

Behavioral Health (BH) Learning Collaborative Charter

Quality Improvement Program – New Jersey
(QIP-NJ)

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The contents of this Charter are for New Jersey (NJ) acute care hospitals participating in QIP-NJ.
The Charter provides the rationale and program details of the BH Learning Collaborative.



PUBLIC
CONSULTING GROUP



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OVERVIEW

WHAT IS QIP-NJ?

NJ State Leadership & Policy Initiatives

NJ State leaders, inclusive of the Murphy Administration, have prioritized addressing the opioid epidemic and unmet demand for services for individuals with BH diagnoses (inclusive of mental health (MH) or substance use disorder (SUD) diagnoses). In 2019, the State passed legislation requiring health insurers to provide coverage for MH and SUD conditions in parity with other illnesses, thus meeting the requirements of the 2008 Mental Health Parity and Addiction Equity Act.ⁱ

During the 2019 Novel Coronavirus (COVID-19) pandemic, access to BH services increased and expanded through telehealth modalities, enabling access to MH and SUD treatment for those unable to travel to a treatment center. ⁱⁱ The State has also pledged \$50 million from its coronavirus relief fund for BH treatment funding and has set up numerous additional pathways for MH and SUD screening, including regional crisis stabilization and SUD counseling hotlines, a website, and primary screening services available in each county. ^{iii,iv,v}

The State has also outlined numerous strategies to counteract the opioid crisis, including increasing access to evidence-based prevention and treatment programs in communities, supporting individuals in their recovery, building a *Prescription Drug Monitoring Database* and *Opioid Data Dashboard*, strengthening infrastructure for the addictions community, and aiding law enforcement to stem the supply of illicit drugs into communities. ^{vi} To assist in funding approaches to these strategies, the State will use funds from various sources including the Centers for Disease Control and Prevention’s Overdose Data to Action (OD2A) grant, which has the stated goal of integrating higher quality data collection and surveillance in opioid usage reduction efforts. ^{vii} The OD2A grant has already led to additional investments in harm reduction centers, which served more than 2,500 individuals in 2020 alone, and in trauma-informed care education programs and emergency medical services (EMS) linkages to care for non-fatal opioid overdoses. ^{viii} The State also removed prior authorization requirements for Medication Assisted Treatment (MAT), invested in training for community providers, created Medicaid incentives to encourage more primary care

providers to offer MAT and funded two Centers of Excellence for opioid treatment to provide expertise and support to community providers establishing Office Based Addiction Therapy (OBAT) clinics.^{ix}

Subject to federal approval from the Centers for Medicare and Medicaid Services and effective July 1, 2021, the Department of Health (DOH) will also implement QIP-NJ to further support the State's focus on improving BH care by allocating funds to hospitals who improve their performance serving Medicaid Managed Care enrolled individuals who have a BH diagnosis. The QIP-NJ BH Learning Collaborative (hereto forward referred to as the "Collaborative") is designed to support hospitals working to achieve QIP-NJ's improvement goals.^x

QIP-NJ

QIP-NJ will be administered by DOH in partnership with the Department of Human Services (DHS) as a Medicaid pay-for-performance initiative open to all acute care hospitals in the state. The focus of QIP-NJ is to advance statewide improvement in maternal health and BH. To encourage service delivery improvement, hospitals will earn QIP-NJ incentive payments by achieving performance targets on maternal health and BH quality measures.^{xi} Designed as a multi-year initiative, QIP-NJ is scheduled to start July 1, 2021, with a BH-focused Learning Collaborative scheduled to begin in September 2021, and a maternal health Learning Collaborative projected to begin in the summer of 2022.

The remainder of this Charter describes the State's scheduled BH Learning Collaborative.

WHAT IS THE QIP-NJ BH LEARNING COLLABORATIVE?

To support hospitals in their effort to improve, DOH, in partnership with PCG, has designed a data-driven Collaborative. The Collaborative is based on a proven model from the Institute for Healthcare Improvement, called the Breakthrough Series (BTS) Collaborative. Success within QIP-NJ will require a multi-faceted approach involving the entire system of BH care; accordingly, the Collaborative will target hospital emergency department (EDs) as a priority setting to test changes for improvements in care processes and outcomes for the Medicaid BH population.

The primary focus of the Collaborative is to increase follow-up visits for individuals with BH (MH or SUD) diagnoses within 30 days of ED discharge. The Collaborative is explained in detail in Parts 3-8 of this Charter.

THE OPPORTUNITY TO IMPROVE CARE IN NJ (PROBLEM STATEMENT)^{xii}

ED Admissions for BH

Individuals with BH diagnoses and related health care needs, which is inclusive of both MH and/or SUD, often present to the ED to access care, yet many EDs are not equipped or designed to adequately support these individuals, especially during times of high volume. Individuals with a primary or secondary MH or SUD diagnosis account for a significant percentage of all ED discharges in NJ. In 2019, 13.1% of all discharges in NJ EDs were individuals with a confirmed primary or secondary MH diagnosis.^{xiii} In the same year, only 4% of ED patients discharged from the ED with a primary or secondary MH diagnosis were transferred to a psychiatric hospital or psychiatric distinct part of a hospital for inpatient treatment.^{xiv} Despite the low relative percentage of inpatient admissions out of the total percent of individuals presenting to the ED with confirmed primary or secondary mental health diagnoses, clinicians across the state note difficulty in finding these individuals a bed in a timely manner.^{xv,xvi} Prompt intervention can reduce the need for inpatient admissions and resolve many psychiatric emergencies in less than 24 hours.^{xvii} Individuals who do get admitted often experience lengthy stays or “boarding times” in the ED itself, straining both ED resources as well as staff.

Impact of the Opioid Crisis

The NJ opioid crisis presents another opportunity for EDs to initiate treatment for individuals with SUD diagnoses and set them on an appropriate follow-up care pathway. In 2019, 4.8% of all ED discharges were for individuals with a confirmed primary or secondary SUD diagnosis.^{xviii} The opioid overdose rate in NJ has sharply and steadily risen year over year and surpassed the national average. Between 2008 and 2018, the opioid overdose death rate in the United States increased from 6.4 deaths to 14.6 deaths per 100,000 individuals. Over the same time frame, the opioid overdose death rate in NJ increased from 3.8 deaths to 29.7 deaths per 100,000 individuals, almost doubling the national average.^{xix} In 2018, NJ had the fifth highest opioid overdose death rate and eighth highest drug overdose death rate in the country.^{xx} As a result of the COVID-19 pandemic, admissions to SUD treatment programs have decreased.^{xxi} The number of overdose deaths in 2020 was 3,046, which continues the upward trend in the state over the last five years.^{xxii,xxiii} In 2019, over 8,000 ED discharges in NJ had a primary or secondary diagnosis of a confirmed opioid or stimulant overdose.^{xxiv} Even prior to the COVID-19 pandemic, NJ struggled to meet the level of need for SUD treatment, as the level of unmet demand^{xxv} averaged over 40% in all NJ counties.^{xxvi} Situations where there is a lack of community providers needed to service patient demand result in additional patients seeking care at EDs and thus a greater opportunity for EDs to begin treatment for SUD patients. Additionally, EDs are often not aware of all the available providers in their community and both EDs and community providers can struggle to establish and maintain effective partnerships.

Trauma-Informed Care Processes and Community Connections

Initiating evidence-based, patient-centered, and trauma-informed care processes, in addition to establishing effective relationships with community providers, are essential steps EDs can take to better serve the state’s individuals with BH diagnoses. The New Jersey Division of Mental Health & Addiction Services (DMHAS) estimates that 43% to 81% of individuals in psychiatric hospitals and up to two thirds of individuals in SUD treatment have experienced trauma.^{xxvii} Providing trauma-informed care can improve assessment, treatment and disposition decision processes and reduce aggressive behavior of individuals receiving services toward staff.^{xxviii} Connecting individuals to community providers on an appropriate care pathway at discharge can help reduce the volume of patients experiencing BH challenges presenting to the ED environment.

Medicaid data from 2019 show that only 25% of Medicaid enrolled individuals with alcohol or other drug use/dependence completed a follow-up visit within 30 days of an ED discharge.^{xxix} While the rate of follow-up visits following an ED discharge among Medicaid enrolled individuals with a MH diagnosis was better at 71.74%, there remains an opportunity to improve connecting patients to ongoing care.^{xxx}

Why a Collaborative for the ED?

EDs across NJ provide essential services for individuals with BH diagnoses and should serve as an additional setting to identify these diagnoses, initiate treatment in a trauma-informed environment, and establish a connection to clinically appropriate and ongoing care in the community. Patients experiencing SUD or MH-related challenges often have multiple comorbidities and can feel stigmatized and a distrust of care teams. Serving the BH population is a complex and resource-intensive challenge for many ED care teams. Evidence-based practices exist to implement improved and efficient ED workflows, build patient trust, and effectively collaborate with community providers. These strategies can help ED teams connect patients to appropriate care pathways, increase feelings of staff safety serving this population, and work to reduce lengths of stay and patient volumes in EDs.^{xxxi}

AIM

DOH has established statewide targets for improving connections to care for individuals with BH related discharges from the ED. These statewide targets set the benchmarks for how participating hospitals will earn funding through a gap-to-goal methodology each year throughout QIP-NJ.^{xxxii}

The statewide targets related to the Collaborative goal are as follows:

QIP-NJ Measure ID#	Measure Title	Statewide Target
BH03	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) (30 day), Based on National Quality Forum (NQF) #3488	25%
BH04	Follow-Up After ED Visit for Mental Illness (FUM) (30 day), Based on NQF #3489	75%

The Collaborative aims to increase follow-up visits for patients with MH or SUD diagnoses within 30 days of ED discharge to meet the statewide targets by September 2022^{xxxiii}, by:

- ▶ Formulating standard and evidence-based ED processes including appropriate treatment, disposition and aftercare plans;
- ▶ Building effective partnerships with community providers and organizations;
- ▶ Adopting trauma-informed care processes; and
- ▶ Engaging patients and their chosen families in care planning and decision-making.

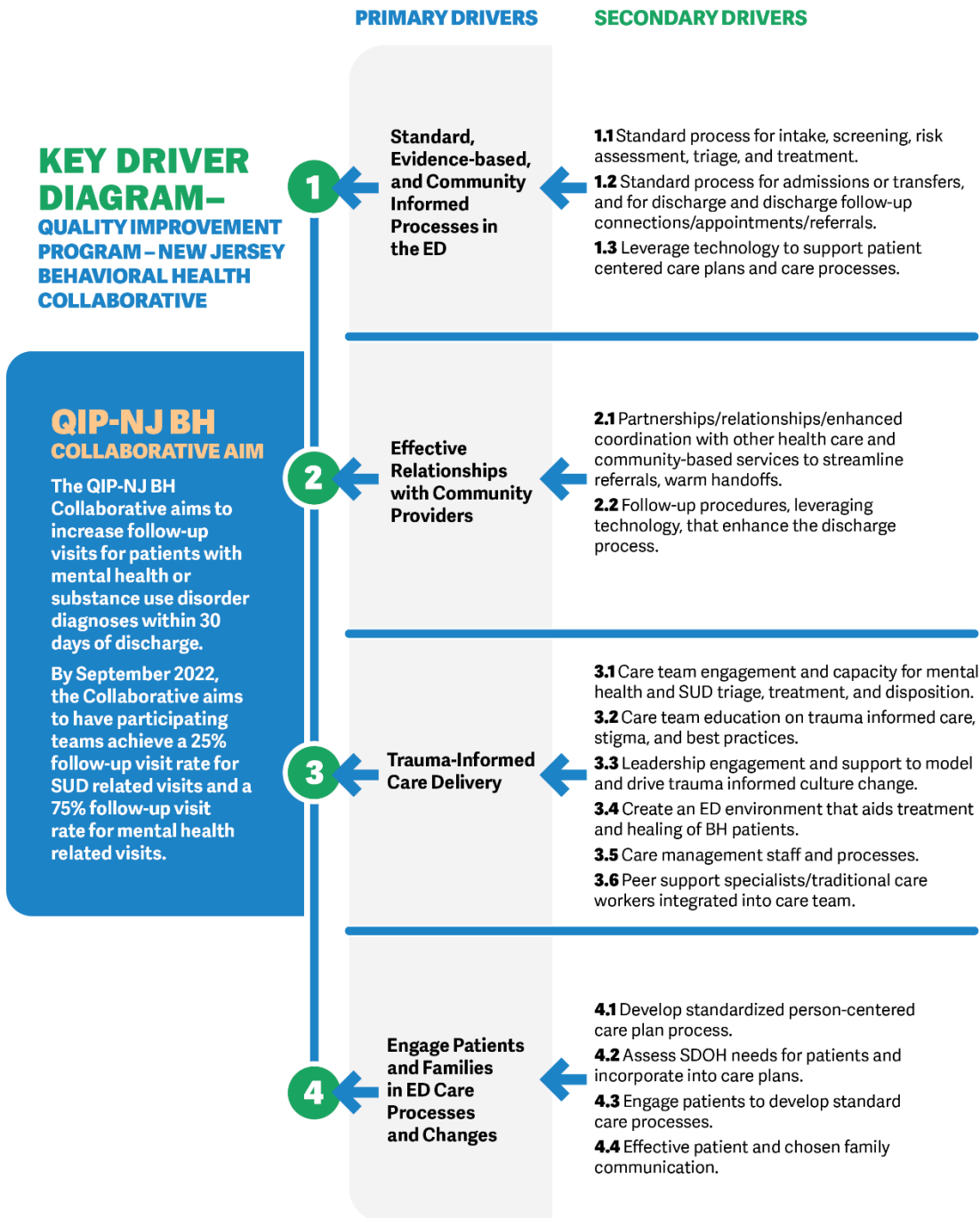
MEASURES

The following measures are under consideration for inclusion in the Collaborative. These measures are currently undergoing feasibility testing to inform a final list of selected measures. Teams will not be expected to collect data on more than eight measures each month. More details on the measures below can be found in the Collaborative *Change Package*.

MEASURE NAME	Type of measure
Measures Reported Monthly	
Preventative Care and Screening: Screening for Depression and Follow-Up	Process
Substance Use Screening and Intervention Composite	Process
Percent of patients with a follow-up visits scheduled before ED discharge	Process
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (30 day)	Outcome
Follow-Up After ED Visit for Mental Illness (30 day)	Outcome
Patient Experience Surveys Completed	Process
Percent of patients or families who participate in and receive the post-ED discharge care plan	Process
ED revisits among patients with primary BH diagnosis for another BH issue	Outcome
ED length of stay for patients with BH diagnosis	Outcome
ED disposition decision to discharge time	Outcome
Average daily duration of ED patients in restraints	Outcome
Initiation of Medications for patients with SUD	Process
Measures to be Reported During Quarterly Self Assessments	
An array of the secondary drivers	
Trauma Informed Trainings Completed or Practices Adopted	Process
Assessments completed of care team trauma informed knowledge, experience, and attitude	Process
Patient Advisory Board Meetings Completed	Process
Equity by race analysis	Outcome

IMPROVEMENT FRAMEWORK

The driver diagram below depicts the primary drivers of change that will form the focus of the Collaborative. More details on the drivers and specific change ideas can be found in the Collaborative *Change Package*.



BENEFITS AND ELIGIBILITY

WHY PARTICIPATE IN THE COLLABORATIVE?

- ▶ Support to meet performance targets on some QIP-NJ pay-for-performance measures;
- ▶ Personalized coaching for frontline care team and hospital leadership from State and National clinical and improvement experts in the field;
- ▶ Increased quality improvement capacity across team members;
- ▶ Access to a peer learning network; and
- ▶ Continuing professional education credits.

WHO IS ELIGIBLE TO PARTICIPATE?

DOH strongly encourages NJ acute care hospitals to participate in the Collaborative, which DOH believes will assist participating hospitals with achieving performance targets, sharing knowledge and best practices across hospitals to drive systemic changes, and supporting overall improvement in BH outcomes for the State's Medicaid population. Hospitals interested in participating in the Collaborative must complete a *Participation Interest Form* by end of day on July 23rd, 2021. The *Form* can be found at <https://qip-nj.nj.gov/lc.html>

All interested hospitals will be considered for participation. Questions and requests for additional information may be sent to: qip-nj@pcqus.com.

DESIGN

THE COLLABORATIVE SCHEDULE

Information Session #1	May 14, 2021
Information Session #2	July 15, 2021
Submit Participation Interest Form	July 23, 2021
Pre-Work and 1:1 coaching	July-September 2021
Learning Session #1	September 2021 (Exact date TBA)
Action Period #1 and one-on-one (1:1) coaching	September 2021 - January 2022
Learning Session #2	January 2022 (Exact date TBA)
Action Period #2 and 1:1 coaching	January - June 2022
Learning Session #3	June 2022 (Exact date TBA)
Action Period #3 and 1:1 coaching	June - September 2022

OVERVIEW

To support hospitals' success in meeting program performance targets on quality measures, DOH, in partnership with PCG, is sponsoring the Collaborative. The aim of the Collaborative is to increase follow-up visits for people with BH (SUD or MH) diagnoses within 30 days of

discharge from the ED. The Collaborative will run from September 2021 to September 2022 and will be based on BTS model^{xxxiv}. Key characteristics of the Collaborative will include:

- ▶ Voluntary participation by health systems and project teams.
- ▶ Peer-to-peer learning (“all teach, all learn”).
- ▶ Real time data collection, regular data review and reporting.
- ▶ Implementation of rapid cycle, small tests of change through Plan, Do, Study, Act (PDSA) cycles.
- ▶ Personalized coaching from improvement advisors.

The Collaborative will focus on hospital EDs as a priority setting to test changes for improvements in BH care processes and outcomes for the State’s Medicaid BH population. An Expert Panel was convened by DOH and partners to develop a quality improvement toolkit, a resource for participating ED teams referred to as the *Change Package*.^{xxxv} The *Change Package* is a set of evidence-based strategies to be tested, adapted and implemented locally by each participating ED.

DESIGN

The BTS model/design relies on iterative cycles of testing and implementing changes and will include a variety of supports, described below:

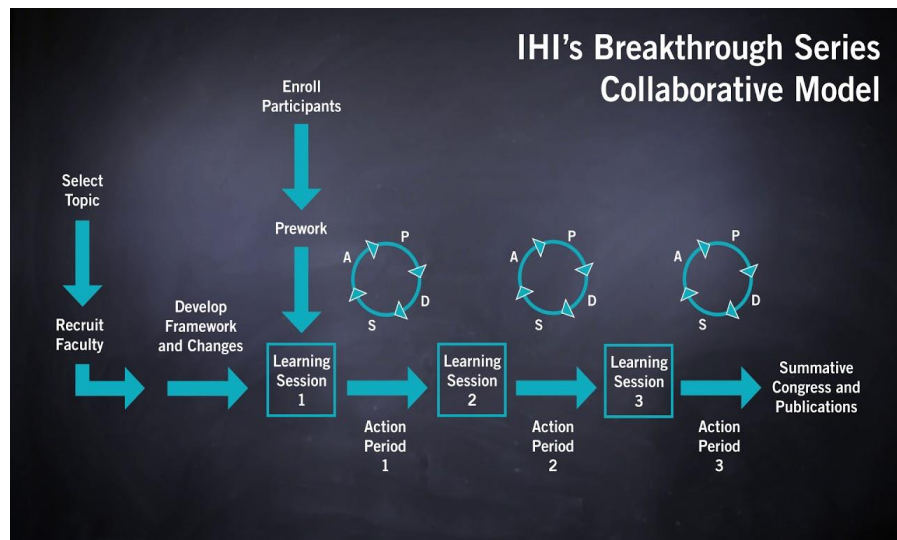


Figure 1. A visual representation of the IHI’s BTS Collaborative model.

Learning Sessions:

There will be three Learning Sessions throughout the course of the Collaborative. In light of Covid-19, Learning Sessions will be scheduled as two half-day virtual encounters, subject to change. Teams will gain new knowledge from State and National experts on clinical practices, building community partnerships, adopting trauma-informed approaches and engaging patients and their chosen care givers in care planning and improvement. Learnings Session s will also include engagement activities where teams can work together to apply their new knowledge and build action plans for improvement while interacting with expert faculty. The Collaborative will also feature special sessions to support ED leadership in their effort to advance their team’s

improvement work. Learning Sessions will consist of plenary presentations, workshops, storyboard rounding or presentations, and team development sessions.

Action Periods:

Between Learning Sessions, teams in the Collaborative will enter an Action Period. During Action Periods, teams test changes in practice and discover how to apply or adapt best practices to their local environment with support. Action Periods consist of the following support structures:

- ▶ 1:1 Onboarding Coaching: Improvement advisors will work with each team to prepare them for successful participation in the Collaborative.
- ▶ Monthly Data Reporting: The Collaborative leadership team will provide data collection guidance and templates.
- ▶ Ongoing Coaching: Hospital teams will participate in facilitated coaching sessions with peers and receive 1:1 support from improvement advisors on a variety of key topics related to the Collaborative aim. Participating teams will be expected to participate by presenting their successes or challenges and/or providing advice and feedback to other teams. The data collected each month from all teams will be anonymized and used during these coaching sessions to guide discussion.
- ▶ Listserv for peer collaboration: Participating teams will gain access to a participant Listserv to allow continuous communication among peers and program faculty.

EXPECTATIONS OF PARTICIPATION

WHAT IS EXPECTED FROM PARTICIPANTS?

To support teams getting the most out of their participation, each hospital ED electing to participate in the Collaborative is asked to:

1. Form an interprofessional project team which would ideally include the following members:
 - Executive leader who will facilitate implementation of key system and cultural changes and help teams overcome administrative barriers (e.g. ED Chair, Medical Director, Chief Quality Officer (CQO) or Senior Vice President (SVP) of Quality);
 - Clinical champion and other clinical and administrative care team members;
 - Quality Improvement lead;
 - Information technology (IT) champion to configure and pull data from the electronic health record (EHR) system;
 - Representatives from staff who support care in the ED for BH and SUD patients;
 - Representatives from key community-based organizations (CBOs) who support care for BH patients after discharge;
 - Representatives from other CBOs who can support effective transitions to community bed services or other social supports;
 - Patient and chosen family representatives.
2. Commit to improvement project team member participation in Collaborative learning events and activities and contribution to shared learning. Members of the improvement project team will work over the course of the 12-month Collaborative to test, adapt and implement strategies for behavioral health care process improvement.
 - Events will include, at minimum, Learning Sessions 1-3 and a monthly coaching session during Action Periods.
 - Testing changes in practice to adopt best practices.
3. Share key information back to other stakeholders within their team, hospital, or larger hospital system, including leadership, so that improvements can be fully implemented, sustained, and spread.
4. Collect data and submit structured data reports to the Collaborative leadership monthly.

WHAT IS EXPECTED OF THE COLLABORATIVE LEADERSHIP TEAM?

To create an impactful, effective, and satisfying program for hospital teams, the Collaborative Leadership team from DOH and PCG will be expected to:

1. Create an engaging curriculum with access to experts in the field;
2. Provide training that enables teams to implement improvements towards the Collaborative's primary goal;
3. Provide one-on-one and group coaching to teams to help teams overcome individual challenges during the implementation process;
4. Disseminate best practices and effective strategies across the peer network based on the implementation experience of participating teams;
5. Connect hospital teams to applicable state resources or aligned programs aiming to make improvements related to the Collaborative aim;
6. Use the lessons learned from the Collaborative to impact future policy decisions; and
7. Provide excellent participant support with timely replies to any question or issue communicated to us by a participating team.

- ⁱ State of New Jersey. “Governor Murphy Signs Mental Health Parity Legislation”. April 11, 2019 <https://www.nj.gov/governor/news/news/562019/20190411a.shtml>
- ⁱⁱ State of New Jersey. “Governor Murphy Announces Departmental Actions to Expand Access to Telehealth and Tele-Mental Health Services in Response to COVID-19” March 22nd, 2020. <https://www.nj.gov/governor/news/news/562020/20200322b.shtml>
- ⁱⁱⁱ State of New Jersey. “Final FY2021 Budget Sustains Most Behavioral Health Funding, Adds Investments”. September 29, 2020. <https://www.insidernj.com/press-release/final-fy2021-budget-sustains-behavioral-health-funding-adds-investments/>
- ^{iv} DHS, DMHAS. Designated Screening Centers in New Jersey. February 9, 2021. https://www.state.nj.us/humanservices/dmhas/home/hotlines/MH_Screening_Centers.pdf
- ^v DHS, ReachNJ. <https://nj.gov/humanservices/reachnj/>.
- ^{vi} State of New Jersey. “Governor Murphy Announces New Initiatives to Combat the Opioid Epidemic”. January 23, 2019. <https://www.nj.gov/governor/news/news/562019/20190123b.shtml>
- ^{vii} NJ DOH. “New Jersey Department of Health Receives \$7.4 Million Federal Grant to Address Overdose Epidemic”. September 11, 2019. <https://www.nj.gov/health/news/2019/approved/20190911a.shtml>
- ^{viii} NJ DOH. “Status Report of NJDOH Overdose Portfolio.” OD2A Grant. 2020.
- ^{ix} The First Lady’s Office has also supported policies promoting behavioral and maternal health improvement in New Jersey. The [Nurture New Jersey initiative](#) is a statewide campaign that is promoting awareness in reducing infant and maternal mortality and ensuring equity in care for mothers and children of all ethnicities.
- ^x This document focuses on the BH component of QIP-NJ. For more information on QIP-NJ, please visit DOH’s website at <https://qip-nj.nj.gov/index.html>.
QIP-NJ’s program design is contingent upon receipt of all necessary approvals from the federal Centers for Medicare and Medicaid Services.
ements, please visit DOH’s website at the following link: <https://qip-nj.nj.gov/>.
- ^{xii} The following data from the New Jersey Hospital Discharge Data Collection System (NJDDCS), the NJ DHS Mental Health Division SUD Annual Medicaid Data Report and data from the CDC intends to highlight the current opportunity for hospital ED teams to engage in quality improvement to support and foster better health outcomes and service delivery for the BH population. Data driven change is a foundational element of the Collaborative. DOH hopes that this document will help hospital ED teams identify common challenges which the Collaborative seeks to address and start a conversation about best practices and strategies for improvement.
- ^{xiii} New Jersey Hospital Discharge Data Collection System (NJDDCS), 2018-2019
- ^{xiv} NJDDCS, 2018-2019
- ^{xv} NJ Spotlight News. “State Calls for Dozens of New Inpatient Treatment Beds.” February, 26, 2018. <https://www.njspotlight.com/2018/02/18-02-25-state-calls-for-dozens-of-new-inpatient-treatment-beds/>
- ^{xvi} <https://www.state.nj.us/health/legal/documents/public-notices/CN%20Call%20for%2053%20AAC%20Psychiatric%20Beds.pdf>
- ^{xvii} Zeller SL. “Treatment of psychiatric patients in emergency settings.” Primary Psychiatry. 2010;17(6):35-41
- ^{xviii} NJDDCS, 2018-2019
- ^{xix} KFF. “Mental Health in New Jersey” 2019. <https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/new-jersey/>
- ^{xx} KFF. “Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted)” 2019. [https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Opioid%20Overdose%20Death%20Rate%20\(Age-Adjusted\)%22.%22sort%22:%22desc%22%7D](https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Opioid%20Overdose%20Death%20Rate%20(Age-Adjusted)%22.%22sort%22:%22desc%22%7D)
- ^{xxi} Center for State Health Policy Presentation. “Rutgers Policy Panel: Covid-19 Impact on BH Services in NJ.” October 16th, 2020.
- ^{xxii} Center for Disease Control. “Drug Overdose Mortality by State” https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm
- ^{xxiii} State of New Jersey. “Governor Murphy Reaffirms Commitment to End the Opioid Epidemic, Releases Final 2020 Year-End Overdose Death Data”. March 21st, 2021. <https://www.nj.gov/governor/news/news/562021/20210304a.shtml>

^{xxiv} NJDDCS, 2018-2019

^{xxv} Unmet demand is defined as the estimated proportion of the adult population who did not receive treatment in the 12-months prior to the interview but who felt they needed and wanted treatment.

^{xxvi} DHS, DMHAS. "Substance Abuse Overview 2019 Statewide". October 2019.

<https://www.state.nj.us/humanservices/dmhas/publications/statistical/Substance%20Abuse%20Overview/2019/Substance%20Abuse%20Overview%20Statewide%20Report%20-%20%202019.pdf>

^{xxvii} New Jersey DHS. DMHAS Trauma Informed Care.

<https://www.state.nj.us/humanservices/divisions/dmhas/tic.html>

^{xxviii} Center for Substance Abuse Treatment. Trauma-Informed Care in Behavioral Health Services. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014.

^{xxix} DHS, Mental Health Division. "CY19 NJ SUD Annual Medicaid Data Report".

^{xxx} DHS, Mental Health Division. "CY19 NJ SUD Annual Medicaid Data Report".

^{xxxi} Review Collaborative Charter for a detailed problem statement.

^{xxxii} For more information on QIP-NJ, please visit DOH's website at <https://qip-nj.nj.gov/index.html>.

^{xxxiii} This is the projected end date of the Collaborative.

^{xxxiv} The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

^{xxxv} A panel of interprofessional experts was convened in February 2021 to design the improvement strategy for the BH Collaborative. Panelists included state policy experts, addiction medicine and emergency psychiatry clinicians, consumer experience and harm reduction experts and a social worker. See QIP-NJ BH *Change Package* available at <https://qip-nj.nj.gov/lc.html>.