CIBHS
CALIFORNIA INSTITUTE FOR BEHAVIORAL HEALTH SOLUTIONS

Fresno County
Wednesday, September 11, 2019
Improving Client Engagement & Retention

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Objectives

- A self-reflective assessment of your current process and capabilities
- With your peers, brainstorm solutions and develop a plan to improve patient retention from first call through the continuum of recovery.
- Identify the linkage of a quality access process and quality assurance measures to improve patient outcomes

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1. What does Great Customer Service Look Like?
2. Overview of the New Continuum
3. Access and Engagement in Your Agency
4. Access and Engagement in the Continuum

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Introductions

- Name, agency, role
- Levels of care and services offered
- Level of care most often referring "Out To"?
- Demographics- Serving which population? (ages, LGBTQIA2-SP, multiple languages, can accommodate physical disabilities.)

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Polling Questions

What is your role in the organization?

- Clinical Director
- Receptionist
- Front desk administration
- Scheduling
- CEO
- Clinician
- Intake coordinator

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Polling Question

At your agency which levels of care do you provide?

- Withdrawal Mgt.
- Outpatient
- Intensive outpatient
- Residential
- Recovery services
- OTP
- Other

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What does Great Customer Service Look Like?
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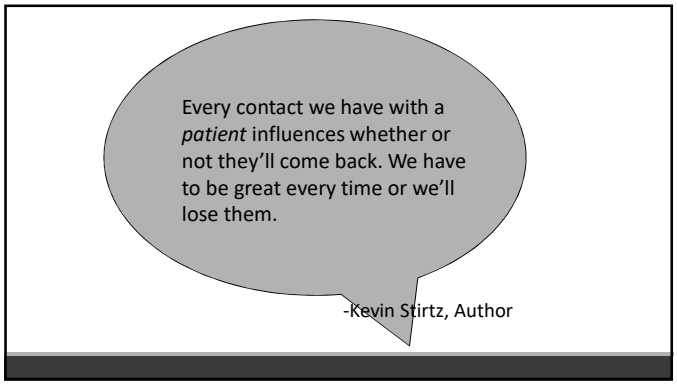
Every contact we have with a *patient* influences whether or not they'll come back. We have to be great every time or we'll lose them.
-Kevin Stirtz, Author

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Disney parking lot VP is tasked with reinventing the parking lot experience every year.
WHY?
Because 70% of the customers arrive in a car.

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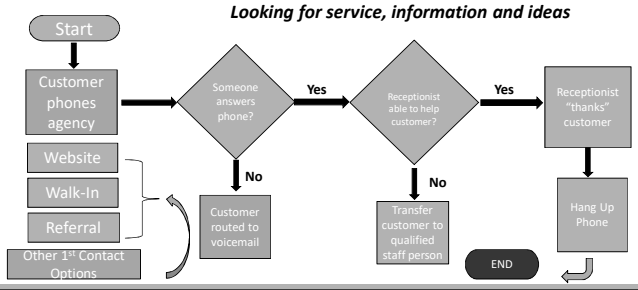
Customer's First Impression

Looking for service, information and ideas



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What the websites promise

- ***The solution*** to your Drug and Alcohol addiction
- Help you ***take back control over your life before it's too late*****,** while lifting the worries of your friends and family
- ***Personalized*** drug, alcohol and other substance abuse treatment programs that ***are both effective and affordable***
- Our Intensive Out Patient (IOP) and Out Patient (OP) programs provide specialized treatment **in either a group or individual setting**
- We are a community safety net, working closely with numerous agencies to ensure that all in ***need receive hope, healing, and recovery.***
- ***Quality is ensured*** through a collaborative approach between psychiatrists, psychologists, and therapists, many of whom have been working together for 20+ years.
- **Provide services in a client-focused**, compassionate manner that underscores our founding values of ***Integrity, Excellence, Hope, Action, Innovation and Dignity*****.**
- **helped thousands of individuals** in their journey to regain control over their lives and in the process, to positively impact the lives of their family, neighborhood, place of employment, and the larger society.

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Promises

- Make you ***feel at home*** as you learn how to heal and ***overcome your addictions, both physically and psychologically***. Our team strongly believes ***world-class treatment*** should be available regardless of one's ability to pay.
- ***Uniquely qualified to evaluate and support adolescents with a full range of substance use problems and disorders***, from teens who have just begun using substances to those struggling with addiction, and their families. We are the most cost effective.

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If you promise it, you need to deliver it!

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What is Great Service?

Unless we define it we may not consistently deliver it.

- Think about a great customer service experience you have had in the past week that was not related to SUD services.
- What made the experience great (better than usual)?
- How did you feel during the experience?
- What is your lasting impression of the provider?

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At your table share your experience:

- Quickly go around the table and discuss your stories
- Identify which story had the most elements that were done well.

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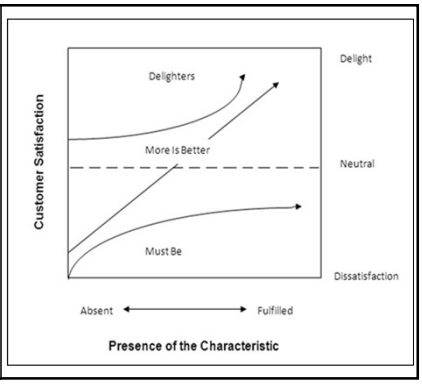
Kano's Model of Customer Satisfaction



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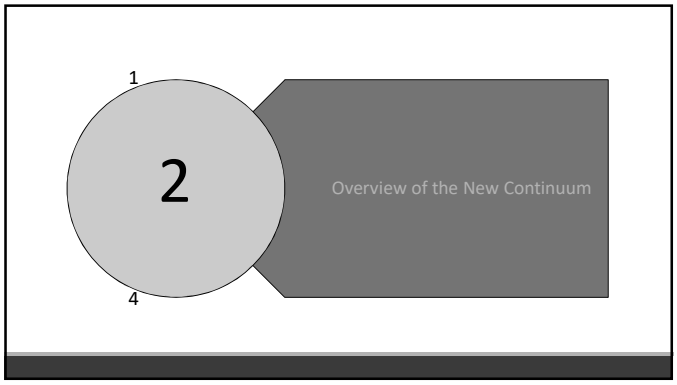

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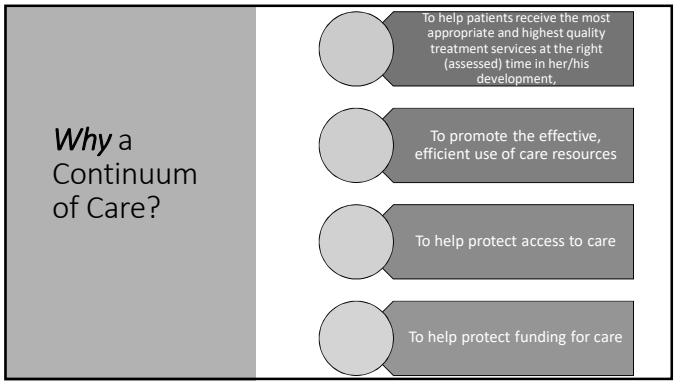

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Guiding Principles of the Continuum of Care

Promote the development and application of clinically driven criteria that preserves access to care and the resources (necessary) for all who suffer from addiction by:

- Move from program-driven to clinically, outcomes- driven care
- Move from fixed to variable lengths of stay
- Move from a limited number of discrete levels of care to a broad and flexible continuum of care
- Focus on Treatment Outcomes
- How does a continuum impact relapse?

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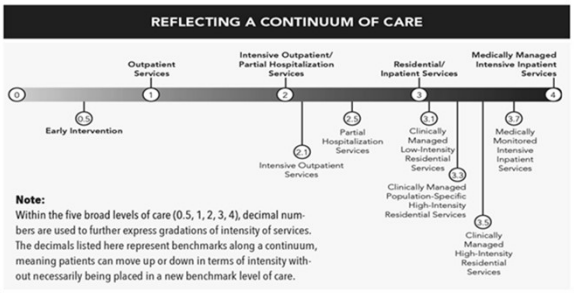
A Continuum of Services within Levels of Care



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Patient Retention in the Continuum of Care

- Goal is still retention in treatment, but 'treatment' is now inclusive of the Continuum
- Patient must commit to the Continuum, not just a 'program'
- Provider must have a developed, 'active' Continuum
- An 'active' Continuum requires:
  - Collaboration and Care Coordination
  - For both internal and external Components and Relationships
- Individualized care-another DMC goal- requires Care Coordination

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Building a Continuum

Historically, while it was good practice to discharge each client with a supportive plan, there was no quality requirement to do so

The quality goal now is to move patients on the Continuum based on re-assessment

Most providers do not operate all Levels of Care in the Continuum

So how do build relationships with organizations that have the Levels you need…

And do so in a way that insures smooth, efficient transfers

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Making the Shift from 'A Program' to Continuum of Care Requires Collaboration and Care Coordination

Collaboration

- Range of programs in the continuum?
- Full array of ancillary services?

Care Coordination

- Internally, do staff work together to move patients between levels?
- Do they understand and agree on the continuum? Has there been Care Coordination training?

Externally

- Does your organization have a 'collaborative culture?' Are you open to informal and formal agreements?

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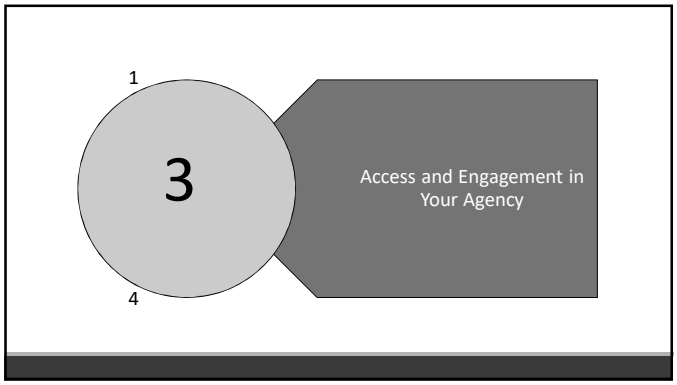

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Prior to admission (or at Admission)

- Avoid admissions when you know you will have low staffing levels and are unable to support quality patient initiation into services.
- Collaborate with referrals who have the authority to follow-up with clients/patients when they miss an appointment or treatment sessions.
  Assign referrer one contact person, preferably the patient's counselor
- Assign a case appropriate counselor (CLAS)
- Assign a peer buddy

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Help Patient Anticipate/Resolve Logistical Problems

With the patient identify potential problem areas, such as:

- Transportation
- Childcare
- Language Cultural considerations/influences
- Referral agencies needs and wants: CJ, CPS, Drug Court
- Employers, work schedules, leaves etc.

Schedule regular conversations to address solutions

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Individualized Care

- Counselor assignment on admission (first 24 hours)

Treatment Plan at admission or soon after

- Tx Plan tied to assessment, with goals
- Discuss MH and medical issues- include in Tx Plan
- With the patient, discuss a treatment team, a support team- get buy-in
- Reinforce with families, agencies, employers

Describe the Continuum; Engage the patient in the Continuum

Reinforce the Continuum of Care concept

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Clinical Alliance

- **Definition**- Relationship/bonding of patient to counselor
- When patient feels positive regarding counselor/therapist, they stay longer
- Relationship depends on counselor
  - Time with the patient (scheduling)
  - Counselor-Patient Ratio
  - Counselor training (clinical, particularly re SUD patients)
  - Counselor self-care (attitude)

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MI for Retention

- Use MI techniques to establish clinical relationship:
  - Asking open-ended questions;
  - Providing affirmations;
  - Reflective listening;
  - Ability to periodically provide summary statements to the client;
  - Non-judgmental, non-confrontational, non-adversarial;
  - Warmth, empathy, acceptance.

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Project Story

Putting this into action

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Retention Early Engagement

- Orient early- what will happen in treatment; expectations of ME
- Client participates in treatment planning- engagement IS retention
- Counselor assignment on admission
- Treatment Plan at admission or soon after
  - Tx Plan tied to assessment, with goals
  - Tailor treatment based on feedback from EACH patient about what groups and what topics she/he most interested in. Ask them to select the groups they want to attend. Patients stay when treatment relevant
  - Discuss MH and medical issues- include in Tx Plan
  - With the patient, discuss a treatment team, a support team
  - Reinforce with families, agencies, employers

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Is Your Organization's Culture Ready for Collaboration?

- Organizational culture is a lens through which an organization views itself. Who are we? What do we stand for?
- Do we have a shared value system, mission, vision, and purpose?
- Do our policies and procedures reflect/reinforce a shared vision. Are activities, services, physical, and emotional environment aligned with the vision?
- How are power, decision making, allocation of resources used to support the vision?

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Include Family from the Start

- Families want to help; they don't know what to do.
- Invite family members and friends to the client's first appointment.
- Educate the client's family and friends so that they know what to expect and how to provide support for the client in treatment.
- Offer support groups for the family and friends of clients in treatment.
- Keep family and friends informed about the client's progress in treatment.

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MR1

Offer a safe, private environment

All confidential discussions private at first touch

Separate intake/assessment rooms

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Melissa Rodriguez, 9/5/2019

Case Management

Help Patient Anticipate or Resolve Logistical Problems Regarding Staying in Treatment

With patient, identify potential problem areas
- Common problem areas:
  - Transportation
  - Childcare
  - Language, cultural issues
  - Referral agencies: CJ, CPS, Drug Court
  - Employers, work schedules, leaves, etc.
- Schedule regular conversations on solutions

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Identify and Reduce At-Risk to Leave

- **Bridge House** in New Orleans, Louisiana increased continuation rates from 48 percent to 63 percent by implementing weekly check-ins, asking clients to rate on a scale of 1-10:
- How willing are you to continue treatment here?
- How important is it for you to stay in treatment?
- How motivated are you to stay?
- How strong has your urge to use been this past week?

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MR1

What does your current process look like?

Flow charting activity – What would it take to have walk-in intakes and assessment?

- Step 1
  - At your tables (with your agency colleagues)
    - Call your agency to schedule an appointment
    - Tell the person who answers the phone who you are and let them know you are doing this for a workshop.
    - Use the case study to describe your condition and symptoms.
  - Flow chart your current intake process.
  - What are your problem areas and bottlenecks?

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MR1

What does your current process look like?

Flow charting activity – What would it take to have walk-in intakes and assessment?

- Step 2 *Identify the following:*
  - Place a check mark next to the process steps that are mandated by policy?
  - Circle problem areas and bottlenecks?
  - Using another marker circle process steps that are designed to make the patient feel welcomed and engaged in their treatment and recovery.
  - Draw a star next to any process step that spells out HOPE for the patient.

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MR1

What does your current process look like?

Flow charting activity – What would it take to have walk-in intakes and assessment?

- Step 3 *Discuss the following at your tables:*
  - Mandated policies? How do you execute to engage patients?
  - Brainstorm problem areas and bottlenecks?
  - Discuss the things you do that delight the customer. Create a list of all ideas.
  - Talk about how you ensure/illustrate HOPE. Write down all of these ideas on a sheet of paper.

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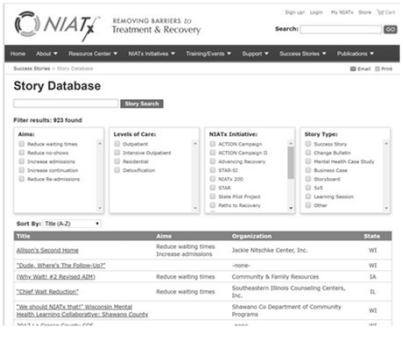
Using the NIATx Model to Make Improvements



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Change Leader Academy

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MR1

What is Care Coordination?

The deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services

Patients and their families are essential partners.

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MR1

What is Collaboration?

Collaboration is where two or more people or organizations work together to realize or achieve a goal or project successfully.

Collaboration is very similar to, but more closely aligned than, cooperation. Most collaboration requires leadership.

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Is your Organization's Culture Ready to Collaborate?

- Organizational culture is a lens through which the organization views itself.
- Do we have a shared value system, mission, vision and purpose?
- Do we use a common language that facilitates communication internally and externally?
- Do our policies and procedures reflect/reinforce a shared vision? Are activities, services, physical and emotional environment aligned with the vision?
- How are power, decision-making, allocation of resources used to support the vision?

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An 'Active' Continuum Usually Requires Partnerships- A 'Must' for Retention

- Don't Wait Until You Need a Modality
- Develop specific professional relationships
- Work out a referral process
  - Required forms, disclosures, authorizations, etc.
  - MOU or other agreement?
- Schedule status reports on patients
- One staff to manage the continuum and referrals? Case Manager?

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Active Continuum- Market Your Services

Meet 'face-to-face at 'their house'

Develop brief, informative materials to leave with them

Offer tours of 'your house', let them see you in action

Give them their own contact; a 'backdoor' phone number

Update open slots daily or weekly

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Strengthening the Continuum of Care through Care Coordination and Collaboration

Work Internally AND Externally to Reinforce the Continuum:

- Introduce next level staff while patient is in care
- Overlap LOC's, even informally
- Use successful peers to reinforce what worked for them
- Engage referring parties (criminal justice, etc.) to reinforce

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WARM HAND OFFS

Facilitate Client Transitions

- Obtain signatures on consents so clinicians can exchange information
- Establish phone contact with next LOC
- Involve case managers
- Alert next LOC of specific transfer
- Send client file
- Foreshadow what the person can expect will happen when they get to your site.
  - Directions, parking, who will they meet with first…..

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What is Care Coordination? How does it Aid Retention?

The deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the delivery of all required or indicated SUD Levels of Care and other health care services.

Care coordination aids retention through smooth, 'trouble-free' movement in the Continuum and to other supportive services.

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Why Care Coordination is important in Improving Retention

- Patient success in long term recovery
- There is an increase in outpatient and continuing care (potential for loss of patient control)
- 77% of Medicare funding is for the 40% of non-institutionalized beneficiaries with chronic conditions
- 78% of all healthcare spending is for people with chronic conditions

  50% of the patients with chronic conditions have multiple chronic conditions AND have 3 or more physicians AND get conflicting advice
- Outpatient + Chronicity = Retention Disaster

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Successful Care Coordination is Team

- Care Coordinators are leaders who assess (and re-assess) the patients needs
- Team consists of practitioners AND patient supporters (family, etc.) AND the patient
- Team members understand roles and limitations of other members
- Leaders educate team members regarding patient status
- While leaders coordinate, decision-making is shared

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Keys to Efficient, Effective Care Management

- Commitment!!!
- Mutual Respect of team members
- Frequent discussions
- Warm handoffs
- Manage the strengths, soft spots, biases of the team

Internal and External

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Activity

1. At your tables, assess your current capabilities.

2. Find a partner agency (that offers the level of care you frequently refer out to) and talk through what you have written.

   Ask them for tips on how to improve

   Have a discussion to find out more about what their needs are and how you could improve your care coordination and collaboration to provide a more successful referral.

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Report Outs

What did you learn about your organization?

What can you do to engage in a more successful referral?

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Questions?

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