**Impact of Home Health Care on Readmission Rates in Geriatric Patients**

**Significance to nursing**

There is an increasing ageing population, which comes with increased number of people needing geriatric care (Zuckerman et al., 2016). The increasing number of geriatric patients mean there is a lot of pressure on health facilities, particularly hospitals for space. For this reason, any interventions that are put in place to minimize the levels of readmission rates in geriatric patients would serve the benefit of relieving hospitals of the patient accommodation pressure they face. Herrin et al. (2015) found that when hospitals are less saturated with patients, it impacts positively on the overall level and quality of care that those on admission receive. This is because nurses and other health professionals get enough time to attend to patients. The proposed study is thus significant in enhancing improved nursing care through reduced readmission rates, which put pressure on geriatric patient care.

**Literature review and synthesis**

There are a number of studies that have already been conducted to ascertain the effectiveness of home health care on geriatric patients. In a study by Deniger, Troller and Kennelty (2015), a special geriatric transitional care program was instituted in a university hospital, where high risk geriatric patients were offered home visits from nurse practitioners. The practice led to 48% reduction in 30-day hospital readmission rates. Similarly, Umegaki et al. (2016) found that even though geriatric patients have declining functional status, and manifest multiple disease conditions, discontinuing home medical care increased the levels of dysfunctional outcomes in patients. These two studies offer very strong basis for appreciating the important role that home care plays for geriatric patients.

While the overall impact of home health care on geriatric patients may be well supported in the body of literature, Ting (2014) argued that there are some key factors that influence the outcomes that patients receive. By this, caution is being given that the mere presence of home care may not necessarily benefit patients and reduce readmission rates. In support of this, Falvey et al. (2016) admonished that in order to optimize the outcomes for geriatric patients when they transition from hospital to community, it is important to offer specific and specialized health services as part of the home care plan. More specifically, they recommended the use of physical therapists. In the opinion of Feltner et al. (2014), the services of physical therapists focus more on daily activities by the older people, which lead to making them self-reliant and thus not requiring hospital readmission.

Even though the services of physical therapists have been found to be very paramount in reducing readmission, Donovan et al. (2016) opined that the home health care concept should be made one that is interdisciplinary and multivariate. By this, reference is made to the need to ensure that not just physical therapists are used in the home care service but that several others, whose presence will be specific to the needs of the patient. As noted by Branowicki et al. (2017), geriatric patients are likely to have impairments relating to cognitive, social and physical (Kripalani et al., 2014). The multidisciplinary home care would thus ensure that any aspect of health condition that the patient is suffering from is given greater attention.

**Purpose**

The purpose of the study will be to examine the efficacy of home health care as an intervention in decreasing readmission rates in geriatric patients who are discharged from the hospital.

**Research questions**

In the course of collecting data to examine the purpose of the study, there are a number of questions that will be asked and answered through the data analysis process. These are presented below as research questions:

1. What are the current trends and rates of readmission among geriatric patients?
2. What are the main factors that account for readmission among geriatric patients?
3. To what extent does home health care address the factors leading to readmission and thus decrease readmission among patients?

**Theoretical framework**

According to Maher, Hanlon and Hajjar (2014), geriatric patients are not just old adults but that they are actual patients who have a number of social, cognitive and physical challenges, which cause some impairments, either temporarily or permanents. Because of the impairment, they often lack the ability to support themselves personally. Based on this limitation, the Dorothea Orem’s self-care theory is an important framework for understanding geriatrics as a whole and the expected outcomes of the study, associated with reduced readmission rates. The main assumption of the self-care theory is that each person should become self-reliant and responsible, so that they can take care of themselves and other dependents (Younas, 2017). Writing on older people, O'shaughnessy (2014) observed that being old should not necessarily come with the impairment of being independent or self-reliant. By this, it is a good step for geriatricians to aim for self-reliance for their patients.

Such self-reliance can however not be said to have been achieved if patients are constantly readmitted to hospitals. According to the self-care theory, one of the main components of primary care prevention is to ensure that nurses play their roles for patients to meet their universal and developmental self-care requisites. In the proposed study, the role of nurses in serving as facilitators for geriatric patients to meet their universal and development self-care requisites will be viewed from the point of offering home health care. That is, in the home environment, nurses are expected to provide supportive care to geriatrics patients, targeted at achieving self-care requisites, which would mean no special or intensive care requiring admission to hospitals.

**References**

Branowicki, P. M., Vessey, J. A., Graham, D. A., McCabe, M. A., Clapp, A. L., Blaine, K., ... & Chiang, V. W. (2017). Meta-analysis of clinical trials that evaluate the effectiveness of hospital-initiated postdischarge interventions on hospital readmission. *Journal for Healthcare Quality*, *39*(6), 354-366.

Deniger, A., Troller, P., & Kennelty, K. A. (2015). Geriatric transitional care and readmissions review. *The Journal for Nurse Practitioners*, *11*(2), 248-252.

Donovan, J. L., Kanaan, A. O., Gurwitz, J. H., Tjia, J., Cutrona, S. L., Garber, L., ... & Field, T. S. (2016). A pilot health information technology–Based effort to increase the quality of transitions from skilled nursing facility to home: Compelling evidence of high rate of adverse outcomes. *Journal of the American Medical Directors Association*, *17*(4), 312-317.

Falvey, J. R., Burke, R. E., Malone, D., Ridgeway, K. J., McManus, B. M., & Stevens-Lapsley, J. E. (2016). Role of physical therapists in reducing hospital readmissions: optimizing outcomes for older adults during care transitions from hospital to community. *Physical therapy*, *96*(8), 1125-1134.

Feltner, C., Jones, C. D., Cené, C. W., Zheng, Z. J., Sueta, C. A., Coker-Schwimmer, E. J., ... & Jonas, D. E. (2014). Transitional care interventions to prevent readmissions for persons with heart failure: a systematic review and meta-analysis. *Annals of internal medicine*, *160*(11), 774-784.

Herrin, J., St Andre, J., Kenward, K., Joshi, M. S., Audet, A. M. J., & Hines, S. C. (2015). Community factors and hospital readmission rates. *Health services research*, *50*(1), 20-39.

Kripalani, S., Theobald, C. N., Anctil, B., & Vasilevskis, E. E. (2014). Reducing hospital readmission rates: current strategies and future directions. *Annual review of medicine*, *65*, 471-485.

Leppin, A. L., Gionfriddo, M. R., Kessler, M., Brito, J. P., Mair, F. S., Gallacher, K., ... & Ting, H. H. (2014). Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials. *JAMA internal medicine*, *174*(7), 1095-1107.

Maher, R. L., Hanlon, J., & Hajjar, E. R. (2014). Clinical consequences of polypharmacy in elderly. *Expert opinion on drug safety*, *13*(1), 57-65.

O'shaughnessy, M. (2014). Application of Dorothea Orem's theory of self-care to the elderly patient on peritoneal dialysis. *Nephrology Nursing Journal*, *41*(5), 495.

Umegaki, H., Asai, A., Kanda, S., Maeda, K., Shimojima, T., Nomura, H., & Kuzuya, M. (2016). Risk factors for the discontinuation of home medical care among low-functioning older patients. *The journal of nutrition, health & aging*, *20*(4), 453-457.

Younas, A. (2017). A Foundational Analysis of Dorothea Orem's Self-Care Theory and Evaluation of Its Significance for Nursing Practice and Research. *Creative Nursing, 23*(1), 13-23.

Zuckerman, R. B., Sheingold, S. H., Orav, E. J., Ruhter, J., & Epstein, A. M. (2016). Readmissions, observation, and the hospital readmissions reduction program. *New England Journal of Medicine*, *374*(16), 1543-1551.