

**Group Protocol Proposal**

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## Group Protocol Proposal

### Section One

In North Dakota, two out of three adults are overweight or obese (North Dakota Department of Health, 2016). Patients with a body mass index (BMI) of over 25 are considered overweight (or obese with a BMI over 30) which is a risk factor for cardiovascular disease including hypertension. Thirty percent of adults in North Dakota are also diagnosed with hypertension, which mirrors national statistics of one in three (North Dakota Department of Health, 2016). According to the North Dakota Department of Health (2016) patients who are diagnosed with hypertension in North Dakota are likely to be on medication for their condition as 80% of patients are prescribed medication for their hypertension.

Cardiovascular disease cost the state of North Dakota 323 million dollars in healthcare expenditures in 2015 (North Dakota Department of Health, 2016). The healthcare costs for patients with hypertension averages \$2000 more than the patients who do not have hypertension (Wiener, 2018). Increased costs may encourage clients to stop their medications due to the higher costs, the prescription costs alone can be up to three times those of patients without hypertension (Wiener, 2018).

Due to the high costs associated with obesity and hypertension a group targeting this population would be beneficial to assist in the management of a high utilizing population. The population for this group will be adults beginning with age 18 and no cap on the age. Every referral will be a patient with hypertension and a BMI of 25 or more. The group will initially consist of ten group members due to space limitations. The group will be six weekly group sessions for one and a half hours scheduled per group. The group members will be required to

attend an initial appointment with the behavioral health consultant for an orientation prior to group entrance.

## **Section Two**

The group will consist of one individual orientation session and six group sessions.

### ***Orientation Session***

- Meet with behavioral health consultant for 15 to 30-minute session to complete and review the Framingham thirty-year risk assessment results. (BHC may complete the assessment prior to the session utilizing client records).
- Provide information on Dietary Approaches to Stop Hypertension (DASH diet). Low sodium diets have been shown to lower cardiovascular risk (Smith-Spangler et al., 2010).
- Provide handout which includes group times and information on download of Care Clinic app for dietary monitoring (*Tracking Sodium with an App*, n.d.).

### ***Group Session Number One***

- Brief introduction of group expectations and norms.
- Utilize motivational interviewing to determine the factors that motivate the patient to change. Weight loss is a behavioral change and motivational interviewing is a key tool in overcoming ambivalence and encouraging change (Wilfley et al., 2018).
- Review of care clinic app, this app can be utilized not only to track the sodium content of the diet but also to track other factors in the patients health condition, this will allow for the patient to be a more active participant in the monitoring of their condition and their care(*Tracking Sodium with an App*, n.d.).
- Homework: Practice utilizing the app and tracking dietary intake.

### ***Group Session Number Two***

- Check-ins for approximately 30 minutes. The patients will be encouraged to discuss successes and struggles with the app, concerns about beginning the diet education portion of the group, or any other concerns they may have related to their diagnosis or changes.
- Continued use of motivational interviewing to assist patient to move along stages of change by identifying motivating factors (Wilfley et al., 2018)
- A nurse practitioner will be available to discuss concerns and meet one on one with patients who have a medical concern that has arisen.
- This session will be co-led by a nutritionist who will provide information on the DASH diet as well as recipe ideas for the group to try. The DASH diet has been shown to reduce body fat (Perry et al., 2019).
- Homework: Each patient will select a recipe to try prior to the next group session.

### ***Group Session Number Three***

- Check ins for approximately thirty minutes to forty-five minutes. Patients will review the success or struggles they had with the recipes they chose. Patients will brainstorm as a group to overcome struggles that were identified.
- Overview of cognitive triangle from Cognitive Behavioral Therapy focusing on thoughts, feelings, and behaviors as they relate to the patient's relationship with food and the requirement for dietary change due to their condition.
- Homework assigned: Thought journal for patients to begin identifying their relationship with food to challenge any negative thoughts providing barriers to change.

### ***Group Session Number Four***

- Check ins for 30 to 45 minutes. Patients will be encouraged to focus their check in on any negative thoughts identified and brainstorming ways to overcome the negative thoughts.

- Utilize motivational interviewing in relation to the negative thought process and connecting the positive factors identified as motivating to the patients (Wilfley et al., 2018).
- introduction of mindfulness to be in the moment and identify thoughts and feelings related to food intake and possible use of food as an unhealthy coping mechanism. Practicing being in the moment with a short meditation. Mindfulness has been shown to allow patients to connect with themselves in the moment and explore their triggers for eating in an unhealthy manner (Wilfley et al., 2018).
- A nurse practitioner will be available to discuss concerns and meet one on one with patients who have a medical concern that has arisen.
- Review of DASH diet and choosing a new recipe to try at home.

#### ***Group Session Number Five***

- Each patient will step out of group to have blood pressure and weight measurements taken to assist in completing Framingham thirty-year risk assessment.
- Review of mindfulness techniques and feedback on successes and barriers.
- Nutritionist will rejoin group this week to review the DASH diet requirements and be available for questions from the group on specific struggles.
- Homework: Practice mindfulness in relation to food and triggers (Wilfley et al., 2018)

#### ***Group Session Number Six***

- Begin with brief check in (30 minutes).
- Brief discussion on group ending allowing room for difficulty with group ending.
- Nurse practitioner available for medical concerns.

- Discussion of available resources in the community for continued healthy changes including shopping resources, information on exercise availability (community center, private gyms, etc.), and any other resources identified as a need during the sessions.

### ***Follow-Up***

- BHC will call in one month to discuss whether patient is continuing with the DASH diet and care clinic app.
- Patient will follow-up as recommended with PCP.

### **Section Three**

The goal of this group is to provide tools needed for patients to utilize positive behavioral health changes in relation to weight loss and reduce hypertension. The tools identified have been shown to increase success in weight loss programming (Wilfley et al., 2018). The DASH diet is a low sodium diet which has been shown to reduce body mass in obese patients (Perry et al., 2019) and to reduce hypertension (Smith-Spangler et al., 2010).

Cardiovascular disease costs hundreds of millions of dollars in healthcare costs in North Dakota. Some patients can reduce hypertension utilizing a low sodium diet (Smith-Spangler et al., 2010). Patients who can reduce their hypertension with dietary and behavioral changes may reduce their healthcare costs as the costs for those with hypertension are higher than those without (Wiener, 2018). Patients who are unable to continue with a medication regimen due to high costs (Wiener, 2018) may have better outcomes by reducing hypertension with behavioral changes including a low sodium diet (Smith-Spangler et al., 2010).

The primary care physicians of patients who are requesting weight loss medications or surgery will be able to utilize the notes from the group to determine if the patient has been adhering to behavioral change attempts and whether medical weight loss interventions may be

indicated. This will assist PCPs in providing appropriate care and reduce the time needed to determine if the patient is following behavioral change guidelines prior to further weight loss interventions. Reduction in time spent managing these patients would allow for more patients to be treated by each PCP. Successful patients who are able to utilize the techniques to reduce their cardiovascular risk will also reduce the impact to the community and local clinics from the natural course of worsening cardiovascular disease.

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