Does Care Coordination Reduce Emergency Room Visits and Hospitalizations in the Diabetic Elderly?

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Diabetes Mellitus is a growing epidemic among the elderly. As this disease continues to increase across the nation; healthcare providers are scrambling for more effective ways of improving outcomes in this vulnerable population. The concept of care coordination is one possible solution that will not only help to reduce emergency room visits and hospitalizations among the diabetic elderly, but provide solid and consistent care to a population that is sometimes forgotten.
Coleman et al., (2001)
The results from this randomized control trial (RCT) show that patients in the intervention group who received monthly physician “group visits” were not only less likely to make an emergency room visit, but they were also less likely to have made multiple emergency room visits.

Leveille et al., (1998)
This RCT was conducted to evaluate the effectiveness of a one year chronic illness and disability prevention program on health, functioning, and healthcare utilization in frail older adults. It was concluded that community-based care coordination with primary care providers can improve function and reduce inpatient utilization in chronically ill older adults.
Kobb, Hoffmann, Lodge, & Kline, (2003)
Findings from this Rural Home Care Project demonstrate that care coordination enhanced by technology reduces hospital admissions, bed days of care, emergency room visits, and prescriptions as well as providing high patient and provider satisfaction.

Dorr et al., (2006)
Results from this study suggest that care managed patients with diabetes had 3.2% fewer hospitalizations.
Chumbler et al., (2005)

These researchers analyzed the differences in health care service use between 400 veterans enrolled in a care coordination program and 400 veterans who were not enrolled in a care coordination program. In the end, the care coordination program reduced pricey hospital admissions.

Counsell, Callahan, Buttar, Clark, & Frank, (2006)

This group of researchers developed the Geriatric Resources for Assessment and Care of Elders (GRACE) model of primary care specifically for low-income seniors and their primary care physicians (PCPs) to improve the quality of geriatric care to optimize health and functional status, decrease excess healthcare use, and prevent long-term nursing home placement. The GRACE model of intervention is still in the evaluation phase, but the hypothesis is that patients enrolled in the GRACE program will have better health status, greater functional independence, fewer emergency department visits and hospitalizations, and fewer nursing home days over two years of follow-up than patients receiving usual care.
Group visits are a new model of care that recognize the discordance between the expanding needs of older adult patients with chronic illness and the acute-care orientation of the typical 15-minute office visit. The main goal of the group visit is to facilitate self-management of self care, peer and professional support, and attention to the psychosocial aspects of living with chronic illness. (Coleman et al., 2001)

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“Group Visits” in New Orleans Senior High Rise Building

- One “group visit” per month with 5 seniors (ages 66-82, 1 Hispanic, 4 Black, 3 females, 2 male, all with several co-morbidities such as HTN, DM, COPD, and CAD). So far, only two “group visits” have been made.
- Providers involved: NP, Podiatrist, Optometrist, RN, and Social Worker
- Visits begin with “meet-n-greet” and then a brief presentation on the topic of the month is given. The medical assistant takes vitals and administers shots while the other providers perform their respective duties. Time is allowed for one-on-one consultations with the PCP. Healthy refreshments are usually offered after each session. Total session time has been approximately 60 minutes.
Evaluation Plan

- Evaluation sheets were administered after the second “group visit”. The patients were asked to indicate where improvements could be made and what additional services were needed.
- So far, the group visits have been a huge success. Many new residents want to attend and several have asked for dental services and additional information on available community resources such as: Road Home information and transportation assistance.
Future Plans

• The future plans are to find a dentist or solicit information from the LSU Dental School about possible dental students to give exams or teeth extractions.

• Offer “group visits” at other senior homes in different neighborhoods.

• Research possible grant options to assist with the acquisition of electronic medical record.

• Consider offering diagnostic capabilities such as: x-ray, EKG, and ultrasound options.
Proposed Journals for Submission

- Journal of the American Academy of Nurse Practitioners
- Geriatric Nursing
- Journal of Advanced Nursing
- Journal of Nursing Administration
- Journal of Professional Nursing
Bibliography