Case Management of Complex Rural Underserved Populations

Jeri Hargrave, Janquilyn Merida, Michele Owens
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Case Management

- Is a system, a clinical decision-making process, a technology, a role, and a service.
- A process of determining, integrating, and monitoring complex client needs.
- Seeks to balance quality of care outcomes with efficient use of existing resources.
Specific characteristics of case management include:

- Emphasis on active client participation
- Holistic orientation
- A self-care, self-deterministic orientation
- Coordination and efficient use of a wide range of human services
Rural Population Special Characteristics

- Represents a vulnerable population
- Faces specific health care challenges
  - Access to care
  - Scarce resources
  - Traditional cultural belief systems
Theoretical Basis

- Rural case managers need to be ‘generalists’
- Framework for nursing case management includes five dimensions:
  - Assessment
  - Planning
  - Implementation
  - Evaluation
  - Interaction
Needs Assessment

- Clinical
- Financial
- Functional well-being
- Satisfaction
- Quality
- Humanistic
Decision Making Concepts

Goal: To provide a continuum of services designed specifically to meet a client’s needs for a specific period of time.

- Availability
- Affordability
- Acceptability
The Veterans Health Administration (VHA) mandated a 200% increase in midlevel providers in response to healthcare over the past decade to expand access to care. Approximately 30% of VHA primary care providers are midlevels.
2009 study at VA examined whether treatment change for diabetic patients presenting with elevated BP differed between physicians and midlevel providers.

(Subramanian et al., 2009)
Hospital-at home care for COPD exacerbations: an observational cohort study of patients managed in hospital or NPs in the community.

• (Ansari, Shamssain, Farrow, & Keaney, 2009)
Review of Literature

- National study sought information from rural patients
  1. to assess the prevalence of health seeking outside of community
  2. examine impact of locally available PCPs and hospital size on bypass odds
  3. identify patient demographic and geographic factors
32% of respondents bypassed local primary care.

Conclusion: Strategies to reduce bypass behavior should be directed at the local community or facility level.

(Liu, Bellamy, Barnet, & Weng, 2008)
1. Interprofessional collaboration has repeatedly been shown to decrease healthcare costs and improve both care quality and health outcomes.

2. DNP graduates in clinician roles engage in balancing acts daily when collaborating with other healthcare professionals.
3. Knowledge of effective collaborative communication between healthcare disciplines will enable DNP graduates to effectively build a bridge between healthcare disciplines.

• (Chism, 2010)
P.T. is a 63 year old, white female

- DX – Insulin dependent diabetes mellitus, s/p cva in 2003
- PMH – Former smoker 1/pk/day for 20 years, quit 2003; does not drink alcohol or use illicit drugs
- SH – worked for American Airlines until stroke, has a disabled son that lives with her, and a male companion.
- Allergies - none
Recent medical problems:
- Fell in spring 2009 and broke an endplate at L4.
- Has used a walker or cane since stroke.
- Since fall relying mostly on walker.
- Spending more time in bed.
- Cut bottom of foot.

Interdisciplinary Care:
- Home health: skilled nurse, occupational therapy, physical therapy.
- Provider: monitor, cleanse, and dress foot wound. Monitor labs.
M.S. is a 57 year old, white male

- Social History- Divorced. Smokes < 1 PPD times 30 years. No ETOH.
- Allergies- Nuts, Sunflower seeds, Pecans, Bee stings, PCN, Glucophage, Velosef
Case Study #2

- Past Medical History - Depression (history of molestation at 12 years), Type 2 DM (Insulin), HTN, Severe OSA,
- Klinefelter Syndrome (XXY)
  - Very long arms and legs, large hands and feet
  - Testosterone deficiency
    - (Lewis, 2008)
Interdisciplinary Care

- Podiatrist (Diabetic foot ulcer)
- Surgeon (Recent skin graft)
- Urologist (Erectile Issues; Potential Penile Implant)
- DADs service through Girling Home Health
  - Provider, nursing care of ulcer by wound vacuum, and dietician

Recent Labs (9/30/09)

- Fasting glucose-192, HA1C-8.4 decreased from 9.1, normal renal and lytes
Case Study #3
**DNP Role**

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<tr>
<th>THE DNP WORKS</th>
<th>THE DNP EMPLOYS</th>
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<tr>
<td>independently</td>
<td>evidence-based practices</td>
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<td>and collaboratively</td>
<td>various information systems</td>
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<td>• In order to aggressively manage the complex, rural underserved population</td>
<td>quality patient care</td>
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<td>evaluate outcomes</td>
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Importance of Case Management of the Complex, Rural Underserved Patient

- Chronically ill patients account for more than 125 million Americans.
- Reported better disease control with case management and thus improved quality of life for the patient.
- Case Management with oversight by nurse practitioners is cost effective.
Who would benefit from the DNP role?

- Patients
- Caregivers
- Clinical and Medical staff
- Third party payors

Stakeholders
DNP and Complex Management

- There is a body of research and practical experiences that support the superior quality and cost benefits possible through case management of the complex rural underserved population by the DNP.
DNP Case Management and Telemedicine

- Telemedicine includes care that is provided despite the distance.
- Telemedicine has an emphasis on patients’ long-term wellness as well as current chronic illness.
- DNP collaboration may be improved through telemedicine by providing consultation in rural areas where care otherwise would not be given.
The DNP often uses the knowledge garnered through the DNP program
  • to integrate evidence-based practice,
  • utilize information technologies,
  • to build a bridge between the disciplines in order to successfully manage the rural underserved population.
References


