Health Related Quality of Life in Persons with Type 2 Diabetes in a Rural Community Served by a Critical Access Hospital

Betsy J. Becker  
*University of Nebraska Medical Center*, betsyj.becker@unmc.edu

Terry F. Nelson  
*St. Francis Memorial Health Center*

Robin High  
*University of Nebraska Medical Center*, rhigh@unmc.edu

Pat Hauer  
*University of South Dakota*

Tell us how you used this information in this short survey.

Follow this and additional works at: [https://digitalcommons.unmc.edu/cahp_pt_pres](https://digitalcommons.unmc.edu/cahp_pt_pres)

Part of the [Physical Therapy Commons](https://digitalcommons.unmc.edu/cahp_pt_pres)

Recommended Citation

[https://digitalcommons.unmc.edu/cahp_pt_pres/3](https://digitalcommons.unmc.edu/cahp_pt_pres/3)

This Conference Proceeding is brought to you for free and open access by the Physical Therapy at DigitalCommons@UNMC. It has been accepted for inclusion in Posters and Presentations: Physical Therapy by an authorized administrator of DigitalCommons@UNMC. For more information, please contact digitalcommons@unmc.edu.
Background

- Compared to urban settings, prevalence of Type 2 diabetes is higher in rural areas

- Life expectancy for an individual with uncontrolled Type 2 Diabetes is a reduced loss of 8-10 years of life.

Hunt et. al 2014, Ablah et. al 2013, Duncan 1992
Background

Incidence of diabetes per county

Behavioral Risk Surveillance Survey of 2010

Northeast Nebraska
Critical Access Hospitals

Designation created in 1997 to help rural health care infrastructure

- in a rural area, no more than 35 miles from another hospital
- provide 24-hour emergency care services
- maximum of 25 acute care and swing beds
- maintain an average length of stay of 96 hours or less for acute patients

The Flex Monitoring Program

Population of Rural Counties serviced by Critical Access Hospital

US Census Bureau (2013)
Study Purpose

To determine whether health related quality of life (QOL) varies by gender and diabetes control (A1C) in rural persons with type 2 diabetes.

Subjects

We surveyed 615 persons with type 2 diabetes who receive care at a critical access hospital that serves a seven county rural area.

We surveyed the entire population of persons on this diabetic registry maintained by the critical access hospital. All of which had an A1c within the last 2 years.
Methods

IRB Approved Study

Cross-sectional Mail Survey

Dillman’s Tailored Design Method of Survey Administration
  • up to 4 contacts with study subjects at 2-week intervals

Dillman, 2000

Methods

Self-reported demographic characteristics, health related quality of life using the D-39 A1c from medical record

We analyzed associations between A1c levels and survey responses using descriptive statistics and Spearman correlations.
Methods:
D-39 Dimensions
- energy and mobility
- diabetes control
- anxiety and worry
- social burden
- sexual functioning
- 2 additional questions: severity, QOL

Results

<table>
<thead>
<tr>
<th>Responses (n)</th>
<th>Age (yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>257</td>
</tr>
<tr>
<td>Males</td>
<td>125 (50%)</td>
</tr>
<tr>
<td>Females</td>
<td>126 (50%)</td>
</tr>
</tbody>
</table>

42% response rate
Results

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Responses (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>245 (95%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (2%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Smoking history</th>
<th>Responses (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>never</td>
<td>171 (69%)</td>
</tr>
<tr>
<td>current/former</td>
<td>76 (31%)</td>
</tr>
</tbody>
</table>

Results

13.4 average years since diagnosis
80% taking insulin, oral medication or combination of the two
Results

Without consideration of other factors, males, have a 0.321 higher median value of A1C than females in this study population (p=0.043).

Average A1c
6.3 mg/dL
(range 4.9-12.4)

Results

Place an X in the box below to show HOW SEVERE you think your diabetes is.

energy and mobility (r=.46)
diabetes control (r=.66)
anxiety and worry (r=.51)
social burden (r=.52)
sexual functioning (r=.38)

Spearman Correlations

= Statistically Significant
Results

Place an X in the box below that indicates your rating of your OVERALL QUALITY OF LIFE.

<table>
<thead>
<tr>
<th>Lowest quality</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Highest quality</th>
</tr>
</thead>
</table>

- energy and mobility ($r=-.11$)
- diabetes control ($r=-.16$)
- anxiety and worry ($r=-.19$)
- social burden ($r=-.11$)
- sexual functioning ($r=-.24$)

Spearman Correlations

Results

Hemoglobin A1c

- energy and mobility ($r=.31$)
- diabetes control ($r=.17$)
- anxiety and worry ($r=.24$)
- social burden ($r=.16$)
- sexual functioning ($r=.11$)

Spearman Correlations
Results

**Gender Differences**

- energy and mobility ($p = .70$)
- diabetes control ($p = .61$)
- anxiety and worry ($p = .45$)
- social burden ($p = .30$)
- sexual functioning ($p < .001$)

= Statistically Significant
Results

Gender Differences

![Graph showing severity and gender interaction at age=55]

![Graph showing severity and gender interaction at age=60]
Conclusions

Since diabetes control is largely due to self-management, it is important to consider the associations between the QOL dimensions, diabetes control (A1C) and gender.

Important for implementing successful intervention strategies for glycemic control in rural critical access hospitals.

Clinical Relevance

Although gender is commonly reported in published studies about diabetes, differences have not been routinely analyzed.

A better understanding of the relationship of QOL and the impact on diabetes control and gender differences can assist the physical therapist in their role in providing optimal care for older adults with type 2 diabetes in rural communities.
Funding provided by:
– Franciscan Care Services, West Point, NE
– University of Nebraska Medical Center, Omaha, NE

References


