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Innovative Approach to Establishing a National Home Hospice Service: The Case of Israel

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Abstract

As palliative care services across the globe struggle with creating a model of service that is financially viable and not dependent on donation based funds Sabar Health has created a national based hospice and home care unit that serves all sectors of the populations in all geographic areas of Israel. This model is financially stable and replicable in other parts of the world.

The business, service and medical model created by Sabar Health can serve as a blueprint for palliative care services worldwide. This article will review the process of creating Sabar Health and discuss how each of the challenges was overcome.

Keywords: Palliative care nursing; Palliative care; Hospice care

Background

In their research on palliative care in Israel, Bentur, Resnizky and Shnoor, 2005, found that less than 10% of the patients who were in need of receiving palliative care actually received it. The main reasons cited for this discrepancy were lack of funds and patient's knowledge about their right to receive palliative care.

Another problem appeared to be a myriad of providers involved concurrently in the patient's treatment. As a result, patients received different and varied levels of palliative care [1].

At the time of this study, there were seven home-based hospice care services in Israel. Five services were operated by two of the HMO's, two, operated by National Governmental Organizations (NGOs). All but one of these hospices operated in urban areas. Hospice services treated 20-30 patients daily and only serviced adults with cancer.

Sabar Health entered this scene in 2005 with a single doctor and nurse as an outgrowth of individual patient's requests to die at home. The vision of the organization was clear, "That people should have the option and the right to end their lives after having done their farewells and closures. They should also have the option to do this in their preferred environment."

Today, Sabar Health, a for-profit enterprise, encompasses four separate wards: home hospice, home rehabilitation, in home advance dementia/frail patients care, and home poly-morbidity hospitalization prevention ward.

As a nationwide service, geographic regions include densely populated urban centers and isolated farmers who live hours from organized medical services. Patients cross economic, religious and educational boundaries.

The home hospice ward is the largest ward in Sabar Health and in Israel. The teams treat over 3000 patients/year, with a mean hospitalization stay of approximately three weeks/patient.

The majority of patients have a cancer diagnosis, although there is a growing experience with end-stage amyotrophic lateral sclerosis, Dementia, Parkinson's disease, heart, lung, liver, and kidney failure patients.

Establishing a national home hospice service - The challenges

The main challenges facing attempts to establish a nationwide home hospice service include:

Government Support - backing of a system that will help move the agenda forward.

Sustainability - the need for any operating modal to be financially sound, cost effective, and viable.

Availability - the need to be on call 24/7/365. A hospice service cannot be closed for service.

Accessibility - the need to be able to provide services even in remote and rural regions, in a clinically appropriate time frame.

Universality - the ability to accommodate the needs of very diverse populations in religious, ethnic, cultural, and language aspects.

Professionalism - the need to ensure all staff members are carefully selected, receive the relevant competencies and are equipped with a very high set of service skills.

Continuity of care - the need for all patient records to be duly recorded, stored, and accessible to all relevant parties at all times.

Below is a look at the model that has been built by Sabar Health and the way that it addresses each of the obstacles to building palliative care units.

Government support

In 2005 the state of Israel passed the Dying Patient Law. Its central objective was to define the 'dying patient' (any patient that a physician has ascertained that he or she have a life expectancy of less than six months), regulate the medical treatment of the terminally ill patient based on an appropriate balance between the value of the sanctity of life, the value of the individual's autonomous will, and the importance of quality of life. It also delineates that there will be no active euthanasia of patients, no assisted suicide, no withdrawal of continuous medical treatment (mainly mechanical ventilation), and describes the provision of palliative care [2].

In 2009, the Israeli Ministry of Health issued a directive that required community health providers and hospitals to establish, within four years, palliative care and hospice services to all dying patients. The directive outlines the purpose, rationale, the patient populations served, the staff training required, and its implementation. In accordance with this directive, health providers in the community and hospitals had to develop and provide ambulatory and outpatient services and to initiate staff training. The palliative care and hospice services are to be available for patients in their homes, clinics, and hospitals on a 24 hour basis, 7 days/week. The directive also states that no extra government funding will be allotted for this purpose, since palliative care services are considered very cost effective and thus are a fund-saving service [3].

With Government support in place, it was incumbent upon the HMO's to find a way to provide this service and make it as cost effective and all-encompassing as possible.

Sustainability - The need for any operating modal to be financially sound, cost effective, and viable

All medical services are built on a three tiered model of delivery. There is the payer, the insurer and the provider. When the Israeli government mandated home hospice services, they took on the role of the payer. The four HMO's are the insurers, but the question that was not yet clear is who could be the provider. As the field was developing in Israel, each of the insurers tried to offer in house services by hiring their own teams to provide services. This did not prove cost effective. To provide nationwide service, would require each HMO to have three regions each with their own professional palliative care team. By building a model which all of the HMO's outsourcing to, we can have one team for each region. The Sabar Health model is built on the idea of economies of scale – the business may lose money on a particular patient or a particular region, but by providing nationwide service, the business itself can be profitable.

Availability - The need to be on call 24/7/365

A hospice service cannot be closed for service. There was limited palliative care access for patients in remote or rural areas. This problem stems from the sheer definition of palliative and hospice care being available 24/7/365 days/year. This accessibility places a large responsibility on health care professional staff calling for a working-in-shifts model, thus doubling or tripling the need for staff.

In addition, each of the four different HMO's needed to establish his own individual hospice operation thus, further raising the need for professional staff. It was obvious that there was a need to "think outside the box" and develop a working model to address the above challenges. Sabar Health created a home based model which is built on the theory of economies of scale. Staff members are divided into regions and service all patients in those regions. The services are contracted to all of the HMO's and anyone in the country who fits the criteria is eligible for service 24/7/365 at home. A hospice team includes are on call 24/7. By providing a dedicated hospice staff and a call schedule, the team is able to manage all technical issues during normal business hours but remain available and accessible for emergencies during evenings and weekends. Staff members receive tablets, cell phones and cars to help them with their accessibility.

By centralizing the services to one main body for all of the health funds, Sabar is able to hire full time staff people who can focus solely on their work without having to divide their hospice work among several different jobs. This results in better care, case management and reduces the risk for error that occurs in handing off patients to shift workers. As the main address, the staff has no room to think, "someone else will take care of it." They hold themselves accountable for the care of their patients 24/7.

When a referral is received in the main office, the patient and family caregiver are contacted immediately to verify administrative details and inquire as to the presence of a caregiver/caregivers, a basic requirement for home hospice care. The caregiver is a person (either a family member or a professional) whom is present and assumes responsibility 24/7. This is necessary because Sabar staff provide an outside structure which supports the patient living well at home. They do not take responsibility for basic needs like feeding, bathing, household chores and purchasing medications. The caregiver must also be able to perform basic medical or nursing procedures under the supervision of the Sabar Health team.

In the event there is no available caregiver, the Sabar team will assist the patient and family caregiver in organizing a professional caregiver or setting the parameters of how far the service extends. Through Israel's National Insurance, it is possible to receive funding for an in home health care aid. Sabar social workers can aid in this process.

Accessibility - The need to be able to provide services even in remote and rural regions, in a clinically appropriate time frame

Each patient and family caregiver are assigned a designated team, that includes a physician, nurse, and social worker. For the entire duration of the home hospitalization, the nurse will visit and place a phone call to the patient at least once/week; the physician will visit at least once every two weeks. All team members are on call and are able to make additional visits and emergency home visits within 3 hours of the call. The team's goal is to enable patients to remain at home until the end of their life, while alleviating, managing, and minimizing physical and spiritual suffering, thus, enabling patients, families, and significant others to have optimal closure.

The nurse or case manager will make an initial contact on the day the referral was received; his/her first home visit is within 24 hours. The doctor's first visit is within 72 hours; the social worker will perform an intake visit within the first week of admission and thereon continue on a need-to-visit basis, in accordance with patient's and family caregiver's needs. The team members are in touch on a daily and as needed basis, sharing important and relevant information with each other at all times.

Using the model of a dedicated staff, allows medical staff to be available for their patients. Originally, in Israel doctors and nurses were working in other settings such as clinics, nursing homes and hospitals and doing piecemeal work through individual insurance companies. This would cause palliative care to always be the "second job," which lowers their ability to fully invest in patients and fully

invest in continuing education. By creating a centralized body that works with all of the HMO's, Sabar can offer competitive salaries thereby elevating the profession of palliative care and the professionalism of the staff.

Access to medications

Physicians and nurses are equipped with a basic supply of medications and medical equipment to enable an immediate response to the medical needs of the patients. Medications include a variety of opiates, haloperidol, dexamethasone, clonazepam, anti-emetics, and midazolam. The latter is used in cases where palliative sedation is needed. All Sabar's prescriptions are accepted and dispensed by the HMO's pharmacies. Sabar Health does not manage a pharmacy. The teams are equipped and educated to perform necessary procedures such as urethral catheterization, abdominal tapping, maintenance of all central lines, and the treatment of wounds. In Israel, opiates are readily available through the HMO'S pharmacies, including the ability to order patient-controlled analgesia (PCA) as needed, directly to the patient's home. During a regular visit, physicians will leave prescriptions for medications that are running low or might be needed and are available to write prescriptions and be directly in touch with the pharmacy as needed.

Universality - The ability to accommodate the needs of very diverse populations in religious, ethnic, cultural, and language aspects

Sabar Health holds at its core the principles of kindness and respect to all human beings. The business model is built upon this platform and it informs both our hiring and treatment practices. As we are a central provider of home services, but not the only provider in the country, Sabar Health does not hire practitioners and does not accept patients that are unwilling to accept the diversity of our staff and patients. Thanks to this philosophy, which we believe is central to palliative care, amidst of the chaos in the Middle East:

A Druze male nurse accompanies a devout Jewish female patient with breast cancer.

An ultra-religious Jewish Chassidic physician doing rounds and visiting patients in East Jerusalem,

A male Christian nurse accompanies an elderly female Russian immigrant whose daughter phones the office to thank us profusely for the nurse's compassionate care, her words being, "his care and kindness goes beyond anything we have ever experienced previously".

During one of the rounds of fighting in Gaza last July, the teams continued treating patients in Muslim towns and villages all over the country. When suggested safety precautions, their answers were always: "we feel safe, we will be protected, the people know why we are here".

Politics, religion, language, uncommon grounds of all sorts, crumble in face of compassion, care, kindness and respect to other human beings.

Professionalism - The need to ensure all staff members are carefully selected, receive the relevant competencies and are equipped with a very high set of service skills

Palliative medicine was approved in 2013 as a sub-specialty for physicians (requiring another specialization e.g., Internal or Family Medicine) to date, only twenty five physicians have been declared as "founding fathers" of this new specialty. In 2016 another 10-15 physicians are expected to be certified as palliative care specialists and centers will be accredited for training [4]. Although there is a plan in place to develop a cohort of physician specialists and a professional governing body, there is not enough accredited staff in the country to meet the needs. In 2009, the Ministry of Health's nursing division established and published Directive #79, criteria for licensing Advanced Palliative Care nurse practitioners [5]. To date there are 60 Advanced Palliative Nurse Practitioners in Israel.

In order to overcome this obstacle, Sabar's founders developed a training program to bring compassionate health care professionals with an interest in palliative medicine into the field.

Sabar Team members are carefully screened, selected, and educated by a team of palliative care specialists of their respective disciplines. The Sabar training program consists of a theoretical educational course where guidelines are studied, revised, and an examination is completed. An "in the field" training program is comprised of three phases:

"Shadowing": in which the new team member must accompany other experienced team members of all disciplines on home visits.

The new team member assumes responsibility for his/her own patients together with a clinical supervisor who decides the progression to phase three.

The team member will visit patients and be assigned a mentor who is available for consultations and who audits documentation on a daily basis.

All health care professional staff members engage in continuous medical/nursing and other educational programs comprising seminars, regional meetings, attendance at national and international conferences, and the Sabar in-house professional journal (the Sabariton).

Continuity of care - The need for all patient records to be duly recorded, stored, and accessible to all relevant parties at all times

After a home visit or phone call, each of the team members must document the visit or call in the patient's electronic health record (EHR). The EHRenables immediate nationwide online access for clinical purposes, supervision, auditing of a patient's care, and continuity of care. Each patient has a treatment plan in place, pre-emptive prescribing, and PRN orders are obligatory. All files are automatically exported and embedded in the patient's electronic medical files in the respective HMO.

Conclusion

Through combining a public/private enterprise based on economies of scale, countries and regions can create a home based palliative enterprise. This model should be further studied with an eye towards saving medical dollars, raising the quality and accessibility of palliative care services worldwide.

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