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Recognizing Barriers in the Elderly Population and Increasing Access to Case Management Services

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Recognizing Barriers in the Elderly Population and Increasing Access to Case Management Services

Executive Summary

Introduction of the Problem

Hospital readmissions are a leading concern in healthcare today. According to Glans et al. (2020), patients aged 65 or older accounted for 56% of early readmissions, while 27% of readmissions can be prevented within 30 days of post-hospital discharge. Several barriers lead to a patient's hospitalization, including socioeconomic status, education level, housing situation, the severity of their chronic conditions, and access to primary care. Patients living in underserved areas with low education levels are more likely to be hospitalized multiple times than those living in urban areas (Fraze et al., 2019). Providing a multicomponent intervention involving primary care appointments, patient satisfaction, patient accountability, and self-care may reduce the number of patients needing emergency room care (Pugh et al., 2021). Patient education regarding new medications, diseases, and treatments can enable patients to take responsibility for their health issues. Using effective strategies to address these factors can reduce hospital readmissions in the geriatric population.

Literature Review

It is difficult to achieve optimal outcomes for geriatric patients without considering their socioeconomic status. Low socioeconomic status includes many factors and can affect how people live and can contribute to the quality of their lives. Access to transportation is essential as it provides people with access to essentials such as food, clothing, medical treatment, and social needs. Another concern is that geriatric patients who may be disabled or have mobility impairments may have difficulty finding access to transportation (Henning-Smith et al., 2017).

Patients with health literacy issues may have difficulty managing chronic conditions and their daily lives. This can include taking care of themselves, independently getting dressed, cleaning themselves, and eating by themselves (Zaben & Khalil, 2019). Chronically ill patients living in underserved communities face a great deal of hardship when it comes to paying for essentials, such as medication, resulting in difficult decisions on what they must give up. Due to disparities, language barriers, and misunderstanding of chronic conditions, older adults may not have access to primary care, leading to multiple emergency room visits and possibly longer hospital stays (Fulmer et al., 2021; Meurs, 2021).

Having case management can help promote better outcomes for patients and provide cost-effective solutions. Individuals seeking help for their social issues, for whom there might not be a lot of resources, can benefit from this, which can decrease the burden on primary care providers. Using case management to advocate on behalf of patients, and to assist them with concerns that hinder them from adequately taking care of themselves, is critical to reducing hospital admission rates.

Project Methods

A questionnaire was distributed to older adult patients at the practice site during the implementation period. Information collected included demographics, living arrangements, ADL needs, family involvement, and the number of hospital visits. The patients' responses were evaluated, and the provider determined if a case management referral was appropriate based on the patient's social needs and/or chronic medical conditions.

Evaluation

Patient questionnaires were administered from June 6, 2022, through August 28, 2022. A post-implementation survey using a Likert scale was administered to the providers and staff to gather feedback on the project and assess strategies to impact future practice (Appendix A).

Two hundred and eighty questionnaires were administered during this project. Patient ages ranged from 65-92 years. Most of the participants were aged 70-79 (Figure 1). Each participant completed a questionnaire during their annual physical. Questions included demographics, how many trips to the emergency room and hospital admissions in the last year, nursing home admissions in the last year, family involvement when needed, help with ADLs, understanding chronic medical conditions, and the primary language used (Figure 3). Out of the 280 patients, ten patients were given a referral to case management for their chronic conditions or their social needs (Figure 4). Out of those ten case management referrals, eight of the participants had followed up with case management for their needs. Patients who were involved in their care, along with their families, and understood their medical conditions, were less likely to visit the emergency room and be admitted to the hospital (Figure 2 and Figure 3). Two weeks after the project implementation period ended, a 5-point Likert scale survey was distributed to the providers and office staff to complete (Appendix A). Scores from the survey demonstrated office staff did not find any hindrance in providing the questionnaire and did not report any disruption in their workflow. Providers reported they found the questionnaire concise in assessing their patient's social needs.

Impact on Practice

Social disparities in the older population can affect their social and medical needs, as well as how access to primary care can help them improve their chronic conditions (Basu, 2019; Frazee et al., 2019; Zaben & Khalil, 2019). Providers reported that ordering a referral to case

management was helpful since it provided additional resources to patients who they felt were at high risk for hospitalization following the implementation of this project. After the implementation of the project, 96% of patients left the office with a clear understanding of their chronic conditions, supporting the fact that providers spent adequate time explaining chronic conditions to their patients during their appointments (Figure 3).

In the long term, providers will screen their patients for comorbid conditions, and if necessary, case management will be ordered. As a result, healthcare providers will be able to respond to their patient's social needs sooner, which will allow them to make better health decisions. This project can be replicated in any health center or clinic with the ability to place referrals for case management in their EHR. The questionnaire used in this project can be replicated and used during any visit with the provider.

Limitations to this project were the low number of participants during the data collection period, the short length of the project, and using a single primary care clinic.

Conclusion

By addressing social disparities among older adults, providers can be proactive in evaluating and initiating case management if necessary. As a result of case management, patients can receive resources to address their social needs, as well as have access to an on-call provider if their condition worsens requiring medical attention. A case management approach can help reduce the disparities that exist in the elderly population, thus decreasing the number of unnecessary hospitalizations resulting in lower healthcare costs.

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