
ALLIANT
HEALTH SOLUTIONS
Learn More, Achieve More: Empowering Communities
for Better Chronic Disease Management in 2025

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Our Kentucky Team
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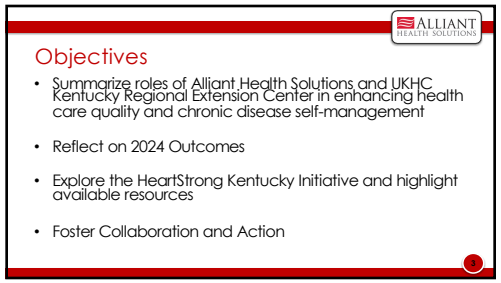
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Objectives
Summarize roles of Alliant Health Solutions and UKHC Kentucky Regional Extension Center in enhancing health care quality and chronic disease self-management
Reflect on 2024 Outcomes
Explore the HeartStrong Kentucky Initiative and highlight available resources
Foster Collaboration and Action

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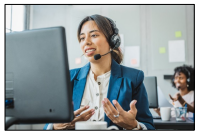
Alliant Health Solutions: Who We Are

- Georgia nonprofit - 50+ years public sector experience
- More than 200 employees supported by practicing clinical consultants from more than 65 specialties
- Quality in all we do…
  - Medicare QIO/PRO since 1984 – grew from one state to supporting seven states across the Southeast
  - URAC Health Utilization Management since 1997
  - HITRUST Certification since 2018



HITRUST CERTIFIED

urac ACCREDITED

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AHS Overview: What We Do

- Serve public and private partners to increase the value, effectiveness and accessibility of health care
- Provide professional services supporting the administration of health care programs
  - Care management
  - Quality management and improvement
  - Compliance and program integrity
- CMS Quality Innovation Network-Quality Improvement Organization (QIN-QIO) supports nursing homes and community collaboratives in seven states – Alabama, Florida, Georgia, Kentucky, Louisiana, North Carolina, and Tennessee – in the 12th SOW with a variety of providers and partners
- Work with physicians in our communities to support the Medicare beneficiary

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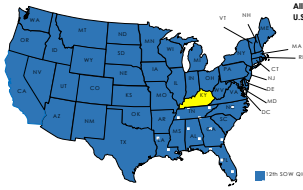
Markets Served as of 2024



Alliant serves customers in all 50 states and U.S. territories.

- State programs in four states, including Medicaid MCOs
- Federal programs in 50 states
  - SAMHSA Center of Excellence in Behavioral Health for Nursing Facilities (COE-NF): 50 U.S. States + Territories
  - Medicare QIN-QIO: 7 States
  - Hospital Quality Improvement Contractor (HQIC): 13 States
  - ESRD Network: 4 States (AL, MS, TN, and TX)

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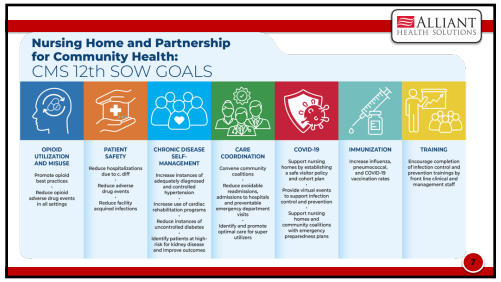
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Nursing Home and Partnership for Community Health:
CMS 12th SOW GOALS
OPIOID UTILIZATION AND MISUSE
Promote opioid best practices
Reduce opioid adverse drug events in all settings
PATIENT SAFETY
Reduce hospitalizations due to c.diff
Reduce adverse drug events
Reduce facility acquired infections
CHRONIC DISEASE SELF-MANAGEMENT
Increase instances of adequately diagnosed and controlled hypertension
Increase use of cardiac rehabilitation programs
Reduce instances of uncontrolled diabetes
Identify patients at high-risk for kidney disease and improve outcomes
CARE COORDINATION
Convene community coalitions
Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits
Identify and promote optimal care for super utilizers
COVID-19
Support nursing homes by establishing a safe visitor policy and cohort plan
Provide virtual events to support infection control and prevention
Support nursing homes and community coalitions with emergency preparedness plans
IMMUNIZATION
Increase influenza, pneumococcal, and COVID-19 vaccination rates
TRAINING
Encourage completion of infection control and prevention trainings by front line clinical and management staff

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Goals of Partnership for Community Health Coalitions
Identify Barriers and Drivers that Impact Readmissions
Reduce Unnecessary Emergency Department Visits
Decrease Adverse Drug Events
Chronic Disease Management

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Key Participants in Partnerships for Community Health Coalitions
Traditional Healthcare Partners
Hospitals
Skilled Nursing Facilities
Assisted Living Facilities
Home Health
Physician Practices
Rehabilitation Facilities
Dialysis Facilities
Hospice
Department Of Health
EMS
FQHC
Community Clinics
Pharmacies
Non-Provider Community Partners
United Way
Area Agency On Aging
AARP local chapters
Health Plans
Health Councils
Faith-Based Organizations
Local Business (i.e., Barbershops, Grocery Store)
Local Senior Centers
Local Political Organizations
Local Transportation Agencies
Housing Agencies
Food Pantries/Shelters
Veterans Association
Universities/Research Centers
Career Source

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KY Chronic Disease Self Management: Diabetes

Lower rate is better

Goal: Decrease the percentage of Medicare FFS Beneficiaries who had a hemoglobin A1c > 9.0 or for whom a hemoglobin test was not done during the measurement year.

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KY Chronic Disease Self-Management: CKD

Higher rate is better

Goal: Screen for, diagnose and manage Medicare beneficiaries with CKD to slow the progression of CKD and prevent ESRD (target 10% CKD management).

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KY Chronic Disease Self-Management: HTN

Higher rate is better

Goal: Increase the percentage of Medicare beneficiaries with hypertension diagnosis and adequately controlled (<140/90 mmHg) blood pressure (target 15%).

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Let's Share to Strengthen Our Impact
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20+ years of healthcare experience including EHR implementation and revenue cycle management.
5 years at Kentucky Regional Extension Center aiding with quality improvement methodology implementation, VBP technical support and practice transformation.
Currently overseeing the CDC Innovative CVH Program grant.
Enjoys reading and spending time with family, especially following her son's swim and track activities.
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HealthCare

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Kentucky Regional Extension Center
UK's Kentucky REC is a trusted advisor and partner to healthcare organizations, supplying expert guidance to maximize quality, outcomes and financial performance.
Physician Services
• HIPAA SRA, Project Management & Vulnerability Scanning
• Patient Centered Medical Home (PCMH) Consulting
• Patient Centered Specialty Practice (PCSP) Consulting
• Value-Based Payment & QPP Support
• Quality Improvement Support
Hospital Services
• Promoting Interoperability
• HIPAA SRA, Project Management & Vulnerability Scanning
• Hospital Quality Improvement Support
Chronic Diseases
• Prediabetes, Diabetes & Hypertension Learning Collaboratives
• Colorectal Cancer Screening
• Breast & Cervical Cancer Screening
• Asthma Self-Management Education

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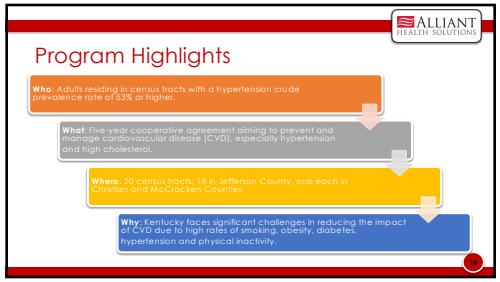
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Program Highlights
Who: Adults residing in census tracts with a hypertension crude prevalence rate of 53% or higher.
What: Five-year cooperative agreement aiming to prevent and manage cardiovascular disease (CVD), especially hypertension and high cholesterol.
Where: 20 census tracts; 18 in Jefferson County, one each in Christian and McCracken Counties.
Why: Kentucky faces significant challenges in reducing the impact of CVD due to high rates of smoking, obesity, diabetes, hypertension and physical inactivity.

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Program Strategies
Community-Based Interventions: Addressing social drivers of health
Clinical Interventions: Improving the quality of care for individuals with hypertension through evidence-based clinical practices
Data-Driven Decision Making: Using data to identify areas of need, measure the impact of interventions & inform future strategies
JHI Learning Collaborative
• Shawnee Christian Healthcare Center (Jefferson)
• KentuckyCare (McCracken)
• Community Medical Clinic (Christian)
Community Collaboration
• Alliant Health Solutions
• Have A Heart Clinic
• Healthy Paducah
• Kentuckiana Health Collaborative

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Join the HeartStrong Kentucky Initiative
What's in it for you?
• Networking opportunities with a diverse group of providers, beneficiaries and community stakeholders
• Sharing promising strategies and best practices to improve community outcomes
• Access to community performance data
• Availability of educational resources for quality improvement techniques and methodology

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Outreach Activities and Community Partnerships
TEAM KENTUCKY
KHC
TASK FORCE
McCRACKEN COUNTY PUBLIC LIBRARY
kNOw MORE 24
Anthem
KDN
Family
BAPTIST HEALTH
CHANGE TODAY CHANGE TOMORROW
PADUCAH
NORTON HEALTHCARE
HEALTH DEPARTMENT
MERCYHEALTH
Humana | Healthy Horizons in Kentucky
UL Health
HEALTHY KENTUCKY
Dare to Care Food Bank

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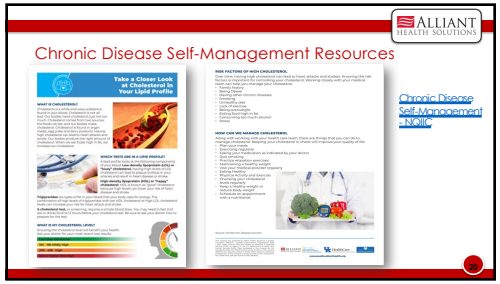
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Chronic Disease Self-Management Resources
Take a Closer Look at Cholesterol in Your Lipid Profile
Chronic Disease Self-Management - NotIC

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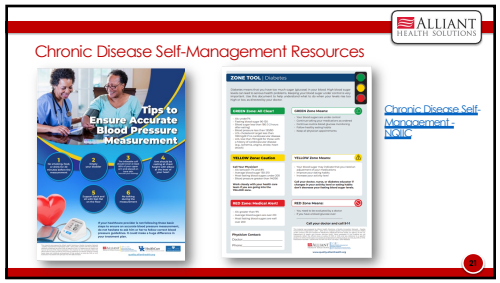
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Chronic Disease Self-Management Resources
Tips to Ensure Accurate Blood Pressure Measurement
ZONE TOOL | Diabetes
Chronic Disease Self-Management - NotIC

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Addressing Social Determinants of Health is Key

- 80-90% of health outcomes are influenced by social, economic, and environmental factors beyond the scope of clinical care. Take a holistic approach to healthcare by addressing social determinants of health such as housing instability, food insecurity, and lack of access to transportation.
- Action: Create a transparent list of local, state, and national partners who provide services that address the root causes of health disparities, not merely their symptoms, and make this list available across the organization and to all individuals in need. Some key places to have this list made available are the front desk with registration, the emergency department, and the nursing and case management teams.

Excerpt from:
Alliant Health Solutions Leadership Lesson: Rosa Abraha, MPH Health Equity Lead

https://quality.allianthealth.org/news/leadership-lesson-april-2024-health-in-action-lessons-from-the-field-for-national-minority-health-month/

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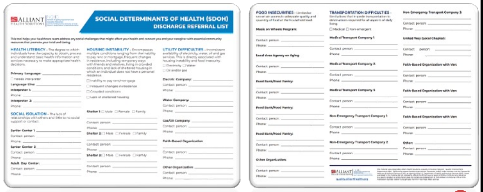
SDOH Referral List



Social Determinants of Health (SDOH) Discharge Referral List (allianthealth.org)

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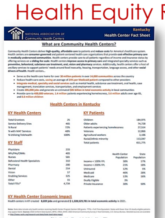
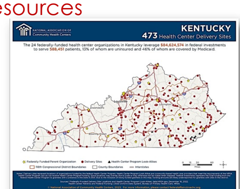
Health Equity Resources





https://findahealthcenter.hrsa.gov/?zip=Louisville%252C%2BKY%252C%2BUSA&radius=250&incrementalsearch=true

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