Title:
"Improving Patient Outcomes through Structured In-Home Support Services: A Case Study of an Elderly Patient with Chronic Conditions"

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1. Background & Significance

- In-home support services (IHSS) help elderly or chronically ill patients live independently.
- However, **caregiver inconsistency, lack of structured plans, and low technology adoption** can lead to hospital readmissions and reduced quality of life.
- This study focuses on **Jane Doe**, an 82-year-old patient with diabetes, hypertension, and mobility issues, to explore how IHSS can be optimized.

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2. Problem Statement

Jane Doe has experienced **multiple hospital readmissions** and inconsistent care due to rotating IHSS staff and limited family support. There is a need to identify **strategies to improve care coordination, adherence to treatment, and patient satisfaction** in IHSS.

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3. Research Questions

1. How does caregiver consistency impact patient outcomes in in-home support services?
2. What barriers prevent elderly patients from fully benefiting from IHSS, including telehealth and technology use?
3. Can a structured IHSS care plan reduce hospital readmissions and improve quality of life for high-risk patients?

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4. Objectives

- Assess current IHSS delivery and identify gaps in care.
- Develop a **structured care plan** tailored to Jane Doe.
- Evaluate the impact of interventions on hospital readmissions, medication adherence, and patient satisfaction.

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5. Methodology

Study Design:

- **Case study** with a mixed-methods approach (qualitative + quantitative).

Data Collection:

1. **Patient Records:** Hospital visits, medication adherence, IHSS logs.
2. **Caregiver Input:** Interviews/surveys on challenges and communication gaps.
3. **Patient Feedback:** Assess satisfaction, comfort, and understanding of care plan.

Intervention (Proposed):

- Assign **consistent IHSS caregivers** to reduce turnover issues.
- Implement **structured daily/weekly care routines** (medication management, exercise, meals).
- Introduce **low-tech or simple digital tools** for monitoring health (e.g., pill organizers, phone reminders).
- Schedule **telehealth follow-ups** with the primary care provider for chronic disease management.

Outcome Measures:

- **Primary:** Number of hospital readmissions over 6 months.
- **Secondary:** Patient satisfaction, medication adherence, caregiver satisfaction, and safety incidents.

Analysis Plan:

- **Quantitative:** Compare pre- and post-intervention readmission rates and adherence metrics.
- **Qualitative:** Thematic analysis of caregiver and patient feedback to identify barriers and improvements.

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6. Expected Outcomes

- Improved continuity of care through consistent IHSS staffing.
- Better chronic disease management and fewer hospital readmissions.
- Higher patient satisfaction and comfort with IHSS.
- Insights into practical interventions that can be generalized to similar IHSS patients.

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7. Limitations

- Single-case focus may limit generalizability.
- Patient-specific factors (resistance to technology, mobility) could affect outcomes.
- Access to detailed health records may be restricted due to privacy regulations.

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8. Timeline

Phase	Activities	Duration
Phase 1	Literature review & data collection	2 weeks
Phase 2	Caregiver interviews & patient feedback	2 weeks
Phase 3	Intervention design & implementation	4 weeks
Phase 4	Post-intervention evaluation	2 weeks
Phase 5	Analysis & report writing	2 weeks

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9. Resources Needed

- Access to IHSS records (with patient consent).
- Cooperation from IHSS caregivers.
- Basic digital tools (pill organizers, reminder apps).
- Hospital or primary care data for readmission tracking.