Join Superior Health Quality Alliance

Our organization and affiliates are interested in participating with the Superior Health Quality Alliance (Superior Health) in the Centers for Medicare & Medicaid Services (CMS) initiatives to enhance performance by improving quality and reducing burden associated with achieving that quality. The participation period will extend through November 2024, with opportunities to join additional initiatives made available to Superior Health during this period. By signing this agreement, our organization affirms our commitment to participate and contribute to any requests for data to aid in the transformation of our state’s health care system thereby improving outcomes for our residents.

At no cost to our organization, we will receive the following benefits for participating:

- Access to data-driven, quality improvement support tailored to meet our organizational needs
- Access to local, regional and national subject matter experts to assist with questions and recommendations around regulatory and reporting requirements
- Opportunities to participate in high-quality educational offerings, both in-person and virtual, to enhance our organization’s quality improvement capacity and advance our project work
- Networking with peers at community coalitions where opportunities for collaboration and best practice sharing exist
- First access to new CMS reporting initiatives with limited enrollment opportunities

Our organization and affiliates will participate in the high-priority health care Aims identified by CMS, including:

- Improve behavioral health outcomes, including a focus on decreasing opioid misuse
- Increase patient safety, including a focus on reducing adverse drug events (ADEs) and health care related infections
- Increase chronic disease self-management, including cardiac and vascular health, diabetes, and slowing and preventing end stage renal disease (ESRD)
- Increase quality of care transitions to engage community partners in reducing avoidable emergency department (ED) visits and hospital readmissions* (Please note: Nursing homes will automatically be enrolled)
- Improve nursing home quality, including guidance to increase Total Quality Scores (TQS), reduce ADEs, infection rates, ED visits and hospital readmissions

Please complete the rest of this form. Then email the signed form and supporting documents to Superior Health at info@superiorhealthqa.org.
We are requesting a key leader sign this agreement. For example, this may include but is not limited to Chief Executive Officer (CEO), Chief Operations Officer (COO), Chief Quality Officer (CQO), Administrator, Director of Nursing (DON), Owner or Community Coalition Chair/Co-Chair.

By signing below, my organization or community coalition agrees to participate with Superior Health initiative for the time period stated above. I understand that our participation involves active engagement and needed data submission to progress toward the health care quality improvement aims.

Name of Organization: ______________________________________________________

Leadership Member’s name (print): ____________________________________________

Leadership Member’s signature: ______________________________________________

Leadership Member’s title (print): _____________________________________________

Leadership Member’s phone number: __________________________________________

Leadership Member’s email address: ___________________________________________

Date: ____________________________________________________________________

In addition to the Leadership Member’s contact information, please provide contact information for the individual with whom we should follow up or contact for next steps:

Contact person’s name: ______________________________________________________

Contact person’s title: _______________________________________________________

Contact person’s phone number: _____________________________________________

Contact person’s email address: _____________________________________________

Please indicate your census (as a number): ___________________________________

Please indicate your CMS Certification Number (CCN): ___________________________
Our organization would like to enroll the following sites and would be interested in participating in the aims as indicated below by an X. Attached to the agreement is a detailed list of our organization/facility names, contact information and corresponding CMS Certification Number (CCN) or Tax Identification Number (TIN).

<table>
<thead>
<tr>
<th>Organization or Facility Type</th>
<th>Total Number of Sites to be Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health or inpatient psychiatric facility (IPF)</td>
<td></td>
</tr>
<tr>
<td>Clinics including federally qualified health centers (FQHCs), Indian health centers, primary care and specialty care</td>
<td></td>
</tr>
<tr>
<td>Community-based organization</td>
<td></td>
</tr>
<tr>
<td>Community coalition</td>
<td></td>
</tr>
<tr>
<td>Dialysis center</td>
<td></td>
</tr>
<tr>
<td>Emergency department or urgent care</td>
<td></td>
</tr>
<tr>
<td>Home health agency</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>Nursing home or skilled nursing facility (SNF)</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Other:_________________________________________</td>
<td></td>
</tr>
</tbody>
</table>