# Transitional Care and Diversion Intervention Workgroup

**Location**

Confluence Technology Center  
285 Technology Center Way #102, Wenatchee, WA 98801

**Conference Information:**

Join from PC, Mac, Linux, iOS or Android:  
[https://zoom.us/j/155569333](https://zoom.us/j/155569333)  
Dial: +1 669 900 6833 or +1 408 638 0968  
Meeting ID: 155 569 333

## Agenda

<table>
<thead>
<tr>
<th>Proposed Agenda</th>
<th>Time</th>
<th>Goals</th>
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</thead>
</table>
| 1. Welcome, Introductions, & Project Planning Structure | 10:00 | • Welcome members  
• Workgroup Chair  
• Review of last meeting  
  o Approaches  
  o Current State Assessment  
  o Proposed Project Planning Timeline |
| 2. Project Data: | 10:15 | • Review of project metrics & Data Review |
| 3. Review of Evidence Based Approaches in Project | 10:30 | • Review Updates for Evidence Based Approaches |
| 4. Current State Assessment | 10:50 | • Template to gather information on current projects occurring. |
| 5. Domain I Linkages | 11:10 | • Workforce, HIT/HIE, Value-Based Payment |
| 6. Application Attributes | 11:20 | • Overview and Ideas  
• Templates? |
| 7. Assignments | | • Review draft application prior to next meeting (will be emailed 1 week prior)  
• Complete Current State Assessment  
• Rank your top two approaches for each project (Transitional Care and Diversion Intervention)  
• Sign Charter Membership Agreement |

**Next Meeting:** February 22nd 10:00-11:30AM at Confluence Technology Center  
(regular meetings are the 4th Thursday of the month)
Transitional Care & Diversion Intervention Workgroup Projects

Diversion from Acute Care

**Approaches:**
1. Community Paramedicine (D)
2. Interact Models (T)
3. LEAD (D)

Acute Care Setting

**Approaches:**
1. Emergency Department Diversion (D)

Transitions out of Acute Care

**Approaches:**
1. Transitional Care Model (T) (Including Care Coordination)
2. Evidence Informed Approaches to Transitional Care leaving Incarceration (T)

**Considerations:**
- The workgroup will have approximately $200K a year to complete work of all projects
- Target Population our workgroup wants to focus in on for each projects
- Will other demonstration projects assist in addressing projects?

(D) = Diversion Intervention Approach
(T) = Transitional Care Approach
<table>
<thead>
<tr>
<th>Evidence Based Approach</th>
<th>Target Population</th>
<th>Approach Details</th>
<th>Updates 1.25.18</th>
<th>Linkage to other projects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Approach #1:</strong></td>
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<tr>
<td>Interventions to Reduce</td>
<td>Medicaid beneficiaries who could transfer to the acute hospital from Skilled Nursing Facilities</td>
<td>The skilled nursing facility (SNF) and project implementation team will utilize INTERACT 4.0 toolkit and resources</td>
<td>Need to determine if Assisted Living and Long Term Care facilities are interested in participating.</td>
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<tr>
<td>Acute Care Transfers,</td>
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<td>Pathways Health (model developer) would be able to come out and complete trainings. Some concerns with facilities has been cost and time to complete</td>
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<tr>
<td>INTERACT 4.0</td>
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<tr>
<td></td>
<td></td>
<td>Focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in the every day practice of long-term care facilities</td>
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<tr>
<td></td>
<td></td>
<td>Four basic types of tools available for approach: Quality Improvement, Communication, Decision Support, Advanced Care Planning</td>
<td>Model is able to expand into Assisted Living and Long Term Care Facilities</td>
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<tr>
<td><strong>Approach #2:</strong></td>
<td>Medicaid beneficiaries discharged from acute care to home or to supportive housing</td>
<td>Use of advanced knowledge and skills by a transitional care nurse (TCN) to deliver and coordinate care of high risk older adults across all health care settings</td>
<td>According to UPENN (model developer) This model can include coaches (Social Workers and CHW) on top of TCNs</td>
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<tr>
<td>Transitional Care Model</td>
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<td>Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months</td>
<td>Confirming that HCA is ok with Social Workers and CHWs as part of model</td>
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<tr>
<td>(TCM)</td>
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<td>Continuity of care facilitated by TCN between hospital, post acute, and primary care clinicians to ensure follow up</td>
<td>Workgroup members felt the TCM model was important and should be incorporated in work if there is flexibility</td>
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<td>Would include elements of</td>
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<td>Includes active engagement of family in decisions</td>
<td>Can include elements of other Care transition models into TCM if HCA allows</td>
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<tr>
<td>the below approaches into</td>
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<tr>
<td>work</td>
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<td>Care Coordination</td>
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<tr>
<td>- Approach #3: The Care</td>
<td>Medicaid beneficiaries returning to the community from prison or jail</td>
<td>Should include strategies for increasing Medicaid enrollment, including a process to identify those who are not covered, assisting</td>
<td>Care Coordination directly in the facility prior to discharge would be advantageous</td>
<td>Split into Diversion</td>
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<tr>
<td>Transitions Intervention</td>
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<td>A strategy for beginning care planning and transition planning prior to release including a process for conducting in-reach to prison/jail, transitional care planning as part of reentry plan, and ensuring care planning is conducted in a culturally competent manner.</td>
<td>Could link to other care coordination agencies including Pathways Hub and Health homes</td>
<td>Intervention</td>
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<td>(CTI)</td>
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<tr>
<td>- Approach #4: Care</td>
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<td>Transitions Intervention</td>
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<tr>
<td>in Mental Health</td>
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**TRANSITIONAL CARE EVIDENCE BASED APPROACHES**
<table>
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<tr>
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<tr>
<td><strong>Approach #1:</strong> Emergency Department (ED) Diversion</td>
<td>Medicaid beneficiaries presenting at the ED for non-acute condition</td>
<td>ED will establish linkages to primary care providers to connect patients with care and the ED will notify primary care when the patient presents to the ED for care</td>
<td>None to date</td>
<td>Care Coordination</td>
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<tr>
<td></td>
<td></td>
<td>Where available, care coordinators can facilitate above process</td>
<td></td>
<td>Transitional Care</td>
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<td>Establish policies for identifying beneficiaries with minor illnesses who do not have a primary care provider and after completing care, assist the patient in receiving a timely appointment with their PCP</td>
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<td>Follow the Washington State Hospital Association &quot;ER is for Emergencies&quot; best practices</td>
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<td><strong>Approach #2:</strong> Community Paramedicine Model</td>
<td>Medicaid beneficiaries who access the EMS system for a non-emergent condition</td>
<td>Approved Medical Program Directors (MPDs) working with first responders, ED practitioners, and primary care providers to develop protocols which may include transporting beneficiaries with non-emergency needs to alternate (non-ED) care sites</td>
<td>Spoke with Ray E around Community Paramedicine Models. Lake Chelan Community Hospital and Aerow Methow are both looking at model</td>
<td>Potentially Care Coordination</td>
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<td>Core issues include how paramedics would be trained, appropriately supervised, and how they will integrate with other programs in the community</td>
<td>Ray will work with North Central Emergency Care Council to gather more information and connect with other EMS agencies (Ballard, Lifeline, AMR) to determine ability to move to this model</td>
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<td>Strong need to identify how paramedics will communicate with other providers (i.e. clinical and social) - This could include improvements to Health Information Exchange (HIE) systems</td>
<td>Certification work and other moves would not be difficult, but ensuring a developed model might be more difficult</td>
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<td><strong>Approach #3:</strong> Law Enforcement Assisted Diversion, LEAD</td>
<td>Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement</td>
<td>Establish a LEAD program as a voluntary agreement among independent decision makers</td>
<td>More details to come</td>
<td>Care Coordination</td>
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<td>Identifying a dedicated project manager</td>
<td>Connecting with Law Enforcement to gather more information around model. No other updates at this point.</td>
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<td>Provide intensive case management - to link diverted individuals to housing, vocational and educational opportunities, treatment, and community services</td>
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<td>Apply a harm reduction housing first approach</td>
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<td>Consider the use of peer supports</td>
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<td>Provide training in the areas of trauma-informed care and evaluation planning</td>
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Current State Assessment NCACH – Transitional Care & Diversion Intervention

Workgroup Notes:

- The below matrix would be populated based on the survey question answers.
- Workgroup Members: Please provide input on the survey by Friday February 2nd to ensure we are asking the right questions to get a meaningful response
- Survey will go out via survey monkey to local partners and NCACH staff will fill in additional details as they meet with key stakeholders.
- A link to each approach will be included in the survey to provide further details for survey takers.

Current State Assessment Questions:

1. Organization Name: __________________________

2. Individual filling out Survey: ________________________

3. County of Operations (Circle all that apply)
   a. Chelan
   b. Douglas
   c. Grant
   d. Okanogan

4. Are you currently implementing any of the following evidence-based approaches?
   a. INTERACT 4.0 – Transfers from Skilled Nursing to Emergency Departments/Hospitals
   b. Transitional Care Model (TCM)
   c. Transitional Care/Care Coordination leaving Hospitals/Emergency Department
   d. Transitional Care/Care Coordination leaving Criminal Justice Facilities
   e. Emergency Department Diversion Program
   f. Community Paramedicine
   g. Law Enforcement Assisted Diversion (LEAD)

5. If yes, please describe the work currently occurring with this evidence-based approach.

6. If no, which evidence-based approach do you find most needed in the region?

7. If NCACH chose an evidence based approach listed above that was directly related to the work of your organization, would your organization be willing to implement the approach?

8. What are the barriers for implementing the evidence based approaches listed?
   a. INTERACT 4.0 – Transfers from Skilled Nursing to Emergency Departments/Hospitals
   b. Transitional Care Model (TCM)
   c. Transitional Care/Care Coordination leaving Hospitals/Emergency Department
   d. Transitional Care/Care Coordination leaving Criminal Justice Facilities
   e. Emergency Department Diversion Program
   f. Community Paramedicine
   g. Law Enforcement Assisted Diversion (LEAD)

9. What other organizations are completing work under the evidence-based approaches listed above? Can you provide details or contact information to reach out to them directly?
# Matrix to be populated by Survey Answers

<table>
<thead>
<tr>
<th>Evidence based Approach</th>
<th>Chelan/Douglas</th>
<th>Grant</th>
<th>Okanogan</th>
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<tr>
<td>INTERACT 4.0 – Transfers from Skilled Nursing to Emergency Departments/Hospitals</td>
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<tr>
<td>Law Enforcement Assisted Diversion</td>
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Required Health Systems and Community Capacity (Domain 1) Focus Areas

Summary of Domain 1 Activities:

The Medicaid Transformation Project Demonstration requires all ACHs to focus on three areas that address the core health system capacities that will be developed or enhanced to transform the delivery system:

- Financial sustainability through value based payment (VBP)
- Workforce
- Systems for population health management.

Work of Initiative 1: Care Transformation

ACHs, in collaboration with HCA and statewide partners and organizations will need to work to use existing infrastructure, and develop sustainable solutions to these strategies that will benefit the Demonstration projects.

The Goal of Domain 1 activities is to create a foundation that the transformational work completed within the Demonstration (i.e. NCACH’s six selected projects) can build upon to ensure successful implementation and sustainability. To achieve this, Domain 1 activities must:

- Link to one another, rather than exist in silos
- Support, not duplicate, existing efforts, and efficiently use limited resources.
- Share investment as much as possible
- Focus on immediate solutions that advance successful implementation of the Demonstration projects
- Enable providers to shape successful implementation of health system transformation
- Endure beyond the Demonstration
- Support all activities in Domains 2 and 3
How capacity-building in these three Domain 1 focus areas will support all selected projects:

Without the foundation of Domain 1 supports, projects will be at risk of dissolving due to the loss of sustainable funding, inability to hire workforce to meet the skill requirements of projects, and inability to coordinate and communicate care plans between partners.

NCACH is approaching capacity building in the three focus areas of Domain 1 in the follow ways:

**Value Based Payments:**

- Sustainability of each project within the Demonstration will be successful if providers are able to align the clinical and community changes in each project with value-based payments
- Specific to clinical providers, if contracts move towards value versus volume, providers will have the flexibility to utilize funding to address the healthcare needs outside of the traditional provider visit.
- The healthcare improvements completed in each workgroup should support the payment models developed under this move to value based care arrangements.

**Workforce Development:**

- Each Demonstration project will require a different set of unique workforce needs. As we change the delivery system to provide integrated, whole person care, we will shift from the need for staffing for a more acute setting to a less intensive outpatient setting.
- This change will create new employment opportunities such as behavioral health practitioners in primary care or physical health providers in community behavioral health.
- Each project will need to review how current workforce capacity and future training opportunities can ensure that staffing needs can be achieved to sustain improvements made in care.

**Population Health Management:**

- NCACH believes that interoperability is a key to achieving care transformation. Interoperable systems allow providers and partners to share information in an efficient manner that will ensure care is not duplicated, and that each partner has the information needed to make good decisions for the health of the patient.
- Each project should review the Health Information Technology/Health Information Exchange needs of that project and what work can be done to ensure communication between partners are made effective.
# Project Metrics by Year – Transitional Care & Diversion Intervention:

## Transitional Care Project Metrics

<table>
<thead>
<tr>
<th>Year</th>
<th>Type</th>
<th>Metric</th>
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</table>
| **2019-2021** | ACH Reported (Pay for Reporting) | - Report against QIP metrics  
- Number of partners trained by selected model/approach: projected vs. actual and cumulative  
- Number of partners participating and number implementing each selected model/approach  
- % partnering provider organizations sharing information (via HIE) to better coordinate care  
- VBP arrangement with payments/metrics to support adopted mode (2021) |
| **2019-2021** | State Reported (Pay for Performance) | - Outpatient Emergency Department Visits per 1000 member months  
- Percent Homeless (Narrow definition)  
- Plan All-Cause Readmission Rate (30 Days) |
| **2020-2021** | State Reported (Pay for Performance) | - Follow-up After Discharge from ED for Mental Health  
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence  
- Follow-up After Hospitalization for Mental Illness  
- Inpatient Hospital Utilization  
- Outpatient Emergency Department Visits per 1000 member months  
- Percent Homeless (Narrow Definition)  
- Plan All-Cause Readmission Rate (30 Days) |

## Diversion Intervention Project Metrics

<table>
<thead>
<tr>
<th>Year</th>
<th>Type</th>
<th>Metric</th>
</tr>
</thead>
</table>
| **2019-2021** | ACH Reported (Pay for Reporting) | - Report against QIP metrics  
- Number of partners trained by selected approach/strategy: projected vs. actual and cumulative  
- Number of partners participating and number implementing each selected approach/strategy  
- % partnering provider organizations sharing information (via HIE) to better coordinate care  
- % of partnering provider organizations with staffing ratios equal or better than recommended  
- VBP arrangement with payments/metrics to support adopted mode (2021) |
| **2019-2021** | State Reported (Pay for Performance) | - Outpatient Emergency Department Visits per 1000 member months  
- Percent Homeless (Narrow Definition) Plan All-Cause Readmission Rate (30 Days) |
| **2020-2021** | State Reported (Pay for Performance) | - Outpatient Emergency Department Visits per 1000 member months  
- Percent Arrested  
- Percent Homeless (Narrow Definition) |