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Integrating nurses in the management and care of patients with NAFLD: Better adherence and outcomes

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Background and aims: Non-alcoholic Fatty Liver Disease (NAFLD) has risen to epidemic proportions in the United States. It is estimated 30-40% of all Americans are obese, paralleling the rate of diagnosed NAFLD. The primary recommendation is lifestyle changes. There is no current medication approved regimen. It has been shown that asking a patient to change their lifestyle behaviours is difficult with inconsistent and poor results to making these changes. With the overwhelming burden of this disease, it is crucial for the Hepatologist (MD) to integrate their provider-extenders including nurses/nurse practitioners/allied health professionals (AHP) into the management and care of NAFLD patients. This is a single center experience in the role of AHP in a specialized community-based clinic in improving the health and outcome of patients with NAFLD.

Method: In a single community Hepatology center, we have set up a standardised protocol for patients referred for NAFLD. Patients with a confirmed NAFLD diagnosis are placed in “NASH-ville” clinics. These dedicated clinics encompass the concept of HALO (Health and Liver Optimization). At the first visit, the patient is asked to complete questionnaires identifying their lifestyle, diet, sleep patterns, fatigue levels, medications, and perception of BMI. Anthropometric measurements were also taken. Subsequent visits evaluated depression, nutrition, and changes in waist circumference, BMI, and physical well-being. Patients are seen every 1-3 months based on mutual goal setting between patient and AHP. Focus groups discussing diet, exercise can occur during scheduled clinic time, individual time is given for the nuances of each person, and the HALO approach was instituted for each patient and family member present.

Results: Patients with NAFLD needed more extended visits and time spent with them to allow for in breadth discussions of their lifestyle changes. Having the patient on board with their current disease state, setting goals and a tailored plan together with them was critical. This had a positive impact on their adherence to their management plan and ultimately their health outcomes. Implementing a dedicated “NASH-Ville” clinic has allowed our community-based clinic to see patients with a similar diagnosis together and individually.

Conclusion: Each NAFLD patient brings their family history, culture, habits, and co-morbidities to the situation requiring an individualized plan of care to assist in their improvement of health and lifestyle behaviours. MDs have extensive responsibilities and limited availability to spend adequate time with NAFLD patients. AHP have the ability to be more flexible/spend time in their schedules to accommodate the holistic needs of the patients. Both complement each other in the care of the patients and management of the disease. AHP’s role had a positive impact on the continuity of care in NAFLD patients.