The Day 91 Gap: The Business Case for Staying in Touch

Alumni management is the right thing to do for the people you've treated. It's also the most reliable growth strategy you're not running.

By Colton Morgan and Travis Moon, Kipu Health

Choosing the right EMR is half the decision. The other half is the move itself.

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Discharge is the most dangerous day in treatment

At the end of any treatment program, a client has spent weeks inside the tightest structure of their adult life: every meal at a set time, every feeling named out loud in group, every hard moment witnessed by people who understood it. They have built the closest relationships they've had since childhood. Then they pack a bag, sign a packet, and get dropped into the exact environment they originally came from.

We have watched that morning play out hundreds of times, and the part that goes unspoken is the grief. Along with the structure and the accountability, the person leaving has just lost the most intimate connections they have had in years, and they are carrying that loss straight back into the place where the problem began. The facility that worked so hard to build those bonds has, without meaning to, compounded the problem it was treating.

That grief is predictable, and so is what follows it. The literature on substance use disorder has consistently shown that roughly 50 to 70% of people leaving addiction treatment resume use within the first year, most of them inside the first 30 to 90 days[1] In the facilities we have run and advised, the operating number is blunter: about 80% of clients regress in symptomology within a year of discharge, even at strong programs.

None of that is a verdict on the program or the person. Addiction is a chronic, progressive disease, and has been officially classified as such since the 1980s. What should trouble a leadership team is the fact that too often, the moment a client walks out the door is the moment the data stops, the relationship stops, and the only way anyone learns how that person is doing is if they call admissions themselves, or someone else's admissions. The window after discharge is where a treatment organization does some of its most important clinical work and, not coincidentally, where it either keeps or loses the patients it already earned.

Most of your admissions have been here before

In the federal Treatment Episode Data Set for 2021, among the 1.36 million admissions with a known treatment history, about 66% involved at least one prior episode. One in five admissions had been through treatment once before, and nearly one in five had been through it five or more times.[2]



That figure counts admissions rather than people, and it covers only publicly funded facilities, so it isn't a precise return rate for your discharges. But the person-level research points the same direction. Michael Dennis and Christy Scott, whose four-year randomized trial is the most rigorous longitudinal work in this area, note that three to four treatment admissions are usually needed before half of people with chronic substance use disorder can sustain a year of abstinence.[3]

Put those facts together and the shape of the job changes. Treatment was never a 30-day thing, or even a 90-day thing; for this population it is a lifelong thing, and relapse is one of its expected chapters. A program can't prevent every relapse, so its real task becomes being the obvious, trusted place a person turns when relapse happens, and shortening the time between the slip and the phone call. The organizations that take alumni seriously treat it as a level of care with its own staff, its own protocol, and its own numbers, the same way they treat detox or IOP.

What a real alumni community does for the person

The closest research analogue to a well-run alumni function is the Recovery Management Checkup model: scheduled follow-up assessments, motivational outreach when someone is struggling, and a direct path back into treatment. In Dennis and Scott's four-year trial of 446 adults with chronic SUD, people who received those checkups were far more likely to return to treatment when they needed it (70% versus 51% in the control group), re-entered sooner and more often, spent fewer months with active substance problems (89 versus 126), and logged more total days abstinent (1,026 versus 932).[3] A separate trial with 480 women released from jail found checkups cut the time to re-entry from 90 days to 60.[4]

Across the wider continuing-care literature, James McKay's review of 19 randomized trials found modest but reliable benefits, with the strongest results coming from programs that ran longer and worked harder to keep people engaged.[5] Passive aftercare, like newsletters and annual reunions, has not been shown to move outcomes as effectively as active, recurring, personal contact has.

What the research measures in abstinent days, people in recovery describe in plainer terms, and the descriptions tend to be small and specific. They talk about having somewhere to be on Thursday night, about the text that arrived from someone who sat next to them in group, about being asked to set up chairs for the weekly meeting and realizing, somewhere around the third week, that the room would be short a person if they didn't show. What they are describing is the experience of being part of something bigger than themselves, something that asks more of them than they thought they could give and then proves them wrong.

That experience doesn't happen by accident, and the programs that produce it reliably share a few design choices. The weekly meeting happens in the evening, when working people can attend, and it is run by alumni rather than by whichever case manager drew the short straw, because people support what they create. Service positions carry real responsibility, and quarterly events make long-term recovery look like something worth showing up for. The effect of that structure is measurable: across the facilities we work with, clients who take a service position within 30 days of discharge are 40% more likely to stay engaged in alumni services over the following year.

For the person on the other side of discharge, this is the difference between losing the most supportive community they've ever known or simply changing their status within it.



What it does for the business

Most behavioral health organizations spend heavily to fill a bed. Cost per acquisition for a single admission commonly runs from $2,500 to $8,500, and in some California markets past $12,000, on marketing budgets that reach into the tens of thousands a month. Every one of those admissions comes with a built-in likelihood of needing care again. Whether that care happens at your facility or at a competitor's is largely determined by what you did in the months after discharge.

Facilities in general see 10 to 15% of admissions come from readmissions and alumni referrals combined. Treatment Professionals in Alumni Services (TPAS), the field's largest alumni-services organization, puts the healthy range at 25 to 40%, a figure we have since verified against roughly 230 facilities we measure directly. The best programs sit squarely in that band.

Consider that math at a mid-sized operator with 500 treatment episodes a year and $10,000 in reimbursement per episode. Moving alumni-sourced admissions from 15% to 25% means 50 additional admits, or $500,000 in annual reimbursement, from people the organization already knows, already has a chart for, and never had to buy a click to reach. At residential rates closer to $18,000 a month, the same ten points clear a million dollars.

Touchstone Recovery Center in Fresno, California, offers the real-world version. In 2024, 21.3% of Touchstone's admissions came from alumni referrals or readmissions. After building a structured alumni program, that share reached 33.7% in 2025 on higher total volume. The 39 additional admits, at roughly $20,000 in reimbursement each, produced a first-year return of about $740,000.

Two honest caveats belong here. First, the peer-reviewed economics measure cost-effectiveness, and no published study has measured provider revenue. In the published analysis of the Dennis and Scott trial, recovery checkups cost about $2,184 per participant over four years and bought an additional abstinent day for $23.38; once societal costs like crime and healthcare were counted, the intervention was both cheaper and more effective than monitoring alone.[6] That is strong evidence that structured follow-up is worth paying for, but it isn't a guarantee of margin. Second, a former client who gets appropriate care somewhere else has still succeeded clinically. The real loss, for the organization and for the person, is when someone exits care entirely and nobody notices.



That last point is where the business case and the human case stop being separate arguments. If 80% of your patients are going to struggle again within a year, the question every leadership team must sit with is how much of that 80% you are content to let go, and whether 15% was ever really an acceptable answer.



Why most alumni programs underdeliver

Nearly every organization we talk to already has an alumni program. Almost 88% of substance use treatment facilities tell SAMHSA they offer aftercare or continuing care, and about 73% say they follow up on outcomes after discharge.[7] On paper, the field looks covered. In the room, it looks different.

When we sit down with a program and ask how many people came to last week's alumni meeting, the answer is usually around eight, and programs that consider themselves strong will proudly report twenty. Measured against annual discharges, that puts the engagement rate at most facilities under 5%. The benchmark our consulting team holds clients to is 30% of annual treatment episodes actively participating in alumni services at any given time, through the weekly meeting, the events, and the service positions. Most programs are an order of magnitude short, and don't know it because nobody is tracking it.

The second failure is structural, and it has a face. The alumni coordinator at a typical facility is handed a list of names and a phone and told to start calling people who haven't heard from the program in months. There is no community for those calls to connect anyone to, so the work has no visible result. By our count, these professionals have the highest turnover rate in behavioral health, with most lasting three to four months before burning out, often right as they've learned the job. In programs that can't afford a coordinator, the work then falls to admissions, where it competes with everything else and loses. When it's everybody's job, it's nobody's job.

The third failure is the one technology vendors, ours included, have to be honest about. Software cannot build a fellowship that doesn't exist. Facilities that buy an alumni app and point it at a dormant community get single-digit adoption and conclude that alumni technology doesn't work. Technology can only accelerate something already alive.

What it takes to do it well

The programs that reach the healthy range share a sequence more than a secret. Each of the four moves below depends on the one before it, which is why organizations that jump straight to the technology, or straight to hiring a coordinator, so often end up with a well-funded program and an empty room. Taken in order, they turn alumni from a line item into a level of care.

01

Start alumni on the day of intake.

By the time someone is standing at the door with their belongings, the window for introducing them to an alumni community has mostly closed. They are absorbing an enormous amount of information and managing the fear of re-entry, and a Thursday meeting time will lose to everything else competing for their attention. Nolan Birchette, Touchstone's COO, onboards every client to the alumni community while they are still in outpatient care. "They know exactly what they're getting into," he says. "It's already familiar. They've been a part of it." Graduation then reads as a change in status within a community the person already belongs to.

02

Build the community before you buy anything.

Our team now writes a facility-specific playbook and activates the community, with its weekly meeting, service structure, and event calendar, before deploying any software. That sequence took our activation rate on post-treatment outcomes from 21% to 47% across the facilities we serve, against a field norm under 10%. Roughly 70% of the result comes from the fellowship, and the technology does the other 30.

03

Make the technology belong to the facility and let it listen.

An app that carries the facility's own name and colors keeps the former client's relationship with the place that treated them, which is where that loyalty already lives. Inside it, the people from their cohort are a directory away, milestones get celebrated by everyone who shared the room, and the scheduled assessments (PHQ-9, GAD-7, BAM) become something people are nudged and rewarded to complete. The part that matters most to a facility is what happens when one of those assessments crosses a threshold for suicidality or symptom regression: a critical alert lands with admissions or clinical staff, in the CRM or inbox they already live in, and someone picks up the phone while there is still time to help.

04

Give the coordinator a job a person should do.

With assessments, reminders, event scheduling, and outcomes collection handled by the system, the alumni professional's day shifts to the work that needs a human: sitting with people, planning events, connecting a nervous new graduate to someone six months ahead of them. The role stops being a call center of one. Birchette's read on his own program is short: "Our alumni program is fun. It's fun to work in."



The next right thing

Long before either of us worked in treatment, a phrase from the recovery community stuck: do the next right thing, and take care of people when nobody is looking. It turns out to be the most reliable growth strategy in behavioral health as well, because the population you serve will need you again, and the organizations that stay present are the ones they come back to.

No matter what you do, first ask yourself what percentage of your admissions came from readmissions and alumni referrals last month. If the answer is under 25%, or if you don't know, you have found the biggest gap in your continuum of care, and the least expensive one to close.

Kipu's Team Recovery division activates alumni communities, builds the facility-branded technology that sustains them, and routes post-discharge outcomes and critical alerts directly into the clinical record.

If you'd like to see what that looks like against your own numbers

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About the authors

Colton Morgan serves as VP of Alumni Services at Kipu Health, bringing extensive experience in behavioral health, recovery support, and alumni engagement. He previously co-founded Team Recovery, where he served as VP before its acquisition by Kipu. Earlier in his career, Colton served as Director of IOP, Sober Living, and Alumni Services for an all-men's 12-step treatment program. Outside of work, he enjoys spending time with his wife and kids, playing soccer, and reading.



Travis Moon, Editor-In-Chief, leads thought leadership and content strategy at Kipu Health, the technology partner for behavioral health and addiction service providers. He works closely with operators across the country on the questions of how to scale durably, what good capital looks like, and how technology should support care without distracting from it.



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Contact us
Phone: 561 349 5910
Email: sales@kipuhealth.com

Corporate address
2332 Galiano St 2nd floor,
Coral Gables, FL 33134

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