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

Home health care is a Boston-area, family-owned home health agency.

**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**

<table>
<thead>
<tr>
<th>Practitioner-driven</th>
<th>Patient-driven</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of touch points</td>
<td>There is limited management of patient and caregiver expectations</td>
</tr>
<tr>
<td>Time spent</td>
<td>Patients often don’t know who to call in case of any medical issue</td>
</tr>
<tr>
<td>Standardization</td>
<td>Patients base current actions on past experiences and cultural norms</td>
</tr>
<tr>
<td>Handoff of patients</td>
<td>Patient condition</td>
</tr>
<tr>
<td>Patient condition</td>
<td>Cultural norms</td>
</tr>
<tr>
<td>Psychological barriers</td>
<td>Past experience</td>
</tr>
<tr>
<td>Understanding of resources</td>
<td>Awareness of condition</td>
</tr>
</tbody>
</table>

**Key Hypotheses**

- Practitioner-driven: There is a lack of standardization of practices across SHHC
- Patient-driven: There is limited management of patient and caregiver expectations

**Potential Impact**

<table>
<thead>
<tr>
<th>Practitioner-driven</th>
<th>Patient-driven</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>High</td>
</tr>
</tbody>
</table>

**Ability to Influence**

- Practitioner-driven: Low
- Patient-driven: High

**Final Recommendations & Pilot Initiatives**

- Standardize patient and caregiver education process and tools
- Improve care touchpoints immediately following referral
- Increase overall number of care touchpoints for high-risk patients
- Track and standardize length of home care visits by care teams
- Centralize non-clinical nurse/PT activities as possible
- 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