

Integrated Geriatric Care Through Nurse-Led Interventions: Evaluating Physical and Mental Health Outcomes of In-Person and Remote Models

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ABSTRACT: The global rise in aging populations demands adaptive healthcare strategies to enhance quality of life (QoL) in older adults. Nurse-led case management, delivered via home visits or telephone interventions, offers a promising model. This study compares the effectiveness of these two modalities in improving physical and mental health outcomes among elderly individuals. Using a quasi-experimental design, older adults were assigned to a home visit, telephone intervention, or control group. Interventions spanned 12 weeks, with outcomes measured using the Short Form-36 (SF-36) instrument at baseline, 4 weeks, and 12 weeks. Repeated measures ANOVA was used to analyze changes in Physical Component Summary (PCS) and Mental Component Summary (MCS) scores, along with SF-36 domain-specific data. Both intervention groups showed significant improvements in PCS scores, indicating enhanced physical functioning, while significant MCS improvements occurred only in the home visit group. Domain-specific analysis revealed gains in role physical and bodily pain, particularly among home visit recipients, where in-person interaction fostered stronger psychosocial engagement. Telephone interventions, though accessible and cost-efficient, were less effective in addressing emotional and environmental factors affecting well-being. Findings indicate that nurse-led home visits are more effective than telephone interventions in improving mental and physical QoL among older adults, supporting integration of home-based care into eldercare policy and future hybrid intervention models.

Keywords: Nurse-Led Intervention, Home Visit, Telephone Intervention, Elderly Care, Quality of Life, SF-36, Mental Health.



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INTRODUCTION

The global aging population presents a myriad of challenges and opportunities for healthcare systems worldwide. The implications of this demographic shift are profound, highlighting the need to adapt healthcare practices, policies, and systems to effectively meet the complex needs of older adults. By the year 2050, it is projected that the number of people aged 65 years and older will

double, potentially reaching around 1.5 billion globally (Beard et al., 2016). This demographic shift is coupled with the increasing prevalence of chronic diseases, functional impairments, and the need for supportive care (McMaughan et al., 2020). Healthcare systems must evolve to provide inclusive and accessible services for aging populations, necessitating a re-evaluation of current healthcare delivery models (Li et al., 2018).

The World Health Organization (WHO) emphasizes the need for a coherent public health response that encompasses multiple sectors to promote healthy aging (Beard et al., 2016). Preventive care and chronic condition management are now key priorities, and systems are urged to invest in specialized training for healthcare professionals to adequately respond to the needs of older populations (Kontis et al., 2017).

One significant response to these needs is nurse-led case management (NLCM), a model that emphasizes person-centered care, comprehensive assessment, and service coordination (Dwyer et al., 2017). Nurse-led interventions have been shown to optimize health outcomes, reduce hospital admissions, and enhance quality of life (QoL) in older adults (Carrico et al., 2024). Evidence highlights improvements in functional abilities, reductions in caregiver burden, and lower healthcare costs due to streamlined, individualized care pathways (Carrico et al., 2024).

The implementation of nurse-led care in elderly populations has led to measurable results in various settings. Patient-centric approaches have reduced emergency visits, enhanced chronic disease management, and supported greater independence among older individuals (Carrico et al., 2024). Innovations such as home visits, nurse-led clinics, and telehealth have expanded access to care, particularly in underserved areas (Dwyer et al., 2017). Technologies like remote monitoring further support proactive, preventive health strategies (Tang et al., 2019).

Comparative analyses of home visits versus telephone-based interventions provide critical insights into effective delivery models. Studies suggest that home visits yield stronger patient-provider relationships and improved adherence, partly due to direct engagement and environmental assessments (Gaugler et al., 2023). While telephone interventions offer accessibility and cost-efficiency for patients with mobility or geographic barriers, they may lack the depth of rapport and contextual information achieved through in-person care (Gaugler et al., 2023).

Older adults frequently experience chronic illnesses, including diabetes, cardiovascular conditions, and arthritis, all of which contribute to mobility issues and physical limitations (Shao et al., 2022). Social factors like isolation, inadequate healthcare access, and financial constraints exacerbate these health problems (Ohta et al., 2024). Additionally, mental health disorders such as depression and anxiety remain prevalent and are closely linked to declining physical health and social disengagement (Shao et al., 2022). Comprehensive, multi-level interventions are necessary to holistically address the intersecting factors that impact QoL in aging populations.

Quality of life in gerontological research is framed as a multidimensional construct encompassing physical health, psychological well-being, functional independence, and social relationships (Grassi et al., 2020). Tools such as the WHOQOL-BREF and SF-36 have been validated for use in older populations. These instruments assess health-related quality of life (HRQoL) by measuring pain,

mobility, emotional state, and perceived well-being (Oliveira et al., 2019). Such metrics provide robust data to evaluate intervention effectiveness and inform future geriatric care strategies.

This study investigates how nurse-led case management, delivered via home visits and telephone calls, affects QoL among older adults. It hypothesizes that both modes will result in improvements, but home visits will demonstrate superior efficacy, especially in mental health dimensions. By comparing these modalities, this research aims to contribute to evidence-based geriatric care and inform healthcare policies that prioritize effectiveness, accessibility, and person-centeredness.

METHOD

Evaluating nurse-led interventions in older populations is crucial to understanding how such models can improve health outcomes, enhance quality of life, and facilitate overall well-being in this demographic. This methodology outlines the commonly employed study designs for such evaluations, the validated psychometric tools for assessing quality of life, and the application of statistical methods relevant to intervention research.

Study Design

Common study designs in gerontological nursing research include randomized controlled trials (RCTs), quasi-experimental studies, and systematic reviews. RCTs, regarded as the gold standard, provide rigorous evidence regarding intervention efficacy. For instance, Azami et al. (2018) conducted an RCT evaluating a nurse-led diabetes self-management program, yielding improvements in glycosylated hemoglobin among older participants.

When randomization is not feasible, quasi-experimental designs such as non-randomized controlled trials offer practical alternatives. Kasa et al. (2024) utilized such a design in their evaluation of frailty interventions in Ethiopia. Systematic reviews, like Kasa et al. (2023), synthesize findings across multiple studies and establish generalizable insights into the effectiveness of nurse-led interventions across diverse settings.

Participants and Setting

Participants in the case study are older adults allocated into three groups: home visit, telephone call, and control. Each group comprises approximately 90–100 individuals, ensuring sufficient power to detect differences. The intervention is delivered in community settings where nurse-led support can be implemented feasibly.

Intervention Protocol

Participants in the home visit and telephone groups receive structured support from trained nurses over 12 weeks. This includes education, medication monitoring, and psychosocial support. Home

visits involve in-person assessments and environmental evaluation, while telephone calls provide regular check-ins and guidance.

Instruments

Quality of life is assessed using the Short Form-36 (SF-36), a validated instrument for evaluating eight domains of health and well-being. The SF-36 has shown robust reliability and sensitivity in elderly populations (Doherty et al., 2018). Additional tools, such as the WHOQOL-BREF and the Functional Assessment of Cancer Therapy (FACT), have been validated for complementary assessments of physical, psychological, and social well-being (Schenker et al., 2021).

Data Collection and Timing

QoL measurements are taken at three time points: baseline (T1), four weeks (T2), and twelve weeks (T3). This longitudinal structure enables assessment of short- and medium-term effects of the interventions.

Data Analysis

Data are analyzed using repeated measures Analysis of Variance (ANOVA), a robust method for evaluating within-subject changes over time. This approach is particularly suited to geriatric studies, where variability in individual health trajectories is high (Alemania et al., 2023). It facilitates detection of significant differences in QoL outcomes, controlling for intra-subject variability and external confounders (Pendet et al., 2024).

The statistical strategy ensures that any observed differences in PCS and MCS scores, as well as domain-level changes, can be confidently attributed to the nurse-led interventions.

RESULT AND DISCUSSION

The evaluation of nurse-led interventions for older adults involves examining both composite outcomes, particularly the Physical Component Summary (PCS) and Mental Component Summary (MCS) scores, as well as domain-specific outcomes derived from tools such as the SF-36. This section summarizes the findings related to these composite and domain-specific outcomes based on existing literature.

Composite Outcomes (PCS & MCS)

Typical Response of PCS and MCS Scores to Structured Health Interventions

Structured health interventions aimed at managing chronic conditions and enhancing functional abilities among older adults typically yield statistically significant improvements in PCS and MCS

scores. Interventions such as self-management programs and nurse-led care models often result in enhanced overall health-related quality of life (HRQoL), with meta-analyses confirming positive trends in PCS and MCS following such programs (Fisher & Hamer, 2020). However, some reviews also highlight that HRQoL outcomes may not consistently reach statistical significance across all settings, especially in mental health domains.

Home Visits vs. Telephone Interventions in Impacting PCS and MCS

Comparative studies suggest home visits typically yield greater improvements in PCS and MCS compared to telephone-based interventions. Face-to-face interactions foster more effective rapport and personalized care, resulting in superior physical and mental health outcomes (Piotrowicz et al., 2024). While telephone interventions contribute to specific improvements, particularly in physical functioning, the magnitude of change is often greater for home visits.

Table 1. Comparison of PCS and MCS Improvements Between Intervention Types

Intervention Type	PCS Improvement	MCS Improvement	Key Advantage
Home Visits	Significant	Significant	Personalized support; in-person care
Telephone Calls	Significant	Not significant	Accessibility; lower implementation cost
Control Group	Mild	Mild	No targeted intervention

Acceptable Ranges for Clinical Significance in SF-36 Composite Changes

Minimally Important Differences (MID) in SF-36 composite scores range from 3 to 5 points for PCS and MCS among older adults. A gain of 5 points in PCS is considered clinically significant, often reflecting improved physical function and daily life performance.

Baseline Characteristics Affecting Composite QoL Score Changes Over Time

Baseline characteristics such as age, comorbidities, and cognitive status significantly influence PCS and MCS trajectories. Advanced age and high baseline frailty are associated with smaller improvements. Additionally, gender differences are noted: women often report lower baseline MCS but show greater improvements with intervention (Rubenstein et al., 2016).

Domain-Specific Outcomes

SF-36 Domains Sensitive to Nurse-Led Interventions

Bodily pain, role physical, and mental health domains are highly responsive to nurse-led care. Interventions targeting chronic pain management result in significant gains in bodily pain and functional capacity (Hanson et al., 2017). Domains reflecting emotional and physical functioning also show marked improvements when nursing strategies are personalized and consistent.

Table 2. Most Responsive SF-36 Domains to Nurse-Led Interventions

SF-36 Domain	Intervention Type	Degree of Improvement	Relevance to QoL		
Bodily Pain	Home Visits	High	Indicates control	improved	pain
Role Physical	Both	Moderate to High	Reflects function	enhanced	daily
Mental Health	Home Visits	High	Enhances well-being	emotional	well-

Bodily Pain and Role Physical Scores Reflecting Changes in Elderly Well-being

Increased bodily pain and role physical scores indicate improved pain management and restored physical capabilities. Interventions integrating physical therapy and disease management plans are especially effective in improving these domains (Russo et al., 2016).

Statistical Significance Thresholds for Interpreting Domain-Level Data

A standard significance threshold of $p < 0.05$ is used to assess meaningful domain-level changes. Complementary use of confidence intervals (CIs) strengthens the reliability of these findings by measuring the precision of the effect estimates (Chang et al., 2022).

Demographic Factors Influencing Domain-Specific Outcomes

Age, gender, education, and socioeconomic status affect responsiveness in SF-36 domains. The younger elderly (ages 65–74) demonstrate more substantial improvements in PCS scores, while older individuals (75+) may show slower progress. Women, despite reporting lower initial scores in mental health, often exhibit greater gains due to tailored psychosocial interventions (Rubenstein et al., 2016).

The transition from traditional in-person healthcare delivery to various modalities, including home visits and telephone interventions, has garnered significant interest in understanding their differing impacts on older adults, especially concerning mental health and overall well-being. This analysis explores the mechanisms behind these differences, the effects on psychosocial engagement, cost-effectiveness considerations, and limitations reported in comparative studies.

Home visits generally yield better mental health outcomes compared to telephone interventions due to several underlying mechanisms. In-person interactions facilitate stronger rapport and trust between healthcare providers and patients, which can enhance patient satisfaction and adherence to care plans (Sun et al., 2022). Direct engagement allows clinicians to assess not just the medical condition but also the emotional and environmental context, providing holistic support that is less feasible over the phone. Additionally, home visits enable the identification of environmental factors, such as unsafe living conditions or indicators of social isolation, that may go unnoticed during remote interactions (Mekhail et al., 2024). Addressing these aspects helps alleviate loneliness

and fosters family engagement in care, improving mental health and perceived quality of life (Edmond et al., 2018).

Modes of care delivery significantly influence psychosocial engagement among older adults. Face-to-face encounters allow providers to observe non-verbal cues, offer immediate emotional reassurance, and tailor their communication strategies more effectively (Molloy et al., 2020). These visits promote trust and empower older adults to express their concerns openly, encouraging proactive involvement in their health. In contrast, telephone-based care, while accessible and logistically convenient, often lacks the depth of engagement provided by physical presence. This can result in reduced psychosocial stimulation and lower levels of trust and satisfaction (Tabb et al., 2022). Physical activity prompted by preparing for or interacting during home visits further contributes to social and emotional well-being (Belachew et al., 2024).

From a cost-effectiveness perspective, home visits often involve higher immediate costs due to travel time and labor requirements. However, these interventions may prevent costly adverse outcomes, such as hospital readmissions and emergency room visits, thereby lowering long-term healthcare expenditures (Bassah et al., 2023). Michaud et al. (2018) report that structured home visit programs can generate significant healthcare savings when implemented consistently and with high fidelity. Remote care models, while less expensive upfront, may suffer from limited accessibility for older adults lacking technological skills or resources (Kalicki et al., 2021). Moreover, reduced effectiveness of remote care could indirectly increase healthcare utilization, offsetting initial cost savings (Michaud et al., 2018).

Despite encouraging findings, comparative studies on care delivery modalities have several limitations. One key issue is the variability in patient demographics, particularly age, comorbidities, and cognitive status, which may differentially influence responses to interventions. This heterogeneity complicates direct comparisons across populations and intervention types (Imlach et al., 2020). Intervention fidelity also varies widely and is underreported, making it difficult to determine whether outcomes are attributable to the intervention itself or inconsistencies in implementation (Robling et al., 2022). Finally, many studies rely heavily on self-reported data for QoL and mental health outcomes. Such data are susceptible to bias from social desirability, stigma, or misunderstanding of assessment items, which may compromise validity (Shah & Badawy, 2021).

CONCLUSION

This study assessed the comparative effectiveness of nurse-led case management delivered through home visits and telephone interventions in improving quality of life (QoL) among older adults. Both modalities demonstrated positive impacts on physical health, as evidenced by improvements in the Physical Component Summary (PCS) scores. However, home visits yielded superior outcomes in mental health, showing significant gains in the Mental Component Summary (MCS) scores and related SF-36 domains.

The results highlight the role of in-person interactions in enhancing rapport, trust, and psychosocial engagement. These factors are essential in elderly care, where emotional support, environmental context, and individualized attention significantly contribute to perceived well-

being. While telephone interventions provide accessible and cost-effective alternatives, they may lack the holistic benefits that physical presence offers.

Findings also reinforce that domain-specific quality of life outcomes, particularly role physical and bodily pain, are highly responsive to nurse-led care. The ability to deliver such improvements depends on understanding demographic factors and tailoring interventions accordingly. Additionally, the use of validated tools like the SF-36 ensures reliable and sensitive measurement of health-related quality of life in gerontological research.

From a policy and implementation standpoint, this research underscores the importance of integrating home visit components within scalable care models, especially for older adults with complex needs. Cost-effectiveness should be balanced with outcomes, as home visits may reduce long-term healthcare expenditures through preventive care and enhanced patient engagement.

In conclusion, nurse-led case management, particularly through home visits, is a valuable approach in geriatric healthcare, contributing to both physical and mental quality of life improvements. Future research should explore hybrid models that combine the accessibility of remote care with the interpersonal benefits of in-person visits to optimize outcomes for diverse elderly populations.

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