SABAR HEALTH
Home Hospital

**IMPORTANT – this document is a free, unofficial translation prepared for the purpose of discussion within the WHAHC community only.**

**The original document is a draft issued by the Israeli Ministry of Health in order to receive feedback from the different healthcare providers.**

**DRAFT**

**Israel Ministry of Health – Medical Directorate Directive**

## Subject: Standards of home hospitalization substitute for acute patients

1. **Background**
   Home hospitalization offers inherent advantages for patients and families suitable for this type of care, with respect to convenience and 'patient experience'. Moreover, substitutive hospital-level care at home will help avoid complications associated with hospital stays, such as cross contaminations, falls and delirium common in hospitalized elderly patients. Home hospitalization alternatives may also prove a solution for patients requiring hospital isolation due to immunosuppression or antibiotic resistant bacterial infections.
   Patients should be offered home hospital when diagnosed with acute medical conditions, in such cases where a supportive community health array exists, which can offer the patients safe, immaculate quality care inclusive of an array equipped to identify clinical decline requiring institutional hospitalization.

2. **Objective:**
   Setting standards for the operation of a home hospital option for acute patients.

3. **Terms & Definitions**
   - "Hospitalization" – a patient's hospital stay (on any ward) for the purpose of diagnosis, supervision and treatment.
   - "Hospitalization Substitute" – a diagnosed, non-hospitalized patient's stay in their home, under the supervision of their HMO, when suffering from a medical condition that may have required hospitalization, for the purpose of supervision and treatment.
   - "Acute Conditions" – medical conditions that had it not been for home-hospital, would have required general hospitalization. These conditions include but are not limited to soft tissue and bone infections (cellulitis, osteomyelitis), respiratory infections (flu, bronchitis, pneumonia), Urinary tract infections, gastrointestinal infections (gastroenteritis), deterioration/ exacerbation in CHF, COPD and other medical conditions, according to medical opinion.

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4. **General**
   4.1. Home hospital substitute for acute patients will be provided under medical responsibility of the HMO's, and by the HMO's or a provider designated by them.
   4.2. The home hospital services will be operated by the HMO's within the framework of regional arrays, according to set regulations approved by the HMO's administration and based on the principles specified in this directive.
   4.3. The HMO's regulations will be designed for dual purposes of referring patients from clinics and community emergency care centers and referring to hospital wards or emergency departments.
   4.4. The HMO will conduct professional supervision as to the quality, safety and organization of the home hospital service.
   4.5. None of the treatments provided as part of the home hospital substitute will require out-of-pocket expense from patients.

5. **Human resources requirements, roles & responsibilities.**
   5.1. **Director of the home hospital service (hereinafter: The Director)**
      5.1.1. The Director of the home hospital alternative service will be a physician with a specialty in a medical field relevant to medical cases treated by the service. The Director must have at least 3 years' experience caring for hospital patients as a specialist in his field.
      5.1.2. Will be responsible for authorization of the selection of patients to be included in the service (triage).
      5.1.3. Will be involved in the examination and treatment of complex patients and will consider referring them to hospital if need be.
      5.1.4. Will serve as round-the-clock on-call supervisor to the service's team.
      5.1.5. Will be responsible of all medical and administrative aspects of the service provided to the patients, including quality, safety and continuity of care.
      5.1.6. Will be responsible of establishing and adhering to work practices and treatment protocols for the teams, their implementation and review.
      5.1.7. Will be responsible of adhering to work routines according to the service's regulations and practices.
      5.1.8. Will be responsible of the service teams' training.
      5.1.9. Will be responsible of reporting irregular cases to the Israel Ministry of Health in accordance with regulations and directives.
      5.1.10. In the Director's absence, a qualified substitute will be appointed.

   5.2. **Head Nurse of the home hospital Service (hereinafter: Head Nurse)**
      5.2.1. The Head Nurse will be a nurse with a recognized nursing degree in a field relevant to the cases treated by the service, per the directives of the Israel Nursing Administration.
      5.2.2. Will be Involved in the nursing care of complex patients.
      5.2.3. Will serve as round-the-clock on-call supervisor to the nursing team.
      5.2.4. Will oversee all nursing care provided to all patients.
      5.2.5. will be responsible of the implementation and assurance of nursing care protocols, as well as professional review and assessments.
      5.2.6. Will supervise the training of the nursing teams.
      5.2.7. In her absence, a qualified substitute will be appointed.

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5.3. **Head of Logistics of the home hospital service (hereinafter: Head of Logistics)**

- 5.3.1. Will oversee the administrative team providing logistical support to the medical teams.
- 5.3.2. Will Oversee the stocking and condition of all medical equipment required by the patient and their primary caregiver, as well as instructing them on appropriate use of equipment.
- 5.3.3. Will Supervise the provision of medications to the patient's home, and medical waste disposal.
- 5.3.4. Will Monitor the transport of medical teams and laboratory samples.
- 5.3.5. Supervise the transportation of patients to and from hospitals, clinics and institutes for medical tests.

## 6. Admitting a patient to a home hospital service

6.1. Patients suffering from an acute medical condition will be referred to a home hospital substitute service by community clinics or hospitals (wards or emergency departments).

6.2. Patients answering to one or more of the following will *not* be referred to a home hospital service:

- 6.2.1. Patients suffering from an undiagnosed condition.
- 6.2.2. Patients with a life-threatening medical condition (such as acute coronary conditions, acute COPD or active bleeding), or that might quickly deteriorate and become life-threatening, per the medical team's opinion.
- 6.2.3. Are hemodynamically unstable or suffering from respiratory instability.
- 6.2.4. Decreased consciousness or in acute delirium.
- 6.2.5. Suffering from a psychiatric condition which may endanger them or surrounding others (e.g. acute psychosis or suicidal behavior).
- 6.2.6. Pregnant women (aside those suffering from hyperemesis).
- 6.2.7. The patient is living alone or lacking continuous familial support.
- 6.2.8. Lack of the verbal, cognitive or technological abilities needed for remote communication and for operating the necessary medical equipment and monitoring devices.
- 6.2.9. limited accessibility to the patient's residence (due to geographic distances or other factors) which restricts accessibility to emergency care.

6.3. A patient will not be admitted to the service unless the patient or his/her legal guardian have provided an informed written consent after having received explanations regarding the terms of the home hospitalization and relevant consequences (the planned course of treatment, benefits and drawbacks, risks and alternatives). An admitted patient who decides to leave the service, will be transferred to a general hospital, should he still require hospitalization. The transport to the hospital will be paid for by the HMO.

6.4. Admittance to the home hospital service will be done pending approval of and coordination with the Director of the home hospital substitute service. When deciding on the admission of a patient, the Director will take under consideration

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any factors relating to the patient's condition, the level of complexity and risk, the patient's home and the family support, and to the suitability of the patient's living conditions to the service. Other factors to be taken under consideration are the team's availability and expertise, and the ability to monitor and treat the patient as his/her diagnosis requires.

6.5. All adjustments to the patient's home required for the home hospitalization, as well as the delivery of all necessary monitoring and care equipment, will be completed prior to the patient's discharge from hospital. Regarding patients referred from community clinics, the above adjustments will be made within 6 hours from the patient's admittance to the home hospital service.

6.6. Transferring a patient from hospital to home hospitalization will be made via ambulance or other vehicles, per the patient's condition. All costs of the transport will be covered by the patient's HMO.

6.7. Admittance to the service will be conducted by a physician and a nurse, as soon as possible after the patient's arrival home from the clinic/hospital, and no later than 4 hours from arrival. On Admittance, the patient and family will receive a detailed explanation of the home hospital regulations and process, instructions on the use of the monitoring devices, and all forms of communicating with the team.

## 7. Caring for a patient suffering from an acute condition in a home hospital setting

7.1. Each patient will be assigned a designated team, which will include a physician (the Attending Physician) and a registered nurse (hereinafter – the team). The team will be responsible for all aspects of the medical care and monitoring of the patient, from the time of admittance and until the patient is discharged from the service. During the home hospitalization, the team should vary as little as possible, in order to maintain the continuum of care.

7.2. The physician and the nurse will visit the patient's home daily (including weekends and holidays), to conduct examinations and provide the needed care.

7.3. The team will be on call around the clock and will arrive at the patient's home beyond the scope of the HMO's service hours, and within 1-hour from the initial contact.

7.4. Laboratory samples (blood, urine, etc.) will be taken at the patient's home, if and as urgently as the patient's condition requires.

7.5. Medical Imaging (when required) will be conducted in the patient's home, or in HMO clinics/facilities or in hospitals, as dictated by the patient's condition.

7.6. Allied healthcare (physical therapy, occupational therapy, speech therapy, dietician, etc.) will be conducted in the patient's home. In certain cases, the allied health professionals may use 'telemedicine', in accordance with the standards detailed in the Medical Directorate Directive titled "Standards of operation of telemedicine services."

7.7. Specialist medical consultations will be provided if and as urgently as the patient's condition requires, in the patient's home, in the HMO's facilities or in hospitals. In relevant cases, specialist consultations may be conducted using telemedicine, in accordance with the standards detailed in the Medical Directorate Directive titled "Standards of operation of telemedicine services."

7.8. Transporting patients to imaging exams, specialist consultations or other treatments will be done under the sole responsibility and financing of the HMO's, using a vehicle suited to the patient's condition.

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7.9. The treating team will be allowed to view relevant medical information in the HMO's computerized patient records. All home hospitalization medical records will be maintained according to the laws and health regulations.

8. **Emergency call center**

8.1. Each patient will be able to directly contact the emergency call center. The call center which will be available to the patients and their families 24/7. All calls to the call center will be answered within 30 seconds or less.

8.2. The emergency call center will include a team of registered nurses, backed up by an on-call physician with a clinical specialty relevant to the patients cared for by the home hospital service.

8.3. The call center team will operate in accordance with a structured follow up protocol, and use technological means enabling visual communication with and assessment of the patients' medical condition. The technology means will include remote telemetry of the patients' vitals ( BodyTemperature, Heartrate, Blood pressure, Respiration rate, O2 saturation, ECG monitoring).

8.4. The call center's team will be trained to decipher the patient's vital signs in order to identify if and when to call an ambulance when there is a concern to the patient's life or suspicion of an acute medical crisis.

8.5. The call center's team will operate in accordance with the monitoring and follow-up regulations set by the treating team. The call center will initiate communication with the patient and family according to the treating team's instructions and to the follow-up protocols, and when necessary, will involve the service's on call professional teams.

8.6. The call center's team will be able to observe relevant information in the patient's records and will document findings and actions. The treating team will receive regular updates via phone from the call center's team, as required by the home hospital service's protocols.

**9. Completing the home hospitalization**

9.1. Referral of a patient from home hospitalization to a hospital will be decided upon or approved by the Director of the home hospital service, in the following cases:

9.1.1. The deterioration of the patient's condition or the absence of a foreseeable improvement.

9.1.2. The patient's condition necessitates completion of the medical diagnosis process, requiring hospital facilities.

9.1.3. The patient wishes to be admitted to hospital, provided his/her condition still requires hospitalization.

9.2. The patient will be given a referral letter detailing his/her diagnosis and prognosis, the treatment received during the home hospitalization, and the reason for the referral.

9.3. Referring the patient to the hospital will be conducted using transportation method suited to the patient's condition and paid for by the HMO.

9.4. When completing the required treatment within home hospital care, the patient will receive a discharge letter detailing his/her prognosis, treatment and medical recommendations. The patient will be referred to the continued care of the primary

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physician or the home care unit, and the entire home hospitalization will be recorded in order to maintain continuity of care.