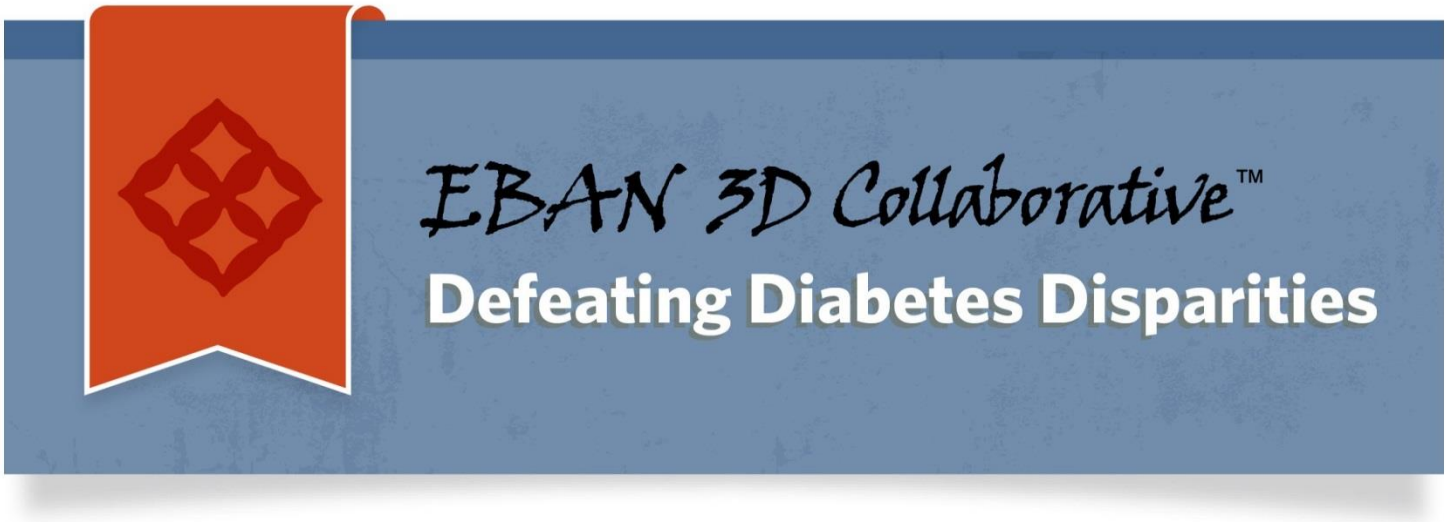


Endocrinology

June 4th, 2014

Team Members

Name	Credentials	Title	Organization
Antoinette Kennedy		Community Partner	Community Member
Patricia A. Lee-Woods		Community Partner	Community Member
George Thompson		Community Partner	Community Member
Norman Harrington		Community Partner	Community Member
Madina Babin	LPN	Lead Nurse-Endocrinology	Health Partners
Martha BaerTaki		Clinic Assistant-Endocrinology	Health Partners
Chris Casteleyn	RD, CDE	Registered Dietitian/Diabetes Educator	Health Partners
Alexis Forsberg	NP	Nurse Practitioner-Endocrinology	Health Partners
Allison Johnson		Sr. Quality Coordinator	Health Partners
Katie Kostelecky	RN, CDS	Care Delivery Supervisor-Endocrinology	Health Partners

Specific Aim

Ultimate Goal

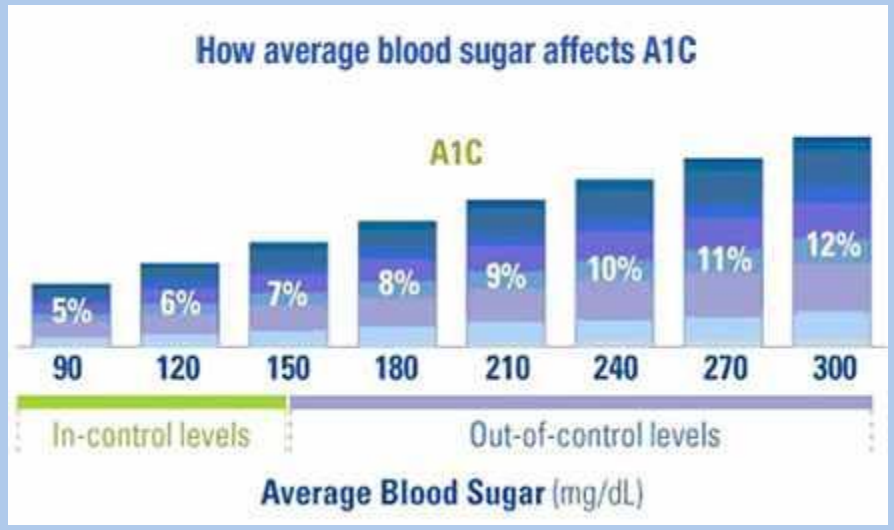
Improve optimal diabetes care for the African American population by 4.2%.

Goal

Improve engagement of patients with diabetes through educational resources.

Aim

Better utilize educational resources and services available through HealthPartners.



PDSA Cycle 1

PDSA #1 – RN Referral to Case Management				
Test Cycle 1	Start Date 6/27/13		End Date 7/24/13	
Plan	Providers identify potential patients who would benefit from Disease & Case Management referral.			
Do	RN/CA reached out to patients and offered Disease & Case Management referral.			
Study	•Attempted to contact 20 patients. •Made contact with 14 patients. •12 of 14 patients accepted referral to Disease & Case Management. •6 of those 12 are currently engaged with Disease & Case Management. •Remaining 6 patients could not be reached by Disease & Case Management. •Overall 30% of patients we attempted to contact are engaged in Disease & Case Management.			
Act	In 1-2 months RN will follow up with patients to survey engagement			

PDSA Cycle 1

- **PDSA #1**
- **Objective**
- To use already established resources to help educate and improve overall diabetes health in the African American community.
- **Prediction**
- 50% of patients will engage with Disease & Case Management.
- **Population**
- African American patients with diabetes from Adult & Seniors Health, and Endocrinology.

PDSA 1 Results

- Success
  - 6 patients now enrolled in Disease & Case Management.
- Challenges
  - Reaching the patients
  - Communication between departments
  - Patient follow-through

Success Story

- 63 year old male with history of diabetes and hypertension
- Identified for Disease Management in July 2013, by live referral from the primary care physician

Patient History	Issues/Barriers
• **Diabetes** • **Hypertension** • **Hyperlipidemia**	• Inconsistent with taking medications, checking blood sugars and with keeping physician appointments • Overwhelmed with health issues and responsibilities at home • Single parent to adopted grandchildren, including one grandchild with severe mental health issues, who was recently placed in a group home • Does not trust the medical community • Possible low literacy level • Financial issues, making it difficult to buy healthy food

Success Story

Disease Management Intervention

- Identified patient's personal goals, preferences and needs using Motivational Interviewing and Intrinsic Coaching skills
- Assessed and filled knowledge gaps related to diabetes, diet and plan of care
- Connected and communicated with the Primary Care Physician, Pharmacist, and Dietician regarding plan of care and possible literacy issues
- Shared information regarding diabetes, stressing the importance of consistently checking glucose levels, making sure to include visual aids due to low literacy
- Assisted patient in prioritizing and planning changes that he wanted to make to enable him to reduce his stress and improve his diabetic control
- Shared information regarding food shelves and food stamp assistance
- Connected with the Medication Therapy Management pharmacist to review medications

Success Story

Outcomes

- Patient has been consistently following his treatment plan, has been taking his medications and has had consistent follow up with his provider (cost, health, experience)
- Patient's weight decreased by 10 pounds over a 2 month period (health, experience)
- Patient had improved glucose and blood pressure readings with Hgb A1c decreased from 8.0 down to 7.0, Blood glucose decreased from 180-200 down to 100-104 and blood pressure decrease from 140's.90's down to 102/64 (cost, health, experience)
- Patient has been actively checking and keeping a log of his blood pressure and blood glucose levels at home (cost, health, experience)
- Patient has made dietary changes and also a better understanding of how to manage his stress (health, experience)

Current Status

- Patient has demonstrated improved self management and feels that his health care goals have been met so he has graduated from the Disease Management program.

Holy Trinity Episcopal
Pilgrim Baptist Church
HealthPartners, EBAN 3D Collaborative
Adults & Seniors/ENDO
A COMMUNITY CONVERSATION

November 12, 2013

"HOW OUR BELOVED COMMUNITY CAN BETTER SERVE AND CARE FOR OUR FAMILY ELDERS LIVING WITH DIABETES"

A COMMUNITY CONVERSATION
"HOW OUR BELOVED COMMUNITY CAN BETTER SERVE AND CARE FOR OUR FAMILY ELDERS LIVING WITH DIABETES"

- PREACHING TO THE CHOIR
- PERSONAL STORIES OF HEALTH CRISIS – LIFE & DEATH
- DISEASE "SCARLETE LETTER OF MORTALITY & SHAME"
- PERSONAL RESPONSIBILTY TO CHANGE BEHAVIOR & FOCUS ON QUALITY OF LIFE & WELL-BEING
- OVERWHELMINGLY CONCERNED ABOUT THE GROWING GENERATION TO GENERATION HEALTH CRISIS

A COMMUNITY CONVERSATION
"HOW OUR BELOVED COMMUNITY CAN BETTER SERVE AND CARE FOR OUR FAMILY ELDERS LIVING WITH DIABETES"

COMMENTS

- INFORMATION AND TOOLS TO SELF-MANAGE DISEASE … AS A PART OF PATIENT CENTERED CARE PLAN
- EFFECTIVE COMMUNICATION REGARDING PRESCRIBED CARE AND MEDICATION IS CRUCIAL TO ACHIEVING IMPROVED INDIVIDUAL HEALTH OUTCOMES AND AVOIDING MISSTEPS IN CARE.
- COMMUNITY/FAMILY GATHERINGS OR FORUMS THAT FOCUS MORE ON SOLUTIONS THAN THE DISPARITY, PROMOTING PERSONAL RESPONSIBILTY TO CHANGE BEHAVIOR, IMPROVE THE QUALITY OF LIFE & WELL-BEING
- OVERWHELMINGLY CONCERNED ABOUT THE GROWING GENERATION TO GENERATION HEALTH CRISIS

THANK YOU
RENEWING THE SPIRIT, HEALTH AND WELL-BEING OF OUR FAMILY

EBAN Support Group

Fun Topics Discussed At Each Meeting

Healthy Lunch Provided

Free Blood Pressure Check

Monday, February 24, 2014

- Crock Pot Cooking & Cooking For The Family
  - Demonstrate fast, easy and healthy options for family meals
  - Focus on diabetic-friendly recipes
  - Show that healthy food can taste good

Monday, March 17, 2014

- Exercise & Physical Fitness
  - Zumba demonstration to show participants how much fun improving their fitness can be
  - Personal Trainer to discuss methods for low impact exercises
  - Physical Therapist to explain how to promote mobility, flexibility and improvement of life

Wednesday, April 23, 2014

- Menu Planning & Grocery Shopping
  - Provide examples of the high cost of fast food
  - Demographic targeting to show participants grocery stores and farmer's markets in their community
  - List of resources containing menu planning tips
  - Demonstrate how to utilize specific dollar amounts to purchase healthy foods and plan menus

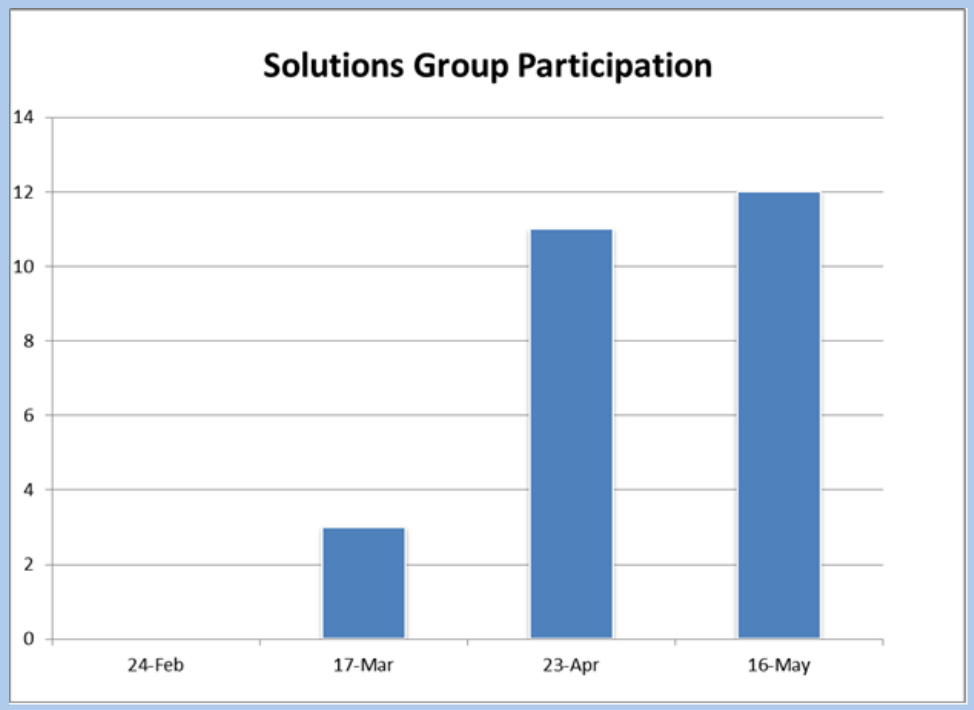
Friday, May 16, 2014

- Gardening
  - Patio Gardening-demonstrate methods for growing herbs and vegetables in your home or on your patio
  - **Lower your diabetes risk:**
  - A number of studies have found that diabetes rates are lower in areas with community gardens, or places where gardening is more common.

PDSA

- Surveys will be gathered at the end of each session seeking feedback from participants.

Results



Lessons Learned

- Many patients need more robust education on diabetes and how to manage.
- Specifically, patients need assistance in understanding what their A1C is, how to manage blood pressure and cholesterol.
- We learned that by reaching out to patients that were newly diagnosed and providing reminder calls, our attendance at the “Solutions Group” increased.

Lessons Learned

- Audio Visual materials are extremely helpful and preferred by many patients.
- Interactive Support/Solutions groups where they can talk and share, are well received.
- Providing participants with some type of healthy snack is a great incentive to participate.
- Providing participants with items to assist them in their healthy lifestyle are great incentives.

How did you integrate community partners into your improvement work?

- Our community partners invited their HP team members to join them in a community conversation with members of their local churches.
- Our community partners met with our team every 2 weeks to continue to develop, plan and prepare for the solutions groups.
- Our community members attended each of the solutions group sessions.

Recommendations for Sustainability

- Given changing landscape in the future, where do you recommend the organization focus?
- Focus on our youth and provide education to help prevent diabetes.
- Treat the individual, not the diagnosis.
- Provide focused education in understandable terms such as A1C levels, LDL, Blood Pressure, smoking cessation and benefits of not smoking and importance of aspirin use as directed by providers.
- What should the organization explore further?
- HP needs to identify staffing and resources to continue work in the community.
- Explore evening and weekend clinic hours. (we believe the added availability of providers and hours will improve patient diabetes management)

Recommendation for Sustainability

- Identify resources to help continue or create a similar Solutions/Support Group.
- Evenings and weekends are the preferred times for busy people.
- Locations for sessions within the communities will produce greater participation.
- Provide audio/visual materials that will be helpful.
- Develop website and ensure community members are aware.
- Identify possible partnerships with churches and community groups.