Quality Improvement Program – New Jersey (QIP-NJ)
Behavioral Health (BH) Learning Collaborative Information Session #1

Friday, May 14, 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 Friday, May 14, 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.

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 information provided in this Q&A document as well as all May 14, 2021 QIP-NJ BH Learning Collaborative (hereto forward, referred to as the "Collaborative") Information Session materials reflect the proposed Collaborative design and are subject to change pending official Centers for Medicare and Medicaid Services (CMS) approval of QIP-NJ.

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Program Focus/Parameters:

1. **Given the fact that the primary outcome measure (30-day appointment) depends on the resources in our area, is there any way to incentivize collaboration between hospital systems and community providers?**

    A. Although the Collaborative is focused on hospitals, participating hospital improvement teams are encouraged and welcome to invite community partners/providers to join their teams to participate in the training and peer network offered through the Collaborative.

    While hospitals are ultimately responsible for meeting or exceeding QIP-NJ performance targets, DOH recognizes that, in many cases, success in QIP-NJ will likely require hospitals to develop relationships and referral networks with community partners/providers. As a result, although DOH will not require or provide direction as to what business and/or contractual arrangements hospitals may wish to enter into with community providers relative to QIP-NJ, DOH does encourage hospitals to develop robust and meaningful connections to care with community-based partners/providers, inclusive of effective follow-up strategies to ensure patients return for appointments in community-based settings, as it is expected that this will help foster increased quality of care for all individuals.

2. **Is it a 30-day follow-up appointment or appointment kept?**

    A. For purposes of QIP-NJ, the BH3, i.e., *Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) (30 day)* and BH4 quality measures, i.e., *Follow-Up After ED Visit for Mental Illness (FUM) (30 day),* are seeking improvement in the percent of individuals who appear for their 30-day follow-up appointments.

3. **Since the focus of the Collaborative is the Emergency Department (ED) but QIP-NJ focuses more broadly on BH services, does QIP-NJ include inpatient and outpatient services in the measures?**

    A. Yes, QIP-NJ attributes individuals to hospitals for performance measurement based on services provided in the ED, inpatient, and outpatient settings. Similarly, the pay-for-performance (P4P) measures in QIP-NJ include individuals seen in the ED, inpatient and outpatient settings. The attribution algorithm and the specific settings of care for which each measure evaluates a hospital's performance are available on the DOH website and outlined in the *Measurement Specifications and Submission Guidelines (Databook) v1.0*.

    The Collaborative will target hospital EDs as a priority setting to test changes for improvements in care processes and outcomes for the Medicaid BH population. The Collaborative is designed to provide additional training and resources to hospital EDs to improve the percent of individuals completing a follow-up visit within 30 days of an ED discharge. The Collaborative purposefully focuses on this targeted outcome within QIP-NJ to help hospitals make the most impact on a targeted outcome in a short period of time (12-15 months). Additional Collaboratives may be planned to help hospitals address other QIP-NJ population health goals in settings beyond the ED.

Data and Measurement:

4. **Are there metrics to determine the "capacity" of community providers to accept individuals from the ED in the 30-day time frame?**

    A. One of the Collaborative's focus areas will be to help hospitals establish effective relationships with community providers. Part of that work will include assessing capacity and other characteristics of the providers in your geographic area. Addressing capacity issues may not appear in the form of a Collaborative measure requiring monthly data collection but may instead be addressed through other training and assessment mechanisms. In addition, as noted in a prior response, DOH encourages hospitals to develop robust and meaningful connections to care with community-based partners/providers, which can be used to assess and address capacity issues and help foster increased quality of care for all individuals.

5. **Will your team be available to assist with questions about the QIP-NJ BH P4P measures?**

    A. Yes, DOH is always available to answer any questions about any aspect of QIP-NJ. You can contact the QIP-NJ team by sending an email to QIP-NJ@pcgus.com. Additionally, DOH is hosting a webinar on May 25, 2021 from 3:00 to 4:30 pm EST to review the *Databook v1.0.* More information regarding this webinar is available on the DOH website. *Over the coming months,* DOH will also be releasing a series of pre-recorded webinars on each chart-based measure to provide additional technical assistance for hospitals interpreting the measure specifications, which will also be available on the DOH website.

6. **Where can I learn more about the data definitions used for the Collaborative and QIP-NJ P4P measures?**

    A. The basic definition for most of the proposed Collaborative measures are currently included in the Collaborative *Change Package*. To date, DOH has engaged three organizations to perform feasibility testing on the proposed Collaborative measures. The list of final measures with detailed definitions will be released after the feasibility testing process is complete. Detailed definitions for the QIP-NJ P4P measures are currently available in the *Databook v1.0*.

7. **Is there a standardized form/template for data submission? What is the sample size required for participation or is it for all individuals within a specified period?**

    A. To date, and as noted in a prior question, DOH has engaged three organizations to perform feasibility testing on the proposed Collaborative measures. The data submission templates and instructions will be released after the feasibility testing process is complete. Unlike the P4P reporting process for QIP-NJ that will include two modes for submission, i.e., using a template developed by DOH to manually enter data, or a flat file submission, the Collaborative's data collection process may be slightly different for each hospital team depending on their resources and the type of EHR or other data platforms in use. The Collaborative faculty will work with each hospital team to develop an effective strategy to collect data based on the forthcoming Collaborative measurement guidance documents, which will be distributed to Collaborative hospital improvement teams as well as posted to the DOH website.

8. **Will hospitals be getting Medicaid Management Information System (MMIS) data more often than once at the end of each measurement year (MY) so they can review individual performance and implement improvements in practice to meet performance targets?**

    A. DOH will provide hospitals with their MMIS measure performance once at the end of each MY. The Collaborative will help hospitals find alternative data sources to monitor process improvements related to the Collaborative primary outcome of increasing the percent of individuals with BH diagnoses (mental health or substance use disorder) who complete a follow-up visit within 30 days of an ED discharge. For other QIP-NJ P4P measures, hospitals can use their historic attribution to run their own reports based upon their unique populations, and DOH will be providing technical assistance and other tools to assist and empower hospitals to set up processes to internally track their own progress towards QIP-NJ performance targets.

Funding:

9. **How can hospitals determine the funds that are potentially available for successful participation and improvement?**

    A. Hospitals will receive their baseline attribution lists by the program start date, i.e., July 1, 2021. At that time, DOH will also share the total attribution for all hospitals participating in QIP-NJ. Taken together, hospitals may be able to project their potential funding based on this baseline attribution information.

Follow-up Services:

10. **In a general sense, will QIP-NJ recognize Licensed Clinical Social Worker (LCSW) services for follow-up?**

    A. QIP-NJ's P4P measures assess performance for services provided. For purposes of QIP-NJ, the BH3, i.e., *Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) (30 day)* and BH4, i.e., *Follow-Up After ED Visit for Mental Illness (FUM) (30 day) quality* measures, the criteria for numerator compliance is based on a set of follow-up visit codes, accessible in the *Databoo) v1.0* and associated Value Set Compendium (VSC). The Databook and VSC should not be construed as billing guidance. For guidance on billing for services provided by LCSWs, providers should consult the NJ Provider Manual, which is available online on the Division of Mental Health and Addiction Services (DMHAS)'s website.

11. **How do we know if a patient followed through with services in community once they left ED? Is this through billing data?**

    A. As noted elsewhere in this document, Hospitals are ultimately responsible for meeting or exceeding QIP-NJ performance targets. As a result, where individuals are referred to community partners/providers for follow-up care, there must be a final, adjudicated Medicaid claim to confirm delivery of the service for inclusion in the P4P performance calculation (e.g., BH quality measures BH2, BH3, BH4, BH5 & BH6). As noted elsewhere in this document, for purposes of the Collaborative measurement strategy, hospitals will receive guidance on finding alternative data sources to monitor improvements related to the Collaborative primary outcome of increasing the percent of individuals with BH diagnoses (mental health or substance use disorder) who complete a follow-up visit within 30 days of an ED discharge.

Participation:

1. How many individuals per hospital can join the Collaborative?

A. There is no limit on the number of individuals per hospital that can join their hospital's improvement team as part of the Collaborative. As hospitals decide to participate, Collaborative faculty will coach each team to form an effective team. DOH encourages hospitals to form an interprofessional team, which includes clinical and non-clinical staff, community providers, and patient or chosen family representatives.