Discharge Readiness Tip Sheet

Discharge Planning Process

- Discharge Planning is not a onetime event. It includes collaboration with provider, member, family, integrated care partners, and supports
- Discharge Planning should begin on the first day of treatment and continue to be an ongoing assessment
- Discharge Plan should be written clearly and agreed by the member
- Titrating services, which is the continual appraisal of current needs, also helps identify when discharge is appropriate
- When all treatment goals and needs have been addressed, **OR** the member has reached their baseline, it is time for discharge

Transition Planning Process

- Member has been engaged in titration of services, has shown improvement, and is meeting their goals and objectives
- Member has been compliant with treatment recommendations
- Member is no longer severely functionally impaired
- To prepare for transition, please encourage the use of the skills learned in treatment:
    - Self-care reminders
    - Coping skills
    - Medication regiments
    - Support systems
- Recommend referrals to connect the member to natural supports after discharge
    - AA/NA
    - Senior centers
    - Community mentors
    - Healthcare specialists/Medication management
    - Sports/hobby groups
    - Online support (for example, apps, groups)
- Discharge Plan and instructions on how to return for care if needed should be provided to member

Consider Family Readiness

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

Please refer to the microlearning training titled Discharge Planning for references

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