Training Handout: Discharge Planning Process

Purpose

This case example illustrates how discharge planning begins at intake and evolves throughout treatment based on the member's progress, supports, and changing needs.

Member Scenario

Presenting Situation

A 34-year-old woman is engaged in behavioral health treatment for co-occurring Alcohol Use Disorder, Generalized Anxiety Disorder, and Major Depressive Disorder. She also manages diabetes through primary care.

Due to concerns related to substance use and stability, her child was removed from the home and is currently in the care of the member's mother. The member is working toward reunification while stabilizing recovery, mental health symptoms, and medical needs.

Phase 1: Discharge Planning Begins at Intake

Initial Assessments and Collaboration

Following intake and comprehensive assessments, the provider and member collaboratively identified clear, measurable discharge criteria. Discharge readiness was defined as:

- Regaining custody of her daughter
- Establishing a transportation plan until she was able to drive again
- Reducing anxiety and depression from a 9/10 to approximately a 3/10 on most days
- Demonstrating the ability to effectively use coping skills

Early Identification of Natural Supports

At intake, natural supports were identified and incorporated into the discharge plan, including:

- Support from her mother
- Participation in Alcoholics Anonymous (AA)
- Ongoing support from her sponsor

These supports helped inform expectations for treatment focus and anticipated duration.

Phase 2: Ongoing Review and Plan Evolution

Revisiting the Discharge Plan

As treatment progressed, the discharge plan was intentionally reviewed and updated during ongoing discussions with the member.

Expansion of Social and Community Supports

The member strengthened her support network by:

- Returning to church on a weekly basis
- Joining a moms' group to increase connection and peer support
- Developing supportive relationships with two neighbors who assisted with transportation and childcare

Each of these changes was documented and reflected in the discharge plan.

Phase 3: Clinical Progress and Treatment Adjustments

Medication Management and Symptom Monitoring

The member began working with a psychiatrist for medication management related to anxiety. She attended follow-up appointments to monitor effectiveness, and progress was incorporated into discharge planning discussions.

Adjusting Intensity and Timeline of Services

Initially, the provider anticipated approximately 12 months of treatment. As the member's symptoms improved more quickly than expected and her support network expanded, the provider:

- Adjusted service frequency
- Updated projected timelines for achieving treatment plan goals

Key Takeaways for Providers

- Discharge planning begins at intake, not at the end of treatment
- Discharge criteria should be clear, measurable, and collaboratively defined
- Natural and community supports are critical components of discharge planning
- Plans should be revisited and updated as progress, supports, and functioning change
- Discharge planning is a dynamic, ongoing process—not a one-time event