**Project 2D: Diversion Interventions**

**Project Objective:** 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.

**Target Population:** Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

**Evidence-supported Diversion Strategies:**

1. **Emergency Department (ED) Diversion**, [http://www.wsha.org/quality-safety/projects/er-is-for-emergencies/](http://www.wsha.org/quality-safety/projects/er-is-for-emergencies/), [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038086/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038086/) - 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.


3. **Law Enforcement Assisted Diversion, LEAD®** [http://www.leadbureau.org/](http://www.leadbureau.org/) - 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.

Reference the “Project Implementation Guidelines” for additional details on the project’s core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

**Project Stages**

**Stage 1 – Planning**
<table>
<thead>
<tr>
<th>Milestone</th>
<th>Proof of Completion</th>
<th>Timeline (complete no later than)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess current state capacity to effectively deliver diversion interventions</td>
<td>Completed current state assessment</td>
<td>DY 2, Q2</td>
</tr>
<tr>
<td>• Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project</td>
<td>Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2C efforts</td>
<td>DY 2, Q2</td>
</tr>
<tr>
<td>• Select target population and evidence-supported approach informed by regional health needs</td>
<td>Definition of target population(s) and evidence-supported strategy/strategies</td>
<td>DY 2, Q2</td>
</tr>
<tr>
<td>o If applicable: Determine which non-emergent condition(s) should be the focus of ED Diversion and/or Community Paramedicine (oral health, general physical health, and/or behavioral health conditions).</td>
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<td></td>
</tr>
<tr>
<td>• Identify, recruit, and secure 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</td>
<td>Identified implementation partners and binding letters of intent; If LEAD is selected: identify participants of community advisory group</td>
<td>DY 2, Q2</td>
</tr>
<tr>
<td>o For LEAD: Establish a community advisory group that includes representation from community members, health care and social services, law enforcement and community public safety leaders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop project implementation plan, which must include:</td>
<td>Completed implementation plan</td>
<td>DY 2, Q3</td>
</tr>
<tr>
<td>o Implementation timeline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o A description of the target communities and populations, including the rationale for selecting them based on regional health needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o In applicable, explanation of how the standard pathways selected in Project 2B align with the target population and evidence-based approach selected in this project.</td>
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<td></td>
</tr>
</tbody>
</table>
o List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely manner.

o Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts. In the case of ED Diversion, explain how the project will build on the Washington State Hospital Association’s “ER is for Emergencies” and “Seven Best Practices” initiatives.

o Description of the service delivery mode, which may include home-based and/or telehealth options

o Roles and responsibilities of partners

o Describe strategies for ensuring long-term project sustainability

### Stage 2 – Implementation

<table>
<thead>
<tr>
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<th>Proof of Completion</th>
<th>Timeline (complete no later than)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop guidelines, policies, procedures and protocols as necessary to support consistent implementation for each selected strategy</td>
<td>Adopted guidelines, policies, procedures and/or procedures</td>
<td>DY 3, Q1</td>
</tr>
<tr>
<td>• Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support each selected strategy</td>
<td>Completed and approved QIP, reporting on QIP measures</td>
<td>DY 3, Q2</td>
</tr>
<tr>
<td>• Implement project, including the following core components across each approach selected: o Ensure implementation addresses the core components of each selected approach o Ensure participating partners are provided with, or have access to, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. o Implement robust bi-directional communication strategies, ensure team members, including client, have access to the information appropriate to their role in the team.</td>
<td>Estimated number of partners implementing each selected strategy</td>
<td>DY 3, Q4</td>
</tr>
</tbody>
</table>
- Establish mechanisms for coordinating care management plans with related community-based services and supports such as those provided through supported housing programs.
- Establish a performance-based payment model to incentivize progress and improvement.

### Stage 3 – Scale & Sustain

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Proof of Completion</th>
<th>Timeline (complete no later than)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Expand the model to additional communities and/or partner organizations.</td>
<td>Document Stage 3 activities in Semi-Annual Reports.</td>
<td>DY 4, Q4</td>
</tr>
<tr>
<td>- Employ continuous quality improvement methods to refine the approach, updating the approach and adopted guidelines, policies and procedures as required</td>
<td></td>
<td>DY 4, Q4</td>
</tr>
<tr>
<td>- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion</td>
<td></td>
<td>DY 4, Q4</td>
</tr>
<tr>
<td>- Identify and document the adoption by partnering providers of payment models that support diversion activities and the transition to value based payment for services.</td>
<td></td>
<td>DY 4, Q4</td>
</tr>
</tbody>
</table>

### Project Metrics

<table>
<thead>
<tr>
<th>Year</th>
<th>Metric Type</th>
<th>Metric</th>
<th>Report Timing</th>
</tr>
</thead>
</table>
| DY 3 – 2019 | P4R – ACH Reported | • Report against QIP metrics  
• Number of partners trained by selected approach / strategy: projected vs. actual and cumulative  
• Number of partners participating and number implementing each selected approach / strategy  
• % partnering provider organizations sharing information (via HIE) to better coordinate care  
• % of partnering provider organizations with staffing ratios equal or better than recommended | Semi-Annual |
| | P4P – State Reported | • Outpatient Emergency Department Visits per 1000 member months  
• Percent Homeless (Narrow Definition) | Annual |
| DY 4 – 2020 | P4R – ACH Reported | • Report against QIP metrics  
• Number of partners trained by selected approach / strategy: projected vs. actual and cumulative  
• Number of partners participating and number implementing each selected approach / strategy  
• % partnering provider organizations sharing information (via HIE) to better coordinate care  
• % of partnering provider organizations with staffing ratios equal or better than recommended | Semi-Annual |
| --- | --- | --- | --- |
| |  | P4P – State Reported | • Outpatient  Emergency Department Visits per 1000 member months  
• Percent Arrested  
• Percent Homeless (Narrow Definition) | Annual |
| DY 5 – 2021 | P4R – ACH Reported | • Report against QIP metrics  
• Number of partners trained by selected approach / strategy: projected vs. actual and cumulative  
• Number of partners participating and number implementing each selected approach / strategy  
• % partnering provider organizations sharing information (via HIE) to better coordinate care  
• % of partnering provider organizations with staffing ratios equal or better than recommended  
• VBP arrangement with payments / metrics to support adopted model | Semi-Annual |
| |  | P4P – State Reported | • Outpatient  Emergency Department Visits per 1000 member months  
• Percent Arrested  
• Percent Homeless (Narrow Definition) | Annual |

**Project Implementation Guidelines**: This section provides additional details on the project’s core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

**Guidance for Project-Specific Domain 1 Strategies**
- **Population Health Management/HIT:** Current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.

- **Workforce:** Capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
  - Shortage of Mental Health Providers, Substance Use Disorder Providers, Social Workers, Nurse Practitioners, Primary Care Providers, Care Coordinators and Care Managers
  - Opportunities for use of telehealth and integration into work streams
  - Workflow changes to support integration of new screening and care processes, care integration, communication
  - Cultural and linguistic competency, health literacy deficiencies

- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts.
  Development of model benefit(s) to cover integrated care models.

### Guidance for Evidence-Based Approaches

**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.

*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.
**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.

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.

**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.

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.