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 evidence-based resources to support your quality improvement efforts in reducing readmissions and increasing 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. Release date: 2/26/21, Expiration date: 2/25/22.
- **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 *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 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 for Physicians, Clinical Nurse Specialists, Nurse Practitioners, Physician Assistants, and Certified Nurse Midwifes

- **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 a revenue-generating opportunity for your organization to consider.

Pain Management and Opioid Misuse

Action Opportunity

- **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.

June Community Connect Collaborative (TCCC) Featured Resources:

Social determinants of health (SDOH) are structural and contextual factors that can be identified by the health care system and addressed in partnership with community resources. **Health-related social needs (HRSN)** are individual-level, adverse social conditions that can negatively impact a person's health or health care.

Action Opportunity

- **SDOH screening and assessment tools:**
  - Office of Minority Health - CLAS Toolkit (culturally and linguistically appropriate services)
  - PRAPARE Toolkit & Assessment Tool (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences)
  - HealthBegins - Upstream Risks Screening Tool & Guide
  - RHIhub-Social Determinants of Health in Rural Communities Toolkit (Rural Health hub)

- **HRSN screening tool:**
  - Centers for Medicaid & Medicare (CMS): A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool**:** Promising Practices and Key Insights (Join July TCCC to hear from Quality Health Network and Western Colorado partners)

AHRQ's Interactive Tool: Social Determinants of Health Data on Internet Access

- Online data visualization tool

Organizational Charter

- Team Charter template

Alzheimer's and Dementia Education, Training & Support

Action Opportunity

Professionals

- Public Health Curriculum on Alzheimer's
- Healthy Brain Initiative Road Map
- Approaching Alzheimer's: First Responder Training

Caregivers, families & individuals

- ALZConnected®- virtual community support groups
- Financial and legal training for caregivers
- Managing Money Pilot Program and Evaluation -*$125.00 gift card
- MedicAlert® with 24/7 Wandering Support

Colorado Partner Resources:

From Colorado Department of Public Health and Environment (CDPHE): Alzheimer's Disease and Related Dementias (ADRD)

- Joanna Espinoza, State Alzheimer's and Related Dementias (ADRD) Coordinator, CDPHE, (303) 692-6347, joanna.espinoza@state.co.us
  - Primary Care: set up a time with Joanna to share your ideas on building the CO ADRD workforce
  - All: To learn more about the CO ADRD state plan and how you can become involved, contact Joanna

From Alzheimer's Association

- Danelle Hubbard, Director of Health Systems, Region 4 Alzheimer's Association, (720) 699-9277, dhubbard@alz.org
  - Alzheimer's Association Cognitive Assessment Toolkit: contact Danelle for technical assistance with implementation

- Needs Addressed: Gaps in Diagnosis; Functional, Cognitive, and Safety Assessments; Evidence-based and Person-Centered Care Planning; Caregiver Resources; End of Life Decisions

- Sign-up for Alzheimer's Association's E-newsletter: https://www.alz.org/e-news
- 24/7 Helpline: (800) 272-3900

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.

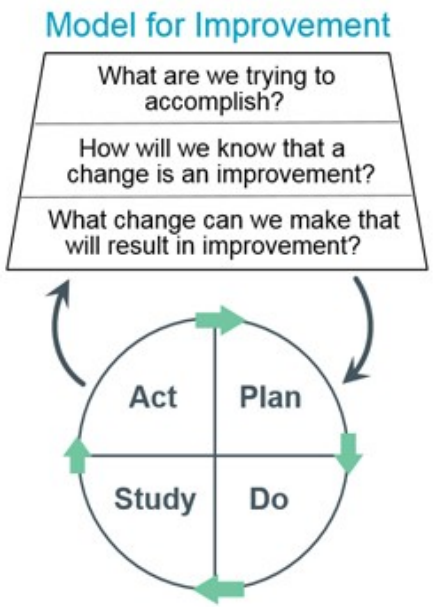
Step 1: Problem Identification/Gap Analysis
Step 2: Root Cause Analysis
Step 3: Select and Implement Change Strategies

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.ihi.org/resources/Pages/HowtoImprove/default.aspx



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

Your Colorado Points of Contact:

Meredith Koob, Community contact- mkoob@telligen.com, (303) 260-9346
Courtnay Ryan, Nursing Home contact - cryan@telligen.com, (303) 612-3111

Telligen
QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
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