**Access to Care Workgroup Initiatives**

**Survey Ranking Results – July 12, 2011**

|  | **INITIATIVE DESCRIPTION** | **RANKING** |
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| 1 | Expand Primary Care Access: Increase access to care to primary care to better align with Harris County's uninsured population; increase community providers in the unincorporated area of Harris County, including FQHCs, school-based clinics, and mental health services in schools.  | 4.41 |
| 2 | Reduce inappropriate Emergency Department (ED) Use: Using community health workers to reduce ER utilization and to enroll individuals in programs that provide health care or basic necessities (e.g., food). Use community health workers to divert patients from ERs to more effective settings and to educate them about proper use of health care resources. Expand existing program at Memorial Hermann. Also educate about Medicaid, CHIP, and Medicare; identify medical home, and troubleshoot care coordination issues.  | 4.06 |
| 3 | Equalize available Primary Care visits based on population of community: Establish satellite medical offices for primary care (hub and spoke model) to provide broader coverage directly overseen by full scale health center and physicians’ offices. Collaborate with public and private providers.  | 4.03 |
| 4 | Primary Care Training for Behavioral Health: Expand primary care providers' ability to incorporate patients with co-occurring behavioral health diagnoses into their panels for treatment plans. Meet patient centered medical home requirements.  | 3.94 |
| 5 | Develop regional strategy to expand access and reduce barriers to medical homes: Expand St. Luke's portal platform for behavioral health services. Establish central call center for available medical homes to help link those individuals without assigned medical homes.  | 3.91 |
| 6 | Improve access to specialty care across community and region: Develop programs for a target population to increase specialist availability. Develop incentives for specialists to expand their capacity.  | 3.91 |
| 7 | Expanded hours of care - nights, weekends, after hours: Develop a home visit program for a target population. Expand capacity of qualified providers and increase coordination between client and provider.  | 3.90 |
| 8 | Expand urgent care facilities and services: Increase capacity and hours of operation at FQHCs and HCHD sites. Add services including x-ray, small injuries, OB, basic lab. Meant for all Houston, prioritized based on ER data.  | 3.90 |
| 9 | Access for Non-Resource Patients: Enroll non-resource patients in a coverage product managed by the MCOs which would provide a medical home. Coverage would include primary and preventive care and limited specialty care. Patient would pay small co-pays similar to the CHIP program. Services would be provided by in-network providers.  | 3.88 |
| 10 | Implement additional FQHC satellite offices: Develop capacity to identify potential sites that have appropriate payer mix and limited competition.  | 3.84 |
| 11 | Provider Health Network (PHN): Maintain and expand the PSN that provides specialty care services for the un/underinsured individuals in the region with income at or below 150% FPL. Program uses care coordination, provider training, and patient educating to assist patient in receiving successful specialty care.  | 3.81 |
| 12 | Increase number of mid-level professionals to support primary care physicians: Develop programs to train and educate mid-level practitioners to ease the work capacity of PCPs.  | 3.75 |
| 13 | Implement facilitated referral programs and excellent communication between primary care and other health care consultants: Develop model of primary care and specialty care integration; expand access to multidisciplinary approach. Permanent rotation of specialists through primary care offices in all areas of Houston. Each practice would need staff resources to coordinate visits of specialists.  | 3.75 |
| 14 | Increase and promote school based clinics prepared to function as medical homes with strong navigation services: Expand use of trained navigators in school-based clinics.  | 3.69 |
| 15 | Expand Primary Care Access: Develop a program for improving access to care in rural areas. Support implementation of improvement plans in neighboring rural counties.  | 3.66 |
| 16 | Provide an early intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.): Expand crisis stabilization services for persons with intellectual and developmental disabilities and challenging behaviors. Expand crisis stabilization model: emergency respite, intensive behavior supports and credentialed direct care staff to prevent out of home emergency care. Fort Bend area. Experienced behavior support and respite provider – facility site; psychiatrist, social worker, credentialed direct care.  | 3.66 |
| 17 | Increase access of Metro to patient base / Region specific transportation needed: Develop a medical transportation/jitney service, prioritizing areas with largest concentration. Reduce extensive and inappropriate use of ambulances.  | 3.61 |
| 18 | Reduce inappropriate Emergency Department (ED) Use: Improve observation status care services to decrease EC overflow.  | 3.55 |
| 19 | Develop program for appropriate use of emergency ambulance services: Identify high-volume use of ambulance services for non-emergency conditions by a target population; develop a transportation system to meet the needs of the population.  | 3.53 |
| 20 | Increase access to care for unfunded dialysis patients: Develop a system of care for dialysis patients that have no consistent form of insurance that could eliminate frequent ED visits.  | 3.53 |
| 21 | Expand pharmacy services & access to affordable medications: Create a program that allows a waiver for 340B funding for community groups that participate in Rx voucher program in Harris County specifically for small mobile clinics and small charity primary care clinics who don’t have their own pharmacy.  | 3.50 |
| 22 | Redesign care delivery, in accordance with medical home recognition program, and develop system that directs patient to medical home: Develop a strategic and implementation plan for the Community Nurse Triage Operation (CNTO)  | 3.50 |
| 23 | Develop regional strategy to reduce barriers to homeless health care services: Expand St. Luke's portal platform for homeless health care. Portal will identify clinics that are suitable for medical homes. Site could provide secure electronic transfer of clinical information to improve care and reduce costs.  | 3.42 |
| 24 | Implement an integrated multi-disciplinary care system to promote team-based care: Expand access to collaborative multidisciplinary approach.  | 3.37 |
| 25 | Expand Homeless Health Care: Partner with area shelters and arrange for designated stop times of mobile clinics to aid in standardization of health care for the homeless in Harris County.  | 3.34 |
| 26 | Home Hospice Benefit: Provide home hospice services as a HCHD benefit.  | 3.34 |
| 27 | Expand specialty care: Increase access to care for unfunded dialysis patients.  | 3.31 |
| 28 | Increase use of Community Health Workers for seniors and persons with disabilities: Expand placement of CHW at local community based organizations to assist navigation of seniors and person with disabilities.  | 3.30 |
| 29 | Improve access to resources for diabetes management: For FQHC providers, develop a specialty care coordination training program dedicated to diabetes patient care management 3 days/wk. Needed in Southeast Houston (high diabetes incidence rate, number of uninsured, limited access to primary care, etc.). Staff would include 1 FTE MD; 1 care coordination specialist; on nurse.  | 3.28 |
| 30 | Enhance service availability (hours, clinic locations, transportation, mobile clinics): Improve access to specialized therapy services to 0-3 age population with developmental delays not severe enough for ECI comprehensive services. 6-county area (Ft. Bend, Waller, Austin, Colorado, Matagorda, Wharton). Coordinate with established ECI programs to identify target population, supplemental home visitation program to monitor progress. Need speech, occupational and physical therapy, child development specialist and clinical setting.  | 3.28 |
| 31 | Improve access to dental care: Develop a program to recruit dentists to expand the capacity to serve a target population.  | 3.22 |
| 32 | Restructure outpatient laboratory medicine to make process more efficient and compliant with best practices: Develop pre-consult evaluations to facilitate faster, more appropriate subspecialty consultations to result in improved throughput and reduction of clinic backlogs. Use evidence-based laboratory workups of patients prior to specialty consultation in hematology, endocrinology, rheumatology, nephrology, etc. to ensure that referrals have the appropriate testing ahead of visits; help specialists see more patients they can treat; help primary care physicians deal more efficiently with complex diagnostic problems and reduce the backlog for consultations.  | 3.22 |
| 33 | Establish ED care teams: Expand community health worker at Care Connections, the aging and disability resource center serving Harris County  | 3.22 |
| 34 | Increase public health preventive services: Increase preventative/awareness and self-management skills of general population. Need partnerships between school nurses and public health; cohesive education.  | 3.19 |
| 35 | Consortium Purchasing of Preexisting condition Insurance: Develop a program for uninsured patients to secure insurance through the ACA Preexisting Condition Insurance (PCIP) using funds from an independent third party or the county indigent programs.  | 3.10 |
| 36 | Establish partnership to facilitate social services for patients: Collaborate and partner with community organizations to support patients with social needs.  | 3.10 |
| 37 | Para Nosotras: Develop and implement an evidence-based, comprehensive program to provide education, community-based patient navigation, and delivery of breast and cervical cancer screening services to underserved Mexican American women living in low income households in the Houston MSA.  | 3.06 |
| 38 | Implement evidence-based strategies to increase screenings for targeted populations: Develop program to provide health screenings at the workplace.  | 3.03 |
| 39 | Orthopedic Clinic Services: Expand orthopedic clinics services for target population.  | 2.94 |
| 40 | Radiation Therapy Services: Develop an outpatient radiation therapy program serving cancer patients in RHP#3; complement existing medical and surgical oncology services at HCHD outpatient clinics and LBJ Hospital.  | 2.93 |
| 41 | Define and promote Centers of Excellence: Identify quality indicators which would set standards for centers of excellence; promote their utilization and creation. Needed in Harris County.  | 2.91 |
| 42 | Expand Bridge Program: Increase support to palliative medicine patients with HCHD benefits.  | 2.81 |
| 43 | Develop care coordination program for Hepatitis C primary care and referrals to specialists: Identify a target population, collaborate with medical professionals to ensure Hepatitis C patients are receiving prompt care, and develop a self-management program.  | 2.75 |
| 44 | Expand resources for HIV prevention and care: Provide a single site where comprehensive services for HIV patients are delivered. Services include dental, transportation, medical, behavioral health, information and referral, etc. Establish a consultation and specialty referral system for rural areas where no services exist.  | 2.72 |
| 45 | Partner with Regional Health Fraud Unit to identify fraud, abuse and waste: Create a protocol that the region will use to identify potential fraud, abuse and waste.  | 2.72 |
| 46 | Urologic Services: Expand urologic services and specialty care for target population.  | 2.67 |
| 47 | Residential AIDS Hospice: Provide end of life care in a residential setting to individuals with HIV/AIDS who do not qualify for Medicaid and/or have no caregivers or a stable home environment.  | 2.61 |
| 48 | Epilepsy Monitoring Unit: Expand Epilepsy Monitoring Unit where patients with intractable seizures/epilepsy are admitted for evaluation for possible surgical resection of a seizure focus.  | 2.60 |
| 49 | Advanced Education in General Dentistry, Periodontics, and Endodontics for patients with HIV/AIDS: Increase advanced education opportunities for dental residents for treatment of patients with HIV/AIDS as workforce enhancement.  | 2.47 |
| 50 | Expand capacity at the UT Infectious Disease for HCHD: Create position and fund ID fellow to expand the consultation services at LBJ, develop home antibiotic administration  | 2.35 |