**Hospitalization Utilization Workgroup Initiatives**

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

|  | **Initiatives** | **Ranking** |
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| 1 | Triage Protocols to Refer Patients from Emergency Department to FQHCs or charity clinics: Develop a process to triage patients from the HCHD Emergency Department to FQHCs or other community-based clinics; develop a call center, as needed. | 4.33 |
| 2 | Develop an aggressive case management programs to reduce inappropriate readmissions/admissions: Provide case managers to assess and identify high or inappropriate utilizers (patients with chronic illnesses or ambulatory sensitive conditions or other) and use IT to track. Targeted interventions with those populations, including connecting to primary care/medical home with reimbursement and follow up. | 4.27 |
| 3 | Reduce inappropriate Emergency Department (ED) Use: Implement clinical protocols to discourage inappropriate use and provide access to other settings of care. Provide case management to help patients access care elsewhere. Utilize technology to assist. | 4.27 |
| 4 | Reduce ED visits by identifying frequent users' needs (e.g. hemodialysis, psychiatric, etc.): Create alternatives for outpatient care– dialysis and specialty clinics capable of serving patients; provide active case management post ED; follow ED protocols for appropriate referrals. | 4.13 |
| 5 | Address inappropriate admissions/readmissions with supportive housing model for mentally ill and homeless: Develop a service package for high utilizers of ED (homeless and mentally ill) and link them to supportive housing setting. Package would include facilitated access to behavioral health services, social supports and case management. | 3.87 |
| 6 | Establish patient health navigator program to assure appropriate use of system: Hire navigators to direct patients to medical homes instead of EDs and other inappropriate settings and to educate about proper use of system. | 3.73 |
| 7 | Establish accountability/incentive model for patients (e.g., who have diabetes and other chronic illnesses) to follow behavior protocols: Patients with diabetes should follow dietary requirements, healthy behavior (feet and eye exams, exercise and weight control, etc.) – establish program to measure these behaviors and incentivize them. Possibly utilize smart phone apps to track, monitor incentives; create services to call patients, provide appropriate education at diabetes clinic. | 3.67 |
| 8 | Develop a shared savings model between providers and payers that maintains quality standards: Develop better transition from childhood to adult providers for high-risk/complicated patients. Place in medical homes to be proactive in care delivery and reduce inappropriate utilization in high cost settings. Provide in central area where all support can be provided in one-stop shop; possible partial interaction with providing NP and MD home visits. Increase Interdisciplinary teams as “transitional medical practices” for CF, Diabetes, Neuro-developmental patients. | 3.47 |
| 9 | Expand "Ask Your Nurse" as a community benefit: Implement nurse call center to coordinate patients to a navigation service to access appropriate care and reduce inappropriate ED utilization. | 3.47 |
| 10 | Create palliative care program to address end of life and other needs: Develop public education campaign about palliative care. Develop program to work with patients re: care options, preferences, etc. Need social workers and patient educators. | 3.27 |
| 11 | Develop NP and MD house call teams: Teams to provide home health services for homebound patients where due to patient condition, transportation to facilities is challenging. Greater concentration in urban areas, optimized with IT. Need provider training, patient education, care coordinator. | 2.93 |