Continuity of Care in a VA Substance Abuse Treatment Program

Elie M. Francis, MD; Joseph DeBaldo, MBA, MEd; Suzanne E. Shealy, PhD; and Cheryl L. Gonzales-Nolas, MD

Continuous care is essential to successful substance abuse treatment (SAT). When the VA implemented the Continuity of Care Performance Measure, this facility's SAT program went the extra mile to exceed the VA's standards.

The methodology for treating patients who have substance use disorders in the United States shifted in the mid-1990s from an inpatient model, in which, patients were admitted and treated in a hospital setting for 28 days under 24-hour nursing supervision, to an outpatient model, in which, patients were treated in less-supervised residential settings or in their own homes.[1] Even with this shift to an outpatient model, however, the emphasis of the treatment community remained on treating patients in an intensive 3- to 4-week program. Various aftercare clinics were made available to patients, but there was never a strong focus on their importance, and patients who did not present for their aftercare groups did not receive follow-up telephone calls. More recently, there has been progress toward adopting a broader approach to substance abuse treatment (SAT), which emphasizes the importance of regular follow-up and integration with other health care services.[2]

Continuity of Care (CoC) as a performance measure for SAT programs was introduced in the VHA in fiscal year 2003,[3] with the goals of decreasing the high dropout and relapse rates that occur during the initial 90 days of treatment, as well as improving patient outcomes by emphasizing the importance of early treatment retention.[4] The VHA determined that these goals could be accomplished by following up with patients who enter an SAT program at least twice per month during the first 90 days of treatment.[3]

The importance of treatment retention is supported by Hser and colleagues, whose study demonstrated that greater treatment service intensity and satisfaction were positively related to either treatment completion or longer treatment retention, which, in turn, was correlated with favorable outcomes for patients in community-based drug treatment programs.[4] According to Hser and colleagues, treatment service intensity was the sum of the number of times that a patient received services, (either in the program or through referrals) including the number of professional services and discussion or counseling sessions that the patient received during the first 3 months of treatment in each of the 7 problem areas that were measured in the Addiction Severity Index. Treatment satisfaction was indicated by 3 measures at the 3-month follow-up that assessed patient's satisfaction with the program, services, and counseling relationships.

It also has been observed that patients who enter outpatient treatment after completing a residential- or hospital-based SAT program have a reduced risk of treatment dropout and subsequent relapse.[5] In a 2002 study that examined a cohort of 2,805 male patients who received treatment in 1 of the 15 SAT programs at the VA, researchers determined that involvement in self-help groups was linked to patients' remission status 2 years after discharge.[6] While no significant relationship emerged between treatment orientation (12-step, cognitive behavioral, or eclectic) and remission status 2 years later, involvement in outpatient mental health care during the first follow-up year and participation in self-help groups during the last 3 months of that year were associated with a greater likelihood of remission at the 2-year follow-up.

In this article, we describe the implementation of procedures in our SAT program that resulted in not only meeting, but exceeding, the

Dr. Francis is a staff physician, **Mr. DeBaldo** is a staff counselor, **Dr. Shealy** is a staff psychologist, and **Dr. Gonzales-Nolas** is program leader, all in the Alcohol and Drug Abuse Treatment Program in the Mental Health and Behavioral Sciences Service at the James A. Haley Veterans' Hospital in Tampa, Florida. In addition, Dr. Francis is an associate professor and Dr. Gonzales-Nolas is an assistant professor, both in the Department of Psychiatry and Behavioral Medicine; and Dr. Shealy is an assistant professor in the Counseling Center for Human Development, all at the University of South Florida in Tampa.

standards of the VA's CoC Performance Measure.

OUR SAT PROGRAM

Over the past several years at the James A. Haley Veterans' Hospital (JAHVH) in Tampa, Florida, we have implemented a number of changes in our SAT program during its transition from an inpatient model to an outpatient model.[7] In order to expand our program and continue to improve patient care, we have added a dual-diagnosis treatment program, a primary care clinic, evening clinics, and relapse prevention groups; we also have increased the number of aftercare clinics. All of these steps have helped us exceed the standards of the CoC Performance Measure when it was introduced in fiscal year 2003. Additionally, 2 important and complementary changes that we implemented were (1) making CoC a part of the program's culture and (2) having a staff member become the champion of this measure.

Promoting a CoC culture

One of the first things we did in our SAT program was to educate and change the mind-set of both patients and staff regarding the benefits of CoC for patients with substance use disorders.

It is important to recognize that alcoholism and drug addiction are chronic, relapsing disorders.[8] Chronic disorders cannot be treated in a 3- to 4-week period, but, rather, require a lifetime of behavioral change maintenance aided by ongoing care and continuous support and follow-up. SAT programs that routinely engage patients in continuing outpatient care are likely to have better outcomes. (The overall duration of care is more important than the number of sessions.)[4] Research literature regarding the importance of continued treatment engagement was shared with program staff during the initial staff meetings to enhance understanding of the rationale for the CoC Performance Measure.

Substance abuse treatment programs that routinely engage patients in continuing outpatient care are likely to have better outcomes.

The Alcohol and Drug Abuse Treatment Program (ADATP) at the JAHVH consists of a 3-week, 20 to 30 hours per week, intensive alcohol and drug abuse outpatient treatment program, and a 6-week, 25 hours per week, intensive dual-diagnosis treatment program. Patients participate in the programs from home (commute to the clinic daily) or from a contracted facility if they are homeless, lack an environment that supports recovery, or live too far from the VA to commute every day during the week.

We speak with patients about the importance of CoC on the day they enter the SAT program, and, in their first week of treatment, patients attend an orientation group that further highlights the importance of CoC. We emphasize to patients the significance of the different phases of treatment, rather than just focusing on the completion of a residential or an outpatient treatment program.

At the end of the intensive phase of treatment, each patient discusses and writes with the counselor a "continuing care" plan, which includes the patient's goals and specific plans for ongoing recovery, and his/her follow-up plans. The continuing care plan encourages the attendance in self-help groups in the community, aftercare groups, and/or relapse prevention groups at the VA, and reminds patients of their other scheduled medical and mental health appointments at the VA. This planning session also provides an opportunity for the staff to update each patient's address and telephone information to help them remain in contact following the intensive treatment phase.

Phase 2 of the program

After completing the intensive treatment phase, patients are transitioned to phase 2 of our program, which consists of relapse prevention groups and continuing care clinics. Our relapse prevention groups meet on Tuesday and Thursday afternoons for 1 hour each session; our continuing care groups meet on Monday and Wednesday afternoons and on Thursday evenings for 1 hour each session. A weekly phase 2 dual-diagnosis group also is available. In addition to these groups, patients are encouraged to follow up individually with their treating counselors and physicians.

The aftercare clinics and the relapse prevention groups are available to every patient who has completed the intensive treatment program. Aftercare groups continue the recovery themes and messages that were taught in the intensive SAT program, with a 12-step–oriented focus. The relapse prevention groups provide

cognitive-behavioral and mindfulness-based skills training, combined with support for 12-step recovery.[9] These groups assist patients with the establishment of a sober support system and the development of coping skills that will help them transition to community life. Patients are encouraged to attend at least 1 aftercare group per week in addition to weekly face-to-face or telephone follow-ups with their ADATP case manager.

Because the groups are available on 4 afternoons and 1 evening per week, and are facilitated by 4 different staff members, it is convenient for patients to select the groups they feel are the most comfortable and beneficial. The evening group is particularly helpful for veterans who are employed or are participating in the VA Compensated Work Therapy program. Several participants have good long-term sobriety, and participants with 5 or even 10 years in recovery are not uncommon.

Championing success in CoC

In addition to influencing program culture and providing a structure for continuing care services, we have found it essential to create a structure and process for tracking and ensuring a continued focus on the CoC Performance Measure. Good CoC with an eye toward improving patient outcomes requires doing many things well, including organization, precise tracking and monitoring, and quick responses to patients after program completion. It requires team effort and the overall coordination of CoC with numerous routine activities.

Successful CoC also requires a champion; someone to take a leadership role and provide the encouragement for staff to go beyond the simple requirements of the program; someone with an eye toward excellence in outcomes improvement. A good champion blends the skills of counseling with those of administration.

In our SAT program, the champion is a senior counselor with over 25 years of experience, who blends his skills in therapy with a background in business administration. The champion works directly with staff to monitor patient contacts and to provide regular reporting of the program's progress toward meeting and exceeding the VA performance measure. This helps to develop the coordinated, team-based strategy that is necessary for more patients to receive successful ongoing care.

Other strategies and program changes promoting success in CoC

Our success in CoC is helped by making the performance measure part of the SAT program's performance improvement plan, which serves as a monthly reminder of this important issue. Our success also is supported by frequently utilizing the nationally available VHA Support Service Center (VSSC) reports and the Case Finder menus.

The VSSC reports provide the official report card for each facility regarding their accomplishment of the CoC Performance Measure. The formal report is updated monthly and is available on the VSSC Web site. The Case Finder was developed by a VA colleague in VISN 16, and was installed and made available at other VA locations, including the JAHVH. The Case Finder searches patient records according to substance abuse stop code and determines which patients meet the qualifying criteria for the CoC Performance Measure, including the all-important "qualifying date," which becomes the start date for the 90 days of follow-up. The ADATP team utilizes the Case Finder frequently, and promptly updates tracking and monitoring systems as changes occur.

While many patients maintain contact through our continuing care groups, some are inhibited from doing so because of distance from the facility, or conflicting work schedules. In order to remain in contact with those patients who are difficult to reach during the day, we created an evening telephone clinic from 5:00 PM to 7:00 PM on Thursday nights, which is staffed by a counselor and a nurse. Counselors provide the names of difficult-to-reach patients to these staff members, increasing the opportunity for successful follow-up.

In 1999, the nurse practitioner in the SAT program, who was responsible for performing the inpatient histories and physical examinations of patients being admitted to the program, became the primary care provider for our outpatients with uncomplicated medical problems. This step has allowed many patients to receive all of their substance abuse, mental health, and medical care in 1 clinic, making it easier for both the patient and the staff to continue their follow-up. CoC follow-up sessions can be coordinated with follow-up medical appointments.

Additionally, staff members' individual performance on this measure is included in their yearly performance evaluations. Exceeding the performance measure has become a factor that helps the staff achieve an outstanding evaluation and become eligible for associated performance or special recognition awards.

THE SUCCESS OF OUR SAT PROGRAM

When the CoC Performance Measure first was adopted in fiscal year 2003, the threshold for successfully meeting the measure was set at 32% (percentage of patients who successfully com-

pleted the 90-day CoC Performance Measure), and for exceeding the measure at 38%.[2] Over the next 5 years, the percentages to meet and exceed the measure have steadily increased to 47% in fiscal year 2008,[10] which has kept it challenging.

In 2003, the JAHVH's ADATP met the performance measure goal. Since then, the program not only has exceeded the measure every year, but also has exceeded our VISN average as well as the national average.

Our staff has taken pride in achieving those numbers, and the success of the program has led to inquiries from other VA programs, and to in-service training within our VISN regarding the methods used by our program to meet and exceed this performance measure.

CONCLUSIONS AND FUTURE DIRECTIONS

As a treatment program, remaining current with the latest treatment recommendations and guidelines is extremely important. Performance measures in the VHA are a way to make sure that effective interventions are implemented.[11] The CoC Performance Measure is an important component of patient care in any SAT program. Patients with chronic mental illnesses or substance use disorders will always benefit from a treatment program that provides them with long-term care and support.[12] In a comparison study of long-term and short-term residential treatment programs for dual-diagnosis patients, at follow-up, individuals in the long-term residential treatment group were more likely to have maintained abstinence and less likely to have experienced homelessness than those in the short-term group.[12]

Educating patients in an SAT program on the benefits of CoC is paramount to the success of their treatment. Educating staff on the latest evidence-based treatments is equally important, as it keeps them motivated to make the changes necessary to provide patients with the best care possible and ensures the program remains successful.

This article does not provide patient data from our program regarding number of patients treated or their demographics. It also does not address how our program's success has impacted our patients' relapse rates. The article's focus mainly is on showing how our program and staff have adapted over the years to meet changes in our health care system, and how we have met and exceeded new VA performance measures that have been implemented to improve patient care and outcomes in SAT programs.

Most recently, our program has been preparing to implement use of the Brief Addiction Monitor (BAM). This 17-item, VA-developed instrument provides a structured means of follow-up for patients with substance use disorders. It is designed as a monitor of progress in SAT and evaluates patient responses regarding 3 reliable factors: substance use, risk factors for use, and pro-recovery behaviors. This instrument allows for an evaluation of outcome in terms of substance use and other indexes of health, role functioning, and well-being, and could provide additional data to continue to improve care for veterans with substance use disorders.

Methods employed for improving CoC should be helpful to those working to track patients' progress using the BAM. With this in mind, here is a list of do's and don'ts for good CoC:

DO:

- create a culture of CoC.
- identify a "champion" staff person who provides case finding, tracking, and feedback.
- clearly assign responsibility to each clinician, but develop an attitude that CoC is a team effort.
- make CoC part of the SAT program's performance improvement plan.
- learn how to navigate the VSSC reports and the Case Finder menus, and utilize the data to pinpoint areas that need improvement.
- develop a tracking system.
- develop a telephone clinic and assign evening staff to make follow-up calls for patients who are difficult to reach during the daytime.
- at the end of the intensive phase of treatment, prepare a comprehensive continuing care plan that includes goals and specific plans for ongoing recovery, with details about follow-up.
- obtain patients' telephone numbers, including cell phone, and provide bus passes, when needed, for patients to return to the clinic for follow-up.
- provide a large number of relapse prevention and aftercare groups, including evening groups for veterans who are employed.
- include CoC performance in the clinicians' yearly individual performance evaluations.

DON'T:

- think of treatment as being 21 or 28 days. Recovery does not end with the end of the intensive treatment program.
- lose sight of the value of teamwork in covering and helping.
- rest with success. Keep the momentum going!

Acknowledgment

This material is the result of work supported with resources and the use of facilities at the JAHVH.

Author disclosures

The authors report no actual or potential conflicts of interest with regard to this article.

Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of Federal Practitioner, *Quadrant HealthCom Inc., the U.S. Government, or any of its agencies. This article may discuss unlabeled or investigational use of certain drugs. Please review complete prescribing information for specific drugs or drug combinations—including indications, contraindications, warnings, and adverse effects—before administering pharmacologic therapy to patients.*

REFERENCES

1. Washton AM, Rawson RA. Substance abuse treatment under managed care: A provider perspective. In: Galanter M, Kleber HD, eds. *Textbook of Substance Abuse Treatment*. 2nd ed. Washington, DC: American Psychiatric Publishing, Inc.; 1999:545-552.
2. McLellan AT. What we need is a system: Creating a responsive and effective substance abuse treatment system. In: Miller WR, Carrol KM, eds. *Rethinking Substance Abuse: What the Science Shows, and What to Do About it*. New York, NY: The Guilford Press; 2006:275-292.
3. Veterans Health Administration Office of Quality and Performance. *FY 2003 VHA Performance Measurement System Technical Manual*. Washington, DC: Veterans Health Administration; 2002.
4. Hser YI, Evans E, Huang D, Anglin DM. Relationship between drug treatment services, retention, and outcomes. *Psychiatr Serv.* 2004;55(7):767-774.
5. Daley DC, Marlatt GA. Relapse prevention. In: Lowinson JH, Ruiz P, Millman RB, Langrod JG, eds. *Substance Abuse: A Comprehensive Textbook*. 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2005:772-785.
6. Ritsher JB, Moos RH, Finney WJ. Relationship of treatment orientation and continuing care to remission among substance abuse patients. *Psychiatr Serv.* 2002;53(5):595-601.
7. Francis E, Hughes P, Schinka J. Improving cost-effectiveness in a substance abuse treatment program. *Psychiatr Serv.* 1999;50(5):633-635.
8. Koob GF. Neurobiology of addiction. In: Galanter M, Kleber HD, eds. *Textbook of Substance Abuse Treatment*. 4th ed. Arlington, VA: American Psychiatric Publishing, Inc.; 2008:3-16.
9. Shealy SE. Toward an integrally informed approach to substance abuse treatment: Bridging the science-spirit gap. *J Integral Theory and Pract.* 2009;4(3):109-126.
10. Veterans Health Administration Office of Quality and Performance. *FY 2008 VHA Performance Measurement System Technical Manual*. Washington, DC: Veterans Health Administration; 2008.
11. Asch SM, McGlynn EA, Hogan MM, et al. Comparison of auality of care for patients in the Veterans Health Administration and patients in a national sample. *Ann Intern Med.* 2004;141(12):938-945.
12. Brunette MF, Drake RE, Woods M, Hartnett T. A comparison of long-term and short-term residential treatment programs for dual diagnosis patients. *Psychiatr Serv.* 2001;52(4):526-528.