Quality Improvement Program – New Jersey (QIP-NJ)
Behavioral Health (BH) Learning Collaborative Information Session #2

Thursday, July 15, 2021 from 11am-12pm

Introduction

The NJ Department of Health (DOH) has produced this Question and Answer (Q&A) document as a follow-up to the *QIP-NJ BH Learning Collaborative Information Session webinar*, held on Thursday, July 15, 2021 from 11:00 am to 12:00 pm EST. The webinar's recording and presentation slides have also been made available on the QIP-NJ Resources webpage.

The first portion of this Q&A document contains responses to questions asked during the live webinar. In developing these responses, duplicative questions were removed, and, where appropriate, remaining questions were grouped and slightly modified for clarity. If any webinar participants notice that a question asked during the presentation has not been addressed or was addressed inadequately, please reach out to program administrators at QIP-NJ@pcgus.com.

The second portion of this Q&A document summarizes strategies that various hospitals and/or health systems shared during the live webinar that they are already implementing to improve connections to care for the BH population that are related to DOH's primary drivers from the Key Driver Diagram. Please note that DOH combined and consolidated responses, if/as appropriate, for purposes of grouping similar strategies.

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Questions:

1. **In the Collaborative Charter, there is a list of suggested team roles. Do participating teams need to have enough people to fill each of those roles?**

   No. DOH and the Collaborative leadership team have put out recommendations for what an effective team might look like in terms of composition; however, each hospital should assess their own personnel and resourcing to determine how many individuals should be on each team and what roles those team members will fulfill. Ideally, hospitals should strive to have enough individuals on their teams to fulfill all responsibilities we have outlined. The Prework handbook that you will receive after turning in your *Participation Interest Form* will provide additional details and recommendations on this.

2. **How will participation look different for an independent hospital versus a hospital that is part of a health system?**

   Participation may vary depending on each hospital and/or health system. For example, relative to forming a team, hospitals that are part of a system in which other hospitals from the system are also participating in the Collaborative may have some team members from the health system corporate/central office who help support aspects of population health or quality improvement. If this is the case, DOH recommends that each hospital forms a local team with individuals from the care team at each participating hospital so that this local team can tackle the unique challenges to their environment while benefiting from the support from the health system central office/team members at the system level.

   Similarly, another example relates to one–on-one (1:1) coaching support. Hospitals that are part of a health system will have the option of scheduling their 1:1 coaching sessions with all hospitals from their health system in a longer format session if that would benefit them. If hospitals desire to take this approach, DOH would recommend internal coordination with all health system team members.

3. **Is it more beneficial to have the project lead and clinical champion be two separate individuals or one person serving both roles?**

   A. It depends. To help hospitals make decisions in this space, DOH has updated the *Participation Interest Form* and the *Charter* to provide more clarity. Please note that the roles described in the *Charter* are intended to be recommendations, and each hospital will have to evaluate their own personnel and resourcing (e.g., how much time a clinical care team member will be able to contribute) to determine how many individuals will join their Collaborative team. For example, an individual with full-time clinical duties and no protected time to participate in quality improvement work may not have sufficient time to execute the administrative functions of managing the Collaborative team as the team leader even if they can attend all team meetings and Collaborative events. Hospitals requiring additional guidance and/or assistance with forming the most effective team for their environment and/or particular needs may sign-up for a coaching session with the Collaborative faculty.

4. **Where can hospitals find the Prework Handbook?**

A. The Prework Handbook will sent to each team leader after DOH receives the *Participation Interest Form*.

5. **Is the letter of support that a hospital leader/executive needs to sign part of the *Participation Interest Form* or something that needs to be drafted separately?**

   A. The signed letter of support must be submitted with a hospital's signed and completed *Participation Interest Form*. DOH has pre-drafted a letter of support template, which is included in the *Participation Interest Form* as an appendix and may be used by hospitals. Alternatively, hospital executive leaders may draft their own letter of support if desired.

6. **Can the Benefit Kitchen application be considered an acceptable social determinants of health (SDOH) screening tool for QIP-NJ? The advantage is that the tool recommends the programs that the patient can benefit from.**

   A. The QIP-NJ Measurement Specifications and Submission Guidelines (Databook) v1.1, updated on July 1, 2021, describes the screening tools that are currently approved to meet the measure criteria for *BH11: Use of a Standardized Screening Tool for Social Determinants of Health* and *M9: Use of a Standardized Screening Tool for Social Determinants of Health*. At this time, the Benefit Kitchen application is not listed as an SDOH screening tool; however, tools other than those listed may be used with the explicit review and approval of NJ DOH. To request review and approval for a tool not listed in the Databook, hospitals should email qip-nj@pcgus.com as soon as possible.

Current Strategies Reported by Hospitals and/or Health Systems:

Number of Hospitals / Health Systems Reporting Use	Identified Strategy(ies)
7	Implementing standard, evidence-based processes in the emergency department (ED), including screening, admission, transfer, discharge, and follow-up (such as person-centered care plans, case management, family engagement, peer support, etc.).
6	Utilizing an Evidence-based Practices (EBP) screening and early-intervention/prevention tools, as well standard, validated scales with interdisciplinary review.
3	Identifying owners/champions for each clinical/quality measure, sharing best practices, and learning from the real-life experiences of colleagues.
3	Implementing enhanced coordination and collaboration efforts relative to trauma-informed care, inclusive of additional staff training.
2	Utilizing motivational interviewing.
2	Utilizing early preventative approaches in the community, inclusive of forging partnerships for BH, addiction and dual diagnosis care.

1	Virtual sharing of crisis services (personnel) across hospital systems to manage surges at various locations.
1	Creating a dashboard for oversight and accountability.
1	Developing a key matrix to assess performance on measures to guide clinical interventions and next steps on implementation.
1	Utilization of health information systems and data to identify opportunities and drive improvements.
1	Utilizing committees and/or subcommittees to help drive change.
1	Taking into consideration SDOH needs of patients.
1	Setting benchmarks for improvement.
1	Promoting harm reduction and use of non-biased language.
1	Implementing a dedicated opioid task force.