



Original Article

Barriers to primary care hospital follow-up among older adults in rural or semi-rural communities



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ABSTRACT

Background: Failure to follow-up with a primary care provider (PCP) following discharge from an acute care setting is strongly associated with readmission within 90 days among elderly patients.

Aim: The purpose of this study was to identify barriers to primary care follow-up among older adults in rural communities.

Methods: This was an explanatory mixed methods study which included scaled survey and interview techniques. Descriptive and inferential statistics were calculated for scaled concepts. Standard content analysis was performed on the qualitative items.

Results: Correlation between intention to follow-up with a PCP and actual follow-up was poor ($r = 0.20$). Patients encountered substantial obstacles to the PCP follow-up visit. Obstacles clustered into two groups: 1) healthcare or social system barriers and 2) personal characteristics of patients.

Conclusions: Individualized discharge planning that reflects the complexities of post-hospitalization adaptation for elders is most likely to be useful for ensuring PCP follow-up.

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1. Background

The true number of preventable hospital readmissions is unknown, but it has been estimated that up to 79% of readmissions could have been avoided (van Walraven, Bennett, Jennings, Austin, & Forster, 2011). This is a significant problem for patients and hospitals. Patient quality of life is diminished, and hospitals experience economic damages as a result of readmissions. The United States government is currently using hospital readmission as an indicator of quality of care and imposing financial penalties on hospitals with unacceptable rates of readmission for patients with heart failure, heart attacks and pneumonia. About two thirds of US hospitals experienced some penalty for readmission in 2012, and penalties are designed to increase.

Discharge planning is required for all patients released from an acute care facility (The Joint Commission, 2012) and is thought to have an impact on readmission. Discharge procedures for elders are most successful when each patient's unique characteristics and contexts are recognized (Dedhia et al., 2009). Discharge planning is usually based on the presumption that the patient experience will include continued care in the community, but studies of hospital readmissions among elderly have documented poor continuity of care from inpatient to out-patient settings (Lin, Barnato, & Degenholtz, 2011). It has also been

shown that failure to follow-up with a primary care or other provider, including general family practice MD or DO and associated nurse practitioners and physician assistants, following discharge to a non-institutional setting from an acute care setting is strongly associated with readmission within 90 days (Lin et al., 2011) among elderly patients. According to research by the Center for Studying Health System Change, one in three adults discharged from acute care hospitals into the community do not see a physician or nurse practitioner in the month following discharge. The same study found that one in twelve adult patients are re-hospitalized within 30 days of discharge and one and three are readmitted within a year (Sommers & Cunningham, 2011).

Follow-up with primary care providers (PCP) is one of the most powerful components of effective after-care; therefore understanding what drives patient decisions to follow-up is important for prevention of hospital readmissions. Coordinated transitional care for elders results in cost savings for insurers (Peikes, Chen, Schore, & Brown, 2009), so interest in innovations that improve transitional care for the elderly is great. Although dedicated inpatient and floating units for geriatric patients staffed with interdisciplinary healthcare teams have been shown to be effective for improving transitional care for elders (Arbaje et al., 2010; Avlund, Jepsen, Vass, & Lundemark, 2002), smaller and rural hospitals rarely have the resources to establish such units. Instead, they tend to discharge elders directly from busy general medical-surgical units. In states such as Texas, which continue to report large rural populations, what happens to patients discharged from smaller community hospitals matters. The primary aim of this project was to identify barriers to prompt hospital follow-up with primary care providers for elderly patients living in rural or semi-rural environments.

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2. Conceptual framework

The concept of transitional care is substantially different from the concept of hospital discharge. Whereas “hospital discharge” connotes an endpoint in a process, “transitional care” conveys the idea that care continues after discharge and can be coordinated. Ineffective care transition was highlighted as one of the most damaging characteristics of the fragmented US healthcare system by the influential IOM publication, *Crossing the Quality Chasm* (2001). Since then, Naylor’s work on a transitional care model emphasizes the importance of continuity of care following discharge by integrating a formal mechanism for connecting patients with primary care providers (Naylor et al., 1994). Ajzen’s theory of planned behavior (TPB) is a useful theory for understanding the forces that motivate patients to cooperate with plans for transitional care. TPB claims that patient behavior is a result of patient intention rooted in a) patient attitudes toward the target behavior, b) cultural norms, and c) patient perception of control (Ajzen, 2002). Given this assumption, post-discharge follow-up with a PCP is as much a function of patient beliefs as it is dependent on hospital staff enabling activities. Ajzen’s theory provides a balance to the tendency to attribute to healthcare professionals complete power to change patient behavior. The TPB recognizes the central role of the patient in planning intentional behavior and suggests that a mechanical process for connecting patients to primary care after discharge may be necessary, but not sufficient to ensure follow-up.

3. Methods

This was an explanatory mixed methods study which included survey and interview techniques. The study was reviewed and approved by the institutional review board (IRB) of the host hospital system. Written informed consent was obtained from each participant.

3.1. Sample

This purposive sample was recruited from patients aged 60 years and older admitted to a general medicine–surgical unit in a small (36 beds) semi-rural hospital. Semi-rural hospitals are those located in urban fringes that continue to serve rural populations, as well as residents of outer ring suburbs. Clientele in this community hospital includes large numbers of older adults who have spent most of their

lives in rural or small town environments performing blue collar or other low-income work.

Patients were eligible to enroll if they spoke English. Patients with a diagnosis of dementia or who appeared confused or belligerent were excluded. Power analysis indicated a sample size of thirty would be sufficient to answer the primary research question. The power analysis was based on the choice of 0.05 for alpha and the assumption that an exact test would be used to evaluate the relationship between stated intention to see a PCP and actually completing the PCP follow-up. The sample size of thirty for the survey was calculated assuming an exact test with intention to see a primary care provider following discharge as the outcome. A homogeneous sample of thirty was also considered sufficient to obtain qualitative data for the purpose of identifying specific barriers to follow-up.

3.2. Recruitment

Both investigators, working singly, participated in recruitment, consenting, and interviewing of subjects. Investigators approached eligible patients on days investigators were present at the study site. Investigators explained the study and if patients were interested, obtained written informed consent. Reasons given by potential participants for refusing to participate included competition with a favorite television program, competition with visitors, fatigue, and disinterest or suspicion.

3.3. Measures

A questionnaire, Patient Attitudes Towards Use of a Primary Provider after Hospital Discharge (PAPPAD) was created by the investigators based on Ajzen’s principles for constructing measures testing the theory of planned behavior (Ajzen, 2002). The questionnaire consisted of 13 scaled items and 12 qualitative items. It was administered to participants at a time convenient to them during admission by one of the investigators. Most participants were able to and preferred reading and completing the scaled survey questions themselves. When needed, an investigator read the questions to subjects and marked the response the participant indicated for scaled items. Qualitative items were administered by the investigators who collected responses in the form of field notes. Completing the questionnaire/interviews took about 15–30 minutes.

Scaled items were written as semantic differentials with adjective anchors at the ends of a 1–7 scale as illustrated in Table 1 (with results).

Table 1
Responses to scaled items.

Item	Range	Mean (SD)
1. Seeing a primary care doctor or nurse practitioner after I am discharged from the hospital would be Unpleasant–Pleasant	1–7	6.6 (1.3)
2. Most people who are important to me approve of seeing a primary care doctor or nurse practitioner every year Disagree–Agree	5–7	6.72 (0.64)
3. Most people who are important to me approve of seeing a primary care doctor or nurse practitioner after being discharged from the hospital Disagree–Agree	2–7	6.67 (0.98)
4. Most people like me do see a primary care doctor or nurse practitioner after being discharged from the hospital Likely–Unlikely*	4–7	6.72 (0.69)
5. I am confident that I can see a primary care doctor or nurse practitioner after being discharged from the hospital False–True	1–7	3.27 (2.38)
6. Seeing a primary care doctor or nurse practitioner after being discharged from the hospital is up to me Disagree–Agree	5–7	6.90 (0.40)
7. Seeing a primary care doctor or nurse practitioner after being discharged from the hospital depends on my family or friends or boss. Disagree–Agree*	6–7	6.97 (0.18)
8. I agree with the things my primary care doctor or nurse says Never–All the time	1–7	3.59 (2.75)
9. My insurance will pay for a follow-up visit to the primary care doctor or nurse practitioner I want to see. Disagree–Agree	4–7	5.97 (1.05)
10. Chances that I will see a primary care doctor or nurse practitioner after being discharged from the hospital this time are: Unlikely–Likely	1–7	6.53 (1.50)
	1–7	6.07 (1.93)

Higher scores indicate more positive responses.

* Reverse scored.

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