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Introduction:

The New Jersey Department of Health (DOH) designed the Quality Improvement Program – New Jersey (QIP-NJ) Behavioral Health (BH) Learning Collaborative (Collaborative) to increase follow-up visits for individuals with mental health (MH) and substance use disorder (SUD) diagnoses within 30 days of an emergency department (ED) discharge. The QIP-NJ measures *BH3: Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) (30 day)* and *BH4: Follow-Up After Emergency Department Visit for Mental Illness (FUM) (30 day)* will be the primary outcome measures that the Collaborative is working to improve, however these are lagging measures due to their reliance on claims data. Therefore, DOH has identified and defined a set of process oriented and proxy outcome measures to serve in the Collaborative's measurement strategy that will support hospitals throughout the improvement process.

The purpose of these Collaborative measures is to support teams to identify if the changes they are making in their care process are having an impact in the short term. Therefore, attention has been paid to selecting measures that can be gathered and displayed at least monthly and that will reflect the impact of changes happening on the ground. The measures defined below are designed to be broadly applicable to Collaborative teams and may not represent all possible measures that can be gathered for a particular site to show impact of their work. Hospital teams are encouraged to identify additional measures unique to their systems to enable them to track the impact of their changes on the ground. These measures are intended for learning and not judgement of participating health systems and therefore teams are encouraged to adapt the measures to their systems in ways that allow them to gather useful insight into the impact of their improvements.

This Collaborative measurement strategy document details the required measures that all participating teams will be expected to collect monthly throughout the Collaborative. Monthly data collection will accelerate your improvement and help teams get the most benefit out of the Collaborative but is not tied to funds earned in QIP-NJ. Included in this document are the list of measures along with their operational definitions and guidance for data collection and reporting. The measures selected for inclusion in the Collaborative measurement strategy were based on the literature, recommendations from an interprofessional panel of experts convened in January 2021, and the results of a feasibility assessment performed by two NJ acute care hospitals and a community partner. As more teams begin to collect data, the Collaborative faculty will continue to revise the guidance around data collection to spread best practices and ameliorate challenges. Any revisions, suggestions or best practice recommendations that lead to a new version of this document will be communicated to hospital teams.

<u>Addressing Disparities in the Collaborative:</u>

To identify disparities in healthcare delivery and patient outcomes by race and ethnicity, DOH asks that each hospital identify one of the Collaborative measures for which your team will stratify results by race and ethnicity. Teams will not be expected to stratify data by race/ethnicity for each monthly data submission. Instead, teams will be asked to submit this analysis on their chosen measure twice throughout the Collaborative in December 2021 and April 2022. Details about the disparities analysis can be found later in this document. Teams are encouraged to use the following stratifications of race/ethnicity to submit their results:

Non-Hispanic Black	Non-Hispanic White	Hispanic	Asian	Other

Required Measure Table for Monthly Reporting

#	Name	Definition	Data Collection Guide
1	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 day)	**Denominator**: Patients >= 18 and <65 with an SUD diagnosis seen in the emergency department. **Numerator**: Patients who completed a follow-up visit within 31 days after their ED discharge. Check QIP-NJ Value Set Compendium to augment the following definitions with code sets used in the pay-for-performance framework of the program: • ED Visit: BH07_Nondx, ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set, ER Category. • SUD Diagnosis: BH03_DetailOID, AOD Abuse and Dependence Value Set. • SUD Follow-up Visit: BH03_AODTxservices.	For all options presented, teams may need to establish a HIPAA process in advance with patients and community providers to enable community providers to share even deidentified aggregate data. For all options presented, teams can either perform a chart audit on a small sample of 20 patients or build a report from the EMR to capture more patient records if possible. **Option 1: Accessing Data from an Available Health Information Exchange (HIE)** If you have access to a regional Health Information Exchange, your team can leverage this system to track the follow-up visits completed for patients in your monthly sample at both hospital based or community based follow-up providers. **Option 2: Report Data from Hospital Based or System Based Clinics** If your hospital or health system runs its own behavioral health or SUD treatment clinics for which your team has shared Electronic Medical Record (EMR) access, teams can begin to report outcomes for this measure limiting the population to these clinics. Teams should assess what percent of their population is referred to these hospital based clinics, recognizing that without access to an HIE pursuing options 3 and 4 will be the only way to gain insight into the success of connecting all other patients to care with community providers. **Option 3: Using Deidentified Aggregate Data from Community Partner(s)** Identify community providers that your emergency department refers (or plans to refer) patients to for SUD follow-up most frequently. Create a system to track the total number of referrals made to this provider each month: Denominator: Total referrals to community provider • I.e., create a report that pulls data from a discreet field indicating that a referral to this provider took place. This will rely on uniform documentation by staff. • Or, develop a system to manually abstract a sample number of charts each week to tally the aggregate number of patients referred to this provider each week. Numerator: completed visits Establish an arrangement with the community provider to report a deidentified aggregate number of patients who showed up for a follow-up visit each month. **Option 4: Establish Data Sharing Agreement with Primary Referral Partner**

			Build a report that follows the specifications outlined in the QIP-NJ Databook but limit your denominator to patients referred to your primary referral partner with which you have established a data sharing agreement, enabling you to check if each patient completed a follow-up visit in the 30-day period of not. **Option 5: Patient Reported Success** Teams who have success with patient outreach after an ED discharge can consider using these encounters to track the success of follow-up visit completion. In this option, your denominator would be further limited to those for whom outreach efforts were successful.
2	Follow-Up After Emergency Department Visit for Mental Illness (30 day)	**Denominator**: Patients >= 18 and <65 with a mental health diagnosis seen in the emergency department. **Numerator**: Patients who completed a follow-up visit within 31 days after their ED discharge. Check QIP-NJ Value Set Directory to augment the following definitions with code sets used in the pay-for-performance framework of the program: • ED Visit: BH07_Nondx, ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set, ER Category. • Mental Health Diagnosis: BH04_DetailOID, Mental Illness; Mental Health Diagnosis; Intentional Self-Harm Value Sets. • Mental Health Follow-up Visit: BH04_Nondx: Mental Health Follow-Up CPT/HCPCS Value Set.	For both options presented, teams may need to establish a HIPAA process in advance with patients and community providers to enable community providers to share even deidentified aggregate data. For all options presented, teams can either perform a chart audit on a small sample of 20 patients or build a report from the EMR to capture more patient records if possible. **Option 1: Accessing Data from an Available Health Information Exchange (HIE)** If you have access to a regional Health Information Exchange, your team can leverage this system to track the follow-up visits completed for patients in your monthly sample at both hospital based or community based follow-up providers. **Option 2: Report Data from Hospital Based or System Based Clinics** If your hospital or health system runs its own behavioral health or SUD treatment clinics for which your team has shared Electronic Medical Record (EMR) access, teams can begin to report outcomes for this measure limiting the population to these clinics. Teams should assess what percent of their population is referred to these hospital based clinics, recognizing that without access to an HIE pursuing options 3 and 4 will be the only way to gain insight into the success of connecting all other patients to care with community providers. **Option 3: Using Deidentified Aggregate Data from Community Partner(s)** Identify community providers that your emergency department refers (or plans to refer) patients to for mental health follow-up most frequently. Create a system to track the total number of referrals made to this provider each month: Denominator: Total referrals to community provider • I.e., create a report that pulls data from a discreet field indicating that a referral to this provider took place. This will rely on uniform documentation by staff. • Or, develop a system to manually abstract a sample number of charts each week to tally the aggregate number of patients referred to this provider each week. Numerator: completed visits

			Establish an arrangement with the community provider to report a deidentified aggregate number of patients who showed up for a follow-up visit each month. **Option 4: Establish Data Sharing Agreement with Primary Referral Partner** Build a report that follows the specifications outlined in the QIP-NJ Databook but limit your denominator to patients referred to your primary referral partner with which you have established a data sharing agreement, enabling you to check if each patient completed a follow-up visit in the 30-day period of not. **Option 5: Patient Reported Success** Teams who have success with patient outreach after an ED discharge can consider using these encounters to track the success of follow-up visit completion. In this option, your denominator would be further limited to those for whom outreach efforts were successful.
3	Case Management Outreach Success	**Denominator**: Patients 18 and older with an SUD and/or MH diagnosis who were discharged from the ED and referred to case management. **Numerator**: Percent of patients for whom a case manager made successful contact in an outreach attempt, either through a home visit or telephonically. Check the QIP-NJ Value Set Compendium to augment the following definitions with code sets used in the pay-for-performance framework of the program: • ED Visit: BH07_Nondx, ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set, ER Category. • Mental Health Diagnosis: BH04_DetailOID, Mental Illness; Mental Health Diagnosis; Intentional Self-Harm Value Sets. • SUD Diagnosis: BH03_DetailOID, AOD Abuse and Dependence Value Set.	**Option 1: Chart Audit** Pick 20 charts each month of patients who were discharged from the ED with SUD and/or MH diagnosis. Review the chart for evidence of referral to and connection with case management services within your system. **Option 2: Report from EMR** Design a report that can track the % of pts each month who have been connected to case management after referral from ED. Creating custom reports can often take time to create. Teams are encouraged to start with a chart audit and move to EMR report once able. **Note:** DOH recognizes the variation present in how case management services are deployed across different hospitals and health care settings. It is acceptable for hospitals to limit the data reported in this measure to hospital-based case management services. Hospitals with access to the necessary data can also include case management outreach success data from community organization or other external agency case management.

		• Case Management Outreach – there are no value sets in the P4P framework to reference for case management outreach.	
4	Percent of patients or families who participate in and receive the post-ED discharge care plan	**Denominator**: Patients 18 and older seen in the ED with a primary diagnosis of SUD and/or mental health disorder. **Numerator**: Patient and/or chosen family member participated in and received discharge care plan or had a documented refusal to participate in care plan discussion. Check the QIP-NJ Value Set Compendium to augment the following definitions with code sets used in the pay-for-performance framework of the program: • ED Visit: BH07_Nondx, ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set, ER Category. • Mental Health Diagnosis: BH04_DetailOID, Mental Illness; Mental Health Diagnosis; Intentional Self-Harm Value Sets. • SUD Diagnosis: BH03_DetailOID, AOD Abuse and Dependence Value Set.	**Option 1: Chart Audit** Pick 20 charts each month of patients who were discharged from the ED with SUD and/or MH diagnosis. Review the chart for evidence of participation in and receiving post ED discharge plan. **Option 2: Report from EMR** Design a report that can track the percent of patients each month who have participated in and received the post ED discharge plan. Creating custom reports can often take time to create. Teams are encouraged to start with a chart audit and move to EMR report once able. **Note**: Teams are encouraged to connect with patients and families to determine what strengths and opportunities exist in their current discharge process and improve the experience of discharge to support executing the recommended steps. Simply handing the patient a discharge summary does not constitute meaningful engagement and participation in the discharge care plan process. Hospitals are advised to create a discreet field to document in a report the percent of patients who participated in and received their discharge care plan.
5	ED Revisits	**Denominator**: Patients who had an ED discharge with a primary diagnosis of SUD and/or mental health disorder. **Numerator**: Patients who had another ED discharge with a primary diagnosis of SUD or MH in the 7 days and 30 days after the index ED admission.	Step 1: Build an ED discharge patient roster that meets the primary diagnosis definition. Step 2: Review Hospital ED Discharge EHR/Database to see patient discharge history to evaluate whether patient met criteria for having a revisit in the 7-day timeframe and then the 30-day timeframe. Step 3: Consider reviewing available health information exchange data sources to determine if your patient had a revisit at another ED.

		Check the QIP-NJ Value Set Compendium to augment the following definitions with code sets used in the pay-for-performance framework of the program: • ED Visit: BH07_Nondx, ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set, ER Category. • Mental Health Diagnosis: BH04_DetailOID, Mental Illness; Mental Health Diagnosis; Intentional Self-Harm Value Sets. • SUD Diagnosis: BH03_DetailOID, AOD Abuse and Dependence Value Set.	
6	Initiation of MAT	**Denominator**: Patients who are discharged from the ED with a primary diagnosis of Opioid Use Disorder or Alcohol Use Disorder. **Numerator**: Patients who have evidence of an MAT prescription documented in their chart at discharge from ED. Check the QIP-NJ Value Set Compendium to augment the following definitions with code sets used in the pay-for-performance framework of the program: • ED Visit: BH07_Nondx, ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set, ER Category. • SUD Diagnosis: BH03_DetailOID, AOD Abuse and Dependence Value Set. • MAT Administration: IET_DetailOID, AOD Medication Treatment, OUD Monthly Office Based Treatment, and OUD Weekly Drug Treatment Service value sets.	**Option 1: Chart Audit** Pick 20 charts each month of patients who were discharged from the ED with a primary diagnosis of SUD. Review the chart for evidence of initiation of MAT either in ED or at discharge from ED. **Option 2: Report from EMR** Design a report that can track the data outlined. Creating custom reports can often take time create. Teams are encouraged to start with a chart audit and move to EMR report once able.

		• OUD Treatment Medication List: Opioid_OID_List • AUD Treatment Medication List: Alcohol_List	
7	Patient Experience Measure	**Reporting Instructions:** This measure seeks to track whether patient experience data is being collected by your team. Teams are expected to review the results of the data collected to guide decision making in the PDSA testing of change process. For this measure, please submit the number of patient experience surveys completed or the number of engagements with patient focus groups or consumer advisory boards that took place in the reporting month. Please ensure the focus of the surveys/engagements is on the experience of the behavioral health population seen in the ED.	**Option 1:** Hospital Teams who have an existing survey process or other structure to collect patient experience data from the behavioral health population in the emergency department are encouraged to continue to use that process. Many existing patient experience data structures (ie. Press Ganey, etc.) often do not reflect a large proportion of patients from the ED, let alone the subset with behavioral health disorders. As such, teams are advised to consider their existing structure carefully and cautiously to ensure it will provide meaningful and actionable data that informs your improvement process. **Option 2:** Hospital teams that do not have adequate structures in place to collect patient experience data from patients with behavioral health disorders coming through the ED are encouraged to use the following brief survey tool. Teams are encouraged to test this screening tool on a few patients prior to a larger roll out of this tool. Teams will have to determine the appropriate personnel and timing for the administration of this survey. On a scale of 1 – 5: (1 disagree; 3 neutral; 5 agree) A. ED staff treated me with respect. B. ED staff communicated effectively with me. C. ED staff listened to my concerns. *Note: this comes from NAMI's research and analysis on factors that contributed to a Bad ED Experience.*
8	Patients in Restraints	**Denominator:** Patients with a primary diagnosis of SUD and/or mental health disorder admitted to the ED. **Numerator 1:** Total number of patients restrained per day. **Numerator 2:** Average daily duration (in minutes) of ED patients in restraints.	**Option 1: chart Audit** Pick 20 charts each month of patients who were admitted to the ED with a primary diagnosis of BH (SUD and mental health disorders). Review the charts for evidence of restraint. **Option 2: Report from EMR** Design a report that can track the data outlined. Creating custom reports can often take time create. Teams are encouraged to start with a chart audit and move to EMR report once able.

		Check the QIP-NJ Value Set Compendium to augment the following definitions with code sets used in the pay-for-performance framework of the program: • ED Visit: BH07_Nondx, ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set, ER Category. • Mental Health Diagnosis: BH04_DetailOID, Mental Illness; Mental Health Diagnosis; Intentional Self-Harm Value Sets. • SUD Diagnosis: BH03_DetailOID, AOD Abuse and Dependence Value Set.	

Optional Measures to Support Improvement

#	Name	Definition	Data Collection Guide
9	Follow-up Appointment Scheduled Prior to Discharge.	**Denominator:** Patients 18 and older with a mental health and/or SUD diagnosis seen in the ED. **Numerator:** Patients who had an appropriate follow-up visit scheduled before leaving the ED (as documented in chart). Check the QIP-NJ Value Set Compendium to augment the following definitions with code sets used in the pay-for-performance framework of the program: • ED Visit: BH07_Nondx, ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set, ER Category. • Mental Health Diagnosis: BH04_DetailOID, Mental Illness; Mental Health Diagnosis; Intentional Self-Harm Value Sets. • SUD Diagnosis: BH03_DetailOID, AOD Abuse and Dependence Value Set. • Mental Health Follow-up Visit: BH04_Nondx: Mental Health Follow-Up CPT/HCPCS Value Set. • SUD Follow-up Visit: BH03_AODTxservices.	**Option 1: Chart Audit** Pick 20 charts each month of patients who were discharged from the ED with an SUD and/or MH diagnosis. Review the chart for evidence of follow-up visit date for an appropriate follow-up visit. **Option 2: Report from EMR** Design a report that can track the percent of patients each month who have an appropriate follow-up visit scheduled prior to patient discharge. Hospitals may have to build a discreet field to capture this process step in a report. Creating custom reports can often take time to create. Teams are encouraged to start with a chart audit and move to EMR report once able. Note: this measure solely reflects ensuring the patient has a follow-up visit scheduled before leaving the ED. It does not reflect if the visit was completed. This measure should be combined with the "follow-up after emergency department visit' measures to observe success in each step of the care connection process. Teams are encouraged to determine how to best approach this measure, particularly what to do about individuals discharged after-hours who fail to respond to outreach attempts after discharge.
10	Preventative Care and Screening: Screening for Depression and Follow-Up	**Denominator**: All individuals 18 through 64 years of age who had an ED visit. **Numerator**: Individuals who received a screen for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate	**Rate 1**: Percent of patient screened. **Rate 2**: Percent of those who had a documented follow-up plan after screening positive. **Option 1: Chart Audit** Pick 20 charts each month of patients who were discharged from the ED. Review the chart for evidence that a Depression screen took place, and a follow-up plan was documented in the case of a positive screen.

		standardized tool and, if positive, a follow-up plan is documented on the date of the eligible encounter. **A documented follow-up for a positive depression screen must include one or more of the following:** • Additional evaluation for depression • Suicide Risk Assessment • Referral to practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression **Exclusions:** • An individual is not eligible if one or more of the following diagnoses (BH07_02a) are documented prior to the encounter during the measurement period, or • Individual is in hospice (BH07_02b). • Exclude individuals receiving Adult Mental Health Rehabilitation (AMHR) within the same calendar month or calendar month subsequent to the index admission (BH07_02c). **Exceptions:** Individuals with a documented reason for not screening for depression: • Individual refuses to participate (BH07_01 code G8433, Screening for depression not completed, documented reason); examples may include:	**Option 2: Report from EMR** Design a report that can track the percent of patients each month who were screened and had a follow-up plan documented in the case of a positive screen. Hospitals may have to build a discreet field to capture this process step in a report. Creating custom reports can often take time to create. Teams are encouraged to start with a chart audit and move to EMR report once able. **Note 1:** Success in the QIP-NJ pay-for-performance definition of this measure includes an assessment of both rate 1 and rate 2, thus reviewing success in both rates is recommended. However, for the purpose of this Collaborative, teams may benefit from an initial focus on rate 2, ensuring they have standard processes in place to form an appropriate follow-up plan in the event a patient screens positive.

		○ Individual is in an emergent situation where time is of the essence and to delay treatment would jeopardize the individual's health status; ○ The individual's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium. Check the QIP-NJ Value Set Compendium to augment the following definitions with code sets used in the pay-for-performance framework of the program: • ED Visit: BH07_Nondx, ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set, ER Category. • Screen for Depression: BH07_01 • Exclusionary diagnoses: BH07_02a • Hospice: BH07_02b • AMHR: BH07_02c • Depression Screen Status: BH07_01 • Acceptable Depression Screens: BH07_03	
11	Substance Use Screening and Intervention Composite	**Denominator**: All individuals 18 through 64 years of age who had an ED visit. **Numerator**: Individuals who received a valid substance use screening at least once within the last 12 months AND who received at least one intervention for all positive screening results.	**Rate 1**: Percent of patient screened. **Rate 2**: Percent of those who received an intervention after screening positive. **Option 1: Chart Audit** Pick 20 charts each month of patients who were discharged from the ED. Review the chart for evidence that an appropriate screen took place, and an intervention was documented in the case of a positive screen. **Option 2: Report from EMR**

		Exclusions: • Documentation of medical reason(s) for not screening (BH08_01: Medical Reasons for Not Screening) • Use of opioids for chronic pain management (Medical notation that a pain contract agreement exists in the patient record; further detail may be accessed at: https://njafp.org/new-prescribing-law/ • Limited life expectancy or hospice (BH08_01: Codes for Hospice) • ED visits that result in an observation stay (BH08_01: Additional CPT Codes (Observation)) **Tobacco use component:** Individuals who were screened for tobacco use at least once within the last 12 months AND who received tobacco cessation intervention if identified as a tobacco user. **Unhealthy alcohol use component:** Individuals who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user. **Drug use component** (nonmedical prescription drug use and illicit drug use): Individuals who were screened for nonmedical prescription drug use and illicit	Design a report that can track the percent of patients each month who were screened and received an intervention in the case of a positive screen. Hospitals may have to build a discreet field to capture this process step in a report. Creating custom reports can often take time to create. Teams are encouraged to start with a chart audit and move to EMR report once able. **Note 1:** Success in the QIP-NJ pay-for-performance definition of this measure includes an assessment of both rate 1 and rate 2, thus reviewing success in both rates is recommended. However, for the purpose of this Collaborative, teams may benefit from an initial focus on rate 2, ensuring they have standard processes in place to perform an intervention in the event a patient screens positive.

		drug use at least once within the last 12 months using a systematic screening method AND who received brief counseling if identified as a nonmedical prescription drug user or illicit drug user. Acceptable screening tools are listed below by individual component and inclusive of the three components (if applicable): <u>Tobacco use component:</u> Fagerstrom Test for Nicotine Dependence (FND) <u>Unhealthy alcohol use component:</u> CAGE Questionnaire for Detecting Alcoholism The Alcohol Use Disorders Identification Test (AUDIT) The Alcohol Use Disorders Identification Test-Concise (AUDIT-C) <u>Drug use component:</u> CAGE-AID Substance Abuse Screening Tool DAST-10 Prescription and Illicit Drug Use Screening Inclusive (tobacco use, unhealthy alcohol use and drug use): NIDA Quick Screen NIDA Drug Use Screening Tool (NMASSIST) Check the QIP-NJ Value Set Compendium to augment the following definitions with code sets used in the pay-for-performance framework of the program: • ED Visit: BH07_Nondx, ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set, ER Category. • Interventions: BH08_Nondx	