Promoting Effective Prevention & Treatment of Chronic Disease

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

atom℠
Alliance for Powerful Change℠

www.atomAlliance.org

An Alliance for Powerful Change

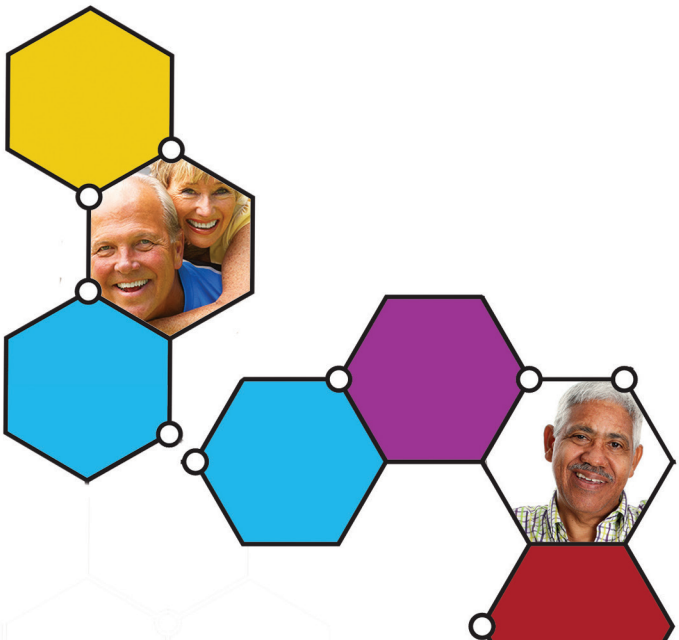
atom Alliance is a five-year, five-state initiative to ignite powerful and sustainable change in healthcare quality. Formed as a partnership between three leading healthcare consultancies, atom Alliance is working under contract to CMS to improve quality and achieve better outcomes in health and healthcare at lower costs for the patients and communities we serve.

Let Us Help You

Through atom Alliance, AQAF in Alabama, IQH in Mississippi and Qsource in Indiana, Kentucky and Tennessee are carrying out an exciting strategic plan, with programs in place to convene, teach and inform healthcare providers, engage and empower patients, share knowledge and spread best practices with communities across the entire healthcare continuum.

Our focus is on promoting prevention activities, reducing cardiac disease and diabetes, reducing healthcare disparities and improving patient and family engagement. We also provide technical assistance for improvement in the Centers for Medicare & Medicaid Services (CMS) value-based purchasing programs, including the physician value-based atom Alliance partners. We are change agents focused on three aims: better patient care, better population health, and lower health care costs through improvement.

As part of the national Quality Innovation Network-Quality Improvement Organization (QIN-QIO), we help CMS achieve quality goals by convening local communities for learning and action. Our experienced staff works in partnership with patients, providers, and practitioners across organizational, cultural, and geographic boundaries to conduct quality improvement activities in a way that puts patients first and equips providers to do the same.



Cardiac Health

Improving Cardiac Health and Reducing Healthcare Disparities

According to the Centers for Disease Control and Prevention (CDC), heart disease and stroke are the first and fourth leading causes of death in the United States, with a disproportionate negative impact among racial and ethnic minorities. This initiative offers participants assistance in providing more effective treatment to patients at risk for heart attack and stroke, especially those in underserved populations. The program is aligned with the Million Hearts® Initiative, a nationwide campaign whose goal is to prevent one million heart attacks and strokes by 2017, (focused on Cardiac ABCs: aspirin therapy when appropriate, blood pressure control, cholesterol management and smoking screening and cessation) and the Home Health Quality Initiative (HHQI), which focuses on reducing heart attacks and strokes in the home health setting.

Partners

- Ambulatory care provider offices
- Home health agencies
- Healthcare providers and practitioners

Goals

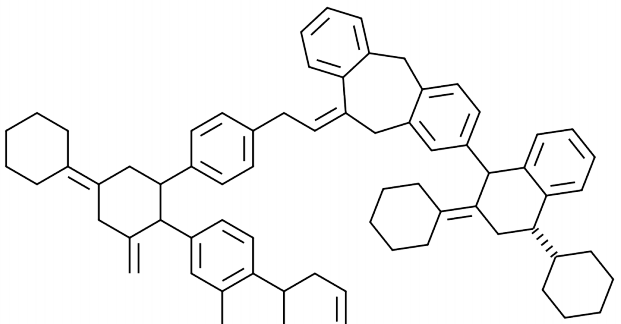
- Improve cardiovascular clinical outcomes
- Empower patients to take an active role in their care management
- Reduce racial and ethnic cardiovascular disparities

Benefits of participation

- Technical assistance, including:
  - Quality data benchmark reports with suggested opportunities for improvement
  - Electronic health record (EHR) standardization of documentation
  - Quality reporting initiatives, including Physician Quality Reporting System (PQRS) value-based modifier and Meaningful Use
- Access to best practices to optimize workflow
- Patient engagement strategies
- Workflow evaluation and redesign
- Process improvement
- Access to Learning and Action Networks (LANs) — a group of health care practitioners, providers, stakeholders and citizens who come together around an action based agenda with a purpose of peer-to-peer learning and solution sharing
- For home health agencies:
  - Cardiovascular Data Registry assistance
  - Implementation of best practice intervention packages (BPIPs) through the Home Health Quality Initiative (HHQI)

Requirements

- Signed participation agreement
- Timely submission of data, including appropriate aspirin therapy use, hypertension control, cholesterol control and tobacco use screening and cessation interventions
- Active involvement in the project for the duration of the initiative, including participating in educational offerings
- For home health agencies:
  - Enrollment in the cardiovascular data registry



Diabetes Management

Everyone with Diabetes Counts: Reducing Disparities in Diabetes Care

According to the CDC, diabetes is the seventh leading cause of death in the United States. This initiative will increase the number of certified diabetes educators and community health workers and increase the number of diabetes self-management education (DSME) classes. With the ultimate goal of empowering patients to effectively manage their diabetes care, this program aims to improve clinical outcomes related to HbA1c, lipids, eye exams, weight, blood pressure control and foot care through the spread of evidence-based practices.

Partners

- Healthcare providers and practitioners
- Community health workers
- Certified diabetes educators

Goals

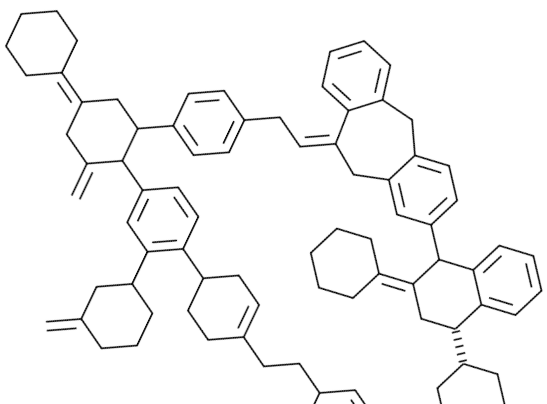
- Improve clinical outcomes related to diabetes core measures
- Increase health literacy
- Foster adherence to clinical guidelines by practitioners related to diabetes core measures

Benefits of participation

- Technical assistance, including:
  - Quality data benchmark reports with suggested opportunities for improvement
  - EHR standardization of documentation
  - Quality reporting initiatives
- Access to best practices
- Patient engagement strategies
- Workflow evaluation and redesign
- Process improvement
- DSME program information
- Access to LANs — a group of health care practitioners, providers, stakeholders and citizens who come together around an action based agenda with a purpose of peer-to-peer learning and solution sharing
- Improved clinical outcomes for diabetic patients due to improved self care and provider interventions

Requirements

- Signed participation agreement
- Utilizing and/or referring patients to DSME for pre-diabetic and diabetic patients
- Active involvement in the project for the duration of the initiative, including participating in educational offerings



Prevention Coordination

Improving Prevention Coordination through Meaningful Use (MU) of Health Information Technology (HIT)

Effective use of HIT improves quality of care, decreases paperwork, improves access to medical records and facilitates care coordination among providers. This initiative offers participants assistance in meeting MU requirements and aligning Meaningful Use with other CMS reporting programs.

Partners

- Healthcare providers and practitioners
- Hospitals including acute care and critical access

Goals

- Improve health for populations and communities through the use of health information technology (HIT)
- Increase screening and delivery of preventive services through care coordination and data analysis with the use of certified electronic health record technology (CEHRT)
- Improve access to care and coordination through electronic patient portals
- Build and foster community engagement

Benefits of participation

- Technical assistance, including:
  - Bi-monthly feedback reports and quarterly trending data analysis with suggested opportunities for improvement
  - Aligning Meaningful Use with other CMS reporting programs including Physician Quality Reporting System (PQRS) and value-based purchasing (VBP)
  - Implementation and ongoing communications with health information exchanges (HIEs) for Meaningful Use and transitions of care
  - Adoption and support for the implementation and promotion of patient portals and the blue button initiative
  - Physician analysis and comparison
- Access to webinars, boot camps and workshops related to MU and PQRS
- Workflow redesign
- Access to best practices
- Access to LANs — a group of health care practitioners, providers, stakeholders and citizens who come together around an action based agenda with a purpose of peer-to-peer learning and solution sharing

Requirements

- Signed participation agreement
- Provide bi-monthly submissions of MU reports to atom Alliance through a portal
- Review feedback reports and implement suggested improvements
- Active involvement in the project until the practice has successfully attested to MU and then remain moderately involved for the duration of the initiative, including participating in educational offerings

Value-Based Payment - Physicians

Improving Quality Through physician ValueBased Modifier and the Physician Feedback Reporting Program

This initiative assists participants in PQRS and helps them avoid potential penalties associated with PQRS and the value-based modifier.

Partners

- Healthcare providers and practitioners

Anticipated impact

- Improve health for populations and communities through the use of HIT
- Build and foster community engagement
- Share successful interventions, best practices and lessons learned across participating providers and communities

Benefits of participation

There are no costs to get involved. Assistance includes support with the following:

- Technical assistance, including:
  - Enabling EHR functionality needed to conduct PQRS reporting
  - Selection of nine PQRS measures across three National Quality Strategy domains
  - Identifying where and how to record specific data elements for each measure
  - Monitoring of PQRS measures to improve performance rates
  - Electronic submission of PQRS measures to CMS
  - Bi-monthly feedback reports and quarterly trending data analysis with suggested opportunities for improvement
  - Avoiding penalties associated with PQRS and value-based modifier
- Identification of targeted patient populations
- Access to webinars and workshops related to MU, PQRS, patient engagement, workflow redesign to optimize care, successful use of clinical decision support and transitions of care utilizing a health information exchange (HIE)
- Implementing a continuous quality improvement program to improve performance rates
- Access to Learning and Action Networks - a group of health care practitioners, providers, stakeholders and citizens who come together around an action based agenda with a purpose of peer-to-peer learning and solution sharing

Requirements

- Signed participation agreement
- Implementation and use of a 2014 certified EHR system
- Participation in the CMS PQRS reporting program
- Provide quarterly submissions of PQRS reports to atom Alliance
- Review feedback reports and implement suggested improvements
- Provide Quality and Use Resource Report (QRUR) annually for review
- Active involvement in the project for the duration of the initiative, including participating in educational offerings

Value-Based Payment - IPF, ASC

Improving Quality Through Value-Based Payment, Inpatient Psychiatric Facility and Ambulatory Surgery Center Quality Reporting

This initiative assists participants with inpatient and outpatient quality reporting and value-based payment.

Partners

- Acute care hospitals
- Critical access hospitals
- Inpatient psychiatric facilities (IPFs)
- Ambulatory surgery centers (ASCs)

Goals

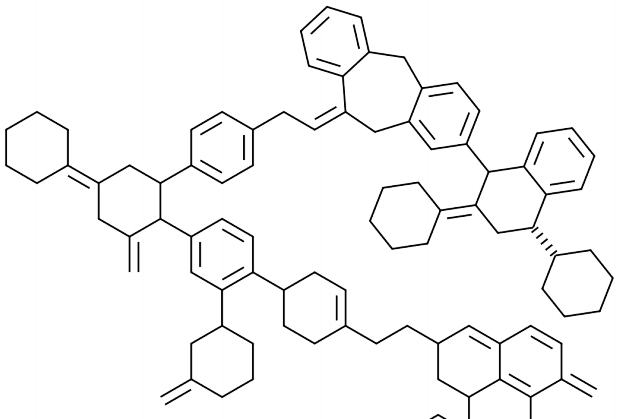
- Improve quality of patient care
- Improve efficiency of healthcare
- Collaborate to exceed the standards of care
- Share successful interventions, best practices and lessons learned

Benefits of participation

- Technical assistance, including:
  - Analytic review of quality reporting data
  - Targeting quality measures for improvement
  - Monitor improvement performance rates
  - Support for hospital value-based payment program
  - Support for quality reporting programs
  - Feedback reports and trending data analysis with suggested opportunities for improvement
- Increasing hospital value-based payment score and performance in quality reporting measures
- Access to webinars and workshops related to CMS Incentive Based Programs
- Implementing a continuous quality improvement program to improve performance rates
- Access to LAN — a group of health care practitioners, providers, stakeholders and citizens who come together around an action based agenda with a purpose of peer-to-peer learning and solution sharing

Requirements

- Signed participation agreement
- Participate in CMS quality reporting program
- Implement suggested improvements
- Active involvement in the project for the duration of the initiative, including participating in educational offerings



Immunization

Improving Adult Immunization Rates

Historically, immunization rates among adults have been low. atom Alliance aims to change that by working with practitioners, providers, and beneficiaries to

- implement evidence-based practices and systems changes to improve routine assessment of patients' vaccination status,
- implement the adult immunization recommendations of the Advisory Committee on Immunization Practices and National Vaccine Advisory Committee standards for adult immunization practice.
- improve immunization rates, especially in racial and ethnic minority populations, rural Medicare beneficiaries and dual-eligible Medicaid and Medicare beneficiaries, and
- increase documentation of Medicare beneficiary immunization status in immunization information systems (IIS) where available for adult patients.

Partners

- Home health agencies
- Practitioner-owned and/or -operated offices/ clinics
- Healthcare facilities

Goals

By 2019, we envision an absolute rate of

- 90 percent for adult immunization status assessment, vaccination or referral and electronic documentation of status via.
- 90 percent for pneumococcal vaccination for those ≥ 65 years of age.
- 70 percent for influenza vaccination for those ≥ 65 years of age.
- 30 percent for Herpes Zoster vaccination for those ≥ 60 years of age.

Benefits of participation

atom Alliance will

- Assist practices with benchmarking and quality improvement activities.
- Assist practices in Centers for Medicare & Medicaid Services (CMS) Programs reporting.
- Assist practices in interpreting electronic health record (EHR) data and CMS reporting results.
- Provide best practices, educational events and other resources as appropriate.

Requirements

- Participate in Learning and Action Network (LAN) activities to share best practices and success stories.
- Utilize tools to educate beneficiaries on the importance of immunization.
- Implement best practices for assessing needs, recommend needed vaccines and administer or refer for recommended vaccines.
- Implement quality improvement techniques to measure and improve rates for Medicare beneficiaries.
- Submit data to the Immunization Information System (IIS).

Behavioral Health

Improving behavioral health screening and outpatient follow-up

Depression and alcohol use disorder are common behavioral health conditions in adults, yet they are often under-identified in primary care settings. Additionally, challenges in effective care coordination for these and other behavioral health conditions contribute to high hospital readmission rates and problems with treatment adherence.

We are determined to bring about change and we need your help to do it. atom Alliance is actively seeking to partner with primary care providers (PCPs) and inpatient psychiatric facilities (IPFs).

Partners

- PCPs
- IPFs
- Patients

Goals

- Increase the identification in primary care settings of adults with depression or alcohol use disorder
- Reduce the 30-day readmission rate
- Increase outpatient follow-up for psychiatric discharges

Benefits of participation

- Technical assistance and targeted training to PCPs, IPFs and associated providers and communities
- Monitoring and evaluating the success of assistance and interventions
- Inviting and involving providers and patients in Learning and Action Netowrks (LANs)
- Engaging with organizations, agencies and other entities working to advance the same goals

Requirements

- Successfully transmit discharge information to follow-up practitioners
- Attempt follow up with patients through visits or calls
- Communicate with the next level practitioner to confirm discharge plan and maintenance of follow-up appointment
- Actively engage and educate patients, families and caregivers in discharge planning and treatment goals
- Monitor performance and pursue continous improvement

Contact Us

	Cardiac Health/ Million Hearts	Everyone with Diabetes Counts	Meaningful Use & Health Information Technology
AL	Lee Pearce lee.pearce@area-G.hcqis.org 205-970-1600 ext. 3104	Lee Pearce lee.pearce@area-G.hcqis.org 205-970-1600 ext. 3104	Lee Pearce lee.pearce@area-G.hcqis.org 205-970-1600 ext.3 104
IN	Don Gettinger don.gettinger@area-G.hcqis.org 812-243-0847	Don Gettinger don.gettinger@area-G.hcqis.org 812-243-0847	Don Gettinger don.gettinger@area-G.hcqis.org 812-243-0847
KY	Margie Banse margie.banse@area-G.hcqis.org 502-680-2857	Nancy Semrau nancy.semrau@area-G.hcqis.org 502-680-2391	Margie Banse margie.banse@area-G.hcqis.org 502-680-2857
MS	Ramona Drake ramona.drake@area-G.hcqis.org 601-957-1575 ext. 231 Stephanie Champion stephanie.champion@area-G.hcqis.org 601-957-1575 ext. 233	Lisa Camel lisa.camel@area-G.hcqis.org 601-957-1575 ext. 257 Willie Ann Thomas willie.thomas@area-G.hcqis.org 601-957-1575 ext. 217	Ramona Drake ramona.drake@area-G.hcqis.org 601-957-1575 ext. 231 Debbie Miller debbie.miller@area-G.hcqis.org 601-957-1575 ext. 226
TN	Patty Brinkley patricia.brinkley@area-G.hcqis.org 615-574-7204	Debra Bratton debra.bratton@area-G.hcqis.org 901-273-2651	Eric Ervin eric.ervin@area-G.hcqis.org 423-557-3024

	Value-based Purchasing & Physician Quality Reporting	Improving Adult Immunization Rates	Behavioral Health
AL	Lee Pearce lee.pearce@area-G.hcqis.org 205-970-1600 ext. 3104	Lee Pearce lee.pearce@area-G.hcqis.org 205-970-1600 ext. 3104	Lee Pearce lee.pearce@area-G.hcqis.org 205-970-1600 ext. 3104
IN	Don Gettinger don.gettinger@area-G.hcqis.org 812-243-0847	Jamesey Thomas jamesey.thomas@area-G.hcqis.org 317-800-5808	Teasa Thompson teasa.thompson@area-G.hcqis.org 317-864-9732
KY	Kristin Celesnik kristin.celesnik@area-G.hcqis.org 502-680-2721	Patricia Pope patricia.pope@area-G.hcqis.org 423-557-3366	Mark Bush mark.bush@area-G.hcqis.org 502-649-5369 Kibibi Wood-Montgomery kibibi.wood-montgomery@area-G.hcqis.org 502-381-5792
MS	Dale Bridges dale.bridges@area-G.hcqis.org 601-957-1575 ext. 223 Debbie Miller debbie.miller@area-G.hcqis.org 601-957-1575 ext. 226	Sarah Miller sarah.miller@area-G.hcqis.org 601-956-1713	Brenda Townsend brenda.townsend@area-G.hcqis.org 601-957-1713 ext. 250 Sara Watkins sara.watkins@area-G.hcqis.org 601-957-1575 ext. 225
TN	Stacy Dorris stacy.dorris@area-G.hcqis.org 901-273-2651	Not Applicable	Archie Hamilton edward.hamilton@area-G.hcqis.org 901-273-2697 Natalie Frady natalie.frady@area-G.hcqis.org 901-483-9624

Which are right for you?

Quality Improvement Initiatives Integration, 2014-2019

The chart below details which healthcare quality initiatives fit together best. How many initiatives suit your practice? Please consider getting involved in more than one.

	Cardiac Health/ Million Hearts	Everyone with Diabetes Counts	Meaningful Use & Health Information Technology	Value-based Purchasing & Physician Quality Reporting	Improving Adult Immunization Rates	Behavioral Health
Cardiac Health/ Million Hearts		⬢	⬢	⬢	⬢	⬢
Everyone with Diabetes Counts	⬢		⬢	⬢	⬢	⬢
Meaningful Use & Health Information Technology	⬢	⬢		⬢	⬢	⬢
Value-based Purchasing & Physician Quality Reporting	⬢	⬢	⬢			⬢
Improving Adult Immunization Rates	⬢	⬢	⬢			
Behavioral Health	⬢	⬢	⬢	⬢		

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