services of a territorial character.

Principal bibliographical references


“A New Deal For Health – the Government programme for the promotion of and equality in health provision for citizens”, appearance by the former Health Minister Livia Turco before the Commission for Social Affairs – Rome June 27th 2006,

Regional regulations on the accreditation of health activities

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1 “The District is the Local Health Authority structure whose aim is to provide, in the territory, a high level of integration between the different services providing healthcare, including social assistance services, in such a way as to allow a coordinated and continuous response to the health needs of the population”. (art.20 L.R. 26/96)

The Health District serves a theoretical population of 60,000 and the standards of reference have to bear in mind certain variables, namely: the territory in a physical sense in relation to the system of infrastructural viability, the concentration of population, the configuration of local bodies present on the territory, etc. On the basis of this, the following can be considered theoretical standards:

DS1 $\equiv$ 25,000 inhabitants – sparse population, mountainous area
DS2 $\equiv$ 40,000 inhabitants – regular population distribution, plain area
DS3 $\equiv$ 35,000 inhabitants – discontinuous population distribution, mixed area
DS4 $\equiv$ 100,000 inhabitants – concentrated population, metropolitan area.

a The hospital’s layout can be identified as four interlinking blocks that develop of different levels at different heights:
- block a, the oldest part, contains the entrance to the whole building, 3 floors
- block b, currently used for a number of activities, over seven floors of which the third is presently uncompleted
- block c, currently uncompleted, three floors
- block d, currently contracted out, four floors.

From the building’s main entrance, situated in block a, users and staff can reach the stairs and lifts that are placed barycentrically to the configuration of the building itself.