DIABETES CLINICAL: BOX 4 FISHBONE DIAGRAM

(P) Possible (I) Implement (C) Challenge (K) Kill

WHAT could help us reach our aim? — HOW do we solve it?

AIM
95% of Central Oregonians with Type 2 Diabetes will have an HbA1c of <9%

Support/Encourage Non-Engaged Patients
- (P) Appt. Reminders
- (C) Clinical: Utilize EMR alerts for increased patient outreach
- (I) Clinical: Behavioral health engagement services
- (C) Non-provider f/u visits
- (K) Home visits
- (C) Clinical: analyze panel of non-engaged patients
- (P) Social media messaging

Referrals to Community Needs
- (C) When writing Rx for DM, always write one for healthy food and classes too
- (I) Food Referrals (WIC, SNAP, Cooking Matters, NeighborImpact, Meals on Wheels, etc.)
- (I) Exercise Referrals (Walk with Ease, Parks & Rec, Silver Sneakers, Etc.)
- (I) Food insecurity Assessment
- (P) Decrease barriers to gym memberships
- (C) Walkable communities
- (I) Flex Funds (Medicaid)

A1c Test Access
- (I) Standardized testing (POC vs. Venus)
- (C) EMR result integration
- (I) Timely reporting
- (K) Health Fair POC test
- (C) Non-PCP provider POC test (dentist, opthamologist, etc.)g

Patient Understanding of Diagnosis & Education
- (I) A1c awareness
- (P) Community-based education programs (ad campaigns)
- (K) Health fairs (POC A1c)
- (P) Social media presence
- (C) Insurance coverage for patient education
- (P) Advertising in local papers, websites, etc.
- (I) Nutrition opportunities

Establish Patients with PC
- (P) Encourage specialty care (gyn, cardiologist, etc.) to refer to PCP
- (C) Increase awareness of importance with younger generation
- (C) Emphasis on prevention & role of PCP within prevention
- (P) More targeted outreach to assigned or lost to care patients
- (C) Alternative ways to establish care

Decrease Co-morbidities
- (C) Prevent future complications of disease
- (C) Increase healthy behaviors
- (I) Tx diseases that are exacerbating DM (i.e. depression)
- (C) Address siloed care model
- (I) Robust ongoing self-management classes
- (I) Ensure comorbidities are assessed
- (I) Early involvement of Behavioral Health, Nutritionist & Diabetes Educator (whole team)

Increase Access to Resources in Rural Settings
- (I) Increase alternative visits (telemedicine, home visits, high risk health clinics, etc.)
- (C) Expand coverage for educators/dieticians
- (C) Expand clinic hours
- (I) Pharmacy access (mail order options, etc.)
- (K) School based health centers
- (C) Mobile clinics
- (C) Coordinated transportation options
- (I) Annual wellness clinics
- (?) High risk health clinics (Kelly)

Motivate Patients
- (I) Nutrition opportunities
- (K) Cost of diabetic complications
- (C) Community stigma/acceptance
- (I) Social norming/ media messaging
- (I) Ask patients
- (K) Health fairs
- (C) Clinical peer consulting
- (?) Clinical incentive programs (Therese)

Increase Referrals Between Sectors of Care
- (C) Collaborative care contracts
- (K) Increase knowledge between specialists
- (C) Interdisciplinary health clinics
- (I) Assigned staff to follow through on referrals
- (K) EMR health info exchange (Reliance HIE)
- (C) Closed loop referrals

Minimize Overall Cost to the patient
- (K) Overall cost or treatment vs. prevention
- (C) Cover diabetes education options
- (I) Awareness of benefits of resources available to patients (insurance, programs, etc.)
- (I) Identify programs that are free or minimal cost to patient
- (C) Political action
- (K) More focus on prevention

Consensus/Standard of Care/Guidelines in Tx & Diagnosis
- (C) Non-PCP Providers
- (C) Regular/standardized visits based on A1c-In-patient/ hospitalized patients guidelines
- (K) How clinics are paid
- (I) RHIP algorithm for type 2 diabetes management
- (I) Provider education
- (C) Insurance formulary coverage consistent with guideline recommended drug therapy
- (C) Insurance coverage of nutrition programs, diet/exercise programs

Ensure Access to Care
- (C) Standardize longer PCP appointments
- (C) Standardize medication reconciliation
- (C) Make appointments available (same day/nights& wknds)
- (C) Develop team-based care (not just PCPs)
- (C) Transporation

Access to Insurance
- (K) Unemployment/Ins. not covered (or unaffordable) at work
- (K) Immigration status & laws
- (P) Help with enrollment
- (K) Ineligibility
- (K) Cost of insurance and treatment
- (I) Patients unaware of ins. availability and options
- (I) OHP re-enrollment awareness & process