Program Title: Transitional Care Pilot

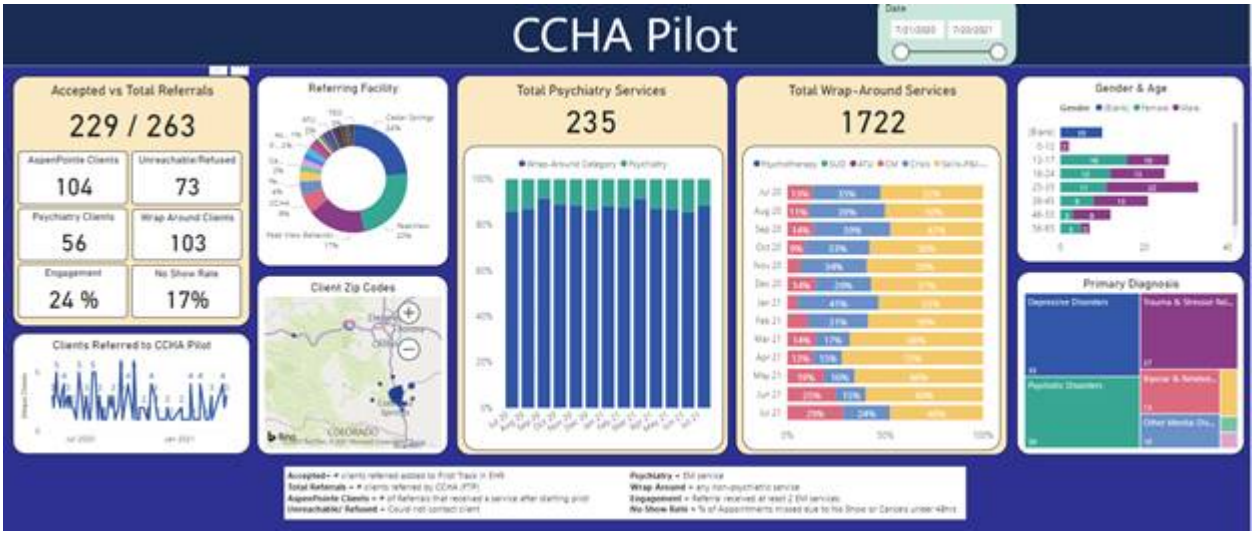
Organization: Diversus Health

Program Abstract (50 words max, please):

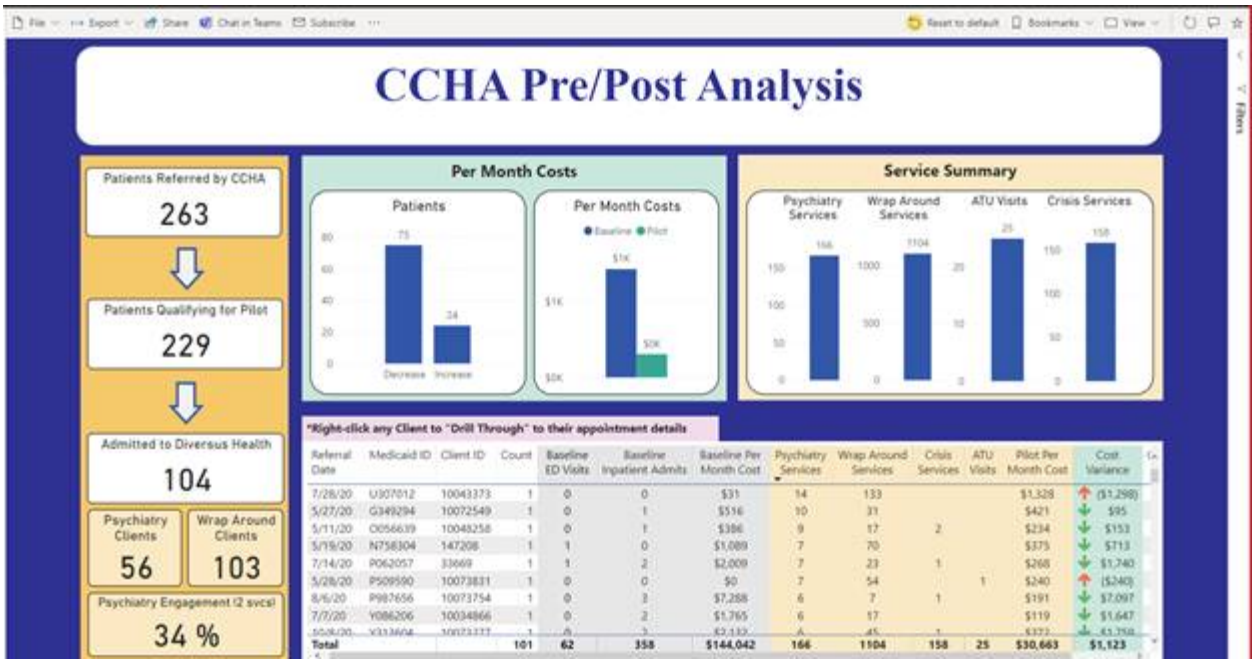
The program was developed in collaboration with CCHA to engage high utilizers into outpatient services. We defined engagement as 2 appointments with psychiatry team. CCHA would identify the patients, refer them to the nurse care manager and case manager who then would outreach to begin engagement.

Program Description (*Include program development, program information, staffing requirements, pertinent data and start-up costs.): *Please limit to 2 pages, and remember to address all criteria specified.*

Program Information: The pilot began on 5/11/2020 and ended on 6/31/2021 with the goal over CCHA sending 500 client referrals. CCHA referred patients that had been identified to have rapid readmissions to inpatient facilities and in need of more intensive outpatient services. Diversus Health RN Care Manager would then begin to work with client on care coordination with the focus of connecting client to initial outpatient psychiatry appointment with a follow up within 30-45 days.
Staffing Requirements: The initial staffing was built for a full time RN Care Manager and a full time Case Manager. The majority of the program was completed with 1 full time RN Care Manager.
Pertinent Data:



- Diversus Health accepted 229 referrals of the 263 total referrals from CCHA.
- 104 patients were previously engaged in Diversus Health services
- 56 patients engaged in outpatient psychiatry services
- 103 patients received wrap around services
- Overall, 24% of clients referred participated in the pilot



- Pre-Pilot, the average cost per month was $1,426.15
- Post Pilot, the average cost per month decreased to $306.63
- There were cost improvements for 75 clients
- There were cost increases for 24 clients

Start Up Cost:

Full Time Case Manager Salary:

- $17.00/hr
- $35,360 annually

1 RN Care Manager

- $35.75/hr
- $74,360 annually

Client Story:

Referred to the CCHA pilot program in July 2020. Client had multiple rapid hospital readmissions for a mood disorder with psychosis as well as substance use. Client was an active IV methamphetamine user at time of referral and was living in his sister's car in front of her house. Client had a strained relationship with his family due to his substance use. Client had multiple hospital ICU admissions due to the physical damage of his substance abuse. Care management team provided weekly home visits for psychiatric and medical assessments, assistance with telehealth appointments, and monthly injections. Care coordination was performed with the MSO team. Client successfully detoxed from methamphetamines and was admitted to the long term program at Ft. Lyons. A recent update informed the team that this client is 90 days sober and is currently working on his GED. He plans to continue his stay at Ft. Lyons.

Referred to the CCHA pilot program in May 2020. Client had multiple rapid hospital readmissions for Schizoaffective disorder and Post-Traumatic Stress Disorder. Client had faced chronic homelessness after being released from prison and was not engaged in psychiatric services. Client became deeply involved in the pilot program and other programs that Diversus Health was able to offer him such as the Covid support program. He has attended all medication management appointments with his prescriber, is involved in the medication monitoring program and remains medication compliant. He also receives a monthly medication injection.

Client has completed his parole requirements and his ankle monitor was removed. Client was linked to Rocky Mountain Human Services who continue to assist client with housing resources. They have assisted him with obtaining a replacement birth certificate, ID card, and social security card. Client has not returned to the hospital since joining the CCHA pilot program.