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RECOVERY NETWORK
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**Foundations Recovery Network Wins National Award for Improving Patient Experiences and Recovery Rate**

**FRN's Culture and Dual Diagnosis Approach Fit Well with Patient Experience Management**

Since Foundations Recovery Network (FRN) was founded, it has been committed to the success of its patients. Its vision is: "To be the best at delivering effective, lasting treatment and providing superb experiences across a continuum of care, in all places", and its company purpose statement is: "Building lifetime relationships for long-term recovery." Its values are to: "Serve with integrity, provide value for all stakeholders, empower people, strive for excellence and promote healing with compassion."

FRN operates in five main locations: Its headquarters (including top officers, support functions and our call center, located in the Nashville area), three treatment facilities that offer primarily residential/inpatient care but also intensive outpatient care (The Canyon in Malibu, Michael's House in Palm Springs and La Paloma in Memphis), and one intensive outpatient treatment center (Roswell Outpatient in Atlanta). One of FRN's quality goals is to provide consistently high levels of treatment and experiences at all locations. Another goal is to provide superior experiences for all key stakeholders, which includes patients (whether Inpatient/Residential or Intensive Outpatient), patient families, alumni, referral sources and staff members.

FRN is known for its Dual Diagnosis approach, which has been proven by research to be extraordinarily effective. FRN's Dual Diagnosis approach includes integrating psychosocial care (such as motivational interventions) and pharmacological treatments, 12-step components, health and wellness components and a multi-disciplinary team approach. All of these elements of the Dual Diagnosis approach are important, but a key piece is the use of multi-disciplinary teams, which link treatment with FRN's quality improvement efforts. Each week, treatment facility staff members - including psychiatrists, medical staff, therapists, residential counselors, administrators and office managers - meet to discuss each patient individually. These meetings ensure that everyone understands each patient's individual needs and treatment plan. This is vital to "promoting healing with compassion" because it allows FRN to treat each patient's unique situation and



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readiness for change while still maintaining consistency of treatment. FRN's willingness to be "patient-centered" rather than "program-driven" is part of what makes its patients successful, and it is supported by research which has found that good relationships are more important than technical procedures to positive outcomes.

**FRN's Patient-Centered Care Initiative Took Place in Four Phases**

FRN's CEO (Michael Cartwright), COO (Rob Waggener) and Board committed to improving their patient experiences. They knew from their reading that providing consistently outstanding customer experiences would lead to two benefits: (1) increased customer satisfaction and recovery and (2) increased revenues arising from more recommendations. So they conducted a "mystery shop", using an intern to check into the facilities as a patient and report his experiences. This convinced FRN leaders that they should improve patient experiences and outcomes. Because the CEO and COO knew this was a huge undertaking and needed to be done right the first time, they hired a quality expert and eight-time Baldrige Quality Award Examiner (Diane Schmalensee of Schmalensee Partners) to design and coordinate the many steps and people in the improvement process.

**Phase 1 – Defining the Challenge**
Almost as soon as Schmalensee Partners began work, the CEO resigned and was replaced by the former COO, Rob Waggener. He continued to lead the effort and was fully committed to its success. From the beginning, he included the CEOs of the treatment facilities in the plans for the project, and they remained engaged throughout.

To define customer needs and determine the scope of work, Diane Schmalensee visited all sites (including the call center and headquarters but excluding the Atlanta site, which did not exist at the time) and conducted 22 focus groups with patients and staff. This required the active support by the facility CEO's, their staff members and Rob Waggener because we interviewed almost 70% of staff members and a large percentage of current patients. She then conducted four telephone focus groups with alumni and two with family members of alumni, followed by seven telephone interviews with referral sources.

Based on this research, Schmalensee Partners identified the major phases of customer contact and recommended that FRN begin its work on improving customer experiences by focusing on the patients. FRN executives agreed that providing great experiences for their patients increase the success of the patients' treatment and also increase family and referral source satisfaction.


**Phase 2 – Turning Customer Needs into Processes**
The next step was to turn patient needs into processes that could be repeated consistently at all locations in order to promote patient satisfaction with their experiences and maximize their recovery rates. This involved writing the first draft of a detailed Process Manual that described, phase by phase, exactly what FRN had to do to meet the needs of patients, alumni, family and referral sources. This manual also specified for each of the phases which of the key staff groups (Medical, Residential Counselors, Therapists, Call Center, Intake, Food/Housekeeping/Grounds, Business Office Managers, Administrative and Top Executives) would conduct the procedural steps.

Schmalensee Partners and Rob Waggener realized they needed staff input to understand how work was currently being done at each location (which often differed from location to location) as well as feedback about how the work should ideally be done. So, they created a series of cross-functional and cross-location teams to work with Diane. These teams, which were called Patient Touch Point Teams, met by phone (usually with the consultant) to agree on specific best practices. The teams included: Dual Diagnosis, Medical, Admit/Intake, Documentation (focusing on Patient and Family Handbooks as well as required admission, medical, treatment, discharge and financial documents), Pre-Admit, Discharge and others. In cases where only one function was involved in the process (such as the call center, alumni relations, research and IT), Diane met with representatives of those functions to identify best practices. Over 60 people (or about 25% of the FRN staff members) participated.

As these team and staff meetings took place, the Process Manual evolved. After each draft, the changes were shared with the FRN Quality Improvement Team at headquarters and with the team that recommended the changes so that they could make final corrections and learn what was expected of them. Because this was an iterative, gradual process, changes in operating procedures began to happen each month as staff members were able to put their recommendations into action. In cases where the processes were very new or required support and resources from the top (as was the case with creating standardized documents and then putting them on a shared intranet system), the CEO always provided the resources and communications to enable the changes to happen.

In addition, Schmalensee Partners and FRN staff drafted Patient and Family Handbooks. Their work on processes revealed that communications are a very important part of satisfaction with FRN, so they wanted to have materials for the patients and families that were as clear and helpful as possible. A key element of these communications was information for arriving patients and families about what to bring to and expect at the treatment centers and how FRN's Dual Diagnosis approach would benefit them.

Because the Dual Diagnosis approach involves meeting each patient where they are, adapting to their stage of readiness to change, and treatment with compassion, one of the biggest challenges was how to individualize treatment and still appear consistent (which is important to patients). FRN had behavioral rules of thumb, which defined Treatment Levels with their accompanying milestones and increasing privileges, and the challenge was to respect individual needs (such as the need for patients with legal issues, employees or young children to interact with the outside world) while still appearing fair to patients who may have been in treatment longer. As a result of feedback from staff and patients, Diane and FRN staff revised FRN's description of its Treatment Levels and privileges to specifically mention that they are guidelines that are adapted to each patient's best interests.

**Phase 3 – Pilot Test and Further Improvements**

After several months we were ready to conduct our one week pilot test. We chose The Canyon as the test site because it was the smallest and had the most demanding patients and highest price point. Diane Schmalensee went on site to see whether work was being done in accordance with the new processes. (The Canyon staff knew about the new processes because the Process Manual was shared with them as it went through its changes and because many staff members from The Canyon participated on various Touch Point Teams.) She determined what new internal processes had been adopted to implement the Process Manual's steps, and she conducted extensive focus groups and individual interviews with the patients, staff members, and family members to learn what they thought was going well, what needed to be improved, and their reactions to the Patient and Family Handbooks and other materials.

The Pilot Test revealed that there was still more room to improve before rolling out our processes and materials system-wide. Some of the things we addressed included:

- **Handbooks:** Family members told us how to improve their handbooks and the family weekends. Patients told us that they didn't understand some sections. Staff told us that they wanted to have copies of the handbooks as part of their orientation training and ongoing training so that they knew what patients and families expected. Finally, we customized the handbooks for each location, using photos, maps and lists of recreational options to conform to site differences.
- **Processes:** We identified some new best practices and found some other processes that needed clarification. We found that some processes that worked well in a small setting like The Canyon had to be handled in a different way at our largest facility (La Paloma). And, we found that differences in state regulations affected how prescriptions and medications were handled. So, we revised the Process Manual again.
- **More standardization of documents**: We found that there were some differences in the documents used across sites, such as which documents to give to patients at discharge. These needed to be further standardized by the FRN QI Team.
- **Sober Fun:** One of the challenges we found was that we were so focused on treatment plans and schedules that we did not provide as much Sober Fun for patients as they wanted and felt would increase their willingness to recover. So we talked to staff members about solutions to this and added them to the Process Manual. We also specified that a Sober Fun question would be added to the weekly patient questionnaire and would be discussed regularly by the QI Teams.
- **Patient surveys**: Although we believed prior to the Pilot that online patient surveys would be efficient, we had to change our plans and use paper questionnaires for each patient. The treatment center staff then entered the data or provided the questionnaires to the corporate Research Group staff for data entry and analysis.
- **Training for staff**: Although we learned that the weekly staff meetings and patient reviews were working very effectively, we also learned that staff members wanted more training. For instance, they wanted to be trained on the materials in the Patient and Family Handbooks and on their particular roles and steps in creating excellent patient experiences. At the same time, they told us their jobs were already challenging and that they would welcome anything that made their work easier and more consistent.

**Phase 4- Roll Out of Patient-Centered Care (PCC)**

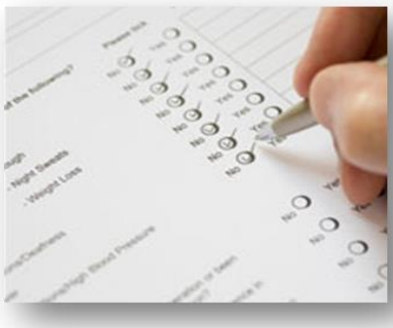
After making these changes, we were ready for the system-wide rollout began planning how to train all staff members.
We knew that we needed to train all of our staff members in a way that would engage their hearts as well as their minds, so we made several important decisions.

- First, the CEO (Rob Waggener) agreed that he would be present and lead off ALL the training programs. Dr. Alan Downs, FRN's Clinical Advisor and an acclaimed author and speaker, worked with Diane Schmalensee to make the training materials as persuasive and appealing as possible. He and Diane helped Rob deliver all training sessions except at the new and relatively small Roswell facility in Atlanta, which Rob delivered by himself.
- Second, we determined that the business-like term, "Customer Experience Management," would not appeal to FRN staff members, who are highly empathetic people-people. So, we called our work "Patient-Centered Care" (PCC) and devoted a large part of the training to explaining how PCC was evidence-based and would benefit their patients as well as them individually.

- Third, we made the training mandatory for all staff members. This involved offering the two-hour course three times (to make it accessible for all shifts) at ALL locations (including headquarters and the three treatment facilities) and paying those who were not scheduled to work to come for the training.

The PCC training was delivered to all staff in one intense week. The FRN staff members were enthusiastic, and we felt terrific about how everyone from top to bottom of the organization was involved and aligned.

**Maintaining Momentum Is Important**



We knew when we rolled out our Patient-Centered Care program that our biggest challenge would be sustaining the staff enthusiasm and conformance to our PCC processes. Over time, without continuous focus, even the best-received initiatives can fade away. In order to maintain this momentum and ensure that the training was understood and put into practice, Schmalensee Partners and the FRN Research Group created several measures of the success of PCC.

**Patient Satisfaction Surveys**

- **Admission Survey:** This is filled out by all new patients as soon as they are sober enough to do so. This has an 81% response rate.
- **Weekly Survey:** This is filled out by all continuing patients as long as they are in residence. Each facility administers the survey at the same time each week (usually at a weekly patient/staff meeting) although the exact times differ from facility to facility. Results are reported weekly and then rolled up monthly for each facility. In the monthly reports, CEOs can see how the facilities are doing compared to others. This has a 70% response rate.
- **Discharge Survey:** This is filled out a day or two before departure by patients who are discharging. Patients who discharge ACA are given an abbreviated version that is administered during a conversation with a staff person. Results are reported monthly. This has a 75% response rate.
- **Post-Discharge Survey:** This is administered by the Research Group 30, 180 and 365 days after discharge. While the focus is on the patients' continued recovery, the 30-day post-discharge survey also captures feedback about satisfaction. The response rate is 64%.

**Other Satisfaction Surveys**

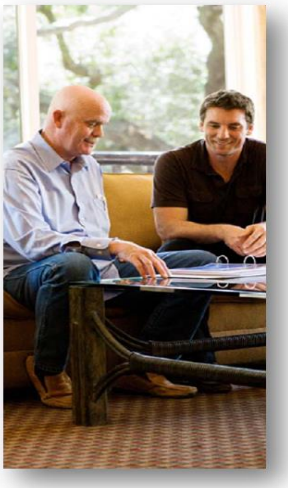
- **Family Weekend Surveys:** These are handed out in paper form to all family members attending the weekends. The questionnaire is standardized except that it permits each facility to add questions at the end about the specifics of its agenda.
- **Family Satisfaction after Discharge:** These are sent to family members just after the patient has been discharged. They can complete the surveys online or by mail.
- **Referral Sources:** This annual survey allows referral sources to reply online or in paper version if they prefer.

Diane Schmalensee and the head of the Research Group (John Seiters) worked on the analysis and reporting plans together. The weekly patient survey results are prepared promptly and sent to the heads of each treatment center and to corporate officers. For instance, one week, one facility saw a dip in satisfaction. When this was pointed out, the CEO shared that there had been a fire and what steps were taken to prevent and handle emergencies like this in the future. Then, each month, Research prepares an aggregated monthly report that shows the results for all facilities. This allows the facilities to see where they have common issues or could learn from each other about best practices. It also allows Rob Waggener to acknowledge especially good results.

In addition to this kind of straightforward reporting of results, the Research Group conducts more sophisticated analyses to look behind the data for cause and effect relationships. For instance, a time-tracking analysis of

the way average patient satisfaction changes over week of stay showed that satisfaction was higher at admission and discharge than during the middle weeks of their stay. This led to a discussion of how to enhance the experience of the middle weeks.

The most important analyses are those that help us prioritize the future opportunities for improvement. These "driver" analyses combine what is important to patients (based not on stated levels of importance but on how closely the scores on specific attributes drive the overall satisfaction scores) with the scores we receive on each of the specific attributes. The attributes with the lowest ratings have the most room to improve. This permits FRN to work on the highest-priority issues.

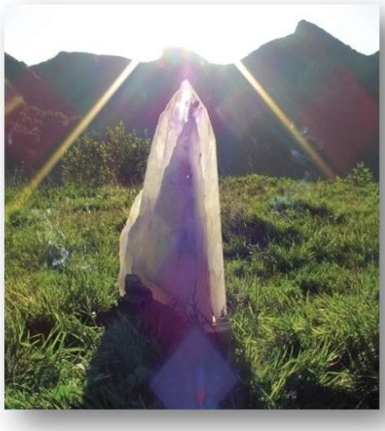


**Top-Level Oversight and Accountability**

Responsibility for continued progress on PCC rests with Rob Waggener and others in the C-suite, with the CEOs of each treatment facility, and with a designated PCC Coordinator. PCC is a routine agenda item for the FRN QI Team and for all senior leadership team meetings. For example, they review and discuss opportunities for improvement identified by the monthly satisfaction survey reports. And, the PCC Coordinator suggests and coordinates the improvement activities.

Some examples of on-going improvements and additions to PCC efforts include: Creating Alumni and Referral Source Advisory Groups, ongoing training, an Employee Recognition and Suggestion and a Baldrige-like assessment of the overall FRN management system to look for addition opportunities for improvement.

**The Award-Winning Results Are Impressive**



FRN's Patient-Centered Care work won the James W. West Quality Improvement Award from the National Association of Addiction Treatment Providers. This high honor is given to the organization that shows a well-executed approach and proven results for its quality improvement efforts.

Our initial PCC goals were to benefit to our patients (increased satisfaction and longer length of stay or recovery time) as well as to boost FRN's bottom line (increased daily census). We achieved these goals plus the unexpected bonus of retaining more of our valued staff members (by decreasing turnover).

When we compared the six months before the PCC roll out with the six months after the roll out, we found that:

- Patient satisfaction rose from 3.8 to 4.2 (beating our goal of 4.0 out of 5.0) – Chart 1
- Willingness to recommend, which had been declining slightly before PCC was introduced, began to climb again – Charts 2 and 3
- Average length of stay increased from 29.4 to 31.1, or an increase of 1.7 days – Chart 4
- The average daily census, which had been declining slightly before PCC was introduced, began to climb again – Charts 5 and 6. The most recent results show an occupancy rate of well over 90%!
- Our staff turnover fell from 4.0% to 2.9% - Chart 7 – which had a positive impact on our costs as well as on our service.

**Chart 1**

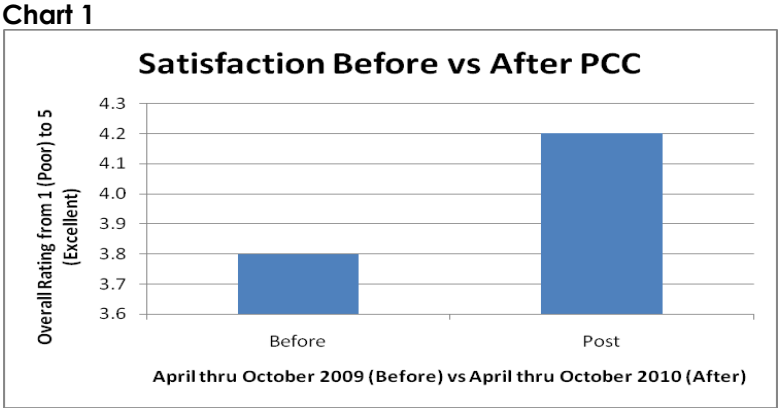



**Chart 2**

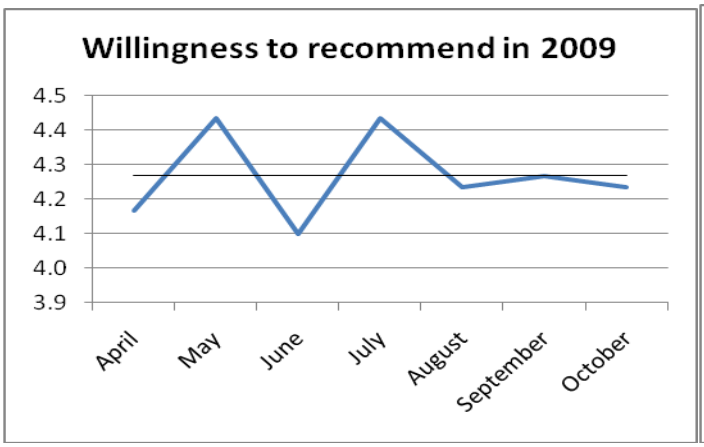



**Chart 3**

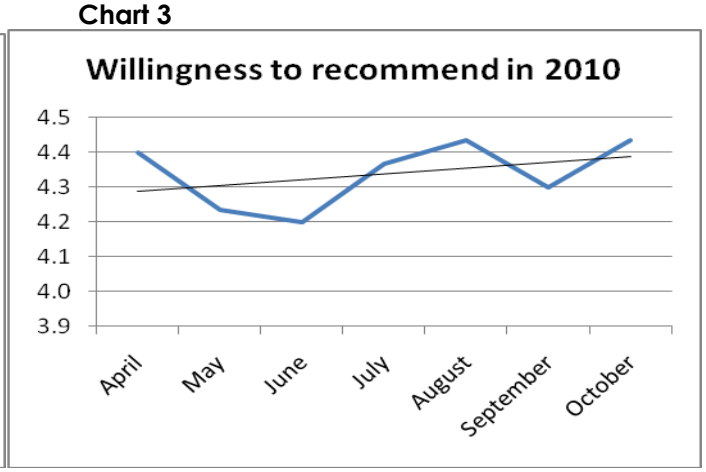





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**Chart 4**

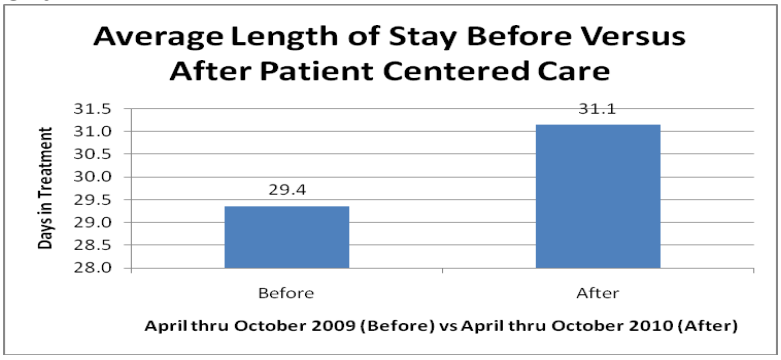
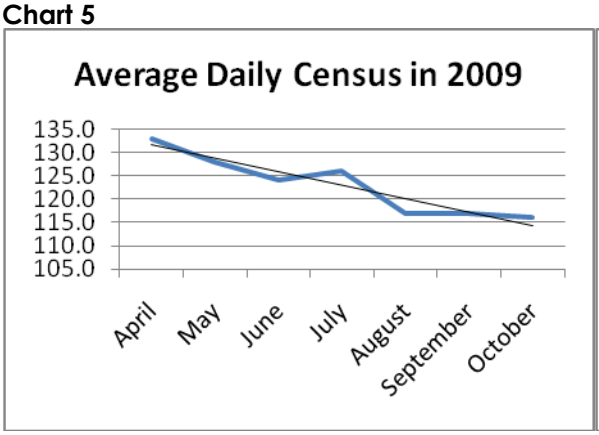



**Chart 5**

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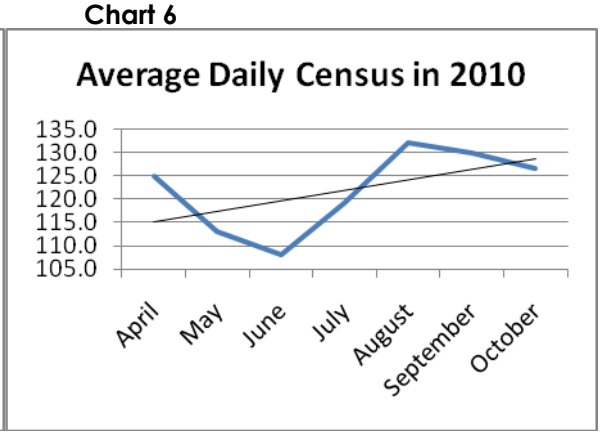
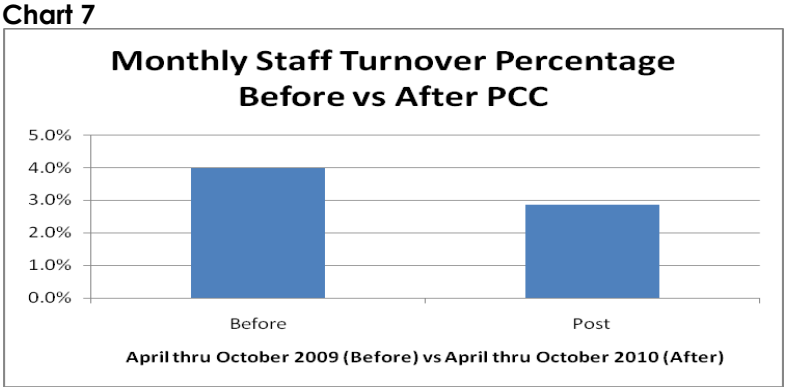



**Chart 7**



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