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Original Research

Homecare Utilization Funnel among Discharged Patients at Universitas Airlangga Hospital

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Abstract

Background: Although homecare is increasingly recognized as an extension of hospital services, limited evidence exists on the operational pathway from identifying potential patients to the actual utilization of homecare following discharge.

Objective: to audit the promotion and utilization funnel of Universitas Airlangga Hospital homecare services among discharged patients from July 2025 to March 2026.

Methods: This retrospective descriptive operational audit examined aggregate secondary data from daily homecare operational reports at Universitas Airlangga Hospital between July 2025 and March 2026. The daily report served as the unit of analysis rather than individual patients. Variables included the number of potential homecare patients, documented offer status, willingness responses, realized visits, service-unit origin, and service-category mentions. Data were analyzed descriptively using frequencies, percentages, and utilization ratios

Result: Over 181 reporting days, 1,007 potential homecare patients and 235 realized homecare visits were identified, corresponding to 23.3 visits per 100 potential patients. In 2025, documented offer status was available for 121 of 656 potential patients (18.4%), of whom 97 (80.2%) had been offered homecare services. Among those offered, 2 (2.1%) were willing to order the service, 94 (96.9%) were still considering, and 1 (1.0%) declined at initial contact. Offer-response variables were not available in the 2026 reporting format. Physiotherapy or medical rehabilitation accounted for the largest proportion of service-category mentions (60.6%), followed by physician or specialist visits (16.5%).

Conclusion: Homecare services at Universitas Airlangga Hospital exhibited substantial post-discharge demand; however, incomplete documentation limited the ability to observe the utilization funnel. Implementing a standardized homecare dashboard integrated with discharge planning could enhance monitoring, follow-up, and evaluation of homecare service utilization.

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Keywords

Homacere; Discharge Planning; Continuity of Care.

Background

The transition from hospital to home represents a high-risk phase of care, as patients may be discharged while still experiencing residual functional limitations, unresolved symptoms, medication-management challenges, wound or device-care needs, caregiver uncertainty, or requirements for specialist follow-up (1, 2). In this context, homecare should be regarded not simply as an additional service, but as an extension of hospital care that ensures continuity and supports patient recovery within the home environment. Effective homecare services facilitate rehabilitation, clinical monitoring, nursing procedures, patient education, and caregiver support following discharge (3, 4).

Recent evidence underscores the significance of transitional care and hospital-to-home interventions in improving patient outcomes. Systematic reviews have shown that discharge support and transitional care programs enhance patient experiences, strengthen continuity of care, and reduce avoidable healthcare utilization among specific patient populations (5, 6). Additionally, studies of hospital-at-home models, remote patient monitoring, and integrated home-based care highlight the necessity for structured governance, patient selection criteria, monitoring systems, and escalation pathways to ensure safe and effective care delivery beyond hospital settings. Collectively, these findings demonstrate that home-based services are becoming increasingly integral to modern healthcare systems (7, 8). In Indonesia, national health policies underscore the importance of structured post-discharge care. Government Regulation Number 28 of 2024, which implements Law Number 17 of 2023 on Health, mandates the provision of integrated and continuous health services across all levels of care. Furthermore, Minister of Health Regulation Number 11 of 2025, which addresses standards for health-service business activities, establishes a regulatory framework supporting the development of community-based and home-based health services. Previous studies in Indonesia have identified variability in discharge-planning implementation and emphasized the need for improved coordination between inpatient care and post-discharge services to maintain continuity of care (9, 10).

Although evidence supporting transitional care is expanding, few studies have investigated the operational processes by which potential homecare patients are identified, offered services, respond to these offers, and ultimately utilize homecare services. Most existing research has concentrated on clinical outcomes, patient satisfaction, readmission rates, or service effectiveness, with limited focus on the operational pathway that determines whether eligible patients actually receive homecare services. Understanding this pathway is critical, as low utilization may result from

inadequate screening, insufficient service promotion, delayed family decision-making, financial or logistical barriers, clinical ineligibility, or deficiencies in documentation systems. Without a comprehensive understanding of the service funnel, healthcare managers cannot reliably distinguish between low demand, unmet demand, and documentation failure.

Universitas Airlangga Hospital has developed homecare services to support continuity of care after hospital discharge. However, routine operational monitoring has primarily addressed service activities and utilization records, while the pathway from patient identification to actual homecare utilization remains unevaluated. The lack of an integrated monitoring system may constrain the hospital's capacity to identify barriers to service uptake, assess the effectiveness of discharge-planning processes, and optimize resource allocation. To the best of current knowledge, no published study has specifically examined the operational homecare utilization funnel using routine service data in an Indonesian hospital context.

This study aimed to audit the promotion and utilization funnel of Universitas Airlangga Hospital homecare services among discharged patients from July 2025 to March 2026. Specifically, the study described the number of potential homecare patients, the completeness of offer documentation, initial family responses to homecare offers, realized homecare visits, the unit-level distribution of potential patients, and patterns of homecare service utilization. The findings are expected to provide an operational baseline to enhance discharge-linked homecare documentation, improve service monitoring, and inform the development of a standardized homecare dashboard for quality improvement initiatives.

Methods

Study Design and Setting

This study used a retrospective, descriptive, operational audit design, drawing on aggregate secondary data from routine homecare operational reports. It was conducted at the Homecare Service Unit of Universitas Airlangga Hospital, Surabaya, Indonesia. Data were collected from daily homecare operational reports between July 2025 and March 2026. The daily operational report, not individual patients, served as the unit of analysis.

Data Source and Instruments

Routine daily home care operational reports served as both the data source and the study instrument. These reports were compiled by the Universitas Airlangga Hospital Homecare Unit for service monitoring and operational evaluation. The reporting fields varied by period. Reports from 2025 included information on potential homecare patients, documented offer status, willingness responses, and utilization records. In contrast, the 2026 reports primarily contained data on potential homecare patients, follow-up records, and realized homecare visits; offer-status and willingness-response variables were not included in the 2026 reporting format. Consequently, variables unavailable in 2026 were treated as structurally unavailable rather than as negative responses.

Eligibility and Data Extraction

Reports were included if they were dated between July 2025 and March 2026 and contained at least one extractable variable related to potential homecare patients, offer status, willingness response, follow-up activities, homecare visits, service-unit origin, or service descriptions. Records without reporting dates and without extractable homecare-related information were excluded from variable-specific analyses. Duplicate entries, when identified, were reviewed using reporting dates and service descriptions to minimize double counting.

Variables

Potential homecare patients were defined as discharged or discharge-planned patients identified by the service unit or homecare team as potentially requiring homecare services. Documented offer status referred to recorded information indicating whether homecare services had been offered. Willingness response referred to the initial documented response of patients or family members following the offer and was categorized as willing to order, considering, or declined. Homecare utilization was defined as realized homecare visits or utilization records. Service categories included physiotherapy or medical rehabilitation, physician or specialist visits, wound/catheter/stoma care, nasogastric tube or suction procedures, acupuncture, and injection or infusion services.

Data Analysis

Descriptive analyses were conducted using frequencies, percentages, ratios, and service classifications. Key indicators derived from the data included offer-documentation completeness, offer coverage among documented cases, distribution of willingness responses, realized homecare visits per 100 potential homecare patients, and the distribution of potential homecare patients across inpatient service units. Comprehensive interpretation of the offer-response funnel was restricted to the 2025 dataset, as the offer-status and willingness-response variables were not available in the 2026 reporting format.

Ethical Considerations

Anonymized aggregate secondary operational data, routinely collected by the Homecare Service Unit of Universitas Airlangga Hospital for service monitoring and quality improvement, were utilized in this study. The dataset excluded patient names, medical record numbers, addresses, telephone numbers, and other personal identifiers. Access and analysis of the operational data were authorized by the management of Universitas Airlangga Hospital. As the study involved secondary analysis of non-identifiable aggregate data without direct interaction with human participants or any intervention, formal ethical review and individual informed consent were not required according to institutional policy.

Result and Discussion

Reporting Volume and Variable Availability

The analysis included 181 reporting days, with 126 days in 2025 and 55 days in 2026. During the observation period, 1,007 potential homecare patients and 235 completed homecare visits were identified. Offer-status and willingness-response variables were present only in the 2025 dataset, while the 2026 dataset contained potential-patient and utilization data but lacked comparable offer-response variables.

Table 1. Summary of Homecare Promotion and Utilization Funnel

Indicator	July-Dec 2025	Jan-Mar 2026	Total/Interpretation
Potential homecare patients	656	351	1,007 patients
Documented offer status	121	Unavailable	18.4% of 2025 potential patients
Offered homecare	97	Unavailable	80.2% of documented 2025 statuses
Not yet offered	24	Unavailable	19.8% of documented 2025 statuses
Willing to order	2	Unavailable	2.1% of offered 2025 cases
Considering	94	Unavailable	96.9% of offered 2025 cases
Declined	1	Unavailable	1.0% of offered 2025 cases
Homecare visits/utilization	147	88	235 visits
Visits per 100 potential homecare patients	22.4	25.1	23.3 visits per 100 potential patients

Note. Offer and response variables were structurally unavailable in the 2026 reporting format; therefore, they should not be interpreted as absent or negative responses.

Table 1 indicates that the number of potential homecare patients far exceeded the number of completed visits, which is typical for a service funnel. The key issue, however, was not just low conversion but limited visibility into the funnel. In 2025, offer status was recorded for only 121 of 656 potential patients (18.4%), leaving 81.6% without documented status. As a result, it is unclear whether these patients were not offered the service, were offered without documentation, or were deemed clinically or logistically unsuitable. Of the cases with documented offer status, most were offered home care (97 of 121; 80.2%). Nearly all of these were still considering the service at initial contact (94 of 97; 96.9%), which should be viewed as an initial decision rather than a final refusal. The reports did not consistently indicate whether families who were considering the service were later contacted, accepted, declined, or chose another option.

Table 2. Funnel Integrity and Operational Conversion Indicators

Indicator	Formula	Observed value	Interpretation
Offer-documentation completeness	Documented offer status / potential patients	121/656 = 18.4%	Largest measurable weakness; most potential cases were not traceable beyond identification.
Recorded offer among all potential patients	Offered / potential patients	97/656 = 14.8%	Underestimates true offer coverage if offers were made but not documented.
Not-yet-offered among all potential patients	Not yet offered / potential patients	24/656 = 3.7%	Indicates a visible delay or incomplete offer process among documented cases.
Initial willingness among offered cases	Willing / offered	2/97 = 2.1%	Represents initial willingness only; no final decision status was consistently available.
Considering among offered cases	Considering / offered	94/97 = 96.9%	Suggests need for structured post-offer follow-up documentation.
Realized visit ratio, all data	Visits / potential patients × 100	235/1,007 = 23.3 per 100	A utilization ratio, not a patient-level conversion rate.

Note. Indicators should be interpreted as service-monitoring metrics. They do not establish patient-level determinants of utilization because individual-level linkage was unavailable.

Unit-Level Distribution of Potential Homecare Patients

Table 3. Units with the Largest Number of Potential Homecare Patients

Service unit	**Number of potential homecare patients**	**Proportion of all potential patients (n = 1,007)**
IRNA 7	279	27.7%
IRNA 6	199	19.8%
IRNA 3	105	10.4%
Stroke Unit	104	10.3%
IRNA 5 OBSGYN	86	8.5%
Top five units combined	773	76.8%

Potential homecare patients were primarily located in a limited number of inpatient units. IRNA 7 contributed the largest proportion, followed by IRNA 6, IRNA 3, the Stroke Unit, and IRNA 5 OBSGYN. Collectively, these five units represented more than three-quarters of all potential homecare patients (773 of 1,007; 76.8%). This distribution highlights priority units for integrating discharge screening, family education, service-offer scripts, and follow-up documentation.

Service-Category Pattern

Table 4. Categories of Homecare Service Mentions

Service category	Frequency of service-category mentions	Proportion (n = 254 service-category mentions)
Physiotherapy/medical rehabilitation	154	60.6%
Physician/specialist visits	42	16.5%
Wound/catheter/stoma care	20	7.9%
NGT/suction procedures	15	5.9%
Acupuncture	14	5.5%
Injection/infusion services	9	3.5%
Total	254	100.0%

The denominator is service-category mentions rather than visits. One utilization record could include more than one service category; therefore, total service-category mentions exceeded realized visits.

Physiotherapy and medical rehabilitation were the most common service categories, representing 154 of 254 mentions (60.6%). Physician or specialist visits were next (42/254; 16.5%), followed by wound, catheter, or stoma care and nasogastric tube or suction procedures. These findings suggest that homecare utilization at Universitas Airlangga Hospital was primarily driven by the need for functional recovery, clinical follow-up, and specific nursing or procedural care after discharge.

Principal Findings

This operational audit identified a substantial pool of potential post-discharge homecare users at Universitas Airlangga Hospital, with 1,007 potential homecare patients recorded during the study period. However, only 235 realized homecare visits were documented, indicating a considerable gap between potential demand and actual utilization. The most important finding was the limited observability of the homecare service funnel. In 2025, documented offer status was available for only 18.4% of potential patients, while comparable offer-response variables were unavailable in the 2026 reporting format. Consequently, the available data were insufficient to determine whether low utilization reflected patient refusal, delayed decision-making, clinical ineligibility, service barriers, or documentation deficiencies.

Interpretation in Relation to Transitional Care

The findings align with existing transitional-care literature, which emphasizes that hospital discharge constitutes a complex process involving communication, coordination, follow-up, and caregiver preparedness rather than a single administrative event. Tyler et al. and Sakashita et al. have demonstrated that structured transitional-care interventions

enhance continuity of care and decrease avoidable healthcare utilization by improving communication and follow-up after discharge (11, 12). Consistent with these results, the present study indicates that incomplete documentation and lack of follow-up records may impede effective transitions from inpatient care to home-based services.

A notable finding was that 96.9% of patients or families offered homecare were documented as still considering the service at the initial contact. This outcome should not be construed as a rejection of homecare services. Prior research has shown that decisions regarding post-discharge care frequently involve considerations such as caregiver availability, financial constraints, perceived clinical needs, transportation barriers, and confidence in home-based care. Consequently, a high proportion of 'considering' responses may indicate the necessity for structured follow-up rather than a lack of interest in homecare services.

Another significant finding was the low rate of complete offer documentation, with only 18.4% of potential homecare patients having a documented offer status. Comparable challenges have been identified in discharge-planning and transitional-care programs, where incomplete documentation affects health organizations' capacity to monitor patient pathways and identify barriers to service utilization. Insufficient documentation may result in underestimating service demand and diminish opportunities for quality improvement initiatives.

Clinical and Operational Implications

Physiotherapy and medical rehabilitation accounted for 60.6% of all service-category mentions, suggesting that functional recovery is the primary driver of homecare utilization. This finding is consistent with previous studies of home-based and hospital-at-home services, which have demonstrated that rehabilitation needs frequently determine post-discharge service use, particularly among patients recovering from neurological, musculoskeletal, and chronic conditions. The significant role of rehabilitation services highlights the importance of integrating physiotherapists and rehabilitation professionals into multidisciplinary homecare teams.

Furthermore, physician visits, wound and catheter care, nasogastric tube management, injection services, and infusion procedures indicate that home care encompasses ongoing clinical management as well as supportive care. Existing evidence emphasizes that home-based healthcare services require well-defined governance structures, competency standards, patient-selection criteria, supervision mechanisms, and escalation pathways to maintain patient safety. Strengthening coordination among inpatient units, outpatient services, and homecare teams is therefore essential to enhance continuity of care and optimize post-discharge outcomes.

This study does not assess the clinical effectiveness of home care. Instead, it provides an operational audit of the home care utilization funnel. Unlike previous research focused on patient outcomes, satisfaction, or readmission rates, this study examines the process from patient identification and service offering to actual utilization. The findings show that routine operational data can reveal gaps in documentation, follow-up, and service monitoring. This approach can help hospitals distinguish between low demand, unmet

demand, delayed decision-making, and documentation failures, supporting evidence-based service improvement.

Recommended Minimum Dashboard

Table 5. Recommended Minimum Variables for an Integrated Homecare Funnel Dashboard

Domain	Minimum variables	Purpose
Identification	Date, inpatient unit, discharge status, clinical indication, patient-risk category	Ensures that potential demand is captured at discharge.
Offer process	Date/time offered, staff member, decision-maker contacted, education material provided	Distinguishes failure to offer from family hesitation.
Response and barrier	Willing, considering, declined, unable to contact; reason/barrier	Makes non-utilization interpretable.
Follow-up	Scheduled call date, follow-up result, final decision status	Prevents "considering" from becoming an unresolved endpoint.
Utilization	Visit date, service category, staff category, visit completion, cancellation reason	Links offer and response to realized service.
Safety and outcome	Escalation, adverse event, referral, satisfaction, readmission or emergency-department visit if available	Supports future clinical quality evaluation.

A practical response for Universitas Airlangga Hospital would be to integrate the dashboard into discharge planning for high-volume units first, particularly IRNA 7, IRNA 6, IRNA 3, the Stroke Unit, and IRNA 5 OBSGYN. Standardized documentation should include a final decision status after follow-up, not only the initial response at discharge. This would allow future analyses to estimate conversion more validly and to identify modifiable barriers to utilization.

Several limitations should be acknowledged. First, the analysis relied on routine aggregate operational reports, making data quality contingent on the completeness and consistency of documentation. Second, the daily report served as the unit of analysis rather than the individual patient, which precluded reconstruction of unique patient trajectories. Third, offer-response variables were available exclusively in the 2025 dataset, limiting the ability to compare the full funnel between 2025 and 2026. Fourth, service-category data were based on mentions, which could exceed the actual number of visits. Fifth, the analysis did not assess patient-level outcomes such as readmission, emergency department utilization, complications, functional improvement, satisfaction, equity, or cost. These limitations necessitate cautious interpretation and preclude causal inferences. Future research should employ patient-level prospective data with unique linkage across discharge screening, offer, response, follow-up, visit realization, clinical outcomes, and cost. A more rigorous study design could assess determinants of utilization, time from discharge to initial homecare visit, reasons for declining or delaying services, functional recovery following rehabilitation, readmission or emergency

department utilization, patient and caregiver satisfaction, and cost-effectiveness. Additionally, mixed-methods research may provide valuable insights into family decision-making processes and staff workflow barriers. To understand family decision-making and staff workflow barriers.

Conclusion

This study found a clear need for post-discharge homecare services at Universitas Airlangga Hospital. Between July 2025 and March 2026, there were 1,007 potential homecare patients and 235 actual homecare visits. Most homecare was for physiotherapy, medical rehabilitation, and clinical follow-up, underscoring the importance of supporting recovery and ongoing monitoring after patients leave the hospital.

The study also found major gaps in how homecare use was documented, especially in tracking service offers, family responses, follow-up steps, and final decisions. These gaps made it harder to monitor service use and spot barriers to access. To address this, the study recommends establishing a standard homecare monitoring system that integrates with discharge planning. This would improve documentation, help maintain continuity of care, and make it easier to evaluate the quality and use of home care services, as well as patient outcomes, in the future.

Declaration of Conflict of Interest
None.

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None.

Author Contributions
ENE and DC designed the research; MACL conducted the research; AR analyzed the data; PFW wrote the first draft of the manuscript; ENE critically reviewed and revised the manuscript; ENE had primary responsibility for the final content. All authors read and approved the final manuscript.

Data Availability Statement
The dataset generated and analysed during the current study is available from the corresponding author upon reasonable request.

Declaration of the Use of AI in Scientific Writing
The authors declare that artificial intelligence (AI) tools were used solely to assist in language refinement and improving the clarity of the manuscript. The AI did not contribute to the study design, data analysis, or interpretation of results.

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