15.777 Healthcare Lab, Fall 2018

Our Host

Suburban Home Health Care is a Boston-area, family-owned home health agency

- Employ 100 nurses & therapists, 500 home health aides
- Care for 1,200 patients/day; ~65% do not speak English
- Key differentiator: use language & culture in assigning providers

Our Team


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What is home health care and who is Suburban Home Health?

Home health care functions as an extension of care during an acute episode (e.g., following discharge from the hospital), and may also aid in management of chronic conditions.

- An estimated 3.4 million patients in the US use home health care; ~80% of patients are elderly
- Care is delivered using interdisciplinary teams of healthcare providers, including nurses, PTs, OTs, and home health aides

What are the key trends in the home health care space?

Readmissions are Increasing

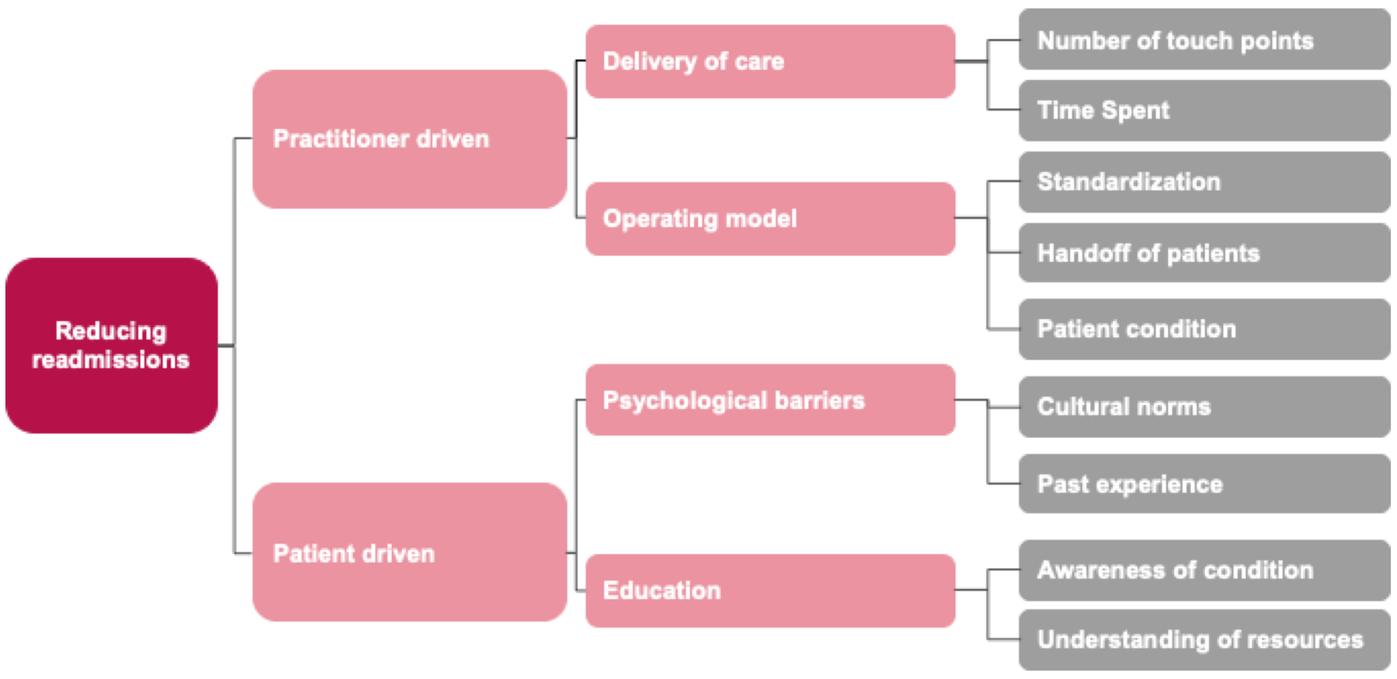
One in five elderly patients is readmitted to the hospital within 30 days of discharge from the hospital

Reimbursement is Challenging

Reimbursement is increasingly determined by both patient satisfaction and clinical outcomes

Problem Statement: How can Suburban reduce re-hospitalizations?

Issue Tree: Key Factors Impacting Readmission Rates



- Suburban has experienced growth in re-hospitalizations over the past 2 years
- Analysis of patient data revealed ~50% of hospitalizations are 0-1 days and do not convert to inpatient visits, suggesting they may be unnecessary
- Key issues surfaced from interviews with practitioners fell into two categories: **practitioner-driven** & **patient-driven**
- Hypotheses were developed based on these issues and a literature review to identify tactics used to impact re-hospitalization rate

Key Hypotheses

Practitioner-driven

		Potential Impact	Ability to Influence
1	There is a lack of standardization of practices across SHHC		
2	Touchpoints can be increased		
3	Communication between teams is limited		
4	Everyone is overworked		

Key Hypotheses

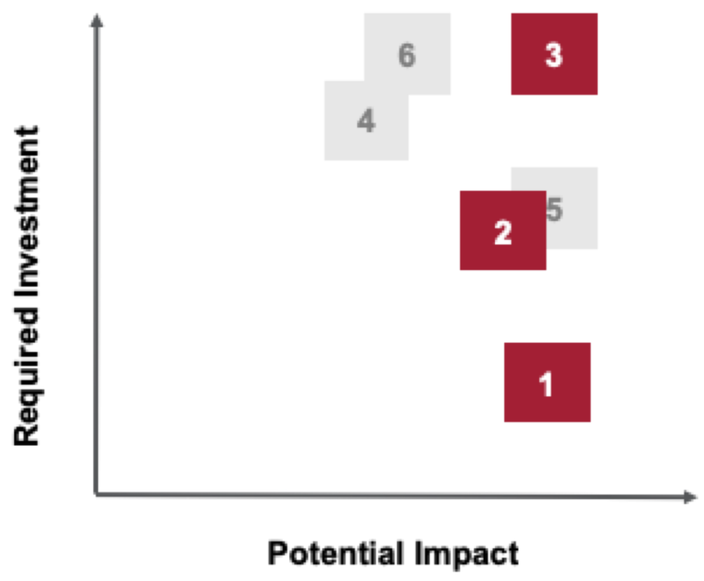
Patient-driven

		Potential Impact	Ability to Influence
1	There is limited management of patient and caregiver expectations		
2	Patients often don't know who to call in case of any medical issue		
3	Patients base current actions on past experiences and cultural norms		

Low High

Final Recommendations & Pilot Initiatives

1	Standardize patient and caregiver education process and tools
2	Improve care touchpoints immediately following referral
3	Increase overall number of care touchpoints for high-risk patients
4	Track and standardize length of home care visits by care teams
5	Centralize non-clinical nurse/PT activities as possible
6	Standardize communication between disciplines on a team and between teams



- Final recommendations addressed both practitioner- and patient-driven issues and were ranked by potential impact and required investment
- Recommendations #1, 2, & 3 were chosen for ongoing pilots
- Each pilot will last 60 days (to represent an episode of care) and outcomes are measured relative to a control group