

Editorial

An Avant-Garde National Home Hospice Service, 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; Home hospice care.

BACKGROUND

A Few Milestones of Palliative Care in Israel

Research on palliative care in the Israel, Bentur, Resnizky and Shnoor, 2005, found that less than 10% of the patients who needed 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. An additional 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

In 2008, Wright, Wood, Lynch and Clark, when first mapping global palliative care, Israel was classified in Group 4, "approaching integration".²

The Israeli Ministry of Health, 2009, issued a directive that required community health providers and hospitals to establish, within four years, palliative care and hospice services to all dying patients.³ Bentur N et al in their 2012 paper, reported three inpatient hospices in Israel-in Jerusalem, Tel Aviv, and Haifa-which have been allotted a total of about 80 beds and serve some 1,000

patients per year and in additional, 3-4 hospitals belonging to the Christian Mission that take in end-of-life patients who cannot be at home but have not yet reached the hospice stage, or for whom there is no hospice in their vicinity.⁴ Two years later in 2014, World Health Organization (WHO) published the Global Atlas of Palliative Care at the End of Life, Israel is classified as 4a "preliminary integration into mainstream service provision".⁵

In 2016, the Ministry of Health published the national program for palliative care and end-of-life situations and stated that although there has been development and growth in the palliative care services, still, a decade later, according to estimates, only a few thousands, with life-threatening diseases are receiving palliative care and a handful are receiving palliative care consultations and service.⁶

The Ministry of Health's quality audit in community palliative care in 2018, reports, 24 home-hospice units comprising of private and health maintenance organization (HMO) providers, treating 6,416 patients, nationally in 2016.⁷ Sabar health was audited as 5 home-hospice units, the division being geographical, and as the sole provider on a nationwide basis, treated over 2,000 patients in 2016.

Many of the existing services do not care for patients with non-cancer diagnosis and the pediatric population.⁴ Community palliative care services: the health providers and insurers HMO's report provision by their primary care professionals and their home care units providing care at home from 8:00 till 18:00 without 24/7 availability/ they do not have a palliative care consultant as a team member. A few of the providers have a home hospice independent unit with 24/7 availability and some have nurses with oncology specialty or palliative care training. Most providers do not have designated home hospice units. There are private providers for palliative care and home hospice and there is collaboration between the public providers and the private providers. There still exist obstacles and lack of information pertaining home hospice provision, visits, staffing, patient's diagnosis and characteristics.

Of the 25 general hospitals in Israel, two have hospice wards; three have an oncology-palliative array for oncology patients. More than half the consultations were with patients whose cancer was widespread.⁶

It seems there has been sparse structured and methodical progress in services development between 2005 and 2016 in hospital and community services available for patients with palliative care needs as for patients who would choose to spend the time, they have left in their homes with their loved ones.

Sabar Health entered the scene in 2005 with a single doctor and nurse with the ideology of respecting individuals and their family to die in the comfort of their home and with their loved ones. The vision of the organization was clear; people have the basic human right to choose the circumstances of their end-of-life, in their preferred environment.

Today, Sabar Health, a for-profit enterprise, providing a public service encompasses four separate wards: home hospice, home rehabilitation, home advanced dementia/frail patients care, and internal medicine home hospital.

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.

Sabar Health's home hospice ward is the largest home hospice service in Israel. The teams treat a shade under 2,800 patients in need of palliative and hospice care a year, with a mean home hospitalization of approximately 26 days.

In 2016 the majority, 89.6 % of patients had a cancer diagnosis, 10.4% with other diagnosis. There is a growing experience with end-stage Motor Neuron Disease, Dementia, Parkinson's Disease, and organ failure end-of-life patients.

Establishing a National Home Hospice Service—The Challenges

The main challenges facing the establishment of a nationwide

home hospice service include:

1. Government support—promotion of policy, regulation, financing and auditing in accordance
2. Sustainability—the need for any operating modal to be financially sounded cost-effective, and viable.
3. Availability—the need to be on call 24/7/365. A hospice service cannot be closed for service.
4. Accessibility—the need to be able to provide services even in remote and rural regions, in a clinically appropriate timeframe.
5. Universality—the ability to accommodate the needs of very diverse populations in religious, ethnic, cultural, and language aspects.
6. 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.
7. Continuity of care—the need for all patient records to be duly recorded, stored, and accessible to all relevant parties always.

Below is a model that has been built by Sabar Health, addressing 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.⁸

In the 2009 Ministry of Health directive, purpose, rationale, the patient populations served, the staff training required, and its implementation is clearly outlined. 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 cost-effective and thus area fund-saving service.³

With government support in place, in accordance the 2009 directive 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,³ 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 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 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 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 healthcare 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 the HMO's and anyone in the country who is within the criteria and 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 can manage all technical issues during normal business hours but remains available and accessible for emergencies during evenings and weekends. Staff members receive tablets, smart phones and cars to help them with their accessibility.

By centralizing the services to one main body for all 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. Teams are solely 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 paid other) 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's social workers can and do aid in this process.⁹

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 every fortnight. All team members are on call and can make additional visits and emergency home visits within 2 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 closures.

The nurse or case manager will make an initial contact within 2 hours of receiving the patient to her care, his/her first home visit is within 24 hours. The doctor's first visit is within 48 hrs; the social worker will perform an intake visit within the first week of admission and thereon continue 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 always.

Using the model of designated staff, allows medical staff to be available for their patients. Originally, in Israel doctors and nurses work in other settings such as clinics, nursing homes and hospitals and doing piecemeal work through individual insurance companies. This would cause palliative and home hospice care to always be the "second job", which lowers their ability of fully invest in patients care and receive ongoing education. By creating a centralized body that works with all 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 opioids, haloperidol, dexamethasone, clonazepam, antiemetics, 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 but does have a clinical pharmacist to provide consultation to all team members. The teams are equipped and educated to perform necessary procedures needed by patients, such as urethral catheterization, abdominal tapping, and maintenance of all central lines, drains and treatment of wounds. In Israel, opioids 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.⁹

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 compassion, kindness, respect and dignity 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 sole provider in the country, Sabar Health does not hire team members 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 crucial to palliative care, amidst 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 a round of clashes in the south and the Gaza strip area July 2014, the teams continued visiting and treating patients in Muslim towns and villages all over the country and in the areas in the south, where missiles were falling. 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.⁹

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),¹⁰ to date, only approximately 25 physicians have been declared as "founding fathers" of this new specialty and a further approximately 5 have accomplished the certification examinations.⁹ Furthermore, palliative care specialists and centers will be accredited for training.⁹ 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 practitioners¹¹ to date there are approximately 60-80 Advanced Palliative Nurse Practitioners in Israel.

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:

1. Shadowing: in which the new team member must accompany other experienced team members of all disciplines on home visits for two weeks.
2. The new team member assumes responsibility for his/her own patients together with a clinical supervisor who decides on the length of the supervision and the progression to phase three.
3. The team member will visit patients and be assigned a mentor who is available for consultations and who reviews documentation in patients records on a regular basis.

All health care professional staff members engage in continuous medical/nursing and other educational programs comprising seminars, webinars, podcasts, regional team meetings, attendance at national and international conferences, and the Sabar in-house professional journal (the Sabariton).⁹ We are now in the final stages of implementing an internet based learning management system (LMS).

Continuity of care—the need for all patient records to be duly recorded, stored, and accessible to all relevant parties and hyperbaric oxygen (HBO's) 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). This enables 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, preemptive prescribing, and pro re nata (PRN) orders and treatment plans are obligatory. All files are automatically exported and embedded in the patient's electronic medical files in the respective HMO.⁹

CONCLUSION

A home-based palliative enterprise is viable, linking public and private enterprises based on economies of scale. The sustainability of this model over the last 15 years proves the economic aspects of this model are sound, saving medical resource and finances, thus enabling expansion of provision and accessibility of quality palliative care services worldwide.

DECLARATION

The Manuscript: "An Avant-Garde National Home Hospice Service Israel" is an improvement and update upon the previous study; "Innovative Approach to Establishing a National Home Hospice Service: The Case of Israel."

CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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