Quality Improvement Program-New Jersey (QIP-NJ) Behavioral Health (BH) Learning Collaborative

Pre-Work Package

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Background

The QIP-NJ BH Learning Collaborative

To support hospitals in their effort to improve outcomes relative to BH and drive systemic improvements in care, the New Jersey (NJ) Department of Health (DOH), in partnership with PCG[1], has designed a data driven Learning Collaborative. The QIP-NJ BH Learning Collaborative (referred to as the "Collaborative") is based on a proven model from the Institute for Healthcare Improvement, called the Breakthrough Series (BTS) Collaborative. The Collaborative will rely upon a holistic and multi-faceted approach involving the entire system of BH care and will target hospital EDs as a priority setting to test changes for improvements in care processes and outcomes for the NJ Medicaid BH population.

The focus of the Collaborative will be to improve connections to care for patients with BH (inclusive of both mental health (MH) or substance use disorder (SUD)) diagnoses seen in the ED within 30 days of their discharge.

Collaborative Aim:

The QIP-NJ BH Collaborative aims to increase the percent of patients seen in the ED who have a BH (MH and/or SUD) diagnosis who then complete a follow-up visit within 30 days of discharge from the ED by:

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

By July 2022, the Collaborative aims to have participating ED teams achieve the QIP-NJ statewide targets of a 25% follow-up rate for ED visits related to SUD and a 75% follow-up rate for visits related to MH.[2]

More details on the Collaborative including the Charter, Change Package, measure descriptions and learning model can be found on the QIP-NJ website (https://qip-nj.nj.gov/lc.html).

Collaborative Checklist: Preparing to Participate

Learning Session 1 of the Collaborative will occur in September 2021. To support your team in getting the most from the session, DOH suggests a few key activities be completed before you attend. They include:

- ☐ Forming an effective Collaborative Team
  - Identify team members and an executive sponsor. See suggested team member, role description and estimated time commitment in Appendix A.
  - Convene your team and hold your kickoff meeting. See a suggested agenda for a kickoff meeting in Appendix C.
  - Schedule onboarding coaching call with the QIP-NJ team by emailing qip-nj@pcgus.com.

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[1] PCG, Public Consulting Group, is a contracted partner of DOH that is assisting with the design, implementation, and oversight of QIP-NJ.

[2] Teams who are performing at or above the performance targets listed in the Collaborative aim should plan to work with Collaborative faculty to determine a new target that represents meaningful improvement for your ED.

- ☐ Understand the strengths and opportunities that exist in your system using the assessment tool in Appendix B.
- ☐ Conduct interviews with staff and patients/chosen family members to explore current strengths and opportunities in your system (see guiding questions in Appendix D).
- ☐ Calculate baseline performance on at least one of the Collaborative's required measures. Information and guidance on data collection and reporting for the Collaborative measures can be found at https://qip-nj.nj.gov/lc.html.
- ☐ Learning Session 1 Preparation
    - Ensure all team members have the details for learning session 1. Registration information can be found on the Collaborative website found at https://qip-nj.nj.gov/lc.html.
    - Prepare Team Storyboard for Learning Session 1. Storyboard template and instructions found at https://qip-nj.nj.gov/Participant/Participant/BHLC_LS_Participant.

Appendix A: Forming a Collaborative team

All teams joining the Collaborative are encouraged to form teams that include the following recommended roles:

1. One Executive Leader.
2. One Team Leader (one of the team members listed below who will be the primary point of contact and will manage the Collaborative team).
3. One Measurement Lead / Information technology (IT) champion.
4. One or more clinical and administrative care team members who support care in the ED for BH (MH and SUD) patients.
5. One or more representatives from key community-based providers or organizations who support care for BH (MH and SUD) patients after discharge.
6. One or more representatives from other community-based organizations who can support effective transitions to community bed services or other social supports.
7. One or more patient and/or chosen family representatives.

Time commitment for team roles is roughly the following, acknowledging that time spent on the work will vary by site depending on the specific changes chosen and internal pace of the work. We recommend that hospitals form teams with enough people to fulfill the roles described below. Hospitals can assess their own resourcing and environment to determine how many people should be on their team. Some team members may have multiple roles.

Team member	Role	Time commitment
Executive Leader	• Creates and promotes the vision of the new system. • Allocates the time and resources needed to achieve the site's aim. • Provides guidance in selecting the pilot ED and identifying team members. • Assists as needed in engaging community stakeholders. • Champions the scale-up of successful changes throughout the organization and among its community partners. • Helps remove institutional or administrative barriers that hinders team progress. • Attends special leadership track sessions at Learning Sessions and during action periods.	2-3 hours/month
Team Leader	• Serves as primary point of contact with Collaborative Leadership Team. • Keeps team moving forward to achieve aim. • Participates in test of change.	4-5 hours/month
Measurement Lead / IT analyst	• Assists teams in accessing IT systems for measurement. • Supports integration of successful changes into IT systems as required. • Bring expertise of IT systems in how they can be leveraged to support change.	Variable
Clinical & Staff representatives	• Bring clinical or other frontline expertise to discussion, choosing and testing change ideas. • Champion the project with peers. • Participates in test of change.	4-5 hours/month

Community provider/organization representatives	• Bring expertise to discussion, choosing and testing change ideas. • Share insight and experience in leveraging community supports. • Champions the project within own organization. • participates in test of change	4-5 hours/month
Patient and chosen family representatives	• Bring expertise as a context expert and person with lived experience of care or caregiving to discussion, choosing and testing change ideas. • Participates in test of change.	2-3 hours/month

Appendix B: System Review

It is important for Collaborative teams to gain an understanding of their current system related to the improvement strategies detailed in the Change Package. Collecting and reflecting on the information below can help your Collaborative team identify the strengths and opportunities within your system, which can guide discussion during your onboarding session with Collaborative faculty. For example, if your Collaborative team does not have a formal structure to collect patient feedback, then your team might want to discuss how to address this gap in your onboarding session.

Who do you serve?

1. What do you know about the patients who access BH (MH and SUD) care in your ED?
   - Age breakdown
   - Most common diagnosis(es)
   - Neighborhoods where they reside
   - Payer mix of Medicaid Fee for Service vs. Medicaid Managed Care compared to the rest of your patient population? (Based on the most recent data available for your entire patient population).

What data systems support your work?

2. Does your electronic health record (EHR) give all care team members access to uniform information from intake to triage to treatment of the admitted patient?
   Yes ☐
   No ☐ (If No, please briefly explain):

3. How does your ED address 42 CFR Part 2[3] with your referral partners? This is sometimes known as the 'break the glass' provision that protects patient records created by federally assisted programs for the treatment of SUD?

4. Do ED staff have access to Population Health Management information and Quality reports?
   Yes ☐(if yes, respond to a, b, and c below):
   No ☐
   a. Who has access to these reports?

   b. How are these reports used?

[3] Electronic Code of Federal Regulations (CFR). PART 2—CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS. Available at: https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=b7e8d29be4a2b815c404988e29c06a3e&rgn=div5&view=text&node=42:1.0.1.1.2&idno=42#sp42.1.2.a.

c. Are reports provided to guide quality improvement in care processes?

5. Is the Prescription Drug Monitoring Program (PDMP) integrated into the EHR?
   Yes ☐
   No ☐(if No, is this data used by providers in another way?)

6. Do providers access the psychiatric advanced directives portal to review documented patient preferences in a crisis?
   Yes ☐
   No ☐

What policies and practices support your work?

7. Does your ED use standard tools and processes to assess patients for MH and/or SUD diagnoses/conditions?
   Yes ☐(if yes, respond to a and b below):
   No ☐
   a. What triage, assessment and screening tool(s) are used?

   b. Additional pertinent information about process/tools used:

8. Does your ED have a standard approach to discharge and follow-up for patients with MH and/or SUD diagnosis/condition?
   Yes ☐(if yes, respond to a, b and c below):
   No ☐
   a. Does your ED routinely schedule follow-up appointments before patients with MH conditions or SUD are discharged from the ED?
      Yes ☐
      No ☐
      Additional pertinent information (optional):

   b. Does your ED include a flag in the patient record to identify high-risk patients, to ensure follow-up with the patient after discharge?
      Yes ☐
      No ☐
      Additional pertinent information:

c. Does your ED provide active patient follow-up with patients with MH and/or SUD diagnoses/conditions following ED discharge?
   Yes ☐
   No ☐
   i. If Yes, what method(s) are used to provide follow-up with patients?

9. Does Your hospital have a BH intervention team that includes a hospital-based mental health provider (e.g., psychiatrist, psychologist or licensed clinical social worker?
   Yes ☐
   No ☐
   Additional information (optional):

10. Does your ED use peer support specialists to provide services to patients with SUD or mental health diagnoses?
   Yes ☐
   No ☐
   Additional information (optional):

11. Does your hospital have a structured approach to obtain patient and family feedback and then use that information in decision making related to improved discharge planning as well as improving hospital operations and services?
   Yes ☐
   No ☐
   a. If Yes, please describe your process:

12. How has your hospital provided training and support on implicit bias and systemic racism? How have ED staff been engaged and/or trained in these areas to date?

What training supports your work?

13. Does your hospital provide training and education to ED staff on how to care for patients with mental health or substance use disorders/conditions?
   Yes ☐
   No ☐
   a. If yes, is this training required and/or available to all staff?

14. Does your hospital provide training and education to ED Staff on Motivational Interviewing techniques?
    Yes ☐
    No ☐
    a. If yes, is this training required and/or available to all staff?

15. Does your hospital provide training and education to ED staff on trauma-informed care?
    Yes ☐
    No ☐
    a. If yes, is this training required and/or available to all staff?

16. Does your hospital provide training on a quality improvement methodology (i.e., Model for Improvement, Plan Do Study Act (PDSA) cycles, Lean management, etc.)?
    Yes ☐
    No ☐
    a. If yes, is this training required and/or available to all staff?

What Community Based Organizations (CBOs) and referral partners support your work?

17. What are the most common CBOs and/or referral partners that your patients access for support in the community?

18. What do you know about how patients access this community service(s) and the community provider's model of care?

19. Who is the key contact at the community provider for the ED?

20. What, if any, data sharing agreements do you have in place with key referral partners or CBOs?

Previous Improvement Initiatives:

21. What previous work has been done either in the ED or at the hospital to focus on improving the outcomes and experience of care for BH (MH and SUD) patients and their chosen family?

Communication Plan

22. In past improvement projects, what strategies, tools, and techniques did the improvement team utilize to effectively communicate with other colleagues and leadership?

23. How will you/your improvement project team communicate with providers, staff, and leadership about the work being done in the Collaborative project?

24. How will you build and maintain excitement, commitment, and momentum for the Collaborative project?

Appendix C: Team Kick-off meeting agenda

Once your improvement team has been selected, the team should meet with their identified Executive Leader to discuss the following:

- ☐ Why this project matters to each member of the team.
- ☐ The aim of the Collaborative and what that might mean for your hospital or health system regarding current and future state.
- ☐ Current, past, or planned improvement initiatives your hospital and/or ED has undertaken or will undertake to address the needs of patient with BH (MH or SUD) diagnoses in your community and what you can leverage or learn from those experiences.
- ☐ Project Team roles and responsibilities.
- ☐ The plan for your team completing the Prework Activities and review of any information already gathered.

Appendix D: Guiding questions for stakeholder interviews

In addition to better understanding the current health care systems and processes related to serving the BH (MH and SUD) populations, Collaborative teams will benefit from learning about the different and oftentimes diverse experiences of others operating within the system. Teams should perform some qualitative interviews with the stakeholders identified below to learn how the current systems are successful, how they could be improved and how all the people within those systems are impacted. The questions below were developed by the Institute for Healthcare Improvement's (IHI) Improving BH Care in ED and Upstream (ED&UP) Collaborative pre-work package.

1. Guiding Questions for Conversations with Patients, Families and Caregivers
   Note: Please use additional questions and/or adapt the ones included below as needed. These are meant to be a guide to help your Collaborative teams have effective conversations.

   [Insert hospital name] appreciates you sharing your experience as a patient (or a family member or caregiver) with us. Your experience can help [insert hospital name] better understand what patients with MH and/or SUD diagnoses/conditions need when they come to the ED.

   - Did you receive the care you wanted and needed at the time of that visit(s)?
   - What could have gone better, if anything, during the visit(s)?
   - Did you feel that you were treated with dignity and respect?
   - Did you know how to take care of yourself when you left the ED?
   - What would have liked to have told the ED staff during your last visit(s) that you were not able to say at the time?
   - What advice do you have for those who are working to improve the care for ED patients with mental health or substance use disorder conditions?

2. Staff Interview Questions
   - Can you recall an experience when you felt that the needs of a patient with MH and/or SUD diagnoses/conditions in the ED were met?
     i. What went well for the patient?
     ii. What went well for you?
   - Can you recall an experience when you felt that the needs of a patient with MH and/or SUD diagnoses/conditions were not met?
     i. What could have gone better for the patient?
     ii. What could have gone better for you?
   - What could help you better meet the needs of those patients presenting to the ED with MH and/or SUD diagnoses/conditions?

3. Community Stakeholder Interview Questions
   - How would you describe the current level of coordination and engagement between the EDs in your local/geographical area and your agency or facility?
   - From your perspective, what is working well in terms of coordination and engagement?
   - From your perspective, what is not working well in terms of coordination and engagement and how might it be improved going forward?

- Can you think of a patient for whom the transition from the ED to your service or facility went well? What happened that contributed to a good experience?
- Can you think of a patient for whom the transition from the ED to your service or facility did not go well? What happened that contributed to a less than ideal experience?

Appendix E: Collaborative Developers

DOH:

DOH, through its Office of Health Care Financing (OHCF) is responsible for implementing and overseeing the successful administration of QIP-NJ. QIP-NJ is a Medicaid pay-for-performance initiative open to all acute care hospitals in NJ and is focused on improving maternal health and BH health outcomes for the NJ Medicaid population, effective July 1, 2021, as approved by the Centers for Medicare and Medicaid Services. For more information, please visit the QIP-NJ website at https://qip-nj.nj.gov/index.html. In addition, the OHCF is the sponsor of the Collaborative, in partnership with PCG.

PCG:

PCG is a leading public sector solutions implementation and operations improvement firm that partners with health, education, and human services agencies to improve lives. Founded in 1986 and headquartered in Boston, Massachusetts, PCG employs over 2,500 professionals in more than 50 offices worldwide. PCG offers in-depth programmatic knowledge and regulatory expertise to help state and municipal health agencies and providers respond to regulatory change, improve access to health care, optimize reimbursement, maximize program revenue, improve business processes, and achieve regulatory compliance. Using industry best practices, PCG helps health organizations deliver quality services with constrained resources to promote improved client outcomes. For more information about PCG, please visit their website at https://www.publicconsultinggroup.com/.