Discharge Readiness Tip Sheet

Discharge Planning Process

- Discharge planning is not a one-time event. It requires collaboration with the entire treatment team including providers, member, family, and additional supports.
- Discharge planning should begin on the first day of treatment and continue to be assessed and frequently discussed with the member.
- The discharge plan should be written clearly and agreed to by the member.
- Titrating services, which is the continuous appraisal of current needs, will also help identify when discharge is appropriate.
- Discharge should occur when: All the treatment goals and needs have been addressed, **OR** member has reached their baseline, **OR** the member has reached the maximum benefit of services for that level of care.

Step-down Planning Process

- Members should begin their step-down plan when they have shown improvement and are meeting their goals and objectives.
- Members should also have been compliant with treatment recommendations and are no longer severely functionally impaired.
- To prepare for transition, encourage the use of the skills learned in treatment:
  - Self-care reminders
  - Coping skills
  - Medication regiments
  - Accessing and utilizing support systems
- Recommend potential referrals to connect the member to natural supports prior to discharge to allow practice using services such as:
  - AA/NA and sponsors
  - Senior centers or respite
  - Employment programs
  - Spiritual or religious supports
  - Community mentors or peer support specialists
  - Sports/hobby groups
  - Online supports (e.g., apps, online groups)
- Discharge plans and instructions on how to return for care if needed should be provided to the member and openly discussed. They should be informed that they can resume services if needed.

Consider Family Readiness

- Refer family to parent education/training, if needed.
- Equip the family with tools and steps to take if the need for treatment arises again.
- Ensure the family's inclusion on discharge planning.