

“Implementing Clinical Quality Improvement Strategies to Address Obesity as a Risk Factor for Hypertension and Diabetes”



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Mississippi Quality Improvement II (MSQII-2)

- Increase implementation of quality improvement processes in health systems to control hypertension and diabetes.
- Increase use of team-based care.



MSQII-2 Method

The engagement of subject matter experts (SMEs) from various disciplines to form the MSQII-2 Leadership Team.

The MSQII-2 Leadership Team developed the Funding Opportunity Announcement (FOA), curriculum, identified presenters, additional partners, resources, and provided ongoing guidance.

Five primary care organizations (Cohorts I) were selected to participate in MSQII-2 through a Request for Proposal Process.

MSQII-2 Clinical Teams participated in four in-person learning sessions, multidisciplinary QI team activities during the action period, and collected data on Coronary Artery Disease, Hypertension, Diabetes.

Self Management Strategies

Aaron E. Henry

- In- House Nutrition Referral for all Hypertensive and Diabetic patients
- Implemented Community Health Worker (CHW) in the MSQII-2

Coastal Family Health Center

- Referral to Gulf Coast Health Educators for patients desiring diabetic teaching or dietary teaching

Family Health Center

- Tracking Coordinator on Staff, Education Classes (diabetes, Htn, etc.), presentation of disease mgmt. cases monthly at provider meetings
- Use Social Services to aide in community outreach and in-house programs

North Hills (Rush Health Systems)

- Partnered with MS CAN Case Manager to encourage patients in self management
- Used HTN & DM template to prompt providers to educate in self-management Goals

Phillips Medical Services

- Started Self-Management Classes that include teaching, cooking demonstration, exercise, and food
- Partnered with Magnolia Medical Foundation to provide Self-Management Services
- Established tracking cards with results for BP, A1c, LDL-C, and weight
- Added Patient Advocate and Community Pharmacist

MSQII-2 Cohort I

Measure: Document of Self-Management Plan for HBP Patients (Goal-80.0)

Cohort I Clinic	Baseline Measure (%)	Last Measure (%)	Percent Change	Average (%)
Aaron E. Henry	20.7	31.3	51.2% Increase	31.6
Coastal	95.3	78.8	-17.3% Decrease	80.0
Family Health	100	100	No Change	100
North Hills	0	55.9	**	46.0
Phillips	0	57.4	**	36.3

Thank You!

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