QIP – NJ Behavioral Health

Breakthrough Series Collaborative

Version 1

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PUBLIC CONSULTING GROUP

CONTENTS

SOURCES

The content of this Change Package was developed by the New Jersey Department of Health, Office of Healthcare Financing in partnership with Public Consulting Group. It has been adapted from the following sources and edited based on the opinion of an interprofessional panel of experts.

1. Schall M, Laderman M, Bamel D, Bolender T. Improving Behavioral Health Care in the Emergency Department and Upstream. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2020. (Available on ihi.org)

2. National Council for Behavioral Health. TCPI Change Package: Transforming Clinical Practice. March, 2016.

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No panelist has any relevant financial or commercial interests to disclose.

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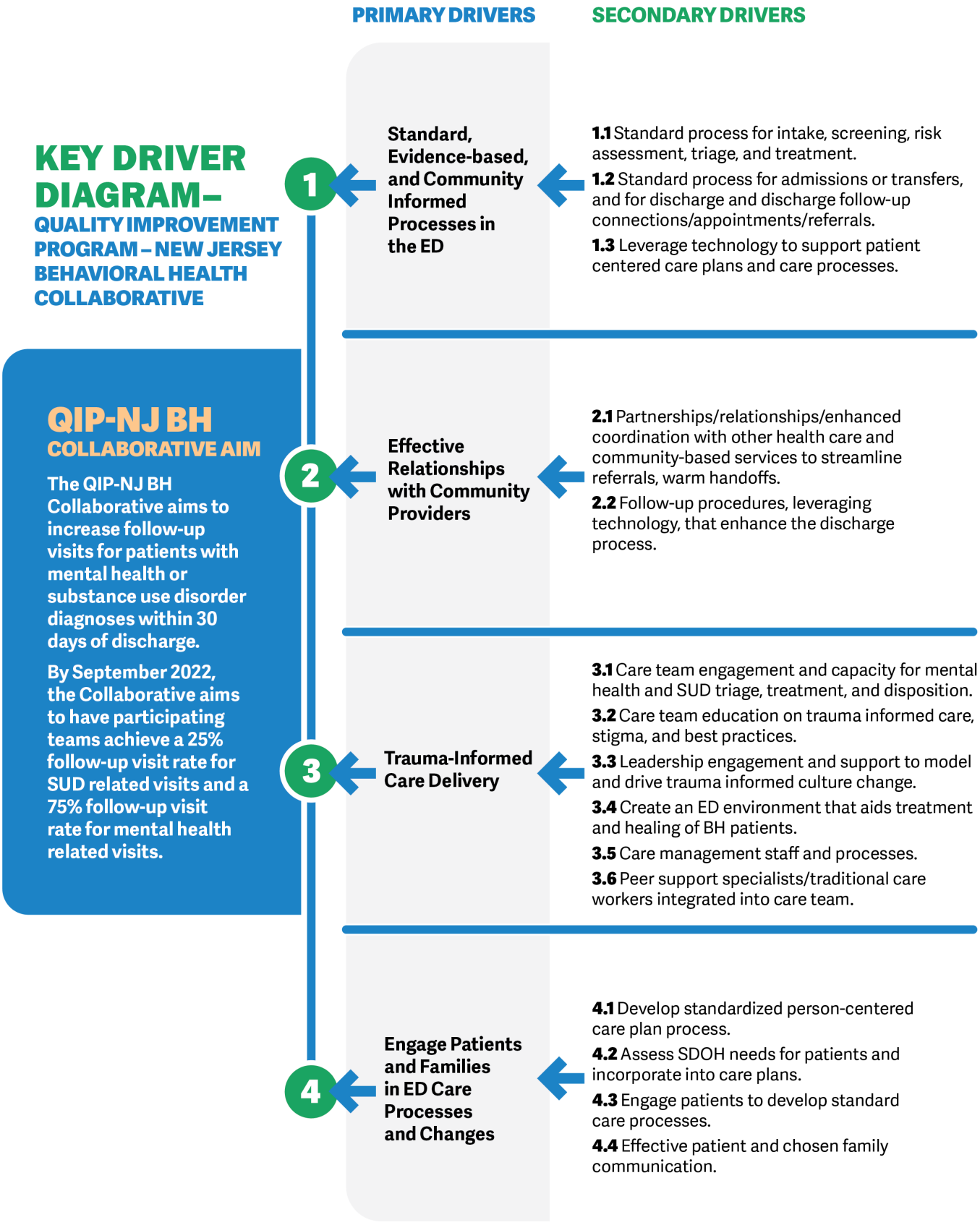
KEY DRIVER DIAGRAM



DETAILED CHANGES

1. STANDARD, EVIDENCE BASED, CARE PROCESSES IN THE ED		
Secondary Driver	High Level Changes	Detailed Changes
1.1 Standard process for intake, screening, risk assessment, and triage for patients with Mental Health and Substance Use Disorders.	Connect the patient with the appropriate mental health or substance use disorder intervention as early as possible	• Conduct medical and psychiatric evaluation in parallel (e.g., use an evidence-based tool such as the SMART Medical Clearance Form to initiate clinically indicated tests in a timely manner).
	Ensure individuals are seen in a comfortable, non-coercive, and nonthreatening environment in the ED	• Establish a patient provider relationship by using, for example, verbal de-escalation and sensory modulation techniques. • Create dedicated beds and/or space inside or outside the ED based on acuity (eg. observation unit, hospital-based crisis stabilization unit or psychiatric emergency unit). • Ensure that the environment is LGBTQIA+ friendly and that each patient is asked what pronouns they prefer. • Staff can take “Safe Zone[1]” trainings to indicate they are open to discussing and are supportive of LGBTQIA+. • LGBTQIAA flyers or symbols on the walls can serve as important signals for patients.
	Assess ED patients for mental health conditions or substance use disorders, stratify patients by risk level and acuity, and develop pathways to needed level of care	• Develop a rapid triage assessment process (e.g., use the Australasian Triage Scale). • Use a brief screening tool to conduct an initial assessment of suicide risk and identify patients who require a full assessment; for full assessment, use a validated, standardized scale. • Assess level of agitation using a validated, standardized tool (e.g., Behavioral Activity Rating Scale). • Tie level of observation and individual placement location to assessment tools.

[1] https://thesafezoneproject.com/about/what-is-safe-zone/

	Gather relevant information from family or support person	• Build an information gathering step into the mental health assessment workflow, specifying how and when this will be done and by whom (may be one or more care team members).
1.1 Standard process for treatment of patients with Mental Health and Substance Use Disorders.	Form a therapeutic alliance with the patient that is compassionate and respectful	• ED staff treat all patients, including those with mental health conditions and substance use disorders, with compassion and respect. • Staff participate in shared decision making with patients rather than ordering compliance with provider-only decisions. • Engage patients and learn their story in their own words. • Review patient history and any additional information provided by a family member or companion who accompanies the patient to the ED. • Build Capacity among ED staff for mental health and/or SUD intake, triage, disposition to support all populations (training to include MI, SBIRT assessments, gender and cultural diversity, strength-based assessments, biases, equity, distress tolerance techniques, emotional regulation techniques, de-escalation techniques, etc.).
	Provide the appropriate level of care to manage symptoms and stabilize the patient	• Regularly re-evaluate the patient for changes in symptoms on disposition and also after stabilization; do not assume patient condition is static from the time of the formal assessment, and if the condition changes disposition options may be different as well. • When medications are indicated, provide without delay to begin relieving patient's distress. For an extended stay patient, consider commencing regular doses of meds rather than prn's, and re-start all home medications if appropriate. • Educate ED staff on safety planning and lethal means restriction following patient discharge from the ED. • Provide prescribed medication at ED discharge when appropriate and when prompt follow-up with outpatient provider is not possible; avoid prescribing additional supply of medications if patient already has enough with them or family/caregivers inform there are sufficient supplies at residence.
	Identify relevant clinical guidelines for major disease states (e.g., agitation, anxiety, psychosis)	• Use EHR prompts, order sets and protocols to assist treatment strategies or decisions. • Create order sets for emergency medicine providers via collaboration with acute psychiatry prescribers to assist in starting targeted and appropriate medications when indicated without delay.

	Provide active treatment with medications in the ED as soon as possible; provide brief interventions where appropriate	• Develop protocols for specific populations and conditions such as medication based on assessed level of agitation. • Create protocols to promptly diagnose substance withdrawal (specifically alcohol, sedative-hypnotic, opioid and tobacco withdrawal) and aggressively treat with medication.
1.2 Standard process for discharge, admission, or transfers	Develop a standardized approach to ED discharge and follow-up for mental health and substance use disorder patients	• Schedule follow-up appointments before patients leave the ED. • Include a flag in the patient record to identify high-risk and frequent recidivist patients, to ensure follow-up with the patient after ED discharge and appropriate continuation of care and utilization of services and resources. • Determine optimal care team member roles for care plan follow-up and outreach to both patients and the next provider or community-based services.
1.3 Leverage technology to support patient centered care plans and care processes	Universal EHR access across entire care team	• Centralized Medical record that gives all care team members access to the same information from intake to triage and treatment. • Train ED staff in collaborative documentation processes including proper application, correct implementation and expected utilization of evidenced-based processes with a universal system of viewing all patient documentation.
	PDMP	• Connect to PDMP, integrate with EHR if possible, allow all providers access.

2. ACCESS TO CARE AND STRONG RELATIONSHIPS WITH COMMUNITY PROVIDERS		
Secondary Driver	High Leverage Changes	Detailed Changes
2.1 Partnerships/relationships/enhanced coordination with other health care and community-based services to streamline referrals, warm handoffs	Identify and make direct and ongoing connections with medical care providers (inpatient and outpatient) and relevant community-based social services that will continue to support patients with mental health and substance use disorders following ED discharge	• Collect information from patient intake forms about where patients get support, other than the ED. • Collaborate with community crisis response teams, crisis counselors, and peer specialists among other community mental health and substance use disorder care providers, to provide community-based care management. • Explore opportunities to tighten linkages with EMS and EDs, especially for overdose patients who are transported by EMS. Many of the change strategies in this change package focused on EDs can also be applied to EMS. • Identify existing partnerships between other hospital departments and community-based organizations. • Invite community partners and peer specialists into the ED for care conferences. • Organize ED staff visits to community providers to broaden awareness of community-based services and resources. • Engage community partners throughout the patient journey: Intake and triage, treatment, and discharge (i.e., clearly delineate roles of each integrated team member).
	Build relationships with community-based organizations, agencies, and providers that refer mental health and substance use disorder patients to the ED	• Conduct an analysis of the community-based agencies and providers that most frequently refer patients to the ED. • Partner to coordinate care across the patient journey, including thriving health and wellness to pre-crisis and crisis. • Recognize that community providers and the ED should have a two-way relationship in patient care and improving relationships and access between each partner will improve overall, long-term care for individuals. • Create regular touchpoints such as conference calls with community providers that frequently take referrals; these can be weekly or monthly depending upon the local context; focus on both successes and challenges during these touchpoints, as ED staff often do not hear about positive outcomes for their patients (since those patients do not return to the ED).

	Co-create a simple referral process with key referring partners	• Develop a one-page referral sheet with key partners for ED staff; consider ways to share referrals electronically. • Employ a licensed substance abuse / mental health counselor, case manager, or social worker in the ED to make referrals to community-based organizations and providers, and to follow up with the patient to improve resource utilization and decrease ED revisits. • Collaborate with urgent care centers and mental health crisis clinics to obtain immediate care for low- and medium-acuity patients and provide a bridge to follow-up care. • Create secure notifications such as encrypted emails or phone calls (e.g., from case manager or social worker) to other care settings (e.g., ED, hospital, primary care provider, outpatient behavioral health). • Consider including dental providers in your network of referral partners, as dental care can be very important to patients and often overlooked.
	Identify existing or develop new patient data and/or information sharing agreements with key referring partners	• Develop a secure data feed (such as a Health Information Exchange) to track patients across settings within the health system. • Enable secure access to patient medical records across care settings (e.g., hospital, primary care, outpatient).
2.2 Follow-up Procedures that enhance the discharge process	Ensure patients and families understand and are engaged in developing the ED discharge plan of care	• Engage the patient and family, with the patient's consent, in establishing the care plan and in designing the ED discharge process. • At discharge, ask the patient and/or family if symptoms were addressed satisfactorily in the ED and if they are equipped to follow through with the care plan following ED discharge. • Explore together the ways that family members can support ongoing connection to community providers. • Consider creation of a "Behavioral Health Advance Directive" to facilitate family/caregiver/significant other participation in treatment, and to provide important history rather than starting from scratch each presentation.
	Provide active patient follow-up following ED discharge	• Follow up with patients via phone calls (sometimes called "caring contacts"); consider focusing on high-risk patients if staff resources are limited.
	Enable the hospital to act as anchor institution to bolster the	• Encourage hospital leadership to meet with government leadership and County/Regional Behavioral Health agencies to emphasize the hospital's willingness to be a leader in behavioral health emergency care that is truly a part of the regional spectrum of behavioral health care. Demonstrate to

	health and wellbeing of the broader community	such VIPs that the hospital and ED support a wellness-and-recovery approach merged with acute medical interventions, that there is no false dichotomy between the approach to care in the hospital versus the community. • Invite several community members to sit on steering boards or advisory committees for the ED so that there is direct representation from the community. • Host regular community stakeholder meetings to understand community concerns and priorities; ensure an open format with ample time for community members to speak freely. • Create an annual "fair" for community members to interact with the ED – basic medical screenings can be done, food/music/artwork, etc. • Each staff member should ride with EMS at least once into the community so as to become more familiar with the local culture.
	Identify the ED's current role in the overall community mental health and substance use disorder care system	• Learn about and participate in any existing roundtables, coalitions, or recurrent public health gatherings in the community to build partnerships and strengthen care coordination. If one does not exist, the hospital ED should host one to learn how the ED can serve their community better. • Demonstrate to such gatherings that the hospital and ED support a wellness-and-recovery approach merged with acute medical interventions, that there is no false dichotomy between the approach to care in the hospital versus the community, and that there are inevitably times when the hospital is the appropriate location for individual care due to acuity or medical comorbidity. Communicate the hospital embraces their role in these circumstances and is dedicated to providing premier levels of trauma-informed care and compassion.
	Participate in community coalitions committed to improved community health	• Support the development and sustainability of community coalitions (e.g., work together to establish a monthly meeting place and time). • Hold cross-organizational case conferences, in compliance with HIPPA limitations, to offer all partners a way to problem solve together, coordinate care effectively, and learn about each other's roles. • Develop a shared release of patient information document that can be tailored to allow sharing across some or all linked agencies for a specified duration of time.

3. TRAUMA INFORMED DELIVERY SYSTEM DESIGN AND CULTURE		
Secondary Driver	High Leverage Changes	Detailed Changes
3.1 Provider engagement and capacity for mental health and SUD triage, treatment, and disposition	Create an ED behavioral health intervention team, including a hospital-based mental health provider (e.g., psychiatrist, psychologist, or licensed clinical social worker [LCSW]; community mental health worker; peer support specialists; patient navigator)	• Maximize the training and expertise of all staff through scheduled trainings and by cultivating a culture of in-the-moment (or scheduled) feedback/discussion. • Increase the availability of psychiatric consults in the ED. This may be done via telepsychiatry (see next item). • Provide virtual access to mental health services for triage, consultation, and treatment via dedicated phone access or utilizing telepsychiatry consults/evaluations and virtual mental health providers (i.e., psychiatrists, LCSWs, psychologists) and teams as needed; these can be consultations between clinicians or direct connections between a virtual clinician and patient. • Engage the ED behavioral health intervention team in interdisciplinary rounds.
	Optimize onsite staff expertise and training in caring for patients with mental health conditions and substance use disorders	• Develop “go-to expertise” (aka champions) within the ED (e.g., nurses and LCSWs with special training) to support ED staff who do not have psychiatric expertise. • Utilize peer support specialists in the ED (e.g., National Alliance on Mental Illness representatives in the ED; Certified Peer Recovery Specialists to address SUD) ensuring adequate resources to support and integrate peer specialists into the care team.
	Make mental health and addiction medicine resources easily accessible to ED staff	• Partner with local academic institutions (medical schools, universities, teaching hospitals) to share resources and educational materials/trainings. • Link relevant online materials/trainings on the ED department website homepage or on a special page for faculty/staff.

3.2 Provider education on trauma informed care, stigma, and best practices.	Train and educate all relevant ED staff in key issues to improve care for individuals with mental health conditions and substance use disorders	• Provide training in the following areas:
		  ○ Implicit bias toward individuals with mental health needs, "drug-seeking" behavior, those experiencing homelessness, and other issues.
		  ○ Inequities related to race, age, gender, insurance coverage, or other populations (identified using quantitative and qualitative data).
		  ○ Diagnosis-based, evidence-based, standardized care models for psychiatric patients.
		  ○ How to provide trauma-informed care; de-escalation; care for agitated patients.
		  ○ Motivational interviewing approaches.
		• Provide ongoing support for all ED staff to reinforce training.
		• Train staff "go-to experts" (aka champions) (such as psychiatric-trained ED nurses) who specialize in working with patients with mental or substance use health needs.
		• Consider creation of a "Psychiatric Emergency Response Team" for immediate response for highly acute, agitated and/or aggressive patients.
		• Include hospital security personnel and all ED staff (including clerks, aides, etc.) on safety and trauma-informed care trainings.
		• Train clinical care team to understand the purpose, expertise, and value of non-traditional workforce members such as peer specialists.

3.3 Leadership engagement and support to model and drive culture change	Ensure productive dialogue and decision making within the ED team to foster engagement and alignment with creating a trauma-informed culture in the ED	• Leaders reframe mental health and substance use disorder needs as analogous to a medical condition, to help shift cultural attitudes. • Leaders conduct weekly ED walk-arounds to reinforce the rationale and importance of a trauma-informed culture to better address mental health and substance use disorder issues. • Senior sponsor of the ED QIP-NJ Collaborative improvement team regularly attends team meetings and holds monthly review meetings to assess progress and barriers. • Incorporate adoption of trauma informed culture into strategic plan.

	Build the health system's and ED's values on creating a team-based and patient centered culture into processes for ED staff hiring and training	• Ensure that there is the compelling vision, strategy, capacity, and capability for change. • Include diverse voices during orientations and training by including peers as speakers; invite patient/community advocates to participate in training activities. • Include trauma-informed care training in ED new hire orientation and including trauma informed training as a desirable trait for new hires. • Review and adapt employment requirements for hospitals that might exclude individuals such as peer specialists with lived experience because of issues with background checks or other requirements.
	Sustainable Business Practices	• Use sound business practices, including budget management and calculation of return on investment for all new programs. • Maximize benefit of participation in alternative and performance payment arrangements. • Advocate for relevant codes and appropriate reimbursements for hospital-based emergency psychiatric care, including observation codes, with Medicaid agencies. • Invest in the capabilities and technology needed to drive performance excellence. • Cultivate joy in work (address burnout); ensure dedicated break spaces and protected break time; provide access to enduring online learning regarding self-care practices.
3.4 Create an ED environment that aids treatment and healing of BH patients	Ensure individuals with mental health conditions and substance use disorders are seen in a comfortable, non-coercive, and non-threatening environment in the ED	• Establish a patient-provider relationship by using, for example, verbal de-escalation and sensory modulation techniques. • Create dedicated beds and/or space inside or outside the ED based on acuity (e.g., observation unit, hospital-based crisis stabilization unit or psychiatric emergency unit) • When possible, employ environmental calming techniques such as white noise or music, calming wall paint colors/artwork, reduction of alarm sounds (i.e., beeping from monitors), access to natural daylight. • Educate care team on avoidance of coercion, forcible involuntary medications, and over sedation, and the benefits of replacing these with a therapeutic alliance.

3.5 Care management staff and processes	Care management	• Consider hiring staff from within your institution's community. • Develop and support a "champion" staff member on each shift who has a special interest in BH/SUD patients. • Enhance the care team for efficient and effective coordination to meet the needs of patient and family. • Define, distribute, and document the roles of all care team members to maximize skill set, training, and licensure/certification and communicate roles to patients and families.
	Population Management	• Use a data-driven approach to create registries and assign patients to panels and confirm panel assignments with both providers and patients. • Ensure tracking of post-discharge patient contacts in the electronic medical record.
3.6 Peer support specialists/traditional care workers integrated into care team	Provide peer support opportunities both during and after ED visits	• Meaningfully integrate peer support specialists into the emergency department care team.
		• Develop partnerships with local NAMI chapter, DBSA and/or other behavioral health or SUD patient advocacy organizations to connect patients and families with peer support and ongoing resources.

4. ENGAGE PATIENTS AND FAMILIES IN ED CARE PROCESSES AND CHANGES		
Secondary Driver	High Leverage Changes	Detailed Changes
4.1 Develop Standardized Person-Centered Care Plan Process	Map the ED care process from the patient's perspective to understand areas for improvement	• Identify and revise any non-evidence-based ED protocols and procedures that adversely affect patient dignity; ensure that all protocols are aligned with a trauma-informed model of care. • Hold a focus group with patients who have been treated in the ED. • Collect and act on patient and family feedback on ED experience of care via text survey or electronic form. • Engage families and caregivers in the design of ED discharge instructions, care planning, and transition to the next setting of care. • Involve peer specialists in a "secret shopper" exercise in the ED to gather as much information as possible about the existing ED care environment (i.e., the peer specialist presents with a medical complaint and takes note of everything that happens during the visit).
	Train and support ED staff to incorporate patient and family engagement into care processes	• Develop a standardized process to engage chosen families, as desired by the patient, throughout the ED stay, from Intake and assessment to initial treatment to discharge, admission, or transfer).
	Provide peer support opportunities both during and after ED visits	• Develop partnerships with local NAMI chapter, DBSA and/or other behavioral health or SUD patient advocacy organizations to connect patients and families with peer support and ongoing resources.
4.2 Assess SDOH needs for patients and incorporate into care plans	Develop and integrate SDOH screening tools in the EMR workflow	• Screen patients for SDOH needs and develop a plan to address these barriers, at least with a catalogue/cheat sheet of local resources to provide the patient. • Create a workflow for a patient's SDOH needs to be addressed by social work prior to discharge (i.e., providing referrals for transportation, housing, etc.).
	Partner with the community to assess and address social determinants of health and health disparities	• Provide transportation and phones to low-income population as needed (DHS funded programs). • Create an action plan or referral resource for the top SDOH barriers identified (i.e., transportation, childcare, lack of phone, lack of housing, etc.).

		• Cultivate a bidirectional relationship with other anchor institutions in the community to share resources.
4.3 Engage patients to develop standard care processes	Identify what does and does not work in the current care approach by talking with and listening to patients with mental health conditions and substance use disorders	• Involve peer specialists in a “secret shopper” exercise in the ED to gather as much information as possible about the existing ED care environment and patient experience (i.e., the peer specialist presents with a medical complaint and takes note of everything that happens during the visit) (note that patient permission is needed for any direct clinical interaction). • Regularly interview patients and staff about their ED care experience and incorporate that qualitative data into the care process redesign. • Ensure the viewpoint of different patient populations is represented (e.g., race, gender, insurance status). • Include a patient on the organization’s board, invite patients to operational meetings or invite patients to join learning collaborative improvement teams. • Implement a patient and family advisory group. • Use real time electronic systems for capturing patient feedback. • Conduct an environmental scan to analyze the communities and cultures served by the ED and ensure that practices are equitable and responsive to the needs of the patients served.
	Engage mental health and substance use disorder patients in designing and testing new ED processes to improve trauma informed care	• Partner with NAMI or other BH/SUD patient advocacy organizations to identify patients and/or families to participate in planning and testing new processes. • Utilize existing patient advocacy groups.
4.4 Effective patient communication	Respect Patient values and preferences	• Train staff in cultural competency. • Always ask patients about preferences, do not assume. Develop standard forms or workflows to accomplish this. • Assess patient’s health literacy. • Be aware of patient’s sexual orientation. • Obtain collateral history information with chosen family and significant others when possible and via consent.

	Identify and address implicit bias/racism in care delivery	• Form a workgroup or task force to specifically address this issue for the ED; task this group with completing an assessment, formulating an action plan, and developing a timetable to measure outcomes/progress and present this regularly to ED and hospital leadership.

MEASURES INTRODUCTION

The following proposed measures are intended to support the improvement process for participating teams. This list represents a combination of measures included in the QIP-NJ pay-for-performance framework in addition to additional measures intended to support the quality improvement process based on recommendations from an interprofessional panel of experts.

We are currently testing the feasibility of these measures with frontline care teams in NJ acute care hospital emergency departments. That testing process will also guide the development of a Collaborative data collection guide to be released to teams prior to the Collaborative start. Teams participating in the Collaborative will not be asked to collect data on more than eight measures each month. **The final list of measures will be published in an updated version of this Change Package after the feasibility testing is completed.**

COLLABORATIVE MEASURES UNDER CONSIDERATION

MEASURE NAME	COLLAB LABEL
Required Measures Reported Monthly	
Preventative Care and Screening: Screening for Depression and Follow-Up	7
Substance Use Screening and Intervention Composite	8
Percent of patients with a follow-up visits scheduled before ED discharge	20
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 day)	1
Follow-Up After Emergency Department Visit for Mental Illness (30 day)	2
Patient Experience Surveys Completed	5
Percent of patients or families who participate in and receive the post-ED discharge care plan	17
ED revisits among patients with primary BH diagnosis for another BH issue	10
Optional Measures Reported Monthly	
ED length of stay for patients with BH diagnosis	12
ED disposition decision to discharge time	13
Average daily duration of ED patients in restraints	14
Initiation of Medications for patients with SUD	21
Measures to be Reported During Quarterly Self Assessments	
An array of the secondary drivers	N/A
Trauma informed trainings completed, or practices adopted	11
Assessments completed of care team trauma informed knowledge, experience, attitude	12
Patient advisory board meetings completed	5
Equity by race analysis	N/A

MEASURE DESCRIPTIONS

COLLAB LABEL	MEASURE	MEASURE DESCRIPTION
1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 day)	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence within 30-days of discharge (31 total days).
2	Follow-Up After Emergency Department Visit for Mental Illness (30 day)	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or intentional self-harm during the measurement year and who had a follow-up visit for mental illness within 30-days of discharge (31 total days).
7	Preventative Care and Screening: Screening for Depression and Follow-Up	Percentage of patients aged 18 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age- appropriate standardized depression screening tool and if positive, a follow-up plan is documented on the date of the eligible encounter.
8	Substance Use Screening and Intervention Composite	Percentage of patients aged 18 years and older who received a substance use screening at least once within the last 24 months AND who received an intervention for all positive screening results.
10	ED revisits among patients with primary BH diagnosis for another BH issue	Total number of patients who revisited the ED within 7 days with MH/SUD issues after ED discharge for MH/SUD diagnosis.
12	ED length of stay for patients with BH diagnosis	For patients with MH/SUD diagnosis, total time from initial presentation to the ED to departure from the ED; plus, length of stay broken out into three segments: • LOS 1: Total time from initial presentation to ED until medical stabilizing process is complete and patient is waiting for mental health evaluation or disposition; • LOS 2: Total time from when patient is ready and waiting for mental health evaluation until mental health evaluation or disposition plan has been completed; • LOS 3: Total time from completion of mental health evaluation and disposition plan to departure from ED.
13	ED boarding time	Total time in minutes when disposition decision has been made to the time of transfer/admission/discharge (does not include patients placed in observation status in emergency settings).

14	Average duration of ED patients in restraints	• Total number of ED patients restrained per day; or • Percentage of agitated patient codes in the ED that result in use of restraints.
16	Patient Experience Measure	MH/SUD patient experience of ED care (using a 1-to-5 scale, survey responses rating the degree to which ED staff treated patients with mental health [MH] conditions and substance use disorders [SUD] with respect, listened to the patient, and communicated effectively)
17	Percent of patients or families who participate in and receive the post-ED discharge care plan	*TBA*
18	Provider/Staff Attitude/Experience Measure	*TBA*
20	Percent of follow-up visits post-ED discharge that are scheduled before discharge	*TBA*
21	Initiation of MAT in the ED	*TBA*