

# **ACTION** Campaign

## **Promising Practices**



**Create  
Seamless Transitions  
Between Levels of Care**

*Evaluating the Hand-off  
Action Guide*

**ACTION** CAMPAIGN  
Making an Impact on Addiction Treatment and Recovery

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## Evaluating the Hand-off

**Purpose:** to help your organization develop ways to follow up on clients' transitions from one level of care to another.

**Introduction:** For clients, transitions are stressful times that can result in relapse or lack of follow-through. After developing a relationship with a clinician and peers in recovery, a client may be overwhelmed at having to start all over again with a new therapist and peer group in a new location. In addition, clients sometimes have to wait weeks after discharge from a higher level of care (detox, residential) for their first appointment at the next level of care. They may feel that if they have made it so far on their own, they don't need to go the next step. Few people make it through detox to a residential or out-patient program. Even fewer make the next transition to aftercare. We can make transitions easier for clients by seeking their feedback and continually evaluating our processes.

**Plan:** Identify a small group of clinicians, one practice location, one level of care, or other small part of your organization in which to pilot your project. Measure what percent of clients successfully make the transition that you wish to impact, even if the transfer is to another organization. For an internal transfer, you can collect all of the information from your own organization. For external transfers, you may want to choose one agency you refer to frequently, and run your pilot only with transfers to that agency. You can collect previous successful transfer rates by identifying all of the clients referred to that agency or level of care for the past week or month. The time period you choose depends on your volume. Higher volume agencies can look at shorter time periods. Contact that agency to see which patients followed through with their appointments. Identify who will make the follow-up calls (clinicians call regarding their own clients, a support staff or intake staff calling on everyone), and develop a script that asks questions regarding the hand-off process for both the client and treatment provider.

**Do:** Run a brief pilot where someone in your agency follows up on every client discharged to a lower level of care. Call the treatment provider to see if the client made the first appointment. Ask the provider how you can improve the next transfer, for both the client and the provider. Follow up with clients who did not make their appointments. What prevented them from making the appointment? What could you do to help get them a new appointment or remove barriers to continuing treatment? Gather data for a brief period of time (a week or two).

**Study:** Review the information gathered through the pilot project. Even if your rate of successful transition has not changed, the information should be rich in possibilities for future changes. What reasons did clients or the next level of care practitioners cite as preventing the transition? Information that other agencies have uncovered includes:

- Clients didn't really want to go to a particular program
- The clinician just needed to put something on the discharge summary, so picked a program for the client, even though both knew there would be no follow through





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- Long waits, transportation, and child care present barriers
- Clients feel overwhelmed by having to see an unknown provider in a new location

The follow-up may lead to improved transitions, but also identifies other ways that your organization can make transitions between levels of care more streamlined and client-friendly.

**Act:** If you feel that your follow-up pilot was successful, expand the pilot to more clinicians, more levels or care, or more programs. Continue to identify ways that you can change your transition processes to improve client follow-through.

### 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 referrals and transfers and percent of follow-ups resulting in completed transfers.*





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### **Palladia, Inc.**

New York City, New York

[www.http://www.palladiainc.org/](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



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- 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.

### Lessons Learned

When implementing this project, Palladia learned:

- As barriers to admission decreased, acuity level of patients increased.
- Patients really do show up for treatment when they receive more immediate appointments.
- Multiple phone calls are a poor indicator of client's motivation.
- Senior management staff need to model change by working with line staff.
- Program changes were needed to accommodate clients who showed up as barriers were reduced.
- From a business case perspective, the contribution margin of this program has tripled from change date to the present.