

The care connection

by ELIZABETH KUMRU

Diabetes is a difficult disease to manage.

It affects the entire body. Management of blood sugar levels through healthy diet and physical activity is critical. Effective management helps patients lower the risks of developing such health problems as kidney disease, heart and blood vessel disease, blindness and neuropathy.

But for millions of uninsured adults, help with management skills and preventive care seem like a luxury.

A team of UNMC College of Nursing researchers want to change that paradigm for patients with Type 2 diabetes mellitus (T2DM) and health care providers across Nebraska. They are studying how the chronic care model can help patients take small incremental steps toward effectively managing their diabetes and other diseases.

"This project will help us determine the effectiveness of our interventions. We know in theory that prevention is good, self-management works and nursing clinics are valuable. Now we're putting all these elements together into one comprehensive care plan," said Susan Beidler, Ph.D., associate professor, community based health, and director of the Morehead Center for Nursing Practice.

The UNMC team is led by project director Teresa Barry, Ph.D., assistant professor, families and health systems, and Dr. Beidler, assistant project director. They are in the second year of a five-year, \$1.6 million Health Resources and Services Administration (HRSA) grant.

"We want to help empower people with diabetes to manage their disease better through small, achievable steps in lifestyle changes," Dr. Barry said. "We find a higher degree

Nursing study examines new model of care for chronic disease

of success if goals are set by the patient rather than the health care provider."

T2DM is the most common form of diabetes, affecting 95 percent of the 21 million people with diabetes. T2DM also is more prevalent in minorities and the uninsured. Lack of insurance leads to significant disparities in access and quality of care received, Dr. Barry said.

In the United States, there are 47 million uninsured people. The diabetes rate among uninsured blacks is twice as high as Caucasians and three times as high among Hispanics, according to the Census Bureau report: Income, Poverty, and Health Insurance Coverage in the United States, 2007.

"For individuals who have limited access to health care and other resources, trying to manage a chronic condition such as T2DM creates stress and can lead to depression and feeling powerless to improve their health," Dr. Barry said.

Untreated, the disease can lead to severe complications and increased cost to the health care system and patient. "We're trying to change these outcomes," Dr. Beidler said.

The research project tests the effectiveness of a "three pronged" approach to care. It involves enhancing undergraduate and graduate student learning opportunities in caring for patients with chronic conditions, incorporating the latest evidence-based practice guidelines in provider practice, and promoting patients' ability to manage their diabetes better.

"If we prove this strategy of care is successful, it can be used in every clinic and applied to other chronic diseases," Dr. Beidler said.

Patients who are eligible to be in the study have limited financial resources and find it difficult to get medication and follow through with their appointments, Dr. Barry said. Often, preventive efforts are not valued because patients don't feel sick and the long-term implications of the disease are not understood.

The research project uses the UNMC Mobile Nursing Center as one way that patients with limited access to a



DRS. SUSAN BEIDLER AND TERESA BARRY ARE STUDYING HOW A CHRONIC CARE MODEL CAN HELP PATIENTS WITH DIABETES MANAGE THEIR DISEASE.

regular health care provider can get referrals for care and free health screening for diabetes and other conditions. This site also gives students an opportunity to work with underserved patients.

Study participants in Omaha who need follow-up care can get health care services from the UNMC Community Health Center or other local health clinics. Participants outside of Omaha are referred to a local health care provider for care.

To date, the study has enrolled 42 low-income patients through the UNMC Family Health Care Center, which is part of the Community Health Center at 5155 S. 36th St.

People enrolled in the study are mostly Hispanic who have little or no insurance. They are offered education support in English or Spanish, group sessions at the clinic, and home visits.

The key component of the study involves the patient using a diabetes action plan. This action plan helps the patient pick a goal they feel they can meet, such as walking two blocks three days a week. The patient and health care provider can talk about the patient's progress toward their self-management goals, as well as possible barriers or changes to the goals. Goal setting, using the action plan, is an ongoing process and successes are acknowledged and celebrated.

So far, 13 people have participated in the home visit program that is conducted through the Ambulatory Care Community Health Nursing Project.

This project pairs undergraduate public/community health nursing students with a patient or family for education and self-management support in their home environment where day-to-day management issues can be dealt with realistically. When needed, Lucy Zavala, a bilingual medical assistant at the health center, provides interpretative services for the home visits.

The research has shown that home visits have helped gain the trust of patients.

JAN HERZOG, PROJECT NURSE COORDINATOR, AND LUCY ZAVALA, A BILINGUAL MEDICAL ASSISTANT, INSPECT THE DIABETES FOOT MODELS THEY USE FOR PATIENT EDUCATION.



Jan Herzog, the project nurse coordinator at the health center, said that behavior changes can be difficult, but home visits reinforce two messages for the patient.

"It says 'we care about you and your challenges' and 'we take your disease seriously,'" she said.

Research shows that home visits also motivate patients to stick to their self-management plan, Zavala said.

"They know we are coming to visit and they want to show improvement. The patients feel comfortable being taken care of in their own home and it has made a difference in their plan of care. They feel a sense of trust and comfort having someone in their home who can speak their language and understand their culture," she said.

Resources available to assist patients with developing a self-management plan include food models to show correct portion sizes, illustrated booklets on nutrition and cooking and handouts on exercise. Plastic foot models are used to demonstrate proper foot care and identify possible complications that may occur.

The team plans to expand the study with other community partners in other College of Nursing sites in Lincoln, Scottsbluff and Kearney. In addition, Drs. Barry and Beidler are exploring opportunities for interprofessional education and practice with other health care team members.

Ultimately, they hope this model of care will be implemented in health care practices across the state to help patients deal with chronic diseases beyond diabetes.

"Then we will truly have established a care connection," Herzog said. ■