

Reviewer Comments:

Reviewer #1: This was an excellent study and a well written article. My points are not major.

The choice of the UCSF Symptom Management Model was highly appropriate. A useful overview of the rationale is provided for readers. I did find myself wondering what models had characterized previous research.

p4. line 16-17; the addition of a model specific to HIV might be very pertinent, but it is a surprise to the reader. one sentence could really help here.

p.5 line 11 (1-11) Personally, I like the APA guideline on anthropomorphism so I do not like "studies" singing, dancing or "identifying", could we say "investigators identified"???

p.8 line 5 what is PAID? need to explain here or earlier, did I miss it? SEARCH did not reveal same, this may be an accident of editing, see line 23. which leads to this note:

Measures: I prefer to be reminded/informed first of the psychometrics for each instrument from previous studies, then tell me what your results were.

P9 line "responses were grouped into compliant (100 and 75%) and non-compliant (50, 25 and 0%)." Consider editing this sentence, I had to read it multiple times before I got that each number was a percent

P9. line 19 please tell us how randomization was accomplished. I have just finished a Cochrane review and that information is required to assess quality of study (random numbers table, concealed from?)

Great to have Community Advisory Board review, any issues arise?

P10 line 1 tell reader if research assistant was blind to condition—was that possible?

P10: see this content from your manuscript [note this system strips italics or any signal that it is text from manuscript], section is hard to read, seems like results not analysis:

Three hypotheses were examined to assess the

14 immediate and longer term effect of the symptom-focused intervention relative to the
15 weight/diet intervention, and the effect of the telephone booster: 1) over the
intervention

16 period, (baseline to month 3), outcomes improved more for the combined SF/B and SF
17 participants than for WD. 2) Over the entire study period to month 9, the outcome
18 improved more for SF/B participants than for SF and WD, and SF improved more
than WD

19 and 3) between 6 and 9 months, the outcome improved more for SF/B participants
than for

20 only SF participants.

P11 I23: Aikake's Information Criteria (AIC), my rule of thumb is if Polit & Hungler don't reference a term, the author needs a citation, EDITOR's CALL

p. 11 line 18 In this manuscript the ATTENTIONAL condition was described as "traditional" diabetes education, on this page in describing the sample I would like to know if participants had previously received education equivalent to the attentional control. If not, please reword [p.7 line 22]. This becomes important later due to the findings.

P12 attrition data with significance testing was very helpful

Data analysis: I commend the Authors for reminding readers of the meaning of the abbreviations, WD, SF etc.

Discussion section is excellent, see my summative comments for other ideas. I especially appreciated the NHANES date to put .76 in context. I wish that the authors would return to their conceptual framework in this section and comment. Especially link us back to why the HIV model was added and whether findings and experience validated use of this combined model.

Summative comments:

Again well done on many counts. Some thoughts:

A home visit is a very expensive intervention. Please consider orienting reader to why this was chosen. Also, when home visit is undertaken, I wish that nurses would collect data that is not available when intervention is conducted elsewhere. What did nurse learn by seeing patient in home setting? What advantages accrued that are really part of the intervention. The discussion is excellent in making case for personalized attention possible in home. Still would like a sentence or two in beginning description of intervention. Also, I found myself wondering, did nurse and patient go into the kitchen, handle foods found there for label reading, discuss exercise options seen in neighborhood, observe chaos in storage of educational materials given to patient, etc.?

Did you see symbols/pictures etc. that would help in future recruitment efforts? Did you observe availability of computers with Internet connection that could be incorporated in future intervention designs to provide support group, graphing etc? The authors hint at a community embedded approach with a board. At the end, future implications look at moving intervention outside the home. What resources did Community Advisory Board and home visits suggest? A senior center with computers? Medical center with patient library and computer access?

Cultural competence. This manuscript does not address culture of participants which could be important. How were they typical of African Americans in other reports?

Anything we can learn from this intimate encounter model? Many reports of working with African Americans highlight spiritual dimensions, was this tracked? Family and social support are important in this population and in this condition. I wondered why this was not a part of intervention, such an opportunity to extend benefits. Telephone booster

was genius. Can the women in study and Advisory Board be recruited to be a telephone tree for each other and for other patients in the recruitment sources? See Health Buddy as potential tool as well.

FORMAT

Table 1 is hard to read, consider reversing rows and columns, I am used to n, M, sd being column headers

Headers and placement: see Findings vs. Results,
--data on sample, where placed?

Reference list: almost perfect APA, but some funny issues

- a) states like Virginia and NJ get US post office abbreviation
- b) inconsistent capitalization after colon in article title, Polonsky for example
- c) psychooncology: check spelling
- d) "Inc." not in APA ref
- e) Search for "Review" at end of one reference
- f) American Diabetes Association, I bet this was retrieved from web, so state

Reviewer #2: Review of Ms NRES-D-08-00195

Title: Nursing Interventions for Improving Health Outcomes of Older African American women with type 2 diabetes

The authors state that the problem is the prevalence of diabetes in African American women, and in rural residents, yet there is virtually no further description of how 'ruralness' creates special 'cultural' circumstances. Are the culturally tailored materials for African Americans or for rural residents. I think the author needs to justify the need to study this race/age/gender/rural aggregate for diabetes?

There are many references throughout the paper on adapting materials (p 3, ln 15-16), but how were measures adapted for this culture? There is description that pilot data was used to identify symptoms commonly reported in this sample, but what else was 'tailored'? A specific example would be useful since it would be of interest to readers. You also state in the discussion how a community advisory board was consulted to refine the intervention, but there is no detail provided. In fact, there is no information provided to describe the community or communities participants come from.

The review of literature is comprehensive and relevant and the conceptual approach uses symptom-focused interventions to guide individuals in interpreting symptoms and explicating how symptoms are related to their disease and self-care behaviors.

The study was a randomized 3 group experimental design to test the effectiveness of a symptom-focused intervention, a symptom-focused intervention with telephone booster calls (done on half of the symptom-focus subjects), and an attentional control condition about weight and diet. Measures obtained at baseline and at 3, 6 and 9 months included: A1c, symptom distress, diabetes-related quality of life, the Problem Areas in Diabetes survey, and diabetes self-care practices. The study design and methods are sound but some descriptions are absent. What was the rationale for providing home based interventions? Was this based on 'tailoring' an intervention to the needs of participants?

Was the rural environment a factor? Please discuss more. Most of the tools used to measure outcomes are well established instruments, but I do not know why the author used the diabetes self-care practices questionnaire. This instrument measures 5, not 7 self-care behaviors as identified by the AADE 7 and ADA. Please provide rationale for this choice. There is no description about the ruralness of the sample. How was the A1c sample obtained? What type or brand of instrument was used?

The writing style of the data analysis section differs from the rest of the manuscript. Hypotheses are referenced yet no hypotheses are posed in the antecedent text. The research questions/comparisons in the data analysis section need to be described more clearly.

Probably the biggest weakness of this manuscript is in the interpretation of the results, or null results, that everyone improved with any type of intervention, although continued contact through booster telephone calls showed better outcomes than the other study conditions. The dimensions of comments, e.g., reactivity, contamination, history effects, and other measurement issues seem to come too much from a text book and do not seem to emerge from the data. In the discussion there is mention of an enrollment period of 3 years. Is this correct? The manuscript I read enrolled people for 9 months. One can speculate that if booster condition, e.g. continuing contact, created significant differences in outcomes, it may be evidence that the population studied was not receiving adequate diabetes care and education, and ongoing contact for problem solving and support is a critical component of effective chronic disease management. The authors need to address the home intervention as limitation to this study, since it doesn't seem likely that one nurse could spend 4 hours plus travel time for a home visit in our current health care system. What more data is needed before this research can be translated to practice? Can it be translated to practice?

In the discussion the authors note that a .57% or .76% change in A1c is 'clinically significant'. Is there any way to discuss this more, such as the translation of A1c percentage values into average blood glucose values in mg/dl? (see Nathan et al, Diabetes Care, 31:1473-1478, 2008).

What about an explanation for results that in this specific population 'usual diabetes care' is sorely lacking? If this is the case, any intervention that addresses symptom management or weight and diet would be beneficial. It might be due to sampling bias, using an A1c greater than 7% as an eligibility criteria eliminated 42% of subjects approached, possibly leading to the enrollment of individuals who were in worse metabolic control possibly because of poor adherence with regular clinic visits and other services provided to patients to management diabetes; and that the home delivery of the intervention removed access to care issues, suggesting that the home setting was a key factor in effectiveness..

The retention rate is impressive over the 9 months. Table 1 the Q1 and Q3 labels are unclear to me. Also spacing, use of italics needs revision. The figures are an effective method for presenting the major results, indicating that there was no 'best' method, but the booster component created lead to significant differences compared to the 2 major study conditions. However, they too would need to be revised to conform to APA format. It's not clear why half of the attentional control condition did not also receive booster calls. Without this comparative data interpretation is more difficult.

Reviewer #3: A well-written and important manuscript. You have nicely described the unexpected findings relative to the control group and this is worthy of highlighting.

Page 5, line 2, last para before objectives - I would place this in Methods, along with objectives as this is really your design.

Be consistent in using HBA1c and A1c.

Pages 5-6: You have a lot of sub-headings - perhaps organize symptom-focused, booster and attention control under larger heading of Study Procedures and include with Intervention procedures on page 9. Was any specific approach to symptom management used, that is education only or cognitive-behavioral, coping-skills, motivational interviewing type approaches?

I had a hard time figuring out the timelines? Were 4 symptom-focused delivered over 4 sessions or more? Why 12 weeks to complete? The telephone booster seemed to have a long lag time (3 mos) after completion of intervention?

Page 8 - Organize measures in same order as introduced in objectives - self-care practices, metabolic control, symptom, QOL; or more self-care practices to last as you present findings in this order; just be consistent, unless the self-care is your primary aim. Are these correlations in YOUR sample?

I wonder why you analyzed over shorter time periods rather than over the course of the entire intervention - doing this way opens you up to criticism related to multiple comparisons and it seems that you want the overall effect. Did you not look at time by group interaction? You should not provide results here (page 10). This also complicates the findings section (too long) as you can see from the figures what is happening; if you keep focused on these individual points (and I don't think you should unless your statistician can justify), perhaps you can provide the individual comparison in the figures to cut down on text as manuscript is a bit long overall.

Did you measure weight (or BMI) seeing that you implemented a diet-weight intervention? This should be reported (and perhaps analyzed also with mixed model). Can you be any more detailed regarding symptoms? I think this is important to document.

The figures nicely illustrate the group differences - the difference with symptom management alone is consistent and striking!

CHECKLIST FOR STYLE

TITLE PAGE --

Supply running head of less than 50 characters (no abbreviations).

REFERENCES --

Reduce number of references to 40; there are 46.

Correct spelling of Selby (or Selbey?).

Update IN-TEXT CITATIONS using APA 5th Ed. Format (The Publication Manual of the American Psychological Association, 5th Edition, pp. 208-209). In particular:

Update "in press" reference - Skelly... 2008.

The following references are not cited in the text. Remove from reference list or add to text:

Diabetes Control & Complications (1993)

Ellis... 2004

Norris... 2002

UKPDS (1998)

FIGURES -- Use x & y axes only; remove horizontal lines within each figure.