Characterizing Hospital at Home in Canada: Developing a National Working Definition

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Background

- Hospital at Home (HaH) is a relatively new model of care in Canada, gaining momentum since the COVID-19 pandemic.[1,2]
- Organization and implementation has varied across Canadian jurisdictions, shaped by available resources, political will, and local practice patterns.[3]
- No formal national definition of HaH exists in Canada, making it difficult to compare programs, share best practices, or plan standardization.
- This poster presents the first phase of a multi-part study to characterize HaH nationally.

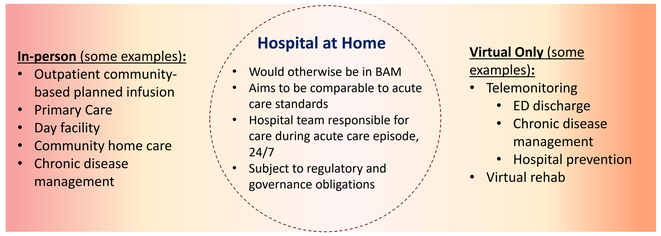


Figure 1: Continuum of care in Canada with respect to virtual versus in-person care.

Methods

REB exemption granted by the University of Calgary's Conjoint Health Research Ethics Board.

1) World Café

In-person session at the Canadian HaH Conference (Montreal) with providers, leaders, health ministry representatives, researchers, patients, and caregivers nationwide.

• Discussed "What is HaH?" and "What is not HaH?" in small then large groups

• Dot-sticker voting classified criteria as: definitely HaH / definitely not HaH / could be considered HaH

• Thematic analysis informed the national survey and consensus meetings.

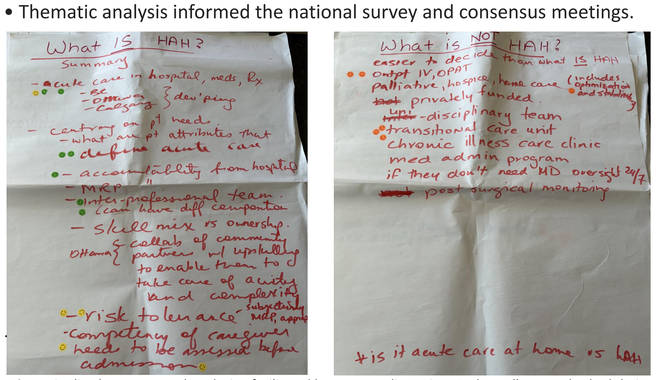


Figure 2: Flip chart notes teaken during facilitated large group discussion. Each small group also had their own flipchart notes on which voting was conducted

2) National Survey

Qualtrics survey of 12 Canadian HaH clinical/operational leaders representing their programs. The survey focused on questions related to patient eligibility, staffing, referral pathways, technology, and ancillary services. Data cleaning is currently in progress.

Results: Thematic Analysis

Six overarching concepts were identified that characterize how Canadian healthcare professionals conceptualize HaH.

1. Acute care, delivered at home
Hospital-level acute care outside the hospital for a defined, reversible illness episode.

2. Not home care or outpatient care
Distinct from traditional home care, primary care, and outpatient services.

3. 24/7 access (strongest consensus)
Requires round-the-clock access to clinical professionals and services.

4. Patient selection and governance
Requires appropriate patient selection and hospital-level clinical governance with physician oversight.

5. Home capability
Programs must recreate hospital-level capability in the home.

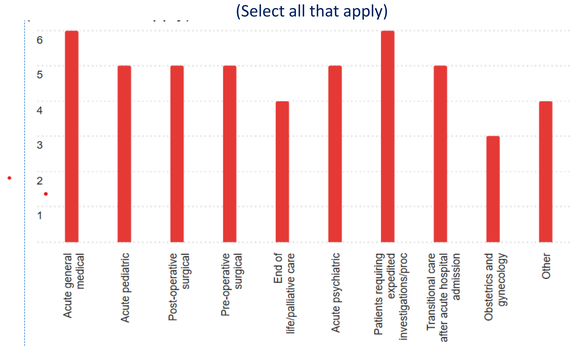
6. System-level strategy
Improves flow and capacity while keeping outcomes comparable to inpatient care.

Results: National Survey

Preliminary responses from Canadian HaH leaders (data cleaning ongoing).

Patient populations served

(Select all that apply)



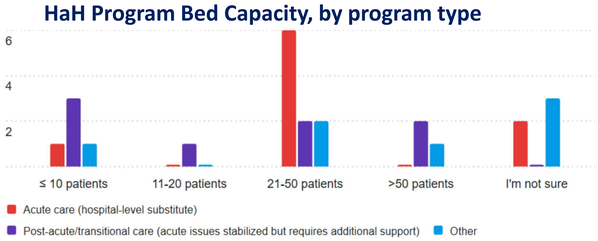
Services offered in the home

- **Diagnostics:** ECG, iSTAT, phlebotomy, mobile x-ray, POCUS, thoracentesis/paracentesis, LP
- **Therapeutics:** IV medications, respiratory support (O2, BiPAP, CPAP), catheters, wound care

Physician visits & escalation

- Physician visits are most often protocol-scheduled by the HaH team, with ad hoc visits as needed.
- Escalation location varies widely — dedicated HaH clinical space, temporary hospital beds, or ED spaces.

HaH Program Bed Capacity, by program type



Admission model

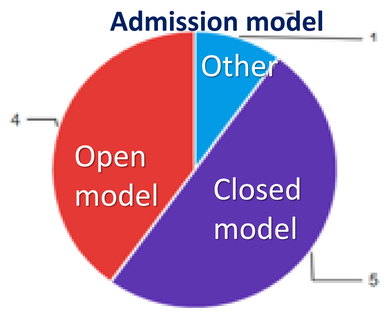
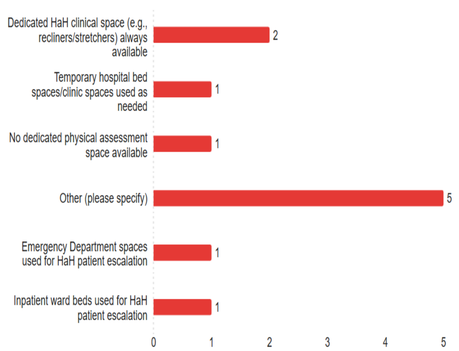


Figure 3: Admission Model
Closed – Dedicated HAH physician assumes responsibility
Open – Referring doctor / family doctor remains responsible
Other - hybrid model or other structure.

Where escalated care provided?

(select all that apply)



Discussion

In context of the literature

- A recent pan-Canadian workshop study similarly identified implementation uncertainty, though it focused on stakeholder perceptions rather than a structured national definition.[4]
- Our six domains largely align with the WHAHC 2023 consensus definition on acuity, reversibility, and governance — extending it with Canadian-specific points of contention around formal admission status.[5]
- Findings suggest HaH risks conceptual drift toward post-acute or home care if governance and 24/7 access are not clearly delineated.[3]

What this means for practice

- Shared domains give programs common language for comparing eligibility, staffing, and governance.
- A working definition can inform accreditation and funding conversations as HaH scales nationally.

Strengths

- National, multi-stakeholder World Café (providers, leaders, policy-makers, patients, caregivers) that helped identify consensus and controversies
- National survey of HaH thought leaders in Canada
- Double reviewer thematic analysis

Limitations

- World Café participants were self-selected and may not represent all Canadian HaH programs.
- National survey participants selected via snowballing. There is a potential that some emerging programs may not have been captured.

Conclusion & Next Steps

Canadian healthcare professionals broadly agree on what HaH is, but provinces differ systematically in operational emphasis. These shared domains give a common starting point for standardization.

Next Steps:

- Complete/clean survey data
- Convene consensus meetings (targeting Dec 2026)
- Develop a Canadian HaH national consensus statement distinguishing HaH from complementary continuum-of-care services

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