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The role and the interventions of the Hospital Social Service (HSS) for the integration of the health and social activities: a comparative survey between 2008 and 2014 in the Social Service of the "Azienda Ospedaliera Universitaria Policlinico Umberto I" in Rome, Italy

C. Trezza[1], M. Mazzotta[1], D. Lorenzetti[2], L. De Vito[3], V. Renzini[4]

Key words: Azienda Ospedaliera Universitaria Policlinico Umberto I, Hospital Social Service (HSS), Social record, Comparative Analysis, Homecare, Sheltered Housing
Parole chiave: Azienda Ospedaliera Universitaria Policlinico Umberto I, Servizio Sociale Ospedaliero (SSO), Cartella Sociale, Analisi Comparativa, Assistenza Domiciliare, Strutture Protette

Abstract

Introduction. *In the Azienda Ospedaliera Universitaria Policlinico Umberto I in Rome, the Hospital Social Services (HSS) is located within the Directorate of Health, reporting directly to the Chief Medical Officer, providing counselling and supporting clinical services. The HSS is part of a network with its own technical, professional and assessment independence. It often serves as liaison between the hospital and the territory, facilitating the development of services and contributing to public health recovery and maintenance, therefore improving the citizens' standard of living thanks to aid projects and specific interventions.*
Methods. *The present Report is based on two different studies carried out in 2008 and 2014, both examining the work of the Hospital Social Service in the "Azienda Ospedaliera Universitaria Policlinico Umberto I" in Rome. The purpose is to compare these surveys and work out the results. The data collection is based on a number of social records from the HSS archives (814 records in 2008 and 790 in 2014).*
The research project followed subsequent stages: planning a draft of the research, where ethnomethodology was used as empirical evaluation technique; collecting data from the HSS's paper and file archives (biographical, clinical and social data); revising, analysing and elaborating the data which showed relevant changes leading to interesting conclusions.
Results and conclusions. *The comparative analysis of data showed a higher demand of HSS healthcare services, despite a smaller number of beds and hospitalisations available in standard regime. Also, it indicated an increase of patients below 18 years and a decrease of the over-65s age group.*
As for the geographical origin of patients reported to the HSS, there was a decrease in the percentage of Italian citizens, while the percentage of irregular non-EU and EU patients increased by over 5%.
Significant results were found comparing the days between the report to the HSS and patient discharge. Data concerning the 'more than 7 days' group was steady over the years, being more consistent for both the variables considered and increasing in 2014.

[1] *Social Service, Azienda Ospedaliera Universitaria Policlinico Umberto I, Rome, Italy*
[2] *Department of Medicine and Psychology, Sapienza University of Rome, Italy*
[3] *Health Directorate, Azienda Ospedaliera Universitaria Policlinico Umberto I, Rome, Italy*
[4] *Department of Public Health and Infectious Diseases, Sapienza University of Rome, Italy*

In the comparative analysis, the interventions with more significant differences were those aimed at promoting homecare and entering sheltered housing. In the former cases, a considerable decrease was observed, if compared to the activation of the integrated health and social homecare services, while there were more requests for homecare assistance; in the latter ones the analysis highlighted a sharp decrease in the percentage of the variable called "assessment to enter Extended Care Units".
The causes of these changes are remarkable and have to be found in the political, historical and cultural scenario:
- a first factor is the increase in the more recent migratory flow from non-EU countries to Italy, which could explain the rising percentage of foreigners taken over by the HSS;
- regional policies, economic cuts imposed on healthcare and higher income limits in order to calculate the patient's economic participation in the costs of institutionalisation have affected the above-mentioned changes;
- the innovations in the regulatory field of Latium Region have brought structural changes in long-term care facilities and in the level of care in Extended Care Units (ECU).

Introduction

Azienda Ospedaliera Universitaria Policlinico Umberto I in Rome is the biggest hospital in Europe and one of the principal, highly specialized teaching hospitals. It is located in the Castro Pretorio area and is administered by the Local Health Authority RM/1 (ASL RM/1 (formerly RM/A) in the 2nd Municipality, 3rd socio-sanitary Borough. It is located in a central area, adjacent to La Sapienza University of Rome and close to Termini railway station. It is therefore easily accessible by public transport.

Policlinico Umberto I combines health care, research and didactic activities. These activities take place in over 50 different buildings. Eight of them are located outside the perimeter wall, some in the surrounding areas (e.g. the Neuropsychiatry Hospital, which is located in the Borough of San Lorenzo), and others far from the central complex (e.g. Palazzo Baleani in Corso Vittorio) (1).

The Hospital Social Services (HSS) operate in the Directorate of Health and play an important role in supporting clinical activities in order to help patients achieve a complete recovery. They are completely independent technically, professionally and in terms of assessment. HSS aims to guarantee follow-up treatments and facilitate patients' rapid re-adjustment back to normal life. This approach will have beneficial effects on the clinical path and ultimately lead to improvements in patients' quality of life (2). The preferred methodology is disease management, which takes an integrated approach to the pathology in order to improve both clinical results and quality of the services provided to the patient. It also allows for economic rationalisation of social spending.

HSS's work is characterized by the specific context in which it operates. In the hospital, the aim is *to care* in a social sense, where *caring means 'take someone or something to heart', cure with the intention of improving the quality of life regardless of the persistence of the pathology (or its own ab-origine existence)* (3).

The role of hospital social workers is to contribute to the humanisation of the context where treatments are given and to respect human dignity, especially in case of

emotionally fragile people; they play a key role in advocacy (4).

Hospital social workers carry out their duties in accordance with decisions taken in State-Regions meetings. The social worker *recognizes the central role of the individual in every intervention, he/she takes into consideration and accepts anyone who makes a request, who is in need, who wants to solve a problem, as unique and different from others in a similar situation and he/she places each person in their life, relational and environmental context, both in an anthropological, cultural and physical sense* (5).

The social service, whether related or not to the hospital, has a broad set of responsibilities and operates within a network of health professionals. It contributes to the maintenance and/or recovery of patients' health (6). Hospital social workers play a key role; they contribute to a common project by recognizing and promoting different professional approaches. Their familiarity with the needs of people and their knowledge of available resources and services enable them to act as a link between the hospital and the territory (7).

The purpose of this report is to compare the data collected in two surveys which were carried out in 2008 and in 2014 at the Hospital Social Service of Azienda Ospedaliera Universitaria Policlinico Umberto I in Rome.

Materials and methods

The investigation at issue was performed between the beginning of 2014 and the end of 2016. It investigated different HSS professional spheres in 2014, and compared its findings with those of a similar study conducted in 2008.

In 2014, 905 social records reporting on the HSS's work were collected. For comparative purposes, the total number of records analyzed in this report was reduced to 790 for the year considered. Social records of cases reported by two entities were not included in this investigation: the Emergency Room (59); 'Sportello Emergenza Codice Rosa' (56) - which has only been operating since 2010 and concerns interventions in favour of women and minors who are victims of domestic and sexual violence. It was not possible to compare the data because these variables were not considered in the previous survey of 2008.

In short, 790 social records from 2014 and 814 of 2008 were analyzed.

The comparative analysis and the interpretation of the results have to be seen in the wider perspective of current regional policies aimed at the re-organization of the regional health care system. These have involved significant budget cuts from health care and a consequent reduction of beds during hospitalisation, both in standard regime and day hospital.

	Year 2008	Year 2014
Beds in standard regime	1,324	1,169
Total number of hospitalisations in standard regime	41,066	36,017
Beds in day hospital	254	146
Total number of hospitalisations in day hospital	22,858	25,284

DRG (Disease Related Group), a criterion based on the classification system of the pathologies treated at the hospital and introduced by the **DLgs N. 502/92**, has penalised medical conditions where the functional recovery time is longer than the time set by the DRG. Sometimes, a patient needs re-admission after being discharged due to an acute exacerbation of the clinical picture.

As we said, the HSS is in charge of follow-up care, which is aimed at integrating healthcare and social requests, and at diminishing the number and length of improper admissions.

The research project can be divided into three phases:

• *Planning a draft of the research project.* Ethnomethodology was chosen as a technique of empirical survey. This is in line with the microanalysis and the study of single cases which were considered in the hospital setting. Hospitalisation represents a change in a person's social status, an upset of everyday balance. In order to intervene effectively it is essential to understand and evaluate the factors beyond the patients' medical conditions.

• *Data collection from social records of the Social Service archive.* File archives were consulted such as the archive and records of the RAD (Rapporto Accettazione Dimissione - Report on Admission and Discharge). These archives contain relevant information of every single hospitalised person. The HSS medical records and the social daily records are essential in the assistance of patients. These documents include information about the patients' relationship with their ecosystem; their health problems; their social circumstances; assessments of their needs and consequent possibilities for intervention and assistance; the plan for social intervention and its targets; different phases of implementation; collaborations and potential provision of other services.

• *The last phase of the research concerned the interpretation and re-elaboration of the data.* In this phase the findings of the research and resulting considerations were underscored with theoretical knowledge.

On the basis of social records information, three specific collection fields were identified: biographical data (age, gender, nationality, domicile, civil status, etc.); clinical data (hospital ward, report to the HSS, the diagnosis of admission and hospital discharge, date of hospitalisation, date of the medical report to the HSS, date of hospital discharge); social data (services already activated, interventions performed and patient's reference figures who intervened in the implementation of the project).

In this comparative report, only the most significant variables were taken into consideration:

• biographical data - age, sex, nationality - differentiated by gender

• clinical data – report to the HSS, days elapsed between hospitalisation and the report to the HSS, days elapsed between the report to the HSS and the conclusion of the clinical case and/or hospital discharge;

• social data – interventions performed - differentiated by gender.

Results and discussions

In the comparative survey of the two periods, the clinical records of social interest were analyzed in relation to the number of beds available in the hospital and the number of hospitalisations in standard regime, when social workers intervene in their area of responsibility.

	Year 2008	Year 2014
Beds in standard regime	1,324	1,169 (- 11.70%)
Total number of hospitalisations in standard regime	41,066	36,017 (- 12.29%)
Beds in day hospital	254	146 (- 42.52%)
Total number of hospitalisations in D.H.	22,858	25,284 (+10.61%)
Social records	814	790
% taken over by the SSO compared to the total of the standard hospitalisations	1.98%	2.19% (+ 0.21%)

The comparison revealed that in 2014 the reports to the HSS increased (+0,21%) although the regional policies reduced the number of beds (-11.70%), affecting the hospitalisations in standard regime (-12.29%).

Biographical data

Age and gender

Nationality.

1. Age and gender

The age groups considered were: 0-18 years old (minors), 19-65 years old (adults), older (>) than 65 years (seniors).

Age Group	Year 2008 (814 cases)	Year 2014 (790 cases)
0-18 years old (minors)	14 patients (1.72%)	55 patients (6.96%)
	10 males (1.23%)	27 males (3.42%)
	4 females (0.49%)	28 females (3.54%)
19-65 years old (adults)	210 patients (25.80%)	235 patients (29.75%)
	132 males (16.22%)	146 males (18.48%)
	78 females (9.58%)	89 females (11.27%)
> 65 years old (seniors)	590 patients (72.48%)	500 patients (63.29%)
	males (29.73%)	223 males (28.23%)
	females (42.75%)	277 females (35.06%)

For 2014 we see an increase in the percentage of minors reported to the HSS (+5.24%). This is presumably a result of immigration, unaccompanied foreign minors on the Italian territory and the children of homeless foreign mothers, for whom the intervention of the HSS is required.

2. Nationality (Table 1)

The variable 'nationality' included:

- patients of Italian nationality;
- patients from the European Union (EU) who possess the European Health Insurance Card (EHIC), which became valid in Italy in 2004. The EHIC affords access to all the medical treatments and to the public health services of the host State; the card is valid for 6 years. The supply of healthcare is regulated by the legislation in force in the host State;
- EU patients with no regular presence on the national territory; they have access to the healthcare thanks to the ENI number (European Number of Identification), which has a half-yearly validity and is renewable. The ENI number ensures out-patients treatment and hospital care; emergency care; essential, long-term care for diseases and injuries; interventions of preventive medicine; pharmaceutical assistance (8).
- Non-EU patients with a valid residence permit in Italy.
- Non- EU patients who are irregularly present on the Italian territory, for whom the right to healthcare is regulated by the Article 35, third paragraph, of the Consolidated Law on immigration. The provisionally present foreigner number (STP number) has been created to implement this article. This number enables the irregular foreign citizens to have access to urgent health services and prevention programmes. It assures their anonymity during their communications with the services (9).

Table 1 shows the decrease of the rate which occurred in 2014 compared to the Italian citizens reported to the HSS (-5.16%). There is a significant increase of both foreign patients with socio-medical problems (+5.16%) and Non- EU irregular citizens on the Italian territory (+2.84%). This last classification includes mainly Romanian citizens (78.38% of Non- EU irregular citizens), who have acquired the status of 'EU citizens' as a result of Romania's entry into the European Union in 2007. These people are devoid of the economic and labour resources, necessary to "regularisation" on the Italian territory.

The table also shows the increase of the Non - EU regular citizens (+1.37%) and Non- EU irregular ones (+1.11%) showed in 2014. This was probably an effect of the significant migratory flow towards Italy during that year.

Clinical data

- Reporting to the HSS
- the days between the hospitalisation and the report to the HSS
- the days between the report to the HSS and the conclusion of the clinical case and/ or the hospital discharge

Table 1 - Nationality

Nationality	2008 – 814 cases						2014 – 790 cases					
	Male	%	Female	%	Total	%	Male	%	Female	%	Total	%
Italian	322	39.56	398	48.89	720	88.45	318	40.25	340	43.04	658	83.29
Foreigners:	62	7.62	32	3.93	94	11.55	78	9.87	54	6.84	132	16.71
EU with regular presence	14	1.72	12	1.47	26	3.19	8	1.01	16	2.03	24	3.04
EU with no regular presence	10	1.23	5	0.61	15	1.84	30	3.80	7	0.89	37	4.68
Non-EU with regular presence	17	2.09	11	1.35	28	3.44	16	2.03	22	2.78	38	4.81
Non-EU with no regular presence	21	2.58	4	0.49	25	3.07	24	3.04	9	1.14	33	4.18
Total	**384**	**47.17**	**430**	**52.83**	**814**	**100.00**	**396**	**50.13**	**394**	**49.87**	**790**	**100.00**

1. Reporting to the HSS

The analysis of the social records led to the identification of different pathologies of reporting agents:

Reporting agents	Year 2008 (814 cases)	Year 2014 (790 cases)
Hospital ward	705 (86.61%)	701 (88.73%)
Family members	41 (5.04%)	38 (4.81%)
Territorial services	38 (4.67%)	29 (3.67%)
Third Sector	17 (2.09%)	13 (1.65%)
The same patient	6 (0.74%)	7 (0.89%)
Friends and acquaintances	4 (0.49%)	1 (0.13%)
Law enforcement	2 (0.25%)	1 (0.13%)
Primary Care Physician	1 (0.12%)	0 (0.00%)

There is no evidence of a significant difference between the two years considered.

2. The days between the hospitalisation and the report to the HSS

This variable has been divided into the following groups: 0-1 days, 2-3 days, 4-7 days, more than 7 days of hospitalisation.

The days between the hospitalisation and the report to the HSS	Year 2008 (814 cases)	Year 2014 (790 cases)
0-1 days	144 (17.69%)	141 (17.85%)
2-3 days	141 (17.32%)	96 (12.15%)
4-7 days	218 (26.78%)	133 (16.84%)
More than 7 days	311 (38.21%)	420 (53.16%)

The data reveals that in 2014 a 5.17% decrease in the clinical records of the 2-3 days group and a decrease of 9.95% in the 4-7 days group. The increase in records of patients who need more time for clinical stabilisation in the acute phase may have affected the variation in frequency. This increase concerned internal pathologies (+17.46%), infectious ones (+1.65%), the ASL disease (+0.40%) and psychiatric pathologies (+0.77%). In 2014 the new variable considering hospitalisations in Obstetrics and Neonatal Intensive Care (NIC) requiring the HSS intervention (4.30%) turned out to be relevant. These clinical

records, which were not considered in 2008, may have influenced the increase in the variable considered. The delay in reporting to the HSS represents a critical issue when implies a rapid response programme which may not be always appropriate. In order to solve this problem Lazio funded the 'Triage Sociale Ospedaliero' project, from April 2014 to November 2014. Tests were carried out in Policlinico Umberto I, which aimed at a prompt taking-over of the most vulnerable patients (within 24 hours from hospitalisation) (10).

Despite this initiative, the clinical records of the "Over 7 days "group increased by 14.96% between 2008 and 2014. This represents the most considerable rate of increase in both surveys. Therefore, this data is significant and deserves further study in relation to the epidemiological approach.

3. The days between the report to the HSS and the conclusion of the clinical case and/or hospital discharge

The above-mentioned variable includes the following groups: 0-2 days, 3-5 days, 6-7 days, over 7 days.

The days between the report to the HSS and the hospital discharge	Year 2008 (814 cases)	Year 2014 (790 cases)
0-2 days	143 (17.57%)	158 (20.00%)
3-5 days	125 (15.36%)	110 (13.92%)
6-7 days	222 (27.27%)	87 (11.01%)
More than 7 days	324 (39.80%)	435 (55.06 %)

There was a decrease of 16.26% in the percentage of the '6-7 days' group and an increase of 15.26% in the 'over 7 days' group. This was presumably due to different factors that changed during the time interval between the two surveys, such as:

- the abolition of nursing homes for long term care hospitalisations approved by Latium Region;
- the limited number of nursing homes with high care intensity for the hospitalisation of chronic patients, which caused an extended hospitalisation and longer waiting for beds.

Social data

The HSS duties take place in the following different areas:

- activation of home care;
- admission to sheltered housing;
- assistance of women and minors;
- special interventions;
- assistance of marginalised and poor people;
- activities related to the secretariat.

In the comparative analysis significant differences are related to:

- interventions aimed at the activation of home care;
- interventions aimed at admission to sheltered housing.

1. Interventions aimed at the activation of home care (Table 2)

Different interventions aimed at the activation of home care have been considered, such as:

- healthcare services provided by the hospice, for people afflicted with terminal illnesses;
- healthcare for residents of Rome and its provinces afflicted with HIV/AIDS pathology. This intervention is undertaken by the CCTAD (Centro di Coordinamento del Trattamento a Domicilio or: "Centre for Coordination of Home Care" of Latium Region at the Lazzaro Spallanzani Hospital in Rome;
- social care for residents of Rome and its provinces afflicted with HIV/AIDS pathologies. This intervention is undertaken by the AIDS office of Dipartimento Politiche Sociali, Sussidiarietà e Salute of the Municipality of Rome, the social intervention of the HSS and the accredited cooperative;
- healthcare provided by home care facilities (CAD) under the jurisdiction of the local authority in charge (ASL);

Table 2 – Interventions aimed at the promotion of the home care

Interventions aimed at the promotion of the home care	2008 – 814 Cases						2014 – 790 Cases					
	Male	%	Female	%	**Total**	%	Male	%	Female	%	Total	%
Hospice home care	31	3.81	39	4.79	70	8.60	44	5.57	29	3.67	73	9.24
Assistance for HIV/AIDS patients:	5	0.61	1	0.12	6	0.74	5	0.63	3	0.38	8	1.01
Inclusion of healthcare assistance	2	0.25	0	0.00	2	0.25	2	0.25	1	0.13	3	0.38
Inclusion of social relevance assistance	3	0.37	1	0.12	4	0.49	3	0.38	2	0.25	5	0.63
Activation of home care structure (c.a.d.)	35	4.30	28	3.44	63	7.74	28	3.54	33	4.18	61	7.72
Activation of the "dimissione protetta"protocol:	66	8.11	120	14.74	186	22.85	57	7.22	81	10.25	138	17.47
Inclusion of health effort	5	0.61	15	1.84	20	2.46	15	1.90	13	1.65	28	3.54
Inclusion of social commitment	12	1.47	28	3.44	40	4.91	10	1.27	11	1.39	21	2.66
Inclusion of health and social services	49	6.02	77	9.46	126	15.48	32	4.05	57	7.22	89	11.27
Individualised healthcare plan (p.a.i.)	2	0.25	0	0.00	2	0.25	7	0.89	1	0.13	8	1.01
Report to the sso on the return to the patient's home:	21	2.58	39	4.79	60	7.37	83	10.51	80	10.13	163	20.63
Healthcare activation	9	1.11	12	1.47	21	2.58	71	8.99	66	8.35	137	17.34
Activation on the territory and of the home-care services	9	1.11	25	3.07	34	4.18	9	1.14	13	1.65	22	2.78
Social services for hiv/aids pathologies	3	0.37	2	0.25	5	0.61	3	0.38	1	0.13	4	0.51
Total	160	19.66	227	27.89	387	47.54	224	28.35	227	28.73	451	57.09

- the 'Dimissioni Protette' protocol involves health and social interventions named 'Dimissioni Protette Complesse' (Complex, Protected Hospital Discharges), or "interventions with a reduced social or medical commitment". Medical services are provided thanks to the coordination between the ASL in charge and the Municipality of that specific territory. The social worker enables effective networking between the two facilities. Different professional figures take part in the intervention: practitioners, nurses, physical therapists if necessary, local social workers, home attendants. It is aimed at patients that are not self-sufficient or medically stable when discharged but should continue to receive treatments at home. Furthermore, the protocol provides an ambulance for the patient, in order to guarantee a safe homecoming, in case of a problematic clinical or social status;

- projects of home hospitalisation for people afflicted with chronic degenerative diseases which are characterized by the need of high intensity care: Amyotrophic Lateral Sclerosis, Spinal Muscular Atrophy, etc. A multi-professional team is needed to carry out these interventions (a practitioner, a nurse, a physical therapist, an occupational therapist, etc.) and social workers act as case managers. After a careful analysis, they write a report named 'Progetto di Assistenza Individualizzato or 'Individualized Assistance Project (PAI) in collaboration with caregivers - if present - and the professional figures involved. The HSS coordinates the territorial services providing services to the patient and the medical team which proposes a plan to be carried out at the patient's house;

- reports to the territorial services in order to have a prompt taking-over of the patient in the post-discharge period. These reports are divided in: homecare activation, activation of the territorial and home-care services, report to the social services for HIV/AIDS.

The activation of homecare services has various benefits, it allows patients to go back to their relational and social context, guaranteeing the continuity of care services through the supervision and support of trained personnel responsible for the territorial services. Family and caregivers' assistance are essential, although sometimes inadequate because of occupational, logistic and economic reasons.

In addition to the reduction in healthcare spending, de-hospitalisation reduces the clinical risk of developing infections which would negatively affect the patient's health.

The aim is not just to reduce costs met by the healthcare system, but also to reduce patients' discomfort, bringing them back rapidly to their normal family and social life (11).

As shown in table 2, there was a 5.38% decrease in the activation of the service 'Dimissioni Protette' between 2008 and 2014. The cause of the decrease is to be found in the limits to the service set by the Municipality of Rome in relation to the activation of the protocol. The table also illustrates a 14.76%increase in the reports to the territory for the activation of healthcare services. When social and healthcare services could not be activated, only a request for health intervention was reported to the competent service.

2. Interventions aimed at the admission to sheltered housing (Table 3)

Sheltered housing consists of residential homes dedicated to healthcare and/or social and healthcare services. In the assessments for admission to the facilities of Extended Care Units (ECU) and post- acute long-term care, two more variables that made home therapy impossible were considered:

- lacking and/or inadequate family resources;
- insufficient and/or inadequate provision of homecare services.

The variables considered in this area were:

- entry to residential homes for people afflicted with HIV/AIDS;
- assessment for admission to ECU;
- placement in a long-term facility; this variable was present in the 2008 investigation but not in that of 2014, because it was cancelled in 2010;
- entry to residential homes for people afflicted with Alzheimer;
- entry to hospices; this intervention was introduced for patients afflicted with terminal illnesses who were deprived of a supporting network and/or when the necessary care could not be provided as homecare service;
- assessment and eventual placement in post-acute long-term care facilities, where medically stable patients are cured and recover their functions;
- assessment and eventual admission to rehabilitation centres for therapeutic projects for the physical and functional recovery of patients after discharge;
- entry to therapeutic communities for people afflicted with addictions. In exceptional circumstances, individual projects are carried out together with the SERT (the Service against addictions) of the ASL for the recovery of particularly motivated people in order to simplify the bureaucratic process and minimise the risk of relapse into addiction.

Non-comparable variables which were anyway considered in this table are related to long-term care, post-acute long-term care, and high-intensity care ECU (RSA-R1).

Table 3 shows a decrease of 12.02% in the assessments for ECU admission in 2014. This assessment could be due to the modification of income parameters, calculated on the basis of the Equivalent Financial Situation Index / Indicatore della Situazione Economica Equivalente (ISEE). This index determines the economic

Table 3 – Interventions aimed at the admission to sheltered housing

Interventions aimed at the admission to sheltered housing	2008 – 814 Cases						2014 – 790 Cases					
	Male	%	Female	%	Total	%	Male	%	Female	%	Total	%
Admissions to accomodations for hiv/aids patients	1	0.12	0	0.00	1	0.12	0	0.00	0	0.00	0	0.00
Assessment of admissions to extended care unit (ecu)	61	7.49	109	13.39	170	20.88	34	4.30	36	4.56	70	8.86
- Lack of family members	44	5.41	64	7.86	108	13.27	19	2.41	16	2.03	35	4.43
- Inadequacy of domestic health and social services	17	2.09	45	5.53	62	7.62	23	2.91	29	3.67	52	6.58
Admissions to extended care unit (ecu)	15	1.84	20	2.46	35	4.30	18	2.28	12	1.52	30	3.80
Admissions to extended care unit with high care intensity (rsa-r1)	-	-	-	-	-	-	3	0.38	3	0.38	6	0.76
Placement in long-term facilities	5	0.61	17	2.09	22	2.70	-	-	-	-	-	-
Entry to alzehimer's health care facilities	1	0.12	0	0.00	1	0.12	0	0.00	0	0.00	0	0.00
Entry to residential hospices	37	4.55	36	4.42	73	8.97	16	2.03	22	2.78	38	4.81
Assessments and placements in post-acute long-term facilities	-	-	-	-	-	-	42	5.32	36	4.56	78	9.87
- Lack of family members	-	-	-	-	-	-	17	2.15	16	2.03	33	4.18
- Inadequacy of domestic health and social services	-	-	-	-	-	-	32	4.05	25	3.16	57	7.22
Entry to rehabilitation facilities	48	5.90	48	5.90	96	11.79	28	3.54	25	3.16	53	6.71
Entry to therapeutic communities for addictions	3	0.37	1	0.12	4	0.49	4	0.51	0	0.00	4	0.51
Total	207	25.43	281	34.52	488	59.95	142	17.97	131	16.58	273	34.56

participation share establishing a daily allowance for hospitalisation to be paid by patients or their family. Growing incomes and greater participation in hospitalisation expenses encourage the activation of homecare services. In 2014 this resulted in a 9.55% increase in the activation of home care interventions and a consequent 25.39% decrease in interventions aimed at admission to sheltered housing.

Reports for home care service activation increased by 14.76% in 2014 and admission to rehabilitation centres fell by 5.08%. This last variation is due to fewer demands to the HSS for such interventions by medical and nursing staff, since the assessment of therapeutic treatments is of exclusive medical competence.

Conclusions

The comparison between the periods 2008 and 2014 allows insight into the development of certain variables, which were indicative of the social context.

First of all, we can see that in both periods most hospital and social service users were people over 65 and mainly women; besides the well-known ageing of the Italian population, this data shows the increased longevity of women compared to men. This has already been mentioned in other statistical surveys.

The presence of foreigners on the Italian territory is due to massive migration flows that, according to an estimate by the United Nations High Commissioner for Refugees (UNHCR), was 3 times higher in 2014 than in 2008. This considers only the migrants arrived in Italy by sea (12).

The new regional regulatory framework and consequent economic cuts also caused fewer health and social care interventions by local providers and hospitals. This factor affected operational strategies and the activation of different interventions:

in 2008, 59.95% of patients required the HSS intervention for admission to sheltered housing, whereas, in 2014, 57.09% of interventions required home care service activation. In the period considered there were changes in the income parameters related to patients' health expenditure participation for hospitalisation in approved healthcare facilities. Structural changes also occurred in this period: long-term care was cancelled and post-acute long-term medical care (with a maximum of 60 days hospitalisation) was introduced. In addition to this, the levels of assistance set for ECU were retrained and changed on the basis of the assistance needed and ECU with high-intensity care (RSA-R1) were introduced for patients with a complex clinical history.

The limited number of these facilities (8 in the Latium Region) and the small number of beds available resulted in a remarkable increase in extended hospitalisations for those patients who were only eligible for hospitalisation in RSA-R1.

These factors caused an increasing demand to the HSS and the consequent need to balance the lack of facilities with the emerging needs: in 2008, 1,140 interventions were carried out, on average 1.4 interventions per patient. In 2014 1,272 interventions were carried out, on average 1.6 interventions per patient. These data are also significant in relation to the 0.21% increase in healthcare demand, despite the diminished number of beds and hospitalisations reported in 2014.

Although the Hospital Social Service is included in a specific healthcare setting, it is characterized by a prompt intervention on the basis of emerging needs, and is essential and helpful in the assistance path, when local service providers in charge fail.

Riassunto

Il ruolo e gli interventi del Servizio Sociale Ospedaliero (SSO) nell'integrazione dei servizi socio-sanitari; indagine comparativa tra gli anni 2008 e 2014 presso il Servizio Sociale dell'Azienda Ospedaliera Universitaria Policlinico Umberto I di Roma

Introduzione. All'interno dell'Azienda Ospedaliera Universitaria Policlinico Umberto I di Roma, il Servizio Sociale Ospedaliero (SSO) è collocato in staff alla direzione Sanitaria Aziendale, alle dirette dipendenze del Direttore Sanitario. È un servizio di consulenza e di supporto al servizio prettamente clinico. Opera in un'ottica di rete e si caratterizza per la propria autonomia tecnico-professionale e l'indipendenza di giudizio. Svolge inoltre una funzione da ponte tra l'ospedale e il territorio: agisce come catalizzatore dei servizi, concorre al recupero e al mantenimento della salute dei cittadini e al conseguente miglioramento della loro qualità di vita mediante progetti di aiuto e interventi mirati.

Metodi. Il presente lavoro si basa su due diverse ricerche condotte, una nell'anno 2008 e 2014; entrambi indagano sulla realtà professionale del Servizio Sociale Ospedaliero, presso l'Azienda Ospedaliera Universitaria Policlinico Umberto I di Roma. La finalità è comparare tali ricerche e interpretare i risultati prodotti. La raccolta dati è avvenuta sulle schede sociali presenti negli archivi del SSO (814 nel 2008 e 790 nel 2014).

Il progetto di ricerca è stato scandito da diverse fasi: la formulazione del disegno di ricerca, in cui si è scelta come tecnica di valutazione empirica l'etnometodologia; la raccolta dati, attraverso la consultazione degli archivi cartacei ed elettronici del SSO (dati anagrafici, dati clinici e dati sociali); la rielaborazione l'interpretazione dei dati, in cui si sono evidenziati i cambiamenti significativi che hanno dato spunto ad interessanti riflessioni.

Risultati e conclusioni. Dall'analisi comparativa dei dati, è emerso un incremento della domanda assistenziale al SSO, nonostante il diminuito numero di posti letto e di relativi ricoveri ordinari. Si è osservato inoltre un aumento della casistica riguardante i minori di 18 anni ed un decremento della casistica relativa alla fascia di età over 65 anni. Riguardo la provenienza geografica dei pazienti segnalati al SSO, si è registrato un decremento della percentuale di cittadini italiani, a fronte dell'aumento di oltre il 5% di cittadini stranieri irregolari, sia comunitari che extracomunitari.

Dalla comparazione, risulta significativo quanto emerso relativamente ai giorni intercorsi dalla segnalazione al SSO, alla dimissione; il dato costante negli anni ha riguardato la fascia "oltre 7 giorni" di maggior consistenza per entrambe le variabili considerate e incrementato nel 2014.

Gli interventi in cui si sono registrate differenze significative nell'analisi comparativa, sono stati quelli

mirati alla promozione dell'assistenza domiciliare e quelli finalizzati all'inserimento in strutture protette; per i primi si è osservato un considerevole calo rispetto all'attivazione del servizio integrato sociosanitario di assistenza domiciliare, a fronte di un incremento della sola richiesta di assistenza sanitaria domiciliare; per i secondi invece, si è evidenziata un netto calo della percentuale della variabile "valutazione inserimento in residenza sanitaria assistenziale".

I cambiamenti significativi osservati hanno dato luogo a spunti di riflessione circa le cause, da ricercare nel panorama politico, storico e culturale:

• un primo fattore da menzionare è l'aumento del fenomeno migratorio verso l'Italia da Paesi extracomunitari, al quale si è assistito negli ultimi anni; ciò spiegherebbe l'innalzamento percentuale di stranieri presi in carico dal SSO;

• le politiche regionali e i tagli economici imposti alla Sanità Pubblica e l'innalzamento delle soglie reddituali per il calcolo della partecipazione economica del paziente alle spese per l'istituzionalizzazione, hanno inciso sulle variazioni sopra menzionate.

Le innovazioni in campo normativo per quanto concerne la Regione Lazio hanno apportato un cambiamento strutturale, riguardo le strutture di lungodegenze e i livelli assistenziali delle Residenze Sanitarie Assistenziali (RSA).

References

1. Azienda Policlinico Umberto I, Piano delle Prestazioni e dei Risultati 2014–2016, La Sapienza, Università di Roma, 2013. Available on: https://www.policlinicoumberto1.it/media/465225/piano_della_performance.pdf [Last accessed 2018 Jan 10].
2. Ferrario F. Le dimensioni dell'intervento sociale. Un modello unitario centrato sul compito. Roma: Carocci, 1999.
3. Folgheraiter F. Integrazione socio-sanitaria. In: Dizionario in lavoro sociale. Trento: Erickson, 2009.
4. Cortigiani M, Marchetti P, eds. L'assistente sociale. Società complesse, nuovi bisogni, strategie e modelli di intervento. Santarcangelo di Romagna: Maggioli editore, 2016.
5. Ordine Nazionale degli Assistenti Sociali. Codice Deontologico Dell'Assistente Sociale, Titolo II, *Principi*, n. 7. 2009.
6. Caprini C. Servizio Sociale e Salute. In: Nuovo dizionario di servizio sociale diretto da Campanini A. Roma: Carocci, 2013.
7. Ranieri ML. Il metodo di rete in pratica. Studi di caso nel servizio sociale. Trento: Erickson, 2013. Available on:https://www.policlinicoumberto1.it/media/465225/piano_della_performance.pdf [Last accessed 201 Jan 10].]
8. "Le Medicine" onlus. Available on: http://www.lemedicine.org/index.php?option=com_content&view=article&id=160&Itemid=1/60 [Last accessed 2018 Jan 10].
9. Bascherini G, Ciervo A. L'integrazione difficile: il diritto alla salute e all'istruzione degli stranieri nella crisi del welfare State. In: Naia R, ed. L'Evoluzione costituzionale delle libertà e dei diritti fondamentali. Saggi e casi di studio. Torino: Giappichelli Editori, 2012.
10. Buoncristiano M, Favali P, Marceca M, Paglione L, Pizzutti S, Russo ML. La Sperimentazione di un "Triage Sociale" Ospedaliero per l'emersione precoce della vulnerabilità sociale nei pazienti ricoverati, Progetto Disuguaglianze Regione Lazio 2013-2014 "Salute senza esclusioni: per un Servizio Sanitario attivo contro le Disuguaglianze", relazione finale delle attività svolte a livello regionale e report Umberto I – Policlinico di Roma. In: Atti del 48° Congresso Nazionale della Società Italiana di Igiene. Milano, 14-17 ottobre 2015.
11. Guarnera L. L'Ambiente di Cura. Bologna: Fondazione CEUR, (N/A).
12. AA.VV. Migranti e rifugiati: 516 arrivi al giorno, 3mila morti in un anno. UNHCR all'Ue: "Fare di più". Roma: La Repubblica, 2014. Available on: http://www.repubblica.it/solidarieta/immigrazione/2014/10/03/news/strage_di_lampedusa_naufragi_unhcr_migranti_3_ottobre_2013_un_anno_dopo-97179503/ [Last accessed 2018 Jan 10].

Corresponding author: Dr Massimiliano Mazzotta, Via dei Sobissi n. 22/a, 00061 Anguillara Sabazia (RM), Italy
e-mail: m.mazzotta@policlinicoumberto1.it