South Jersey Behavioral Health Innovation Collaborative

Project Charter

Increasing Quality, Capacity, Accessibility and Coordination

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1. Purpose of the Charter

This charter will define the vision, scope, goals, objectives, and overall approach for the South Jersey Behavioral Health Innovations Collaborative. This charter will be the single point of reference on the project for the project work plan, budget and roles and responsibilities as well. In addition, it will serve as a contract between the Project Team and the Hospital CEOs, stating what will be delivered according to the budget, time constraints, risks, resources, and standards agreed upon for the project. Changes in the charter will require the approval of the charter committee, project team and the Hospital CEOs.

2. Problem Statement

There is a consensus among the participating organizations in the South Jersey Behavioral Health Innovations Collaborative (SJBHIC) that the current system for delivering care to patients living with behavioral health diagnoses is broken. To varying degrees, patients who present to emergency rooms, or are admitted to community hospitals, because of acute behavior health conditions, represent upstream failures in the system. The hypothesis of the SJBHIC is that tertiary care delivery, crisis and community-based service systems are underfunded, antiquated and dysfunctional. Further, we hypothesize that current state policies limit the availability of outpatient services and are not responsive to the current demand, nor do these policies represent an understanding of contemporary best practices in behavioral health care delivery.

While the downstream results of a sub-optimal, fragmented system are many, some important examples of the problems facing community hospitals (safety net facilities) include:

- Delays in patient care
- Inappropriate burden on ER's including extended boarding
- Increased risk and liability for hospitals
- Increased avoidable (re)hospitalizations
- Injuries to staff from patients with mental health and addiction issues

Several policy decisions over the past decade may be contributing to the problem. The loss of over 600 inpatient long-term mental health beds across the state and the closure of facilities for the developmentally disabled are among them. In addition, in an environment where patient volume has grown steadily, funding for short term care facilities and crisis intervention services has remained flat, or in some cases, decreased. Moreover, there are questions about whether the current approach to payment, which carves out behavioral health services from Medicaid managed care contracts and which relies on supplemental funding through state mental health contracts to augment Medicaid reimbursement rates, is the best way to deliver high quality, well-coordinated care. Finally, these issues are compounded by stigma around behavioral health illness disclosure, diagnosis and treatment as well as a dearth of professional and public education surrounding behavioral health. All of these issues have resulted in a lack of access to effective upstream behavioral health care that meets demand and needs of patients.

The 2013 Tri-County Health Needs Assessment Collaborative identified mental health and substance abuse treatment as one of five key health issues facing the region. However, no holistic, data-driven assessment of the current state of behavioral health services in the region exists and well-intentioned stakeholders continue to approach solutions in a piecemeal and siloed manner. Until the entire universe of stakeholders is engaged

and disparate sets of data are aggregated and analyzed, the true nature of the problem(s) facing patients with behavioral health diagnoses (and their health care providers) will continue to be purely speculative. Does the system have the right number of beds at the right level of care? Are there adequate services in the community and do they deploy the appropriate staffing and program models and engage those most in need of services? Absent a holistic analysis, these questions will remain unanswered, proposed solutions will continue to be speculative, and real innovation will not be possible.

Financial Implications to Hospitals

Hospitals face significant challenges in the marketplace that are exacerbated by patients with behavioral health comorbidities.

- Direct and indirect costs associated with clinical and operational inefficiencies
- Increased length of stay for patients with behavioral health comorbidities
- Risk associated with the delivery of acute care in an inappropriate setting
- Reductions in funding from the state/unfunded mandates
- Lack of funding for costs incurred and/or revenue lost due to flawed system design & poor oversight/implementation of community services
- Penalties for high rate of readmissions due to unmanaged behavioral health issues
- Loss of Hospital Relief Subsidy Fund
- Staffing costs for one to one patients
- Loss of business: individuals leaving without treatment
- Reduction in patient and staff satisfaction

3. Project Vision

The South Jersey Behavioral Health Innovations Collaborative aspires to understand and communicate the current state of the behavioral health care delivery system in the region, draw evidence informed conclusions, and recommend both pilot projects and policy changes that will result in more timely (earlier diagnosis and intervention) and more appropriate care for consumers of behavioral health care in our region.

4. Project Description

The Chairman and the members of the Collaborative will oversee and support a project that has six phases. The day to day management of the project will be the responsibility of the Camden Coalition of Health Care Providers and the New Jersey Hospital Association with roles and responsibilities defined below. While this project is described in phases, not all of the project activities and deliverables will be sequential. Some activities may overlap, or continue throughout the duration of the project.

1. Project Planning, Budgeting and Resource Identification
2. Listening, Understanding and Defining
3. Measuring & Mapping
4. Mixed-Methods Data Analysis and Reporting
5. Identification of Policy Initiatives and Pilot Projects
6. Dissemination of Findings, Implementation of Pilots & Policy Initiatives

Detailed first draft of the project plan to attached as Appendix B to this charter by January 15th

5. Timeline

Project Planning Period: November 24th, 2014 through January 15th, 2015
Start of Project: At execution of agreement
Date of Completion: One year from final execution of agreement

6. Budget

Estimated: $250,000: *Detailed budget to be attached as Appendix A of this charter on or before January* 15th

7. Core Organizational Participants

Organization	Lead Participant
Our Lady of Lourdes	Kim Barnes Maureen Shaughnessy JoAnn Steeger
Cooper University Hospital	Sunil Marwaha Barbara Smith
Virtua Health System	Kim Briggs Chris Chekouras
Kennedy Health System	Russ Micoli Marlana Cannata
Inspira Health Network	David Moore Susan Speranza
New Jersey Hospital Association	Mary Ditri Sarah Lechner
Camden Coalition of Healthcare Providers	Jeffery Brenner Mark Humowiecki

8. Goals & Objectives

Goals	Objectives
A) **Seeing and Understanding- Stakeholder Engagement:** This project will engage a holistic universe of stakeholders through outreach efforts, and involvement in SJBHIC initiatives.	1. Conduct stakeholder mapping sessions with the collaborative members and community partners to identify the broadest possible set of stakeholders to be engaged. 2. Draft and implement a communications plan for the project that leverages the resources of the NJHA and collaborative members to facilitate the bi-directional flow of information about the project. (Include innovative ways to use social media to amplify the communications plan and stakeholder engagement in the project)

		3.	Invite providers, experts, innovators policy makers, funders and other stakeholders to present and dialogue with members of collaborative at monthly meetings.
		4.	Use a combination of methods including surveys, focus groups, and interviews, fly-on the wall observations, walk-a-mile immersion to gather and synthesize qualitative data from the identified stakeholders.
B)	**Seeing and Understanding-Data Gathering and Analysis:** This project will map the current state, and estimate the comprehensive cost, of social service, primary, secondary and tertiary behavioral healthcare in the region.	1.	Building on the stakeholder maps and existing data, construct a geospatial map of all behavioral health services in the region.
		2.	Consult with stakeholders and experts to identify the data sets needed to conduct a comprehensive analysis, execute legal agreements when necessary, and create an integrated data set, managed by the Camden Coalition.
		3.	Aggregate descriptive data and conduct exploratory data analysis on these data.
		4.	Create system maps documenting a patient's journey from the manifestation of symptoms, through diagnosis, social services, primary, secondary and tertiary care for four distinct sets of patients: a) those with a diagnosis of serious mental illness, b) those with a diagnosis of alcohol or substance abuse, c) those with a dual-diagnosis and d) those with multiple co-morbidities.
		5.	Overlay the geospatial maps with funding sources, cost, capacity, and throughput data.
		6.	Identify barriers, bottlenecks and areas where demand exceeds supply etc.
		7.	Draft the current state mapping section of the summary report.
C)	**Prototyping-Policy Recommendations**: The project will produce a report that includes policy recommendations that will build capacity within the behavioral health system in the region to meet patient demand. Areas of focus will include: • Access to care • Quality of care • Patient, provider and public safety • Reduction/mitigation of inappropriate ED and inpatient utilization • Reduction in avoidable readmissions caused by the inadequate or inefficient delivery of behavioral health services	1.	Conduct exhaustive review of current federal and state policies on behavioral health that highlights major changes in the recent past, gaps in service delivery, and unfunded mandates.
		2.	Identify currently proposed, but not yet adopted, policy initiatives that impact the delivery of behavioral health in the region.
		3.	Conduct literature review of best practice, national models and innovative, evidence based approaches to the delivery of behavioral health services focusing on system wide initiatives, hospital- and community-based initiatives that use data and technology to amplify the reach and impact of existing services.
		4.	Present policy initiatives to stakeholders and members of the collaborative to reduce to the vital few to be pursued.
		5.	Draft the policy & advocacy section of the summary report.
		6.	Identify policy champions at the state level.
		7.	Develop a collaborative policy and advocacy agenda and implement.
D)	**Prototyping-Intervention Recommendations:** The project will produce a report that recommends a vital few pilot projects and programs that can be implemented by the members of the collaborative without policy changes. These pilots will be	1.	Building on the work product and findings of Goals, A, B & C the collaborative will hold, hold human centered design sessions, and use Six Sigma Methodology where applicable to co-create a list of pilot projects.
		2.	Map the pilot projects identified in importance/difficulty and cost/benefit matrices.
		3.	Identify potential funding sources for pilot projects.

designed to increase efficacy and efficiency to better serve consumers of behavioral health services in the region. The areas of focus will be the same as in Goal D above.	4. Based on the assessment of the benefits, costs, risks, length and potential funding sources for the pilot projects, the collaborative will recommend one or more pilot projects for implementation. 5. Using a methodology akin to Lean Startup, members of the collaborative will commit to implementation of pilot projects that test the hypotheses of service delivery innovations. 6. To the extent that "low-hanging fruit" initiatives present themselves to the group during the project, collaborative members may implement these initiatives prior to the completion of the summary report.

9. Assumptions

    a. A commitment to sharing relevant data from collaborative members with the Camden Coalition

    b. Key stakeholder buy-in and willingness to participate

    c. The scope aligns with the time and resources allocated to the project

10. Scope

    a. **Mixed-Methods Data Gathering** – This will attempt to provide a comprehensive view of costs, points of care, and flow of patients through the system to understand where gaps exist and bottlenecks are occurring. The project will include a literature review, stakeholder engagement for qualitative data gathering and an identification of quantitative data that will inform the project (i.e., hospital claims, DMHAS volume & funding, community provider and client level data).

    b. **Mixed-Methods Data Analysis** –Descriptive and exploratory data analysis work by the Camden Coalition of Healthcare Providers and its partners will include a deep dive into the qualitative and quantitative data that will be developed into visual renderings and summary reports and recommendations related to the Region's mental health system.

    c. **Policy Analysis**—Comprehensive policy analysis of the current state and federal policies related to the delivery of behavioral health services in the region. The policy analysis will highlight recent changes in policy and policy initiatives already underway, but not yet implemented.

    d. **Outreach to Stakeholders & Community to Communicate Findings and Proposed Initiatives** – Using the data and analysis work in progress, efforts would be made to present findings and link to successful national models in program areas that present themselves as an opportunity for improvement to the widest possible set of stakeholders. **Development of Policy & Advocacy Initiatives**-- Identification of a vital few policy and advocacy initiatives that the Collaborative will pursue.

    e. **Recommendations for Pilot Projects** – Using the findings of the above work streams, pilot projects will be designed to test hypotheses and in some cases implemented at scale. There will be two types of pilot projects related to this initiative:

a. Those that can bring about system changes for issues considered to be logical/low-hanging fruit. Small behavioral health pilot projects for service delivery innovation that would be useful for building cohesion, extracting learning, gaining publicity, and inspiring participants about the possible future.

b. Those that will require a broader group of stakeholders and/or capital investment to be implemented.

11. Out of Scope

Logical areas not considered part of the boundaries of this project?

a. Implementing and evaluating pilot projects
b. Drafting of State or Federal legislation
c. A formal advocacy strategy
d. Wide dissemination of findings
e. Stakeholder groups:
    a. Police
    b. Schools
    c. Correctional facilities

12. Project Milestones

Milestone	Deliverable
1. Milestone Description	• Deliverable 1—description • Deliverable 2—description • Deliverable n—description
2. Milestone Description	• Deliverable 1—description • Deliverable 2—description • Deliverable n—description

13. Project Organization

The South Jersey Behavioral Health Innovations collaborative has convened a committee of experts to understand the current state of and make evidence-informed recommendations for improving the behavioral health care delivery system in South Jersey.

Committee members have volunteered to contribute their time and individual expertise to this project. Members of the committee will meet monthly to explore evidence, dialog, draw conclusions and come to consensus and make recommendations. CCHP and NJHA staff will support the committee through study design and day to day management; evidence gathering, analysis, and synthesis; meeting and workgroup facilitation; and report writing and dissemination. Individual committee members are responsible for providing their insight, guidance, and expertise in committee meetings, workgroups, and processes as well as representing the shared vision of the committee at their institutions, to outside stakeholders, and the public.

14. Implementation and Dissemination Milestones

Milestone	Date Estimate	Deliverable(s) Included	Responsible Party
Milestone 1	mm/dd/yy	Deliverable 1 Deliverable 2	
Milestone 2	mm/dd/yy	Deliverable 1 Deliverable 2	

15. Key dependencies
   a. Access to data in a timely manner
   b. The achievement of consensus on the project goals, objective and scope prior to January 15
   c. Hiring of needed project management personnel/consultants

16. Key Stakeholders

As part of the planning and early work of the project, the team will conduct a comprehensive stakeholder identification/mapping exercise to assure that we engage the broadest possible set of individuals to inform the project. Below is the start of a partial list, to be augmented in the coming weeks:

   a. National Association for the Mentally Ill (NAMI), Phil Lubitz
   b. Rutgers Center for State Health Care Policy, Joel Cantor

    c.   Sentinel Project, John Jacobi

17. Resources (people, finances, equipment, materials)
    a.

18. Risks

#	Risk Area	Likelihood	Risk Owner	Project Impact-Mitigation Plan
1	Inability to access required data			
2	Inability to access key stakeholders			
3	Inability to secure capable staff			
4	Quantitative or qualitative data not representative of population			
5	Poor quality data			
6	Data security breach			
7	Substantial policy changes resulting in an outdated analysis			

#	Risk Area	Likelihood	Risk Owner	Project Impact-Mitigation Plan
8	Withdrawal of a collaborative member			
9	Collaborative fails to reach consensus on findings			
10	High rate of staff turnover			

19. Constraints

20. Roles and Responsibilities

<u>CCHP</u>

- **Data collection and analysis**
    - o Conduct literature review
    - o Facilitate identification of data sources
    - o Draft legal agreements for data gathering and integration
    - o Perform qualitative data gathering
    - o Perform data analysis
- **Project Management**
    - o Draft project plan
    - o Recruit and oversee project manager
    - o Facilitate 6-sigma and human centered design sessions
    - o Facilitate and manage the Charter Committee
- **Stakeholder Management**
    - o Facilitate stakeholder mapping
    - o Gather voices of stakeholders
    - o Manage ongoing stakeholder communications
- **Intervention design and evaluation**
    - o Work with the Committee to identify potential areas for pilot projects
    - o Facilitate design of interventions/pilot projects

NJHA

- **Communications**
    - o Build and manage webpage
    - o Compile and distribute all public communications materials
    - o Manage press strategy
    - o Drive the Communications Committee
- **Event planning**
    - o Schedule and coordinate meeting logistics
    - o Plan special events and conferences as appropriate
- **Education**
    - o Gather and disseminate educational materials
    - o Facilitate stakeholder education

21. Charter Version Control

Version	Date	Author	Change Description
1	11/12/2014	Sunil Marwaha	Draft document created
2	11/24/2014	Len Terranova	Added Sections to Charter including Problem Statement, Financial Impact…
3	12/15/2014	Maggie Hawthorne	Updated language in Problem Statement, Financial Impact and Goals/Objectives sections based on feedback from Collaborative members

22. Approvals

Prepared by   _____
                    Collaborative Chairman

Prepared by   _____
                    NJHA Project Manager

Prepared by   _____
                    CCHP Project Manager

Approved by   _____
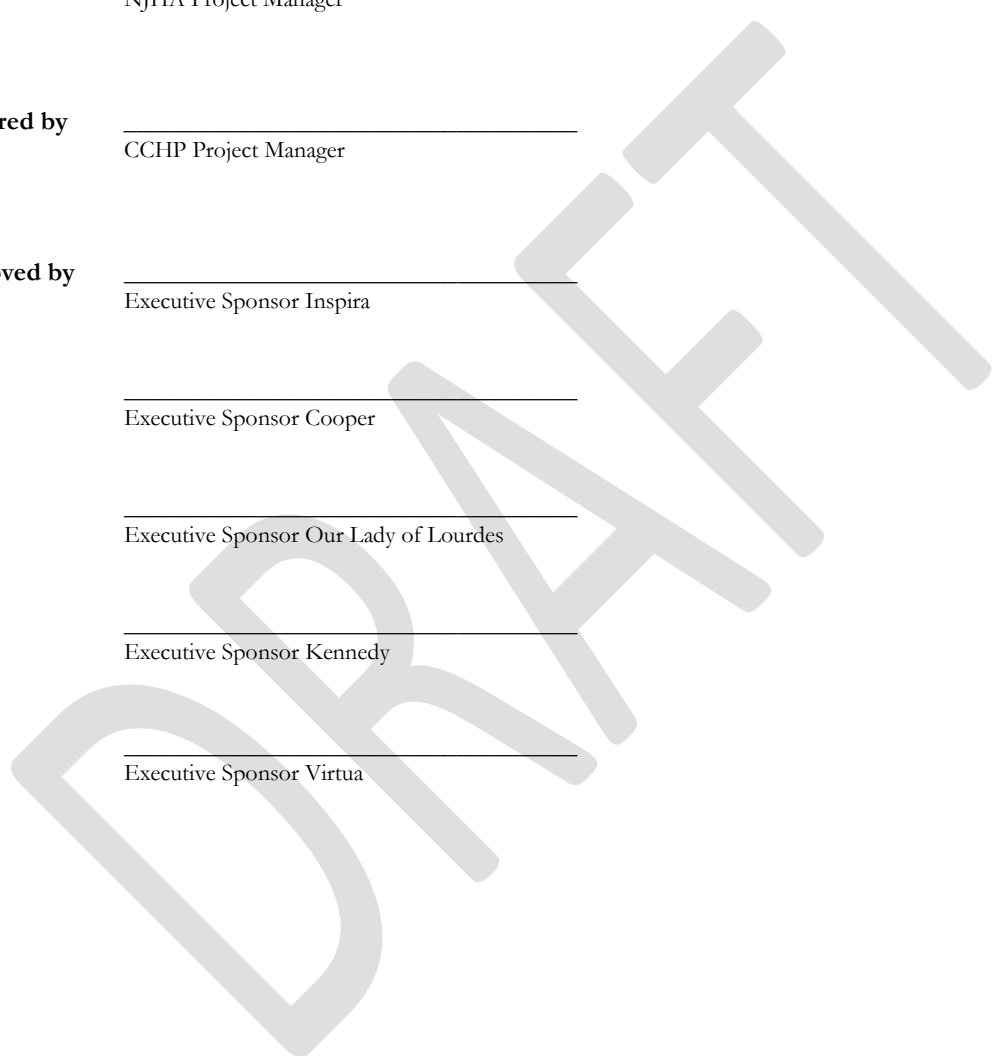   Executive Sponsor Inspira

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                    Executive Sponsor Cooper

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                    Executive Sponsor Our Lady of Lourdes

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                    Executive Sponsor Kennedy

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                    Executive Sponsor Virtua

23. Appendices