

# Bridging the Gap: Improving Access to Specialty Care for Adults with Type 2 Diabetes in Rural Communities

Reality

## Background

- There is a significant lack of specialty diabetes care for adults with Type 2 Diabetes Mellitus (T2DM) in rural Humboldt County
- Humboldt County has a primary care workforce vacancy of 37% (Humboldt County Health Profile, 2023).
- Rural populations experience higher diabetes prevalence rates compared to urban populations, with some rural counties reporting rates exceeding 15% among adults (CDC, 2024).
- Systemic Issues: Hospital care is often task-oriented, prioritizing acute issues over chronic disease management due to high nurse-to-patient ratios.

## Importance of Issue

- **Patients:** Without specialty care, patients face high rates of poor glycemic control and preventable complications such as renal impairment, neuropathy, and cardiovascular disease.
- **Community:** Poorly managed T2DM leads to increased hospitalizations and emergency department (ED) visits, straining rural healthcare systems and increasing overall costs.
- **Nursing Profession:** Nurses are critical in bridging the specialty gap; nurse-led education is an evidence-based strategy that significantly improves glycemic levels and patient outcomes.

## Framework: Model for EBP Change

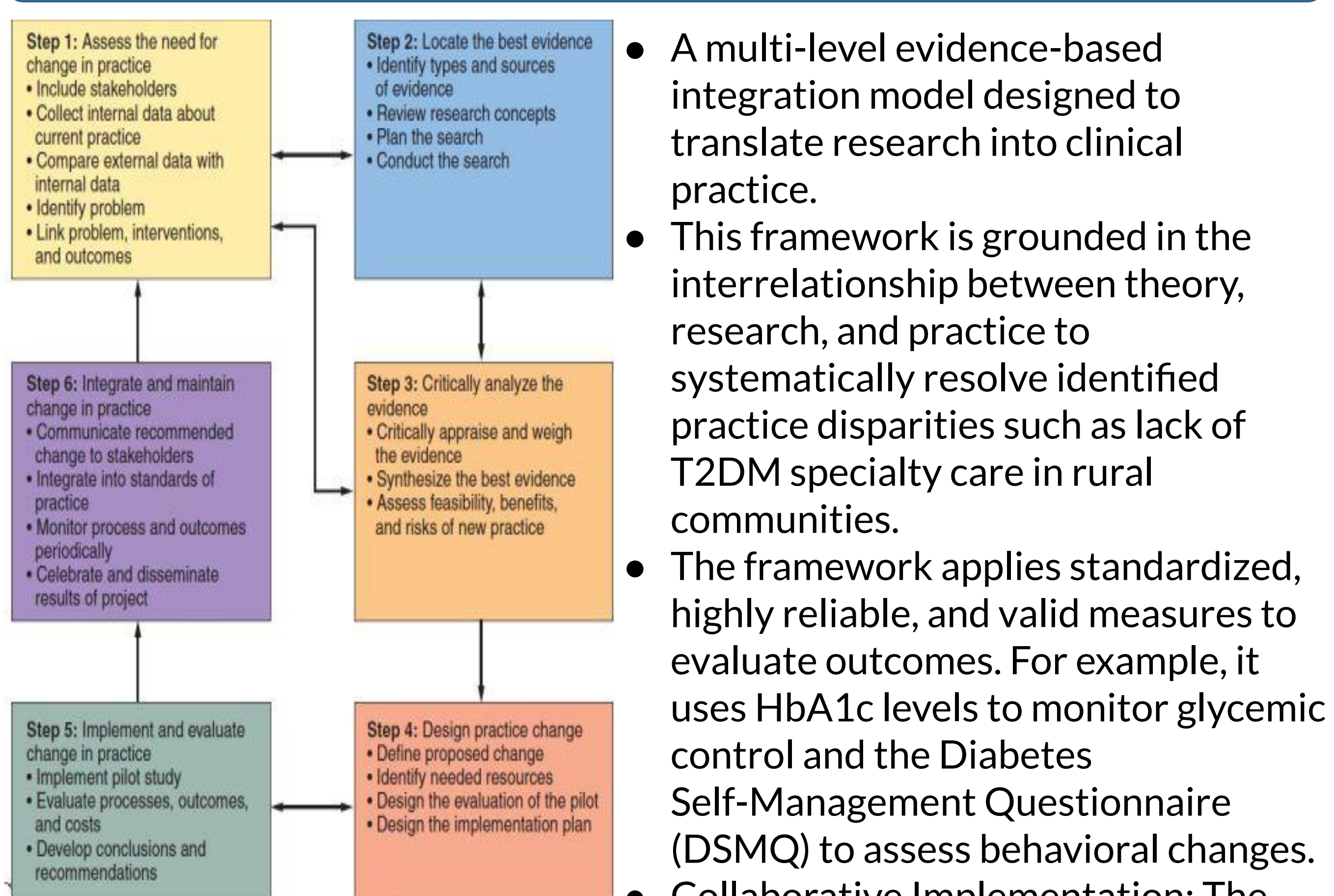
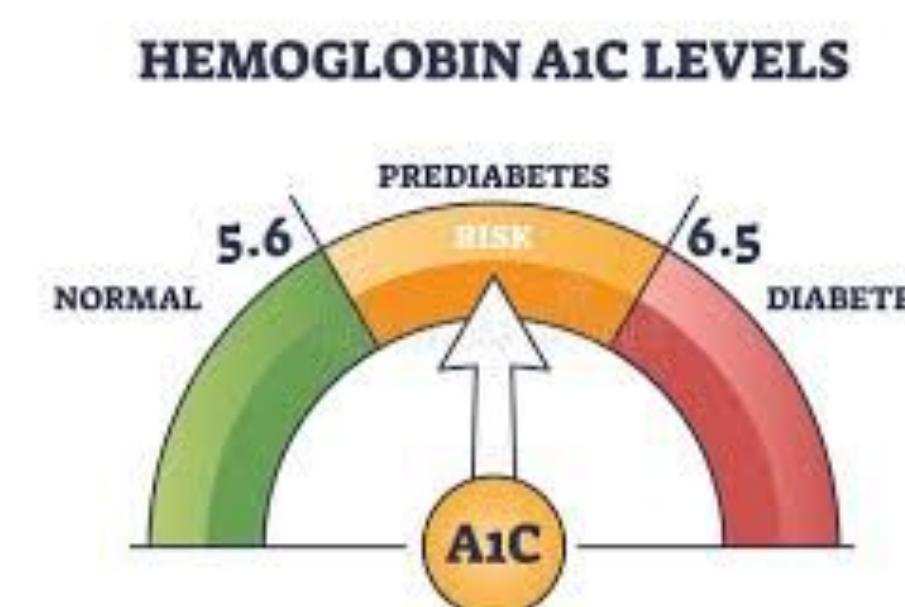


Fig. 14.5: A model of evidence based practice change. (Larabee, J.H. (2009). Nurse to nurse: Practic. McGraw-Hill. P. 484.

Theoretical

## Key Concepts & Outcomes

- **Overall Outcome:** To improve glycemic control and self-management behaviors among adults with T2DM in rural Humboldt County by increasing access to specialized, nurse-led care.  
 -Reduce diabetes related complications such as amputations, neuropathy, retinopathy, and cardiovascular disease.
- **SMART Objective:** Within 3 months, 75% of enrolled patients will demonstrate improved diabetes self-management behaviors and reduce HbA1c levels by at least 0.5%.



## Interventions & Solutions

- **Individual Intervention:** Implement Diabetes Self-Management Education and Support (DSMES) delivered by a specialist diabetes nurse educator at the bedside and reinforced upon discharge.  
 -Nurse-led interventions produce “beneficial impacts on glycosylated haemoglobin values” with measurable reductions in HbA1c levels (Holloway et al., 2023).
- **Community/Unit Intervention:** Establish a nurse educator-led inpatient management program and integrate daily interdisciplinary care coordination rounds to improve provider communication.  
 -Fostering a collaborative approach within the interdisciplinary team is also shown to have a positive effect on the management of a patient’s diabetes diagnosis (Andersen et al., 2023).
- **Policy/Protocol Intervention:** Develop a standardized hospital protocol for automatic diabetes education consults for all patients admitted with uncontrolled diabetes or complications.



Sydney Ann Castil, RN

Cal Poly Humboldt  
H. Nursing

## Key Players

- **Patient Population:** Adults with T2DM, specifically targeting older adults (45+), low-income individuals, and racial/ethnic minorities who face the greatest disparities.
- **Key Players:**  
 -Hospital Leadership: CNO and Quality Improvement Director for resource allocation.  
 -Healthcare Team: Specialist diabetes nurse educator, primary care providers, registered dietitians and bedside RNs.  
 -Patients/Families: Central to the intervention, participating in goal setting and education.
- **Community Partners:** Local tribal health clinics and community representatives to ensure culturally tailored care.

## Evaluation

- **Outcome Measurement:** The primary outcome is measured via HbA1c levels (a highly reliable/valid clinical indicator) and the Diabetes Self-Management Questionnaire (DSMQ).
- **Process Evaluations:**  
 -Enrollment/Attendance: Tracking the number of patients enrolled in educator-led care and attendance at group sessions.  
 -Policy Tracking: Monitoring the adoption rate of the standardized protocol across rural clinics.
- **Impact Evaluations:**  
 -Clinical Improvement: Measuring the reduction in HbA1c levels post-intervention.  
 -System Utilization: Tracking the decrease in ED visits and hospital readmissions related to uncontrolled diabetes.

## References

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