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

September 2025

Agenda

- Welcome
- REAL TTIME Presentation
- Upcoming Events
- MBQIP Core Measure Set and Information Guide
- 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.

REAL TTIME

Rural **E**xpanded **A**ccess to OUD Care and **L**inkage Using **T**oxicologists for **T**elehealth-**I**nitiated Treat**ME**nt

Emily Kiernan, DO

REAL TTIME Project Director

Emergency Medicine | Medical Toxicology

Emory University

Georgia Poison Center

EMORY UNIVERSITY SCHOOL OF MEDICINE | Medical Toxicology | Department of Emergency Medicine | Georgia Poison Center

Introductions – REAL TTIME

- Project Director / Primary Investigator: Emily Kiernan, DO
- Georgia Poison Center Lead / Data Coordinator: Patrick Filkins, PharmD, BCPS, DABAT
- Co-investigator: Alaina Steck, MD
- Co-investigator: Joseph Carpenter, MD
- Georgia Council For Recovery Lead: Emily Ribblett MBA, CPS-AD, CPS-MH
- Statistician / Study Design: Timothy Moran, PhD

REAL TTIME

Why

Who

What

Where

When

REAL TTIME

Why?

Problem & Solution

PROBLEM

Limited access to:

-MOUD prescribers

-structured long-term care

SOLUTION

Novel collaboration to improve OUD care:

-GPC

-Medical toxicologists

-Virtual peer recovery coaches

Why the Emergency Department?

- **Critical healthcare access point for OUD patients without regular access to primary care services**
- **Barriers:**
  - Unfamiliar with prescribing MOUD
  - Unwilling to prescribe MOUD without follow up
  - Uncertain about local options for outpatient addiction care

Why the GPC?

https://www.georgiapoisoncenter.org/wp-content/uploads/2021/03/2020-Annual-ReportFinal.pdf

REAL TTIME

Who

What

Where

When

How

- Patients in rural counties in Georgia who have opioid use disorder

REAL TTIME

Who

What

Where

When

How

- Rural EDs
- Georgia Council For Recovery (Recovery Community Organizations
- GA Community Service Board
- Federally Qualified Health Centers

REAL TTIME

Who

What

Where

When

How

Collaborations with:

- Southern Healthcare Collaboration
- GCEP
- State Office of Rural Health
- Hometown Health
- Department of Public Health
- DBHDD
- Georgia Crisis and Access Line
- Georgia Rural Health Association
- SE Telehealth Network
- Christopher White Crusade

Who are peer recovery coaches?

- People with lived experience, in long-term recovery
- Receive formal certification/education through GC4R
- Services offered:
  - Harm reduction counseling
  - Virtual and in-person peer support
  - Linkage to resources
  - Referral to treatment

REAL TTIME

Who

What

Where

When

How

- Education
- Encourage MOUD prescription at discharge
- Link to virtual peer recovery coach in the ED
- Optimize outpatient resources

REAL TTIME

Who

What

Where

When

How

Rural EDs
Tanner – Villa Rica
Tanner - Carrolton
Tanner - Higgins
Jeff Davis
Taylor Memorial
Bleckley Memorial
Bacon County

REAL TTIME

Who

What

Where

When

How

- Grant period
  - Start: September 1, 2022
  - End: August 31, 2026 (likely 2027)
- Actively promoting to all hospitals in GA

REAL TTIME

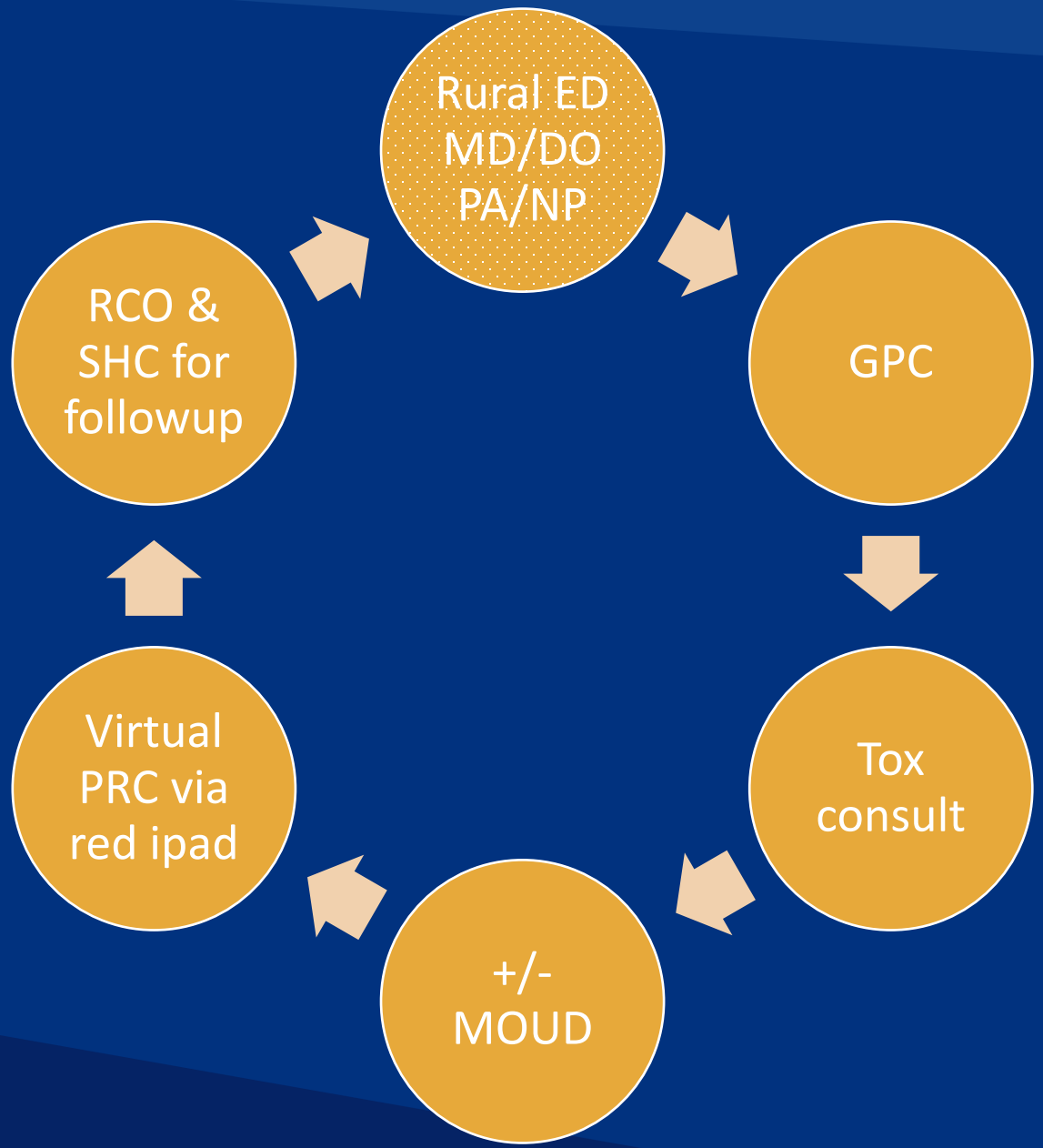
Who

What

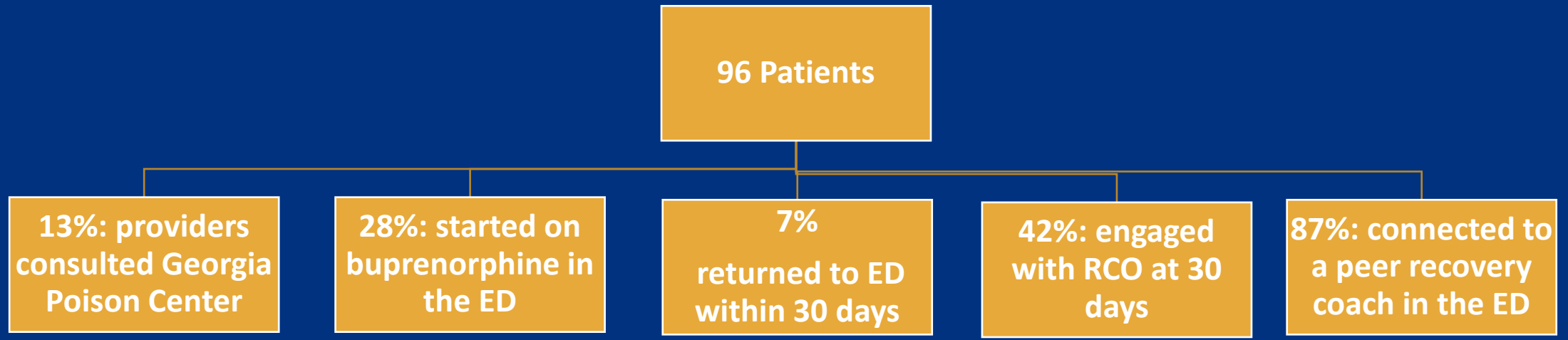
Where

When

How



How are we doing (as of December 2024)?



"I remember feeling like someone finally cared," P1 reminisced later. "For once, I wasn't just another addict in the ER. I was a person in need of help, and they saw that."

"To the ED staff at Tanner Hospital and to the Never Alone Clubhouse," P1 concluded with emotion in his voice, "thank you for seeing me when others didn't. Thank you for giving me hope when I needed it most."

Patient stories

"If that nurse hadn't taken the time to introduce me to the Real Time project," I acknowledged gratefully, "I might never have known such a program existed. It's changed everything for me."

"In my experience with addiction, trust has been hard to come by," I shared later. "But the peer support providers at The Never Alone Clubhouse have consistently followed through on their promises. They've shown me that I can rely on them."

The REAL TTIME Model

rapid, evidence-based treatment for OUD

Suboxone

24/7 expert assistance

Georgia Poison Center

connection to ongoing care

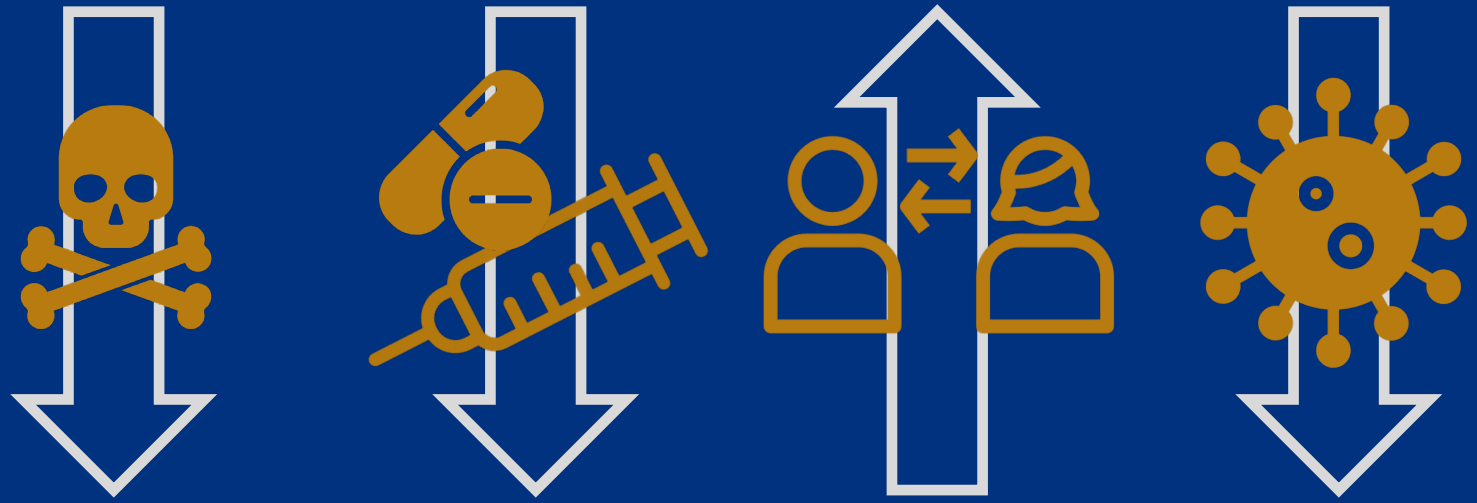
Peer Recovery Coaches

community connection

Recovery Community Organizations & SHC

Evidence-Based Treatment: MOUD

MOUD = **M**edications for
Opioid **U**se **D**isorder



Larochelle MR, et al. (Ann Int Med 2018); Nielsen S, et al. (Cochrane Database Syst Rev 2016); Mattick RP, et al. (Cochrane Database Syst Rev 2014); Sordo L, et al. (BMJ 2017);Strang J, et al. (Lancet 2012); Volkow ND, et al. (NEJM 2014); Weiss RD, et al. (Arch Gen Psychiatry 2011);

Georgia Council for Recovery and Georgia's Peer Recovery Coaches

PRC = **P**eer **R**ecovery **C**oach

- People in long term recovery
- Assist with transition into treatment & provide harm reduction
- Navigate treatment resources, transportation, obtaining ID's, basic human needs

Suboxone is a HARM REDUCTION strategy

Less “high” than opioids

Less respiratory depression

Less misuse potential

Can block ”high” and respiratory depression if suboxone onboard

Indications

OUD (DSM-V criteria)

– and –

experiencing opioid withdrawal (COWS)

Available on MD calc or as a EMR dot phrase!

Transitions of Care

If indicated, give patient prescription for Suboxone to bridge to outpatient appointment

This is where your REAL TTIME team comes in!

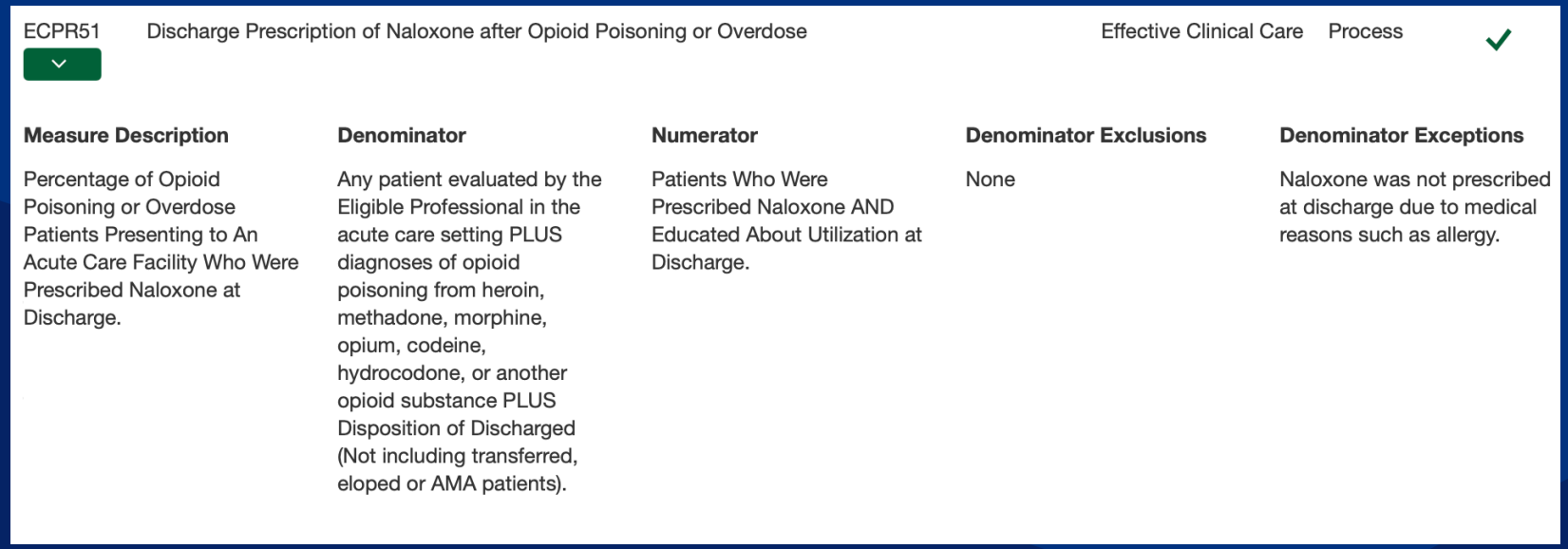
Get the RED IPAD!

Virtual PRC will meet with patient during ED visit and arrange follow up / transportation / medication assistance

Compliance & Quality Care

Qualified Clinical Data Registry

- Collates data that can be utilized for fulfilling Merit-Based Incentive Payment Plan (MIPS)
  - One of the two CMS Quality Payment Program (QPP) tracks



ECPR51 Discharge Prescription of Naloxone after Opioid Poisoning or Overdose Effective Clinical Care Process

Measure Description	Denominator	Numerator	Denominator Exclusions	Denominator Exceptions
Percentage of Opioid Poisoning or Overdose Patients Presenting to An Acute Care Facility Who Were Prescribed Naloxone at Discharge.	Any patient evaluated by the Eligible Professional in the acute care setting PLUS diagnoses of opioid poisoning from heroin, methadone, morphine, opium, codeine, hydrocodone, or another opioid substance PLUS Disposition of Discharged (Not including transferred, eloped or AMA patients).	Patients Who Were Prescribed Naloxone AND Educated About Utilization at Discharge.	None	Naloxone was not prescribed at discharge due to medical reasons such as allergy.

The Medicare Rural Hospital Flexibility (Flex) Grant Program

EMORY UNIVERSITY SCHOOL OF MEDICINE
Medical Toxicology
Department of Emergency Medicine

Medicare Beneficiary Quality Improvement Project

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** *(annual submission)*	***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 Determinants of Health Screening** *(annual submission)* **Social Determinants 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)*

New Measure for MBQIP Reporting Within the Flex Program	
MBQIP 2025 Core Measure Set	
Measure Name – Screening for Social Drivers of Health (SDOH Screening)	
MBQIP Domain	Care Coordination
Encounter Period	Calendar Year (January 1, 20XX – December 31, 20XX)
Submission Deadline	May 15, 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	The Screening for Social Drivers of Health Measure assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. To report on this measure, hospitals will provide: (1) The number of patients admitted to the hospital who are 18 years or older at time of admission and who are screened for each of the five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; **and** (2) the total number of patients who are admitted to the hospital who are 18 years or older on the date they are admitted. A specific screening tool is not required to be used, but all areas of health-related social needs must be included.

Hospital Harm - Opioid-Related Adverse Events	H-AE	CMS819v3	3501e		
Hospital Harm - Pressure Injury	HH-PI	CMS826v2	3498e		
Hospital Harm - Severe Hyperglycemia	HH-Hyper	CMS871v4	3533e		
Hospital Harm - Severe Hypoglycemia	HH-Hypo	CMS816v4	3503e		
Intensive Care Unit Venous Thromboembolism Prophyl	VTE-2	CMS190v13	Not Applicable		
Safe Use of Opioids - Concurrent Prescribing	Non	CMS506v7	3316e		There is a known issue on CMS506v7. See issue EKI-31 on the ONC... Read more

The DEA wants you to prescribe MOUD!

Dear DEA Registrant,

In 2022, 6.1 million people in the United States had an opioid use disorder (OUD). Among them, only 18.3% received medication-assisted treatment. The removal of the Drug Addiction Treatment Act of 2000 "x-waiver" in December 2022 eliminated a significant barrier to treatment for OUD, dramatically increasing the number of medical professionals who can prescribe buprenorphine from the previously eligible 130,000 prescribers.

The Drug Enforcement Administration (DEA) and the Department of Health and Human Services (HHS) are committed to ensuring safe and ready access to medications for opioid use disorder (MOUD), especially in rural or underserved areas where treatment options have been limited. With the passage of the Consolidated Appropriations Act, 2023,[1] there was an immediate and significant increase in the number of practitioners who can prescribe schedule III MOUD products (e.g., buprenorphine combination products containing buprenorphine and naloxone) for patients with OUD.

As access to treatment increases, it is understood that the use of MOUD products will likely increase at the same time. DEA recognizes that there have been recent increases in demand for certain schedule III MOUD controlled substances as compared to years prior to the Opioid Public Health Emergency, and that there may be a corresponding increase in prescriptions for these medications from medical providers. DEA supports collaboration amongst all DEA registrants to ensure there is an adequate and uninterrupted supply of MOUD products when these products are appropriately prescribed. Distributors should carefully examine quantitative thresholds they have established to ensure that individuals with OUD who need buprenorphine are able to access it without undue delay. DEA has posted a guidance document on its portal related to this issue: https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-065)(EO-DEA258)_Q_A_SOR_and_Thresholds_(Final).pdf.

For more information, please visit www.samhsa.gov and/or www.DEAdiversion.usdoj.gov. It is our sincere hope that the remarkable increase in the number of medical professionals who can prescribe this life-saving medication will not only change the lives of individuals with OUD, but will also stem the escalating rate of opioid-related deaths at a population level.

Please join us in this fight to save lives.

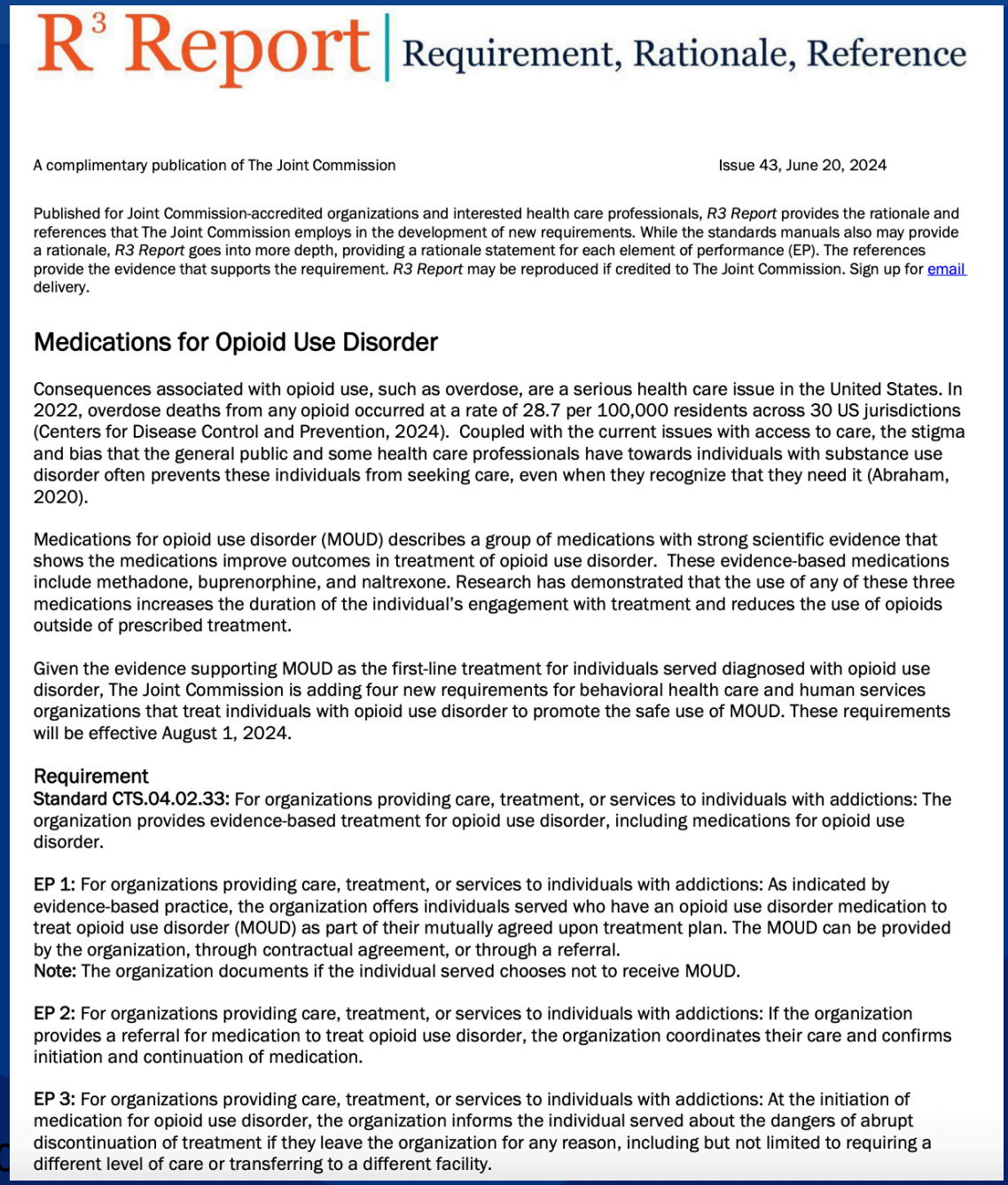
Sincerely,

Anne M. Milgram
Administrator,
Drug Enforcement Administration
Department of Justice

Rachel L. Levine, M.D.
ADM, USPHS
Assistant Secretary for Health
Department of Health and Human

Miriam E. Delphin-Rittmon, Ph.D.
Assistant Secretary for Mental
Health and Substance Use
Department of Health and Human
Services

The Joint Commission wants you to prescribe MOUD!



R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission — Issue 43, June 20, 2024

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

Medications for Opioid Use Disorder

Consequences associated with opioid use, such as overdose, are a serious health care issue in the United States. In 2022, overdose deaths from any opioid occurred at a rate of 28.7 per 100,000 residents across 30 US jurisdictions (Centers for Disease Control and Prevention, 2024). Coupled with the current issues with access to care, the stigma and bias that the general public and some health care professionals have towards individuals with substance use disorder often prevents these individuals from seeking care, even when they recognize that they need it (Abraham, 2020).

Medications for opioid use disorder (MOUD) describes a group of medications with strong scientific evidence that shows the medications improve outcomes in treatment of opioid use disorder. These evidence-based medications include methadone, buprenorphine, and naltrexone. Research has demonstrated that the use of any of these three medications increases the duration of the individual's engagement with treatment and reduces the use of opioids outside of prescribed treatment.

Given the evidence supporting MOUD as the first-line treatment for individuals served diagnosed with opioid use disorder, The Joint Commission is adding four new requirements for behavioral health care and human services organizations that treat individuals with opioid use disorder to promote the safe use of MOUD. These requirements will be effective August 1, 2024.

Requirement

Standard CTS.04.02.33: For organizations providing care, treatment, or services to individuals with addictions: The organization provides evidence-based treatment for opioid use disorder, including medications for opioid use disorder.

EP 1: For organizations providing care, treatment, or services to individuals with addictions: As indicated by evidence-based practice, the organization offers individuals served who have an opioid use disorder medication to treat opioid use disorder (MOUD) as part of their mutually agreed upon treatment plan. The MOUD can be provided by the organization, through contractual agreement, or through a referral.
Note: The organization documents if the individual served chooses not to receive MOUD.

EP 2: For organizations providing care, treatment, or services to individuals with addictions: If the organization provides a referral for medication to treat opioid use disorder, the organization coordinates their care and confirms initiation and continuation of medication.

EP 3: For organizations providing care, treatment, or services to individuals with addictions: At the initiation of medication for opioid use disorder, the organization informs the individual served about the dangers of abrupt discontinuation of treatment if they leave the organization for any reason, including but not limited to requiring a different level of care or transferring to a different facility.

Requirement

Standard CTS.04.02.33: For organizations providing care, treatment, or services to individuals with addictions: The organization provides evidence-based treatment for opioid use disorder, including medications for opioid use disorder.

EP 1: For organizations providing care, treatment, or services to individuals with addictions: As indicated by evidence-based practice, the organization offers individuals served who have an opioid use disorder medication to treat opioid use disorder (MOUD) as part of their mutually agreed upon treatment plan. The MOUD can be provided by the organization, through contractual agreement, or through a referral.
Note: The organization documents if the individual served chooses not to receive MOUD.

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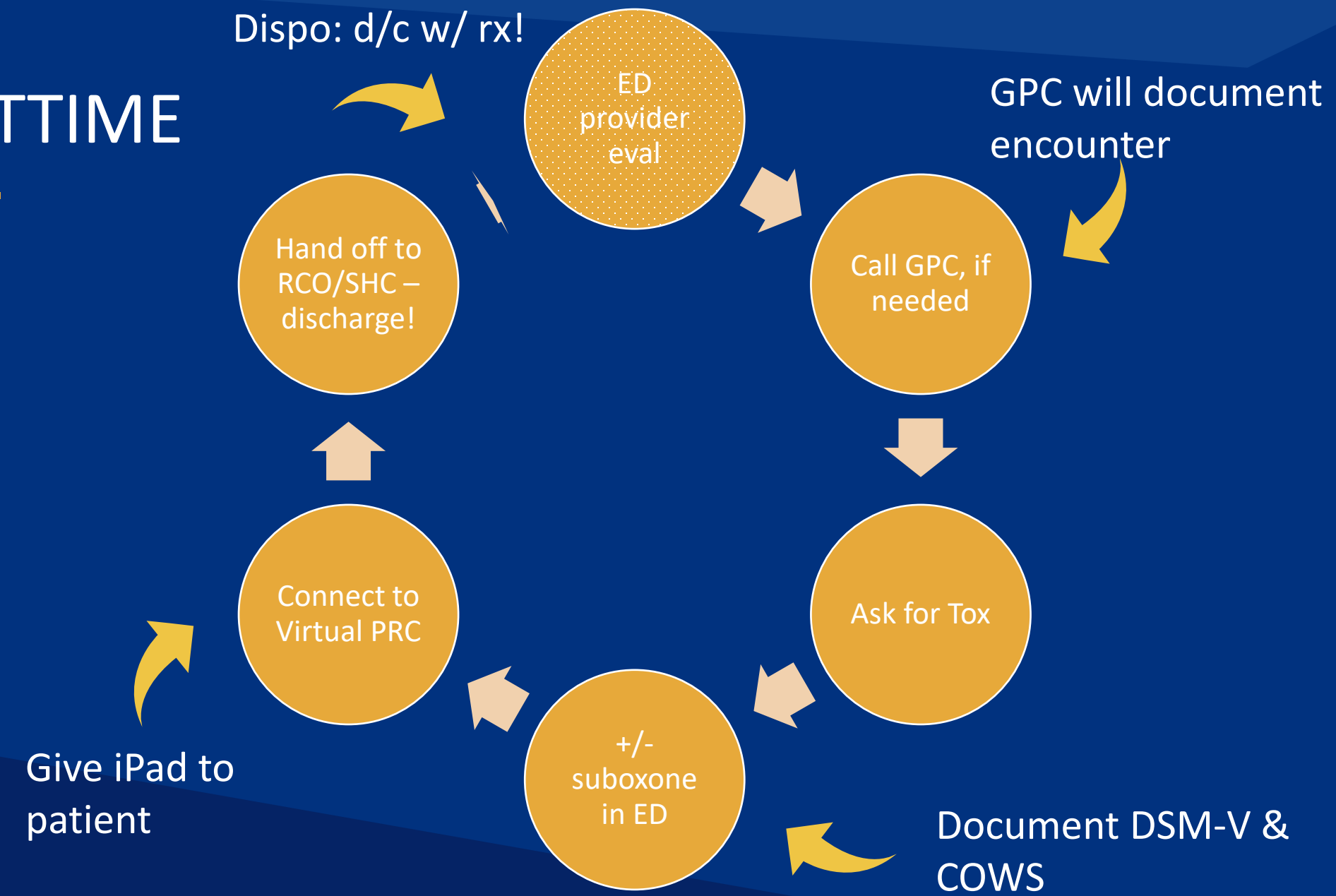
Document discussion with GPC

Care coordination via peer/GPC

Referral via peer coach/GPC

REAL TTIME


Dispo: d/c w/ rx!
ED provider eval
GPC will document encounter
Call GPC, if needed
Ask for Tox
+/- suboxone in ED
Document DSM-V & COWS
Connect to Virtual PRC
Give iPad to patient
Hand off to RCO/SHC – discharge!

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)

Safe Use of Opioids

What are your challenges, barriers, needs?

What would be most beneficial to assist with this measure?

Project Timeline

Date	To-Do List
9/23/25	□ Kickoff for Safe Use of Opioids
10/25-11/25	□ Complete Assessment sent by AHS

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/

Learning Outcome:

Following this activity, learners will be able to utilize data to determine those patients that are at the highest risk of unintentional overdose or misuse of opioids and implement staff and patient education processes to improve the safe use of opioids.

Accreditation Council for Continuing Medical Education (ACCME)

Alliant Health Solutions is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

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Expiration Date: 12/31/25

Bibliography: References are available in the presentation.


Questions?
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A Division of the Georgia Department of Community Health