Transitional Care and Diversion Intervention Workgroup
10:00 AM – 11:30 AM Thursday March 22nd

Location
Grant Integrated Services
840 E Plum Street Moses Lake, WA (Conference Room)

Conference Information:
Please join my meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/604175533

You can also dial in using your phone.
United States: +1 (872) 240-3412
Access Code: 604-175-533

First GoToMeeting? Let's do a quick system check:
https://link.gotomeeting.com/system-check

Agenda

<table>
<thead>
<tr>
<th>Proposed Agenda</th>
<th>Time</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome &amp; Introductions</td>
<td>10:00</td>
<td>• Review of last meeting</td>
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<tr>
<td>Eric Skansgaard</td>
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<tr>
<td>2. Transitional Care Subgroup Update</td>
<td>10:10</td>
<td>• Update from Small Group meeting, recommendations, and next steps</td>
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<tr>
<td>John Schapman</td>
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<td>3. Community Paramedicine Update</td>
<td>10:25</td>
<td>• Review of EMS Meeting</td>
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<tr>
<td>Ray Eickmeyer</td>
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<td>• Recommendations to the Workgroup</td>
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<td>4. Project Funding Approaches</td>
<td>10:40</td>
<td>• Updated Funding template</td>
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<tr>
<td>John Schapman</td>
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<td>• Discussion on Funding amounts to organizations</td>
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<td>5. Roundtable/Adjournment</td>
<td>11:20</td>
<td>• Roundtable of workgroup members in room and on phone</td>
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<tr>
<td>Eric Skansgaard</td>
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Next Meeting: April 26th 10:00-11:30AM
North Central ESD (Second Floor Ponderosa Room)
430 Olds Station Rd. Wenatchee, WA 98801
(regular meetings are the 4th Thursday of the month)
# Transitional Care and Diversion Intervention Workgroup

10:00 AM – 11:30 AM Thursday February 22

## Location
North Central ESD  
430 Olds Station Rd. Wenatchee, WA 98801 (Second Floor Ponderosa Room)

## Conference Information:
Join from PC, Mac, Linux, iOS or Android: [https://ncesd.zoom.us/j/434180147](https://ncesd.zoom.us/j/434180147)  
Meeting ID: 434 180 147

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<tr>
<th>Proposed Agenda</th>
<th>Goals</th>
<th>Notes</th>
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</table>
| 1. Welcome, Introductions, & Project Planning Structure | • Welcome members  
• Workgroup chair  
• Review of last meeting  
• Next Workgroup meeting location | **Attendance:** Rick Hourigan, Jackie Weber, Kevin Risdon, Caroline Tillier, John Schapman, Christal Eshelman, Eric Skaansgard, Sherrill Castrodale, Mike Beaver, Kate Haugen, Alicia Komar, Linda Evans Parlette, Kris Davis, Shannon Mack, Edgar Reinfield, Teresa Davis, Ray Eickmeyer, Jerry Perez, Kelly Allan  
**Phone:** Teri Riley Brown, Vicki Polamus, Kris Neff, Mike Beaver, Brooklyn Holton, Molly Morris, S Wilson, Laurie Bergman  
• Eric Skaansgard has agreed to be the Chair for this workgroup  
• Next meeting location: Will be either in Grant or Okanogan County |
| 2. Project Data: | • Overview | Caroline gave a data overview, asked the workgroup to digest this information. We need to decide if we want to start in one county and expand out.  
Questions: Grant county has the higher numbers for ED usage…why? Is there a lack of services? Yes, there is a lack of walk in and urgent care. Lack of providers, no homeless shelters, no detox. |
Due to lack of providers, this group could help to develop a more economical way to treat patients. The states definition of homelessness is different from what we consider homeless (couch surfers).

Will be following up with law enforcement for some ideas on diversion.

HCA is working on getting the follow up after hospitalization for Mental Illness data. Caroline will follow up with HCA, possibly Beacon.

These measures are what we are held to. If there are other measures that the group wants to track, we can look into locally.

Payers do not see any missing measures. MCO's follow up with people that are currently engaged. But there is a large population that they can't connect with.

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<th>3. Project Funding Approaches</th>
<th>Overview</th>
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<td>Partner Application/Engagement Approach</td>
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We are now planning on the project implementation happening in October 2018. John went over the principles applied to funding distribution.

As a workgroup, we have decided not to select Criminal Justice Diversion, but still believe that this is an important aspect and are looking for other ways of supporting Law Enforcement.

Approach #1: Each org gets funding, but they develop shared learning with other organizations. The funding is there to support staff resources. They would apply separately but by submitting the application, they are committing to working with other agencies.

- Like this approach but also think they should have one application for all the groups working together, distribute money equally amongst the participants on the application.

Approach #2: Work as a community within the projects

Approach #3: Organizations apply individually

Group feels that law enforcement needs would fit into this model. If there is something that you need from law enforcement, they need to be told now. The workgroup would need data from law enforcement. Chelan Douglas does not currently track their calls by
mental health, homeless etc. This is where the group can help. Caroline will look into finding a measurable statistic that law enforcement can lawfully track. Idea to hire a crosswalk person that can see law enforcement records and mental health, it would need to be on the medical side. Funding to Law Enforcement Agencies is not needed. Law Enforcement agencies need mental health training. Continued funding for CIT would get them to 100% staff trained. This is the biggest thing that can be done for law enforcement.

Group would like to see what times people are using the ED (nights, weekends)

4. Review of Transitional Care Evidence Based Approach
   - Overview of Approaches
   - Discussion on how they fit with Pathways and Diversion Projects
   - Connection with other NCACH workgroups
   - Sherrill Castrodale, Intern for the NCACH gave a review of the Transitional Care Projects (see PowerPoint slides)

   **Discussion:** Are we already locally doing these things? MCO's and Central Washington Hospital are already doing something similar. They handle their intervention at 80% to 90% with a phone call. Community Para Medicine model fits perfectly with this.

   We have some flexibility to build our own plan and present to HCA. With our rural area, we do not fit well into the models presented by HCA. We need to develop a model that will be used throughout our regions. Most hospitals are not having more than 5 discharges a day so there are models that could be manageable. Doctors and patients need to know what to expect. Confluence will share their process with the group. Will convene a small group outside of TCDI meeting to review regional approach.

5. Current State Assessment
   - Template to gather information on current projects occurring.

   Tabled for next meeting

6. Workgroup Member Roundtable
   - Roundtable of workgroup members in room and on phone

   EMS could do both Transition and Diversion approaches in a valuable way. What value would it be for EMS to do this work? What information would you need? This is something that we need to explore.

7. Assignments
   - Complete new version of Current State Assessment
   - Finalize Approach Selection

   **Next Meeting:** March 22nd 10:00-11:30AM at - Location (TBD)
   (regular meetings are the 4th Thursday of the month)
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<tr>
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<th>Sign Charter Membership Agreement</th>
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North Central Accountable Community of Health
Transitional Care and Diversion Intervention Workgroup

March 23rd, 2018
**TCDI WORKGROUP PROJECT - PROPOSED PLANNING TIMELINE**

- May vary based on final approach for funding process selected by the workgroup
- Has been updated based on new understanding of LOI and current state assessment deliverables to the Health Care Authority
- * Partners must register in the FE portal to be eligible to submit applications

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<th>January</th>
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<td><strong>Finalize Approach</strong></td>
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<td><strong>Current State Assessment</strong></td>
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<td><strong>Develop Engagement Process</strong></td>
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<td><strong>Partners submit plans for implementation work</strong></td>
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<td><strong>Draft LOIs for Partners</strong></td>
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<td><strong>Review Plans</strong></td>
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<td><strong>Implement Plans</strong></td>
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TCDI Selected Approaches:

- These are selected approaches to Health Care Authority.
- **NCACH will still look at how it promotes and supports:**
  - Interactions between Behavioral Health and Law Enforcement

<table>
<thead>
<tr>
<th>NCACH Approach</th>
<th>Evidence Based Approach</th>
<th>Target Population</th>
<th>Implementation Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Diversion</td>
<td>ER is for Emergencies Seven Best Practices</td>
<td>Medicaid beneficiaries presenting at the ED for non-acute condition</td>
<td>Emergency Departments</td>
</tr>
<tr>
<td>Transitional Care Services</td>
<td>Local Transitional Care Model (CH – TCM)</td>
<td>Medicaid beneficiaries discharged from acute care to home or to supportive housing</td>
<td>Acute Care Facilities Care Coordination Agencies</td>
</tr>
<tr>
<td>EMS</td>
<td>Community Paramedicine*</td>
<td>Medicaid beneficiaries who access the EMS system for a non-emergent condition</td>
<td>EMS Providers</td>
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</table>

*Community Paramedicine will not be an HCA selected approach, but will receive continued review by workgroup
Transitional Care Model (CH-TCM)

Summary
• Collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services across settings

<table>
<thead>
<tr>
<th>Category</th>
<th>Transitional Care</th>
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<tbody>
<tr>
<td>Target Population</td>
<td>Patients who have one or more of 12 identified chronic conditions, as well as social determinants of health that negatively impact their wellness.</td>
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<tr>
<td>Phone or In-home</td>
<td>Both (Depending on severity)</td>
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<tr>
<td>Staff Qualifications</td>
<td>RN or SW Reviewing Training other Staff (i.e. Health Coaches)</td>
</tr>
<tr>
<td>Staff Training</td>
<td>Web based from the American Case Management Association</td>
</tr>
<tr>
<td>Involves EHR</td>
<td>Yes</td>
</tr>
<tr>
<td>SMI &amp; SUD Patients</td>
<td>Patients with serious mental illness &amp; substance abuse are included in the patient population.</td>
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</tbody>
</table>
Emergency Department Diversion

- ED establishes linkages to community primary care provider(s), and policies and procedures for identifying beneficiaries with minor illnesses who do not have a primary care provider.

Focus is on the Washington State Health Association’s ER is for Emergencies Seven Best Practices:

1. Electronic Health Information
2. Patient Education
3. Identify Frequent Users of the Emergency Department and EMS
4. Develop Patient Care Plans for Frequent ER Users
5. Narcotic Guidelines
6. Prescription Monitoring
7. Use of Feedback Information
Community Paramedicine

Summary
• An evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles

Examples Include:

Prehospital Services
• Transport patients to alternate, non-emergency department locations.
• After treatment determine whether it is appropriate to refer or release an individual at the scene of an emergency response.
• Helping frequent 911 callers access primary care and other social services.

Post-Hospital or Community Health Services
• Provide follow-up care for persons recently discharged from the hospital.
• Provide support for persons with multiple chronic conditions.
• Partner with community health workers and primary care providers in underserved areas to provide preventive care.
Workgroup Format

- Workgroup is starting to form smaller groups of direct implementation partners to provide input on the selected approaches
- These small subgroups will help refine the TCDI approaches
- The workgroup will review any input from the subgroups and provide recommendations to the Board
Principles Applied to Funding Distribution

1. Supports investments needed to link acute care providers with clinical & social service providers
2. Whenever possible, the Workgroup will only fund work which demonstrates a clear path toward sustainability or sustained change.
3. Funding will be distributed to partners to create new or build on existing capacity and infrastructure.
4. Funding will be distributed to partners that demonstrate a clear way to evaluate impact including data for measurement of success.
Principles Applied to Funding Distribution

5. Projects that demonstrate the following will be considered more competitive in funding process

• Cross-sector and/or regional collaboration
• Serving a larger geographical area and/or larger Medicaid population
• Clear advancement of health equity
• Addressing or reinforcing other NCACH project areas (bi-directional integration of primary care and behavioral health, care coordination, transitional care, diversion interventions, and chronic disease prevention and control)
TCDI Funding Approaches:

**Approach #1:** Partners within a given sector would be funded by joining a collaborative group across the region to implement process improvement changes (tying back to the selected Evidence Based Approaches by workgroup)

**Approach #2:** Partners that take care of patients within a specific region will be able to submit a joint application to provide Transitional Care and Diversion Intervention Services in the area.

**Approach #3:** Each Organization would submit an application for a set dollar amount to make improvements in the way they deliver care.
Approach #1

1. Work as a Learning Community with in Sector Across the region (i.e. ED)

<table>
<thead>
<tr>
<th>Columbia Basin ED</th>
<th>Confluence ED</th>
<th>Samaritan ED</th>
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- A partner applies to join the regional approach
- A sector would work together and collaborate on learning process
- Sectors would choose agreed upon data points to track
- Sectors would be required to articulate how they will work with partners across the communities/other sectors
Potential Implementation Partners

• Emergency Department Diversion
  • Emergency Departments (10)

• Transitional Care Model
  • Hospitals/Emergency Departments (10)

• Paramedicine/EMS Improvements
  • Transport Emergency Medical Services (7): Ballard, Lifeline, Moses Lake Fire, AMR, LCCH, Aerow Methow, Cascade Medical
Funding (Planning and Implementation)

- Work of TCDI will be done through 3 stages:
  - planning, implementation and scale and sustain
- Initial funds distribution in 2018 for implementation partners will be for partners to initiate planning and process improvement
Funding (Distribution)

• Funding main focus in 2018 will be to support the projects chosen by the TCDI workgroup. Money can be used to support training and implementation across partners.

• The workgroup will review how additional partners and work may be supported in 2019.

• The workgroup has approximately $500K annually towards all TCDI work.

• All final funding recommendations will be presented to the Governing Board.
Funding (Partner Distribution)

Available Funds
~$500K/yr

Regional training and infrastructure investments that improve all projects

TCM
ED Diversion
EMS

*Direct Implementation Partner Support*

Training and support of other partners
Funds Distribution (Partner Distribution)

• Implementation Partners will work with each subgroup to define a common list of goals/barriers to help implement projects within the region.

• NCACH will develop a plan to address barriers and implement changes including:
  • Training needs
  • Direct Organizational investments (i.e. funding to offset staff cost to train)
  • Enhancements in workforce training and health information exchange (i.e. help with the implementation of EDIE/Pre-Managed across region)
Major Funding Questions/Discussion:

1. What do we think we can do with available funding?
2. Does each project get variable funding amounts or similar amounts?
3. Can we identify items that will benefit all projects/partners and support that work (i.e. health information exchange)?
4. Are we able to support implementation partners directly with limited funding?
### Short Description

**Overview**

**RN Care Management (RN-CM)** is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services across settings to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote optimum level of wellness and functional capability. Case Management uses a tiering tool to assess patient eligibility. The tiering tool utilizes criteria to establish medical complexity, lack of psych-social supports, and lack of education regarding patient’s disease process or medication that impact patient’s health. Based on referral source, eligible patients are contacted by phone within 1-2 business days to set up an interactive contact either a phone or face to face initial assessment of needs.

Referrals from Hospital based RNCM & SW, PCP MD, Specialty MD, Emergency MD, are received via EMR EPIC, Outlook E-mail, verbal/phone request, or by system generated report. Case management is also notified of hospital discharges as well as ED utilization via a daily report. Follow up patient phone call is made within 24-48 hours of discharge.

The post discharge phone call affirms that the patient has a follow up appointment with their PCP, medication reconciliation, if they have all of their post hospital services arranged i.e.: DME, O2, HH/Hospice, AFH/ALF, and or caregiver help. Any problems identified will be worked on and then directed to the PCP’s office. Subsequent follow up calls will be made every one (1) week for a total of four follow up contacts. At the completion of these phone calls the RNCM will assess using the tiering tool to transition the patient to either active case management or discharge status.

**Nurse Care Managers (NCM)** coordinate care across settings and engage in education, medication reconciliation and phone follow-up based on protocol triaging risk. Phone-based model designed to complement evidence-based home-visit transitional care programs by offering a similar, but phone-based, protocolized, transitional care option for patients who refuse home-visits, are not ill enough or live too far away to qualify for home-visit based transitional care, or who cannot access such programs because they are in low-resource health care settings.

The NCM actively participates in discharge rounds, identifies hospital patients who would benefit from the C-Trac program and will be offered to participate, meets with patient prior to discharge, 48-72 hour follow-up call, calls participant weekly until medical follow-up has taken place, the patient and Nurse Case Manager agree no further follow-up is necessary, or until four weeks have passed since discharge.
| **CONFLUENCE HEALTH TRANSITIONAL CARE MODEL**  
<table>
<thead>
<tr>
<th><strong>(CH-TCM)</strong></th>
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<tbody>
<tr>
<td><strong>TARGET POPULATION</strong></td>
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<tr>
<td>Confluence Health (CH) RNCM and Transitions of Care Options are available to patients who have accessed healthcare within the CH system regardless of payer source. There are different pathways for patients that have Health Alliance Medicare, CH Employee Insurance Plan, and Molina MC.</td>
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<td><strong>STAFF QUALIFICATIONS</strong></td>
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<tr>
<td>Currently the team is comprised of RN’s and SW’s. The team is part of CH Care Management service line which also includes collaboration with Inpatient Case Managers, Social workers, and Discharge planners. Looking into trialing others disciplines with healthcare related background i.e. Health Coaches. Certification in Case Management encouraged.</td>
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<td><strong>STAFF TRAINING</strong></td>
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<td>CH Case Managers have a web based orientation and continuing education program from the American Case Management Association titled Compass. These modules help prepare the new RNCM/Transitional Care Nurse. The CM completes a month long orientation which includes the modules and clinical opportunities while being paired with a mentor.</td>
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| **COORDINATED TRANSITIONAL CARE**  
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<th><strong>(C-TRAC)</strong></th>
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<tr>
<td><strong>TARGET POPULATION</strong></td>
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<tr>
<td>Transitional care option for Medicaid beneficiaries who refuse home-visits, are not ill enough or live too far away to qualify for home-visit based transitional care, or who cannot access such programs because they are in low-resource health care settings.</td>
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<td><strong>STAFF QUALIFICATIONS</strong></td>
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<td>RN or Advanced Practice Nurse (APN). Pilot testing of the C-TraC program suggests that long-term knowledge of patients who may be frequently admitted is important to the success of the program. As such, continuity of Nurse Case Manager staff is an important consideration for program staffing.</td>
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<td><strong>STAFF TRAINING</strong></td>
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<td>Would have to be determined.</td>
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<td>For example, see footnote [1] for link to implementation process in six Colorado Critical Access Hospitals.</td>
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<tr>
<td>CONFLUENCE HEALTH TRANSITIONAL CARE MODEL (CH-TCM)</td>
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<td><strong>Studies</strong></td>
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<td><strong>TARGET POPULATION</strong></td>
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### Other Considerations

| **Value Added** | **Pros:** Program patterned after a well-established national evidence based Care Management/Transition of care program (MCG & CMS). Already applied to Chelan, Douglas, Okanogan, and Grant counties through Confluence Health’s outreach clinics in those areas. Works in a rural health setting. Increased reimbursement for PCP providers through the CMS TCM services protocol. Low 30 day hospital readmits. Able to provide follow-up/home visits in the rural areas. Standard work and standard documentation templates in EPIC.  
**Cons:** Inability to see patient records outside of CH. |
| **Electronic Health Record** | **Pros:** Fills existing transitional care gap by targeting rural areas, low cost with high net savings, potential savings to Medicare and Medicaid, expressed interest in sustainable funding streams, policies in place for scale.  
**Cons:** Results from RCT not yet released.  
**Templates are built in the EPIC EMR** |
| **Dementia** | **Dementia patients are included in the patient population.** |
| **Serious Mental Illness & Substance Abuse** | **Dementia patients included in study population.**  
**Patients with serious mental illness & substance abuse are included in the patient population. Referrals to RNCM which includes referral sources to appropriate disciplines/therapies.**  
**The initial testing of the program did not include patients whose primary diagnosis was alcohol withdrawal or who were primarily hospitalized for psychiatric care. Because these patients may have vastly different care needs post-hospitalization, the C-TraC program may not be as effective in improving their transitional care needs.** |