DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE:	ADULT DIVERSION BED STABILIZATION SERVICES	4.23

Authority:	Title 71A RCW	Developmental Disabilities
	Chapter 388-825 WAC	DDA Service Rules
	Chapter 388-845 WAC	DDA Home and Community Based Waivers
	Chapter 388-101 WAC	Certified Community Residential Services and Supports
	Chapter 388-101D WAC	Requirements for Providers of Residential Services and Supports
	WAC 246-840-930	Nurse Delegation
Reference:	DDA Policy 3.03	Transitional Care Management
	DDA Policy 4.01	One Referral
	DDA Policy 5.06	Client's Rights
	DDA Policy 5.14	Positive Behavior Support Principles
	DDA Policy 5.15	Restrictive Procedures: Community
	DDA Policy 5.16	Psychotropic Medications
	DDA Policy 5.17	Physical Intervention Techniques
	DDA Policy 5.18	Cross-System Crisis Plans
	DDA Policy 5.21	Functional Assessments and Positive Behavior Support Plans
	DDA Policy 5.25	Integrated Settings
	DDA Policy 6.12	Incident Management and Reporting Requirements for Residential Service Providers
	DDA Policy 6.15	Nurse Delegation Services
	DDA Policy 6.19	Residential Medication Management
	DDA Policy 15.04	Standards for Community Protection Residential Services

BACKGROUND

Diversion services provide temporary stabilization services and supports in a community residential setting for eligible clients who are experiencing behavioral health concerns that cannot be safely managed in their current setting or covered by Medicaid State Plan programs.

Services are designed to provide habilitative supports to improve skills and prevent the need for inpatient treatment to address behavioral health issues which may result in harm to self or others or otherwise indicate probable institutionalization or hospitalization. This service may also be available as a transitional setting for a client who is cleared for discharge from a medical or behavioral health facility without a long-term support setting identified and would be at risk of re-institutionalization if not for stabilization supports. This service is intended to provide a short-term alternative to hospitalization or institutionalization to facilitate a client's stabilization and, once stabilized, transition to their preferred community setting.

PURPOSE

This policy establishes service referral, acceptance, and delivery, as well as post-diversion transition and quality assurance requirements for DDA's adult diversion bed services.

SCOPE

This policy applies to DDA Staff and providers of contracted community residential diversion bed services for adults.

DEFINITIONS

Behavioral Health Administrative Service Organizations (BH ASO) means an organization that provides mental health or substance use disorder (SUD) treatment services, including crisis services, treatment, and recovery supports, within specific regional service areas.

Case resource manager (CRM) means the case carrying DDA case manager who is the liaison to the client.

Community protection program treatment plan means a participant's individualized plan written by a qualified professional, therapist, or CPP skills provider.

Cross-system crisis plan (CSCP) means a guide for service providers, crisis responders, and other community partners across systems of care to deliver a coordinated and collaborative response to a client experiencing, or at risk of experiencing, a crisis as defined in DDA Policy 5.18, *Cross-System Crisis Plans*.

Designated crisis responder (DCR) means a mental health professional who is specially trained to conduct an evaluation of an individual's risk of harm to self or others or grave disability and is at imminent risk or needs assisted outpatient behavioral health treatment.

Diversion Bed means a 24-hour staffed residential home operated by a contracted provider in which clients receive stabilization and residential habilitation supports.

Diversion transition support services means assistance and supports offered by the contracted diversion provider for a client and their residential service provider to facilitate post diversion maintenance of stabilization and skills developed while the client was receiving diversion bed services to promote long-term stability.

Habilitation means services delivered by community residential providers to assist people with intellectual and developmental disabilities to acquire, retain, and improve upon the self-help, socialization, and adaptive skills necessary to reside successfully in the community.

Individualized support team means the group of people who work together to provide formal and informal supports to a client. A typical team includes the client, the legal representative if applicable, the client's family with client consent, diversion provider, the DDA CRM, a representative from the regional clinical team, the residential service provider, care coordinators and other community partners when appropriate CPP services are identified in Chapter 388-101D WAC.

Legal representative means a parent of a client if the client is under age 18, a court-appointed guardian if a decision is within the scope of the guardianship order, or any other person authorized by law to act on behalf of the client.

Managed Care Organization (MCO) means a type of health insurance plan that delivers healthcare services through a network of managed care providers.

Positive behavior support means concepts and techniques utilized to accomplish change, teach functional skills, and improve the client's quality of life in accordance with DDA Policy 5.14.

Positive behavior support plan means a plan designed to:

- Strengthen or improve a client's existing adaptive behaviors and skills;
- Expand the client's existing adaptive behaviors and skills to new tasks or settings;
- Teach the client new, adaptive behaviors and skills;
- Provide supports to the client;
- Modify, reduce, and eliminate situations in the environment known to reinforce, setup, or cause target behaviors; and
- Reduce or eliminate the use of target behaviors.

Referral packet means the documents required by DDA Policy 4.01 and DSHS 15-600, *Respite, Stabilization, and RHC Support Referral*.

Regional clinical team means the regional team responsible for providing clinical consultation, assessment, and support for clients, their legal representatives or families, and their providers in support of addressing complex behavioral health needs and promoting best practices in service delivery.

Residential service provider means an entity that will support the client after transition from the diversion setting, such as a supported living provider or a community first choice residential provider. For purposes of this policy, a family member or other primary caregiver of in-home supports will be considered the client's residential service provider.

Restrictive Procedure means a procedure that restricts a person's freedom of movement, restricts access to personal property, requires a person to do something which they do not want to do, or removes something the person owns or has earned.

Stabilization services means short-term intermittent, or episodic supports to assist a client who is experiencing a crisis and is at immediate risk of hospitalization or institutionalization as defined in Chapter 388-845 WAC.

Target behavior means a specific, observable, and measurable behavioral barrier to reaching a goal that requires modification or replacement as identified by the client's individualized support team.

Transition framework means the process to facilitate a client's timely and stable transition from one setting to another.

POLICY

A. Diversion Bed Stabilization Target Population

1. For a person to be considered for referral to diversion bed services they must be:

a. A client of the Developmental Disabilities Administration.

b. At least 18 years old.

c. Experiencing behavioral health concerns warranting modification, or otherwise engaging in behaviors which may result in, but are not limited to:

i. Harm to themselves or others;
ii. Serious property destruction;
iii. Loss of residence and caregiver(s); or
iv. Serious deterioration in mental functioning.

Note: Individuals who may not meet criteria in subsection c. above may be approved to access diversion bed services on a case-by-case basis with approval of the regional administrator.

d. Agreeable to accept the supports and services offered in the diversion setting and voluntarily agree to be served by diversion provider.

2. Before a provider begins assessing whether they are able to support a referred client, the client or their legal representative must sign DSHS 15-475, *Voluntary Participation Consent*.

B. Diversion services are available to approved clients for up to 90 days.

1. Diversion bed services are intended to address behavioral health challenges that may result in disruption to the client's residence, caregiver support, or otherwise result in a need for inpatient services. Diversion bed services are not intended to provide respite services for a client not otherwise meeting program eligibility.

2. Client referrals for diversion bed services must follow procedures outlined in DDA Policy 4.01.

3. Diversion bed services are a 24-hour stabilization service and as such, must not be authorized in conjunction with other DDA-funded stabilization services.

C. Service Delivery

1. The diversion bed provider must provide:

a. Access to diversion bed services 24 hours per day, seven days per week, and 365 days per year;

b. A healthy, safe environment;

c. 24-hour per day supervision and staff support tailored to the client's needs;

d. Three meals per day plus snacks appropriate for the client's dietary needs and preferences;

e. Access to personal care assistance appropriate to the client's needs;

f. Medication management services as needed;

g. Coordination of client's ongoing mental health and medical services including scheduling, transportation, and accompanying the client to those appointments as needed;

h. Access to a minimum of four hours of planned daily activities to the greatest extent possible;

i. Support and facilitation of the continuation of other preferred community activities (including employment, school, and family events) to the extent possible;

j. Comply with integrated setting requirements in DDA Policy 5.25 Integrated Settings.

2. A diversion bed setting must include:

a. A private furnished bedroom, supplied with bedding and towels;
b. An equipped kitchen and dining area;
c. Other physical attributes appropriate to a residential setting, including:

i. Access to a telephone;
ii. Access to free laundry facilities;
iii. A secure place to store medications;
iv. A place to securely maintain confidential client records; and
v. Furnished common areas, with television.

D. Diversion Bed Initial Client Support Plans and Discharge Planning

1. In accordance with WAC 388-101D-0530, transition and discharge planning must begin no more than 48 hours after admission. Transition and discharge planning activities must include:

a. Meeting with the client, legal representative if applicable, DDA CRM, and other members of the client's individualized support team to explore residential service options for the client;

b. Development of the initial client support plan;

c. Assisting the client to visit prospective community residences and meet with potential providers; and

d. Providing information, guidance, and feedback to the client's residential service provider(s) with the client or legal representative's consent regarding progress made during the client's diversion stay, any unresolved concerns, and supports that have been developed which may assist in maintaining stabilization in the next setting, including but not limited to, an updated functional assessment (FA) and positive behavior support plan (PBSP) or CSCP, training and consultation.

2. Diversion providers must submit a copy of the client's transition and discharge plan to the client, their legal representative, the regional stabilization specialist and the CRM.

3. The provider must develop a functional assessment within 45 days and a positive behavior support plan within 60 days of the client entering the diversion bed setting. Per DDA Policy 5.21, FA and PBSP strategies may be incorporated in the initial client support plan if client's diversion bed stay does not exceed 60 days.

4. A provider serving a client enrolled in the community protection program must follow the client's CPP plan if such a plan has been developed and remains active. Diversion providers must notify the CRM of any CPP plan concerns or if the client chooses not to engage in the CPP during a diversion stay.

5. The use of restrictive procedures must meet requirements under DDA Policy 5.15, *Restrictive Procedure: Community*.

E. Diversion Transition Support Services

The diversion provider must:

1. Provide technical assistance and support to the client's residential provider on support strategies developed by the diversion provider for up to 14 calendar days after the client exits the diversion bed to facilitate a successful transition to their next setting.

2. Assist with training and supporting the client's residential provider on the FA and PBSP, behavioral data collection, effective habilitative support goals and strategies, and the CSCP.

F. Certification

Contracted diversion bed providers are certified as Certified Community Residential Services and Supports providers by Residential Care Services and must comply with all certification and monitoring requirements in accordance with Chapter 388-101 WAC.

PROCEDURES

A. Referral Process

1. The CRM must follow any regional review and approval processes, including sending the completed referral packet to their supervisor or designee for review before submitting the final packet to the regional clinical team (RCT) for further consideration.

2. The CRM must include in the diversion referral packet all the current documents required in accordance with DDA Policy 4.01, *One Referral*.

3. DSHS 15-475, *Diversion Services Voluntary Participation Consent,* must be included with all diversion referrals.

B. Pre-Acceptance and Provider Assessment

1. The regional stabilization specialist sends approved referrals for diversion services to the identified provider for consideration. The diversion provider must:

   a. Accept referrals from designated DDA staff only.

   b. Confirm receipt of initial referral no more than one business day after receipt.

   c. After assessing the referral, accept or decline the referral no more than five business days after receipt.

d. Work collaboratively with the client, hospital staff, evaluation and treatment centers, DCRs, MCOs and BH ASOs, community mental health and medical providers, DDA staff and contracted providers, the client's family and legal representative if applicable, and other parties as necessary to ensure a safe transition and establishment of appropriate supports upon admission to the diversion bed.

2. Provider Assessment of Referrals

a. Providers are encouraged to meet with the client, their legal representative if applicable, and members of the client's individualized support team, including the CRM and the DDA regional stabilization specialist, before deciding whether to accept or decline the referral. The meeting may be conducted in person or virtually.

b. Providers must consider their ability to meet the client's health, safety, stabilization and residential support needs in determining whether to accept or decline the referral.

c. The provider must follow confidentiality requirements under Chapter 388-101D WAC.

d. The provider must ensure nurse delegation services, if necessary, are in place before the client begins receiving residential services. For a client who needs nurse delegation services, the provider must not begin serving the client until nurse delegation services, or equally appropriate services, are in place.

C. Declined Referrals

1. If the provider declines a referral, they must provide a detailed explanation of that decision, including any barriers to service, to the DDA regional stabilization specialist within the timeframe indicated above, and must be willing to re-evaluate a declined referral with DDA to consider additional information or exceptional circumstances when requested.

2. After declining a referral, the provider must destroy or delete the referral information in accordance with WAC and statutes on proper destruction of confidential information.

3. The provider must keep their regional stabilization specialists informed of any potential barriers to accepting referrals. If a provider determines they are unable to accept referrals due to issues such as necessary repairs to the home or staffing and training barriers, they must notify the regional stabilization specialist no more than five business days after making that determination.

D. Reports

At the end of each service month, the provider must submit the following to the regional stabilization specialist:

1. A monthly summary of diversion activities and supports provided;

2. A monthly billing document that includes the name of each client served and the dates and length of service;

3. Data collection and tracking information for each client served; and

4. Any concerns or barriers to service not previously identified.

E. A diversion bed provider is a mandatory reporter under Chapter 74.34 RCW and must follow incident and mandatory reporting requirements in accordance with DDA Policy 6.12.

F. When supporting a client accessing diversion bed and post-diversion transition services, the CRM must:

1. Ensure the client's DDA assessment is current and accurate when preparing a referral for service.

2. Update the PCSP through an interim or significant change assessment, if appropriate, to ensure information included in the client's DDA assessment accurately reflects their support and stabilization needs and service approval.

3. Complete a planned action notice (PAN) for the approval of the service in CARE.

4. Update the change of residence on the contact details screen in CARE using residence type "mental health diversion" with the diversion bed address and start date.

5. Participate in weekly case discussions with the diversion provider and other members of the client's individualized support team.

6. Complete a nurse delegation referral when appropriate in accordance with DDA Policy 6.15, *Nurse Delegation Services*. If nurse delegation is required, the CRM must complete and submit the ND referral at least seven days before the client is scheduled to access the diversion bed service.

7. Submit referrals for requested residential or other long-term services in accordance with DDA Policy 4.01 if the client will not be returning to their previous home.

8. Create and maintain Transitional Care Planning and Tracking Document on DSHS 10-574 per DDA Policy 3.03, *Transitional Care Management*.

G. Regional Clinical Team involvement

1. Regional stabilization specialists must notify the client, guardian, CRM, involved community partners (hospital social workers when relevant, E&T support team, etc.) that the diversion provider has accepted the referral and is initiating their assessment.

2. The stabilization specialist must share the diversion provider's contact information with relevant members of the client's individualized support team.

3. The diversion provider must coordinate with the RCT to schedule and facilitate weekly meetings to discuss the client's case with the client, their legal representative if applicable, the regional stabilization specialist and other members of the client's individualized support team to review the following:

   a. Progress towards identified goals;
   b. Debrief of any reportable incidents per DDA Policy 6.12;
   c. Data tracking and outcomes; and
   d. Barriers to discharge from diversion services.

4. The regional stabilization specialist must authorize payment for diversion bed services as follows:

   a. Authorize the client's diversion bed services for 90 days upon entrance to the diversion setting.

b. Authorize a provider diversion retainer payment after the end of the service month for each calendar day the bed was unoccupied.

H. Discharge and Transition Planning

1. Diversion transition support services include provision of technical assistance, training, and support to the client's caregiver or residential provider on support strategies developed by the diversion provider.
2. Services are approved for up to 14 days after the client exits the diversion bed setting to facilitate a successful transition to their next residential setting.

EXCEPTION

Any exception to this policy must have the prior written approval of the Director or designee.

Approved: _____ Date: August 15, 2025

Director
Developmental Disabilities Community Services