## Agenda

<table>
<thead>
<tr>
<th>Proposed Agenda</th>
<th>Time</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Welcome &amp; Introductions</strong></td>
<td>10:00</td>
<td>• Welcome members&lt;br&gt;• Explain context of meeting&lt;br&gt;• Review of Charter</td>
</tr>
<tr>
<td>John Schapman</td>
<td></td>
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</tr>
</tbody>
</table>
| **2. Introduction to Healthier, WA & Demonstration**         | 10:15  | • Introduction to Healthier Washington<br>• Medicaid Demonstration Project– 6 projects<br>• Transitional Care & Diversion Intervention Projects  
  o Metrics from toolkit – P4R, P4P<br>  o Potential funding |
| Linda Parlette & Chrystal Eshelman                           |        |                                                                      |
| **3. Project Data**                                          | 10:45  | • Health and Community Data Review<br>  o Demographic data<br>  o Hospital data<br>  o Criminal Justice data<br>• Community Input Data<br>  o CHI & Survey data<br>• Data measures from toolkit
  Next steps related to data gathering                         |
| Caroline Tillier                                             |        |                                                                      |
| **4. Project Plan Timeline**                                 | 11:15  | • 6 – 9 month timeline<br>• Alignment with all 6 projects<br>• Project Plan Application (due Nov 16th, 2017) and Implementation Plan (due Sept 30th, 2018) |
| John Schapman                                                |        |                                                                      |
| **5. Other Announcements:**                                 | 11:25  | • A Doodle Poll will be sent out to schedule the next and regular workgroup meeting<br>• Please return signed member agreement prior to Nov 16th to john.schapman@cdhd.wa.gov |

**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  
Dial: +1 669 900 6833 or +1 408 638 0968  
Meeting ID: 155 569 333
Transitional Care and Diversion Interventions Workgroup Charter

Background
On January 9th, 2017 the Washington State Health Care Authority (HCA) signed an 1115 Waiver, now known as the Medicaid Transformation Demonstration Project. The goal of the Demonstration is to improve care, increase efficiency, reduce costs and integrate Medicaid contracting. To align clinical integration with payment integration within the Demonstration Project, HCA developed the Medicaid Demonstration Project Toolkit. Two of the projects that were selected are Transitional Care and Diversion Intervention. The project objects, as described in the toolkit, are:

- Transitional Care – improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place
- Diversion Interventions – Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.

Charge
The Transitional Care and Diversion Interventions Workgroup will ensure that the North Central region implements effective evidence based practices that align with the milestones and approaches described in the Toolkit. Specifically the Workgroup will complete the following:

- Provide recommendations to the NCACH Governing Board and staff on approaches to take for Transitional Care and Diversion Interventions projects.
- As much as possible, ensure Diversion Interventions and Transitional Care projects align with all six projects NCACH selected to implement.
- Collect, synthesize, and use stakeholder and community input on project planning and implementation.
- Work with NCACH partners to implement sustainable changes in the regional health care system (broadly conceived) that improve effective transitions for patients re-entering the community from intensive care settings or incarceration, and provide more effective alternatives to incarceration, inpatient treatment or emergency department care for patients whose needs can be better addressed in other ways.
- Determine how work completed through Transitional Care and Diversion Interventions are able to be financially sustainable past the Demonstration period.
- As much as possible, ensure projects effectively connect patients with resources to mitigate the negative consequences of the social determinants of health.
- Identify how IT, workforce, and value-based payment strategies can support this project.

Composition
The Transitional Care and Diversion Interventions Workgroup will include representatives from Grant, Chelan, Douglas, and Okanogan Counties. Workgroup membership is not a prerequisite to receiving funding through the Demonstration. The NCACH Executive Committee will recommend to the Governing Board workgroup members from a list of interested parties which may include representation from:

- Emergency Medical Services (EMS)
- Law Enforcement
- Legal Services
- Regional Justice Centers (Jails)
• Hospitals
• Skilled Nursing Facilities/Assisted living/Long-term Care Facility/Hospice
• Aging and Adult Care
• Managed Care Organizations (*Operating in all 4 NCACH counties after January 1st, 2018*)
• Behavioral Health Administrative Service Organization
• Behavioral Health Providers including Crisis providers
• Primary Care Providers
• Care Coordination agency/Case Managers
• Education
• Tribal

Additional representation will be added to the Workgroup by the Executive Director if it is deemed necessary. A Workgroup Chair will be appointed by the Executive Director. The Transitional Care and Diversion Interventions Workgroup is a sub-committee of the NCACH board and as such will be led by the Workgroup Chair and NCACH staff and must have a minimum of two board members serving on the Workgroup.

**Meetings**
Transitional Care and Diversion Interventions Workgroup meetings will be held once per month, with additional meetings scheduled as necessary. Meetings will be held in Chelan, Douglas, Grant, and Okanogan Counties; locations will vary and an effort will be made to hold meetings in each of the Local Health Jurisdictions throughout the year. Whenever possible, meetings will have an option to participate via teleconference or audioconference for those unable to attend in person, although in-person participation is encouraged. NCACH program staff and the Workgroup Chair shall be responsible for establishing the agendas. Notes for all meetings will be provided to the Workgroup by NCACH staff within two weeks of each meeting. Monthly meetings will be open meeting minutes and materials will be posted on the NCACH website (www.ncach.org).

**Membership Roles and Responsibilities**

1. Attend at least 75% of regular meetings of the Workgroup and actively participate in the work of the Workgroup.
2. Sign a Membership Agreement (attachment A)
3. Communicate with other members of your sector and/or community to ensure broader input into the design, planning, and implementation process.
4. Assess current state capacity to effectively deliver Transitional Care and Diversion Interventions.
5. Select initial target population and evidence-supported approaches informed by the regional health needs assessment and community data.
6. Review prepared data to recommend target population(s), to guide project planning and implementation, and to promote continuous quality improvement
7. Assist in identifying, recruiting, and securing formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.
8. Recommend to the Board a project implementation plan, including a financial sustainability model and how projects will be scaled to full region in advance of HCAs project implementation deadline.

9. Monitor project implementation plan, including scaling of implementation plan across region, and provide routine updates and recommended adjustments of the implementation plan to the NCACH Governing Board.

10. Develop and recommend a funding process to the NCACH Governing Board for non-primary care and outpatient behavioral health members involved in Transitional Care and Diversion Interventions projects.

11. Collaborate with NCACH staff on data and reporting needs related to Demonstration metrics, and on the application of continuous quality improvement methods in this project.

12. Use strategies that are supported by regional data, to advance equity and reduce disparities in the development and implementation of the Transitional Care and Diversion Intervention Projects.

**Authority**
The Transitional Care and Diversion Interventions Workgroup is an advisory body that will inform decision-making by the NCACH Governing Board and ensure regional priorities and local considerations are incorporated in program design decisions. Recommendations and input developed by the Workgroup will be shared in regular monthly progress reports to the NCACH Governing Board.
North Central Accountable Community of Health
Transitional Care and Diversion Interventions Workgroup
(Attachment A)

Membership Agreement

I acknowledge by my signature of this membership agreement that I have read, understood, and agreed to follow the guidelines and policies outlined in the North Central Accountable Community of Health Transitional Care and Diversion Interventions Workgroup Charter.

I understand that continued membership in the Workgroup is contingent on following the requirements of membership that are outlined in the Charter. Not meeting the requirements for membership could result in the loss of my membership status in the Workgroup.

Dated: ______________________________  Signed: ______________________________

Print Name: ______________________________

Title: ______________________________
North Central Accountable Community of Health

Transitional Care and Diversion Interventions Workgroup

October 24th, 2017
Healthier Washington

Healthier WA is a statewide initiative that is focused on achieving system wide change to link clinical and community factors that support health and spread integrated value based payment and care delivery models.

To achieve these goals, Healthier WA focuses on three goals:

1. Building healthier communities through a collaborative regional approach.
2. Integrating how we meet physical and behavioral health needs so that health care focuses on the whole person.
3. Improving how we pay for services by rewarding quality over quantity.

Locally, this work is accomplished through Regional Collaboratives such as the Accountable Communities of Health.
5 Years from now

Current system
- Fragmented care delivery
- Disjointed care transitions
- Disengaged clients
- Capacity limits
- Impoverishment
- Inconsistent measurement
- Volume-based payment

Transformed System
- Integrated, whole-person care
- Coordinated care
- Activated clients
- Access to appropriate services
- Timely supports
- Standardized measurement
- Value-based payment
A Regional Approach

• ACHs play a critical role:
  • **Coordinate** and **oversee** regional projects aimed at improving care for Medicaid beneficiaries.
  • **Apply** for transformation projects, and incentive payments, on behalf of partnering providers within the region.
  • **Solicit** community feedback in development of Project Plan applications.
  • **Decide** on distribution of incentive funds to providers for achievement of defined milestones.
Medicaid Transformation Demonstration

• Through a five-year demonstration, Healthier WA will use up to $1.5 Billion to address three initiatives aimed at transforming Medicaid to improve quality and control costs:

  • Initiative 1: Transformation Through Accountable Communities of Health
  • Initiative 2: Long-term Services and Supports to Enable Older Adults to Live At Home Longer
  • Initiative 3: Supportive Housing and Supported Employment

• Of the $1.5 Billion available through the Demonstration, $1.125 Billion will be available to address Initiative 1.
**Medicaid Transformation Demonstration**

**Initiative 1**  
Transformation through Accountable Communities of Health

- Delivery System Reform
  - Each region, through its Accountable Community of Health, will be able to pursue projects that will transform the Medicaid delivery system to serve the whole person and use resources more wisely.

**Initiative 2**  
Enable Older Adults to Stay at Home; Delay or Avoid the Need for More Intensive Care

- Benefit: Medicaid Alternative Care (MAC)  
  - Community based option for Medicaid clients and their families  
  - Services to support unpaid family caregivers

- Benefit: Tailored Supports for Older Adults (TSOA)  
  - For individuals “at risk” of future Medicaid LTSS not currently meeting Medicaid financial eligibility criteria  
  - Primarily services to support unpaid family caregivers

**Initiative 3**  
Targeted Foundational Community Supports

- Benefit: Supportive Housing  
  - Individualized, critical services and supports that will assist Medicaid clients to obtain and maintain housing. The housing-related services do not include Medicaid payment for room and board.

- Benefit: Supported Employment  
  - Services such as individualized job coaching and training, employer relations, and assistance with job placement.

**Transformation Projects**

**Medicaid Benefits/Services**

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North Central Accountable Community of Health
Initiative 1: Care Transformation

Domain 1: Health Systems and Community Capacity Building
- Financial sustainability through value-based payment
- Workforce
- Systems for population health management

Domain 2: Care Delivery Redesign
- Bi-directional integration of physical and behavioral health through care transformation
- Community-Based care coordination
- Transitional Care
- Diversion interventions

Domain 3: Prevention and Health Promotion
- Addressing the opioid use public health crisis
- Chronic disease prevention and control
Domain 1: Health Systems and Community Capacity Building

Domain 1 addresses the core health system capacities to be developed and enhanced. Three required focus areas are to be implemented and expanded across the delivery system. Each of these areas will need to be addressed progressively throughout the five-year timeline. State agencies will provide leadership but the ACH will have a role in each focus area.

Focus Areas
1. Financial Sustainability through Value Based Payment
2. Workforce
3. Data Systems for Population Health Management
Initiative 1: Care Transformation

Domain 1: Health Systems and Community Capacity Building
- Financial sustainability through value-based payment
- Workforce
- Systems for population health management

Domain 2: Care Delivery Redesign
- Bi-directional integration of physical and behavioral health through care transformation
- Community-Based care coordination
- Transitional Care
- Diversion interventions

Domain 3: Prevention and Health Promotion
- Addressing the opioid use public health crisis
- Chronic disease prevention and control
# Projects and general target populations

<table>
<thead>
<tr>
<th>Project</th>
<th>Objective</th>
<th>General target population (as defined by HCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bi-Directional Integration</td>
<td>Integrate health system and community approaches to improve chronic disease management and control.</td>
<td>Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a <strong>focus on those populations experiencing the greatest burden of chronic disease(s) in the region.</strong></td>
</tr>
<tr>
<td>Community-Based Care Coordination (aka HUB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitional Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diversion Interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addressing the Opioid Use Public Health Crisis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Disease Prevention and Control</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
More Information
Resources and Relationships

• Domains and Projects *should not* be implemented in isolation from one another.
  • Projects will be highly interrelated and interdependent

• Transformation projects must:
  • Be based on community-specific needs for the Medicaid population
  • Avoid redundancy and duplication

• Regional projects will be assessed based on achievement of defined milestones and metrics.
Funding the Demonstration Projects

Each project involves metrics

Funding will depend, in part, on our performance

• This is not a grant program. There will be up-front money for start-up, but much of the project funding must be earned by reaching performance targets.

• In the early years of the projects, we will be judged mainly on the progress we make in implementing project plans.

• In the later years of the projects, we will be judged mainly in terms of health care improvements such as reductions in unnecessary ER visits and hospitalization, and on clinical quality metrics such as the percent of Medicaid diabetes patients receiving HbA1c testing, percent receiving depression screening, and many others.

• It will be a heavy lift to measurably improve Medicaid clinical quality by the end of 2021.
Transitional Care & Diversion Workgroup

Workgroup will ensure that the region implements effective evidence based practices that align with the Toolkit. Specifically the following:

- Provide recommendations to the NCACH Governing Board and staff on approaches to take for Transitional Care and Diversion Interventions projects.
- Ensure projects align with all six projects NCACH selected to implement.
- Use stakeholder and community input on project planning and implementation.
- Work with NCACH partners to implement sustainable changes in the regional health care system & Criminal Justice System
- Ensure projects effectively connect patients with resources to mitigate the negative consequences of the social determinants of health.
- Identify how IT, workforce, and value-based payment strategies can support this project.
Evidence Based Approaches:

1. Interventions to Reduce Acute Care Transfers, INTERACT™4.0
2. Transitional Care Model (TCM)
3. Care Transitions Intervention® (CTI®)
4. Care Transitions Interventions in Mental Health
5. Transitional Care for People with Health and Behavioral Health Needs Leaving Incarceration

Diversion Intervention

1. Emergency Department (ED) Diversion
2. Community Paramedicine Model
3. Law Enforcement Assisted Diversion (LEAD)
Transitional Care and Diversion Interventions Implementation Timeline

**2017**

- **DY1**
  - By November 16
    - Preliminary Project Plan due to HCA
      - Expected outcomes
      - Preliminary implementation approach and timing
      - Partnering Providers
      - Regional Assets, anticipated challenges and proposed solutions
      - Monitoring and continuous improvement
      - Sustainability

**2018**

- **DY2**
  - By June 30
    - Nov 2017 – Feb 2018
      - Assess current state capacity
      - Select Target population
      - Select Evidence-Based Approach
    - March 2018 – June 2018
      - Identify implementation partners and binding letters of intent
      - Financial Sustainability, Workforce, Population Health Management strategies
  - By September 30
    - Completed Implementation Plan (Prefer July 2018)

**2019**

- **DY3**
  - By March 31
    - Adopt guidelines, policies, procedures, and protocols
  - By June 30
    - Completed and Approved Quality Improvement Plan
    - Begin reporting on QIP measures semi-annually
  - By December 31
    - Implement Projects

**2020**

- **DY4**
  - By December 31
    - Increase scope and scale by serving additional high-risk populations, adding partners, and spreading to additional communities
    - Continuous quality improvement
    - Provide ongoing training, technical assistance, and/or learning collaboratives to support continuation and expansion
    - Identify and document the adoption by partnering providers of payment models that support transitional care, diversion activities, and the transition to value-based payment for services

**2021**

- **DY5**
  - By December 31
    - Ensure people are getting the right care in the right place by improving transitional care services.
    - Promote more appropriate use of emergency care services through increased access to primary care and social services.

**Goals:**
- By March 31
  - Adopt guidelines, policies, procedures, and protocols
- By June 30
  - Completed and Approved Quality Improvement Plan
  - Begin reporting on QIP measures semi-annually
- By December 31
  - Implement Projects

**P4R Payments**
- November: DY2 P4R
- November: DY3 P4R
- November: DY4 P4R
- November: DY5 P4R

**P4P Payments**
- May: DY2 P4P
- May: DY3 P4P
- May: DY4 P4P
- May: DY5 P4P

**P4P Measurement**
- April 2021: DY3 P4P
- April 2022: DY4 P4P
- April 2023: DY5 P4P

**DY3 P4P Baseline**
- November: DY2 P4P

**DY4 P4P Baseline**
- November: DY3 P4P

**DY5 P4P Baseline**
- November: DY4 P4P

**DY3 P4P Meas. Year**
- November: DY2 P4P

**DY4 P4P Meas. Year**
- November: DY3 P4P

**DY5 P4P Meas. Year**
- November: DY4 P4P

**DY3 P4P Meas. Year**
- November: DY5 P4P

**DY4 P4P Meas. Year**
- November: DY5 P4P

**DY5 P4P Meas. Year**
- November: DY5 P4P
# Implementation Plan

## Minimum Requirements

- Implementation timeline.
- Description of selected evidence-based approach, target population, justification for how approach is responsive to specific needs in the region.
- If applicable, explanation of how the standard pathways selected in Project 2B (Pathways Community HUB) align with the target population and evidence-based approach selected in this project.
- Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts.
- Roles and responsibilities of implementation partners.
- List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely manner.
- Descriptions of service delivery mode, which may include home-based and/or telehealth options.
- Describe strategies for ensuring long-term project sustainability.
Data Preview

Transitional Care & Diversion Intervention Workgroup
10/24/2017 Meeting
Regional Health Needs

Source: Community Health Needs Assessment
Medicaid Population Demographics

**NCACH Region (N=94,009)**

**Age Group**
- Adult (19+): 45% (42,231)
- Child (<19): 55% (51,778)

**Gender**
- Female: 53% (49,446)
- Male: 47% (44,563)

**Ethnicity**
- Hispanic: 47% (43,912)
- Not Hispanic: 39% (36,995)
- Unknown: 14% (13,102)

**Race**
- AI/AN: 3% (3,105)
- Asian: 1% (509)
- Black: 1% (866)
- NH/PI: 0% (380)
- White: 57% (53,873)
- Multiracial: 1% (661)
- Other: 27% (25,738)
- Unknown: 9% (8,877)

*Source: Healthier Washington Dashboard (Measurement period = 10/1/2015 – 9/30/2016)*
### Age Group

<table>
<thead>
<tr>
<th></th>
<th>CHELAN</th>
<th>DOUGLAS</th>
<th>GRANT</th>
<th>OKANOGAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult (19+)</td>
<td>48% (12,538)</td>
<td>43% (5,772)</td>
<td>41% (15,273)</td>
<td>51% (8,648)</td>
</tr>
<tr>
<td>Child (&lt;19)</td>
<td>52% (13,559)</td>
<td>57% (7,760)</td>
<td>59% (22,072)</td>
<td>49% (8,387)</td>
</tr>
</tbody>
</table>

### Gender

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<thead>
<tr>
<th></th>
<th>CHELAN</th>
<th>DOUGLAS</th>
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<th>OKANOGAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>52% (13,497)</td>
<td>53% (7,117)</td>
<td>53% (19,961)</td>
<td>52% (8,871)</td>
</tr>
<tr>
<td>Male</td>
<td>48% (12,600)</td>
<td>47% (6,415)</td>
<td>47% (17,384)</td>
<td>48% (8,164)</td>
</tr>
</tbody>
</table>

### Ethnicity

<table>
<thead>
<tr>
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<th>CHELAN</th>
<th>DOUGLAS</th>
<th>GRANT</th>
<th>OKANOGAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>42% (11,072)</td>
<td>47% (6,311)</td>
<td>58% (21,769)</td>
<td>28% (4,760)</td>
</tr>
<tr>
<td>Not Hispanic</td>
<td>38% (9,981)</td>
<td>37% (4,947)</td>
<td>34% (12,608)</td>
<td>56% (9,459)</td>
</tr>
<tr>
<td>Unknown</td>
<td>19% (5,044)</td>
<td>17% (2,274)</td>
<td>8% (2,968)</td>
<td>17% (2,816)</td>
</tr>
</tbody>
</table>

### Race

<table>
<thead>
<tr>
<th></th>
<th>CHELAN</th>
<th>DOUGLAS</th>
<th>GRANT</th>
<th>OKANOGAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI/AN</td>
<td>1% (237)</td>
<td>1% (137)</td>
<td>1% (139)</td>
<td>14% (2,352)</td>
</tr>
<tr>
<td>Asian</td>
<td>1% (191)</td>
<td>1% (98)</td>
<td>0% (51)</td>
<td>1% (123)</td>
</tr>
<tr>
<td>Black</td>
<td>1% (173)</td>
<td>1% (84)</td>
<td>1% (169)</td>
<td>0% (66)</td>
</tr>
<tr>
<td>NH/PI</td>
<td>0% (117)</td>
<td>0% (77)</td>
<td>0% (120)</td>
<td>0% (66)</td>
</tr>
<tr>
<td>White</td>
<td>52% (13,561)</td>
<td>49% (6,665)</td>
<td>66% (24,566)</td>
<td>53% (9,081)</td>
</tr>
<tr>
<td>Multiracial</td>
<td>0% (117)</td>
<td>1% (92)</td>
<td>1% (278)</td>
<td>1% (174)</td>
</tr>
<tr>
<td>Other</td>
<td>32% (8,231)</td>
<td>34% (4,633)</td>
<td>25% (9,204)</td>
<td>22% (3,670)</td>
</tr>
<tr>
<td>Unknown</td>
<td>13% (3,470)</td>
<td>13% (1,746)</td>
<td>6% (2,143)</td>
<td>9% (1,518)</td>
</tr>
</tbody>
</table>
# FY2016 Hospital Census

<table>
<thead>
<tr>
<th>Hospital</th>
<th># of Medicaid Discharges</th>
<th>Mean Length of Stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cascade Medical Center</td>
<td>5</td>
<td>3.60</td>
</tr>
<tr>
<td>Columbia Basin Hospital</td>
<td>25</td>
<td>2.16</td>
</tr>
<tr>
<td>Confluence-Central WA Hospital</td>
<td>3,129</td>
<td>3.46</td>
</tr>
<tr>
<td>Confluence – Wenatchee Valley Hospital &amp; Clinics</td>
<td>42</td>
<td>10.07</td>
</tr>
<tr>
<td>Coulee Medical Center</td>
<td>228</td>
<td>2.24</td>
</tr>
<tr>
<td>Lake Chelan Community Hospital</td>
<td>156</td>
<td>2.12</td>
</tr>
<tr>
<td>Mid-Valley Hospital</td>
<td>466</td>
<td>1.99</td>
</tr>
<tr>
<td>North Valley Hospital</td>
<td>175</td>
<td>2.35</td>
</tr>
<tr>
<td>Quincy Valley Medical Center</td>
<td>4</td>
<td>3.00</td>
</tr>
<tr>
<td>Samaritan Healthcare</td>
<td>1,233</td>
<td>1.98</td>
</tr>
<tr>
<td>Three Rivers Hospital</td>
<td>193</td>
<td>2.09</td>
</tr>
</tbody>
</table>

*Source: Department of Health CHARS data | Measurement Period: 1/1/16 – 12/31/16*

Critical Access Hospitals circled in red
### Top Ten Most Common Causes of Acute Hospitalizations Among Medicaid Recipients

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of Acute Hospitalization</th>
<th>Count</th>
<th>%</th>
<th>State Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Injury and Poisoning</td>
<td>266</td>
<td>12.1</td>
<td>2 (9.4%)</td>
</tr>
<tr>
<td>2</td>
<td>Mental and Behavioral Disorders</td>
<td>171</td>
<td>7.8</td>
<td>1 (18.2%)</td>
</tr>
<tr>
<td>3</td>
<td>Diseases of Heart</td>
<td>135</td>
<td>6.1</td>
<td>4 (5.7%)</td>
</tr>
<tr>
<td>4</td>
<td>Respiratory Infections</td>
<td>132</td>
<td>6.0</td>
<td>9 (3.6%)</td>
</tr>
<tr>
<td>5</td>
<td>Diseases of the Musculoskeletal System and Connective Tissue</td>
<td>115</td>
<td>5.2</td>
<td>5 (4.5%)</td>
</tr>
<tr>
<td>6</td>
<td>Substance Use Disorder</td>
<td>105</td>
<td>4.8</td>
<td>6 (4.6%)</td>
</tr>
<tr>
<td>7</td>
<td>Septicemia</td>
<td>105</td>
<td>4.8</td>
<td>3 (7.4%)</td>
</tr>
<tr>
<td>8</td>
<td>Cancer/Malignancies</td>
<td>102</td>
<td>4.6</td>
<td>8 (3.6%)</td>
</tr>
<tr>
<td>9</td>
<td>Diabetes</td>
<td>94</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Diseases of Liver, Biliary Tract, and Pancreas</td>
<td>84</td>
<td>3.8</td>
<td>7 (3.7%)</td>
</tr>
</tbody>
</table>

Source: Health Care Authority Starter Kit, determined by primary diagnosis field in HCA ProviderOne Medicaid Data System
# Top Ten Most Common Causes of Outpatient ED Utilization Among Medicaid Recipients

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of Acute Hospitalization</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Symptoms, signs &amp; abnormal clinical and lab findings</td>
<td>8,007</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>Injury, poisoning, and certain other consequences of external causes</td>
<td>7,822</td>
<td>23</td>
</tr>
<tr>
<td>3</td>
<td>Diseases of the respiratory system</td>
<td>3,860</td>
<td>11</td>
</tr>
<tr>
<td>4</td>
<td>Diseases of the digestive system</td>
<td>2,169</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>1,635</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Mental and behavioral disorders</td>
<td>1,554</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>Diseases of the skin and subcutaneous tissue</td>
<td>1,423</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>Diseases of the genitourinary system</td>
<td>1,352</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>Pregnancy, childbirth and the puerperium</td>
<td>1,195</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>Infectious and parasitic diseases</td>
<td>1,104</td>
<td>3</td>
</tr>
</tbody>
</table>

*Source: Health Care Authority (ED utilization by Facility data set)*

*Data for North Central ACH (Oct 1, 2015 - Sep 30, 2016)*
ED utilization by Triage Levels

Counts by Hospital and Triage Level

Source: Health Care Authority (ED utilization by Facility data set)
Note: Triage Levels based on CPT code groupings
Arrest/Incarceration Data

NCACH Criminal Justice Summary by County

Source: Washington State Statistical Analysis Center County Profiles
Youth Detention Rates

Figure 3. Youth-Level Detention Rates by County. This figure shows the number of youth (per 1,000 youth age 10-17 in the county) who had at least one detention stay in 2016.

*Detention data were not available for the full 2016 calendar year from these counties.

Source: Washington State Center for Court Research (Juvenile Detention 2016 Annual Report)
Youth Detention Rates

Figure 5. Youth in Detention in 2016 by Race/Ethnicity and County. This figure shows the racial/ethnic breakdown of youth who had at least one detention stay in 2016.

Source: Washington State Center for Court Research (Juvenile Detention 2016 Annual Report)
Accountability Measures

Transitional Care & Diversion Interventions

Source: Health Care Authority and DSHS-RDA
Measurement period 10/1/2015-9/30/2016
## Risk Factors for ED Utilization

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>X times more likely to exhibit risk factor, if have 3+ ED visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematological</td>
<td>8.85 (extra high) 4.3 (medium) 4.3 (low)</td>
</tr>
<tr>
<td>Type 1 diabetes (high)</td>
<td>7.2</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>6.8 (very high) 4.7 (medium)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>6.6 (very high) 4.1 (medium)</td>
</tr>
<tr>
<td>Renal (extra high)</td>
<td>6.0</td>
</tr>
<tr>
<td>Co-occurring mental illness/substance use disorder</td>
<td>5.2</td>
</tr>
<tr>
<td>Substance abuse (low)</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Source: DSHS Research and Data Analysis cross-system outcome measures
Date specific to Medicaid members in NCACH region
## Risk Factors for Arrests

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>X times more likely to exhibit risk factor, if have 3+ ED visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse - low (drug abuse/dependence)</td>
<td>6.5</td>
</tr>
<tr>
<td>SUD treatment need</td>
<td>5.4</td>
</tr>
<tr>
<td>Co-occurring mental illness/substance use disorder</td>
<td>4.8</td>
</tr>
<tr>
<td>Substance abuse – very low (alcohol abuse/dependence)</td>
<td>3.4</td>
</tr>
<tr>
<td>HIV (asymptomatic infection)</td>
<td>3.0</td>
</tr>
<tr>
<td>Psychiatric – high (schizophrenia)</td>
<td>2.7</td>
</tr>
<tr>
<td>Psychiatric – medium (bipolar)</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Source: DSHS Research and Data Analysis cross-system outcome measures  
Date specific to Medicaid members in NCACH region
### Feedback from CHIS

<table>
<thead>
<tr>
<th>Implications for Transition Care</th>
<th>Implications for Diversion Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Release to homelessness (lack of affordable housing, rigid transitional housing, lack of wet/low barrier shelters)</td>
<td>Ranked order of needs for client populations served by CHI members (both medical and social service providers)</td>
</tr>
<tr>
<td></td>
<td>1. Non-acute ER use (no same day appointments, nighttime access)</td>
</tr>
<tr>
<td></td>
<td>2. Mental health and substance abuse challenges a big issue</td>
</tr>
<tr>
<td></td>
<td>3. Inappropriate use of EMS</td>
</tr>
<tr>
<td>Need follow up post release (primary care, coaching, patient education, follow up phone calls)</td>
<td>Low health literacy</td>
</tr>
<tr>
<td>Referrals to other community resources (non-medical) – need to match to biggest issue</td>
<td>No access to care (in clients’ minds) – don’t know how to access services, lack system navigator, transportation</td>
</tr>
<tr>
<td>Legal barriers post incarceration</td>
<td>Lack of coordination of services</td>
</tr>
<tr>
<td>Lack of interagency planning</td>
<td>Contact with law enforcement often symptom of lack of engagement with social service network</td>
</tr>
<tr>
<td>Lack of system supports (overwhelming, systems not well explained)</td>
<td></td>
</tr>
<tr>
<td>Discharge instructions should be written at 3rd grade level</td>
<td></td>
</tr>
</tbody>
</table>
Feedback from CHIs

Data Requests

• Where do ED utilizers (including high utilizers) live? (zip code frequencies and mapping)

• For *Outpatient ED visits* measure from HCA, could we get demographic breakouts?

• For top reasons for hospitalization, can we get data by county?

• Is there aggregate information we could request from WSHA (EDIE) that would help with project planning?

• Can we get measure rates for projects broken out by county?

• What else would you like to add?
Feedback from CHIs

Questions / Thoughts

• Is there a way to increase primary urgent care to avoid ER visits? Is there capacity with such few providers? (workforce implications)
• Need to recognize that rural areas with no urgent care clinics may have not other option than ER (e.g. Okanogan County)
• Provide more health literacy course for parents who are taking children to ER
• There is misuse of EMS for non-emergent transport to services
• What other questions or thoughts do you have?
Project Reporting Measures

• 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
• % of partnering provider organizations with staffing ratios equal or better than recommended (Diversion only)
• VBP arrangement with payments/metrics to support adopted model (2021 only)
Project Performance Measures
Transitional Care

- Antidepressant Medication Management
- Child and Adolescents’ Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- 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
- Medication Management for People with Asthma (5 – 64 Years)
- Mental Health Treatment Penetration (Broad Version)

- Outpatient ED Visits per 1000 Member Months
- Plan All-Cause Readmission Rate (30 Days)
- Substance Use Disorder Treatment Penetration
- Percent Homeless (Narrow definition)
- Percent Arrested
- Medication Assisted Therapy (MAT): With Buprenorphine or Methadone
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Substance Use Disorder Treatment Penetration (opioid)
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)
Project Performance Measures

Diversion Interventions

- Antidepressant Medication Management
- Child and Adolescents’ Access to Primary Care Practitioners
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- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)
Next Steps – Project Planning

Project Plan Application Due November 16th
- Preliminary Evidence based Approaches and Target Populations
- Signed Membership Agreement (email to john.Schapman@cdhd.wa.gov)

Project Implementation Planning Timeline
- Read Evidence Based Approaches & review data for Target Populations
- Ensure Alignment with other Demonstration Projects

Nov 2017 – Feb 2018
- Assess current state capacity
- Select Target population
- Select Evidence-Based Approach

March 2018 – June 2018
- Identify implementation partners and binding letters of intent
- Financial Sustainability, Workforce, Population Health Management strategies

June 2018 – Sept 2018
Completed
Implementation Plan
*Prefer completion by July 2018*
Contact

John Schapman
Transitional Care and Diversion Interventions Project Lead
email: john.Schapman@cdhd.wa.gov
Emergency Department (ED) Diversion

A systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.

Target Population: Medicaid beneficiaries presenting at the ED for non-acute condition

Summary of Evidence Based Approach: While there is no single model for effective ED Diversion, a variety of examples can be found that share common elements. The following elements must be reflected in the implementation, unless noted otherwise:

- ED will establish linkages to community primary care provider(s) in order to connect beneficiaries without a primary care provider to one, or for the purpose of notifying the current primary care provider of the ED presentation and coordinating a care plan. Where available, care coordinators can facilitate this process.
- ED will establish policies and procedures for identifying beneficiaries with minor illnesses who do not have a primary care provider. After completing appropriate screenings validating a non-emergency need, will assist the patient in receiving a timely appointment with a primary care provider.

A major focus of Emergency Department diversion in the Demonstration will be focused on the Washington State Health Association’s ER is for Emergencies Seven Best Practices:

1. **Electronic Health Information** – Adoption of an electronic emergency department information system on a statewide basis to create and act on a common, integrated plan of care related to patients with high needs (5 or more visits in a rolling calendar year) by all emergency rooms, payors, mental health clinics, and is sent to primary care providers.

2. **Patient Education** – Dissemination of patient education materials by hospitals and payors to help patients understand and utilize the appropriate resources for care. This would include plans sharing with patients and providers where they can get off hours coverage for primary or urgent care including through nurse call lines and having this information easily available on their web sites.

3. **Identify Frequent Users of the Emergency Department and EMS** – Frequent emergency department (ER) or EMS users are identified as those patients seen or transported to the ER five (5) times within the past 12 months. Hospitals should identify those frequent ER users upon arrival to the emergency department and develop and coordinate case management, including utilization of care plans. Plans, EMS, and mental health clinics will work with patients with five or more visits to identify and overcome core issue which is documented in statewide information system.
4. **Develop Patient Care Plans for Frequent ER Users** – A process to assist frequent ER users with their care plans, such as contacting the primary care provider within 72-96 hours and/or notifying the PCP of an ER visit if no follow-up is required. Payors will provide the information system with the names of the primary care or group for Medicaid patients and provider fax number.

5. **Narcotic Guidelines** – Reduce drug-seeking and drug-dispensing to frequent ER users through implementation of guidelines that incorporate the WA-Acep guidelines.

6. **Prescription Monitoring** – ER Physician enrollment in the state’s Prescription Monitoring Program (PMP). The PMP is an electronic online database used to collect data on patients who are prescribed controlled substances ensuring coordination of prescription drug prescribing practices.

7. **Use of Feedback Information** – Designation of a hospital emergency department physician and hospital staff responsible for reviewing the reports of frequent ER users to ensure interventions are working, including a process of reporting to executive leadership.
Community Paramedicine Model

An evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations.

Target Population: Medicaid beneficiaries who access the EMS system for a non-emergent condition

Summary of Evidence Based Approach: 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, such as urgent care centers and/or patient-centered medical homes. Providers may collaborate to develop Community Paramedicine programs. Core issues to be addressed in the design of a community paramedicine program should include:

- A detailed explanation about how the community paramedics would be trained and would maintain their skills.
- A description of how appropriate medical supervision would be ensured.
- A description of how data to evaluate quality assurance and quality improvement activities would be obtained and monitored.
- An evaluation plan for assessing the impacts on quality and cost of care, and how the local EMS agency will ensure that all patients are treated equally regardless of insurance status and health condition, among other factors.
- A plan for integrating the CP program with other community-based health care and social service programs and for analyzing the potential impacts of the CP program on these providers, including safety-net providers.
- How to leverage the potential of electronic health records (EHRs) and Health Information Exchange (HIE) to facilitate communication between community paramedics and other health care providers.

Potential Community Paramedicine Services:

Prehospital Services

- Transport patients with specified conditions not needing emergency care to alternate, non-emergency department locations.
- After assessing and treating as needed, determine whether it is appropriate to refer or release an individual at the scene of an emergency response rather than transporting them to a hospital emergency department.
- Address the needs of frequent 911 callers or frequent visitors to emergency departments by helping them access primary care and other social services.
Post-Hospital or Community Health Services

- Provide follow-up care for persons recently discharged from the hospital and at increased risk of a return visit to the emergency department or readmission to the hospital.
- Provide support for persons with diabetes, asthma, congestive heart failure, or multiple chronic conditions.
- Partner with community health workers and primary care providers in underserved areas to provide preventive care.
Law Enforcement Assisted Diversion, LEAD®

A community-based diversion approach with the goals of improving public safety and public order, and reducing the criminal behavior of people who participate in the program.

Target Population: Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement

Summary of Evidence Based Approach: Review resources and assistance available from the LEAD® National Support Bureau. Many components of LEAD® can be adapted to fit local needs and circumstances, however, the following core principles must be built into the implementation:

- Establish the LEAD® program as a voluntary agreement among independent decision-makers.
- Engage law enforcement and generate buy-in, including obtaining Commander level support.
- Identify a dedicated project manager.
- Tailor the LEAD® intervention to the community.
- Provide intensive case management – to link diverted individuals to housing, vocational and educational opportunities, treatment, and community services. Participants may need access to medication-assisted therapy and other drug treatment options; they may also need access to food, housing, legal advocacy, job training, and other services.
  - Apply a harm reduction/housing first approach – develop individual plans that address the problematic behavior as well as the factors driving that behavior.
  - Consider the use of peer supports.
- Provide training in the areas of trauma-informed care and cultural competencies.
- Prepare an evaluation plan.

*See attached facts sheet for additional information*
Interventions to Reduce Acute Care Transfers, INTERACT™4.0

*a quality improvement program that focuses on the management of acute change in resident condition*

**Target Population:** Medicaid beneficiaries who are could transfer to the acute hospital from a Skilled Nursing Facility

**Summary of Evidence Based Approach:** The overall goal of the INTERACT® program is to reduce the frequency of transfers to the acute hospital. Transfers to the hospital can be emotionally and physically difficult for residents, result in numerous complications of hospitalization, and are costly.

By improving the identification, evaluation, and communication about changes in resident status, some, but not all acute care transfers can be avoided.

**Interact 4.0:** The skilled nursing facility (SNF) and the project implementation team will utilize INTERACT™4.0 toolkit and resources and implement the following core components:

- Educate leadership in the INTERACT™ principles.
- Identify a facility champion who can engage other staff and serve as a coach.
- Develop care pathways and other clinical tools for monitoring patients that lead to early identification of potential instability and allow intervention to avoid hospital transfer.
- Provide all staff with education and training to fill their role in the INTERACT™ model.
- Educate patients and families and provide support that facilitates their active participation in care planning.
- Establish enhanced communication with acute care hospitals, relying on technology where appropriate.
- Establish quality improvement process, including root cause analysis of transfers and identification and testing of interventions.
- Demonstrate cultural competence and client engagement in the design and implementation of the project.

There are four basic types of tools used in Interact:

1. Quality Improvement tools
2. Communication tools
3. Decision Support tools
4. Advance Care Planning tools

The specific tools are designed for use by selected members of the care team. However, in order for the INTERACT® team to be successful, all members of the care team should be aware of all of the tools and their uses. An INTERACT® project champion will assist the team in using the tools on a daily basis. The tools have been designed to help staff improve care, but not increase unnecessary paperwork.
Transitional Care Model (TCM)

*a nurse led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up.*

**Target Population:** Medicaid beneficiaries discharged from acute care to home or to supportive housing

**Summary of Evidence Based Approach:** Manages transitions in care, especially among elderly patients, enhances patient experiences, improves health and quality-of-life outcomes, and represents wiser use of finite resources.

**Essential elements of the TCM model:**

- Use of advanced knowledge and skills by a transitional care nurse (TCN) to deliver and coordinate care of high risk older adults within and across all health care settings. The TCN is primary coordinator of care throughout potential or actual episodes of acute illness;
- Comprehensive, holistic assessment of each older adult’s priority needs, goals and preferences;
- Collaboration with older adults, family caregivers and team members in implementation of a streamlined, evidenced-based plan of care designed to promote positive health and cost outcomes;
- Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months;
- Continuity of health care between hospital, post-acute and primary care clinicians facilitated by the TCN accompanying patients to visits to prevent or follow-up on an acute illness care management;
- Active engagement of patients and family caregivers with a focus on meeting their goals;
- Emphasis on patients’ early identification and response to health care risks and symptoms to achieve longer term positive outcomes and avoid adverse and untoward events that lead to acute care service use (e.g., emergency department visits, re-hospitalizations);
- Multidisciplinary approach that includes the patient, family caregivers and health care providers as members of a team;
- Strong collaboration and communication between older adults, family caregivers and health care team members across episodes of acute care and in planning for future transitions (e.g., palliative care); and
- Ongoing investment in optimizing transitional care via performance monitoring and improvement.
The Care Transitions Intervention® (CTI®)

*a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives.*

**Target Population:** Medicaid beneficiaries discharged from acute care to home or to supportive housing

**Summary of Evidence Based Approach:** The Care Transitions Intervention® is also known as the CTI®, the Skill Transfer Model™, the Coleman Transitions Intervention Model® and the Coleman Model®. During a 4-week program, patients with complex care needs and family caregivers receive specific tools and work with a Care Transitions Coach to learn self-management skills that will ensure their needs are met during the transition from hospital to home. This is a low-cost, low-intensity evidence-based intervention comprised of a home visit and three phone calls.

**Transition Coach:** The Transitions Coach® is key to encouraging the patient and family caregiver to assume a more active role in their care. The Transitions Coach® does not fix problems and does not provide skilled care though she or he possesses these skills from prior health professional training. Rather, Transitions Coaches® model and facilitate new behaviors, skill transfer, and communication strategies for patients and families to build confidence that they can successfully respond to common problems that arise during care transitions. The patient’s goal drives the agenda. The main steps in implementing the CTI model are:

- A meeting with a Transitions Coach® in the hospital (where possible, as this is desirable but not essential) to discuss concerns and to engage patients and their family caregivers.
- Set up the Transitions Coach® in home follow-up visit and accompanying phone calls designed to increase self-management skills, personal goal attainment and provide continuity across the transition.
Care Transitions Interventions in Mental Health

provides a set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness (SMI).

Target Population: Medicaid beneficiaries with SMI discharged from inpatient care

Summary of Evidence Based Approach: Set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness - including discharge from intensive behavioral health care, and discharge from ER for mental health, alcohol, or other drug dependence. Those components are as follows:

- **Prospective modeling:** employ prospective modeling to identify who is at greatest risk. Consider different patterns of morbid conditions within and among mental illnesses, substance abuse disorders and general medical/surgical conditions that might require modifications.
- **Patient and family engagement:** create culturally competent engagement strategies to drive authentic inclusion of patient and/or family in treatment/transitional care plan. Adapt engagement strategies for individuals with SMI.
- **Transition planning:** establish an appropriate client specific plan for transition to the next point of care. Consider how to utilize step-down mental health services, such as day treatment and intensive outpatient care. Consider trade-offs between length of stay for stabilization and risk of re-hospitalization. Include assessment of need of primary care planning as well as substance abuse and dual disorders. An assessment and specific plan for housing and other social services should be included.
- **Information transfer/personal health record:** ensure all information is communicated, understood, and managed, and links patients, caregivers, and providers. Establish protocols to ensure privacy and other regulations are followed. Establish pathways for information flow among providers and clinics.
- **Transition coaches/agents:** define transition coach role, tasks, competencies, training, and supervision requirements. Consider the need for mental health providers, such as social workers, to serve as transition agents or to train other personnel in mental health tools and techniques. Consider use of health information technology to augment/assist coaches.
- **Provider engagement:** providers at each level of care should have clear responsibility and plan for implementing all transition procedures/interventions. Communication and hand-off arrangements should be pre-specified in a formal way.
• **Quality metrics and feedback:** gather metrics on follow-up post-hospitalization, re-hospitalization and other feedback on process and outcomes and consumer/family perspective. Utilize metrics in quality improvement and accountability.

• **Shared accountability:** all providers share in expectations for quality as well as rewards/penalties. Accountability mechanisms may include financial mechanisms and public reporting with regard to quality and value. Consumers/families share in accountability as well.

(http://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf)
Evidence-informed Approaches to Transitional Care for People with Health and Behavioral Health Needs Leaving Incarceration

outcomes-focused research on effective integrated health and behavioral health programs for people leaving incarceration

Target Population: Medicaid beneficiaries returning to the community from prison or jail.

Summary of Evidence-Informed Approach: Considerable evidence on effective integrated care models, prison/jail reentry, and transitional programming has paved the way for increased understanding of critical components of an integrated transitional care approach, such as:

- Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison
- A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders

For projects targeting people transitioning from incarceration, they should include in the implementation plan at a minimum:

- Strategy to increase Medicaid enrollment, including:
  - Process for identifying (1) individuals who are covered under Medicaid and whose benefits will not be terminated as a result of incarceration; (2) individuals whose Medicaid eligibility will terminate as a result of incarceration; (3) individuals who will likely be Medicaid eligible at release regardless of current or prior beneficiary status;
  - Process for completing and submitting Medicaid applications for individuals (2) and (3) above, timed appropriately such that their status moves from suspended to active at release; and
  - Agreements in place with relevant criminal justice agencies to ensure individuals (1) above receive community-based, Medicaid reimbursable care in a timely matter when clinically appropriate (with particular consideration of populations “at risk,” such as the elderly, LGBTQ, chronically ill, those with serious mental illness and/or substance use disorders, and more).
- Strategy for beginning care planning and transition planning prior to release, including:
  - A process for conducting in-reach to prison/jails and correctional facilities, which leverages and contemplates resources, strengths, and relationships of all partners;
  - A strategy for engaging individuals in transitional care planning as a one component to a larger reentry transition plan; and
  - A strategy for ensuring care planning is conducted in a culturally competent manner and contemplates social determinants of health, barriers to accessing services or staying healthy, as well as barriers to meeting conditions of release or staying crime-free.
As the United States addresses the urgent crisis of mass criminalization and incarceration, there is a clear need to find viable, effective alternatives, particularly at the front end by preventing people from entering the criminal justice system unnecessarily. This task requires assessing government’s current response to safety, disorder, and health-related problems; critically re-examining the role that police officers are asked to play in our communities; and developing alternative-system responses independent of the justice system, while finding ways to improve relationships between the police and those they serve. Law Enforcement Assisted Diversion (LEAD) is a response to these gaps. LEAD uses police diversion and community-based, trauma-informed care systems, with the goals of improving public safety and public order, and reducing law violations by people who participate in the program.

**BACKGROUND**

In 2011, in an attempt to move away from the War on Drugs paradigm and to reduce gross racial disparities in police enforcement, LEAD -- a new harm-reduction oriented process for responding to low-level offenses such as drug possession, sales, and prostitution -- was developed and launched in Seattle, WA. LEAD was the result of an unprecedented collaboration between police, prosecutors, civil rights advocates, public defenders, political leaders, mental health and drug treatment providers, housing providers and other service agencies, and business and neighborhood leaders -- working together to find new ways to solve problems for individuals who frequently cycle in and out of the criminal justice system under the familiar approach that relies on arrest, prosecution, and incarceration.

**WHAT IS LEAD?**

In a LEAD program, police officers exercise discretionary authority at point of contact to divert individuals to a community-based, harm-reduction intervention for law violations driven by unmet behavioral health needs. In lieu of the normal criminal justice system cycle -- booking, detention, prosecution, conviction, incarceration -- individuals are instead referred into a trauma-informed intensive case-management program where the individual receives a wide range of support services, often including transitional and permanent housing and/or drug treatment. Prosecutors and police officers work closely with case managers to ensure that all contacts with LEAD participants going forward, including new criminal prosecutions for other offenses, are coordinated with the service plan for the participant to maximize the opportunity to achieve behavioral change.

LEAD holds considerable promise as a way for law enforcement and prosecutors to help communities respond to public order issues stemming from unaddressed public health and human services needs -- addiction, untreated mental illness, homelessness, and extreme poverty -- through a public health framework that reduces reliance on the formal criminal justice system.

**EVALUATION RESULTS**

After three years of operation in Seattle, a 2015 independent, non-randomized controlled outcome study found that LEAD participants were 58% less likely to be arrested after enrollment in the program, compared to a control group that went through “system as usual” criminal justice processing. With significant reductions in recidivism, LEAD functions as a public safety program that has the potential to decrease the number of those arrested, incarcerated, and are otherwise caught up in the criminal justice system. Additionally, preliminary program data collected by case managers also indicate that LEAD improves the health and well-being of people struggling at the intersection of poverty and drug and mental health problems. And the multi-sector collaboration between stakeholders who are often otherwise at odds with one another demonstrates an invaluable process-oriented outcome that is increasingly an objective of broader criminal justice and drug policy reform efforts.
Many components of LEAD can be adapted to fit local needs and circumstances. However, there are certain core principles that are essential in order to achieve the transformative outcomes seen in Seattle. These include LEAD’s harm reduction/Housing First framework, which requires a focus on individual and community wellness, rather than an exclusive focus on sobriety; and the need for rank and file police officers and sergeants to be meaningful partners in program design and operations.

4. UNDO
racial disparities at the front end of the criminal justice system

5. SUSTAIN
funding for alternative interventions by capturing and reinvesting justice systems savings

6. STRENGTHEN
the relationship between law enforcement and the community

An unplanned, but welcome, effect of LEAD has been the reconciliation and healing it has brought to police-community relations. While tensions rise between law enforcement and community members and civil rights advocates, LEAD has led to strong alliances among traditional opponents in policy debates surrounding policing, and built a strong positive relationship between police officers and people on the street who are often a focus of police attention. Community public safety leaders rallied early and have remained staunch in their support for this less punitive, more effective, public-health-based approach to public order issues. LEAD begins to answer the pressing question of what the community wants from the police with regard to public order problems by introducing an alternative evidence-based model.

Jurisdictions across the country are interested in replicating this transformative model. In 2014, Santa Fe, NM became the second jurisdiction to launch. In 2015 and 2016, Huntington, WV, Albany, NY, and Fayetteville, NC followed. Dozens of jurisdictions are exploring LEAD programs, and those on pace to launch in 2017 include Baltimore, MD; Portland, OR; Thurston Co, WA; Madison, WI; San Francisco, Stockton and Los Angeles, CA; and several cities in North Carolina. LEAD-aligned programs are planned in Atlanta, GA and New Orleans, LA.

In July 2015, the White House hosted a National Convening on LEAD with interested delegations from nearly 30 jurisdictions including district attorneys, police chiefs, city council members, community police reform advocates, state legislators, and human service providers.

GOALS AND CORE PRINCIPLES OF LEAD

LEAD advances six primary goals:

1. REORIENT
government’s response to safety, disorder, and health-related problems

2. IMPROVE
public safety and public health through research based, health-oriented and harm reduction interventions

3. REDUCE
the number of people entering the criminal justice system for low level offenses related to drug use, mental health, sex work, and extreme poverty

4. UNDO
racial disparities at the front end of the criminal justice system

5. SUSTAIN
funding for alternative interventions by capturing and reinvesting justice systems savings

6. STRENGTHEN
the relationship between law enforcement and the community

LEAD’S POTENTIAL FOR RECONCILIATION & HEALING

REPLICATING THE LEAD MODEL NATIONALLY