Telligen QI Connect™

Partnering to improve health outcomes through relationships and data

AIM	Primary Driver What are the main factors that influence our aim?	Secondary Driver What factors affect the performance/influence primary drivers?	Change Idea What actions can be tested?	Measure of Effectiveness How will we measure the impact of the chosen idea?
Mentioned throughout: *Health illiteracy and inequity* (including culture, belief systems, language). See The Agency for Healthcare Research and Quality (AHRQ) "*Health Literacy Universal Precautions Toolkit, 2nd Edition*" for tools that strengthen support for patients.				
By November 30th, 2021, we will reduce hospital readmissions by 5% in Colorado communities.	**Continuity of Care for Super-Utilizer Patients** (Super utilizer defined as small proportion of patients who account for disproportionate amount of utilization and cost)	**Late identification and communication of high-risk patients**	Increase utilization of "Welcome to Medicare" preventive visits, Annual Wellness, and Chronic Care Management visits	Example: • __ % increase of DSMES referrals generated from 2-1-1.
		Low self-management program referral and utilization	Increase chronic disease screening and referrals to self-management programs (e.g., diabetes prevention program (DPP)) • New in Q1 2021! CO Diabetes Self-Management Education and Support (DSMES) programs can be found on 2-1-1 Colorado, including DPP when applicable.	
		Case management	• Use data to identify and case manage super-utilizer patients • Include education, monitoring, support, etc. • Engage social workers • Refer to community agencies (e.g., Area Agencies on Aging/AAA)	
		Social determinants of health (SDOH) • Limited access to primary care (rural communities)	Refer to community agencies such as local AAA or by using 2-1-1 directory. Employ community health workers to connect patients with community resources to assist with social determinants, finding a PCP, etc.	

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		Undiagnosed cognitive impairment (June 2021 TCCC partner highlight: Alzheimer's Association)	Ask person receiving discharge instructions if they are the primary caregiver. If not, coordinate with PCP to ensure communication with the primary caregiver for the person with cognitive or hearing impairment Alzheimer's Association Cognitive Impairment Care Planning Toolkit – for practitioners eligible to report E/M services Age Friendly Health System (AFHS) recognition (Example: AHCM Community Report- How a social needs screening, care coordination, and community collaboration effort is improving health for Western Coloradans) AD8 Informant Tool – screening tool; referral made if there are concerns; can be used by any provider; versatile Screening at discharge Ensure patient understands diagnosis when being prescribed medication prior to discharge Teach Back method	Example: most prevalant needs are identified by screening (to identify resources that assist with the need).

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		Not the appropriate level of care	Implement post discharge follow-up calls for patient education Divert superutilizers to urgent care	
	Care Transitions	**Communication at points of transition** • System tracking for admissions, discharges, transfers (ADTs)	Implement SBAR Tool while communicating during care transitions Improve communication with patients and more timely communication with readmission hospitals Closed loop referrals (e.g., Unite Us Colorado)	Number of referrals Results sent back to PCP?
		Coordination of care	Adopt and utilize transitional care management (TCM) and advanced care planning (ACP)	
		Stigma	Engage community groups to help with stigma, taking steps leading up to the ultimate goal of rehab	

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		SDOH • Fixed income – unable to afford medications	Address social needs at discharge (e.g., food, transportation, COVID restrictions) Outreach to mortgage companies that may have access to home equity data Address SDOH at admission; be mindful at all points, even outside of hospital/ED admission Accountable Health Communities Model (AHCM screener), CMS – focus on SDOH screeners at intake and prior to discharge. Community Resource Network (CRN) Platform – used to help with referrals; tied to Health Information Exchange • Social needs screening • Closed loop referrals • Sherri Corey -Quality Health Network - scorey@qualityhealthnetwork.org Ensure patient has internet access and/or smart phone for telehealth	Education – who we can talk to, how many Number of referrals Screenings done How has implementation of CRN platform affected readmissions

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		Family member unable to: • care for patient who returns to the ER for help • follow directions as given or didn't understand challenges with care **Discharged too soon**	An attempt at change that CareTreks is trying to make is to provide resources to working family caregivers by providing easy resource access as an employee benefit. Allow proxy access to family member's electronic health record	
	Adverse Drug Events (ADEs)	**Medication reconciliation**	Implement Medications at Transitions and Clinical Handoffs (MATCH) Toolkit and distribute the ADE Trigger Tool to at least 5 patients	
		Medication adherence – patient and caregiver teaching • medication regimens • start dates • frequencies of PRN medications • knowledge deficit for new meds	Educate patients (by pharmacy, clinic, hospital) on new meds; drug regimen review Provide education on new meds	
		Pain management (healthcare providers and pharmacies)	Register for and check your state or jurisdiction's Prescription Drug Monitoring Program (PDMP)	

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	Opioid Related Misuse	**Pain management programs**	Send 10 tabs of narcotic home with patients; make a f/u appt with their PCP who will be in control of patient's narcotic usage once they are home <u>Colorado Take Back Medication Program</u> Distribute medication disposal kits; educate patients and families on proper medication disposal Start gradual does reduction (GDR) process and monitor patient's level of pain tolerance Is there a way we can link opioid handouts with pain management support? Perhaps a useful link as people decrease use of opioids after surgery	Number of prescriptions, maybe by zip code
		Alternative methods for pain control	Use non-opioid options for managing pain • Non-pharmacological therapies, including pain self-management programs • Heat • Ice • Medication-assisted treatment (MAT)	
		Support systems	Resource referrals, community resources, reviewing patient's chart to see risk, educating patient on coping mechanisms	

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		Patient and caregiver education • proper use and awareness of overdose	Share the GeriatricPain.org FAST FACTS pain assessment information with patients, families, and caregivers Safe use of opioid handout(s) at discharge, including: • Appropriate use of variety of pain management tools • Instructions for safe dispose of unused opioids following recovery • (Example: Dignity Health brochure- A Guide for Patients and Caregivers: Opioid safety and how to use naloxone)	
		Patient and caregiver education • proper disposal of medications not needed	Distribute medication disposal kits; educate patients and families on proper medication disposal Promote National Prescription Drug Take Back Day (April 24, 2021)	

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