Recovery Coaches Building the Bridge for Care Transition: Keeping Patients Engaged in Outpatient Care

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Background

Deaths related to opioid overdoses continue to rise in New York State, increasing to 2,185 in 2015 (NYS DOH, 2017), and evidence has demonstrated that integration of Recovery Coaches into the care team facilitates more effective transitions between inpatient and outpatient care (Tracy 2011).

At Arms Acres, a New York State licensed provider of inpatient and outpatient substance use treatment services, only 47% of patients discharged from inpatient substance use treatment actually attended their first follow-up outpatient treatment visit. In many cases, this number was achieved due to staff driving patients to their first visit.

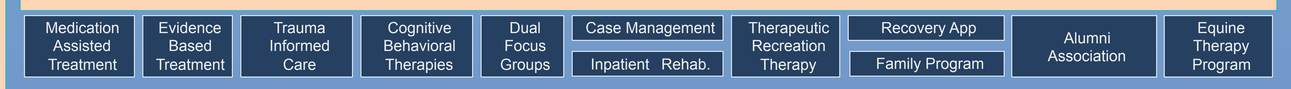
With a goal of improving transitions of care between inpatient and outpatient treatment, the Montefiore Hudson Valley Collaborative- one of 25 Performing Provider Systems (PPS) participating in the New York State Delivery System Redesign Incentive Payment (DSRIP) program- provided innovation funding for a novel pilot project that integrated Recovery Coaches into the care team at Arms Acres.

Project Aim

To improve 7 and 30-day follow-up HEDIS metrics (follow-up care after discharge to improve transitions of care between inpatient and outpatient substance use treatment) by adding a Recovery Coach to the multidisciplinary team and testing changes utilizing rapid cycle improvement methodology.

Setting

Arms Acres is a New York State licensed provider of inpatient and outpatient substance use disorder treatment. They provide comprehensive treatment services for patients residing in all 7 Hudson Valley counties utilizing a multidisciplinary team model incorporating physicians, psychiatrists, nurses, certified alcoholism and substances use counselors, social workers, family specialists, and activities specialists.



Intervention

In an effort to improve care transitions between inpatient and outpatient substance use disorder treatment providers, Arms Acres paired Recovery Coaches (Peers) with consenting patients who clinicians identified as having a high risk of recidivism. The Recovery Coach met with patients prior to discharge to collaboratively develop recovery goals and assist with linkages to harm reduction, local or online support groups, family support and education. Recovery Coaches were also available to accompany patients to their first outpatient appointment and self-help meetings. Over the first 9 months of this ongoing innovation pilot project, two Recovery Coaches worked with 106 recoverees to not only improve 1st outpatient appointment adherence, but also to increase patient engagement in care for the longer term.

The following data was collected: adherence to outpatient treatment (1st and 2nd outpatient visit adherence), long term patient engagement in care, routine discharge and readmission rates.

Results

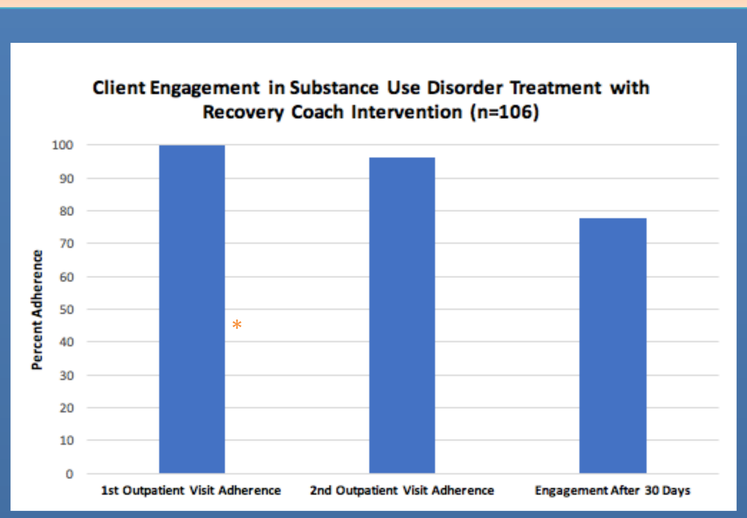


Figure 1: This graph demonstrates engagement in outpatient care for patients with Recovery Coaches. 30 day engagement was defined as attending group and individual SUD treatment at a NYS Oasis licensed outpatient provider post-discharge.
*Pre-intervention, patients only had a 47% adherence rate to 1st outpatient appointments (included all aftercare appointments: behavioral, medical, substance use).

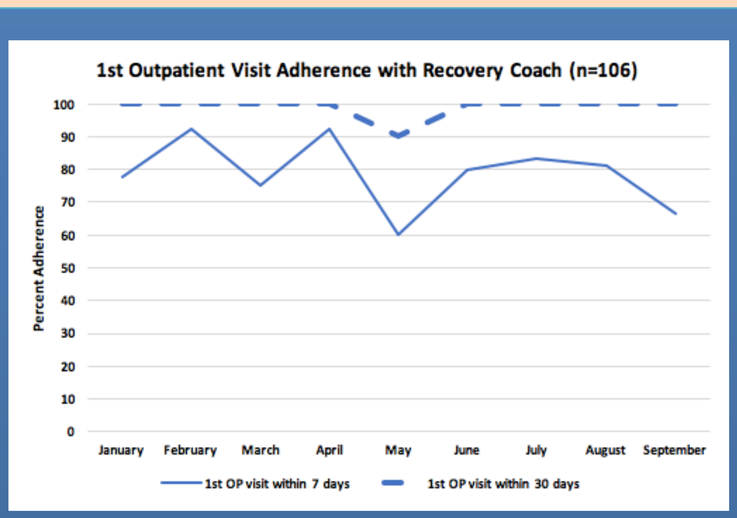


Figure 2: This graph demonstrates high visit adherence throughout the first 9 months of project implementation (n=106 recoverees engaged by two Recovery Coaches).

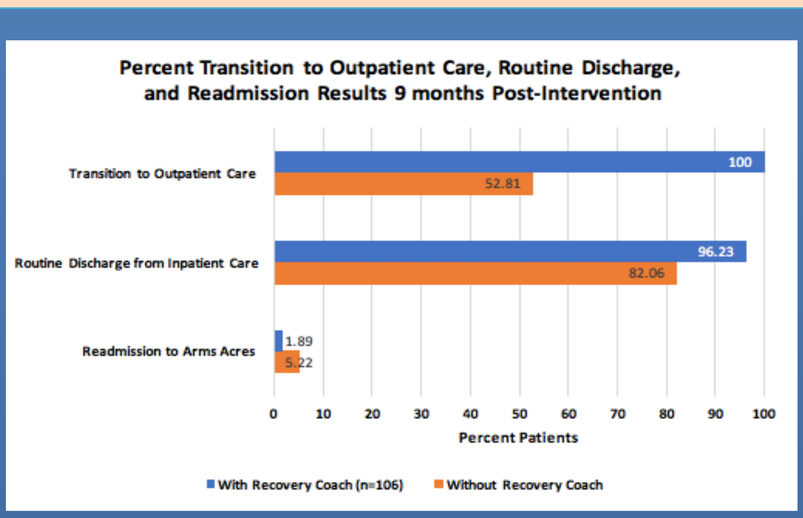


Figure 3: Recovery Coach intervention improved transition to outpatient care (1st outpatient appointment adherence)** by 89.4%, increased routine discharge from inpatient care by 17.3%, and reduced readmission within 90 days by 63.8%.
** Intervention Groups only looked at substance use follow up appointments while non-Recovery Coach group looked all aftercare appointments (behavioral, medical, substance use)

Conclusions and Discussion

Utilization of Recovery Coaches to support transitions of care for patients with addiction led to higher routine discharge rates, improved transitions to outpatient care, and decreased readmission rates. It is important to note a limitation of the data that may explain why the group without Recovery Coaches also demonstrated slight improvement in first visit follow-up rates. First, outpatient visits for the group without Recovery Coaches included medical, behavioral and substance use follow up appointments, whereas only substance use follow up appointments were captured in the measure for the group with Recovery coaches. In addition, providers selected patients at highest risk of recidivism for the intervention group (Recovery Coach), thereby removing the most non-adherent patients from the group without Recovery Coaches.

Overall, the Recovery Coach intervention improved patient engagement in care leading to positive outcomes for the patients themselves. It also has clear implications for the reduction of downstream healthcare costs. We estimate that the innovation program prevented approximately 63 ED visits and 315 inpatient days in the first year, with an ROI of over $225,000. Next steps include continuing to collect and analyze data on ROI, and considering the various settings in which the use of Peers could be spread.

References:
New York State Department of Health. Opioid-related Data in New York State (2017). Available at: https://www.health.ny.gov/statistics/opioid/.
Tracy K, Burton M, Nich C, et al.: Utilizing peer mentorship to engage high recidivism substance-abusing patients in treatment. **American Journal of Drug and Alcohol Abuse** 37:525–531, 2011.