A survey among hospital members of the Italian Hospital and Territory Society

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Abstract

To describe hospital activities distributed across the national territory, we conducted an online survey, addressed to all hospital members of the Italian Hospital and Territory Society (SIGOT) by email, and disseminated using SIGOT social channels. The questionnaire was available from June to September 2024. The survey addressed general and demographic characteristics of 126 respondents from different Italian geriatric hospital wards and the peculiarities of the activities inherent to comprehensive multidimensional assessment or specific techniques (non-invasive ventilation, high-flow oxygen therapy), type of organizations, and connection with intermediate care. Results of this survey show the importance of geriatricians in the acute-care setting, as well as point out some critical issues, such as the difficulty of clinicians to balance the objectives of economic efficiency (assigned yearly to the hospital unit) with those regarding quality of care and improved patients' clinical outcomes.

Introduction

By 2020, approximately 1 billion individuals (13.5% of the global population) were 60 years or older, and this number is expected to reach 2.1 billion by 2050. However, while more people are living longer, they often face poor health during their last years of life.[1-3]

The aging process brings a higher prevalence of multi-comorbidities, which, coupled with the rapid increase in the older population, are straining healthcare systems, leading to higher healthcare costs and greater demand for services.[4,5] This demographic shift also influences family caregiving dynamics, especially in countries where older individuals are often perceived as a societal burden.[6,7]

Several studies have identified predictors of prolonged hospitalization in older adults, such as admission diagnoses, comorbidities, and functional and cognitive decline. Admission diagnosis of older adults in Acute Geriatric Wards has been reported as an important predictor of length of hospitalization.[8-10] Despite scientific evidence, acute care for older adults is typically provided for patients with an acute illness without focusing on functional, nutritional, and psychosocial needs,[11] making the geriatrician's presence crucial in hospital settings. The Acute Geriatrics Unit is a strategic point in the network of services for the old patients because acute illness and hospitalization can represent a time when complications or impairment of pre-existing functional autonomy arise.

One of the pillars of managing older adults in healthcare settings is the Comprehensive Geriatric Assessment (CGA). CGA is a methodology developed by geriatricians for the clinical management of complex patients and is useful for tailored interventions according to the patient's needs, resources and priorities.[12] Research has shown that CGA leads to better health outcomes, including improved physical capacity, reduced hospitalizations, decreased healthcare utilization, appropriate resource allocation, and finally lower mortality rates, and that these benefits occur mostly in the acute-care hospital setting.[13,14] Evidence in the literature demonstrates further superiority if the same medical/nursing team that performs the multidimensional geriatric assessment also performs clinical management, taking charge of the patient in a dedicated setting, with a dedicated medical/nursing team,[15] because the approach to acute events must be timely and intensive to avoid the so-called "cascading decompensations" typical of frail old patients. The dramatic experience of the pandemic has also confirmed that, to reduce complications and mortality, in addition to increased hospital capacity, it would be necessary to provide many of the hospitalized old patients with timely access to intensive or semi-intensive care services. Without these, the prognosis would not be significantly different compared to continuing care in a nursing home or at home. For this reason, Acute Geriatric Units, as also envisioned in internal medicine units, should also be able to provide some beds with technology suitable for a sub-intensive approach (infusion pumps, monitors, non-invasive ventilators, suction, *etc*.), while ensuring that patients apply the principles of geriatric care that have been shown to improve outcomes for the acutely frail old patients.[16] Thus, the Italian Hospital and Territory Society (SIGOT) conducted a survey to obtain useful information about the activities of hospital geriatricians and hospital geriatric units in Italy to provide valuable insights into the evolving role of Geriatrics in the Italian healthcare system.

Materials and Methods

The survey was designed considering the best practices in conducting and reporting survey-type research.[17-19] An online survey, to collect information on hospitals where Italian geriatricians who are members of SIGOT work, was conducted. The survey was formatted with Google Forms and sent in June 2024 to all SIGOT members *via* e-mail. The survey was available at: https://docs.google.com/forms/d/117pdZPQSXd-kTRiJHiAQuG4hjn-VEe7JDIWzIdxAIkc/edit, until September 15, 2024. The full questionnaire, translated into English, is available in this manuscript as *Supplementary Material*. Filling out the survey only took a few minutes. All quantitative variables were expressed as percentages (%).

Results

A total of 126 hospital geriatricians responded to the survey. Respondents work mainly in northern Italy (52.4%), but also in central (18.3%) and southern Italy and islands (29.4%). Most of the respondents worked in standard hospital or university hospital (31.7%) or Hub hospitals (25.4%), mostly in Complex Operative Units (78.6%), with "hospital" director in charge (81%), *i.e*., director of the unit without university assignment in the Italian Heath System; the Complex Operative Unit is the highest form of hospital service. We found that 63.5% of respondents were not the director of the Unit. In addition, 55.6% of respondents reported that they cover only a 12-hour shift within the geriatric unit (from 8 am to 8 pm on working days), while the 24 hours are covered jointly with doctors of other medical units.

Our survey proves the persistent disconnect between hospital and community care, with 90.5% of respondents feeling community services are inadequate to support patient discharge (Figure

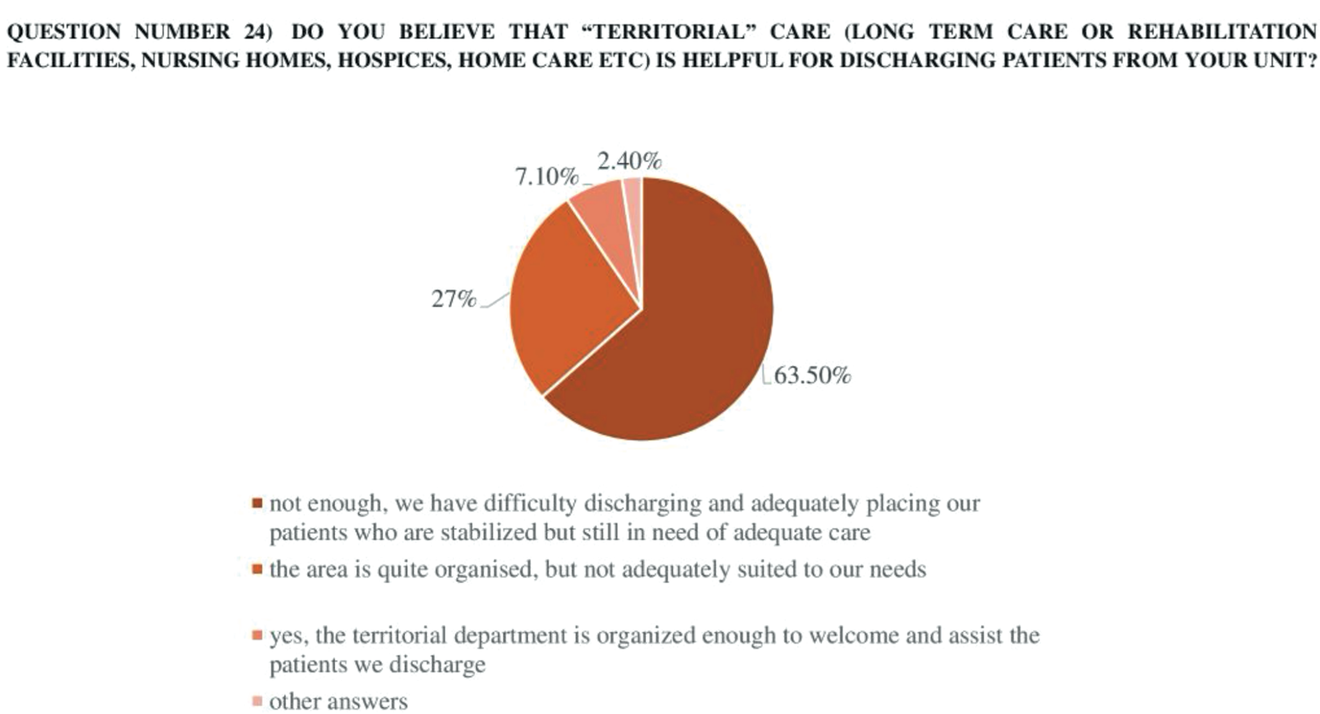

Figure 1. Perception of transitional care (in %).

1). Besides, this survey highlights that in a striking 65.1% of cases, the patient is not fully involved in care-planning decisions in hospital discharge (Figure 2). Positive evidence is the high utilization of non-invasive ventilation (NIV) techniques by 58.7% of geriatric units (Figure 3). While most geriatricians (57%) pragmatically acknowledge that economic parameters are necessary for healthcare sustainability, they strongly believe these must be balanced with goals of efficacy, such as improved quality of care and reduced negative outcomes (Figure 4). Conversely, nearly 1 in 3 respondents (29.4%) feels that a narrow focus on efficiency goals has a definitively negative impact, increasing the risk to patient care and professional liability while fostering internal conflict (Figure 4). Results related to the survey are summarized in Figures 1-4.

Discussion

Our survey, including 126 respondents from different Italian geriatric hospital wards, provides a valuable snapshot of the current state of hospital-based geriatrics in Italy, showing that the role of the geriatrician goes far beyond just managing multimorbidity and chronicity. A key finding is the substantial involvement of geriatric units in the treatment of older adults with acute and criti-

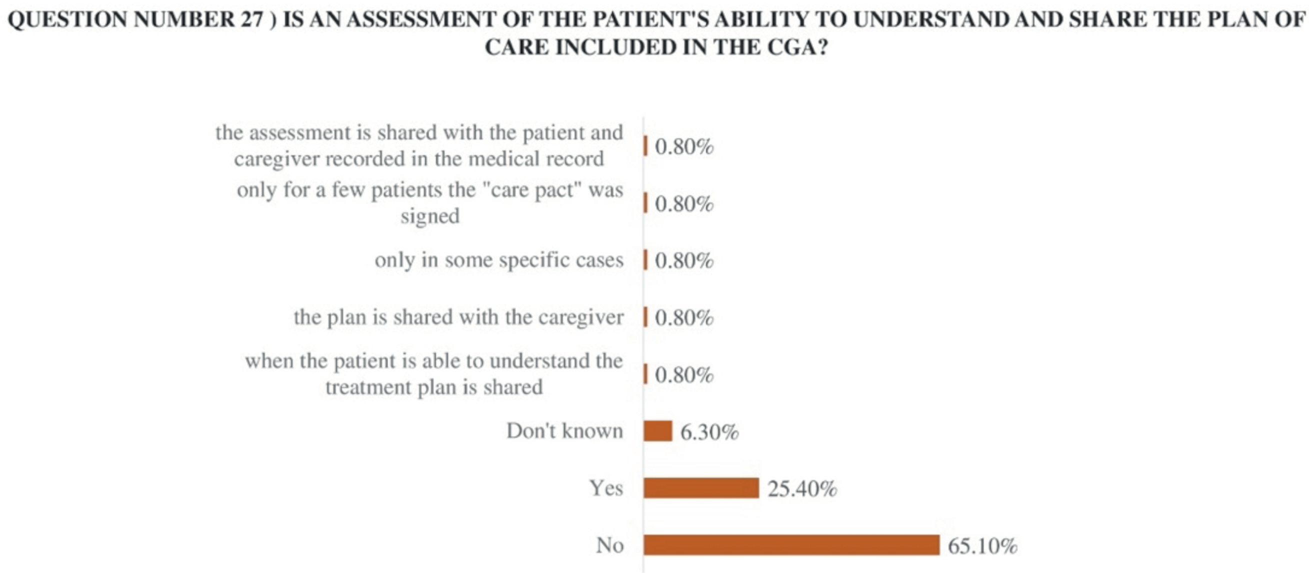

Figure 2. Involvement of the patient in the Comprehensive Geriatric Assessment (CGA).

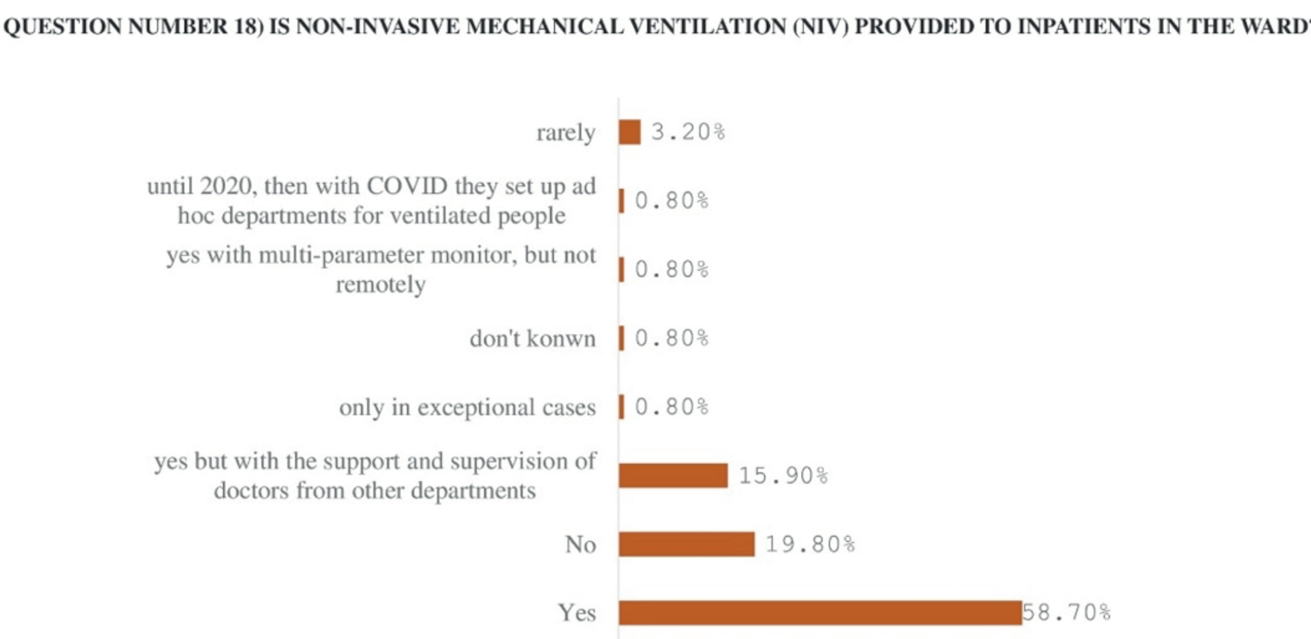

Figure 3. Use of non-invasive mechanical ventilation in geriatric acute settings.

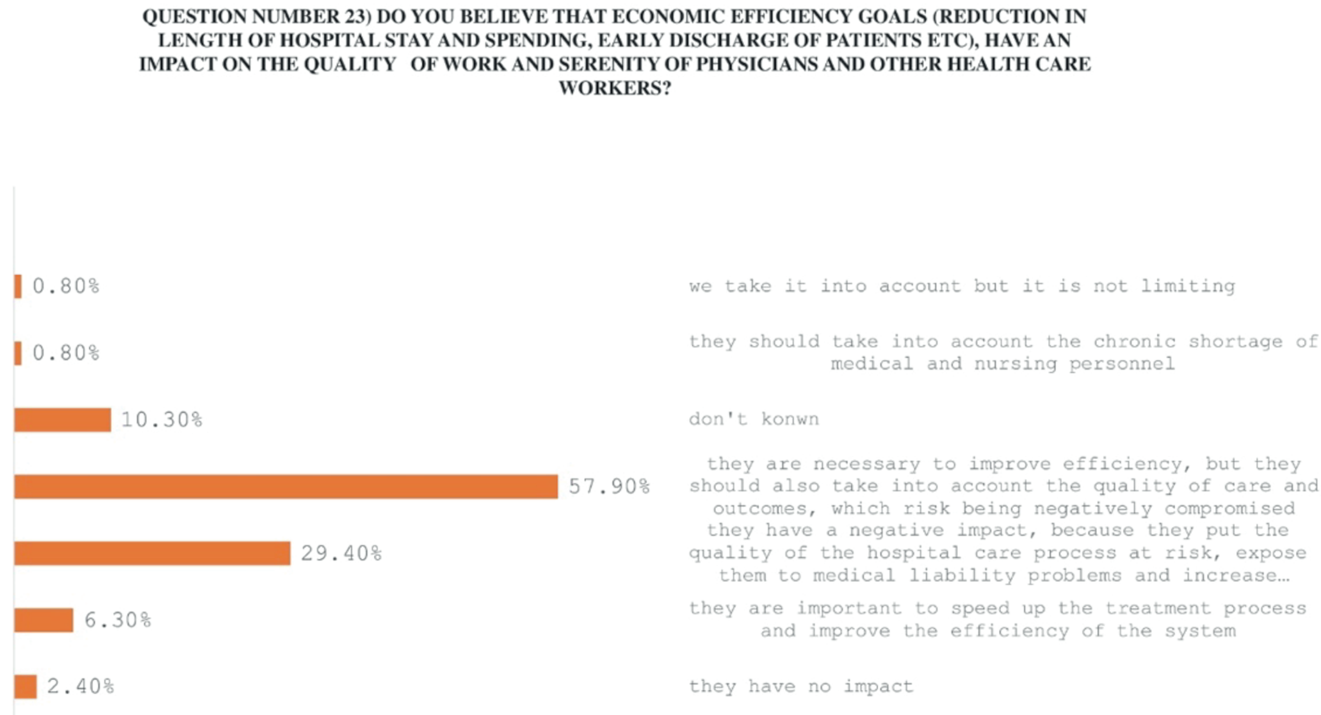

Figure 4. Impact of efficiency outcomes on the quality of work of healthcare professionals.

cal diseases, a role that has been amplified and brought into sharp focus by recent public health emergencies. A paradigmatic example is the response to the SARS-CoV-2 pandemic, during which 57% of responding geriatric wards were directly charged with managing patients with such infection. This required a high level of acute care competency, evidenced by the high utilization of NIV techniques (Figure 3). This aligns with international experiences, which demonstrate the relevance of a comprehensive geriatric approach for capturing atypical presentations of COVID-19 in frail older adults and tailoring treatment strategies as ventilation therapies.[18-20] However, the results also reveal significant variability in capabilities; while many units provided NIV, 15.9% could only do so with support from other departments, and nearly 20% did not provide it at all. This, combined with the finding that only 16.7% of wards are equipped with a dedicated sub-intensive care area, suggests a critical gap in standardized acute care training and resources within geriatric units. Such models are vital for reducing in-hospital mortality and alleviating pressure on intensive care units, and, considering the newly proposed reform of differentiated autonomy, which will further decentralize healthcare governance, a strict commitment by the National Health authorities is needed to reduce disparities between regions. Further complicating the provision of continuous, high-quality care is the prevalent staffing model. A concerning 55.6% of respondents reported that geriatricians cover only a 12-hour shift (8 am to 8 pm), with overnight coverage handled by doctors from other medical units. This model potentially undermines the core principles of geriatric care, which rely on the continuous application of a CGA by a specialized team. The absence of a geriatrician overnight could lead to fragmented care, a higher risk of hospital-related complications such as delirium, and less effective management of nocturnal emergencies in this vulnerable population.

The data that demonstrates a lack of integration between the hospital and territory reveals a more nuanced problem. Beyond a simple lack of resources, 27% of geriatricians stated that local services, while organized, are “not adequately suited to our needs”. This points to a qualitative mismatch, where long-term care facilities or home care services may not be equipped to handle the high degree of clinical complexity and frailty characteristic of patients being discharged from Acute Geriatric Wards. Previous experiences highlighted the importance of such organization models to reduce in-hospital mortality and intensive care unit overcrowding.[21] However, this deficiency may consequently lead to prolonged hospital stays in older subjects who no longer require acute hospital care, configuring the so-called “bed blockers” phenomenon, and increasing the risk of several hospital-related complications (*i.e.*, immobilization syndrome, delirium, nosocomial infections).[22] Therefore, it is still necessary to increase the efficiency and capability of the “territory” health system, mostly in its capacity to accept from hospitals complex and frail older patients, with the aim of reducing unjustified prolongations of hospitalization. A cornerstone of modern geriatrics is patient-centered care, yet the survey highlights a significant deficiency in this area. This is not a simple monolith of exclusion; the data shows a spectrum of issues, from involving only the caregiver to sharing the plan only when the patient is deemed able to understand (Figure 2). This suggests that the principles of shared decision-making are not being systematically implemented, failing to honor patient autonomy and self-determination as a central component of the clinical-care plan.

Finally, the survey illuminates the tension between clinical quality and economic efficiency. These data convey a clear message: in the complex environment of acute geriatric care, quality indicators like mortality, rehospitalization rates, and prevention of hospital-acquired conditions must be prioritized alongside, and not supplanted by, economic targets like reduced length of stay. Evaluating costs over a wider timeframe that includes the post-discharge period would provide a more accurate measure of true efficiency.

These challenges are likely magnified by regional disparities, as over half of respondents (52.4%) were from northern Italy, compared to just 29.4% from southern Italy and the islands. The call to increase the number of Acute Geriatric Wards is therefore most urgent in the south. The newly proposed reform of differentiated autonomy risks deepening these healthcare inequalities, necessitating a firm commitment from national health authorities to ensure equitable care for older adults across all regions.

Some limitations should be acknowledged. First, there was a preponderance of respondents who were not directly the director or the person responsible for the ward. Therefore, some administrative data was not sufficiently provided. Moreover, since participants were asked for information regarding the previous year, a bias cannot be ruled out.

Conclusions

Geriatric skills and comprehensive multidimensional assessment constitute milestones for the management of acute illnesses in the hospital setting and supplement the competent and timely treatment of acute conditions by emergency medicine methods such as non-invasive mechanical ventilation and high flow oxygen therapy, as demonstrated in the COVID-19 pandemic emergency.[16,23,24] Some studies demonstrated that geriatrician-led models of care were associated with lower odds of extended hospitalization and reduced costs.[11] This survey identifies some peculiar aspects of hospital geriatric activity, such as the management of acute illnesses. Excluding old patients from acute care services would create a clear inequity in access to age-related care, but it would also lead to an increase in negative outcomes (disability and care costs), increasing the burden of chronic conditions. The interconnection between hospital and post-hospital community healthcare activities is still deemed unsatisfactory by Italian hospital geriatricians. Notably, the survey highlights how the work of the hospital geriatrician is conditioned by budget and economic objectives. Furthermore, the importance of the "patient" as the heart of the clinical decision-making process still needs to be promoted in the real-life Italian hospital practice.

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Online supplementary material:

Supplementary Material. Full questionnaire, translated into English. The content of this file is original to the authors.