Intensive Residential Treatment (Level III.7, III.5)
Long Term Residential Treatment (Level III.3, III.1)
Intensive Outpatient Treatment (Level II.1)
Outpatient Treatment (Level I)
Early Intervention (Level .5)
Continuing Care

Variables in Levels of Care
- Amount of Medical Monitoring
- Intensity of Clinical Services
- Housing
Common Clinical Pathway

Intensive Treatment (Level III.7 or Level III.5) → Less Intensive Treatment (Level III.1, Level II.1 or Level I) → Continuing Care

Elements of Continuing Care

- Recovery checkup form
  - Relapse Risk Assessment
- Flexibility in frequency of contact between clinician and patient
- Face-to-face counseling sessions if needed
- Referral for support services if needed
- Renewal every three months

Frequency of Contact

- Months 1 – 3: Weekly phone calls
- Months 4 – 12: Every 2 weeks
- Months 13 – Indefinitely: Monthly
Flexibility
- Increase or decrease phone call frequency
- Schedule face-to-face sessions as needed
- Transfer the patient to higher level of care

Duration
- Three month increments
- Patient may participate in Continuing Care indefinitely

Why Continuing Care?
Support can prevent challenges from leading to relapses, and relapses from becoming life crises
Early identification of difficulties in recovery process → Intervention → Re-entry into treatment or support services → Better recovery outcomes

Who Benefits?

- **System**
  - Fewer re-admissions
  - Fewer admissions to intensive levels of care
  - More access for first admissions to treatment
- **Clinician**
  - Follow patient longer, see more success

Benefits to Patients

- Better quality of care: supports recovery and relapse prevention
- Encourages self-monitoring
- Helps patients identify and take advantage of protective factors
- Helps patients identify and strategize on managing their risk factors
- Once engaged, patients like it!
Eligibility

- Patient has successfully used a relapse prevention plan for at least a month
- Maintaining contact with program as scheduled

Based upon a patient's level of functioning or need, these additional criteria may apply:

- Patient is in an action or maintenance stage of change;
- Patient psychosocial needs (e.g., housing, legal, employment, etc.) are stable, being addressed, or not so great as to require intervention;
- Medical healthcare needs are stable or being addressed;
- Mental health needs are stable or being addressed, and/or
- Patient is being successfully dis-enrolled from an ASAM level of care.

Exercise One
Recovery Planning

- Strengths based
- Focused on goals and strategies for achieving them
- Problems are viewed as barriers/challenges that need to be addressed in the process of goal achievement

Admission into Continuing Care

- Orientation Session
  - Frequency of contact
  - Flexibility of services
  - Duration of agreement
  - Additional services available
  - Complete Continuing Care Agreement

Admission into Continuing Care

- Orientation Session
  - Review Recovery Plan
  - Complete Risk and Protective Factor Data screen
  - Review Recovery Check-up form
  - Complete Emergency Safety Contract
  - Complete consent form – collateral contacts
  - Schedule first phone session
Patient must be dis-enrolled from current level of care (i.e., Level 1 – outpatient) and enrolled in Continuing Care.

Review with the patient all open release of information and collateral contact information.

On the first page of the SMART encounter note record the type of service provided, session start/end times, and the funding source.

Exercise Two

Continuing Care Contacts

- Review Risk assessment items on Recovery Check-Up
- Provide feedback on risk level and suggest change in frequency of contact, type of contact, or level of care if warranted
- Review progress/goals from last call
- Identify upcoming high-risk situations
Continuing Care Contacts

- Select target for remainder of call
- Brief problem solving regarding target concern(s)
- Set goals for interval before next call
- Schedule next phone call

Exercise Three

Documentation

- Use Recovery Check-Up form in SMART and the first page of the Encounter Note.
- Document contact within 24 hours
- Use Encounter Note to document any significant contact beyond Recovery Check-Up
Renewal of Participation
- Renew in three month increments
- Review Recovery Plan
- Review Risk and Protective Factor Data
- Update information if necessary
- Document renewal of Continuing Care Agreement in an Encounter Note

Transfer-Higher Level of Care
- Identification of a high relapse risk will trigger a conversation with patient regarding need to move to higher level of care or access more support
- If patient consents, clinician will facilitate transfer to appropriate level of care
- Patient will be given priority for next available ADAA funded slot

Missed Appointments
- Attempt to reach patient at least three times within the first week
- Periodically contact patient to re-establish connection
- Must dis-enroll patient after 365 days with no contact
Disenrollment - Continuing Care

- The patient may choose not to participate in Continuing Care
- The patient may be transferred to another level of care
- The patient has no contact with the Continuing Care clinician for 365 days

Continuing Care Training Process

- CC Train the Trainer event
- CC Trainer trains programs in their jurisdiction
- Sands training rooster to Larry Stevens

Then...

- Larry notifies the regional SMART trainer that program is trained
- SMART Trainer adds Continuing Care to the program’s business practice, and notifies program
- Program can begin enrolling patients in Continuing Care
Questions/ suggestions/ compliments and complaints about Continuing Care should be directed to Larry Stevens – ADAA Continuing Care Training Manager.
Larry will be available to assist trainers with training if needed, provide technical assistance and inform ADAA of Continuing Care training status statewide.

Your Mission..should you Accept
- Establish a training plan for your jurisdiction
- Complete a training roster at each training and submit to Larry Stevens lstevens@dhmh.state.md.us
- Attend follow-up technical assistance forums with other State trainers to discuss progress, suggest changes, and share resources.
- Watch Continuing Care blossom and move us closer to a Recovery Oriented System of Care.

Glitches: Lessons Learned From Others…
- Staff Resistance: “I didn’t go to school to do telemarketing!”
- Patients not available during regular business hours.
- Confidentiality: Can’t leave messages.
- Stigma: Don’t want family to know about treatment, especially mental health treatment.
Questions?

- Comments, etc.