

Integrated Care Matters

Community Hospitals across the Globe

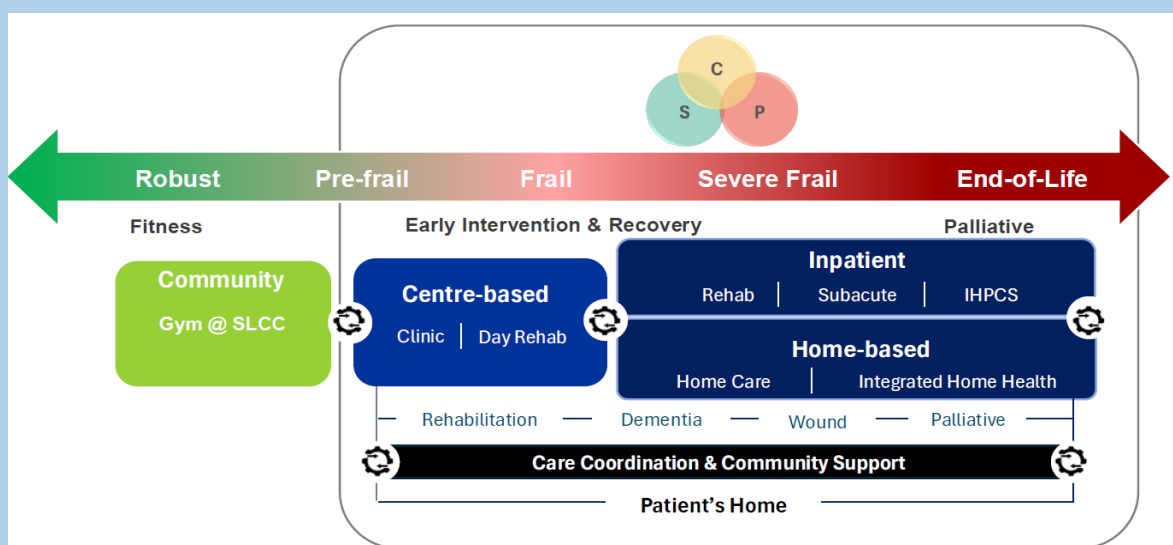
FLASH REPORT

150 People from 23 Countries Registered for the Webinar

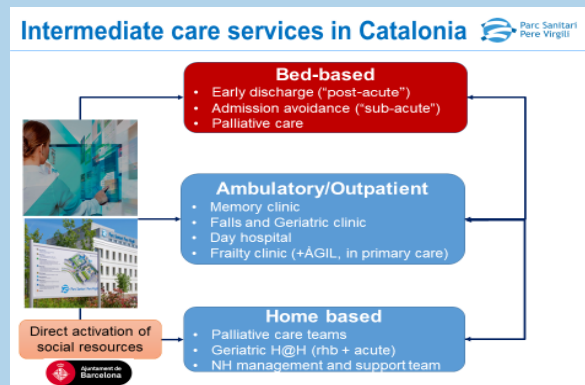
This webinar showcased the important contribution of community hospitals, subacute hospitals and transitional care units to the delivery of integrated intermediate care, rehabilitation and support closer to home. We were pleased to co-host this session with the UK [Community Hospitals Association](#), a membership organisation that supports those involved in community hospitals through networking, sharing quality improvements, and contributing to evidence through research.



Associate Prof Tan Boon Yeow, CEO and Senior Consultant Physician, St Luke's Hospital, Singapore outlined the evolution of Community Hospitals (CHs) in Singapore. Currently 11 CHs provide around 3500 beds for a population of 6 million. Serving as a **bridge between acute care and community**, most also provide community care services such as **Day Rehab** and **Home Care**. For example, St Luke's Hospital offers a **comprehensive and integrated ecosystem of care** including screening, prevention and active ageing. CHs have an important role to anchor care in the community, supporting primary care, care at home and aged care providers as well as providing alternatives to acute hospital admission or stay.



Marco Inzitari, Professor of Aging, Universitat Oberta de Catalunya and CEO, Parc Sanitari Pere Virgili (PSPV), Barcelona described the Intermediate Care network across Catalonia, comprising 8254 beds across 98 providers plus a range of ambulatory and palliative care services. He described PSPV as an open, multi-services space that offers intermediate care, geriatric medicine, palliative care, rehabilitation and primary care and acts as a hub for research-implementation on complex interventions and care services for older persons. Marco outlined a shift towards step-up admission avoidance care alongside expansion of Hospital at Home, where PSPV have generated considerable evidence of impact.



Strategic Implications

Cost Efficiency:

- Transitional care costs are 30-50% lower than acute care (\$750/day vs \$1,100+ for acute).
- Model yields net system savings in under 6 months, a strong early ROI

Patient – Centered Care:

- The reduction of patients directed to LTC to home, and the community outreach team support better health outcomes.

Scalability Potential:

- Showing consistent ROI, this model could be replicated in other high-demand areas.



Lynda Culley, Manager, Community Transitions outreach team, Nova Scotia Health described West Bedford Transitional Health, a collaboration with a private sector provider to co-design transitional care for Nova Scotia Health patients who no longer require acute care but need additional time, support, and resources prior to returning home. The facility has 68-beds, with a further 110 rooms planned for phase 2. Lived experience from four patient family advisors is ensuring a person and family focus. Nova Scotia Health Outreach Reablement Team partners with patients and families within 48 hrs of admission to develop and achieve discharge goals. Outreach staff provide case management and guidance in the home for up to 16 weeks post discharge addressing complex issues and social determinants of health that impact recovery, such as housing, food security, financial benefits; banking, groceries and IADLs.

Around 90% of patients have returned home, 16 people have avoided moving to Long Term Care, and there has been a 7.1% reduction in alternate levels of care patients within acute care settings in the Central Zone.

Sue Greenwood, Queen's Nurse, Modern Matron and clinical lead for Cornwall Partnerships NHS Foundation Trust described her experience of establishing a Community Assessment and Treatment Unit at Camborne Redruth Community Hospital, serving a deprived and densely populated area of West Cornwall. She described a basket of service pathways that contribute to admission avoidance for adults, particularly those who have Clinical Frailty Score of 4 or more. Sue shared some remarkable data that illustrated the reduction in numbers having to attend the main hospital in Truro.

Signposting

Onward Referrals to Home First and STEPS services

Hospital at Home onward monitoring

DN Services

Community Matron/ UCR

GP Primary Care

Urgent Treatment Unit

Referral to ED if appropriate

SDEC Same Day Emergency Care

Chest Pain Pathway

Rule out Fractured Neck of Femur

6 trolleys and recliner chairs

Working with Acute GP service

Head Injury Pathway

Point of Care Testing

ALOS 5 to 6 but aiming for 3

TAKE HOME MESSAGES

*Relationships with
Primary Care is the
secret!*

*It was a critical bridge
from hospital recovery to
reclaiming independence*

*They care about
people, not
transactions*

- It is time to recognise the true value of community hospitals and how they can shape care closer to the community they serve
- Moving healthcare upstream is key – give community hospitals larger roles and allow overloaded acute hospitals to focus on patients who need emergency or acute specialist care
- Community Hospitals support the community sector through clinical reinforcement, training and social prescribing
- Since their inception, Community Assessment and Treatment Units have naturally evolved to encompass new knowledge skills and practices delivered close to home.
- By working creatively the true potential of delivering Same Day Emergency Care within the community is enabling care at place
- Community outreach team effortlessly carried on the work that had started in acute care and rehabilitation
- Wrap around support is not bubble wrap, it is working with the patient to support them to live the life they want to live!

You will find the webinar recording [here](#)

Presentation slides and Flash Report [here](#)



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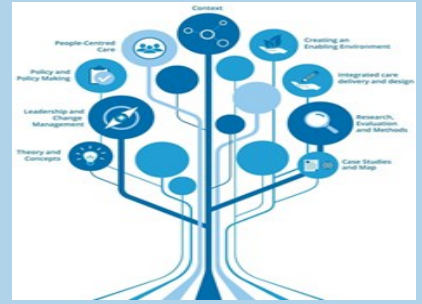


<https://integratedcarefoundation.org/ific-scotland-3>



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Topic Resource



Check out publications and CHA webinars at [Community Hospitals Association](#)

[Joint webinar on Community Hospitals November 2024](#)

St. Luke's Hospital, Singapore <https://www.slh.org.sg/>

St. Luke's Hospital publication: Collaborating to Advance Health and Well-Being
[Harvard Business Impact](https://hbsp.harvard.edu/product/W30019-PDF-ENG-Education)[https://hbsp.harvard.edu/product/W30019-PDF-ENG Education](https://hbsp.harvard.edu/product/W30019-PDF-ENG-Education)

Parc Sanitari Pere Virgili <https://perevirgili.gencat.cat/ca/inici/>

Barcelona Aging and Longevity Lab (www.ballaginglab.org)

Publications related to the models of care in this webinar

Sezgin, D., O'Caoimh, R., O'Donovan, M.R. et al. **Defining the characteristics of intermediate care models including transitional care:** an international Delphi study. *Aging Clin Exp Res* 32, 2399–2410 (2020).
<https://doi.org/10.1007/s40520-020-01579-z>

Sezgin, D., O'Caoimh, R., Liew, A. et al. **The effectiveness of intermediate care including transitional care interventions on function, healthcare utilisation and costs: a scoping review.** *Eur Geriatr Med* 11, 961–974 (2020). <https://doi.org/10.1007/s41999-020-00365-4>

Inzitari, M., Arnal, C., Ribera, A., Hendry, A., Cesari, M., Roca, S., & Pérez, L.M. (2023). **Comprehensive Geriatric Hospital at Home: Adaptation to Referral and Case-Mix Changes During the COVID-19 Pandemic.** *J Am Med Dir Assoc.* 2023 Jan;24(1):3-9.e1. doi: 10.1016/j.jamda.2022.11.003. Epub 2022 Nov 10. PMID: 36470320; PMCID: PMC9647017.

Mazzarone T, Pérez LM, Villa L, Planesas-Pérez O, Verri FM, de Andrés A, Luna AG, Velarde MF, Martí-Tarradell R, Inzitari M, Ribera A. **Comprehensive geriatric hospital-at-home increases the days at home in older adults compared to bed-based intermediate care: a propensity score matching analysis.** *Age Ageing.* 2025 May 31;54(6):afaf162. doi: 10.1093/ageing/afaf162. PMID: 40494341; PMCID: PMC12151491.

Jennifer Kirsty Burton, Simon Paul Conroy, Terence J Quinn. **No place like home—the importance of home in older adult research,** *Age and Ageing*, Volume 54, Issue 8, August 2025, afaf222,
<https://doi.org/10.1093/ageing/afaf222>

British Geriatrics Society (2022) Bringing hospital care home: Virtual Wards and Hospital at Home for older people <https://www.bgs.org.uk/virtualwards>

This report explores the potential benefits, limitations, and current scientific evidence to be considered when providing a safe, effective, and person-centred alternative to hospital inpatient care for older adults. It builds on the earlier report ***Right time, right place: Urgent community-based care for older people.***
<https://www.bgs.org.uk/righttimerightplace>

Arsenault-Lapierre, G., Henein, M., Gaid, D., Le Berre, M., Gore, G., & Vedel, I. (2021). **Hospital-at-Home Interventions vs In-Hospital Stay for Patients With Chronic Disease Who Present to the Emergency**

Department: A Systematic Review and Meta-analysis. JAMA Netw Open;4(6):e2111568.
doi:10.1001/jamanetworkopen.2021.11568

Healthcare Improvement Scotland (2021) Admission avoidance hospital at home for older people with frailty Summarises the findings of an evidence synthesis on admission avoidance hospital at home (HaH) for frail elderly patients. Available at <https://www.healthcareimprovementscotland.scot/>

Pearson M, Hemsley A, Blackwell R et al (2017). Improving Hospital at Home for frail older people: insights from a quality improvement project to achieve change across regional health and social care sectors BMC Health Serv Res 17, 387
The objective was to change practice in order to deliver a Hospital at Home programme (admission avoidance and early supported discharge) for frail older people across a regional commissioning area.
<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2334-9#Sec6>

NHS Confederation (2023) Getting frailty patients home earlier: virtual wards in North West Anglia
<https://www.nhsconfed.org/case-studies/getting-frailty-patients-home-earlier-virtual-wards-north-west-anglia>
How eligible frail patients, who would otherwise have needed to be kept in hospital, are being supported at home by a multidisciplinary team.

NHS Confederation (2023) Providing urgent health care at home for older people living with frailty
<https://www.nhsconfed.org/case-studies/providing-urgent-health-care-home-older-people-living-frailty>

NHS England (2021) Frailty virtual ward (Hospital at Home for those living with frailty) Guidance note - Virtual ward pathway for frailty virtual wards otherwise known as Hospital at Home
<https://www.england.nhs.uk/wp-content/uploads/2021/12/B1207-ii-guidance-note-frailty-virtual-ward.pdf>

Healthcare Improvement Scotland, 2020. Hospital at Home: Guiding principles for service development.
Available at: <https://ihub.scot/project-toolkits/hospital-at-home/hospital-at-home/>

Involving Unpaid Carers in Hospital Discharge
<https://ihub.scot/improvement-programmes/people-led-care/unpaid-carers-improvement-programme/tools-and-resources/involving-carers-in-hospital-discharge-change-package/>

NICE: Moving between Hospital and Home including Care Homes
<https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/moving-between-hospital-and-home-including-care-home>

Sezgin, D., Hendry, A., Liew, A., O'Donovan, M., Salem, M., Carriazo, A.M., López-Samaniego, L., Rodríguez-Acuña, R., Kennelly, S., Illario, M., Arnal Carda, C., Inzitari, M., Hammar, T. and O'Caoimh, R. (2020), "Transitional palliative care interventions for older adults with advanced non-malignant diseases and frailty: a systematic review", Journal of Integrated Care, Vol. 28 No. 4, pp. 387-403.
<https://doi.org/10.1108/JICA-02-2020-0012>