Quick Scan



A product of the Contextualized Health Research Synthesis Program
Newfoundland & Labrador Centre for Applied Health Research

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This Quick Scan report was published on October 15, 2026. This report includes references and links to information that capture the status of available information at the date of publication. Readers are cautioned that this information may change/ become out of date after publication.

We further caution readers that researchers at the Newfoundland & Labrador Centre for Applied Health Research are not experts on the subject topic and are relaying work produced by others. This report has been produced quickly and it is not exhaustive, nor have any included studies been critically appraised.

Hospital at Home Models: Jurisdictional Scan & Evidence

Search focus: For this *Quick Scan* report, CHRSP researchers searched for and identified:

1. Information on Hospital at Home programs in Canadian jurisdictions, including how these programs are described in publicly available online materials; and
2. Research evidence on how hospitals and health systems in other jurisdictions are implementing Hospital at Home models.

What we found: This report begins with key definitions related to Hospital at Home (HaH) to establish a common understanding of the model and its terminology. It then presents a quick scan of jurisdictional information on Hospital at Home programs implemented across Canada, including examples from Alberta, British Columbia, Manitoba, Ontario, and Quebec.

The report also includes a list of research literature related to the implementation of HaH published primarily between 2021 and 2026. This evidence base comprises 8 overview and scoping reviews, 7 systematic reviews and meta-analyses, 3 other review articles, and 17 primary studies. References are organized by study type and listed in reverse chronological order within each evidence category to facilitate review of the most recent evidence first. Quotes that reflect key areas of inquiry are **highlighted in bold.**

Content summary: This report comprises 3 sections, which are:

- Section 1: Hospital at Home - Definitions and Supporting Organizations;
- Section 2: Jurisdictional Quick Scan of Hospital at Home Programs in Canada; and
- Section 3: Select Evidence on Implementing Hospital at Home Models.

Section 1: Hospital at Home - Definitions and Supporting Organizations

Defining Hospital at Home

Hospital at Home (HaH) models have been adopted in countries such as Australia, France, Israel, Italy, Spain, the United Kingdom, and the United States, as well as in some parts of Canada. However, the terminology used to describe HaH models can vary across jurisdictions. For example, some jurisdictions use the term Virtual Wards interchangeably with HaH, while others distinguish between the two models or use other terms (e.g., Hospital in the Home, Virtual Home Hospital).

Several organizations have been established to support the growth and development of HaH models. One such international platform, the World Hospital at Home Community, promotes HaH by sharing global best practices and advancing patient-centred acute care enabled in the home. In 2023, Professor Michael Montalto presented a consensus definition of Hospital at Home at the World Hospital at Home Congress. Since then, the definition has been increasingly referenced in the literature and supported by organizations such as the Royal College of Physicians and the Canadian Hospital at Home Community. The World Hospital at Home Community publishes the following definition on its website:

> *"**Hospital at Home/ Hospital in the Home (HaH/ HITH) is an acute clinical service that takes staff, equipment, technologies, medication and skills usually provided in hospitals and delivers that hospital care to selected people in their homes or in nursing homes. It substitutes for acute inpatient hospital care**."*

"Hospital at Home IS:

- *Subject to regulatory and governance obligations;*
- *Care that is hospital-directed by specialist physicians;*
- *Episodic*
- *Provided 24/7*
- *Fully responsible for the patient – provides all medical, nursing, allied care; observation, diagnostics and therapeutics during the episode at home."*

"Hospital at Home IS NOT:

- *Outpatient care (thus, not self-administered intravenous treatment, and not Outpatient Parenteral Antimicrobial Therapy;*
- *A hospital prevention program*
- *A community-based chronic disease management program;*
- *Solely virtual care or remote telemonitoring;*
- *Day facility-based treatment;*
- *Primary home care;*
- *Community nursing or standard skilled home health care.'"*

A national Canadian network, the Canadian Hospital at Home Community links to the World Hospital at Home Community's consensus definition and adds its own definition with minor wording revisions:

> ***"Hospital at Home (HaH), also known as Hospital in the Home (HITH) is an innovative model of care that delivers hospital-level treatment (including staff, equipment, technologies, therapies) to patients in the comfort of their own home. It is a safe, effective, patient-centered alternative to traditional inpatient hospitalization for selected individuals with acute medical conditions that substitutes for acute care days in hospital."***

"Hospital at Home IS:

- *Episodic care (not chronic disease management)*
- *24/7 medical oversight*
- *Daily virtual or in-person physician care*
- *In-home nursing, diagnostics, and therapies*
- *Remote monitoring technologies*
- *Rapid response pathways for escalation"*

"Hospital at Home IS NOT:

- *Primary care*
- *Skilled nursing facility care*
- *Home care*
- *Outpatient parenteral therapy*
  Virtual only care
- *Hospital prevention outpatient care"*

The table below lists a selection of organizations and groups supporting Hospital at Home models.

Selection of Organizations and Groups Supporting Hospital at Home

Organization/ Group/Support	Description	LINK
World Hospital at Home Community (International)	• "an international platform to advance the hospital at home (HaH) model and ecosystem. Best practices are shared from across the globe in an effort to drive a new era of patient-centric acute care that further enables the home to be the primary place of human healing."	LINK
Canadian Hospital at Home Community	• "a national network of researchers, health leaders, clinicians and policymakers advancing the development, implementation, and financial as well as environmental sustainability of Hospital at Home (HaH) programs across Canada. Their mission is to foster innovation, collaboration, and knowledge exchange to improve patient care, reduce hospital pressures, and transform the way acute care is delivered." • **Future event: Canadian Hospital at Home Conference May 14-15, 2026**	LINK
	Canadian Hospital at Home Community Group Page (Canada Health Infoway) • "a collaborative space dedicated to the advancement and implementation of hospital at home models in Canada." • "Our community is a hub for healthcare providers, leaders, patients, caregivers, policy-makers enthusiastic about this cutting edge model of	LINK

Organization/ Group/Support	Description	LINK
	acute home-based care. As we build this community, we aim to connect, share insights, and advocate for the growth of hospital at home services across the nation."	
	GLOBE-HaH Tool • "is a global initiative designed to define, compare, and analyze Hospital at Home (HaH) programs. It was collaboratively developed for HaH programs that provide acute hospital-level substitutive care at home, as defined by WHAHC 2023"	LINK LINK
Hospital@Home (Europe)	• "A European initiative that brings hospital-level care directly to patients' homes, transforming how chronic and complex conditions are diagnosed, monitored, and treated. Using intelligent digital technologies, AI-enabled decision support, and patient-centered care models, H@H sets the foundation for future integrated, sustainable healthcare systems across Europe."	LINK
UK Hospital at Home Society	• "The UK Hospital at Home Society is for all those with an interest in Hospital at Home, including NHS staff, patients, caregivers, policy makers and the academic community."	LINK
	• Research and Resources webpage	LINK
Hospital at Home Users Group (United States)	• "a dynamic collaborative of Hospital at Home programs around the United States. We share resources and best practices, work together to expand the reach of our programs, and develop the program and policy standards to inform regulatory and reimbursement policies necessary to spread this hopeful model broadly."	LINK
	The National Hospital at home Quality Registry • "Launched by Hospital at Home Users Group Quality Indicators Council in 2022" • "the first de-identified, patient-level dataset that seeks to capture information on patients enrolled in waiver and non-waiver Hospital at Home programs nationwide, dating back to November 2020"	LINK
Hospital in the Home (HITH) Society Australasia	• "is the leading independent organisation dedicated to advancing hospital-level care in the home. As a volunteer-driven, not-for-profit society, we are committed to enhancing healthcare through evaluation, advocacy, and the promotion of best practices in HITH services"	LINK
Other	**Journal of Home Medicine** • "JAHM seeks to establish itself among the peer-reviewed, high quality, respected journals of the world. We are a not-for-profit and have achieved both open access for readers and low cost for contributing authors (made possible by our multiple Collaborating Societies, more below)" • "Health care worldwide is headed home, and JAHM will be a big-tent journal, hoping to attract the world's premier scholarship on advanced home medicine."	LINK

A note on approaches to Hospital at Home models

In the research literature, two common approaches to Hospital at Home (HaH) are frequently described:

- **Admission avoidance:** Services that replace admission to hospital, for people whose condition would normally need treatment in a hospital bed, and
- **Supported early discharge approach**: Services that enable patients to leave the hospital sooner by providing ongoing acute care at home following an inpatient admission.

Please refer to Section 3 for select evidence on implementing HaH Models.

Section 2: Jurisdictional Quick Scan of Hospital at Home Programs in Canada

This section presents a quick scan of jurisdictional information on Hospital at Home (HaH) programs in Canada gathered from publicly available online sources. Information is organized by province and program and includes the following categories:

- Main links
- Description of the program
- Tiers or levels of service (e.g., education, occasional monitoring, full monitoring, etc.).
- Eligibility
- Referrals
- Implementation information and lessons learned
- Related links and resources

Key quotations from primary online sources have been included to highlight relevant information. Please note that the information presented in this section is intended to provide an overview and is not exhaustive. This section concludes with reports and guidance from other jurisdictions that have implemented HaH models, identified during our search for Canadian resources.

Readers may also wish to refer to *Appendix A: Hospital at Home Models of Care in Canada and Elsewhere (non-exhaustive list)* (p. 26) in the resource listed below. This source is included in more detail in Section 3:

- Almeida N, Suarthana E. **Hospitals at home: guiding principles for establishing virtual acute care wards**. (Report no. 93). Technology Assessment Unit (TAU) of the McGill University Health Centre (MUHC): Montreal (QC); 2023 (LINK)

Alberta

Alberta Health Services – Virtual Home Hospital

- **Main links**
  - Alberta Health Services Webpage Virtual Home Hospital (LINK);

- Alberta Health Services Webpage for Programs & Services - Virtual Home Hospital (LINK)

- **Description of Virtual Home Hospital**
  - "…allow eligible patients the opportunity to leave the hospital early and may even avoid admission to a physical hospital by moving the care you need to your home or other safe location"
  - "…have been successfully providing care to Albertans in Calgary and Edmonton since 2018, with patients reporting high levels of satisfaction with their care."
  - "Delivers hospital-level care in the home through virtual technologies and in-person visits, in partnership with community providers, for eligible patients and health conditions."
  - **Note: Prior to 2023, Virtual Home Hospital was known in Edmonton as "Edmonton Zone Virtual Hospital" and the "Complex Care Hub" in Calgary**.
- **Tiers or levels of service** (e.g., education, occasional monitoring, full monitoring, etc.).
  - "As a Virtual Home Hospital patient, you will have a healthcare team that will support you throughout your care. Your treatment plan will be unique to your healthcare needs. Some patients may require more in-person home or facility visits, while others can have most of their care monitored through virtual visits with their Virtual Home Hospital care team."
  - "Your care is our priority. If your medical condition changes while you are a patient of a Virtual Home Hospital, we may decide it is in your best interest to be admitted to a physical hospital."
  - "Virtual Home Hospital care is optional. If you are not comfortable with continuing your care at home, or do not feel like you have the support you need to do so, you can let your physician know it is not right for you."
  - "Virtual Home Hospitals allow eligible patients the opportunity to leave the hospital early and may even avoid admission to a physical hospital."
  - "Patient care is provided by a Virtual Home Hospital care team (e.g., physicians, nurses, pharmacists) through virtual care technologies (e.g., video calls and remote patient monitoring) and in-person facility visits, if needed. The care team also works closely with community providers (e.g., community paramedics and Home Care) to deliver hands-on care in the patient's home, or other location they choose to receive care."
  - **Service providers may include:**
    - "doctors, nurse practitioners (NPs), pharmacists, paramedics, registered nurses (RNs)"
    - "While in the care of a Virtual Home Hospital, specific treatment plans will be unique to a patient's healthcare needs. They will receive:
      - Regular check-in visits, either by phone, videoconference or in person at the Virtual Home Hospital site, if required. Care will be provided in their home by community partners (e.g., community paramedics and Home Care providers) when required and with patient consent.
      - Medication management, including intravenous (IV) fluids if needed.

        - Education to help patients understand and manage their medical condition and treatment plan.
        - Any other care necessary, based on their treatment plan."
    - "Patients may also require lab work, medical tests and procedures as part of their care, and may also be connected with other healthcare providers and specialists as necessary. Some patients may require more in-person home or facility visits, while others can have most of their care monitored virtually."
  - **How will I receive care**?
    - "You'll be cared for through virtual care technologies, like phone or video calls. You might need to come to our location if we need to see you in person. "
    - "You'll get a kit of digital devices that allows us to monitor your health remotely. This includes a blood pressure cuff, pulse oximeter and heart rate monitor (measures your oxygen level and heart rate), weigh scale and thermometer. We'll show you how to use these devices."
    - "If you need hands-on care in your home, it will be provided with your consent by our community paramedics, with community partners like Home & Community Care. Some patients need more hands-on care in their home, while others can have most of their care managed through virtual visits."
- **Eligibility**
  - "Before becoming admitted to a Virtual Home Hospital, you will be thoroughly assessed to ensure your health condition can be safely managed from home and that you have the necessary supports in place."
  - "There are specific criteria that you must meet before being referred to the program. For example, you must be at least 18 years old and able to provide consent to being treated at home and have reliable technology access for virtual appointments."
  - "Virtual Home Hospitals have been successfully providing care to Albertans in Calgary and Edmonton since 2018, with patients reporting high levels of satisfaction with their care. As we expand into other parts of Alberta, more Albertans will have access to a Virtual Home Hospital."
  - "Virtual Home Hospital patients will have a healthcare team supporting them throughout their care. The team will include the healthcare professionals they need, including a patient's family doctor or nurse practitioner, if needed. If the patient has family or a caregiver supporting them at home, they will be supported as they help the Virtual Home Hospital care team care for them."
  - "There are specific criteria that you must meet before being referred to the program. You must also:
    - be at least 18 years old and able to consent to being treated at home
    - be able to communicate by phone or computer (language interpretation / translation are available) and are open to using technology

        - be engaged and willing to participate in your care
        - be functionally able to be in your home or other safe location where you choose to receive care (e.g., home is set-up to accommodate you)
        - if necessary, have adequate support in place at home, such as having a caregiver
        - live within the area serviced by the Virtual Home Hospital. Please consult with your healthcare provider"

- **Referrals**
    - "Physician referral is required. Patients will be thoroughly assessed to ensure their health condition can be safely managed from home and that they have the necessary supports in place."
    - "Virtual Home Hospital care is optional. If a patient prefers to continue receiving their care at an appropriate AHS facility, they can do so."
- **Virtual Home Hospital Locations**
    - Virtual Home Hospital - Edmonton and Area; Contact: ezvh@ahs.ca
    - Virtual Home Hospital - Rockyview General Hospital; Contact: CGYVirtualHomeHospital.RGH@ahs.ca
    - Virtual Home Hospital - South Health Campus; Contact: CGYVirtualHomeHospital.SHC@ahs.ca
- **Implementation information and lessons learned**
    - **Benefits of Virtual Home Hospital care**
        - "Receiving care through a Virtual Home Hospital can promote independence, mobility and improved outcomes overall. It can also lower a patient's risk of some complication that may be more likely to occur in a hospital facility. Patients who have received care through the Virtual Home Hospital have reported high levels of satisfaction with their care."
    - **Related Research** (Included in Section 3 under Primary Study List in more detail)
        - Reynolds et al., 2026 **Virtual Home Hospital Postpartum Hypertension Care: The Patient Experience**. J Obstet Gynaecol Can. 2026 Jun;48(6):103265. (LINK)
        - Mathura P, et al., 2024. **Advancing a virtual home hospital: a blueprint for development and expansion**. BMJ Open Quality. 13:e003048. (LINK)
    - **News stories on Virtual Home Hospital**
        - Katie McLaughlin, 2025. **Edmonton Zone Virtual Home Hospital marks a record year**. (LINK)
        - Katie McLaughlin, 2024. Edmonton's Virtual Home Hospital a lifeline for cardiac patients. (LINK)
- **Related links resources**
    - Brochures
        - Virtual Home Hospital Patient Support Brochure (LINK)
        - Virtual Home Hospital Caregiver Support Brochure (LINK)

        - Virtual Home Hospital Frequently Asked Questions for Patients and Caregivers (LINK)
    - Dr. Rahul Mehta, 2025. **Do virtual Hospitals work? Not merely a cost-saving measure**. Alberta Doctor's Digest. (LINK)
    - Christina Harris, 2022. **'Virtual hospital' treats patients in comfort of home**. (LINK)
    - Health Quality Alberta, 2022. Complex Care Hub 2022 PEA. Youtube Video.(LINK)
    - Alberta Health Services, 2019. **Virtual Hospital: Hospital-level care delivered in the home**. Youtube Video. (LINK)
    - Blain Fairbairn, 2018. **Complex Care Hub a home-grown option**. (LINK)

Alberta Children's Hospital – Hospital at Home

- **Main Links**
    - Alberta Children's Hospital Foundation Webpage on Hospital at Home (LINK)
    - ACHFKIds Vimeo Page (LINK)
    - Alberta Health Services Hospital at Home Webpage (LINK)
- **Description of Hospital at Home**
    - "…began in 2012 as an Alberta Children's Hospital Foundation donor-funded pilot project. As a first of its kind program in Canada, Hospital at Home provides in-home treatment and care for children and teens diagnosed with cancer, blood and immunology disorders."
- **Tiers or levels of service** (e.g., education, occasional monitoring, full monitoring, etc.)
    - Limited online information on specifics of this program but according to the example given on Alberta Health Services website:
        - "the nurse performs a complete physical exam on each patient at each visit, including blood pressure, temperature, oxygen saturation, and heart rate. The patient is then given the chemotherapy through a medication pump into an intravenous line placed into the chest. The entire process takes approximately 45 minutes."
        - "Through the program, specialized oncology nurses deliver therapies, medications and chemotherapy to children in their homes. More than 3,000 Hospital at Home visits have occurred since the program."
        - "The Hospital at Home program has expanded the types of care provided to patients in the home as well as increasing the days of service offered from five days a week to seven days a week and accounts for approximately 15 per cent of outpatient treatments for HOT patients."
- **Eligibility**
    - "…children and teens diagnosed with cancer, blood and immunology disorders"
- **Referrals**
    - "…began in 2012 and 45 new HOT patients are referred to the program each year, ranging in age from 0 – 17 years of age"

- **Implementation information and lessons learned**
    - "Last year, 100 young people benefited from this program, with the team administering more than 75 types of medications in the comfort of the family living room. Hospital at Home saved 13-year-old Lauren Gamble from having to spend over 50 more nights in hospital while she undergoes treatment for bone cancer."
    - "By providing care in their homes, we are saving families multiple days in hospital and relieving some of the emotional and practical stress that comes from that. With the generous support of the community behind us, we can provide this unparalleled level of care for children and their parents."
- **Related links and resources**
    - Patient story (LINK)
    - Transforming care through Hospital at Home (LINK)
    - Hospital News, 2016. **Hospital at home program eases stress for kids**. (LINK)

British Columbia

Vancouver Coastal Health – Hospital at Home

- **Main links**
    - Vancouver Coastal Health, Hospital at Home Webpage (LINK)
    - Vancouver Hospital at Home Patient Brochure (LINK)
- **Description of Hospital at Home**
    - "…gives eligible patients the choice to receive hospital-level services in the comfort of their own home"
    - "…an internationally recognized model that has been operating in countries across the world for more than 20 years. It is also a growing trend in British Columbia. It is already available in other regions in the province such as Island Health, Northern Health and Providence Health Care at St. Paul's Hospital."
    - "Only those patients who meet our strict eligibility criteria can safely receive this type of care. After admission to hospital, a Hospital at Home doctor will assess your medical requirements and determine if this program will meet your care needs. Enrollment in the Hospital at Home program is voluntary."
- **Tiers or levels of service** (e.g., education, occasional monitoring, full monitoring, etc.)
    - "Although you will be at home, you will be registered as an in-patient of VGH and remain under the care of a hospital doctor and care team. You will continue to receive safe, effective and quality care from health-care providers who are experienced in hospital medicine and acute care. Your care team will:
        - Provide daily in-person visits supplemented by virtual care and monitoring
        - Provide medicines, wound care and take lab/blood samples
        - Supply all of the health-care equipment you will need (e.g. blood pressure monitor, oxygen level, tablet, etc.)

        - Coordinate diagnostic tests or medical imaging (e.g. x-ray, MRI, CT, etc.), including your transportation.
        - While in the Hospital at Home program, you will be able to call your care team 24 hours a day, seven days a week.
        - If you do not feel safe, your condition changes or you no longer wish to participate, we will coordinate your transfer to VGH."
    - **Patient Brochure**
        - "Your care team will:
            - Monitor and assess your medical condition and home safety on a regular basis
            - Provide daily in-person visits supplemented by virtual care and monitoring
            - Provide medicines, wound care and take lab/blood samples
            - Supply all of the healthcare equipment you will need (e.g. blood pressure monitor, oxygen level, tablet etc.)
            - Coordinate diagnostic tests or medical imaging (e.g. x-ray, MRI, CT etc.), including your transportation.
            - Be available to support and trouble shoot with you, as needed"
        - "Your care team may include: Hospital doctor; Nurse; Pharmacist; Occupational Therapist; Physiotherapist; Social Worker; Care Management Leader; Indigenous Patient Navigator. While in the HaH program, you will have a virtual call bell and phone number connect with your care team 24/7."
    - **Integrating Virtual Care Technology**
        - "At home, patients have access to physicians, registered nurses and multi-disciplinary health-care teams. Patients can go home with acute care services provided through a mix of in-person and virtual visits with all members of the health-care team, remote monitoring through the use of virtual technologies, and 24/7 access to nursing. You will always be in the care of our team."
    - **What to do if you need help?**
        - "While in the Hospital at Home program, you can call us any time at (604) 875-4111 Ext 62211 to connect with your care team, 24 hours a day, 7 days a week."
- **Eligibility**
    - "A broad range of hospital patients are well suited to the Hospital at Home program. We assess everyone referred to us individually to see if the program fits your needs. Some of our minimum criteria include:
        - You are an admitted Medicine patient at **Vancouver General Hospital or UBC Hospital**.
        - You want to receive hospital-quality care at home.
        - You need close care and monitoring for a period of days by a hospital care team.

        - Your doctor isn't concerned that your health may suddenly decline rapidly.
        - You can comfortably look after yourself at home or have existing help.
        - You live within, or can stay within, Vancouver in a safe home environment for the duration of your Hospital at Home stay.
        - You are an adult (17 years and older).
    - "To be eligible for the Hospital at Home program, you do not need to have a caregiver at home to support you. You are welcome to have added support from friends or family at any point should you prefer it."
- **Referral**
    - "VGH and UBC Hospital patients are screened for the Hospital at Home program by their treating team in consultation with you—the patient, the Hospital at Home physician, and the Hospital at Home team. You will be enrolled if you meet the program's eligibility criteria, it aligns with your care needs, and you want to participate."
    - "Enrollment in the Hospital at Home program is voluntary. If you wish to return to the hospital at any point, you will be readmitted to the hospital."
    - **"Participation in this program is voluntary"**
        - "Before you agree to participate in the Hospital at Home (HaH) program, the HaH care team will work with you to make sure you are appropriate for this program as well as answer any questions and concerns you may have"
- **Implementation information and lessons learned**
    - "It is already available in other regions in the province such as Island Health, Northern Health and Providence Health Care at St. Paul's Hospital."
    - "As part of our continuous learning, we will invite you and your family to share your experience and feedback once your HaH program stay is complete."
- **Related links and resources**
    - **Contact**: To contact us or ask more questions
        - Hospital at Home (HaH) Vancouver General Hospital
        - 604-875-4111 Ext. 62211
    - CBC News, 2024. **Hospital at Home acute care program comes to Vancouver**. (LINK)
        - "Hospital At Home started rolling out in January of this year in other parts of B.C., including Vancouver Island and the north"

Fraser Health

- **Main links**
    - No relevant online information identified at this time other than a research study linked below.
- **Implementation and lessons Learned**
    - **Research** (Included in Section 2 under primary study list in more detail)

        - Wong et al. **Hospital-at-Home for South Asian Communities in British Columbia, Canada: Qualitative Interview Study**. JMIR Hum Factors. 2026 Jan 5;13:e79675. (LINK) –
    - **Video**
        - **Frazer Virtual Health**: Charting the Course for Hospital at Home - Workshop 5: What Are The Best Practices for Communication. Webinar on Youtube (LINK)

Interior Health – Hospital at Home

- **Main links**
    - Interior Health Hospital at Home Webpage (LINK)
    - Interior Health, 2025. New Home-Based Hospital Care Begins at Kelowna General Hospital. (LINK)
    - Interior Health, 2025. Hospital at Home making a difference in patients' lives. (LINK)
- **Description of the program**
    - "HaH aims to improve the patient, caregiver and health-care provider experience of care. It's an internationally recognized model of care, operating for over 20 years. Programs exist in other countries, and in other B.C. health authorities.
        - Patients receive 24/7 care through a combination of virtual and in-person visits to the home
        - Vital sign readings are taken in the home and communicated electronically to the care team
        - All required technology and medications are provided
        - There is no cost to patients on the program"
    - "Interior Health launched an HaH program at Kelowna General Hospital (KGH) in January 2025."
- **Tiers or levels of service (e.g., education, occasional monitoring, full monitoring, etc.)**
    - "a 24 hour a day service that is designed for acute patients …who still need daily visits and monitoring but are stable"
    - "A dedicated team of health professionals will provide daily visits, virtual consultations, and 24/7 support to ensure high-quality care."
    - "Each day, patients will receive at least one in-person visit, along with regular virtual check-ins, ensuring consistent and personalized care."
    - "Patients are guaranteed at least one daily home-visit by a nurse. They are also trained to take their own vitals such as heart rate and blood pressure with equipment provided by the Hospital at Home program. A caregiver can also be trained by the staff at KGH."
    - "There is remote patient monitoring: physicians and nurses analyze the results remotely from Kelowna General."
    - "In addition, each patient is provided with a secure medical call bell that is worn around their neck in case of an emergency."

- "They can push the button and that will directly link to our charge nurse phone or the phone of their nurse to have immediate direct contact with us," says program lead Lauren Morrison." The medical call bell is automatically triggered when there is a fall."

- **Eligibility**:
  - "Patients must meet the following criteria to be considered for the KGH program:
    - Live within a 20-minute drive of the hospital
    - Be admitted to KGH with a known medical diagnosis and treatment plan
    - Require medical care, but be in stable condition
    - Be 17 years of age or older*
    - Agree to participate in the program and receive in-person and virtual care
    - *17- and 18-year-old patients require parental/guardian consent and presence while the patient is on the program"
    - "has capacity to support many types of patients, including medical, surgical, trauma and oncology if they fit the eligibility criteria and are deemed safe for the program."

- **Referrals**
  - No relevant online information identified at this time.

- **Implementation and lessons learned**
  - "Aside from close connections with families, Hospital at Home has freed up valuable bed space at KGH."
  - "From its launch January 14 until the end of October, it's estimated the Hospital at Home program has seen 240 patients and has saved more than 1,800 bed days, meaning space for more critical patients."

Island Health – Hospital at Home

- **Main links**
  - Island Health Webpage Get hospital at home (LINK)
  - Island Health Hospital at Home Patient Experience webpage (LINK)

- **Description of Hospital at Home**
  - "Hospital Care at Home may be an option if you:
    - Need to be admitted to hospital
    - Need hospital-level treatment
    - Can receive the care you need safely at home
    - Would prefer to receive care at home
    - Taking part is your choice."

- **Tiers or levels of service** (e.g., education, occasional monitoring, full monitoring, etc.)
  - **"How it works**

        - You remain registered as a hospital patient but receive your care at home. A Hospital at Home doctor oversees your care while you are in the program.
        - You will receive:
            - An in-person visit each day
            - Virtual visits when needed
            - Access to your care team at any time, day or night
            - Hospital treatments and tests in your home
            - You can return to the hospital if your health or care needs change."
    - **"Care you can receive at home**
        - Depending on your needs, your care at home may include:
            - Checking your vital signs
            - Oxygen therapy
            - Medication given through an intravenous line, or IV
            - Collection of samples for lab testing
            - Other hospital-level treatments and monitoring
        - Some tests and treatments cannot be provided at home. If you need an X-ray, CT scan, ECG, blood transfusion or another hospital-based service, the team will arrange an appointment at the hospital."
    - **"Your care team**
        - Your Hospital at Home team may include: Doctors; Registered nurses; Nursing unit assistants; Pharmacists; Allied health professionals; Team members have experience providing hospital and urgent medical care."
    - **"Contacting your care team**
        - While you are in the program, you can contact your care team at any time using Call4Care. This home calling device connects you directly with the team when you need unexpected support."
        - Hospital at Home patients and caregivers can access their nurse 24/7 by calling the office directly.
    - **General information on HAH Patient Experience** (LINK)
        - "Hospital at Home will supply equipment and set it up in the patient's home. The nurse will teach the patient and family caregivers how to use the equipment. All participants are required to have their own refrigerator and telephone in the home. Patients use a Samsung tablet and Home Health Monitoring kit to measure their vital signs several times a day."
        - "On a typical day, the Hospital at Home nurses phone their patients between 7:30am and 8:00am to check in and hear how the night went. During this call, they discuss the plan for the day and when patients can expect their daily home visit from the nurse. Nurses visit their patients at least once daily, while other patients may require additional visits depending on their individual needs.

Patients and their family caregivers can connect with the nurse anytime by phoning the HaH office."

- "Patients are asked to set aside their own medications while in the program. All medications are provided by the hospital pharmacy, organized in vials, and documented by the patient on the program's medication administration record. Intravenous medications are either given by the nurse or self-administered by the patient or family caregiver."
- "If a patient requires oxygen, the nurse will provide an oxygen concentrator to use in the home and provide instruction on how to use it. If required, the nurse will collect lab samples (including blood tests) in the home and deliver the specimens to the hospital."
- 'During their time in the program, patients and family caregivers are connected to other members of the HaH team, which includes: registered nurses, physicians, pharmacists, dietitians, clinical nurse leaders, occupational therapist, diabetic nurse educator, and rehabilitation assistant. These interactions may take place over the phone, during in-person home visits, or virtually using a tablet."
- "Sometimes a patient will require a service not able to be provided in the home, such as an x-ray or transfusion. Patients are brought back on-site to receive the service and return home afterwards. Transport is typically by personal vehicle, taxi, or Medivan, depending on the needs of the patient."

- **Safety**
  - "Before being accepted into the program, one of the nurses will speak with the patient (and caregiver, if available) to complete a questionnaire related to the residence and staff safety considerations."
  - "Patients with pets will be asked to secure the animal in a separate room when Island Health staff are present for home visits. Smoking is not allowed when Island Health staff are on the premises. Additionally, occupants will be asked to refrain from smoking for a specified duration prior to home visits."
  - "The care team will wear Personal Protective Equipment [PPE] when they come to your home. Depending on the diagnosis, this could include a mask, gown, and/or eye protection. The patient and other occupants will be asked to wear a medical-grade mask when HaH staff come to the home; these will be provided by the nurse."
  - "Sometimes a patient's health status may change unexpectedly, or the patient/caregiver no longer wish to participate in the program. If the patient is no longer be suitable to stay at home, the patient will be returned to the hospital."

- **Eligibility**
  - "You may be eligible if you need to be admitted to: Victoria General Hospital; Royal Jubilee Hospital; Cowichan District Hospital
    - You must also meet the Hospital at Home program's eligibility requirements.
    - Your doctor and the Hospital at Home team will assess your health, treatment needs and home situation to decide whether the program is safe and appropriate for you."
- **Referral**
  - "Referral is required"
  - "Tell your doctor that you are interested in Hospital Care at Home. Your doctor can review the eligibility requirements and discuss your care with the Hospital at Home team. If the program is right for you, the team will explain what to expect and arrange your care at home."
  - "Most Responsible Providers [MRP] can contact the HaH physician directly to discuss potential patients or to make referrals."
- **Implementation information and lessons learned**
  - **Research** (Included in Section 3 under primary study list in more detail)
    - Spina et al., 2026. **Patient, Family Caregiver and Health Care Provider Experiences With a Hospital at Home Program in British Columbia, Canada**. Qual Manag Health Care. (LINK)
    - Tierney S, Spina SP et al., 2026. **A Tool for Predicting the Risk of Escalation in Hospital at Home**. The Journal of Advanced Home Medicine. 1(1):58-65. (LINK)
    - Patrick M, Spina SP et al., 2023. **Investigation of the impact of a Pharmacist in a Hospital At Home Care Team (IN PHACT**). Can Pharm J (Ott) 156:324-330 (LINK)
    - Spina SP, et al., 2023. **Patients' and Family Caregivers' experiences with a newly implemented Hospital at Home program in British Columbia, Canada**. – Part I: Preliminary results. Patient Experience Journal. 10(1):93-106. (LINK)
    - Spina SP al., 2022. **Engaging patients and families in developing, implementing, and evaluating hospital at home: A Canadian case study. Patient Experience Journal**. 9(1):217-226. (LINK)
    - Patrick M, Spina SP et al., 2022. **Hospital at Home: The Role for Clinical Pharmacists in an Innovative Acute Care Model in British Columbia**. Canadian Pharmacists Journal;155:1 (LINK)
    - Island Health, 2021. **Hospital at Home: Reporting on what we heard**. (LINK)
  - **Video**
    - Dr. Sean Spina, 2021. **Hospital at Home (HaH) Public Engagement "What We Heard" SUMMARY**. Vimeo Video (LINK)
    - Dr. Sean Spina, 2021. **Virtual Care - Hospital at Home: From Inception to Implementation Webinar**. School of Health Information Science, UVic (LINK)
- **Related links and resources**
  - Island Health, 2022. **Island Health succeeds with Hospital At Home** (LINK); (LINK)

- Victoria General Hospital
    - Island Health Hospital at Home Victoria webpage (LINK)
    - Bala, 2020. **Hospital at home pilot program kicks off at Victoria General Hospital**. (LINK)
    - Harnett, 2020. Creating hospital beds 'out of thin air': Hospital at Home program launches in Victoria. Times Colonist. (LINK)
    - Victoria Hospitals Foundation, 2020. **Mark's story – Hospital at Home**. (LINK)

Northern Health – Hospital at Home

- **Main links**
    - Northern Health Hospital at Home Webpage (LINK)
    - Northern Health Physicians Hospital at Home Webpage (LINK)
- **Description**
    - "Hospital at Home is a program where eligible, medically stable patients get hospital-level care in their homes, instead of going to hospital."
    - "A doctor, nurse, and other team members care for the patient using both in-person home visits and virtual visits (phone and/or video). The team also uses technology to monitor the patient."
    - "Hospital at Home care is short-term (on average, 3-7 days) and is available 24 hours a day, 7 days a week, and 365 days a year."
    - "Northern Health is currently trialing Hospital at Home in Prince George, through the University Hospital of Northern BC (UHNBC)."
- **Tiers or levels of service** (e.g., education, occasional monitoring, full monitoring, etc.)
    - "If you need to go to hospital and you're eligible for the program, you might be asked if you'd like to use Hospital at Home. You might also be asked if you'd like to be part of Hospital at Home while you're already in the hospital."
    - "Using Hospital at Home is optional; we understand that you might prefer to go to hospital."
    - "If you choose to use Hospital at Home, the care team will look after you both in person at your home, and by virtual care (phone/video). The team is made up of doctors, nurses, licensed practical nurses (LPN's), pharmacists, social workers and respiratory therapists."
    - "Most of your care will happen in your home. However, you'll still be registered as a hospital patient. If your condition gets worse, or if you need more tests or scans, your care team will help arrange transportation to the hospital."
    - "All the technology that's needed will be set up in your home when you're referred to the Hospital at Home program.
        - You don't need a computer, tablet, or mobile device.
        - All you need is a working cellphone or landline phone."

- "Your condition will be regularly monitored and assessed, and your treatment plan will be updated accordingly. If your condition worsens to the point where it becomes unstable, you'll be transferred to the hospital."
- "Because you're already admitted to the hospital as part of the program, you can bypass the emergency department and go straight to the appropriate inpatient unit (unless you need emergency care)."
- "You and your caregiver will be given clear information on who they should contact if they have concerns."
- "Hospital at Home will have systems and processes in place to quickly recognize, respond to, and escalate care for deteriorating patients."

- **Eligibility**

  - "Patients ages 19 and over with conditions such as infection, heart disease, chronic obstructive pulmonary disease, other short-term acute illnesses, and patients recovering from surgery may be eligible to participate."
  - "We'll ask you some questions to determine if you meet the requirements for the program:
    - Do you have a known diagnosis and are you clinically stable?
    - Are you unlikely to require multiple in-hospital tests, treatments or consultations?
    - Do you have a safe home environment and a caregiver in the home?
    - Do you live close to the hospital?"
  - "When determining whether you are eligible for the program, your health and safety is always of the utmost importance."
  - "The program is voluntary for eligible patients/caregivers who live in close proximity to the hospital, and who have good support and coping capacity at home. Patients and caregivers, along with the care team, can determine if participation in the program is appropriate."
  - "Patients and caregivers must provide informed consent for admission to the program. Admitting physicians are expected to consider any other relevant factor(s) that may affect the patient's likelihood of doing well in the Hospital at Home program."

- **Referrals**

  - "Referrals are being accepted through the UHNBC emergency department, inpatient units at UHNBC, family doctors, or surgeons. As the program evolves, this may change."
  - "If you live in Prince George, your family doctor or surgeon will decide if you meet the requirements to be referred to the program."
  - "If you're eligible and willing to receive care through the program, the Hospital at Home care team will work with you to support your return home and share information about your care plan and how you'll be supported in your home."

- **Implementation information and lessons learned**

- "The UHNBC Hospital at Home (H@H) inpatient unit did a 'soft' launch on March 15, 2021 for an eight-week prototyping phase. For the prototype phase of Hospital at Home, we focused on the following patient specific complex medical populations:
    - Patients already receiving community-based palliative care services who temporarily require acute-level care (i.e., for a pain crisis, uncontrolled symptoms, congestive heart failure).
    - Patients who require enhanced IV therapy that extends beyond regular services to allow time for adjustments to medication routine that will fit within regular extended hours services.
    - Specific post-surgical patients who require 24 hour care following surgery (i.e., Laparoscopic Assisted Vagina Hysterectomy).
- During this time, the team successfully admitted, cared for and discharged 36 patients, the majority of which were in the medicine service and a few under the surgical service.
- Between 1/4 – 1/3 were palliative care patients (mainly IV antibiotics). The top 10 admitting diagnoses included: Cholecystitis, Dehydration, Diverticulitis, Esophageal Mass, Laparoscopic Assisted Vaginal Hysterectomy, Myomectomy, Pancreatitis, Pneumonia, Pulmonary Embolism, Urosepsis
- Patients and their families provided overwhelming positive feedback about their experience.
- **Barriers to admission included**: no caregiver for patient support and safety, patients identified from long-term care and assisted living, and patients who had medical conditions not included in the admission criteria. An additional positive impact was that 12 patients were identified as being appropriate for discharge from acute care."

Manitoba

Shared Health - The Virtual Medicine Ward

- **Main Links**
    - The Virtual Medicine Ward Shared Health Webpage (LINK)
    - Virtual Medicine Ward Patient Information Sheet (LINK)
- **Description**
    - "…the Virtual Medicine Ward provides hospital-level care within the comfort of a patient's home."
    - "This service leverages technology to support up to 30 admitted patients across Winnipeg. By providing essential treatments such as IV therapy, and oxygen, the VMW ensures patients receive the care they need from a dedicated multidisciplinary team of health care professionals."
    - "The Virtual Medicine Ward prioritizes patient safety and quality care with a goal of optimizing patient flow across Winnipeg's hospital facilities."
    - "Tiers or levels of service (e.g., education, occasional monitoring, full monitoring, etc.). "

- **Tiers or levels of service**

  - "The VMW Care Team is made up of:
    - Doctors; Registered Nurses; Pharmacists; Unit Clerks; EPIC (Emergency Paramedics in the Community) will assist the Virtual Ward in patient care by performing at home visits when needed."
  - "How Will I Be Monitored?
    - Once you are accepted into our program, you will be visited by a VMW Nurse and will receive a Telus Home Monitoring Kit. This kit will assist you in taking your vital signs daily at home, and will automatically send the data to the VMW Care Team for review.
    - The Home Monitoring Kit includes: A Tablet; Thermometer; Oximeter; Blood Pressure Monitor
    - The tablet will also host video calls between you and the VMW Care Team. It is important that you have good cell service / WIFI access at home, and feel comfortable using technology. Within 24 hours of returning home, you will have a scheduled virtual visit with a VMW Nurse and a Physician. During this visit the Care Team will determine a follow-up schedule.
    - Your care will happen at home or your current residence, however:
      - If you require bloodwork, you may have to visit Dyna Care or hospital labs to get your blood work done. If transportation is an issue, let your care team know.
      - If you require imaging, you have to get it done in diagnostic labs either in hospitals or clinics. If transportation is an issue, let your care team know.
      - If your condition worsens, you may need to be transported back to the hospital for further care."
  - **Once at Home…**
    - You will connect with your team of doctors and nurses using your tablet or via phone call. Your nurse will let you know how and when to do your assessments and what time to expect the team to connect with you.
    - If your well being becomes critical, do not wait to connect with a VMW nurse, please call 911 right away and identify yourself as a VMW patient."
    - "Monitoring Tips
      - Ensure your tablet is always plugged in and charging so that it is ready to go when you need it.
      - Store devices in a safe place away from water & pets, to avoid drops and damage.
      - For better connectivity, connect the tablet to your home WIFI. Instructions come with the kit.

- When receiving phone calls from a VMW doctor, please be aware the number may come up as PRIVATE"

- **Eligibility**
  - "A physician to physician consultation is required for patients to be admitted to the virtual ward.
    - Contact the Virtual Ward physician via TigerConnect or HSC paging. Navigate to the roles section and search for 'Virtual Ward-Medicine-Physician'
    - The admission of a patient to the virtual ward should be considered as a transfer from their current service area to the virtual ward. Virtual ward patients are and should be thought of as admitted patients.
    - Once a patient is accepted, follow these steps to transfer your patient to the Virtual Ward:
    - Retrieve a Virtual Ward Kit (Transfer package will be enclosed)
    - Follow the steps outlined in the transfer package
    - Forms, Documents, quick guides and tip can be found on the resources page."
- **Referral**
  - For Physicians: Think '4-3-2-1-0' Before Referring to Virtual Ward:
    - **Exclusion criteria –**
      - **4 -**Patient requires more than 4L/min of supplemental oxygen.
      - **3** - Any of three vital signs (HR, BP, RR) are unstable.
      - **2** - Requires IV medications or nursing interventions more than twice daily.
      - **1** - Needs bloodwork more than once daily.
      - **0** - No ability to manage technology, self-care, or ADLs even with family or existing home care support.
    - Questions? Contact the Virtual Ward Program at 204-787-1930.
    - Use this checklist of exclusion criteria to determine whether any of the following apply to your patient."
- **Implementation information and lessons learned**
  - Manitoba Government, 2025. Manitoba Government expands virtual medicine ward to support home recovery and reduce emergency room wait times. News release. (LINK)
    - "To date [Dec. 2025], it has freed up more than 90 hospital bed days and has capacity to support up to 30 patients at a time, the equivalent of 30 acute-care beds, the minister noted, with patients typically remaining in the program for four to nine days and only a small number requiring a return to hospital."
    - "Shared Health hired four nurses to support the expansion, with one additional nursing position and three clerk positions to be filled. Patients have already been referred from Grace Hospital, Concordia Hospital, St. Boniface Hospital and

Health Sciences Centre Winnipeg, and meetings are underway with Victoria Hospital as expansion continues."

- **Related links and resources**
  - **Contacts**
    - Marcy Bialowas, Manager of Health Services, Health Sciences Centre, Email: mbialowas@hsc.mb.ca
    - Kevin Campbell, Director of Health Services, Health Sciences Centre, Email: kcampbell2@hsc.mb.ca
  - Shared Health, Revised: January 15, 2026. **Standard Operation Procedure: ED/UC or Inpatient Transfer of Care to Virtual Medicine Ward (VMW)**. (LINK)
  - Shared Health, 2026. **Virtual Medicine Ward Grand Round**. YouTube. (LINK)
  - Government of Manitoba, 2025. **News Release: Manitoba Government expands Virtual Medicine Ward to support home recovery and reduce emergency room wait time**. (LINK)
  - Shared Health, **Virtual Ward Referral and Transfer Process Document** (LINK)
  - Shared Health, **Virtual Medicine Ward Checklist** (LINK)
  - Shared Health, **Manitoba Consent for Virtual Care** (LINK)
  - Shared Health, **Manitoba Information Transfer Referral Form** (LINK)
  - Winnipeg Health Authority, **Oxygen Safety Questionnaire** (LINK)
  - Shared Health, **Tablet setup** (LINK)
  - Shared Health, **Virtual Medicine Ward (VMW) Frequently Asked Questions** – Staff (LINK)

Ontario

The Ottawa Hospital – Hospital at Home

- **Main Links**
  - The Ottawa Hospital. **The Ottawa Hospital launches Hospital at Home to expand access to acute care in the community**. October 23, 2025. (LINK)
- **Description**
  - "The Ottawa Hospital (TOH), in partnership with CBI Home Health, has launched Hospital at Home, **Ontario's first program to deliver acute hospital-level care directly to patients in their homes**."
  - "Hospital at Home helps ease pressure on hospital resources while ensuring timely, high-quality treatment."
  - "Hospital at Home reflects TOH's mission to expand access, increase capacity and deliver safe, patient-centred care. By bringing hospital-level treatment into the home, the program responds to system pressures such as high Emergency Department volumes and prolonged wait times. It also enhances patient and caregiver experiences, improves outcomes and makes the best use of health-care resources."
- **Tiers or levels of service** (e.g., education, occasional monitoring, full monitoring, etc.)

- "Care is delivered by a team of physicians, nurses and community partners and supported by remote monitoring and virtual tools

- **Eligibility**
  - "Designed for patients who can safely receive care outside of a traditional hospital setting"
- **Implementation information and lessons Learned**
  - No relevant online information identified at this time

Hamilton General Hospital – Hamilton Health Sciences @ Home (HHS@Home)

- **Main links**
  - Hamilton Health Sciences, 2025. **New HHS@Home program hits the right note by bringing hospital-level care to patients where they** live. (LINK)
- **Description**
  - "…a provincial program that provides care in the community for patients who no longer require acute care but still need significant medical and social supports. The program aims to relieve pressure on hospitals and improve patient outcomes by expanding high-quality care into the community."
  - "…to provide wrap-around services to support a patient's transition from hospital to home and optimize recovery in the most appropriate setting."
  - "Developed under Ontario Health's direction, HHS@Home aligns with provincial goals to modernize home care delivery, reduce hospital congestion, and improve patient satisfaction. With its early success and potential for growth, the program positions HHS as a leader in delivering community-based care."
- **Tiers or levels of service**
  - "Under the leadership of HHS, care at home is provided through a partnership with Bayshore Integrated Care Services, a home and community service."
  - "In addition to home visits by nurses, personal support workers, occupational therapists, physiotherapists, respiratory therapists, dieticians, social workers, and more, the program also covers equipment needs for the first 30 days, such as commodes, walkers, and bath chairs."
  - "16 weeks of home visits from a multidisciplinary care team"
- **Eligibility**
  - "HHS@Home serves patients who are medically stable enough to be discharged but still require substantial follow-up care to get back to their regular lives."
- **Referral**
  - No relevant online information identified at this time.
- **Implementation/Lessons Learned**
  - **Benefits for patients and the system**

        - "Since launching in fall 2024, more than 500 patients have successfully left the hospital for care at home through HHS@Home. The results have been overwhelmingly positive, both for patients and hospital staff eager for a new discharge option. At HHS, the program has received funding to expand from Hamilton General Hospital to Juravinski Hospital and Cancer Centre in 2026 as well."
        - "By helping patients safely leave the hospital earlier, HHS@Home reduces Alternate Level of Care (ALC) pressures, which are a significant issue in Ontario hospitals where beds are occupied by patients waiting for discharge supports. In addition, the program has resulted in fewer people coming back to the emergency department for care, and fewer hospital readmissions."
    - **Research** (Included in more detail in Section 3 under Primary Study List)
        - Le et al., 2021. **The Hospital at Home Model vs Routine Hospitalization for Acute Heart Failure: A Survey of Patients' Preferences**. CJC Open. 4(3):263-270. (LINK)
- **Related links and resources**
    - Rehabilitative Care Alliance, 2026. HHS@Home. thehealthline.ca. (LINK)
    - Ontario has a related service called **Hospital to Home** to support patients after discharge from the hospital, aiming to reduce ER visits and hospital readmissions through wraparound home and community care.
        - Hospital News, 2026. **Hospital to Home program aims to reduce ER visits**. (LINK)
        - Ontario Health, 2026. **From Hospital to Home: How One Ontario Health System Is Easing this Transition**. (LINK)
        - Hamilton Health Science, 2017. **HHS team receives Minister's Medal for health quality & safety.** (LINK)
        - Health Standards Organization. **Leading Practices Hospital To Home Team: Bridging The Gap In Health Disparities** (LINK)

Michael Garron Hospital Toronto East Health Network - Virtual Ward

- **Main Links**
    - Michael Garron Hospital Remote Care Monitoring Page (LINK)
    - Michael Garron Hospital, 2018. Virtual Ward Enhances Health and Quality of Life: One Patient's Story (LINK)
- **Description**
    - "The Virtual Ward provides support and care for patients in their homes after they've been discharged from hospital. We provide regular phone calls, perform medical reconciliation and arrange follow-up appointments. We liaise with home care and community partners to keep the updated on progress and suggestions. We work

together with patients and families to help navigate the healthcare system and available supports."

- **Tiers or levels of service** (e.g., education, occasional monitoring, full monitoring, etc.)
    - Lack of information available online but one of the links described the following: "The hospital provides nurse case managers and an office with a dedicated phone line where providers from both hospital and community come together to collaborate around patients' care needs."
- **Implementation and lessons learned**
    - No relevant online information was identified at this time.

Quebec

Hospital@Home/ Hôpital@domicile

- **Main Links**
    - Quebec Government Hôpital@domicile Webpage (LINK)
    - Quebec Telehealth Network, 2024. Telehealth at the heart of home hospitalization. (LINK)
- **Description**
    - "People who have acute medical or surgical conditions and whose clinical condition is considered stable and safe can spend their hospitalization, or part of it, in their own home, surrounded by their family. They are still considered hospitalized as they would be in hospital and have the same priority access to care and services as during a traditional hospitalization in a hospital centre, in particular for diagnostic examinations and consultations in specialized medicine."
    - "Home hospitalization will be implemented gradually in 13 health care facilities in Quebec by the spring of 2025. The first ten projects will be presented in Greater Montreal and the Capitale-Nationale area in 2024."
    - "Home hospitalization is already offered by some hospitals in the greater Montreal area. Other healthcare facilities in the province will follow in the coming months. The government has committed to deploying home hospitalization throughout Quebec by 2026."
- **Tiers or levels of service** (e.g., education, occasional monitoring, full monitoring, etc.)
    - "Patients have virtual access to a dedicated nursing team 24 hours a day, 7 days a week."
    - "The main care and services offered to people receiving home hospitalization are as follows:
        - clinical monitoring;
        - remote assessment and monitoring of health status through the use of connected medical devices;
        - monitoring of authorized and prescribed treatments;
        - moral and physical assistance."

- "The length of stay is assessed daily based on the patient's clinical condition. When the situation requires it, home visits are offered by home support services."
- "In practical terms, patients hospitalized at home…
  - are monitored by their attending physician;
  - are in contact with a nurse 24 hours a day, 7 days a week;
  - have visits from caregivers for physical care;
  - have their medications and medical supplies delivered free of charge;
  - retain priority access to examinations and consultations with specialists."

- **Eligibility**
  - "The eligibility criteria are determined by each health facility depending on the medical specialties participating in the physical health home hospitalization program."
- **Referral**
  - No relevant online information was identified at this time.
- **Implementation information and lessons Learned**
  - **News articles** related to implementation or lessons learned
    - Zeidenberg, 2026. **Jewish General Hospital brings AI into Hospital@Home**. Canadian Healthcare Technology. (LINK)
    - Daniel, 2023. **Healthcare providers are expanding their hospital-at-home programs.** Canadian Healthcare Technology (LINK)
    - JGH News, 2022. **Patients in pioneering JGH program are monitored remotely while completing recovery at home**. (LINK)
  - **Research** (Included in Section 3 in more detail)
    - Almeida N & Suarthana E, 2023. **Hospitals at home: guiding principles for establishing virtual acute care wards**. (Report no. 93). Technology Assessment Unit (TAU) of the McGill University Health Centre (MUHC): Montreal (QC). (LINK)
- **Related links and resources**
  - JGH News. **Hospital@Home wins international award for value-based health care**. May. 17, 2024 (LINK)
  - University Network. **Care Everywhere officially launched by CIUSSS West-Central Montreal**. 2023. (LINK)

Section 3: Select Evidence on Implementing Hospital at Home Models

The section below provides select evidence on how hospitals and health systems in other jurisdictions are implementing Hospital at Home models published recently (2021-2026). Please note that the references are intended to provide a starting point for exploring this topic and are not intended to be exhaustive.

Evidence is presented in reverse chronological order and for each resource, key quotes have been included, primarily from study abstracts, to highlight relevant findings.

Overviews & Scoping Reviews

Kumari et al, 2025. **Advancing Regional and Remote Health Care with Virtual Hospital Implementation: Rapid Review**. JMIR Hum Factors. 3;12:e64582. (LINK)

- **Study type:** Rapid Review (23 peer-reviewed articles & 12 gray literature sources)
- **Aim**: "to examine the role of VHs in enhancing regional and remote health care by focusing on accessibility, patient and health care provider experiences, and implementation barriers and facilitators. **It provides tailored recommendations for large-scale implementation in communities with access issues, contributing to the discussion on equitable health care**."
- **Definitions:**
    - "**Hospital-at-home programs**, a subset of VH [virtual hospitals] or stand-alone initiatives, provide hospital-level care in the patient's home, incorporating remote monitoring and regular consultations"
- **Methods**: "Studies were included if they focused on regional or remote populations and addressed VHs or virtual care. Studies that solely discussed hybrid models of care were excluded."
- **Results**: "A total of 35 articles were included in this review, comprising 23 (66%) peer-reviewed studies and 12 (34%) gray literature sources. **Positive clinical outcomes were reported in 9 (26%) articles, highlighting outcomes such as reduced disease transmission, improved patient safety, fewer admissions and readmissions, lower mortality, shorter hospital stays, and better adherence to clinical best practices**. Health system outcomes were identified in 15 (43%) articles, including **reduced costs, enhanced patient experience and safety, improved care delivery and health care provider support, greater efficiency, broader geographic coverage, and better integration of services**. Patient and health care provider perspectives were discussed in 12 (34%) articles, with positive views attributed to convenience, time and cost savings, and improved service quality. **Barriers and facilitators were the most frequently discussed themes, appearing in 27 (77%) and 26 (74%) articles, respectively, with challenges and enablers commonly linked to people, processes, technology, and financial sustainability**."

Glenister et al, 2025. **Facilitators and barriers to provision of hospital in the home: does geographical location matter? A scoping review.** BMC Health Serv Res 25, 875. (LINK)

- **Study type**: Scoping review (35 articles)

- **Aim**: "to **identify facilitators and barriers to the provision of hospital in the home services in rural areas**"
- **Definitions**:
    - "**There is no single, universally accepted definition of hospital in the home**. The terminology related to 'Hospital In The Home' (HITH) varies internationally and includes 'Hospital at Home' (HAH) and 'Home Hospital'"
    - "**For the purpose of this review, the term 'hospital in the home (HITH)' was used, and followed the World Hospital at Home Congress consensus statement definition**:
        - "[**HITH/HAH] is an acute clinical service that takes staff, equipment, technologies, medication and skills usually provided in hospitals and delivers that hospital care to selected people in their homes or in nursing homes. It substitutes for acute inpatient hospital care. Its goal is to improve the lives of sick people who need hospitals, by changing the culture of hospitals to deliver hospital-level care at home**"
- **Methods**: "A scoping review of literature published in English between 1990 and 2023 …. A key term search strategy was employed using 'hospital in the home' and 'rural' plus equivalent search terms. **Inclusion criteria primarily focused on articles that described acute, in-patient bed substitution for adult patients**."
- **Results**: "Thirty-five articles met the inclusion criteria. These articles were diverse in terms of methodology, models of care, patient populations and country of origin. **Many facilitators and barriers to the provision of hospital in the home were not necessarily specific to rural contexts, for example, workflows and patient selection. Rural specific facilitators included rurally tailored models of care, and rural community strengths such as resourcefulness, social capital and reciprocity. Conversely, rural specific barriers included travel distances and associated costs, complicated by challenging weather conditions or terrain**."
- **Conclusion**: "Whilst the evidence base for provision of hospital in the home care in rural areas was limited, consideration of the facilitators and barriers identified in this review should assist with the provision of hospital in the home services in rural areas."

Sultani et al., 2025. **Transforming acute care: a scoping review on the effectiveness, safety and implementation challenges of Hospital-at-Home models**. BMJ Open. (LINK)

- **Study type**: Scoping review (9 RCTs)
- **Aim**: "to comprehensively map and summarise the evidence **on both admission avoidance and early-supported discharge** up until now."
- **Definitions**:
    - "The HaH model encompasses two core strategies: **(1) early supported discharge and (2) admission avoidance**. The concept of early supported discharge aims to facilitate the prompt discharge of hospitalised patients to the HaH while ensuring ongoing support and monitoring by a multidisciplinary team. Admission avoidance enables direct

admission into the HaH through referrals from general practitioners, thereby bypassing physical contact with the hospital, or through direct admission from the emergency room without an inpatient stay"

    - "Although HaH has been implemented for several decades, the lack of a universally accepted definition for HaH has led to heterogeneity among HaH care models….. Therefore, a generally accepted definition was formulated describing key features that define HaH. **HaH is defined as a substitutive healthcare delivery model where acute hospital-level care is provided to patients in their own homes, who would otherwise be admitted to the hospital, aiming to achieve comparable or better clinical outcomes to those obtained in a traditional hospital setting"**

- **Design**: "A scoping review of randomised controlled trials (RCTs), conducted…"
- **ELIGIBILITY CRITERIA FOR SELECTING STUDIES**: "We included English-language RCTs published from 2005 onwards, involving adults (≥18 years) receiving acute care at home who would otherwise require hospital admission. Eligible studies **evaluated admission avoidance or early supported discharge** within HaH settings for acutely ill patients. Studies focusing on outpatient care, non-acute conditions or interventions not aligning with the widely accepted HaH definition were excluded. COVID-19-related studies were also excluded to avoid context-specific bias."
- **Data extraction and synthesis**: "Two reviewers independently extracted data on study characteristics, interventions and **outcomes including mortality, length of stay, escalation rates, costs and patient and caregiver satisfaction**. **Implementation facilitators and barriers were also collected**."
- **Results**: "Nine RCTs were identified. The review shows that the **HaH model is at least as safe as usual care, with lower or comparable mortality rates. Length of stay varied, with some studies reporting longer stays in the HaH group due to cautious clinical practices. Cost analyses often indicate lower healthcare costs with staffing as the largest expense. Patient and caregiver satisfaction was high, but essential implementation factors were not clearly addressed**."
- **Conclusion**: "The HaH model represents a promising alternative to acute inpatient care for suitable patients. Future research should focus on conducting larger RCTs, expanding the range of conditions suitable for HaH. **Despite favourable clinical outcomes, substantial implementation barriers remain underexplored in current RCTs**. **This underscores the need to identify strategies for successful implementation, including the integration of technological advancements and qualitative insights into patient and caregiver experiences**."

CADTH, 2024. Horizon Scan. **Virtual Medicine Wards and Hospital-at-Home Programs**. Volume 4, Issue 5 (LINK)

- **Study type**: Horizon Scan including Canadian information
- **Aim**:
    - "**…present any existing evaluations of virtual ward and HAH programs for early supported discharge**, highlighting their structure, patient population, outcomes

measured, and any patient or provider experiences associated with them **as well as any descriptions of virtual ward programs in Canada**."

- "…**focuses on the use of early supported discharge for generalist care settings**. Information related to patients receiving postsurgical, oncology, or palliative care in specialist settings were not included. Due to the volume of available literature, publications that investigated the creation and use of virtual wards specifically to manage patients with COVID-19 during the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic were not included in this report."

- **Definitions**:
  - **"Virtual wards, also known as hospital-at-home programs**, support the provision of inpatient-level acute medical care in a patient's home.
    - There are 2 main models of these programs: **admission avoidance and supported early discharge. This report focuses on the latter type.**
    - Many of these programs are technology-enabled and incorporate remote monitoring devices to record the patient's vital signs and tablets or web portals to facilitate data sharing. Video calls with the clinical team are also used in combination with in-person visits by health care providers."
- **Considerations:**
  - **"Canadian cost data were not identified**, but it is generally accepted that virtual ward programs are associated with reduced costs when compared with traditional in-hospital care.
  - The inclusion of digital monitoring and record keeping technologies as part of virtual ward programs may disproportionately exclude people from some groups, including older people, people living in social housing or without housing, people with lower incomes, people who are unemployed, people living with disabilities, and people who live in rural areas without access to such programs.
  - **Key recommendations** for development of virtual ward programs in Canada include **using a single remote patient-monitoring platform that connects with the hospital's electronic health record system, choosing a technology to connect patients and providers that best fits the needs of the virtual ward program, and ensuring data security, confidentiality, and data management protocols are in place**."
- **How Are They Used in Canada?**
  - "In July 2023, researchers at McGill University Health Centre published a set of guiding principles for the establishment of virtual acute care wards in Canada. These principles were created in collaboration with representatives from other established HAH or remote monitoring programs in Quebec, Ontario, and British Columbia. The principles were created to inform a pilot project in which 8 hospitals in Quebec would implement a HAH care model for patients to receive acute care while remaining at home."

- **"Most of the Canadian virtual ward models identified in the review used a "device and tablet" concept in which patients use Bluetooth-enabled medical devices (e.g., blood pressure monitors) to measure biometric data and a tablet to transmit that data to the clinician for monitoring and interpretation. This model requires the patient be provided access to the smart devices as well as have a reliable Wi-Fi connection**."
- "These digital monitoring systems can be integrated with existing electronic health record systems. A summary of technologies that may be used to enable HAH models in Canada and elsewhere is provided in Table 3 (page 10) of the McGill report1. No other features about these models were reported."

Wang et al, 2024. **Patients' and caregivers' perceptions of the quality of hospital-at-home service: A scoping review**. J Clin Nurs. 33(3):817-838. (LINK)

- **Study type**: Scoping review (24 articles)
- **Aim**: "to provide an overview of patients and caregivers perceptions of hospital-at-home (HaH) services."
- **Definitions**:
  - "**Hospital-at-home (HaH**) services provide acute hospital-level care at home aiming to avoid hospital admission and support early discharge from hospital or transfer to their home to complete the acute hospital admission at home and shown to be feasible and effective."
- **Method**: "Literature from PubMed, Web of Science, Ovid, CINAHL, Cochrane and Mednar databases were searched. Relevant studies published between 1st January 2005 and 31st December 2022 were identified. The conceptual model of the development of patient perceptions of quality was used for data extraction and tabulation."
- **Findings**: "The review included 24 articles. **Expectation attributions were identified as needs, types of service, hospitalisation experiences, family care preferences, social-demographics and coping skills. From patient's and caregiver's perspectives, HaH was safe, effective and viewed positively. Perceived concerns/barriers and enablers/facilitators were associated with individual, caregiver and system factors, but demonstrated an overall satisfaction in the HaH service**."
- **Conclusion**: "HaH provides an excellent service according to patients' and caregivers' perceptions. However, **gaps in care were identified such as prioritising patient-centred care, along with improved multidisciplinary continuity of care and future studies should incorporate these into their research of HaH**."

Almeida N & Suarthana E, 2023. **Hospitals at home: guiding principles for establishing virtual acute care wards**. (Report no. 93). Technology Assessment Unit (TAU) of the McGill University Health Centre (MUHC): Montreal (QC). (LINK)
(Included as a source in the CADTH Horizon Scan)

- **Study type**: Brief report with literature review and interviews with Hospital at Home and remote patient monitoring centres
- **Aim**: "to evaluate the requirements of establishing a home hospital care model, with a particular emphasis on the technologies involved. The specific objectives were to:
    - Review the technologies (telehealth platforms and remote patient monitoring equipment) required for hospitals at home;
    - Review general guiding principles for the establishment of hospitals at home.
- **Findings: "**Our literature review and interviews with Hospital at Home and remote patient monitoring centres revealed that diligent planning and mapping is required to establish a successful model, with the following as key requirements
    - Patient eligibility criteria
    - Human resource
    - Technology considerations
    - Care coordination and communication
- "We obtained information on the experience of the MUHC and hospitals with established 'hospital at home' or remote patient monitoring models through correspondence, interviews or information sessions with the following people:
    - Island Health, Victoria, BC:
        - Sean Spina, principal investigator for the Alternatives to Traditional Hospital Care Offered in Monitored Environments (AT-HOME) research team and Regional Manager, Clinical Pharmacy Services, Island Health;
        - Dr. Nancy Humber, Clinical lead, Hospital at Home, Royal Jubilee Hospital and
    - Victoria General Hospital;
        - Tara Mulcaster, Manager, Hospital at Home, Royal Jubilee Hospital and Victoria General Hospital; Jewish General Hospital, Montreal, QC
        - Erin Cook, MScN, Director of Quality, Transformation, Evaluation, Value, Clinical & Organizational Ethics, and Virtual Care, CIUSSS Centre-Ouest-de-l'Île-de-Montréal; Hopital Montfort, Ottawa, ON
        - France Morin, MScN, Clinical Director, Family Birthing Centre, Telemedicine
        - Nazila Sattari, IA/RN, BScN, Med, Virtual Care and Remote Care Coordinator
        - Michelle Dorion, PT, PhD, Advisor to the professional practice-interprofessions
    - Ottawa Heart Institute, Ottawa, ON
        - Erika MacPhee, Vice-President, Clinical Operations
        - Michael Garron Hospital, Toronto East Health Network, ON
        - Regan Lalonde, Communications and Community Engagement Coordinator
    - MUHC
        - Carole Lapierre, Associate Director, Partnership Office, DSP
        - Keith Woolrich, Director, DQEPE
- See Table 2. Principal considerations for telemonitoring technologies in home hospitals

- See Table 3. Technologies to enable Hospital at Home models used in Canada and elsewhere
- **See APPENDIX A: HOSPITAL AT HOME CARE MODELS INESSS as of 2021**
- See APPENDIX B: HEALTH TECHNOLOGY ASSESSMENTS

Norman et al, 2023. **Virtual wards: a rapid evidence synthesis and implications for the care of older people**. Age Ageing. 8;52(1):afac319. (LINK)

- **Study type**: Rapid Evidence Synthesis (28 evidence syntheses)
- **Aim:** "To rapidly synthesize evidence from existing evidence syntheses, which was relevant **to the clinical and cost-effectiveness of virtual wards; the barriers and facilitators to their use; the ways in which they are used; and the experience of patients, carers and staff**. For this paper, we have adopted a focus on the relevance of the evidence to older people and people with frailty."
- **Definitions:**
    - "**Hospital at home** services provide face-to-face care at home through a multidisciplinary team (MDT) based in the community. They are provided as an alternative to inpatient care"
    - "**Virtual wards** are a hospital-led and managed alternative to in-patient hospital care that is enabled by technology. They enable the delivery at home of acute care, monitoring and treatment to prevent admissions or support early discharge. They use a variable combination of remote monitoring and face-to-face care, and may incorporate remote monitoring, for example, through apps, technology platforms, wearables and devices such as pulse oximeters"
    - "**Remote monitoring** includes aspects of many virtual wards but is a broader term and is not always restricted to people who would otherwise require inpatient hospital care."
    - **"Step-up models of care** use virtual wards or hospital at home as an alternative to avoid inpatient admission to hospital."
    - "Step-down models of care **use early discharge to** virtual wards or hospital at home **for a condition that would have otherwise required continuation of hospital inpatient care."**
- **Methods**: "searched …for evidence syntheses which addressed clinical-effectiveness, cost-effectiveness, barriers and facilitators, or staff, patient or carer experience for virtual wards, hospital at home or remote monitoring alternatives to inpatient care"; "Because of the close relationship between virtual wards and both hospital at home and remote monitoring we searched for, and included, systematic reviews relating to any one of these, where the service was provided as an alternative to inpatient hospital admission"
- **Results: "**We included 28 evidence syntheses mostly relating to hospital at home. **There is low to moderate certainty evidence that clinical outcomes including mortality** (example pooled RR 0.77, 95% CI 0.60–0.99**) were probably equivalent or better for hospital at home**. Subsequent residential care admissions are probably reduced (example pooled RR 0.35, 95% CI 0.22–0.57).

Cost-effectiveness evidence demonstrated methodological issues which mean the results are uncertain. **Evidence is lacking on cost implications for patients and carers. Barriers and facilitators operate at multiple levels (organisational, clinical and patient). Patient satisfaction may be improved by hospital at home relative to inpatient care. Evidence for carer experience is limited**."

- **Conclusions:** "**There is substantial evidence for the clinical effectiveness of hospital at home but less evidence for virtual wards**. **Guidance for virtual wards is lacking on key aspects including team characteristics, outcome selection and data protection. We recommend that research and evaluation is integrated into development of virtual ward models. The issue of carer strain is particularly relevant**."

Partington et al, 2022. **Identifying Potential Populations for Home Hospitalisation: A scoping review of the literature to support the review of the South Australian My Home Hospital service**. College of Medicine and Public Health Flinders Health and Medical Research Institute (LINK)

- **Study type:** Scoping review (47 studies)
- **Aim:** "To support the review and continual improvement of the MyHH in South Australia, the Flinders Health and Medical Research Institute (FHMRI) were commissioned by Wellbeing SA to conduct a scoping review of the recent literature since 2017, to identify novel populations for whom HITH services have been provided elsewhere, and who may represent people within South Australia who may also benefit from MyHH access into the future."
    - "What are the characteristics of participants in home-based admitted care?"
    - "In which setting and context have these services been implemented or maintained?"
- **Definitions**:
    - "This review considered studies where **a service or intervention enables the delivery of hospital-type care within a home setting**. Within this, we were also only interested in the 'admitted' subset of hospital services – be they acute, elective, sub-acute or non-acute. Services related primarily to non-admitted (e.g., emergency department, only) and outpatient clinic visits were excluded from the review."
- **Executive summary**:
    - "Observational studies and trialled models from the international and Australian literature are presented in this report, to firstly chart out the different targeted populations, before then summarising the evidence and providing insights for future extensions of the service, and diversification of home hospitalisation in South Australia."
    - "Drawing upon the activity observed within Australia – **three ADRGs are proposed as 'High Proportion Services' which are not currently within the scope of the MyHH, including septic arthritis; digestive malignancy; and infective endocarditis**. Potential additionally relevant 'High Volume Services' were seen in digestive malignancy; miscellaneous musculoskeletal procedures for infection or inflammation of bone and joint; sleep apnoea; and septicaemia. 'Other Targets' from the Australian activity worth noting were also those for other digestive system disorders and septicaemia."

- "The trialled models that emerged, having also not been observed within the present national activity data, included those for dehydration and electrolyte imbalances; falls, frailty, and functional decline; delirium; and asthma exacerbation."
- "While beyond the current targets of the configuration of the MyHH service in SA, the review also highlighted future diversification considerations in post-surgery early supported discharge; children's services; palliative care; mental health; and rural and remote services."
- "The insights provided here are based on observed HITH activity across Australia and the development of novel service delivery models, published within the international literature. To prioritise between these options, further local evidence can be used to profile the expected costs and effects of different options, relative to each other."

Systematic Reviews & Meta-Analyses

Ko et al., 2026**. Implementation determinants, strategies and outcomes for scale-up of hospital-at-home: a systematic review**. Implement Sci Commun. (LINK)

- **Study type**: Systematic review (27 studies)
- **Aim**: "conducted a systematic review of HaH studies reporting implementation contexts, strategies and outcomes with the primary aim to synthesise the implementation evidence on HaH. Our secondary aim was to develop a framework of HaH implementation outcome indicators for future studies to apply."
- **Definitions**:
  - **"Hospital-at-home (HaH) is a home-based inpatient substitutive care model, which has been expanding worldwide to augment hospital bed capacity as populations age(1). It features multi-disciplinary healthcare teams that care for patients in their homes, who would otherwise have required a hospital bed."**
- **Methods**: "We searched the literature PubMed, Embase and Scopus, for publications from 2012 to 2022. We included studies related to HaH that included at least one implementation context and at least one implementation outcome variable, excluding clinical outcomes measures. At least two reviewers independently selected studies, abstracted data and assessed quality. **We coded the implementation determinants to the Consolidated Framework for Implementation Research (CFIR); implementation strategies to the Expert Recommendations for Implementing Change (ERIC); and implementation outcomes to the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) frameworks**."
- **Discussion**
  - "The implementation determinants identified across CFIR domains are largely consistent with the qualitative evidence synthesis by Wallis and colleagues (12), who similarly identified **system factors including policy and financing structures, and resources and skills, as central to successful implementation**. First, mapping determinants systematically to CFIR constructs, we provide a replicable checklist against which

implementors in new contexts can audit their local conditions before attempting scale-up."

  - "we **identify information technology infrastructure as the single most frequently reported barrier (six studies),** a finding that sits within CFIR's inner setting domain. The recurrence of this barrier across geographically and clinically diverse settings suggests it represents a structural constraint on HaH scaling rather than a context-specific challenge, and points to IT interoperability as a priority target for implementation strategy development."
  - "the key strategy clusters – training, new clinical team creation, and adaptability – as the most commonly deployed responses, suggesting generalisability of these strategy-barrier pairings beyond any single health system"
  - **Weakness and gaps in HaH implementation evidence**: "Most strategies in the included studies were evaluated informally through clinician interviews or operational observation rather than formally tested, and only one study measured strategy effectiveness using a validated tool."
- **Conclusions**: "We identified a list of implementation determinants, strategies and outcomes that can be used to inform scale-up of HaH, and have developed a framework for consistent reporting of HaH implementation studies grounded onto RE-AIM."

Cucurachi et al, 2025. **Barriers and facilitators to the use of virtual wards: a systematic review of the qualitative evidence**. Int J Qual Health Care. 4;37(3). (LINK)

- **Study type**: Systematic review of qualitative evidence (16 studies)
- **Aim**: "to understand the **barriers to and facilitators for the successful implementation** and sustainability of virtual wards from the perspective of any involved stakeholder, using behavioural change models."
- **Definitions**:
  - "**Virtual wards** seek to mirror the mechanisms, staffing, and daily operations of a traditional hospital ward, without the need for a physical facility. In essence, virtual wards function as a multidisciplinary case management model that usually provides short-term transitional care [1]. The aim of this emerging model of care is to reduce non-elective secondary care usage through early discharge, by allowing patients to continue their recovery at home, and by preventing admissions or readmission to the hospital [2]."
- **Findings**: "**Common barriers for patients and family members were a lack of language skills, technical skills, and medical knowledge**. Caregivers were also required to take on significant medical responsibilities, while patients had to remain self-motivated. The introduction of appropriate training was seen as a valuable facilitator**. Healthcare providers faced numerous technological barriers that had the potential to affect care delivery. Strong leadership was an essential facilitator for effective care coordination in virtual wards**. From a healthcare system

perspective, the availability of resources — such as staffing, equipment, and funding —along with standardized protocols, is crucial for the successful implementation of virtual wards."

- **Conclusions**: "Virtual wards can ease hospital capacity issues and support the delivery of safe and effective care in patients' own homes. However, to realize this potential, we must understand the barriers to, and facilitators of, the use and successful implementation of virtual wards for patients, carers, and healthcare professionals. This understanding will allow targeted strategies and interventions to be developed to support both the delivery and receipt of care on virtual wards."

Goh et al, 2025. **Hospital-at-home care in Singapore: A review of overseas protocols and guidelines to support implementation and policy redesign (systematic review)**. PLoS One. 2025. (LINK)

- **Study type**: Review of protocols and guidelines (14 guidelines and 7 sections)
- **Aim**: "…to distil information from existing guidelines worldwide to collate the best practices for HaH implementation."
- **Definitions**:
    - "**Hospital-at-Home** (HaH) delivering acute, hospital-level care to patients in their own homes, typically for a specified duration, as a substitute for acute inpatient admission."
    - "Eligible studies defined HaH as **the provision of acute short-term care to patients at home instead of inpatient hospital care, specifically for adult patients in geriatric, internal medicine, and general medicine specialties**. Internal, family, or general medicine were defined as managing conditions beyond single-organ specialties or subspecialties. This involved more generalised, multi-system disease conditions."
- **Methods**: "A literature review across three databases and an Advanced Internet Search was performed to collect guidelines that included recommendations on HaH implementation requirements."
- **Results**: "Fourteen guidelines and seven sections were identified, which covered the following topics: inclusion & exclusion criteria, admission process, clinical handover, discharge, team structure, partnerships with external stakeholders, and medication administration. **Key observations underline deficiencies in addressing staff safety, appropriate medical supply storage, and admission after hours. The main discrepant recommendations included self-discharge, team structure, partnerships with primary care providers, and medication self-administration**. Methodological quality of guidelines varied, with overall AGREE II scores ranging from 38.5% to 58.4%. Individual domain scores were consistently low for Rigour of Development and Editorial Independence. Despite low scores in these domains, all fourteen guidelines were deemed appropriate for information extraction."
- **Conclusion**: "Despite inconsistencies among guidelines, a set of streamlined recommendations were consolidated. In Singapore, **addressing home environment constraints, fostering stronger partnerships with community providers, and leveraging on multidisciplinary care can enhance the feasibility and sustainability of these HaH recommendations**. **Policy redesign should focus on further stratifying patients based on home suitability, leveraging on technology to support**

clinical handovers or collaborations, and investing in multidisciplinary training to strengthen workforce capabilities. In all, healthcare providers around the world should consider contextualising these recommendations within local socioeconomic and healthcare contexts for optimal HaH implementation."

Gomez-Cabello et al, 2024. **Barriers to hospital-at-home acceptance: a systematic review of reasons for patient refusal**. Mhealth. 4;10:34. (LINK)

- **Study type**: Systematic review (7 studies)
- **Aim**: "we analyze why patients refuse H@H, focusing on the motives provided by patients after being offered care at a H@H setting."
- **Definitions**:
    - **H@H programs provide acute or subacute treatment in a patient's residence for care that would typically require admission to a hospital**. By definition, patients receive the same treatment they would have received in the hospital, including monitoring, diagnostic testing (e.g., laboratory tests, electrocardiograms, and radiographs), intravenous (IV) medication, and active in-person care from nurses and physicians.
- **Methods**: "Our search focused on papers reporting patient-provided reasons for declining treatment in a H@H setting without language or country restrictions. In addition to reasons for refusal, we extracted patient demographics and predictors for refusal to ensure a broad understanding of the factors influencing patient decisions."
- **Findings**: "The papers reported reasons from 418 patients participating in diverse H@H models from the United States, United Kingdom, Spain, and Singapore, primarily focusing on acute home-based care. **The most common reasons for declination included concerns about model effectiveness, safety at home, preference for in-hospital care, physician advice, family burden, and visitor concerns. Additionally, common significant demographic factors associated with decliners were the enrollment site, partnership or marital status, risk of adverse outcomes, and previous healthcare utilization**."
- **Conclusions**: "Understanding patients' motivations for declining H@H is crucial for its successful implementation. **Targeted communication strategies and collaboration between healthcare providers are paramount to ensure that patients understand the benefits and safety of H@H models. Future research should explore effective communication and engagement techniques to address patient apprehensions and broaden H@H adoption**."

Nikmanesh et al, 2024. **Dimensions and components of hospital-at-home care: a systematic review**. BMC Health Serv Res. 25;24(1):1458. (LINK)

- **Study type**: Systematic review (179 articles)
- **Aim**: "to explore the dimensions and components of HaH care"
- **Methods**: "The inclusion criteria of the study included articles published in the English language, and and those pertaining to various dimensions and components of HaH care. The quality of the

studies was assessed using the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist and data were analysed using the framework analysis method."

- **Findings**: "A total of 4078 articles were retrieved. After screening and quality assessment, 179 articles were included in the review, identifying **88 dimensions and components of HaH care across seven main categories: benefits, challenges and obstacles, facilitators, management-related factors, medical conditions, factors associated with patients and their families, and factors associated with caregivers**. The common components included cost savings (n = 30), patient and family satisfaction (n = 23), reduction in re-admissions (n = 13), medication management (n = 12), communication, coordination, and cooperation among healthcare teams, patients, and families (n = 12), preferences of patients and families (n = 12), and education of patients, families, and healthcare teams (n = 10)."
- **Conclusions**: "Based on the results, HaH includes many and diverse dimensions and components. So, **healthcare policymakers and planners are urged to consider the dimensions and components of HaH care including benefits, challenges and obstacles, facilitators, management-related factors, medical conditions, factors associated with patients and their and their families, and factors associated with caregivers when developing models and programs to ensure effective outcomes following implementation."**

Wallis et al, 2024. **Factors influencing the implementation of early discharge hospital at home and admission avoidance hospital at home: a qualitative evidence synthesis**. Cochrane Database Syst Rev. 5;3(3):CD014765. (LINK)

(Included as a source in the CADTH Horizon Scan)

- **Study type:** Qualitative evidence synthesis
- **Objectives**
  - (1) To identify, appraise and synthesise qualitative research evidence on the **factors that influence the implementation of Admission Avoidance Hospital at Home and Early Discharge Hospital at Home**, from the perspective of multiple stakeholders, including policy makers, health service managers, health professionals, patients and patients' caregivers.
  - (2) To explore how our synthesis findings relate to, and help to explain, the findings of the Cochrane intervention reviews of Admission Avoidance Hospital at Home and Early Discharge Hospital at Home services.
- **Definitions**:
  - **"Hospital at Home** provides hospital-level care at home, for people who would otherwise be inpatients in hospital. One type of Hospital at Home is to avoid admission to hospital. This is called **Admission Avoidance Hospital at Home**. These services replace an admission to hospital, for people whose condition would normally need treatment in a hospital bed, for example for a flare-up of a lung condition. Instead, a doctor can refer a patient they assess as being suitable to receive treatment for an illness in their own home (or the place where they usually live, including in residential

care), for a limited time. Another type is called **Early Discharge Hospital at Home**. These services shorten the length of time people need to stay in hospital after being admitted as an inpatient, for example following surgery or treatment for an illness or condition. The care patients would usually receive from healthcare professionals in a hospital bed is instead provided in their home, and is not expected to compromise the quality of care."

- **Selection criteria**: "We included qualitative studies and mixed-methods studies with qualitative data collection and analysis methods examining the implementation of new or existing Hospital at Home services from the perspective of different stakeholders."
- **Data collection and analysis**: "Two authors independently selected the studies, extracted study characteristics and intervention components, assessed the methodological limitations using the Critical Appraisal Skills Checklist (CASP) and assessed the confidence in the findings using GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research). We applied thematic synthesis to synthesise the data across studies and identify factors that may influence the implementation of Hospital at Home.
- **Main results**: "From 7535 records identified from database searches and one identified from citation tracking, we included 52 qualitative studies exploring the implementation of Hospital at Home services (**31 Early Discharge, 16 Admission Avoidance, 5 combined services**), across 13 countries and from the perspectives of 662 service-level staff (clinicians, managers), eight systems-level staff (commissioners, insurers), 900 patients and 417 caregivers. Overall, we judged 40 studies as having minor methodological concerns and we judged 12 studies as having major concerns. Main concerns included data collection methods (e.g. not reporting a topic guide), data analysis methods (e.g. insufficient data to support findings) and not reporting ethical approval. Following synthesis, we identified 12 findings graded as high (n = 10) and moderate (n = 2) confidence and classified them into four themes: **(1) development of stakeholder relationships and systems prior to implementation, (2) processes, resources and skills required for safe and effective implementation, (3) acceptability and caregiver impacts, and (4) sustainability of services**.
- **Authors' conclusions**: "Implementing Admission Avoidance and Early Discharge Hospital at Home services requires early development of policies, stakeholder engagement, efficient admission processes, effective communication and a skilled workforce to safely and effectively implement person-centred Hospital at Home, achieve acceptance by staff who refer patients to these services and ensure sustainability. Future research should focus on lower-income country and rural settings, and the perspectives of systems-level stakeholders, and explore the potential negative impact on caregivers, especially for Admission Avoidance Hospital at Home, as this service may become increasingly utilised to manage rising visits to emergency department"

Cordero-Guevara et al, 2022. **Factors associated with the workload of health professionals in hospital at home: a systematic review**. BMC Health Serv Res. 26;22(1):704. (LINK)

- **Study Type**: Systematic review (18 studies)

- **Aim**: "to identify such factors according to published evidence."
- **Definitions**:
    - "Different health care models have been labelled as hospital at home (HaH) in the international literature over time. Such models vary according to the general organisational guidelines of the health system in each country and according to the funding and the profile of the patients (or diseases) for which care is provided. Heterogeneity is also observed in the type of team in charge of coordinating the care (e.g., hospital vs community-based), the care team composition (e.g., nurses, physiotherapists, occupational therapists), the programme components (e.g., additional elements such as patient and caregiver education), the number of home visits, the availability of after-hours support and specific medical services provided (e.g., home oxygen, intravenous fluids)"
    - "**UK Hospital at Home Society and some authors have defined HaH as "the care service offered for a limited period of time that provides active treatment by health care professionals in the patient's home, for a condition that otherwise would require acute hospital in-patient care". In Spain, HaH is defined as "a care alternative that consists of an organized model capable of providing a set of medical and nursing care and attention of hospital rank (provided by health professionals and material resources of the hospital itself), both in quality and quantity to patients at home, when they no longer require hospital infrastructure but still need active monitoring and complex care**."
    - "Due to the heterogeneity of HaH models, **HaH was defined as a care that provides a set of medical and nursing care and attention of hospital rank to patients at home, when they no longer require hospital infrastructure but still need active monitoring and complex care.**"
- **Findings**: "Workload was measured as time, number of visits or both. The predictive factors of the workload included variables related to patient characteristics and other valid and reliable patient classification systems, as well as characteristics of the institutions where the studies were conducted. The factors associated with higher workloads were: being older, male, living in a rural environment, presenting a higher number of diagnoses, having worse functional status and being unable to assume self-care."
- **Conclusions**: "**The identified predictors of workload are mostly associated with home nursing care.** The results could be useful and applicable to different organisational models of HaH health systems. More studies that include physicians and proxy measures of workload are needed."

Reviews

Cherukara et al, 2025. **Bringing heart care home: management of acute cardiovascular pathologies in the Home Hospital**, European Heart Journal. Acute Cardiovascular Care, Volume 14, Issue 6. (LINK)

- **Study type**: Review

- **Aim**: "…outlines a blueprint for acute cardiac care in HH, focusing on heart failure, atrial arrhythmias, and venous thromboembolism while emphasizing the critical role of patient selection, recruitment strategies, management protocols, and escalation criteria."; "These protocols are intended as suggested guidelines, serving as a foundation for further refinement and adaptation to specific health system needs."
- **Definitions**:
    - "**Home Hospital** is an evidence-based healthcare delivery model in which patients receive acute, hospital-level care at home as a substitute for traditional BAM wards. It offers comprehensive medical services, including 24/7 accessibility, physician-led management, nursing care, specialty consultations, intravenous (IV) medications, diagnostic testing, and most other services typically available in a BAM setting. Home Hospital is distinct from outpatient community care (e.g. complex chronic disease management or home care); it provides care that would otherwise require hospitalization if the HH programme were not available."
    - "**In Canada, this model has emerged in several provinces, but regulatory standards have yet to be established**"
- **Includes sections on**:
    - Overview of Home Hospital; **Scaling Home Hospital**; Home Hospital capabilities; Admission settings; Patient selection; Clinical team; Workflow; Remote monitoring; Escalation
    - Evidence base for Home Hospital
        - Discuss the following conditions: (i) heart failure (HF), (ii) atrial arrhythmias, and (iii) venous thromboembolism (VTE).

Denecke & Reichenpfader, 2024. **Preparing for Hospital at Home: A Review of the Current Landscape of Training Practices**. Stud Health Technol Inform. 22;321:48-52. (LINK)

- **Study type**: Review
- **Aim**: "to consolidate the information of HaH-related education and training to support the development of standardized curricula to ensure safe hospitalization at home"
- **Definitions**:
    - **"**According to Public Health Scotland, **Hospital at Home (HaH, also home hospitalization) is a care model in which a patient is treated "in their own bed rather than occupying a hospital bed and is managed by a dedicated team with clear lines of clinical responsibility identified.** The activity would otherwise be delivered in a hospital setting"
- **Methods**: "We compiled relevant information from the scientific literature on HaH approaches and studies and conducted a web search."
- **Findings**: "**Our results indicate that healthcare professionals are trained in short training sessions, covering specific skills needed in the HaH context. These skills comprise, among**

others, communication, medication safety, infection control, and wound care. Patients and their families receive training in recognizing symptoms of deterioration and self-care. **Concrete guidelines or standardized training programs are still missing**."

Kadakia et al, 2022. **Hospital-at-Home: Multistakeholder Considerations for Program Dissemination and Scale**. Milbank Q. 100(3):673-701. (LINK)

- US based
- **Study type**: Review
- **Description**: "the National Academy of Medicine (NAM) convened a multistakeholder meeting to discuss the post-pandemic future of acute care, with a particular focus on Hospital-at-Home (HaH) as an alternative to facility-based approaches. The meeting's objectives were to (1) define the current scope of HaH care models, (2) create a shared understanding across stakeholders of the priority areas and challenges for HaH, and (3) identify sector-specific levers to maximize HaH's benefits and scalability."
- **Definitions and Model Components**:
    - HaH programs are defined by the presence of several operational features.
        - First, **the model must substitute a portion or the entirety of inpatient acute care with hospital-level, at-home treatment**. This acuity criterion distinguishes HaH from other home-based care models. For example, some home-based models are specific to nonacute services (e.g., hospice care) or are intended to be longitudinal (e.g., home-based primary care), as opposed to episode based. In terms of staffing, multidisciplinary teams composed of the same types of providers as in traditional inpatient care (e.g., physicians and nurses) are typically deployed, along with other allied professionals as needed (e.g., physical therapists). HaH clinicians also frequently leverage a combination of digital technologies, such as remote patient monitoring (RPM), mobile apps, and enhanced video visits. A potential benefit of HaH is its flexibility to integrate wraparound services (e.g., meal deliveries) tailored to a patient's needs and social context.
        - Second, HaH models **must be limited to a specified geographic catchment area** because in the event of clinical deterioration, proximity to the hospital facilitates timely care escalation. In contrast, other home-based care models have a lower risk of rapid escalation due to the stage of intervention (e.g., chronic disease management) or level of service intensity (e.g., community-level services)."
- See **Table 2** for Sector-Specific Policy Considerations for Hospital-at-Home from different stakeholder perspectives

Primary Studies

Bradley et al, 2026. **Factors affecting implementation of hospital inpatient-level care at home: a qualitative study of virtual wards in North West England**. BMJ Open.16(4):e111868. (LINK)

- Conducted in one regional health and social care system in North West England, UK.
- **Study type**: Qualitative semi-structured interviews with implementation leads
- **Aim**: "To identify key factors influencing the implementation of technology-enabled virtual wards (VWs), also known as hospital at home, drawing on the qualitative accounts of stakeholders involved in implementation, using the updated Consolidated Framework for Implementation Research (CFIR) as a guiding analytical framework."
- **Definitions**:
    - "**Virtual wards (VWs), often also referred to as Hospital at Home (HaH**), have emerged as a key component of wider healthcare system strategies to address overwhelming demand on hospital inpatient and urgent and emergency care. **These services aim to provide acute clinical services to patients in their usual place of residence, equivalent to that received in acute inpatient hospital care. They may be used to prevent the patient being admitted into hospital ('step-up' approach) or to support early discharge from hospital ('step-down' approach)."**
    - **"**Various forms of VWs/HaH models have been in operation for several years in the UK and other countries. However, **in April 2022, the National Health Service (NHS) in England introduced a large-scale national VW programme, with an allocation of up to £450 million of funding**. **Key components of the NHS England (NHSE) model of VWs include**: clinical oversight from a consultant physician/practitioner or general practitioner (GP); technology-enabled care, including remote monitoring; hospital-level diagnostics and intervention/treatment; time-limited with a recommended length of stay up to 14 days; and intended for acute care not safety netting or intermediate care.3 Throughout this paper we use the term VW to refer to both VW and HaH service."
- **Methods**: "Qualitative semi-structured interviews with implementation leads. All interviews were conducted online, using MS Teams or Zoom, between January–June 2024, and audio-recorded with consent….The updated CFIR was used to guide thematic analysis of interview data."
- **Findings**: "20 interviews were conducted with 22 participants. **Four implementation themes were identified: (1) complexity and adaptability**: the ability to adapt the service to local conditions was valued by leads, but also contributed to wide variation in operational, clinical, workforce and digital components of VW models; **(2) resource and infrastructure**: workforce capacity was identified as a key implementation challenge along with information technology system capability and interoperability; **(3) performance demands**: leads were concerned that an excessive focus on bed numbers and occupancy levels, without accounting for patient acuity, could negatively affect implementation, straining the service and staff capacity; and (**4) readiness for change**: organisational and professional readiness for change was considered crucial for increasing referrals and enabling successful implementation, yet leads reported that the level of behavioural and cultural change required had been underestimated."
- **Conclusions**: "**Implementation of a national VWs programme has resulted in wide service variation in one UK region, which raises questions about service equity and poses challenges for wider programme evaluation**. Despite this variation, common factors found to help or hinder implementation have been identified. This study provides greater understanding of the

factors that influence the implementation of VW services and outlines actionable insights to help refine VW strategies. These insights can support future planning and sustainability of technology-enabled inpatient-level care at home more widely."

Desai, Grinman et al, 2026. **Hospital Care at Home for Adults Living in Rural Settings: A Qualitative Evaluation**. J Rural Health. 42(3):e70199. (LINK)

- Includes 1 Canadian site - Wetaskiwin Hospital and Care Centre (Wetaskiwin, Alberta, Canada)
- **Study Type:** Qualitative evaluation
- **Aim: "**Describe the perceptions of patients receiving rural home hospital (RHH) care."
- **Definitions**:
    - "**Home hospital (HH) models** … a patient receives care for their acute illness at home, instead of in the brick-and-mortar (BAM) hospital. HH typically includes daily in-home and/or virtual visits from the care team, monitoring of vital signs, 24/7 in-home response, and portable diagnostics.
    - "RHH [rural hospital at home] programs provided patients with twice-daily nurse/paramedic visits, daily physician visits (remote), hospital-level diagnostics and treatments in the home, and other care tailored to the patient."
    - **Rural**: "For the RHH RCT Canadian site Alberta Health Services (AHS), the following definition of "rural" based on the 2018 AHS/Alberta Health (AH) official standard geographic areas was used. Rural includes "Large Rural Centers and Surrounding Areas" as defined by the AHS/AH [17]: 10,000 to less than 25,000 population (Brooks, Canmore, Wetaskiwin, Camrose, Lloydminster, Cold Lake)."
- **Methods: "**This is a qualitative evaluation of a randomized controlled trial comparing RHH (intervention) versus brick-and-mortar (BAM) care (control) in **three rural sites in the United States and Canada** between February 23, 2022, and January 17, 2024. Participants include acutely ill patients who received RHH. RHH programs provided patients with twice-daily nurse/paramedic visits, daily physician visits (remote), hospital-level diagnostics and treatments in the home, and other care tailored to the patient. Patient experience while receiving RHH care analyzed thematically to identify advantages and disadvantages of this model of care in the rural setting."
- **Findings: "**We interviewed 38 of 79 RHH patients recruited to our randomized controlled trial. Mean age was 67 (SD 17), 100% were White, 29% female, 82% Medicare recipients, and 62% retired. **Patient perceptions clustered around three main themes: (1) perceived quality of care; (2) perceived comfort; and (3) experience with technology. Overall, home hospitalized patients were satisfied with the care they received at home.** This was driven by strong rapport with the care team and receiving safe and effective medical care in the comfort of their home. Patients noted perceived comfort from familiar home surroundings and improved social support, nutrition, and sleep. Patients felt technology facilitated their experience and noted it presented a learning curve and occasional barrier to care."
- **Conclusions: "**RHH **patients reported positive patient experiences principally across perceived quality, comfort, and technology, with some opportunity for improvement in technology interfaces for select patients**."

Magel T et al, 2026. **Guidance for Building Hospital at Home: Qualitative Descriptive Thematic Analysis of a Pan-Canadian Community Participatory Workshop Series** J Med Internet Res;28:e88921. (LINK)

- Conducted in Canada
- **Study type**: descriptive, qualitative study
- **Aim:** "to synthesize key interest holder–generated perspectives about the implementation, sustainability, and equity of HaH models in Canada using data generated through a national participatory workshop series."
- **Definitions**:
    - "While there are several models for designing and implementing HaH, **most follow an extended nursing care model**, **where nurses (or paramedics) perform daily home visits and an overseeing physician provides daily assessments, either remotely or in person**. The program offers hospital-level treatments, monitoring, and diagnostic services in the relative comfort of the patient's home. When receiving care in an HaH model, patients often have shorter treatment durations, lower hospital readmission rates, and better clinical outcomes than those receiving in-hospital treatment."
- **Results**: "Three themes were constructed from the data: **(1) making HaH work for health care systems, (2) making HaH work for its people, and (3) making HaH better now and in the future**. Participants reported generally positive outcomes and high satisfaction with HaH programs in Canada. Participants highlighted the **need for clear communication and collaboration across care teams, technology support for staff, managing health care provider and caregiver workloads, and ensuring access for rural and remote communities**. **There is a need to better understand the economic sustainability of the HaH program and to study and share outcomes from HaH models to help others and refine the model**."
- **Conclusions**: "Our findings highlight the importance of equity, communication, care workloads, and fiscal sustainability in supporting HaH models."

McGlen et al. **Enablers and Barriers Affecting Implementation of Hospital at Home Services in England – A Regional Qualitative Study of Hospital at Home**. The Journal of Advanced Home Medicine. 2026;1(1):14-26. (LINK)

- Conducted in the NHS England
- **Study type**: comparative qualitative case study
- **Aim**: "To explore the key factors that enable or impede the successful development and implementation of HaH services within the English NHS, focusing on provider and system-level influences."
- **Definitions**:
    - "**Virtual Wards** were initially conceived as a technology-supported remote monitoring system, rather than delivering acute multidisciplinary care at home. However, the NHS England 2024 operational framework has renamed these services 'Hospital at Home' and changed the specification so that the care model is closer to the internationally recognised HaH definition."

- **Design/Intervention**: "A comparative qualitative case study design was employed, involving in-depth data collection across eight HaH services within three Integrated Care Systems (ICSs) in England. Data was collected from 81 interviews with clinicians, policymakers and managers along with observations and documentation."
- **Setting**: "The study was conducted in multiple HaH services operating within ICSs in England, encompassing diverse organizational and service delivery contexts."
- **Results: "**The results revealed **five key themes: adaptation of clinical practices for home-based care; Influence of change agents and leadership experience; access to resource and support, including staffing and digital infrastructure; governance structures, with innovation-friendly policies supporting progress; shared learning and collaboration with hospital-based clinicians**"
- **Conclusion:** "The successful implementation of HaH services depends on dynamic adaptation of clinical practices, effective leadership, supportive governance, and ongoing cross-sector collaboration. These findings offer practical insights for healthcare leaders and policymakers aiming to expand HaH and similar home-based care models within complex healthcare systems."

McGowan et al, 2026. **Commissioners' views and experiences of implementing virtual wards in Integrated Care Systems in England: a longitudinal qualitative study using the Consolidated Framework for Implementation Research (CFIR).** BMC Health Serv Res. 27;26(1):1027. (LINK)

- Conducted in the UK
- **Study type**: Longitudinal qualitative study
- **Aim**: "to investigate **commissioners' perceptions and experiences of implementing VWs** in integrated care systems (ICSs) in England, with a particular focus on changes and continuities in implementation influences over time."
- **Methods**: "A longitudinal qualitative design was adopted. Semi-structured interviews were conducted via Teams with commissioners involved in the implementation of VWs at two timepoints (TP) six months apart; TP1 (n = 20) and TP2 (n = 14). Interviews focused on perceptions and opinions of the VWs programme, including barriers and facilitators to successful implementation. Data were analysed using the Consolidated Framework for Implementation Research (CFIR) in line with the Framework Method. The CFIR comprises five domains: Innovation, Outer Setting, Inner Setting, Individuals, and Implementation Process."
- **Findings**: "Implementation progress diverged across sites at follow-up, with some scaling back due to challenges while others expanded their VW programs. On a domain level, **Inner Setting (ICS) constructs appeared most influential on implementation over time, with constructs in the Individuals domain seemingly becoming less important**. The **main barriers to implementation included**: limited staff capacity, recruitment issues, and inefficient communication and interoperability of systems (Inner Setting); uncertainty around long-term funding (Outer Setting); inequalities in patients' home circumstances and lack of buy-in from clinicians (Individuals); and lack of detailed implementation planning (Implementation processes). **Key facilitators included**: building on existing similar services (Innovation); collaborative working (Inner Setting); and national guidance (Outer Setting) with flexibility to adapt to local contexts (Implementation Process). Commissioners perceived patient acceptability to be generally high, with a reported preference for receiving care at home."

- **Conclusions:** "**Buy-in from clinicians, collaboration, detailed advanced planning on an ICS level, and sustainable funding are particularly important for implementation of VWs. To avoid generating inequalities, tailored additional support should be provided to disadvantaged patients.** Directions for future research includes exploring the perspectives of clinicians."

de Oliveira CF et al., 2026. **Advanced Home Medicine in Ibero-America - A Cross-National Comparative Survey of Regulations, Service Models, and Quality Standards**. The Journal of Advanced Home Medicine. 1(1):27-35. (LINK)

- Conducted in Ibero-American (Brazil, Colombia, Chile, Argentina, and Spain)
- **Study Type**: cross-sectional survey
- **Aim**: "To analyze and compare home-based care models throughout Ibero-America, identifying differences in regulatory frameworks, service provision approaches, and quality assurance measures.
- **Definitions**:
    - "..there is a **limited international consensus on standards and heterogeneous regulations combined with the rapid expansion of home-based healthcare**, such as:
        - **Home-Based Primary Care (HBPC)** defined as the provision of primary care within the patient's home, with a primary emphasis on the continuous management and follow-up of chronic diseases;
        - **Advanced Home Medicine (AHM)** extends this concept by integrating high-complexity medical services into the home setting, encompassing remote monitoring, multidisciplinary support, and seamless continuity of care; and
        - **Hospital at Home (HaH) that constitutes a model of home hospitalization in which patients receive comprehensive medical care equivalent to that of an inpatient hospital stay, but without the necessity of physical hospital admission.**"
    - "Although this paper broadly refers to home-based care, **its primary focus is on advanced home care models - that is, care models that provide higher-intensity, more complex health services in the home setting, often serving as a substitute for hospital-level care**."
- **Methods**: "A cross-sectional survey was **conducted with senior professionals from Brazil, Colombia, Chile, Argentina, and Spain**, **who ranked 32 criteria across six categories** (regulation, financing, service models, technology, quality standards, and training) using a 5-point Likert scale. Descriptive statistics and the Kruskal–Wallis H test were used to evaluate inter-country differences."
- **Results**: "Data collected in November–December 2024 revealed significant cross-country differences in the implementation of home-based care ($p = .015$). Brazil and Colombia showed the highest overall scores, surpassing Spain, Argentina, and Chile. Despite these differences, countries generally reported high scores on questions about quality standards and service models, and low scores on questions about training. Greater variability was observed in

responses related to financing, regulation, and technology, indicating inconsistent implementation in these aspects of their care models."

- **Conclusion**: "The **study highlights critical disparities in the implementation of advanced home care across Ibero-America**, **with uneven development in regulatory frameworks, financing, digital infrastructure, and workforce training**. Based on these survey findings, coordinated regional efforts —potentially led by institutions such as ASIADES (Ibero-American Association of Home Healthcare) — could promote common standards, knowledge exchange, and sustainable models of care."

Reynolds et al, 2026. **Virtual Home Hospital Postpartum Hypertension Care: The Patient Experience**. J Obstet Gynaecol Can. 48(6):103265. (LINK)

- Specific to Alberta's Virtual Home Hospital
- **Study type**: mixed-methods approach employing an experience survey with quantitative and qualitative questions
- **Background**: "The Edmonton Zone Virtual Home Hospital (VHH) program piloted a multidisciplinary care pathway for postpartum HTN care in the community, integrating remote patient monitoring and in-home acute care using specialist physician, nursing, pharmacist, and community paramedic support."
- **Aim**: "This study highlights patient experiences with this novel care model."
- **Definitions**:
    - "**Virtual home hospital (VHH) models** offer an innovative approach to delivering multidisciplinary, hospital-level care in home-based settings.These models combine RPM with in-person services, aiming to enhance accessibility, convenience, and the overall patient experience. The **Alberta Health Services Edmonton Zone VHH (the Edmonton Zone VHH) is an example of this innovative approach.** This program is a multidisciplinary team that provides moderately acute level care to patients virtually within the comfort of their own homes. Recognizing an unmet need for the care of patients with postpartum HTN, **local obstetric services partnered with the Edmonton Zone VHH to pilot an at-home care pathway for postpartum HTN management (the Virtual Postpartum HTN Pilot). This care pathway integrates physicians, nurses, and pharmacists from the Edmonton Zone VHH with community paramedics and obstetric care teams, and to the best of our knowledge, is the first Canadian model to provide this multi-disciplinary team-based approach to postpartum HTN care at home."**
- **Methods**: "A mixed-methods approach employing an experience survey with quantitative and qualitative questions, distributed to eligible postpartum patients from November 2022-April 2023. Descriptive statistics and inductive thematic analysis were used to examine survey results."
- **Results**: "**Most of the 22 respondents reported being satisfied with their care** (73% very satisfied; 23% satisfied) and **4 key themes emerged: benefits of being at home, care team support, self-management, and experiences with technology.** Patients felt involved in care

decisions, prepared to manage their condition upon program discharge and would recommend this care model to others. Patient concerns were mitigated through rapid team response and personalized support."

- **Conclusions**: "The Virtual Postpartum HTN Pilot elicited high patient satisfaction and delivered hospital-level postpartum HTN care at home. This patient-centred pathway addressed key barriers to postpartum care, positively impacting accessibility, comfort, and convenience, while extending active acute management into the community. The innovative Edmonton Zone VHH model demonstrated strong potential for broader implementation to other patient populations well-suited to virtual care."

Spina et al, 2026. **Patient, Family Caregiver and Health Care Provider Experiences With a Hospital at Home Program in British Columbia, Canada**. Qual Manag Health Care. Jan 30. (LINK)

- Specific to British Columbia's Island Health Hospital at home program
- **Study type**: prospective survey
- **Aim:** "In this paper, we discuss the results of implementing a prospective survey over 18 months (October 2021-April 2023) using a convenience sample method to assess patient and FCG experiences with the Island Health HaH program and give an overview of HCP experience"
- **Island Health HaH program**:
    - began "in November 2020 to increase hospital capacity and provide an alternative to in-hospital care. The program started with nine inpatient "beds" registered at Victoria General Hospital."
    - "In March 2021, the program expanded to another Island Health site, **Royal Jubilee Hospital**, with an additional nine inpatient "beds.
        - The program provides acute care medical services to patients in their own homes, by a team made up of family-medicine hospitalist physicians, clinical nurse leaders, clinical pharmacists, registered nurses, occupational therapists and a physiotherapist.
        - Around-the-clock care coverage is provided to HaH patients, including scheduled and unscheduled in-person visits.
        - Technology includes a mobile tablet computer that connects to the blood pressure monitor/cuff, pulse oximeter, temporal thermometer, and weight scale. These devices allow the patient to take vital signs at home and for the team to remotely monitor the patient using Bluetooth technology. The mobile computer also allows for virtual visits with a member of the HaH care team.
        - Blood samples are collected by nurses in the home and taken to the hospital lab for processing. Medical imaging and reassessment by a specialist if needed is facilitated with transport services to and from the hospital. If a family caregiver (FCG) is present, their role includes assisting the patient with care needs, taking vital sign measurements, administering medications, assisting with intravenous

care, communicating with healthcare providers (HCP), driving the patient to appointments if required, and assisting with daily living activities."

- **Methods**: "Patient and FCG experience are reported among many themes, such as admission, care quality, medication management, technology, intravenous treatment/infection prevention, discharge, FCG roles and responsibilities, and overall experience."
- **Results**: "This paper reports that **100% of patients** (n = 266**) and 98% of FCG** (n = 142) **would recommend HaH to their friends and family**, and 98% of patients (n = 262) and 97% of FCG (n = 144) would choose to be admitted to HaH if they were in the same position again. Similarly, 100% of HCP (n = 40) would recommend HaH to friends/family who require care and meet the criteria. Overall, patients, FCG and HCP continued to report having a positive experience with the HaH program and provided vital feedback for further improvement."
- **Conclusion**: "The HaH model of care is newly implemented in hospitals in Victoria, BC, Canada, and has been shown to positively impact the experience of patients, FCGs, and HCPs."

Tierney S, Spina SP et al. 2026. **A Tool for Predicting the Risk of Escalation in Hospital at Home**. The Journal of Advanced Home Medicine. 1(1):58-65. (LINK)

- Specific to British Columbia's Victoria Hospital at Home program
- **Study type**: retrospective chart review
- **Aim**: "The aim of this study was to identify independent risk factors for escalation, with the goal of creating an escalation risk prediction tool."
- **Definitions:**
  - "**Hospital at Home (HaH)** is an emerging model of acute care that can be offered to stable patients in lieu of a brick-and-mortar (BAM) hospital admission. In an effort to standardize the global practice of HaH, the Scientific Committee of the World Hospital at Home Congress released its definition of HaH in 2023"
- **HaH Program Victoria BC**
  - "In 2020, the Canadian city of Victoria, British Columbia began an adult HaH program that complies with the WHAHC definition of HaH. The Program operates as an inpatient medical unit of the local tertiary care hospital, providing in-person nursing visits, virtual and in-person physician visits, and 24-hour patient support through the availability of an on-call nurse and physician who can perform home visits after hours. The **Patient Eligibility Criteria are listed in Table 1**, with different criteria for patients who live with a caregiver and those who live alone. The Program accepts physician referrals for patients who are presently admitted to the hospital. The Program uses intermittent remote vital sign monitoring technology. The Program does not provide soley palliative care because that service is provided by a separate community palliative care program. It does, however, treat patients with a reversible illness who also have an underlying palliative diagnosis such as metastatic cancer."
- **Methods**: "We performed a retrospective chart review of 1000 consecutive cases over approximately one year in an HaH program for 11 hypothesized clinical and demographic risk factors. A logistic regression analysis was used to identify which factors were independent risk factors for escalation. The linear regression model was used to generate a percentage risk of

escalation for each combination of risk factors. We also used the model to create a Web-based tool that provides a patient's risk of escalation based on their risk factors."

- **Setting**: "The HaH Program in Victoria, British Columbia, Canada, which operates as an adult inpatient medical unit, and provides a mixture of in-person and virtual nursing and physician care to acutely ill adults referred from the BAM hospital. The Program uses remote patient monitoring and provides 24/7 support."
- **Outcomes**: "Clinical and demographic risk factors for escalation, and the risk of escalation for each combination of risk factors."
- **Results:** "**Advanced cirrhosis, severe heart failure, frailty, metastatic cancer and male gender were identified as independent risk factors for escalation**. The risk of escalation increased as the number of risk factors increased, from 4.1% (no risk factors) to 95.0% (all risk factors). Advanced cirrhosis was associated with a very high risk of escalation. **The following factors were not identified as escalation risk factors: advanced age, end stage lung disease, severe renal failure, transplant status, being on chemotherapy and living alone**."
- **Conclusion:** "Some, but not all, end stage comorbidities and male gender appear to be escalation risk factors in a Canadian adult medical HaH program, and a patient's risk of escalation may be predictable based upon their risk factor profile. Advanced age and living alone did not increase the risk of escalation. These findings require validation by other HaH programs."

Wong et al, 2026. **Hospital-at-Home for South Asian Communities in British Columbia, Canada: Qualitative Interview Study**. JMIR Hum Factors. 5;13:e79675. (LINK)

- Specific to British Columbia's Fraser Health Hospital at Home
- **Study type**: qualitative study using semi structured interviews
- **Aim**: "to explore the experiences of South Asian community members with in-person hospital care and their perceptions, attitudes, and expectations regarding virtual Hospital-at-Home services, with the goal of identifying culturally tailored strategies to improve access, quality, and satisfaction."
- **Definitions:**
    - "virtual **hospitals-at-home** (commonly referred to as simply Hospital-at-Home) provide an alternative to traditional "brick and mortar" hospital admissions, allowing patients to receive the care they need from the comfort of their own home"
- **Methods**: "A qualitative study using semistructured interviews was conducted with 20 South Asian community members in the Fraser Health region in British Columbia, Canada. Interviews explored experiences with in-person hospital care, perceptions of a virtual hospital service (also known as Hospital-at-Home), and recommendations for enhancing awareness and accessibility. Interviews were audio-recorded, transcribed, and analyzed thematically to identify key patterns in perceptions, experiences, and needs."
- **Results**: "**Participants described multiple systemic barriers to in-person hospital care, including long wait times, overcrowding, transportation challenges, and difficulty navigating the health system**. Cultural and religious needs, such as gender-concordant care and culturally appropriate food, were frequently unmet, while language-concordant care and family involvement were

critical to positive experiences. Discrimination and assumptions based on ethnicity or age further shaped perceptions of care. Virtual hospital services were valued for convenience, comfort, reduced exposure to hospital-acquired infections, and support for family involvement. However, participants raised concerns about clinical quality, the absence of physical examinations, digital literacy, privacy, and home-based responsibilities. Acceptance varied by age, immigration status, and familiarity with technology. Participants emphasized the importance of culturally tailored outreach, leveraging community leaders, ethnic media, and peer testimonials to increase awareness and trust."

- **Conclusions**: "South Asian patients and caregivers recognize both challenges in traditional hospital care and potential benefits of Hospital-at-Home services. Implementation strategies that address systemic barriers, integrate cultural and linguistic considerations, and engage trusted community networks are essential to improving equity, access, and satisfaction. Findings highlight the need for culturally responsive, patient-centered approaches in the design and delivery of virtual health services for racialized populations."

Denecke, K, 2025. **Mapping the landscape of Hospital at home (HaH) care: a validated taxonomy for HaH care model classification**. BMC Health Serv Res 25, 84. (LINK)

- **Study Type:** Taxonomy
- **Aim**: "This paper introduces a comprehensive taxonomy of HaH care models, aiming to categorize and compare the various ways HaH services are delivered as an alternative to traditional hospital care."
- **Definitions:**
    - "According to the definition of the World Hospital at Home Community, "**Hospital at Home/ Hospital in the Home** (HaH) is an acute clinical service that takes staff, equipment, technologies, medication and skills usually provided in hospitals and delivers that hospital care to selected people in their homes or in nursing homes. It substitutes for acute inpatient hospital care"
- **Methods: "**We developed a taxonomy of characteristics for HaH care models based on scientific literature and by applying a taxonomy development framework. To validate the taxonomy, and to analyze the current landscape of HaH models we matched the taxonomy to HaH care models described in literature. Finally, to identify types of HaH care implementations, we applied the k-means clustering method to care models represented using the taxonomy."
- **Results**: "Our taxonomy consists of **12 unique dimensions structured into 5 perspectives following the progression from triaging, through care delivery, operational processes, and metrics for success: Persons and roles (2 dimensions), Target population (1 dimension), Service delivery and care model (6 dimensions), outcomes and quality metrics (2 dimensions), and training and education (1 dimension).** Cluster analysis of 34 HaH care models revealed three distinct types: One cluster (50%, 17/34) focuses on patient eligibility and home environment suitability, a care model to be chosen for clinically complex patients. A second cluster (29.4%, 10/34) aggregates technology-enabled models using telemedicine and remote monitoring that are adaptable across settings. This type could be chosen for generalizable care. The third cluster

(20.6%, 7/34) includes complex interventions involving informal caregivers and advanced medical devices, requiring caregiver training, supportive policies, and user-friendly technology to reduce caregiver burden and improve safety."

- **Conclusions**: "The clusters identified highlight practical considerations for adapting HaH care approaches to patient and contextual needs. These findings can guide policymakers in developing guidelines and assist practitioners in tailoring HaH care models to specific patient populations. The challenges encountered in collecting information on different characteristics of the taxonomy underscore the urgent need for more comprehensive and standardized reporting in scientific papers on HaH interventions."

Litchfield et al, 2025. **Factors Influencing the Implementation of a Multispecialty Virtual Ward Program in the United Kingdom: Qualitative Exploration of Staff Experiences and Perspectives**. J Med Internet Res. 19;27:e75406. (LINK)

- Conducted in the UK
- **Study type**: Qualitative study
- **Aim**: "to explore the experience of staff involved in designing, developing, and delivering VWs as part of the national program, in order to understand the factors that influence their implementation and sustainability."
- **Definitions**:
    - **Virtual Wards**: "These combine digital and analog tools and monitoring systems with teams of multidisciplinary care providers to support patients in their place of residence who might otherwise be cared for in a hospital."
- **Methods**: "Qualitative data were collected through semistructured interviews with staff and senior stakeholders involved in developing, leading, and delivering the virtual ward program within one of the largest integrated care systems in England. Data were analyzed using directed content analysis, informed by the Non-adoption, Abandonment, Scale-up, Spread, and Sustainability (NASSS) framework."
- **Findings**: "We interviewed 20 participants from clinical and nonclinical roles, including service transformation leads, program leads, physiotherapists, nurses, and consultants. Using the NASSS framework, **we identified several key findings: patient context** was as important as clinical criteria in determining referral suitability **(Condition)**. **Stand-alone digital monitoring solutions with offline capability** improved accessibility **(Technology)**. While benefits to patient rehabilitation and hospital capacity were widely understood, concerns over the lack of evidence remained (Value proposition). **Clearer messaging about the nature and benefits of VWs was needed for patients and carers, and staff** described challenges with remote care and shared responsibility across settings (Adopters). **Pre-existing collaborative arrangements helped but varied by specialty (Organizations).** NHS targets and metrics of success were considered unrealistic **(Wider system)**. Finally, participants recommended more coherent regional planning that involved consultation with patients **(Embedding over time)."**
- **Conclusions:** "If the United Kingdom's VWs program is expected to move forward, **it requires patients, their families, carers, and staff to receive coherent messaging of their responsibilities and benefits. Targeted training and ring-fenced time for staff would help, as would the**

provision of purposely designed patient-facing technologies. Finally, **extended planning and funding cycles are needed to gather robust evidence and refine VWs, ensuring better integration with existing services that incorporate the needs and preferences of patients from various sociocultural backgrounds**."

Karlsen et al, 2024. **The experiences of hospital staff with decision-making concerning patient enrolment in hospital at home services: A complex and dynamic process**. PLoS One. 19(9):e0310820. (LINK)

- Conducted in Norway
- **Study type**: Semi structured interviews
- **Aim**: "to explore the experiences of hospital staff in the decision-making process concerning patient enrolment in hospital at home."
- **Definitions**:
    - **Hospital at home:** "also referred to as Hospital in the Home, Home Hospital, Home Hospitalization, and Hospital-based Home Care. HaH offers an alternative care setting for individuals who would otherwise require hospitalization, providing acute hospital-level care at home for patients stable enough to be at home [3, 6, 7]. This helps alleviate the demand for hospital beds."
    - "**Approaches to HaH vary widely both within and across countries and healthcare settings**, including variations between high-income versus low-to middle-income countries, single-payer versus multiple-payer systems, and urban versus regional or rural contexts. **Differences also exist in referral mechanisms, boundaries with other services, and definitions of HaH. Under the HaH umbrella, programs differ in the illnesses and patient groups they address, the interventions they provide, and the stakeholders involved in care delivery. Additionally, the duration of treatment, the technology involved, organizational structures, and funding mechanisms vary**."
- **Methods**: "In total, 22 semi-structured individual interviews were conducted with hospital staff members between January and May 2022 at the participants' workplace or in a public office depending on their preferences. Data were analysed using reflexive thematic analysis."
- **Results:** "We identified four themes pertaining to the experiences of hospital staff with the decision-making process concerning patient enrolment in hospital at home: "beneficial for the patients; an important motivating factor", "patient eligibility; prioritizing safety", "contextual factors within hospital ward units; opportunities and limitations", and "collaboration with municipalities; crucial but challenging".
- **Conclusions**: "Hospital staff described a complex and dynamic decision-making process when considering patient eligibility for enrolment to hospital at home services**. The findings highlight both barriers and enablers pertaining to this process and emphasize the need to provide support to hospital staff as they navigate this complex situation**. **A key finding pertains to the critical importance of high-quality decision-making in ensuring positive outcomes and the overall effectiveness of hospital at home care services**. Additionally, this study proposes a deeper exploration of the ethical considerations associated with balancing the goal of patient

safety with that of equitable access to high-quality, person-centred care within the context of hospital at home."

Mathura P. et al, 2024. **Advancing a virtual home hospital: a blueprint for development and expansion**. BMJ Open Quality. 13:e003048. (LINK)

- Specific to Alberta's Virtual home hospital
- **Study Type: "**overview of the model's development and outline the progress achieved over a span of 5 years, from 2018 to 2022"
- **Aim**: "This study describes a dynamic approach to constructing a VHH and outlines the progress over 5 years."
- **Definitions:**
    - "**Virtual home hospital (VHH)** models deliver hospital-level care to patients with acute illnesses or chronic conditions safely managed at home, using a combination of remote and in-person care facilitated by digital technology. Eligible patients are typically discharged from inpatient hospital care to the VHH or admitted directly from the ED or their general practitioner (GP), avoiding a hospital stay."
- **Background**: "In 2018, a multicentre VHH was developed in Edmonton, Alberta, Canada, using an innovation lab approach, fostering collaboration among healthcare stakeholders for design, prototyping and testing. Over a 5-year period (2018–2022), the VHH underwent trial and adaptation using the Model for Improvement and the Dynamic Sustainability Framework, refining integrated care for a broader patient population. Within the VHH, patients received acute, hospital-level care at home, using technology, existing services and hospital and community personnel. **Outcome measures included number of patient cohorts, staffing numbers, patients served, capacity and hospitals/health centres supported**."

Spina et al. **Patients' and Family Caregivers' experiences with a newly implemented Hospital at Home program in British Columbia, Canada. – Part I: Preliminary results**. Patient Experience Journal. 2023; 10(1):93-106. (LINK)

- Specific to British Columbia's Hospital at Home
- **Study type**: review development of the survey instruments, present preliminary findings of the observational research study
- **Background**: "The Hospital at Home (HaH) model of care, which enables the provision of acute-level care in the patient's own home as an alternative to brick and mortar hospital admission, was introduced in British Columbia, Canada in November 2020, starting with 9 inpatient "beds" in the community. The AT-HOME research group applied a patient-oriented approach to evaluate the patients' and family caregivers' (FCGs) experiences with the program as it was implemented and expanded throughout Victoria, BC.
- **Aim**: "In this paper, we discuss the development of the survey instruments, including process and timelines (three phases); and present preliminary findings of the observational research study (six months of patient and FCG feedback data)."
- **Definitions:**

- "The **HaH model** provides acute level care in the patient's own home and is distinct from community health care services in that it provides a level of care that would traditionally require a hospital admission. Initially it was conceived to alleviate pressures on health care systems by increasing hospital capacity, however, over the years it has been recognized as a patient-centred care model that is preferred by many patients."

- **Hospital at Home Program Island Health and Royal Jubilee Hospital**
  - **"Island Health Hospital at Home program** aimed to develop a patient-centred model of care, by collaborating with patient partners and multidisciplinary stakeholders. The unit was implemented in November 2020 starting with nine inpatient "beds" registered at the Victoria General Hospital."
  - "The program was expanded to another Island Health site, the **Royal Jubilee Hospital**, in March 2021 by adding another nine "beds."
    - "The model was initiated by physicians and provides acute care to patients while they remain in their homes.
    - The medical services are provided by a team comprised of two family-medicine hospitalist physicians, two clinical nurse leaders, two clinical pharmacists and six registered nurses. After the first few months of implementation, an occupational therapist and rehabilitation assistant were also added to the team.
    - 24-hour care coverage is provided, including scheduled and unscheduled in-person visits. The use of technology, including a mobile tablet computer (e.g., iPad), blood pressure monitor and cuff, pulse oximeter, temporal thermometer and weight scale (optional), enable the patients to take their vital signs at home and the HaH team to remotely monitor the patient. Blood samples are collected by nurses in the home, and they are taken to the hospital laboratory for processing.
    - Patients have priority access to onsite diagnostics such as medical imaging. The program provides transport services from hospital to home as needed.
    - For the first six months of the program, the presence of an FCG at home and their consent in assisting the patient was a requirement for program enrollment. Ongoing reviews of the enrollment criteria were made as the program grew and one of the adjustments made was to waive the requirement of an FCG at home for certain patients.
    - The scope of the FCGs' roles includes assisting the patient with their care needs, taking vital sign measurements, administering medications, assisting with intravenous care, communicating with the health care providers (HCPs), driving the patient to appointments if required, and assisting with daily living activities, if these were not already part of their usual living arrangements."

- **Results**: "The **preliminary results show that 100% of patients (n=75) and 95% of FCGs (n=57) had an overall positive experience with the program** (rated 6-10 on a 10-point scale where 0 meant 'very poor' and 10 'very good'). **100% of these patients and 96% of these FCGs would recommend the program to their friends and family and 97% of these patients and 96% of these FCGs would choose the program again if faced with the same situation**. The preliminary results on metrics pertaining to care quality; information sharing and experiences with the admission and discharge processes; FCG's roles, medication management, and more are discussed here. The final results of the patient and FCG experiences will be reported at the end

of the data collection period. **We can conclude that this new HaH program has been positively received by patients and FCGs thus far and they support program expansion**"

Spina et al, 2022. **Engaging patients and families in developing, implementing, and evaluating hospital at home: A Canadian case study**. Patient Experience Journal. 9(1):217-226. (LINK)

- Specific to British Columbia's Hospital at home
- **Study type**: Patient Oriented research with survey
- **Aim:** "A multi-stakeholder, Patient Oriented Research team in Victoria, British Columbia, Canada engaged patients and family/friend caregivers (PFCs) across all components of the HaH program. Guided by best practices in patient and public engagement, the team collaborated to
    - 1) explore the potential impact of in-home acute care on PFCs' experiences;
    - 2) identify health, social, and practice outcomes that matter to PFCs;
    - 3) examine the social and environmental factors which may impact delivery of HaH; and 4) inform the HaH evaluation framework that includes PFC priority measures related to experience and outcomes.
- **Definitions:**
    - "The **Hospital at Home (HaH)** care model is naturally patient-centred, with improved patient and family experiences and outcomes firmly anchoring the innovative approach to care."
- **Findings**: "A public, online survey (n=543 PFC respondents) **revealed both program-specific and evaluation-specific themes**. These included a focus on patients achieving their own health goals and standard health outcomes, as well as patients and caregivers receiving training to support care at home. **Engaging PFCs throughout HaH conception and implementation ensured the end program accurately reflected the priorities, concerns, and values of those that HaH is meant to serve**."

Le et al, 2021. **The Hospital at Home Model vs Routine Hospitalization for Acute Heart Failure: A Survey of Patients' Preferences**. CJC Open. 4(3):263-270. (LINK)

- Conducted in Ontario
- **Study Type**: Survey of patient preferences
- **Definitions**:
    - "**Hospital at Home (HaH)** is a model in which hospital ward–level care is delivered to patients by healthcare professionals in their own homes. In HaH programs, patients are offered monitoring, visits from nurses and physicians at least daily, intravenous diuretics, and digital electrocardiograms in their homes. In the event of clinical deterioration requiring transfer to a traditional hospital, patients can either seek input from HaH personnel or self-trigger emergency transfer via ambulance services to the emergency department."
- **Methods:** "We administered a 9-item questionnaire on perceived effectiveness, safety, convenience, and acceptability of a HaH model among patients hospitalized for HF at **2 academic hospitals in Ontario**. The primary outcome was HaH care acceptability, defined as a preference for or neutrality to HaH care over routine hospitalization. We used partial Spearman rank

correlations (ρ) and multivariable logistic regression analyses to explore associations with outcomes.

- **Results:** "Of 297 eligible patients, 269 (90.6%) completed the questionnaire. The mean age was 76.2 (standard deviation, 12.3) years; 48.3% were female; and 70.5% lived in their own home, commonly with a relative or caregiver (67.9%). As many as 211 patients (78.4%; 95% confidence interval [CI] 73.0%-83.2%) found **HaH care acceptable**, **with 169** (62.8%; 95% CI, 56.8%-68.6%) **preferring HaH care over routine hospitalization**. Perceived convenience (ρ, 0.57; *P* < 0.001) and safety (ρ, 0.37; p < 0.001) were associated with HaH acceptability, whereas perceived effectiveness was not (ρ, 0.14; *P* = 0.021). A college (adjusted odds ratio [aOR], 5.96; 95% CI, 2.01-17.62; *P* = 0.001) or university (aOR, 3.58; 95% CI, 1.07-12.06; *P* = 0.039) education was associated with greater odds of HaH acceptability, whereas residing in a caregiver's home was associated with lower odds (aOR, 0.34; 95% CI 0.14-0.84; *P* = 0.019)."
- **Conclusions**: "A **majority of patients with HF perceived HaH care to be an acceptable alternative to routine hospitalization, prioritizing perceived convenience and safety over effectiveness**. Postsecondary education and living independently without caregiver support were associated with HaH acceptability."