# Hospital at Home in Practice – a Start-up Manual

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# 1. Introduction

Hospital at Home means that patients receive acute medical care in their own home. With the right working practices, combining home visits with digital services, care has been shown to be deliverable at the same or higher quality as on a traditional hospital ward.

Establishing and laying the foundations for a successful Hospital at Home programme within an organisation is, however, a significant challenge regardless of context. This applies equally when the care level is added to an existing home care structure – such as palliative or other specialised care at home, or episodic care through ambulatory care teams. The straightforward explanation is that delivering round-the-clock care for acutely ill patients outside hospital walls is complex, particularly when it must be done safely and efficiently.

## A Stepwise Process Rather Than All at Once

A successful launch requires a structured, stepwise process in which the most important prerequisites are established in the right order. This includes:

- defining new working practices and operational routines
- securing staff resources and competencies
- establishing new work roles and responsibilities
- meeting technical needs, including equipment, digital support tools and adaptations to existing systems
- establishing inclusion criteria and referring units
- defining which treatments can and should be offered at home
- establishing a command centre or coordination function

## Buy-in Focused on Launch and Feasibility

Implementing Hospital at Home requires broad internal buy-in, for example from clinical managers, chief medical officers, IT, procurement, finance and union representatives. In many contexts, external actors such as social services and municipal home nursing are also important for care delivery to work in practice, particularly in regions with large geographic distances. From an organisational and financial perspective, regional decision-makers may also need to be involved at an early stage.

At the same time, the large number of stakeholders means that implementations often risk getting stuck in the buy-in phase. Although long-term funding and formal collaboration structures are important for future scaling, they should not become a barrier to getting started. In these situations, it may be more practical to start small, with a clear delimitation of both scope and dependencies, for example by drawing on one or a few internal services.

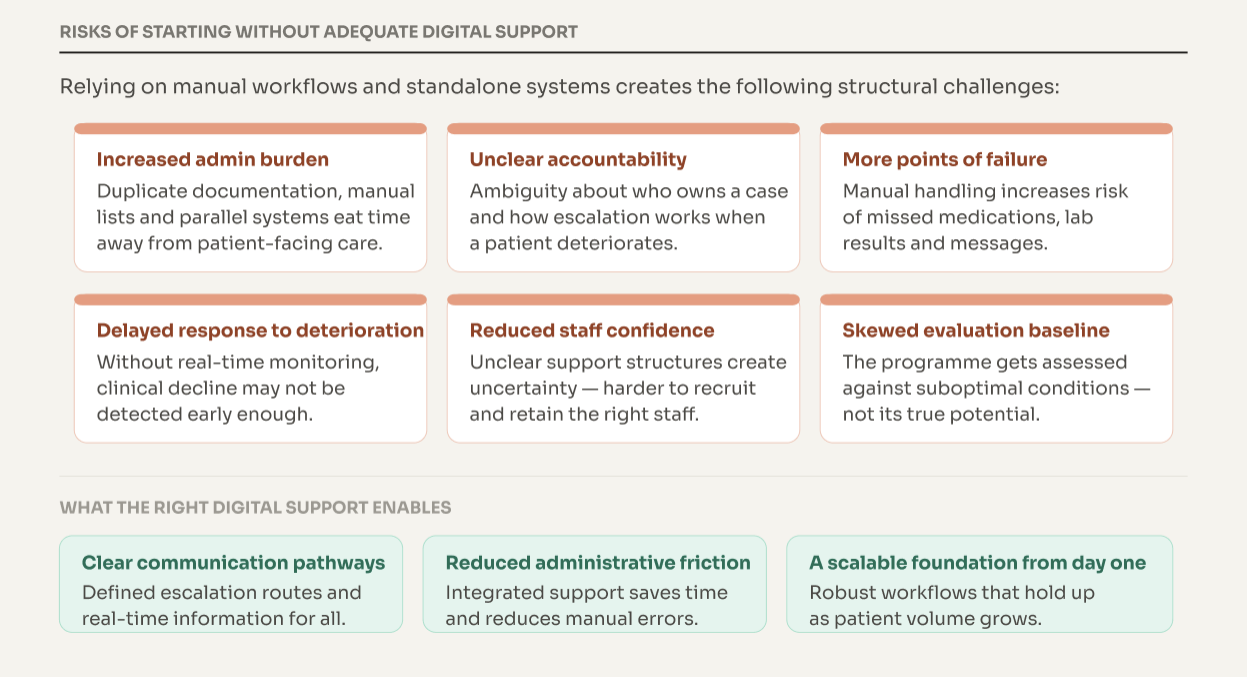
In practice, this may mean that the service is initiated within an existing budget – for example by temporarily converting a limited number of traditional inpatient beds into virtual care places with the same staffing resources. Once the model has proven to work in practice, it becomes significantly easier to build on the existing structure and scale operations in a controlled and sustainable way.

## The Role of Technology – An Important but Often Misunderstood Question

It is entirely possible to start a Hospital at Home service with a combination of standalone systems, manual workflows, telephone communication and basic documentation solutions. In many organisations, the launch happens in exactly this way.

At the same time, such solutions often mean that working practices are adapted to fit available tools, rather than the tools supporting a fit-for-purpose approach. In practice, this can lead to a number of structural challenges, such as:

- increased administrative burden
- unclear lines of communication and accountability
- more potential points of failure
- delayed response to clinical deterioration
- reduced sense of safety among staff
- a user experience that does not fully reflect the potential of the Hospital at Home model

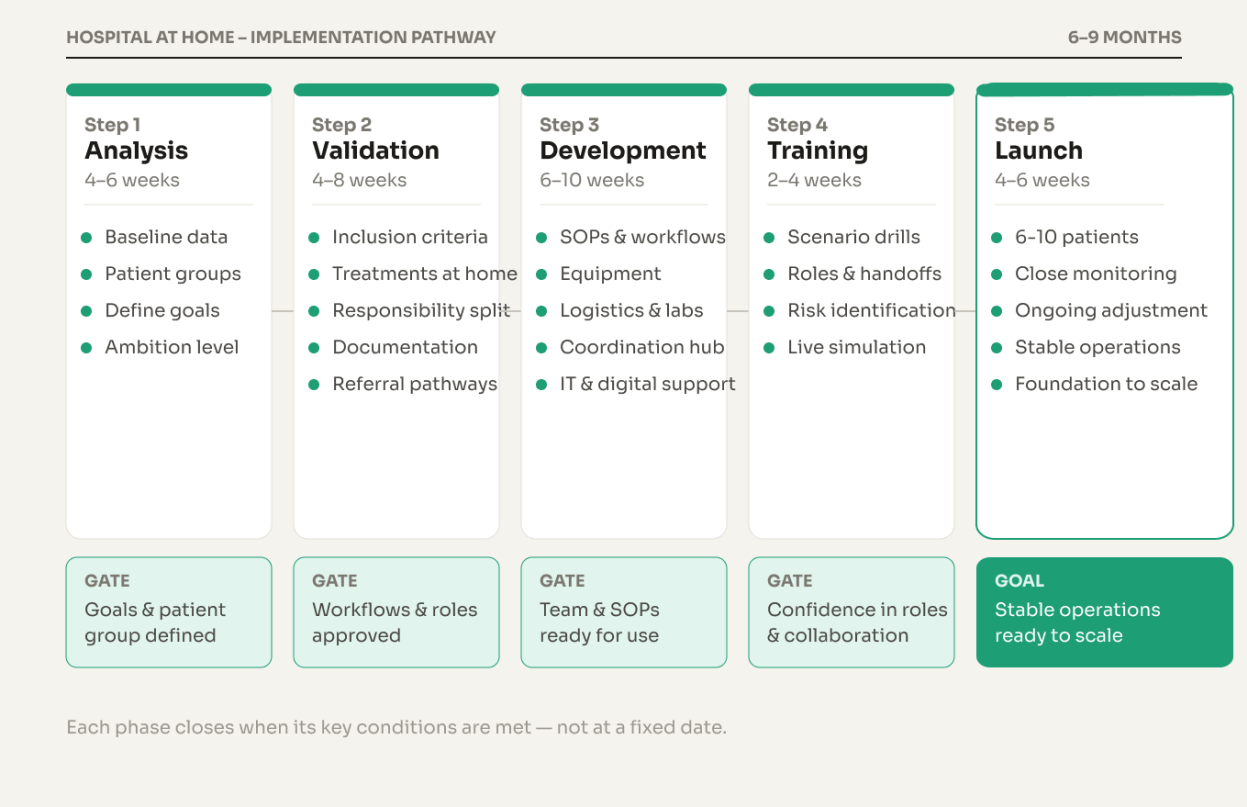


There is therefore a significant risk that the care model is evaluated against conditions that are not optimally suited to its purpose, which can affect assessments of both safety and quality, as well as efficiency.

A fit-for-purpose digital operational support tool therefore does not aim to introduce technology for its own sake, but rather to create stable and coherent conditions for a robust way of working—particularly as the service transitions from launch to scaling.

## Purpose of This Manual

This manual describes a practical and achievable path from initial analysis to safe small-scale operations. The starting point is a launch with approximately six to ten concurrent patients, with a clear mandate and a plan for gradual scaling as working practices, collaboration and support structures are established.



# 2. Timeline and Governance

Introducing Hospital at Home represents an organisational change that affects several parts of the organisation at once. For the process to be feasible, a clear timeline, a structured working process and explicit ownership are therefore required. The timeline should be realistic, transparent and secured with leadership from the very start.

## Project Organisation and Responsibilities

A formal project manager should be appointed with responsibility for planning, coordination and follow-up of the implementation. The project manager needs a clear mandate from senior leadership and access to key people across the organisation in order to manage dependencies and remove obstacles at an early stage.

The project manager should be supported by a cross-professional project group. The following competencies are recommended as a minimum:

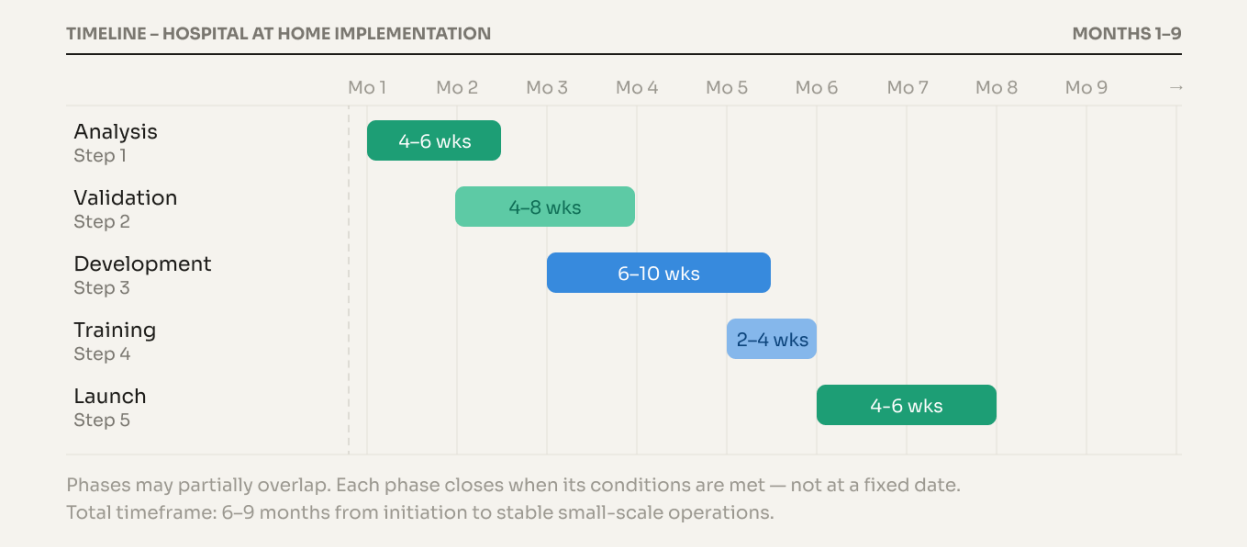
- physician
- nurse
- service improvement lead
- IT, preferably with decision-making authority

The project group needs allocated time for the work and a clear mandate to drive the process forward. If the implementation competes with other development activities without clear prioritisation, there is a significant risk that progress will slow or stall.

## Overall Timeline

A typical Hospital at Home launch takes approximately **6 months** from initiation to small-scale operations, depending on starting conditions and level of ambition. Experience shows it is more practical to plan the work in clear phases rather than trying to control the entire process in detail from the outset.

Each phase should only close once its key conditions have been met, rather than at a fixed date.




# 3. Stepwise Implementation – from Analysis to Stable Operations

A stepwise implementation creates the conditions for control, learning and adjustment over time. The following five overarching steps together form a practical framework for launching Hospital at Home.

## Step 1: Analysis – Define Purpose and Scope

The purpose of the analysis phase is to build a shared and realistic picture of why Hospital at Home is being introduced and what needs the model should initially address. The focus should be on identifying a limited number of patient groups and a clear use case, rather than trying to cover all potential applications.

In practice, this means:

- analysing relevant baseline data, such as length of stay, bed occupancy and readmission rates
- identifying patient groups that are frequently admitted to hospital despite a relatively stable condition
- clarifying what the organisation aims to achieve through the launch, for example relieving pressure on inpatient beds or improving continuity of care

**Before proceeding to the next step:** the goals, starting patient group and approximate level of ambition should be clearly defined and agreed.

## Step 2: Validation – Confirm Feasibility

In this step, the intended model is tested against the organisation's actual conditions. The aim is to confirm that the chosen approach is medically, organisationally and legally feasible.

The work includes:

- establishing inclusion criteria and referral pathways
- clarifying which treatments and examinations can be carried out in the home
- defining the allocation of responsibility in the event of deterioration and escalation
- ensuring that medical record-keeping and prescribing routines work within existing systems
- securing buy-in for the model among relevant services and support functions

**Before proceeding to the next step:** core workflows, staffing and responsibilities should be established and approved.

## Step 3: Development – Build the Necessary Structures

The development phase aims to establish the practical conditions required for operations, with a particular focus on what is needed for small-scale implementation. The ambition should be to create a stable foundation rather than a fully developed organisation.

This means, for example:

- developing SOPs for admission, daily follow-up, escalation and discharge
- securing access to the necessary equipment and medicines
- establishing functioning logistics for sampling and transport
- clarifying where operations are coordinated, for example via a command centre or virtual ward

**Before proceeding to the next step:** team, SOPs and logistics should be tested and ready for live use.

## Step 4: Training and Launch – Establish Safe Operations

Before the first patients are admitted, staff need the opportunity to practise working methods and collaboration in practice. Scenario training is particularly important for identifying ambiguities and risks that would otherwise only be discovered in live operations.

The launch should then proceed in a controlled manner, with a limited number of patients and close follow-up. A reasonable starting point is approximately six to ten concurrent patients, which typically provides sufficient complexity for learning without placing excessive demands on the organisation.

**The goal of this phase is:** to achieve stability in working practices, roles and collaboration before the service is scaled up.

# 4. Closing Reflections

Hospital at Home is not a time-limited project but a new level of care that needs to be progressively integrated into the ordinary care structure. A successful launch is often characterised by:

- clear ownership and prioritisation
- a realistic level of ambition in early operations
- a focus on working practices before complete technical perfection
- learning based on real operations rather than theoretical assumptions

Once the model is working in practice, better conditions are created for both scaling up and broader collaboration.