**Disease Management Workgroup Initiatives**

**Survey Ranking Results – July 12, 2012**

|  | **Initiatives** | **Ranking** |
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| 1 | Implement post-discharge support for target population admitted to a hospital: Reduce readmission rates for specific populations through structured and integrated discharge management led by a case management champion, (e.g. top 3 readmission types in last 30 days).  | 4.08 |
| 2 | Implement an evidence-based care coordination model in a target population: Reduce readmission of chronic conditions such as COPD, asthma – prevent with proactive outpatient management that increase diagnostics and treatment compliance.  | 3.92 |
| 3 | Develop registry for chronic conditions similar to the tumor registry: Enhance public health and population management for chronic conditions. Create longitudinal registry databases of health care utilization and services for patients with common chronic diseases and/or ambulatory sensitive conditions.  | 3.67 |
| 4 | Transition Medicine for Adolescents/Young Adults: Develop proactive care for adolescent/young adults with chronic conditions leaving the pediatric health care system. Need adult and sub-specialists that understand the pediatric disease process and provide a continuum of care by providers who understand the age group.  | 3.64 |
| 5 | Access to Behavioral Health: Provide mental health services to children and families to complement the physical and medical treatment of diabetes.  | 3.64 |
| 6 | Care coordination integrated with Navigation Service provided by certified Community Health Workers to address high-risk conditions: Expand current programs for all high-risk clinics in RHP#3.  | 3.58 |
| 7 | Establish a telehealth program/network to provide additional health care services (i.e., home health, self-care, and translation services): Deliver specialty and sub-specialty expertise to communities and rural areas to improve access to care.  | 3.50 |
| 8 | Develop an obesity preventive program: Use evidence-based self-management tools to help patients self-mange obesity.  | 3.50 |
| 9 | Expand disease management and health promotion for working uninsured: Implement wellness/care coordination/disease management strategies among the working uninsured population to increase early detection and intervention, when necessary.  | 3.42 |
| 10 | Preventive education model: Use evidence-based self-management tools to help patients self-mange chronic conditions at an early stage. Incorporate telehealth within the model.  | 3.33 |
| 11 | Implement a text-messaging system for management of chronic conditions: Develop a program for text messaging to improve compliance and outcomes of treatment in chronic diseases  | 3.25 |
| 12 | Implement an algorithm to reduce the time from an abnormal CXR to a definitive treatment in lung nodule clinics: Create a referral system that will expedite referrals for abnormal imaging suspicious for lung cancer.  | 3.25 |
| 13 | Expand specialty care: Develop care coordination program for Hepatitis C primary care referrals.  | 3.25 |
| 14 | Implement an evidence-based care coordination model in a target population: Expand use of evidence-based chronic disease self-management training utilizing the Stanford curriculum by Lorig, et. al. Train facilitators to help patients manage their chronic disease.  | 3.17 |
| 15 | Develop a disease management program for COPD: Implement a district-wide disease management program for COPD and target populations, improve smoking cessation quit rates, start pulmonary rehab program.  | 3.17 |
| 16 | Access to Behavioral Health: Provide mental health services to children and families to complement the physical and medical treatment of HIV.  | 3.17 |
| 17 | Develop a region-wide registry of community screenings and outreach: Identify screening programs and patient inventory in region, consolidate into a registry, disseminate information, and develop a quality matrix.  | 3.08 |
| 18 | Develop a coordination center for administration of directly-observed therapy for TB: Develop a system of referrals for all suspect cases; automatic referral from radiologist for suspicious CxR, automatically referrals for all AFB cultures; referrals for positive TB skin tests, referrals from homeless shelters, and active case findings in shelters, /IV drug users & jails.  | 2.50 |
| 19 | Establish a Back Pain Program: Develop patient education/awareness program to properly identify signs/symptoms to seek appropriate treatment. Develop provider training and care coordination to diagnose and manage properly.  | 2.33 |
| 20 | Improve access to resources for patients diagnosed with Obstructive sleep apnea: Develop a collaborative of public health providers and durable medical equipment vendors to provide access to refurbished C-PAP and Bi-PAP equipment at low or no costs, for eligible residents with annual household incomes at or below 200% of the FPL, who are unable to purchase the equipment.  | 2.25 |
| 21 | Develop rapid diagnosis and management of obstructive sleep apnea: Implement evidence based strategies to rapidly diagnose obstructive sleep apnea and obesity hypoventilation syndrome  | 2.08 |
| 22 | Create pediatric/adult interstitial fibrosis and pulmonary hypertension clinic for HCHD to improve access to specialty care: Access to diagnose and treat complicated advanced lung disease such as interstitial fibrosis/pulmonary hypertension/sarcoidosis.  | 2.08 |