



# Telligen QI Connect™

Partnering to improve health outcomes through relationships and data

## Resource and Action Guide

This Resource and Action Guide is intended as a resource to assist with quality improvement initiatives. It walks through each step of an improvement project beginning with problem identification and ending with the plan-do-study-act (PDSA) cycle. Each section provides resources to help generate ideas for improvement strategies, example change strategies, and metrics to monitor progress. We offer resources to help determine what issue to focus on for improvement and provide strategies and tools. This guide is not exhaustive; rather it should be used along with a thorough assessment of current activities in your organization, an understanding of your organization's operations and culture, and technical assistance available for targeted quality improvement.

### Putting Evidence-Based Guidelines into Action

The following sources will offer ideas for selecting an appropriate intervention or change strategy for the identified problem.

**Opportunities for Action:** Through our monthly Community Connect Calls we provide you with tools and evidenced base resources to support your quality improvement efforts in reducing readmissions and increase health equity. 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.

### 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 to complete this.
    - **Intermediate:** Identify your care transitions and care coordination partners and invite them to complete this same activity.
    - **Advanced:** Schedule a meeting with your care transitions and care coordination partners that complete this activity 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 types can 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. Amy Boutwell, [Designing & Delivering Whole-Person Transitional Care](#).
    - **Intermediate:** Download and use [Tool 4: Community Inventory](#) to identify gaps and consider providers or agencies 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.





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## Action Opportunity

- **Easy:** Sign in/login to INTERACT® website, navigate to the appropriate provider type and review the tools available.
- **Intermediate:** Speak with your clinical or quality improvement director to determine if INTERACT® is being used 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 transfer process. Is there an opportunity to update your process?
- **Advanced:** Use INTERACT® tool(s) for your next quality improvement project around one of your lower performing 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 your action 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 the project.

## Chronic Care Management (CCM)

### Action Opportunity

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

## May Community Connect Call Featured Resources:

- AHA’s Institute for Diversity and Health Equity (IFDHE)

- [Toolkits to prioritize health equity](#)

**Action Opportunity:** Recognizing there is no predetermined starting point, these toolkits are designed to meet organizations where they currently stand. Initial processes may include:

- Establishing the organization’s baseline experience
- Focusing on one or two key areas to drive change
- Tracking progress over time





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- **Wellness Recovery Action Plan®** or **WRAP®**

## Action Opportunity:

Build your [Wellness Toolbox](#)

- [Feelings Pyramid](#)
- [Crisis Plan](#)
- [WRAP® App](#)
- [Webinars](#)

## Model for Improvement

The Model for Improvement is a simple, yet powerful tool for accelerating improvement. This model is not meant to replace change models that organizations may already be using, but rather to accelerate improvement.

**Step 1:** Problem Identification/Gap Analysis

**Step 2:** Root Cause Analysis

**Step 3:** Select and Implement Change Strategies

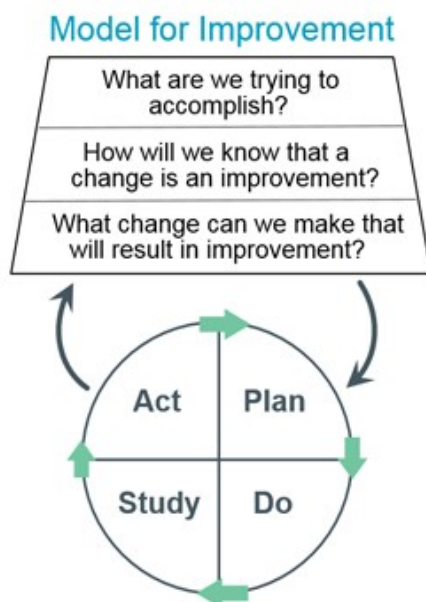
## Plan-Do-Study-Act (PDSA) Cycle

Conducting a Plan-Do-Study-Act (PDSA) to test the intervention or change strategy on a small scale and determining whether it improves the identified gap or problem may be helpful as part of piloting the change before implementing it widely in the organization.

Use the Telligen PDSA worksheet to walk through a PDSA cycle:

<https://www.telligenqinqio.com/wp-content/uploads/2020/05/QII-PDSA-Template-2.pdf>

Visit the **Institute for Healthcare Improvement (IHI) Model for Improvement** for additional guidance, tools, and resources related to PDSAs: <http://www.ihl.org/resources/Pages/HowtoImprove/default.aspx>





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- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in an improvement?

## 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

## Colorado Partner Resources:

- Quality Health Network (Thanks for sharing, Sherri Corey!)
  - Community Resource Network: [www.communityresourcenet.org](http://www.communityresourcenet.org).
  - Accountable Health Communities Model Community (AHCM) Report (attached to 5/18 follow-up e-mail).
- [Unite Us](#) - free resource for community organizations for referrals. (Thanks for sharing, Peggy Budai!)
- Thank you, Amanda Varga for sharing:  
“While it might seem odd for a mortgage company to be involved in this, by educating discharge planners, care/case managers on the options their discharging clients may have to access their home equity to help them afford private-pay care, home modifications, etc. Our purpose really is to help those who want to be home do so safely. Anyone can reach me at [Amanda@OrionMortgage.net](mailto:Amanda@OrionMortgage.net). I'm happy to share what we do and how we hope to help.”
- Dignity Health®: Opioid safety and how to use naloxone brochure (Attached to 5/18 follow-up e-mail. (Thanks for sharing, Mary Schramke!)
- Alzheimer’s Association May Events Calendar: <https://stage.alz.org/media/co/Regional-Education-May-2021-pub.pdf>. (Thanks for sharing, Danelle Hubbard!)
- National Consortium of Telehealth Resource Centers Webinar – [Mistakes, Myths and Misconceptions Your Telehealth Diabetes Program Needs To Avoid to be Successful](#), 5/20/21.





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- Age Friendly Health Systems recognition technical assistance is available. (Attached to 5/18 follow-up e-mail. Thanks for sharing, Shawn Elliott!)
- Looking for CO nursing home teams *serious* about participating in 5-10 months of free virtual training on **The Validation Method® - Truly Successful Communication with Persons living with Dementia** thanks to a Colorado Nursing Home Innovations Grant. Please feel free to contact Carmen at [carmen@edu-catering.com](mailto:carmen@edu-catering.com) or 303-981-7228. To be considered, a home will have to submit a completed MOU. Acceptance is on a first come, first served basis.

## Colorado

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**QIN-QIO**  
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Quality Improvement Organizations  
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