Diabetes Disease and Case Management

African-American Population

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Section HD 31(30719)

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May 07, 2014

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Type 2 Diabetes is a chronic but controllable disease that interferes with the body’s ability to produce or proper use of insulin. Insulin is a hormone that is needed to convert sugar, starches, and other food into energy for daily life. If the body is unable to do this, it can results in high levels of blood glucose. Over the time diabetes can lead to serious complications, such as blindness, kidney failure, nerve damage, heart disease, and even premature death. The most well recognized symptoms of type 2 diabetes are feeling tired or ill, unusual increased thirst, frequent urination, especially at night, weight loss, blurred vision, drowsiness, frequent infections, and slow healing wounds (Cohen & Cesta, 2009, p. 215). While an estimated 26 million have been diagnosed with type 2 diabetes, 7 million are undiagnosed (www.diabetes.org). Type 2 diabetes is believed to be a complex, multi causal disease not only the result of genetic susceptibilities triggered by an individual’s behaviors but also influences by social, environmental, psychological, and cultural factors (Cesta & Tahan, 2008, p. 186).

It captured my attention and interest that African Americans, compared with white Americans, have the highest risk factors and prevalence of diabetes, higher rates of ” micro vascular complications of diabetes, including end-stage renal disease, retinopathy, and peripheral vascular disease that often results on lower extremity amputations”. I believe that comprehensive diabetes case management can influence and diminish the occurrences of these complications in African Americans population.

In 2008, African American men were 2.7 times as likely to start treatment for ERSD related to diabetes and 1.7 times as likely to be hospitalized. In 2010, African Americans were 2.2 times as likely to die from diabetes as non-Hispanic Whites (www.diabetes.org)

There are some factors that contribute to the high prevalence of diabetes type II in minority communities, particularly among African American population: family history of diabetes, less physical activities during leisure time, obesity (BMI more then 40), fewer years of formal education, low socio-economic status. Not only a race become a risk factor for diabetes, but also because at risk groups commonly live in poverty, the likelihood of proper intervention and lifestyle changes decreases significantly (Crow, Lakes, & Carter, 2008, p. 96)

African Americans tend to underestimate their chances for being diagnosed with diabetes, and often not fully aware of their high-risk status. The goal of disease and case management in order to engage members in preventative care is culturally competent and race sensitive approaches (Crow, Lakes, & Carter, 2008, p. 242).

Preventive diabetes programs should disseminate common misperceptions of diabetes, increase the awareness of controllable risk factors, and help to maintain of preventative health behaviors. These programs design to be relevant to African American communities by approaching cultural perceptions of diabetes. It has been known that African Americans having a family history of diabetes would have a better awareness of diabetes risk factors, complexity and severity of diabetes complications, have a higher daily consumption of fruit and vegetables, more often participate in diabetes screening, and would be more receptive to preventative strategies (Crow, Lakes, & Carter, 2008, p. 245)

One of the major factors of reducing risk for diabetes in African American is prevention. Still without the knowledge and perception of diabetes rick, persons in jeopardy to be more inactive participants in preventing actions and putting themselves at further risk. The first step in diabetes prevention case manager must understand individual’s knowledge and beliefs concerning chronic disease. Then prevention programs should be tailored to be both culturally sensitive and address the needs of African American community (Skelly, 2010).

According to Skelly (2010), the far-reaching devastating, physical, social and economic consequences of diabetes are as follows:

* In the United States, diabetes is the third leading cause of non-traumatic amputations, blindness and end-stage renal disease among African American population.
* Diabetes is the third leading cause of death by disease, primarily because of the high rate of cardiovascular disease among people with diabetes, especially African Americans.
* Hospitalization rates for people with diabetes are 7.4 times greater for adults and 5.3 times greater for children than for the general population.
* In 2008, the total cost of diabetes was approximately $142 billion, of which $98 billion was for direst medical cost and $48 billion was for indirect costs associated disability and death. Inpatient hospital care and nursing home care accounted for approximately $ 47 billion and $ 5 billion respectively, for the direct medical costs. Nearly 20 million days of hospitalization and more than $92 million nursing home days were attributed to diabetes in 2008.

In earlier 1990s, managed care organizations began an intense utilization review process to identify areas in which cost control measures would be appropriate. Diabetes was one of the first diseases selected because there is great opportunity to treat this disease more effectively and to develop programs that will help payers and plans manage the high costs associated with it. Disease and Case management are two innovative interventions for health delivery that showed promise for improving care and health outcomes, and reducing cost for individuals with diabetes.

Disease management is “approach that identifies the optimal treatment for patients with a specific disease and implements processes to afford compassionate and clinically evidenced-based care that will prevent disease complications and improve the health and quality of life of a given patient and patient population” (Powell & Tahan, 2010, p. 14). To decrease African American risk for and prevalence of Diabetes, disease management program uses many strategies to encourage getting recommended tests, treatments, and changes in life style.

According to Crow, Lakes & Carter (2008), disease and case management may improve the overall health status of high-risk diabetic client, reduce healthcare costs to the client, and reduce the cost and burden of care to the community (p.92). Therefore by educating the patients, this will help them to be more active participant in their care, setting healthcare goals, and be cooperative with case manager and other healthcare professionals. Disease management also evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving economic health status. Disease and case management should take in consideration the influences on diabetes self-management behavior of African American population from social-cultural and family context. Any interventions to improve self-management of diabetes have to recognize the impact of spirituality, general life style, multi-care giving responsibilities of African American women, and psychological effect of diabetes in whole community (Crow, Lakes, & Carter, 2008, p. 57).

Disease and case management are using diverse and effective programs that empower the patient by teaching and encouraging self-management, focusing on coordinating treatment across all disciplines and aspects of health care. Disease management program becomes a main part in reducing the burden of healthcare on society and improving outcomes, especially in population at risk. Therefore, case management becomes an important team player in facilitating and implementing quality programs. Disease and case management interventions have family-centered and church-based approaches in African American community (Cesta & Tahan, 2008, p. 124).

Case management in diabetes has five essential best practice features:

1. Identification of eligible people – those at high risk for excessive resource use, poor outcomes, or poor coordination of services. All persons with diabetes might be targeted, but more commonly a subset with specific disease risk factors (e.g., coexisting cardiovascular disease or poor glycemic control), or high health care usage (e.g., as determined by visits or costs) is targeted.
2. Comprehensive assessment of each individual’s need.
3. Development of an individual, culturally sensitive care plan.
4. Implementation of the culturally competent care plan.
5. Monitoring of outcomes. Monitoring of the individual patient or population may involve several outcomes, including process (e.g., client satisfaction, service usage), health, quality of life, or economic outcomes as a cost of hospital admissions (Cesta & Tahan, 2008, p. 96)

To coordinate care for patient with diabetes, the case managers encourage early patient referral to a certified diabetes educator, dietitian, endocrinologist, and educate about the proper use of a glucose meter, and the meaning and importance of the glycosylated hemoglobin (HbA1c) test, the role of diet choices and importance of exercises, the correct intake of medication and the management of hyper and hypoglycemia (Cohen & Cesta, 2009, p. 48). The goal of nursing case management is to create plans of care based on the levels of prevention that support health promotion and disease prevention. Case management becomes an important team player in facilitating and implementing quality programs (Powell & Tahan, 2010, p. 54). For the treatment of diabetes to be successful adequate self-care behaviors is essential. Patient education is an important and beneficial aspect for diabetes patients. Patient education should include self-care, sugar control, healthy eating, and physical activity, monitoring and taking medications, problem solving strategies, healthier coping and risks reduction”. The knowledge and skills are two important basics for adequate self management, and they only will convert to behavior when the affected person is really willing in making these changes (Cohen & Cesta, 2009, p. 49).

However without the knowledge and perception of diabetes risk, individuals in jeopardy not only are more likely to be inactive participants in preventing diabetes, but might also be putting themselves at further risk. The first step in diabetes prevention therefore must be an understanding of individuals‘knowledge and beliefs concerning chronic disease. Once at risk individuals‘health knowledge and beliefs are recognized, prevention programs can then be tailored to be both culturally sensitive and address the needs of particular communities (Cesta & Tahan, 2008, p. 19). Individual‘s perceptions of disease risk become more important for diabetes prevention, because acknowledgement of risk increases the likelihood of earlier intervention

In summary, disease and case management can improve diabetes patient outcomes and quality of life while potentially reducing overall costs. It is an important approach to integrated care. Disease management programs continue to evolve: case managers now have a significant opportunity to lead the development of systematic and innovative culturally appropriate, personalized interventions to improve metabolic outcomes and quality of life of African Americans with type II diabetes.

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