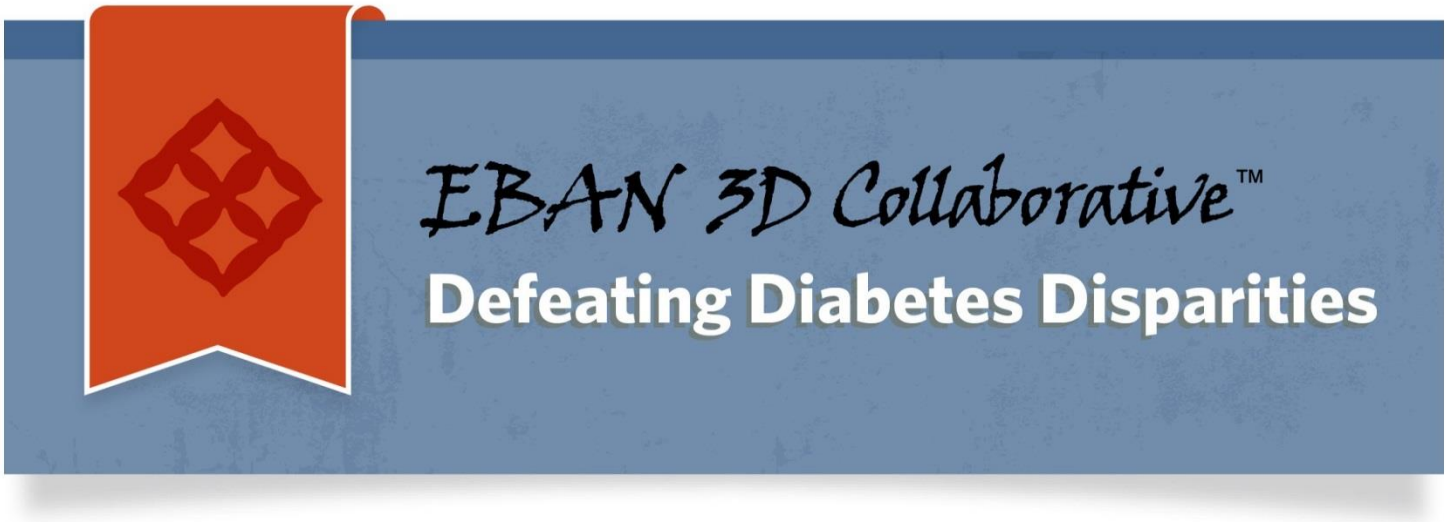


Team Midway

June 4th, 2014

Team Members

Name	Title	Organization
Jennifer Hines	Staff Physician, HP Midway Clinic	HealthPartners
Larisa Turin	CDS, HP Midway Clinic	HealthPartners
Sharon Brown Rowe	BSS, HP Midway Clinic	HealthPartners
Tracy Carr	RN, HP Midway Clinic	HealthPartners
Jackie Cooper		Community Partner
Kizzy Downie		Community Partner
Vicki Emelife	LPN, HP Midway Clinic	HealthPartners
Chris Foye		Community Partner
Julia Freeman		Community Partner, patient
Allison Johnson	Statistician	HealthPartners
Patricia Lacy-Aiken		Community Partner
Jodi Lavin-Tompkins	CDE	HealthPartners
Tamara Mattison		HealthPartners
Ann Moyer	Pharmacist	HealthPartners
Makeda Norris		Community Partner
Bernard Turner		Community Partner
Ann Wolf	National Committee for QA	Community Partner

Specific Aim

To partner with African American (AA) diabetics in the Hines Care Panel to develop strategies for self-management of their diabetes and related measures for improved disease control with an emphasis of blood pressure control.

Hines Care Panel

71 (40 women; 31 men) AA diabetics

1. Average age for both sexes-56 years old
2. Average body mass index (BMI)-women: 34
   men: 31. 10 patients with BMI>=40.
3. 30% with depression; 12% with other psych.
   disorders; 16% chemically dependent
4. 59% with tobacco abuse

PDSA Cycle 1

Test Cycle 1	Start Date	End Date
	6/27/2013	7/26/2013

Plan: Questionnaire to all AA diabetics that came into the clinic for routine appointment if their blood pressure was not at goal (>=140/90).

Do: We asked 17 total patients, including 4 who only had HTN.

Study: Results revealed a significant number of patients thinking that their blood pressure was related to stress, diet and had no solutions for this. >50% had not taken medications that day.

Act: Ask further questions about what the patient knows about HTN and what would motivate them to improve their own condition.

Questionnaire #1

1. Why do you think your blood pressure is high today?
2. When did you last take your blood pressure medication(s)?
3. What did you eat within the last 24 hours?
4. What is going on in your life right now?
5. Are you willing to work towards having a better blood pressure in 1 week? What needs to be done?

PDSA Cycle 2

Test Cycle 2	Start Date	End Date
	9/17/2013	9/26/2013

Plan: Questionnaire #2 about what the patients knew about HTN and what would motivate them for better control.

Do: 10 patients were surveyed

Study: Many related HTN to family history of stroke and symptoms of dizziness and headache. None felt that they needed an outside incentive for better control besides how it helped their personal health.

Act: Development of handout to aid in goal setting to improve self management of DM and related diseases.

Questionnaire #2

1. What do you know about HTN or high blood pressure?
2. What are the factors contributing to your medical condition?
3. What incentive(s) would motivate you to stay compliant with treatment?

Discussions

1. We touched on what the group thought were major areas of concern in the AA community-
    a. Depression and Chemical Dependency
    b. Lack of health literacy and application
    c. Mistrust; shame; fear of disease outcomes
2. Availability of healthy food resources
3. High stress brought on by social issues
4. Obesity epidemic
5. Violence in the communities

PDSA Cycle 3

Test cycle 3	Start date	End Date
	10/16/2013	5/19/2014

Plan: Use the developed handout for all AA diabetics to help them set goals for diabetes and related disease management.

Do: About 80% of the eligible cohort (71 patients) were seen at least once during the period and exposed to the handout.

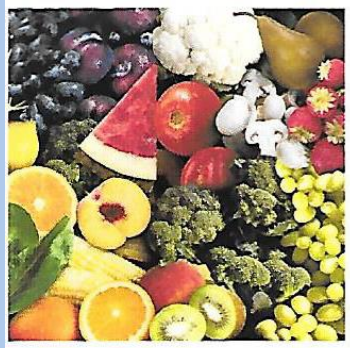
Study: 38 patient activities were chosen and 22 demonstrated improvement during the period.

Act: Spend time improving resources to help patients with goals with emphasis on exercise motivation.

Handout choices

What you can do

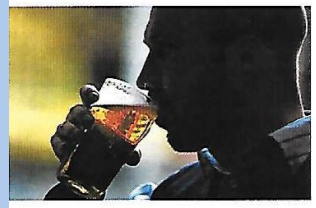
Eat a diet with fruits, vegetables and low fat dairy



Regular daily activity for 30-60 minutes

Lose 10 lbs

Reduce alcohol intake



Lower your stress

Resources

1. Dietary materials from HP, ADA, Weight Watchers, “Biggest Loser. . .,” nutrition assessments
2. Mapping food resources in the community
3. Emphasizing the use of gyms and the community centers in St. Paul
4. Behavioral Health interventions; meditation, breathing exercises

Resources

We had a speaker, Juliet Mitchell come and talk with us about the project, “I Can Prevent Diabetes,” that is being spread through the community through area churches. Her program welcomes known diabetics and their families.

Sponsored by MDH and involves 12 week sessions of cooking classes and exercise with incentives.

Results

Patient #s	Goals	Improvement	No changes
11	Dietary changes	7	4
7	Exercise Program	3	4
7	Weight reduction	5	2
6	Smoking cessation	1	5
2	Salt restriction	2	-
2	Alcohol abuse	1	1
3	Stress reduction	3	-

Comments

1. Improvement was loosely defined as making one change in eating; starting an exercise regimen; having definite stress reduction strategies as part of the lifestyle.
2. Many of the patients needed, on the average, 3-4 visits before goals were set and acted on.
3. Concerning blood pressure, of the 68 eligible patients during the period, **73% reached goal measures.**

PDSA Cycle #4

We wanted to expand on the idea of motivating the patients to start to exercise.

A team song was developed called, “You Can Do It, Too!!!” and a simple exercise video was created by the team to encourage and empower those patients having problems getting started with exercise.

We used members of the team in the video to help patients relate with the different ages and body types included.

Video production

Lessons Learned

1. It is very easy to work ineffectively within a very narrow perspective on how to impact patient clinical measures without patient input.
2. It is important to understand the community resources that patients can access and be relatable to in order to use as tools in your outreach.

Lessons Learned

3. It was very engaging for us as a team to come together from inside and outside of the clinic. We saw the value of community partners and drew on the creativity and experiences of the members that helped our motivation to work harder in the clinic for these patients.

4. Great challenges in getting patients to just be consistent in keeping appointments, picking up medications and getting labs done. Prioritizing things for the patients were key. Problem solving for them in the setting of huge socioeconomic barriers is ongoing.

Lessons Learned

5. We need to develop more peer educators, use of community health workers that can reinforce self management goals and stay relatable in the process.

6. Making things fun and exciting keeps anyone motivated for change.

Recommendations for Sustainability

1. Takes dedicated time that is incorporated into the work week to meet with community partners and work on community projects.
2. Important to have patient feedback and maybe even a committee for each clinic to help with logistics in carrying out projects.
3. More provider buy in that won't take a lot of time to develop projects and not have them spend a lot of time trying to run.