



Paths to Recovery: Changing the Process of Care for Substance Abuse

An RWJF national program

SUMMARY

Paths to Recovery: Changing the Process of Care for Substance Abuse Programs was a national program of the Robert Wood Johnson Foundation (RWJF) designed to increase access to substance abuse treatment by improving the quality and efficiency of the delivery system at the provider level.

Participating agencies used process improvement strategies originally developed by private industry to increase the number of people who entered and remained in treatment. These strategies emphasized incremental changes that were tested, revised, retested and adopted in a series of rapid-cycle changes.

Paths to Recovery ran from July 2002 through December 2008 and was a partnership between RWJF and the Strengthening Treatment Access and Retention (STAR) program of the federal Center for Substance Abuse Treatment (CSAT). Some 39 nonprofit treatment agencies in two cohorts and six state-level funding agencies participated in *Paths to Recovery* and STAR.

The Network for the Improvement of Addiction Treatment (NIATx) served as the umbrella for *Paths to Recovery*, STAR and ultimately several other organizations and initiatives. NIATx created a learning community for participating agencies and guided them in using process improvement strategies to achieve four primary aims, i.e., to:

- Reduce wait time between the first request for help and the first treatment session
- Reduce no-shows
- Increase admissions
- Increase continuation rates by keeping people in treatment longer

NIATx also aimed to spread the culture of process improvement beyond the original group of agencies to treatment centers throughout the country.

Key Results

- The NIATx learning community proved to be an effective structure for teaching treatment agencies to apply process improvement techniques. NIATx staff provided participants with trained coaches, collaborative learning sessions, interest circle conference calls and online resources through the NIATx [Website](#).
- During the first 18 months of the program, participating agencies conducted 127 change projects that involved some 500 rapid-cycle change exercises.
- NIATx launched Strengthening Treatment Access and Retention—State Implementation ([STAR-SI](#)) in 2006. Under STAR-SI, RWJF and CSAT funded nine state-level agencies to use process improvement methods to improve their state's treatment policies and systems and increase access to and retention in outpatient treatment.
- NIATx secured a \$9.5 million grant from the National Institute on Drug Abuse (NIDA) in 2007 to support [NIATx 200](#)—a five-year study to identify the most cost-effective ways to implement quality improvement initiatives and organizational change based upon the NIATx model.
- By 2008, the NIATx learning community had evolved into a national resource center for spreading process improvement to behavioral health agencies nationwide. As of January 2010, over 2,100 organizations had become NIATx members.

Key Evaluation Findings

An evaluation of Paths to Recovery and STAR conducted by the Oregon Health and Science University found that:

- Wait time from first contact to first treatment session dropped from 19.6 days in October 2003 to 12.4 days in December 2004, a 37 percent decrease.
- Retention in care increased. In October 2003, about 72 percent of patients returned for a second outpatient treatment visit (outpatient treatment is a structured program of services for *fewer than* nine hours per week) or intensive outpatient treatment visit (intensive outpatient treatment is a structured program of services for *at least* nine hours per week) or a second week in residential care. By December 2004, nearly 85 percent of patients returned for a second visit.
- The NIATx model is replicable. A second cohort of *Paths to Recovery* grantees achieved similar improvements as the original group. Wait time in these agencies dropped from 30.7 days in January 2005 to 19.4 days in June 2006, a 38 percent reduction.
- The NIATx model is sustainable. Follow-up data showed that the original group of participating agencies sustained their gains for an additional 20 months.

Program Management

In 2002, the University of Wisconsin-Madison established the [Center for Health Enhancement Systems Studies](#) (CHESS). RWJF chose it as the national program office for Paths to Recovery and the STAR program. David Gustafson, Ph.D. was the program's director. In 2003, CHESS created NIATx as the umbrella for both programs.

Funding

The RWJF Board of Trustees authorized *Paths to Recovery* in October 2001 for up to \$9.5 million. RWJF's partner, the [Center for Substance Abuse Treatment](#) (CSAT), provided \$10.5 million to support the Strengthening Treatment Access and Retention (STAR) program.

CONTEXT

At the time *Paths to Recovery* began, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) reported that some 26 million Americans aged 12 or older needed substance abuse treatment. Yet only about 11 percent of them actually received it.

Patients' lack of readiness to enter treatment, limited funding and other factors beyond the control of treatment agencies all helped explain why so few people were getting the care they needed. Still, systemic and programmatic reasons under the control of the treatment agency played equally important roles.

Organizational Barriers to Care

A study published in *Addictive Behaviors* in 1999 (Stasiewicz PR and Stalker R. 24: 579–582) found that when treatment staff engages clients in treatment within 48 hours, clients are more likely to enroll. Yet, few agencies had systems in place that met this timetable. Patients requesting treatment encountered barriers such as difficult admission procedures, poorly designed telephone systems and an un-engaging reception staff. Instead of an appointment, they often received a request to "call back later," according to a 2007 article in the *Joint Commission Journal on Quality and Patient Safety* (33(2): 95–103, 2007).

Many people who enter treatment do not remain, and factors that create barriers to entry are also barriers to retention. Continuation in treatment has been linked to friendly and supportive environments and is thwarted by inflexible and burdensome administrative requirements. Just over 51 percent of people who entered treatment completed it, according to the *2002 National Survey on Drug Use and Health*.

Improvements to administrative processes were needed to make it easier for people to enter and remain in treatment. Improvements could also reduce frustration experienced by administrators and clinicians who were trying to deliver services.

The Use of Process Improvement in Health Care

In 2001, the Institute of Medicine released *Crossing the Quality Chasm*, a major report calling for a redesign of the U.S. health care system through the application of process improvement strategies previously used by the manufacturing sector.

Process improvement dates back to the 1930s. Working in the manufacturing sector, Walter Shewhart, W. Edwards Deming, Joseph Juran and others helped evolve and apply the concept of continuously improving product and process quality by reducing variation and error and meeting customer needs. Shewhart and Deming defined the Plan-Do-Study-Act (PDSA) cycle, a problem-solving technique now widely used by businesses in making process improvements.

Innovators in the health sector were interested in process improvement even before the Institute of Medicine released its report. In a 1998 article in the *Annals of Internal Medicine*, Donald Berwick, M.D., president of the Institute for Healthcare Improvement, noted, "Improving the daily practice of medicine requires making changes in processes of care. In many circumstances, the most powerful way to make such changes is to conduct small, local tests (PDSA cycles) in which one learns from taking action."

Process Improvement in Substance Abuse Treatment

The nation's 14,000 residential and outpatient substance abuse treatment providers stood to benefit from using process improvement strategies, but few were participating in these efforts in the early 2000s. Improving quality has always been a daunting challenge for these agencies, many of which struggle with weak organizational structures, unstable staffing patterns, limited financial resources and little capacity to collect and organize data.

Most efforts to improve treatment services had focused on quality assurance procedures such as inspecting case records and improving counselor skills. Less attention was paid to comprehensive systemwide redesign efforts.

An exception was the work done from 1999 to 2001 at CAB Health and Recovery Services (CAB), a substance abuse treatment agency serving northeastern Massachusetts and greater Boston. CAB president and chief executive officer Victor Capoccia Ph.D. (later the RWJF program officer for Paths to Recovery), led the agency in piloting the Darwin Project, a quality improvement initiative aimed at improving CAB's operations in six business areas.

RWJF Strategy

In 2002, RWJF provided CAB with a grant of \$82,000 to help replicate the Darwin model. See [Program Results Report](#) for details on this project. However, RWJF staff realized that it would take a larger initiative to spread process improvement methods to the nation's 14,000 treatment providers.

RWJF's initial focus in the area of substance abuse (1990–2000) was on preventing addiction, principally through initiatives to combat underage drinking and drug use, with a focus on alcohol abuse. In 2001, following a presentation on the growing scientific knowledge of the neurobiology of addiction, the Board of Trustees decided to shift the grantmaking emphasis from preventing addiction to improving the quality of addiction treatment.

Following that decision, RWJF hired Capoccia and devised a comprehensive strategy to improve the quality of publicly oriented addiction treatment in the United States. Primary components of the strategy were:

- Introducing and sustaining small- and large-scale changes in the treatment delivery and financing system
- Defining and measuring quality
- Developing appropriate treatment policies
- Defining consumer focused care

Paths to Recovery was the first initiative funded under this strategy. By testing quality improvement strategies on a small scale in treatment agencies while spreading a culture of performance improvement throughout the field, it contributed to RWJF's larger strategy of improving treatment. It is the subject of this report.

Other national programs that were funded as part of this strategy were:

- *Resources for Recovery: State Practices that Expand Treatment Opportunities.* This \$3 million program focused on treatment financing and on state agencies that set policies and purchased treatment services. The program began in July 2002 and ran until 2006.

Five states received grants and 10 received technical assistance to analyze their state's treatment financing, administration and delivery and to identify strategies for using existing resources to purchase more and better services. See [Program Results Report](#) for more detail on the program.

- *Advancing Recovery: State and Provider Partnerships for Quality Addiction Care.* This \$11 million program focuses on large-scale change by funding partnerships between providers and the state agencies that fund them. Payer-provider partnerships

in 12 states received grants to implement systemwide changes promoting the use of evidence-based practices such as medication-assisted treatment, continuing care and wraparound services.

Advancing Recovery is a partnership between NIATx (the Paths to Recovery national program office) and the Treatment Research Institute (TRI), a nonprofit research and development group in Philadelphia. RWJF launched *Advancing Recovery* in January 2006. The program runs through June 2010.

RWJF also provided the Washington-based National Quality Forum with two grants to identify evidence-based standards for the treatment of substance use conditions.

Under the first grant in December 2004, the National Quality Forum identified seven core evidence practices; see [Program Results Report](#) for more information. Under the second grant, the forum used its consensus development process to identify 11 evidence-based treatment practices that should receive priority for widespread implementation. See [Program Results Report](#) for details.

THE PROGRAM

The Key Ideas Forming the Program

Paths to Recovery evolved from the hypothesis that the process improvement techniques used to achieve improvements in private industry and other segments of the health care sector could be applied to addiction treatment.

David Gustafson, Ph.D., professor of industrial engineering and preventive medicine at the Center for Health Systems Research and Analysis at the University of Wisconsin-Madison, was an early proponent of these ideas.

In a 1995 [article](#) in *Health Care Management Review*, Gustafson outlined key ideas that laid the foundation for *Paths to Recovery*. Gustafson reviewed research on organizational change in 13 industries, wherein 80 factors were identified that might explain why some organizations were able to improve while others floundered. He noted five factors he thought were especially good predictors of organizational change. These became the basis for the five NIATx principles.

The NIATx Model

Gustafson founded the Network for the Improvement of Addiction Treatment (NIATx) in 2003 to guide substance abuse and behavioral health organizations in applying process improvement strategies in their programs.

NIATx Principles. The NIATx design is based on principles, aims and roles for participants:

- *Understand and involve the customer.* Asking customers what they think needs to be improved had more predictive power in separating successful from unsuccessful organizations than all other factors combined.
- *Fix the key problems.* Solve the problems that keep the executive awake at night. This secures executive support and establishes a business case for testing strategies.
- *Pick a powerful change leader.* The person who leads change should have a position of authority, a close working relationship with the chief executive, respect from colleagues and sufficient time to devote to the initiative.
- *Get ideas from outside the organization or field.* Others can offer fresh perspectives on problems, challenges and solutions.
- *Use rapid-cycle testing to establish effective changes:* Testing changes on a small scale dispels the myth that change is hard. NIATx uses the Plan-Do-Study-Act cycle:
 - *Plan the change:* pick the goal, predict outcomes and identify steps to get there.
 - *Do the plan:* test the change for a short time and examine problems and results.
 - *Study the results:* compare the predicted outcomes with the actual results.
 - *Act on knowledge:* adopt, adapt or abandon the change and set the next cycle.

NIATx Aims. The NIATx aims were based on the program design submitted by Victor Capoccia, RWJF senior program officer, to the RWJF Board of Trustees and later evaluated by Dennis McCarty, Ph.D., of Oregon Health and Sciences University. These performance measures became the NIATx aims:

- To reduce wait time between the first request for help and the first treatment session
- To reduce no-shows
- To increase admissions
- To increase continuation rates by keeping people in treatment longer

NIATx Roles for Agency Staff. The NIATx model specifies three key roles for staff of treatment agencies seeking to implement rapid-cycle changes:

- The "executive sponsor," usually the chief executive officer of an organization, authorizes time and resources for the project.
- The "change leader" is an employee selected by the executive sponsor who has the ability and leverage to lead the project within the organization.

- The "change team," comprised of agency staff and, in some cases, consumers, carries out the projects.

The [NIATx Workbook](#) provides details about the NIATx principles, aims, key roles and guidelines for implementing change projects.

Implementing *Paths to Recovery*

From July 2002 through December 2008, NIATx implemented *Paths to Recovery* to teach substance abuse organizations how to apply process improvement strategies in their programs. *Paths to Recovery* had two overarching goals, which were to:

- Test the application of process improvement principles in addiction identified treatment agencies that participated in a learning community
- Generate a deeper understanding and spread of process improvement throughout the addiction treatment field

Paths to Recovery included four components:

- *A communications campaign* to inform the substance abuse treatment field about process improvement
- *Grants and technical assistance* to selected treatment providers to help them learn process improvement techniques and apply them in their programs
- *A website and educational opportunities* to provide process improvement resources to others in the alcohol and drug treatment fields
- *An evaluation* to gain a better understanding of how to apply process improvement techniques

A Public-Private Partnership: RWJF and CSAT

Paths to Recovery was a partnership between RWJF and the federal Center for Substance Abuse Treatment (CSAT). In February 2003, CSAT authorized \$10.5 million for Strengthening Treatment Access and Retention (STAR) as a companion program to *Paths to Recovery*.

Mady Chalk, Ph.D., director of CSAT's Division of Services Improvement, and Frances Cotter, M.P.H., a team leader in the division, were champions of the partnership. They saw it as a way to sustain CSAT's [Practice Improvement Collaboratives](#) program, which began in 1999 and was ending when *Paths to Recovery* was in the planning stages. Under the Practice Improvement Collaboratives, 14 state and metropolitan groups introduced evidence-based practices to improve the quality of addiction treatment.

STAR required agencies to use process improvement strategies, but it focused on helping them introduce evidence-based practices into their agencies. STAR also incorporated the principles of partnership established by the earlier Practice Improvement Collaboratives program.

National Program Office

The University of Wisconsin-Madison established the [Center for Health Enhancement Systems Studies](#) (CHESS). RWJF chose it as the national program office for *Paths to Recovery* and the STAR program.

In 2003, the center created NIATx as the umbrella for *Paths to Recovery* and STAR and ultimately, for several other organizations. NIATx became the "brand" under which several organizations and strategies operated.

David Gustafson, Ph.D., was the national program director. Todd Molfenter, Ph.D., and Betta Owens, M.S., were the original co-deputy directors. Kim Johnson became co-deputy director in July 2008, replacing Ms. Owens who continued her involvement as a NIATx coach.

National Advisory Committee

In 2002, national program office staff recruited and trained 10 experts from industry, academia, government and addiction treatment to form a national advisory committee to NIATx. The committee refined the criteria for selecting projects, reviewed proposals and provided ongoing program oversight. A three-person advisory committee provided guidance in the later phases of the project. (See [Appendix 1](#) for a list of members of both committees.)

Application and Selection Process

RWJF released calls for proposals for two rounds of *Paths to Recovery* funding: Round I in 2002 and Round II in 2004. In Round I, national program office staff convened two workshops for applicants, one in Chicago and one in Portland, Ore., in January 2003. Each workshop attracted about 250 attendees from 40 states.

In order to be considered for funding under the program, applicant organizations had to:

- Have at least 100 admissions per year
- Be financially healthy, nonprofit or government-controlled and rely mostly on public funding sources such as Medicare or Medicaid
- Control a continuum of care, either within the corporation or through networking arrangements

The solicitation required applicants to conduct and report on a "walk-through" of their agency's admission process. In walk-throughs, senior staff members apply for services and ask for help as if they are clients. Walk-throughs allow them to uncover false assumptions, inconsistencies and limitations of their systems. They also generate practical ideas for improvements.

National program office and RWJF program staff reviewed these preliminary proposals about what applicants had learned in the walk-throughs and invited a subgroup of applicants to complete a full proposal. In this stage, applicants had to make one change in a two-week period based on the walk-through conducted for the preliminary proposal.

- Some 328 agencies submitted preliminary proposals in Round I. Of these, 45 were invited to submit full proposals and 44 did. Staff visited 16 applicants and in September 2003 recommended 10 for full funding.
- Some 185 agencies submitted preliminary proposals in Round II. Of these, 44 were invited to submit full proposals and 43 did. Staff visited 17 applicants and in January 2005 recommended 13 for full funding.

Agencies received between about \$110,000 to \$220,000 for 18 months. Funds could not be used to hire new staff or pay for client services, but could be used to cover the cost of change leader time, travel expenses, consultants and modest operating expenses.

Self-Funded and Partially Funded Sites. NIATx staff and the national advisory committee invited agencies that submitted strong proposals but were not selected to join *Paths to Recovery* at their own expense or with partial funding. This allowed more agencies to participate and allowed NIATx staff to learn whether agencies with only limited support could perform at a level equal to their fully funded peers.

Four Round I applicants joined the program at their own expense. Three of these (Fayette Companies, Cornerstone Counseling and Central New York Services) became fully funded Round II grantees. The fourth program, CAB, did not participate in Round II.

Two Round II applicants participated in the program with limited funding of \$30,000 from the national program office to reimburse costs for travel and process improvement coaches only. (See [Round II site list](#) below.)

PROGRAM SITES & STAR SITES

Paths to Recovery and STAR included 39 substance abuse treatment agencies and six state-level funding agencies:

- *Paths to Recovery* included 26 agencies, some fully and some partially funded.
- CSAT's STAR program included 13 nonprofit treatment agencies.

- A state-agency pilot project included six state-level funding agencies.

Paths to Recovery Round I Sites

The following sites received Round I *Paths to Recovery* grants or were partially funded (as noted) in September 2003.

- *Acadia Hospital*, a freestanding mental health and addiction treatment facility in Bangor, Maine
- *Axis I Center of Barnwell*, a treatment program for adults and teens in Barnwell, S.C.
- *Brandywine Counseling*, an outpatient treatment program, based in Wilmington, Del., offering counseling services in seven sites throughout the state
- *Daybreak*, an inpatient and outpatient addiction treatment program for adolescents in Spokane, Wash., and the Pacific Northwest
- *Gosnold on Cape Cod*, an addiction recovery and outpatient mental health service provider in Falmouth, Mass., with eight locations across the southeastern part of the state
- *Jackie Nitschke Center*, a drug and alcohol treatment provider in Green Bay, Wis., offering a continuum of services through a 14-bed residential program, two intensive outpatient programs, three aftercare groups and an alumni group
- *Kentucky River Community Care*, a community mental health center and substance abuse service provider for residents of Jackson, Ky., and the surrounding rural eight-county Appalachian Region
- *Perinatal Treatment Services*, a residential and outpatient substance abuse treatment program for pregnant and parenting women and adolescent females in Seattle
- *Prairie Ridge Addiction Treatment Services*, a substance abuse prevention and treatment program, in Mason City, Iowa, serving an eight-county region in North Central Iowa and also provides residential care statewide
- *St. Christopher's Inn*, a temporary shelter and chemical dependency treatment program in Garrison, N.Y.

Paths to Recovery Round II Sites

The following 15 sites received *Paths to Recovery* grants in January 2005; of the sites, two were partially funded, as noted.

- *Asian Counseling and Referral Service*, a community-based agency providing a range of services to Asian Pacific Americans in the Seattle area

- *Central New York Services*, a behavioral health service provider, offering outpatient and residential programs to residents of Syracuse, N.Y., and the surrounding four-county area
- *Comprehensive Options for Drug Abusers (CODA)*, a substance abuse treatment program in Portland, Ore., operating the state's oldest and only nonprofit methadone service
- *Connecticut Renaissance* (partially funded), a mental health and substance abuse treatment agency headquartered in Bridgeport providing outpatient, residential and halfway house services throughout Connecticut
- *Cornerstone Counseling Center*, an agency providing individual and family mental health, substance abuse and domestic violence treatment and prevention services to residents of Salt Lake City
- *Fayette Companies*, a management and consultation corporation, located in Peoria, Ill. It operates three substance abuse and mental health service agencies and specializes in the treatment of pregnant and postpartum women.
- *Gateway to Prevention and Recovery*, an outpatient substance abuse treatment and prevention program for residents of Shawnee, Okla., and the surrounding four-county area
- *Hill Health Center/South Central Rehabilitation Center* (partially funded), a medically monitored freestanding detoxification program in New Haven, Conn.
- *Mid-Eastern Council on Chemical Abuse (MECCA)*, an agency offering substance abuse prevention, early intervention, evaluation, detoxification, treatment and aftercare to residents of Iowa City and the surrounding six-county area
- *Palladia*, a multi-service agency, founded in 1970, providing inpatient and outpatient substance abuse services to residents of New York City through 24 service programs
- *Signal Behavioral Health Network*, a Denver-based corporation managing public funds for a network of 17 substance abuse treatment providers in 35 Colorado counties. RWJF funds supported process improvement projects in one of Signal's subcontracting treatment agencies, Island Grove Regional Treatment Center.
- *Southwest Florida Addiction Services*, a comprehensive agency providing substance abuse prevention, assessment, day and residential treatment services in Fort Myers, Fla.
- *Stanley Street Treatment and Resources (SSTAR)*, a multi-service agency in Fall River, Mass., providing residents of southeastern Massachusetts with substance abuse and behavioral health services, as well as HIV/AIDS and primary care programs
- *STEPS at Liberty Center*, an agency providing inpatient and outpatient substance abuse treatment services, including jail-based treatment, in Wooster, Ohio

- *Women's Recovery Association*, a residential and outpatient program in Burlingame, Calif., serving women and adolescent girls affected by substance abuse in six Northern California counties

See [Appendix 2](#) for grant details on fully funded sites.

Strengthening Treatment Access and Retention (STAR) Sites

In September 2003, CSAT awarded three-year STAR grants for approximately \$300,000 each to 13 treatment programs:

- *Boston Public Health Commission*, the City of Boston's public health agency
- *Bridge House Corporation*, a residential treatment program in New Orleans
- Center for Drug-Free Living, a comprehensive treatment and prevention program in Orlando, Fla.
- *Mid-Columbia Center for Living*, a behavioral health company providing mental health and addiction treatment services in Dalles, Ore., and surrounding rural counties
- *NRI Community Services*, an agency providing home and community-based behavioral health and social services in Woonsocket, R.I.
- *The Patrician Movement*, a residential and outpatient substance abuse treatment program for residents of San Antonio with special services for pregnant and postpartum women and infants.
- *PORT Human Services*, a Greenville, N.C., agency offering outpatient and residential substance abuse services as well as psychiatry and case management to residents of Greenville
- *PROTOTYPES*, a substance abuse treatment organization with locations throughout Southern California. The largest PROTOTYPES program is the Women's Center in Pomona, Calif.
- *Sinnissippi Centers*, a community-based behavioral health care center in Dixon, Ill.
- *TERROS*, a large metropolitan agency, based in Phoenix, offering substance abuse and mental health services to some 22,000 clients a year at 13 locations
- *Vanguard Services Unlimited*, a substance abuse treatment agency, located in Arlington, Va., serving residents of the Washington metropolitan area including Maryland and Virginia
- *VIP Community Services*, a community-based organization located in the Bronx, N.Y., offering residential and outpatient treatment for individuals with histories of chemical dependency

- *Women's Alliance for Strengthening Treatment Access and Retention (WASTAR)*, a partnership between the Center for the Application of Substance Abuse Technologies at the University of Nevada, and STEP 2, a community-based women's treatment organization in Reno, Nev.

State Agency Sites: The State Pilot Project

State governments are the largest purchasers of addiction treatment services and their policies either facilitate or inhibit the ability of provider agencies to improve programs. Therefore, in 2004, CSAT and RWJF created a pilot project to help state substance abuse funding agencies:

- Develop an infrastructure to support process improvement initiatives
- Test process improvement techniques on a small scale
- Develop a plan for improving access to and retention in treatment across the state

RWJF and CSAT invited six state-level funding agencies to join NIATx. These agencies joined in November 2004:

- RWJF funded the Oklahoma Department of Mental Health and Substance Abuse Services to participate: (ID# 052431).
- CSAT funded four state agencies and one behavioral health network to participate:
 - Delaware Division of Substance Abuse and Mental Health
 - Iowa Department of Public Health, Division of Behavioral Health and Professional Licensure
 - North Carolina Department of Health and Human Services, Division of Mental health, Developmental Disabilities and Substance Abuse Services. The department worked with CSAT's North Carolina STAR site, PORT Human Services.
 - Signal Behavioral Health Network, a nonprofit managed care entity contracting with the state of Colorado to deliver substance abuse services in three regions. Signal worked with the RWJF-funded Island Grove Regional Treatment Center.
 - Texas Department of State Health Services, Community and Substance Abuse Services, Compliance and Consumer Rights and Services. The department worked closely with CSAT's Texas STAR site, the Patrician Movement.

Creating a Learning Community for Participating Agencies

NIATx created a learning community for participating providers and state funding agencies. Through the learning community, participants received assistance in understanding process improvement strategies, applying them in their agencies and

disseminating lessons in their agencies and communities. Examples of assistance included:

- **Assigning an experienced coach to each participating agency.** Coaches visited each site quarterly, held weekly telephone conference calls and provided ad hoc assistance via e-mail communications. Coaches played key roles in helping agency staff members address challenges in conducting rapid-cycle changes.
 - One such challenge involved collecting baseline data against which to measure changes. See the [description](#) of how several NIATx coaches advised grantees in this important area.
- *Convening "learning sessions."* These multi-day meetings allowed change teams to learn from one another and from outside experts. NIATx sponsored six all-site learning sessions between 2003 and 2006.
- *Chairing "interest circle" telephone calls.* In these calls, agency staff talked with experts from other fields that used process improvement techniques and brainstormed about challenges they faced in their own attempts to use these techniques.
- **Providing online resources via the NIATx website.** A section includes tools, publications and training programs for users.

Building the Field with the NIATx Resource Center

Building on its work directing *Paths to Recovery*, the center established a national NIATx resource center as a source for technical support to the treatment field as a whole. See [Overall Program Results](#) for more information about the resource center.

CHALLENGES FOR THE SITES

National program office staff reported several challenges it and the sites faced in implementing *Paths to Recovery*:

Lack of technical expertise and infrastructure to collect data. Addiction treatment agencies typically do not view data collection, management and analysis as priorities. Many *Paths to Recovery* and STAR agencies, particularly those in rural areas and those with small budgets, struggled to meet the data collection requirements of the program.

Acadia Hospital's change team leader Scott Farnum observed "Our organization, and perhaps the entire NIATx collaborative, underestimated the amount of staff hours needed to collect data associated with the project."

Daybreak's chief executive Tim Smith noted, "This [integrity and availability of data] is an enormous problem and challenge. While we have made many gains, our weaknesses in this area create ongoing problems for us (...) We still have a long way to go."

For examples of how NIATx coaches helped grantees overcome this challenge, read the [sidebar on collecting data](#).

Taking on too many changes at once. *Paths to Recovery* and STAR agencies were strongly encouraged to address all four NIATx aims, but they were equally advised to do so one aim at a time. When walk-throughs uncovered multiple problems, however, staff wanted to tackle all of the problems at once.

For a description of how grantees met the challenge of selecting and narrowing their focus on a single aim, read [the sidebar on solving one problem at a time](#).

Maintaining momentum for change as the number of changes increased. Acadia Hospital's Farnum noted "the time and energy required to sustain changes, coupled with starting new changes, was significant. Internally, our organization responded by increasing the number of staff members who learned the NIATx treatment model."

Maintaining momentum for change when executive directors turned over. As executive directors of *Paths to Recovery* and STAR agencies retired or accepted new positions, some programs found it hard to sustain changes that had been made or undertake new change projects. New executive directors were not always familiar with process improvement strategies or did not view this work as a priority.

NIATx coaches worked with new executive directors to help them understand the rapid-cycle change model and their role in guiding the agency through change projects. NIATx also included executive leadership discussions at the all-site learning sessions. Read [the sidebar on the ways agencies and coaches faced these leadership challenges](#).

Choosing the right change leader. Agencies often looked to the least busy person to lead the change process rather than selecting someone who had authority and the "ear" of the chief executive.

As this challenge became apparent, national program office staff ensured that *Paths to Recovery* and STAR coaches supported and monitored change leaders as part of ongoing technical assistance. For a discussion of how participating agencies faced this challenge, read [the sidebar on choosing the right change leader](#).

Difficulty predicting which sites would succeed. Despite scoring well in a rigorous selection process, some sites that appeared promising were not able to implement their projects as planned. Others that scored less well elected to join the program at their own expense and performed well in implementation.

National program office staff developed a greater awareness of the attributes of a strong site, such as the ability to collect and analyze data, and incorporated some of these factors in the Round II call for proposals.

An ingrained culture of learned helplessness. Struggling with limited resources and frequent budget cuts, many agencies saw themselves as overburdened and "too busy to change."

National program office staff found it futile to argue against this self-perception. Instead, they worked with agencies to use new strategies such as walk-throughs and the rapid-cycle change to demonstrate the feasibility of making improvements.

Agency directors worked to overcome this problem within their agencies. Some transferred employees who had key positions but could not accommodate the changes. In some cases, employees left the agency because they were not comfortable with the new way of working.

Janet Soo Hoo, executive director of Asian Counseling and Referral Service noted, "A major reason for staff reluctance came from the perception that the change exercises created more work for them. By piloting the change exercises with just two staff before implementation with everyone and by sharing successes and positive experiences, we were able to address fears without resorting to management requiring the change."

Discrepancies between management and clinician priorities. The bottom-line financial problems that keep an executive awake at night may not be the same concerns that clinicians and front-line workers experience.

Paths to Recovery coaches helped agency leaders communicate the connection between the agency's financial situation and its ability to help both staff and clients. National program office staff also created the [NIATx Business Case Series \(Volume I\)](#) and other tools to help participants understand the importance of establishing a strong business case for change.

Daybreak's director, Tim Smith, explained his challenge: "In the end, most of the energy for initiating and sustaining this project and its principles is coming from senior managers. Line staff participates with good energy when asked or invited, but they are not yet generating ideas and process improvements. We will continue working on this."

Suspicion of ideas from outside the field. Some agencies believed that addiction treatment was unique and there was nothing to learn from organizations in other fields.

National program office staff used "interest circle calls" that focused on bringing in experts from other fields, such as the restaurant business, to talk with agency staff.

Slow-moving state government bureaucracies. In Oklahoma, treatment agency staff found that their cumbersome state bureaucracy conflicted with the rapid-cycle change model essential to the NIATx approach.

A group of leaders within the state substance abuse and mental health services agency supported the NIATx project and pushed for changes within the agency. This improved staff morale and made it easier for staff to use the rapid-cycle change model.

OVERALL PROGRAM RESULTS

The national program office reported the following overall results of the program in several reports to RWJF:

Treatment Improvement

- **From 2003 to 2006, 39 treatment agencies used performance improvement strategies to improve patient access to and retention in treatment.**
 - Sites varied in agency size, rural/urban setting and complexity. Most served clients through multiple levels of care and partnerships with other treatment and community agencies.
 - Although performance varied, all 39 agencies demonstrated the ability to use the rapid-cycle change method to reduce wait time, reduce no-shows, increase admissions and increase continuation in treatment.

NIATx staff noted that the 10 Round I treatment agencies conducted 127 change projects with more than 500 change cycles during their 18-month grant period.

- For a list of promising practices as of October 2006, see [Appendix 3](#). New practices are posted on the [NIATx website](#) as they are documented.
- The [Best Practice Case Studies](#) section of the NIATx website describes how *Paths to Recovery* and STAR grantees implemented the NIATx model in their agencies.
- Improving financial status is not one of the four NIATx aims, but grantees demonstrated how an organizational commitment to improving treatment access and retention also helps solve financial problems.

The [NIATx Business Case Series \(Volume I\)](#) contains examples of how improvements in treatment access and retention translated into bottom-line results for *Paths to Recovery* and STAR grantees.

- Three agencies that participated in the learning community on a partially or self-funded basis achieved results equaling those of fully funded agencies.

Technical Assistance

- **The NIATx learning community proved to be an effective structure for teaching addiction treatment agencies how to apply process improvement techniques.** The

learning community components evolved and expanded over the course of the program:

- **Coach the Coaches.** National program office staff recruited and trained eight coaches starting in August 2003. By the end of 2008, staff had trained 62 coaches based throughout the country. These coaches assisted organizations in implementing process improvement practices.

Many coaches are executive directors and change leaders of *Paths to Recovery* sites who went on to become coaches.

Click on these links to find out how coaches helped treatment agencies overcome some of the most challenging obstacles to implementing the NIATx model, such as:

- [Collecting data](#)
 - [Choosing the right change leader](#)
 - [Solving one problem at a time.](#)
- **Learning Sessions.** The multi-day learning sessions started during the program have continued and evolved into annual NIATx summits that attract several hundred attendees from treatment agencies, state funding agencies and others across the country.

Communications

The Website

- **The NIATx website was launched in 2002 and has been continuously enhanced since then.** The website is a major resource for disseminating information about NIATx and for facilitating networking among original grantees and people from the wider treatment fields.

The website allows users to join the NIATx network and access free online resources, including grantee "success stories", the monthly NIATx e-news and research findings published in peer-reviewed journals. It also offers a portfolio of basic and advanced information on process improvement that is available online at no cost. These include:

- The NIATx Workbook
- A provider toolkit with a list of promising practices related to each of the four aims, spreadsheets for data collection and templates for conducting change projects
- A list of tools for conducting walk-throughs, Plan-Do-Study-Act rapid-cycle changes and forming a "change team"

The website also includes a networking section with a range of opportunities for becoming involved in NIATx through participating in coaching, learning collaboratives, etc. These are available for purchase.

Publications and Presentations

- **By December 2008, national program office and evaluation staff had published 10 articles in peer-reviewed journals**, including the *Journal of Substance Abuse Treatment* and *Drug and Alcohol Dependence*. More articles were underway.
- **Nearly 30 articles appeared in trade journals such as *Join Together Online* and *Alcohol and Drug Abuse Weekly***. These included four articles published in November 2002 that were designed to introduce the treatment field to process improvement techniques and the need for a learning community like NIATx to help spread the approach.
- **National program office staff produced tools including the NIATx Change Bulletin, the NIATx Workbook, the NIATx Business Case Series and the NIATx Smart Chart**. Most of these are available online from the NIATx website.
- **In June 2005, Program Director David Gustafson used *Paths to Recovery* experiences in briefing the bipartisan Congressional Addiction Treatment and Recovery Caucus on the need to improve access to and retention in treatment**. In November 2005, he addressed the 21st Annual Rosalynn Carter Symposium on Mental Health Policy.
- **In 2007, RWJF released a [Research Brief \(Process Improvement in Addiction Treatment\)](#) with findings from the program's cross-site evaluation** illustrated by examples of process improvements implemented by one *Paths to Recovery* grantee, The Acadia Hospital in Maine. See [The Evaluation & Its Findings](#).

Outreach to Policy-Makers

- **In 2004, eight Round I *Paths to Recovery* grantees participated in the RWJF-funded [Connect project](#)**. Connect helps RWJF grantees frame their messages to build or enhance relationships with members of Congress and other policy makers. This led to Gustafson's invitation to meet with the Congressional Addiction, Treatment and Recovery Caucus.

See the [Bibliography](#) for details on communications activities and products.

Spreading the Model

- **In 2006, NIATx launched [Strengthening Treatment Access and Retention—State Implementation \(STAR-SI\)](#)**. Building on the state pilot projects, STAR-SI, which ran through 2009, promoted state-level process improvement strategies to improve access to and retention in outpatient treatment. RWJF funded STAR-SI projects in New York and Oklahoma through a grant to NIATx. CSAT funded projects in

Florida, Illinois, Iowa, Maine, Ohio, South Carolina, and Wisconsin. Montana participated as a self-funded state.

For names of grantee state agencies and a summary of the STAR-SI program, see [Appendix 4](#). For detailed descriptions of each state's project, see the STAR-SI section of the NIATx [website](#).

- **In October 2007, NIATx launched the 18-month [Action \(Adopting Changes To Improve Outcomes Now\) Campaign](#) to spread the NIATx model to addiction providers around the country.** By the end of ACTION I in March 2009, the campaign had introduced over 950 organizations and 1,200 individual members in 50 states to NIATx approaches via online information and teleconferences.

ACTION I was supported by the Center for Substance Abuse Treatment and RWJF with several other national organizations providing in-kind support.

Agencies that joined ACTION I had access to free online resources, including ACTION Kits. They could also participate in free teleconferences to help them implement 12 changes aimed at providing rapid access to services, improving engagement in services and creating a seamless transition across levels of care.

NIATx launched ACTION II in 2009. See [Challenges for the Future](#).

- **NIATx established a national resource center supported by a three-year \$2 million "capstone" grant from RWJF** (Grant ID# 059714). In addition to serving as a resource for the nation's 14,000 treatment providers, the resource center integrates the work of RWJF's investments in improving treatment quality (three national programs: *Paths to Recovery*, *Resources for Recovery* and *Advancing Recovery*; and grants to the National Quality Forum) with efforts funded by CSAT to reinforce a uniform message and face for quality addiction treatment.

Core functions of the resource center include:

- Continuing and building a comprehensive, active NIATx website. The website will be the hub of the center's information resources.
 - Delivering targeted technical assistance to help addiction treatment payers and providers adopt proven practices that improve treatment quality.
 - Sponsoring Learning Communities that focus on topics such as enhancing access for adolescents; improving retention for women with preschool children and engaging people recently released from prison into community treatment.
- **To help sustain the learning community, NIATx created a line of products and services available through the resource center for a fee, including:**
 - The [NIATx Change Leader Academy](#). Some 47 *Paths to Recovery* and STAR agency change leaders attended the first academy in 2006. In 2008, 412

participants attended one of nine academies across the country. NIATx also added executive leadership and coaching academies to its offerings.

- **Annual National NIATx Summits.** The first summit, held in April 2007 in San Antonio drew 620 attendees from 39 states, Canada and Nepal. The 2008 summit, in Orlando, Fla., co-sponsored by the State Associations of Addiction Services (SAAS), attracted nearly 700 attendees.
- **Communities of Commitment.** Communities are small working groups led by a faculty member. Each community includes online learning sessions, telephone conference calls among members and a one-day preconference at the annual NIATx summit. Examples of Communities of Commitment include Leadership, the Business Case and Whole Systems Change.

By February 2009, the national resource center had raised almost \$280,000 from the sale of these services.

KEY SITE RESULTS

Results for *Paths to Recovery* Sites

Following are brief summaries of how some *Paths to Recovery* grantee sites addressed each of the four aims. See also [Success Stories](#) on the NIATx website.

These results are categorized by each of the four NIATx aims for simplicity. In reality, however, sites were encouraged to recognize the relationships across the aims and address them holistically and comprehensively.

NIATx Aim: To Reduce Wait Time

- **The Acadia Hospital, a freestanding treatment facility in Bangor, Maine, cut wait time for its outpatient program from 4.1 days to 1.3 days, a 68 percent reduction.** In 2003, only 25 percent of clients scheduled for outpatient care showed up for their appointments, and only 19 percent made it into treatment. To reduce wait time, staff:
 - Gave all clients appointments for the day after they called or contacted the agency. Clients did not have to call back or join a waiting list. Clients who met admissions criteria were asked to show up the next day at 7:30 a.m. for a full mental health or substance abuse evaluation.
 - Established a clinician pool to handle situations in which too many clients appeared at 7:30 a.m.
 - Allowed same-day admissions for people needing intensive outpatient or chemical dependency services.

For more on how Acadia's walk-through and subsequent change projects reduced wait time, read the [sidebar](#).

- **Asian Counseling and Referral Services, a community-based organization serving Asian Pacific Americans in the Seattle area reduced wait time for outpatient services from 87.7 days in 2004 to 13.5 days in 2005.** The change team tested several rapid-cycle changes to reduce wait time. These included:
 - Instituting a "three in three" rule. Instead of taking weeks to locate family members for collateral information on clients, staff limited attempts to three tries in three days. After the third try, they completed a summary assessment with the information they had on hand and sought more information later if needed.
 - Requiring that admissions screeners return voice mail requests for assessments within one day, and establishing a paging system to ensure that staff responded to a caller or walk-in client immediately.
 - Admitting patients on the same day as their assessment by providing motivational interviewing and cultural education to staff about the benefits of starting treatment in a timely manner.

For more information on Asian Counseling and Referral Services, read the [sidebar](#).

- **In a project called "Come on Down," staff at a partially funded site, Connecticut Renaissance, in Bridgeport, Conn., reduced the wait time from first contact to treatment from 45 days to one day.** Staff accomplished this by:
 - Combining intake and evaluation appointments into one appointment
 - Scheduling open evaluation times and offering walk-in evaluations at night as well as during the day

These changes also led to a 51 percent increase in the number of evaluations conducted.

- **Staff at the self-funded CAB Health and Recovery Services in Danvers, Mass., changed the program's intake process to reduce wait time and no-shows.** Process improvements included:
 - Having the intake coordinator conduct assessments by telephone and offer the caller an appointment. This cut wait time from two weeks to 2.5 days.
 - Implementing a telephone reminder system for appointments. This reduced no-shows by 27 percent.
 - With fewer barriers to access, lower no-show rates and the addition of more groups and evening hours, CAB's volume of business—and its bottom line—both increased.

NIATx Aim: Reduce No-Shows

- **Daybreak, a treatment agency for teens in Spokane, Wash., reduced its no-show rate from 28 percent in October 2003 to 10.4 percent in October 2005.** The change team achieved this outcome by implementing a series of rapid-cycle changes, including:
 - Electronic daily feedback to staff about their "no-show" rates
 - Reminder calls to clients the day before appointments
 - Rewards, such a pizza party, for groups with a 90 percent show rate

To find out more about how Daybreak reduced no-shows, read the [sidebar](#).

- **Axis I Center of Barnwell, a treatment program for adults and teens in rural South Carolina reduced no-shows for outpatient appointments from about 60 percent in October 2003 to 40 percent in October 2005.** To achieve this outcome, the agency:
 - Hired a case manager who called clients if they did not appear, arranged for transportation to the program and identified and addressed other barriers to treatment
 - Offered child care services for parents in treatment

For more information on how Axis I Center reduced no-shows, read the [sidebar](#).

NIATx Aim: Increase Admissions

- **Perinatal Treatment Services in Seattle increased occupancy in its Fresh Start program for teen girls from less than 50 percent in 2003 to over 80 percent by 2005.** This level ensured that the 16-bed residential treatment program, which had been on the verge of failure, remained financially solvent. To achieve this outcome, staff:
 - Revamped the program, which had focused on pregnant girls, by redirecting efforts to attract and treat nonpregnant teenage girls. The agency made this decision based on data showing that few referral sources had heard of this program and that there were too few pregnant teens statewide to warrant specialized services.
 - Renamed the program "Fresh Start" and created a new brochure. The new brochure omitted reference to pregnancy and featured a cooperative program with the local school district to reintegrate clients into the educational system.
 - Used "lessons learned" at a NIATx learning session to network with Daybreak, another *Paths to Recovery* participating agency. The two agency directors decided to co-market their programs by establishing a cross-referral plan that would increase occupancy rates at both agencies.

According to Kay Seim, former chief executive at Perinatal Treatment Services, process improvement became a "way of life" at her agency. To find out more about how this agency used the rapid-cycle change method to increase admissions and improve overall systems and quality, read the [sidebar](#).

- **SSTAR (Stanley Street Treatment and Resources) in Fall River, Mass., increased the occupancy rate in its dual diagnosis unit from 14 to 15 beds between June 2004 and January 2005.** This one-bed increase translated into a revenue increase of \$116,000 per year. To achieve this aim, SSTAR tested four strategies over four weeks.
 - The first two strategies—increasing coverage by an admissions nurse and offering to pick patients up from psychiatric hospitals—had no impact on admissions.
 - Under the third strategy, staff designated five hospitals that generated the most referrals to SSTAR's inpatient facility as "priority referents." They streamlined admissions of patients from these hospitals, omitting record review as a prerequisite and faxing daily notices of bed availability.
 - Under the fourth strategy, staff established a special admissions hotline only for the five priority hospitals.
 - By the end of week four, strategies three and four had resulted in an average daily census that was the highest in the unit's history.

For more details on SSTAR's efforts to increase admissions, read the [sidebar](#).

NIATx Aim: Increase Retention in Care

- **Fayette Companies in Peoria, Ill., reduced the dropout rate in New Leaf, its residential program for women.** In October 2003, data showed that about 12 percent of women left treatment within the first two days and 21 percent left within the first week. To keep women from leaving treatment prematurely, the change team:
 - Revised the role of admission peer sponsors and added a clinical staff person to provide orientation and assign women to their rooms quickly
 - Eliminated the "blackout" week for phone calls and visitors to clients, thereby allowing clients to call their families early in their treatment
 - Gave new clients a "welcome package" of stationery, envelopes and stamps, and provided a map to assist family and friends in locating the facility
 - Distributed one "recovery voucher" for each of the first seven days of treatment, which the women could redeem for a gift certificate on the seventh day

As a result of these changes, the number of clients discharged against medical advice dropped from 81 in 2003 to 28 in 2005. Occupied bed days increased by 1,055 over a six-month period, translating into a \$166,000 increase in revenue.

- **Gosnold on Cape Cod, in Falmouth, Mass., increased treatment completion rates in its men's residential facility from 47 percent to 75 percent.** Men's satisfaction with their care saw a dramatic increase, from a range of 60 percent, to 70 percent, to 100 percent over a four-month period. Changes included:

- Placing an "R" next to the names of patients at risk of leaving treatment prematurely. Dietary, maintenance and housekeeping staff often knew who was at risk, but had no mechanism to communicate concerns. Under a new procedure, any employee could ask that an "R" be placed next to the patient's name and staff provided extra support to those patients.
- Adapting the Plan-Do-Study-Act cycle for patients, with a modification. Plan-Do-Measure-Act (PDMA) encouraged men to set measurable goals for change in three areas (physical, mental and spiritual) each week. Examples of goals include quitting smoking, praying more often and losing weight.
- Placing older and younger men into separate units in order to increase affiliation and camaraderie and add structure and activities for younger men.

For more information about Gosnold and how it spread improvements to other units, read the [sidebar](#).

- **The Jackie Nitschke Center in Green Bay, Wis., increased retention in its aftercare and alumni groups.** A series of rapid-cycle change exercises at this small, 14-bed facility focused on improving long-term recovery by engaging and retaining patients in a continuum of outpatient services. The center:

- Revamped the aftercare process to ensure that clients started aftercare immediately after completing intensive outpatient care. No breaks and no "misses" were allowed in the first five weeks of the 16-week aftercare program.

As a result of this change, the percent of clients completing aftercare rose from 38 percent in February 2004 to 83 percent in April 2004.

- Increased participation in the alumni group, an ongoing support group for clients who completed aftercare. Staff invited people who completed 10 aftercare sessions to attend an alumni group meeting, which would count as one of the required 16 aftercare sessions.

Membership in the alumni group rose from 3 to 4 in 2004 to about 20 in 2009, according to William LaBine, the executive director.

For more information on Jackie Nitschke and how it increased continuation rates, read the [sidebar](#).

Results for State/Payer Pilot Site

Following are brief summaries of the key results for the RWJF-funded state payer site.

- **From 2004 to 2007, the Oklahoma Department of Mental Health and Substance Abuse Services, working with local treatment agencies, implemented the following changes to improve access to and retention in treatment in the state:**
 - Eliminated an income eligibility requirement. This reduced paperwork and cut average statewide wait time for outpatient treatment from more than 30 days to three days.
 - Eliminated duplicate paperwork. Among providers participating in this pilot project, time required to admit someone to residential treatment dropped from eight hours to less than three hours. Time to admit someone to outpatient dropped from four to five hours down to from two to three hours.
 - Introduced a new progress note format that reduced residential counselors' paperwork by 57 percent. The average number of hours spent on progress notes each day dropped from 4.6 hours to 3.5 hours, a 24 percent decrease.
 - Changed state rules to require all substance abuse agencies to conduct a walk-through and document results.

See [Success Stories](#) on the NIATx website for more detail on CAB's change projects.

THE EVALUATION & ITS FINDINGS

A research team from the Department of Public Health and Preventive Medicine, [Oregon Health and Science University](#), designed an evaluation of Paths to Recovery and STAR. Dennis McCarty, Ph.D., directed the evaluation. RWJF funded McCarty to conduct the evaluation of the Paths to Recovery sites. CSAT contracted with Northrop Grumman to evaluate the STAR sites.

The evaluation included a quantitative and qualitative component to address five questions:

- What changes were made in the delivery of services?
- How were the changes implemented?
- Did access to and retention in treatment improve?
- Were improvements sustained over time?
- Were development and technical assistance activities helpful?

Quantitative Evaluation

The quantitative cross-site evaluation assessed the extent to which participating agencies achieved two of the four NIATx aims:

To reduce wait time for admission into treatment, measured by changes in the number of days between first contact with the program and first treatment episode.

To increase retention in treatment, measured by changes in the percent of patients who started treatment and then completed two, three and four units of care. A unit of care is one outpatient visit, one day of intensive outpatient treatment and one week of residential treatment.

Agencies provided data for the quantitative evaluation by abstracting information from administrative records regarding dates of contact, admission and sessions attended. Staff also completed change reports on which they recorded each change initiative, the target of the change, the level of care, the location, the population addressed and the results.

Evaluators conducted three analyses to ascertain impact on wait time and retention:

- *The initial cross-site evaluation:* Researchers analyzed admission and retention data collected between October 2003 and December 2004 by 13 Round I *Paths to Recovery* and STAR treatment agencies.
- *The replication analysis:* Researchers analyzed the same admission and retention data collected between January 2005 and June 2006 from 11 treatment agencies that received Round II *Paths to Recovery* grants.
- *The sustainability analysis:* Researchers assessed the sustainability of the gains made by 11 Round I *Paths to Recovery* and STAR agencies by analyzing an additional 20 months of data collected between January 2004 and August 2005.

Findings

McCarty and colleagues reported the following findings from 13 Round I *Paths to Recovery* and STAR agencies, in an article published in 2007 in *Drug and Alcohol Dependence*, volume 88:

- **Wait time from first contact to first treatment decreased for all levels of care. The decline was significant for outpatient programs and intensive outpatient programs, but not for residential programs.** Outpatient treatment is regularly scheduled and professionally directed individual and/or group sessions totaling fewer than nine hours per week. Intensive outpatient treatment is regularly scheduled and professionally directed individual and/or group sessions for at least nine hours per week. Patients receive a full spectrum of services but live at home or in special residences.

Days from first contact to first treatment declined 37 percent (from 19.6 days to 12.4 days).

- For the seven outpatient programs, days from first contact to first treatment dropped from 32 in October 2003 to 20 in December 2004.
- For the four intensive outpatient programs, days from first request to first treatment dropped from almost 12 in December 2003 to seven in December 2004.
- For the four residential programs, days from first contact to admission dropped from about 11 in October 2003 to about eight in November/December 2004. This reduction is not statistically significant.

- **Retention in treatment increased for all levels of care, but reached a level of significance for intensive outpatient services only.**

- *Retention to second visit:* In October 2003, about 72 percent of patients returned for a second visit (outpatient or intensive outpatient) or second week (residential). By December 2004, almost 85 percent returned for a second visit or week.

Retention in intensive outpatient programs increased by 18 percent. Retention in outpatient programs increased by 11 percent, and retention in residential treatment increased by 15 percent; however, these gains are not significant.

- *Retention to third visit:* In October 2003, 62 percent of patients returned for a third visit or week. By December 2004, 73 percent returned for a third visit or week. This gain is statistically significant.
- *Retention to fourth visit:* In October 2003, 54 percent of patients returned to a fourth visit or week. By December 2004, 60 percent of patients returned for a fourth visit or week, but this gain is not statistically significant.

Qualitative Evaluation

Researchers explored:

- Factors that affected agencies' ability to implement process improvement strategies
- The capacity of participating organizations to utilize data in making decisions
- The composition of the change teams
- The effectiveness of technical assistance provided by the national program office

Evaluators collected qualitative data through site visits to treatment agencies and semistructured telephone interviews with agency staff.

Using descriptions of walk-throughs conducted by 327 agencies that submitted preliminary proposals in 2003, evaluators and national program office staff also analyzed

treatment admissions-related problems and the value of walk-throughs as an assessment tool.

Findings

Researchers reported findings from the qualitative analysis of walk-through exercises conducted by 327 agencies as part of their Paths to Recovery applications, in a 2007 article published in the *Journal of Substance Abuse Treatment*, volume 33:

- **Problems reported during the admission process included:**

- *Poor staff engagement and interaction with clients.* Misinformation or conflicting information from agency staff affected clients' ability to navigate the admission process and might have influenced their ability to make informed decisions about treatment.

For example, "A total of five different persons became involved in responding to the first caller's inquiry for help, and the caller was passed to different people in an effort to find the right person with whom to speak. Both callers had numerous interruptions due to other calls coming into the agency. In the end, neither caller was able to successfully complete an intake process."

- *Burdensome procedures and processes.* Large volumes of paperwork, redundancies in information collected and the mechanical "feel" of the intake process negatively affected client engagement in treatment.

For example, "One of the most salient observations about this process [intake] was that there [are] way too much redundant data gathered in this process. Mr. Doe's [walk-through client] medical history was requested three times in detail."

- *Difficulties addressing clients' complex lives and needs.*
 - Agencies had few resources to help patients struggling with complexities such as language barriers. These problems were compounded if family members were excluded from planning and treatment.
 - Patients with mental health problems were often turned away because either substance abuse programs serving people with both mental illness and addiction were full or (more often) substance abuse programs lacked a mental health component.
 - Patients mandated to treatment by courts found little coordination between court and treatment staff, making it hard for them to comply with legal requirements.

For example, "The client ... had to play telephone tag with the case manager for several days before contact was made. This was very frustrating to her

because a court appearance was upcoming and she was threatened with jail if she was not in treatment by that date."

- *Deficiencies in infrastructure.* Antiquated phone systems, crowded waiting rooms and unpleasant bathrooms were among the factors creating an environment that undermined client engagement with the treatment agency.

Researchers reported findings from the qualitative assessment of how agencies used data, in a 2006 article published in the *Journal of Behavioral Health Services and Research*, volume 33:

- **Factors that contributed to agency successes in using data included:**
 - Agency leaders who valued data and provided resources to support it
 - Training programs telling staff why data was needed and how it would be used
 - Dissemination of results of data-driven change projects to wide audiences
 - Successes in implementing rapid-cycle change projects
- **When NIATx began, agencies typically used unsophisticated information systems, and staff lacked experience and expertise in using data to improve operations and services.**
 - All agencies collected data related to local and state reporting requirements and some had quality improvement offices. In general, data focused on patient satisfaction and treatment completion rather than on measurable aims.
 - Agencies reported a wide range of data collection methods. Some used state databases or commercial software, but others used outdated software or internally developed automated or manual systems to collect client information.
 - Staff did not generally use data systems for quality improvement, partly because the systems were designed for client payment and accounting and not for tracking client outcomes or improvement activities.
- **Agencies made significant adjustments to manage rapid-cycle changes and client-level data requirements.**
 - By the end of 18 months, most agencies established systems to collect client data as to wait time and retention, although many struggled to do so. Few agencies had incorporated data directly into their management information systems. Many tracked client-level data manually, which was time-consuming.
- **Agencies faced specific barriers in making-data driven decisions.**
 - High staff turnover meant that training about data had to be repeated frequently. Loss of a data "champion" often set back the agency's entire focus on data.

- Few agencies had staff whose primary focus was data management, although some developed this capability by training or hiring staff during the course of the project.
- Many agencies experienced resistance from staff at all levels. Some staff members believed data collection detracted from their ability to serve people, some feared it would unearth shortcomings that might jeopardize funding and some thought collecting information manually was adequate.

To better understand how treatment agencies use data, in 2007 RWJF funded the Center for Health Enhancement Systems Studies to analyze the flow of data in eight *Paths to Recovery* agencies (ID# 57582). For more information about findings from this study, see [Program Results Report](#).

The Replication and Sustainability Analyses

Evaluators reported findings from the replication and sustainability analyses in a 2008 article published in *Drug and Alcohol Dependence*, volume 98:

- **The Round II *Paths to Recovery* grantees achieved reductions in wait time and improvements in retention similar to those achieved by Round I grantees, evidence that the NIATx model is replicable.**
 - Wait time dropped from 30.7 days in January 2005 to 19.4 days in June 2006, a 38 percent decline.
 - Retention in care improved during the period January 2005 to June 2006:
 - Retention to second visit rose from 75.4 percent to 85 percent.
 - Retention to third visit rose from 69.2 percent to 77.7 percent.
 - Retention to fourth visit rose from 57.1 percent to 67.5 percent.
- **The original group of 13 *Paths to Recovery* and STAR sites maintained reductions in wait time and improvements in retention for an additional 20 months, evidence that the NIATx model was sustainable and had been institutionalized by agencies.**
 - Outpatient, intensive outpatient and residential programs all sustained the gains in reducing wait time and improving retention they had made in the first 18 months.
 - Outpatient programs saw further improvements between January 2005 and August 2006:
 - Wait times dropped from 18 days to 15 days.
 - Retention to fourth visit rose from 45.4 percent to 56.6 percent.

- Retention to second and third visits increased but was not significant.

McCarty received subsequent funding from the National Institute on Drug Abuse to analyze whether programs continued to sustain their gains. See [Challenges for the Future](#).

Evaluation Conclusions

McCarty concluded that "NIATx results suggest that it is feasible to apply process improvement strategies to the delivery of care for alcohol and drug disorders. The reductions in days to admission and the improvements in retention rates document the potential for applying these strategies to other facets of the treatment system.... Incremental improvements may seem modest but when aggregated over time and across sites they can lead to substantive reductions in days to treatment and to consistent gains in retention in care for thousands of patients."

Researchers also concluded that while NIATx agencies were able to implement short-term process-oriented data collection methods to make improvements in their systems, implementing long-term data management and diffusion of a "data focus" agencywide were more challenging.

They noted that "federal, state and local governments may wish to dedicate a larger share of resources toward these data-related infrastructure issues, so that the data can be used to lower overall costs and improve effectiveness within and across treatment agencies."

Limitations

Researchers noted the following limitations of the study in their articles in *Drug and Alcohol Dependence*:

- **Decreases in wait time and gains in retention were most apparent in the aggregated data.** At the agency level, results varied from month to month. Programs reporting fewer than 15 to 20 admissions per month had the most difficulty achieving stable gains, while estimates are more consistent and stable where there are more admissions per month.
- **The agencies applied to participate and received awards to support participation.** The application process sought agencies with strong leaders and a commitment to process improvement. Less receptive programs may not achieve similar results. Grantees received financial resources to implement change teams and attend national meetings. Agencies tended to continue to support change efforts after the grants ended, but it is likely to be more difficult to initiate change without additional resources.
- **Some programs were unable to provide data for the evaluation.** Despite access to coaches and funds for data collection, of the 23 agencies in the first evaluation cohort,

one did not provide any data and six did not provide sufficient data to be included in the outcome analysis.

- **Factors other than *Paths to Recovery* and STAR may have contributed to the results.** Confidence in the findings is limited because agencies were not randomly assigned to experimental or control groups and there were no comparison clinics that did not attempt process improvements. In addition, of the many changes programs made, it was not clear which were most responsible for the observed improvements.
- **The evaluation assessed retention in care through only four sessions.** Researchers did not monitor changes in long-term retention, which is ultimately more important. However, since most clients leave after only one or two sessions of care, the program's focus on early retention was essential.
- **Differences in the application process for *Paths to Recovery* and STAR grantees may have promoted variation in project outcomes.** *Paths to Recovery* agencies piloted process improvements for their application. Thus, many had already reduced wait time before becoming *Paths to Recovery* grantees. Agencies participating in STAR did not conduct process improvements during their applications and were relatively uninformed about process improvement when the project began.

In the *Journal of Substance Abuse Treatment* article, researchers noted the following limitation to the qualitative analysis of walk-throughs conducted by program applicants:

- **The data for the analysis are from letters of intent submitted by agencies seeking funding.** The accounts of their walk-through exercises are streamlined and were likely presented in ways that the agencies expected would appeal to the funding agency.

LESSONS LEARNED

Advice from the National Program Office and RWJF

1. **Use NIATx resources to survive in hard times.** Participating treatment agencies and others have been crushed by the changes in the economy. The free resources available on the NIATx website and the ACTION Campaign Learning Collaborative offer great appeal to states and treatment providers facing shrinking training budgets. (National Program Deputy Director/Molfenter)
2. **Don't underestimate the value of paper and pencil data.** Most grantees struggled to collect the baseline data needed to measure the impact of their changes. Without minimizing this challenge, the national program director reminded grantees that simple statistics that don't require any type of analysis other than common sense are extremely powerful. "Everybody can remember them." (National Program Director/Gustafson)

3. **Remember that substance abuse is a field where staff "works on improvement every day of their professional lives."** While these efforts are directed at helping clients improve their lives, staff has developed ways to improve organizational processes as well. These assets in initiating change can help offset the apparent liabilities of treatment agencies—e.g., scarcity resources, lack of public understanding and support and mixed records of results in implementing evidence-base practices. (RWJF Program Officer/Capoccia)
4. **Use the wisdom of frontline workers to implement changes that address real problems.** Front-line staff constantly changes the way they work, usually by informally adapting to persistent problems. Leaders should give front-line staff permission, a structure and incentives to acknowledge and properly address problems, rather than work around these staff. (RWJF Program Officer/Capoccia)
5. **Look for opportunities to use the NIATx model to implement change in other fields.** Organizations inside and out of addiction services are trying to find ways to increase output and achieve better results with fixed resources. If resource-starved treatment organizations can accomplish positive change, then other organizations committed to improvement can likely do the same. (RWJF Program Officer/Capoccia)
6. **Use contracted consultants to deploy your workforce as needed.** In 2009, only six of the 62 NIATx coaches were employees of the national program office. The rest were on contracts that allow NIATx to expand and contract based on demand without having to carry the overhead burden of a larger workforce. (National Program Deputy Director/Molfenter)
7. **Don't be afraid to make the application process rigorous.** The program's call for proposals required applicants to conduct a walk-through and implement a rapid-cycle change. This did not deter applicants as some feared. The application generated more than 400 proposals and gave the staff a rich pool from which to select grantees. "We feel the quality of our grantees provided the foundation of the results of the program and was instrumental to program's spread efforts." (National Program Deputy Director/Molfenter)
8. **Keep the intervention simple and focused. NIATx's clear focus on its four aims and on the rapid-cycle change strategy provided a common focal point for participating agencies.** The combination of a simple approach and focused outcomes aided the diffusion of the Paths to Recovery interventions. (National Program Deputy Director/Gustafson)
9. **Don't hesitate to drop a change that doesn't work.** After each change, an organization can adopt it, adapt it or abandon it. "This common-sense approach encourages organizations to experiment." (National Program Deputy Director/Molfenter)

10. **Never forget the consumer!** The simplest principle remains the strongest. Customer needs must guide the adoption of innovations. (National Program Director/Gustafson)

Advice from Grantees

11. **Use walk-throughs—they are a great way of seeing your agency through the consumer's eyes.** Many agencies had never conducted walk-throughs before applying for *Paths to Recovery* funds. Staff found walk-throughs an eye-opening experience that allowed them to see problems in their admissions and other processes from the patient's perspective. Many agencies have since adopted walk-throughs as a central component of their process improvement "toolkits." (Project Director/STAR project, Nancy Paull)
12. **Make sure your team is focused on one change at a time and make data a priority.** When staff at the Acadia Hospital starts a change project, all team members get a blank template to complete. "When we didn't do that, eight different people had eight different ideas," said David Prescott, Ph.D., a change leader. To keep the team focused on the goal, Prescott adds that all team members were required to have data to report at each meeting. "If we don't have paper and pencil data ready, we cancel the meeting."
13. **Don't waste time on problems that are out of your control.** The change team at Gosnold on Cape Cod wanted to reduce the wait time for admission to its detoxification program by cutting down duplicate paperwork requirements. When the team learned that state regulations dictated these data collection procedures, it decided this change was beyond the scope of the project and turned to other activities.
14. **Develop partnerships with state agencies.** Problems like that faced by Gosnold led RWJF to fund a pilot project involving state-level funding and regulatory agencies. According to Terry L. Cline, Ph.D., former commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services, the state's desire to review, identify and improve cumbersome internal processes impressed the providers. "After years of resistance to the state authority, it was almost as if providers felt they could be open and honest and express what was working," he said.
15. **Make small changes. They are simple, easy to implement and can make a big difference.** Oklahoma's Cline spoke for many grantees when he said "You identify a problem, test a solution, and move on to the next problem. It's an incremental approach that can have a huge impact." For example, the Axis I of Barnwell project director noted that the impact of a simple change like brightening up a waiting room, had an impact of the staff and motivated them to take on more difficult challenges.
16. **Celebrate success but don't "rest on your laurels!"** Seeing immediate results from a rapid-cycle change can generate momentum for change, but leaders should not assume that an initial "can do" attitude translates into sustained improvement. Staff turnover and waning enthusiasm mean a return to "business as usual" in many cases. Leaders have to develop policies that make changes permanent, provide ongoing

coaching and offer opportunities for staff feedback. (Project Director/Gosnold, Project Director/Asian Counseling and Referral)

17. **Pay attention to how staff will receive, adjust to and implement changes.** Staff morale increased greatly when they learned of small successes that were backed by data. They embraced change projects when managers addressed work capacity issues related to their involvement in the projects and were sensitive to their cultural backgrounds and preferences. (Project Director/Asian Counseling and Referral Service)
18. **Don't make NIATx a top-down directive.** Gosnold on Cape Cod's Executive Director Raymond Tamasi and change leader Tommie Ann Bower worried that if staff believed changes were a response to management directives, they would not sustain over time. Bower decided to expand the change team to include a counselor aide and a counselor since both these positions have critical roles in patient admissions. (Project Director/Gosnold)
19. **Take advantage of technical assistance provided by a foundation.** Daybreak's chief executive and other grantees found participating in RWJF's Connect project communications trainings very helpful in teaching them to "tell the story" of *Paths to Recovery* accomplishments to other providers and policy-makers. (Project Director/Daybreak)

Advice from the Coaches

20. **Recruit coaches from both outside and inside the addiction treatment field.** Coach Elizabeth Strauss came from a background in industrial engineering and systems thinking. She thought that substance abuse providers appreciated the "fresh new perspective" she brought to solving problems. Yet, Lynn Madden of Acadia Hospital noted that providers also like working with coaches who knew the "ins and outs" of the substance abuse field, especially financial issues. (Project Director/Acadia, NIATx Coach)

Advice from the Evaluation Team

21. **Provide continuing supervision and coaching to ensure that both experienced and new staff sustain improvements.** Interviews conducted by the evaluation team suggested that training and monitoring are ongoing issues. (Evaluator/McCarty)
22. **NIATx may not be a good fit for every organization providing treatment for alcohol and drug disorders.** Evaluation interviews suggested that agencies with inconsistent leadership and unstable financial environments often abandoned the NIATx change efforts. (Evaluator/McCarty)

SIGNIFICANCE TO THE FIELD & CHALLENGES FOR THE FUTURE

Paths to Recovery "led to a shift in thinking about the meaning of quality" in the addiction treatment field according to Todd Molfenter, the deputy director. The program helped providers learn how to measure and, more importantly, how to improve on quality indicators such as access to and retention in care.

Molfenter also reported that as of December 2008, more than 1,000 treatment agencies had been introduced to process improvement techniques. Directors of all 50 state agencies responsible for substance abuse treatment have identified process improvement as a primary training need for their providers. Many states have started process improvement strategies modeled after *Paths to Recovery*.

In his article published in *Drug and Alcohol Dependence*, volume 28, evaluator Dennis McCarty noted that the potential gain from the small changes that NIATx promotes is "stunning." McCarty goes on to write: "Incremental improvements may seem modest but when aggregated over time and across sites they can lead to substantive reductions in days to treatment and to consistent gains in retention in care for thousands of patients. If 1000 outpatient clinics averaged a 12-day reduction in days to admission, for example, and served 100 patients per year, there would be about 1.2 million fewer days waiting to enter outpatient care."

Challenges for the Future

The NIATx learning community continues to grow. As of January 2010, more than 2,175 organizations had become members of the NIATx learning community. See the [map](#) showing participating organizations in each state (click on a state for the list).

In late summer 2009, NIATx launched its [ACTION Campaign II](#) in response to the economic downturn and the severe financial crises facing many treatment agencies. The 18-month campaign focuses on helping behavioral health care organizations reduce costs, improve services and increase revenue. ACTION II is supported with funds from RWJF, the Center for Substance Abuse Treatment, Magellan Health Services and the California Endowment.

In its [Accelerating Reform Initiative](#), which began in December 2009 and runs through July 2010, NIATx is providing technical assistance to help agencies prepare for the challenges and opportunities that health care reform and decreased funds may bring. As of January 2010, 22 organizations (including seven *Paths to Recovery* grantees) were participating in the initiative, which is supported by RWJF (through ID# 059714, creating a national quality resource center for addiction treatment) and the Center for Substance Abuse Treatment.

NIATx is conducting a number of federally funded research projects, including:

- **NIATx 200.** This \$9.5 million study aims to identify the most cost-effective ways to implement quality improvement and organizational change projects using the NIATx model. The National Institute on Drug Abuse (NIDA) is funding the study, which began in 2007 and runs through 2012. State authorities for addiction treatment in Massachusetts, Michigan, New York, Oregon and Washington and about 40 treatment programs in each state are participating in the randomized controlled study.
- Evaluators at Oregon Health and Science University continue to analyze the capacity of treatment agencies to sustain process improvements. NIDA awarded the evaluation team a five-year (2005–2010) \$3,276,104 grant to study whether *Paths to Recovery* sites maintained the gains and continue the use of process improvement.
- In 2008, the **National Institute on Alcohol Abuse and Alcoholism (NIAAA)** awarded NIATx a five-year, \$2.8 million grant to conduct a randomized clinical study to determine whether a mobile phone-based, virtual support system reduces rates of relapse among people in recovery from alcohol dependence. These smart phones include built-in linkages to peer support, recovery assistance plans, locations and times of local AA meetings as well as prompts to assist people with medication adherence.

This work is part of NIATx's *Innovations for Recovery* initiative to harness the power of technology to aid in addiction recovery. For more information on this program, which is partly funded by RWJF, see [Program Results Report](#).

NIATx continues to convene annual summits, co-sponsored by the State Associations of Addiction Services. The 2009 summit was held in Tucson, Ariz.; the 2010 summit is scheduled for July 2010 in Cincinnati. NIATx also hosts free or low-cost webinars on process improvement topics. *Paths to Recovery* grantees, including many who have become NIATx coaches, often lead these Web-based learning sessions.

Staff has also started to develop mechanisms to increase the impact of NIATx not only in the addiction treatment field but the broader field of behavioral health. This includes developing a growth model that relies on research grants, demonstration grants and revenue-generating projects and services.

Sidebars

COLLECTING DATA

NIATx (Network for Improvement of Addiction Treatment) Program Director David Gustafson has a surprising confession to make: he “hates data.” So Gustafson could empathize when staff at drug treatment agencies struggled to collect the data that would tell them whether their quality improvement projects worked.

Coaches Help Agencies Collect Data

Betta Owens, a NIATx coach and former *Paths to Recovery* deputy director, said, “My advice to them was to just measure one thing. You don’t need a database. The back of an envelope will do to determine whether a cycle of improvement is working or not. Use simple measures that can be collected and analyzed in a simple way. That will take mystery or fear out of it.”

Owens acknowledges that many agencies struggled with the requirement to collect data. “Where people haven’t had much research experience and did not receive research grants, they tried not to use data.” But NIATx made two solid contributions to treatment agencies, Owens adds. “One was its insistence on using rapid-cycle changes. The other was convincing agencies that they ‘can’t do it without data.’”

NIATx coaches and staff offered skeptical agencies “hands on practical stuff,” according to Owens. “We showed agencies that they can talk about numbers. If staff could show that performance improved after a rapid-cycle change exercise, they saw how these numbers might impress payers as evidence of the agency’s efficiency and quality.”

NIATx staff learned to introduce ideas and strategies in increments appropriate to each agency’s stage of learning. *Paths to Recovery* grants allowed agencies to budget some funds for data collection. “We weren’t piling on things that were a surprise or that they were not being compensated to do,” said Owens.

NIATx coach Elizabeth Strauss agrees. A graduate student of Gustafson’s, Strauss provided technical assistance to *Paths to Recovery* grantees on the West Coast. Strauss had worked in process improvement for large health systems and describes herself as a translator, a “go-between” who identifies problems and works with CEOs and staff to broker solutions.

“If a grantee says they don’t get why we need baseline data, we take it in little pieces, one step at a time. It also helped to guide them in picking an issue that would yield data quickly—something they could do with paper and pencil and not wait for two months for feedback.”

Having coaches located near agencies and able to make shorter visits more often was a plus, according to Strauss. "Rather than an all-day session, it was really nice to be able to spend an hour with grantees and a few weeks later come back."

NIATx coach Pauley Johnson found a solution in setting up "something that looks like a course syllabus at the beginning. Working with the agency is critical, so they can say 'this is our outline, these are our deadlines, this is what we'll shoot for and here's how we are going to collect data.' It's almost impossible to be too specific."

Coaches Learn Too

Jay Ford is technical director at NIATx. Ford spent 18 years in systems improvement for a hospital system in Tennessee before moving to the University of Wisconsin, where he earned a doctorate in health systems engineering. Ford is also a NIATx coach who, like Owens, Strauss and Johnson, realized that it wasn't only *Paths to Recovery* agencies that had some learning to do.

"We didn't do as good a job as we should have in teaching grantees how to collect data. When they filled out templates, we'd find characters in date cells, dates out of sequence. We'd try to walk them through and sometimes they'd improve, but sometimes not. We got better at explaining how to collect data. We developed Excel templates that we asked applicants to use to send us data as part of the grant application."

Ford also notes that the NIATx approach to data collection mellowed over time. "We were more prescriptive at the beginning. Although we still use templates, we got away from saying 'there is one way to collect baseline data.' If grantees want to do something around paperwork reduction, we tell them to write down what time they gave a form to the client and write down when they gave it back. We tell them to do that for five clients and measure the results."

Ford adds, "Once grantees did the walk-through [a core NIATx component, in which as part of the application process staff walk through the agency's admission process taking the role of a client], they wanted to implement changes but didn't know where to begin. Our advice was to slow down and collect baseline data before you get going. It was a challenge to get grantees to go back and collect baseline data. Sometimes, the change leader was a data collection person, sometimes a counselor with a big caseload, factors that also affected how well an agency coped with data collection requirements."

Overcoming the Fear: Learning to Love Data

William LaBine, chief executive officer of the Jackie Nitschke Center in Green Bay, Wis., recounts how his small agency with few resources became a convert to the power of data. Jackie Nitschke was like many smaller alcohol and drug treatment agencies when

it applied for a *Paths to Recovery* grant in 2003. "We were light years behind in terms of technology," admits Judy Glenz, Jackie Nitschke's executive director at that time.

Glenz (now retired) saw *Paths to Recovery* as a way of acquiring tools to implement process improvements, particularly through training staff in the use of computers to collect data. LaBine, then the center's clinical services director admits that he didn't "care for data" prior to the *Paths to Recovery* grant. He credits Glenz' enthusiasm with changing his mind.

"Judy did a great job collecting and explaining data. She changed the way I thought about data. One of our rapid-cycle change projects had improved the outpatient continuation rate and the no-show rate dropped way down. Judy went back and looked at the data to see areas of commonality among those who completed treatment compared with those who did not complete. Judy presented the data understandably, and I understood how it worked."

LaBine's enthusiasm spread to the rest of the staff. A rapid-cycle change project to reduce the time from first contact to treatment got everyone involved. "We trained the entire staff to make outpatient appointments and give out information on programs. We put up a huge poster that explained the project and kept all staff informed and interested.

We had a punch card system. If a client called in and started treatment in four days, we put an "X" on the punch card. Once we hit 10 clients, all staff got four extra hours of time off with pay. It was fun and built momentum. Most important, we went from 13 days to four days from first contact to first treatment session."

LaBine, who became a mentor for other *Paths to Recovery* grantees and later a NIATx coach, sums it up. "When I saw the power of positive data, something clicked and my attitude changed completely. I was not afraid of it anymore."

Learn more about the Jackie Nitschke Center's involvement in *Paths to Recovery* in the [sidebar](#) on the center.

A Different View from a Small Agency

Daybreak, a small Spokane, Wash.-based treatment agency for teens with substance abuse problems, received a *Paths to Recovery* grant in 2003. Collecting baseline data was hard, says Tim Smith, executive director, because the agency hadn't instituted spreadsheets. "We used paper and pencil. Staff put in a lot of hours pulling pieces of paper out of files."

Smith credits his agency's in-house change team leader Richard Miles with helping Daybreak improve its data collection systems. (*Paths to Recovery* grantees were required to establish in-house change teams to implement rapid-cycle change projects.) Miles

created spreadsheets and graphs to collect two years of data on every client in the system and to record how Daybreak was progressing in meeting its goals.

Looking back on Daybreak's efforts to improve use of data, Smith reports mixed progress.

"We're still using rudimentary spreadsheets and a very crude little database program. A local university wanted to partner with us to do client-based research, but they had to go through medical files. There was no database to make things easy for them. The technology deficit is an anchor that drags on our ability to be as sophisticated as we'd like. ...while we have made many gains, our weaknesses in this area create ongoing problems for us. We have created a number of data collection procedures and systems, but they are cumbersome, time-consuming and not as reliable or durable as we need them to be. As a result, we still have to scramble to get good reporting data, or we have to catch up because data entry has not been completed in a timely way.... We still have a long way to go."

Smith believes that the digital divide between smaller agencies and larger ones is growing. Initially, none of the *Paths to Recovery* participating agencies had sophisticated systems. "Everyone struggled to get the data submitted. We were guinea pigs...starting out from scratch." The move to electronic health records helps in many ways, but for many smaller agencies like Daybreak, acquiring an electronic health record [system] isn't yet a possibility.

Although lack of technical sophistication hampers Daybreak, Smith credits *Paths to Recovery* with giving the agency motivation to move forward. Learning how to organize change teams and implement process improvement projects has opened the door to partnerships with local universities that want to do real world research. Daybreak is moving aggressively to create an infrastructure that will enable it to do academic-level research.

Learn more about Daybreak's involvement with *Paths to Recovery* in the [sidebar](#).

SOLVING ONE PROBLEM AT A TIME

When administrators and staff at substance abuse treatment agencies discover problems in their internal processes, they want to fix them "Now!" This desire is admirable and understandable, but it isn't always realistic or feasible.

Staff at **NIATx** (Network for Improvement of Addiction Treatment) found that treatment agencies were so eager to attack several problems at once that they were struggling to succeed at fixing any one of them.

Simple is Beautiful: The Four NIATx Aims

To help agencies avoid the natural tendency to take on too much at once, NIATx focused improvement efforts on achieving four aims: reduce waiting times, reduce no-shows, increase admissions and increase continuation rates.

For Janet Soo Hoo, executive director of Asian Counseling and Referral Service in Seattle, "The beauty of the NIATx model is its simplicity and clear focus. Limiting grantees to the four aims was a good choice by RWJF and the national program office—a way to narrow thinking to have greater impact."

Although the goal is for each agency to address all four aims in order to achieve systemwide transformation, NIATx coaches taught grantees to start small—with one aim, one level of care and one location at a time. Soo Hoo, who later became a coach herself, agrees. Her agency began by focusing on reducing wait time to admission for treatment and conducted a lot of change exercises to address that one goal.

Learn more about Asian Counseling and Referral Service's participation in *Paths to Recovery* in the [sidebar](#).

The Peril of Too Much Enthusiasm

The NIATx "one aim at a time" philosophy was hard for some *Paths to Recovery* agencies to embrace, at least at first. The problem was too much enthusiasm, according to Jay Ford, Ph.D., NIATx technical director and one of the original NIATx coaches. He recalls visiting *Paths to Recovery* agencies early on and advising staff to "slow down."

NIATx's own protocols prompted some of this exuberance and enthusiasm. As part of their *Paths to Recovery* grant applications, agencies had to conduct a "walk-through" of their admission process, introduce a change based on the walk-through and report on the results. In walk-throughs, employees "apply" for admission to their agencies as if they are clients.

Ford often found that staff had identified many problems during the application walk-through exercise. In the interim—after the agency received its *Paths to Recovery* grant but before the NIATx coach arrived—staff started to make changes. "When coaches showed up for the onsite visit, they found agencies managing five or six projects," says Ford, "but when you asked them what worked, some of them couldn't say."

Some grantees learned the hard way and had already concluded that they were trying to do too much before the coach came to their rescue. But, Ford laughs, "Some people, to be honest, already had jumped in fully clothed. They're not going to get out and put on a bathing suit; they're going to keep swimming."

Ford's advice? "Let's try one thing at a time." He told them to "Look at what you are doing. Go back to the walk-through, identify key problems and then pick one thing to work on first. I encouraged them not to set aside other great change ideas, but see them as opportunities for the future."

"Park Your Good Ideas" and Other Advice from a Coach

Pauley Johnson, NIATx coach, found that creating a "parking lot" for future change efforts helped grantees take it slow without losing their enthusiasm. "I persuaded the team at Daybreak [a *Paths to Recovery* participating agency] to make a list of their priorities. I also reminded them that starting with one project didn't mean that other projects dear to their hearts would be ignored. I advised them that 'you have to start somewhere.'"

[Learn more](#) about Daybreak's involvement in *Paths to Recovery* in the [sidebar](#).

Johnson heard one message several times: Start with an issue the in-house change team wants to tackle first. Officials at Signal Behavioral Health Network in Colorado, a NIATx partner funded by the federal Center for Substance Abuse Treatment, wanted to tackle wait times, but staff said they were overburdened and not ready. Johnson suggested "Let's clean up our act in other ways first, by looking at what's really bugging staff."

In this case, Signal employees wanted to reduce paperwork that was creating stress for front-line staff. Addressing this problem first helped secure staff buy-in for the entire model of change. "We are clearing off the table before we put something else on it" said Johnson of this experience.

Over time, some agencies developed strong leaders and committed in-house change teams that were spearheading and prioritizing the process improvement activities. These agencies got to the point where they could try several projects at one time. But for others, having two or three change teams addressing large complex problems was a "recipe for disaster."

Ford recalls one agency that had six in-house change teams working at once. The executive director, in his enthusiasm to fix problems, was driving staff to initiate too many projects. The effort bogged down, so Ford advised the director to identify a few "short term wins" that everybody could support. With that approach and a new in-house change team leader, the agency moved forward to address a few priority areas.

Elizabeth Strauss, a graduate student of National Program Director David Gustafson's at the University of Wisconsin-Madison College of Engineering and a health systems engineer, served as a NIATx coach for *Paths to Recovery* agencies on the West Coast. Strauss agrees with Ford's view that agencies tended to plunge in fast. She noted that

Paths to Recovery grantees knew they were supposed to pick one aim at a time, but enthusiasm often got in the way!

"They were so excited and made so many changes, they didn't know which caused the improvement. I didn't want to discourage them, but I did teach them to use the NIATx process very specifically and pick one change at a time to focus on," says Strauss.

Over time, Strauss relaxed her approach, however, trusting to the wisdom of agencies. With support from NIATx coaches and the learning community, "I trust they'll discover how to use the process on their own. I tell them to treat the whole improvement process as a rapid-change cycle."

LEADERSHIP CHALLENGES

Paths to Recovery taught leaders in substance abuse treatment agencies to use process improvement strategies originally developed by private industry to improve their business operations. These strategies emphasized incremental changes that were tested, revised, retested and adopted in a series of rapid-cycle changes.

Although these strategies emphasized incremental, small-scale changes, they brought about systemwide transformations that addressed big problems that keep the CEO awake at night. Agency leaders and their staff learned to apply process improvement techniques that both improved the quality of services and stabilized the organization's finances.

Starting at the Top: The Role of the Executive Sponsor

In the NIATx model of process improvement, agency staff form change teams to achieve four NIATx aims: reduce wait time for services, reduce no shows, increase admissions and improve retention in care. An executive sponsor, usually the executive director, leads the team by ensuring that they have the resources and time to succeed.

The executive sponsor should be "passionate about change" according to NIATx staff. He or she should provide a "steady drumbeat" that reverberates through the organization, motivating staff at all levels. A key role of the Executive Sponsor is to choose and support the right in-house Change Leader, the person in charge of day to day change activities. Still, the Executive Sponsor needs to be a champion of change.

NIATx staff identified several ways that an Executive Sponsor can foster organizational receptiveness to change. These include impromptu visits to team meetings, reading and commenting on minutes of team meetings and rewarding and acknowledging "heroes."

What if the Executive Sponsor "Doesn't Get It"?

Some *Paths to Recovery* Executive Sponsors became champions right away. Nancy Paull, executive director of Stanley Street Treatment and Resources (SSTAR) in Fall River, Mass., was frustrated with traditional total quality management approaches and knew "there must be a better way."

According to Paull, "We were used to total quality management and CQI (continuous quality improvement) approaches. You'd sit in meetings and nothing changed. You have 10 to 12 people in the room, the most expensive people in your organization, the value of their time had to be \$2000 or more, and nothing changed." Paull was intrigued by the hands-on, quick-turnaround approach fostered by *Paths to Recovery* and decided to apply. Learn more about Paull's experiences in *Paths to Recovery* in the [sidebar](#) on the SSTAR project.

Other leaders embraced the NIATx model more slowly. Sometimes an executive who resisted at the start did eventually "take off," according to Jay Ford, a NIATx coach who advised and guided agencies in using process improvement strategies. Tim Smith, executive director at Daybreak in Spokane, Wash., is a case in point. Smith "struggled with the NIATx model of incremental rapid-cycle changes and hesitated to become actively engaged. Then, a light turned on and he got it."

Since NIATx offers a range of learning resources—formal learning sessions, teleconferences, coaching and informal peer networking, the switch that caused the light to go on could have been any one or a cluster of factors. Whatever the cause, says Ford, Smith is going "great guns."

Pauley Johnson, NIATx coach, also saw the transformation in Smith. Johnson observes "He [Smith] saw a real effect on his bottom line. NIATx improved the productivity and efficiency of Daybreak staff. They were able to see more people without any degradation in quality in quality of care."

Data and the ability to "tell stories" with data also played a part in converting Smith to the NIATx approach. According to Johnson, in reviewing data on staff productivity, Smith saw that some people had "stunningly better results than others had. He got staff together to talk about specific things they were doing right that others could use."

Learn more about Daybreak's involvement in *Paths to Recovery* in the [sidebar](#).

When Leaders Move On, What Then?

When an executive director or executive sponsor leaves the agency, it is easy for things to revert to prior practice. To avoid losing the hard-earned gains of process improvement,

the executive sponsor should ensure that systems are in place to institutionalize change and embed a culture of change in the routines of staff throughout the agency.

Two important actions a departing executive can take to sustain the gains, according to NIATx staff, are:

- Appointing a "sustain leader" who will take over monitoring activities after a change team has completed its work on a change project.
- Making sure change teams document the changes they have put in place. This can include writing new policies or protocols, for example, or training all affected staff in the new procedures.

Even when such measures are in place, process improvement can be disrupted or derailed when a chief executive who has been a NIATx champion leaves and is not replaced by someone receptive to the rapid-cycle model.

Coach Elizabeth Strauss recalls a difficult situation involving a new executive director who "didn't get" process improvement. The director attended a NIATx Change Leaders Summit and Strauss was set to follow-up with individual coaching. However, before that happened, the agency's board of directors became tired of waiting for the "NIATx light" to turn on and asked the director to leave.

Three employees of this agency had become strong advocates of the NIATx model and could have sustained the momentum. Instead, perceiving that their agency was no longer an environment where performance improvement was embraced, these employees resigned to start their own spinoff agency.

"This was an unusual case, says Strauss. "In some ways it was really cool how performance improvement had gotten so ingrained that three people took that step." However, it also highlights the pitfalls that can occur during times of transition.

Ford takes the "30,000-foot view" when it comes to turnover. When executive sponsors do leave, their departure does not have to mean the initiative has ended or that it has less priority. The Jackie Nitschke Center is a small treatment agency in Green Bay, Wis. When the executive director retired, changes made as a result of rapid-cycle projects began to erode. The board of directors appointed William LaBine, who had been the agency's change leader, as the new director, and he got things moving forward again.

Learn more about the Jackie Nitschke Center's involvement in *Paths to Recovery* in the [sidebar](#) on the center.

"Everybody hits a bump in road," says Ford, "but the sites do get it and are making great strides." Many executive directors would echo the assessment of Daybreak's Tim Smith:

"NIATx is no longer an experiment. It had a transformative effect on our agency. It's just the way we do business now."

CHOOSING THE RIGHT CHANGE LEADER

Leaders in most organizations face many challenges, including matching the right person to the job. Executive directors of substance abuse treatment agencies are not exempt from these challenges.

Paths to Recovery taught leaders in substance abuse treatment agencies to use process improvement strategies originally developed by private industry to improve their business operations. These strategies emphasized incremental changes that were tested, revised, retested and adopted in a series of rapid-cycle changes.

What Makes a Good Change Leader?

In the NIATx model of process improvement, agency staff form change teams that work on four NIATx aims: reduce wait time, reduce no-shows, increase admissions and improve retention in care. An executive sponsor, usually the agency director or chief executive officer leads the team and ensures that it has the resources and time to succeed.

The executive sponsor selects a change leader who leads, facilitates, implements and evaluates the rapid-cycle change projects undertaken by the team. A key task of the executive sponsor is choosing the right person for this role and then giving him or her time to perform it.

The change leader has to be capable of guiding and supporting the team and possess the ability and authority to interact with employees at all levels in the organization. The change leader should expect to devote one-third to one-half of his or her time to process improvement.

Based on feedback from change leaders and executive sponsors, NIATx staff identified the top leadership qualities of an effective change leader as:

- Willingness to challenge the status quo
- Ability to get results and verify them with data
- Persistence
- Respect from staff at all levels of the organization
- Goal-oriented and focused on change-project objectives

Other key qualities, according to NIATx, are enthusiasm, energy and an ability to instill optimism in staff.

Finding the Right Change Leader, Sometimes the Second Time Around

Not surprisingly, executive sponsors sometimes chose the wrong person as change leader the first time around.

In one treatment program for pregnant women and teens, the executive director chose an employee who lacked the charisma and skills to empower employees to offer ideas and work in teams. This employee was one of the agency's treatment counselors and did not have authority to assign responsibilities to members of the change team and hold them accountable.

The change team became discouraged. There was no "esprit de corps" recalled the executive director, who knew something had to be done but was uncertain about the best action to take. She credits her NIATx coach Elizabeth Strauss with giving her the confidence to appoint a new change leader. "We were able to move ahead in a more dynamic way after that."

Strauss tries to deflect the credit: "Finding a new change leader was the director's idea. She wanted to change, and I said 'Fine do it!' Everything's an experiment. If it doesn't work, change it. Many other agencies ended up with the wrong change leaders at first. It's important to know it's OK to change."

Tapping the Right Skill Set

Strauss and other NIATx coaches concluded that one rule of thumb for executive directors is to consider assigning the agency's clinical director to serve as the change leader. In most cases, the clinical director is respected by staff, has influence over agency policies, has access to the executive director and can make things happen.

Executive directors might consider nonclinical or lower-level employees as change leaders in cases where changes are expected to be administrative rather than clinical. In addition, serving as change leaders can give less senior employees an opportunity to develop leadership skills and potential. This approach is better used after an agency has experience in conducting rapid-cycle change projects, and is not a good idea for the first few projects.

Even a skilled change leader can become overwhelmed if responsibilities are not reassigned so that time is allocated for the task. A good choice for a change leader is often a person who already has too much on their plate, says Strauss, recalling that when the executive director of the teen program did select a new change leader, that person tried to "do it all" and didn't want to admit she was overwhelmed.

Some executive directors decided to appoint the agency's quality improvement officer as change leader. This brings the advantage of having someone with agencywide responsibilities in charge of change efforts and might increase the chance that changes will be spread across the entire agency.

Strauss suggests caution and notes that much depends on the situation. She recalls one agency in which the quality improvement officer served as change leader. "That didn't work," Strauss noted "because the change leader's office was a half-hour away from the program site where the changes were taking place. "They needed someone onsite who could check in on a regular basis."

Strauss suggests that the quality improvement officer be a member of the change team, charged with spreading new practices throughout the agency and perhaps teaching clinical directors at other locations how to become change leaders.

Coaching the Change Leader

Even with the right mix of leadership qualities, change leaders needed the support, feedback and an occasional pep talk from NIATx coaches. Early on, coaches helped change leaders use the rapid-cycle change model. But they also provided ongoing support as change leaders confronted typical project problems such as delays, waning enthusiasm for change, resistance or confusion among staff and difficulties collecting data.

For Pauley Johnson, NIATx coach, the key is making sure change leaders know what they are getting into. "They need to know the specifics—when is the kickoff with other agencies, when do they need a course in 'rapid-cycle change 101'. Even more important they need to know how important their roles are and they have to hear that more than once. If they get that, they begin to understand their role clearly early on and can bring other staff aboard."

ACADIA HOSPITAL: REDUCING WAIT TIME FROM FIRST REQUEST TO TREATMENT

[Acadia Hospital](#) in Bangor, Maine, is a psychiatric and substance abuse hospital covering the state's central region. The 100-bed facility provides inpatient medical detoxification, outpatient drug treatment and outpatient methadone and buprenorphine treatment for opiate-dependent clients. Acadia also has a residential substance abuse rehabilitation program, an emergency shelter for homeless substance abusers and transitional housing.

From September 2003 to June 2006, Acadia Hospital participated in *Paths to Recovery* national program. Participating agencies used process improvement strategies originally developed by private industry to improve business operations. These strategies

emphasized incremental changes that were tested, revised, retested and adopted in a series of rapid-cycle changes.

Addiction Services: A Stepchild in Quality Improvement

In 2003, Acadia Hospital received an average of 320 calls each week from people seeking treatment. In addition, many of the 1,000 people who called each week asking for mental health services also suffered from substance abuse disorders. At the time Acadia applied for its *Paths to Recovery* grant, its substance abuse services had been operating at or over capacity for nearly 10 years.

With heavy demands for services, staff had not had time to examine and plan how to deliver care more effectively. Acadia's quality improvement activities were "pretty diffuse," according to David Prescott, Ph.D., a clinical psychologist and later Acadia's director of performance improvement. "We didn't pick one kind of change and focus in. Addiction was a stepchild program, not fully a part of our quality improvement efforts."

When Lynn Madden, Acadia's chief operating officer, heard about *Paths to Recovery*, she saw it as a rare opportunity to examine Acadia's business process and enhance its quality improvement efforts. Outpatient admissions seemed the right place to begin: only 25 percent of clients who initially called for outpatient care at Acadia ever showed up for their assessment appointments, and only 19 percent ever made it into treatment.

What made these low rates even more disturbing, according to Victor Capoccia, RWJF's former program officer for *Paths to Recovery*, was that Acadia was one of the highest rated addiction treatment agencies in the country.

Learning to See with the Patient's Eyes: the Walk-through

Acadia started learning lessons from NIATx even before the hospital received its *Paths to Recovery* grant. As part of applying for *Paths to Recovery*, Acadia staff had to conduct a "walk-through" and report on the result. In walk-throughs, employees request help or seek admission to their agency's programs as if they are clients. Prescott and Madden decided to conduct Acadia's walk-through by "applying" for admission to outpatient treatment.

What they found was a surprise according to Prescott. As walk-through "clients," they faced a confusing system for scheduling intake interviews. They had to place multiple calls to the Assessment Center to schedule an appointment, and, once there, were often separated from family members for long time periods.

"We found out how much we made the client work to get an appointment here," said Prescott. "We made appointment seekers call back, thinking that if they don't call back they're not motivated. If they want treatment, they'll call back. We realized how much we

set up initial calls for our convenience, rather than the client's. 'Let's make darn sure that people we get in the door are a perfect fit before we let them in,' in other words."

Paths to Recovery helped agencies use rapid-cycle changes to make improvements in four key areas—reduce wait time to admission, improve retention in treatment, increase admissions and reduce no-shows. But, NIATx coaches advised agencies to address these challenges one at a time.

For the change exercise required as part of Acadia's *Paths to Recovery* application, Prescott and Madden decided to focus on cutting down the average time of 4.1 days from first contact to admission to the hospital's intensive outpatient treatment program.

Revamping Admissions

Scott Farnum, Acadia's clinical supervisor of substance abuse services led the agency's in-house change team. The team began by redesigning the admissions process to accommodate an unlimited number of new admissions each day.

The first, bold step was to stop giving appointments altogether. The team proposed a system in which callers were instructed to come to the hospital at 7:30 a.m. on the following day. No limits were placed on the number of people given this instruction.

Staff rearranged schedules to arrive by 7:30 a.m. On arrival, clients received a full mental health and substance abuse evaluation by a clinician who admitted them into treatment immediately if appropriate. If the clinician concluded that intensive outpatient was not the right level of care, he or she referred the client to a more appropriate level.

Prescott recalls how the team felt about this first experiment in process improvement. "You get really really nervous—even though staff bought the concept, they thought it was impossible. We used to say 'we only have three slots. What if 11 people show up?' It forced us to rethink. We have 120 licensed people. We told them 'intake has high priority, so in a pinch, we may have to call on you on some days to fill in. If you're not working with another patient, come and help out.'"

Reactions varied, Prescott recalls. "The good news was the program took on an unbelievable energy. Clinicians could see they were doing things they got in business to do in first place—opening doors to the community. Other the hand, if you got a person who was difficult, it took all morning."

Front-line and support staff had complaints too. Coming in at 7:30 rather than 8:00 and changing daily routines required a lot of flexibility. Food was another challenge. To encourage clients to come at 7:30 and wait for the same-day evaluation, staff offered food for the waiting area. With more people coming in, staff had to order four times as much food. "We'll go broke," Prescott recalls them warning.

Although the "worst case scenario"—20 people showing up at 7:30 a.m.—happened less often than staff feared, it did happen, admits Prescott. "Every 15 days or so, but that's what you remember. Clients have to wait and some walk, but we say 'come back and we will have the same thing tomorrow. We'll be here at 7:30.'"

Results: Impact on Waiting Time and the Bottom Line

The immediate result of eliminating appointments was that average time from first call to first contact fell from 4.1 days to 1.3 days. The percentage of clients who were screened and then went on to seek treatment rose from 25 percent to 65 percent.

These changes prompted other improvements. Admissions to the outpatient program rose from 16 per month in 2002 (the year before the change) to an average of 73 per month by June 2004. As a result of the dramatic increase in admissions, Acadia added a counselor to its staff. This added to billable hours, which in turn increased revenue by 56 percent and enhanced the profit margin by approximately \$400,000 from 2002 to 2004.

Changing Services for Changing Clients

Providing service on demand brought a different type of client to Acadia. The "new" clients were typically younger, addicted to opiates rather than alcohol or marijuana and relatively new to treatment. These clients forced Acadia staff to rethink the agency's clinical program.

In response, staff added group sessions focusing on preventing and managing overdose, the biology of addictive substances and safe needle use. They developed plans to better treat people with Hepatitis-C and to better serve families in which a child is born to a mother in the methadone treatment program. Acadia was able to recognize these needs because of the process improvements that made it easier for clients to walk through the door.

Building on Success: Reducing Wait Time in the Methadone Maintenance Program

Acadia's change team moved on to its next goal: reducing wait times in the methadone program. By redesigning the intake process to allow laboratory work, physician visits, nursing assessments and clinician interviews all to occur in the same morning, staff:

- Reduced the average time from initial assessment to first day of medication from 3.25 days to less than one-half day
- Increased the number of patients receiving medication on the day of admission ("same day dosing") from 19 percent to 62 percent

- Cut the number of patients waiting two or more days for the first dose of medication from 65 percent to 2 percent

In addition to providing better clinical care, same day dosing allowed Acadia to expand its intake capacity in the narcotics treatment program. By double-booking new appointments and relying on clinical teams rather than individuals to conduct intake interviews, Acadia increased admissions from 11 clients in September 2005 to 36 clients in October 2005. This helped increase the average daily census from 312 in September 2004, before same day dosing was introduced, to 393 in January 2005 and to 696 in September 2006.

Reflections

In an article entitled, "Making Stone Soup," published in the *Joint Commission Journal on Quality and Patient Safety*, former program officer Capoccia and Acadia's Madden, Farnum and others reflected on the significance of Acadia's work within the larger context of NIATx. The authors observe, "Acadia's experience suggests that if an organization designs changes with the customer's perspective in mind, applies rapid PDSA [Plan, Do, Study Act] cycle changes and if it promotes changes that are properly aligned with its overarching goals, it can then make significant improvements in a short period of time."

They continued, "In addition, the process improvement team consisted of two key members of Acadia's operations management team who could remove barriers to the change process and work directly with the line staff to implement these changes."

In a May 2009 interview, Prescott noted, "We implemented about nine change projects while we were part of *Paths to Recovery* and we implemented at least eight more after that grant ended. These were all successful—the ones that weren't working, we dropped."

In a report to RWJF, Farnum noted that Acadia's experience affected state policies as well. "The [*Paths to Recovery*] project's success has helped encourage the State of Maine's Office of Substance Abuse to adopt NIATx principles as its primary strategy for improving treatment. In 2005, the state office successfully implemented a pilot program to replicate the NIATx program with six substance abuse treatment agencies in Maine. Members of Acadia Hospital's *Paths to Recovery* team served as coaches for this pilot program."

ASIAN COUNSELING AND REFERRAL SERVICE: REDUCING WAIT TIME FROM FIRST CONTACT TO TREATMENT

The Seattle-based [Asian Counseling and Referral Service](#) agency promotes social justice and the well-being and empowerment of Asian Pacific American individuals, families and communities in King County, Wash. Grassroots activists started the agency in 1973 out of concern that Asian Pacific Americans were at risk of misdiagnosis and inappropriate care by service providers unfamiliar with their culture and language.

By 2006, some 200 agency employees speaking 30 languages were serving over 22,000 low-income clients. In addition to behavioral health and addiction treatment services, clients have access to a continuum of services from 12 programs, including a food bank, a legal clinic and a job developer.

The agency's substance abuse treatment program began in 1999. Yoon Joo Han, M.Ed., M.S.W., program director of behavioral health recalls, "We were getting lots of inquiries asking for substance abuse treatment delivered in Asian languages. Lots of people needed help but there was no linguistically and culturally relevant treatment in this area." The agency assigned one staff to provide these services; in three years, the number of clients had doubled.

To meet this demand, the agency added more staff, introduced a new curriculum and enhanced its infrastructure. But, says Joo Han, "We were getting complaints from people waiting for service and from providers referring clients that we were not responding quickly enough."

When Deputy Director Janet Soo Hoo, heard about [Paths to Recovery](#), she was eager to become part of it. Soo Hoo saw the program as an opportunity to establish a quality improvement process that would make her agency more responsive to clients.

A Walk-Through Unearths a Delay

As part of their [Paths to Recovery](#) grant applications, staff had to conduct a "walk-through" of their agency's admission process, introduce a change based on the walk-through and report on the results. In walk-throughs, employees "apply" for help from their agency as if they are clients.

Soo Hoo decided to conduct the walk-through herself. To add a layer of complexity, she played the role of a client who spoke only Mandarin Chinese. With her "sister" accompanying her as an interpreter, Soo Hoo sat for six hours waiting for an initial assessment. "It was painful," she recalls as she struggled to communicate with intake staff who spoke Vietnamese.

Paths to Recovery also required applicant agencies to establish in-house change teams to implement change projects and report on results. Asian Counseling and Referral Service's change team began by looking at lessons from the walk-through.

Line staff wanted to focus on reducing the gap between the time a worker first interviewed a client and the time the counselor wrote the assessment summary. Soo Hoo agreed, noting that by giving priority to staff concerns, it's easier to get results.

Producing summaries quickly was important from an organizational perspective as well. Many Asian Counseling and Referral Services clients are court-ordered to treatment after an arrest for driving under the influence (DUI). Court staff uses the summaries as the basis for assigning offenders to treatment as part of their sentence.

According to Joo Han, when Legal Services referred clients with DUI convictions, "They wanted us to respond in one or two weeks, and we were not able to do so. People got lost in the process and we had difficulty matching clients to treatment providers who spoke their language."

A review of agency records showed that it was taking about 28 days for staff to complete the assessment summary. This delayed treatment and placed additional stress on individuals and families uncertain about what the court might decide.

Analyzing the Problem Leads to a "Three in Three" Policy

Staff determined that a big reason for delay was an agency requirement that workers collect collateral contact information from others to supplement data provided by the client. With no clear guidelines about how many people to contact or how many attempts to make, staff was spending an average of two to three weeks trying to reach these collateral contacts.

The change team decided to revise this procedure. They experimented by limiting contact attempts to three within three business days—later dubbed the "three in three" policy. If they could not reach collateral contacts within three days, staff finished the summary and created the treatment recommendation with available information.

The result? All summaries after the "three in three" policy were completed in less than five days, compared with only 29 percent of summaries completed in less than five days under the prior system.

Armed with this evidence that a simple change tripled the number of clients who could receive their summaries within five days of assessment, the agency incorporated the "three in three" policy into its policy and procedure manual.

Asian Counseling and Referral Service's success with "three in three" helped it secure a *Paths to Recovery* grant in January 2005.

The Next Step: Reducing Time to Treatment

Paths to Recovery helped agencies use rapid-cycle changes to make improvements in four key areas—reduce wait time to admission, increase admissions, reduce no-shows and improve retention in treatment. But, NIATx coaches advised agencies to address these challenges one at a time.

Staff at Asian Counseling and Referral Service decided to start by tackling the challenge of reducing the time from first contact with a client to the first treatment session.

Baseline data as of January 2005 showed that the average wait time to treatment was 87.7 days. The data also indicated that the longest lag occurred between the time the assessment summary was completed and the time the client enrolled in treatment.

Part of the delay was beyond the agency's control because staff had to wait for court decisions, and most clients entered treatment only if court-ordered to do so. Nevertheless, Soo Hoo believed that an 87.7 day wait was unacceptable. Based on her success with "three in three" she wanted to try a rapid-cycle change project to cut wait time to 10 days.

To achieve this goal, Soo Hoo realized she would also have to address a psychological barrier—the denial of problems. Denial was often intensified by the stigma attached to substance abuse among the Asian Pacific American community.

Using the *Paths to Recovery* grant, support from a trained process improvement coach provided by NIATx and information gleaned through teleconferences and learning sessions, agency staff tried from 12 to 16 rapid-cycle change projects focused on reducing wait time from intake to treatment. These included:

- Requiring screeners to return calls from potential clients requesting assessments in one day. Staff set aside a designated time to check messages and return calls daily. Because most staff carried out multiple tasks, checking calls had been a low priority.
- Creating a paging system to ensure that staff responded immediately when screeners were not available. The change team suspected that since many potential clients did not speak English, they might not leave a telephone message. The paging system increased the odds that a caller would speak to someone.
- Ensuring that clients received an assessment appointment within 10 days of the call. The agency added back up assessment staff if waits got too long.
- Streamlining paperwork and prioritizing information needed at the assessment or admission appointment.

The Results: Shorter Wait Times, Increased Revenue and Engaged Staff

These change projects attacked the problem from multiple perspectives and at multiple points in time between the client's first contact with the agency and the first treatment session.

By March 2005, the average wait time had dropped from 87.7 days to 46.5 days. By December, it fell to 13.5 days. This change allowed the agency to increase admissions to outpatient treatment from 96 in 2004 to 150 in 2005. Revenues increased by about 15 percent.

Focusing on rapid-cycle changes that addressed staff priorities as well as client concerns had other benefits, according to Soo Hoo. The collaborative approach equipped staff and clients with skills and motivation to make changes and strengthened agency efforts to address other *Paths to Recovery* goals, including reducing no-shows.

Using rapid-cycle change exercises, Asian Counseling and Referral Service:

- Reduced no-show rates from 39.43 percent in the last quarter of 2004 to 14.17 percent in the last quarter of 2005
- Increased private-fee payments from clients from \$30,238 in 2004 to \$44,836 in 2005

Soo Hoo notes that the NIATx model of rapid-cycle changes had an effect beyond the agency's substance abuse services. "We spread NIATx to other departments, including our children's services, mental health—and in administration, where we wanted to cut back on our paper and photocopier usage. In fact, I brought directors of other departments to a NIATx learning session."

DAYBREAK: REDUCING DRUG TREATMENT NO-SHOWS

Daybreak was founded in 1980 by a group of citizens concerned about youth substance abuse in Spokane, Wash. Over the decades, the program grew. By 2006, its inpatient and outpatient programs were serving about 1,100 young people between the ages of 12 and 17 from Washington, Idaho and Oregon each year.

Daybreak's outpatient program began as a day treatment service for youth who had been expelled from school due to chemical use. The program provides substance abuse counseling at two locations in the Spokane area, serving over 300 youth per year in weekly individual, group, and family sessions.

Frustrations with the Status Quo

In 2003, Richard Miles, Daybreak's treatment director, was hearing complaints from agencies referring adolescents to Daybreak and from the families of clients. "They were frustrated and were asking us why they had to go to all this trouble to apply to inpatient and outpatient services. The counselors were always frustrated too."

Miles and Tim Smith, Daybreak's executive director, were dissatisfied as well. They wanted to make it easier for teens to get into Daybreak but they also wanted these teens to attend regularly once they were admitted.

Daybreak didn't have the right tools to make things change. Miles recalls, "We were spending enormous amounts of time collecting volumes of data for state reports and clinical records, but we couldn't easily or quickly retrieve the data for our own use. We asked ourselves 'Is there data that we could collect that would be more useful to us?'"

Paths to Recovery Presents an Opportunity to Change

Miles remembers, "Daybreak doesn't apply for a lot of grants, but somehow we got wind of *Paths to Recovery*. I don't know what attracted me. Maybe it was the idea of a systematized, data-driven quality improvement approach. In the back of our minds, both Tim and I were concerned with our agency's lack of specific improvement objectives. We didn't know why we were doing things."

Miles and Smith decided to apply for a *Paths to Recovery* grant. "None of us had any training in process improvement," Miles recalls. "We had a sense of bumbling along but we began to understand more as we went through the process. By the time we got to the point of our walk-through—after four months of planning—we understood what we were getting into and what we wanted."

Reducing No-Shows for Outpatient Services

Paths to Recovery helped agencies use rapid-cycle changes to make improvements in four key areas—reduce wait time to admission, increase admissions, reduce no-shows and improve retention in treatment. But, NIATx coaches advised agencies to address one challenge at a time.

When Daybreak received its *Paths to Recovery* award in September 2003, Smith and Miles decided to start by trying to reduce no-shows in the agency's outpatient program.

Although 85 percent of parents and teens showed up for their initial appointment, 40 percent either refused a second appointment or failed to show up if they did schedule one. Adolescents need appointments primarily after school hours, from 2:00 p.m. to 7:00 p.m., so losing two to three hours a day to no-shows was not acceptable.

Problems continued even for teens who kept their appointments. The agency's typical treatment plans recommended about 10 hours per month of treatment. But, agency reports indicated that the average teen received only five hours per month of services, due largely to poor attendance. Counselors often operated at 50 percent to 75 percent of capacity.

Low attendance meant the outpatient program failed to bring in enough revenue to support itself. Other Daybreak programs were subsidizing the outpatient program at a rate of nearly \$17,000 per month, one-third of its operating budget. The agency could not sustain this level of internal subsidy, according to Smith, and needed to find a way for the outpatient program to break even at the least.

Tackling the Problem

Staff wanted to fix this problem. Everyone knew that many clients were not showing up, but no one was collecting baseline data to define and quantify the problem. So, staff began by painstakingly going through separate appointment books to hand-count all no-shows.

They learned that 28 percent of people with appointments for October 2003 did not show up. The *Paths to Recovery* in-house change team established by Smith and Miles decided that a no-show meant someone who missed an appointment without 24-hour notice. The team then decided that its first rapid-cycle change goal would be to reduce no-shows to 10 percent of scheduled appointments.

First, the team simplified the way the agency recorded no-shows. Daybreak had been using a paper-and-pencil "Service Activity Log" (SAL) that notified counselors of services rendered for billing purposes. The Log did not include a place to indicate "service not rendered because of no-shows."

By December 2003, after a few pilot tests, the change team implemented an electronic service activity log in which billing, service and no-show data were compiled daily and automatically. The only additional work for counselors was to check a 'no-show' box on the log. The new procedure provided counselors with daily feedback about their no-show rates.

No-show rates dropped from 26.3 percent in November 2003 to 22.2 percent in December.

Next, one counselor, with the help of a secretary began making reminder calls to her clients the day before the appointment. This counselor's no-show rate dropped, so Daybreak decided to expand the calls to all clinicians and sites. No-shows dropped to 15.8 percent by January 2004, and to 15.4 percent by February.

Staff looked for more opportunities to reach the goal of 10 percent no-shows, and found one in the high no-show rate at group sessions. Staff began sending out twice-monthly e-mails telling each counselor how many no-shows that counselor had compared with the no-shows for other counselors.

Staff also started rewarding clients for attending group sessions. The change team introduced end-of-month pizza parties or similar events for groups that had 90 percent attendance during the month. Weekly progress graphs were posted in group rooms to provide feedback to clients.

Daybreak was able to sustain these improvements over time. Although subsequent no-show rates ran as high as 21 percent, the average rate was 10.4 percent for the 12-month period ending October 2005. According to Smith, "In the first six months of 2009, no-shows ranged from 6 percent to 15 percent and averaged about 11 percent."

Observations and Lessons

Paths to Recovery provided one of Daybreak's first disciplined attempts at rapid-cycle improvement. The changes had significant impact on the agency's bottom line and on staff motivation to move forward with more change projects. These and subsequent improvements enabled the outpatient department to operate with a tolerable profit margin.

For Smith, the "main thing is fully embracing process improvement as the system that will improve the program as a whole, spreading change throughout the agency, not in a spotty way. If a department was really isolated, it could make a change on its own, but our personal philosophy is to spread it throughout the agency.

"Through *Paths to Recovery*, we also settled upon fairly firm ideas about setting very clear measurable standards with ongoing measurements of whether we do or don't achieve them." Change leaders have to be a little "obsessive," Smith concludes.

Staff resistance to change presented an early and significant barrier to undertaking process improvement exercises. At first, staff believed that change would take "too much time." Already overburdened, staff saw additional requests as "just way, way too much," according to Miles.

By introducing simple, short-term projects, the change team realized some quick successes from small investments of time. This demonstrated that small changes can yield good results. Miles notes, "We asked staff: 'Are you getting what you need from leadership on these projects?' They told us that the results of the changes were so dramatic, why wouldn't we want to do this? We'll live with it."

Participating in *Paths to Recovery* also affected Daybreak's internal decision-making structure. According to Miles, "Our managers and supervisors meetings evolved into a more comprehensive group of managers across sites meeting to develop and oversee change projects. These groups also focus on standards for improvement and replicating improvements across the agency. This didn't happen before."

Smith adds his reflections on the lasting impact of the NIATx change process. "While we pay a lot of attention to no-show rates and the other NIATx aims, such as reducing waiting time, we have taken on other projects. During 2007, we used a number of change teams to completely redesign the inpatient treatment program and the way in which clients were taught the curriculum.

"This was a top to bottom change, accomplished within six weeks, in small steps but with the big picture in mind. On large and small levels, the NIATx process improvement model is continually rolling on."

AXIS I CENTER OF BARNWELL: REDUCING NO-SHOWS

Axis I opened in 1973 when the South Carolina legislature mandated that the 24,000 residents of rural Barnwell County be provided with alcohol and other drug treatment services. First called the Barnwell County Commission on Alcohol and Other Drug Abuse, the agency became the Axis I Center of Barnwell in 1996.

Over the years, Axis I Center has grown into a comprehensive agency providing education, prevention, intervention and treatment services. It also has its own food banks, thrift store and teen pregnancy program.

Axis I delivers prevention and outpatient treatment services at its main facility in Barnwell and in the county's three school districts (with nine school facilities). Adolescents make up 36 percent of Axis I clients.

Confronting a Budget Crisis

In October 2002, the center was in dire straits due to state program and budget cuts. It had lost its domestic violence program and a case management program for families on public assistance. A third program, Communities in Schools, had eliminated all of its part-time employees and was slated to close by the end of 2003.

Executive Director Cheryl Azouri Long put it this way: "With these program and staff cuts, we had to increase productivity by implementing process improvements or we couldn't continue serving the citizens of Barnwell County. At a time when the need was

most acute, our resources to conduct data-driven improvement projects were at a low point. Information technology positions were vacant due to staffing cuts."

When Long heard about *Paths to Recovery* national program, she saw it as a means to build the process improvement system the agency needed. At the same time, she was wary of the resources required to apply. "I asked myself 'do we want to write this grant?' We can't waste a dollar or use it in the wrong way, so we have to look at everything and measure whether it's worth it."

She decided to go ahead. "We didn't know what we were getting into—it just sounded good."

Seeing Your Agency Through a Client's Eyes

As part of their *Paths to Recovery* grant application, agencies had to conduct a "walk-through" of their admission process and report on the results. In walk-throughs, employees "apply" for admission to their agencies as if they are clients.

In the walk-through, the Axis I finance director "became a new client" coming for her intake appointment. Although the finance director knew the agency's clerical staff, she acted and was treated like a real first-time client. "Honest to God," said the clerical staff person, "I forgot her when we got busy." The "client" sat in the waiting room and finally knocked on the receptionist's window to get her attention.

As with other *Paths to Recovery* applicants, Long and her staff were startled by what they saw. They knew that Axis I staff cared deeply about clients, but the walk-through demonstrated that clients might not see this level of care.

A change team comprised of Axis I employees decided to test whether a case manager could provide the personal touch that would make clients feel welcome and more interested in engaging in treatment.

Medicaid funds paid for case management services while clients were waiting for intake assessments so Long temporarily assigned a case manager whose job had been eliminated by budget cuts. This case manager conducted intake interviews for all Medicaid clients.

The change team implemented several other initiatives over a three week period in 2003. Clients were invited to walk in and see the case manager at open hours each day. In addition, the case manager called all "no-shows" within 72 hours of the missed appointment. She also secured services such as transportation, child care and help with medical appointments, food, housing or other problems that made it difficult for clients to use the center's services.

After the three-week exercise ended, the team manually reviewed the case manager's appointment list. The list indicated a no-show rate of 22 percent for the case manager. The no-show rate for appointments not scheduled with the case manager was 58 percent.

Multiple Strategies to Reduce Treatment No-Shows

Axis I Center's strong application gained it a *Paths to Recovery* grant of \$219,420 in September 2003. Long and the change team decided to continue the work they started during the application.

Paths to Recovery helped agencies use rapid-cycle changes to make improvements in four key areas—reduce wait time to admission, increase admissions, reduce no-shows and improve retention in treatment. But, NIATx coaches advised agencies to address one challenge at a time.

Long decided to start by addressing the agency's high no-show rate for adult outpatient appointments, which hovered at 63 percent in October 2003. The change team devised a range of strategies to reach this aim. Long offered permanent employment to the Medicaid-funded case manager and charged her with identifying and reducing barriers to treatment.

The agency undertook several new strategies:

Telephone Calls and Home Visits

Clients could no longer "just fade into the woodwork," Long said. "If you have nine people in a group and the tenth person doesn't show up, and it's quarter after nine, the case manager calls you at home. But it doesn't stop there. The case manager also calls your mom's number and then four or five more numbers until you've got your whole family mad at you."

The case manager also worked with adolescents in a truancy and alternative school life skills program. If the adolescent misses an appointment, the case manager visits the home. "This has kept down no-shows" according to Long, because "kids will do anything to keep us from coming to their house."

The case manager focused special attention on the Women's Treatment Group. Instead of meeting once per week, the group met three times per week. When calling women, the case manager would probe for clues about unmet needs that might be hindering the women from keeping their appointments.

Supportive Services

If a woman lacked transportation, a common situation in this poor, rural community, the case manager would ask back-up staff to pick her up, or she arranged for the county van

service, Local Motion, to provide transportation. Once women arrived, Axis I offered child care during treatment sessions as well as snacks for women or children who arrived hungry.

"We'll help you with whatever your needs are," says Long. "Clients get so much that they're going to come back. Clients truly have the sense that they are being taken care of. Every time you come to a session, you'll get something for children. It's fun! We incorporate life into the treatment we're giving—we really do care."

Long laughs as she recalls, "I heard the case manager on the phone saying, 'we'll buy the drugs.' I almost had heart failure until I realized she was calling the drugstore on behalf of a woman who needed aspirin. After 36 years in the business, I've learned to act like a drug dealer who gives you what you want for free until you want it so much you'll pay for it."

Warm Greetings

Axis I Center recognized that front line staff is important in making clients feel welcome. Long calls it the "personality stuff.... A clerical staff member is the first person you talk to when you come in and the last person who talks to you when you go out. She asks if you are doing okay and reminds you to call. In two or three months, you know her by voice and name, a human being you make contact with, not a survey you fill out."

Improvements Realized

The change strategies—combined with the "personality stuff"—made a difference. By March 2004, the no-show rate at Axis I Center dropped to 45 percent, a 28.6 percent decrease.

Food is Important Too!

Addressing transportation problems by arranging for rides on Local Motion was an important strategy for reducing the no-show rate, but the strategy brought problems of its own. The van arrived at clients' homes early in the morning and dropped them off at the center much earlier than the start of treatment. Some women walked to the center. Whether travelling on foot or by van, many had not had time to make breakfast.

Axis I began providing snacks and refreshments, a warm drink in cold weather and juice when it was hot. Women embraced this idea and expanded it by bringing covered dish breakfasts. This evolved into a breakfast club, which then evolved into a peer support group. Women began urging each other to leave abusive relationships or other risky situations. "They don't go to bars if they find a network of people they like," says Long.

Help and Support From NIATx

Todd Molfenter, NIATx coach and deputy program director, provided ongoing on-site and telephone guidance to Long and the change team. Long observes: "Todd was wonderful. We hadn't a clue and he gave us hands-on help. He was the token male in our all-female group. He helped us decide what to do and then helped us understand how to read and format data to make it useful. This was one of the most important parts of being in *Paths to Recovery*.

"It was also great for our staff to travel to other locations and network with colleagues who were struggling with the same problems."

Sustaining the Momentum

These improvements worked well for a time, but as for several *Paths to Recovery* agencies, staff turnover made them hard to sustain. When the first case manager left her job, Axis I replaced her with several others, but none were able to establish the same connection with the clients. A male case manager hired in 2006 has been able to relate well with clients and his involvement again increased the number of clients who remain in treatment.

Despite setbacks, in 2009, three years after the *Paths to Recovery* grant ended, Long is even more convinced of the value of the case manager and the NIATx method overall. "Budget cuts are a fact of life, so whenever we turn around we need to use NIATx," says Long. "We have Plan A and Plan B. We must be up to Z by now. When one counselor is out, we turn to Plan B, we double book, triple book—it's what happens.

NIATx is a part of everything we do. It's even what we do when we put a new roof on the building! We're still changing the organization to be more aware of customers' needs. We have a person who comes in once a month to work with staff on cultural change and being customer friendly. NIATx is part of our consciousness.

"Our change team still meets regularly, at the same time every other week. We still call it the RWJF change team. We look at data about no shows at each program—women's treatment, alternative schools—and we use the rapid-cycle change format to see the best way to make a change."

PERINATAL TREATMENT SERVICES: INCREASING ADMISSIONS TO TREATMENT

[Perinatal Treatment Services](#), located in Seattle, is a residential and outpatient substance abuse treatment program for pregnant and parenting women. Many of the women also

have mental health problems, a history of domestic violence and a need for parenting education and support in addition to treatment for addiction.

The residential program serves pregnant women and women with children up to age six, who stay at facilities in Seattle and Tacoma, Wash., for up to 180 days. An adolescent residential program serves non-pregnant teens for up to 60 days, providing substance abuse and mental health treatment combined with academic instruction.

From September 2003 to June 2006, Perinatal Treatment Services participated in *Paths to Recovery*, in which participating agencies used process improvement strategies originally developed by private industry to improve business operations. These strategies emphasized incremental changes that were tested, revised, retested and adopted in a series of rapid-cycle change exercises.

The Walk-Through: Looking at Intake through a Client's Eyes

Kay Seim became Perinatal Treatment Services executive director in November 2001. Seim brought more than 30 years experience in substance abuse treatment, most of them leading for-profit companies. The opportunity to apply for a *Paths to Recovery* grant was "perfectly timed" says Seim, to coincide with her charge to look at the organization with "new eyes."

Seim led Perinatal Treatment Services staff through several rapid-cycle change exercises aimed at increasing admissions, reducing no-shows for treatment sessions and increasing retention. She started with what happens when a woman walks through the door.

Paths to Recovery required participating agencies to conduct "walk-throughs," or exercises in which employees request help from or seek admission to their agency's programs as if they are clients. Seim used the walk-through to examine her agency's intake process for residential treatment. She found the results shocking.

"The 'client' was not treated respectfully, according to Seim. "Her belongings and clothing were searched in the cold, sterile and noisy lobby in full view of other people. Family and friends had to wait in the lobby. Any need for reassurance or a comforting gesture—such as the offer of a snack—was ignored. Intake staff was interrupted by other staff members or clients, making it hard to focus on the needs of the woman seeking help."

After the walk-through, staff found a secluded office that could be used exclusively for intake interviews. The room had a table where intake staff could search personal belongings away from public view.

Staff also outfitted a small room as a child-care and waiting area. They provided comfortable chairs and toys, hung pictures on walls and offered water and snacks. Seim

hoped these efforts would make it easier for women to decide to enter treatment and would create positive relationships between clients and staff.

Paths to Recovery helped agencies use rapid-cycle changes to make improvements in four key areas—reduce wait time to admission, increase admissions, reduce no-shows and improve retention in treatment. But, NIATx coaches advised agencies to address one challenge at a time.

The following story describes how Perinatal Treatment Services used rapid-cycle changes to increase admissions in its women's and adolescent programs.

Increasing Admissions to Residential Treatment

With a cheerful space ready to welcome new patients, Seim and an in-house change team focused on increasing admissions to the women's residential programs. They wanted to reach 95 percent of capacity. To achieve this goal, beds would have to be filled by a new woman shortly after a resident was discharged, transferred or left against medical advice.

The change team used a rapid-cycle change exercise to get started. First, they created a process for ensuring that the residential treatment counselor or clinician notified the Placement Coordinator immediately whenever a resident left.

Next, they introduced Treatment Readiness Groups to prevent women on the wait list from changing their minds about entering treatment. Potential clients met with counselors in small Treatment Readiness Groups twice each week. Counselors used the groups to provide basic education about drug dependence, to receive personal updates from the women and to create strong and trusting relationships.

Agency staff noted, "By the time a person's name comes up on bed list they are already connected to us, so there are few no-shows."

Overcoming Barriers and Seeing Results

In 2003, Perinatal Treatment Services had only 26 licensed residential beds in its women's program, which severely limited the number of people it could admit. In September 2005, a change in the State Department of Health formula for licensing residential space gave the center four more beds.

Before the center could use the new beds to increase admissions, however, it had to solve another barrier: transportation. In 2003, Perinatal Treatment Services moved from central Seattle to a facility in north Seattle. The new location offered more space but was less accessible in that it required from two to four transfers on the bus. Most women didn't have cars, so getting to the center posed a real hardship.

Staff responded by creating a Monday to Friday pick-up and drop-off service in downtown Seattle, adjacent to the city transit transfer station. This change increased admissions and attendance and reduced no-shows.

In March 2004, before staff introduced these changes, Perinatal Treatment Services averaged five admissions to residential treatment per month. From January through June 2006, the program averaged 10 admissions per month, a 100 percent increase. The agency ended fiscal year 2006 with an overall occupancy of 94 percent, very close to its ambitious 95 percent goal.

The Adolescent Program: Increasing Admissions by Making "A Fresh Start"

In 2005, Perinatal Treatment Services' 16-bed residential program for pregnant and nonpregnant teens was floundering. Since opening in March 2003, the program's occupancy rate was less than 50 percent, and it had lost \$140,000 in its first 15 months of operation.

To address this problem, Perinatal Treatment Services applied the NIATx strategy of partnering with state substance abuse funding agencies, in this case the Division of Alcohol and Substance Abuse. Seim knew the state would take back funds if the adolescent program did not raise occupancy rates. "We were facing cuts of up to 50 percent," she recalled.

Seim also knew that the state had a strong investment in the success of her program, the only residential program for adolescents in Washington. The Division of Alcohol and Substance Abuse agreed to give Perinatal Treatment Services a one-time grant to analyze the problem and find a solution, and Seim promised that she would increase the occupancy rate to the break-even point of 80 percent.

State officials conducted a statewide online needs assessment and satisfaction survey, asking referral sources what they thought and knew of the Perinatal Treatment Services' program. The answers were eye-opening.

Few referral sources had heard of the program. Those who knew of it hesitated to refer non-pregnant girls because of concerns that mixing pregnant and nonpregnant teens would "romanticize pregnancy." The survey also showed that there were not enough pregnant and parenting teens with substance abuse problems to warrant a specialized program.

Seim and staff used this information to redirect services to better match community needs. They refocused the adolescent residential program on nonpregnant adolescent girls with substance abuse problems, and named it "Fresh Start."

The agency created a new brochure and used state funds to hire a temporary community outreach representative to visit agencies around the state and educate staff about Fresh Start. The State Division of Alcohol and Substance Abuse also notified treatment agencies across the state about Fresh Start.

This change project resuscitated the adolescent program. The Fresh Start census immediately increased from an average occupancy of 59 percent in April 2005 to 84 percent at the end of the project three months later. After state funds for the community outreach worker ended, Perinatal Treatment Services hired the person full time to sustain the gains.

The lesson for Seim is "Do not be afraid to be direct with your financial source regarding financial problems and ask them to partner with you to attain solutions."

NIATx Networking: Mutual Benefits

Applying the NIATx strategy of peer-to-peer networking yielded another boost in admissions. At one of the NIATx-sponsored learning sessions, Seim was chatting with Tim Smith, executive director of Daybreak, a Spokane, Wash.-based agency and another *Paths to Recovery* grantee agency serving adolescents.

Seim and Smith realized that while they might be perceived as competitors, in fact they had a great opportunity to collaborate. They created a strategy to co-market their programs and refer potential client's to each other's agency.

At the time, Daybreak was trying to change its payers from state funds only to commercial insurance. Perinatal Treatment Services was mandated to serve low-income people and could accept reimbursement only from the state. Perinatal Treatment Services agreed to send clients with commercial insurance to Daybreak. Daybreak in turn pledged to send state-funded clients to Perinatal Treatment Services.

Based on this successful collaboration, Seim's advice to other agencies is to consider partnering with facilities and programs despite competitive concerns.

Learn more about Daybreak in its [*sidebar*](#).

STANLEY STREET TREATMENT AND RESOURCES (SSTAR): INCREASED ADMISSIONS

SSTAR (Stanley Street Treatment and Resources) provides a range of services to residents of southeastern Massachusetts and Rhode Island. These include inpatient detoxification, substance abuse treatment, treatment for people dually diagnosed with

substance abuse and mental health problems, women's services, primary health care, family interventions and services for people with HIV/AIDS.

SSTAR's core program—inpatient detoxification—began in 1927 when SSTAR took over a tuberculosis hospital. SSTAR has always relied on its inpatient detoxification unit for a significant portion of its annual revenue. By 2004, however, this core program was losing \$300,000 per year, creating serious budget problems and worries for staff.

"There Must Be a Better Way"

Nancy Paull, SSTAR chief executive officer, was familiar with total quality management approaches that had been used in private industry but she had not been impressed with the results. "You'd sit in meetings of 10 to 12 people, the most expensive people in your organization. The value of their time had to be \$2,000 or maybe \$4,000. And nothing changed. Big projects, but nothing changed."

Paull knew there had to be a way to make improvements without draining staff resources. The shortfalls in the inpatient detoxification program were "keeping the chief executive officer awake at night" and were dragging down the agency. When Paull heard of *Paths to Recovery*, she thought that might be the better way.

Initial Steps: Calming the Chaos in Inpatient Detox

When Paull applied for a *Paths to Recovery* grant, she wanted to focus on reducing the number of people who left inpatient detox against medical advice after only two or three days. When people leave that early, they are more likely to relapse and it is hard for staff to keep beds occupied. Variations in occupied beds—the average daily census—affect the financial viability of the agency.

The "revolving door" of clients in SSTAR's regular detox unit and in its detox unit for people dually diagnosed with substance abuse and mental health problems created a chaotic atmosphere for staff and clients alike. Paull, who describes herself as a "relationship person and a bottom-line person," knew that if SSTAR did a better job engaging detox clients at the start, it would also raise the average daily census and be more financially stable.

As part of *their Paths to Recovery* grant applications, agencies had to conduct a "walk-through" of their admission process, introduce a change based on the walk-through and then report on the results. In walk-throughs, employees "apply" for admission and are processed as if they are clients.

Patricia Emsellem, SSTAR's chief operating officer laughs with some embarrassment as she describes the walk-through. "We had two staff people get admitted as patients to our detox facilities. A Fall River employee was admitted to our Rhode Island detox, and a

Rhode Island employee was admitted in Mass. Both employees had worked on our inpatient units for years and enthusiastically volunteered to go through the admission process, including staying in detox for two days.

They both bailed out by nightfall the first night. This was an eye-opener for all of us. Both "clients" were both highly anxious and felt confused and alone, frustrated by not knowing what to expect. In the Fall River walk-through, the "client's" description of difficulties getting through to admissions by phone was horrifying and embarrassing to us," she adds.

The walk-through "clients" reported that their anxieties dropped dramatically after they talked with a counselor. So, Paull and Emsellem designed a one-week test in which clients met with a counselor as soon as they showed up. The counselor told clients how long they would have to wait and why, answered questions, brought snacks or drinks if needed, showed the new clients through the unit and introduced them to staff and other clients.

These simple changes reduced the number of detox patients who left treatment during the first three days by 45 percent. The percentage of clients who left against medical advice dropped from 33 percent in June 2003, to around 23 percent after the rapid-cycle change exercise in June 2004.

Increasing Admissions to Inpatient Detox: Dually Diagnosed Patients

SSTAR received a *Paths to Recovery* grant of \$111,298 in January 2005. Emsellem led the agency's in-house change team responsible for implementing rapid-cycle changes.

Paths to Recovery helped agencies use rapid-cycle changes to make improvements in four key areas—reduce wait time to admission, increase admissions, reduce no-shows and improve retention in treatment. But, NIATx coaches advised agencies to address one challenge at a time.

SSTAR's change team decided to continue its focus on the core inpatient detox program.

Although the first rapid-cycle change reduced the number of patients who left detox against medical advice, the unit's average daily census—13.77 occupied beds at the end of June 2005—was still too low. Emsellem and the change team wanted to increase the average daily census in the detox unit for dually diagnosed patients to 14.77. This one-bed-per-day increase would mean \$116,000 more revenue per year.

But, before starting a project to increase the census, the change team had to address a problem with nurse staffing. So, SSTAR revamped its nursing orientation program. This change reduced mandatory overtime, lowered costs, and improved retention of new nurses.

The agency was now ready to tackle admissions.

Four Weeks, Four Changes: "If It Doesn't Work, Don't Use It."

By September 2005, the change team was ready to begin testing four strategies over a four-week period. Each strategy took a different approach to increasing the average daily census.

- In *week one*, the team placed a new admissions nurse in the detox unit Monday through Friday to expedite intake of patients.

"It didn't have the impact we thought it would," Emsellem recalls. "The census actually went down. Staff was less stressed but our solution—adding nursing coverage in admissions—didn't address the census problem. This shows that what you think intuitively is the way to solve a problem isn't always the case when you look at the data."

- In *week two*, SSTAR offered to transport dually diagnosed clients from psychiatric hospitals that were major referral sources for SSTAR. Drivers at these hospitals left at 1:00 p.m., so SSTAR offered to pick up patients after that time on two afternoons and to add an evening admission nurse to accommodate late-day admissions.

"This didn't do the trick either," says Emsellem, noting that no hospitals requested the service.

- In *week three*, the change team revised the way staff reviewed patient information faxed by referring hospitals. Team members recalled getting complaints from hospital staff that it took too long for their patients to be approved for admission. The hospital faxed patient information to a SSTAR intake worker, who took it to a nurse for review and approval. Sometimes that process took all day.

The change team looked at the history and realized that SSTAR had never refused an admission request coming from one of its five major referral hospitals. SSTAR therefore designated these five hospitals as priority referents. "We said 'let's waive the record review process for these hospitals and assure them if they called and we had a bed, we would say yes,'" said Emsellem.

By the end of the week, the average daily census reached 14.43. "We knew we were on the right track so we said 'let's make it even easier,'" recalls Emsellem.

- In *week four*, SSTAR established a special hotline for the hospitals. The hotline connected directly to a portable phone that the admissions clerk kept with her at all times. When staff from these hospitals called, the admissions clerk answered their questions immediately. When the clerk was unavailable, the nurse on the detox unit took the phone.
- With this change, the census rose to 15.86 by the end of the week—the highest census of any week in the unit's history.

Emsellem looks back on these changes. "That level has been sustained through September 2009. The lesson for SSTAR is that when we did rapid-cycle change projects we really saw what worked and what didn't, which was just as useful. Improved census, combined with increased beds on another unit, resulted in the inpatient department operating at an overall surplus for the first time in more than decade."

The Case of a Homeless Front-Line Worker: NIATx and Jobs to Careers/the Synergy of Two RWJF National Programs

Through participating in NIATx and *Paths to Recovery*, SSTAR increased its average daily census, increased admissions and strengthened the bottom line. But, says Paull, "We still needed the staff to serve more patients. If the staff didn't have the necessary training—as a certified addiction counselor, for example—we couldn't bill for the services."

This challenge was brought home to Paull when she received a desperate call from a long-time employee who, with her four children, was about to become homeless. This employee "worked every day," but because the program's pay levels were low "we had made her poor," Paull said. The situation brought Paull to tears, but she was able to do something about it thanks to *Jobs to Careers*, an RWJF national program providing work-based training to frontline health care workers.

In this case, SSTAR's board of directors gave the employee a bonus based on years of service, which enabled her to pay a security deposit and first month's rent at a new apartment. The employee enrolled in *Jobs to Careers* where she received training as a billing clerk and went on to become a billing manager.

As a *Jobs to Careers* grantee, SSTAR receives technical assistance and other resources to help its employees learn and apply new skills while on the job. Resources from *Jobs to Careers* also prepare workers to earn their certified addiction counselor credential. Some 17 SSTAR employees participated in the certified addiction counselor track 2009. Fifteen of them had increased their earnings and accumulated credits they could apply toward the higher associate's degree.

Drawing from lessons learned in *Paths to Recovery* and tools available on the NIATx Web site, SSTAR administrators can measure how their investment in staff training translates into bonuses and increased wages for staff, a healthier bottom line for the agency and better quality of care for patients.

GOSNOLD ON CAPE COD: INCREASING RETENTION AND COMPLETION RATES IN INPATIENT TREATMENT

Gosnold on Cape Cod is the largest provider of addiction and mental health services on Cape Cod, with five inpatient and eight outpatient clinics located across Cape Cod and southeastern Massachusetts.

Inpatient services include a 50-bed detoxification and stabilization program, a 33-bed residential treatment center for men, a 44-bed residential center for pregnant and parenting women and teens and a 40-bed rehabilitation program.

A Challenge and an Opportunity

A 2002 fiscal crisis in Massachusetts resulted in a severe reduction in funds for substance abuse services. Raymond Tamasi, Gosnold CEO, knew he would have to improve internal systems to maximize the agency's efficiency and quality to sustain his agency in this tight fiscal environment.

Gosnold had invested over \$300,000 in an agencywide practice management software system that would coordinate clinical and administrative services. Gosnold was also using evidence-based interventions and best practices to guide its treatment services.

These top-down driven improvements increased operational efficiency but were not creating a culture of change in the agency as a whole. When Tamasi heard about *Paths to Recovery*, he saw an opportunity to help Gosnold achieve systemic changes.

The Walk-Through: Identifying the Problem

NIATx required that *Paths to Recovery* applicants conduct "walk-throughs" as part of their proposals. In walk-throughs, employees request help from their agency as if they are clients. Staff then had to conduct a rapid-cycle change project to address a problem uncovered in the walk-through and report the outcome in their proposals.

Tamasi didn't start out thinking the walk-through would lead to many changes. "I had read about it, but until you do a walk-through you don't know how valuable it is. In January 2003, I flew to Chicago for the *Paths to Recovery* applicant workshop and came back with a booklet and little bits of knowledge. We read the instructions and just did it. It was amazing to see the difference between what you think you're doing and what you are actually doing."

Tamasi, a 30-year veteran in the treatment field, speaks passionately about the walk-through. "It was a call to action. Many of the ideas exposed to us as we tried the walk-through helped us highlight our mission. It filled the gap between our high ideals and our reality and brought us back to our initial orientation of reaching out to the customer.

"Our systems thinking was there but we didn't know how to formalize it. We had lots of quality measures and tons of evaluative data on specific aspects of programming and services. We were going in the right direction but lacked the mechanism that NIATx provided. From the beginning, the walk-through was a great instructional tool, letting us drill down to the data bits that would allow us to improve."

Gosnold conducted four walk-through exercises as part of the grant application. In one, a "patient" requested admission to the inpatient detoxification unit. It took more than two hours for the "patient" to be admitted, during which time she interacted with seven different staff members who were often performing other tasks, such as answering phones.

During the walk-through exercise, staff interviewed recently admitted patients about their experiences. These patients confirmed that a long wait left them with negative first impressions, which in turn made it harder to stay engaged in treatment. As one nurse said, "what happens in the first 20 minutes to a patient can dictate their entire stay. If it's bad, it's uphill the whole way on."

The NIATx Rapid-Cycle Change: Testing a Solution

In April 2003, Tamasi and Tommie Ann Bower, Gosnold's director of program development and quality, led the agency's in-house change team in a simple, two-week rapid-cycle change project. The goal was to cut the time from patient arrival at the program the onset of treatment to no more than one hour.

In this change project, a nurse (not an aide or admissions clerk) met the patient in a special triage room as soon as he or she arrived. The nurse immediately assessed whether the patient was an urgent or routine admission and sent urgent cases to an exam room, postponing non-urgent admission tasks until the patient was settled. This protocol reduced the number of people new patients had to interact with and reassured patients that the person meeting them had the skills and authority to help.

During the two-week test, 57 percent of patients were admitted in less than one hour, 21 percent took between one and three hours and only 4 percent took two hours or more. Information was not collected on 18 percent of patients. This project also demonstrated that, with the right tools, employees were willing to become involved in a learning community and take shared ownership of a project.

Increasing Continuation in Detox: The "R" and "No Wrong Staff"

Based on its strong *Paths to Recovery* application, Gosnold on Cape Cod received a *Paths to Recovery* grant from RWJF in September 2003.

Paths to Recovery helped agencies use rapid-cycle changes to make improvements in four key areas—reduce wait time to admission, increase admissions, reduce no-shows and improve retention in treatment—and then incorporate the NIATx model of rapid-cycle changes into their way of doing business. But, NIATx coaches advised agencies to address one challenge at a time.

Using technical assistance, toolkits, a coach provided by NIATx and the momentum of a newly energized Gosnold staff, Tamasi and Bower decided to start by trying to increase retention rates in the agency's inpatient detoxification program.

A quarter of the 2,846 patients admitted to the detoxification and rehabilitation unit in 2004 left prematurely, but no one knew exactly why they left or who was at risk or leaving early.

To learn why patients left early, Tamasi called an all-staff meeting to solicit insights of frontline staff normally excluded from clinical matters. During the meeting, it became clear that dietary, maintenance and housekeeping staff often knew who was at risk for leaving, but they had no mechanism to communicate their concerns.

The group devised a new procedure. Any of the 50 or more employees could ask that an "R" be placed on a central board next to the name of a patient considered to be at risk of leaving. Staff made special efforts to focus on these patients and engage them in treatment. After this procedure was implemented, 85 percent of patients completed detoxification, compared to 75 percent at baseline.

This positive experience prompted Tamasi to establish a "no wrong staff" network to sustain the gains and expand the approach to other areas of the organization.

The network paid off. For example, during a routine encounter, a staff member in patient accounts learned that a patient was ready to leave the program and asked what she could do to convince him to stay. The frustrated patient revealed that no one was helping him get papers signed for his employer. The staff member promised to find the right person to process the paperwork and did.

The papers were signed and the patient remained in the program. He returned to the employee 14 days later to thank her for helping him make the decision to stay. As an added bonus, he later made a substantial donation to Gosnold.

Increasing Retention in the Men's Residential Facility: Miller House

Next, Tamasi and Bower turned to Miller House, a 60–90 day residential treatment program for men age 16 and older. In early 2004, only 57 percent of men completed their stay in this program. The 43 percent who dropped out were highly likely to relapse into

substance use shortly after leaving treatment. Previous "fixes" by Gosnold staff, including adding supervision of the men and educating staff, had not worked.

Tamasi and Bower created a new change team comprised of a former resident, seven employees not involved with prior rapid-cycle change projects and one "veteran" of two other teams. This change team met with program graduates about their experiences in treatment. The men said they liked the small group sizes and strong staff commitment. They were critical of the social environment and described tensions between older and younger residents.

Based on these insights and a review of records showing that younger men had higher rates of relapse and discharges for disruptive behavior than older men, the change team divided the men into two age groups. Men in their late teens to early twenties joined the Miller Intensive Treatment group, which provided more time for physical activity, additional time with staff and treatment meetings held outside of the unit. Older men remained in the original Miller House program.

Residents and staff noticed that tension decreased and the atmosphere seemed more conducive to treatment progress. Younger men especially liked the opportunities for more staff interaction and off-campus treatment meetings.

Despite the popularity of this change among residents, three out of eight young men in the Miller Intensive Treatment group soon relapsed into substance abuse and left the program.

Back to the Drawing Board: Three More Changes

When the change team realized that the younger men continued to leave residential treatment prematurely, it reviewed the data and came up with three new changes.

First, the team borrowed the strategy that had worked in the detox program. If a client showed ambivalence about staying in treatment, a staff member placed an "R" on the chart next to his name. Other staff were notified and at least five—including nurses, counselors and counselor aides—talked to the patient about his feelings and explained why he should remain in the program.

Second, a staff member created a "residential continuance contract" to review with "R" patients every two days. These contracts recorded the patient's commitment to remain in treatment for the next 48 hours. The contracts were repeated in as many cycles as necessary to help the person to stay on track with treatment.

Finally, the change team knew that relapses were more likely to happen when residents received weekend passes early in their treatment. The team changed the protocol to restrict these passes during the first month of residence.

Sharing the Rapid-Cycle Change Model with Patients

With a further review of change results, Gosnold decided that there was room for one more strategy to improve men's treatment continuation rates. Since rapid-cycle changes had worked so well for staff, Bower and the change team decided to share them with men in treatment as a useful tool in the recovery process.

The team created a form with a grid for the men to complete every week. Using the grid as a template, residents identified and recorded physical, mental and spiritual improvements they planned to make during the coming week. Aims included specific activities such as quitting smoking, praying more often, losing weight.

These rapid-cycle change projects for residents shifted treatment discussions from a focus on feelings to a focus on reaching goals and solving problems. They quickly became an integral component of treatment at Miller House.

Within four months of completing the series of changes, the treatment completion rate for the men's residential treatment program at Gosnold had risen from the baseline of 57 percent to 75 percent. And patient satisfaction with their care at Miller House saw a dramatic increase from a range of 60 percent to 70 percent to 100 percent.

JACKIE NITSCHKE CENTER: INCREASING RETENTION IN TREATMENT

The [Jackie Nitschke Center](#), located on a quiet side street in Green Bay, Wis., has a history of helping people with substance abuse problems. The center opened in 1971 as Samaritan House, a halfway house for women and men discharged from the area's alcohol residential treatment center. When that center closed in 1995, Samaritan House took its place as the primary residential treatment source in the area.

In February 1997, Samaritan House changed its name to the Jackie Nitschke Center to honor the wife of former Green Bay Packer football star Ray Nitschke. Jackie Nitschke was the first prominent woman in the community to publicly announce her own addiction to alcohol.

A Small Center Joins a Big Program

In September 2003, the Jackie Nitschke Center received a grant under *Paths to Recovery*. With just 14 beds, Jackie Nitschke was the smallest of the 23 grantees and, like other small agencies, had been isolated from other centers. "We had little contact with the outside world," said William LaBine, chief executive officer. With two-thirds of its funds

coming from county contracts, the center had few resources for conferences or employee training, so staff made do with in-house training from manuals.

LaBine attended the *Paths to Recovery* grant application workshop held in January 2003. He came away excited and convinced that NIATx Director David Gustafson, Ph.D., and his team were "really dedicated to making improvements for patients—and taking better care of staff."

The Change Exercise: Engaging Clients When they Walk in the Door

As part of their *Paths to Recovery* grant application, staff had to conduct a "walk-through" of their agency's admission process and report on the results. In walk-throughs, employees "apply" for admission and are processed as if they are clients.

The walk-through convinced Jackie Nitschke's staff that they needed to alleviate the loneliness clients felt when coming to their first group treatment session. A change team consisting of five counselors and LaBine generated a list of 15 ideas for changes in the way clients were admitted to outpatient treatment. Team members discussed each idea and took turns role-playing a new client to identify which ideas might be most effective.

Based on feedback from these "clients," staff started by creating a more welcoming environment, sprucing-up the group therapy rooms with soft lighting and pictures. The goal was to reduce the apprehension most clients felt when they started their outpatient sessions—and increase the likelihood that they would continue.

Then, staff invited new clients to arrive 15 minutes early for their appointment. A counselor stood at the door to greet new clients and give them a tour of the facility. The counselor also introduced new clients to a peer who served as a "buddy" during the early stages of treatment.

The result? Before these changes, nine of 13 outpatient clients who completed a written survey admitted to feelings of anxiety or fear during their initial group treatment session. Afterwards, only one client of five surveyed reported feeling anxious or fearful.

Center leaders quickly saw that staff as well as patients benefited from these changes. Each time staff members met to discuss an issue and develop a plan of action, they seemed to be more "energized," said Judith Glenz, former executive director. Process improvements gave staff more control over their work environment and made them more willing to take an active role in implementing the changes.

Step One: Increasing Retention by Increasing Access

Paths to Recovery helped agencies use rapid-cycle changes to make improvements in four key areas—reduce wait time to admission, increase admissions, reduce no-shows

and improve retention in treatment. But, NIATx coaches advised agencies to address one challenge at a time.

When the center received its *Paths to Recovery* grant in September 2003, its leaders began a several-step process that spanned a client's entire involvement with the program, from the first call for help to joining the alumni group. All the steps aimed to increase the percentage of clients who remained in treatment. Jackie Nitschke and most other *Paths to Recovery* grantees found that one improvement led to another.

In Jackie Nitschke's case, staff realized that if the center made it easier for clients to enter intensive outpatient treatment, they would be more likely to remain once they started. Data indicated that patients were waiting up to 10 days between their first call for help and their first outpatient treatment session, and many dropped out before they finished.

The change team started by improving the way staff responded to initial calls from clients. All staff received training in how to make appointments on the spot, rather than asking the client to call back or transferring the call to someone else. Unless clients had a good reason for delay, they were given the first available appointment for an assessment and expected to start treatment that night.

To support this change, the center increased the number of assessment appointments and made more staff available to conduct the assessments. Staff also received training in motivational interviewing in order to convince new patients of the importance of starting their treatment the same night as the assessment.

The result? The time from the client's first call for service to the first day of intensive outpatient treatment dropped from nine days in June 2003 to less than four in August 2004.

A related bonus? Retention for the first four days of treatment also rose and consistently remained around 90 percent during this period. To sustain the improvements, the center created a policy that made the new procedures the "usual way of doing business."

Step Two: Engaging Clients in Aftercare and Keeping Them There

Changes that succeed often have a ripple effect—they create more opportunities that lead to more challenges, according to LaBine, who took over as executive director when Glenz retired.

Making it easier for clients to enter treatment increased the number who attended outpatient treatment. But the success on the front end had the unintended consequence of making it harder for counselors to prepare and engage clients for their next step to sustained recovery—the aftercare program.

Ideally, clients begin the center's free, 16-week aftercare program within a few days after they graduate from the 18-session intensive outpatient treatment program. In responding to the increased demands of seeing more patients in intensive outpatient services, counselors began to let a week or two pass before engaging clients in aftercare.

Counselors also sometimes rushed through paperwork and discharge planning with clients completing intensive outpatient. These activities were supposed to be done with the client as part of the last individual session, giving the counselor time to talk to the patient about the importance of aftercare. Instead, overworked counselors were doing this work during breaks, without an opportunity to talk personally with clients.

Staff began to notice an increase in no-shows to aftercare and a decrease in the number of clients completing aftercare. The change team then set a goal of increasing the percentage of clients who attended the first five aftercare sessions from 38 percent to 80 percent and the percentage of people completing all 16 sessions from 46 percent to 70 percent.

Glenz searched the data for clues about factors that motivated clients to enroll in the aftercare program and stay in it. She looked for similarities among people who completed aftercare and shared her findings with staff. Staff also participated in a walk-through and interviewed clients in aftercare. "Walk-through was a tool we used throughout the project," says LaBine.

The change team selected the most promising ideas from a list generated by the walk-through and by Glenz' analyses, which indicated that patients who attend all of the first five aftercare sessions are more likely to complete all aftercare sessions.

"We got started right away", said LaBine, "designing changes based on the data Judy provided on successful aftercare patients. Staff changed the admission documents to include instructions stressing the need to start aftercare right away, the importance of punctuality and emphasizing the rule allowing no more than two absences during the 16-week period. We also invited a client who missed an appointment in the first five weeks to participate in a staffing session to plan how they could be successful in aftercare because the data showed that missing early on predicted dropping out."

The result? The changes were dramatic: Among a group of clients who began aftercare under the new system, 83 percent completed the first five sessions and 63 percent completed all 16 sessions. Based on these results, the improvements became agency policy.

Step Three: Increasing Participation in the Alumni Group

The change team then addressed ways to increase participation in the Jackie Nitschke alumni group, the last component in the continuum of services. Formed in 1999, the

alumni group meets twice monthly to provide support and therapy to graduates of the aftercare program. Like the aftercare program, the alumni group is free.

In 2004, the alumni group had only three or four members, recalls LaBine. One of the alumni, who was also a member of the center's change team decided to do something about the low level of participation. The change team designed a rapid-cycle change project that involved inviting aftercare clients to attend an alumni group session earlier, after completing their 10th aftercare session.

People arrested for driving under the influence are a big part of center business. These individuals must complete the 18-session intensive outpatient program and the 16-session aftercare program to reclaim their driver's license. The change team introduced a protocol in which attending an alumni session counted as one of the mandatory aftercare sessions, an incentive for clients to accept the invitation—and hopefully be persuaded to join.

The persuasion—and the improvements—worked. From 13 to 15 clients were actively participating in the alumni group in 2009, giving support as well as receiving it. Alumni help each other and they reach out to clients in residential treatment, facilitating study groups and creating the Alumni Fun Day and the Gratitude Party. One client said, "I am truly honored to be a part of this because it allows me to 'carry the message' and help others."

Summing Up

The center had 15 employees in 2009, up from 12 in 2003. Each year it sets new records for the number of days of care provided and, therefore, the amount of revenue received. The center decided to accept clients with a dual diagnosis of substance abuse and mental health disorders, a group the leaders would not take in the past. The use of evidence-based practices, a big part of *Paths to Recovery*, gave LaBine and the Jackie Nitschke staff confidence that they could succeed in helping these more complicated patients.

Prepared by: Jayme Hannay

Reviewed by: Mary Nakashian and Molly McKaughan

Program Officers: Ann P. Pomphrey and Victor Capoccia

APPENDIX 1

Paths to Recovery National Advisory Committee Members

First National Advisory Committee

Walter Bland, M.D.

Assistant Professor
Department of Psychiatry
Howard University Hospital
Washington, D.C.

Frances Cotter

Center for Substance Abuse Treatment
Substance Abuse Mental Health Services
Agency (SAMHSA)
Rockville, Md.

Arthur C. Evans, Ph.D.

Deputy Commissioner
State of Connecticut
Department of Mental Health & Addiction
Services
Hartford, Conn.

Dean Lea

Principal, Tupelo Group
Burlington, Vt.

James C. May, Ph.D.

Director of Substance Abuse Services
Richmond Behavioral Health Authority
Richmond, Va.

Kevin Norton

President & CEO
CAB Health & Recovery Services
Danvers, Mass.

Carole Otero

Former Director, Albuquerque Metropolitan
Central Intake
Albuquerque, N.M.

Paul Plsek

President
Paul Plsek Associates
Roswell, Ga.

Susan Rook

Communications and Outreach Director
Faces and Voices of Recovery
Alexandria, Va.

Richard Suchinsky

Associate Chief Consultant for Addictive
Disorders
U.S. Department of Veterans Affairs
Washington, D.C.

Ann S. Uhler

Former Executive Director
CODA, Inc.
Tigard, Ore.

Thomas Zastowny, Ph.D.

Director of Research and Evaluation
Coordinated Care Services, Inc.
Rochester, N.Y.

Final National Advisory Committee

Victor Capoccia, Ph.D.

Project Director
Open Society Institute
Baltimore, Md.

John Daigle

Independent Consultant
Former President, Florida Alcohol and Drug
Abuse Association
Tallahassee, Fla.

Dean Lea

Principal, Tupelo Group
Burlington, Vt.

APPENDIX 2

Fully Funded Paths to Recovery grantees (Round I and Round II)

Round I: Starting September 2003

Acadia Hospital Corp. (Bangor, Maine)

ID# 049451 (September 2003 to June 2006): \$227,131

Project Director:

Scott O. Farnum, L.C.P.C.

(207) 973-6077

sfarnum@emh.org

Barnwell County Commission on Alcohol and Drug Abuse (Barnwell, S.C.)

ID# 049466 (September 2003 to June 2006): \$219,420

Project Director:

Cheryl Azouri Long, C.A.C. II, N.C.A.C. II, C.S.P.P.

(803) 541-1245

clong@axis1.org

Brandywine Counseling, Inc. (Wilmington, Del.)

ID# 049458 (September 2003 to June 2006): \$182,060

Project Director:

William James Harrison

(302) 656-2348

jharrison@brandywinecounseling.org

Daybreak (Spokane Valley, Wash.)

ID# 049456 (September 2003 to June 2006): \$179,556

Project Director:

Richard A. Miles

(509) 624-3227, ext. 14

rmiles@daybreakinfo.org

Gosnold on Cape Cod (Falmouth, Mass.)

ID# 049446 (September 2003 to June 2006): \$214,296

Project Director:

Raymond V. Tamasi

(508) 540-6550
rtamasi@gosnold.org

Jackie Nitschke Center, Inc. (Green Bay, Wis.)
ID# 049460 (September 2003 to June 2006): \$202,756

Project Director:
William LaBine
(920) 435-2093
nitschke@bayland.net

Kentucky River Community Care Inc. (Jackson, Ky.)
ID# 049462 (September 2003 to June 2006): \$220,284

Project Director:
Robert Jackson, M.S.
(606) 666-9006
krccrjackson@yahoo.com

Perinatal Treatment Services (Seattle, Wash.)
ID# 049463 (September 2003 to June 2006): \$208,075

Project Director:
Kay Seim
(206) 223-1300, ext. 228

Prairie Ridge Addiction Treatment Services (Mason City, Iowa)
ID# 049447 (September 2003 to June 2006): \$183,217

Project Director:
Mark Dodd
(641) 424-2391
mdodd@prairieridge.net

St. Christopher's Inn, Inc. (Garrison, N.Y.)
ID# 049465 (September 2003 to June 2006): \$193,234

Project Director:
David Gerber
(845) 424-3616, ext. 285
dgerber@atonementfriars.org

Round II: Starting January 2005

Asian Counseling and Referral Service (Seattle, Wash.)

ID# 052370 (January 2005 to June 2006): \$111,000

Project Director:

Yoon Joo Han, M.Ed., M.S.W.

(206) 695-7591

yoonyooh@acrs.org

Central New York Services, Inc. (Syracuse, N.Y.)

ID# 052379 (January 2005 to June 2006): \$110,890

Project Director:

Mathew R. Roosa, L.C.S.W.

(315) 478-2453

Comprehensive Options for Drug Abusers, Inc. (Portland, Ore.)

ID# 052371 (January 2005 to June 2006): \$110,905

Project Director:

Janet L. Bardossi, L.C.S.W.

(503) 239-8400, ext. 216

janetbardossi@codainc.org

Cornerstone Counseling Center (Salt Lake City, Utah)

ID# 052437 (January 2005 to June 2006): \$111,327

Project Director:

Steven Kay, Psy.D.

(801) 355-2846

skay@cornerstoneslc.com

Fayette Companies (Peoria, Ill.)

ID# 052438 (January 2005 to June 2007): \$110,239

Project Director:

Michael G. Boyle

(309) 671-8025

mboyle@fayettecompanies.org

Gateway to Prevention and Recovery Inc. (Shawnee, Okla.)

ID# 052372 (January 2005 to June 2006): \$110,737

Project Director:

Marilyn L. Thoms, B.A.

(405) 273-1170, ext. 118

mthoms@gatewaytoprevention.org

Mid-Eastern Council on Chemical Abuse (MECCA) (Iowa City, Iowa)

ID# 052373 (January 2005 to June 2007): \$111,686

Project Director:

Angela Thiesen, M.S.

(515) 262-0349

athiesen@meccaia.com

Palladia Inc. (New York, N.Y.)

ID# 052374 (January 2005 to June 2007): \$110,700

Project Director:

Debra Pantin, M.S.W.

(212) 979-0100

debbie.pantin@palladiainc.org

Signal Behavioral Health Network (Denver, Colo.)

ID# 052375 (January 2005 to June 2006): \$110,804

Project Director:

Michael G. Allen, L.C.S.W., C.A.C. III (no longer at Signal)

Southwest Florida Addiction Services, Inc. (Fort Myers, Fla.)

ID# 052376 (January 2005 to June 2007): \$110,354

Project Director:

Chrissy L. DeWerff

(239) 278-7595

c_dewerff@swfas.org

Stanley Street Treatment and Resources (SSTAR) (Fall River, Mass.)

ID# 052377 (January 2005 to June 2006): \$111,298

Project Director:

Patricia N. Emsellem, M.S., L.A.D.C.I.
(508) 324-3599
pemsellem@sstar.org

STEPS at Liberty Center, Inc. (Wooster, Ohio)

ID# 052378 (January 2005 to June 2006): \$111,428

Project Director:

J. Charles Ross, L.I.S.W., L.P.C.C.
(330) 264-8498
rossc@steps-ewh.org

Women's Recovery Association of San Mateo County, Inc. (Burlingame, Calif.)

ID# 052449 (January 2005 to June 2006): \$114,414

Project Director:

Susie Finch, M.F.T.
(650) 348-6603, ext. 205
sfinch@womensrecovery.org

APPENDIX 3

Promising Practices for Improvement Projects

Staff at NIATx compiled the following list of promising practices gleaned from their work with substance abuse treatment agencies using rapid-cycle change projects:

Improve Timeliness (Reduce Waiting Time)

- Reduce intake and assessment paperwork.
- Offer assessments every day and in the evening.
- Use open schedules.
- Double-book assessments.
- Allow walk-in appointments.

Reduce No-Shows

- Get patient to the first appointment quickly.
- Address barriers patients face in attending assessment appointment.

- Clearly explain to the client what he/she can expect at first appointment.
- Model communication with the patient on motivational interviewing/enhancement techniques.
- Make reminder calls to patients scheduled for an assessment.

Increase Admissions

- Target marketing.
- Build lasting relationships with referral "customers" and measure referrals.
- Building Capacity: Develop/expand new or existing programs.
- Reshaping Capacity: Reduce admission steps.
- Reshaping Capacity: Reduce paperwork.

Increase Continuation

- Scheduling—e.g., connect patient to counselor and other support staff within 24 hours of admission.
- Provide a welcoming live or video orientation, establish clear two-way expectations and assign a peer buddy.
- On an ongoing basis, identify patients at risk of leaving and barriers to continuing in treatment. Resolve barriers to continuing in treatment.
- Maintain counselor resiliency with staff collaboration and personal care/development.
- Tailor treatment to patient's individual circumstances and needs; use individual client-driven treatment plans.
- Along with a variety of educational and treatment activities, have fun.
- Offer positive reinforcements for continuing in treatment.

APPENDIX 4

STAR-SI Participants and Program Framework

Participating State Agencies

Funded by RWJF

- New York State Office of Alcoholism and Substance Abuse Services, Menands
- Oklahoma Department of Mental Health and Substance Abuse Services, Oklahoma City

Funded by CSAT

- Florida State Department of Children and Families, Tallahassee
- Illinois State Department of Human Services, Chicago
- Iowa State Department of Public Health, Des Moines
- Maine State Department of Health and Human Services, Augusta
- Ohio State Department of Alcohol and Drug Addiction Services, Columbus
- South Carolina State Department of Alcohol and Other Drug Abuse, Columbia
- Wisconsin State Department of Health and Family Services, Madison

Self-Funded

- Montana Department of Public Health and Human Services, Helena

STAR SI Program Framework

NIATx staff developed a State Diffusion Model based on lessons from the state pilot projects. The model includes five core components:

- State leadership
- Payer/provider partnerships
- An access and retention improvement network
- State performance management to track progress and provide feedback
- Sustainability and spread

Using the State Diffusion Model as a framework, NIATx helps participating state agencies:

- Use peer-to-peer learning networks to help providers and state agencies use process improvement techniques.
- Create partnerships with outpatient treatment providers and key fiscal intermediaries.
- Implement a performance management system to track progress and provide feedback on outcomes.

As part of their process improvement efforts, these state agency grantees are making fiscal, regulatory and policy changes to remove barriers and create incentives to improve treatment access and retention. These activities make STAR-SI different from *Paths to Recovery* or STAR, both of which focused on changing front-line services.

NIATx coaches help STAR-SI grantees create collaborative infrastructures that support process improvement at the state and provider level. If successful, these infrastructures should empower treatment agencies to honestly report problems and should help state officials understand how state policies create barriers to treatment access and retention.

State agencies report on the following outcome measures:

Number of treatment providers participating in the state

Number of unduplicated client admissions to participating providers' programs

Client length of stay in participating programs

Number of units of service provided between intake and discharge

These state agencies also report on at least two state-specific access and/or retention measures. One of these measures must address timeliness to get to treatment such as the number of first contacts that continue to admission, time from first contact to admission and number of clients who proceed from admission to succeeding units of service.

BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

National Program Office Bibliography

Articles

Bartlett JB. "From the Field: Improving Addiction Treatment Services: The Need." *Alcoholism & Drug Abuse Weekly*, November 11, 2002.

Enos GA (ed.). "Reforming the Process of Care." *Addiction Professional*. Posted January 1, 2007. Available [online](#).

Fitzgerald M. "Operator Assistance with Process Improvement." *Behavioral Healthcare and Management*, 20–22, May 2006. Available [online](#).

Fitzgerald M. "Improving Substance Abuse Treatment Delivery." *Counselor, The Magazine for Addiction Professionals*, 7(4): 47–50, 2006. Available [online](#).

Fitzgerald M. "St. Christopher's Inn Counselor Among the First to be Certified as a NIATx Change Leader." *Alcoholism and Drug Abuse Weekly*, 18(45): 5, November 2006. Available [online](#).

Fitzgerald M. "Time to Take Action." *Behavioral Healthcare*, 27(9), 2007. Available [online](#).

Fitzgerald M. "Measuring Outcomes Enhances Addictions Treatment Access and Retention." *National Council Magazine*, 2, 2007. Available [online](#).

Fitzgerald M and Evans A. "Inspiring Change Leaders." *Behavioral Healthcare*, 26(10): 14–16, October 2006.

Fitzgerald M and Ford J. "Helping States and Providers Work Together." *Behavioral Healthcare*, 27(5), May 2007. Available [online](#).

Gustafson DH. "From the Field: Designing Systems to Improve Addiction Treatment: The Foundation." *Alcoholism & Drug Abuse Weekly*, November 4, 2002.

Holloway DC. "Improving Addiction Treatment Services: The Opportunity." *Alcoholism & Drug Abuse Weekly*, November 25, 2002.

Insinger A. "In One of Its Last Grants to Field, RWJF Focuses on Sustainability." *Alcoholism and Drug Abuse Weekly*, 18(47), December 2006.

Insinger A. "Tempered Hopes for Federal Progress Have Field Leaders Looking Inward for '07." *Alcoholism and Drug Abuse Weekly*, 19(1), January 2007.

Insinger A. "Massachusetts Agency to Bring Efficiencies to New Outpatient Services." *Alcoholism and Drug Abuse Weekly*, 19(3), January 2007.

Insinger A. "Process Improvement Goes National with Announcement of Campaign." *Alcoholism and Drug Abuse Weekly*, 19(39), October 2007. Available [online](#).

Molfenter T. "From the Field: Designing Organizational Systems to Improve Treatment: The Process(es)." *Alcoholism & Drug Abuse Weekly*, Monday, November 18, 2002.

Reports

NIATx Business Case Series. Madison, WI: NIATx National Program Office at the University of Wisconsin-Madison, 2007. Available [online](#).

NIATx Change Bulletin. Madison, WI: NIATx National Program Office at the University of Wisconsin-Madison. 2006.

Reynard S. *NIATx Workbook: An Introduction to the NIATx Model of Process Improvement*. Madison, WI: National Program Office at the University of Wisconsin-Madison, Undated. Available [online](#).

Uzoigwe C. (Research Brief) *The Network for the Improvement of Addiction Treatment (NIATx): Process Improvement in Addiction Treatment*. Princeton, NJ: Robert Wood Johnson Foundation, Number 4, April 2007. Available [online](#).

World Wide Websites

www.niatx.net. The website contains a portfolio of online tools, publications and networking opportunities to teach individuals and agencies to apply the NIATx model of process improvement. The site includes a toolbox with training on topics such as walk-throughs and group process techniques, a Weblog for peer discussion groups and a secure portion for members to report data and track progress.

Presentations and Testimony

Lynn Madden, "Utilizing Rapid Cycle Process Improvement to Improve Access and Retention in Healthcare Settings and to Advance Organizational Strategic Goals," at the APHA Scientific Session, November 2006. Available [online](#).

Dave Prescott. Lynn Madden. Scott Farnum. "Utilizing Rapid-Cycle Process Improvement To Improve Access and Retention In Healthcare Settings And To Advance Organizational Strategic Goals," at the APHA 134th Annual Meeting and Exposition, November 7, 2006, Boston. Available [online](#).

Dave Gustafson at the 21st Annual Rosalynn Carter Symposium on Mental Health, November 3, 2005, Atlanta. Available [online](#).

Jay Ford, Jennifer Glover, Jennifer Wisdom, "Drug Treatment Program Adoption of Information Technology Systems to Guide Data-Driven Decision-Making," at the Addictions Health Service Research Conference, October 24, 2005, San Diego. Available [online](#).

Evaluation Bibliography

Book Chapters

McCarty D, Capoccia VA and Gustafson DH. "Quality Improvement in Addiction Treatment." In *Principles of Addiction Medicine: Fourth Edition*. Ries R, Fiellin D, Miller S and Saitz R (eds.), pp. 433–440. Philadelphia: Lippincott, Williams & Wilkins, 2009.

Articles

Capoccia VA, Cotter F, Gustafson DH, Cassidy E, Ford J, Madden L, Owens BH, Farnum SO, McCarty D and Molfenter T. "Making 'Stone Soup': Improvements In Clinic Access and Retention In Addiction Treatment." *Joint Commission Journal on Quality and Patient Safety*, 33(2): 95–103, 2007.

Ford JH, Green CA, Hoffman KA, Wisdom JP, Riley KJ, Bergmann L and Molfenter T. "Process Improvement Needs in Substance Abuse Treatment: Admissions Walk-through Results." *Journal of Substance Abuse Treatment*, 33(4): 379–389, 2007. Available [online](#).

Hoffman KA, Ford II JH, Dongseok C, Gustafson DH and McCarty D. "Replication and Sustainability of Improved Access and Retention within the Network for the Improvement of Addiction Treatment." *Drug and Alcohol Dependence*, 98: 63–69, 2008. Available [online](#).

McCarty D. "Performance Measurement for Systems Treating Alcohol and Drug Problems." *Journal of Substance Abuse Treatment*, 33: 353–354, 2007.

McCarty D, Gustafson DH, Wisdom JP, Ford J, Choy D, Molfenter T, Capoccia V and Cotter F. "The Network for the Improvement of Addiction Treatment (NIATx): Enhancing Access and Retention." *Drug Alcohol Dependence*, 88(2–3): 138–145, 2007. Abstract available [online](#).

McCarty D, Gustafson DH, Capoccia V and Cotter F. "Improving Care for the Treatment of Alcohol and Drug Disorders." *Journal of Behavioral Health Services & Research*, 36(1): 52–60, 2009. Abstract available [online](#) (scroll down to abstract).

Molfenter T, Sets C, Dodd M, Owens B and McCarty D. "Reducing Errors of Omission in Chronic Disease Management." *Journal of Interprofessional Care*, 19: 521–523, 2005.

Wisdom JP, Ford JH, Hayes RA, Hoffman K, Edmundson E and McCarty D. "Addiction Treatment Agencies' Use of Data: A Qualitative Assessment." *Journal of Behavioral Health Services and Research*, 33(4): 394–407, 2006. Abstract available [online](#).

PROJECT LIST

- Does Process Improvement in Substance Abuse Treatment Agencies Change Client Outcomes? (Grant ID# 64146, January 2012)