Analysis of costs for pandemic management in a tertiary-care hospital in Italy: An investment for a more resilient structure

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To the Editor—The tertiary-care teaching hospital of Pisa (Azienda Ospedaliero Universitaria Pisana, AOUP) received its first coronavirus disease 2019 (COVID-19) patient on March 4. During the outbreak, this hospital setting underwent major reorganization to respond to the situation. Hospital wards and patient management protocols were modified to quickly adapt to the clinical needs of the patients as well as to ensure patient safety and healthcare worker (HCW) protection from infection.1,2 The execution of this strategy to deal with the epidemic imposed significant costs on our hospital. Currently, many expenditure models have been published, as data concerning national health insurance and losses in terms of investments in the various economic sectors.3,5

We quantified economic costs incurred by the AOUP from March to July 2020 for the management of the COVID-19 pandemic, focusing on the structural costs for the implementation of the present structure and for the realization of a new COVID-19 hospital.

AOUP is organized into 2 main facilities for a total of 1,082 beds. For pandemic management, the Cisanello facility was reorganized and 160 bed places were dedicated to COVID-19 patients in medical wards, 39 beds in intensive care units, and 24 bed for C-PAP therapy.1 Santa Chiara facility is an old pavilion hospital that has been gradually disused. A building that used to accommodate the old emergency room has been renovated as the city’s COVID-19 center.

For the purpose of this analysis, we considered 3 phases: phase 1 (March 4–May 4); phase 2 (May 4–July 4), and phase 3 (March 15–July 4).

In the first phase, the emergency was addressed by increasing response to COVID-19 patients. Ordinary wards were progressively closed to dedicate these areas to COVID-19 patients. Therapeutic pathways were reorganized, and COVID-19 cases were stratified into patients requiring low-, medium-, and high-intensity care. Construction of negative pressure chambers in operating theatres and the extension of intensive care wards were carried out.

In the second phase, the objectives were the radical sanitization of the areas dedicated to COVID-19 patients, the reconversion to their original use, and the gradual resumption of outpatient activities by eliminating the waiting lists created and of visits to patients.

The objective of the third phase was to create a hospital for COVID-19 patients in the Santa Chiara facility to prepare for future outbreaks.

For each phase, we analyzed costs directly related to the preparedness and the management of the epidemic (Table 1).

In phase 1, the final cost accrued was €342,444.91 (US $399,952.17) for the technical area. Furthermore, €70,000.00 (US$81,755.20) was attributed to the adaptation of the ventilation system of the wards from positive pressure to negative pressure. For the costs sustained by the health management unit (HMU), we estimated the total expenditure to be €2,479,421.79 (US $2,895,794.65). In total, €1,586,505.57 (US $1,852,929.72) was attributed to medical devices. For pharmaceuticals, €680,000.00 (US$794,119.19) was spent, and €40,000.00 (US$46,712.89) was spent to purchase hydroalcoholic gel for the entire hospital. Screening of patients and HCWs for severe acute respiratory coronavirus virus 2 (SARS-CoV-2) cost €1,466,666.67 (US $1,712,806.10). In addition, €585,136.49 (US$683,346.90) was spent to recruit healthcare workers, and €10,000.00 (US$11,678.42) was spent in accommodation services for employees.

In phase 2, €740,000.00 (US$864,202.99) was spent on the technical area for cleaning and reconversion of the aereal facilities. In addition, €560,000.00 (US$653,991.45) was spent by the HMU for cleaning and sanitizing COVID-19 wards. Costs related to environmental monitoring and microbiological analyses performed before the reopening of the departments and restart of ordinary activities amounted to €13,672.00 (US$15,972.23).

In phase 3, €3,817,882.00 (US$4,460,216.00) was spent for the construction of the new COVID-19 patients hospital. Most of this expense was for structural costs and health furnishings. In addition, €6,882.00 (US$8,039.85) was spent for environmental microbiological analyses.
In total, €13,556,355.43 (US$15,837,124.73) was spent globally for the 3 phases: €8,417,919.43 (US$9,837,164.61) was spent in phase 1, €1,313,672.00 (US$1,535,154.60) was spent in phase 2, and €3,824,764.00 (US$4,469,611.93) was spent in phase 3.

Healthcare facilities had to quickly adapt; they underwent huge changes to protect HCWs, to manage COVID-19 patients, and to limit the risk of infection for other inpatients. The way health services are delivered has been greatly modified at our institution during the pandemic.

Meeting these challenges has entailed significant expenditure in economic terms. Even if many reports on the costs that health systems had to face because of the COVID-19 emergency have already been published, it is difficult to quantify the real expenditure, and the estimates are most likely underrepresented. In Italy, according to the ALTEMs report, the total impact on hospital expenditures has been €1,586,858,655 (US$1,854,400,002).

In our study, the entire process of conversion (the reconversion of Cisanello and requalification of Santa Chiara) cost a total of €13,556,355.43 (US$15,837,124.73). These resources were deployed by making decisions toward significant benefits. Furthermore, we set up adequate infrastructures to meet possible future waves.

The placement of these funds is in accordance with the WHO guidelines, which affirm that expenditures for COVID-19 should lead to longer-term, wider benefits in line with national needs for sustainable capacities. Our hospital has made efforts and incurred costs to adapt in a short time to the emerging crisis. We used this opportunity to increase the hospital’s resilience and preparedness. The strategies adopted, with the related costs, have allowed us not only to overcome the acute phase but also to prepare the necessary resources for future crises.

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References
Is it wise not to include hair and shoe covers in personal protective equipment (PPE) recommendations?

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To the Editor—Coronavirus disease 2019 (COVID-19), caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), has been spreading globally for more than half a year.1 Healthcare workers (HCWs) on COVID-19 floors and units are aware of the higher risk of contracting SARS-CoV-2.1 “Routine care can be resumed only with sufficient and adequate personal protective equipment (PPE)” to protect HCWs to ensure continuous patient care during this pandemic.5 In China, 4% of confirmed cases in the first month of COVID-19 outbreak occurred among HCWs, with even higher rates in Europe due to delayed recognition of COVID-19 rather than PPE failures.6 However, the items included in PPE protocol and policies vary from institution to institution. The US Centers for Disease Control and Prevention (CDC) does not include hair covers and shoe covers in their PPE recommendations for HCWs.4

Despite the CDC not including them, hair covers and shoe covers, along with face masks, gowns, gloves, and other PPE are often used to prevent contamination from patient contact and droplets.1 A recent study suggested that the shoes of HCWs might serve as a vector of SARS-CoV-2, transferring it from floors in COVID-19 rooms to floors throughout the unit.5 This is not surprising because SARS-CoV-2 contamination was common on floors in COVID-19 patient rooms.5,6 Although data on how long SARS-CoV-2 can survive on hairs, or whether it is common to have the contamination on hairs of HCWs are very limited, the virus remains viable for hours to days on different materials.7 Therefore, the potential contamination on hairs of HCWs may represent risks of nosocomial infection among non–COVID-19 patients.

We believe it is better to be cautious rather than regretful, and HCWs should be provided shoe covers and hair covers as part of PPE when providing care for COVID-19 patients. More studies will also be needed to assess the risk of contamination on human hairs as well as the efficacy of hair and shoe covers in healthcare settings.

References