



IAFF Center of Excellence for Behavioral Health Treatment and Recovery | 855.900.8437

IAFF Center of Excellence for Behavioral Health Treatment and Recovery Discharge and Aftercare Protocol

The following discharge process was developed at the IAFF Center of Excellence Advisory Committee meeting on December 12th, 2017 and amended by the clinical subcommittee on March 7th, 2018, to include a process for outcome measurement and aftercare support in the 18-month post discharge timeframe:

UPON DISCHARGE

Discharge Plan

Upon discharge, the patient will receive a discharge plan that utilizes the Wellness Recovery Action Plan (WRAP) model and includes the minimum following components, including the first appointment within 7 days whenever possible:

- Referral to clinically indicated level of care (Intensive outpatient or outpatient)
- Individual therapist appointment
- Psychiatrist/ prescriber appointment if applicable
- Primary care appointment
- List of local resources for self-help support (AA, NA, SMART Recovery groups)

The case manager/ discharge planner will ask patient to sign ROI and COE will fax/ email discharge summary (including any recommendations for weekly urinalysis) to accepting treatment provider(s).

Prior to discharge, the case manager/ discharge planner will attempt to make contact with the patient's Recovery Mentor (peer/ friend/ family member) identified upon admission to support the member going forward.

IAFF Center of Excellence Discharge Survey

Within 72 hours prior to patient's discharge, the Primary Therapist or Center of Excellence Research Assistant (RA) will ensure the patient completes the IAFF Center of Excellence Discharge Survey, which includes several standardized clinical measurements intended to measure changes in symptoms compared to admission.

Introduction to the Research Assistant

Prior to the patient's discharge, the Primary Therapist is responsible for physically introducing their patient to the RA. The RA may also be called "Outreach Specialist".

The RA will then briefly explain to the patient the 18-month outreach process and the purpose behind it, to provide ongoing recovery support and measure treatment outcomes. The RA will obtain the patient's expressed and written consent to be contacted by phone and email for this purpose. Patients should be encouraged to participate in 18-month outreach process, but may decline to do so. This consent form will be scanned into the patient's chart and the original copy will be kept by the RA. The patient may choose to provide a "back-up" contact, typically the patient's identified Recovery Mentor.

If the RA is unsuccessful in reaching the patient after 3 attempts and the patient has not completed the online survey, the RA has permission to contact the "back-up" contact, as means to reach the patient. Providing a back-up contact is voluntary and the patient can decline.

AFTERCARE SUPPORT (0-18 months)

The RA is responsible for ongoing phone and email contact with the patient after their discharge. The electronic survey administered upon admission and discharge will be expanded to include a customized questions on related to aftercare compliance, treatment recidivism, social, and occupational functioning.

At the designated post-discharge intervals below, the electronic survey will be emailed to the patient, followed by a brief wellness check-in phone call by the RA. The purpose of this call will be to 1) thank the patient for completing the survey, or 2) encourage them to complete the survey, and 3) provide general encouragement on their progress after reviewing survey results. If a patient conveys high distress or immediate safety risks on the phone call, the COE Clinical Director will be notified immediately.

The online survey will be sent, followed by the wellness check-in call for each patient at the following intervals:

- 1 month
- 2 months
- 3 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months