ALLIANT HEALTH SOLUTIONS | SORH State Office of Rural Health
A Division of the Georgia Department of Community Health

GA FLEX Quality Improvement Project Monthly Meeting

May 27, 2025

Agenda

- Welcome
- MBQIP Core Measure Set and Information Guide
- Safe Use of Opioids
- Hospital Action Plans "Quality Council"
- Project Timeline Updates
- Resources
- Q&A/Wrap Up

GA FLEX Improvement Project Lead

Melody "Mel" Brown, MSM
State Quality Manager - Georgia
melody.brown@allianthealth.org

Melody has over 40 years of health care experience, including varied roles at Alliant Health Solutions, where she works on the CMS contract for the Quality Innovation Network-Quality Improvement Organization (QIN-QIO). As Georgia's state quality manager, her focus is on quality improvement processes and interventions for health care entities throughout the state.

Hospital Quality Reporting (HQR) Data Submission and Timeline

Program	Performance Period	Data Submission Deadline	Potential Public Reporting	Payment Determination
IQR	January 1, 2024 – December 31, 2024	May 15, 2025	October 2025	FY2026
IQR	January 1, 2025 – December 31, 2025	May 15, 2026	October 2026	FY2027

https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

MBQIP 2025 Measure Core Set Information Guide Version 2.2

Measures in gold denote ^**new measures added for MBQIP reporting within the Flex Program** and are to be added to reporting data by calendar year 2025.

Measures in *blue denote **existing measures within the MBQIP Flex Program.**

MBQIP 2025 Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
+^**CAH Quality Infrastructure** *(annual submission)* Hospital Commitment to Health Equity	***HCP/IMM-3:** Influenza Vaccination Coverage Among Healthcare Personnel (HCP) *(annual submission)* ***Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey *(annual submission)* ^**Safe Use of Opioids (eCQM)** *(annual submission)*	***Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *(quarterly submission)*	^**Hybrid Hospital-Wide Readmission** *(annual submission)* ^**Social Drivers of Health Screening** *(annual submission)* ^**Social Drivers of Health Screening Positive** *(annual submission)*	***Emergency Department Transfer Communication (EDTC)** *(quarterly submission)*: ***OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients *(quarterly submission)* ***OP-22:** Patient Left Without Being Seen *(annual submission)*

Discontinue

Add in Sep 2025

https://quality.allianthealth.org/wp-content/uploads/2025/04/MBQIP-2025-Information-Guide_v2.2_508.pdf

Safe Use of Opioids

Measure Name – Safe Use of Opioids – Concurrent Prescribing	
MBQIP Domain	**Patient Safety**
Encounter Period	Calendar Year (January 1, 20XX – December 31, 20XX)
Submission Deadline	February 28, 20XX ; Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.
Measure Description	Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids, or an opioid and benzodiazepine concurrently at discharge.
Measure Rationale	Unintentional opioid overdose fatalities have become an epidemic and major public health concern in the United States. Concurrent prescriptions of opioids, or opioids and benzodiazepines, places patients at a greater risk of unintentional overdose due to increased risk of respiratory depression. Patients who have multiple opioid prescriptions have an increased risk for overdose, and rates of fatal overdose are ten (10) times higher in patients who are co-dispensed opioid analgesics and benzodiazepines than opioids alone. A measure that calculates the proportion of patients with two or more opioids or opioids and benzodiazepines concurrently has the potential to reduce preventable mortality and reduce costs associated with adverse events related to opioids.
Measure Program Alignment	Safe Use of Opioids is a current measure of the Medicare Promoting Interoperability (PI) Program. Critical access hospitals must meet PI Program requirements on an annual basis to avoid a downward payment. One of the program requirements is submission of electronic clinical quality measures (eCQM) data from certified electronic health record technology (CEHRT).

Improvement Noted As	Decrease in the rate
Numerator	Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge.
Denominator	Inpatient hospitalizations that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge.
Exclusions	Inpatient hospitalizations where patients have cancer pain that begins prior to or during the encounter or are ordered or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the hospitalization or in an emergency department encounter for observation stay immediately prior to hospitalization, patients receiving medication for opioid use disorder, patients with sickle cell disease, patients discharged to another inpatient care facility or left against medical advice, and patients who expire during the inpatient stay.
Measure Population (Determines the cases to abstract/submit)	Inpatient hospitalizations that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge.
Sample Size Requirements	No sampling – report all patients that meet data elements
Calculations	Numerator divided by Denominator
Data Source	Certified electronic health record technology (CEHRT)
Data Collection Approach	Electronic Extraction from EHRs via Quality Reporting Document Architecture (QRDA) Category I File
Measure Submission and Reporting Channel	Annually, via Hospital Quality Reporting (HQR) Secure Portal as any combination of: QRDA Category I File, zero denominator declarations and/or case threshold exemptions (<=5 cases in the reporting quarter)
Data Available On	• CMS Care Compare • CMS Provider Data Catalog
Measure Resources	• RQITA Website: Safe Use of Opioids Concurrent Prescribing • Critical Access Hospital eCQM Resource List | National Rural Health Resource Center (ruralcenter.org)

Q&A

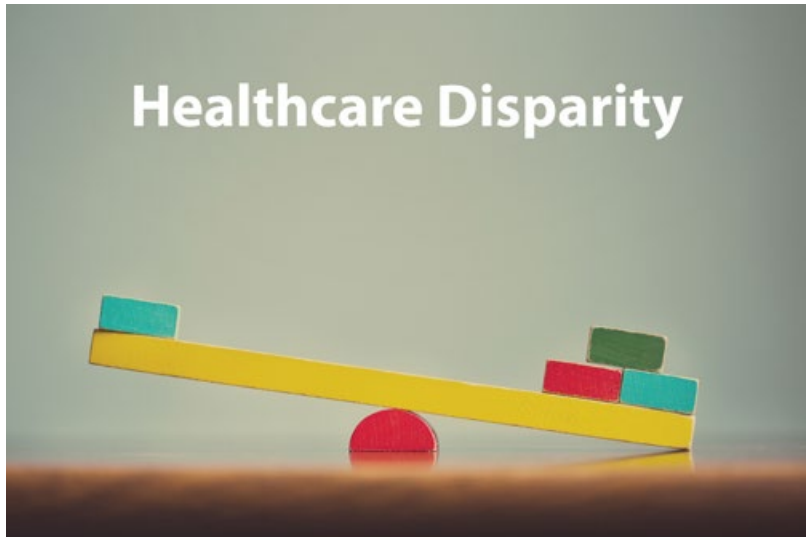
Q. When including physicians in my data, should we include ED physicians?

A. My interpretation of the MBQIP guidance for Safe Use of Opioids is that ED physicians would be excluded from the measure. The numerator and denominator descriptions both specify “inpatients” at “discharge” so ED encounters (and ED Physicians) would not be included.

Dawn Waldrip I *Senior Manager*
SORH Program and Hospital Services

Domain 3: Data Analysis Components

1. Key performance outcome (or process of care measure), e.g., 30-day readmissions, mortality
2. **Stratify priority population**
    1. REaL, e.g., race
    2. SDOH, e.g., transportation
3. Display gaps in dashboard or current way of internal review of quality measures
4. What's currently on your hospital quality dashboard? Readmissions, mortality, length of stay
5. Active quality improvement teams
6. Use charts and graphs
7. Benchmarking against industry standards



Show the Health Disparity

Hospital Action Plan Sharing

- Your time to shine!
- Review your strategic plans.
- Reference Domain 1B in your Strategic Plan (Playbook). We can Email you the Playbook if needed.
- Each hospital will report out on at least one goal and action steps by July 22, 2025.
- Use PPT template plus any data analysis graphs.
- Select date to share with others.

Quality Council Schedule

Presented	May 27	Jun 24	Jul 22
Jeff Davis	Effingham Hospital	SGMC - Lanier	Bacon County
Morgan Medical	Jasper Memorial	Monroe Hospital	Archbold Mitchell
Candler County	Atrium Health Peach	Liberty Regional	Warm Springs
Chatuge Regional	Archbold Brooks	Miller County	Phoebe Worth
	Atrium Health Floyd Polk	Mountain Lakes	Putnam General
	Elbert Memorial	Optim - Screven	Wellstar Sylvan
		Optim - Tattnall	Wills Memorial
		Clinch Memorial	Early Medical Center
		Jenkins County	Bleckley Memorial

Hospital Action Plan:
Jasper Memorial Hospital

Goal: *Identify community resources to address the five CMS domains, focusing on food insecurities and transportation needs.*

Jasper Health Services, Inc.

Action Plan/Steps	Status	Performance Outcomes (baseline, trending, or target goal)	Lessons Learned
Identify priority populations that currently experience health disparities by collecting and analyzing AHC SDOH data and tracking the number of patients who screened positive. Focus on readmissions of Black female patients as that was the highest population of readmitted patients in 2023.	*Ongoing*	*There were no Black female patients readmitted in 2024.*	*There were no Black females admitted in 2024. Will shift our focus to diagnosis-based reasons for readmission as our inpatient population is very small.*
Explore transportation options, as this was a need identified in our 2022 and 2025 CHNA. Community members specifically mentioned travel to out-of-town specialist appointments as a need.	*Ongoing*	*5% of patients screened positive for transportation needs. No patients screened positive for food insecurities or housing instability; 5% screened positive for utility difficulties and 15% screened positive for interpersonal safety concerns.*	*Exploring options for having more specialty clinics to reduce the need for patients to travel out of town.*
Identify ways to increase access to nutritious, diet-appropriate foods.	*Ongoing*	*Poor nutrition was identified as a top 3 issue again on our 2025 CHNA (exact data not available yet)*	*Pamphlet given to all patients at discharge for information on Food Bank hours and accessibility.*

AHN Peach

Health Equity Data Analysis

Healthy Communities

Angeline Doh – Manager

LaShauna Hunt – Community Health Supervisor

Quality Data Disclaimer

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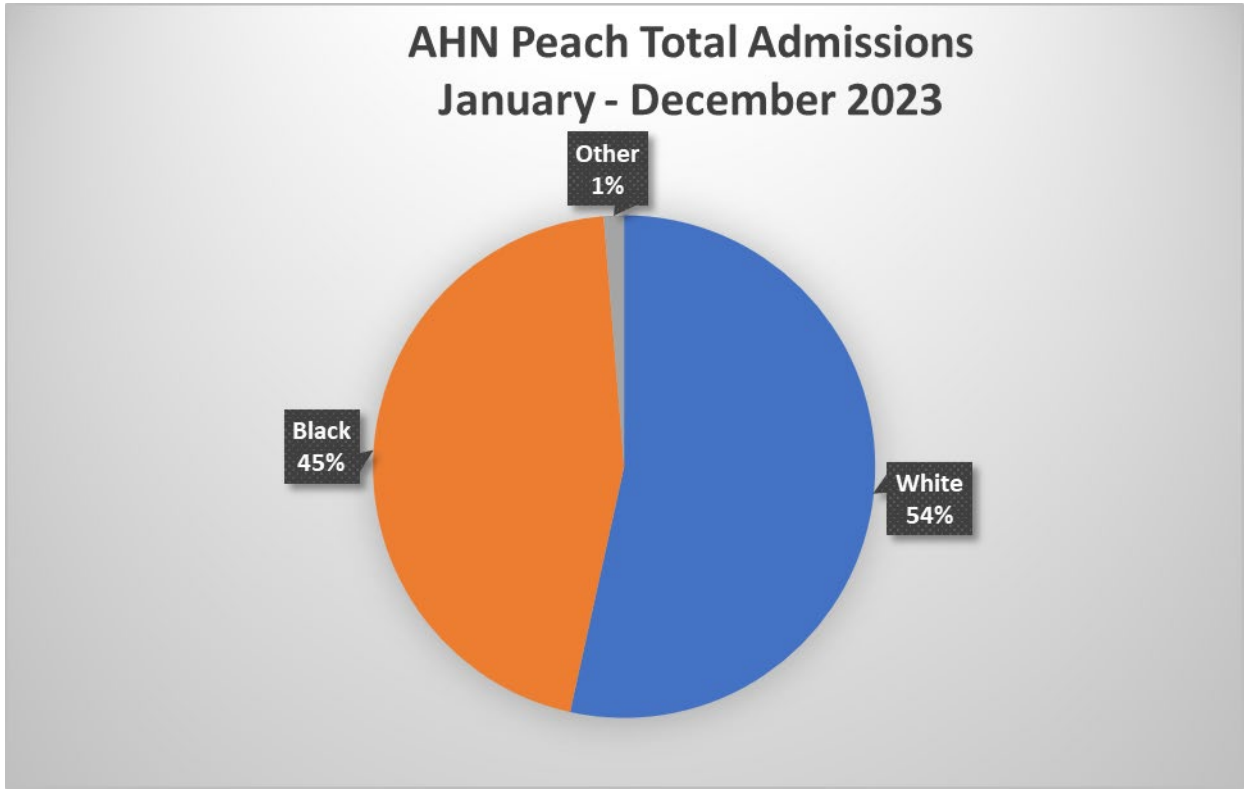
Atrium Health Navicent Peach

AHN Peach Overview

One Year Lookback

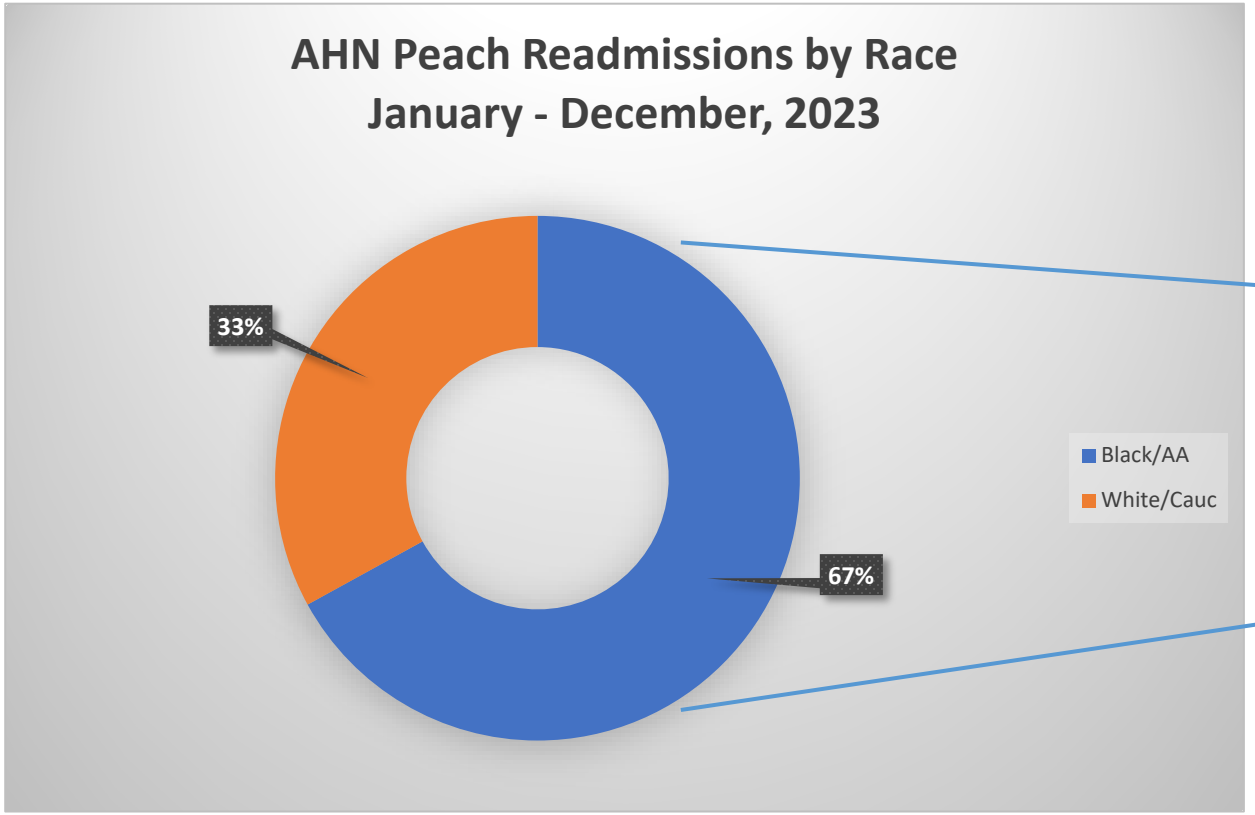
January 1, 2023 – December 31, 2023

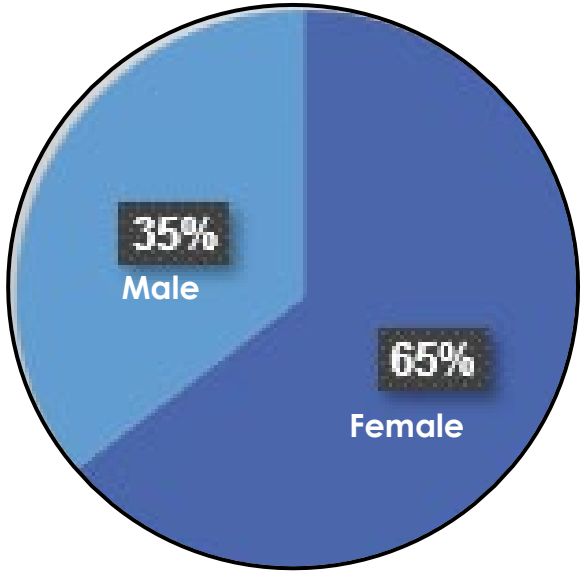
- 1,440 Hospital admissions
- 84 Readmissions
- Data Sources
  - Epic
  - Quality Scorecard
  - SDOH PowerBi
  - CHNA



1,440 Admissions

AHN Peach Readmissions 2023





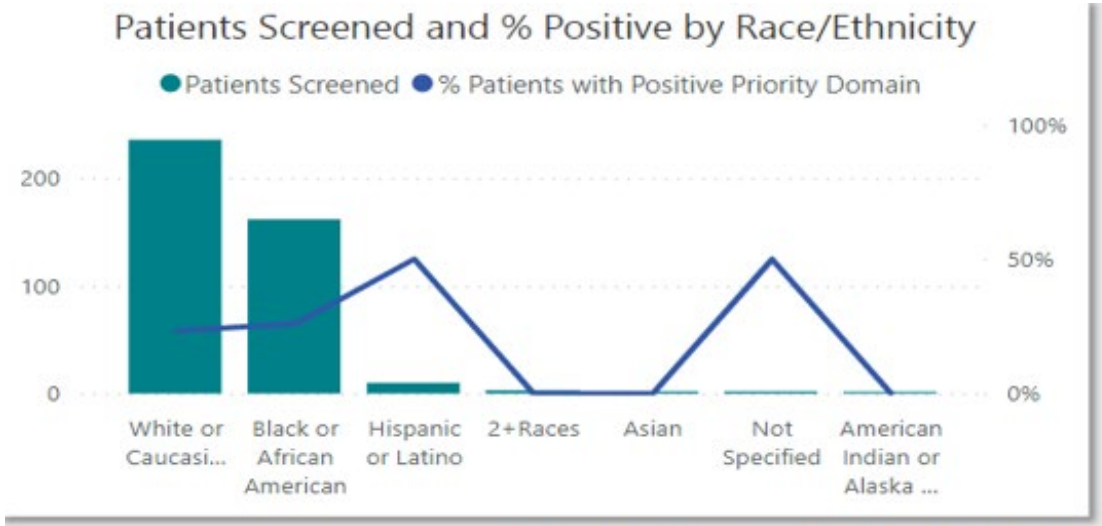
African-American females make up the largest % of readmissions

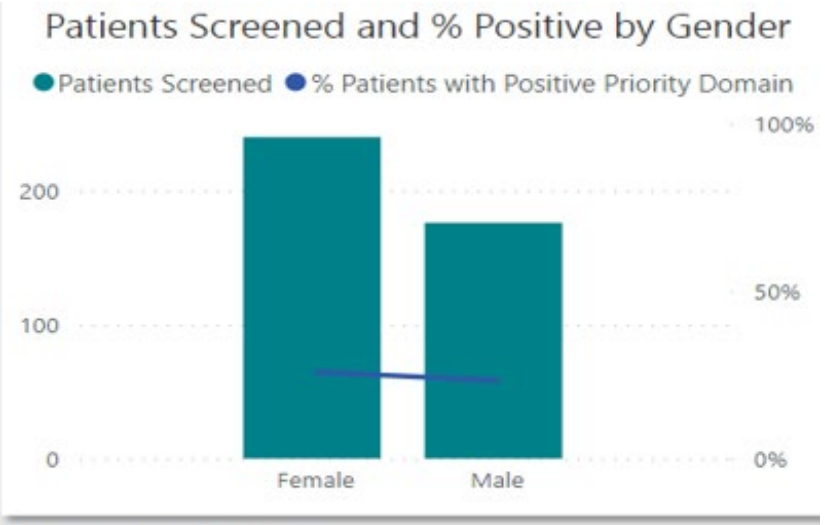
84 Readmissions

SDOH – Domains Surveyed

Month Year Label	Screening Count	Priority Domain % Positive	Food Insecurity Survey Count	Food Insecurity % Positive	Housing Survey Count	Housing % Positive	Transportation Survey Count	Transportation % Positive	Utility Response Count	Utility % Positive	Safety Response Count	Safety % Positive
Jul - 2023	6	50.00%	6	33.33%	6	50.00%	6	16.67%	5	40.00%	1	
Aug - 2023	9	33.33%	9	33.33%	9		9		9	22.22%		
Sep - 2023	6	33.33%	6	33.33%	6		6		6	16.67%		
Oct - 2023	3	0.00%	3		3		3		3			
Nov - 2023	79	16.46%	79	11.39%	79	5.06%	79	6.33%	79	6.33%	78	2.56%
Dec - 2023	149	28.86%	149	10.74%	149	8.05%	149	14.77%	149	9.40%	149	4.03%
Jan - 2024	160	22.50%	158	9.49%	159	5.03%	158	10.13%	158	7.59%	159	1.89%
Feb - 2024	58	18.97%	58	12.07%	58	1.72%	58	13.79%	58	3.45%	58	1.72%
Total	**470**	**23.62%**	**468**	**11.54%**	**469**	**5.97%**	**468**	**11.11%**	**467**	**8.14%**	**445**	**2.70%**

SDOH – Patient Survey





Patients Screened and % Positive by Race and Ethnicity

Ethnicity	Hispanic or Latino		Not Hispanic or Latino		Not Specified		**Total**	
Race	Patients Screened	% Patients with Positive Priority Domain	Patients Screened	% Patients with Positive Priority Domain	Patients Screened	% Patients with Positive Priority Domain	**Patients Screened**	**% Patients with Positive Priority Domain**
White or Caucasian	9	55.56%	234	23.50%	2	0.00%	**245**	**24.49%**
Black or African American	1	0.00%	159	25.16%	3	66.67%	**163**	**25.77%**
Asian	1	0.00%	2	0.00%			**3**	**0.00%**
Not Specified	1	0.00%	1	100.00%	1	0.00%	**3**	**33.33%**
2+Races			1	0.00%			**1**	**0.00%**
American Indian or Alaska Native			1	0.00%			**1**	**0.00%**
Total	**12**	**41.67%**	**398**	**24.12%**	**6**	**33.33%**	**416**	**24.76%**

AHN Peach 2024 Readmissions

- Readmission Cases – 33
- Readmissions Expected – 18
- Readmissions O/E = 1.8

Readmission Risk Score at Initial Discharge
1
8
24

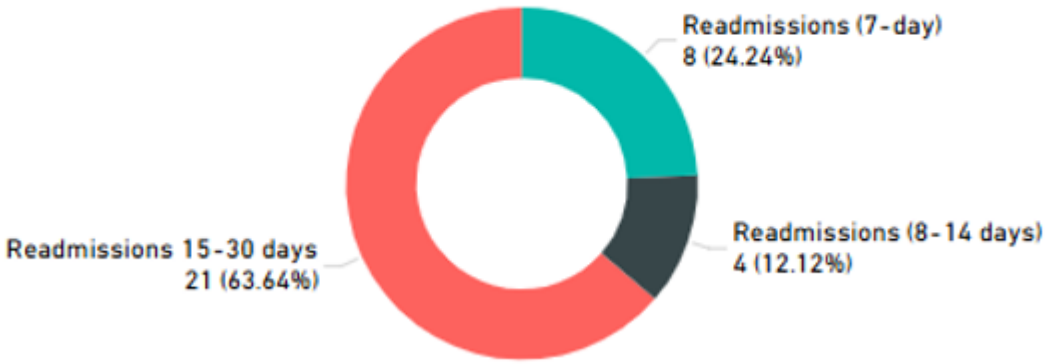


Table represents number of readmitted patients in each risk category.

Low risk = green

Medium risk = yellow

High risk = red

Health Equity Goal 1

Reduce readmissions for African American females with Sickle Cell Disorder

- **Increase use of order sets and the Sickle Cell Clinical Pathway to communicate a plan of care with patient on Day 1 of admission?**
  - This has been discontinued.
    - Developing individualized plans for each patient.
  - Schedule follow up appointments with local hematologist.

- **Sickle Cell Foundation of Georgia to provide CHW support and resources at the patient's bedside during hospital stay**
  - Workflow development to include referral process - in progress
  - Provider and staff training is in process of being scheduled
    - Evidence-based protocols for the management and treatment of sickle cell disease. Interactive training where they review physiology, perceptions and experiences of individuals living with sickle cell disease.

- **Dr. LaVoie - Physician Champion**

- **Distributing FindHelp cards in ED waiting rooms**

Health Equity Goal 2

Increase the rate of SDOH screening and referrals

- Atrium Health has an enterprise-wide goal for SDOH screens
  - Threshold (45%), goal (50%), stretch (55%)
- Currently have enterprise-wide data only. The hospital system is working on market and individual area hospital rates.
- We will discuss AHN Peach rates with stakeholders as data becomes available.

Increase the rate of closed-loop referrals accessing resources

- The FindHelp platform will help us increase closed-loop referrals.
- Native + was launched in North Carolina hospitals. It will roll out to the Georgia market later.
- We are working to increase the number of trusted partners.

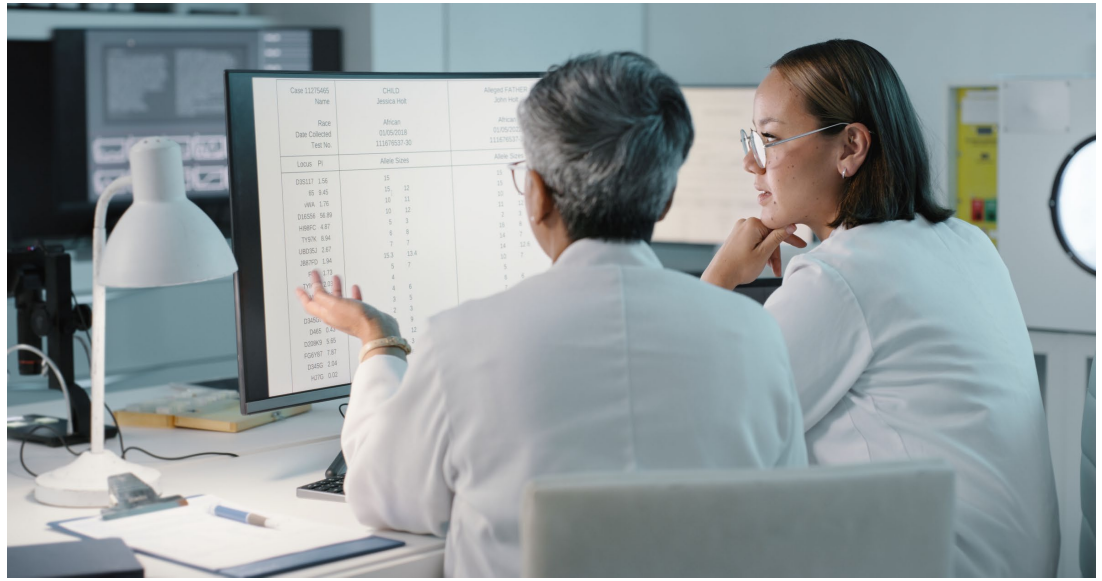
Health Equity Goal 3

Increase bias reduction and sensitivity awareness among teammates working with an identified population (sickle cell patients)

- Ongoing: Education provided to teammates through our Core Connect learning platform
- Partnership with the Sickle Cell Foundation of Georgia will help reduce bias and increase sensitivity awareness among teammates through provider training

Future State

Review data for improvement opportunities to increase patient health outcomes.



Hospital Action Plan:

Elbert Memorial Hospital
Elberton-Elbert County Authority

Goal: *Identify effective approaches to enhance safety measures for children and persons of color, identify interventions for patients who lack commitment to over-all well-being and identify methods involving patients that lack healthcare accessibility.*

Action Plan/Steps	Status	Performance Outcomes (baseline, trending, or target goal)	Lessons Learned
Assess monthly data identified by our SDOH assessments that reflex a positive screening of our children and persons of color.	*In progress*	*Data is collected through our re-dash system that is collected on admissions.*	
Identified patients within the community that lack commitment to overall well-being. Partnered with PARMC for wellness classes taught by expert clinicians. Collected/ assessed monthly data who lack healthcare accessibility.	*In progress* *In progress*	*Full class for initial diabetic education class. Public engaged and eager to join* *Elbert County Transit Authority and Ride share program for community awareness*	*Partnerships and collaboration amongst system wide facilities and community are needed*

Hospital Action Plan:

Archbold Brooks

Kortney Thomas, MSN, RN Administrator/DON

Goal: To provide safe, patient-centered and equitable care by improving quality and safety to ensure the best possible outcomes for underserved patients and their caregivers who experience health disparities.

Action Plan/Steps	Status	Performance Outcomes (baseline, trending, or target goal)	Lessons Learned
1. Develop a tool to assess the organization's incorporation of best practices in health equity. Conduct a health equity gap analysis. The organization's vice president of quality was appointed as the "health equity officer," a designated leader at the system facilities was assigned the role of "health equity champion." Finally, they utilized the Plan-Act-Do method to outline a process that would involve developing the PRAPARE tool. 2. To collect and evaluate race, ethnicity, and language (REaL) data in addition to housing insecurities, food insecurities, transportation issues, utilities, and safety needs (SDOH) data to help improve patient overall outcomes. 3. To provide patients with a community resource list that will include resources to help aid and assist individuals with specific needs.	In progress	1. The SDOH PRAPARE tool data collection is done by case management/swing bed coordinator on admission, and health equity data is reported as requested. It is apart of the patients EHR. 2. The hospital health equity champion designated the case manager and swingbed coordinator as the health-related social needs task force. Using the PRAPARE tool embedded in our electronic health record (EHR), we collect SDOH data from all acute and swing bed admissions. 3. As of August 2023, the community resource list was revamped and provided to all patients on admission.	1. Learned that SDOH information is available to generate in real time. Allows the case manager/ swingbed coordinator to be proactive with assisting each patient with resources to help with each individuals specific needs. 2. Our quality team can extract this data electronically at any time. 3. This has proven beneficial to patients who screen positive for housing and food insecurities, utility difficulties, and safety needs.

Project Timeline

Date	To-Do List
May 27	□ Introduce Safe Use of Opioids □ Workgroup discussion "Quality Council" of Hospital Action Plans □ Begin to add Hospital Action Plans to the GA Flex webpage
June 24	□ Send any questions about Safe Use of Opioids □ Workgroup discussion "Quality Council" of Hospital Action Plans

Email melody.brown@allianthealth.org to schedule a meeting.

Alliant Health Website and GA Flex Resources

https://quality.allianthealth.org/ga-flex/

GA Flex Resources

Hospital Resources

Medicare Beneficiary Quality Improvement Project (MBQIP) 2025 Measure Core Set Information Guide – Version 2.2 – 3.1.2025

The Rural Quality Improvement Technical Assistance (RQITA) Resource Center

Safe Use of Opioids

Safe Use of Opioids – Concurrent Prescribing

Social Determinants of Health (SDOH)

Screening for SDOH Measure and the Screen Positive Rate Measure

FAQs Social Determinants of Health (SDOH) Measures

Discharge Referral List

Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes

Show More

Resources

1. The Rural Quality Improvement Technical Assistance (RQITA) Resource Center: https://www.telligen.com/rqita/

2. Rural Health Information Hub website: https://www.ruralhealthinfo.org/

3. Rural Health Research Gateway: https://www.ruralcenter.org/


Questions?
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