Resource and Action Guide

April 21, 2021 – Chronic Disease Self-Management

Learning Series: Sharing Best Practices through the COVID-19 Pandemic: Chronic Disease Self-Management, PainManagement, and Care Transitions
Learning Session 3: Promising Practices to Improve Outcomes for People with Cardiovascular Disease and Diabetes

Opportunities for Action: As you continue your participation in the learning series, we will provide you with tools and resources related to each learning session. In addition to the ideas brought forward during the sessions, our team has identified specific actions you can take that will advance learning into action. There is something for everyone, some actions will take only a few minutes while others could support an entire quality improvement project.

Putting the CDC Evidence-Based Guidelines into Action

- **Easy**: Explore screening tools for
  - Diabetes (Are You at Risk for Type 2 Diabetes?)
  - CVD
- **Intermediate**: Implement at least one screening tool or referral process after reviewing Healthy People 2030 Diabetes and/or Heart Disease and Stroke evidence-based resources
- **Advanced**:
  - Consider becoming a CDC-recognized DPP provider or an accredited/recognized DSMES program site
  - Consider administering your own Blood-Pressure Self-Monitoring Program

American Heart Association (AHA) Recommended Tools and Resources

- Know Diabetes by Heart
  - Information on inpatient and outpatient programs
- ADA's Living With Type 2 Diabetes Program
- ADA's Ask the Experts Q&A series
- ADA's Ask the Experts Weekly Podcast It's Personal
- Outpatient recognition submission
  - Recognition submission is open now through May 28 11:59 ET, based on 2020 clinical activities
- ASCVD Risk Calculator
- AHA Check. Change. Control. Cholesteral
- AHA Target: BP
- 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease

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- General professional links
- Self-Management Blood Pressure Program (SMBP) Workflow
- Contact with questions

YMCA of Metropolitan Denver Recommended Tools and Resources

- NIH and CDC research behind the National Diabetes Prevention Program (DPP)
- Check It Change It Program
- YMCA of the USA Blood Pressure Self-Monitoring (BPSM) Program
- Contact Amy Sagendorg, MS, NBC-HWC with any questions: asagendorf@denverymca.org or (720) 545-8856

Diabetes Screening, Prevention, and Self-Management Tools

- CDC Road to Type 2 Diabetes infographic
- Diabetes diagnosis tests
- ADA/CDC Prediabetes Risk Test
- Diabetes Prevention Program (DPP)
  - National DPP CDC infographic
  - CDC About National DPP
  - Registry of CDC-recognized DPP organizations
- Diabetes Self-Management Education and Support (DSMES)
  - American Diabetes Association (ADA) Education Recognition Program
  - Association of Diabetes Care & Education Specialists (ADCES) Diabetes Education Accreditation Program (DEAP)
  - CDC DSMES Toolkit for healthcare providers
  - Find accredited and recognized DSMES program

Cardiovascular Disease Screening and Self-Monitoring Tools and Programs

- CDC Road to Type 2 Diabetes infographic
- AHA High Blood Pressure Toolkit for healthcare providers
- Million Hearts Self-Measured Blood Pressure Monitoring (SMBP) Action Steps

April 7, 2021 – Pain Management and Opioid Misuse

Learning Series: Sharing Best Practices through the COVID-19 Pandemic: Chronic Disease Self-Management, PainManagement, and Care Transitions
Learning Session 2: Applying Evidence-Based Guidelines for the Management of Chronic Pain

Opportunities for Action: As you continue your participation in the learning series, we will provide you with tools and resources related to each learning session. In addition to the ideas brought forward during the sessions, our team has identified specific actions you can take that will advance learning into action. There is something for everyone, some actions will take only a few minutes while others could support an entire quality improvement project.

Putting the CDC Evidence-Based Guidelines into Action

- **Easy**: Utilization of Prescription Drug Monitoring Program (PDMP) – Reducing Opioid Misuse
  - PDMP: What Healthcare Providers Need to Know
  - Prescription Drug Monitoring Program Training and Technical Assistance Center
  - Colorado PDMP Illinois PDMP Iowa PDMP Oklahoma PDMP
- **Intermediate:** Increase opioid and pain management patient, family and caregiver education
  - Helpful Material for Patients
  - Patient Education: General Drug Facts & Information about Addiction
  - Patient, Family & Caregiver Opioid and other Drug Education
- **Advanced:** Development or Enhancement of a Pain Management Program
  - Implementation of evidence-based practice for opioid prescribing and pain management alternatives
  - Complete "Easy" and "Intermediate" Action Plans
  - Become a MAT Waivered Provider (if applicable)
  - Commit to becoming a Telligen QI Connect™ Mastermind – get involved to make the change
  - Measurement of Effectiveness – track and monitor opioid prescribing, overdose, and deaths data
  - Share your successes with your Telligen QI Connect™ partners – the Telligen team wants to hear from you.

Centers for Disease Control and Prevention (CDC) Recommended Tools and Resources

- CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016
- HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics
- Pocket Guide: Tapering Opioids for Chronic Pain
- The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update
- How to Qualify for a waiver to prescribe buprenorphine - SAMHSA
- SAMHSA Providers Clinical Support System (PCSS)
- Opioid Treatment Providers Resources and Information
- CDC Guideline Resources: Online training modules & webinars
- CDC Provider and Patient Education Tools
- Quality Improvement and Care Coordination

This material was prepared by Telligen, the Medicare Quality Innovation Network Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. This material is for informational purposes only and does not constitute medical advice; it is not intended to be a substitute for professional medical advice, diagnosis or treatment. 12SOW-QIN-QIN-03/24/21-4040

COVID-19, Opioids, Pain Management Tools and Resources

- Biden-Harris Administration's Statement of Drug Policy Priorities
- COVID-19 Telemedicine/Virtual Medical Care Resources
- Changes in Opioid Prescribing Practices
- Medication Assisted Treatment (MAT) - Prescription Drug and Opioid Addiction Funding Opportunities
- MAT for Opioid-Use Disorder During the COVID-19 Pandemic

March 24, 2021 – Care Transitions

Learning Series: Sharing Best Practices through the COVID-19 Pandemic: Chronic Disease Self-Management, PainManagement, and Care Transitions
Learning Session 1: Highlighting the Role of Pharmacy in Care Transitions During COVID-19

Opportunities for Action: In addition to the ideas brought forward during the session, our team has identified specific actions you can take that will advance learning into action. There is something for everyone, some actions will take only a few minutes while others could support an entire quality improvement project.

Pharmacy Partnership

» National Alliance of State Pharmacy Associations State Fact Sheets
Action Opportunity

- **All**: Locate your state's 2020 State Fact Sheet to determine potential partnership opportunities.

Readmissions and Transitions of Care

» **National Transitions of Care Coalition (NTOCC)Action Opportunity**

- **Easy**: Review the Safe and Effective COVID-19 Transitions of Care: Interprofessional Strategies Across the Spectrum of Illness and Healthcare Settings activity description and details determine if you would like tocomplete this.
- **Intermediate**: Identify your care transitions and care coordination partners and invite them to complete thissame activity.
- **Advanced**: Schedule a meeting with your care transitions and care coordination partners that complete thisactivity and identify a community action you can take based on what you learned.

» AHRQ - Designing and Delivering Whole-Person Transitional Care (Most provider or community organization typescan find an applicable tool here)
Action Opportunity

- **Hospital-specific**: Use Tool 1, Data Analysis to understand your *all-payer, all-condition* readmissions.

- **Easy**: Watch this 27-minute webinar from a national care transitions and readmissions expert, Dr. AmyBoutwell, *Designing & Delivering Whole-Person Transitional Care.*
- **Intermediate**: Download and use *Tool 4: Community Inventory* to identify gaps and consider providers oragencies you may want partner with to ensure a whole-person plan.
- **Advanced**: Work with your community to create or update a *Community Resource Guide, Tool 11.*

» INTERACT® (Interventions to Reduce Acute Care Transfers) for skilled nursing, assisted living, or home health.
Action Opportunity

- **Easy:** Sign in/login to INTERACT® website, navigate to the appropriate provider type and review the toolsavailable.
- **Intermediate:** Speak with your clinical or quality improvement director to determine if INTERACT® is beingused in your organization.
  - If so, investigate if there are any other tools that might help improve low performing measures (ex.Medicare Compare).
  - If not, choose one tool and use it to evaluate your current transitions of care/patient transferprocess. Is there an opportunity to update your process?
- **Advanced:** Use INTERACT® tool(s) for your next quality improvement project around one of your lowerperforming measures.

Reducing Adverse Drug Events (ADEs) in Communities

» MATCH Toolkit for Medication Reconciliation - Medications at Transitions and Clinical Handoffs
Action Opportunity

- **Easy**: Assembling a medication reconciliation team is an important first step, use this guide to form youraction team.
- **Intermediate**: Use these tools for Designing/Redesigning a Medication Reconciliation Process.
- **Advanced:** The MATCH Work Plan supports the implementation and documents outcomes related to theproject.

Chronic Care Management (CCM)

Action Opportunity

- **Easy:** Research who your local Medicare Administrative Contractor (MAC) is here. (The MACs processMedicare CCM claims.)
- **Intermediate:** Visit your MAC website to find local coverage and guidance for CCM services by searching thewebsite for "Chronic Care Management."
- **Advanced:** If you are not billing CCM services, speak with your leadership to determine if this would be anopportunity for your organization to consider.

Quality Improvement Resource Tools

- RCA Pathway
- When to Use RCA
- RCA Tool Selection Guide
- Fishbone diagram
- Five Whys Worksheet and Example
- Institute for Healthcare Improvement (IHI) Driver Diagram Tutorial
- Telligen Driver Diagram
- Plan Do Study Act (PDSA) Worksheet

Telligen QI Connect™ Opportunities and Events (Colorado, Iowa, Illinois, and Oklahoma)

- Telligen QI Connect™ Mastermind Team interest form
- Telligen Community Ambassador flyer
- Telligen Portal
- Telligen QI Connect™ Events calendar

Telligen State Points of Contact

Colorado

Meredith Koob, Community point of contact – mkoob@telligen.com
Courtnay Ryan, Nursing Home point of contact – cryan@telligen.com

Iowa

Vicky Kolar, Community point of contact – vkolar@telligen.com
Gina Anderson, Nursing Home point of contact – ganderson@telligen.com

Illinois

Kristen Marino, Community point of contact – kmarino@telligen.com
Lisa Bridwell, Nursing Home point of contact – lbridwel@telligen.com

Oklahoma

Belinda Rogers, Community point of contact – brogers@telligen.com
Sherry Longacre, Nursing Home point of contact – slongacre@telligen.com

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