



Recovery Management: Continuing Care Following Acute Treatment

Background

There are a number of ways of defining “continuing care.” In some of the research literature extended care and continuing care include step down to outpatient care following intensive outpatient services, step down within outpatient care from more frequent to less frequent visits for group or individual counseling, family/couples therapy, etc. For the purposes of this discussion about performance measurement, we are talking about extended monitoring after outpatient treatment.

In the past 5-10 years, a significant clinical research literature about addictions as a chronic illness has been published (McLellan *et al.*, 2000). Substance use disorders are notoriously difficult to treat in a number of ways. Patients who receive detoxification services often do not enter the treatment system (Mark *et al.*, 2003); patients who enter the treatment system often do not complete treatment; and, patients who complete acute treatment often relapse following discharge (Finney & Moos, 1992; Hubbard *et al.*, 1997; Lamb *et al.*, 1998). Sustained abstinence or reductions in use are very difficult for many patients to achieve.

The literature has also included comparisons of the characteristics of addictions with other chronic illnesses (McLellan *et al.*, 2000) including diagnosis, genetics, the role of personal responsibility and behavior, and pathophysiology as well as comparisons of treatment response between addictions and other chronic diseases. Treatment of chronic conditions is not considered effective without continuing care by a health care professional. Consumers have been made aware that they should expect their health plans to provide continuing care visits and other services for chronic conditions following episodes of acute illness. Regardless of whether we are talking about telephone calls, check-ups, or computer-based methods, the key issue is the need for health plans and treatment systems to be accountable for some form of continuing care following an acute episode and treatment completion.

The Institute of Medicine report “Improving the Quality of Health Care for Mental and Substance Use Conditions” recommended that the chronic care model (which includes self-management) used in the treatment of asthma, hypertension and other chronic conditions be implemented for mental and substance use disorders. With regard to continuing care, there is less research evidence for substance use disorders than there is for other chronic diseases such as asthma, diabetes, and hypertension. The notion of a “continuous healing relationship,” care that is customized according to the patients needs

and values, client-centered care, free flow of information across providers and between the clinician and the client, and decision making that is grounded in an evidence base has been less obviously embedded in addiction treatment than it is in healthcare.

Brief Review of Evidence Regarding the Case for Continuing Care:

Since about 1991, there have been a number of studies that provide evidence supporting the therapeutic use of continuing care in the treatment of addictions. The chronic nature of addiction has begun to be recognized and to be examined in the scientific literature. The chronicity of addictions has led to recognition of the need to extend contact between the client and the treatment system for longer periods of time than was true in the past. The models of “continuing care” that continue to be the most prevalent are self/mutual help groups and methadone maintenance programs. Some suggest that without continuing active involvement in these types of programs, people with addictions will not be able to maintain the positive outcomes of treatment.

Despite the potential benefits of continuing care, most individuals receive rather brief treatment either by design, because of limited insurance benefits, because they drop out of treatment, and mechanisms are not in place to continue to manage, monitor, or check-up on their status (Donovan, 1998; Hawkins & Catalano, 1985; McKay, 2001).

While the research that has been published on continuing care is not definitive it has shown that post-acute care telephone calls can be used to monitor patient status at the individual level; deliver extended counseling and carry out risk assessments; and be a major component in the continuum of care. The telephone seems to have a positive therapeutic role in monitoring and continuing treatment for other chronic illnesses such as depression, diabetes, smoking-cessation, congestive heart failure, and chronic pulmonary disease (Baer *et al.*, 1993; Baer *et al.*, 1995; Greist *et al.*, 1998; Jerant *et al.*, 2001; Osgood-Hynes *et al.*, 1998; Ries *et al.*, 2003; Roter *et al.*, 1998; Wasson *et al.*, 1992). In McKay’s study (McKay *et al.*, 2005) of the effects of telephone continuing care for alcohol and cocaine the conclusions drawn were that “for most substance-dependent patients who complete an initial stabilization phase of outpatient treatment, telephone-based monitoring and brief counseling appears to be as effective a form of step-down continuing care as more intensive face-to-face treatments.” (p. 205)

While a few studies have tested the appropriate content for calls as well as the preferred frequency of calls there is not enough evidence to make other than very indirect recommendations about how often these calls should be, how quickly they should taper, etc. The only recommendations that can be made are based on comparing studies that have had positive outcomes with those that did not.

Another model of continuing care following outpatient services, the “recovery management checkup” (RMC) has been studied by Christy Scott and Michael Dennis (Scott & Dennis, 2002). The RMC is a “routine” scheduled (every quarter for 8 quarters) face-to-face 45 minute interview and assessment following acute treatment focused on a

patient's substance use and living situation. If the patient is stable with no reports of substance use interviewers encourage the patient to continue and to come for the next scheduled checkup. If the patient reports slips a "linkage manager" works with the patient to return to treatment. Published reports of these studies (Godley *et al.*, 2004; Scott & Dennis, 2002; Scott *et al.*, 2005) indicate that patients who are beginning to relapse and are receiving "check ups" return to treatment more quickly and stay longer than those who do not receive the RMC interventions.

While the research on the effectiveness of continuing care can only be said to be suggestive with regard to the method of intervention (telephone, face-to-face brief interview), the spacing of interventions (weekly, monthly, quarterly), or the duration of continuing care what has been shown is that long-term recovery support matches the clinical course of addictive disorders. Very recent protocols have focused on adapting the level, intensity, and length of long-term continuing care interventions (whether on the phone or face-to-face) to the status of the individual following acute treatment based on the positive results of adaptive care with other chronic diseases (Collins *et al.*, 2004; Lavori *et al.*, 2000).

In addition to the published research about continuing care, several states have begun regional initiatives to pilot implementation of continuing care including the necessary administrative, regulatory, and financing arrangements (RI, VT, CT). Each of these states will implement continuing care in a different way but all will be using performance measures to track their implementation initiatives. One state (RI) has created a continuing care manual for its treatment providers and case managers. Each of these pilots is either in the early stages of implementation or planning so no research data is available.

Definition of Continuing Care in Performance Measurement:

Given what we know, how should we define continuing care? The research literature suggests the following definition: "Regular contact with a therapist (e.g., counselor, primary care clinician) that includes a risk assessment and allows flexibility for increasing and decreasing contact according to the patient's circumstances."

Studies by Samet, Friedmann, and Saitz (Samet *et al.*, 2001) as well as Weisner, Mertens, Parthasarathy, Moore, and Lu (Weisner *et al.*, 2001) provide some support for the following protocol until there are more definitive results from current clinical trials:

- Weekly contact in the first month following completion of acute treatment in any level of care;
- Monthly contact for the first year of recovery with adjustments as necessary (up or down according to the patient's symptoms and level of functioning);
- Extended contact for years, rather than months
- Availability of medications
- Availability of treatment options of varying types and intensities should the need arise

As McKay has pointed out (McKay, 2005) “although the field is lacking in good theories about factors that facilitate the maintenance of behavior change (Rothman, 2000), individuals are surely more likely to continue to participate in extended treatment protocols if they enjoy the therapeutic contacts, find the interventions not unduly burdensome, and feel that they have a say in the nature of the treatment they receive at any given point.” (p. 1606)

2. Purpose of Measure

The purpose of the measure is to increase accountability for assessing risk (how the client is doing, problems client is having, identified need to return to some form of treatment, etc.) intervention at the earliest possible time if the client has begun to relapse, and return to treatment as quickly as possible if needed.

3. Measures

A single measure has to be implemented at the organization level:

- Has extended continuing care been implemented (Yes/No)?

In order to manage performance, there needs to be a set of items at the client level that are measured weekly for the first month, bi-weekly for months 2 and 3, and monthly thereafter as follows:

- In contact (Yes/No)
- If in contact, frequency of contact
- If in contact, mode of contact (telephone, group, face-to-face, computer)

4. Setting

Both in the general health and specialty health care setting (how do we do this without double counting?); how do we track across systems?

5. Population

Adults should be the initial focus for recovery management measures, although these kinds of measure have been implemented for adolescents by Chestnut Health Systems (Scott & Dennis, 2002) using face-to-face interviews. There are multiple examples of systems that are implementing post-acute treatment recovery management services: Hazelton using the WEB; Chestnut doing face-to-face interviews; the Betty Ford using the telephone and “alumni” groups for people who want and need them; McKay using the telephone.

6. Data Sources

Right now there are only a few States that can track these measures and there are a few private sector programs that have now implemented telephone and computer-based follow-up after acute treatment completion. There are likely to be very many more in the future so we could start with patient survey and then move to administrative data as it becomes more available.

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