



ACTION Campaign

Promising Practices



**Create
Seamless Transitions
Between Levels of Care**

*Introduce Clients to
Ongoing Supports
Action Guide*

ACTION CAMPAIGN
Making an Impact on Addiction Treatment and Recovery



Introduce Clients to Ongoing Supports

Purpose: This ACTION Campaign promising practice will help your agency develop processes and protocols for live hand-offs as people transition from one level of care to the next, or to recovery supports post-treatment.

Introduction: Transitions are stressful: whether changing homes, schools, jobs—or treatment programs. In substance abuse treatment, clients are more likely to relapse or drop out of treatment entirely when moving from one level of care to the next. Providing personal support as clients transition through care can improve outcomes. Agencies that arrange a “live handoff” from one level of care to the next find that the resulting increase in continuation improves the bottom line.

Before testing this Promising Practice, collect data on the number of discharges from your agency by level of care. For each level of care, determine if the discharge status or disposition was a referral to another level of care. If yes, record the level of care that the client was discharged to— for example, from Residential to Intensive Outpatient. Was that discharge successful? In other words, was the client admitted to the next level of care? If yes, track that information as well. Which discharge process is most successful? Note: Collecting this baseline data will require a historical look at your agencies’ discharge patterns and it may take some time to collect.

Plan: Choose one level of care transition to modify, ideally the one with the lowest number of successful transfers after you have collected your data. It may be detox to residential, residential to out-patient, out-patient to recovery supports. Choose the transition that you believe to be the most difficult in your organization. Hold a focus group or interview clients that have made it through the level of care transition process. What worked for them? What made transition more difficult? Are there ways that your organization can change its processes to reduce or eliminate the things that made it difficult to transition or enhance the things that made it easier?

Clients often report feeling like they are starting all over at the next level of care, with people they don’t know asking questions they’ve answered already. They question the value of rehashing their prior treatment with someone new; they don’t want to repeat the process of developing rapport with a new counselor all over again. Clients may have developed a comfortable routine at one level of care. Now they have to go to a new facility, learn new transportation routes, parking norms, develop rapport with a new receptionist, new counselor, and new group mates. Collect data on the percent of people who make a successful transition to the next level of care. Identify those aspects of transition that make your clients less likely to transition and make one change.



Do: Implement the change in the level of care transition that you have identified. Some changes that have worked at other agencies include:

- Holding a joint counseling session with the current and prospective counselor
- Allowing a client to participate in the next level of care while still in the present one



Introduce Clients to Ongoing Supports

- Rewarding the client for that participation
- Keeping the same counselor through level of care transitions

You may test this change with only one or two clinicians or for a two-week period, depending on the change.

Study: Compare the percent of people that made the transition before and after the change. If the change involves only a few counselors, be sure to use comparable data by comparing the percent of their clients who made the transition successfully before and after the change. What did you learn? Did live hand-offs improve the show rate at the next level of care? Can you quantify that improvement to demonstrate improved revenue streams as well as improved outcomes for the clients? Did the change result in more efficient use of resources, such as increased numbers of clients participating in an existing group? Discuss the change with the staff, and if possible, with the clients involved. What went well? What could use modification? If appropriate, expand the pilot or:

Act: Implement the pilot across the level of care transition that you identified. Start the process over again with another potential improvement. Submit your data to the ACTION Campaign Web site.

Measuring the Impact of Change

The length of time necessary to test a change will vary depending on an agency's size. Scientifically, the preferred sample size is at least 40 clients. However, since you are testing a hypothesis, what you need are just enough clients before and after the change to see a trend. Pilots should not last more than a month, or they tend to lose their pilot status. We recommend that you run your change project pilot long enough to have at least 20 clients experience your new way of operating. For smaller agencies, depending on the change, this may take a month. Larger agencies probably should run a change for at least a week, even if that gives a sample larger than 40.

Practice Measure: Number of people who move to the next level of care after completing the previous level of care.



Introduce Clients to Ongoing Supports

Palladia, Inc.

New York City, New York

<http://www.palladiainc.org>



Palladia, Inc., is one of the largest not-for-profit, multi-service agencies in New York City. With more than 30 years of experience, Palladia serves largely urban, poor individuals and families of color and is nationally recognized for its innovative service delivery in the fields of substance abuse, homelessness, HIV, mental illness and trauma, domestic violence, criminality, and family services.

Project Aim Increase continuation

Change Leader / Executive Sponsor Deb Pantin

Goals & Measures

Palladia's Continuing Care Treatment (CCT) offers outpatient aftercare services to clients who have graduated from its Starhill and other residential substance abuse treatment programs. CCT programs and services promote a healthy drug-free lifestyle and reintegration into the larger community. CCT's comprehensive approach helps clients with their recovery needs and the challenges of self-sufficiency. Services include individual and group addiction counseling and support, relapse prevention, vocational and educational services, job search assistance, and assistance with budgeting and housing.

One of the first problems the Palladia Change Team identified after joining NIATx was that patients would leave Starhill with a referral to Continuing Care Treatment (CCT), but they would not successfully transfer to CCT. Palladia assembled a Change Team that included administrative staff from both the Starhill and Continuing Care Treatment facilities. The team established a goal to create a seamless transition from residential to continuing care treatment for each Starhill client.

Changes Implemented

The Change Team explored ways to improve the transfer between levels of care, using rapid-cycle PDSA testing. Through flow-charting, the team identified weaknesses in the Starhill discharge process and the CCT intake process. With a better picture of the processes, the team tested modifications to the system. These included:

- Sending a patient's Starhill discharge application to CCT 30 days before the client's scheduled discharge date
- Testing electronic transfer of paperwork between facilities
- Requiring CCT to call Starhill upon receipt of the discharge paperwork; after this point, CCT staff would schedule the client's CCT intake within seven days of receipt of the discharge paper work



Introduce Clients to Ongoing Supports

- Requiring that Starhill clients complete CCT intake and attend at least two group sessions at CCT before departing Starhill
- Starhill staff distributed CCT program information to residents; CCT staff offered monthly presentations at Starhill.

Business Case Impact

Palladia has seen improved transfer between Starhill residential treatment and Continuing Care. Communication between clients and staff has improved at both facilities. Pantin cites other improvements as well. "Palladia staff are beginning to understand what true continuation is: minimizing as many gaps in treatment as possible. In New York City, it's easy for gaps to develop naturally as a result of the complex systems our clients have to navigate. The philosophy at Palladia is now to eliminate barriers and make continuation from residential care to community care a routine component of the recovery process."

Lessons Learned

Change Team I included 12 administrators from three different administrative levels. "Members generated ideas focused on 'system,'" says Pantin. "Including a consumer on the team would have generated more 'out of the box' thinking. However, the advantage to having a team consist of administrators was that it secured buy-in from staff at different sites. Staff at all levels are enthused about NIATx, feel more invested in change projects, and are excited at seeing immediate results."

Promising practices Palladia uses to improve continuation between levels of care

- Makes CCT programming available at times most convenient to clients
- Integrates clients into CCT treatment community before they leave the residential treatment site
- Provides orientation to CCT at the residential site; establishes clear two-way expectations and communication
- Identifies and addresses barriers; ensures that clients' needs are being met
- Stresses the importance of CCT as a crucial part of the recovery process
- Works to continuously improve communication between residential and continuing care services



Introduce Clients to Ongoing Supports

Additional Success Stories Creating a Seamless Transition

Agency	Level of Care	Change	Action Impact
Acadia Hospital	Detoxification to IOP	IOP counselors visited patients in Detoxification to invite to IOP	Increase % of clients who continued from Detoxification to IOP from 55 to 75%
Jackie Nitschke Center ¹	IOP to Aftercare	Start Aftercare immediately Attend same Aftercare group No misses in 1 st five Aftercare session	Improve client attendance at 1 st five aftercare sessions from 38 to 83% Improved client completion of Aftercare from 46 to an average of 71%
Manatee-Glens Sarasota	Detox to Outpatient	OP staff meets pts in Detoxification Recovery coaches explain program/invite Recovery coaches + calls to remind 1 day prior Coaches + calls + detox come as a group when appropriate	Reduce No-shows for the Next Level of Care from 66 to 26%

¹ http://www.niatx.net/PDF/PIPractice/CaseStudies/JNC%20Continuation%20in%20Aftercare_101705.pdf



Introduce Clients to Ongoing Supports

Additional Success Stories Creating a Seamless Transition

Agency	Level of Care	Change	Action Impact
Palladia ¹	Residential to Outpatient	Makes CCT programming at times convenient to client <i>Integrates clients into CCT treatment community before leaving residential</i> Provides orientation to CCT at the residential site and established clear two-way expectations and communication Identify and addresses barriers	89% of Referrals still in Treatment
Port Human Services	Detoxification to Aftercare	Changed process so that 1 st Aftercare appointment took place while client was still in Detoxification	Increases % of clients who continued from Detoxification to Aftercare from 62 to 81%

¹ http://www.niatx.net/PDF/PIPractice/CaseStudies/Palladia_Continuation_031006.pdf