# Transitional Care and Diversion Intervention Workgroup

**10:00 AM – 11:30 AM Thursday December 21st**

<table>
<thead>
<tr>
<th>Location</th>
<th>Conference Information:</th>
</tr>
</thead>
</table>
| Confluence Technology Center 285 Technology Center Way #102, Wenatchee, WA 98801 | 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>
</tr>
</thead>
</table>
| **1. Welcome, Introductions, & Project Planning Structure** | 10:00 | • Welcome members  
• Context of meeting  
• Review of last meeting  
• Project Plan Application Summary  
• Proposed Project Planning Structure and Timeline  
  o Diversion Project and Transitional Care Projects |
| **2. Project Data:** | 10:30 | • Review of project metrics & Data Review |
| **3. Review of Evidence Based Approaches in Project** | 10:45 | • Review all Evidence Based Approaches  
• Recommend and prioritize strategies for WPCC and/or the Opioid Workgroup  
• Method for final approach selection |
| **4. Next Steps:** | 11:15 | • Please return signed member agreement  
• Final selection of approaches  
• Next meeting Thursday January 18th  
  10 AM – 11:30 AM  
• Appoint Workgroup Chair  
• Attachments to meeting request:  
  o Project Plan Application summary  
  o One Pagers for Evidence Based Approaches  
  o Meeting Agenda and Presentation  
• Please returned sign member agreement to [john.schapman@cdhd.wa.gov](mailto:john.schapman@cdhd.wa.gov) |
Transitional Care and Diversion Intervention Workgroup Notes
10:00 AM – 11:30 AM Tuesday October 24th 2017

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

Attendance in person:  Steve Wilson, Nancy Nash-Mendez, Deb Miller, Jackie Weber, Misty Kuntsman, Christal Eshelman, John Schapman, Caroline Tillier, Linda Parlette
Via phone:  Mike Beaver, Molly Morris, Kevin Risdon, Kris Neff, Shannon Mack, Naudia Pickens, Brooklyn Holton, Teri Riley Brown, Vicki Polhamus
Notes:  Teresa Davis

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome &amp; Introductions</td>
<td>• Workgroup Charter: These are two different projects but we are merging into one workgroup. Please read the charter and return signed membership form as soon as possible via email to John Schapman</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Introduction to Healthier, WA &amp;</td>
<td></td>
</tr>
<tr>
<td>Demonstration</td>
<td>• Linda Parlette gave an introduction to Healthier Washington.</td>
</tr>
<tr>
<td></td>
<td>• Christal Eshelman gave a high level overview of Medicaid Demonstration Project—went over the 6 projects that our region has selected.</td>
</tr>
<tr>
<td></td>
<td>• John Schapman explained how the funding for Transitional Care &amp; Diversion Intervention projects will work. Conservative estimate is a couple hundred thousand dollars a year to fund these projects. The toolkit gives guidance on the target populations and evidence based approaches. Will send out the section that applies to this workgroup. This group will make recommendations to the NCACH Governing Board and they will vote on approval. This workgroup will be trying to figure out how to incorporate the social determinants of health. We will have to show how these projects will align with other projects in the demonstration. This work needs to be sustainable—we need to make sure that there is a funding mechanism going forward after the 5 year project ends. November 16th we have a preliminary project plan that we have to submit. What we are putting in the project plan will be preliminary and will change if the workgroup and data shows another direction that we should head.</td>
</tr>
</tbody>
</table>


### 3. Project Data
**Caroline Tillier**
- Caroline Tillier gave a Health and Community Data Review
  - Demographic data – As we are deciding where to prioritize our planning, we need to use the data to see the biggest need.
  - Hospital data – Are ED visits being double counted if they are transferred to another hospital? Caroline will check with HCA.
  - Criminal Justice data – Okanogan County has a drug court program. They are also working on a diversion program. They are noticing an increase of drug use with violence and that makes them ineligible for the program. They are working with the prosecutor about looking at history vs one time incident of violence to make more people eligible for program. Youth incarceration may have a lot to do with homelessness. Home demographics also has a lot to do with it ie: what the kids return home to. A community center and/or more community support would make a difference in these numbers. Native American and Hispanic cultures are accustom to living with family but would be considered homeless by HUD standards.
- Community Input Data
  - CHI & Survey data – Among getting out of jail, there is not case management to help get back on Medicaid, many wait until they go to the doctor. Would be interesting to know what the average stay in jail is, what they are in for and how to access the client during that stay.

### 4. Project Plan Timeline
**John Schapman**
- 6 – 9 month timeline
- Alignment with all 6 projects
- Project Plan Application (due Nov 16th, 2017) and Implementation Plan (due Sept 30th, 2018)

### 5. Other Announcements:
- A Doodle Poll will be sent out to schedule the next and regular workgroup meeting – Nancy suggested aligning with the board meetings. We will also rotate the county to have the meetings at.
- Regarding evidence based approaches – do you want more homework between meetings or go over during presentations? Initially read the one pagers that were sent out to discuss at the next meeting. Send any questions or ideas / requests for data to John by Mid November and we can send out more info.
- **Please return signed member agreement prior to Nov 16th to john.schapman@cdhd.wa.gov**

### Action Items
- John to send out the section of toolkit that applies to these projects
- John to send out a doodle poll for next meeting scheduling
NCACH Diversion Intervention Project Plan Application Summary – Submitted to HCA Nov. 16, 2017

**Rationale:** Access to care has been identified as a priority for NCACH in multiple assessments and community surveys, including the regional Community Health Needs Assessment (CHNA) completed in December 2016. The CHNA identified insufficient numbers of providers and travel distance to health care providers as key barriers to accessing care. In fact, many low-income and Department of Social and Health Services clients live in more rural and distant parts of the four counties included in the NCACH’s large and agricultural region. However, NCACH has a number of Emergency Medical Service (EMS), primary care providers, and social service agencies that are spread across the region which could provide better care to patients and reduce the likelihood they will end up in high cost acute settings.

**Preliminary Target Population and Approaches:** NCACH is gravitating towards two initial evidence-based approaches (ED Diversion and Community Paramedicine) and two target populations for our “preliminary target groups” that we will review further with our Transitional Care and Diversion Interventions Workgroup from quarter 4 of 2017 to quarter 2 of 2018.

- Specific to ED utilization, NCACH’s preliminary target population is Medicaid beneficiaries presenting to the ED for non-acute conditions.
- Specific to community paramedicine, NCACH’s preliminary target population is Medicaid beneficiaries who access EMS services for non-acute issues.

Over the next eight months, our workgroup will be tasked with narrowing the focus down to one or two of the three toolkit approaches depending on available funding. They will further fine tune our target population with respect to initial implementation strategies and outline a plan for scaling approaches more broadly across our region.

**Health Equity:** The Transitional Care and Diversion Intervention Workgroup will ensure health equity is considered in the project plan and during implementation. More Medicaid enrollees in the region identify as Hispanic compared to the state average (47% and 21%, respectively). As we review data to select strategies, we will consider how we can implement and support projects that will help close gaps in health disparities, and how we include cultural considerations into the direct planning and implementation.

**Workgroup Connection with Regional Councils:** There are a number of regional councils in North Central Washington that can be leveraged to assist in gathering information for the planning, implementation, and scaling of projects. Two of the councils include the North Central Regional Hospital Council and the North Central Emergency Care Council.

---

**Source:** Washington State Department of Health, “EMS and Trauma Hospital Designations and Responses Areas.”
Primary Care and Behavioral Health Partners: An aspect of the Transitional Care and Diversion project will be to ensure individuals who are coming into contact with acute care settings are connected to receive both primary care and behavioral health services to ensure they do not continue to end up in high cost settings. These services will be implemented through our Whole Person Care Collaborative (WPCC). In 2018, WPCC members will be tasked with developing organizational change plans to address bi-directional integration of primary care and behavioral health. The change plans will also incorporate key clinical aspects of the other five projects (i.e., Care Coordination Project, Transitional Care Project, etc.).

Community Based Care Coordination: The Pathways Hub project can closely align with Diversion Intervention projects by assigning a community based care coordinator to assist in connecting patients to both the medical and social service outside of the acute setting (Hospital, Emergency Department, and Criminal Justice)

Monitoring and Continuous Improvement: The goal of NCACH’s monitoring plan is to use real-time or close to real-time data to support project implementation and continuous improvement. Key elements of this system include:

1. Convening key stakeholders;
2. Identifying monitoring metrics, benchmarks, and improvements;
3. Building data infrastructure to collect, aggregate, analyze, and report data for monitoring; and
4. Implementing continuous improvement processes.

NCACH plans to develop a data infrastructure to collect and aggregate project information, in order to support continuous analysis, monitoring and improvement. Through our Whole Person Care Collaborative, we are planning on using a customized web portal (Healthcare Communities) developed by one of our current contractors, CSI Solutions, Inc. This portal would serve multiple functions, providing centralized access to resource sharing, document sharing, tracking of process measures through consistent form-fillable reporting templates and surveys, and tracking of measures through dashboards. Based on conversations with CSI Solutions, it seems very likely that we can leverage this web portal for monitoring progress and reporting associated the Transitional Care and Diversion Intervention Projects.

Reports from implementation partners will focus on project milestones and process details that can be used to support overall monitoring, identify potential challenges or barriers that individual or multiple partners are experiencing, and identify potential champions and best practices. Reporting will be contractually required of project partners, though every effort will be made to keep these reports simple in order to minimize the reporting burden for partners (one of our key design principles).

<table>
<thead>
<tr>
<th>Potential Monitoring Metrics – Diversion Interventions Project</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Implementation/Operational Measures – Regional monitoring metrics to track implementation progress</strong></td>
</tr>
<tr>
<td>Measures TBD; examples may include:</td>
</tr>
<tr>
<td>• Type of non-emergent ED and 911 encounters</td>
</tr>
<tr>
<td>• Number/percent of non-emergent 911 calls</td>
</tr>
<tr>
<td>• Number of paramedics trained in community-paramedicine</td>
</tr>
<tr>
<td>• Number of level 1 and 2 ED visits</td>
</tr>
<tr>
<td><strong>Toolkit P4R Measures – Required metrics for ACH reporting</strong></td>
</tr>
<tr>
<td>• Number of partners trained</td>
</tr>
<tr>
<td>• Number of partners implementing selected approaches</td>
</tr>
<tr>
<td>• Percent of partnering provider organizations sharing information (via HIE) to better coordinate care</td>
</tr>
<tr>
<td>• Percent of partnering provider organizations with staffing ratios equal or better than recommended</td>
</tr>
<tr>
<td>• VBP arrangement with payments/metrics to support adopted model</td>
</tr>
<tr>
<td><strong>Toolkit P4P Measures – Incentive measures, which will be reported by the ACH</strong></td>
</tr>
<tr>
<td>• Outpatient Emergency Department Visits per 100 member months</td>
</tr>
<tr>
<td>• Percent Arrested</td>
</tr>
<tr>
<td>• Percent Homeless (Narrow Definition)</td>
</tr>
<tr>
<td><strong>Quality Improvement Plan Metrics – Regional performance metrics</strong></td>
</tr>
<tr>
<td>QIP metrics will be identified by Demonstration Year 3, quarter 2</td>
</tr>
</tbody>
</table>

Sustainability: Sustainability has been and continues to be a key factor in all NCACH project decisions. NCACH firmly believes that Demonstration funds should not be used to fund direct services, except on a limited basis where there is a clear and relatively quick path to sustainability. The primary charge of the Transitional Care and Diversion Intervention Workgroup is to look at current processes that are occurring in high cost settings and implement the evidence based strategies that will help reduce the number of acute care visits and the overall cost of care. This will be predominately by expanding the current roles and skills of existing departments and workforce.

Full Project Plan Application available at: [https://tinyurl.com/yca5pg4](https://tinyurl.com/yca5pg4); pages 294 - 355
**Rationale:** The Transitional Care Project was selected because it ranked high in terms of being relevant to all four counties, being able to improve outcomes during the Demonstration period, and being sustainable after the Demonstration. During our project selection process, 169 community members were surveyed and some noted that this project had care coordination at its core and that improved transitional care was well-aligned with the Pathways Community HUB, a care coordination system that will assist the medical community to connect their patients with the social services needed to address the health needs that cannot be met in the clinic. This project with an enhanced community based care coordination system will help reduce the number of high cost visits to emergency departments and help individuals better transition out of high cost care settings (Emergency Department and Criminal Justice Facilities).

**Preliminary Target Population and Reach:** Based on analysis of regional data, we believe our Transitional Care Project will target beneficiaries in transition from intensive settings of care or institutional setting, including beneficiaries discharged from acute care, beneficiaries with serious mental illness (SMI) discharged from inpatient care, or clients returning to the community from prison or jail (including youth detentions)

Our preliminary goal is to eventually reach all Medicaid adults and adolescents incarcerated in our county jail and detention facilities (about 600 youth per year¹ and 6,500 adults per year²) and NCACH residents being released from emergency departments (EDs) and hospitals based on a primary diagnosis of mental and behavioral disorders (about 1,700)³.

**Preliminary Evidence Based Approaches:** Based on these potential target populations, we are gravitating towards the following evidence-based approaches as they specifically target people struggling with behavioral health issues:

- Care Transitions Intervention;
- Care Transitions Interventions in Mental Health; and,
- Evidence-Informed approaches to transitional care for people with health and behavioral health needs leaving incarceration.

Over the next eight months, our workgroup will be tasked with narrowing the focus down to one or two of the 5 toolkit approaches depending on available funding. They will further fine tune our target population with respect to initial implementation strategies and outline a plan for scaling approaches more broadly across our region.

**Health Equity:** The Transitional Care and Diversion Intervention Workgroup will ensure health equity is considered in the project plan and during implementation. More Medicaid enrollees in the region identify as Hispanic compared to the state average (47% and 21%, respectively). In Okanogan County, 14% of the Medicaid population identifies as Native American. As we review data to select strategies, we will consider how we can implement and support projects that will help close gaps in health disparities, and how we include cultural considerations into the direct planning and implementation.

**Primary Care and Behavioral Health Partners:** An aspect of the Transitional Care project will be to ensure individuals who are leaving acute care settings are connected to receive both primary care and behavioral health services. These services will be implemented through our Whole Person Care Collaborative (WPCC). In 2018, WPCC members will be tasked with developing organizational change plans to address bi-directional integration of primary care and behavioral health. The change plans will also incorporate key clinical aspects of the other five projects (i.e., Diversion Intervention, Transitional Care Project, etc.).

---


² Washington State Statistical Analysis Center. *County Profiles.* Based on total adult arrests in 2016 for Chelan, Douglas, Grant and Okanogan counties combined. We will need to follow up with our local corrections partners to get more accurate data, since total arrests are not an accurate indicator of total adults incarcerated in county jails. However, jail bookings are also a poor indicator since other jurisdictions send inmates to Chelan County Jail. *Is this how you want this citation to look?*

³ Based on HCA data. Hospitalization data included in “Starter Kit” showed 171 counts of acute hospitalizations among Medicaid recipients for mental and behavioral disorders. ED utilization by Facility showed 1,554 ED visits among Medicaid recipients for mental and behavioral disorders.
Community Based Care Coordination: The Pathways Hub project can closely align with Transitional Care projects by assigning a community based care coordinator to assist in connecting patients to both the medical and social service outside of the acute setting (Hospital, Emergency Department, and Criminal Justice). In some instances, Transitional Care approaches can help align the processes completed at the medical organization to better hand off the patient to a community based care coordinator who can complete more intensive home visiting and coordinate services provided.

Monitoring and Continuous Improvement: The goal of NCACH’s monitoring plan is to use real-time or close to real-time data to support project implementation and continuous improvement. Key elements of this system include:

1. Convening key stakeholders;
2. Identifying monitoring metrics, benchmarks, and improvements;
3. Building data infrastructure to collect, aggregate, analyze, and report data for monitoring; and
4. Implementing continuous improvement processes.

NCACH plans to develop a data infrastructure to collect and aggregate project information, in order to support continuous analysis, monitoring and improvement. Through our Whole Person Care Collaborative, we are planning on using a customized web portal (Healthcare Communities) developed by one of our current contractors, CSI Solutions, Inc. This portal would serve multiple functions, providing centralized access to resource sharing, document sharing, tracking of process measures through consistent form-fillable reporting templates and surveys, and tracking of measures through dashboards. Based on conversations with CSI Solutions, it seems very likely that we can leverage this web portal for monitoring progress and reporting associated the Transitional Care and Diversion Intervention Projects.

Reports from implementation partners will focus on project milestones and process details that can be used to support overall monitoring, identify potential challenges or barriers that individual or multiple partners are experiencing, and identify potential champions and best practices. Reporting will be contractually required of project partners, though every effort will be made to keep these reports simple in order to minimize the reporting burden for partners (one of our key design principles).

<table>
<thead>
<tr>
<th>Potential Monitoring Metrics – Transitional Care Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation/Operational Measures – Regional monitoring metrics to track implementation progress</td>
</tr>
<tr>
<td>Measures TBD; examples may include:</td>
</tr>
<tr>
<td>• Partnering provider patient volume</td>
</tr>
<tr>
<td>• Number and percent of partners adopting HIE</td>
</tr>
<tr>
<td>• Number of providers receiving training and technical assistance on guidelines</td>
</tr>
<tr>
<td>Toolkit P4R Measures – Required metrics for ACH reporting</td>
</tr>
<tr>
<td>• Number of partners trained</td>
</tr>
<tr>
<td>• Number of partners implementing selected approaches</td>
</tr>
<tr>
<td>• Number of partners achieving certification</td>
</tr>
<tr>
<td>• Number of clients receiving transitional care plans prior to release</td>
</tr>
<tr>
<td>• Number and percent of partners sharing information via HIE to better coordinate care (cross-partner communication, including transitional care plans)</td>
</tr>
<tr>
<td>• Number of clients who meet with a Transitions Coach in the hospital</td>
</tr>
<tr>
<td>• Number of in-reach visits to jails</td>
</tr>
<tr>
<td>Toolkit P4P Measures – Incentive measures, which will be reported by HCA and tracked by the ACH</td>
</tr>
<tr>
<td>• Follow-up after Discharge from ED for:</td>
</tr>
<tr>
<td>• Mental Health</td>
</tr>
<tr>
<td>• Alcohol or other Drug Dependence</td>
</tr>
<tr>
<td>• Follow-up After Hospitalization for Mental Illness</td>
</tr>
<tr>
<td>• Inpatient Hospital Utilization</td>
</tr>
<tr>
<td>• Outpatient Emergency Department Visits per 1000 member months</td>
</tr>
<tr>
<td>• Percent Homeless (Narrow Definition)</td>
</tr>
<tr>
<td>• Plan All-Cause Readmission Rate (30 Days)</td>
</tr>
<tr>
<td>Quality Improvement Plan Metrics – Regional performance metrics</td>
</tr>
<tr>
<td>QIP metrics will be identified by quarter 2 of 2019</td>
</tr>
</tbody>
</table>

Sustainability: Sustainability has been and continues to be a key factor in all NCACH project decisions. NCACH firmly believes that Demonstration funds should not be used to fund direct services, except on a limited basis where there is a clear and relatively quick path to sustainability. The primary charge of the Transitional Care and Diversion Intervention Workgroup is to look at current processes that are occurring in high cost settings and implement the evidence based strategies that will help reduce the number of acute care visits and the overall cost of care. This will be predominately by expanding the current roles and skills of existing departments and workforce.

Full Project Plan Application available at: [https://tinyurl.com/ycav5pg4](https://tinyurl.com/ycav5pg4); pages 235-293
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 ModelTM, 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

Evidence-informed Approaches to Transitional Care for People with Health and Behavioral Health Needs 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.
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
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.
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

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.

LEAD’S POTENTIAL FOR RECONCILIATION & HEALING

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.

REPLICATING THE LEAD MODEL NATIONALLY

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.
<table>
<thead>
<tr>
<th>Evidence Based Approach</th>
<th>Target Population</th>
<th>Approach Details</th>
<th>Questions</th>
<th>Scope</th>
<th>Collaboration with other projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach #1: Interventions to Reduce Acute Care Transfers, INTERACT 4.0</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>Is this a target population currently have a need we should focus on in the NCACH? What percentage of this population are Medicaid beneficiaries?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approach #2: Transitional Care Model (TCM)</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>Is this currently occurring across the region? If not is it feasible to have a TCN deliver and coordinate care across the region?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Approach #3: The Care Transitions Intervention (CTI)</td>
<td>Medicaid beneficiaries discharged from acute care to home or to supportive housing</td>
<td>A meeting with a Transition’s Coach in the hospital (where possible—this is desirable but not essential) to discuss concerns and to engage patients and their family caregivers of the Care Transitions Intervention®</td>
<td>Can this model be completed through the Pathways Hub work?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Approach #4: Care Transitions Intervention in Mental Health</td>
<td>Medicaid beneficiaries with SMI discharged from Inpatient care</td>
<td>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.</td>
<td>How does this approach compare to the Transitional Care Model?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Approach #5: Evidence-Informed Approaches to Transitional Care for People with Health and Behavioral Health Needs Leaving incarceration</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>Is this currently going on in the Community?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice of long-term care facilities

Your basic types of tools available for approach:

| Quality Improvement, Communication, Decision Support, Advanced Care Planning |

Continuity of care facilitated by TCN between hospital, post acute, and primary care clinicians to ensure follow up

Includes active engagement of family in decisions

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. 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.

Components include prospective modeling to identify risk, patient and family engagement, transition planning with the facility, providing discharge, communication of patient information, transition coaches/agents, provider engagement, quality metrics and feedback, shared accountability

Level of the transition coach could be at the Social Worker or Mental Health Provider level to assist in dealing with unique circumstances

Facility would need to be able to develop transition plans and exchange patient information to a coach/outpatient facility

Could we link to both health homes and non-health home services currently occurring? Do we know if these individuals will generally have a high PRISM Score?

Are we able to support transitions out of high cost care for SMI clients by including social workers and Mental Health Providers into the work?

What kind of coaching do we need to provide for SMI clients, do we need something that is more intensive? Could we complete an approach for both SMI and non SMI patients?

What type of transitional care planning is currently occurring in the region?

Could we link to both health homes and non-health home services currently occurring? Do we know if these individuals will generally have a high PRISM Score?

Are we able to gather data around the number of transfers from SNF to an acute hospital setting to determine the level of need/impact we will make with this approach?

Are we able to gather data around the number of transfers from SNF to an acute hospital setting to determine the level of need/impact we will make with this approach?

Would criminal justice facilities like to participate in this work? | Yes | |

Is this currently occuring across the region? If not is it feasible to have a TCN deliver and coordinate care across the region? | Yes | |

What aspects of jail transitions would be the biggest priority to focus on? | Yes | |
<table>
<thead>
<tr>
<th>Evidence Based Approach</th>
<th>Target Population</th>
<th>Approach Details</th>
<th>Questions</th>
<th>In WPCC Scope</th>
<th>Linkage to other projects</th>
</tr>
</thead>
<tbody>
<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>What is the cost and feasibility to complete this project in the community?</td>
<td>Yes</td>
<td>Care Coordination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Where available, care coordinators can facilitate above process</td>
<td>Does it connect well with other projects we are completing?</td>
<td></td>
<td>Transitional Care</td>
</tr>
<tr>
<td></td>
<td></td>
<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>
<td>Can we improve the measures associated with the project - Reduced Outpatient ER visits, Homelessness, and Percent Arrested?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Follow the Washington State Hospital Association “ER is for Emergencies” best practices</td>
<td>Can we scale and sustain this to other providers?</td>
<td></td>
<td></td>
</tr>
<tr>
<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>What is the cost and feasibility to complete this project in the community?</td>
<td>Yes</td>
<td>Care Coordination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Core issues include how paramedics would be trained, appropriately supervised, and how they will integrate with other programs in the community</td>
<td>Does it connect well with other projects we are completing?</td>
<td></td>
<td>Transitional Care</td>
</tr>
<tr>
<td></td>
<td></td>
<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>Can we approve the measures associated with the project - Reduced Outpatient ER visits, Homelessness, and Percent Arrested?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Can we scale and sustain this to other providers?</td>
<td></td>
<td></td>
</tr>
<tr>
<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>Is law enforcement open to utilize this process in their work?</td>
<td></td>
<td>Care Coordination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identifying a dedicated project manager</td>
<td>If this process is implemented, do we have the supportive services that law enforcement will need to complete LEAD effectively</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide intensive case management - to link diverted individuals to housing, vocational and educational opportunities, treatment, and community services</td>
<td>How much will this approach cost to implement?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Apply a harm reduction housing first approach</td>
<td>Can we improve the measures associated with the project - Reduced Outpatient ER visits, Homelessness, and Percent Arrested?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consider the use of peer supports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide training in the areas of trauma-informed care and evaluation planning</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DIVERSION INTERVENTION EVIDENCE BASED APPROACHES