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

October 2025

Agenda

- Welcome
- Review Georgia Poison Center/last month
- Yearly Assessment
- Workgroup discussion/Opioids
- Project Timeline Updates
- Resources
- Q&A/Wrap Up

GA FLEX Improvement Project Lead

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State Quality Manager - Georgia
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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

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

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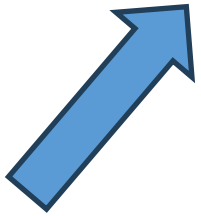
Document discussion with GPC

Care coordination via peer/GPC

Referral via peer coach/GPC



Yearly Assessment

FLEX yearly assessment link:

https://www.surveymonkey.com/r/QNFL68M

- Deadline for completion: November 26
- Complete at least one per hospital/more than one acceptable
- Addition of drop-down boxes this year

FLEX cycle 2025-2026

September 2025-August 2026

1. Safe Use of Opioids
2. HCAHPS Composite 6

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)

HCAHPS Composite 6:

Communication About Medicines measures how often hospital staff explain the purpose and side effects of new medications to patients in a way they can understand. This composite is calculated based on patient responses to two key survey questions and is used to assess a hospital's performance on patient satisfaction and safety.

Purpose of medication:

"Before receiving any new medications, how often did hospital staff tell you what the medicine was for?“

Side effects:

"Before receiving any new medications, how often did hospital staff describe side effects in a way you could understand?"

HCAHPS Score:

This composite is one of the key measures used to calculate a hospital's overall performance score in programs like the Hospital Value-Based Purchasing (VBP) Program.

How hospitals can improve:

- **Consistent education:** Staff should consistently educate patients on their medications for every dose.
- **Clear communication:** Explain the medication's name, dosage, purpose, and side effects in simple, understandable terms.
- **Repeat information:** Repeat key information to ensure the patient has understood it.
- **Encourage questions:** Empower patients to ask questions for clarification.
- **Use patient materials:** Provide written instructions or educational materials to reinforce verbal communication.

Specification eCQM

Here are the specifications for the Safe Use of Opioids eCQM:

https://ecqi.healthit.gov/ecqm/eh/2023/cms0506v5

Swing Bed

SNF PPS Swing Bed

Rural Hospitals with Swing Beds

Program of Activities: In accordance with 42 CFR 483.15(f), swing beds must provide "for" a program of activities.... If the hospital infrequently uses swing beds, or has a length of stay inappropriate to activities, they would need to have a plan for activities in policy and procedure to address when it would be appropriate and how they would provide the activities. If the activities are inappropriate from the medical point of view because of the condition of the patient and the length of stay, an activities program needs to be modified to be appropriate for the patient.

Social Work Services: 42 CFR 483.15(g) requires "social work services". A social worker is only required if the facility is more than 120 beds. Our requirement is for **medically related social services**. If an RN is trained and educated to provide these services, it would meet the requirement.

Change in Level of Care/Discharge: Swing bed payment regulations can be found at 42 CFR 409.30. Standard (a) discusses discharge from the hospital. Basically a SNF patient does not have to be from the same hospital or CAH as the swing bed.

42 CFR 482. 12(c)(4) defines that a physician is responsible for the care of the patient. 482.24(c)(2)(vii) states that all records must document a discharge summary with outcome of hospitalization, disposition of care, and provisions for follow-up care. As the person responsible for the care of the patient it therefore follows the physician must do the discharge summary.

Discharge from the acute care hospital bed is required because the patient is changing from one form of reimbursement (PPS) to another (SNF PPS). This is a reimbursement requirement for payment. A swing bed is not considered hospital level care. It is defined in the payment regulations as SNF level care and is reimbursed at a lesser amount.

It therefore follows that the patient must have a discharge summary following acute care services. When the patient is discharged from the swing bed, they need a discharge summary of SNF level services.

[Information for Swing Bed Hospitals in the Process of Converting to Critical Access Hospitals (CAHs)]

Safe Use of Opioids

- What are your challenges, barriers, needs?
- What would be most beneficial to assist with this measure?

Communication About Medications

- Are questions being consistently asked and documented?

Project Timeline

Date	To-Do List
10/28/25	□ Monthly call
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/


Questions?
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